EDIT 0001 - GENERIC ELIGIBILITY USED
This edit posts when the first two digits of the beneficiary's id number starts with a 58, 59, or 50. This edit does not deny the claim.

EDIT 0002 - INVALID OR MISSING BILLING PROVIDER NUMBER
This edit posts when the billing provider number is invalid or missing.

EDIT 0004 - INVALID OR MISSING PRESCRIBER'S MEDICAID ID NUMBER
This edit will post to a claim when the prescribing physician's Medicaid ID Number is missing. If the prescribing physician does not participate with NJ Medicaid, the provider may use 6666666, if the prescribing physician is out of state and non participating the provider may use 5555555.

Pharmacy claims may not use 6666666 or 5555555, if the prescribing physician for a pharmacy claim is non participating, the pharmacy may use the prescribing physician's state license number or the prescribing physician's NPI number.

EDIT 0006 - INVALID REFERRING/OTHER INDIVIDUAL MEDICAID ID NUMBER
This edit will post when the referring or other physician field on the submitted claim is invalid or not numeric. Below are the form locators that relate to this edit:

CMS-1500	17A
UB-04	78 & 79
MC-6	23
MC-9	17
MC-19	17A

837 Institutional- 2310D:NM1-09(NPI#)
837 Professional- 2300: 2310A-NM1-09(NPI#)
837 Dental- 2300: 2310A-NM1-09(NPI#)
NCPDP- AM03: 466-EZ=01 OR 08 AND 411-DB

EDIT 0007 - BILLING PROVIDER CHECK DIGIT INVALID
This edit posts if the provider's check digit, calculated by the system, is not consistent with the billing provider number on the claim.

EDIT 0009 - SERVICES NOT COVERED FOR THIS BENEFICIARY
The beneficiary is not entitled to the service billed.

EDIT 0010 - INVALID SERVICING MEDICAID ID NUMBER
The Medicaid provider number of the servicing provider must have seven numeric digits and must be valid. If a servicing provider number is not required, that corresponding field must be blank. On the CMS 1500 claim form, enter the servicing provider number in Field 33 to the right of PIN.

EDIT 0011 - RECIPIENT NUMBER MISSING OR INVALID
The beneficiary ID number must be 12 numeric digits, including the person number. The correct beneficiary number can be received by calling REVS (the Recipient Eligibility Verification System) at 1-800-676-6562 using the beneficiary's CCN from their Medicaid Identification card. For Charity Care claims this edit reads; Charity Care % invalid, and posts following EDI information in loop 2800 is not correct: Segment HI, field HI, field HI01-2 must = 69, field HI01-5 must = 20, 40, 60, 80, or 100.

EDIT 0012 - MISSING RECIPIENT NAME
The last and/or first name of the recipient are not on the claim form or are not legible.

EDIT 0013 - INVALID BIRTHDATE
The date of birth entered on the claim form does not match the date of birth on the beneficiary's eligibility file. It must be entered in MM/DD/YYYY format. The month and year of birth are printed on the beneficiary's eligibility card. If the day is not available, use '01' as the default.

EDIT 0014 - STATEMENT THRU DATE IS LESS THAN OCCURRENCE DATE
The date entered to the right of the Occurrence Code on the UB-92 claim form must not be later than the Statement "through" date entered in Form Locator Number 6.

EDIT 0015 - STATEMENT THRU DATE IS LESS THAN STATEMENT FROM DATE
The date span reported in Form Locator 6 on the UB-92 claim form is invalid; e.g., the date might be entered as 10/01/2001-10/30/2000.

EDIT 0016 - INVALID/MISSING SERVICE "FROM" DATE
The "from" date of service must have six numeric digits entered in MMDDYY format; e.g., August 15, 2001 would be 081501. If the date of service does not span days, then the "from" date must be the same as the "to" or "through" date.

EDIT 0017 - INVALID/MISSING "TO" OR "THROUGH" DATE
The "to" or "through" date of service must have six numeric digits entered in MMDDYY format; e.g., August 15, 2001 would be 081501. If the date of service does not span days, then the "to" or "through" date must be the same as the "from" date.

EDIT 0018 - SERVICE "THROUGH" DATE IS LESS THAN "FROM" DATE
The "from" date of service is greater than the "to" or "through" date; e.g., the "from" date is 093001 and the "to" or "through" date is 093000.

EDIT 0020 - SERVICE "THROUGH" DATE IS GREATER THAN DATE RECEIVED
This edit posts when the claim is received by the Fiscal Agent on a date that is earlier than the "to" or "through" date of service. Claims cannot be received until on or after the "to" or "through" date as entered on the claim.

EDIT 0021 - BILLED DATE LESS THAN "TO" OR "THROUGH" DATE
This edit posts because the signature date on the claim form is before the "to" or "through" date on the claim form.

EDIT 0022 - INVALID/MISSING BILLING DATE
This edit posts because the date of signature is missing or invalid. The date of signature must be present on the claim form and cannot be earlier than the "to" or "through" date of service.

EDIT 0023 - BILLED DATE IS LESS THAN STATEMENT "TO" OR "THROUGH" DATE
The claim form must be signed on or after the date of service. This edit posts because the claim form was signed before the "to" or "through" date of service.

EDIT 0024 - POS REVERSAL REJECTED-RESUBMIT USING FD 999 FORM
This edit is only posted to pharmacy void requests that are submitted via the Point Of Sale (POS) system. The information submitted does not match a paid claim. A completed FD-999 adjustment form reflecting the paid claim to be voided is required.

EDIT 0025 - INVALID OR MISSING DISPENSING DATE
The date the prescription was dispensed is missing or invalid. It must be entered in MMDDYY format; e.g., September 18, 2001 would be 091801.

EDIT 0026 - CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING
This edit posts when the claim received is more than one year from the date of service and there is no attachment to prove that the claim was previously submitted within timely filing guidelines. Medicaid claims must be received within one year of the "from" date of service.

Claims submitted for processing more than one year from the date of service require proof that the fiscal agent originally received the claim within the year. An example for proof of timely filing is a copy of a Remittance Advice page listing the control number of the original submission. Remittance Advice(s) showing claim(s) denied for timely filing edits (026,076,080) may not be used to prove timely filing. This edit does not apply to any specific form locator.

HIPAA - N/A

EDIT 0027 - INPATIENT CLAIM WITHOUT ATTACHMENT EXCEEDS TIMELY FILING
This edit posts when the Fiscal Agent receives an inpatient claim more than one year from the "from" date of service and there is no attachment to prove that claim was previously submitted within timely filing guidelines. Inpatient claims must be received within one year of the "from" date of service.

Claims submitted for processing more than one year from the "from" date of service require proof that the fiscal agent originally received the claim within the year. An example for proof of timely filing would be a copy of a Remittance Advice page listing the control number of the original submission. Remittance Advice(s) showing claim(s) denied for timely filing edits (027,077,080) may not be used to prove timely filing.

Resubmit the claim and attach a copy of the RA showing that the claim was submitted timely.

EDIT 0028 - EPSDT FILING LIMIT
This edit posts when the date of service on the claim is 45 days old. This edit does not deny the claim.

EDIT 0029 - MEDICARE CROSSOVER CLAIM EXCEEDS TIMELY FILING LIMIT
This edit is posted if the claim receipt exceeds Medicaid's timely filing rule of 1 year from the date of service. Medicaid requires that the claim be received by Medicare within the year which is determined by a review of the ICN on the Medicare EOB. The only exception is when Medicare receives the claim within the year but processed the claim after the year expired. In that case only, the provider has 90 days from Medicare's payment date to submit the claim to Medicaid. This edit does not apply to any specific form locator.

HIPAA- N/A

EDIT 0030 - CONDITION CODE LIABILITY
This edit posts if the condition code is 01 - 05, 08, or 10 which would indicate that the claim is possible involved in a liability case. This edit does not deny the claim.

EDIT 0031 - CONDITION CODE 85 PRESENT- REQUIRES REV CODE 912
This edit posts to outpatient claims for partial hospitalization. When Condition Code 85 is present, Revenue Code 912 must be present.

EDIT 0033 - SUBMITTER ID IS NOT NUMERIC OR IS EQUAL TO "0"
This edit posts to pharmacy claims submitted via POS. The required seven-digit submitter number was either invalid or missing. The software vendor can provide the appropriate field for this data element.

EDIT 0034 - MISSING LABORATORY SERVICE REVENUE CODE
This edit posts to outpatient hospital claims. The claim contains a laboratory procedure code in Form Locator 44, but a corresponding Revenue Code in the 300 through 319 range is missing.

EDIT 0035 - HOSPICE CLAIM - NUMBER OF UNITS NOT EQUAL TO NUMBER OF DAYS
The number of units must equal the number of days as per the dates of service. If the date span is more than one day, the system counts the number of days covered by the "from" and "through" dates and compares the result to the number of units billed.

EDIT 0036 - INVALID ACUTE DAYS
The field for acute days is required for both inpatient and inpatient crossover claims. This edit posts when the first four digits in Form Locator 2 on the UB-92 claim form are blank or not numeric. A provider must add leading zeros to the number of acute days to make this a 4-character field; e.g., twenty-one acute days are entered as 0021.

EDIT 0037 - INVALID SNF DAYS
This edit posts when the fifth, sixth, seventh and eighth digits in Form Locator 2 on the UB-92 claim form are blank or not numeric. If there are no SNF days, the four digits must be zeros. If there are SNF days, a provider must add leading zeros to the number of days to make this a four-character field; e.g., five SNF days is entered as 0005.

EDIT 0038 - INVALID ICF DAYS
This edit posts when the ninth, tenth, eleventh and twelfth digits in Form Locator 2 on the UB-92 claim form are blank or not numeric. If there are no ICF days, the four digits must be zeros. If there are ICF days, a provider must add leading zeros to the number of days to make this a four-character field; e.g., five ICF days is entered as 0005.

EDIT 0039 - INVALID RESIDENTIAL DAYS
This edit posts when the thirteenth, fourteenth, fifteenth and sixteenth digits in Form Locator 2 on the UB-92 claim form are blank or not numeric. If there are no residential days, the four digits must be zeros. If there are residential days, a provider must add leading zeros to make this a four-character field; e.g., three residential days is entered as 0003.

Note: Social Necessity Days are days when a hospital keeps DYFS children longer than needed until a placement can be found. These days are billed as residential days and as "non-covered" days. The provider must submit the claim with an explanatory cover letter to Hospital Reimbursement Unit, PO Box 712, Trenton NJ 08625.

EDIT 0040 - INVALID OR MISSING ADMISSION DATE
This edit posts when the date of admission on the UB-92 claim form is invalid or missing. The date of admission must be entered in MMDDYY format; e.g., September 15, 2001 would be 091501.

EDIT 0041 - ADMISSION DATE IS GREATER THAN "FROM" DATE OF SERVICE
This edit posts because the date of admission is greater than the date of service; e.g., the date of admission is 101501 but the first service date is 011501.

EDIT 0042 - INVALID OR MISSING TYPE BILL CODE
The entry in Form Locator 4 on the UB-92 claim form must be a three digit numeric code specifying the type of bill. Check the billing supplement for valid codes.

EDIT 0043 - INVALID OR MISSING BIRTH WEIGHT
The birth weight must be entered in grams in Form Locators 39-41 on the UB-92 claim form with Value Code 80. This is a nine-character field requiring 3 or 4 leading zeros and 2 trailing zeros.

EDIT 0044 - INVALID OR MISSING TYPE OF ADMISSION
This edit posts when the type of admission on the UB-92 claim form is invalid or missing. The type of admission in Form Locator 19 must be one of the following: 1 = Emergency, 2 = Urgent, 3 = Elective, 4 = Newborn, 9 = Information not available

EDIT 0045 - INVALID OR MISSING PATIENT STATUS CODE
The entry in Form Locator 22 on the UB-92 claim form must be a two-digit numeric code denoting patient status. Check the billing supplement for valid codes.

EDIT 0046 - TOTAL DAYS NOT EQUAL TO DATES OF SERVICE
The total days billed (Acute + SNF + ICF + Residential) entered in Form Locator 2 on the UB-92 claim form must equal the number of days in the dates of service span in Form Locator 6.

Medicaid does not count the discharge date. The number and type of inpatient days must be entered in Form Locator 2 in the following sequence: acute (digits 1-4), SNF (digits 5-8), ICF (digits 9-12), and residential (digits 13-16). Zeroes are required for any type of inpatient days not applicable to a particular claim; e.g. a 17-day hospital confinement consisting of ten acute days, three SNF days, four ICF days and no residential days would be entered as 0010000300040000.

The total number of acute, SNF, and ICF days must equal the number entered in Form Locator 7. The number of residential days must be listed as "non-covered" in Form Locator 8. The number of units reported for room and board Revenue Codes must equal the sum from Form Locator 2 and the sum of Form Locator numbers 7 and 8. These must also agree with the date of service span in form locator 6.

EDIT 0047 - DATES OF SERVICE NOT ELIGIBLE FOR POS PROCESSING
The date of service on the claim is prior to the submitter agreement date on file at the Fiscal Agent. The pharmacy must submit the claim hard copy.

EDIT 0048 - MISSING ICD-9 SURGICAL PROCEDURE CODE
This edit posts because a surgical date is present on the claim, but the surgical procedure code is not. The provider must enter the appropriate ICD-9 surgical procedure code.

EDIT 0049 - INVALID OR MISSING SURGICAL DATE
This edit posts when a surgical procedure code is present on the claim, but the corresponding date is missing or invalid. If there were no charges to this surgical code, remove the code.

EDIT 0050 - BLOOD NOT REPLACED AMOUNT MUST BE NUMERIC
This edit posts to hospital claims when the blood units that are not replaced are not numeric.

EDIT 0051 - RENAL REVENUE CODE IS PRESENT - RENAL BILL TYPE IS MISSING
The type of bill in Form Locator 4 on the UB-92 claim form for an ESRD claim, defined by the Revenue Code, must be 721, 722, 724, 725, or 729.

EDIT 0052 - TOTAL BLOOD PINTS FURNISHED INCORRECT
When revenue codes 380 through 389 appear on the UB-92 claim form, Form Locators 34-42 must include either Value Code 37 (and the number of pints furnished to the patient), or Value Code 39 (and the number of pints replaced by the patient).

EDIT 0053 - INVALID/MISSING ACCOMMODATION DAYS
Room and Board Revenue Codes are present on the UB-92 claim form, but the units are missing or invalid. The total room and board days must equal the sum of the Acute, SNF, ICF, and residential days entered in Form Locator 2.

EDIT 0055 - 1 IS NOT PRESENT IN THE 'PA IND' FIELD AND A PA NUMBER IS PRESENT
This edit posts to pharmacy claims submitted via POS. The pharmacy must enter 1 in the PA INDICATOR field preceding the prior authorization number issued by First Health.

EDIT 0056 - INVALID/MISSING REVENUE UNITS
This edit posts when the number of units for one or more claim lines is missing, invalid, or equal to zero.

EDIT 0057 - CONDITION CODE 40 - FROM/THROUGH NOT EQUAL
Condition code 40 reflects a same day transfer. When using this condition code, the "from" date of service and the "through" date in Form Locator 6 must be the same.

EDIT 0058 - INVALID/MISSING PROCEDURE CODE OR REVENUE CODE CHARGE
This edit posts if one or more Revenue Codes entered on the UB-92 claim form reflects a charge that is invalid or missing. The dollar and cents amount must be numeric. Do not use a decimal or the $ sign.

EDIT 0059 - MISSING CHARITY CARE WRITE-OFF DATE
This edit posts to Charity Care claims when the write off date is not entered in loop 2300 field NTE02 positions 29-36. Format is CCYYMMDD. (eg.20050501 is May 1, 2005)

EDIT 0060 - INVALID/MISSING OCCURRENCE CODE - SUPPLY VALID CODE OR REMOVE DATE
Form Locator 32 on the UB-92 claim form reflects a date but the Occurrence Code is either missing or invalid. Either correct the Occurrence Code or remove the date.

EDIT 0061 - CHARITY CARE WRITE-OFF DATE BEFORE 01-01-95
This edit posts to Charity Care claims if the write off date is before 01-01-95. Claims written off prior to this date were not processed through Molina Medicaid Solutions.

EDIT 0062 - INVALID CONDITION CODE
This edit will post when the Condition Code(s) recorded in Form Locators 18-28 on the UB-04 claim form must be (a) two-digit numeric code(s). The Condition code entered on the claim is invalid.

NOTE: Condition Code 80 (Crossover Claim) is only used for inpatient crossover claims. It is not valid for outpatient crossover claims.

EDIT 0063 - INVALID OR MISSING ADMISSION HOUR
All hospital claims require an admission hour in Form Locator 18 on the UB-92 claim form. This edit posts when this data element is missing.

Check the billing supplement for valid codes.

EDIT 0064 - SERVICE "THROUGH" DATE IS GREATER THAN STATEMENT "THROUGH" DATE
The line item "through" service date recorded in Form Locator 43 on the UB-92 claim form is greater than the "through" service date recorded in Form Locator 6.

EDIT 0065 - PINTS OF BLOOD FURNISHED MUST BE NUMERIC
This edit posts to hospital claims when the blood units that are furnished are not numeric.

EDIT 0067 - INVALID OR MISSING NON-COVERED HOSPITAL DAYS
When Form Locator 2 on the UB-92 form reflects Residential Days (the 13th, 14th, 15th and 16th characters), the number of Residential Days is required in Form Locator 8.

EDIT 0068 - INVALID SOURCE OF ADMISSION
This edit posts when the source of admission entered in Form Locator 20 on the UB-92 claim form is not valid. It must be a valid one-digit numeric code. Check the billing supplement for valid codes.

EDIT 0069 - INVALID OCCURRENCE DATE
The date entered in Form Locators 32-36 on the UB-92 claim form must be in the MMDDYY format; e.g., September 15, 2001 would be 091501.

EDIT 0070 - CHARITY CARE WRITE-OFF DATE TOO FAR IN FUTURE
This edit posts to Charity Care claims if the write-off date is after the month following the ICN date; e.g. if the ICN date is 09/17/00, then the write-off date cannot exceed 10/31/00.

EDIT 0071 - INVALID STATEMENT COVERS FROM DATE
The statement "from" date in Form Locator 6 on the UB-92 claim form must be entered in MMDDYY format; e.g., September 15, 2001 would be 091501.

EDIT 0072 - INVALID STATEMENT COVERS "THROUGH" DATE
The statement "through" date in Form Locator 6 on the UB-92 claim form must be entered in MMDDYY format; e.g., September 30, 2001 would be 093001.

EDIT 0073 - SERVICE COVERS FROM DATE IS LESS THAN STATEMENT FROM DATE
The line item "from" service date as recorded in Form Locator 43 on the UB-92 claim form cannot be less than the "from" statement date entered in Form Locator 6.

EDIT 0074 - STATEMENT COVERS FROM DATE IS GREATER THAN "THROUGH" DATE
The "from" statement date in Form Locator 6 on the UB-92 claim form cannot be greater than the "through" service date.

EDIT 0075 - PINTS OF BLOOD REPLACED NOT NUMERIC
This edit posts to hospital claims when the blood units that are replaced entry are not numeric.

EDIT 0076 - CLAIM WITH ATTACHMENT EXCEEDS TIMELY FILING
This edit posts when a claim is received more than one year from the date of service with an attachment that does not prove timely filing. The provider must resubmit the claim with proof of timely filing. Claims submitted for processing more than one year from the date of service require proof that the fiscal agent originally received the claim within the year. An example for proof of timely filing is a copy of a Remittance Advice page listing the control number of the original submission. Remittance Advice(s) showing claim(s) denied for timely filing edits (026,076,080) may not be used to prove timely filing. This edit does not apply to any specific form locator.

HIPAA - N/A

EDIT 0077 - INPATIENT CLAIM EXCEEDS TIMELY FILING LIMIT
An original inpatient claim must be received within one year from the date of discharge. This edit posts when an inpatient claim is received more than one year from the discharge date with an attachment that does not prove timely filing. The provider must resubmit the claim with an attachment that proves that the original submission was within a year.

EDIT 0078 - CHARITY CARE WRITE-OFF DATE EXCEEDS ALLOWABLE SUBMISSION PERIOD
This edit is for Charity Care claims. It posts when the claim entry code is July 1 or later and the date associated with the J3 Occurrence Code is for the prior year (or earlier).

EDIT 0079 - INPATIENT CLAIM REQUIRES AT LEAST ONE ACCOMMODATION CODE
Inpatient claims require at least one accommodation Revenue Code. This edit posts when an accommodation Revenue Code does not appear on the claim.

EDIT 0080 - ICN DATE IS GREATER THAN TWO YEARS FROM DATE OF SERVICE
This edit posts when the internal control number indicates that the Fiscal Agent received the claim more than two years after the date of service. The provider must request a Fair Hearing to have the claim considered for payment.

EDIT 0081 - INVALID/MISSING CLINIC CODE
For Emergency Room charges (Revenue Codes 450 or 459) and Clinic charges (Revenue Codes 510, 511, 512, 513, 514, 515 or 519) a two-digit numeric clinic code must be entered to the right of the "through" service date entered in Form Locator 43 on the UB-92 claim form.

EDIT 0082 - EMERGENCY ROOM REVENUE CODE PRESENT - CLINIC CODE "00" IS MISSING
If the Revenue Code entered on the claim form is 450 or 459, the Clinic Code 00 must be entered to the right of the "through" service date in Form Locator 43 on the UB-92 claim form.

EDIT 0083 - REV CODE 099, 36X, 37X, 49X OR 71X REQUIRES VALID ICD9 SURG PROC
When one or more revenue codes indicate that surgery was performed, a valid ICD-9-CM surgical procedure code and date of service must be entered in Form Locator 80 on the UB-92 claim form. If there was more than one procedure, the surgical procedure code(s) must be entered in Form Locator 81.

EDIT 0084 - BABY & MOTHER - ADMIT SOURCE INVALID FOR ADMIT TYPE (NEWBORN)
Edit 084 posts with Edit 068. They post when the type of admission entered in Form Locator 19 on the UB-92 claim form is 4 (Newborn) and the source of admission entered in Form Locator 20 is not valid for a newborn. The valid source of admission codes for newborns are: 1 - Normal delivery, 2 - Premature delivery, 3 - Sick baby, 4 - Extramural birth (outside hospital), 9 - Information not available

EDIT 0085 - INVALID/MISSING DAYS/UNITS/VISITS

This edit is posted to claims when the days/units/visits are not numeric or equal to zeroes. In addition, this edit can post when the number of units billed does not equal the number of days indicated.

CMS-1500	24G
UB-04	46
MC-6	17
MC-9	25D
MC-12	24F
MC-19	24G

837 Institutional -	The number of units must be entered in Loop 2400; SV2 Segment, field SV205, where SV204 = UN.
837 Professional -	The number of units must be entered in Loop 2400; SV2 Segment, field SV104, where SV103 = UN.
837 Dental -	The number of units must be entered in Loop 2400; SV2 Segment, field SV306.
NCPDP -	The 442-E7 Quantity Dispensed field in the AM07 Claim Segment must be correctly entered.

EDIT 0086 - NUMBER OF UNITS EXCEEDS MONTHS/DAYS OF SERVICE

This edit is posted when the number of units exceeds the maximum allowable units for the procedure code on the claim.

CMS-1500	24G
UB-04	46
MC-6	17
MC-9	25D
MC-12	17F
MC-19	14G

837 Institutional - LOOP 2400 SEGMENT SV201
837 Professional - LOOP 2400 SEGMENT SV103 837
Dental - LOOP 2400 SEGMENT SV306

EDIT 0087 - CLAIM INDICATES SURGERY - SURGEON NUMBER MISSING

This edit is posted if the claim contains a surgical procedure code in the range of 8700-9999. The surgeon's Medicaid provider ID is required. This only applies to Hospital claims.

UB-04 74, 77

837 Institutional - When the Revenue Code(s) and surgical procedure code(s) entered on the claim indicates that surgery was performed, the Surgeon's NPI must be entered in Loop 2310B in field NM109 where field NM108 = XX. For HIPAA NON-COVERED ENTITIES ONLY, enter the seven-digit Medicaid Provider Number in field REF02 when REF01 = 1D. If the operating physician does not participate in New Jersey Medicaid, enter "5555555" to identify an out-of-state physician or "6666666" to identify an in-state physician.

EDIT 0088 - DATE OF SURGERY IS LESS THAN STATEMENT FROM DATE
The surgery date, entered in Form Locator 80-81 on the UB-92 claim form, is less than the statement "from" date entered in Form Locator 6.

EDIT 0089 - DATE OF SURGERY IS GREATER THAN "THROUGH" SERVICE DATE
The surgery date entered in Form Locator 80-81 on the UB-92 claim form is greater than the "through" date entered in Form Locator 6.

EDIT 0090 - SUBMISSION TIME ELAPSED
This edit is for Charity Care. It posts to adjustments when the claim entry code is July 1 or later and the date associated with the J3 Occurrence Code is for the prior year (or earlier).

EDIT 0091 - INVALID/MISSING EPSDT LABORATORY INDICATOR
This edit posts when one or more laboratory indicators entered in Item 19 on the MC-19 claim form reflect an entry other than numeric digits 1-6, or are blank. This is a required field.

EDIT 0092 - INVALID/MISSING EPSDT IMMUNIZATION STATUS CODE
This edit posts when one or more immunization status codes entered in Item 20 on the MC-19 claim form reflect an entry other than numeric digits 1-4, or are blank. This is a required field.

EDIT 0093 - INVALID/MISSING EPSDT SCREENING INFORMATION INDICATORS
This edit posts when one or more screening codes entered in Item 15B-H on the MC-19 claim form reflects an entry other than numeric digits 1-6, or is blank. This is a required field.

EDIT 0094 - INVALID/MISSING OR CONFLICTING EPSDT PHYSICAL DATA INDICATOR
This edit posts when one or more physical codes entered in Item 15A on the MC-19 claim form reflect an entry other than numeric digits 1-6 or are blank. This is a required field.

EDIT 0095 - INVALID/MISSING EPSDT RACE CODE
This edit posts when one of the blocks in Item 10 on the MC-19 claim form is not checked to indicate the beneficiary's race. This item must be complete.

EDIT 0096 - ANTICIPATORY GUIDANCE
This edit posts to a claim when the Anticipatory Guidance/Health Education Indicator is not equal to 'y' or 'n'. This edit does not deny the claim.

EDIT 0097 - INVALID EPSDT PHYSICAL SCREEN INDICATOR
This edit posts to a claim when the EPSDT - SCRN-DATA-IND is equal to 'y' and the fields be low have a value of something other than 1-4. This edit does not deny the claim.

EDIT 0098 - INVALID OR MISSING EPSDT CONTINUED CARE
This edit post to a claim when the EPSDT-SCRN-DATA-IND is equal to 'y' and the Continued Care IND is not equal to 'y' or 'n'. This edit does not deny the claim.

EDIT 0099 - EPSDT WIC INDICATOR MISSING OR INVALID
This edit posts when the WIC IND is not equal to 'y' or 'n'. This edit does not deny the claim.

EDIT 0100 - ORIGINAL RECIPIENT IDENTIFICATION NUMBER CHANGED
This edit posts when the original recipient identification number has been updated. This edit does not deny the claim.

EDIT 0101 - ABNORMAL INDICATOR IN THE PHYS/SCRN
This edit posts when the EPSDT-SCRN-DATA-IND is equal to 'y' and the fields below do not have the appropriate value. This edit does not deny the claim.

