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<tr>
<td>C</td>
<td>Ward</td>
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<tr>
<td>E</td>
<td>ICU</td>
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<td>G</td>
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## STANDARD ACCOMMODATION RATE CODES
(As carried on the provider file)

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<td>4</td>
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## NON-STANDARD ACCOMMODATION RATE CODES

*(Jamestown State Mental Hospital)*

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<th>CODE</th>
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<tr>
<td>B</td>
<td>Semi-Private</td>
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<tr>
<td>C</td>
<td>Ward</td>
</tr>
<tr>
<td>E</td>
<td>Intensive Care</td>
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<tr>
<td>G</td>
<td>Nursery</td>
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### STANDARD ANCILLARY SERVICE CODES

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### STANDARD ANCILLARY SERVICE CODES

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## STANDARD ANCILLARY SERVICE CODES

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## STANDARD ANCILLARY SERVICE CODES

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# STANDARD ANCILLARY SERVICE CODES

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# Authorized Service Codes

(As listed on the MMIS file)

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An (*) indicates the services which can be covered under the Federal Waiver. If these services are provided for a recipient eligible for TITLE XIX the services will be reported under Home and Community.
### DAY PROGRAM SERVICES

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<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Adult Day Care</td>
</tr>
<tr>
<td>B</td>
<td>Development Work Activity</td>
</tr>
<tr>
<td>I</td>
<td>Extended Services (Non-Waivered)</td>
</tr>
<tr>
<td>K</td>
<td>Infant Development</td>
</tr>
<tr>
<td>L</td>
<td>Day Activity</td>
</tr>
<tr>
<td>M</td>
<td>Prevocational</td>
</tr>
<tr>
<td>N</td>
<td>Extended Services – HCBS (Waivered)</td>
</tr>
</tbody>
</table>

### RESIDENTIAL SERVICES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Congregate Care</td>
</tr>
<tr>
<td>H</td>
<td>State ICF/DD</td>
</tr>
<tr>
<td>O</td>
<td>Extended Family Care – Habilitation</td>
</tr>
<tr>
<td>P</td>
<td>Transitional Care Living – Room</td>
</tr>
<tr>
<td>Q</td>
<td>Transitional Care Living Facility</td>
</tr>
<tr>
<td>R</td>
<td>Extended Family Care – Personal Care Services</td>
</tr>
<tr>
<td>S</td>
<td>Minimum Supervised Living Arrangement</td>
</tr>
<tr>
<td>T</td>
<td>Supported Living</td>
</tr>
<tr>
<td>V</td>
<td>Transitional Care Living – Board</td>
</tr>
<tr>
<td>W</td>
<td>Extended Family Care – Room</td>
</tr>
<tr>
<td>X</td>
<td>Extended Family Care – Board</td>
</tr>
<tr>
<td>Y</td>
<td>Minimum Supervised Living – Room</td>
</tr>
<tr>
<td>Z</td>
<td>Minimum Supervised Living – Board</td>
</tr>
<tr>
<td>1</td>
<td>Specialized Placement</td>
</tr>
<tr>
<td>2</td>
<td>Specialized Placement – Room</td>
</tr>
<tr>
<td>3</td>
<td>Specialized Placement – Board</td>
</tr>
<tr>
<td>4</td>
<td>ISLA – Habilitation</td>
</tr>
<tr>
<td>5</td>
<td>ISLA – Personal Care Services</td>
</tr>
<tr>
<td>6</td>
<td>Congregate Care – Room</td>
</tr>
<tr>
<td>7</td>
<td>Congregate Care – Board</td>
</tr>
<tr>
<td>8</td>
<td>ISLA – Room</td>
</tr>
<tr>
<td>9</td>
<td>ISLA – Board</td>
</tr>
</tbody>
</table>

### SINGLE UNIT SERVICES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>U</td>
<td>Family Subsidy</td>
</tr>
</tbody>
</table>

(return to top)
Inpatient Accommodation

A. Private Room.............................. 110-119, 140-149, 160-169
B. Semi-Private..............................120-139
C. Ward......................................150-159
E. ICU.......................................200-219, 233, 234
G. Nursery...................................170-179, 231

Nursing Home Accommodation
1. Home Leave
2. Hospital Leave
3. SNF
4. ICF
5. SNF in ICF
6. Day Care
G. Nursery
H. Emergency Room
J. Occupational Therapy
K. Speech Therapy
L. Physical Therapy
M. Inhalation Therapy
N. Radiology
Q. Blood Administration
R. EKG
S. EEG
T. Other Cardiology
U. Anesthesia

OS Nursing Accommodation
1. Home Leave
2. Hospital Leave
3. SNF
4. ICF
5. SNF in ICF
6. Day Care

OS Nursing Ancillary
J. Occupational Therapy
K. Speech Therapy
L. Physical Therapy
Z. Other
## Accommodation and Ancillary to Revenue Code Cross Reference

### Service Code

<table>
<thead>
<tr>
<th>IS - Nursing - Accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.   Home Leave</td>
</tr>
<tr>
<td>2.   Hospital Leave</td>
</tr>
<tr>
<td>3.   SNF</td>
</tr>
<tr>
<td>4.   ICF</td>
</tr>
<tr>
<td>5.   SNF in ICF</td>
</tr>
<tr>
<td>6.   Day Care</td>
</tr>
<tr>
<td>G.   Nursery</td>
</tr>
<tr>
<td>H.   Emergency Room</td>
</tr>
<tr>
<td>J.   Occupational Therapy</td>
</tr>
<tr>
<td>N.   Radiology</td>
</tr>
<tr>
<td>Q.   Blood Administration</td>
</tr>
<tr>
<td>R.   EKG</td>
</tr>
<tr>
<td>S.   EEG</td>
</tr>
<tr>
<td>T.   Other Cardiology</td>
</tr>
<tr>
<td>U.   Anesthesia</td>
</tr>
</tbody>
</table>

### State Hospital Accommodation

| 3.   Acute Psychiatric Care  |
| 4.   Extended Medical Care   |
| 5.   Acute Medical Care      |
| 6.   Mental Health - Inpatient |
| A.   Private                 |
| B.   2-3-4 Bed               |
| C.   Ward                    |
| E.   ICU                     |

### Home Leave - Nursing Home

| 1.   Home Leave               |
| G.   Home Leave - ICF        |
| H.   Home Leave - ICF in SNF |

### Hospital Leave - Nursing Home

| 2.   Hospital Leave           |
| J.   Hospital Leave - ICF    |
| N.   Hospital Leave - ICF in SNF |

*(return to top)*
Ancillary Service Codes

H. Emergency Room.......................450-459, 500, 760, 762
    Observation Room......................761
J. Occupational Therapy...............430-439
K. Speech Therapy.......................440-449
L. Physical Therapy.....................420-429
M. Inhalation Therapy...................410-419, 460-469
N. Radiology.............................280-289, 320-339
O. Laboratory................................300-319
P. Blood Units not Replaced...............380-389
    (chargeable)
Q. Blood Administration..................390, 391, 399
R. EKG.....................................730-739
S. EEG.......................................740-749
T. Other Cardiology......................480-489
U. Anesthesia.............................370-379, 964
V. Delivery Room.........................720, 722-729
W. Operating Room........................360-369
X. Supplies (Med./Surg. Center)...........260-279, 290-299,
    .........................................600-604, 621, 622,
    .........................................640-649,
    .........................................660-662, 946
Y. Pharmaceutical..........................250-259, 630-636
Z. Other.....................................220, 229, 340-359,
    .........................................400-409, 470-479,
    .........................................490-499, 510-519,
    .........................................521, 540-549, 551, 552
    .........................................559, 561, 562, 569, 571,
    .........................................572, 579, 581, 582, 589
    .........................................610-612, 619, 651-659
    .........................................700-719,
    .........................................721, 750-759, 769, 790,
    .........................................799, 800-899, 900-945,
    .........................................947-949, 951, 982

Invalid Nurse Accommodation

S
T
U
V
W
X
Y

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SSA will generate a code in this field to inform the State of the source of the request which caused the production of the record (i.e., the type of input of SSA) as follows:

B The request originated as a result of the State's buy-in activity.

C The record is an SSA-generated notice of a change in SMI status, benefit rate, payment status, SOC, HOC, SMI/HI entitlement or termination, SPAC, HPAC to SMI premium payer. This code will appear only for records previously identified by the State for inclusion in the Bendex System.

D The request originated by direct submission by the State to the Bendex system, or the State has attempted to buy in for a disabled person who has not completed the 24 month "SMI waiting period." On the latter, an automatic accretion to Bendex will occur if the State has a demonstrated direct input deletion capability. This which could affect eligibility for buy-in coverage. A Bendex change record will be sent to the State when the person is automatically enrolled for SMI and enters the 22nd month of disability, thus alerting the State to again attempt the buy-in accretion. A direct input deletion record should be prepared when State eligibility ceases.
SSA will inform the State of the payment status of the individual. If the individual is receiving only hospital or supplemental medical insurance benefits, (T or M Claim Number Suffix) from SSA (That is, he is not eligible for RSDI Benefits), a U will appear in position 68 and the monthly benefit payable (MSP) will be blank.

This field will be blank for those records not fully processed. Records fully processed may be identified by the legends "Matched", "CF XXX", "Deleted", "FIN MMYY", and "REP PAYE" in field 17, communication code.

The payment status code or LAF, indicates whether the benefit amount is payable or the reason it is not payable. Only a cp in the payment status code indicates that the benefit is payable.

Possible SSA LAF codes are as follows:

A(X) - The beneficiary's record has been withdrawn for adjustment because of a change in the SSA program service center jurisdiction, a change in rate or a change in payment status. The reason can be identified by the character following the letter A; E.G., AJ means cancellation of a worker's compensation offset is in process. The State can normally expect to receive a subsequent notice on this beneficiary when the action in process is completed (I.E., on matched or rep paye cases).

NOTE: except for very unusual circumstances, no payments are released by SSA to a beneficiary while the beneficiary is in an adjustment status. The reason codes applicable include:

0, 1, 2, 3, 4, 5, 6, or 7 - one of several possible rate adjustments being figured.
8 - Changed from a foreign to a domestic address. (obsolete)
9 - Miscellaneous adjustment not provided with specific code.
A - Withdrawal to split payments (advanced file only).
C - Change in benefit rate not due to a recomputation to include additional earnings.
D - An auxiliary's/supervisor's benefits are being combined with that individual's own old-age insurance benefit.
E - Withdrawn for recomputation.
F - File is being transferred to another program service center (obsolete)
J - Cancellation of a worker's comp offset is in process.
M - Beneficiary who has been entitled to HIB only is now being awarded monthly benefits.
P - Adjustment to change payment identification code or postentitlement action.
S - Adjusted for simultaneous entitlement.
W - Worker's compensation offset is being imposed.
& - Status being changed from nonpayment status to current payment status.
- - Status being changed from current payment status to suspense or deferred payment status.
BENDEX PAYMENT STATUS CODE

(Ledger Account File - LAF)

B - Abatement status. Claim filed; claimant has died prior to entitlement.

CP - Beneficiary in current payment status.

D(X) - Benefits are deferred for future payment. The reason for the deferral can be identified by the character following the letter D; E.G., D2 means benefits are deferred because of current work. The reason codes applicable include:

1 - Beneficiary is engaging in foreign work.
2 - To recover an overpayment which resulted because of the beneficiary's work.
3 - Auxiliary's benefits withheld because of a D2 status for the primary beneficiary.
4 - Failure to have child in care.
5 - Auxiliary's benefits withheld because of a D1 status for the primary beneficiary.
6 - To recover an overpayment which resulted for reasons not attributable to earnings.
9 - Miscellaneous deferment not provided with specific code.
P - Deferred because beneficiary is receiving public assistance.
W - Deferred because beneficiary is receiving worker's comp.
N - Disallowed claim. Disallowed due to failure to meet a Title II requirement (Nondisability).
ND- Denied claim. Denied due to failure to meet a Title II requirement (Disability).
P or PB - Delayed claim (Adjudication pending). Delayed pending proof (E.G., age, marriage, etc.).
PT- Terminated from a pending or denied claim.

P(X) - Delayed. Upon adjudication, the LAD P will convert to LAF S with the same subscript.

S(X) - Benefits are currently in suspense. The reason for the suspension can be identified by the character following the letter S; E.G., S2 means suspension because the beneficiary is currently working. The reason codes applicable include:

0 - Continuing disability investigation is being conducted on this beneficiary.
1 - Beneficiary is engaged in foreign work.
2 - Beneficiary is currently working and expects earnings in excess of annual allowable limits.
3 - Auxiliary's benefits withheld because of an S2 status for the primary beneficiary.
4 - Failure to have child in care.
5 - Auxiliary's benefits withheld because of an S1 status for the primary beneficiary.
6 - Check has been returned; SSA is investigating to find the correct address.
7 - Disability beneficiary refused vocational rehabilitation services.
8 - Payee for this beneficiary is being determined.

{return to top}
**BENDEX PAYMENT STATUS CODE**

(Ledger Account File - LAF)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Miscellaneous reasons not provided for with specific code.</td>
</tr>
<tr>
<td>B</td>
<td>Benefits due but not paid (usually less than $1.00).</td>
</tr>
<tr>
<td>F</td>
<td>Special age 72 (Prouty) beneficiary suspended because of failure to meet residency requirements.</td>
</tr>
<tr>
<td>H</td>
<td>Special age 72 (Prouty) beneficiary suspended because of receiving a government pension.</td>
</tr>
<tr>
<td>J</td>
<td>Alien suspension sections of social security act apply.</td>
</tr>
<tr>
<td>K</td>
<td>Beneficiary has been deported.</td>
</tr>
<tr>
<td>L</td>
<td>Beneficiary resides in country to which checks cannot be sent.</td>
</tr>
<tr>
<td>M</td>
<td>Beneficiary refused social security payments (entitled to HIB-SMIB only).</td>
</tr>
<tr>
<td>P</td>
<td>Special Age 72 (Prouty) beneficiary suspended because receiving public assistance.</td>
</tr>
<tr>
<td>W</td>
<td>Worker's compensation payments preclude social security payments.</td>
</tr>
<tr>
<td>Z</td>
<td>Obsolete. Same as S6.</td>
</tr>
</tbody>
</table>

**T(X) - Benefits have been terminated on this can.** The reason for the termination can be identified by the character following the T; E.G., T1 means benefits were terminated because of death of the beneficiary. The reason codes applicable include:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Benefits are payable by some other agency.</td>
</tr>
<tr>
<td>1</td>
<td>Death of the beneficiary.</td>
</tr>
<tr>
<td>2</td>
<td>Death of the primary beneficiary of this record.</td>
</tr>
<tr>
<td>3</td>
<td>Beneficiary divorced, married or remarried.</td>
</tr>
<tr>
<td>4</td>
<td>Child attained age 18 (or 22 in a student) and is not disabled or attending school; mother/father terminated based on last entitled child's attainment of age 18.</td>
</tr>
<tr>
<td>5</td>
<td>Beneficiary is entitled to equal or greater benefits on another record.</td>
</tr>
<tr>
<td>6</td>
<td>Child is no longer a student or disabled, or (if beneficiary is a mother/father) the last entitled child died or married.</td>
</tr>
<tr>
<td>7</td>
<td>Child beneficiary was adopted; mother terminated, last entitled child adopted (no longer acceptable as a new LAF).</td>
</tr>
<tr>
<td>8</td>
<td>Primary beneficiary recovered from a disability, or the last disabled child recovered from a disability.</td>
</tr>
<tr>
<td>9</td>
<td>Miscellaneous reason not provided with specific code.</td>
</tr>
<tr>
<td>A</td>
<td>Termination prior to entitlement.</td>
</tr>
<tr>
<td>B</td>
<td>Beneficiary became entitled to widow(er's) benefits based on disability.</td>
</tr>
<tr>
<td>C</td>
<td>A disabled widow(er) has attained age 65 and is being converted to aged benefits (can suffix will change from W to D).</td>
</tr>
<tr>
<td>J</td>
<td>Termination prior to entitlement; action taken too late to stop check from being issued. (Obsolete)</td>
</tr>
<tr>
<td>P</td>
<td>Changes of beneficiary attained age 65 (E.G., B to D).</td>
</tr>
<tr>
<td>&amp;</td>
<td>Claim was withdrawn.</td>
</tr>
</tbody>
</table>

- Disabled beneficiary attained age 65 (NAD is being transferred to an old-age insurance benefit). (Obsolete)
- The beneficiary is not entitled to cash payments but is entitled only to hospital and/or supplemental medical insurance.
- Withdrawal before entitlement.

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X(X) - The beneficiary was entitled to hospital or supplemental medical insurance benefits only (i.e., was not entitled to monthly benefits payments) and was removed from that category. The reason for removal can be identified by the character following the letter X; e.g., X5 means the beneficiary became entitled to another type of benefit. The reason codes applicable include:

0 - Claim transferred to RRB.
1 - Death of a beneficiary.
5 - Beneficiary became entitled to cash benefit payments.
7 - HI/SMI terminated.
9 - Miscellaneous termination reason not provided with specific code.
D - Withdrawn for adjustment.
F - File is being transferred to another program service center. (obsolete)
J - Alien suspension sections of social security act apply. (obsolete)
K - Beneficiary was deported.
& - Withdrawal of SMIB (beneficiary was entitled to SMIB only).
- - Terminated from LAF U status. (obsolete)
BENDEX COMMUNICATION CODE

This information is supplied by SSA to help the state analyze records returned in response to state direct input, records being accreted through the buy-in system and records previously established as Bendex which are undergoing a change. Records fully processed, housing pertinent MBR data, contain one of the following five matched codes:

Matched - Fully processed record, with pertinent data extracted from the MBR.
Rep Paye - Benefits are paid to other than beneficiary.
Deleted - Communication code 'DTH' or 'DPA' was received on direct input record. (Indicates matched).
FIN MMYY - Termination due to payment status (LAF) code or death.
CF XXX - record is in conflict with another agency, XXX. This record represents the last automated data for the receiving agency. Since Bendex receives input from most states, as well as other SSA Systems, a priority of processing has been established to follow in the event multiple actions are received in a month for an individual.

A Bendex direct input accretion will be given priority over an accretion originating from a state buy-in system. An accretion will have priority over internally - SSA generated actions. The action will generate the regular Bendex output to the appropriate state. Conflict cases will be produced in the following circumstances:

1. A direct input and a buy-in accretion are received from different states. The lower-priority (buy-in accretion) action will result in generation of a CF response to the state attempting to buy in, with the agency code of the state with higher priority shown in record positions 82-84.

2. Two direct input accretions are received from different states. The state which differs from the state of residence for the recipient as shown on the SSA MBR (Field 28) will receive the CF response.

3. An accretion - direct input or buy-in - is received for an individual previously accreted by another state. The new accretion will be processed and a CF record will be generated to the former state with the agency code currently-accreting state being shown in record positions 82-84.

It is important for the state to understand that receipt of a CF record means that Bendex exchange has not been established in the case of an attempted accretion (1. and 2. above), or that Bendex exchange is being discontinued for a previously-accreted individual (3. above). Further, the state should be alerted by this type of record to the possibility of fraudulent entitlement to public assistance from multiple agencies.

The following are returned without MBR data:
BL only - Entitled to black lung benefits, not entitled to Title II benefits.
BL-RRB - Entitled to black lung and RRB benefits, Not entitled to Title II benefits.
DOB UNM - Date of birth unmatched. Processing ceased. (see matching criteria below).
GIV UNM - Given name unmatched. Processing ceased. (see matching criteria below).
IMP CAN - Impossible claim number. The CAN/SSN (positions 1-9) on the input record is invalid. They are not all numeric or are out of range issued by SSA; I.E., all zeros, area 588-699, or areas 729-999.
IMP-CODE - The communication code, field 13, on direct input record is either blank or invalid.
NO AUTH - Category of assistance code, Field 11, on direct input case is missing or invalid.

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NO DEX - Accretion and deletion cases received as direct input for same CAN/SSN. SSA is unable to determine which action the state is attempting. Neither processed.

NO FILE - Claim number in possible range but nonexistent on master beneficiary record. No entitlement to SSA benefits on this can. (If an SSN was submitted and the CAN is known, the record should be resubmitted using the can.)

RRB Only - Entitled to RRB benefits, not entitled to Title II benefits.

SI-BL-RR - Entitled to SSI, black lung and RRB benefits; not entitled to Title II benefits.

SSA INV - SSA is continuing to investigate.

SSI-BL - Entitled to SSI and black lung benefits, not entitled to Title II benefits.

SSI Only - Not entitled to Title II benefits.

SSI-RRB - Entitled to SSI and RRB benefits, not entitled to Title II benefits.

SUR UNM - Surname unmatched. Processing ceased. (see matching criteria below.)

Xref Num - A cross-reference number which SSA is unable to locate is involved. The State is asked to resubmit the case after determining the other number.

Matching criteria to assure that data exchange is accomplished for the proper beneficiary/recipient.

Claim Number Furnished:

<table>
<thead>
<tr>
<th>Claim Number</th>
<th>Surname</th>
<th>1st Name</th>
<th>DOB</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQL on 11</td>
<td>EQL</td>
<td>EQL</td>
<td>---</td>
<td>Matched</td>
</tr>
<tr>
<td>EQL on 11</td>
<td>EQL</td>
<td>UNEQL</td>
<td>EQL</td>
<td>Matched</td>
</tr>
<tr>
<td>EQL on 11</td>
<td>EQL</td>
<td>UNEQL</td>
<td>ENEQL No Match-(GIV UNM)</td>
<td></td>
</tr>
<tr>
<td>EQL on 11</td>
<td>UNEQL</td>
<td>--------</td>
<td>---</td>
<td>No Match-(SUR UNM)</td>
</tr>
</tbody>
</table>

(SSN/CAN only furnished or not match on suffix):

<table>
<thead>
<tr>
<th>SSN/CAN</th>
<th>Surname</th>
<th>1st Name</th>
<th>DOB</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQL on 9</td>
<td>EQL</td>
<td>EQL</td>
<td>EQL</td>
<td>Matched</td>
</tr>
<tr>
<td>EQL on 9</td>
<td>EQL</td>
<td>UNEQL</td>
<td>---</td>
<td>No Match-(GIV UNM)</td>
</tr>
<tr>
<td>EQL on 9</td>
<td>EQL</td>
<td>EQL</td>
<td>UNEQL No Match-(DOB UNM)</td>
<td></td>
</tr>
<tr>
<td>EQL on 9</td>
<td>UNEQL</td>
<td>---</td>
<td>---</td>
<td>No Match-(SUR UNM)</td>
</tr>
</tbody>
</table>

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BENDEX SSI INDICATOR CODE

The legend "SSI MMYY" is returned to the states for informational purposes. This legend includes a specific SSI indicator. For many states, there will be no need to continue Bendex exchange for an individual once he/she is determined be SSA to be eligible for SSI benefits. A Bendex/SSI writeoff will be performed, preparing final records on all SSI eligible individuals upon state request. No further Bendex data exchange for these casees will be sent to the state, since verification of current status and/or amount of benefit may be obtained through the SSI/SDX system. Should SSI benefits be later terminated and the State desire further verification of SSA data, it will be necessary for the state to reintroduce data exchange through Bendex by means of direct input, at that time, the State should review the categorical assistance indicator used to be certain that authorization exists for this exchange.

Position 90 of the Bendex output record will contain an alphabetic code reflecting the individual's status in the SSI program if an SSI Master record has been established by SSA. The SSI status codes (SISC) have been designated as follows:

<table>
<thead>
<tr>
<th>SISC (SSI Status Code)</th>
<th>Meaning</th>
<th>SIED (MMYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Terminated. May have been terminated. May have been caused by Title II benefit rate increase.</td>
<td>1st month of Noneligibility</td>
</tr>
<tr>
<td>C</td>
<td>Conditional SSI Payment</td>
<td>1st month of entitlement</td>
</tr>
<tr>
<td>D</td>
<td>Denied</td>
<td>Date of filing/Denial Date</td>
</tr>
<tr>
<td>E</td>
<td>Entitled-1st Mo. paid</td>
<td>1st Month of entitlement</td>
</tr>
<tr>
<td>I</td>
<td>Ineligible</td>
<td>Date of filing/Denial date</td>
</tr>
<tr>
<td>L</td>
<td>Erroneous initial entitlement</td>
<td>1st month of noneligibility (obsolete)</td>
</tr>
<tr>
<td>M</td>
<td>Entitled to Title XIX only (Medicaid)</td>
<td>1st month of noneligibility (obsolete)</td>
</tr>
<tr>
<td>P</td>
<td>Pending SSI determination</td>
<td>Date of filing/Denial date</td>
</tr>
<tr>
<td>S</td>
<td>Entitled to SSI state supplement only</td>
<td>1st month of entitlement</td>
</tr>
<tr>
<td>T</td>
<td>Terminated-1st month of noneligibility</td>
<td>1st month of noneligibility</td>
</tr>
<tr>
<td>V</td>
<td>Terminated (T30), but not reaccreted</td>
<td>1st month of noneligibility</td>
</tr>
<tr>
<td>W</td>
<td>State supplement terminated</td>
<td>1st month of noneligibility</td>
</tr>
<tr>
<td>X</td>
<td>Terminated-Death</td>
<td>1st month of noneligibility</td>
</tr>
<tr>
<td>Y</td>
<td>Terminated-Excess income</td>
<td>1st month of noneligibility</td>
</tr>
<tr>
<td>Z</td>
<td>Terminated-Excess resources</td>
<td>1st month of noneligibility</td>
</tr>
</tbody>
</table>
SSA will show the currently recorded SMI option code. The possible SMI option codes are:

C-NO. Cessation of disability.
D-NO. Denied.
P-NO. Invalid enrollment has been terminated.
G-YES. Beneficiary enrolled under SSA's 'Good cause' provisions.
N-NO. No response from the beneficiary when asked for election.
P- Beneficiary entitled to SMIB; railroad retirement board has jurisdiction for premium collection.
R-NO. SMI refused.
S-NO. No longer under renal disease provision.
T-NO. SMI terminated because of nonpayment of premiums.
W-NO. Voluntary withdrawal from SMIB.
Y-YES. Enrolled in SMIB.

Numeric "1" to "9" will indicate that a 10% to 90% penalty is applicable. The letter "Z" will indicate that 100% penalty is applicable. The letter "X" will indicate that a 110% penalty is applicable. The presence of a penalty indication assures a "Y" option.
The currently recorded HI option code. The possible HI option codes are:

C-NO. Cessation of disability.
D-NO. Denied.
E-YES. Automatic entitlement, no premium necessary.
F-NO. Terminated for invalid enrollment or enrollment voided.
G-YES. Good cause.
H-NO. Not eligible for free part A, or did not enroll for premium part A.
P- Railroad jurisdiction.
R-NO. Refused free part A.
S-NO. Terminated-No longer entitled under renal disease provision.
T-NO. Terminated for nonpayment of premiums.
W-NO. Withdrawal from premium part A.
Y-YES. Premium part A is payable.

(return to top)
BENDEX BLACK LUNG CODE (BLES)

Will be present when there is black lung involvement. The applicable black lung indicators are:

E - Entitled, First month paid
N - Nonpayment
P - Pending black lung entitlement
T - Terminated, last month paid

(return to top)
The state will be advised of a recipient SSI status via the data exchange. Position 46 of the accretion, alert or deletion format is used to enter a one-position alpha character as follows:

Accretions or alerts

E. Eligible for SSI; may or may not be receiving a federally administered state supplement.
S. Eligible for SSI by only receiving a federally administered state supplement.
C. Conditionally eligible for SSI.

Deletions

Y. Termination of SSI because of excess income.
Z. Termination of SSI because of excess resources.
W. State withdrawal of agreement for federal administered state supplementation payments.
T. Termination for reason other than the above.

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<tr>
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<th>SB103050</th>
<th>CLAIM TYPE</th>
<th>BATCH</th>
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<td>(M) MEDICAL 837 (ENCOUNTER)</td>
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<td>SB1042</td>
<td>(X) CROSSOVER</td>
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**CROSSOVERS ARE ALLEGEDLY DIVIDED INTO 3 RANGES**

**RANGE 000-049 - MEDICARE RELATED-DIRECT TAPE TO TAPE**

**RANGE 050-074 - PROFESSIONAL CROSSOVER**

**RANGE 075-099 - INSTITUTIONAL CROSSOVER**

40 SB1J0132 SB1032 (M) MEDICAL HCFA1500 (ELECTRONIC MEDIA) 001-342* 
49 SB1J033 SB1032 (M) MEDICAL HCFA1500 (ELECTRONIC MEDIA)(ENCOUNTER) 001-342* 
40 SB1J043A SB1041 (U) UB INPATIENT 850-851* 
40 SB1J043A SB1041 (R) UB HOME HEALTH 850-851* 
40 SB1J043A SB1041 (Q) UB OUTPATIENT 850-851* 
80 SB1J043 SB1043 (X) CROSSOVER 000-650* 
80 SB1J043 SB1043 (X) CROSSOVER 000-650* 
80 SB1J043 SB1043 (X) CROSSOVER 000-650* 
80 SB1J047 SB1044 (X) CROSSOVER 000-000* 
95 SB1J046 SB1146 (M) MEDICAL 352-499* 
20,21 SB1J018 SB1080 (N) NURSING HOME, BASIC CARE 120-140* 
20,21 SB1J118 SB1080 (N) NURSING HOME, BASIC CARE (ELECTRONIC MEDIA) 141-649* 
?? ( ) RECIPIENT ELIGIBILITY TRANSACTIONS 200-279 
94 SB1J021 SB1140 (M) MEDICAL (HCBC-DD) 300- 
95 SB1J046 SB1146 (M) MEDICAL (DEPT OF INSTR) 300-350 
50 SB1J019 HC6795 (M) MEDICAL (VRIS) 300-342 
40 SB1J042 SB1032 (M) MEDICAL (MEDTRACK) 343- 
94 SB1J123 SB1140 (M) HCBC (ELECTRONIC MEDIA) 351- * 
50 SB1J019 HC6795 (L) DENTAL (VRIS) 385-399 
50 SB1J019 HC6795 (D) DRUG (VRIS) 400-409 
40 SB1J009 SB1050 (D) DRUG 400-549 
50 SB1J019 HC6795 (D) DRUG (VRIS) 450-458 
50 SB1J019 HC6795 (D) DRUG (VRIS) 465-473 
50 SB1J019 HC6795 (D) DRUG (VRIS) 480-549 
90 SB1J010 SB1010 (I) INPATIENT (KEYMASTER) 550- 
50 SB1J019 HC6795 (U) UB - INPATIENT (VRIS) 560-599 
50 SB1J019 HC6795 (Q) UB - OUTPATIENT (VRIS) 606-619 
50 SB1J019 HC6795 (R) UB - HOME HEALTH (VRIS) 620-649 
?? ( ) FINANCIAL - BUYN TRANSACTIONS 695-699 
?? ( ) FINANCIAL - A/R SETUPS 700-707 
?? ( ) FINANCIAL - CASH DISPOSITION TRANSACTIONS 708-713 
?? SB1J065 SB1210 ( ) FINANCIAL - ADJUSTMENT CLAIMS - SB187A 714-724 
?? SB1J870 SB1870 ( ) FINANCIAL - RETROACTIVE (MASS) RATE ADJUST- SB187A 739-767 
?? SB1J065 SB1210 ( ) FINANCIAL - RBL ADJUSTMENT CLAIMS - SB187A 768* 
?? ( ) FLAGGED PROVIDER ON REVIEW TRANSACTIONS 769-774 
?? ( ) FINANCIAL - COLLECT AND PARTIAL REIMB. 775-784
Revised Batch Ranges - Continued Page 2

April 2003

- MOSTLY PAPER TURNAROUNDS--------------------------------------------------
  - THESE CLAIMS ARE WHERE REGIONS 10, 20, 21, 30, 60, 70, 90, 91, 92 AND 93 ARE USED-----

- BATCHES WITH NO END RANGE DO NOT HAVE A BATCH END RANGE IN THE PROGRAM THAT ICN’S THEM. THEY WILL KEEP INCREMENTING UNTIL ALL THE CLAIMS HAVE BEEN ICN’ED.
- BATCH RANGES WITH AN ASTERISK INDICATES INCREMENTING BY ONE RATHER THAN BY TEN.

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CASE NUMBER SUFFIX (C-1)

DESCRIPTION

11
OAA - MALE

12
OAA-FEMALE

21
BLIND-MALE

22
BLIND-FEMALE

31, 32, 33, 34, ETC.
AFDC - 1st, 2nd, 3rd, 4th, etc.
Family Member applying

41
AD-MALE

42
AD-FEMALE

50-59
AID TO BLIND-REMEDIAL

61, 62, 63, ETC.
REFUGEE PROGRAM

71, 72, 73, ETC.
FOSTER HOME

800-890
CCS

801-891
CCS-SSIDCP

910, 920
STATE HOSPITAL OVER AGE 18 BUT UNDER 21

911
MO-MALE-OAA

912
MO-MALE-BLIND

913, 923, 933, ETC.
MO-AFDC-1st, 2nd, 3rd, etc.
Family Member applying

914
MO-MALE-AD

917, 927, 937, ETC.
MO-FOSTER HOME

(return to top)
CASE NUMBER SUFFIX (C-1)

921
MO-MALE-OAA

922
MO-MALE-BLIND

924
MO-MALE-AD

930, 940
STATE HOSPITAL UNDER AGE 18

971
MO-MALE-STATE HOSPITAL

981
MO-MALE-STATE HOSPITAL

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<tr>
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<tr>
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<td>Inpatient Hospital</td>
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<td>02</td>
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<td>SNF</td>
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<tr>
<td>04</td>
<td>ICF</td>
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<tr>
<td>05</td>
<td>Physician</td>
</tr>
<tr>
<td>06</td>
<td>Other Practitioner</td>
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<tr>
<td>07</td>
<td>Dental</td>
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<td>08</td>
<td>Drug</td>
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<tr>
<td>09</td>
<td>Lab and Radiology</td>
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<tr>
<td>10</td>
<td>Home Health Care and Rural Health Clinics</td>
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<tr>
<td>11</td>
<td>State Hospital</td>
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<td>12</td>
<td>Other</td>
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<tr>
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<td>Home and Community Base Care</td>
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<td>14</td>
<td>Home and Community Base Care for the Elderly/Disabled</td>
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<tr>
<td>21</td>
<td>Educational-CCS/SSIDCP</td>
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<tr>
<td>22</td>
<td>Social/Development-CCS/SSIDCP</td>
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<td>23</td>
<td>Rehabilitative Services-CCS/SSIDCP</td>
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<tr>
<td>70</td>
<td>Personal Care</td>
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<tr>
<td>99</td>
<td>EPSDT Screening Documents</td>
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</table>

In the pricing program (SB1130 SB1J050): 

**For Maj-Cat-Serv:**

```plaintext
05 MAJOR-CAT-OF-SVCS.
  10 MAJOR-INPUT-HOSP PIC X(2) VALUE '01'.
  10 MAJOR-OUTPAT-HOSP PIC X(2) VALUE '02'.
  10 MAJOR-SNF PIC X(2) VALUE '03'.
  10 MAJOR-ICF PIC X(2) VALUE '04'.
  10 MAJOR-PHYS PIC X(2) VALUE '05'.
  10 MAJOR-OTHER PIC X(2) VALUE '06'.
  10 MAJOR-DENTAL PIC X(2) VALUE '07'.
  10 MAJOR-DRUG PIC X(2) VALUE '08'.
  10 MAJOR-LAB PIC X(2) VALUE '09'.
  10 MAJOR-HOME-HEALTH PIC X(2) VALUE '10'.
  10 MAJOR-STATE-HOSP PIC X(2) VALUE '11'.
  10 MAJOR-DEFAULT PIC X(2) VALUE '12'.
  10 MAJOR-DD PIC X(2) VALUE '13'.
  10 MAJOR-HCBC-ELD-DIS PIC X(2) VALUE '14'.
  10 MAJOR-PC PIC X(2) VALUE '70'.
  10 MAJOR-SCREEN PIC X(2) VALUE '99'.
```

If mental health provider = '12'
If ICFMR Provider = '04'
If State Hospital Provider = '11'
If QSP or HSC Provider:
  If Legal County is 55 or 56 = '14'
  If Legal County is 90 = '13'
  If Legal County is 91 AND
    Procedure code = 00050-00099 = '13'
  All others = '14'

*(return to top)*
If Pharmacy Claim = '08'
If Inpatient Claim, DD, and Legal County = '90' = '13'
If Inpatient Claim or (Xovr claim and Xovr Inpatient) = '01'
If Outpatient Claim or (Xovr Claim and Xovr Outpatient) = '02'
If Swing Bed Provider and NH claim
   If service code = '7' or '9' = '03'
   If service code = '8' = '04'

If NH claim or (Xovr and SNF):
   If Provider Type = Nursing Home = '03'
   If Provider Type = ICF or ICF Mentally Retarded = '04'
   If State Hospital Accom = '12'
   If Nursing Accommodation = '03'
   If Basic Care Provider and Nursing Accommodation = '70'
If Dental Claim = '07'
If Provider type = 24, 24 or 50 (physician) = '05'
If Provider type = 70-72 (Lab) = '09'
If Provider type (26, 28, 30, 31, 33 34, 35, 37, 53, 65, 66, 67)(other) = '06'
If Home Health Claim or Provider Type = 58 (QSP) = '10'
If claim does not fit any of those = '12'

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## Category of Service - Intermediate

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<td>Co-Insurance</td>
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<tr>
<td>4</td>
<td>Family Planning</td>
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In the pricing program (SB1130 SB1J050):

### For Int-Cat-Serv:

- If Mental Health Provider = '5'
- If ICF/MR Provider = '6'
- If Inpatient Claim and DD Claim and Legal county = 90 = '0'
- If QSP or HSC Provider = '0'
- If Xovr Claim and procedure code = 09991 = '1'
- If Xovr Claim and procedure code = 09992 = '1'
  - Also moves '21' to Min-cat-serv
- If Xovr claim and procedure code = 09990 = '2'
- If Xovr claim and other procedure = '0'
- If Nursing Home claim
  - If Swing Bed
    - If Service Code 7 or 8 = '0'
    - If Service Code 9 = '2'
    - If Service Code R = '2'
  - If claim is result of referral = '3'
- If Institutional Claim = '0'
- If Family Planning = '4'
- If none of the above = '0'

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<table>
<thead>
<tr>
<th>CODE</th>
<th>CATEGORY</th>
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<tbody>
<tr>
<td>01</td>
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<td>Hospital-Aged</td>
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<td>Hospital-Under 21</td>
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<td>Skilled nursing care in a swing bed</td>
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<td>05</td>
<td>Intermediate nursing care in a swing bed</td>
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<td>Medicare coinsurance in a swing bed</td>
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<td>Nursing care in home-skilled</td>
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<td>Nursing care for hospital-skilled</td>
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<td>Blood</td>
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<td>Transportation-ambulance and other emergency</td>
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<td>Other supplies purchased in drug store</td>
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<td>Appliances</td>
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<td>Dental-Prosthodontics (Fixed)</td>
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<td>EPSDT Screening</td>
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<td>Other Services/Practitioner</td>
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In the pricing program (SB1130 SB1J050):

**For Min-Cat-Serv:** (Note: The line items have the same major category of service, but the Minor and Intermediate category of services are done at the line item only)

- If Mental Health Provider = '53'
- If Inpatient Claim and DD and Legal County = 90 = '54'
- If QSP Provider = '54'

(return to top)
If Major Cat is Inpatient Hospital:
If Inpatient Claim and Rev Code
= 100-219 or 230-239 (Accom) = '01'
If Service Code = a, b, c, e, g
(Inpat Accom) or 1, 2 (Nursing Accom) = '01'
For all others, the program looks the service code up in a table and
Puts the corresponding match in the Min-cat-of-serv:
H=26 J=67 K=65 L=66 M=68 N=55 O=56 P=21
Q=22 R=23 S=24 T=25 U=50 V=27 W=28 X=73 Y=72
If Major Cat is Outpatient Hosp
Uses the same table as the Inpatient Hosp above
If Major Category is SNF OR Major Category is ICF
If the provider is out of state:
If it is an ancillary service, uses the same table as the
Inpatient Hosp above
If service code = '6' = '19'
If service code = '1' = '18'
If Service code = '2' = '17'
If none of the above = '16'
If the provider is in-state:
If the service code is 1 = '12'
If the service code is 2 = '11'
For all others, the program looks the service code up in a table and
Puts the corresponding match in the Min-cat-of-serv:
1=12 2=11 3=10 4=13 5=30 6=19 7=07 8=08 9=09 G=15 H=31 J=14 N=32
Q=35 R=36 S=37 T=33 U=34 V=20 W=29 X=38 Y=39 K=65 L=66 M=68
If none of the above = '10'
If Major Category is Physician OR Major Category is Other Practioner
If type of service is R = '92'
If type of service is 9
If procedure is 04000-04299 (CCS) = '99'
If procedure 04000-04099 (Educat) moves '21' to Major Cat of Serv
If procedure 04100-04199 (Soc Dev) moves '22' to Major Cat of Serv
If neither, moves '23' to Major Cat of Serv
If conditions do not meet the above, the program looks the provider type
Up in a table and puts the corresponding match in Min-cat-of-serv:
24=45 25=46 26=47 28=48 30=42 31=44 33=58 34=65 35=66 53=44
59=51 61=76 62=75 65=51 66=51 67=51 80=61 81=60

{return to top}
If the provider type is not found in the above table:

- If provider is '50165' = '62'
- If type of service is 1
  - If procedure 90801-90899 (psych) = '48'
  - If procedure 90941-90999 (dialy) = '57'
  - If procedure 99070 (cast) = '64'
  - If none of those = '01'
- If type of service is 2 = '63'
- If type of service is 3 = '40'
- If type of service is 4 or 6 = '55'
- If type of service is 5 = '56'
- If type of service is 8 = '41'
- If type of service is G or A = '50'
- If type of service is 9

The program looks the procedure code up in a table and puts the corresponding match in Minor-cat-of-serv:

- 00001-00999=75  E0000-E9999=75  01000-01199=73  L0100-L9999=73
- A4200-A4927=73  01300-01399=65  01400-01499=66  01500-01599=67
- 01600-01699=47  01700-01799=58  01800-01899=59  01900-01999=76
- 02000-02199=44  90050-92355=44  Z2037-Z22107=44  02200-02299=95
- 02200-Z2207=95  V2620-V2629=95  02300-02399=42  02400-02499=45
- 02500-02599=51  02600-02699=43  02700-02799=62  02800-02899=60
- A0090-A0140=60  03300-03999=56

- If it does not match any in the table = '99'

If Major Category is Dental:
- If the recipient's aid category is '08'
  - If one of the diagnosis codes is 74900-74920 (CCS) = '81'

- If type of service = '7'
  - The program looks the procedure code up in a table and puts the corresponding match in Minor-cat-of-serv:
    - 00100-00999=82  01000-01999=83  02000-02999=84  03000-03999=85
    - 04000-04999=86  05000-05999=87  06000-06999=88  07000-07999=89
    - 08000-08999=80
  - If none of the above = '90'

If Major Category is Lab:
- If provider type is 70 or type of service is 5 = '56'
- If provider type is 71 or type of service is 4 or 6 = '55'
- If type of service is H or J
  - If procedure is 70000-79999 (xray) = '55'
  - If not = '99'
- If type of service is 9
  - If procedure is less than 03300 = '99'
  - If procedure is greater than 03999 = '99'
  - If neither = '56'
- If none of the above criteria is met = '99'

If Major Category is Home Health = '43'

(reu**t to top)
If Major Category is State Hospital
If service code is A, B, C, E or G
   (Inpatient accommodation)
   If under 21 years            = '05
   If over 65 years             = '04'
   All others                   = '01'

All other service codes:
The program looks the service code up in a Table and puts the corresponding match in Min-cat-serv
   H=26  J=67  K=65  L=66  M=68  N=55  O=56  P=21
   Q=22  R=23  S=24  T=25  U=50  V=27  W=28  X=73
   Y=72

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050  Walsh  099
051  Ward  101
052  Wells  103
053  Williams  105
Out of State  000
054  Home and Community Base Care
055  Expanded SPED
056  Service Payments to ELD/DIS (SPED)
057  Out of State
058  Refugee Assistance
059  C C S
060  D I S A B L E D
061  Vocational Rehabilitation
062  Disability Determination Services
063  Developmental Disability
064  Grafton State School
065  San Haven State Hospital
066  State Penitentary
067  State Industrial School
068  Regional Intervention Services
069  State Hospital
089  ICF Mentally Retarded
090  HSC-Home and Community Base Care Waiver
091  Home and Community Base Care ELD/DIS
092  Refugee Assistance - Title XIX
093  Traumatic Brain Injury
095  Department of Public Instruction

**CODE**  **CENTERS**

081  Northwest Human Service Center
082  North Central Human Service Center
083  Lake Region Human Service Center
084  Northeast Human Service Center
085  Southeast Human Service Center
086  South Central Human Service Center
087  West Central Human Service Center
088  Badlands Human Service Center

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### CURRENT LOCATION STATUS

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**DISCHARGE DESTINATION (PATIENT STATUS)**

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# DRUG REPORTING UNITS

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<td>27</td>
<td>Miscellaneous</td>
<td>MIS</td>
</tr>
</tbody>
</table>

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EPSDT PROBLEM CODES/SCREENING RESULTS CODES

01 Vision/Eyes
02 Hearing/Ears
03 Dental
04 Height/Weight
05 (Not Used)
06 Nutrition
07 Skin
08 Musculoskeletal
09 Infections/Lymphatic
10 (Not Used)
11 Pulmonary/Respiratory
12 Cardiovascular/Circulatory
13 Blood Pressure
14 Digestive/Gastointestinal
15 Endocrine
16 (Not Used)
17 Genitourinary
18 Neurological
19 Mental/Development/Emotional
20 Speech
21 Blood/Anemia
22 Serology/Smears
23 Parasites
24 Birth Defects
25 Physical Exam, General
26 Counseling
27 Other
28 (Not Used)
29 Polio/Immunization
30 DPT-Immunization
31 Measles (Ruboela) Immunization
32 Rubella (German Measles) Immunization
33 Mumps Immunization
34 Other Immunization
35 (Not Used)

Screening Results Codes

1 Positive Findings - Referred for Diagnosis and Treatment
2 Positive Findings - Not Referred - Under Treatment
3 Positive Findings - Parent/Recipient Refused Referral
4 Screening Not Completed - Parent/Recipient Refused Exam
6 Positive Findings - Treated on-site

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<table>
<thead>
<tr>
<th>Code</th>
<th>Response Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Accepts Offer of Service</td>
</tr>
<tr>
<td>1</td>
<td>Refuses Services because Current Health Care Satisfactory</td>
</tr>
<tr>
<td>2</td>
<td>Deemed Refused because of Multiple Missed Screeing Appointments</td>
</tr>
<tr>
<td>3</td>
<td>Recipient Refused, Reason not Specified</td>
</tr>
</tbody>
</table>
### EOB CODES

**Explanation of Benefits to Provider**

<table>
<thead>
<tr>
<th>EOB</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Provider of Service not Eligible on Date of Service</td>
</tr>
<tr>
<td>002</td>
<td>Recipient not Eligible on Date of Service</td>
</tr>
<tr>
<td>003*</td>
<td>Co-Payment Amount</td>
</tr>
<tr>
<td>004*</td>
<td>The Procedure Code Is Inconsistent With The Modifier Used Or A Required Modifier Is Missing</td>
</tr>
<tr>
<td>005</td>
<td>Dental Visits to the Nursing Home Require Documentation of Medical Necessity</td>
</tr>
<tr>
<td>006*</td>
<td>The Procedure/Revenue Code Is Inconsistent With The Patient's Age</td>
</tr>
<tr>
<td>007</td>
<td>The Medicaid Program Limits the Frequency of this Service</td>
</tr>
<tr>
<td>008</td>
<td>Denied, Physician not Enrolled in this Clinic</td>
</tr>
<tr>
<td>009</td>
<td>Denied, Please File Hard Copy with Description</td>
</tr>
<tr>
<td>010</td>
<td>Claim or Service Previously Paid</td>
</tr>
<tr>
<td>011</td>
<td>Denied, Maximum of 44 Lines per UB-92 Claim, Resubmit Summary Claim</td>
</tr>
<tr>
<td>012</td>
<td>Payment for In-Hospital Medical Care for this Period Paid to Another Physician</td>
</tr>
<tr>
<td>013</td>
<td>Service(s) not Covered Under Scope of Provider's Practice</td>
</tr>
<tr>
<td>014</td>
<td>Non-approved Charge for your Hospital</td>
</tr>
</tbody>
</table>
| 015* | A) Payment Adjusted Because The Submitted Authorization Number Is Missing, Invalid , Or Does Not Apply To The Billed Services Or Provider.  
B) M/I Date Of Service |
| 016* | A) Claim/Service Lacks Information Which Is Needed For Adjudication.  
Additional Information Is Supplied Using Remittance Advice Remarks Codes Whenever Appropriate  
B) M/I Prescription/Service Reference Number |
| 017* | Payment Adjusted Because Requested Information Was Not Provided Or Was Insufficient/Incomplete. Additional Information Is Supplied Using The Remittance Advice Remarks Codes Whenever Appropriate |
| 018* | Duplicate Claim/Service |
| 019  | Bill type is not valid for provider/services |
| 020  | Not a Benefit of Crippled Childrens Services |
| 021  | Units Billed not Compatible with Procedure Code Used |
| 022* | Payment Adjusted Because This Care May Be Covered By Another Payer Per Coordination Of Benefits. |
| 023  | Total charges do not equal sum of the detail lines |
| 024* | Payment For Charges Adjusted. Charges Are Covered Under A Capitation Agreement/Managed Care Plan |
| 025  | Denied - The Date Dispensed is Earlier than the RX Date |
| 026* | 1) Expenses Incurred Prior To Coverage.  
2) M/I Unit Of Measure |
| 027* | Expenses Incurred After Coverage Terminated |
| 028  | Procedure not Consistent with Recipient's Sex |
| 029* | C: The Time Limit For Filing Has Expired.  
N: M/I Number Refills Authorized. |
| 030* | Co-Payment Amount |
| 031* | Denied As Patient Cannot Be Identified As Our Insured |
| 032  | Denied. Maximum quantity on nicorette gum exceeded |
| 033  | Denied, Description Required for Lab Codes Ending in '99' |
| 034  | Date of Service Exceeds 2 Yr Limitation for Adjudication of Claims |
| 035* | A) Lifetime Benefit Maximum Has Been Reached.  
B) M/I Primary Care Provider Id |

* MMIS System Generated EOB Explanation
## EOB CODES

*(Explanation of Benefits to Provider)*

### EOB MESSAGE

<table>
<thead>
<tr>
<th>EOB</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>036</td>
<td>Claim Submitted on Wrong Form, Please Submit Services on a Pharmacy Claim Form</td>
</tr>
<tr>
<td>037</td>
<td>Innovator Multiple Source Drug Not Payable</td>
</tr>
<tr>
<td>038*</td>
<td>Services Not Provided Or Authorized By Designated (Network/Primary Care) Provider</td>
</tr>
<tr>
<td>039</td>
<td>No Additional Amount Coming, Mac Drug</td>
</tr>
<tr>
<td>040</td>
<td>Denied - Date dispensed is missing or invalid</td>
</tr>
<tr>
<td>041</td>
<td>Denied - RX Number is Missing</td>
</tr>
<tr>
<td>042*</td>
<td>Charges Exceed Our Fee Schedule Or Maximum Allowable Amount</td>
</tr>
<tr>
<td>043</td>
<td>Denied - Your Medicaid rates have not been received for this claim. Rebill</td>
</tr>
<tr>
<td>044</td>
<td>Denied - Refill Number is Missing or Invalid</td>
</tr>
<tr>
<td>045</td>
<td>Denied - Days Supply is Missing or Invalid</td>
</tr>
<tr>
<td>046</td>
<td>Denied - Quantity Billed is Missing or Non-Numeric</td>
</tr>
<tr>
<td>047*</td>
<td>This (These) Diagnosis(Es) Is (Are) Not Covered, Missing, Or Are Invalid</td>
</tr>
<tr>
<td>048</td>
<td>Rebill</td>
</tr>
<tr>
<td>049</td>
<td>Denied, Procedure Code not Consistent with Operative Report</td>
</tr>
<tr>
<td>050</td>
<td>Assistant services not payable for this procedure</td>
</tr>
<tr>
<td>051</td>
<td>Denied - No Charges were submitted on this claim</td>
</tr>
<tr>
<td>052*</td>
<td>N) The Referring/Prescribing/Rendering Provider Is Not Eligible To Refer/Prescribe/Order/Perform The Service Billed.</td>
</tr>
<tr>
<td>053</td>
<td>Dates of service missing/invalid/exceeds 1 per day.</td>
</tr>
<tr>
<td>054</td>
<td>Denied, Misc. Compound Code not Accepted. Use Specific Assigned Compound Code</td>
</tr>
<tr>
<td>055</td>
<td>You have not been Approved to Bill for this Procedure Code, Check with County OK to Process. Reviewed by Third Party Liability</td>
</tr>
<tr>
<td>056</td>
<td>Payment Denied/Reduced Because The Payer Deems The Information Submitted Does Not Support This Level Of Service, This Many Services, This Length Of Service, T His Dosage, Or This Day's Supply</td>
</tr>
<tr>
<td>057*</td>
<td>Procedure Code Missing or Invalid. Rebill code. Do not adjust.</td>
</tr>
<tr>
<td>058</td>
<td>Denied, No Invoice for Frame or Lens</td>
</tr>
<tr>
<td>059</td>
<td>Insurance payment equal or exceeds amount payable.</td>
</tr>
<tr>
<td>060</td>
<td>Denied. Incorrect Prov# billed recip authorized for AETS funding.</td>
</tr>
<tr>
<td>061</td>
<td>Claim Denied As Patient Cannot Be Identified As Our Insured.</td>
</tr>
<tr>
<td>062*</td>
<td>Denial, Supplies/Services to be Provided by Nursing Home/Swingbed/ICFMR</td>
</tr>
<tr>
<td>063</td>
<td>This Payment Reflects the Proper Allowable Amt to Correct Error Made when Initia</td>
</tr>
<tr>
<td>064</td>
<td>lly Processing your Claim. The original Amt Paid has been Deducted; See Entry Ap</td>
</tr>
<tr>
<td>065</td>
<td>Check Cancelled - 1099 Credited</td>
</tr>
<tr>
<td>066</td>
<td>Partial Deduction of Orig Pmt Due to Adjmnt Balance will Deduct on Future RA's</td>
</tr>
<tr>
<td>067</td>
<td>Adj request Reviewed. Orig. Paid at Medicaid Allowables. No Add'l Amount Payable</td>
</tr>
</tbody>
</table>

* MMIS System Generated EOB Explanation

*(return to top)*
**EOB CODES**

(Explanation of Benefits to Provider)

<table>
<thead>
<tr>
<th>EOB</th>
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</tr>
</thead>
<tbody>
<tr>
<td>070</td>
<td>This Amount Represents the Current Deduction of Previously Adjusted Claim</td>
</tr>
<tr>
<td>071</td>
<td>Additional Payout for Outstanding Balance</td>
</tr>
<tr>
<td>072</td>
<td>Thank you for your Refund - Your 1099 has been credited accordingly</td>
</tr>
<tr>
<td>073</td>
<td>A Repayment Receivable has been Established for this Claim paid in Error</td>
</tr>
<tr>
<td>074</td>
<td>Entire Deduction of Original Payments as a Result of an Adjustment</td>
</tr>
<tr>
<td>075</td>
<td>This Payment is an Adjustment to Reasonable cost on a Previously Allowed Charge</td>
</tr>
<tr>
<td>076</td>
<td>Paid at Medicaid maximum allowable for this service</td>
</tr>
<tr>
<td>077</td>
<td>Not a Benefit of Vocational Rehabilitation</td>
</tr>
<tr>
<td>078*</td>
<td>Reviewed by State Examiner</td>
</tr>
<tr>
<td>079</td>
<td>Maximum Allowable days Hospital Leave is 15 per Stay</td>
</tr>
<tr>
<td>080</td>
<td>Prior Treatment Authorization Amount has been Exceeded</td>
</tr>
<tr>
<td>081</td>
<td>Denied, No Invoice. Bill paper claim and attach invoice.</td>
</tr>
<tr>
<td>082</td>
<td>Maximum allowable home leave days exceeded.</td>
</tr>
<tr>
<td>083</td>
<td>Paid as Billed</td>
</tr>
<tr>
<td>084</td>
<td>Billed Amount Exceeds EAC Plus Fee</td>
</tr>
<tr>
<td>085*</td>
<td>A) Interest Amount.</td>
</tr>
<tr>
<td></td>
<td>B) Claim Not Processed</td>
</tr>
<tr>
<td>086</td>
<td>MAC Drug - MD Cert Present - Billed Amount Exceeds EAC Plus Fee</td>
</tr>
<tr>
<td>087*</td>
<td>Transfer Amount</td>
</tr>
<tr>
<td>088*</td>
<td>A) Adjustment Amount Represents Collection Against Receivable Created In Prior Over Payment.</td>
</tr>
<tr>
<td></td>
<td>B) Dur Reject Error.</td>
</tr>
<tr>
<td>089</td>
<td>New NDC number is not effective on date of service. Please correct NDC.</td>
</tr>
<tr>
<td>090</td>
<td>The Inpatient Rate Charged was Greater than the Approved Rate</td>
</tr>
<tr>
<td>091</td>
<td>Payment Calculated After Deducting Co-Pay Amount</td>
</tr>
<tr>
<td>092</td>
<td>Nursing Home Rate Charged was Greater than Approved Rate</td>
</tr>
<tr>
<td>093</td>
<td>Denied, Chrg for Lab Proc done Elsewhere not Payable. Lab must bill us Directly</td>
</tr>
<tr>
<td>094</td>
<td>Denied-Exact Duplicate of this Charge Being Paid on this claim.</td>
</tr>
<tr>
<td>095</td>
<td>Medicare is Considered the First Resource. Please Direct your Request for Reconsideration to Medicare</td>
</tr>
<tr>
<td>096*</td>
<td>A) Non-Covered Charge(S).</td>
</tr>
<tr>
<td></td>
<td>B) Scheduled Downtime</td>
</tr>
<tr>
<td>097*</td>
<td>A) Payment Is Included In The Allowance For Another Service/Procedure.</td>
</tr>
<tr>
<td></td>
<td>B) Payer Unavailable</td>
</tr>
<tr>
<td>098</td>
<td>Reviewed by State Consultant</td>
</tr>
<tr>
<td>099</td>
<td>Denied, Tooth Surface Invalid</td>
</tr>
<tr>
<td>100</td>
<td>Claim not Processable - See Attached Letter-Correct and Resubmit</td>
</tr>
<tr>
<td>101*</td>
<td>Deductible Amount</td>
</tr>
<tr>
<td>102</td>
<td>Service Provided not Consistent with Specialty</td>
</tr>
<tr>
<td>103</td>
<td>Post OP Service, Included in Surgical Fee</td>
</tr>
<tr>
<td>104</td>
<td>Denied, Ambulatory Surgical CTR Facility not Payable for this Procedure Code</td>
</tr>
<tr>
<td>105</td>
<td>Denied, Maximum of 5 room Charges per UB-92. Refile Summary Claim</td>
</tr>
<tr>
<td>106</td>
<td>Payment for Ass't Surgeon Fee for this Procedure Paid to Another Provider</td>
</tr>
<tr>
<td>107</td>
<td>This Procedure Incidental to Major Procedure</td>
</tr>
<tr>
<td>108</td>
<td>Not Payable for Chiropractic Services</td>
</tr>
<tr>
<td>109</td>
<td>Denied, Bill Medicare for this Item/Service</td>
</tr>
</tbody>
</table>

* MMIS System Generated EOB Explanation

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### EOB CODES

(Explanation of Benefits to Provider)

<table>
<thead>
<tr>
<th>EOB</th>
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</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>This service is included in ASC payment</td>
</tr>
<tr>
<td>111</td>
<td>This service should be performed in a physician setting/office.</td>
</tr>
<tr>
<td>112</td>
<td>Procedure requires written Patient Consent 30 Days Before Service</td>
</tr>
<tr>
<td>113</td>
<td>Limit or 32 Units per Day Payable</td>
</tr>
<tr>
<td>114</td>
<td>Denied frame and/or lenses are covered under warranty.</td>
</tr>
<tr>
<td>115</td>
<td>Denied, Duplicate, Same Data of Service, Same NDC, Different RX Number</td>
</tr>
<tr>
<td>116</td>
<td>LTC Credit</td>
</tr>
<tr>
<td>117</td>
<td>Denied, Multiple Errors in Billing on this Claim. Please Rebill</td>
</tr>
<tr>
<td>118</td>
<td>Adjusted per provider request.</td>
</tr>
<tr>
<td>119*</td>
<td>Benefit Maximum For This Time Period Has Been Reached</td>
</tr>
</tbody>
</table>
| 120* | A) The Diagnosis Is Inconsistent With The Provider Type.  
B) M/I Patient Location. |
| 121 | Denied. Physician number invalid. Check recent list of prescribing Drs. Rebill. |
| 122 | Do not adjust |
| 123 | Denied, Provider must accept Assignment and bill Medicare |
| 124 | Paid in Accordance with per Diem Rate |
| 125* | Payment Adjusted Due To A Submission/Billing Error(S). Additional Information Is Supplied Using The Remittance Advice Remarks Codes Whenever Appropriate. |
| 126 | Case Management Limited to One Per Month |
| 127 | Deny, No Medical Treatment Provided |
| 128 | Billing Period Includes days of Serv PD to Another Hosp. Paymnt Adjusted Accord |
| 129* | Claim Adjustment Because The Claim Spans Eligible And Ineligible Periods Of Coverage |
| 130 | Denied, Physician Number Closed/Invalid or Missing, Rebill, Do Not Adjust |
| 131 | Denied, Manufacturer Did not Sign up for rebate Agreement with HCFA |
| 132 | Denied, No Pre-admission assessment on file for this Client |
| 133 | Returned to County for More Information |
| 134 | Denied, Referring Physician Name/Number/or Occurrance Date Missing or Invalid |
| 135* | Claim Denied. Interim Bills Cannot Be Processed |
| 136 | Claim not Processable per Surs Determination. See Attached Claim and Letter |
| 137 | Denied. Previously processed claim must be handled by an adjustment (Form 600R) |
| 138 | Recipient Name and Number Disagree, Please check with County or Family |
| 139 | Denied. Prescription refilled prior to 70% utilized. |
| 140* | A) The Date Of Birth Follows The Date Of Service.  
B) M/I Eligibility Clarification Code |
| 141* | Claim Adjustment Because The Claim Spans Eligible And Ineligible Periods Of Coverage |
| 142 | Maximum Allowable already paid for Maternity Care |
| 143 | Persons age 21 and over are required to pay for eyeglasses lost within one year of original purchase |
| 144 | Denied. Submit adjustment with UPIN and attach supporting PCP referral. |
| 145 | Denied. Date of service not within effective dates of PCP. Bill client |
| 146 | Denied. Date of service exceed physician’s orders. |
| 147 | Denied Payment for these Services already paid to Another Provider |
| 148 | Procedure Code and Fee Adjusted to Medicaid allowable for this Service |

* MMIS System Generated EOB Explanation
OE0 CODES
(Explanation of Benefits to Provider)

**EOB**

**MESSAGE**

150  Claim Indicates Third Party Liability.  Rebill and Attach EOB.  Do Not Adjust.

151  Denied.  Quantity Not Metric

152  Denied.  Services not performed by PHYSICIAN IN SAME GROUP AS PCP.  Bill client

153  Limit of One N. H. Visit per Month Payable without a Report

154  Stainless Steel Crowns are still Intended for the use on Posterior Teeth

155  Not payable on Posterior Teeth

156  Provider name/number incorrect.  Claim corrected.  Please correct your files for

157  future submission

158  Denied.  No authorized contract for dates of service.

159  Denied, Exact Duplication of these Charges being processed on another claim.

160  Partial dentures and fixed bridgework to replace single missing posterior teeth

161  Are not a covered service.

162  Denied, Extraction fee includes Anesthesia

163  Hysterectomy not Payable without the 339 Form Properly Comp. and Attch to Auth.

164  Denied.  Medical necessity for ambulance not demonstrated.  Bill entity that called for service.

165  Payment made to the lower of billed charges or your state’s Drg rate.

166  Denied, Claim Past one Year Filing.  You may Request Reconsideration of the denial by rebilling paper claim with documentation.

167  Consult not payable when referring physician is same as performing physician.

168  Consult not Payable when Followed by Surgery Done by the Same Provider

169  Bill medicare on HCFA 1500 for oral chemotherapy.  If not oral chemotherapy rebill medicaid on paper claim with diagnosis in remarks

170  Reversal of pharmacy claim per provider request.

171  This Payment reflects the Correct Allowable Amt in Response to your adjustment Request.  The amount of the original has been deducted; see entry Appearing at the end of the statement

172  1993 clinical lab codes not valid for services until after May 1, 1993

173  Denied, items now subject to prior approval.

174  Only one Nursing Home Visit per Day payable

175  Deny, Information requested, Reply Received Insufficient to Justify payment

176  Recipient on claim does not match recipient on prior authorization.

177  Recipient not Eligible for all days Billed.  Rebill eligible days only.

178  This Claim has been Paid on the Medicare tape Billing

179  Denied client not MA elig or screened HCBS

180  Procedure(s) in this instance require review.  Rebill paper claim with report.

181  Lock in recip-payable only to Lockin Provider, EM SVS or referred Phys.  If ref

*return to top*
**EOB CODES**

*(Explanation of Benefits to Provider)*

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<tbody>
<tr>
<td>187</td>
<td>erred, rebill with copy of referral.</td>
</tr>
<tr>
<td>188</td>
<td>Recipient in ICF for Mentally Retarded. Nonlegend Drugs to be PD. by this Fac.</td>
</tr>
<tr>
<td>189</td>
<td>Denied. Non Medical Related Transportation</td>
</tr>
<tr>
<td>190</td>
<td>Only one Hospital Admission charge Payable per Admission</td>
</tr>
<tr>
<td>191</td>
<td>Expenses Payable for Only One Necessary Person</td>
</tr>
<tr>
<td>192</td>
<td>Adjustment Request Reviewed. Payment Not Allowable</td>
</tr>
<tr>
<td>193</td>
<td>Paym't for Anes. All 'D Only when Performed by Phys. Other than Oper. Or Asst M.D.</td>
</tr>
<tr>
<td>194</td>
<td>Your Adjustment request submitted for Wrong Line.</td>
</tr>
<tr>
<td>195</td>
<td>Claim Held Pending Pros Pymt Info From Minnesota Medicaid</td>
</tr>
<tr>
<td>196</td>
<td>Denied. Modifier missing or invalid.</td>
</tr>
<tr>
<td>197</td>
<td>Denied. Bill entity that called for service.</td>
</tr>
<tr>
<td>198</td>
<td>Partial Paymnt Only. Bal. Will be pd on Subsequent Auth. Created in our Office</td>
</tr>
<tr>
<td>199</td>
<td>Paymnt Could be made for only Chgs Rec'd within a Yr of the Date of Service</td>
</tr>
<tr>
<td>200</td>
<td>See claim and SPN form 631 enclosed with this RA regarding insurance info.</td>
</tr>
<tr>
<td>201</td>
<td>Medicare denied as routine. Refile Medicare/Medicaid stating medical necessity.</td>
</tr>
<tr>
<td>202</td>
<td>Services non-allowed by Medicare. Bill Medicaid allowable chgs on paper claim.</td>
</tr>
<tr>
<td>203</td>
<td>Denied. Diagnosis code is not Valid. Rebill with Appropriate Code.</td>
</tr>
<tr>
<td>204</td>
<td>Client is Medicaid eligible. Update your “Medicare” files.</td>
</tr>
<tr>
<td>205</td>
<td>Denied. Bill Medicare for outpt services furnished to inpt. Resubmit UB92 claim.</td>
</tr>
<tr>
<td>206</td>
<td>With all Medicare EOBS and a copy of the claim submitted to Medicare.</td>
</tr>
<tr>
<td>207</td>
<td>Denied. Medicaid does not Pay Maintenance Therapy</td>
</tr>
<tr>
<td>208</td>
<td>Denied. Emergency services not medically necessary.</td>
</tr>
<tr>
<td>209</td>
<td>Your adjustment request submitted for wrong claim.</td>
</tr>
<tr>
<td>210</td>
<td>Drug not a Benefit of Medicaid</td>
</tr>
<tr>
<td>211</td>
<td>Denied, Medical Necessity not Demonstrated</td>
</tr>
<tr>
<td>212</td>
<td>Denied, Medicaid doe not Reimburse for Routine Circumcision</td>
</tr>
<tr>
<td>213</td>
<td>Paymnt can be made only to Prov or Service, not to a 3rd Party</td>
</tr>
<tr>
<td>214</td>
<td>Proc. Code Revised to Procedure Authorization on PTAR</td>
</tr>
<tr>
<td>215</td>
<td>Denied. Required prior authorization not obtained for materials outside of the vision contract.</td>
</tr>
<tr>
<td>216</td>
<td>Adjustment request submitted for wrong claim. New adjustment entered here</td>
</tr>
<tr>
<td>218</td>
<td>Denied. Multiple priors on claim.</td>
</tr>
<tr>
<td>219</td>
<td>Denied, Not a Medicaid Claim</td>
</tr>
<tr>
<td>220</td>
<td>Partial Payment made on Previous Billings</td>
</tr>
<tr>
<td>221</td>
<td>Do not enter co-payment on claim</td>
</tr>
<tr>
<td>222</td>
<td>Fee for Suture Removal included in Surgical Procedure</td>
</tr>
<tr>
<td>223</td>
<td>Modifier required with nurse practitioner.</td>
</tr>
<tr>
<td>224</td>
<td>Client is Medicaid/qualified Medicare beneficiary. Non-covered items must be b</td>
</tr>
</tbody>
</table>

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EOB CODES
(Explanation of Benefits to Provider)

EOB MESSAGE

225 Rebill after checking Medicare denial and if Medicaid eligible. Rebill under Medicaid ID #. Rebill after checking Medicare denial and if Medicaid eligible.

226 Denied. Not state assigned NDC for durable medical equipment.

227 Lock in recip– payable if RX is by lock in phys/pharm, EM or referred phys.

228 Prior authorization valid. Not enough/no units remaining.

230 Rebill paper claim with completed consent and breakdown of sterilization chgs.

231 Recipient may be Medicare Eligible. Hold Billing 60-90 days and Bill Medicare. Your Claim was paid at our Max. Allowables for Codes Billed. Perhaps Codes should be rechecked.

232 Denied. Rebill with recipient’s TEC I.D. number. Refer to TEC client ID # on RA.

233 Claim processed at allowed amount. Insurance not on system. Send carrier name and policy number to state TPL unit.

234 Date of service not consistent with PA approved dates.

235 for extension of limit

239 Denied. Please submit copy of Emergency report with paper claim.

240 Denied. SVS do not appear to be a true emergency based on info. Bill patient.

241 Surgical Procedure code Missing or Invalid

242 Denied. Diagnosis not approved for provider specialty.

243 Denied. Consent form Signed more than 180 days prior to Sterilization Surgery

244 Denied. Medical necessity not established because the abortion was not performed to save the life of the woman or because the pregnancy was not the result of an act of rape or incest.

245 Insurance on claim. No insur. On state system. Bill on paper with attached EOB.

248 Denied. Payment for These Ancillary Services Included in the Swing Bed Rate

249 Denied. Incorrect Living Arrangement. Contact County

250 Maximum of three Modalities per day payable

251 Denied. No Record of Claim for These Services Submitted to us for Payment within One Year Period of Service Dates

252 Denied. Home Health Claims not Processable Through DataTrac System

253 Denied. Recipient Approved for Crippled Childrens Services Only

254 Recipient number not on our files/missing. Check with county or family.

255 Limit of One per Day Payable

256 Recipients health benefits have been reinstated. Bill insurance again

258 Denied. No Prior Approval Obtained, you have the Right to Appeal this Decision

259 Parent Responsible for part or all of Medical Bills.

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EOB CODES
(Explanation of Benefits to Provider)

EOB MESSAGE

260 Denied. Our records indicate Medicare supplement. Please check with verify
denied due to primary insurance determination. Submit appeal to primary
insurance company
262 Denied. Services included in drug rate.
263 No Amount Paid. System Generated Charge used to Process Nonpayable Medicare
Day
264 Hospital Leave days in Excess of 15 per Hospital Stay are Nonpayable
265 Denied. Performing Physician number is Missing or Invalid
266 Denied. Insurance was in effect at time of Service
267 One or more insurances indicated. Bill insurances and attach all applicable
Ins
urance explanation of benefits and/or documentation on a paper claim.
268 Qualified Medicare Beneficiary has other Insurance Coverage. Contact Patient
270 Recipient rec’d no services. Delete record from file prior to next
transmission.
271 Recipient not screened for Level of Care for Dates of Services Billed
272 Denied. Recipient ineligible for infant development
273 Denied. Discharge Date not Equal to Last Date of Service
274 Leave days not payable when resident is in a Medicare benefit period.
275 Denied. Numbers of Service Days Does not Equal Number of Days Billed.
276 Screening approval not obtained on or prior to admission
277 Denied. Discharge Date Cannot Equal Thru Date
278 Denied. Discharge Code Missing or Invalid
279 Denied. Thru Date Later than Discharge Date
280 Denied. Discharge Date Missing or Invalid
281 Denied. Admission Date Missing or Invalid
282 Denied. Accomodation or Ancillary Code Missing or Invalid
283 Partial Paym't of Invoice Cost. Tint & Cosmetic Enhance. Not Benefits of
Medicaid
284 Denied. Limit of 1 eye exam per yr for ages under 21/or every 2 yrs 21 &
over.
285 Denied. Infant development is limited to 5 detail lines
286 Payment for Postage not a Benefit of Medicaid
288 Day of death not payable in a Medicare benefit period. Rebill.
289 Denied. Repair, Replacement or lost glasses within 2 yrs of service.
290 Denied. MDS/Resident Classification not on file or not for your Facility
291 Denied. Supplies to be Included in your Daily Rate
292 Denied. Case management system Indicates Recipient not Eligible for this
Service
293 Denied. Nonwaivered Services for this Recipient cannot be Billed Alongside
Waive

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EOB CODES
(Explanation of Benefits to Provider)

<table>
<thead>
<tr>
<th>EOB</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>295</td>
<td>Rebill using replacement codes</td>
</tr>
<tr>
<td>296</td>
<td>Denied. Name and/or Social Security Number Missing or Invalid</td>
</tr>
<tr>
<td>297</td>
<td>Denied. From Day/Thru Day missing or invalid. Rebill entire claim.</td>
</tr>
<tr>
<td>298</td>
<td>Denied. Review Date on Screening Passed</td>
</tr>
<tr>
<td>299</td>
<td>Denied. Recipient not Screened for your Facility</td>
</tr>
<tr>
<td>300</td>
<td>Denied. Recipient has elected hospice for all or part of a month. Rebill the Da ys prior to election of hospice</td>
</tr>
<tr>
<td>301</td>
<td>Denied. Payment for Follow-up services included in fee for Initial Services</td>
</tr>
<tr>
<td>302</td>
<td>Denied. No approval on file from first mental health</td>
</tr>
<tr>
<td>303</td>
<td>Denied. Dates of service outside approved dates.</td>
</tr>
<tr>
<td>304</td>
<td>Payment made to the lower of billed charges or your state’s drg rate.</td>
</tr>
<tr>
<td>305</td>
<td>Denied. Authorization period missing or invalid.</td>
</tr>
<tr>
<td>306</td>
<td>Adjustment based on HCBS Finding(s) of Billing Error(s)</td>
</tr>
<tr>
<td>307</td>
<td>Denied. Claim not a Home &amp; Community Based Care Service</td>
</tr>
<tr>
<td>308</td>
<td>Denied. Provider not a Provider of Home &amp; Community Based Care</td>
</tr>
<tr>
<td>309</td>
<td>Denied. Wrong claim form. Rebill on turnaround.</td>
</tr>
<tr>
<td>310</td>
<td>Denied. Medicare review date is missing, invalid or not within the year of service</td>
</tr>
<tr>
<td>311</td>
<td>Denied. Insurance Paid to patient. Payment is patient’s responsibility</td>
</tr>
<tr>
<td>312</td>
<td>Providers must use the CPT code and the XV modifier for vaccinations covered under the VFC program</td>
</tr>
<tr>
<td>313</td>
<td>SPED ID not valid for functional assessment.</td>
</tr>
<tr>
<td>314</td>
<td>Denied. Provider Agreement for Transplants Only.</td>
</tr>
<tr>
<td>315</td>
<td>Denied. No Record of out of state Referral by Appropriate Specialist</td>
</tr>
<tr>
<td>316</td>
<td>Denied. Client not screened for this procedure/code.</td>
</tr>
<tr>
<td>317</td>
<td>This charge already included in Medicare allowable charge</td>
</tr>
<tr>
<td>318</td>
<td>Recipient is only SLMB Eligible on dates of service</td>
</tr>
<tr>
<td>319</td>
<td>Denied. Services obtained outside of recipients community</td>
</tr>
<tr>
<td>320</td>
<td>Clinic Number not Valid for Prescribing/performing Physician Number</td>
</tr>
<tr>
<td>321</td>
<td>Units of Service Missing or Invalid</td>
</tr>
<tr>
<td>322</td>
<td>DME rental costs/months exceed limit.</td>
</tr>
<tr>
<td>323</td>
<td>Effective July, 1 1996 Code 90782 is not payable with an immunization CPT code.</td>
</tr>
<tr>
<td>324</td>
<td>Cannot Work Adjustment. Resubmit Original Claim Returned to you for correction</td>
</tr>
<tr>
<td>325</td>
<td>Denied. Not Eligible for HCB Care. File indicates recipient in Nursing Home</td>
</tr>
<tr>
<td>326</td>
<td>Denied. Case Management already included in the services Billed</td>
</tr>
</tbody>
</table>

(return to top)
<table>
<thead>
<tr>
<th>EOB</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>330</td>
<td>Denied. Related outpatient charges are being adjusted. Refile this inpatient claim and include all charges.</td>
</tr>
<tr>
<td>331</td>
<td>Denied. Claim past 1 yr filing limit from the remittance advice date for resubmission. See Medicaid bulletin dated July 1998.</td>
</tr>
<tr>
<td>332</td>
<td>Reduction in fee by 13 Percent</td>
</tr>
<tr>
<td>333</td>
<td>System Used System Calculated Fee</td>
</tr>
<tr>
<td>334</td>
<td>Denied. 2 Evaluation and management services by same physician on same day. Diagnosis not payable to this provider.</td>
</tr>
<tr>
<td>335</td>
<td>Denied. This amount Exceeds the Total Medicare Allowable</td>
</tr>
<tr>
<td>336</td>
<td>This Claim held in our office for Receipt of Provider Information. Will be re-entered when Provider Number is on File</td>
</tr>
<tr>
<td>337</td>
<td>Denied. Please rebill paper claim with description and quantity. These charges must be billed by a durable medical equipment supplier. J3490 requires product name and strength. Use specific HCPC code (if available) Drugs not Administered as Part of Office Visit are Non-Payable Amb. to State Hosp. not Payable when Recipient is between ages 21 and 65 Collect this amount of copay and/or SSI from the recipient. Limit of one Anesthesia per Quadrant Denied. No parental placement agreement on file. Contact regional DD admin. Resubmit on a Summarized Claim Denied. Supplies/Services to be Provided by Hospice Surgical Procedure date is Invalid or Missing The UB82 Source of Admission is Invalid or Missing PSRO Code Missing or Invalid Revenue Code not Authorized for Rural Health Claim Revenue Code not Authorized for Medicaid Revenue Code not Authorized for Inpatient Claim Revenue Code not Authorized for Outpatient Claim Revenue Code not Authorized for Home Health Claim Denied. ICF unit Certified Title XIX. Resubmit under Medical Services Billing Adjustment Request (Form 600R) not Processable. Contact DD Division for method of Settlement Collect this amount of copay from the recipient Denied. EXT SVCS hours billed exceed authorized.</td>
</tr>
</tbody>
</table>

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## EOB CODES
*(Explanation of Benefits to Provider)*

<table>
<thead>
<tr>
<th>EOB</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>366</td>
<td>Claim Adjusted Billed Amount Plus Accumulated Paid Amount Exceeds Maximum Allowable for this Contract Period</td>
</tr>
<tr>
<td>367</td>
<td>Denied. Evaluation and Therapy to be Supplied by Nursing Home, Group, Swing Bed</td>
</tr>
<tr>
<td>368</td>
<td>Father is Court Ordered to pay half of Medical Expenses. The billed amount has been reduced by Half. Please bill father for this portion</td>
</tr>
<tr>
<td>369</td>
<td>Denied. Rebill hard copy with description and quantity and attach approved DME prior authorization form.</td>
</tr>
<tr>
<td>370</td>
<td>Denied. Enroll with vaccine program and refile administration fee.</td>
</tr>
<tr>
<td>371</td>
<td>Recipient name Incorrect. Claim Changed to Correct Name. Please correct file for future submission.</td>
</tr>
<tr>
<td>372</td>
<td>Claim Submitted on Wrong form. Please Submit Services on a 600C Swingbed form</td>
</tr>
<tr>
<td>373</td>
<td>Claim Submitted on Wrong form. Please Submit Services on a UB-92 form</td>
</tr>
<tr>
<td>374</td>
<td>Claim Submitted on Wrong form. Submit Services on a HCFA 1500 (12 – 90 Version)</td>
</tr>
<tr>
<td>375</td>
<td>Denied. Bill on Dental Claim form</td>
</tr>
<tr>
<td>376</td>
<td>Claim should cross from Medicare, allow 60 days before billing a crossover.</td>
</tr>
<tr>
<td>377</td>
<td>Denied. Incorrect Provider of EFC Recipient</td>
</tr>
<tr>
<td>378</td>
<td>DRG Payment per Transfer Policy</td>
</tr>
<tr>
<td>379</td>
<td>DRG Manually Priced</td>
</tr>
<tr>
<td>380</td>
<td>Generic Limit Drug, MD Cert Absent. Billed Amt Exceeds MAC Plus Fee</td>
</tr>
<tr>
<td>381</td>
<td>Generic Limit Drug, MD Cert Present. Billed Amt Exceeds EAC Plus Fee</td>
</tr>
<tr>
<td>382</td>
<td>Interim Bill Denied waiting for Final Bill</td>
</tr>
<tr>
<td>383</td>
<td>Denied. Retroactive PCP referral not accepted after 6/1/00</td>
</tr>
<tr>
<td>384</td>
<td>Denied. Use state assigned DME Code</td>
</tr>
<tr>
<td>385</td>
<td>Denied. Injection Administration fee included in Drug Charge</td>
</tr>
<tr>
<td>386</td>
<td>Denied. Rebill paper claim with diagnosis from prescriber/physician.</td>
</tr>
<tr>
<td>387</td>
<td>Denied. Provider enrolled with vaccine for children (VFC) program.</td>
</tr>
<tr>
<td>388</td>
<td>DRG Paid Claim. Late Charges not Applicable for Adjustment</td>
</tr>
<tr>
<td>389</td>
<td>Two Basic Emergency Room Codes are not Payable on the same Date of Service</td>
</tr>
<tr>
<td>390</td>
<td>Denied. Payment for ER, Office call or hospital visit paid to another phys. med NEC for same SVS by another phys not demonstrated.</td>
</tr>
<tr>
<td>391</td>
<td>Claim held Pending DRG payment information from your state’s Medicaid.</td>
</tr>
<tr>
<td>392</td>
<td>Denied. Client not on basic care resident payment file. Contact county office.</td>
</tr>
<tr>
<td>393</td>
<td>This Claim has been Reduced based on maximum limit of $980/1012.66 per month</td>
</tr>
<tr>
<td>394</td>
<td>Claim held in State office Pending Nursing Home, H.C.B.C., or DD payment</td>
</tr>
</tbody>
</table>

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EOB CODES
(Explanation of Benefits to Provider)

EOB | MESSAGE |
--- | --- |
400 | Claim held in State Office, Pending Recalculation or Adjustment/Recip Liability |
401 | Payment Denied. If a Recipient chooses a frame for more than $30.00 Wholesale, They will be responsible for the Entire Retail Cost |
402 | Payment denied. Only one Special Svcs Procedure code Payable for same ER visit |
403 | Payment reduced to half when only one service is Performed (Either Lens or Frame) |
404 | Denied; Anesthesia Administered by the Surgeon is not Payable |
405 | Denied. Rebill on paper claim with report. Do not adjust. |
406 | Unable to Process Claim, Rebill paper claim with Dr's Orders |
407 | Deduction of previous capitation payment. |
408 | HMO capitation payment |
409 | Consnet not properly completed. |
410 | Denied, Recipient Responsible for Co-Pay |
411 | Denied, Each Month of Service must be billed separately |
412 | Denied. Please bill family planning services only on separate claim form |
413 | Denied. Rebill paper claim with Consent Form. Do not Adjust |
415 | Denied. Desi Drug. Not Payable by Medical Services |
416 | Denied; Patient did not Follow the Proper Procedure to insure coverage by his insurance carrier |
417 | Denied. Application Pending- Rebill Claim upon Receipt of Recipient notice of approved Eligibility |
418 | Denied. Duplicate dates of service and procedure(s) - different units or charge. |
419 | Denied. Claim was Pd in full by Recp Liability Pd Directly to Provider Prior to Submission of Claim |
420 | Payment Reduced by Recipient Liability Paid Directly to Provider Prior to Submission of Claim |
421 | Denied; Dates of Service are Overlapping to Another Previously billed Claim |
422 | Claim Held in State Office Pending HCBC Residential Payment. Do not Submit |
423 | Recipient has not been Authorized or Determined Eligible for the date of service billed. You should advise the recipient to contact the county Social Service |

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<table>
<thead>
<tr>
<th>EOB</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>430</td>
<td>Board to Resolve the Eligibility Issue. Rebill if Verify Indicates Eligibility</td>
</tr>
<tr>
<td>431</td>
<td>Has been Established</td>
</tr>
<tr>
<td>432</td>
<td>Denied. DRG claim cannot be Processed. Diagnosis is not valid as Discharge Code</td>
</tr>
<tr>
<td>433</td>
<td>Necessity for Ambulance Service not Demonstrated. Payment is our allowable for non-medical transportation</td>
</tr>
<tr>
<td>434</td>
<td>Medical Necessity for Advanced Life Support not Demonstrated. Claim is Being Processed as Basic Life Support</td>
</tr>
<tr>
<td>435</td>
<td>Denied. Our records indicate Swingbed for these Dates of Service and Nursing Home/HCBS Bed cannot be Reimbursed, Patient must be discharged</td>
</tr>
<tr>
<td>436</td>
<td>Denied. Incorrect Provider Number for Contracted Service Billed</td>
</tr>
<tr>
<td>437</td>
<td>Service not payable because of disqualifying transfer. Rebill for payable days</td>
</tr>
<tr>
<td>438</td>
<td>Denied. Combined number of units billed exceeds allowable for day services.</td>
</tr>
<tr>
<td>439</td>
<td>Claim denied by Medicare. Not payable by Medicaid. Check Medicare EOB</td>
</tr>
<tr>
<td>440</td>
<td>Denied. Recipient has selected an HMO. Bill the HMO.</td>
</tr>
<tr>
<td>441</td>
<td>Denied. Duplicate Billing. Services previously Processed and reduced in full or Partially by Recipient Liability</td>
</tr>
<tr>
<td>442</td>
<td>Denied. Duplicate Services already Billed, First Claim is Pending and will be Processed in the near future</td>
</tr>
<tr>
<td>443</td>
<td>Procedure Code Cannot be Processed on Tape. Rebill hard copy indicating drug name, strength and dosage.</td>
</tr>
<tr>
<td>444</td>
<td>Recipient Number Incorrect. Claim Changed to Correct Number. Please Correct your file for future Submission</td>
</tr>
<tr>
<td>445</td>
<td>Denied. Claim not a Dept of Instruction Service</td>
</tr>
<tr>
<td>446</td>
<td>Denied. Provider not a provider of Dept of Instruction</td>
</tr>
<tr>
<td>447</td>
<td>Claim held in our office until the Recipient Liability has been met</td>
</tr>
<tr>
<td>448</td>
<td>Denied. Obsolete Drug NDC. Check for Current NDC and Rebill</td>
</tr>
<tr>
<td>449</td>
<td>Claim Denied. Client has Recipient Liability which must be met before claim can be processed</td>
</tr>
<tr>
<td>450</td>
<td>Denied. Consent not obtained and documented prior to Sterilization Procedure. Federal Regulations do not allow a Corrected Consent form or Appeal</td>
</tr>
</tbody>
</table>

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EOB CODES

(Explanation of Benefits to Provider)

EOB CODE  MESSAGE
460  Denied. Incorrect Provider # billed, recipient not authorized for AET funding.
461  Denied. Resident Classification review not on file
462  Denied. This claim should have been billed hardcopy on a 600B Pharmacy form.
463  Adjust on a 600RP form per IV/TPN Services Guidelines
464  Claim Denied. Maximum limit of $450/465 per month has been met
465  This claim has been reduced based on Maximum limit of $450/465 per month
466  Claim denied because Maximum allowed per month has been met
467  Claim reduced to Maximum allowed per month
468  Denied. Sped Eligible only, Bill Services on a Turnaround Document
469  Denied. This Claim will be paid from Alternate Program
470  Unable to Process VR Office will Resubmit
471  Denied. Pending appeal on another third party
472  Ineligible for Nursing Home/Swing Bed Payment
473  Denied. Number of days exceeds limits. Rebill.

A8*  Claim Denied; Ungroupable Drg
B15* Payment Adjusted Because This Procedure/Service Is Not Paid Separately.
B18* Payment Denied Because This Procedure Code/Modifier Was Invalid On The Date Of Service Or Claim Submission.
B5* Payment Adjusted Because Coverage/Program Guidelines Were Not Met Or Were Exceeded
B6* This Payment Is Adjusted When Performed/Billed By This Type Of Provider, By This Type Of Provider In This Type Of Facility, Or By A Provider Of This Specialty.
B7* This Provider Was Not Certified/Eligible To Be Paid For This Procedure/Service On This Date Of Service.
M33* Claim Lacks The Upin Of The Ordering/Referring Or Performing Physician Or Practitioner, Or The Upin Is Invalid. (Substitute Npi For Upin When Effective)
M50* N - Requires Manual Claim, R - Monthly Rental Payments Can Continue Until The Earlier Of The 15th Month From The First Rental Month, Or The Month When The Equipment Is No Longer Needed.
M52* Incomplete/Invalid "From" Date(S) Of Service.
M53* Did Not Complete Or Enter The Appropriate Number (One Or More) Of Days Or Units Of Service.
M54* Did Not Complete Or Enter The Correct Total Charges For Services Rendered.
M68* Incomplete/invalid attending or referring physician identification.
M79* Did Not Complete Or Enter The Appropriate Charge For Each Listed Service.
MA04* Secondary Payment Cannot Be Considered Without The Identity Of Or Payment Information From The Primary Payer. The Information Was Either Not Reported Or Was Illegible.
MA06* Incorrect/Incomplete/Missing Beginning And/Or Ending Date(S) On Claim.
MA30* Incomplete/Invalid Type Of Bill.
MA31* Incomplete/Invalid Beginning And Ending Dates Of The Period Billed.
MA32* Incomplete/Invalid Number Of Covered Days During The Billing Period.
MA40* Incomplete/Invalid Admission Date.
MA42* Incomplete/Invalid Source Of Admission.
MA61* Did Not Complete Or Enter Correctly The Patient's Social Security Number Or Health Insurance Claim Number.
N10* You May Appeal This Decision In Writing Within The Required Time Limits Following Receipt Of This Notice.

* MMIS System Generated EOB Explanation

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**EOB CODES**  (E-4)
(Explanation of Benefits to Provider)

<table>
<thead>
<tr>
<th>EOB</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N30*</td>
<td>Required/Consent Form Incomplete, Incorrect, Or Not On File.</td>
</tr>
<tr>
<td>N34*</td>
<td>Incorrect Claim Form For This Service.</td>
</tr>
<tr>
<td>N37*</td>
<td>Tooth Number/Letter Required.</td>
</tr>
<tr>
<td>N43*</td>
<td>Bed Hold Or Leave Days Exceeded.</td>
</tr>
<tr>
<td>N50*</td>
<td>Eob Received From Previous Payer. Claim Not On File.</td>
</tr>
<tr>
<td>N56*</td>
<td>Procedure Code Billed Is Not Correct For The Service Billed.</td>
</tr>
</tbody>
</table>

* MMIS System Generated EOB Explanation

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### FEDERAL CATEGORY CODE/STATE AID CATEGORY CORRELATION

(For 2082 Reporting) (F-1)

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<thead>
<tr>
<th>FEDERAL CATEGORY CODE</th>
<th>STATE AID CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 --</td>
<td>Old Age Assistance</td>
</tr>
<tr>
<td>02 --</td>
<td>Aid to Needy Blind</td>
</tr>
<tr>
<td>03 --</td>
<td>Disabled Assistance</td>
</tr>
<tr>
<td>04 --</td>
<td>Aid to Families with Dependant Children - under 21</td>
</tr>
<tr>
<td>05 --</td>
<td>Aid to Families with Dependent Children</td>
</tr>
<tr>
<td>06 --</td>
<td>Other Categorically Needy</td>
</tr>
<tr>
<td>07 --</td>
<td>Other Categorically Needy - 21 and Over</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STATE AID CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
</tr>
<tr>
<td>2 29</td>
</tr>
<tr>
<td>4, 30, 31</td>
</tr>
<tr>
<td>3, 7, 22, 23, 25, 27, 32, 33</td>
</tr>
<tr>
<td>10, 20, 21, 24, 26</td>
</tr>
<tr>
<td>6, 9, 11, 34, 35</td>
</tr>
<tr>
<td>(NONE)</td>
</tr>
</tbody>
</table>

### STATE AID CATEGORIES EXCLUDED FROM 2082 REPORTING

- 05 - A and B Remedial
- 06 - Refugee Assistance
- 08 - CCS
- 12 - SSI - Disable Children
- 14 - Disability Determination Services
- 15 - Vocational Rehabilitation
- 16 - Developmental Disabilities

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## FEDERAL MONEY CODE/STATE GRANT CODE CORRELATION

(For 2082 Reporting) (F-2)

<table>
<thead>
<tr>
<th>FEDERAL MONEY CODE</th>
<th>STATE GRANT CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Receiving Money Payments</td>
<td>1</td>
</tr>
<tr>
<td>2 - Medically Needy</td>
<td>2</td>
</tr>
<tr>
<td>3 - Not Receiving Money Payments</td>
<td>3, 4, 5</td>
</tr>
<tr>
<td>4 - Medically Needy Spenddown</td>
<td>Not Used</td>
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</table>

(return to top)
# FOREIGN COUNTY BIRTH PLACE CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>COUNTRY</th>
<th>CODE</th>
<th>COUNTRY</th>
</tr>
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<tbody>
<tr>
<td>AC</td>
<td>Africa</td>
<td>IT</td>
<td>Italy</td>
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<tr>
<td>AT</td>
<td>Argentina</td>
<td>JM</td>
<td>Jamacia</td>
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<tr>
<td>AS</td>
<td>Australia</td>
<td>JA</td>
<td>Japan</td>
</tr>
<tr>
<td>AU</td>
<td>Austria</td>
<td>KR</td>
<td>Korea</td>
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<td>BG</td>
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<td>LB</td>
<td>Liberia</td>
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<td>Bermuda</td>
<td>LI</td>
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<td>BV</td>
<td>Bolivia</td>
<td>MM</td>
<td>Mexico</td>
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<tr>
<td>BZ</td>
<td>Brazil</td>
<td>NE</td>
<td>Netherlands</td>
</tr>
<tr>
<td>BU</td>
<td>Bulgaria</td>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>CN</td>
<td>Canada</td>
<td>NU</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>CQ</td>
<td>Chile</td>
<td>NW</td>
<td>Norway</td>
</tr>
<tr>
<td>CB</td>
<td>Columbia</td>
<td>PV</td>
<td>Panama</td>
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<tr>
<td>CR</td>
<td>Costa Rica</td>
<td>PU</td>
<td>Paraguay</td>
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<td>CC</td>
<td>Cuba</td>
<td>PI</td>
<td>Peru</td>
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<td>CK</td>
<td>Chechoslovakia</td>
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<td>Phillipine</td>
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<td>DK</td>
<td>Denmark</td>
<td>PO</td>
<td>Poland</td>
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<td>Dominican Republic</td>
<td>PT</td>
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<td></td>
<td>RH</td>
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<td>RU</td>
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<tr>
<td>EU</td>
<td>Ecuador</td>
<td>SR</td>
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<td>EY</td>
<td>Egypt</td>
<td>SP</td>
<td>Spain</td>
</tr>
<tr>
<td>EN</td>
<td>England</td>
<td>SE</td>
<td>Sweden</td>
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<td>EO</td>
<td>Ethiopia</td>
<td>SZ</td>
<td>Switzerland</td>
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<td>FD</td>
<td>Finland</td>
<td>SY</td>
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<td>FN</td>
<td>France</td>
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<td>Thailand</td>
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<td>GE</td>
<td>German</td>
<td>TY</td>
<td>Turkey</td>
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<td>GC</td>
<td>Greece</td>
<td>UY</td>
<td>Uruguay</td>
</tr>
<tr>
<td>GT</td>
<td>Guatemala</td>
<td>SR</td>
<td>USSR or Soviet</td>
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<tr>
<td>HK</td>
<td>Hong Kong</td>
<td></td>
<td>Union</td>
</tr>
<tr>
<td>HU</td>
<td>Hungary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>India</td>
<td>VZ</td>
<td>Venezuela</td>
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<tr>
<td>IR</td>
<td>Iran</td>
<td>VM</td>
<td>Vietnam</td>
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<td>IQ</td>
<td>Iraq</td>
<td>WG</td>
<td>West Germany</td>
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<tr>
<td>IE</td>
<td>Ireland</td>
<td>WN</td>
<td>West Indies</td>
</tr>
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<td>IS</td>
<td>Israel</td>
<td>YG</td>
<td>Yugoslavia</td>
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<tr>
<td></td>
<td></td>
<td>YY</td>
<td>All other Countries</td>
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</table>

*(return to top)*
## FINANCIAL INPUT ERROR CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>MESSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>E01</td>
<td>Not Valid Action Code</td>
</tr>
<tr>
<td>E02</td>
<td>Not Valid Transaction Code</td>
</tr>
<tr>
<td>E03</td>
<td>Amounts Do No Crossfoot</td>
</tr>
<tr>
<td>E04</td>
<td>Action Code Setup - Transaction Not</td>
</tr>
<tr>
<td>E05</td>
<td>Action Code Disposition - Transaction Code Not</td>
</tr>
<tr>
<td>E06</td>
<td>Disposition Against A/R Requires A/R Number</td>
</tr>
<tr>
<td>E07</td>
<td>Invalid Case Number</td>
</tr>
<tr>
<td>E08</td>
<td>Setup with Number Already on File</td>
</tr>
<tr>
<td>E09</td>
<td>CTL Number Matches File, BUT Not Disposition, Change, Delete</td>
</tr>
<tr>
<td>E10</td>
<td>CTL Number Not on File for this Provider</td>
</tr>
<tr>
<td>E11</td>
<td>Disposition Original Amount Not Equal Setup Original Amount</td>
</tr>
<tr>
<td>E12</td>
<td>Transaction Amount Greater than Remaining Amount</td>
</tr>
<tr>
<td>E13</td>
<td>No Outstanding A/R's for this Provider on File</td>
</tr>
<tr>
<td>E14</td>
<td>A/R Control Number does not Match any File Items</td>
</tr>
<tr>
<td>E15</td>
<td>A/R Transaction Amount Greater than Remaining Amount on A/R</td>
</tr>
<tr>
<td>E16</td>
<td>More than 10 Dispositions Against this A/R this Cycle</td>
</tr>
<tr>
<td>E17</td>
<td>Duplicate Transaction this Cycle</td>
</tr>
<tr>
<td>E18</td>
<td>Provider not on File</td>
</tr>
<tr>
<td>E19</td>
<td>Sequence Detail Blank</td>
</tr>
<tr>
<td>E20</td>
<td>A Numeric ICN Must be Entered (This may be 0)</td>
</tr>
<tr>
<td>E21</td>
<td>Valid Numeric Date Must be Submitted</td>
</tr>
<tr>
<td>E22</td>
<td>A Valid Aid Category Must be Submitted on the Financial Input Form</td>
</tr>
<tr>
<td>E23</td>
<td>Action Code, Type Claim Invalid</td>
</tr>
<tr>
<td>E24</td>
<td>Incorrect Match Code</td>
</tr>
<tr>
<td>E25</td>
<td>Incorrect Category of Service</td>
</tr>
<tr>
<td>E26</td>
<td>Sequence Detail Must be Greater 00</td>
</tr>
<tr>
<td>E27</td>
<td>Invalid 'A/R Number ICN' for a Drug Rebate Collection/Payout</td>
</tr>
<tr>
<td>E28</td>
<td>MATCH-CODE equals 41 and ICN-REGION not equal 94 or MATCH-CODE equals 42 and ICN-REGION not equal 21.</td>
</tr>
<tr>
<td>E29</td>
<td>TRANSACTION-CODE equals 70 and REMAINING AMOUNT not equal zero</td>
</tr>
<tr>
<td>E30</td>
<td>Invalid Social Security</td>
</tr>
</tbody>
</table>

*(return to top)*
** The following Financial (Input Error Codes (E31-E38)) are for VR an Supportive Employment Financials.

E31  Authorization Number not Numeric or Equal to Zeros
E32  Region 94 with Authorization Number Present but Procedure Code not Equal to 00052, 00053 or 00054
E33  Biennium (Last 2 Positions in Comments Field) not Numeric, or Equal to Zeroes, or an Even Year
E34  Authorization Record not Found on VR Authorization File
E35  Transaction Amount Greater than Total Actual Paid on VR Authorization File
E36  Transaction Amount Greater than the Current Paid Amount for the Biennium Entered in the Last 2 Positions of the Comments Field
E37  Transaction Amount is Greater than (Total Paid Amount - Total Credit Amount) from VR Authorization Payment Record which is Read when the A/R Number is Entered on the Financial Form
E38  Transaction Code must be a '20', '30', '22', '24', or '32'

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CASH DISPOSITION ERROR CODES
(Reported on the SB1230AA Recipient Data Sheets)

H1: Base Soc Sec # and ICN # don't match. (Thru "MMIS", Enter "E" on CRT, and Soc Sec # off of input transaction. This code indicated Soc Sec # & ICN do not match).

H2: Adjustment on original claim ICN #. (Enter "K" on CRT - Check for Auth # = if not on CRT look at backup on paid case report - microfiche). (Check history status (Claim Adj 20) Recip Data Sheet)
This code indicates ID # and ICN # match but original ICN # has been adjusted - look for new ICN #.

H3: Sequence detail is less than amount refunded or has been used already. (Enter "K" on CRT - May have to check printout for collected refunds. Cancel or go to paid case report or remittance advice). This code indicates the refund amount is greater than the amount on the sequence detail line.

H4: Wrong detail # to wrong amount.
(Check Backup on setup). This code indicates the sequence detail listed on the transaction is not out on the system - sequence detail line has to be changed.

H5: Financial transaction case number does not match the related history record case number.

CASH DISPOSITION ERROR CODES
For DRG Related Financials in SB1210

H1: Base Soc Sec # and ICN # don't match. (Thru "MMIS", enter "E" on CRT, and Soc Sec # off of input transaction. This code indicates Soc Sec # & ICN do not Match).

H2: Original ICN # has been fully refunded.

H3: Financial transaction amount greater than original reimbursement amount or the total amount refunded will be greater than the original amount. On a state check void the transaction amount does not equal the original amount of the check.

H4: Claim detail number greater than those in history file.

H5: Financial transaction case number does not match the related history record case number.

{return to top}
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Recoupment A/R</td>
</tr>
<tr>
<td>04</td>
<td>Repayment A/R</td>
</tr>
<tr>
<td>06</td>
<td>Payout</td>
</tr>
<tr>
<td>20</td>
<td>Personal Check</td>
</tr>
<tr>
<td>22</td>
<td>Refund Disposition with History</td>
</tr>
<tr>
<td>24</td>
<td>Refund Disposition without History</td>
</tr>
<tr>
<td>26</td>
<td>Payment on A/R - Personal Check</td>
</tr>
<tr>
<td>30</td>
<td>State Check</td>
</tr>
<tr>
<td>32</td>
<td>Disposition Void</td>
</tr>
<tr>
<td>36</td>
<td>Payment on A/R - State Check</td>
</tr>
<tr>
<td>40</td>
<td>Buy-In</td>
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<tr>
<td>41</td>
<td>Buy-In Neg</td>
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<td>50</td>
<td>Collection Item</td>
</tr>
<tr>
<td>70</td>
<td>County Payment</td>
</tr>
<tr>
<td>72</td>
<td>State Payment</td>
</tr>
<tr>
<td>74</td>
<td>Federal Payment</td>
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<tr>
<td>JOB NUMBER</td>
<td>TRANSACTION NAME</td>
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<tr>
<td>------------</td>
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<td>HDR</td>
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<tr>
<td>2101</td>
<td>Drug Claims</td>
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<td>2102</td>
<td>Inpatient Claims</td>
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<tr>
<td>2103</td>
<td>Outpatient Claims</td>
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<tr>
<td>2104</td>
<td>Professional Claims</td>
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<td>2105</td>
<td>Dental Claims</td>
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<td>2106</td>
<td>Nursing Home Claims</td>
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<td>2107</td>
<td>EPSDT Screenings</td>
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<tr>
<td>2108</td>
<td>Prof. X-Over Claims</td>
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<td>2109</td>
<td>Inst. X-OverClaims</td>
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<tr>
<td>2110</td>
<td>State Hospital Billing</td>
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<tr>
<td>2111</td>
<td>UB82 Inpatient Claims</td>
</tr>
<tr>
<td>2112</td>
<td>UB82 Outpatient Claims</td>
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<tr>
<td>2113</td>
<td>UB82 Home Health Claims</td>
</tr>
<tr>
<td>2120</td>
<td>Provider Base TXN</td>
</tr>
<tr>
<td>2121</td>
<td>Provider Enrollment Status</td>
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<tr>
<td>2122</td>
<td>Provider Review Data</td>
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<tr>
<td>2123A</td>
<td>Auth. Svc./Prof. Component</td>
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<tr>
<td>2124A</td>
<td>Accom. Rate/Reimbursement Rate</td>
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<tr>
<td>2124</td>
<td>Accom. Rate Tsn</td>
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<td>2130</td>
<td>Prov. Claim Status Request</td>
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<td>Total Provider Status Request</td>
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<td>Individual Provider Status Request</td>
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<td>Provider Status Request by County</td>
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<tr>
<td></td>
<td>Provider Status Request by Specialty</td>
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<td>2140</td>
<td>Drug Maintenance</td>
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<td>2141</td>
<td>Diagnosis Maintenance</td>
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<tr>
<td>2142</td>
<td>Level I Maintenance</td>
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<tr>
<td>2143</td>
<td>Level II Maintenance</td>
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<td>Level III Maintenance</td>
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<td>Revenue Code Maintenance</td>
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<tr>
<td>2151</td>
<td>Claim Activation</td>
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<tr>
<td>2160</td>
<td>Mass Adjustment Request</td>
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<tr>
<td>2161</td>
<td>Financial Input Form</td>
</tr>
<tr>
<td>2162</td>
<td>EOB Message Maintenance Form</td>
</tr>
<tr>
<td>2180</td>
<td>Data Sheet Request - Drug</td>
</tr>
<tr>
<td>2181</td>
<td>Adjustment Request - Individual</td>
</tr>
<tr>
<td>2182</td>
<td>Third Party Rec. Update</td>
</tr>
<tr>
<td>2183</td>
<td>Data Sheet Request - No Drug</td>
</tr>
<tr>
<td>2184</td>
<td>Medical Criteria Update</td>
</tr>
<tr>
<td>2185</td>
<td>Institutional Criteria Update</td>
</tr>
<tr>
<td>2186</td>
<td>Procedure List Update</td>
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<tr>
<td>2187</td>
<td>Diagnosis List Update</td>
</tr>
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<td>2188</td>
<td>Limit Audit Update</td>
</tr>
<tr>
<td>2189</td>
<td>Relationship Audit Update</td>
</tr>
<tr>
<td>2190</td>
<td>Ancillary Audit Update</td>
</tr>
<tr>
<td>3600</td>
<td>Mars Provider Report Requests</td>
</tr>
<tr>
<td>3601</td>
<td>Mars Cat. Svc. Report Requests</td>
</tr>
<tr>
<td>3602</td>
<td>Mars 2082 YTD Report Requests</td>
</tr>
<tr>
<td>3603</td>
<td>Mars Cost Settlement Off</td>
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</tbody>
</table>

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INFOREX JOBS

3604 Mars Budget Input
3605 Mars Buy-In Premium Input
3606 Mars CCS Fiscal Year End Report Requests
3607 In EPSDT Records
3608 In EPSDT Follow-up Records
3610 Recipient Inquiry TXN
3611 Buy-In/Bendex Input Phase TXN
3612 Buy-in/Bendex Output Phase TXN
3701 Class Group Control, A-1
3702 Class Group Control, A-2
3703 Class Group Control, A-3
3704 Class Group Control, A-4
3705 Class Group Control, B
3706 Prov. Rept. Definition, C
3707 Prov. Rept. Definition, D
3708 Prov. Exception Control, E
3709 Prov. Freq. Dist. Control, F
3710 Prov. Forced Exception, G
3711 Prov. Forced Exception, H
3712 Prov. Forced Exception, I
3713 Prov. Special Study Control, J-1
3714 Prov. Special Study Control, J-2
3715 Recip. Class Group Control, L-1
3716 Recip. Class Group Control, L-2
3717 Recip. Rept. Definition, M
3718 Recip. Rept. Definition, N
3719 Recip. Exception Control, P
3720 Recip. Freq. Dest. Control, Q
3721 Recip. Forced Exception Control, R
3722 Recip. Forced Exception Control, S
3723 Recip. Forced Exception Control, T
3724 Recip. Special Study Control, U-1
3725 Recip. Special Study Control, U-2
3726 Phys. Treatment Analysis Control, V-1
3727 Phys. Treatment Analysis Control, V-2
3728 Phys. Treatment Analysis Control, V-3
3729 Phys. Treatment Analysis Control, V-4
3730 Phys. Treatment Analysis Control, V-5
3731 Phys. Treatment Analysis Control, V-6
3732 Phys. Treatment Analysis Except. Control, X
3733 Inst. Treatment Analysis Except. Control, W
3734 Diagnosis Grouping Control, Y
3735 Treatment Analysis Report Selection, Z 1-4
3736 Treatment Analysis Report Selection, Z 5
3737 Treatment Analysis Report Selection, Z 6
3738 Treatment Analysis Report Selection, Z 7
3739 Prov. Claim Detail Selection, 0
AUDT Data Correction - Audit
AUTH Prior Auth. File Maintenance
DATA Data Correction-Edit
E201 Elig. File Master Change Form (Base Record)
E252 Insert Eligibility Period
E254 Changed Elig. Period Information
---- PA Elig. Forms (600-3, 600-4, 600-RA)
---- FC Elig. Forms (423-1)
---- CCS Elig. Forms (265-2 SS)
---- Change SSN Form (MMIS)

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ICN - CHECK DIGIT COMPUTATION

(1) Divide entire 13 digit number by "9"
(2) The remainder is equal to the check digit

Example: ICN = 1078250300070 / 9 = 119805588896
With the remainder of 6.
Check digit is therefore, 6.

