Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
001	001-Invalid diagnosis code	MD	MD		MD = Medicare Default
002	002-Diagnosis and age conflict	MD	MD		NO = Health Plan will not apply this edit
003	003-Diagnosis and sex conflict	NO	NO	changed from MD eff (process) date 8/7/2018	YES = Health Plan will apply this edit
004	004-Medicare secondary payor alert	NO	NO		
005	005-E-code cannot be used as principal diagnosis	MD	MD		
006	006-Invalid procedure code	MD	MD		
007	007-Procedure and age conflict	MD	MD		
008	008-Procedure and sex conflict	NO	NO	changed from MD eff (process) date 8/7/2018	
009	009-Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion	NO	NO		
010	010-Service submitted for denial (condition code 21)	MD	MD		
011	011-Service submitted for FI/MAC review (condition code 20)	NO	NO		
012	012-Questionable covered service	NO	NO		
013	013-Separate payment for services is not provided by Medicare	NO	NO		
014	014-Code indicates a site of service not included in OPPS	MD	MD		
015	015-Service units exceed maximum/Medically Unlikely Edits	YES	YES	changed from MD eff (process) date 8/29/2018	
016	016-Multiple bilateral procedures without modifier 50	MD	MD		
017	017-Inappropriate specification of bilateral procedure	MD	MD		
018	018-Inpatient procedure	NO	NO	changed from MD eff (process) date 8/29/2018	
019	019-Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present	MD	MD		

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
020	020-Code 2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	MD	MD		MD = Medicare Default
021	021-Medical visit on same day as a type “T” or “S” procedure without modifier 25	MD	MD		NO = Health Plan will not apply this edit
022	022-Invalid Modifier	MD	MD		YES = Health Plan will apply this edit
023	023-Invalid Date	MD	MD		
024	024-Date Out of OCE Range	NO	NO		
025	025-Invalid Age	MD	MD		
026	026-Invalid Sex	NO	NO	changed from MD eff (process) date 8/7/2018	
027	027-Only Incidental Services Reported	MD	MD		
028	028-Code not recognized by Medicare for outpatient claims; alternate code for same service may be available	NO	NO		
029	029-Partial hospitalization service for non-mental health diagnosis	NO	NO	changed from MD eff (process) date 4/16/2019	
030	030-Insufficient services on day of partial hospitalization	NO	NO	changed from MD eff (process) date 4/16/2019	
031	031-Partial hospitalization on same day as ECT (electroconvulsive therapy) or type “T” procedure	NO	NO	changed from MD eff (process) date 4/16/2019	
032	032-Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days	NO	NO	changed from MD eff (process) date 4/16/2019	
033	033-Partial hospitalization claim spans more than 3 days with insufficient number of days meeting PHP services	NO	NO	changed from MD eff (process) date 4/16/2019	
034	034-Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	NO	NO	changed from MD eff (process) date 4/16/2019	
035	035-Only mental health education and training services provided	NO	NO	changed from MD eff (process) date 06/29/2021	

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
036	036-Extensive mental health services provided on day of ECT (electroconvulsive therapy) or type “T” procedure	MD	MD		MD = Medicare Default
037	037-Terminated bilateral procedure or terminated procedure with units greater than 1	MD	MD		NO = Health Plan will not apply this edit
038	038-Inconsistency between implanted device or administered substance and implantation or associated procedure	NO	NO	changed from MD eff (process) date 8/29/2018	YES = Health Plan will apply this edit
039	039-Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present	MD	MD		
040	040-Code 2 of a code pair that would be allowed by NCCI if appropriate modifier were present	MD	MD		
041	041-Invalid revenue code	MD	MD		
042	042-Multiple medical visits on same day with same revenue code without condition code G0	MD	MD		
043	043-Transfusion or blood product exchange without specification of blood product	NO	NO	changed from MD eff (process) date 8/29/2018	
044	044-Observation revenue code on line item with non-observation HCPCS code	MD	MD		
045	045-Inpatient separate procedures not paid	NO	NO	changed from MD eff (process) date 8/29/2018	
046	046-Partial hospitalization condition code 41 not approved for type of bill	NO	NO	changed from MD eff (process) date 4/16/2019	
047	047-Service is not separately payable	MD	MD		
048	048-Revenue center requires HCPCS code	MD	MD		
049	049-Service on same day as inpatient procedure	NO	NO	changed from MD eff (process) date 8/29/2018	
050	050-Non-covered under any Medicare outpatient benefit, based on statutory exclusion	NO	NO		

