Advanced Claim Edits (A.C.E.)

MEDICA®

ACE Smart Edit Code	ACE Smart Edit Message	ACE Smart Edit Description
BCC	"Per LCD or NCD guidelines, procedure code G0247 has not met the associated Code-to-Code relationship criteria for CMS ID(s) 70.2.1."	**(BCC) Local Coverage Document (LCD) Part B Code to Code Missing or Invalid** The BCC edit identifies claim lines that do not meet LCD policies requirement for a code to code relationship.
BPO	"Per LCD or NCD guidelines, procedure code G0445 has not met the associated Place of Service relationship criteria for CMS ID(s) 210.10."	**(BPO) LCD Part B Invalid Place of Service** The BPO edit identifies claims containing Current Procedural Terminology *(CPT®)* codes that can only be performed in specified Place(s) of Service per LCD/NCD *(National Coverage Document policy)* .
BPS	"The place of service ***XX*** is missing or invalid."	**(BPS) Missing or Invalid Place of Service** The BPS System Rule verifies the place of service *(POS)* code submitted on each claim line against the Centers for Medicare & Medicaid Services *(CMS)* Place of Service list found in the Code Repository.
BSP	"Per LCD or NCD guidelines, procedure code G0445 has not met the associated Provider Specialty relationship criteria for CMS ID(s) 210.10. ."	**(BSP) LCD Part B Missing or Invalid Provider Specialty** The BSP edit identifies claim lines that the provider specialty does not meet an LCD policies requirement.
CAG	"Procedure Code ***XXXXX*** is not typical for a patient whose age is ***XX*** . The typical age range for this procedure is **YY** - **ZZ**."	**(CAG) Procedure Not Typical with Patient Age** The CAG System Rule identifies claim lines that contain a patient's age not typical for the procedure code.
CDL	"Procedure Code **XXXXX** has been deleted as of **mm/dd/yyyy**."	**(CDL) Deleted Procedure Code** The CDL System Rule identifies claim lines that contain a CPT/Healthcare Common Procedure Coding System *(HCPCS)* code that has been deleted.
CPT	● "Procedure code **XXXXX** is invalid." ● "Procedure code **XXXXX** is disabled."	**(CPT) Invalid Procedure Code** The CPT System Rule identifies claim lines that do not contain a valid procedure code. A valid procedure code is one that is present in the system and is effective.

DOB	"Patient's Date of Birth is missing or invalid."	**(DOB) Missing or Invalid Date of Birth** The DOB System Rule identifies claim lines where the Date of Birth is missing or is prior to the date of service.
IAG	"Dx **XXXYY** is not typical for a patient whose age is (**XX**). The typical age range for this diagnosis is **X**-**Y**."	**(IAG) Diagnosis Not Typical with Patient Age** The IAG System Rule identifies claim lines that contain a diagnosis code not appropriate with a patient's age.
ICD	● "The diagnosis **XXXYY** is invalid" ● "The diagnosis **XXXYY** is disabled."	**(ICD) Invalid Diagnosis Code** The ICD System Rule identifies diagnosis codes that are not valid. This edit looks for blank diagnosis fields as well as a diagnosis code that is not present in the KnowledgeBase.
ICM	"There is no Primary Diagnosis listed for this procedure."	**(ICM) Missing Diagnosis Code** The ICM System Rule identifies claim lines where the Primary Diagnosis Code is missing.
IDL	"Dx **XXXYY** has been deleted."	**(IDL) Deleted Diagnosis Code** The IDL System Rule identifies claim lines where the submitted diagnosis code is no longer valid and has been deleted.
IDX	Code " + the value of 'diagnosis code' + " is an incomplete diagnosis code and requires additional character(s)." ,	**(IDX) Nonspecific Diagnosis Code** The IDX System Rule identifies claim lines that contain a diagnosis code requiring a 4th or 5th digit for appropriate specificity.
IMC	"Modifier **XX** cannot be billed on the same claim line as modifier **YY**.	**(IMC) Inappropriate Modifier Combination** The IMC edit identifies claim lines that contain modifiers that cannot be on the same claim line together.
