

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	List of Claim Server Edits														
2	Note: Edits having sequence number = 0, are the ones executed for every claim before executing other edits in sequence.														
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
4	Y	Y	Y	Y	Y	Y	V2005	F0004	0	NA	Claim Type Code is missing	CS1 & CS3	ALL		Confirm the Claim Type GEN. This field is set by the CMS Batch Reader/Interactive reader and not on the input TFE (Tandem Front End) file.
5	Y	Y	Y	Y	Y	Y	V2000	F0001	0	1	Claim Header Record ID is an invalid value	CS1 & CS3	ALL		Verify Header record id "35" from TFE
6	Y	Y	Y	Y	Y	Y	V2003	F0003	0	NA	Program Type is a required field	CS1	ALL		Verify LTC Program Type "001" on claim input header. This field is not on input TFE file. It is set by the CMS Batch Reader/Interactive Reader.
7	N/A	N/A	N/A	N	N	Y	V2203	F0279	0	NA	NPI/API is required.	CS1	SG 1/SC 6(NAT)		Only for NAT Claim: (Electronic and (Nat - contract nbr <> spaces and Client_id = spaces and SSN <> spaces))
8	N/A	N/A	N/A	N	N	Y	V2204	F0280	0	NA	NPI/API cannot be associated to Contract Number.	CS1	SG 1/SC 6(NAT)		Only for NAT Claim: (Electronic and (Nat - contract nbr <> spaces and Client_id = spaces and SSN <> spaces)) Read Contract table to match NPI with Contract nbr
9	Y	Y	Y	Y	Y	Y	V2206	F0282	0	NA	NPI/API is invalid.	CS1	ALL		Read Contract table by just matching NPI
10	Y	Y	Y	Y	Y	Y	V2205	F0281	0	NA	Contract Number for NPI cannot be determined.	CS1	ALL		Get the Contract for that correct NPI. If the NPI, has multiple contracts then get the unique contract with NPI and referral number pairing (Service Auth used to match referral nbr)
11	Y	Y	Y	Y	Y	Y	V2038	F0041	0	NA	Service Group is missing, invalid, inactive, or cannot be determined	CS1	ALL		SG derivation is done before this edit (if Provider linked to multiple SGs then SG indicated using modifier on the claim in this logic) Edit confirms that Service Group on the claim header matches service group on the reference table.
12	Y	Y	Y	Y	Y	Y	V2200	F0112	0	NA	Claim Header contains no details	CS1, CS3	ALL		Edit confirms that claim is submitted at least with 1 detail
13	Y	Y	Y	Y	Y	Y	V2202	F0233	0	NA	Claim has more than 28 details	CS1	ALL		No more than 28 details submitted on the claim
14	Y	Y	Y	Y	Y	Y	S0053	F0318	0	NA	System Error. CMS is unable to retrieve OI and/or Medicare eligibility data from C21. TMHP is researching the issue	CS1 & CS3	SG 1/SC *, SG 6/SC *, SG 8/SC *		System Error. CMS is unable to retrieve OI and/or Medicare eligibility data from C21. TMHP is researching the issue
15	Y	Y	Y	Y	Y	Y	OP203	NA	0	203	Temp -- derives the claim earliest begin date and latest service end date	CS2	ALL		Derives the claim header Service Begin Date and Service End Date by combining the service dates on claim details
16	Y	Y	Y	Y	Y	Y	OP200	NA	1	NA	Runs edits V2091 (billing code validation) and V2133 (service code plug)	CS2	ALL		Runs edits V2091 (billing code validation) and V2133 (service code plug)

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3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
17	Y	Y	Y	Y	Y	Y	V2091	F0077	1	NA	Billing Code Cross-walk: Billing Code was not submitted or cannot be determined.	CS2	ALL		This is the Local Billing Code Cross-walk logic. Based on the Submitted information on the claim like HCPCS code etc and other references like Client Level, Service Auth etc the unique Billing Code is derived by this logic. There is separate document to explain this logic. National Billing Combination table is mainly used here for the cross-walk logic. (Billing code is derived at this point.)
18	Y	Y	Y	Y	Y	Y	V2133	F0114	1	NA	Unable to determine Service Code from supplied information, verify Billing Code.	CS2	ALL		Based on the Service group and Local billing code derived earlier this edit reads the Billing Combination table and Service Code table to derive Service code for the detail.
19	Y	Y	Y	Y	Y	Y	V2011	F0275	2	92	Claim must be filed via a HIPAA compliant transaction set.	CS2	ALL	SG */ SC 6 (NAT)	Edit checks if the Provider is allowed to submit Pre-HIPAA format. Checks the table Contract_Format_Exception for the current contract and the date range. No longer active. Table is empty today.
20	Y	Y	Y	Y	Y	Y	V2001	F0002	3	3	Test/Production Flag is missing or invalid.	CS2	ALL		Edit confirms that the test production indicator is T or P. For test claims with "T" indicator TMHP run all the edits but ICN is not created.
21	Y	Y	Y	Y	Y	Y	V2016	F0013	6	9	The claim total amount billed is not in a valid format.	CS2	ALL		Confirm the numeric format for the Billed amt. Checks space anywhere in the field
22	Y	Y	Y	Y	Y	Y	V2014	F0011	7	8	Total Claim Positive Indicator must be present	CS2	ALL		Edit checks total billed amt positive indicator for value Y or N
23	Y	Y	Y	Y	Y	Y	V2019	F0016	8	11	Last Name must be present in order to process a claim.	CS2	ALL		Edit checks if Client Last Name submitted on the claim header is not blank (Client table not checked)
24	Y	Y	Y	Y	Y	Y	V2012	F0009	30	7	Detail Count must be present	CS2	ALL		Checks if the detail count on the claim header is numeric
25	Y	Y	Y	Y	Y	Y	V2013	F0010	31	19	Detail Count is an invalid value	CS2	ALL		Detail count should be between 1 and 28
26	Y	Y	Y	Y	Y	Y	V2075	F0063	32	39	Claim Detail Segment ID is an invalid value	CS2	ALL		Confirms that the claim detail segment starts with the string "ID"
27	Y	Y	Y	Y	Y	Y	V2076	F0064	33	40	Detail Number must be present	CS2	ALL		Detail Number is present on the claim
28	Y	Y	Y	Y	Y	Y	V2080	F0067	35	43	Detail Number is greater than Detail Count in Header	CS2	ALL		Matches details count mentioned on the Claim header with the actual number of claim details
29	Y	Y	Y	Y	Y	Y	V2081	F0068	36	42	Detail Number is an invalid value	CS2	ALL		Detail Number is an invalid value
30	Y	Y	Y	Y	Y	Y	V2082	F0069	37	44	Detail Numbers are not consecutive	CS2	ALL		Detail Numbers are not consecutive
31	Y	Y	Y	Y	Y	Y	V2083	F0070	38	45	Line item is missing a Service Begin Date.	CS2	ALL		Line item is missing a Service Begin Date.
32	Y	Y	Y	Y	Y	Y	V2085	F0071	39	47	Services cannot be before January 1, 1971.	CS2	ALL		Services cannot be before January 1, 1971.
33	Y	Y	Y	Y	Y	Y	V2086	F0072	40	48	The Service End Date is missing.	CS2	ALL		The Service End Date is missing.
34	Y	Y	Y	Y	Y	Y	V2089	F0073	41	51	The Service Begin Date must be on or before the Service End Date.	CS2	ALL		Edit for each detail: The Service Begin Date must be on or before the Service End Date.