(return to top)
<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Off Reservation</td>
<td></td>
</tr>
<tr>
<td>Own Home</td>
<td>1</td>
</tr>
<tr>
<td>State Hospital</td>
<td>4</td>
</tr>
<tr>
<td>SNF - Nursing Home</td>
<td>5</td>
</tr>
<tr>
<td>Other Institution</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>On Reservation</td>
<td></td>
</tr>
<tr>
<td>Own Home</td>
<td>A</td>
</tr>
<tr>
<td>State Hospital</td>
<td>D</td>
</tr>
<tr>
<td>SNF - Nursing</td>
<td>E</td>
</tr>
<tr>
<td>Other Institution</td>
<td>H</td>
</tr>
<tr>
<td>Other</td>
<td>J</td>
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</tbody>
</table>
## LEGAL STATUS CODES

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No Court Jurisdiction</td>
</tr>
<tr>
<td>2</td>
<td>Parents have Custody, TPR Initiate</td>
</tr>
<tr>
<td>3</td>
<td>Parental Rights Terminated</td>
</tr>
<tr>
<td>4</td>
<td>Juvenile Court Jurisdiction other than TPR or SYA</td>
</tr>
<tr>
<td>5</td>
<td>Indian Court Jurisdiction</td>
</tr>
<tr>
<td>6</td>
<td>Guardianship</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
</tr>
<tr>
<td>8</td>
<td>State Youth Authority</td>
</tr>
</tbody>
</table>
SSA will provide a buy-in eligibility code in all cases where SSA initiates an accretion to the State's buy-in account or generates an accretion alert. If the recipient's SSI benefits terminate, SSA will delete the buy-in eligibility code. State should provide an eligibility code in Field 11, Position 50 when initiating a subsequent accretion. The states are requested to use only the eligibility codes, an explanation of each, and an indication of who may initiate; i.e., SSA State, or both.

A. Aged Recipient (SSA and State)
B. Blind Recipient (SSA and State)
C. Part A Title IV (State Only)
D. Disability Recipient (SSA and State)
E. Aged Recipient Supplementation (SSA and State)
F. Blind Recipient Supplementation (SSA and State)
G. Disabled Recipient Supplementation (SSA and State)
M. Medical Assistance Only (State)
S. Unknown: System Cannot Determine Basis For Eligibility (State)
Z. Individual Eligible in Accordance with Provisions of Section 249E of PL 92-603.

(return to top)
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Receiving Cash</td>
</tr>
<tr>
<td>2</td>
<td>Not Receiving Cash – Medically Needy</td>
</tr>
<tr>
<td>3</td>
<td>Not Receiving Cash – Other Reason</td>
</tr>
<tr>
<td>4</td>
<td>Not Receiving Cash – Institutionalized</td>
</tr>
<tr>
<td>5</td>
<td>Not Receiving Cash – SSA Pass-on</td>
</tr>
</tbody>
</table>

MATCH CODES AND APPLICABLE PERCENTAGES  
(M-3)  
Effective October 1, 2002 thru September 30, 2003

NOTE: NOT ALL THESE MATCH CODES ARE IN THE PROGRAMS THAT DEAL/WORK WITH MATCH CODES. THE MATCH CODE TABLES DO SHOW ALL OF THE MATCH CODES AND THE PERCENTS THAT GO WITH THE MATCH CODES.

<table>
<thead>
<tr>
<th>DATE</th>
<th>DESCRIPTION</th>
<th>MATCH CODE</th>
<th>FEDERAL</th>
<th>GENERAL</th>
<th>SPECIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>* * * * * * CURRENT CODES FOR CLAIM PAYMENT * * * * * * * * * *</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCS - 57% FED</td>
<td>&quot; 1 &quot;</td>
<td>100.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCBC DD, HCBC TBI</td>
<td>&quot; 2 &quot;</td>
<td>68.36%</td>
<td>30.13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TITLE XIX</td>
<td>&quot; 3 &quot;</td>
<td>68.36%</td>
<td>30.13%</td>
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<td></td>
</tr>
<tr>
<td>FOSTER CARE SERVICES</td>
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<td>26.18%</td>
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</tr>
<tr>
<td>STATE PROGRAMS</td>
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<td>100.00%</td>
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<td></td>
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<tr>
<td>DEPT. OF CORRECTIONS</td>
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<td>100.00%</td>
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<td></td>
</tr>
<tr>
<td>NON-TITLE XIX REF ASST</td>
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<tr>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>FAMILY PLANNING</td>
<td>&quot; 29&quot;</td>
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<td></td>
</tr>
<tr>
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<td></td>
</tr>
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<td>FAMILY PLANNING</td>
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<td>10.00%</td>
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<td></td>
</tr>
<tr>
<td>VOC REHAB - 78.70% FED</td>
<td>&quot;91 &quot;</td>
<td>100.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VOC REHAB - 100% FED</td>
<td>&quot;92 &quot;</td>
<td>100.00%</td>
<td>0.00%</td>
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<td></td>
</tr>
<tr>
<td>HSC</td>
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<td>30.13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEVELO. DISABILITY</td>
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<td>100.00%</td>
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<td></td>
</tr>
<tr>
<td>DIABILITY DETER. SERV.</td>
<td>&quot;05 &quot;</td>
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<td>0.00%</td>
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<td></td>
</tr>
<tr>
<td>MISCELLANEOUS ADJ.</td>
<td>&quot;10 &quot;</td>
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<td>100.00%</td>
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<td></td>
</tr>
<tr>
<td>DEPT OF PUBLIC INSTRUC.</td>
<td>&quot; 3 &quot;</td>
<td>68.36%</td>
<td>30.13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STARTING 03/01/94</td>
<td>SPED</td>
<td>&quot;41 &quot;</td>
<td>0.00%</td>
<td>95.00%</td>
<td>5.00%</td>
</tr>
<tr>
<td>EXPANDED SPED</td>
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<td>0.00%</td>
<td>100.00%</td>
<td>0.00%</td>
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</tr>
<tr>
<td>STARTING 01/01/95</td>
<td>BASIC CARE</td>
<td>&quot;42 &quot;B</td>
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<td>100.00%</td>
<td></td>
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<tr>
<td>BASIC CARE</td>
<td>&quot;42 &quot;F</td>
<td>0.00%</td>
<td>100.00%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(return to top)
MATCH CODES AND APPLICABLE PERCENTAGES

Effective October 1, 2001 thru September 30, 2002

NOTE: NOT ALL THESE MATCH CODES ARE IN THE PROGRAMS THAT DEAL/WORK WITH MATCH CODES. THE MATCH CODE TABLES DO SHOW ALL OF THE MATCH CODES AND THE PERCENTS THAT GO WITH THE MATCH CODES. ***FOR ADJUSTMENTS TO CLAIMS OLDER THAN 10/01/00.***

<table>
<thead>
<tr>
<th>DATE</th>
<th>DESCRIPTION</th>
<th>MATCH CODE</th>
<th>FEDERAL</th>
<th>GENERAL</th>
<th>SPECIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/01-09/30/02</td>
<td>&quot;2&quot; REPLACED BY:</td>
<td>&quot;022&quot;</td>
<td>69.87%</td>
<td>30.13%</td>
<td></td>
</tr>
<tr>
<td>10/01/01-09/30/02</td>
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<td>&quot;023&quot;</td>
<td>69.87%</td>
<td>30.13%</td>
<td></td>
</tr>
<tr>
<td>10/01/01-09/30/02</td>
<td>&quot;9&quot; REPLACED BY:</td>
<td>&quot;029&quot;</td>
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<td>30.13%</td>
<td></td>
</tr>
<tr>
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<td>&quot;028&quot;</td>
<td>69.87%</td>
<td>30.13%</td>
<td></td>
</tr>
<tr>
<td>10/01/01-09/30/02</td>
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<tr>
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<td>&quot;2&quot; REPLACED BY:</td>
<td>&quot;002&quot;</td>
<td>70.42%</td>
<td>29.58%</td>
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</tr>
<tr>
<td>10/01/99-09/30/00</td>
<td>&quot;3&quot; REPLACED BY:</td>
<td>&quot;003&quot;</td>
<td>70.42%</td>
<td>29.58%</td>
<td></td>
</tr>
<tr>
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<td>&quot;009&quot;</td>
<td>70.42%</td>
<td>29.58%</td>
<td></td>
</tr>
<tr>
<td>10/01/99-09/30/00</td>
<td>&quot;888&quot; REPLACED BY:</td>
<td>&quot;008&quot;</td>
<td>70.42%</td>
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<td></td>
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<tr>
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<tr>
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<td>30.01%</td>
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<tr>
<td>10/01/00-09/30/01</td>
<td>&quot;3&quot; REPLACED BY:</td>
<td>&quot;013&quot;</td>
<td>69.99%</td>
<td>30.01%</td>
<td></td>
</tr>
<tr>
<td>10/01/00-09/30/01</td>
<td>&quot;9&quot; REPLACED BY:</td>
<td>&quot;019&quot;</td>
<td>69.99%</td>
<td>30.01%</td>
<td></td>
</tr>
<tr>
<td>10/01/00-09/30/01</td>
<td>&quot;888&quot; REPLACED BY:</td>
<td>&quot;018&quot;</td>
<td>69.99%</td>
<td>30.01%</td>
<td></td>
</tr>
<tr>
<td>10/01/00-09/30/01</td>
<td>&quot;18&quot; REPLACED BY:</td>
<td>&quot;181&quot;</td>
<td>78.99%</td>
<td>21.01%</td>
<td></td>
</tr>
</tbody>
</table>

MATCH CODE

Match Code is a three position alphanumeric field on the claim record. It is redefined into three separate one position fields (Current, Prior and Medical), however normally the current MMIS system looks at the field as a whole. Basically, the match code is taken right from the 'simulated eligibility' file that contains eligibility periods for both Tecfs/Vision clients (ES150030), or from the old MMIS eligibility file.

The match code is changed from the original one brought over from the eligibility tables under certain conditions in program SB1090 (SB1J040) which is the batch job that does the eligibility/PCP/TPL processing. Those conditions are following:

If claim is not DDS, Voc Rehab, Crippled Children and legal cnty is not 58
  If provider number is 54516-54522, 53468, 53494-53497, 51882, 53482
    Match code = '888'
  If the procedure code is 05000 and professional claim and prov 54523
    Match code = '2'
  If the provider number is 53498 or 54523
    Match code = '888'

(return to top)
If Voc Rehab claim
   If VR fund code is 01 or 20, Match code = '91'
   If VR fund code is 02, Match code = '05'
   If VR fund code is 03 or 23, Match code = '92'
   If VR fund code is 04, Match code = '20'
   If VR fund code is 06, Match code = '04'
If I.H.S. Region, Match code = '8'
If not DDS or Voc Rehab claim
   If ICF/MR Provider, Match code = '9'
If HCBC Elderly Disabled
   If legal county is 55 or 56, Match code = '41'
   If procedure code is 00050-00053, 00055, 00057, 00059, 00060-00078,
      00092, 00096, 00098, T1016, T2025, Match code = '2'
   If procedure code is 00002, Match code = '41'
   If procedure code is 00015 or 00017
      If provider is HCBC and recipient not ‘E’ screened Match code = '3'
   If none of the above, Match code = '9'
If provider number is 51517 (I believe these are sub-adopt)
   If Tecs aid category is AFF4 or AFFA, Match code = '1'
   If record on Vision Client_Case_Table with F4 or FA, Match code = '1'
If Aid category = 006 and age under 21, Match code = '7'
If Basic Care Region, Match code = '42'
If Department of Instruction region, Match code = '3'
If Development Disability Region or Provider is DD provider,
   Match code = '04'
If provider number = 35008, Match code = '05'
If provider 50522-50553, Match code = '8'
If first two digits of case number 01-53 (regular county) and Developmental
   Disability region or DD provider
   If Targeted Case Management claim, Match code = '3'
If Developmental Disability claim and service code R, Match code = '444'
If aid category is 051, Match code = '18'
If aid category is 033 and < 18 years old, Match code '18'
If not DD provider with service code of D, F, O or U,
   If Asset_question on Vision table = 'y', Match code = '18'

(return to top)
"CURRENT" MATCH CODES ARE THOSE MATCH CODES USED FOR CLAIMS GOING THROUGH THE SYSTEM AS OF OCTOBER 1, 2000.

"CURRENT" MATCH CODES WHOSE PERCENTAGE RATES DO NOT CHANGE ARE: '1', '4', '5', '6', '8', '29', '39', '79', '91', '92', '04', '05', & '10'.

"CURRENT" MATCH CODES WHOSE PERCENTAGE RATES DO CHANGE EACH YEAR ARE: '2', '3', '7', '9', & '888'.

WHEN "CURRENT" MATCH CODE PERCENTAGE RATES CHANGE FOR THE NEW FEDERAL FISCAL YEAR, A DIFFERENT MATCH CODE IS SET UP TO REPRESENT PREVIOUS YEAR RATES FOR THAT CODE. THIS ENABLES AN ADJUSTMENT TO BE SENT THROUGH THE SYSTEM, WHICH WILL CONVERT TO THE MATCH CODE THAT REPRESENTS THE RATES (FOR A SPECIFIC TIME PERIOD) OF THE ORIGINAL CLAIM SENT THROUGH.

NOTE: DO NOT CHANGE THE SPED MATCH CODE '41' OR THE BASIC CARE MATCH CODE '42' OR THEIR VALUES WHEN CHANGING THE OTHERS, UNLESS SPECIFICALLY INSTRUCTED TO DO SO.

>>>POINT OF SALE<<<
POS WILL GET ITS MATCH CODES IN SB1210... PER CONVERSATION WITH TERI EVENSON. SB710022 PROGRAM DEALS WITH THE CURRENT MATCH CODES. (SEARCH FOR POSFI-FED-MATCH-CODE). CURRENTLY NO PROGRAM CHANGES NEED TO BE MADE TO POS PROGRAMS. (JUST DEALING WITH MATCH CODES) (9/20/96)

-- Update chart entitled 'MATCH CODES AND APPLICABLE PERCENTAGES' and replace it in tables manual (M-3). Send copy to Coordinator and to Charlie (Saved in SB01 library as SB.SBMATCH)

-- Update the SB1890GG Report layout on Doc.Lib with any changes to the column headings.

SB1090 - No changes are made in this program. This is however where the match codes are assigned.

SB1130 - Changes are made here only if family planning ('29', '39', '79') percentages change.

SB1210 - Put in checks to accommodate new match codes that represent rates from a previous year. Example:
If HSTW-CLM-PAY-DT-P > 910930 and < 921001 - Previous Year
If HSTW-FED-MATCH-CODE = '2' - Old Match Code
Move '922' to FINW-FED-MATCH-CODE - New Match Code
(Update 'EEAC-UPDATE-HIST-WITH-CD')

SB1330 - Put in checks to Accomodate new match codes that represent rates from a previous year. Example:
(Update 'METHOD-FOR-PAYING-ADJ-17 SECTION')
***Follow paragraphs down the line***
If ADJI-CLM-PAY-DT-P > 910930 AND < 921001 - Previous Year
If ADJI-FED-MATCH-CODE = '2' - Old Match Code
Move '922' to WORK-FED-MATCH-CODE - New Match Code

{return to top}
NOTES FOR YEARLY FEDERAL MATCH CODE PROGRAM CHANGES (M-3)

ALSO - Temporary changes are made here to change the existing match code on the claim credit file (SB133050) to the new match codes so the rates will be used in the computations. Remove asterisks on the IF stmt to 'PERFORM CHANGE-MATCH-CODE' in 'READ-ADJ-SUSP-11' and transfer to production. After a clean run - put asterisks in again, recompile and transfer to production.

SB1500 - Change values for field 'SI-ME-VALID-MATCH-CODES' in sort record, delete obsolete codes (Ask Charlie in Finance if any are), add any new codes, update 'CAA-IN-LOOP' with changes to match code '9' values.

ALSO - Temporary changes are made here to change the existing match code on the PROV ACCT MSTR (SB150050) to the new match codes. Remove asterisks on the statements that update 'ACTI-MATCH-CODE' in 'CCAAA-READ-LOOP' and xfer to production. After a clean run - Put asterisks in again, recompile, and transfer to production.

SB1550 - Changes are made to 'FINO-MATCH-CODE' in 'CAI-NONCLM SECTION'.

SB1580 - Add, delete or change any match code and federal percentage rates in table 'MATCH-PERCENTS'. When length of table changes be sure to change the occurs for 'OVERLAY-ITEMS' 'MS-ALL' 'ST-MS-ALL' and update 'MS-INDX1' accordingly in the following paragraphs: 'CEAA-LOOP' 'CEC-LOOP' 'CECA-GET-MATCH SEC' CECA-LOOP 'CEGE-APPLY-SHR SEC'

Charlie usually has changes to make to the journal voucher.. Search for Journal-List. Code will also have to be changed in the following paragraph:

CGC-Print-Journal Section
*
* If WS-Grant-4 = "S055" or "S142"
    ---> Move '97' to WS-Grant5-6 JVP-Grant-FY
Else
   If JV-Cost-Cntr(Jv) = '3651' or '4113' or '5205'
      or '5210' or '5203' or '3080' or '4112'
      move '95' to WS-Grant5-6 JVP-Grant-FY
   Else
      If JV = 39 or 51 or 52 or 53 or 38
      move spaces to WS-Grant5-6 JVP-Grant-FY
   Else
      Move WS-CCS-Year to WS-Grant5-6 JVP-Grant-FY.

SB1608 - Change the Federal Match Codes listed in the EAGA-Write-Refund paragraph. After this program gets on its regular schedule (April 96) it will only need the match code for the current & previous year.

SB185L - (Called Program) This program and SB1890 are directly related to each other. Add, delete, or change the match codes and percentages rates in table 'WK-MATCH-VALUES' - also change the xref index(es) to coincide with the SB1890GG rpt column headings for rate totals. WK-MAX-MATCH will also need to be changed to match the value of occurs in the redefines of WK-MATCH-FIELD.

05 WK-MATCH-FIELD
   Redefines WK-MATCH-DEFINED
   ---> Occurs 61 times
      Indexed by WK-MATCH-IDX.

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NOTES FOR YEARLY FEDERAL MATCH CODE PROGRAM CHANGES (M-3)

<<< The WK-MAX-MATCH must match the occurs above...Example 61 >>>
01 WK-MAX-VALUES Comp Sync.
  05 WK-MAX-CAT-SERV PIC S9(4) VALUE +21.
  --> 05 WK-MAX-MATCH PIC S9(4) VALUE +61.
  05 WK-MAX-MATCH-DISP PIC S9(4) VALUE +11.

(Do not compile this with initials, as it is a called program). Also, change
documentation for SB1-890-GG as to how the match codes and percentages
pertain to the report. The documentation for this report is in the SB
library called SB.SB1890GG.

Note when this program is compiled remember to re-compile SB1850 so the new
changes in SB185L will take place.

SB1890 - Change 'RPTL-DETAIL-HEADER-2' AND '-3' to accomodate any new rates. These
column headings should coincide with the xref indexes in SB185L. If any
obsolete rates are deleted, their xref index(es) should be changed to
correspond to the 'OTHER' column.

SB1895 - (NEW PROGRAM 10-01-86) - Only needs to be changed if match codes for family
planning are changed (' 29', ' 39' ' 79').

SB2295- Add, delete, or change any match codes and federal percentage rates in table
'Match-Percents'. When length of table changes be sure to change the occurs
for 'overlay items'. Also, change the at end statement in 'CCEA-COMPUTE-FED-
SHARE' to reflect the last occurance of the table. USEFED

SB2940 - Add, delete, or change match codes and fed percentage rates in table "MATCH-
PERCENTS". Modify 'OVERLAY ITEMS' accordingly. Need to change the code in
AAA-BUILD-SORT-RECS so it reflects the changed codes. For instance, match
code '969' replaced code ' 9 ' and '968' replaced '888', you have to add the
most current one that replaces ' 9 ' and '888'.

SS8520 - Add, delete, or change match codes and federal percentage rates in 'MATCH-
PERCENT-TABLE'. Modify the occurs accordingly. Check codes in EC-CC-MATCH-
CODE-BREAK, ACACG-UNDUP-SORTS, ACACE-RETRO-ACTIVITY-SORT, ACACC-RETRO-PAID-
AMT-SORT, ACACA-REGULAR-ACTIVITY-SORT, AND ACAA-FINANCIAL-REC-SORTS to see if
the need to be altered.

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JOBS TO RUN FOR TESTING
(* = Show test results to User)

To test non financial claims, run a dyle program to select about 500 records of each claim type. Select the program SB1090-->File SB107020. Once you do this, put the file you created in SB1J040 and run the rest of the jobs down the line. End with SB1J710.

Run these jobs below to get results with non financials claims....

SB1J040
SB1J050
SB1J075
SB1J076
SB1JSORT--> CC2.SB1JSORT
SB1J085
SB1J510
SB1J520
SB1J700
SB1J710

Use the non-financial test to check reports SB1-890-GG (Federal Matching Funds Distribution, Journal Voucher/County Voucher (SB1-580-AA), and the Check Register (SB1-570-AA). Be aware that values will appear in SB1-890-GG under the column headings for the new fiscal year.

Below is a list that shows where each program is located that have match code changes:

SB1J001 - Input test data from Human Services
SB1J020 - Input SB102020 from SB1J001
SB1J500 - (SB1500) - Input SB102010 from SB1J001
SB1J040 -
SB1J050 - (SB1130)
SB1J075 -
SB1J076
SB1J065 - (SB1210) - Run when history records are needed
SB1J085 - (SB1330) - Check suspense for error codes
SB1J086 - Creates work sheet (use 'SB1390X' as setup for SB1390 step)
*SB1J510 - (SB1550 - SB1580)
*SB1J520 -
SB1J700 - Create Month End Claim (SB179010) and financial (SB221010) Files
*SB1J710 - (SB185L-SB1890-SB1895) - Input SB179010
*SB2J295 - (SB2295) - Input SB179010 if Region 94 and HSC providers
*SB2J016 - (SB2940) - Input SB221010 (Refunds and Cancellations Rpt)

(return to top)
JOBS TO RUN FOR TESTING
(* = Show test results to User)

SS8J002 - Creates file for SS8J004 if there are claims w/dd prov on SB179010

*SS8J004 - (SS8520) - DD Expenditure report by matching code

*SB1J608 - (SB1608)

*** TO TEST MATCH CODES IF GIVEN FINANCIALS FOLLOW THIS TEST PATTERN***

<<<KIND OF FINANCIALS YOU WILL NEED TO GET TO TEST MATCH CODE CHANGES.
YOU WILL NEED SOME FINANCIALS WITH A REFUND AND SOME WITH A REFUND WITH HISTORY. JCL FOR THESE JOBS CAN BE FOUND IN RY80.DEV.FYMC - SUFFIX 'T' FOR SETTING UP FOR THE REFUND (1ST PASS THROUGH) AND SUFFIX 'S' FOR THE ACTUAL REFUND (2ND PASS THROUGH). CREATES REPORTS SB1-890-GG, JOURNAL VOUCHER, COUNTY VOUCHER, AND CHECK REGISTER.>>>

RUN THE FOLLOWING JOBS TO PROCESS THE SETUP ('20') FOR REFUNDS: SB1J608
RUN THE FOLLOWING JOBS TO PROCESS THE SETUP 'C'
  SB1J001
  SB1J500
  SB1J065
  SB1J085
  SB1J510
  SB1J520

On the setup you will get blank files from SB1J500, This is normal and the file will be SB1J510

RUN THE FOLLOWING JOBS TO PROCESS THE ACTUAL FINANCIAL 'V'
RUN THE FOLLOWING JOBS TO PROCESS A REFUND W/HISTORY ('22'), A REFUND W/O HISTORY ('24'), A RECOUIMENT ('00'), OR A PAYOUT ('06'): SB1J608
  SB1J001
  SB1J500
  SB1J065

--- > SB1J065 (SB1210 - FOR HISTORY - BEGIN IN SORT (S3))
(TO GET ADJUSTMENT CREDITS - SB121040)
WHEN SB1J065 IS RUN SB1210S4 (STEP) A DF.SB121040 FILE IS CREATED. THE DF.SB121040 FILE WILL THEN BE USED IN SB1J066(SBGENRS6). A TP.SB121045 TAPE IS CREATED. THE TP.SB121045 TAPE IS THEN USED IN SB1J085 IN STEP SBSORT58. YOU CAN PUT THE SB121040 FILE THAT YOU CREATED IN SB1J065 RIGHT INTO SB1J085.

  SB1J085(TO GET ADJUSTMENT CREDITS - SB121040)
  SB1J510
  SB1J520
  SB1J700
  SB1J710

SB1J065 UPDATES VSAM - SB189720 (STEP 4)
SB1J085 UPDATES (SB1330)
SB1J520 UPDATES ADABAS (CLIENT BASIC)
SB1J710 UPDATES VSAM

Mistakes in entering match code changes:

Request #531102 found the ERROR with the match codes.
JOBS TO RUN FOR TESTING

(* = Show test results to User)
If the match codes are entered by mistake due to the match code changes, run SB1J510 to get the SB1-555-AA report. Charlie (Finance) should have this report just in case the match code mistake(s) are not found until 2 months down the line. This way whoever is working on the error will know what the match codes looked like before the October 1 match code changes (need to look at September around the 26th). Once you have the before report you will need to get the after report. The first run with the match code(s) changes (around October 2). This will help whoever is working on the match code error(s) in finding which match code(s) are correct and which ones are wrong.

Files that need to be converted due to match code mistakes made when the October 1st match code changes went in is:

- SS850020
- SB179010 NEED TO CONVERT THESE
- SB150050
- SB185070
- SB159020'S
- SB121010 DIDN'T NEED TO CONVERT THESE

**If there is an error all these files need to be check just in case.

Cindy Chowen has all the DYL programs she used to convert the match code error(s). They are

- CC2.SB150050
- CC2.SB185070
- CC2.SB179010
- CC2.SS850020

(return to top)
<table>
<thead>
<tr>
<th>TITLE</th>
<th>DEPARTMENT</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Medical (Professional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Nursing Home</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Crossover</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Screen</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Adjustments</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Provider Enrollment/Reenrollment/Changes</td>
<td>H</td>
<td></td>
</tr>
<tr>
<td>Other Provider Correspondence</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Recipient Eligibility Transactions</td>
<td>J</td>
<td></td>
</tr>
<tr>
<td>Recipient Eligibility Correspondence</td>
<td>K</td>
<td></td>
</tr>
<tr>
<td>Recipient Explanation of Monthly Benefit</td>
<td>L</td>
<td></td>
</tr>
<tr>
<td>Returns (REOMB's)</td>
<td></td>
<td></td>
</tr>
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</table>

*(return to top)*
## NATURE OF ADMISSION

<table>
<thead>
<tr>
<th>UB16 CODE</th>
<th>UB82 CODE</th>
<th>NATURE (TYPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Emergency</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
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<tr>
<td>3</td>
<td>2</td>
<td>Urgent</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Newborn</td>
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</table>

*(return to top)*
<table>
<thead>
<tr>
<th>Document Codes</th>
<th>MMIS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>3</td>
<td>Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>Intermediate Care Facility (ICF)</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>ICF in SNF</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Day Care (Adult)</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>Home Leave - SNF</td>
</tr>
<tr>
<td>G</td>
<td>G</td>
<td>Home Leave - ICF</td>
</tr>
<tr>
<td>H</td>
<td>H</td>
<td>Home Leave - ICF in SNF</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Hospital Leave - SNF</td>
</tr>
<tr>
<td>J</td>
<td>J</td>
<td>Hospital Leave - ICF</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
<td>Hospital Leave - ICF in SNF</td>
</tr>
<tr>
<td>Q</td>
<td>Q</td>
<td>Medicare 20 Day Full Benefit Period</td>
</tr>
<tr>
<td>R</td>
<td>R</td>
<td>Medicare 80 Day Full Benefit Period</td>
</tr>
<tr>
<td>S</td>
<td>S</td>
<td>Medicare Noncovered Leave Day</td>
</tr>
<tr>
<td>T</td>
<td>T</td>
<td>ICF/MR in Facility</td>
</tr>
<tr>
<td>U</td>
<td>U</td>
<td>ICF/MR - Leave of Absence</td>
</tr>
<tr>
<td>V</td>
<td>V</td>
<td>ICF/MR Phys Hdcp - In House Days</td>
</tr>
<tr>
<td>W</td>
<td>W</td>
<td>ICF/MR Phys Hdcp Leave of Absence</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
<td>ICF/MR Child in House Days</td>
</tr>
<tr>
<td>Y</td>
<td>Y</td>
<td>ICF/MR Child Leave of Absence</td>
</tr>
</tbody>
</table>
## NURSING HOME ACCOMODATION CODES - POSITIONAL

(As Carried on the Provider File)

<table>
<thead>
<tr>
<th>CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Medicare Coinsurance (LTC)</td>
</tr>
<tr>
<td>8</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>9</td>
<td>Intermediate Care Facility</td>
</tr>
<tr>
<td>10</td>
<td>Skilled in Intermediate Care Facility</td>
</tr>
<tr>
<td>11</td>
<td>Day Care</td>
</tr>
</tbody>
</table>

( return to top )
### NURSING HOME SWING BED ACCOMODATION CODES (N-4)

<table>
<thead>
<tr>
<th>CLAIM</th>
<th>MMIS FORM</th>
<th>SYSTEM CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 7</td>
<td>Skilled Nursing Facility in a Swing Bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B 8</td>
<td>Intermediate Care Facility in a Swing Bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C 9</td>
<td>Medicare Coinsurance in a Swing Bed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(return to top)*
## NURSING HOME ELIGIBILITY SERVICE CODES
### LEVEL OF CARE DETERMINATION

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>NURSING CARE</td>
</tr>
<tr>
<td>* B</td>
<td>ICF CARE IN ICF FACILITY</td>
</tr>
<tr>
<td>* C</td>
<td>ICF CARE IN SKILLED FACILITY</td>
</tr>
<tr>
<td>D</td>
<td>ICF/MR CARE IN ICF/MR FACILITY</td>
</tr>
<tr>
<td>E</td>
<td>HCBS/AGED OR DISABLED</td>
</tr>
<tr>
<td>* F</td>
<td>HCBS CARE IN ICF FACILITY</td>
</tr>
<tr>
<td>G</td>
<td>HCBS/DD</td>
</tr>
<tr>
<td>H</td>
<td>SWING BED</td>
</tr>
<tr>
<td>* I</td>
<td>SWING BED IN ICF FACILITY</td>
</tr>
<tr>
<td>J</td>
<td>DAY CARE</td>
</tr>
<tr>
<td>K</td>
<td>SCREENED OTHER THAN LTC</td>
</tr>
<tr>
<td>L</td>
<td>NON MR-DD</td>
</tr>
<tr>
<td>M</td>
<td>HCBS/TBI (TRAUMATIC BRAIN INJURY)</td>
</tr>
<tr>
<td>P</td>
<td>UNDER AGE 21 IN INSTITUTION</td>
</tr>
<tr>
<td>Q</td>
<td>PERSONAL CARE/BASIC CARE</td>
</tr>
</tbody>
</table>

* CODES MARKED WITH AN ASTERISK ARE NO LONGER IN USE.
## PLACE OF SERVICE

<table>
<thead>
<tr>
<th>CODE</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>2</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>3</td>
<td>Home (Patients)</td>
</tr>
<tr>
<td>4</td>
<td>Office (Of Provider)</td>
</tr>
<tr>
<td>5</td>
<td>SNF (Skilled Nursing Facility)</td>
</tr>
<tr>
<td>6</td>
<td>ICF (Intermediate Care Facility)</td>
</tr>
<tr>
<td>7</td>
<td>Independent Lab</td>
</tr>
<tr>
<td>8</td>
<td>Other Location (Location not included in 1-7)</td>
</tr>
<tr>
<td>9</td>
<td>None of the above (SB1015 - SB1J031)</td>
</tr>
<tr>
<td>A</td>
<td>Emergency Room</td>
</tr>
</tbody>
</table>

**PLACE OF SERVICE**

Place of service is a one position alphanumeric field on the detail line of a claim.

For Dental Claims:
- Place of service = ‘4’

For Medical Claims:
- If the incoming 837P or paper claim has 21, 25, 51 or 61 in POS ‘1’ is moved to the claim
- If the incoming 837P or paper claim has 22, 24, 52, or 62 in POS ‘2’ is moved to the claim
- If the incoming 837P or paper claim has 12 in POS ‘3’ is moved to the claim
- If the incoming 837P or paper claim has 11, 49, 50, 53, 71 or 72 in POS ‘4’ is moved to the claim
- If the incoming 837P or paper claim has 31 or 32 in POS ‘5’ is moved to the claim
- If the incoming 837P or paper claim has 54 in POS ‘6’ is moved to the claim
- If the incoming 837P or paper claim has 51 in POS ‘7’ is moved to the claim
- If the incoming 837P or paper claim has 03, 26, 33, 34, 41, 42, 55, 56, 57, 65, or 99 in POS ‘8’ is moved to the claim
- If the incoming 837P or paper claim has 23 in POS ‘A’ is moved to the claim
- All other incoming POS ‘9’ is moved to the claim

*(return to top)*
For Nursing Home Claims
If LTC Region and NOT provider 1086, 2435, 50383 or Basic Care Provider
  If Service code = 1, 2, 3, 5, H, N, Q, R or S
    ‘5’ is moved to the claim
  If Service code = 6
    ‘8’ is moved to the claim
  All other service codes
    ‘6’ is moved to the claim

If NOT LTC region or Basic Care and NOT provider 1086, 2435 or 50383
If provider number is 1900-1999
  If Service code = A
    POS = ‘5’ and SVCD = ‘R’ on the claim
  If Service code = B
    POS = ‘6’ and SVCD = ‘8’ on the claim
  If Service code = C
    POS = ‘5’ and SVCD = ‘9’ on the claim
All other providers
  If Service code = A
    POS = ‘5’ and SVCD = ‘3’ on the claim
  If Service code = B
    POS = ‘6’ and SVCD = ‘4’ on the claim
  If Service code = C
    POS = ‘5’ and SVCD = ‘5’ on the claim
  If Service code = E
    POS = ‘8’ and SVCD = ‘6’
If Service code = 7
  SVCD = ‘A’
If Service code = 8
  SVCD = ‘B’
If Service code = 9
  SVCD = ‘C’
If Service code = 0
  SVCD = ‘E’

(return to top)
# PLACE OF SERVICE CONVERSION TABLE

<table>
<thead>
<tr>
<th>FEDERAL CODES</th>
<th>STATE CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-OFFICE</td>
<td>4-OFFICE</td>
</tr>
<tr>
<td>2-PATIENT'S NAME</td>
<td>3-PATIENT'S NAME</td>
</tr>
<tr>
<td>3-INPATIENT</td>
<td>1-INPATIENT HOSPITAL</td>
</tr>
<tr>
<td>4-NURSING HOME</td>
<td>5-SNF (SKILLED NURSING FACILITY)</td>
</tr>
<tr>
<td>4-NURSING HOME</td>
<td>6-ICF (INTERMEDIATE NURSING FACILITY)</td>
</tr>
<tr>
<td>5-OUTPATIENT HOSPITAL/</td>
<td>2-OUTPATIENT HOSPITAL</td>
</tr>
<tr>
<td>EMERGENCY ROOM/CLINIC</td>
<td>7-EMERGENCY ROOM</td>
</tr>
<tr>
<td>6-OTHER</td>
<td>8-OTHER LOCATION</td>
</tr>
<tr>
<td>6-OTHER</td>
<td>9-NONE OF THE ABOVE</td>
</tr>
</tbody>
</table>

*THIS TABLE EFFECTS VARIABLE 17 ON THE IP-CLAIM, LT-CLAIM, AND OT-CLAIM FILES.*

(return to top)
PRICING INDICATOR (PAC)

### STANDARD CODE

<table>
<thead>
<tr>
<th>CODE</th>
<th>INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Normal (Pay at lower of billed, Level 1, Level 2 and Level 3)</td>
</tr>
<tr>
<td>01</td>
<td>Pay at Level 1</td>
</tr>
<tr>
<td>02</td>
<td>Pay at Level 2</td>
</tr>
<tr>
<td>03</td>
<td>Pay at Level 3</td>
</tr>
<tr>
<td>04</td>
<td>(Not Used)</td>
</tr>
<tr>
<td>05</td>
<td>Pay as billed (High variance applies)</td>
</tr>
<tr>
<td>06</td>
<td>Manual pricing required</td>
</tr>
<tr>
<td>07</td>
<td>Manually priced (System Generated) (Forced)</td>
</tr>
<tr>
<td>08</td>
<td>Clerically Denied (System Generated)</td>
</tr>
<tr>
<td>09</td>
<td>Do not pay</td>
</tr>
</tbody>
</table>

### DRUG FILE

<table>
<thead>
<tr>
<th>CODE</th>
<th>INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>EAC</td>
</tr>
<tr>
<td>02</td>
<td>MAC</td>
</tr>
<tr>
<td>03</td>
<td>Non-Legend</td>
</tr>
<tr>
<td>04</td>
<td>Compound</td>
</tr>
<tr>
<td>05</td>
<td>Not used</td>
</tr>
<tr>
<td>06</td>
<td>Needs manual pricing</td>
</tr>
<tr>
<td>07</td>
<td>Manually priced (System Generated) (Forced)</td>
</tr>
<tr>
<td>08</td>
<td>Clerically denied (System Generated)</td>
</tr>
<tr>
<td>09</td>
<td>Do not pay</td>
</tr>
</tbody>
</table>

**NOTE:**
Drug claims with pricing action code 1 or 2 should reference the professional component fee field on the drug file before adding the professional fee to the claim. If value 3 is found in this field, the professional fee should not be added.

**NOTE:**
Non-legend drugs (pricing indicator '3') are priced in the following manner:

\[
1.5 \times \text{EAC} \times \frac{\text{Units on claim}}{\text{Units on file}}
\]
### PRICING MODIFIERS

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Set type of service 'H', Pay as allowed.</td>
</tr>
<tr>
<td>27</td>
<td>TOS J pay as allowed.</td>
</tr>
<tr>
<td>50, 51, 52</td>
<td>Pay 50% of allowed.</td>
</tr>
<tr>
<td>22, 54, 55, 56</td>
<td>Suspend for manual review</td>
</tr>
<tr>
<td>59, 76, 97, 99, AB, AD, AE, AH BP, BR, BU, CC, GE, LL, MS, NR, QM, QN, QQ, RP, RR, SG, UC, VP, ZZ</td>
<td></td>
</tr>
<tr>
<td>80, 81, 82</td>
<td>Set type of service to '8' - assistant surgery. Pay 20% of allowed.</td>
</tr>
<tr>
<td>86 AN or AU</td>
<td>Set type of service to '1'. Pay 75%.</td>
</tr>
<tr>
<td>87 or AS</td>
<td>Set type of service to '8'. Pay 15%.</td>
</tr>
<tr>
<td>90</td>
<td>Pay as allowed - valid for TOS 5 procedures.</td>
</tr>
<tr>
<td>XV</td>
<td>Pay a flat $8.00 on codes 90700, 90701, 90707, 90712, 90718, 90720, 90731, 90737, 90744</td>
</tr>
<tr>
<td>20, 21, 23, 24</td>
<td>Pay at Allowed Price</td>
</tr>
<tr>
<td>25, 32, 47, 57, 58, 62, 66, 77, 78, 79, AA, AC, AF, AG, AM, AP, AT, DD, EJ, EM, EP, ET, E1, E2, E3, E4, FA, FP, F1, F2, F3, F4, F5, F6, F7, F8, F9, GA, GB, GC, GE, G1, G2, G3, G4, G5, KA, KB, KC, KD, KE, KG, KH, KI, KJ, KK, KL, KM, KN, K0, KP, KQ, K1, K2, K3, K4, LC, LD, LR, LS, LT, MP, NU, PL, QA, QB, QC, QD, QE, QF, QG, QH, QJ, QK, QQ, QP, QR, QS, QT, QU, QW, Q1, Q2, Q3, Q4, Q5, Q6, Q7, Q8, Q9, RC, RT, SF, SP, TA, TC, TM, T1, T2, T3, T4, T5, T6, T7, T8, T9, UE, YY, ZK, ZY</td>
<td></td>
</tr>
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</table>

**NOTE:** These values are referenced in SB1070 (to check validity) and in SB1130 (for pricing)

(return to top)
# PROCEDURE CODE BILLED AS CONSECUTIVE DAYS

<table>
<thead>
<tr>
<th>Code 1</th>
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<td>77410</td>
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<td>02724</td>
</tr>
<tr>
<td>CODE</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>01</td>
<td>General Hospital</td>
</tr>
<tr>
<td>02</td>
<td>Mental Hospital</td>
</tr>
<tr>
<td>03</td>
<td>General Hospital and Nursing Facility (ECF)</td>
</tr>
<tr>
<td>04</td>
<td>TB Hospital</td>
</tr>
<tr>
<td>05</td>
<td>State Hospital</td>
</tr>
<tr>
<td>06</td>
<td>Alcohol and Substance Abuse Center</td>
</tr>
<tr>
<td>10</td>
<td>Nursing Home - General (SNF)</td>
</tr>
<tr>
<td>12</td>
<td>Intermediate Care Facility (ICF)</td>
</tr>
<tr>
<td>13</td>
<td>ICF - Mentally Retarded</td>
</tr>
<tr>
<td>14</td>
<td>ICF/SNF</td>
</tr>
<tr>
<td>15</td>
<td>Basic Care</td>
</tr>
<tr>
<td>16</td>
<td>Day Care</td>
</tr>
<tr>
<td>20</td>
<td>Physician</td>
</tr>
<tr>
<td>24</td>
<td>Osteopath</td>
</tr>
<tr>
<td>25</td>
<td>Developmental Disability Provider</td>
</tr>
<tr>
<td>26</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>27</td>
<td>Licensed Independent Clinical Social Worker (LICSW)</td>
</tr>
<tr>
<td>28</td>
<td>Psychologist</td>
</tr>
<tr>
<td>30</td>
<td>Podiatrist</td>
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<tr>
<td>31</td>
<td>Optometrist</td>
</tr>
<tr>
<td>32</td>
<td>Optician</td>
</tr>
<tr>
<td>33</td>
<td>Audiologist</td>
</tr>
<tr>
<td>34</td>
<td>Speech Therapist</td>
</tr>
<tr>
<td>35</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>37</td>
<td>Nurse Anesthetist</td>
</tr>
<tr>
<td>40</td>
<td>Dentist</td>
</tr>
<tr>
<td>41</td>
<td>Licensed Social Worker (LSW)</td>
</tr>
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PROVIDER TYPE OF PRACTICE

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2. Partnership
3. Corporation
4. Hospital Based Physician
5. Non Profit
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</table>

(return to top)
PROVIDER NUMBERING SCHEME

PROVIDER NUMBERS
01000-01899 - Hospital
  -(01002, 01003, 01012, 01018, 01023 and 01041)*
  -State Hospital 01086*
  -James River 02435*
  -IHS (01058, 01061, 01063, 01068, 01307, 01312, 01323-01332, 02331, 02333-02335, 02372, 02400)*

01900-02000 - Swing Beds*

05000-05999 - Rural Health Clinics*

10000-19999 - Clinics, MD, SC, DPM, DO

20000-29999 - Pharmacies

30000-34999 - Nursing Homes
  -30225*
  -30000-30699*
  -30700-30799 BASIC CARE*
  -30800-30899 ICP-MR*
  -32000-32313 QSP*
  -32314-32321 HSC*
  -32322-34999 QSP*

35000-37999 - Developmental Disabilities

38800-39999 - HCBC Elderly Disabled*
  -38859*
  -38897-39999 QSP*

40000-49999 - Dentists

50000-58999 - Misc. Trans., Lodging, Meals, Durable Medical Suppliers, Nurses and Opticians
  -50165*
  -50711-50762 CFS*

59000-59999 - Lab in Hospital

60000-69999 - Optometrists

70000-79999 - Dummy Number

80000-89999 - Vocational Rehabilitation

90000-99999 - DDS (we don't use)*

* Referenced in MMIS Software. Notify data processing if change is needed.

(return to top)
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<tr>
<th>SPECIALTY</th>
<th>TYPE</th>
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<td>02 General Surgery</td>
<td>20 Physician</td>
</tr>
<tr>
<td>03 Allergy</td>
<td>20 Physician</td>
</tr>
<tr>
<td>04 Otology, Larynology, Rhinology</td>
<td>20 Physician</td>
</tr>
<tr>
<td>05 Anesthesiology</td>
<td>20 Physician</td>
</tr>
<tr>
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<td>37 Nurse</td>
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<tr>
<td>06 Cardiovascular Disease</td>
<td>20 Physician</td>
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<tr>
<td>07 Dermatology</td>
<td>20 Physician</td>
</tr>
<tr>
<td>08 Family Practice</td>
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<tr>
<td></td>
<td>24 Osteopath</td>
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<tr>
<td>09 Gynecology (DO)</td>
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<tr>
<td>10 Gastroenterology</td>
<td>20 Physician</td>
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<tr>
<td>11 Aviation Medicine</td>
<td>20 Physician</td>
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<tr>
<td>12 O. M. T</td>
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<tr>
<td>13 Neurology</td>
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<tr>
<td>14 Neurological</td>
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<tr>
<td>15 Obstetrics (DO)</td>
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<tr>
<td>16 OB-Gynecology (MD Only)</td>
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<td>17 Eye, Ear, Nose, Throat (DO)</td>
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<tr>
<td>18 Ophthalmology</td>
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<tr>
<td>19 Dentistry</td>
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<td>54 Professional Clinic-Optometry</td>
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<tr>
<td>20 Orthopedic Surgery</td>
<td>20 Physician</td>
</tr>
<tr>
<td>21 Pathologica Anatomy, Clinic Pathology (DO)</td>
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<tr>
<td>22 Pathology</td>
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<tr>
<td>23 Periphereral Vascular Disease or General Surgery (DO)</td>
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<tr>
<td>24 Plastic Surgery</td>
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<tr>
<td>25 Physical Medicine or Rehab</td>
<td>20 Physician</td>
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<td>26 Psychiatry</td>
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<tr>
<td>27 Psychiatry, Neurological (DO)</td>
<td>24 Osteopath</td>
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<tr>
<td>28 Proctology</td>
<td>20 Physician</td>
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<td>29 Pulmonary Disease</td>
<td>20 Physician</td>
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<tr>
<td>30 Radiology</td>
<td>20 Physician</td>
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<tr>
<td></td>
<td>71 Independent X-Ray Svc</td>
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<tr>
<td></td>
<td>72 Independent X-Ray/Lab</td>
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<tr>
<td>31 Reonctgenology, Radiology (DO)</td>
<td>24 Osteopath</td>
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<tr>
<td>32 Radiation Therapy (DO)</td>
<td>24 Osteopath</td>
</tr>
<tr>
<td>33 Thoracic Surgery</td>
<td>20 Physician</td>
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<td>34 Urology</td>
<td>20 Physician</td>
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<tr>
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<td>20 Physician</td>
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<td>37</td>
<td>Pediatrics</td>
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<td>48</td>
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<td>Geriatrics</td>
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<td>Hand Surgery</td>
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<td>Internal Medicine</td>
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<td>43</td>
<td>Pediatric Allergy</td>
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<td>Podiatry-Surg.-Chiropody</td>
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<td>Misc. Transportation</td>
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<td>Other Med. Supply Co.</td>
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<td>59</td>
<td>Private Ambulance Service</td>
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<td>60</td>
<td>Public Health or Welfare Agencies and Clinics</td>
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<td>Voluntary Health or Charitable Agencies</td>
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<td>Psychology</td>
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<td>Portable X-Ray Supplier</td>
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<tr>
<td>64</td>
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<td>Respiratory Therapist</td>
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<td>69</td>
<td>Independant Laboratory (billing independently)</td>
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<td>Code</td>
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<td>LPN</td>
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<td>95</td>
<td>Speech Therapy</td>
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<td>96</td>
<td>Food &amp; Lodging</td>
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*(return to top)*
### RACE CODE CATEGORY

**DESCRIPTION**

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<td>American Indian/Native Alaskan</td>
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<tr>
<td>Black</td>
<td>3</td>
</tr>
<tr>
<td>Asian</td>
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<tr>
<td>Native Hawaiian</td>
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</table>

(return to top)
An individual whose work has been primarily with the railroads will have a Social Security Number, but his benefits will be established on a Railroad Annuity Number not his Social Security Claim Number. The railroad annuitant's wife, widow, child, etc., may also be entitled using a RR number rather than a Social Security Number.

All RR annuity numbers contain a prefix rather than a suffix designating the type of annuity. Same RR annuity number consist of a prefix and a six digit number issued by the RRB. Other RR annuity numbers consist of a prefix and the annuitant's Social Security Number (E.G., a-123456 or WCD-123-45-6789). RR annuity number prefixes consist of from one to three alphabetic characters.

The following are the prefixes used in connection with claims which involve railroad annuitants:

### TABLE I

<table>
<thead>
<tr>
<th>TYPE RR ANNUITANT</th>
<th>RR NUMBER PREFIX</th>
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<tbody>
<tr>
<td>Retirement---Employee</td>
<td>A</td>
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<tr>
<td>RR Pensioner (Age or Disability)</td>
<td>H</td>
</tr>
<tr>
<td>Spouse of RR Employee</td>
<td>MA</td>
</tr>
<tr>
<td>Spouse of Pensioner</td>
<td>MH</td>
</tr>
<tr>
<td>Child of RR Employee</td>
<td>WCH</td>
</tr>
<tr>
<td>Child of RR Survivor</td>
<td>WCA</td>
</tr>
<tr>
<td>Child of RR Annuitant</td>
<td>CA</td>
</tr>
<tr>
<td>Widow or Widower of RR Employee</td>
<td>WD</td>
</tr>
<tr>
<td>Widow or Widower of RR Annuitant</td>
<td>WA</td>
</tr>
<tr>
<td>Widow or Widower of RR Pensioner</td>
<td>WH</td>
</tr>
<tr>
<td>Widow of Employee w/child in her care</td>
<td>WCD</td>
</tr>
<tr>
<td>Widow of Annuitant w/child in her care</td>
<td>WCA</td>
</tr>
<tr>
<td>Widow of Pensioner w/child in her care</td>
<td>WCH</td>
</tr>
<tr>
<td>Parent of RR Employee</td>
<td>PD</td>
</tr>
<tr>
<td>Parent of RR Annuitant</td>
<td>PA</td>
</tr>
<tr>
<td>Parent of RR Pensioner</td>
<td>PH</td>
</tr>
<tr>
<td>Survivor Joint Annuitant</td>
<td>JA</td>
</tr>
</tbody>
</table>

Similarly, our Buy-in records and health insurance records for railroad annuitants are maintained using a number based on the individual's RR annuity number. Railroad annuity numbers are converted to a basic Social Security Number, by our third-party EDP System.

Accretion of a Railroad Annuitant may be made using either the individual's RR Annuity Number or the Pseudo Social Security Number. Since our Buy-in record uses the converted Psuedo Social Security Number rather than the RR Annuity Number, and deletions and adjustments must be submitted using the Pseudo Number, it is necessary for the state to know how the conversion is made.

*(return to top)*
Accretions submitted using the RR Annuity Number with a prefix and a six digit number will be converted to an 11 position Pseudo Social Security Number (Ex. WA123456 will be returned to the state as + 0012345616). The alphabetic RR prefix is converted to a two digit Pseudo numeric value suffix (See Table II) and is placed in the 10th and 11th positions. Since the RR Number only has six digits, the first three positions of the converted number are shown as + 00.

<table>
<thead>
<tr>
<th>RR PREFIX</th>
<th>NUMERIC VALUE</th>
<th>SUFFIX</th>
<th>EDP PSEUDO NUMERIC VALUE</th>
<th>SUFFIX</th>
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<tr>
<td>A</td>
<td>10</td>
<td>PD</td>
<td>45</td>
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<tr>
<td>JA</td>
<td>11</td>
<td>WD</td>
<td>46</td>
<td></td>
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<tr>
<td>WCA</td>
<td>13</td>
<td>H</td>
<td>80</td>
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<tr>
<td>MA</td>
<td>14</td>
<td>WCH</td>
<td>83</td>
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<td>PA</td>
<td>15</td>
<td>MH</td>
<td>84</td>
<td></td>
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<tr>
<td>WA</td>
<td>16</td>
<td>PH</td>
<td>85</td>
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<tr>
<td>CA</td>
<td>17</td>
<td>WH</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td>WCD</td>
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<td></td>
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<td>43</td>
</tr>
</tbody>
</table>

Accretions submitted using a RR Annuity Number with a prefix and a nine digit number will also be converted to an 11 positions pseudo Social Security Number (Ex. WH123456789 will be returned to the state as A2345678986). The alphabetic RR prefix is converted to a two digit pseudo numeric value suffix (Table II) and the first digit of the nine digit number is converted to an alphabetic character (See Table III).

<table>
<thead>
<tr>
<th>NUMERIC INITIAL</th>
<th>EDP PSEUDO ALPHA CHARACTER</th>
<th>INITIAL NUMERIC</th>
<th>EDP PSEUDO ALPHA CHARACTER</th>
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<tr>
<td>0</td>
<td>+</td>
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<td>D</td>
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<tr>
<td>1</td>
<td>A</td>
<td>5</td>
<td>E</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>6</td>
<td>F</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>7</td>
<td>G</td>
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</table>

(return to top)
## REASON FOR OPENING - PUBLIC ASSISTANCE

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<th>CODE</th>
<th>OASDI BENEFITS</th>
<th>REASON FOR OPENING</th>
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<td>01-69</td>
<td>01X-69X</td>
<td>Material change in income or resources:</td>
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<tr>
<td></td>
<td></td>
<td>loss of employment or decreased earnings of recipient due to:</td>
</tr>
<tr>
<td>01</td>
<td>01X</td>
<td>Illness, injury or other impairment</td>
</tr>
<tr>
<td>11</td>
<td>11X</td>
<td>Layoff, Discharge or other reason</td>
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<tr>
<td></td>
<td></td>
<td>Loss of or reduction in support from other person in home as a result of:</td>
</tr>
<tr>
<td>31</td>
<td>31X</td>
<td>Death</td>
</tr>
<tr>
<td>32</td>
<td>32X</td>
<td>Leaving home and stopping or reduction</td>
</tr>
<tr>
<td>33</td>
<td>33X</td>
<td>Illness, injury or other impairment</td>
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<tr>
<td>34</td>
<td>34X</td>
<td>Layoff, Discharge or other reason</td>
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<td>42</td>
<td>42X</td>
<td>Loss of or reduction in support from person outside home:</td>
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<tr>
<td>51</td>
<td>51X</td>
<td>Loss of or Reduction in other income</td>
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<tr>
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<td></td>
<td>Exhaustion or reduction of assets to meet:</td>
</tr>
<tr>
<td>61</td>
<td>61X</td>
<td>Medical Care Costs</td>
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<tr>
<td>62</td>
<td>62X</td>
<td>Other Costs</td>
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<tr>
<td>69</td>
<td>69X</td>
<td>Other material Change in resources (Specify)</td>
</tr>
<tr>
<td>71-99</td>
<td>710-99X</td>
<td>No material change in income or resources:</td>
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<td>71</td>
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<td>72X</td>
<td>Consideration of Resources</td>
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<td>73</td>
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<td>81</td>
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<td>82</td>
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<td>Programs in another state</td>
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<td>96X</td>
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<td>ADC Mother</td>
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<td>Leaving home and stopping or reducing support</td>
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<td>31</td>
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<td>Loss of or reduction in support from other person in home as a result of:</td>
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<td>Illness, injury, or other impairment</td>
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<td>Lay-off, discharge or other reason</td>
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<td>Loss of or reduction in support from person outside home:</td>
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<td>42</td>
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<td>ADC Father</td>
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<td>43</td>
<td>43X</td>
<td>Other person</td>
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<td>51</td>
<td>51X</td>
<td>Loss of or reduction in other income</td>
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<td>61</td>
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<td>Exhaustion or reduction of assets to meet:</td>
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<td>Medical Care Costs</td>
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<td>69</td>
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<td>Other costs</td>
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<td>Consideration of Resources</td>
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<td>Other type of public or private aid</td>
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(Specify)
## REASON FOR OPENING - PUBLIC ASSISTANCE

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<th>REASON FOR OPENING</th>
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<tr>
<td>96</td>
<td>96X</td>
<td>Living below agency standards</td>
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<td>97</td>
<td>97X</td>
<td>Previously included in another assistance grant</td>
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<td>98X</td>
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<td>Other (Specify)</td>
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*(return to top)*
REASON FOR CLOSING AND ACTION TAKEN - PUBLIC ASSISTANCE

(R-5)

CODE A. REASONS FOR CLOSING
01  Death
10-39 No longer meets state standards for financial eligibility
   A. Material change in income or resources:
      Employment or increased earnings of person in home:
      10  Recipient or Spouse
      11  AFDC Father
      12  AFDC Mother
      13  AFDC Child
      14  Other Person
      Receipt of or increase in support as a result of:
      15  Absent Parent's Return (AFDC)
      16  Remarriage of Parent (AFDC)
      Receipt of or increase in support from support outside home:
      17  Absent AFDC Father
      18  Other Person
      Receipt of or increase in cash benefits or pensions under:
      19  Federal
      20  Other Federal
      21  State or Local
      22  Nongovernmental Program
      29  Other material change in income or resources
      No material change in income or resources
      30  Decrease in requirements
      31  9 month AFDC post Medicaid eligibility expires
      39  Other
      40-49 No longer meets eligibility requirements other than financial need
      40  No longer blind, disabled or incapacitated
      41  Became resident of public institution
      42  AFDC parent returned home or remarried
      43  No longer an eligible child in home
      44  Loss or residence
      45  Change in law or agency policy
      49  Other (Specify)
      50-59 Refused after approval to comply with procedural requirements
      50  Recovery, lien and/or assignment provisions
      51  Relative responsibility provisions
      52  Refused to accept referral, employment, training, or project assignment under work incentive program for AFDC recipients
      53  Refused to register and seek work other than under WIN Program.
      54  Employment Security Referral
      55  Other source of employment offer
      56  Refused to accept or complete training or education other than under WIN Program
      59  Other
      88  Closed due to 4 month extend
      89  Delete
      90-99 All other reasons not specified under 01-59
      90  Transferred form MA to AADB or AFDC
      97  AFDC case changed from state case to county case
      98  Change of Payee
<table>
<thead>
<tr>
<th>CODE</th>
<th>A. REASONS FOR CLOSING</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>Other (Specify)</td>
</tr>
</tbody>
</table>

B. Action taken after closing if some specific action was taken by caseworker

1. Continued for Social Services
2. Referred to other programs administered by the CWB or to other agencies for specific types of service:
   2. Income Maintenance
   3. Health Care or Medical Service
   4. Vocational Rehabilitation
   5. Employment or training (Including Education)
   6. Child Welfare Services
   7. Other (Specify)
9. No specific action taken

C. Cases closed that were coded 10-14 that participated in work, training, rehabilitation, or education program within six months prior to closing of money payment

WIN Program for AFDC Recipients:

1. Regular Employment or on-the-job training
2. Institutional or work experience training
3. Special work projects
4. Manpower development and training program
5. Other Federal work or training program
6. State Vocational Rehabilitation program
7. State or Local Vocational or Adult Education Program
8. Other State or Local Program
9. Did not participate

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REASONS FOR OPENING - CCS

WHY - OPEN

NOTE:  (1) Must be Medically Eligible
       (2) Must be Financially Eligible

$return_to_top$
REASONS FOR CLOSING - CCS

F - 21 Years Old
G - Death
H - Moved to another county
I - Left State
J - Max Benefits
K - Parents are paying
L - Other
1 - Placed for adoption
2 - Returned to parents
3 - Placed with Relatives
4 - Care continued with private funds
5 - Supported by other public program
6 - In State Institution
7 - Living Independently
8 - Death of Child
9 - Other
REASONS FOR OPENING - FOSTER CARE

1 - Plan for Adoption
2 - Deliquency
3 - Unruliness
4 - Deprivation
5 - Incapacitated
6 - Training or education
7 - Other
8 - Subsidized Adoption

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REASONS AND STATUS FOR DENIAL OR OTHER DISPOSITION
PUBLIC ASSISTANCE

(A) Status of denials in respect of financial eligibility

1. Met Standards
2. Did not meet such standards
3. Financial eligibility not determined

B. Reason for Denial

01-03 Did not meet state standard for financial eligibility:

01. Income exceeds determined need (AABD and AFDC)
02. Excess income exceeds medical needs (MA)
03. Resources exceed permitted limits

10-29 Did not meet other condition of eligibility

10. Age
11. Blindness
12. Permanent and total disability
13. Is living in public nonmedical institution
14. Child not deprived of parental care or support by reason of the death, continued absence from home or physical or mental incapacity of the parent as determined by PWB.
15. Child not living with relative within specified degree of relationship
16. Child aged 18-20 not attending school as required by state plan
18. Residence
19. Citizenship
20. Applicant or other family member considered employable
29. Other (Specify)

30-39 Refused to comply with procedural requirements

30. Recovery lien and/or assignment provisions
31. Relative responsibility provisions
32. Refused to register for and seek work
33. Refused to accept suitable employment
34. Employment Security Referral
35. Other source of employment offer
39. Other (Specify)

C. Referral or action taken after denial if specific action was taken by the caseworkers:

1. Approved for continuing social services
2-8 Referred to other programs administered by the CWB or other agencies for specified types of service

2. Income Maintenance
3. Health care or medical services
4. Vocational Rehabilitation
5. Employment or training
   (Including education)
6. Child welfare services
8. Other (Specify)
9. No specific action taken by case worker after denial

Disposcd of otherwise reasons for other dispositions

50. CWB unable to locate applicant
51. Moved to another county or state
52. Death of applicant or dependent child
53. Withdrawl of application by applicant
54. Referral to another program administered by CWB or to another agency
59. Other (Specify)
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<tr>
<th>CODE</th>
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<tr>
<td>01</td>
<td>Adult male Medicaid eligible recipient age 18 or older*</td>
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<tr>
<td>02</td>
<td>Adult female Medicaid eligible recipient age 18 or older*</td>
</tr>
<tr>
<td>03, 04, 05, Etc.</td>
<td>These codes are assigned to ADC children sequentially, beginning with the oldest child. If an older child is added after younger children have been set up in the recipient master file, the next available number in the family sequence should be assigned to him/her.</td>
</tr>
<tr>
<td>90</td>
<td>Used only to indicate an incapacitated father who is not the payee but is in the ADC aware or an incapacitated stepfather.</td>
</tr>
<tr>
<td>98</td>
<td>Used only to indicate a parent who is not the payee nor an ENR but is included in the budget.</td>
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**NOTE:** There cannot be both an '01' and an '02' in the same case. For non-ADC categories, each have a separate case number.
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<thead>
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<td>B</td>
<td>Blue Shield</td>
</tr>
<tr>
<td>C</td>
<td>Blue Cross/Blue Shield</td>
</tr>
<tr>
<td>D</td>
<td>Commercial Insurance, Hospital</td>
</tr>
<tr>
<td>E</td>
<td>Commercial Insurance, Medical</td>
</tr>
<tr>
<td>F</td>
<td>Commercial Insurance, Hospital &amp; Medical</td>
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<tr>
<td>G</td>
<td>Medicare - Part A</td>
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<tr>
<td>H</td>
<td>Medicare - Part B</td>
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<td>J</td>
<td>Medicare - Part A &amp; B</td>
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<td>K</td>
<td>F. E. P.</td>
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<td>L</td>
<td>F. E. P. Supplemental</td>
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<td>M</td>
<td>Champus</td>
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<td>N</td>
<td>Veteran's Administration</td>
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<td>P</td>
<td>Self (Copay Per Services)</td>
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<td>Q</td>
<td>Accident &amp; Paternity Cases</td>
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<td>S</td>
<td>Recipient Liability</td>
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<td>T</td>
<td>Medicare Supplemental</td>
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### FAMILY PLANNING (MALE)

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<td>89300</td>
<td>Semen Analysis</td>
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<tr>
<td>89310</td>
<td>Semen Analysis, Mobility and Count</td>
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<tr>
<td>89320</td>
<td>Semen Analysis, Complete</td>
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<tr>
<td>89325</td>
<td>Sperm Antibodies</td>
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<td>Sperm Evaluation</td>
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### FAMILY PLANNING (FEMALE)

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<td>01802</td>
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<td>01804</td>
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<td>01805</td>
<td>Diaphragm Fitting at time of Annual Exam</td>
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<tr>
<td>01806</td>
<td>Diaphragm Fitting at time other than Annual Exam</td>
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<tr>
<td>01807</td>
<td>IUD Insertion</td>
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<td>11975</td>
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<td>11976</td>
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<td>W2365</td>
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### FAMILY PLANNING (FEMALE) cont.

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<td>58600</td>
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<td>Laparoscopy w/Occlusion of Oviducts</td>
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### VENERAL DISEASE (MALE OR FEMALE)

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<td>01865</td>
<td>Doxycycline</td>
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<tr>
<td>01874</td>
<td>Ampicillan 500 mg.</td>
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<tr>
<td>86592</td>
<td>Syphilis Test Qualitative</td>
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<tr>
<td>86593</td>
<td>Syphilis Test Quantitative</td>
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<tr>
<td>86781</td>
<td>Treponema Antibodies</td>
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<tr>
<td>87164</td>
<td>Dark field exam w/Collection</td>
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<tr>
<td>87166</td>
<td>Dark field without collection</td>
</tr>
<tr>
<td>87205</td>
<td>Smear, primary source</td>
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<tr>
<td>87070</td>
<td>Culture baterial</td>
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<tr>
<td>86687</td>
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</tr>
<tr>
<td>86688</td>
<td>HTLV II</td>
</tr>
<tr>
<td>86689</td>
<td>HTLV or HIV Antibody</td>
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<tr>
<td>86701</td>
<td>HIV I</td>
</tr>
<tr>
<td>86702</td>
<td>HIV II</td>
</tr>
<tr>
<td>86703</td>
<td>HIV I and HIV II</td>
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*(return to top)*
# REOMB CONFIDENTIAL SERVICES, PROCEDURES, AND DIAGNOSTIC CODES

## Abortions

<table>
<thead>
<tr>
<th>CODE</th>
<th>PROCEDURE</th>
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<tbody>
<tr>
<td>59812</td>
<td>Treatment of incomplete abortion, any trimester, completed surgically</td>
</tr>
<tr>
<td>59820</td>
<td>Treatment of missed abortion, complete surgically, first trimester</td>
</tr>
<tr>
<td>59821</td>
<td>Second Trimester</td>
</tr>
<tr>
<td>59830</td>
<td>Treatment of Seplic Abortion, compete surgically</td>
</tr>
<tr>
<td>59840</td>
<td>Induced Abortion, by Dilation and Curettage</td>
</tr>
<tr>
<td>59841</td>
<td>Induced Abortion, by Dilation and evacuation</td>
</tr>
<tr>
<td>59850</td>
<td>Induced Abortion, by one or more intraamniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;</td>
</tr>
<tr>
<td>59851</td>
<td>With Dilation and Curettage and/or Evacuation</td>
</tr>
<tr>
<td>59852</td>
<td>With Hysterotomy (failed intra-amniotic injection)</td>
</tr>
<tr>
<td>59855</td>
<td>Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, Laminaria), including hospital admission and visits; delivery of fetus and secundines</td>
</tr>
<tr>
<td>59856</td>
<td>With Dilation and Curettage and/or Evacuation</td>
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<tr>
<td>59857</td>
<td>With Hysterotomy (Failed Medical Evaluation)</td>
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## Diagnosis Code (Abortion)

<table>
<thead>
<tr>
<th>CODE</th>
<th>PROCEDURE</th>
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<tbody>
<tr>
<td>632</td>
<td>Missed Abortion</td>
</tr>
<tr>
<td>634</td>
<td>Spontaneous Abortion</td>
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<tr>
<td>6340</td>
<td>Complicated by genital tract and pelvic infection</td>
</tr>
<tr>
<td>6341</td>
<td>Complicated by delayed or excessive hemorrhage</td>
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<tr>
<td>6342</td>
<td>Complicated by damage to pelvic organs or tissues</td>
</tr>
<tr>
<td>6343</td>
<td>Complicated by Renal Failure</td>
</tr>
<tr>
<td>6344</td>
<td>Complicated by Metabolic Disorder</td>
</tr>
<tr>
<td>6345</td>
<td>Complicated by Shock</td>
</tr>
<tr>
<td>6346</td>
<td>Complicated by Embolism</td>
</tr>
<tr>
<td>6347</td>
<td>With other specified complications</td>
</tr>
<tr>
<td>6348</td>
<td>With unspecified complications</td>
</tr>
<tr>
<td>6349</td>
<td>With mention of completion</td>
</tr>
<tr>
<td>635</td>
<td>Legally induced abortion</td>
</tr>
<tr>
<td>6350</td>
<td>Complicated by genital tract and pelvic infection</td>
</tr>
<tr>
<td>6351</td>
<td>Complicated by delayed or excessive hemorrhage</td>
</tr>
<tr>
<td>6352</td>
<td>Complicated by damage to pelvic organs or tissues</td>
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<td>Complicated by Renal Failure</td>
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<td>6354</td>
<td>Complicated by Metabolic Disorder</td>
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<td>Complicated by Shock</td>
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<td>6356</td>
<td>Complicated by Embolism</td>
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<td>6357</td>
<td>With other specified complications</td>
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<tr>
<td>6358</td>
<td>With unspecified complication</td>
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<tr>
<td>6359</td>
<td>Without mention of complication</td>
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<tr>
<td>636</td>
<td>Illegally induced abortion</td>
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<td>6360</td>
<td>Complicated by genital tract and pelvic infection</td>
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<tr>
<td>6361</td>
<td>Complicated by delayed or excessive hemorrhage</td>
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<tr>
<td>6362</td>
<td>Complicated by damage to pelvic organs or tissues</td>
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<td>Complicated by Renal Failure</td>
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<td>Complicated by Shock</td>
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<td>Complicated by Embolism</td>
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DIAGNOSIS CODE (ABORTION)

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<tr>
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<tr>
<td>6368</td>
<td>With unspecified complication</td>
</tr>
<tr>
<td>6369</td>
<td>Without mention of complication</td>
</tr>
<tr>
<td>637</td>
<td>Unspecified abortion</td>
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<tr>
<td>6370</td>
<td>Complicated by genital tract and pelvic infection</td>
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<tr>
<td>6371</td>
<td>Complicated by delayed or excessive hemorrhage</td>
</tr>
<tr>
<td>6372</td>
<td>Complicated by damage of pelvic organs or tissues</td>
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<tr>
<td>6373</td>
<td>Complicated by Renal Failure</td>
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<tr>
<td>6374</td>
<td>Complicated by Metabolic Disorder</td>
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<tr>
<td>6375</td>
<td>Complicated by Shock</td>
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<tr>
<td>6376</td>
<td>Complicated by Embolism</td>
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<tr>
<td>6377</td>
<td>With other specified complications</td>
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<tr>
<td>6378</td>
<td>With unspecified complications</td>
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<tr>
<td>6379</td>
<td>Without mention of complication</td>
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<tr>
<td>638</td>
<td>Failed attempted abortion</td>
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<td>6380</td>
<td>Complicated by genital tract and pelvic infection</td>
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<td>6381</td>
<td>Complicated by delayed or excessive hemorrhage</td>
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<td>Complicated by damage of pelvic organs or tissues</td>
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<td>6383</td>
<td>Complicated by Renal Failure</td>
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<tr>
<td>6388</td>
<td>With unspecified complications</td>
</tr>
<tr>
<td>6389</td>
<td>Without mention of complication</td>
</tr>
<tr>
<td>639</td>
<td>Complications following abortion and ectopic and molar pregnancies</td>
</tr>
<tr>
<td>6390</td>
<td>Complicated by genital tract and pelvic infection</td>
</tr>
<tr>
<td>6391</td>
<td>Complicated by delayed or excessive hemorrhage</td>
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<tr>
<td>6392</td>
<td>Complicated by damage of pelvic organs or tissues</td>
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<td>Complicated by Renal Failure</td>
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<tr>
<td>6396</td>
<td>Complicated by Embolism</td>
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<tr>
<td>6398</td>
<td>Other Specified complications following abortion or ectopic and molar pregnancy</td>
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<tr>
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<td>Unspecified complication following abortion or ectopic and molar pregnancy</td>
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DIAGNOSIS CODE (CONTRACEPTION AND STERILIZATION)

- '090 ' - '09999'
- '6060 ' - '60699'
- '6280 ' - '62899'

V016
V026
V027
V028
V157
V25 Encounter for Contraception Management
V250 General Counseling and Advice
V2501 Prescription of Oral Contraceptives
V2502 Initiation of other contraceptives measures
V2509 Other

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V251  Insertion of Intrauterine Contraceptive Device
V252  Sterilization
V253  Menstual Extraction
V254  Surveillance of Previously Prescribed Contraceptive methods
V2540 Contraceptive Surveillance, Unspecified
V2541 Contraceptive Pill
V2542 Intrauterine Contaceptive Device
V2543 Inplantable Subdermal Contraceptive
V2549 Other Contraceptive Method
V255  Insertion of Implantable Subdermal Contraceptive
V258  Other specified contraceptive management
V259  Unspecified contraceptive management
V26  Procreative Management
V260  Tuboplasty or Vasoplasty after previous sterilization
V261  Artificial insemination
V262  Investigation and testing
V263  Genetic Counseling
V264  General Counseling and Advice
V268  Other specified procreative management
V269  Unspecified procreative management

DIAGNOSIS CODE (AIDS)

'042' - '04499'

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<table>
<thead>
<tr>
<th>REOMB MESSAGES</th>
<th>SERVICE DESCRIPTIONS</th>
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<tr>
<td>'MEDICAL SERVICES'</td>
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<tr>
<td>'PHYSICIAN VISITS'</td>
<td>TYPE SERVICE=1 AND CPT4=90000-90599</td>
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<tr>
<td>'INJECTION'</td>
<td>TYPE SERVICE=1 AND CPT4=90720-90749 OR J0120-J9929 OR 90782-90799</td>
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<tr>
<td>SURGERY'</td>
<td>TYPE SERVICE=2</td>
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<td>'CONSULTATION'</td>
<td>TYPE SERVICE=3</td>
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<td>'RADIOLOGY SERVICES'</td>
<td>TYPE SERVICE=4</td>
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<tr>
<td>'LABORATORY SERVICES'</td>
<td>TYPE SERVICE=5</td>
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<tr>
<td>'RADIOTHER./NUC. SERV.'</td>
<td>TYPE SERVICE=6</td>
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<tr>
<td>'DENTAL SERVICES'</td>
<td>TYPE SERVICE=7</td>
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<tr>
<td>'ASSISTANT SURGEON FEES'</td>
<td>TYPE SERVICE=8</td>
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<tr>
<td>'ANESTHESIA'</td>
<td>TYPE SERVICE=G</td>
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<tr>
<td>'OPTOMETRIC SERVICES'</td>
<td>TYPE SERVICE=9 AND CPT4=02000-02209 OR V2620-V2629 OR 92002-92355 OR 22037-22207</td>
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<tr>
<td>'HUMAN SVC CNTR THER'</td>
<td>TYPE SERVICE=9 AND CPT4=02720-02726 OR D2720-D2722 OR 02778-02779</td>
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<tr>
<td>'DURABLE MED EQUIP'</td>
<td>TYPE SERVICE=9 AND CPT4=00001-00004 OR E1000-E1699 OR 06355-06369 OR 06600-06603 OR 06755-06762</td>
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<tr>
<td>'MEDICAL TRANSPORTATION'</td>
<td>TYPE SERVICE=9 AND CPT4=02800-02804 OR A0010-A0225 OR 09800-09806</td>
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<td>'SPEECH THERAPY'</td>
<td>TYPE SERVICE=9 AND CPT4=01300-01308</td>
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<td>'PHYSICAL THERAPY'</td>
<td>TYPE SERVICE=9 AND CPT4=01450-01452</td>
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<td>'OCCUPATIONAL THERAPY'</td>
<td>TYPE SERVICE=9 AND CPT4=01500-01505</td>
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<td>'AUDIOLOGICAL SERVICES'</td>
<td>TYPE SERVICE=9 AND CPT4=01700-01725</td>
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<td>'HEARING AID EQUIPMENT'</td>
<td>TYPE SERVICE=9 AND CPT4=01900-01902</td>
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<td>'PRIVATE DUTY NURSING'</td>
<td>TYPE SERVICE=9 AND CPT4=02500-02501</td>
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<td>'HOME HEALTH SERVICES'</td>
<td>TYPE SERVICE=9 AND CPT4=02600-02604</td>
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<td>CLAIM TYPE=UB82 HOME HEALTH AND PROVIDER NUMBER NOT 5000-5999</td>
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<tr>
<td>'RURAL HEALTH CLIN SVC'</td>
<td>CLAIM TYPE=UB82 HOME HEALTH OR UB82 OUTPATIENT AND PROVIDER NUMBER IS 5000-5999</td>
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<tr>
<td>'MEDICARE COINS. &amp; DED.'</td>
<td>CLAIM TYPE=CROSSOVER</td>
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<td>'PRESCRIBED DRUGS'</td>
<td>CLAIM TYPE=DRUG AND TYPE SERVICE = D</td>
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<td>'INPATIENT HOSP CHARGE'</td>
<td>CLAIM TYPE=INPATIENT OR UB82 INPATIENT</td>
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<td>'NURSING HOME CARE'</td>
<td>CLAIM TYPE=NURSING HOME</td>
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<td>'OUTPATIENT HOSP CHARGE'</td>
<td>CLAIM TYPE=OUTPATIENT</td>
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<td>CLAIM TYPE=UB82 OUTPATIENT AND PROVIDER NUMBER NOT 5000-5999</td>
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<td>'AMBULANCE TRANS'</td>
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<tr>
<td>'MEDICAL SUPPLIES'</td>
<td>MINOR COS=73 OR 74</td>
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<tr>
<td>'EYEGLASSES'</td>
<td>MINOR COS=95</td>
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<td>'MISC. MEDICAL SERVICES'</td>
<td>DEFAULT-ASSIGNED IF THE CRITERIA NOT MET</td>
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<td>DESCRIPTION</td>
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<tr>
<td>10</td>
<td>Regular Medical Assistance</td>
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<td>20</td>
<td>Long Term Care - Regular</td>
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<td>21</td>
<td>Basic Care</td>
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<td>30</td>
<td>Crippled Childrens Services (CCS)</td>
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<tr>
<td>40</td>
<td>Tape to tape (EMC) Billing</td>
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<td>50</td>
<td>Vocational Rehabilitation</td>
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<td>60</td>
<td>Disability Determination Services</td>
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<tr>
<td>70</td>
<td>Indian Health Services</td>
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<tr>
<td>80</td>
<td>Take-over Region</td>
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<tr>
<td>90</td>
<td>Developmental Disabilities</td>
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<tr>
<td>91</td>
<td>Director of Institutions</td>
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<td>92</td>
<td>Regional Intervention Services</td>
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<td>93</td>
<td>State Hospital</td>
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<td>94</td>
<td>Home and Community Based Care (HCBC)</td>
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<td>95</td>
<td>Department of Public Instruction</td>
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<tr>
<td>99</td>
<td>All Regions Combined (Summary)</td>
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<tr>
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<td>Third Party - Medicare</td>
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<td>92</td>
<td>Third Party - Health Insurance</td>
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<td>93</td>
<td>Third Party - Casualty Insurance</td>
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<tr>
<td>94</td>
<td>Third Party - Reimbursements received from responsible relations</td>
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<tr>
<td>95</td>
<td>Probate collections - all types</td>
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<td>96</td>
<td>Fraud and abuse</td>
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<tr>
<td>97</td>
<td>Voluntary repayments - all types</td>
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<tr>
<td>98</td>
<td>Other collections - Overpayments, payments to wrong vendor and collections</td>
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<td>Drug rebates</td>
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### SSA CLAIM NUMBER SUFFIXES

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<td>A. Primary Beneficiary*</td>
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<tr>
<td>B. Aged wife (1st Claimant)*</td>
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</tr>
<tr>
<td>B1. Husband (1st Claimant)*</td>
<td></td>
</tr>
<tr>
<td>B2. Young wife (1st Claimant)*</td>
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<tr>
<td>B3. Aged wife (2nd Claimant)*</td>
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<tr>
<td>B4. Husband (2nd Claimant)*</td>
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<tr>
<td>B5. Young wife (3rd Claimant)*</td>
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<tr>
<td>B6. Divorced wife (1st Claimant)*</td>
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<tr>
<td>B7. Young wife (3rd Claimant)*</td>
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<tr>
<td>B8 Aged wife (3rd Claimant)*</td>
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<tr>
<td>B9. Divorced wife (2nd Claimant)*</td>
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<tr>
<td>C1, C2 Child or grandchild (Including disabled or student child)* etc.</td>
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<tr>
<td>D. Aged widow (1st Claimant)</td>
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<td>D1. Widower (1st Claimant)</td>
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<tr>
<td>D2. Aged Widow (2nd Claimant)</td>
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<td>D3. Widower (1st Claimant)</td>
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<tr>
<td>D4. Widow (Remarried after attaining age 60)</td>
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<td>D5. Widower (Remarried after attaining age 60)</td>
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<tr>
<td>D6. Surviving Divorced wife (1st Claimant)</td>
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<td>D7. Surviving Divorced wife (2nd Claimant)</td>
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<td>D8. Aged Widow (3rd Claimant)</td>
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<tr>
<td>E. Mother (Widow) (1st Claimant)</td>
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<td>E1. Surviving Div. Mother (1st Claimant)</td>
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<td>F2. Mother</td>
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<td>F3. Stepfather</td>
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<td>F4. Stepmother</td>
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<td>F5. Adopting Father</td>
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<td>F6. Adopting Mother</td>
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<tr>
<td>F7. Second alleged father</td>
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<tr>
<td>F8. Second alleged mother</td>
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<tr>
<td>J1. Primary prouty entitled to HIB (Less than 3 Q,C,)**</td>
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<td>J2. Primary prouty entitled to HIB (Over 3 Q,C,)</td>
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<tr>
<td>J3. Primary prouty not entitled to HIB (Less than 3 Q,C,)</td>
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<tr>
<td>J4. Primary prouty not entitled to HIB (Over 2 Q,C,)</td>
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<td>K1. Prouty wife entitled to HIB (Less than 3 Q,C,)</td>
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<td>K2. Prouty wife entitled to HIB (Over 2 Q,C,)</td>
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<td>K3. Prouty wife not entitled to HIB (Less than 3 Q,C,)</td>
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<td>K4. Prouty wife not entitled to HIB (Over 2 Q,C,)</td>
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SSA CLAIM NUMBER SUFFIXES (S-1)

W. Disabled widow (1st Claimant)
W1. Disabled widower (1st Claimant)
W2. Disabled widow (2nd Claimant)
W3. Disabled widower (2nd Claimant)
W6 Disabled Surviving Divorced Wife (1st Claimant)
W7. Disabled Surviving Divorced Wife (2nd Claimant)

* If preceded by 'H', the primary is receiving disability benefits
** Quarters of covered employment

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# SOURCE OF ADMISSION

## CODE STRUCTURE FOR EMERGENCY, ELECTIVE OR URGENT SOURCE OF ADMISSION

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## NEWBORN CODE STRUCTURE

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## TYPE OF SERVICE CODES

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Modifier = 86 or AN or AU

| 2     | Surgery                         | CPT4 Range: 10000-69999       |                  |
| 3     | Consultation                    | CPT4 Range: 90600-90699       |                  |
|       |                                 | 99241-99245                   |                  |
|       |                                 | 99251-99255                   |                  |
|       |                                 | 99261-99263                   |                  |
|       |                                 | 99271-99275                   |                  |

| 4     | Radiology                       | CPT4 Range: 70000-77399       |                  |
|       |                                 | 78000-78999                   |                  |

| 5     | Laboratory                      | CPT4 Range: 80000-89999       |                  |
| 6     | Radiother/Nuc Med               | CPT4 Range: 77400-77999       |                  |
|       |                                 | 79000-79999                   |                  |

| 7     | Dental                          | All dental proc based on claim type | |
| 8     | Asst surg/phys                  | Modifier = 80 or 87 or 81 or AS  |                  |
| 9     | Other                           | PT4 Range:                    | 00001-09999      |
|       |                                 |                               | 98940-98942      |
|       |                                 |                               | A0000-A9999      |
|       |                                 |                               | B1000-B9999      |
|       |                                 |                               | C0001-C9999      |
|       |                                 |                               | D0001-D9999      |
|       |                                 |                               | E0100-E1699      |
|       |                                 |                               | F0001-F9999      |
|       |                                 |                               | G0001-G9999      |
|       |                                 |                               | H0001-H9999      |
|       |                                 |                               | K0001-K9999      |
|       |                                 |                               | L0100-L1699      |
|       |                                 |                               | M0000-M9999      |
|       |                                 |                               | N0001-N9999      |
|       |                                 |                               | O0001-O9999      |
|       |                                 |                               | P0001-P9999      |
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TYPES OF SERVICE CODES

R0001-R9999
S0001-S9999
T0001-T9999
U0001-U9999
V0001-V9999
W0001-W0134
W0136-W0140
W0142-W0150
W0152-W0450
W0452-W0692
W0694-W0704
W0706-W0894
W0896-W0990
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W1451-W1580
W1582-W1584
W1586-W1600
W1602-W1880
W1882-W2010
W2012-W2144
W2146-W2164
W2166-W2324
W2327-W2360
W2362-W2404
W2406-W2510
W2513-W2804
W2806 W2808-W2964
W2966-W3064
W3066-W3204
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W3381-W3404
W3406-W3410
W3413-W3460
W3462-W7144
W7146-W9014
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W9093-W9140
W9143-W9190
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W9252-W9260
W9262-W9999
X0001-X9999
Y0001-Y9999
Z2037-Z2207
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### TYPES OF SERVICE CODES

Or any provider specialty code of '62' or '81'

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### TYPES OF SERVICE CODES

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<td>Radiology/Lab Radiother. Nuclear Med/Prof Comp</td>
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<td>J</td>
<td>X-Ray &amp; Lab-Tech Comp</td>
<td>27 or TC</td>
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<td>K</td>
<td>Nurse Anesthetists</td>
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<tr>
<td>R</td>
<td>Durable Med Equip Supply</td>
<td>59 or RR</td>
</tr>
<tr>
<td>S</td>
<td>Ambulatory Surgery</td>
<td>97 or SG</td>
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#### TYPE OF SERVICE CODE

Type of service code (TY-SVCD) is a one position alphanumeric field on the detail line item of a claim.

Dental Claim

TY-SVCD = ‘7’

Home Health or UB outpatient and Revenue code 982

TY-SVCD = ‘9’

Inpatient or Outpatient

TY-SVCD = ‘2’

If Modifier or Extra Modifier =

80, 81, 82, 87, AS then TY-SVCD = ‘8’
86, AN, AU then TY-SVCD = ‘1’
26 then TY-SVCD = ‘H’
27, TC then TY-SVCD = ‘J’
59, RR then TY-SVCD = ‘R’
97, SG then TY-SVCD = ‘S’

UB outpatient on Home Health and Bill Type 711

If CPT4 on list 123 then TY-SVCD = ‘1’
If CPT4 on list 124 then TY-SVCD = ‘2’
If CPT4 on list 125 then TY-SVCD = ‘3’
If CPT4 on list 126 then TY-SVCD = ‘4’
If CPT4 on list 127 then TY-SVCD = ‘5’
If CPT4 on list 128 then TY-SVCD = ‘6’
If CPT4 on list 129 Then TY-SVCD = ‘9’

(return to top)
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<td>Exception Drugs (cost)</td>
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<td>Formulary Drugs - Brand</td>
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<td>G</td>
<td>Formulary Drugs - Generic</td>
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<tr>
<td>N</td>
<td>Non-Formulary Drugs - Brand</td>
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<tr>
<td>R</td>
<td>Non-Formulary Drugs - Generic</td>
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<tr>
<td>X</td>
<td>Over-the-counter Drugs - Non-Formulary</td>
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<tr>
<td>Z</td>
<td>Over-the-counter Drugs - Formulary</td>
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100 CARDIOVASCULAR DRUGS
110 Antihypertensives
111 Combinations
120 Cardiac Preparations (Digitals, Etc.)
130 Coronary Vasodilators
140 Non-Mercurial Diuretics (THEOBIR)
141 Combinations
142 Mercurial Diuretics
190 Miscellaneous Cardiovasculars (Quinidine, Quin, Niacin, KI)

200 BLOOD MODIFIERS
210 Hematinics
211 Vitamin B-12 Injections
212 Liver Injections
220 Anticoagulants
240 Anti-neoplastic Preparations
290 Miscellaneous Blood Modifiers (KCL) (NAACL)

300 HORMONAL AND METABOLIC DRUGS
320 Androgens
321 Androgen-Estrogen Combinations
330 Estrogens
340 Thyroid Agents
350 Insulins
360 Oral Antidiabetic Agents
370 Contraceptive Agents
380 Vitamins and/or Basic Minerals
390 Miscellaneous Hormonal and Metabolic Drugs (Amphetamines)
391 Corticoids
392 Topical Corticoid Preparations

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THERAPEUTIC CLASSIFICATION CODE

400 NEUROLOGICALS
410 Analgesics and Narcotics
411 Hard Narcotics
420 Anticonvulsants
430 Barbituates
431 Chlora Hudsonate and Non-Barb. Sedatives
440 Anti-Phychotics
441 Anti-Anxiety (Meprobamate)
442 Anti-Depressants (Tricyclic)
460 Anti-arthritics
470 Anti-parkinsonism
480 Miscellaneous Neurologicals (Prostigmin, Antabuse)

500 ANTIBIOTICS
510 Chloramphenical
520 Erythromycin
530 Penicillins (G, V, and K)
540 Streptomycin
550 Tetracyclines
560 Ampicillins
590 Other Antibiotics
592 Topical Preparations

600 ANTI-INFECTIVES
610 Sulfonamides
620 Antibacterials
621 Genitourinary
630 Anthelmintics
640 Antituberculosis Preparations
650 Anti-Inflammatory Enzymes, Oral and Topical
660 Topical Inti-Infectives
670 Anti-Funguls
690 Other Anti-infectives

800 SUPPLIES (COLOSTOMY, Etc.)
801 Disp. Syringes and Needles

900 MISCELLANEOUS AGENTS
910 Antihistaminics
920 EENT Preparations
921 Miotics
930 Gastroenterics
931 Antacid Suspensions
932 Antacid Tablets
933 Anti-Cholinergics
940 Oxytcics (Ergot Comb.)
950 Dermatologicals
960 Diagnostic Reagents
970 Bronchodilators and Decongentants
980 Compound Formulas
990 Drugs not elsewhere classified (Biologica}\n
(return to top)
# STANDARD CLASSIFICATION CLASSES

<table>
<thead>
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<th>CLASSES</th>
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<td>02</td>
<td>Emetics</td>
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<td>Antidiarrheals</td>
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<tr>
<td>04</td>
<td>Antispasmodic-Anticholinergins</td>
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<td>05</td>
<td>Bile Therapy</td>
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<td>06</td>
<td>Laxatives</td>
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<td>07</td>
<td>Antaractics-Tranquilizers</td>
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<td>08</td>
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<td>CNS Stimulants</td>
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<td>All other Antiobesity Preps</td>
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<td>Antihistamines</td>
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<td>Bronchial Dilators</td>
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<td>Cough Preparations/Expectorants</td>
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<td>Cold and Cough Preparations</td>
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<td>Andrenergics</td>
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<td>Vaginal Cleansers</td>
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# STANDARD CLASSIFICATION CLASSES

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# TEETH LETTERS/NUMBERS

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# TOOTH SURFACE CODES

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[return to top]
TPL-MMIS CLAIMS PROCESSING INTERFACE (T-5)

If you are making changes to the TPL Interface (SB1090) remember to change (SB1210) non-drug only - MV12

The following is the criteria used in the claims processing subsystem to determine if a claim should be suspended for possible third party liability.

A. Dental Claim (Claim type = 'L').
   If any of the following coverages are found, the claim will suspend.
   1. Dental (code = 'D')
   2. Court Ordered (code = 'J')

B. Inpatient Claim (Claim type = 'I') or UB82 inpatient claim (claim type = 'U').
   If any of the following coverages are found, the claim will suspend.
   1. Basic Hospital (code = 'A')
   2. Cancer Policy (code = 'G')
   3. Champus (code = 'H')
   4. HMO (code = 'I')
   5. Court Ordered (code = 'J')
   6. Medicare Part A (code = 'K')
      Except Providers '01061' and '01068' and Accomodation/Ancillary Codes H, J, K, L, M, N, O, Z, P
   7. Medicare Extended (code = 'M')
      Except Providers '01061' and '01068'
   8. Accident (code = 'P')
   9. Medicare Part B (code = 'L')
      Except Providers '01061' and '01068' and '01086' and Accomodation/Ancillary Codes A, B
   10. Major Medical (code = 'C')

C. Outpatient Claim (Claim type = 'O') or UB82 outpatient claim (claim type = 'Q').
    If any of the following coverages are found, the claim will suspend.
    1. Basic Hospital (code = 'A' See Note 2)
    2. Major Medical (code = 'C' See Note 2)
    3. Cancer Policy (code = 'G' See Note 2)
    4. Champus (code = 'H' See Note 2)
    5. HMO (code = 'I')
    6. Court Ordered (code = 'J')
    7. Medicare Part B (code = 'L' See Note 1)
    8. Medicare Extended (code = 'M' See Note 1)
    9. Accident (code = 'P')
    10. Dental (code = 'D') all Region 70 and revenue code=512
    11. Pharmacy (code = 'N') all Region 70 and revenue code=250
    12. Vision (code = 'E') all region 70 and revenue code=510

Note 1 – Include region 70 only if provider number is 1058 or 1063 but exclude if revenue codes 250, 510, 512, 519 are used.

Note 2 – Exclude region 70 and revenue codes 250, 510 and 512

(return to top)
D. Nursing Home Claim (Claim type = 'N')
If any of the coverages is a nursing home (code = 'F'), the claim will suspend.
1. Nursing Home (code = 'F') AND NOT Medicare Extended (Code='M')
   Except for Accomodation Codes Q, 2, 1, S
2. Nursing Home (code = 'F') AND Medicare Extended (code = 'M')
on same policy. Exclude Accomodation Codes Q, 3, 2, 7 1, S from suspending

Do not subject Region 20 Nursing Home claims to ESC 556, or ESC 631, except providers '001086' and '002435'.

E. Inpatient Crossover Claim (claim type = 'X' and crossover record code = '1')
If any of the following coverages are found, the claim will suspend.
1. Basic Hospital (code = 'A')
2. Cancer Policy (code = 'G')
3. HMO (code = 'I')
4. Medicare Extended (code = 'M')
5. Accident (code = 'P') and Procedure Code is not equal to 09990 through 09995.

F. Claim Type 'R' (Home Health, Hospice and Rural Health Clinics) or Medical Crossover Claim (Claim type = 'X' and crossover record code = '4' Xover Home Health or '5' Xover Medical)
If any of the following coverages are found, the claim will suspend.
1. Doctor (code = 'B')
2. HMO (code = 'I')
3. Medicare Extended (code = 'M') except
   1. Claim type = 'R' and
      A. Bill type 331-334 and 1st date of service is within 12 months of the HH-Medicare Review Date.
      B. Bill type 811-814 Revenue Code 659.
   4. Accident (code = 'P')
4. Medicare Part A (code = 'K') except
   1. Claim type = 'R' and
      A. Bill type 711
      B. Bill type 331-334 and 1st date of service is within 12 months of the HH-Medicare Review Date.
      C. Bill type 811-814 Revenue Code 659.
   2. Claim type = 'X' and Record Code = '4' or '5' (Home Health and Medical Respectively)
6. Medicare Part B (code 'L') except
   1. Claim type = 'R' and
      A. Bill type 331-334 and 1st date of service is within 12 months of the HH-Medicare Review Date.
      B. Bill type 811-814
   2. Claim type = 'X' and Record Code = '4' or '5' (Home Health and Medical Respectively)
7. Cancer (code = 'G')
8. Major Medical (code = 'C' if bill type 711)
9. Champus (code = 'H')
10. Court Ordered (code = 'J')
G. Outpatient Crossover Claim (Claim type = 'X' and crossover record code='2')
If any of the following coverages are found, the claim will suspend.
1. Basic Hospital (code = 'A')
2. Medical-Surgical (code = 'B')
3. Cancer Policy (code = 'G')
4. HMO (code = 'I')
5. Medicare Extended (code = 'M')
6. Accident (code = 'P')
7. Major Medical (code = 'C') and procedures are not equal to 09990 through 09995.
8. Champus (code = 'H')
9. Court Ordered (code = 'J')

H. Physician Medical (Claim type = 'M' and not HCBC Elderly Disabled (Region=94) and (Type of Service = 1-6, 8, 9, A, H, J, R, S) and Procedure codes = 00001-02700, 03000-04999, 05001-05049, 05100-08499, 08511-91299, 92000-92287, 92500-99999, A2000, A4190-A9901, A0360-A0424, B4034-B9999, E0100-E9999, G0001-G9999, J0110-J9999, K0001-K9999, L0100-L9999, P2028-P9999, Q0034-Q9999, R0070-R0076, W0030-W9999.
If any of the following coverages are found, the claim will suspend.
1. Doctor (code = 'B')
2. Major Medical (code = 'C')
3. Cancer Policy (code = 'G')
4. Champus (code = 'H')
5. HMO (code = 'I')
6. Court Ordered (code = 'J')
7. Medicare Part B (code = 'L')
8. Medicare Extended (code = 'M')
9. Accident (code = 'P')

*Items 1, 2, 3, 4, 7, 8, and 9:
Exclude type of service 9, provider type 31 or 32 when procedure code 92015 is used in conjunction with 99201-99215 or in conjunction with 92002-92014.

*Items 1-9: Exclude Type of Service 9 when Procedure Code is 01320-01348. Exclude Provider Type 51 and 52.

I. Optometric Medical Claim (Claim type = 'M') and procedure codes = 92002-92499, 20000-29999 or V2020-V2799.
If any of the following coverages are found, the claim will suspend.
1. Visions (code = 'E')
2. Court Ordered (code = 'J')
3. HMO (code = 'I')
4. Accident (code = 'P')

{return to top}
J. Drug Claim (Claim type = 'D')—exclude Drug Control Code = 3. If billed amount is 15.01 and above will suspend, if billed amount is 15.00 or less, claim should go to pay. If any of the following coverages are found, the claim will suspend.
1. Drug (code = 'N')
2. Court Ordered (code = 'J')
3. Cancer Policy (code = 'G') and Drug Class = V1A, V1B, V1C, V1D, V1E, V1F
4. Medicare Part B (code = 'L') and Medicare Indicator equal to Yes.
6. Champus (Code = 'H')

*****IF A CLAIM SUSPENDS WITH AN ESC 408, ESC 509 OR ESC 630 OR ESC 631 OR ESC 639, A TPL WORKSHEET WILL BE PRINTED OUT. THE TPL WORKSHEET WILL PRINT ALL THE CONTRACT/POICY RECORDS ON THE TECS TPL-INDIVIDUAL-DBF FILE THAT WOULD CAUSE THE CLAIM TO SUSPEND. (See program SB1390).

*****NO RESOLUTION WORKSHEETS WILL BE PRINTED FOR ESC 408, 509, 556, 630 OR 631, EXCEPT FOR UB82 CLAIMS (Q, U, R) REGION 40.

**Error Status Codes:**
ESC 556 - Any insurance payment and no TPL in the system
ESC 509 - No insurance payment and any TPL in the system
ESC 630 - Less than 50% insurance payment and more than 1 TPL in the system
ESC 631 - 1-59% insurance payment and 1 TPL in the system
ESC 408 - Any insurance payment and more than 1 TPL in the system
ESC 639 - Potential Medicare coverage

**EOB's attached to above ESC's**
76  Paid at Medicaid maximum allowable for this service
100  Claim not processable. See attached SFN 631. Correct and resubmit
120  Reviewed by state. Any applicable insurance applied
200  See claim and SFN 631 enclosed with the RA regarding insurance information
235  Claims processed at allowed amount, insurance not on state system. Send
carrier name and policy number to state TPL unit.
247  Insurance on claim. No insurance on state system. Bill on paper claim and attache EOB
267  One or more insurance's indicated. Bill insurance's and attache all applicable EOB's and/or documentation on a paper claim.

(return to top)
## TPL-MMIS CLAIMS PROCESSING INTERFACE

### Order of Suspense Error for TPL

<table>
<thead>
<tr>
<th>Medical</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st-ESC 556</td>
<td>1st-ESC 556</td>
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<tr>
<td>2nd-ESC 509</td>
<td>2nd-ESC 509</td>
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<tr>
<td>3rd-ESC 631</td>
<td>3rd-ESC 630</td>
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<tr>
<td>4th-ESC 408</td>
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</tbody>
</table>

### TPL & All Claim Types but Pharmacy

1. **No insurance payment & any TPL in System**
   - **Error Code 509**
   - Paper-capture & check for EOB; NO, deny if appropriate with EOB 200 & return with Form 631; YES, force pay if appropriate with EOB 120

2. **Any payment & no TPL in system**
   - **Error Code 556**
   - Paper-capture & check for EOB; NO, deny if appropriate with EOB 200 & return with Form 631; YES, force pay if appropriate with EOB 120

3. **One to 59% payment and 1 TPL in system**
   - **Error Code 631**
   - Paper-capture & check for EOB; NO, deny if appropriate with EOB 200 & return with Form 631; YES, force pay if appropriate with EOB 120

4. **Payment equal to or greater than 60% & one TPL in system**
   - **Error Code 408**
   - Paper-autopay with EOB 076

5. **Any payment & more than one TPL in system**
   - **Error Code 408**
   - Paper-capture & check for EOB; NO, deny if appropriate with EOB 200 & return with Form 631; YES, force pay with EOB 120

### NOTE: for #5 above: if balance due equals zero, autopay with EOB 076

*return to top*
<p>| Number | Condition                                                                 | Paper- | POS- |
|--------|---------------------------------------------------------------------------| autopay | autopay |
| 1      | Billed equal to or less than 15 dollars                                  | with applicable EOB | with applicable EOB |
| 2      | No insurance payment &amp; any TPL in system                                 | capture &amp; check for EOB; NO, deny if appropriate with EOB 200 or 267; YES, force pay if appropriate with EOB 120 | capture &amp; deny if appropriate with EOB 267 or force pay if appropriate with EOB 120 |
| 3      | Any insurance payment &amp; no TPL in system                                 | capture &amp; check for EOB; NO, force pay with EOB 235; YES, give resolution worksheet &amp; EOB to Bev &amp; force pay with EOB 120 | autopay with EOB 235 |
| 4      | Any insurance payment &amp; one TPL in system                                | autopay with applicable EOB | autopay with Applicable EOB |
| 5      | Insurance payment is less than 50% &amp; more than one TPL in system          | capture &amp; check for EOB; NO, deny if appropriate with EOB 200 or 267 &amp; return with Form 631; YES, force pay if appropriate with EOB 120 | capture &amp; deny if appropriate with EOB 267 or force pay if appropriate with EOB 120 |
| 6      | Insurance payment is equal to or greater than 50% &amp; more than one TPL in system | autopay with applicable EOB | autopay with applicable EOB |
| 7      | Potential Medicare coverage                                              | captured, Denial 109 and send back worksheet force living arrangement of 5 | captured, Denial 109 and send back worksheet force living arrangement of 5 |</p>
<table>
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<tr>
<th>CODE</th>
<th>USE</th>
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<tbody>
<tr>
<td>1. MAS</td>
<td>MASS ADJUSTMENTS</td>
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<tr>
<td>2. DE1</td>
<td>COMPUTER GENERATED ADJUSTMENTS</td>
</tr>
<tr>
<td>3. DE2</td>
<td>COMPUTER GENERATED PAYOUTS (PCP)</td>
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<tr>
<td>4. RBL</td>
<td>COMPUTER GENERATED ADJUSTMENTS (RECOUPMENTS)</td>
</tr>
<tr>
<td>5. MAJ/DAV</td>
<td>COMPUTER GENERATED DRUG DATA SHEET REQ.</td>
</tr>
</tbody>
</table>

(MAJOR MEDICAL)
## Contents: Edit/Audit Codes

1. Error_003  
2. Error_004  
3. Error_005  
4. Error_006  
5. Error_007  
6. Error_008  
7. Error_009  
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9. Error_011  
10. Error_013  
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37. Error_047
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</table>
ERROR STATUS CODE: 003

A. CLAIM TYPE: ALL
B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED: 02/11/2004

EDIT NAME: PROVIDER NUMBER MISSING

A. EDIT DESCRIPTION: BILLING PROVIDER NUMBER IS SPACES
B. EDIT DESCRIPTION:
   WHEN THE PROVIDER NUMBER = ZERO OR SPACES
   OR THE WORK COMP BIN NUMBER = '627174'
   AND THE WORK COMP PROVIDER NUMBER POSITION 7:1 = SPACES
   OR THE WORK COMP BIN NUMBER = '627174'
   AND THE WORK COMP PROVIDER NUMBER POSITION 8:1 NOT = SPACES

METHOD OF CORRECTION:

VERIFY THE BILLING PROV NUMBER LISTED ON SUSPENDED CLAIM IS SAME AS THAT WHICH IS ENTERED ON ORIGINAL CLAIM. IF THESE ARE NOT SAME, ENTER THE ORIGINAL CLAIM BILLING NUMBER ONTO CORRECTION FIELD AND PROCESS CLAIM. IF PROV NUMBER CORRESPONDS WITH NUMB ON CLAIM, REFER TO PROV ENROLLMENT FOR VERIFICATION OF CORRECT PROV NAME MATCH AND PROV NUMBER. IF PROV NOT ON FILE, FOLLOW INSTRUCTIONS FROM PROV ENROLLMENT. WHEN USING REMARK CODE "57" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

A. JOB: SB1J020                      PROGRAM: SB1070
B. JOB: CICS POS SYSTEM       PROGRAM: SB710022
ERROR CODE: 004

A. CLAIM TYPE: ALL EXCEPT MEDICAL CLAIM REGION 49
B. CLAIM TYPE: ALL DRUG CLAIMS
   EXCEPT THOSE THAT HAVE AN ERROR 003 ASSIGNED
   THEN ONLY IF THE CLIENT IS NOT FOUND ON THE
   TECS CLIENT BASIC DBF FILE
   OR THE TEAM CLIENT DB2 DATABASE FILE
   OR ADABASE FILE SB620010 FILE
   OR THE CURRENT PCN = SPACES
   OR A WORK COMP CLAIM WITH PCN (10:1) = SPACES

DATE UPDATED: 02/10/2004

EDIT NAME: PROVIDER NUMBER NOT ON FILE

A. EDIT DESCRIPTION: PROVIDER NUMBER MISSING FROM MASTER PROVIDER VSAM FILE   STATUS 23
B. EDIT DESCRIPTION: PROVIDER NUMBER MISSING FROM MASTER PROVIDER VSAM FILE   STATUS 23

METHOD OF CORRECTION:
VERIFY THAT PROV NAME/NUMBER ENTERED CORRESPONDS TO NAME/NUMBER WHICH
APPEARS ON ORIGINAL CLAIM. IF NAME/NUMBER DO NOT MATCH AS A RESULT OF INCORRECT DATA ENTRY,
MAKE CORRECTION AND PROCESS CLAIM. IF ALL DATA ENTRY IS CORRECT, REFER CLAIM TO PROVIDER
ENROLLMENT. WHEN USING REMARK CODE "M57" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD
6.