IMD	"The diagnosis **XXXX** and modifier **YY** combination are inappropriate..	**(IMD) Inappropriate Modifier to Diagnosis** This edit is used to identify diagnosis code and modifier combinations that are not appropriate. Laterality is part of specific ICD-10 diagnosis codes and because of this conflicting laterality modifiers should not be submitted on the same line.
IMO	"Modifier **XX** is invalid or disabled."	**(IMO) Invalid Modifier Code** The IMO System Rule validates the modifier codes on a claim line against the modifiers found in the Code Repository to make sure they are present and valid.

LBI	"Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Diagnosis Code relationship criteria for CMS ID(s) L31896"	**(LBI) LCD Part B Missing or Invalid Diagnosis** The LBI is issued if a diagnosis code does not meet guidelines for a policy with non- sequenced diagnosis codes.
LBM	"Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Modifier Code relationship criteria for CMS ID(s) 90.1. "	**(LBM) LCD Part B Missing Required Modifier** This edit identifies claims containing CPT codes that require a modifier per LCD/NCD guidelines.
LBP	"Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Primary Diagnosis Code relationship criteria for CMS ID(s) 100.1."	**(LBP) LCD Part B Missing Required Primary Diagnosis** The LBP is issued when a diagnosis code is required to be in a primary position and it is not or if the diagnosis in the primary position is not covered and the policy has sequencing requirements.
LBS	"Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Secondary Diagnosis Code relationship criteria for CMS ID(s) 100.1. "	**(LBS) LCD Part B Missing Required Secondary Diagnosis** The LBS is issued when the primary sequencing is met, and the diagnosis in the secondary position does not meet the secondary sequencing requirements.
LBT	"Per LCD or NCD guidelines, procedure code **XXXXX**, has not met the associated Tertiary Diagnosis Code relationship criteria for CMS ID(s) 100.1. "	**(LBT) LCD Part B Missing Required Tertiary Diagnosis** The LBT is issued when the primary sequencing is met, and the diagnosis in the tertiary position does not meet the tertiary sequencing requirements.
LDY	"Per LCD or NCD guidelines, procedure code **XXXXX** has met the associated Deny relationship criteria for CMS ID(s) 100.1."	**(LDY) LCD Part B Deny** The LDY edit is an edit action. If a claim line meets a LCD policy deny criteria, this flag is issued.
M26	"Procedure Code **XXXXX** requires a modifier -26 when billing for the professional component in place of service **XX** [description of the value of the submitted Place of Service found in 'Place of Service' System List for 'the current line']."	**(M26) Modifier 26 Required** The M26 edit identifies claim lines that do not contain modifier 26 (Professional Component) for a procedure with a PC/TC split that was performed in an Inpatient hospital, emergency room or other Outpatient place of service.
mANM	"Anesthesia code on this line requires an appropriate modifier."	**(mANM) Medicare Anesthesia Modifiers** The mANM edit will analyze all claim lines to determine if an anesthesia code has been billed without an appropriate anesthesia modifier appended to the line.
mAP	"The primary procedure code on history line **1/2** that is associated with this add-on procedure code has received an edit with a deny or review status."	**(mAP) Medicare Deny Add-On Procedure** The mAP edit is set when the current line's add-on procedure was billed with a primary procedure but the primary procedure was denied by a prior edit.

