Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

Table of Contents
(Rev. 1557, 05-02-08)

10 - General Information About the Common Working File (CWF) System

(Rev. 1, 10-01-03)

A3-3800, B3-6000

The Common Working File (CWF) is comprised of nine localized databases called Hosts. Hosts maintain total beneficiary claim history and entitlement information for the beneficiaries in their jurisdiction. Each jurisdiction is a network of intermediaries and carriers (Satellites) located in a defined geographic area (sector). Each Satellite within the sector is linked to its Host via telecommunications. The Satellites transmit daily files with claims ready for payment to the Host. The Host returns approvals, rejects, or adjustments and informational trailers daily.

Each beneficiary is assigned to only one Host site. Beneficiaries are assigned to a Host site based on where the beneficiary signs up for their Social Security Administration (SSA) benefits. For example, if a beneficiary signs up for their SSA benefits in Dallas, Texas, the Southwest Host will get the beneficiary. The information the Host site maintains for its beneficiaries is called a CWF Master Record. This record contains complete entitlement, utilization, history, Medicare Secondary Payer (MSP), and Health Maintenance Organization (HMO) data. All Part A and B claims for a beneficiary are processed against this single file prior to claims payment. The record is updated daily with data from adjusted and approved claims.

When a Satellite receives a claim, it processes the claim to the point of payment or denial, using data from its own files and the data on the claim. Prior to payment, the claim is transmitted to the Host site. The Host uses the CWF files to determine the beneficiary's most recent utilization and entitlement status and uses that information to decide whether the claim should be approved for payment. The Host determines whether to accept the claim as submitted, accept the claim with adjustments, or reject the claim for corrective action by the Satellite.

Each Host site is responsible for processing those claims submitted for beneficiaries on its database. These claims are processed through a shared software system supplied to each Host by the CWF Maintenance Contractor (CWFM). Each change made to the CWF software is released to all Host sites in a uniform manner. This software performs consistency and utilization editing on claims for corrective action by the Satellite.

20 - Communication Between Host and Satellite Sites

(Rev. 1, 10-01-03)

A3-3800, B3-6001, B3-6003

The local CWF database for each sector resides at a Host. Each Satellite within the sector is linked to its Host's database. Communication between them is electronic, with claims ready for payment or denial communicated to the Host, and adjustments,

approvals, rejects, and informational trailers returned from the Host via a daily process. The Satellite usually initiates this process. On occasion, the CWF Host will initiate an "unsolicited response" to the Satellite as a result of a new claims action that affects a previously processed claim action.

Each file the Satellite transmits is preceded by a header record and followed by a trailer record. These records indicate the beginning and end of each file. Complete documentation including record formats, can be reviewed and downloaded at the http://cms.csc.com/cwf.

Claims are processed by CWF in the same order that they are received, regardless of the dates on which expenses were incurred. This first-in-first-out method of processing requests for payment facilitates prompt handling of claims.

20.1 - Records the Satellites Transmit to Their Host

(Rev. 1, 10-01-03)

A3-3800.1, B3-6004

20.1.1 - Medicare Secondary Payer (MSP) Maintenance Transaction Record/Fiscal Intermediary (FI) and Carrier MSP Auxiliary File Update Responsibility

(Rev. 1, 10-01-03)

A3-3800.1, B3-6004.2, AB-00-74, AB-02-107

See Chapter 6 of the MSP Manual.

20.1.2 - Claim Records

(Rev. 1, 10-01-03)

A3-3800.1, B3-6004.1

The CWF Claim Record is a record of a claim that the Satellite has processed and is ready for payment or denial. It is submitted in daily files to the Host for approval. The Host clears the claim record through regular CWF consistency edits, MSP consistency edits, regular CWF utilization edits and then MSP utilization edits, in that order, and makes its approval, adjustment or rejection determination. The final determination is returned on a Basic Reply Record. (See §20.2.1.) Claim records can be of the following types:

Part B (Carrier) Claim Record

Carrier bills are input on the HUBC record. Refer to CWF Systems Documentation (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), Record Name: CWF Part B Claim, for the complete record layout and field descriptions.

DMEPOS Claim Record: DMEPOS bills are input on the HUDC record. Refer to CWF Systems Documentation (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), Record Name: CWF Part B and DMEPOS Claim, for the complete record layout and field descriptions.

Inpatient/Skilled Nursing Facility Claim Record: Inpatient hospital and SNF bills are input on the HUIP record. (See http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf for the record format.)

Outpatient Claim Record: Outpatient bills are input on the HUOP record. (See http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf for the record format.)

Home Health Claim Record: Home health bills are input on the HUHH record. (See http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf for the record format.)

Hospice Claim Record: Hospice bills on the HUHC record. (See http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf for the record format.)

20.1.3 - Hospice Notice of Election

(Rev. 1, 10-01-03)

A3-3800.1

Hospice Notices of Election are input on the HUHC record (Type of Bill 81A, 81B, 81C, 81D, 82A, 82B, 82C, or 82D). See http://cms.csc.com/cwf for the record format. Regional Home Health Intermediaries (RHHIs) use the HUHC record described in http://cms.csc.com/cwf for subsequent hospice bills.

20.1.4 - Adjustments to Posted Claims

(Rev. 1, 10-01-03)

A3-3800.1, B3-6004.3

Two actions can be taken on a claim that is already posted to CWF history. These actions are the same whether submitted by a carrier or an FI; however, the codes used are different:

- **Void -** Use a void to cancel original data on the beneficiary database and totally remove the dollar amounts. To void a posted claim, send the claim with the original document control number and a "Full Credit" code (Entry Code 3 for carriers and Action Code 4 for FIs).

- **Change -** Send a full claim with a "Replacement Debit" code (Entry Code 5 for carriers and Action Code 3 for FIs) and the original document control number to make a change to a posted claim. This code is used to change most claims information. The old claim information will be backed out and replaced with the new claim information. The CWF will keep a record of the old claim so that any investigation of the actions taken on the claim will include the fact that there was a replacement action taken.

20.1.5 - Form CMS-382, ESRD Beneficiary Selection

(Rev. 1, 10-01-03)

A3-3644.4

Each Medicare home dialysis beneficiary chooses the method by which Medicare pays for his/her dialysis services. To do this, the beneficiary completes the Beneficiary selection Form CMS-382 and the facility forwards the form to its intermediary. See Chapter 8, §70.1 for information about the ESRD Method Selection process.

20.2 - Records the Host Transmits to its Satellites

(Rev. 1, 10-01-03)

A3-3800.2, B3-6005

20.2.1 - Basic Reply Record

(Rev. 1, 10-01-03)

A3-3800.2, B3-6005.1

When the Host receives each claim or adjustment, it searches the Beneficiary File to find the Beneficiary Record. If the Beneficiary Record is found, the record is processed and a reply record is transmitted to the Satellite. See §20.2.2, for an explanation of the procedure if the Beneficiary Record is not found ("Not in File.")The record type returned by CWF is dictated by the claim record type as follows:

- **Part B/Carrier Basic Reply Record -** Reply record for each CWF Part B/carrier bill (HUBC) processed. Refer to CWF Systems Documentation, Record Name: CWF Part B Basic Reply Record (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), for the complete record layout and field descriptions.

- **DMEPOS Basic Reply Record -** Reply record for each CWF DMEPOS bill (HUDC) processed. Refer to CWF Systems Documentation, Record Name: CWF DMEPOS Claim Response Record (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), for the complete record layout and field descriptions.

- **Inpatient/SNF Bill Basic Reply Record -** Reply record for each Inpatient/SNF bill (HUIP) processed. Refer to CWF Systems Documentation, Record Name: CWF Inpatient/SNF Bill Basic Reply Record (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), for the complete record layout and field descriptions.

- **Outpatient/Home Health**/Inpatient Part B **Bill Basic Reply Record -** Reply record for each Outpatient/Home Health/Inpatient Part B bill (HUOP and HUHH) processed. Refer to CWF Systems Documentation, Record Name: CWF Outpatient/Home Health/Inpatient Part B Bill Basic Reply Record (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), for the complete record layout and field descriptions.

- **NOE/Hospice Bill Basic Reply Record -** Reply record for each Hospice Notice of Election and all subsequent Hospice bills (HUHC) processed. Refer to CWF Systems Documentation, Record Name: CWF NOE/Hospice Bill Basic Reply Record (http://cms.csc.com/cwf/downloads/docs/pdfs/copyxtnl.pdf), for the complete record layout and field descriptions.

Each reply record will contain a disposition code in field 11 that indicates the action taken on the bill by the Host and what action the Satellite should take next.

The following is a list of actions that CWF may take on a claim record. Disposition codes, cross-reference/alpha search/NIF situations, their associated trailers, and bill recycling instructions are also included:

20.2.1.1 - Accepted (as is) for Payment

(Rev. 1, 10-01-03)

The claim record is posted to CWF history as submitted to the Host. The Satellite pays the claim accordingly.

- Disposition code 01.

- **Basic Reply Trailers -** These are informational trailers that contain entitlement, utilization, MSP, or other information, as appropriate, and are returned with the Reply. They give the Satellite the most recent information available about the beneficiary's claim history and other important data. Satellites must use this information to update their own data to improve the accuracy of future claims processing.

- **Return Alerts -** These are sent to the Satellite when CWF believes that there is a potential problem or error in the claim. The presence of an alert indicates that the Satellite should examine the information and make adjustments if necessary.

20.2.1.2 - Adjusted and Then Accepted for Payment

(Rev. 1, 10-01-03)

The deductible and/or payment limitations field(s) on the claim record were in error and CWF recalculated the field(s). The Host posts the record to CWF after these corrections are made. The Satellite must make the same adjustments to its files using information from basic reply Trailers 07 and 11 and pay the claim accordingly. Satellites must not resubmit the claim to CWF.

- Disposition code 02
- Basic Reply Trailers (07 and 11)
- A/B Crossover Alerts

20.2.1.3 - Cancel/Void Claim Accepted

(Rev. 1, 10-01-03)

This action cancels or voids a previously processed claim posted to CWF History. All utilization and deductibles associated with the claim are backed out. The Satellite receives a disposition code informing it that the cancel/void action was accepted.

- Disposition code 03
- Basic Reply Trailers

20.2.1.4 - Rejected

(Rev. 1, 10-01-03)

The claim record contains errors that prevent CWF from posting the claim to history. The claim is returned to the Satellite with codes explaining the errors. The Satellite must correct the CWF Claim Record and resubmit it.

- **Disposition Code ER, UR, CR, or RT, as Appropriate -** There will never be a combination of ER, UR, CR, and RT error codes on the same reply.
- **Consistency Error Codes (ER) -** Consistency edits examine the information on the claim itself. The consistency error codes indicate the errors in consistency found on the claim. These codes are returned on Basic Reply Trailer 08 and can contain up to four consistency error codes. Refer to CWF Systems Documentation, http://cms.csc.com/cwf/downloads/docs/pdfs/editcons.pdf, for a detailed description of these error codes.
- **Utilization Error Codes (UR) -** Utilization edits compare the information on the CWF Claim Record with the information found on the CWF Beneficiary Master

Record. The utilization error codes indicate discrepancies between the CWF Claim Record and the CWF Beneficiary Master Record. Since the CWF Beneficiary Master Record is presumed to be correct, these codes inform the Satellite what corrections it must make. The code is returned on basic reply Trailer 08 and contains only one utilization error code. Refer to CWF Systems Documentation, http://cms.csc.com/cwf/downloads/docs/pdfs/editutil.pdf, for a detailed description of these error codes.

- **A/B Crossover Edits (CR) -** When the Host receives a Part A bill, CWF automatically checks the information in the record against the beneficiary's history files for both Part A and Part B utilization. If there is a conflict (or "crossover") of services, CWF will generate an A/B Crossover error code. These are returned on the reply Trailer 13 and will contain only one A/B crossover error code. Refer to CWF Systems Documentation, http://cms.csc.com/cwf/downloads/docs/pdfs/desclv3b.pdf, for a description of these error codes.

Refer to CWF Systems Documentation, http://cms.csc.com/cwf/downloads/docs/pdfs/editutil.pdf, for detailed descriptions and resolutions of these error codes.

20.2.2 - Not in Host's File (NIF)

(Rev. 1, 10-01-03)

A3-3800.2, B3-6005.2

When the Host receives a claim record from a Satellite, it first searches its beneficiary and cross reference files. If it does not find the beneficiary's record in either place, it searches the Transfer Not in File (TNIF) file. If the record is not found there, the Host puts a response on the reply record in the form of a disposition code 50 or 52, indicating that the Beneficiary Record for which the Satellite submitted a claim record is not located at the Satellite's Host.

The TNIF file contains a record of every beneficiary for whom the Host has received a claim, and whose records are located at another Host. It shows at which Host the beneficiary file resides. If the Beneficiary Record is located at another Host, the original Host checks the out-of-service area response file to see if the claim record response is already waiting there. If there is not a response waiting, the claim is sent to the proper Host for processing. If there is a response, the Host gives that information to the Satellite.

There are many disposition codes that are returned to the Satellite for various NIF situations. Following is a list of codes and actions the Satellite takes in response to each disposition code.

20.2.2.1 - Disposition Code 50 (Not in File)

(Rev. 1, 10-01-03)

Disposition code 50 can come with any of the following seven error codes:

1. With Error Code 5052 - Beneficiary Identification Incorrect - The name and/or claim number shown on the bill is incorrect or claim number is not in file. If the TNIF file does not indicate another Host, the beneficiary's records may not have been assigned to a Host and are still resident at CMS or they were assigned to another Host site and the TNIF File was not updated. When the Host is not sure which is the case, it gives disposition code 50 and Trailer 08 with error code 5052 on the reply to the Satellite. Carriers and FIs verify through inquiry to the Host that the HICN is correct on the bill. If the bill is correct, and the Host HIMR agrees with the reject (no record), carriers and FIs must notify the Host of the error. The Host will contact CMS to determine eligibility.

2. With Error Code 5054 - The Host returns code 50 with Trailer 08 and error code 5054 when an auxiliary indicator is present on the CWF Beneficiary Master Record, but no auxiliary record is found.

- Concurrent with this response to the Satellite, the Host sends a request for transfer to CMS requesting the beneficiary's records from CMS' Master File.

- The carrier or FI must recycle the claim every four working days until an approval, adjustment or reject (AAR) response is received, or 45 working days have passed since receipt of the original code 50.

- The carrier or FI reports through locally established procedures to the Host if 45 days pass with no AR response.

3. With Error Code 5055 - The Host returns code 50 with Trailer 08 and error code 5055 (Beneficiary Blocked at CWF Host and CMS Batch Pending Clerical Update) if CMS must investigate a beneficiary's entitlement because of suspicion of fraud or abuse. The Satellite recycles the claim every 15 working days until otherwise notified.

Definition of Day One for CWF Satellite Recycle - Day one is the day that the Satellite receives the disposition code back from the Host. For example, a Satellite sends the update file to the Host on Monday, April 1, at 10 p.m. The Satellite receives the response file from its Host site at 9 a.m. Tuesday, April 2. Tuesday, April 2, is day one for Satellite recycle.

4. With Error Code 5056 - The Host returns code 50 with Trailer 08 and error code 5056 (Skeleton - No Beneficiary Record on HI Master File) when the HICN involved is for a beneficiary whose date of death is prior to 1975.

- The records for these beneficiaries have been purged from the file.

- Carriers and FIs research the HICN and confirm that the HICN submitted on the claim is correct. If incorrect, it resubmits the claim with the correct HICN.

- If the originally submitted HICN was correct, carriers or FIs refer the case to the RO.

5. With Error Code 5057 - The Host returns disposition code 50 with Trailer 08 and error code 5057 (Skeleton on HI Master File). This indicates that the beneficiary has died.

- There has been no claims activity for six months since date of death, and the beneficiary information is located on the inactive file.

- Carriers and FIs research the HICN and confirm that the HICN submitted on the claim is correct. If incorrect, resubmit the claim with the correct HICN.

- If the originally submitted HICN was correct, the carrier or FI recycles the claim every 15 working days to allow CMS time to retrieve the records.

- After 45 working days have passed with no approval, adjustment, or reject (AAR) response, Satellites contact their RO.

6. With Error Code 5058 - The Host returns disposition code 50 with Trailer 08 and error code 5058 (Blocked). The records have been blocked due to cross-reference activity. There are two numbers for one beneficiary, both of which show claims activity. The information is manually placed under one primary number in one record.

- Satellites recycle the claim every 15 working days to allow time for CMS processing.

- After receiving a second code 58, they contact the RO.

7. With Error Code 5059 - The Host returns this as disposition code 50 and Trailer 08 with error code 5059 (Frozen). Miscellaneous clerical corrections are being made to these beneficiary records.

- Satellites recycle the claim every 15 working days.

- After receiving a second code 59, they contact the RO.

20.2.2.2 - Disposition Code 51 (True Not in File on CMS Batch System)

(Rev. 1557; Issued: 07-18-08; Effective/Implementation Date: 08-18-08)

The Host gives this response with a 08 Trailer and error code 5052. The CMS has performed an alpha search of its records and cannot locate the beneficiary's records. Alpha search is the process of searching for the records based on the first six positions of the surname. All beneficiaries with the same first six letters in their surnames are listed with their HICNs. The system checks for possible matches, including the possibility that

numbers were transposed. This search is performed only if no match is found during the search by HICN.

This code can be given in two forms:

1. With Trailer 01 - Trailer 01 will contain a possible corrected HICN. The carrier or FI investigates the possible HICN and, if it believes the new HICN is for the same beneficiary, it resubmits the claim with the new HICN to the Host. The CWF will respond with the appropriate disposition code and any associated trailers for processing the claim.

2. Without Trailer 01 - This response indicates that after performing the alpha search operation, no match is found against the HICN submitted and CMS records. Since Medicare eligibility cannot be established, contractors shall return the claim to the provider as unprocessable and take the following actions:

- Contractors shall return to provider (RTP) Part A claims. Contractors shall not mail an MSN for these claims.

- Contractors shall return as unprocessable Part B claims. Contractors shall use Reason Code 140 (Patient/Insured health identification number and name do not match). Contractors shall not mail an MSN for these claims.

- *For assigned and* unassigned Part B claims submitted by the beneficiary on the Form CMS-1490S *or Form CMS-1500,* contractors shall *manually return the claim in accordance with Pub.100-04, chapter 1, section 80.3.2 A. "Special Considerations."*

20.2.2.3 - Disposition Code 52 (Beneficiary Record at Another Host)

(Rev. 1, 10-01-03)

- When CMS receives a request for transfer, it searches its Master File to determine if the Beneficiary Record resides at another Host.

- The CMS first searches the record based on the HICN. If a match is found, and the beneficiary has not already been assigned to a Host, CMS sends the records to the requesting Host. After the Host receives the record, it can process the claim from the Satellite on its next cycle.

- If a match is found that indicates the beneficiary has been assigned to another Host, CMS sends the requesting Host a code 52. The requesting Host then sends the claim information to the receiving Host that has the Beneficiary Record.

- The requesting Host will give the processing Satellite a code 52 and Trailer 08 with a 5052 error code.

- The Satellite holds the claim and resends (recycles) it in five working days to see if there is a response waiting.

- If the response is present on the first recycle of the claim, the Satellite finishes processing the claim according to the response.

- If a response is not present, the Satellite receives another disposition code 52 and the claim is sent to the proper Host for processing.

- The Satellite recycles the claim after another five working days, and continues recycling the claim until it receives an approval, adjustment, or reject (AAR) response, or until 45 working days have passed.

- After 45 working days have passed with no AAR response, the Satellite reports the problem to the Host through locally established reporting procedures.

20.2.2.4 - Disposition Code 53 (Record in CMS Alpha Match)

(Rev. 1, 10-01-03)

- If CMS sends a claim to alpha search, it must send a disposition code 53 to the Host. The Host puts a code 53 on its TNIF file.

- The Satellite receives code 53 and Trailer 08 with a 5052 error code on the next recycle of the claim.

- The Satellite must recycle the claim 15 working days after receiving this code.

- If an AAR response is not received after the receipt of the third code 53 for the same claim, the Satellite must deny the claim using the following messages:

  MSN message 5.1: "Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office."

  Remittance remark code MA61: "Did not complete or enter correctly the patient's social security number or health insurance claim number."

20.2.2.5 - Disposition Code 54 (Matched to Cross-referenced HICN)

(Rev. 1, 10-01-03)

- The Host provides the Satellite with disposition code 54 and Trailer 08 with error code 5052 when it discovers a cross-reference number in its own files for the name or number the Satellite submitted. Disposition Code 54 applies only to carrier submitted claims. The possible number and the new full name is returned to the Satellite on Trailers 1 and 10.

- The carrier or FI investigates the information provided and corrects the information on the claim and resends it.
- If the Satellite continues to receive a code 54, it contacts the Host through locally established procedures.

20.2.2.6 - Disposition Code 55 (Personal Characteristic Mismatch)

(Rev. 1557; Issued: 07-18-08; Effective/Implementation Date: 08-18-08)

- The Host provides the Satellite with this disposition code and Trailer 08 with error code 5052 when it discovers a mismatch of name and personal characteristics such as sex or date of birth.

- The Host returns what it believes to be the proper information on Trailer 10. The header portion of the response also contains the corrected sex and birth date, if applicable.

If CWF rejects a claim and sends back disposition code 55 with the 08 trailer containing Error Code 5052 when the beneficiary name does not match the HICN, contractors shall return the claim to the provider as unprocessable and take the following actions:

- Contractors shall return to provider (RTP) Part A claims. Contractors shall not mail an MSN for these claims.

- Contractors shall return as unprocessable Part B claims. Contractors shall use Reason Code 140 (Patient/Insured health identification number and name do not match). Contractors shall not mail an MSN for these claims.

- For *assigned and* unassigned Part B claims submitted by the beneficiary on the Form CMS-1490S *or Form CMS-1500,* contractors shall *manually return the claim in accordance with Pub.100-04, Chapter 1, Section 80.3.2 A. "Special Considerations."*

20.2.3 - MSP Maintenance Response Record

(Rev. 1, 10-01-03)

B3-6005.3

This informational record is sent in response to the MSP Maintenance Transaction Record sent by the Satellite (See §20.1.1 for MSP Maintenance Transaction Record processing procedures. Note that there have been significant changes in this process.) It acknowledges the Host's receipt of the MSP Maintenance Transaction Record and indicates any errors or informational data. Following are the types of codes and other information associated with this record:

- Disposition codes;

- MSP consistency error codes;

- MSP utilization error codes; and
- Basic Reply Trailers.

For more detailed information about MSP processing in CWF see the MSP Manual, Chapters 4and 5.

30 - Online Health Insurance Master Record (HIMR) Display

(Rev. 1, 10-01-03)

A3-3800.3, B3-6007

Beneficiary entitlement and utilization data on all nine CWF databases is available online through the HIMR transaction. It allows the Satellite to do further investigation about a claim or inquire about beneficiary entitlement and utilization status. This function is a display of information only. The user at the Satellite site cannot make changes to the screens accessed through HIMR. Refer to CWF Systems Documentation for detailed information about individual HIMR screens. Or see http://cms.csc.com/cwf/downloads/docs/pdfs/himrnav.pdf and http://cms.csc.com/mgmntcwf/docmgmt/pdfs/promptr.pdf for an explanation and layouts of all the available HIMR screens.

This information is applicable only to Satellites and Host site staff. Providers do not have access to the HIMR screens, but they can request eligibility information via the ELGA and ELGB transaction through their shared system. The response to the ELGA/ELGB is limited to a subset of information from the HIMR screen. See http://cms.csc.com/cwf/downloads/docs/pdfs/scrHost.pdf for more information on the HIQA transaction.

40 - Requesting Assistance in Resolving CWF Utilization

(Rev. 1, 10-01-03)

B3-6008

40.1 - Requesting Assistance in Resolving CWF Utilization Problems

(Rev. 1, 10-01-03)

B3-6008.1

This section applies only to Satellites; it does not apply to providers.

In the normal course of claims processing activities, Satellites can expect to encounter problems involving the CWF Claim Record and/or basic reply record procedures. The action necessary to resolve the problem depends upon the problem identified. For utilization problems, the Satellite sends all master beneficiary, summary history, and

inpatient summary history screen-prints for the beneficiary to the CWF HICR contractor for investigation. The Satellite takes the following steps:

- Put the error code causing the problem in the upper right-hand corner of the Beneficiary Master screen print;
- Mark on all of the screen prints exactly what the problem is and what is believed to be the correction needed;
- The Satellite (contractor) sends these marked screen prints to the CWF HICR contractor. They coordinate with the other contractor to determine who needs to correct the problem; and
- The CWF HICR contractor will investigate the problem and correct it. If a response is not received within 45 days of mailing the request for assistance, the contractor sends a second request marked "SECOND REQUEST."

NOTE: Congressionals are faxed to the CWF HICR contractor. Faxes must be reviewed and corrective action taken within 24-48 hours of receipt.

For problems involving the Host CWF Site, the Satellite utilizes the HICR transaction. This transaction provides the Host CWF site a method of creating transactions that correct the local database.

For more information, see CWF System Documentation, http://cms.csc.com/mgmntcwf/docmgmt/pdfs/scrHost.pdf.

40.2 - Social Security Administration (SSA) Involvement

(Rev. 1, 10-01-03)

B3-6008.4

SSA maintains the Master Beneficiary Record (MBR) from which the Health Insurance (HI) Master Record is established. The CWF's eligibility record is accreted from this HI Master Record. The HI Master Record is updated periodically from a variety of sources, including the MBR, and in turn updates the Host maintaining the CWF record. However, errors occur where the MBR fails to correctly update the HI Master Record or where the HI Master Record fails to correctly update the CWF record.

If the problem is caused by difficulties in determining the beneficiary's correct entitlement status, the carrier or FI must request assistance of the SSO. The SSO is responsible for processing the case. Examples of situations covered by this procedure are:

- Problems involving Railroad Retirement Board (RRB) jurisdiction, i.e., the RRB has jurisdiction of the beneficiary's Medicare, and the claim was erroneously referred to the area carrier;

- Evidence that a beneficiary has utilization under more than one health insurance claim number (HICN), but the Satellite is not aware of any cross-reference action taken by CMS; or

- Assistance is needed to obtain or verify a beneficiary's name and/or HICN. (See specific procedures in §20.2.2.6 under disposition code 55.)

In the event the SSO is unable to resolve the entitlement problem, e.g., a disposition code 55 is received after SSA verified the beneficiary's name and/or HICN, the Satellite requests assistance from the RO. It includes complete details of the nature of the problem and a description of its efforts to resolve it.

40.3 - Critical Case Procedure - Establishing Entitlement

(Rev. 1, 10-01-03)

A3-3524, B3-6008.2

The Satellite uses the "critical case" procedure (see §40.4, below) to expedite the processing of claims which have been delayed because of an error in the beneficiary's CWF Master Record. The "critical case" procedure provides speedy correction of the master record. The Satellite uses this procedure when there is an error in the CWF Master Record, which prevents the receipt of an approval disposition code on the basic reply record. This may occur when one of the following conditions exists:

- The Satellite is unable to make payment on a claim even though the beneficiary apparently has entitlement because CWF transmitted a Basic Reply Record with an inaccurate or repeated disposition code of "50," "51," 52," "53," "54," "55," "57," "58," "59," "60," "61," "AB," "CI," "ER," "UR," "CR;" or

- The Satellite received a Basic Reply Record and the recycled CWF Claim Records have not received a disposition code, which permits processing the claim to payment or denial.

40.4 - Referral of Critical Cases to the Regional Office

(Rev. 1, 10-01-03)

A3-3524, B3-6008.3

When the Satellite identifies a claim meeting the criteria listed below, it contacts the RO via established referral methods. The Satellite identifies the beneficiary by name and HICN, specifies the nature of the problem, states that the criteria are met, and gives the dates of all actions. The Satellite provides all available supporting documentation. Examples of such documentation are:

- Social Security Administration's (SSA) reply to Form CMS-1980 in the case of entitlement questions; and

- A copy of the Health Insurance Master Record Entitlement Status Query (ESQ) received from an SSA District Office.

The criteria are:

- Two follow-ups have been made to the Social Security Office (SSO) and the CWF Master Record has not been corrected;
- At least 60 days have elapsed since the correction procedures were initiated;
- A serious hardship to the beneficiary or a public relations problem has developed;
- Corrections or changes to HMO termination dates are necessary; and
- The SSO response indicates that both the MBR and HI Master Records are correct.

The Satellite marks the information "CRITICAL CASE." The Satellite flags the file for special handling and expedites the claim as soon as the reply is received.

The Satellite must diary the case for 30 calendar days. By that time the RO should have a response and advise the Satellite. If the Satellite receives a positive basic reply record before hearing from the RO, it notifies the RO.

50 - Requesting or Providing Assistance to Resolve CWF Rejects

(Rev. 1, 10-01-03)

A3-3860

When a Satellite has difficulty processing a bill because a prior bill was incorrectly processed and posted to CWF by another Satellite (carrier or FI), the two contractors must work together to resolve the error. Where help is needed from another contractor (carrier or FI), the submitting Satellite requests assistance from the contractor whose bill was processed incorrectly. The contractor that processed the bill is identified in the CWF reject trailer.

50.1 - Requesting Contractor Action

(Rev. 1, 10-01-03)

A3-3860

The requesting contractor furnishes the assisting contractor with sufficient information to identify the issue, and perform the necessary resolution actions. The data shown on the Request for Assistance Form (see Exhibit 1) is needed. This format must be used when designing a form letter so that both the requesting contractor 's address and the assisting contractor's address will be visible through a window envelope. A separate page is used

for each request to enable the assisting contractor to return each claim as completed instead of holding claims until all claims on a request are completed. The requesting contractor enters its request after "The following action is requested." The requesting contractor provides claim-identifying information as shown. The requesting contractor adds information to help it associate the response with its pending record, if needed.

If a response has not been received within 30 calendar days of the request, the requesting contractor sends a follow-up request. If no response is received within an additional 15 days, follow-up with the RO responsible for the assisting contractor. A status report indicating and defining problems that prevent processing of the request is considered a response in deciding whether to follow-up with the RO.

In addition, the requesting contractor considers whether an interim payment to the provider without CWF approval is appropriate. (See §60 of this chapter for procedures for paying without CWF approval.)

50.2 - Assisting Contractor Action

(Rev. 1, 10-01-03)

A3-3860

Upon receipt of a request for assistance, the assisting contractor adjusts or cancels the posted bill, as appropriate, and informs the requesting contractor by annotating the request form (under explanation of action taken by assisting contractor) with a description of its action (e.g., adjustment cleared CWF (date), current dates of service are _____.)

The assisting contractor completes corrective actions within 30 calendar days of receiving the request. If it cannot complete action within 30 days, provide a status reply explaining the reasons on a copy of the request form. The assisting contractor sends a copy of the reply to the RO.

The assisting contractor uses the request form on all correspondence to the requesting contractor to facilitate association of its response with the pending action.

50.3 - Format for Requesting Assistance From Another Contractor on CWF Edits

(Rev. 1, 10-01-03)

A3-3860

Exhibit 1 contains the required format for requesting assistance. The requesting contractor uses that format in designing its form letter so that both its address and the assisting contractor's address will be visible through a window envelope. The requesting contractor completes all data elements. Note that the form is designed so that a standard number 10 - 4 1/8 by 9 1/2 inch window envelope can be used for your request. The

assisting contractor may refold the form and use the same size window envelope in its reply. The requesting contractor enters its address in the bottom address space, and uses the following in the top address space:

Medicare Intermediary Claims Processing Department (if FI),

or

Medicare Carrier Claims Processing Department (if carrier)
Name of Contractor
PO Box or Street Address
City, State, ZIP Code

Exhibit 1 - Request for Assistance

Date_____

To:

Request: ___ First
___ Follow up
___ RO copy

Date of First Request _____
(If Follow up)

We request assistance in resolving CWF reject, edit code_____
enter code #

The following action is requested:

IDENTIFYING INFORMATION

_____ _____
Claim HIC# Beneficiary Name

_____ _____
Your ICN Your Provider

_____ _____
From Date Through Date

Explanation of action taken by assisting contractor:

REQUESTOR INFORMATION

_____
Claim #

_____
Dates of Service

Response Date
____ Final
____ Status

_____
Provider

_____
Other

Return To:
Requesting Contractor Name
Address Line 1
Address Line 2
Address Line 3 (if needed)

_____
Contact Person and Phone #

60 - Paying Claims Without CWF Approval

(Rev. 1, 10-01-03)

A3-3800.4, A3-3863, B3-6009

The CWF must approve each claim before it is paid. There may be special circumstances, however, when it is necessary to pay claims outside of the CWF system. The CMS will notify the contractor of these instances. They include:

- New coverage policies are enacted by Congress with effective dates that preclude making the necessary changes to CWF timely; and

- Errors are discovered in CWF that cannot be corrected timely. Carriers and FIs are responsible for reporting CWF problems to their host sites.

60.1 - Requesting to Pay Claims Without CWF Approval

(Rev. 1, 10-01-03)

A3-3800.4, A3-3863, B3-6009.1

The contractor may also request approval from the RO in specific situations to pay claims without CWF approval. Examples of such situations are:

- Other contractors cannot complete action to remove an impediment that blocks a contractor from processing of a claim; and/or

- A systems error cannot be corrected timely, and the provider's cash flow will be seriously endangered.

- Administrative Law Judge (ALJ) decisions, court decisions, and CMS instructions in particular cases may necessitate that payment be made outside the normal CWF process.

60.2 - Procedures for Paying Claims Without CWF Approval

(Rev. 1, 10-01-03)

A3-3800.4, A3-3863, B3-6009.2, R1886A3

Before a claim can be paid outside of CWF, the contractor must obtain approval from CMS Central Office or the RO. In all instances involving payment outside CWF, the contractor applies the following procedures:

- FIs submit the claim with an "X" in the tape-to-tape flag, and the system will determine payment as if the payment were final. Process inpatient PPS payments through MCE, Grouper and Pricer. Make hospice payments using the appropriate

hospice rate. Pay for ESRD visits using the composite rate. Use the appropriate fee schedules or interim rates. Apply deductible and coinsurance based on the most current data available. Do not apply the 70 percent reduction applicable to accelerated payment;

- Carriers should follow shared system procedures to avoid sending claim to CWF at time of payment, but maintain a record for later submission.

- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.

- Maintain a record of payment and implement controls to be sure that duplicate payment is not made, i.e., when the claim record is updated to CWF, or in response to a duplicate request by the provider.

- Monitor CWF to determine when the impediment to CWF processing is removed. Update CWF when the impediment is removed. Show the actual payment date outside CWF in the scheduled payment data field.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a monthly report of all claims paid without CWF approval. The list of claims paid outside of CWF is to include the following information:

    - HICN
    - Name
    - Provider number
    - Total charges
    - From and through date
    - Amount paid
    - Paid date
    - CWF error condition preventing payment.

Also, include summary data for each edit code showing claim volume and payment.

Send a copy of the summary data to:

CMS, OIS
7500 Security Blvd.
Baltimore, MD 21244-1850

70 - Change Control Procedures

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010

The CWF software is changed quarterly to accommodate revised CMS requirements, new provisions of law, to correct errors, or to enhance the system. Carriers and FIs may also request changes to CWF through certain change control procedures.

70.1 - Satellite Procedure

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010.1

When a Satellite has a recommendation for software changes, it follows the change control process below:

- Enter change requests into the CWF Information Management System (INFOMAN). For specific instructions about INFOMAN, refer to CWF Systems Documentation chapter on the Information Management System at http://cms.csc.com/cwf/downloads/docs/pdfs/overcwf.pdf

- .After entering change requests into INFOMAN, submit all supporting documentation to the Host for review and forwarding to both CMS and the CWF Maintenance Contractor (CWFM) for consideration and entry into the Change Control System.

- Monitor progress of all changes submitted from your site through INFOMAN.

- Review implementation of all changes from your own site to insure that needs are addressed.

70.2 - Process Flow of a Change Request

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010.2

- Complete a CMS CWF Change Request (CR) through INFOMAN. When the CR is created a CR number will automatically be assigned.

- Forward three copies of all supporting documentation to the Host site. Include the CR number on all documentation. The Host will review it and the CR for accuracy, completeness, and relevance. The review may also determine whether a problem reported is a CWF problem or a problem with the Satellite's software.

- When the Host approves the CR, it releases the Change Request to the CWFM and to the CMS central office in accordance with current procedures.

- The CMS and the CWFM review the Change Requests as received throughout the month.

- The CMS distributes all change requests to the appropriate CMS component for review and approval as they are received.

- A monthly Change Control meeting of CMS and CWFM staff is held to schedule approved Change Requests for release.

- Following the meeting, the CWFM enters approval and priority status of all Change Requests into the automated system. As work progresses, the CWFM enters the status of all changes, Quality Assurance (QA) activities and work performed.

70.3 - Handling Emergency Problems and Problems With Recent CWF Releases

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010.3

A problem is considered an emergency if a large number of claims are paid incorrectly, cannot be paid, or the Satellite/Host system abnormally ends (abends). When an emergency occurs, the Satellite follows these procedures:

1. The Satellite will convey information about the emergency to the Host immediately. The Satellite must be able to submit documentation of the problem.

2. The Host will report the problem to the CWFM immediately via CWFM customer service. The service is available 24 hours a day, 7 days a week.

3. During business hours, CWFM will respond immediately. After business hours, CWFM will contact the Host within one hour of report of the problem.

70.4 - Distribution of "CWF Change Control" Reports

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010.4

- CWFM distributes a monthly "Status of CWF Changes" report and "Schedule of CWF Changes" report to all Host sites, CMS ROs, and CMS CO staff.

- Each Host site distributes the reports to its Satellite sites within three working days of receipt.

70.5 - Channels of Communication

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010.5

All Satellite inquiries should be made to the Host staff, according to locally established procedures.

70.6 - Schedule of CWF Software Releases

(Rev. 1, 10-01-03)

A3-3800.5, B3-6010.6

- **Regular Releases** - Approved CWF Change Requests are programmed into the regular releases of updated CWF software. These releases are quarterly.

- **Emergency Releases** - If there is a serious problem with a release of CWF software, CMS CO and the CWFM have the option to prepare and issue emergency releases of CWF software to resolve the problem(s).

- **Special Releases** - The CWFM will issue special releases as directed by CMS, which contain software changes that affect a specific topic or subject.

80 - Processing Disposition and Error Codes

(Rev. 1, 10-01-03)

B3-6006, CWF DispCode
(http://cms.csc.com/cwf/downloads/docs/pdfs/dispcode.pdf)

The results of CWF processing are communicated through a set of codes categorized as either disposition or error codes. There are specific disposition codes for inquiry, transfer/not in file request, and each claim type. Claims have consistency, utilization, A/B crossover, and duplicate error codes. Transactions for End Stage Renal Disease (ESRD), Medicare Secondary Payer (MSP), and Certificate of Medical Necessity (CMN) error codes are also available.

If the Host rejects a claim, the FI or carrier must suspend the claim and review it. After the review is complete and corrections made, they resubmit the claim with an indication that a review was performed and corrections made.

80.1 - Disposition Codes

(Rev. 1, 10-01-03)

80.1.1 - CWF Part A Inquiry Reply Disposition Codes

(Rev. 1, 10-01-03)

01 - Approved (never used Part A services)

02 - Approved (used some Part A services)

03 - Reject

20 - Qualified approval, may require further investigation

25 - Qualified approval, begins a new benefit period

50 - Not in file

51 - Not in file on CMS batch system

52 - Master Record housed at another CWF site

53 - Record in CMS alpha match

55 - Does not match master record

60 - I/O error on database

61 - Cross reference/database problem

62 - Beneficiary Master Hospice Auxiliary Indicator is on, but no Hospice Auxiliary record found

63 - Beneficiary Master HMO900 Auxiliary Indicator is on, but no HMO900 Auxiliary record found

ER - Consistency Edit Reject

AA - Auto Adjust error

AB - Transaction caused CICS ABEND

CI - CICS processing problem

SV - Security Violation

80.1.2 - CWF Part B/Carrier Inquiry Reply Disposition Codes

(Rev. 1, 10-01-03)

01 - Accepted item

03 - Reject

20 - Qualified approval, may require further investigation

50 - Not in file

51 - Not in file on CMS batch system

52 - Master Record housed at another CWF site

53 - Record in CMS alpha match

55 - Does not match master record

60 - I/O error on database

61 - Cross reference/database problem

62 - Beneficiary Master Hospice Auxiliary Indicator is on, but no Hospice Auxiliary record found

63 - Beneficiary Master HMO900 Auxiliary Indicator is on, but no HMO900 Auxiliary record found

ER - Consistency Edit Reject

AA - Auto Adjust error

AB - Transaction caused CICS ABEND

CI - CICS processing problem

SV - Security Violation

80.1.3 - CWF Transfer Request Reply Disposition Codes

(Rev. 1, 10-01-03)

These reply disposition codes are used in response to a Host site's request for a transfer of beneficiary records.

01 - Accept; record will be requested from CMS central office

02 - Reject; request already in progress

50 - Reject; record is already on CWF database

60 - I/O error on data base

ER - Consistency Edit Reject

AB - Transaction Caused CICS ABEND

CI - CICS processing problem

SV - Security Violation

80.1.4 - Consolidated Claims Crossover Process

(Rev. 1, 10-01-03)

01 - Debit accepted. No automatic adjustment

02 - Debit accepted automatic adjustment applies

03 - Cancel accepted

05 - Cancel returned

50 - Not in file

51 - Not in file on CMS Batch System

52 - Master Record housed at another CWF site

53 - Record in CMS Alpha Match

55 - Name/Personal Characteristics mismatch

60 - I/O error on data

61 - Cross Reference/Data Base problem

AA - Auto Adjust error

AB - Transaction caused CICS ABEND

BT - History Claim not present to support spell

CI - CICS processing error

CR - Crossover Reject

ER - Consistency Edit Reject

UR - Utilization Reject

80.1.5 - Claims Crossover Disposition Indicators

(Rev. 1, 10-01-03)

01 - Debit accepted. No automatic adjustment

02 - Debit accepted automatic adjustment applies

03 - Cancel accepted

04 - History accrete accepted

50 - Not in file

51 - Not in file on CMS Batch System

52 - Master Record housed at another CWF site

53 - Record in CMS Alpha Match

55 - Name/Personal Characteristics mismatch

60 - I/O error on data

61 - Cross-Reference/data base problem

AA - Auto Adjust error

AB - Transaction caused CICS ABEND

BT - History claim not present to support spell

CI - CICS processing error

CR - Crossover Reject

ER - Consistency Edit Reject

RT - Retrieval pending

UR - Utilization Reject

80.1.6 - CWF Hospice Bill Basic Reply Record Disposition Codes

(Rev. 1, 10-01-03)

01 - Debit accepted. No automatic adjustment

03 - Cancel accepted

50 - Not in file

51 - Not in file on CMS Batch System

52 - Master Record housed at another CWF site

53 - Record in CMS Alpha Match

55 - Name/Personal characteristics mismatch

60 - I/O error on data

61 - Cross-Reference/database problem

AA - Auto Adjust Error

AB - Transaction caused CICS ABEND

CI - CICS processing error

CR - Crossover Reject

ER - Consistency Edit Reject

UR - Utilization Reject

80.1.7 - Part B/Carrier Claim Basic Reply Record Disposition Codes

(Rev. 1, 10-01-03)

B3-6011

01 - Debit Accepted. No automatic adjustment.

02 - Debit Accepted. Automatic adjustment applies.

03 - Cancel Accepted

04 - Entry Code 9 Accepted (Accrete Bill History)

50 - Not in File

51 - Not in File on CMS Batch System

52 - Master Record Housed at Another CWF Site

53 - Record in CMS Alpha Search

54 - Match to Cross Reference Number

55 - Name/Personal Characteristics Mismatch

60 - I/O Error on Data

61 - Cross Reference/Database Problem

AA - Auto Adjust Error

AB - Transaction Caused CICS ABEND

CI - CICS Processing Error

CR - Crossover Reject

ER - Consistency Edit Reject

RT - Retrieve Pending

SV - Security Violation

UR - Utilization Reject

80.2 - Inpatient, SNF, Outpatient, Home Health, and Hospice Utilization Error Codes

(Rev. 1, 10-01-03)

A3-3807, CWF Editutil (http://cms.csc.com/cwf/downloads/docs/pdfs/editutil.pdf), B-02-049, A-02-068

Utilization edit rejects are denoted by a value of UR in the disposition field on the Part A reply record. Trailer 08, containing one utilization error code, will follow. Trailer 12 will be returned for UR and AA dispositions. Listed below are the possible utilization error codes with a general description.

Inpatient, SNF, Outpatient, Home Health, and Hospice Utilization Error Codes

Error Code	Explanation
AAAA	HOSPITAL

UR "AAAA" is set for VA claims which have passed all consistency and utilization edits.

Purpose:

To indicate that no errors have been set.

Resolution:

No resolution necessary.

Error Code	Explanation
RT01	OP Claim is waiting retrieval of archived history. Claim is to be recycled in six days. **Purpose:** To recall archived outpatient history that relates to current claim processing. **Resolution:** The Host retrieves the archived history records. This retrieval process executes weekly. Resubmit the claim in six days.
RT02	OP Attempted history retrieval, but the beneficiary history pointers were full. **Purpose:** The retrieval process found a matching record, but the pointers are full, and the record cannot be retrieved from archived history. **Resolution:** Contact the Host to perform an ARCMINI purge (archiving and purging of pointers) to retrieve the history record.
28#1	OP The claim contains an Occurrence Span Code "36," the Occurrence Date is greater than the claim Thru Date of Service, and the claim From Date of Service is less than 12/21/2000; or The accumulated days are greater than the Transplant Allowed days; or The service From Date is less than or equal to the Earliest Transplant Discharge Date or greater than or equal to the covered Thru Date of the transplant. **Purpose:** To ensure that post transplant services are approved only during the post transplant coverage period.

Error Code	Explanation
	Resolution: Reject indicating that the service was not provided within the eligible coverage period. Use MSN 4.2 - "This service is covered up to (insert appropriate number) months after transplant and release from the hospital." - Not used on remittance advice (RA) unless service being denied is exceeding this limit, in which case PR 35 would apply.
5A#1	OP An MCCD outpatient (HUOP) record with demonstration number 37 (Medicare Coordinated Care Demonstration) and units greater than 1 for HCPCS Codes G9001 - G9008. **Purpose:** To ensure that Medicare pays coordinated care fees only within their allowed frequency. **Resolution:** Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5050	H, S, HH, HOSP, OP Beneficiary record has been deleted by CMS. **Purpose:** To ensure that Medicare does not pay for services for which the beneficiary is not entitled. **Resolution:** Verify HICN. If incorrect, correct and resubmit. If correct, deny claim with MSN 5.1 - "Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office."

Error Code	Explanation
5052	H, S, HH, HOSP, OP Beneficiary identification incorrect - The name and/or claim number shown on the bill is incorrect or claim number is not on the Health Insurance master file (used only for Disposition Codes 50, 51, 52, 53, and 55). **Purpose:** To match the correct utilization with the correct beneficiary. **Resolution:** Verify through inquiry to the Host that the HICN is correct on the bill. If the bill is correct, and the Host HIMR agrees with the reject (no record), notify the Host of the error. Host will contact CMS to determine eligibility.
5053	H, S, HH, HOSP, OP Beneficiary is temporarily blocked due to a merge of beneficiary data mandated by CMS. **Purpose:** To prevent processing of transactions while beneficiary history data is being merged. **Resolution:** Recycle claim every 15 days until an approval, adjustment, or reject response is received or until otherwise notified.
5054	H, S, HH, OP Beneficiary auxiliary record missing and requested from CMS. **Purpose:** To inform the FI that the beneficiary auxiliary record has been requested from CMS. **Resolution:** Recycle claim every four days until a response is received.

Error Code	Explanation
5055	H, S, HH, HOSP, OP Beneficiary blocked at CWF Host and CMS batch pending clerical update. **Purpose:** To inform the FI that the Beneficiary Record has been blocked pending a clerical update. **Resolution:** Recycle claim every 15 days until an approval, adjustment, or reject response is received, or until otherwise notified.
5056	H, S, HH, HOSP, OP The beneficiary number requested by this bill is not available to the Host at this time because the Beneficiary Record at CMS central office has a skeleton record (This is done when the beneficiary has a date of death and the beneficiary has had no claims activity for at least six months). **Purpose:** To properly identify the beneficiary receiving the service. **Resolution:** Check with the SSO to determine the proper HICN for this beneficiary. If the HICN and ID are correct, resubmit the bill in 15 working days.
5057	H, S, HH, HOSP, OP The beneficiary number requested by this bill is not available to the Host. This record is marked as a skeleton at CMS central office and has been purged. The number being used is possibly an incorrect number and should be investigated through Social Security. **Purpose:** To properly identify the beneficiary receiving the services. **Resolution:** Check with the SSO to determine the proper HICN for the beneficiary. If the HICN and ID are correct, resubmit in 15 working days.

Error Code	Explanation
5058	H, S, HH, HOSP, OP The beneficiary number requested by this bill is not available to the Host at this time because the Beneficiary Record at CMS central office is blocked (this is done during cross-reference processing). **Purpose:** To notify the contractor that this bill cannot be posted to the Host master at this time. **Resolution:** Check to determine accuracy of the HICN and identification on the claim. If incorrect data is present, correct and resubmit. If the bill is correct, resubmit in 15 working days.
5059	H, S, HH, HOSP, OP The beneficiary number requested by this bill is not available to the Host at this time because the Beneficiary Record at CMS central office is frozen (this is done while clerical corrections are being done). **Purpose:** To notify the contractor that the bill submitted could not be posted to the Host master. **Resolution:** Resubmit bill in 15 working days if all beneficiary identification is accurate.
5100	HOSP Hospice NOE for Termination (8xB), Change of Provider (8xC), Void of Election Period (8xD), or Change of Ownership (8xE), and no Hospice Master Data is present for this beneficiary. **Purpose:** To ensure a Hospice NOE for Termination, Change of Provider, Void of Election Period, or Change of Ownership is not accepted for a beneficiary that has not had a NOE to establish an initial election period posted.

Error Code	Explanation
	Resolution: Return to provider indicating that there is no Hospice Master Record present for this beneficiary.
5105	HOSP Hospice NOE to add a new election period (Bill Type 81A or 82A) with a Start Date between two previously established election periods; less than 90 days exists between the two election periods already present on the Hospice Master File for this beneficiary. **Purpose:** To maintain continuity between election periods. **Resolution:** Verify that the new election period dates are correct, if so, cancel the second period and all bills against it and resubmit new NOE.
5106	HOSP Hospice NOE to add a new election period (Bill Type 81A, or 82A) with a Start Date that falls within a previously established Hospice election period. **Purpose:** To prevent the establishment of overlapping election periods. **Resolution:** Return to provider indicating that the Hospice NOE received falls within a previously established Hospice election period.

