Palmetto GBA Smart Edits

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Line Number	Smart Edits #	Smart Edits Message	Smart Edits Description
1.	001PPRM	The current claim line contains HCPCS J code **XXXXX** and the submitted charge is greater than or equal to $10,000.00. The claim line should be reviewed for potential overpayment.	(001PPRM) J Code with Billed Amount Greater Than 10,000 The 001PPRM System Rule identifies claim lines submitted with a procedure code beginning with 'J' and the billed amount is greater than or equal to $10,000.00.
2.	012F	Per Medicare Guidelines, Code **XXXXX** has not met the coverage criteria for NCD 20.8.3, Article A54831.	(012F) Cardiac Pacemakers The 012F edit fires when the diagnosis and modifier criteria for the submitted code is not met.
3.	032POVP	This claim line has a radiology CPT code in the same body area as a radiology procedure code on this claim. Please review for appropriate payment.	(032POVP) Multiple Radiology Different Claim The 032POVP System Rule identifies claim lines with multiple radiology procedures for the same body area.
4.	061POVP	The E/M code **XXXXX** on this claim line is billed in addition to another E/M code. The billing provider should bill one E/M code per patient per day. Please review for payment accuracy.	(061POVP) Multiple Different E&M Codes on Same Day for Same Rendering Provider The 061POVP System Rule identifies claims when multiple E/M codes are submitted on the same date of service.
5.	062OVP	This claim line contains Radiology CPT Code **XXXXX** submitted with a 26 modifier. The same code and modifier was found billed by a separate servicing provider for the same date of service.	(062OVP) Radiology Modifier 26 Two Providers The 062OVP System Rule identifies claim lines when the same radiology service is submitted by two different servicing providers.
6.	062POVP	This claim line contains Radiology CPT Code **XXXXX** submitted with a 26 modifier. The same code and modifier was found billed by a separate servicing provider for the same date of service.	(062POVP) Radiology Service Submitted by Two Different Providers The 062POVP System Rule identifies claim lines when the same radiology service is submitted by two different servicing providers.
7.	069POVP	Only one EM charge should be billed per visit. *This claim line should be reviewed because another EM charge has been submitted for a consecutive date.*	(069POVP) E&M Codes on Separate Consecutive Days for Same Rendering Provider The 069POVP System Rule identifies E/M services submitted by the same servicing provider on consecutive days.
8.	ADR	**JJ:** Palmetto GBA is pending response from your agency for an ADR for one or more claims. Please refer to your ADR letter(s) for more details. Please see link https://www.palmettogba.com/palmetto/jjb.nsf/DIDC/ASNPH36180~Medical%20Review~Targeted%20Probe%20and%20Educate **JM:** Palmetto GBA is pending response from your agency for an ADR for one or more claims. Please refer to your ADR letter(s) for more details. Please see link https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/ASNPH36180~Medical%20Review~Targeted%20Probe%20and%20Educate	(ADR) Additional Documentation Request An informational message received when a submitter is non-responsive to a Postpayment Review Medical Review ADR Letter. MR ADR Response Forms are available as a self-service tool function via eServices.
		RR: Upon request, providers are required to submit medical record documentation. Palmetto GBA is pending response from your agency for a medical record request. Use the link below to identify requested medical records https://www.palmettogba.com/palmetto/rr.nsf/DIDC/8M4JMB3760~Medical%20Review	(ADR-RR) Medical Review Documentation Request The ADR edit identifies services submitted which have been deemed to require additional-medical records documentation
9.	ANE	Procedure **XXXXX** was billed by a provider not listed as an Anesthesiology provider.	(ANE) Anesthesia Performed by Non-Anesthesia Provider The ANE System Rule identifies claim lines with anesthesia procedure codes and a provider specialty NOT present in the Anesthesia Provider Specialty List of "05" (Anesthesiology), "32" (Anesthesiologist Assist), or "43" (CRNA).
10.	APSURV	**JJ & JM Part B:** Your feedback is important to us. Please visit our website to complete our Palmetto GBA redetermination online survey at https://bit.ly/3JiDS0Z.	(APSURV) JJ.JM Appeals Survey The APSURV edit sends an informational message to providers who have also received another message regarding the Redetermination Status Tool. The APSURV message informs the provider world that an appeals survey is available for them online.