mDD	"Procedure Code [**XXXXX**] is within the global period of **ZZ** days of History Procedure Code [**YYYYY**] performed on **mm/dd/yyyy** on Claim ID [**1234**], Ext/Int Line ID [**1/2**] by a provider from the same department and specialty as the current line billing provider. The diagnosis indicates it is not for the same condition. Delete---Please review to determine if a modifier is appropriate."	**(mDD) Medicare Post-Op Unrelated Service by Department/Specialty** If a Medicare Evaluation & Management *(E/M)* procedure code was submitted within the Follow-up days determined for services by a different provider, same department and specialty for a different diagnosis code then the mDD edit will be triggered.
mDP	"Procedure Code [**XXXXX**] is within the global period of **ZZ** days of History Procedure Code [**YYYYY**] performed on **mm/dd/yyyy** on Claim ID [**1234**], Ext/Int Line ID [**1/2**] by the same provider. The diagnosis indicates it is not for the same condition. Please review to determine if a modifier is appropriate."	**(mDP) Medicare Post-Op Unrelated Service by Provider** If a Medicare E/M procedure code was submitted within the Follow-up days determined for services by the same provider, same department and specialty for a different diagnosis code then the mDP edit will be triggered.
mDPh	Per Medicare guidelines history procedure code [XXXXX] performed onmm/dd/yyyy on Claim ID [1234], Ext/Int Line ID [1/2] by the same provider is within the global period of procedure code [YYYYY]. The diagnosis indicates it is not for the same condition.	**(mDPh) Medicare Post-Op Unrelated Service by Provider in History** New history rule for the existing global rules that were created to capture claims that have been submitted out of sequence.
mDT	"Per the Medicare Physician Fee Schedule, Procedure Code **XXXXX** describes a diagnostic procedure that requires a professional component modifier in this POS **YY**."	**(mDT) Medicare Diagnostic Testing in a Hospital Setting** The mDT edit identifies claim lines which have procedure codes that are diagnostic tests performed in an Inpatient or Outpatient hospital or skilled nursing setting. When a provider is billing these services in an Inpatient or Outpatient hospital or skilled nursing setting, only the professional component should be billed (modifier 26).
mEM	● "E/M code [**XXXXX**] is billed the same date of service as a minor procedure without an appropriate modifier." ● "E/M code [**XXXXX**] is billed without an appropriate modifier for the same date of service as a minor procedure on History Claim ID **XYZ** on History Line ID **123**." ● "E/M code [**XXXXX**] is billed on the same date of service or one day prior to a major procedure without an appropriate modifier." ● "E/M code [**XXXXX**] is billed without an appropriate modifier for the same date of service or one day prior as a major procedure on History Claim ID **XYZ** on History Line ID **123**."	**(mEM) Medicare E/M and Surgery without Modifier** The mEM edit identifies claim lines where an E/M code is billed without modifier 25 on the same Date of service *(DOS)* as a minor surgical procedure, or billed without modifier 57 on the same DOS or one day before a major surgical procedure.

mEV	Procedure Code [**XXXXX**] was performed on the same day of History Procedure Code [**YYYYY**] performed on Claim ID [**1234**], Ext/Int Line ID [**1/2**] by the same provider or provider in the same specialty and group. The diagnosis indicates it is for the same condition	**(mEV) Medicare Multiple Evaluation and Management Codes** New rule to capture if more than one evaluation and management (face-to-face) service is provided on the same day, to the same patient, by the same physician, or more than one physician in the same specialty, in the same group, for the same diagnosis. Only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems.
mFD	"Procedure Code [**XXXXX**] is within the global period of **ZZ** days of History Procedure Code [**YYYYY**] performed on **mm/dd/yyyy** on Claim ID [**1234**], Ext/Int Line ID [**1/2**] by a provider from the same department and specialty as the current line billing provider. The diagnosis indicates it is for the same condition. Please review to determine if a modifier is appropriate."	**(mFD) Medicare Global Follow-Up by Department/Specialty** The mFD Medicare Rule identifies claim lines where an E/M procedure code was submitted within the Follow-up days determined for services by a different provider, same department and specialty for the same diagnosis code.
mFDh	Per Medicare guidelines history procedure code [**XXXXX**] performed on **mm/dd/yyyy** on Claim ID [**1234**], Ext/Int Line ID [**1/2**] by a different provider within the same department and specialty is within the global period of procedure code [**YYYYY**]. The diagnosis indicates it is for the same condition.	**(mFDh) Global Follow-Up by Department/Specialty in History** New history rule for the existing global rules that were created to capture claims that have been submitted out of sequence.
