Detailed Non-OPPS Program Edits

Edit	Generated when ...
1. Invalid diagnosis code	The principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid for the selected version of the program.
2. Diagnosis and age conflict	The diagnosis code includes an age range, and the age is outside that range.
3. Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match.
5. E-diagnosis code can not be used as principal diagnosis	The first letter of the principal diagnosis code is an E. This edit is not applicable to the admit diagnosis.
6. Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.
8. Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure coded on the record.
9. Non-covered for reasons other than statute	The procedure code is non-covered for reasons other than statute Revenue code is 099x with SI of E and is submitted without a HCPCS.
10. Service submitted for denial (condition code 21)	The claim has a condition code 21.
11. Service submitted for FI/MAC review (condition code 20)	The claim has a condition code 20.
12. Questionable covered service	The procedure code is a questionable covered service.

15. Service unit out of range for procedure	The maximum units allowed is greater than zero The sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure Modifier 91 is not present or modifier 91 is present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. Units for all line items with the same HCPCS code on the same day are added together when applying this edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS code is on a list of codes that are exempt, the unit edits are not applied.
17. Inappropriate specification of bilateral procedure	The same inherent bilateral procedure code occurs two or more times (based on units and/or lines) on the same service date. This edit is applied to all relevant bilateral procedure lines. This edit is bypassed when the bill type is 85x. Note: For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17.
22. Invalid modifier	The modifier is not in the list of valid modifiers in the IOCE.
23. Invalid date	The From, Through, or Service date is invalid, or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. All lines must have a service date.
24. Date out of OCE range	The From date falls outside the date range of any version of the program. The From date will be used for program version selection, even if the From-Through dates span more than one version. Presence of this edit condition terminates processing for the claim.
25. Invalid age	The age is non-numeric or outside the range of 0-124 years.
26. Invalid sex	The sex is non-numeric or outside the range of 0-2.

28. Code not recognized by Medicare; alternate code for same service may be available	The procedure code is ‘Not recognized by Medicare’.
41. Invalid revenue code	The revenue code is not valid.
46. Partial hospitalization condition code 41 not approved for type of bill	Bill type 12x or 14x is present with condition code 41.
50. Non-covered based on statutory exclusion	Code is on ‘statutory exclusion’ list in the IOCE.
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.
54. Multiple codes for the same service	Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035.
61. Service can only be billed to the DME MAC	The procedure code is ‘DME only’.
65. Revenue code not recognized by Medicare	The revenue code is 100x, 210x, 310x, 0500, 0509, 0583, 0660-0663, 0669, 0905-0907, 0931, or 0932.
67. Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.
68. Service provided prior to date of National Coverage Determination (NCD) approval	The line item date of service of a code is prior to the code activation date.
69. Service provided outside approval period	The service was provided outside the period approved by CMS.
72. Service not billable to the Fiscal Intermediary/Medicare Administrative Contractor	A code has a status indicator M. (This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x.)

Note: The selected version of the program corresponds to the date of service on the claim.