OptumCare ACE Smart Edits

Updated 9/1/2023

Edit / Claim Type	ACE Edit Name / Type	Edit Message	Description	Market	Effective Date
Rejection	**occ009NCS** (Institutional)	Per Medicare, the item, service, or code is a non-covered service. Please update as applicable.	**Facility Non-Covered Codes** The 009NCS edit will fire when an outpatient claim contains a HCPCS/CPT code that is designated as non-covered based on other than statute. The services in this list are a subset of the services assigned to payment status of "E" or the revenue code is 099x with status indicator of "E" submitted without a HCPCS/CPT code for OPPS. The edit will also fire on claim lines submitted with revenue code 0760 without a HCPCS code. Medicare has a list of HCPCS codes that are considered to be non-covered under Medicare's outpatient benefit for reason other than statute. The Integrated Outpatient Code Editor contains an edit which will deny the claim line when a service is submitted with a status indicator of "E" indicating the service is non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion for OPPS and Non-OPPS. In addition, per the OCE V20.2, edit 009NCS will also fire when revenue code 760 is submitted with a blank HCPCS. In summary, the 009NCS edit will fire when a HCPCS code is on the 'non-covered HCPCS codes' list for OPPS and Non-OPPS or when revenue code 099x or 0760 is submitted without a HCPCS code for OPPS. This edit applies to both OPPS and non OPPS claims. Examples: 69090 Ear Piercing V5011 Hearing Aid Fitting Check. Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual Chapter 4 Section 10.1.1, CMS Integrated Outpatient Code Editor (IOCE) Specifications V16.0. for further information.	Medicare	**5/11/2023**
Catch and Release	**occ01ODID** (Institutional)	The other diagnosis codes <1> are invalid due to having an incomplete number of digits. Please update as applicable.	**Inpatient Incomplete Other Diagnosis** The 01ODID edit identifies an inpatient claim when the secondary diagnosis code does not have the required additional digits. The Medicare Code Editor checks each diagnosis including the admitting diagnosis against a table of valid ICD codes. If an entered code does not agree with any code on the internal list, it is assumed to be invalid. Please refer to the Centers for Medicare and Medicaid Services, Claim Processing Manual Chapter 3, Section 20.2.1; Chapter 32, Section 240.1, Centers for Medicare and Medicaid Services Definitions of Medicare Code Edits Version 34.0 at https://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf) for further information.	Medicare	**5/11/2023**
Rejection	**occ023BDS** (Institutional)	The service date <1> on line <2>, is not within the From and Through dates of service on the claim. Please update as applicable.	**Invalid Date** The 023BDS edit identifies when the service date falls outside the range of the From and Through dates. Please refer to the Integrated Outpatient Code Editor (IOCE) Version 15.2 at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ IntegOCEspecsV152 .pdf) for further information.	Medicare	**5/11/2023**
Rejection	**occ048RRH** (Institutional)	Claim line revenue code <1> requires submission of a HCPCS code.	**Revenue Center Requires HCPCS** The 048RRH edit identifies claim lines containing bill types 13x, 74x, 75x, 76x, or 12x/14x without condition code 41, HCPCS is blank, and the revenue center status indicator is not N or F. This edit is bypassed when the revenue code is 100x, 210x, 310x, 099x, 0905-0907, 0500, 0509, 0583, 0660-0663, 0669, 0931, 0932, 0521, 0522, 0524, 0525, 0527, 0528, 0637, or 0948. Per the Outpatient Code Editor (OCE) V20.2, this edit should be bypassed when revenue code 760 is submitted with a blank HCPCS. Please refer to the Integrated Outpatient Code Editor (IOCE) V18.0, Centers for Medicare and Medicaid Services, Claim Processing Manual Chapter 4 Section 20.1 at https://www.cms.gov/Medicare/Coding /OutpatientCodeEdit/OCEQtrReleaseSpecs.html) for further information.	Medicare	**3/30/2023**
Rejection	**occ049SIP** (Institutional)	Ancillary service billed on the same day as an inpatient only procedure. Please update as applicable.	**Service on Same Day as Inpatient Procedure** The 049SIP edit identifies when a claim line has a C status indicator and is not on the 'separate procedure' list or a claim line has a C status indicator and is on the 'separate procedure' list, and there are no type T lines on the same day and Modifier CA is not present. Please refer to the Integrated Outpatient Code Editor (IOCE) Centers for Medicare and Medicaid Services, Claim Processing Manual Specification Version 22.0 at https:// www.cms.gov/Medicare/Coding/OutpatientCodeEdit/ OCEQtrReleaseSpecs) for further information.	Medicare	**4/6/2023**
Rejection	**occ092DDP** (Institutional)	A device-dependent procedure <1> requires that a device HCPCS code be submitted on the same day. Please update as applicable.	**Device-Intensive Procedure Reported Without Device Code** The 092DDP edit identifies when a device-dependent procedure is submitted without the device HCPCS code on the same date of service. Effective January 1, 2015, the submission of a device-dependent procedure also requires that a device be submitted on the same day. If any device dependent procedure is submitted without a code for a device on the same date of service, the claim will be returned. Discontinued procedures (indicated by the presence of modifier 52, 73 or 74 on the line) are not returned for a missing device code. Effective 1/1/2019, certain device-intensive procedures codes are applicable for bypass if an insertion of a device is not completed (e.g., revised only). For this edit to be bypassed a device procedure on the "Edit 92 Modifier Bypass" list is reported with modifier CG. Please refer to the Integrated Outpatient Code Editor (IOCE) Centers for Medicare and Medicaid Services Specifications, V22.1 at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit /OCEQtrReleaseSpecs) for further information.	Medicare	**4/13/2023**

Rejection	**occ099LPP** (Institutional)	This claim contains a pass-through or non-pass-through drug or biological HCPCS <1> but lacks the associated payable procedure that must be submitted on the same claim. Please update as applicable.	**Claim With Pass-Through or Non-Pass-Through Drug Or Biological Lacks Payable Procedure** The 099LPP edit identifies when a pass-through or nonpass-through drug or biological is billed without an associated payable procedure on the same claim. Passthrough drugs and biologicals include radiopharmaceuticals, contrast agents, skin substitute products and stress agents. Claims containing drugs and biological HCPCS codes with pass-through status (SI = G) or non-pass-through status (SI = K) that are reported without an OPPS payable procedure (SI = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V) are returned to the provider. Source: Please refer to the Integrated Outpatient Code Editor (IOCE) Centers for Medicare and Medicaid Services Specifications V17.3, CMS Transmittal R3591CP, Software Manual V17.3 at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrRelease Specs .html) for further information.	Medicare	**4/20/2023**
Catch and Release	**occ19LOS** (Institutional)	Procedure code 5A1955Z should not be reported when the patient's length of stay is less than or equal to four days. Please update as applicable.	**Facility Inpatient Procedure Inconsistent with Length of Stay** The 19LOS edit identifies when ICD-10 procedure code 5A1955Z (Respiratory Ventilation, Greater than 96 Consecutive Hours) is reported with a length of stay less than or equal to four days, after subtracting number of days reported with Occurrence Span Code 74, effective for date of service on or after October 1, 2015. For original inpatient claims received on or after October 1, 2016, the contractor shall determine the consecutive day count as previously instructed by using the procedure code date for mechanical ventilation (ICD-9-CM procedure code 96.72 or ICD-10-CM procedure code 5A1955Z) instead of the claim 'from' date. The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four consecutive days during the length of stay: Effective October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours. Please refer to the Centers for Medicare and Medicaid Services, Transmittal R3504CP, Policy, Pub 100-4, Chapter 3, Section 20.2.1 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R35 04CP.pdf) for further information.	Medicare	**5/4/2023**
Rejection	**occAKIPf** (Professional)	The Acute Kidney Injury (AKI) claim is missing the required procedure code. Please update as applicable.	**Acute Kidney Injury Claim Without Required Procedure** The BPS System Rule verifies the place of service (POS) code submitted on each claim line against the Centers for Medicare & Medicaid Services (CMS) Place of Service list found in the Code Repository. Please refer to Centers for Medicare and Medicaid Services for further information.	Medicare	**5/11/2023**