A. JOB: SB1J050 PROGRAM: SB1130
B. JOB: CICS POS SYSTEM PROGRAM: SB710022
ERROR CODE: 005

A. CLAIM TYPE: ALL EXCEPT MEDICAL CLAIM REGION 49 AND MASS ADJUSTMENT CLAIMS
B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED:

EDIT NAME: PROV NAME AND NUMBER DISAGREE

A. EDIT DESCRIPTION: IF THE PROVIDER LAST NAME DOESN’T MATCH THE PROVIDER LAST NAME ON THE
MASTER PROVIDER VSAM FILE THEN THIS ERROR IS GIVEN
B. EDIT DESCRIPTION: IF THE PROVIDER LAST NAME DOESN’T MATCH THE PROVIDER LAST NAME ON THE
MASTER PROVIDER VSAM FILE THEN THIS ERROR IS GIVEN

METHOD OF CORRECTION:
VERIFY THE LETTERS INPUT FROM NAME AND PROV NUMBER WERE TRANSCRIBED CORRECTLY FROM CLAIM
USING PROPER PROVIDER NAME MATCH VERIFY THE PROVIDER NUMBER WAS ENTERED CORRECTLY FROM
ORIGINAL CLAIM. IF EITHER OF THESE ENTRIES ARE IN ERROR ENTER CORRECT DATE AND PROCESS CLAIM.
NEVER ASSUME THE PROV NUMBER IS CORRECT, REFER TO PROV ENROLLMENT FOR CORRECTION. WHEN USING
REMARK CODE "M57" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

A. JOB: SB1J050 PROGRAM: SB1130
B. JOB: CICS POS SYSTEM PROGRAM: SB710022
ERROR STATUS CODE: 006

CLAIM TYPE: All Claim Types (SB1070) for none drug (SB710022) for drug Claims

DATE UPDATED: 8/31/2004

EDIT NAME: PROV NAME IS MISSING OR WAS NOT ENTERED BY DATE ENTRY

EDIT DESCRIPTION:

If the provider last name is spaces the error is given

METHOD OF CORRECTION:

COMMENTS: IF NO NAME APPEARS ON SCREEN, REFERENCE ORIGINAL CLAIM. IF NAME APPEARS ON CLAIM, ENTER FIRST TWO LETTERS OF PROVIDER NAME. IF THERE IS A QUESTION OF THE MATCH, BRING UP 'G' SCREEN TO VERIFY. FOR PROVIDERS USING INITIALS SUCH AS B & B OR B & G, THE MATCH WOULD BE 'B', 'SPACE' NOT BB. REFER TO PROVIDER ENROLLMENT FOR FURTHER ACTION. WHEN USING REMARK CODE "M57" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:

CICS POS system SB710022
SB1J020 SB1070
ERROR CODE: 007

A. CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT DRUG CLAIMS
B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED:

EDIT NAME: RECIP NUMBER MISS OR INVALID

A. EDIT DESCRIPTION: IF CURRENT PCN = SPACES AND NOT REGION 40 ERROR 007 IS GIVEN
   IF CURRENT PCN = SPACES AND REGION 40 IT AUTO DENYS WITH A HEADER EOB OF ' 31' AND A
   DETAIL EOB OF ' MA61'
   OR IF THE 8-9 POSITIONS OF THE PCN = ‘VR’ AND THE REGION IS NOT 50 AND NOT 40 THE 007 ERROR IS
   GIVEN
   IF THE 8-9 POSITION OF THE PCN IS ‘VR’ AND THE REGION IS 40 IT AUTO DENYS WITH A HEADER EOB
   OF ' 31' AND A DETAIL EOB OF ' MA61'

B. IF THE CURRENT PCN POSITIONS 1-2 = ‘RW’ AND THE BIN NUMBER NOT ‘610115’ THEN GIVE THE 007
   ERROR
   IF THE CURRENT PCN POSITIONS 1-2 = ‘67’ AND THE BIN NUMBER NOT ‘610116’ THEN GIVE THE 007 ERROR
   IF THE CURRENT PCN POSITIONS 1-2 = ‘CC’ OR ‘CS’ AND THE BIN NUMBER NOT ‘610110’ THEN GIVE THE 007 ERROR
   IF THE DATE-STATUS-NORMAL SWITCH = NOT = ‘N’
   IF THE CURRENT PCN = SPACES OR THIS IS A WORK COMP CLAIM BIN
   NUMBER ‘627174’ AND THE CURRENT PCN POSITION 10:1 = SPACES THEN GIVE THE 007 ERROR

METHOD OF CORRECTION:
COMMENTS: WHEN CORRECTING RECIP NUMB OR MEDICAID ID NUMBER, THE 9 DIGIT SSN MUST ALWAYS BE USED.
IF THE RECIP NUMB IS INCORRECTLY ENTERED BY DATA ENTRY OR OMITTED, IT SHOULD BE CORRECTED WITH
PROPER NUMERIC DIGITS IN CORRECTION FIELD. IF RECIP NUMBER OF CLAIM IS INVALID AND CANNOT BE
CORRECTED WITH INFO ON HAND, DETERMINE WHETHER ENOUGH INFO IS PRESENT ON CLAIM TO DETERMINE
CORRECT NUMBER. IF NOT THE CLAIM IS RETURNED TO PROV FOR CORRECTED ID NUMBER. IF CLAIM IS SUPPOSED
TO BE A VR CLAIM AND ICN REGION IS NOT A ‘50’, CLAIM MUST BE REBATCHED.

A. JOB: SB1J020 PROGRAM: SB1070
B. JOB: CICS POS SYSTEM PROGRAM: SB710022

Top
ERROR CODE: 008

A. CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT DRUG WHICH ARE IN THE POS SYSTEM FROM SB1J020

B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED: 02/10/2004

EDIT NAME: RECIPIENT NUMBER NOT ON FILE

A. EDIT DESCRIPTION: IF THE SPECIAL PROCEDURES FLAG 3RD POSITION IN THE TABLE = 1 AND THE REGION NOT 40 OR THIS IS AN ADJUSTMENT THEN THE 008 ERROR IS GIVEN
   IF THE SPECIAL PROCEDURES FLAG 3RD POSITION IN THE TABLE = 1 AND THE REGION IS 40 AND NOT AN ADJUSTMENT THEN IT DENYS WITH A HEADER EOB OF ' 31' AND A DETAIL EOB OF ' MA61'
   IF THIS EDIT DOESN'T GIVE THE ERROR THEN THE PROGRAM CHECKS TECS BY READING ADABAS FILE SB640010
   IF TECS QUALIFIED THEN THE CLAIM IS QUALIFIED BUT CHECKING FOR TEAM INFORMATION.
   IF THIS IS NOT A CROSSOVER CLAIM
   AND NOT A NURSING HOME CLAIM
   AND NOT A UB82 INPATIENT CLAIM WITH ALL-DEDUCT-COINS = Y AND MCARE-A-STATUS = A
   THE ERROR IS THEN GIVEN IF THIS IS NOT A REGION 40 OR THIS IS AN ADJUSTMENT
   IF THE TEST FAILS THE CLAIM IS CHECKED FOR TEAM COVERAGE
   IF TEAM QUALIFIED AND ALL-XOVR-SW = 'N' OR ALL-DEDUCT-COINS = 'N'
   THE ERROR IS THEN GIVEN IF THIS IS NOT A REGION 40 OR THIS IS AN ADJUSTMENT
   IF THE CLAIM ISN'T FOUND ON TECS OR TEAM AND IT IS NOT A PRIOR AUTHORIZATION CLAIM THE ERROR WILL BE GIVEN IF THIS IS NOT A REGION 40 OR THIS IS AN ADJUSTMENT
   IF THIS CLAIM IS A REGION 40 AND NOT AN ADJUSTMENT THE CLAIM WILL DENY WITH A HEADER EOB OF ' 31' AND A DETAIL EOB OF ' MA61'

B. THE PROGRAM DETERMINES IF THIS IS A TECS OR TEAM CLAIM
   IF A TECS CLIENT THE ERROR IS GIVEN IF THE READ OF CLIENT-BASIC-DBF IS NOT NORMAL AND A RECORD ISN'T FOUND
   IF THIS IS A TEAM CLIENT THEN THE ERROR IS GIVEN IF THE READ ON THE CLIENT TABLE FAILS TO PRODUCE A RECORD
   THE ERROR IS ALSO GIVEN IF THE CLIENT CANT BE FOUND ON THE ES100000 ADABAS FILE

METHOD OF CORRECTION:
CHECK CLAIM AND ATTACHMENTS FOR RECIP NUMBER. VERIFY NUMBER APPEARING ON SCREEN IS SAME AS THAT ON CLAIM FORM. IF NOT, CHECK 'D' SCREEN FOR CORRECT ID NUMBER. IF NO MATCH, CLAIM SHOULD BE RETURNED TO PROVIDER FOR CORRECT INFO. TAPE BILLER CLAIMS (REGION 40) WILL AUTOMATICALLY DENY WHEN USING REMARK CODE "MA61" YOU MUST ENTER CLAIM ADJUSTMENT REASON "31" IN FIELD 6.

A. JOB: SB1J040 PROGRAM: SB1090
B. JOB: CICS POS SYSTEM PROGRAM: SB710022

Top
ERROR CODE: 009

A. CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT DRUG CLAIMS
B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED: 02/10/2004

EDIT NAME: RECIPIENT NAME & NUM DISAGREE

A. EDIT DESCRIPTION: IF THE NAME ON THE CLAIM AND THAT OBTAINED FROM THE ELIGIBILITY-BASE-RECORD DON'T MATCH AND THE RECIPIENT CURRENT PCN POSITIONS 8:2 NOT = 'CS' OR THE RECIPIENT ORIGIONAL PCN POSITION 8:2 NOT = 'CS' THEN ERROR 009 IS GIVEN

METHOD OF CORRECTION:
1. IF THE NAME INFORMATION ON THE SCREEN DOES NOT AGREE WITH THE INFORMATION ON THE CLAIM, THEN THE RECIPIENT NUMBER SHOULD BE COMPARED TO SEE THAT IT WAS PICKED UP CORRECTLY BY THE COMPUTER. IF IT WAS NOT, THEN THIS EDIT MAY BE SOLVED BY CORRECTING THE RECIPIENT NUMBER ON THE SCREEN.

2. IF THE RECIPIENT NUMBER MATCHED AND, THE NAMES ON THE CLAIM AND SCREEN DO NOT AGREE, THEN THE BIRTHDATE, SEX AND NAME FIELDS MUST BE REVIEWED TO ATTEMPT TO DETERMINE IF THE RECIPIENT ON THE CLAIM IS THE SAME PERSON AS ON THE SCREEN. THE FOLLOWING FACTORS SHOULD BE CONSIDERED:
   A. NICKNAMES THAT EFFECT THE FIRST INITIAL, SUCH AS ROBERT (R) VERSUS (B).
   B. SPELLING ERRORS
   C. PUT EOB CODE 374 IN FIELD 6 WHEN CORRECTING NAME MATCH AND EOB CODE 450 WHEN CORRECTING ID NUMBER.

IF THE RECIPIENT NUMBER IS CORRECT AND IT CAN BE DETERMINED THAT THE RECIPIENT IS THE SAME PERSON, CORRECT THE ID NUMBER OR THE NAME ONLINE.

3. TAPE BILLER CLAIMS (REGION 40) WILL AUTOMATICALLY DENY WITH EOB CODE OF 138 WHEN THIS ERROR OCCURS.

   A. JOB: SB1J040 PROGRAM: SB1090
   B. JOB: CICS POS SYSTEM PROGRAM: SB710022

Top
ERROR CODE: 010

A. CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT DRUG CLAIMS
B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED: 02/10/2004

EDIT NAME: RECIP NAME MISS OR INVALID

A. EDIT DESCRIPTION: IF THE RECIPIENT LAST NAME = SPACES AND NOT REGION 40 OR THIS IS AN
ADJUSTMENT THIS ERROR IS GIVEN
IF THE RECIPIENT LAST NAME = SPACES AND THIS IS A REGION 40 AND NOT AN ADJUSTMENT THEN IT IS
OUTO DENIED WITH A HEADER EOB OF ’ 140’
B. IF THE RECIPIENT LAST NAME = SPACES OR THE BIN NUMBER FOR WORK COMP = ‘627174’ AND
RECIPIENT FIRST NAME = SPACES THIS ERROR IS GIVEN

METHOD OF CORRECTION:
IF NO NAME APPEARS ON SCREEN, REFERENCE THE ORIGICAL CLAIM. IF NAME APPEARS ON CLAIM, ENTER
NAME ABBREVIATION ON WORKSHEET AND PROCESS CLAIM. IF THERE IS NO NAME ON CLAIM, RTP
WITH EOB M58 AND 16 REQUESTING THIS INFO.

A. JOB: SB1J020 PROGRAM: SB1070
B. JOB: CICS POS SYSTEM PROGRAM: SB710022

Top
ERROR CODE: 011

CLAIM TYPE: CLMT-UB82-INPATIENT-CLAIMS  TYPE ‘U’

DATE UPDATED: 02/11/2004

EDIT NAME: DRG COULD NOT BE DETERMINED

EDIT DESCRIPTION: IF THE PDV13-RETURN-CODE NOT = 0 (WHICH INDICATES THAT AN ERROR CONDITION WAS FOUND IN THE DRG GROUPER)

ONE OF THE FOLLOWING ERROR CONDITIONS HAS OCCURRED:
1. DX CAN NOT BE USED AS PRINCIPAL.
2. RECORD DOES NOT MATCH CRITERIA FOR ANY DRG IN MDC INDICATED BY PRINCIPAL DX.
3. INVALID AGE.
4. INVALID SEX.
5. INVALID DISCHARGE STATUS.
6. ILLOGICAL PRINCIPAL DX.
7. INVALID PRINCIPAL DX.


METHOD OF CORRECTION: CORRECT CLAIM OR DENY

JOB: SB1J050                     PROGRAM: SB1130

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ERROR CODE: 013

CLAIM TYPE: CLMT-UB82-INPATIENT-CLAIMS THAT HAVN’T BEEN DENIED

DATE UPDATED: 02/11/2004

EDIT NAME: NO EFFECTIVE DRG PRICING INFO

EDIT DESCRIPTION: THIS ERROR IS GIVEN WHEN THE CLIENT DATE OF DISCHARGE IS LESS THAN THE DRUG EFFECTIVE DATE OR THE DRUG EFFECTIVE DATE IS ALL ZEROS

METHOD OF CORRECTION:

JOB: SB1J050
PROGRAM: SB1130

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ERROR CODE: 014
A. CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT DRUG CLAIMS AND CLMT-UB82-INPATIENT-CLAIMS WITH CLMT-DRG-CODE > 0 OR CLMT-CLM-BTH-NO > 738 AND < 769 OR CLMT-ELIG-PART-A
B. CLAIM TYPE:

DATE UPDATED: 02/11/2004

EDIT NAME: NET CHARGE OUT OF BALANCE

A. EDIT DESCRIPTION: THE PROGRAM FIGURES THE TOTAL CLAIM CHARGE BY ADDING THE NET CLAIM CHARGE THE TOTAL OTHER INSURANCE AND PATIENT LIABILITY TOGETHER. THE NEW WORKING TOTAL CLAIM CHARGE IS FIGURED BY SUBTRACTING THE TOTAL NON-COVERED CHARGE FROM THE WORKING TOTAL CLAIM CHARGE. IF THIS NEW WORKING TOTAL CLAIM CHARGE IS NOT EQUAL TO THE TOTAL CLAIM CHARGE ON THE CLAIM THE ERROR IS ISSUED
B. EDIT DESCRIPTION:

METHOD OF CORRECTION:
VERIFY THAT ALL AMTS HAVE BEEN TRANSCRIBED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. OTHERWISE, TOTAL THESE FIGURES (TWICE) AND ENTER CORRECT AMT IN BALANCE DUE COLUMN (NET CHARGE). IF TOTAL BILLED EXCEEDS THE ACTUAL TOTAL, A CHARGE MAY HAVE BEEN OMITTED BY PROVIDER. IF THIS APPEARS LIKELY, CLAIM COULD BE RETURNED TO PROVIDER FOR POSSIBLE CORRECTION. WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

A. JOB: SB1J020 PROGRAM: SB1070
B. JOB: SB1J076 SB1J079 PROGRAM: SB1280 CALLED PROGRAM SB133A
ERROR CODE: 015

A. CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT DRUG CLAIMS, CROSSOVER CLAIMS AND UB82-INPATIENT-CLAIMS WITH CLMT-DRG-CODE > 0
B. CLAIM TYPE: ALL DRUG CLAIMS

DATE UPDATED:

EDIT NAME: CLM CHG & LINE AMTS DISAGREE

A. EDIT DESCRIPTION: IF THE WORKING TOTAL CLAIM CHARGE NOT EQUAL TO THE CLAIM TOTAL CLAIM CHARGE THIS ERROR IS ISSUED.
B. EDIT DESCRIPTION: IF THE FIRST POSITION OF THE PROVIDER NUMBER = '*' THEN GIVE THIS ERROR

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

A. JOB: SB1J020 PROGRAM: SB1070
B. JOB: CICS POS SYSTEM PROGRAM: SB710041
ERROR CODE: 019

CLAIM TYPE:

DATE UPDATED: UB82-INPATIENT-CLAIMS, UB82-OUTPATIENT-CLAIM

EDIT NAME: PRIOR AUTHORIZ NO. IS INVALID

EDIT DESCRIPTION:
CLMT-UB82-INPATIENT-CLAIMS WITH PROVIDER NUMBERS OF '000001072' '000001870' '000002008' '000002030'
'000002031' '000001793' '000001811' '000001816' '000001826' ARE EXCLUDED FROM THIS ERROR
REGION 50 VR-REGION CLAIMS ARE ALSO EXCLUDED FROM THIS ERROR
RECIPIENT COUNTY LESS THAN 0 AND GREATER THAN 53 ARE EXCLUDED

IF THIS CLAIM IS A UB82-INPATIENT-CLAIM AND PROCEDURE CODE MEETS PCLIST 0146 REQUIREMENTS FOR A ‘Y’
RETURN IT MUST ALSO BE CLMT-URGENT OR CLMT-ELECTIVE AND CLMT-PRIOR-AUTH-CTL-NO = SPACES AND
CLMT-TOT-OTHER-INS < 0 OR = 0 TO GET THE ERROR
IT THEN CHECKS EB92-PROCEDURE 1 THRU 3 AND UB82-SURG-PRCD 2 AND 3 FOR PCLIST 0146 COMPLIANCE AND IF
A ‘Y’ THE CLAIM MUST ALSO BE CLMT-URGENT OR CLMT-ELECTIVE AND CLMT-PRIOR-AUTH-CTL-NO = SPACES
AND CLMT-TOT-OTHER-INS < 0 OR = 0 TO GET THE ERROR

IF THIS CLAIM IS UB82-OUTPATIENT-CLAIM AND PROCEDURE CODE MEETS PCLIST 0176 REQUIREMENTS FOR A ‘Y’
RETURN IT MUST ALSO HAVE CLMT-PRIOR-AUTH-CTL-NO = SPACES AND CLMT-TOT-OTHER-INS < 0 OR = 0 IT WILL
GET THE ERROR
THE PROGRAM THEN CHECKS THE -UB82-SURG-PROCEDURE CODES THAT ARE TABLED
IT THEN CHECKS EB92-PROCEDURE 1 THRU 3 AND UB82-SURG-PRCD 2 AND 3 FOR PCLIST 0176 COMPLIANCE AND IF
A ‘Y’ THE CLAIM MUST ALSO HAVE CLMT-PRIOR-AUTH-CTL-NO = SPACES AND CLMT-TOT-OTHER-INS < 0 OR = 0 TO
GET THE ERROR

METHOD OF CORRECTION: REASON CODE "62" MAY BE USED ALSO

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 020

CLAIM TYPE: UB82-INPATIENT-CLAIM

DATE UPDATED: 02/12/2004

EDIT NAME: INTERIM BILL BY DRG PROVIDER

IF THE REGION IS A 40 AND NOT AN ADJUSTMENT THE PROGRAM DENIES THE CLAIM AND PLACES ’135’ IN THE EOB HEADER AND DETAIL

METHOD OF CORRECTION:

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE: 021

CLAIM TYPE: UB82-CLAIM NOT REGION 70

DATE UPDATED: 02/12/2004

EDIT NAME: NO DRG PRICING RECORD ON FILE


METHOD OF CORRECTION:

JOB: SB1J020
PROGRAM: SB1130
ERROR CODE: 022

CLAIM TYPE: UB82-HOME-HEALTH, UB82-OUTPATIENT, UB82-INPATIENT, and MEDICAL-CLAIMS(EXCEPT PROVIDER TYPE 58)

DATE UPDATED: 05/25/2004

EDIT NAME: PRIMARY DIAGNOSIS IS MISSING

EDIT DESCRIPTION: IF DIAGNOSIS CODE IS SPACES AND THE REGION IS 40 AND THE CLAIM IS NOT AN ADJUSTMENT THE CLAIM IS DENIED WITH REASON CODE 47. IF DIAGNOSIS CODE IS SPACES AND THE REGION IS NOT 40 OR THE CLAIM IS AN ADJUSTMENT ERROR 022 IS GIVEN.

METHOD OF CORRECTION: CHECK 'REMARKS' SECTION ON AUTHORIZATION FOR DESCRIPTION OF DIAGNOSIS. IF MISSING AND CLAIM IS MEDICAL OR HOSPITAL, RETURN TO PROVIDER FOR PROPER CODE.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 023

CLAIM TYPE: MEDICAL-CLAIMS, INPATIENT-CLAIMS, OUTPATIENT-CLAIMS  
UB82-OUTPATIENT-CLAIMS, UB82-HOME-HEALTH CLAIMS AND  
UB82-INPATIENT-CLAIMS

DATE UPDATED: 02/12/2004

EDIT NAME: PRIMARY DIAG CODE INVALID

EDIT DESCRIPTION: THIS EDIT READS THE TABLED DIAGNOSIS CODES

IF PROVIDER-TYPE CODE = '26' AND THE PROVIDER SPECIALTY CODE = '35' AND  
THE 1ST-DAY-OF-SERVICE > 19841130 AND THE DIAGNOSSIS CODE = 'Y000'  
IF THIS CLAIM IS NOT A DDS-REGION CODE ‘70'  
THEN THE 023 ERROR IS GIVEN  
FOR MEDICAL-CLAIMS, OUTPATIENT CLAIMS AND INPATIENT CLAIMS THE EXTRA DIAGNOSIS CODES ARE ALSO  
CHECKED WITH SAME EDIT

METHOD OF CORRECTION:
CHECK CODE WITH DIAG MISSING. A ZERO MAY NEED TO BE ADDED OR DELETED.  
IF CODE ON FILE, CHECK IDC-9-CM FOR CORRECT DIAG. IF NOT IDENTIFIABLE, CHECK WITH SUPERVISOR. IF CODE INCORRECT AND NO DIAG GIVEN, RETURN TO PROVIDER WITH EOB M58 AND 16 IN FIELD 6.

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE: 024

CLAIM TYPE: DEVELP-DISABILITY-REG REGION 90 CLAIMS OR THOSE WITH PROVIDER NUMBERS BETWEEN 000035000' AND '000037999 AND NOT EQUAL TO THESE PROVIDER NUMBERS 000035432' '000035434' '000035201'

DATE UPDATED: 02/13/2004

EDIT NAME: PROV NOT AUTHORIZ FOR DD RECIP


METHOD OF CORRECTION:
REFER THE DD UNIT FOR INFO. ADJUDICATE PER THEIR DECISION.

JOB: SB1J040
PROGRAM: SB1090
ERROR CODE: 025

CLAIM TYPE:

DATE UPDATED:

EDIT NAME: ATTENDING PHYSICIAN NUMBER IS INVALID

EDIT DESCRIPTION: Commented out in SB1070 (No longer used)

METHOD OF CORRECTION:

COMMENTS: REVIEW FOR CORRECT TRANSCRIPTION. IF NAME OF PHYS IN REMARKS BLOCK, CHECK SCREEN 'H' FOR CORRECT NUMBER. REFER TO PROV ENROLLMENT FOR PROPER NUMB. IF PROV ENROLLMENT DOES NOT HAVE, RTP FOR CORRECTION. HOSP MAY USE INSTATE OR OUT-OF-STATE DUMMY NUMBER IF NAME IS ON CLAIM.

WHEN USING REMARK CODE "M68" YOU MUST ENTER CLAIM ADJUSTMENT REASON "52" OR "125" IN FIELD 6.

JOB: SB1J020 previously

PROGRAM: SB1070
ERROR CODE: 026

CLAIM TYPE:
INPATIENT AND OUTPATIENT CLAIMS, WITH ANCILLARY CODES ‘H’ AND ‘J THRU Z’
NURSING HOME CLAIMS WITH PROVIDER LOCATION 90 THRU 99 (OUT OF STATE) AND ANCILLARY CODE ‘J’ OR ‘K’ OR ‘L’ OR ‘Z’

DATE UPDATED: 02/17/2004

EDIT NAME: OPERATING PHYS NO. IS INVALID

EDIT DESCRIPTION:
IF THE DETAIL SERVICE CODE = 'W' OR 'V' AND OPR-SURG-PROV-NO = SPACES OR ZEROES THEN THIS ERROR IS GIVEN

METHOD OF CORRECTION:
CHECK TRANSCRIPTION FOR ACCURACY. OTHERWISE ENTER NUMBER OF ATTENDING PHYSICIAN FROM BLOCK 14.

WHEN USING REMARK CODE "M68" YOU MUST ENTER CLAIM ADJUSTMENT REASON "52" OR "125" IN FIELD 6.

JOB: SB1J050 PROGRAM: SB1130

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FIELD NUMBER:                                                                                      ERROR CODE: 027

CLAIM TYPE: PAYABLE CLAIM THAT ISN’T DENIED

DATE UPDATED: 02/17/2004

EDIT NAME: NO MATCH CODE

EDIT DESCRIPTION: IF THE FEDERAL MATCH CODE = SPACES AND THE TRANSACTION-TYPE = '3' AND THE
RECIPIENT IS ELIGIBLE (ERROR-CODE NOT = '007' OR '008' OR '009' OR '010') THEN THIS ERROR IS GIVEN

METHOD OF CORRECTION:

REFER THE CLAIM TO FINANCE. THEY WILL ADVISE WHEN PROBLEM IS CORRECTED AND CLAIM CAN BE
RECYCLED FOR PAYMENT.

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE: 028

CLAIM TYPE: INPATIENT-CLAIM

DATE UPDATED: 02/17/2004

EDIT NAME: FIRST SURGERY DATE IS INVALID

EDIT DESCRIPTION: IF THE DATE OF SURGERY IS IN ERROR THEN THIS DATE IS GIVEN (NOT A PROPER DATE FORMAT OR IMPROPER CALENDER DATE)

METHOD OF CORRECTION:
COMMENTS: VERIFY CORRECT DATE WAS TRANSCRIBED. VERIFY SURGERY DATE IS WITHIN ADMISSION/DISCHARGE DATES. IF NO DISCHARGE DATE IS PRESENT, ASSUME THROUGH 'STATEMENT COVERS PERIOD' DATE IS TO BE LAST DATE FOR CLAIM ON WHICH SURG MAY BE PERF. SHOULD SURG NOT FALL WITHIN DATES OF STAY AND SURG WAS NOT PERF DURING PERIOD WHICH PROV IS BILLING, RETURN CLAIM WITH EOB M58 AND 16 IN FIELD 6. WHEN USING REMARK CODE "M67" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.  EOB "MA66" MAY BE USED IN PLACE OF "M67"

JOB: SB1J020                      PROGRAM: SB1070

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ERROR CODE: 029

CLAIM TYPE: INPATIENT-CLAIM

DATE UPDATED: 02/17/2004

EDIT NAME: FIRST SURGERY DATE RANGE ERROR

EDIT DESCRIPTION: IF DATE OF SURGERY NOT = ZEROS AND DATE OF DISCHARGE NOT = ZEROS THEN IF THE DATE OF SURGERY IS GREATER THAN THE DATE OF DISCHARGE THE ERROR IS GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY CORRECT DATE WAS TRANSCRIBED. VERIFY SURG DATE IS WITHIN ADM/DISCH DATES. IF NO DISCH DATE IS PRESENT, ASSUME THROUGH 'STMT COVERS PERIOD' DATE IS TO BE LAST DATE FOR CLAIM ON WHICH SURG MAY BE PERFORMED. SHOULD SURG NOT FALL WITHIN DATES OF STAY AND SURG WAS NOT PERF DURING PERIOD WITH PROV IS BILLING, RETURN CLAIM WITH EOB M58 AND 16 IN FIELD 6.

WHEN USING REMARK CODE "M67" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6. EOB "MA66" MAY BE USED IN PLACE OF "M67"

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE:  030

CLAIM TYPE:  ENTRX-CD1 = 'A' WHICH IS AN ADDED TRANSACTION

DATE UPDATED: 02/17/2004

EDIT NAME:  OVERLAPPING MONTHS

EDIT DESCRIPTION:  IF LTC-REG REGION 20 OR HCBC-ELDERLY-DISABLED REGION 21 OR BASIC-CARE-REG REGION 94 IF THE MONTH IS NOT EQUAL FROM THE FIRST PROCEDURE SERVICE DATE AND THE LAST PROCEDURE SERVICE DATE THEN THERE ARE OVERLAPPING MONTHS AND THE ERROR IS GIVEN

METHOD OF CORRECTION:
VERIFY THAT SERVICE DATES FOR DETAIL LINES ARE CORRECT. IF THEY ARE NOT CORRECT, ENTER CORRECT DATE AND PROCESS CLAIM. IF THEY ARE CORRECT THE CORRECT DATA IN THE HEADER DATES OF SERVICE (FIELDS 7 AND 8).

WHEN USING REMARK CODE "N74" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB:  SB1J020  PROGRAM:  SB1070
ERROR CODE: 031

CLAIM TYPE: DEVELOP-DISABILITY-REG REGION 90 CLAIMS OR THOSE WITH PROVIDER NUMBERS BETWEEN 000035000' AND '000037999 AND NOT EQUAL TO THESE PROVIDER NUMBERS 000035432' '000035434' '000035201'

DATE UPDATED: 02/17/2004

EDIT NAME: PROV NOT AUTH FOR EXT SVS RECP


METHOD OF CORRECTION: REFER TO DD UNIT FOR INFO. ADJUDICATE PER THEIR DECISION.

JOB: SB1J040 PROGRAM: SB1090
ERROR CODE: 032

A.        CLAIM TYPE: ALL CLAIMS
B.        CLAIM TYPE: MEDICAID RECIPIENT DRUG CLAIM

DATE UPDATED: 02/17/2004

EDIT NAME: LIFETIME NICORETTE LIMIT EXCEEDED

A.        EDIT DESCRIPTION: FROM THE TABLED DRUG LI CLAIMS IF GENERIC-CODE = '03200' AND DATE-DISPENSED GREATER THAN 19910630. IF THE NEW CLAIM QUANTITY PLUS THE RELATED HISTORY QUANTITY IS GREATER THAN 1153 THE ERROR CODE IS GIVEN
B.        EDIT DESCRIPTION: IF GENERIC CODE = '03200' OR '03201'
ADD QUANTITY DISPENSED TO NICORETTE-QUANTITY
IF NICORETTE QUANTITY > 1164
SUBTRACT QUANTITY DISPENSED FROM NICORETTE QUANTITY
THEN GIVE THE ERROR

METHOD OF CORRECTION:
1. VERIFY INFO WAS INPUT CORRECTLY, CORRECT ANY ERRORS  2. DENY LINE WITH EOB 35.

A.        JOB: SB1J075                          PROGRAM: SB1250
B.        JOB: CICS POS SYSTEM                PROGRAM: SB710024
ERROR CODE: 034

CLAIM TYPE: INPATIENT CLAIMS, NURSING HOME CLAIMS, UB82 INPATIENT CLAIMS, AND CROSS OVER CLAIMS, NURSING HOME CLAIM WITH SERVICE CODES OF '1' '2' '3' 'Q' 'R' 'S' 'T' 'U' 'V' 'W' 'X' OR 'Y'.

DATE UPDATED: 02/18/2004

EDIT NAME: ADMISSION DATE IS INVALID

EDIT DESCRIPTION: IF THE ADMISSION DATE = ZEROS
IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE ADMISSION DATE IS NOT = ZEROS AN EDIT IS PERFORMED TO INSURE THIS IS A PROPER DATE. IF THE DATE ERRORS WITH A CODE 1 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE ADMISSION DATE = ZEROS OR THE DATE ERRORS IN THE EDIT PROCESS WITH CODE 1
IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ' 125' TO THE HEADER EOB AND MOVE ' MA40' TO THE DETAIL EOB FOR THE FIRST DETAIL

IF THE RECORD IS A CROSSOVER WITH RECORD TYPE CODE 1 OR 3
IF THE ADMISSION DATE = ZEROS
IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE ADMISSION DATE IS NOT = ZEROS AN EDIT IS PERFORMED TO INSURE THIS IS A PROPER DATE. IF THE DATE ERRORS WITH A CODE 1 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE ADMISSION DATE = ZEROS OR THE DATE ERRORS IN THE EDIT PROCESS WITH CODE 1
IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ' 125' TO THE HEADER EOB AND MOVE ' MA40' TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION:
COMMENTS: VERIFY ADMISSION DATE HAS BEEN ENTERED CORRECTLY WITH NO SPACES, DASHES OR SLASHES AND HAS BEEN TRANSCRIBED PROPERLY. IF NOT, ENTER CORRECT DATE ON WORKSHEET. IF ADMISSION DATE IS MISSING OR NON-NUMERIC, CHECK THE PSRO AND CORRECT ACCORDINGLY.
WHEN USING REMARK CODE "MA40" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 035

OR ‘Y’, AND UB82 INPATIENT CLAIMS

DATE UPDATED: 02/18/2004

EDIT NAME: ADMISSION DATE AFTER FROM DATE

EDIT DESCRIPTION: IF THE ADMISSION DATE DOESN’T HAVE A PREVIOUS ERROR THEN THE DATE IS CHECKED TO
INSURE IT IS BEFORE THE RELEASE DATE. IF THE ADMISSION DATE IS AFTER THE RELEASE DATE AND THE REGION
NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE DATE FAILS THE ABOVE TEST BUT THE REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’125′ TO THE HEADER EOB AND MOVE ’MA40′ TO
THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION:
1. VERIFY ADMISSION DATE INPUTTED CORRECTLY  2. DATE IS MISSING OR NONUMERIC, CHECK PSRO ABSTRACT FOR CORRECT INFO. ENTER CORRECT DATE IN FIELD 09 AND PROCESS THE
CLAIM  3. NURSING HOME IS SAME AS FOR ERROR 034.

WHEN USING REMARK CODE "MA40" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 037


DATE UPDATED: 02/18/2004

EDIT NAME: ADMISSION CODE MISS OR INVALID

EDIT DESCRIPTION: IF THE ADMISSION CODE IS NOT 1 OR 2 OR 3 OR 4
IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN FOR ALL EXCEPT CROSSOVER CLAIMS

FOR CROSSOVER CLAIMS WITH A RECORD-TYPE = '1' OR '3' AND THE NATR-OF-ADM = SPACE AND THE CLAIM BATCH NUMBER NOT BETWEEN 075 AND 99 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT AND THE ABOVE CONDITIONS ARE MET THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’ 125’ TO THE HEADER EOB AND MOVE ’ MA40’ TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION: 1-EMERGENCY, 2-ELECTIVE, 3-URGENT, 4-NEWBORN
IF OTHER THAN ONE OF THE ABOVE ADMISSION CODES IS ENTERED IN ADMISSION CODE FIELD, OR PROVIDER HAS LEFT BLCK (19) BLANK, CHECK DIAGNOSIS FOR TYPE OF ADMISSION.
WHEN USING REMARK CODE "MA41" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 038


DATE UPDATED: 02/18/2004

EDIT NAME: DISCHARGE CODE MISS OR INVALID

EDIT DESCRIPTION: IF THE DISCHARGE DESTINATION CODE NOT = 1,2,3,4,5,6,8,9 AND THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’125’ TO THE HEADER EOB AND MOVE ’N50’ TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION: WHEN USING REMARK CODE "N51" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 039

A. CLAIM TYPE: MEDICAL CLAIMS, UB82 INPATIENT CLAIMS, INPATIENT CLAIMS OR NURSING HOME CLAIMS

B. CLAIM TYPE

DATE UPDATED: 02/18/2004

EDIT NAME: NUMBER OF DAYS BILLED INVALID

A. EDIT DESCRIPTION: IF THE REGION = '94' AND A MEDICAL CLAIM AND THE DATE-OF-SERVICE-FROM IS NUMERIC AND DATE-OF-SERVICE-TO IS NUMERIC AND THE PROCEDURE CODE = '00001' OR '00013' OR '00014' OR '00026' OR '00030' OR '00057' OR '00098') PROCESS THE DATE FROM AND TO TO TOTAL THE DAYS AND CHECK TO SEE THAT THE TOTAL IS EQUAL TO THE UNIT OF SERVICE ON THE DETAIL. IF THE DAYS EQUAL THEN CHECK TO SEE IF THE MONTH AND YEAR ARE EQUAL. IF ANY ERROR IS FOUND IN THE DATE THE CLAIM WILL RECEIVE THE ERROR IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT.

IF THE REGION = 40 AND NOT AN ADJUSTMENT
THE DETAIL WILL DENY AT THE DETAIL LEVEL BY MOVE 0 TO DETAIL-PAID-AMOUNT AND DETAIL ALLOWED CHARGE AND MOVE '8' TO THE PRICING INDICATOR THEN MOVE '125' TO THE HEADER EOB AND MOVE 'M53' TO THE DETAIL EOB BEING CHECKED

IF UB82 INPATIENT CLAIM AND UB82 TOTAL DAYS BILLED = ZERO THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE REGION = 40 AND NOT AN ADJUSTMENT
THE UB82 INPATIENT CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE '125' TO THE HEADER EOB AND MOVE 'M53' TO THE DETAIL EOB FOR THE FIRST DETAIL


IF THE REGION = 40 AND NOT AN ADJUSTMENT

B. EDIT DESCRIPTION:

METHOD OF CORRECTION:
VERIFY TOTAL DAYS ENTERED IS SAME AS TOTAL DAYS INDICATED ON CLAIM. DAYS BILLED IN ACCOMODATION SECTION MUST EQUAL DAYS IN BLOCK 23 ON CLAIM. COMPLETE FIELD 12 WITH
TOTAL DAYS, AND PROCESS CLAIM. IF PROV DOES NOT SATISFY TOTAL NUMBER OF DAYS OF STAY.

**NOTE**
WHEN USING REMARK CODE "M53" YOU MUST ENTER ADJUSTMENT REASON '125' IN FIELD 6.

A. JOB: SB1J020                                PROGRAM: SB1070
B. JOB: SB1J085                                PROGRAM: SB1330
ERROR CODE: 041

CLAIM TYPE: INSTITUTIONAL CLAIMS, PROFESSIONAL CLAIMS, UB82 INSTITUTIONAL CLAIMS OR CROSSOVER CLAIMS

DATE UPDATED: 02/18/2004

EDIT NAME: BILLING FROM DATE INVALID

EDIT DESCRIPTION: IF THE BILLING FROM DATE = ZEROS AND THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE BILLING FROM DATE IS NOT = ZEROS AN EDIT IS PERFORMED TO INSURE THIS IS A PROPER DATE. IF THE DATE ERRORS WITH A CODE 1 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’125’ TO THE HEADER EOB AND MOVE ’MA31’ TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION:
COMMENTS: VERIFY PROPER TRANSCRIPTION. OTHERWISE, ENTER CORRECT DATE OF SERVICE, USING FIRST PROCEDURE SERVICE DATE FOR PROF CLAIM TYPES.
EOB "M52" OR "M59" MAY BE USED IN PLACE OF "MA31"

WHEN USING REMARK CODE "MA31", "M52" OR "59" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 042

CLAIM TYPE: INPATIENT CLAIMS, NURSING HOME CLAIMS WITH SERVICE CODE '1' '2' '3' 'Q' 'R' 'S' 'T' 'U' 'V' 'W' 'X' OR 'Y', AND UB82 INPATIENT CLAIMS

DATE UPDATED: 02/18/2004

EDIT NAME: DISCHG STAT PRESENT DATE BLANK

EDIT DESCRIPTION: IF THIS CLAIM IS (DISCHARGE DESTINATION '9' AND DATE OF DISCHARGE = ZEROS) OR (DISCHARGE DESTINATION '6' AND DATE OF DISCHARGE = ZEROES) AND (REGION 20 OR REGION 21) AND (PROVIDER NUMBER > '000029999' AND < '000040000') THE CLAIM WILL SKIP THE EDIT. IF THE PRECEEDING IS FALSE THEN THE FOLLOWING EDIT IS DONE

IF NOT A VALID DISCHARGE DESTINATION (1,2,3,4,5,6,8,9) AND THE DATE OF DISCHARGE = ZEROS AND THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE REGION = 40 AND NOT AN ADJUSTMENT THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ' 125' TO THE HEADER EOB AND MOVE ' N50' TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION: VERIFY THAT DISCHARGE DATE HAS BEEN TRANSCRIBED PROPERLY. IF NOT, ENTER THE CORRECT DATE.

WHEN USING REMARK CODE "N50" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070

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ERROR CODE: 043

CLAIM TYPE: INSTITUTIONAL CLAIMS, PROFESSIONAL CLAIMS, UB82 INSTITUTIONAL CLAIMS OR CROSSOVER CLAIMS

DATE UPDATED: 02/18/2004

EDIT NAME: BILLING THRU DATE IS INVALID

EDIT DESCRIPTION: IF THE BILLING TO DATE = ZEROS AND THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE BILLING TO DATE IS NOT = ZEROS AN EDIT IS PERFORMED TO INSURE THIS IS A PROPER DATE. IF THE DATE ERRORS WITH A CODE 1 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’125’ TO THE HEADER EOB AND MOVE ’N50’ TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION:
COMMENTS: VERIFY PROPER TRANSCRIPTION. ENTER CORRECT DATE OF SERVICE, USING LAST PROCEDURE SERVICE DATE FOR PROF CLAIM TYPES. IF BLANK, RETURN TO PROVIDER WITH EOB "M58" AND 16 IN FIELD 6 WHEN USING REMARK CODE "M59" YOU MUST ENTER ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 045


DATE UPDATED: 02/18/2004

EDIT NAME: DISCHARGE DATE IS INVALID

EDIT DESCRIPTION: IF THE DISCHARGE DESTINATION = ‘9’ OR = ‘6’ SKIP THIS EDIT ELSE IF THE DATE OF DISCHARGE = ZEROS AND THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE DATE OF DISCHARGE IS NOT = ZEROS AN EDIT IS PERFORMED TO INSURE THIS IS A PROPER DATE. IF THE DATE ERRORS WITH A CODE 1 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’ 125’ TO THE HEADER EOB AND MOVE ’ N50’ TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION: VERIFY DISCHARGE DATE BEEN TRANSCRIBED CORRECTLY. IF NOT, ENTER CORRECT DATE ON WORKSHEET. IF PROV HAS LEFT BLOCK BLANK, ENTER DATE SHOWN IN BLOCK 22B. IF PROV ENTERED INVALID DATE, CHECK BLOCK 22B FOR CORRECT DATE. IF CORRECT DATE CANNOT BE FOUND, RETURN FOR CORRECTION. PSRO ABSTRACT CAN ALSO BE REFERRED TO FOR DISCHARGE DATE. WHEN USING REMARK CODE "N50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070

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ERROR CODE: 046


DATE UPDATED: 02/18/2004

EDIT NAME: DSCHG DATE PRES STAT = 9 OR 6

EDIT DESCRIPTION: IF (DISCHARGE DESTINATION = ‘9’ AND DATE OF DISCHARGE > ZEROS OR DISCHARGE DESTINATION = ‘6’ AND DATE OF DISCHARGE > ZEROS)
AND (REGION = 20 OR REGION = 21)
AND (PROVIDER NUMBER > '000029999' AND < '000040000')
THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF CLMT-CLM-REGION = 40 AND NOT AN ADJUSTMENT
THE CLAIM WILL AUTO DENY AT THE HEADER LEVEL AND MOVE ’ 125’ TO THE HEADER EOB AND MOVE ’ N50’ TO THE DETAIL EOB FOR THE FIRST DETAIL

METHOD OF CORRECTION:
COMMENTS: VERIFY IF PATIENT IS STILL RESIDENT ON LAST DATE OF BILLING. IF THIS IS THE CASE, DISCHARGE CODE 6 OR 9 IS CORRECT, AND DISCHARGE DATE DATA MUST BE REMOVED FROM FIELD 13. (CHANGE TO 6 ZEROS). IF PATIENT WAS DISCHARGED ON DATE ENTERED IN BLOCK 22B, STATUS CANNOT BE 9 IN DISCHARGE CODE FIELD 14. CHANGE DISCHARGE CODE TO REFLECT DESTINATION.
WHEN USING REMARK CODE "N50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 047

CLAIM TYPE: DEVELOP-DISABILITY-REG REGION 90  OR  THE PROVIDER NUMBER IS BETWEEN '000035000' AND '000037999' BUT NOT '000035432' OR '000035434' OR '000035201'

DATE UPDATED: 02/18/2004

EDIT NAME: PROV NOT AUTHORIZED FOR AETS RECIP

EDIT DESCRIPTION: IF THE SERVICE DATES ARE CORRECT BUT THE PROVIDER NUMBER ON THE SB644010 FILE FOR THIS CLIENT IS INCORRECT THE PROGRAM MOVES A NUMBER TO THE SUB9 FIELD. IF THE SUB9 FIELD IS NOT = 0 THEN THE PROGRAM PROCESSES ERRORS BASED ON THE SERVICE CODES ON THE DETAILS.

IF THE PROVIDER IS ONE OF THE FOLLOWING 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233

IF THE DETAIL SERVICE CODE = 'T' AND DDR-SERV-PROV-18 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = '4' AND DDR-SERV-PROV-29 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = '5' AND DDR-SERV-PROV-30 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = 'E' AND DDR-SERV-PROV-05 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = 'L' AND DDR-SERV-PROV-10 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = 'M' AND DDR-SERV-PROV-11 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = 'N' AND DDR-SERV-PROV-12 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = 'S' AND DDR-SERV-PROV-17 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN
OR THE DETAIL SERVICE CODE = 'Q' AND DDR-SERV-PROV-15 (SUB9) NOT = PROVIDER NUMBER THE ERROR IS GIVEN

METHOD OF CORRECTION:

JOB: SB1J040  PROGRAM: SB1090
ERROR CODE: 048

CLAIM TYPE: DEVELOP-DISABILITY-REG REGION 90 OR THE PROVIDER NUMBER IS BETWEEN '000035000' AND '000037999' BUT NOT '000035432' OR '000035434' OR '000035201'

DATE UPDATED: 02/19/2004

EDIT NAME: PROV. AUTHORIZED FOR AETS RECIPIENT

EDIT DESCRIPTION: IF THE SERVICE DATES ARE CORRECT BUT THE PROVIDER NUMBER ON THE SB644010 FILE FOR THIS CLIENT IS INCORRECT THE PROGRAM MOVES A NUMBER TO THE SUB9 FIELD. IF THE SUB9 FIELD IS NOT = 0 THEN THE PROGRAM PROCESSES ERRORS BASED ON THE SERVICE CODES ON THE DETAILS.

IF THE DETAIL SERVICE CODE = 'T' AND
(DVR-SERV-PROV-18 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN

IF THE DETAIL SERVICE CODE = '4' AND
(DVR-SERV-PROV-29 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN

IF THE DETAIL SERVICE CODE = '5' AND
(DVR-SERV-PROV-30 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN

IF THE DETAIL SERVICE CODE = 'E' AND
(DVR-SERV-PROV-05 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN

IF THE DETAIL SERVICE CODE = 'L' AND
(DVR-SERV-PROV-10 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN

IF THE DETAIL SERVICE CODE = 'M' AND
(DVR-SERV-PROV-11 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR 37078 OR 37097 OR 37108 OR 37126 OR 37135 OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR 37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN
THE ERROR IS GIVEN
IF THE DETAIL SERVICE CODE = 'N' AND
(DDR-SERV-PROV-12 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR
37078 OR 37097 OR 37108 OR 37126 OR 37135
OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR
37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN
IF THE DETAIL SERVICE CODE = 'S' AND
(DDR-SERV-PROV-17 (SUB9) = 37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR
37078 OR 37097 OR 37108 OR 37126 OR 37135
OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR
37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN
IF THE DETAIL SERVICE CODE = 'Q' AND
(DDR-SERV-PROV-15 (SUB9) =  37003 OR 37004 OR 37010 OR 37011 OR 37033 OR 37043 OR 37051 OR 37068 OR 37072 OR
37078 OR 37097 OR 37108 OR 37126 OR 37135
OR 37138 OR 37145 OR 37154 OR 37162 OR 37165 OR 37172 OR 37173 OR 37180 OR 37190 OR 37196 OR 37201 OR 37203 OR
37204 OR 37227 OR 37231 OR 37233
THE ERROR IS GIVEN

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N30" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J040
PROGRAM: SB1090

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ERROR CODE: 049

CLAIM TYPE: REGION 90 CLAIMS

DATE UPDATED: 02/19/2004

EDIT NAME: DAY SUPPORT EXCEEDS MAX OF 184 UNITS

EDIT DESCRIPTION:
THE FIRST CHECK IS FOR A SINGLE OR SPLIT CLAIM THAT EXCEEDS 184 UNITS OF SERVICE
IF THE DETAIL SERVICE CODE = 'N' AND THE FIRST DATE OF SERVICE < 20001001
    OR THE FIRST DATE OF SERVICE > 20010630
ADD DETAIL UNITS OF SERVICE TO WK-N-UNT
IF WK-N-UNT > 184
GIVE THIS ERROR

THE SECOND CHECK IS FOR CREATING HISTORY OF THE PRESENT CLAIM OR SPLIT CLAIMS
IF THE DETAIL SERVICE CODE = 'N' AND THE FIRST DATE OF SERVICE < 20001001
    OR THE FIRST DATE OF SERVICE > 20010630
ADD THE UNITS OF SERVICE FOR THIS CLIENT TO THE HISTORY NEW CLAIM TABLE IF THE COMBINATION OF
SAVED HISTORY UNITS ARE LESS THAN 184.
IF THE TOTAL IS > 184
THE ERROR IS GIVEN

THE FINAL CHECK ADDS IN THE HISTORY FROM PREVIOUS RECORDS TO CHECK FOR A TOTAL OF HISTORY WITH
THE PRESENT CLAIM.
IF THE HISTORY UNITS + NEW CLAIM UNITS > 184
    AND FIRST DAY OF SERVICE < 20001001 OR THE FIRST DAY OF SERVICE > 20010630
TOTAL ALL THE UNITS FOR ALL FOR THE NEW CLAIMS AND HISTORY
IF THE TOTAL NEW CLAIM UNITS PLUS THE HISTORY UNITS > 184
    AND FIRST DAY OF SERVICE > 20000930 AND
    FIRST DAY OF SERVICE < 20010701
GIVE THE ERROR

METHOD OF CORRECTION:

JOB: SB1J075                      PROGRAM: SB1250

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ERROR CODE:

CLAIM TYPE: ALL PAYABLE CLAIMS EXCEPT SCREENING CLAIMS

DATE UPDATED: 02/19/2004

EDIT NAME: INV CLAIM TYPE FOR SPED RECIP

EDIT DESCRIPTION: IF THE RECIPIENT LEGAL COUNTY = 56 OR 55 AND REGION NOT = '94' THEN
IF THE REGION IS NOT = 40 OR THIS IS AN ADJUSTMENT CLAIM THE ERROR WILL BE GIVEN
IF THE REGION = 40 AND NOT AN ADJUSTMENT CLAIM
THE EOB ' 125' WILL BE MOVED TO THE HEADER RELEASE CODE
THE EOB ' N34' WILL BE MOVED TO THE FIRST DETAIL RELEASE CODE
THE CLAIM WILL DENY AT THE HEADER LEVEL WITH A 'D' IN THE CLAIM STATUS CODE
MOVE 0 TO DETAIL PAID AMOUNT (1) AND ALLOWED CHARGE (1)
MOVE '8' TO PRICING INDICATOR (1)

METHOD OF CORRECTION:
WORKSHEET SHOULD BE RECEIVED THAT WILL SHOW AN ICN WHICH IS CAUSING THE 050 ERROR.
WHEN USING REMARK CODE "N34" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 051

CLAIM TYPE: INPATIENT CLAIM

DATE UPDATED: 02/19/2004

EDIT NAME: TOTAL DAYS CERTIFIED ARE INV

EDIT DESCRIPTION: IF THE PROVIDER LOCATION CODE NOT 90 THRU 99
AND THE TOTAL DAYS CERTIFIED = ZEROS
THEN THIS ERROR IS GIVEN

METHOD OF CORRECTION:
VERIFY TOTAL DAYS CERTIFIED AND TOTAL DAYS BILLED HAVE BEEN TRANSCRIBED PROPERLY. IF NOT, ENTER CORRECT NUMBER(S) AND PROCESS CLAIM. IF TOTAL DAYS CERTIFIED MISSING, NON-NUMERIC OR IS LESS THAN TOTAL DAYS BILLED, RETURN CLAIM TO PROV WITH EOB CODE 100 AND ATTACH 345 FORM (CHECK 36 IF PSRO CERTIFICATION IS MISSING ALTOGETHER). IF DAYS BILLED ARE MORE THAN DAYS CERTIFIED, WRITE THIS UNDER 'OTHER OR COMMENTS' OR FORM 345.

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 054

CLAIM TYPE: INSTITUTIONAL CLAIM OR UB82 INSTITUTIONAL CLAIM
OR UB82 HOME HEALTH WITH BILL TYPE = '711' AND
THAT IS FOUND ON THE PROVIDER VSAM FILE WITH CURR-OPT-REIMBERSMENT RATE > 0

DATE UPDATED: 02/20/2004

EDIT NAME: STMT FROM DATE LATER THAN THRU

EDIT DESCRIPTION:
IF BILL TO DATE LESS THAN BILL FROM DATE
THIS ERROR IS GIVEN

METHOD OF CORRECTION:
VERIFY THAT STMT COVERS PERIOD 'FROM' AND 'THROUGH' DATE WERE TRANSCRIBED CORRECTLY. IF NOT,
CORRECT AND PROCESS CLAIM. OTHERWISE, RETURN THE CLAIM
TO THE PROV WITH EOB "M58" AND "16" IN FIELD 6.
WHEN USING REMARK CODE "MA31" YOU MUST ENTER CLAIM ADJUSTMENT REASON
"125" IN FIELD 6.

JOB: SB1J020                      PROGRAM: SB1070
ERROR CODE: 056

CLAIM TYPE: INPATIENT CLAIMS, OUTPATIENT CLAIMS, UB82 INPATIENT CLAIMS, UB82 OUTPATIENT CLAIMS, UB82 HOME HEALTH, AND NURSING HOME CLAIMS

A. INSTITUTIONAL CLAIM OR UB82 INSTITUTIONAL CLAIMS OR (UB82 HOME HEALTH WITH BILL TYPE = '711' AND THAT IS FOUND ON THE PROVIDER VSAM FILE WITH CURR-OPT-REIMBRSMENT RATE > 0)
B. CLAIM TYPE: INPATIENT CLAIMS

DATE UPDATED: 02/20/2004

EDIT NAME: ACCOM/ANCIL MISS OR INVALID

A. EDIT DESCRIPTION: FOR NURSING HOME CLAIMS:
   IF PROVIDER NUMBER BETWEEN '000030699' AND '000030800'
   AND THE DETAIL SERVICE CODE NOT = '1' AND NOT = '2' AND NOT = '3' AND NOT = '4'
   THEN THE ERROR WILL BE GIVEN IF THE CLAIM IS NOT A REGION 40 OR THIS IS AN ADJUSTMENT

   FOR OTHER CLAIMS QUALIFIED IF THE DETAIL SERVICE CODE IS NOT AN ‘H’ OR NOT J THRU Z, THEN THE ERROR WILL BE GIVEN IF THE CLAIM IS NOT A REGION 40 OR THIS IS AN ADJUSTMENT

   IF THE CLAIM IS A REGION 40 AND NOT AN ADJUSTMENT ‘ 125’ WILL BE MOVED TO THE HEADER EOB AND ‘ M50’ WILL BE MOVED TO THE DETAIL EOB
   THEN 0 WILL BE MOVED TO THE DETAIL PAID AMOUNT AND THE DETAIL ALLOWED CHARGE ‘8’ WILL BE MOVED TO THE DETAIL PRICING INDICATOR

B. EDIT DESCRIPTION:

   FOR INPATIENT CLAIMS THAT ARE NOT REGION 70 OR 90 AND THEIR ANCILLARY CODES ARE ONE OF THE FOLLOWING (‘A’ ‘B’ ‘C’ ‘E’ ‘G’). THEN A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY CODE) IS ON THE ACC-ANL-ENTRY TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN


   FOR INPATIENT CLAIMS THAT ARE NOT REGION 70 OR 90 AND THEIR ANCILLARY CODES ARE OTHER THAN (‘A’ ‘B’ ‘C’ ‘E’ ‘G’). AND THE ANCILLARY CODE ARE = ‘H’ OR = ‘J’ THRU ‘Z’ THEN A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY CODE) IS ON THE ACC-ANL-ENTRY TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

   FOR UB82 INPATIENT CLAIMS THAT ARE NOT REGION 70 AND THEIR REVENUE CODES ARE NOT BETWEEN 100 AND 999 THEN THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

   FOR UB82 INPATIENT CLAIMS THAT ARE NOT REGION 70 AND THEIR REVENUE CODES ARE BETWEEN 100 AND 219 OR BETWEEN 230 AND 239 THEN IF THE DRUG PRICING INDICATOR IS NOT A ‘Y’ THEN A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY CODE) IS ON THE ACC-ANL-ENTRY TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

   FOR UB82 INPATIENT CLAIMS THAT ARE NOT REGION 70 AND THEIR REVENUE CODES ARE NOT BETWEEN 100 AND
219 AND NOT BETWEEN 230 AND 239 BUT THEIR REVENUE CODES ARE BETWEEN 220 AND 229 OR BETWEEN 240 AND 999 THEN A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY CODE) IS ON THE ACC-ANL-ENTRY TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR UB82 OUTPATIENT CLAIMS OR UB82 HOME HEALTH CLAIMS THAT DON’T HAVE A ‘C’ IN THE REVENUE CODE FIELD R1RV-ALLOW-OUTP-CLAIM IN THE PRICING FILE AND THE REVENUE CODES ARE NOT BETWEEN 220 AND 229 AND NOT BETWEEN 240 AND 999 THEN THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR UB82 OUTPATIENT CLAIMS OR UB82 HOME HEALTH CLAIMS THAT DON’T HAVE A ‘C’ IN THE REVENUE CODE FIELD R1RV-ALLOW-OUTP-CLAIM IN THE PRICING FILE AND THE REVENUE CODES ARE BETWEEN 220 AND 229 OR ARE BETWEEN 240 AND 999 THEN A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY CODE) IS ON THE ACC-ANL-ENTRY TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR OUTPATIENT CLAIMS OTHER THAN THOSE WITH ANCILLARY CODE ‘O’ AND DETAIL SUBMITTED CHARGE GREATER THAN ZERO. THEN IF THE ANCILLARY CODE NOT = ‘H’ AND NOT = ‘I’ THRU ‘Z’ AND THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR OUTPATIENT CLAIMS OTHER THAN THOSE WITH ANCILLARY CODE ‘O’ AND DETAIL SUBMITTED CHARGE GREATER THAN ZERO. THEN IF THE ANCILLARY CODE IS = ‘H’ AND NOT = ‘I’ THRU ‘Z’ THEN A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY CODE) IS ON THE ACC-ANL-ENTRY TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR NURSING HOME CLAIMS THAT HAVE A DETAIL SERVICE CODE (NURSING ACCOMODATION VALUES) 1 THRU 9 OR G THRU H OR J THRU N OR Q THRU Y OR HAVE A DETAIL SERVICE CODE (OS-NURSING-ANCILLARY) ‘J’ ‘K’ ‘L’ ‘Z’. AND ARE NOT JAMESTOWN MENTAL HOSPITAL PROVIDER NUMBER 001086 AND ARE NOT AN OUT OF STATE PROVIDER, PROVIDER LOCATION NUMBER 90 THRU 99 AND ARE NOT (IS-NURSING-ACCOM) SERVICE CODE VALUES 1 THRU 9 OR “G” OR “H” OR “J” OR “N” OR Q THRU Y THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE DETAIL SERVICE CODE ARE EQUAL TO (STATE-HOSP-ACCOM) VALUES ‘3 THRU 6’ OR ‘A THRU C’ OR ‘E’ THEN
A TEST IS DONE TO SEE IF THE CLAIM DETAIL SERVICE CODE (ANCILLARY SERVICE) IS ON THE ACC-ANL-ENTRY
TABLE IF IT IS NOT FOUND THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE
GIVEN FOR NURSING HOME CLAIMS THAT HAVE A DETAIL SERVICE CODE OF ‘A THRU F’ OR ‘I’ OR ‘O’ OR ‘P’ OR
ARE THE JAMESTOWN HOSPITAL PROVIDER NUMBER 001086 THEN IF THE PROVIDER NUMBER IS ONE OF THE
FOLLOWING ‘001086’ OR ‘002435’ OR ‘050383’ OR ‘017553’
IF THE DETAIL SERVICE CODE NOT EQUAL TO (STATE-HOSP-ACCOM) VALUES ‘3 THRU 6’ OR ‘A THRU C’ OR ‘E’ THEN
IF THE CLAIM IS NOT A REGION 40 OR IT IS AN ADJUSTMENT THE ERROR WILL BE GIVEN
FOR NURSING HOME CLAIMS THAT HAVE A DETAIL SERVICE CODE OF ‘A THRU F’ OR ‘I’ OR ‘O’ OR ‘P’ OR ARE THE
JAMESTOWN HOSPITAL PROVIDER NUMBER 001086 THEN IF THE PROVIDER NUMBER IS NOT ONE OF THE
FOLLOWING ‘001086’ OR ‘002435’ OR ‘050383’ OR ‘017553’ THEN IF THE CLAIM IS NOT A REGION 40 OR IT IS AN
ADJUSTMENT THE ERROR WILL BE GIVEN IF THE REGION = 40 AND THIS IS NOT AN ADJUSTMENT ‘125’ WILL BE
MOVED TO THE HEADER EOB AND ‘M50’ TO THE DETAIL EOB 0 WILL BE MOVED TO THE DETAIL PAID AMOUNT
AND THE DETAIL ALLOWED CHARGE,’8’ TO WILL BE MOVED TO THE DETAIL PRICING INDICATOR

METHOD OF CORRECTION:
VERIFY THAT ACCOM/ANC CODES HAVE BEEN TRANSCRIBED CORRECTLY AND THAT
NONE HAVE BEEN MISSED. ENTER CORRECT CODE.
WHEN USING REMARK CODE "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON
"125" IN FIELD 6.
FIELD NUMBER:                                                                                      ERROR CODE:  058
CLAIM TYPE: INSTITUTIONAL CLAIMS OR UB82 INSTITUTIONAL CLAIMS
OR (UB82 HOME HEALTH CLAIMS WITH BILL-TYPE = '711' AND ARE FOUND ON THE PROVIDER FILE WITH PROV-
CURR-OPT-REIMBURSMENT RATE GREATER THAN 0)

DATE UPDATED: 02/25/2004

EDIT NAME: UNITS OF SERVICE ARE INVALID

EDIT DESCRIPTION: IF THE DETAIL UNITS OF SERVICE = ZEROS THE ERROR IS GIVEN

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 060

CLAIM TYPE: INSTITUTIONAL CLAIMS OR UB82 INSTITUTIONAL CLAIMS
   A. OR (UB82 HOME HEALTH CLAIMS WITH BILL-TYPE = '711' AND ARE FOUND ON THE PROVIDER FILE WITH
      PROV-CURR-OPT-REIMBURSMENT RATE GREATER THAN 0)
   B. DRUG CLAIMS

DATE UPDATED: 02/25/2004

EDIT NAME:

   A. EDIT DESCRIPTION: IF THE DETAIL SUBMITTED CHARGE = ZEROS THEN IF THE REGION IS NOT = 40 OR
      THIS IS AN ADJUSTMENT CLAIM THE ERROR WILL BE GIVEN
      IF THE REGION = 40 AND NOT AN ADJUSTMENT
      MOVE ' 125' TO THE HEADER EOB AND MOVE ' M79' TO THE DETAIL EOB
      MOVE 0 TO THE DETAIL PAID AMOUNT AND DETAIL ALLOWED CHARGE
      MOVE '8' TO THE DETAIL PRICING INDICATOR
   B. EDIT DESCRIPTION: IF DETAIL DRUG CLAIM-LDG-TOT = ZERO THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:

   A. JOB: SB1J020                 PROGRAM: SB1070
   B. JOB: CICS POS SYSTEM         PROGRAM: SB710022

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ERROR CODE: 061

CLAIM TYPE: NURSING HOME CLAIMS, CROSSOVER CLAIMS, AND PROFESSIONAL CLAIMS THAT ARE NOT (UB82 HOME HEALTH WITH BILL-TYPE = '711' THAT ARE FOUND ON THE PROVIDER FILE WITH PROVIDER-CURR-OPT-REIMBURSMENT RATE GREATER THAN 0 AND UB82 HOME HEALTH CLAIMS WITH BILL TYPE = 711

DATE UPDATED: 02/25/2004

EDIT NAME: PROC/REV DOS MISSING OR INVALID

EDIT DESCRIPTION:
IF A NURSING HOME CLAIMS AND REGION 20 OR 21 AND THE PROVIDER NUMBER IS NOT = '001086' AND NOT = '002435' AND NOT = '050383') IF THE DETAIL LAST PROCEDURE SERVICE DATE IS NOT NUMERIC OR THE MONTH LESS THAN 1 OR GREATER THAN 12 OR THE DAY IS LESS THAN 1 OR GREATER THAN 31 THEN IF THE REGION IS NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR PROFESSIONAL OR CROSSOVER AS STATED ABOVE IF THE DETAIL FIRST PROCEDURE SERVICE DATE = ZEROS IF THE REGION IS NOT 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

FOR PROFESSIONAL OR CROSSOVER AS STATED ABOVE IF THE DETAIL FIRST SERVICE DATE FORMATED IMPROPERLY IF THE REGION IS NOT 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF UB82-HOME-HEALTH AND TYPE-OF-BILL = '711' IF THE HEADER BILL FROM DATE = HEADER BILL TO DATE THEN IF THE DETAIL FIRST PROCEDURE SERVICE DATE IS GREATER THAN OR LESS THAN THE HEADER BILL FROM DATE OR THE DETAIL LAST PROCEDURE SERVICE DATE IS LESS THAN OR GREATER THAN THE HEADER BILL TO DATE AND THE DETAIL PRICING CODE IS NOT = 8 THEN IF THE REGION NOT = 40 OR THIS IS AN ADJUSTMENT THE ERROR WILL BE GIVEN

IF THE REGION = 40 AND THIS IS NOT AN ADJUSTMENT ' 125' WILL BE MOVED TO THE HEADER EOB AND ' MA06' WILL BE MOVED TO THE DETAIL EOB THEN 0 WILL BE MOVED TO THE DETAIL PAID AMOUNT AND THE DETAIL ALLOWED CHARGE THEN 8 WILL BE MOVED TO THE DETAIL PRICING INDICATOR

METHOD OF CORRECTION: PROCEDURE DATES OF SERVICE ARE PRESENT, NUMERIC, AND CONTAIN NO SPACES. IF MISSING OR INVALID, RETURN THE CLAIM TO PROV WITH EOB "M58" AND "16" IN FIELD 6. HCBS DENY SPECIFIC LINE WITH "M67". YOU MAY ALSO USE "MA06" OR "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USTIN REMARK CODE "M67", "MA06" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT "125" IN FIELD 6.

JOB: SB1J020                       PROGRAM: SB1070

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ERROR CODE: 063

CLAIM TYPE: NURSING HOME CLAIMS

DATE UPDATED: 02/26/2004

EDIT NAME: LAST PROC SERVICE DATE INVALID

EDIT DESCRIPTION:
IF THIS IS A NURSING HOME CLAIM AND REGION = 20 OR = 21 AND THE VR PROVIDER NUMBER NOT = '001086' AND NOT = '002435' AND NOT = '050383' IF THE HEADER LAST PROCEDURE SERVICE DATE NOT EQUAL THE DETAIL LAST PROCEDURE SERVICE DATE AND THE DETAIL SERVICE CODE = 'I' OR '2' OR '3' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y' THEN THE ERROR IS GIVEN

IF THIS IS A NURSING HOME CLAIM AND REGION = 20 OR = 21 AND THE VR PROVIDER NUMBER NOT = '001086' AND NOT = '002435' AND NOT = '050383' IF THE DETAIL FIRST PROCEDURE SERVICE DATE NOT NUMERIC OR THE MONTHS '01' TO '12' OR DAYS '01' TO '31' ARE INCORRECT THEN IF THE CLAIM REGION NOT = 40 OR IS AN ADJUSTMENT THE ERROR IS GIVEN

IF THE REGION IS 40 AND THIS IS NOT AN ADJUSTMENT '125' WILL BE MOVED TO THE HEADER EOB AND 'MA31' WILL BE MOVED TO THE DETAIL EOB 0 WILL BE MOVED TO THE DETAIL PAID AMOUNT AND DETAIL ALLOWED CHARGE 8 WILL BE MOVED TO THE DETAIL PRICING INDICATOR

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M67" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
FIELD NUMBER:                                                                                      ERROR CODE: 064
FLAG:                                                                                                         FIELD LENGTH:
OVERRIDE:                                                                                               CLEAR MECHANISM:
DATA CORRECTABLE:

CLAIM TYPE: NURSING HOME CLAIM

DATE UPDATED: 02/26/2004

EDIT NAME: 1ST PROC DATE LATER THAN LAST

EDIT DESCRIPTION:
IF THIS IS A NURSING HOME CLAIM AND REGION = 20 OR = 21 AND THE VR PROVIDER NUMBER NOT = '001086' AND NOT = '002435' AND NOT = '050383' THEN IF THE DETAIL FIRST PROCEDURE SERVICE DATE IS GREATER THAN THE DETAIL LAST PROCEDURE SERVICE DATE THE ERROR IS GIVEN

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M67" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020                                              PROGRAM: SB1070
ERROR CODE: 065

CLAIM TYPE: CROSSOVER CLAIMS AND (PROFESSIONAL CLAIMS THAT ARE NOT
UB82 HOME HEALTH CLAIMS THAT HAVE A BILL TYPE = '711' AND ARE FOUND ON THE PROVIDER FILE WITH A
PROV-CURR-OPT-REIMBURSMENT RATE GREATER THAN 0

DATE UPDATED: 02/26/2004

EDIT NAME: PLACE OF SERVICE MISS OR INV

EDIT DESCRIPTION: IF THE PLACE OF SERVICE IS NOT 1 THRU 8 OR AN ‘A’ AND THE PROVIDER NUMBER NOT
BETWEEN '000059000' AND '000059999' THEN THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:
CHECK ORIGINAL CLAIM FORM AND COMPARE IT TO WORKSHEET. IF A VALID PLACE OF SERVICE HAS NOT BEEN
ENTERED ON CLAIM, DETERMINE FROM PROCED OR FROM ATTACHMENTS WHERE SERVICES WERE PERFORMED.
ENTER THIS CODE ON WORKSHEET. IF UNABLE TO LOCATE PLACE OF SVCE FROM CLAIM, RETURN CLAIM TO PROV
WITH EOB "M58" AND "16" IN FIELD 6. YOU MAY ALSO USE "58" IN PLACE OF "5" (MOST APPROPRIATE)

JOB: SBIJ020 PROGRAM: SB1070
ERROR CODE: 067

A. CLAIM TYPE: PAYABLE CLAIMS

B. CLAIM TYPE: CROSSOVER CLAIMS AND (PROFESSIONAL CLAIMS THAT ARE NOT

((UB82 HOME HEALTH CLAIMS WITH BILL-TYPE = '711 THAT ARE FOUND ON THE PROVIDER FILE WITH
PROV-CURR-OPT-REBURSMENT RATE GREATER THAN 0) OR HAVE REVENUE CODE 983)

DATE UPDATED:

EDIT NAME: PROCEDURE CODE MISS OR INVALID

PROCEDURE CODE IS IN AN UNACCEPTABLE FORMAT, OR IS MISSING ALL TOGETHER (SURG PROC CODE EXP)

A. EDIT DESCRIPTION:

IF TECS ELIGIBLE OR QMB ELIGIBLE OR THE DATES OF ELIGIBILITY FOR TECS OR QMB ARE NOT VALID
THEN IF THE RECIPIENT LEGAL COUNTY = 56 OR 55 AND THE REGION IS 94 AND THE PROCEDURE CODES 00098,
00096, 00050, 00051, 00052, 00053, 00054, 00055, 00092, 00061, 00060, 00059 ARE FOUND THEN THE ERROR WILL BE
GIVEN

OR IF THE PROVIDER IS NOT IN THESE RANGES 32000 THRU 34999 AND 38800 THRU 39999 AND THE
PROCEDURE CODE IS T1019 OR T1020 THE ERROR IS GIVEN

B. EDIT DESCRIPTION

IF THE PROV-NO = '000054631' OR = '000054635' THEN THE PCLIST 0255 (VALUES 05000) IS CHECKED IF A
MATCH IS NOT FOUND THEN THE ERROR IS GIVEN

OR IF THE PROCEDURE CODE MODIFIER OR EXTRA MODIFIERS (1 THRU 3) = '80' OR '81' OR '82' OR '87' OR
'AS' AND THE TYPE-SERVICE CODE = '8' AND THE PRICING RECORD WAS FOUND ON SB450010 PRICING FILE THE
CLAIM IS ATTEMPTED TO BE PRICED, THEN IF THE RANDOM PRICE READER FAILS TO PRICE THE CLAIM BY
GETTING A BAD PRICE RETURN CODE OF 'N' OR THIS CLAIM IS NOT A REVENUE CODE 983 CLAIM THEN THE ERROR
IS GIVEN

OR IF THE RANDOM PRICE READER RETURNS A BAD PRICE RETURN CODE VALUE 'N' OR (LVL3-PROC-
STAT = 1 AND CLMT-LST-DA-OF-SERV NOT > WORK-LEVEL3-DATE-N)) AND NOT A 983 REVENUE CODE THEN IF ANY
OR ALL OF THE FOLLOWING ARE FALSE PRICING-LEVEL3 = '3' OR TYPE-SERVICE CODE = 'S' OR THE MODIFIER OR
EXTRA MODIFIERS = '97' OR 'SG' THE ERROR WILL BE GIVEN

OR IF THE RANDOM PRICE READER RETURNS A GOOD PRICE RETURN CODE VALUE 'Y' AND NOT (LVL3-
PROC-STAT = 1 AND CLMT-LST-DA-OF-SERV NOT > WORK-LEVEL3-DATE-N)) OR THIS IS A 983 REVENUE CODE THEN
IF THIS IS AN INACTIVE PROCEDURE CODE FOR LEVEL 3 PRICING AND THE DATE THE PROCEDURE CODE BECAME
INACTIVE IS LESS THAN THE DETAIL LAST PROCEDURE SERVICE DATE ON THE CLAIM THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:

COMMENTS: VERIFY PROCED CODE HAVE BEEN TRANSCRIBED CORRECTLY AND THAT NONE HAVE BEEN MISSED.
IF NARRATIVE DESCR IS PRESENT ON CLAIM, REFER TO PROPER CONSULTANT FOR 5 DIGIT CODE. CODE SHOULD BE
ENTERED WITH ON DIGIT TOS CODE FOLLOWED BY PROCED CODE AND THE TWO DIGIT MODIFIER WHEN
APPLICABLE.

A. JOB: SB1J040                  PROGRAM: SB1090
B. JOB: SB1J050                  PROGRAM: SB1130
ERROR CODE: 069

A. CLAIM TYPE: DRUG CLAIMS
B. CLAIM TYPE: DRUG CLAIMS

DATE UPDATED: 02/26/2004

EDIT NAME: NDC CODE MISSING OR INVALID

NDC CODE IS NOT ENTERED, IS NON-NUMERIC OR IS INVALID IN LENGTH.

A. EDIT DESCRIPTION: IF THE DRUG CODE IS ZEROS OR SPACES THE ERROR IS GIVEN
B. EDIT DESCRIPTION: IF THE DRUG CODE (1:11) = ZERO OR SPACES THE ERROR WILL BE GIVEN

OR IF THE DRUG CODE IS NOT FOUND ON THE SB751201 FILE WITH THE KEY BEING THE DRUG CODE AND RECORD CODE OF ‘53’ THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY THAT CORRECT DATA WAS TRANSCRIBED. VERIFY THAT NDC CODE HAS BEEN ENTERED. IF ENTERED CORRECTLY, DENY LINE WITH EOB 047 UNLESS THAT CLAIM HAS ONLY ONE LINE; IN THAT CASE RTP WITH 345 FORM FOR CORRECTION. EXCEPTION-IF PROV HAS INDICATED HE CAN'T FIND A CODE AND NEEDS ASST REFER TO PHARMACY CONSULTANT

A. JOB: CICS POS SYSTEM PROGRAM: SB710022
B. JOB: CICS POS SYSTEM PROGRAM: SB710023

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ERROR CODE: 070

CLAIM TYPE: DRUG CLAIM (POS SYSTEM)

DATE UPDATED: 02/26/2004

EDIT NAME: QUANTITY DISPENSED MISS OR INV

SET IF NON-NUMERIC OR FIELD IS BLANK

EDIT DESCRIPTION:
IF QUANTITY DISPENSED = ZERO AND REASON CODE NOT = ('1' AND '2' AND '3' AND '4' AND '5' AND '6' AND '7' AND '8' AND '9') THEN IF COMPOUND CODE NOT = '2' THE ERROR WILL BE GIVEN

OR

IF DISPENCE STATUS = ('P' OR 'C') AND QUANTITY INTEND DISPENSED = ZEROS THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY QUANTITY HAS BEEN TRANSCRIBED CORRECTLY. IF NOT, CORRECT AND PROCESS THE CLAIM. OTHERWISE, EXAMINE CLAIM AND ATTEMPT TO DETERMINE APPROPRIATE QUANTITY WITH SHOULD BE ENTERED. THE QUANTITY MUST BE NUMERIC. IF PROVIDER BILLS IN OUNCES BOTH FOR WEIGHT AND VOLUME-CHANGE TO METRIC USING THE CONVERSION FACTOR OF '30' TO MILLILITERS OR GRAMS.

WHEN USING REMARK CODE "53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: CICS POS SYSTEM PROGRAM: SB710022
ERROR CODE: 071

CLAIM TYPE: CLMT-DEVELP-DISABILITY-REG OR CLAIMS WITH PROVIDER NUMBERS BETWEEN '000035000' AND '000037999' BUT NOT PROVIDER NUMBERS '000035432', '000035434', '000035435'

DATE UPDATED: 02/26/2004

EDIT NAME: PWA OR ES NOT MA AND/OR HCBS

EDIT DESCRIPTION:

IF THE RECIPIENT IS ON THE SB644010 FILE USING THE RECIPIENT BASE ID OR THE TECS ID AND RECORD CODE 1 AS THE KEY THEN IF THE FIRST DAY OF SERVICE LESS THAN 19991101 IF TECS ELIGIBLE AND THE FIRST TWO DIGITS OF THE CASE NUMBER ARE GREATER THAN '54' THEN IF DETAIL SERVICE CODE = 'E' OR EQUALS 'M' THEN THE ERROR IS GIVEN


37003 OR 37004 OR 37010 OR 37011
OR 37033 OR 37043 OR 37051 OR 37068 OR 37072
OR 37078 OR 37097 OR 37108 OR 37126 OR 37135
OR 37138 OR 37145 OR 37154 OR 37162 OR 37165
OR 37172 OR 37173 OR 37180 OR 37190 OR 37196
OR 37201 OR 37203 OR 37204 OR 37227 OR 37231
OR 37233

THE ERROR IS GIVEN


37003 OR 37004 OR 37010 OR 37011
OR 37033 OR 37043 OR 37051 OR 37068 OR 37072
OR 37078 OR 37097 OR 37108 OR 37126 OR 37135
OR 37138 OR 37145 OR 37154 OR 37162 OR 37165
OR 37172 OR 37173 OR 37180 OR 37190 OR 37196
OR 37201 OR 37203 OR 37204 OR 37227 OR 37231
OR 37233

THE ERROR IS GIVEN


37003 OR 37004 OR 37010 OR 37011
OR 37033 OR 37043 OR 37051 OR 37068 OR 37072
OR 37078 OR 37097 OR 37108 OR 37126 OR 37135
OR 37138 OR 37145 OR 37154 OR 37162 OR 37165
OR 37172 OR 37173 OR 37180 OR 37190 OR 37196
OR 37201 OR 37203 OR 37204 OR 37227 OR 37231
OR 37233
THE ERROR IS GIVEN

METHOD OF CORRECTION:

COMMENTS:

JOB: SB1J040                      PROGRAM: SB1090

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ERROR CODE: 072

CLAIM TYPE: DRUG CLAIMS

DATE UPDATED: 02/27/2004

EDIT NAME: DATE DISPENSED MISS OR INVALID

DATE IS NON-NUMERIC, INVALID LENGTH OR IS MISSING

EDIT DESCRIPTION: THE DATE IS CHECKED BY CALLING PROGRAM SB710511 THIS PROGRAM CHECKS THE DATE TO SEE IF IT IS NUMERIC IF IT ISN'T NUMERIC THE ERROR WILL BE GIVEN IT THEN CHECKS TO INSURE THAT THE DATE IS FORMATTED PROPERLY IF THE DATE ISN'T FORMATTED PROPERLY THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:

COMMENTS: VERIFY BOTH DATE DISPENSED AND DATE PRESCRIBED TRANSCRIBED CORRECTLY. IF DATE DISPENSED IS MISSING OR INVALID FORMAT/LENGTH, RETURN TO PROV WITH EOB "58" IN "16" IN FIELD 6.

JOB: CICS POS SYSTEM

PROGRAM: SB710022
ERROR CODE: 073

CLAIM TYPE: DRUG CLAIMS

DATE UPDATED: 02/27/2004

EDIT NAME: DAYS SUPPLY MISS OR INVALID

DAYS SUPPLY MUST BE NUMERIC AND GREATER THAN ZERO.

EDIT DESCRIPTION:
IF THE DAYS SUPPLY = ZERO THE ERROR IS GIVEN

OR
IF THE DETAIL DISPENSE STATUS = ('P' OR 'C') AND
POSFI-DAYS-SUPP-INTEND-DISPEN= ZEROS THE RROR IS GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY THAT FIELD WAS CORRECTLY ENTERED. IF NOTHING WAS ENTERED IN THIS FIELD ON THE CLAIM, RETURN IT TO THE PROV WITH EOB "M58" AND "16" IN FIELD 6 ATTACH 631 CHECK 'OTHER' BOX AND EXPLAIN THE REASON FOR RETURNING THE CLAIM.

JOB: CICS POS SYSTEM               PROGRAM: SB710022

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ERROR CODE: 074

CLAIM TYPE: DRUG CLAIMS (POS SYSTEM)

DATE UPDATED: 02/27/2004

EDIT NAME: DATE PRESCRIBED MISS / INVALID

EDIT DESCRIPTION:
THE PROGRAM CALLS 'SQTODATE' USING VALIDATION-DATE D-FORMAT DATE-ERROR
IF DATE-ERROR NOT = ' ' OR POSFI-DT-PRSB (R-SUB) = ZEROS THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY PRESCR DATE ENTERED CORRECTLY. IF DATE MISSING OR CONTAINS INVALID CHARACTERS,
RETURN TO PROV WITH EOB "58" AND "16" IN FIELD 6, ATTACH 631

JOB: CICS POS SYSTEM               PROGRAM: SB710022
ERROR CODE: 076

A. CLAIM TYPE: NURSING HOME CLAIMS
B. CLAIM TYPE: PAYABLE CLAIM THAT IS REGION 21

DATE UPDATED: 02/27/2004

EDIT NAME: RECIP NOT RESID IN LTC FACILT

A. EDIT DESCRIPTION:
IF NURSING HOME CLAIM AND NOT PROVIDER NUMBERS '000001086' '000002435' '000050383' AND NOT QMB ELIGIBLE THEN CHECK ALL THE DETAIL SERVICE CODES IF NONE OF THE DETAIL SERVICE CODE = '6' IF PROVIDER TYPE CODE NOT = '15' OR '16'
THEN IF THE RECIPIENT LIVE ARRANGE NOT = '5' AND NOT = 'E' AND NOT = '8'
THE ERROR WILL BE GIVEN

B. EDIT DESCRIPTION:
IF THE CLAIM STATUS CODE = 'M' OR IS SPACES THEN CHECK THE SB681010 ADABASE TABLE WITH THE KEY =

MOVE ZEROES TO SB681010-TEMP-TECS-ID-N
MOVE CLMT-RECIP-CUR-PCN-N TO SB681010-TEMP-PCN
MOVE SB681010-TEMP-TECS-ID-N TO SB681010-KEY-TECS-ID
MOVE '1' TO SB681010-KEY-REC-CODE
MOVE ZEROES TO SB681010-KEY-PYMNT-MONTH

IF THE RECORD IS NOT FOUND THEN THE ERROR WILL BE GIVEN

IF THE CLAIM STATUS CODE = 'M' OR IS SPACES THEN CHECK THE SB681010 ADABASE TABLE WITH THE KEY =

MOVE ZEROES TO SB681010-TEMP-TECS-ID-N
MOVE CLMT-RECIP-CUR-PCN-N TO SB681010-TEMP-PCN
MOVE SB681010-TEMP-TECS-ID-N TO SB681010-KEY-TECS-ID
MOVE '1' TO SB681010-KEY-REC-CODE
MOVE ZEROES TO SB681010-KEY-PYMNT-MONTH

IF THE RECORD IS FOUND THEN CHECK THE DATA BY MOVING THE CLOSING-DATE TO SB681010-CLOSE-DATE-N
IF THIS DATE SB681010-CLOSE-YMD NOT = ZEROES OR
THE DATE SB681010-CLOSE-DATE-N IS LESS THAN THE FIRST DAY OF SERVICE
THE ERROR WILL THEN BE GIVEN

IF THE CLAIM STATUS CODE = 'M' OR IS SPACES THEN CHECK THE SB681010 ADABASE TABLE WITH THE KEY =

MOVE ZEROES TO SB681010-TEMP-TECS-ID-N

04/04/06
MOVE CLMT-RECIP-CUR-PCN-N TO SB681010-TEMP-PCN
MOVE SB681010-TEMP-TECS-ID-N TO SB681010-KEY-TECS-ID
MOVE '1' TO SB681010-KEY-REC-CODE
MOVE ZEROES TO SB681010-KEY-PYMNT-MONTH

IF THE RECORD IS FOUND THEN CHECK THE DATA BY MOVING THE
CLOSING-DATE TO SB681010-CLOSE-DATE-N
IF THIS DATE SB681010-CLOSE-YMD = ZEROES OR
THE DATE SB681010-CLOSE-DATE-N IS NOT LESS THAN THE FIRST DAY OF SERVICE
THEN THE ADABASE FILE IS CHECKED AGAIN USING THE DATE OBTAINED FROM THE FIRST READ SETTING
THE KEY AS FOLLOWS

MOVE '2' TO SB681010-KEY-REC-CODE
MOVE ZEROES TO SB681010-PYMNT-DATE-N
MOVE CLMT-1ST-DA-OF-SERV TO SB681010-PYMNT-DATE-N
MOVE SB681010-PYMNT-CYM-N TO SB681010-KEY-PYMNT-MONTH

IF THIS RECORD IS NOT FOUND THEN THE ERROR WILL BE GIVEN

METHOD OF CORRECTION:

A. JOB: SB1J040 PROGRAM: SB1090
B. JOB: SB1J077 PROGRAM: SB1275
ERROR CODE: 077

CLAIM TYPE: DRUG CLAIM (POS SYSTEM)

DATE UPDATED: 02/27/2004

EDIT NAME: REFILL NUMBER MISS OR INVALID

EDIT DESCRIPTION:
ALL THE DETAIL FILL NUMBERS ARE CHECKED
IF FILL-NUMBER NOT BETWEEN 0 AND 99 THE ERROR IS GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY REFILL INDICATOR WAS PROPERLY INPUT. IF REFILL INDICATOR EXCEEDS 0-5, DENY WITH EOB "B17" IF REFILL NUMBER IS MISSING, CHECK PRESC DATE AGAINST DATE OF SERVICE. IF THESE 2 DATES ARE THE SAME, ENTER '0' IN FIELD 55. IF DATES ARE NOT SAME, DENY THE LINE WITH EOB "B17"

JOB: CICS POS SYSTEM

PROGRAM: SB710022
ERROR CODE: 080

CLAIM TYPE: INSTITUTIONAL CLAIMS, UB82 INSTITUTIONAL CLAIMS
OR (UB82-HOME-HEALTH CLAIMS THAT HAVE BILL-TYPE = '711' AND ARE FOUND ON THE PROVIDER FILE AND
PROV-CURR-OPT-REIMBURSMENT RATE GREATER THAN 0)

DATE UPDATED: 02/27/2004

EDIT NAME: N'COV DTL & CLAIM AMT DISAGREE

EDIT DESCRIPTION:
FOR UB82 HOME HEALTH CLAIMS, UB82 INSTITUTIONAL CLAIMS, UB82 INPATIENT CLAIMS
AND UB82 OUTPATIENT CLAIMS
THE PROGRAM ADDS ALL THE DETAIL NONE COVERED CHARGE AMOUNTS INTO A TOTAL FIELD WK-NCOV-CHG IF
THE TOTAL DETAIL NONE COVERED CHARGES ARE NOT EQUAL TO THE TOTAL UB82 NON-COVERED CHARGES ON
THE HEADER THIS ERROR IS GIVEN

FOR INPATIENT CLAIMS, OUTPATIENT CLAIMS, AND NURSING HOME CLAIMS
THE PROGRAM ADDS ALL THE DETAIL NONE COVERED CHARGE AMOUNTS INTO A TOTAL FIELD WK-NCOV-CHG IF
THE TOTAL DETAIL NONE COVERED CHARGES ARE NOT EQUAL TO THE TOTAL NON-COVERED CHARGES ON THE
HEADER THIS ERROR IS GIVEN

METHOD OF CORRECTION:
COMMENTS: VERIFY INDIVID AND TOTAL NONCOVERED CHARGES AMTS ENTERED CORRECTLY. IF AMOUNTS
HAVE BEEN, EXAMINER HAS TWO OPTIONS: A. TOTAL ALL NONCOVERED CHARGES AND ENTER CORRECT TOTAL;
PROCESS REST OF CLAIM. B. DENY CLAIM WITH EOB "M58" AND "16" IN FIELD 6. ATTACH 631 WITH EXPLANATION
THAT COVERED CHARGES FO NOT CROSS TOTAL.
WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020                  PROGRAM: SB1070

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ERROR CODE: 081

A. CLAIM TYPE: Crossover claims and professional claims that are not UB82 home health claims that have a bill type = '711' and are found on the provider file with a prov-curr-opt-reimbursement rate greater than 0 and not revenue code 983

B. CLAIM TYPE: Drug claims (POS system)

DATE UPDATED: 02/27/2004

EDIT NAME: Pricing action code is invalid

A. EDIT DESCRIPTION:
If the detail pricing indicator is other than 0 thru 9 the error is given

B. EDIT DESCRIPTION:
If the detail drug-control-code not equal '0' or '3' or '7' or '8' then the error is given

METHOD OF CORRECTION:
Contact your supervisor. Maintenance completed on either of the above mentioned files must be checked and corrected if necessary. The claim must then be reprocessed after the correction has been made.

A. JOB: SB1J050 PROGRAM: SB1130

B. JOB: CICS POS SYSTEM PROGRAM: SB710023
ERROR CODE: 085

CLAIM TYPE: DRUG CLAIMS (POS SYSTEM)

DATE UPDATED: 03/02/2004

EDIT NAME: DATE DISP EARLIER DATE PRESCRIB

EDIT DESCRIPTION:
IF THE DETAIL DATE DISPENSED (1) IS LESS THAN THE DETAIL DATE PRESCRIBED THE ERROR IS GIVEN

METHOD OF CORRECTION:
VERIFY BOTH DATE DISPENSED AND DATE PRESCRIBED ENTERED CORRECTLY. IF DATE DISPENSED IS EARLIER THAN DATE PRESCRIBED, DENY THE CLAIM WITH EOB "B17"

JOB: CICS POS SYSTEM PROGRAM: SB710022
ERROR CODE: 087

CLAIM TYPE: INPATIENT CLAIMS

DATE UPDATED: 03/02/2004

EDIT NAME: N.H. CLASS/PROV MISS/CHANGED

EDIT DESCRIPTION:

OR
THE PROGRAM WILL READ SB651010 WITH THE KEY BEING THE CLIENT ORIGIONAL PCN AND THE CK-CLASS-1ST-DATE WHICH IS THE DETAIL IST PROCEDURE SERVICE DATE.

THEN
IF THE CLIENT ORIGIONAL PCN NOT = SSN OF SB651010 OR THE CLIENT ORIGIONAL PCN = SSN OF SB651010 AND CLASS-FROM-DATE OF SB651010 IS GREATER THAN THE DETAIL LAST PROCEDURE SERVICE DATE THE ERROR IS GIVEN

METHOD OF CORRECTION:
1. CHECK TO MAKE SURE THAT THE SSN ON TECS FOR THIS CLIENT MATCHES THE SSN ON SB651010 RCR FILE. IF THEY ARE DIFFERENT, THEN CHANGE THE RCR SSN TO MATCH TECS. IF THE PERSON IS NOT ON THE RCR FILE, FIND OUT WHY, ADD IT TO THE FILE AND RECYCLE THE CLAIM. DENY IF THIS CLAIM SHOULD NOT GET PAID.
2. CHECK THE RCR FILE AND COMPARE THE DATES TO THE DATES ON THE CLAIM. CORRECT THE DATES ACCORDINGLY ON THE CLAIM TO MATCH THE RCR FILE.
3. IF THE CLASSIFICATION CHANGED DURING ANY ONE OF THE DETAIL LINES TIME PERIOD, THEN THE CLAIM WILL HAVE TO BE SPLIT MANUALLY BY ADDING LINES TO THE CLAIM AND CHANGING THE TIME PERIOD TO MATCH THE RCR TIME PERIODS.
4. FIND OUT WHY THE BILLING PROVIDER IS NOT ON THE CASE MIX PROVIDER FILE (SB515010). IF IT SHOULD BE, ADD IT TO THE FILE AND RECYCLE THE CLAIM. IF THE BILLING PROVIDER IS INCORRECT, CHANGE IT TO THE CORRECT ONE OR DENY THE CLAIM.
5. COMPARE THE BILLING PROVIDER NUMBER WITH THE RCR'S PROVIDER NUMBER(S) FOR THE CLAIM SERVICE DATES. ONE OR MORE RCR RECORDS HAVE PROVIDER NUMBERS OTHER THAN THE BILLING PROVIDER NUMBER. EITHER DENY THE LINES NOT COVERED BY THIS PROVIDER OR DENY THE ENTIRE CLAIM.

JOB: SB1J050
PROGRAM: SB1130

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FIELD NUMBER:  ERROR CODE: 088

CLAIM TYPE: INPATIENT CLAIMS

DATE UPDATED: 03/03/2004

EDIT NAME: NO MDS CLASSIFICATION FOUND

EDIT DESCRIPTION:

METHOD OF CORRECTION:
AN MDS CLASSIFICATION WAS NOT FOUND FOR THE PERIOD BILLED. RECYCLE CLAIM FOR ONE WEEK, IF CLAIM STILL SUSPENDS CHECK FOR AN MDS CLASSIFICATION ON THURSDAY. IF CLASSIFICATION IS FOUND, RECYCLE CLAIM. IF MDS IS NOT FOUND, DENY CLAIM WITH EOB "B70"

JOB: SB1J050          PROGRAM: SB1130

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ERROR CODE: 090
CLAIM TYPE: CROSSOVER CLAIMS
DATE UPDATED: 03/03/2004

EDIT NAME: MED TOT ALL NOT IN BAL-HEADER

EDIT DESCRIPTION:

METHOD OF CORRECTION:
VERIFY ALL AMTS HAVE BEEN ENTERED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. OTHERWISE, ENTER CORRECT TOTAL USING DESCRIPTION ABOVE
WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070

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ERROR CODE: 091

CLAIM TYPE: CROSSOVER CLAIMS

DATE UPDATED:

EDIT NAME: MED TOT BILL NOT IN BALANCE


METHOD OF CORRECTION:
VERIFY ALL AMTS HAVE BEEN ENTERED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. OTHERWISE, ENTER CORRECT TOTAL USING DESC ABOVE
WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070

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ERROR CODE: 092

CLAIM TYPE: CROSSOVER CLAIMS

DATE UPDATED: 03/03/2004

EDIT NAME: MED TOT ALL NOT IN BAL-DETAIL

EDIT DESCRIPTION:
IF CROSSOVER RECORD TYPE NOT = 5 AND THE SUM OF CLMT-CSH-DED, CLMT-BLD-DED, CLMT-COIN-AMT, AND
CLMT-MCARE-PAID IS GREATER THAN CLMT-MCARE-COV-CHG THE ERROR IS GIVEN

METHOD OF CORRECTION:
VERIFY ALL AMTS ENTERED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM.
OTHERWISE, ENTER CORRECT TOTAL USING DESC ABOVE WHEN USING REMARK CODE "M54" YOU MUST ENTER
CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 093
CLAIM TYPE: CROSSOVER CLAIMS
DATE UPDATED: 03/03/2004

EDIT NAME: MED TOT BILL NOT IN BALANCE


METHOD OF CORRECTION:
VERIFY ALL AMTS ENTERED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. OTHERWISE, ENTER CORRECT TOTAL USING ABOVE DESC. WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 094

CLAIM TYPE: CROSSOVER CLAIMS

DATE UPDATED: 03/03/2004

EDIT NAME: NET CHARGE NOT IN BALANCE

EDIT DESCRIPTION: IF CROSSOVER RECORD TYPE NOT = 5 AND THE SUM OF
CLMT-COIN-AMT + CLMT-BLD-DED + CLMT-CSH-DED MINUS THE SUM OF
(CLMT-TOT-PATIENT-LIAB AND CLMT-TOT-OTHER-INS THEN IF THIS AMOUNT IS NOT EQUAL CLMT-NET-CLM-CHG
THE ERROR IS GIVEN

METHOD OF CORRECTION:
COMMENTS: YOU MAY ALSO USE "H9" IN PLACE OF "DU" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125"IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 096

CLAIM TYPE: PAYABLE CLAIMS

DATE UPDATED: 03/03/2004

EDIT NAME: PROV NOT AUTH FAMILY SUP RECIP

EDIT DESCRIPTION:
IF THIS IS A REGION 90 CLAIM OR THE PROVIDER NUMBER IS BETWEEN '000035000' AND '000037999' AND NOT PROVIDER NUMBERS '000035432' '000035434' OR '000035201'
THEN READ SB644010 USING THE KEY CLIENT BASE ID ON RECORD CODE 1 OR TECS CLIENT ID AND RECORD 1 IF THE RECORD IS FOUND THEN IF THE DETAIL SERVICE CODE = 'G' AND THE DETAIL 1ST-PROCEDURE SERVICE DATE IS GREATER THAN 19990630
AND DDR-SERV-PROV-07 (SUB9) NOT = THE HEADER PROVIDER NUMBER

IF THIS IS A REGION 90 CLAIM OR THE PROVIDER NUMBER IS BETWEEN '000035000' AND '000037999' AND NOT PROVIDER NUMBERS '000035432' '000035434' OR '000035201'
THEN READ SB644010 USING THE KEY CLIENT BASE ID ON RECORD CODE 1 OR TECS CLIENT ID AND RECORD 1 IF THE RECORD IS FOUND THEN IF THE DETAIL SERVICE CODE = 'H' AND THE DETAIL 1ST-PROCEDURE SERVICE DATE IS GREATER THAN 19990630
AND DDR-SERV-PROV-25 (SUB9) NOT = THE HEADER PROVIDER NUMBER

IF THIS IS A REGION 90 CLAIM OR THE PROVIDER NUMBER IS BETWEEN '000035000' AND '000037999' AND NOT PROVIDER NUMBERS '000035432' '000035434' OR '000035201'
THEN READ SB644010 USING THE KEY CLIENT BASE ID ON RECORD CODE 1 OR TECS CLIENT ID AND RECORD 1 IF THE RECORD IS FOUND THEN IF THE DETAIL SERVICE CODE = 'J' AND THE DETAIL 1ST-PROCEDURE SERVICE DATE IS GREATER THAN 19910831
AND DDR-SERV-PROV-08 (SUB9) NOT = THE HEADER PROVIDER NUMBER

METHOD OF CORRECTION:

JOB: SB1J040
PROGRAM: SB1090

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ERROR CODE: 097

A. CLAIM TYPE: PAYABLE CLAIMS
B. CLAIM TYPE: DRUG CLAIMS

DATE UPDATED: 04/5/2004

EDIT NAME: REG 70/95 RECIP LIAB > 60 DAYS

A. EDIT DESCRIPTION:
IF CLML-HEADER-RELS-CD(1) = '30' AND
   (CLMT-DEPT-OF-INSTRUCTION OR CLMT-IHS-REGION)
PERFORM 089A1-SUSPEND-97-30 THIS MOVES DATA TO FIELDS THEN CHECKS THE DAYS DIFFERENCE BY
PERFORMING 089AAA-CAL-DAYS-DIFF WHICH CALCULATES THE FROM AND TO DATES, IF THE DIFFERENCE IS
MORE THAN 60 DAYS THEN THE ERROR IS GIVEN

B. EDIT DESCRIPTION:
IF WA-003-CC-STATUS = 'AU' AND
   (CLML-DEPT-OF-INSTRUCTION (CLML-INDEXR)
   OR CLML-IHS-REGION (CLML-INDEXR))
   PERFORM 089A1-SUSPEND-97-30 THIS CHECKS TO SEE IF THE FROM DATE IS LESS THAN 60 DAYS FROM THE
   TO DATE IF THE NUMBER OF DAYS BETWEEN THE TO AND FROM DATES IS GREATER THAN 60 THE ERROR IS
   GIVEN

OR
IF MEMD-CLNT-STATUS = 'AU' AND
   (CLML-DEPT-OF-INSTRUCTION (CLML-INDEXR)
   OR CLML-IHS-REGION (CLML-INDEXR))
   PERFORM 089A1-SUSPEND-97-30 THIS CHECKS TO SEE IF THE FROM DATE IS LESS THAN 60 DAYS FROM THE
   TO DATE IF THE NUMBER OF DAYS BETWEEN THE TO AND FROM DATES IS GREATER THAN 60 THE ERROR IS
   GIVEN

METHOD OF CORRECTION:

A. JOB: SB1J077 PROGRAM: SB1275
B. JOB: CICS POS SYSTEM PROGRAM: SB710038
ERROR CODE: 099

CLAIM TYPE: INPATIENT-CLAIM OR UB82-INPATIENT-CLAIM

DATE UPDATED: 04/05/2004

EDIT NAME: ADMIT DATE NOT CONSIST W/Cover

EDIT DESCRIPTION:

MOVE ADMISSION DATE TO WK-YYYYMMDD
MOVE WK-CCYY TO HOLD-CCYY WK-A-YEAR
ADD 1 TO WK-A-YEAR
MOVE CLMT-1ST-DA-OF-SERV TO WK-YYYYMMDD
IF (WK-CCYY NOT = WK-A-YEAR)
   AND (WK-CCYY NOT = HOLD-CCYY)
   * DON'T ERROR FOR STATE HOSPITAL *
   AND CLMT-VR-PROV NOT = '001086'
IF THE FIRST DATE OF SERVICE IS NOT IN THE PRESENT YEAR OR THE NEXT YEAR THEN THE ERROR IS GIVEN

METHOD OF CORRECTION:

CHECK FIELD 15 FOR VALIDITY OF ENTRY. IF IN ERROR, CORRECT AND PROCESS CLAIM.
WHEN USING REMARK CODE "MA40" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.
ERROR CODE: 107

CLAIM TYPE: ALL

DATE UPDATED: 02/10/04

EDIT NAME: CLAIM HAS NO DETAIL LINE(S)

EDIT DESCRIPTION: SET IF NUMBER OF DETAILS GREATER THAN ZERO AND REGION
NOT EQUAL 40 AND NOT AN ADJUSTMENT.

METHOD OF CORRECTION:

COMMENTS: VERIFY DETAILS HAVE NOT BEEN MISSED BY DATE ENTRY. IF MISSED, FOR
EACH LINE NOT ENTERED, ADD A LINE USING 'A' TRANSACTION AND ENTER FIELD '45' WITH
APPROPR. DATE FOR FIRST CYCLE. ON FOLLOWING CYCLE ENTER APPROPR. DATA. FOR
DRUG CLAIMS: DELETE ENTIRE PAPER CLAIM FROM SYSTEM USING ICN DELETE FORM.
ENTER ON LINE ENTRY ON ICN DELETE FORM FOR EACH WORKSHEET THAT WAS
GENERATED BY CLAIM. TRANSFER CLAIM TO M/C CONTROL FOR RE-ENTRY INTO
SYSTEM, WITHIN CORRECT BATCH WHEN USING "M79" ENTER CLAIM ADJUSTMENT
REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070, DETAIL.
ERROR CODE: 108
CLAIM TYPE: ALL
DATE UPDATED: 02/10/04

EDIT NAME: DATES OF SERVICE > ICN DATE

EDIT DESCRIPTION:

1. IN SB1070:
   A. SET IF JULIAN FROM DATE GREATER THAN BATCH DATE, AND TYPE OF SERVICE NOT EQUAL ‘R’, AND PRO
      CODE NOT EQUAL 'A0110' AND 'A0140'.
   B. SET IF JULIAN TO DATE GREATER THAN BATCH DATE, AND TYPE OF SERVICE NOT EQUAL ‘R’, AND PRO
      CODE NOT EQUAL 'A0110' AND 'A0140'.
   C. SET IF CLMT-PROV-NO LESS THAN '000020000' OR GREATER THAN '000029999'
      IF JULIAN TO DATE GREATER THAN BATCH DATE, AND TYPE OF SERVICE NOT EQUAL ‘R’,
      AND PROCEDURE CODE NOT EQUAL 'A0110' AND 'A0140'.

2. IN SB710022:
   A. SET IF DATE PRESCRIBED GREATER THAN CURRENT CENTURY.
   B. SET IF DATE DISPENSED(1) GREATER THAN CURRENT CENTURY.

METHOD OF CORRECTION:
COMMENTS: VERIFY PROPER DATE ENTRY, CORRECT IF NECESSARY, OTHERWISE DENY
CLAIM WITH EOB 110, OR RETURN TOProv FOR CORRECTION.

JOB: SB1J020       PROGRAM: SB1070, SB710022 , HEADER AND DETAIL

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ERROR CODE: 109

CLAIM TYPE: ALL

DATE UPDATED: 02/10/04

EDIT NAME: CATEGORY OF SERVICE CODE MISS.

EDIT DESCRIPTION:

1. IN SB1130
   
   A. SET IF CATEGORY OF SERVICE EQUALS SPACES AND ALLOWED CHARGE IS GREATER THAN ZERO.

METHOD OF CORRECTION:

COMMENTS: CONTACT PROGRAMMING. CATEGORY OF SVC IS A SYSTEM ASSIGNED FIELD. IF CATEGORY OF SVC IS SPACES THERE IS A PROGRAMMING ERROR THAT MUST BE CORRECTED. WHENEVER SB1130 IS CHANGED, THE POSSIBILITY EXISTS THAT CODE FOR ASSIGNING CATEGORY OF SVC WILL BE BYPASSED. AFTER THE PROGRAM HAS BEEN CORRECTED, CLAIM SHOULD BE RECYCLED.