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11.	ASD	An anesthesia service with an equal or higher base unit value than **XXXXX** was billed on **mm/dd/yyyy**. Only the anesthesia code with the higher base unit value should be billed per operative session.	(ASD) Anesthesia Secondary Procedure The ASD System Rule identifies anesthesia related claims by a Type of Service "7" (Anesthesia) OR by an anesthesia provider specialty of "05" (Anesthesiology), "32" (Anesthesiologist Assist), or "43" (CRNA). The rule then identifies whether or not more than one anesthesia procedure code was billed for the same date of service. The code with the highest base unit is allowed.
12.	ASH	An anesthesia service with lower base unit value than **XXXXX** was billed on **mm/dd/yyyy**. Only the anesthesia code with the higher base unit value should be billed per operative session.	(ASH) Anesthesia Secondary Procedure in History -- (History Edit) The ASH System Rule identifies claim lines in the patient's history which should have been flagged by the ASD edit.
13.	BAG	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Age relationship criteria for CMS ID(s) **XXXX**.	(BAG) LCD Part B Procedure Not Typical with Patient Age The BAG edit identifies claims containing CPT codes that can only be performed with a specified age per LCD/NCD
14.	BCC	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Code-to-Code relationship criteria for CMS ID(s) **XXXXX**.	(BCC) LCD Part B Code to Code Missing or Invalid The BCC edit identifies claim lines that do not meet an LCD policies requirement for a code to code relationship.
15.	BDS	The beginning or ending Date of Service (DOS) is invalid or missing.	(BDS) Missing or Invalid Date of Service The BDS System Rule identifies claim lines where the Date of Service is missing or invalid.
16.	BFR	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Frequency relationship criteria for CMS ID(s) **XXXXX**.	(BFR) LCD Part B Procedure Frequency Exceeded The BFR edit identifies a claim where a procedure code has been billed that exceeds frequency requirements for the policy.
17.	BPO	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Place of Service relationship criteria for CMS ID(s) **XXXXX**.	(BPO) LCD Part B Invalid Place of Service The BPO edit identifies claims containing CPT codes that can only be performed in specified Place(s) of Service per LCD/NCD policy.
18.	BPS	The place of service is missing or invalid.	(BPS) Missing or Invalid Place of Service The BPS System Rule verifies the place of service (POS) code submitted on each claim line against the CMS Place of Service list found in the Code Repository.
19.	BSP	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Provider Specialty relationship criteria for CMS ID(s) **XXXXX**.	(BSP) LCD Part B Missing or Invalid Provider Specialty The BSP edit identifies claim lines that the provider specialty does not meet an LCD policies requirement.
20.	BSX	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Gender relationship criteria for CMS ID(s) **XXXXX**	(BSX) LCD Part B Missing or Invalid Patient Gender The BSX edit identifies claims containing CPT codes that can only be performed on a specific gender per LCD/NCD.
21.	C19CSN	Per Medicare Guidelines, Code **XXXXX** should not be submitted with Modifier CS.	(C19CSN) Modifier CS Coverage The C19CSN edit fires when Modifier CS is submitted but not valid for the service.
22.	C19OTCF	**XXXXX** has exceeded the maximum allowed of 8 COVID-19 OTC tests in a calendar month.	(C19OTCF) COVID-19 Over The Counter Tests Frequency Exceeded The C19OTCF edit fires to identify claim lines of COVID-19 OTC tests which exceed the allowable 8 tests per beneficiary in a calendar month
23.	C19p734	**XXXXX** is non-covered by Part B when submitted in Place of Service **XX**. Please submit to the correct payer/contractor.	(C19p734) Inappropriate Place of Service The C19p734 edit fires when a service is submitted in an inappropriate place of service.
24.	CAG	Procedure Code **XXXXX** is not typical for a patient whose age is **XX**. The typical age range for this procedure is **YY - XX.**	(CAG) Procedure Not Typical with Patient Age The CAG System Rule identifies claim lines that contain a patient's age not typical for the procedure code.

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25.	**CAR**	**JJ:** Improve your services and patient outcomes; your practice is being encouraged and advised to review the Palmetto GBA article entitled "Cardiovascular Disease and Intensive Behavioral Therapy" using the following URL https://tinyurl.com/yxpunbye **JM:** Improve your services and patient outcomes; your practice is being encouraged and advised to review the Palmetto GBA article entitled "Cardiovascular Disease and Intensive Behavioral Therapy" using the following URL https://tinyurl.com/y286eeq2	(CAR) Cardiovascular Behavioral Therapy Informational Message to help providers with Cardiovascular Intensive Behavioral guidelines
26.	**CAT**	Procedure Code **XXXXX** is not allowed when performed by an optometrist. Exception: For post-operative care only, review our CPT Modifier 55 website article to determine if it is appropriate for this procedure.	(CAT) Optometrist Cannot Bill Service without 55 Modifier Determines when an Optometrist (NPI) bills certain services without a 55 modifier.