Error Code	Explanation
5107	HOSP Hospice NOE to add a new election period (Bill Type 81A or 82A) with a Start Date that falls between two previously posted Hospice election periods (only two periods are present with at least 90 days between the periods) and the second period has a Date of Last Billing Action greater than 30 days beyond the second period Start Date. (CWF will not insert a new election period between two current election periods if by doing so a third period would be created with a Date of Last Billing Action greater than the last date of the new third election period.) or An NOE (8xA) with a Start Date that falls between two previously posted Hospice election periods (only 2 periods are present with at least 90 days between the periods) and the second period has a Date of Last Billing Action greater than 30 (prior to 08/05/1997) or 60 (08/05/1997 and after) days beyond the second period Start Date. **Purpose:** To prevent the creation of improper election periods. **Resolution:** Verify election period dates, resubmit NOE with adjusted dates or revoke second period then resubmit NOE.
5109	HOSP Hospice NOE for revocation (8xB), Change of Change of Provider (8xC), Void of Election Period (8xD), or Change of Ownership (8xE) does not match to a posted election period on the Hospice Master Record for this beneficiary. **Purpose:** To ensure that the requested activity is recorded against the correct election period. **Resolution:** Return to provider indicating that there is no matching Hospice election period present for this beneficiary.

Error Code	Explanation
5110	HOSP Hospice NOE for revocation (8xB), Change of Provider (8xC), Void of Election Period (8xD), or Change of Ownership (8xE), and Hospice Start Date on transaction is equal to previously posted Hospice election period Termination Date, and the Revocation Indicator is other than zero. **Purpose:** To disallow action on a period that has already been terminated. **Resolution:** Return to provider indicating that the Hospice election period has been previously terminated.
5111	HOSP Hospice NOE for revocation (Bill Type 8XB) or Void of Election Period (Bill Type 8XD); Start Date on transaction falls within a previously posted Hospice election period on the Hospice Master File for this beneficiary. **Purpose:** To ensure that a revocation or void is performed on the correct election period. **Resolution:** Return to provider indicating that there is no matching election period on file for this beneficiary.
5112	HOSP • Hospice NOE for revocation (Bill Type 8XB); Start Date matches a posted Hospice election period Start1 Date, but Provider Number does not match Provider 1 on the Hospice Auxiliary File; • Start Date matches a posted Hospice election Change of Ownership Start1 Date, and Provider Number does not match the Change of Ownership Provider 1 Number on the Hospice Auxiliary File; • Start Date matches a posted Hospice election Start2 Date, and Provider Number does not match Provider 2 Number on master; or • Start Date matches a posted Hospice election Change of Ownership Start2 Date, and Provider Number does not match the Change of Ownership Provider 2 Number on the Hospice Auxiliary File.

Error Code	Explanation
	Purpose: To prevent activity from any provider other than the current provider on file. **Resolution:** Return to provider indicating that the Billing Provider Number does not match the Provider Number on file. If billing provider verified as correct, reject using MSN 26.4 - "This service is not covered when performed by this provider."
5113	HOSP Hospice NOE for revocation (Bill Type 8XB); Start Date matches a posted Hospice election period Start Date but new Revocation Date matches current Termination Date and Revocation Indicator is other than zero. (This is a duplicate revocation notice, or a claim has processed with Occurrence Code 23 Date of Cancellation, or 42 Date of Hospice Revocation, and has caused the revocation information to be posted to the master record.) **Purpose:** To ensure duplicate transactions are not processed. **Resolution:** Return to provider indicating that the election period has already been terminated.
5114	HOSP Hospice NOE for revocation (Bill Type 8XB); Start Date matches a posted Hospice election period Start Date, but the Thru Date on the transaction is greater than the current Termination Date on the Hospice Master Record. **Purpose:** To ensure that revocations are processed only against active election periods. **Resolution:** Return to provider indicating that the requested Revocation Date is after the election period terminated.

Error Code	Explanation
5115	HOSP Hospice NOE for revocation (Bill Type 8XB); Start Date matches a posted Hospice election period Start Date but the Thru Date on the transaction is less than the Date of Last Billing Action (DOLBA) on the Hospice Master Record. **Purpose:** To ensure that an election period cannot be revoked if claims have already been posted beyond the Revocation Date. **Resolution:** Return to provider for a change in Revocation Date. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
5116	HOSP Hospice NOE indicates revocation (Bill Type 8XB); the Start Date matches a posted Hospice election period Start Date that has previously been revoked. **Purpose:** To ensure a Hospice revocation is not accepted for an election period that has already been revoked. **Resolution:** Return to provider indicating the Hospice NOE revocation is for an election period that has already been revoked.
5117	HOSP Hospice NOE for Change of Provider (Bill Type 81C or 82C) is a duplicate change, based on the Start Date and Provider Number. **Purpose:** To ensure a duplicate Hospice NOE for a Change of Provider is not accepted.

Error Code	Explanation
	Resolution: Return to provider indicating the Hospice NOE for a change in provider is a duplicate transaction.
5118	HOSP Hospice NOE for Void of Election Period (Bill Type 8XD) matches a revoked Hospice election period and the Thru Date on the NOE does not equal the Termination Date on Hospice Master Record. **Purpose:** To ensure a Hospice Void of Election Period is not accepted for an election period that has already been revoked. **Resolution:** Return to provider indicating the Hospice Void of Election Period is for an election period that has previously been revoked.
5119	HOSP Hospice NOE for Void of Election Period (Bill Type 8XD) matches a posted Hospice election period Start1 Date, but the transaction Provider Number does not match Provider 1 Number on master; Start Date matches a posted Hospice election Change of Ownership Start1 Date, and the transaction Provider Number does not match the Change of Ownership Provider 1 Number on master; Start Date matches a posted Hospice election Start2 Date, and the transaction Provider Number does not match Provider 2 Number on master; or Start Date matches a posted Hospice election Change of Ownership Start2 Date, and the transaction Provider Number does not match the Change of Ownership Provider 2 Number on master. **Purpose:** To ensure a Hospice Void of Election Period is not accepted if the transaction Provider Number does not match the master Provider Number.

Error Code	Explanation
	Resolution: Return to provider indicating that the Hospice Void of Election Period transaction is for a Provider Number that does not match the master Provider Number. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
511A	HOSP Hospice NOE for Change of Ownership transaction (Bill Type 8XE) is for either Start1 or Start2 Provider in the election period, but a Change of Ownership is already present. **Purpose:** To ensure that only one Change of Ownership is made for each provider during an election period. **Resolution:** Return to provider indicating that a Change of Ownership transaction has already been processed during the stated election period.
511B	HOSP Hospice NOE for Change of Ownership (Bill Type 8XE) Start Date matches Prov1 Start Date. **Purpose:** The Change of Ownership Effective Date cannot equal the associated Provider Start Date. **Resolution:** Return to provider indicating that the original NOE should be voided and a new one submitted with the new owner information.
5120	HOSP Hospice NOE for Void of Election Period (Bill Type 8XD) matches a posted Hospice election period but a Date of Earliest Billing Action (DOEBA) is present and greater than zero.

Error Code	Explanation
	Purpose: To ensure a Hospice election period cannot be deleted after bills have been processed against it unless posted claims are cancelled. **Resolution:** Return to provider indicating that a bill or bills have been processed against this election period and that the provider will need to cancel all posted bills before voiding the period.
5121	HOSP Hospice NOE for Void of Election Period (Bill Type 8XD) matches a posted Hospice first, second, or third election period, but a fourth period is present on the Hospice Master File. **Purpose:** To ensure that Hospice election periods one, two, or three cannot be deleted if a fourth period is present. **Resolution:** Return to provider indicating that election period 1, 2, or 3 cannot be voided because a fourth period is on file, the fourth period must be voided prior to an earlier election period void.
5126	HOSP Hospice NOE (Bill Type 8XA) with Action Code 2 and no Hospice master data is present for this beneficiary. **Purpose:** To ensure that Hospice transactions are processed correctly. **Resolution:** Change the Action Code to 1 and resubmit.

Error Code	Explanation
5127	HOSP Hospice NOE (Bill Type 8XA) with Action Code 2 and original Hospice Start Date (field 29) does not match a posted Hospice period Start1 or Start2 Date, or matches a posted Start1 or Start2 Date but Provider Number and/or Intermediary Number does not match Election Period Date. **Purpose:** To identify a Hospice NOE that does not match on one of the following: Hospice Start Date, Provider Number or Intermediary number. **Resolution:** Verify the Intermediary Number, if a discrepancy is found, correct the error and resubmit the NOE to CWF. Or, return to the provider to verify the Start Date and/or Provider Number.
5128	HOSP Hospice NOE (Bill Type 8XA) with Action Code 2 and Original Hospice Start Date (Field 29) matches a current posted Hospice Period Start1 Date, but the new Start Date is equal to or greater than the posted Change of Ownership Start1 Date, or the new Start1 Date is greater than the Start2 Date. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a Change of Ownership or a subsequent period. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5129	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and original Hospice Start Date (field 29) matches a current posted Hospice second, third, or fourth Period Start Date and the new Hospice Start Date is greater than the current posted Start1 Date and prior election period is not revoked.

Error Code	Explanation
	Purpose: CWF will not allow a gap to be created between two established Hospice periods unless a revocation of Hospice benefits has occurred on the prior period. For claims and periods after August 4, 1997, this edit will apply to periods 2 up to a maximum of 180 periods. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that would create a gap between election periods. The provider will need to investigate and resubmit, if appropriate, with corrected information.
512A	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and original Hospice Start Date (Field 29) matches a current posted Hospice period Start2 Date, but the new date is equal to or greater than the Change of Ownership Start2 Date for this election period. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a Change of Ownership start date. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5130	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and original Hospice Start Date (field 29) matches a current posted Hospice period Start Date, and the new Hospice Start Date is less than current posted Start Date and is less than the prior Hospice period's Termination Date.

Error Code	Explanation
	Purpose: If a gap does not exist between the Hospice periods that will allow posting of the new Start Date, the prior period must be adjusted with a change of election notice prior to acceptance of change notices for subsequent periods. For claims and periods after August 4, 1997, this edit will apply to periods two up to a maximum of 180 periods. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a prior period. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5132	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and original Hospice Start Date (field 29) matches a current posted Hospice Start1 Date and the new Hospice Start Date is greater than the Date of Earliest Billing Action (DOEBA) in the matching Hospice election period. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement**.** **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with the Date of Earliest Billing Action (DOEBA). The provider will need to investigate and resubmit, if appropriate, with corrected information.
5133	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and Original Hospice Start Date (field 29) matches a current posted Hospice Start Date and the new Hospice Start Date is greater than the Termination Date of the period and the period has been revoked by the beneficiary (Revocation Indicator is equal to 1). **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement.

Error Code	Explanation
	Resolution: Return to provider indicating that the period they are attempting to establish has a start date that conflicts with the Termination Date of the period. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5134	HOSP Hospice NOE Bill Type 8XA with Action Code of 2 and Original Hospice Start Date (field 29) matches a current posted Hospice Start Date and the new Hospice Start Date is greater than the Start1 Date of the next posted Hospice election period (when present). **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a subsequent election period. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5135	HOSP Hospice NOE Bill Type 8XA with Action Code of 2 and original Hospice Start Date (Field 29) matches an existing Start Date but the new date is more than 90 days earlier than a Change of Ownership Start1 Date, Start2 Date, or Change of Ownership Start2 Date within the period being changed. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a Change of Ownership start date. The provider will need to investigate and resubmit, if appropriate, with corrected information.

Error Code	Explanation
5136	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and original Hospice Start Date (field 29) matches a current posted Hospice Start2 Date and the new Hospice Start Date is less than the original Start2 Date and a claim has been previously posted to history from the Provider1 Hospice with a Thru Date greater than the new Hospice Start Date. **Purpose:** CWF will not post a Change of Election Start Date if any posted claim would become inconsistent with the updated Hospice Master File data. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a previously posted claim. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5137	HOSP Hospice NOE (Bill Type 8XA) with Action Code of 2 and original Hospice Start Date (field 29) matches a current posted Hospice Start2 Date and the new Hospice Start Date is greater than the original Start2 Date and a claim has been previously posted to history from Hospice Provider2 with a From Date less than the new Hospice Start Date. **Purpose:** CWF will not post a Change of Election Start Date if any posted claim would become inconsistent with the updated Hospice Master File data. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a previously posted claim. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5138	HOSP Hospice NOE Bill Type 8XB with Action Code of 2 and no Hospice master data is present for this beneficiary.

Error Code	Explanation
	Purpose: To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that there is no Hospice master data present for this beneficiary.
5139	HOSP Hospice NOE (Bill Type 8XB) with Action Code of 2 and NOE Hospice Start Date matches a posted Hospice Period Start1 or Start2 Date but the NOE Original Revocation Date (field 29) does not match the Revocation Date on the Hospice period. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to terminate has a revocation date that conflicts with a previously posted revocation date. The provider will need to investigate and resubmit, if appropriate, with corrected information.
513A	HOSP Hospice NOE Bill Type 8XA with Action Code of 2 and original Hospice Start Date (Field 29) matches a Change of Ownership Start1 Date and the new date is equal to or less than the previous Start1 Date for this period, or the original date matches a Change of Ownership Start2 Date, and the new date is equal to, or less than, the previous Provider Start2 Date. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement.

Error Code	Explanation
	Resolution: Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a previously posted Change of Ownership date. The provider will need to investigate and resubmit, if appropriate, with corrected information.
513B	HOSP Hospice NOE Bill Type 8XA with Action Code of 2 and original Hospice Start Date (Field 29) matches a Change of Ownership Start Date. The new date is less than the original date and there is a claim in history with a Thru Date equal to, or greater than, the new Start Date. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a previously posted claim. The provider will need to investigate and resubmit, if appropriate, with corrected information.
513C	HOSP Hospice NOE Bill Type 8XA with Action Code of 2 and original Hospice Start Date (Field 29) matches a Change of Ownership Start Date. The new date is greater than the original date, and there is a claim in history with a From Date that is less than the new Start Date. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to establish has a start date that conflicts with a previously posted claim. The provider will need to investigate and resubmit, if appropriate, with corrected information.

Error Code	Explanation
5140	HOSP Hospice NOE (Bill Type 8XB) with Action Code of 2 and NOE Hospice Start Date does not match a posted Hospice Start1 or Start2 Date on the master file, or matches a posted Start1 or Start2 Date, but the NOE FI and/or Provider Number does not match election period information. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Verify Intermediary Number and resubmit if appropriate. Or, return to provider indicating that the Provider Number conflicts with previously posted information.
5141	HOSP Hospice NOE Bill Type 8XB with Action Code of 2 and Start Date matches a posted Hospice period Start1 Date or Change of Ownership Start1 Date on the Hospice Master File, and a Start2 Date or Change of Ownership Start2 Date is present for the election period (only the latest provider within a period can revoke the election). **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to terminate has a start date that conflicts with a previously posted Change of Ownership date. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5142	HOSP Hospice NOE Bill Type 8XB with Action Code of 2 and NOE Hospice Start Date matches a posted Hospice period Start1, or Start2 Date, but the election period has not been revoked, or canceled (Revocation Indicator is zero).

Error Code	Explanation
	Purpose: To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to terminate has previously been revoked or canceled. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5143	HOSP Hospice NOE Bill Type 8XB with Action Code of 2 and NOE Hospice Start Date matches a posted Hospice period Start1 or Start2 Date but the NOE new Hospice Thru Date is greater than the CWF calculated Termination Date (Hospice Start1 Date +89 for the first and second periods, or +29 for the third period). **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement. **Resolution:** Return to provider indicating that the period they are attempting to terminate has a Thru Date that conflicts with the CWF calculated Termination Date. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5144	HOSP Hospice NOE Bill Type 8XB with Action Code of 2 and NOE Hospice Start Date matches a posted Hospice period Start1 or Start2 Date and the NOE original Revocation Date (Field 29) is equal to the Hospice period Revocation Date but NOE Hospice Through Date is less than the Date of Last Billing Action (DOLBA) for the Hospice period. **Purpose:** To ensure that election periods are consistently established according to the beneficiary's entitlement.

Error Code	Explanation
	Resolution: Return to provider indicating that the period they are attempting to terminate has a Thru Date that conflicts with a previously posted claim. The provider will need to investigate and resubmit, if appropriate, with corrected information.
5145	HOSP Hospice NOE (Bill Type 8XB) with Action Code of 2, NOE Hospice Start Date matches a posted Hospice period Start1, or Start2 Date, and the NOE original Revocation Date (Field 29) is equal to the Hospice period Revocation Date, but a posted Hospice history is present with Occurrence Code 23 (Canceled Date), or 42 (Revocation Date). **Purpose:** CWF will not update a Hospice Revocation Date with a NOE transaction if a claim was the source of the posted Revocation Date. In this situation a debit/credit action must be performed to adjust the Hospice Revocation Date. **Resolution:** Return to provider indicating that the period they are attempting to terminate conflicts with a previously posted claim, a debit/credit action must be performed to adjust this revocation date.
5146	HOSP Hospice NOE type 8xB with Action Code of 2 and NOE Hospice Start Date matches a posted Hospice period Start1 or Start2 Date and new Hospice Revocation Date is equal to zeros, and a later period is present with a Start1 Date not equal to the new calculated Hospice Termination Date plus one. **Purpose:** CWF will not accept a removal of a Revocation Date if a gap or an overlap would be created in the Hospice enrollment by doing so. **Resolution:** Return to provider indicating that the termination they are attempting to reverse would cause conflict with a later period. The provider will need to investigate and resubmit, if appropriate, with corrected information.

Error Code	Explanation
5147	HOSP Hospice NOE for Change of Provider (Bill Type 8XC) and new Start2 Date (From Date on NOE) is less than, or equal, to the Date of Last Billing Action (DOLBA), and the period has been revoked or canceled. **Purpose:** To prevent action on an election period that has been revoked or canceled. **Resolution:** Return to provider indicating that election period has been revoked or canceled.
5148	HOSP Hospice NOE for Change of Ownership (8xE) matches a posted Hospice period Start Date, but there are claims in history with statement dates in conflict with the Change of Ownership Start Date. **Purpose:** To ensure that Change of Ownership dates are accurate. **Resolution:** Return to provider indicating that the Start Date needs to be corrected. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
5149	HOSP Hospice NOE with Bill Type 8XC and Action Code 1 to change Hospice provider, but the Start Date is less than a Change of Ownership Start1 Date. **Purpose:** To ensure that the Hospice Provider on file is correct. **Resolution:** Return to provider indicating that a Change of Ownership transaction needs to be cancelled prior to processing the change in Hospice provider.

Error Code	Explanation
514A	HOSP Hospice NOE with Bill Type 8XC and Action Code 1 to change Hospice provider, but the Start Date is equal to the History Thru Date and the history claim is not a discharge bill. **Purpose:** To ensure the proper payment of claims during a Change of Provider. **Resolution:** Return to provider indicating that the Start Date must be at least one day after the Discharge Date or last bill Thru Date of the former provider. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
5150	HOSP Hospice claim received but there is no Hospice master file present for this beneficiary. **Purpose:** To ensure claims are paid only for beneficiaries who have elected Hospice benefits. **Resolution:** Return to provider indicating that a NOE should be submitted prior to resubmitting this claim.
5151	HOSP Hospice claim received and Hospice master file present with no posted Hospice periods, or claim From Date is prior to the first posted Hospice election period. **Purpose:** To ensure that claims are not paid for which there is not a corresponding election period.

Error Code	Explanation
	Resolution: Return to provider indicating that no Hospice election periods have been posted for the beneficiary or claim From Date is prior to the first election period.
5155	HOSP Hospice claim received and four Hospice election periods are present on the Hospice master file, and the claim From Date is greater than the third period Termination Date and is less than the fourth period Start Date. (This situation should not occur at this time. The CWF system allows only a fourth period Start Date to be one day greater than the third period Termination Date.) **Purpose:** Edit is obsolete. **Resolution:** Edit is obsolete, contact Host if this code is received.
5157	HOSP Hospice claim is received with a From Date greater than the most recent Hospice period, and the prior period was revoked, or canceled. (Revocation Indicator is other than zero.) **Purpose:** To ensure that claims are not paid if they do not have corresponding election periods on file. **Resolution:** Return to provider indicating that no matching election period is on file for this beneficiary.
5158	HOSP A Hospice claim received with a From Date greater than the first Hospice election period Termination Date, and less than the second period Start Date, or with From Date greater than the second period election Termination Date and less than the third period election Start Date.

Error Code	Explanation
	Purpose: To ensure that claims are not paid if they do not have corresponding election periods on file. **Resolution:** Return to provider indicating that no matching election period is on file for this beneficiary.
5159	HOSP Hospice claim received with a From Date greater than the most recent posted Hospice election period and claim contains Occurrence Code 42 (Date of Hospice Revocation) with an associated date greater than the calculated Termination Date for the new election period. **Purpose:** To ensure that Hospice claims are processed only for Dates of Service that have a matching election period on file. **Resolution:** Return to provider indicating that Dates of Service are not within an election period on file.
5160	HOSP Hospice claim received with a From Date within, or greater than, the most recent posted Hospice election period, and if accepted, would create two, or more new Hospice election periods. **Purpose:** CWF will not allow a claim to create more than one new election period. **Resolution:** Return to provider indicating that the claim will need to be split into shortened time periods.

Error Code	Explanation
5161	HOSP Hospice claim received and the From Date falls within a posted Hospice election period that has been revoked by the beneficiary, or canceled by the FI (Revocation Indicator is other than zero) and the claim Thru Date is greater than the election period Termination Date. **Purpose:** CWF will not allow creation of a new period by a claim if the previous election period has been revoked by the beneficiary, or canceled by the FI. **Resolution:** Return to provider indicating that a new Hospice NOE is required to begin a new period in this situation.
5162	HOSP A Hospice claim is received with a Thru Date greater than the most recent posted Hospice election period and claim contains Occurrence Code 23 (Date of Hospice Cancellation), or 42 (Date of Hospice Revocation), with an associated date greater than the calculated Termination Date for the new election period. **Purpose:** To ensure that Hospice claims are processed only for Dates of Service that have a matching election period on file. **Resolution:** Return to provider indicating that Dates of Service/cancellation are not within an election period on file.
5163	HOSP Hospice claim From Date falls within a posted Hospice election period and claim Thru Date is greater than the next posted election period and no subsequent election period is posted or a subsequent period is present but is not contiguous with the prior period, i.e., A gap exists between the two periods.

Error Code	Explanation
	Purpose: CWF will not create a new Hospice election period from a bill that spans across two or more posted periods. **Resolution:** Return to provider indicating that either the claim should be split or a new NOE should be submitted for the gap.
5165	HOSP Hospice claim From Date falls within a posted Hospice election period and claim Thru Date is greater than Termination Date on the period and a subsequent election period is posted but is not contiguous with the prior period; i.e., A gap exists between the two periods. **Purpose:** CWF will not create a new Hospice election period from a bill with a Thru Date greater than a Termination Date if a gap exists between two periods. A gap should exist only if one period has been revoked. **Resolution:** Return to provider indicating that a new NOE should be submitted for the gap in election periods before resubmitting this claim.
5166	HOSP Hospice claim From Date falls within a posted Hospice election period, and both the Change of Ownership Start1 Date and Start2 Date are equal to zeros (neither a Change of Ownership nor a Change of Provider has occurred), and the Provider Number on the claim is not equal to Provider 1 in effect for the billing period on the posted Hospice election period. **Purpose:** To ensure that only the provider that the beneficiary has elected is paid for Hospice services. **Resolution:** Return to provider for verification of provider number, the NOE provider is different than the billing provider.

Error Code	Explanation
5167	HOSP Hospice claim falls within a posted Hospice election period, and either the Change of Ownership Start1 Date or Start2 Date is present (either a Change of Ownership or a Change of Provider has occurred). The claim From Date is prior to the Start2 Date and the Provider Number in effect. **Purpose:** To ensure correct payment of services during a transition between providers or owners. **Resolution:** Return to provider for verification of dates. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
5168	HOSP Hospice claim falls within a posted Hospice election period and Start2 Date is present (a Change of Provider has occurred) and claim From Date is prior to Hospice election Start2 Date and claim Thru Date is greater than election Start2 Date, or Thru Date is equal to Start2 Date and it is not a discharge bill. **Purpose:** To ensure that services are paid appropriately during a transition between providers. **Resolution:** Return to provider indicating that a Change of Provider is on file and this bill must therefore have a Thru Date one day prior to the Effective Date of the Change of Provider.
5169	HOSP Hospice claim falls within a posted Hospice election period, Start2 Date or Change of Ownership Start2 Date is present (a Change of Provider or Change of Ownership has occurred), and the claim From Date is equal to or greater than Start2 or Change of Ownership Start2 Date, but claim Provider Number does not match the number in effect for the billing period.

Error Code	Explanation
	Purpose: To ensure that services are paid appropriately during a transition between providers. **Resolution:** Return to provider indicating that a Change of Provider/ownership is on file but the billing provider is not appropriate for the billing period.
5170	HOSP Claim dates fall within a Hospice period with no Revocation Indicator and an Occurrence Code of 42 is on the claim; or Claim dates fall within the fourth Hospice period and the claim Revocation or Cancel Date is less than the Date of Latest Billing Activity (DOLBA). **Purpose:** To ensure Medicare does not pay for services after a revocation or cancel. **Resolution:** Return to provider for date verification.
5171	HOSP Claim dates fall within the first, second, or third Hospice period, which has been revoked, or canceled, and the claim Revocation Date is prior to the Date of Latest Billing Activity (DOLBA) or is greater than the calculated Termination Date. **Purpose:** To ensure Medicare does not pay for services after a revocation or cancel. **Resolution:** Return to provider for date verification.
5172	HOSP Claim days used plus the days used currently posted to the Hospice period are greater than those allowed for the period (90 days for period one and two, 60 days for subsequent periods).

Error Code	Explanation
	Purpose: To ensure Medicare does not pay for services for which the beneficiary is not entitled. **Resolution:** Return to provider indicating that a new NOE must be processed prior to re-submittal.
5173	HOSP The From Date of an incoming Hospice claim is equal to the Thru Date of a Hospice claim already posted to history, or the Thru Date of an incoming Hospice claim is equal to the From Date of a Hospice claim already posted to history and the Provider Number of both the posted claim and the incoming claim are the same or associated with Change of Ownership. **Purpose:** To ensure that Medicare does not pay for the same service more than once. **Resolution:** Return to provider indicating that overlapping dates exist with a claim in history.
5174	HOSP A Notice of Election transaction is not allowed after death. **Purpose:** To ensure Medicare does not pay for services that are not performed. **Resolution:** Return to provider for a correction in dates of service.
5175	HOSP This transaction reverses a Hospice revocation and will result in overlapping Hospice election periods.

Error Code	Explanation
	Purpose: To prevent the posting of overlapping election periods. **Resolution:** Return to provider indicating that this action would result in overlapping election periods.
5176	HOSP Bill Type (TOB) 815 or 825 (Hospice late charge claim) with service dates that do not match an existing Hospice claim posted to history. **Purpose:** To ensure that late charge claims are processed correctly. **Resolution:** Return to provider indicating that a late charge claim must coincide with a claim in history.
5177	HOSP Hospice claim falls within a posted Hospice election period, and a Change of Ownership is present. Claim From Date is prior to Hospice Change of Ownership Start Date, and claim Thru Date is equal to or greater than the associated Change of Ownership Start Date. **Purpose:** To ensure the correct processing of claims during a Change of Ownership. **Resolution:** Return to provider indicating that the claim must be split according to the dates of the Change of Ownership.
5178	HOSP Hospice claim received with Patient Status Code 40, 41, or 42 (beneficiary expired). The Date of Death is earlier than Dates of Service on claims posted to Hospice history.

Error Code	Explanation
	Purpose: To ensure that a Date of Death is correctly recorded. **Resolution:** Verify Date of Death, correct and resubmit claim.
5179	HOSP Hospice claim with Occurrence Code 23, or 42 falls within a posted Hospice election period, but the Provider Number does not match the last Provider Number on the Hospice Auxiliary File for the election period. **Purpose:** To ensure that cancels/terminations of election periods can be performed only by the provider on file for the election period. **Resolution:** Return to provider indicating that the billing provider number does not match the provider number on file for the election period.
5180	HOSP This transaction will reverse a Hospice revocation and result in a gap between Hospice periods. **Purpose:** CWF will not allow a gap to be created between two established Hospice periods unless a revocation of Hospice benefits has occurred on the prior period. **Resolution:** Return to provider indicating that this transaction would result in a gap between Hospice periods.
5181	HOSP Hospice claim will generate a new Hospice period and no NOE submitted with claim or NOE Date does not equal the Start Date of the new Hospice period.

Error Code	Explanation
	Purpose: To ensure that claims are paid only if a corresponding election period exists. **Resolution:** Return to provider for addition of Occurrence Code 27; or if already present correct code 27 date to be equal to the first day of the new period. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
5182	H, S The RNHCI Notice of Election (41A) matches the RNHC Aux. File, which already indicates an election period. The election period on file does not have a Term Date posted, or the Election Date on the new NOE is prior to the most recent Revocation Date on the RNHC Aux. file. **Purpose:** To ensure that duplicate or overlapping RNHCI election periods are not created. **Resolution:** Return to provider indicating that the Election Date requested duplicates or overlaps an existing RNHCI election period.
5183	H, S The RNHCI Notice of Election (41A) is within one full year (365 days) of the date of the most recent Revocation Date on file. The RNHC Aux. File has indicated two prior Revocation Dates on file. **Purpose:** To ensure that a waiting period of 1 year is enforced when a beneficiary wishes to elect a third period of RNHCI services. The waiting period is from the Date of Revocation of the second election period. **Resolution:** Reject indicating that the beneficiary has not fulfilled the required 1 year waiting period prior to making a third election.

Error Code	Explanation
5184	H, S

The RNHCI Notice of Election (41A) is within five full years (1825 days) of the date of the most recent Revocation Date on file. The RNHC Aux. file has indicated three prior Revocation Dates on file.

Purpose:

To ensure that a waiting period of 5 years is enforced when a beneficiary wishes to elect a fourth or subsequent period of RNHCI services. The waiting period is from the date of revocation of the most recent election period.

Resolution:

Reject indicating that the beneficiary has not fulfilled the required 5-year waiting period prior to making a fourth or subsequent election.

5185 H, S

RNHCI Notice of Revocation (41B), or a Notice of Cancellation (41D) and there is no RNHCI master data present for the beneficiary;

RNHCI Notice of Revocation (41B) Date is prior to the posted election period;

A Revocation Date is present on the posted election period on file;

RNHCI Notice of Cancellation (41D) Date does not match the Election Date on the RNHC Aux. File; or

The Notice of Cancellation (41D) does not match the most recent Revocation Date on the RNHC Aux. File.

Purpose:

To ensure that an RNHCI revocation or cancellation is not processed if a matching election period has not been established for the beneficiary.

Resolution:

Return to provider indicating that the beneficiary does not have an active election period on file or that the dates of the revocation or cancellation do not match the posted election period.

Error Code	Explanation
5186	H, S

RNHCI Notice of Cancellation (41D) and there are RNHCI claims that have been posted during the election period that is being canceled.

Purpose:

To ensure that an RNHCI election period cannot be cancelled if claims have already been processed against it.

Resolution:

Return to provider indicating that the RNHCI election period cannot be cancelled unless all claims processed against it are voided first.

5187 H, S

RNHCI claim with Dates of Service on or after, July 1, 2000 and no RNHC master file for the Beneficiary.

Purpose:

To ensure that RNHCI claims are not approved if an election period has not been established.

Resolution:

Return to provider indicating that an RNHCI Notice of Election must be processed prior to submitting any RNHCI claims.

5188 H, S

RNHCI claim with Dates of Service on or after, July 1, 2000 and the Dates of Service do not fall within a posted election period, or the Dates of Service are after the Revocation Date.

Purpose:

To ensure that RNHCI claims are not approved if the Dates of Service do not fall within a posted election period.

Resolution:

Return to provider indicating that the Dates of Service do not fall within a posted election period.

Error Code	Explanation
5189	H, S Part A claim (non-41x) or a Part B/carrier claim, the Excepted/Nonexcepted Care Indicator is not a one, or two, and the Dates of Service are during an RNHCI election period on file. **Purpose:** To suspend for review all non-RNHCI claims for a beneficiary with a posted RNHCI election period. **Resolution:** Review claim to determine if the care received by the RNHCI beneficiary was excepted or nonexcepted. Resubmit the claim to CWF indicating what type of care was received: Indicator 1 for excepted care Indicator 2 for nonexcepted care.
5200	H, S, HH, HOSP, OP There is no record of the beneficiary's entitlement to the type of services shown on the claim. **Purpose:** To provide benefits for only those services that the beneficiary is entitled to. **Resolution:** Deny the claim for the provider and the beneficiary. The provider is responsible for developing correct data and resubmitting the bill. Use MSN 9.7 - "We have asked your provider to resubmit the claim with the missing or correct information." (NOTE: Add-on to other messages as appropriate.)
5202	H, S, HOSP No record of Hospice election.

Error Code	Explanation

Purpose:

To provide for Hospice benefits only after notice of election by the beneficiary.

Resolution:

Check with the Host via inquiry to determine the status of the beneficiary. The Satellite should check their records for a Hospice notice of election. If there is evidence that a notice of election has been received and processed, the Satellite should notify the Host.

5203 H, S, HOSP

The Dates of Service do not fall within a period of Hospice election.

Purpose:

To ensure that Hospice benefits are covered only during a period of Hospice election.

Resolution:

The Host will start a new period of Hospice care based on the bill, if the From Date on the bill is within a 90 day period of election or one day after the 90 day period ends. (A period ending by the beneficiary's action will not be extended). If three Hospice periods have already been established, the Host will not start a fourth period.

5210 H, S, HH, HOSP, OP

Services are after benefits terminated.

Effective January 1, 2003, only the start date of claims for HCPCS code A4253, A4255, A4256, and A4259 is considered for this edit (not the entire span of service dates).

Purpose:

To prevent coverage of benefits after coverage termination.

Error Code	Explanation
	Resolution: Deny the claim. If the provider disagrees, research the termination information through the local SSO. Use MSN 5.1 - "Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office."
5211	H, S, HH, HOSP, OP The statement From/Thru Date is greater than the Date of Death on Beneficiary Master Record. HOSP The statement Thru Date is greater than the Date of Death on the Beneficiary Master Record. HH The statement Thru Date does not fall within the same month as the beneficiary's Date of Death or the statement Thru Date is not within the month after the Date of Death on Beneficiary Master Record. Effective January 1, 2003, only the From Date of claims for HCPCS codes A4253, A4255, A4256, and A4259 is considered for this edit (not the entire span of service dates). **Purpose:** To prevent payment of services after the beneficiary's death. **Resolution:** Deny the claim indicating that services were furnished after the date of death on file. The provider must submit the correct Dates of Service. If the provider indicates that the beneficiary is not dead, validate the information by checking the Date of Death Update Field. If a "2" appears in this field, adjust the prior claim. If the beneficiary is dead and the date is wrong, verify through the SSO. Use MSN 5.3 - "Our records show that the date of death was before the date of service."

Error Code	Explanation
5212	H, S, HH, HOSP, OP The claim has a patient status of beneficiary deceased with a Thru Date prior to another claim with a patient status of beneficiary deceased. **Purpose:** To ensure that patient status of beneficiary deceased is submitted on only one bill. **Resolution:** Return to provider for correction of patient status. Use remittance message MA 130 - "Resubmit this claim with the missing or correct information."
5220	H, S, HH, HOSP, OP Services prior to the date of entitlement. **Purpose:** To prevent payment for services prior to the beneficiary's entitlement. **Resolution:** Deny the claim. If the provider disagrees, research the entitlement information through the local SSO. Use MSN 5.1 - "Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office."
5231	H An inpatient claim is received with a Condition Code of 04, without the GHO plan id, and Dates of Service not within any GHO period on the GHO Auxiliary File. **Purpose:** To ensure that only claims eligible for GHO services are processed as such.

Error Code	Explanation
	Resolution: Delete Condition Code 04 and resubmit.
5232	H, S, HH, OP Services overlap GHO entitlement and Override Code is not one (investigation shows GHO not applicable); or Services overlap CHOICES/ESRD Managed Care Demonstration entitlement and the CHOICES/ESRD Identification Number is not present. **Purpose:** To ensure that Managed Care claims are processed correctly. **Resolution:** Return to provider indicating a need for removal of Override Code or for correction of the CHOICES/ESRD Identification Number.
5233	H, S, HH, OP, HOSP A claim or Hospice election dates fall within or overlaps an HMO period and neither the HMO pay code or condition code 69 are on the claim. For PPS claims, and claims with Provider Numbers beginning with "210," the Admission Date falls within a risk GHO Paid period, but no GHO Paid Code or Condition Code "69," is indicated on the claim. **Purpose:** To prevent duplication of payment by Medicare for HMO benefits or the HMO for services within a Hospice election period. **Resolution:** Return to provider to bill services for HMOs to the entity responsible for payment and bill Medicare only those services payable by Medicare.
5234	H, S, HH, OP Beneficiary Master Record with GHO data, but incoming claim record is missing GHO Identification Number. (Error does not apply to GHO option one).

Error Code	Explanation
	Purpose: To ensure that required GHO data is on the claim. **Resolution:** Obtain proper M+C Organization number from provider and resubmit the claim to CWF with required M+CO number in GHO data field.
5235	H, S, HH, OP Services fall within a risk GHO period and within a Hospice election period, and Condition Code 07 is not present on the claim; An RNHCI Notice of Election (41A), the Admission Date falls within a risk GHO period and a Hospice election period; or An MCCD Notice of Election (89A), the From Date falls within a risk GHO Period and a Hospice election period. **Purpose:** To prevent overlapping Hospice and GHO periods. **Resolution:** Reject indicating that transaction conflicts with an active GHO period and Hospice election period. Use MSN 11.3 - "Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them."

Error Code	Explanation
5236	H, S, HH, OP For PPS claims: The Admission Date is not within a risk GHO period, but the GHO Pay Code on the claim is one, or the Condition Code 69 is present; The Admission Date falls within a risk GHO period, but the Statement Dates fall on, or after, the Hospice Revocation Date, but before the month following the Revocation Date, the GHO Pay Code indicated on the claim is other than zero, or the Condition Code 69 is present, however a risk GHO is not liable for claims during the month of Hospice revocation; or The Statement Dates are within a Hospice period and the claim has a Condition Code 07 indicating treatment of a non-terminal illness. This includes abbreviated Encounter (TOB 11z) records. H, S For Non-PPS Inpatient and SNF claims: The Statement Dates do not fall within a risk GHO period but the GHO Pay Code on the claim is one, or the Condition Code 69 is present; The Statement Dates fall within a risk GHO period, but on, or after, a Hospice Revocation Date, but before the month following the Revocation Date, the GHO Pay Code indicated on the claim is one, or the Condition Code 69 is present, however a risk GHO is not liable for claims during the month of Hospice revocation; or The Statement Dates are within a Hospice period and the claim has a Condition Code 07 Indicating treatment of a non-terminal illness. This includes abbreviated Encounter (TOB 11z) records. HH, OP Service Dates do not fall within a risk GHO period but the GHO Pay Code on the claim is one; Service Dates fall within a risk GHO period, but on, or after, the Hospice Revocation Date, but before the month following the Revocation Date, the GHO Pay Code indicated on the claim is one however, a risk GHO is not liable for claims during the month of Hospice revocation; or The Statement Dates are within a Hospice period and the claim has a Condition Code 07 indicating treatment of a non-terminal illness.

Error Code	Explanation
	Purpose: To ensure that GHO and Hospice claims are processed correctly. **Resolution:** Return to provider indicating that there is conflicting information on the claim and/or the beneficiary's master file pertaining to GHO/Hospice status or GHO/Hospice only billable items.
5237	H, S, HH, HOSP, OP Claim indicates a CHOICES GHO site but the beneficiary does not have a GHO Auxiliary record, or the GHO Auxiliary record is not associated with a CHOICES GHO site; The claim indicates a CHOICES site, but the GHO Pay Code on the claim is not equal to one; For PPS claims: The claim Admit Date does not fall within a CHOICES GHO period; For Non-PPS/SNF claims: The claim From and Thru Dates do not fall within a CHOICES GHO period; Claim indicates an ESRD Managed Care Demonstration GHO site but the beneficiary does not have a GHO Auxiliary Record, or the GHO Auxiliary Record is not associated with an ESRD Managed Care Demonstration GHO site; Claim indicates an ESRD Managed Care Demonstration site, but the GHO Pay Code on the claim is not equal to one; For PPS claims: The claim Admit Date does not fall within an ESRD Managed Care Demonstration GHO period; or For Non-PPS/SNF claims: The claim From and Thru Dates do not fall within an ESRD Managed Care Demonstration GHO period. **Purpose:** To ensure that CHOICES/ESRD services are paid for only in the time period for which the beneficiary is eligible.

Error Code	Explanation
	Resolution: Return to provider indicating that the billed services do not match the CHOICES/ESRD information on file.
5238	H, S, HH, OP Claim Admit/Statement Dates are within a CHOICES/ESRD Managed Care Demonstration period of entitlement but the CHOICES/ESRD Identification Number is not present; or Claim does not indicate an ESRD Managed Care Demonstration site, but GHO Auxiliary record shows that the beneficiary is associated with an ESRD Managed Care Demonstration site. **Purpose:** To ensure that fee-for-service claims are not paid when a beneficiary is enrolled in a GHO. **Resolution:** Reject claim indicating that the beneficiary is enrolled in a GHO. Use MSN 21.9 - "Payment cannot be made for unauthorized service outside the managed care plan."
5239	H, S, HH, OP Both the claim and the GHO Auxiliary Record indicate a CHOICES site, but the CHOICES identifiers are different; or Both the claim and the GHO Auxiliary Record indicate an ESRD Managed Care Demonstration site, but the ESRD Managed Care Demonstration identifiers are different. **Purpose:** To ensure GHO beneficiary claims are processed only for the GHO in which the beneficiary is enrolled. **Resolution:** Reject claim indicating that Medicare records do not show the beneficiary as enrolled in the billing GHO.

Error Code	Explanation
5243	H

UMWA Beneficiary contains a Participating Center of Excellence (PCOE) or Cardiac Artery Bypass Graft (CABG) Demonstration Number.

Purpose:

To ensure that claims are paid appropriately based on the beneficiary's status. UMWA beneficiaries are not eligible for PCOE or CABG demonstrations.

Resolution:

Return to provider indicating that UMWA beneficiaries are not eligible for claims payment under PCOE or CABG demonstration rules.

5244 H, S

Claim contains a CABG or PCOE Demonstration number but the beneficiary does not have both Part A and Part B entitlement.

Purpose:

To ensure that claims are paid appropriately based on the beneficiary's status. Beneficiaries are not eligible for PCOE or CABG demonstrations if they do not have both Part A and Part B entitlement.

Resolution:

Reject indicating that beneficiaries not having both Part A and Part B entitlement are not eligible for claims payment under PCOE or CABG demonstration rules.

Use MSN 5.5 - "Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice."

5245 H, S

RRB beneficiary contains a CABG or PCOE demonstration number.

Purpose:

To ensure that claims are paid appropriately based on the beneficiary's status. RRB beneficiaries are not eligible for PCOE or CABG demonstrations.

Error Code	Explanation
	Resolution: Return to provider indicating that RRB beneficiaries are not eligible for claims payment under PCOE or CABG demonstration rules.
5246	H GHO/Medicare CHOICES beneficiary contains a CABG or PCOE demonstration number. **Purpose:** To ensure that claims are paid appropriately based on the beneficiary's status. GHO/Medicare CHOICES beneficiaries are not eligible for PCOE or CABG demonstrations. **Resolution:** Return to provider indicating that GHO/Medicare CHOICES beneficiaries are not eligible for claims payment under PCOE or CABG demonstration rules.
524A	H Inpatient Bill Type is 11A. The beneficiary does not have at least one lifetime reserve day remaining on a Participating Centers of Excellence "07" or Provider Partnership Demonstration Number "08." **Purpose:** To ensure that beneficiaries that do not have at least one lifetime reserve day remaining are not admitted to demonstration "07" or "08." **Resolution:** Reject NOA and inform provider to bill for this beneficiary under traditional Part A or Part B Medicare coverage.
524B	H Inpatient Bill Type is 11A. The beneficiary has a MSP record on a Participating Centers of Excellence "07" or Provider Partnership Demonstration Number "08."

Error Code	Explanation
	Purpose: To ensure that beneficiaries for whom Medicare is a secondary payer are not admitted to demonstration "07" or "08." **Resolution:** Reject NOA and inform provider to bill for this beneficiary under traditional Part A or Part B Medicare coverage.
524C	H Notice of Admission Bill Type 11A has an Admit Date that equals an Admit Date on file for a Participating Centers of Excellence "07" or Provider Partnership "08" Demonstration Number. **Purpose:** To ensure that duplicates are not processed. **Resolution:** Return to provider as a duplicate, indicating that an NOA has already been filed with this Admit Date.
524D	H Notice of Admission Bill Type 11A has an Admit Date that overlaps the Admit Date and Discharge Date for a Participating Centers of Excellence "07" or Provider Partnership "08" Demonstration Number. **Purpose:** To ensure that duplicates are not processed. **Resolution:** Return to provider as a duplicate, indicating that an NOA has already been filed with dates overlapping this Admit Date.
524E	H Cancellation Notice Bill Type 11D has an Admit Date that does not match a posted Admit Date or does not have a CEPP file, or does match the Admit Date but the Discharge Date is present for a Participating Centers of Excellence "07" or Provider Partnership "08" Demonstration Number.

Error Code	Explanation
	Purpose: To ensure Cancellation Notices are processed correctly. **Resolution:** Return to provider for date correction.
524F	H, S Bill Type 11X other than 11A or 11D with Demonstration Number "07" or "08" and no Participating Centers of Excellence or Provider Partnership Auxiliary file. **Purpose:** To ensure the correct processing of demonstration claims. **Resolution:** Return to provider indicating that provider should re-bill with appropriate condition code and without demonstration number or if beneficiary is a demonstration patient a NOA (11A) must be submitted prior to processing of this claim.
524G	H, S Condition Code "B1" is present and the Admit Date equals a beneficiary's Participating Centers of Excellence (07) or Provider Partnership (08) Admit Date on the Auxiliary file. **Purpose:** To ensure the correct processing of demonstration claims. **Resolution:** Return to provider indicating that a NOA is on file and must be cancelled prior to processing of this claim.
524I	H, S Bill Type 11X other than 11A, 11D, or 11Z and no Demo Number "07" or "08" is present and the Admit Date equals the Participating Centers of Excellence or Provider Partnership's Admit Date on the Auxiliary file.

Error Code	Explanation
	Purpose: To ensure the correct processing of demonstration claims. **Resolution:** Return to provider indicating that the Demo Number must be on this claim.
524J	H, S A claim with POS "21," "22," or "23" with no Site of Service ID# and either Service From or Thru Date either matches the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date or if no Discharge Date but on or after the Admit Date on the Auxiliary file. **Purpose:** To ensure the correct processing of demonstration claims. **Resolution:** Return to provider for inclusion of Site of Service ID#.
524K	H A claim for POS "21," "22," or "23" with no Site of Service ID# and either First Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Discharge Date on the Auxiliary file, or Last Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Admit Date on the Auxiliary file. **Purpose:** To ensure the correct processing of demonstration claims. **Resolution:** Process as a no-pay claim.

Error Code	Explanation
524L	H A claim for POS "21," "22," or "23" and the Site of Service ID# on the record does match the Participating Centers of Excellence or Provider Partnership's Provider Number on the Auxiliary file and either First Expense Date is on or between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date on the Auxiliary file; or Last Expense Date is on or between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date on the Auxiliary file. **Purpose:** To ensure the correct processing of demonstration claims. **Resolution:** Process as a no-pay claim.
524M	H A claim with POS "21," "22," or "23" and the Site of Service ID# on the record does not match the Participating Centers of Excellence or Provider Partnership's Provider Number on the Auxiliary file and either First Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Discharge Date on the Auxiliary file, or Last Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Admit Date on the Auxiliary file. **Purpose:** To ensure the correct processing of demonstration claims. **Resolution:** Process as a no-pay claim.
524N	H A claim with POS "21," "22," or "23" with no Site of Service ID# and the First and Last Expense Dates overlaps more than one open Admission period on the Participating Centers of Excellence or Provider Partnership's Auxiliary file.

Error Code	Explanation
	Purpose: To ensure the correct processing of demonstration claims. **Resolution:** Process as a no-pay claim.
5255	OP Outpatient (Action Code 7), or Part B/carrier (Entry Code 9) history only bill for PAP smear codes (G0141, G0143-G0145, G0147-G0148), or mammography, but the Service Date on the claim does not match a Technical, or Professional Component Date on the Beneficiary Master Record. **Purpose:** To ensure that the technical and professional components of a PAP or mammography claim are not in conflict. **Resolution:** Investigate dates on this claim and claim on history, make correction to claim in error, and recoup any payments if necessary.
5256	H, S, HH, HOSP, OP Lung Volume Reduction Demonstration Number 30 is present on the claim record, but the HIC Number is not on the Lung Volume Reduction Eligibility File. **Purpose:** To ensure that Medicare pays LVRS only for beneficiaries enrolled in the NETT/LVR Demonstration.

Error Code	Explanation
	Resolution: Reject claim with reason code 96 and the following messages: Provider Remittance Notice: MA84: "Patient identified as participating in the National Emphysema Treatment Trial, but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact the Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy." MSN: 16-10: "Medicare does not pay for this item or service." 15-4: "The information provided does not support the need for this service or item." 15-16: "Your claim was reviewed by our medical staff (add on to other messages as appropriate." EOMB: 16-17: "Medicare does not pay for this item or service." 15-9: "The information we have in your case does not support the need for this service." (If your Medical staff reviewed the claim, add: "Your claim was reviewed by our Medical staff.")
5257	H, S, HH, HOSP, OP Lung Volume Reduction Demonstration Number 30 is present on the claim, but the earliest First-Expense Date on the claim is less than the Phase One Effective Date on the Lung Volume Reduction Eligibility File, or the Last-Expense Date is greater than the Demonstration Termination Date. HH, HOSP, OP Lung Volume Reduction Demonstration Number 30 is present, but the claim From Date (or if present, Occurrence Code 72 From Date) is less than the Phase One Effective Date on the Lung Volume Reduction Eligibility File, or the claim Thru Date (or if present, Occurrence Code 72 Thru Date) is greater than the Demonstration Termination Date.