EDIT 0102 - INVALID/MISSING TOOTH SURFACE CODE
The code entered in Item 17G on the MC-10 claim form must be a single alpha digit. Valid Tooth Surface Codes are: M - Mesial, I - Incisal, D - Distal, B - Buccal, O - Occlusal, L - Lingual

EDIT 0104 - LATE SUBMISSION: (-) ADJ/VOID OK
This edit is for Charity Care. It posts to adjustments or voids when the date of service is greater than 2 years and a void or negative adjustment is submitted. This is an EOB message.

EDIT 0105 - FOR TPL/HMO CLAIMS HAVING AN ATTACHMENT CODE 15
This edit posts to all claims having an HMO co-payment EOB. These claims will be pended for manual pricing. This is an EOB message.

EDIT 0106 - CONSECUTIVE LEAVE TYPES - OVERLAPPING DATES OF SERVICE
The leave of absence dates for two separate leaves on the TAD must not overlap. This edit posts when the "to" date for one leave is the same as the "from" date for another reported leave. Or, the first leave overlaps the second leave.

EDIT 0109 - ALLOWABLE AMOUNT IS LESS THAN CO-PAY AMOUNT
This edit posts to co-pay claims when the Medicaid allowable amount is less than the co-pay amount entered in the manual-pricing field.

EDIT 0110 - DATE OF SERVICE IS LESS THAN ADMISSION DATE
The "from" and/or "to" service date entered in Items 10 and 11 on the TAD cannot be before the date of admission recorded in Item 8.

EDIT 0111 - LIVERY CLAIM FILED > 90 DAYS AFTER SERVICE
This edit posts for selected transportation providers and selected procedure codes if the claim receipt date is more than 90 days after the service through date.

EDIT 0113 - LTC/HOSPICE CLAIM SPANS MONTHS
LTC: The dates of service entered on the TAD in Items 10 and 11 must be within the same calendar month. Each month must be submitted on a separate TAD line or EDI 837 Institutional claim record. HOSPICE: The dates of service entered on the CMS-1500 form in item 24A must be within the same calendar month. Each month of service must be on a separate CMS-1500 claim form or EDI 837 Professional claim record.

EDIT 0114 - INVALID/MISSING ADMIT CODE
The admit code entered in Item 9 on the TAD is either missing or invalid. Check the billing supplements for valid codes.

EDIT 0115 - INVALID GENSTAT/ DISCHARGE CODE
The discharge code entered in Item 12 on the TAD is either missing or invalid. Check the billing supplements for valid codes.

EDIT 0116 - INVALID LEAVE OF ABSENCE DATE
The leave of absence dates entered in Items 24-32 on the TAD must be entered in MMDD format; e.g., the "from" leave date would be 0910 while the "to" leave date would be 0915.

EDIT 0117 - LEAVE OF ABSENCE DATE (S) OUTSIDE DATES OF SERVICE
The leave of absence dates entered in Items 24-32 on the TAD must be the same or within the service dates entered in Items 10 and 11.

EDIT 0118 - LEAVE OF ABSENCE FROM/ THROUGH DATE CONFLICT
The "from" leave of absence date on the TAD must be less than the "to" leave of absence date for the same leave; e.g., if the "from" leave date is 0925 the "to" leave date cannot be 0915.

EDIT 0119 - INVALID/MISSING LEAVE OF ABSENCE CODE
When leave of absence dates appear in Items 24-32 on the TAD a corresponding leave of absence code is required in the block to the immediate left of the dates. Valid codes are: T - Therapeutic leave, H - Hospital leave, M - Hospital leave while on Medicare. This edit also post if a valid code does not have any associated dates.

EDIT 0120 - INVALID LTC TAD ADDITIONAL SERVICES/THERAPIES
Each block for additional nursing services (Item 17) and therapies (Item 18) on the TAD must reflect an entry of Y for yes, or N for no. The fields for additional nursing services are: TRA - Tracheotomy, RES - Respiratory Therapy, IVT - IV Therapy, HTR - Head Trauma, OXY -Oxygen, NGT - Tube Feed and WOU - Wound Care, The fields for Therapies are PHY - Physical Therapy, SPE Speech Therapy and OCC - Occupational Therapy

EDIT 0121 - MEDICARE BED HOLD BEGIN DATE OUTSIDE DATES OF SERVICE
When the leave of absence code denotes a Medicare hospital leave (Code M on the TAD) the "from" service date recorded in Item 10 and the "to" date in Item 11 must be the same as the dates for the Medicare hospital leave (or bed hold days).

The Medicare leave is claimed when a beneficiary goes to the hospital while Medicare is the primary payer for the LTC service period. The Medicare hospital leave of absence must always be billed on a separate TAD line. If the beneficiary spent time in the facility before the Medicare leave, that time must also be billed on a separate TAD line. If the beneficiary also spent time in the facility after the Medicare leave, that time must be billed on a single claim. In this example, three separate TAD lines must be submitted for the same month.

EDIT 0122 - MEDICARE BED HOLD END DATE OUTSIDE DATES OF SERVICE
When the leave of absence code denotes a Medicare hospital leave of absence (Code M on the TAD) the "from" service date recorded in Item 10 and the "to" service date in Item 11 must be the same as the dates for the Medicare hospital leave (or bed hold days).

The Medicare leave is claimed when a beneficiary goes to the hospital while Medicare is the primary payer for the LTC service. The Medicare hospital leave of absence must always be billed on a separate TAD line. If the beneficiary spent time in the facility before the Medicare leave, that time must also be billed on a separate TAD line. If the beneficiary also spent time in the facility after the Medicare leave, that time must be billed on a single claim. In this example, three separate TAD lines must be submitted for the same month.

EDIT 0123 - SUBMIT SR GOLD BY POS NOT EMC
This edit post when the beneficiary's id number starts with a '7' and the claim was submitted via EMC not POS.

EDIT 0124- INCORRECT CUSTOMER LOCATION CODE REPORTED
The customer location code submitted on the POS claim is not in the range of 00-11.

EDIT 0125 - THIS PROVIDER INVALID WITH MODIFIER US, U6, WI, & WR
The provider designated by DMAHS as a "recycled DME" provider may only use the modifiers UE, U6, WI and WR.

EDIT 0126 - COMPOUND DRUG INDICATOR MUST BE 'Y' OR 'N'
The compound drug indicator must indicate Y for yes or N for no.

EDIT 0127 - NDC CODE MISSING OR INVALID
This edit posts when the NDC code contains one or more non-numeric characters, or if positions 1-5 (the drug manufacturer code) reflect zeros or positions 6-9 (the drug product code) reflect zeros.

EDIT 0128 - CLAIM > $400: VERIFY METRIC QUANTITY REPORTED
This edit posts when, after review, it was determined that the metric quantity entered on the MC-6 claim form was not correct. This is an EOB message.

EDIT 0129 - INVALID ATTACHMENT CODE > 15
This edit posts when the attachment code indicated on the HIPAA attachment cover sheet is not within the range of 03 through 15.

EDIT 0130 - INVALID/MISSING DAYS SUPPLY
The days supply for the prescription must reflect numeric digits greater than zero.

EDIT 0131 - INVALID/MISSING PRESCRIPTION NUMBER
The prescription number must be entered on the claim.

EDIT 0132 - INVALID/MISSING FACILITY (LTC) INDICATOR
The LTC indicator is a required field. One block must be checked to indicate whether or not the beneficiary resides in a Long-Term Care facility.

EDIT 0133 - RECIPIENT PARTICIPATES IN PERSONAL PREFERENCE PROGRAM (PPP)
This recipient participates in the PPP Program and receives a monthly grant to pay for home care services. The provider must collect payment from the beneficiary.

EDIT 0134 - USE PROPER PROCEDURE CODE
This edit posts when the claim submitted has an invalid procedure code.

EDIT 0135 - INVALID/MISSING CURRENT EXAM DATE
The current exam date entered in Item 20B on the MC-9 Claim Form (Vision Care) must appear in MMDDYY format; e.g., September 15, 2001 would be 091501.

EDIT 0136 - COPAY CLAIM DENIED- NO BENEFICIARY OR PROGRAM LIABILITY
This edit posts to outpatient claims submitted for HMO co-payment will be satisfied on the 1st service line of the claim. The remaining lines deny with this message.

EDIT 0137 - CURRENT EXAM GREATER THAN DATE DISPENSED
The current exam date entered in Item 20B on the MC-9 Claim Form must not be greater than the date dispensed entered in Item 20C; e.g., if the exam date is 091501 the date of dispense cannot be 090101.

EDIT 0138 - ACCIDENT INDICATOR MUST BE Y, N, OR BLANK
This edit posts when the accident indicator fields reflect an entry other than Y, N, or blank. Check the billing supplement for the appropriate form locators on your claim form.

EDIT 0139 - EPSDT INDICATOR NOT Y, N, OR SPACE
The field indicating whether services provided result from an EPSDT referral differs among claim forms. For Optical and Dental providers, form locator 9 on your claim form must be check "YES" or "NO". For providers using the CMS-1500 form, form locator 24 "H" must be "1", "2", or "3". Blank would be "NO".

EDIT 0140 - LABORATORY INDICATOR MUST BE Y OR N
The entry to indicate whether or not lab services were performed in the office must be either Y for yes or N for no.

EDIT 0141 - INVALID/MISSING PLACE OF SERVICE
This edit posts when field 24B on the CMS-1500 Claim Form is either blank or contains an invalid place of service code. Check the billing supplements for the valid codes list for the claim form that you are using.

EDIT 0142 - INVALID/MISSING ORIGIN CODE
The one digit numeric origin code must appear to the right of the "from" line in Item 17H on the MC-12 Claim Form (transportation). The codes are listed on the claim form in form locator 19. For EDI submitters: use the appropriate modifier to you service code that indicates the correct origin/destination combination.

EDIT 0143 - INVALID/MISSING DESTINATION CODE
The one digit numeric destination code must appear to the right of the "to" line in Item 17H on the MC-12 Claim Form. The codes are listed on the claim form in form locator 19. For EDI submitters: use the appropriate modifier to you service code that indicates the correct origin/destination combination.

EDIT 0147 - FAMILY PLANNING INDICATOR MUST BE 'Y' OR 'N'
This edit posts for EDI claims submitted with an invalid family planning indicator. Check the HIPAA Companion Guide for specifications. For CMS-1500 submitters: in form locator 24H this is equal to "2" or "3" (YES) or "1" is equal to "NO".

EDIT 0148 - RESPITE CARE EXCEEDS MAXIMUM OF 5 DAYS
If a procedure code for respite care is used, the number of days cannot exceed 5. The provider must enter the appropriate procedure code or units and resubmit the claim.

EDIT 0149 - CONTINUOUS HOME CARE BILLED LESS THAN 8 HOURS
The number of units for continuous care must be at least 8.

EDIT 0150 - INVALID PROCEDURE CODE FOR EPSDT FORM - REBILL ON CMS 1500
This edit will post to all services claimed on the MC-19 claim form, if the 1st service line is filed is not the EPSDT visit, or the EPSDT visit is not approved by Molina Medicaid Solutions. If this was not an EPSDT visit, services must be billed on the CMS-1500. If this service was a valid EPSDT visit, resubmit the valid visit and incentive codes on the MC-19 claim form and make sure all fields are completed correctly.

EDIT 0151 - INVALID/MISSING CLAIM LINE CHARGE
The dollar and cents amount must be numeric-using zeros for the cents if applicable, e.g., the entry 25- will be keyed as .25. The correct entry would be 25 00. Moreover, the $ sign should not be used.

On Hardcopy claims if there is a dotted line separating the dollar and cents amount, a decimal is not necessary. If there is no dotted line, a decimal will separate the dollar amount from the cent amount.

EDIT 0152 - INVALID/MISSING TOTAL CHARGES
This edit is posted if the total claim charge submitted by the provider is equal to zeros.

ADA	33
CMS-1500	28
UB-04	"TOTALS" line MC-6 25
MC-9	28
MC-12	20
MC-19	16

837 Institutional - 2300: CLM02@ doc level
837 Professional - 2400: SV102 @ line level
837 Dental- 2400: SV302 @ line level
NCPCP - AM11: 426-DQ

EDIT 0153 - INCORRECT TOTAL CHARGES
This edit posts when the total claim charge submitted by the provider does not equal the sum of the total claim lines. Below are the claim forms and form locators that apply:

ADA	33
CMS1500	28
MC-9	28
MC-12	20
MC-19	16
UB-04	47 (with revenue code 001)

837 Institutional- LOOP 2300 SEGMENT CLM02
837 Professional - LOOP 2300 SEGMENT CLM02
837 Dental - LOOP 2300 SEGMENT CLM02

EDIT 0154 - CO-INSURANCE AND/OR LIFETIME RESERVE DAYS CONFLICT DATE OF SERVICE
This edit posts on institutional crossover claims when the beneficiary is not eligible on the date of admission. The total number of days entered in Form Locators 9 and 10 on the UB-92 Claim Form cannot be greater than the total number of service dates recorded in Form Locator 6.

EDIT 0155 - COINSURANCE DAYS, LIFETIME RESERVE DAYS AND/OR BLOOD DEDUCTIBLE MISSING
Institutional crossover claims require an entry in at least one of these three UB-92 fields:

Form Locator 9: Numeric digit reflecting the number of co-insurance days.
Form Locator 10: Numeric digit reflecting the number of lifetime reserve days.
Form Locators 39-41: Value Code 06 and the blood deductible amount. (Only if applicable)

EDIT 0156 - COINSURANCE DAYS AND/OR LIFETIME RESERVE DAYS NOT NUMERIC
This edit posts when the coinsurance and/or lifetime reserve days are not numeric on the claim.

EDIT 0157 - ACUTE DAYS GREATER THAN 150
This edit posts when the acute days are greater than 150 and the condition code '80' is not present.

EDIT 0158 - ACUTE DAYS GREATER THAN 90
This edit posts when the lifetime reserved days are equal to 0 and the acute days are greater than 90.

EDIT 0159 - NO MEDICAID LIABILITY - MEDICARE REIMBURSES AT 100 %
Medicare pays this procedure at 100 percent. Therefore, there is no Medicaid liability.

EDIT 0160 - INVALID ANESTHESIA CLAIM - CORRECT PROCEDURE AND UNITS
This edit posts when a claim crosses over from Medicare with a procedure code that Medicaid does not recognize. The provider should resubmit the claim with a Medicaid procedure code and the Medicare EOMB. Modifier AA denotes services performed by an anesthesiologist or a certified nurse-anesthetist supervised by an anesthesiologist.

The procedure code will usually be the surgeon's primary surgical HCPCS procedure code. The provider must convert the time to units. Each fifteen-minute increment is equal to one (1) unit and fractions should not be billed. The base units are automatically added to the time units on the claim form.

EDIT 0161 - INVALID/MISSING HCPCS PROCEDURE CODE
This edit posts if the procedure code entered on the claim form is missing or invalid for NJ Medicaid.

UB-92 Outpatient Claims require a five-digit procedure code in Form Locator 44. Revenue Codes 370-379 and 720-729 may be billed without a corresponding procedure code.

EDIT 0162 - INVALID OR MISSING PROCEDURE CODE MODIFIER
This edit posts when the procedure code entered on the claim form requires a modifier, but a modifier is not present on the claim. It will also post if Medicaid does not recognize a modifier submitted on a claim form.

EDIT 0163 - PROCEDURE - SPANNING DATES OF SERVICE
This edit is posted if the procedure code billed does not allow for spanned dates of service. One date per line must be billed. Below are the form locators that apply to this edit:

ADA	24
CMS-1500	24A
MC-9	25A
MC-12	17A
MC-19	14A

837 Institutional - OP: 2400: SV202-1=HC, SV202-2 AND DTP=472, DTP03=DOS
837 Professional - SV101=HC, SV101-2 AND DTP=472, DTP03=DOS
837 Dental - SV301=AD, SV301-2 AND DTP=472, DTP03=DOS

EDIT 0165 - EMC - INVALID HCPCS PROCEDURE PREFIX
This edit posts to EDI crossover claims when the first position of the procedure code is W, X, Y or Z.

EDIT 0166 - INVALID/MISSING DIAGNOSIS CODE
This edit posts if the diagnosis code entered on the claim form is either missing or invalid. Medicaid uses ICD-9-CM coding for diagnosis.

EDIT 0167 - MISSING PRIMARY DIAGNOSIS CODE
For UB-92 claims the primary diagnosis code is required in Form Locator 67.

For TADs the primary diagnosis code is required in Item 14.

EDIT 0171 - INVALID/MISSING CARRIER CODE
The third party insurance carrier code recorded on the claim form is missing or invalid. If the beneficiary has no other insurance, field 10D on the CMS-1500 Claim Form must be blank. If other coverage exists a valid three-digit numeric code must appear.

EDIT 0172 - INVALID PAYER CODE
If the beneficiary has no other insurance, payer code 012 (Medicaid) must appear in Form Locator 50A on the UB-92 form. If other coverage and/or Medicare is primary, the three-digit payer code representing the other carrier(s) must appear in Form Locator 50A/B and payer code 012 must appear in Form Locator 50B/C. et al. Payer code 35 is no longer used for Charity Care claims.

EDIT 0173 - INVALID COINSURANCE DAYS
This edit only posts to LTC claims when Medicare is the primary payer. The provider must divide the coinsurance amount on the EOMB by the coinsurance per Diem amount. That result must equal the total days billed.

EDIT 0174 - IMP XOVER - RESUBMIT CAID CLM
This edit posts when the claim is processed as a Medicare crossover and it is not. The provider should resubmit the claim.

EDIT 0175 - BLOOD DEDUCTIBLE CHARGES MUST BE NUMERIC
Form Locator 39-41 on the UB-92 Claim Form reflects a value for blood deductible (06), but a dollar amount was not entered.

EDIT 0176 - MEDICARE DEDUCTIBLE AMOUNT MUST BE NUMERIC
Form Locator 39-41 on the UB-92 Claim Form reflects a value for Medicare deductible (A1, B1, or C1), but a dollar amount was not entered. The letter "a", "B", or "C" reflects Medicare's position as primary, secondary, or tertiary payer on the claim.

EDIT 0177 - MEDICARE CO-INSURANCE AMOUNT MUST BE NUMERIC
Form Locator 39-41 on the UB-92 Claim Form reflects a value for Medicare coinsurance (A2, B2, or C2), but a dollar amount was not entered. The letter "A", "B", or "C" reflects Medicare's position as primary, secondary, or tertiary payer on the claim.

EDIT 0178 - BLOOD DEDUCTIBLE (PINTS) MUST BE NUMERIC
This edit posts to hospital claims when the blood units deductible is not numeric.

EDIT 0179 - MISSING / INVALID COINSURANCE DAYS
This edit posts to institutional LTC crossover claims that do not contain coinsurance days.

EDIT 0180 - OTHER INSURANCE INDICATOR MUST BE Y OR N
One of the two insurance indicator boxes on the claim form must be checked to indicate whether or not the beneficiary has other coverage. Check the billing supplement for specific instructions.

EDIT 0181 - TOTAL TPL AMOUNT MUST BE NUMERIC
The dollar and cents amount must be numeric-using zeros for the cents if applicable, e.g., 25- will be keyed as .25. The correct entry would be 25 00.

If there is a dotted line separating the dollar and cents amount, a decimal is not necessary. If there is no dotted line, a decimal will separate the dollar amount from the cent amount.

EDIT 0183 - MEDICARE PAYMENT DATE IS MISSING OR INVALID
This edit posts if the Medicare EOMB provided is of poor quality and the payment date is not visible, or the EOMB might be cut, showing only the information for this beneficiary. This edit also posts if a Provider generated EOMB does not include a payment date.

EDIT 0184 - INVALID OR MISSING ADJUSTMENT REASON
This edit posts to adjustment transactions when the adjustment reason field is blank or does not contain a valid code.

EDIT 0185 - FORMER ICN NUMBER INVALID OR MISSING
This edit posts to adjustment transactions when the ICN number of the claim to be adjusted is missing or invalid.

EDIT 0186 - MEDICARE ALLOWED NOT NUMERIC OR NOT > ZERO
This edit posts when the Medicare allowed field on the claim is not numeric or the Medicare allowed field on the claim is not greater than zero.

EDIT 0187 - DEDUCTIBLE, BLOOD DEDUCTIBLE, AND/OR CO-INSURANCE AMOUNT MISSING
For UB-92 claims the cash deductible, coinsurance and/or blood deductible value codes, and corresponding dollar amounts, are required in Form Locator 39 through 41. The value codes are:

Cash Deductible: A1, B1, C1; Coinsurance: A2, B2, C2; Blood Deductible: 06

Note: The alpha character must correspond to the payer code line used in Form Locator 50. For example, if Payer Code 011 (Medicare Part A) appears in Form Locator 50A, the Part A coinsurance Value Code would be A2. If payer code 015 (Medicare Part B) appears in Form Locator 50B, then the Part B coinsurance Value Code would be B2.

EDIT 0188 - CASH DEDUCTIBLE AMOUNT EXCEEDS THE YEARLY MAXIMUM
For Outpatient Claims the Medicare cash deductible recorded in Form Locator 39-41 on the UB-92 Claim Form cannot exceed $110.00. For dates of service on or after 01/01/05.

For Inpatient Claims the Medicare cash deductible recorded in Form Locator 39-41 cannot exceed the following yearly amounts: 2005- $912.00, 2004 - $876.00, 2003 - $848.00, 2002 - $812.00, 2001 - $792.00, 2000 - $776.00.

EDIT 0189 - EXPIRATION OF CCF TIME LIMIT OR NO CHANGE INDICATED ON CCF
This edit posts to a paper submitted claim when there was a correctable error and the Provider was sent a Claim Correction Form (CCF) that was never returned or there were no changes indicated. A CCF gives a provider the opportunity to correct or complete information, which would otherwise cause the claim to deny. CCFs are mailed with the weekly Remittance Advice (RA) and they refer to specific field(s) that are incorrect. Molina Medicaid Solutions must receive them within 30 days of receipt. If the form is not received, or if the CCF does not reflect a change, the claim will deny for this edit. *Website allows 53 days before denial for non-return. See Newsletter Vol. 13 #22.

Hardcopy Claim -This edit applies to any correctable field.
HIPAA - N/A

EDIT 0190 - FIRST TWO POSITIONS OF BILL TYPE CONFLICTS WITH PAYER ID
If the first two digits of the bill type entered in Form Locator 4 on the UB-92 form is 11 (denoting Part A), then the payer code in Form Locator 50 cannot be 015 (Part B). If Part B is involved, the first two digits of the bill type of bill must be 12. If Part B is not involved, payer code 015 should not appear.

EDIT 0192 - MEDICAID NOT PRIMARY PAYER SINCE TPL AMOUNT IS GREATER THAN ZERO
If a dollar amount appears in Form Locator 54 on the UB-92 form, then the entry in Form Locator 50A cannot be 012. This Medicaid payer code must be the last one listed. If an amount was entered in Form Locator 54 in error, the provider should remove it. If another carrier remitted, then the payer code for that insurance company must appear in Form Locator 50A.

EDIT 0195 - CORRECT UNITS-15 MINUTES ANESTHESIA TIME = 1 UNIT OF SERVICE
The edit posts when the reported units for anesthesia time seem excessive. To correctly report anesthesia services, providers must use the HCPCS code for the main surgery performed and add modifier "AA". The surgical "base" units are automatically calculated based on this code. A Medical staff member reviews the claim in process and will determine whether the time billed is reasonable. The provide must report the anesthesia time units, where 1 unit is equal to 15 minutes of anesthesia services. In addition, the time in and time out of the operating room are reported in Item19 (reserved for local use) on the claim form.

EDIT 0196 - TIMELY FILING EDIT BYPASSED DUE TO CONSENT ORDER
This edit posts when the timely filing edits are bypassed due to a consent order from the State. This is an EOB message only.

EDIT 0197 - MISSING/INVALID NCPDP MAND
This edit posts to pharmacy claims when one of the new fields is not populated correctly. The field that is not populated correctly will be returned to the provider in the NCPDP reject code segment.

EDIT 0201 - SERVICING PROVIDER NOT ELIGIBLE ON DATE OF SERVICE
This edit posts when a servicing provider is not a New Jersey Medicaid participant on the claim's date of service. If the date is erroneous on the claim, the provider should correct it and resubmit.

EDIT 0202 - PROVIDER CANNOT SUBMIT THIS CLAIM TYPE
This edit is posted when a billing provider is not authorized to bill using the claim form submitted or has billed a procedure code that can not be specified on the submitted claim. This does not apply to a specific form locator.

HIPAA - N/A

EDIT 0203 - PROVIDER ON REVIEW - STATE PEND
This edit posts when the provider is under state review. This is an EOB message.

EDIT 0204 - SERVICING AND BILL/ING PROVIDER NOT LINKED ON DATE OF SERVICE
This edit posts when the Medicaid billing provider number and Medicaid servicing provider number are not linked on the claim's date of service. Check the accuracy of provider numbers reported on the claim. If this does not resolve the problem, contact Provider Enrollment to verify provider status.

EDIT 0205 - SERVICING PROVIDER IS GROUP PROVIDER
This edit posts when the Servicing Provider Number on the claim is in reality the provider number assigned to a Group Practice.

EDIT 0206 - BILLING PROVIDER NOT ON FILE
This edit posts when the billing provider number is not on file.

EDIT 0207 - BILLING PROVIDER INELIGIBLE ON DATE OF SERVICE
This edit posts when the Medicaid billing provider number is not eligible on the claim's date of service.

EDIT 0209 - GROUP MUST BILL FOR MEMBER OF GROUP
This edit posts when a servicing provider number appears in the field reserved for the billing provider.

ADA	52A & 58
CMS-1500	33A&B
MC-9	10 & 27

837 Institutional - 2010AA
837 Professional - 2010AA
837 Dental - 2010AA

EDIT 0210- PROVIDER NOT CERTIFIED FOR THIS PROCEDURE
The procedure code on the claim requires an appropriate certification on the provider's Medicaid file. Contact Provider Enrollment to update this information.

EDIT 0212 - SERVICING PROVIDER NOT ON FILE
The Provider Master File does not reflect the servicing provider number. Check the number for accuracy.

EDIT 0214 - PROVIDER NOT ELIGIBLE FOR HEALTHSTART PROCEDURES
The provider is not eligible to render HealthStart services identified by procedure codes appearing on the claim form.

EDIT 0216 - SERVICING (INDIVIDUAL) PROVIDER NUMBER REQUIRED
This edit posts when the Servicing Provider Number does not appear on the claim. It only posts when the billing (or group) provider file indicates that a servicing provider is also required, or if invalid date is entered in the servicing provider number fields on the claim form. Check the billing supplement for specific instructions.

EDIT 0217 - LTC PROVIDER NOT ELIGIBLE FOR ENTIRE PERIOD - CUTBACK
This edit posts when the provider is not eligible for the entire claim period, or when the PAS file shows a different LTC provider for some or all of the service period reported on the TAD.

EDIT 0218 - REFERRING/OTHER PHYSICIAN NOT ON FILE
This edit posts when Item 17A (referring physician) on the CMS-1500 Claim Form reflects an entry that is not a valid 7-digit Medicaid number. If the Referring Physician does not participate with NJ Medicaid, the default is 6666666 for in state providers or 5555555 for out-of-state providers.