JOB: SB1J050 PROGRAM: SB1130 , HEADER.
ERROR CODE: 111

CLAIM TYPE: D

DATE UPDATED: 02/10/04

EDIT NAME: OBSOLETE NDC

EDIT DESCRIPTION:

1. IN SB710023

   A. SET IF DRUG CONTROL CODE EQUALS ‘1’.

METHOD OF CORRECTION: NO METHOD OF CORRECTION.

JOB: PROGRAM: SB710023 , HEADER.
ERROR CODE: 112
CLAIM TYPE: D
DATE UPDATED: 02/10/04

EDIT NAME: PRESCR PHYS NOT ON PROV FILE.

EDIT DESCRIPTION:

1. IN SB1090
   A. SET IF PROVIDER NOT FOUND AND REGION NOT EQUAL '49' AND NOT MEDICAL CLAIM.

2. IN SB710022
   A. SET IF PRESCRIPTION ID EQUALS SPACES OR ZERO.
   B. SET IF PRESCRIPTION ID NOT FOUND ON MMIS PROVIDER MASTER.

METHOD OF CORRECTION:
COMMENTS: VERIFY PRESCR PHYS # ENTERED CORRESPONDS TO # WHICH APPEARS ON ORIG CLAIM. IF NUMB ENTERED DOES NOT MATCH ORIG PRESCR PHYS #, CORRECT WORKSHEET AND PROCESS CLAIM. OTHERWISE, VERIFY PRESCR PHYS # WHICH IS ENTERED IS NOT ON NUMERIC PROV LISTING. IF IT DOES NOT APPEAR, ENTER DUMMY # '52471' FOR INSTATE AND '53 168' FOR OUT OF STATE IN PLACE OF ONE WHICH WAS ORIGINALLY ENTERED. WHEN USING REMARK CODE "M68" YOU MUST ENTER CLAIM ADJUSTMENT REASON "52" OR "B7" (MOST APPROPRIATE) IN FIELD 6.

JOB: SB1J040 PROGRAM: SB1090, SB710022, HEADER.
ERROR CODE: 113

CLAIM TYPE: M, L, R., O.

DATE UPDATED: 02/10/04

EDIT NAME: PREFERED PHYS NOT ON PROV FILE.

EDIT DESCRIPTION:

1. IN SB1090
   A. IF PROVIDER NOT FOUND AND REGION NOT EQUAL ‘49’ AND NOT MEDICAL CLAIM.
      SET IF REGION NOT ‘40’ AND NOT AN ADJUSTMENT.
   B. IF PROVIDER NOT FOUND AND REGION NOT EQUAL ‘49’ AND NOT MEDICAL CLAIM.
      SET IF REGION NOT ‘40’ AND NOT AN ADJUSTMENT.

2. IN SB1130
   A. IF REGION NOT ‘49’ AND NOT MEDICAL CLAIM
      IF DETAIL PHYSICIAN EQUALS SPACES OR ZERO, OR DETAIL PERFORMING
      PHYSICIAN < "000010000"
      SET IF REGION NOT EQUAL ‘40’ AND NOT AN ADJUSTMENT.
   B. IF PROVIDER NOT FOUND AND REGION NOT ‘49’ AND NOT MEDICAL CLAIM
      SET IF REGION NOT EQUAL ‘40’ AND NOT AN ADJUSTMENT..
   C. IF PROVIDER NOT EQUAL TO PREFERED GROUP1 AND NOT GROUP2 AND NOT
      GROUP3 AND NOT GROUP4.
      IF REGION NOT EQUAL ‘49’ AND NOT MEDICAL CLAIM
      SET IF REGION NOT EQUAL ‘40’ AND NOT AN ADJUSTMENT.

METHOD OF CORRECTION:

COMMENTS: VERIFY PERF PHYS/DENTIST HAS BEEN ENTERED CORRECTLY. IF NOT,
CORRECT AND PROCESS CLAIM. IF A PHYS NUMBER IS PRESENT, CHECK WITH PROV
ENROLLMENT FOR POSSIBLE CHANGES AND/OR NEED FOR FILE UPDATE. RTP THE
CLAIM ONLY UPON ADVICE FROM PROV ENROLLMENT. WHEN USING REMARK CODE
"M68" YOU MUST ENTER CLAIM ADJUSTMENT REASON "52" OR "B7" (MOST
APPROPRIATE) IN FIELD 6.

JOB: SB1J040 PROGRAM: SB1090, DETAIL.
JOB: SB1J050 PROGRAM: SB11130, DETAIL.

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ERROR CODE: 114

CLAIM TYPE: N, Q, R, U
DATE UPDATED: 02/12/04

EDIT NAME: CLAIM TYPE PROV NUM MISMATCH.

EDIT DESCRIPTION:

1. IN SB1070
   A.  IF A NURSING HOME CLAIM “N”
       IF BATCH NUMBER EQUALS 650 OR 651
       IF PROVIDER IS NOT GREATER OR EQUALS ‘000030000’ AND NOT LESS ‘000040000’
   B.  IF UB82 CLAIM “Q, R, U”
       SET IF REVENUE CODE EQUALS ‘951’ OR ‘521’ OR ‘522’ AND PROVIDER NUMBER LESS THAN ‘000050000’ OR GREATER ‘000005999’.

2. IN SB710022
   A.  SET IF PROVIDER NUMBER (1) NOT GREATER OR EQUALS ‘000019999’ AND NOT LESS OR EQUALS ‘000030000’.

METHOD OF CORRECTION: YOU MAY ALSO USE "05" IN PLACE OF "E9" (MOST APPROPRIATE)

JOB: SB1J020 PROGRAM: SB1070, SB710022. HEADER, DETAIL.
ERROR CODE: 115

CLAIM TYPE
DATE UPDATED: 02/12/04

EDIT NAME: PRESC PHYS NUM USED CLINIC NUM.

EDIT DESCRIPTION:

1. IN SB1130
   EXISTS IN SB1130 WORK STORAGE, BUT NOT SET ANYWHERE.

METHOD OF CORRECTION:

COMMENTS: YOU MAY ALSO USE "E2" IN PLACE OF "56" (MOST APPROPRIATE) WHEN USING REMARK CODE "MA112" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM: SB1130.
ERROR CODE: 116

CLAIM TYPE: Q
DATE UPDATED: 02/12/04

EDIT NAME: INVALID PROV NUM FOR REG 92.

EDIT DESCRIPTION:

1. IN SB1130

   A. SET IF REGIONAL-INTERVENTION-REG “92” AND PROVIDER EQUALS '000001002' OR '000001003' OR '000001012' OR '000001023' OR '000001041'.

METHOD OF CORRECTION: CHANGE PROVIDER NUMBER TO HOSPITAL'S PYSCH NUMBER.

JOB: SB1J050 PROGRAM : SB1130 , HEADER.

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ERROR CODE: 117

CLAIM TYPE:
DATE UPDATED: 02/12/04

EDIT NAME:

EDIT DESCRIPTION: OTHER PHYSICIAN 2.

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M68" YOU MUST ENTER CLAIM ADJUSTMENT REASON "52" OR "B7" (MOST APPROPRIATE) IN FIELD 6.

JOB: PROGRAM:

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ERROR CODE: 120

CLAIM TYPE: M, L, X.
DATE UPDATED: 02/12/04

EDIT NAME:

EDIT DESCRIPTION: SERVICES LIMITED TO DDS ONLY.

1. IN SB1070
   A. SET IF PROCEDURE CODE NOT FOUND ON PROCEDURE TABLE 0117.

METHOD OF CORRECTION: NO CORRECTION METHOD.

JOB: SB1J020       PROGRAM : SB1070 , DETAIL.

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ERROR CODE: 121

CLAIM TYPE: M, L, X.
DATE UPDATED: 02/17/04

EDIT NAME: SERVICE LIMITED TO VR ONLY.

EDIT DESCRIPTION:

1. IN SB1070
   A. SET IF PROCEDURE CODE NOT FOUND ON PROCEDURE TABLE 0131.

METHOD OF CORRECTION: NONE.

JOB: SB1J020 PROGRAM: SB1070 , DETAILS.

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ERROR CODE: 122
CLAIM TYPE:
DATE UPDATED: 02/12/04

EDIT NAME: FUND CODES DO NOT MATCH.

EDIT DESCRIPTION: NO LONGER USED.

1. IN SB1190

METHOD OF CORRECTION:
DETERMINE WHICH FUND CODE IS INVALID, MAKE NECESSARY CORRECTIONS AND SEND CLAIM THROUGH AGAIN.

JOB: SB1J050 PROGRAM : SB1190, COMBINATION OF ALL DETAILS.
ERROR CODE: 131

CLAIM TYPE: N
DATE UPDATED: 02/17/04

EDIT NAME: DISCHARGE DATE NOT EQUAL THRU DATE.

EDIT DESCRIPTION:

1. IN SB1070
   A. IF NURSING HOME CLAIM AND (LONG TERM CARE REGION OR BASIC CARE REGION)
      AND (PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383')
      IF DATE OF DISCHARGE NOT EQUAL ZERO
      IF DISCHARGE DESTINATION EQUALS '2'
      SET IF DATE OF DISCHARGE NOT EQUALS LAST PROCEDURE SERVICE DATE.

METHOD OF CORRECTION:
COMMENTS: REVIEW FOR CORRECT DATA ENTRY AND CORRECT AS NEEDED. IF ALL ENTRIES
CORRECT, DENY WITH EOB N50. WHEN USING REMARK CODE "N50" YOU MUST ENTER CLAIM
ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM : SB1070, HEADER.
ERROR CODE: 132

CLAIM TYPE: N
DATE UPDATED: 02/17/04

EDIT NAME: SERVICE DATE NOT EQUAL DAYS BILLED.

EDIT DESCRIPTION:

1. IN SB1070
   A. SET IF TOTAL DAYS BILLED NOT EQUAL CALCULATED DAYS AND PROVIDER LESS THAN '000030700' AND GREATER THAN '000030799'.

   B. IF UNITS OF SERVICE GREATER THAN ZERO
      SET IF UNITS OF SERVICE GREATER THAN TOTAL DAYS BILLED AND PROVIDER GREATER OR EQUALS '000030700' AND LESS THAN OR EQUALS '000030799'.

   C. SET IF CALCULATED DAYS NOT EQUAL TOTAL DAYS BILLED AND PROVIDER LESS THAN '000030700' AND GREATER THAN '000030799'.

METHOD OF CORRECTION:
CHECK DATA ENTRY WITH SPECIAL ATTENTION TO DISCHARGE CODE. IF OBVIOUS ERRORS, CHANGE. OTHERWISE, DENY WITH EOB MA32 WHEN USING REMARK CODE "MA32" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 133
CLAIM TYPE: N
DATE UPDATED: 02/17/04

EDIT NAME: RECIP NOT ON NH ELIGIBILITY.

EDIT DESCRIPTION:

1. IN SB1090

   A. IF ACCIDENT TYPE EQUALS SPACES
      IF (NURSING HOME CLAIM AND LONG TERM CARE REGION AND PROVIDER NOT
      EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR (PROVIDER NOT
      LESS THAN '000001900' AND NOT GREATER THAN '000002000') AND QMB-ELIGIBLE-SW
      EQUALS 'N'
      IF NO RECORD FOUND ON SB644010 AND NO RECORD FOUND ON TECS
      IF CLAIM REGION NOT EQUAL '94' AND (PROVIDER NOT GREATER THAN '000032313'
      AND NOT LESS THAN '000032322') OR (PROVIDER NOT GREATER THAN '000033055' AND NOT
      LESS THAN '000033060')
      SET IF (MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON 0149 TABLE LIST).
      SET IF NOT (UB82-INPATIENT CLAIM AND PROVIDER TYPE CODE NOT EQUAL '02' AND
      RECIPIENT AGE GREATER THAN 20.

   B. IF CLAIM REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL '56' AND NOT EQUAL '55')
      AND (PROCEDURE CODE NOT FOUND ON PROCEDURE TABLE LIST 0148)
      AND PROCEDURE CODE IS NOT 000015 OR 00019(TARGETED CASE MANAGEMENT)
      IF NO RECORD FOUND ON SB644010 AND NO RECORD FOUND ON TECS
      IF CLAIM REGION NOT EQUAL '94' AND (PROVIDER NOT GREATER THAN '000032313'
      AND NOT LESS THAN '000032322') OR (PROVIDER NOT GREATER THAN '000033055' AND NOT
      LESS THAN '000033060')
      SET IF (MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON 0149 TABLE LIST).
      SET IF NOT (UB82-INPATIENT CLAIM AND PROVIDER TYPE CODE NOT EQUAL '02' AND
      RECIPIENT AGE GREATER THAN 20.

   C. IF FIRST DAY OF SERVICE GREATER THAN 20011031
      IF MEDICAL CLAIM AND PROVIDER NOT EQUAL '000050383'
      IF PROCEDURE CODE IS FOUND ON 0149 TABLE LIST
      IF NO RECORD FOUND ON SB644010 AND NO RECORD FOUND ON TECS
      IF CLAIM REGION NOT EQUAL '94' AND (PROVIDER NOT GREATER THAN '000032313'
      AND NOT LESS THAN '000032322') OR (PROVIDER NOT GREATER THAN '000033055' AND NOT
      LESS THAN '000033060')
      SET IF (MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON 0149 TABLE LIST).
      SET IF NOT (UB82-INPATIENT CLAIM AND PROVIDER TYPE CODE NOT EQUAL '02' AND
      RECIPIENT AGE GREATER THAN 20.

   D. IF (UB82-INPATIENT CLAIM AND PROVIDER TYPE CODE NOT EQUAL '02' AND
      RECIPIENT AGE LESS THAN 21.
IF NO RECORD FOUND ON SB644010 AND NO RECORD FOUND ON TECS
IF CLAIM REGION NOT EQUAL '94' AND (PROVIDER NOT GREATER THAN '000032313'
AND NOT LESS THAN '000032322') OR (PROVIDER NOT GREATER THAN '000033055' AND NOT
LESS THAN '000033060')
SET IF (MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON 0149 TABLE LIST).
SET IF NOT (UB82-INPATIENT CLAIM AND PROVIDER TYPE CODE NOT EQUAL ‘02’ AND
RECIPIENT AGE GREATER THAN 20.

METHOD OF CORRECTION:
COMMENTS: CHECK ALL ENTRIES FOR CORRECTNESS. IF ERRORS IN DATE, ENTER
CHANGE. IF NO ERRORS, DENY. YOU MAY ALSO USE "N153" IN PLACE OF "N141" (MOST
APPROPRIATE) WHEN USING REMARK CODE "N141" OR "N153" YOU MUST ENTER CLAIM
ADJUSTMENT

JOB: SB1J040 PROGRAM : SB1090, HEADER.
EDIT NAME: RECIP NOT ELIGIBLE ON NH FILE.

EDIT DESCRIPTION:

1. IN SB1090

A. IF NOT A NURSING HOME CLAIM AND IS QMB ELIGIBLE
   IF (PROVIDER GREATER THAN '000030699' AND LESS THAN '000030800')
   AND (FIRST DAY OF SERVICE GREATER THAN PERS CARE IMPLEMENTATION DATE)
   SET IF SERVICE CODE EQUALS '4' AND REGION EQUALS '21'

   SET IF SERVICE CODE NOT EQUALS '4' AND REGION = '20'

B. IF CARE EFFECTIVE DATE NOT LESS THAN FIRST DAY OF SERVICE
   IF (PROVIDER GREATER THAN '000030699' AND LESS THAN '000030800')
   AND (FIRST DAY OF SERVICE GREATER THAN PERS CARE IMPLEMENTATION DATE)
   SET IF SERVICE CODE EQUALS '4' AND REGION EQUALS '21'

   SET IF SERVICE CODE NOT EQUALS '4' AND REGION = '20'

C. IF MAXIMUM NURSING HOME INDEX EQUALS +1
   IF (PROVIDER GREATER THAN '000030699' AND LESS THAN '000030800')
   AND (FIRST DAY OF SERVICE GREATER THAN PERS CARE IMPLEMENTATION DATE)
   SET IF SERVICE CODE EQUALS '4' AND REGION EQUALS '21'

   SET IF SERVICE CODE NOT EQUALS '4' AND REGION = '20'

D. IF ((NURSING HOME CLAIM AND LONG TERM CARE REGION AND VR PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR (PROVIDER-NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000')) AND (NOT QMB ELIGIBLE)
   IF RECORD FOUND ON SB644010 USING BASE-ID OR TECS NUMBER
   IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
   OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
   IF NOT NURSING HOME ELIGIBLE
   IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
   IF (CLAIM REGION NOT EQUAL '94) AND (NOT FOUND ON PROCEDURE LIST TABLE 0102 AND 0101)
   SET IF NOT DEVELOPMENT DISABILITY REGION.

E. IF CLAIM REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL 56 AND NOT EQUAL 55)
   IF PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0148
   IF RECORD FOUND ON SB644010 USING BASE ID OR TECS NUMBER
   IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
   OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
IF NOT NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF (CLAIM REGION NOT EQUAL '94) AND (NOT FOUND ON PROCEDURE LIST TABLE 0102 AND 0101)
SET IF NOT DEVELOPMENT DISABILITY REGION.

F. IF FIRST DAY OF SERVICE IS GREATER THAN 20011031
IF (MEDICAL CLAIM AND PROVIDER NO NOT EQUAL '000050383')
IF PROCEDURE CODE FOUND ON PROCEDURE LIST TABLE 0149
IF RECORD FOUND ON SB644010 USING BASE ID OR TECS NUMBER
IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
IF NOT NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF (CLAIM REGION NOT EQUAL '94) AND (NOT FOUND ON PROCEDURE LIST TABLE 0102 AND 0101)
SET IF NOT DEVELOPMENT DISABILITY REGION.

G. IF FIRST DAY OF SERVICE IS GREATER THAN 20011031
IF NOT MEDICAL CLAIM AND PROVIDER NO NOT EQUAL '000050383'
IF (UB82 INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21))
IF PROCEDURE CODE FOUND ON PROCEDURE LIST TABLE 0149
IF RECORD FOUND ON SB644010 USING BASE ID OR TECS NUMBER
IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
IF NOT NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF (CLAIM REGION NOT EQUAL '94) AND (NOT FOUND ON PROCEDURE LIST TABLE 0102 AND 0101)
SET IF NOT DEVELOPMENT DISABILITY REGION.

H. IF ((NURSING HOME CLAIM AND LONG TERM CARE REGION AND VR PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR (PROVIDER NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000')) AND (NOT QMB ELIGIBLE)
IF RECORD IS FOUND ON SB644010 USING BASE ID OR USING TECS NUMBER
IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
IF NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF CLAIM REGION NOT EQUAL '94'
IF DDR-SERVICE CODE EQUALS 'K'
SET IF NOT DEVELOPMENT DISABILITY REGION

IF (SERVICE CODE EQUALS '1' OR '2' OR 'Q' OR 'S')
SET IF (DDR-SERVICE CODE NOT = 'A' AND NOT DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '3'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'A' AND NOT EQUAL 'H') AND NOT DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS 'R'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'A' AND NOT EQUAL 'B' AND NOT EQUAL 'C' AND NOT EQUAL 'H' AND NOT EQUAL 'T') AND NOT DEVELOPMENT DISABILITY REGION)
IF (SERVICE CODE EQUALS 'G' OR EQUALS 'J')
SET IF (DDR-SERVICE CODE NOT EQUAL 'B' AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'S' OR EQUALS 'H')
SET IF (DDR-SERVICE CODE NOT EQUAL 'C' AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'T' OR EQUALS 'U' OR EQUALS 'V' OR EQUALS 'W' OR EQUALS 'X' OR EQUALS 'Y')
SET IF (DDR-SERVICE CODE NOT EQUAL 'D' AND NOT (DEVELOPMENT DISABILITY REGION)
IF SERVICE CODE EQUALS '6'

SET IF ((DDR-SERVICE CODE NOT EQUAL 'J' AND DDR-SERVICE CODE-2 NOT = 'J') AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS '7' OR EQUALS '9')
SET IF (DDR-SERVICE CODE NOT EQUAL 'H' AND NOT (DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '8'
SET IF (DDR-SERVICE CODE NOT EQUAL 'I' AND NOT (DEVELOPMENT DISABILITY REGION)

IF NURSING HOME NO SERVICE SWITCH EQUALS 'N'
IF DDR-SERVICE CODE –2 NOT EQUAL 'J'
IF PROVIDER NO NOT EQUALS DDR-PROVIDER NO
SET IF NOT DEVELOPMENT DISABILITY REGION

I. IF CLAIM REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL 56 AND NOT EQUAL 55)
IF PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0148
IF RECORD IS FOUND ON SB644010 USNIG BASE ID OR USING TECS NUMBER
IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S') OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
IF NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF CLAIM REGION NOT EQUAL '94'
IF DDR-SERVICE CODE EQUALS 'K'
SET IF NOT DEVELOPMENT DISABILITY REGION

IF (SERCICE CODE EQUALS '1' OR '2' OR 'Q' OR 'S')
SET IF (DDR-SERVICE CODE NOT = 'A' AND NOT DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '3'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'A' AND NOT EQUAL 'H') AND NOT DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS 'R'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'A' AND NOT EQUAL 'B' AND NOT EQUAL 'C' AND NOT EQUAL 'H' AND NOT EQUAL 'I') AND NOT DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'G' OR EQUALS 'J')
SET IF (DDR-SERVICE CODE NOT EQUAL 'B' AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'S' OR EQUALS 'H')
SET IF (DDR-SERVICE CODE NOT EQUAL 'C' AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'T' OR EQUALS 'U' OR EQUALS 'V' OR EQUALS 'W' OR EQUALS 'X' OR EQUALS 'Y')
SET IF (DDR-SERVICE CODE NOT EQUAL 'D' AND NOT (DEVELOPMENT DISABILITY REGION)
IF SERVICE CODE EQUALS '6'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'J') AND DDR-SERVICE CODE-2 NOT = 'J')
AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS '7' OR EQUALS '9')
SET IF (DDR-SERVICE CODE NOT EQUAL 'H' AND NOT (DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '8'
SET IF (DDR-SERVICE CODE NOT EQUAL 'I' AND NOT (DEVELOPMENT DISABILITY REGION)

IF NURSING HOME NO SERVICE SWITCH EQUALS 'N'
IF DDR-SERVICE CODE –2 NOT EQUAL 'J'
IF PROVIDER NO NOT EQUALS DDR-PROVIDER NO
SET IF NOT DEVELOPMENT DISABILITY REGION

J. IF FIRST DAY OF SERVICE GREATER THAN 20011031
IF (MEDICAL CLAIM AND PROVIDER NO NOT EQUAL '000050383')
IF PROCEDURE CODE IS FOUND ON PROCEDURE TABLE LIST 0149
IF RECORD IS FOUND ON SB644010 USING BASE ID OR USING TECS NUMBER
IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
OR (NURSING HOME CLAIM AND (SERVICE CODE_EQUALS 'I' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM
IF NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF CLAIM REGION NOT EQUAL '94'
IF DDR-SERVICE CODE EQUALS 'K'
SET IF NOT DEVELOPMENT DISABILITY REGION

IF (SERVICE CODE EQUALS '1' OR '2' OR 'Q' OR 'S')
SET IF (DDR-SERVICE CODE NOT = 'A' AND NOT DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '3'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'A' AND NOT EQUAL 'H') AND NOT DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS 'R'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'A' AND NOT EQUAL 'B' AND NOT EQUAL 'C' AND NOT EQUAL 'H' AND NOT EQUAL 'I') AND NOT DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'G' OR EQUALS 'J')
SET IF (DDR-SERVICE CODE NOT EQUAL 'B' AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'S' OR EQUALS 'H')
SET IF (DDR-SERVICE CODE NOT EQUAL 'C' AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS 'T' OR EQUALS 'U' OR EQUALS 'V' OR EQUALS 'W' OR EQUALS 'X' OR EQUALS 'Y')
SET IF (DDR-SERVICE CODE NOT EQUAL 'D' AND NOT (DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '6'
SET IF ((DDR-SERVICE CODE NOT EQUAL 'J' AND DDR-SERVICE CODE-2 NOT = 'J')
AND NOT (DEVELOPMENT DISABILITY REGION)

IF (SERVICE CODE EQUALS '7' OR EQUALS '9')
SET IF (DDR-SERVICE CODE NOT EQUAL 'H' AND NOT (DEVELOPMENT DISABILITY REGION)

IF SERVICE CODE EQUALS '8'
SET IF (DDR-SERVICE CODE NOT EQUAL 'I' AND NOT (DEVELOPMENT DISABILITY REGION)

04/04/06
IF NURSING HOME NO SERVICE SWITCH EQUALS 'N'
IF DDR-SERVICE CODE =2 NOT EQUAL 'J'
IF PROVIDER NO NOT EQUALS DDR-PROVIDER NO
SET IF NOT DEVELOPMENT DISABILITY REGION

K. IF ((NURSING HOME CLAIM AND LONG TERM CARE REGION AND
VR PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR
(PROVIDER NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000')) AND
(NOT QMB ELIGIBLE)
IF RECORD IS FOUND ON SB644010 USNIG BASE ID
IF NOT LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S'
OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM)
IF NURSING HOME ELIGIBLE
IF NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM
IF CLAIM REGION EQUAL '94'
IF PROCEDURE CODE NOT FOUND ON PROCEDURE TABLE LIST 0151 AND
DDR-SERVICE CODE NOT EQUAL 'L'
IF PROCEDURE CODE IS FOUND ON TABLE LIST 0171
SET IF DDR-SERVICE CODE NOT EQUAL 'L' AND NOT DEVELOPMENT DISABILITY REGION

IF PROCEDURE CODE IS NOT FOUND ON PROCEDURE TABLE LIST 0171
IF PROCEDURE CODE IS FOUND ON PROCEDURE TABLE LIST 0122
IF ((PROCEDURE CODE IS NOT FOUND ON PROCEDURE TABLE LIST 0102) OR
(PROCEDURE CODE IS NOT FOUND ON PROCEDURE TABLE LIST 0101)) AND
(DDR-SERVICE CODE EQUALS 'G') AND (CLAIM REGION NOT EQUAL '94')
SET IF PROCEDURE CODE IS FOUND ON PROCEDURE TABLE LIST 0134 AND
(DDR-SERVICE CODE NOT EQUAL 'M')

IF PROCEDURE CODE NOT FOUND ON PROCEDURE TABLE LIST 0134 AND
(DDR-SERVICE CODE EQUALS 'M')
SET IF DDR-SERVICE CODE NOT EQUAL 'G' AND NOT EQUAL 'L' AND NOT EQUAL 'M'
AND NOT DEVELOPMENT DISABILITY REGION

IF PROCEDURE CODE NOT FOUND ON PROCEDURE TABLE LIST 0122
SET IF DDR-SERVICE CODE NOT EQUAL 'E' AND NOT EQUAL 'F' AND
NOT DEVELOPMENT DISABILITY REGION

IF NURSING HOME NO SERVICE SWITCH = 'Y'
SET IF NOT DEVELOPMENT DISABILITY REGION

L. IF (TECS ELIGIBLE' OR QMB ELIGIBLE) OR ERR-411-ON OR ERR-409-ON
IF (RECIPIENT CASE-1-2 (COUNTY) GREATER THAN 00 AND LESS THAN 54) AND
-FIRST DAY OF SERVICE NOT LESS THAN 19830401) AND
(DEVELOPMENT DISABILITY REGION OR
(PROVIDER NO NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999'))
IF NURSING HOME ELIGIBLE
IF DDR-SERVICE CODE NOT EQUAL 'G'
IF (PROVIDER NO EQUALS '000035432' OR '000035434' OR '000035201')
IF DDR-SERVICE CODE EQUALS 'K'
SET IF NOT DEVELOPMENTAL DISABILITY REGION

METHOD OF CORRECTION:
CHECK DATA ENTRY ON TURNAROUND DOCUMENT FOR CORRECT ENTRY. CHECK ELIG
FILE. IF NOT SCREEN FOR PARTICULAR SERVICE THEY ARE BILLING FOR, DENY.
*NOTE REGIONAL 90 CLAIMS (DD) AND PERSONAL CARE CLAIMS WILL NOT RECEIVE THE 134 ERROR.
WHEN USING REMARK CODE "N146" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.
JOB: SB1J040           PROGRAM : SB1090, HEADER.

Top
ERROR CODE: 135

CLAIM TYPE: N.
DATE UPDATED: 02/26/04

EDIT NAME: PROVIDER 30800-30899, SERVICE CODE NOT TYPE -Y.

EDIT DESCRIPTION:

1. IN SB1070

   A. SET IF NURSING HOME CLAIM AND LONG TERM CARE REGION AND
      (VR-PROVIDER NO NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383')
      IF (PROVIDER NO NOT LESS THAN '000030800' AND NOT GREATER THAN '000030899')
      AND (SERVICE CODE NOT EQUAL 'T' AND NOT EQUAL 'U' AND NOT EQUAL 'V'
      AND NOT EQUAL 'W' AND NOT EQUAL 'X' AND NOT EQUAL 'Y')

METHOD OF CORRECTION:
REVIEW DATE ENTRY. IF ALL ENTRIES CORRECT, DENY WITH EOB B7 (QMB EOB).

JOB: SB1J020 PROGRAM: SB1070, DETAIL.

Top
ERROR CODE: 136

CLAIM TYPE: .
DATE UPDATED: 02/26/04


EDIT DESCRIPTION:

1. IN SB1070

   IF INSTITUTIONAL CLAIM OR UB82-INSTITUTIONAL CLAIM OR
   (UB82-HOME-HEALTH AND BILL-TYPE EQUALS '711' AND
   PVF-STATUS EQUALS ZEROS AND P1M1-PROVIDER-CURR-OPT-RR GREATER THAN ZERO)
   IF NUMBER OF LINE ITEMS GREATER THAN ZERO
   IF NOT UB82-CLAIM
   IF NURSING HOME CLAIM AND T-LTC-REG OR CLMT-BASIC-CARE-REG) AND
   (VR-PROVIDER NO NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383')
   SET IF (SERVICE CODE EQUAL 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y') AND
   (PROVIDER NO LESS THAN '000030800' OR GREATER THAN '000030899')

METHOD OF CORRECTION:
VERIFY ALL ENTRIES ARE CORRECT. OTHERWISE MAKE CHANGES AS INDICATED.
IF ALL ENTRIES ARE VALID, DENY WITH EOB B7.

JOB: SB1J020 PROGRAM: SB1070, DETAIL.
ERROR CODE: 137

CLAIM TYPE: I, O, N, Q, U, N.

DATE UPDATED: 02/26/04

EDIT NAME: SERVICE DAYS NOT EQUAL DETAIL COVERED DAYS.

EDIT DESCRIPTION:

1. IN SB1070

   A. IF INSTITUTIONAL CLAIM OR UB82-INSTITUTIONAL CLAIM OR
      (UB82-HOME-HEALTH AND BILL-TYPE EQUALS '711' AND
      PVF-STATUS EQUALS ZEROS AND P1M1-PROVIDER-CURR-OPT-RR GREATER THAN ZERO)
      IF NUMBER OF LINE ITEMS GREATER THAN ZERO
      IF NOT UB82-CLAIM
      IF DEVELOPMENTAL DISABILITY REGION
      IF (SERVICE CODE EQUALS 'A' OR 'B' OR 'C' OR 'H' OR 'I' OR 'K' OR 'L' OR 'M' OR 'O' OR 'P' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'X' OR 'Y' OR 'Z' OR '1' OR '2' OR '3' OR '4' OR '5' OR '6' OR '7' OR '8' OR '9')
      OR (SERVICE CODE EQUALS 'J' AND (FIRST PROCEDURE SERVICE DATE GREATER THAN 19910831
      AND FIRST PROCEDURE SERVICE DATE LESS THAN 19990701)) OR (CLMT-SVCD (LSUB) EQUALS 'G'
      AND CLMT-1ST-PROC-SVDT (LSUB) < 19990701)
      IF (CALCULATED DAYS NOT EQUAL UNITS OF SERVICE AND NOT VALID DISCHARGE DESTINATION
      SET IF CLAIM REGION NOT EQUAL 40

   B. IF NURSING HOME CLAIM AND LONG TERM CARE REGION OR BASIC CARE REGION) AND
      (VR-PROVIDER NO NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383')
      IF (CALCULATED DAYS NOT EQUAL UNITS OF SERVICE AND NOT VALID DISCHARGE DESTINATION
      SET IF CLAIM REGION NOT EQUAL 40

METHOD OF CORRECTION:
CHECK THAT ALL DATA BEEN ENTERED CORRECTLY. IF ANY ERRORS, MAKE CORRECTIONS.
OTHERWISE DENY WITH EOB MA32 WHEN USING REMARK CODE "MA32" YOU MUST ENTER CLAIM
ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020   PROGRAM: SB1070, DETAIL.
ERROR CODE: 138

CLAIM TYPE: I, O, N, Q, U, R.
DATE UPDATED: 02/26/04

EDIT NAME: SERVICE CODE EQUALS Q, S. NONCOVERED NOT EQUAL BILLED

EDIT DESCRIPTION:

1. IN SB1070

   A. IF INSTITUTIONAL CLAIM OR UB82-INSTITUTIONAL CLAIM OR
      (UB82-HOME-HEALTH AND BILL-TYPE EQUALS '711' AND
      PVF-STATUS EQUALS ZEROS AND P1M1-PROVIDER-CURR-OPT-RR GREATER THAN ZERO)
      IF NUMBER OF LINE ITEMS GREATER THAN ZERO
      IF NURSING HOME CLAIM AND (LONG TERM CARE REGION OR BASIC CARE REGION) AND
      (VR-PROVIDER NO NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383')
      IF (SERVICE CODE EQUALS 'Q' OR 'S') AND (UNITS OF SERVICE NOT EQUAL NON-COVERED DAYS)
      SET IF CLAIM REGION NOT EQUAL 40 AND ADJUSTMENT CLAIM

METHOD OF CORRECTION:
VERIFY THAT ALL DATA HAS BEEN ENTERED CORRECTLY AND THAT BILLED AND NON-COVERED AMTS
AND DAYS MUST BE SAME. IF ANY ERRORS, MAKE CORRECTIONS. OTHERWISE, DENY WITH EOB 96
NURSING HOME - CHECK FIELD 37(NONCOV AMT) AND 61 (NONCOV DAYS).

JOB: SB1J020 PROGRAM: SB1070, DETAIL.
ERROR CODE: 139

CLAIM TYPE:
DATE UPDATED: 02/26/04

EDIT NAME: RECIPIENT NOT ON RTC/PSYCH ELIGIBILITY.

EDIT DESCRIPTION:

1. IN SB1090

   A. IF ((NURSING HOME CLAIM AND LONG TERM CARE REGION AND
       VR-PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR
       (PROVIDER NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000'))
      AND NOT (QMB-ELIGIBLE)
      IF NOT FOUND ON SB644010 USING BASE ID AND TECS NUMBER
      IF (CLAIM REGION NOT EQUAL '94') AND ((PROVIDER NO NOT GREATER '000032313' AND
       NOT LESS THAN '000032322') OR (PROVIDER NO NOT GREATER THAN '000033055' AND
       NOT LESS THAN '00033060'))
      SET IF MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0149.

      IF NOT A MEDICAL CLAIM
      SET IF (UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND
              (RECIPIENT AGE LESS THAN 21))

   B. IF CLAIM REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL 56 AND NOT EQUAL 55)
      IF PROCEDURE CODE FOUND ON PROCEDURE TABLE 0148
      IF NOT FOUND ON SB644010 USING BASE ID AND TECS NUMBER
      IF (CLAIM REGION NOT EQUAL '94') AND ((PROVIDER NO NOT GREATER '000032313' AND
       NOT LESS THAN '000032322') OR (PROVIDER NO NOT GREATER THAN '000033055' AND
       NOT LESS THAN '00033060'))
      SET IF MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0149

      IF NOT A MEDICAL CLAIM
      SET IF (UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND
              (RECIPIENT AGE LESS THAN 21))

   C. IF FIRST DAY OF SERVICE GREATER 20011031
      IF (MEDICAL CLAIM AND NOT PROVIDER NO EQUALS '000050383')
      IF PROCEDURE CODE FOUND ON PROCEDURE TABLE 0149
      IF NOT FOUND ON SB644010 USING BASE ID AND TECS NUMBER
      IF (CLAIM REGION NOT EQUAL '94') AND ((PROVIDER NO NOT GREATER '000032313' AND
       NOT LESS THAN '000032322') OR (PROVIDER NO NOT GREATER THAN '000033055' AND
       NOT LESS THAN '00033060'))
      SET IF MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0149

      IF NOT A MEDICAL CLAIM
SET IF (UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21))

D. IF (UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21))
   IF NOT FOUND ON SB644010 USING BASE ID AND TECS NUMBER
   IF (CLAIM REGION NOT EQUAL '94') AND ((PROVIDER NO NOT GREATER '00032313' AND NOT LESS THAN '00032322') OR (PROVIDER NO NOT GREATER THAN '00033055' AND NOT LESS THAN '00033060'))
   SET IF MEDICAL CLAIM AND PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0149

   IF NOT A MEDICAL CLAIM
   SET IF (UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21))

METHOD OF CORRECTION:
CHECK ALL ENTRIES FOR CORRECTNESS. IF ERRORS IN DATE, ENTER CHANGE. IF NO ERRORS, DENY WITH EOB 62

JOB: SB1J040       PROGRAM: SB1090, HEADER.
ERROR CODE: 140

CLAIM TYPE: M, N, U.
DATE UPDATED: 02/27/04

EDIT NAME: RECIP NOT ELIGIBLE ON RTC/PSYCH FILE.

EDIT DESCRIPTION:

1. IN SB1090

A. IF (NURSING HOME CLAIM AND LONG TERM CARE REGION AND
   VR-PROVIDER NO NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR
   (PROVIDER NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000')
   AND (NOT QMB-ELIGIBLE)
   IF FOUND ON SB644010 USING BASE ID OR TECS NUMBER
   IF NOT LONG TERM REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
   OR (NOT NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR 'Q'
   OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'))
   IF NOT NURSING HOME ELIGIBLE
   IF MEDICAL CLAIM AND UB82-INPATIENT CLAIM
   IF DDR-SERVICE CODE EQUALS 'P' AND PROVIDER NO NOT EQUAL '000050383'
   SET IF MEDICAL CLAIM AND PROCEDURE CODE EQUALS '02782'
   IF NOT MEDICAL CLAIM
   SET IF UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND
   (RECIPIENT AGE LESS THAN 21)

B. IF CLAIM-REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL 56 AND NOT EQUAL 55)
   IF PROCEDURE CODE FOUND ON PROCEDURE TABLE 0148
   IF FOUND ON SB644010 USING BASE ID OR TECS NUMBER
   IF NOT LONG TERM REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
   OR (NOT NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR 'Q'
   OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'))
   IF NOT NURSING HOME ELIGIBLE
   IF MEDICAL CLAIM AND UB82-INPATIENT CLAIM
   IF DDR-SERVICE CODE EQUALS 'P' AND PROVIDER NO NOT EQUAL '000050383'
   SET IF MEDICAL CLAIM AND PROCEDURE CODE EQUALS '02782'
   IF NOT MEDICAL CLAIM
   SET IF UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND
   (RECIPIENT AGE LESS THAN 21)

C. IF FIRST DAY OF SERVICE GREATER THAN 20011031
   IF (MEDICAL CLAIM AND NOT PROVIDER NO EQUALS '000050383')
   IF PROCEDURE CODE FOUND ON PROCEDURE TABLE 0149
   IF FOUND ON SB644010 USING BASE ID OR TECS NUMBER
   IF NOT LONG TERM REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
   OR (NOT NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR 'Q'
   OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'))
   IF NOT NURSING HOME ELIGIBLE
IF MEDICAL CLAIM AND UB82-INPATIENT CLAIM
IF DDR-SERVICE CODE EQUALS 'P' AND PROVIDER NO NOT EQUAL '00050383'
SET IF MEDICAL CLAIM AND PROCEDURE CODE EQUALS '02782'

IF NOT MEDICAL CLAIM
SET IF UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21)

D. IF (UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21))
IF FOUND ON SB644010 USING BASE ID OR TECS NUMBER
IF NOT LONG TERM REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S')
OR (NOT NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'))
IF NOT NURSING HOME ELIGIBLE
IF MEDICAL CLAIM AND UB82-INPATIENT CLAIM
IF DDR-SERVICE CODE EQUALS 'P' AND PROVIDER NO NOT EQUAL '00050383'
SET IF MEDICAL CLAIM AND PROCEDURE CODE EQUALS '02782'

IF NOT MEDICAL CLAIM
SET IF UB82-INPATIENT CLAIM AND (PROVIDER TYPE CODE EQUALS '02') AND (RECIPIENT AGE LESS THAN 21)

METHOD OF CORRECTION:
CHECK DATA ENTRY ON TURNAROUND DOCUMENT FOR CORRECT ENTRY. CHECK ELIG FILE. IF NOT SCREEN FOR PARTICULAR SERVICE THEY ARE BILLING FOR, DENY WITH EOB N29. *NOTE REGIONAL 90 CLAIMS (DD) WILL NOT RECEIVE THE 140 ERROR.
WHEN USING REMARK CODE "N29" YOU MUST ENTER CLAIM ADJUSTMENT REASON "16" IN FIELD 6.

JOB: SB1J040 PROGRAM: SB1090, HEADER.
Top
ERROR CODE: 151

CLAIM TYPE: X.
DATE UPDATED: 02/27/04

EDIT NAME: COUNTY/CCS CERTIF SIGN MISS.

EDIT DESCRIPTION:

1. IN SB1070
   A. IF TAKE OVER REGION
      IF CROSSOVER CLAIM
      IF NOT UB82 CLAIM
      SET IF NOT SIGNED BY COUNTY

METHOD OF CORRECTION:
VERIFY SIGN IND WAS ENTERED CORRECTLY BY INFOREX. IF NOT, CORRECT WITH A 'Y' AND PROCESS CLAIM. IF SIGN IS INDEED NOT PRESENT AND CLAIM HAS NOT BEEN AUTH BY COUNTY/CCS AGENCY, RTP CLAIM WITH EOB CODE 100. ATTACH 345, IT IS PROV RESPONSIBILITY TO DETERMINE CLAIM IS PROPERLY COMPLETED, PRIOR TO SENDING IT TO SOCIAL SVC BOARD FOR PAYMENT.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
Top
ERROR CODE: 152

CLAIM TYPE: X.
DATE UPDATED: 03/01/04

EDIT NAME: PROVIDER SIGNATURE MISSING.

EDIT DESCRIPTION:

1. IN SB1070
   A. IF TAKE OVER REGION
      IF CROSSOVER CLAIM
      SET IF NOT SIGNED BY PROVIDER

METHOD OF CORRECTION:
VERIFY SIGNATURE INDICATOR WAS TRANSCRIBED CORRECTLY. IF SIGN MISSING
RTP CLAIM WITH EOB CODE 100. ATTACH 345. IF PRESENT, ENTER 'Y' IN FIELD 28.
IF CLAIM HAS BEEN PAID BY OCR, MAKE COPY OF CLAIM AND PLACE IN PACKET. RETURN
CLAIM TO PROV DIRECTLY (NOT WITH RA) AND ASK THAT THEY SIGN AND RETURN TO
SPECIFIC AUDITOR HANDLING CLAIM. WHEN CLAIM IS RETURNED, REPLACE IN PACK AND
DESTROY COPY.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 153

CLAIM TYPE: X.
DATE UPDATED: 03/01/04

EDIT NAME: INVALID SCREEN REASON CODE.

EDIT DESCRIPTION:

1. IN SB1070
   A. IF CROSSOVER CLAIM
      IF NOT UB82-CLAIM
      SET IF SCREEN REASON CODES GREATER THAN 35

METHOD OF CORRECTION: VERIFY CORRECT TRANSCRIPTION OF SCREENING CODES.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 154

CLAIM TYPE:
DATE UPDATED: 03/01/04

EDIT NAME: SURGERY PROCEDURE CODE NOT ON FILE.

EDIT DESCRIPTION: NOT USED.

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF IN ERROR, CORRECT AND PROCESS CLAIM. OTHERWISE, VERIFY THAT PROCEDURE IS NOT A VALID. CHECK 'SURGICAL PROCEDURE DESCRIPTION' BLOCK. WITH THIS INFO, SURGICAL CODE CAN BE OBTAINED FROM ICD.9 CM-3. IF SURGERY IS NOT DESCRIBED, RETURN CLAIM WITH EOB "M58" AND "16" IN FIELD 6. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J070 PROGRAM: SB1070, HEADER.
ERROR CODE:  156

CLAIM TYPE:  I, O, N, Q, R, U.
DATE UPDATED:  03/01/04

EDIT NAME:  FAM PLAN FRACTION NOT 1-100%.

EDIT DESCRIPTION:

1.  IN SB1070

   A.  IF INSTITUTIONAL CLAIM OR UB82-INSTITUTIONAL CLAIM OR
        (UB82-HOME HEALTH AND BILL TYPE EQUALS '711' AND
         PROVIDER FILE STATUS EQUALS ZERO AND PROVIDER CURRENT OPTION-RR GREATER THAN 0)
        IF UB82-CLAIM
        SET IF UB82-FAMILY-PLAN-FRACTION GREATER THAN 1 OR LESS THAN 0

        IF NOT UB82-CLAIM
        SET IF FAMILY-PLAN-FRACTION GREATER THAN 1 OR LESS THAN 0

METHOD OF CORRECTION:  CHECK FAMILY PLANNING PERCENTAGE AND ENTER THE AMOUNT.

JOB:  SB1J020        PROGRAM:  SB1070, HEADER.
ERROR CODE:  158

CLAIM TYPE:  X.
DATE UPDATED:  03/01/04

EDIT NAME:  X-OVER TYPE IS INVALID.

EDIT DESCRIPTION:

1.        IN SB1070

   A.        IF CROSSOVER CLAIM
   SET IF NOT VALID CROSSOVER RCRD

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF INCORRECT, ENTER CORRECT TYPE CODE UTILIZING
PROV NAME AND PROCEDURE BILLED. CONTACT SUPERVISOR IF THIS EDIT OCCURS.

JOB:  SB1J020        PROGRAM: SB1070, HEADER.
ERROR CODE: 160
CLAIM TYPE: ALL.
DATE UPDATED: 03/01/04

EDIT NAME: OVERLAPPING AUTHORIZ PERIODS.

EDIT DESCRIPTION:

1. IN SB1090
   A. IF (TECS ELIGIBLE OR ERR-411-ON OR ERR-409-ON) AND (DEVELOPMENT METAL DISABILITY REGION)
      IF ELIGIBLE INDEX EQUALS TECS MMIS ENTRIES
      IF EARLIEST DATE LESS THAN START-DATE OR LATEST DATE GREATER THAN STOP DATE
      SET IF ERR-CD(1) NOT EQUAL '409' OR ERR-CD(2) NOT EQUAL '409' OR
         ERR-CD(3) NOT EQUAL '409' OR ERR-CD(4) NOT EQUAL '409' OR
         ERR-CD(5) NOT EQUAL '409' OR ERR-CD(6) NOT EQUAL '409' OR
         ERR-CD(7) NOT EQUAL '409' OR ERR-CD(8) NOT EQUAL '409' OR
         ERR-CD(9) NOT EQUAL '409' OR ERR-CD(10) NOT EQUAL '409'.

METHOD OF CORRECTION: NONE.

JOB: SB1J040 PROGRAM: SB1090, HEADER.
ERROR CODE: 161

CLAIM TYPE:
DATE UPDATED: 03/01/04

EDIT NAME: PROBLEM CONDITION NOT VALID.

EDIT DESCRIPTION:

1. IN SB1070
   A. EXISTS IN SB1070, BUT NOT USED.

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF IN ERROR, CORRECT AND PROCESS CLAIM. OTHERWISE, CORRECT THE CODE IN ERROR.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 162

CLAIM TYPE:
DATE UPDATED: 03/01/04

EDIT NAME: SCREEN TYPE NOT VALID.

EDIT DESCRIPTION:

1. IN SB1070
   A. EXISTS IN SB1070, BUT NOT USED.

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF IN ERROR, CORRECT AND PROCESS CLAIM. OTHERWISE, CHECK ELIGIBILITY FILE TO DETERMINE IF IT IS AN INITIAL OR PERIODIC VISIT AND INPUT CORRECT CODE.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 163

CLAIM TYPE: M, L, X.
DATE UPDATED: 03/01/04

EDIT NAME: MODIFIER IS INVALID.

EDIT DESCRIPTION:

1. IN SB1070
   A. IF NUMBER OF DETAILS GREATER THAN ZERO
      IF MEDICAL CLAIM OR DENTAL CLAIM OR CROSSOVER MEDICAL
      SET IF NOT VALID MODIFIER

      IF NUMBER OF DETAILS GREATER THAN ZERO
      IF MEDICAL CLAIM OR DENTAL CLAIM OR XOVR-MEDICAL
      IF NOT VALID MODIFIER
      SET IF CLAIM REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

METHOD OF CORRECTION:
VERIFY MODIFIER AND PROCED CODE TRANCRIBED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM.
IF CORRECT, CHECK TO SEE MODIFIER ENTERED IN FIELD IS INDEED NUMERIC. IF NOT, CORRECT TO
PROPER MODIFIER AND PROCESS CLAIM. FOR A LIST OF VALID MODIFIERS, REFERENCE CPT-4 MANUAL. IF
MODIFIER IS IN ERROR, RETURN THE CLAIM TO PROV WITH EOB "M58" AND "16" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070, DETAIL.
ERROR CODE: 164

CLAIM TYPE: L.
DATE UPDATED: 03/01/04

EDIT NAME: TOOTH NUMBER MISS OR INVALID.

EDIT DESCRIPTION:

1. IN SB1070

   A. IF DENTAL CLAIM AND NO PREDETERMINED BENEFITS
      IF NOT VALID TEETH
      SET IF CLAIM-REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

   B. IF DETAIL LINE GREATER THAN ZERO
      IF DENTAL CLAIM
      IF PROCEDURE CODE FOUND ON PROCEDURE TABLE 0147
      SET IF CLAIM REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

      IF DENTAL CLAIM AND TYPE SERVICE CODE EQUALS '7'
      IF PROCEDURE CODE FOUND
      IF NOT VALID TEETH
      SET IF CLAIM REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

METHOD OF CORRECTION:
VERIFY CORRECT DATA TRANSCRIBED. IF THE PROCEDURE CODE OR REMARKS INDICATE THAT SVCS
BILLED DO NOT RELATE TO PARTICULAR TOOTH, ENTER 33. IF DATA HAS BEEN TRANSCRIBED
CORRECTLY, RETURN TO PROC WITH EOB "M58" AND "16" IN FIELD 6. WHEN USING REMARK CODE "N37"
YOU MUST ENTER CLAIM ADJUSTMENT REASON "17" IN FIELD 6.

JOB: SB1J020        PROGRAM: SB1070, DETAIL.
ERROR CODE: 165

CLAIM TYPE: L.
DATE UPDATED: 03/01/04

EDIT NAME: TOOTH SURFACE MISS OR INVALID.

EDIT DESCRIPTION:

1. IN SB1070

   A. IF PROCEDURE CODE FOUND
      SET IF NOT VALID SURFACE OR SURFACE NOT EQUAL 'B'

METHOD OF CORRECTION:
SURFACE NUMBER OR LETTER WAS OMITTED OR ENTERED INCORRECTLY, ENTER THE CORRECT NUMBER
OR LETTER, IF POSSIBLE. IF PROCEDURE IS BILLED WHICH REQUIRES A SURFACE AND ONE IS NOT
SUPPLIED, RETURN TO PROV WITH EOB "M58" AND "16" IN FIELD 6. WHEN USING REMARK CODE "N75" YOU
MUST ENTER CLAIM ADJUSTMENT REASON "17" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070, DETAIL.
ERROR CODE: 166

CLAIM TYPE: M.
DATE UPDATED: 03/01/04

EDIT NAME: DETAIL DIAGNOSIS CODE NOT ON FILE.

EDIT DESCRIPTION:

1. IN SB1070

   A. IF CLAIM TYPE EQUALS ‘M’
      IF DETAIL DIAGNOSIS POINTER NOT EQUAL SPACES
      SET IF (DETAIL DIAGNOSIS POINTER LESS THAN '1' OR GREATER THAN '8')

      SET IF DIAGNOSIS(COUNT) NOT GREATER THAN SPACES.

METHOD OF CORRECTION:
VERIFY THAT DETAIL DIAGNOSIS WAS TRANSCRIBED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM.
OTHERWISE, CLEAR DIAGNOSIS IN ERROR AND PROCESS CLAIM.

JOB: SB1J020       PROGRAM: SB1070, DETAIL.
ERROR CODE: 167

CLAIM TYPE:
DATE UPDATED: 03/01/04

EDIT NAME: MAC WAIVER INDICATOR INVALID.

EDIT DESCRIPTION: NOT USED.

METHOD OF CORRECTION:
THIS ERROR USUALLY OCCURS ON ADJUSTMENTS WHEN PROVIDER HAS FAILED TO INDICATE WAIVER ON ORIGINAL CLAIM. ENTER 'W' IN FIELD 50.

JOB: PROGRAM:

Top
ERROR CODE: 169

CLAIM TYPE: D.
DATE UPDATED: 03/01/04

EDIT NAME: PRESCRIP NUM MISSING/INVALID.

EDIT DESCRIPTION:
1. IN SB710022
   A. SET IF PRESCRIPTION REFERENCE NUMBER EQUALS SPACES OR ZERO

METHOD OF CORRECTION:
VERIFY KEYING OF DATA. IF IN ERROR, ENTER CORRECT DATA AND PROCESS CLAIM. OTHERWISE, DENY CLAIM (THE DETAILS OF THE PAPER CLAIM THAT ARE IN ERROR) WITH EOB B17

JOB: PROGRAM: SB710022, HEADER.
ERROR CODE: 171

CLAIM TYPE:
DATE UPDATED: 03/01/04

EDIT NAME: ALLOWED CHARGE IS INVALID.

EDIT DESCRIPTION: NOT USED

METHOD OF CORRECTION: NONE

JOB: PROGRAM:

Top
ERROR CODE: 172

CLAIM TYPE: M, L, R.
DATE UPDATED: 03/01/04

EDIT NAME: AUTH NUMBER MISS OR INVALID.

EDIT DESCRIPTION:

IN SB1070

A. IF NOT UB82-CLAIM AND NOT DEPARTMENT OF INSTRUCTION
   SET IF DOCUMENT NUMBER EQUALS SPACES.

B. IF (PROFESSIONAL CLAIM
   AND NOT (UB82-HOME HEALTH AND BILL TYPE EQUALS '711'
   AND PROVIDER FILE STATUS EQUALS ZERO
   AND PROVIDER CURRENNT OPTION-RR GREATER THAN 0))
   OR CROSSOVER CLAIM
   SET IF REGION 95 (DEPARTMENT OF INSTRUCTION)
   AND PROCEDURE CODE IS '08507' OR '08508'
   AND DOCUMENT NUMBER EQUAL TO SPACES.

METHOD OF CORRECTION:
VERIFY THAT AUTH NUMB OF CLAIM/WORKSHEET TRANSCRIBED CORRECTLY. THIS EDIT FAILS FOR
TRANSCRIPTION/KEYING ERRORS ONLY.

JOB: SB1J020        PROGRAM: SB1070, HEADER uses DETAIL

Top
ERROR CODE: 179

CLAIM TYPE: ALL.
DATE UPDATED: 03/01/04

EDIT NAME: NO EOB CODE ON DENIED DET LN.

EDIT DESCRIPTION:

IN SB1130

   A. IF CLERICAL DENY
       SET IF RELEASE CODE EQUALS SPACES

METHOD OF CORRECTION: NONE.

JOB: SB1J050  PROGRAM: SB1130, DETAIL
ERROR CODE: 180

CLAIM TYPE: U.
DATE UPDATED: 03/01/04

EDIT NAME: FROM/THRU DATE NOT = DAYS BILL.

EDIT DESCRIPTION:

IN SB1070

A. IF NOT LONG TERM CARE REGION OR NOT BASIC CARE REGION OR NOT OUTPATIENT CLAIM
   OR NOT UB82-OUTPATIENT CLAIM OR NOT UB82-HOME HEALTH
   OR (PROVIDER NO LESS THAN '000035000' AND GREATER THAN '000037999')
   OR NOT NURSE-HOME-CLAIM
   IF UB82-INPATIENT CLAIM
   IF CALCULATED DAYS-TOO LESS THAN UB82-TOTAL DAYS BILLED
   IF NOT UB82-INPATIENT CLAIM
   SET IF CLAIM REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

   IF NURSING HOME CLAIM AND NOT BASIC CARE REGION
   IF SERVICE CODE EQUALS '1' OR '2' OR '3' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'
   IF CALCULATED DAYS-TOO NOT EQUAL TOTAL DAYS BILLED
   SET IF CLAIM REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

IN SB1090

A. IF UB82-INPATIENT CLAIM AND NOT AN ADJUSTMENT AND NOT DISCHARGE-DEATH
   IF (UB82-TOTAL DAYS BILLED + UB82-NONCOVERED DAYS) NOT EQUAL JULIAN-DATE-TOTAL-DAYS
   SET CLAIM REGION NOT EQUAL 40

METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA32" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020, SB1J040       PROGRAM: SB1070, SB1090, HEADER.
ERROR CODE: 181

CLAIM TYPE: I, U.
DATE UPDATED: 03/01/04

EDIT NAME: TOT DAYS CERT < TOT DAYS BILL.

EDIT DESCRIPTION:

IN SB1130

A. IF INPATIENT CLAIM
   IF NOT PROVIDER-OUT-OF-STATE
   SET IF TOTAL DAYS CERTIFIED LESS THAN TOTAL DAYS BILLED

   IF UB82-INPATIENT CLAIM
   IF NOT PROVIDER-OUT-OF-STATE
   IF PSRO APPROVED INDICATOR EQUALS ‘3’
   SET IF TOTAL DAYS CERTIFIED LESS THAN TOTAL DAYS BILLED

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. CHECK PSRO ATTACHMENT AND VERIFY THAT DAYS CERTIFIED AS ACTUALLY LESS THAN BILLED. IF SO, RETURN TO PROV WITH EOB "M58" AND "16" IN FIELD 6. ATTACH 631 EXPLAIN ERROR IN 'OTHER OR COMMENTS' SECTION WHEN USING REMARK CODE "N10" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 183

CLAIM TYPE: D, I, L, M, N, O, X
DATE UPDATED: 03/02/04

EDIT NAME: CTY/CCS FROM DATE MISS/INVALID.

EDIT DESCRIPTION:
IN SB1070
A. IF (NOT UB82-CLAIM) AND (NOT TAPE-BILL-REGION)
   SET IF AUTHORIZATION-START EQUALS ZERO
   IF (NOT UB82-CLAIM) AND (NOT TAPE-BILL-REGION)
   IF AUTHORIZATION-START NOT EQUAL ZERO
   SET IF DATE-ERROR EQUALS 'E'

METHOD OF CORRECTION:
VERIFY 'FROM' DATE WAS TRANSCRIBED CORRECTLY. VERIFY THAT DATE IS VALID LENGTH AND IS NUMERIC. IF NOT, RETURN TO PROV WITH EOB "M58" AND "16" IN FIELD 6. ATTACH 631 (CHECK #2).

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 184

CLAIM TYPE: ALL.
DATE UPDATED: 03/02/04

EDIT NAME: CTY/CCS THRU DATE INVALID.

EDIT DESCRIPTION:

IN SB1070

A. IF AUTHORIZATION-END NOT EQUAL ZERO
   SET IF DATE-ERROR EQUALS 'E'

METHOD OF CORRECTION:
VERIFY THAT 'THROUGH' DATE WAS TRANSCRIBED CORRECTLY. VERIFY THAT DATE IS VALID LENGTH AND IS NUMERIC. IF NOT, ENTER LAST DAY OF THE 'THROUGH DATE' MONTH.

JOB: SB1J020   PROGRAM: SB1070, HEADER.
ERROR CODE: 185

CLAIM TYPE: L, M, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: 7TH DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF INPUT DIAGNOSIS DOES NOT APPEAR ON MASTER DIAGNOSIS FILE.
B. SET IF INPUT DIAGNOSIS DOES NOT APPEAR ON MASTER DIAGNOSIS FILE

METHOD OF CORRECTION: CORRECT OR CHANGE CODE TO SPACES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 186

CLAIM TYPE: L, M, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: 8TH DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF INPUT DIAGNOSIS DOES NOT APPEAR ON MASTER DIAGNOSIS FILE.

B. SET IF INPUT DIAGNOSIS DOES NOT APPEAR ON MASTER DIAGNOSIS FILE

METHOD OF CORRECTION: CORRECT OR CHANGE CODE TO SPACES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 187

CLAIM TYPE: Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: 9TH DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF INPUT DIAGNOSIS DOES NOT APPEAR ON MASTER DIAGNOSIS FILE.

METHOD OF CORRECTION: CORRECT OR CHANGE CODE TO SPACES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 188

CLAIM TYPE: Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: ADMITTING DIAG NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF INPUT DIAGNOSIS DOES NOT APPEAR ON MASTER DIAGNOSIS FILE.

METHOD OF CORRECTION: CORRECT OR CHANGE CODE TO SPACES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 189

CLAIM TYPE: Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: E-CODE NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF E-CODE NOT ON FILE.

METHOD OF CORRECTION: CORRECT OR CHANGE CODE TO SPACES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.

Top
ERROR CODE: 190

CLAIM TYPE: X.
DATE UPDATED: 03/02/04

EDIT NAME: EOB NOT PRESENT FOR X-OVER.

EDIT DESCRIPTION:

IN SB1070

A. SET IF EOB-ATTACHEMENT EQUALS ‘NO’.

METHOD OF CORRECTION:
VERIFY THAT MEDICARE EOB IS NOT ATTACHED TO CLAIM. IF IT IS, VERIFY EOB INFO AGAINST CLAIM INFO. RECIPIENT NAME AND NUMBER MUST MATCH; PROV NAME AND NUMBER MUST MATCH; DATES AND SVCS BILLED MUST CORRESPOND. IF EOB IS INDEED ATTACHED, CHANGE MEDICARE EOB INDICATOR TO 1 TO REFLECT THIS AND PROCESS CLAIM. IF EOB IS NOT ATTACHED, RTP THE CLAIM WITH EOB CODE 100. ATTACH FORM 345.

JOB: SB1J020 PROGRAM: SB1070, HEADER.

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ERROR CODE: 191
CLAIM TYPE: M, L, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: PRIMARY DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:
IN SB1130

A. SET IF PRIMARY DIAGNOSIS CODE EQUALS ‘E’
   SET IF PRIMARY DIAGNOSIS NOT ON FILE.

METHOD OF CORRECTION:
VERIFY CORRECT DIAGNOSIS WAS TRANSCRIBED. VERIFY DIAGNOSIS ON CLAIM DOES NOT APPEAR ON
MASTER DIAGNOSIS FILE PRINTOUT SB4700 DD. IF NOT ON MASTER, CHECK ICDA MANUAL #1 UNDER
DESCRIPTION OF CONDITION. IF NOT FOUND, REVIEW WITH SUPERVISOR. DO NOT RETURN TO PROVIDER
UNLESS CODE IS INCORRECT AND NO INFO AS TO CONDITION IS CLARIFIED ON CLAIM.

JOB: SB1J050    PROGRAM: SB1130, HEADER.
ERROR CODE: 192

CLAIM TYPE: M, L, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: SECOND DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF SECOND DIAGNOSIS CODE NOT ON FILE.

METHOD OF CORRECTION:
VERIFY CORRECT DIAGNOSIS WAS TRANSCRIBED. VERIFY THAT DIAGNOSIS ON CLAIM DOES NOT APPEAR ON MASTER DIAGNOSIS FILE. CHECK ICDA MANUAL FOR DIAGNOSIS. IF DIAGNOSIS DOES NOT APPEAR IN MANUAL, CLEAR THE FIELD AND PROCESS CLAIM. CONTACT SUPERVISOR IF FILE MAINTENANCE IS NECESSARY. UB-82 DRG CLAIMS MUST HAVE CORRECT CODES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.

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ERROR CODE: 193

CLAIM TYPE: M, L, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: THIRD DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF THIRD DIAGNOSIS CODE NOT ON FILE.

METHOD OF CORRECTION:
CHANGE CODE TO SPACES. UB82 DRG CLAIMS MUST HAVE CORRECT CODES. IF INVALID, DENY HARDCOPY AND RETURN TO PROVIDER.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 194

CLAIM TYPE: M, L, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: FOURTH DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF FOURTH DIAGNOSIS CODE NOT ON FILE.

METHOD OF CORRECTION:
CHANGE CODE TO SPACES. UB82 DRG CLAIMS MUST HAVE CORRECT CODES. IF INVALID, DENY HARDCOPY AND RETURN TO PROVIDER.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 195

CLAIM TYPE: M, L, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: FIFTH DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF FIFTH DIAGNOSIS CODE NOT ON FILE.

METHOD OF CORRECTION:
CHANGE CODE TO SPACES. UB82 DRG CLAIMS MUST HAVE CORRECT CODES. IF INVALID, DENY HARDCOPY AND RETURN TO PROVIDER.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 196
CLAIM TYPE: M, L, Q, R, U.
DATE UPDATED: 03/02/04

EDIT NAME: SIXTH DIAGNOSIS NOT ON FILE.

EDIT DESCRIPTION:

IN SB1130

A. SET IF SIXTH DIAGNOSIS CODE NOT ON FILE.

METHOD OF CORRECTION:
THIS IS NOT A REQUIRED FIELD AT THIS TIME (6-1-85). CHANGE CODE TO SPACES.

JOB: SB1J050 PROGRAM: SB1130, HEADER.
ERROR CODE: 197

CLAIM TYPE: I, N, U.
DATE UPDATED: 03/02/04

EDIT NAME: COVERED DAYS GREATER THAN DAYS BILLED.

EDIT DESCRIPTION:

IN SB1070

A. IF (INPATIENT-CLAIM OR NURSING-HOME-CLAIM WITH SERVICE CODE '1' '2' '3' 'Q' 'R' 'S' 'T' 'U' 'V' 'W' 'X' OR NOT (UB82-INPATIENT-CLAIM AND (DRUG-CODE GREATER THAN 0))
   IF COVERED-DAYS GREATER THAN TOTAL-DAYS-BILLED
   IF COVERED-DAYS GREATER THAN (TOTAL-DAYS-BILLED + NONCOVERED-DAYS)
   SET IF CLAIM-REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

   IF UB82-INPATIENT-CLAIM AND NOT (UB82-INPATIENT-CLAIM AND (DRUG-CODE GREATER THAN 0))
   IF COVERED-DAYS GREATER (TOTAL-DAYS-BILLED + NONCOVERED-DAYS)
   SET IF CLAIM-REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

B. IF ((DAYS LESS THAN 5) OR (DAYS EQUAL 5)) AND (DAYS NOT EQUAL UNITS-OF-SERVICE))
   SET IF CLAIM-REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

METHOD OF CORRECTION:
VERIFY THAT BOTH COVERED DAYS AND TOTAL DAYS BILLED FIELDS HAVE BEEN TRANSCRIBED PROPERLY. IF THEY HAVE NOT CORRECT AND PROCESS CLM. VERIFY THAT THE TOTAL DAYS BILLED CORRESPONS TO STMT PER 'START'AND 'TO' DATES. OTHERWISE RTP WITH EOB "M58" AND "16"IN FLD 6.
EXPLAIN IN OTHER/COMMENTS SECTION-COVERED DAYS EXCEEDS TOTAL DAY BILLED. IF REGION 94,BATCH # 300 AND PROC CODE 00052-DENY WITH EOB "M53" YOU MAY ALSO USE "MA32" IN PLACE OF "M53" (MOST APPROPRIATE) WHEN USING "M53" ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070, HEADER.
ERROR CODE: 198

CLAIM TYPE: ALL.
DATE UPDATED: 03/02/04

EDIT NAME: RECIPIENT NOT MEDICAID ELIG.

EDIT DESCRIPTION:

IN SB1090

A. IF ((PROVIDER NO NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999')
   AND (RECIPIENT-LEGAL-COUNTY NOT EQUAL 063 AND NOT EQUAL 090))
   OR ((PROVIDER NO EQUALS '000053468' OR '000053494' OR '000053496' OR '000053497' OR '000051882'
   OR '000053482' OR '000053498' OR '000053495' OR '000053497' OR '000054516' OR '000054517' OR '000054518' OR '000054519'
   OR '000054520' OR '000054521' OR '000054522' OR '000054523')
   AND (RECIPIENT-LEGAL-COUNTY EQUALS 060 OR 063 OR 090))
SET IF CLAIM-REGION NOT EQUAL 40 AND IS AN ADJUSTMENT

METHOD OF CORRECTION: NONE.

JOB: SB1J040 PROGRAM: SB1090, HEADER.
ERROR CODE:  200

CLAIM TYPE:
A)  This error applies to all NON UB82 institutional claims.
B)  This error applies to NON-DENIED claims with a report type indicator of ‘08’.

DATE UPDATED:
02-10-04

EDIT NAME:
PROV 1900-2000 SVCD NOT 7,8,9

EDIT DESCRIPTION:
A)  A NON UB82 institutional claim having a provider number in the range ‘000001900’ through ‘000002000’ may NOT have a service code of ‘7’, ‘8’, ‘9’, ‘3’ or ‘R’.
B)  For detail lines where the pricing indicator is NOT ‘8’ AND NOT ‘5’, the newly calculated paid amount for the detail line is NOT EQUAL to the current paid amount already found at that detail line, given the current detail paid amount is GREATER THAN zero.

METHOD OF CORRECTION:
VERIFY PROVIDER NUMBER TRANSCRIBED PROPERLY. IF NOT, MAKE CORRECTIONS. IF PROVIDER NUMBER CORRESPONDS TO NUMBER ON CLAIM, REFER TO PROVIDER RELATIONS FOR CORRECTION.

OTHERWISE, ENTER CORRECT SERVICE CODE 7,8, OR 9 TO FIELD 51. CHECK MANUAL FOR INFO ON PROPER SERVICE CODES. IN ANCILLARY CHARGES BILLED, DENY WITH EOB 97 YOU MAY ALSO USE "B15" IN PLACE OF "97" (MOST APPROPRIATE).

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ERROR CODE: 201

CLAIM TYPE:
This error applies to all NON UB82 institutional claims.

DATE UPDATED:
02-11-04

EDIT NAME:
SVCD 7,8,9; PROV NOT 1900-2000

EDIT DESCRIPTION:
A NON UB82 institutional nursing home claim having a service code of ‘7’, ‘8’ or ‘9’ may NOT have a provider number in the range ‘000001900’ through ‘000002000’.

METHOD OF CORRECTION:
VERIFY THAT PROVIDER NUMBER AND SERVICE CODE ARE TRANSCRIBED CORRECTLY. IF NOT, ENTER CORRECTIONS AND PROCESS CLAIM. OTHERWISE, CHECK WITH PROVIDER ENROLLMENT TO DETERMINE CORRECT PROVIDER NUMBER. IF PROVIDER NOT ON FILE, THIS PROB WILL BE HANDLED BY PROVIDER ENROLLMENT. AUTHORIZATION WILL BE RETURNED TO AUDITOR WHEN PROVIDER NUMBER IS ON FILE. WHEN USING REMARK CODE "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" OR "B7" (MOST APPROPRIATE) IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 202

CLAIM TYPE:
A provider number in the range of 1900 through 2000 but the claim is not a nursing home claim (claim type ‘N’).

DATE UPDATED:
02-11-04

EDIT NAME:
PROV 1900-2000; CLM NOT N

EDIT DESCRIPTION:
A claim having a provider number in the range 1900 through 2000 must be a ND nursing home claim (claim type ‘N’).

METHOD OF CORRECTION:
VERIFY THAT PROVIDER NUMBER IS TRANSCRIBED CORRECTLY. IF NOT, ENTER CORRECT NUMBER.

NOTE: MAKE THIS CHANGE ONLY IF ERROR IN TRANSCRIPTION. OTHERWISE, REFER TO PROVIDER ENROLLMENT.
ALSO VERIFY CLAIM IS BATCHED WITH PROPER CLAIM TYPE. IF NOT, ICN DELETE CLAIM, ENTER INFO ON FACE OF BATCH ENVELOPE AND REENTER IN CORRECT BATCH.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 210

CLAIM TYPE:
NON-denied institutional, professional, UB82 institutional and crossover claims.

DATE UPDATED:
02-11-04

EDIT NAME:
PROV NO < 40000-NOT MED ALLOW

EDIT DESCRIPTION:
A claim of region 10 must not have a provider number in the range of '000080000' through '000099998'.

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N95" YOU MUST ENTER ADJUSTMENT REASON "8" IN FIELD 6.

JOB: SB1J020                     PROGRAM: SB1070
ERROR CODE: 211

CLAIM TYPE:
A) All claim types.
B) All claims NOT of region 40 OR adjustment claims.
C) All claim types.

DATE UPDATED:
02-11-04

EDIT NAME:
PROV INELIGIBLE ON SVC DATE

EDIT DESCRIPTION:
A) Billing provider is ineligible for Medicaid for given date(s) of service.
B) Billing provider is ineligible for Medicaid for given date(s) of service on claims that are not of region 40 as well as claims that are adjustment claims.
C) Billing provider eligibility start date is not greater than zeroes indicating an invalid date.

METHOD OF CORRECTION:
CHECK DATES OF SERVICE ON WORKSHEET AGAINST THOSE ON CLAIM. VERIFY THAT THEY WERE ENTERED CORRECTLY. IF DATES OF SERVICE DO NOT MATCH, ENTER CORRECT DATES FROM ORIGINAL CLAIM ONTO WORKSHEET AND PROCESS CLAIM. OTHERWISE, CHECK WITH PROVIDER ENROLLMENT TO DETERMINE STATUS OF PROVIDER. PROCESS CLAIM ON ACCORDANCE WITH THEIR DECISION. IF CLAIM IS TO BE DENIED, USE EOB ‘B7’. CHECK DRUG MAINTENANCE FILE – OPTION 'S'.

JOB:                        PROGRAM:
A)  SB1J050    SB1130
B)  SB1J050    SB1130MV
C)  CICS POS SYSTEM    SB710022
ERROR CODE: 212

CLAIM TYPE:
A) All drug claims.
B) All drug claims.

DATE UPDATED:
02-11-04

EDIT NAME:
DOS EARLIER THAN LAST DRUG DT

EDIT DESCRIPTION:
A) Date of service is EARLIER THAN the last drug date.
B) The beginning date of service of the drug price entry is LATER THAN the dispensed date (beginning date) on the claim.

METHOD OF CORRECTION:

YOU MAY ALSO USE "EA" IN PLACE OF "21" (MOST APPROPRIATE) WHEN USING REMARK CODE "N60" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
A) SB1J050 SB1130
    (note: SB1130 contains this error code but does not apply the code in it’s claim processing)
B) CICS POS SYSTEM SB710023

Top
ERROR CODE: 216

CLAIM TYPE:
A) Developmental Disability claims.
B) Developmental Disability claims.

DATE UPDATED:
02-12-04

EDIT NAME:
DD SERV EXCEEDS MAX OF 23 DAYS

EDIT DESCRIPTION:
Service codes A, B, I, K, L, M, N and units GREATER THAN 23 days. OR Region 94, batch #300, procedure code 00052 and units GREATER THAN 23.

METHOD OF CORRECTION:
REFER TO DEVELOPMENTAL DISABILITY UNIT FOR INFO. ADJUDICATE PER THEIR DECISION. IF REGION 94 AND BATCH NUMB 300 AND PROCEDURE CODE 00052, DENY DETAIL LINE WITH EOB 119.

JOB: PROGRAM:
A) SB1J020 SB1070
B) SB1J075, SB1J079 SB1250
ERROR CODE: 217

CLAIM TYPE:
Developmental Disability claims.

DATE UPDATED:
02-12-04

EDIT NAME:
SERV E OR F > 180 UNTS OF CARE

EDIT DESCRIPTION:
For DD claims with service codes of E or F, the number of care units is GREATER THAN 180. Excess units belong in extended service.

METHOD OF CORRECTION:
CHANGE UNITS TO AMOUNT WHICH, WHEN ADDED TO ACCUMULATED UNITS ON DD CLIENT ELIGIBILITY FILE, WILL EQUAL 180. ENTER EOB 364 IN FIELD 06 AT HEADER LEVEL. IF E OR F, ACCUMULATED UNITS = 180, AND NO EXTENDED UNITS HAVE BEEN AUTHORIZED, DENY CLAIM WITH EOB 240. IF EXTENDED UNITS HAVE BEEN AUTHORIZED, CHANGE SERVICE CODE TO E OR J MATCHING ELIGIBILITY.

JOB: ???
PROGRAM: ??? (not found in any programs in LIBRN Master)

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ERROR CODE: 218

CLAIM TYPE:
Claims with legal county code ‘090’

DATE UPDATED:
02-12-04

EDIT NAME:
CTY90,SVCD=BDHIOPRVWXYZ236789

EDIT DESCRIPTION:

OR

Claims MAY NOT have a detail-level service code of ‘O’, ‘R’ AND a beginning date of service EARLIER than July 1st, 1993.

OR

Claims MAY NOT have a detail-level service code of ‘H’ AND a beginning date of service EARLIER than July 1st, 1999.

METHOD OF CORRECTION:
(no method given in MMIS menu option ‘W’ – POS error processing control)

JOB: SB1J040
PROGRAM: SB1090

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ERROR CODE: 219

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-13-04

EDIT NAME:
PROVIDER NOT ON DD FILE

EDIT DESCRIPTION:
No provider was found on the developmental disability file for the current DD claim.

METHOD OF CORRECTION:

CHECK WITH PROV ENROLLMENT. IF VALID PROV, CHANGE AS INDICATED BY PROV ENROLLMENT. IF INVALID PROV, DENY.

JOB: SB1J050 PROGRAM: SB1130

Top
ERROR CODE: 220

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-13-04

EDIT NAME:
DD CLAIM, PROV NOT 35000-37999

EDIT DESCRIPTION:
A DD claim MUST have a provider number in the range of ‘000035000’ through ‘000037999’.

METHOD OF CORRECTION:
CHECK WITH PROVIDER ENROLLMENT. IF VALID PROV, CHANGE AS INDICATED BY PROV ENROLLMENT. IF INVALID, DENY.

JOB: SB1J020
PROGRAM: SB1070

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ERROR CODE: 221

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-13-04

EDIT NAME:
PROV 35000-37999, CLAIM NOT DD

EDIT DESCRIPTION:
A provider number in the range of ‘000035000’ through ‘000037999’ MUST BE a DD claim.

METHOD OF CORRECTION:
CHECK VALIDATION OF PROV MEMBER WITH PROV ENROLLMENT. IF PROV NUMBER IS CORRECT, DENY CLAIM AS ONLY SPECIFIC DD SVCS CAN BE PAID TO DD PROVIDERS.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 222

CLAIM TYPE:
A) Developmental disability claims.
B) Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
DD SERV-INVALID OR INELIGIBLE

EDIT DESCRIPTION:
A) The service code for this DD claim is invalid OR the dates of service are invalid.
B) The service code for this DD claim is invalid OR the dates of service are invalid.

METHOD OF CORRECTION:
CHECK WITH DEVELOPMENTAL DISABILITY UNIT CONCERNING SVCE OR ELIGIBILITY. CHANGE IS SVCE IS VALID AND RECIPIENT ELIGIBLE. IF EITHER CRITERIA NOT MET, DENY. CHECK MMIS, DD (ELIGIBILITY FILES) AND IHP. WHEN USING REMARK CODE "N30" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

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ERROR CODE: 223

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
NO RATE FOR DD SERVICE

EDIT DESCRIPTION:
Claim service dates are spaces
OR
The claim ending service date is GREATER THAN ancillary table ending date
OR
The claim beginning service date is LESS THAN ancillary table beginning date

METHOD OF CORRECTION:
CHECK WITH PROV ENROLLMENT. IF RATE WILL BE ON FILE, HOLD UNTIL DESIGNATED DATE AND RECYCLE. IN INVALID SERVICE, DENY.

JOB: SB1J050
PROGRAM: SB1130

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ERROR CODE: 224

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
DD SERV EXCEEDS MAX OF 31 DAYS

EDIT DESCRIPTION:
Service code is 'C', 'H', 'O', 'P', 'Q', 'S', 'T', 'V', 'W', 'X', 'Y', 'Z', '1', '2', '3', '4', '5', '6', '7', '8', '9', number of units GREATER THAN 31

OR

Service code is 'G', 'J', 1st date of service LESS THAN 19990701, number of units GREATER THAN 31

OR

Service code is 'G', 'J', 1st date of service GREATER THAN OR EQUAL TO 19990701, number of units GREATER THAN 999

METHOD OF CORRECTION:
(no entry on MMIS menu option ‘W’)

JOB: PROGRAM:
SB1J020 SB1170

Top
ERROR CODE: 225

CLAIM TYPE:
Developmental disability claims.
Professional claims.

DATE UPDATED:
02-17-04

EDIT NAME:
DD SERV EXCEEDS MAX OF 5 DAYS

EDIT DESCRIPTION:

OR

Professional claim number of units GREATER THAN 5

METHOD OF CORRECTION:

(no entry on MMIS menu option ‘W’)

JOB: PROGRAM:
SB1J020 SB1170

Top
ERROR CODE:  226

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
DD SERVICE MUST EQUAL 1 UNIT

EDIT DESCRIPTION:

METHOD OF CORRECTION:

REFER TO DD. ADJUDICATE PER THEIR DECISION. WHEN USING REMARK CODE "M53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB:                                                PROGRAM:
SB1J020                        SB1170

Top
ERROR CODE: 227

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-17-04

EDIT NAME:
COUNTY 63, CLAIM NOT DD

EDIT DESCRIPTION:
Legal county code EQUAL ‘063’, claim NOT developmental disability claim

OR

Legal county code EQUAL ‘063’, developmental disability claim provider number NOT in the range of ‘000035000’ through ‘000037999’

METHOD OF CORRECTION:

NOT CORRECTABLE. DENY WITH EOB 31

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 228

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
DD CLAIM, PAT-LIABILITY > ALLOWED CHARGE

EDIT DESCRIPTION:
DD claim has a patient liability GREATER THAN the allowed charge for this type of service.

METHOD OF CORRECTION:
(no entry in MMIS option ‘W’)

JOB: SB1J050
PROGRAM: SB1130
(note: this error code is found in SB1130, but is never used in claim processing.)
ERROR CODE: 229

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
RECIPIENT NOT ON DD FILE

EDIT DESCRIPTION:
DD claim’s recipient number was not found on TECS.

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N30" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J040       PROGRAM: SB1090
ERROR CODE: 230

CLAIM TYPE:
DDS, CCS, VR, DD claims.

DATE UPDATED:
02-17-04

EDIT NAME:
TP-CLM NOT PAYBL THRU MEDICAID

EDIT DESCRIPTION:
Tape claims with the first two digits of the case number of ‘59’, ‘61’ through ‘69’

OR

Take-over claims with the first two digits of the case number of ‘59’, ‘61’ through ‘69’

METHOD OF CORRECTION:
DENY WITH EOB 31

JOB: SB1J040
PROGRAM: SB1090
ERROR CODE: 231

CLAIM TYPE:
Developmental disability claims.

DATE UPDATED:
02-17-04

EDIT NAME:
AUTH PERIOD > MAX OF 31 DAYS

EDIT DESCRIPTION:
DD claims have a total number of authorized days GREATER THAN 31

METHOD OF CORRECTION:
CHECK TURNAROUND DOCUMENT. CHANGE DATES OF SVCE TO A ONE MONTH PERIOD

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 232
CLAIM TYPE: All claim types.

DATE UPDATED: 02-17-04

EDIT NAME: AETS CLIENT NOT MA/HCBS

EDIT DESCRIPTION:

OR


OR


OR


METHOD OF CORRECTION:
(no entry on MMIS option ‘W’)

JOB: SB1J040
PROGRAM: SB1090
ERROR CODE: 259

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-17-04

EDIT NAME:
MUST BILL 00015 OR 00017 INDIVIDUALLY

EDIT DESCRIPTION:
Current claim contains procedure codes ‘00015’, ‘00017’

METHOD OF CORRECTION:
PROCEDURE CODE 00015 (CASE MANAGEMENT - OTHER) AND PROCEDURE CODE 00017 (CASE MANAGEMENT - ASSESSMENT) CANNOT BE BILLED WITH ANY OTHER PROCEDURE CODE DUE TO MATCHING FUND IMPLICATIONS.

JOB: PROGRAM:
SB1J040         SB1090
CICS POS SYSTEM  SB710041

Top
ERROR CODE: 260

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-17-04

EDIT NAME:
QSP PROVIDER, REGION NOT = 94

EDIT DESCRIPTION:
Provider number in the ranges ‘000032000’ through ‘000034999’, ‘000038800’ through ‘000039999’ AND region NOT ‘94’.

METHOD OF CORRECTION:
CHECK FOR ACCURACY OF PROVIDER NUMBER. IF PROV NUMBER IS CORRECT AND CARE IS NOT HCBC, DENY YOU MAY ALSO USE "N34" OR "N95" IN PLACE OF "M57" (MOST APPROPRIATE) WHEN USING REMARK CODE "M57" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070

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ERROR CODE: 261

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-17-04

EDIT NAME:
REGION = 94, NOT A QSP PROV

EDIT DESCRIPTION:
Region '94' AND provider number NOT in the ranges ‘000032000’ through ‘000034999’, ‘000038800’ through ‘000039999’.

METHOD OF CORRECTION:
CHECK FOR ACCURACY OF PROVIDER NUMBER. IF PROVIDER NUMBER IS ENTERED CORRECTLY AND PROVIDER DOES NOT PROVIDE HOME AND COMMUNITY BASED CARE, DENY WHEN USING REMARK CODE "M57" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070

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ERROR CODE: 262
DATA CORRECTABLE:

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-17-04

EDIT NAME:
ICN=94, PROC NOT = 00001-00099

EDIT DESCRIPTION:

METHOD OF CORRECTION:

CHECK PROCEDURE CODE FOR VALIDITY OF ENTRY. IF CODE HAS BEEN ENTERED ON CLAIM INCORRECTLY, MAKE NECESSARY CORRECTION. OTHERWISE, DENY LINE

JOB:                                             PROGRAM:
SB1J020                                          SB1070 (note: SB1070 contains this error code but never uses it in claim processing.)
ERROR CODE: 263

CLAIM TYPE:
All NON UB82 Home Health claims.

DATE UPDATED:
02-17-04

EDIT NAME:
PROC 00001-00099, ICN NOT = 94

EDIT DESCRIPTION:
Procedure code in the range ‘0001’ through ‘00099’

AND

Claim type is NOT ‘R’, UB82 Home Health claim.

AND

Claim is NOT of region ‘94’.

METHOD OF CORRECTION:
CHECK PROCEDURE CODE TO SEE IF ENTERED TO SYSTEM FROM CLAIM CORRECTLY. IF NOT, CORRECT ENTRY. OTHERWISE, DENY LINE WITH EOB 058.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 264

CLAIM TYPE:
A) NON UB82 Home Health claims.
B) All Professional claims.

DATE UPDATED:
02-17-04

EDIT NAME:
CONFLICTING PROCEDURE CODES

EDIT DESCRIPTION:
A) NON UB82 Home Health claim with procedure codes ‘0154’ AND ‘0122’.
B) Professional claim with procedure codes ‘0148’ AND ‘0103’

OR

Professional claim with procedure codes ‘0148’ AND legal county code NOT in the range of ‘1’ to ‘53’.

METHOD OF CORRECTION:

IF PROCEDURE CODES FOR AGING ARE USED WITH PROCEDURE CODES FOR DD WAIVER ON SAME CLAIM, DENY LINE WHEN USING REMARK CODE "N30" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
A) SB1J020 SB1070
B) SB1J040 SB1090

Top
ERROR CODE: 265

CLAIM TYPE:
All region '94' claims.

DATE UPDATED:
02-18-04

EDIT NAME:
RECIPIENT INELIGIBLE

EDIT DESCRIPTION:
Region '94' claim has the first two digits of it’s case number LESS THAN ‘01’

OR

Region ‘94’ claim has the first two digits of it’s case number GREATER THAN ‘56’

OR

Region ‘94’ claim has the first two digits of it’s case number EQUAL TO ‘54’

METHOD OF CORRECTION:
CHECK ELIGIBILITY FILE ON CRT. IF LEGAL COUNTY FOR THE ELIGIBILITY PERIOD SPECIFIED IS NOT 1 THROUGH 53
A DETERMINATION HAS TO BE MADE. IF IT SHOULD BE 1 THROUGH 53 THEN ELIGIBILITY HAS TO BE CHANGED AND
THE CLAIM RECYCLED. IF IT SHOULD BE WHAT IS ON ELIGIBILITY, DENY THE CLAIM.
YOU MAY ALSO USE "27" IN PLACE OF "26" (MOST APPROPRIATE)

JOB: SB1J040  PROGRAM: SB1090

Top
ERROR CODE: 268

CLAIM TYPE:
All claims.

DATE UPDATED:
02-18-04

EDIT NAME:
REVENUE CODE INVALID MEDICAID

EDIT DESCRIPTION:
Claim has a revenue code that is not Medicaid allowed

AND

Claim is NOT a UB82 Inpatient claim with a DRG code GREATER THAN ‘0’.

METHOD OF CORRECTION:
CHECK FOR CORRECT KEYING OF REVENUE CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC CLAIM DENY LINE ITEM WHEN USING REMARK CODE "M50' YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE:     269

CLAIM TYPE:
All NON a UB82 Inpatient claims.

DATE UPDATED:
02-18-04

EDIT NAME:
REVENUE CODE INVALID - INPAT

EDIT DESCRIPTION:
Claim is NOT a UB82 Inpatient claim with DRG code GREATER THAN ‘0’.

AND

Claim is NOT of region ‘40’ OR it is an adjustment claim.

METHOD OF CORRECTION:

CHECK FOR CORRECT KEYING OF REVENUE CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH,
CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING,
DENY LINE WHEN USING REMARK CODE "M50' YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD6.

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE: 270

CLAIM TYPE:
All UB82 Outpatient claims.

DATE UPDATED:
02-18-04

EDIT NAME:
REVENUE CODE INVALID - OUTPAT

EDIT DESCRIPTION:
UB82 Outpatient claim is NOT of region *40*

OR

UB82 Outpatient claim is an adjustment claim.

METHOD OF CORRECTION:

CHECK FOR CORRECT KEYING OF REVENUE CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, DENY LINE WHEN USING REMARK CODE "M50' YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE:  271

CLAIM TYPE:
All UB82 Home Health claims.

DATE UPDATED:
02-18-04

EDIT NAME:
REVENUE CODE INVALID - H.H.

EDIT DESCRIPTION:
UB82 Home Health claim is NOT of region ‘40’

OR

UB82 Home Health claim is an adjustment claim.

METHOD OF CORRECTION:
CHECK FOR CORRECT KEYING OF REVENUE CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, DENY LINE WHEN USING REMARK CODE "M50' YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J050        PROGRAM: SB1130
ERROR CODE: 272

CLAIM TYPE:
A) All UB82 claims.
B) All claim types.

DATE UPDATED:
02-18-04

EDIT NAME:
REVENUE CODE INVALID

EDIT DESCRIPTION:
A1) Current claim is NOT a UB82 Inpatient claim OR the current claim revenue code is NOT VALID

AND

Current claim is NOT of region ‘40’ OR current claim is an adjustment claim.

A2) Current claim is a UB82 Outpatient claim, billing code ‘731’, revenue code is NOT ‘634’, revenue code is NOT ‘821’

AND

Current claim is NOT of region ‘40’ OR current claim is an adjustment claim.

A3) Current claim’s revenue code is NOT ‘540’ OR current claim is an IHS claim where the provider number is NOT ‘000001058’, ‘000001063’, ‘000001307’ or ‘000002335’ with a revenue code of ‘100’ or ‘540’

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

A4) If ICF/MR Provider and revenue code = 184 and DOS after 03/31/2004 and not region 40
A5) If ICF/MR Provider and revenue code = 185 and DOS before 04/01/2004 and not region 40

B1) Current UB82 Home Health claim, billing code of ‘711’, revenue code NOT ‘983’, ‘521’ or ‘523’

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

Current claim has a provider number in the range of ‘000030800’ through ‘000031999’ where the service code is NOT a ‘T’, ‘U’, ‘V’, ‘W’, ‘X’, or ‘Y’
orCurrent claim has a provider number in the range of ‘000001900’ through ‘000001999’ where the service code is NOT a ‘3’, or ‘R’

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

B3) Current claim does NOT have a revenue code of ‘983’

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

B4) Current UB82 Home Health claim has a billing code of ‘711’ with an allowed charge of zero

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

B5) Current UB82 Inpatient claim has a revenue code that is NOT ‘100’, ‘961’ or ‘987’

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

METHOD OF CORRECTION:

CHECK FOR CORRECT KEYING OF REV CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, DENY LINE WHEN USING REMARK CODE "M50' YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

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ERROR CODE:  273

CLAIM TYPE:
All UB82 claims.

DATE UPDATED:
02-18-04

EDIT NAME:
CPT-4 PROC CODE MISS / INVALID

EDIT DESCRIPTION:
1) Current claim is a UB82 Outpatient claim of IHS region with a billing code of ‘131’ and revenue code of ‘987’.

   AND

   It’s CPT4 code is NOT in the ranges of ‘99221’ through ‘99239’, ‘99291’ through ‘99297’, ‘99431’ through ‘99440’ or ‘99261’ through ‘99263’.

2) Current, un-priced UB82 Outpatient, un-priced UB82 Home Health claim has a CPT4 code that IS NOT ‘03000’, ‘03001’, ‘03005’, ‘03006’, ‘97535’, or ‘99078’ with a revenue code of ‘982’

   OR

   Current, un-priced UB82 Outpatient, un-priced UB82 Home Health claim has a CPT4 code that is SPACES and is an adjustment or a tape-bill claim.

METHOD OF CORRECTION:

CHECK FOR CORRECT KEYING OF CPT-4 CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, DENY LINE

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 274

CLAIM TYPE:
UB82 Inpatient claims.

DATE UPDATED:
02-18-04

EDIT NAME:
INVALID SOURCE OF ADMISSION

EDIT DESCRIPTION:
Current claim has a source of admission code that’s LESS THAN ‘1’ OR GREATER THAN ‘9’

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

METHOD OF CORRECTION:

IF HARDCOPY AND SOURCE MISKEYED, CORRECT AND PROCESS CLAIM. IF HARDCOPY OR SOURCE NOT MISKEYED, DENY WITH EOB 100. IF DIRECT (EMC) BILLING, DENY WHEN USING REMARK CODE "MA42" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 275

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-18-04

EDIT NAME:
SURG PROC DATE IS INVALID

EDIT DESCRIPTION:

METHOD OF CORRECTION:

CHECK FOR CORRECT KEYING OF PROCEDURE CODE DATE FROM CLAIM HARDCOPY. IF THE NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, DENY CLAIM YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070 (note: this err code is found only in SB1070 but is no longer used in claim processing – request #312701)
ERROR CODE: 276

CLAIM TYPE: All claim types.

DATE UPDATED: 02-18-04

EDIT NAME: PSRO CODE FOR UB82 INPT CLAIM INVALID

EDIT DESCRIPTION:

METHOD OF CORRECTION:
(no entry in MMIS option ‘W’)

JOB: SB1J020  PROGRAM: SB1070 (note: this err code is found only in SB1070 but is no longer used in claim processing – request #312701)
ERROR CODE: 277

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-18-04

EDIT NAME:
SURG PROC DATE (3RD) INVALID

EDIT DESCRIPTION:

METHOD OF CORRECTION:

CHECK FOR CORRECT KEYING OF PROCEDURE CODE DATE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, DENY CLAIM YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070 (note: this err code is found only in SB1070 but is no longer used in claim processing – request #312701)
ERROR CODE: 278

CLAIM TYPE:
UB82 claims.

DATE UPDATED:
02-18-04

EDIT NAME:
UB82 NH INCREMENTS MUST BE SPLIT

EDIT DESCRIPTION:

METHOD OF CORRECTION:

VERIFY DETAIL AND/OR DETAILS CAUSING PROBLEM. IF A DETAIL NEEDS TO BE SPLIT FOR DIFFERENT ACCOMMODATIONS THEN ADD A DETAIL LINE WITH A APPROPRIATE MOUNTS FOR THE DETAIL BEING SPLIT AND PROCESS CLAIM. OTHERWISE RTP WITH EOB "M58" AND "16" IN FIELD 6. ATTACH 631 - EXPLANATION -UB92 NURSING INCREMENTS MUST BE SPLIT FOR DIFFERENT ACCOMODATIONS. WHEN USING REMARK CODE "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: ?
PROGRAM: ? (note: this err code is found only on the MMIS menu option 'W', not in production)
ERROR CODE: 280

CLAIM TYPE:
All UB92 Nursing Home claims.

DATE UPDATED:
02-18-04

EDIT NAME:
UB92 NURSING INC MUST BE SPLIT

EDIT DESCRIPTION:
Current claim has remaining units GREATER THAN zero

AND

Current claim is NOT a UB82 Inpatient claim with a DRG code GREATER THAN zero

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 281

CLAIM TYPE:
All UB92 claims.

DATE UPDATED:
02-18-04

EDIT NAME:
UB92 NURS INC CD NE ACCOM CD

EDIT DESCRIPTION:
Current claim has a revenue code of ‘231’, ‘233’, or ‘234’

AND

Current claim is a NOT UB82 Inpatient claim with a DRG code GREATER THAN zero

METHOD OF CORRECTION:

WHEN USING REMARK CODE "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
SB1J020 SB1070

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ERROR CODE: 282

CLAIM TYPE:
UB92 claims.

DATE UPDATED:
02-18-04

EDIT NAME:
UB92 INPAT > 5 ACCOMODATIONS

EDIT DESCRIPTION:

METHOD OF CORRECTION:

VERIFY THAT THERE HAVE BEEN NO DUPLICATION OF REVENUE CODE ON TWO LINES THAT CAN BE COMBINED OR OTHER THAT CAN BE COMBINED. CORRECT AND PROCESS THE CLAIM OTHERWISE RTP WITH EOB "58" AND "16" IN FIELD 6. ATTACH 631 -EXPLANATION -ONLY 5 DIFFERENT REVENUE ACCOMMODATION FOR PRIVATE, SEMI-PRIVATE OR WARD ARE ALLOWED PER CLAIM.

WHEN USING REMARK CODE "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
? ? (note: err 282 is found in MMIS menu option ‘W’
      but not in any production programs)
ERROR CODE: 283

CLAIM TYPE: All claim types.

DATE UPDATED: 02-18-04

EDIT NAME: PROV 19000-19031, ICN NOT = 95

EDIT DESCRIPTION: The current claim has a provider number in the range of '000019000' through '000019031'

AND

The current claim is NOT of region '95'

METHOD OF CORRECTION:

DEPARTMENT OF INSTRUCTION PROV IDENTIFIED BY PROV NUMBERS 000019000 THROUGH 000019031. CHECK FOR ACCURACY OF PROVIDER NUMBER. IF PROVIDER NUMBER IS CORRECT AND THE CARE IS NOT DEPARTMENT OF INSTRUCTION, DENY WHEN USING REMARK CODE "N34" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070
ERROR CODE: 284

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-19-04

EDIT NAME:
ICN = 95, PROV NOT 19000-19031

EDIT DESCRIPTION:
The current claim is of region ‘95’

AND

The current claim has a provider number NOT in the range of ‘000019000’ through ‘000019031’

METHOD OF CORRECTION:
CHECK FOR ACCURACY OF PROVIDER NUMBER. IF PROV NUMBER IS ENTERED CORRECTLY AND PROVIDER DOES
NOT PROVIDE DEPARTMENT OF INSTRUCTION SERVICES, DENY

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 285

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-19-04

EDIT NAME:
ICN = 95, PROC NOT 08500-08509

EDIT DESCRIPTION:
The current claim is of region ‘95’

AND


METHOD OF CORRECTION:
CHECK PROCEDURE CODE FOR VALIDITY OF ENTRY. IF CODE HAS BEEN ENTERED OFF THE CLAIM INCORRECTLY, MAKE NECESSARY CORRECTION; OTHERWISE DENY

JOB: SB1J020
PROGRAM: SB1070 (note: this error code is only found in
SB1070, but was commented out and is no longer
used – request #622606)

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ERROR CODE:         286

CLAIM TYPE:
All claim types.

DATE UPDATED:
02-19-04

EDIT NAME:
PROC 08500-08509, ICN NOT = 95

EDIT DESCRIPTION:
The current claim procedure code is in the range of ‘08500’ through ‘08509’

AND

The current claim is NOT of region ‘95’

METHOD OF CORRECTION:
CHECK PROCEDURE CODE TO SEE IF ENTERED TO THE SYSTEM FROM THE CLAIM CORRECTLY, IF NOT, DENY WITH EOB 058.

JOB:                                                PROGRAM:
SB1J020                        SB1070

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ERROR CODE:  397

CLAIM TYPE:  ALL CLAIM TYPES

DATE UPDATED: 02/23/2004

EDIT NAME: FSS FCO 3 AND NOT MA/HCBS

EDIT DESCRIPTION: If the first day of service is greater than 11/01/1999 and the claim is tecs eligible and the case number is greater than ‘53’ and if the service code is equal to ‘H’.

METHOD OF CORRECTION: No entry listed on MMIS menu.

JOB:  SB1J040                     PROGRAM: SB1090
ERROR CODE:  398

CLAIM TYPE:

DATE UPDATED:  2/23/04

EDIT NAME: ERROR BUT TABLE FULL

EDIT DESCRIPTION:

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS MENU.

JOB: SB1J085 PROGRAM: SB133A
ERROR CODE: 399

CLAIM TYPE:

DATE UPDATED: 2/23/04

EDIT NAME: CLAIM AWAITING NH/HCBC/SH BILL

EDIT DESCRIPTION:

METHOD OF CORRECTION: No entry listed on MMIS menu.

JOB: PROGRAM:

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ERROR CODE: 400

CLAIM TYPE: INSTITUTIONAL, UB82-INST, CROSSOVER, XOVR-INPATIENT, XOVR-OUTPATIENT

DATE UPDATED: 2/25/04

EDIT NAME: FILE CLAIM WITH MEDICARE

EDIT DESCRIPTION: if the care effective date is greater than the first day of serv or if it's not a nursing home claim that is qmb elig

if the claim is TECS or QMB eligible or if the latest date is greater than the starting date or if the latest date is greater than the stop date or if the claim is not TECS or QMB eligible or the latest date is greater than the starting date or if the latest date is greater than the stop date and the claim type is not INSTITUTIONAL, UB82-INST, CROSSOVER, XOVR-INPATIENT, XOVR-OUTPATIENT

if the claim is not a crossover, or medical, or ub82 claim, and the medicare status is an "A" or "B" and the recipient aid is greater than 27 and less than 32.

if recipient legal county is greater than zero and less than 54 or the recipient case no is greater than zero and less than 54

if the value returned from the read of the adabas recipient file is equal to or less than zero

METHOD OF CORRECTION: CAPTURED FOR REVIEW/MEDICARE COVERAGE

JOB: SB1J040 PROGRAM: SB1090

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ERROR CODE: 401

CLAIM TYPE:

DATE UPDATED: 2/25/04

EDIT NAME:

EDIT DESCRIPTION: THIS IS NO LONGER IN OUR SYSTEM!!!

METHOD OF CORRECTION:

JOB: PROGRAM:

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ERROR CODE: 402

CLAIM TYPE: DENTAL CLAIMS

DATE UPDATED: 2/25/04

EDIT NAME: PROV NUMBER NOT ON PTAR FILE

EDIT DESCRIPTION: IF THE CLAIM IS A DENTAL AND
(IF THE PRIOR AUTHORIZATION FLAG IS EQUAL TO A '1' AND IT'S A REGULAR CLAIM OR
IF THE PRIOR AUTHORIZATION FLAG IS EQUAL TO A '1' AND IT'S AN ADJUSTMENT) AND
IF THE STATUS KEY IS EQUAL TO '00' AND
IF THE PROVIDER NUMBER EQUALS THE STORED PROVIDER NUMBER OR
IF THE PROVIDER NUMBER IS NOT EQUAL TO THE STORED PROVIDER NUMBER AND IF THE FIRST
PROCEDURE SERVICE DATE IS LESS THAN THE PRIOR AUTHORIZATION FROM DATE
OR IF THE LAST PROCEDURE SERVICE DATE IS GREATER THAN THE PRIOR AUTHORIZATION TO DATE
AND IF THE ERROR CODE STATUS IS EQUAL TO AN 'F' AND THE ERROR CODE IS EQUAL TO '407'
AND THE ERROR CODE LINE NUMBER EQUALS THE NUMBER OF LINE ITEMS.

METHOD OF CORRECTION: PULL ORIGINAL PTAR AND REVIEW. IF PTAR ASSIGNED TO A DIFFERENT PROVIDER,
RETURN TO BILLING PROV AND REQUEST THEY SUBMIT A PTAR REQUEST FOR CONTINUATION OF THEIR SVCS.
USUALLY THIS ERROR OCCURS ON ORTHODONTIC CARE. IF A ONE-TIME SVCE BY THIS PROVIDER, OVERRIDE AS
DENTIST IS PROBABLY SUBSTITUTING FOR REGULAR PRACTITIONER.

JOB: SB1J077          PROGRAM: SB1275

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ERROR CODE: 403

CLAIM TYPE: DENTAL CLAIMS

DATE UPDATED: 2/26/04

EDIT NAME: PTAR NUMBER REQUIRED

EDIT DESCRIPTION: IF THE RECORD WAS NOT FOUND ON THE VSAM PTAR MASTER FILE.

METHOD OF CORRECTION:

REVIEW ORIGINAL PTAR AND CHECK FOR CORREC TRANSACTION. IF INCORRECT, CHANGE OR RETURN FOR CORRECTION BY PROVIDER. IF NO PTAR ON FILE, DENY
IF NO PTAR NUMBER IS REQUIRED FOR THIS PROCEDURE CODE, CHANGE THE AUTHORIZATION INDICATOR TO 0 ON THE LEVEL 3 PRICING FILE THROUGH KEY MASTER.

JOB: SB1J077                PROGRAM: SB1275
ERROR CODE:  404

CLAIM TYPE:

DATE UPDATED:  2/26/04

EDIT NAME:  RECIP NUMBER NOT ON PTAR FILE

EDIT DESCRIPTION:  NO LONGER IN OUR SYSTEM.

METHOD OF CORRECTION:  CHECK SS NUMBER, TRANSCRIPTION AND NAME MATCH. IF NOT ENTERED CORRECTLY, MAKE NECESSARY CORRECTIONS. IF TRANSCRIPTION CORRECT, CHECK FOR PTAR IN PTAR FILE. IF NOTHING FOUND, RTP FOR COPY OF PTAR.

JOB:  

PROGRAM:  

Top
ERROR CODE: 405
CLAIM TYPE: ALL
DATE UPDATED: 3/01/04

EDIT NAME: ALLOWED CHARGE > PTAR CHARGE

EDIT DESCRIPTION:
IF THE RECORD WAS FOUND ON THE VSAM PTAR MASTER FILE

IF THE CURRENT PROVIDER NUMBER IS NOT EQUAL TO THE STORED PROVIDER NUMBER
AND IF THE ERROR CODE STATUS IS EQUAL TO 'F' AND THE ERROR CODE IS EQUAL TO ‘402'
OR IF THE CURRENT PROVIDER NUMBER IS EQUAL TO THE STORED PROVIDER NUMBER

IF THE FIRST PROCEDURE SERVICE DATE IS GREATER THAN THE PRIOR AUTHORIZATION FROM DATE
OR IF THE LAST PROCEDURE SERVICE DATE IS LESS THAN THE PRIOR AUTHORIZATION TO DATE

IF THE PROCEDURE NUMBER IS EQUAL TO THE PROCEDURE CODE
OR IF THE PRIOR AUTHORIZATION PROCEDURE NUMBER IS EQUAL TO THE PROCEDURE CODE
OR IF ALL DETAIL LINES ARE PROCESSED
OR IF THE PRIOR AUTHORIZATION PROCEDURE NUMBER IS EQUAL TO SPACES OR  ZEROES
AND IF THE PRIOR AUTHORIZATION TYPE OF SERVICE IS EQUAL TO SPACES
OR THE PRIOR AUTHORIZATION TYPE OF SERVICE IS EQUAL THE TYPE OF SERVICE CODE

IF THE CLAIM PRIOR AUTHORIZATION CHARGE PLUS THE ALLOWED CHARGE IS GREATER THAN THE
PRIOR AUTHORIZATION DOLLAR SUB

IF THE ERROR CODE STATUS IS NOT EQUAL TO AN 'F' AND THE ERROR CODE IS NOT EQUAL TO A
'405' AND THE ERROR CODE LINE NUMBER IS NOT EQUAL TO THE NUMBER OF LINE ITEMS.

METHOD OF CORRECTION: REVIEW APPROVED AMOUNT ON PTAR FILE. IF ERROR, CORRECT FILE OR
TRANSCRIPTION. OTHERWISE, REVIEW WITH DENTAL CONSULTANT AND ABIDE BY HIS/HER DECISION.