27.	**CDL**	Procedure Code **XXXXX** has been deleted as of **mm/dd/yyyy**.	(CDL) Deleted Procedure Code The CDL System Rule identifies claim lines that contain a CPT/HCPCS code that has been deleted.
28.	**CPT**	Procedure code **XXXXX** is invalid.	(CPT) Invalid Procedure Code The CPT System Rule identifies claim lines that do not contain a valid procedure code. A valid procedure code is one that is present in the system and is effective.
29.	**CSX**	Procedure code **XXXXX** is not typically performed for a patient whose gender is **X.**	(CSX) Procedure Not Typical with Patient Gender The CSX System Rule identifies claim lines that contain a patient's gender not typical for the procedure code.
30.	**DCP**	This line is a possible duplicate of a claim performed by the same provider on the same day.	(DCP) ACE Duplicate Claim by Provider The DCP System Rule identifies claim lines that are a possible duplicate of another claim line on a separate claim in the patient's history.
31.	**DEP**	**JJ:** Improve your services and patient outcomes; your practice is being encouraged and advised to review the Palmetto GBA article entitled "Annual Depression Screening: HCPCS Code G0444" using the following URL https://tinyurl.com/y22cn4uv **JM:** Improve your services and patient outcomes; your practice is being encouraged and advised to review the Palmetto GBA article entitled "Annual Depression Screening: HCPCS Code G0444" using the following URL https://tinyurl.com/yxjcrelb	(DEP) Depression Screening Informational Message to help providers with Annual Depression screening guidelines
32.	**DLP**	This line is a possible duplicate of another line billed by the same provider for the same date of service on this claim.	(DLP) ACE Duplicate Line by Provider The DLP System Rule identifies claim lines that are a possible duplicate of another claim line on the same claim.
33.	**DME**	Per the DMEPOS Jurisdiction List, code **XXXXX** should be submitted to the DME Medicare Administrative Contractor (MAC).	(DME) Durable Medical Equipment The DME edit will set when a DME code is submitted to Part B
34.	**DOB**	Patient's Date of Birth is missing or invalid.	(DOB) Missing or Invalid Date of Birth The DOB System Rule identifies claim lines where the Date of Birth is missing or is prior to the date of service.
35.	**DOC**	Code **XXXXX** may require additional documentation for processing. Review to determine if additional documentation should be submitted. **OR** A submitted modifier may require additional documentation for processing. Review to determine if additional documentation should be submitted.	(DOC) Procedure Code Requires Documentation A code or modifier requires documentation for processing and documentation is not submitted. For more information, select the appropriate link: JM JJ RR Mod 52 RR Mod 53
36.	**DTU**	Discrepancy detected between the number of units **XXXXX** on this claim line and the difference between the Beginning DOS mm/dd/yyyy and the Ending DOS mm/dd/yyyy which is XX days.	(DTU) Date of Service to Units Discrepancy The DTU System Rule identifies claim lines where the number of units entered is not equal to the date span starting from Beginning DOS to the Ending DOS.

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37.	**eCS**	Claim status is available as a self-service option via the Claims tab in the eServices portal. We recommend submitters utilize this method. Please visit the eServices homepage at PalmettoGBA.com for eServices registration and claim status instructions.	(eCS) Claim Status Inquiries An informational message received when a submitter calls the Provider Contact Center for self-service tool functions that can obtained via eServices or the IVR.
38.	**eELG**	Eligibility is available for self-service retrieval via the Eligibility tab in the eServices portal. We recommend submitters utilize this method. Please visit the eServices homepage at PalmettoGBA.com for eServices registration and eligibility instructions.	(eELG) Eligibility Inquiries An informational message received when a submitter calls the Provider Contact Center for self-service tool functions that can obtained via eServices or the IVR.
39.	**EMT**	You have been identified as billing E/M 99214-15 at a higher rate than your peers. Consider performing a self-audit to ensure you are in compliance with guidelines for billing these codes. Go to PalmettoGBA.com and search CBR.	(EMT) Evaluation and Management An informational message the provider will receive when it is determined the provider is billing at a higher rate than his/her peers.
