

**Unisys WV Medicaid Edits and Descriptions as of 09/27/2007
(edits used on the Claims in Process(CIP) Report)**

Edit/Rule ID	Edit/Rule ID Description
1	SNF-No Authorization
2	SNF-Member Share of Cost Reduced From Contracted Amount
3	Benefit Exhaustion Period Reported
4	Medicare Crossover/COB/TPL Calculations Applied
5	Medicare Crossover 90% Processing Rules Applied
6	Medicare Crossover RHC/FQHC Guidelines Applied
7	Medicare Crossover QMB processing rules applied
8	Medicare Crossover Override Based on Medicare Processing
10	Medicare Crossover Claim Pays at Zero Dollars
11	HMO Guidelines Apply
12	Medicare covered service must be billed to Medicare
13	TPL Calculation Applied
14	TPL Claim Pays At Zero Dollars
15	Service not covered for patients in a Medicaid supported fac
16	No COB Info on Claim Line
17	Xover SQL pays zero dollars based on TOB logic
18	SNF Part A - Claim Pays Zero
19	No Estimated Amount Due
20	Revenue Codes 183 & 185 are Present on Part A Claim
22	Multiple AAA Codes
23	Revenue Code Not Valid for SNF Part A Claim
24	NDC is Missing/Invalid
25	NDC is not Rebate Eligible
26	Invalid NDC Units
27	SNF SQL denies claim when one or more lines are in deny stat
28	DOS not within LTC effect & term dates
101	No active provider contract
102	Provider not active for Plan on DOS
103	Invalid approved provider service for provider
104	Incomplete provider
105	Provider on Pay hold
106	No attending physician ID (outpatient)
107	Negative charge on claim line
108	Uncredentialed provider
109	Claim amt exceeds maximum allowed during mass adjudication
111	Provider Watch
112	Claim amount exceeds the maximum allowed
113	Specialty code required for provider
114	Provider does not match required type
116	Annual Benefit Amount Exceeded
117	Lifetime Benefit Amount Exceeded
119	Family LifeTime Limit exceeded
120	Family Annual Limit exceeded
121	Validate External Provider's Program
122	PCP reassignment override days
123	Individual Lifetime Visits Exceeded
124	Family Lifetime Visits Exceeded
125	Partial Units on Lifetime/Individual Visit Limits

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126	Partial Units on Lifetime Visit Limits
127	Employer Watch
128	Remaining visits less than date span. Units not allocated.
129	Process Partial Units
130	Program Watch
132	Individual Coinsured Charge Maximum Exceeded
133	Family Coinsured Charge Maximum Exceeded
134	Claim payment amt exceeds max allowed for mass adjudication
135	Claim payment amount exceeds the maximum allowed
140	Test
149	Benefit does NOT meet date criteria of the claim
150	No contract term found for service
151	Excluded Contract Term for Service
152	Provider type does not match type required by benefit
153	PCP is solely responsible for service: pay as capitated
154	Benefit requires Specialty Code not found on Provider
155	Benefit has age restriction
156	Provider type does NOT match type required by contract term
157	Contract Term requires Specialty Code not found on Provider
158	Invalid CPT code on DOS
159	Price a UB by cpt yes/no
160	Generate 1500 from EPSDT Form
161	Show Type of Service column on 1500 forms
162	Contract term requires documentation
163	Benefit requires documentation
164	Contract requires document review
165	Dental Areas on Claim Line and Benefit do not match
166	Benefit procedure NOT found in claims history
167	Benefit requires prosthesis designation
168	Member does NOT meet age criteria for term
169	Claim and contract term modifiers do NOT match
170	Claim and contract term type of service do NOT match
171	Term Applies to assigned members only
172	Term does NOT meet date criteria of the claim
173	Diagnosis on claim does NOT match terms valid range
174	Procedure code on claim does NOT match terms valid procedure
175	Bill type on claim does NOT match contract term
176	Emergency requirements on claim do NOT match contract term
177	Term is for EPSDT claims only
178	Member is NOT in capitation and contract term is capitated
179	Location specific term does NOT match claim
180	No Employer Fee for service
181	Stop Loss Applied to Claim
182	No external price found for provider
183	Submission date exceeds policy termination run-off period
184	DOS end date exceeds policy termination date
185	Location-specific benefit does NOT match claim
186	No skilled nursing coverage