EDIT 0219 - PROVIDER NOT AUTHORIZED PARTIAL CARE/PARTIAL HOSPITALIZATION
The provider master file indicates that this provider is not authorized for partial care or partial hospitalization services for the claim date(s).

EDIT 0220 - CLAIM SPANS FISCAL YEAR
Providers who are paid per diem cannot submit claims that span the provider's fiscal year. Two separate claims are required. The "through" service date recorded in Form Locator 6 on the first claim must be the last day of the first fiscal year. The "from" service date recorded in Form Locator 6 on the second claim is the first day of the following fiscal year. When Medicare is primary, the Medicare claims must reflect the same service periods.

EDIT 0221- PROVIDER NOT CERTIFIED/BONDED AT TIME OF SERVICE
The procedure code entered on the claim requires a specific certification on file at Molina Medicaid Solutions. Contact Provider Enrollment for instructions on how to submit the form or bond.

EDIT 0224 - PRESCRIBING PHYSICIAN/PRACTITIONER NUMBER NOT ON FILE
The seven-digit number provider number entered in the field designed for referring or prescribing physician is not on the Medicaid file. Check the number for accuracy.

EDIT 0225 - BILLING PROVIDER IS NOT A GROUP
This edit posts when different provider numbers appear in the servicing and billing provider fields, and the billing number does not reflect a group.

EDIT 0226 - BILL PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE
This edit posts when a claim is received for a billing provider listed as inactive in the system. The claim will suspend indefinitely until the provider’s status is reactivated. When a provider has had no claim activity for more than 18 consecutive months, the provider’s status will automatically be deactivated in the system. In order for services to be reimbursed after this period, the provider must contact provider enrollment to initiate reactivation.

EDIT 0227 - PROVIDER NOT APPROVED FOR EMC
This edit posts for EDI, POS or Medicare crossover claims if the provider is not eligible to submit EMC. The provider must submit hard copy claims.

EDIT 0229 - SERVICE PROVIDER DEACTIVATED DUE TO INACTIVITY 18 MO. OR MORE
This edit posts when a claim is received for a servicing provider within the group listed as inactive in the system. The claim will suspend indefinitely until the provider's status is reactivated. When a servicing provider has had no claim activity for more than 18 consecutive months, that provider's status will automatically be deactivated in the system. In order for any services provided by this provider to be reimbursed after this period, provider enrollment must be contacted to initiate reactivation.

EDIT 0230 - BILLING OR SERVICING PROVIDER NOT ALLOWED
This edit posts when the Billing or Servicing Provider is not allowed to bill on their own.

EDIT 0232 - YD MODIFIER NOT ALLOWED
The YD modifier is not allowed for the procedure code billed.

EDIT 0233 - PROVIDER NOT CERTIFIED FOR MAMMOGRAPHY
Molina Medicaid Solutions has not yet received the provider's Mammogram Certification Form, or the certification date has expired. Contact Provider Enrollment to resolve this issue.

EDIT 0236 - PROCEDURE /PLACE OF SERVICE RESTRICTION
This edit posts when the Place of Service conflicts with the Procedure code billed. Below are the claim forms and Form Locators that apply:

ADA	38
CMS1500	24B
MC-9	25K
MC-19	14B

837 Professional - Place of Service code; Loop 2300, field CML05-1 or Facility Code Value; Loop 2400, field SV105 must be valid for the Procedure Code; Loop 2400, field SV101-2, where SV101-1 = HC, and Procedure Code Modifier in fields SV101-3 and SV101-4.

837 Dental - Place of Service code; Loop 2300, field CML05-1 or Facility Code Value; Loop 2400, field SV105, must be valid for the Procedure Code; Loop 2400 field SV301-2, Procedure Code modifier, fields SV301-3 and SV301-4, and tooth number field TOO02.

EDIT 0237 - PROCEDURE/PROVIDER SPECIALTY RESTRICTION
This edit posts when the provider's specialty does not allow the procedure code billed. For example an internal medicine physician can not bill for anesthesia services. Below are the claim forms and Form Locators that apply:

ADA	29
CMS1500	24D
UB-04	43
MC-9	25B
MC-12-	17B
MC-19-	14D

837 Institutional - LOOP 2000A PRV SEGMENT
837 Professional - LOOP 2000A PRV SEGMENT; LOOP 2310A PRV SEGMENT; LOOP 2310B PRV SEGMENT; LOOP 2420A PRV SEGMENT
837 Dental - LOOP 2000A PRV SEGMENT; LOOP 2310A PRV SEGMENT; LOOP 2310B PRV SEGMENT; LOOP 2420A PRV SEGMENT

EDIT 0238 - PROCEDURE CODE NOT SUBSTANTIATED BY DOCUMENT
The procedure code billed requires either an operative report and/or pathology report attached to the claim. These documents were either not attached or did not substantiate the procedure code.

EDIT 0239 - ALTERED DOCUMENTATION-ORIGINAL PRICE LIST OR INVOICE NEEDED
The document(s) attached to the claim was (were) altered. The provider should resubmit with an original price list or invoice.

EDIT 0241 - 22 MODIFIER NOT JUSTIFIED/PAID AT UNMODIFIED RATE
Using the 22 modifier was not justified. The provider may submit an adjustment form (FD-999), along with documentation, to support the request for unusual services.

EDIT 0242 - SPECIAL PROGRAM/PROCEDURE CODE RESTRICTION
This edit posts when the beneficiary is in a special program and the procedure code billed is not consistent with the special program.

EDIT 0243 - PROVIDER NOT AUTHORIZED - TARGETED CASE MANAGEMENT
The servicing provider is not authorized to bill for Adult Clinical Case Management or Adult Liaison Services.

EDIT 0245 - ATTACHMENT REQUIRED OR INCORRECT ATTACHMENT FOR PROCEDURE
The procedure code on the claim requires specific documentation.

EDIT 0246 - PROLONGED DETENTION BILL
This edit posts when the claim is pending for a medical review.

EDIT 0247 - REVENUE CODE/PROCEDURE CODE ON CLAIM CONFLICTS WITH CLAIM TYPE
The revenue code or procedure code billed on the claim is not allowed for this claim type.

EDIT 0248 - ICD9 PROCEDURE CODE NOT ON FILE
Medicaid does not recognize the surgical procedure code billed on the UB-92 Claim Form in Form Locator 80 or 81.

EDIT 0251 - DENY FOR DIAGNOSIS
This edit posts when the diagnosis code reported does not support the procedure code billed.

EDIT 0252 - PROCEDURE, REVENUE, NDC, OR DIAGNOSIS CODE REQUIRES REVIEW
The procedure code, revenue code, NDC code or diagnosis code entered on the claim requires review. The provider should submit the claim hardcopy, not EMC.

EDIT 0253 - REVENUE/PROCEDURE NOT ACTIVE ON DATE OF SERVICE
The revenue code or procedure code entered on the claim is not valid on the date of service.

EDIT 0254 - PROCEDURE CODE/AGE RESTRICTION
The procedure code, revenue code, NDC code or diagnosis code is restricted to a specific age group. This edit posts when the beneficiary's age is not consistent with the code(s) billed.

EDIT 0255 - PROCEDURE SEX RESTRICTION
The procedure code, revenue code, NDC code or diagnosis code is restricted to one sex. This edit posts when the beneficiary's sex is not consistent with the code(s) billed.

EDIT 0256 - PROCEDURE MODIFIER REQUIRED
The procedure code entered on the claim requires an appropriate modifier.

EDIT 0257 - PROC/NDC/REV/ICD9 NOT COVERED BY MEDICAID
Medicaid does not cover the procedure code, revenue code, NDC code or diagnosis code entered on the claim.

EDIT 0258 - AMBULATORY SURGICAL CENTER - DAYS/DATES INCONSISTENT
The "from" service date and the "to" date entered in item 24A on the CMS-1500 form must be identical. Moreover, the number of units entered in item 24G must be 1.

EDIT 0259 - HCPC PROCEDURE CODE NOT ON FILE
Medicaid does not recognize the procedure code entered on the claim form.

EDIT 0260 - DIAGNOSTIC REPORT (X-RAYS, LAB, ETC) REQUIRED
Medical review determined that a diagnostic report, e.g., X-ray report, lab reports etc. is required. The provider should resubmit the claim with the clarifying report(s).

EDIT 0261 - OPERATIVE, HISTORY AND/OR PATHOLOGY REPORT REQUESTED
Medical review determined that an operative report, a pathology report or the medical history report is required. The provider should resubmit the claim with the clarifying report(s).

EDIT 0262 - REFERRING/OTHER PHYSICIAN REQUIRED - CONSULT 2ND OPINION
This edit posts when the procedure code denotes a consultation or second opinion visit. These services require a referring physician. The doctor's name and seven-digit Medicaid Provider number must appear in Items 17 and 17A respectively on the CMS-1500 Claim Form. If the doctor does not participate with New Jersey Medicaid, the default is 6666666 for an in state doctor or 5555555 for an out-of-state provider.

EDIT 0263- NON-COVERED SERVICE FOR SPECIAL PROGRAM CODE
This edit posts when the beneficiary has alien status and the service billed is not an emergency. Services for aliens are limited to emergency care, labor and delivery. The provider may resubmit with a completed FD-80 form attached to explain and document the emergency condition.

This edit will also post for premium support beneficiaries. It indicates that the billed service is not covered by the beneficiary's Family Care program.

EDIT 0264 - SPECIAL PROGRAM CODE - REVIEW ATTACHMENT
This edit will post when a service for an alien is determined to be a non-emergency. However, there is an attachment to the claim that will be reviewed. If it is not the required FD-80 form, the claim will deny for edit 263.

This edit will also post for claims involving premium support beneficiaries. It indicates that the claim is in process pending review of the other insurance EOB.

EDIT 0265 - MISSING ASC LEVEL DATA
This edit posts if the claim is for an ambulatory surgical center and the code is not valid.

EDIT 0266 - NOT AN SAI COVERED SERVICE
The billing provider is a Workfirst NJ/SAI provider. This special program does not cover the procedure code entered on the claim form.

EDIT 0267 - PROCEDURE CODE DOES NOT WARRANT ANESTHESIA SERVICES
Modifier AA, indicating anesthesia services, cannot be billed with this procedure code.

EDIT 0268 - ANESTHESIA UNITS NOT ON PROCEDURE FILE FOR DATES OF SERVICE
This edit posts when the anesthesia procedure code was not active on the claim service date. Base units cannot be calculated.

EDIT 0270 - HEPATITIS 'A' NON-COVERED SERVICE
This edit posts after a State review, if the procedure is 90730 and is used for routine immunization this claim will deny.

EDIT 0271- SUBMITTER NOT APPROVED FOR PROVIDER
The provider is not authorized to submit claims electronically on the claim's date of service.

EDIT 0272 - USE PROPER PROCEDURE CODE
This edit post when the procedure code used is invalid.

EDIT 0273 - PROCEDURE DOES NOT WARRANT SURGICAL ASSISTANT
The procedure code billed does not permit reimbursement to a surgical assistant. Make sure that the modifier is correctly codes.

EDIT 0275 - RADIOLOGY SERVICES REQUIRE REFERRING PHYSICIAN
This edit posts when a specific radiology service requires that a referring physician be indicated on the claim on the appropriate field. This edit only applies to the forms indicated below:

CMS 1500 17A&B

837 Professional-2310A: NM109 Missing

EDIT 0276 - UTILIZATION EXCEEDS ESTABLISHED PARAMETERS
This Medicaid maximum limit is exceeded. This edit posts to pharmacy claims for condoms.

EDIT 0277 - REFERRING PROVIDER NUMBER REQUIRED
The referring physician's seven-digit Medicaid number must be entered on the claim form. If the doctor does not participate with New Jersey Medicaid, 6666666 is the default for in-state doctors and 5555555 for out-of-state doctors.

EDIT 0278 - PROVIDER NOT AUTHORIZED FOR THIS PROCEDURE
This edit posts for procedure codes 59855 or 59856 with modifiers WZ and 22 when the provider number is not 2979802.

EDIT 0279 - DENIED AS A RESULT OF PREPAYMENT REVIEW BY DMAHS
This edit posts when a state reviewer denies payment for a claim previously in process for edit 203. For POS, it indicates that the state reviewer denied payment for this previously approved claim. This is an EOB message.

EDIT 0281 - POS VOID PROVIDER-ON-REVIEW
This edit posts when the claim being voided is for a provider on review.

EDIT 0283 - PROVIDER LIMITED TO NON DYFS BENEFICIARIES
This edit posts to a Long Term Care claim and the 3rd and 4th digits of the Medicaid ID number are '60'.

EDIT 0284 - PRIVATE DUTY NURSING - SPANNING DATES OF SERVICE
The "from" date of service date and the "to" date entered in item 24A on the CMS-1500 Claim Form must be the same.

EDIT 0285 - HOSPICE RECIPIENT IS NOT MEDICARE ELIGIBLE
Hospice Procedure codes Y6339 and Y6343 can only be billed if beneficiary is eligible for Medicare.

EDIT 0287 - HOSPICE RELATED CLAIM
This edit posts to a claim when the beneficiary is enrolled in the Hospice Waiver.

EDIT 0288 - VETERANS HOME RESIDENT, NON-COVERED SERVICE
Beneficiaries who reside in a New Jersey Veterans Home are only eligible to receive pharmaceutical services. No other Medicaid services are available.

EDIT 0289 - PAYMENT BASED ON PLACE OF SERVICE
This edit posts when the claim is a professional claim without a '26' modifier and the procedure codes is within the range of 91000 - 97799, and a place of service of '0', '3', '7'. The system will automatically plug in a '26' modifier and price the claim accordingly.

EDIT 0290 - INVALID SECONDARY DIAGNOSIS
Medicaid does not recognize the secondary diagnosis code entered on the claim form.

EDIT 0294 - DIAGNOSIS NOT VALID AS PRIMARY DIAGNOSIS
A diagnosis code beginning with E cannot be used as the primary diagnosis code.

EDIT 0295 - INVALID THIRD, FOURTH, OR FIFTH DIAGNOSIS
Medicaid does not recognize one or more diagnosis codes entered on the claim form.

EDIT 0296 - DIAGNOSIS CODE IS NOT ON FILE
Medicaid does not recognize the primary diagnosis code entered on the claim form.

EDIT 0297 - PROVIDER NOT ENROLLED IN CLIA
The billed services are payable only to providers whose Medicaid provider file includes a CLIA certificate. The provider's profile does not reflect this data element.

EDIT 0298 - PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE
The eligibility dates on the CLIA certificate recorded on the Medicaid Provider file do not include the claim date(s) of service.

EDIT 0299 - SERVICE PROVIDER NOT ELIGIBLE TO PERFORM THIS PROCEDURE
The provider's CLIA certificate is on file, but the certification level does not cover the procedure code billed.

EDIT 0300 - HMO COVERED SERVICE
This beneficiary is enrolled in an HMO on the claim date of service, and this is an in-plan service. It must be billed to the beneficiary's HMO. If the provider has received a denial from a HMO already; check the eligibility hotline 1-800-676-6562 to verify the correct HMO for this beneficiary. If the correct HMO denied the claim, appeal to the HMO. If this still does not resolve the issue, contact DMAHS Managed Care Unit at 1-800-356-1561 for assistance.

EDIT 0301 - RECIPIENT INELIGIBLE ON DATES OF SERVICE

This edit posts when the Beneficiary is not eligible for the date(s) of service listed on the claim. A provider may verify eligibility by calling REVS at 1-800-676-6562, or logging onto E-MEVS. This does not apply to any specific form locator for hardcopy claims.

837 Institutional Relational edit I/P: 2010BA-NM1-09 & 2300-DTP-01=435, . O/P: 2010BA-NM1-09, 2400-DTP-01=472, DTP-02=DOS
837 Professional - *R: 2010BA-NM1-09, 2400-DTP-01=472, DTP-02=DOS
837 Dental - *R: 2010BA-NM1-09, 2400-DTP-01=472, DTP-02=DOS
NCPCP - AM04-302-C2, 303-C3, 401-D1

EDIT 0302 - NAME MISMATCH

This edit posts when the beneficiary's last name entered on the claim form does not match the recipient eligibility file. Below are the claim forms and form locators that apply.

ADA	12
CMS1500	2
MC-6	5
MC-9	1
MC-12	1
MC-19	1
LTC TAD	3
UB-04	58

837 Institutional - The Beneficiary's last name entered on the claim must match the recipient eligibility file. Correct the last name (Loop 2010BA; Segment NM1, field NM103) on the claim and resubmit.
837 Professional - The Beneficiary's last name entered on the claim must match the recipient eligibility file. Correct the last name (Loop 2010BA; Segment NM1, field NM103) on the claim and resubmit.
837 Dental - The Beneficiary's last name entered on the claim must match the recipient eligibility file. Correct the last name (Loop 2010BA; Segment NM1, field NM103) on the claim and resubmit.
NCPCP - The following information in the claim must match the recipient eligibility file for the patient. AM01 Patient Segment; fields 304-C4, 305-C5, 310-CA or 311-CB.

EDIT 0303 - RECIPIENT IS SERVICE OR PROVIDER RESTRICTED

This edit posts to pharmacy claims when the recipient is restricted to another provider.

EDIT 0304 - CLAIM TYPE IS NOT COVERED FOR PRESUMPTIVELY ELIGIBLE RECIPIENT

This recipient is not eligible for inpatient hospital services. chiropractor, or Long Term Care.

EDIT 0305 - CCPED OR HCEP NON-COVERED SERVICE

The beneficiary is enrolled in the CCPED or HCEP program, and these special programs do not cover the billed service.

EDIT 0306 - MEDICAID RECIPIENT ID CORRECTED
This edit posts when the beneficiary's Medicaid number submitted on the claim has been updated by the system to reflect the most correct Medicaid Identification Number. Below are the claim forms and form locators that apply:

ADA	15
CMS1500	1A
MC-6	1 & 2
MC-9	3 & 4
MC-12	3 & 4
MC-19	8
LTC TAD	5
UB-04	60

837 Institutional -	The Beneficiary's ID number; Loop 2010BA, field NM109 is to Match the eligibility file for the eligibility period being billed.
837 Professional -	The Beneficiary's ID number; Loop 2010BA, field NM109 is to match the eligibility file for the eligibility period being billed
837 Dental -	The Beneficiary's ID number; Loop 2010BA, field NM109 is to match the eligibility file for the eligibility period being billed.
NCPDP -	The Beneficiary's ID number; AM04 Segment, fields 302-C2 (the first 10 digits of the Beneficiary's ID or the 16 digit HBID Card Number) and 303-C3 (the 2 digit Person Code) are to match the eligibility file for the eligibility period being billed.

EDIT 0308 - INELIGIBLE SERVICES UNDER MEDICALLY NEEDY PROGRAM
The billed service is not payable when rendered to a beneficiary enrolled in the Medically Needy program.

EDIT 0309 - GSHP SERVICES ARE OUT OF PLAN
This edit posts when the beneficiary has GSHP and the services are one of the following; Long Term Care, Medical Day Care, Prosthetic and Orthotic, Transportation, or Dental.

EDIT 0310 - GSHP RECIPIENT - NOT ELIGIBLE FOR LTC SERVICES
This edit posts when the beneficiary is GSHP and not eligible for Long Term Care services.

EDIT 0311 - CORRECT DOB OR RESUBMIT CLAIM UNDER BABY'S NUMBER
According to the Newborn Plus 60 Program, service to newborns may be billed using the qualified mother's beneficiary number through the end of the month in which the baby becomes 60 days old. This edit may post when:

1. The date of birth on the claim does not match the date of birth on the eligibility file.

2. The mother's date of birth is entered on the baby's claim. Enter the baby's date of birth.

3. The procedure code entered on the claim form is restricted to newborns, but the beneficiary is not a newborn.

4. The date of service is more than 60 days from the date of birth entered on the claim. The provider must resubmit with baby's beneficiary number entered accordingly.

EDIT 0312 - CORRECT RECIPIENT NUMBER AND RESUBMIT
This edit posts when the beneficiary number being used is not valid and the provider must rebill using the correct identification number.

EDIT 0314 - CLAIM SERVICE DATES OVERLAP SPECIAL PROGRAM ELIGIBILITY
This edit posts when the beneficiary is eligible for a special program after the first date of service on the claim. The provider may resubmit two separate claims, one with the date of service prior to the special program begin date and the other with the dates of service on and/or after the special program begin date.

EDIT 0315 - RECIPIENT ON REVIEW
This edit posts when the beneficiary is on review with the State.

EDIT 0316 - LOCK-IN AUTHORIZATION FORM INCORRECT OR INCOMPLETE
Under the Medicaid lock-in policy this beneficiary is restricted to another pharmacy. The attached State form (SSP-14) authorizing Molina Medicaid Solutions to override Edit 303 does not meet established guidelines.

EDIT 0318 - MED NEEDY SPENDDOWN RECIP - ATTACHMENT REVIEW
This edit posts when the dates of service on a claim are within the spend down period for a medically needy beneficiary, and the claim attachment requires review.

EDIT 0319 - INCORRECT/MISSING MEDICALLY NEEDY TRANSMITTAL FORM
This edit posts when the data on the Medically Needy Transmittal Form (FD-311) does not match the data on the claim form, or the form is completed incorrectly.

EDIT 0320 - MEDICALLY NEEDY SPENDDOWN - NO ATTACHMENT PRESENT
This is a Medically Needy beneficiary with a spend down dollar amount. The Medically Needy Transmittal Form (FD-311) must be attached to the claim.

EDIT 0321 - RECIPIENT NOT ON FILE
This edit is posted if the Medicaid ID Number submitted on the claim could not be located. The correct ID number should be located by utilizing REVS, eMEVS or MEVS.

ADA	15
CMS-1500	1A
UB04	60
MC-6	1 & 2
MC-9	3
MC-12	3
MC-19	8
LTC/TAD	5

837 Institutional- 2010BA: NM1-09
837 Professional - 2010BA: NM1-09 837 Dental - 2010BA: NM1-09
NCPDP - AM04: 302-C2, 303-C3

EDIT 0322 - HMO COVERED SERVICE - REVIEW REQUIRED
This edit posts when the claim shows an HMO covered service and the State needs to review.

EDIT 0323 - SERVICE COVERED BY HMO - NO MEDICAID PAYMENT DUE
This beneficiary is enrolled in an HMO, and the service is covered by the HMO capitation payment.

EDIT 0324 - HMO ATTACHMENT INVALID
This edit posts after someone reviews the claim and determines that the service is covered by the HMO.

EDIT 0325 - RECIPIENT INELIGIBLE
This edit posts when the service is not covered by the HMO and the provider send it to Medicaid. If the beneficiary's plan either has limits to a benefit or not covered under that plan then, the beneficiary is not covered by the HMO or Medicaid for that service.

EDIT 0326 - LTC RECIPIENT NOT ON FILE
The beneficiary number entered in Item 5 on the TAD is not on the beneficiary file. Check the beneficiary's ID number reported for accuracy. The provider may verify the number by calling REVS @ 1-800-676-6562.

EDIT 0327 - HMO BENEFITS EXHAUSTION UNDOCUMENTED
This edit posts when the recipient is enrolled in managed care and the service billed is considered in-plan. However, an Exhaustion of Benefits letter does not document HMO benefits exhaustion.

EDIT 0328 - MHC RECIPIENT - NO MEDICAID ELIGIBILITY
This edit posts when the eligibility file indicates that no Medicaid eligibility exists for this Managed Health Care recipient for this period.

EDIT 0330 - HYSTERECTOMY DID NOT MEET PROGRAM REQUIREMENTS
This edit posts when a review of the hysterectomy form and claim form determined the hysterectomy program requirements were not met.

EDIT 0331 - SECOND OPINION REQUIRED
This edit posts when the surgical procedure performed required a second opinion and a second opinion or second opinion waiver was not obtained prior to the surgery date. In addition, an attachment confirming that this was an emergency situation was not included with the claim.

EDIT 0332 - STERILIZATION IS NOT COVERED FOR RECIPIENT UNDER 21
This edit posts when a sterilization procedure was performed on a recipient who is less than 21 years old. Medicaid will not pay for a sterilization procedure performed on a minor.

EDIT 0333 - INVALID/MISSING 2ND OPINION INDICATOR
This edit post when the claim is missing or has an invalid 2nd opinion indicator.

EDIT 0334 - DATE OF CONSENT MUST BE AT LEAST 30 BUT NOT GREATER THAN 180 DAYS FROM DATE OF SERVICE
This edit posts when the date the beneficiary signed the Sterilization Consent form is less than 30 days or more than 180 days from the date of surgery.

EDIT 0335 - ABORTION CERTIFICATE FORM REQUIRED
This edit posts when the procedure code represents an abortion, "incomplete" abortion, or "missed" abortion. For abortion procedures, the provider must attach the Physician Certification form (FD-179). If an abortion was not induced, the operative report and discharge summary must be attached to confirm this.

EDIT 0336 - ABORTION REQUIRES REVIEW
This edit is posted if the ICD-9 or HCPCS procedure code is an abortion related procedure. A review of the certification form is required. This does not apply to any specific form locator.

EDIT 0337 - CONSENT FORM REVIEW
This edit posts when the Sterilization Consent Form (7473-M) submitted requires review.

EDIT 0338 - HYSTERECTOMY REQUIRES REVIEW
This edit posts when the procedure requires a review of the Hysterectomy Receipt of Information Form (FD-189).

EDIT 0339 - SECOND OPINION NOT OBTAINED
The State requires the beneficiary to seek a second opinion before this surgery. The Second Opinion form was not attached to the claim. There are two exceptions to the Second Surgical Opinion requirement:

1 The surgery was an emergency, in which case an Operative Report, Discharge Summary and a letter from the attending physician indicating that the emergency surgery was necessary, are required.

2. The surgery was due to cancer, in which case a Pathology Report and History, as well as a Physical Exam record are required.

EDIT 0340 - ABORTION CERT FORM DATA INCORRECT/MISSING OR ILLEGIBLE
This edit posts when the data on the Abortion Certification form is incorrect, missing or is not legible. Check the billing supplement for specific instructions.

EDIT 0342 - RECIPIENT DATES, SIGNATURE MISSING ON HYSTERECTOMY FORM
This edit posts if the recipient's signature and/or signature date is not on the Hysterectomy form. Check the billing supplement for instructions.

EDIT 0344 - PHYSICIAN SIGN/NUMBER DATES MISSING ON ABORTION FORM
This edit posts when the physician's signature and/or the Medicaid provider number are not on the Abortion Certification Form. It will also post when the physician does not date the form. Check the billing supplement for specific instructions.

EDIT 0345 - MISSING ABORTION PROCEDURE CODE
This edit posts when Condition Code A7 (induced abortion, danger to life) or A8 (induced abortion, victim rape/incest) is entered in Form Locator 24-30 on the UB-92 (or Form Locators 18-28 on the UB-04) Claim Form, but the claim does not include an abortion surgical procedure code. The provider must either remove the condition code or enter a correct procedure code.

EDIT 0349 - SECOND OPINION FORM INCOMPLETE, MISSING DATA OR IS OUT OF DATE
This edit posts when the Second Opinion form has incorrect or missing data and/or the data was not legible and/or the surgery date was more than a year after the second opinion referral was issued. Check the billing supplement for examples.

EDIT 0351 - RECIPIENT AGE AT THE TIME OF STERILIZATION CONSENT DATE IS LESS THAN 21
New Jersey Medicaid policy does not cover a sterilization procedure when the consent form is signed before the recipient's twenty-first birthday. The date of birth on the recipient's eligibility file was compared to the date of consent, and it was determined that the recipient was underage when the form was signed.