40.	**EMTA**	You have been identified as billing E/M 99204-05 at a higher rate than your peers. Consider performing a self- audit to ensure you are in compliance with guidelines for billing these codes. Go to PalmettoGBA.com and search CBR.	(EMT) Evaluation and Management An informational message the provider will receive when its determined the provider is billing at a higher rate than his/her peers.
41.	**eServices**	It's Never Been Easier To Get Eligibility, Claim Status, and So Much More With eServices at www.palmettogba.com/eservices	(eServices) Claim Status, Eligibility Inquiries, etc. An informational message received when a submitter calls the Provider Contact Center for information that can be obtained via PalmettoGBA.com.
42.	**f17**	The procedure code / modifier combination is a non-covered service.	(f17) Ambulance Services Submitted with Modifier QL The f17 edit will set when an ambulance service (A0425-A0427, A0432-A0436) is submitted with Modifier QL.
43.	**f27**	Records indicate the patient has received care by Provider XXX within the last 3 years. Please review to see if an established patient code is more suitable. **XXXXX** was billed for date of service xx/xx/xxxx.	(f27) New Patient Code Billed for an Established Patient The f27 edit will set when the patient history indicates the patient has been seen by the same provider within 3 years of the current claim line's beginning date of service.
44.	**f30**	Procedure Code **XXXXX** should not be submitted with Modifier 59, XE, XP, XS or XU. Procedure Code **XXXXX** should not be submitted with Modifier 59 and Modifier XE, XP, XS or XU.	(f30) Services Submitted with Modifier 59, XE, XP, XS, XU The f30 edit will set when a code/modifier combination is not valid.
45.	**f31**	Code **XXXXX** has not been deemed a medical necessity. Please review the diagnosis for coverage requirements.	(f31) Services Submitted without a Covered Diagnosis Code The f31 edit will set when a covered diagnosis is submitted
46.	**f35**	Per NCD 160.7, the billing guidelines for Code L8679 have not been met. Please review.	(f35) Code L8679 Billed without Covered Services The f35 edit will set when Code L8679 is submitted without a covered surgical service.
47.	**f37**	Code **XXXXX** is non-covered when submitted in Place of Service **XX**. Please Review	(f37) Inpatient-Only Codes The f37 edit will set when an inpatient code is submitted in Place of Service 11 or 12
48.	**f40**	Place of Service **XX** is an inappropriate place of service for **XXXXX**	(f40) Code L8679 Billed in Place of Service 12 The f40 edit will set when code L8679 is submitted with Place of Service 12.
49.	**f42**	The service has not been deemed a medical necessity. Please review.	(f42) Code Billed with Non-Covered Diagnosis The f42 edit will set when a procedure code is submitted with a non-covered diagnosis code.
50.	**f57**	A required laterality modifier is missing	(f57) Service Submitted without Laterality Modifier LT, RT or 50 The f57 edit will set when required modifier LT, RT or 50 is not submitted
51.	**f65**	Code **XXXXX** is a gender-specific service. **X** is an inappropriate Gender. The patient is ineligible for this service. Please review.	(f65) Gender Specific Services The f65 edit will set when a gender-specific service is submitted with an inappropriate patient gender.
52.	**f69**	Code **XXXXX** has exceeded the allowable amount of services for the time period. Please review	(f69) Denial of Cognitive Assessment and Care Plan Services - Frequency The f69 edit will set when an assessment and care plan has been submitted more than once within 180 days.

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53.	**G13**	Learn how to become a Railroad Medicare provider today! Get all the facts at www.PalmettoGBA.com/RR/PE	(G13-RR) PE Education G13 is a Provider Enrollment edit which directs certain providers to a link where they can receive education on PE requirements.
54.	**G61**	Avoid denials and rejections. Sign up for Railroad Medicare electronic billing today at www.PalmettoGBA.com/RR/EDI	(G61-RR) EDI Misroutes This edit identifies and educates providers whose specific claim denials or rejections may be avoided if claims are billed electronically.
55.	**H7Y**	Avoid Rejections! Verify if your provider is enrolled before filing your claim with our PTAN Lookup & Request Tool at www.PalmettoGBA.com/RR/PTAN	(H7Y-RR) PTAN Lookup & Request Tool This edit sets to remind submitters to verify a provider's enrollment status (specifically PTAN) as well as ensure the PTAN is active and valid.
56.	**ICD**	• The diagnosis **XXXXX** is invalid. • The diagnosis **XXXXX** is disabled.	(ICD) 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.