mGT	"Per the Medicare Physician Fee Schedule, procedure code **XXXXX** describes the global code of a service or diagnostic test. Modifier **<26 or TC>** is not appropriate."	**(mGT) Medicare Global Test Only** The mGT Medicare Rule identifies claim lines which have stand alone global diagnostic test codes and the modifier 26 or TC are attached, this is indicated by the PC/TC Indicator of 4. Modifiers 26 and TC are inappropriate with these codes.
mIC	"Per Medicare guidelines, procedure code **XXXXX** is a service covered incident to a physician's service and modifier **ZZ** is not appropriate."	**(mIC) Medicare Incident to Codes** The mIC Medicare Rule identifies procedure codes that describe services covered incident to a physician's service when auxiliary personnel employed by the physician and working under his or her direct personal supervision provide them. Carriers for these services may not make payment when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC are not appropriate with these codes.

mLP	"Per the Medicare Physician Fee Schedule, Procedure **XXXXX** is inappropriate with Modifier -TC. Performance of the test is paid under the lab fee schedule."	**(mLP) Laboratory Physician Interpretation** The mLP Medicare Rule identifies claim lines which have clinical laboratory codes that are interpreted by laboratory physicians, for which separate payment may be made, and the modifier TC is attached. Modifier -TC (technical component) cannot be used with these codes.
mPC	"Per the Medicare Physician Fee Schedule, procedure code **XXXXX** describes the physician work portion of a diagnostic test. Modifier **<26 or TC>** is not appropriate."	**(mPC) Professional Component Only** The mPC flag identifies the claim lines which have procedure codes, per the MPFS, a PC/TC indicator of 2, that represent the professional portion of selected diagnostic tests and the 26 or TC modifier is attached. The modifier 26 and TC are not appropriate. The PC/TC concept does not apply since these services can not be split into professional and technical components.
mPS	"Per the Medicare Physician Fee Schedule, procedure code **XXXXX** describes the physician services. Use of modifier **<26 or TC>** is not appropriate."	**(mPS) Medicare Physician Service Code** The mPS flag identifies the claim lines which have codes that describe physician services, PC/TC indicator is '0' and a 26 or TC modifier is present. The concept of professional and technical components splits (PC/TC) does not apply since physician services cannot be split into professional and technical components. Modifiers -26 (Professional), and -TC (Technical) cannot be used with these codes.
mSB	"Add-on procedure code **XXXXX** has been submitted without an appropriate primary procedure."	**(mSB) Medicare Add-On Procedure without Primary Procedure** mSB flag is set when a Medicare claim line has an add-on procedure and no primary procedure has been billed by the same provider on the same claim for the same date of service or when claim line has a One day Add On procedure with primary procedure billed by the same provider on the same claim for the same date of service.
mTC	"Per the Medicare Physician Fee Schedule, procedure code **XXXXX** describes only the technical portion of a service or diagnostic test. Modifier **<26 or TC>** is not appropriate."	**(mTC) Medicare Technical Component Only** The mTC Medicare Rule identifies the claim lines which have procedure codes that represent the technical portion of selected diagnostic tests and a 26 or TC modifier is present. The PC/TC concept does not apply since these services can not be split into professional and technical components.

mUN mUH mUO	"Per CCI Guidelines, Procedure Code **XXXXX** [PROCEDURE DESCPRITION] has an unbundle relationship with Procedure Code **YYYYY** [PROCEDURE DESCRIPTION] on Claim [**1234**], Ext/Int Line ID [**1**/**2**]. Review documentation to determine if a modifier is appropriate."	**(mUO) Unbundled Procedure (as per Medicare) on Current Line, Possible Modifier Override** The mUO Medicare Unbundle System Rule verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicare. If there is another procedure in the patient's history which should not be billed with the current line's procedure code, the respective Unbundle flag will be triggered.
mUN mUH mUO	"Per CCI Guidelines, Procedure Code **XXXXX** has an unbundle relationship with history Procedure Code YYYYY Ext/Int Line ID [**1**/**2**] on Claim [**XYZ**]."	**(mUN) Unbundled Procedure (as per Medicare) on Separate Claim -- (History Edit)** The Medicare Unbundle System Rule verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicare. If there is another procedure in the patient's history which should not be billed with the current line's procedure code, the respective Unbundle flag will be triggered.