Error Code	Explanation
	Purpose: To ensure that Medicare pays LVRS only for beneficiaries enrolled in the NETT/LVR Demonstration. **Resolution:** Reject claim with reason code 96 and the following messages: Provider Remittance Notice: MA84: "Patient identified as participating in the National Emphysema Treatment Trial, but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact the Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy." MSN: 16-10: "Medicare does not pay for this item or service." EOMB: 16-19: "Medicare does not pay for this because it is a treatment that has yet to be proved effective."
5258	H, S, HH, HOSP, OP Lung Volume Reduction Demonstration Number 30 and CPT Code 32491 are present, but the Date of Surgery is less than the Phase 3A (surgery) Effective Date on the Lung Volume Reduction Eligibility File. HH, HOSP, OP Lung Volume Reduction Demonstration Number 30 and ICD-9 Code 3222 are present on the claim record, but the claim Thru Date (or if present, Occurrence Code 72 Thru Date) is less than the Phase 3A (surgery) Effective Date on the Lung Volume Reduction Eligibility File. **Purpose:** To ensure that Medicare pays LVRS only for beneficiaries enrolled in the NETT/LVR Demonstration.

Error Code	Explanation
	Resolution: Reject claim with reason code 96 and the following messages: Provider Remittance Notice: MA84: "Patient identified as participating in the National Emphysema Treatment Trial, but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact the Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy." MSN: 16-10: " Medicare does not pay for this item or service." 15-4: "The information provided does not support the need for this service or item." EOMB: 16-17: "Medicare does not pay for this item or service." 15-9: "The information we have in your case does not support the need for this service."
5262	H, OP GHO Plan Number does not match a GHO Auxiliary file or a matching GHO Auxiliary record is not found. **Purpose:** To ensure that a beneficiary has been enrolled in an GHO plan before GHO benefits are utilized. **Resolution:** Return to provider indicating that the beneficiary does not have an GHO Auxiliary record on file for the Plan Number entered on the claim.

Error Code	Explanation
5263	H The Stay Covered From and Thru Dates are not within the GHO period on the GHO Auxiliary file. OP For Outpatient Encounter claims where the Dates of Service are not within a risk GHO Aux. Record. **Purpose:** To ensure that service dates on GHO claims are within an GHO enrollment period. **Resolution:** Return to provider indicating that the Dates of Service on the claim are not within the beneficiary's GHO enrollment period on file.
5310	H, S, OP, HH, HOSP No pre-entitlement psychiatric reduction. **Purpose:** Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. The limitation applies only to services furnished in a psychiatric hospital. Days prior to entitlement do not count against the patient's lifetime reserve, even though pre-entitlement days may have been counted against the 150 days eligibility in the first spell of illness. **Resolution:** This error occurs when a beneficiary is in a psychiatric hospital (XX4000 Provider Number) prior to Medicare entitlement, but no pre-entitlement psychiatric days are shown. The total of pre-entitlement days, plus post-entitlement psychiatric days, cannot exceed 150 days for the first spell of illness when a beneficiary is in a psychiatric hospital prior to entitlement, and is still a patient in a psychiatric hospital on the day of entitlement. Determine the amount of any applicable reduction. Investigate if the current admission is to a psychiatric hospital. Investigate any utilization in the 150-day period before entitlement.

Error Code	Explanation
5340	H, S, HH, HOSP, OP Claim indicates "Benefits Exhausted," but CWF file indicates benefits remaining. **Purpose:** To prevent under-utilization of benefit days. **Resolution:** If earlier bills with sufficient utilization to exhaust benefits are sent to the Host and rejected, the Satellite must make the necessary corrections and resubmit those bills prior to resubmitting the "Benefits Exhausted" bill. Otherwise, reprocess the bill as a paid bill based on the beneficiary's remaining utilization and make proper payment to the provider.
5341	H, S The Occur Code 23 Catastrophic Date is not within the posted catastrophic earliest From and latest Thru Dates. **Purpose:** Edit is obsolete. **Resolution:** Edit is obsolete, contact Host if this code is received.
5342	H, S The Service Dates do not match a record on the Beneficiary Master file for Bill Type 115, 125, 185, or 225. **Purpose:** To ensure that late charge bills have corresponding bills on history. **Resolution:** Return to provider for date verification.
5360	H Age and/or sex disagree with DRG determination.

Error Code	Explanation
	Purpose: To ensure compatibility between the beneficiary's master record and the DRG assigned to the bill. **Resolution:** Change the information on the claim to be compatible with that on HIMR.
5361	OP Mammography bill with a Date of Service greater than 12/31/1990 and a male beneficiary. **Purpose:** To prevent inappropriate payment. **Resolution:** Assure that the beneficiary's sex is male and deny the claim. If sex is female, change the information on the claim and resubmit.
5362	OP Claim for mammography screening with a beneficiary under age 35 when screening was performed. **Purpose:** To ensure payment is made to eligible beneficiaries. **Resolution:** Deny the claim using MSN 18.3 - "Screening mammography is not covered for women under 35 years of age."
5363	OP Mammography bill for a beneficiary who is over 34 and less than 40 and has had a previous screening after 12/31/1990. **Purpose:** To ensure payment is made for only one mammography screening between the ages of 34 and 40.

Error Code	Explanation
	Resolution: Deny the claim using MSN 18.6 - "A screening mammography is covered only once for women age 35 - 39."
5364	OP Mammography bill for a beneficiary whose last screening was within 11 months, and either the age is greater than 39 and less than 50 with high-risk indicated, or the age is greater than 49 and less than 65. **Purpose:** To ensure payment is made for only one mammography screening within 12 months. **Resolution:** Deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5365	OP Last mammography screening was within 23 months, and either age is greater than 39 and less than 50 and not high-risk, or age is greater than 64. **Purpose:** To ensure payment is made for only one mammography screening within 23 months following the month of the last screening. **Resolution:** Deny the claim using MSN 18.8 - "Screening mammograms are covered for women 40 - 49 years of age without high risk factors only once every 24 months." Or, MSN 18.11 - "Screening mammograms are covered for women 65 years of age and older only once every 24 months."
5366	OP CMS records show a prior mammography screening date equal to this screening month and year.

Error Code	Explanation
	Purpose: To prevent duplicate payment. **Resolution:** Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5367	OP Date of Service is prior to mammography screening date on CMS records and Date of Service is less than 12 months prior to posted Date of Service. **Purpose:** To ensure payment is made for no more than one mammography screening per year. **Resolution:** Deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5368	OP Outpatient bill for mammography. Date of Service is prior to screening date on CMS records and the bill Date of Service is less than 24 months prior to the posted Date of Service. **Purpose:** To ensure payment is made for no more than one screening mammography every two years. **Resolution:** Deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)

Error Code	Explanation
5373	OP

Mammography claim is submitted for a beneficiary within 11 full months of the last mammography screening. Beneficiary is over 39 year of age and service is performed after 12/31/1997.

Purpose:

To ensure that mammography screening is covered by Medicare only once in a 12-month period.

Resolution:

Deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)

5374 OP

Medicare will not pay for two screening fecal occult blood test services (G0107) within 11 months of each other.

Purpose:

To ensure that screening fecal occult blood test services are covered by Medicare only once in a 12-month period.

Resolution:

Deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)

5375 OP

Medicare will not pay for two screening barium enema services performed on different dates, within 47 months of each other nor two screening barium enemas performed as an alternative to screening flexible sigmoidoscopy services performed on different dates, within 47 months of each other.

Purpose:

To ensure that Medicare only pays only for certain services only within their allowed frequency.

Error Code	Explanation
	Resolution: Deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
5376	OP Medicare will not pay for Screening Flexible Sigmoidoscopy services performed within 47 months of a Screening Barium Enema as an alternative to Screening Flexible Sigmoidoscopy service. Medicare does not cover high-risk Screening Colonoscopy service performed within 23 months of a Screening Barium Enema as an alternative to Screening Colonoscopy services for beneficiaries at high-risk for developing colorectal cancer. Medicare does not cover Screening Barium Enema as a alternative to Screening Colonoscopy services performed within 23 months of a screening Colonoscopy service. Medicare does not cover Screening Barium Enema as an alternative to Screening Flexible Sigmoidoscopy service performed within 47 months of a Screening Flexible Sigmoidoscopy service. **Purpose:** To ensure that Medicare pays for certain services only within their allowed frequency. **Resolution:** Deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
5377	OP Medicare will not pay for two high-risk screening colonoscopy services performed on different dates, within 23 months of each other for beneficiaries at high-risk for developing colorectal cancer. In addition, Medicare will not pay for two screening barium enema services as an alternative to screening colonoscopy services performed on different dates, within 23 months of each other.

Error Code	Explanation
	Purpose: To ensure that Medicare pays for certain services only within their allowed frequency. **Resolution:** Deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
5378	OP Medicare will not pay for certain colorectal cancer screening services when the beneficiary is less than age 50. **Purpose:** To ensure that Medicare does not pay for services for which the beneficiary is not entitled. **Resolution:** Deny the claim using MSN 18.13 - "This service is not covered for beneficiaries under 50 years of age."
5379	OP HCPCS Code G0160 (cryosurgical ablation of localized prostate cancer, primary treatment only) has been billed more than once on the same claim, or it is already posted with the same Date of Service. **Purpose:** To ensure that Medicare pays for certain services only within their allowed frequency. **Resolution:** Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
538A	OP Duplicate HCPCS Code, 55873 (cryosurgical ablation of the prostate), is already posted for the same Date of Service.

Error Code	Explanation
	Purpose: To ensure that Medicare pays for certain services only within their allowed frequency. **Resolution:** Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
538B	OP Medicare will not pay for a screening flexible sigmoidoscopy HCPCS Code G0104 performed within 10 years of a colorectal cancer screening HCPCS Code G0121. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within the allowed frequency. **Resolution:** Deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
538C	Medicare will not pay for a colorectal cancer screening HCPCS Code G0121 performed within 10 years of a colorectal cancer screening HCPCS Code G0121. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within the allowed frequency. **Resolution:** Deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."

Error Code	Explanation
538F	HH The From Date and Provider Number on the Home Health claim equals the Start Date and Provider Number on the Home Health PPS episode. **Purpose:** To ensure that Medicare does not make duplicate payments for services covered under a Home Health episode payment. **Resolution:** Deny the claim.
538G	HH The Statement Dates on the Home Health claim are overlapping a Home Health PPS episode but the Provider Numbers equal. **Purpose:** To ensure that Medicare does not make duplicate payments for services covered under a Home Health episode payment. **Resolution:** Deny the claim.
538I	HH The Statement Dates on the Home Health claim are overlapping a Home Health PPS episode with a different Provider Number and Source Code "B" or "C" is not present. **Purpose:** To ensure that Medicare does not make duplicate payments for services covered under a Home Health episode payment. **Resolution:** Deny the claim.
538K	IP, OP Information from SSA indicates Beneficiary has been Deported.

Error Code	Explanation
	Purpose: To ensure that Medicare does not make payments for beneficiaries that are not entitled. **Resolution:** Verify HICN with SSA.
538L	HH, Hospice, Hospital, OP, SNF More than 10 hours DSMT paid in initial year. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency. **Resolution:** Deny the claim.
538N	OP More than 3 hours MNTT paid in initial year. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency. **Resolution:** Deny the claim.
538P	OP More than 2 hours follow-up MNTT paid. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency.

Error Code	Explanation
	Resolution: Deny the claim.
5380	OP HCPCS Code G0161 has been billed, and HCPCS Code G0160 is not on the incoming record, or posted with the same Date of Service. **Purpose:** To ensure that auxiliary services are not covered if the main service on which they depend has not also been billed. **Resolution:** Return to provider indicating that the primary service bill has not been received.
5381	OP Duplicate HCPCS Code G0161, G0161/TC, or G0160/26, is on an incoming record, or posted to CNCR Auxiliary file, with the same Date of Service. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency. **Resolution:** Investigate duplicate claim. Correct and resubmit claim if appropriate, or deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5382	Medicare will not pay for prostate cancer screening services when the beneficiary is less than age 50. **Purpose:** To ensure that Medicare does not pay for services for which the beneficiary is not entitled.

Error Code	Explanation
	Resolution: Deny the claim using MSN 18.13 - "This service is not covered for beneficiaries under 50 years of age."
5383	Medicare will not pay for two digital rectal examinations (G0102 Prostate Cancer Screening) within eleven months of each other; **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency. **Resolution:** Deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5384	HH Bill Type 34X is present with Revenue Code 0636, HCPCS Code J0630 (injection, calcitonin salmon, up to 400 units), the Dates of Service are on or after October 1, 2000, and the Provider Number is not the same as the Home Health PPS episode. **Purpose:** If an open HH episode exists, only the provider on the episode record can bill this service. **Resolution:** Reject claim using MSN 26.4 - "This service is not covered when performed by this provider."

Error Code	Explanation
5385	HH

The Statement Dates on the Home Health claim are overlapping an existing Home Health PPS episode on file without the appropriate Patient Status (06), or Source of Admission Code B, or C.

Effective January 1, 2003, this edit is no longer set when the RAP or claim overlapping an existing episode has the same provider number, and the RAP or claim From Date matches or differs from the episode Start Date of the existing episode. This edit will also no longer be set when a claim which corresponds to an episode of less than 60 days, overlaps another existing episode on which source of admission code B or C is not present.

Purpose:

To ensure that conflicting Home Health claims are not approved.

Resolution:

Reject claim indicating overlapping dates with a HH PPS episode.

For claims submitted April 1, 2002 and after: If the conflicting claim is for an earlier episode than the claim on history and there are no line item dated services that fall within the later episode, the shared systems will change the patient status code to 06 and reprocess the claim as a partial episode payment (PEP) before returning it to CWF.

5386 HH

The detail line item date on the final claim does not fall within the Home Health PPS episode period on file; or

The Home Health PPS episode has a Cancellation Indicator of one posted.

Purpose:

To ensure that Home Health claims are not approved if they do not fall within a Home Health episode period.

Error Code	Explanation
	Resolution: Reject claim indicating that the Dates of Service are not within a Home Health PPS episode period. Use MSN 21.21 - "This service was denied because Medicare covers this service only under certain circumstances."
5387	HH Patient Status 30 is present on a final claim and the Thru Date does not equal the calculated Episode End Date on file. **Purpose:** To ensure that final claims are processed correctly. **Resolution:** Return to provider for correction of Patient Status.
5388	OP Prostate screening with invalid sex on Beneficiary Master Record (G0102, G0103, G0160, G0161, or 55873). **Purpose:** To prevent payment for prostate screening to female beneficiaries. **Resolution:** Assure that the beneficiary's sex is female and deny the claim. If sex is male, change the information on the claim and resubmit.
5389	OP This edit deactivated with release R2002100. The detail line item Date of Service is within the Start and End Date of a Home Health PPS episode, and a non-routine medical supplies HCPCS code is present. **Purpose:** To ensure that duplicate payment is not made for services included as part of other services.

Error Code	Explanation
	Resolution: Reject claim with reason code B15 (Claim denied/reduced because this procedure/service is not paid separately) and the following messages: Remittance: N70: "Home Health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement." MSN: 16.29: "Payment is included in another service you have received." EOMB: 9.55" "Payment is included in another service you have received."
539A	OP Medicare will not pay for HCPCS Code G9008 more than two times per month. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency. **Resolution:** Deny the claim using MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
5390	OP The detail line item Date of Service or From and Thru Date (if detail line item Date of Service is not present) is within the Start and DOLBA of the Home Health PPS episode, and a Therapy Revenue Code/HCPCS code is present. **Purpose:** To ensure that duplicate payment is not made for services included as part of other services.

Error Code	Explanation
	Resolution: Reject claim with reason code B15 (Claim denied/reduced because this procedure/service is not paid separately) and the following messages: Remittance: N70: "Home Health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement." MSN: 16.29: "Payment is included in another service you have received." EOMB: 9.55: "Payment is included in another service you have received."
5391	HH Invalid Final claim with Action Code 1; or LUPA Final claim with Action Code 1, an episode exists on file, and the RAP (3x2) has not been canceled. **Purpose:** To ensure the correct processing of final claims. **Resolution:** Correct Action Code and resubmit claim.
5392	OP The MCCD/DMD Notice of Election (89A) matches the MCCD Aux. file, which already indicates an election period and the period has no Revocation Date posted, or the Election Date is prior to the previous Revocation Date on the MCCD Aux. File. **Purpose:** To ensure that duplicate or overlapping election periods are not posted.

Error Code	Explanation
	Resolution: Return to provider indicating that an election period is already posted for the specified date.
5393	OP MCCD/DMD Notice of Revocation (89B) or a MCCD Notice of Cancellation (89D) and there is no MCCD master data present for the beneficiary; MCCD/DMD Notice of Revocation (89B) Date is prior to the posted election period; A MCCD/DMD Revocation Date (89B) is present on the posted election period on file; A MCCD/DMD Revocation Date (89B) is prior to the latest MCCD HCPCS Code Date on the MCCD Aux. file; A MCCD/DMD Notice of Cancellation (89D) Date does not match the Election Date on the MCCD Aux. file; or A MCCD/DMD Notice of Cancellation Date does not match the previous Revocation Date on the MCCD Aux. file. **Purpose:** To ensure that revocations and cancellations that do not correctly match an election period do not get posted. **Resolution:** Return to provider indicating that the revocation or cancellation does not have a matching election period.
5394	OP MCCD/DMD Notice of Cancellation (89D) and there are MCCD claims (Part A outpatient claims and/or Part B/carrier claims) that have been posted during the election period that is being canceled. **Purpose:** To ensure that an election period cannot be cancelled if claims have been posted against it.

Error Code	Explanation
	Resolution: Return to provider indicating that an election period cannot be cancelled if claims have been posted against it.
5395	OP MCCD/DMD outpatient claims with no MCCD master file for beneficiary. **Purpose:** To ensure that MCCD claims are not paid for beneficiaries that are not enrolled in the demo. **Resolution:** Deny the claim with group code CO, reason code 96, and the following messages: Provider Remittance Notice: (M138) Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants. MSN or EOMB: 60.6 - "A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you are not currently enrolled or your enrollment has not yet been approved for the demonstration."
5396	OP MCCD outpatient claims with Dates of Service that do not fall within a posted election period, or the Dates of Service are after the Revocation Date. **Purpose:** To ensure that MCCD claims are not paid for Dates of Service outside of a posted election period.

Error Code	Explanation
	Resolution: Deny the claim with group code CO, reason code 96, and the following messages: Provider Remittance Notice: (M138) Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants. MSN or EOMB: 60.7 - "A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you have either terminated your election to participate in the demonstration project or the Dates of Service are outside the demonstration participation dates."
5397	OP MCCD/DMD outpatient claims with Demo Number 37 and a HCPCS code is present that is not in the range of G9001-G9012. **Purpose:** To ensure that services not approved for the MCCD demo are processed under normal Medicare coverage policy. **Resolution:** Split the claim, placing all MCCD services on one claim and all non-MCCD services on another claim, resubmit both claims.
5398	OP Medicare will not pay (G9001, G9002, G9003, G9004, G9005, G9009, G9010, or G9011) twice in the same calendar month. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within their allowed frequency.

Error Code	Explanation
	Resolution: Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5399	OP Medicare will not pay for HCPCS Code G9007 more than four times in a calendar year. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within the allowed frequency. **Resolution:** Deny the claim using MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
539C	OP Medicare will not pay for MCCD/DMD HCPCS Code(s) (G9013, G9014, or G9015) twice in the same calendar month. **Purpose:** To ensure that Medicare pays for certain services (or similar services) only within the allowed frequency. **Resolution:** Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5400	OP Blood deductible is over applied. **Purpose:** To assure proper calculation of deductibles. **Resolution:** Resubmit the claim showing the correct blood deductible.

Error Code	Explanation
5401	OP Blood deductible is under applied. **Purpose:** To assure that excessive Medicare funds are not spent. There is blood deductible remaining to be met for this benefit period. **Resolution:** Resubmit the claim showing the correct blood deductible.
5420	OP Expenses subject to deductible are incorrect. **Purpose:** To ensure that the deductible is calculated correctly. **Resolution:** Correct claim and resubmit.
5421	OP Deductible and coinsurance adjustments necessary for Medicare Secondary Payer. **Purpose:** To assure proper payment when MSP is involved. **Resolution:** Correct the deductible and coinsurance on the claim as appropriate.
5430	OP Outpatient immunosuppressive drug bill shows a discharge date for a covered transplant (Occurrence Code 36) and there is no covered inpatient hospital transplant stay.

Error Code	Explanation
	Purpose: To prevent erroneous payment. **Resolution:** Verify with provider that a covered transplant was performed. If so, verify that an inpatient bill has been submitted. If an inpatient bill has been submitted, but has not processed through CWF hold claim and resubmit. If there was no covered transplant, deny the claim.
5520	H Current psychiatric utilization days are greater than zero and current psychiatric utilization days plus total pre-entitlement psychiatric days are greater than 150. **Purpose:** To limit a psychiatric first spell of illness to 150 days, including pre-entitlement days. **Resolution:** The total of pre-entitlement days, plus post-entitlement psychiatric days, cannot exceed 150 days for the first spell of illness when a beneficiary is in a psychiatric hospital prior to entitlement, and is still a patient in a psychiatric hospital on the day of entitlement. Determine the amount of any applicable reduction. Investigate if the current admission is to a psychiatric hospital. Investigate any utilization in the 150-day period before entitlement.
5530	H Over-utilization of Lifetime Psychiatric Days or over-utilization of psychiatric benefits in a benefit period where a pre-entitlement reduction is applicable. **Purpose:** To ensure that the maximum number of psychiatric days (190) are not exceeded.

Error Code	Explanation
	Resolution: Correct the bill and resubmit according to utilization remaining. If Lifetime Reserve Days are needed, then a beneficiary election is required.
5550	S SNF claim with Occurrence Code 70 (qualifying inpatient hospital stay service dates) Thru Date that is not equal to or greater than the beneficiary's Part A Entitlement Date. **Purpose:** To ensure that Medicare payments are not paid for services obtained prior to the beneficiary's entitlement. **Resolution:** Deny claim using MSN 5.5 - "Our records show you did not have Part A coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice."
5600	H, S, HH, HOSP, OP Duplicate Claim HUIP Bills - This HUIP bill matches a posted HUIP bill on the From Date and Thru Date fields. This bill has Action Code 1, 3, or 9 (if posted bill Action Code is other than an 8). An incoming pay bill will overlay a posted no-pay bill unless the posted bill is an MSP bill. HUOP Bills - This bill matches a posted bill on Provider Number, Bill Type, Dates of Service (or Span Code 72, first and last service dates, if present), Revenue Codes, Revenue Charges and Total Charges; the last digit of Bill Type is not a 5 (late charges); and the Action Code is a 1, 3 or a 9 (if the posted bill Action Code is other than an 8). **Purpose:** To prevent duplicate payments to provider.

Error Code	Explanation
	Resolution: Check bill history to determine if the posted bill was sent by the provider. If not, obtain a Host HIMR to determine which Satellite processed the posted bill. Correct the bill or notify the provider that the bill has been canceled as a duplicate bill. If another FI processed the bill incorrectly, have the other FI submit credit, debit, or cancel-only bills to correct the Host history.
5601	H, S This bill overlaps a posted bill From Date and Thru date. **Purpose:** To prevent payment to providers for overlapping claims. **Resolution:** For HUIP Bills - The Satellite checks its bill history to determine if the posted HUIP bill was sent by them. If not, request a HIMR from the Host to determine the origin of the posted bill, and contact the originating Satellite to determine where the error in billing dates occurred. The Satellite at fault takes action to correct the error and submits either credit/debit actions or corrects the bill and resubmits it. If this bill needs to be corrected, notify the provider and prepare a remittance advice, if indicated. For HUOP Bills - This bill overlaps the service dates of a posted HUOP bill and matches Provider Number, Bill Type, Revenue Codes; the last digit of the Bill Type is not a 5 (late charges), and the Action Code is a 1 or 3. Check the bill history to determine if the posted bill was sent by that provider. If another FI processed the posted bill, determine who is at fault. The FI at fault should prepare either a credit/debit adjustment or correct this bill and resubmit. The final remittance advice(s) reflects payment to the provider.
5603	H Payment request (Action Code 9) service date does not fall within an existing spell of illness. **Purpose:** A payment request (Action Code 9) must have a corresponding debit with no pay code "R" on history.

Error Code	Explanation
	Resolution:
	Verify dates and resubmit.
5604	H
	Payment request (Action Code 9) submitted, but no match found on history.
	Purpose:
	A payment request (Action Code 9) must have a corresponding debit with no pay code "R" on history.
	Resolution:
	Verify dates and resubmit.
5606	H, S
	An incoming inpatient hospital or SNF claim has an Admit Date that is less than the From Date, and a history claim is not present with a Thru Date the day before the From Date of the incoming claim.
	Purpose:
	To ensure that initial, interim, and final claims have sequential Dates of Service.
	Resolution:
	Return to provider for date verification and correction.
5607	H, S
	An incoming inpatient hospital or SNF claim has an Admit Date that is less than the From Date, but a history claim is not present with the same Admit Date, same Provider Number and a Patient Status 30.
	Purpose:
	To ensure that initial, interim, and final claims have sequential Dates of Service.
	Resolution:
	Return to provider for date verification and correction.

Error Code	Explanation
5608	H, S

An incoming inpatient hospital or SNF claim has service dates that fall between the Admit Date and service From Date of a history claim. The Admission Date or Provider Number is not the same as the history claim and the Patient Status is not 30.

Purpose:

To ensure that duplicate services are not paid for by Medicare.

Resolution:

Reject claim for overlapping dates with a claim on history.

Use MSN 7.1 - "This is a duplicate of a charge already submitted."

5610 OP

Duplicate claim information for Action Code 7 - accrete bill history. match only on processing Intermediary Number and Document Control Number.

Purpose:

To ensure that an outpatient claim that is submitted to the Host is not already on the Host claims history file.

Resolution:

Ensure that the outpatient claim is coded properly and is not already on the Host claims history file. If coded improperly, correct the Action Code 7 outpatient claim and resubmit the claim to the Host. If the claim is on the Host claim history file, delete Action Code 7 outpatient claim and take whatever action that necessitated the claim to be on the claim history file.

5612 OP

Screening PAP smear indicates that a prior procedure was performed within three years and the beneficiary is not high-risk.

Purpose:

To prevent this procedure from being billed more frequently than permitted.

Error Code	Explanation
	Resolution: Deny because the diagnosis does not meet the eligibility criteria. Use MSN 18.4 - "This service is being denied because it has not been 36 months since your last examination of this kind."
5614	OP Medicare will not pay for two cancer screening pelvic/breast examination services within two years of each other for beneficiaries who are considered at low-risk for developing cervical or vaginal cancer and the Date of Service is on, or after 07/01/2001; or Medicare will not pay for two cancer screening pelvic/breast examination services within three years of each other for Beneficiaries who are considered at low-risk for developing cervical or vaginal cancer and the Date of Service is prior to 07/01/2001. **Purpose:** To ensure that services are not paid for more frequently than allowed. **Resolution:** Deny claim using MSN 18.4 - "This service is being denied because it has not been xx months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5620	H, S, HOSP, OP Beneficiary record is full, cannot update history. **Purpose:** To notify an FI when a beneficiary's record is full. **Resolution:** Contact Host to request purge of beneficiary's history.
5700	H Claim dates span three or more spells of illness.

Error Code	Explanation
	Purpose: To alert the contractor of the likelihood of improperly posted From and Thru dates for one or more of the stays. **Resolution:** Verify the From and Thru dates. Correct the bill(s) to enable proper calculation of the spells of illness.
5701	H, S, HH, HOSP, OP Non-utilization days as indicated by Noncovered Occurrence Span Code (M1, 70, 74, 76, and 79) and benefit exhaust dates (Occurrence Code 23) are less than the non-utilization field submitted on claim. This does not apply to Action Codes 2 or 4, Non-Payment Codes of B, C, or N, or to MSP cost avoided claims - Non-Payment Codes of E, F, G, H, J, K, Q, T, U, V, W, or Y. **Purpose:** To assure proper spell and utilization determination. **Resolution:** If this bill is valid, take corrective action to change the patient status on the posted bill (credit/debit). Verify with the provider that the bill charges need to be adjusted.
5702	H Over utilization of coinsurance and/or LTR days during the DRG inlier period. Occurrence Code A3 and Condition Code 60 or 61 are present. **Purpose:** To ensure proper calculation of utilization. **Resolution:** Correct utilization days and resubmit.

Error Code	Explanation
5901	H This bill is identified as a Kron bill, but does not meet the Kron bill criteria as: (1) Occurrence Codes 21, 22, or 23, Occurrence Span Code 77, or Nonpayment Codes R or X appears in history within 60 days of the Kron bill "from" date; (2) The "through" date on a hospital history bill is within 60 days of the Kron bill "from" date; (3) A SNF history bill contains all covered days and the "through" date is within 60 days of the Kron bill "from" date; or (4) A SNF history bill contains covered and noncovered days, but no Span Codes or Occurrence Codes specifying the noncovered period, and the calculated covered "through" date (determined when CWF subtracts the number of noncovered days from the SNF "through" date) is within 60 days of the Kron bill "from" date. **Purpose:** To assure proper calculation of spell of illness. **Resolution:** Verify validity of use of KRON Indicator and/or history. Correct as necessary and resubmit the claim.
5902	S A claim was submitted within 60 days prior to a spell of illness that contains a KRON bill as the earliest claim. **Purpose:** To assure proper calculation of spell of illness. **Resolution:** The Kron Indicator must be on the first claim in the spell. Adjust the Kron bill accordingly.

Error Code	Explanation
5903	H This Kron bill received within 60 days before the "from" date of an inpatient bill with Nonpayment Code B, benefits exhausted or beneficiary chose not to use lifetime reserve days. Nonpayment code B no longer applicable due to Kron bill's establishment of a new spell of illness. The incoming inpatient claim contains the Kron Indicator and will split the posted spell of illness into two spells. However, the split would cause an under-utilization situation in the "first" spell. **Purpose:** To prevent an under-utilization situation in a previously processed claim. **Resolution:** CWF Trailer Code 06, overlap/duplicate bill trailer, is returned with edit 5903 to identify the Nonpayment Code B bill. Cancel the Nonpayment Code B bill. Reprocess the Kron bill to payment, and then re-enter the B bill, but without Nonpayment Code B. If the B bill was processed by a different FI than that processing the Kron bill, the Kron FI must notify the B FI to cancel and subsequently resubmit the corrected B bill.
5904	H The Kron bill submitted requires that an existing spell of illness be split into two spells, but the spell of illness on the master record is not consistent with the spell data in history. **Purpose:** To assure proper calculation of spell of illness. **Resolution:** Forward a printout highlighting the problem field(s), annotated with the correct information to CWF Host using CWF assistance request. Reprocess the Kron bill for system payment when the edit condition has been cleared.
6000 series	6000 series errors apply to adjustment bills.

Error Code	Explanation
6000	No match on Admission Date, Stay Thru Date, Discharge Date, Deductible, Lifetime Reserve, Full Days, Coinsurance Days, Blood Pints Deductible, Blood Pints Furnished, Blood Pints Unreplaced, Provider Number [OP, HH] - No match on trailer year and/or archived history. **Purpose:** To alert the contractor of a material discrepancy that must be investigated and resolved prior to adjustment of claim payment. **Resolution:** Verify the data with the provider. Enter the corrected data. If no archived history, request HIMR. If not present, use Action Code 7 process.
6001	H, S The cancel/credit claim service dates do not fall within a spell of illness on the Beneficiary Master file. **Purpose:** To alert the contractor of a material discrepancy that must be investigated and resolved prior to adjustment of claim payment. **Resolution:** Verify the data with the provider. Enter the corrected data.
6002	H, S The cancel/credit claim service dates overlap a spell of illness on the Beneficiary Master Record. **Purpose:** To assure proper spell and adjustment determinations. **Resolution:** If the cancel/credit bill is valid, take corrective action to change the From/Thru Dates and correct the spell of illness. If not valid, correct the bill as needed.

Error Code	Explanation
6004	H, S A debit claim is combining two spells of illness and there is no history for one or both spells of illness. **Purpose:** To assure proper spell of illness determinations. **Resolution:** Verify the debit dates and enter any corrections. If necessary submit history accretion (action code 7).
6005	H, S A debit claim is editing out as a result of bad data on the HICA. A manual correction of the HICA will be required. Catastrophic-only edit. **Purpose:** To notify Host when a manual correction of data is required. **Resolution:** Contact Host for correction.
6006	H, S, HH, HOSP, OP Adjustment claim; match found on ICN but history bill contains a Cancel Date. **Purpose:** To ensure that previously canceled claims cannot have adjustments processed against them. **Resolution:** Return to provider indicating that the claim had been previously canceled.

Error Code	Explanation
6007	OP The transaction is an Action Code 7 (history add only), Action Code 4 (cancel only) or Action Code 3 (debit adjustment) and it contains a cash deductible amount but the deductible amount is greater than the amount for the trailer year that matches the service year of the claim. HOSP Hospice adjustment is processing to cancel a bill on history, and the number of utilization days on the bill being cancelled is greater than the number of utilization days indicated on the Hospice period the bill falls into. **Purpose:** To ensure proper calculation of deductible and utilization. **Resolution:** Correct deductible/utilization days and resubmit.
6008	H, S The bill being adjusted was cancelled during the process of rebuilding spells from history. The new debit was not applied. **Purpose:** To ensure that previously canceled claims cannot have adjustments processed against them. **Resolution:** Return to provider indicating that the claim had been previously canceled. If claim needs to be processed, submit a payment only claim (Action Code 1).

Error Code	Explanation
6009	HH, OP An Action Code 7 claim has deductible applied and the service year on the claim is not prior to the fifth Part B/carrier trailer year and does not match a Part B/carrier trailer year, or, there are less than five Part B/carrier trailer years present and the service year on the claim is not equal to any of the trailer years. HH There is no matching Part B/carrier trailer year for the claim service year, or there are no units in the visits field for the trailer year. **Purpose:** To ensure proper processing of an accrete history only claim (Action Code 7). **Resolution:** Correct claim and resubmit.
6010	HOSP This edit has been disabled for Inpatient processing. Adjustment for Hospice bill, but there is no Outpatient history. The incoming claim is Hospice, and there is no Hospice history for the beneficiary. **Purpose:** To assure proper processing of adjustments. **Resolution:** Verify the dates on the credit/cancel/debit bill with the provider. Correct the initial record or the adjustment bill, as needed, to enable a match.
6011	OP Adjustment/Credit - No match on trailer year. **Purpose:** To ensure proper processing of adjustments.

Error Code	Explanation
	Resolution: Correct claim and resubmit.
6030	OP Action Code = 7 (restore bill history record) insufficient expenses in beneficiary master trailer for this record. **Purpose:** To ensure that when a history add-only action is received (outpatient claim with an Action Code 7), there has been sufficient utilization posted. The only problem is that the claim is missing from history, but had been processed by either the UNIBILL batch system or CWF previously. **Resolution:** Since this claim had not been previously posted by either the UNIBILL batch system or the CWF system, resubmit the outpatient claim as an Action Code 1. Ensure the claim is not paid again, if previously paid.
6800 series	6800 series errors apply to MSP.
6801	H, S, HH, HOSP, OP MSP indicated on claim, but Host has no MSP Auxiliary Record. **Purpose:** To assure correct payment on an MSP claim. **Resolution:** Prepare an "I" MSP maintenance transaction and resubmit claim to CWF.
6802	H, S, HH, HOSP, OP MSP indicated on claim, no direct match on Auxiliary record iteration, but dates match on claim. **Purpose:** To assure correct payment on an MSP claim.

Error Code	Explanation
	Resolution: Analyze CWF auxiliary file; create a new "I" MSP auxiliary record; and resubmit claim.
6803	H, S, HH, HOSP, OP MSP is not indicated on the bill, but there is an MSP Auxiliary Record indicating that the MSP service dates are within the From and Thru dates on the bill. **Purpose:** To assure that proper payment is made by a primary payer. **Resolution:** Change the claim to indicate MSP, notify the provider and/or change the remittance advice to the provider and send the corrected claim to the Host. **Resolution:** (1) Deny claim. Advise beneficiary/provider: "Resubmit claim with other payer's Explanation of Benefits for possible secondary payment. If other insurance has terminated, resubmit with documentation showing termination dates of other insurance." If the contractor has documentation showing termination of the insurance coverage indicated in the CWF MSP occurrence, process as follows: (2) Post a termination date; or (3) Resubmit claim as MSP.
6805	H, S, HH, HOSP, OP MSP conditional payment claim and matching MSP record with "Y" validity indicator not found. **Purpose:** To ensure that MSP data is captured on CWF for possible future MSP involvement.

Error Code	Explanation
	Resolution: Input an MSP Maintenance Transaction Record to annotate MSP data to CWF. **Resolution:** (1) Create an "I" MSP Auxiliary Record. (2) Resubmit claim.
6806	H, S, OP, HH, HOSP The bill shows an MSP Override Code of M or N and no MSP Auxiliary Record is found with dates that fall within the Dates of Service on the bill. **Purpose:** To assure proper primary payer on all bills.

Error Code	Explanation
	Resolution: Change the bill to indicate Medicare primary payer and notify the provider unless development has assured the contractor that it is correct. Send an MSP maintenance transaction record to update the Host MSP Auxiliary File and resubmit the bill. **Resolution:** (AB-00-107) (1) Resubmit claim without an override code; or (2) Create an "I" MSP auxiliary record. An auxiliary record must be present to process a claim using an override code. Override Codes will be used as follows: Override code M = GHP services involved. Verify MSP auxiliary record exists. Matching criteria: Dates of Service on claim fall within Effective and Termination Dates on auxiliary record and validity indicator is equal to "Y." The service provided is: Not a covered service under the primary payer's plan; Not a covered diagnosis under the primary payer's plan; or Benefits have been exhausted under the primary payer's plan. Override Code N = Non-GHP involved. Verify MSP auxiliary record exists. Matching criteria are: Dates of Service on the claim fall within Effective and Termination Dates on auxiliary record and validity indicator is equal to "Y." The service provided is: Not a covered service under the primary payer's plan; Not a covered diagnosis under the primary payer's plan; or Benefits have been exhausted under the primary payer's plan. **NOTE:** Part B/carrier - Override Code "M" or "N" should be placed in MSP Code (field 95) of the CWF Part B claim record. When processing any primary claim not using an Override Code, this field must be left blank.
6810	Part A claim was processed and only a Part B/carrier (Insurer type K) matching record was found.

Error Code	Explanation
	Purpose: To ensure the correct processing of MSP data. **Resolution:** Process Part A claim as Medicare primary claim.
6812	OP An MCCD/DMD Notice of Election and Medicare is not primary, or MCCD outpatient (HUOP) record with Demo Number 37 and Medicare is not primary. **Purpose:** To ensure that enrollment in the MCCD demo is limited to beneficiaries who do not have Medicare as a secondary payer. **Resolution:** Reject the transaction indicating that MSP is not accepted under the demo.
7701	OP Outpatient claims with statement From Dates 01/01/1998 and later require HCPCS Code 90999 and a Modifier between G1 and G5 when the Revenue Code equals 0820, 0821, or 0829. Alert only. **Purpose:** To ensure the use of the proper modifier and HCPCS code for these revenue codes. **Resolution:** Notify provider of HCPCS code and modifier reporting requirements for these revenue codes.
8001	H Hospital full days over-applied. More full hospital days were applied than were available to the beneficiary.

Error Code	Explanation
	Purpose: To assure that excessive days are not paid for by Medicare. **Resolution:** Complete processing of claim with changes applied by CWF.
8002	H Hospital full days under-applied. There are hospital full days remaining that should be applied to this claim. **Purpose:** To assure that all beneficiaries receive all program benefits to which they are entitled. **Resolution:** Complete processing of claim with changes applied by CWF.
8003	H Hospital coinsurance days under-applied and lifetime reserve days were submitted. There are coinsurance days remaining that should be applied to this claim. **Purpose:** To assure that all beneficiaries receive all program benefits to which they are entitled. **Resolution:** Complete processing of claim with changes applied by CWF.
8004	H Hospital coinsurance days over-applied. More coinsurance hospital days were applied than were available to the beneficiary. **Purpose:** To assure that excessive days are not paid for by Medicare.

Error Code	Explanation
	Resolution:
	Complete processing of claim with changes applied by CWF.
8005	H
	Hospital LTR days over-applied. More LTR hospital days were applied than were available to the beneficiary.
	Purpose:
	To assure that excessive days are not paid for by Medicare.
	Resolution:
	Complete processing of claim with changes applied by CWF.
8006	H
	Cash deductible over-applied. Cash deductible submitted is greater than the amount left to be met.
	Purpose:
	To assure that all beneficiaries receive all program benefits to which they are entitled, and to minimize their out-of-pocket expenses.
	Resolution:
	Complete processing of claim with changes applied by CWF.
8007	H
	Cash deductible under-applied. Cash deductible submitted is less than what is left to be met for the benefit period, and total charges are greater than the deductible to be met.
	Purpose:
	To assure that excessive Medicare funds are not spent. There is inpatient cash deductible remaining to be met for this benefit period (spell).
	Resolution:
	Complete processing of claim with changes applied by CWF.

Error Code	Explanation
8008	H
	Blood deductible over applied. Blood deductible submitted is greater than what is left to be met in the benefit period.
	Purpose:
	To assure that all beneficiaries receive all program benefits to which they are entitled, and to minimize their out-of-pocket expenses.
	Resolution:
	Complete processing of claim with changes applied by CWF.
8009	H
	Blood deductible under applied. Blood deductible submitted is less than what is left to be met, and blood furnished is equal to or exceeds what is to be met for the benefit period.
	Purpose:
	To assure that excessive Medicare funds are not spent. There is blood deductible remaining to be met for this benefit period (spell).
	Resolution:
	Complete processing of claim with changes applied by CWF.
8010	S
	SNF full days over-applied. More full SNF days were applied than were available to the beneficiary.
	Purpose:
	To assure that excessive days are not paid for by Medicare.
	Resolution:
	Complete processing of claim with changes applied by CWF.
8011	S
	SNF full days under-applied. There are SNF full days remaining that should be applied to this claim.

Error Code	Explanation
	Purpose: To assure that all beneficiaries receive all program benefits to which they are entitled. **Resolution:** Complete processing of claim with changes applied by CWF.
8012	S SNF coinsurance days over-applied. More coinsurance SNF days were applied than were available to the beneficiary. **Purpose:** To assure that excessive days are not paid for by Medicare. **Resolution:** Complete processing of claim with changes applied by CWF.
8014	OP Outpatient cash deductible over-applied. The cash deductible amount required for the year has already been met on previously posted claims. **Purpose:** To assure that all beneficiaries receive all program benefits to which they are entitled, and to minimize their out-of-pocket expenses. **Resolution:** Complete processing of claim with changes applied by CWF.
8015	OP Outpatient (Part B) cash deductible under-applied. The cash deductible amount required for the year has not been met. **Purpose:** To assure that excessive Medicare funds are not spent. There is outpatient cash deductible remaining to be met for this calendar year.

Error Code	Explanation
	Resolution:
	Complete processing of claim with changes applied by CWF.
8026	HH
	Incorrect Billing Record Code submitted. Beneficiary has Part B benefits only and Billing Record Code on claim indicates Part A coverage.
	Purpose:
	To assure only actual beneficiary coverage is utilized.
	Resolution:
	Resubmit with correct Billing Record Code on claim, i.e., for Part B benefits.
8027	HH
	Incorrect Billing Record Code submitted. Beneficiary has Part A benefits and Billing Record Code on claim indicates Part B coverage.
	Purpose:
	To assure only actual beneficiary coverage is utilized.
	Resolution:
	Resubmit with correct Billing Record Code on claim, i.e., for Part A benefits.
8028	HH
	Bill Type 32X requires that the beneficiary have Part B entitlement;
	Bill Type 33X requires that the beneficiary have Part A entitlement; or
	Bill Type 32X, or 33X with a "U" RIC requires both Part A and Part B entitlement.
	Purpose:
	To ensure that Medicare pays only for services to which the beneficiary is entitled.

Error Code	Explanation
	Resolution: Return to provider requesting the provider to bill services for which the beneficiary is entitled. (HH services are payable under Part A first if the beneficiary has Part A. If not, the services can be billed under Part B.)
8029	HH Bill Type Code is 33X and there is no qualified inpatient stay; or For Dates of Service on or after, October 1, 2000, Value Code 62 is present, and there is not qualified inpatient stay. **Purpose:** To ensure that all beneficiaries utilizing Home Health services have had a qualifying inpatient stay. **Resolution:** Shared system will automatically correct TOB and resubmit.
8030	HH Part A Bill Type Code is 33X and the Part A visits submitted exceeds those available; or A Home Health claim with Value Code 62 for Dates of Service on or after, October 1,2000, and the Part A visits exceed those available. **Purpose:** To ensure that utilization of Home Health visits do not exceed the allowed number. **Resolution:** Shared system will automatically correct TOB and resubmit.
8031	HH Bill Type Code 32X, and there are Part A visits available; or Bill Type 32X, or 33X with no Value Code 62, for Dates of Service on, or after, October 1, 2000, and Part A visits are available.

Error Code	Explanation
	Purpose: To ensure that available Part A visits are utilized before billing against available Part B visits. **Resolution:** Shared system will automatically correct TOB and resubmit.
8032	HH Part A visits submitted exceed those available, and the claim links two Home Health Benefit periods. Part A Bill Type Code is 33X and the Part A visits submitted exceeds those available, or a Home Health claim with Value Code "62" for Dates of Service on, or after, 10/01/2000, and the Part A visits exceed those available. Furthermore, the Part A visits will cause two Home Health Benefit Periods to combine as one period. **Purpose:** To ensure that utilization of Home Health visits do not exceed the allowed number. **Resolution:** Shared system will automatically correct TOB and resubmit.
9000	H, S Hospital bill not subject to PPS or covered SNF bill contains Dates of Service (statement From and Thru date) that span more than two calendar years. Only PPS hospital and noncovered SNF claims can contain more than two calendar years within the Dates of Service. **Purpose:** To accommodate correct processing of bills spanning 3 or more years with covered and noncovered days and are part of two spells of illness in addition to a catastrophic record. **Resolution:** Return to provider indicating that the bill needs to be split.

80.3 - Part B/Carrier and DMEPOS Utilization Error Codes

(Rev. 1, 10-01-03)

B3-6011, CWF Editutil (http://cms.csc.com/cwf/downloads/docs/pdfs/editutil.pdf), B-02-049,

Utilization edit rejects are denoted by a value of "UR" in the disposition field on the Part B/carrier Reply Record. A Trailer 08, containing four utilization error codes, will always follow. A Trailer 12 will also be returned for UR & AA dispositions. Listed below are the possible utilization error codes with a general description of the error and a general description of the corrective action to be taken. This action is meant to be a re-examination of the claim information the contractor has on hand, and correction of the information submitted on the CWF Part B/carrier or DMEPOS Claim Record, not an exhaustive search for additional information.

Part B/Carrier and DMEPOS Utilization Error Codes

Error Code	Explanation
RT01	Claim is waiting retrieval of archived history. **Purpose:** To inform the FI that archived history is being retrieved and that they should hold claim before attempting to reprocess. **Resolution:** The Host retrieves the archive history records, a process that is executed weekly. Resubmit the claim in 6 working days.
RT02	Attempted history retrieval, but the beneficiary history pointers were full. **Purpose:** To notify the carrier that a history retrieval was unsuccessful. **Resolution:** Request the record manually or use the accrete process.
5050	Beneficiary record has been deleted by CMS. **Purpose:** To notify the carrier/DMERC that a Beneficiary Record has been deleted.

Error Code	Explanation
	Resolution: The beneficiary number requested by this claim is not available to the HOST. This record has been deleted at the CMS central office. The number the contractor is trying to use is a possible incorrect number and should be investigated through Social Security. If beneficiary number is correct, deny claim using MSN 5.1 - "Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office."
5052	Beneficiary Identification Incorrect - The Name and/or Claim Number shown on the bill is incorrect or claim number is not in file (not used for UR, used only for Disposition Codes 50, 51, 52, 53, 54, 55). **Purpose:** To ensure that the correct beneficiary is identified. **Resolution:** Take action indicated by the disposition code received. (See §20.2.2)
5053	Beneficiary is temporarily blocked due to a merge of beneficiary data mandated by CMS. **Purpose:** To prevent processing of transactions while beneficiary history data is being merged. **Resolution:** Recycle claim every 15 days until approval, adjustment, or reject response is received, or until otherwise notified.
5054	Beneficiary Auxiliary record missing and requested from CMS. **Purpose:** To inform the carrier/DMERC that a Beneficiary Record is temporarily unavailable and that they should hold claim before attempting to reprocess.

Error Code	Explanation
	Resolution: Recycle claim in specified number of days.
5055	Beneficiary blocked at CWF Host and CMS batch pending clerical update. **Purpose:** To inform the carrier/DMERC that a Beneficiary Record is temporarily unavailable and that they should hold claim before attempting to reprocess. **Resolution:** Recycle claim every 15 days until an approval, adjustment, or reject response is received, or until otherwise notified.
5056	The beneficiary number requested on this claim is not available to the Host. This record is marked as a skeleton at CMS central office and has been purged. The number being used is a possible incorrect number. **Purpose:** To inform the carrier/DMERC that a Beneficiary Record is unavailable and that further investigation may be necessary. **Resolution:** Check with the SSO to determine the proper HICN for this beneficiary. If the HICN and ID are correct, resubmit the bill in 15 working days.
5057	The beneficiary number requested by this claim is not available to the Host at this time because the Beneficiary Record at CMS central office has a skeleton record. (This is done when the beneficiary has a date of death and the beneficiary has not had claims activity for at least 6 months.) **Purpose:** To inform the carrier/DMERC that a Beneficiary Record is temporarily unavailable and that they should hold claim before attempting to reprocess. **Resolution:** Recycle claim every 15 working days. If 45 days pass without an approval, adjustment or reject (AAR) response, contact the RO.

Error Code	Explanation
5058	The beneficiary number requested by this claim is not available to the Host at this time because the Beneficiary Record at CMS central office is blocked. (This is done during cross-reference processing.) **Purpose:** To inform the carrier/DMERC that a Beneficiary Record is temporarily unavailable and that they should hold claim before attempting to reprocess. **Resolution:** Recycle claim every 15 working days. If no AAR response after receipt of second "58," contact the RO.
5059	The beneficiary number requested by this claim is not available to the Host at this time because the Beneficiary Record at CMS central office is frozen. (This is done while clerical corrections are being done.) **Purpose:** To inform the carrier/DMERC that a Beneficiary Record is temporarily unavailable and that they should hold claim before attempting to reprocess. **Resolution:** Recycle claim every 15 working days. If no AAR response after receipt of second "59," contact the RO.
5189	Part B Only The excepted/nonexcepted care indicator is not a 1, or 2, and the Dates of Service are during an RNHCI election period on file. **Purpose:** To suspend for review all non-RNHCI claims for a beneficiary with a posted RNHCI election period.