57.	**IDL**	• Dx **XXXXX** has been deleted.	(IDL) Deleted Diagnosis Code The IDL System Rule identifies claim lines where the submitted diagnosis code is no longer valid and has been deleted.
58.	**IDX**	Code **XXXX** is an incomplete diagnosis code and requires an additional character(s).	(IDX) Nonspecific Diagnosis Code The IDX System Rule identifies claim lines that contain a diagnosis code requiring a 4th or 5th digit for appropriate specificity.
59.	**IMC**	Modifier **XX** is invalid with **XX** and cannot be submitted on the same claim line.	(IMC) Inappropriate Modifier Combination The IMC edit identifies claim lines that contain modifiers that cannot be on the same claim line together.
60.	**IMO**	Modifier **XX** is invalid.	(IMO) Invalid Modifier Code The IMO System Rule validates the modifier codes on a claim line against the modifiers found in the Code Repository to make sure they are present and valid.
61.	**INC2**	Per Medicare guidelines, Procedure Code **XXXXX** is a service covered incident to a physician's service and modifier 26 or TC is not appropriate.	(INC2) Incident-To Services The INC2 edit fires when an incident-to service is submitted with modifier 26 or TC.
62.	**INFO**	A potential coding error was identified with this claim. Please see STC 2220D Loop for specific information. If you wish to continue without updates, please resubmit the claim in its current state to bypass additional SmartEditing.	(INFO) Informational Edit An informational message the submitter will receive when a review flag sets on a claim.
63.	**ISX**	Diagnosis code(s) **XXXXX** is not typical for a patient whose gender is **X**.	(ISX) Diagnosis Not Typical with Patient Gender The ISX System Rule identifies claim lines that contain a diagnosis code not typical for a patient's gender.
64.	**LBI**	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Diagnosis Code relationship criteria for CMS ID(s) **XXXXX**.	(LBI) LCD Part B Missing or Invalid Diagnosis The LBI is issued if a diagnosis code does not meet guidelines for a policy with non-sequenced diagnosis codes.
65.	**LBM**	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Modifier Code relationship criteria for CMS ID(s) **XXXXX**.	(LBM) LCD Part B Missing Required Modifier This edit identifies claims containing CPT codes that require a modifier per LCD/NCD guidelines.
66.	**LBP**	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Primary Diagnosis Code relationship criteria for CMS ID(s) **XXXXX**.	(LBP) LCD Part B Missing Required Primary Diagnosis The LBP is issued when a diagnosis code is required to be in a primary position and it is not or if the diagnosis in the primary position is not covered and the policy has sequencing requirements.

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67.	**LBS**	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Secondary Diagnosis Code relationship criteria for CMS ID(s) **XXXXX**.	(LBS) LCD Part B Missing Required Secondary Diagnosis The LBS is issued when the primary sequencing is met, and the diagnosis in the secondary position does not meet the secondary sequencing requirements.
68.	**LBT**	Per LCD or NCD guidelines, procedure code **XXXXX** has not met the associated Tertiary Diagnosis Code relationship criteria for CMS ID(s) **XXXXX**.	(LBT) LCD Part B Missing Required Tertiary Diagnosis The LBT is issued when the primary sequencing is met, and the diagnosis in the tertiary position does not meet the tertiary sequencing requirements.
69.	**LPR**	Repeat lab procedure **XXXXX** may require a repeat modifier.	(LPR) Repeat Lab Procedure The LPR System Rule identifies claim lines where a repeat laboratory procedure is submitted without an Unbundle Lab Override modifier.
70.	**LPRS**	Repeat lab procedure **XXXXX** may require a repeat modifier.	(LPRS) Same Claim Repeat Lab Procedure The LPRS System Rule identifies claim lines where a repeat laboratory procedure is submitted without an Unbundle Lab Override modifier.
71.	**mAM**	Per Medicare guidelines, HCPCS Code **XXXXX** is identified as an ambulance code and requires an ambulance modifier appended.	(mAM) Medicare Ambulance Modifiers Per Medicare, ambulance HCPCS codes require an ambulance modifier. This edit will fire if an ambulance modifier is not included.
72.	**mANM**	Anesthesia code on this line requires an appropriate modifier.	(mANM) Medicare Anesthesia Modifiers The mANM edit will analyze all claim lines to determine if an anesthesia code has been billed without an appropriate anesthesia modifier appended to the line.