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187	Benefit requires documents to be reviewed
188	Noncontracted provider requires EOMB
189	Level of Care Benefit Not Found
190	Authorization contract overriding contracted provider
191	Determine PAR status from group affiliate contracts
192	Benefit requires contracted (PAR) provider
193	Determine network from group affiliates network affils
194	Restrict Benefit by Date of ONSET
195	Date of Onset is Missing on Claim
196	Benefit requires non-contracted (NONPAR) provider
197	Procedure code on claim NOT valid for benefit
198	Date of Service is after paid through date
199	Benefit Rider not valid for member/DOS
200	Benefit Day Limit Exceeded
201	No enrollment segment
202	No Benefit for Service
203	Benefit is excluded from benefit plan
204	Invalid accommodation days
205	Benefit requires authorization
206	Benefit Visit Limit Exceeded
207	Benefit Dollar Limit Exceeded
208	Benefit Applies to PCP Only
209	Benefit coverage not started
210	Member NOT enrolled on DOS
211	Provider is not part of network required for benefit
215	Potential Spenddown
216	No COB entered with a Secondary Enrollment
217	Member has an active restriction on enrollment
218	Member lost eligibility during date span
219	Provider overlap of global days period
221	Assistant surgeon not allowed
222	Co-Surgeon not allowed
223	Team surgeon not allowed
224	Benefit Requires Manual Review
225	Contract Term Requires Manual Review
226	Reimburse Member On Non-Par Contract
227	Member is responsible when provider is non-participating
228	Member is responsible when provider is participating
229	Member is responsible when provider is out of area
230	Multiple surgeries detected
231	COB Calculations apply to Capitated Services
232	Autogeneration of carriermemid
233	Retroterm without security period
234	Waive copay per diem on readmission
235	Override Reimburse Member option
236	Benefit requires either authorization or referral document
237	COB will be manually distributed on claim lines
238	Invalid Medicare Action Code

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239	Apply Tiered Modifier Discounts
240	Not all standard reserve days have been used
241	Exceeds number of covered days in a standard benefit period
242	Service days submitted exceed standard reserve days
243	Service days submitted exceed extended reserve days
244	No claim in std benefit period before use of reserve days
245	Multiple surgeries - claim submitted missing modifier 51
246	Member has Preexisting Condition on DOS for Diagnosis
247	Preexisting Condition May Exist
248	Member policy is Suspended
249	Continue to apply copay per diem on readmission
252	Pend claim if COB is 0 on secondary enrollment claim
253	Internal enrollment and COB amounts entered
254	Medicare non-allowed claim submitted hard copy
255	Medicare non-allowed claim submitted electronically
256	Invalid Medicare COB Amount
257	Visit units have been traded
258	Emergency Claim does not match Emergency Benefit
260	Pursue and pay for HCFA 1500 claims with no information
261	Pursue and pay for UB92 claims with no information
262	Claim requires Pursue and Pay
263	Auto Accident indicated on claim - Pursue and Pay
264	Auto Insurance information on claim - Pursue and Pay
265	Other Insurance indicated on claim - Pursue and Pay
266	Other Insurance information unknown - Pursue and Pay
267	Letter of Inquiry No Response or Outdated - Pursue and Pay
268	COB Coverage Not for Claim Type
269	Benefit requires authorization and has associated penalty
270	Enable Benefit Restriction Group Validation
271	Benefit Restriction Group Validation Failed
272	Member does not have coverage code required on benefit
273	Srvc denied due to base benefit restriction group
274	Srvc denied due to supplemental benefit restriction group
280	Apply penalty calculation method(s) defined on Penalty Type
281	Process DENIED lines first in Benefit Adjudication
300	Duplicate Claim (member/DOS)
301	Invalid or missing admission date
302	Attending Physician Required for Inpatient Claims
303	Claim Total Mismatch
304	Invalid Bill Type
305	Primary ICD-9 diagnostic code is required
306	Discharge status is required for inpatient and SNF claims
307	Duplicate Claim (Same Provider/Member/DOS)
308	Invalid Admit Hour (0 -- 23)
309	Invalid Discharge Hour (0 -- 23)
311	Claim Submission Window Exceeded
312	Invalid coinsurance days for 11x bill type
313	Covered days do not match accommodation revcode days