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3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
35	Y	Y	Y	Y	Y	Y	V2090	F0075	42	52	The Service Begin Date is not for the same month and year as the Service End Date	CS2	ALL		Edit for each detail: The Service Begin Date is not for the same month and year as the Service End Date
36	N/A	N/A	N/A	N	N	Y	V2102	F0080	43	86	Training Hours must be in a valid format	CS2	ALL		TRAINING_HOURS on the claim detail is 4 digit numeric number. 1 decimal place assumed here. Is this field only applicable for NAT claims?
37	Y	N/A	Y	Y	Y	Y	V2107	F0083	44	60	Applied Income is not in a valid format.	CS2	ALL		Confirms the billed AI and Copay amt field is numeric (no decimal, 2 decimal places assumed). Set the filed value by deviding 100 and set the billed AI Copay indicator to "A" (Service_Group_Service_Code table not checked here for the type)
38	N/A	N/A	N/A	N	N	Y	V2110	F0087	45	62	Co-payment Amount is not in a valid format.	CS2	ALL		Confirms the billed Copay amt field is numeric (no decimal, 2 decimal places assumed). Set the filed value by deviding 100 and set the billed AI Copay indicator to "C" (Service_Group_Service_Code table not checked here for the type)
39	N/A	N/A	N/A	N	N	Y	V2113	F0091	46	64	Co-Payment Percentage is not in a valid format.	CS2	ALL		Co-Payment Percentage is not in a valid format.
40	Y	Y	Y	Y	Y	Y	V2116	F0094	47	66	Number of Units Billed is missing.	CS2	ALL		Number of Units Billed is missing.
41	Y	Y	Y	Y	Y	Y	V2114	F0092	48	65	Units Billed Pos/Neg indicator must be present	CS2	ALL		Units Billed Pos/Neg indicator must be present
42	Y	Y	Y	Y	Y	Y	V2120	F0097	49	69	Unit Rate must is missing or invalid	CS2	ALL		Unit rate is checked for the numeric value here. But starting 5010 implementation unit rate is no longer received on the claim. It is now derived by dividing billed amt by billed units. Not sure if that logic is called before calling this edit or after. But this edit is not applicable now.
43	Y	Y	Y	Y	Y	Y	V2123	F0100	50	71	Line Item Total Billed must be in a valid format	CS2	ALL		Line Item Total Billed must be in a valid format
44	Y	Y	Y	Y	Y	Y	V2121	F0098	51	70	Claim Detail Line Item Total Positive/Negative Indicator must be present	CS2	ALL		Claim Detail Line Item Total Positive/Negative Indicator must be present
45	N/A	N/A	N/A	N	N	Y	V2131	F0106	52	13	Claim Leave Days must be in a valid format.	CS2	ALL		Claim Leave Days must be in a valid format.
46	N/A	N/A	N/A	N	N	Y	V2132	F0204	53	15	The Budget Number is invalid.	CS2	ALL		The Budget Number is invalid.
47	Y	Y	Y	Y	N	Y	V2078	F0065	54		Claim Detail Adjustment Line Reference Number is an invalid value	CS2	ALL RETRO		When billed units count < 0 found on any detail set New_claim_indicator on the claim header to "N". Then it checks if ADJUST_DTL_REF_NBR on the claim detail is the number between 0 and 28. I see this field on the claim details saved on the retro claim. Also the Retro Claim TFE showing this field. Applicable only for Retro (system) Claims.
48	Y	Y	Y	Y	Y	Y	V2007	F0272	55	90	The Billed Unit Rate exceeds the current maximum.	CS2	ALL		Check for Billed unit rate more than 99,999.99

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49	Y	Y	Y	Y	Y	Y	V2008	F0273	56	91	The Billed Units Count exceeds the current maximum.	CS2	ALL		Check for Billed unit count more than 99,999.99
50	N/A	N/A	N/A	N	N	Y	V2037	F0274	57	93	The Billed Applied Income/Billed Co-Pay Amount is in an incorrect format	CS2	ALL		Check Applied income/copay amt received on the claim header segment. This was a 4010 format edit.
51	N/A	N/A	N/A	N	N	Y	V2211	F0315	58		Other insurance and Medicare information are not applicable for this service group. Clear data and resubmit.	CS2	All SG, SC	SG 1, 6, 8	<ul style="list-style-type: none"> Claim is for Service Group other than 1,6,8, AND Any OI field or Medicare field is entered: (Effective Date; Term. Date; Company Name; Company Address; Company City; Company State; Company ZIP Code; Company Phone #; Subscriber Relationship; Subscriber First Name; Subscriber Last Name; Subscriber SSN; Subscriber DOB; Employer Name; Subscriber/Policy #; Group Number; OI Disposition; OI Billed Date; OI Disposition Date; OI Disposition Reason; OI Paid Amount (OI Tab); OI Paid Amount (Details Tab); Insurance Claim No.; Medicare Part A Total Amt; Medicare Part C Total Amt)
52	Y	Y	Y	Y	Y	Y	V2208	F0293	59		OI Attestation is required.	CS2	SG 1, 6, 8	SG 1/SC 6	<ul style="list-style-type: none"> Service group for claim is 1,6, or 8 AND Attestation (Other Insurance) checkbox is NULL or invalid (valid = Y)
53	Y	N/A	N/A	Y	Y	Y	V2212	F0311	60		Medicare Part A Total Amount or Medicare Part C Total Amount entered in error See the client's MESAV for eligibility and service authorization details	CS2	SG1/SC3		Medicare Part A Total Amount is entered AND Medicare Part C Total Amount is entered

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54	Y	Y	Y	Y	Y	Y	V2213	FO295	61		Other Insurance Policy Information on the claim is missing or invalid.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> • Effective Date is invalid (valid = YYYYMMDD format) (if entered), OR • Termination Date is invalid (valid = YYYYMMDD format) (if entered), OR • Company Name is NULL or invalid (valid = alphanumeric), OR • Company Address is invalid (valid = alphanumeric), OR • Company City is invalid (valid = alpha), OR, • Company State is invalid (valid = standard State list), OR • Company ZIP Code is invalid (valid = 5 or 9 numeric characters), OR • Company Phone is invalid (valid = exactly 10 numeric characters), OR • Subscriber Relationship to Client is NULL or something OTHER than C, M, O, P, or S, OR • Subscriber First Name is NULL or invalid (valid = alpha), OR • Subscriber Last Name is NULL or invalid (valid = alpha), OR • Subscriber/Policy # is NULL or invalid (valid=alphanumeric), OR • Subscriber SSN is invalid (valid = exactly 9 numeric characters), OR • Subscriber DOB is invalid (valid = YYYYMMDD), OR • Employer Name is invalid (valid=alphanumeric), OR • Group Number is invalid (valid=alphanumeric)
55	Y	Y	Y	Y	Y	Y	V2219	F0298	62		Other Insurance Billed Date is missing or is invalid.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> • Other Insurance Billed Date is NULL or not a valid date in YYYYMMDD format
56	Y	Y	Y	Y	Y	Y	V2215	F0313	63		Incorrect other insurance billed date.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> • Other Insurance Billed Date is earlier than any Detail Service End Date, OR • Other Insurance Billed Date is later than claim submission date, OR • Other Insurance Billed Date is less than 110 (0-109) calendar days earlier than claim submission date, OR • Other Insurance Billed Date is greater than 365 calendar days earlier than claim submission date
57	Y	Y	Y	Y	Y	Y	V2216	F0313	64		Incorrect other insurance billed date.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> • Other Insurance Billed Date is later than claim submission date, OR • Other Insurance Billed Date is less than 110 (0-109) calendar days earlier than claim submission date, OR • Other Insurance Billed Date is greater than 365 calendar days earlier than claim submission date
58	Y	Y	Y	Y	Y	Y	V2214	F0296	65		Other insurance Disposition is missing or is invalid	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> • Other Insurance Disposition is NULL or something OTHER than P, D, NI or NS