73.	**mAS**	Medicare statutory payment restriction for assistants at surgery applies to the procedure **XXXXX**.	(mAS) Medicare No Payment for Assistant Surgeons The mAS edit identifies claim lines that contain an assistant surgeon modifier and a procedure code that Medicare typically does not allow reimbursement for surgical assistants.
74.	**mAT**	Per Medicare guidelines procedure code **XXXXX** requires modifier GP, GO, or GN.	(mAT) Medicare Always Therapy The mAT edit fires when a therapy procedure code is submitted and required modifier GP, GO or GN is not on the detail line.
75.	**mAWF**	Per Medicare, this service is covered once in a lifetime.	(mAWF) Medicare Once In A Lifetime The mAWF edit identifies procedures that are only covered once in a lifetime.
76.	**mAWP**	Service occurred within a year of an initial preventive physical exam.	(mAWP) Medicare Annual Wellness Visit Within a Previous Initial Preventive Physical Examination The mAWP edit identifies services that occurred within a year of an initial preventive physical exam.
77.	**mAWS**	Service occurred within a year of last covered annual wellness visit.	(mAWS) Medicare Annual Wellness Visit Within a Previous Annual Wellness Visit. The mAWS edit identifies an annual wellness visit has been submitted and another annual wellness visit is in history.
78.	**MBI**	Medicare will only accept MBIs after December 31, 2019. Use our eServices portal if your patients do not have their Medicare cards at the time of service. Please visit www.PalmettoGBA.com for eServices registration and Lookup Tool instructions.	(MBI) Medicare Beneficiary Identifier The MBI rule identifies claims that are not submitted with a MBI.
79.	**mCO**	Billing for co-surgeons is not permitted for the procedure **XXXXX**.	(mCO) Medicare Co-Surgeons Not Permitted The mCO edit identifies claim lines that contain a co-surgeon modifier and a procedure code that Medicare typically does not allow reimbursement for co-surgeons.
80.	**mDP**	Procedure Code **XXXXX** is within the global period of **XX** days of History Procedure Code **YYYYY** performed on **mm/dd/yyyy** by the same provider. The diagnosis indicates it is not for the same condition. Please review to determine if a modifier is appropriate.	(mDP) Medicare Post-Op Unrelated Service by Provider If a Medicare E/M procedure code was submitted within the Follow-up days determined for services by the same provider, same department and specialty for a different diagnosis code then the mDP edit is fired.

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81.	**mDT**	Per the Medicare Physician Fee Schedule, Procedure Code **XXXXX** describes a diagnostic procedure that requires a professional component modifier in this POS **XX**.	(mDT) Medicare Diagnostic Testing in a Hospital Setting The mDT edit identifies claim lines which have procedure codes that are diagnostic tests performed in an Inpatient or Outpatient hospital or skilled nursing setting. When a provider is billing these services in an Inpatient or Outpatient hospital or skilled nursing setting, only the professional component should be billed (modifier 26).
82.	**mEM**	• E/M code **XXXXX** should not be billed on the same date of service as a minor procedure without an appropriate modifier. • E/M code **XXXXX** should not be billed without an appropriate modifier on the same date of service as a minor procedure. • E/M code **XXXXX** should not be billed on the same date of service or one day prior to a major procedure without an appropriate modifier. • E/M code **XXXXX** should not be billed without an appropriate modifier on the same date of service or one day prior as a major procedure.	(mEM) Medicare E/M and Surgery without Modifier The mEM edit identifies claim lines where an E/M code is billed without modifier 25 on the same DOS as a minor surgical procedure, or billed without modifier 57 on the same DOS or one day before a major surgical procedure.
83.	**mEPG**	Evaluative procedure code **XXXXX** requires the reporting of one or more functional G-codes, G8978-G8999, G9186, G9158-G9176.	(mEPG) Therapy Evaluation Codes without Reporting G-Codes The mEPG edit identifies evaluative or re-evaluative procedure codes that are billed without the appropriate nonpayable functional reporting G-codes.
84.	**mFD**	Procedure Code **XXXXX** is within the global period of **XX** days of History Procedure Code **YYYYY** performed on **mm/dd/yyyy** by a provider from the same department and specialty as the current line billing provider. Review to determine if a modifier is appropriate.	(mFD) Medicare Global Follow-Up by Department/Specialty The mFD Medicare Rule identifies claim lines where an E/M procedure code was submitted within the Follow-up days determined for services by a different provider, same department and specialty for the same diagnosis code.