Rejection	**occARGf** (Professional)	Argatroban, HCPCS code J0883 can not be submitted on TOB 072X. Please update as applicable.	**Argatroban, HCPCS J0883, Can Not Be Submitted On TOB 072X** The ARGf edit will fire when an End Stage Renal Disease (ESRD) claim, type of bill 072X, is billed with HCPCS code J0883. This is based on a requirement from the Centers for Medicare and Medicaid Services. CMS Transmittal R231BP, Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2017, dated November 4, 2016 supports this requirement. It states, "Medicare contractors shall return to the provider type of bill 072X (ESRD) when non-ESRD HCPCS are reported on the claim: J0883 - Injection, Argatroban, 1mg (for non-ESRD use). Note: There is a new HCPCS J0883 for argatroban for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x." In summary, the ARGf edit will fire on an ESRD claim that is submitted with HCPCS code J0883. Please refer to the Centers for Medicare and Medicaid Services, Transmittal R231BP, Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2017, dated November 4, 2016 for further information.	Medicare	**5/11/2023**
Rejection	**ocBICCL** (Professional)	CLIA ID <1> does not meet the certification level for procedure code <1>. Please update as applicable.	**Invalid CLIA Cert Level (Billing Provider)** The lab certification level must support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. If the code is under waiver a modifier will be required. Please refer to the Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-and-guidance /legislation /CLIA for further information.	Medicare	**5/25/2023**
Rejection	**occBPS** (Professional)	The place of service (<1>) is missing or invalid. Please update as applicable.	**Missing or Bad POS** The BPS System Rule verifies the place of service (POS) code submitted on each claim line against the Centers for Medicare & Medicaid Services (CMS) Place of Service list found in the Code Repository. Please refer to Centers for Medicare and Medicaid Services for further information.	Medicare	**5/11/2023**
Rejection	**occCCRCf** (Institutional)	Type of bill <1> requires an appropriate claim change reason condition code. Please update as applicable.	**Appropriate Claim Change Reason Code Required on Adjusted Claims** The CCRCf edit requires a single reason best describing the adjustment being requested. The claim change reason code is entered as a condition code on the hard copy Form CMS-1450 or the electronic equivalent. For reason codes D0-D4 and D7-D9, the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8. Please refer to the Centers for Medicare and Medicaid Services Pub. 100-04 Ch. 1 §130.1.2 (CMS) at https://www.cms.gov/regulations and guidance/guidance/manuals/downloads/clm104c01.pdf for further information.	Medicare	**4/13/2023**
Rejection	**ocCCIPS** (Professional)	Provider state <1> submitted on the claim does not match the state registered with CLIA <2>. Please update claim as applicable.	**CLIA Invalid Provider State** CLIA Certificate Identification number and their associated state will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-and-guidance/legislation/CLIA for further information.	Medicare	**5/25/2023**

Rejection	**ocCCIPZ** (Professional)	Provider ZIP Code <1> submitted on the claim does not match ZIP code registered with CLIA <2>. Please update claim as applicable.	**Commercial CLIA Invalid Provider ZIP** CLIA Certificate Identification number and their associated state will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-and-guidance/legislation/CLIA for further information.	Medicare	**5/25/2023**
Catch and Release	**occDCCf** (Institutional)	Per CMS guidelines, one condition code 59, 71, 72, 73, 74, 76, 80 or 87 must be present on End Stage Renal Disease (ESRD) type of bill 072x claims. Please update as applicable.	**Condition Code Must Be Present On All TOB 072X ERSD Claims** The DCCf edit will fire on an ESRD claim Type of Bill (TOB) 072X when there is not a valid ESRD condition code submitted on the claim. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8, Section 50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS states, "for hospital-based and independent renal facilities, one of the condition codes 71-76 is applicable for every ESRD bill." Section 80.2.1 - Required Billing Information for Method I Claims has the same requirements as 50.3 with the addition of condition codes 74 and 80. In addition, CMS transmittal R1715OTN, dated September 16, 2016, states that "Medicare Contractors shall add condition code 87 to the list of acceptable condition codes for dialysis treatments submitted on ESRD claims type of bill (TOB) 72x." Condition Code; 59 - Non-primary ESRD Facility - Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility. 71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility 72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility 73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis 74 - Home - Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply 76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility 80 - Home Dialysis - Nursing Facility - Home dialysis furnished in a SNF or nursing facility. 87 - ESRD Self Care Retraining In summary, DCCf will fire when an ESRD claim TOB 072X is submitted without a valid ESRD condition code. Please refer to Centers for Medicare and Medicaid Services, Claims Processing Manual Chapter 8 Section 50.3 and 80.2.1, CMS Transmittal R1715OTN for further information.	Medicare	**5/25/2023**
Catch and Release	**occICD** (Professional)	The diagnosis code(s) <1> are invalid. Please update as applicable.	**Invalid Diagnosis Code** The ICD System Rule identifies diagnosis codes that are not valid. This edit looks for blank diagnosis fields as well as a diagnosis code that is not present in the KnowledgeBase. Validation Edit.	Medicare	**6/15/2023**
Catch and Release	**occIDL** (Professional)	Diagnosis code <1> has been deleted. Please update as applicable.	**Deleted Diagnosis Code** The IDL System Rule identifies claim lines where the submitted diagnosis code is no longer valid and has been deleted. Validation Edit.	Medicare	**6/8/2023**
Catch and Release	**occIDX** (Professional)	Additional digits are required for nonspecific diagnosis code(s) <1>. Please update as applicable.	**Nonspecific Diagnosis Code** The IDX System Rule identifies claim lines that contain a diagnosis code requiring a 4th or 5th digit for appropriate specificity. Please refer to the ICD-10-CM and ICD-9-CM Official Guidelines for Coding and Reporting for further information.	Medicare	**6/15/2023**
Rejection	**occIMO** (Professional)	The modifier code(s) <1> are invalid. Please update as applicable.	**Invalid Modifier Code** The IMO edit identifies the claim line which has one or more invalid modifier code(s). All modifiers are validated to verify if they are present in the Modifier Edits table and valid for the date of service. If there is a modifier on the claim line which is not present in the system, has been disabled, or is not effective or valid for the date of service the IMO flag is fired. Please refer to the ICD-10-CM Official Guidelines for Coding and Reporting for further information.	Medicare	**5/11/2023**
Rejection	**occmAM** (Professional)	Per CMS guidelines, HCPCS Code <1> is identified as an ambulance code and requires an ambulance modifier appended. Please update as applicable.	**Medicare Ambulance Origin and Destination Modifiers** For ambulance service claims, Facility-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, except for X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. The mAM edit identifies claim lines that contain an ambulance HCPCS code without an ambulance modifier appended that has a first character of D, E, G, H, I, J, N, P, R or S and a second character of D, E, G, H, I, J, N, P, R, S or X. When an ambulance HCPCS code without an appropriate ambulance modifier is on the current claim, the mAM edit is triggered. Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25 for further information.	Medicare	**4/20/2023**
Rejection	**occmANM** (Professional)	Per Medicare guidelines, anesthesia code <1> on claim line ID <2> requires an appropriate modifier. Please update as applicable.	**Medicare Anesthesia Modifiers** The mANM edit uses the CMS Medicare Claims Processing Manual to identify anesthesia services that were submitted without an anesthesia modifier. This edit fires on all claim lines that contain an anesthesia code, excluding CPT code 01996, submitted without modifier AA, AD, QK, QX, QY or QZ appended. Physicians must append the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised. Payment for the service is determined by the use of these modifiers. Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual, Chapter 4 Section 10.1.1, and the Centers for Medicare and Medicaid Services, Integrated Outpatient Code Editor (IOCE) Specifications V16.0 for further information.	Medicare	**5/11/2023**

Rejection	**occmAS** (Professional)	Procedure code <1> is not appropriate when billed by an assistant surgeon. Please update codes as applicable.	**No Payment For Assistant Surgeons Procedure Edits** For ambulance service claims, Facility-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, except for X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. The mAM edit identifies claim lines that contain an ambulance HCPCS code without an ambulance modifier appended that has a first character of D, E, G, H, I, J, N, P, R or S and a second character of D, E, G, H, I, J, N, P, R, S or X. When an ambulance HCPCS code without an appropriate ambulance modifier is on the current claim, the mAM edit is triggered. Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual, Chapter 15, 30 - General Billing Guidelines, Page 25 for further information.	Medicare	**4/27/2023**