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314	Non-covered days less that leave of absence days
315	Invalid Lifetime Reserve Days
316	Admit type does not match admit source
317	Other agency may be responsible for payment
318	Invalid coinsurance days for 21x bill type
319	Coinsurance days exceeds covered days
320	Coinsurance days missing associated value codes
321	Covered days and coinsured days exceed maximum for hospital
322	Covered days exceeds maximum for hospital
323	Covered days and coinsured days exceed maximum for SNF
324	Covered days exceed maximum for SNF
325	Non-covered days exceed statement-covered period
326	Life reserve days exceed maximum
327	Admit type requires 450 revcode
328	Admission Source Required
329	Invalid patient status for bill type
330	Invalid diagnosis code for benefit
331	Enable DRGActive Product
332	DRG mismatch with DRGActive product
333	DRGActive Product Error
334	APC/OPPS claim pricing failure
335	HIPPS RUGS DOS is not within assessment modifier time period
336	HIPPS RUGS billed amount should not have a dollar amount
337	HIPPS RUG rate code requires rehabilitation therapy
338	HIPPS RUGS length of stay not in sync with accommodation day
339	APC claim has lines that have rolled up into other lines
340	HH PPS too many SCICs detected. Manual review is required.
341	HH PPS No Rap present for claim
342	HH PPS Therapy threshold not met. Fallback used for payment
343	No matching RAP claim lines
344	No previously processed RAP claim lines
345	Detail line REV code not 0023
346	Unable to locate fee schedule
347	RAP has more than one detail line
348	Line #1 date must equal episode start date
349	LUPA episode is not 60 days
350	Valid admit date required for HHPPS
351	Credit for prior RAP payment
352	Previous RAP payment exceeds claim amount
353	Detail line REV code not 0022
354	Base fee not found or equals \$0.00
355	SNF provider missing SNF per diem amount
356	Overlapping RAP episodes
357	HHPPS RAP From and Through DOS not equal
358	Micro-Dyn PricerActive component error
359	Micro-Dyn DRGActive component error
360	DRG is NOT in the selected DRG Group
361	No end date on claim configured for Micro-Dyn PricerActive