85.	**MFD**	Procedure Code **XXXXX** with an allowed daily frequency of X has been exceeded by **X** for date of service **XX/XX/XXXX**.	(MFD) Typical Daily Frequency Exceeded The MFD edit fires when the typical frequency for a procedure code has been exceeded.
86.	**MFDS**	Procedure Code **XXXXX** with an allowed daily frequency of X has been exceeded by **X** for date of service **XX/XX/XXXX**.	(MFDS) Same Claim Typical Daily Frequency Exceeded The MFDS edit fires when the typical frequency for a procedure code has been exceeded.
87.	**mFL**	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code **XXXXX** is missing or invalid.	(mFL) Medicare Influenza Vaccine New rule to capture the submission of Influenza administration and vaccine procedure codes without the required diagnosis code per CMS guidelines.
88.	**mFP**	Procedure Code **XXXXX** is within the global period of procedure code **YYYYY**. The diagnosis indicates it is for the same condition. Please review to determine if a modifier is appropriate.	(mFP) Medicare Global Follow-Up by Provider The Medicare E/M Global Follow-Up System rule determines whether an E/M service was billed within the follow-up period of a prior service. If a Medicare E/M procedure code was submitted within the Follow-up days determined for services by the same provider, department and specialty with the same diagnosis code then mFP edit is fired.
89.	**mGT**	Per the Medicare Physician Fee Schedule, Procedure **XXXXX** describes the global code of a service or diagnostic test. Use of modifier **XX** is inappropriate for this procedure code.	(mGT) Medicare Global Test Only The mGT Medicare Rule identifies claim lines which have stand-alone global diagnostic test codes and the modifier 26 or TC are attached, this is indicated by the PC/TC Indicator of 4. Modifiers 26 and TC are inappropriate with these codes.
90.	**mHB**	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code **XXXXX** is missing or invalid.	(mHB) Medicare Hepatitis B Vaccine New rule to capture the submission of Hepatitis B administration and vaccine procedure codes without the required diagnosis code per CMS guidelines.
91.	**mI10**	Per CMS guidelines ICD-9 codes and ICD-10 codes cannot be billed on the same claim.	(mI10) Medicare ICD10 Code Rule The mI10 flag will set if ICD-9 and ICD-10 codes are submitted on the same claim.
92.	**mI9**	Per CMS guidelines ICD-9 codes cannot be billed with dates of service greater than September 30, 2015	(mI9) Medicare ICD9 Code Rule The mI9 edit identifies one of the following situations has occurred: 1. DOS is 10/1/15 and after, diagnosis qualifier is ICD-9 with an ICD-9 diagnosis code 2. DOS is 10/1/15 and after, diagnosis qualifier is ICD-9 with an ICD-10 diagnosis code

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Line Number	Smart Edits #	Smart Edits Message	Smart Edits Description
93.	**mIM**	• Modifier 26 is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule. • Modifier TC is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule. • A Co Surgeon Modifier 62 is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule. • A Team Surgeon Modifier 66 is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule. • An assistant surgeon modifier **XX** is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule. • A Multiple Procedure Modifier 51 is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule. • Modifier 22 is not appropriate for Procedure Code **XXXXX**, as per Medicare Fee Schedule.	(mIM) Medicare Inappropriate Modifier The mIM edit identifies claim lines that contain a modifier that is not appropriate for the given procedure code per the MPFS.
94.	**mIN**	Medicare considers Procedure Code **XXXXX** as a bundled service when other payable services **YYYYY** are billed on the same day by the same provider and department.	(mIN) Medicare Injection Service The mIN edit identifies claim lines that contain on injection service, status indicator of "T" in the MPFS, and a procedure with a status indicator of "A", meaning active; the injection services are deemed not payable by Medicare.
95.	**mMFL**	Per Medicare guidelines, the associated administration code for vaccine procedure code **XXXXX** is missing or invalid.	(mMFL) Medicare Influenza Vaccine New rule to capture the submission of an Influenza vaccine procedure code without the required administration code.
96.	**mMHB**	Per Medicare guidelines, the associated administration code for vaccine procedure code **XXXXX** is missing or invalid.	(mMHB) Medicare Hepatitis B Vaccine New rule to capture the submission of a Hepatitis B vaccine procedure code without the required administration code.
97.	**mMOD**	Per Medicare, use of modifier **XX** is not typical for procedure **XXXXX**.	(mMOD) Medicare Modifier Code Not Typical for Procedure Code The mMOD edit identifies a procedure code(s) that are submitted with a modifier(s) that is not typical for the procedure code.