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
59	Y	Y	Y	Y	Y	Y	V2220	F0299	66		Other Insurance Disposition information is missing or invalid.	CS2	SG 1, 6, 8		Other Insurance Disposition Date is NULL, OR <ul style="list-style-type: none"> Other Insurance Disposition Date is not a valid date in YYYYMMDD format. OR Other Insurance Disposition Reason is NULL, OR Insurance Claim No. is NULL, OR Insurance Claim No. is invalid (valid = alphanumeric)
60	Y	Y	Y	Y	Y	Y	V2221	F0300	67		Other Insurance Paid Amount is missing or invalid.	CS2	SG 1, 6, 8		Other Insurance Disposition is P AND One or more of the following conditions is met: <ul style="list-style-type: none"> Other Insurance Paid Amount (OI/Finish tab) is NULL OR Other Insurance Paid Amount (OI/Finish tab) is not valid (valid = numeric) OR Other Insurance Paid Amount (OI/Finish tab) is less than \$0.01 Bypass if OI policy being evaluated has Other Insurance Disposition Reason of P3
61	Y	Y	Y	Y	Y	Y	V2222	F0312	68		Other Insurance Paid Amount is prohibited.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> (OI policy being evaluated has Other Insurance Disposition of P AND Other Insurance Disposition Reason of P3 – AND Other Insurance Paid Amount is not NULL and not zero) OR (OI policy being evaluated has Other Insurance Disposition of D or NI or NS AND Other Insurance Paid Amount is not NULL and not zero)
62	Y	Y	Y	Y	Y	Y	V2217	F0297	69		The OI Disposition information on the claim is invalid.	CS2	SG 1, 6, 8	Exclude for Retro Claims	<ul style="list-style-type: none"> Other Insurance Billed Date is later than claims submission date, OR Other Insurance Billed Date is greater than 365 calendar days earlier than claim submission date Other Insurance Disposition Date is later than claims submission date, OR Other Insurance Billed Date is on or after Other Insurance Disposition Date OR Other Insurance Disposition Reason is something other than P1 or P2 or P3 Bypass if OI policy being evaluated has Other Insurance Disposition OTHER than P

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63	Y	Y	Y	Y	Y	Y	V2218	F0297	70		The OI Disposition information on the claim is invalid.	CS2	SG 1, 6, 8	Exclude for Retro Claims	<ul style="list-style-type: none"> Other Insurance Billed Date is later than claim submission date, OR Other Insurance Billed Date is greater than 365 calendar days earlier than claim submission date, OR Other Insurance Disposition Date is later than claim submission date, OR Other Insurance Billed Date is on or after Other Insurance Disposition Date, OR Other Insurance Disposition Reason is something other than D1, D2, D2, D4, D5, D6, D7, D8, D9, D10, D11, D12, D13, D14, D15, or D16 Bypass if OI policy being evaluated has Other Insurance Disposition OTHER than D.
64	Y	Y	Y	Y	Y	Y	V2209	F0316	71		Other Insurance Paid Amount (Details tab) is invalid.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> OI Paid Amount (Details tab) is not valid (valid = numeric) OR OI Paid Amount (Details tab) is less than \$0.00
65	Y	Y	Y	Y	Y	Y	V2210	F0317	72		Sum of OI Paid Amount on Details tab must equal sum of OI Paid Amount on OI tab.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> Sum of all instances of OI Paid Amount on Details tab ≠ sum of all instances of OI Paid Amount on OI/Finish tab
66	Y	Y	Y	Y	Y	Y	V2224	F0324	73		Medicare Part A Total Amount or Medicare Part C Total Amount not compatible with services billed. Review claim details entered.	CS2	SG 1, 6, 8		<ul style="list-style-type: none"> Medicare Part A Total Amount is entered AND claim contains zero details for SG 1 / SC 3, OR Medicare Part C Total Amount is entered AND claim contains zero details for SG 1 / SC 3
67	N/A	N/A	N/A	N	N	Y	V2225	F0325	74	20	Line Item Control Number-Required HHMM (military format)	CS2	SG 14/SC 12C		Rund for TCM Claims to confirm that first 4 chars on the Line Item Control Number submitted on the claim details indicates the Service Time in military format (0000 to 2359 range)
68	N/A	N/A	N/A	N	N	Y	S0054	F0326	75	236	Day/Date Limitation - Incorrect number of days billed for this service	CS2	SG 14/SC 12C		Runs for TCM Claims. Confirms that each detail is billed for one day of service (Service Begin Date is same as Service End Date)
69	N/A	N/A	N/A	N	N	Y	S0001	F0118	76 & 123	101	Incorrect number of billed units for this service.	CS2	SG 1/SC 6, SG 9/SC 6, SG 14/SC 12C		On the positive details this edit confirms that only 1 unit is billed per claim detail
70	Y	Y	Y	Y	Y	Y	S0029	F0214	100	131	Provider number is missing or invalid.	CS2	ALL	SG 7/SC 26 (IHFSP)	Confirms that numeric contract number on claim header
71	Y	Y	Y	Y	Y	Y	P0001	F0128	101	106	Provider is not enrolled to provide CMS services, or invalid provider number entered	CS2	ALL	SG 7/SC 26 (IHFSP)	Read Contract table for the Contract number on the claim header for the active record
72	N/A	N/A	N/A	N	N	Y	S0034	F0040	102	177	Trainee Social Security Number is missing or invalid.	CS2	SG */ SC 6 (NAT)		Trainee Social Security Number is missing or invalid. Client id is zero for these claims. NAT SSN is used instead