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362	For Micro-Dyn PricerActive PlanProvID must be 6 digit number
363	Check DRG on Claim
364	Pricing requires provider DRG values-values are not defined
365	Pricing requires DRG values-values are not defined
366	Workers Compensation Claim
367	Contract term requires authorization
368	Pay POS 24 Based on Approved ASC Services
369	Request Refunds for Member Reimbursement Claim Reversals
375	Enable Term Restriction Group Validation
376	Contract Term Restriction Group Validation Failed
377	EOB not received on Claim
378	No COB Amount on claim
379	Member has privacy payee defined for claim
380	Other Carrier Paid exceeds Other Carrier Allowed
381	Member responsibility when global payment allocated
382	Global payment allocated
383	Allocate global payment across lines
384	Potential Other Accident
400	Gender is invalid for Medical Policy
401	Age is invalid for Medical Policy
402	Maximum units exceeded for Medical Policy
403	Diagnoses invalid for Medical Policy
404	Place of Service invalid for Medical Policy
405	Provider Type is invalid for Medical Policy
406	Physician specialty is invalid for Medical Policy
407	Modifier(s) is invalid for Medical Policy
408	Line failed for Medical Policy Rule
409	Line failed for Medical Policy rule overridden on Cert
501	Entry in Local Use field is required
502	Duplicate Line on Same Claim
503	Invalid CPT Modifier
504	Invalid CPT/HCPCS code
505	Invalid Revenue Code
506	Modifier Required for CPT/HCPCS
507	Revenue Code Requires HCPCS
511	Invalid From DOS
512	Invalid Thru DOS
514	Invalid Revenue Code for Bill Type
515	Invalid HCPCS for Revenue Code
516	Surgical Procedure Requires HCPCS
518	Admit type required for 11x bill type
519	Duplicate Claim Line (Same Member/DOS/CPT(Rev))
521	Procedure code not found or invalid for date of service
522	Duplicate Mem/DOS/Service code/Rendering Phys/Modifier
523	Invalid ICD-9 diagnosis code
524	CPT codes billed include bundled and unbundled CPTs
525	ICD-9 diagnosis code is not valid on DOS
526	Claim submitted out of sequence

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530	Insufficient units for date span
531	Duplicate Mem/DOS/Service code/Pay To/Modifier
532	Duplicate Mem/DOS/Service code/Pay To/Rendering Phys/Modifie
533	Duplicate Mem/DOS/Pay To/Rendering Phys/Charges
534	Duplicate Modifier Exact Match
535	Duplicate Claim Check for Additional Claim Status
536	CPT Code is Bundled with Other CPT
537	Evaluate Diagnosis Codes at the Claim Level
538	Diagnosis Pointer Required on Service Line for ICD-9 Codes
539	Date of Service beyond Pay Thru Date and Grace Period Date
540	Date of Service is during the Grace Period
542	No Fault Payment Exceeds Allowable
601	Prior Authorization Is Closed
602	Prior Authorization Is Awaiting Medical Review
603	Prior Authorization Is Pended
604	Prior Authorization Is Denied
606	Prior authorization number NOT found
607	Prior authorization not for same member
608	Prior authorization not for same provider
609	Prior authorization dates do not match claim
610	Prior Authorization Services do not match claim
611	Prior authorization has no available units
612	Prior authorization has insufficient units remaining
613	Claim Requires Manual Processing
614	No Available Bed Days on Auth
615	Claim Line Exceeds Available Bed Days-Partial Units Paid
616	Authorization Line Denied
617	Provider's specialty does not match authorized specialty
618	Provider's group does not match authorized group
619	Provider's network does not match authorized network
620	Provider's participation status does not match authorized
621	Provider type does not match authorized provider type
622	Place of Service does not Match Authorized
623	NDC Code Mismatch on Authorization
624	Authorization Line Manually Denied
625	Authorization Line Manually Pended
626	Authorization Status Manually Set
627	Allow manual setting of Benefit Level on Auth
628	Claim Line date span crosses calendar/policy year
629	Multi unit Claim Line date span crosses calendar/policy year
630	Enable claim history functionality when processing claims
632	No Determining Claims Found
633	A determining claim matched - using that benefit preference
634	Benefit preference selection forced manually through the UI
638	Allow override of contract amt based on benefit preference
640	Enable Inpatient Rehab Facility PPS
641	Multiple Instances of Revenue Code 0024 on Claim
642	Invalid Bill Type found on an IRF claim