Error Code	Explanation
	Resolution: Review claim to determine if the care received by the RNHCI beneficiary was excepted or nonexcepted. Resubmit the claim to CWF indicating what type of care was received: Indicator 1 for excepted care. Indicator 2 for nonexcepted care.
5200	No entitlement - There is no record of the beneficiary's entitlement to the type of service on the claim. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Investigate. If appropriate, correct and resubmit claim.
5210	Services after benefits terminated. Effective January 1, 2003, only the start date of claims for HCPCS Code A4253, A4255, A4256, and A4259 is considered for this edit (not the entire span of service dates). **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Investigate (Trailer 04 and 09 will be present). Correct and resubmit claim, if appropriate.
5211	Services after death (Note: DME rental billing allowed within 30 days of Date of Death regardless of month end as long as the From Date is less than the Date of Death.) Effective January 1, 2003, only the From Date of claims for HCPCS Code A4253, A4255, A4256, and A4259 is considered for this edit (not the entire span of service dates).

Error Code	Explanation
	Purpose: To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate expense dates. Trailer 04 will be present. Resubmit claim if appropriate.
5220	Services prior to date of entitlement. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate expense dates. If appropriate, correct and resubmit claim.
5232	Services overlap GHO entitlement and override code is not = "1" (investigation shows not applicable). **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate expense dates and HMO Override Code. Trailer 05 will be present. Correct and resubmit claim.

Error Code	Explanation
5237	Claim indicates a CHOICES site, but Beneficiary either does not have a GHO Auxiliary Record, or the GHO Auxiliary Record is not associated with a CHOICES site, or the service dates overlap a CHOICES entitlement period; or Claim indicates an ESRD Managed Care Demonstration site, but Beneficiary either does not have a GHO Auxiliary Record, or the GHO Auxiliary Record is not associated with an ESRD Managed Care Demonstration site, or the service dates overlap an ESRD Managed Care Demonstration entitlement period; or Claim indicates an ENCOUNTER, but Beneficiary either does not have a GHO Auxiliary Record, or the GHO Auxiliary Record is not associated with a ENCOUNTER GHO ID, or the Service Dates overlap a risk GHO entitlement period. **Purpose:** To ensure that CHOICES/ESRD/ENCOUNTER services are paid for only in the time period for which the beneficiary is eligible. **Resolution:** Return to provider indicating that the billed services do not match the CHOICES/ESRD/ENCOUNTER information on file.
5239	Both the claim and the GHO Auxiliary record indicate a CHOICES site, but the CHOICES Identifiers are different; or Both the claim and the GHO Auxiliary Record indicate an ESRD Managed Care Demonstration site, but the ESRD Managed Care Demonstration Identifiers are different.; or Both the claim and the GHO Auxiliary Record indicate and ENCOUNTER site, but the ENCOUNTER Identifiers are different. **Purpose:** To ensure GHO beneficiary claims are processed only for the GHO in which the beneficiary is enrolled. **Resolution:** Reject claim indicating that Medicare records do not show the beneficiary as enrolled in the billing GHO.

Error Code	Explanation
5240	Part B Only CWF site processing non-RRB Beneficiary. This edit will be bypassed for all CHOICES, ESRD Managed Care Demonstration, and VA bills. **Purpose:** To ensure the appropriate carrier processes claim. **Resolution:** Validate processing carrier number and BIC. Have appropriate carrier resubmit claim. Use MSN 11.1 - "Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them." (NOTE: Use for carriers, FIs, RRB, United Mine Workers.
5242	Part B Only CWF site cannot process RRB beneficiary. This edit will be bypassed for all CHOICES, ESRD Managed Care Demonstration, VA bills, Encounter claims, and Indian Health Demo claims. **Purpose:** To ensure the appropriate carrier processes claim. **Resolution:** Check HICN to confirm RRB. Send claim to Palmetto RRB for processing. Do not deny claim. Use MSN 11.1 - "Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them." (NOTE: Use for carriers, FIs, RRB, United Mine Workers.
5243	Cannot process United Mine Workers beneficiary. **Purpose:** To ensure the appropriate carrier processes claim.

Error Code	Explanation
	Resolution: Confirm UMW beneficiary. Forward claim to UMW. Use MSN 11.1 - "Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them." (NOTE: Use for carriers, FIs, RRB, United Mine Workers.
5244	Part B Only Claim contains a CABG or Participating Center of Excellence Demonstration Number but the beneficiary does not have both Part A and Part B entitlement. **Purpose:** To ensure that claims are paid appropriately based on the beneficiary's status. Beneficiaries are not eligible for PCOE or CABG demonstrations if they do not have both Part A and Part B entitlement. **Resolution:** Reject indicating that beneficiaries not having both Part A and Part B entitlement are not eligible for claims payment under PCOE or CABG demonstration rules. Use MSN 5.5 - "Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice."
5245	Part B Only RRB Beneficiary contains a CABG or Participating Center of Excellence Demonstration Number. **Purpose:** To ensure that claims are paid appropriately based on the beneficiary's status. RRB beneficiaries are not eligible for PCOE or CABG demonstrations.

Error Code	Explanation
	Resolution: Return to provider indicating that RRB beneficiaries are not eligible for claims payment under PCOE or CABG demonstration rules. Use MSN 29.13 - "Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency." (NOTE: Use Add-on message as appropriate.)
5246	Part B Only GHO/Medicare CHOICES Beneficiary contains a CABG or Participating Center of Excellence Demonstration Number. **Purpose:** To ensure that claims are paid appropriately based on the beneficiary's status. GHO/Medicare CHOICES beneficiaries are not eligible for PCOE or CABG demonstrations. **Resolution:** Return to provider indicating that GHO/Medicare CHOICES beneficiaries are not eligible for claims payment under PCOE or CABG demonstration rules.
524Z	Service dates fall within Hospice Period and Override Code is not = "1" (investigation shows not applicable). **Purpose:** To ensure that Medicare pays for only services for which the beneficiary is entitled. **Resolution:** Validate first and last expense dates. Trailer 02 will be present. Resubmit claim.
5255	Part B Only Outpatient (Action Code 7), or Part B (Entry Code 9) history only bill for PAP Smear codes (G0141, G0143-G0145, G0147-G0148), or Mammography, but the service date on the claim does not match a Technical, or Professional Component Date on the Beneficiary Master Record.

Error Code	Explanation
	Purpose: To ensure that the technical and professional components of a PAP or Mammography claim are not in conflict. **Resolution:** Investigate dates on this claim and claim on history, make correction to claim in error.
5256	Part B Only Lung Volume Reduction Demonstration Number (30) is present on claim record, but the HIC number is not on the Lung Volume Reduction Eligibility file. **Purpose:** To ensure that Medicare paid LVRS only for beneficiaries enrolled in the NETT/LVR Demonstration.

Error Code	Explanation
	Resolution: Reject claim with reason code 96 and the following messages: Provider Remittance Notice: MA84: "Patient identified as participating in the National Emphysema Treatment Trial, but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact the Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy." MSN: 16-10: "Medicare does not pay for this item or service." 15-4: "The information provided does not support the need for this service or item." 15-16: "Your claim was reviewed by our medical staff" (add on to other messages as appropriate). EOMB: 16-17: "Medicare does not pay for this item or service." 15-9: "The information we have in your case does not support the need for this service." (If the claim was reviewed by your Medical Staff, add: "Your claim was reviewed by our Medical staff.")
5257	Part B Only A Demonstration Number of 30 is on an incoming claim and the line item Service Date is not equal to, or within, the Effective Date/Termination Date range on the Lung Volume Reduction Eligibility file. **Purpose:** To ensure that Medicare paid LVRS only for beneficiaries enrolled in the NETT/LVR Demonstration.

Error Code	Explanation
	Resolution: Reject claim with reason code 96 and the following messages: Provider Remittance Notice: MA84: "Patient identified as participating in the National Emphysema Treatment Trial, but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact the Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy." MSN: 16-10: "Medicare does not pay for this item or service." EOMB: 16-19: "Medicare does not pay for this because it is a treatment that has yet to be proved effective."
5258	Part B Only A Demonstration Number of 30 is on an incoming claim and the line item has a CPT Code of "32491," and the claim First-Expense Date for the associated line item is prior to the Phase "3A" Effective Date on the Lung Volume Reduction Eligibility File. **Purpose:** To ensure that Medicare paid LVRS only for beneficiaries enrolled in the NETT/LVR Demonstration.

Error Code	Explanation
	Resolution: Reject claim with reason code 96 and the following messages: Provider Remittance Notice: MA84: "Patient identified as participating in the National Emphysema Treatment Trial, but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact the Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy." MSN: 16-10: "Medicare does not pay for this item or service." 15-4: "The information provided does not support the need for this service or item." EOMB: 16-17: "Medicare does not pay for this item or service." 15-9: "The information we have in your case does not support the need for this service."
525Z	Service Dates fall within a risk GHO and Hospice Election Period, and the Hospice Override Code is not "1" (investigation shows not applicable). **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Deny the claim using MSN 11.3 - "Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them."

Error Code	Explanation
526Z	CHOICES/ENCOUNTER claim dates fall within CHOICES/GHO and Hospice periods, but Hospice Override Code 1 (Hospice Investigation shows not applicable) is present; or CHOICES/ENCOUNTER claim dates fall within CHOICES/GHO period, are on, or after, the Hospice Revocation Date and within the calendar month of the Hospice Revocation. **Purpose:** To ensure correct processing of managed care claims. **Resolution:** Return to provider indicating that a conflict exists between GHO and Hospice information on the claim or on the Beneficiary Master Record. Provider will need to investigate and make appropriate corrections.
5270	The Beneficiary is in a risk HMO with a Modifier QV (routine care), and the Deductible Indicator is not a 1. **Purpose:** To ensure that deductibles are not applied to HMO claims. **Resolution:** Change deductible indicator to "1" and resubmit claim.
5340	Part B Only Benefits exhausted on claim, but CWF indicates benefits are not exhausted for Psych, OT, or PT services Edit deactivated with r20003HE release. **Purpose:** To ensure that Medicare pays for all services for which the beneficiary is entitled. **Resolution:** Investigate expenses. Trailer 11 will be present. Correct your records and resubmit claim.

Error Code	Explanation
5361	Part B Only Claim for mammography screening, but CMS records show beneficiary is a male. **Purpose:** To ensure that Medicare pays only for services appropriate for a beneficiary's sex. **Resolution:** Validate beneficiary sex and type of service. Resubmit claim if appropriate.
5362	Part B Only Bill for mammography screening, but CMS records shows Beneficiary age as under 35 when screening was done. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate beneficiary age, type of service and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.3 - "Screening mammography is not covered for women under 35 years of age."
5363	Part B Only CMS records show beneficiary is over 34 and less than 40 and has had 1 previous screening. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate beneficiary age and number of screenings. Resubmit claim if appropriate. Or, deny the claim using MSN 18.6 - "A screening mammography is covered only once for women age 35 - 39."

Error Code	Explanation
5364	Part B Only CMS shows beneficiary as over 39 and less than 50, high risk is indicated and beneficiary has had a screening within 11 months; or Beneficiary is over 49 and less than 65 and has had a screening within 11 months. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate beneficiary age, risk category, last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5366	Part B Only CMS records show a prior screening date equal to this screening month and year. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5367	Part B Only Date of service is prior to screening date on CMS records and the date of service is less than 12 months prior to the posted date of service. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled.

Error Code	Explanation
	Resolution: Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.4 -"This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5368	Part B Only Date of service is prior to a screening date on CMS records and the bill date of service is less than 24 months prior to the posted date of service. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5369	Part B Only Screening mammography professional component bill already paid for this period. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate that a professional component bill has already been paid for this period and deny using MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
5373	Part B Only Mammography claim is submitted for a beneficiary within 11 full months of last Mammography Screening. Beneficiary is over 39 years of age and service is performed after 12/31/1997.

Error Code	Explanation
	Purpose: To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5374	Part B Only Medicare will not pay for two Screening Fecal Occult Blood test (G0107) services within 11 months of each other. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5375	Part B Only Medicare will not pay for two Screening Flexible Sigmoidoscopy services performed on different dates within 47 months of each other nor two Screening Barium Enemas performed as an alternative to Screening Flexible Sigmoidoscopy services performed on different dates, within 47 months of each other. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled.

Error Code	Explanation
	Resolution: Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
5376	Part B Only Medicare will not pay for a Colorectal Screening Colonoscopy service (G0121) performed within 48 months of a Screening Flexible Sigmoidoscopy (G0104). **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
5377	Part B Only Medicare will not pay for two Screening Colonoscopy services performed on different dates within 23 months of each other for beneficiaries at high risk for developing colorectal cancer. In addition, Medicare will not pay for two screening barium Enemas as an alternative to Screening Colonoscopy Services performed, within 23 months of each other. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."

Error Code	Explanation
5378	Part B Only Medicare will not pay for certain Colorectal cancer screening services when the beneficiary is less than age 50. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate beneficiary age. Resubmit claim if appropriate. Or, deny the claim using MSN 18.13 - "This service is not covered for beneficiaries under 50 years of age."
5379	Part B Only HCPCS Code G0160 has been billed more than once on the same claim, or it is already posted to the SURG900 file with the same Date of Service. **Purpose:** To ensure that Medicare pays only for certain services within their allowed frequency. **Resolution:** Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5380	Part B Only HCPCS Code G0161 has been billed, and HCPCS Code G0160 is not on the incoming record, or posted to the SURG900 file with the same Date of Service. **Purpose:** To ensure that auxiliary services are not covered if the main service on which they depend has not also been billed. **Resolution:** Return to provider indicating that the primary service bill has not been received.

Error Code	Explanation
5381	Part B Only Duplicate HCPCS Code G0161, G0161/TC, or G0160/26, is on an incoming record, or posted to CNCR Auxiliary file, with the same Date of Service. **Purpose:** To ensure that Medicare pays only for certain services (or similar services) within their allowed frequency. **Resolution:** Investigate duplicate claim. Correct and resubmit claim if appropriate, or deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5382	Part B Only Medicare will not pay for Prostate Cancer Screening services when the beneficiary is age 50 or less. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate beneficiary age. Resubmit claim if appropriate. Or, deny the claim using MSN 18.13 - "This service is not covered for beneficiaries under 50 years of age."
5383	Part B Only Medicare will not pay for two Digital Rectal Examinations (G0102 - Prostate Cancel Screening) performed within 11 months of each other; or Medicare will not pay for two Prostate Specific Antigen Tests (G0103 - Prostate Cancel Screening) within 11 months of each other. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled.

Error Code	Explanation
	Resolution: Validate beneficiary last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.4 - "This service is being denied because it has not been 12 months since your last examination of this kind." (NOTE: Insert appropriate number of months.)
5388	Part B Only Prostate screening with invalid sex on Beneficiary Master Record. (G0102, G0103, G0160, G0161, or 55873). **Purpose:** To ensure that Medicare pays only for services appropriate for a beneficiary's sex. **Resolution:** Validate beneficiary sex and type of service. Resubmit claim if appropriate.
5389	DMEPOS Only The detail line item Date of Service is within the DOEBA and DOLBA if present, if not, Start and End Date of a Home Health PPS episode, and a non-routine medical supplies HCPCS code is present. 5390: The detail line item Date of Service is within the DOEBA and DOLBA if present, if not, Start and End Date of a Home Health PPS episode, and a Therapy Revenue Code/HCPCS code is present. **Purpose:** To ensure that duplicate payment is not made for services included as part of other services.

Error Code	Explanation
	Resolution: Reject claim with reason code B15 (Claim denied/reduced because this procedure/service is not paid separately) and the following messages: Remittance: N70: "Home health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement." MSN: 16.29 "Payment is included in another service you have received." EOMB: 9.55: "Payment is included in another service you have received."
538A	Part B Only Duplicate HCPCS Code 55873 already posted to SURG900 file for the same Date of Service. **Purpose:** To ensure that Medicare does not pay for the same service more than once. **Resolution:** Investigate duplicate claim. Correct and resubmit claim if appropriate. Or, deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
538B	Part B Only Medicare will not pay for a Screening Flexible Sigmoidoscopy HCPCS Code G0104 performed within 10 years of a Colorectal Cancer Screening HCPCS Code G0121. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled.

Error Code	Explanation
	Resolution: Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
538C	Part B Only Medicare will not pay for a Colorectal Cancer Screening HCPCS Code G0121 performed within 10 years of a Colorectal Cancer Screening HCPCS Code G0121. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate last screening date and first expense date. Resubmit claim if appropriate. Or, deny the claim using MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
538D	Part B Only Medicare will not pay for screening Glaucoma HCPCS Codes G0117 or G0118 within twelve months of another posted "G0117" or "G0118." **Purpose:** To ensure that Medicare pays only for certain services (or similar services) within the allowed frequency. **Resolution:** Deny the claim using MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
5390	Part B Only The detail From and Thru Date is within or overlaps the Start and DOLBA Date of a Home Health PPS episode, and a Therapy Revenue Code/HCPCS Code(s) is present.

Error Code	Explanation
	Purpose: To ensure that duplicate payment is not made for services included as part of other services. **Resolution:** Reject claim with reason code B15 (Claim denied/reduced because this procedure/service is not paid separately) and the following messages: Remittance: N70: "Home health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement." MSN: 16.29: "Payment is included in another service you have received." EOMB: 9.55: "Payment is included in another service you have received."
5395	Part B Only MCCD/DMD Outpatient claims with no MCCD master file for the Beneficiary. **Purpose:** To ensure that MCCD claims are not paid for Beneficiaries that are not enrolled in the demo.

Error Code	Explanation
	Resolution: Deny the claim with group code CO, reason code 96, and the following messages: Provider Remittance Notice: (M138) Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants. MSN or EOMB: 60.6: "A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you are not currently enrolled or your enrollment has not yet been approved for the demonstration."
5396	Part B Only MCCD/DMD Part B Claims (HUBC) with Dates of Service that do not fall within a posted election period, or the Dates of Service are after the Revocation Date. **Purpose:** To ensure that MCCD claims are not paid for Dates of Service outside of a posted election period.

Error Code	Explanation
	Resolution: Deny the claim with group code CO, reason code 96, and the following messages: Provider Remittance Notice: M138: "Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants." MSN or EOMB: 60.7: "A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you have either terminated your election to participate in the demonstration project or the dates of service are outside the demonstration participation dates."
5397	Part B Only MCCD/DMD Part B claims (HUBC) with a Demo Number 37 and a HCPCS code is present that is not in Category 74. **Purpose:** To ensure that services not approved for the MCCD demo are processed under normal Medicare coverage policy. **Resolution:** Split the claim, placing all MCCD services on one claim and all non-MCCD services on another claim, resubmit both claims.
5398	Part B Only Medicare will not pay MMCD/DMD HCPCS Codes (G9001, G9002, G9003, G9004, G9005, G9009, G9010, or G9011) twice in the same calendar month. **Purpose:** To ensure that Medicare pays only for certain services (or similar services) within the allowed frequency.

Error Code	Explanation
	Resolution: Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
5399	Part B Only Medicare will not pay for HCPCS Code G9007 more than four times in a calendar year. **Purpose:** To ensure that Medicare pays only for certain services (or similar services) within their allowed frequency. **Resolution:** Deny the claim using MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
539A	Part B Only Medicare will not pay for HCPCS Code G9008 more than two times per month. **Purpose:** To ensure that Medicare pays only for certain services (or similar services) within their allowed frequency. **Resolution:** Deny the claim using MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
5400	Part B Only Blood Deductible Over-applied. **Purpose:** To ensure that Medicare pays for all services for which the beneficiary is entitled.

Error Code	Explanation
	Resolution:
	Investigate and correct blood deductible. Trailer 11 will be present. Resubmit claim.
5401	Part B Only
	Blood deductible under-applied.
	Purpose:
	To ensure that Medicare pays only for services for which the beneficiary is entitled.
	Resolution:
	Investigate and correct blood deductible. Trailer 11 will be present. Resubmit claim.
5410	Deductible adjustment necessary for MSP claim.
	Purpose:
	To ensure that deductibles are correctly calculated.
	Resolution:
	Correct claim and resubmit.
5411	Part B Only
	Psychiatric limitation adjustment necessary for MSP claim.
	Purpose:
	To ensure that MSP claim are processed correctly.
	Resolution:
	Correct claim and resubmit.
5412	Part B Only
	Physical Therapy adjustment necessary for MSP record claim.

Error Code	Explanation
	Purpose: To ensure that MSP claim are processed correctly. **Resolution:** Correct claim and resubmit.
5413	Part B Only Occupational Therapy adjustment necessary for MSP claim. **Purpose:** To ensure that MSP claim are processed correctly. **Resolution:** Correct claim and resubmit.
5414	Cash deductible amounts must be applied to all MSP line items prior to non-MSP services. **Purpose:** To ensure that MSP claim are processed correctly. **Resolution:** Correct claim and resubmit.
5501	DMEPOS Only There is no record on the ESRD Auxiliary File for the Beneficiary. **Purpose:** To ensure the beneficiary has an ESRD Auxiliary record on file. **Resolution:** Return to provider indicating that an ESRD Auxiliary record is not on file for this beneficiary.

Error Code	Explanation
5506	DMEPOS Only Claim for home dialysis is not assigned. **Purpose:** To ensure that only assigned claims for home dialysis are paid. **Resolution:** Deny the claim.
5507	DMEPOS Only Place of service is other than the beneficiary's residence. The place of service on an ESRD line item must be one of: 12 - Home, 31 - Skilled Nursing Facility, 32 - Nursing Facility, 33 - Custodial Care Facility, 54 - Intermediate Care Facility/Mentally Retarded. **Purpose:** To ensure that claims for home dialysis have a place of service of "Home" or an equivalent. **Resolution:** Verify place of service, deny claim if correct.
5510	DMEPOS Only Emergency ESRD supplies already furnished for this month. **Purpose:** Medicare will pay for only 1 month's worth of supplies to be kept in reserve in case of emergency. **Resolution:** Deny the claim using MSN 4.9 - "Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached."

Error Code	Explanation
5511	DMEPOS Only Emergency ESRD supplies exceed the monthly payment limit. The line item modifier indicates emergency supplies, and the Provider reimbursement on the line item exceeds the monthly CCPD or non-CCPD cap. **Purpose:** Medicare will pay for only 1 month's worth of supplies to be kept in reserve in case of emergency. **Resolution:** Deny the claim using MSN 4.9 - "Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached."
5600	Duplicate claim for Entry Code 1 (original debit) matched on processing carrier number, document control number, and first and last expense dates; cancel date on CWF history record = zero. **Purpose:** To ensure that Medicare does not pay for the same service more than once. **Resolution:** Investigate duplicate debit claim. Correct and resubmit claim, if appropriate.
5610	Duplicate claim for Entry Code 9 (accrete claim history only) matched on processing carrier number and document control number. **Purpose:** To ensure that Medicare does not pay for the same service more than once. **Resolution:** Investigate duplicate claim. Correct and resubmit claim if appropriate.

Error Code	Explanation
5612	Part B Only Screening PAP smear indicates prior procedure performed less than two years ago, beneficiary is low-risk, and the Date of Service is on or after 07/01/2001; or Screening PAP smear indicates prior procedure performed less than three years ago, beneficiary is low-risk, and the Date of Service is prior to 07/01/2001. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate the prior PAP smear procedure date and risk category. Resubmit claim. Or, deny using MSN 18.4 - "This service is being denied because it has not been xx months since your last examination of this kind."
5614	Part B Only Medicare will not pay for two Cancer Screening pelvic/breast examination services within two years of each other for Beneficiaries who are considered at low-risk for developing cervical or vaginal cancer and the Date of Service is on or after 07/01/2001; or Medicare will not pay for two Cancer Screening pelvic/breast examination services within three years of each other for Beneficiaries who are considered low-risk for developing cervical or vaginal cancer and the Date of Service is prior to 07/01/2001. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Validate the prior procedure date and risk category. Resubmit claim. Or, deny claim using MSN 18.4 - "This service is being denied because it has not been xx months since your last examination of this kind." (NOTE: Insert appropriate number of months.)

Error Code	Explanation
5620	Beneficiary record is full, cannot update history. **Purpose:** To notify a carrier/DMERC when a beneficiary's record is full. **Resolution:** Contact Host to request purge of beneficiary's history.
6000	Adjustment Claim - Unable to find match on history. **Purpose:** To ensure adjustments are processed against the correct history claim. **Resolution:** Check ARCPTRS file to determine if history record is available. If dates of service differ from the archived record, use the manual retrieval process. If there is no archived record, use the entry code 9 process.
6010	Adjustment Claim - No match to history claim. Note: Entry Code 3 (Full Credit) - Match on Processing Carrier Number, Document Control Number, and First and Last Expense Dates; Cancel Date on history record is zero. Entry code 5 (Replacement Debit) - Match on Processing Carrier Number, Document Control Number, and Year of Service; Cancel Date on history record is zero. **Purpose:** To ensure adjustments are processed against the correct history claim. **Resolution:** If the claim history exists under a different service date year than the service date year on the replacement debit, then resubmit the action as an Entry Code "3" cancel only claim followed by an Entry Code "1" debit claim.
6020	Adjustment Claim - insufficient expenses in the beneficiary master trailer for full credit (entry code 3 or 5).

Error Code	Explanation
	Purpose: To ensure that adjustments are processed correctly. **Resolution:** Investigate expenses submitted. Correct and resubmit claim.
6030	Entry Code 9 (restore history record) insufficient expenses in beneficiary master trailer for this record. **Purpose:** To ensure that adjustments are processed correctly. **Resolution:** Validate expenses. Correct and resubmit claim, if appropriate.
6040	Master Beneficiary Record contains incorrect spell and/or catastrophic data. **Purpose:** To ensure correct claim processing. **Resolution:** Verify spell and/or catastrophic data. Contact CMS for correction.
6801	MSP indicated on claim, but no auxiliary record exists. Matching criteria: MSP types are equal, validity indicator equals "Y," dates of service are within MSP period, and no override codes. **Purpose:** To assure correct payment on an MSP claim. **Resolution:** Prepare an "I" MSP maintenance transaction and resubmit claim to CWF.

Error Code	Explanation
6802	MSP indicated on claim, no direct match on auxiliary record iteration, but dates match on claim. Matching criteria: MSP types are equal, validity indicator equals "Y," dates of service are within MSP period, and no override codes. **Purpose:** To assure correct payment on an MSP claim. **Resolution:** Analyze CWF auxiliary file; create a new "I" MSP auxiliary record; and resubmit claim.
6803	DMEPOS Only MSP auxiliary record exists, no MSP indicated on claim but dates of service match. Matching criteria: the validity indicator equals "Y," dates of service are within the MSP period, and no override codes. **Purpose:** To assure that proper payment is made by a primary payer. **Resolution:** Change the claim to indicate MSP, notify the provider and/or change the remittance advice to the provider and send the corrected claim to the Host. **Resolution:** (1) Deny claim. Advise beneficiary/provider: "Resubmit claim with other payer's Explanation of Benefits for possible secondary payment. If other insurance has terminated, resubmit with documentation showing termination dates of other insurance." If the contractor has documentation showing termination of the insurance coverage indicated in the CWF MSP occurrence, process as follows: (2) Post a termination date; or (3) Resubmit claim as MSP.

Error Code	Explanation
6805	MSP Type Code equals "C" and MSP record found with Validity Indicator not equal to "I" or "Y." **Purpose:** To ensure that MSP data is captured on CWF for possible future MSP involvement. **Resolution:** Input an MSP Maintenance Transaction Record to annotate MSP data to CWF. **Resolution:** (1) Create an "I" MSP Auxiliary Record. (2) Resubmit claim.
6806	DMEPOS Only MSP Override Code "M" or "N" and no MSP record found with overlapping Dates of Service. or MSP cost avoid of "E," "F," "G," "H," "J," "K," "Q," "T," "U," "V," "Y," "00," "12," "13," or "14" with no MSP record originated by COB contractor. **Purpose:** To assure proper primary payer on all bills.

Error Code	Explanation

Resolution:

Change the bill to indicate Medicare primary payer and notify the provider unless development has assured the contractor that it is correct. Send an MSP Maintenance Transaction record to update the Host MSP Auxiliary File and resubmit the bill.

Resolution: (AB-00-107)

(1) Resubmit claim without an override code; or

(2) Create an "I" MSP auxiliary record. An auxiliary record must be present to process a claim using an override code.

Override codes will be used as follows:

Override code M = GHP services involved. Verify MSP auxiliary record exists. Matching criteria: Dates of service on claim fall within effective and termination dates on auxiliary record and validity indicator is equal to "Y."

The service provided is:

Not a covered service under the primary payer's plan;

Not a covered diagnosis under the primary payer's plan; or

Benefits have been exhausted under the primary payer's plan.

Override code N = Non-GHP involved. Verify MSP auxiliary record exists. Matching criteria are: Dates of service on the claim fall within effective and termination dates on auxiliary record and validity indicator is equal to "Y."

The service provided is:

Not a covered service under the primary payer's plan;

Not a covered diagnosis under the primary payer's plan; or

Benefits have been exhausted under the primary payer's plan.

NOTE: Part B - Override code "M" or "N" should be placed in MSP Code (field 95) of the CWF Part B Claim record. When processing any primary claim not using an override code, this field must be left blank.

Error Code	Explanation
6811	Part B Only DMERC claim was processed, and only a Part A (Insurer Type "J") matching record was found. **Purpose:** To ensure that Medicare pays only for services for which the beneficiary is entitled. **Resolution:** Deny claim, use MSN 5.5 - "Our records show you did not have Part B coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice."
6812	MCCD/DMD Part B (HUBC) record with Demo Number 37 and Medicare is not primary. **Purpose:** To ensure that enrollment in the MCCD demo is limited to beneficiaries who do not have Medicare as a secondary payer. **Resolution:** Reject the transaction indicating that MSP is not accepted under the demo.
8018	Cash deductible has been over-applied. Deductible submitted is greater than the amount to be met for the given year. **Purpose:** To ensure that Medicare pays for all services for which the beneficiary is entitled. **Resolution:** Trailer 07 will be present. Investigate and correct cash deductible. Resubmit claim.
8019	Part B cash deductible under-applied. Deductible submitted is less than the amount to be met and the total charges are equal to or greater than the deductible to be met.

Error Code	Explanation
	Purpose: To ensure that Medicare does not over-pay for beneficiary services. **Resolution:** Trailer 07 will be present. Investigate and correct cash deductible. Resubmit claim.
8020	Part B psychiatric expense limitation over-applied. The psychiatric expense submitted is greater than the expense to be met. **Purpose:** To ensure that Medicare does not over-pay for beneficiary services. **Resolution:** Trailer 07 will be present. Investigate and correct psychiatric limitation. Resubmit claim.
8022	Physical therapy limitation has been over-applied. Physical therapy expense submitted is greater than the expense to be met. **Purpose:** To ensure that Medicare does not over-pay for beneficiary services. **Resolution:** Trailer 07 will be present. Investigate and correct physical therapy limitation. Resubmit claim.
8024	Occupational therapy limitation has been over-applied. Occupational expense submitted is greater than the occupational therapy expense to be met. **Purpose:** To ensure that Medicare does not over-pay for beneficiary services. **Resolution:** Trailer 07 will be present. Investigate and correct occupational therapy limitation. Resubmit claim.

Error Code	Explanation
86X6	Part B Only Claim line Dates of Service do not fall within a certificate period on the CLIA record for the CLIA number on the claim line. **Purpose:** To ensure that CLIA certification is in place for dates of service. **Resolution:** Reject the claim.
86X7	Part B Only Line item HCPCS code category does not match the category type of the certificate for the line item From Date. **Purpose:** To ensure that the proper CLIA certification is in place for dates of service. **Resolution:** Reject the claim.
86XD	Part B Only CLIA certificate type is regular (type 1), accreditation (type 3), or partial accreditation (type 5); and although at least one of the lab Class Codes associated with the claim line HCPCS code, on the HCPCS record, matches the Specialty/Sub-Specialty Code(s) on the CLIA record, the claim line From Date of Service does not fall within the effective and termination dates, inclusive, of the matched Specialty/Sub-Specialty Code(s) on the CLIA record. **Purpose:** To ensure that the proper CLIA certification is in place for dates of service. **Resolution:** Reject the claim.

Error Code	Explanation
D901	DMEPOS Only DMEPOS item requires Certification; there are no CMN records for this Beneficiary and DMEPOS item, and there is no "MS" modifier present on the claim. **Purpose:** To ensure proper certifications are maintained. **Resolution:** Return to provider indicating that a CMN is required. Use MSN 8.21 - "This item cannot be paid without a new, revised or renewed certificate of medical necessity."
D902	DMEPOS Only DMEPOS Service Date not within a valid Certification date range. First and last line item service dates are not contained within the CMN date range. **Purpose:** To ensure proper certifications are maintained. **Resolution:** Return to provider indicating that a corresponding CMN is not on file for the dates of service. Use MSN 8.36 - "Payment is denied because the certificate of medical necessity on file was not in effect for this date of service."

Error Code	Explanation
D903	DMEPOS Only For HCPCS codes that require a CMN (Category 59): Capped Rental, Electric Wheelchair and PEN pump claims (without the "MS" or "RP" modifiers) are not allowed once the purchase option or rental cap has been met. CHOICES and ESRD Managed Care Demonstration claims are not subject to this edit under these circumstances. For HCPCS codes that do not require a CMN: Paid Claims History (PCH) indicates that the rental cap has been met for HCPCS codes of E0452, E0570, or E0600 and claims with these HCPCS codes are not allowed once the rental cap has been met. CHOICES and ESRD Managed Care Demonstration claims are subject to this edit under these circumstances. **Purpose:** To limit the duration that Medicare will pay for rental equipment. **Resolution:** Deny the claim.
D904	DMEPOS Only Claims for the maintenance of DMEPOS items are allowed only if the rental cap has been met and cannot take place until six months have passed from the Certification End Date (three months for parenteral pumps). **Purpose:** Maintenance fees are paid only after a rental cap has been met and can be billed only once every 6 months. **Resolution:** Deny the claim using MSN 8.14 - "Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 6-month period after the end of the 15th paid rental month."

Error Code	Explanation
D906	DMEPOS Only Inexpensive/Routinely Purchased item rental payments cannot exceed the cost of the item. The sum of the rental payments must not exceed the DME allowed amount. **Purpose:** The total rental payment amount may not exceed the allowed amount of a direct purchase. **Resolution:** Deny or reduce the allowed amount on the claim. Use MSN 8.6 - "A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made."
D907	DMEPOS Only Claim Type of Service does not match the Type of Service on the DMEPOS certification. **Purpose:** To ensure proper certifications are maintained. **Resolution:** Return to provider indicating discrepancy. Use MSN 8.21 - "This item cannot be paid without a new, revised or renewed certificate of medical necessity."
D908	DMEPOS Only Claim for Oxygen equipment must be based on the Flow Rate requirement established in the DMEPOS certification. **Purpose:** To ensure correct payment for Medicare services. **Resolution:** Recalculate allowed amount and resubmit.

Error Code	Explanation
D909	DMEPOS Only Immunosuppressive drug record Last Expense Date is greater than the coverage period when compared to the most recent Medicare covered transplant Discharge Date on the CMN record. **Purpose:** To ensure that Medicare does not pay for services for which the beneficiary is not entitled. **Resolution:** Deny the claim using MSN 4.2 - "This service is covered up to (insert appropriate number) months after transplant and release from the hospital. - Not used on remittance advice (RA) unless service being denied is exceeding this limit, in which case PR 35 would apply."
D910	DMEPOS Only Immunosuppressive Drug Claim shows First-Expense Date is less than the Discharge Date of a covered transplant hospital stay, or is not within the covered period of a transplant Discharge Date using the CMN Transplant Discharge Date. **Purpose:** To ensure that Medicare does not pay for services for which the beneficiary is not entitled. **Resolution:** Deny the claim using MSN 4.2 - "This service is covered up to (insert appropriate number) months after transplant and release from the hospital. - Not used on remittance advice (RA) unless service being denied is exceeding this limit, in which case PR 35 would apply."
D912	DMEPOS Only A full CMN must be posted to the CMNAUX file before a PEN HUDC transaction will be accepted. PEN HUDC transactions, which are in DMEPOS category 7, cannot be processed if the matching CMN record is a skeleton CMN.

Error Code	Explanation
	Purpose: To ensure proper certifications are maintained. **Resolution:** Return to provider indicating need for full CMN. Use MSN 8.21 - "This item cannot be paid without a new, revised or renewed certificate of medical necessity."
D919	DMEPOS Only Only one month of service per detail for this HCPCS code. The HCPCS code on the detail is Capped Rental or PEN Pumps, and the "Number of Services" field on the detail contains a value greater than 1. **Purpose:** Only one month of service is allowed per detail line for the HCPCS code. **Resolution:** Return to provider for correction, if more than one month of service is being billed split the bill into multiple line items.
D921	DMEPOS Only Therapeutic Shoes, Inserts, or Modification HCPCS codes without modifier RT or LT must have a units value of 2, 4, or 6. **Purpose:** Information required for proper payment. **Resolution:** Return to provider for addition of information. Use MSN 9.7 - "We have asked your provider to resubmit the claim with the missing or correct information." (NOTE: Add-on to other messages as appropriate.)

Error Code	Explanation
D922	DMEPOS Only Annual maximum allowance of therapeutic shoes, inserts, or modifications exceeded. **Purpose:** To ensure that Medicare does not pay for services for which the beneficiary is not entitled. **Resolution:** Deny the claim using MSN 17.8 - "Payment was denied because the maximum benefit allowance has been reached."
D929	DMEPOS Only PEN Pump (HCPCS code Category "10") or Oxygen (DMEPOS Category "5") claim with Dates of Service that are greater then the CMN Scheduled Re-certification Date and less than the CMN End Date on the CMN record. **Purpose:** To ensure required CMN information is up-to-date. **Resolution:** Return to provider, indicating that a new CMN will need to be filed prior to processing of this claim.

80.4 - IP, SNF, OP, HH, and Hospice Consistency Error Codes

(Rev. 1, 10-01-03)

A3-3809, CWF Editcons (http://cms.csc.com/cwf/downloads/docs/pdfs/editcons.pdf), A-02-031, A-02-064

The following are Part A consistency edits and the Bill Types each edit is applied to: General-all; H-Hospital; S-Skilled Nursing Facility; HH-Home Health; HOSP-Hospice; OP-Outpatient; NOE-Hospice Notice of Election.

Consistency edit rejects are denoted by a value of "ER" in the disposition field on the Part A Reply Record. A Trailer of 08 containing up to four Consistency error codes will always follow. Listed below are the possible Consistency error codes with a general description.

IP, SNF, OP, HH, and Hospice Consistency Error Codes

Error Code	Explanation	Action
A001	General	
	Invalid response code.	Contact Host.
A002	General	
	Invalid claim number.	Validate claim number. Resubmit claim.
A003	General	
	Invalid BIC.	Validate BIC. Resubmit claim.
A004	General	
	Invalid surname.	Validate surname. Resubmit claim.
A005	General	
	Invalid first initial.	Validate first initial. Resubmit claim.
A006	General	
	Invalid date of birth.	Correct date of birth. Resubmit claim.
A007	General	
	Invalid sex code.	Correct sex code (0, M, F). Resubmit claim.
A008	General	
	Invalid intermediary number.	Correct intermediary number. Resubmit claim.
A009	General	
	Invalid Contractor Number for Host site	Contact Host.

Error Code	Explanation	Action
A010	General	
	Requestor id (internal testing of transactions) field missing.	Correct Requestor Id field and resubmit claim.
A011	Hospital, SNF, OUTP, HHA, Hospice	
	Invalid Printer Destination.	Internal CWF edit, notify CWF Host.
A024	General	
	Invalid second initial.	Validate second initial. Resubmit claim.
A025	OP	
	For Financial or Revenue Override Code 0004, Bill Type must be Outpatient (13X), Federally Qualified Health Center (73X), Ambulatory Surgery Center (83X), or Rural Primary Care Hospital (85X).	Validate override code. Resubmit claim.
A026	OP	
	For Bill Type 73X expenses subject to deductible cannot be greater than zero.	Correct deductible applied. Resubmit claim if appropriate.
A027	M+CO	
	Bill Type is 11Z and the GHO Id is spaces or low values.	Correct the GHO Id field and resubmit claim.
A028	M+CO	
	Bill Type is 11Z and the Medicare Provider Number is spaces.	Correct the Medicare Provider Number and resubmit claim.

Error Code	Explanation	Action
A029	M+CO	
	Bill Type is 11Z and the principal diagnosis code is spaces or low values.	Return to provider for correction of principal diagnosis code.
A030	M+CO	
	The record is for Encounter Start-Up Data (Bill Type 11Z) but the GHO plan ID Number is for CHOICES, or ESRD.	Reject claim.
A031	M+CO	
	Bill Type is 11Z and Condition Code 04 is not present; Condition Code 69 is present and Condition Code 04 is not present; or The first 2 digits of the Bill Type are 11 or 21, a GHO number is present, the GHO Pay Code is 1, and the Condition Code 04 is not present.	Verify claim is a GHO Encounter; if so, plug Condition Code 04. Resubmit claim if appropriate.
A033	M+CO	
	Bill Type is 11Z and the Approval Date is zero.	Correct the Approval Date and Resubmit claim.
A034	H	
	The record is for IME/GME payment (Condition Code 69), but the GHO paid code is a 1.	Verify Condition Code 69 and GHO paid code. Resubmit claim.
A035	General	
	The record/segment count is missing one or more segments.	Correct record count and resubmit.
A036	General	
	The record/segment count has extra segment records.	Correct record count and resubmit.

Error Code	Explanation	Action
A037	General	
	A segment record without segment 01.	Contact Host.
A038	General	
	The total line count for claim is invalid.	Correct total line count and resubmit claim.
A039	General	
	The total line count for segment is invalid.	Correct total line count and resubmit claim.
A040	General	
	The record/segment count cannot be more than 01 for a Hospice NOE.	Correct record count and resubmit NOE.
A041	HH	
	LUPA indicator L is valid only for Bill Type 32X or 33X with four or less visits and the Dates of Service are on or after October 1, 2000.	Verify LUPA indicator, Bill Type, and Dates of Service. Resubmit claim if appropriate.
0011	H	
	Invalid action code, or, for Hospice NOE, action code not "1."	Validate action code, resubmit claim.
0012	HOSP	
	Only Outpatient claims are allowed to "Post to History" with Action Code 7.	Verify Action Code and resubmit claim if appropriate.
0013	H, S	
	CABG demonstration number 06 is present but the Admission Date is before 05/01/1997; or	Verify demo number and admission date. Resubmit claim if appropriate.
	Participating Center of Excellence Demonstration Number 07 is present but the Admission Date is before 10/01/1997.	

Error Code	Explanation	Action
0014	H	
	Claim classified as a Demo claim, but a Demonstration Numbers other than 03, 05, 06, 07, 08, 15, 30, 31, 38, 39, or 40 was submitted; or	Verify demo number and project id. Resubmit claim if appropriate.
	Claim classified as a Demo claim, but the proper Demonstration Project Identifier is not available.	
0015	General	
	Bill is submitted as an ESRD Managed Care Demonstration but Demo Number 15 is not present; or	Verify demo number and resubmit claim.
	Demo Number 15 is present but the bill is not submitted as an ESRD Managed Care Demonstration.	
0016	H	
	Inpatient claim with Provider Number 670899 or 674499 and VA Demonstration Number 31 is not present; or	Verify demo number and provider number. Resubmit claim.
	Inpatient claim with VA Demonstration Number 31 and the Provider number is not 670899, or 674499.	
0018	H	
	An Inpatient claim is submitted with VA Demonstration Number 31, and the Action Code is not equal to 1.	Correct the Action Code and resubmit claim.
0019	H, S	
	Demonstration Number "07" (Participating Centers of Excellence) "08" (Provider Partnership) is present with Condition Code "B1."	Return to provider for removal of either the demonstration number or the "B1" Condition Code.

Error Code	Explanation	Action
0020	General	
	The cancel-only adjustment bill does not contain the cancel-only Adjustment Code , or contains a code other than A, B, C, D, E, F, H, P, or S. A - Do not remove the home health episode period. B – Do not remove the home health episode period and set the cancel indicator to A 1. C - Coverage only code. D - Duplicate billing. E – FI removing the home health episode period. F - Provider removing the home health episode period. H – Other P - Plan transfer S – Scramble	Validate the cancel-only Adjustment Code and resubmit claim.
0021	H, S	
	A demonstration claim with criteria that matches more than one demonstration project.	Return to provider for clarification and correction.
0022	HH	
	Invalid cancel only code for a Home Health record.	Correct the Action Code and resubmit claim.
0401	General	
	The Bill Type is impossible, incomplete, missing, or is inconsistent with the provider number.	Correct the Bill Type and resubmit claim.

Error Code	Explanation	Action
	Valid Bill Type/provider number range combinations:	
	Bill Type	**Provider Number** (Positions 3-6)
0401 cont.	11X Hospital Inpatient Part A	0001-0999
		1200-1399
		2000-2299
		3025-3099
		3300-3399
		4000-4499
		T000-T999
		S000-S999
		000E-999E
		000F-999F
0401 cont.	12X Hospital Inpatient Part B	Same as 11X

Error Code	Explanation	Action
0401 cont.	13X Hospital Outpatient	1800-1989
		2300-2499
		0001-0999
		1200-1399
		2000-2299
		3025-3099
		3300-3399
		4000-4499
		000E-999E
		000F-999F
0401 cont.	14X Hospital Other Part B	1800-1989
		0001-0999
		1200-1399
		2000-2299
		3025-3099
		3300-3399
		4000-4499
		000E-999E
		000F-999F
0401 cont.	18X Hospital Swing Bed	U000-U999
		Y000-Y999
		W000-W999
		Z300-Z399

Error Code	Explanation	Action
0401 cont.	21X SNF Inpatient	5000-6499
0401 cont.	22X SNF Inpatient Part B	1800-1989
		5000-6499
0401 cont.	23X SNF Outpatient	5000-6499
0401 cont.	24X SNF Outpatient (Other Part B)	5000-6499
0401 cont.	28X SNF Swing Bed	5000-6499
0401 cont.	32X Home Health	1800-1989
		3100-3199
		7000-8499
		9000-9499
0401 cont.	33X Home Health	1800-1989
		3100-3199
		7000-8499
		9000-9499
0401 cont.	34X Home Health (Part B Only)	1800-1989
		3100-3199
		7000-8499
		9000-9499
0401 cont.	41X Religious Non-medical Health Care Institutions	1990-1999
0401 cont.	71X Rural Health Clinic	3400-3499
		3800-3999
		8500-8999

Error Code	Explanation	Action
0401 cont.	72X ESRD Clinic	0001-0999
		1200-1299
		2300-2999
		3300-3399
		3500-3799
0401 cont.	73X Federally Qualified Health Center	1800-1989
0401 cont.	74X Clinic OPT	6500-6899
		6900-6989
0401 cont.	75X CORF	3200-3299
		4500-4599
		4800-4899
		6500-6989
0401 cont.	76X Community Mental Health Center	1400-1499
		4600-4799
		4900-4999
0401 cont.	81X Non-hospital based Hospice	1500-1799
0401 cont.	82X Hospital based Hospice	1500-1799
0401 cont.	83X ASC payment limit	Same as 11X
		(Except 1300-1399)
0401 cont.	85X Critical Access Hospital (CAH)	1300-1399

Error Code	Explanation	Action
0401 cont.	89X Other Outpatient (Coordinated Care Demo)	0001-0999
		1200-1399
		1400-1499
		1800-1989
		2000-2299
		2300-2999
		3025-3099
		3100-3199
		3200-3299
		3300-3399
		3400-3499
		3500-3799
		3800-3999
		4000-4499
		4500-4599
		4600-4799
		4800-4899
		4900-4999
		5000-6499
		6500-6899
		6900-6989
		7000-8499
		8500-8999
		9000-9499
		000E-999E

Error Code	Explanation	Action
0402	HOSP	
	TOB 815 or 825 (Hospice late charge claim) and Revenue Codes other than 0657 are present. TOB 815 or 825 is valid when only Revenue Code 0657 is present.	Return to provider for correction.
0406	OP	
	Mammography bill with revenue code 403 and HCPCS Codes 76092, G0202, or G0203 is missing (and HCPCS code 76085 after 01/01/2002).	Validate revenue and HCPCS codes. Resubmit claim.
0407	HH, OP	
	For respite care bills with From Date after 12/31/90, Bill Type not 34X, but revenue code 66X is present.	Validate Bill Type and revenue code, resubmit claim if appropriate.
0410	OP	
	Outpatient immunosuppressive drug bill with occurrence code 36 present, but no revenue code 25X or 636.	Validate occurrence code and revenue code, resubmit claim if appropriate.
041A	H	
	Bill Type is 11A or 11D and Demonstration Number "07" or "08" is not present.	Return to provider for inclusion of demo number.
0412	H, S, OP	
	Late Charge Bill (Bill Type 115, 125, 185, 225, or 285) contains Accommodation Revenue Codes.	Return to provider for correction.
0413	OP, HH, HOSP	
	Claim contains a CABG or Participating Center of Excellence or Provider Partnership demonstration number that is valid only for Bill Type 11X.	Verify TOB and resubmit if appropriate.

Error Code	Explanation	Action
0414	HOSP, HH	
	Value Code 61 and corresponding MSA Code greater than zero is not present on Bill Type 81X or 82X with Revenue Code 0651 and/or 0652; or	Verify Value Code and MSA Code. Resubmit claim.
	Value Code 61 is present but corresponding MSA Code is not present on Bill Type 32X, 33X, or 34X.	
0415	HH	
	The RIC must be W if the Bill Type code is 32X and V if the Bill Type code is 33X, unless RIC is U, than allow either Bill Type 32X, or 33X.	Verify RIC and TOB. Resubmit claim.
0416	General	
	Record is a Non-PPS claim (not Bill type 21X) and a Revenue Code of 0022 is present.	Verify TOB and Revenue Code. Resubmit claim.
0417	HH	
	Revenue Code 0023 is valid only with Bill Type 32X or 33X with Dates of Service on, or after, October 1, 2000.	Verify Revenue Code and TOB. Resubmit claim.
0418	HH	
	Bill Type 3x5 and the Dates of Service are on or after October 1, 2000.	Reject claim.
0419	HH	
	Invalid RIC based on Value Code submitted.	Verify RIC and Value Code. Resubmit claim.
0701	General	
	Provider number positions 1-2 not numeric.	Correct provider number and resubmit claim.