Catch and Release	**occmB50** (Professional)	A bilateral procedure code <1> submitted with modifier 50 and billed with more than 1 unit of service is inappropriate Please update as applicable.	**Bilateral Modifier 50 Billed With More Than 1 Unit** The mB50 edit identifies claim lines that contain a procedure code with modifier 50 appended and billed with more than 1 unit of service. These codes are identified by indicators "1" or "3" in the bilateral column of the Medicare Physician Fee Schedules (MPFS). "Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported. If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one." Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual chapter 23 section 20.9.3.2 and Claims Processing Manual chapter 12 section 40.7 for further information.	Medicare	**4/27/2023**
Catch and Release	**occmBC** (Professional)	Per CMS guidelines, payment for procedure code <1> is always bundled into payment for other services not specified and no separate payment is made. Please update as applicable.	**Medicare Bundled Code** OptumCare will not separately reimburse for specific CPT/HCPCS codes assigned a status code “B” on the NPFS Relative Value File indicating a bundled procedure. B Bundle Codes are not reimbursable services regardless of whether they are billed alone or in conjunction with other services. Please refer to Section 20.3 of the Medicare Centers for Medicare and Medicaid National Physician Fee Schedule / Claims Processing Manual for further information.	Medicare	**5/11/2023**
Catch and Release	**occmCO** (Professional)	Per Medicare guidelines, billing for co-surgeons is not permitted for procedure code <1>. Please update as applicable.	**Co-Surgeons Not Permitted Procedure** The mCO edit identifies claim lines that contain procedure codes with modifier 62 appended inappropriately under CMS guidelines. CMS has designated codes that are identified by the indicator of "0" in the co-surgeon column of the National Physician Fee Schedule (NPFS) as ineligible for modifier 62.The NPFS defines the indicator "0" in the co-surgery column as follows: “0=Co-Surgeons not permitted for this procedure.” Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File at http://www.cms.gov/Medicare /Medicare- Fee-for-Service-Payment /PhysicianFeeSched/PFSRelative-Value-Files.html for further information.	Medicare	**4/20/2023**
Rejection	**occmDT** (Professional)	Per Medicare guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in place of service <2>. Please update as applicable.	**Diagnostic Test in Hospital** The mDT edit uses the CMS NPFS to determine eligibility of a CPT code to be split into professional and technical components. This edit will identify codes that have an indicator of 1 in the PC/TC column of the NPFS that are submitted without modifier 26 appended with a location of inpatient hospital, outpatient hospital or skilled nursing facility. The mDT edit identifies claim lines that contain codes that do not have the modifier 26 appended appropriately when submitted with a place of service of inpatient hospital, outpatient hospital or skilled nursing facility under Medicare rules. The concept of professional and technical component splits (PC/TC) does apply to these codes that are identified by the indicator of 1 in the PC/TC column of the NPFS. When billing these services in an inpatient hospital, outpatient hospital or skilled nursing facility, only the professional component should be billed by the physician. Billing of the technical component is inappropriate by the physician as the facility should be responsible for submitting it. Modifiers 26 and TC can be used with these codes. Please refer to the National Physician Fee Schedule Relative Value File for further information.	Medicare	**5/4/2023**
Rejection	**occMHBf** (Institutional)	A diagnosis code(s), which meets medical necessity for procedure code <1>, is missing or invalid. Please update as applicable.	**Medicare Hepatitis Vaccine Requires Diagnosis** The MMHBf and MHBf edits utilizes the Centers for Medicare and Medicaid Services guidelines found in the Medicare Claims Processing Manual, Medicare Benefit Policy Manual, and The Guide to Medicare Preventive Services to identify Hepatitis B procedures. This edit fires on all claim lines that contain a Hepatitis B vaccine code and a Hepatitis B administration code is not found or a Hepatitis B administration code and a Hepatitis B vaccine code is not found for the same patient and same date of service. This edit will also fire when a Hepatitis B vaccine code or a Hepatitis B administration code is found on the claim without the required diagnosis code for the same patient on the same date of service. All providers bill the FIs/AB MACs for hepatitis B on Form CMS-1450. Hepatitis B Vaccine guidelines Medicare pays for the Hepatitis B virus (HBV) vaccine and administration for patients determined to be at intermediate or high risk for HBV infection. A physician order and supervision is required for the hepatitis B vaccine to be administered. A CPT® code for the vaccine (90740, 90743, 90744, 90746, or 90747) is required to be submitted with the administration code (G0010) along with a specific diagnosis code (V05.3). CMS Transmittal R3329CP, dated August 14, 2015, states ICD-10-CM diagnosis code Z23 may be used for an encounter for immunizations effective with the implementation of ICD-10. The MMHBf and MHBf edits identifies a claim line that contains a Hepatitis B vaccine, and a valid Hepatitis B administration code is not found, or a Hepatitis B administration code and a valid Hepatitis B vaccine code is not found for the same patient on the same date of service. This edit will also fire when a Hepatitis B vaccine code or a Hepatitis B administration code is found on the claim without the required diagnosis code. Please refer to the Centers for Medicare and Medicaid Services Transmittal R3329CP, Transmittal R2438CP, Medicare Preventive Services - Quick Reference Information: Medicare Immunization Billing, Seasonal Influenza Virus, Pneumococcal, and Hepatitis B for further information.	Medicare	**5/11/2023**

Catch and Release	**occmIM** (Professional)	Modifier is not appropriate for procedure code. Please update as applicable.	**<u>Medicare Inappropriate Modifier- Follow Up Days</u>** In accordance with correct coding, OptumCare will consider reimbursement for a procedure code/modifier combination only when the modifier has been used appropriately. Please refer to the Medicare Claims Processing Manual chapter 4 section 20.6, chapter 12 sections 20.4.6, 20.4.6, 40.6, and 40.9 chapter 23 section 20.9.1, as well as Medicare Contractor Beneficiary and Provider Communication Manual chapter 5 section 20.4 for further information.	Medicare	**5/18/2023**
Catch and Release	**occmLP** (Professional)	Per Medicare guidelines, procedure code <1> is inappropriate with Modifier TC. Performance of the test is paid under the lab fee schedule. Please update as applicable.	**<u>Laboratory Physician Interpretation</u>** The mLP Medicare Rule identifies claim lines which have clinical laboratory codes that are interpreted by laboratory physicians, for which separate payment may be made, and the modifier TC is attached. Modifier -TC (technical component) cannot be used with these codes. Please refer to National Physician Fee Schedule Relative Value File for further information.	Medicare	**6/1/2023**
Rejection	**occmM54** (Professional)	Per CMS Guidelines, the presence of modifier 54 indicates that only the intraoperative portion of the global fee should be reimbursed. Please update as applicable.	**<u>Intra-Operative Care Only Reduction</u>** The mM54 rule utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) and the Medicare Claims Processing Manual to identify when a code with modifier 54 appended is eligible for a reduction. This flag fires on all claim lines that contain a code submitted with modifier 54 appended and have a number, other than zero, in the Intra Op column of the NPFS. The NPFS defines the Intra Op column as follows: "Intraoperative Percentage = Percentage for intraoperative portion of global package, including postoperative work in the hospital." Modifier 54 indicates that only intraoperative care was provided by the physician. The Claims Processing Manual instructs that when a physician performs surgery and relinquishes care at the time of discharge, he or she needs to indicate the date of surgery and bill wit+D61h modifier 54. The NPFS designates procedures that are appropriate for appendage of modifier 54. When a procedure code is listed in the NPFS with a number other than zero in the Intra Op column it indicates those procedure codes are eligible for an intraoperative care only reduction and are eligible for modifier 54. Per CMS Guidelines, the presence of modifier 54 indicates that only the intraoperative portion of the global fee should be reimbursed. The mM54 rule will fire on all claim lines when the modifier 54 is present and a number, other than zero, is listed in the Intra Op column in the NPFS. The mM54 rule will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 54 is present and a zero is listed in the Intra Op column in the NPFS the line will not receive the flag. Also when modifier 54 is not present and a number, other than zero, is listed in the Intra Op column in the NPFS the line will not receive the flag. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File for further information.	Medicare	**5/11/2023**