JOB: SB1J077 PROGRAM: SB1275
ERROR CODE: 406

CLAIM TYPE: ALL

DATE UPDATED: 4/20/04

EDIT NAME: PROC CODE NOT ON PTAR FILE

EDIT DESCRIPTION:

IF THE RECORD WAS FOUND ON THE VSAM PTAR MASTER FILE

IF THE PROVIDER NUMBER EQUALS THE STORED PROVIDER NUMBER

IF THE FIRST PROCEDURE SERVICE DATE IS NOT GREATER THAN THE PRIOR AUTHORIZATION FROM DATE OR THE LAST PROCEDURE SERVICE DATE IS NOT LESS THAN THE PRIOR AUTHORIZATION TO DATE

IF THE PRIOR AUTHORIZATION PROCEDURE NUMBER IS EQUAL TO THE PROCEDURE CODE AND IF THE PRIOR AUTHORIZATION TYPE OF SERVICE IS EQUAL TO SPACES OR IF THE PRIOR AUTHORIZATION TYPE OF SERVICE IS EQUAL TO THE TYPE OF SERVICE CODE OR IF THE PRIOR AUTHORIZATION PROCEDURE NUMBER IS NOT EQUAL TO THE PROCEDURE CODE

METHOD OF CORRECTION:

REFER TO PTAR FOR ORIGINAL APPROVAL. IF PROVIDER HAS USED A PROCEDURE CODE NOT APPROVED, DENY OR RETURN TO PROVIDER. IF RETURNED, ASK FOR CLARIFICATION OR CORRECTION. IF NEW INFO RECEIVED, REVIEW WITH DENTAL CONSULTANT.

JOB: SB1J077 PROGRAM: SB1275
ERROR CODE: 407

CLAIM TYPE: ALL

DATE UPDATED: 4/20/04

EDIT NAME: DATES OF SERV NOT ON PTAR FILE

EDIT DESCRIPTION:

IF THE RECORD WAS FOUND ON THE VSAM PTAR MASTER FILE

IF THE PROVIDER NUMBER IS EQUAL TO THE STORED PROVIDER NUMBER

IF THE FIRST PROCEDURE SERVICE DATE IS LESS THAN THE PRIOR AUTHORIZATION FROM DATE
OR THE LAST PROCEDURE SERVICE DATE IS GREATER THAN THE PRIOR AUTHORIZATION TO DATE
AND IF THE ERROR CODE STATUS IS EQUAL TO AN 'F'
AND ERROR CODE IS EQUAL TO A '407'
AND ERROR CODE LINE NUMBER IS EQUAL TO NUMBER OF LINE ITEMS

METHOD OF CORRECTION:

VERIFY THAT ALL DATE(S) OF SVCE ON CLAIM/WORKSHEET HAVE BEEN TRANSCRIBED CORRECTLY. IF NOT,
CORRECT AND PROCESS CLAIM. OTHERWISE, DENY ALL SERVICES
WHICH FALL OUTSIDE OF THE AUTHORIZED SERVICE DATES, AND PROCESS THE REST OF THE CLAIM.
NOTE: DENTAL CONSULTANT MAY WISH TO REVIEW THESE AUDIT FAILURES. THE DENTAL CONSULTANT IS THE
ONLY PERSON AUTHORIZED TO OVERRIDE THIS EDIT.

JOB: SB1J077 PROGRAM: SB1275
ERROR CODE: 408

CLAIM TYPE: ALL.

DATE UPDATED: 4/20/04

EDIT NAME: INS. PMT AND MORE THAN 1 TPL

EDIT DESCRIPTION:

IF THE ACCIDENT TYPE IS A "C" (CHILD ABUSE)
OR
IF THE ACCIDENT TYPE IS A SPACE

[((IF THE CLAIM IS NOT A NURSING HOME THAT IS NOT QMB ELIGIBLE
OR
IF THE CARE EFFECTIVE DATE IS GREATER THAN THE FIRST DAY OF SERVICE
IF THE MISC NURSING HOME INDEX IS EQUAL TO ONE))

IF NOT REGION 90
IF IT IS A PAYABLE CLAIM
   IF THE CLAIM IS NOT QMB ELIGIBLE AND IT ORIGINATES FROM MMIS

IF THE CLAIM HAS TPL COVERAGE AND HAS OTHER INSURANCE

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS SYSTEM.

JOB: SB1J040                PROGRAM: SB1090

Top
ERROR CODE: 409

CLAIM TYPE: MEDICAL, CROSSOVER, INSTITUTIONAL, UB82, XOVER INPATIENT, XOVER OUTPATIENT, NURSING HOME

DATE UPDATED: 4/29/04

EDIT NAME: RECIPIENT INELIGIBLE

EDIT DESCRIPTION:
IF THE ACCIDENT TYPE IS A "C" (CHILD ABUSE)
OR
IF THE ACCIDENT TYPE IS A SPACE
AND
IF NOT NURSING HOME CLAIM AND IS NOT QMB ELIGIBLE
OR
IF THE CARE EFFECTIVE DATE IS GREATER THAN THE FIRST DAY OF SERVICE
OR IF THE MISC NURSING HOME INDEX IS EQUAL TO ONE)
AND
IF NOT TECS ELIGIBLE OR IF NOT QMB ELIGIBLE
(OR IF THE FROM DATE IS GREATER THAN THE STARTING DATE
AND THE TO DATE IS LESS THAN THE STARTING DATE
OR IF THE TO DATE IS LESS THAN THE STOP DATE)
AND IT IS NOT AN INSTITUTIONAL OR UB82 INSTITUTIONAL OR CROSSOVER
AND NOT CROSSOVER INPATIENT OR CROSSOVER OUTPATIENT OR MEDICAL
AND IF THE LAST DAY OF SERV IS GREATER THAN THE 99999999
OR IF THE FIRST DAY OF SERVICE IS LESS THAN 99999999
AND THE FROM DATE OF SERVCE IS GREATER THAN THE STOPPING DATE AND
THE STOPPING REASON IS BLANK
AND IF FROM DATE IS EQUAL TO THE TO DATE
AND THE CLAIM REGION IS EQUAL TO '50'
OR IF CLAIM REGION IS NOT EQUAL TO '50'
AND THE TECS ID IS LESS THAN ZERO
AND THE CLAIM IS AN UNAUTHORIZED RECIPIENT ON THE VISION SYSTEM
OR IF THE TECS ID IS GREATER THAN ZERO
OR IF MEDICAL OR INSTITUTIONAL OR CROSSOVER OR UB82 CLAIM
AND THE LAST DAY OF SERVICE IS GREATER THAN 99999999
OR IF NOT TECS ELIGIBLE OR IF NOT QMB ELIGIBLE
(OR IF THE FROM DATE IS GREATER THAN THE STARTING DATE
AND THE TO DATE IS LESS THAN THE STARTING DATE
OR IF THE TO DATE IS LESS THAN THE STOP DATE)
AND IT IS NOT AN INSTITUTIONAL OR UB82 INSTITUTIONAL OR CROSSOVER
AND NOT CROSSOVER INPATIENT OR CROSSOVER OUTPATIENT OR MEDICAL
AND IF THE LAST DAY OF SERV IS GREATER THAN THE 99999999
OR IF THE FIRST DAY OF SERVICE IS LESS THAN 99999999
IF FROM DATE EQUAL TO THE TO DATE
IF STOPPING REASON IS NOT EQUAL TO A SPACE OR REGION EQUALS '50'
OR FROM DATE NOT GREATER THAN STOPPING DATE
OR IF TECS ID IS GREATER THAN ZERO AND THE CLAIM IS AN UNAUTHORIZED RECIPIENT ON VISION
MOVE ERR-CLM-409 TO ERR-CODE
OR IF TECS ID IS LESS THAN ZERO

IF QMB ELIGIBLE AND NURSING HOME CLAIM
AND THE SERVICE CODE IS NOT EQUAL TO 'R' '9' '5'
OR
IF QMB ELIGIBLE AND NURSING HOME OR CROSSOVER OR MEDICAL OR UB82
AND THE MCARE STATUS IS EQUAL TO AN 'A' OR 'B' AND IT'S THE FIRST OCCURRENCE
AND IF MCARE COVERAGE IS EQUAL TO A SPACE
OR IF MCARE COVERAGE IS EQUAL TO A 'Y'

OR IF UNAUTHORIZED RECIPIENT ON VISION
AND IF ERROR CODE IS EQUAL TO '108'

METHOD OF CORRECTION:

YOU MAY ALSO USE "27" IN PLACE OF "26" (MOST APPROPRIATE)

JOB: SB1J040 PROGRAM: SB1090
ERROR CODE: 410

CLAIM TYPE: ALL

DATE UPDATED: 4/30/04

EDIT NAME:
DME = NURSING HOME RESIDENT

EDIT DESCRIPTION:

A) IF RECIPIENT IS FOUND ON THE SB640010 FILE
   IF THE ERROR RETURN IS EQUAL TO '1'
   OR
   IF THE FIRST TWO CHARACTERS OF THE RECIPIENTS LAST NAME EQUAL THE FIRST TWO CHARACTERS
   OF THE SAVED RECIPIENTS NAME
   OR IF THE FIRST TWO CHARACTERS OF THE RECIPIENTS LAST NAME DO NOT EQUAL THE FIRST
   TWO CHARACTERS OF THE SAVED RECIPIENTS NAME
   AND THE EIGHTH AND NINTH POSITIONS OF THE PCN IS EQUAL TO 'CS'
   IF THE RECIPIENT LIVING ARRANGEMENT IS EQUAL TO A '4' OR '5' OR '6' OR '9'
   AND IT IS A PROFESSIONAL CLAIM WITH A PROVIDER TYPE CODE OF '62'
   IF THE FIRST PROCEDURE SERVICE DATE IS GREATER THAN 19911231
   AND IT IS A PROFESSIONAL CLAIM

B) E410 - SB710023 - err-clm-410
   MAIN-LINE-LOGIC.
   IF THE NUMBER OF DRUG OCCURANCES COUNT IS EQUAL TO '1'
   AND
   IF N1500212 DRUG CONTROL CODE IS NOT EQUAL TO '3' OR '8'
   AND DRUG CODE IS NOT EQUAL '00999'
   AND DRUG-CODE IS EQUAL '130'
   AND RECIPIENT LIVING ARRANGEMENT IS NOT EQUAL TO '5' OR '9'
   IF RECIPIENT AID CATAGORY IS NOT EQUAL TO '007  ' OR
   PROVIDER ZIP CODE IS LESS THAN '55000 ' AND GREATER THAN '57000 '
   IF N1500213 NURSING HOME INDICATOR IS NOT EQUAL TO '0'
   AND DRUG CODE IS NOT EQUAL TO '00999'
   AND DRUG CODE EQUAL TO '130'
   AND RECIPIENT LIVING ARRANGEMENT IS NOT EQUAL TO '5' OR '9'
   IF RECIPIENT AID CATEGORY IS NOT EQUAL TO '007  '

IF THE NUMBER OF DRUG OCCURANCES COUNT IS NOT EQUAL TO '1'
AND
IF DRUG TPL COUNT IS GREATER THAN 0
   OR DRUG CANCER COUNT IS GREATER THAN 0
   AND N1500211 DRUG THERA CLASS SPEC IS EQUAL TO
   'V1A' OR 'V1B' OR 'V1C' OR 'V1D' OR 'V1E' OR 'V1F'
   OR DRUG CHAMPUS COUNT IS GREATER THAN 0
   OR DRUG MEDICARE COUNT IS GREATER THAN 0
   AND N1500212 DRUG CONTROL CODE IS EQUAL TO '3'
   OR IF THE CLAIM REGION IS EQUAL TO '10 OR '040'
   AND DRUG CLM LDG TOT IS LESS THAN 15.01
OR
IF THE CLAIM REGION IS EQUAL TO A '10' OR A '40'
   IF POLICY COUNT IS EQUAL TO 1
       AND TOTAL OTHER INSURANCE IS GREATER THAN 0
   OR POLICY COUNT IS GREATER THAN 1
       AND TOTAL OTHER INSURANCE IS NOT LESS THAN
       (DRUG CLM LDG TOT * .50)

AND
IF N1500212 DRUG CONTROL CODE IS NOT EQUAL '3' OR '8'
   AND DRUG CODE IS NOT EQUAL '00999'
   AND DRUG CODE IS EQUAL '130'
   AND RECIPIENT LIVING ARRANGEMENT IS NOT EQUAL '5' OR '9'
   IF RECIPIENT AID CATEGORY IS NOT EQUAL '007 ' OR
      PROVIDER ZIP CODE IS LESS THAN '55000 ' AND GREATER THAN '57000 '
OR
IF N1500213 NURSING HOME INDICATOR IS NOT EQUAL TO '0'
   AND DRUG CODE IS NOT EQUAL TO '00999'
   AND DRUG CODE IS EQUAL TO '130'
   AND RECIPIENT LIVING ARRANGEMENT IS NOT EQUAL TO '5' OR '9'
   IF RECIPIENT AID CATEGORY IS NOT EQUAL TO '007 '

METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA101" YOU MUST ENTER CLAIM ADJUSTMENT REASON "97" IN FIELD 6.

JOB:                                      PROGRAM:
A) SB1J040                                 A) SB1090
B) MMIS POS SYSTEM                         B) SB710023
ERROR CODE: 411

CLAIM TYPE: DENTAL, NURSING HOME, CROSSOVER, PROFESSIONAL, INSTITUTIONAL, UB82 INSTITUTIONAL, CROSSOVER INPATIENT, CROSSOVER OUTPATIENT, MEDICAL

DATE UPDATED: 5/1/04

EDIT NAME:
OVERLAPPING DATES OF SERVICE

EDIT DESCRIPTION:
A) IF NOT TECS ELIGIBLE OR IF NOT QMB ELIGIBLE
(OR IF THE FROM DATE IS GREATER THAN THE STARTING DATE
AND THE TO DATE IS LESS THAN THE STARTING DATE
OR IF THE TO DATE IS LESS THAN THE STOP DATE)
AND IT IS NOT AN INSTITUTIONAL OR UB82 INSTITUTIONAL OR CROSSOVER
AND NOT CROSSOVER INPATIENT OR CROSSOVER OUTPATIENT OR MEDICAL
AND IF THE LAST DAY OF SERV IS GREATER THAN THE 99999999
OR IF THE FIRST DAY OF SERVICE IS LESS THAN 99999999
AND THE FROM DATE OF SERVICE IS GREATER THAN THE STOPPING DATE
AND THE STOPPING REASON IS BLANK
IF THE FROM DATE IS NOT EQUAL TO THE TO DATE

OR

IF DECEASED-SW = 'N'
IF NOT TECS ELIGIBLE OR IF NOT QMB ELIGIBLE
(OR IF THE FROM DATE IS GREATER THAN THE STARTING DATE
AND THE TO DATE IS LESS THAN THE STARTING DATE
OR IF THE TO DATE IS LESS THAN THE STOP DATE)
AND IT IS NOT AN INSTITUTIONAL OR UB82 INSTITUTIONAL OR CROSSOVER
AND NOT CROSSOVER INPATIENT OR CROSSOVER OUTPATIENT OR MEDICAL
AND IF THE LAST DAY OF SERV IS GREATER THAN THE 99999999
OR IF THE FIRST DAY OF SERVICE IS LESS THAN 99999999
AND THE FROM DATE OF SERVICE IS GREATER THAN THE STOPPING DATE
AND IF THE FROM DATE IS NOT EQUAL TO THE TO DATE

OR

IF TECS ELIGIBLE OR IF QMB ELIGIBLE
(OR IF THE FROM DATE IS LESS THAN THE STARTING DATE
AND THE TO DATE IS GREATER THAN THE STARTING DATE
OR IF THE TO DATE IS GREATER THAN THE STOP DATE)
AND IT IS AN INSTITUTIONAL OR UB82 INSTITUTIONAL OR CROSSOVER
AND NOT CROSSOVER INPATIENT OR CROSSOVER OUTPATIENT OR MEDICAL
AND IF THE LAST DAY OF SERV IS LESS THAN THE 99999999
OR IF THE FIRST DAY OF SERVICE IS GREATER THAN 99999999
AND THE FROM DATE OF SERVICE IS LESS THAN THE STOPPING DATE
AND IF THE FROM DATE IS EQUAL TO THE TO DATE

AND
IF CROSSOVER, OR CROSSOVER INPATIENT, OR CROSSOVER OUTPATIENT, INSTITUTIONAL, OR UB82 INSTITUTIONAL
IF FIRST DAY OF SERVICE IS LESS THAN THE STARTING DATE
IF THE LAST DAY OF SERVICE IS GREATER THAN THE STARTING DATE
IF THE LAST DAY OF SERVICE IS GREATER THAN THE STOPPING DATE
IF CLAIM IS REGION '50'
    MOVE ERR-CLM-411 TO ERR-CODE

B) IF ERROR SWITCH IS EQUAL TO ZERO

IF ENTRX CODE IS EQUAL TO 'T' OR 'O' OR 'N'

IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR '+'

IF NURSING HOME CLAIM
    IF BATCH NUMBER IS EQUAL TO '650' OR '651'
        IF (PROVIDER NUMBER IS GREATER THAN OR EQUAL TO '000001900' AND LESS THAN '000002000'
            IF (AUTHORIZATION START DATE NOT EQUAL TO THE AUTHORIZATION END DATE) OR
                (AUTHORIZATION START DATE IS EQUAL TO ZERO)
                MOVE E411 TO ERR-CD
        OR
    OR

IF (PROFESSIONAL CLAIM AND NOT
    (UB82 HOME HEALTH AND BILL TYPE IS EQUAL TO '711' AND
    PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR IS GREATER THAN ZERO))
    OR CROSSOVER CLAIM

IF ((PROVIDER NUMBER IS GREATER THAN '000004999' AND LESS THAN '000006000') OR
    (DENTAL CLAIM)) AND
    (AUTHORIZATION START DATE IS NOT EQUAL TO AUTHORIZATION END DATE

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N74" YOU MUST ENTER CLAIM ADJUSTMENT REAS
ON "125" IN FIELD 6.

JOB:                                                PROGRAM:

A) SB1J040                                       A) SB1090
B) SB1J020                                       B) SB1070

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ERROR CODE:

CLAIM TYPE:  ALL CLAIM TYPES

DATE UPDATED:  5/10/04

EDIT NAME:
SERVICE TO BE SUPPLIED BY N.H.

EDIT DESCRIPTION:
IF THE ERROR RETURN IS EQUAL TO '1'
OR
IF THE FIRST TWO CHARACTERS OF THE RECIPIENTS LAST NAME EQUAL THE FIRST TWO CHARACTERS
OF THE SAVED RECIPIENTS NAME
OR IF THE FIRST TWO CHARACTERS OF THE RECIPIENTS LAST NAME DO NOT EQUAL THE FIRST
TWO CHARACTERS OF THE SAVED RECIPIENTS NAME
AND THE EIGHTH AND NINTH POSITIONS OF THE PCN IS EQUAL TO 'CS'

IF UB82 OUTPATIENT AND
(BILL TYPE IS GREATER THAN '130' AND LESS THAN '140' OR
BILL TYPE EQUAL TO '141') AND
(RECIPIENT LIVING ARRANGEMENT EQUAL TO '5' OR '9')
IF (REV-300-329-CNT NOT EQUAL TO 88888) OR
(REV-300-329-CNT NOT EQUAL TO CURRENT DETAIL LINE)
OR

IF (PROVIDER SPECIALTY CODE IS EQUAL TO '90' OR '81') AND
(RECIPIENT LIVING ARRANGEMENT IS EQUAL TO '5' OR '9')
OR

IF PROFESSIONAL CLAIM
IF THE PROCEDURE CODE IS FOUND ON THE PCLIST
IF RECIPIENT LIVING ARRANGEMENT IS EQUAL TO '5' OR '9'

METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA101" YOU MUST ENTER CLAIM ADJUSTMENT REASON "97" IN FIELD 6.

JOB:  SB1J040 PROGRAM:  SB1090

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ERROR CODE: 413
CLAIM TYPE: ALL CLAIM TYPES
DATE UPDATED: 5/10/04

EDIT NAME:
MMIS BASE ID ON TECS INVALID

EDIT DESCRIPTION:
IF THE CALL TO SB109A IS GOOD AND THE RECORD WAS FOUND ON THE TECS SYSTEM AND THE ICN REGION IS EQUAL TO '50'

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS.

JOB: SB1J040  PROGRAM: SB1090
ERROR CODE: 414
CLAIM TYPE: N/A
DATE UPDATED: 5/10/04

EDIT NAME:
NO INNOVATOR CODE PRESENT

EDIT DESCRIPTION: NOT ON MMIS.

METHOD OF CORRECTION:
CLAIM SHOULD BE REFERRED TO PHARMACY CONSULTANT FOR PAYMENT OR DENIAL.

JOB: N/A PROGRAM: N/A
ERROR CODE: 415
CLAIM TYPE: N/A
DATE UPDATED: 5/10/04

EDIT NAME: RECIPIENT CERTIFICATION PAST DUE
EDIT DESCRIPTION: NO ENTRY ON MMIS.

METHOD OF CORRECTION:
VERIFY AL DATE OF SVC HAVE BEEN TRANSCRIBED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. OTHERWISE, FAILURE OF THIS AUDIT INDICATES THAT RECIPIENT IS OVERDUE FOR RECERTIFICATION. RECIPIENT ELIGIBILITY FILE MAINTENANCE MAY BE REQUIRED. CONTACT YOUR SUPERVISOR WHEN THIS ERROR OCCURS. THIS AUDIT MAY BE OVERIDEN WITH EOB "N10" AND "42" IN FIELD 6.

JOB: N/A                                        PROGRAM: N/A
ERROR CODE: 416
CLAIM TYPE: ALL CLAIM TYPES
DATE UPDATED: 5/10/04

EDIT NAME: SUSPECT RECIPIENT

EDIT DESCRIPTION:
IF SUSPECT CODE NOT EQUAL TO 'Y' AND NOT EQUAL TO SPACES
   IF 1ST DAY OF SERVICE IS LESS THAN REVIEW START DATE
      IF LAST DAY OF SERVICE IS GREATER THAN REVIEW START DATE
   OR IF 1ST DAY OF SERVICE IS GREATER THAN REVIEW START DATE
      IF REVIEW STOP DATE IS EQUAL TO 0
         OR
      IF 1ST DAY OF SERVICE IS LESS THAN REVIEW START DATE
   AND
   IF THE ERROR RETURN IS EQUAL TO '1'
   OR
   IF THE FIRST TWO CHARACTERS OF THE RECIPIENTS LAST NAME EQUAL THE FIRST TWO CHARACTERS
      OF THE SAVED RECIPIENTS NAME
   OR IF THE FIRST TWO CHARACTERS OF THE RECIPIENTS LAST NAME DO NOT EQUAL THE FIRST
      TWO CHARACTERS OF THE SAVED RECIPIENTS NAME
      AND THE EIGHTH AND NINTH POSITIONS OF THE PCN IS EQUAL TO 'CS'

IF DATE-OKAY-SW = 'Y'
   IF THE CLAIM REGION IS NOT EQUAL TO '94'
      AND (PROVIDER NUMBER LESS THAN '000030700' OR GREATER THAN '000030799')
         IF SUSPECT CODE IS EQUAL TO 'A'
         OR IF RECORD CODE IS EQUAL TO SUSPECT CODE

METHOD OF CORRECTION:
VERIFY RECIPIENT IDENTIFICATION NUMBER WAS TRANSCRIBED CORRECTLY. REFER TO THE S/UR
ADMINISTRATOR.

JOB: SB1J040 PROGRAM: SB1090

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ERROR CODE: 417

CLAIM TYPE: UB82, PAYABLE, PROFESSIONAL, UB82-HOME-HEALTH, UB82-INPATIENT, UB82-OUTPATIENT

DATE UPDATED: 5/11/04

EDIT NAME:
UNITS REQUIRED FOR REVENUE CODE

EDIT DESCRIPTION:
IF CLMT-UB82-CLAIM AND THE CLAIM REGION NOT EQUAL TO '70'
OR
IF IT IS A PAYABLE CLAIM AND NOT A DENIED CLAIM
IF NOT UB82-HOME-HEALTH
AND BILL TYPE NOT EQUAL TO '711'
AND REVENUE CODE EQUAL TO 983
AND REVENUE CODE EQUAL TO '521' OR '522'
AND (PVF-STATUS NOT EQUAL TO '00' AND
(1ST DAY OF SERVICE LESS THAN P1M0-PROV-CURR-OPT-EFDT)
AND P1M0-PROV-CURR-OPT-RR NOT EQUAL TO 0)
AND
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE IS EQUAL TO '711'
AND PVF-STATUS IS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE IS EQUAL TO '983'
OR CROSSOVER CLAIM
AND
IF UB82-HOME-HEALTH
IF UB82 INPATIENT CLAIM
IF CLMT-UB82-UNITS (LSUB) = ZERO
    IF R1RV-UNITS-REQ-INPATIENT = 'I'
        IF CLAIM REGION NOT EQUAL TO 40
            AND AN ADJUSTMENT
OR
IF UB82 OUTPATIENT CLAIM OR (UB82 HOME HEALTH
AND BILL TYPE IS EQUAL TO '711' AND THE REVENUE CODE IS NOT EQUAL TO 983
AND PVF-STATUS IS EQUAL TO '00' AND (P1M0-PROV-CURR-OPT-RR IS GREATER THAN 0 OR
P1M0-PROV-PREV-OPT-RR GREATER THAN 0))
IF UB82 UNITS (LSUB) IS EQUAL TO ZERO
    IF R1RV-UNITS-REQ-OUTPATIENT IS EQUAL TO 'O'
        IF CLAIM REGION IS NOT EQUAL TO 40

METHOD OF CORRECTION:
CHECK FOR MISSED KEYING OF THE UNITS FROM CLAIM HARDCOPY. IF PRESENT, CORRECT AND PROCESS THE CLAIM. IF NOT PRESENT, FORCE WITH ONE UNIT OF SERVICE. WHEN USING REMARK CODE "M53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J050 PROGRAM: SB1130

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ERROR CODE: 418
CLAIM TYPE: UB82-INPATIENT-CLAIM
DATE UPDATED: 5/12/04
EDIT NAME: INVALID BILL TYPE
EDIT DESCRIPTION:
B) IF PAYABLE CLAIM AND NOT A DENIED CLAIM
   AND IF UB82 HOME HEALTH AND BILL TYPE IS EQUAL TO '711' AND
   PVF-STATUS EQUAL TO '00' AND REVENUE CODE NOT EQUAL TO '983' AND
   ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
     AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
   (REVENUE CODE EQUAL TO '521' OR '522' AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
    (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
   (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
     AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE EQUAL TO '521' OR '522'))
   AND
   IF INSTITUTIONAL CLAIM OR UB82 CLAIM
   AND
   IF CLAIM REGION IS EQUAL TO '70'
   IF (UB82 INPATIENT CLAIM AND BILL TYPE IS EQUAL TO '111'
     AND REVENUE CODE NOT EQUAL TO '100')
     IF CLAIM REGION IS NOT EQUAL TO 40
     OR AN ADJUSTMENT
METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA30" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB:  A) SB1J020 – N/A
      B) SB1J050
PROGRAM:  B) SB1070 - ERROR IS NOT GIVEN
          B) SB1130

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ERROR CODE: 419
CLAIM TYPE: ALL CLAIM TYPES
DATE UPDATED: 5/13/04

EDIT NAME:
DOS WITHIN DISQ. TRANS. PERIOD

EDIT DESCRIPTION:
LIVING ARRANGEMENT 'IM' OF 'LT' AND RECIPIENT HAS A DISQUALIFYING TRANSFER. IF THE NURSING HOME CLAIM DATES OF SERVICE PARTIALLY FALL WITHIN THE DISQUALIFYING TRANSFER DATES THE CLAIM WILL SUSPEND.

LIVING ARRANGEMENT 'LH' AND RECIPIENT HAD A DISQUALIFYING TRANSFER. IF A HOSPICE CLAIM, REVENUE CODE 651-569, WITH DATES OF SERVICE THAT PARTIALLY FALL WITHIN THE DISQUALIFYING TRANSFER DATES THE CLAIM WILL SUSPEND.

LIVING ARRANGEMENT 'HS' AND RECIPIENT HAS A DISQUALIFYING TRANSFER. IF A CLAIM COMES WITH A DD RESIDENTIAL, LEGAL COUNTY OF 90 AND RESIDENTIAL SERVICE (CODE - C, O, Q, R, S, 1) OR IF A CLAIM COMES IN WITH A DD REGION, LEGAL COUNTY OF 90 AND DAY SERVICE (CODE = A, D, F, G, J, K, L, M, N, T, 4, 5) OR IF A CLAIM COMES IN WITH A HCBC REGION WITH LEGAL COUNTY OF 90 WITH DATES OF SERVICE THAT PARTIALLY FALL WITHIN THE DISQUALIFYING TRANSFER DATES THE CLAIM WILL SUSPEND.

LIVING ARRANGEMENT 'HH' AND RECIPIENT AND THERE IS A 'G' SCREENING AND THE RECIPIENT HAS A DISQUALIFYING TRANSFER. IF A CLAIM COMES IN WITH A DD REGION, LEGAL COUNTY OF 90 AND TRANSFER DATES OF SERVICE THAT PARTIALLY FALL WITHIN THE DISQUALIFYING TRANSFER DATES, THE CLAIM WILL SUSPEND.

LIVING ARRANGEMENT 'SH' AND RECIPIENT HAS A DISQUALIFYING TRANSFER. IF CLAIM COMES IN WITH A LTC REGION (20) AND PROVIDER NUMBER 1086 WITH DATES OF SERVICE THAT PARTIALLY FALL WITHIN THE DISQUALIFYING TRANSFER DATES, THE CLAIM WILL SUSPEND.

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS.

JOB: PROGRAM:

Top
ERROR CODE: 420

CLAIM TYPE:

DATE UPDATED: 5/13/04

EDIT NAME: SUSPENDED FOR AUDITOR REVIEW

EDIT DESCRIPTION:
A) 0230-PROCESS-ENTRX-FILE.
IF ERROR-SW NOT EQUAL TO ZERO
   IF ENTRX-CD2 NOT EQUAL TO '4' OR '5'
      PERFORM 0300-CREATE-NEW-TRANSACTION
   .
   IF ENTRX-CD2 NOT EQUAL TO '2'
      AND ENTRX-CD1 EQUAL TO 'A'
      PERFORM 0800-FORMAT-NON-DRUG-OUTPUT.

0800-FORMAT-NON-DRUG-OUTPUT.
IF ENTRX-CD1 = 'Q' OR 'R' OR 'U'
   PERFORM 9700-FORMAT-UB82-RCD

9700-FORMAT-UB82-RCD.
IF UBOT-ACTION-FLAG = 'Y'

B) IF POSFI-VERSION (1) (1:1) IS EQUAL TO '5'
   AND
   IF POSFI-COMPOUND-CODE (R-SUB) IS EQUAL TO '2'
      AND POSFI-NUMBER-DRUG-OCCUR-CNT (R-SUB) GREATER THAN 1

C) IF POSFI-DRUG-CD (R-SUB 1) IS EQUAL TO ('00033333333' OR '00099999999')
   OR POSFI-DRUG-CD (R-SUB 1) (1:5) IS EQUAL TO ('00999' OR '00099')
   AND
   IF POSFI-NUMBER-DRUG-OCCUR-CNT (R-SUB) GREATER THAN 1
      AND POSFI-DRUG-CLM-LDG-TOT (R-SUB) GREATER THAN 100

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N29" YOU MUST ENTER CLAIM ADJUSTMENT REASON "16" IN FIELD 6.

JOB:  A) SB1J020  PROGRAM: B) SB1070
    B) ONLINE POS  B) SB710022
    C) ONLINE POS  C) SB710025
ERROR CODE: 421

CLAIM TYPE: UB82(INPAT, OUTPAT, HOME HEALTH) U, Q, R

DATE UPDATED: 5/13/04

EDIT NAME:
MANUAL SUSPEND CODE

EDIT DESCRIPTION:
IF PAYABLE CLAIM THAT IS NOT DENIED

IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS EQUAL TO '00' AND REVENUE CODE NOT EQUAL TO '983' AND
  ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
     AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
  (REVENUE CODE EQUAL TO '521' OR '522' AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
   (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
     AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE IS NOT EQUAL TO '521' OR '522'))
  AND
IF UB82 OUTPATIENT CLAIM
  IF REVENUE CODE IS EQUAL TO '360' THRU '369'
    OR '490' THRU '499'
    IF NOT UB82 EMERGENCY

METHOD OF CORRECTION:
REFER CLAIM TO SUPERVISOR. ERROR MAY BE FORCE PAID AT LOWEST ASC RATE
OR DENIED WITH THE PROPER EOB. WHEN USING REMARK CODE "N29" YOU MUST ENTER CLAIM ADJUSTMENT
REASON I "16" IN FIELD 6.

JOB: SB1J050               PROGRAM: SB1130
ERROR CODE: 422
CLAIM TYPE: N/A
DATE UPDATED: 5/14/04

EDIT NAME: SURGICAL PROCEDURE CODE - 2 IS INVALID

EDIT DESCRIPTION: NO ENTRY LISTED ON MMIS.

METHOD OF CORRECTION:
CHECK FOR CORRECT KEYING OF PROCEDURE CODE FROM CLAIM HARDCOPY. THE NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OR EMC BILLING, CLAIM MAY BE FORCED. IF NUMBERS MATCH OR EMC BILLING, CLAIM MAY BE DENIED AND RETURNED TO PROVIDER. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:

Top
ERROR CODE:  423
CLAIM TYPE:  N/A
DATE UPDATED:  5/14/04

EDIT NAME:  SURGICAL PROCEDURE CODE - 3 IS INVALID

EDIT DESCRIPTION:  NO ENTRY LISTED ON MMIS.

METHOD OF CORRECTION:
CHECK FOR CORRECT KEYING OF PROCEDURE CODE FROM CLAIM HARDCOPY. IF NUMBERS DO NOT MATCH, CORRECT AND PROCESS CLAIM. IF NUMBERS MATCH OF EMC BILLING, CLAIM MAY BE FORCED. IF EMC BILLING, DENY

JOB:                                                PROGRAM:

Topics
ERROR CODE: 424

CLAIM TYPE: CROSSOVER

DATE UPDATED: 5/14/04

EDIT NAME: MEDICARE ALLOWED AMOUNT EQUAL TO ZERO.

EDIT DESCRIPTION:
IF PAYABLE CLAIM THAT IS NOT DENIED
AND
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR IF REVENUE CODE IS EQUAL TO '983'
OR CROSSOVER CLAIM
AND
IF CROSSOVER CLAIM AND
PRICING INDICATOR NOT EQUAL TO '8'
IF PROCEDURE CODE NOT EQUAL TO '09990' AND NOT EQUAL TO '09991'
AND NOT EQUAL TO '09992' AND NOT EQUAL TO '09993' AND NOT EQUAL TO '09993'
AND NOT EQUAL TO '09994' AND NOT EQUAL TO '09995'

METHOD OF CORRECTION:
LOOK UP THE BCBS EOB IN THE DIAGNOSIS CODE AND DETERMINE WHETHER WE SHOULD PAY THE CLAIM OR NOT, DENY OR FORCE DEPENDING ON.

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE: 425

CLAIM TYPE: UB82-INPATIENT

DATE UPDATED: 5/14/04

EDIT NAME: UB92 NURS INC UNTS NE ACC UNTS

EDIT DESCRIPTION:

IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF UB82 INPATIENT CLAIM AND DRUG CODE EQUAL TO 0
  IF WK-REV-230-239-TOT-UNITS GREATER THAN ZERO
    IF WK-REV-230-239-TOT-UNITS NOT EQUAL TO WK-COVERED-DAYS

METHOD OF CORRECTION:
VERIFY TOTAL DETAIL NURSING UNITS ON CLAIM TO TOTAL ACCOMMODATION UNITS. IF KEYED IMPROPERLY,
CORRECT AND PROCESS CLAIM. IF EVERYTHING IS OK IT CAN BE FORCED. OTHERWISE, RTP WITH EOB "M58" AND
"16" IN FIELD 6 - EXPLANATION - NURSING UNITS NOT = ACCOMMODATION UNITS. WHEN USING REMARK CODE
"M53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070

Top
ERROR CODE: 426

CLAIM TYPE: NURSING HOME

DATE UPDATED: 5/17/04

EDIT NAME: INS PAY-NO F TPL-PROV NOT 1086

EDIT DESCRIPTION:
IF (NURSE HOME CLAIM AND TOTAL OTHER INSURANCE NOT EQUAL TO + 0)
AND (VR PROVIDER NOT EQUAL TO '001086' AND NOT EQUAL TO '002435' AND NOT
EQUAL TO '050383') AND
WL-015-ORIGIN-MMIS AND NOT QMB ELIGIBLE
AND (PROVIDER NUMBER LESS THAN '000030700' OR GREATER THAN '000030799')

METHOD OF CORRECTION:
THE CLAIM MUST EITHER BE DENIED, OR IF THE CLIENT IS ON TECS, A TPL COVERAGE CODE OF 'F' MUST BE ADDED
WITH APPROPRIATE EFFECTIVE DATES. IF THE CLIENT IS ON MMIS, THEY MUST HAVE TPL COVERAGE TYPE 'F'
ADDED USING THE THIRD PARTY LIABILITY MENU (SB7500).

JOB: SB1J040  PROGRAM: SB1090
ERROR CODE: 427

CLAIM TYPE: INSTITUTIONAL CLAIM OR UB82 INPATIENT CLAIM

DATE UPDATED: 5/18/04

EDIT NAME: NOT HCBS, NOT ON COPAY FILE

EDIT DESCRIPTION:
IF THE CLAIM IS TECS ELIGIBLE
AND REGULAR CLAIM
OR
IF INSTITUTIONAL CLAIM OR UB82 INPATIENT CLAIM
OR
IF DISCHARGE DESTINATION IS EQUAL TO A '2'
OR
IF THE CLAIM IS TECS ELIGIBLE
    IF THE STOPPING DATE IS EQUAL TO 0
        IF THE SPECIALTY PROCEDURE CODE FLAG IS EQUAL TO '1'
AND
IF CLAIM REGION IS EQUAL TO '90' OR
    (PROVIDER NUMBER NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999')
IF (PROVIDER NUMBER NOT EQUAL TO '000035432' AND NOT EQUAL TO '000035434'
    AND NOT EQUAL TO '000035201')
    IF VALID RECORD FOUND ON SB644010
AND
IF 1ST DAY OF SERVICE IS GREATER THAN 19930701
AND
IF 1ST DAY OF SERVICE IS LESS THAN 19991101
    IF THE CLAIM IS TECS ELIGIBLE
        IF LMTE-CASE-NO1-2IS LESS THAN '53'
AND
IF RECIPIENT LEGAL COUNTY IS NOT EQUAL TO 90
    IF (SERVICE CODE IS NOT EQUAL TO 'T' OR '4' OR '5' OR
        'E' OR 'L' OR 'M' OR 'S' OR 'Q') AND
        (PROVIDER NUMBER IS NOT EQUAL TO 37003 OR 37004 OR 37010 OR 37011
         OR 37033 OR 37043 OR 37051 OR 37068 OR 37072
         OR 37078 OR 37097 OR 37108 OR 37126 OR 37135
         OR 37138 OR 37145 OR 37154 OR 37162 OR 37165
         OR 37172 OR 37173 OR 37180 OR 37190 OR 37196
         OR 37201 OR 37203 OR 37204 OR 37227 OR 37231
         OR 37233)
AND
    IF (SERVICE CODE IS EQUAL TO 'A' OR 'C' OR 'L'
        OR 'N' OR 'Q' OR 'S' OR '1' OR '4' OR '5'
        OR 'G' OR 'H' OR 'J' OR 'T' OR 'E' OR 'K')
OR
IF THE 1ST DAY OF SERVICE IS GREATER THAN 19991101
IF TECS ELIGIBLE
    IF LMTE-CASE-NO1-2(L-ELIG-INDEX) IS GREATER THAN '53'
    IF (SERVICE CODE NOT EQUAL TO 'T' OR '4' OR '5' OR
        'N' OR 'E' OR 'L' OR 'M' OR 'S' OR 'Q') AND
        'E' OR 'L' OR 'M' OR 'S' OR 'Q')
    AND
        (PROVIDER NUMBER NOT EQUAL TO 37003 OR 37004 OR 37010 OR 37011
         OR 37033 OR 37043 OR 37051 OR 37068 OR 37072
         OR 37078 OR 37097 OR 37108 OR 37126 OR 37135
         OR 37138 OR 37145 OR 37154 OR 37162 OR 37165
         OR 37172 OR 37173 OR 37180 OR 37190 OR 37196
         OR 37201 OR 37203 OR 37204 OR 37227 OR 37231
         OR 37233)
METHOD OF CORRECTION:
WHEN USING REMARK CODE "N146" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J040  PROGRAM: SB1090
ERROR CODE: 428
CLAIM TYPE:
All payable claims

DATE UPDATED:
05/26/04

EDIT NAME:
SERV NOT DONE BY PCP/NO REF. #

EDIT DESCRIPTION:
1) Current claim is an adjustment claim OR it is of HMO encounter region (region 49)

2) The primary care provider’s start date on file is GREATER THAN the primary care provider’s inform date

   AND

   it is an adjustment claim OR it is of HMO encounter region (region 49)

3) Current claim’s header release code is NOT EQUAL TO ‘38’

   AND

   the primary care provider’s inform date is GREATER THAN zero AND LESS THAN OR EQUAL TO the claim’s first date of service.

   AND

   it is an adjustment claim OR it is of HMO encounter region (region 49)

4) Current claim’s header release code is EQUAL TO ‘38’

   AND

   its primary care provider’s inform date is EQUAL TO zero OR GREATER THAN the claim’s first date of service.

   AND

   it is an adjustment claim OR it is of HMO encounter region (region 49)

5) The primary care provider’s stop date is GREATER THAN OR EQUAL TO the current claim’s last date of service AND the primary care provider’s stop date is GREATER THAN OR EQUAL TO its case composition inform date

   OR

   the primary care provider’s stop date is EQUAL TO ‘01/01/0001’

   AND
the UPIN on file is GREATER THAN spaces

AND

the current claim’s UPIN is NOT EQUAL TO spaces AND is NOT EQUAL TO the UPIN on file

AND

it is an adjustment claim OR it is of HMO encounter region (region 49)

6) The quantity of primary care provider records on file is NOT GREATER THAN zero

AND

it is an adjustment claim OR it is of HMO encounter region (region 49)

7) The primary care provider information is valid (PCP-OK-SW = ‘Y’) 

AND

it is an adjustment claim OR it is of HMO encounter region (region 49)

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M33" YOU MUST ENTER CLAIM ADJUSTMENT REASON IN FIELD 6.

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 429

CLAIM TYPE: ALL CLAIM TYPES

DATE UPDATED: 6/7/04

EDIT NAME: WAITING NH PAY-SRV DY > 60 DAY

EDIT DESCRIPTION:
IF THE FIRST OCCURANCE OF THE ERROR CODE IS GREATER THAN SPACES
OR THE FIRST OCCURANCE OF THE HEADER RELEASE CODE IS GREATER THAN SPACES
AND THE FIRST OCCURANCE OF THE HEADER RELEASE CODE IS ‘30’
AND THE CLAIM REGION IS A ‘95’ OR A ‘70’
AND IF THE NUMBER OF DAYS DIFFERENCE BETWEEN THE DATES IS GREATER THAN 60

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS.

JOB: SB1J077 PROGRAM: SB1275

Top
ERROR CODE: 430

CLAIM TYPE: ALL EXCEPT UB82 HOME HEALTH

DATE UPDATED: 6/8/04

EDIT NAME: REFER PHYS NOT ON PROV MASTER

EDIT DESCRIPTION: IF THE RECORD IS NOT FOUND WHEN THE PROVIDER FILE IS READ AND THE RECORD IS NOT A UB82-HOME-HEALTH RECORD.


JOB: SB1J040 PROGRAM: SB1090
ERROR CODE: 431

CLAIM TYPE: MEDICAL, CROSSOVER, NURSING HOME, UB82

DATE UPDATED: 6/8/04

EDIT NAME: SLMB - RECIPIENT IS SLMB ELIGIBLE ONLY

EDIT DESCRIPTION:

IF THE ACCIDENT TYPE IS EQUAL TO 'C' OR SPACES
AND
IF NOT A NURSING HOME CLAIM AND IS QMB ELIGIBLE

IF REVIEW STARTING DATE IS GREATER THAN THE 1ST DAY OF SERVICE
OR IF THE NURSING HOME INDEX IS AT THE MAX OF (3)

AND
IF IT'S A PAYABLE MEDICAL CLAIM

OR
IF THE CLAIM IS FOUND ON THE SB640010 FILE

OR
IF IT'S A PAYABLE NURSING HOME CLAIM

AND
IF THE FROM DATE OF SERVICE IS NOT LESS THAN THE STARTING DATE AND
THE TO DATE OF SERVICE IS NOT GREATER THAN THE STOPPING DATE

AND
IF AID CATEGORY IS EQUAL TO '036'

OR
IF AID CATEGORY IS EQUAL TO '041' OR '042'

METHOD OF CORRECTION:

CLAIMS ARE AUTOMATICALLY DENIED UNLESS THEY ARE ADJUSTMENTS.

JOB: SB1J040                     PROGRAM: SB1090

Top
ERROR CODE: 432

CLAIM TYPE:
Drug claims

DATE UPDATED:
06/08/04

EDIT NAME:
PRESCRIBER INELIG ON DTE PRESC

EDIT DESCRIPTION:
A) (note: error code exists in SB1130 but is never used in processing)

B) Current claim’s detail-level provider enrollment start date is NOT EQUAL TO zeroes

AND

its detail-level enrollment status code is NOT EQUAL TO ‘03’ or ‘07’

METHOD OF CORRECTION:
VERIFY THAT PRESCRIBING PHYSICIAN NUMBER WAS KEYED CORRECTLY ON HARDCOPY CLAIMS. ELECTRONIC CLAIMS WILL AUTO DENY.

JOB: PROGRAM:
A) SB1J050 SB1130

B) online CICS SB710022
ERROR CODE: 433

CLAIM TYPE: ?

DATE UPDATED: 06/08/04

EDIT NAME: COPAY EXEMPTION

EDIT DESCRIPTION: (note: error code exists but is not currently implemented)

METHOD OF CORRECTION: REVIEW THE AGE OF RECIPIENT AND, IF UNDER 18, OVERRIDE AUDIT.

JOB: MMIS POS system PROGRAM: SBPOS039
ERROR CODE: 434

CLAIM TYPE:
Outpatient claims

DATE UPDATED:
06/08/04

EDIT NAME:
LAB CHG NOT PAYBL ON HOSP CLM

EDIT DESCRIPTION:
Current claim’s detail-level service code is EQUAL TO ‘O’

AND

its detail-level submitted charge is GREATER THAN zeroes

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: SB1J050
PROGRAM: SB1130

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ERROR CODE: 435

CLAIM TYPE: ?

DATE UPDATED:
06/08/04

EDIT NAME:
NO PRE-ASSESSMENT ON FILE

EDIT DESCRIPTION:
(note: this error code exists but is not implemented in claim processing)

METHOD OF CORRECTION:
VERIFY THAT CORRECT DATA WAS ENTERED. IF INFO WAS ENTERED CORRECTLY, DENY CLAIM

JOB: SB1J040
PROGRAM: SB1190
MMIS POS system SBPOS039

Top
ERROR CODE: 436

CLAIM TYPE:
UB82 claims

DATE UPDATED:
06/08/04

EDIT NAME:
DOS MISSING OR INVALID

EDIT DESCRIPTION:
Current claim is a UB82 Home Health claim with a bill type EQUAL TO '711'

AND

its bill from date is NOT EQUAL TO its bill to date

AND

its detail-level date of service is EQUAL TO zeroes

AND

it is not of region 40 OR it is an adjustment claim

METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA06" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070

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ERROR CODE: 437

CLAIM TYPE:
A) Payable claims
B) Payable claims

DATE UPDATED:
06/09/04

EDIT NAME:
SUSPECT PROVIDER - S/UR UNIT

EDIT DESCRIPTION:
A) Current claim’s detail-level provider review end date is NOT EQUAL TO zero

    AND

    its detail-level first procedure service date is NOT LESS THAN the detail-level provider begin date AND its detail-level first
    procedure service date is NOT GREATER THAN the detail-level provider end date

    AND

    current claim has been flagged as ‘Utilization Suspect’

B) Current claim has been flagged as ‘Utilization Suspect’

METHOD OF CORRECTION:
VERIFY THAT PROVIDER NUMBER WAS TRANSCRIBED CORRECTLY. REFER TO SURS UNIT FOR DISPOSITION OF
CLAIM.

JOB: PROGRAM:
A) SB1J040 SB1090
B) SB1J050 SB1130

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ERROR CODE: 438

CLAIM TYPE:
A) Payable claims
B) Payable claims

DATE UPDATED:
06/09/04

EDIT NAME:
SUSPECT PROVIDER - ADMINISTR

EDIT DESCRIPTION:
A) Current claim’s detail-level provider review end date is NOT EQUAL TO zero

    AND

    its detail-level first procedure service date is NOT LESS THAN the detail-level provider begin date AND its detail-level first procedure service date is NOT GREATER THAN the detail-level provider end date

    AND

    current claim has been flagged as ‘Admin Suspect’

B1) Current claim has been flagged as ‘Admin Suspect’

B2) Current claim has NOT been flagged as ‘Admin Suspect’

    AND

    has NOT been flagged as ‘Fraud Abuse Suspect’

    AND

    has NOT been flagged as ‘Provider Needs PA’

    AND

    has already been flagged with an Err 484

METHOD OF CORRECTION:
VERIFY THAT PROVIDER NUMBER WAS TRANSCRIBED CORRECTLY. IF PROVIDER HAS BILLED A LAB PROCEDURE WITH MODIFIER ‘90’, FORCE PAY. THIS MEANS THEIR LAB DID NOT PROVIDE THE SERVICE. OTHERWISE, REFER TO SUPERVISOR AS FILE UPDATE MAY BE INDICATED. IF SUPERVISOR ADVISES DENIAL, USE EOB B7

JOB:                      PROGRAM:
A) SB1J040               SB1090
B) SB1J050               SB1130

Top
ERROR CODE: 439

CLAIM TYPE: Drug claims

DATE UPDATED: 06/09/04

EDIT NAME: NO EFFECTIVE PROVIDER DRG INFO

EDIT DESCRIPTION: Current claim has no provider data on file

AND

its DRG code is NOT EQUAL TO 469 or 470

AND

its provider location code is EQUAL TO 1

AND

it has no valid DRG group date range

METHOD OF CORRECTION:
THE AMOUNT TO BE PAID CAN BE FORCED AT THE HEADER LEVEL. ONLY THE TOTAL AMOUNT CAN BE FORCED, SO THERE WILL BE NO BREAKDOWN OF THE PAYMENT ON THE REMITTANCE ADVICE.

JOB: SB1J050
PROGRAM: SB1130

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ERROR CODE: 440

CLAIM TYPE:
Institutional claims

DATE UPDATED:
06/09/04

EDIT NAME:
MORE THAN 15 DAYS HOSP LEAVE

EDIT DESCRIPTION:
Current claim has been flagged for hospital leave

AND

its detail-level units of service minus a day for discharge date is GREATER THAN the maximum hospital leave amount of 15.

METHOD OF CORRECTION:

JOB: SB1J050
PROGRAM: SB1130

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ERROR CODE: 441

CLAIM TYPE:
A) ?
B) ?
C) Drug claims

DATE UPDATED:
06/09/04

EDIT NAME:
CLAIM PAST FILING LIMIT (DOS)

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)
B) (note: this error code exists but is not currently implemented in claim processing)
C) Current claim’s first date dispensed is 3 years in the past.

METHOD OF CORRECTION:
VERIFY DATE(S) OF SERVICE TRANSCIBED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. ALSO CHECK ORIGINAL DATE CLAIM RECEIVED (ICN DATE) TO SEE IF IT WAS WITHIN 1 YEAR OF DATE OF SERVICE. IF SO, FORCE PAY CLAIM WITH 078. OTHERWISE, DENY EACH DETAIL WITH DATE OF SERVICE BEYOND 24 MONTH LIMIT WITH EOB CODE 034 AND PROCESS CLAIM. EXCEPTION: IF THERE WAS SSI APPEAL AND CLAIM HAS BEEN SIGNED BY ASST DIRECTOR, OK TO PROCESS. **IF ENTIRE CLAIM IS FOR SERVICES PROVIDED MORE THAN 24 MONTHS PRIOR TO ICN DATE, DENY AT HEADER LEVEL

JOB: PROGRAM:
A) SB1J050 SB1130
B) SB1J020 SB1070
C) online CICS SB710022

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ERROR CODE: 442

CLAIM TYPE:
A) ?
B) Payable claims

DATE UPDATED:
06/09/04

EDIT NAME:
CLAIM PAST FILING LIMIT (STMT)

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)

B) Current claim’s billing to date is NOT EQUAL TO zeroes
   AND
   its billing date does contain a valid date
   AND
   it is NOT a nursing home claim of LTC region (region 20) or of basic care region (region 21)
   AND
   its last billing date is GREATER THAN 712 days

METHOD OF CORRECTION:
VERIFY THAT ‘THROUGH’ STATEMENT COVERS PERIOD DATE WAS TRANSCRIBED CORRECTLY. IF NOT, CORRECT
AND PROCESS THE CLAIM. OTHERWISE, DENY THE CLAIM

JOB: PROGRAM:
A) SB1J050 SB1130
B) SB1J020 SB1070
ERROR CODE: 443

CLAIM TYPE: Inpatient claims, Crossover claims

DATE UPDATED: 06/09/04

EDIT NAME: DOS OVERLAP HMO

EDIT DESCRIPTION: Current claim’s primary care provider UPIN (ID # on file) is GREATER THAN spaces

AND

its UPIN is GREATER THAN ‘068999’ and LESS THAN ‘070000’

AND

it is not of regions 49, 90 or 94

AND

it contains a procedure code that is NOT EQUAL TO ‘0136’

AND

it is NOT a medical claim (record code ‘M’)

AND

it is NOT an adjustment

METHOD OF CORRECTION: CHECK TO SEE IF CHARGES ARE DRG RELATED-IF SO FORCE PAY. IF CHARGES ARE NOT DRG RELATED, RTP AND HAVE THEM BILL EACH MOTH SEPARATELY.

JOB: SB1J040
PROGRAM: SB1090
ERROR CODE:  444

CLAIM TYPE:
HCBC Elderly Disabled claims

DATE UPDATED:
06/09/04

EDIT NAME:
HCBC PROC=00001, BILL SEPARATE

EDIT DESCRIPTION:
Current claim is of region ‘94’

AND

its recipient legal county code is NOT EQUAL TO 56 or 55

AND

its number of detail lines is GREATER THAN 1

AND

it currently has a procedure code of 0151 AND is NOT in a state of clerical deny

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB:  PROGRAM:
SB1J040  SB1090

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ERROR CODE: 445

CLAIM TYPE: UB82 claims

DATE UPDATED: 06/09/04

EDIT NAME: HM HLTH MEDICARE REV. DT INVAL

EDIT DESCRIPTION: Current claim's Medicare revision date is GREATER THAN zero AND its Medicare revision date is invalid

METHOD OF CORRECTION: CORRECT FIELD ON CLAIM. FORCE OR DENY ERROR. WHEN USING REMARK CODE "M45" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE: 446

CLAIM TYPE:
A) Payable claims
B) Drug claims

DATE UPDATED:
06/09/04

EDIT NAME:
PROCEDURE NEEDS MANUAL PRICE

EDIT DESCRIPTION:
A) Current claim has a detail-level pricing indicator EQUAL TO ‘6’

B) Current claim’s point of sale wholesale cost is EQUAL TO zero, point of sale MAC price is EQUAL TO zero, point of sale allowed charge is EQUAL TO zero, quantity dispensed is NOT EQUAL TO zero

OR

its point of sale drug codes is EQUAL TO ‘00033333333’ or ‘00099999999’

OR

its point of sale quantity dispensed is GREATER THAN OR EQUAL TO 9999

METHOD OF CORRECTION:
REFER TO PROPER CONSULTANT FOR APPROPRIATE PRICING AMOUNT AFTER VERIFYING PROCEDURE NUMBER HAS BEEN TRANSCRIBED CORRECTLY. WHEN ENTERING A MANUAL PRICE, THE APPROPRIATE EOB CODE MUST BE USED. NOTE: WHEN MANUALLY PRICING DRUG CLAIMS, BE SURE TO INCLUDE THE PROFESSIONAL FEE OF $3.75 IF A LEGEND DRUG. YOU MAY ALSO USE "68" IN PLACE OF "67" (MSOT APPROPRIATE)

JOB: PROGRAM:
A) SB1J050 SB1130
B) online CICS SB710023

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ERROR CODE: 447

CLAIM TYPE: Payable claims

DATE UPDATED: 06/09/04

EDIT NAME: NO LEVEL #1 PRICE ON FILE

EDIT DESCRIPTION:
1) Current claim’s detail-level pricing indicator is EQUAL TO ‘1’
   AND
   its detail-level customary medical charge is EQUAL TO zero
   AND
   its provider number is NOT in the range of ‘000032000’ through ‘000034999’, ‘000038800’ through ‘000039999’, ‘000050000’ through ‘000059999’, ‘000019000’ through ‘000019099’, ‘000005000’ through ‘000005999’
2) Current claim’s detail-level pricing indicator is EQUAL TO ‘1’
   AND
   it’s NOT a UB82 Home Health claim
   AND
   its detail-level customary medical charge is EQUAL TO zero
   OR
   its provider number is LESS THAN ‘000050000’ or GREATER THAN ‘000059999’
3) Current claim’s detail-level pricing indicator is EQUAL TO ‘1’
   AND
   it’s a UB82 Home Health claim
   AND
   its detail-level allowed charge is EQUAL TO zero
   OR
   its provider number is NOT in the range of ‘000032000’ through ‘000034999’, ‘000038800’ through ‘000039999’, ‘000050000’ through ‘000059999’, ‘000019000’ through ‘000019099’, ‘000005000’ through ‘000005999’

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 448

CLAIM TYPE: OUTPATIENT, UB82 HOME HEALTH, PROFESSIONAL

DATE UPDATED: 6/10/04

EDIT NAME: NO LEVEL 2 PRICE ON FILE

EDIT DESCRIPTION:

IF IT IS A SPLIT CLAIM
IF PAYABLE CLAIM
IF NOT A DENIED CLAIM
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE IS EQUAL '711'
AND PVF-STATUS = '00' AND P1M0-PROV-CURR-OPT-RR IS GREATER THAN 0))
OR REVENUE CODE EQUAL TO '983'
OR CROSSOVER CLAIM
IF NOT A BAD-PRICE-RETURN OR LVL3-PROC-STAT NOT EQUAL TO 1
IF NOT LVL3-INACTV-PROC AND
(WORK-LEVEL3-DATE-N GREATER THAN CLMT-LST-DA-OF-SERV)
IF LEVEL2 PRICE
IF LVL2 PRVL CHARGE EQUAL TO +0
OR
IF UB82 OUTPATIENT CLAIM AND THE REGION IS EQUAL TO '70'
AND BILL TYPE EQUAL TO '131'
AND REVENUE CODE EQUAL TO '987'
IF ((CPT4 CODE GREATER THAN '99220' AND LESS THAN '99240')
OR (GREATER THAN '99290' AND LESS THAN '99298')
OR (GREATER THAN '99430' AND LESS THAN '99441')
OR (GREATER THAN '99260' AND LESS THAN '99264'))

OR

IF UB82 OUTPATIENT CLAIM OR UB82 HOME HEALTH
IF R1RV-ALLOW-OUTP-CLAIM IS EQUAL TO 'C'
IF ALREADY PRICED
OR
IF R1RV-ALLOW-OUTP-CLAIM IS NOT EQUAL TO 'C'
IF CPT4 CODE NOT EQUAL TO SPACES
IF (BILL TYPE NOT EQUAL TO '141') OR
((REVENUE CODE NOT EQUAL TO '982') AND
(CPT4 CODE NOT EQUAL TO '03000' OR NOT EQUAL TO '03001' OR NOT EQUAL TO '97535' OR NOT EQUAL TO '99078'))
AND
IF LEVEL2 PRICE
IF LVL2-PRVL-CHG EQUAL TO ZERO

METHOD OF CORRECTION:

VERIFY TRANSCRIPTION OF PROCEDURE/MODIFIER CODES. DETERMINE FROM THE
PROCEDURE FILE, THE PAC FOR THE PROCEDURE BILLED. IF PAC IS IN ERROR, FILE MAIN
TANENCE IS NECESSARY. MANUALLY PRICE THE DETAIL WITH THE APPROPRIATE EOB CODE AND UPDATE THE
LEVEL-3 FILE WITH CORRECT PAC.
Top
ERROR CODE: 449

CLAIM TYPE:
Payable claims

DATE UPDATED:
06/10/04

EDIT NAME:
NO LEVEL 3 PRICE ON FILE

EDIT DESCRIPTION:
1) Current claim’s detail-level pricing indicator is EQUAL TO ‘3’

   AND

   its detail-level allowed charge (level 3) is EQUAL TO zero

2) Current claim has received has been incorrectly priced OR it contains a level 3 procedure code

3) Current claim has a level 3 inactive procedure code

   AND

   its level3 service date is LESS THAN the last date of service

4) Current claim’s detail-level pricing indicator is EQUAL TO ‘3’

   AND

   its detail-level allowed charge (level 3) is EQUAL TO zero

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION OF PROCEDURE/MODIFIER CODES. FOE MEDICAL PROCEDURES REFER TO SUPERVISOR TO REVIEW WITH MEDICAL CONSULTANT FOR APPROPRIATE ALLOWABLE AMT. CONSULTANT WILL DETERMINE IF FEE SHOULD BE ADDED TO LEVEL 3 FILE. DENTAL PROCEDURES WITHOUT LEVEL 3 FEES ARE USUALLY REFERRED DIRECTLY TO DENTAL CONSULTANT BY AUDITOR. DENTAL CONSULTANT WILL DETERMINE IF FEE CAN BE ADDED TO FILE.

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 450

CLAIM TYPE:
A) ?
B) Drug claims

DATE UPDATED:
06/10/04

EDIT NAME:
DRUG DOS NOT IN PRICING RANGE

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)

B) Current claim processing has exhausted all drug price entries on file

AND

its most valid drug price match has a beginning date GREATER THAN the date dispensed on the current claim

METHOD OF CORRECTION:
VERIFY THAT ALL AMTS TRANSCRIBED CORRECTLY. IF NOT, CORRECT AND PROCESS CLAIM. IF THE ERROR OCCURRED BECAUSE OF INVALID TRANSCRIPTION OF DATES, CORRECTION OF PROPER ENTRIES WILL CLEAR THE CLAIM. IF THE ERROR OCCURRED BECAUSE THE START DATE IS LATER THAN THE DATE OF SERVICE, REFER TO THE PHARMACY CONSULTANT. FILE UPDATE MAY BE INDICATED. YOU MAY ALSO USE "68" IN PLACE OF "67" (MOST APPROPRIATE) WHEN USING REMARK CODE "N60" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
A) SB1J050 SB1130
B) online CICS SB710023

Top
ERROR CODE:  451

CLAIM TYPE:
A)  ?

B)  Drug claims

DATE UPDATED:
06/10/04

EDIT NAME:
LEGEND DRUG CHG OVER $200.00

EDIT DESCRIPTION:
A)  (note: this error code exists but is not currently implemented in claim processing)

B)  Current claim’s detail-level drug control code is NOT EQUAL TO ‘3’

    AND

    its detail-level point of sale pricing indicator is NOT EQUAL TO ‘6’

    AND

    its detail-level point of sale ledger total is GREATER THAN 200.00

METHOD OF CORRECTION:
VERIFY THAT CHARGE HAS BEEN TRANSCRIBED CORRECTLY. REFER CLAIM TO PHARMACY CONSULTANT FOR REVIEW. PAY IN ACCORDANCE WITH CONSULTANT'S DETERMINATION. NOTE: WHEN A MANUAL PRICE IS ENTERED FOR THE DRUG IN ERROR, BE SURE TO INCLUDE THE PROFESSIONAL FEE OF $4.60 IN THE DRUG CHARGE. YOU MAY ALSO USE "68" IN PLACE OF "67" (MOST APPROPRIATE)

JOB:  PROGRAM:
A)  SB1J050          SB1130

B)  online CICS      SB710023

Top
ERROR CODE: 452

CLAIM TYPE: 
?

DATE UPDATED:
06/10/04

EDIT NAME:
INNOV MULT SOURCE DRUG NOT PD

EDIT DESCRIPTION:
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:
CLAIM WILL AUTOMATICALLY DENY WITH EOB MESSAGE 037.

JOB:                  PROGRAM:
online POS system     SBPOS039

Top
ERROR CODE: 453

CLAIM TYPE:
A) ?
B) Drug claims

DATE UPDATED:
06/10/04

EDIT NAME:
NONLEGEND DRUG CHG > $100.00

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)
B) Current claim’s detail-level drug control code is NOT EQUAL TO ‘3’

AND

its detail-level point of sale pricing indicator is NOT EQUAL TO ‘6’

AND

its detail-level point of sale ledger total is GREATER THAN 100.00

METHOD OF CORRECTION:
VERIFY THAT CHARGE HAS BEEN TRANSCRIBED CORRECTLY. REFER TO PHARMACY CONSULTANT. PAY IN ACCORDANCE WITH HIS/HER ADVISEMENT.

JOB:
A) SB1J050
B) online CICS

PROGRAM:
A) SB1130
B) SB710023
ERROR CODE: 455

CLAIM TYPE: 

DATE UPDATED: 06/10/04

EDIT NAME: SURGERY PROC NOT ON FILE

EDIT DESCRIPTION: (note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION: VERIFY TRANSCRIPTION. IF IN ERROR, CORRECT AND PROCESS CLAIM. OTHERWISE, VERIFY THAT THE PROCEDURE IS NOT A VALID PROCEDURE. CHECK 'SURGICAL PROCEDURE DESCRIPTION' BLOCK AND 'SURGERY' SECTION ON PSRO FOR WRITTEN DESCRIPTION OF PROCEDURE. WITH THIS INFO, SURGICAL CODE CAN BE OBTAINED FROM ICD-9-CM '3'. IF SURGERY IS NOT DESCRIBED, RETURN THE CLAIM WITH EOB "M58" AND "16" IN FIELD 6. ATTACH 631 CHECK #30. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING "M67" OF "MA66" ENTER CLAIM ADJUSTMENT REASON "125" IN FLD 6.

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE: 456

CLAIM TYPE: Payable claims

DATE UPDATED: 06/10/04

EDIT NAME: LIMIT EXCEEDED

EDIT DESCRIPTION:
A. Current claim’s detail-level procedure code is EQUAL TO ‘03000’ AND its limit count is GREATER THAN 1
   OR
   its detail-level procedure code is EQUAL TO ‘03001’ AND its limit count is GREATER THAN 3
   OR
   its detail-level procedure code is EQUAL TO ‘03005’ AND its limit count is GREATER THAN 2
   OR
   its detail-level procedure code is EQUAL TO ‘03006’ AND its limit count is GREATER THAN 4
B. If the number of units for a personal care claim with procedure T1019 is more than the authorized units on the SB560010 file, the error is given.

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: PROGRAM:
A. SB1J075, SB1J079 SB1250
B. SB1J085 SB1330
ERROR CODE: 457

CLAIM TYPE: Payable claims

DATE UPDATED: 06/10/04

EDIT NAME: ZERO ALLOWED AMOUNT

EDIT DESCRIPTION:

1) Current claim has a valid pricing indicator and a detail-level revenue code of ‘360’ through ‘369’, or ‘490’ through ‘499’

   AND

   its detail-level allowed charge is EQUAL TO zeroes

2) Current UB82 Outpatient claim has a bill type EQUAL TO ‘831’, detail-revenue code of ‘490’, first date of service LESS THAN 19990301, and a provider number of ‘000001018’ or ‘000001063’ OR current UB82 Outpatient claim has a bill type EQUAL TO ‘131’, detail-revenue code of ‘540’, first date of service LESS THAN 19990301, and a provider number of ‘000001018’ or ‘000001063’

   AND

   its detail-level allowed charge is EQUAL TO zeroes

3) Current UB82 Outpatient claim or UB82 Home Health claim has NOT been priced

   AND

   its detail-level CPT4 code is EQUAL TO ‘03000’, ‘03001’, ‘03005’, ‘03006’, ‘97535’, or ‘99078’ OR its detail-level revenue code is NOT EQUAL TO ‘982’

   AND

   its detail-level CPT4 code is NOT EQUAL TO spaces

   AND

   its bill type is NOT EQUAL TO ‘141’ AND (its detail-level revenue code is NOT EQUAL TO ‘982’ OR its CPT4 code is NOT EQUAL TO ‘03000’, ‘03001’, ‘97535’, or ‘99078’)

   AND

   it’s a main region claim (region ‘10’) or a tape bill region claim (region ‘40’) AND its Lab procedure code ends in ‘99’

4) Current claim is NOT a main region claim (region ‘10’) or a tape bill region claim (region ‘40’) OR its first date of service is NOT GREATER THAN 19960831

   AND

   its detail-level allowed charge is LESS THAN OR EQUAL TO zero AND its provider number is in the range of ‘000050000’ through ‘000059999’ with a total claim charge GREATER THAN OR EQUAL TO 200 and a detail-level type of service code
EQUAL TO ‘9’

AND

it has NOT been previously flagged for suspense (mod-suspend-sw = ‘y’, mod-22-sw = ‘y’ or mod-rr-59-sw = ‘y’)

5) Current claim is NOT a main region claim (region ‘10’) or a tape bill region claim (region ‘40’) OR its first date of service is NOT GREATER THAN 19960831

AND

its detail-level allowed charge is LESS THAN OR EQUAL TO zero AND its provider number is in the range of ‘000050000’ through ‘000059999’ with a total claim charge GREATER THAN OR EQUAL TO 200 and a detail-level type of service code EQUAL TO ‘9’

AND

it has NOT been previously flagged for suspense (mod-suspend-sw = ‘y’, mod-22-sw = ‘y’ or mod-rr-59-sw = ‘y’) AND its DME modifier is NOT EQUAL TO ‘R’

6) Current claim’s detail-level allowed charge is EQUAL TO zero

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: SB1J050
PROGRAM: SB1130

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ERROR CODE:  458

CLAIM TYPE:
Payable claims

DATE UPDATED:
06/10/04

EDIT NAME:
CALENDAR YEAR LIMIT EXCEEDED

EDIT DESCRIPTION:
Current claim's service limit exceeded the present maximum of 45 days

METHOD OF CORRECTION:
THE CALENDAR YEAR LIMIT ESTABLISHED FOR THIS SERVICE WAS EXCEEDED.

JOB:  PROGRAM:
SB1J075, SB1J079  SB1250

Top
ERROR CODE: 459

CLAIM TYPE: Payable claims

DATE UPDATED: 06/10/04

EDIT NAME: HIGH VARIANCE

EDIT DESCRIPTION:
1) Current nursing home claim has an out of state provider and is NOT of developmental disability region (region 90)

   AND

   its detail-level allowed charge is GREATER THAN the ancillary variance limit

   AND

   this claim is NOT a takeover claim (region ‘80’)

2) Current claim has a pricing indicator EQUAL TO ‘5’ (price as bill)

   AND

   its level3 allowed charge is LESS THAN the submitted charge

   AND

   it’s NOT of region ‘80’ or ‘90’

   AND

   it’s a medical claim or a UB82 home health claim

   AND

   it’s of region ‘10’ or ‘40’

   AND

   its provider number is in the range of ‘000050000’ through ‘000059999’ AND its type of service is EQUAL TO ‘57’, ‘80’, ‘81’

   AND

   its service code is a valid entry according to the table of service codes on file

3) Current claim has a pricing indicator EQUAL TO ‘5’ (price as bill)

   AND

   its level3 allowed charge is LESS THAN the submitted charge
AND

it’s NOT of region ‘80’ or ‘90’

AND

it’s a dental claim

4) Current claim’s first date of service is GREATER THAN 19960831 AND it's a main region claim (region 10) or tape bill region claim (region 40)

AND

its detail-level allowed charge is EQUAL TO zero

AND

its prior authorization control number is GREATER THAN spaces OR EQUAL TO zeroes

AND

DME prior authorization is required

AND

its DME maximum reimbursement amount is GREATER THAN zero AND GREATER THAN OR EQUAL TO the detail-level submitted charge

AND

it contains a valid procedure code

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB:                                                PROGRAM:
SB1J050                        SB1130

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ERROR CODE: 460

CLAIM TYPE: INSTITUTIONAL, UB82 INST, UB82 HOME HEALTH

DATE UPDATED: 6/10/04

EDIT NAME: MANUAL REVIEW REQUIRED

EDIT DESCRIPTION:
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF NOT UB82 CLAIM
AND
IF CLMT-DEVELP-DISABILITY-REG

METHOD OF CORRECTION:
AFTER REVIEWING SUBMITTED CHARGES FOR REASONABLE OVERRIDE AND PAY THE
REASONABLE RATE FOR EQUIVALENT IN-STATE PROVIDERS WITH EOB CODE 078.

JOB: SB1J020                           PROGRAM: SB1070
ERROR CODE: 461
CLAIM TYPE: N/A
DATE UPDATED: 6/10/04
EDIT NAME: NEW CLAIM/OLD ELG POTENTIAL RECIP R/L
EDIT DESCRIPTION: NOT ON MMIS SYSTEM
METHOD OF CORRECTION:
COMMENTS: REFER TO MMIS COORDINATOR AND ISD TEAM LEADER FOR RESOLUTION, YOU MAY ALSO USE "27" IN PLACE OF "26" (MOST APPROPRIATE)
    JOB: N/A                   PROGRAM: N/A
ERROR CODE: 462
CLAIM TYPE: N/A
DATE UPDATED: 6/10/04
EDIT NAME: REG 40 - POTENTIAL RECIP LIABILITY
EDIT DESCRIPTION: NOT ON MMIS SYSTEM

METHOD OF CORRECTION:
YOU MAY ALSO USE "27" IN PLACE OF "26" (MOST APPROPRIATE)
JOB: N/A PROGRAM: N/A
ERROR CODE: 463
CLAIM TYPE: N/A
DATE UPDATED: 6/10/04
EDIT NAME: REG 70 - POTENTIAL RECIP LIABILITY
EDIT DESCRIPTION: NOT ON MMIS SYSTEM

METHOD OF CORRECTION:
YOU MAY ALSO USE "27" IN PLACE OF "26" (MOST APPROPRIATE)
   JOB: N/A          PROGRAM: N/A

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ERROR CODE: 464

CLAIM TYPE: INSTITUTIONAL, PROFESSIONAL, UB82 INSTITUTIONAL, CROSSOVER

DATE UPDATED: 6/11/04

EDIT NAME: HOSP BILL ON PROFES CLAIM FORM

EDIT DESCRIPTION:
IF ENTRX-CD1 = 'Q' OR 'R' OR 'U' OR 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X'
AND
IF IT'S NOT A DENIED CLAIM
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
  OR UB82 INST CLAIM OR CROSSOVER CLAIM
AND
IF THE CLAIM IS SPLIT
IF CLMT-PROFESSIONAL-CLAIM

METHOD OF CORRECTION:
CHECK DATA ENTRY. IF A HOSPITAL PROVIDER NUMBER RETURN TO PROVIDER TO BILL ON UB92 OR FOR THE
CORRECT (DOCTOR/CLINIC) PROVIDER NUMBER. WHEN USING REMARK CODE "N34" YOU MUST ENTER CLAIM
ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020 PROGRAM: SB1070

Top
ERROR CODE: 465

CLAIM TYPE:
Payable claims

DATE UPDATED:
06/11/04

EDIT NAME:
DIAG NOT CONSISTENT WITH SEX

EDIT DESCRIPTION:
1) Current claim is NOT flagged as being for both sexes

   AND

   the diagnosis indicates a male recipient AND the recipient is NOT male

2) Current claim is NOT flagged as being for both sexes

   AND

   the diagnosis indicates a female recipient AND the recipient is NOT female

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 466

CLAIM TYPE: Payable claims

DATE UPDATED: 06/11/04

EDIT NAME: DIAG NOT CONSISTENT WITH AGE

EDIT DESCRIPTION: Current claim’s recipient has an age that is GREATER THAN the high diagnosis limit OR its recipient has an age that is LESS THAN the low diagnosis limit

AND

it’s NOT an HCBC elderly disabled claim

METHOD OF CORRECTION: (note: no correction method is given on the MMIS system)

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE: 467

CLAIM TYPE: Payable claims

DATE UPDATED: 06/11/04

EDIT NAME: REIMB PCT NOT >=50 AND <=100

EDIT DESCRIPTION: Current Inpatient claim has a provider number that is in the range of ‘000035000’ through ‘000037999’

AND

its reimbursement ratio is LESS THAN the minimum rate (50) OR its reimbursement ratio is GREATER THAN the maximum rate (100)

METHOD OF CORRECTION: PROVIDER FILE UPDATE HAS BEEN MADE WHERE THE INPUT REIMBURSEMENT RATE IS NOT EQUAL TO OR BETWEEN 50 AND 100 PERCENT. PROVIDER MAINTENANCE MAY HAVE TO BE REDONE. CONTACT SUPERVISOR WHEN ERROR OCCURS.

JOB: SB1J050 PROGRAM: SB1130

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ERROR CODE: 468

CLAIM TYPE:
Payable claims

DATE UPDATED:
06/11/04

EDIT NAME:
PROV NEEDS PTAR FOR PROC

EDIT DESCRIPTION:
Current claim is NOT under suspense, nor is it flagged as a suspect claim

AND

its provider has flagged the claim as requiring prior authorization

AND

its current detail-level prior authorization flag is EQUAL TO spaces or zeroes

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: PROGRAM:
SB1J050 SB1130

Top
ERROR CODE: 470

CLAIM TYPE:
A) Payable claims
B) Payable claims

DATE UPDATED:
06/11/04

EDIT NAME:
SUSP FOR ELIG DETERMINATION

EDIT DESCRIPTION:
A) Current claim is TECS eligible AND has a suspense indicator EQUAL TO ‘S’

    OR

    it’s QMB eligible AND has a suspense indicator EQUAL TO ‘S’

B) FND-470 is EQUAL TO ‘Y’

METHOD OF CORRECTION:
WHEN ERROR APPEARS, SKIP THE CLAIM. WHEN THE LAST CYCLE OF MONTH IS RUN, SYSTEM WILL AUTOMATICALLY PAY THE CLAIMS IF THERE IS NOT RECIPIENT LIABILITY FOR THAT MONTH.

JOB:               PROGRAM:
A) SB1J045        SB1090
B) online CICS    SB710022
ERROR CODE: 471

CLAIM TYPE: ALL EXCEPT NURSING HOME

DATE UPDATED: 6/11/04

EDIT NAME: FREE MA ELIG; MONTH NOT AUTHOR

EDIT DESCRIPTION:
IF THE ACCIDENT TYPE IS EQUAL TO 'C' OR SPACES
AND
IF NOT A NURSING HOME CLAIM AND IS QMB ELIGIBLE

IF REVIEW STARTING DATE IS GREATER THAN THE 1ST DAY OF SERVICE
OR IF THE NURSING HOME INDEX IS AT THE MAX OF (3)

AND
IF IT'S A PAYABLE MEDICAL CLAIM

OR
IF THE CLAIM IS FOUND ON THE SB640010 FILE

OR
IF IT'S A PAYABLE NURSING HOME CLAIM

AND
IF THE FROM DATE OF SERVICE IS NOT LESS THAN THE STARTING DATE AND
THE TO DATE OF SERVICE IS NOT GREATER THAN THE STOPPING DATE

IF (TEC-ELIG-SW EQUAL TO 'Y' AND LMTE-SUSP-IND(L-ELIG-INDEX) EQUAL TO 'U')
OR (QMB-ELIG-SW EQUAL TO 'Y' AND TQMB-SUSP-IND (QMB-INDEX) EQUAL TO 'U')
IF CURRENT DATE LESS THAN FIRST DAY OF SERVICE

METHOD OF CORRECTION:
ERROR WILL BE AUTOMATICALLY RECYCLED FOR TWO MONTHS FROM THE FIRST DATE OF SERVICE. IF THE CASE
HAS NOT BEEN AUTHORIZED AFTER TWO MONTHS THE CLAIM W ILL SUSPEND WITH A 474 ERROR. YOU MAY ALSO
USE "27" IN PLACE OF "26" (MOST APPROPRIATE)

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 472

CLAIM TYPE:
Professional claims

DATE UPDATED:
06/11/04

EDIT NAME:
DIAG FILE INDICATES FP NEEDED

EDIT DESCRIPTION:
1) Current claim is NOT a UB82 home health claim OR it has a bill type NOT EQUAL to ‘711’ OR it does NOT have a detail-level revenue code of ‘983’ OR the provider VSAM file has returned a status NOT EQUAL TO ‘00’

   AND

   it’s a professional claim related to family planning AND family planning is NOT specified on the diagnosis

2) Current claim pertains to family planning AND there are no diagnosis codes to indicate such

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 473

CLAIM TYPE: INPATIENT, OUTPATIENT, PROFESSIONAL, UB82 HOME HEALTH, INSTITUTIONAL, UB82

DATE UPDATED: 6/11/04

EDIT NAME: FAMILY PLANNING % NEEDED

EDIT DESCRIPTION:
IF ENTRX-CD1 = 'Q' OR 'R' OR 'U' OR 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X'
AND
IF IT'S NOT A DENIED CLAIM
AND IF NOT UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND REVENUE CODE NOT EQUAL TO '983' AND REVENUE CODE NOT EQUAL TO '521' OR '522'
AND (PVF-STATUS EQUAL TO '00' AND
(1ST DAY OF SERV NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT)
AND P1M0-PROV-CURR-OPT-RR EQUAL TO 0)
OR
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS = '00' AND REVENUE CODE NOT EQUAL TO '983' AND
((1ST DAY OF SERVICE NOT LESS THAN PROVIDER CURRENT EFFECTIVE DATE
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(IF REVENUE CODE EQUAL TO '521' OR '522' AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE EQUAL TO '521' OR '522'))
OR
IF (PROFESSIONAL CLAIM AND NOT (UB82 HOME HEALTH AND
BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO '983'
OR CROSSOVER CLAIM
OR
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
IF NOT UB82 CLAIM
IF NOT HEAD FAMILY PLAN
OR
IF FAMILY PLAN FRACTION GREATER THAN +0
OR
IF UB82 CLAIM
IF UB82 HEAD FAMILY PLAN
IF UB82 FAMILY PLAN FRACTION LESS THAN +0
OR
IF UB82 FAMILY PLAN FRACTION GREATER THAN +0

METHOD OF CORRECTION:
VERIFY THAT DIAGNOSIS/INDICATOR HAVE BEEN TRASCRIBED CORRECTLY. IF THEY HAVE NOT, CORRECT AND PROCESS THE CLAIM. OTHERWISE, ENTER THE FAMILY PLANNING PERCENTAGE ONTO THE WORKSHEET, AND PROCESS THE CLAIM.

JOB: SB1J050  PROGRAM: SB1130
ERROR CODE:  474

CLAIM TYPE:  ALL EXCEPT NURSING HOME

DATE UPDATED:  6/11/04

EDIT NAME:  FREE MA  ELIG; MONTH NOT AUTH.

EDIT DESCRIPTION:
IF THE ACCIDENT TYPE IS EQUAL TO 'C' OR SPACES
AND
IF NOT A NURSING HOME CLAIM AND IS QMB ELIGIBLE

IF REVIEW STARTING DATE IS GREATER THAN THE 1ST DAY OF SERVICE
OR IF THE NURSING HOME INDEX IS AT THE MAX OF (3)

AND
IF IT'S A PAYABLE MEDICAL CLAIM

OR
IF THE CLAIM IS FOUND ON THE SB640010 FILE

OR
IF IT'S A PAYABLE NURSING HOME CLAIM

AND
IF THE FROM DATE OF SERVICE IS NOT LESS THAN THE STARTING DATE AND
THE TO DATE OF SERVICE IS NOT GREATER THAN THE STOPPING DATE
AND
IF (TEC-ELIG-SW EQUAL TO 'Y' AND LMTE-SUSP-IND(L-ELIG-INDEX) EQUAL TO 'U')
OR (QMB-ELIG-SW EQUAL TO 'Y' AND TQMB-SUSP-IND (QMB-INDEX) EQUAL TO 'U')

IF CURRENT DATE GREATER THAN FIRST DAY OF SERVICE

METHOD OF CORRECTION:
YOU MAY ALSO USE "27" IN PLACE OF "26" (MOST APPROPRIATE)

JOB:                                                PROGRAM:
SB1J040                        SB1090

Top
ERROR CODE: 475

CLAIM TYPE: INPATIENT

DATE UPDATED: 6/11/04

EDIT NAME: IHS SRV "P" NEEDS MANUAL PRICE

EDIT DESCRIPTION:
IF ENTRX-CD1 = 'Q' OR 'R' OR 'U' OR 'T' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X'
AND
IF IT'S NOT A DENIED CLAIM
AND
IF NOT UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND REVENUE CODE NOT EQUAL TO '983' AND
REVENUE CODE NOT EQUAL TO '521' OR '522'
AND (PVF-STATUS EQUAL TO '00' AND
(1ST DAY OF SERV NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT)
AND P1M0-PROV-CURR-OPT-RR EQUAL TO 0)
OR
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS = '00' AND REVENUE CODE NOT EQUAL TO '983' AND
((1ST DAY OF SERVICE NOT LESS THAN PROVIDER CURRENT EFFECTIVE DATE
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(IF REVENUE CODE EQUAL TO '521' OR '522' AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE EQUAL TO '521' OR '522'))
OR
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF INPATIENT CLAIM
IF CLAIM REGION IS EQUAL TO '70' AND
(SERVICE CODE IS EQUAL TO 'P' OR 'B' OR 'Z')

METHOD OF CORRECTION:
CHECK THE CLAIM FOR VALID CPT-4 AMBULATORY SURGICAL PROCEDURE CODE. IF CODE IS NOT A VALID CPT-4
AMBULATORY SURGICAL PROCEDURE CODE, WITH DENY ENTRY WITH EOB CODE 058 OR RETURN THE CLAIM TO
PROVIDER BY 345 AND DENY CLAIM WITH EOB CODE 100. IF CODE IS VALID, CHECK HOSPITAL AMBULATORY
SURGICAL CODING LISTING TO DETERMINE PROPER LEVEL FOR PAYMENT. FOCE PAY AT APPROPRIATE FEE WITH
EOB CODE 078.

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 476

CLAIM TYPE:
A) ?
B) Drug claims

DATE UPDATED:
06/11/04

EDIT NAME:
QUAN. BILLED TOO SMALL/LARGE

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)

B) Current claim’s detail-level quantity dispensed is NOT EQUAL TO zero AND it’s LESS THAN the minimum supply or GREATER THAN the maximum supply

METHOD OF CORRECTION:
VERIFY THAT NO TRANSCRIPTION ERROR HAS BEEN MADE. CHECK THE NDC FILE AND VERIFY THAT THE UNITS BILLED ARE IN EXCESS OF THE MAXIMUM. IF THEY ARE, CUT-BACK THE NUMBER OF UNITS/CHARGE BILLED WITH EOB CODE 076 TO THE MAXIMUM ALLOWABLE.
WHEN USING REMARK CODE "M53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
A) SB1J050 SB1130

B) online CICS SB710023

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ERROR CODE: 477

CLAIM TYPE: PROFESSIONAL

DATE UPDATED: 6/11/04

EDIT NAME: DIAG FILE INDICATES FP NEEDED

EDIT DESCRIPTION:

IF ENTRX-CD1 = ‘Q’ OR ‘R’ OR ‘U’ OR ‘T’ OR ‘O’ OR ‘N’ OR ‘M’ OR ‘S’ OR ‘L’ OR ‘X’
AND
IF IT’S NOT A DENIED CLAIM
AND IF NOT UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’ AND REVENUE CODE NOT EQUAL TO ’983’ AND
REVENUE CODE NOT EQUAL TO ’521’ OR ’522’
AND (PVF-STATUS EQUAL TO ’00’ AND
(1ST DAY OF SERV NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR EQUAL TO 0))
OR
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’ AND
PVF-STATUS = ’00’ AND REVENUE CODE NOT EQUAL TO ’983’ AND
((1ST DAY OF SERVICE NOT LESS THAN PROVIDER CURRENT EFFECTIVE DATE
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(IF REVENUE CODE EQUAL TO ’521’ OR ’522’ AND 1ST DAY OF SERVICE GREATER THAN 20011231
AND
(PROVIDER NUMBER GREATER THAN ’000004999’ AND LESS THAN ’000006000’) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE EQUAL TO ’521’ OR ’522’))
OR
IF (PROFESSIONAL CLAIM AND NOT (UB82 HOME HEALTH AND
BILL TYPE EQUAL TO ’711’
AND PVF-STATUS EQUAL TO ’00’ AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO ’983’
OR CROSSOVER CLAIM
AND
IF NOT CROSSOVER CLAIM
 IF NOT UB82 HOME HEALTH
AND
IF DET-FAM-PLAN-DIAG
  IF NOT NON-FPLAN-MCH-CD
    IF HDIAG-FPLAN-SW EQUAL TO ’Y’
  OR
    IF DET-FAM-PLAN-DIAG
    IF HDIAG-FPLAN-SW EQUAL TO ’N’

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS.

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 478

CLAIM TYPE:
A) Medical claims
B) Medical claims

DATE UPDATED:
06/11/04

EDIT NAME:
MODIFIER REQ MANUAL REVIEW

EDIT DESCRIPTION:
A1) Current claim is NOT a main region claim (region 10) AND it’s NOT a tape bill region claim (region 40)

OR

its first day of service is NOT GREATER THAN 19960831

AND

its detail-level allowed charge is NOT GREATER THAN zero

AND

its provider number is in the range of ‘000050000’ through ‘000059999’ OR its total claim charge is LESS THAN 200 with a detail-level type of service code EQUAL TO ‘9’

AND

it has been flagged for suspense with modifiers EQUAL TO ‘22’ or ‘59

A2) Current claim’s ‘pay 8 dollars’ switch EQUALS ‘Y’ AND its procedure code is NOT FOUND among the valid procedure codes

OR

its ‘pay 8 dollars’ switch EQUALS spaces AND it contains a valid procedure code

AND

it does NOT have a ‘983’ revenue code

A3) Current claim has been previously flagged for ‘modifier on review’

A4) Current claim is of region 49

AND

it’s a medical claim with a detail-level place of service EQUAL TO ‘1’ or ‘2’

AND

its detail-level procedure code is NOT LESS THAN ‘70000’ and NOT GREATER THAN ‘89999’
AND

its detail-level modifier is EQUAL TO spaces

A5) Current claim’s provider type code is EQUAL TO ‘67’ AND its provider specialty code is EQUAL TO ‘93’

OR

the same provider on file has a type code EQUAL TO ‘67’ AND the same provider on file has a specialty code EQUAL TO ‘93’

AND

its detail-level procedure code is LESS THAN ‘09990’ or GREATER THAN ‘09996’ AND NOT EQUAL TO ‘36415’ AND NOT EQUAL TO ‘99000’ AND NOT EQUAL TO ‘99001’ AND NOT in the range of ‘90281’ through ‘90799’

AND

its explanation of benefits is EQUAL TO ‘223’ and does NOT have a revenue code of ‘983’

B) Current medical claim has a detail-level place of service EQUAL TO ‘1’

AND

its detail-level modifier is EQUAL TO ‘QX’ or ‘QZ’

METHOD OF CORRECTION:
SEE LISTING WHICH EXPLAINS WHY MODIFIER(S) HAS SUSPENDED.

JOB:                  PROGRAM:
A) SB1J050            SB1130
B) SB1J020            SB1070

Top
ERROR CODE: 479
CLAIM TYPE: N/A
DATE UPDATED: 6/11/04
EDIT NAME: MAX REFILLS EXCEEDED
EDIT DESCRIPTION: NOT ON MMIS SYSTEM.

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF MAXIMUM HAS BEEN EXCLUDED, DENY OR CUT-BACK EACH DRUG DISPENSED BEYOND THE 5 REFILL LIMIT.

JOB: N/A
PROGRAM: N/A
ERROR CODE: 480

CLAIM TYPE: ALL EXCEPT FOR NURSING HOME

DATE UPDATED: 6/11/04

EDIT NAME: ACCOMMODATION UNAUTHORIZED

EDIT DESCRIPTION:
A)
IF ENTRX-CD1 = 'Q' OR 'R' OR 'U' OR 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X'
AND
IF IT'S NOT A DENIED CLAIM
AND IF NOT UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND REVENUE CODE NOT EQUAL TO '983' AND
REVENUE CODE NOT EQUAL TO '521' OR '522'
AND (PVF-STATUS EQUAL TO '00' AND
(1ST DAY OF SERV NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT)
AND P1M0-PROV-CURR-OPT-RR EQUAL TO 0))
OR
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS = '00' AND REVENUE CODE NOT EQUAL TO '983' AND
((1ST DAY OF SERVICE NOT LESS THAN PROVIDER CURRENT EFFECTIVE DATE
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(IF REVENUE CODE EQUAL TO '521' OR '522' AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE EQUAL TO '521' OR '522'))
AND
IF INPATIENT CLAIM
IF CLAIM REGION IS NOT EQUAL TO '70' AND
(SERVICE CODE IS NOT EQUAL TO 'P' OR 'B' OR 'Z')
IF CLAIM REGION IS NOT EQUAL TO '90'
AND
IF INPATIENT ACCOMODATION
AND
IF INPATIENT CLAIM
IF NOT CLAIM REGION '70'
IF SERVICE CODE IS EQUAL TO ACCOM-PRIVATE-ROOM-A

B)
OR
IF 1ST DAY OF SERVICE IS LESS THAN
P1M0-PROV-RTE-EFDT (ACCOM-INDEX, MISC-INDX)
AND
IF MISC-INDX = MAX-ACCOM-DATE

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF PRIVATE ROOM IS BILLED, UNLESS A PHYS ORDER
FOR PRIV ROOM IS ATTACHED, DEDUCT $3.00 FOR EACH DAY BILLED. (ENTER AMT AS NON-COVERED ON LINE AND
HEADER LEVEL, AND ADJUST NET CHARGE). THEN FORCE ESC 480 AT BILLED AMT. (SYSTEM WILL DEDUCT NON-
COVERED CHARGES AND PAY AT HOSP. REIMB. RATE). EXCEPTION: IF 'ISOLATION' IS ALSO BILLED ON THE SAME
CLAIM, AND 'ISOLATION' HAS BEEN APPROVED TO PAY, DO NOT DEDUCT $3.00 PER DAY. FORCE PAY AT BILLED
AMOUNT.

JOB: PROGRAM:
FIELD NUMBER:  ERROR CODE: 481

CLAIM TYPE: ALL CLAIM TYPES

DATE UPDATED: 6/11/04

EDIT NAME: ANCILLARY UNAUTHORIZED

EDIT DESCRIPTION:
 IF 1ST DAY OF SERVICE LESS THAN
     P1M0-PROV-SERV-AUTH-DT (AUTH-INDEX MISC-INDX)
 AND
 IF THE CLAIM REGION IS NOT EQUAL TO '40'
 OR
 IF 1ST DAY OF SERVICE LESS THAN
     P1M0-PROV-SERV-AUTH-DT (AUTH-INDEX MISC-INDX)
 AND
 IF MISC-INDX EQUAL TO MAX-PAY DATE
     IF CLAIM REGION NOT EQUAL TO '40'
 OR
 IF 1ST DAY OF SERVICE LESS THAN
     P1M0-PROV-SERV-AUTH-DT (AUTH-INDEX MISC-INDX)
 AND
 IF THE CLAIM REGION IS NOT EQUAL TO '40'
 AND
 IF UB82 SERVICE CODE NOT EQUAL TO 'Z'
     IF CLAIM REGION NOT EQUAL TO '40'
 OR ADJUSTMENT CLAIM

METHOD OF CORRECTION:
VERIFY DATA ENTRY. DETERMINE IF ANCILLARY IS UNAUTHORIZED 1.IF ANCILLARY IS APPROVED SERV, FORCE PAY. 2.IF ANCILLARY IS SERVICE WHICH REQUIRES A PTAR, FORCE PAY AT AMT APPROVED AMT ON PTAR. 3.IF A NON APPROVED SERV OR SUPERVISOR INDICATED SERV TO BE DENIED, DENY. 4.IF MORE INFO REQUIRED OR PROV HASN'T ITEMIZED SERV ON LINE Z, TRN W/ EOB "M58" AND "16" IN FLD 6. NOTE IN COMMENTS INFO REQUIRED. YOU MAY ALSO USE "M50 IN PLACE OF "15" (MOST APPROPRIATE). WHEN USING "M50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J050

PROGRAM: SB1130
ERROR CODE: 482

CLAIM TYPE: N/A

DATE UPDATED: 6/11/04

EDIT NAME: MANUAL PRICE ZERO OR OVER BILL

EDIT DESCRIPTION: NO ENTRY LISTED ON MMIS

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 483

CLAIM TYPE: ALL

DATE UPDATED: 6/11/04

EDIT NAME: PROV NOT AUTH ISLA RECIP

EDIT DESCRIPTION:
IF TEC ELIGIBLE
AND REGULAR CLAIM
OR
IF INSTITUTIONAL CLAIM OR UB82 INPATIENT CLAIM
OR
IF CLMT-DSCH-DEST IS NOT EQUAL TO '2'

OR
IF L-ELIG-INDEX IS GREATER THAN +0
IF STOPPING DATE IS EQUAL TO 0
OR
IF CLMT-SPL-PRCS-FLG (6) IS EQUAL TO 'I'

AND
IF CLAIM REGION EQUAL TO '90' OR
(PROVIDER NUMBER NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999')
AND
IF (PROVIDER NUMBER NOT EQUAL TO '000035432' AND NOT EQUAL TO '000035434'
AND NOT EQUAL TO '000035201')

AND
IF IT IS A VALID RECORD ON THE SB644010 FILE > 0

AND
IF (SUB9 NOT EQUAL TO 0)
IF SERVICE CODE IS EQUAL TO '4' AND
DDR-SERV-PROV-29 (SUB9) NOT EQUAL TO WK-PROV-C
MOVE ERR-CLM-483 TO ERR-CODE
OR
IF SERVICE CODE IS EQUAL TO '5' AND
DDR-SERV-PROV-30 (SUB9) NOT EQUAL TO WK-PROV-C
MOVE ERR-CLM-483 TO ERR-CODE
OR
IF SERVICE CODE IS EQUAL TO '8' AND
DDR-SERV-PROV-33 (SUB9) NOT EQUAL TO WK-PROV-C
MOVE ERR-CLM-483 TO ERR-CODE
OR
IF SERVICE CODE IS EQUAL TO '9' AND
DDR-SERV-PROV-34 (SUB9) NOT EQUAL TO WK-PROV-C
MOVE ERR-CLM-483 TO ERR-CODE

METHOD OF CORRECTION:
REFER TO DEVELOPMENTAL DISABILITY UNIT FOR INFORMATION. ADJUDICATE PER THEIR DECISION.

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 484

CLAIM TYPE:
A) Professional claims
B) Professional claims
C) Professional claims

DATE UPDATED: 06/11/04

EDIT NAME: PROV ON REVIEW (FRAUD & ABUSE)

EDIT DESCRIPTION:
A) Current claim’s provider has NOT been flagged as admin suspect AND it has NOT been flagged as utilization suspect AND it has been flagged as fraud abuse suspect

B) Current claim’s detail-level provider review end date is NOT EQUAL TO zero

AND

its first procedure service date is NOT LESS THAN the provider’s review beginning date AND its first procedure service date is NOT GREATER THAN the provider’s review ending date

AND

its provider has NOT been flagged as admin suspect AND it has NOT been flagged as utilization suspect AND it has been flagged as fraud abuse suspect

C) Current claim’s first procedure service date is NOT LESS THAN the provider’s review beginning date AND its first procedure service date is NOT GREATER THAN the provider’s review ending date

METHOD OF CORRECTION:
VERIFY THAT THE PROVIDER NUMBER WAS TRANSCRIBED CORRECTLY. REFER TO SURS UNIT FOR THEIR DECISION.

JOB: PROGRAM:
A) SB1J050 SB1130
B) SB1J040 SB1090
C) online CICS SB710022

Top
ERROR CODE: 485

CLAIM TYPE:
Payable claims

DATE UPDATED:
06/11/04

EDIT NAME:
PROCEDURE ON REVIEW

EDIT DESCRIPTION:
Current claim has a level3 review procedure code AND its level3 review date is LESS THAN the last date of service

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M51" YOU MUST ENTER CLAIM ADJUSTMENT REASON "16" IN FIELD 6.

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 486

CLAIM TYPE:
Professional claims

DATE UPDATED:
06/11/04

EDIT NAME:
DIAGNOSIS ON REVIEW

EDIT DESCRIPTION:
Current claim has a diagnosis code that has been flagged for review

METHOD OF CORRECTION:
IF ON REVIEW OF FAMILY PLANNING, REFER TO SUSPENSE EXAMINER PROCESSING THIS TYPE OF CLAIM. OTHERWISE, REFER TO SUPERVISOR.

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 487

CLAIM TYPE:
A) ALL EXCEPT NURSING HOME
B) ALL

DATE UPDATED: 6/11/04

EDIT NAME: SUSPECT CSHS/ADAP/WC CLAIM

EDIT DESCRIPTION:
A) IF THE ACCIDENT TYPE IS EQUAL TO 'C' OR SPACES
AND
IF NOT A NURSING HOME CLAIM AND IS QMB ELIGIBLE
IF REVIEW STARTING DATE IS GREATER THAN THE 1ST DAY OF SERVICE
OR IF THE NURSING HOME INDEX IS AT THE MAX OF (3)
AND
IF VALID RECORD ON SB644010
OR
IF ((TECS OR QMB ELIGIBLE)
OR (IF FROM DATE OF SERVICE IS GREATER THAN STARTING DATE
OR IF TO DATE OF SERVICE IS GREATER THAN STOPPING DATE
OR IF NOT TECS ELIGIBLE))
OR IF (NOT TECS OR QMB ELIGIBLE)
OR (IF FROM DATE OF SERVICE IS LESS THAN STARTING DATE
OR IF TO DATE OF SERVICE IS LESS THAN STOPPING DATE
AND NOT (INSTITUTIONAL CLAIM OR
UB82 INST CLAIM OR (CROSSOVER CLAIM AND
(XOVR INPATIENT OR XOVR OUTPATIENT))))
AND
IF PROVIDER NUMBER NOT GREATER THAN '000035000' AND NOT LESS THAN '000037999'
AND
IF AID CATEGORY IS EQUAL TO '8' OR '12'
OR CLAIM REGION IS EQUAL TO 30

B) IF CLAIM REGION IS EQUAL TO 30 OR 96 OR 97

METHOD OF CORRECTION:
REGION 30 FOR CSHS, REGION 97 FOR WC, REGION 96 FOR ADAP

JOB:                        PROGRAM:
A) SB1J040                  A) SB1090
B) N/A                      B) SB710022

Top
ERROR CODE:          488

CLAIM TYPE:
A) ?

B) Drug claims

DATE UPDATED:
06/11/04

EDIT NAME:
DOS BEFORE BIRTH DATE

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)

B) Current claim’s recipient birth date is GREATER THAN the date dispensed

METHOD OF CORRECTION:
VERIFY THAT THE DATE OF SERVICE WAS TRANSCRIBED CORRECTLY. IF NOT, CORRECT FIELD. IF SO, CHECK THE
RECIPIENT FILE TO VERIFY RECIPIENTS BIRTH DATE. IF THE FAILURE IS CORRECT, DENY THE CLAIM WITH EOB 002.
IF EDIT WAS FLAGGED IN ERROR (RECIP BORN IN PREVIOUS CENTURY) OVERRIDE EDIT WITH EOB 078. IF A
MEDICALLY NEEDY CASE (919) AND MOTHER IS OVER 21, MATERNITY CHARGE MUST BE BILLED ON BABY’S CARD.
IN THIS CASE, IT IS POSSIBLE HOSPITAL SERVICES ARE PROVIDED BEFORE DATE OF BABY’S BIRTH AND EDIT CAN
BE OVERRIDEN.

JOB:                                                PROGRAM:
A) SB1J040                        SB1090

B) online CICS                        SB710022

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ERROR CODE: 489

CLAIM TYPE:
Payable claims

DATE UPDATED:
06/11/04

EDIT NAME:
CHILD ABUSE INDICATED

EDIT DESCRIPTION:
Current claim has been previously flagged for child abuse

METHOD OF CORRECTION:
VERIFY ALL INFO ENTERED CORRECTLY INTO SYSTEM. IF CHILD ABUSE IS INDICATED, MAKE A COPY OF CLAIM AND REFER TO THE ADMINISTRATOR OF CHILD ABUSE AND NEGLECT PROGRAM IN THE OFFICE OF HUMAN SERVICES.

JOB: SB1J040
PROGRAM: SB1090

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ERROR CODE: 490

CLAIM TYPE:
A) ?
B) Drug claims

DATE UPDATED:
06/11/04

EDIT NAME:
DATE OF SERVICE IS > 366 DAYS

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)
B) Current claim’s detail-level date dispensed is GREATER THAN its date prescribed

METHOD OF CORRECTION:
VERIFY THAT BOTH DATE DISPENSED AND DATE PRESCRIBED WERE TRANSCRIPTED CORRECTLY. IF DATE DISPENSED IS MORE THAN ONE YEAR LATER THAN THE PRESCRIPTION DATE (AS LISTED ON ORIGINAL CLAIM), DENY THE CLAIM
WHEN USING REMARK CODE "N57" YOU MUST ENTER ADJUSTMENT REASON "B5" IN FLD 6

JOB: PROGRAM:
A) SB1J020     SB1070
B) online CICS  SB710022

Top
ERROR CODE: 491

CLAIM TYPE: ALL EXCEPT NURSING HOME

DATE UPDATED: 6/11/04

EDIT NAME: MANUAL RECIP AID CATEGORY ON REVIEW

EDIT DESCRIPTION:
IF THE ACCIDENT TYPE IS EQUAL TO 'C' OR SPACES
AND
IF NOT A NURSING HOME CLAIM AND IS QMB ELIGIBLE

IF REVIEW STARTING DATE IS GREATER THAN THE 1ST DAY OF SERVICE
OR IF THE NURSING HOME INDEX IS AT THE MAX OF (3)
AND
IF VALID RECORD ON SB640010
OR
IF ((TECS OR QMB ELIGIBLE)
OR (IF FROM DATE OF SERVICE IS GREATER THAN STARTING DATE
OR IF TO DATE OF SERVICE IS GREATER THAN STOPPING DATE
OR IF NOT TECS ELIGIBLE))
OR IF (NOT TECS OR QMB ELIGIBLE)
OR (IF FROM DATE OF SERVICE IS LESS THAN STARTING DATE
OR IF TO DATE OF SERVICE IS LESS THAN STOPPING DATE
AND NOT (INSTITUTIONAL CLAIM OR
UB82 INST CLAIM OR (CROSSOVER CLAIM AND
(XOVR INPATIENT OR XOVR OUTPATIENT))))
AND
IF THE FIRST POSITION OF THE AID CATEGORY IS EQUAL TO A '-'

METHOD OF CORRECTION:
AS NOTED IN INSTRUCTIONS FOR EACH CATEGORY WHICH REQUIRE SUSPENSION.
A LISTING OF ALL RECIPIENT AID CATEGORIES WHICH ARE ON REVIEW SHOULD BE AVAILABLE TO EACH
EXAMINER. INSTRUCTIONS FOR RESOLVING EACH AID CATEGORY ON REVIEW SHOULD BE INCLUDED ON THIS
LISTING.