PCM	"Modifier -26 is not appropriate with Procedure Code **XXXXX** because that procedure is defined as 100% professional or 100% technical."	**(PCM) Invalid Professional Component Modifier** The PCM edit identifies claim lines that contain a procedure code that is considered 100% technical and modifier 26 is appended.
PRE	"Pre-Op E/M Service [**XXXXX**] performed one day before the History Surgical Procedure Code [**YYYYY**] on Claim ID-Ext/Int Line ID [**XYZ**-**1**/**2**] is not allowed as part of the global surgical package."	**(PRE) Pre-Op Procedure One Day Before Surgery** The PRE edit identifies claim lines that contain an E/M procedure code performed on the same day or the day before a surgical procedure, without the presence of modifier 57.
PRV	"The Provider ID is missing." (remove department from messaging)	**(PRV) Missing Provider ID** The PRV System Rule identifies claim lines where the Provider ID field is empty.
PSX	"The Gender for this patient is either missing or invalid."	**(PSX) Missing Patient Gender** The PSX System Rule identifies claim lines where the patient's gender is missing or invalid.

RDL	"Repeat radiology procedure **XXXXX** may require a repeat procedure modifier."	**(RDL) Repeat Radiology Requires Repeat Modifier** The RDL System Rule identifies claim lines with a repeat radiology procedure that does not have the appropriate modifier appended. The modifier 76 should be used if the same provider is performing the procedure and the modifier 77 should be used if a different provider. This rule first looks at the unmodified radiology procedure and then compares the current line provider.
SAM	"There is more than one occurrence of Proc [**XXXXX**], on the same date of service, on Claim ID - Ext/Int Line ID [**XYZ** - **1/2**] with a surgical assistant modifier. Only one surgical assistant is allowed per procedure."	**(SAM) Multiple Assistant Surgeons Not Typical** The SAM edit identifies claim lines that contain an assistant surgeon modifier for which a previous claim was submitted for the same procedure with an assistant surgeon modifier.
sUN	Per Medicaid National Correct Coding Initiative edits, Procedure Code [**XXXXX**] has an unbundle relationship with history Procedure Code [**YYYYY**], Ext/Int Line ID [**1/2**].	**(sUN) Medicaid National Correct Coding Initiative Edits** The Medicaid National Correct Coding Initiative Edit System Rule is an unbundle rule that verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicaid.
sUO	Per Medicaid National Correct Coding Initiative edits, Procedure Code **[XXXXX]** [description of adjusted procedure code on 'the current line'] has an unbundle relationship with Procedure Code [**yyyyy**] [description of adjusted procedure code on 'the history line'] on Claim **1234**, Ext/Int Line ID [**1/2**]. Review documentation to determine if a modifier is appropriate.	**(sUO) Medicaid National Correct Coding Initiative Edits** The Medicaid National Correct Coding Initiative Edit System Rule is an unbundle rule that verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicaid.
UNB HNB **UEX HEX** **UOV HOV**	"Procedure Code **XXXXX** [PROCEDURE DESCRIPTION] has an Unbundle or Incidental relationship with Procedure Code **YYYYY** [PROCEDURE DESCRIPTION] on Claim **XYZ**, Ext/Int Line ID [**1/2**]."	**(UNB) Unbundle Procedure - Unbundle or Incidental** The Unbundle System Rule verifies if the Procedure Code on the current Line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together. If there is another procedure in the Patient's history which should not be billed with the Current Line's Procedure Code, the respective Unbundle flag will be triggered.