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73	N/A	N/A	N/A	N	N	Y	S0035	F0044	103	178	Payee Identification Number must be submitted on claim.	CS2	SG 7/SC 26 (IHFSF)		Edit checks if Client Payee Id submitted on the claim is numeric for this service. If edit pass then set the Contract Number to 0 and the Contract_payment_ind to "N" to indicate that these claims don't require Contract Number and paid to the Client. Currently we do NOT pay any Clients in the system using this functionality.
74	N/A	N/A	N/A	N	N	Y	S0048	F0289	104	115	No service authorization found in the TMHP LTC CMS system.	CS2	SG 14/SC 12A, SG 14/SC 12C		Edit runs for Targeted Case Management Claims for checking Service Auth by matching SG, SC, Client, Contract and date range. Also confirms continuous coverage. If this edit fails then the claims are suspended and recycled after 7 business days.
75	Y	Y	Y	Y	Y	Y	S0030	F0018	105	160	The Client/Medicaid Number is missing or invalid.	CS2	ALL	SG */ SC 6 (NAT)	Verifies that numeric Client id submitted on the claim (not matched with the Client table in this edit)
76	N/A	N/A	N/A	N	N	Y	S0031	F0025	106	174	Medicaid Patient Days Percent is missing.	CS2	SG */ SC 6 (NAT)		Medicaid Patient Days Percent is missing.
77	N/A	N/A	N/A	N	N	Y	S0032	F0032	107	175	Medicare Patient Days Percent is missing.	CS2	SG */ SC 6 (NAT)		Medicare Patient Days Percent is missing.
78	N/A	N/A	N/A	N	N	Y	S0033	F0037	108	176	Private Patient Days % is missing.	CS2	SG */ SC 6 (NAT)		Private Patient Days % is missing.
79	N/A	N/A	N/A	N	N	Y	S0014	F0196	109	150	The sum of the Medicaid Patient Days % &/or Medicare Patient Days % &/or Private Days % add up to between 99.7 and 100	CS2	SG */ SC 6 (NAT)		Edit verifies that for NAT Claims, the patient Days % fields (Private, Medicare, Medicaid) addup to between 99.7 and 100%
80	N/A	N/A	N/A	N	Y	Y	S0016	F0200	110	152	Procedure Code is missing.	CS2	ALL (SC 30, SC 5, SC 5A, SC 5AW, 5AY, 5B received)		Read Service_Procedure table for the current detail. Match procedure code submitted on the Claim detail with the Procedure code found on the Service_Procedure table. Today only SC 30, SC 5, SC 5A, SC 5AW, 5AY, 5B received in Service_Procedure table
81	N/A	N/A	N/A	N	Y	Y	S0018	F0202	112	154	This Service requires a Tooth ID.	CS2	SG 1/SC 5, SG 17/SC 5		Edit for Dental claims. First read the Procedure Code table where tooth id indicator is set to Y. If the claim is submitted for one of these Procedure codes then tooth id in the range of 01 to 32 or 99 expected
82	N/A	Y	N/A	Y	Y	Y	S0017	F0201	113	153	An Item Code is required for this Service.	CS2	ALL (SC 15/SC 17/SC 5B)		Read Service_Item table for the current Service Code on the claim detail. If the record found then read Item table to confirm that submitted Item code on the claim detail matches item code linked to the Service Code, Today SC 15, SC 17 and SC 5B only received Service_Item records
83	N/A	N/A	N/A	N	N	Y	S0002	F0119	115	102	Claims for month following submission must be submitted within last week of month	CS2	SG 11/SC *		For PACE service group check if the Claims are submitted in the last 7 days of the month. Also some logic related to the service dates allowed for the next month. Need more research to understand this.
84	Y	Y	Y	Y	Y	Y	S0006	F0126	116	105	Claim line items cannot span current Fiscal Years.	CS2	ALL		Confirms that all the details are submitted for the same Fiscal Year. Also set the Miscellaneous indicator if the service dates are older than 3 fiscal years.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
85	Y	Y	Y	Y	Y	Y	S0015	F0198	118	151	Cannot bill for future Service Dates or current date.	CS2	ALL	SG 11/SC *	Fail edit is Service End Date on the claim detail is greater than or same as the Claim Submission Date
86	Y	Y	Y	Y	Y	Y	S0027	F0117	119	170	Unit Rate must be greater than zero.	CS2	ALL		Billed Unit Rate greater than zero
87	Y	Y	Y	Y	Y	Y	S0026	F0116	120	169	The Units Billed must be greater than zero.	CS2	ALL		Billed Units count greater than zero
88	N/A	N/A	N/A	N	N	Y	S0012	F0151	121	164	Cannot bill for more than 5 consecutive days for this service	CS2	SG 8/SC 1		No more than 5 days billed on the claim detail. Only runs for Billing Codes T0200 and T0300
89	N/A	N/A	N/A	N	N	Y	S0005	F0125	122	159	Units billed exceed possible number of Units for Dates of Service.	CS2	ALL		Read Service_Group_Service_Code table for SG/SC Combinations where Hourly Vlidation indicator is set to Y. If the claim is for one of these SG/SC combinations then multiply number of service days by 24 to get max allowed units. If it exceeds then fail the edit. Upto 24 units per service date are allowed.
90	N/A	N/A	N/A	N	N	Y	S0001	F0118	76 & 123	101	Incorrect number of billed units for this service.	CS2	SG 1/SC 6, SG 9/SC 6, SG 14/SC 12C		On the positive details this edit confirms that only 1 unit is billed per claim detail
91	N/A	N/A	N/A	N	N	Y	S0028	F0208	124	167	Leave Days may not exceed the Units Billed.	CS2	ALL		Edit checks if the Leave days on claim detail does not exceeds number of units submitted on the claim detail
92	Y	N	Y	Y	Y	Y	S0042	F0241	125	186	Applied Income or Co-pay must exist for the dates of service.	CS2	ALL		Read the Service_Group_Service_Code table to get the list of SG/SC Combinations with the responsibility type A(Applied Income) or C(Copay). For the claim detail read Client Responsibility table by matching Client id, date range and Responsibility type. Continuous coverage for the same responsibility type is checked in this edit.
93	N/A	N/A	N/A	N	N	Y	S0044	F0284	126	230	Daily Units Exceed the Number of Days Billed	CS2	SG 8/SC 1		One unit per day checked. E.g. if the claim billed for 5 days then only 5 max units allowed on the claim detail. This edit runs only for certain billing code T0200.
94	N/A	N/A	N/A	N	N	Y	S0045	F0285	127	187	Can only bill for incremental (0.25, 0.50, 0.75, and whole) units for specified services	CS2	SG 21/SC (LONG LIST), SG 22/SC (LONG LIST)		Can only bill for incremental (0.25, 0.50, 0.75, and whole) units for specified services
95	N/A	N/A	N/A	N	N	Y	S0046	F0286	128	188	Can only bill for incremental (0.50, 0.75, and whole) units for specified services	CS2	SG 21/SC 10C		Can only bill for incremental (0.50, 0.75, and whole) units for specified services
96	N/A	N/A	N/A	N	N	Y	S0004	F0251	150	207	Nat claims may only contain one detail line item.	CS2	SG */SC 6(NAT)		Edit confirms that only one positive detail is submitted on NAT claim
97	N/A	N/A	N/A	N	N	Y	S0008	F0252	151	208	Incorrect number of training hours for this training course billing code	CS2	SG */SC 6(NAT)		Edit confirms that the NAT claim for billing code N0708 is billed with at training hours between the range 38 and 75