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE:  492

CLAIM TYPE:  ALL EXCEPT NURSING HOME

DATE UPDATED:  6/11/04

EDIT NAME:  PROV TYPE/SPECIALTY ON REVIEW

EDIT DESCRIPTION:
IF PVS-STATUS IS EQUAL TO '00'
AND
IF THE FIRST TWO POSITIONS OF THE PROVIDER SPECIALTY CODE IS EQUAL TO '--'
OR THE FIRST TWO POSITIONS OF THE PROVIDER TYPE CODE IS EQUAL TO '--'

METHOD OF CORRECTION:
ON MEDICAL CLAIMS IF PROVIDER USES PSYCHIATRY CODES AND SPECIALTY IS
NOT SPECIALTY '26', DENY
REFER ALL OTHER CLAIMS TO SUPERVISOR.
YOU MAY ALSO USE "B17" IN PLACE OF "B60" (MOST APPROPRIATE)

JOB:                                                PROGRAM:
SB1J050                                                SB1130

Top
ERROR CODE:  493

CLAIM TYPE:  ALL EXCEPT NURSING HOME

DATE UPDATED:  6/11/04

EDIT NAME:  ADMISSION AND DISCHARGE DATE =

EDIT DESCRIPTION:
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF CLAIM REGION NOT EQUAL TO '20 OR '21'
OR NOT OUTPATIENT CLAIM
OR NOT UB82 OUTPATIENT CLAIM OR NOT UB82 HOME HEALTH
OR (PROVIDER NUMBER NOT GREATER THAN '000035000' AND NOT LESS THAN '000037999')
OR NOT NURSE HOME CLAIM
OR
IF UB82 INPATIENT CLAIM
OR
IF INPATIENT CLAIM
AND CALC-DAYS = +0 AND CLMT-TOT-DY-BILL = +1
   IF (PROVIDER NUMBER NOT = '000001058' AND NOT =
       '000001061' AND NOT = '000001063' AND NOT =
       '000001068' AND NOT = '000002331' AND NOT =
       '000002333' AND NOT = '000002334' AND NOT =
       '000002335' AND NOT = '000002372' AND NOT =
       '000001307' AND NOT = '000001323' AND NOT =
       '000001312' AND NOT =
       '000001324' AND NOT = '000001325' AND NOT =
       '000001326' AND NOT = '000001327' AND NOT =
       '000001328' AND NOT = '000001329' AND NOT =
       '000001330' AND NOT = '000001331' AND NOT =
       '000001332' AND NOT = '000002400')
   AND NOT (UB82 INPATIENT CLAIM
   AND (DRUG CODE GREATER THAN 0))
   MOVE E493 TO ERR-CD
OR
IF CALC-DAYS-TOO LESS THAN UB82 TOT DAYS BILLED
OR
IF UB82 INPATIENT CLAIM
AND CALC-DAYS-TOO EQUAL TO +0 AND UB82 TOTAL DAYS BILLED EQUAL TO +1
   IF (PROVIDER NUMBER NOT = '000001058' AND NOT =
       '000001061' AND NOT = '000001063' AND NOT =
       '000001068' AND NOT = '000002331' AND NOT =
       '000002333' AND NOT = '000002334' AND NOT =
       '000002335' AND NOT = '000002372' AND NOT =
       '000001307' AND NOT = '000001323' AND NOT =
       '000001312' AND NOT =
       '000001324' AND NOT = '000001325' AND NOT =
       '000001326' AND NOT = '000001327' AND NOT =
       '000001328' AND NOT = '000001329' AND NOT =
       '000001330' AND NOT = '000001331' AND NOT =
       '000001332' AND NOT = '000002400')
   AND NOT (UB82 INPATIENT CLAIM
   AND (DRUG CODE GREATER THAN 0))
   MOVE E493 TO ERR-CD
AND (DRUG CODE GREATER THAN 0))

METHOD OF CORRECTION:
VERIFY THAT DATES HAVE BEEN ENTERED CORRECTLY. IF ALL DATA CORRECT, FORCE PAY AT HEADER LEVEL. YOU MAY ALSO USE "N50" IN PLACE OF "MA40" (MOST APPROPRIATE) WHEN USING REMARK CODE "MA40" OR "N50" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: SB1J020
PROGRAM: SB1070

Top
ERROR CODE: 494

CLAIM TYPE:
A) ?
B) Drug claims

DATE UPDATED:
06/11/04

EDIT NAME:
NONLEGEND DRUG FOR N.H. RESID

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)

B) Drug control code on file is EQUAL TO '8' AND the point of sale drug control code is NOT EQUAL TO '00999' AND its point of sale living arrangement code is EQUAL TO '5' or '9'

AND

its point of sale detail-level recipient aid code is NOT EQUAL TO '007 ' AND the point of sale provider zip code is NOT in the range of '55001 ' through '56999 ' 

METHOD OF CORRECTION:
DETERMINE IF NURSING HOME INDICATOR (HARD COPY CLAIMS) OR NDC PROCEDURE NUMBER HAS BEEN KEYED IN ERROR. IF SO, CORRECT AND PROCESS CLAIM. OTHERWISE, CHECK LIST OF RECIPIENTS IN SNF, ICF OR ICF/MR OR REPORT 0724 BB- LIVING ARRANGEMENT 5,6, OR 9. IF NAME APPEARS ON LIST, DENY WITH EOB 006. IF NAME IS NOT ON LIST, GO TO SCREEN 'C' AND NOT LIVING ARRANGEMENT NOW ON FILE. MAKE A COPY OF THIS INFO AND SEND TO ECONOMIC ASST FOR FILE UPDATE.

JOB: PROGRAM:
A) SB1J050 SB1130
B) online CICS SB710023
ERROR CODE: 495

CLAIM TYPE:
A) ?

B) Payable claims

DATE UPDATED:
06/11/04

EDIT NAME:
LEAVE DAYS NOT PRICEABLE

EDIT DESCRIPTION:
A) (note: this error code exists but is not currently implemented in claim processing)

B) Current region 20 claim has a first service code EQUAL TO ‘Q’ or ‘R’ with a valid first date of service. The second service code is EQUAL TO ‘1’ or ‘2’ AND the last date of service is equal to the previous detail line first date of service.

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: PROGRAM:
A) SB1J050 SB1130

B) SB1J075, SB1J079 SB1250

Top
ERROR CODE: 496

CLAIM TYPE:
A) Institutional claims
B) ?

DATE UPDATED:
06/11/04

EDIT NAME:
MORE THAN 18 DAYS OF HOME LEAVE

EDIT DESCRIPTION:
A) Current claim is of home leave origin

AND

its detail-level units of service minus a day for the discharge date is GREATER THAN the home leave maximum of 18 days.

B) (note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. VERIFY EDIT WITH PRINTED RECIPIENT HISTORY ON THE WORKSHEET. IF RECIPIENT HAS MORE THAN 18 DAYS HOME LEAVE, CUT-BACK CLAIM AS APPROPRIATE.
WHEN USING REMARK CODE "N43" YOU MUST ENTER CLAIM ADJUSTMENT CODE "42" IN FIELD 6.

JOB: PROGRAM:
A) SB1J050          SB1130
B) SB1J075, SB1J079  SB1250

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ERROR CODE: 497

CLAIM TYPE:
A) Payable claims
B) Drug claims

DATE UPDATED:
06/11/04

EDIT NAME:
CLAIM NOT SUBMITTED IN 1 YEAR

EDIT DESCRIPTION:
A) Current claim’s batch number is NOT in the range of 739 through 768
   OR
   its provider number is NOT in the range of ‘000032314’ through ‘000032321’, ‘000033056’ through ‘000033059’, or NOT
   EQUAL TO ‘000035434’, ‘000035432’ or ‘000035301’
   AND
   its calculated days difference is GREATER THAN 366 AND it’s NOT a take-over claim or HMO encounter claim
B) Current claim’s first date dispensed is GREATER THAN OR EQUAL TO 1 year from the present

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB: PROGRAM:
A) SB1J020 SB1070
B) online CICS SB710022

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ERROR CODE: 498

CLAIM TYPE: Payable claims

DATE UPDATED: 06/11/04

EDIT NAME: PROC FILE INDICATES FP NEEDED

EDIT DESCRIPTION: Current claim is on file as having a family planning indicator EQUAL TO ‘Y’

AND

its detail-level family planning indicator is NOT EQUAL TO ‘Y’

METHOD OF CORRECTION:
VERIFY THAT PROCEDURE IS ACTUALLY A FAMILY PLANNING PROCEDURE. IF 'YES', CHECK THE CLAIM FORM AND ENTER THE APPROPRIATE CHARACTER TO INDICATE FAMILY PLANNING. THE APPROPRIATE CHARACTER IS A 'Y' IN BLOCK 53.

JOB: SB1J050 PROGRAM: SB1130
ERROR CODE:         499

CLAIM TYPE:         Payable claims

DATE UPDATED:       06/11/04

EDIT NAME:          HCBC BILLED W/RL, NO SCREENING

EDIT DESCRIPTION:  Current claim’s recipient living arrangement is NOT EQUAL TO ‘1’
                   AND
                   its client MA status on file is EQUAL TO ‘AU’ OR its client AFDC status is EQUAL TO ‘UN’
                   OR
                   its client TEEM status is EQUAL TO ‘UN’ AND the benefit month on file is LESS THAN the claims current benefit month

METHOD OF CORRECTION: REFER TO DEVELOPMENTAL DISABILITY UNIT FOR INFORMATION. ADJUDICATE PER THEIR DECISION.

JOB:                PROGRAM:
SB1J040             SB1090
FIELD NUMBER:                                                                                      ERROR CODE:         500
FLAG:                                                                                                        FIELD LENGTH:
OVERRIDE:                                                                                                     CLEAR MECHANISM:
DATA CORRECTABLE:

CLAIM TYPE:
A) UB82 Inpatient claims.
B) All NON-Denied claims.

DATE UPDATED:
02-19-04

EDIT NAME:
OUT OF STATE PROV - MAN. PRICE

EDIT DESCRIPTION:
A) Current claim has a DRG code that is NOT ‘469’ and NOT ‘470’
AND
Current claim’s provider location code is NOT ‘1’, indicating an out of state provider. Manually price this claim.

B) Current claim’s net claim charge is NOT EQUAL to the total submitted charges at the detail level.

METHOD OF CORRECTION:
(no entry in MMIS menu option ‘W’)

JOB:                     PROGRAM:
A) SB1J050              SB1130
B) SB1J665              SB1520

Top
ERROR CODE:  501

CLAIM TYPE:
A)  Payable claims.
B)  Drug claims.

DATE UPDATED:
02-25-04

EDIT NAME:
EXACT DUPLICATE CLAIM

EDIT DESCRIPTION:
A1)  Current claim has a pricing indicator NOT EQUAL to ‘8’.

AND

Current claim is NOT of region ‘40’ OR it is an adjustment claim.

A2)  Current claim is a Drug claim NOT of region ‘40’ OR it is an adjustment claim OR its reimbursement amount is zero OR the quantity dispensed is the same for both detail lines OR its submitted charge is the same for both detail lines OR the transaction type is ‘4’ OR the dates of service are the same for both detail lines.

A3)  Current dates of service, submitted charges and revenue codes are the same for both detail lines

AND

Current claim is a UB82 Inpatient claim OR current claim is a UB82 Home Health claim OR current claim is a UB82 Outpatient claim with detail lines having the same CPT4 code.

A4)  Current dates of service and service codes are the same for both detail lines.

B1)  Claims have the same drug code, prescription reference number and quantity dispensed amount.

B2)  Claims have the same date dispensed, drug code, quantity dispensed, provider number and prescription number.

METHOD OF CORRECTION:
(no entry in MMIS menu option ‘W’)

JOB:                                                  PROGRAM:
A)  SB1J075, SB1J079                                  SB1250
B)  MMIS POS SYSTEM                                   SB710024

Top
ERROR CODE: 502

CLAIM TYPE:
Drug claims.

DATE UPDATED:
02-25-04

EDIT NAME:
DRG REQUIRES MANUAL PRICING

EDIT DESCRIPTION:
Current claim has a DRG code of ‘469’ or ‘470’.

METHOD OF CORRECTION:
(no entry in MMIS menu option ‘W’)

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 503

CLAIM TYPE:
A) Payable claims.
B) Drug claims.

DATE UPDATED:
02-25-04

EDIT NAME:
SUSPECT DUPLICATE CLAIM

EDIT DESCRIPTION:
A1) Claims have overlapping dates of service.
A2) Beginning and ending dates of service are equal, submitted charges are equal and revenue codes are equal.

AND

Claim is a UB82 Inpatient claim OR claim is a UB82 Outpatient claim with equal CPT4 codes OR claim is a UB82 Home Health claim.

A3) Claims have overlapping dates of service

AND

Claims are UB82 Inpatient claims with equal revenue codes.

OR

Claims are UB82 Outpatient claims with equal revenue codes and equal CPT4 codes.

OR

Claims are non-UB82 Inpatient/Outpatient claims with equal revenue codes.

B) Claims have equal, covered, drug codes.

METHOD OF CORRECTION:
(no entry in MMIS menu option ‘W’)

JOB: PROGRAM:
A) SB1J075, SB1J079 SB1250
B) MMIS POS SYSTEM SB710024
ERROR CODE: 504

CLAIM TYPE: MEDICAL, OCCUPATIONAL THERAPY.

DATE UPDATED: 02-26-04

EDIT NAME: MORE THAN ONE SERVICE PER DAY

EDIT DESCRIPTION: EDIT WILL FAIL IF PROVIDER ENTERS MORE THAN '1' IN UNIT COLUMN FOR PROCEDURE CODES 01500 THROUGH 01505.

METHOD OF CORRECTION:

CHECK BILLING AND DESCRIPTION. PROVIDER MAY HAVE BILLED INCORRECTLY. IF PROVIDER BILLS MORE THAN ONCE FOR 01505 ON SEPARATE LINES, ENTER MODIFIER '50' FOR THE SECOND CHARGE. IF PROVIDER BILLS MORE THAN TWICE ON SEPARATE LINES, REFER TO MEDICAL CONSULTANT. WHEN USING REMARK CODE "M53" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6.

JOB: MMIS POS SYSTEM
PROGRAM: SBPOS039

Top
ERROR CODE: 505

CLAIM TYPE:
MEDICAL, CHIROPRACTIC.

DATE UPDATED:
02-26-04

EDIT NAME:
MORE THAN ONE SERVICE PER DAY

EDIT DESCRIPTION:
EDIT WILL FAIL IF PROVIDER BILLS 01600 MORE THAN ONE TIME PER DAY.

METHOD OF CORRECTION:
CHECK FOR CORRECT TRANSCRIPTION. CHANGE IF NECESSARY. IF SERVICE BILLED MORE THAN ONE TIME IN A DAY, DENY THE DUPLICATED BILLING WITH EOB 256. IF PROVIDER CLARIFIES A MEDICAL NECESSITY, REFER TO MEDICAL CONSULTANT FOR HIS/HER DECISION. ADJUDICATE CLAIM AS ADVISED. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6.

JOB: MMIS POS SYSTEM
PROGRAM: SBPOS039

Top
ERROR CODE: 506

CLAIM TYPE: MEDICAL, H. S. CENTERS.

DATE UPDATED: 02-26-04

EDIT NAME: LIMIT OF 32 UNITS PER DAY

EDIT DESCRIPTION: EDIT WILL FAIL IF HUMAN SERVICES CENTERS BILL FOR MORE THAN 32 UNITS PER DAY FOR PARTIAL CARE, 15 MIN. INTERVALS (02723).

METHOD OF CORRECTION:
CHECK BILLING AND CRT FOR CORRECT TRANSCRIPTION AND CHANGE IF INDICATED. OTHERWISE, DENY ANY AMOUNT IN EXCESS OF 32 UNITS

JOB: MMIS POS SYSTEM
PROGRAM: SBPOS039
ERROR CODE: 507

CLAIM TYPE:
MEDICAL, H. S. CENTERS.
CODE 02777

DATE UPDATED:
02-26-04

EDIT NAME:
MORE THAN 2 UNITS PER DAY

EDIT DESCRIPTION:
EDIT WILL FAIL IF HUMAN SERVICE CENTERS BILL MORE THAN 2 UNITS FOR DAILY ACTIVITY.

METHOD OF CORRECTION:
VERIFY CORRECT TRANSCRIPTION. OTHERWISE DENY ALL UNITS IN EXCESS OF ‘2’ PER DAY.

JOB: MMIS POS SYSTEM
PROGRAM: SBPOS039
ERROR CODE: 508

CLAIM TYPE:
Medical claims.

DATE UPDATED:
02-26-04

EDIT NAME:
HCBC/SPED EXCEEDS LIMIT

EDIT DESCRIPTION:
A) Current claim is of region ‘94’ AND NEWER THAN June of 1987

AND

Current claim has valid procedure codes

AND

Current claim has a legal county code of ‘056’ or ‘055’

AND

Current claim’s last procedure service date is OLDER THAN February 1, 1992 AND the allowed claim charge is GREATER THAN OR EQUAL what is allowed by medical for that period.

METHOD OF CORRECTION:

YOU MAY ALSO USE "119" IN PLACE OF "35" (MOST APPROPRIATE)

    JOB:                PROGRAM:

A)    SB1J075, SB1J079   SB1250
B)    MMIS POS SYSTEM    SBPOS039

Top
ERROR CODE: 509

CLAIM TYPE:
A) Payable claims.
B) Medical claims.

DATE UPDATED:
02-26-04

EDIT NAME:
NO INS PMT AND ANY TPL ON FILE

EDIT DESCRIPTION:
A) Current claim has ONE OR MORE policies on file AND total other insurance is ZERO.

B) Current claim has ONE OR MORE policies on file AND total other insurance is ZERO.

AND

Current claim is NOT Medicare OR Claim has a living arrangement NOT EQUAL to ‘5’ OR the claim’s policy count is NOT EQUAL to ‘1’.

METHOD OF CORRECTION:
REVIEW INSURANCE AMT IN REFERENCE TO CLAIM. REVIEW EOB FROM INSURANCE FOR VERIFICATION. IF NO EOB, CONSIDER SERVICES BILLED, TYPE OF SERVICES, TYPE OF INSURANCE, AND BALANCE DUE. IF INSURANCE AMOUNT APPEARS INADEQUATE, REVIEW WITH SUPERVISOR BEFORE RETURNING TO PROVIDER FOR COPY OF INSURANCE EXPLANATION BENEFITS. IF INSURANCE AMOUNT APPEARS ADEQUATE, OVERRIDE EDIT.

JOB:
A) SB1J040
B) MMIS POS SYSTEM

PROGRAM:
A) SB1090
B) SB710023
ERROR CODE: 510

CLAIM TYPE:
A) Pharmacy claims.
B) Pharmacy claims.

DATE UPDATED: 02-26-04

EDIT NAME: RECIPIENT ON LOCK-IN

EDIT DESCRIPTION:
A1) Current claim is NOT a Developmental Disability, HCBC Elderly Disabled, LTC, Dept. of Instruction, Basic Care, Crossover, Nursing Home or UB82 Inpatient claim type.

AND

Current claim is NOT a UB82 claim currently on review.

AND

Current claim has does NOT have a provider specialty code of ‘49’ or ‘81’.

AND

Current claim 1st date of service is LESS THAN the claim’s review date.

AND

Current claim last date of service is GREATER THAN OR EQUAL to the claim’s review date.

A2) Current claim is NOT a Developmental Disability, HCBC Elderly Disabled, LTC, Dept. of Instruction, Basic Care, Crossover, Nursing Home or UB82 Inpatient claim type.

AND

Current claim is NOT a UB82 claim currently on review.

AND

Current claim has does NOT have a provider specialty code of ‘49’ or ‘81’.

AND

Current claim 1st date of service is GREATER THAN OR EQUAL to the claim’s review date.

AND

Current claim’s review stop date EQUALS ZERO or the current claim’s 1st date of service is LESS THAN OR EQUAL to the claim’s review date.
A3) Current claim is NOT a Developmental Disability, HCBC Elderly Disabled, LTC, Dept. of Instruction, Basic Care, Crossover, Nursing Home or UB82 Inpatient claim type.

   AND

   Current claim is currently on review.

   AND

   Current claim’s 1st date of service is LESS THAN the claim’s review date and claim’s last date of service is GREATER THAN OR EQUAL to the claim’s review date.

A4) Current claim is NOT a Developmental Disability, HCBC Elderly Disabled, LTC, Dept. of Instruction, Basic Care, Crossover, Nursing Home or UB82 Inpatient claim type.

   AND

   Current claim is currently on review.

   AND

   Current claim’s 1st date of service is GREATER THAN OR EQUAL to the claim’s review date and claim’s review stop date is EQUAL to ZERO.

A5) Current claim is NOT a Developmental Disability, HCBC Elderly Disabled, LTC, Dept. of Instruction, Basic Care, Crossover, Nursing Home or UB82 Inpatient claim type.

   AND

   Current claim is currently on review.

   AND

   Current claim’s 1st date of service is GREATER THAN OR EQUAL to the claim’s review date and the claim’s 1st date of service is LESS THAN OR EQUAL to the claim’s review stop date.

B1) Current claim has a dispensed date GREATER THAN OR EQUAL the provider’s primary start date and LESS THAN OR EQUAL to the provider’s primary end date.

   OR

   Current claim has a dispensed date GREATER THAN OR EQUAL the provider’s primary start date, the provider’s primary end date is EQUAL to ZERO and the provider’s primary start date is NOT EQUAL to ZERO.

   AND

   The primary provider number is in the range of ‘000020000’ through ‘000029999’

B2) Current claim has a dispensed date GREATER THAN OR EQUAL the provider’s primary start date and LESS THAN OR EQUAL to the provider’s primary end date.

   OR

   Current claim has a dispensed date GREATER THAN OR EQUAL the provider’s primary start date, the provider’s primary end date is EQUAL to ZERO and the provider’s primary start date is NOT EQUAL to ZERO.

   AND
The primary provider number is in the range of ‘000040000’ through ‘000049999’

METHOD OF CORRECTION:

GIVE WORKSHEET WITH AUTHORIZATION TO SURS UNIT WITH YOUR NAME ON THE WORKSHEET. INDICATE ON THE FRONT OF PACKET TO WHOM THE CLAIM IS GIVEN. SURS WILL REVIEW AND RETURN CLAIM TO YOU WITH A DETERMINATION AS TO FORCE PAY OR TO DENY. WHEN USING REMARK CODE "N35" YOU MUST ENTER CLAIM ADJUSTMENT REASON "38" IN FIELD 6.

JOB:                                               PROGRAM:
A) SB1J040                                      SB1090
B) MMIS POS SYSTEM                               SB710022

Top
ERROR CODE: 511

CLAIM TYPE:
B) All claim types

DATE UPDATED:
03-17-04

EDIT NAME:
DUPLICATE CLM/R.L. PREV APPLD

EDIT DESCRIPTION:
A duplicate claim was encountered; R/L was previously applied.

METHOD OF CORRECTION:
(no correction method given)

JOB: PROGRAM:
A) SB1J075, SB1J079          SB1250
B) MMIS POS SYSTEM          SB710024

Top
ERROR CODE:  512

CLAIM TYPE:
UB82 Home Health claims

DATE UPDATED:
03-18-04

EDIT NAME:
ONLY 1 SERVICE PAYABLE PER DAY

EDIT DESCRIPTION:
claim has a bill type of ‘711’

AND

the detail revenue code is ‘529’ OR ‘951’

AND

The claim’s 1st procedure service date is NOT EQUAL to its last procedure service date OR the number of units is NOT EQUAL to 1

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF CORRECT, RTP FOR CORRECTION OF BILLING. PROVIDER CANNOT BILL CONSECUTIVE DAYS FOR THIS PROCEDURE. THEREFORE THEY MUST BILL AND INDIVIDUAL CHARGE FOR EACH DATE OF SERVICE.

WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6

JOB:                                                PROGRAM:
SB1J020                        SB1070

Top
ERROR CODE:  513

CLAIM TYPE:
All claim types

DATE UPDATED:
03-22-04

EDIT NAME:
LIMIT 32 UNITS/DAY FOR HCBS

EDIT DESCRIPTION:
PROV BILLS MORE THAN 1 SVCE PER DAY FOR CERTAIN HOME AND COMM BASED CARE SVCE (LIST 0016)

METHOD OF CORRECTION:
VERIFY CORRECT TRANSCRIPTION. OTHERWISE DENY ALL UNITS IN EXCESS OF ONE PER DAY.

JOB: MMIS POS system
PROGRAM: SBPOS039

(note: this error code exists, but is not currently applied in claim processing)

Top
ERROR CODE: 514

CLAIM TYPE: All claim types

DATE UPDATED: 03-22-04

EDIT NAME: CASE MANAGE SERV/LIMIT 1/MONTH

EDIT DESCRIPTION: PROV BILLS MORE THAN 1 UNIT FOR PROCED CODES 00015 THRU 00017

METHOD OF CORRECTION: VERIFY TRANSCRIPTION AND CORRECT IF NECESSARY. OTHERWISE, DENY ANY UNITS IN EXCESS OF ONE PER MONTH.

JOB: MMIS POS system
PROGRAM: SBPOS039

(note: this error code exists, but is not currently applied in claim processing)
ERROR CODE: 515

CLAIM TYPE:
All claim types

DATE UPDATED:
03-22-04

EDIT NAME:
FOSTER CARE LIMIT 1 PER DAY

EDIT DESCRIPTION:
COUNTY BILLS MORE THAN ONE FOSTER CARE SERVICE 00024 THRU 00027 PER DAY

METHOD OF CORRECTION:

VERIFY TRANSCRIPTION. DENY UNITS IN EXCESS OF ONE PER DAY. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6

JOB: MMIS POS system
PROGRAM: SBPOS039

(note: this error code exists, but is not currently applied in claim processing)
ERROR CODE:  516

CLAIM TYPE:
All claim types

DATE UPDATED:
03-22-04

EDIT NAME:
LIMIT OF 1 INJECTION PER DAY

EDIT DESCRIPTION:
HUMAN SERVICE CENTER BILL MORE THAN ONE PROC CODE 02726 PER DAY

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. OTHERWISE, DENY ALL UNITS BILLED IN EXCESS OF ONE. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6.

JOB:                                        PROGRAM:
MMIS POS system                          SBPOS039

(note: this error code exists, but is not currently applied in claim processing)
ERROR CODE:  517

CLAIM TYPE:
All claim types

DATE UPDATED:
03-22-04

EDIT NAME:
LIMIT OF 1 INIT EXTRACTION/DAY

EDIT DESCRIPTION:
PROV BILLS MORE THAN ONE INITIAL EXTRACTION PROCEDURE CODE 07110 IN SAME DAY

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. IF THIS CHARGE IS BILLED UP TO 4 TIMES PER DAY - CHANGE PROCEDURE CODES OF THE ENTRIES TO 07120 FOR THE ADDITIONAL EXTRACTIONS. IF PROV BILLS INITIAL EXTRACTION MORE THAN 4 TIMES A DAY, RTP AND ADVISE ON CORRECT CODING FOR THE ADDITIONAL EXTRACTION.
WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6

JOB: MMIS POS system
PROGRAM: SBPOS039

(note: this error code exists, but is not currently applied in claim processing)
ERROR CODE: 518

CLAIM TYPE:
All Drug claims

DATE UPDATED:
03-22-04

EDIT NAME:
NO REBATE AGREEMENT WITH CMS

EDIT DESCRIPTION:
Current claim’s Drug Control code EQUALS ‘9’

METHOD OF CORRECTION:

DENY CLAIM WITH EOB "B5" WHICH STATES THAT THE MANUFACTURER IS NOT IN REBATE AGREEMENT WITH CMS. FORCE ERROR AT APPROPRIATE AMOUNT. CHANGE CMS DRUG REBATE FILE - SB440010, WITH CORRECT INFO TO ALLOW PAYMENT

JOB: MMIS POS system
PROGRAM: SB710023

Top
ERROR CODE: 519

CLAIM TYPE:
All In-Patient, Out-Patient, UB82 In-Patient, UB82 Out-Patient, UB82 Home-Health, Medical claims

DATE UPDATED:
03-22-04

EDIT NAME:
OUT OF STATE PROVIDER ON REVIEW

EDIT DESCRIPTION:
Current claim’s provider number is NOT in the range of ‘000035000’ through ‘000037999’

AND

Provider location code is ‘97’, ‘98’ or ‘99’ with a 1st Date of Service GREATER THAN 19831219, specialty code that is NOT EQUAL to ‘54’ or ‘69’ and claim is NOT a HCBC Elderly Disabled claim type

METHOD OF CORRECTION:

CHECK CASE NUMBER. IF SUFFIX 70 THRU 79, OVERRIDE EDIT AS THIS SUFFIX INDICATES FOSTER CARE. CHECK DATE, IF SERVICE DATE PRIOR TO 12-21-83, OVERRIDE. IF SERVICE DATE AFTER 12-21-83, CHECK BOX 12 FOR NUMBER OF REFERRING PHYSICIAN. CHECK RECORD KEPT OF RECIPIENT REFERRALS. IF NAME APPEARS IN THE RECORDS, OVERRIDE AUDIT. OTHERWISE, REFER TO SUPERVISOR FOR LETTER TO REFERRING PHYSICIAN. YOU MAY ALSO USE "95" IN PLACE OF "62" (MOST APPROPRIATE)

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 520

CLAIM TYPE:
All claim types

DATE UPDATED:
03-22-04

EDIT NAME:
INVALID DATE OF SERVICE

EDIT DESCRIPTION:
Current claim has an invalid beginning/ending service date

METHOD OF CORRECTION:

COMMENTS: WHEN USING REMARK CODE "MA06" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: SB1J040
PROGRAM: SB1090

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ERROR CODE: 521

CLAIM TYPE: ?

DATE UPDATED: 03-22-04

EDIT NAME: ?

EDIT DESCRIPTION: ?

METHOD OF CORRECTION: ?

JOB: PROGRAM: ?

Top
ERROR CODE: 522

CLAIM TYPE:
All claim types

DATE UPDATED:
03-22-04

EDIT NAME:
PEND 60 DAY FREE MA POSSIBLE

EDIT DESCRIPTION:
PEND 60 DAY FREE MA POSSIBLE

METHOD OF CORRECTION:
(no method given in MMIS system)

JOB: MMIS POS system
PROGRAM: SBPOS039

Top
ERROR CODE: 523

CLAIM TYPE:
All claim types

DATE UPDATED:
11-17-04

EDIT NAME:
BUDGET ON HOLD, REBUDGET

EDIT DESCRIPTION:
BUDGET ON HOLD, REBUDGET

METHOD OF CORRECTION:

IF CLAIM HAS RECIPIENT LIABILITY AND THE BUDGET BILLING AUTHORIZATION INDICATOR IS EQUAL TO AN 'R' OR 'N'.
'R' - MEANING, REPORTED, NEEDS TO BE REVIEWED.
'N' - MEANING, DRG/CROSSOVER REPORTED, NEEDS TO BE REVIEWED.

JOB: SB1J278
     SB1J077
     ONLINE

PROGRAM: SB127A
          SB71038B
          SB710038

Top
ERROR CODE:  524

CLAIM TYPE:
Institutional claims

DATE UPDATED:
03-23-04

EDIT NAME:
MORE THAN 1 OFFICE VISIT/DAY

EDIT DESCRIPTION:
Current claim is a UB82 Home Health claim with a bill type of ‘711’, provider number in the range of ‘000005000’ to ‘000005999’, 1st date of service GREATER THAN 20011231

AND

its revenue code is ‘521’, ‘522’ or ‘951’ with the units of service GREATER THAN 1

METHOD OF CORRECTION:

VERIFY TRANSCRIPTION. CHECK PROVIDER NUMBER IN FIELD 60 AND DETERMINE HIS/HER SPECIALTY. INDICATE THAT INFO ON WORKSHEET AND REFER TO MEDICAL CONSULTANT FOR HIS/HER DECISION.

WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6.

JOB: SB1J050
PROGRAM: SB1130

MMIS POS system SBPOS039

Top
ERROR CODE:         525

CLAIM TYPE:
All claim types

DATE UPDATED:
03-23-04

EDIT NAME:
MORE THAN 1 HOSPITAL CALL/DAY

EDIT DESCRIPTION:
SERVICE BILLED BY MORE THAN ONE PROVIDER FOR CODES 90240 THRU 90292

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. OTHERWISE, CHECK PROVIDER NUMBER IN FIELD 60 AND DETERMINE PRACTITIONER'S SPECIALTY. NOTE ON WORKSHEET AND REFER TO MEDICAL CONSULTANT FOR HIS DECISION. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6.

JOB:                                                PROGRAM:
MMIS POS system                SBPOS039
ERROR CODE: 526

CLAIM TYPE:
All claim types

DATE UPDATED:
03-23-04

EDIT NAME:
MORE THAN 1 ER VISIT PER DAY

EDIT DESCRIPTION:
MORE THAN 1 ER VISIT CHARGED PER DAY BY SAME OR DIFFERENT PHYSICIAN

METHOD OF CORRECTION:

VERIFY TRANSCRIPTION. IF MORE THAN ONE BILLED PER DAY BY SAME PHYSICIAN, CHECK AUTHORIZATION FOR VALID REASON. IF VALID, FORCE PAY. IF BILLING INCLUDES AFTER-HOURS CHARGE, OVERRIDE IF CODE IS 99050, 99052, OR 99054. OTHERWISE, DENY. IF MORE THAN ONE PHYSICIAN, CHECK SPECIALTY, DIAGNOSIS AND CLINIC NUMBER. REFER TO MEDICAL CONSULTANT FOR DECISION.

WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE: 527

CLAIM TYPE:
All claim types

DATE UPDATED:
11-17-04

EDIT NAME:
BUDGET ON HOLD - ADJUSTMENT

EDIT DESCRIPTION:
BUDGET ON HOLD - ADJUSTMENT

METHOD OF CORRECTION:
IF CLAIM HAS RECIPIENT LIABILITY AND THE BUDGET BILLING AUTHORIZATION INDICATOR IS EQUAL TO AN 'A'. 'A' - MEANING AUTHORIZATION PENDING.

JOB: PROGRAM:
SB1J278 SB127A
SB1J077 SB71038B
ONLINE SB710038

Top
ERROR CODE: 528

CLAIM TYPE:
All claim types

DATE UPDATED:
03-23-04

EDIT NAME:
REG 70/95, CLAIM HAS RECIPIENT LIABILITY

EDIT DESCRIPTION:
DPI CLAIM BEING PROCESSED HAS RL

METHOD OF CORRECTION:
CLAIM WILL AUTO RECYCLE FOR 60 DAYS. IF CLAIM DOES NOT CLEAR OUT OF THE PAYMENT SYSTEM BECAUSE THERE IS UNMET RECIPIENT LIABILITY, THE AUDITOR WILL DENY CLAIM

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE: 530

CLAIM TYPE:
Developmental Disability claims (region ‘90’)

DATE UPDATED:
03-23-04

EDIT NAME:
DD CLIENT RESIDING IN ICF/MR

EDIT DESCRIPTION:
Current claim’s 1st procedure service date is NOT LESS THAN the effective from-date on file and is NOT GREATER THAN the effective to-date on file

OR

Current claim’s last procedure service date is NOT LESS THAN the effective from-date on file and is NOT GREATER THAN the effective to-date on file

METHOD OF CORRECTION:
CHECK WITH DEVELOPMENTAL DISABILITY UNIT CONCERNING SERVICE FOR ELIGIBILITY. CHECK MM, DD (ELIG FILES) AND ISP. IF NO LONGER ELIGIBLE FOR SERVICE CODE H, FORCE PAY. CHECK MMIS PAID CASE FILE (SSN) FOR H PAYMENT. IF PAYMENT HAS PROCESSED THROUGH AND/OR ELIGIBLE FOR SERVICE CODE H, DENY WITH EOB T129.

JOB: SB1J040
PROGRAM: SB1090

MMIS POS system SBPOS039
ERROR CODE: 531

CLAIM TYPE: All claim types

DATE UPDATED: 03-23-04

EDIT NAME: CLM PENDING AUTHORIZED STATUS

EDIT DESCRIPTION: Current claim’s total days is LESS THAN OR EQUAL to 60

METHOD OF CORRECTION: CLAIM WILL RECYCLE THROUGH SYSTEM.

JOB: SB1J040  PROGRAM: SB1090
MMIS POS system  SBPOS039
ERROR CODE: 532

CLAIM TYPE: All claim types

DATE UPDATED: 03-23-04

EDIT NAME: OVERLAPPING MONTHS/RECIP LIAB

EDIT DESCRIPTION: OVERLAPPING MONTHS/RECIP LIAB

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N74" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: MMIS POS system
called program

PROGRAM: SBPOS039
SB710038

Top
ERROR CODE: 534

CLAIM TYPE:
All claim types

DATE UPDATED:
03-23-04

EDIT NAME:
RECIPIENT UNAUTHORIZED

EDIT DESCRIPTION:
A. Current claim’s total days is GREATER THAN 60
B. Current claim is a personal care claim with procedure T1019 and there is no units authorized for this person during the service dates billed with, give the error.

METHOD OF CORRECTION:
CLAIM WILL RECYCLE THROUGH THE SYSTEM FOR 60 DAYS, IF RECIPIENT DOES NOT BECOME ELIGIBLE, CLAIMS SHOULD BE DENIED

JOB:                                       PROGRAM:
A. SB1J040               SB1090
   MMIS POS system        SBPOS039
B. SB1J085               SB1330
ERROR CODE:      535

CLAIM TYPE:     All claim types

DATE UPDATED:   03-23-04

EDIT NAME:      CLIA NUMBER NOT ON FILE

EDIT DESCRIPTION:
1)  Current claim has an invalid procedure code
2)  Current claim has a certificate type code of ‘4’ and an invalid procedure code
3)  Current claim has no matching information on CLIA vsam file SB540010

METHOD OF CORRECTION:

CLAIM MAY BE DENIED. DATA ON CLAIM MAY BE CORRECTED AND CLAIM RECYCLED. DATA ON SB540010 MAY BE CORRECTED AND CLAIM RECYCLED.
WHEN USING REMARK CODE "MA120" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B7" IN FIELD 6

JOB:                                   PROGRAM:
SB1J050                                SB1130
MMIS POS system                        SBPOS039

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ERROR CODE: 537

CLAIM TYPE:
UB82 claims
Institutional claims

DATE UPDATED:
03-24-04

EDIT NAME:
SURGICAL PROCEDURE CODE 1

EDIT DESCRIPTION:
1) Current claim’s dates of surgery are NOT EQUAL to zero

   AND

   Current claim’s surgery procedure codes are EQUAL to zeroes or spaces.

2) Current claim’s service code is EQUAL to ‘W’ or ‘V’

   AND

   Current claim’s surgery procedure codes are EQUAL to zeroes or spaces.

3) Current claim’s UB82 service code is EQUAL to ‘W’ or ‘V’

   AND

   Current claim’s UB82 surgery procedure codes are EQUAL to spaces OR zeroes AND the claim’s
   UB82 procedure codes are EQUAL to spaces OR zeroes

METHOD OF CORRECTION:
CORRECT CODE. DELETE DATE. ADD CODE TO LEVEL 3 PRICING MASTER. FORCE OR DENY ERROR. YOU MAY ALSO
USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B18" IN FIELD 6

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 538

CLAIM TYPE:
A) UB82 claims

B) Institutional claims, UB82 claims

DATE UPDATED:
03-24-04

EDIT NAME:
SURGICAL DATE 1

EDIT DESCRIPTION:
A1) Current UB82 Inpatient claim has a date of discharge NOT EQUAL to zeroes

AND

the date of surgery is NOT EQUAL to zeroes

AND

the date of surgery is GREATER THAN the date of discharge

A2) Current UB82 Inpatient claim has a bill type of ‘111’

AND

the date of surgery GREATER THAN zeroes

AND

the date of surgery is LESS THAN the 1st date of service OR the date of surgery is GREATER THAN the last date of service

A3) Current UB82 Inpatient claim has a date of surgery GREATER THAN zeros

AND

the date of surgery contains an invalid date
B1) Current UB82 claim has a date of surgery EQUAL to zeroes

   AND

   the surgery procedure code is GREATER THAN spaces

B2) Current claim has a service code of ‘W’ OR ‘V’

   AND

   the dates of surgery are EQUAL to zeroes

B3) Current UB82 claim has a service code of ‘W’ OR ‘V’

   AND

   the UB82 dates of surgery are EQUAL to zeroes AND the UB92 dates of surgery are EQUAL to zeroes

METHOD OF CORRECTION:

CORRECT DATE. DELETE PROCEDURE CODE. FORCE OR DENY ERROR.
YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB:                           PROGRAM:
A) SB1J020                SB1070
B) SB1J050                SB1130
ERROR CODE: 539

CLAIM TYPE:
All claim types

DATE UPDATED:
03-25-04

EDIT NAME:
SURGICAL PROCEDURE CODE 2

EDIT DESCRIPTION:
1) Current UB82 claim has the second date of surgery NOT EQUAL to zeroes

   AND

   its second surgery procedure code is EQUAL to spaces OR zeroes

2) Current claim has a pricing error OR it has a level 3 inactive procedure code OR it has a level 3 procedure code error

   AND

   it has a surgery index EQUAL to 2

3) Current claim has a pricing error OR it has a level 3 inactive procedure code OR it has a level 3 procedure code error

   AND

   it has a UB82 surgery index EQUAL to 2

METHOD OF CORRECTION:

CORRECT DATE. DELETE DATE. ADD CODE TO LEVEL 3 PRICING MASTER. FORCE OF DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 540

CLAIM TYPE:
A) UB82 Inpatient claims
B) UB82 claims

DATE UPDATED:
03-25-04

EDIT NAME:
SURGICAL DATE 2

EDIT DESCRIPTION:
A1) Current UB82 Inpatient claim has a UB82 date of discharge NOT EQUAL to zeroes
    AND
    its second UB82 date of surgery is GREATER THAN its UB82 date of discharge

A2) Current UB82 Inpatient claim has a bill type EQUAL to ‘111’
    AND
    its second UB82 date of surgery is LESS THAN its 1st date of service OR GREATER THAN its
    last date of service

A3) Current UB82 Inpatient claim has a second date of surgery GREATER THAN zeroes
    AND
    its second date of surgery contains and invalid date

B) Current UB82 claim has a second surgery date EQUAL TO zeroes
    AND
    its second UB82 surgery procedure code is GREATER THAN spaces

METHOD OF CORRECTION:
CORRECT DATE. DELETE PROCEDURE CODE. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF
"M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: SB1J020
PROGRAM: SB1070
ERROR CODE:  541

CLAIM TYPE:
UB82 claims

DATE UPDATED:
03-25-04

EDIT NAME:
SURGICAL PROCEDURE CODE 3

EDIT DESCRIPTION:
1) Current UB82 claim has a third date of surgery NOT EQUAL to zeroes

    AND

    its third UB82 surgery procedure code is EQUAL to spaces OR is EQUAL to zeroes

2) Current UB82 claim has a bad price return OR a level 3 inactive procedure OR a level 3 procedure error

    AND

    its UB82 surgery index is EQUAL to ‘3’

METHOD OF CORRECTION:
CORRECT CODE. DELETE DATE. ADD CODE TO LEVEL 3 PRICING MASTER. FORCE OF DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 542

CLAIM TYPE:
A) UB82 Inpatient claims
B) UB82 Inpatient claims

DATE UPDATED:
03-25-04

EDIT NAME:
SURGICAL DATE 3

EDIT DESCRIPTION:
A1) Current UB82 Inpatient claim’s UB82 discharge date is NOT EQUAL to zeroes

AND

its third UB82 surgery date is NOT EQUAL to zeroes

AND

its third UB82 surgery date is GREATER THAN its discharge date

A2) Current UB82 Inpatient claim’s bill type is EQUAL to ‘111’

AND

its third UB82 surgery date is GREATER THAN zeroes

AND

its third UB82 surgery date is LESS THAN its 1st date of service OR its third UB82 surgery date is GREATER THAN its last date of service

A3) Current UB82 Inpatient claim’s third date of surgery is GREATER THAN zeroes

AND

its third date of surgery contains an invalid date
B) Current UB82 Inpatient claim’s third date of surgery is EQUAL to zeroes

AND

its third UB82 surgery procedure code is GREATER THAN spaces

METHOD OF CORRECTION:

CORRECT DATE, DELETE PROCEDURE CODE. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: PROGRAM:
A) SB1J020        SB1070
B) SB1J050        SB1130

Top
ERROR CODE: 543

CLAIM TYPE:
UB82 claims

DATE UPDATED:
03-25-04

EDIT NAME:
SURGICAL PROCEDURE CODE 4

EDIT DESCRIPTION:
1) Current UB82 claim’s first UB92 surgery date that is NOT EQUAL to zeroes
   AND
   its first UB92 procedure code is EQUAL to spaces OR its first UB92 procedure code is EQUAL to spaces

2) Current claim has an error in pricing OR it has a level3 inactive procedure code OR it has a level3 procedure code error
   AND
   its surgery index is EQUAL to ‘1’

METHOD OF CORRECTION:
CORRECT CODE. DELETE DATE. ADD CODE TO LEVEL 3 PRICING MASTER. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON “125” IN FIELD 6

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE:  544

CLAIM TYPE:
A) UB82 Inpatient claims
B) UB82 claims

DATE UPDATED:
03-25-04

EDIT NAME:
SURGICAL DATE 4

EDIT DESCRIPTION:
A1) Current UB82 Inpatient claim’s discharge date is NOT EQUAL to zeroes

AND

its first UB92 surgery date is NOT EQUAL to zeroes

AND

its first UB92 surgery date is GREATER THAN the discharge date

A2) Current UB82 Inpatient claim’s bill type is EQUAL to ‘111’

AND

its first UB92 surgery date is GREATER THAN zeroes

AND

its first UB92 surgery date is LESS THAN the 1st date of service OR its first UB92 surgery date is GREATER THAN the last date of service

A3) Current UB82 Inpatient claim’s first UB92 surgery date is GREATER THAN zeroes

AND

it’s first UB92 surgery date is invalid

B) Current UB82 claim’s first UB92 surgery date is EQUAL to zeroes

AND

its first UB92 procedure code is GREATER THAN spaces
METHOD OF CORRECTION:
CORRECT DATE. DELETE PROCEDURE CODE. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: PROGRAM:
A) SB1J020 SB1070
B) SB1J050 SB1130

Top
ERROR CODE: 545

CLAIM TYPE: UB82 claims

DATE UPDATED: 03-25-04

EDIT NAME: SURGICAL PROCEDURE CODE 5

EDIT DESCRIPTION:
1) Current UB82 claim second UB92 surgery date is NOT EQUAL to zeroes
   AND
   its second UB92 procedure code is EQUAL to spaces OR its second UB92 procedure code is
   EQUAL to zeroes

2) Current claim has a pricing error OR a level3 inactive procedure code OR a level3 procedure code
   error
   AND
   its surgery index is EQUAL to '2'

METHOD OF CORRECTION:

RE CODE. DELETE DATE. ADD CODE TO LEVEL 3 PRICING MASTER. FORCE OF DENY ERROR. YOU MAY ALSO
USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: SB1J050  PROGRAM: SB1130

Top
ERROR CODE: 546

CLAIM TYPE:
A) UB82 Inpatient claims
B) UB82 claims

DATE UPDATED:
03-26-04

EDIT NAME:
SURGICAL DATE 5

EDIT DESCRIPTION:
A1) Current UB82 Inpatient claim’s date of discharge is NOT EQUAL to zeroes

    AND

    its second UB92 surgery date is NOT EQUAL to zeroes

    AND

    its second UB92 surgery date is GREATER THAN the discharge date

A2) Current UB82 Inpatient claim’s bill type is EQUAL to ‘111’

    AND

    its second UB92 surgery date is GREATER THAN zeroes

    AND

    its second UB92 surgery date is LESS THAN the 1st date of service OR its second UB92 surgery
date is GREATER THAN the last date of service

A3) Current UB82 Inpatient claim’s second UB92 surgery date is GREATER THAN zeroes

    AND

    its second UB92 surgery date is invalid
B) Current UB82 claim’s second UB92 surgery date is EQUAL to zeroes

AND

its second UB92 procedure code is GREATER THAN spaces

METHOD OF CORRECTION:

CORRECT DATE, DELETE PROCEDURE CODE. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: PROGRAM:
A) SB1J020 SB1070
B) SB1J050 SB1130

Top
ERROR CODE: 547

CLAIM TYPE:
UB82 claims

DATE UPDATED:
03-26-04

EDIT NAME:
SURGICAL PROCEDURE CODE 6

EDIT DESCRIPTION:
1) Current UB82 claim’s third UB92 surgery date is NOT EQUAL to zeroes
   AND
   its third UB92 procedure code is EQUAL to spaces OR its third UB92 procedure code is EQUAL to zeroes

2) Current claim has a pricing error OR a level3 inactive procedure code OR a level3 procedure code error
   AND
   its surgery index EQUALS '3'

METHOD OF CORRECTION:
CORRECT CODE. DELETE DATE. ADD CODE TO LEVEL 3 PRICING MASTER. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE) WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: SB1J050
PROGRAM: SB1130
ERROR CODE: 548

CLAIM TYPE:
A) UB82 Inpatient claims
B) UB82 claims

DATE UPDATED:
03-26-04

EDIT NAME:
SURGICAL DATE 6

EDIT DESCRIPTION:
A1) Current UB82 Inpatient claim’s discharge date is NOT EQUAL to zeroes

    AND

    its third UB92 surgery date is NOT EQUAL to zeroes

    AND

    its third UB92 surgery date is GREATER THAN the discharge date

A2) Current UB82 Inpatient claim’s bill type is EQUAL to ‘111’

    AND

    its third UB92 surgery date is GREATER THAN zeroes

    AND

    its third UB92 surgery date is LESS THAN the 1st date of service OR third UB92 surgery date is GREATER THAN the last date of service

A3) Current UB82 Inpatient claim’s third UB92 surgery date is GREATER THAN zeroes

    AND

    its third UB92 surgery date is invalid
B) Current UB82 claim’s third UB92 surgery date is EQUAL to zeroes

AND

its third UB92 procedure code is GREATER THAN spaces

METHOD OF CORRECTION:

CORRECT CODE. DELETE PROCEDURE CODE. FORCE OR DENY ERROR. YOU MAY ALSO USE "MA66" IN PLACE OF "M67" (MOST APPROPRIATE)
WHEN USING REMARK CODE "M67" OR "MA66" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6

JOB: PROGRAM:
A) SB1J020 SB1070
B) SB1J050 SB1130

Top
ERROR CODE: 550

CLAIM TYPE: All claim types

DATE UPDATED: 03-26-04

EDIT NAME: INVALID RECIPIENT ID #

EDIT DESCRIPTION: Current claim had no recipient ID # match upon return from called program SB109A

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: SB1J040 PROGRAM: SB1090

Top
ERROR CODE: 554

CLAIM TYPE:
All claim types

DATE UPDATED:
03-29-04

EDIT NAME:
QMB-SLMB MEDICAID DUAL ELIGIBILITY

EDIT DESCRIPTION:
Current claim is of region ‘10’ OR has a batch number of ‘850’

AND

its QMB eligible (ie: it has an aid category of ‘28’, ‘29’, ‘39’ or ‘31’)

METHOD OF CORRECTION:

RECIPIENT IS EITHER DUALLY ELIGIBLE FOR MEDICAID COVERAGE AND QMB / SLMB COVERAGE FOR ELIGIBLE
FOR QMB COVERAGE ONLY. IF THE SERVICE LINE IS A NON-COVERED MEDICARE SERVICE, CHANGE MEDICARE
INDICATOR TO ’N’ AND F12 CLAIM. IF NON-COVERED MEDICARE SERVICE WAS BILLED WITH COVERED MEDICARE
PROVIDER CAN THEN REBILL W/NON-COVERED SERVICE ONLY, 554 ERROR WILL AGAIN BE SET, CHANGE
INDICATOR TO ’N’ AND CLAIM WILL PROCESS UNDER THE MEDICAID ELIGIBILITY

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 555

CLAIM TYPE:
All claim types

DATE UPDATED:
03-29-04

EDIT NAME:
QMB TPL INDICATED

EDIT DESCRIPTION:
Current claim’s earliest eligibility start date is GREATER THAN OR EQUAL to the start date on file AND the eligibility stop date is LESS THAN OR EQUAL to the stop date on file

AND

the aid category on file for this recipient is NOT EQUAL to ‘036’, ‘041’ or ‘042’

AND

third party liability (TPL) exists for this recipient

METHOD OF CORRECTION:

METHOD FOR CORRECTION WILL WORK MUCH LIKE ERROR 408, IN FACT THE CLAIM COULD ALSO GET ERROR 408 IF PERSON IS MEDICAID ELIG. CORRECT CLAIM LIKE ANY OTHER CLAIM WITH ERROR 408. PLEASE NOTE THAT IF RECIPIENT IS ONLY QMB ELIG, THERE WILL NOT BE ANY TPL DATE OR A TPL WORKSHEET TO LOOK AT.

JOB: SB1J040

PROGRAM: SB1090

Top
ERROR CODE: 556

CLAIM TYPE:
A) All claim types
B) All claim types

DATE UPDATED:
03-29-04

EDIT NAME:
INSURANCE PMT & NO TPL ON FILE

EDIT DESCRIPTION:
A) Current claim is NOT a nursing home claim OR it is NOT of LTC region (region ‘20’) OR its VR
   provider number is EQUAL to ‘001086’, ‘002435’ or ‘050383’

   AND

   its policy count is EQUAL to zero AND its total other insurance is GREATER THAN zero

B1) Current claim’s policy count is EQUAL to zero AND its total other insurance is GREATER
    THAN zero

B2) Current claim’s policy count is EQUAL to zero AND its total other insurance is GREATER
    THAN zero

   AND

   it is NOT of tape-bill region (region ‘40’)

METHOD OF CORRECTION:

IF EOB PRESENT, GIVE TO BEV & FORCE PAY WITH EOB 120. WHEN USING REMARK CODE "MA04" YOU MUST ENTER
CLAIM ADJUSTMENT REASON "22" IN FIELD 6.

JOB: PROGRAM:
A) SB1J040 SB1090
B) MMIS POS system SB710023
ERROR CODE: 557

CLAIM TYPE:
Nursing Home claims

DATE UPDATED:
03-29-04

EDIT NAME:
NEW ADMIT-MEDICARE COVERAGE

EDIT DESCRIPTION:
NURSING HOME CLAIM WITH SERVICE CODE ‘1’ ‘2’ ‘3’ ‘Q’ ‘R’ ‘S’ ‘T’ ‘U’ ‘V’ ‘W’ ‘X’ OR ‘Y’ AND RANGE OF 1 TO 26 OR RANGE 46 TO 49.

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: SB1J050
PROGRAM: SB1130

Top
ERROR CODE: 558

CLAIM TYPE:
Nursing Home claims

DATE UPDATED:
03-29-04

EDIT NAME:
RE-ADMISSION-MEDICARE COVERAGE

EDIT DESCRIPTION:
Current claim’s first procedure service date is GREATER THAN 19981231 AND is of region ‘20’ AND its service code is NOT EQUAL to ‘Q’, ‘R’, or ‘2’ AND its nursing home class is in the range of 1 through 25 or in the range of 46 through 49

AND

its dates of service is within 3 days of previous dates of service

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: SB1J075, SB1J079
PROGRAM: SB1250
ERROR CODE: 559

CLAIM TYPE: All claim types

DATE UPDATED: 03-29-04

EDIT NAME: VFC VACCINE - REQUIRES MANUAL REVIEW

EDIT DESCRIPTION: Current claim has a revenue code EQUAL to ‘983’ AND a valid procedure code AND its detail-level procedure code is EQUAL to ‘90782’

METHOD OF CORRECTION:
REVIEW CLAIM FOR AGE AND FOR CURRENT POLICY ON REIMBURSEMENT FOR VFC COVERED VACCINES.

JOB: SB1J050 PROGRAM: SB1130

Top
ERROR CODE:  561

CLAIM TYPE:  NURSING HOME CLAIMS

DATE UPDATED:
04-20-04

EDIT NAME:
OOS NH - MEDICARE CVRG - ANCILLARY CHGS

EDIT DESCRIPTION:
IF SERVICE CODE ‘Q’ ‘R’ OR ‘S’ AND THERE ARE ANY OTHER DETAILS BEING BILLED WITH ANCILLARY SERVICES
SET ERROR.

METHOD OF CORRECTION:
DENY LINE WITH REASON CODE 97.

JOB:                    PROGRAM:
SB1J050                SB1130

Top
ERROR CODE: 600

CLAIM TYPE:
A) Drug claims
B) Drug claims

DATE UPDATED:
03-30-04

EDIT NAME:
RESTRICTED USE DRUG

EDIT DESCRIPTION:
A) Current claim’s DRG code is EQUAL to zero

AND

its reimbursement amount is NOT EQUAL to the total amount paid at the detail level

B) Current claim’s drug control code is EQUAL to ‘2’

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: PROGRAM:
A) SB1J665 SB1520
B) MMIS POS system SB710023

Top
ERROR CODE:       601

CLAIM TYPE:    Drug claims

DATE UPDATED:   03-30-04

EDIT NAME:     NON-PAYABLE, OR DESI DRUG

EDIT DESCRIPTION:
1) Current claim’s drug control code is EQUAL to ‘4’

2) Current claim’s drug control code is EQUAL to ‘0’, ‘3’, ‘7’ or ‘8’

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: MMIS POS system          PROGRAM: SB710023
ERROR CODE: 602

CLAIM TYPE:
Drug claims

DATE UPDATED:
03-30-04

EDIT NAME:
DRUG DISCONTINUED, BILL NEW NDC

EDIT DESCRIPTION:
Current claim’s drug control code is EQUAL to ‘5’

METHOD OF CORRECTION:
WHEN USING REMARK CODE "N60" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B7" IN FIELD 6

JOB: MMIS POS system
PROGRAM: SB710023

Top
ERROR CODE: 604

CLAIM TYPE:
A) All claim types
B) All claim types
C) All claim types

DATE UPDATED:
03-30-04

EDIT NAME:
PA VALID, NOT ENOUGH UNITS REMAINING

EDIT DESCRIPTION:
A) Current claim’s number of units remaining is GREATER THAN zero

AND

it contains a valid procedure code indicating 3 months of rental OR it contains a valid procedure code indicating 1 month of rental

B) Current claim’ number of allowed units is GREATER THAN zero

AND

its number of units remaining is LESS THAN zero

C) Current claim’s total number of units is GREATER THAN its number of allowed units

AND

its number of units allowed is NOT EQUAL to the number of units used

METHOD OF CORRECTION:

(note: no correction method given on MMIS system)

JOB: PROGRAM:
A) SB1J050 SB1130
B) SB1J077 SB1275
C) MMIS POS system SB710025

Top
ERROR CODE: 605

CLAIM TYPE:
A) All claim types
B) All claim types
C) All claim types

DATE UPDATED:
03-30-04

EDIT NAME:
PA VALID, NOT ENOUGH/NO UNITS REMAIN

EDIT DESCRIPTION:
A) Current claim’s number of units remaining is GREATER THAN zero

AND

it contains a valid procedure code indicating 3 months of rental OR it contains a valid procedure code indicating 3 months of rental

B) Current claim’s number of allowed units is GREATER THAN zero

AND

its number of units remaining is EQUAL to zero

C) Current claim’s number of units requested is GREATER THAN the number of units allowed

METHOD OF CORRECTION:

(note: no correction method given on MMIS system)

JOB: PROGRAM:
A) SB1J050 SB1130
B) SB1J077 SB1275
C) MMIS POS system SB710025
ERROR CODE: 606

CLAIM TYPE:
A) Adjustment claims
B) All prior authorization claims

DATE UPDATED:
04-15-04

EDIT NAME:
PA VALID, NOT ENOUGH/NO UNITS REMAIN

EDIT DESCRIPTION:
A) Current adjustment claim’s beginning date of service is LESS THAN OR EQUAL TO the beginning date allowed OR it’s ending
date of service is GREATER THAN OR EQUAL TO the ending date allowed
B) Current claim’s date dispensed is LESS THAN the dispensed date authorized OR the date
dispensed is GREATER THAN the dispensed date authorized.

METHOD OF CORRECTION:
WHEN USING REMARK CODE "M54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "62" IN FIELD 6.

JOB:                  PROGRAM:
A) SB1J050            SB1130
B) MMIS POS system    SB710025

Top
ERROR CODE: 607

CLAIM TYPE:
A) All claim types
B) All prior authorization claims.

DATE UPDATED:
04-19-04

EDIT NAME:
PRODUCT DOES NOT MATCH PA

EDIT DESCRIPTION:
A) Current claim’s service start date on file is NOT GREATER THAN its service start date AND its service stop date on file is NOT LESS THAN its service stop date

B) Current prior authorization claim’s number of units is GREATER THAN OR EQUAL to 6 OR fill number is currently NOT EQUAL to zeros

AND

there are currently no other error codes assigned to the claim.

METHOD OF CORRECTION:

WHEN USING REMARK CODE "N54" YOU MUST ENTER CLAIM ADJUSTMENT REASON "15" IN FIELD 6.

JOB: PROGRAM:
A) SB1J050 SB1130
B) MMIS POS system SB710025
ERROR CODE: 608

CLAIM TYPE:
A) Crossover claims, Adjustment claims
B) Prior Authorization claims

DATE UPDATED:
04-19-04

EDIT NAME:
PA WAS NOT FOUND

EDIT DESCRIPTION:
A1) Current claim has NO primary procedure code AND NO secondary procedure code
A2) Current claim has NO prior authorization
    AND
    it has NO primary procedure code AND NO secondary procedure code
    AND
    it has been previously denied
    AND
    it is an adjustment claim
A3) Current claim has NO prior authorization
    AND
    it has NO primary procedure code AND NO secondary procedure code
    AND
    it has valid service dates (i.e. error code 607 has NOT been assigned to this claim)
B) Current prior authorization claim has no error code assigned to it AND has no prior authorization
    code AND is NOT at its proton pump claim limit

METHOD OF CORRECTION:
(no correction method given on MMIS system)

JOB:
A) SB1J050
PROGRAM:
A) SB1130
B) MMIS POS system               SB710025

Top
ERROR CODE: 609

CLAIM TYPE:
All claim types

DATE UPDATED:
04-23-04

EDIT NAME:
DUR - DRUG DISEASE (INFERRRED)

EDIT DESCRIPTION:
(note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:
?

JOB: PROGRAM:
MMIS POS system SBPOS039

Top
ERROR CODE: 610

CLAIM TYPE:
All claim types

DATE UPDATED:
04-23-04

EDIT NAME:
DUR - DRUG DISEASE (REPORTED)

EDIT DESCRIPTION:
(note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:
?

JOB: MMIS POS system
PROGRAM: SBPOS039

Top
ERROR CODE: 611

CLAIM TYPE: All claim types

DATE UPDATED: 04-23-04

EDIT NAME: DUR - DRUG/DRUG INTERACTION

EDIT DESCRIPTION: (note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:

?

JOB: MMIS POS system

PROGRAM: SBPOS039
ERROR CODE: 612

CLAIM TYPE:
All claim types

DATE UPDATED:
04-23-04

EDIT NAME:
DUR - LOW DOSE ALERT - ADULT

EDIT DESCRIPTION:
(note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:

?

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE: 613

CLAIM TYPE:
All claim types

DATE UPDATED:
04-23-04

EDIT NAME:
DUR - HIGH DOSE ALERT - ADULT

EDIT DESCRIPTION:
(note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:
?

JOB: MMIS POS system
PROGRAM: SBPOS039

Top
ERROR CODE: 614

CLAIM TYPE: All claim types

DATE UPDATED: 04-23-04

EDIT NAME: DUR - INGREDIENT DUPLICATION

EDIT DESCRIPTION: (note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:
?

JOB: MMIS POS system PROGRAM: SBPOS039
ERROR CODE: 615

CLAIM TYPE:
A) All claim types
B) Drug claims

DATE UPDATED: 04-23-04

EDIT NAME: EARLY REFILL < 80% UTILIZED

EDIT DESCRIPTION:
A) (note: This error code exists but is not currently implemented in any program)
B) Current claim has been refilled before 80% of original prescription has been used.

METHOD OF CORRECTION:
(note: No correction method given on MMIS system)

JOB: PROGRAM:
A) MMIS POS system SBPOS039
B) called program SB710026

Top
ERROR CODE: 616

CLAIM TYPE:
Drug claims

DATE UPDATED:
04-26-04

EDIT NAME:
DUR - THERAPEUTIC DUPLICATION

EDIT DESCRIPTION:
(note: This error code exists but is not currently implemented in any program)

METHOD OF CORRECTION:
(note: No correction method given on MMIS system)

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE: 617

CLAIM TYPE: All claim types

DATE UPDATED: 04-27-04

EDIT NAME: POS SUSPENSE FILE IS OUT OF SERVICE

EDIT DESCRIPTION: Current CICS process resulted an unknown return code.

METHOD OF CORRECTION:
YOU MAY ALSO USE "97" IN PLACE OF "92" (MOST APPROPRIATE)

JOB: MMIS POS system  PROGRAM: SBPOS039
online CICS SB710021
online CICS SB710022
online CICS SB710023
online CICS SB710024
online CICS SB710041

Top
ERROR CODE: 618

CLAIM TYPE: All claim types

DATE UPDATED: 04-27-04

EDIT NAME: RECIPIENT MASTER FILE OUT OF SERVICE

EDIT DESCRIPTION: Current CICS process resulted an unknown return code.

METHOD OF CORRECTION:

(note: no correction method is given on the MMIS system)

JOB:          PROGRAM:
MMIS POS system    SBPOS039
called program    SB127A
online CICS     SB710021
online CICS     SB710022
online CICS     SB710023
online CICS     SB710024
online CICS     SB710025
online CICS     SB710038
online CICS     SB71038B
online CICS     SB710041

Top
ERROR CODE: 619

CLAIM TYPE:
All claim types

DATE UPDATED:
04-27-04

EDIT NAME:
DRUG PRICING FILE IS OUT OF SERVICE

EDIT DESCRIPTION:
Current CICS process resulted an unknown return code.

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB: MMIS POS system
PROGRAM: SBPOS039

online CICS SB710021
online CICS SB710022
online CICS SB710023
online CICS SB710024
online CICS SB710025
online CICS SB710041
ERROR CODE: 620

CLAIM TYPE:
All claim types

DATE UPDATED:
04-27-04

EDIT NAME:
PROVIDER MASTER FILE OUT OF SERVICE

EDIT DESCRIPTION:
Current CICS process resulted an unknown return code.

METHOD OF CORRECTION:

(note: no correction method is given on the MMIS system)

JOB: PROGRAM:
MMIS POS system SBPOS039
online CICS SB710021
online CICS SB710022
online CICS SB710023
online CICS SB710024
online CICS SB710025
online CICS SB710041
ERROR CODE:  621

CLAIM TYPE:
A) All claim types
B) All claim types

DATE UPDATED:
04-27-04

EDIT NAME:
OTHER MASTER FILE OUT OF SERVICE

EDIT DESCRIPTION:
A) This program only contains the list of available error codes
B) Current CICS process resulted an unknown return code.

METHOD OF CORRECTION:

YOU MAY USE "97" IN PLACE OF "92" (MOST APPROPRIATE)

JOB: PROGRAM:
A) MMIS POS system SBPOS039
B) online CICS SB710041
ERROR CODE:         622

CLAIM TYPE:
All claim types

DATE UPDATED:
04-28-04

EDIT NAME:
DME ITEM, USE STATE ASSIGNED CODE

EDIT DESCRIPTION:
Current claim’s drug control code is EQUAL TO 6

METHOD OF CORRECTION:
(note: No correction method given on MMIS system)

JOB:                                                PROGRAM:
online CICS                        SB710023
MMIS POS system           SBPOS039

Top
ERROR CODE: 623

CLAIM TYPE: Drug claims

DATE UPDATED: 04-29-04

EDIT NAME: DATA FIELD PROBLEMS IN DRUG FILE

EDIT DESCRIPTION:
Point of sale drug pricing indicator is NOT EQUAL to 6

OR

Point of sale fee indicator is NOT EQUAL to ‘ ’, ‘B’, or ‘C’

METHOD OF CORRECTION:
(note: No correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710023

MMIS POS system SBPOS039

Top
ERROR CODE: 624

CLAIM TYPE: All claim types

DATE UPDATED: 04-29-04

EDIT NAME: SUPER SUSPEND

EDIT DESCRIPTION:
A) Point of sale claim has a transaction type EQUAL TO ‘4’

AND

Current claim’s DISP indicator is EQUAL TO ‘2’

AND

Current claim has already received and error code ‘2’ from point of sale

METHOD OF CORRECTION:

(note: No correction method given on MMIS system)

JOB: PROGRAM:
A) online CICS SB710025
B) MMIS POS system SBPOS039
ERROR CODE: 625

CLAIM TYPE: All claim types

DATE UPDATED: 05-03-04

EDIT NAME: PENDING ELIGIBILITY

EDIT DESCRIPTION:
A1) Current claim’s WD-010-CC-CL-STAT-MA is EQUAL TO ('WA' OR 'RE')

   OR

   its WD-010-CC-CL-STAT-AF is EQUAL TO 'AU'

A2) Current claim’s MEMD-CLNT-STATUS is EQUAL TO 'UN' or 'RE'

METHOD OF CORRECTION:

(note: No correction method given on MMIS system)

JOB: PROGRAM:
A) online CICS          SB710022
B) MMIS POS system     SBPOS039
ERROR CODE: 630

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-04-04

EDIT NAME:
INS PMT>0 BUT <50% AND >1 TPL

EDIT DESCRIPTION:
Current claim's policy count is GREATER THAN 1
AND
its total other insurance from the point of sale system is GREATER THAN 0 and LESS THAN
half of its drug ledger total from the point of sale system

METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA04" YOU MUST ENTER CLAIM ADJUSTMENT REASON "22" IN FIELD 6

JOB: online CICS
PROGRAM: SB710023
ERROR CODE: 631

CLAIM TYPE: Payable claims

DATE UPDATED: 05-04-04

EDIT NAME: INS. PMT 1-59% AND 1 TPL

EDIT DESCRIPTION:
1) Current claim is NOT a nursing home claim OR it is NOT of LTC region OR its provider number is 1086, 2435, or 50383
   AND
   its policy count is EQUAL TO 1
   AND
   its other insurance amount is GREATER THAN 0, but is LESS THAN 60% of the submitted charge

2) Current claim is NOT a nursing home claim OR it is NOT of LTC region OR its provider number is 1086, 2435, or 50383
   AND
   its policy count is EQUAL TO 1
   AND
   its total other insurance amount is GREATER THAN 0, but is LESS THAN 60% of the total claim charge

METHOD OF CORRECTION:
WHEN USING REMARK CODE "MA04" YOU MUST ENTER CLAIM ADJUSTMENT REASON "22" IN FIELD 6

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE: 634

CLAIM TYPE:
All claim types

DATE UPDATED:
05-04-04

EDIT NAME:
DUR- IATROGENIC

EDIT DESCRIPTION:
Current claim’s detail line has an error code EQUAL TO ‘501’ and its error code status is NOT EQUAL to ‘F’ or ‘D’

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB: online CICS
PROGRAM: SB710024
ERROR CODE:       637

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-04-04

EDIT NAME:
PHARMACY DUP, SAME RX NUMBER

EDIT DESCRIPTION:
Current claim’s date dispensed is EQUAL TO the date dispensed on point of sale

AND

its provider number is EQUAL TO the provider number on point of sale

AND

its prescription number is EQUAL TO the prescription number on point of sale

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB:                                                PROGRAM:
online CICS                        SB710024

Top
ERROR CODE: 638

CLAIM TYPE: Drug claims

DATE UPDATED: 05-05-04

EDIT NAME: PHARMACY DUP, SAME NDC

EDIT DESCRIPTION: Current claim’s date dispensed is EQUAL TO the date dispensed on point of sale

AND

its provider number is EQUAL TO the provider number on point of sale

AND

its drug code is EQUAL TO the drug code on point of sale

METHOD OF CORRECTION:

(note: no correction method is given on the MMIS system)

JOB: online CICS PROGRAM: SB710024

Top
ERROR CODE:       639

CLAIM TYPE:     Drug claims

DATE UPDATED:    05-05-04

EDIT NAME:    POTENTIAL MEDICARE COVERAGE

EDIT DESCRIPTION:  
Current Medicare claim has a dispensed date that is GREATER THAN OR EQUAL TO 12-01-1999

AND

its recipient’s living arrangement is NOT EQUAL TO ‘5’

METHOD OF CORRECTION:

POTENTIAL MEDICARE COVERAGE EXISTS. REVIEW MEDICARE/INSURANCE AMT IN REFERENCE TO CLAIM. CONSIDER SERVICE BILLED AS MEDICARE COVERAGE IS OFTEN SPECIFIC TO DIAGNOSIS. REVIEW COMMENTS POSTED ON TPL INTERFACE AS SPECIFIC COVERAGE CRITERIA MAY BE NOTED. REFER QUESTIONS TO ADMINISTRATOR, PHARMACY SERVICES.

JOB: online CICS
PROGRAM: SB710023
ERROR CODE: 640

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-06-04

EDIT NAME:
DAYS SUPPLY EXCEEDS 34 DAYS.

EDIT DESCRIPTION:
Current claim’s number of days supply is GREATER THAN 34
AND
its detail-level total other insurance is EQUAL TO zero

METHOD OF CORRECTION:
YOU MAY ALSO USE "AG" OR "19" IN PLACE OF "76" (MOST APPROPRIATE)

JOB: online CICS
PROGRAM: SB710023

Top
ERROR CODE:  641

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-06-04

EDIT NAME:
INVALID RX REFERENCE NUMBER QUALIFIER

EDIT DESCRIPTION:
Current claim has a detail-level prescription reference qualifier that is NOT EQUAL to ‘ ’ or ‘1’

METHOD OF CORRECTION:
(note: no correction method is given on the MMIS system)

JOB:                                                PROGRAM:
online CICS                        SB710022

Top
ERROR CODE: 642

CLAIM TYPE: Drug claims

DATE UPDATED: 05-06-04

EDIT NAME: M/I PROD/SERVICE ID QUALIFIER

EDIT DESCRIPTION: Current claim’s product identification qualifier is NOT EQUAL to ‘’, ‘00’ or ‘03

METHOD OF CORRECTION: FIELD 436 IS IN ERROR-MUST BE 03 WHICH DESIGNATES THE CODE AS AN NDC CODE

JOB: online CICS PROGRAM: SB710022
ERROR CODE: 643

CLAIM TYPE: Drug claims

DATE UPDATED: 05-06-04

EDIT NAME: M/I ASSOC RX/SERVICE REF #

EDIT DESCRIPTION: Current claim’s detail-level dispense status is EQUAL TO ‘C’

AND

its prescription service reference number is EQUAL TO zero

METHOD OF CORRECTION: (note: no correction method given on MMIS system)

JOB: online CICS PROGRAM: SB710022

Top
ERROR CODE: 644

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-06-04

EDIT NAME:
M/I ASSOC RX/SERVICE DATE

EDIT DESCRIPTION:
1) Current claim’s detail-level dispense status is EQUAL TO ‘C’

   AND

   it contains an invalid service date

2) Current claim’s detail-level dispense status is EQUAL TO ‘C’

   AND

   its detail-level associate prescription service date is EQUAL TO the detail-level prescription dispensed date

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710022
ERROR CODE: 645

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-07-04

EDIT NAME:
ASSOC PRESC/SERVICE DATE NOT BLANK

EDIT DESCRIPTION:
Current claim's detail level dispense status is EQUAL TO 'P'

AND

its detail-level associated prescription service date is NOT EQUAL TO zero

METHOD OF CORRECTION:
PARTIAL FILL MUST HAVE NO DATE IN THE ASSOC PRESC/SERVICE DATE FIELD

JOB: online CICS
PROGRAM: SB710022
ERROR CODE: 646

CLAIM TYPE: Drug claims

DATE UPDATED: 05-07-04

EDIT NAME: COMPOUND SEGMENT NOT SUBMITTED

EDIT DESCRIPTION: Current claim's detail-level compound code is EQUAL TO ‘2’

AND

its number of drug occurrences (detail count) is EQUAL TO 1

METHOD OF CORRECTION: (note: no correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710022

Top
ERROR CODE: 647

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-07-04

EDIT NAME:
AT LEAST 1 NDC NOT COV ON COMPOUND CL

EDIT DESCRIPTION:
(note: error code exists but is not implemented in any processing)

METHOD OF CORRECTION:
YOU MAY ALSO USE "TE" IN PLACE OF "RE" (MOST APPROPRIATE)

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE: 649

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-07-04

EDIT NAME:
M/I COMP DOSAGE FORM DESC CODE

EDIT DESCRIPTION:
Current claim’s detail-level compound code is EQUAL TO ‘2’

AND

its detail-level compound dosage description code is NOT in the range of ‘01’ through ‘18’

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710022

Top
ERROR CODE: 650

CLAIM TYPE: Drug claims

DATE UPDATED: 05-07-04

EDIT NAME: M/I COMP DISPENSING UNIT FORM IND

EDIT DESCRIPTION: Current claim’s detail-level compound code is EQUAL TO ‘2’

AND

its detail-level dispensing unit form indicator is NOT in the range of ‘01’ through ‘03’

METHOD OF CORRECTION: (note: no correction method given on MMIS system)

JOB: online CICS PROGRAM: SB710022

Top
ERROR CODE: 651

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-07-04

EDIT NAME:
M/I COMP ROUTE OF ADMIN

EDIT DESCRIPTION:
Current claim's detail-level compound code is EQUAL TO ‘2’

AND

its detail-level compound route of administration is NOT in the range of ‘01’ through ‘22’

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710022

Top
ERROR CODE: 652

CLAIM TYPE: Drug claims

DATE UPDATED: 05-07-04

EDIT NAME: M/I COMP INGREDIENT QUANTITY

EDIT DESCRIPTION:
Current claim’s detail-level quantity dispensed is EQUAL TO zero

AND


AND

its detail-level compound code is EQUAL TO ‘2’

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710022
ERROR CODE: 653

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-07-04

EDIT NAME:
M/I DISPENSE AS WRITTEN (DAW) CODE

EDIT DESCRIPTION:
Current claim's detail-level dispense-as-written code is EQUAL TO ‘1’

AND

its detail-level co-payment indicator is EQUAL TO ‘N’

METHOD OF CORRECTION:
(note: no correction method given on MMIS system)

JOB: online CICS
PROGRAM: SB710023

Top
ERROR CODE: 655

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-10-04

EDIT NAME:
PLAN LIMITATIONS EXCEEDED

EDIT DESCRIPTION:
A) Current claim’s detail-level quantity dispensed is NOT EQUAL TO zero, its detail-level number of days supply is NOT EQUAL TO zero, its detail-level drug maximum supply is NOT EQUAL TO zero, its detail-level drug maximum days is NOT EQUAL TO zero, its detail-level drug maximum supply is NOT EQUAL TO 99999
   AND
   its daily dosage amount is GREATER THAN the amount currently on file

B1) Current claim is of erectile dysfunction origin
   AND
   its quantity back is GREATER THAN the maximum allowed Viagra amount

B2) Current claim is of erectile dysfunction origin
   AND
   its quantity forward is GREATER THAN the maximum allowed Viagra amount

C) Current claim has no prior error code assigned to it
   AND
   its detail-level prior authorization flag is EQUAL TO ‘4’

METHOD OF CORRECTION:
1. VERIFY INFO WAS INPUT CORRECTLY, CORRECT ANY ERRORS  2. DENY LINE
   YOU MAY ALSO USE "35" IN PLACE OF "B5" (MOST APPROPRIATE)

JOB: PROGRAM:
A) online CICS  SB710023
B) online CICS  SB710024
C) online CICS  SB710025
ERROR CODE: 656

CLAIM TYPE: Drug claims

DATE UPDATED: 05-12-04

EDIT NAME: DRUG PRICED AT ADD $.15/UNIT

EDIT DESCRIPTION: Current claim's detail-level dosage indicator is EQUAL TO ‘4’

AND

it’s priced 15 cents GREATER THAN the generic drug equivalent

METHOD OF CORRECTION: (note: no correction method is given on MMIS system)

JOB: online CICS PROGRAM: SB710023
ERROR CODE: 657

CLAIM TYPE: Drug claims

DATE UPDATED: 05-19-04

EDIT NAME: PROVIDER OVERRIDE OF EARLY REFILL

EDIT DESCRIPTION: Current claim’s prior prescription end date plus eighty days is GREATER THAN the current prescription start date

AND

its prior prescription start date is LESS THAN current prescription end date plus eighty days

AND

its current prescription start date is GREATER THAN OR EQUAL TO 19960601

AND

its prior prescription start date is GREATER THAN OR EQUAL TO 19960601

AND

it has already been given an error ‘615’ (EARLY REFILL < 80% UTILIZED)

METHOD OF CORRECTION: (note: no correction method is given on MMIS system)

JOB: online CICS
PROGRAM: SB710026

Top
ERROR CODE: 658

CLAIM TYPE: All claim types

DATE UPDATED: 05-19-04

EDIT NAME: BIRTH DATE INVALID

EDIT DESCRIPTION: Current claim has an invalid birth date

OR

the claim has birth date that does NOT match the birth date on file for this recipient number

METHOD OF CORRECTION: (note: no correction method is given on MMIS system)

JOB: online CICS
PROGRAM: SB710022

Top
ERROR CODE: 660

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-19-04

EDIT NAME:
DISPENSE FEE POT PAID PREV

EDIT DESCRIPTION:
Current claim shows payment GREATER THAN zero AND payment is already on file

OR

it shows payment GREATER THAN zero AND payment already exists on claim history

METHOD OF CORRECTION:
YOU MAY ALSO USE "RF" IN PLACE OF "HD" (MOST APPROPRIATE)

JOB: online CICS
PROGRAM: SB710026

Top
ERROR CODE: 661

CLAIM TYPE: Drug claims

DATE UPDATED: 05-21-04

EDIT NAME: PROV OVERRIDE OF 1 DISPENSE FEE/MONTH

EDIT DESCRIPTION:
Current claim’s number of dispense fees is GREATER THAN zero

AND

its detail-level point of sale CLAR-CODE is EQUAL TO 5

METHOD OF CORRECTION:
PROVIDER OVERRIDE OF ONE DISPENSING FEE PER MONTH LIMIT - THE PHARMACIST IS INDICATING THAT THE PHYSICIAN HAS DETERMINED A CHANGE IN THERAPY WAS REQUIRED

JOB: online CICS
PROGRAM: SB710026

Top
ERROR CODE:         662

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-23-04

EDIT NAME:
M/I UNIT OF MEASURE

EDIT DESCRIPTION:
Current claim's point of sale version is EQUAL TO '32'

AND

its drug unit quantity is NOT EQUAL TO '1', '2', or '3' OR its detail-level unit of measure is NOT EQUAL TO 'EA', 'ML', or 'GM'

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB:                                                PROGRAM:
online CICS                        SB710023

Top
ERROR CODE:  663

CLAIM TYPE:  All claim types

DATE UPDATED:  05-23-04

EDIT NAME:  M/I DATE OF INJURY

EDIT DESCRIPTION:  Current claim’s detail-level date of injury is NOT EQUAL TO zeros

AND

the detail-level date of injury is an invalid date

METHOD OF CORRECTION:  
(note: no correction method is given on MMIS system)

JOB:  online CICS  PROGRAM:  SB710022

Top
ERROR CODE: 664

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-23-04

EDIT NAME:
PROVIDER BILLED $50 (OR MORE) < ALLOWED

EDIT DESCRIPTION:
The difference of the current claim’s detail-level ledger total minus the professional fee is within $50.00 of the wholesale cost for this specific drug

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: online CICS
PROGRAM: SB710023
ERROR CODE: 665

CLAIM TYPE: Drug claims

DATE UPDATED: 05-23-04

EDIT NAME: PROVIDER BILLED AMOUNT > 10 TIMES ALLOWED

EDIT DESCRIPTION: Current claim’s detail-level ledger total minus the detail-level professional fee is GREATER THAN 10 times the wholesale cost of that same drug

METHOD OF CORRECTION: (note: no correction method is given on MMIS system)

JOB: online CICS PROGRAM: SB710023
ERROR CODE: 666

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-23-04

EDIT NAME:
NUMBER OF CLAIMS AUTHORIZED EXHAUSTED

EDIT DESCRIPTION:
(note: this error code exists but is not currently implemented)

METHOD OF CORRECTION:
CHECK PA AND VERIFY THAT # OF REFILLS HAS BEEN EXCEEDED

JOB: MMIS POS system
PROGRAM: SBPOS039
ERROR CODE:         667

CLAIM TYPE:
Drug claims

DATE UPDATED:
05-24-04

EDIT NAME:
PRESCRIBER DOESN'T MATCH PA

EDIT DESCRIPTION:
Current claim’s prescriber lock-in code is EQUAL TO ‘Y’

AND

its detail-level prescriber ID from point of sale is NOT EQUAL to the prescriber ID from the claim

METHOD OF CORRECTION:
MD ON PA DOESN'T MATCH MD ON PA

JOB:                                                PROGRAM:
CICS online program                SB710025

Top
ERROR CODE: 668

CLAIM TYPE: Drug claims

DATE UPDATED: 05-24-04

EDIT NAME: PHARMACY DOESN'T MATCH PA PHARMACY

EDIT DESCRIPTION:
1) Current claim’s prescriber lock-in indicator is EQUAL TO ‘Y’, its detail-level prescriber ID from the point of sale system is NOT EQUAL TO the claims’ prescriber ID

   AND

   its pharmacy lock-in indicator is EQUAL TO ‘Y’, its detail-level provider number from the point of sale system is NOT EQUAL TO the claim’s pharmacy ID

2) Current claim’s pharmacy lock-in indicator is EQUAL TO ‘Y’, its detail-level provider number from the point of sale system is NOT EQUAL TO the claim’s pharmacy ID

METHOD OF CORRECTION: PHARMACY SUBMITTING CLAIM DOESN'T MATCH PHARMACY SUBMITTING PA

JOB: CICS online program
PROGRAM: SB710025

Top
ERROR CODE: 669

CLAIM TYPE: Drug claims

DATE UPDATED: 05-25-04

EDIT NAME: M/I COMPOUND CODE

EDIT DESCRIPTION: Current claim’s detail-level compound code is NOT EQUAL TO ‘2’ AND its number of detail-level drug occurrences is GREATER THAN 1

METHOD OF CORRECTION: IF BILLING FOR COMPOUND MUST HAVE COMPOUND CODE OF ’2’ IN FIELD 406-D6 IN THE CLAIM SEGMENT

JOB: CICS online program
PROGRAM: SB710022
ERROR CODE: 670

CLAIM TYPE: Drug claims

DATE UPDATED: 05-25-04

EDIT NAME: 5 DAY PA FILL

EDIT DESCRIPTION:
1) Current claim's detail-level prior authorization flag is EQUAL TO '1' or '4'
   AND
   its detail-level number of days supply from the point of sale system is LESS THAN 6
   AND
   its detail-level fill number from the point of sale system is EQUAL TO zero

2) Current claim's bypass units indicator is EQUAL TO 'Y'
   AND
   the number of units used is GREATER THAN the number of units approved
   AND
   its detail-level prior authorization flag is EQUAL TO '1' or '4'
   AND
   its detail-level number of days supply from the point of sale system is LESS THAN 6
   AND
   its detail-level fill number from the point of sale system is EQUAL TO zero

3) Current claim's bypass units indicator is EQUAL TO 'Y'
   AND
   its claim unit limit is GREATER THAN zero
   AND
   its number of units used is GREATER THAN the unit limit
its detail-level prior authorization flag is EQUAL TO ‘1’ or ‘4’

AND

its detail-level number of days supply from the point of sale system is LESS THAN 6

AND

its detail-level fill number from the point of sale system is EQUAL TO zero

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB: CICS online program
PROGRAM: SB710025
ERROR CODE: 700

CLAIM TYPE: MEDICAL, UB82

DATE UPDATED: 6/21/04

EDIT NAME: SEX CODE ERROR PER CRITERIA.

EDIT DESCRIPTION:
A) SB1270 -
If (Provider number greater than '009999' and less than '020000') or
   (Provider number greater than '039999' and less than '050000')
   If claim region is equal to '60'
Or
If (Provider number less than '009999' and greater than '020000') or
   (Provider number less than '039999' and greater than '050000')
   And
If medical claim or UB82 claim
If medical return code is equal to zeros
   If not MCW-BOTH
   And
   If output recipient sex code not equal to input recipient sex code

B) SB710023 -
If (N1500211-DRUG-SEX-CODE is equal to 'F' and
   POSFI-RECIP-SXCD NOT EQUAL TO '2')
Or
(N1500211-DRUG-SEX-CODE EQUAL TO 'M' AND
   POSFI-RECIP-SXCD NOT EQUAL TO '1')

METHOD OF CORRECTION:
Verify the procedure numb and recip id number (recip ssn) have been accurately
transcribed. If all data has been entered correctly, determine whether
procedure may logically be perf on sex indicated. If it is not, RTP for
correction or clarification. If procedure/sex logical combo, override edit
with code "N10" and "42" in field 6.

JOB:  
A) SB1J075, SB1J079
B) ONLINE

PROGRAM:
A) SB1270
B) SB710023

Top
ERROR CODE:         702

CLAIM TYPE:
A) Medical claims
B) Medical claims
C) Medical claims

DATE UPDATED:
06-22-04

EDIT NAME:
RECIPIENT AGE NOT IN CRITICAL RANGE

EDIT DESCRIPTION:
A1) Current medical claim contains a valid procedure code

AND

its recipient’s age is GREATER THAN 3

A2) Current medical claim has a first date of service GREATER THAN 20030531

AND

it contains a valid procedure code

AND

its detail-level performing physician (provider) number is in the range of ‘000079000’ through ‘000079999’

AND

its recipient’s age is GREATER THAN 21

B1) Current claim’s recipient age is LESS THAN the minimum required age OR it’s GREATER THAN the maximum required age

AND

it’s NOT an HCBC elderly disabled claim

C1) Current claim’s drug coverage indicator is EQUAL TO ‘I’

AND

the recipient’s age is LESS THAN the minimum required age OR it’s GREATER THAN the maximum required age
C2) Current claim’s drug coverage indicator is EQUAL TO ‘E’

AND

the recipient’s age is GREATER THAN OR EQUAL TO the minimum required age AND it’s LESS THAN OR EQUAL TO the maximum required age

METHOD OF CORRECTION:

CERIFY CORRECT PROCEDURE CODE AND DATE OF SERV WERE TRANSCRIBED FROM LAIM. IF TWO PROCED CODES EXIST FOR SAME PROCED BUT FOR DIFFERENT AGE ATIENTS AND WRONG PROCED NUMB HAS BEEN USED, PROCED MAY BE CHANGED TO ACCURATELY REFLECT NARRATIVE DESCR OF SVCE AND AGE. VERIFY CORRECT RECIP NUMB WAS USED. INCORRECT AGE MAY HAVE BEEN ACCESSED OFF OF ELIG FILE. IF NO ERROR, DETERMINE WHETHER OR NOT TO PAY PROCED FOR RECIP OF AGE INDICATED. THEN EITHER OVERRIDE EDIT WITH "N10" AND "42 IN FLD 6 OR DENY

JOB: PROGRAM:
A) SB1J040 SB1090
B) SB1J075, SB1J079 SB1270
C) online CICS SB710023

Top
ERROR CODE: 703

CLAIM TYPE: Professional claims

DATE UPDATED: 06-22-04

EDIT NAME: POS NOT CONSISTENT WITH CRIT

EDIT DESCRIPTION: Current claim’s first place of service code is NOT EQUAL TO zeroes

AND

its first place of service code is NOT EQUAL TO the first place of service code on file

AND

its second place of service code is NOT EQUAL TO the second place of service code on file

AND

its third place of service code is NOT EQUAL TO the third place of service code on file

METHOD OF CORRECTION:

VERIFY PROCEDURE NUMBER AND PLACE OF SERVICE WERE ACCURATELY TRACRIBED. IF NOT, CORRECT AND PROCESS CLAIM. IF ALL DATA WAS ENTERED CORRECTLY, DETERMINE WHETHER TO PAY OR DENY THE SERVICE. IF IT SHOULD BE PAID, OVERRIDE THE EDIT WITH OVERRIDE CODE "N10" AND "42" IN FIELD 6 IF PLACE OF SERVICE IS INCORRECT, RTP FOR CORRECT CODE

JOB: SB1J075, SB1J079 PROGRAM: SB1270
ERROR CODE: 704

CLAIM TYPE:
A) Medical claims
B) Medical claims

DATE UPDATED:
06-22-04

EDIT NAME:
PROV TYPE NOT CONSIS W/CRT

EDIT DESCRIPTION:
A) Current medical claim’s first date of service is GREATER THAN 20030531
   AND
   it contains a valid procedure code
   AND
   the performing physician (provider) number is NOT in the range of ‘000079000’ through
   ‘000079999’
B) Current claim’s first provider type code is NOT EQUAL TO zeroes
   AND
   its first provider type code is NOT EQUAL TO the first provider type code on file
   AND
   its second provider type code is NOT EQUAL TO the second provider type code on file
   AND
   its third provider type code is NOT EQUAL TO the third provider type code on file

METHOD OF CORRECTION:
VERIFY PROCEDURE NUMBER WAS ACCURATELY TRANSCRIBED. IF NOT, CORRECT AND PROCESS CLAIM. IF ALL
DATA WAS ENTERED CORRECTLY, CHECK THE PROV'S TYPE FROM MASTER PROVIDER FILE. FROM THIS
DETERMINE IF THERE IS LOGICAL RELATIONSHIP. IF THE PROCED/PROV TYPE IS NOT LOGICAL COMBO, DENY
DETAIL AND PROCESS REST OF CLAIM. IF SERVICE SHOULD BE PAID, OVERRIDE EDIT WITH EOB "N10" AND "42" IN
FIELD 6 CONTACT SUPERVISOR-FILE MAINTENANCE MAY BE REQUIRED.

JOB: PROGRAM:
A) SB1J040 SB1090
B) SB1J075, SB1J079 SB1270

Top
ERROR CODE: 705

CLAIM TYPE:
A) Medical claims
B) Medical claims
C) Medical claims

DATE UPDATED:
06-22-04

EDIT NAME:
PROV NOT CONSIS W/PHARM CLAIM

EDIT DESCRIPTION:
A1) Current medical claim contains a detail-level procedure code in the range of ‘90801’ through ‘90899’ AND the provider specialty code on file is NOT ‘26’, or ‘62’

OR

it’s a medical claim containing a detail-level type of service code EQUAL TO ‘A’ AND the provider specialty code on file is NOT ‘5’

AND

it’s NOT of HMO encounter region (region 49)

A2) Current medical claim contains a detail-level procedure code EQUAL TO 0121

AND

it’s NOT of HMO encounter region (region 49)

A3) Current medical claim of HMO encounter region (region 49)

AND

detail-level type of service code EQUAL TO ‘A’

B1) Current claim’s first detail-level specialty code is NOT EQUAL to what is on file for this recipient

AND

its second detail-level specialty code is NOT EQUAL to what is on file for this recipient

AND

its third detail-level specialty code is NOT EQUAL to what is on file for this recipient

AND

it’s NOT of HMO encounter region (region 49)
B2) Current claim’s first detail-level specialty code is NOT EQUAL to what is on file for this recipient AND is NOT EQUAL TO zeroes

AND

its second detail-level specialty code is NOT EQUAL to what is on file for this recipient

AND

its third detail-level specialty code is NOT EQUAL to what is on file for this recipient

AND

it’s NOT of HMO encounter region (region 49)

C) Current claim has a provider type of service code that is NOT EQUAL TO ‘20’, ‘24’, ‘30’, ‘31’, ‘40’, ‘56’, ‘65’ or ‘67’

METHOD OF CORRECTION:

YOU MAY ALSO USE "05" IN PLACE OF "E9" (MOST APPROPRIATE). YOU MAY ALSO USE "B6" IN PLACE OF "52" (MOST APPROPRIATE)

JOB: PROGRAM:
A) SB1J050 SB1130
B) SB1J075, SB1J079 SB1270
C) online CICS SB710022

Top
ERROR CODE: 706

CLAIM TYPE:
Medical claims

DATE UPDATED:
06-22-04

EDIT NAME:
DIAG NOT CONSISTEN W/CRIT

EDIT DESCRIPTION:
1) Current claim’s first diagnosis code is NOT EQUAL TO spaces
   AND
   its first diagnosis code is NOT in the range of allowed diagnosis codes
2) Current claim’s second diagnosis code is NOT EQUAL TO spaces
   AND
   its second diagnosis code is NOT in the range of allowed diagnosis codes

METHOD OF CORRECTION:
VERIFY THAT PROCEDURE AND ICDA DIAGNOSIS CODE WERE TRANSCRIBED CORRECTLY AND THAT DIAGNOSIS IS
CORRECTLY REFERENCED. IF NO ERROR HAS BEEN MADE, DETERMINE WHETHER THE PROCEDURE SHOULD HAVE
BEEN PERFORMED. A MEDICAL CONSULTANT’S ADVICE MAY BE REQUIRED. IF IT WAS MEDICALLY NECESSARY,
OVERRIDE WITH EOB "N10" AND "42 IN FIELD 6 IF IT WAS NOT NECESSARY, DENY

JOB: SB1J075, SB1J079
PROGRAM: SB1270

Top
ERROR CODE: 707

CLAIM TYPE: ?

DATE UPDATED: 06-22-04

EDIT NAME: DIAG NOT CONSIS W/ PROV TYPE

EDIT DESCRIPTION: (note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION: (note: no correction method is given on the MMIS system)

JOB: PROGRAM:
A) SB1J050 SB1130
B) point of sale system SBPOS039
ERROR CODE:  709

CLAIM TYPE:  
?

DATE UPDATED:  
06-22-04

EDIT NAME:  
SUSPEND FOR MEDICAL REVIEW OF ER SVS

EDIT DESCRIPTION:  
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:  
ALL CLAIMS THAT SUSPEND FOR THIS AUDIT ARE REFERRED TO MEDICAL CONSULTANT FOR REVIEW. IF APPROVED BY CONSULTANT, FORCE PAY LINE 'H' AT BILLED AMOUNT WITH EOB 098. IF MEDICAL CONS DOES NOT APPROVE, PAY LINE 'H' IN ACCORDANCE WITH FEE FOR CPT IV CODE INDICATED BY CONSULTANT. THIS IS ACCOMPLISHED BY ENTERING DIFFERENCE BETWEEN BILLED AMT AND ALLOWED AMT IN NON-COVERED BLOCK. FORCE PAY AT ALLOWED AMT

JOB:  
point of sale system

PROGRAM:  
SBPOS039
ERROR CODE: 711

CLAIM TYPE: Medical claims

DATE UPDATED: 06-22-04

EDIT NAME: SERVICES WITHIN 2 YEARS

EDIT DESCRIPTION:
1) Current claim’s prior authorization control number is EQUAL TO spaces

   AND

   the recipient’s age is GREATER THAN 20

   AND

   its detail-level first procedure service date is GREATER THAN 19970831

   AND

   it contains a valid code for its second procedure code

2) Current claim’s detail-level diagnosis code is in the range of ‘3670’ through ‘36799’ OR its detail-level diagnosis code is EQUAL TO ‘V720’

   AND

   it contains a valid code for its second procedure code


   AND

   its detail-level extra diagnosis code is in the range of ‘3670’ through ‘36799’

   OR

   its detail-level extra diagnosis code is EQUAL TO ‘V720’

METHOD OF CORRECTION:

A WORKSHEET SHOULD BE RECEIVED INDICATING WHAT SERVICE PERFORMED WITHIN THE LAST 2 YEARS. THE AUDITOR SHOULD REVIEW THE HISTORY TO DETERMINE IF THE SERVICE IS PAYABLE OR NOT. IF THE CLAIM INDICATES NECESSITY FOR VISIT, CONSULT WITH SUPERVISOR FOR PAYMENT. IF NOT, DENY

JOB:  
PROGRAM:  

04/04/06
ERROR CODE:    712

CLAIM TYPE:  
?

DATE UPDATED:  
06-22-04

EDIT NAME:  
MORE THAN 1 SERVICE PER DAY

EDIT DESCRIPTION:  
(note: this error exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:  
WORKSHEET SHOULD BE RECEIVED, THAT WILL INDICATE IF THERE WAS MORE THAN ONE SERVICE IN A DAY. IF IT IS AN EXACT DUPLICATE, DENY WITH AN 010, IF THERE WAS MORE THAN ONE SERVICE IN A DAY, DENY. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6.

JOB:  
point of sale system

PROGRAM:  
SBPOS039

Top
ERROR CODE: 713

CLAIM TYPE: ?

DATE UPDATED: 06-22-04

EDIT NAME: MAT CARE LIMIT 1 PER 275 DAYS

EDIT DESCRIPTION: (note: this error exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. OBTAIN RECIPIENT HISTORY AND CHECK FOR ACCURACY OF BILLING. REVIEW PROCEDURE CODES WITH PROVIDER.

JOB: point of sale system
PROGRAM: SBPOS039
ERROR CODE:  714

CLAIM TYPE:

DATE UPDATED:  6/23/04

EDIT NAME:  ONE ROUTINE NURSING HOME VISIT

EDIT DESCRIPTION:  ON MEDICAL CRITERIA FILE.  SB1270 PROGRAM.

METHOD OF CORRECTION:
REVIEW HISTORY PROVIDED BY A SYSTEM PRINT-OUT (UNLESS ALL CLAIMS ARE
BILLED ON THE SUSPENDED AUTH). FOR THIS AUDIT, SYSTEM CHECKS EXACTLY 30 DAYS. HOWEVER, SOME
INSTANCES THE TIME BETWEEN MAY BE A FEW DAYS LESS THAN 30 DAYS BUT STILL REGARDED AS MONTHLY
VISIT DEPENDING ON PHYSICIANS SCHEDULE. IF THIS APPEARS TO BE THE CASE, OVERRIDE THE AUDIT.
OTHERWISE REFER TO MEDICAL CONS FOR HIS/HER REVIEW. IN ACCORDANCE WITH REVIEW, OVERRIDE AND PAY,
RTP FOR MORE INFO OR DENY

JOB:  SB1J075                                          PROGRAM:  SB1270
ERROR CODE: 715

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: ONE LIMIT 1 TELEPHONIC ANAL/MONTH

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION: VERIFY TRANSCRIPTION AND HISTORY OF WORKSHEET. RETURN TO PROVIDER FOR EXPLANATION. REFER EXPLANATION WHEN RECEIVED TO MEDICAL CONSULTANT AND PROCESS IN ACCORDANCE WITH HIS/HER ADVISEMENT.

JOB: SB1J075            PROGRAM: SB1270
ERROR CODE: 716

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: ONE LIMIT 1 HOSP ADMIT CHARGE/DAY

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
REVIEW FOR APPROPRIATENESS OF CHARGE. IF INVESTIGATION INDICATES RECIPIENT ADMITTED AND THEN TRANSFERRED TO A SECOND HOSPITAL, ADMISSION FEE TO THE FIRST HOSPITAL SHOULD BE PAID. HOWEVER, ONLY ONE FEE ALLOWABLE PER ADMISSION FOR SAME HOSPITAL. DENY SECOND ADMISSION FEE WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE:  717

DATE UPDATED:  6/23/04

EDIT NAME:  ONE HOSP CARE & OV INCLUD SURG FEE

EDIT DESCRIPTION:  ON MEDICAL CRITERIA FILE.  SB1270 PROGRAM.

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. REFER TO MEDICAL CONSULTANT FOR DECISION. FILE
UPDATE FOR MINOR PROCEDURE MAY BE INDICATED. OTHERWISE, PROCESS IN ACCORDANCE WITH DECISION OF
MEDICAL CONSULTANT.
WHEN USING REMARK CODE "M144" YOU MUST ENTER CLAIM ADJUSTMENT REASON "97" IN FIELD 6
JOB:  SB1J075                                           PROGRAM:  SB1270
ERROR CODE: 719

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: ANES SERV INCLUDED EXTRACT FEE

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
IN THIS CASE THE LINE WITH THE EXTRACTION FEE WILL SUSPEND. DENY ANY ANESTHESIA CHARGE

JOB: SB1J075 PROGRAM: SB1270

Top
ERROR CODE: 720

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: MAXIMUM MODALITIES

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION. CHECK BILLING. IF A QUESTION, RTP TO CLARIFY INTENT OF PROVIDER. IF 01452 BILLED IN ADDITION TO THE OTHER CODES, DENY OTHER CODES AS PROCEDURES CODE 01452 INCLUDES MAXIMUM MODALITIES PAYABLE PER DAY FOR PHYSICAL THERAPISTS.

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE: 721

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: ONE PERIAPICAL/DATE OF SERVICE

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
IF MORE THAN ONE FIRST FILM PERIAPICAL IN A DAY, DENY ANY ADDITIONAL SERVICE OR SERVICES. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B5" IN FIELD 6

JOB: SB1J075                      PROGRAM: SB1270
ERROR CODE: 722

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: 5 ADDITIONAL PERIAPICALS/DATE

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
CHECK TRANSCRIPTION. IF ALL CORRECT, CHECK NUMBER OF ADDITIONAL PERIAPICAL FILMS BILLED. DENY ANY CHARGES FOR ADDITIONAL FILMS OVER 5

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE: 723

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: ONE FIRST EXTRA ORAL/DATE

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
IF PROVIDER BILLS FOR MORE THAN ONE 'FIRST' EXTRA ORAL FILM PER DAY,
DENY ADDITIONAL CHARGES. WHEN USING REMARK CODE "M63" YOU MUST ENTER CLAIM ADJUSTMENT REASON
"B5" IN FIELD 6

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE: 724

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: 3 ADDITION EXTRA ORAL/DATE

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:
REVIEW TRANSCRIPTION. IF PROVIDER HAS BILLED FOR MORE THAN 4 EXTRA ORAL FILMS PER DAY (1-00250 AND 3-00260) DENY

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE:  725

CLAIM TYPE:  PAYABLE, PROFESSIONAL, CROSSOVER

DATE UPDATED:  6/22/04

EDIT NAME:   INVALID CD FOR CHIRO SERVICES

EDIT DESCRIPTION:
IF CLMT-PAYABLE-CLAIM
AND
IF NOT A DENIED CLAIM
AND
IF (PROFESSIONAL CLAIM
AND NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO A '983'
OR CROSSOVER CLAIM
AND
IF (PROVIDER TYPE CODE IS EQUAL TO '26') AND (PROVIDER SPECIALTY CODE IS EQUAL TO '35')
AND
  IF PCLIST-2ND-PROC-SW NOT EQUAL TO 'Y'
  OR PCLIST-FOUND-PROC-SW NOT EQUAL TO 'Y'
  OR (PROCEDURE CODE NOT GREATER THAN '09990' AND NOT LESS THAN '09994')
  IF CLAIM REGION IS NOT EQUAL TO 40
  AND AN ADJUSTMENT CLAIM

METHOD OF CORRECTION:
REVIEW TRANSCRIPTION. OTHERWISE, DENY
YOU MAY ALSO USE "B7" IN PLACE OF "96" (MOST APPROPRIATE)

JOB:   SB1J050                                               PROGRAM:  SB1130
ERROR CODE:  726

CLAIM TYPE:  
?

DATE UPDATED:  
06-22-04

EDIT NAME:  
NEWBORN CASE, LIMIT 1/365 DAYS S

EDIT DESCRIPTION:  
(note: this error exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:  
CHECK TRANSCRIPTION. OTHERWISE, DENY MORE THAN ONE CHARGE FOR THIS SERVICE. IF A QUESTION, REFER TO SUPERVISOR.

JOB:  
point of sale system

PROGRAM:  
SBPOS039

Top
ERROR CODE: 727

CLAIM TYPE:
?

DATE UPDATED:
06-22-04

EDIT NAME:
MAX OF $100 PAYABLE IN 275 DAY

EDIT DESCRIPTION:
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:

REVIEW TRANSCRIPTION. REVIEW HISTORY RECEIVED OR WORKSHEET WITH CLAIM. HISTORY MAY USE DUPLICATE BILLINGS IN SOME CLAIMS WERE RETURNED TO PROVIDER. IF A CAREFUL REVIEW INDICATES MORE THAN $100 BILLED AND/OR PAID, DENY SERVICES OVER THE $100 AMOUNT. NOTE: THIS EDIT APPLIES ON PHYS. SERVICES AND DOES NOT INCLUDE ANY LAB OR XRAY CHARGES. A MEDICAL NECESSITY MAY BE INDICATED. IN THAT CASE, REFER TO MEDICAL CONS. AND ADJUDICATE IN ACCORDANCE WITH HIS/HER DECISION.

JOB: SB1J075, SB1J079
PROGRAM: SB1270

point of sale system: SBPOS039
ERROR CODE:    728

CLAIM TYPE:    

DATE UPDATED:  06-22-04

EDIT NAME:     LIFETIME SERVICE PER PROVIDER

EDIT DESCRIPTION:  
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:
(note: no correction method is given on MMIS system)

JOB:    PROGRAM:
point of sale system    SBPOS039

Top
ERROR CODE: 729

CLAIM TYPE: 
?

DATE UPDATED: 
06-22-04

EDIT NAME: 
LIMIT 1 ANNUAL EXAM PER YEAR

EDIT DESCRIPTION: 
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION: 
REVIEW INFO ON WORKSHEET. IN AN 'ANNUAL' EXAMINATION HAS ALREADY BEEN PROVIDED BY SAME DOCTOR OR A DOCTOR WITHIN THE SAME CLINIC IN THE PAST 365 DAYS, DENY. ENTER INFO CONCERNING PAYMENT OF FIRST CLAIM ON DENIED CLAIM FOR FUTURE REFERENCE.

JOB: 
point of sale system

PROGRAM: 
SBPOS039
ERROR CODE: 730

CLAIM TYPE: 
?

DATE UPDATED:
06-22-04

EDIT NAME:
MORE THAN 1 SURG PROC PER DAY

EDIT DESCRIPTION:
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:

IF QUANTITY GREATER THAN 1 LISTED IN COLUMN 15, CHECK TO ASCERTAIN IF MORE THAN 1 UNIT IS INDICATED. IF NOT, CHANGE QUANTITY TO 1. IF MORE THAN ONE SURGICAL PROCEDURE ITEMIZED, REFER TO SUPERVISOR FOR REVIEW WITH MEDICAL CONSULTANT. FORCE PAY OR DENY IN ACCORDANCE WITH MEDICAL CONS.'S DECISION.

JOB: online point of sale
PROGRAM: SBPOS039
ERROR CODE: 731

CLAIM TYPE: 
?