UNB HNB UEX HEX UOV HOV	"Procedure Code **XXXXX** [PROCEDURE DESCRIPTION] has an Exclusive relationship with Procedure Code **YYYYY** [PROCEDURE DESCRIPTION] on Claim **XYZ**, Ext/Int Line ID [**1**/**2**]."	**(UEX) Unbundle Procedure - Exclusive** The Unbundle System Rule verifies if the Procedure Code on the current Line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together. If there is another procedure in the Patient's history which should not be billed with the Current Line's Procedure Code, the respective Unbundle flag will be triggered.
UNB HNB UEX HEX UOV HOV	"Procedure Code **XXXXX** [PROCEDURE DESCRIPTION] has an Unbundle relationship with Procedure Code **YYYYY** [PROCEDURE DESCRIPTION] on Claim **XYZ**, Ext/Int Line ID [**1**/**2**]. Delete: Review documentation to determine if a modifier is appropriate."	**(UOV) Unbundle Procedure - Possible Modifier Override** The Unbundle System Rule verifies if the Procedure Code on the current Line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together. If there is another procedure in the Patient's history which should not be billed with the Current Line's Procedure Code, the respective Unbundle flag will be triggered.
CAG1	Procedure code 99100 is not typical for age of patient.	
CDL	Procedure Code <1> has been deleted as of <2>.	
GFP1	Procedure Code <1> is within the global period of a surgical procedure code performed by the same provider.	
IDCI	Diagnosis codes <1> identify mutually exclusive codes; two conditions that cannot be reported together.	
INJ1	Separate reporting is allowed for the injection procedure performed in POS <1> when supply code <2> of injectable materials is reported.	
mI10	Per CMS guidelines ICD9 codes and ICD10 codes cannot be billed on the same claim.	
mI9	Per CMS guidelines ICD-9 codes cannot be billed with dates of service greater than September, 30, 2015.	
mIM	Modifier is not appropriate for procedure code.	
NPT	This patient received care by provider <1> on Claim ID <2> on Date of Service <3> and is within three years of Procedure Code <4> on current line. An established patient	
SUBD	A definitive add-on procedure code <1> has been submitted without an appropriate primary procedure code.	
BRF	"Per LCD or NCD guidelines, procedure code G0445 has not met the associated Frequency relationship criteria for CMS ID(s) 210.10."	**(BRF) LCD Part B Procedure Frequency Exceeded** The BFR edit identifies a claim where a procedure code hjas been billed that exceeds frequency requirements for the policy.
LNM	"Inappropriate use of a repeat modifier with a laboratory procedure."	**(LNM) Inappropriate Use of repeat Modifier** The LNM System Rule identifies claim lines where a repeat modifier should not be submitted with the laboratory procedure
mDEY	Per Medicare guidelines, Medicare does not pay for a service or items that do not have a physician order or prescription.	**(mMey) (mDEY) Medicare Modifier EY** New rule to capture the submission of modifier EY based on Medicare Guidelines which state that all lines with modifier EY will be denied.

mFP	"Procedure Code [XXXXX] is within the global period of XY days of History Procedure Code [YYYYY] performed on mm.dd.yyyy on Claim ID [XYZ], Ext/Int Line ID [1/2]. The diagnosis indicates it is for the same condition."	**(mFP) Medicare Global Follow-Up by Provider** The Medicare E/M Global Follow-Up System rule determines whether an E/M service was billed within the follow-up period of a prior service. If a Medicare E/M procedure code was submitted within the Follow-up days determined for services by the same provider, department and specialty with the same diagnosis code then mFP edit will be triggered.
mMGY	The presence of modifier GY is inconsistent with the statutory requirements.	**(mMGY) Medicare Modifier GY** The GY modifier is defined as an item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit. This rule is based on the modifier definition and Medicare guidelines that state carriers may auto-deny based on the presence of the GY modifier.
mMGZ	Identifies claim lines with GZ modifier appended.	**(mMGZ) Medicare Modifier GZ** The presence of modifier GZ indicates this is not eligible for payment.
