Detailed OPPS Program Edits

Edit	Generated when ...
1. Invalid diagnosis code	The principal diagnosis field is blank, there are no diagnoses entered on the claim, or the entered diagnosis code is not valid for the selected version of the program.
2. Diagnosis and age conflict	The diagnosis code includes an age range, and the age is outside that range.
3. Diagnosis and sex conflict	The diagnosis code includes sex designation, and the sex does not match.
4. Medicare secondary payer alert	The procedure code has a MSP alert warning indicator. This edit applies to v1.0 and v1.1 only, and is not applicable to the admit diagnosis.
5. E-diagnosis code can not be used as principal diagnosis	The first letter of the principal diagnosis code is an E. This edit is not applicable to the admit diagnosis.
6. Invalid procedure code	The entered HCPCS code is not valid for the selected version of the program.
7. Procedure and age conflict (*inactive*)	
8. Procedure and sex conflict	The sex of the patient does not match the sex designated for the procedure coded on the record.
9. Non-covered for reasons other than statute	The procedure code is non-covered for reasons other than statute Revenue code is 099x with SI of E and is submitted without a HCPCS code.
10. Service submitted for denial (condition code 21)	The claim has a condition code 21.
11. Service submitted for FI/MAC review (condition code 20)	The claim has a condition code 20.
12. Questionable covered service	The procedure code is a questionable covered service.

13. Separate payment for services is not provided by Medicare	The claim is OPPS and the bill type is 12/14x without condition code 41 or the bill type is 13x, and the HCPCS code is on the 'Separate payment for service not provided by Medicare' list in the IOCE The claim is non-OPPS and the bill type is any other than those defined for OPPS claims (above), the HCPCS code is on the 'Separate payment for service not provided by Medicare' list in the IOCE, and the status indicator is not B. This edit applies to v1.0–v6.3 only.
14. Code indicates a site of service not included in OPPS	The procedure code has a 'Not included in OPPS indicator'. This edit applies to v1.0–v6.3 only.
15. Service unit out of range for procedure	The maximum units allowed is greater than zero The sum of the service units for all line items with the same procedure code on the same day exceeds the maximum allowed for this procedure Modifier 91 is not present or modifier 91 is present but the HCPCS code is not on the list of laboratory/pathology codes which are exempt from this edit. Units for all line items with the same HCPCS code on the same day are added together when applying this edit. If the total units exceed the code's limits, the procedure edit return buffer is set for all line items that have the HCPCS code. If modifier 91 is present on a line item and the HCPCS code is on a list of codes that are exempt, the unit edits are not applied.
16. Multiple bilateral procedures without modifier 50	The same bilateral procedure code occurs two or more times on the same service date. This edit is applied to all relevant procedure lines for dates of service prior to 10/01/05 only. Additionally, this edit applies to v1.0–v6.2 only.
17. Inappropriate specification of bilateral procedure	(A) The same bilateral procedure code occurs two or more times (based on units and/or lines) on the same service date. This condition (A) is for dates of service prior to 10/01/05 only. Additionally, condition A applies to v1.0–v6.2 only. (B) The same inherent bilateral procedure code occurs two or more times (based on units and/or lines) on the same service date. This edit is applied to all relevant bilateral procedure lines. **Note:** For codes with an SI of V that are also on the Inherent Bilateral list, condition code G0 will take precedence over the bilateral edit; these claims will not receive edit 17.

18. Inpatient procedure	A line has a C status indicator and is not on the 'separate procedure' list A line has a C status indicator and is on the 'separate procedure' list, and there are no type T lines on the same day. Modifier CA is not present. All other line items on the same day as the line with a C status indicator are denied (line item denial/rejection flag = 1, APC return buffer) and edit 49 is assigned. Edit 18 is performed before any other non-fatal edits. No other edits are run on any line(s) with edit 18 or 49.
19. Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.
20. Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	The procedure is identified as part of another procedure on the claim coded on the same day, where the use of a modifier is not appropriate. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
21. Medical visit on the same day as a type T or S procedure without modifier 25	One or more type T or S procedures occur on the same day as a line item containing an E&M code without modifier 25.
22. Invalid modifier	The modifier is not valid.
23. Invalid date	The From, Through, or Service date is invalid, or the Service date falls outside the range of the From and Through dates. This edit terminates processing for the claim. Prior to10/01/2003, a blank service date is not considered an error when the HCPCS code field is blank; as of that date, all lines must have a service date.
24. Date out of OCE range	The From date falls outside the date range of any version of the program. The From date will be used for program version selection, even if the From-Through dates span more than one version. Presence of this edit condition terminates processing for the claim.
25. Invalid age	The age is non-numeric or outside the range of 0-124 years.
26. Invalid sex	The sex is non-numeric or outside the range of 0-2.