EDIT 0353 - STERILIZATION CONSENT FORM DATA INCORRECT/MISSING
After a medical review of the Sterilization Consent form, it was determined that required data is either missing, incomplete or not legible. Check the billing supplement for the specific instructions to complete this form.

EDIT 0354 - HYSTERECTOMY REQUIRES ATTACHMENT
This edit posts when the billed procedure code denotes a hysterectomy and the Hysterectomy Receipt of Information Services Form (FD-189) is missing. Check the billing supplement for the specific instructions to complete this form.

EDIT 0355 - STERILIZATION FORM REQUIRED
This edit posts when the procedure code denotes a sterilization procedure and the Sterilization Consent Form (7473-M) is missing. If the procedure did not leave the beneficiary in a sterile condition, attach an operative report and discharge summary that will support this.

EDIT 0356 - RECIPIENT/PHYSICIAN DATE, SIGNATURE MISSING ON STERILIZATION FORM
This edit posts when the recipient's and/or physician's signature, or the respective date of signature(s), is missing from the (7473-M) Sterilization Consent Form. Check the billing supplement for the specific instructions to complete this form.

EDIT 0357 - HYSTERECTOMY RECEIPT OF INFORMATION FORM - DATA INCORRECT, MISSING OR ILLEGIBLE
This edit posts when the required data on the Hysterectomy Receipt of Information form is incorrect, missing or not legible. Check the billing supplement for the specific instructions to complete this form.

EDIT 0358 - SECOND OPINION DATE RESTRICTION
This procedure requires a second opinion prior to the date of service. The provider must attach the Second Opinion form to the claim.

EDIT 0359 - SECOND OPINION DATE AND AGE RESTRICTION
This procedure requires a second opinion when a beneficiary is age 19 or older. The provider must attach the Second Opinion form to the claim.

EDIT 0360 - PHYSICIAN SIGNATURE OR DATE MISSING ON SECOND OPINION FORM
This edit posts when the Second Opinion form is either not signed and/or not dated by the doctor.

EDIT 0361 - INSUFFICIENT MEDICAL DOCUMENTATION FOR HYSTERECTOMY
This edit posts when the documentation submitted with the (FD-189) Hysterectomy Receipt of Information Form is not sufficient. The Hysterectomy Receipt of Information Form may be waived if the beneficiary was sterile prior to the surgery only if a signed, dated statement from the physician indicating this is attached.

EDIT 0362 - CLAIM IS POSSIBLE STERILIZATION
This edit posts to EDI claims only. The procedure code denotes a possible sterilization; if the procedure was voluntary, the provider must resubmit the claim using the CMS 1500 (paper claim form), along with the (7473-M) Sterilization Consent Form. If the procedure was involuntary, the provider must resubmit the claim using the CMS 1500 (paper claim form), along with the Operative and Discharge Summary reports attached. These documents must include the beneficiary's name and surgery date.

EDIT 0363 - CLAIM IS POSSIBLE ABORTION
This edit posts to EDI claims only. The procedure code denotes a possible abortion. If an abortion was induced, the provider must resubmit the claim using the CMS 1500 (paper claim form), along with the (FD-179) Abortion Certification form. If no abortion was performed, the provider must resubmit the claim using the CMS 1500 (paper claim form), along with the Operative and Discharge Summary reports attached. These documents must include the beneficiary's name and surgery date.

EDIT 0364 - CLAIM SPANS HMO ENROLLMENT
The claim dates of service are spanned. During this span the beneficiary enrolled in a Medicaid HMO. The provider should call REVS at 1-800-676-6562 to determine the HMO effective date. The provider may bill fee-for-service for the appropriate dates.

EDIT 0371 - CSOCI (UNABLE TO DETERMINE)
This edit is for CSOCI services. The claim is pending for an internal review in order to determine if the service billed is covered by CSOCI.

EDIT 0373 - CSOCI (NON-COVERED SERVICE)
This edit posts when a provider bills under a CSOCI number and is seeking reimbursement for a service other than an allowable mental health service.

EDIT 0374 - SERVICE UNITS MUST BE >1 AND
This edit will post if the service units are not greater than 1 and less than 6.

EDIT 0380 - CLAIM SUBMITTED FFS - SERVICE IS IN-PLAN (MANAGED CARE)
This edit posts when the beneficiary is enrolled in a HMO and the service is in-plan. The provider should not bill Medicaid fee-for-service. The provider should call REVS at 1-800-676-6562 or logon to E-MEVS to determine which HMO the beneficiary is enrolled in; providers must participate with that HMO in order for the claim to be considered for payment. This edit does not apply to any specific form locator for hard copy claims.

837 Institutional -	Service = From Date Loop 2300; fields DTP03, where DTP01 = 434 and DTP02 = D8 or RD8 and Thru Date Loop 2300; fields DTP03, where DTP01 = 434 and DTP02 = RD8. Beneficiary = Loop 2010BA; fields where NM102 = 1, NM103 = Last Name, NM104 = First Name, NM109 = 12-digit Medicaid ID Number or 9-digit Social Security Number for Charity Care or 10-position SBI (State Bureau Identification) identifier for Depart of Corrections.
837 Professional -	Service = Loop 2400; field SV101-2, where SV101-1 is HC), and Procedure Code Modifiers, fields SV101-3 and SV101-4. Beneficiary = Loop 2010BA; fields where NM102 = 1, NM103 = Last Name, NM104 = First Name, NM109 = 12-digit Medicaid ID Number or 9-digit Social Security Number for Charity Care or 10-position SBI (State Bureau Identification) identifier for Depart of Corrections.
837 Dental -	Service = Loop 2400; fields SV301-2, Procedure Code Modifier SV301-3 and SV301-4 and same Tooth Number field TOO02. Beneficiary = Loop 2010BA; fields where NM102 = 1, NM103 = Last Name, NM104 = First Name, NM109 = 12-digit Medicaid ID Number or 9-digit Social Security Number for Charity Care or 10-position SBI (State Bureau Identification) identifier for Depart of Corrections.
NCPCP-	Service = Transaction Header Segment; field 401-D1, AM07 Claim Segment; field 407-D7. Beneficiary = AM01 Patient Segment; fields 310-CA = First Name, 311-CB = Last Name, AM03 Insurance Segment; fields 302-C2 = First 10-digits of Beneficiary ID or 16-digit HBID Card Number, 303-C3 = Last 2-digits of Beneficiary ID.

EDIT 0385 - FAMILY CARE NON-COVERED SERVICE
This service is not payable under the New Jersey Kid-Care/Family-Care programs. Check the website for appropriate Newsletter to determine covered services.

EDIT 0387 - BILLING PROVIDER NOT ENROLLED IN CLIA
The procedure code on the claim requires the provider to have CLIA certification. This edit posts when this data element does not exist on the provider file.

EDIT 0388 - BILLING PROVIDER NOT CLIA ELIGIBLE ON DATE OF SERVICE
The procedure code on the claim requires CLIA certification. This edit posts when the provider's CLIA certification does not include the claim service date.

EDIT 0389 - BILLING PROVIDER NOT ELIGIBLE TO PERFORM THIS SERVICE
The procedure code on the claim requires CLIA certification. This edit posts when the provider's CLIA certification is not the appropriate level to perform this procedure.

EDIT 0390 - COUNTY OF RESIDENCE NOT IN RANGE FROM 01-21
Home based hospice services, identified by procedure codes (codes are expired, use T2042), are only payable for a beneficiary who does not reside in an institution and who is eligible for Medicaid through a county-based Medical Assistance program. The first two digits of the beneficiary's Medical Assistance Identification Number must be 01-21, denoting the county code.

EDIT 0391 - PREMIUM SUPPORT - BILL OTHER INSURANCE
This edit posts to pharmacy claims for premium support beneficiaries. It indicates that the pharmacist must bill the other insurance.

EDIT 0394 - MEDICARE ENROLLMENT REQUIRED TO RECEIVE PAAD / SR GOLD PAYMENT
This edit posted because the pharmacy provider must be enrolled in Medicare before PAAD (Pharmaceutical Assistance to the Elderly or Disabled) or Senior Gold claims can be paid by these programs.

EDIT 0395 - INITIAL PRESCRIPTION LIMITED TO A 34-DAY SUPPLY
The maximum days supply for original prescriptions is 34. For refills only, Medicaid beneficiaries may receive a supply exceeding 34 days or 100 units of a prescribed medication - whichever is greater.

EDIT 0396 - REFILL RX LIMITED TO 34 DAYS / 100 UNITS
This edit posts on refill pharmacy claims when the days supply exceeds 34 and the number of units exceeds 100. Both parameters cannot be exceeded.

EDIT 0401 - DATE OF SERVICE IS LESS THAN THE DATE OF BIRTH
This edit posts when the claim date of service is earlier than the beneficiary's date of birth on the Medicaid eligibility file.

EDIT 0403 - DURATION AT THIS DOSAGE EXCEEDED
This edit posts to Point of Sale pharmacy claims only. It establishes DUR standards for the duration of the drug based on the generic code or specific therapeutic class.

EDIT 0404 - DURATION STANDARD EXCEEDED- POSSIBLE CUTBACK
This edit posts to Point of Sale pharmacy claims only. It establishes DUR standards for the duration of the drug based on the generic code or specific therapeutic class.

EDIT 0405 - THERAPEUTIC DUPLICATION
This edit is usually due to the pharmacist filing a claim for a drug that is in the same therapeutic class or category with an existing medication on the Beneficiary's profile. A review of the other drugs on the profile similar to the one being processed could provide an answer to this edit. In the event the original prescription

was filled at a different pharmacy, then there is no way to know this and the pharmacist would have to depend on the MEP representative for guidance.

EDIT 0406 - INAPPROPRIATE UNITS; BULK SOLUTION IS MORE THAN 100cc
This edit posts to pharmacy claims for compound drugs when the drug form is 2 (liquid) and the package size is greater than 100.

EDIT 0407 - THERAPEUTIC DUPLICATION CLAIM THRESHOLD EXCEEDED
This edit is usually due to the pharmacist filing a claim for a drug that is in the same therapeutic class or category with an existing medication on the Beneficiary's profile. A review of the other drugs on the profile similar to the one being processed could provide an answer to this edit. In the event the original prescription was filled at a different pharmacy, then there is no way to know this and the pharmacist would have to depend on the MEP representative for guidance.

EDIT 0408 - PRIOR AUTHORIZATION NUMBER INVALID
This edit posts if the prior authorization number entered on the claim is invalid. It must be 10 numeric digits in length and begin with 01 through 15.

ADA	2
CMS-1500	23
UB-04	63
MC-9	verify top right pre-printed number
MC-12	verify top right pre-printed number

837 Institutional - 2300/REF
837 Professional - 2300/REF
837 Dental - 2300/REF NCPDP - 462-EV

EDIT 0409 - PROSTHETIC AND/OR ORTHOTIC CHARGES REQUIRES PA
This edit posts when charges exceed the following limits and no prior authorization is on file: Prosthesis with a charge of $1,000.00 or more; Orthotics with a charge of $500.00 or more; Replacement part(s) with charge of $250.00 or more.

EDIT 0413 - 2 PRESCRIPTIONS REMAIN WITHOUT THE NEED FOR PRIOR AUTHORIZATION
This edit posts when only two prescriptions remain before prior authorization for additional prescriptions must be obtained.

EDIT 0414 - 1 PRESCRIPTION REMAINS WITHOUT THE NEED FOR PRIOR AUTHORIZATION
This edit posts when only one prescription remains before prior authorization for additional prescriptions must be obtained.

EDIT 0415 - NO PRESCRIPTIONS REMAIN WITHOUT THE NEED FOR PRIOR AUTHORIZATION
This edit posts when no additional prescriptions may be dispensed without prior authorization.

EDIT 0416 - PRESCRIPTION VOLUME EXCEEDS THRESHOLD - PA REQUIRED
This edit posts when the number of prescriptions a beneficiary may have during a one-month period has been reached.

EDIT 0417 - MANDATORY GENERIC
This edit will post when a pharmacist inputs a brand name claim for a product that has a multisource generic equivalent available. If the prescriber indicates "Brand Medically Necessary" on the prescription, the

pharmacist should alert the prescribing provider to contact Molina Medicaid Solutions MEP (1-877-888-2939) to justify the use of the brand medication and obtain a PA if approved. If this was in error (pharmacist not aware of generic availability), a quick review of available generic NDCs for the product should resolve this.

EDIT 0419 - CLAIM PROCESSED AS ADDP
This claim was billed as a WFNJ/GA or NJFL claim. This edit posts when the claim is paid with funds from the ADDP program.

EDIT 0420 - CLAIM PAYABLE BY WFNJ/GA OR FC
This edit posts when the submitted claim is paid under the WFNJ/GA or FC program.

EDIT 0421 - SERVICE UNITS VALUE FACTORED FOR PROCESSING
This is an Explanation of Benefit (EOB), which posts to indicate that the units reported on the paper Remittance Advice Statement represent the number of the actual units reported on the claim form divided by 10. The approved amount on the RA was calculated from the total units reported on the original claim.

EDIT 0423 - MEDICAID PRIOR AUTHORIZATION REQUIRED
This edit is posted to claims that require a Prior Authorization based on the service billed. The claim did not contain a PA Number In the appropriate field. Below are the form locators related to this edit.

ADA	2
CMS-1500	23
UB-04	63
MC-9	verify top right pre-printed number
MC-12	verify top right pre-printed number

837 Institutional - 2300-REF-01=G1, REF-02=PA#
837 Professional - 2300-REF-01=G1, REF-02=PA#
837 Dental - 2300-REF-01=G1, REF-02=PA#

EDIT 0424 - ELIGIBILITY ENDED BEFORE CLAIM THRU DATE FOR DME - CUT BACK APPLIED
This edit posts only to approved DME claims when the beneficiary's Medicaid eligibility ended prior to the last date of service reported on the claim. The payment amount is 'cut back' to pay only the Medicaid eligible days.

EDIT 0432 - THIS LEGEND DRUG IS NOT PAYABLE FOR PAAD
This edit posts when the PAAD program does not cover the dispensed drug.

EDIT 0433 - "POSSIBLE UNDERUTILIZATION"
This edit does not deny the claim.

EDIT 0434 - "VERIFY DOSAGE BASED ON WEIGHT"
This edit does not deny the claim.

EDIT 0438 - PAYOR ID QUALIFIER DOES NOT EQUAL 99 PBN LIST
This edit will post if any of the OTHER PAYOR ID QUALIFIER fields are entered with anything other than '99'.

EDIT 0439 - INVALID OTHER PAYOR ID CODE NOT ON PBN LIST
This edit will post if any OTHER PAYOR AMOUNT PAID FIELDS are greater then zero and the related OTHER PAYOR ID field does not contain one of the codes from the PBN list.

EDIT 0440 - PHARMACY INELIGIBLE FOR UD RECYCLING
This edit will post if the provider submits invalid facility ID for a Unit Dose Recycling Transaction.

EDIT 0441 - NUMBER OF UNITS RESTOCKS EXCEED ORIGINAL UNITS PAID
This edit will post if the service units on a Unit Dose Recycling adjustment claim is equal to or greater than the units on the previously paid claim.

EDIT 0442 - ORIGINAL CLAIM INELIGIBLE FOR UNIT DOSE RESTOCKING/RECYCLING
This edit will post to the claim if the following is true.

1. The original claim is less than $12.00.
2. The first eight digits of the NDC on the original claim is different from the one on the adjustment transaction.
3. The original and incoming claims are Sr. Gold or PAAD recipients.
4. The amount payable by Medicaid is less than the cutback plus TPL amount on the adjustment transaction.

EDIT 0443 - TPL PAYMENT EXPECTED PAYOR ID ON CLAIM BUT NO TPL AMOUNT
This edit will post if any of the OTHER PAYER AMOUNT PAID fields are zero and the related OTHER PAYER ID field does not contain a valid PBM code. See NCPDP 5.1 HIPAA Companion Guide section 3 for a complete list.

EDIT 0444- DIAGNOSIS CODE REQUIRED/CALL FIRST HEALTH
This Medicare covered drug requires a diagnosis code. Contact First Health for the appropriate code.

EDIT 0446- DRUG NOT COVERED BY CF PROGRAM
This edit code posts to a pharmacy claim for a beneficiary on the CF Drug Distribution Program. The drug submitted is not in the State formulary for this program.

EDIT 0452 - CERTIFICATION OF EMERGENCY FORM REQUIRED
This edit is posted when an out-of-state hospital claim for emergency service(s) does not include the required Certification of Emergency Form. This edit only applies to Hospital claims.

HIPAA- N/A

EDIT 0453 - PA / CERT DATES OR RECIPIENT ID# CONFLICT WITH CLAIM
This edit posts when the Fiscal Agent received an out-of-state hospital claim and one of the following problems exist:

On the LD-25 Form either the dates that were authorized on it or the recipient's name does not match the date entered on the claim.

On the Emergency Certification Form either the dates that were authorized or the recipient's names does not match the data on the claim.

EDIT 0455 - RECIPIENT NOT ELIGIBLE ON "FROM" D.O.S. NO DEDUCTIBLE DUE
This edit posts to Inpatient Crossover claims because the Medicaid recipient was not eligible for Medicaid on the date of admission. Therefore, Medicaid is not responsible for the Medicare deductible.

EDIT 0460 - INSURANCE ATTACHMENT INVALID/MISSING
This edit posts to Inpatient Crossover claims when it is determined that the service provided resulted from an accident. Therefore, the provider must bill the third party that is responsible for coverage.

EDIT 0461 - ESRD CLAIM - OCCURRENCE CODE 35 IS REQUIRED
This edit posts to ESRD claims when Occurrence Code 35 and the date treatment started are not entered in Field Locator 32-36 on the UB-92 claim form.

EDIT 0462 - RENAL REVENUE CODE PRESENT - RENAL CONDITION CODE REQUIRED
When an ESRD Revenue code (821, 829, 831, 839, 841, 849, 851 or 859) is on the claim form, an ESRD Condition Code must be reported in Form Locator 24-30. They are: 71 - Full-care in unit (ESRD), 72 - Self-care in unit (ESRD), 73 - Self-care training (ESRD), 74 - Home (ESRD), 75 - Home 100% Reimbursement (ESRD) and 76 - Back-up facility dialysis (ESRD).

This edit posts when the Revenue Code is present, but the condition code is missing.

EDIT 0464 - HIPAA CLAIM DENIED NO ATTACHMENT SUBMITTED
This edit posts to a HIPAA EDI claim submission after the 30-day suspend review has expired and Molina Medicaid Solutions has either not received a valid HIPAA Attachment Cover Sheet, or the Cover Sheet did not have the correct attachment present. The edit code showing which attachment was required should also be posted.

EDIT 0471 - FQHC ENCOUNTER WITH NO PAID HCPCS ON HIST
This edit posts for a claim submitted by a Federally Qualified Health Center (FQHC). In order for the Encounter Code to pay, the system needs to see that the procedure done on that day is processed for a zero payment before the encounter will process.

EDIT 0473 - TOTAL CALCULATED CHARGE NOT EQUAL TO TOTAL BILLED CHARGE
This edit posts if sum of the charges entered on the claim does not equal the total charge entered.

EDIT 0474 - NET CALCULATED CHARGES NOT EQUAL TO NET BILLED CHARGE
This edit posts when the line item charges on the claim do not equal the total charges.

EDIT 0475 - HISTORY RECORD ALREADY ADJUSTED OR VOIDED
This edit posts to pharmacy adjustment or void requests when the claim being adjusted has already been denied or voided.

EDIT 0476 - NO CLAIM IN HISTORY TABLE MATCHES REVERSAL REQUEST
This edit only posts to POS claims when there is a data entry error on the reversal attempt.

EDIT 0479 - PRIVATE PSYCH HOSPITAL - DIAGNOSIS 21900 - 31600 - PATIENT AGE IS MORE THAN 21 AND LESS THAN 65
This edit posts when Medicaid does not cover the service billed because the patient is between ages 21 and 65.

EDIT 0480 - GROUPER ASSIGNED A NEW DRG CODE
This edit posts when the system calculates a DRG that is different from the DRG code entered on the claim. NOTE: If a provider disagrees with the DRG assignment they must submit a DRG review request along with the claim and the RA showing Edit 480 to:

DMAHS; P.O. BOX 712; TRENTON, NJ 08625 ATTN: DRG APPEAL

EDIT 0483 - LAB TEST INCLUDED IN ESRD COMPOSITE RATE
This edit posts when a review determines that the claim contains several HCPCS codes for lab test. Charges for lab tests must be included in the ESRD composite rate.

EDIT 0484 - ESRD POSSIBLE ELIGIBLE FOR MEDICARE
This edit posts when the occurrence code equals 35 and the system calculated days from the occurrence code date to the from date of service, is more than 90 days. The claim should be submitted to Medicare for payment. Below are the form locators that apply:

UB-04 31

837 Institutional - 2300: HI01=BI,HI02> 90 and HI01=BH, HI02=35

EDIT 0488 - DRG INTERIM BILL, APPROVAL REQUIRED
This edit posts when a DRG claim is received while the patient is still an inpatient. The State Medicaid office must approve this interim bill.

EDIT 0489 - BABY AND MOTHER ACCOMMODATION REVENUE CODES ON CLAIM
This edit posts when hospital services rendered to mother and baby are billed on the same claim. They must be billed on separate claims.

EDIT 0490 - INPATIENT DATE OF SURGERY IS LESS THAN SERVICE FROM DATE
This edit posts when the surgery date entered in Form Locator 80-81 on the UB-92 Claim Form is less than the "from" statement date entered in Form Locator 6.

EDIT 0499 - ACUTE DAYS EQUAL ZERO
This edit posts when the number of acute days entered in Form Locator 2 on the UB-92 Claim Form is zero.

EDIT 0503 - REVENUE CODE NOT ON FILE
This edit posts when Medicaid does not recognize one or more Revenue Codes entered on the UB-92 Claim Form.

EDIT 0505 - LTC CENSUS DATA MISSING FOR SERVICE MONTH
This edit posts when the Fiscal Agent does not receive the monthly Certification Statement. This data must be received before the month's claims can be processed.

EDIT 0506 - RECIPIENT INELIGIBLE TO RECEIVE LTC SERVICES
This edit posts when the recipient is not eligible to receive LTC services.

EDIT 0508 - PROVIDER NOT MEDICARE CERTIFIED - BED HOLD NOT ALLOWED
This edit posts when the Medicaid Provider File does not indicate that this provider is Medicare certified.

EDIT 0509 - MEDICARE BED HOLD INVALID
This claim has at least two leave of absence periods reported in Items 23-32. A hospital leave while on Medicare (Code M) cannot be used during the same billing period as a therapy leave (Code T) or a hospital leave (Code H). Leave Type M must be billed on a separate TAD line.

EDIT 0510 - CO-INSURANCE DAYS MUST BE BILLED PRIOR TO LIFETIME RESERVE DAYS
This edit posts when Lifetime Reserve Days are billed before all 30 coinsurance days have been used.

EDIT 0512 - DRUG NOT PAYABLE - NO ADDP REBATE AGREEMENT
This edit posts when a pharmacy bills for an ADDP beneficiary (first four positions of the beneficiary's number are 5901), and the drug file does not reflect a rebate agreement for the NDC billed.

EDIT 0514 - NURSING FACILITY LEAVE/RETURN RESTRICTED
This edit posts when the provider file indicates that this facility has terminated its Medicaid agreement or is curtailing Medicaid admissions. The provider should resubmit the claim, entering Code 1 (discharge to hospital) in Item 12, and the "from" leave of absence date recorded in Item 24-32 must be entered as the "to" service date (Item 11).

EDIT 0515 - NURSING FACILITY ADMIT RESTRICTED
This edit posts when the provider file indicates that this facility has terminated its Medicaid agreement or is curtailing Medicaid admissions. The code entered in Items 8 and 9 indicates a new admission, but Medicaid cannot cover the service.

EDIT 0517 - PASARR RECORD MISSING (DATES INVALID)
This edit posts when the claim service date is earlier than the LTC assessment date, or the claim service date is after that LTC assessment termination date, or the LTC assessment date is zero.

EDIT 0518 - INVALID PASARR DATA
This edit posts when the LTC assessment code or the PASARR code is invalid.

EDIT 0521 - RECIPIENT NOT ON LTC MASTER FILE
LTC: This edit posts when there is no PAS record on file at the Fiscal Agent. The Pre-Admission Screening (PAS) record must be on file in order for Molina Medicaid Solutions to approve this claim. You must contact your local Long Term Care Field Office (LTCFO) in order to resolve this condition. HOSPICE: This edit posts when there is no PAS record on file at the Fiscal Agent. This is an Explanation of Benefit (EOB) message only.

EDIT 0522 - INCORRECT PROVIDER FOR LTC SPECIAL PROGRAM
This edit is posted when the servicing provider on the LTC (Long Term Care) claim is not authorized.

EDIT 0524 - INVALID LTC PSYCH RECIPIENT AGE
This edit posts when the claim is for a recipient between ages 21 and 65. Payment for services in this facility is not allowed.

EDIT 0526 - PA-3L INCOME GREATER THAN PATIENT PAY AMT PA-3L USED
This edit posts when the patient payment amount entered in Item 35 of the LTC TAD is less than the PA-3L amount recorded on the beneficiary's eligibility file.

This edit only applies to the LTC TAD form locator 35.

837 Institutional - *R: w/PA3L & 2300: HI01-2=BE, HI01-2=31, HI01-5=Patient Liability

EDIT 0528 - LTC RECIPIENT NOT ELIGIBLE FOR ENTIRE PERIOD - CUTBACK ASSESSMENT DATE
This edit posts when the assessment history date indicates that the recipient is not eligible for the entire billing period.

EDIT 0529 - CLAIM DATES SERVICE BEFORE INITIAL ASSESSMENT DATE
This edit posts when the claim dates of service are prior to the original assessment date.

EDIT 0530 - LTC OVERLAPPING LEAVE PERIODS
This edit posts when the "from" or "to" date on one leave of absence overlaps the "from" or "to" date on another leave for the same billing period.

EDIT 0531 - LTC/HOSPICE REQUIRES PR-1 OR LTC REQUIRES PATIENT PYT AMOUNT
LTC: This edit posts when the patient paid amount is blank or zero on the TAD and there is no PR-1amount with a valid effective date on the beneficiary's eligibility file for this billing period. You must contact your local County Board of Social Services (CBOSS) in order to resolve this condition.

HOSPICE: This edit posts when the patient paid amount is blank or zero on the TAD and there is no PR-1amount with a valid effective date on the beneficiary's eligibility file for this billing period.. This is an Explanation of Benefit (EOB) message only.

EDIT 0532 - THIS NON LEGEND DRUG IS NOT COVERED FOR PAAD
This edit posts when the claim is for an over the counter drug which PAAD does not cover.

EDIT 0533 - OTC DRUG INCLUDED IN NF PER DIEM
This edit posts when the claim is for an over the counter drug dispensed to a beneficiary residing in a nursing home. These drugs are already included in the nursing home payment.

EDIT 0534 - DRUG NOT PAYABLE/IRS DESI
This edit posts when the claim is for an IRS (Identical, Related, Similar) DESI drug. Medicaid does not cover these products.

EDIT 0535 - DAILY QUANTITY EXCEEDED - 30 DAY EXTENSION
This edit posts when a drug quantity exceeds its 30-day limit.