Error Code	Explanation	Action
0702	H, S	
	Provider number not consistent with the Bill Type 11X.	Validate Bill Type and resubmit claim if appropriate.
	IP	
	Position 1	E, F
	Position 3	Zero, S, T
	Position 3-6	0999
		1200-1299
		1990-2499
		3000-3099
		3300-3399
		4000-4499
	SNF	
	Position 1	U, 5
	Position 3-6	6000-6499
0703	OP	
	Sex is male on mammography screening bill.	Validate sex and resubmit claim if appropriate.
1001	OP	
	The PRO indicator is not consistent with the action code, total charges, or reimbursement amount.	This edit is obsolete, if received. Contact CWF Host.
1501	H, S, HH	
	Date of admission is impossible or incomplete.	Correct date of admission and resubmit claim.

Error Code	Explanation	Action
1502	H, S, HH	
	Date of admission is later than From Date.	Validate date of admission and From Date, resubmit claim.
1503	S	
	Date of admission is more than 30 days after the Thru Date of the qualifying hospital stay and there is no Condition Code 55, 56, 57, or 58 present.	Validate date of admission and condition codes, resubmit claim if appropriate or deny. Use MSN 13.2 - "Skilled nursing facility benefits are available only after a hospital stay of at least 3 days."
1504	H, S	
	Date of admission or stay From or stay Thru Date is greater than the current date.	Verify dates; return to provider if necessary.
2101	H, S, HOSP	
	Patient status code omitted or impossible.	Correct patient status code and resubmit claim.
2102	H, S, HOSP	
	Patient status code is not correct. Code is 40, 41, or 42, and bill is not a Hospice Bill, or code is 20 and bill is a Hospice bill.	Validate patient status code and resubmit claim if appropriate.
2103	H	
	Invalid patient status with CMG rate code. Patient status should be 20.	Correct patient status and resubmit claim.
2201	General	
	From date is impossible or incomplete.	Correct From Date and resubmit claim.

Error Code	Explanation	Action
2202	HOSP	
	The statement From Date is later than the statement Thru Date. Note: This edit is performed on hospice notice of termination only (Bill Types 81B and 82B).	Validate from and Thru Dates, resubmit claim if appropriate.
2203	General	
	The statement Thru Date is an impossible or incomplete entry. **NOTE:** Performed on Hospice notice of termination only (Bill Types 81B and 82B).	Correct Thru Date and resubmit claim.
2204	General	
	The Statement From Date on this claim is prior to the Effective date of this aspect of the Medicare program: EGHP-Working Aged: 01/1/83 EGHP-ESRD Bene: 10/1/81 CORF: 07/1/81 Hospice: 11/1/83 PPS: 10/1/83 Bill Type 73X: 10/1/1991	Deny claim using MSN 21.11 - "This service was not covered by Medicare at the time you received it."
2205	OP	
	From date year not the same as the Thru Date year.	Verify dates and resubmit claim or return to provider indicating that they claim will have to be split.

Error Code	Explanation	Action
2206	H	
	Invalid Dates of Service. The Discharge Date on an IME/GME (Condition Code 69) record is before 01/01/1998.	Deny claim using MSN 21.11 - "This service was not covered by Medicare at the time you received it."
2207	OP	
	Mammography bill First Service Date on claim or first Span Code 72 Date must be equal to, or greater than, 01/01/1991.	Deny claim using MSN 21.11 - "This service was not covered by Medicare at the time you received it."
2208	S	
	Invalid Date of Service on a SNF Claim.	Verify date and resubmit or deny as appropriate.
2209	H	
	Home Health claim Dates of Service overlap July 1, 1999; or Home Health claim Dates of Service overlap October 1, 2000.	Return to provider.
2210	HOSP	
	Hospice NOE Bill Type 8xA, or 8xB with Action Code 2 and Field 29 does not contain a valid MMDDYY entry. This field should contain the original Hospice Election Period start date for claim type 8xA, or the original Hospice revocation date for 8xB.	Correct date and resubmit claim.
2211	H	
	A RNHCI Notice of Election (41A), Notice of Revocation (41B), or Notice of Cancellation (41D) is received, and the Admission Date is prior to July 1, 2000.	Return to provider for date correction.

Error Code	Explanation	Action
2212	H, S	
	Bill Type 51X and the Dates of Service are on, or after, July 1, 2000.	Return to provider for Bill Type correction.
2213	HH	
	Bill Type 32X or 33X should not be greater than 60 days, when the Dates of Service are on, or after, October 1, 2000.	Return to provider to be split into multiple claims.
2214	OP	
	A MCCD/DMD Notice of Election (89A), Notice of Revocation (89B), or Notice of Cancellation (89D) and the From Date is prior to January 1, 2001.	Return to provider for correction, coinsurance amounts should not appear on these transactions.
	Value Code (Coinsurance) A2, B2, or C2 is present.	
2215	OP	
	A MCCD/DMD Outpatient record with Demo Number 37 or Outpatient Encounter record and Value Code (Coinsurance) A2, B2, or C2 is present.	Return to provider for correction, coinsurance should not apply to MCCD claim.
2216	OP	
	An MCCD/DMD Outpatient record with Demo Number 37 and the expenses subject to Deductible is greater than 0 or Outpatient Encounter record, or Clinical Trail record with Condition Code 30 and Dates of Service on or after September 19, 2000	Return to provider for correction, deductible should not apply to MCCD claim.

Error Code	Explanation	Action
2301	H, S	
	Bill contains utilization days entry other than a number; Psychiatric facility (Provider range 4000-4499 or S001-S999) contains utilization days exceeding 150; or Bill with dates of service before or after 1989. A hospital bill exceeds 150. A SNF bill exceeds 100.	Correct utilization days field and resubmit claim.
2302	H, S	
	The sum of utilization days plus non-utilization days must equal the difference between the Thru Date minus the From Date in the Statement Covers Period. Exception: If a patient status code is 30 or if the From Date is equal to the thru date, the sum of utilization days plus non-utilization days must equal the difference between the thru date minus the From Date in the Statement Covers Period, plus 1.	Verify utilization days, non-utilization days, From Date, and Thru Date. Resubmit claim if appropriate.
2303	H, S	
	The number of Cost Report Days exceeds the number of Accommodation Days, but the date of admission and discharge are not the same.	Verify Cost Report Days, Accommodation Days, admission date, and discharge date. Resubmit claim if appropriate.
2304	H	
	No utilization days are shown on patient filed bill.	Correct utilization days and resubmit claim.

Error Code	Explanation	Action
2305	H, S	
	Utilization and/or non-utilization days are present on a Hospital Inpatient or SNF Inpatient late-charge claim.	TOB 115 and 215 should not be accepted by FI, if this edit is received confirm TOB and reject if appropriate.
2306	H, S	
	Utilization days are shown as 0. The From Date covered by the statement is not the same as the Thru Date. A nonpayment code is present, and some payment is being made. (Does not apply to credit or cancel only adjustment bills).	Verify utilization days, nonpayment code, and payment. Resubmit claim if appropriate.
2307	H, S	
	Same day transfer bill should not show utilization, deductible, or coinsurance when the bill has: Admission date, From Date and Thru Date equal; Patient status 02 or 03; or Condition code 40 present.	Verify utilization, deductible, and coinsurance. Resubmit claim if appropriate.
2308	H, S	
	No-pay Code of R must have utilized days. Utilization days are shown as 0; the Admission Date is not the same as the Thru Date; the patient status is not 02, 03, 05, 61, 71, or 72.	Verify the no-pay code, utilization days, and patient status. Resubmit claim.
2401	H, S	
	Non-utilized days are other than numeric or spaces (when spaces defaults to zero).	Correct non-utilized days field and resubmit claim.

Error Code	Explanation	Action
2501	H, S	
	The 1st and 2nd year coinsurance days' entry is incomplete or other than a number.	Correct coinsurance days field and resubmit claim.
2502	H, S	
	Coinsurance days or lifetime reserve days exceed the number of utilization days.	Verify coinsurance days, lifetime reserve days, and utilization days
2503	H, S	
	If hospital bill, utilization days minus coinsurance days exceed 60. If SNF bill, utilization days minus coinsurance days exceed 20.	Verify utilization days and coinsurance days.
2504	H, S	
	The coinsurance rate (Coinsurance Amount divided by Coinsurance Days) exceeds the rate that applies to the calendar year in which the coinsurance days occur.	Recalculate the coinsurance rate.
2506	H, S	
	Coinsurance days are shown, but no amount is shown for either Value Code 09 or Value Code 11.	Verify coinsurance days, Value Code 09, and Value Code 11. Resubmit claim if appropriate.
2507	H	
	The sum of coinsurance days plus lifetime reserve days in either the year of admission or the year of discharge on a bill that spans a calendar year end, is greater than the number of days in the period covered by the statement for either the year of admission or discharge on the bill.	Verify coinsurance days, lifetime reserve days, admission date, and discharge date. Resubmit claim.

Error Code	Explanation	Action
2601	H, S	
	On a hospital bill, this item contains an entry other than a number or a number that exceeds 60. An entry for a SNF bill is inappropriate as lifetime reserve days apply only to inpatient hospital stays.	Verify lifetime reserve days and resubmit claim.
2602	H	
	The lifetime reserve days are shown, but no amount is shown for either value code 08 or value code 10; or A valid Value Code 08 or 10 amount is present, but no lifetime reserve days are present.	Verify lifetime reserve days, value code 08 amount, and value code 10 amount. Resubmit claim if appropriate.
2603	H	
	The lifetime reserve rate (lifetime reserve amount divided by lifetime reserve days) exceeds the rate that applies to the calendar year in which the lifetime reserve days occurred.	Recalculate the lifetime reserve rate and resubmit claim.
	Occurrence Codes	
	The third digit of the following error codes represents the sequence in which the code occurred. The sequence is 1 through 0, with 0 representing the 10th code.	
28#1	H, S, HH, HOSP, OP	
	Invalid occurrence code.	Correct the occurrence code and resubmit claim.
28#2	S	
	Date Guarantee of Payment Began--entry is inappropriate as this item applies only to hospital bills.	Remove date from claim and resubmit.

Error Code	Explanation	Action
28#3	H	
	Date Guarantee of Payment Began--Hospital Bill. Date is earlier than the admission date or later than the statement covers Thru Date.	Verify dates and resubmit claim.
28#4	H	
	Date of Guarantee of Payment Began--Utilization days cannot exceed 12 days beyond the admission date, if admission date and the statement covers period From Date are the same, unless the billing dates cover the period 12/24 through 1/2, in which case 13 days cannot be exceeded.	Verify dates and resubmit claim or return to provider for correction.
28#5	H	
	If the Guarantee of Payment Date is shown and the admission date and From Date are not equal, utilization days cannot exceed 12 days, unless the billing dates cover the period 12/24 thru 1/2, in which case 13 days cannot be exceeded.	Verify dates and resubmit claim or return to provider for correction.
28#6	H	
	The Date Guarantee of Payment Began is earlier than the Date Benefits Exhausted (Occurrence Code 23).	Verify dates and resubmit claim or return to provider for correction.
28#7	H	
	The Date Guarantee of Payment Began plus utilization days (less coinsurance and non-utilization days) cannot exceed the statement covers period Thru Date, unless the patient status code is 30 (Still Patient), in which case the Thru Date cannot be exceeded by more than 1 day.	Verify dates and resubmit claim or return to provider for correction.

Error Code	Explanation	Action
28#8	H, S	
	Active Care Ended date is after the Thru Date.	Verify dates and resubmit claim or return to provider for correction.
28#9	H, S	
	Utilization days exceed the number of days between the From Date and the Date Active Care Ended (Occurrence code 22) minus any days for Noncovered Level of Care (Occurrence Span Codes 74, 76, 77, 79, and M1) reported on the bill.	Recalculate utilization days and resubmit claim.
28#A	H, S	
	Utilization days are greater than the number of days between the From Date and the date benefits exhausted and on a hospital bill, and Guarantee of Payment Began Date is not present.	Recalculate utilization days and verify all dates. Resubmit claim if appropriate.
28#B	HH, HOSP, OP	
	The benefits exhausted date is prior to the From Date.	Verify the benefits exhausted date and the From Date. Benefits exhaust date should be later than From Date on claim. Resubmit claim.
28#C	HH, HOSP, OP	
	The date the benefits were exhausted is not greater than the stay From Date.	Verify the benefits exhausted date and the stay From Date. Resubmit claim if appropriate, otherwise deny.
28#E	H, S, OP, HH	
	More than one Benefits Exhausted Date Occurrence Code (A3, B3, C3-in any combination) is present on the claim.	Verify appropriate Occurrence Code and remove others. Resubmit claim.

Error Code	Explanation	Action
28#L	H	
	More than one Occurrence Code 20 has been found on a single claim.	Verify Occurrence Code 20 date and remove all other occurrences from claim. Resubmit claim.
28#M	HOSP	
	Occurrence Code 42 date does not equal the service Thru Date on the claim.	Verify dates and resubmit claim.
28#N	H, S, OP	
	Claim indicates benefits exhausted, Medicare is primary and the Occurrence Code present is not A3; Claim indicates benefits exhausted, Medicare is secondary and the Occurrence Code present is not B3; or Claim indicates benefits exhausted, Medicare is tertiary and the Occurrence Code present is not C3.	Correct Occurrence Code and resubmit claim.
28#O	H, S	
	Benefits Exhausted--This Date is outside the "Statement Covers Period" Dates. HOSP Invalid or missing Occurrence Code 23 or 42 Date.	Verify Benefits Exhausted Date and resubmit claim if appropriate.
28#P	HOSP	
	Occurrence Code 23 Date does not equal the service Thru Date on the claim.	Verify dates and resubmit claim.

Occurrence Span Codes and Dates Required

The third digit of the following error codes represents the sequence of the Occurrence Span Code reported on the bill.

Error Code	Explanation	Action
33#1	H, S	
	A span code from or Thru Date is an invalid or inconsistent date entry.	Verify span code dates and resubmit claim.
33#2	S	
	Qualifying Stay Dates--The Thru Date is the same as, or prior to, the From Date.	Correct dates and resubmit claim.
33#3	S	
	Qualifying Stay Dates--The 3-day stay requirement is not met or in the case of a Rural Primary Care Hospital (RPCH) 2 days. The Thru Date is not 3 or more days later than the From Date or in the case of a RPCH 2 days.	Verify dates. Resubmit claim if appropriate or deny for lack of a qualifying stay. Use MSN 13.2 - "Skilled nursing facility benefits are available only after a hospital stay of at least 3 days."
33#4	S	
	Qualifying Stay Dates--the Thru Date is later than the current admission date.	Verify dates. Resubmit if appropriate or deny for lack of qualifying stay. Use MSN 13.2 - "Skilled nursing facility benefits are only available after a hospital stay of at least 3 days."
33#5	H	
	Occurrence span code 70 dates are invalid due to: 1) Span code From Date is equal to the From Date of the statement and it is not a catastrophic transition claim; or 2) The claim from and Thru Dates are catastrophic.	Verify dates and resubmit or deny claim if appropriate.
33#6	OP	
	Screening Colorectal or Screening Prostate Cancer are billed multiple times on the same claim.	Deny duplicate line items using MSN 7.1 - "This is a duplicate of a charge already submitted."

Error Code	Explanation	Action
	Condition Codes	
	The second and third digit of the following error codes represents the sequence of the condition code reported on the bill.	
35#1	H	
	Condition Codes 61/66 cannot be present on a non-PPS claim or there is more than one PPS Condition Code present or; Condition Code "65" is present on a PPS claim.	Return to provider for verification of Condition Codes.
35#2	H	
	Condition Code 61 (Cost Outlier) is present and Value Code 17 is not present.	Return to provider for addition of Value Code 17 and amount.
35#4	SNF, OUTP, HHA, Hospice	
	Condition Code 69 is invalid on Bill Type other than 11X.	Verify Condition Code and TOB. Resubmit claim.
3900	General	
	ICN is blank, or invalid.	Correct ICN and resubmit claim.
	Value Code	
	The third digit of the following error codes represents the sequence of the Value Code reported on the bill.	
4600	H	
	PPS capital total amount not equal to the sum of its parts.	Recalculate total and resubmit claim.

Error Code	Explanation	Action
46#1	General	
	Valid Value Code contains an impossible amount.	Correct value code amount and resubmit claim.
46#2	General	
	Blood deductible amount present with no blood deductible pints.	Validate blood deductible fields. Resubmit claim if appropriate.
46#3	H, S, OP	
	Value Code 06--Medicare blood deductible is reported, but the total charges and noncovered charges for revenue center code 001 are equal, indicating that blood cannot be applied towards the blood deductible.	Validate blood deductible, total charges, and noncovered charges. Resubmit claim if appropriate.
46#4	H	
	Value Code A1, B1, or C1 and the Inpatient deductible amount shown exceeds Inpatient deductible for the year.	Recalculate deductible and resubmit claim.
46#5	S	
	Value Code A1, B1, or C1-Inpatient Deductible is present on a SNF Bill.	Correct Value Code. Resubmit claim.
46#6	H	
	Value Code 17--Outlier amount is present, but neither a Day Outlier (Condition Code 60) nor Cost Outlier (Condition Code 61) is reported.	Add appropriate Condition Code (60 or 61) as appropriate or remove Value Code 17.
46#7	H	
	Value Code 17 - Outlier amount is greater than the reimbursement amount or the Y4 amount with Demo Number 06, 07, or 08; plus the total deductible and primary payer amount.	Verify outlier amount and resubmit claim.

Error Code	Explanation	Action
46#8	H, OP	
	More than one Cash Deductible Value Code (A1, B1, or C1 - in any combination) is present on the claim.	Remove inappropriate value codes and resubmit claim.
46#9	General	
	Incorrect deductible application on MSP claims.	Validate deductible. Resubmit claim if appropriate.
46#A	General	
	Invalid Value Code with Condition Code 26.	Correct or remove value code and resubmit claim.
46#B	HH, HOSP, OP	
	More than one Coinsurance Value Code (A2, B2, or C2 - in any combination) is present on the claim.	Remove inappropriate value codes and resubmit claim.
46#C	H, S	
	Deductible or coinsurance amount is present on a late-charge claim.	Remove deductible and/or coinsurance and resubmit claim.
46#D	OP	
	The number of Blood Deductible Pints is greater than 3.	Recalculate Blood Deductible and resubmit claim.
46#E	H, S, OP	
	Blood Deductible number of pints is entered but no blood usage is shown in Blood Pints Furnished.	Remove Blood Deductible and resubmit claim.

Error Code	Explanation	Action
46#F	H, S, OP	
	Blood Deductible number of pints is more than the number left after subtracting the number of pints replaced from the number 3.	Recalculate Blood Deductible and resubmit claim.
46#H	H, S, OP	
	"Blood Pints Furnished" is zero with charges shown for Value Code 06. For Outpatient, "Blood Furnished Pints" is zero with charges shown for "Verified Patient Liability, Blood Deductible field."	Return to provider for correction.
46#I	OP	
	Blood Deductible Pints greater than 0 but Blood Pints Furnished = 0.	Remove Blood Deductible and resubmit claim.
46#J	OP	
	Cash Deductible exceeds Expenses Subject to Deductible.	Recalculate deductible and resubmit claim.
46#K	OP	
	Invalid Cash Deductible.	Correct cash deductible and resubmit claim.
46#L	H, S, OP	
	Blood Pints Furnished cannot be less than Blood Pints Replaced.	Verify Blood Pints Furnished and Blood Pints Replaced. Resubmit claim.
46#M	General	
	Blood Pints (Value Codes 37, 38, 39) must be reported as full pints; partial pints are not accepted.	Round Blood Pints to next highest whole amount and resubmit claim.

Error Code	Explanation	Action
46#N	General	
	If blood furnished pints (Value Code 37), blood deductible (Value Code 38), or blood replaced pints (Value Code 39) are present, then the amount must be greater than zero.	Return to provider.
46#O	H, S, OP	
	Blood Deductible pints (Value Code 38) is present, but Blood Deductible dollars (Value Code 06) is missing.	Recalculate Blood deductible dollars and resubmit claim.
46#P	H, S, OP	
	Blood furnished (Value Code 37) minus blood replaced (Value Code 39) is greater than zero, but claim does not contain Revenue Code 0380, 0381, or 0382; or The claim contains Revenue Code 0380, 0381, or 0382 but the number of units associated with the Revenue Code does not equal the difference between blood furnished and blood replaced.	Return to provider.
46#Q	H, S, OP	
	Blood furnished (Value Code 37) and blood replaced (Value Code 39) are equal, but Blood Deductible Pints are present.	Recalculate Blood Deductible Pints and resubmit claim.
46#R	H, S, OP	
	Blood furnished pints (Value Code 37) minus blood replaced pints (Value Code 39) is equal to zero but Revenue Code 0380, 0381, or 0382 is present.	Return to provider.

Error Code	Explanation	Action
46#S	H	
	Claim contains a CABG (06), Participating Center of Excellence (07), or Provider Partnership demonstration number but Value Codes Y1, Y2, Y3, and Y4 are not present or the codes are present without an amount.	Return to provider.
46#T	H	
	MSP Value Codes are present on a CABG, Participating Center of Excellence, or Provider Partnership demonstration claim.	Remove MSP Value Codes and resubmit claim.
46#U	HH	
	Value Codes 62 and 64, or Value Codes 63 and 65, must be present on a Home Health claim when the Dates of Service are on, or after, October 1, 2000. 62- HH visits under A. 63- HH visits under B. 64 HH dollars under A. 65 HH dollars under B.	Return to provider.
46#V	HH	
	The visits in Value Code 62 and 63 do not equal the Revenue Center Code for 042x, 043x, 044x, 055x, 056x, and 057x. Visits should = units for the listed revenue codes.	Return to provider for correction
46#W	H	
	Condition Code 30 and Value Code A1, B1 or C1 are present on the same claim.	Verify Condition Code and Value Code. Resubmit claim if appropriate or return to provider.

Error Code	Explanation	Action
	Financial Data	
	For error codes involving the revenue code and associated items, # equals 1-R. Where 1 is the 1st revenue code, 2 is the 2nd revenue code, 0 is the 10th revenue code, A is the 11th revenue code, Q is the 27th revenue code and R is the 28th revenue code.	
5A#1	OP	
	An MCCD/DMD Outpatient record with Demo Number 37 and the units are greater than 1 for HCPCS Codes G9001-G9005 or G9007-G9015.	Deny access units. Use MSN 16.25 - "Medicare does not pay for this much equipment, or this many services or supplies." Use CO 57 if denied as this quantity is not medically necessary.
511H	S	
	RUGS SNF claims must contain a Revenue Code in the range of: 9000 - 9044. A RUGS SNF claim is indicated with the values 2, 3, or 4 placed in the RUGS Provider Indicator field.	Return to provider.
51#3	H,S,HH,HOSP, OP	
	Revenue Code Unit entry is missing or invalid; units are required for these revenue codes:	Correct units field and resubmit claim.
	Revenue Code Description	**Bill Type Code**
	a. 100-169 Inpatient accommodations	11X, 18X, 41X, 21X
	b. 200-219 Inpatient accommodations	11X, 41X
	c. 510-519 Clinic Visits	13X, 71X, 73X
	d. 450 & 456 Emergency Room	13X, 85X
	e. 381-382 Blood	11X, 13X, 21X, 23X, 71X, 72X, 18X

Error Code	Explanation	Action
	f. 550-559 Skilled Nursing Visits	71X, 74X, 32X, 33X
	g. 420-429 Physical Therapy	13X, 71X, 74X, 32X, 33X, 22X
	h. 430-439 Occupational	13X, 22X, 32X, 33X, 71X, 74X
	i. 560-569 Medical Social Services	22X, 32X, 33X, 71X, 74X
	j. 570-579 Home Health Aide	32X, 33X, 71X
	k. 650-659 Hospice Services	81X, 82X
	l. 801, 802, 803, 804 Dialysis Sessions	11X
	m. 821, 831, 841, 851, Dialysis Sessions	13X, 74X, 72X
	n. 410-419 Respiratory Services	13X, 22X, 74X
	o. 440-449 Speech Language Pathology	22X, 23X, 32X, 33X, 74X, 71X
	p. 472 Audiology	13X, 22X, 23X, 32X, 33X, 74X, 71X
	q. 300-319 Laboratory	13X, 14X, 22X, 23X, 24X, 71X, 72X
	r. 403 Mammography	14X, 22X, 23X, 71X
51#4	H, S, HH, HOSP, & OP	
	Total Charges or Noncovered Charges field is invalid.	Correct charge fields and resubmit claim.
51#5	H, S, HH, HOSP, & OP	
	Noncovered Charges exceed Total Charges.	Verify and correct charge fields. Resubmit claim.

Error Code	Explanation	Action
51#6	H, S, HH, HOSP, & OP	
	A revenue center code is shown, but total charges for the revenue center is zero and special action code is not 4.	Determine if revenue code is appropriate without charges and add action code "4." Otherwise return to provider for addition of charges.
51#7	OP	
	Outpatient mammography bill with first From Date of service after 12/31/90. Revenue code 403 invalid for Bill Type other than 14X, 22X, 23X, 71X, or 85X.	Return to provider for correction of Bill Type.
51#8	OP	
	For screening mammography bills, revenue code 403 is reported more than once, or other revenue codes are present.	Deny additional line items.
51#9	OP	
	IOL insertion (HCPCS Codes 66983, 66984, 66985) can be used only with Revenue Code 036X or 049X and Bill Type 13X, 83X, or 85X.	Verify Revenue Code and Bill Type. Resubmit claim.
51#A	HH, HOSP, OP	
	Eyewear must be billed only with Revenue Code 274.	Correct Revenue Code and resubmit claim.
51#C	HH, HOSP, OP	
	Anti-cancer drugs (HCPCS codes J8510, J8520, J8521, J8530, J8560, J8600, J8610, J8999) and oral anti-emetic drugs (Q0163-Q0181) can be billed only with a Diagnosis Code of cancer (140-239.9 and/or V58.0-V58.1). Bypass the edit for HCPCS Codes J8530 and J8610 when Occurrence Code 36 is present.	Deny claim. Use MSN 14.9 - "Medicare cannot pay for this service for the diagnosis shown on the claim."

Error Code	Explanation	Action
51#D	HH, HOSP, OP	
	Anti-cancer drugs and anti-emetic drugs require units.	Return to provider for addition of units.
51#E	HH, HOSP, OP	
	Anti-cancer drugs and the oral anti-emetic drugs can be used only with Revenue Code 0636 for all Types of Bill, and for Home Health Bill Type 32X, 33X, or 34X only Revenue Code 294 can be used.	Correct revenue code and resubmit claim.
51#F	HH, HOSP, OP	
	Anti-cancer drugs and oral anti-emetic drugs can be used only with these Bill Types: 12X, 13X, 14X, 22X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 75X, 81X, 82X, 83X, 85X.	Correct Bill Type and resubmit claim.
51#G	H, S	
	Blood clotting factor (HCPCS Codes J7190, J7191, J7192, J7193, J7194, J7195, J7196, J7198, J7199, Q0160, Q0161, Q0187, Q2022) can be billed only with a principal or other diagnosis of hemophilia (286.0, 286.1, or 286.4).	Deny claim. Use MSN 14.9 - "Medicare cannot pay for this service for the diagnosis shown on the claim."
51#O	S	
	A SNF/PPS claim contains a Revenue Code of 0022 and the total charges on the 0022revenue line are greater than zero and override code "4" is not present.	Return to provider indicating that 0022 revenue line(s) should not contain any total charges.

Error Code	Explanation	Action
51#P	HH, OP	
	For Revenue Codes 042x-044x and 055x-059x, a line item Date of Service is required if the Bill Type is 32X or 33X, and the Dates of Service are on, or after, June 1, 1998; or For Revenue Codes 0274, 029x, 060x, or 0636 (with only HCPCS Code J0630), a line item Date of Service is required if the Bill Type is 32X, 33X, or 34X and the Dates of Service are on, or after, October 1, 2000.	Return to provider for addition of line item dates.
51#R	S	
	A SNF/PPS claim contains a Revenue Code of 0022 and an invalid line item Date of Service is present on the revenue line.	Verify and correct the line item date of service. Resubmit claim.
51#S	S	
	A SNF/PPS claim contains a Revenue Code of 0022 with HIPPS Code of RUAXX, RUBXX, and/or RUCXX, a minimum of two Rehab Therapy Codes (042x and/or, 043x and/or, 044x) is not present with the covered units greater than 10.	Return to provider for verification. If two rehab services were not performed, refer claim to medical review.
51#T	S	
	A SNF/PPS claim contains Revenue Code of 0022 with HIPPS Code of RHAxx, RHBxx, RHCxx, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx, and/or RVCxx, a minimum of one Rehab Therapy Code (042x, 043x, and/or 044x) is not present with the covered units greater than 10.	Return to provider for verification. If one rehab services were not performed, refer claim to medical review.

Error Code	Explanation	Action
51#U	S	
	The sum of the Accommodations Units (Revenue Code 010x- 017x and Revenue Code 019x-021x) is not equal to the sum of the SNF PPS units (Revenue Code 0022)	Return to provider for recalculation of SNF/PPS Units.
51#V	S	
	Missing a valid HIPPS Code (AAA00-SSC78) on Revenue Code 0022 for a SNF PPS claim.	Return to provider for addition of missing information
51#W	OP, HH	
	HCPCS Code 97504 cannot be billed with HCPCS Code 97116 on the same day.	Deny line item using MSN 16.8 - "Payment is included in another service received on the same day."
51#X	HH	
	For Revenue Code 029x, 060x, or 0636 a HCPCS code is required if the Bill Type is 32X, 33X, or 34X, and the Dates of Service are on, or after, October 1, 2000.	Return to provider for addition of HCPCS code.
51#Y	HH	
	Revenue Code 0023 requires a HRG code in the HCPCS code field for Bill Type 32X or 33X, and the Dates of Service are on, or after, October 1, 2000.	Return to provider for addition of HRG code.
51#Z	HH	
	Revenue Code 0624 is present on Bill Type 32X or 33X and the Dates of Service are on, or after, October 1, 2000.	Deny claim, use MSN 16.13 - "The code your provider used is not valid for the date of service billed."

Error Code	Explanation	Action
5241	H	
	IME/GME claim, with Condition Code "04/69," is during a non-risk HMO period. For PPS IME/GME claims, the Admission Date is within a non-risk HMO period. Option Code is equal to "1" or "2."	Return to provider indicating that claims paid by HMOs should be submitted to Medicare with a non-payment code of B or N.
538J	OP	
	HCPCS Codes G0245 or G0246 has been paid within six months.	Deny claim.
5800	General	
	On all claim types submitted by FIs (HUIP, HUOP, HUHH, and HUHC), with Action Codes 3 and 9 the original ICN cannot be blanks, or nulls.	Correct ICN and resubmit claim.
5802	HH	
	Reimbursement Amount exceeds amount allowed for billing period. This edit is bypassed if Condition Code M2 is present.	Deny claim, use MSN 17.8 - "Payment was denied because the maximum benefit allowance has been reached."
5803	HH	
	Units exceed number allowed for billing period.	Deny excess units using 16.25 - Medicare does not pay for this much equipment, or this many services or supplies. Use CO 57 if denied as this quantity is not medically necessary.
6101	H, S, HH, HOSP, & OP	
	Total Charges (revenue code 001) are not equal to the sum of the charges for all other revenue codes.	Correct total charges field and resubmit claim.

Error Code	Explanation	Action
6102	General	
	Noncovered charges (revenue code 001) are not equal to the sum of the noncovered charges for all other revenue center codes.	Correct the total noncovered charges field and resubmit claim.
6103	H, S	
	Prior Payment Amount greater than Total Charges and either Reimbursement Amount or Utilization Days are present.	Recalculate reimbursement amount and utilization days and resubmit claim.
6105	H, OP, HOSP, HH	
	Multiple 0001 Revenue Codes present on bill.	Verify correct 0001 line and delete all other 0001 lines. Resubmit claim.
6106	HH	
	Revenue Code line 0023 on a RAP claim (3x2) does not equal the sum of Revenue Code line 0001.	Return to provider for recalculation of the 0001 revenue line.
61#6	OP, HH	
	Payment method in the financial data is missing, or invalid. As of January 1, 2003, hospitals that provide Part B only services to their inpatients will be excluded from the Outpatient Prospective Payment System (OPPS) and this edit. This policy was effective for dates of service starting January 1, 2002.	Correct payment method and resubmit claim.
61#8	OP	
	Blood Deductible Cash Amount missing, or invalid.	Correct deductible amount and resubmit claim.

Error Code	Explanation	Action
61#9	OP	
	Cash Deductible Amount missing, or invalid.	Correct deductible amount and resubmit claim.
61#E	OP	
	Provider Payment Amount in the financial data is invalid, or missing.	Correct payment amount and resubmit claim.
61#F	OP	
	Beneficiary Payment Amount invalid.	Correct payment amount and resubmit claim.
61#H	OP, HH	
	Medicare Payment Amount invalid.	Correct payment amount and resubmit claim.
61#I	General	
	The line item Date of Service is invalid, or not within the Dates of Service of the claim.	Return to provider for date correction.
61#J	OP	
	HCPCS Code 55873 has been billed more then once on the same claim with the same Dates of Service.	Deny the duplicate line item using MSN 7.1 - "This is a duplicate of a charge already submitted."
61#K	OP	
	Screening Glaucoma billed more than once on the same claim.	Deny the duplicate line using MSN 7.1 - "This is a duplicate of a charge already submitted."
61#L	H	
	Revenue Code 0024 reported more than once.	Return to provider indicating that 0024 revenue lines should not be reported more than once on the same claim.

Error Code	Explanation	Action
61#M	H	
	Provider Number not in the IRF Provider range (digits 3-6, "3025-3099," of the 13-digit Provider Number, or a third digit of "T") when Revenue Code 0024 is present.	Return to provider indicating that 0024 revenue lines should not be reported by this provider.
61#N	H	
	Not a valid HIPPS code range ("A0101 - A5104," "B0101 - B2102," "C0101 - C2102," and "D0101-D2102") with Revenue Code 0024.	Return to provider indicating that this is not a valid HIPPS code for Revenue Code 0024
61#O	H	
	IRF PPS interrupted stay greater than three days.	Return to provider indicating that Span Code "74" dates must be for 3 days or less.
61#R	OP	
	Invalid Bill Type or Revenue Code for Screening Glaucoma.	Return to provider for correction of Bill Type.
61#S	OP	Deny line item.
	HCPCS Codes G0247 cannot be paid when HCPCS Codes G0245 or G0246 are not payable.	
61#T	OP	Deny line item.
	HCPCS Codes G0245 or G0246 billed multiple times on same record, with a Date of Service that is within six months.	
6201	H, S	
	Total Deductions (the sum of Value Codes "06" through "11") is greater than the difference between the charges and noncovered charges for revenue code 001.	Correct the total deductions field and resubmit claim.

Error Code	Explanation	Action
6901	H, S	
	The Kron indicator is not allowed on SNF bills, and the hospital bill must contain utilization days, unless Medicare is secondary to another insurer.	Remove Kron indicator and resubmit.
6902	H, S	
	The Kron indicator is not allowed with non-payment codes of B, C, E, F, G, H, J, K, N, Q, T, U, V, X, or Y.	Remove Kron indicator and resubmit.
6910	HH, HOSP, OP	
	Use of Revenue Codes 0291, 0292, 0293, 0299, or 060X are allowed only on Home Health Bill Types (32X, 33X, 34X).	Return to provider for correction of revenue codes.
6911	HH, HOSP, OP	
	Use of Revenue Code 0274 is allowed only on Outpatient and Home Health Bill Types (12X, 13X, 22X, 23X, 32X, 33X, 34X, 74X, 75X, 76X, and 83x), (also, 71X with Provider ranges 3400-3499, 3975-3999 and 8500-8899, and 85X with Provider range 1300-1399).	Verify revenue code. Return to provider for correction if necessary.
6912	HH, HOSP, OP	
	Invalid Revenue Code (other than 0270, 0272, 0274, 0278, or 0624) for prosthetics and orthotics. As of October 1, 2002, this edit applies only to Bill Types 12x, 13x, 22x, 32X, 33X, 34X, 74x, 75x, 83x, and 85x.	Verify revenue code. Return to provider for correction if necessary.
6913	HH, HOSP, OP	
	Invalid Revenue Code (other than 060X) for oxygen equipment, supplies, or contents.	Verify revenue code. Return to provider for correction if necessary.

Error Code	Explanation	Action
6914	HH, HOSP, OP	
	Invalid Revenue Code (other than 0291, 0292, 0293, or 0299) for DME (inexpensive or routinely purchased, items requiring frequent maintenance, and capped rental). As of October 1, 2002, this edit applies only to Bill Types 32X, 33X, and 34X.	Verify revenue code. Return to provider for correction if necessary.
6916	HH, HOSP, OP	
	Purchase (Revenue Codes 0292 or 0293) of DME items requiring frequent maintenance are not allowed on or after 06/01/1989.	Deny claim using MSN 8.7 - "This equipment is covered only if rented."
6917	HH, HOSP, OP	
	Purchase of seat lift chairs (Revenue Code 0292 or 0293 and HCPCS Code E0620) is not allowed on or after 01/01/1991 and prior to 01/01/2002.	Deny claim using MSN 21.11 - "This service was not covered by Medicare at the time you received it."
6918	HH, HOSP, OP	
	Use of HCPCS Codes Q0078-Q0080 is not allowed after 02/29/1992.	Deny claim using MSN 21.11 - "This service was not covered by Medicare at the time you received it."
6920	HH, HOSP, OP	
	When HCPCS Codes A4214, A4310-A4455, A4481, A4622, A4623, A4625, A4629, and A5051-A5149 are present on a claim with a Bill Type equal to 32X or 33X, Revenue Code 0270 must be present.	Return to provider for addition/change of revenue code.
6922	HH, HOSP, OP	
	If HCPCS Codes A5119-A5131 are present on Bill Type 83X, along with HCPCS Codes 44340-44346, 44380, 44382, 44388-44392, or 50953-50961, the Revenue Code must be 0274.	Return to provider for addition/change of revenue code.

Error Code	Explanation	Action
6923	HH, HOSP, OP	
	Rental of certain DME customized items (HCPCS Codes = E1220, K0008, K0013, or K0109) is not allowed with Revenue Code 0291.	Return to provider for removal/change of revenue code.
6924	HH, HOSP, OP	
	Invalid modifier for capped rental (other than QR, QP, QA, BP, BR or BU) on Bill Type 32X, 33X, or 34X.	Return to provider for correction of modifier.
6925	HH, HOSP, OP	
	HCPCS Codes E0720, E0730, E0731, A4557, and A4595 are allowed only on Bill Types 32X, 33X, or 34X.	Verify Bill Type and resubmit claim or return to provider for correction.
7266	OP	Deny line item.
	HCPCS Codes 11055, 11056, 11057, 11719, 11720, or 11721 paid within six months of HCPCS Codes G0245, G0246, or G0247.	
7601	H	
	Invalid diagnosis or Procedure Codes not allowed with Bill Type 11x.	Return to provider for correction of diagnosis or procedure code.
7602	H	
	Invalid diagnosis fourth or fifth digit, not allowed with Bill Type 11x.	Return to provider for verification.
7603	H	
	E-Code as principal diagnosis, not allowed with Bill Type 11x.	Return to provider for verification.

Error Code	Explanation	Action
7604	H	
	Duplicate of principal diagnosis not allowed with Bill Type 11x.	Return to provider for verification.
7606	H	
	Sex conflict with diagnosis, not allowed with Bill Type 11x.	Correct sex and resubmit if appropriate or if sex is correct, return to provider for diagnosis verification.
7607	H	
	Manifestation Code as principal diagnosis, not allowed with Bill Type 11X.	Return to provider for verification.
7608	H	
	Unacceptable principal diagnosis, not allowed with Bill Type 11x.	Return to provider for verification of diagnosis.
7609	H	
	Invalid sex, not allowed with Bill Type 11x.	Verify sex and resubmit if appropriate.
7610	H	
	Invalid Discharge date, not allowed with Bill Type 11x.	Correct discharge date, and resubmit claim if appropriate or return to provider for discharge date correction.
8301	OP	
	PAP Smear screening bill with inconsistent Sex, Diagnosis, or Bill Type.	Verify the sex, diagnosis, and Bill Type. Resubmit claim if appropriate.
8302	OP	
	Cervical/vaginal Cancer Screening pelvic/breast examination bill with inconsistent sex or diagnosis.	Verify the sex and diagnosis. Resubmit claim if appropriate.

Error Code	Explanation	Action
8303	OP	
	Invalid sex code for a Prostate Screening (G0102, G0103, G0160, G0161, or 55873).	Verify sex and resubmit claim if appropriate.
9101	H, S, OP	
	An Investigational Device Exemption (IDE) number contains zeros or special characters.	Correct IDE number and resubmit claim.
9201	General	
	Attending physician identification is required and was not entered. UPIN, last name, and first initial must be present.	Verify and complete UPIN, last name, and first initial fields. Resubmit claim.
9202	General	
	Attending physician identification is not valid. Bytes 1-3 must not be spaces. Byte 1 must be alpha and bytes 2-3 must be alpha or numeric.	Correct physician id and resubmit claim.
9203	General	
	Attending physician identification number is not valid. Positions 4-6 must be numeric.	Correct physician id and resubmit claim.
9300	H, OP	
	Operating physician identification number is required and was not entered.	Enter operating physician id and resubmit claim.
9301	H, OP, HH, HOSP	
	If the operating physician UPIN is present, the last name and first initial must be present.	Return to provider for additional physician information.
9302	H, OP, HH, HOSP	
	Operating physician UPIN is present, but first three characters not alpha or numeric.	Return to provider for correction of operating physician UPIN.

Error Code	Explanation	Action
9303	H, OP, HH, HOSP	
	Operating physician UPIN is present, but fourth and sixth characters not numeric.	Return to provider for correction of operating physician UPIN.
9351	General	
	Other physician data incomplete. Enter UPIN, last name and first initial.	Return to provider for additional physician information.
9352	General	
	Other physician identification number is not valid. Bytes 1-3 must not be spaces. Byte 1 must be alpha and bytes 2-3 must be alpha or numeric.	Return to provider for correction of other physician UPIN.
9353	General	
	Other physician identification number is not valid. Bytes 4-6 must be numeric.	Return to provider for correction of other physician UPIN.
9401	H	
	Invalid principal diagnosis. The principal diagnosis is a valid code, but cannot be used as principal diagnosis.	Return to provider for correction of principle diagnosis.
9402	H	
	Claim does not meet the criteria for any DRG in a major diagnostic category (MDC) based on principal Diagnosis Code.	Return to provider for correction of principle diagnosis.
9403	H	
	Invalid Beneficiary Age (not between 0 and 124).	Verify and correct beneficiary age. Resubmit claim.

Error Code	Explanation	Action
9404	H	
	Sex is not male or female.	Correct sex field and resubmit claim.
9407	H	
	The code used as principal diagnosis is not a valid ICD-9-CM code.	Return to provider for correction of diagnosis code.
9408	H	
	Invalid DRG Code.	Correct DRG code and resubmit claim.
9409	H	
	DRG calculated by CMS does not match DRG.	Correct DRG code and resubmit claim.
9410	H	
	Claim contains a CABG demonstration number and DRG is not 106, or 107; or Claim contains a Participating Center of Excellence demonstration number and DRG is not one of the following: 104, 105, 106, 107, 109, 112, 124, 125, 209, or 471.	Return to provider for correction or deny using MSN 60.11- "This payment is being retracted because the services provided are covered under a demonstration project in which the hospital receives payment for all physician and hospital services related to this admission. The provider should seek reimbursement directly from the hospital where the care was provided. Any deductible or coinsurance paid by you or your supplemental insurer for these services should be returned by the provider."

Error Code	Explanation	Action
94A1	H, S	
	Verified Noncovered Stays--The From date is impossible or incomplete.	Correct the From date and resubmit claim.
94A2	H, S	
	Verified Noncovered Stays--The From date is later than the Thru Date.	Verify the From and Thru date. Resubmit claim.
94A3	H, S	
	Verified Noncovered Stays--The Thru Date is impossible or incomplete.	Correct the Thru Date and resubmit claim.
94A5	H, S	
	The Thru Date is more than 60 days prior to the admission date.	Return to provider for verification of dates.
94C1	H	
	This item (Prior Psychiatric Days) contains an entry other than a number.	Correct data and resubmit.
94C3	H	
	For psychiatric hospital bills, the Utilization Days plus Prior Psychiatric Days Used exceed 150.	Deny portion of bill that exceeds 150 days
94F2	H	
	Amount Paid--The GHO Paid Code indicates that an GHO paid on behalf of Medicare, but a payment amount greater than zero is shown.	Recalculate payment amount and resubmit claim.

Error Code	Explanation	Action
94G1	OP, HH	
	Non-Payment Code, the code entered is other than B, C, E, F, G, H, J, K, N, Q, R, T, U, V, W, X, Y, or Z (for RAP, or LUPA final).	Correct the Nonpayment Code and resubmit claim.
94G2	H, S, OP, HH, HOSP	
	Nonpayment Code--No code is entered in this field, but the total noncovered charges are equal to the total charges, and bill is not an HMO paid.	Correct the Nonpayment Code and resubmit claim.
94G3	H, S, OP, HH, HOSP	
	Nonpayment Code (B, C, or N) is shown with total deductions and/or payment present. A nonpayment bill may not contain Value Codes 06 (Blood Deductible), 07 (Part A Cash Deductible), 08 (Lifetime Reserve Amount First Year), 09 (Coinsurance First Calendar Year), 10 (Lifetime Reserve Amount Second Year), or 11 (Coinsurance Second Calendar Year) and may not contain a payment amount.	Validate deductible, nonpayment code, and payment fields. Resubmit claim if appropriate.
94G4	H, S	
	Nonpayment Code--Code R is shown in this item with payment present.	Validate nonpayment code, and payment fields. Resubmit claim if appropriate.
9901	H, S, HH, HOSP, & OP	
	No detail revenue code shown on this bill.	Return to provider.
9902	H, S	
	The inpatient bill contains no accommodation charges, i.e., the bill does not contain a revenue code between 100 and 219 (between 100 and 169 for SNF bills) and From and Thru dates are not equal.	Return to provider for correction.

Error Code	Explanation	Action
9903	OP	
	No clinic visits are shown for an independent RHC.	Return to provider for correction.
9904	S	
	Neither Occurrence Span Code 70 (Qualifying Stay Dates) nor Condition Code 16 (SNF Transition Exemption) is present on an initial SNF bill.	Return to provider for verification and addition of qualifying stay or exemption if appropriate.
9920	OP	
	Verified Patient Liability - cash deductible is other than a number or larger than $75.	Correct deductible. Resubmit claim.
9933	OP	
	Outpatient mammography bill with Rate on financial data line greater than allowed amount.	Recalculate rate and resubmit claim.
9940	OP	
	Provider Payment Distribution is other than a number.	Correct the Provider Payment Distribution and resubmit claim.
9941	OP	
	Payment Amount greater than zero for Condition Code 77, indicating primary payer is liable for entire claim; or Total Charges equal Primary Payer Amount (Amount for Value Codes 12, 13 or 43, or for MSP codes A, B, or G).	Recalculate payment amount and resubmit claim.
9942	OP	
	Patient Payment Distribution is other than a number.	Correct the Patient Payment Distribution and resubmit claim.

Error Code	Explanation	Action
9945	OP	
	Medicare will not pay for Colorectal Cancer Screening services performed prior to 1/1/1998.	Deny claim. Use MSN 21.11 - "This service was not covered by Medicare at the time you received it."
9946	OP	
	Medicare will pay for only Colorectal Cancer Screening services performed at an appropriate facility under the correct bill classification.	Deny claim. Use MSN 21.21 - "This service was denied because Medicare covers this service only under certain circumstances."
9947	OP	
	Medicare will not pay for cervical or vaginal cancer screening pelvic/breast examination services performed prior to 01/01/1998.	Deny claim. Use MSN 21.11 - "This service was not covered by Medicare at the time you received it."

80.5 - Part B and DMEPOS Consistency Error Codes

(Rev. 1, 10-01-03)

B3-6011, CWF EditCons (http://cms.csc.com/cwf/downloads/docs/pdfs/editcons.pdf)

Consistency edit rejects are denoted by a value of "ER" in the disposition field on the Part B Reply Record. A Trailer 08, containing up to four consistency error codes, will always follow. Listed below are the possible consistency error codes with a general description of the error and a general description of the corrective action to be taken. This action is meant to be a reexamination of the claim information the contractor has on hand, and correction of the information submitted on the CWF Part B or DMEPOS Claim Record, not an exhaustive search for additional information.

Part B and DMEPOS Consistency Error Codes

Error Code	Explanation	Action
A0x1	Part B Only Invalid Zip Code.	Verify ZIP code and resubmit claim.

Error Code	Explanation	Action
A1x1	Part B Only Invalid value in Percentage Allowed field. Valid values are 0 - N/A 1 - 65% Physician assistants (PA) prevailing charges for assistant at surgery services. 2 - 75% PA services furnished in a hospital other than assistant at surgery services. 3 - 85% PA services for other than assistant at surgery.	Verify Percentage Allowed and resubmit claim if appropriate.
D101	DMEPOS Only Ordering Physician UPIN is incorrectly formatted.	Correct UPIN and resubmit claim.
D102	DMEPOS Only Invalid Date of Birth.	Return to supplier for correction of birth date.
D2x5	DMEPOS Only Invalid Waiver of Provider Liability.	Return to supplier for correction.
D3x1	DMEPOS Only Invalid National Drug Code.	Return to supplier for correction of drug code.
D4x1	DMEPOS Only Invalid Beneficiary Residence State Code.	Verify and correct residence state code.
D4x2	DMEPOS Only DMERC is processing a claim for a Beneficiary residing outside the DMERC's service area.	Verify permanent address, deny claim if correct or contact CWF for a change if incorrect.

Error Code	Explanation	Action
D4x3	DMEPOS Only Invalid Supplier State Code	Verify and correct supplier state code and resubmit claim.
D5x1	DMEPOS Only Invalid HCPCS code for a DMEPOS HUDC claim.	Deny claim, use MSN 8.20- "Medicare does not pay for this equipment or item."
D5x2	DMEPOS Only NOC (Not Elsewhere Classified) Descriptor missing and the line item HCPCS code is categorized as a NOC.	Return to supplier for addition of descriptor.
D5x3	DMEPOS Only Invalid use of "MS" modifiers. Type of Service must be R for capped rental items, electric wheelchairs and PEN pumps.	Return to supplier for correction.
D5x4	DMEPOS Only NDC not present online item.	Return to supplier for addition of NDC code.
D5x5	DMEPOS Only NDC must be present on anti-cancer line item.	Return to supplier for addition of NDC code.
D5x6	DMEPOS Only Payment not allowed for condition and drug submitted.	Return to supplier for verification of diagnosis code.
D6x1	DMEPOS Only Supplier number missing.	Correct supplier number and resubmit claim.
D7x1	DMEPOS Only Invalid DME Purchase Allowable Amount.	Recalculate the allowable amount and resubmit claim.