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
051	051-Multiple observations overlap in time	MD	MD		MD = Medicare Default
052	052-Observation does not meet minimum hours, qualifying diagnoses, and/or type “T” procedure conditions	NO	NO	changed from MD eff (process) date 8/29/2018	NO = Health Plan will not apply this edit
053	053-Codes G0378 and G0379 only allowed with bill type 13x	MD	MD		YES = Health Plan will apply this edit
054	054-Multiple codes for the same service	MD	MD		
055	055-Non-reportable for site of service	MD	NO		
056	056-E/M condition not met and line item date for observation code G0244 is not 12/31 or 1/1	MD	MD		
057	057-Composite E/M condition not met for observation and line item date for code G0378 is 1/1	MD	NO		
058	058-G0379 only allowed with G0378	MD	NO		
059	059-Clinical trial requires diagnosis code V707 as other than primary diagnosis	MD	MD		
060	060-Use of modifier CA with more than one procedure not allowed	MD	MD		
061	061-Service can only be billed to the DMERC	NO	NO		
062	062-Code not recognized by OPPS; alternate code for same service may be available	NO	NO		
063	063-OT (occupational therapy) code only billed on partial hospitalization claims	NO	NO	changed from MD eff (process) date 4/16/2019	
064	064-AT (activity therapy) service not payable outside the partial hospitalization program	NO	NO	changed from MD eff (process) date 4/16/2019	
065	065-Revenue code not recognized by Medicare	MD	MD		
066	066-Code requires manual pricing	NO	NO		
067	067-Service provided prior to FDA approval	MD	MD		
068	068-Service provided prior to date of National Coverage Determination (NCD) approval	NO	NO		

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
069	069-Service provided outside approval period	MD	MD		MD = Medicare Default
070	070-CA modifier requires patient status code 20	MD	MD		NO = Health Plan will not apply this edit
071	071-Claim lacks required device code	NO	NO	changed from MD eff (process) date 8/29/2018	YES = Health Plan will apply this edit
072	072-Service not billable to the Fiscal Intermediary/MAC	NO	NO		
073	073-Incorrect billing of blood and blood products	NO	NO	changed from MD eff (process) date 8/29/2018	
074	074-Units greater than one for bilateral procedure billed with modifier 50	MD	MD		
075	075-Incorrect billing of modifier FB or FC	MD	MD		
076	076-Trauma response critical care code without revenue code 068X and CPT 99291	NO	NO	changed from MD eff (process) date 8/29/2018	
077	077-Claim lacks allowed procedure code	NO	NO	changed from MD eff (process) date 8/29/2018	
078	078-Claim lacks required radiolabeled product	MD	MD		
079	079-Incorrect billing of revenue code with HCPCS code	MD	MD		
080	080-Mental health code not approved for partial hospitalization program	NO	NO	changed from MD eff (process) date 4/16/2019	
081	081-Mental health service not payable outside the partial hospitalization program	NO	NO	changed from MD eff (process) date 4/16/2019	
082	082-Charge exceeds token charge ($1.01)	NO	NO		
083	083-Service provided on or after effective date of NCD non-coverage	NO	NO		
084	084-Claim lacks required primary code. Claim has been returned to the provider.	MD	MD		