EDIT 0536 - DAILY QUANTITY POSSIBLY EXCEEDED
This is an EOB edit that will post when the billed drug's daily dosage exceeds the specified standard daily dosage.

EDIT 0537 - MAXIMUM DOSE
This edit posts when the dose or part of the combination drug (e.g. acetaminophen in Percocet) exceeds the daily drug quantity. A quick review of the claim or verification of dose with the prescribing provider would save time. There are of course some exceptions - when the prescribing provider confirms the need to dispense dose as prescribed. The MEP representative would then decide if the request is within clinical reason.

EDIT 0538 - DAILY METRIC QUANTITY EXCEEDS DUR STANDARD/AGE
All impotency drug therapies are limited by the number of therapies allowed per month and limited to male beneficiaries who are over the age of 18. This edit posts when either or both of these conditions are not met.

EDIT 0539 - THIS LIVERY SERVICE IS ONLY VALID IN COUNTY 07, 09, 90
This edit posts when Medicaid does not cover the livery service.

EDIT 0541 - COMPOUND DRUG MANUAL REVIEW REQUIRED
This edit posted when the compound indicator on the MC-6 claim form was present, and the GSHP indicator was zero, requiring a manual review.

EDIT 0542 - NON-LEGEND DRUG NOT PAYABLE FOR DATE OF SERVICE
This edit posts when the claim is for a non-legend drug not payable by Medicaid on the claim date of service.

EDIT 0544 - DRUG NOT PAYABLE FEDERAL DESI
This edit posts when the claim is for a DESI drug determined by the Federal government as ineffective. Therefore, Medicaid does not cover it.

EDIT 0545 - NDC NOT ON FILE
This edit posts when Medicaid does not recognize the NDC billed.

EDIT 0546 - PAAD CLAIM SUBMITTED BY OUT-OF-STATE PROVIDER
The PAAD program does not reimburse out-of-state pharmacies, and the claim is from an out-of-state provider.

EDIT 0547 - UNIT DOSE PAYABLE FOR NURSING HOME RECIPIENT ONLY
Medicaid recipients are not eligible to receive unit doses unless they reside in a nursing facility. This edit posts when the claim does not indicate that the recipient is in a nursing facility.

EDIT 0548 - DAYS SUPPLY EXCEEDS PROGRAM MAXIMUM
This edit posts when the 34-day maximum supply for new prescriptions is exceeded.

EDIT 0549 - DRUG NOT PAYABLE - NO REBATE AGREEMENT
Medicaid reimbursement for legend and non-legend drugs is limited to manufacturers who have entered into a rebate agreement with the Secretary of the U.S. Department of Health and Human Services. This edit posts when there is no rebate agreement with the manufacturer.

EDIT 0551 - NDC PROBABLY OBSOLETE, CHECK LABEL/COMPUTER
This edit posts when the NDC on the claim is no longer valid for the date of service.

EDIT 0552 - ADDP - SERVICE NOT COVERED FOR THIS RECIPIENT
This edit posts when the patient is in the ADDP program, which does not cover the NDC billed.

EDIT 0553 - COMPOUND DRUG DID NOT CONTAIN LEGEND DRUG
This edit posts when the billed compound drug does not contain at least one legend drug.

EDIT 0555 - PAAD RECIPIENT INELIGIBLE FOR MEDICAID SERVICES
This edit posts when the claim is for a PAAD beneficiary, but the service is other than a pharmacy service.

EDIT 0556 - COMPOUND DRUG NOT COVERED
After review, it was determined that at least one of the NDCS listed on the claim is not covered or is a DESI drug.

EDIT 0557 - COMPOUND DRUG NOT COVERED FOR PAAD RECIPIENTS
This edit posts when a review determines that the recipient is a PAAD patient. However, PAAD does not cover compound drugs.

EDIT 0559 - COMPOUND DRUG/NDC CODE MISSING OR INVALID
This edit posts when, after review, it was determined that one or more NDC(s) in the compound drug either did not match the description or did not appear in the NDC File.

EDIT 0560 - COMPOUND DRUG - QUANTITY MISSING OR INVALID
This edit posts when, after review, it was determined that the quantity of at least one NDC in the compound drug was not written on the back of the claim form.

EDIT 0561 - COMPOUND DRUG NOT COVERED FOR LTC RECIPIENT
This edit posts when, after review, it was determined that the compound drug billed contains an OTC drug that is not covered for a Medicaid recipient residing in a LTC facility.

EDIT 0562 - COMPOUND DRUG WITH INGREDIENT NOT COVERED BY REBATE AGREEMENT
This edit posts when, after review, it was determined that at least one NDC listed on the claim is not covered by the drug rebate agreement. Medicaid reimbursement for legend and non-legend drugs is limited to manufacturers who have entered into a rebate agreement with the U.S. Department of Health and Human Services.

EDIT 0565 - OTC DRUG NO UNIT PRICE ON FILE
This edit posts when the NDC for this OTC drug is not covered on the date of service.

EDIT 0566 - OTC DRUG NO PACKAGE PRICE ON FILE
This edit posts when the NDC for this OTC drug is not covered on the date of service.

EDIT 0567 - TEAMCARE - DRUG NO UNIT PRICE ON FILE
This edit posts when the NDC is not covered on this date of service.

EDIT 0568 - TEAMCARE - DRUG NO PACKAGE PRICE ON FILE
This edit posts when the NDC is not covered on this date of service.

EDIT 0569 - LEGEND DRUG NO PACKAGE PRICE ON FILE
This edit posts when this NDC is not covered on this date of service.

EDIT 0570 - DRUG NOT PAYABLE - NO PAAD REBATE AGREEMENT
This edit posts when the beneficiary is enrolled in the PAAD Program and there is no manufacturers rebate agreement on file with the PAAD program.

EDIT 0577 - GENERAL ASSISTANCE
The State of NJ established this edit as part of clinical monitoring of the GA population. Unless it is associated with another edit (e.g. duplication [405] or ddi [916], this claim requires the MEP representative to conduct a general profile review.

EDIT 0578 - CLAIM PRICED UTILIZING CHARITY CARE 30 PERCENT RULE
This edit posts to Charity Care claims if the Medicaid tentative pay less TPL amount is greater than the PA authorized amount (patient 30 percent threshold amount used in Charity).

EDIT 0581 - DENTAL SERVICES AFTER ELIGIBILITY TERMINATED
The edit posts when the claim date of service occurs after the beneficiary's eligibility terminated.

EDIT 0582 - MISSING/INVALID TOOTH SURFACE CODE
This edit posts when the entry in Item 17G on the MC-10 Dental Claim form is not a valid Medicaid tooth surface code. The valid codes are: B - Buccal, M - Mesial, O - Occlusal, I - Incisal, D - Distal, L - Lingual.

EDIT 0583 - PAYMENT DENIED; VACCINE AVAILABLE THROUGH THE VFC PROGRAM
This edit posts when the procedure code on the claim is for a child vaccine. NJ Medicaid does not pay child vaccines as fee-for-service. The provider must enroll in the Vaccines for Children program since the vaccines are given to the provider free of charge.

EDIT 0585 - SERVICE UNITS INCONSISTENT WITH PRODUCT PACKAGING
This edit posts to a pharmacy claim when the units billed do not match the package size of the drug they are billing for.

EDIT 0586 - MISSING/INVALID TOOTH QUADRANT
This edit posts when the entry in Item 17F on the MC-10 Claim Form is not a valid tooth quadrant code. This field is used for either tooth number or quadrant. This edit posts when the code entered in Item 17F is a valid tooth surface code, but a valid quadrant code is missing or invalid. The valid tooth quadrant codes are: UL = upper left, UR = upper right, LL = lower left and LR = lower right.

EDIT 0587 - MISSING/INVALID TOOTH NUMBER
This edit posts when the tooth number as recorded in Item 17F on the MC-10 Claim Form is either missing or is not a valid Medicaid tooth number. The valid codes are A to T for primary, 1 to 32 for permanent and SN for supernumerary. Item 17F must never have more than one tooth code entered. When billing for a service not specific to a single tooth or quadrant, this field must be blank.

EDIT 0589 - MODIFIER NOT ALLOWED
This edit posts if the modifier entered on the claim is not valid for the billed procedure code.

EDIT 0590 - PROCEDURE CODE BILLED IS ONLY PAYABLE TO A SPECIALIST
The provider file for the servicing provider indicates a non-specialist. This edit posts when the billed procedure code is only payable to a board certified or board eligible specialist.

EDIT 0591 - PROVIDER NOT ON PROVIDER RATE FILE
This edit posts if the billed rate is not on the provider rate file. The Fiscal Agent is unable to price the claim.

EDIT 0595 - REVENUE CODE/CONDITION CODE CONFLICT FOR COMPOSITE RATE PRICING
This edit posts when Revenue Code 821, 829, 831, 839, 841, 849, 851, or 859 is entered on the claim, but Condition Code(s) 71-76 is (are) missing. If one of these condition codes is on the claim, one of the above Revenue Codes must also appear.

EDIT 0597 - VERIFY OR CORRECT PROCEDURE CODE/NDC FOR DATES OF SERVICE
This edit posts if there is no fee on file for this procedure code or NDC.

EDIT 0598 - INVALID LEVEL OF CARE CODE
This edit posts to a claim with an invalid level of care code.

EDIT 0599 - INVALID LTC COUNTY OF CHARGE
This edit posts to an ICF.MR claim where the county of charge is invalid.

EDIT 0600 - LTC RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE
This edit posts when the LTC recipient is not eligible on the date of service.

EDIT 0601 - PAYMENT REDUCED TO MEDICAID MAXIMUM
This edit posts when a claim is priced at the Medicaid allowable for laboratory services.

EDIT 0602 - MISSING DRG CODE
This edit posts when the claim is subject to DRG pricing and a valid three-digit DRG code is not entered in Form Locator 71 of the UB-04 claim form, or the claim is not subject to DRG pricing and there is an entry in Form Locator 71.

EDIT 0603 - PROVIDER NOT ON DRG RATE FILE
This edit posts when a claim is received from a New Jersey, New York or Pennsylvania hospital, but a record does not exist on the state DRG rate file for the provider billing for the DRG.

EDIT 0605 - OUT OF STATE DRG CLAIM REQUIRES MANUAL PRICING
This edit posts when the claim is submitted by a hospital outside the Tri-State Area and there is no rate on file.

EDIT 0607 - LOW VARIANCE ERROR
This edit posts when the system detects an inconsistency. There is an error in the number of units billed and/or the charge amount on the claim is incorrect.

EDIT 0608 - MANUAL PRICING REQUIRED
This edit posts when the claim submitted requires manual pricing. If this is a DME, Hearing Aid, or Prosthetic and Orthotic claim it will require pricing. Medical claims require Medical Records for pricing. This edit does not apply to a specific form locator.

HIPAA- N/A

EDIT 0610 - MANUAL PRICING EXCEEDS BILLED CHARGES
This edit posts when the special price amount is greater than the claim charge or if the special price amount is greater than the claim charge and there is no co-payment attachment.

EDIT 0612 - PER DIEM INPATIENT RATE NOT FOUND ON PROVIDER RATE FILE
This edit posts when the claim cannot be priced because rate information is missing on the Provider rate file.

EDIT 0613 - DRG CODE SUBMITTED PRIOR TO DRG TRIM EFFECTIVE DATE
This edit posts when the claim cannot be priced because information is missing on the Provider DRG file.

EDIT 0615 - DRG NOT EFFECTIVE ON CLAIM SERVICE DATE
This edit posts when the claim cannot be priced because information is missing on the Provider DRG file.

EDIT 0617 - CALCULATED PAYMENT AMOUNT ZERO
This edit posts when the program calculates the payment to be zero.

EDIT 0618 - VALID RATE FOR DATES OF SERVICE NOT FOUND ON RATE FILE
This edit is posted when the claim cannot be priced because there is no rate information available on the provider file for the date of service submitted. This edit only applies to Hospital and LTC claims. Contact with the State may be required. This edit does not apply to a specific form locator.

HIPAA - N/A

EDIT 0619 - VALID RATE FOR LEVEL-OF-CARE NOT FOUND ON RATE FILE
This edit posts when the claim cannot be priced because no valid rate was found for this level of care in the provider rate file. The claim service date may be prior to the provider rate effective dates, or the level of care may not be present for the provider.

EDIT 0620 - RECIPIENT NOT ELIGIBLE FOR FULL SERVICE PERIOD: CUTBACK
This is a split claim, and the beneficiary did not become Medicaid eligible until after the date of admission. This edit posts when the claim is prorated, paying only the eligible days.

EDIT 0621 - DRG CODE NOT ON FILE
This edit posts when Medicaid does not recognize the DRG entered in Form Locator 71 of the UB-04 Claim Form.

EDIT 0623 - MEDICAID ALLOWABLE AMOUNT PAID IN FULL BY MEDICARE
This edit posts because Medicaid will not reimburse for coinsurance or deductible when the Medicare payment is equal to or exceeds the Medicaid allowable.

EDIT 0624 - PRICE NOT ON U/C
This edit posts when there is no price on the U & C file for the procedure code and billed date of service.

EDIT 0625 - CHARITY CARE ALLOWABLE REDUCED BY OTHER INSURANCE
This edit posts to Charity Care claims if the Charity Care allowed amount is reduced by any TPL payment, excluding Medicare.

EDIT 0630 - LTC LEAVE CUT BACK TO MAXIMUM ALLOWED
This edit posts when the maximum LTC therapeutic leave days allowed, i.e. 24 per calendar year and 10 hospital bed hold days per occurrence, have been exceeded.

The maximum RTC therapeutic and hospital leave days is fourteen per occurrence.

EDIT 0633 - AMBULANCE/INVALID COACH IS LESS THAN 16 MILES
The procedure code entered on the claim can be used only if the mileage is 16 miles and over. This edit posts if the mileage entered on the claim is less than 16 miles.

EDIT 0634 - DRG CODE SUBMITTED PRIOR TO PROVIDER'S DRG EFFECTIVE DATE
This edit posts when the provider file indicates a date of service prior to the provider's eligibility date on the file.

EDIT 0635 - LTC ADMIT < ASSESS DATE
This edit posts when the admission date on the TAD form is before the initial assessment date.

EDIT 0637 - MEDICARE COINSURANCE DAYS USED AS PAYABLE DAYS
This edit posts when Medicare coinsurance days are used as payable days for an LTC claim.

EDIT 0638 - LTC PHARMACY PROVIDER NOT FOUND
This edit posts when the provider file does not indicate that this LTC facility has selected a pharmacy to provide pharmaceutical services to its residents.

EDIT 0639 - REFERRING PROVIDER MUST BE NURSING FACILITY
This edit posts when the system determines that the beneficiary transferred from a LTC facility, and that facility's Medicaid provider number was not entered in Item 17A on the CMS-1500 claim form.

EDIT 0640 - INVOICE PRICE LIST ATTACHED IS INVALID OR INSUFFICIENT
This edit posts to a claim when the pricing documentation sent is not acceptable.

EDIT 0641 - RX FROM PHYSICIAN REQUIRED
This edit posts when a review determined that this claim could not be manually priced without the prescription from the physician.

EDIT 0642 - RESUBMIT CLAIM WITH INVOICE OR MANUFACTURER'S PRICE LIST ATTACHED
This edit posts when the claim must be manually priced and the manufacturers price list or invoice is not attached.

EDIT 0643 - OUT OF REGION NON-DRG HOSPITAL REQUIRES MANUAL PRICING FOR DOS
This edit posts when an out of state hospital submits a claim that must be manually priced. The provider must resubmit attaching either the hospital's Medicaid per Diem rate or Medicaid percentage of charge for the date(s) of service.

EDIT 0644 - OUT OF REG NON DRG HOSP REQ MAN PRICING-NO PRO RATE RECORD
This edit posts when a hospital out of the tri-state area does not have their rate on file.

EDIT 0645 - MISSING NEW YORK EXEMPT FACILITY RATE DATE
This edit posts to inpatient claims submitted by New York hospitals that are exempt from DRG pricing and a DRG rate record is present for the billing provider.

EDIT 0648 - INVALID NEW YORK EXEMPT UNIT RATE CODE
This edit posts to a New York Hospital claim when the Provider reports an invalid per diem rate code in fields 39 A, B, C, and D - 41 A, B, C, and D. For the UB-92 form the Provider would type or print X9 and a valid per diem rate code. On the UB-04 the Provider would type or print 24 and a valid per diem rate code.

**Valid per diem rate codes are 2852, 2853, 2908, 2957, 2959, 2993, and 2994.

EDIT 0658 - NO PROVIDER RATE RECORD FOR BILLING PROVIDER
This edit posts when a claim is submitted by a New York or Pennsylvania hospital that is exempt from DRG pricing.

EDIT 0659 - NF RATE NOT ON FILE
This edit posts on claims submitted by a New Jersey hospital and is subject to DRG pricing, and there are SNF and ICF days billed, and an entry in the NF per diem table cannot be located.

EDIT 0660 - NUMBER OF ACCOMMODATION DAYS NOT EQUAL TO TOTAL DAYS BILLED
This edit posts when the total days billed (Acute + SNF + ICF + Residential) entered in Form Locator 2 on the UB-92 Claim Form does not agree with the number of room and board days (Revenue codes 090-219).

EDIT 0661 - INVALID/MISSING DRG CODE
This edit posts when the entry in Form Locator 78 on the UB-92 Claim Form is not a valid three-digit numeric DRG code.

EDIT 0664 - ITEM BILLED IS INCLUDED IN ADMINISTRATION/SUPPLY KIT
This edit posts when a review determined that this item should not be billed separately because payment is included in the administration or supply kit code.

EDIT 0665 - PROCEDURE DESCRIPTION DOES NOT MATCH PRICE LIST
This edit posts when, after review, it is determined that the provider used the wrong procedure code, e.g. the pricing documentation reflects gauze pads, but the procedure code reflects a linear yard dressing.

EDIT 0667 - COMPUTED DRUG COST ALLOWANCE IS ZERO
This edit posts when the drug quantity is not entered on the claim.

EDIT 0668 - USE ASSIGNED PROCEDURE CODE/NDC CODE TO MATCH DESCRIPTION GIVEN
This edit posts when a review determined that the procedure code or NDC does not match the description written on the claim form.

EDIT 0669 - DETAILED DESCRIPTION NEEDED FOR PROCEDURE CODE BILLED
This edit posts when, after review, it was determined that the claim with attachments did not provide enough information to price it. The description on the component page does not match the corresponding data on the invoice or price list, or the pricing documentation is unacceptable. The description on the component page must include the name of the item (exactly as recorded on the invoice or price list) and the model, serial, or catalog number quantity. The listing on the component page must include:

The procedure code (This code must match the procedure code on the claim form.)

The sequential number of the item (This number must be entered next to the circled data on the corresponding page of the invoice or price list.)

The name of the item (This must match the invoice or price list.)

The model number, the serial number or the catalog number (This number must match the invoice or price list.)

The quantity

The component charge

The total item charge (This must match the charge on the component page and on the claim.)

EDIT 0670 - NO PAYMENT DUE - MEDICARE PAYMENT EXCEEDS MEDICAID ALLOWABLE
This edit posts when the Medicare payment exceeds the Medicaid allowable amount. Medicaid, therefore, does not reimburse for the coinsurance and/or deductible amounts. Below are the claim forms and Form Locators that apply:

ADA	32
CMS1500	29
MC-6	26
MC-9	29
MC-12	21
MC-19	17
LTC TAD	37
UB-04	54

837 Institutional - This Medicare payment (COB Total Medicare Paid Amount; Loop 2320 field AMT02, where AMT01 is N1) must not exceed the Medicaid allowable amount.

837 Professional - This Medicare payment (COB Total Medicare Paid Amount; Loop 2320 field AMT02, where AMT01 is N1) must not exceed the Medicaid allowable amount.

EDIT 0682 - SERVICE / PRODUCT NOT MEDICAID ELIGIBLE
This edit posts to pharmacy claims when Medicaid does not cover the NDC.

EDIT 0690 - PROVIDER NOT PARTICIPATING IN REQUIRED PROGRAM
This edit posts to a claim when the provider does not participate with the program they are billing for.

EDIT 0691 - PROVIDER NOT PARTICIPATING IN REQUIRED PGM ON DATE OF SERVICE
This edit posts to a claim when the provider does not participate with the program they are billing for.

EDIT 0695 - ADJUSTMENT/VOID ALREADY IN PROCESS
This edit posts when there is an adjustment or a void for this claim already in process in the system.

EDIT 0696- CLAIM DENIED PROVIDER NOT RE-ENROLLED
This edit posts to a claim when the provider has not been re-enrolled.

EDIT 0700 - CONFLICTING SAME DAY LAB SERVICE
This edit posts when at least one other claim for lab services was paid for the same beneficiary on the same date of service.

EDIT 0701 - DUPLICATE CONSULTATION
This edit posts when a claim for a comprehensive or initial consultation has already been paid within a year from the date of service on the current claim. These consultations are limited to one per beneficiary per provider per year.

EDIT 0702 - SERVICE CONFLICTS WITH SIMILAR SAME DAY PROCEDURE
The edit posts when the billed procedure code conflicts with a similar paid procedure for the same date of service.

EDIT 0703 - EPISIOTOMY INCLUDED IN DELIVERY
This edit posts when a charge for an episiotomy is billed separately from the delivery charge. The allowable amount for the delivery includes the allowable amount for the episiotomy.

EDIT 0704 - OUTPATIENT PARTIAL HOSPITALIZATION- PA REQUIRED
This edit posts to an outpatient claim with the following conditions:

1. Service date greater than or equal to 02/05/07
2. Outpatient revenue code of 913
3. Recipient is 22 years of age or older
4. A prior authorization number is not present

EDIT 0705 - CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - PA REQUIRED
This edit posts if the number of units or dollars on previously paid dental claims has reached the maximum allowed for this beneficiary. Prior authorization is required for further service.

EDIT 0706 - 30-DAY NEONATAL CARE LIMIT
This edit posts when the maximum number of units (30) allowed for this neonatal procedure code has been reached.

EDIT 0707 - 60-DAY NEONATAL CARE LIMIT
This edit posts when the maximum number of units (60) allowed for this neonatal procedure code has been reached.

EDIT 0708 - GLOBAL OB CARE/SERVICE CONFLICT
This edit posts when individual prenatal, delivery, and postnatal services are billed in conjunction with a global obstetrical care code.

EDIT 0712 - CLAIM UNITS/DOLLARS EXCEEDS MAXIMUM - DENY
This edit posts when the number of units or dollars, on previously paid claims, have met the Medicaid allowable amount. Therefore, the current claim is denied.

EDIT 0713 - LAB TEST CONFLICT/LAB PANEL PROCEDURE PREVIOUSLY PAID
This edit posts when the lab service on the current claim was previously paid as part of a comprehensive lab code.

EDIT 0714 - LAB TEST CONFLICT, INDIVIDUAL TEST PREVIOUSLY PAID
The edit posts when the current claim contains an individual lab test that has already been paid for this date of service.

EDIT 0715 - MENTAL HEALTH SERVICES OVER $400.00 - NF/BOARDING HOME
This edit posts when payment for mental health services provided to a beneficiary residing in a nursing facility or boarding home has exceeded the $400.00 limit. Prior authorization is required for additional services.

EDIT 0716 - PROCEDURE INCLUDED IN THE PHYSICIAN VISIT
This edit posts when the billed procedure is included in the payment for an office visit.

EDIT 0717 - PRIOR AUTHORIZATION UNITS/DOLLARS EXHAUSTED
This edit posts when the units on the prior authorization have all been used.

EDIT 0718 - HOSPITAL LEAVE OF ABSENCE EXCEEDS LIMIT
This edit posts if the maximum payable bed hold days (ten for nursing facilities; fourteen for residential treatment centers) have been exceeded. Psychiatric hospitals and ICF/MR facilities are not paid for bed hold days.

EDIT 0719 - THERAPEUTIC LEAVE OF ABSENCE EXCEEDS LIMIT
This edit posts if the therapeutic leave entered on the claim exceeds the allowed limit. Up to 24 therapeutic bed hold days per year are allowed for nursing facilities and up to 14 are allowed for residential treatment centers.

EDIT 0720 - MONTHLY TARGETED CASE MANAGEMENT LIMIT EXCEEDED
This edit posts when the billed service on this claim has already been paid for this beneficiary. The payment was under a different procedure code and/or servicing provider.

EDIT 0721 - CONFLICTING TARGETED CASE MANAGEMENT SERVICE
This edit posts when the procedure code on the claim is an initial visit (Z5004) and the history file reflects at least one other paid claim, for the same procedure code, within the year.

EDIT 0722 - SERVICE/VISIT CONFLICT
This edit posts when an office or hospital visit is billed on the same date as the surgery date.

EDIT 0723 - LAB PANEL PROCEDURE CODE NOT ON FILE
This edit posts when the individual procedure code, which corresponds to the lab panel procedure code, is invalid or not on file.

EDIT 0724 - INDIVIDUAL LAB TEST EXCEED PANEL ALLOWANCE; REDUCED PAYMENT
This edit posts when the system determines that multiple urine and blood tests were performed on the same service date, for the same recipient and by the same provider. The total amount previously paid plus this claim exceeds the maximum allowance for the blood or urine panel. Therefore, the payment for the current claim is reduced.

EDIT 0725 - BIOPSY/ D&C CONFLICT
This edit posts when claims for both a biopsy and a D & C are submitted for the same date of service.

EDIT 0726 - INDIVIDUAL LAB TESTS EXCEEDS PANEL ALLOWANCE- REDUCED PAYMENT
This edit posts when individual lab tests have been paid for this beneficiary, to the same provider on the same date of service. The payment for these tests has exceeded the Medicaid allowable for a lab panel, resulting in a reduced payment.

EDIT 0727 - INDIVIDUAL LAB TESTS ALLOWANCE EXCEEDS PANEL ALLOWANCE
This edit posts when individual lab tests have been paid for this beneficiary, to the same provider on the same date of service. The payment for these tests has exceeded the Medicaid allowable for a lab panel.

EDIT 0728 - INDIVIDUAL LAB TEST/CBC CONFLICT
This edit posts when a claim for a complete blood count for the same date of service has previously paid.

EDIT 0729 - CLAIM PAYMENT REDUCED FOR PREVIOUSLY PAID VISIT
This edit posts when the current claim reflects surgery and payment for a previously paid post-operative office visit is being recouped via this claim. Medicaid does not pay for post-operative office visits; the payment for surgery is considered inclusive.

EDIT 0730 - SPECIMEN COLLECTION GREATER THAN ONE
This edit posts when a claim for specimen collection exceeds the Medicaid maximum of one per day.

EDIT 0731 - THREE-YEAR X-RAY LIMITATION EXCEEDED
This edit posts when a claim for a complete mouth x-ray series, limited to once every three years, has been submitted, and payment has already been made for this beneficiary within this time frame.

EDIT 0732 - ADJUSTMENT TO DENTURES WITHIN SIX MONTHS OF DELIVERY
This edit posts when a claim for a denture adjustment has been submitted within 6 months of the insertion date.

EDIT 0733 - CLAIM EXCEEDS LIMIT OF ONE UNIT OF SERVICE
This edit posts when the Medicaid limit for the billed service is one, and the number of units billed is greater than one.

EDIT 0734 - SERVICE EXCEEDS PROGRAM FREQUENCY GUIDELINES
This edit posts when the service billed exceeds the Medicaid limits.