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
98	N/A	N/A	N/A	N	N	Y	S0010	F0261	152	209	Incorrect number of training hours for this training course billing code	CS2	SG */SC 6(NAT)		Edit confirms that the NAT claim for billing code N0700 is billed with at least 75 training hours
99	Y	Y	Y	Y	Y	Y	E0002	F0139	200	121	Client/Medicaid Number does not match information on file.	CS2	ALL	SG */SC 6(NAT)	Read Client table by matching Client id. Check Separated_Alias_Indicator on Client table. If M(Merged) then read previous_reference table for finding new Client id. Also merged date is checked on this table. This Merged Client condition will be used later in edit E0003. If the indicator is "Y"(Separated) then pass the indicator for edit E0012 for further check. If indicator is "T" (Merged Client by SAS but no merged date) then treat this like non-merged Client.
100	Y	Y	Y	Y	Y	Y	E0003	F0141	201	122	Client ID is a previous reference which is not valid for the service dates.	CS2	ALL	SG */SC 6(NAT)	If merged Client and old/previous Client id used for the claim then the DOS can not be after Client Merged date. FYI: SEP_ALIAS_IND = "M" on the Client Header table indicates if the Client is Merged. Merged Client will stop using the old Client Id and start using the new Client Id.
101	Y	Y	Y	Y	Y	Y	E0012	F0270	202	224	Cannot bill a positive line item for a separated alias client ID.	CS2	ALL	SG */SC 6(NAT)	If the claim is from Separated Client and if the claim is billed with the positive billed units then the edit fails. Separated Clients are discontinued Clients from TIERS. FYI: SEP_ALIAS_IND = "Y" on the Client Header table indicates if the Client is Separated.
102	Y	Y	Y	Y	Y	Y	P0003	F0132	203	108	Provider is not authorized to perform this service for these Service Dates, verify Billing Code	CS2	ALL	SG 7/SC 26(IHFSP)	Read Contract_Service records by matching Contract Number, Service Code and the date range. Continuous Coverage is confirmed in this edit.
103	Y	Y	Y	Y	Y	New	E0017	F0333			Claim contains at least one adjustment (negative) claim detail. Please do not file adjustments for MCO clients.		SG1		COR 135 Edit - Rejects adjustment claims submitted for clients enrolled in STAR+PLUS.
104	Y	Y	Y	Y	Y	New	E0018	F0334			Claim denied due to a change in client eligibility. Please resubmit claim.		SG1		COR 135 Edit - Denies suspended claims submitted for clients retro-enrolled in STAR+PLUS.
105	Y	Y	Y	Y	Y	New	E0015	F0331			Claim details contain both Fee-For-Service and MCO Services. Please do not file for mixed services.		SG1		COR 135 Edit - Rejects when all claim details contain a mix of Fee-For-Service and STAR+PLUS services.
106	N	Y	Y	Y	Y	New	E0020	F0338			Dental providers must bill directly to the DMO.		SG1		Cor 135 Edit - Rejects when dental claims are submitted for STAR+PLUS clients.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
107	Y	Y	Y	Y	Y	New	E0016	F0332			Claim details are for services from different Managed Care Plan Codes. Please do not file for multiple Managed Care Plan Codes.		SG1		COR 135 Edit - Rejects when the claim details have multiple STAR+PLUS Plan Codes.
108	Y	Y	Y	Y	Y	New	E0019	F0337			Claim details contain both daily care and other services. Please do not file for mixed services.		SG1		COR 135 Edit - Rejects when the claim details have both Daily Care (SG1/SC1) and Add-On Services.
109	N	Y	N	Y	Y	New	P0012	F0339			Taxonomy is required for Billing Provider NPI		SG1		COR 135 Edit - Rejects claims submitted with an NPI, but have a blank Taxonomy.
110	Y	Y	Y	Y	Y	New	I0025	F0335			Claim was forwarded to a Managed Care Organization.		SG1		COR 135 Edit - Information edit for accepted claims when the STAR+PLUS forwarding criteria is met.
111	Y	N	Y	Y	N	Y	P0009	F0138	205	114	A valid Service Authorization for this client for this Service on these dates is not available	CS2	ALL	SG */SC 6(NAT), SG 3/SC 17, SG 3/ SC 17A, SG 3/SC 17B, SG 3/SC 17W, SG 3/SC 17Y	Read Service_Auth by matching Client, SG, SC and date range. If the detail is covered by multiple Service Auths then also confirm that continuous coverage is there for the claim detail. Also Agency Code is the same for all Service Auth segments. (Contract Number is not matched for the Service Auth read in this edit. Edit P0006 match that)
112	N/A	N/A	N/A	N	N/A	Y	P0011	F0268	206	221	A valid service auth. For client for these service dates not available or claim dates cannot overlap more than one service auth.	CS2	SG 20/SC *, SG 21/SC *, SG 22/SC *, SG 3/SC 17, SG 3/SC 17A, SG 3/SC 17B, SG 3/SC 17W, SG 3/SC 17Y, SG 18/SC 11M, SG 18/SC 11N, SG 18/SC 11P, SG 18/SC 11Q, SG 18/SC 11R, SG 18/SC 11S, SG 18/SC 11T, SG 18/SC 11U, SG 18/SC 11V	Read Service_Auth by matching Client, SG, SC and date range. This edit confirms that only ONE Service Auth is covering the claim detail.	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
3	Y	N	Y	Y	N	Y	P0006	F0148	207	111	Provider not authorized to provide services billed for client.	CS2	ALL	SG */SC 6(NAT), SG 7/SC 26(IHFSP)	Read Service_Auth by matching Client, SG, SC and date range. Confirm that Service Auth Contract Number is matching with the Claim Header Contract Number. If the detail is covered by multiple Service Auths then also confirm that Contract Number is same as Claim header contract number for each segment. Continuous Coverage is not checked in this edit since it is done in edit P0009
113	Y	Y	Y	Y	N	Y	E0014	F0288	210	190	Claim cannot be paid because consumer is on Client Hold for the given waiver program and Date(s) of Service.	CS2	ALL	SG */SC 20	Read Client_Hold for matching Client-id, SG and Date range. If the Client Hold segment is found for the detail then fail the edit.
114	Y	Y	Y	Y	N	Y	S0007	F0155	213	116	Unable to determine appropriate Fund Code for Service billed, verify Medicaid Eligibility	CS2	ALL		This is complicated edit. First it checks Service Auth for the claim details and see if the Fund Code is on the Service Auth itself (it is called override Fund Code. E.g. we used this option for Katrina claims with Fund Code 19K. These claims will not require Medicaid Eligibility and Medicaid Requirement table. SC 81 claims for PASRR also using this option). If the Fund Code is not found on the Service Auth then it checks the Medicaid Eligibility and then Medicaid Requirement table to get the Fund Code. If the Medicaid Eligibility is not found then it checks Title XX Eligibility and then Medicaid requirement table to get the Fund Code. If the Fund Code is still not derived then this edit is failed. (Main Edit that checks for Medicaid Eligibility)
115															