Error Code	Explanation	Action
0013	Part B Only • CABG Demonstration Number "06" is present, but the Admission Date is before 05/01/1997; • Participating Center of Excellence demonstration Number "07" is present but the Admission Date is before 10/01/1997; or • Demonstration Number "08" is present and the Date of Service is before 01/01/2002.	Verify demonstration number and admission date. Resubmit claim if appropriate.
0014	Demonstration Numbers other than "01," "04," "05," "06," "07," "08," "15," "30," "31," "37" or "38" are invalid.	Verify the demo number and project id. Resubmit claim if appropriate.
0015	• Claim is submitted as ESRD Managed Care Demonstration but Demo Number 15 is not present; or • Demo Number 15 is present but the claim is not submitted as an ESRD Managed Care Demonstration.	Verify demo number and ESRD Managed Care Demo status. Resubmit claim.
0016	Part B Only • A Part B physician claim is submitted with "V" in the first position of the HUBC-Provider Number field, Contractor "00900," and the Demonstration Project Number is not equal to 31; or • A Part B physician claim is submitted with Demonstration Project Number equal to 31, and the first character of the HUBC-Provider Number field is not equal to "V," and/or Contractor "00900" is not present.	Verify the HUBC-Provider Number, the Contractor Number, and the Demonstration Project Number. Resubmit claim.
0018	Part B Only A claim is submitted with Demonstration Project Number 31 and the Entry Code is not equal to 01.	Verify Demo Project Number and Entry Code. Resubmit claim if appropriate.

Error Code	Explanation	Action
0021	Part B Only A Part B Demonstration Claim with criteria that matches more than one Demonstration Project.	Verify Demonstration Number, GHO Id, and HCPCS code. Resubmit claim if appropriate or return to provider for correction.
0101	Invalid record id.	Enter valid record id (HIBC, HIDC, HUBC, HUDC)) and resubmit claim.
0301	Invalid claim number.	Validate claim number. Resubmit claim.
0302	Invalid BIC.	Validate BIC. Resubmit claim.
04A1	Invalid surname.	Validate surname. Resubmit claim.
04B1	Invalid first initial.	Validate first initial. Resubmit claim.
05x4	Part B Only UPIN required for Type of Service 3, 4, 5.	Return to provider for addition of UPIN.
05x5	Ordering Physician UPIN required for HCPCS code on specified line item.	Return to provider for addition of UPIN.
0601	Invalid sex code.	Correct sex code (0, M, F). Resubmit claim.
0701	Invalid processing Carrier or DMERC.	Correct Carrier/DMERC id and resubmit claim.
0702	Invalid Contractor Number for Host Site.	Contact Host.
0703	Part B Only Invalid contractor number for a CABG or PCOE demonstration claim.	Reject claim.
1301	Number of line items is less than 1 or greater than 13.	Enter correct number of line items. Resubmit claim.

Error Code	Explanation	Action
13x2	Part B Only Multiple line items for the same type of service not allowed for mammography (type of service B or C). The only situation where multiple mammography lines are allowed is, if the Procedure Code is "76092" or "76085," two line items can occur when one has a modifier of "TC," the other has a modifier of "26."	Review number of line items. If submitted number is more than 1, deny claim. If submitted number is 1, correct claim record and resubmit.
1501	Invalid entry code.	Correct entry code (1, 3, 5, 9). Resubmit claim.
1601	Invalid investigation indicator.	Correct indicator (X, 0). Resubmit claim.
1701	Invalid split indicator.	Correct indicator (Y, N, R, B). Resubmit claim.
1801	Invalid payment/denial Code.	Correct payment/denial codes. They are 0-9 and A, B, D, E, F, G, H, J, K, Q, T, U, V, X, or Y). Resubmit claim.
1802	Claim is allowed but all line items are denied.	Investigate line items. Submit new claim, if necessary.
1803	Part B Only Claim is MSP cost avoided but all line items are not cost avoided with the same value.	Investigate line items. Submit new claim, if necessary.
1901	Invalid ED override code.	Correct override code (0, 1). Resubmit claim.
2001	Invalid Hospice override code.	Correct override code (0, 1). Resubmit claim.
2101	Invalid GHO override code.	Correct override code (0, 1). Resubmit claim.

Error Code	Explanation	Action
2201	Invalid HCPCS code year.	Correct HCPCS code year. Resubmit claim.
2301	Document control number missing.	Assign claim control number. Resubmit claim.
2501	Impossible receipt date.	Correct receipt date (MMDDYY). Resubmit claim.
2503	Receipt date after paid/denied date.	Correct receipt date (MMDDYY). Resubmit claim.
2601	Impossible paid/denied date.	Correct paid/denied date (MMDDYY). Resubmit claim.
2602	Paid/denied date after current date plus 30 days.	Correct paid/denied date. Resubmit claim.
33x6	Part B Only Screening colorectal or screening prostate cancer are billed multiple times on the same claim.	Review number of services. If submitted number is more than 1, deny extra line items. If submitted number is 1, correct claim record and resubmit.
3701	Invalid assignment indicator.	Correct assignment indicator (A, N). Resubmit claim.
3702	Part B Only ESRD claim for home dialysis is unassigned. Supplier must accept assignment.	Confirm assignment indicator properly set. Correct and resubmit or deny claim. Use MSN 16.6 - "This item or service cannot be paid unless the provider accepts assignment."
3801	Amount paid by beneficiary not numeric.	Enter numeric amount ($$$$cc). Resubmit claim.
4201	Part B Only Invalid CPO Number.	Verify CPO Number and resubmit claim. Valid numbers are: 1500-1799, 1800-1989, 3100-3199, 7000- 8499, and 9000-9999.
4501	Primary diagnosis must be present.	Enter primary diagnosis code (ICD-9-CM). Resubmit claim.

Error Code	Explanation	Action
4801	Invalid Investigative Devices (IDE) Number.	Correct IDE Number and resubmit claim.
49x1	Part B Only • Claim contains a CABG, Provider Partnership, or Participating Center of Excellence demonstration number but Denial Code D is not present in Field 18; or • Denial Code D is present in Field 18 but a Participating Center of Excellence demonstration number 07, Provider Partnership demonstration number 08, or CABG Demonstration 06 is not present in Field 49.	Verify Demo Number and Denial Code. Resubmit claim if appropriate.
49x2	DMEPOS Only Claim contains a CABG or Participating Center of Excellence Demonstration Number 06 or 07 that is not valid on DME claims.	Verify demonstration enrollment and deny claim if accurate.
538J	Part B Only HCPCS Codes G0245 or G0246 has been paid within six months.	Deny the line item.
57x1	Invalid specialty code - CMS assigned.	Correct line item physician specialty code. Resubmit claim.
57x2	Part B Only Physical therapy service must have a physician specialty code of 65.	Correct line item physician specialty code if service is for physical therapy. Resubmit claim.

Error Code	Explanation	Action
57x3	Part B Only Reimbursement indicator of 1 (100%) and a deductible indicator of 1 (not subject to deductible) at place of service 81 (independent lab) for type of service 5 (diagnostic lab) must have a physician specialty code of 69.	Correct line item physician specialty code if corresponding line item fields meet described criteria. Resubmit claim.
57x4	Part B Only Invalid specialty code (must be 49) for ASC (type of service of 2, 4, 7, 8, 9, F). Reject all services with Specialty Code "35" except if input with HCPCS Codes 98940 thru 98943 (manipulation of spine by chiropractor) and services not listed in Category 60.	Correct line item specialty code if type of service is 2, 4, 7, 8, 9 or F. Resubmit claim.
58x1	Invalid provider or supplier type.	Correct line item provider/supplier type (0-8). Resubmit claim.
59x1	Invalid type of service for HCPCS code submitted.	Correct line item type of service (0-9, A-C, F-J, L-M, P, R, T-W, Y, Z). Resubmit claim.
59x2	Part B Only Invalid type of service for ambulatory surgical care place of service.	Correct line item type of service if place of service is ASC. Resubmit claim.
59x3	Part B Only Invalid Type of Service for this modifier. The following are the Type of Services valid for these Modifiers: Modifier TOS 23, 47, AB 7	Correct TOS and resubmit claim.

Error Code	Explanation		Action
	SG	F	
	80, 81, 82, AS	8 or N	
	QK, QX, QZ, AA	7, 8, or N	
	QX, QZ	2, 7, 8, or N	
	AK, AL, AM, AN, AU, AV, AW, AY, QB, QU	8	
59x4	Part B Only Reimbursement indicator of 1 (100%) and a deductible indicator of 1 (not subject to deductible) must have a type of service of N (Kidney Donor), V (Pneumococcal Vaccine), 5 (Diagnostic Lab), or 2 (Surgery).		Correct line item type of service if corresponding line fields meet the described criteria. Resubmit claim.
59x5	Part B Only Sex is male on a screening mammography bill (line item type of service B or C).		Validate sex code and line item type of service. Resubmit claim.
59x7	Purchase of capped DME is not allowed (line item type of service = A or P).		Validate line item type of service. Resubmit claim.
59x8	Purchase of DME requiring frequent and substantial servicing is not allowed (line item type of service = A or P).		Validate line item type of service. Resubmit claim.
59x9	Rental of DME HCPCS Code E1220 is not allowed (line item type of service = R).		Validate line item HCPCS code and type of service. Resubmit claim.
59xA	Rental of prosthetic and orthotic devices is not allowed (with the exception of codes E0720, E0730, E0731) (line item type of service = R).		Validate line item type of service and HCPCS code. Resubmit claim.

Error Code	Explanation	Action
59xB	Purchase of oxygen service HCPCS Codes E0425, E0430, E0435, E0440, E1400-E1406, Q0036, or Q0037 is not allowed (line item type of service = A or P).	Validate line item type of service and HCPCS code. Resubmit claim.
59xE	Part B Only Type of service is B (high risk screening mammography) and diagnosis code indicates low risk; Type of service is C (low risk screening mammography) and diagnosis code indicates high risk; or The Primary Diagnosis Code is low-risk (V76.1 2) and a Secondary Diagnosis Code is high-risk (V15.89, V103, V163).	Validate risk indicator and diagnosis code. Resubmit claim if appropriate.
59xH	Purchase of seat lift chairs (HCPCS code E0620) is not allowed on or after 1/1/91 (line item Type of Service = A or P) and prior to 01/01/02.	Deny claim. Use MSN 21.11 - "This service was not covered by Medicare at the time you received it."
59xK	DMEPOS Only Invalid TOS for PEN Pump or PPMP mnemonic.	Correct TOS and resubmit claim.
60x1	Invalid assignment indicator.	Correct assignment indicator. Resubmit claim.
61x1	Invalid process indicator.	Correct payment/denial line item field (A-J, L-V, X, or Y). Resubmit claim.
61x2	Denied claim but line item is not denied.	Validate payment/denial line item field and payment/denial code. Resubmit claim.
61x3	Line item allowed but allowed charges not greater than zero.	Validate payment/denial line item field and allowed charges line item field. Resubmit claim.

Error Code	Explanation	Action
62x1	Invalid reimbursement indicator.	Correct reimbursement indicator (0-3). Resubmit claim.
62x6	Part B Only Place of service 21 (Inpatient Hospital - Rad/Path) must have a reimbursement indicator of 0 (80%) and a deductible indicator of 0 (subject to deductible).	Validate line item fields. Resubmit claim.
62x7	Part B Only Place of service 24 (Ambulatory Surgical Center) must have a reimbursement indicator of 1 (100%) and a deductible indicator of 1 (not subject to deductible).	Validate line item fields. Resubmit claim.
62x8	Part B Only Type of service N (Kidney Donor) or Modifier Q3 must have a reimbursement indicator of 1 (100%) and a deductible indicator of 1 (not subject to deductible).	Validate line item fields. Resubmit claim.
62x9	Part B Only The only HCPCS codes that should be allowed with TOS V, and Reimbursement Indicator 1 are G0008, G0009, 90724, 90657, 90658, 90659, 90660, and 90732.	Validate type of service. If valid, correct line item indicators. Resubmit claim, if appropriate.
62xA	Part B Only Type of service W (Physical therapy), U (Occupational therapy), B (High Risk Mammography), or C (Low Risk Mammography) must have a reimbursement indicator of 0 (80%).	Validate type of service. If valid, correct reimbursement indicator. Resubmit claim.

Error Code	Explanation	Action
62xC	Part B Only An MCCD/DMD Part B claim with Demo Number 37 and the Reimbursement Indicator is not equal to 1, or the Deductible Indicator is not equal to 1.	Verify demo number, reimbursement indicator, and deductible indicator. Resubmit claim.
63x1	Invalid deductible indicator.	Correct deductible indicator (0 or 1). Resubmit claim.
63x2	Part B Only Deductible and/or coinsurance is present on a CABG, Provider Partnership, or Participating Center of Excellence claim.	Verify demo number, coinsurance, and deductible. Resubmit claim.
64x1	Part B Only Invalid provider id indicator.	Correct provider sample indicator (0-4). Resubmit claim.
65x1	Invalid payment indicator.	Correct payment screen indicator (1-9). Resubmit claim.
66x1	Invalid units amount.	Correct units. Resubmit claim.
66x2	Units indicator equals 1 - 5 but unit amount not greater than 0.	Validate units indicator and units field. Resubmit claim.
66x3	Units indicator equals 0 but unit amount not equal to 0.	Validate units indicator and units field. Resubmit claim.
66x4	Units indicator is equal to 3 but the number of units not equal to number of services.	Validate units indicator and units field. Resubmit claim.
66x7	Part B Only An MCCD/DMD Part B record with Demo Number 37 and the units are greater than 1 for HCPCS Codes G9001 - G9015.	Verify demo number and units. Resubmit claim if appropriate or deny excess units using MSN16.25 - "Medicare does not pay for this much equipment, or this many services or supplies."

Error Code	Explanation	Action
67x1	Invalid units indicator.	Correct units indicator (0-5). Resubmit claim.
67x2	Allowed charge greater than 0 but units indicator = 0.	Validate units indicator and allowed charge field. Resubmit claim.
67x3	Part B Only Type of service and HCPCS code indicates anesthesia, but MTU indicator not = 2.	Validate MTU indicator. Correct and resubmit claim if appropriate.
67x4	Part B Only HCPCS code indicates ambulance, but MTU indicator not = 1.	Validate HCPCS code and MTU indicator. Correct and resubmit claim.
67x6	Part B Only Invalid Procedure Code for Units Indicator 2 (anesthesia).	Verify procedure code and units indicator. Resubmit claim.
67x7	Part B Only Invalid Units Indicator with Type of Service 0 (blood).	Verify units indicator and resubmit claim.
67x8	Part B Only Invalid Procedure Codes for units indicator 4 (oxygen).	Verify units indicator and resubmit claim.
68x1	Invalid HCPCS procedure code.	Validate HCPCS procedure code. Resubmit claim.
68x2	HCPCS procedure code for a screening mammography bill (type of service = B or C) should be 76092.	Validate type of service/HCPCS code. Resubmit claim.
68x4	HCPCS code invalid for Date of Service.	Deny claim. Use MSN 21.11 - "This service was not covered by Medicare at the time you received it."

Error Code	Explanation	Action
68x5	Part B: Invalid type of service for units indicator 5 (blood units). DMEPOS: KH, KI, or KJ modifier appropriate only with Capped Rental, Pen Pump, or TENS Units HCPCS code.	Verify units indicator and resubmit claim.
68x7	DMEPOS Only ZX modifier is required with all Therapeutic Shoes, Inserts, or Modification HCPCS code.	Return to supplier for verification of modifiers.
68xA	Screening Glaucoma billed more than once on the same claim.	Deny the claim using MSN 7.1 - "This is a duplicate of a charge already submitted."
69xA	Part B Only Modifier not valid for HCPCS code action.	Return to provider for correction of modifier.
69xB	Part B Only A Part B claim with HCPCS Code 97504 and 97116 on the same day.	Deny claim. Use MSN 16.8 - "Payment is included in another service received on the same day."
71x1	Submitted charge not numeric.	Correct submitted charge field. Resubmit claim.
71x2	Part B Only Allowed charges exceed limit for mammography screening claim.	Correct allowed charge field and resubmit claim.
72x1	Allowed charge not numeric.	Correct allowed charge field. Resubmit claim.
72x2	Allowed charges are greater than submitted charges.	Validate charges. Resubmit claim if appropriate.
72x3	Allowed charges are greater than 0 for denied line item.	Validate allowed charges and payment/denial indicator. Resubmit claim if appropriate.

Error Code	Explanation	Action
73x1	Provider/supplier tax number missing.	Furnish provider tax number and resubmit claim if appropriate.
73x2	DMEPOS Only Carrier assigned Provider number must be present.	Add provider number and resubmit claim.
74x1	Part B Only Invalid pricing locality code.	Correct pricing locality code. Resubmit claim if appropriate.
76x1	Place of service code is other than 11, 21, 22, 23, 25, 26, 33, 50, 51, 61, 62, 71 or 99 on mammography screening claim.	Correct place of service code and resubmit claim.
77x1	Invalid place of service.	Correct place of service field. Resubmit claim if appropriate.
77x2	Part B Only Type of service W (physical therapy) must have a place of service of 11 (office), 12(home), 25 (Birthing Center), 26 (Military Treatment Center), 32 (nursing facility), 33 (Custodial Care Facility), 54 (Intermediate Care Facility/Mentally Retarded), 55 (Substance Abuse Treatment Facility), 56 (Psychiatric Treatment Facility), 71 (Public Health Clinic) or 72 (Rural Health Clinic).	Correct place of service if service is physical therapy. Resubmit claim if appropriate.

Error Code	Explanation	Action
77x3	Part B Only Physician specialty 65 (physical therapy) performing service type 9 (other medical) or A (used DME) must be performed at a place of service 11 (office), 12 (home), 25 (Birthing Center), 26 (Military Treatment Center), 32 (Nursing Facility), 33 (Custodial Care Facility), 54 (Intermediate Care Facility/Mentally Retarded), 55 (Substance Abuse Treatment Facility), 56 (Psychiatric Treatment Facility), 71 (Public Health Clinic), or 72 (Rural Health Clinic).	Correct place of service if service is physical therapy and type is other medical or used DME. Resubmit claim.
77x5	Part B Only Place of service is other than home and ESRD claim is for home dialysis supplies.	Validate place of service and correct and resubmit claim, or deny as appropriate.
77x6	Part B Only Place of Service must be 24 for Type of Service of F.	Verify POS and TOS, resubmit claim.
78x1	From date impossible.	Validate first expense date. Resubmit claim if appropriate.
78x2	From Date is less than 07/01/1966.	Validate first expense date. Resubmit claim if appropriate.
78x3	From date is later than through date.	Validate first and last expense dates. Resubmit claim.
78x4	Part B Only From date is later than receipt date.	Validate first expense date and receipt date. Resubmit claim if appropriate.
78x5	Part B Only From date is later than paid-deny date.	Validate first expense date and paid/denied date. Resubmit claim if appropriate.

Error Code	Explanation	Action
79x1	Through date impossible.	Validate last expense date. Resubmit claim if appropriate.
79x2	Thru Date is less than 07/01/1966.	Validate last expense date. Resubmit claim if appropriate.
79x3	Part B Only Through date is later than receipt date.	Validate last expense date and receipt date. Resubmit claim.
79x4	Part B Only Through date is later than paid-deny date (excluding DME).	If service is not for DME, validate last expense date and paid/denied date. Resubmit claim if appropriate.
81x1	• Total Number of Services not numeric or less than 1; or • Mammography Bill and Number Services greater than 1.	Correct number of services field. Resubmit claim if screening appropriate.
83x1	Line item diagnosis code required.	Provide line item diagnosis. Resubmit claim if appropriate.
84x1	Part B Only Sex and HCPCS code not consistent with diagnosis; screening PAP smear involved.	Validate sex, HCPCS code, and diagnosis. Resubmit claim.
84x2	Part B Only Impossible DME coverage period start date.	Correct date and resubmit claim.
84x3	Part B Only DME coverage period start date is required.	Correct date and resubmit claim.
84x4	Part B Only Cervical/vaginal cancer screening pelvic/breast examination claim with inconsistent sex or diagnosis.	Verify sex and diagnosis. Resubmit or deny claim as appropriate. Use MSN 14.9 - "Medicare cannot pay for this service for the diagnosis shown on the claim."

Error Code	Explanation	Action
84x5	Part B Only Oral anti-emetic drugs HCPCS Codes Q0163 - Q0181, or anti-cancer drugs HCPCS Codes J8510, J8520, J8521, J8530, J8560, J8600, J8610, or J8999 with service dates on or after 04/01/1998 can be billed only with a Diagnosis Code of cancer (140-239.9 and/or V580 and/or V581).	Verify diagnosis and resubmit claim if appropriate. Use MSN 14.9 - "Medicare cannot pay for this service for the diagnosis shown on the claim."
84x6	Part B Only Invalid sex code for a prostate screening (G0102, G0103, G0160, G0161, or 55873).	Verify sex. Resubmit or deny claim as appropriate.
84x8	Part B Only HCPCS Code 55873 has been billed more then once on the same claim with the Dates of Service equal to each other and 04/01/2001, or greater.	Deny duplicate line item. Use MSN 7.1 - "This is a duplicate of a charge already submitted."
86x1	Part B Only Clinical lab id not entered or not valid for specified HCPCS code entered.	Verify lab id and HCPCS code. Resubmit claim if appropriate.
86x2	Part B Only Invalid Clinical Lab Id.	Correct lab id and resubmit claim.
86x4	Part B Only CLIA does not match on CLIA file.	Verify CLIA number and resubmit claim if appropriate.
86x8	Part B Only CLIA required for HCPCS code.	Return to provider for addition of CLIA number.
91x1	Patient reimbursement greater than zero but pay code indicates otherwise.	Validate reimbursement to patient and payment/denial code fields. Resubmit claim.

Error Code	Explanation	Action
92x1	Patient reimbursement not numeric.	Correct patient reimbursement field. Resubmit claim.
92x2	Provider/supplier reimbursement not numeric.	Correct provider reimbursement field. Resubmit claim.
92x3	Reimbursement greater than zero for denied line item.	Validate provider reimbursement. Resubmit claim if appropriate.
92x4	Reimbursement greater than zero when MSP amount greater than allowed amount.	Validate MSP involvement. Validate allowed and provider reimbursement amounts. Resubmit claim if appropriate.
92x5	Line item reimbursement not equal to computed line item reimbursement.	Re-compute line item reimbursement and resubmit claim.

Error Code	Explanation	Action
	NOTE: Computed line item reimbursement = (allowed charge minus MSP* amount, minus deductible applied) x % indicated by reimbursement indicator plus interest minus Gramm Rudman. *For MSP codes other than A, B, or G For psychiatric, physical therapy and occupational therapy replace allowed charge with limitation applied. For psychiatric use limitations applied times 62.5%. Note: This edit is bypassed for the following psych claims: For service dates before 1/1/90: CMS type of service is T, cash deductible equals (limitation amount X .625) and total reimbursement is zero. For service dates on or after 1/1/90: CMS type of service is T, cash deductible equals (allowed charges X .625) and total reimbursement is zero. For MSP codes, A, B, or G with dates of service prior to 11/13/89. 1. Non-Assigned Claims • Determine Medicare reasonable charge and payment as if the claim was primary; • Determine which is higher - a) the Medicare reasonable charge, or b) the EGHP allowable charge. Take the higher amount; • Subtract from #2, the amount paid by the EGHP. • Pay the lower of result #1 or #3. 2. Assigned Claims with dates of service prior to 11/13/89 and all MSP claims with dates of service after 11/12/89. • Determine Medicare reasonable charge and payment as if the claim was primary; • Determine Medicare reasonable charge; • Subtract from #2, the amount paid by the EGHP. • Pay the lower of result #1 or #3.	
92x7	Provider/supplier reimbursement greater than 0, but pay code indicates otherwise.	Validate reimbursement to provider/supplier and payment/denial code fields. Resubmit claim if appropriate.

Error Code	Explanation	Action
9301	Cash deductible totaled from each line item greater than 0 for denied claim.	Validate cash deductible and payment/denial code fields. Resubmit claim if appropriate.
9303	Cash deductible totaled from each line item greater than current deductible.	Validate cash deductible applied. Resubmit claim.
93x1	Cash deductible not numeric.	Correct cash deductible applied. Resubmit claim.
93x2	Cash deductible greater than 0 when line item deductible indicator is 1 (not subject to deductible).	Validate deductible indicator field. Resubmit claim.
93x3	Cash deductible greater than 0 for denied line item.	Validate cash deductible applied and payment/denial code. Resubmit claim.
93x5	Cash deductible greater than current deductible.	Correct deductible applied. Resubmit claim if appropriate.
9401	Part B Only Blood deductible amount totaled from each line item greater than 3.	Correct limitations applied field. Resubmit claim.
9402	Part B Only Blood furnished totaled from each line item less than blood deductible.	Correct limitations applied field. Resubmit claim.
94x1	Part B Only Limitations/blood deductible amount not numeric.	Correct limitations applied field. Resubmit claim.
94x2	Part B Only Blood deductible amount greater than 3 for blood services.	Validate limitations applied field. Resubmit claim.

Error Code	Explanation	Action
94x3	Part B Only Yearly limits exceeded for non-blood Services.	Validate limitations applied field. Resubmit claim.
94x4	Part B Only Blood furnished less than blood deductible.	Validate limitations applied field and blood furnished. Resubmit claim if appropriate.
94x5	Part B Only Computed limit not equal to submitted limits for EGHP.	Validate limitations applied field. Resubmit claim.
95x1	Invalid MSP code.	Correct MSP code. Resubmit claim if appropriate.
95x2	MSP amount not numeric.	Correct MSP data. Resubmit claim if appropriate.
95x3	MSP amount greater than submitted charges.	Validate MSP data. Resubmit claim if appropriate.
95x4	MSP amount not equal to zero for Medicare primary payor.	Validate MSP data. Resubmit claim if appropriate.
95x7	Part B Only An MSP or Cost Avoid Code is present on a CABG or Participating Center of Excellence demonstration claim.	Remove MSP or Cost Avoid Code and resubmit claim.
96x1	One or more Other Amounts Applied not numeric.	Correct Other Amounts Applied field. Resubmit claim.
96x2	Other amounts value is interest.	Validate other amounts applied field. Resubmit claim.

Error Code	Explanation	Action
97x1	One or more other amounts indicators invalid.	Correct other amount indicators and resubmit claim.
98x1	Coinsurance amount is not numeric.	Validate coinsurance field. Resubmit claim if appropriate.
	Note: This edit is bypassed for the following psych claims: CMS type of service is T, cash deductible equals (allowed charges X .625) and coinsurance amount is zero.	
98x3	No MSP involvement and coinsurance is not 20% of the allowed charge on a Immunosuppressive Drug Bill when Type of Service = G.	Recalculate coinsurance and resubmit claim.
98x5	When the allowed charge is greater than the deductible and the reimbursement indicator is 0, coinsurance must be greater than zero.	Verify deductible and reimbursement indicators and recalculate coinsurance. Resubmit claim.

80.6 - A/B Crossover Error Codes

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A3-3808, A-02-038, CWF EditXov

http://cms.csc.com/cwf/downloads/docs/pdfs/editabx.pdf

A/B Crossover edit rejects are denoted by a value of CR in the disposition field on the Reply Record. A Trailer 08 containing one crossover error code, will always follow. Also, Trailer 12 will be returned. A/B Crossover alerts are denoted by a value of 01 in the disposition field on the Reply Record. A Trailer 13 containing one crossover Alert Code, will always follow. Listed below are the possible crossover Error and Alert Codes with a general description.

A/B Crossover Error Codes

Error Code	Explanation

Error Code	Explanation
7010	Reject • An inpatient, outpatient, or home health bill with dates of service equal to or overlapping a Hospice election period, and Condition Code 07 (Treatment of a non-terminal condition) is not present on the bill; or • An MCCD Notice of Election (89A) From Date overlaps a Hospice election period. **Purpose:** To detect bills during a hospice benefit period when a non-terminal condition is not reported. **Resolution:** Deny the bill, use MSN 27.1 - "This service is not covered because you are enrolled in a hospice."
7020	Reject Claim Bill Type is 12X and the From/Thru dates are equal to the posted outpatient 73X Bill Type service dates or Span Code 72 From/Thru dates. **Purpose:** To detect duplicate billing of inpatient and FQHC services. **Resolution:** Deny the claim as a duplicate, use MSN 7.1 - "This is a duplicate of a charge already submitted."

Error Code	Explanation
7050	Reject • An Outpatient claim (Bill Type 12X, 13X, 14X, 22X, 23X, 24X, 71X, 72X, 73X, 74X, 75X, 83X, or 85X) has From/Thru Dates (or Occurrence Span Code 72 From/Thru Dates), which are equal to, overlap, or are within the From/Thru Dates on a Hospital Inpatient claim (Bill Type 11X, 21X, or 41X) in history. The Provider Number on the incoming claim is the same as the Provider Number on the history claim; or • An Outpatient claim (Bill Type 12X, 13X, 14X, 22X, 23X, 33X, 34X, 74X, or 75X) for physical therapy, occupational therapy, and/or speech –language pathology has From/Thru Dates (or Occurrence Span Code 72 From/Thru Dates) which are equal to, overlap, or are within the From/Thru Dates on an SNF Inpatient claim (Bill Type 18X, 21X, or 28X,) for physical therapy, occupational therapy, or speech –language pathology. The Provider Number on the incoming claim is the same as the Provider Number on the history claim. **Purpose:** To detect duplicate bills for physical therapy, speech-language pathology and/or occupational therapy. **Resolution:** Deny the bill as a duplicate, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7055	Reject Outpatient services (Bill Types 13X, 14X, or 83X) billed with From/Thru Dates that are equal to, within, or overlapping the From/Thru Dates on an outpatient ambulatory surgical claim (ASC - Bill type 83X). The Provider Number of both claims are the same. **Purpose:** To ensure that Medicare does not pay for the same services more than once.

Error Code	Explanation
	Resolution: Review claim to ensure both claims are valid and not duplicate billings, deny if duplicate, override error and resubmit if both bills are valid. If denied, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7080	Reject OP, HH • An Outpatient claim has a From/Thru Date that overlaps an Inpatient claim and the Provider Numbers are different; or • A Home Health claim has a detail line item Date of Service that overlaps an Inpatient, SNF, or RNHCI claim on history. **Purpose:** To detect outpatient claims that should have been bundled into the inpatient bill. **Resolution:** Deny the bill, use MSN 21.7 - "This service should be included on your inpatient bill. The provider must review the original (paid) inpatient bill to determine that all charges were included. The hospital pays the supplier."
7108	Alert An outpatient bill for physical therapy (PT), speech –language pathology (SLP), or occupational therapy (OT) for the same or overlapping dates of service (or Occurrence Span Code 72 dates), and a revenue code, HCPCS code, or a revenue to HCPCS code match for PT, SLP, or OT bill on history. Billed by the same provider or another provider, physician, or independent therapist. The incoming outpatient bill is matched against both Part A outpatient and Part B carrier claims. **Purpose:** To detect duplicate billings either by the same provider or for a beneficiary receiving the same services from multiple provider specialties that can perform physical therapy, speech-language pathology, and/or occupational therapy services.

Error Code	Explanation
	Resolution: Deny the bill if the same provider submitted a duplicate claim, use MSN 21.7 - "This service should be included on your inpatient bill." If the services are furnished by a different provider or are not duplicated, refer the bill to medical review for determination of medical necessity. If the claim is denied as a duplicate or as the result of medical review, recover the erroneous payment and process an adjustment to the Host.
7109	Reject An Outpatient claim with the Thru date (or Occurrence Span Code 72 Thru Date) greater than the Inpatient Admission Date minus four days or is equal to the Inpatient Admission Date and one or more diagnostic Revenue Codes or procedure codes are present. **Purpose:** To detect outpatient bills that should be included on an inpatient history bill. **Resolution:** Return the outpatient bill to the provider. The provider may adjust the inpatient bill if charges were omitted. If Part B deductible or coinsurance were collected by the provider, any monies collected must be returned to the beneficiary.
7111	Reject An inpatient PPS bill (type 111, condition code 65 not present) is posted to the Host history and the From date (on the posted bill) is equal to the Through date on the incoming inpatient PPS bill (type 111, condition code 65 not present) and the patient discharge status is 01 (discharged to home or self care). As of October 1, 2002, this edit is bypassed if one of the bills, either history or incoming has an IRF provider number (XX-3025 – XX-3099 or the third position of the provider number is "T"). **Purpose:** To identify transfers between PPS hospitals. This reject prevents incorrect DRG payments.

Error Code	Explanation
	Resolution: Change the patient status code to 02 (transferred to another acute care facility) and reprocess the bill.
7112	Reject Inpatient claim (HUIP record) From Date or From Date minus 1 day equals the last service date (or Occurrence Span Code 72 First/Last Visit Date) on a posted Part B claim (HUOP record) and the provider numbers are the same. **Purpose:** To detect inpatient bills that have posted Part B bills with charges that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient bill, use MSN 21.7 - "This service should be included on your inpatient bill." Notify the provider why the outpatient bill was canceled. If any beneficiary Part B deductible was collected on the canceled Part B bill, the beneficiary must be paid any amounts collected towards that outpatient bill. Ensure that the inpatient bill has the outpatient charges included. After the outpatient bill is canceled, resubmit the inpatient bill for processing.
7113	Reject An inpatient claim with the Admission Date less than 4 days from the Through Date (or Occurrence Span Code 72 date) on an outpatient history record and the outpatient claim is for diagnostic services only. **Purpose:** To detect outpatient bills for diagnostic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.

Error Code	Explanation
7114	Reject An outpatient claim that contains both therapeutic and diagnostic services with the Through date equal to or up to 4 days less than an Inpatient Admission Date. **Purpose:** To detect therapeutic or diagnostic services on an outpatient bill that should be included on an inpatient claim. **Resolution:** Return the outpatient bill to the provider to re-bill for only the therapeutic services and to determine whether an adjustment to the inpatient bill is needed to include diagnostic services. Use MSN 21.7 - "This service should be included on your inpatient bill."
7115	Reject An Inpatient claim against a posted Outpatient history claim which contains therapeutic and diagnostic services and the Thru Date (or Span Code 72 Thru Date) on the Outpatient claim is greater than the Inpatient Admission Date minus 4 days or is equal to the Inpatient Admission Date. Both claims contain the same provider number. **Purpose:** To detect outpatient diagnostic services that should have been included in the inpatient bill. **Resolution:** Cancel the outpatient claim containing the therapeutic and diagnostic services, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the outpatient diagnostic services have been included on the inpatient bill. Resubmit the inpatient bill for processing. The provider may re-bill the therapeutic services separately.

Error Code	Explanation
7119	Reject An Outpatient claim with the Thru Date (or Span Code 72 Thru Date) equal to an Inpatient Admission Date, or 1 day less then the Inpatient Admission Date. One or more diagnostic Revenue Codes are on the Outpatient claim and the Inpatient history claim has a Condition Code of 65. . Both claims contain the same provider number. **Purpose:** To detect outpatient bills that should be included on an inpatient history bill. **Resolution:** Return the outpatient bill to the provider, use MSN 21.7 - "This service should be included on your inpatient bill." The provider may adjust the inpatient bill if charges were omitted. If Part B deductible or coinsurance were collected by the provider, any monies collected must be returned to the beneficiary.
7120	Reject An Inpatient claim with Condition Code 65, an Admission Date or the Admission Date minus 1 day equal to an Outpatient history Thru date (or Occurrence Span Code 72 Thru Date), and the Outpatient history claim has one or more diagnostic Revenue Codes present. . Both claims contain the same provider number. **Purpose:** To detect outpatient bills for diagnostic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.
7121	Reject An Outpatient claim with the Thru Date (or Occurrence Span Code 72 Date) equal to an Inpatient Admission Date or an Inpatient Admission Date minus one day. One or more therapeutic Revenue Codes are on the Outpatient claim. The Inpatient history claim has a Condition Code of 65.

Error Code	Explanation
	Purpose: To detect outpatient bills for therapeutic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.
7122	Reject An Inpatient claim with Condition Code 65, with the Admission Date or the Admission Date minus one day equal to an Outpatient history Thru Date (or Occurrence Span Code 72 Thru Date), and the Outpatient history claim has one or more therapeutic Revenue Codes present. **Purpose:** To detect outpatient bills for therapeutic services that should have been bundled into the inpatient bill. **Resolution:** Cancel the outpatient claim and recover any payment, use MSN 21.7 - "This service should be included on your inpatient bill." Return the inpatient bill for verification that the appropriate charges are posted to the inpatient bill.
7171	Alert Outpatient claim with From/Thru Dates of Service or if present Occurrence Span Code "72" Dates equal or overlap Part B Date of Service. **Purpose:** To detect duplicate billings of physician services for a RHC. **Resolution:** Determine if the physicians charge is a duplicate charge. If the RHC is in error, adjust the claims. If the carrier billing is in error, send all pertinent information to the carrier for necessary action. Use MSN 7.1 - "This is a duplicate of a charge already submitted."

Error Code	Explanation
7172	Reject An outpatient bill for a screening pap smear matches an outpatient or Part B history claim for a screening pap smear and the dates of service are equal. **Purpose:** To reject either the hospital outpatient bill or the Part B physician nonprofessional component for billing duplicate services. **Resolution:** Reject the bill and notify the beneficiary and the provider that this service (a screening pap smear) is allowed only once every 3 years. Use MSN 7.1 - "This is a duplicate of a charge already submitted."
7211	Alert Outpatient, Part B or DMEPOS claim submitted with approved eyewear when no prior bill received indicating cataract or intraocular lens (IOL) insertion on/before the date of the eyewear claim. **Purpose:** To establish an audit trail on the incoming claim. **Resolution:** No action is required.
7220	Reject Outpatient, Part B or DMEPOS claim submitted with eyewear on/after an intraocular lens (IOL) insertion and coverage limitation of one piece of eyewear had already been met by another claim. **Purpose:** To ensure that payment is made for only one eyewear for each cataract surgery with an IOL insertion. **Resolution:** Deny the claim, use MSN 26.3 - "Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant."

Error Code	Explanation
7230	Reject Outpatient, Part B or DMEPOS claim submitted with eyewear on/after an intraocular lens (IOL) insertion and more than one piece of eyewear is being billed on the claim. **Purpose:** To ensure that the beneficiary's eyewear benefit is limited to a single eyewear for each cataract surgery with the insertion of an IOL. **Resolution:** Deny the claim, use MSN 26.3 - "Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant."
7241	Reject • An incoming Outpatient claim with Revenue Code 0274 has the same Date of Service and the same HCPCS code as a paid DME or Outpatient claim in history; or • An incoming DME claim has the same Date of Service and the same HCPCS code as a paid Outpatient claim with Revenue Code 0274 in history. **Purpose:** To ensure that Medicare does not pay for the same service twice. **Resolution:** Deny the claim, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7242	Reject An incoming Outpatient claim with Revenue Code 0623 has the same Date of Service and the same HCPCS code as a paid DME or Outpatient claim in history; or An incoming DME claim has the same Date of Service and the same HCPCS code as a paid Outpatient claim with Revenue Code 0623 in history.

Error Code	Explanation
	Purpose: To ensure that Medicare does not pay for the same service twice. **Resolution:** Deny the claim, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7244	Reject A Part B service for physical therapy, occupational therapy, or speech – language pathology has From/Thru Dates which are equal to, overlap, or are within the From/Thru Dates on an Inpatient stay in history. **Purpose:** To ensure that physical, occupation, and speech–language pathology services are not paid by Part B during hospitalization. **Resolution:** Deny the claim, use MSN 16.27 - "This service is not covered since our records show you were in the hospital at this time."
7245	Reject Duplicate billing for oral anti-emetic drugs or anti-cancer drugs on the incoming claim, SURG900 file, or in history. An Outpatient or DME claim is submitted with an anti-emetic drug HCPCS code, and there is no "matching" claim for anti-cancer drugs on history, or there is a Duplicate anti-emetic drug claim. **Purpose:** To ensure that anti-emetic drugs are not billed without a matching anti-cancer drug and to ensure that duplicate anti-emetic drugs claims are not paid. **Resolution:** Deny the claim. Use MSN 21.21 - "This service was denied because Medicare covers this service only under certain circumstances;" or MSN 7.1 - "This is a duplicate of a charge already submitted."

Error Code	Explanation
7246	Reject • The incoming Part B/DME claim does not contain a CABG demonstration number but there is an Inpatient CABG demonstration claim in history with Covered Service Dates that are equal to, within, or overlapping the service dates on this claim; or • The incoming Inpatient claim contains a CABG demonstration number and there is a Part B/DME claim in history with Service Dates that are equal to, within, or overlapping the Part A Covered Service Dates, but Demonstration Number 06 is not present on the history Part B/DME claim. **Purpose:** To ensure that Medicare does not pay for services not covered for beneficiaries enrolled in a CABG demonstration. **Resolution:** Investigate claim dates of service if part B/DME claim is for the same date as a transfer in or out of the CABG demonstration and the service was medically necessary pay both the part B/DME and the Inpatient claim. Otherwise, pay the Inpatient claim and deny the part B/DME claim or recoup payment if necessary.
7247	Reject An Outpatient or part B claim containing an anti-emetic drug HCPCS code, and there is a duplicate anti-emetic drug claim on history. **Purpose:** To ensure that Medicare does not pay for the same service twice. **Resolution:** Deny the claim, use MSN 7.1 - "This is a duplicate of a charge already submitted."
7248	Reject Outpatient claims with HCPCS Codes 97504 and 97116 cannot be billed on the same day with the same Provider Number.

Error Code	Explanation
	Purpose: To ensure that procedure codes 97504 and 97116 are not paid by Medicare to the same provider on the same day. **Resolution:** Deny the claim, use MSN 18.16 - "This service is being denied because payment has already been made for a similar procedure within a set time frame."
7249	H Dates of Service during IRF PPS interrupted stay on history. **Purpose:** To ensure Medicare pays only for services that are performed. **Resolution:** Return to provider for verification of Dates of Service.
7250	Reject OP, HH Duplicate DME billing for Home Health claims (32X, 33X, and 34X), against DMERC, Part B, or Outpatient claims with the same HCPCS code and detail line item for Date of Service October 1, 2000, and after. **Purpose:** To ensure that services are not paid for twice. **Resolution:** Deny the claim, use MSN 7.1 -"This is a duplicate of a charge already submitted."
7530	Alert An outpatient bill (Bill Types 13X, 14X, 34X, 74X, or 75X) is one of three or more in a series of outpatient bills from different providers for the same beneficiary, same revenue and/or HCPCS Code(s), and dates of service within 30 days.

Error Code	Explanation
	Purpose: To detect inappropriate utilization of services by beneficiaries. **Resolution:** Forward the bill to medical review. If services are subsequently denied, recover the erroneous payment and process an adjustment to CWF. If denied, use MSN 15.5 - "The information provided does not support the need for similar services by more than one doctor during the same time period."
7531	Alert The Discharge Date of one PPS Inpatient claim is equal to the Admission Date of another PPS Inpatient claim. An inpatient PPS bill (type 111, condition code 65 not present) is posted to the Host history with a patient discharge status code other than 02 (discharged/transferred to another acute care facility), 05 (discharged/transferred to another type of institution) or 07 (left against medical advice or discontinued care). Condition code 61 (cost outlier) is not present or the DRG is not equal to 385 or 456 and an inpatient PPS bill with a From date equal to the Through date of the posted bill. As of October 1, 2002, this edit is bypassed if one of the bills, either history or incoming has an IRF provider number (XX-3025 – XX-3099 or the third position of the provider number is "T"). **Purpose:** To identify transfers between PPS hospitals. This alert identifies the posted bill that had an inappropriate patient discharge status. **Resolution:** Adjust the original bill using a 11I Bill Type and change the patient status code to 02 (discharged/transferred to another acute care facility). Process the adjustment according to the transfer payment guidelines.

Error Code	Explanation
7532	Alert The same provider bills outpatient services monthly or more frequently for the same beneficiary for a period of 6 months or more. The Bill Type(s) is 13X, 23X, 34X, 71X, 74X, 75X. The revenue code(s) is 42X, 43X, 44X, 51X, 52X, 90X, 91X, 94X. **Purpose:** To detect over-utilization of services. **Resolution:** Refer the claim to medical review. If services are subsequently denied, recover the erroneous payment and process an adjustment to CWF. If denied, use MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
7533	Alert A home health bill (33X or 34X) for a DME or prosthetic device with dates of service equal to or overlapping a supplier billing for the same DME/prosthetic device. **Purpose:** To detect duplicate billing for DME by an HHA and a DME supplier. **Resolution:** Deny duplicate bills, use MSN 7.1 - "This is a duplicate of a charge already submitted." Recover the erroneous payment from the HHA and process an adjustment to CWF. If the bill is not a duplicate, release the bill.
7534	Alert An outpatient hospital bill (Bill Type 13X) with cardiac rehabilitation revenue code (943) has charges for repeat cardiovascular stress testing (HCPCS Codes 93015, 93017, and/or 93018) in a period of less than 90 days since prior testing. **Purpose:** To detect billing for cardiac rehabilitation where stress testing is performed more frequently than allowed by coverage guidelines.

Error Code	Explanation
	Resolution: Determine if stress testing meets the cardiac rehab coverage screens. If tests exceed, deny the charges and recover the inappropriate payment. Process an adjustment to CWF. Use MSN 15.6 - "The information provided does not support the need for this many services or items within this period of time."
7535	Reject An outpatient hospital bill is for a service for which the related physicians service has been denied. **Purpose:** To detect medically unnecessary Part A services when the related physicians component has been denied. **Resolution:** Refer the claim to medical review for a determination of the medical necessity of the provider service. If the alerted claim is subsequently denied, recover the erroneous payment and process an adjustment to CWF. Use MSN 15.4 - "The information provided does not support the need for this service or item."
7545	Alert An Inpatient claim (TOB 11x) with From and Thru Dates that equal, or overlap, the From and Thru Dates (or Occurrence Span Code 72 From and Thru Dates) on an Outpatient claim (TOB 12x, 13x, 14x, 32X, 33X, 34X, 72x, 73x, 74x, 75x, 76x, or 83x) in history. **Purpose:** To eliminate outpatient billings for the same services which should have been included in the inpatient claim. **Resolution:** Cancel the outpatient bill. Send a notice to the provider explaining that the charges should have been included on the inpatient bill and they should look to the hospital for payment. Use MSN 21.7 - "This service should be included on your inpatient bill."

Error Code	Explanation
7546	Alert HH The Outpatient record (Bill Type 34X) with Revenue Code 0636, HCPCS Code J0630 on history, does not have the same Provider Number as the incoming Home Health claim. **Purpose:** If an open HH episode exists, this service can be billed only by the same provider as is on episode record. **Resolution:** Verify service dates, deny if claim dates overlap. Use MSN 21.18 - "This item or service is not covered when performed or ordered by this provider."
7547	Alert DME Method II ESRD supplies billed during Inpatient stay. **Purpose:** During an inpatient stay, the hospital or SNF is responsible for providing all supplies and equipment needed for dialysis. In the month following a home dialysis patient's hospitalization, the supplier must reduce the monthly delivery of, and billing for, new supplies to account for the supplies the Method II beneficiary did not use during his or her hospitalization. **Resolution:** If the Inpatient stay was 3 or more days, deny the portion of the claim that coincided with the inpatient stay (do not deny the admission or discharge day), or return to provider for correction. Use MSN 16.27 - "This service is not covered since our records show you were in the hospital at this time."
8100	Alert An inpatient claim (11X), outpatient claim (13X) or ASC claim (83X) for the same beneficiary, having the same one time only surgical procedure performed on different dates of service in the same or a different place of service as a claim on history.

Error Code	Explanation

Purpose:

To detect billings for surgical procedures that are not bilateral procedures that had been previously performed.

Resolution:

Review the bill to determine if the correct procedure code(s) was entered into the system. If the corrected code is not a duplicate of the code in the Trailer 13 record, release the claim for processing. If the coding is correct, forward the claim to medical review. If the alerted claim is subsequently denied, recover the erroneous payment and process an adjustment to CWF, use MSN 7.1 - "This is a duplicate of a charge already submitted." If the alerted claim is correct but a prior claim is in error, adjust the prior claim or contact the appropriate servicing FI for the prior claim.

80.7 - MSP Maintenance Transaction Error Codes

(Rev. 1, 10-01-03)

A3-3810, CWF EditMnts
(http://cms.csc.com/cwf/downloads/docs/pdfs/editmnts.pdf)

MSP Maintenance Transaction edit rejects are denoted by a value of SP in the disposition field on the Reply Record. A Trailer of 08 containing up to four error codes will always follow. Listed below are the possible MSP Maintenance Transaction error codes with a general description.

MSP Maintenance Transaction Error Codes

Error Code	Explanation
SP11	Invalid MSP transaction record type (Mandatory).

Purpose:

To ensure a valid record type: nonblank, "HUSP," "HISP," "HCSP," or "HBSP."

Resolution:

Correct the transaction record type and resubmit.

SP12	Invalid HICN (Mandatory).

Error Code	Explanation
	Purpose:
	To ensure validity for equitable conversion.
	Resolution:
	Correct the HICN and resubmit.
SP13	Invalid beneficiary Surname (Mandatory).
	Purpose:
	To ensure a valid format: nonblank, alphabetic.
	Resolution:
	Verify and correct the beneficiary surname and resubmit.
SP14	Invalid beneficiary first name initial (Mandatory).
	Purpose:
	To ensure a valid format: nonblank, alphabetic.
	Resolution:
	Verify and correct beneficiary first name initial and resubmit.
SP15	Invalid beneficiary date of birth (Mandatory).
	Purpose:
	To ensure a valid format: nonblank, numeric.
	Resolution:
	Correct date of birth and resubmit.
SP16	Invalid beneficiary Sex Code (Mandatory).