27. Only incidental services reported	All line items are incidental (status indicator N) All line items have a line item denial/rejection flag = 0 All line items have a line item action flag = 0. Edit 27 is run immediately when edit 18 is not triggered; no other edits are performed on a claim with edit 27.
28. Code not recognized by Medicare; alternate code for same service may be available	The procedure code is not recognized by Medicare.
29. Partial hospitalization service for non-mental health diagnosis	The principal diagnosis is not related to mental health.
30. Insufficient services on day of partial hospitalization	Three or more services from the partial hospitalization services list are not present, or at least one of the three is not a psychotherapy service. For multiple-day claims, this edit will only trigger if edits 32, 33, or 34 have also been activated.
31. Partial hospitalization on same day as ECT or type T procedure	Electroconvulsive therapy or a significant procedure (status indicator T) occurs on the same day as partial hospitalization, and APC 33 (partial hospitalization) is assigned to a mental health service on the same day. This edit applies to v1.0–v6.3 only.
32. Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days	A claim suspended for medical review (edit 30) does not span more than three days.
33. Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	A claim suspended for medical review (edit 30) spans more than three days. However, partial hospitalization services were not provided on at least 57% (4/7) of the days.
34. Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	A claim suspended for medical review (edit 30) spans more than three days and partial hospitalization services were provided on at least 57% (4/7) of the days. However, on the days when partial hospitalization services were provided, less than 75% of the days met the partial hospitalization day of service criteria (i.e., edit 30 occurred on the line item).
35. Only Mental Health education and training services provided	Only education and training services are present without other mental health service; the claim fails mental health status.
36. Extensive mental health services provided on day of type T procedure	Electroconvulsive therapy or a non mental health type T procedure APC is present on the same day as extensive mental health service. This edit applies to v1.0–v6.3 only.

37. Terminated bilateral procedure or terminated procedure with units greater than one	A modifier 52 or 73 is present, as well as: a) an independent or conditional bilateral procedure with modifier 50 b) a procedure with units greater than 1.
38. Inconsistency between implanted device or administered substance and implantation or associated procedure	The status indicator is H or APC 987-997 (Implant) is present, but no type S, T, or non-implant type X procedures are present on the claim.
39. Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present	The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a mutually exclusive pair is rejected; the column 1 code of the pair is not marked as an edit.
40. Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	The procedure is identified as part of another procedure on the claim coded on the same day, where the modifier was either not coded or is not an NCCI modifier. Only the code in column 2 of a code pair is rejected; the column 1 code of the pair is not marked as an edit.
41. Invalid revenue code	The revenue code is not in the list of valid revenue code entries in the IOCE.
42. Multiple medical visits on same day with same revenue code without condition code G0	Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other.
43. Transfusion or blood product exchange without specification of blood product	A blood transfusion or exchange is coded but no blood product is coded.
44. Observation revenue code on line item with non-observation HCPCS code	A 762 (observation) revenue code is used with a HCPCS other than observation (99217-99220, 99234-99236, G0378, G0379).
45. Inpatient separate procedures not paid	On the same day, all lines with status indicator C are on the ‘separate procedure’ list in the IOCE, and there is at least one type T line.
46. Partial hospitalization condition code 41 not approved for type of bill	Bill type 12x or 14x is present with condition code 41.