Rejection	**occmM56** (Professional)	Per CMS Guidelines, the presence of modifier 56 indicates that only the preoperative portion of the global fee should be reimbursed. Please update as applicable.	**<u>Pre-Operative Care Only Reduction</u>** The mM56 rule utilizes the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) and the Medicare Claims Processing Manual to identify when a code with modifier 56 appended is eligible for a reduction. This flag fires on all claim lines that contain a code submitted with modifier 56 appended and have a number, other than zero, in the Pre Op column of the NPFS. The NPFS defines the Pre Op column as follows: "Preoperative Percentage = Percentage for preoperative portion of global package." The NPFS designates procedures that are appropriate for appendage of modifier 56. When a procedure code is listed in the NPFS with a number other than zero in the Pre Op column it indicates those procedure codes are eligible for a preoperative care only reduction and are eligible for modifier 56. The mM56 rule will fire on all claim lines when the modifier 56 is present and a number, other than zero, is listed in the Pre Op column in the NPFS. The mM56 rule will review a primary surgical procedure code to determine if it is eligible for a reduction. When the modifier 56 is present and a zero is listed in the Pre Op column in the NPFS the line will not receive the flag. Also when modifier 56 is not present and a number, other than zero, is listed in the Pre Op column in the NPFS the line will not receive the flag. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File for further information.	Medicare	**5/11/2023**
Catch and Release	**occmMAT** (Professional)	Per Medicare guidelines, modifier AT is required when billing procedure code <1> for active treatment. Medicare does not pay for maintenance therapy. Please update as applicable.	**<u>Medicare Modifier AT For Chiropractic Services</u>** The mMAT edit utilizes the Centers for Medicare and Medicaid Services (CMS) guidelines to identify when procedure codes 98940, 98941, and 98942 are billed without modifier AT (Acute Treatment) for chiropractic services. CMS MLN 1602 states, "The Active Treatment (AT) modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, the AT Modifier is required under Medicare billing to receive reimbursement for CPT codes 98940-98942. For Medicare purposes, the AT modifier is used only when chiropractors bill for active/corrective treatment (acute and chronic care). The policy requires the following: 1. Every chiropractic claim for 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed; and 2. The AT modifier should not be used if maintenance therapy is being performed. MACs deny chiropractic claims for 98940/98941/98942, with a date of service on or after October 1, 2004, that does not contain the AT modifier." The mMAT edit will fire on all claim lines with procedure codes 98940, 98941, and 98942 without modifier AT appended. Please refer to the Centers for Medicare and Medicaid Services, Medicare Learning Network, SE1602 for further information.	Medicare	**5/25/2023**
Rejection	**occmMOD** (Professional)	Per Medicare guidelines use of modifier <1> is not typical for procedure code <2>. Please update as applicable.	**<u>Medicare Modifier Code Not Typical for Procedure Code</u>** The mMOD edit validates whether the Modifier Codes on a claim line may be billed with the procedure code on the claim line, based on the Centers for Medicare and Medicaid Services (CMS). Modifiers that are covered by other Medicare rules and modifiers that do not have a specific national CMS source or a source that addresses specific codes that these modifiers should be appended to are excluded from this rule. All modifiers are validated to determine whether they may be billed with the procedure code on the claim line. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule at http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/PFS-Relative-Value-Files.html for further information.	Medicare	**3/23/2023**

Rejection	**occmMSP** (Professional)	Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101. Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101. Please update as applicable.	**Medicare Screening Pelvic** Per Medicare guidelines the diagnosis code(s) billed does not support the medical necessity of G0101. Please refer to Centers for Medicare and Medicaid Services for further information.	Medicare	**5/11/2023**
Rejection	**occmNC** (Professional)	Per Medicare guidelines, the HCPCS code or modifier billed is a non-covered HCPCS code or modifier. Please update as applicable.	**Medicare Non-Covered HCPCS Codes and Modifiers Rule** The mNC edit utilizes the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) file to determine a non covered service code. This edit will fire on all claim lines containing HCPCS codes and HCPCS modifiers that have an indicator of "I", "M", or "S" in the coverage column of the HCPCS file. The record layout for the HCPCS file defines the indicator "I", "M", and "S" in the coverage column as follows: I = Not payable by Medicare; M = Non-covered by Medicare; S = Non-covered by Medicare statute. The mNC edit identifies claim lines that contain codes that are non covered service codes under Medicare rules based on having been assigned the coverage indicator of "I", "M" or "S" in the coverage column of the HCPCS file. Please refer to the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System for further information.	Medicare	**5/11/2023**
Rejection	**occmNP** (Professional)	Procedure Code <1> does not typically require performance by a physician in Place of Service <2> per Medicare Guidelines. Please update as applicable.	**Medicare Non-Physician Services** The mNP edit identifies claim lines that contain a certain place of service (hospital Inpatient, hospital Outpatient, or nursing facility residents) and a PC/TC status indicator of 5. These procedures typically do not require performance by a physician. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule at http: //www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html for further information.	Medicare	**5/11/2023**
Rejection	**occmNS** (Professional)	Procedure code <1> is not covered by Medicare. Please update as applicable.	**Medicare Non-Covered Services** The BPS System Rule verifies the place of service (POS) code submitted on each claim line against the Centers for Medicare & Medicaid Services (CMS) Place of Service list found in the Code Repository. Please refer to Centers for Medicare and Medicaid Services for further information.	Medicare	**5/11/2023**
Rejection	**occMODf** (Institutional)	Use of modifier(s) <1> is not typical for procedure code <2>.	**Modifier Not Appropriate** The MOD edit identifies claim lines that contain a modifier that is not appropriate for the procedure code. Please refer to the Centers for Medicare and Medicaid Services, NCCI Policy, Chapter 1 for further information.	Medicare	**4/27/2023**
Catch and Release	**occMODJf** (Institutional)	Modifier JA or JB must be submitted with code Q4081 or J0882. Please update as applicable.	**Modifier JA or JB Required On HCPCS Code Q4081 or J0882** The MODJf edit will fire on ESRD claims with Type of Bill (TOB) 072X, when HCPCS code J0882 or Q4081is reported on a line without modifier JA or JB. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8, Section 60.4.2 - Facility Billing Requirements for ESAs states, "Effective for claims with dates of services on or after January 1, 2012, all facilities billing for injections of ESA for ESRD beneficiaries must include the modifier JA on the claim to indicate an intravenous administration or modifier JB to indicate a subcutaneous administration. ESRD claims containing ESA administrations that are submitted without the route of administration modifiers will be returned to the provider for correction." Transmittal R2311CP, dated September 23, 2011, states "CMS will require the reporting of modifiers JA (intravenous administration) or JB (subcutaneous administration) indicating the route of administration on all ESRD claims with dates of service on or after January 1, 2012 when reporting the administration of ESAs. ESRD claims that do not contain modifier JA or JB when ESA administration is indicated will be returned to the provider for correction." In addition it contains a requirement which states "Medicare contractors shall return to provider 72x bill types with dates of service on or after January 1, 2012 that do not contain modifier code JA or JB for ESA route of administration when reporting Q4081 or J0882." In summary, the MODJf edit will fire when HCPCS code J0882 or Q4081 is submitted on a claim with TOB 072X and modifier JA or JB is not present. Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual Chapter 8 60.2.3.1 Transmittal R2311CP for further information.	Medicare	**5/25/2023**
Catch and Release	**occmPDP** (Professional)	The PD modifier must be billed with the 26 modifier. Please update as applicable.	**Modifier PD when Modifier 26 is Missing** The mPDP edit sets when the PD modifier is submitted on a professional code but the detail line does not include a 26 modifier. Please refer to the Centers for Medicare and Medicaid Services, Manual System Pub 100-04 and Medicare Claims Processing Transmittal 2373 for further information.	Medicare	**6/15/2023**