Error Code	Explanation
	Purpose: To ensure only valid values are used: nonblank, must be 0, 1, or 2: 0 = unknown 1 = male 2 = female **Resolution:** Correct sex code and resubmit.
SP17	Invalid contractor number (Mandatory). **Purpose:** To ensure a valid format: nonblank; numeric, must be valid CMS assigned contractor number. **Resolution:** Correct contractor number and resubmit.
SP18	Invalid document control number. Mandatory for HUSP and HBSP Transactions. Only blank for all others. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; : **Resolution:** Correct DCN and resubmit.
SP19	Invalid maintenance transaction type (Mandatory). **Purpose:** To ensure only valid values are used: nonblank, 0, or 1: 0 = Add/change MSP Data transaction 1 = Delete MSP Data transaction

Error Code	Explanation
	Resolution:
	Correct maintenance transaction type and resubmit.
SP20	Invalid Validity Indicator (Mandatory).
	Purpose:
	To ensure only valid values are used: nonblank, Y, I, or N:
	Y = Beneficiary has MSP coverage
	I = Beneficiary has MSP coverage
	N = Beneficiary does not have MSP coverage
	Resolution:
	Correct validity indicator and resubmit.
SP21	Invalid MSP Code (Mandatory).
	Purpose:
	To ensure only valid values are used: nonblank, A, B, D, E, F, G, H, or I:
	A = Working Aged
	B = ESRD
	D = Auto Liability
	E = Workers Comp
	F = Federal (Public Health)
	G = Disabled
	H = Blank Lung
	I = Veterans
	Resolution:
	Correct MSP code and resubmit.

Error Code	Explanation
SP22	Invalid diagnosis Code. **Purpose:** To ensure only valid values are used: Alphabetic, Numeric, Space. All spaces, if not used. **Resolution:** Correct diagnosis code and resubmit.
SP23	Invalid Remarks Code. **Purpose:** To ensure only valid values are used: 1-3, 01-12, 20-26, 30-44, 50-62, 70-72, and spaces:

Error Code	Explanation
	01 = Beneficiary retired as of Termination Date.
	02 = Beneficiary's employer has less than 20 employees.
	03 = Beneficiary's employer has less than 100 employees.
	04 = Beneficiary is dually entitled to Medicare, based on ESRD, and age, or ESRD and disability.
	05 = Beneficiary is not married.
	06 = The Beneficiary is covered under the group health plan of a family member whose employer has less than 100 employees.
	07 = Beneficiary's employer has less than 20 employees, and is in a multiple, or multi-employer plan which has elected the working aged exception.
	08 = Beneficiary's employer has less than 20 employees, and is in a multiple, or multi-employer plan which has not elected the working aged exception.
	09 = Beneficiary is self-employed.
	10 = A family member of the Beneficiary is self-employed.
	20 = Spouse retired as of Termination Date.
	21 = Spouse's employer has less than 20 employees.
	22 = Spouse's employer has less than 100 employees.
	23 = Spouse's employer has less than 100 employees but is in a qualifying multiple, or multi-employer plan.
	24 = Spouse's employer has less than 20 employees, and is multiple, or multi-employer plan which has elected the working aged exception.
	25 = Spouse's employer has less than 20 employees, and is multiple, or multi-employer plan which has not elected the working aged exception.

Error Code	Explanation
	26 = Beneficiary's spouse is self-employed.
	30 = Exhausted benefits under the plan.
	31 = Preexisting condition exclusions exist.
	32 = Conditional payment criteria met.
	33 = Multiple primary payers, Medicare is tertiary payer.
	34 = Information has been collected indicating that there is not a parallel plan that covers medical services.
	35 = Information has been collected indicating that there is not a parallel plan that covers hospital services.
	36 = Denial sent by EGHP, claims paid meeting conditional payment criteria.
	37 = Beneficiary deceased.
	38 = Employer certification on file.
	39 = Health plan is in bankruptcy, or insolvency proceedings.
	40 = The Termination Date is the Beneficiary's Retirement Date.
	41 = The Termination Date is the spouse's Retirement Date.
	42 = Potential non-compliance case, Beneficiary enrolled is supplemental plan.
	43 = GHP coverage is a legitimate supplemental plan.
	44 = Termination Date equals Transplant Date.
	50 = Employment related accident.
	51 = Claim denied by workers comp.
	52 = Contested denial.
	53 = Workers compensation settlement funds exhausted.
	54 = Auto accident - no coverage.

Error Code	Explanation
	55 = Not payable by black lung. 56 = Other accident - no liability. 57 = Slipped and fell at home. 58 = Lawsuit filed - decision pending. 59 = Lawsuit filed - settlement received. 60 = Medical malpractice lawsuit filed. 61 = Product liability lawsuit filed. 62 = Request for waiver filed. 70 = Data match correction sheet sent. 71 = Data match record updated. 72 = Vow of Poverty correction. **Resolution:** Correct remarks code and resubmit.
SP24	Invalid insurer type. **Purpose:** To ensure only valid values are used: A-M and spaces: A = Insurance or Indemnity B = GHO C = Preferred Provider Organization (PPO) D = Third Party Administrator arrangement under an Administrative Service Only (ASO) contract without stop loss from any entity. E = Third Party Administrator arrangement with stop loss insurance issued from any entity. F = Self-Insured/Self-Administered.

Error Code	Explanation
	G = Collectively-Bargained Health and Welfare Fund. H = Multiple Employer Health Plan with at least one employer who has more than 100 full and/or part-time employees. I = Multiple Employer Health Plan with at least one employer who has more than 20 full and/or part-time employees. J = Hospitalization Only Plan - A plan which covers only Inpatient hospital services. K = Medical Services Only Plan - A plan which covers only non-Inpatient medical services. M = Medicare Supplemental Plan, MEDIGAP, Medicare Wraparound Plan or Medicare Carve Out Plan. SPACES = Unknown **Resolution:** Correct insurer type and resubmit.
SP25	Invalid insurer name. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; : . Spaces if not used. Insurer Name must be present if Validity Indicator = y. **Resolution:** Correct insurer name and resubmit.
SP26	Invalid Insurer Address 1 and/or Address 2. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct insurer address and resubmit.

Error Code	Explanation
SP27	Invalid Insurer City.
	Purpose:
	To ensure only valid values are used: alphabetic, space, comma, & - ' . @ # / ; :. Spaces if not used.
	Resolution:
	Correct insurer city and resubmit.
SP28	Invalid Insurer State.
	Purpose:
	To ensure only valid values are used: alphabetic, spaces if not used. Must match on valid state table.
	Resolution:
	Correct insurer state and resubmit.
SP29	Invalid Insurer Zip Code.
	Purpose:
	To ensure only valid values are used: Cannot be low values. If present, the first five positions must be numeric and the last four positions may be spaces. If foreign country, "FC" State code then nine positions may be spaces, if not used.
	Resolution:
	Correct insurer ZIP code and resubmit.
SP30	Invalid Policy Number.
	Purpose:
	To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces if not used.
	Resolution:
	Correct policy number and resubmit.

Error Code	Explanation
	Other Effective Date coverage edits:
SP31	Invalid MSP Effective Date (Mandatory).
	Purpose:
	To ensure only valid values are used: nonblank, nonzero, numeric. Number of days must correspond with the particular month. MSP Effective Date must be less than, or equal to, the current date.
	If MSP Code = A (Working Aged and Spousal Working Aged), effective date must be the later of: • January 1, 1983; or • Calculated date beneficiary turned 65 (first day of month).
	If MSP Code = B (ESRD). Effective date must be the later of: • October 1, 1981; or • Prior to the 1st day of the month the beneficiary turns 65.
	If MSP Code = D (Auto/No-fault/Liability), effective date must be later than December 5, 1980.
	If MSP Code = E (Workers' Compensation), effective date must be later than July 1, 1966.
	If MSP Code = F (Federal/Public Health), effective date must be later than July 1, 1966.
	If MSP Code = G (Disabled), effective date must be later than January 1, 1987.
	If MSP Code = H (Black Lung), effective date must be later than July 1, 1973.
	If MSP Code = I (Veterans' Administration), effective date must be later than July 1, 1966.
	If MSP Code = L (Liability), effective date must be later than December 1, 1980.
	Resolution:
	Correct MSP effective date and resubmit.

Error Code	Explanation
	Other Termination Date coverage edits:
SP32	Invalid MSP Termination Date must be numeric, may be all zeros if not used, if used, date must correspond with the particular month.
	Purpose:
	To ensure only valid values are used: Must be numeric. May be all zeros, if not used. If used, date must correspond with the particular month. • Must be greater than the MSP effective date by 1 month. If validity indicator is N, then termination date may equal effective date. • Cannot be greater than the current date plus 6 months, except when MSP Code = B. • If MSP effective date is 2/1/90 or later, the termination date cannot exceed the MSP effective date by more than 18 months if MSP Code = B. • If the MSP effective date is prior to 2/1/90, the termination date cannot exceed the MSP effective date by more than 12 months if MSP Code = B. • Cannot be greater than the first day beneficiary turned 65 if the MSP code is B or G. • Termination date must be present on type A, B, or G record when accreting a new record with type A, B, or G.
	Resolution:
	Correct MSP Termination Date and resubmit.
SP33	Invalid patient relationship.
	Purpose:
	To ensure only valid values are used: 01-19:

Error Code	Explanation
	01 = Patient is Insured 02 = Spouse 03 = Natural child, insured has financial responsibility 04 = Natural child, insured does not have financial responsibility 05 = Step child 06 = Foster child 07 = Ward of the court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ donor 12 = Cadaver donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured plaintiff 16 = Sponsored dependent 17 = Minor dependent of a minor dependent 18 = Parent 19 = Grandparent **Resolution:** Correct Patient Relationship and resubmit.
SP34	Invalid subscriber first name.

Error Code	Explanation
	Purpose: To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct subscriber first name and resubmit.
SP35	Invalid subscriber last name. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct subscriber last name and resubmit.
SP36	Invalid employee ID number. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct employee id number and resubmit.
SP37	Invalid payer source code. **Purpose:** To ensure only valid values are used: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, 00, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, or 14. **Resolution:** Correct payer source code and resubmit.
SP38	Invalid employee information data code.

Error Code	Explanation
	Purpose: To ensure only valid values are used: Spaces, if not used. Alphabetic values P, S, M, F: P = Patient S = Spouse M = Mother F = Father **Resolution:** Correct employee information data code and resubmit.
SP39	Invalid employer name. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct employer name and resubmit.
SP40	Invalid employer address. **Purpose:** To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used. **Resolution:** Correct employer address and resubmit.
SP41	Invalid employer city. **Purpose:** To ensure only valid values are used: alphabetic, space, comma, & - ' . @ # / ; :. Spaces, if not used.

Error Code	Explanation
	Resolution:
	Correct employer city and resubmit.
SP42	Invalid employer State.
	Purpose:
	To ensure only valid values are used: alphabetic, spaces if not used. Must match on valid State table.
	Resolution:
	Correct employer state and resubmit.
SP43	Invalid employer ZIP code.
	Purpose:
	To ensure only valid values are used: nonzero, all spaces if not used. Must be within valid ZIP code range on ZIP code table. If foreign country, "FC" state code. The first five digits can be zeros and last four can be blanks.
	Resolution:
	Correct employer ZIP code and resubmit.
SP44	Invalid insurance group number.
	Purpose:
	To ensure only valid values are used: alphabetic, numeric, space, comma, & - ' . @ # / ; :. Spaces, if not used.
	Resolution:
	Correct insurance group number and resubmit.
SP45	Invalid insurance group name.
	Purpose:
	To ensure only valid values are used: alphabetic, space, comma, & - ' . @ # / ; :. Spaces, if not used.

Error Code	Explanation
	Resolution:
	Correct insurance group name and resubmit.
SP46	Invalid prepaid health plan date.
	Purpose:
	To ensure only valid values are used: numeric, number of days must correspond with the particular month.
	Resolution:
	Correct health plan date and resubmit c.
SP47	Beneficiary MSP indicator not on for delete transaction.
	Purpose:
	To ensure proper processing of MSP information.
	Resolution:
	Verify MSP indicator and resubmit if appropriate.
SP48	MSP Auxiliary Record not found for delete data transaction.
	Purpose:
	To notify Host of missing MSP data.
	Resolution:
	Verify MSP applicability and resubmit if appropriate.
SP49	MSP auxiliary occurrence not found for delete data transaction.
	Purpose:
	To notify Host of missing MSP data.
	Resolution:
	Verify MSP applicability and contact Host.
SP50	Invalid function for update or delete. Contractor number unauthorized.

Error Code	Explanation
	Purpose: To ensure correct contractor number is submitted. **Resolution:** Verify contractor number, correct and resubmit.
SP51	MSP Auxiliary Record has 17 occurrences and none can be replaced. **Purpose:** To notify Host when MSP Auxiliary Record has reached its maximum size. **Resolution:** Contact Host.
SP52	Invalid Patient Relationship Code which is mandatory for MSP Codes A, B, and G when the Validity Indicator is I or Y. **Purpose:** To ensure only valid Patient Relationship Indicators are used: • MSP code A = 01 Patient 02 Spouse • MSP code B = 01 Patient 02 Spouse 03 Child 04 Natural Child 05 Step Child 18 Parent

Error Code	Explanation
	• MSP code G = 01 Patient 02 Spouse 03 Child 04 Natural Child 05 Step Child 18 Parent **Resolution:** Correct Patient Relationship Code and resubmit.
SP53	The maintenance transaction was for Working Aged EGHP, and there is a Disability EGHP entry on file that has a Termination Date after the Effective Date on the incoming transaction, or is not terminated, and the Contract Number on the maintenance transaction is not equal to 11102, 11104, 11105, 11106, 33333, 66666, 77777, or 88888. **Purpose:** To ensure overlapping MSP records are not created. **Resolution:** Verify dates and resubmit.
SP54	MSP Code A, B, or G has an effective date that is in conflict with the date the beneficiary attained age 65. For MSP Code A, the effective date must not be prior to the date the beneficiary attains age 65. For MSP Code B and G, the effective date must not be later than the date the beneficiary attains age 65. **Purpose:** To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility. **Resolution:** Verify dates and resubmit.

Error Code	Explanation
SP55	MSP effective date is prior to beneficiary's Part A or Part B entitlement dates. **Purpose:** To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility. **Resolution:** Verify dates and resubmit.
SP56	MSP PHP Date must be equal to, or greater than, MSP Effective Date, or less than MSP Termination Date. **Purpose:** To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility. **Resolution:** Verify dates and resubmit.
SP57	Termination Date is greater than six months prior to date added for Contractor Numbers other than "11100-11114," "33333," "55555," "77777," "88888," or "99999." **Purpose:** To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility. **Resolution:** Verify dates and resubmit or contact Host.
SP58	Invalid Insurer Type, MSP Code, and Validity Indicator combination. **Purpose:** To ensure that codes do not contradict each other. **Resolution:** Verify Insurer Type, MSP Code, and Validity Indicator. Resubmit.

Error Code	Explanation
SP59	Invalid Insurer type, and Validity Indicator combination. **Purpose:** To ensure that codes do not contradict each other. **Resolution:** Verify Insurer Type and Validity Indicator. Resubmit.
SP60	Other Insurer Type for same period on file (Non J or K), Insurer Type on incoming maintenance record is equal to J, or K, and Insurer Type on matching Auxiliary record is not equal to J, or K. **Note:** Edit applies only to MSP codes A - Working Aged B - ESRD EGHP G - Disability EGHP **Purpose:** To ensure proper processing of MSP information. **Resolution:** Verify Insurer Type and resubmit.
SP61	Other Insurer type for same period on file (J or K) Insurer type on incoming maintenance record is not equal to J or K, and Insurer type on matching Aux. record is equal to J or K. **Note:** Edit applies only to MSP codes A - Working Aged B - ESRD EGHP G - Disability EGHP **Purpose:** To ensure proper processing of MSP information.

Error Code	Explanation
	Resolution:
	Verify Insurer Type and resubmit.
SP62	Incoming Term Date is less than MSP Effective Date.
	Purpose:
	To ensure that MSP record effective dates are accurate.
	Resolution:
	Verify dates and resubmit.
SP66	MSP Effective Date is greater than the Effective Date on matching occurrence on Auxiliary file.
	Purpose:
	To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.
	Resolution:
	Verify dates and resubmit.
SP67	Incoming Term Date is less than posted Term Date for Provident.
	Purpose:
	To ensure that MSP record effective dates are accurate and correspond to Medicare eligibility.
	Resolution:
	Verify dates and resubmit.
SP72	Invalid Transaction attempted. A HUSP add transaction is received from a FI or carrier (non-COB Contractor) with a Validity Indicator other than I.
	Purpose:
	To ensure that correct information is recorded on the MSP Auxiliary record.

Error Code	Explanation
	Resolution: Correct Validity Indicator and resubmit.
SP73	Invalid Term Date/Delete Transaction attempted. An FI or carrier is attempting to change a Term Date on a MSP Auxiliary record with a I or Y Validity Indicator that is already terminated. **Purpose:** To ensure that MSP transactions are processed correctly. **Resolution:** Verify segment to delete, correct and resubmit if necessary.
SP74	Invalid, cannot update I record. **Purpose:** To ensure that MSP transactions are processed correctly. **Resolution:** Reject transaction.
SP75	Invalid transaction, no Medicare Part A benefits. **Purpose:** To ensure that Medicare pays only for claims for those who are entitled to Medicare benefits. **Resolution:** Reject transaction.

80.8 - ESRD Maintenance Transaction Error Codes

(Rev. 1, 10-01-03)

A3-3644.4, CWF EditMnts
(http://cms.csc.com/cwf/downloads/docs/pdfs/editmnts.pdf)

The "50xx" series of beneficiary edits that are returned on claim transaction response records that receive a Disposition "50," "51," etc. can also be returned on this maintenance transaction.

ESRD Maintenance Transaction Error Codes

Error Code	Explanation
Consistency Edits	The following are consistency edits for ESRD method selection transactions.
RD02	Invalid HICN (mandatory). **Purpose:** To ensure equitable BIC conversion and identification of correct beneficiary. **Resolution:** Verify HICN, correct and resubmit if appropriate.
RD03	Invalid beneficiary surname (mandatory). **Purpose:** To ensure proper format and identification of correct beneficiary: cannot be blank or null, there may be non-alphabetic characters. **Resolution:** Verify surname, correct and resubmit if appropriate.
RD04	Invalid beneficiary first initial (mandatory). **Purpose:** To ensure proper format and identification of correct beneficiary: must not be blank or null.

Error Code	Explanation
	Resolution:
	Verify first initial, correct and resubmit if appropriate.
RD05	Invalid beneficiary date of birth (mandatory).
	Purpose:
	To ensure proper format and identification of correct beneficiary: must be numeric and a valid date prior to the current date.
	Resolution:
	Verify birth date, correct and resubmit if appropriate.
RD06	Invalid beneficiary sex code (mandatory).
	Purpose:
	To ensure proper identification of beneficiary sex, valid codes:
	1= Male
	2= Female
	Resolution:
	Verify and correct sex code and resubmit.
RD07	Invalid provider number (mandatory). Must not be blank or null.
	Purpose:
	To ensure proper format:
	If Override Code is equal to 4, Provider Number must be either blank or it must be numeric in positions 1-2 and 4-5, and alphabetic or numeric in position 3 and 6.
	If Override Code is not equal to 4, Provider Number must be numeric in positions 1-2 and 4-5 and alphabetic or numeric in positions 3 and 6.
	Resolution:
	Correct Provider Number or use Override Code 4 and resubmit.
RD08	Invalid method (mandatory).

Error Code	Explanation
	Purpose: To ensure only valid values are submitted: If Override Code is equal to 4, Method Code must equal 1, 2, or blank. If Override Code is not equal to 4, Method Code must be equal 1 or 2. **Resolution:** Correct Method Code or use Override Code 4 and resubmit.
RD09	Invalid dialysis type (mandatory). **Purpose:** To ensure only valid values are submitted: If Override Code is equal to 4, dialysis type must equal 1, 2, 3, 4, or blank. If Override Code is not equal to 4, dialysis type must equal 1, 2, 3, or 4. **Resolution:** Correct dialysis type or use Override Code 4 and resubmit.
RD10	Invalid Select Date (mandatory). **Purpose:** To ensure only valid dates are submitted: If Override Code is blank, Select Date must be numeric, a valid date, and prior to current date. If Override Code is 1, 2, or 3, Select Date must be blank; or numeric, a valid date, and prior to current date. If Override Code is 4, Select Date is edited under edit code RD14. If Override Code does not have a valid value, Select Date must still be numeric, a valid date, and prior to current date. **Resolution:** Correct Select Date and/or Override Code and resubmit.

Error Code	Explanation
RD11	Invalid Exception Indicator. **Purpose:** If Override Code is blank, Exception Indicator must equal Y or N. If Override code is 4, Exception Indicator must be blank. If Override Code is 1, 2, or 3, and either the Option Year, or Select Date is entered, the Exception Indicator must equal Y or N. If Override Code is 1, 2, or 3, and both the Option Year and Select Date are blank, Exception Indicator must equal Y, N, or blank. If Override Code does not have a valid value, Exception Indicator must still be Y, N, or blank. **Resolution:** Correct Exception Indicator and/or Override Code and resubmit.
RD12	Invalid override code. **Purpose:** To ensure only valid values are submitted: must be blank, null, 1, 2, 3, or 4. **Resolution:** Correct Override Code and resubmit.
RD13	Invalid option year. **Purpose:** To ensure valid values are submitted: If Override Code is a 1, 2, or 3, Option Year cannot equal 0 or low-values. If Override Code is not a 1, 2, or 3, Option Year must be blank. **Resolution:** Correct Option Year and/or Override Code and resubmit.
RD14	Invalid select date.

Error Code	Explanation
	Purpose: To ensure only valid Select Dates are submitted: If Override Code is 4, Select Date must be numeric, a valid date, and prior to current date. **Resolution:** Correct Select Date and resubmit.
RD15	Invalid Contractor Number. **Purpose:** To ensure Contractor Number in valid: must be numeric. **Resolution:** Correct Contractor Number and resubmit.
RD16	Invalid Document Control Number (DCN). **Purpose:** To ensure DCN is present: must not be blank or null. **Resolution:** Correct DCN and resubmit.
RD17	Invalid Contractor Number for Host site. **Purpose:** To ensure that Host site processes only transactions for "member" contractors. **Resolution:** Correct Contractor Number and resubmit or submit to correct Host site.
Utilization Edits	The following are utilization edits for ESRD Method Selection Transactions:
RD31	No match on beneficiary surname.

Error Code	Explanation
	Purpose: To ensure processing for correct beneficiary. **Resolution:** Verify surname, correct and resubmit if appropriate.
RD32	No match on beneficiary first initial. **Purpose:** To ensure processing for correct beneficiary. **Resolution:** Verify first initial, correct and resubmit if appropriate.
RD33	No match on beneficiary date of birth. **Purpose:** To ensure processing for correct beneficiary. **Resolution:** Verify date of birth, correct and resubmit if appropriate.
RD34	No match on beneficiary sex code. **Purpose:** To ensure processing for correct beneficiary. **Resolution:** Verify sex code, correct and resubmit if appropriate.
RD36	Select Date not equal to a Select Date in any method selection iteration and not greater than the Select Date in the current iteration.

Error Code	Explanation
	Purpose: If the Override Code is blank, the Select Date must either: Match one of the existing select dates on the ESRD Auxiliary record; or Be greater than the most recent select date on the ESRD Auxiliary record. **Resolution:** Verify data submitted, correct and resubmit if appropriate.
RD37	Override Code is a 1, 2, or 3, but the iteration requested does not exist. **Purpose:** To ensure that if the Override Code is 1, 2, or 3, an iteration with that value already exists. **Resolution:** Verify data submitted, correct and resubmit if appropriate.
RD38	Override Code is a 1, 2, or 3, and based upon the Exception Indicator and Select Date year, the Option Year is incorrect. **Purpose:** If the Override Code is 1, 2, or 3, and the Option Year has been entered: If the Exception Indicator is Y, the Option Year on the transaction must equal the Select Year on the transaction (or the Select Year on the ESRD Auxiliary Record if there is none on the transaction). If the Exception Indicator is N, the Option Year on the transaction must be 1 greater than the Select Year on the transaction (or the Select Year on the ESRD Auxiliary Record if there is none on the transaction). **Resolution:** Verify data submitted, correct and resubmit if appropriate.
RD39	Override Code is a 4, and the Select Date is not equal to a Select Date on any of the method selection iterations on the Beneficiary Master Record.

Error Code	Explanation
	Purpose: If Override Code is 4, Select Date must match one of the existing Select Dates on the ESRD Auxiliary Record. **Resolution:** Verify data submitted, correct and resubmit if appropriate.
RD40	If override code is 1, 2, 3, or 4, the ESRD auxiliary record must already contain method selection data. **Purpose:** To ensure Override Code corresponds to information on the ESRD Auxiliary Record. **Resolution:** Verify data submitted, correct and resubmit if appropriate.
RD41	If Override Code is 1, 2, or 3, and the Select Date is changed, the Select Date must not match the Select Date on any other existing iteration. **Purpose:** To ensure a change in the Select Date does not duplicate an existing iteration. **Resolution:** Verify data submitted, correct and resubmit if appropriate.

80.9 - Duplicate Checking Alert Error Codes

(Rev. 1, 10-01-03)

B-02-065, B-02-049, CWF EditAlert
(http://cms.csc.com/cwf/downloads/docs/pdfs/editalrt.pdf)

The following error codes refer to the duplicate claim Alert Codes. These codes will be included on the Trailer 06 returned on PAID claims. The alert is given so that the contractor can investigate if a duplicate claim exists and cancel the inappropriate claim if necessary.

To resolve these ALERT codes, the contractors investigate if a duplicate exists and cancel the duplicate claim and/or adjust the first claim and recover any overpayments if appropriate.

Duplicate Checking Alert Error Codes

Error Code	Explanation
761x	Duplicate claim processed with different ICN. ("x" equals 1, 2, 4, 5, or 6 only).
762x	Beneficiary receiving duplicate services from different providers.
763x	Beneficiary receiving duplicate services where only the revenue codes are different.
764x	Beneficiary receiving duplicate services where only the HCPCS codes are different.
765x	Beneficiary receiving duplicate services where only the charges are different.
766x	Beneficiary receiving duplicate services from different FIs.
Part B Alerts	
7600	Duplicate claim being processed except for Document Control Number (DCN).
76x1	Duplicate billing(s) by the same provider.
76x2	Beneficiary receiving duplicate billing(s) from multiple providers.
76x3	Beneficiary receiving duplicate billings by the same provider but is not contractor specific.
DMEPOS	
DA01	A DMEPOS claim has capped rental, electrical wheelchair, or PEN pump items, and 60 days have passed since the last claim without an intervening Inpatient or SNF bill. Claims with modifiers "MS" and "KH" are excluded.
DA02	A claim for DMEPOS items with service dates that overlap an Inpatient admission are not allowed. This edit is bypassed for Therapeutic Shoe Insert claims, and select NOC code claims. Effective January 1, 2003, only the start date of claims for HCPCS codes A4253, A4255, A4256, and A4259 is considered for this edit (not the entire span of service dates). Beginning April 1, 2003, override of this edit is allowed.

Error Code	Explanation
DA03	Maintenance/service allowed only every 6 months. DMEPOS Claims for the maintenance or servicing (Modifier MS) of rental items and rented enteral pumps (HCPCS Code B9000 and B9002) that have met their cap are allowed only every 6 months following the 22nd month after delivery.
DA04	Maintenance/service allowed only every 3 months. DMEPOS claims for the maintenance or servicing (Modifier MS) for rented parenteral pumps (HCPCS Code B9004 and B9006) that have met their cap are allowed only every 3 months after the rental limit has been met.
DA05	For immunosuppressive drug claims duplicate billing by the same supplier detected. This edit is bypassed for Therapeutic Shoe insert claims, and claims with selected NOC HCPCS codes. Beginning April 1, 2003, override of this edit will be allowed.

80.10 - Duplicate Checking Reject Error Codes

(Rev. 1, 10-01-03)

B-02-065, B-02-049, CWF EditUtil (http://cms.csc.com/cwf/downloads/docs/pdfs/editutil.pdf)

The following error codes refer to the duplicate claim Reject Codes. **To resolve these error codes contractors verify and correct invalid data, then resubmit transaction or deny as duplicate claim.**

Duplicate Checking Reject Error Codes

Error Code	Explanation
5613	OP, HH Duplicate claim being processed with different ICN.
5700	Part B Possible split global surgical claim.

Error Code	Explanation
5701	Part B Non-Utilization Days, as indicated by Noncovered Occurrence Span Code, and Benefit Exhaust Dates, are less than the Non-Utilization field submitted on the claim. Complete global fee for the same surgery may already have been paid. Bypass Non-Payment Codes "B," "C," "E," "F," "G," "H," "J," "K," "N," "Q," "T," "U," "V," "W," or "Y."
5702	Part B Complete global fee for the same post-op procedure may already have been paid.
5703	Possible duplicate billing - billing by the same physician for the same surgery within 90 days.
5704	Possible duplicate billing - billing by the same physician for any procedure within 90 days.
5705	Possible split global surgical claim within 90 days.
BD01	Duplicate billing by the same supplier detected.
BD02	More than one supplier may be billing for the same items to the same beneficiary.
BD03	The same service provided by the same supplier using its NSC assigned number, and its Part B carrier assigned number. There is a DMEPOS claim on history for the same item which is being submitted on the Part B claim. The Provider HIC Number corresponding to the NSC assigned Supplier HIC Number on the DMEPOS claim matches the Provider HIC Number on the Part B claim.
DA05	Duplicate billing by the same supplier detected. This edit is bypassed for Therapeutic Shoe Insert claims and claims with selected NOC HCPCS codes. Beginning April 1, 2003, override of this edit will be allowed.
DA06	More than one supplier may be billing for the same items to the same beneficiary. This edit is bypassed for claims with selected NOC HCPCS codes. Beginning April 1, 2003, override of this edit will be allowed.

Error Code	Explanation
DA07	Same service provided by the same supplier using its Part B carrier HIC Number, and the NSC HIC Number of a business owned by the supplier. There is a Part B claim on history for the same supply that is being submitted on the DMEPOS claim. The NSC Supplier Number corresponding to the Provider Number on the Part B claim matches the NSC Supplier number on the DMEPOS claim. This edit is bypassed for claims with selected HCPCS codes. Beginning April 1, 2003, override of this edit will be allowed.
DA09	A claim for the purchase of an inexpensive and routinely purchased DMEPOS item with Service Dates that overlap an Inpatient admission is not allowed, unless the purchase date is equal to the Date of Admission, or Date of Discharge. Effective January 1, 2003, only the start date of claims for HCPCS code A4253 is considered for this edit (not the entire span of service dates). Beginning April 1, 2003, override of this edit is allowed.

80.11 - Certificate of Medical Necessity (CMN) Maintenance Transaction Error Codes

(Rev. 1, 10-01-03)

B-02-043, CWF EditMnts
(http://cms.csc.com/cwf/downloads/docs/pdfs/editmnts.pdf)

Certificate of Medical Necessity (CMN) Maintenance Transaction error codes indicate either a consistency error in the CMN Transaction Record (HUCM), or an error attempting to update the Host CMN Auxiliary file with an HUCM transaction. Consistency errors and file update errors can be encountered by the Hosts during Satellite Auxiliary file processing. Such transactions will be rejected with a "CM" Disposition Code in the CMN Transaction Reply Record. A trailer 08 with up to four error codes will always follow.

Consistency errors are numbered C001 through C069. General file update errors are numbered starting with the C100 code. Other update errors are numbered according to the type of CMN transaction being processed: C2xx for initial certifications, C3xx for revisions, and C4xx for re-certifications.

Listed below are the possible CMN consistency and file update errors. The consistency errors are documented with the requirements for the specific field, and a corrective action to be taken in case the error occurs. Each file update error includes a description of the error, and a corrective action. File update errors should always be investigated by querying the current information for the beneficiary at the CWF Host.

To resolve these error codes verify and correct invalid data according to the information specified under "purpose," then resubmit transaction.

CMN Maintenance Transaction Error Codes

Error Code	Explanation
C001	Invalid CMN transaction record type. **Purpose:** To ensure valid values: HUCM, HBCM, HICM
C004	Invalid beneficiary surname. As of January 1, 2003, CWF will accept apostrophes, hyphens, and periods in a beneficiary's name. **Purpose:** To ensure presence and proper alphabetic format.
C005	Invalid beneficiary first name initial. As of January 1, 2003, CWF will accept apostrophes, hyphens, and periods in a beneficiary's name. **Purpose:** To ensure presence and proper alphabetic format.
C007	Invalid beneficiary date of birth. **Purpose:** To ensure presence and proper numeric format.
C008	Invalid beneficiary sex code. **Purpose:** To ensure valid values: 0, 1, or 2.
C009	Invalid DMERC Number. **Purpose:** To ensure valid numeric format.
C010	Invalid CMN Control Number. **Purpose:** To ensure presence of CMN Control Number.
C014	Invalid DMEPOS certification type.

Error Code	Explanation
	Purpose: To ensure valid values: 1 = Initial CMN 2 = Revision 3 = Re-certification (Cat 5 and 7 only)
C015	Invalid DMEPOS CMN transaction type. **Purpose:** To ensure valid values: 1 = Add 2 = Update 3 = Delete
C016	Invalid approved HCPCS code. **Purpose:** To ensure presence of HCPCS code.
C017	Invalid DMEPOS category. **Purpose:** To ensure valid values: 1, 2, 3, 4, 5, 6, 7, 8, 9, or A.
C018	Invalid initial certification date. **Purpose:** To ensure format is valid date and date is not more than 60 days in the future.
C019	Invalid re-certification/revision date.

Error Code	Explanation
	Purpose: To ensure re-cert/revision date is greater than initial certification date and not more than 60 days in the future.
C020	Invalid scheduled re-certification date. **Purpose:** To ensure valid values: If cert. type = 1 • Initial cert. date plus 3 months if category 5 and medical necessity length = 3. • Initial cert. date plus 12 months if category 5 and medical necessity length = 12. If Cert. Type = 3 • Re-certification date plus 3 months if medical necessity length = 3. • Re-certification date plus 12 months if medical necessity length = 12.
C021	Invalid discontinue certification date. **Purpose:** To ensure valid values: Can be used only if adding cert. type 2. Must be greater than, or equal to, the initial certification date.
C022	Invalid medical necessity length.

Error Code	Explanation
	Purpose:
	To ensure valid values:
	Must be 00-15 or 99, if Category is 4 and Cert. Type is 2 or 3.
	Must be 01-15 or 99, if Category is 4 and Cert. Type is 1.
	Must be 00-36, if Category is 6 and Cert. Type is 2 or 3.
	Must be 01-36, if Category is 6 and Cert. Type is 1.
	Must be 00-15 or 99, for PEN pumps, and must be 03-99 for other PEN items, if Category is 7 and Cert. Type is 2 or 3.
	Must be 01-15 or 99, for PEN pumps, and must be 03-99 for other PEN items, if Category is 7 and Cert. Type is 1.
	Must be 00-99, if Category is 5 and Cert. Type is 2 or 3.
	Must be 01-99 if Category is 5 and Cert. Type is 1.
C024	Invalid diagnosis code 1.
	Purpose:
	To ensure only valid ICD9 Diagnosis Codes are submitted.
C025	Invalid Diagnosis Code 2.
	Purpose:
	To ensure only valid ICD9 Diagnosis Codes are submitted.
C026	Invalid Diagnosis Code 3.
	Purpose:
	To ensure only valid ICD9 Diagnosis Codes are submitted.
C027	Invalid Diagnosis Code 4.
	Purpose:
	To ensure only valid ICD9 Diagnosis Codes are submitted.

Error Code	Explanation
C028	Invalid date last seen. **Purpose:** To ensure only spaces or valid dates are submitted.
C029	Invalid patient residence. **Purpose:** To ensure valid values: 12, 31-34, 54-56, 61, or spaces.
C030	Invalid ordering physician UPIN. **Purpose:** To ensure valid format: Positions 1-3, alphabetic or numeric. Positions 4-6, numeric only.
C032	Invalid ordering physician surname. **Purpose:** To ensure presence of ordering physician surname.
C033	Invalid ordering physician initial. **Purpose:** To ensure presence of ordering physician initial.
C034	Invalid supplier number. **Purpose:** To ensure the presence of a valid supplier number.
C036	Invalid delivery date. **Purpose:** To ensure valid format: Zeros if not used, or valid date.
C037	Invalid warranty information.

Error Code	Explanation
	Purpose:
	To ensure presence when the CMN warranty indicator is equal to Y
C039	Invalid replacement item.
	Purpose:
	To ensure valid values: Y, N, or spaces.
C041	Invalid flow rate.
	Purpose:
	To ensure valid values: Spaces, QE, QF, or QG.
C042	Invalid ABG level.
	Purpose:
	To ensure only valid ABG levels are submitted.
C043	Invalid ABG date.
	Purpose:
	To ensure valid format: zeros if not used, or valid date.
C044	Invalid saturation level.
	Purpose:
	To ensure a valid format: numeric, spaces if not used.
C045	Invalid oximetry date.
	Purpose:
	To ensure a valid format: zeros if not used, or valid date.
C047	Invalid oximetry test condition.
	Purpose:
	To ensure valid values: 1, 2, 3, or spaces.

Error Code	Explanation
C048	Invalid severity of illness.
	Purpose:
	To ensure valid values: N, Y, or spaces.
C049	Invalid route of administration.
	Purpose:
	To ensure valid values: 1, 3, 7, or spaces.
C050	Invalid impairment indicator.
	Purpose:
	To ensure valid values: N, Y, or spaces.
C051	Invalid method of administration.
	Purpose:
	To ensure valid values: 1, 2, 3, 4, or spaces.
C053	Invalid PB indicator.
	Purpose:
	To ensure valid values: N, Y, or spaces.
C054	Invalid type of therapy.
	Purpose:
	To ensure valid values: E, P, or spaces.
C055	Invalid frequency per week.

Error Code	Explanation
	Purpose: To ensure valid values: If field 54 is P, frequency per week = number of feedings required per week. If field 54 is E, frequency per week = number of daily feedings (field 59) times 7.
C058	Invalid enteral calories per day. **Purpose:** To ensure valid format: numeric.
C062	Invalid transplant failure indicator. **Purpose:** To ensure valid values: N, Y, or spaces. Must be spaces if Cert. Type equals 1 and Cat. equals 6.
C065	Invalid facility name. **Purpose:** To ensure valid values: valid facility name, or spaces.
C066	Invalid facility city. **Purpose:** To ensure presence of facility city.
C067	Invalid facility state. **Purpose:** To ensure valid value: AK, AL, AR, AS, AZ, CA, CO, CT, DC, DE, FC, FL, FM, GA, GU, HI, IA, ID, IL, IN, KY, KS, LA, MA, MD, ME, MH, MI, MN, MO, MP, MS, MT, NB, NC, ND, NE, NH, NM, NJ, NV, NY, OH, OK, OR, PA, PR, PW, RI, SC, SD, TN, TX, UT, VA, VI, VT, WA, WI, WV, or WY.
C068	Invalid transplant discharge date.

Error Code	Explanation
	Purpose: To ensure presence and valid date format.
C069	ABG or oximetry tests required on initial CMN. **Purpose:** To ensure valid values: • Either ABG test data (fields 42-43), and/or oximetry test data (fields 44-47) must be supplied; or • Both ABG test data (fields 42-43), and oximetry test data (fields 46-47) must be supplied. Incomplete sets of test information are not allowed.
C076	PEN pumps and electric wheelchairs with Medical Necessity of 99 must have a Type of Service A or P. Capped rental may not have a Medical Necessity of 99. **Purpose:** To ensure valid values for Medical Necessity and Type of Service fields.
C077	Invalid contractor number for Host site. **Purpose:** To ensure that the transaction contractor number matches the header contractor number.
C078	Invalid scheduled re-certification date, or necessity length for parenteral nutrition or pump. **Purpose:** To ensure valid values: If Cert. Type = 1 and DMEPOS Category 7/HCPCS Category 20, B9004, or B9006: Initial Cert. Date must be plus 6 months, or less, and not blanks and Necessity Length must be 6 months, or less.
C100	HIC number not valid for equatable conversion. The HIC Number indicated on the HUCM must be valid for equatable conversion.

Error Code	Explanation
	Purpose: To ensure the railroad board beneficiary HIC number converts to a valid Social Security HIC number.
C101	Carrier number must be a valid DMERC Number. The number indicated on the HUCM transaction is not equal to a valid DMERC HIC Number. **Purpose:** To ensure that the CMN auxiliary maintenance transaction contractor number is found on the carrier locality code/address table.
C102	Surname must match beneficiary surname. The surname indicated on the HUCM transaction does not match the surname on the Beneficiary record. As of January 1, 2003, CWF will accept apostrophes, hyphens, and periods in a beneficiary's name. **Purpose:** To ensure that the CMN auxiliary maintenance transaction beneficiary surname matches the master beneficiary surname.
C103	First initial must match beneficiary first initial. **Purpose:** To ensure the CMN auxiliary maintenance transaction beneficiary initial matches the master beneficiary initial.
C104	Date of birth must match beneficiary date of birth. The Date of Birth indicated on the HUCM transaction does not match the Date of Birth on the Beneficiary record. **Purpose:** To ensure that the CMN auxiliary maintenance transaction beneficiary date of birth matches the master beneficiary date of birth.
C105	Sex code must match beneficiary sex code. **Purpose:** To ensure that the CMN auxiliary maintenance transaction beneficiary sex code matches the master beneficiary sex code.

Error Code	Explanation
C106	No matching CMNAUX initial record. A matching initial CMNAUX record must exist to accept the HUCM transaction. **Purpose:** To ensure the CMN auxiliary maintenance transaction has a matching record on the CMN auxiliary file.
C107	No matching CMNAUX revision/re-certification record. **Purpose:** To ensure a matching revision or re-certification CMNAUX record exists on the CMN Auxiliary file.
C108	HUCM initial CMN not found. No initial certification was found with the initial Certification Date indicated on the HUCM transaction. **Purpose:** To ensure a matching Certification Date exists on the CMN Auxiliary file.
C109	HUCM revision or re-certification not found. No revision or re-certification was found with the revision or re-certification Date indicated on the HUCM transaction. **Purpose:** To ensure a matching record is found on the CMN Auxiliary file.
C110	Contractor numbers must match. Only the originating contractor (DMERC) can update, or delete an existing initial, revision, or re-certification HUCM transaction. This edit is waived if the existing occurrence is a skeleton CMN. **Purpose:** To ensure that only an eligible contractor can make a change to an HUCM transaction.
C111	HCPCS code is not valid. **Purpose:** To ensure only valid HCPCS codes are submitted.

Error Code	Explanation
C112	HCPCS code is not valid for the DMEPOS category. **Purpose:** To ensure that the HCPCS code on the HUCM is valid for the DMEPOS category indicated on the HUCM transaction.
C113	HUCM update must contain original medical necessity length. **Purpose:** To ensure that when an HUCM update transaction is received, the medical necessity length on the transaction matches the length originally submitted.
C115	Skeleton CMN cannot be revised or re-certified. A skeleton CMN cannot be revised, or re-certified, except for the setting of the Discontinue Date. **Purpose:** To ensure that a skeleton CMN cannot be revised or re-certified, except for the setting of the Discontinue Date.
C116	HCPCS code has been cross-referenced to a new National Code. New certifications for this item must use the current HCPCS code. **Purpose:** To ensure that only current HCPCS codes are accepted.
C117	Invalid type of service. **Purpose:** To ensure the type of service is spaces or matches a code on the HCPCS file.
C200	Invalid initial certification date. **Purpose:** To ensure that when adding a subsequent initial certification the initial Certification Date of the HUCM transaction is greater than the initial Certification Date of the current CMNAUX occurrence.

Error Code	Explanation
C201	Initial certification not greater than end date of an existing certification, or if a TENs unit, the initial certification not greater than, or equal to, the End Date of an existing certification. **Purpose:** To ensure that when adding a new initial certification, the HUCM initial Certification Date follows the prior Certification Date, unless the certification is for a TENs unit, then the Certification Date must be the same as, or greater than, the prior Certification Date, or if medical necessity length is 99, the prior Certification must be discontinued.
C202	Useful life of prior item not expired. **Purpose:** To ensure that an HUCM transaction to add a CMN has an initial certification prior to the end of the Useful Life Period of the current CMNAUX occurrence for the item. This transaction is permitted only for replacement items, or if the previous CMN has been discontinued, and the initial date is greater than the previous CMN's Discontinue Date.
C203	EPO permitted for ESRD Method II beneficiaries only. **Purpose:** To ensure that an initial CMN for EPO can be added only if the beneficiary had selected ESRD Method II when the CMN was issued.
C300	Revision date is after the certification end date. **Purpose:** To ensure that the revision date on an HUCM transaction cannot be after the termination date of the certification.
C302	New revision must be later than a prior revision. **Purpose:** To ensure that an HUCM revision date cannot be later than the date on the most current CMNAUX revision.
C303	Purchased DMEPOS item cannot be revised.

Error Code	Explanation
	Purpose: To ensure that a certification for a purchased item in DMEPOS Category 1-4, 9, A, and PEN pumps in Category 7 cannot be revised.
C400	Re-certification dates do not match.
	Purpose: To ensure that an HUCM re-certification date is equal to, greater than, or within the 30 days preceding the current certification's scheduled re-certification date.
C401	Discontinued certifications cannot be re-certified.
	Purpose: To ensure that the HUCM re-certification date is not after the CMNAUX discontinue date.
C402	New re-certification must follow prior re-certification.
	Purpose: To ensure that an HUCM re-certification date follows the date on the most current CMNAUX re-certification.
C403	Cannot re-certify old certifications.
	Purpose: To ensure that re-certifications are accepted for the current certification only.
C404	Re-certification re-tests required.
	Purpose: When adding the first oxygen re-certification, and the ABG Level was > 55, or the Saturation Level was > 88 on the initial CMN, either ABG test results (fields "42-43"), or oximetry test results (fields 44-47) must be supplied.
C405	ABG/Oximetry retest not performed within 61-90 days.

Error Code	Explanation
	Purpose: When adding the first oxygen re-certification, and the ABG Level was > 55, or the Saturation Level was > 88 on the initial CMN, the ABG, or Oximetry Test Date must be within 61-90 days of the initial Certification Date.
C406	Re-certification of parenteral nutrient and PEN pumps (HCPCS Codes B9004 or B9006) for lifetime cannot take place PRIOR to 6 months from the initial certification date. **Purpose:** To ensure that re-certifications take place within the required timeframe.

80.12 - Utilization Alert Codes

CWF Edit Alert (http://cms.csc.com/cwf/downloads/docs/pdfs/editalrt.pdf)

Alert Codes are sent to the Satellite when CWF believes that there is a potential problem or error in the claim. **The presence of an alert indicates that the Satellite should examine the information and make adjustments if necessary**.

Utilization Alert Codes

Alert Code	Explanation
5370	Part B This edit deactivated with R2003200. Mammography claim missing the certificate number, or certificate number is not numeric.
5371	Part B This edit deactivated with R2003200. Mammography certificate number does not match on mammography facility ID #.

Alert Code	Explanation
5372	Part B This edit deactivated with R2003200. Mammography bill submitted with service From Date not equal to, or greater than, certification Start Date and service From Date not less than, or equal to, the certification Stop Date.
5512	DMEPOS Beneficiary has received emergency supplies at least once before.
7701	OP Outpatient claims with statement From Dates 01/01/1998 and later require HCPCS Code 90999 and a Modifier between G1 and G5 when the Revenue Code is equal to 0820, 0821, or 0829. Claims 1998 thru 12/31/02 alert is valid and claims from 01/01/2003 forward alert is deactivated and changed to Consistency Edit 58#4.
C114	CMN Claims History Alert. A HUCM delete transaction has been accepted and an entire certification, revision, or re-certification has been deleted. However, claims had been accepted for this item during the deleted certification period. The HUCM disposition is set to "AL" if this condition occurs.
D911	DMEPOS Purchase decision for a capped rental item must be received prior to the thirteenth rental month. For capped rental items, a purchase decision Modifier ("BP," "BR," or "BU") must be present on the claim for the eleventh rental month.
D920	DMEPOS No CMN was found for the submitted HCPCS, but the line item was successfully validated against a skeleton CMN for a commonly down coded HCPCS.

Alert Code	Explanation
D926	DMEPOS Capped Rental, Electric Wheelchair, or PEN Pump rental months recalculated based on paid claims history data.
D927	DMEPOS Inexpensive and routinely purchased item rental payments recalculated based on paid claims history data and may be suspect.

80.13 - Beneficiary Other Insurance Information (HUBO) Maintenance Transaction Error Codes

(Rev. 1038, Issued: 08-25-06; Effective: 01-01-07; Implementation: 01-02-07)

(CWF EditMnts (http://cms.csc.com/cwf/downloads/docs/pdfs/editmnts.pdf)

HUBO (Beneficiary Other Insurance Information) Maintenance Transaction edit rejects are denoted by a value of "BO" in the disposition field on the Reply Record. A Trailer 08 containing up to four error codes will always follow. Listed below are the possible BOxx Maintenance Transaction error codes with a general description. **Each error must be corrected and the transaction resubmitted to CWF.**

The "50xx" series of Beneficiary edits that are returned on claim transaction response records that receive a Disposition "50," "51," etc. can also be returned on this maintenance transaction. The narrative description for these error codes is in the claim transaction edit sections.

HUBO Maintenance Transaction Error Codes

Error Code	Explanation
BO01	Beneficiary Health Insurance Number is missing, or invalid.
BO02	Beneficiary Surname is missing, or invalid.
BO03	Beneficiary Date of Birth is missing, or invalid.
BO04	Beneficiary Sex Code is invalid.
BO05	The Contractor Number is not equal to "11120."
BO06	The Date of Accretion is invalid.
BO07	The Deletion Date is invalid.

Error Code	Explanation
BO08	The Document Control Number is invalid.
BO09	The Action Type is missing, or invalid.
BO10	The Update Date is invalid.
BO11	The Insurance Coverage Type is missing, or invalid.
BO12	The Insurer Name or Address Info is invalid.
BO13	The Insurance Policy Number is invalid.
BO14	The Insurance Effective Date is invalid.
BO15	The Termination Date is invalid.
BO16	The Identifier Number is invalid.
BO17	The COBA Number is invalid.
BO18	The Plan ID Number is invalid.
BO19	The Other Insurer Number is invalid.
BO20	No match for update or delete found on BOI file.
BO21	Duplicate occurrence exists on the BOI file.
BO22	Record already deleted on BOI file.

Effective with January 2, 2007, the CWF shall accept and process a HUBO transaction that either updates an existing Beneficiary Other Insurance (BOI) auxiliary record **or** adds a new BOI auxiliary record occurrence.

If the CWF receives an incoming HUBO transaction whose COBA identification number (ID) and 'beneficiary supplemental eligibility-from date' (CCYYMMDD) match the equivalent elements within an existing BOI auxiliary record, it shall overlay the existing record with the incoming record. However, if the CWF receives an incoming HUBO transaction whose COBA ID and 'beneficiary supplemental-from date' do **not** match the equivalent elements within an existing BOI auxiliary record, it shall create a new BOI auxiliary record occurrence.