mMOD	"Per Medicare, use of modifier ZZ (crosswalks to YY), is not typical for procedure XXXXX."	**(mMOD) Medicare Modifier Not Typical for Procedure Code** The mMOD Medicare Rule validates whether the Modifier Codes on a claim line may be billed with the procedure code on the claim line, as per the Code Repository/Knowledgebase. All modifiers are validated to determine whether they may be billed with the procedure code on the claim line. If the modifier is not allowed with the procedure code, the mMOD flag will be triggered.
mPI	"Per the Medicare Physician Fee Schedule, procedure code XXXXX describes a physician interpretation for service and is not appropriate in place of service ZZ."	**(mPI) Medicare Physician Interpretation** The mPI Medicare Rule identifies claim lines which have the inpatient professional component of clinical laboratory codes, this is indicated by the PC/TC indicator of 8 in the MPFS, and a non inpatient place of service is present. Billing of the technical component is inappropriate.
NPD	"Dx1 XXXYY describes an external cause, or requires the ICD code for the first underlying disease, and should never be listed as the primary diagnosis for a procedure."	**(NPD) Not a Primary Diagnosis Code** The NPD System Rule identifies claim lines that contain a diagnosis code that have been identified as not appropriate as a primary diagnosis.
POS	"Procedure Code XXXXX is not typically performed by a physician at Place of Service XX **[description of the value of the submitted Place of Service found in 'Place of Service' System List for 'the current line']**."	**(POS) Place of Service Not Typical with Procedure** The POS System Rule identifies claim lines that contain a place of service that the specified procedure is not typically performed in.
CPO	Only one individual may report a single care plan oversight CPT code per patient in the same month	

CPO1	Procedure code 99091 cannot be reported within 30 days of the care plan oversight code reported on claim ID <2>.	
FCRP	Procedure code <1> found on claim ID <2> is a facility service code. This service is not to be reported on a professional claim.	
mUB **mUBh** **mUM** **mUMh**	"Per Medicare Guidelines, Procedure Code XXXXX has an unbundle relationship with history Procedure Code YYYYY, Ext/Int Line ID [1/2]."	**(mUB) Medicare Unbundled Procedure on Current Line** The mUB edit identifies claim lines that contain a procedure code on the current line is present in the Medicare unbundle data and another code submitted has an unbundle relationship with the code on the current line.
GFP	"Procedure Code XXXXX is within the global period of 10 days of History Procedure Code XXXXX performed on 01/30/2014 on Claim ID [1234], Ext/Int Line ID [1/1] by the same provider. Please review documentation for appropriate modifier.	**(GFP) Global Follow-Up by Provider** The GFP System Rule determines whether an E/M service was billed within the follow-up period of a prior service. If an E/M procedure code was submitted within the Follow-up days determined for services by the same provider, and same department and at least one diagnosis code from same class as any diagnosis code on the current line, then GFP edit will be triggered.
GSP	Procedure Code [31603] is within the global period of 90 days of History Procedure Code [31595] performed on 02/22/2016 on Claim ID [TEST GFP], Ext/Int Line ID [1/1] by the same provider. Please review documentation for an appropriate modifier.	**(GSP) Post-Op Surgery by Provider** The GSP System Rule identifies line items containing surgical procedure codes submitted within the follow-up days without an appropriate modifier. If a Surgical procedure code was submitted within the Follow-up days determined for services by the same provider with the same diagnosis code then GSP edit will be triggered.
mSP	"Per Medicare guidelines procedure code XXXXX is within the global period of history procedure code YYYYY performed on mm/dd/yyyy on Claim ID [XYZ], Ext/Int Line ID [1/2] by the same provider."	**(mSP) Medicare Post-Op Surgery By Provider** The mSP edit identifies claim lines that contain a date of service and a surgical procedure code that is submitted within the follow-up (global) days of surgical procedure, by the same physician.
UNL	"Procedure Code XXXXX is an unlisted procedure or service and requires documentation. Please refile this claim as originally submitted."	**(UNL) Unlisted Procedure Code** The UNL System Rule identifies claim lines that contain a procedure code considered to be "Unlisted".