Catch and Release	**occmPDT** (Professional)	The PD modifier may not be billed with the TC modifier. Please update as applicable.	**Modifier PD Billed With Modifier TC** The mPDT edit utilizes the Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual to identify procedures appended with the PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days) modifier in addition to the TC (Technical Component) modifier. When both the PD modifier and the TC modifier are appended to the same claim line, the mPDT will fire. The Medicare Claims Processing Manual, Chapter 12, Section 90.7.1 states: CMS has established HCPCS payment modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated physician office to a patient who is admitted as an inpatient within 3 days), and requires that the modifier be appended to the physician preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/CPT codes, which are subject to the 3-day payment window policy. The wholly owned or wholly operated physician's office will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the practice of an inpatient admissions for a patient who received services in a wholly owned or wholly operated physician office within the 3-day (or, when appropriate,1-day) payment window prior to the inpatient stay. The modifier is effective for claims with dates of service on or after January 1, 2012. Wholly owned or wholly operated per their readiness to do so. Entities have the discretion to apply these policies for claims with dates of service on and after January 1, 2012, but shall comply with these polices no later than July 1. 2012. "When the modifier is present on claims for service CMS shall pay only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the 3-day (or, in the case of non- IPPS hospitals, 1-day) payment window, and the facility rate for codes without a TC/PC split." CMS Transmittal 2373, Section I, Paragraphs 7502.3 and 7502.4 state: "When the PD modifier is appended to a globally billed service, i.e., a service for which both professional and technical components apply, and the service is billed without a -26 or TC modifier, contractors shall apply their routine procedures for not paying the TC component, e.g., denying or rejecting the claim or paying for only the professional component. When the PD modifier is appended to a service which could be globally billed, i.e., a service for which both professional and technical components apply, and the service is billed with a TC modifier, contractors shall deny the claim." The mPDT edit identifies claim lines that have the PD modifier and TC modifier appended. CMS policy allows only the Professional Component (PC) for CPT/HCPCS codes with a TC/PC split that are provided in the 3-day (or, in the case of non-IPPS hospitals, 1-day) payment window. The mPDT edit fires on all claim lines which have the PD modifier appended in addition to the TC modifier. Please refer to the Centers for Medicare and Medicaid Services, Manual System Pub 100-04 and Medicare Claims Processing Transmittal 2373 for further information.	Medicare	**6/8/2023**
Rejection	**occmPI** (Professional)	Per Medicare guidelines, Procedure Code <1> describes a physician interpretation for this service and is inappropriate in Place of Service <2>. Please update as applicable.	**Physician Interpretation Only Policy** The mPI edit identifies claim lines that contain codes that are billed with a place of service other than inpatient. The concept of professional and technical component splits (PC/TC) does not apply since these codes describe professional inpatient services. Centers for Medicare and Medicaid Services has designated place of service "21" as inpatient and it is the only recognized place of service designation when the PC/TC indicator is "8." All other place of service designations are inappropriate. Please refer to the Centers for Medicare and Medicaid Services for further information.	Medicare	**3/23/2023**
Catch and Release	**occmPS** (Professional)	Per Medicare guidelines, procedure code <1> describes the physician service. Use of modifier 26 or TC is not appropriate. Please update as applicable.	**Medicare Physician Service Code** The mPS flag identifies the claim lines which have codes that describe physician services, PC/TC indicator is ‘0’ and a 26 or TC modifier is present. The concept of professional and technical components splits (PC/TC) does not apply since physician services cannot be split into professional and technical components. Modifiers -26 (Professional), and -TC (Technical) cannot be used with these codes. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File for further information.	Medicare	**6/1/2023**
Catch and Release	**occmSE** (Professional)	Per Medicare guidelines the procedure code billed is an item or service that is excluded from the National Physician Fee Schedule by regulation. Please update as applicable.	**Medicare Excluded from Physician Fee Schedule** The mSE edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify CPT codes with the indicator "E" in the Status Code column of the NPFS as Excluded from Physician Fee Schedule by regulation. Attachment A of the NPFS defines the indicator or "E" in the Status Code column as follows: "E = Excluded from Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures." The mSE edit identifies items or services that are excluded from the NPFS by regulation. No RVUs are reflected for these codes and payment is not made under the fee schedule. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File for further information.	Medicare	**4/27/2023**
Catch and Release	**occmTC** (Professional)	Per Medicare guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate. Please update as applicable.	**Technical Component Only Policy** If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 3, then ACE will generate this flag. If the procedure code has modifier 26 or modifier TC on it and the Medicare MPFS PC/TC indicator for the procedure code = 3, then ACE will generate this flag. Please refer to the Centers for Medicare and Medicaid Services, National Physician Fee Schedule Relative Value File for further information.	Medicare	**5/11/2023**
Rejection	**occNPD** (Professional)	Diagnosis code <1> describes an external cause or requires the diagnosis code for the first underlying disease and should never be listed as the primary diagnosis for a procedure. Please update as applicable.	**Not a Primary Diagnosis Code** The NPD edit identifies codes that are not recommended for reporting alone or as a primary diagnosis (i.e., sequenced first). Please refer to the ICD-10-CM Official Guidelines for Coding and Reporting at https://www.cms.gov/medicare/icd-10/2022-icd-10-cm) and American Hospital Association (AHA) Coding Clinic guidelines for further information.	Medicare	**3/30/2023**

Rejection	**occPDIf** (Institutional)	Principal ICD-10 diagnosis N18.6 is required on all 072X ESRD claims. Please update as applicable.	**Principal Diagnosis Required for End Stage Renal Disease- ICD-10** The PDIf edit will fire on an ESRD claim with Type of Bill (TOB) 072X with a principal diagnosis code other than 585.6 (ICD-9) or N18.6 (ICD-10) End Stage Renal Disease. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8 - Section 50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS states that the principal diagnosis code for hospital-based and independent renal facilities must include a diagnosis of end stage renal disease. In summary, PDIf will fire when an ESRD claim is submitted with TOB 072X without diagnosis code 585.6 or N18.6 as the principal diagnosis. Please refer to the Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual Chapter 8 Section 50.3 for further information.	Medicare	**5/11/2023**
Rejection	**occPDO** (Professional)	The ICD-10-CM code <1> may only be used as first-listed or primary diagnosis position. Please update as applicable.	**ICD-10-CM Primary Diagnosis Only** Per ICD-10-CM Official Guidelines for Coding and Reporting certain Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined. Please refer to ICD-10-CM Official Guidelines for Coding and Reporting at https://www. cms.gov/Medicare/icd-10/2022-icd-10-cm for further information.	Medicare	**4/6/2023**
Rejection	**occVCD5f** (Institutional)	Value code D5 is required on TOB 072X ESRD claims. Please update as applicable.	**Value Code D5 Not Present on ESRD Claim TOB 072x** All ESRD claims with dates of service on or after July 1, 2010, must indicate the applicable Kt/V reading for the dialysis patient. The reading result and the date of the reading must be reported on the claim Value Code D5 - Result of last Kt/V reading. This code is effective and required on all ESRD claims with dates of service on or after July 1, 2010. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the claim date of service. If the provider has not performed the Kt/V test for the patient the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. In addition, requirements also state that contractors shall return to the provider 072x bill types with dates of service on or after July 1, 2010, that do not contain a value code D5. In summary, the VCD5f will fire on a claim with bill type 072x without value code D5 to report the last Kt/V reading. Please refer to the Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual Chapter 8 Section 50.9, Coding for Adequacy of Dialysis, Vascular Access and Infection, for further information.	Medicare	**3/23/2023**