DATE UPDATED:
06-22-04

EDIT NAME:
LIMIT MODALITY 18 PER 45 DAYS

EDIT DESCRIPTION:
(note: this error code exists but is not currently implemented in claim processing)

METHOD OF CORRECTION:

REVIEW WITH MEDICAL CONSULTANT. MEDICAL CONS. OR SUPERVISOR MAY NEED TO CONTACT REFERRING PHYSICIAN FOR RECOMMENDATIONS AND EXPECTATIONS. ADJUDICATE PER MEDICAL CONSULTANT'S DECISION.

JOB: point of sale system

PROGRAM: SBPOS039

Top
ERROR CODE: 732

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: LIMIT MODALITY 18 PER 45 DAYS

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION:

    JOB: SB1J075    PROGRAM: SB1270
ERROR CODE:  733

CLAIM TYPE:

DATE UPDATED:  6/23/04

EDIT NAME:  LIMIT MODALITY 18 PER 45 DAYS

EDIT DESCRIPTION:  ON MEDICAL CRITERIA FILE.  SB1270 PROGRAM.

METHOD OF CORRECTION:  NOTHING LISTED ON MMIS

            JOB:  SB1J075                        PROGRAM:  SB1270
ERROR CODE: 734

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: LIMIT MODALITY 18 PER 45 DAYS

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION: NOTHING LISTED ON MMIS

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE: 735

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: LIMIT MODALITY 18 PER 45 DAYS

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION: NOTHING LISTED ON MMIS

JOB: SB1J075 PROGRAM: SB1270
ERROR CODE:  736

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: LIMIT MODALITY 18 PER 45 DAYS

EDIT DESCRIPTION: ON MEDICAL CRITERIA FILE. SB1270 PROGRAM.

METHOD OF CORRECTION: NOTHING LISTED ON MMIS

JOB: SB1J075    PROGRAM: SB1270
ERROR CODE: 737

CLAIM TYPE: Medical claims

DATE UPDATED: 06-22-04

EDIT NAME: BILL + ACCUM PD > CONTRACT AMT

EDIT DESCRIPTION:
1) Current claim has a detail-level service code EQUAL TO ‘E’ AND its current number of units billed is GREATER THAN the allowed amount of units
2) Current claim has a detail-level service code EQUAL TO ‘F’ AND its current number of units billed is GREATER THAN the allowed amount of units
3) Current claim’s dates of service are valid AND the SUM of prior billing and the current billing is GREATER THAN the contract amount on file

METHOD OF CORRECTION:
REFER TO DEVELOPMENTAL DISABILITIES UNIT FOR INFO. ADJUDICATE PER THEIR DECISION. (CHANGE BILLED AMT TO AN AMT WHICH WILL EQUAL CONTRACT AMT WHEN ADDED TO ACCUMULATED AMT ON THE FAMILY SUBSIDY CONTRACT FILE. ENTER EOB CODE 366 IN FIELD 06 AT HEADER LEVEL)

JOB: SB1J040 PROGRAM: SB1090

Top
ERROR CODE: 738

CLAIM TYPE: Medical claims

DATE UPDATED: 06-22-04

EDIT NAME: NO CONTRACT AMT FOT DTE OF SVS

EDIT DESCRIPTION:
1) Current claim has a detail-level service code EQUAL TO ‘E’, ‘F’ OR its detail-level first procedure service date is GREATER THAN 19990630 with a detail-level service code EQUAL TO ‘J’ or ‘G’

   AND

   its recipient ID number is NOT EQUAL TO the previous claim’s recipient ID number

   AND

   its recipient ID number is not found on TECS (SB515020)

2) Current claim’s recipient ID number is EQUAL TO the previous claim’s recipient ID number with a detail-level service code EQUAL TO ‘E’, ‘F’, ‘J’ or ‘G’

   AND

   its service date is outside of the range of dates on file for this current recipient/claim

3) No contract data is on file (SS880010 – Adabas #189) for current claim

   AND

   the current claim’s client number is NOT found on the DB2 table CLIENT_XREF_ID

4) Current claim’s service date is outside of the range of dates on file for this current recipient/claim

METHOD OF CORRECTION:

ACCESS FOR FAMILY SUBSIDY CONTRACT FILE. IF CLAIM IS VALID, RECYCLE. IF NO CONTRACT EXISTS, DENY. WHEN USING REMARK CODE "N30" YOU MUST ENTER CLAIM ADJUSTMENT REASON "B7" IN FIELD 6

JOB: SB1J040
PROGRAM: SB1090

Top
ERROR CODE:  739

CLAIM TYPE:  ALL

DATE UPDATED:  6/22/04

EDIT NAME: DD SERV > MAX OF 1 DETAIL LINE

EDIT DESCRIPTION:
IF CLAIM IS NOT TECS ELIGIBLE
AND NOT REGULAR CLAIM
  IF NOT INSTITUTIONAL CLAIM OR NOT UB82 INPATIENT CLAIM
    IF CLMT-DSCH-DEST IS NOT EQUAL TO '2'
  OR
    IF L-ELIG-INDEX GREATER THAN =0
      IF STOPPING DATE IS EQUAL TO 0
        AND IF THE SPECIALTY PROCEDURE CODE FLAG IS EQUAL TO '1'
      OR
        IF STOPPING DATE IS NOT EQUAL TO 0
          IF THE SPECIALTY PROCEDURE CODE FLAG IS EQUAL TO '1'
  AND
  IF REGION '90' OR
    (PROVIDER NUMBER IS NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999')
    IF (PROVIDER NUMBER NOT EQUAL TO '000035432' AND NOT EQUAL TO '000035434'
      AND NOT EQUAL TO '000035201')
      IF VALID RECORD ON THE SB644010 FILE
  AND
  IF SERVICE CODE IS EQUAL TO 'D'
    IF SERV-CDE-D = 'Y'
  OR
    IF SERVICE CODE IS EQUAL TO 'U'
      IF SERV-CDE-U = 'Y'

METHOD OF CORRECTION:
CHECK TURNAROUND DOCUMENT. IF COMPLETED CORRECTLY, DELETE ANY LINE OTHER THAN LINE ONE. TOTAL CHARGE AND NET CHARGE MUST EQUAL BILLED AMOUNT-LINE ONE.
ERROR CODE: 747

CLAIM TYPE: PROFESSIONAL

DATE UPDATED: 6/23/04

EDIT NAME: FSS BILLED UNITS EXCEED ACCUM PAID

EDIT DESCRIPTION:

A)
IF NOT TECS ELIGIBLE
AND NOT REGULAR CLAIM
IF NOT INSTITUTIONAL CLAIM OR UB82 INPATIENT CLAIM
    IF DSCH-DEST IS NOT EQUAL TO '2'
OR
IF L-ELIG-INDEX GREATER THAN +0
    IF STOPPING DATE IS EQUAL TO 0
        IF SPECIALTY PROCEDURE CODE FLAG IS EQUAL TO 'I'
    OR
    IF STOPPING DATE IS NOT EQUAL TO 0
        IF SPECIALTY PROCEDURE CODE FLAG IS EQUAL TO 'I'
AND
    IF CLAIM REGION IS EQUAL TO '90' OR
        (PROVIDER NUMBER IS NOT LESS THAN '000035000' AND NOT GREATER THAN  '000037999')
    IF (PROVIDER NUMBER NOT EQUAL TO '000035432' AND NOT EQUAL TO '000035434'
        AND NOT EQUAL TO '000035201')
    IF VALID RECORD ON SB644010
AND
IF DT-FD-SW IS EQUAL TO 'Y' AND SB515020-SW IS EQUAL TO 'Y' AND PERIOD-SW IS EQUAL TO 'Y'
    IF SERVICE CODE IS EQUAL TO 'G'
    AND 1ST PROCEDURE SERVICE DATE GREATER THAN 19990630
    IF WK-DD-UNITS-7 GREATER THAN WS-SB51-HRS
OR
    IF SERVICE CODE IS EQUAL TO 'J'
    AND 1ST PROCEDURE SERVICE DATE IS GREATER THAN 19990630
    IF WK-DD-UNITS-8 GREATER THAN WS-SB51-HRS

B)
IF CLAIM STATUS CODE IS EQUAL TO 'M'
IF PROFESSIONAL CLAIM
IF REMB-SWITCH EQUAL TO SPACE
IF INDX-1 GREATER THAN WORK-LINES
IF REGION '90' AND
    (PRICING INDICATOR IS NOT EQUAL TO '8')
    IF UPDAT-ADA-CNT GREATER THAN ET-ADA-CNT-NUM
OR
    IF WORK-CLAIM-CREDIT
OR
    IF NOT CREDIT CLAIM
    IF (SERVICE CODE EQUAL TO 'E' OR 'F' OR 'J')
        OR (SERVICE CODE EQUAL TO 'G'
            AND 1ST PROCEDURE SERVICE DATE GREATER THAN 19990630)
    IF UPDAT-SB51-CNT GREATER THAN ET-SB515020-UPD-CNT
AND
IF SERVICE CODE NOT EQUAL TO 'E' OR 'F'
METHOD OF CORRECTION: REFER TO DD UNIT

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</table>
ERROR CODE: 748

CLAIM TYPE:

DATE UPDATED: 6/23/04

EDIT NAME: NO ENTRY LISTED ON MMIS

EDIT DESCRIPTION:
IF PAYABLE CLAIM
AND
IF NOT A DENIED CLAIM
AND
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO '983'
AND ((1ST DAY OF SERVICE NOT LESS THAN PROVIDER CURRENT EFFECTIVE DATE
  AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0)
OR
  (REVENUE CODE IS EQUAL TO '521' OR '522' AND 1ST DAY OF SERVICE GREATER THAN 20011231
AND (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
  (1ST DAY OF SERVICE NOT LESS THAN PROVIDER CURRENT EFFECTIVE DATE
  AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL TO '521' OR '522'))
AND
IF TOOTH-EXT-SW EQUAL TO 'Y' AND LOCAL-ANEST-SW EQUAL TO 'Y'
AND
IF LOCAL-ANEST-DTL-LN(SUB-LN) GREATER THAN ZERO
AND ANEST-SVDT(SUB-LN) EQUAL TO TOOTH-SVDT(SUB-TO)

METHOD OF CORRECTION: NO ENTRY LISTED ON MMIS

JOB: SB1J050                   PROGRAM: SB1130
ERROR CODE: 875

CLAIM TYPE: Payable claims

DATE UPDATED: 06/11/04

EDIT NAME: RECIP SEX CODE NOT CONS W/CRIT

EDIT DESCRIPTION: Current claim's recipient sex code is NOT EQUAL TO the sex code on file for the very same recipient

METHOD OF CORRECTION: VERIFY THE PROCEDURE NUMBER AND RECIPIENT ID NUMBER (RECIP SSN) HAVE BEEN ACCURATELY TRANSCRIBED FOR THE CLAIM. IF ALL DATA HAS BEEN ENTERED CORRECTLY, DETERMINE WHETHER PROCEDURE MAY LOGICALLY BE PERFORMED AND PROCESS REST OF CLAIM. IF PROCEDURE/SEX IS A LOGICAL COMBO, OVERRIDE EDIT WITH EOB "N10" AND "42" IN FIELD 6

JOB: SB1J075, SB1J079 PROGRAM: SB1270
ERROR CODE:  877

CLAIM TYPE:  Nursing Home (N), UB82 Inpatient (U), UB82 Outpatient (Q), Inpatient (I)

DATE LAST UPDATED:  04/02/2003

EDIT NAME:  PRIOR AUTH REQ BUT NOT PRESENT

EDIT DESCRIPTION:

For claim type ‘I’ (Institutional claims):

If claim has no Audit Errors (400+ error code)
   Sets up a key to read the Institutional Criteria file
   provider type code 02 – mental hospital
   diagnosis code 1 from claim
   if found on the Institutional Criteria file
      and record found says diagnosis requires PA
      and the PA number from the claims is spaces
      set 877 error
   if not found
      set up key to read the Institutional Criteria file
      provider type code 01 - general hospital
      diagnosis code 1 from claim
      if found on the Institutional Criteria file
      and record found says diagnosis requires PA
      and the PA number from the claims is spaces
      set 877 error

Claim type ‘U’ (UB82 Inpatient claim):

If claim has no Audit Errors (400+ error code)
   Sets up a key to read the Institutional Criteria file
   provider type code 02 – mental hospital
   diagnosis code 1 from claim
   if found on the Institutional Criteria file
      and record found says diagnosis requires PA
      and the PA number from the claims is spaces
      set 877 error
   if not found
      set up key to read the Institutional Criteria file
      provider type code 01 - general hospital
      diagnosis code 1 from claim
      if found on the Institutional Criteria file
      and record found says diagnosis requires PA
      and the PA number from the claims is spaces
      set 877 error

Claim type ‘Q’ (UB82 Outpatient claim):
If claim has no Audit Errors (400+ error code)

Sets up a key to read the Institutional Criteria file

provider type code 03 – General Hospital and Nursing Facility (ECF)
diagnosis code 1 from claim
if found on the Institutional Criteria file
and record found says diagnosis requires PA
and the PA number from the claims is spaces
set 877 error
if not found
set key to read the Institutional Criteria file
provider type code 01 - General Hospital
diagnosis code 1 from claim
if found on the Institutional Criteria file
and record found says diagnosis requires PA
and the PA number from the claims is spaces
set 877 error

Claim type ‘N’ (Nursing Home Claim):

If claim has no Audit Errors (400+ error code)

Sets up a key to read the Institutional Criteria file

provider type code 04 – TB Hospital
diagnosis code 1 from claim
if found on the Institutional Criteria file
and record found says diagnosis requires PA
and the PA number from the claims is spaces
set 877 error
if not found
set key to read the Institutional Criteria file
provider type code 01 - General Hospital
diagnosis code 1 from claim
if found on the Institutional Criteria file
and record found says diagnosis requires PA
and the PA number from the claims is spaces
set 877 error

METHOD OF CORRECTION:

JOB: PROGRAM:

Top
ERROR CODE: 878

CLAIM TYPE:
A) Inpatient claims
B) Inpatient claims

DATE UPDATED:
06/11/04

EDIT NAME:
LENGTH STAY CRITERIA NOT MET

EDIT DESCRIPTION:
A) Current non-adjustment, UB82 inpatient claim has an admission date GREATER THAN 19950630

        AND

        its VR provider number is NOT ‘002433’, ‘001086’, ‘001793’ or ‘001479’

        AND

        its admission date is NOT EQUAL to the billing from date AND its provider type code is NOT EQUAL TO ‘02’, ‘04’ or ‘06’

        AND its DRG code is EQUAL TO zero AND the recipient’s age is GREATER THAN 20

B1) Current claim’s total days is NOT GREATER THAN the required minimum length of stay

B2) Current claim’s total days is LESS THAN the required maximum length of stay

METHOD OF CORRECTION:
VERIFY TRANSCRIPTION OF EACH DATE. CHECK HOSPITAL TYPE AGAINST NUMBER OF DAYS BILLED. CHECK ADMIT DATE IF OTHER CLAIMS HAVE BILLED OVER THE LIMIT. DENY CLAIMS IF CRITERIA NOT MET. WHEN USING REMARK CODE "MA31" YOU MUST ENTER CLAIM ADJUSTMENT REASON "125" IN FIELD 6.

JOB: PROGRAM:
A) SB1J050           SB1130
B) SB1J075, SB1J079    SB1270

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ERROR CODE: 999

CLAIM TYPE:
A) All claims
B) All claims
C) All claims

DATE UPDATED:
06/11/04

EDIT NAME:
MAX CLAIMS THIS RECIP EXCEEDED

EDIT DESCRIPTION:
A1) Current professional claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
A2) Current inpatient claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50

OR
its inpatient claim detail line count for a specific recipient is GREATER THAN 1500

A3) Current drug claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
A4) Current screening claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 20
A5) Current nursing home claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50

OR
its nursing home claim detail line count for a specific recipient is GREATER THAN 1500

A6) Current crossover claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
A7) Current UB82 claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
    OR
    its UB82 claim detail line count for a specific recipient is GREATER THAN 1500

B1) Current professional claim detail line count for a specific recipient is GREATER THAN 1500
    OR
    its professional claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50

B2) Current inpatient claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
    OR
    its inpatient claim detail line count for a specific recipient is GREATER THAN 1500

B3) Current UB82 claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
    OR
    its UB82 claim detail line count for a specific recipient is GREATER THAN 1500

B4) Current nursing home claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50
    OR
    its nursing home claim detail line count for a specific recipient is GREATER THAN 1500

B5) Current crossover claim count for a specific recipient is EQUAL TO the maximum allowed claim count of 50

C) The online CICS point of sale programs utilize this error code as a Miscellaneous Error. Their processing doesn’t exactly pertain to a maximum number of claims for a given recipient as the ‘EDIT NAME’ above suggests.

METHOD OF CORRECTION:
SUBMIT A RECYCLE TRANSACTION PF9, UNLESS THERE ARE OTHER ERRORS. THEN WORK THOSE TRANSACTIONS AND PF12.

JOB:                                                PROGRAM:
A) SB1J075, SB1J079                SB1250
B) SB1J075, SB1J079                SB1270
C) online CICS                        SB710021, SB710022, SB710023, SB710025, SB710041
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EXPLANATION OF BENEFITS (EOB) CODE: 003

MESSAGE TEXT: CO-PAYMENT AMOUNT

SOURCE CODE: “P” = PATIENT RESPONSIBILITY

DATE CREATED: 11/21/02

PROGRAM(s): SB1335 JOB(s): SB1J085

SITUATION:

IF NOT DATE RECORD
IF NOT DRUG DIAG RECORD
IF NOT ICN FILE DELETE
IF (RECORD CODE IS NOT EQUAL TO 'C' OR 'V')
   OR (TRANSACTION TYPE NOT EQUAL TO '8' OR '0')
   OR ((ACTION CODE NOT EQUAL TO 'C' OR 'V' OR 'W' OR 'Y')
      AND (TRANS CODE NOT EQUAL TO '00' OR '04' OR '06'
         OR '20' OR '22' OR '24' OR '26'
         OR '30' OR '32' OR '34' OR '36'
         OR '40' OR '41' OR '50' OR '70'
         OR '72' OR '74'))

AND
IF CLAIM REGION EQUAL TO 90
AND
IF (REGULAR-CLAIM
   OR ADJUSTMENT CLAIM)
   AND NOT DENIED CLAIM
AND
IF DD-COPAY-SW = 'Y'
IF A094-SW = 'Y'
OR B094-SW = 'Y'
IF SR-AMOUNT-REMAINING GREATER THAN 0
OR
IF WS-AMOUNT-REMAINING NOT = 0
EXPLANATION OF BENEFITS (EOB) CODE: 004

MESSAGE TEXT:
THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1070 JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO ’2’ OR ’4’ OR ’5’
AND
IF ENTRX-CD1 = ’I’ OR ’O’ OR ’N’ OR ’M’ OR ’S’ OR ’L’ OR ’X’ OR ’A’ OR ’Q’ OR ’R’ OR ’U’
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO ’Z’ OR ’ ’
OR
(IF CORRECTION ID EQUAL TO ’R’
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO ’Y’
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO ’MAS’)
    IF WK-DAYS EQUAL TO 1
    OR
    IF DAYO-TYPE-OF-CYCLE EQUAL TO ’Y’ AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO ’D’
AND
    IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
    OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
    IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
    OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’ AND
    PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
    IF MEDICAL CLAIM OR DENTAL CLAIM OR XOVR MEDICAL
    IF NOT VALID-MODIFIER OR
        (DETAIL XTRA MODIFIER NOT EQUAL TO ’XV’ AND
         1ST PROCEDURE SERVICE DATE GREATER THAN 20040501 )
    AND
        IF CLAIM REGION EQUAL TO 40
        AND NOT ADJUSTMENT CLAIM
OR
    IF MEDICAL CLAIM OR DENTAL CLAIM OR XOVR MEDICAL
    IF NOT VALID MODIFIER OR (MODIFIER NOT EQUAL TO ’XV’ AND
1ST PROCEDURE SERVICE DATE GREATER THAN 20040501 )
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: 006

MESSAGE TEXT:
THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE.

SOURCE CODE: “C” = Contractual Obligation

DATE CREATED: 11/21/2002

PROGRAM(s): SB1090  JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM WITH A VALID RECIPIENT ID NUMBER ON FILE

AND

(IF CURRENT CLAIM HAS ALREADY BEEN ASSIGNED AN ERROR CODE OR
REC-NAME-SAVE-1 = REC-NAME-SAVE-2 OR
(RECIPIENT’S EIGHTH AND NINETH POSITIONS OF THE ID NUMBER IS EQUAL TO 'CS' OR
RECIPIENT’S EIGHTH AND NINETH POSITIONS OF THE ORIGINAL ID NUMBER IS EQUAL TO
'CS')
IF CURRENT CLAIM IS A PROFESSIONAL CLAIM
  IF CURRENT CLAIM CONTAINS A VALID PROCEDURE CODE
    IF CURRENT CLAIM IS A MEDICAL CLAIM
      IF (CURRENT CLAIM’S RECIPIENT AGE IS GREATER THAN 3 OR (CURRENT CLAIM’S
RECIPIENT AGE IS GREATER THAN 21 AND CURRENT CLAIM IS
NOT AN ADJUSTMENT CLAIM))

Top
EXPLANATION OF BENEFITS (EOB) CODE: 015

MESSAGE TEXT:
   A) PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
   B) M/I DATE OF SERVICE

SOURCE CODE:
   A) “C” = CONTRACTUAL OBLIGATION
   B) “N” = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1130    JOB(s): SB1J050

   IF PAYABLE CLAIM
   IF NOT A DENIED CLAIM
   AND
   IF 1ST DAY OF SERVICE IS GREATER THAN 19960831
   AND (IF CLAIM REGION IS EQUAL TO 10 OR 40)
   AND
   IF PCLIST-2ND-PROC-SW EQUAL TO 'Y'
   OR ((SUBMITTED CHARGE GREATER THAN 199.99)
   AND IF FOUND ON PROCEDURE CODE LIST)
   IF DME-NEED-PRIOR-SW EQUAL TO 'Y'
      IF NOT CROSSOVER CLAIM
      AND RENTAL-LEEWAY-SW = 'Y'
   AND
   IF PRIOR-FOUND-SW = 'N'
   IF RENTAL-LEEWAY-SW = 'N'
      IF PRIOR-DENY-SW NOT EQUAL TO 'Y'
      AND
      IF 607-SW EQUAL TO 'Y'
      IF NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE : 016

MESSAGE TEXT:
   A) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR
      ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE
      ADVICE REMARKS CODES WHENEVER APPROPRIATE
   B) M/I PRESCRIPTION/SERVICE REFERENCE NUMBER

SOURCE CODE:
   A) "C" = CONTRACTUAL OBLIGATION
   B) "N" = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1090, SB1130 JOB(s): SB1J040, SB1J050

SB1090(SB1J040) - SITUATION:
IF CURRENT CLAIM IS A PAYABLE CLAIM AND NOT AN ADJUSTMENT CLAIM
IF ((CLAIM ALREADY CONTAINS A DETAIL-LEVEL ERROR CODE OF '409' or '411')
   AND (HAS A HOLD-STOP REASON INDICATOR EQUAL TO 'CL')
   AND (IS NOT OF REGION 90)
   AND (ITS FIRST DATE OF SERVICE IS GREATER THAN ITS HOLD-END-DATE))
OR ((CLAIM ALREADY CONTAINS A DETAIL-LEVEL ERROR CODE OF '008', '009' or '265')
   AND (CLAIM IS OF REGION 94)
   AND (CURRENT CLAIM'S PROVIDER NUMBER IS GREATER THAN '000032313'
   AND CURRENT CLAIM'S PROVIDER NUMBER IS LESS THAN '000032322'))
IF CURRENT CLAIM IS OF REGION 30
IF CLAIM IS NOT OF TAKE-OVER REGION OR IT CONTAINS A DETAIL-LEVEL ERROR
   CODE NOT EQUAL TO '107'
   IF CLMT-TAPE-BILL-REG (40) OR
      (CLMT-IHS-REGION (70) AND (CLMT-CLM-BTH-NO > 814 AND < 831)) OR
      (CLMT-CROSSOVER-CLAIM AND (CLMT-IHS-REGION (70) OR
         CLMT-TAKE-OVER-REG (80)))
   IF CLMT-ERR-CD (CLMT-INDX8) NOT = '009'
   IF CLMT-ERR-CD (CLMT-INDX8) NOT = '008'
   IF CLMT-ERR-CD (CLMT-INDX8) = '556'

SB1130(SB1J050) - SITUATION:
IF PAYABLE CLAIM
   AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
   ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
      AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
    (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER
      THAN 20011231 AND
         (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
    (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
      AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
      EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
   NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
      AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
OR
IF (PROFESSIONAL CLAIM AND
    NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711
    AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
    OR REVENUE CODE EQUAL TO 983
    OR CROSSOVER CLAIM
AND
IF CROSSOVER CLAIM AND NOT ADJUSTMENT CLAIM
    IF CLAIM REGION EQUAL TO 80
        IF WK-PROC-LST-2 EQUAL TO '99' OR PROCEDURE CODE EQUAL TO '99070'
            OR WK-PROC-1ST-1 EQUAL TO 'V'
    Top
EXPLANATION OF BENEFITS (EOB) CODE : 017

MESSAGE TEXT:
PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE. ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1070       JOB(s): SB1J020

SITUATION:
A) IF CORRECTION ID EQUAL TO 'R'
   OR
   IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND
   IF UPDATE-SW NOT EQUAL TO ZERO
   AND
   IF PERR-SW EQUAL TO 'Y'
   OR
   IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
     IF WK-DAYS EQUAL TO 1
     OR
     IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
   IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   AND
   IF DENTAL CLAIM
   AND PRED-BENEFITS-SW NOT EQUAL TO 'Y'
   AND
   IF TYPE OF SERVICE IS EQUAL TO '7'
   AND
   IF PROCEDURE CODE IS ON LIST 0147
   AND
     IF NOT VALID TEETH
     IF CLAIM REGION IS EQUAL TO 40
     AND NOT ADJUSTMENT CLAIM

B) IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' ' 
   OR
   (IF CORRECTION ID EQUAL TO 'R'
   OR
   IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
       IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
   IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
       PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
   IF MEDICAL CLAIM OR DENTAL CLAIM OR XOVR MEDICAL
   IF NOT VALID-MODIFIER OR
       (DETAIL XTRA MODIFIER NOT EQUAL TO 'XV' AND
        1ST PROCEDURE SERVICE DATE GREATER THAN 20040501 )
   AND
       IF CLAIM REGION EQUAL TO 40
       AND NOT ADJUSTMENT CLAIM
OR
IF DENTAL CLAIM AND TYPE OF SERVICE CODE IS EQUAL TO '7'
IF PROCEDURE CODE IS FOUND ON PROCEDURE CODE LIST
IF NOT VALID-TEETH
   IF CLAIM REGION EAUAL TO 40
   AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE : 018

MESSAGE TEXT: DUPLICATE CLAIM/SERVICE.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1250      JOB(s): SB1J075

SITUATION:
A) IF SW-PCN-BRK EQUAL TO 'YES'
   AND IF PLI-SUB GREATER THAN ZEROS
   AND PROFESSIONAL-DUPL-CHECK SECTION.
   PDC-010.
   IF RECORD CODE NOT EQUAL TO 'L'
   OR IF WTP1-SURFACE EQUAL TO 'A' OR WTP2-SURFACE EQUAL TO 'A'
   OR IF WTP1-SURFACE NOT EQUAL TO SPACES
   IF WTP1-SURFACE (1) EQUAL TO WTP2-SURFACE (1) OR
   WTP1-SURFACE (1) EQUAL TO WTP2-SURFACE (2) OR
   WTP1-SURFACE (1) EQUAL TO WTP2-SURFACE (3) OR
   WTP1-SURFACE (1) EQUAL TO WTP2-SURFACE (4)
   OR IF WTP1-SURFACE (2) EQUAL TO WTP2-SURFACE (1)
   OR WTP1-SURFACE (2) EQUAL TO WTP2-SURFACE (2)
   OR WTP1-SURFACE (2) EQUAL TO WTP2-SURFACE (3)
   OR WTP1-SURFACE (2) EQUAL TO WTP2-SURFACE (4)
   OR IF WTP1-SURFACE (3) EQUAL TO WTP2-SURFACE (1)
   OR WTP1-SURFACE (3) EQUAL TO WTP2-SURFACE (2)
   OR WTP1-SURFACE (3) EQUAL TO WTP2-SURFACE (3)
   OR WTP1-SURFACE (3) EQUAL TO WTP2-SURFACE (4)
   OR IF WTP1-SURFACE (4) EQUAL TO WTP2-SURFACE (1)
   OR WTP1-SURFACE (4) EQUAL TO WTP2-SURFACE (2)
   OR WTP1-SURFACE (4) EQUAL TO WTP2-SURFACE (3)
   OR WTP1-SURFACE (4) EQUAL TO WTP2-SURFACE (4)
   AND IF WTP1-RECIP-ORG-PCN EQUAL TO WTP2-RECIP-ORG-PCN AND
   WTP1-TY-SVCD EQUAL TO WTP2-TY-SVCD AND
   (WTP1-PRCD EQUAL TO WTP2-PRCD OR PRCD-SW EQUAL TO 'Y') AND
   MOD-EXACT-SW EQUAL TO 'Y' AND
   WTP1-1ST-PROC-SVDT EQUAL TO WTP2-1ST-PROC-SVDT AND
   WTP1-LST-PROC-SVDT EQUAL TO WTP2-LST-PROC-SVDT AND
   WTP1-PROV-NO EQUAL TO WTP2-PROV-NO AND
   WTP1-SUBM-CHG EQUAL TO WTP2-SUBM-CHG
   AND
   IF WS-FORCE-DENY-SW EQUAL TO 'N'
   IF (VR PROVIDER GREATER THAN '033055' AND LESS THAN '033060')
   AND NOT ADJUSTMENT CLAIM
   OR
   IF CLAIM REGION EQUAL TO 40
   AND NOT (WTP1-INTNL-CTL-NO EQUAL TO WTP2-INTNL-CTL-NO)
   AND NOT ADJUSTMENT CLAIM
B) IF SW-PCN-BRK EQUAL TO 'YES'
AND IF ILI-SUB GREATER THAN ZEROS
AND IF SERVICE CODE EQUAL TO STORED SERVICE CODE
OR IF (SERVICE CODE GREATER THAN ' ' AND LESS THAN '8') AND
(STORED SERVICE CODE GREATER THAN ' ' AND LESS THAN '8')
AND IF PROVIDER NUMBER EQUAL TO STORED PROVIDER NUMBER
AND SUBMITTED CHARGE EQUAL TO STORED SUBMITTED CHARGE
AND BEGINNING FROM DATE EQUAL TO STORED BEGINNING FROM DATE
AND BEGINNING TO DATE EQUAL TO STORED BEGINNING TO DATE
AND IF WS-FORCE-DENY-SW EQUAL TO 'N'
IF (VR PROVIDER EQUAL TO '035201' OR '035432' OR '035434')
AND NOT ADJUSTMENT CLAIM
OR IF CLAIM REGION EQUAL TO 40
AND NOT (ICN EQUAL TO STORED ICN)
AND NOT ADJUSTMENT CLAIM
OR IF NHLI-SUB GREATER THAN ZEROS
AND IF SERVICE CODE EQUAL TO STORED SERVICE CODE
OR IF (RECORD CODE IS EQUAL TO 'N' AND
STORED RECORD IS EQUAL TO 'N') AND
((CLAIM REGION EQUAL TO '20' OR '21')
AND (STORED CLAIM REGION EQUAL TO '20' OR '21'))
AND IF PROVIDER NUMBER EQUAL TO STORED PROVIDER NUMBER
AND SUBMITTED CHARGE EQUAL TO STORED SUBMITTED CHARGE
AND BEGINNING FROM DATE EQUAL TO STORED BEGINNING FROM DATE
AND BEGINNING TO DATE EQUAL TO STORED BEGINNING TO DATE
AND IF WS-FORCE-DENY-SW EQUAL TO 'N'
IF CLAIM REGION EQUAL TO 40
AND NOT (ICN EQUAL TO STORED ICN)
AND NOT ADJUSTMENT CLAIM
OR IF DLI-SUB GREATER THAN ZEROS
AND IF WS-FORCE-DENY-SW EQUAL TO 'N'
IF CLAIM REGION EQUAL TO 40
AND NOT (ICN EQUAL TO STORED ICN)
AND NOT ADJUSTMENT CLAIM
OR IF SLI-SUB GREATER THAN ZEROS
AND IF WS-FORCE-DENY-SW EQUAL TO 'N'
IF CLAIM REGION EQUAL TO 40
AND NOT (ICN EQUAL TO STORED ICN)
AND NOT ADJUSTMENT CLAIM
OR IF ULI-SUB GREATER THAN ZEROS
IF ERROR CODE NOT EQUAL TO '503'
AND IF CLAIM REGION EQUAL TO 40
AND NOT (ICN EQUAL TO STORED ICN)
AND NOT ADJUSTMENT CLAIM

C)
IF SW-PCN-BRK EQUAL TO 'YES'
IF ORIGINAL PCN NOT EQUAL TO ZEROES
AND
IF WAH-RECIPIENT ORIGINAL PCN LESS THAN WAT-RECIPIENT ORIGINAL PCN
AND IF WAH-RECIPIENT ORIGINAL PCN EQUAL TO WAT-RECIPIENT ORIGINAL PCN
AND
IF PROFESSIONAL CLAIM
   IF NOT UB82 HOME HEALTH
      PERFORM APPLY-PROFESSIONAL-HISTORY
   OR
   IF CROSSOVER CLAIM
      IF WTP2-DUPL-IND EQUAL TO SPACE AND 'D'
   AND
IF WTP1-RECIPIENT ORIGINAL PCN EQUAL TO WTP2-RECIPIENT ORIGINAL PCN
AND WTP1-TYPE OF SERVICE CODE EQUAL TO WTP2-TYPE OF SERVICE CODE
AND (WTP1-PROCEDURE CODE EQUAL TO WTP2-PROCEDURE CODE
   OR IF PROCEDURE CODE ON PROCEDURE CODE LIST FILE)
AND MOD-EXACT-SW EQUAL TO 'Y'
AND WTP1-1ST PROCEDURE SERVICE DATE EQUAL
   TO WTP2-1ST PROCEDURE SERVICE DATE
AND WTP1-LAST PROCEDURE SERVICE DATE EQUAL
   TO WTP2-LAST PROCEDURE SERVICE DATE
AND WTP1-PROVIDER NUMBER EQUAL TO WTP2-PROVIDER NUMBER
AND WTP1-SUBMITTED CHARGE EQUAL TO WTP2-SUBMITTED CHARGE
AND WTP1-TOOTH NUMBER EQUAL TO WTP2-TOOTH NUMBER
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
   IF (CLAI REGION EQUAL TO 40
      OR (VR PROVIDER GREATER THAN '033055' AND LESS THAN '033060'))
   OR NOT ADJUSTMENT CLAIM
OR
IF SCREENING CLAIM
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
AND
   IF CLAIM REGION EQUAL TO '40'
   AND NOT ADJUSTMENT CLAIM
OR
IF DRUG CLAIM
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
AND
   IF CLAIM REGION EQUAL TO '40'
   AND NOT ADJUSTMENT CLAIM
OR
IF REIMBURSTMENT AMOUNT GREATER THAN ZERO
AND WTD1-QUANTITY DISPENSED EQUAL TO WTD2-QUANTITY DISPENSED
AND WTD1-SUBMITTED CHARGE EQUAL TO WTD2-SUBMITTED CHARGE
AND WTD2-TRANSACTION TYPE NOT EQUAL TO '4'
AND (CLAIM REGION EQUAL TO '10' OR '40')
OR
IF HSTT-INPATIENT-CLAIM
AND
   IF (WTI1-SVCD = WTI2-SVCD) AND (WTI1-SVCD NOT = 'N')
   OR
   IF (WTI1-SERVICE CODE GREATER THAN ' ' AND LESS THAN '8') AND
(WTI2-SERVICE CODE GREATER THAN '' AND LESS THAN '8') AND
IF WTI1-PROVIDER NUMBER EQUAL TO WTI2-PROVIDER NUMBER
AND WTI1-SUBMITTED CHARGE EQUAL TO WTI2-SUBMITTED CHARGE
AND WTI1-BEGINNING FROM DATE EQUAL TO WTI2-BEGINNING FROM DATE
AND WTI1-BEGINNING TO DATE EQUAL TO WTI2-BEGINNING TO DATE
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
IF (CLAIM REGION EQUAL TO 40
OR (VR PROVIDER EQUAL TO '035201' OR '035432' OR '035434'))
AND NOT ADJUSTMENT CLAIM
OR
IF NURSE HOME CLAIM
AND IF WTN2-DUPL-IND EQUAL TO SPACE AND 'D'
AND IF WTN1-SERVICE CODE EQUAL TO WTN2-SERVICE CODE
OR
IF (WTN1-CLAIM RECORD CODE EQUAL TO 'N' AND
 WTN2-CLAIM RECORD CODE EQUAL TO 'N') AND
((W1-CLAIM REGION EQUAL TO '20' OR '21')
AND (W2-CLAIM REGION EQUAL TO '20' OR '21'))
AND IF WTN1-PROVIDER NUMBER EQUAL TO WTN2-PROVIDER NUMBER
AND WTN1-SUBMITTED CHARGE EQUAL TO WTN2-SUBMITTED CHARGE
AND WTN1-BEGINNING FROM DATE EQUAL TO WTN2-BEGINNING FROM DATE
AND WTN1-BEGINNING TO DATE EQUAL TO WTN2-BEGINNING TO DATE
AND WTN1-SERVICE CODE EQUAL TO WTN2-SERVICE CODE
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
D)
IF SW-PCN-BRK EQUAL TO 'YES'
AND IF UB82 CLAIM
AND IF WTU2-CLM-NO-CR-P NOT EQUAL TO ZEROS
IF WTU2-CLM-NO-CR-P EQUAL TO WTU1-INTNL-CTL-NO
OR
IF WTU2-DRG NOT EQUAL TO SPACES OR WTU1-DRG NOT EQUAL TO SPACES
IF WTU2-LINE ITEM NUMBER EQUAL TO 1
AND WTU1-LINE ITEM NUMBER EQUAL TO 1
IF WTU1-BEGINNING FROM DATE EQUAL TO WTU2-BEGINNING FROM DATE
AND WTU1-BEGINNING TO DATE EQUAL TO WTU2-BEGINNING TO DATE
OR
IF WTU1-BEGINNING FROM DATE EQUAL TO WTU2-BEGINNING FROM DATE
AND WTU1-BEGINNING TO DATE EQUAL TO WTU2-BEGINNING TO DATE
AND WTU1-SUBMITTED CHARGE EQUAL TO WTU2-SUBMITTED CHARGE
AND WTU1-REVENUE CODE EQUAL TO WTU2-REVENUE CODE
IF (UB82 INPATIENT)
OR (UB82 OUTPATIENT)
OR (UB82 HOME HEALTH)
OR
IF (WTU1-BEGINNING FROM DATE GREATER THAN WTU2-BEGINNING FROM DATE
AND LESS THAN WTU2-BEGINNING TO DATE) OR
(WTU1-BEGINNING TO DATE GREATER THAN WTU2-BEGINNING FROM DATE
AND LESS THAN WTU2-BEGINNING TO DATE) OR
((WTU1-BEGINNING FROM DATE LESS THAN WTU2-BEGINNING FROM DATE)
AND (WTU1-BEGINNING TO DATE GREATER THAN WTU2-BEGINNING TO DATE))
IF UB82 INPATIENT
OR
IF UB82 OUTPATIENT
OR
IF WTU1-REVENUE CODE EQUAL TO WTU2-REVENUE CODE
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
   IF ERROR-CODE NOT EQUAL TO '503'
   AND
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
IF INPATIENT CLAIM
   IF ULI-SUB GREATER THAN ZEROES
      IF (DUPLICATE INDICATOR NOT EQUAL TO 'D' OR 'Z')
   AND
   IF WTU2-CLM-NO-CR-P NOT EQUAL TO ZEROS
      IF WTU2-CLM-NO-CR-P EQUAL TO WTU1-INTNL-CTL-NO
   OR
   IF WTU2-DRG NOT EQUAL TO SPACES OR WTU1-DRG NOT EQUAL TO SPACES
      IF WTU2-LINE ITEM NUMBER EQUAL TO 1
      AND WTU1-LINE ITEM NUMBER EQUAL TO 1
      IF WTU1-BEGINNING FROM DATE EQUAL TO WTU2-BEGINNING FROM DATE
      AND WTU1-BEGINNING TO DATE EQUAL TO WTU2-BEGINNING TO DATE
   OR
   IF WTU1-BEGINNING FROM DATE EQUAL TO WTU2-BEGINNING FROM DATE
      AND WTU1-BEGINNING TO DATE EQUAL TO WTU2-BEGINNING TO DATE
      AND WTU1-SUBMITTED CHARGE EQUAL TO WTU2-SUBMITTED CHARGE
      AND WTU1-REVENUE CODE EQUAL TO WTU2-REVENUE CODE
   OR
   IF (WTU1-BEGINNING FROM DATE GREATER THAN WTU2-BEGINNING FROM DATE
      AND LESS THAN WTU2-BEGINNING TO DATE) OR
   (WTU1-BEGINNING TO DATE GREATER THAN WTU2-BEGINNING FROM DATE
      AND LESS THAN WTU2-BEGINNING TO DATE) OR
   ((WTU1-BEGINNING FROM DATE LESS THAN WTU2-BEGINNING FROM DATE
      AND WTU1-BEGINNING TO DATE GREATER THAN WTU2-BEGINNING TO DATE))
   AND
   IF WS-FORCE-DENY-SW EQUAL TO 'N'
      IF ERROR-CODE NOT EQUAL TO '503'
      IF CLAIM REGION EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM

E)
IF SW-PCN-BRK EQUAL TO 'YES'
   IF OUTPATIENT CLAIM
      IF ULI-SUB GREATER THAN ZEROES
      IF (DUPLICATE INDICATOR NOT EQUAL TO 'D' OR 'Z')
      IF WTU2-CLM-NO-CR-P NOT EQUAL TO ZEROS
         IF WTU2-CLM-NO-CR-P EQUAL TO WTO1-ICN
   OR
   IF WTO1-BEGINNING FROM DATE EQUAL TO WTU2-BEGINNING FROM DATE
      AND WTO1-BEGINNING TO DATE EQUAL TO WTU2-BEGINNING TO DATE
      AND WTO1-SUBMITTED CHARGE EQUAL TO WTU2-SUBMITTED CHARGE
      AND WTO1-SERVICE CODE EQUAL TO WTU2-UB82 SERVICE CODE
   OR
   IF (WTO1-BEGINNING FROM DATE NOT LESS THAN WTU2-BEGINNING FROM DATE
      AND NOT GREATER THAN WTU2-BEGINNING TO DATE) OR
(WTO1-BEGINNING TO DATE NOT LESS THAN WTU2-BEGINNING FROM DATE
AND NOT GREATER THAN WTU2-BEGINNING TO DATE) OR
((WTO1-BEGINNING FROM DATE LESS THAN WTU2-BEGINNING FROM DATE
AND (WTO1-BEGINNING TO DATE GREATER THAN WTU2-BEGINNING FROM DATE))
IF WTO1-SERVICE CODE EQUAL TO WTU2-UB82 SERVICE CODE
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
  IF ERROR-CODE NOT EQUAL TO '503'
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM

F)
IF SW-PCN-BRK EQUAL TO 'YES'
IF ORIGINAL PCN NOT EQUAL TO ZEROES
AND
IF WAH-RECIPIENT ORIGINAL PCN LESS THAN WAT-RECIPIENT ORIGINAL PCN
AND IF WAH-RECIPIENT ORIGINAL PCN EQUAL TO WAT-RECIPIENT ORIGINAL PCN
AND
IF UB82 CLAIM
IF ULI-SUB NOT GREATER THAN ULI-SUB
OR
IF LI-SUB2 GREATER THAN ULI-SUB
AND
IF UB82 INPATIENT AND (ILI-SUB GREATER THAN ZEROES)
IF (DUPLICATE INDICATOR NOT EQUAL TO 'D' OR = 'Z')
IF WTU2-CLM-NO-CR-P NOT EQUAL TO ZEROS
  IF WTU2-CLM-NO-CR-P EQUAL TO WTO1-ICN
OR
IF WTO1-BEGINNING FROM DATE EQUAL TO WTU2-BEGINNING FROM DATE
AND WTO1-BEGINNING TO DATE EQUAL TO WTU2-BEGINNING TO DATE
AND WTO1-SUBMITTED CHARGE EQUAL TO WTU2-SUBMITTED CHARGE
AND WTO1-SERVICE CODE EQUAL TO WTU2-UB82 SERVICE CODE
OR
IF (WTO1-BEGINNING FROM DATE NOT LESS THAN WTU2-BEGINNING FROM DATE
AND NOT GREATER THAN WTU2-BEGINNING TO DATE) OR
(WTO1-BEGINNING TO DATE NOT LESS THAN WTU2-BEGINNING FROM DATE
AND NOT GREATER THAN WTU2-BEGINNING TO DATE) OR
((WTO1-BEGINNING FROM DATE LESS THAN WTU2-BEGINNING FROM DATE
AND (WTO1-BEGINNING TO DATE GREATER THAN WTU2-BEGINNING FROM DATE))
  IF WTO1-SERVICE CODE EQUAL TO WTU2-UB82 SERVICE CODE
AND
IF WS-FORCE-DENY-SW EQUAL TO 'N'
  IF ERROR-CODE NOT EQUAL TO '503'
    IF (CLAIM REGION EQUAL TO 40
      OR (VR PROVIDER EQUAL TO '035201' OR '035432' OR '035434'))
    AND NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE: 022

MESSAGE TEXT:
PAYMENT ADJUSTED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.

SOURCE CODE: C
“C” = Contractual Obligation

DATE CREATED: 11/21/02

PROGRAM(s): SB1090  JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER
AND
( IF CLAIM IS NOT OF DEVELOPMENTAL DISABILITY, VR or BASIC CARE REGIONS
   IF (CLAIM IS NOT QMB ELIGIBLE AND RECIPIENT’S SOCIAL SECURITY NUMBER IS
      NOT ON FILE AS BEING QMB ELIGIBLE) OR CLAIM’S ORIGIN CODE ON FILE IS
      EQUAL TO ‘T’
   IF (THIRD PARTY LIABILITY COVERAGE (1) NOT EQUAL TO SPACES) OR CLAIM IS
      A MEDICAL CLAIM
   IF CLAIM IS A CROSSOVER CLAIM AND NOT AN ADJUSTMENT CLAIM
   IF CLAIM IS OF TAKEOVER REGION
   IF THIRD PARTY LIABILITY COVERAGE (SUB1) EQUAL TO ‘M’
)

Top
MESSAGE TEXT:
PAYMENT FOR CHARGES ADJUSTED. CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.

SOURCE CODE:
“C” = Contractual Obligation

DATE CREATED: 11/21/02

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER

AND

((IF CURRENT CLAIM’S PROVIDER NUMBER IS GREATER THAN ‘000068999’ AND ITS PROVIDER NUMBER IS LESS THAN ‘000070000’
   IF CURRENT CLAIM IS NOT AN ADJUSTMENT CLAIM)

OR

(IF CLAIM CONTAINS A VALID PRIMARY CARE PROVIDER ID NUMBER
   IF ITS PRIMARY CARE PROVIDER ID NUMBER IS GREATER THAN ‘068999’ AND ITS PRIMARY CARE PROVIDER ID NUMBER IS LESS THAN ‘070000’
   IF CLAIM’S REGION IS NOT EQUAL TO 49, 90 or 94
   IF CLAIM’S PROCEDURE CODES ARE FROM BOTH HMO AND NON-HMO PROVIDERS
   IF CLAIM IS A MEDICAL CLAIM OR CLMT-UB82-HOME-HEALTH OR CLAIM IS A UB82 OUTPATIENT CLAIM
   IF CLAIM IS NOT HMO EXEMPT
   IF CLAIM IS NOT AN ADJUSTMENT CLAIM)

OR

(IF CLAIM CONTAINS A VALID PRIMARY CARE PROVIDER ID NUMBER
   IF ITS PRIMARY CARE PROVIDER ID NUMBER IS GREATER THAN ‘068999’ AND ITS PRIMARY CARE PROVIDER ID NUMBER IS LESS THAN ‘070000’
   IF CLAIM’S REGION IS NOT EQUAL TO 49, 90 or 94
   IF CLAIM’S PROCEDURE CODES ARE FROM BOTH HMO AND NON-HMO PROVIDERS
   IF CLAIM IS NOT A MEDICAL CLAIM
   IF CLAIM IS NOT AN ADJUSTMENT CLAIM
   IF (CLAIM IS NOT AN INPATIENT-CLAIM OR ITS MONTH OF SERVICE IS EQUAL TO THE MONTH OF SERVICE ON FILE) AND (CLAIM IS NOT A CROSSOVER CLAIM)

OR

(IF PRIMARY CARE PROVIDER’S ID NUMBER ON FILE IS GREATER THAN SPACES
IF PRIMARY CARE PROVIDER’S ID NUMBER IS GREATER THAN '068999' AND
PRIMARY CARE PROVIDER’S ID NUMBER IS LESS THAN '070000'
IF CLMT-CLM-REGION NOT EQUAL 49, 90 or 94
IF CLAIM CONTAINS BOTH HMO AND NON-HMO PROCEDURE CODES
  IF CLAIM CONTAINS AN INVALID PROCEDURE CODE

OR

(IF PRIMARY CARE PROVIDER’S ID NUMBER ON FILE IS GREATER THAN SPACES
IF PRIMARY CARE PROVIDER’S ID NUMBER IS GREATER THAN '068999' AND
PRIMARY CARE PROVIDER’S ID NUMBER IS LESS THAN '070000'
IF CLMT-CLM-REGION NOT EQUAL 49, 90 or 94
IF CLAIM CONTAINS ONLY HMO PROCEDURE CODES OR ONLY NON-HMO
  PROCEDURE CODES
  IF CLAIM IS A MEDICAL CLAIM OR A UB82 HOME HEALTH CLAIM OR A UB82
  OUTPATIENT CLAIM
  IF CLAIM’S PROVIDER IS ON FILE
  IF ((CLAIM’S PROVIDER TYPE CODE IS NOT EQUAL TO ‘31’, ‘32’ or ‘40’) OR
  CLAIM IS A MEDICAL CLAIM))

OR

(IF PRIMARY CARE PROVIDER’S ID NUMBER ON FILE IS GREATER THAN SPACES
IF PRIMARY CARE PROVIDER’S ID NUMBER IS GREATER THAN '068999' AND
PRIMARY CARE PROVIDER’S ID NUMBER IS LESS THAN '070000'
IF CLMT-CLM-REGION NOT EQUAL 49, 90 or 94
IF CLAIM CONTAINS ONLY HMO PROCEDURE CODES OR ONLY NON-HMO
  PROCEDURE CODES
  IF CLAIM IS A MEDICAL CLAIM OR A UB82 HOME HEALTH CLAIM OR A UB82
  OUTPATIENT CLAIM
  IF CLAIM’S PROVIDER IS NOT ON FILE)
EXPLANATION OF BENEFITS (EOB) CODE: 026

MESSAGE TEXT:
1) EXPENSES INCURRED PRIOR TO COVERAGE.
2) M/I UNIT OF MEASURE

SOURCE CODE:
1) “P” = Patient Responsibility
2) “N” = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER

AND

(IF CLAIM’S RECIPIENT IS TECS ELIGIBLE AND NOT QMB ELIGIBLE AND THE CLAIM’S RECIPIENT SSN IS NOT QMB ELIGIBLE
IF CLAIM IS OF MAIN REGION (10), IHS REGION (70), TAKE-OVER REGION (80), TAPE-BILL REGION (40) or DEPT. OF INSTRUCTION REGION (95)
IF THE FIRST 2 DIGITS OF THE RECIPIENT’S CASE NUMBER IS LESS THAN 1 OR GREATER THAN 53
IF CLAIM IS NOT AN ADJUSTMENT CLAIM
IF THE NUMBER OF ELIGIBILITY RECORDS GREATER THAN ZERO
    IF CLAIM’S FIRST DAY OF SERVICE IS LESS THAN ITS ELIGIBILITY START DATE(L-ELIG-INDEX))

OR

(IF CLAIM’S RECIPIENT IS TECS ELIGIBLE AND NOT QMB ELIGIBLE AND THE CLAIM’S RECIPIENT SSN IS NOT QMB ELIGIBLE
IF CLAIM IS OF MAIN REGION (10), IHS REGION (70), TAKE-OVER REGION (80), TAPE-BILL REGION (40) or DEPT. OF INSTRUCTION REGION (95)
IF THE FIRST 2 DIGITS OF THE RECIPIENT’S CASE NUMBER IS LESS THAN 1 OR GREATER THAN 53
IF CLAIM IS NOT AN ADJUSTMENT CLAIM
IF THE NUMBER OF ELIGIBILITY RECORDS GREATER THAN ZERO
    IF CLAIM’S FIRST DATE OF SERVICE IS GREATER THAN OR EQUAL TO ITS ELIGIBILITY START DATE (L-ELIG-INDEX)
    IF CLAIM’S FIRST DATE OF SERVICE IS LESS THAN OR EQUAL TO ITS ELIGIBILITY STOP DATE (L-ELIG-INDEX))

OR
(If claim’s recipient is TECS eligible and not QMB eligible and the claim’s recipient SSN is not QMB eligible
If claim is of main region (10), IHS region (70), take-over region (80), tape-bill region (40) or dept. of instruction region (95)
If the first 2 digits of the recipient’s case number is less than 1 or greater than 53
If claim is not an adjustment claim
If the number of eligibility records less than or equal to zero)
EXPLANATION OF BENEFITS (EOB) CODE : 027

MESSAGE TEXT:
EXPENSES INCURRED AFTER COVERAGE TERMINATED.

SOURCE CODE:
“P” = Patient Responsibility

DATE CREATED: 11/21/02

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER
AND

(IF CLAIM’S RECIPIENT IS TECS ELIGIBLE AND NOT QMB ELIGIBLE AND THE CLAIM’S RECIPIENT SSN IS NOT QMB ELIGIBLE
IF CLAIM IS OF MAIN REGION (10), IHS REGION (70), TAKE-OVER REGION (80), TAPE-BILL REGION (40) or DEPT. OF INSTRUCTION REGION (95)
IF THE FIRST 2 DIGITS OF THE RECIPIENT’S CASE NUMBER IS LESS THAN 1 OR GREATER THAN 53
IF CLAIM IS NOT AN ADJUSTMENT CLAIM
IF THE NUMBER OF ELIGIBILITY RECORDS GREATER THAN ZERO
IF CLAIM’S FIRST DAY OF SERVICE IS GREATER THAN ITS ELIGIBILITY START DATE(L-ELIG-INDEX))

Top
EXPLANATION OF BENEFITS (EOB) CODE : 029

MESSAGE TEXT:
C: THE TIME LIMIT FOR FILING HAS EXPIRED.
N: M/I NUMBER REFILLS AUTHORIZED.

SOURCE CODE:
“C” = Contractual Obligation
“N” = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER
AND
(IF CURRENT CLAIM’S FEDERAL MATCH CODE IS EQUAL TO ’444’
 IF (ITS FIRST DATE OF SERVICE IS LESS THAN 20031001 AND ITS PAID DATE IS
GREATER THAN 20040220)
 OR (ITS FIRST DATE OF SERVICE IS LESS THAN 20040701 AND ITS PAID DATE IS
GREATER THAN 20041220)
 OR (ITS FIRST DATE OF SERVICE IS LESS THAN 20050101 AND ITS PAID DATE IS
GREATER THAN 20051220)
 OR (ITS FIRST DATE OF SERVICE IS LESS THAN 20050701 AND ITS PAID DATE IS
GREATER THAN 20061220)
 OR (ITS FIRST DATE OF SERVICE IS LESS THAN 20060701 AND ITS PAID DATE IS
GREATER THAN 20071220))
EXPLANATION OF BENEFITS (EOB) CODE: 030

MESSAGE TEXT: CO-PAYMENT AMOUNT

SOURCE CODE: “P” = PATIENT RESPONSIBILITY

DATE CREATED: 07/01/03

PROGRAM(s): SB710038 JOB(s): ONLINE

SB1070(SB1J020) - SITUATION:

A) IF VALID RECORD ON CLIENT-BASIC-A01 FILE
   AND IF WA-003-CC-STATUS EQUAL TO ‘AU’ AND
      (DEPARTMENT OF INSTRUCTION
       OR CLAIM REGION EQUAL TO 70)
      AND IF TOT-DAYS LESS THAN 60
      MOVE ’30’ TO CLML-HEADER-RELS-CD (CLML-INDEXR).

B) IF WK-020-RECIP-LIAB NOT EQUAL TO 0.00
   AND IF (((PROVIDER NUMBER EQUAL TO ‘000038859’) OR
            (PROVIDER NUMBER GREATER THAN ’000032313’ AND LESS THAN ’000032322’))
            AND (PROCEDURE CODE EQUAL TO ’00092’))
   IF TOT-DAYS GREATER THAN 60
EXPLANATION OF BENEFITS (EOB) CODE: 031

MESSAGE TEXT:
CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

SOURCE CODE: “P” = Patient Responsibility

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090  JOB(s): SB1J020, SB1J040

SB1070(SB1J020) - SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO ‘2’ OR ‘4’ OR ‘5’
AND
IF ENTRX-CD1 = ‘I’ OR ‘O’ OR ‘N’ OR ‘M’ OR ‘S’ OR ‘L’ OR ‘X’ OR ‘A’ OR ‘Q’ OR ‘R’ OR ‘U’
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO ‘Z’ OR ‘ ’
OR
(IF CORRECTION ID EQUAL TO ‘R’
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO ‘Y’
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO ‘MAS’)
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO ‘Y’ AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO ‘D’
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF CLAIM REGION IS EQUAL TO 80
AND
IF CROSSOVER CLAIM
AND
IF CLMT-RECIP-CUR-PCN-N EQUAL TO SPACES
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF WK-ID8-9 EQUAL TO ‘VR’ AND CLAIM REGION NOT EQUAL TO 50
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF CLAIM SEQUENCE NUMBER IS EQUAL TO ‘01’
IF UB82 HOME HEALTH AND BILL TYPE IS EQUAL TO ‘711’
IF BEGINNING FROM DATE NOT EQUAL TO BEGINNING TO DATE
IF DETAIL DATE OF SERVICE IS EQUAL TO ZEROS
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT IS NOT AN ADJUSTMENT CLAIM

AND

(IF CLMT-SPL-PRCS-FLG (3) IS EQUAL TO '1'
 IF (CLMT-CLM-REGION IS EQUAL TO 40
 OR ((CLMT-VR-PROV IS GREATER THAN '032310' AND IS LESS THAN '032322')
 OR (CLMT-VR-PROV IS GREATER THAN '033055' AND IS LESS THAN '033060')
 OR (CLMT-VR-PROV IS EQUAL TO '035201', '035432' OR = '035434'))) OR

(IF NO TECS ELIGIBILITY AND NOT CLMT-CROSSOVER-CLAIM
 AND NOT CLMT-NURSE-HOME-CLAIM
 AND NOT (CLMT-UB82-INPATIENT-CLAIM
 AND ALL-DEDUCT-COINS IS EQUAL TO 'Y'
 AND CLMT-ELIG-PART-A)
 AND QMB-ELIG-SSN-SW IS EQUAL TO 'N'
 IF (CLMT-CLM-REGION IS EQUAL TO 40
 OR ((CLMT-VR-PROV IS GREATER THAN '032310' AND IS LESS THAN '032322')
 OR (CLMT-VR-PROV IS GREATER THAN '033055' AND IS LESS THAN '033060')
 OR (CLMT-VR-PROV = '035201', '035432' OR = '035434'))) OR

(IF CLAIM HAS A VALID RECIPIENT ID
 AND
 IF CLMT-CROSSOVER-CLAIM OR CLMT-NURSE-HOME-CLAIM OR
 ((CLMTMEDICAL-CLAIM OR CLMT-UB82-CLAIM) AND
 (CLMT-ELIG-PART-A OR CLMT-ELIG-PART-B))
 IF (NO-FIND-SW IS EQUAL TO 'Y' AND
 (ALL-XOVR-SW IS EQUAL TO 'N' OR ALL-DEDUCT-COINS IS EQUAL TO 'N'))
 IF (CLMT-CLM-REGION IS EQUAL TO 40
 OR ((CLMT-VR-PROV GREATER THAN '032310' AND LESS THAN '032322')
 OR (CLMT-VR-PROV GREATER THAN '033055' AND LESS THAN '033060')
 OR (CLMT-VR-PROV IS EQUAL TO '035201', '035432' OR = '035434'))) OR

(IF ((CLMT-ERR-CD (CLMT-INDX8) NOT EQUAL TO '409' or '411')
 OR (HOLD-STOP-REAS NOT EQUAL TO 'CL')
 OR (CLMT-CLM-REGION NOT EQUAL TO 90)
 OR (CLMT-1ST-DA-OF-SERV LESS THAN OR EQUAL TO HOLD-END-DATE))
 AND ((CLMT-ERR-CD (CLMT-INDX8) NOT EQUAL TO '008', '009' or '265')
 OR (CLMT-CLM-REGION NOT EQUAL TO 94)
 OR (CLMT-PROV-NO LESS THAN OR EQUAL TO '000032313'
 OR CLMT-PROV-NO GREATER THAN OR EQUAL TO '000032322'))
 AND
 IF NOT CLMT-TAKE-OVER-REG OR CLMT-ERR-CD (CLMT-INDX8) NOT EQUAL TO '107'
 AND
 IF CLMT-TAPE-BILL-REG OR
 (CLMT-IHS-REGION AND (CLMT-CLM-BTH-NO GREATER THAN 814 AND LESS
 THAN 831)) OR (CLMT-CROSSOVER-CLAIM AND (CLMT-IHS-REGION OR
 CLMT-TAKE-OVER-REG))
 AND
IF CLMT-ERR-CD (CLMT-INDX8) EQUAL TO '008')

OR

(IF NOT (CLMT-CROSSOVER-CLAIM OR ((CLMT-MEDICAL-CLAIM OR CLMT-UB82-CLAIM) AND (CLMT-ELIG-PART-A OR CLMT-ELIG-PART-B))) IF CLMT-RECIP-CUR-PCN EQUAL TO WSS-PCN AND IF (RECIPIENT NOT FOUND OR CLAIM IS NOT QMB ELIGIBLE) AND CLAIM IS NOT A PRIOR AUTHORIZATION CLAIM AND CLAIM IS OF REGION 40 OR ((CLMT-VR-PROV GREATER THAN '032310' AND LESS THAN '032322') OR (CLMT-VR-PROV GREATER THAN '033055' AND LESS THAN '033060') OR (CLMT-VR-PROV EQUAL TO '035201', '035432' or '035434'))))

OR

(IF (((CLMT-PROV-NO NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999') AND (CLMT-RECIP-LEGAL-CNTY NOT EQUAL TO 063 or 090)) OR (((CLMT-PROV-NO EQUAL TO '000053468', '000053494', '000053496', '000053497', '000051882', '000053482', '000053498', '000053495', '000054516', '000054517', '000054518', '000054519', '000054520', '000054521', '000054522', or '000054523') AND (CLMT-RECIP-LEGAL-CNTY EQUAL TO 060, 063 or 090)) IF CLMT-CLM-REGION EQUAL TO 40)

OR

(CLAIM'S ELIGIBILITY RECORDS WERE NOT FOUND ON FILE AND IF ((CLMT-VR-PROV GREATER THAN '032310' AND LESS THAN '032322') OR (CLMT-VR-PROV GREATER THAN '033055' AND LESS THAN '033060') OR (CLMT-VR-PROV EQUAL TO '035201', '035432' or '035434'))))
EXPLANATION OF BENEFITS (EOB) CODE: 035

MESSAGE TEXT:
A) LIFETIME BENEFIT MAXIMUM HAS BEEN REACHED.
B) M/I PRIMARY CARE PROVIDER ID

SOURCE CODE:
A) “P” = PATIENT RESPONSIBILITY
B) “N” = NCPDP

DATE CREATED: 05/13/04

PROGRAM(s): SB1250   JOB(s): SB1J075

SITUATION:
IF SW-PCN-BRK EQUAL TO 'YES'
AND
IF WTD2-GENERIC-CD EQUAL TO '03200'
   AND WTD2-DT-DSPNS NOT LESS THAN 19910701
   IF WS-NICORETTE-QTY + WTD2-QTY-DSPNS GREATER THAN 1153
   AND
   IF NOT ADJUSTMENT CLAIM
OR
IF PLI-SUB GREATER THAN ZEROS
AND
IF RECORD CODE EQUAL TO 'M'
   IF WTP1-RECORD NUMBER EQUAL TO WTP2-RECORD NUMBER
   AND
   IF TYPE OF SERVICE CODE IS EQUAL TO '4'
   IF PROCEDURE CODE FOUND ON PROCEDURE CODE LIST FILE
   IF STORED SERVICE DATE YEAR EQUAL TO CHIRO-RAD-YR
   IF UNITS OF SERVICE GREATER THAN ALLOWED LIMIT AMOUNT
EXPLANATION OF BENEFITS (EOB) CODE: 038

MESSAGE TEXT:
P) SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK/PRIMARY CARE) PROVIDER
N) M/I BASIS OF COST

SOURCE CODE:
“P” = Patient Responsibility
“N” = NCPDP

DATE CREATED: 05/13/2004

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER

AND

(IF THE FIRST DATABASE QUERY RETURNED NO DATA
 IF CLAIM IS NOT AN ADJUSTMENT CLAIM AND IT’S NOT OF REGION 49
  IF CURRENT CLAIM IS A LAB & X-RAY CLAIM
   IF CLAIM HAS NO LAB & X-RAY REVENUE CODES ASSOCIATED WITH IT)

OR

(IF THE FIRST DATABASE QUERY RETURNS CLAIM’S PRIMARY CARE PROVIDER DATA
 IF THE CLAIM’S START DATE ON FILE IS GREATER THAN THE PRIMARY CARE PROVIDER’S INFORM DATE AND CLAIM’S START DATE ON FILE IS GREATER THAN THE CLAIM’S FIRST DATE OF SERVICE
 IF CLAIM IS NOT AN ADJUSTMENT CLAIM AND IT’S NOT OF REGION 49
  IF CURRENT CLAIM IS A LAB & X-RAY CLAIM
   IF CLAIM HAS NO LAB & X-RAY REVENUE CODES ASSOCIATED WITH IT)

OR

(IF CLAIM’S PRIMARY CARE PROVIDER DATA IS ON FILE
 CLAIM’S PRIMARY CARE PROVIDER START DATE ON FILE NOT EQUAL TO THE CLAIM’S PRIMARY CARE PROVIDER START DATE
 IF CLAIM HAS NOT ALREADY BEEN DENIED
 IF CLAIM’S PRIMARY CARE PROVIDER START DATE ON FILE IS LESS THAN OR EQUAL TO THE CLAIM’S FIRST DATE OF SERVICE
 IF CLAIM’S PRIMARY CARE PROVIDER STOP DATE ON FILE IS GREATER THAN OR EQUAL TO THE CLAIM’S LAST DATE OF SERVICE AND CLAIM’S PRIMARY CARE PROVIDER STOP DATE ON FILE IS GREATER THAN OR EQUAL TO THE CLAIM’S PRIMARY CARE PROVIDER INFORM DATE
 IF ((CLAIM’S PRIMARY CARE PROVIDER STOP DATE ON FILE GREATER THAN OR EQUAL TO CLAIM’S FIRST DATE OF SERVICE) AND (CLAIM’S PRIMARY CARE PROVIDER STOP DATE ON FILE GREATER THAN OR EQUAL TO CLAIM’S PRIMARY CARE PROVIDER INFORM DATE))
 OR CLPC-PCP-STOP-DT EQUAL TO ‘01/01/0001’
 IF FK-PCPH-UPIN GREATER THAN SPACES
IF WK-UPIN NOT EQUAL SPACES
IF WK-UPIN NOT EQUAL FK-PCPH-UPIN
IF NOT CLMT-ADJUSTMENT AND CLAIM IS NOT OF REGION 49
IF LAB-SW EQUAL 'N')

OR

(IF CURRENT CLAIM'S RECORD TYPE CODE IS EQUAL TO 'Q', 'U', or 'R'
 IF CURRENT CLAIM'S PROVIDER NUMBER IS IN THE RANGE OF '000050522'
 THROUGH '000050553'
 IF CURRENT CLAIM CONTAINS A TEEM RECIPIENT NUMER
 IF PRIMARY CARE PROVIDER'S START DATE IS A VALID DATE
 AND PRIMARY CARE PROVIDER'S INFORM DATE IS GREATER THAN ZERO
 AND PRIMARY CARE PROVIDER'S INFORM DATE NOT GREATER THAN
 CURRENT CLAIM'S FIRST DATE OF SERVICE
 IF CURRENT CLAIM'S PRIMARY CARE PROVIDER DATA IS ALREADY ON FILE
 AND CURRENT CLAIM'S PRIMARY CARE PROVIDER START DATE ON FILE
 NOT EQUAL TO THE CURRENT CLAIM'S START DATE
 IF CURRENT CLAIM HAS NOT ALREADY RECEIVED THE ' 38' HEADER-
 LEVEL RELEASE CODE
 IF CURRENT CLAIM'S RECIPIENT ID NUMBER NOT EQUAL TO SPACES
 IF CURRENT CLAIM'S CHANGE REASON CODE NOT EQUAL TO 'Y'
 IF QUANTITY OF PRIMARY CARE PROVIDER RECORDS NOT GREATER
 THAN ZERO
 IF CURRENT CLAIM IS NOT AN ADJUSTMENT CLAIM
 AND CURRENT CLAIM IS NOT OF REGION 49
 IF CURRENT CLAIM IS NOT A LAB-AND-XRAY CLAIM)

OR

(IF CURRENT CLAIM'S RECORD TYPE CODE IS EQUAL TO 'Q', 'U', or 'R'
 IF CURRENT CLAIM'S PROVIDER NUMBER IS IN THE RANGE OF '000050522'
 THROUGH '000050553'
 IF CURRENT CLAIM CONTAINS A TEEM RECIPIENT NUMER
 IF PRIMARY CARE PROVIDER'S START DATE IS A VALID DATE
 AND PRIMARY CARE PROVIDER'S INFORM DATE IS GREATER THAN ZERO
 AND PRIMARY CARE PROVIDER'S INFORM DATE NOT GREATER THAN
 CURRENT CLAIM'S FIRST DATE OF SERVICE
 IF CURRENT CLAIM'S PRIMARY CARE PROVIDER DATA IS ALREADY ON FILE
 AND CURRENT CLAIM'S PRIMARY CARE PROVIDER START DATE ON FILE
 NOT EQUAL TO THE CURRENT CLAIM'S START DATE
 IF CURRENT CLAIM HAS NOT ALREADY RECEIVED THE ' 38' HEADER-
 LEVEL RELEASE CODE
 IF CURRENT CLAIM'S RECIPIENT ID NUMBER NOT EQUAL TO SPACES
 IF CURRENT CLAIM'S CHANGE REASON CODE NOT EQUAL TO 'Y'
 IF THE PROVIDER NUMBER ON FILE IS NOT EQUAL TO THE CLAIM'S
 PROVIDER NUMBER, ATTENDING PHYSICIAN NUMBER or REFERING
 PHYSICIAN NUMBER
 IF THE CLAIM IS NOT AN ADJUSTMENT CLAIM AND IT IS NOT OF
 REGION 94
 IF THE CLAIM IS NOT A LAB-AND-XRAY CLAIM)

OR

(IF MC-SW NOT EQUAL TO 'Y'
 IF BYPASS-PCP NOT EQUAL TO 'Y' AND BYPASS-TCM NOT EQUAL TO 'Y'
 IF CURRENT CLAIM'S DETAIL-LEVEL PERFORMING PHYSICIAN EQUAL TO SPACES
 IF CURRENT CLAIM'S PRIMARY CARE PHYSICIAN DATA IS NOT ON FILE
 IF CURRENT CLAIM'S PLACE OF SERVICE CODE IS NOT EQUAL TO '7' or 'A'
 IF CURRENT CLAIM IS NOT AN ADJUSTMENT CLAIM AND IT IS NOT OF
 REGION 49)
OR

(IF MC-SW NOT EQUAL TO 'Y'
 IF BYPASS-PCP NOT EQUAL TO 'Y' AND BYPASS-TCM NOT EQUAL TO 'Y'
 IF CURRENT CLAIM'S DETAIL-LEVEL PERFORMING PHYSICIAN EQUAL TO SPACES
 IF CURRENT CLAIM'S PRIMARY CARE PHYSICIAN DATA IS ON FILE
 IF CURRENT CLAIM'S START DATE ON FILE IS GREATER THAN ITS PRIMARY
 CARE PROVIDER'S INFORM DATE AND CURRENT CLAIM'S START DATE ON
 FILE IS GREATER THAN THE CLAIM'S FIRST DATE OF SERVICE AND
 CURRENT CLAIM'S DETAIL-LEVEL PLACE OF SERVICE CODE IS NOT EQUAL
 TO '7' or 'A'
 IF CURRENT CLAIM IS NOT AN ADJUSTMENT CLAIM AND CURRENT CLAIM IS
 NOT OF REGION 49)

OR

(IF MC-SW NOT EQUAL TO 'Y'
 IF BYPASS-PCP NOT EQUAL TO 'Y' AND BYPASS-TCM NOT EQUAL TO 'Y'
 IF CURRENT CLAIM'S DETAIL-LEVEL PERFORMING PHYSICIAN EQUAL TO SPACES
 IF CURRENT CLAIM'S PRIMARY CARE PHYSICIAN DATA IS ON FILE
 IF CURRENT CLAIM'S RECIPIENT ID NUMBER EQUAL TO SPACES AND ITS
 DETAIL-LEVEL PLACE OF SERVICE CODE IS NOT EQUAL TO '7' or 'A'
 IF CURRENT CLAIM'S CHNG REASON CODE NOT EQUAL TO 'EX'
 IF NOT CLMT-ADJUSTMENT AND CURRENT CLAIM IS NOT OF REGION 49)

OR

(IF MC-SW NOT EQUAL TO 'Y'
 IF BYPASS-PCP NOT EQUAL TO 'Y' AND BYPASS-TCM NOT EQUAL TO 'Y'
 IF CURRENT CLAIM'S DETAIL-LEVEL PERFORMING PHYSICIAN EQUAL TO SPACES
 IF CURRENT CLAIM'S PRIMARY CARE PHYSICIAN DATA IS ON FILE
 IF CURRENT CLAIM'S RECIPIENT ID NUMBER NOT EQUAL TO SPACES AND ITS
 DETAIL-LEVEL PLACE OF SERVICE CODE IS NOT EQUAL TO '7' or 'A'
 IF CURRENT CLAIM'S CHNG REASON CODE NOT EQUAL TO 'PE'
 IF NOT CLMT-ADJUSTMENT AND CURRENT CLAIM IS NOT OF REGION 49)

OR

(IF CURRENT CLAIM'S RECORD CODE IS NOT EQUAL TO 'Q', 'U' or 'R'
 IF ((CURRENT CLAIM'S PROVIDER TYPE CODE IS NOT EQUAL TO '01' or '70 WITH A
 PROVIDER SPECIALTY CODE NOT EQUAL TO '15', '16', '18', '26', '05', '30' or '71) OR
 CURRENT CLAIM'S PROVIDER TYPE CODE IS NOT EQUAL TO '26', '28', '30', '31',
 '40', '37', '71' or '72)) AND CLAIM'S PROVIDER NUMBER IS NOT IN THE RANGE OF
 '000050522' through '000050553'
 IF CURRENT CLAIM'S DETAIL-LEVEL PERFORMING PHYSICIAN IS EQUAL TO
 SPACES
 IF CURRENT CLAIM'S PRIMARY CARE PROVIDER DATA IS ALREADY ON FILE
 AND ITS PRIMARY CARE PROVIDER START DATE IS NOT EQUAL TO THE FIRST
 DATE OF SERVICE ON THE CURRENT CLAIM
 IF PRIMARY CARE PROVIDER IS LESS THAN OR EQUAL TO THE FIRST DATE
 OF SERVICE ON THE CURRENT CLAIM
 IF CURRENT CLAIM'S PRIMARY CARE PROVIDER STOP DATE IS GREATER
 THAN OR EQUAL TO THE CLAIM'S LAST DATE OF SERVICE
 AND CURRENT CLAIM'S PRIMARY CARE PROVIDER STOP DATE IS
 GREATER THAN THE CLAIM'S INFORM DATE
 IF ((CURRENT CLAIM'S PRIMARY CARE PROVIDER STOP DATE ON FILE IS
 GREATER THAN OR EQUAL TO THE CLAIM'S LAST DATE OF SERVICE) AND (CURRENT CLAIM'S PRIMARY CARE PROVIDER STOP DATE ON FILE IS GREATER THAN OR EQUAL TO THE CLAIM'S PRIMARY CARE PROVIDER STOP DATE))

PROVIDER'S INFORM DATE)) OR CURRENT CLAIM'S PRIMARY CARE PROVIDER STOP DATE ON FILE IS EQUAL TO '01/01/0001'
IF CURRENT CLAIM'S RECIPIENT ID NUMBER ON FILE IS GREATER THAN SPACES
IF CURRENT CLAIM'S RECIPIENT ID NUMBER IS NOT EQUAL SPACES TO CURRENT CLAIM'S RECIPIENT ID NUMBER ON FILE
IF NOT CLMT-ADJUSTMENT)

OR

( IF CURRENT CLAIM'S RECORD CODE IS NOT 'Q', 'U' or 'R'
IF ((CURRENT CLAIM'S PROVIDER TYPE CODE IS NOT EQUAL TO '01' or '70 WITH A PROVIDER SPECIALTY CODE NOT EQUAL TO '15', '16', '18', '26', '05', '30' or '71) OR CURRENT CLAIM'S PROVIDER TYPE CODE IS NOT EQUAL TO '26', '28', '30', '31', '40', '37', '71' or '72)) AND CLAIM'S PROVIDER NUMBER IS NOT IN THE RANGE OF '000050522' through '000050553'
IF CURRENT CLAIM'S DETAIL-LEVEL PERFORMING PHYSICIAN IS EQUAL TO SPACES
IF CURRENT CLAIM'S PRIMARY CARE PROVIDER DATA IS ALREADY ON FILE AND ITS PRIMARY CARE PROVIDER START DATE IS NOT EQUAL TO THE CLAIM'S FIRST DATE OF SERVICE
IF CURRENT CLAIM'S RECIPIENT ID NUMBER IS NOT EQUAL TO SPACES OR (CURRENT CLAIM'S DETAIL-LEVEL PLACE OF SERVICE INDICATOR IS NOT EQUAL TO '7' or 'A')
IF CURRENT CLAIM'S PRIMARY CARE PROVIDER HAS NO ALTERNATE ALIAS ON FILE
IF NOT CLMT-ADJUSTMENT AND CURRENT CLAIM IS NOT OF REGION 49)

Top
EXPLANATION OF BENEFITS (EOB) CODE : 042

MESSAGE TEXT:
CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1130, SB1250, SB1330, SB710025
JOB(s): SB1J050, SB1J075, SB1J085, ONLINE

SITUATION:
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER
THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF (NOT BAD-PRICE-RETURN OR (LVL3-PROC-STAT NOT EQUAL TO 1
AND LAST DAY OF SERVICE NOT LESS THAN WORK-LEVEL3-DATE-N))
AND REVENUE CODE EQUAL TO '983'
AND
IF NOT LVL3-INACTV-PROC AND
(WORK-LEVEL3-DATE-N GREATER THAN LAST DAY OF SERVICE)
AND
AND
IF PRICING INDICATOR IS EQUAL TO 0
OR
IF PRICING INDICATOR IS EQUAL TO 1
OR
IF PRICING INDICATOR IS EQUAL TO 2 OR 4
AND
IF CLMT-LVL2-PRVL-CHG EQUAL TO +0
OR
IF (PROVIDER NUMBER GREATER THAN '000058999' AND LESS THAN '000060000')
AND PROCEDURE CODE WAS FOUND ON THE PROCEDURE CODE LIST FILE
OR
IF PRICING INDICATOR IS EQUAL TO 3
   IF CLMT-LVL3-ALW-CHG EQUAL TO +0
   OR
      IF (PROVIDER NUMBER GREATER THAN '000058999' AND LESS THAN '000060000')
      AND PCLIST-FOUND-PROC-SW = 'Y'
   OR
      IF MANUAL PRICE
   OR
      IF CLMT-PRICE-AS-BILL
   OR
      IF NOT VALID-PROC-PRICE-IND
   AND
   IF DENTAL CLAIM AND RELEASE CODE IS EQUAL TO SPACES
   AND SUBMITTED CHARGE IS GREATER THAN ALLOWED CHARGE

SB1250 – SB1J075 – SITUATION:
   IF SW-PCN-BRK EQUAL TO 'YES'
   AND
       IF NHLI-SUB GREATER THAN ZEROS
   AND
       IF WTN1-RECORD CODE EQUAL TO 'N' AND
       WTN1-RECORD NUMBER EQUAL TO NHCT-SUB
       IF WTN1-SERVICE CODE EQUAL TO 'I'
       IF CLAIM REGION EQUAL TO 20
           AND (WTN1-TRANS STATUS NOT EQUAL TO '2' AND
           WTN1-TRANS STATUS NOT EQUAL TO '3')
           IF STORED SERVICE DATE YEAR EQUAL TO NH LEAVE YEAR
           IF WTN1-UNITS OF SERVICE GREATER THAN ALLOWED SERVICE LIMIT
   OR
       IF WORK SERVICE DATE NOT LESS THAN LEAVE FROM DATE AND
       NOT GREATER THAN LEAVE TO DATE
       IF UNITS OF SERVICE GREATER THAN ALLOWED SERVICE LIMIT

SB1330 – SB1J085 – SITUATION:
   IF DEL-CLM-STCD = 'G' OR 'B' OR '
   OR
   IF THE CLAIM HAS COPAY
   AND
   IF WS-SB109B-TEEM-CLIENT EQUAL TO 'Y'
       AND WORK-PASSED-MED-POL
       IF SQLCODE EQUAL TO +100
       IF ERR-RETURN EQUAL TO 3
   OR
   IF ERR-RETURN EQUAL TO 3
   OR
   IF CLAIM REGION IS EQUAL TO 90
   OR
   IF (CLAIM REGION IS EQUAL TO 90) AND
   (PRICING INDICATOR NOT EQUAL TO 8)
   IF UPDAT-ADA-CNT GREATER THAN ET-ADA-CNT-NUM
   AND
   IF TIMES-SW EQUAL TO '
   IF SQLCODE NOT EQUAL TO 0
   AND
   IF (CLAIM REGION 10 OR 40)
   OR 1ST DAY OF SERVICE NOT LESS THAN 19960831
   AND
IF (MEDICAL CLAIM OR CROSSOVER CLAIM)
  IF NOT DENIED CLAIM
  AND
  IF TYPE OF SERVICE CODE EQUAL TO '9' OR 'R'
  IF PRICE LEVEL USED NOT EQUAL TO 'A'
  AND PRICE LEVEL USED NOT EQUAL TO 'C'
  AND PRICE LEVEL USED NOT EQUAL TO '5'
  IF (PRICE LEVEL USED EQUAL TO '3'
      AND LVL3 ALLOWED CHARGE EQUAL TO 0)
  OR (PRICE LEVEL USED EQUAL TO '2'
      AND LVL2 PRVL CHARGE) EQUAL TO 0)
  OR (PRICE LEVEL USED EQUAL TO '1'
      AND LVL1 CUST MEDICAL CHARGE EQUAL TO 0)
  OR (PRICE LEVEL USED NOT LESS THAN 'E'
      AND NOT GREATER THAN 'P')
  IF PROCEDURE CODE NOT FOUND ON THE PROCEDURE CODE LIST FILE
  IF (RELEASE CODE IS NOT EQUAL TO 'N10')
  IF PROCEDURE CODE-1 NOT LESS THAN 'A' AND NOT GREATER THAN 'W'
  OR (PROCEDURE CODE FOUND ON PROCEDURE CODE LIST FILE)
  IF PROCEDURE CODE NOT FOUND ON THE PROCEDURE CODE LIST FILE
  IF DETAIL PAID AMOUNT GREATER THAN 0

SB710025 – SITUATUON:
  IF POSFI-DRUG-CD EQUAL TO ('00033333333' OR '00099999999')
  OR POSFI-DRUG-CD (1:5) EQUAL TO ('00999' OR '00099')
  AND
  IF WS-CLAIM-DISP-IND NOT EQUAL TO '1' AND CA-POS-CLAIM
  AND
  WHEN WS-CLAIM-DISP-IND NOT EQUAL TO '1' OR '2' OR '3'
  AND
  IF PRICING INDICATOR EQUAL TO '6'
    IF RELEASE CODE EQUAL TO SPACES
    OR
  IF PRICING INDICATOR NOT EQUAL TO '6'
    IF POSFI-DAW-CD EQUAL TO '1' AND
       POSFI-NUMBER-DRUG-OCCUR-CNT EQUAL TO 1
       AND POSFI-ACQ-WHSE-CST GREATER THAN ZEROS
       IF RELEASE CODE EQUAL TO SPACES
    OR
    IF POSFI-MAC-PRICE GREATER THAN ZEROS
       AND POSFI-MAC-PRICE LESS THAN POSFI-ACQ-WHSE-CST
       IF RELEASE CODE EQUAL TO SPACES
    OR
    IF RELEASE CODE EQUAL TO SPACES

Top
EXPLANATION OF BENEFITS (EOB) CODE : 047

MESSAGE TEXT:
THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED, MISSING, OR ARE INVALID.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1070 JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR '
' OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
   IF ((UB82 CLAIM)
       AND DRUG CODE IS EQUAL TO SPACES) OR (MEDICAL CLAIM
       AND DRUG CODE IS EQUAL TO SPACES AND PROVIDER TYPE CODE
       NOT EQUAL TO '58')
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: 052

MESSAGE TEXT:
N) THE REFERRING/PRESCRIBING/RENDERING PROVIDER IS NOT ELIGIBLE TO REFER/PRESCRIBE/ORDER/PERFORM THE SERVICE BILLED.

C) NON-MATCHED CARDHOLDER ID

SOURCE CODE:
“N” = NCPDP
“C” = Contractual Obligation

DATE CREATED: 11/21/2002

PROGRAM(s): SB1090  JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM WITH A VALID RECIPIENT ID NUMBER ON FILE

AND

(IF CURRENT CLAIM HAS ALREADY BEEN ASSIGNED AN ERROR CODE OR REC-NAME-SAVE-1 = REC-NAME-SAVE-2 OR (RECIPIENT’S EIGHTH AND NINTH POSITIONS OF THE ID NUMBER IS EQUAL TO 'CS' OR RECIPIENT’S EIGHTH AND NINTH POSITIONS OF THE ORIGINAL ID NUMBER IS EQUAL TO 'CS') IF CURRENT CLAIM IS A PROFESSIONAL CLAIM IF CURRENT CLAIM CONTAINS A VALID PROCEDURE CODE IF CURRENT CLAIM’S DETAIL-LEVEL PERFORMING PHYSICIAN ID NUMBER IS LESS THAN '000079000' OR GREATER THAN '000079999') IF CURRENT CLAIM IS NOT AN ADJUSTMENT)
EXPLANATION OF BENEFITS (EOB) CODE: 057

MESSAGE TEXT:
PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY.

SOURCE CODE: “C” = Contractual Obligation
“C” = Contractual Obligation
“P” = Patient Responsibility
“N” = NCPDP
“R” = Remittance Advice

DATE CREATED: 11/21/2002

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER AND

(CURRENT CLAIM HAS DATA ALREADY ON SB644010 ADABAS FILE AND CLAIM HAS ALREADY RECEIVED AN ERROR CODE OF ‘232’)

Top
EXPLANATION OF BENEFITS (EOB) CODE : 062

MESSAGE TEXT:
CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

SOURCE CODE:
“P” = PATIENT RESPONSIBILITY

DATE CREATED: 11/21/02

PROGRAM(s): SB1090, SB1130, SB1250       JOB(s): SB1J040, SB1J050, SB1J075

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM, RECIPIENT IS ON FILE

AND

(IF CLAIM IS A UB82-INPATIENT-CLAIM AND ITS ADMISSION DATE IS GREATER THAN 19950630 AND IT’S NOT AN ADJUSTMENT
IF ITS VR-PROVIDER NOT EQUAL TO '002433' AND NOT EQUAL TO '001086'
AND NOT EQUAL TO '001793' AND NOT EQUAL TO '001479'
IF ((ITS PROVIDER TYPE CODE EQUAL TO '02') AND (ITS RECIPIENT AGE IS GREATER THAN 20))
IF ITS TOTAL DAYS BILLED IS GREATER THAN 21)

OR

(IF CLAIM IS A UB82-INPATIENT-CLAIM AND ITS ADMISSION DATE IS GREATER THAN 19950630 AND IT’S NOT AN ADJUSTMENT
IF ITS VR-PROVIDER NOT EQUAL TO '002433' AND NOT EQUAL TO '001086'
AND NOT EQUAL TO '001793' AND NOT EQUAL TO '001479'
IF ((ITS PROVIDER TYPE CODE EQUAL TO '04' or '06') AND (ITS RECIPIENT AGE IS GREATER THAN 20))
IF ITS TOTAL DAYS BILLED IS GREATER THAN 30)

OR

((CURRENT CLAIM HAS BEEN FLAGGED FOR CHILD ABUSE OR ITS ACCIDENT TYPE INDICATOR IS EQUAL TO SPACES) AND
IF QUANTITY OF SB644010 LESS THAN OR EQUAL TO ZERO
IF QUANTITY OF SB644010 LESS THAN OR EQUAL TO ZERO
IF (CLAIM’S REGION EQUAL TO ‘94’ AND ((ITS PROVIDER NUM GREATER THAN ‘000032313’ AND LESS THAN ‘000032322’) OR (ITS PROVIDER NUM GREATER THAN ‘000033055’ AND LESS THAN ‘000033060’)) OR (CLAIM’S REGION IS EQUAL TO ‘90’
AND (ITS PROVIDER NUM EQUAL TO ’000034784’, ’000034785’, or ’000034786’))))

SB1130(SB1J050) – SITUATION:
IF PAYABLE CLAIM
IF NOT A DENIED CLAIM
AND
IF 1ST DAY OF SERVICE IS GREATER THAN 19960831
AND (IF CLAIM REGION IS EQUAL TO 10 OR 40)
AND
IF PCLIST-2ND-PROC-SW EQUAL TO 'Y'
OR ((SUBMITTED CHARGE GREATER THAN 199.99)
AND IF FOUND ON PROCEDURE CODE LIST)
IF DME-NEED-PRIOR-SW EQUAL TO 'Y'
   IF NOT CROSSOVER CLAIM
   AND RENTAL-LEEWAY-SW = 'Y'
AND
IF PRIOR-FOUND-SW = 'N'
   IF RENTAL-LEEWAY-SW = 'N'
      IF PRIOR-DENY-SW = 'Y'
         IF NOT ADJUSTMENT CLAIM
OR
      IF 606-SW EQUAL TO 'Y'
         IF NOT ADJUSTMENT CLAIM
OR
      IF NOT ADJUSTMENT CLAIM
SB1250 – SB1J075 – SITUATION:
   IF SW-PCN-BRK EQUAL TO 'YES'
   AND
      IF DCDT-636-ERR EQUAL TO 'Y'
   AND
      IF WTP2-ICN EQUAL TO DCDT-ICN
      AND WTP2-LINE ITEM NUMBER EQUAL TO DCDT-DETAIL NUMBER
      IF NOT ADJUSTMENT CLAIM
Top
EXPLANATION OF BENEFITS (EOB) CODE: 078

MESSAGE TEXT: REVIEWED BY STATE EXAMINER

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB710025 JOB(s): SB1J020, ONLINE

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'M' OR 'L' OR 'A' OR 'Q' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' '
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
  IF WK-DAYS EQUAL TO 1
  OR
  IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF Crossover CLAIM
OR Institutional CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR Crossover CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 Home Health AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF Nurse Home CLAIM AND
  (CLAIM REGION IS EQUAL TO A 20 OR 21) AND
  (VR PROVIDER NUMBER NOT EQUAL TO '001086' AND NOT EQUAL TO '002435'
  AND NOT EQUAL TO '050383')
  IF (SERVICE CODE IS EQUAL TO 'Q' OR 'S') AND
  (UNITS OF SERVICE NOT EQUAL TO NON COVERED DAYS)
  IF CLAIM REGION IS EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
SB710025 – SITUATION:
  IF POSFI-DRUG-CD EQUAL TO ('00033333333' OR '00099999999')
  OR POSFI-DRUG-CD (1:5) EQUAL TO ('00999' OR '00099')
  AND
  IF WS-CLAIM-DISP-IND NOT EQUAL TO '1' AND CA-POS-CLAIM
  AND
  WHEN WS-CLAIM-DISP-IND NOT EQUAL TO '1' OR '2' OR '3'
  AND
  IF PRICING INDICATOR EQUAL TO '6'
    IF RELEASE CODE EQUAL TO SPACES
  OR
  IF PRICING INDICATOR NOT EQUAL TO '6'
  IF POSFI-DAW-CD EQUAL TO '1' AND
  POSFI-NUMBER-DRUG-OCCUR-CNT EQUAL TO 1
  AND POSFI-ACQ-WHSE-CST GREATER THAN ZEROS
  IF RELEASE CODE EQUAL TO SPACES
  OR
  IF POSFI-MAC-PRICE GREATER THAN ZEROS
  AND POSFI-MAC-PRICE LESS THAN POSFI-ACQ-WHSE-CST
  IF RELEASE CODE EQUAL TO SPACES
  OR
  IF RELEASE CODE EQUAL TO SPACES
EXPLANATION OF BENEFITS (EOB) CODE : 085

MESSAGE TEXT:
   A) INTEREST AMOUNT.
   B) CLAIM NOT PROCESSED

SOURCE CODE:
A) “C” = CONTRACTUAL OBLIGATION
B) “N” = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1550      JOB(s): SB1J510

SITUATION:
   IF TRAN-READ-KEY EQUAL TO HIGH-VALUES
   OR
   IF PAYABLE CLAIM
      IF PROVIDER NUMBER NOT EQUAL TO STORED PROVIDER NUMBER
      AND
   IF ACTI-ACTIVE
      IF ACTI-AR-REC
      AND
   IF ACTI-SETUP
      IF ACTI-AR-RECOUP
         IF REIMBURSTMENT AMOUNT GREATER THAN ZERO
         OR
      IF NOT ACTI-AR-RECOUPEMENT
      IF ACTI-AR-PAYOUT
      AND
   IF RECIPIENT CURRENT PCN NOT EQUAL TO ’999777777'
   IF NOT ACTO-AR-RECOUP
EXPLANATION OF BENEFITS (EOB) CODE : 087

MESSAGE TEXT: TRANSFER AMOUNT.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1130 JOB(s): SB1J050

SITUATION:
IF PAYABLE CLAIM
AND
IF NOT DENIED CLAIM
AND
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711' AND
PVF-STATUS NOT EQUAL TO '00' AND REVENUE CODE EQUAL TO 983
AND ((1ST DAY OF SERVICE LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR LESS THAN 0)
OR (REVENUE CODE NOT EQUAL TO 521 OR 522
AND 1ST DAY OF SERVICE LESS THAN 20011231 AND
(PROVIDER NUMBER LESS THAN '00004999' AND GREATER THAN '000006000'))
OR (1ST DAY OF SERVICE LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND PROV-PREV-OPT-RR LESS THAN 0
AND REVENUE CODE EQUAL TO 521 OR 522))
AND
IF NOT (PROFESSIONAL CLAIM AND
(UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS NOT EQUAL TO '00' AND PROV-CURR-OPT-RR LESS THAN 0))
OR REVENUE CODE NOT EQUAL TO 983
OR NOT CROSSOVER CLAIM
AND
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF UB82 INPATIENT CLAIM
IF DTE-RANGE-FND EQUAL TO 'Y'
AND
IF NOT CLMT-DENIED-CLAIM
IF DTE-RANGE-FND EQUAL TO 'Y' OR FOUND-F439 EQUAL TO 'Y'
IF NOT BAD-PRICE-RETURN
IF DTE-RANGE-FND EQUAL TO 'Y'
AND
IF TRANSFER-DRG-PRICE GREATER THAN 0
EXPLANATION OF BENEFITS (EOB) CODE : 088

MESSAGE TEXT:
A) ADJUSTMENT AMOUNT REPRESENTS COLLECTION AGAINST RECEIVABLE CREATED IN PRIOR OVER PAYMENT.
B) DUR REJECT ERROR.

SOURCE CODE:
A) “C” = CONTRACTUAL OBLIGATION
B) “N” = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1550 JOB(s): SB1J510

SITUATION:
A)
IF TRAN-READ-KEY NOT EQUAL TO HIGH-VALUES
IF CLAIM CREDIT
IF WORK-ICN NOT EQUAL TO ADJ-ICN-HOLD
OR
IF CLMO-REIMBURSTMENT AMOUNT GREATER THAN EOP-AMOUNT-CLAIMS-ATP
OR
IF WORK-ICN EQUAL TO ADJ-ICN-HOLD
B)
IF TRAN-READ-KEY NOT EQUAL TO HIGH-VALUES
AND
IF CLM-PRCS-TXCD EQUAL TO ‘10’
OR
IF CLM-PRCS-TXCD EQUAL TO ‘80’ OR ‘90’
AND
IF CLM-PRCS-TXCD EQUAL TO ‘80’
OR
IF CLM-PRCS-TXCD NOT EQUAL TO ‘80’
C)
IF TRAN-READ-KEY EQUAL TO HIGH-VALUES
OR
IF PAYABLE CLAIM
IF PROVIDER NUMBER NOT EQUAL TO STORED PROVIDER NUMBER
AND
IF ACTI-ACTIVE
IF ACTI-AR-REC
AND
IF ACTI-SETUP
IF ACTI-AR-RECOUP
IF REIMBURSTMENT AMOUNT GREATER THAN ZERO
OR
IF NOT ACTI-AR-RECOUPEMENT
IF ACTI-AR-PAYOUT
AND
IF RECIPIENT CURRENT PCN NOT EQUAL TO ‘999777777’
IF ACTO-AR-RECOUP
OR
IF ACTO-CLERK EQUAL TO ‘LTC’
EXPLANATION OF BENEFITS (EOB) CODE: 096

MESSAGE TEXT:
A) NON-COVERED CHARGE(S).
B) SCHEDULED DOWNTIME.

SOURCE CODE
A) "P" = PATIENT RESPONSIBILITY
B) "N" = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1130, SB1330  JOB(s): SB1J050, SB1J085

SITUATION:
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711'
AND (PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000')
AND 1ST DAY OF SERVICE LESS THAN 20011231
AND
IF INPATIENT CLAIM
IF CLAIM REGION NOT EQUAL TO 70 AND
(SERVICE CODE NOT EQUAL TO 'P' OR 'B' OR 'Z')
AND
IF NOT CLAIM REGION 90
AND
IF SERVICE CODE IS EQUAL TO 'A' OR 'B' OR 'C' OR 'E' OR 'G'
OR
IF UB82 INPATIENT CLAIM
IF CLAIM REGION NOT EQUAL TO 70
AND
IF CLMT-REV-VALID-ACCOM
IF DRG-PRICING NOT EQUAL TO 'Y'
OR
IF NURSE HOME CLAIM AND DD PROCEDURE CODE NOT EQUAL TO '022'
IF (SERVICE CODE EQUAL TO '1' THRU '9'
OR 'G' THRU 'H' OR 'J' THRU 'N' OR 'Q' THRU 'Y')
OR SERVICE CODE EQUAL TO 'J' OR 'K' OR 'L' OR 'O' OR 'Z')
AND VR PROVIDER NOT EQUAL TO '001086'
IF (PROV-OUT-OF-STATE
    AND SERVICE CODE EQUAL TO '1' THRU '9' OR 'G')
OR SERVICE CODE EQUAL TO '1' THRU '9'
    OR 'G' OR 'H' OR 'J' OR 'N' OR 'Q' THRU 'Y'
OR
IF VR PROVIDER EQUAL TO '001086' OR '002435' OR '050383'
    OR '017553'
    IF SERVICE CODE EQUAL TO '3' THRU '6'
AND
IF NURSE HOME CLAIM
AND
IF SERVICE CODE EQUAL TO 'Q' OR 'S'

SB1330 – SB1085 – SITUATION:
IF DEL-CLM-STCD = 'G' OR 'B' OR ' ' OR
OR
IF THE CLAIM HAS COPAY
AND
IF WS-SB109B-TEEM-CLIENT EQUAL TO 'Y'
    AND WORK-PASSED-MED-POL
    AND
    IF SQLCODE EQUAL TO +100
    IF ERR-RETURN EQUAL TO 3
OR
IF ERR-RETURN EQUAL TO 3
OR
IF CLAIM REGION IS EQUAL TO 90
OR
IF (CLAIM REGION IS EQUAL TO 90) AND
    (PRICING INDICATOR NOT EQUAL TO 8)
    IF UPDAT-ADA-CNT GREATER THAN ET-ADA-CNT-NUm
    AND
    IF NOT CLAIM CREDIT
    IF (SERVICE CODE EQUAL TO 'E' OR 'F' OR 'J')
        OR (SERVICE CODE EQUAL TO 'G'
            AND 1ST PROCEDURE SERVICE DATE GREATER THAN 19990630)
    IF UPDAT-SB51-CNT GREATER THAN ET-SB515020-UPD-CNT
    AND
    IF VALID RECORD ON SB515020 FILE
    IF SUSPEND-DD EQUAL TO 'Y'
AND
    IF ERR-RETURN EQUAL TO 3
AND
IF DEL-008-FLAG EQUAL TO '1'
    IF DEL-ERR-CD (1) EQUAL TO '008'
    IF DEL-ERR-CD-STAS (1) EQUAL TO 'D'
    IF DEL-ERR-CD (2) EQUAL TO SPACES
OR
    IF LEVEL 3 IS EQUAL TO 1
EXPLANATION OF BENEFITS (EOB) CODE: 097

MESSAGE TEXT:
A) PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
B) PAYER UNAVAILABLE

SOURCE CODE
A) “C” = CONTRACTUAL OBLIGATION
B) “N” = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1130 JOB(s): SB1J050

SITUATION:
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF NURSE HOME CLAIM
IF NOT PROVIDER OUT OF STATE
AND NOT(PROVIDER NUMBER GREATER THAN '000030799' AND LESS THAN
'000032000')
AND NOT(PROVIDER NUMBER GREATER THAN '000001899' AND LESS THAN
'000002000')
IF SERVICE CODE EQUAL TO 'J' OR 'K' OR 'L' OR 'E'
OR 'H' OR 'M' OR 'N' OR 'O' OR 'P' OR 'U'
OR 'W' OR 'X' OR 'Y' OR 'Z'
OR IF DD PROCEDURE CODE EQUAL TO '022'
OR
IF UB82 INPATIENT CLAIM
AND (PROVIDER TYPE CODE EQUAL TO '02' OR '04')
AND 1ST DAY OF SERVICE GREATER THAN 20020731
IF NOT VALID-REV
OR
IF UB82 OUTPATIENT CLAIM
IF REVENUE CODE IS EQUAL TO 912
((REVENUE CODE GREATER THAN 429 AND LESS THAN 440) OR
(REVENUE CODE EQUAL TO 901 OR 903 OR 904

04/04/06
OR 910 OR 914 OR 915 OR 916 OR 918 OR 942) OR
(CPT4 CODE EQUAL TO 'G0129' OR 'G0176' OR 'G0177'))
OR
IF (CPT4 CODE EQUAL TO 'G0129' OR 'G0176' OR 'G0177')
AND 1ST DAY OF SERVICE GREATER THAN 20020731
OR
IF (PROVIDER NUMBER GREATER THAN OR EQUAL TO '000003000'
AND LESS THAN OR EQUAL TO '000003099')
AND (REVENUE CODE NOT EQUAL TO 912)
OR
IF ASC-TY-S EQUAL TO 'Y'
IF F457-SW EQUAL TO 'Y'
EVALUATE REVENUE CODE
WHEN '250' THRU '252'
WHEN '257' THRU '259'
WHEN '270'
WHEN '272'
WHEN '370' THRU '399'
WHEN '450' THRU '459'
WHEN '510' THRU '529'
WHEN '700' THRU '719'
WHEN '750' THRU '769'
WHEN '920'
WHEN '929'
WHEN '940'
WHEN '949'
IF RELEASE CODE NOT GREATER THAN SPACES

Top
EXPLANATION OF BENEFITS (EOB) CODE : 101

MESSAGE TEXT:
DEDUCTIBLE AMOUNT.

SOURCE CODE:
“P” = PATIENT RESPONSIBILITY

DATE CREATED: 11/21/02

PROGRAM(s): SB1070 JOB(s): SB1J020

SITUATION:
IF ERROR-SW EQUAL TO ZERO
  IF ENTRX-CD2 EQUAL TO '4' OR '5'
AND
IF ENTRX-CD1 EQUAL TO CLAIM RECORD CODE
  IF ENTRX-CD2 EQUAL TO '4'
AND
IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
  IF WK-DAYS EQUAL TO 1
   OR
     IF DAYO-TYPE-OF-CYCLE = 'Y' AND CLMI-NO-ERRORS
AND
IF DENTAL CLAIM
  AND PRED-BENEFITS-SW = 'Y'
EXPLANATION OF BENEFITS (EOB) CODE: 119

MESSAGE TEXT:
BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.

SOURCE CODE: “P” = PATIENT RESPONSIBILITY

DATE CREATED: 11/21/02

PROGRAM(s): SB1070  JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS IS EQUAL TO ZERO AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF PROVIDER NUMBER IS EQUAL TO '000035434'
AND
IF UNITS OF SERVICE COUNTER IS GREATER THAN 184
AND
IF NOT ADJUSTMENT CLAIM
OR
IF CLAIM REGION EQUAL TO 94
AND DET-GT-5-SW NOT EQUAL TO 'Y'
IF PROCEDURE CODE FOUND ON PROCEDURE CODE LIST
AND
    IF WS-UNITS GREATER THAN 23
    IF (PROVIDER NUMBER GREATER THAN '000033055' AND LESS THAN '000033060')
    IF NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: 120

MESSAGE TEXT:
A) THE DIAGNOSIS IS INCONSISTENT WITH THE PROVIDER TYPE.
B) M/I PATIENT LOCATION

SOURCE CODE:
A) “C” = CONTRACTUAL OBLIGATION
B) “N” = NCPDP

DATE CREATED: 11/13/02

PROGRAM(s): SB710023     JOB(s): ONLINE

SITUATION:

IF POSFI-NUMBER-DRUG-OCCUR-CNT EQUAL TO 1
  IF PRICING INDICATOR IS EQUAL TO ‘6’
    OR (POSFI-MAC-PRICE EQUAL TO ZERO
        AND POSFI-ACQ-WHSE-CST EQUAL TO ZERO)
    OR
      IF HOLD-DRUG-PRICE LESS THAN .01
AND
  IF N1500213-MCARE-INDICATOR EQUAL TO 'Y'
      AND WTBLDRUG-MEDICARE EQUAL TO 'Y'
      IF POSFI-DT-DSPNS NOT LESS THAN 19991201
      AND RECIPIENT LIVING ARRANGEMENT NOT EQUAL TO '5'
    OR
    IF POLICY-CNT EQUAL TO 0
      AND TOTAL OTHER INSURANCE GREATER THAN ZERO
      IF CLAIM REGION IS EQUAL TO 40 OR 10
        IF RELEASE CODE IS EQUAL TO SPACES OR '00000'
    OR
    IF (POLICY COUNT GREATER THAN 0
        AND TOTAL OTHER INSURANCE EQUAL TO 0)
        IF N1500213-MCARE-INDICATOR NOT EQUAL TO 'Y'
        AND WTBLDRUG-MEDICARE NOT EQUAL TO 'Y'
        AND RECIPIENT LIVING ARRANGEMENT NOT EQUAL TO '5'
        AND POLICY-CNT NOT EQUAL TO 1
    OR
    IF (POLICY-CNT GREATER THAN 1
        AND (TOTAL OTHER INSURANCE GREATER THAN 0
            AND LESS THAN (POSFI-DRUG-CLM-LDG-TOT (R-SUB) * .50)))
    OR
    IF POSFI-NUMBER-DRUG-OCCUR-CNT NOT EQUAL TO 1
    IF N1500213-MCARE-INDICATOR EQUAL TO 'Y'
      AND WTBLDRUG-MEDICARE EQUAL TO 'Y'
      IF POSFI-DT-DSPNS NOT LESS THAN 19991201
      AND RECIPIENT LIVING ARRANGEMENT NOT EQUAL TO '5'
    OR
    IF POLICY-CNT EQUAL TO 0
      AND TOTAL OTHER INSURANCE GREATER THAN ZERO
      IF CLAIM REGION IS EQUAL TO 40
      AND
        IF NOT (SUSP-EDIT OR SUSP-AUDIT OR REJECTED OR EDIT-ERROR
          OR AUDIT-ERROR OR ERROR-CLAIM OR DENIED-CLAIM)
OR
IF (POLICY-CNT GREATER THAN 0
   AND TOTAL OTHER INSURANCE EQUAL TO 0)
   IF N1500213-MCARE-INDICATOR NOT EQUAL TO 'Y'
   AND WTBLDRUG-MEDICARE NOT EQUAL TO 'Y'
   AND RECIPIENT LIVING ARRANGEMENT NOT EQUAL TO '5'
   AND POLICY-CNT NOT EQUAL TO 1
OR
IF (POLICY-CNT GREATER THAN 1
   AND (TOTAL OTHER INSURANCE GREATER THAN 0
       AND LESS THAN (POSFI-DRUG-CLM-LDG-TOT * .50)))
EXPLANATION OF BENEFITS (EOB) CODE : 125

MESSAGE TEXT:
PAYMENT ADJUSTED DUE TO A SUBMISSION/BILLING ERROR(S). ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.