M62	Modifier 62 is not present on procedure code <1> and is reported by a different provider on claim ID <2>.	
IDCI	Diagnosis codes <1> identify mutually exclusive codes; two conditions that cannot be reported together.	
mAT	Per Medicare guidelines procedure code <1> requires modifier GP, GO, or GN.	
ML1	Modifier L1 is inappropriate to be reported on a professional claim. It is appropriate to report on a facility claim.	
MOD25	An E/M code <1> reported with modifier 25 was provided on the same date as a major surgical procedure on Claim ID <2>. Please review documentation for appropriate modifier, if decision for surgery was made.	
MOD57	An E/M code <1> reported with modifier 57 was provided on the same date as a minor surgical procedure on Claim ID <2>. Please review documentation for appropriate modifier.	
OBA	Antepartum care code <1> cannot be submitted 280 days prior to global delivery codes 59400, 59510, 59610, 59618 by the same provider.	

ONL	Online code <1> cannot be reported for services related to an E/M provided in the previous 7 days.	
PDO	The ICD-10-CM code <1> may only be used as first-listed or primary diagnosis position.	
sM62	Modifier 62 is present on procedure code <1>. The same procedure code without modifier 62 appended was reported by a different provider on claim ID<2>.	
TCM	<1> is included in transitional care management service, 99495-99496, when reported in the same 30 day period.	
TEL	Telephone code <1> cannot be reported for services related to an E/M provided in the previous 7 days.	
UNB25	Modifier 25 should only be reported on an E/M code <1> when another claim with the same provider and same date of service is found in history requiring the use of this modifier.	
UNB57	Modifier 25 should only be reported on an E/M code <1> when another claim with the same provider and same date of service is found in history requiring the use of this modifier.	
UNID	Report only remote services when an in person interrogation device evaluation is performed during the same time period as the remote interrogation device evaluation.	
26TC	The global procedure code <1> has been submitted in history on claim ID <2> without the modifiers 26 or TC.	
mAM	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended.	
mPT	Per Medicare guidelines, procedure code <1> is a physical therapy service. No payment is made if provided in place of service <2>.	
sAM	Per Medicaid guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended.	
sDT	Per Medicaid guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in place of service <2>.	
sEM	Per Medicaid guidelines, E/M code <1> billed on the same day of a minor procedure or the same day or day before a major procedure requires an appropriate modifier.	
sIC	Per Medicaid guidelines, procedure code <1> is a service covered incident to a physician's service and modifier TC or 26 is not appropriate.	
sIM	Per Medicaid guidelines, modifier <1> is not appropriate for procedure code <2>.	
sIN	Per Medicaid guidelines, procedure code <1> is considered a bundled service when other payable services are billed on the same day by the same provider.	
sM54	Per Medicaid guidelines, the presence of modifier 54 indicates that only the intraoperative portion of the global fee should be reimbursed.	
sM55	Per Medicaid guidelines, the presence of modifier 55 indicates that only the postoperative portion of the global fee should be reimbursed.	
sM56	Per Medicaid guidelines, the presence of modifier 56 indicates that only the preoperative portion of the global fee should be reimbursed.	
sMEY	Per Medicaid guidelines, all claim lines on the same claim must contain the modifier EY.	
sNP	Per Medicaid guidelines, procedure code <1> does not typically require performance by a physician in place of service <2>.	
sOG	Per Medicaid guidelines, procedure code 99024 is outside the global period of a related procedure code found in history or could not be located in history. Use a separately billable E/M instead of 99024.	
sPI	Per Medicaid guidelines, procedure code <1> describes a physician interpretation for a service and is not appropriate in place of service <2>.	
sTS	Per Medicaid guidelines, team surgery is not permitted for procedure code <1>.	
DLP	"This line is a possible duplicate of Claim Line ID [XYZ-1/2]."	**(DLP) Duplicate Line by Provider** The DLP System Rule determines whether the current claim line is a possible duplicate of another claim line by the same provider.

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