Catch and Release	**occVCHf** (Institutional)	An appropriate value code is required for HCPCS codes Q4081 or J0882. Please update as applicable.	**HCPCS Codes Q4081 or J0882 Requires Value Code 48 or 49** The VCHf edit will fire on an ESRD claim with Type of Bill (TOB) 72X on a line containing HCPCS codes J0882 or Q4081 and value code 48 or value code 49 is not submitted. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8 - Section 60.4.1 - Epoetin Alfa (EPO) Facility Billing Requirements and Section 60.7.1 Darbepoetin Alfa (Aranesp) Facility Billing Requirements state the hematocrit reading taken prior to the last administration of EPO during the billing period must also be reported on the UB-04/Form CMS-1450 with value code 49. The hemoglobin reading taken during the billing period must be reported on the UB-04/Form CMS-1450 with value code 48. The hematocrit reading taken prior to the last administration of Aranesp during the billing period must also be reported on the UB-04/Form CMS-1450 with value code 49. A hemoglobin reading may be reported on Aranesp claims using value code 48. In addition it also states Effective January 1, 2012, ESRD facilities are required to report hematocrit or hemoglobin levels on all ESRD claims irrespective of ESA administration. Reporting the value 99.99 is not permitted when billing for an ESA. The CMS Transmittal 1307, date July 20, 2007 states renal dialysis facilities are required to report hematocrit or hemoglobin levels for their Medicare patients receiving erythropoietin products. Hematocrit levels are reported in value code 49 and reflect the most recent reading taken before the start of the billing period. Hemoglobin readings before the start of the billing period are reported in value code 48. In summary the VCHf edit will fire when value codes 48 or 49 are not submitted on an ESRD claim with TOB 72X and codes J0882 or Q4081 is present. Please refer to the Centers for Medicare and Medicaid Services, Claims Processing Manual Chapter 8 Sections 60.4 and 60.7 Transmittal R1307CP for further information.	Medicare	**5/25/2023**
Rejection	**ocIBC** (Professional)	Billing CLIA ID submitted on the claim is not valid based on QIES and CDC database. Please resubmit claim with a valid CLIA ID.	**Invalid Billing CLIA ID** A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-andguidance/legis lation/CLIA for further information.	Medicare	**5/25/2023**
Catch and Release	**ocIIRA** (Professional)	Per CMS, between May 1, 2023 and June 30, 2023 J1817 can only be billed with modifier JK. J1817, J1811, J1813 cannot be billed without modifier JK or JL after July 1, 2023. Please update as applicable.	**Insulin Inflation Reduction Act** Section 1833(b) of the Social Security Act (the Act) is amended by Section 11407 of the Inflation Reduction Act, which waives the Medicare Part B deductible beginning July 1, 2023 for insulin furnished through an item of DME covered under section 1861(n) of the Act. Also, Section 1833(a) of the Act is amended by Section 11407 of the Inflation Reduction Act, which requires that beneficiary coinsurance for a month's supply of insulin furnished through an item of durable medical equipment is not to exceed $35 beginning July 1, 2023. The supplier payment is to be adjusted as necessary so that Medicare pays for the rest of the amount for the month's supply of insulin. The Shared Systems Maintainers (SSMs) shall implement necessary changes to their respective systems in order to ensure their systems are programmed to adjudicate Medicare Part B claims containing HCPCS for insulin administered via DME pump, ensuring the beneficiary coinsurance for a month's supply of insulin is not to exceed $35. The supplier payment is to be adjusted as necessary, so that Medicare pays for the rest of the amount for the month's supply of insulin. The following modifiers are effective April 1, 2023: JK - Short Descriptor: Drug supply 1 month or less; Long Descriptor: One month supply or less of drug or biological JL - Short Descriptor: Drug 3-month supply; Long Descriptor: Three-month supply of drug or biological. Please refer to Centers for Medicare and Medicaid Services, Manual System Pub 100-104 and Medicare Claims Processing Chapter 20 140.1.1 Transmittal 11917 for further information.	Medicare	**6/1/2023**

Catch and Release	**ocIIRAf** (Institutional)	Per CMS, between May 1, 2023 and June 30, 2023 J1817 can only be billed with modifier JK. J1817, J1811, J1813 cannot be billed without modifier JK or JL after July 1, 2023. Please update as applicable.	**Insulin Inflation Reduction Act** Section 1833(b) of the Social Security Act (the Act) is amended by Section 11407 of the Inflation Reduction Act, which waives the Medicare Part B deductible beginning July 1, 2023 for insulin furnished through an item of DME covered under section 1861(n) of the Act. Also, Section 1833(a) of the Act is amended by Section 11407 of the Inflation Reduction Act, which requires that beneficiary coinsurance for a month's supply of insulin furnished through an item of durable medical equipment is not to exceed $35 beginning July 1, 2023. The supplier payment is to be adjusted as necessary so that Medicare pays for the rest of the amount for the month's supply of insulin. The Shared Systems Maintainers (SSMs) shall implement necessary changes to their respective systems in order to ensure their systems are programmed to adjudicate Medicare Part B claims containing HCPCS for insulin administered via DME pump, ensuring the beneficiary coinsurance for a month's supply of insulin is not to exceed $35. The supplier payment is to be adjusted as necessary, so that Medicare pays for the rest of the amount for the month's supply of insulin. The following modifiers are effective April 1, 2023: JK - Short Descriptor: Drug supply 1 month or less; Long Descriptor: One month supply or less of drug or biological JL - Short Descriptor: Drug 3-month supply; Long Descriptor: Three-month supply of drug or biological. Please refer to Centers for Medicare and Medicaid Services, Manual System Pub 100-104 and Medicare Claims Processing Chapter 20 140.1.1 Transmittal 11917 for further information.	Medicare	**6/1/2023**
Rejection	**ocISC** (Professional)	Servicing CLIA ID submitted on the claim is not valid based on QIES and CDC database. Please resubmit claim with a valid CLIA ID.	**Invalid Servicing CLIA ID** A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-and-guidance/legislation/CLIA for further information.	Medicare	**5/25/2023**
Rejection	**ocMCID** (Professional)	CLIA ID was not submitted on the claim. Please resubmit claim with a valid CLIA ID.	**Missing CLIA ID** A valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent. Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and rejected or denied. Submitting the correct loop, segment, and associate line level qualifier on the claim is important to ensure the CLIA certification identification number is submitted appropriately. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-and-guidance/legislation/CLIA for further information.	Medicare	**5/25/2023**
Rejection	**ocSICCL** (Professional)	CLIA ID <1> does not meet the certification level for procedure code <2>. Please update as applicable.	**Invalid CLIA Cert Level (Servicing Provider)** The lab certification level must support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported will not be reimbursed. If the code is under waiver a modifier will be required. Please refer to Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA) at https://www.cms.gov/regulations-and-guidance/legislation/CLIA for further information.	Medicare	**5/25/2023**
Catch and Release	**occmPC** (Professional)	Per Medicare guidelines, procedure code <1> describes the physician work portion of a diagnostic test. Modifier 26 or TC on current line ID <2> is not appropriate. Please update as applicable.	**Professional Component Only** This edit utilizes the Centers for Medicare & Medicaid Services Physician Fee Schedule (NPFS) to determine if a procedure code is submitted with modifier 26 or TC inappropriately. This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical components splits (PC/TC) does not apply since professional component only codes identified by the indicator of "2" in the PC/TC column of the NPFS cannot be split into professional and technical components under Medicare rules. Modifiers 26 and TC can not be used with these codes. If a provider bills a claim containing codes that have an indicator of "2" in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended then deny payment for procedure code because the submitted procedure cannot be split into professional and technical components per CMS guidelines. Centers for Medicare & Medicaid Services Physician Fee Schedule National Physician Fee Schedule Relative Value File. PCTC Indicator 2: 2 = Professional Component Only Codes - This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.	Medicare	**7/20/2023**
Catch and Release	**occmM66** (Professional)	Modifier 66 is not present on procedure code <1>. The same procedure code with modifier 66 appended was reported by a different provider on claim ID <2> and line id <3>. Please update as applicable.	**Medicare Team Surgeon Rule- Modifier 66** 40.8. Claims for Co-Surgeons and Team Surgeons (Rev. 1, 10-01-03) B3-4828, B3-15046 A. General Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery. B. Billing Instructions The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons: • If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.); • If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." Field 25 of the MFSDB identifies certain services submitted with a "-66" modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report." • If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.) For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.	Medicare	**7/20/2023**