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
116	N/A	N/A	N/A	N	N	Y	S0019	F0203	214	180	The client's eligibility requires a Budget Number to be submitted.	CS2	ALL		Based on the derived Fund Code for claim detail, if the budget required indicator on the Fund Code table is set to Y then budget number should be submitted on the claim detail. FYI: Fund Codes 100 & 20 (State Funded) are set-up with Budget required indicator today. Positive details on the Retro Claims bypass this logic (Edit S0025 will plug Budget Number on detail for these details)
117	N/A	N/A	N/A	N	N	Y	S0025	F0115	215	171	Unable to determine Budget Key from supplied information.	CS2	ALL		Check in Budget Number Submitted on detail, Check detail Fund Code to see if budget required. If Yes, Read Contract_Budget table (Client Rate No longer used). Also check the budget table Budget Number derived for retro positive line
118	N/A	N/A	N/A	N	N	Y	S0037	F0216	216	156	The Payee Identification Number on the claim is not associated with the Client/Medicaid number	CS2	SG */SC 26		I don't think we are paying any Clients using Client Payee Id submitted on the claim. May be SC 26 is no longer used? Logic: Read Client_Rate table for the current client and match payee id submitted on claim with payee id on the Client_Rate table
119	Y	Y	Y	Y	N	Y	S0043	F0250	218	206	Late billing - Claim must be filed 12 months from the end of the month of service or 12 months from the end of the eligibility add date	CS2	ALL		Check if claim is filed before last day of the (Service Month + 12 month) for the claims with Fund Code required Medicaid Eligibility. Exception logic is there if the Eligibility segment is Added in the last 12 months. It allows the late claim until Eligibility Add Date + 12 months
120	Y	N/A	N/A	Y	Y	Y	S0049	F0294	225		Medicare Part A Total Amount and Medicare Attestation are required.	CS2	SG 1/SC 3		<ul style="list-style-type: none"> Detail is for Service Group 1/Service Code 3, AND Client has NO Medicare Part C eligibility for Detail date(s) of service, AND NO policy in OI database for client with TOC M (with coverage dates for Detail date(s) of service), AND Either of the following fields are invalid: <ul style="list-style-type: none"> - Medicare Part A Total Amount (valid = numeric value greater than \$0.00) - Attestation (Medicare) (valid = Y)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
121	Y	N/A	N/A	Y	Y	Y	S0050	F0306	226		Medicare Part C Total Amount and Medicare Attestation are required.	CS2	SG 1/SC 3		<ul style="list-style-type: none"> Detail is for Service Group 1/Service Code 3, AND (Client has Medicare Part C eligibility for Detail date(s) of service) OR (Existing policy in OI database for client with TOC M (with coverage dates for Detail date(s) of service)), AND Either of the following fields are Invalid: <ul style="list-style-type: none"> Medicare Part C Total Amount (valid = numeric value greater than \$0.00) Attestation (Medicare) (valid = Y) Detail is for Service Group 1/Service Code 3, AND (Client has Medicare Part C eligibility for Detail date(s) of service) OR (Existing policy in OI database for client with TOC M (with coverage dates for Detail date(s) of service)), AND Either of the following fields are Invalid: <ul style="list-style-type: none"> Medicare Part C Total Amount (valid = numeric value greater than \$0.00) Attestation (Medicare) (valid = Y)
122	Y	N/A	N/A	Y	Y	Y	S0051	F0301	227		The Unit Rate, days billed, and/or Medicare Part A Total Amount are invalid on the claim.	CS2	SG 1/SC 3		<ul style="list-style-type: none"> Detail is for Service Group 1/Service Code 3, AND Billed Units multiplied by Billed Unit Rate for all SG 1/SC 3 line items (Details tab) is not equal to Medicare Part A Total Amount <p>Bypass is client has Elig Part C or TOC M effective for the dates of service.</p>
123	Y	N/A	N/A	Y	Y	Y	S0052	F0302	228		The Unit Rate, days billed, and/or Medicare Part C Total Amount are invalid on the claim.	CS2	SG 1/SC 3		<ul style="list-style-type: none"> Detail is for Service Group 1/Service Code 3, AND (Client has Medicare Part C eligibility for Detail date(s) of service) OR (Existing policy in OI database for client with TOC M (with coverage dates for Detail date(s) of service)), AND Billed Units multiplied by Billed Unit Rate for all SG 1/SC 3 line items (Details tab) is not equal to Medicare Part C Total Amount (+ or - \$1)
124	N	N	N	N	N	Y	E0013	NA	230	119	Pre check for edit E0001	CS2	SG 1/SC *, SG 9/SC *, SG 10/SC *		This is not real edit. For SG 1, 9 & 10 this pre-edit check is added to see if the Service Dates are BEFORE 2007-01-01. Only for the older period it forces that claim to go through edit E0001 logic. Based on the fact that they can not bill for the claims for DOS before 2007-01-01 this edit is not effective. With the new COR 135 we will propose to not run this edit for SG 1,9 & 10