EDIT 0735 - INITIAL VISIT/ANNUAL EXAM/EPSDT EXAM LIMIT
This edit posts when the procedure code on the MC-19 Claim Form conflicts with another paid claim.

EDIT 0737 - PAAD RECIPIENT REFILL EXCEEDS 12 MONTHS FROM ORIGINAL RX
This edit posts if the prescription number entered on the claim reflects a refill, but the original prescription was not paid within the year.

EDIT 0738 - REFILL EXCEEDS PROGRAM MAXIMUM
This edit posts when six claims, with this same prescription number, were paid within six months. Medicaid policy allows an original and 5 refills per prescription in a six-month period. A new prescription is required.

EDIT 0739 - TRANSPORT CLAIM MUST PAY FIRST
This edit posts when a claim for waiting time is received before the claim for the transportation itself. The provider may resubmit the waiting time claim after the transportation claim is paid.

EDIT 0740 - OPTICAL APPLIANCE EXCEEDS PROGRAM LIMITATION
This edit posts when the program limitation for optical appliances is exceeded. The Medicaid limit is one appliance service per year for beneficiaries under 19 years old or over 60. For beneficiaries between 19 and 60, the limitation is every two years.

EDIT 0742 - DENTAL SERVICE ON PREVIOUSLY EXTRACTED TOOTH
This edit posts when the history record indicates that the tooth number on which the service was provided had been previously extracted. Contact the Dental Bureau at (609) 588-7136 for further instruction.

EDIT 0743 - DENTAL X-RAYS - AGE LIMIT
This edit posts when the maximum number of x-rays allowed for this service date is exceeded. The maximum number of units per day for beneficiaries 6 years of age and younger is 7. For ages 7 through 14 it is 11, and for ages 15 and above it is 15 units.

EDIT 0744 - PANORAMIC/INDIVIDUAL FILMS LIMIT
The procedure codes for dental x-ray panoramic and individual films have limits by age, as indicated below. The panoramic film procedure equals 10 individual films. This edit posts when the panoramic limit is exceeded. The maximum number of units per day for beneficiaries 6 years of age and younger is 7. For ages 7 through 14 it is 11, and for ages 15 and above it is 15 units.

EDIT 0745 - HOSPITAL CALL/CONSULTATION CONFLICT
This edit posts when claims are submitted for a hospital visit and a consultation on the same date of service. Medicaid policy does not allow payment for both procedures on the same date.

EDIT 0747 - PROPHYLAXIS LIMIT
This edit posts when a claim for dental prophylaxis exceeds the Medicaid limit. The limit is once every six months for beneficiaries through age 17 and once per year for beneficiaries who are 18 years of age and over.

EDIT 0748 - ORAL EXAMINATION LIMIT
This edit posts when a claim for an oral examination exceeds the Medicaid limit. The limit is once every six months for beneficiaries through age of 20, and once per year for beneficiaries who are 21 years of age and over.

EDIT 0749 - ANESTHESIA SERVICE ALREADY PAID FOR SAME DATE OF SERVICE
This edit posts when a claim is submitted for anesthesia service and a payment has been made for a similar service on the same date.

EDIT 0750 - MULTIPLE ANESTHESIA ON THE SAME DAY
This edit posts when two claims are submitted for the administration of anesthesia; one for the primary surgery (the code with the AA modifier) and the other for the insertion of the tube. The time for the latter service must be included with the former one.

EDIT 0751 - PAYMENT REDUCED SURGERY/VISIT LIMITATION
This edit posts when it is determined that the procedure on the claim cannot be paid in full because payment for the same day office visit is inclusive.

EDIT 0752 - VISIT OR SERVICE NOT PAYABLE WITH COMPREHENSIVE EYE EXAM
This edit posts when a claim has been received for both a comprehensive eye exam and an office visit, visual field exam, tonometry, or ophthalmoscopy on the same service date.

EDIT 0753 - SURGERY/VISIT CONFLICT
This edit posts when a claim has been received for both surgery and an office or hospital visit on the same date of service.

EDIT 0755 - REFILL EARLY
This edit posts to a pharmacy claim when the old prescription has not surpassed at least 75%.

EDIT 0758 - SURGERY/ANESTHESIA CONFLICT
This edit posts when a claim has been submitted for anesthesia, and has been considered as being included with payment for the surgical procedure code.

EDIT 0759 - PAYMENT REDUCED - SURGERY ANESTHESIA CONFLICT
This edit posts when a provider submits a claim for a nerve block and another for a surgical procedure. New Jersey Medicaid will not reimburse both procedures on the same date of service but will pay the higher of the two allowable amounts.

EDIT 0760 - NORPLANT EXCEEDED 2 IN 5 YEARS - SAME PROVIDER
This edit posts when the maximum number of Norplant implants in a five-year period exceeds two, and the billing provider has already been paid for two.

EDIT 0761 - NORPLANT EXCEEDED 2 IN 5 YEARS - DIFFERENT PROVIDER
This edit posts when the maximum number of Norplant implants in a five-year period exceeds two, and another provider has already been paid for two.

EDIT 0762 - MENTAL HEALTH SERVICES EXCEEDED $900.00
This edit posts when a claim is submitted for mental health services in a private office setting, and the $900 limit per rolling year is exceeded. Prior authorization is required for additional services.

EDIT 0763 - INDEPENDENT CLINIC MENTAL HEALTH SERVICE EXCEED $6000.00
This edit posts when a claim is submitted for mental health services provided by an independent clinic, and the $6,000 limit per rolling year is exceeded. Prior authorization is required for additional services.

EDIT 0764 - PARTIAL CARE AND FULL DAY CARE NOT PAYABLE ON SAME DAY
This edit posts when a claim is received for both partial care and full day care for the same date of service.

EDIT 0765 - DELIVERY/ABORTION PROCEDURE LIMITS
This edit posts when the current claim conflicts with another paid claim. Medicaid allows payment for one abortion procedure, for the same beneficiary, during a 75-day period to the same or a different provider. For delivery procedures, Medicaid will pay one in a 183-day period to the same or a different provider.

EDIT 0766 - WAIVER SERVICE CONFLICT
This edit posts when a claim is submitted for two separate waiver services for the same date of service. The Medicaid limit is one.

EDIT 0767 - PARTIAL CARE/MEDICATION MANAGEMENT CONFLICT
This edit posts when a claim is submitted for partial care (Z0180 and Z0170) and medication management (90862) for the same beneficiary on the same date of service. Medicaid policy does not allow payment for both services.

EDIT 0768 - EXCESSIVE PRIVATE DUTY NURSING HOURS - PA REQUIRED
This edit posts when the Medicaid limit for private duty nursing service is exceeded. The limit is 16 hours per day. Prior authorization is required for hours in excess of 16.

The exceptions to this rule are procedure codes Z1710 WT, Z1730 WT and Z1735 WT. These codes always require prior authorization.

EDIT 0770 - PROCEDURE CODE NOT INCLUDED IN PRIOR AUTHORIZATION
This edit posts when the Medicaid Prior Authorization file does not include the procedure code or NDC entered on the claim, or all the authorized units have been used.

EDIT 0771 - DAYS SUPPLY INCORRECTLY REPORTED AS ONE DAY
This edit posts if the days supply entry equals 1, but the entry for quantity is not 1, or vice versa.

EDIT 0772 - PA/PROVIDER NOT AUTHORIZED
This edit posts if the provider number entered on the claim does not match the provider number on the prior authorization file.

EDIT 0773 - DATE OF SERVICE CONFLICT WITH PRIOR AUTHORIZATION DATES
This edit posts when the date of service on the claim is not within the authorized date span on the prior authorization file.

EDIT 0774 - PRIOR AUTHORIZATION NOT ON FILE
This edit posts if the prior authorization number entered on the claim is not on the prior authorization file.

EDIT 0775 - PA RECORD NOT ACTIVE
This edit posts if the prior authorization number entered on the claim form reflects a prior authorization that is either suspended or inactive.

EDIT 0776 - PA DOLLARS EXHAUSTED - CUTBACK
This edit posts if the number of units entered on the claim exceeds the number of available prior authorized units.

EDIT 0779 - PA NUMBER INVALID
One of the Prior Authorization numbers reported on the claim does not begin with the appropriate prefix 01-15 or is not numeric.

EDIT 0786 - PREVIOUSLY DENIED CLAIM CANNOT BE ADJUSTED - RESUBMIT CLAIM
This edit posts when the ICN on the adjustment form (FD-999) reflects a denied claim. Denied claims must be resubmitted, not adjusted.

EDIT 0787 - ADJUSTMENT CLAIM TYPE NOT MATCHED
This edit posts to adjustment requests when the claim types do not match.

EDIT 0788 - ADJUSTMENT DENIED, ORIGINAL PAID CORRECTLY
This edit posts when, after review, it is determined that the original claim processed correctly, and this adjustment (FD-999) should not be processed.

EDIT 0789 - FORMER ICN INVALID OR SPACES
This edit posts to adjustment requests when the former ICN is invalid.

EDIT 0791 - ADJUSTMENT REQUIRES MANUAL UPDATE
This edit posts to an adjustment that requires a manual update in the system. This edit does not apply to any specific form locator.

HIPAA - N/A

EDIT 0793- ADJUSTMENT PENDED FOR ARCHIVE CYCLE
This edit is posted to an adjustment request that is in process. The claim will continue to process when the original claim file is reestablished at Molina Medicaid Solutions.

EDIT 0796 - BILLING PROVIDER NOT MATCHED ON HISTORY
This edit posts if the billing provider number on the original claim does not match the billing provider number entered on the adjustment form (FD-999).

EDIT 0797 - DUPLICATE ADJUSTMENT RECORDS ENTERED
This edit posts to adjustment requests when the system locates an adjustment transaction with the same recipient ID and former ICN as the transaction previously processed.

EDIT 0798 - HISTORY RECORD ALREADY ADJUSTED OR VOIDED
This edit posts when the ICN that was entered on the adjustment form (FD-999) has already been adjusted.

EDIT 0799 - NO CLAIM IN HISTORY FILE MATCHES ADJUSTMENT / VOID REQUEST
This edit posts if the data entered on the adjustment form (FD-999) does not match a paid claim in the history file.

EDIT 0800 - EXACT DUPLICATE CLAIM
This edit posts when the current claim conflicts with an identical claim that has already been paid. This edit does not apply to any specific form locator for hardcopy claims.

837 Institutional - The following criteria on a previous paid claim must not match that of the incoming claim: Billing Provider Number; Loop 2010AA, field NM109. Beneficiary ID; Loop 2010BA, field NM109. Patient Account

837 Professional - Same

837 Dental - Same

NCPDP - The following criteria on a previous paid claim must not match that of the incoming claim: Billing Provider Number; Transaction Header Segment, field 201-B1.

EDIT 0801 - POSSIBLE DUPLICATE CONFLICT
This edit will post if an incoming claim meets the following criteria when matched against a previously paid claim. This does not apply to any specific form locator.

HIPAA - N/A

EDIT 0802 - PHYSICIAN AND EPSDT DUPLICATE ERROR
This edit posts when the current claim has already been paid to the same provider, but as a different claim type.

EDIT 0803 - INPATIENT AND LTC DUPLICATE ERROR
This edit posts when there is a paid inpatient or LTC claim for the same date of service or span dates.

EDIT 0804 - INPATIENT AND OUTPATIENT DUPLICATE ERROR
This edit posts when the current outpatient claim conflicts with a paid inpatient claim for the same hospital, the same beneficiary and has overlapping dates of service.

EDIT 0805 - INPATIENT AND HOME HEALTH DUPLICATE ERROR
This edit posts when the current home health claim conflicts with a paid hospital claim, or vice-versa.

EDIT 0806 - LTC AND HOME HEALTH DUPLICATE ERROR
This edit posts when a LTC or home health claim has been paid, and the LTC claim does not include a home leave period.

EDIT 0807 - INPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE
This edit posts when the current inpatient claim conflicts with an institutional crossover claim that has been paid with either the same or overlapping dates of service, or vice versa.

EDIT 0809 - POSSIBLE DUPLICATE
This edit posts when the current claim conflicts with a paid claim that has a revenue code with the same first two digits.

EDIT 0810 - DUPLICATE BILL - OVERLAPPING DATES OF SERVICE
This edit is posted when an incoming claim matches a previously paid claim. This does not apply to any specific form locator.

HIPAA - N/A

EDIT 0812 - TRANSPORTATION AND INPATIENT HOSPITAL DUPLICATE ERROR
This edit posts when the current transportation claim conflicts with a paid hospital claim. Hospitals are responsible for the cost of transporting patients from one hospital to another. If the hospital requested transportation, the transportation provider must request reimbursement from the facility.

EDIT 0813 - OUTPATIENT AND INSTITUTIONAL CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare institutional crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0814 - PHYSICIAN AND PHYSICIAN CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare physician crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0815 - AMBULANCE AND AMBULANCE CROSSOVER DUPLICATE
This edit posts when the current Medicare transportation crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0816 - CLINIC AND CLINIC CROSSOVER CLAIM
This edit posts when the current Medicare clinic crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0817 - P&O AND P&O CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare P & O crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0818 - DME AND DME CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare DME crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0819 - LAB AND LAB CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare laboratory crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0820 - OPTOMETRIST AND OPTOMETRIST DUPLICATE ERROR
This edit posts when the current Medicare optometrist crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0821 - MIDWIFE AND MIDWIFE CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare midwife crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0822 - EPSDT AND EPSDT CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare EPSDT crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0823 - LTC AND LTC CROSSOVER DUPLICATE ERROR
This edit posts when the current Medicare LTC crossover claim conflicts with a paid claim for the same servicing provider, the same beneficiary, and the same or overlapping dates of service, or vice versa.

EDIT 0825 - INPATIENT CLAIM CUTBACK BY PREVIOUSLY PAID OUTPATIENT CLAIM
This edit posts to inpatient claims because the hospital had already been paid for an outpatient claim with one or more dates of service within the inpatient stay. The inpatient payment is reduced accordingly.

EDIT 0826 - DUPLICATE OF PREVIOUSLY PAID CLAIM - DENIED AFTER REVIEW
This edit posts to hardcopy pharmacy claims previously denied for 827. After review, it was determined that the reason for dispensing two prescriptions was not sufficiently explained, or the reason did not substantiate Medicaid reimbursement.

EDIT 0827 - PHARMACY EXACT DUPLICATE BILL - SAME PROVIDER
This edit posts when there is a paid claim on file for the same provider, same beneficiary, same date of service and the same NDC generic code.

EDIT 0828 - PHARMACY EXACT DUPLICATE BILL - DIFFERENT PROVIDER
This edit posts when the same claim was paid to another pharmacy.

EDIT 0829 - EARLY REFILL SAME PROVIDER, DENIED AFTER REVIEW
This edit posts when a pharmacy claim and the attached explanation for an early refill are reviewed and determined to be not payable.

EDIT 0830 - EARLY REFILL - SAME PROVIDER
This edit posts when the prescription being filled is not 85% use. If the Beneficiary is General Assistance the prescription can not be filled until 90% is gone.

EDIT 0831 - EARLY REFILL- DIFFERENT PROVIDER, DENIED AFTER REVIEW
This edit posts when a pharmacy claim and the attached explanation for an early refill are reviewed and determined to be not payable.

EDIT 0832 - EARLY REFILL - DIFFERENT PROVIDER
This edit posts for a early refill done by the same provider. Refills must be at least 85% used unless it is for a General Assistance then it must be 90% used.

EDIT 0833 - CLAIM FOR CONTINUOUS LEAVE - NO PRIOR SERVICE DATE PAID CLAIM
This edit posts when a beneficiary who receives Medicare benefits is admitted to a hospital, and the LTC facility entered leave code H instead of M on the TAD.

EDIT 0837 - TBI BEHAVIOR PROGRAM EXCEED UNITS OF SERVICE
The maximum number of units payable for Y7564 is four per calendar year. This edit posts because the history file indicates payment for four units.

EDIT 0838 - PROVIDER PRODUCED EOB IS INCOMPLETE
This edit posts when a claim is submitted with a computer generated EOMB, but after review, it is determined that the EOMB did not supply all the required data. It must always include 1) the beneficiary's name, 2) the amount billed to Medicare, 3) the Medicare allowed amount, 4) the date of service and 5) the coinsurance amount.

In addition, the following information must be included on the EOMB if applicable:

If Medicare denied the claim, the denial reason must be included.

If the beneficiary's name on the claim does not match the EOMB, the beneficiary's Medicare number must be included.

If the service date is over the timely filing limit, the EOMB must include the Medicare payment date and their Internal Control.

If a deductible amount is involved, it must be included.

EDIT 0839 - ADJUSTMENT MUST HAVE CORRECTED CLAIM WITH ATTACHMENTS
This edit posts when, after review of the adjustment request, it is determined that the EOMB or TPL attachment was not included with the FD-999.

EDIT 0840 - EXACT DUPLICATE WITHIN GROUP PRACTICE
This edit posts when the current claim conflicts with a paid claim for the same date of service, same beneficiary number, same procedure code, but a different servicing provider.

EDIT 0841 - PROVIDER CANNOT BE SURGEON AND ASSISTANT SURGEON OR ANESTHESIOLOGIST
This edit posts when the current claim conflicts with at least one other paid claim for the same servicing provider, and with the modifier 80 or AA or vice versa.

EDIT 0842 - ADJUSTMENT MUST HAVE CORRECTED CLAIM ATTACHED
This edit posts when, after review of this adjustment (FD-999), it is determined that the description did not identify the requested change, and a corrected claim was not attached to the FD-999. The provider must resubmit the adjustment with a corrected claim attached to the FD-999, and identify the requested change clearly and concisely in Item 5 on the FD-999.

EDIT 0843 - ADJUSTMENT REQUEST NEEDS TO BE MORE SPECIFIC
This edit posts when, after review of this adjustment (FD-999), it is determined that the description entered in Item 5 did not identify the requested change. The provider must resubmit the adjustment, and identify the requested change clearly and concisely in Item 5 on the FD-999.

EDIT 0845 - ADJUSTMENT DENIED/EOMB REQUIRED
This edit posts when, after review of this adjustment (FD-999), it is determined that the Explanation of Medicare Benefits (EOMB) must also be reviewed before the adjustment can be processed. The EOMB is required for all Medicare crossover adjustments.

EDIT 0846 - ADJUSTMENT MUST HAVE RA ATTACHED
This edit posts when, after review, it is determined that all Remittance Advice (RA) pages relevant to the paid claim were not attached to the FD-999, and those pages are essential for the review. The provider must resubmit the FD-999 with the relevant RA pages.

EDIT 0847 - INCORRECT ICN ON FD-999
This edit posts when, after review, it is determined that the beneficiary's name on the paid claim matches the name on the FD-999, but other claim data (diagnosis code, procedure code etc.) does not match the attached claim form.

EDIT 0848 - ADJUSTMENT CLAIM MISSING PAYER/CARRIER CODE/OR TPL PAYMENT
This edit posts when, after review, it is determined that the adjustment (FD-999) cannot be processed because the payer, carrier code and/or TPL payment amount was not entered either in Item 5 of the FD-999 or on the attached claim. The provider must resubmit the correct FD-999 with a correct claim form.

EDIT 0849 - RENTAL DENIED PURCHASE WITHIN 24 MONTHS
This edit posts to a DME claim when the system shows that there has been a purchase for the same procedure code paid to the same provider for the same beneficiary within a 24 month period. This edit does not apply to any specific form locators.

EDIT 0851 - RENTAL DENIED 6 WITHIN 24 MONTHS.
This edit posts to a DME claim when the system shows that there has been a purchase for the same procedure code paid to the same provider for the same beneficiary within a 24 month period. This edit does not apply to any specific form locators.

EDIT 0852 - RENTAL DENIED 10 WITHIN 24 MONTHS.
This edit posts to a DME claim when the system shows that there were already 10 months paid for the same procedure, for the same beneficiary and provider within a 24 month period. Any rental over $100.00 is only eligible to be paid for 10 months after that, it is considered a purchase. This edit does not apply to any specific form locators.

EDIT - 0853 PURCHASE DENIED 6 RENTALS WITHIN 24 MONTHS.
This edit posts to a DME claim when the system shows that there were 6 rentals paid for the same procedure, for the same beneficiary and provider within a 24 month period. This edit does not apply to any specific form locators.

EDIT - 0854 PURCHASE DENIED 10 RENTALS WITHIN 24 MONTHS.
This edit posts to a DME claim when the system shows that there were 10 rentals paid for the same procedure, for the same beneficiary and provider within a 24 month period. This edit does not apply to any specific form locators.

EDIT - 0855 PURCHASE DENIED 1 IN 24 MONTHS
This edit posts to a DME claim when the system shows that there was a payment made for a purchase of the same procedure, for the same beneficiary and provider within a 24 month period. This edit does not apply to any specific form locators.

EDIT 0857 - WEEKLY PCA/MENTAL HEALTH HRS EXCEED 25 HRS
This edit posts because the maximum hours for Personal Care Assistant mental health services has been exceeded. It is 25 hours a week per beneficiary.

EDIT 0858 - WEEKLY PCA HOURS EXCEED 40 HRS
This edit posts because the maximum hours for Personal Care Assistant services has been exceeded. It is 40 hours a week per beneficiary.

EDIT 0859 - CLAIM OVERLAPS WEEK
This edit posts because the service week for Personal Care Assistant services overlaps from one week to the next. The PCA workweek starts at 12:01 am on Sunday and ends at 12:00 Midnight on Saturday.

EDIT 0860 - PROCEDURE CODE MODIFIERS IN CONFLICT
This edit posts for a DME claim when there is either a paid purchase or rental already on file.

EDIT 0861 - LIMIT OF 6 CONSECUTIVE RENTALS EXCEEDED
This edit posts when the rental period for DME has been exceeded, and the item is considered purchased.

EDIT 0862 - LIMIT OF 10 CONSECUTIVE RENTALS EXCEEDED
This edit posts when the rental period for DME has been exceeded, and the item is considered purchased.

EDIT 0865 - LTC AND HOSPICE DUPLICATE ERROR
This edit posts when a LTC and Hospice claim have the same or overlapping dates of service for the same beneficiary.

EDIT 0866 - CUTBACK / PAYMENT REDUCED BY PRIOR RENTALS
This edit posts to DME claims and indicates consecutive rentals just prior to the purchase. Medicaid reduces the payment by the number of prior consecutive rentals.

EDIT 0867 - PCA SERVICES > 25 HRS & VALID PA NUMBER IS NOT ON CLAIM
This edit posts when weekly Personal Care Assistant services for this beneficiary exceed 25 hours. A "week" begins at 12:01 am on Sunday and ends at 12:00 midnight on Saturday.

EDIT 0868 - PCA UNITS OF SERVICE EXCEEDS WEEKLY ALLOWABLE ON THE PA
This edit posts when the weekly Personal Care Assistant services for this beneficiary have exceeded the available hours on the prior authorization file.

EDIT 0869 - POSSIBLE (SEVERE) DD CONFLICT - 30 DAY EXIT
This is an EOB edit that will determine if the drug billed will cause severe harm to the beneficiary if taken with another drug at the same time. It posts if the generic code is subject to the 30-day supply extension defined by the Medical Exception process.

EDIT 0870 - POSSIBLE WARFARIN CONFLICT
This EOB edit will determine if the drug billed will cause severe harm to the beneficiary if taken with another drug at the same time. It will post if there is a claim on history for the beneficiary with a Standard Therapeutic Class that conflicts with the new claim.

EDIT 0872 - KIDCARE THERAPY SERVICE LIMITS
This edit posts when benefits to this beneficiary, limited to 60 visits for speech, occupational and physical therapy per HMO contract, have been exceeded within the contract year. The contract year starts on 10/01 and ends on 09/30.

EDIT 0873 - KIDCARE D MENTAL HEALTH SERVICE EXCEEDED
This edit posts when benefits to this beneficiary, limited to 35 inpatient days and 40 outpatient services per calendar year, have been exceeded.

EDIT 0875 - FAMILY CARE PE FUNDS EXHAUSTED
This edit posts because the available funds to pay for services rendered to Family Care presumptively eligible (PE) patients are limited. Prior Family Care PE claims have exhausted the State's fiscal limit. The fiscal year is from July 1 through June 30.

EDIT 0876- CO-PAY FOR SERVICE DATE PAID
This edit posts when there is a previously paid outpatient co-pay claim on file for the same provider, same beneficiary and same or overlapping dates of service.

EDIT 0878 - NO EMERG CLAIM FOR ALIEN TRANS
This edit is posted to emergency transportation claims with specific procedure codes for a beneficiary on a special program without an additional emergency claim on file for the same day.

EDIT 0880 - CUMULATIVE RETRO REVIEW
This EOB edit posts when the threshold for the drug billed is exceeded by prior claims.

EDIT 0881 - URO / DRG ADJUST - REQUEST DENIED
This edit advises providers that the claim they are attempting to void or adjust has already been adjusted based on a Utilization Review audit.

EDIT 0884 - CLAIM DENIED, SUBMIT DME CLAIM TO MEDICARE
This edit posts when a beneficiary is eligible for Medicare, and the billed drug is payable by Medicare.

EDIT 0885 - NON-PARTIC PHARM PROV SVE W/PA
This EOB edit posts to override edit 893, which denies a claim because the beneficiary's file reflects other coverage.

EDIT 0886 - OVERRIDE EDIT 893 NOT NECESSARY
This EOB edit indicates that the beneficiary has no other coverage on file. However, an Other Coverage code of 1 was incorrectly reported on the claim.

EDIT 887 - POS/MATCHING HISTORY NOT FOUND
This edit posts to Pharmacy POS claims only when no matching ICN is found for the adjustment/void submitted for processing. This does not apply to any specific form locator.

HIPAA - N/A

EDIT 0892 - NO INSURANCE COVERAGE KNOWN, BUT INSURANCE PAYMENT REDUCED
This edit posts to a pharmacy claim when the beneficiary's eligibility file does not reflect other coverage, but the provider received an insurance payment.

EDIT 0893 - INSURANCE COVERAGE KNOWN, OTHER COVERAGE CODE = 0
This edit posts to pharmacy claims when the beneficiary has other coverage, but the other coverage indicator is 0, reflecting no specified coverage.

EDIT 0894 - OVERRIDE FOR EDIT 893
This edit will override edit 893 when the pharmacy reports the other coverage indicator of 1.

EDIT 0895 - TPL PAYMENT CONFLICTS WITH OTHER COVERAGE CODE
This edit posts to pharmacy claims when the other coverage indicator denotes no coverage, no coverage for the product, or payment not collected.

EDIT 0896 - NO INSURANCE PAYMENT RECEIVED, BUT OTHER COVERAGE CODE = 2
This edit posts to pharmacy claims when no other insurance payment is reported on the claim, but the pharmacist reported the other coverage indicator of 2.

EDIT 0901 - MULTIPLE SURGERY - PAID AS PRIMARY PROCEDURE
This edit posts when more than one surgery is billed for the same date of service, and only the primary surgery is paid at the Medicaid allowable amount. The primary surgery reflects the one with the highest Medicaid allowable. The other "secondary" surgeries are paid at 50 percent of the Medicaid allowable up to a maximum of 200 percent of the primary surgery payment amount. Surgeries beyond this threshold are paid at zero.

EDIT 0902 - MULTIPLE SURGERY - PAID AS SECONDARY PROCEDURE
This edit posts to all secondary surgeries paid at 50 percent of the Medicaid allowable.