47. Service is not separately payable	The claim consists entirely of a combination of lines that: a) are denied or rejected b) have a status indicator N Edit 47 is assigned to all lines with status indicator N, or that change from Q to N, that are not already denied or rejected and have no other service on the claim.
48. Revenue center requires HCPCS	The bill type is 13x, 74x, 75x, 76x, or 12x/14x without condition code 41, HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed when the revenue code is 100x, 210x, 310x, 099x, 0905-0907, 0500, 0509, 0583, 0660-0663,0669, 0931, 0932, 0521, 0522, 0524, 0525, 0527, 0528, or 0948; *see also edit 65*.
49. Service on same day as inpatient procedure	Line item occurs on the same day as a C status indicator.
50. Non-covered based on statutory exclusion	Code is on ‘statutory exclusion’ list in the IOCE.
51. Multiple observations overlap in time (*inactive*)	
52. Observation does not meet minimum hours, qualifying diagnoses, and/or ‘T’ procedure conditions	The observation period is less than 8 hours There is no diagnosis of CHF, chest pain or asthma There is a T procedure (except 90780) on the same or previous day. This edit applies to v3.0–v6.3 only.
53. Codes G0378 and G0379 only allowed with bill type 13x or 85x	Codes G0378 and/or G0379 appear on the claim and the bill type is not 13x or 85x.
54. Multiple codes for the same service	Any of the following three pairs of codes appear on the same claim: C1012 and P9033, C1013 and P9031, or C1014 and P9035.
55. Non-reportable for site of service	A HCPCS code beginning with the letter C is entered and the bill type is not 12x, 13x or 14x.
56. E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1	There is no E/M visit the day of or the day preceding the observation The date of observation is not 12/31/yyyy or 01/01/yyyy. This edit applies to v4.0–v6.3 only.

57. Composite E/M condition not met for observation and line item date for code G0378 is 1/1	There is no specified E/M or critical care visit the day of or the day preceding the observation The date of observation is 01/01/yyyy.
58. G0379 only allowed with G0378	Code G0379 is present without code G0378 for the same line item date
59. Clinical trial requires diagnosis code V707 as other than primary diagnosis	Code G0292, G0293 or G0294 is present Diagnosis code V707 is not present as admit or secondary diagnosis.
60. Use of modifier CA with more than one procedure not allowed	Modifier CA is present on more than one line Modifier CA is submitted on a line with multiple units.
61. Service can only be billed to the DMERC	The procedure code has a 'DME only' indicator.
62. Code not recognized by OPPS; alternate code for same service may be available	The procedure code has a 'Not recognized by Medicare for OPPS' indicator.
63. This OT code only billed on partial hospitalization claims	Occupational therapy services are present and the bill type is 12x, 13x or 14x without condition code 41.
64. AT service not payable outside the partial hospitalization program	Activity therapy services are present and the bill type is 12x, 13x or 14x without condition code 41.
65. Revenue code not recognized by Medicare	The revenue code is 100x, 210x, 310x, 0500, 0509, 0583, 0660-0663, 0669, 0905-0907, 0931, or 0932; *see also edit 48*.
66. Code requires manual pricing	The HCPCS code is an unclassified drug code.
67. Service provided prior to FDA approval	The line item date of service of a code is prior to the date of FDA approval.
68. Service provided prior to date of National Coverage Determination (NCD) approval	The line item date of service of a code is prior to the code activation date.
69. Service provided outside approval period	The service was provided outside the period approved by CMS.
70. CA modifier requires patient status code 20	Modifier CA occurs on an inpatient line and patient status code 20 is missing.

71. Claim lacks required device code	A specified procedure is submitted on a claim without the code(s) for the required device(s). (This edit is bypassed if the procedure is terminated - modifier 52, 73, or 74.)
72. Service not billable to the Fiscal Intermediary/Medicare Administrative Contractor	A code has a status indicator M. (This edit is bypassed when the bill type is 85x and revenue code is 096x, 097x, or 098x.)
73. Incorrect billing of blood and blood products	Blood product claims lack two identical lines (of HCPCS code, units, and modifier BL), one line with revenue code 38x and the other line with revenue code 39x.
74. Units greater than one for bilateral procedure billed with modifier 50	Any code on the Conditional or Independent bilateral list is submitted with modifier 50 and units of service are greater than one on the same line.
75. Incorrect billing of modifier FB or FC	Modifier FB or FC is present and SI is not S, T, V or X.
76. Trauma response critical care code without revenue code 068x and CPT 99291	Trauma response critical care code is present without revenue code 068x and CPT code 99291 on the same date of service.
77. Claim lacks allowed procedure code	A specified device is submitted on a claim without a code for an allowed procedure, and the bill type is not 12x.
78. Claim lacks required radiopharmaceutical	A specified nuclear medicine procedure is submitted on a claim without the code for a required radiopharmaceutical.

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