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
125	N	N	N	N	N	Y	E0001	F0179	300	120	Claim can not be paid because Client is a Managed Care Client.	CS2	SG 1/SC * (Service Dates before 2007-01-01 SG 9/SC * (Service Dates before 2007-01-01 SG 10/SC * (Service Dates before 2007-01-01 SG 3/SC *, SG 7/SC *, SG 17/ SC *, SG 18/SC *, SG 21/SC *, SG	SG */SC 6 (NAT), SG 7/SC 65	Read managed care segment for that Client for the overlapping service dates. If the plan code is set-up to run this edit (All STAR+PLUS plan codes are set to run this edit) then check if the Fund Code derived for the detail is required medicaid. If Fund Code suggest that the Medicaid eligibility required then fail the edit saying that this claims should be billed to the MCO and not to TMHP/LTC. FYI: State funded programs like Title XX don't require Medicaid eligibility and in that case this edit is not applicable. Fund Code indicates this condition. Some additional logic for Merged Client in this edit
126	N/A	N/A	N/A	N	N	Y	E0004	F0153	302	123	Client is eligible for Medicare enrollment. Please bill Medicare first.	CS2	SG 8/SC *	SG 8/SC 31, SG 8/SC 32, SG 8/SC 33, SG8/SC 4	Read CMS Other Insurance table for Medicare_indicator "Y" and fail the edit. Special logic for merged Client to use different Client ID. This edit is old edit added before COR-53 implementation and not changed. Still it used SAS other insurance data for medicare check and not actually do any checks with MODS OI Data like COR-53 Edits
127	N	Y	N/A	Y	N	Y	E0005	F0150	303	124	Client not living in approved Nursing Facility on Service Dates.	CS2	SG 1/SC 4, SG 1/SC 7, SG 1/SC 8, SG 1/SC 9		Read Service_Auth by matching Client, SG, SC and date range. Also logic to make sure that continuous coverage for the claim (multiple SA segments covering the claim detail)
128	Y	Y	Y	Y	N	Y	E0006	F0142	304	125	Client Medicaid Eligibility is not currently active or is on hold for dates of service	CS2	ALL	SG */SC 6 (NAT) SG 20/SC * (Guardianship)	First check Eligibility segment for the Coverage Code "H" (Hold), If yes, check Service_Auth to see if the Fund Code is override fund code (on Srvc_Auth instead of using Medicaid req table). Fail the edit if Fund code is NOT supplied from Service Auth.
129	Y	Y	Y	Y	N	Y	E0007	F0143	305	126	Client last name not on file.	CS2	ALL	SG */SC 6 (NAT)	Match Client last name from claim header to the last name on Client table. Extra logic for the merged Clients. Informational for Retro Claims.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
130	Y	Y	Y	Y	N	Y	E0010	F0147	307	129	Client's LOS Type and Level do not match Service Group and Billing Code Requirements	CS2	ALL		Read Billing Combination for the claim, if the levels are not blank on the billing combination table then check the Client Level of Service table to see the levels. If the levels from billing combination table and Client Level of service tables are matched then edit is passed. Some extra logic for Hospice (8/31) claims in here. Also if the Contract Nbr on the Client Level record is 0 (for all providers) then levels are matched without contract nbr on the claim
131	N/A	N/A	N/A	N	N	Y	E0011	F0163	308	130	Item Code billed is not authorized for the Service provided.	CS2	SG 6/SC 15		Verify if the Client is authorized for the item code billed on the claim: Check match Service Auth and then SA_ITEM table
132	Y	Y	Y	Y	N	Y	S0036	F0215	309	181	Unable to determine rate key for detail or contract, verify billing code, if correct contact TMHP help desk	CS2	ALL		Read Contract_rate table for matching contract nbr, srvc dates and Service Code to see if valid rate key found. Special logic for hospice (8/31) claims to use NF rates. Client pay logic in this edit is not applicable now. This will be a zero priced claim and forwarded to the MCO
133	N	N	N	N	N	Y	C0006	F0110	402	134	Matching history detail not found or not in adjustable status	CS2	ALL		Only applicable for Adjustment claims: This is condition used to match negative details on the Adjustment claim to find paid positive detail from the History claim: Read Each Paid history_claim.cms_claim_hdr Where Matching Contract_nbr, Srvc_grp, Client_id, NAT_SSN, And history_claim.Contract_payment_ind = Y and history_claim.Adjusted_ind = N and ((history_claim.claim_source_cd <> 'S') or (history_claim.claim_source_cd = S and history_claim.icn = import_retro_old_icn)) Also match on HHMM for LICN for SG14/SC12C
134	N/A	N/A	N/A	N	N	Y	P0008	F0177	403	113	The Budget Number is not valid for provider.	CS2	ALL		Budget Number submitted on the claim should be associated to the Budget Key derived in S0025. Reading Budget table

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
3	Y	Y	Y	Y	N	Y	S0039	F0236	500	182	Unable to determine appropriate state accounting codes for this claim. Tmhp is researching this problem.	CS2	ALL		Read Fiscal Reference for each detail by matching SG, Agency, Billing Code, Fund Code and Service Dates
135															
136															

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
3															
137	The following edits are applicable to SG1 claims as indicated by columns A-C, but will not be run for STAR+PLUS MCO forwarded claims.														
138	List of Audit Edits In sequence within the server LTC Policy A (Duplicates and mutually exclusive edits)														
139						Active	Edit		Sequence		Complete Description				
140	Y	Y	Y	Y	N	Y	H0001	F0165			This service has already been paid. Please do not file for duplicate services.				
141	N/A	N/A	N/A	N	N	Y	H0002	F0167			A claim for this procedure for this tooth has already been paid.				
142	Y	Y	Y	Y	N	Y	H0022	F0269			Claim Detail is an Exact Dup. Of History Claim Detail.				
143	Y	Y	Y	Y	N	Y	H0012	F0234			Service is duplicate of another line item on same claim for same or overlapping service dates.				
144	N/A	N/A	N/A	N	N	Y	H0013	F0247			The billed tooth id has been previously billed.				
145	N/A	N/A	N/A	N	N	Y	H0010	F0152			Records show that client has received this service for more than 5 consecutive days (Runs for SG8/T0200-T0300)				
146	N/A	N/A	N/A	N	N	Y	H0024	F0329			This Service has already been paid. Please do not file for duplicate service.				
147	N/A	N/A	N/A	N	N	Y	H0025	F0330			Service is a duplication of another line item on the same claim for the same or overlapping service dates.				
148	Y	Y	Y	Y	N	Y	M0001	F0174			Claim is for a Service Group that is mutually exclusive with Service Group for previous claim.				
149	Y	Y	Y	Y	N	Y	M0003	F0264			Claim is for a Billing Code that is mutually exclusive with Billing Code for previous Claim				
150															
151	The following edits are not applicable to STAR+PLUS MCO forwarding.														
152	List of Audit Edits In sequence within the server LTC Policy B (History checks NAT Claims)														
153						Active	Edit		Sequence		Complete Description				
154	N/A	N/A	N/A	N	N/A	Y	H0003	F0168			Claim denied because Trainee has already completed the full training course.				
155	N/A	N/A	N/A	N	N/A	Y	H0004	F0169			Claim denied because Trainee has not completed the full training course.				

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
156	N/A	N/A	N/A	N	N/A	Y	H0014	F0253			A completed NAT training course has been billed for earlier dates				
157	N/A	N/A	N/A	N	N/A	Y	H0020	F0257			An incomplete NAT training course has been billed for later dates				
158	N/A	N/A	N/A	N	N/A	Y	H0015	F0254			Only one incomplete training course per trainee is allowed for NAT				
159	N/A	N/A	N/A	N	N/A	Y	H0016	F0255			Failed skills test previously paid for this trainee				
160	N/A	N/A	N/A	N	N/A	Y	H0017	F0256			This NAT service has been paid the maximum number of times				
161	N/A	N/A	N/A	N	N/A	Y	H0018	F0259			Failed oral test previously paid for this trainee				
162	N/A	N/A	N/A	N	N/A	Y	H0019	F0260			Failed written test previously paid for this trainee				
163	N/A	N/A	N/A	N	N/A	Y	H0005	F0170			Trainee has already passed a Skills Test.				
164	N/A	N/A	N/A	N	N/A	Y	H0006	F0171			Trainee has not previously passed a Skills Test.				
165	N/A	N/A	N/A	N	N/A	Y	H0007	F0172			Trainee has previously passed a Written or Oral Examination.				
166	N/A	N/A	N/A	N	N/A	Y	H0008	F0173			Trainee has previously passed a Written or Oral Examination.				
167															
168											The following edits were analyzed separately and the highlight green will impact STAR+PLUS MCO forwarded claims.				
169											List of Edits sequencing within Pricing server (Pricing edits will be executed after all LTC policy edits)				
170						Active	Edit		Sequence		Complete Description				Comment/Details
171	Y	Y	Y	Y	N	Y	P0002	P0012			Provider has been placed on hold.				
172	N/A	N/A	N/A	N	N	Y	F0002	F0189			Amount of claim exceeds available budget.				
173	N/A	N/A	N/A	N	N	Y	F0007	F0228			Units on claim exceeds available budget				
174	N/A	N/A	N/A	N	N	Y	F0008	F0258			Amount of claim exceeds available budget.				
175	N/A	N/A	N/A	N	N	Y	F0004	F0231			Procedure Rate Not Found (Procedure rate not found edit)				
176	N/A	N/A	N/A	N	N	Y	F0005	F0230			County Rate Not Found(County rate not found edit) - Checked for Contract Rate or County Rate				
177	Y	N	Y	Y	Y	Y	F0006	F0229			Rate not found				
178	N/A	N/A	N/A	N	N	Y	I0015	F0265			This claim is approved to pay (PAD/EXP)				
179	Y	Y	Y	Y	N	Y	I0012	F0238			This line item is approved to pay				
180	Y	N/A	N/A	Y	Y	Y	I0019	F0309			Allowed amount determined using billed unit rate as entered on claim, not to exceed Medicare-approved rate.				Medicare Part C/OI TOC M
181	Y	Y	Y	Y	N	Y	F0001	F0187			No units available from client Service Authorization(Service Authorization Units available > 0 Edit)				
182	Y	Y	Y	Y	N	Y	I0007	F0225			Units billed exceeds allowable units for this client(Service Authorization Units available > Billed units info only edit)				