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
085	085-Claim lacks required device code or required procedure code. Claim has been returned to the provider	MD	MD		MD = Medicare Default
086	086-Manifestation code not allowed as principal diagnosis. Claim has been returned to the provider.	MD	MD		NO = Health Plan will not apply this edit
087	087-Skin substitute application procedure without appropriate skin substitute product code.	NO	NO	changed from MD eff (process) date 8/29/2018	YES = Health Plan will apply this edit
088	088-FQHC payment code was not reported for FQHC Claim	MD	MD		
089	089-FQHC claim lacks required qualifying visit code	MD	MD		
090	090-Incorrect revenue code reported for FQHC payment code	MD	MD		
091	091-Item or Service not covered under FQHC PPS	MD	MD		
092	092-Device-dependent procedure reported without device code	NO	NO	changed from MD eff (process) date 8/29/2018	
093	093-Corneal tissue processing reported without cornea transplant procedure	NO	NO	changed from MD eff (process) date 8/29/2018	
094	094-Biosimilar HCPCS reported without biosimilar modifier	MD	MD		
095	095-Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service	NO	NO	changed from MD eff (process) date 4/16/2019	
096	096-Partial hospitalization interim claim from and through dates must span more than 4 days	NO	NO	changed from MD eff (process) date 4/16/2019	
097	097-Partial hospitalization services are required to be billed weekly	NO	NO	changed from MD eff (process) date 4/16/2019	
098	098-Claim with pass-through device, drug or biological lacks required procedure	MD	MD		
099	099-Claim with pass-through/non-pass-through/biological lacks OPPS payable procedure	NO	NO	changed from MD eff (process) date 8/29/2018	

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
100	100-Claim for HSCT allogenic transplant lacks required revenue code line for donor acquisition services	NO	NO	changed from MD eff (process) date 8/29/2018	MD = Medicare Default
101	101-Item or service with modifier PN not allowed under PPS	MD	MD		NO = Health Plan will not apply this edit
102	102-Modifiers PO/PN not allowed on the same line	MD	MD		YES = Health Plan will apply this edit
103	103-Modifier reported prior to FDA approval date	MD	MD		
104	104-Service not eligible for all-inclusive rate	MD	MD		
105	105-Claim reported with pass-through device prior to FDA approval for the procedure	MD	MD		
106	106-Add-on code reported without required primary procedure code	MD	MD		
107	107-Add-on code reported without required contractor-defined primary procedure code	MD	MD		
108	108-Add-on code reported without required primary procedure or required contractor-defined primary procedure code	MD	MD		
109	109-Code first diagnosis present without mental health diagnosis as the first secondary diagnosis	NO	NO		
110	110-Service provided prior initial marketing date	NO	NO		
111	111 - Service cost is duplicative; included in cost of associated biological	MD	MD		
112	112-Information only service(s)	NO	NO		
113	113-Supplementary or additional code not allowed as principal DX	MD	MD		
114	114-Item or service not allowed with modifier CS	NO	NO		
115	115-COVID-19 lab add-on code reported without required primary procedure	MD	MD		

Outpatient Code Editor (OCE) Clinical Edits

OCE	OCE Description	OPPS (APC)	non-OPPS (non-APC)	NOTE	NOTE
116	116-Opioid treatment program service not payable outside the opioid treatment program	NO	NO		MD = Medicare Default
117	117-Token charge less than $1.01 billed by provider	MD	MD		NO = Health Plan will not apply this edit
118	118-Invalid bill type	MD	MD		YES = Health Plan will apply this edit
119	119-Invalid claims processing receipt date	MD	MD		
120	120-Incorrect reporting of modifier PT	NO	NO		
121	121-Non-covered service reported with inpatient only procedure where patient expired or transferred	NO	NO		
122	122-340B-acquired drug modifier(s) reported inappropriately	NO	NO		
123	123-Modifier used after CMS termination date	NO	NO		
124	124-HCPCS reported after CMS termination date	NO	NO		
125	125-Incorrect billing of IMRT planning and delivery	MD	MD		
126	126-A code not flagged as “Telehealth” is present with modifiers 95, GT or GQ	MD	MD		
127	127-The revenue code reported is not on the allowable list for the Part B Inpatient claim, bill type 12x	NO	NO		