Catch and Release	**occOUEDf** (Facility)	Codes Q4081 and J0882 must be submitted with code G0257. Please update as applicable.	**EPO and Aransep Should Not Be Submitted Without HCPCS Code G0257** The OUEDf edit will fire on a line with HCPCS J0882 or Q4081 and the Type of Bill is 013X or 085X and HCPCS G0257 is not submitted on the same claim. This is based on a requirement from The Centers for Medicare and Medicaid Services (CMS). The Medicare Claims Processing Manual, Chapter 8, Sections 60.4.3.2 - Epoetin Alfa (EPO) Provided in the Hospital Outpatient Department, and Section 60.7.3.2 - Payment for Darbepoetin Alfa (Aranesp) in the Hospital Outpatient Department state when ESRD patients come to the hospital for an unscheduled or emergency dialysis treatment they may also require the administration of EPO and Aranesp. Hospitals use type of bill 13X (or 85X for Critical Access Hospitals) and report charges under the respective revenue code. The CMS Transmittal R1503CP, dated May 16, 2008 states the definition for HCPCS code G0257 is as follows: Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility. Medicare allows for reimbursement of ESRD-related EPO and Aranesp provided during an unscheduled or emergency dialysis treatment in the outpatient hospital setting. It contains requirements that state Medicare contractors shall only make payment for ESRD-related EPO or Aranesp in the outpatient hospital setting (13x and 85x bill types) and when HCPCS code G0257 appears on the same claim for dates of service on or after October 1, 2008. In addition, claims will be returned to the provider when outpatient hospital claims contain ESRD-related EPO or Aranesp and HCPCS code G0257 does not appear on the same claim. In summary, OUEDf will fire when HCPCS J0882 or Q4081 is submitted on a claim with TOB 013X or 085X and HCPCS G0257 is not present.	Medicare	**7/20/2023**
Catch and Release	**occSIP**	Sequential intravenous push code 96376 reported on Claim ID <1>, Line ID <2> may only be reported by facilities. This service is not to be reported on a professional claim. Please update as applicable.	**Sequential Intravenous Push Reported by a Physician** Current Procedural Terminology (CPT®) code 96376 may not be reported on a professional claim. This code is to be reported by a facility only. The CPT codebook states, “96376 may be reported by facilities only.” The Centers for Medicare and Medicaid Services (CMS) Transmittal 2636 states, "96376 - may be reported by facilities only."	Medicare	**7/20/2023**
Catch and Release	**occIDNR**	Per ICD-10-CM guidelines, diagnosis code(s) <1> is only for use on the maternal record, never on the newborn record. Please update as applicable.	**Inappropriate Diagnosis Code(s) on Newborn Record** This edit identifies when a maternal delivery diagnosis code(s) is reported on a newborn record. The obstetric diagnosis codes for this rule are identified as Chapter 15 codes O00-O9A and category codes Z3A and Z37. Per ICD-10-CM guidelines “Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn” and “Codes from Chapter 15, the obstetric chapter, are never permitted on the newborn record." The guidelines for Z37 category codes state, “The outcome of delivery codes, category Z37, should be included on all maternal delivery records. It is always a secondary code. Codes in category Z37 should not be used on the newborn record." In addition, the guidelines for Z3A category state, “Codes from category Z3A are for use, only on the maternal record, to indicate the weeks of gestation of the pregnancy, if known." A newborns' age (perinatal period) is defined as 0-28 days per ICD-10-CM guidelines.	Medicare	**7/20/2023**
Catch and Release	**occmSM**	Per Medicare guidelines the procedure code billed is an item or service that Medicare considers a measurement code and is used for reporting purposes only. Please update as applicable.	**Medicare Measurement Code** The mSM edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify CPTÂ® codes with the indicator "M" in the Status Code column of the NPFS as measurement codes. These codes are only utilized for reporting purposes. Attachment A of the NPFS defines the indicator or "M" in the Status Code column as follows: "M = Measurement codes. Used for reporting purposes only." The mSM edit identifies items or services that have been identified as measurement codes per the NPFS.	Medicare	**7/20/2023**
Catch and Release	**occDRCf** (Facility)	Only revenue codes for Part B inpatient services can be submitted on TOB 012X. Please update as applicable.	**Revenue Codes Cannot Be Reported On Part B Hospital TOB 012X** The Medicare Claims Processing Manual, Chapter 4, Section 240.2 - Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A states Medicare pays under Part B for the limited set of non-physician medical and other health services provided in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, §10.2 (that is, when furnished by a participating hospital to an inpatient of the hospital who is not entitled to benefits under Part A, has exhausted his or her Part A benefits, or receives services not covered under Part A), the contractor shall set revenue code edits to prevent payment on Type of Bill 12x for claims containing specified revenue codes.	Medicare	**8/3/2023**
Catch and Release	**occsBUN**	Per Medicaid guidelines, payment for this procedure code is always bundled into payment for other services not specified; no separate payment is made. Please update as applicable.	**Physician-Related or Professional Healthcare-Bundled Services** The sBUN edit uses Medicaid policies and guidelines to identify claim lines that report procedures and/or services that are inherently bundled into another procedure rendered on the same date of service. Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-10 Official Guidelines for Coding and Reporting and specialty-specific coding rules when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration and scope of services within broad federal guidelines. This edit will use scenarios disclosed in a state's Medicaid manual that indicates that a specified or unspecified procedure and/or service is considered bundled or incidental to another procedure and/or service rendered on the same date of service. The sBUN edit will identify Medicaid claim lines that report a procedure and/or service that is bundled or incidental to another procedure and/or service rendered on the same date of service per Medicaid policies and guidelines.	Medicaid	**8/3/2023**
Catch and Release	**occsCO**	Per Medicaid guidelines,billing for co-surgeons is not permitted for procedure code <1>. Please update as applicable	**Co-Surgeons Not Permitted Procedure** The edit identifies claim lines that contain procedure codes with modifier 62 appended inappropriately under CMS guidelines. CMS has designated codes that are identified by the indicator of “0” in the co-surgeon column of the NFPS as ineligible for modifier 62. The NPFS defines the indicator "0" in the co-surgery column as follows: “0=Co-Surgeons not permitted for this procedure.”	Medicaid	**8/10/2023**
Catch and Release	**occsPI**	Per Medicaid guidelines, procedure code <1> describes a physician interpretation for a service and is not appropriate in place of service <2>. Please update as applicable.	**Physician Interpretation Only Policy** This edit identifies claim lines that contain codes that are billed with a place of service other than inpatient. The concept of professional and technical component splits (PC/TC) does not apply since these codes describe professional inpatient services. CMS has designated place of service "21" as inpatient and it is the only recognized place of service designation when the PC/TC indicator is "8." All other place of service designations are inappropriate.	Medicaid	**8/10/2023**

Catch and Release	**occsDT**	Per Medicaid guidelines, procedure code <1> describes a diagnostic procedure that requires a professional component modifier in place of service <2>. Please update as applicable.	**Diagnostic Test in Hospital** The edit identifies claim lines that contain codes that do not have the modifier 26 appended appropriately when submitted with a place of service of inpatient hospital, outpatient hospital, or skilled nursing facility under CMS guidelines. The concept of professional and technical component splits (PC/TC) does apply to these codes that are identified by the indicator of "1" in the PC/TC column of the NPFS. When billing these services in an inpatient hospital, outpatient hospital, or skilled nursing facility, only the professional component should be billed by the physician. Billing of the technical component is inappropriate by the physician as the facility should be responsible for submitting it. Modifiers 26 and TC can be used with these codes. Attachment A of the NPFS defines the indicator "1" in the PC/TC column as follows: "1 = Diagnostic Tests for Radiology Services--Identifies codes that describe diagnostic tests. Examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy. These codes have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense."	Medicaid	**8/17/2023**
Catch and Release	**occsB50**	Per Medicaid guidelines, a bilateral procedure code <1> submitted with modifier 50 and billed with more than 1 unit of service is inappropriate. Please update as applicable.	**Bilateral Modifier 50 Billed With More Than 1 Unit** The edit identifies claim lines that contain a procedure code with modifier 50 appended and billed with more than 1 unit of service. These codes are identified by indicators "1" or "3" in the bilateral column of the MPFS. "Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported. If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one."	Medicaid	**8/24/2023**