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
3	Applicable to SG1/SC3 FFS?	Applicable to Add-on FFS?	Applicable to SG1/SC1 for FFS?	MCO Applicable Edit?	TMHP Run for Forwarded Claim?	Active	Edit	EOB	Sequence	Routine Number	EOB Description	Where Run	Runs for SG/SC Combinations	Exception SG/SC	Comment/Details
183	Y	N/A	Y	Y	Y	Y	I0008	F0224			Applied Income amount exceeds claim line item amount				
184	N/A	N/A	N/A	N	N	Y	I0010	F0222			Co-Payment amount exceeds claim line item amount				
185	Y	Y	Y	Y	N	Y	F0019	F0307			Client has OI coverage that is missing from claim and must be billed prior to Medicaid. See the client's MESAV for OI and resubmit. (Missing OI edit)				Cost Avoidance
186	Y	Y	Y	Y	N	Y	F0020	F0308			Provider stated unacceptable OI disposition reason.(Invalid OI disposition reason edit)				Cost Avoidance
187	Y	N/A	N/A	Y	Y	Y	F0016	F0303			Client is not eligible for Medicare benefits. See the client's MESAV for Medicare eligibility details.				Cost Avoidance
188	Y	N/A	N/A	Y	Y	Y	F0018	F0305			Service dates billed are not consistent with entered Medicare Part A Total Amount.				Cost Avoidance
189	Y	N/A	N/A	Y	Y	Y	F0017	F0304			Client is enrolled in a Medicare Part C Advantage Plan (MAP) contracted with HHSC to cover all cost sharing obligations. See the client's MESAV for Medicare and				Cost Avoidance
190	Y	Y	Y	Y	Y	Y	I0020	F0310			Allowed amount reduced by the client's applied income and amount indicated as paid by other insurance.				Cost Avoidance
191	N/A	N/A	N/A	N	N	Y	F0007	F0228			Units on claim exceeds available budget (Units do not				
192	N/A	N/A	N/A	N	N	Y	F0008	F0258			Amount of claim exceeds available budget.(Paid amount does not exceed budget edit)				
193	N/A	N/A	N/A	N	N	Y	I0009	F0223			Amount reduced, billed amount is greater than maximum allowed(Billed amount <= Paid amount info only edit)				
194	Y	Y	Y	Y	Y	Y	I0013	F0239			Claim line item paid amount differs from claim line item billed amount(Billed amount not equal paid amount info only edit)				

	Pricing Edit	Description	Current Action	Apply to Forwarded Claims?	EOB Number	EOB Description	HCP01 Code	HCP01 Description	Paid Amount
1	F0006	Rate Not Found	Deny Detail - will not be able to price claim	Run for forwarded claims. If this edit fails, indicate zero in detail paid amount.	F0229	Rate Not Found	00	Zero Pricing (Not Covered Under Contract)	\$0.00
2	I0019	Allowed amount determined using billed rate, not to exceed Medicare approved rate. (SG1/SC3 only)	Informational Edit; Results in Detail Cutback	Run for forwarded claims. Determine if Medicare Approved Rate exceed the Billed Rate.	F0309	Allowed amount determined using billed rate, not to exceed Medicare approved rate.	02	Adjustment Pricing	Paid amount is calculated using the lesser of Medicare approved rate or Billed rate.
3	I0008	Applied Income amount exceeds detail amount	Informational Edit; Results in Detail Cutback	Run for forwarded claims. Apply Applied Income Reduction to Paid Amount. Results in zero paid amount.	F0224	Applied Income amount exceeds claim line item amount.	14	Adjustment Pricing	\$0.00
4	F0016	Client is not eligible for Medicare benefits. (SG1/SC3 only)	Deny Detail - will not be able to price claim	Run for forwarded claims. If this edit fails, indicate zero in the detail paid amount.	F0303	Client is not eligible for Medicare benefits	00	Zero Pricing (Not Covered Under Contract)	\$0.00
5	F0018	Service dates billed are not consistent with medicare Part A Total Amount. (SG1/SC3 only)	Deny Detail - will not be able to price claim	Run for forwarded claims. If this edit fails, indicate zero in the detail paid amount.	F0305	Service dates billed are not consistent with medicare Part A Total Amount. (SG1/SC3 only)	00	Zero Pricing (Not Covered Under Contract)	\$0.00
6	F0017	Client is enrolled in Medicare Part C Advantage Plan (SG1/SC3 only)	Deny Detail - will not be able to price claim	Run for forwarded claims. If this edit fails, indicate zero in the detail paid amount.	F0304	Client is enrolled in Medicare Part C Advantage Plan (MAP) contracted with HHSC to cover all cost sharing obligations. See the client's MESA for Medicare and Medicaid eligibility details.	00	Zero Pricing (Not Covered Under Contract)	\$0.00
7	I0020	Other Insurance Cutback	Informational Edit; Results in Detail Cutback	Run for forwarded claims. Apply Other Insurance Reduction to Paid Amount.	F0310	Allowed amount reduced by the client's applied income and amount indicated as paid by other insurance.	14	Adjustment Pricing	Paid Amount is reduced by the Other Insurance amount on the detail.
8	I0013	Billed amount is not equal to Paid Amount (fixed rates). (This will happen when Billed Unit Rate is different than Allowed Unit Rate. This could also reflect changes due to AI or Other Insurance.)	Informational Edit; Results in Detail Cutback/Increase	Run for forwarded claims. Apply Reduction/Increase to Paid Amount.	F0239	Claim line item paid amount differs from claim line item billed amount.	14	Other Pricing	Paid Amount reflects all reductions.
9	None	Detail paid as billed with no reductions.	Run for non-forwarded claims. No reduction or increase to Paid Amount.	Run for forwarded claims. No reduction or increase to Paid Amount.	N/A	N/A	02	Priced at the Standard Fee Schedule	Paid Amount equals Billed Amount.
10	System Err	Any system problem will suspend the claim. For example: Call to MODS EDI is not successful	Suspend Claim *may not be able to price claim	If there is a system error, indicate zero in detail paid amount.	N/A	N/A	00	Zero Pricing (Not Covered Under Contract)	\$0.00
11	Add-Ons-	N/A	N/A	N/A	N/A	N/A	BLANK		\$0.00