SOURCE CODE: “C” = Contractual Obligation

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090, SB1130 JOB(s): SB1J020, SB1J040, SB1J050

SITUATION:
A):
IF ERROR-SW IS EQUAL TO ZERO
   IF ENTRX-CD2 IS NOT EQUAL TO '4' OR '5'
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2'
      AND ENTRX-CD1 EQUAL TO 'A'
      AND
      IF ENTRX-CD1 NOT EQUAL TO 'I' OR 'O' OR 'N'
      AND
      IF ENTRX-CD1 EQUAL TO 'M' OR 'S' OR 'L'
      AND
      IF MEDICAL CLAIM
      AND
      IF CLAIM REGION IS EQUAL TO '94' AND
      (FROM DATE OF SERVICE IS NUMERIC)
      AND (TO DATE OF SERVICE IS NUMERIC)
      AND (PROCEDURE CODE IS EQUAL TO '00001' OR '00013' OR '00014'
      OR '00026' OR '00030' OR '00057' OR '00098')
      IF (WK-DAY-CALC NOT EQUAL TO UNITS OF SERVICE
      OR
      (WORK-MON NOT EQUAL TO WORK2-MON) OR (WORK-YR NOT EQUAL TO WORK2-YR)
      IF CLAIM REGION IS EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM

B)
IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' '
   OR
   (IF CORRECTION ID EQUAL TO 'R'
   OR
   IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND
   IF UPDATE-SW NOT EQUAL TO ZERO
   AND
   IF PERR-SW EQUAL TO 'Y'
   OR
   IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM
AND
IF CLAIM REGION IS EQUAL TO 80
AND
IF CROSSOVER CLAIM
AND
IF (UB82 INPATIENT CLAIM AND NOT (BILL TYPE EQUAL TO '111
OR '112' OR '113' OR '114' OR '121'))
OR (UB82 OUTPATIENT CLAIM
AND NOT (BILL TYPE EQUAL TO '131' OR '132' OR '133 OR '134' OR '141' OR '731' OR '831'))
OR (UB82 HOME HEALTH AND NOT (BILL TYPE EQUAL TO '331'
OR '332' OR '333' OR '334' OR '121' OR '711' OR '811' OR '812' OR '813' OR '814'))
OR ((CLMT-UB82-HOME-HEALTH)
AND (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000'))
AND (BILL TYPE NOT EQUAL TO '711'))
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF UB82 INPATIENT CLAIM
IF UB82 SRC OF ADM LESS THAN '1' OR GREATER THAN '9'
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF BILLING FROM DATE IS EQUAL TO ZEROS
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF PERFORMED-EDIT-ERR-SW = 1
IF CLMT-CLM-REGION = 40
AND NOT CLMT-ADJUSTMENT

C)
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR 'Z'
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
OR
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
IF WK-DAYS EQUAL TO 1
OR
IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF BILLING TO DATE IS EQUAL TO = ZEROS
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF PERFORMED-EDIT-ERR-SW EQUAL TO 1
IF CLAIM REGION NOT EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

D)

IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' '
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
IF WK-DAYS EQUAL TO 1
OR
IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF NOT OUTPATIENT CLAIM
OR UB82 OUTPATIENT CLAIM
OR UB82 HOME HEALTH
AND
IF NOT A NURSING HOME CLAIM
AND
IF ADMISSION DATE IS EQUAL TO ZEROS
AND
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
AND
IF PERFORMED-EDIT-ERR-SW IS EQUAL TO 1
IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
   IF NOT OUTPATIENT CLAIM
   OR UB82 OUTPATIENT CLAIM
   OR UB82 HOME HEALTH
   OR IF CLAIM REGION NOT EQUAL TO 40
      AND ADJUSTMENT CLAIM
      IF NOT NURSING HOME CLAIM
      IF ADMISSION DATE GREATER THAN BILLING FROM DATE
      IF CLAIM REGION EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM
OR
   IF NOT OUTPATIENT CLAIM
   OR UB82 OUTPATIENT CLAIM
   OR UB82 HOME HEALTH
   AND
      IF NATURE OF ADMISSION IS NOT EQUAL TO 1 THRU 4
      IF NOT NURSE HOME CLAIM
      IF CLAIM REGION EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM
OR
   IF NOT OUTPATIENT CLAIM
   OR UB82 OUTPATIENT CLAIM
   OR UB82 HOME HEALTH
   AND
      IF NOT (DISCHARGE DESTINATION IS EQUAL TO '9' AND DATE OF DISCHARGE IS
      EQUAL TO ZEROS)
      OR (DISCHARGE DESTINATION IS EQUAL TO '6' AND DATE OF DISCHARGE IS
      EQUAL TO ZEROS)
      AND (CLAIM REGION IS EQUAL TO 20 OR 21)
      AND (PROVIDER NUMBER IS GREATER THAN '000029999' AND LESS THAN
      '000040000')
      AND
      IF DISCHARGE DESTINATION IS EQUAL TO 1 THRU 6, 8, 9
      AND DATE OF DISCHARGE IS EQUAL TO ZEROS
      IF NOT NURSING HOME CLAIM
      IF CLAIM REGION EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM
OR
   IF NOT OUTPATIENT CLAIM
   OR UB82 OUTPATIENT CLAIM
   OR UB82 HOME HEALTH
   OR
      IF (DISCHARGE DESTINATION NOT EQUAL TO '9' OR '6')
      AND
      IF NOT NURSING HOME CLAIM
      IF DATE OF DISCHARGE EQUAL TO ZEROS
      OR
      PERFORMED-EDIT-ERR-SW EQUAL TO 1
      AND
      IF CLAIM REGION EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM
OR
   IF NOT OUTPATIENT CLAIM OR UB82 OUTPATIENT CLAIM OR
   UB82 HOME HEALTH
   AND
      IF NOT VALID DISCHARGE DESTINATION
      AND
      IF NOT NURSING HOME CLAIM
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF UB82 INPATIENT CLAIM
IF UB82 TOTAL DAYS BILLED IS EQUAL TO ZEROS
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF NOT OUTPATIENT CLAIM OR UB82 OUTPATIENT CLAIM OR
UB82 HOME HEALTH
AND
IF ((DISCHARGE DESTINATION IS EQUAL TO '9' AND DISCHARGE DATE IS
GREATER THAN ZEROS)
OR (DISCHARGE DESTINATION IS EQUAL TO '6' AND DISCHARGE DATE IS
GREATER THAN ZEROS))
AND (CLAIM REGION IS EQUAL TO 20 OR 21)
AND (PROVIDER NUMBER GREATER THAN '000029999' AND LESS THAN
'000040000')
IF NOT NURSING HOME CLAIM
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF CLAIM REGION IS NOT EQUAL TO 20 OR 21
OR NOT OUTPATIENT CLAIM
OR NOT UB82 OUTPATIENT CLAIM OR NOT UB82 HOME HEALTH
OR (PROVIDER NUMBER NOT GREATER THAN '000035000' AND NOT LESS THAN
'000037999')
OR NOT NURSE HOME CLAIM
AND
IF UB82 INPATIENT CLAIM
AND
IF CALC-DAYS-TOO NOT GREATER THAN TOTAL DAYS BILLED
AND
IF NOT UB82 INPATIENT CLAIM
AND CALC-DAYS-TOO NOT EQUAL TO +0 AND TOTAL DAYS BILLED NOT
EQUAL TO +1
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF NURSE HOME CLAIM AND NOT CLAIM REGION 21
IF NOT NURSING HOME CLAIM
IF CALC-DAYS-TOO NOT EQUAL TO TOTAL DAYS BILLED
AND
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF THE NUMBER OF DETAIL IS NOT GREATER THAN ZERO
AND
IF CLM-CLM-REGION = 40
AND NOT CLM-ADJUSTMENT

OR
IF (INPATIENT CLAIM OR NURSE HOME CLAIM) AND
NOT (UB82 INPATIENT CLAIM AND (DRUG CODE GREATER THAN 0))
IF NURSE HOME CLAIM
IF NOT NURSING HOME CLAIM
IF WK-COVERED-DAYS GREATER THAN (TOTAL DAYS BILLED + UB82 NON
COVERED DAYS)
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF WK-COVERED-DAYS GREATER THAN (TOTAL DAYS BILLED + UB82 NON COVERED DAYS)
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
    OR
    IF UB82 INPATIENT CLAIM AND
    NOT (UB82 INPATIENT CLAIM AND (DRuG CODE GREATER THAN 0))
    IF WK-COVERED-DAYS GREATER THAN (UB82 TOTAL DAYS BILLED + UB82 NON COVERED DAYS)
    IF CLAIM REGION EQUAL TO 40
    AND NOT CLMT-ADJUSTMENT

E)
IF ERROR-SW IS EQUAL TO ZERO
    AND
    IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
    AND
    IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
    AND
    IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
    OR
    (IF CORRECTION ID EQUAL TO 'R'
    OR
    IF ENTRX-ICN GREATER THAN SUSP-ICN
    AND
    IF UPDATE-SW NOT EQUAL TO ZERO
    AND
    IF PERR-SW EQUAL TO 'Y'
    OR
    IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
    IF WK-DAYS EQUAL TO 1
    OR
    IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
    AND
    IF CROSSOVER CLAIM
    OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
    IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
    AND
    IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
    OR UB82 INST CLAIM OR CROSSOVER CLAIM)
    AND
    IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
    OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
    PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
    AND
    IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
    AND
    IF NOT A UB82 CLAIM
    AND
    IF PROVIDER NUMBER IS EQUAL TO '000035434'
    AND
    IF UNITS OF SERVICE ARE GREATER THAN 8
    OR
    IF NOT REGION '90'
    AND CLAIM SERVICE CODE NOT EQUAL TO 'A' THRU 'Z'
    AND
    IF NOT INPATIENT CLAIM
    AND SERVICE CODE NOT EQUAL TO A OR B OR C OR E OR G
    AND
    IF NURSE HOME CLAIM
IF (REGION 20 OR REGION 21)
   OR (VR PROVIDER IS NOT EQUAL TO '001086' OR '002435'
   OR '050383')
IF SERVICE CODE IS EQUAL TO '1' OR '2' OR '3'
   OR 'Q' OR 'R' OR 'S' OR 'T'
   OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'
   AND
   IF (PROVIDER NUMBER IS GREATER THAN '000030699'
    AND LESS THAN '000030800')
   AND (SERVICE CODE IS NOT EQUAL TO '1' AND NOT EQUAL TO '2'
    AND NOT EQUAL TO '3' AND NOT EQUAL TO '4')
IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
   IF NOT NURSE HOME CLAIM
   IF NOT ANCILLARY-SERVICE
   AND
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
   IF SUBMITTED CHARGE IS EQUAL TO ZEROS
   AND DD-PROCEDURE CODE NOT EQUAL TO '022'
IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
   IF CLAIM REGION IS EQUAL TO 90
   IF (SERVICE CODE IS EQUAL TO 'A' OR 'B' OR 'C' OR 'H'
    OR 'I' OR 'K' OR 'L' OR 'M' OR 'O' OR 'P'
    OR 'Q' OR 'S' OR 'T' OR 'V' OR 'W' OR 'X'
    OR 'Y' OR 'Z' OR '1' OR '2' OR '3' OR '4' OR '5'
    OR '6' OR '7' OR '8' OR '9')
   OR (SERVICE CODE IS EQUAL TO 'J'
    AND (1ST PROCEDURE SERVICE DATE IS GREATER THAN 19910831
     AND 1ST PROCEDURE SERVICE DATE IS LESS THAN 19990701))
OR (SERVICE CODE IS EQUAL TO 'G'
   AND 1ST PROCEDURE SERVICE DATE IS LESS THAN 19990701)
IF (CALC-DAYS NOT EQUAL TO UNITS OF SERVICE)
   AND NOT VALID DISCHARGE DESTINATION
   IF CLAIM REGION IS EQULA TO 40
   AND NOT ADJUSTMENT CLAIM
OR
   IF NURSE HOME CLAIM
   AND (CLAIM REGION 20 OR 21)
   AND (VR PROVIDER NUMBER NOT EQUAL TO '001086' AND NOT EQUAL TO
    '002435'
    AND NOT EQUAL TO '050383')
   AND
   IF FROM DATE IS NOT NUMERIC
   OR (FROM MONTH IS LESS THAN '01' OR GREATER THAN '12')
   OR (FROM DAY IS LESS THAN '01' OR GREATER THAN '31')
IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
   IF NURSE HOME CLAIM
   AND (CLAIM REGION IS EQUAL TO A 20 OR 21)
   AND (VR PROVIDER NOT EQUAL TO '001086' AND NOT EQUAL TO '002435'
    AND NOT EQUAL TO '050383')
   IF TO DATE NOT NUMERIC
    OR (TO MONTH LESS THAN '01' OR GREATER THAN '12')
    OR (TO DAY LESS THAN '01' OR GREATER THAN '31')
   IF CLAIM REGION EQUAL TO 40
AND NOT CLMT-ADJUSTMENT

OR

IF NURSE HOME CLAIM AND
(CLAIM REGION IS EQUAL TO 20 AND 21) AND
(VR PROVIDER NOT EQUAL TO '001086' AND NOT EQUAL TO '002435'
AND NOT EQUAL TO '050383')
  IF SERVICE CODE IS EQUAL TO '1' OR '2' OR '3'
  OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U'
  OR 'V' OR 'W' OR 'X' OR 'Y'
  IF (CALC-DAYS NOT EQUAL TO UNITS OF SERVICE)
  AND NOT VALID DISCHARGE DESTINATION
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

OR

IF NOT UB82 INPATIENT CLAIM AND NOT REV-VALID-ACCOM
  IF NOT REV-VALID-ANCIL
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM

OR

IF UB82 OUTPATIENT CLAIM
  IF BILL TYPE EQUAL TO '731'
    IF REVENUE CODE NOT EQUAL TO '634'
    AND NOT EQUAL TO '821'
    IF CLAIM REGION IS EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM

OR

IF REVENUE CODE EQUAL TO '540'
OR (REVENUE CODE EQUAL TO '100' OR '540')
AND CLAIM REGION IS EQUAL TO '70'
AND (PROVIDER NUMBER NOT EQUAL TO '000001058'
  AND NOT EQUAL TO '000001063'
  AND NOT EQUAL TO '000001307'
  AND NOT EQUAL TO '000002335'))
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

OR

IF SUBMITTED CHARGE EQUAL TO ZEROES
AND DD PROCEDURE CODE NOT EQUAL TO '022'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR

IF NUMBER OF DETAILS IS LESS THAN ZERO
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR

IF 1ST PROCEDURE SERVICE DATE EQUAL TO Zeros
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR

IF 1ST PROCEDURE SERVICE DATE NOT EQUAL TO Zeros
AND
IF PERFORMED-EDIT-ERR-SW EQUAL TO 1
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR

IF CLAIM REGION EQUAL TO 94
AND DET-GT-5-SW NOT EQUAL TO 'Y'
IF PROCEDURE CODE FOUND ON PROCEDURE CODE LIST
AND

04/04/06
IF (PROVIDER NUMBER GREATER THAN '000033055' AND LESS THAN '000033060')
   IF PRICING INDICATOR NOT EQUAL TO '8'
   IF UNITS OF SERVICE NOT EQUAL TO '1'
   F)
   IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
   OR
   (IF CORRECTION ID EQUAL TO 'R'
    OR
    IF ENTRX-ICN GREATER THAN SUSP-ICN
    AND
    IF UPDATE-SW NOT EQUAL TO ZERO
    AND
    IF PERR-SW EQUAL TO 'Y'
   OR
   IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO '1'
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
   IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
   AND
   IF CROSSOVER CLAIM
   AND
   IF CROSSOVER RECORD TYPE IS EQUAL TO '1' OR '3'
   IF ADMISSION DATE IS EQUAL TO ZEROS
   IF CLAIM REGION IS EQUAL TO '40'
   AND NOT ADJUSTMENT CLAIM
   OR
   IF ADMISSION DATE IS NOT EQUAL TO ZEROS
   IF PERFORMED-EDIT-ERR-SW EQUAL TO '1'
   IF CLAIM REGION EQUAL TO '40'
   AND NOT ADJUSTMENT CLAIM
   OR
   IF CROSSOVER RECORD TYPE IS EQUAL TO '1' OR '3'
   IF NATURE OF ADMISSION IS EQUAL TO SPACE
   IF CLAIM BIRTH NUMBER IS LESS THAN 074 OR GREATER THAN 100
   AND
   IF CLAIM REGION IS EQUAL TO '40'
   AND NOT ADJUSTMENT CLAIM
   OR
   IF (CROSSOVER RECORD TYPE EQUAL TO '1' OR '3') AND DISCHARGE DESTINATION GREATER THAN ''
   IF NOT STILL PATIENT AND NOT DISCHARGE LEFT
   IF DATE OF DISCHARGE IS EQUAL TO ZEROS
   IF CLAIM REGION EQUAL TO '40'
   AND NOT ADJUSTMENT CLAIM
   OR
   IF CLAIM SEQUENCE NUMBER IS EQUAL TO '01'
   IF UB82 HOME HEALTH AND BILL TYPE IS EQUAL TO '711'
IF BEGINNING FROM DATE NOT EQUAL TO BEGINNING TO DATE
   IF DETAIL DATE OF SERVICE IS EQUAL TO ZEROS
   IF CLAIM REGION IS EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM
   OR
   IF 1ST PROCEDURE SERVICE DATE IS LESS THAN THE BEGINNING FROM DATE
   OR 1ST PROCEDURE SERVICE DATE IS GREATER THAN THE BEGINNING TO DATE
   OR LAST PROCEDURE SERVICE DATE IS LESS THAN THE BEGINNING FROM DATE
   OR LAST PROCEDURE SERVICE DATE IS GREATER THAN THE BEGINNING TO DATE
   IF PRICING INDICATOR NOT EQUAL TO '8'
      IF CLAIM REGION EQUAL TO 40
         AND NOT ADJUSTMENT CLAIM

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM, RECIPIENT IS ON FILE
   AND
   (IF CLAIM IS A UB82 INPATIENT CLAIM AND NOT AN ADJUSTMENT CLAIM AND
      (NOT FLAGGED FOR DISCHARGE OR DEATH)
      IF (SUM OF TOTAL DAYS BILLED AND NONCHARGED DAYS NOT EQUAL TO TOTAL
         DAYS ON FILE FOR THIS RECIPIENT
         IF CLMT-CLM-REGION EQUAL TO 40)
   OR
   (IF ((CLAIM’S ERROR CODE (CLMT-INDX8) NOT EQUAL TO '409' or '411')
      OR (SERVICE STOP REASON NOT EQUAL TO 'CL') OR (CLAIM’S REGION EQUAL TO 90)
      OR (FIRST DAY OF SERVICE LESS THAN OR EQUAL TO END DATE ON FILE))
      AND ((CLAIM’S ERROR CODE (CLMT-INDX8) NOT EQUAL TO '008', '009' or '265')
      OR (CLAIM’S REGION NOT EQUAL TO 94) OR (CLAIM’S PROVIDER NUM LESS THAN OR
      EQUAL TO '000032313' OR CLAIM’S PROVIDER NUM GREATER THAN OR EQUAL TO
      '000032322'))
      IF CLAIM IS OF TAKEOVER REGION AND CLAIM’S ERROR CODE (CLMT-INDX8) EQUAL
      TO '107')
   OR
   (IF (CLAIM’S RECIPIENT LEGAL COUNTY IS EQUAL TO 56 OR 55)
      AND CLAIM’S REGION IS NOT EQUAL TO '94'
      IF CLAIM’S REGION IS EQUAL TO 40
      AND THE CLAIM IS NOT AN ADJUSTMENT
      MOVE '  125' TO CLMT-HEADER-RELS-CD)
   OR
   (IF WS-VALID-DATE EQUAL TO 'N'
      IF CLMT-CLM-REGION EQUAL TO 40
      AND CLAIM IS NOT AN ADJUSTMENT)

SB1130  -  SB1J050  -  SITUATION:
   A)
   IF PAYABLE CLAIM
   IF DENIED CLAIM
      IF CLAIM SEQUENCE NUMBER IS NOT EQUAL TO '01'
AND
IF UB82 HOME HEALTH
AND BILL TYPE EQUAL TO '711'
AND REVENUE CODE NOT EQUAL TO '983'
AND REVENUE CODE NOT EQUAL TO '521' OR '522'
AND (PVF-STATUS EQUAL TO '00' AND
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT)
  AND P1M0-PROV-CURR-OPT-RR EQUAL TO 0)
IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

B)
IF INPATIENT CLAIM
  IF CLAIM REGION IS EQUAL TO 70 AND
    (SERVICE CODE EQUAL TO 'P' OR 'B' OR 'Z')
ELSE
  IF CLAIM REGION IS EQUAL TO 90
ELSE
  IF SERVICE CODE IS EQUAL TO A OR B OR C OR E OR G
ELSE
  IF SERVICE CODE IS EQUAL TO H OR J THRU Z
ELSE
  IF CLAIM REGION IS EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
OR
IF UB82 INPATIENT CLAIM
  IF CLAIM REGION IS EQUAL TO 70
ELSE
  IF REVENUE INPATIENT ACCOMIDATION IS 100 THRU 219 OR 230 THRU 239
ELSE
  IF REVENUE INPATIENT ACCOMIDATION IS 220 THRU 229 OR 240 THRU 999
ELSE
  IF CLAIM REGION IS EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
OR
IF OUTPATIENT CLAIM
  IF SERVICE CODE IS EQUAL TO 'O'
    AND SUBMITTED CHARGE IS GREATER THAN ZEROS
ELSE
  IF VALID ANCILLARY SERVICE
ELSE
  IF CLAIM REGION IS EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
OR
IF UB82 OUTPATIENT CLAIM OR UB82 HOME HEALTH
  AND
    IF ALLOWED OUTPUT CLAIM NOT EQUAL TO 'C'
    AND
      IF ANCILLARY CODE NOT EQUAL TO 220 THRU 229 OR 240 THRU 999
    AND
      IF CLAIM REGION EQUAL TO 40
        AND NOT ADJUSTMENT CLAIM
OR
IF NURSE HOME CLAIM AND DD PROCEDURE CODE NOT EQUAL TO '022'
  IF (NURSING ACCOMODATION
    OR OUT OF STATE NURSING ANCILLARY
    AND NOT JAMESTOWN MENTAL HOSPITAL
    IF (PROVIDER OUT OF STATE
      AND OUT OF STATE NURSING ACCOMIDATION)
    OR IN STATE NURSING ACCOMIDATION
  OR
    IF (PROVIDER OUT OF STATE

04/04/06
AND OUT OF STATE NURSING ANCILLARY)
OR
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
OR
  IF VR PROVIDER EQUAL TO '001086' OR '002435' OR '050383'
  OR '017553'
  OR
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
OR
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
OR
  IF (PROVIDER NUMBER GREATER THAN OR EQUAL TO '000001900' AND LESS THAN OR EQUAL TO '000001999')
  AND DD PROCEDURE CODE NOT EQUAL TO '022'
    IF SERVICE CODE NOT EQUAL TO '3'
    IF CSERVICE CODE NOT EQUAL TO 'R'
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
OR
  IF DD PROCEDURE CODE NOT EQUAL TO '022'
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM

C)
IF PAYABLE CLAIM
  AND IF NOT DENIED CLAIM
  AND IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
    PVF-STATUS EQUAL TO '00' AND REVENUE CODE NOT EQUAL TO 983 AND
    ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
    AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
    (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN '
    20011231
    AND
    (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
    (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
    AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL
    TO 521 OR 522))
    AND
    IF UB82 OUTPATIENT CLAIM AND
    1ST DAY OF SERVICE GREATER THAN 19990228
    IF BILL TYPE EQUAL TO '831' AND ASC-360-490 EQUAL TO 'N'

D)
IF PAYABLE CLAIM
  AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
  ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
  AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
  (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN '
  20011231
  AND
  (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
  AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL
  TO 521 OR 522))
OR
  IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
 IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF NURSE HOME CLAIM
  IF ((PROVIDER NUMBER GREATER THAN '000029999' AND LESS THAN '000030800')
  AND (SERVICE CODE EQUAL TO 'A' OR 'G' OR 'U' OR 'W' OR 'Y'))
OR ((PROVIDER NUMBER GREATER THAN '000030799' AND LESS THAN '000032000')
AND NOT (SERVICE CODE EQUAL TO 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'))
OR ((PROVIDER NUMBER GREATER THAN '000001899' AND LESS THAN '000002000')
AND NOT (SERVICE CODE EQUAL TO '3' OR 'R'))
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

E)

IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
 IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF UB82 CLAIM AND CLAIM REGION NOT EQUAL TO 70
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
 AND
IF UB82 HOME HEALTH
AND
IF BAD-PRICE-RETURN AND REVENUE CODE NOT EQUAL TO 983
 IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
IF R1RV-MEDICAID-ALLOWED EQUAL TO 'N'
AND NOT (UB82 INPATIENT CLAIM AND DRG CODE GREATER THAN 0)
 IF CLAIM REGION 40 AND NOT ADJUSTMENT CLAIM
   IF FIRST LINE ITEM

F)

IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER
THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))

OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM

OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF UB82 CLAIM AND CLAIM REGION NOT EQUAL TO 70
AND
IF UB82 INPATIENT CLAIM
IF (R1RV-ALLOW-INP-CLAIM NOT EQUAL TO 'X')
OR ((PROVIDER NUMBER NOT EQUAL TO '000001072')
AND (REVENUE-CODE NOT EQUAL TO '290' OR '291' OR '292' OR '293' OR '299'))
AND
IF NOT (UB82 INPATIENT CLAIM AND DRG CODE GREATER THAN 0)
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF BAD-PRICE-RETURN AND REVENUE CODE IS NOT EQUAL TO 983
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF R1RV-MEDICAID-ALLOWED EQUAL TO 'N'
AND NOT (UB82 INPATIENT CLAIM AND DRG CODE GREATER THAN 0)
IF CLAIM REGION IS EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
IF IT'S THE FIRST DETAIL LINE

OR
IF UB82 OUTPATIENT CLAIM OR (UB82 HOME HEALTH
AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0)
IF R1RV-ALLOW-OUTP-CLAIM NOT EQUAL TO 'X' OR 'C' OR 'S'
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF UB82 INPATIENT CLAIM
IF UB82 UNITS EQUAL TO ZERO
IF R1RV-UNITS-REQ-INPATIENT EQUAL TO 'I'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF UB82 OUTPATIENT CLAIM OR (UB82 HOME HEALTH
AND BILL TYPE EQUAL TO '711' AND REVENUE CODE NOT EQUAL TO 983
AND PVF-STATUS EQUAL TO '00' AND (PROV-CURR-OPT-RR GREATER THAN 0
OR P1M0-PROV-PREV-OPT-RR GREATER THAN 0))
IF UB82 UNITS EQUAL TO zero
IF R1RV-UNITS-REQ-OUTPATIENT EQUAL TO '0'
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

OR
IF UB82 HOME HEALTH AND NOT (BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0)
  IF ALLOW-HH-CLAIM NOT EQUAL TO 'X' OR 'S' OR (BILL TYPE NOT EQUAL TO '711'
  AND PVF-STATUS NOT EQUAL TO '00' AND PROV-PREV-OPT-RR LESS THAN 0)
  AND
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

OR
IF UB82 HOME HEALTH AND NOT (BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND (PROV-CURR-OPT-RR GREATER THAN 0 OR
  PROV-PREV-OPT-RR GREATER THAN 0))

IF UB82 UNITS EQUAL TO ZEROES
  IF R1RV UNITS REQ HOME HEALTH EQUAL TO 'H'
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

G)
IF PAYABLE CLAIM
  AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
  AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
  (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
  20011231 AND
  (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
  AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
  EQUAL TO 521 OR 522))

OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
  IF INSTITUTIONAL CLAIM OR UB82 CLAIM

AND
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711'
  AND (PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000')
  AND 1ST DAY OF SERVICE LESS THAN 20011231

AND
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
  IF P1M0-AUTHORIZED
  AND
  IF 1ST DAY OF SERVICE LESS THAN PROVIDER SERVICE AUTHORIZATION DATE
  OR
  IF MISC-INDX EQUAL TO MAX-PAY-DATE
  IF UB82 SERVICE CODE EQUAL TO 'Z'
  IF CLAIM REGION NOT EQUAL TO 40
  AND ADJUSTMENT CLAIM

AND
IF (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
  AND ALLOWED CHARGE EQUAL TO 0)
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
H) IF PAYABLE CLAIM
    AND NOT A DENIED CLAIM
    IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
    PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
    ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
    AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
    (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
    20011231 AND
    (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
    (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
    AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
    EQUAL TO 521 OR 522))
    OR
    IF (PROFESSIONAL CLAIM AND
    NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
    AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
    OR REVENUE CODE EQUAL TO 983
    OR CROSSOVER CLAIM
    IF INSTITUTIONAL CLAIM OR UB82 CLAIM
    AND
    IF UB82 INPATIENT CLAIM
    IF CLAIM REGION EQUAL TO 70
    OR
    IF UB82 OUTPATIENT CLAIM AND CLAIM REGION EQUAL TO 70
    AND
    IF (UB82 INPATIENT CLAIM AND BILL TYPE EQUAL TO '111'
    AND REVENUE CODE NOT EQUAL TO '100')
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
    OR
    IF (UB82 INPATIENT CLAIM AND NOT
    (REVENUE CODE EQUAL TO '100' OR
    '961' OR '987')) OR
    (UB82 OUTPATIENT CLAIM AND NOT
    (REVENUE CODE EQUAL TO '490' OR '500' OR '510'
    OR '512' OR '540' OR '513' OR '519' OR '250'
    OR '509' OR '961' OR '987'))
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE : 129

MESSAGE TEXT: CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB710032 JOB(s): ONLINE

SB1070(SB1J020) - SITUATION:

IF CICS RESPONSE IS NORMAL
AND
IF ADJUSTMENT-TYPE-IN EQUAL TO 'A'
OR IF CICS-RESP-NOTFND
OR
IF ADJUSTMENT-TYPE-IN NOT EQUAL TO 'A'
AND
IF ADJUSTMENT-TYPE-IN EQUAL TO 'R'

Top
EXPLANATION OF BENEFITS (EOB) CODE: 135

MESSAGE TEXT: CLAIM DENIED. INTERIM BILLS CANNOT BE PROCESSED.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1130  JOB(s): SB1J050

SITUATION:
IF PAYABLE CLAIM
AND
IF NOT DENIED CLAIM
AND
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711' AND
PVF-STATUS NOT EQUAL TO '00' AND REVENUE CODE EQUAL TO 983
AND ((1ST DAY OF SERVICE LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR LESS THAN 0)
OR (REVENUE CODE NOT EQUAL TO 521 OR 522
AND 1ST DAY OF SERVICE LESS THAN 20011231 AND
(PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000'))
OR (1ST DAY OF SERVICE LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND PROV-PREV-OPT-RR LESS THAN 0
AND REVENUE CODE EQUAL TO 521 OR 522))
AND
IF NOT (PROFESSIONAL CLAIM AND
(UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS NOT EQUAL TO '00' AND PROV-CURR-OPT-RR LESS THAN 0))
OR REVENUE CODE NOT EQUAL TO 983
OR NOT CROSSOVER CLAIM
AND
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF UB82 INPATIENT CLAIM
IF DTE-RANGE-FND EQUAL TO 'Y'
AND
IF UB82 DISCHARGE DESTINATION IS EQUAL TO '9'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE: 140

MESSAGE TEXT:
A) THE DATE OF BIRTH FOLLOWS THE DATE OF SERVICE.
B) M/I ELIGIBILITY CLARIFICATION CODE

SOURCE CODE:
A) "C" = Contractual Obligation
B) "N" = NCPDP

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090 JOB(s): SB1J020, SB1J040

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF CLAIM REGION IS EQUAL TO 80
AND
IF CROSSOVER CLAIM
AND
IF RECIPIENT LAST NAME IS EQUAL TO SPACES
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND ITS RECIPIENT IS ON FILE
AND

(IF REC-NAME-SAVE-1 IS NOT EQUAL TO REC-NAME-SAVE-2
  IF (CLMT-RECIPIENT-CUR-PCN(8:2) NOT EQUAL TO 'CS'
    AND CLMT-RECIPIENT-ORIGINAL-PCN(8:2) NOT EQUAL TO = 'CS')
  IF (CLMT-TAKE-OVER-REG
    OR ((CLMT-VR-PROV > '032310' AND < '032322')
    OR (CLMT-VR-PROV > '033055' AND < '033060')
    OR (CLMT-VR-PROV = '035201' OR = '035432'
        OR = '035434')))
  AND NOT CLMT-ADJUSTMENT)

OR

(IF ((CLMT-ERROR-CD (CLMT-INDEX8) NOT EQUAL TO '409' or '411')
  OR (HOLD-STOP-REAS NOT EQUAL TO 'CL')
  OR (CLMT-CLM-REGION EQUAL TO 90)
  OR (CLMT-1ST-DA-OF-SERV LESS THAN OR EQUAL TO HOLD-END-DATE))
AND ((CLMT-ERROR-CD (CLMT-INDEX8) NOT EQUAL TO '008', '009' or '265')
  OR (CLMT-CLM-REGION NOT EQUAL TO 94)
  OR (CLMT-PROV-NO LESS THAN OR EQUAL TO '000032313'
      OR CLMT-PROV-NO GREATER THAN OR EQUAL TO '000032322'))
AND
IF CLMT-TAKE-OVER-REG OR CLMT-ERROR-CD (CLMT-INDEX8) NOT EQUAL TO '107'
AND
IF CLMT-TAPE-BILL-REG OR
  (CLMT-IHS-REGION AND (CLMT-CLM-BTH-NO GREATER THAN 814 AND LESS THAN
   831)) OR
  (CLMT-CROSSOVER-CLAIM AND (CLMT-IHS-REGION OR
   CLMT-TAKE-OVER-REG))
IF CLMT-ERROR-CD (CLMT-INDEX8) EQUAL TO '009'

Top
EXPLANATION OF BENEFITS (EOB) CODE : 141

MESSAGE TEXT: CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE

SOURCE CODE: “P” = PATIENT RESPONSIBILITY

DATE CREATED: 11/21/02

PROGRAM(s): SB710038 JOB(s): ONLINE

SB1070(SB1J020) - SITUATION:

IF SAVE-INDX GREATER THAN 0
  IF (NEW-BILLED-IND EQUAL TO 'Y' OR 'S' OR 'R' OR 'D' OR 'B')
    IF DISQUALIFY-SW EQUAL TO 'T'

Top
EXPLANATION OF BENEFITS (EOB) CODE : A8

MESSAGE TEXT: CLAIM DENIED; UNGROUPABLE DRG

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1130         JOB(s): SB1J050

SITUATION:
IF PAYABLE CLAIM
  AND
IF NOT DENIED CLAIM
  AND
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711' AND
  PVF-STATUS NOT EQUAL TO '00' AND REVENUE CODE EQUAL TO 983
  AND ((1ST DAY OF SERVICE LESS THAN P1M0-PROV-CURR-OPT-EFDT
    AND P1M0-PROV-CURR-OPT-RR LESS THAN 0)
  OR (REVENUE CODE NOT EQUAL TO 521 OR 522
    AND 1ST DAY OF SERVICE LESS THAN 20011231 AND
    (PROVIDER NUMBER LESS THAN '00004999' AND GREATER THAN '00006000'))
  OR (1ST DAY OF SERVICE LESS THAN P1M0-PROV-PREV-OPT-EFDT
    AND PROV-PREV-OPT-RR LESS THAN 0
    AND REVENUE CODE EQUAL TO 521 OR 522))
  AND
IF NOT (PROFESSIONAL CLAIM AND
  (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
    AND PVF-STATUS NOT EQUAL TO '00' AND PROV-CURR-OPT-RR LESS THAN 0))
  OR REVENUE CODE NOT EQUAL TO 983
  OR NOT CROSSOVER CLAIM
  AND
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
  AND
IF UB82 INPATIENT CLAIM
    IF DTE-RANGE-FND EQUAL TO 'Y'
    AND
    IF PDV13-RETURN-CODE NOT = 0
      IF CLMT-CLM-REGION = 40
      AND NOT CLMT-ADJUSTMENT
EXPLANATION OF BENEFITS (EOB) CODE : B15

MESSAGE TEXT:
PAYMENT ADJUSTED BECAUSE THIS PROCEDURE/SERVICE IS NOT PAID SEPARATELY.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1130 JOB(s): SB1J050

SITUATION:

A) IF PAYABLE CLAIM
   AND NOT A DENIED CLAIM
   IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
   ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
   AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
   (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
   (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
   (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
   AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
   EQUAL TO 521 OR 522))
   OR
   IF (PROFESSIONAL CLAIM AND
   NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
   AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
   OR REVENUE CODE EQUAL TO 983
   OR CROSSOVER CLAIM
   IF INSTITUTIONAL CLAIM OR UB82 CLAIM
   AND
   IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711'
   AND (PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000')
   AND 1ST DAY OF SERVICE LESS THAN 20011231
   AND
   IF UB82 OUTPATIENT CLAIM
   IF ASC-360-490 EQUAL TO 'Y' AND PCP-SW EQUAL TO 'Y'
   AND
   IF INPATIENT CLAIM
   IF CLAIM REGIONIS EQUAL TO 70 AND
   (SERVICE CODE EQUAL TO 'P' OR = 'B' OR = 'Z')
   ELSE
   IF CLAIM REGION IS EQUAL TO 90
   ELSE
   IF SERVICE CODE EQUAL TO 'A' OR 'B' OR 'C' OR 'E' OR 'G'
   ELSE
   IF SERVICE CODE EQUAL TO 'H' OR 'J' THRU 'Z'
   OR
   IF OUTPATIENT CLAIM
   IF SERVICE CODE EQUAL TO 'O'
   AND SUBMITTED CHARGE IS GREATER THAN ZEROS
   ELSE
   IF SERVICE CODE EQUAL TO 'H' OR 'J' THRU 'Z'
   OR
   IF NURSE HOME CLAIM AND DD PROCEDURE CODE NOT EQUAL TO '022'
IF (SERVICE CODE IS EQUAL TO '1' THRU '9' OR 'G' THRU 'H' OR 'J' THRU 'N' OR 'Q' THRU 'Y'
    OR SERVICE CODE IS EQUAL TO '1' THRU '9' OR 'G')
AND VR PROVIDER NOT EQUAL TO '001086'
IF (NOT PROVIDER OUT OF STATE
    AND SERVICE CODE NOT EQUAL TO '1' THRU '9' OR 'G')
OR SERVICE CODE IS NOT EQUAL TO '1' THRU '9' OR 'G'
OR 'H' OR 'N' OR 'Q' THRU 'Y'
AND
IF (PROVIDER OUT OF STATE
    AND SERVICE CODE IS EQUAL TO 'J' OR 'K' OR 'L' OR 'O' OR 'Z')
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF 1ST DAY OF SERVICE LESS THAN P1M0-PROV-SERV-AUTH-DT
AND
IF MISC-INDX EQUAL TO MAX-PAY-DATE
    IF CLAIM REGION EQUAL TO 40
    AND NOT ADJUSTMENT CLAIM
B)
IF PAYABLE CLAIM
    AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
    AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231
    AND (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
    AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
    EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
    NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
    AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
    IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF UB82 INPATIENT CLAIM
    IF CLAIM REGION EQUAL TO 70
ELSE
    IF REV-INPATIENT-ACCOMM EQUAL TO '100' THRU '219' OR '230' THRU '239'
ELSE
    IF REV-ANCILLARY-SERVICES EQUAL TO '220' THRU '229' OR '240' THRU '999'
OR
IF UB82 OUTPATIENT CLAIM OR UB82 HOME HEALTH
    IF ALLOW-OUTP-CLAIM EQUAL TO 'C'
ELSE
    IF REV-ANCILLARY-SERVICES EQUAL TO '220' THRU '229' OR '240' THRU '999'
OR
IF UB82 OUTPATIENT CLAIM AND CLAIM REGION EQUAL TO 70
    AND BILL TYPE EQUAL TO '131'
AND REVENUE CODE EQUAL TO '987'
IF ((CPT4 CODE GREATER THAN '99220' AND LESS THAN '99240')
    OR GREATER THAN '99290' AND LESS THAN '99298')
    OR GREATER THAN '99430' AND LESS '99441')
    OR GREATER THAN '99260' AND LESS '99264')
OR IF UB82 OUTPATIENT CLAIM OR UB82 HOME HEALTH
IF ALLOW-OUTP-CLAIM EQUAL TO 'C'
IF PRICING INDICATOR IS EQUAL TO '7'
OR IF CPT4 CODE EQUAL TO SPACES
AND IF (BILL TYPE NOT EQUAL TO '141') OR
((REVENUE CODE NOT EQUAL TO '982')
AND (CPT4 CODE NOT EQUAL TO '03000' OR '03001' OR '97535' OR '99078'))
AND IF LPF-STAT EQUAL TO 23
AND IF (((CPT4 CODE GREATER THAN '80002' OR LESS THAN '89399')
OR (CPT4 CODE NOT EQUAL TO '99000' OR '99001' OR '78270' OR '78271'
OR '99195' OR '94700' OR '36415' OR '36430' OR 'G0001' OR '03000'
OR '03005' OR '03006' OR '03001' OR '97535' OR '99078'))
AND (REVENUE CODE NOT EQUAL TO '982'))
AND IF REV-ANCILLARY-SERVICES EQUAL TO '220' THRU '229' OR '240' THRU '999'
AND IF UB82 SERVICE CODE NOT EQUAL TO 'Z'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR IF 1ST DA OF SERVICE LESS THAN PROVIDER SERVICE AUTHORIZATION DATE
AND IF MISC-INDEX EQUAL TO MAX-PAY-DATE
IF UB82 SERVICE CODE NOT EQUAL TO 'Z'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE: B18

MESSAGE TEXT:
PAYMENT DENIED BECAUSE THIS PROCEDURE CODE/MODIFIER WAS INVALID ON THE DATE OF SERVICE OR CLAIM SUBMISSION.

SOURCE CODE: “C” = Contractual Obligation

DATE CREATED: 11/21/2002

PROGRAM(s): SB1090   JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER

AND

(IF CURRENT CLAIM’S PROVIDER NUMBER IS GREATER THAN ‘000050521’ AND ITS PROVIDER NUMBER IS LESS THAN ’000050554’
IF CURRENT CLAIM CONTAINS AN INVALID PROCEDURE CODE)
EXPLANATION OF BENEFITS (EOB) CODE : B5

MESSAGE TEXT:
PAYMENT ADJUSTED BECAUSE COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED

SOURCE CODE: “P” = PATIENT RESPONSIBILITY

DATE CREATED: 11/21/02

PROGRAM(s): SB1090     JOB(s): SB1J040
               SB1070     SB1J020

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM, RECIPIENT IS ON FILE

AND

(IF (CLAIM CONATINS AN AID CATEGORY OF ‘041’ or ‘042’) AND
 IF CLAIM IS NOT AN ADJUSTMENT)

OR

(IF CLAIM CONATINS AN AID CATEGORY OF ‘036’
 IF CLAIM IS NOT TECS ELIGIBLE
 IF CLAIM IS NOT AN ADJUSTMENT)

OR

(IF CLAIM IS OF REGION 94
 AND (CLAIM’S PROVIDER NUM GREATER THAN OR EQUAL TO ‘000033056’ AND LESS
 THAN OR EQUAL TO ‘000033059’)
 IF CLAIM CONTAINS A VALID PROCEDURE CODE
 IF RECIPIENT’S AGE GREATER THAN 3 OR (RECIPIENT’S AGE IS EQUAL TO 3 AND
 RECIPIENT’S LAST DATE OF SERVICE IS GREATER THAN THE RECIPIENT’S
 BIRTHDATE)
 IF Claim IS NOT AN ADJUSTMENT

OR

(IF CLMT-CROSSOVER-CLAIM
 IF CLAIM’S PROCEDURE CODE (LSUB) LESS THAN ‘09990’ OR GREATER THAN
 ‘09996’
 IF CLAIM IS NOT AN ADJUSTMENT)

OR

(IF CURRENT CLAIM IS A NURSING HOME CLAIM
 IF CLMT-SVCD(LSUB) NOT EQUAL TO ‘R’ AND NOT EQUAL TO ‘9’ AND NOT EQUAL
 TO ‘5’
 IF CLAIM IS NOT AN ADJUSTMENT)

OR
(IF CURRENT CLAIM IS A NURSING HOME CLAIM
   IF CLAIM'S SERVICE CODE(LSUB) NOT EQUAL TO 'R', '9', or '5'
   IF CLAIM IS NOT AN ADJUSTMENT)

OR

(IF CURRENT CLAIM IS A MEDICAL or UB82 CLAIM
   IF CLAIM'S MEDICARE COVERAGE(LSUB) NOT EQUAL TO 'Y'
   IF CLAIM IS NOT AN ADJUSTMENT)

SB1070 - SB1020 - SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' ' OR (IF CORRECTION ID EQUAL TO 'R'
   OR
   IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND
   IF UPDATE-SW NOT EQUAL TO ZERO
   AND
   IF PERR-SW EQUAL TO 'Y'
   OR
   IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
   IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
       PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
   AND
   IF DET-GT-5-SW EQUAL TO 'Y' AND CLAIM REGION EQUAL TO 94
   AND CLAIM BIRTH NUMBER EQUAL TO '300'
   AND NOT (PROVIDER NUMBER GREATER THAN '000033055' AND LESS THAN '000033060')
EXPLANATION OF BENEFITS (EOB) CODE: B6

MESSAGE TEXT:
THIS PAYMENT IS ADJUSTED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER, BY THIS TYPE OF PROVIDER IN THIS TYPE OF FACILITY, OR BY A PROVIDER OF THIS SPECIALTY.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1130
JOB(s): SB1J050

SITUATION:
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER
THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF (PROVIDER TYPE CODE EQUAL TO '26')
AND (PROVIDER SPECIALTY CODE EQUAL TO '35')
IF PCLIST-2ND-PROC-SW NOT EQUAL 'Y'
OR PCLIST-FOUND-PROC-SW NOT EQUAL 'Y'
OR (PROCEDURE CODE LESS THAN '09990' AND GREATER THAN '09994')
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE: B7

MESSAGE TEXT:
THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.

SOURCE CODE: “C” = CONTRACTUAL OBLIGATION

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090, SB1130 JOB(s): SB1J020, SB1J040, SB1J050

SITUATION:
SB1070 – (SB1J020) SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR '
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
IF WK-DAYS EQUAL TO 1
OR
IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF PROVIDER NUMBER IS EQUAL TO '000035434'
AND
IF (CLAIM WAS BILLED ON A SATURDAY OR SUNDAY)
OR
IF CLAIM REGION EQUAL TO 94
AND DET-GT-5-SW NOT EQUAL TO 'Y'
    IF PROCEDURE CODE FOUND ON PROCEDURE CODE LIST
AND
    IF (PROVIDER NUMBER GREATER THAN '000033055' AND LESS THAN '000033060')
        IF (DATE BILLED IS A SATURDAY OR SUNDAY)

SB1090 – (SB1J040) SITUATION:
A)
    IF PAYABLE CLAIM AND VALID RECIPIENT ID
    IF (CLAIM RECORD CODE EQUAL TO 'M' AND CLAIM REGION EQUAL TO '94'
        AND DETAIL LINE GREATER THAN ZERO)
    AND
    IF L-ELIG-INDEX GREATER THAN +0
        IF STOPPING DATE IS EQUAL TO 0
            IF CLMT-SPL-PRCS-FLG EQUAL TO '1'
        OR
            IF CLAIM REGION EQUAL TO 90
                OR (PROVIDER NUMBER NOT LESS THAN '000035000' AND NOT GREATER THAN '000037999')
                IF (PROVIDER NUMBER NOT EQUAL TO '000035432' AND NOT EQUAL TO '000035434'
                    AND NOT EQUAL TO '000035201')
                IF VALID RECORD ON SB644010 FILE
                AND
                IF ERR-CODE EQUAL TO '047'
                    ' B7'
                OR
                IF ERR-CODE EQUAL TO '048'
                    ' B7'

B)
    (IF CURRENT CLAIM IS A PAYABLE CLAIM THAT HAS NOT BEEN DENIED
        IF CLMT-PROFESSIONAL-CLAIM OR CLMT-OUTPATIENT-CLAIM
        IF CURRENT CLAIM HAS A RECORD CODE EQUAL TO 'M', 'L' or 'S'
            IF NO MATCHING PROVIDER DATA IS FOUND ON THE PROVIDER MASTER FILE
                AND CURRENT CLAIM IS OF REGION 49 OR CURRENT CLAIM IS NOT A MEDICAL CLAIM
                IF CURRENT CLAIM IS OF REGION 40
                    AND NOT CLMT-ADJUSTMENT)

C)
    (IF CURRENT CLAIM IS A PAYABLE CLAIM THAT HAS NOT BEEN DENIED
        IF CLMT-PROFESSIONAL-CLAIM OR CLMT-OUTPATIENT-CLAIM
        IF CURRENT CLAIM HAS A RECORD CODE EQUAL TO 'M', 'L' or 'S'
            IF ANY OF THE FIRST 4 CHARACTERS OF THE PROVIDER NUMBER ARE NOT NUMERIC
                IF NO DATA IS FOUND ON THE SB510025 UPIN FILE
                    AND CURRENT CLAIM IS NOT OF REGION 49 OR IT IS NOT A MEDICAL CLAIM
                    IF CURRENT CLAIM IS OF REGION 40 AND IT IS NOT AN ADJUSTMENT CLAIM)

SB1130 – (SB1J050) SITUATION:
A)
    IF PAYABLE CLAIM
    IF NOT DENIED CLAIM
    AND
    IF VALID RECORD ON THE PROVIDER VSAM FILE
    OR
    IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711' AND
    PVF-STATUS NOT EQUAL TO '00' AND REVENUE CODE NOT EQUAL TO 983 AND
    ((1ST DAY OF SERVICE NOT GREATER THAN P1M0-PROV-CURR-OPT-EFDT
        AND P1M0-PROV-CURR-OPT-RR LESS THAN 0) OR
    (REVENUE CODE NOT EQUAL TO 521 OR 522
        AND 1ST DAY OF SERVICE LESS THAN 20011231 AND

04/04/06
(PROVIDER NUMBER LESS THAN ’000004999’ AND GREATER THAN ’000006000’)) OR
(1ST DAY OF SERVICE NOT GREATER THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR LESS THAN 0 AND REVENUE CODE EQUAL TO 521
OR 522))
AND
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’
AND PVF-STATUS EQUAL TO ’00’ AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF VALID RECORD ON THE PROVIDER VSAM FILE
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

B)
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’ AND
PVF-STATUS EQUAL TO ’00’ AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
20011231 AND
(PROVIDER NUMBER GREATER THAN ’000004999’ AND LESS THAN ’000006000’)) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’
AND PVF-STATUS EQUAL TO ’00’ AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’
AND (PROVIDER NUMBER GREATER THAN ’000004999’ AND LESS THAN ’000006000’)
AND 1ST DAY OF SERVICE GREATER THAN 20011231
IF (REVENUE CODE EQUAL TO 951
OR (REVENUE CODE EQUAL TO 522
IF DUP-SW EQUAL TO ’Y’
OR
IF REVENUE CODE NOT EQUAL TO 951

C)
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO ’711’ AND
PVF-STATUS EQUAL TO ’00’ AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
20011231 AND
(PROVIDER NUMBER GREATER THAN ’000004999’ AND LESS THAN ’000006000’)) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF VALID PROVIDER
IF TEST TYPE IS EQUAL TO '20' OR '56' OR '48' THRU '54'
AND P1M0-IN-STATE
AND P1M0-PROV-NO-IN-GRP GREATER THAN ZEROES
AND NOT CROSSOVER CLAIM
AND
IF NOT (CLAIM REGION EQUAL TO 49 AND MEDICAL CLAIM)
IF (DETAIL PERFORMING PHYSICIAN EQUAL TO SPACES OR ZEROS)
OR DETAIL PERFORMING PHYSICIAN LESS THAN '000010000'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF PVF-STATUS NOT EQUAL TO ZEROES
AND NOT (CLAIM REGION EQUAL TO 49 AND MEDICAL CLAIM)
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF FOUND-PROV EQUAL TO 'N'
IF NOT (CLAIM REGION EQUAL TO 49 AND MEDICAL CLAIM)
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF PVF-STATUS EQUAL TO ZEROES
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
D)
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
IF INSTITUTIONAL CLAIM OR UB82 CLAIM
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF (NOT BAD-PRICE-RETURN OR (LVL3-PROC-STAT NOT EQUAL TO 1
AND LAST DAY OF SERVICE NOT LESS THAN WORK-LEVEL3-DATE-N))
AND REVENUE CODE EQUAL TO '983'
AND
IF NOT LVL3-INACTV-PROC AND
(WORK-LEVEL3-DATE-N GREATER THAN LAST DAY OF SERVICE)
AND
AND
IF REV983-SW EQUAL TO 'Y' AND REVENUE CODE NOT EQUAL TO '983'
EXPLANATION OF BENEFITS (EOB) CODE: M33

MESSAGE TEXT: CLAIM LACKS THE UPIN OF THE ORDERING/REFERRING OR PERFORMING PHYSICIAN OR PRACTITIONER, OR THE UPIN IS INVALID. (SUBSTITUTE NPI FOR UPIN WHEN EFFECTIVE)

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1130 JOB(s): SB1J050

SITUATION:
IF PAYABLE CLAIM
   AND NOT A DENIED CLAIM
   IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
      PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
      (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
       AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
      (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
       (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
      (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
       AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL TO 521 OR 522))
   OR
   IF (PROFESSIONAL CLAIM AND
      NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
      AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
      OR REVENUE CODE EQUAL TO 983
      OR CROSSOVER CLAIM
      IF INSTITUTIONAL CLAIM OR UB82 CLAIM
      AND
      IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711'
      AND (PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000')
      AND 1ST DAY OF SERVICE LESS THAN 20011231
      AND
      IF UB82 OUTPATIENT CLAIM
      IF ASC-360-490 EQUAL TO 'Y' AND PCP-SW EQUAL TO 'Y'
EXPLANATION OF BENEFITS (EOB) CODE: M50

MESSAGE TEXT:
N - REQUIRES MANUAL CLAIM
R - MONTHLY RENTAL PAYMENTS CAN CONTINUE UNTIL THE EARLIER OF THE 15TH MONTH FROM THE FIRST RENTAL MONTH, OR THE MONTH WHEN THE EQUIPMENT IS NO LONGER NEEDED.

SOURCE CODE:
“N” = NCPDP
“R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1130     JOB(s): SB1J020, SB1J050

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF PROVIDER NUMBER IS EQUAL TO '000035434'
AND
IF NOT REGION '90'
AND CLAIM SERVICE CODE NOT EQUAL TO 'A' THRU 'Z'
AND
IF NOT INPATIENT CLAIM
AND SERVICE CODE NOT EQUAL TO A OR B OR C OR E OR G
AND
IF NURSE HOME CLAIM
IF (REGION 20 OR REGION 21)
  OR (VR PROVIDER IS NOT EQUAL TO '001086' OR '002435'
    OR '050383')
IF SERVICE CODE IS EQUAL TO '1' OR '2' OR '3'
  OR 'Q' OR 'R' OR 'S' OR 'T'
  OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y'
AND
IF (PROVIDER NUMBER IS GREATER THAN '000030699'
  AND LESS THAN '000030800')
AND (SERVICE CODE IS NOT EQUAL TO '1' AND NOT EQUAL TO '2'
  AND NOT EQUAL TO '3' AND NOT EQUAL TO '4')
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF NOT NURSE HOME CLAIM
IF NOT ANCILLARY-SERVICE
AND
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF NOT UB82 INPATIENT CLAIM AND NOT REV-VALID-ACCOM
IF NOT REV-VALID-ANCIL
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF UB82 OUTPATIENT CLAIM
IF BILL TYPE EQUAL TO '731'
IF REVENUE CODE NOT EQUAL TO '634'
  AND NOT EQUAL TO '821'
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF REVENUE CODE EQUAL TO '540'
OR (REVENUE CODE EQUAL TO '100' OR '540')
AND CLAIM REGION IS EQUAL TO '70'
AND (PROVIDER NUMBER NOT EQUAL TO '000001058'
  AND NOT EQUAL TO '000001063'
  AND NOT EQUAL TO '000001307'
  AND NOT EQUAL TO '000002335'))
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

SB1130 - SB1J050 - SITUATION:

A)
IF PAYABLE CLAIM
IF DENIED CLAIM
  IF CLAIM SEQUENCE NUMBER IS NOT EQUAL TO '01'
AND
IF UB82 HOME HEALTH
AND BILL TYPE EQUAL TO '711'
AND REVENUE CODE NOT EQUAL TO '983'
AND REVENUE CODE NOT EQUAL TO '521' OR '522'
AND (PVF-STATUS EQUAL TO '0' AND
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT)
AND P1M0-PROV-CURR-OPT-RR EQUAL TO 0)
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

B)
IF INPATIENT CLAIM
IF CLAIM REGION IS EQUAL TO 70 AND
(SERVICE CODE EQUAL TO 'P' OR 'B' OR 'Z')
ELSE
IF CLAIM REGION IS EQUAL TO 90
ELSE
IF SERVICE CODE IS EQUAL TO A OR B OR C OR E OR G
ELSE
IF SERVICE CODE IS EQUAL TO H OR J THRU Z
ELSE
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF UB82 INPATIENT CLAIM
IF CLAIM REGION IS EQUAL TO 70
ELSE
IF REVENUE INPATIENT ACCOMIDATION IS 100 THRU 219 OR 230 THRU 239
ELSE
IF REVENUE INPATIENT ACCOMIDATION IS 220 THRU 229 OR 240 THRU 999
ELSE
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF OUTPATIENT CLAIM
IF SERVICE CODE IS EQUAL TO 'O'
AND SUBMITTED CHARGE IS GREATER THAN ZEROS
ELSE
IF VALID ANCILLARY SERVICE
ELSE
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF UB82 OUTPATIENT CLAIM OR UB82 HOME HEALTH
AND
IF ALLOWED OUTPUT CLAIM NOT EQUAL TO 'C'
AND
IF ANCILLARY CODE NOT EQUAL TO 220 THRU 229 OR 240 THRU 999
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF NURSE HOME CLAIM AND DD PROCEDURE CODE NOT EQUAL TO '022'
IF (NURSING ACCOMODATION
OR OUT OF STATE NURSING ANCILLARY
AND NOT JAMESTOWN MENTAL HOSPITAL
IF (PROVIDER OUT OF STATE
AND OUT OF STATE NURSING ACCOMIDATION)
OR IN STATE NURSING ACCOMIDATION
OR
IF (PROVIDER OUT OF STATE
AND OUT OF STATE NURSING ANCILLARY)
OR
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF VR PROVIDER EQUAL TO '001086' OR '002435' OR '050383' OR '017553'
OR
IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
OR
IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
OR
IF PROVIDER NUMBER GREATER THAN OR EQUAL TO '000001900' AND LESS THAN OR EQUAL TO '000001999'
AND DD PROCEDURE CODE NOT EQUAL TO '022'
IF SERVICE CODE NOT EQUAL TO '3'
IF CSERVICE CODE NOT EQUAL TO 'R'
IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
OR
IF DD PROCEDURE CODE NOT EQUAL TO '022'
IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
C)
IF PAYABLE CLAIM AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0)) OR REVENUE CODE EQUAL TO 983 OR CROSSOVER CLAIM IF INSTITUTIONAL CLAIM OR UB82 CLAIM AND IF NURSE HOME CLAIM IF ((PROVIDER NUMBER GREATER THAN '000029999' AND LESS THAN '000030800') AND (SERVICE CODE EQUAL TO 'A' OR 'G' OR 'U' OR 'W' OR 'Y')) OR ((PROVIDER NUMBER GREATER THAN '000030799' AND LESS THAN '000032000') AND NOT (SERVICE CODE EQUAL TO 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR ((PROVIDER NUMBER GREATER THAN '000001899' AND LESS THAN '000002000') AND NOT (SERVICE CODE EQUAL TO '3' OR 'R'))
IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
D)
IF PAYABLE CLAIM AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))

OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
  IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF UB82 CLAIM AND CLAIM REGION NOT EQUAL TO 70
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
  IF UB82 HOME HEALTH
AND
IF BAD-PRICE-RETURN AND REVENUE CODE NOT EQUAL TO 983
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM

E)

IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
  ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
  AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
  (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER
  THAN 20011231 AND
  (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
  (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
  AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
  EQUAL TO 521 OR 522))

OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
  IF INSTITUTIONAL CLAIM OR UB82 CLAIM
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF UB82 CLAIM AND CLAIM REGION NOT EQUAL TO 70
AND
IF UB82 INPATIENT CLAIM
  IF (R1RV-ALLOW-INP-CLAIM NOT EQUAL TO 'X')
  OR ((PROVIDER NUMBER NOT EQUAL TO '000001072'
  AND (REVENUE-CODE NOT EQUAL TO '290' OR '291' OR '292' OR '293' OR '299'))
  AND
IF R1RV-ALLOW-INP-CLAIM NOT EQUAL TO 'S'
AND
IF NOT (UB82 INPATIENT CLAIM AND DRG CODE GREATER THAN 0)
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
IF BAD-PRICE-RETURN AND REVENUE CODE IS NOT EQUAL TO 983
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF UB82 OUTPATIENT CLAIM OR (UB82 HOME HEALTH
AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0)
IF R1RV-ALLOW-OUTP-CLAIM NOT EQUAL TO 'X' OR 'C' OR 'S'
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF UB82 HOME HEALTH AND NOT (BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0)
IF ALLOW-HH-CLAIM NOT EQUAL TO 'X' OR 'S' OR (BILL TYPE NOT EQUAL TO '711'
AND PVF-STATUS NOT EQUAL TO '00' AND PROV-PREV-OPT-RR LESS THAN 0)
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

F)

IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
   ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
   AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
   (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
   20011231 AND
   (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000') OR
   (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
   AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
   EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
   NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
   AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
   IF INSTITUTIONAL CLAIM OR UB82 CLAIM
AND
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711'
   AND (PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000')
   AND 1ST DAY OF SERVICE LESS THAN 20011231
AND
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
   IF P1M0-AUTHORIZED
   AND
   IF 1ST DAY OF SERVICE LESS THAN PROVIDER SERVICE AUTHORIZATION DATE
OR
   IF MISC-INDX EQUAL TO MAX-PAY-DATE
   IF UB82 SERVICE CODE EQUAL TO 'Z'
   IF CLAIM REGION NOT EQUAL TO 40
   AND ADJUSTMENT CLAIM
AND
IF (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND ALLOWED CHARGE EQUAL TO 0)
IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM

G)
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN 20011231 AND (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL TO 521 OR 522)) OR IF (PROFESSIONAL CLAIM AND NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0)) OR REVENUE CODE EQUAL TO 983 OR CROSSOVER CLAIM IF INSTITUTIONAL CLAIM OR UB82 CLAIM AND IF UB82 INPATIENT CLAIM IF CLAIM REGION EQUAL TO 70 OR IF UB82 OUTPATIENT CLAIM AND CLAIM REGION EQUAL TO 70 AND IF (UB82 INPATIENT CLAIM AND NOT (REVENUE CODE EQUAL TO '100' OR '961' OR '987')) OR (UB82 OUTPATIENT CLAIM AND NOT (REVENUE CODE EQUAL TO '490' OR '500' OR '510' OR '512' OR '540' OR '513' OR '519' OR '250' OR '509' OR '961' OR '987'))) IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: M52

MESSAGE TEXT:
INCOMPLETE/INVALID "FROM" DATE(S) OF SERVICE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090 JOB(s): SB1J020, SB1J040

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
(IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF CLAIM REGION IS NOT EQUAL TO 20 OR 21
OR NOT OUTPATIENT CLAIM
OR NOT UB82 OUTPATIENT CLAIM OR NOT UB82 HOME HEALTH
OR (PROVIDER NUMBER NOT GREATER THAN '000035000' AND NOT LESS THAN
'000037999')
OR NOT NURSE HOME CLAIM
AND
IF UB82 INPATIENT CLAIM
AND
IF CALC-DAYS-TOO NOT GREATER THAN TOTAL DAYS BILLED
AND
IF NOT UB82 INPATIENT CLAIM
AND CALC-DAYS-TOO NOT EQUAL TO +0 AND TOTAL DAYS BILLED NOT EQUAL TO +1
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR
IF NURSE HOME CLAIM AND NOT CLAIM REGION 21
IF NOT NURSING HOME CLAIM
IF CALC-DAYS-TOO NOT EQUAL TO TOTAL DAYS BILLED
AND
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM, RECIPIENT IS ON FILE

AND

(IF CLAIM IS AN INPATIENT CLAIM AND NOT AN ADJUSTMENT CLAIM AND
(NOT FLAGGED FOR DISCHARGE OR DEATH)
IF (THE SUM OF TOTAL DAYS BILLED AND NON-CHARGED DAYS IS NOT EQUAL TO
JD-TOTAL-DAYS
IF CLAIM’S REGION IS EQUAL TO 40)
EXPLANATION OF BENEFITS (EOB) CODE: M53

MESSAGE TEXT:
DID NOT COMPLETE OR ENTER THE APPROPRIATE NUMBER (ONE OR MORE) OF DAYS OR UNITS OF SERVICE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070    JOB(s): SB1J020

SITUATION:
A) IF ERROR-SW IS EQUAL TO ZERO
   IF ENTRX-CD2 IS NOT EQUAL TO '4' OR '5'
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2'
   AND ENTRX-CD1 EQUAL TO 'A'
   AND
   IF ENTRX-CD1 NOT EQUAL TO 'I' OR 'O' OR 'N'
   AND
   IF ENTRX-CD1 EQUAL TO 'M' OR 'S' OR 'L'
   AND
   IF MEDICAL CLAIM
   AND
   IF CLAIM REGION IS EQUAL TO '94' AND
   (FROM DATE OF SERVICE IS NUMERIC)
   AND (TO DATE OF SERVICE IS NUMERIC)
   AND (PROCEDURE CODE IS EQUAL TO '00001' OR '00013' OR '00014'
   OR '00026' OR '00030' OR '00057' OR '00098')
   IF (WK-DAY-CALC NOT EQUAL TO UNITS OF SERVICE
   OR
   (WORK-MON NOT EQUAL TO WORK2-MON) OR (WORK-YR NOT EQUAL TO WORK2-YR)
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM

B) IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
   OR
   (IF CORRECTION ID EQUAL TO 'R'
   OR
   IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND
   IF UPDATE-SW NOT EQUAL TO ZERO
   AND
   IF PERR-SW EQUAL TO 'Y'
   OR
   IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF UB82 INPATIENT CLAIM
IF UB82 TOTAL DAYS BILLED IS EQUAL TO ZEROS
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

C)
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' '
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
IF WK-DAYS EQUAL TO 1
OR
IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF PROVIDER NUMBER IS EQUAL TO '000035434'
AND
IF UNITS OF SERVICE ARE GREATER THAN 8
OR
IF CLAIM REGION EQUAL TO 94
AND DET-GT-5-SW NOT EQUAL TO 'Y'
IF PROCEDURE CODE FOUND ON PROCEDURE CODE LIST
AND
  IF (PROVIDER NUMBER GREATER THAN '000033055' AND LESS THAN '000033060')
    IF PRICING INDICATOR NOT EQUAL TO '8'
      IF UNITS OF SERVICE NOT EQUAL TO 1
EXPLANATION OF BENEFITS (EOB) CODE: M54

MESSAGE TEXT: DID NOT COMPLETE OR ENTER THE CORRECT TOTAL CHARGES FOR SERVICES RENDERED.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070 JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
  IF WK-DAYS EQUAL TO 1
   OR
     IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
  IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
  OR UB82 INST CLAIM OR CROSSOVER CLAIM
AND
  IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
  OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
  PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
  IF CLAIM REGION IS NOT EQUAL TO 20 OR 21
  OR NOT OUTPATIENT CLAIM
  OR NOT UB82 OUTPATIENT CLAIM OR NOT UB82 HOME HEALTH
  OR (PROVIDER NUMBER NOT GREATER THAN '000035000' AND NOT LESS THAN '000037999')
  OR NOT NURSE HOME CLAIM
AND
  IF UB82 INPATIENT CLAIM
AND
    IF CALC-DAYS-TOO NOT GREATER THAN TOTAL DAYS BILLED
AND
    IF NOT UB82 INPATIENT CLAIM
    AND CALC-DAYS-TOO NOT EQUAL TO +0 AND TOTAL DAYS BILLED NOT
EQUAL TO +1
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF THE NUMBER OF DETAIL IS NOT GREATER THAN ZERO
AND
IF CLMT-CLM-REGION = 40
AND NOT CLMT-ADJUSTMENT
OR
IF NUMBER OF DETAILS IS LESS THAN ZERO
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: M68

MESSAGE TEXT:
INCOMPLETE/INVALID ATTENDING OR REFERRING PHYSICIAN IDENTIFICATION.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1130  JOB(s): SB1J050

SITUATION:
A)
IF PAYABLE CLAIM
IF NOT DENIED CLAIM
AND
IF VALID RECORD ON THE PROVIDER VSAM FILE
OR
IF NOT UB82 HOME HEALTH AND BILL TYPE NOT EQUAL TO '711' AND
PVF-STATUS NOT EQUAL TO '00' AND REVENUE CODE NOT EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT GREATER THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR LESS THAN 0) OR
(REVENUE CODE NOT EQUAL TO 521 OR 522
AND 1ST DAY OF SERVICE LESS THAN 20011231 AND
(PROVIDER NUMBER LESS THAN '000004999' AND GREATER THAN '000006000')) OR
(1ST DAY OF SERVICE NOT GREATER THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR LESS THAN 0 AND REVENUE CODE EQUAL TO 521
OR 522))
AND IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
OR REVENUE CODE EQUAL TO 983
OR CROSSOVER CLAIM
AND
IF VALID RECORD ON THE PROVIDER VSAM FILE
AND
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

B)
IF PAYABLE CLAIM
AND NOT A DENIED CLAIM
IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
(REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER
THAN 20011231 AND
(PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
(1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
EQUAL TO 521 OR 522))
OR
IF (PROFESSIONAL CLAIM AND
NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0)) OR REVENUE CODE EQUAL TO 983 OR CROSSOVER CLAIM IF INSTITUTIONAL CLAIM OR UB82 CLAIM OR IF (PROFESSIONAL CLAIM AND NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711 AND PVF-STATUS EQUAL TO '00' AND PROV-CURR-OPT-RR GREATER THAN 0)) OR REVENUE CODE EQUAL TO 983 OR CROSSOVER CLAIM AND IF VALID PROVIDER IF TEST TYPE IS EQUAL TO '20' OR '56' OR '48' THRU '54' AND P1M0-IN-STATE AND P1M0-PROV-NO-IN-GRP GREATER THAN ZEROES AND NOT CROSSOVER CLAIM AND IF PVF-STATUS EQUAL TO ZEROES AND IF CLAIM REGION EQUAL TO 40 AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE : M79

MESSAGE TEXT:
DID NOT COMPLETE OR ENTER THE APPROPRIATE CHARGE FOR EACH LISTED SERVICE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090      JOB(s): SB1J020, SB1J040

SB1070(SB1J020) - SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'V'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
      PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF PROVIDER NUMBER IS EQUAL TO '000035434'
AND
IF SUBMITTED CHARGE IS EQUAL TO ZEROS
   AND DD-PROCEDURE CODE NOT EQUAL TO '022'
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR
IF SUBMITTED CHARGE EQUAL TO ZEROES
AND DD PROCEDURE CODE NOT EQUAL TO '022'
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

SB1090(SB1J040) - SITUATION:
IF CURRENT CLAIM IS A PAYABLE CLAIM AND NOT AN ADJUSTMENT CLAIM
IF ((CLAIM ALREADY CONTAINS A DETAIL-LEVEL ERROR CODE OF ‘409’ or ‘411’)
    AND (HAS A HOLD-STOP REASON INDICATOR EQUAL TO ‘CL’)
    AND (IS NOT OF REGION 90)
    AND (ITS FIRST DATE OF SERVICE IS GREATER THAN ITS HOLD-END-DATE))
OR ((CLAIM ALREADY CONTAINS A DETAIL-LEVEL ERROR CODE OF '008', '009' or '265')
    AND (CLAIM IS OF REGION 94)
    AND (CURRENT CLAIM’S PROVIDER NUMBER IS GREATER THAN '000032313'
        AND CURRENT CLAIM’S PROVIDER NUMBER IS LESS THAN '000032322'))
IF CURRENT CLAIM IS OF REGION 30
   IF CLAIM IS OF TAKE-OVER REGION AND CONTAINS A DETAIL-LEVEL ERROR CODE
       EQUAL TO '107'
EXPLANATION OF BENEFITS (EOB) CODE : MA04

MESSAGE TEXT:
SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1090 JOB(s): SB1J040

SITUATION:
IF CURRENT CLAIM IS A PAYABLE CLAIM AND NOT AN ADJUSTMENT CLAIM
IF ((CLAIM ALREADY CONTAINS A DETAIL-LEVEL ERROR CODE OF ‘409’ or ‘411’)
 AND (HAS A HOLD-STOP REASON INDICATOR EQUAL TO ‘CL’)
 AND (IS NOT OF REGION 90)
 AND (ITS FIRST DATE OF SERVICE IS GREATER THAN ITS HOLD-END-DATE))
OR ((CLAIM ALREADY CONTAINS A DETAIL-LEVEL ERROR CODE OF '008', '009' or '265')
 AND (CLAIM IS OF REGION 94)
 AND (CURRENT CLAIM’S PROVIDER NUMBER IS GREATER THAN '000032313'
 AND CURRENT CLAIM’S PROVIDER NUMBER IS LESS THAN '000032322'))
IF CURRENT CLAIM IS OF REGION 30
IF CLAIM IS NOT OF TAKE-OVER REGION OR IT CONTAINS A DETAIL-LEVEL ERROR CODE NOT EQUAL TO ‘107’
IF CLMT-TAPE-BILL-REG (40) OR
 (CLMT-IHS-REGION (70) AND (CLMT-CLM-BTH-NO > 814 AND < 831)) OR
 (CLMT-CROSSOVER-CLAIM AND (CLMT-IHS-REGION (70) OR
 CLMT-TAKE-OVER-REG (80))))
IF CLMT-ERR-CD (CLMT-INDX8) NOT = '009'
 IF CLMT-ERR-CD (CLMT-INDX8) NOT = '008'
 IF CLMT-ERR-CD (CLMT-INDX8) = '556'
EXPLANATION OF BENEFITS (EOB) CODE : MA06

MESSAGE TEXT:
INCORRECT/INCOMPLETE/MISSING BEGINNING AND/OR ENDING DATE(S) ON CLAIM.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070        JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
IF NURSE HOME CLAIM
   AND (CLAIM REGION IS EQUAL TO A 20 OR 21)
   AND (VR PROVIDER NOT EQUAL TO '001086' AND NOT EQUAL TO '002435'
AND NOT EQUAL TO '050383')
   IF TO DATE NOT NUMERIC
   OR (TO MONTH LESS THAN '01' OR GREATER THAN '12')
   OR (TO DAY LESS THAN '01' OR GREATER THAN '31')
   IF CLAIM REGION EQUAL TO 40
   AND NOT CLMT-ADJUSTMENT
OR
  IF 1ST PROCEDURE SERVICE DATE EQUAL TO ZEROS
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
OR
  IF 1ST PROCEDURE SERVICE DATE NOT EQUAL TO ZEROS
  AND
  IF PERFORMED-EDIT-ERR-SW EQUAL TO 1
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
OR
  IF 1ST PROCEDURE SERVICE DATE IS LESS THAN THE BEGINNING FROM DATE
  OR 1ST PROCEDURE SERVICE DATE IS GREATER THAN THE BEGINNING TO DATE
  OR LAST PROCEDURE SERVICE DATE IS LESS THAN THE BEGINNING FROM DATE
  OR LAST PROCEDURE SERVICE DATE IS GREATER THAN THE BEGINNING TO DATE
  IF PRICING INDICATOR NOT EQUAL TO '8'
  IF CLAIM REGION EQUAL TO 40
  AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE : MA30

MESSAGE TEXT:
INCOMPLETE/INVALID TYPE OF BILL.

SOURCE CODE: “R” = Remittance Advice

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1130   JOB(s): SB1J020, SB1J050

SITUATION:

SB1070 – (SB1J020) – SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF CLAIM REGION IS EQUAL TO 80
AND
IF CROSSOVER CLAIM
AND
IF (UB82 INPATIENT CLAIM AND NOT (BILL TYPE EQUAL TO '111
   OR '112' OR '113' OR '114' OR '121'))
OR (UB82 OUTPATIENT CLAIM
   AND NOT (BILL TYPE EQUAL TO '131' OR '132' OR '133 OR '134' OR '141' OR '731' OR '831'))
OR (UB82 HOME HEALTH AND NOT (BILL TYPE EQUAL TO '331'
   OR '332' OR '333' OR '334' OR '121' OR '711' OR '811' OR '812' OR '813' OR '814'))
OR ((CLMT-UB82-HOME-HEALTH)
   AND (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000'))
   AND (BILL TYPE NOT EQUAL TO '711'))
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
SB1130 – (SB1J050) – SITUATION:

A) IF PAYABLE CLAIM
   AND IF NOT DENIED CLAIM
   AND IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS EQUAL TO '00' AND REVENUE CODE NOT EQUAL TO 983 AND
   ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
   AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
   (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
   20011231
   AND
   (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
   (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
   AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT EQUAL
   TO 521 OR 522))
   AND
   IF UB82 OUTPATIENT CLAIM AND
   1ST DAY OF SERVICE GREATER THAN 19990228
   IF BILL TYPE EQUAL TO '831' AND ASC-360-490 EQUAL TO 'N'

B) IF PAYABLE CLAIM
   AND NOT A DENIED CLAIM
   IF UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS EQUAL TO '00' AND REVENUE CODE EQUAL TO 983 AND
   ((1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-CURR-OPT-EFDT
   AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0) OR
   (REVENUE CODE EQUAL TO 521 OR 522 AND 1ST DAY OF SERVICE GREATER THAN
   20011231
   AND
   (PROVIDER NUMBER GREATER THAN '000004999' AND LESS THAN '000006000')) OR
   (1ST DAY OF SERVICE NOT LESS THAN P1M0-PROV-PREV-OPT-EFDT
   AND P1M0-PROV-PREV-OPT-RR GREATER THAN 0 AND REVENUE CODE NOT
   EQUAL TO 521 OR 522))
   OR
   IF (PROFESSIONAL CLAIM AND
   NOT (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711'
   AND PVF-STATUS EQUAL TO '00' AND P1M0-PROV-CURR-OPT-RR GREATER THAN 0))
   OR REVENUE CODE EQUAL TO 983
   OR CROSSOVER CLAIM
   IF INSTITUTIONAL CLAIM OR UB82 CLAIM
   AND
   IF UB82 INPATIENT CLAIM
   IF CLAIM REGION EQUAL TO 70
   OR
   IF UB82 OUTPATIENT CLAIM AND CLAIM REGION EQUAL TO 70
   AND
   IF (UB82 INPATIENT CLAIM AND BILL TYPE EQUAL TO '111'
   AND REVENUE CODE NOT EQUAL TO '100')
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM

Top
EXPLANATION OF BENEFITS (EOB) CODE : MA31

MESSAGE TEXT:
INCOMPLETE/INVALID BEGINNING AND ENDING DATES OF THE PERIOD BILLED.

SOURCE CODE: “R” = Remittance Advice

DATE CREATED: 11/21/02

PROGRAM(s): SB1070  JOB(s): SB1J020

SITUATION:
A) IF ERROR-SW IS EQUAL TO ZERO
   AND IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
   OR (IF CORRECTION ID EQUAL TO 'R'
   OR IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND IF UPDATE-SW NOT EQUAL TO ZERO
   AND IF PERR-SW EQUAL TO 'Y'
   OR IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
   AND IF CLAIM REGION IS EQUAL TO 80
   AND IF CROSSOVER CLAIM
   AND IF BILLING FROM DATE IS EQUAL TO ZEROS
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
   OR IF PERFORMED-EDIT-ERR-SW = 1
   IF CLMT-CLM-REGION = 40
   AND NOT CLMT-ADJUSTMENT

B) IF ERROR-SW IS EQUAL TO ZERO
   AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
   IF NURSE HOME CLAIM
   AND (CLAIM REGION 20 OR 21)
   AND (VR PROVIDER NUMBER NOT EQUAL TO '001086' AND NOT EQUAL TO '
   '002435'
   AND NOT EQUAL TO '050383')
AND
IF FROM DATE IS NOT NUMERIC
   OR (FROM MONTH IS LESS THAN '01' OR GREATER THAN '12')
   OR (FROM DAY IS LESS THAN '01' OR GREATER THAN '31')
IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: MA32

MESSAGE TEXT:
INCOMPLETE/INVALID NUMBER OF COVERED DAYS DURING THE BILLING PERIOD.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070 JOB(s): SB1J020

SITUATION:
A) IF ERROR-SW IS EQUAL TO ZERO
   AND IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
   OR (IF CORRECTION ID EQUAL TO 'R'
   OR IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND IF UPDATE-SW NOT EQUAL TO ZERO
   AND IF PERR-SW EQUAL TO 'Y'
   OR IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND
   IF (INPATIENT CLAIM OR NURSE HOME CLAIM) AND
   NOT (UB82 INPATIENT CLAIM AND (DRUG CODE GREATER THAN 0))
   IF NURSE HOME CLAIM
   IF NOT NURSING HOME CLAIM
   IF WK-COVERED-DAYS GREATER THAN (TOTAL DAYS BILLED + UB82 NON COVERED DAYS)
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
   OR
   IF WK-COVERED-DAYS GREATER THAN (TOTAL DAYS BILLED + UB82 NON COVERED DAYS
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
   OR
   IF UB82 INPATIENT CLAIM AND
   NOT (UB82 INPATIENT CLAIM AND (DRUG CODE GREATER THAN 0))
   IF WK-COVERED-DAYS GREATER THAN (UB82 TOTAL DAYS BILLED + UB82 NON COVERED DAYS
   IF CLAIM REGION EQUAL TO 40
AND NOT CLMT-ADJUSTMENT

B) IF ERROR-SW IS EQUAL TO ZERO
AND IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR (IF CORRECTION ID EQUAL TO 'R'
OR IF ENTRX-ICN GREATER THAN SUSP-ICN
AND IF UPDATE-SW NOT EQUAL TO ZERO
AND IF PERR-SW EQUAL TO 'Y'
OR IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO NOT EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
   PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND IF NOT A UB82 CLAIM
AND IF CLAIM REGION IS EQUAL TO 90
   IF (SERVICE CODE IS EQUAL TO 'A' OR 'B' OR 'C' OR 'H'
      OR 'I' OR 'K' OR 'L' OR 'M' OR 'O' OR 'P'
      OR 'Q' OR 'S' OR 'T' OR 'V' OR 'W' OR 'X'
      OR 'Y' OR 'Z' OR 'I' OR '2' OR '3' OR '4' OR '5'
      OR '6' OR '7' OR '8' OR '9')
      OR (SERVICE CODE IS EQUAL TO 'J'
      AND (1ST PROCEDURE SERVICE DATE IS GREATER THAN 19910831
      AND 1ST PROCEDURE SERVICE DATE IS LESS THAN 19990701))
   OR (SERVICE CODE IS EQUAL TO 'G'
   AND 1ST PROCEDURE SERVICE DATE IS LESS THAN 19990701)
   IF (CALC-DAYS NOT EQUAL TO UNITS OF SERVICE)
   AND NOT VALID DISCHARGE DESTINATION
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
OR IF NURSE HOME CLAIM AND
   (CLAIM REGION IS EQUAL TO 20 AND 21) AND
   (VR PROVIDER NOT EQUAL TO '001086' AND NOT EQUAL TO '002435'
   AND NOT EQUAL TO '050383')
   IF SERVICE CODE IS EQUAL TO '1' OR '2' OR '3'
OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U'
OR 'V' OR 'W' OR 'X' OR 'Y'
IF (CALC-DAYS NOT EQUAL TO UNITS OF SERVICE)
   AND NOT VALID DISCHARGE DESTINATION
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: MA40

MESSAGE TEXT:
INCOMPLETE/INVALID ADMISSION DATE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070 JOB(s): SB1J020

SITUATION:
A) IF ERROR-SW IS EQUAL TO ZERO
   AND IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' ' OR (IF CORRECTION ID EQUAL TO 'R' OR IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND IF UPDATE-SW NOT EQUAL TO ZERO
   AND IF PERR-SW EQUAL TO 'Y'
   OR IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
     IF WK-DAYS EQUAL TO 1
     OR IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM OR UB82 INST CLAIM OR CROSSOVER CLAIM)
   AND IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
   AND IF NOT OUTPATIENT CLAIM
   OR UB82 OUTPATIENT CLAIM
   OR UB82 HOME HEALTH
   AND IF NOT A NURSING HOME CLAIM
   AND IF ADMISSION DATE IS EQUAL TO ZEROS
   AND IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
   AND...
IF PERFORMED-EDIT-ERR-SW EQUAL TO 1
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF NOT OUTPATIENT CLAIM
OR UB82 OUTPATIENT CLAIM
OR UB82 HOME HEALTH
OR IF CLAIM REGION NOT EQUAL TO 40
AND ADJUSTMENT CLAIM
IF NOT NURSING HOME CLAIM
IF ADMISSION DATE GREATER THAN BILLING FROM DATE
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF NOT OUTPATIENT CLAIM
OR UB82 OUTPATIENT CLAIM
OR UB82 HOME HEALTH
AND
IF NATURE OF ADMISSION IS NOT EQUAL TO 1 THRU 4
IF NOT NURSE HOME CLAIM
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

B) IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' '
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
IF WK-DAYS EQUAL TO 1
OR
IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF Crossover Claim
OR Institutional Claim OR UB82 Inst Claim
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF Institutional Claim OR Professional Claim
OR UB82 Inst Claim OR Crossover Claim
AND
IF Crossover Claim
AND
IF Crossover Record Type IS EQUAL TO 'I' OR '3'
IF ADMISSION DATE IS EQUAL TO ZEROS
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF ADMISSION DATE IS NOT EQUAL TO ZEROS
IF PERFORMED-EDIT-ERR-SW EQUAL TO 1
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

OR

IF CROSSOVER RECORD TYPE IS EQUAL TO 'I' OR '3'
IF NATURE OF ADMISSION IS EQUAL TO SPACE
IF CLAIM BIRTH NUMBER IS LESS THAN 074 OR GREATER THAN 100
AND
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE : MA42

MESSAGE TEXT:
INCOMPLETE/INVALID SOURCE OF ADMISSION.

SOURCE CODE: “R” = Remittance Advice

DATE CREATED: 11/21/02

PROGRAM(s): SB1070     JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
(IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF CLAIM REGION IS EQUAL TO 80
AND
IF CROSSOVER CLAIM
AND
IF UB82 INPATIENT CLAIM
   IF UB82 SRC OF ADM LESS THAN '1' OR GREATER THAN '9'
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: MA61

MESSAGE TEXT:
DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070, SB1090 JOB(s): SB1J020, SB1J040

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
   OR
   IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
   IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
IF CLAIM REGION IS EQUAL TO 80
AND
IF CROSSOVER CLAIM
AND
IF CLMT-RECIP-CUR-PCN-N EQUAL TO SPACES
IF CLAIM REGION EQUAL TO 40
AND NOT ADJUSTMENT CLAIM
OR
IF WK-ID8-9 EQUAL TO 'VR' AND CLAIM REGION NOT EQUAL TO 50
IF CLAIM REGION IS EQUAL TO 40
AND NOT ADJUSTMENT CLAIM

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT IS NOT AN ADJUSTMENT CLAIM
AND

(IF CLMT-SPL-PRCS-FLG (3) IS EQUAL TO '1'
   IF (CLMT-CLM-REGION IS EQUAL TO 40
      OR ((CLMT-VR-PROV IS GREATER THAN '032310' AND IS LESS THAN '032322')
         OR (CLMT-VR-PROV IS GREATER THAN '033055' AND IS LESS THAN '033060')
         OR (CLMT-VR-PROV IS EQUAL TO '035201', '035432' OR = '035434'))))

OR

(IF NO TECS ELIGIBILITY AND NOT CLMT-CROSSOVER-CLAIM
   AND NOT CLMT-NURSE-HOME-CLAIM
   AND NOT (CLMT-UB82-INPATIENT-CLAIM
      AND ALL-DEDUCT-COINS IS EQUAL TO 'Y'
      AND CLMT-ELIG-PART-A)
   AND QMB-ELIG-SSN-SW IS EQUAL TO 'N'
   IF (CLMT-CLM-REGION IS EQUAL TO 40
      OR ((CLMT-VR-PROV GREATER THAN '032310' AND LESS THAN '032322')
         OR (CLMT-VR-PROV GREATER THAN '033055' AND LESS THAN '033060')
         OR (CLMT-VR-PROV = '035201', '035432' OR = '035434'))))

OR

(CLAIM HAS A VALID RECIPIENT ID
   AND
   IF CLMT-CROSSOVER-CLAIM OR CLMT-NURSE-HOME-CLAIM OR
      ((CLMT-MEDICAL-CLAIM OR CLMT-UB82-CLAIM) AND
      (CLMT-ELIG-PART-A OR CLMT-ELIG-PART-B))
   IF (NO-FIND-SW IS EQUAL TO 'Y' AND
      (ALL-XOVR-SW IS EQUAL TO 'N' OR ALL-DEDUCT-COINS IS EQUAL TO 'N'))
   IF (CLMT-CLM-REGION IS EQUAL TO 40
      OR ((CLMT-VR-PROV GREATER THAN '032310' AND LESS THAN '032322')
         OR (CLMT-VR-PROV GREATER THAN '033055' AND LESS THAN '033060')
         OR (CLMT-VR-PROV IS EQUAL TO '035201', '035432' OR '035434'))))

OR

(IF NOT (CLMT-CROSSOVER-CLAIM OR ((CLMT-MEDICAL-CLAIM OR CLMT-UB82-CLAIM)
   AND (CLMT-ELIG-PART-A OR CLMT-ELIG-PART-B))
   IF CLMT-RECIP-CUR-PCN EQUAL TO WSS-PCN
   AND
   IF (RECIPIENT NOT FOUND OR CLAIM IS NOT QMB ELIGIBLE)
   AND
   CLAIM IS NOT A PRIOR AUTHORIZATION CLAIM
   AND
   CLAIM IS OF REGION 40
   OR ((CLMT-VR-PROV GREATER THAN '032310' AND LESS THAN '032322') OR
      (CLMT-VR-PROV GREATER THAN '033055' AND LESS THAN '033060') OR
      (CLMT-VR-PROV EQUAL TO '035201', '035432' or '035434')))
EXPLANATION OF BENEFITS (EOB) CODE : N10

MESSAGE TEXT: YOU MAY APPEAL THIS DECISION IN WRITING WITHIN THE REQUIRED TIME LIMITS FOLLOWING RECEIPT OF THIS NOTICE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB710027 JOB(s): ONLINE

SITUATION:
   IF CICS-RESP-NORMAL
   AND
   IF CLAIM STATUS CODE IS EQUAL TO ‘M’
   IF CICS-RESP-NOTFND

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EXPLANATION OF BENEFITS (EOB) CODE: N30

MESSAGE TEXT:
REQUIRED/CONSENT FORM INCOMPLETE, INCORRECT, OR NOT ON FILE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM AND IT CONTAINS A VALID RECIPIENT ID NUMBER AND IT IS NOT AN ADJUSTMENT CLAIM

AND

((IF (CURRENT CLAIM HAS BEEN FLAGGED FOR CHILD ABUSE OR IT HAS AN ACCIDENT TYPE INDICATOR EQUAL TO SPACES)
   IF CURRENT CLAIM’S AID CATEGORY IS EQUAL TO ‘41’ or ‘42’)

OR

(IF (CURRENT CLAIM HAS BEEN FLAGGED FOR CHILD ABUSE OR IT HAS AN ACCIDENT TYPE INDICATOR EQUAL TO SPACES)
   IF CURRENT CLAIM’S AID CATEGORY IS EQUAL TO ‘36’)

OR

(IF RECIPIENT’S AGE GREATER THAN 3 OR (RECIPIENT’S AGE EQUAL TO 3 AND THE CLAIM’S LAST DATE OF SERVICE IS GREATER THAN THE RECIPIENT’S BIRTH DATE))

OR

(IF CURRENT CLAIM IS NOT A NURSING HOME CLAIM OR IT IS NOT QMB ELIGIBLE
   IF CURRENT CLAIM HAS AN AID CATEGORY EQUAL TO ‘36’, ‘41’ or ‘42’)

OR

(IF CURRENT CLAIM PERTAINS TO A TECS RECIPIENT
   IF CCW-UNAUTHORIZED-STAT EQUAL TO "Y"
   IF CURRENT CLAIM HAS NOT ALREADY RECEIVED A 108 ERROR AND CLMT-ERR-CD(1 THROUGH 10) IS NOT EQUAL TO ‘061’
   IF TOTAL DAYS OF SERVICE IS LESS THAN OR EQUAL TO 60))
EXPLANATION OF BENEFITS (EOB) CODE: N34

MESSAGE TEXT:
INCORRECT CLAIM FORM FOR THIS SERVICE.

SOURCE CODE: “R” = Remittance Advice

DATE CREATED: 11/21/2002

PROGRAM(s): SB1090 JOB(s): SB1J040

SB1090(SB1J040) - SITUATION:
CURRENT CLAIM IS A PAYABLE CLAIM WITH A VALID RECIPIENT ID NUMBER ON FILE

AND

(IF (CURRENT CLAIM’S RECIPIENT LEGAL COUNTY CODE IS EQUAL TO 56 or 55)
 AND CURRENT CLAIM IS NOT OF REGION 49
 IF CURRENT CLAIM IS OF REGION 40
 AND CURRENT CLAIM IS NOT AN ADJUSTMENT CLAIM)
EXPLANATION OF BENEFITS (EOB) CODE: N37

MESSAGE TEXT:
TOOTH NUMBER/LETTER REQUIRED.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070  JOB(s): SB1J020

SITUATION:

A) IF CORRECTION ID EQUAL TO 'R'
   OR IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND IF UPDATE-SW NOT EQUAL TO ZERO
   AND IF PERR-SW EQUAL TO 'Y'
   OR IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
      IF WK-DAYS EQUAL TO 1
      OR IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   AND IF DENTAL CLAIM
   AND PRED-BENEFITS-SW NOT EQUAL TO 'Y'
   AND IF TYPE OF SERVICE IS EQUAL TO '7'
   AND IF PROCEDURE CODE IS ON LIST 0147
   AND IF NOT VALID TEETH
      IF CLAIM REGION IS EQUAL TO 40
      AND NOT ADJUSTMENT CLAIM

B) IF ERROR-SW IS EQUAL TO ZERO
   AND IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
   OR (IF CORRECTION ID EQUAL TO 'R'
   OR IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND IF UPDATE-SW NOT EQUAL TO ZERO
   AND IF PERR-SW EQUAL TO 'Y'
OR
 IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
   IF WK-DAYS EQUAL TO 1
     OR
     IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR CROSSOVER CLAIM)
   AND
   IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
 OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
 PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
 AND
 IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
 AND
 IF MEDICAL CLAIM OR DENTAL CLAIM OR XOVR MEDICAL
   IF NOT VALID-MODIFIER OR
   (DETAIL XTRA MODIFIER NOT EQUAL TO 'XV' AND
   1ST PROCEDURE SERVICE DATE GREATER THAN 20040501 )
   AND
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
 OR
 IF DENTAL CLAIM AND TYPE OF SERVICE CODE IS EQUAL TO '7'
 IF PROCEDURE CODE IS FOUND ON PROCEDURE CODE LIST
 IF NOT VALID-TEETH
 IF CLAIM REGION EQUAUL TO 40
 AND NOT ADJUSTMENT CLAIM

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EXPLANATION OF BENEFITS (EOB) CODE: N43

MESSAGE TEXT: BED HOLD OR LEAVE DAYS EXCEEDED.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1280 JOB(s): SB1J076

SITUATION:
WHEN SORT ICN EQUAL TO CURRENT ICN
IF SORT DETAIL LINE NUMBER NOT GREATER THAN
CURRENT NUMBER OF LINE ITEMS
EXPLANATION OF BENEFITS (EOB) CODE : N50

MESSAGE TEXT:
EOB RECEIVED FROM PREVIOUS PAYER. CLAIM NOT ON FILE.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070    JOB(s): SB1J020

SITUATION:
A) IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' ' OR
   (IF CORRECTION ID EQUAL TO 'R'
   OR
   IF ENTRX-ICN GREATER THAN SUSP-ICN
   AND
   IF UPDATE-SW NOT EQUAL TO ZERO
   AND
   IF PERR-SW EQUAL TO 'Y'
   OR
   IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
     IF WK-DAYS EQUAL TO 1
     OR
     IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
   AND
   IF CROSSOVER CLAIM
   OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
   IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
   AND
   IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
   OR UB82 INST CLAIM OR Crossover CLAIM)
   AND
   IF BILLING TO DATE IS EQUAL TO = ZEROS
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
   OR
   IF PERFORMED-EDIT-ERR-SW EQUAL TO 1
   IF CLAIM REGION NOT EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM

B) IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
 IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ' ' 
 OR
 (IF CORRECTION ID EQUAL TO 'R'
 OR
 IF ENTRX-ICN GREATER THAN SUSP-ICN
 AND
 IF UPDATE-SW NOT EQUAL TO ZERO
 AND
 IF PERR-SW EQUAL TO 'Y'
 OR
 IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
 IF WK-DAYS EQUAL TO 1
 OR
 IF DANO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
 AND
 IF CROSSOVER CLAIM
 OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
 IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
 AND
 IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
 OR UB82 INST CLAIM OR CROSSOVER CLAIM)
 AND
 IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
 OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
 PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
 AND
 IF NOT OUTPATIENT CLAIM
 OR UB82 OUTPATIENT CLAIM
 OR UB82 HOME HEALTH
 AND
 IF NOT (DISCHARGE DESTINATION IS EQUAL TO '9' AND DATE OF DISCHARGE IS
 EQUAL TO ZEROS)
 OR (DISCHARGE DESTINATION IS EQUAL TO '6' AND DATE OF DISCHARGE IS
 EQUAL TO ZEROES)
 AND (CLAIM REGION IS EQUAL TO 20 OR 21)
 AND (PROVIDER NUMBER IS GREATER THAN '000029999' AND LESS THAN
 '000040000')
 AND
 IF DISCHARGE DESTINATION IS EQUAL TO 1 THRU 6, 8, 9
 AND DATE OF DISCHARGE IS EQUAL TO ZEROS
 IF NOT NURSING HOME CLAIM
 IF CLAIM REGION EQUAL TO 40
 AND NOT ADJUSTMENT CLAIM
 OR
 IF NOT OUTPATIENT CLAIM
 OR UB82 OUTPATIENT CLAIM
 OR UB82 HOME HEALTH
 OR
 IF (DISCHARGE DESTINATION NOT EQUAL TO '9' OR '6')
 AND
 IF NOT NURSING HOME CLAIM
 IF DATE OF DISCHARGE EQUAL TO ZEROS
 OR
 PERFORMED-EDIT-ERR-SW EQUAL TO 1
 AND
 IF CLAIM REGION EQUAL TO 40
 AND NOT ADJUSTMENT CLAIM
 OR
 IF NOT OUTPATIENT CLAIM OR UB82 OUTPATIENT CLAIM OR
 UB82 HOME HEALTH

04/04/06
AND
   IF NOT VALID DISCHARGE DESTINATION
   AND
   IF NOT NURSING HOME CLAIM
      IF CLAIM REGION EQUAL TO 40
         AND NOT ADJUSTMENT CLAIM
   OR
   IF NOT OUTPATIENT CLAIM OR UB82 OUTPATIENT CLAIM OR
      UB82 HOME HEALTH
   AND
   IF ((DISCHARGE DESTINATION IS EQUAL TO '9' AND DISCHARGE DATE IS
        GREATER THAN ZEROS)
      OR (DISCHARGE DESTINATION IS EQUAL TO '6' AND DISCHARGE DATE IS
          GREATER THAN ZEROS))
   AND (CLAIM REGION IS EQUAL TO 20 OR 21)
   AND (PROVIDER NUMBER GREATER THAN '000029999' AND LESS THAN
        '000040000')
   IF NOT NURSING HOME CLAIM
   IF CLAIM REGION IS EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM

C)
   IF ERROR-SW IS EQUAL TO ZERO
   AND
   IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
   AND
   IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
   AND
   IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
      OR
      (IF CORRECTION ID EQUAL TO 'R'
       OR
       IF ENTRX-ICN GREATER THAN SUSP-ICN
      AND
       IF UPDATE-SW NOT EQUAL TO ZERO
      AND
       IF PERR-SW EQUAL TO 'Y'
      OR
       IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
         IF WK-DAYS EQUAL TO 1
            OR
            IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
      AND
       IF CROSSOVER CLAIM
      OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
      IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
      AND
       IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
           OR UB82 INST CLAIM OR CROSSOVER CLAIM)
   AND
   IF CROSSOVER CLAIM
   AND
       IF (CROSSOVER RECORD TYPE EQUAL TO '1' OR '3') AND DISCHARGE
           DESTINATION GREATER THAN ''
   IF NOT STILL PATIENT AND NOT DISCHARGE LEFT
   IF DATE OF DISCHARGE IS EQUAL TO ZEROS
   IF CLAIM REGION EQUAL TO 40
   AND NOT ADJUSTMENT CLAIM
EXPLANATION OF BENEFITS (EOB) CODE: N56

MESSAGE TEXT:
PROCEDURE CODE BILLED IS NOT CORRECT FOR THE SERVICE BILLED.

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 11/21/02

PROGRAM(s): SB1070      JOB(s): SB1J020

SITUATION:
IF ERROR-SW IS EQUAL TO ZERO
AND
IF ENTRX-CD2 NOT EQUAL TO '2' OR '4' OR '5'
AND
IF ENTRX-CD1 = 'I' OR 'O' OR 'N' OR 'M' OR 'S' OR 'L' OR 'X' OR 'A' OR 'Q' OR 'R' OR 'U'
AND
IF SPLIT CLAIM INDICATOR IS EQUAL TO 'Z' OR ''
OR
(IF CORRECTION ID EQUAL TO 'R'
OR
IF ENTRX-ICN GREATER THAN SUSP-ICN
AND
IF UPDATE-SW NOT EQUAL TO ZERO
AND
IF PERR-SW EQUAL TO 'Y'
OR
IF ADJUSTMENT CLAIM AND (CLMI-PRCR-CLK-NO EQUAL TO 'MAS')
    IF WK-DAYS EQUAL TO 1
    OR
    IF DAYO-TYPE-OF-CYCLE EQUAL TO 'Y' AND CLMI-NO-ERRORS
AND
IF CROSSOVER CLAIM
OR INSTITUTIONAL CLAIM OR UB82 INST CLAIM
IF CLAIM STATUS CODE IS NOT EQUAL TO 'D'
AND
IF INSTITUTIONAL CLAIM OR PROFESSIONAL CLAIM
OR UB82 INST CLAIM OR CROSSOVER CLAIM)
AND
    IF INSTITUTIONAL CLAIM OR UB82 INST CLAIM
    OR (UB82 HOME HEALTH AND BILL TYPE EQUAL TO '711' AND
    PVF-STATUS IS EQUAL TO ZEROS AND P1M1-PROV-CURR-OPT-RR GREATER THAN 0)
AND
IF THE NUMBER OF DETAILS IS GREATER THAN ZERO
AND
IF NOT A UB82 CLAIM
AND
    IF PROVIDER NUMBER IS EQUAL TO '000035434'
    AND
    IF (CLAIM WAS BILLED ON A SATURDAY OR SUNDAY)
OR
IF CLAIM REGION EQUAL TO 94
    AND DET-GT-5-SW NOT EQUAL TO 'Y'
    IF PROCEDURE CODE FOUND ON PROCEDURE CODE LIST
AND
  IF (PROVIDER NUMBER GREATER THAN '000033055' AND LESS THAN '000033060')
  IF (DATE BILLED IS A SATURDAY OR SUNDAY)
EXPLANATION OF BENEFITS (EOB) CODE : N146

MESSAGE TEXT: MISSING SCREENING DOCUMENT

SOURCE CODE: “R” = REMITTANCE ADVICE

DATE CREATED: 04/04/2005

PROGRAM(s): SB1090    JOB(s): BATCH

SITUATION:
1. IF ((NURSING HOME CLAIM AND LONG TERM CARE REGION AND VR PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR (PROVIDER-NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000')) AND (NOT QMB ELIGIBLE)
   OR IF CLAIM REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL 56 AND NOT EQUAL 55) AND PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0148.
   OR IF FIRST DAY OF SERVICE IS GREATER THAN 20011031 AND MEDICAL CLAIM AND PROVIDER IS NOT EQUAL TO '00050383' AND PROCEDURE CODE IS FOUND ON THE PROCEDURE LIST TABLE 0149.
   OR IF FIRST DAY OF SERVICE IS GREATER THAN 20011031 AND UB82 INPATIENT CLAIM AND PROVIDER TYPE CODE IS '02' AND THE RECIPIENT'S AGE IS LESS THAN 21 AND PROCEDURE CODE FOUND IN PROCEDURE LIST TABLE 0149.

   THEN IF (RECORD FOUND ON SB644010 USING BASE-ID OR TECS NUMBER) AND (( LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S') OR (NOT LONG TERM CARE REGION AND SERVICE CODE EQUALS 'Q' OR 'S')) OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM) AND THERE IS NURSING HOME ELIGIBLE AND NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM AND CLAIM REGION NOT EQUAL '94'
     IF SERVICE CODE EQUALS '4'
       SET N146 IF (DDR-SERVICE CODE NOT EQUAL 'Q' AND NOT (DEVELOPMENT DISABILITY REGION)

2. IF ((NURSING HOME CLAIM AND LONG TERM CARE REGION AND VR PROVIDER NOT EQUAL '001086' AND NOT EQUAL '002435' AND NOT EQUAL '050383') OR (PROVIDER-NO NOT LESS THAN '000001900' AND NOT GREATER THAN '000002000')) AND (NOT QMB ELIGIBLE)
   OR IF CLAIM REGION EQUALS '94' AND (LEGAL COUNTY NOT EQUAL 56 AND NOT EQUAL 55) AND PROCEDURE CODE NOT FOUND ON PROCEDURE LIST TABLE 0148.
   OR IF FIRST DAY OF SERVICE IS GREATER THAN 20011031 AND MEDICAL CLAIM AND PROVIDER IS NOT EQUAL TO '00050383' AND PROCEDURE CODE IS FOUND ON THE PROCEDURE LIST TABLE 0149.
   OR IF FIRST DAY OF SERVICE IS GREATER THAN 20011031 AND UB82 INPATIENT CLAIM AND PROVIDER TYPE CODE IS '02' AND THE RECIPIENT'S AGE IS LESS THAN 21 AND PROCEDURE CODE FOUND IN PROCEDURE LIST TABLE 0149.

   THEN IF (RECORD FOUND ON SB644010 USING BASE-ID OR TECS NUMBER) AND (( LONG TERM CARE REGION AND (SERVICE CODE NOT EQUAL 'Q' OR 'S') OR (NOT LONG TERM CARE REGION AND SERVICE CODE EQUALS 'Q' OR 'S')) OR ((NURSING HOME CLAIM AND (SERVICE CODE EQUALS '1' OR '2' OR '3' OR '4' OR 'Q' OR 'R' OR 'S' OR 'T' OR 'U' OR 'V' OR 'W' OR 'X' OR 'Y')) OR NOT NURSING HOME CLAIM) AND THERE
IS NO NURSING HOME ELIGIBLE AND NOT MEDICAL CLAIM AND NOT UB82 INPATIENT CLAIM AND NOT INSTITUTIONAL CLAIM WITH PROVIDERS 35432 OR 35434 OR 35201 AND ((CLAIM REGION NOT EQUAL '94) OR (NOT FOUND ON PROCEDURE LIST TABLE 0102 AND 0101))

IF SERVICE CODE EQUALS '4'
    SET N146 IF (DDR-SERVICE CODE NOT EQUAL 'Q' AND NOT (DEVELOPMENT DISABILITY REGION)

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