Catch and Release	**occmDEY**	Per Medicare guidelines, a service or item that does not have a physician order or prescription is not payable. Please update as applicable.	**Deny Modifier EY** The edit identifies claims that contain an EY modifier on all lines indicating "no physician or other licensed health care provider order for this item or service." Per CMS guidelines, claim lines that do not have a physician order or prescription for the service or item provided, will cause return of the claim as unprocessable. If the supplier has obtained a prescription for some, but not all, of the items provided to a particular beneficiary, the supplier must submit a separate claim for the items with no physician order. Failure to include the EY modifier on all line items will result in the return of the claim as unprocessable. Modifier EY - No physician or other licensed health care provider order for this item or service. Note: The edit is dependent on Data Driven Rule 115 to function appropriately.	Medicaid	**7/20/2023**
Catch and Release	**occsANM**	Per Medicaid guidelines, anesthesia code <1> on claim line ID <2> requires an appropriate modifier. Please update as applicable.	**Medicaid Anesthesia Modifiers** All anesthesia codes in the range of 00100 – 01999 are included with the exception of code 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration). Category II and category III codes are excluded as well. The required modifiers indicate the conditions under which the service was rendered, and this edit will fire on all claim lines that contain anesthesia codes submitted without modifier AA, AD, QK, QX, QY, or QZ. Physicians must append the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised; payment for the service is determined by the use of these modifiers.	Medicaid	**8/31/2023**
Catch and Release	**occsTC**	Per Medicaid guidelines, procedure code <1> describes only the technical portion of a service or diagnostic test. Modifier 26 or TC is not appropriate. Please update as applicable.	**Technical Component Only Policy** This edit identifies claim lines that contain codes that have the modifier 26 or TC appended inappropriately. The concept of professional and technical components splits (PC/TC) does not apply since technical component only codes identified by the indicator of "3" in the PC/TC column of the NPFS cannot be split into professional and technical components under Medicare rules. Modifiers 26 and TC cannot be used with these codes. If a provider bills a claim containing codes that have an indicator of "3" in the PC/TC column of the NPFS that are submitted with modifier 26 or TC appended then deny payment for procedure code because the submitted procedure cannot be split into professional and technical components per CMS and Medicaid guidelines.	Medicaid	**8/31/2023**
Rejection	**occmSM**	Per Medicare guidelines the procedure code billed is an item or service that Medicare considers a measurement code and is used for reporting purposes only. Please update as applicable.	**Medicare Measurement Code** The mSM edit utilizes the Centers for Medicare and Medicaid Services' (CMS) National Physician Fee Schedule (NPFS) to identify CPTÂ® codes with the indicator "M" in the Status Code column of the NPFS as measurement codes. These codes are only utilized for reporting purposes. Attachment A of the NPFS defines the indicator or "M" in the Status Code column as follows: "M = Measurement codes. Used for reporting purposes only." The mSM edit identifies items or services that have been identified as measurement codes per the NPFS.	Medicare	**9/21/2023**
Rejection	**ocROAM**	Per Medicare guidelines, HCPCS code <1> must be billed with either modifier JA or JB. Please update as applicable.	**Route of Administration Modifier** The use of the JA and JB modifiers is required for drugs which have one HCPCS Level II (J or Q) code but multiple routes of administration. Drugs that fall under this category must be billed with JA Modifier for the intravenous infusion of the drug or billed with JB Modifier for subcutaneous injection of the drug.	Medicare	**9/21/2023**
Rejection	**ocROAMf** (Facility)	Per Medicare guidelines, HCPCS code <1> must be billed with either modifier JA or JB. Please update as applicable.	**Route of Administration Modifier** The use of the JA and JB modifiers is required for drugs which have one HCPCS Level II (J or Q) code but multiple routes of administration. Drugs that fall under this category must be billed with JA Modifier for the intravenous infusion of the drug or billed with JB Modifier for subcutaneous injection of the drug.	Medicare	**9/21/2023**
Rejection	**ocNPM**	Per Medicare guidelines, modifier <> is a nonpayable modifier. Please update as applicable.	**NonPayable Modifiers** According to the definition of the modifier, the code billed with the modifier is not payable. Please refer to the CMS HCPCS Release Code Sets quarterly update at https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update.	Medicare	**9/28/2023**

Rejection	**ocNPMf** (Facility)	Per Medicare guidelines, modifier <> is a nonpayable modifier. Please update as applicable.	**<u>NonPayable Modifiers</u>** According to the definition of the modifier, the code billed with the modifier is not payable. Please refer to the CMS HCPCS Release Code Sets quarterly update at https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update.	Medicare	**9/28/2023**
Rejection	**ocUPDf** (Facility)	Per CMS ICD-10-CM Guideline, Section II, diagnosis code <1> is not eligible as a primary diagnosis. Refer to MCE for diagnosis codes that are considered acceptable as a principal diagnosis code.	**<u>Unacceptable Principal Diagnosis Inpatient Facility</u>** Per the MCE (Medicare Code Editor) there are selected diagnosis codes that are considered unacceptable as principal diagnosis codes. In accordance with CMS guidelines, OptumCare Medicare Advantage will apply diagnosis coding guidelines that identify codes that should never be billed as a principal diagnosis but should always be coded as a secondary or subsequent diagnosis code to ensure appropriate assignment of Inpatient DRG (Diagnostic Related Group) Payment. Please refer to Section II of the 2021 CMS coding guidelines.	Medicare	**10/5/2023**
Rejection	**ocmORM**	Ordering or Referring physician NPI is not found for service code <1>. Per CMS, physicians must be enrolled with a valid NPI. Please verify physician record and resubmit the claim with a valid NPI.	**<u>Ordering and Referring Physician Missing NPI</u>** CMS regulations require physicians or other eligible professionals to be enrolled or validly opted-out for the Medicare Program to order or refer items and services for Medicare beneficiaries. The submitted CPT code requires a valid NPI submitted in either the Ordering Provider NPI found in 2420E/NM109 or Line Level Referring Provider NPI found in 2420F/NM109 or Claim Level Referring Provider NPI found in 2310A/NM109. See the Medicare Claims Processing Manual, Chapter 26, Page 11 at cms.gov for more information about services that require an ordering/referring physician, including services/situations where the ordering physician is also the performing physician, as often is the case with in-office clinical laboratory tests. For additional information please refer to: Physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available in https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1311.pdf on the CMS website or Medicare Benefit Policy Manual Chapter 15, section 40. (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads /bp102c15.PDF)For the complete list of providers who can order/refer beneficiary services for HHAs see SE 1305 (Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856) at http://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/Downloads/se1305.pdf on the CMS website.	Medicare	**10/5/2023**
Rejection	**ocmMAC**	COVID-19 monoclonal antibody code <1> should be billed to Original Medicare for dates of service prior to 1/1/22. This claim has been rejected and will not be processed.	**<u>Medicare Monoclonal Antibody Codes</u>** For Medicare health plans, the CMS Medicare Administrative Contractor will reimburse claims for Medicare beneficiaries with no cost share (copayment, coinsurance or deductible) through 2021. Charges for monoclonal antibody infusions or injects should be submitted to Original Medicare and not a United Healthcare Medicare Advantage plan.	Medicare	**10/5/2023**
Rejection	**ocmMACf** (Facility)	COVID-19 monoclonal antibody code <1> should be billed to Original Medicare for dates of service prior to 1/1/22. This claim has been rejected and will not be processed.	**<u>Medicare Monoclonal Antibody Codes</u>** For Medicare health plans, the CMS Medicare Administrative Contractor will reimburse claims for Medicare beneficiaries with no cost share (copayment, coinsurance or deductible) through 2021. Charges for monoclonal antibody infusions or injects should be submitted to Original Medicare and not a United Healthcare Medicare Advantage plan.	Medicare	**10/5/2023**
Rejection	**ocMIT2f** (Facility)	I21.A1 is an inappropriate principal diagnosis per ICD-10 guidelines and will not be forwarded for claim adjudication. Please resubmit claim with an appropriate principal diagnosis.	**<u>Myocardial Infarction Type 2 Reporting</u>** According to Medicare ICD-10-CM Official Coding Guidelines it states- "Type 2 Myocardial Infarction is assigned to I21.A1 with the underlying cause coded first." Please refer to ICD-10-CM Official Guidelines for Coding and Reporting found on www.cms.gov.	Medicare	**10/5/2023**