For purposes of applying COBA eligibility files to the BOI auxiliary file, the CWF maintainer shall redefine Action Type '0- Add' as '1-Add/Update.' For purposes of applying COBA eligibility files to the BOI auxiliary record, the CWF shall now accept and

process **only** two Action Types—'1 - Add/Update' and '2 – Delete'—from the COBC as part of the COBA crossover process.

The CWF shall continue to apply the applicable 'BO' edits that would relate to add/update or delete actions accomplished via the HUBO transaction.

80.14 - Consolidated Claims Crossover Process

(Rev. 1497, Issued: 05-02-08, Effective: 07-01-08, Implementation: 07-07-08)

A. The Mechanics of the CWF Claims Selection Process and BOI and Claim-based Reply Trailers

1. CWF Receipt and Processing of the Coordination of Benefits Agreement Insurance File (COIF)

Effective July 6, 2004, the COBC will begin to send copies of the Coordination of Benefits Agreement Insurance File (COIF) to the nine CWF host sites on a weekly basis. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria exclusions (claim or bill types that the trading partner does not want to receive via the crossover process) along with an indicator (Y=Yes; N=No) regarding whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). During the COBA parallel production period, which is estimated to run from July 6, 2004, to October 1, 2004, CWF will exclusively return an "N" MSN indicator to the Medicare contractor.

The CWF shall load the initial COIF submission from COBC as well as all future weekly updates.

Upon receipt of a claim, the CWF shall take the following actions:

a. Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs];

b. Refer to the COIF associated with each COBA ID (NOTE: CWF shall pull the COBA ID from the BOI auxiliary record) to obtain the COBA trading partner's name and claims selection criteria;

c. Apply the COBA trading partner's selection criteria; and

d. Transmit a BOI reply trailer 29 to the Medicare contractor only if the claim is to be sent, via 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file, to the COBC to be crossed over. (See Pub.100-04, Chap. 28, §70.6 for more information about the claim file transmission process involving the Medicare contractor and the COBC.)

Effective with the October 2004 systems release, CWF shall read the COIF submission to determine whether a Test/Production Indicator "T" (test mode) or "P" (production mode) is present. CWF will then include the Test/Production Indicator on the BOI reply trailer 29 that is returned to the Medicare contractor. (See additional details below.)

2. BOI Reply Trailer 29 Processes

For purposes of eligibility file-based crossover, if CWF selects a claim for crossover, it shall return a BOI reply trailer 29 to the Medicare contractor. The returned BOI reply trailer 29 shall include, in addition to COBA ID(s), the COBA trading partner name(s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, the insurer effective and termination dates, and a 1-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. Effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator "T" (test mode) or "P" (production mode) on the BOI reply trailer 29 that is returned to the Medicare contractor.

B. MSN Crossover Messages

As specified above, during the COBA parallel production period (July 6, 2004, to October 1, 2004), CWF will exclusively return an "N" MSN indicator via the BOI reply trailer, in accordance with the information received via the COIF submission. If a Medicare contractor receives a "Y" MSN indicator during the parallel production period, it shall ignore it.

Beginning with the October 2004 systems release, when a contractor receives a BOI reply trailer 29 from CWF that contains a Test/Production Indicator "T" (test mode), it shall ignore the MSN Indicator provided on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing Trading Partner Agreements (TPAs).

Beginning with the October 2004 systems release, when a contractor receives a BOI reply trailer 29 from CWF that contains a Test/Production Indicator "P" (production mode), it shall read the MSN indicator (Y=Yes, print trading partner's name; N=Do not print trading partner's name) returned on the BOI reply trailer 29. (Refer to Pub.100-4, chapter 28, §70.6 for additional details.)

C. Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) from CWF that contains a "T" Test/Production Indicator, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advice(s) that is/are in production. Contractors shall, however, populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when contractors receive a BOI reply trailer (29) from CWF that contains a "P" Test/Production Indicator, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

1. Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [NOTE: Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

2. Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.
- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.
- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.
- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification.)
- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record.

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

Effective with the implementation of the COBA Medigap claim-based crossover process, when a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health insurer/benefit plan that has signed a national COBA), CWF shall sort the COBA IDs and trading partner names in the following order:

1) Eligibility-based Medigap, 2) Supplemental, 3) TRICARE, 4) Others, 5) Claim-based Medigap, and 6) Eligibility-based Medicaid. When two or more COBA IDs fall in the same range (see item 24 in the BOI Auxiliary File table above), CWF shall sort numerically within the same range.

3. CWF Treatment of Non-assigned Medicaid Claims

When CWF receives a non-assigned Medicare claim for a beneficiary whose BOI auxiliary record contains a COBA ID with a current effective date in the Medicaid eligibility-based range (70000-77999), it shall reject the claim by returning edit 5248 to the Part B

contractor's system only when the Medicaid COBA trading partner is in production mode (Test/Production Indicator=P) with the COBC. At the same time, CWF shall only return a Medicaid reply trailer 36 to the Part B contractor that contains the trading partner's COBA ID and beneficiary's effective and termination dates under Medicaid when the Medicaid COBA trading partner is in production mode with the COBC. CWF shall determine that a Medicaid trading partner is in production mode by referring to the latest COBA Insurance File (COIF) update it has received.

If, upon receipt of CWF edit 5248 and the Medicaid reply trailer (36), the Part B contractor determines that the non-assigned claim's service dates fall during a period when the beneficiary is eligible for Medicaid, it shall convert the assignment indicator from "non-assigned" to "assigned" and retransmit the claim to CWF. After the claim has been retransmitted, the CWF will only return a BOI reply trailer to the Part B contractor if the claim is to be sent to the COBC to be crossed over.

Effective with October 1, 2007, CWF shall cease returning an edit 5248 and Medicaid reply trailer 36 to a Durable Medical Equipment Medicare Administrative Contractor (DMAC). In lieu of this procedure, CWF shall only return a BOI reply trailer (29) to the DMAC for the claim if the COBA Insurance File (COIF) for the State Medicaid Agency indicates that the entity wishes to receive non-assigned claims.

NOTE: Most Medicaid agencies will not accept such claims for crossover purposes.

If CWF determines via the corresponding COIF that the State Medicaid Agency does not wish to receive non-assigned claims, it shall exclude the claim for crossover. In addition, CWF shall mark the excluded claim with its appropriate claims crossover disposition indicator (see §80.15 of this chapter for more details) and store the claim with the information within the appropriate Health Insurance Master Record (HIMR) detailed history screen.

DMACs shall no longer modify the provider assignment indicator on incoming non-assigned supplier claims for which there is a corresponding COBA ID in the 'Medicaid' range (70000-77999).

4. Additional Information Included on the HUIP, HUOP, HUHH, HUHC, HUBC and HUDC Queries to CWF

Beneficiary Liability Indicators on Part B and DMAC CWF Claims Transactions

Effective with the January 2005 release, the Part B and DMAC systems shall be required to include an indicator 'L' (beneficiary is liable for the denied service[s]) or 'N' (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

Currently, the DMAC shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug

Programs (NCPDP) format. The DMAC shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" shall be included in a field on the HUDC query that is separate from the fields used to indicate whether a beneficiary is liable for all services denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding denied services on claims with or without beneficiary liability and NCPDP claims.

Beneficiary Liability Indicators on Part A CWF Claims Transactions

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the field=L or N).

As Part A contractors adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an 'L' indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an 'N' beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an 'L' or 'N' beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive 'original' fully denied claims with beneficiary liability (crossover indicator 'G') or without beneficiary liability (crossover indicator 'F') or 'adjustment' fully denied claims with beneficiary liability (crossover indicator 'U') or without beneficiary liability (crossover indicator 'T').

CWF shall deploy the same logic for excluding Part A fully denied 'original' and 'adjustment' claims with or without beneficiary liability as it now utilizes to exclude fully denied 'original' and 'adjustment' Part B and DMAC/DME MAC claims with and without beneficiary liability, as specified elsewhere within this section.

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.15 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL,

and HOSL), to illustrate the indicator ('L' or 'N') that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If a Part A contractor sends values other than 'L' or 'N' in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the Part A contractor for correction. Following receipt of the CWF rejection, the Part A contractor shall change the incorrect value placed within the newly defined beneficiary liability field and retransmit the claim to CWF.

5. Modification to the CWF Inclusion or Exclusion Logic for the COBA Crossover Process

Beginning with the October 2006 release, the CWF or its maintainer shall modify its COBA claims selection logic and processes as indicated below. The CWF shall continue to include or exclude all other claim types in accordance with the logic and processes that it had in place prior to that release.

D. New Part B Contractor Inclusion or Exclusion Logic

The CWF shall read the first two (2) positions of the Business Segment Identifier (BSI), as reported on the HUBC claim, to uniquely include or exclude claims from state-specific Part B contractors, as indicated on the COBA Insurance File (COIF).

E. Exclusion of Fully Paid Claims

The CWF shall continue to exclude Part B claims paid at 100 percent by checking for the presence of claims entry code '1' and determining that each claim's allowed amount equals the reimbursement amount and confirming that the claim contains no denied services or service lines.

The CWF shall continue to read action code '1' and determine that there are no deductible or co-insurance amounts for the purpose of excluding Part A original claims paid at 100 percent. In addition, CWF shall determine that the Part A claim contained a reimbursement amount before excluding a claim with action code '1' that contained no deductible and co-insurance amounts and that the claim contained no denied services or service lines.

F. Claims Paid at Greater than 100 Percent of the Submitted Charge

The CWF shall modify its current logic for excluding Part A original Medicare claims paid at greater than 100 percent of the submitted charges as follows:

> In addition to meeting the CWF exclusion criteria for Part A claims paid at greater than 100 percent of the submitted charges, CWF shall exclude these claims only when there is no deductible or co-insurance amounts remaining on the claims.

NOTE: The current CWF logic for excluding Part B original Medicare claims paid at greater than 100 percent of the submitted charges/allowed amount (specifically, type F ambulatory surgical center claims, which typically carry deductible and co-insurance amounts) shall remain unchanged.

G. Claims with Monetary or Non-Monetary Changes

The CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to determine whether a monetary adjustment change to an original Part A, B, or DMAC claim occurred.

To exclude non-monetary adjustments for Part A, B, and DMAC claims, the CWF shall check the reimbursement amount as well as the deductible and co-insurance amounts on each claim to confirm that there were no monetary changes on the adjustment claim as compared to the original claim.

Effective with April 1, 2008, the CWF shall also include total submitted/billed charges as part of the foregoing elements used to exclude adjustment claims, monetary as well as adjustment claims, non-monetary. (See sub-section N, "Overarching Adjustment Claim Exclusion Logic," for details concerning the processes that CWF shall follow when the COBA trading partner's COIF specifies exclusion of **all** adjustment claims.)

H. Excluding Adjustment Claims When the Original Claim Was Also Excluded

When the CWF processes an adjustment claim, it shall take the following action when the COIF indicates that the "production" COBA trading partner wishes to receive adjustment claims, monetary **or** adjustment claims, non-monetary:

1) Return a BOI reply trailer 29 to the contractor if CWF locates the original claim that was marked with an 'A' crossover disposition indicator **or** if the original claim's crossover disposition indicator was blank/non-existent;

2) Exclude the adjustment claim if CWF locates the original claim and it was marked with a crossover disposition indicator other than 'A,' meaning that the original claim was excluded from the COBA crossover process.

CWF shall **not** be required to search archived or purged claims history to determine whether an original claim had been crossed over.

The CWF maintainer shall create a new 'R' crossover disposition indicator, as referenced in a chart within §80.15 of this chapter, to address this exclusion for customer service purposes. The CWF maintainer shall ensure that adjustment claims that were excluded because the original claim was not crossed over shall be marked with an 'R' crossover disposition indicator after they have been posted to the appropriate Health Insurance Master Record (HIMR) detailed history screen.

I. Excluding Part A, B, and DMAC Contractor Fully Paid Adjustment Claims Without Deductible and Co-Insurance Remaining

The CWF shall apply logic to exclude Part A and Part B (including DMAC) adjustment claims (identified as action code '3' for Part A claims and entry code '5' for Part B and DMAC claims) when the COIF indicates that a COBA trading partner wishes to exclude adjustment claims that are fully paid and without deductible or co-insurance amounts remaining.

Effective with October 1, 2007, the CWF shall develop logic as follows to exclude fully paid Part A adjustment claims without deductible and co-insurance remaining:

1) Verify that the claim contains action code '3';

2) Verify that there are no deductible and co-insurance amounts on the claim;

3) Verify that the reimbursement on the claim is greater than zero; and

4) Confirm that the claim contains no denied services or service lines.

Special Note: Effective with October 1, 2007, CWF shall cease by-passing the logic to exclude Part A adjustments claims fully (100 percent) paid in association with home health prospective payment system (HHPPS) types of bills 329 and 339. The CWF shall exclude such claims if the COBA Insurance File (COIF) designates that the trading partner wishes to exclude "adjustment claims fully paid without deductible or co-insurance remaining" or if these bill types are otherwise excluded on the COBA Insurance File (COIF).

The CWF shall develop logic as follows to exclude Part B or DMAC fully paid adjustment claims without deductible or co-insurance remaining:

1) Verify that the claim contains an entry code '5';

2) Verify that the allowed amount equals the reimbursement amount; and

3) Confirm that the claim contains no denied services or service lines.

The CWF maintainer shall create a new 'S' crossover disposition indicator for adjustment claims that are paid at 100 percent. The CWF maintainer shall ensure that excluded adjustment claims that are paid at 100 percent shall be marked with an 'S' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Adj. Claims-100 percent PD" to the COBA Insurance File Summary screen (COBS) on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

J. Excluding Part A, B, and DMAC Contractor Adjustment Claims That Are Fully Denied with No Additional Liability

The CWF shall apply logic to exclude Part A and Part B (including DMAC) fully denied adjustment claims that carry no additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude such claims.

Effective with October 1, 2007, the CWF shall apply logic to the Part A adjustment claim (action code '3') where the entire claim is denied **and** the beneficiary has no additional liability as follows:

1) Verify that the claim was sent as action code '3'; and

2) Check for the presence of an 'N' beneficiary liability indicator in the header of the fully denied claim. (See the "Beneficiary Liability Indicators on Part A CWF Claims Transactions" section above for additional information.)

The CWF shall apply logic to the Part B and DMAC adjustment claims (entry code '5') where the entire claim is denied **and** the beneficiary has **no** additional liability as follows:

1) Verify that the claim was sent as entry code '5'; and

2) Check for the presence of an 'N' liability indicator on the fully denied claim.

The CWF maintainer shall create a new 'T' crossover disposition indicator for adjustment claims that are 100 percent denied with no additional beneficiary liability. The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained no beneficiary liability shall be marked with a 'T' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Denied Adjs-No Liab" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

K. Excluding Part A, B, and DMAC Contractor Adjustment Claims That Are Fully Denied with No Additional Liability

The CWF shall apply logic to exclude Part A and Part B (including DMAC) fully denied adjustment claims that carry additional beneficiary liability when the COIF indicates that a COBA trading partner wishes to exclude such claims.

Effective with October 1, 2007, the CWF shall apply logic to the Part A adjustment claim (action code '3') where the entire claim is denied **and** the beneficiary has additional liability as follows:

1) Verify that the claim was sent as action code '3'; and

2) Check for the presence of an 'L' beneficiary liability indicator in the header of the fully denied claim. (See the "Beneficiary Liability Indicators on Part A CWF Claims Transactions" section above for additional information.)

The CWF shall apply logic to exclude Part B and DMAC adjustment claims (entry code '5') where the entire claim is denied **and** the beneficiary has additional liability as follows:

1) Verify that the claim was sent as entry code '5'; and

2) Check for the presence of an 'L' liability indicator on the fully denied claim.

The CWF maintainer shall create a new 'U' crossover disposition indicator for adjustment claims that are 100 percent denied with additional beneficiary liability. The CWF maintainer shall ensure that excluded adjustment claims that were entirely denied and contained beneficiary liability shall be marked with a 'U' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "Denied Adjs-Liab" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

L. Excluding MSP Cost-Avoided Claims

The CWF shall develop logic to **exclude** MSP cost-avoided claims when the COIF indicates that a COBA trading partner wishes to exclude such claims.

The CWF shall apply the following logic to **exclude** Part A MSP cost-avoided claims:

a) Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.

The CWF shall apply the following logic to **exclude** Part B and DMAC MSP cost-avoided claims:

a) Verify that the claim contains one of the following MSP non-pay codes: E, F, G, H, J, K, Q, R, T, U, V, W, X, Y, Z, 00, 12, 13, 14, 15, 16, 17, 18, 25, and 26.

The CWF maintainer shall create a new 'V' crossover disposition indicator for the exclusion of MSP cost-avoided claims. The CWF maintainer shall ensure that excluded MSP cost-avoided claims shall be marked with a 'V' crossover disposition indicator after they have been posted to the appropriate HIMR detailed history screen. In addition, the CWF maintainer shall add "MSP Cost-Avoids" to the COBS on HIMR so that this exclusion will be appropriately displayed for customer service purposes.

M. Excluding Sanctioned Provider Claims from the COBA Crossover Process

Effective with April 2, 2007, the CWF maintainer shall create space within the HUBC claim transaction for a newly developed 'S' indicator, which designates 'sanctioned provider.'

Contractors, including Medicare Administrative Contractors (MACs), that process Part B claims from physicians (e.g., practitioners and specialists) and suppliers (independent laboratories and ambulance companies) shall set an 'S' indicator in the header of a fully denied claim if the physician or supplier that is billing is suspended/sanctioned. NOTE: Such physicians or suppliers will have been identified by the Office of the Inspector General (OIG) and will have had their Medicare billing privileges suspended. Before setting the 'S' indicator in the header of a claim, the Part B contractor shall first split the claim it is contains service dates during which the provider is no longer sanctioned. This will ensure that the Part B contractor properly sets the 'S' indicator for only those portions of the claim during which the provider is sanctioned.

Upon receipt of an HUBC claim that contains an 'S' indicator, the CWF shall exclude the claim from the COBA crossover process. The CWF therefore shall not return a BOI reply trailer 29 to the multi-carrier system (MCS) Part B contractor for any HUBC claim that contains an 'S' indicator.

N. Overarching Adjustment Claim Exclusion Logic

"Overarching adjustment claim logic" is defined as the logic that CWF will employ, independent of a specific review of claim monetary changes, when a COBA trading partner's COBA Insurance File (COIF) specifies that it wishes to exclude all adjustment claims.

New CWF Logic

Effective with April 1, 2008, the CWF maintainer shall change its systematic logic to accept a new version of the COIF that now features a new "all adjustment claims" exclusion option.

For the COBA eligibility file-based crossover process, where CWF utilizes both the BOI auxiliary record and the COIF when determining whether it should include or exclude a claim for crossover, CWF shall apply the overarching adjustment claim logic as follows:

- 1) Verify that the incoming claim has an action code of 3 or entry code of 5 or, if the claim has an action or entry code of 1 (original claim), confirm whether it has an "A" claim header value, which designates adjustment claim for crossover purposes; and

- Verify that the COIF contains a marked exclusion for "all adjustment claims." If these conditions are met, CWF shall exclude the claim for crossover under the COBA eligibility file-based crossover process.

If both of these conditions are met, CWF shall exclude the claim for crossover under the COBA eligibility file-based crossover process. IMPORTANT: Independent of the foregoing requirements, CWF shall continue to only select an adjustment claim for COBA crossover purposes if 1) it locates the matching original claim; and 2) it determines that the original claim was selected for crossover (see "H. Excluding Adjustment Claims When the Original Claim Was Also Excluded" above for more information).

New Crossover Disposition Indicator

Upon excluding the claim, CWF shall mark the claim as it is stored on the appropriate Health Insurance Master Record (HIMR) claim detail history screen with a newly developed "AC" crossover disposition indicator, which designates that CWF excluded the claim because the COBA trading partner wished to exclude all adjustment claims. (See §80.15 of this chapter for a description of this crossover disposition indicator.)

The CWF shall display the new indicator within the "eligibility file-based crossover" segment of the HIMR detailed claim history screen.

Exception Concerning COBA IDs in the Medigap Claim-based Range

CWF shall never apply the new overarching adjustment claim exclusion logic to incoming HUBC or HUDC claims whose field 34 ("Crossover ID") header value falls within the range of 0000055000 to 0000059999, which represents the COBA identifier of a COBA Medigap claim-based crossover recipient, and for which there is not a corresponding BOI auxiliary record that likewise contains that insurer identifier. (See §80.17 of this chapter for more information concerning the COBA Medigap claim-based crossover process.)

80.15 - Claims Crossover Disposition Indicators
(Rev. 1360, Issued: 11-02-07, Effective: 04-01-08, Implementation: 04-07-08)

Effective with the October 2004 systems release, when a COBA trading partner is in production mode (Test/Production Indicator sent via the COIF submission=P), CWF shall annotate each processed claim on detailed history in the Health Insurance Master Record (HIMR) with a claims crossover disposition indicator after it has applied the COBA trading partner's claims selection criteria. (See the table below for a listing of the indicators.) In addition, when a COBA trading partner is in production mode, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the terms of the COBA.

CWF shall not annotate processed Medicare claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator sent via the COIF submission=T).

Once the claims crossover process is fully consolidated under the Coordination of Benefits Contractor (COBC), Medicare contractor customer service staff will have access to a CWF auxiliary file that will display the crossover disposition of each beneficiary claim. The crossover disposition indicators that will appear on the HIMR detailed history screens (INPH, OUTH, HOSH, PTBH, DMEH, and HHAH) are summarized below.

Effective with October 2006, the CWF maintainer shall update its data elements/documentation to capture the revised descriptor for crossover disposition indicators "E," as reflected below. In addition, the CWF maintainer shall update its data elements/documentation to capture the newly added "R," "S," "T," "U," and "V" crossover disposition indicators, as reflected in the Claims Crossover Disposition Indicators table below.

Effective with July 2007, the CWF maintainer shall update its data elements/ documentation to capture the newly added "W," "X," and "Y" crossover disposition indicators, as well as all other changes, reflected in the table directly below.

As reflected in the table below, the CWF maintainer is creating crossover disposition indicators "Z" and "AA" to be effective October 1, 2007. The CWF maintainer is creating and utilizing a new "AC" crossover disposition indicator as part of its COBA claims selection processing effective April 1, 2008.

Claims Crossover Disposition Indicator	**Definition/Description**
A	This claim was selected to be crossed over.
B	This Type of Bill (TOB) excluded.
C	Non-assigned claim excluded.
D	Original Fully Paid Medicare claims without deductible and co-insurance remaining excluded.
E	Original Medicare claims paid at greater than 100% of the submitted charges without deductible or co-insurance remaining excluded (Part A). **Also covers the exclusion of Original Medicare claims paid at greater than 100% of the submitted charges excluded for Part B ambulatory surgical center (ASC) claims, even if deductible or co-insurance applies.
F	100% denied claims, with no additional beneficiary liability excluded.

G	100% denied claims, with additional beneficiary liability excluded.
H	Adjustment claims, monetary, excluded (not representative of mass adjustments).
I	Adjustment claims, non-monetary/statistical, excluded (not representative of mass adjustments).
J	MSP claims excluded.
K	This claim contains a provider identification number (ID) or provider state that is excluded by the COBA trading partner.
L	Claims from this Contractor ID excluded.
M	The beneficiary has other insurance (such as Medigap, supplemental, TRICARE, or other) that pays before Medicaid. Claim excluded by Medicaid.
N	NCPDP claims excluded.
O	All Part A claims excluded.
P	All Part B claims excluded.
Q	All DMERC claims excluded.
R	Adjustment claim excluded because original claim was not crossed over.
S	Adjustment fully paid claims with no deductible or co-Insurance remaining excluded.
T	Adjustment Claims, 100% Denied, with no additional beneficiary liability excluded.
U	Adjustment Claims, 100% Denied, with additional beneficiary liability excluded.
V	MSP cost-avoided claims excluded.
W	Mass Adjustment Claims—Medicare Physician Fee Schedule (MPFS) excluded.
X	Mass Adjustment Claims—Other excluded.

Y	Archived adjustment claim excluded.
Z	Invalid Claim-based Medigap crossover ID included on the claim.
AA	Beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided
AB	**Not Used**; already utilized in another current CWF application or process.
AC	All adjustment claims excluded.

80.16 - Special Mass Adjustment and Other Adjustment Crossover Requirements

(Rev. 1189, Issued: 02-28-07, Effective: 07-01-07, Implementation: 07-02-07)

1. Developing a Capability to Exclude Mass Adjustment Claims Tied to the Medicare Physician Fee Schedule Updates and Mass Adjustment Claims-Other

Effective with July 2, 2007, the Common Working File (CWF) maintainer shall create a new header field for a one (1)-byte mass adjustment indicator within its HUBC, HUDC, HUOP, HUHH, and HUHC claims transactions. The valid values for the newly created field shall be 'M'—mass adjustment claim-Medicare Physician Fee Schedule (MPFS) and 'O'—mass adjustment claim-other. Further, effective with that date, the Coordination of Benefits Contractor shall send the CWF host sites a modified Coordination of Benefits Agreement Insurance File (COIF) that contains two new claims exclusion categories: mass adjustments-MPFS and mass adjustments-other.

Upon receipt of a claim that contains an 'M' indicator (new field) in the header of an HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim, CWF shall read the COIF to determine whether the COBA trading partner wishes to exclude the claim. If CWF determines that the trading partner wishes to exclude the mass adjustment-MPFS claim, it shall exclude the claim from the COBA crossover process.

Upon receipt of a claim that contains an 'O' indicator in the header of an HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim, which designates 'mass adjustment claim-other,' the CWF shall read the COIF to determine whether the COBA trading partner wishes to exclude the claim. If CWF determines that the trading partner wishes to exclude mass adjustment claims-other, it shall exclude the claim from the COBA crossover process.

Creation of New Crossover Disposition Indicators

In relation to its receipt of a claim that has either an 'M' or an 'O' header value, the CWF shall create two new crossover disposition indicators 'W' ("mass adjustment claim-MPFS)

and ‘X’ (“mass adjustments claim-other excluded”) on the Health Insurance Master Record (HIMR) detailed history screens in association with excluded processed claims for ‘production’ COBA trading partner. The CWF shall display each of the new crossover disposition indicators appropriately in association with the processed mass adjustment claim-MPFS on the HIMR detailed history screen. (See §80.15 of this chapter for further information.) In addition, the CWF maintainer shall develop and display two (2) new exclusion fields within the COBA Inquiry Screen (COBS) for ‘mass adj.-M’ (mass adjustments-MPFS) and ‘mass adj.-O’ (mass adjustments-other).

2. Developing a Capability to Treat Entry Code ‘5’ and Action Code ‘3’ Claims As t Recycled ‘Original’ Claims For Crossover Purposes

Effective with July 2007, the CWF maintainer shall create a new header field within its HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims transactions for a 1-byte - adjustment indicator (valid values=‘N’--non adjustment claim for crossover purposes; ‘A’--adjustment claim for crossover purposes; or space).

In instances when CWF returns an error code 5600 to a contractor, thereby causing it to reset the claim’s entry code to ‘5’ to action code to ‘3,’ the contractor shall set a newly developed ‘N’ non-adjustment claim indicator (‘treat as an original claim for crossover purposes’) in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The contractor’s system shall then resend the claim to CWF.

Upon receipt of a claim that contains entry code ‘5’ or action code ‘3’ with a non-adjustment claim header value of ‘N,’ the CWF shall treat the claim as if it were an ‘original’ claim (i.e., as entry code ‘1’ or action code ‘1’) for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an ‘A’ (“claim was selected to be crossed over”) crossover disposition indicator.

Additional Contractor Requirements Following Receipt of a CWF Beneficiary Other Insurance (BOI) Reply Trailer 29 for Such Claims

Upon receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors’ systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of ‘1’ (original). In addition, the contractors’ systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies ‘adjustment.’

3. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes

In instances where contractors must send adjustment claims to CWF as entry code ‘1’ or action code ‘1’ (situations where the accrete claim cannot be processed at CWF), they

shall set an ‘A’ indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

Upon receipt of a claim that contains entry code ‘1’ or action code ‘1’ with a claim adjustment indicator value of ‘A,’ the CWF shall take the following actions:

- Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**; and

- Suppress the claim from crossover if the COBA trading partner wishes to exclude either adjustments, monetary or adjustments, non-monetary, or both.

(**NOTE:** The expectation is that such claims do **not** represent mass adjustments tied to the MPFS or mass adjustments-other.)

ByPassing of Logic to Exclude Adjustment Claim if Original Claim was Not Crossed Over

For purposes of excluding entry code ‘1’ or action code ‘1’ claims that contain an ‘A’ adjustment indicator value, CWF shall 1) assume that the ‘original’ claim that was purged from its online history was crossed over, and 2) bypass its logic for crossover disposition indicator ‘R’ (cross the adjustment claim over only if the original claim was previously crossed over). Refer to §80.14 of this chapter for further details regarding this logic.

Actions to Take When Contractors Send Invalid Values

If contractors claim adjustment indicator values other than ‘N,’ ‘A,’ or space within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors’ systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

Creation of a New Crossover Disposition Indicator For This Scenario

In relation to its receipt of a claim that has an ‘A’ header value, the CWF shall create a new crossover disposition indicator ‘Y’ (“archived adjustment claim-excluded”) on the HIMR detailed history screens in association with excluded processed claims for ‘production’ COBA trading partners. The CWF shall display the new ‘Y’ crossover disposition indicator in association with the processed mass adjustment claim-MPFS on the HIMR detailed history screen. (See §80.15 of this chapter for further information.)

Additional Contractor Requirements Following Receipt of a CWF Beneficiary Other Insurance (BOI) Reply Trailer 29

If contractors receive a BOI reply trailer (29) on a claim that had an ‘A’ indicator set in its header, the contractors’ systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (‘Claim Frequency Type Code’)

segment with a value that designates 'adjustment' rather than 'original' to match the 2330B loop REF*T4*Y that they create to designate 'adjustment claim.'

If a contractor's system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

80.17 - Coordination of Benefits Agreement Medigap Claim-Based Crossover Process

(Rev. 1332, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

In advance of October 1, 2007, CMS will issue for its participating Medicare providers' use a listing of claim-based Medigap crossover recipients along with their pre-existing Other Carrier Name and Address (OCNA) or N-key identifiers versus their current COBA Medigap claim-based crossover ID. For this purpose, CMS will be making a "Medigap Claim-based Billing Identifier" spreadsheet available on the Coordination of Benefits Contractor (COBC) Web site. The COBC will **not** populate the spreadsheet until after 1) it has signed a national crossover agreement with a Medigap insurer, and 2) that insurer has tested the Medigap claim-based crossover process with the COBC. Prior to October 1, 2007, the affected contractors will continue to cross claims over to their Medigap claim-based crossover recipients as normal during this timeframe. However, effective with claims submitted to Medicare on October 1, 2007, and after, participating providers will be expected to include this identifier on these incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with October 1, 2007, claim-based Medigap crossovers will occur exclusively through the Coordination of Benefits Contractor (COBC) in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim format (version 4010A1 or more current standard) and National Council for Prescription Drug Programs (NCPDP) claim format.

A. Changes to Contractor Up-Front Screening Processes for COBA Claim-based Medigap Crossovers

Effective with claims that the Part B contractors, including MACs, and DMACs cable to CWF on October 1, 2007, their internal processes for screening claims for Medigap claim-based crossovers shall be modified to accommodate the new Medigap claim-based COBA crossover process. The affected contractors' processes for screening claims for Medigap claim-based crossovers shall now feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. In addition, for incoming 837 professional and NCPDP claims, contractors shall ensure that the Medigap claim-based COBA ID is entered within the appropriately designated field, loop, or segment of the incoming Medicare claim.

If the claim fails the syntactic verification, the contractor shall not copy the identifier from the incoming claim and populate it within field 34 ("Crossover ID") of the HUBC or HUDC claim transaction that is sent to the Common Working File (CWF) for verification and validation. Instead, the contractor shall continue to follow its pre-existing processes for notifying the provider via the ERA or other remittance advice and

the beneficiary via the MSN that the information reported did not result in the claim being crossed over. The affected contractors' screening processes for Medigap claim-based crossovers shall also continue to include verification that the provider participates with Medicare and that the beneficiary has assigned benefits to the provider.

If the provider-populated value for the Medigap claim-based ID passes the contractor's syntactic editing process, the affected contractors' systems shall copy the Medigap claim-based COBA ID value from the incoming claim to field 34 of the HUBC or HUDC claims transactions that are sent to CWF for verification and validation. The contractors shall populate the identifier in field 34 right-justified and prefixed with five zeroes.

B. CWF Validation of Values within Field 34 of the HUBC and HUDC Transactions

Upon receipt of HUBC and HUDC claims that contain a value within field 34 ("Crossover ID"), the CWF shall read the value that is present within the field for purposes of conducting a validity check. The CWF shall accept the following values as valid within field 34: a value within the range of 0000055000 to 0000059999, or spaces.

If the contractor has sent an inappropriate value in field 34 of the HUBC and HUDC claims transaction, CWF shall return an alert code 7704 on the "01" disposition response via the claim-based alert trailer 21. For customer service purposes, the CWF maintainer shall create a new crossover disposition indicator "Z" to accommodate the scenario of the contractor sending an incorrect value within field 34 of the HUBC and HUDC transaction. (See §80.15 of this chapter for more information regarding this crossover disposition indicator.) At the point that CWF returns an alert code 7704 to the affected contractor, it shall take the following actions with respect to the claim:

1. Mark the claim with crossover disposition indicator "Z" ("invalid Medigap claim-based crossover ID included on the claim"); and

a. Display the indicator, together with the invalid COBA ID value from field 34, in association with the claim on the appropriate Health Insurance Master Record (HIMR) detailed history screen in the "claim-based crossover" segment.

See Pub.100-04 chapter 28, §70.6.4 for an explanation of contractor processes following receipt of a CWF alert code 7704 via a 21 trailer.

C. CWF Processing for COBA Claim-based Medigap Crossovers

Following receipt of an HUBC and HUDC claims transaction that contains a valid value within field 34 (a value within the range of 0000055000 to 0000059999 or spaces), CWF shall check for the presence of a Beneficiary Other Insurance (BOI) auxiliary record for the purpose of triggering eligibility file-based crossovers. CWF shall then read the COBA Insurance File (COIF) to determine the claims selection criteria for any eligibility file-based trading partners (all other COBA IDs) as well as for the Medigap claim-based insurer (range 0000055000 to 0000059999). If the HUBC or HUDC claim contains a valid COBA Medigap claim-based ID within field 34 but the valid ID cannot be found on

the COIF, the CWF shall post the valid COBA Medigap claim-based ID without an accompanying crossover disposition indicator in association with the claim within the "claim-based crossover" segment of the appropriate HIMR claim detailed history screen.

If the claim meets the COBA trading partner's selection criteria, as per the COIF, and none of the other scenarios presented below applies, CWF shall return a Beneficiary Other Insurance (BOI) reply trailer (29) to the contractor for purposes of having the contractor trigger a crossover to the COBC

Duplicate Check

The CWF shall perform a duplicate check to determine if the beneficiary is identified for crossover to a Medigap eligibility file-based insurer (COBA ID 30000-54999) and to a Medigap claim-based insurer (COBA ID 0000055000-0000059999). If CWF determines that the beneficiary is identified for crossover to both a "production" Medigap eligibility file-based insurer (COBA ID range=30000 to 54999) and a Medigap claim-based Medigap insurer (COBA ID range=0000055000 to 0000059999), it shall suppress the BOI reply trailer (29) for the claim-based Medigap insurer (COBA ID range= 0000055000 to 0000059999).

Crossover Disposition Indicator "AA"

Effective with October 1, 2007, the CWF maintainer shall create a new crossover disposition indicator "AA" to accommodate the CWF duplicate check, where it has determined that the beneficiary's claim is eligible for crossover to both a "production" Medigap eligibility file-based insurer and a Medigap claim-based crossover insurer. After CWF has determined that beneficiary has already been identified for Medigap eligibility file-based crossover, it shall take the following actions with respect to the claim:

1. Mark the associated claim with indicator "AA" ("beneficiary identified on Medigap insurer eligibility file; duplicate Medigap claim-based crossover voided);

2. Display this indicator, together with the affected claim-based Medigap COBA ID, in association with the claim on the appropriate HIMR detailed history screen in the "claim-based crossover" segment.

D. BOI Reply Trailer (29) Process

If CWF determines that the claim meets the trading partner's claims selection criteria, it shall select the claim and return a BOI reply trailer 29 for the claim to the affected Medicare contractor. The CWF shall display the appropriate crossover disposition indicator for the claim-based crossover claim within the "claim-based crossover" segment of the HIMR claim detailed history screens. As with the COBA eligibility file-based crossover process (see §80.14 of this chapter for more details regarding this process), CWF shall display the COBA ID and accompanying crossover disposition indicator on claim detailed history screens, with the exception of circumstances where the valid ID

cannot be located on the COIF, as discussed above, or the Medigap claim-based insurer is in "test" mode with the COBC. In these situations, only the COBA Medigap claim-based ID shall be displayed.

Modification of the CWF Sort Routine For Multiple COBA IDs and Accompanying Contractor Actions Following Receipt of the BOI Reply Trailer (29)

In light of the new COBA Medigap claim-based crossover process, the CWF sort routine for COBA IDs to be returned via the BOI reply 29 trailer shall be modified as follows: Medigap eligibility file-based (30000-54999), Medigap claim-based (55000-59999), supplemental (00001-29999), TRICARE for Life (60000-69999), Other insurer (80000-89999), and Medicaid (70000-79999). (NOTE: This information is also being updated in Pub.100-04, chapter 27 §80.14.)

Upon receipt of the BOI reply trailer (29), the affected contractors shall continue to utilize information from this source to populate the beneficiary's MSN and provider ERA or other remittance advice in production in accordance with the existing guidance that appears in §80.14 of this chapter.

90 - CWF Adjustment Actions

(Rev. 1, 10-01-03)

A3-3816

The CWF performs only two types of internal adjustment actions: (1) correcting utilization on bills that are already posted and notifying the Satellite of that action using a Form CMS-L1001, and (2) canceling posted bills when CWF discovers an error in the posted utilization and notifying the Satellite of that action using a Form CMS-L1002. Section 90.1 describes the actions contractors are to take in response to these notices.

90.1 - Notification of Internal Adjustment Action(s) Taken by CMS

(Rev. 1, 10-01-03)

A3-3816.1

Forms CMS-Ll00l and CMS-L1002, Notification of Internal Adjustment Action(s) Taken by CMS, are issued when CWF identifies and internally adjusts specific provider bills that were accepted and now reflect incorrect utilization of available benefits. Carriers and FIs are notified of these adjustments via Form CMS-L1001 for debit/credit and Form CMS-L1002 for cancel only.

These forms are used by CWF when merging two active Beneficiary Master Records for some reason (e.g., cross-reference process) or processing an out-of-sequence inpatient hospital or SNF claim that causes two benefit periods to become one benefit period. If CWF can determine what the correct benefits are, the Form CMS-L1001 is used to correct the utilization on a previously processed claim. However, if CWF cannot

determine what the correct benefits are, the previously processed claim is cancelled and a Form CMS-L1002 is used.

Upon receipt of a Form CMS-L1001, the contractor must correct internal files and either recover any overpayment or pay any underpayment. Do not resubmit the claim to CWF.

Upon receipt of a Form CMS-L1002, the contractor must reprocess the claim and resolve the disposition of the claim. Resubmit the corrected claim to CWF as an initial claim. If this action results in a need for adjustment to other claims, the contractor adjusts those claims and submits them to CWF as adjustments. If one or more of the "other" claims requiring adjustment is a result of a Form CMS-L1001, the new debit is the claim to be adjusted. The contractor uses Bill Type xxG to identify all adjustments made in response to a CWF notification. This includes those "other" claims to be adjusted as a result of a Forms CMS-L1001 or CMS-L1002.

Upon receipt of Forms CMS-L1001 and/or CMS-L1002, the contractor will also receive pertinent data to assist it in resolving any discrepancies. However, this information may not be sufficient by itself. If not, the contractor inquires into the CWF online system via the HIMR transaction for additional information.

Ensure that in-house records comply with the adjustment action. Also, the contractor notifies the provider. Beyond that, no further action is necessary.

NOTE: When scrambled utilization is detected and CMS can identify the appropriate beneficiaries, CWF initiates the necessary internal adjustment actions to remove utilization from the incorrect record. If a bill has not been posted for the correct record, the contractor submits one. The CWF cannot create the initial bill for the beneficiary's record.

100 - CWF Unsolicited Response

(Rev. 1, 10-01-03)

AB-01-111, AB-01-149, AB-02-002, AB-02-021, AB-02-023, AB-02-037, B-02-059, B-02-067, B-02-087, A-02-008, A-02-068, A-02-107

The CWF unsolicited response and automatic adjustment process is a means to retroactively adjust certain paid claims where subsequent claims or other subsequent actions are the first indicator that payment was inappropriate. Examples are:

- Home health agency (HHA)
- Medicare Quality Partnerships Demonstration (formerly referred to as "Medicare Centers of Excellence Demonstration")
- Medicare Provider Partnership Demonstration
- Skilled nursing facility (SNF)

The CWF sends an unsolicited response to carriers and/or FIs in response to these inappropriate claims. Edit codes usually are in the AB crossover categories.

When the carrier or FI receives an unsolicited response they are required to review each designated line item for possible recovery of payment. Claims subject to these unsolicited response edits are outlined in the following sections.

100.1 - Claims Related to an HH PPS Episode

(Rev. 1, 10-01-03)

AB-01-111, A-02-008

The CWF sets an error code for paid therapy and non-routine supply claims that contain line items for a date of service that is within a home health episode that is subject to HH PPS consolidated billing. These claims would have been processed prior to the posting of a claim for a HH PPS episode.

Upon receipt of a HH PPS claim, CWF will search paid claims history to determine whether any services subject to consolidated billing related to the HH PPS episode period were paid by any FI or carrier. CWF will compare the period between the HH claim from and through date (which represent the episode start date and the date of discharge) to the line item service dates of the claims on history. Services that must be consolidated in the HH PPS claim will be identified. CWF will generate an unsolicited response, with a trailer containing the identifying information regarding the claim subject to consolidated billing and a trailer containing line item specific information that identifies all the individual services on that claim that fall within the HH claim dates. The unsolicited response will have all necessary information to identify the claim, including document control number and health insurance claim number. CWF will electronically transmit this unsolicited response to the FI or carrier that originally processed the claim with consolidated services. These unsolicited responses will be included in the existing unsolicited response file. The unsolicited responses in that file that are claims to be adjusted for consolidated billing will be identified with a unique transaction identifier and disposition code. The previously paid claim will not be canceled and will remain on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response file, the FI shared system software will read the line item information in the new trailer for each claim and perform an automated adjustment to each claim. Carriers will perform a manual adjustment. The adjustment will line-item deny the services subject to consolidated billing. The adjusted claims will then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. FIs will return the claims with action code "3." Carriers and durable medical equipment regional carriers (DMERCs) will return the claims with entry code "5." Carriers must return both the covered and the denied services to CWF on the adjustment claim. FIs must return only the covered lines to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible will be updated on the beneficiary's file and the corrected deductible information will be returned to the FI or carrier in Trailer 11.

Any monies due back to Medicare resulting from these denials will be recovered using current recovery procedures.

In the event that a denial is reversed upon appeal, based upon evidence that the home health claim information on CWF that generated the denial was inaccurate, an override procedure for the CWF denial is available to permit payment to be made.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim will be adjusted by the FI or carrier shared system to line item deny all the services on the claim. Carriers must return these fully denied claims to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS' National Claims History file. Carrier and DMERC systems will use existing processes for the submission of fully denied claims. FIs should hold fully denied claims resulting from these changes until instructions are released.

110 - Crosswalk to CWF Documentation

(Rev. 1, 10-01-03)

To view the CWF file, click on the file name in the left column.

Common Working File Documentation	
ACRONYMS	Acronyms
ARCHIVE	Archive/Retrieval Guide
COPYINPR	Inter-Program Communication Copybooks
COPYINTL	Internal Record Specification
COPYXTNL	External Record Specification
CROSSRE	Element/Definition Cross Reference - Alphabetic List of definitions cross-referred to the CWF data element name, e.g., a unique ID assigned to Payers/Processor of Health Care Claims - HUIP-PAYOR-ID
CWFMACRO	Macro Specifications
DATAFLOW	Process Model Data Flows and Data Stores

Common Working File Documentation	
DATAMODL	CWF Data Model Entity Relationship Model, business entity descriptions, data N-ARY, relationship descriptions, Conceptual Data Model, data model overview, and data model entity descriptions.
DESCLVL1	CWF Process Model Manual - Provide CWF Software
DESCLVL2	CWF Process Model Manual - Maintain CWF Data
DESCLV3B	Outpatient Utilization edits
DISPCODE	Inquiry Reply Disposition Codes
EDITALRT	Utilization Alert Codes
EDITCONS	Consistency Error Codes - Inpatient, SNF, Outpatient, Home Health, Hospice
EDITLIST	Duplicate/UR Checking Alert Error Codes
EDITMNTS	Transaction Error Codes - Medicare Secondary Payer (MSP), End Stage Renal Disease (ESRD), Certificate of Medical Necessity (CMN), Clinical Lab Improvement Amendment (CLIA) and Beneficiary Other Insurance Information (HUBO)
EDITUTIL	Utilization Error Codes (UR Disposition Code) - Inpatient, SNF, Outpatient, Home Health, Hospice
EDITXOV	Crossover Alert and Crossover Reject Edit Codes
ELEATTR	Data element attributes.
ELEDESC	Alphabetic list of CWF data elements and the description of each.
HCPCS	CWF HCPCS by category. Code definitions not supplied.
HOSTJCL	Host Job Control Language (JCL)
INSTALL	Host - Overview/Installation of CWF Software
LAYBENE	Beneficiary Database Files
LAYSUPP	CWF Support Files
OVERCWF	Introduction
OVERELIG	Satellite Manual - Technical Specifications - Eligibility

Common Working File Documentation	
OVERHIHO	HMO User Documentation
OVERHIMR	Satellite Manual
OVERINFO	General Information Manual - Change Control System
PROGDTL	CWF Computer Programming Detail
PROMPTC	HIMR Prompt/Definition Cross Reference Listing
PROMPTR	HIMR Screen Prompts with definitions and codes
PTBELG	Eligibility - Part B
REPTPROD	Satellite Production Reports
RPTL1001	Format of CWF report to Satellite of internal CWF adjustments affecting a relevant area of claims, e.g., benefit status, entitlement, etc.
SCRHOST	Host Site Screen Transactions
SYSDEF	Glossary
TABLECO	Table of Codes - Equatable BIC to BIC
TBLEMANT	Maintenance Facility Model - describes three facilities: HCPCS File (HCPCCMNT), Edit Table (MANTCEDT), and Carrier Locality and Address File (MANTCKAR). There is a Terminal User Guide, which describes the use of the facilities. The facilities are modeled with Data Flow Diagrams, which depict the process and contains narratives for each.
TRANSCLM	CMS Claims Transactions
TRANSINT	CWF Internal Transactions
TRANSMNT	CMS Maintenance Transactions Return Codes - This chapter identifies the processing of Return Codes for CMS Maintenance and Out Of Service Area Processing for Part B Query and Part B Payment Record transactions.

Common Working File Documentation	
XREF	Cross Reference - Phase II - The Purpose of the project is to give CMS the capability of correcting Beneficiary records that were erroneously loaded to two separate Hosts (specifically for 3,000 to 5,000 Beneficiaries, which were originally sent to the Mid-Atlantic Host, and the South-Western Host). It also allows CMS to correct situations where two HIC Numbers exist for the same Beneficiary because of a clerical error. The volume of these corrections is expected to be low, but the project will be an on-going process, not a one-time fix.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1557CP	07/18/2008	Beneficiary Submitted Claims	08/18/2008	5683
R1497CP	05/02/2008	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	07/07/2008	6037
R1436CP	02/05/2008	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process – Replaced by Transmittal 1497	07/07/2008	5866
R1399CP	12/19/2007	Handling Personal Identifiable Information on the Medicare Summary Notice	01/07/2008	5770
R1360CP	11/02/2007	Modifications to the Coordination of Benefits Agreement (COBA) Common Working File	04/07/2008	5766
R1332CP	08/31/2007	Transitioning the Mandatory Medigap (“Claim Based”) Crossover Process to the Coordination of Benefits Contractor (COBC)	10/01/2007	5601
R1296CP	07/18/2007	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	10/01/2007	5569
R1242CP	05/18/2007	Transitioning the Mandatory Medigap (“Claim Based”) Crossover Process to the Coordination of Benefits Contractor (COBC) - Replaced by Transmittal 1296	10/01/2007	5601
R1232CP	04/27/2007	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	10/01/2007	5569
R1189CP	02/28/2007	Differentiating Mass Adjustments From Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters	07/02/2007	5472

Rev #	Issue Date	Subject	Impl Date	CR#
R1179CP	02/02/2007	Differentiating Mass Adjustments From Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters – Replaced by Transmittal 1189	07/02/2007	5472
R1110CP	11/09/2006	Excluding Sanctioned Provider Claims from the Coordination of Benefits Agreements (COBA) Crossover Process	04/02/2007	5353
R1038CP	08/25/2006	The Coordination of Benefits Agreement (COBA) Eligibility File Claims Recovery Process	01/02/2007	5250
R1006CP	07/21/2006	Modification to the Coordination of Benefits Agreement (COBA) Claims Selection Criteria and File Transfer Protocols	10/02/2006	5094
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R967CP	05/26/2006	Modification to the Coordination of Benefits Agreement (COBA) Claims Selection Criteria and File Transfer Protocols	10/02/2006	5094
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R533CP	04/29/2005	Modification to the Common Working File (CWF) Edit Process for Non-Assigned Medicaid Coordination of Benefits Agreement (COBA) Crossover Claims	07/05/2005	3842
R250CP	07/23/2004	Update of CWF Procedures	01/03/2005	3404
R158CP	04/30/2004	Transition to Medicare Coordination of Benefits Contractor (COBC)	10/04/2004	3273

Rev #	Issue Date	Subject	Impl Date	CR#
R138CP	04/09/2004	Transition to Medicare Coordination of Benefits Contractor (COBC)	07/06/2004	3218
R098CP	02/06/2004	Transition to Medicare Coordination of Benefits Contractor (COBC)	07/06/2004	3109
R001CP	10/01/2003	Initial Publication of Manual	NA	NA