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Edit/Rule ID	Edit/Rule ID Description
643	Multiple or invalid HIPPS codes found on IRF claim
644	Charges were not set to zero on an IRF claim
645	Non-covered days reported with code 74 not accurate
646	Days must equal payable days + loa days + non-covered days
647	Claim line has a revenue code of 018X and a HCPCS/Rate
648	Claim line units not = days reflected with span code 74
649	Sum of units with accommodation codes not equal covered days
650	Charges not equal to daily room rate multiplied by days
651	Claim is an interrupted stay
652	Length of stay on claim was less than average length of stay
653	Claim is a short stay
654	Benefits were exhausted during stay
655	Benefits were exhausted prior to admission
656	Claim is an Interim IRF bill
657	Error encountered with Micro-Dyn IRF Priceractive component
658	Invalid claim data found on IRF claim
661	Enable provider reimbursement based on service locations
662	Contract for service location on claim was not found
700	Invalid Dental Procedure
701	Invalid Dental Warranty Period
702	Invalid CDT code on DOS
703	Invalid tooth number
704	Invalid tooth surface for tooth
705	Submitted code requires billing package
706	CDT already billed on this date by same provider
707	CDT already billed on this date
708	CDT Requires Tooth
709	CDT requires tooth surface
710	Service Line has been Downcoded
711	Replace obsolete code
750	Inclusively priced ITS claim cannot be priced
800	Claim Check: Rebundling
801	Claim Check: Incidental Services
802	Claim Check: Mutually Exclusive Service
803	Claim Check: Assistant Surgeon
804	Claim Check: Age Conflict
805	Claim Check: Age Replacement
806	Claim Check: Gender Conflict
807	Claim Check: Gender Replacement
808	Claim Check: Cosmetic Surgery
809	Claim Check: Unlisted Procedure
810	Claim Check: Experimental Procedure
811	Claim Check: Pre-Op Audit
812	Claim Check: Post-Op Audit
813	Claim Check: Medical Visit
814	Claim Check: New Visit E&M Audit
815	Claim Check: Intensity of Service Audit
816	Claim Check: Diag to Procedure Audit

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817	Claim Check: Cross Provider Total Audit
818	Claim Check: TPL Audit
819	Claim Check: Claim Stop audit
820	Claim Check: Enable Integration
821	Claim Check: General Error
822	Claim Check: Exceeded 40 Claim Lines
823	Auto-populate Authorization Id on Claim
824	Claim Check: Future Date of Service Error
825	Claim Check: Add modifier 26 or TC to global billed claim
911	Invalid For Male
912	Invalid For Female
913	Manual Pend of Claim
914	Electronic Claim has COB
915	Claim has been manually denied
916	Claim does not have any service lines
917	Manually-altered pay amount
918	aQtrans Requires Claim Review
919	Contract Price on Service Line has been Manually Overridden
920	Contract Price on Service Line Manually Overridden to Zero
921	Claim manually priced with no balance checks or validation
922	Manual Contract Price exceeds Billed Amount on Service Line
930	ITS: Alim Initialization Failed
931	ITS: Alim L2 Call Failed
932	ITS: Alim L3 Call Failed
933	ITS: Alim 90 Call Failed
934	ITS: Alim C2 Call Failed
935	ITS: Alim C3 Call Failed
938	Unable to Adjust ITS Claim
939	Duplicate SCCF number found during SF import
940	Status change caused by SF Message Code
941	Previous claim not found for adjustment
942	Previous claim for adjustment not finalized
943	Claim reversal for adjustment failed
944	Multiple enrollments found for member name but no DOB match
945	Multiple enrollments found for member name and DOB
946	Invalid prefix for date of service specified
947	Local contracted provider found for claim
948	Multiple local contracted providers found for claim
949	Must pay provider for assigned ITS Medicare claim
951	ITS - Initial Global Fee on Claim
952	ITS - Follow-up Global Fee on Claim
953	ITS - Late Follow-up Global Fee on Claim
954	SF indicates Host plan pays provider for ECRP claim
955	SF indicates Host plan pays subscriber for ECRP claim
960	Customized Member Responsibility for COB
961	Customized Member Responsibility for Capitated COB