EDIT 0903 - MULTIPLE SURGERY - PRIMARY PROCEDURE REDUCED BY PRIOR PAID CLAIM
This edit posts when a primary surgery claim is processed after the secondary surgeries. The amount that was previously paid, because it was paid as primary, is recouped and reflected as a cutback on this claim.

EDIT 0904 - MULTIPLE SURGERY - ZERO PAID, 200 % LIMIT EXCEEDED
This edit posts to a secondary surgery when the 200 percent threshold has been reached.

EDIT 0905 - MULTIPLE SURGERY - REDUCED BY INCIDENTAL PROCEDURE
This edit posts when a primary surgery claim is processed after the secondary surgeries, and 100 percent of the previous payment is recouped and reflected as a cutback on this claim.

EDIT 0906 - MULTIPLE SURGERY - ZERO PAID, INCIDENTAL PROCEDURE
This edit posts to a secondary surgery because Medicaid determined that this surgery is incidental to one of the other surgeries and is not payable.

EDIT 0907 - MULTIPLE SURGERY - FIRST UNIT PRIMARY, ADDITIONAL AS SECONDARY
This edit posts to a claim reflecting multiple units with a procedure code representing surgery. One of the units on the claim is priced as primary (100 percent of the Medicaid allowable) while the remaining units are priced as secondary (50 percent of the Medicaid allowable) up to 200 percent of the primary payment.

EDIT 0910 - PAYMENT EXCEEDS THRESHOLD
This edit posts when a review determines that this claim is not payable because it would exceed the Medicaid threshold.

EDIT 0914 - NICU PROCEDURES INCLUDED IN GLOBAL FEE
This edit posts when the current claim is for a general procedure that was already included in the payment for neonatal intensive care.

EDIT 0915 - MULTIPLE LTC/HOSPICE CLAIMS PROCESSED SAME MONTH AND YEAR
This edit is posted when multiple LTC/Hospice claims are processed for the same calendar month and year. The patient payment amount of the claim will be set to zero. This does not apply to specific form locator.

HIPAA - N/A

EDIT 0916 - SEVERE DRUG / DRUG INTERACTION
This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors severe interaction between two or more drugs.

EDIT 0917 - MODERATE DRUG / DRUG INTERACTION
This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors moderate interaction between two or more drugs.

EDIT 0919 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR NEW JE
This edit denies the second claim submitted to Molina Medicaid Solutions when the first claim is paid in a NJ Hospital readmission situation. A readmission situation in NJ is when discharge and readmission dates are at the same hospital for the same beneficiary with the same first three digits of the principle diagnosis within seven (7) days.

For these readmissions, hospital stays must be combined for pricing purposes. However, if the hospital does not agree that the two stays should be combined, they can appeal the denied claim as described in the June 1998 Newsletter, Volume 8, No. 44 for Hospital readmissions.

EDIT 0920 - DISCHARGE DATE AND READMIT DATE WITHIN SET SPANS FOR PENNSYLVANIA
This edit denies the second claim submitted to Molina Medicaid Solutions when the first claim is paid in a PA Hospital readmission situation. A readmission situation in PA is when discharge and readmission dates are at the same hospital for the same beneficiary with the same first three digits of the principle diagnosis within thirty-one (31) days.

For these readmissions, hospital stays must be combined for pricing purposes. However, if the hospital does not agree that the two stays should be combined, they can appeal the denied claim as described in the June 1998 Newsletter, Volume 8, No. 44 for Hospital readmissions.

EDIT 0921 - MILD DRUG / DRUG INTERACTION
This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors mild interaction between two or more drugs.

EDIT 0922 - PREGNANCY PRECAUTION -DUR
This edit establishes Drug Utilization Review (DUR) standards for the duration of the drug. It monitors potential pregnancy drug conflicts.

EDIT 0924 - DISCHARGE DATE AND READMIT DATE WITHIN SET TIME SPAN FOR NEW YORK
This edit denies the second claim submitted to Molina Medicaid Solutions when the first claim is paid in a NY Hospital readmission situation. A readmission situation in NY is when discharge and readmission dates are at the same hospital for the same beneficiary with the same first three digits of the principle diagnosis within thirty (30) days.

For these readmissions, hospital stays must be combined for pricing purposes. However, if the hospital does not agree that the two stays should be combined, they can appeal the denied claim as described in the June 1998 Newsletter, Volume 8, No. 44 for Hospital readmissions.

EDIT 0925 - UTILIZATION REVIEW APPROVAL MISSING/INCORRECT
This edit is posted as a denial if the hospital's readmission appeal for two stays instead of one stay is denied by the State and the claims must be combined as described in the June 1998 Newsletter, Volume 8, No. 44 for Hospital Readmissions.

The claim paid if the hospital's readmission appeal for two stays instead of one stay was approved by the State. (Please see edit codes 919, 920 and 924).

EDIT 0926 - AUTHORIZATION FOR ORTHO SERVICES EXCEEDED PA REQUIRED
This edits posts to a dental claim for orthodontic services for procedure code D8080 that exceeds 2 years from the date of initial payment. Pa is now required.

EDIT 0927 - DUR EDIT POSTED - PA REQUIRED AFTER 30 DAYS SUPPLIED
This edit posts to pharmacy claims to notify the pharmacist that a prescription exceeds the DUR standards and will require prior authorization if the next claim for the drug exceeds the 30 day extension.

EDIT 0928 - DUR EDIT POSTED, 30 DAY SUPPLY PARTIALLY EXHAUSTED, PA REQUIRED
This edit posts to notify the pharmacist that the prescription exceeds the DUR standards and the 30-day supply extension. To receive full payment, prior authorization is required.

EDIT 0929 - DUR EDIT - ALLOWABLE 30 DAY SUPPLY EXHAUSTED - PA REQUIRED
This edit posts to notify the pharmacist that the prescription exceeds the DUR standards and the 30-day supply extension. To receive payment for the claim, prior authorization is required.

EDIT 0930 - BED-HOLD EXCEEDS MAXIMUM OF 10 CONSECUTIVE DAYS
This edit posts when the bed-hold maximum of 10 consecutive days is exceeded.

EDIT 0931 - OVERLAPPING DATES OF SERVICE FOR PROCEDURE CODE GROUP
This edit posts when more than one of the following procedure codes is billed on the same date of service: Y6333 (routine home care), Y6334 (continuous home care), Y6335 (inpatient respite care), Y6336 (general inpatient care), Y6337 (therapeutic leave days), Y6338 (bed hold days), Z2015 (room and board).

EDIT 0932 - THERAPEUTIC LEAVE EXCEEDS MAXIMUM TO 24 CONSECUTIVE DAYS
This edit posts when the therapeutic leave maximum of 24 days within a year is exceeded.

EDIT 0935 - GENERAL INPATIENT CARE AND INPATIENT CLAIM BILLED SAME DAY
This edit posts when a current claim with procedure code Y6336 or T2045 conflicts with a paid inpatient claim for the same date of service, or vice versa.

EDIT 0936 - INPATIENT RESPITE CARE EXCEEDS MAXIMUM OF 5 CONSECUTIVE DAYS
This edit posts when the maximum, per occurrence, for inpatient respite care (Y6335) of 5 days is exceeded.

EDIT 0939 - RECIPIENT IS MEDICARE PART A ELIGIBLE
This edit posts when it is determined that the services on the claim are payable by Medicare. The provider must bill Medicare Part A first.

EDIT 0941 - SENIOR GOLD CO-PAY APPLIED FROM VOIDED CLAIM
This EOB edit posts when the cutback dollar amount for a Senior Gold beneficiary is not recalculated because the same prescription was filled and voided.

EDIT 0947 - MEDICARE OUTPATIENT PART B EOMB MISSING
This edit posts when a review determines that Payer Code 015 was on the claim, but the Medicare Part B EOMB was not attached.

EDIT 0949 - CLAIM VOIDED - BILLING PROVIDER ERROR
This edit explains an adjustment when a provider billed under the wrong provider number.

EDIT 0952 - CLAIM VOIDED - RECIPIENT ID ERROR
This edit explains an adjustment when a provider billed under the wrong beneficiary id number.

EDIT 0953 - CLAIM VOIDED - SERVICE BILLED INCORRECTLY
This edit explains an adjustment done from a service not provided.

EDIT 0954 - CLAIM VOIDED - SYSTEM PROCESSING ERROR
This edit explains an adjustment from a system error.

EDIT 0955 - CLAIM VOIDED; RESUBMITTED AS ORIGINAL CLAIM
This edit posts when a claim has been voided and reprocessed.

EDIT 0956 - CLAIM REPROCESSED TO CORRECT PAYMENT
This is an informational edit only to advise that the claim has been reprocessed to correct a previous payment. This does not apply to a specific form locator.

HIPAA - N/A

EDIT 0957 - CLAIM CORRECT OR REPROCESSED BY REQUEST
This edit posts to an adjusted claim to specify that it is a Provider requested adjustment. This does not apply to any specific form locator for hardcopy claims.

HIPAA - N/A

EDIT 0959 - CLAIM UPDATED WITH TPL PAYMENT
This edit explains an adjustment involving third party insurance.

EDIT 0960 - CLAIM UPDATED WITH PATIENT PAYMENT
This EOB edit explains an adjustment involving beneficiary liability.

EDIT 0961 - SYSTEM UPDATE TO PATIENT INCOME
This EOB edit explains an adjustment involving system-generated updates to beneficiary income.

EDIT 0962 - ADJUSTMENT OR VOID CORRESPONDS TO PROVIDER REFUND
This EOB edit explains an adjustment involving a provider refund.

EDIT 0965 - MEDICARE INPATIENT PART A EOMB MISSING
This edit posts when a review determines that Payer Code 011 was on the claim, but the Medicare Part A EOMB was not attached.

EDIT 0966 - MEDICARE INPATIENT PART B EOMB MISSING
This edit posts if a review determines that this beneficiary has Medicare Part B. A provider must bill Medicare Part B first.

EDIT 0970 - BILL THIRD PARTY CARRIER FIRST
This edit is posted if the TPL file contains coverage data in effect for the beneficiary on the service dates billed on the claim. The TPL EOB must be attached to the claim with the corresponding carrier or payer code indicated in the appropriate field on the claim. Below reflects the form locators related to this edit:

ADA	11
CMS-1500	10d and 11d
UB-04	50 & 60
MC-6	28
MC-9	7
MC-12	8

NCPDP - AM04; 340-7C

EDIT 0971 - MISSING CARRIER CODE/PAYER CODE
This edit is posted if the TPL carrier/payor code is not coded on the claim. This code is used to identify the other insurance and the presence of an attached EOB. Below reflects the form locators related to this edit:

ADA	11
CMS-1500	10D
UB-04	50
MC-6	28
MC-9	7
MC-12	8

837 Institutional - 2330B/NM109
837 Professional - 2330B/NM109
837 Dental - 2330B/NM109

EDIT 0972 - NO EOB ATTACHED; RECIPIENT WITH OTHER RESOURCE INDICATED
This edit posts when a three-digit carrier code or payer code is present on the claim but the EOB or letter of denial was not submitted with the claim.

EDIT 0973 - CLAIM REQUIRES REVIEW FOR MULTIPLE TPL RESOURCE
This edit posts when a claim is received with multiple carrier or payer codes and a payment amount from third party sources. The sum of payments on the EOB attachments, including zero payments must equal the TPL amount on the claim.

EDIT 0974 -TPL PAYMENT ON EOB MISSING FROM CLAIM
This edit will post when the claim contains carrier codes and the TPL EOB payment was not billed on the claim.

ADA	32
CMS-1500	29
UB-04	54
MC-6	26
MC-9	29
MC-12	21
MC-19	29

837 Institutional - LOOP 2430 SEGMENT SVD02
837 Professional - LOOP 2430 SEGMENT SVD02
837 Dental - LOOP 2430 SEGMENT SVD02
NCPDP - 111-AM;431-DV

EDIT 0975 - RESOURCE FILE INDICATES INSURANCE OTHER THAN THAT BILLED
This edit is posted when the recipient has private insurance and the carrier code was missing from the claim or the carrier code does not match the resource file. Below are the form locators that relate to this edit:

ADA	11
CMS-1500	10D
UB-04	50
MC-6	22
MC-9	7
MC-12	8
MC-19	9

HIPAA - N/A

EDIT 0976 - MEDICAID PAYMENT REDUCED BY OTHER INSURANCE
This edit posts because the claim reflects a TPL amount that has been subtracted from the Medicaid tentative allowable amount. If there has been no prior payment, then the amount paid field must be blank or $0. Below are the claim forms and the form locators that apply:

ADA	32
CMS-1500	29
MC-6	26
MC-9	29
MC-12	21
MC-19	17
LTC TAD	36
UB04	54

837 Institutional - 2430/SVD02
837 Professional - 2430/SVD02
837 Dental - 2430/SVD02 NCPDP - 431-DV

EDIT 0979 - RECIPIENT IS MEDICARE PART B ELIGIBLE
This edit posts when the beneficiary is eligible for Medicare/Medicare HMO, and Medicare covers the procedure code entered on the claim. The provider must bill Medicare, or resubmit with the Medicare EOMB attached to the claim. This edit does not apply to any specific form locator for hardcopy claims.

HIPAA - N/A

EDIT 0980 - EOB ATTACHED FOR CARRIER/PAYER NOT REPORTED ON CLAIM
This edit posts because, after review, it is determined that either the attached EOB does not match the carrier code or payer code entered on the claim, or an EOB is missing that corresponds to a carrier code or payer code that appears on the claim.

EDIT 0981 - RECIPIENT/DATES OF SERVICE DO NOT MATCH EOB
This edit posts when, after review, it is determined that either the date of service or the beneficiary's name does not match the EOB.

EDIT 0982 - EOB INDICATES BILLING ERROR, REBILL TO CARRIER
This edit posts when the EOB or EOMB attached to the claim indicates that another insurance company or Medicare denied the claim for a correctable error. Because Medicaid is the payer of last resort, the other carrier must be re-billed.

EDIT 0983 - RESOURCE FILE INDICATES INSURANCE OTHER THAN PAYER CODE CODED
This edit posts when the payer code entered on the UB-92 Claim Form is not listed on the Medicaid TPL resource file. The provider must enter payer code that identifies the beneficiary's other carrier.

EDIT 0985 - TPL PAYMENT ON CLAIM DOES NOT EQUAL PROVIDER PAYMENT ON EOBs
This edit posts when, after review, it is determined that the TPL payment indicated on the EOB does not match the payment amount entered on the claim form.

EDIT 0986 - INVALID PAYER ID
This edit posts if a payer code entered on the claim is not listed on the Medicaid TPL Resource file.

EDIT 0993 - CLAIM DENIED AT PROVIDER REQUEST
This edit is manually applied when a provider requests that a claim in process be denied for any reason.

EDIT 0994 - PRIOR PAY AMOUNT MISSING OR DOES NOT MATCH
This edit posts when, after review, it is determined that the TPL payment on the EOB does not match the payment amount entered on the claim form.

EDIT 1001 - REVENUE UNITS (45 LINES) ARE GREATER THAN 999
This edit posts when the claim being billed (up to 45 lines) has revenue units greater than 999.

EDIT 1002 - DAYS ACUTE ARE GREATER THAN 999
This edit posts when the claim being billed has more than 999 acute days.

EDIT 1003 - DAYS SNF ARE GREATER THAN 999
This edit posts when the claim being billed has more than 999 SNF days.

EDIT 1004 - DAYS ICF ARE GREATER THAN 999
This edit posts when the claim being billed has more than 999 ICF days.

EDIT 1005 - DAYS RESIDENTIAL ARE > 999
This edit posts when the claim being billed has more than 999 Residential days.

EDIT 1203 - STATE REQUESTED ON LINE HISTORY ONLY DENIAL
This edit will post as a result of claims that have been in a Pend Status and the State has requested that this denial be a history-only transaction and have no financial impact. Therefore, the denied claim has not appeared on the provider's remittance advice. This EOB is to indicate that the claim is not on an RA.

EDIT 1204 - ANESTHESIA SERV NOT PAYABLE-SURG PROC WITH AA MOD REQ
This edit posts when the claim is being billed with a code not valid.

EDIT 1214 - INVALID NDC OR NDC NOT ON FILE
This edit is posted to the claim if the claim has a procedure code: J0120 thru J9999; Q0144 thru Q0181; Q4079 thru Q4081; Q9945 thru Q9999, Q3025, Q3026, Q2009, Q2017. These procedure codes require a corresponding NDC in order to price and process the claim. Below are the form locators that relate to this edit:

CMS-1500 24A shaded area
UB-04 43

837 Institutional - OP: 2410: LIN03
837 Professional - 2410: LIN03

EDIT 1215 - PROCEDURE/NDC COMBINATION IS INVALID OR NOT ON FILE
This edit posts when the Procedure code and NDC do not match.

EDIT 1217 - TAXONOMY CODE IS MISSING FOR THE BILLING PROVIDER
This edit posts when the taxonomy code is missing for the billing provider.

EDIT 1218 - TAXONOMY CODE IS INVALID FOR THE BILLING PROVIDER
This edit posts when the taxonomy code is invalid for the billing provider.

EDIT 1219 - TAXONOMY CODE IS MISSING FOR THE SERVICING PROVIDER
This edit posts when the taxonomy code is missing for the servicing provider.

EDIT 1220 - TAXONOMY CODE IS INVALID FOR THE SERVICING PROVIDER
This edit posts when the taxonomy code is invalid for the servicing provider.

EDIT 1221 - NPI IS MISSING FOR SERVICING/RENDERING PROVIDER
This edit posts when the NPI is missing for the servicing/rendering provider.

EDIT 1222 - NPI IS INVALID FOR SERVICING/RENDERING PROVIDER
This edit posts when the NPI is invalid for the servicing/rendering provider.

EDIT 1223 - NPI IS MISSING FOR ATTENDING PROVIDER
This edit posts when the NPI is missing for the attending provider.

EDIT 1224 - NPI IS INVALID FOR ATTENDING PROVIDER
This edit posts when the NPI is invalid for the attending provider.

EDIT 1225 - NPI IS MISSING FOR REFERRING PROVIDER
This edit posts when the NPI is missing for the referring provider.

EDIT 1226 - NPI IS INVALID FOR REFERRING PROVIDER
This edit posts when the NPI is invalid for the referring provider.

EDIT 1227 - NPI IS MISSING FOR OPERATING PROVIDER
This edit posts when the NPI is missing for the operating provider.

EDIT 1228 - NPI IS INVALID FOR THE OPERATING PROVIDER
This edit posts when the NPI is invalid for the operating provider.

EDIT 1229 - NPI IS MISSING FOR BILLING PROVIDER
This edit posts when the NPI is missing for the billing provider.

EDIT 1230 - NPI IS INVALID FOR BILLING PROVIDER
This edit posts when the NPI is invalid for the billing provider.

EDIT 1231 - NPI IS MISSING FOR OTHER PROVIDER
This edit posts when the NPI is missing for the other provider.

EDIT 1232 - NPI IS INVALID FOR OTHER PROVIDER
This edit posts when the NPI is invalid for the other provider.

EDIT 1233 - NPI IS MISSING FOR PRESCRIBING PROVIDER
This edit posts when the NPI is missing for prescribing provider.

EDIT 1234 - NPI IS INVALID FOR PRESCRIBING PROVIDER
This edit posts when the NPI is invalid for the prescribing provider.

EDIT 1235 - NPI NOT ON FILE FOR SERRVICING/RENDERING PROVIDER
This edit posts when the NPI is not on file for the servicing/rendering provider.

EDIT 1236 - ZIP CODE IS MISSING OR INVALID
This edit posts when the Zip code is missing or invalid.

EDIT 1237 - PROVIDER NOT MAPPED - SERV/REND
This edit posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

EDIT 1238 - PROVIDER NOT MATCHED - SERV/REND
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1239 - NPI NOT ON FILE - BILLING
This edit posts when the NPI is not on file for the billing provider.

EDIT 1240 - PROVIDER NOT MAPPED - BILLING
This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

EDIT 1241 - PROVIDER NOT MATCHED - BILLING
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1242 - NPI NOT ON FILE - ATTENDING
This edit posts when the NPI is not on file for the attending provider.

EDIT 1243 - PROVIDER NOT MAPPED – ATTENDING
This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

EDIT 1244 - PROVIDER NOT MATCHED - ATTENDING
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1245 - NPI NO TON FILE - REFERRING
This edit posts when the NPI is not on file for the referring provider.

EDIT 1246 - PROVIDER NOT MAPPED-REFERRING
This edit is posted to an electronic claim when an NPI was found, but there is no corresponding entry and a default provider was not found.

EDIT 1247 - PROVIDER NOT MATCHED - REFERRING
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1249 - MISSING PRIMARY PAYER ID
This edit will post to an inpatient hospital claim when the primary payer ID is equal to zeroes or spaces. The system has determined that the Primary approved amount, paid amount, deductible/coinsurance amount is greater than zeroes.

EDIT 1250 - MISSING SECONDARY PAYER ID
This edit will post to an Inpatient hospital claim when the secondary payer ID is equal to zeroes or spaces. The system has determined that the Secondary approved amount, paid amount, deductible/coinsurance amount is greater than zeroes.

EDIT 1251 - MISSING TERTIARY PAYER ID
This edit will post to an inpatient hospital claim when the tertiary payer ID is equal to zeroes or spaces. The system has determined that the tertiary approved amount, paid amount, deductible/coinsurance amount is greater than zeroes.

EDIT 1252 - MISSING DEDUCTIBLE, COINSURANCE OR CO-PAYMENT AMOUNT
This edit will post to an Inpatient hospital claim with a carrier approved amount or paid amount on the claim that is greater than zero and the sum of the deductible, coinsurance or co-payment amount is zero.

EDIT 1253 - SUM OF SUBMITTED DEDUCT, COINS OR CO-PAY EXCEEDS APPR AMT
This edit will post to an inpatient hospital claim when the claim indicates a sum for deductible, coinsurance and/or co-payment amount that exceeds the Medicare approved amount. This edit applies to HIPAA claims only.

EDIT 1254 - INVALID PRIMARY BENEFITS EXHAUST DATE
This edit will post to an inpatient hospital claim when the Primary Benefits Exhaust Date is not prior to or equal to the service through date.

EDIT 1255 - NO PRIMARY PAYOR LIABILITY AMOUNTS
This edit will post to an Inpatient Medicare Supplementation claim when the exhausted charges indicated show no Patient Liability Amounts corresponding to the Primary Payor submitted on the claim.

EDIT 1256 - NO SECONDARY PAYOR LIABILITY AMOUNTS
This edit will post to an Inpatient Medicare Supplementation claim when the exhausted charges indicated show no Patient Liability Amounts corresponding to the Secondary Payor submitted on the claim.

EDIT 1257 - NO TERTIARY PAYOR LIABILITY AMOUNTS
This edit will post to an Inpatient Medicare Supplementation claim when the exhausted charges indicated show no Patient Liability Amounts corresponding to the Tertiary Payor submitted on the claim.

EDIT 1258 - SERVICES PAID AT CHILDREN'S RATE
This edit posts when the claim is for a beneficiary 21 years or younger and the procedure is being paid at the children's rate. This rate can be found at www.njmmis.com under Forms and Documents". This does not apply to any specific form locator for hardcopy claims.

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EDIT 1260 - NPI NOT ON FILE - OPERATING
This edit posts when the NPI is not on file for the operating provider.

EDIT 1261 - PROVIDER NOT MAPPED - OPERATING
This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

EDIT 1262 - PROVIDER NOT MATCHED - OPERATING
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1263 - NPI NO TON FILE OTHER
This edit posts when the NPI is not on file for the other provider.

EDIT 1264 - PROVIDER NOT MAPPED - OTHER
This edit is posted to an electronic claim when an NPI was found, but there is no corresponding provider entry and a default provider was not found.

EDIT 1265 - PROVIDER NOT MATCHED - OTHER
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1266 - NPI NOT ON FILE - PRESCRIBING
This edit posts when the NPI is not on file for the prescribing provider.

EDIT 1267 - PROVIDER NOT MAPPED-PRESCRIBING
This edit is posted to an electronic claim when it was determined that an NPI was found, but there is no corresponding provider entry and a default provider was not found.

EDIT 1268 - PROVIDER NOT MATCHED - PRESCRIBING
This edit is posted to an electronic claim if the provider number submitted on the claim is not equal to the provider number on the NPI database.

EDIT 1269 - ATTENDING NPI SAME AS BILLING/SERVICING NPI
This edit will post to an electronic claim if the attending NPI is the same as the billing and/or servicing NPI.

EDIT 1270 - REFERRING NPI SAME AS BILLING/SERVICING NPI
This edit will post to an electronic claim if the referring NPI is the same as the billing and/or servicing NPI.

EDIT 1271 - OTHER NPI SAME AS BILLING/SERVICING NPI
This edit will post to an electronic claim if the "Other" NPI is the same as the billing and/or servicing NPI.

EDIT 1272 - PRESCRIBING NPI SAME AS BILLING/SERVICING NPI
This edit will post to an electronic claim if the prescribing NPI is the same as the billing and/or servicing NPI.

EDIT 1310 - MISSING/INVALID DENTAL CLINIC REV CODE
This edit will post under the following circumstances for claims with a service date equal or greater than November 1, 2008:
- The claim is an Outpatient claim
- The procedure code is a dental procedure code
- The revenue code is not equal to 512

EDIT 1311 - MISSING/INVALID DENTAL PROCEDURE CODE
This edit will post under the following circumstances for claims with a service date equal or greater than November 1, 2008:
- The claim is an Outpatient claim
- The procedure code is Not a dental procedure code
- The revenue code is equal to 512

EDIT 1312 - MISSING/INVALID PRESENT ON ADMISSION INDICATOR
This edit will post when an Inpatient claim is submitted with a diagnosis code that has a missing or invalid Present On Admission (P.O.A.) Indicator.

Valid values for Present On Admission indicators are as follows:
- N = Not present at time of admission
- U = Undetermined if condition was present at time of admission
- W= Clinically undetermined
- Y= Yes, Present at time of admission
- 1= Unreported/Not used

The only valid P.O.A. indicators that can be used on the primary diagnosis are the values of 'Y' and 'W'.

EDIT 1315 - AUTHORIZING PROVIDER/CLAIM PROVIDER MISMATCH
This edit is posted when the servicing provider on the claim is not the same as the one authorized.

EDIT 1320 - P.O.A. Indicator with NO Corresponding Diagnosis Code
This edit will post when an Inpatient or Inpatient Crossover claim is submitted with a Present On Admission (P.O.A.) Indicator that does not have a corresponding diagnosis code.

EDIT 1601- PA REQUIRED NOT IN LTC FACILITY ON DOS
This edit is for transportation and transportation crossover claims that indicate a skilled nursing facility is the beginning and/or ending transportation service, but there is no corresponding claim indicating that the recipient was in a skilled nursing facility on the date of service billed. A PA number must be supplied in the appropriate field if the beneficiary was not in a LTC on the date of service. Below are the form locators that apply to this edit:

MC-12 - Enter PA# in the top right hand corner where PA# field is indicated

837 Professional- 2300, REF01

EDIT 1602 - OP PSYCH SERVICE CONFLICT
This edit will post if the incoming claim matches the following on a previously paid claim with the same recipient number, with any overlap in dates of service, with service dates on or after July 1, 2008 for BA/IIC services; Partial Care; Partial Hospital or Hospital Outpatient services; or YCM claims.

EDIT 1603 - ADJUSTMENT/VOID CREATED FOR RECIPIENT CHANGE FROM GA TO OTHER ELIGIBILITY
This edit is posted by the system when a claim is reprocessed because a GA Beneficiary was granted retroactive eligibility to another program. Claims that were reprocessed had no financial impact on the provider. This does not apply to any specific form locator for hardcopy claims.

HIPAA- N/A

EDIT 1611 - PARTIAL PR-1 DEDUCTION APPLIED
This edit posts to a LTC claim when the total deducted amount on the Remittance Advice is less than the PR-1 amount from the LTC file. The PR-1 deducted amount is reduced by the amount reported on a previously approved Hospice claim for the same billing month. This is an Explanation of Benefit (EOB) message only.

EDIT 1612 - PARTIAL PATIENT PAYMENT AMOUNT APPLIED
This edit posts to a LTC claim when the total deducted amount on the Remittance Advice is less than the Patient Payment amount reported on the claim. The amount is reduced by the amount reported on an Approved Hospice claim for the same billing month. This is an Explanation of Benefit (EOB) message only. Make sure the Patient Payment amount reported on the claim represents the total income collected from the beneficiary for that billing month.

EDIT 1614 - OBSERVATION OFFICE VISIT CONFLICT WITH OTHER DENTAL SERVICE
This edit posts for a dental claim when the code being billed is for observation (D9430) and there is another claim for the same provider, same beneficiary, same date of service has already been paid for one of the following procedure code ranges;

D0120 - D0119
D0331 - D9999

EDIT 1621 - DENY CODE/EXPL.NOT ON EOB
This edit posts when the other insurance denies the claim and there is no explanation why.

EDIT 1622 - CHARITY CARE AND MEDICAID DUPLICATE ERROR
This edit will post if an incoming Medicaid fee for service claim was matched against a previously paid Charity Care claim.

EDIT 1624 - PAYMENT AMOUNT WAS REDUCED DUE TO PATIENT LIABILITY
This edit post on an Inpatient claim when the final claim payment amount was reduced to be the sum of the Patient Liability amounts because the value is less than the Medicaid approved amount minus TPL.

EDIT 1801 - CLAIM DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DATE
This edit will post if the ICD-9 diagnosis code has expired.

EDIT 1802 - CLAIM DIAGNOSIS INVALID BASED ON ICD-10 EXPIRATION DATE
This edit will post if the ICD-10 diagnosis code has expired.

EDIT 1803 - INVALID OR MISSING GENDER INDICATOR
This edit will post if the gender indicated is not M or F, or if the gender indicator is missing.

EDIT 1804 - COSMETIC PROCEDURE NOT COVERED
This edit will post if the procedure code on the claim is classified as cosmetic.

EDIT 1805 - CLAIM LINES EXCEED THE MAXIMUM
This edit will post if the number of claim lines exceed the maximum allowed.

EDIT 1807 - COSMETIC/UNLISTED PROCEDURE CODE NOT COVERED
This edit will post if the procedure is classified and cosmetic and unlisted.

EDIT 1808 - INVALID PROCEDURE CODE
This edit will post if the procedure code on the claim is invalid.

EDIT 1809 - DATE OF BIRTH CAN NOT BE GREATER THAN DATE OF SERVICE
This edit will post if the date of birth on the claim is greater than the date of service.

EDIT 1810 - EXPERIMENTAL PROCEDURE NOT COVERED
This edit will post if the procedure code is classified as experimental.

EDIT 1811 - OBSOLETE PROCEDURE NOT COVERED
This edit will post if the procedure code is classified as obsolete.

EDIT 1812 - PROCEDURE CODE IS MISSING
This edit will post if the procedure code is missing on the claim.

EDIT 1813 - DATE OF SERVICE REQUIRED FOR PROCEDURE
This edit will post if the required date of service for the procedure is missing.

EDIT 1814 - MODIFIER 26 NOT ALLOWED FOR PROCEDURE CODE
This edit is posted if the procedure code does not have a professional component.

EDIT 1815 - DUPLICATE PROCEDURE BILLED FOR SAME DATE OF SERVICE
This edit will post if there is a duplicate procedure for the same date of service.

EDIT 1818 - PROCEDURE CODE NOT VALID DUE TO REBUNDLING
This edit will post if the procedure code should not be used.

EDIT 1819 - SERVICE DAYS EXCEED NUMBER OF UNITS
This edit will post if the service days exceed the number of units billed.

EDIT 1820 - DATE OF SERVICE IS A FUTURE DATE
This edit will post if the date of service is a future date.

EDIT 1821 - BIRTH DATE IS A FUTURE DATE
This edit will post if the beneficiary date of birth is indicated as a future date.

EDIT 1822 - PROCEDURE CODE IS MISSING
This edit will post if the procedure code is missing on the claim.

EDIT 1823 - NUMBER OF UNITS EXCEED NUMBER OF SERVICE DAY
This edit will post if the number of units on the claim exceeds the number of service days.

EDIT 1824 - AGE CAN NOT BE GREATER THAN 124 YEARS
This edit will post if the beneficiary age is greater than 124 years.

EDIT 1825 - PROCEDURE INDICATED FOR NEONATAL PATIENT
This edit will post if the beneficiary is not 0-30 days old.

EDIT 1826 - PROCEDURE INDICATED FOR PEDIATRIC PATIENT
This edit will post if the beneficiary is not 31 days-17 years old.

EDIT 1827 - PROCEDURE INDICATED FOR MATERNITY PATIENT
This edit will post if the beneficiary is not 12-55 years old.

EDIT 1828 - PROCEDURE INDICATED FOR ADULT PATIENT
This edit will post if the beneficiary is not over 14 years old.

EDIT 1829 - PROCEDURE NOT INDICATED FOR A MALE
This edit will post if the procedure code billed is for a female.

EDIT 1830 - NUMBER OF PROCEDURES IS GREATER THAN 100
This edit will post if the number of procedure codes is greater than 100.

EDIT 1831 - PROCEDURE NOT INDICATED FOR A FEMALE
This edit will post if the procedure code billed is for a male.

EDIT 1843 - INVALID DIAGNOSIS CODE
This edit will post if the diagnosis code is invalid.

EDIT 1847 - INVALID DIAGNOSIS CODE
This edit will post if the diagnosis code is invalid.

EDIT 1849 - INVALID DATE OF BIRTH CENTURY
This edit will post if the date of birth does not contain a valid century.

EDIT 1850 - INVALID DATE OF BIRTH
This edit will post if the beneficiary date of birth is invalid.

EDIT 1851 - INVALID CLAIM DATE OF SERVICE
This edit will post if the date of service is invalid.

EDIT 1852 - INVALID DATE OF SERVICE
This edit will post if the date of service is invalid.

EDIT 1853 - INVALID CHARGE AMOUNT
This edit will post if the charge amount is invalid.

EDIT 1854 - INVALID NUMERIC FIELD
This edit will post if the numeric field contains invalid data.

EDIT 1857 - NUMERIC FIELD NOT POPULATED
This edit will post if the numeric field contains spaces.

EDIT 1858 - CLAIM LINES EXCEED THE MAXIMUM
This edit will post if the claim exceeds the maximum of 100 lines.

EDIT 1862 - MISSING PROVIDER ON CLAIM
This edit will post if the provider ID is missing from the claim.

EDIT 1879 - ICD-9 INVALID BASED ON ICD-9 EXPIRATION DATE
This edit will post if the ICD-9 diagnosis code has expired.

EDIT 1880 - ICD-10 INVALID BASED ON ICD-10 EXPIRATION DATE
This edit will post if the ICD-10 diagnosis code has expired.

EDIT 1881 - PROCEDURE CODE IS AGE RESTRICTED
This edit will post if there is a discrepancy in the beneficiary's age and the procedure code.

EDIT 1882 - ASSISTANT SURGEON DENIED
This edit will post if the assistant surgeon was denied.

EDIT 1883 - ASSISTANT AT SURGERY DENIED
This edit will post if the assistant surgeon was denied.

EDIT 1887 - INCIDENTAL PROCEDURE NOT COVERED
This edit will post if the procedure has been determined to be in conjunction with other procedures as a component of the overall service provided.

EDIT 1889 - MUTUALLY EXCLUSIVE PROCEDURE NOT COVERED
This edit will post if the procedure is mutually exclusive to another procedure.

EDIT 1890 - POST OPERATIVE PROCEDURE NOT COVERED
This edit will post if the procedure is determined to be a post-operative procedure.

EDIT 1891 - PRE-OPERATIVE PROCEDURE NOT COVERED
This edit will post if the procedure is determined to be a pre-operative procedure.

EDIT 1892 - PROCEDURE NOT VALID DUE TO REBUNDLING
This edit will post if the procedure code should not be used.

EDIT 1893 - PROCEDURE GENDER RESTRICTION
This edit will post if there is a discrepancy with the beneficiary's gender and the procedure code.

EDIT 1895 - DUPLICATE PROCEDURE
This edit will post if a duplicate procedure exists for the same date of service and was already paid to the Provider. This does not apply to any specific form locator for hard copy claims.

837 Institutional - 2400/DTP
837 Professional - 2400/DTP 8
37 Dental- 2400/DTP
NCPCP - 401-D1

EDIT 1896 - MEDICAL VISIT PROCEDURE NOT COVERED
This edit will post if the medical visit should not be reimbursed.

EDIT 1897 - PROCEDURE NOT EXPECTED FOR DIAGNOSIS
This edit is posted when set by Claim Check if the procedure code is not expected for the diagnosis code. The procedure and diagnosis code should be reviewed for accuracy. Below are the form locators that relate to this edit:

CMS 1500	21&24D
MC 9	12&25B
MC19	14D&F

837 Institutional - *R- 2300: HI01-1=BK or BJ or BF, HI01-2=DX with 2400: SV201/SV202
837 Professional - *R-2300: HI01-1=BK, HI01-2=DX +/or HI02-1=BF, HI02-2=DX with 2400: SV101=HC, SV101-2=PROC CODE

EDIT 2000 - SERVICE ADMINISTRATIVELY DENIED
This edit posts when the claim has been reviewed by the State and Administratively denied.

EDIT 2001 - COMPOUND CONTAINS DUPLICATE INGREDIENTS
This edits posts when the claim is a compound drug and two or more ingredients are the same.

EDIT 2002 - LTC COMPOUND MUST CONTAIN ACTUAL NDC
This edit posts when the claim is a compound drug for a recipient in a LTC facility and one or more of the ingredients are in the drug class of "V". (Vial)

EDIT 2003 - COMPOUND DRUG-INCORRECT INGREDIENT QUANTITY/COST
This edit will post when the claim is a compound drug and one or more of the ingredients are charged higher than the usual and customary charge on file.

EDIT 2004 - CLAIM PENDING RE-ENROLLMENT
This edit post when the provider has either sent back incomplete/invalid information on their re-enrollment package, or the provider has not sent the package back to Molina Medicaid Solutions at all.

EDIT 2005 - INVALID PART D DEDUCTIBLE AMOUNT
This edit posts when the Medicare Part D deductible amount is less than zero or greater than $250.00.

EDIT 2006 - PART D CO-POAY AMOUNT IS NEGATIVE
This edit post when the Medicare Part D co-insurance/co-pay amount is less than zero.

EDIT 2007 - PRIOR AUTHORIZATION (PA) REQUIRED
This edit posts for some drugs that need to meet certain DURB-established criteria. Sometimes simple knowledge of the Beneficiary's diagnosis especially for first fill would help expedite the call.

EDIT 2008 - PART D COB BYPASS EARLY REFILL
This edit posts when the claim is bypassing early refill edits 0830-0832.

EDIT 2010 - WRONG PCN (104-A4) VALUE MUST = SUPPNJ, ADDP, OR PAAD
This edit post when the above mentioned values are incorrect.

EDIT 2011 - CLAIM PAID BY DIFFERENT PDP
This edit posts when the claim has a PDP New Jersey Insurer Code (Medicare D) that is different from what is on the Molina Medicaid Solutions file. This edit does not deny the claim.

EDIT 2012 - POSSIBLE PART D ELIGIBLE BENEFICIARY HAS PART A OR B COVERAGE
This edit posts when the drug is a Medicare Part D covered drug and the beneficiary has Medicare Part A or B and has not yet enrolled but not declined for Part D coverage. This edit does not deny the claim.

EDIT 2013 - POSSIBLE PART D ELIGIBLE > 64 YRS OLD
This edit posts when the beneficiary is not enrolled in a Medicaid Special Program for Aliens, greater than 64 years old, not yet applied for Part D, but not yet declined. This edit does not deny the claim.

EDIT 2014 - POSSIBLE PART D ELIGIBLE / BENEFICIARY DISABLED
This edit posts when the beneficiary is PAAD Disabled, is eligible for Part D, has not yet enrolled or declined. This edit does not deny the claim.

EDIT 2015 - PART D ELIGIBLE BUT NO PDP ON FILE
This edit posts when the drug is a Part D covered drug, and the beneficiary has not yet enrolled or declined Part D. This edit does not deny the claim.

EDIT 2016 - BENEFICIARY PART D ELIGIBLE: REQUEST INSURANCE CARD
This edit will post when the drug is a Part D covered drug and the beneficiary has declined part D coverage.

Please send an E1 query to determine/verify Part D enrollment. If E1 query returns a "no match", submit the claim to Anthem at 800-662-0210. (See Newsletter Vol. 16 No. 20)

EDIT 2017 - PART D COVERAGE KNOWN BILL PART D
This edits posts when the drug is a Part D covered drug and the claim does not reflect that Part D was billed.

EDIT 2018 - PART D PDP PAID BUT KNOW COVERAGE ON FILE
This edit posts when the claim comes in showing PDP paid and Molina Medicaid Solutions does not show coverage on the beneficiary file.

EDIT 2019 - PART D CO-INSURANCE/CO-PAY + DEDUCTIBLE CANNOT BOTH BE ZERO
This edit posts when the claim is submitted with the above fields all equal to zero.

EDIT 2021 - PART D WRAPAROUND WITH PA
This edit posts when the drug is on the POS wraparound (with prior authorization required table).

This edit does not deny the claim.

EDIT 2022 - RESUBMIT USING ALTERNATE ID #
This edit post when the claim is submitted for a beneficiary with ADDP eligibility and Medicaid or other eligibility open for the date of service on the claim. The pharmacy billed under the wrong Recipient ID number for that type of drug.

EDIT 2023 - BENEFICIARY NOT ELIGIBLE FOR PART D
This edit posts if the date of service is before 01/03/05 and the claim is for an ADDP, PAAD, or Senior Gold Beneficiary. This edit does not deny the claim.

EDIT 2024 - PART D DRUG EMERGENCY SUPPLY-ONE TIME ONLY
This edit posts for Part D drugs dispensed as an emergency supply. This edit does not deny the claim.

EDIT 2025 - PART D WRAPAROUND
This edit posts if the drug is on the Part D wraparound drug table. (with or without prior authorization).

This edit does not deny the claim.

EDIT 2026 - PART D EMERGENCY SUPPLY OF ANTIBIOTICS
This edit posts if the drug is on the part D Emergency Supply Antibiotics Table.

This edit does not deny the claim.

EDIT 2027 - PART D DEDUCTIBLE/COPAY CLAIM
This edit posts for Part D PDP approved Part D claims where the tent-pay is the sum of co-insurance and the deductible amounts.

This edit does not deny the claim.

EDIT 2028 - INCORRECT CLAIM COB AMOUNT
This edit pots for a Medicare Part D covered drug and the payment to the pharmacy is greater than $125,000.00.

EDIT 2029 - PART D PAPER CLAIM NOT ALLOWED FOR PART D COB CLAIMS
This edit will post when a pharmacy Part D claim is submit by paper.

EDIT 2030 - Part D Co-payment exceeds $3.00/$3.10
This edit posts if the drug has been approved by Medicare Part D and effective on the DOS, the low income subsidy info indicates the max allowed co-pay is $3.00 for 2006 and $3.10 for 2007 and the Medicare Part D co-pay/co-insurance is greater than $3.00 for a date of service in 2006 and $3.10 if date of service is in 2007.

EDIT 2031 - PART D CO-PAYMENT EXCEEDS $5.00/$5.35
This edit posts if the drug has been approved by Medicare Part D and effective on the DOS, the low income subsidy info indicates the max allowed co-pay is $5.00 for 2006 and $5.35 for 2007 and the Medicare Part D co-pay/co-insurance is greater than $5.00/$5.35.

EDIT 2032 - DAILY DRUG QUANTITY EXCEEDS APPROVED AMOUNT
This edit posts when the days supply/units exceeds the amount approved on the prior authorization file.

EDIT 2034 - MEDICARE PART D - NOT COVERED AS WRAPAROUND BENEFIT
This edit posts to a pharmacy claim being billed with a Part D denial and our records show that this is not a wraparound drug. This claim is the responsibility of the PDP.

EDIT 2035 - INVALID PDP REJECT CODE FOR PART D WRAPAROUND BENEFIT
This edit posts to a pharmacy claim that is for a Medicare Part D covered drug being billed to Medicaid without a NCPDP reject code of AC, 60, 61, 66, 70, or MR and the drug is on the Medicare Part D wraparound table.

EDIT 2036 - MAIL ORDER NOT ELIGIBLE
This edit posts for Pharmacies only when a beneficiary is not eligible for mail order drugs due to a special program.

EDIT 2038 - FIRST FILL OF THIS DRUG (BY NDC/GCN/STC) REQUIRES PRIOR AUTHORIZATION
This edit posts to a pharmacy claim if the drug (NDC, GCN, or STC) on the claim is deemed "First Fill". The Pharmacy must contact the MEP Unit at 1-877-888-2939.

EDIT 2039 - EXEMPT LTC RECIPIENTS FROM MEDICARE PART D CO-PAYMENT
This edit posts when the submitted Medicare Part D co-pay/co-insurance is greater than zeros. This recipient is exempt from any Medicare Part D co-pay liability since they reside in a nursing home.

EDIT 2040 - MEDICARE PART D CO-PAYMENT EXCEEDS MAX ALLOWED
This edit is applicable to Medicare Part D/pharmacy claims only. This edit is posted if the following are true:

a. The claim is for Medicaid recipient and
b. The claim has been approved by Medicare Part D and
c. Effective on DOS, the Low Income Subsidy info (co-pay level 4), and
    1) The Medicare Part D co-pay/co-insurance is greater than $10,000.00 and the STC is NOT equal to 'MOE' or 'MOF', OR
    2) The Medicare Part D co-pay/co-insurance is greater than $125,000.00 and the STC IS equal to 'MOE' or MOF'.

EDIT 2041 - INVALID DEDUCTIBLE FOR RECIPIENT
This edit posts if the Medicare Part D deductible is greater than zeros.

EDIT 2042 - COPAY EXCEEDS CHARGE FOR 3 MONTH SUPPLY
This edit will post to a Part D pharmacy claim for a 90 day supply and the copay is greater than 3x's the allowed amount for the beneficiary's Low Income Subsidy (LIS) level.

EDIT 2043 - RECIPIENT ELIGIBLE FOR MEDICARE PART D
This edit post to a pharmacy claim when the drug shows to be a Part D payable drug and the beneficiary shows to be eligible for Part D.

EDIT 2044 - PART D EMERGENCY SUPPLY MAY BE FILLED ONLY ONCE IN 90 DAYS
This edit post to a pharmacy claim when the incoming claim is a Part D claim and the days supply is less than 90 days and there was a prescription for an emergency supply already paid within 90 days.

EDIT 2046 - PRESCRIPTION NOT ALLOWED DUE TO CHANGE OF THERAPY
This edit post to a pharmacy claim when the Medical Exception Process (MEP) Unit has determined that this beneficiary should not be filling this prescription at this time.

EDIT 2047 - PA REQUIRED: DRUG / PRESCRIBER RESTRICTION
This edit posts to pharmacy claims when there is a special entry that restricts either the Prescriber or the Beneficiary by drug for a specific date range. The Pharmacy must call the MEP Unit at 1-877-888-2939.

EDIT 2048 - PHARMACY NOT APPROVED STATE PROVIDER
This edit posts when a pharmacy is not approved to provide services to certain Medicaid Pharmacy Programs. The provider can refer the beneficiary to another participating pharmacy provider.

EDIT 2050 - BAD PRESCRIBER LICENSE NUMBER
This edit posts to pharmacy claims when the State License on the claim is not found, missing or invalid, or not from NJ, PA, DE, MD, NY, CT, or FL.

EDIT 2051 - FIELD 411-DB PRESCRIBER ID MUST CONTAIN A STATE LICENSE NUMBER
This edit posts to a pharmacy claim when the prescriber ID on the in-coming claim is not the State License Number.

EDIT 2052 - PART D CLAIM EMERGENCY SUPPLY - NO PDP REJECT CODE
This edit post when a Pharmacy Part D emergency supply claim has no PDP reject code.

EDIT 2053 - CLAIM REJECTED BY PART D PDP
This edit posts to a pharmacy claim with a PDP denial showing a coinsurance and or deductible. The provider needs to take out the coinsurance and or deductible and resubmit the claim.

EDIT 2054 - CLAIM IS INCORRECTLY BILLED - NO MEDICARE ON FILE
This edit posts to pharmacy claims when there is no Medicare information on file and the Provider indicates otherwise.

EDIT 2055 - PART D PDP RESPONSIBLE FOR PAYMENTS/BILL PRIMARY PAYER
This edit posts to a pharmacy claim when there is a discrepancy in the Part D COB/Other Payments Segment.

EDIT 2056 - THE LENGTH OF THE SERVICE/BILLING NPI IS INVALID
This edit posts when the length of the service/billing NPI is invalid.

EDIT 2057 - SERVICE/BILLING PROVIDER NPI FAIL CHECK DIGIT 201-B1
This edit posts when the service/billing provider failed checking digits 201-B1.

EDIT 2058 - SERVICING/BILLING PROVIDER NPI OS REQUIRED AS OF 05/23/08
This edit posts when the servicing/billing provider NPI is missing.

EDIT 2059 - THE FIRST DIGIT OF THE SERVICING/BILLING NPI IS INVALID
This edit posts when the first digit of the servicing/billing NPI is invalid.

EDIT 2060 - THE MEDICAID ID IS NOT FOUND FOR SERVICING/BILLING NPI
This edit posts when the Medicaid ID is not found for the servicing/billing NPI.

EDIT 2061 - FOUND MULTIPLE MEDICAID IDS FOR THE SERVICING/BILLING NPI
This edit posts when there are multiple Medicaid IDS for the servicing/billing NPI.

EDIT 2062 - THE LENGTH THE PRESCRIBER NPI IS INVALID
This edit posts when the length of the prescriber NPI is invalid.

EDIT 2063 - CHECK DIGIT VALIDATION FAIL FOR THE PRESCRIBER NPI
This edit posts when the validation failed to check the prescribing NPI.

EDIT 2064 - PRESCRIBER NPI IS REQUIRED AS OF 05/23/08
This edit posts when the claim is not submitted with the prescriber's NPI.

EDIT 2065 - THE FIRST DIGIT OF THE PRESCRIBER NPI IS INVALID
This edit posts when the first digit of the prescriber's NPI is invalid.

EDIT 2066 - THE MEDICAID ID IS NOT FOUND FOR THE PRESCRIBER NPI
This edit posts when the Medicaid number is not found for the prescriber NPI.

EDIT 2067 - FOUND MULTIPLE MEDICAID IDS FOR THE PRSCRIBING NPI
This edit posts when the system finds multiple Medicaid IDS for the prescribing provider.

EDIT 2069 - METRIC QUANTITY MUST REFLECT WHOLE PACKAGE
This edit posts to a pharmacy claim when a pharmacy tries to split up a package. Pharmacies must bill for the whole package size; this can not be broken up.

EDIT 2070 - EXCEEDS MAXIMUM METRIC QUANTITY FOR PACKAGE SIZE/FULL PKGS
This edit posts when the number of packages dispensed exceeds the maximum allowed.

EDIT 2071 - PAAD RECIPIENT W/MEDICAID COVERAGE
This edit posts when the system determines that the PAAD Beneficiary has Medicaid coverage.

EDIT 2072 - DUPLICATE STATE LICENSE # FOUND ON PROVIDER FILE
This edit post when there are more than one State License number found on the provider's file and the Medicaid number is populated with "4444444".

EDIT 2073 - REQUESTOR IS NOT AUTHORIZED TO ADJUST/VOID THIS CLAIM
This edit posts to pharmacy claims when the person requesting an adjustment/void is not authorized to do so.

EDIT 2074 - CLAIM HAS BEEN PREVIOUSLY VOIDED BY THE STATE - CANNOT RESUBMIT
This edit will post to a pharmacy claim that has been previously voided by the State. The system will not process.

EDIT 2076 - SENIOR GOLD RECIPIENT W/MEDICAID COVERAGE
This edit posts to a pharmacy claim when the system determines that the Senior Gold Beneficiary has Medicaid coverage.

EDIT 2077 - MEDICAID DUPLICATE ELIGIBILTY WITH PAAD OR SENIOR GOLD
This edit posts to a pharmacy claim when the system shows that the beneficiary has Medicaid coverage and coverage with either PAAD or Senior Gold.

EDIT 2078 - MEDICAID DUPLICATE ELIGIBILITY WITH PAAD OR SENIOR GOLD
This edit posts to a pharmacy claim when the beneficiary has duplicate eligibility with PAAD and Senior Gold.

EDIT 2083 - DAYS SUPPLY GREATER THAN 34 FOR NURSING HOME EARLY REFILL
This edit posts to a pharmacy claim when a beneficiary has a change in nursing home status. The pharmacy must change the days supply to not more than 34.

EDIT 2084 - PRESCRIPTION FILLED BY MAIL ORDER PHARMACY
This edit posts to a claim for a PAAD, Senior Gold, or ADDP beneficiary who has Medicare Part D and the prescription is filled by a mail order pharmacy.

EDIT 2085 - MAC OVERRIDE NOT ALLOWED - DISPENSE AS WRITTEN INDICATOR IS INCORRECT
This edit posts to pharmacy claims when the (DAW) Dispense as Written Indicator is incorrect.

EDIT 2086 - SUBMISSION OF 6666666 FOR NJ PRESCRIBER IS INVALID
This edit posts to a pharmacy claim when the pharmacy uses 6666666 instead of the Medicaid ID number in the prescribing physician field. If the prescribing physician does not have a NJ Medicaid ID number, the pharmacy may use the State License number, or NPI.

EDIT 2089 - DIABETIC SUPPLIES NOT COVERED - BILL MEDICARE PART B OR OTHER TPL
This edit will post for a pharmacy claim with a date of service of 07/01/08 or greater for a beneficiary with PAAD or Senior Gold. This item is no longer covered, the provider must bill the beneficiary's other insurance.

EDIT 2090 - PRESCRIBER LICENSE# SENT/NPI REQUIRED
This edit posts to Pharmacy claims only when the provider submitted a claim with a License # and they should have submitted with an NPI number.

EDIT 2091 - COPAY APPLIED FOR BRAND DRUG
This edit applies to pharmacy claims only when the date of service is on or after 08/01/2008 and the drug is determined to be is Brand Name; there will be a $7.00 copay.

EDIT 2092 - COPAY APPLIED FOR GENERIC DRUG
This edit applies to pharmacy claims only when the date of service is on or after 08/01/2008 and the drug is determined to be Generic; there will be a $6.00 copay.