98.	**mMPN**	Per Medicare guidelines, the associated administration code for vaccine procedure code **XXXXX** is missing or invalid.	(mMPN) Medicare Pneumococcal Vaccine New rule to capture the submission of a Pneumococcal vaccine procedure code without the required administration code.
99.	**mMUE**	Per Medicare's Medically Unlikely Edits, the units of service billed for procedure code **XXXXX** exceed the allowed units.	(mMUE) Medicare Medically Unlikely Edits CMS developed Medically Unlikely Edits (MUEs) to define the maximum units of a service that a provider would report under most circumstances for a single patient on a single date of service. Not all HCPCS/CPT have an assigned MUE. CMS does not publish all MUE's, therefore, this rule edits for only those codes that are made public by Medicare.
100.	**mNP**	Procedure Code **XXXXX** does not typically require performance by a physician in Place of Service XX, per Medicare Guidelines.	(mNP) Medicare Non-Physician Service 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.
101.	**MOD**	Use of modifier **XX** (crosswalks to **XX**), is not typical for procedure **XXXXX**.	(MOD) Modifier Not Appropriate With Procedure The MOD edit identifies claim lines that contain a modifier that is not appropriate for the procedure code.
102.	**MOLDX**	Code **XXXXX** is missing a required Z-Code or the Procedure Code/Z-Code combination is invalid. Please see the MolDX website: https://www.palmettogba.com/moldx	(MOLDX) Molecular Services The MOLDX edit fires when a Procedure Code requires a Z-Code and the Z-Code is missing, or the Procedure Code / Z-Code combination is invalid.

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103.	**MOLDX1**	Code **XXXXX** is missing a required Z-Code or the Procedure / Z-Code combination is invalid. Learn more here: www.tinyurl.com/stk9zxba	(MOLDX1) Molecular Diagnostic Services The MOLDX1 edit fires when a Procedure Code which the ACE system identifies as one which also required the submission of an associated Z-Code, and the Z-Code is missing, or the Procedure Code \ Z-Code combination is considered invalid then.
104.	**mPC**	Per the Medicare Physician Fee Schedule, Procedure **XXXXX** describes the physician work portion of a diagnostic test. Modifier **XX** is not appropriate.	(mPC) Professional Component Only The mPC flag identifies the claim lines which have procedure codes, per the MPFS, a PC/TC indicator of 2, that represent the professional portion of selected diagnostic tests and the 26 or TC modifier is attached. The modifiers 26 or TC are not appropriate. The PC/TC concept does not apply since these services cannot be split into professional and technical components.
105.	**mPDP**	The PD modifier must be billed with the 26 modifier.	(mPDP) 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.
106.	**mPI**	Per the Medicare Physician Fee Schedule, Procedure Code **XXXXX** describes a physician interpretation for this service and is inappropriate in POS **XX**.	(mPI) Medicare Physician Interpretation The mPI Medicare Rule identifies claim lines which have the inpatient professional component of clinical laboratory codes, this is indicated by the PC/TC indicator of 8 in the MPFS, and a non-inpatient place of service is present. Billing of the technical component is inappropriate.
107.	**mPN**	Per Medicare guidelines, a diagnosis code(s), which meets medical necessity for procedure code **XXXXX** is missing or invalid.	(mPN) Medicare Pneumococcal Vaccine New rule to capture the submission of Pneumococcal administration and vaccine procedure codes without the required diagnosis code per CMS guidelines.
108.	**mPS**	Per the Medicare Physician Fee Schedule, the PC/TC concept does not apply to Procedure **XXXXX**. Use of modifier **XX** is inappropriate.	(mPS) 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.
109.	**mPT**	Procedure Code **XXXXX** is a physical therapy service. No payment is made if provided in Place of Service **XX**, per Medicare Guidelines.	(mPT) Medicare Physical Therapy Service The mPT edit identifies claim lines that contain a certain place of service (hospital Inpatient or hospital Outpatient) and a PC/TC status indicator of 7. These procedures are physical therapy and payment is not allowed for these specific places of service, per Medicare.
110.	**mPV**	Per Medicare guidelines, in the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) and its associated administration is not covered.	(mPV) Medicare Preventative Vaccines Per Medicare guidelines, vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered.
111.	**mSB**	Add-on procedure code **XXXXX** has been submitted without an appropriate primary procedure code.	(mSB) Medicare Add-On Procedure without Primary Procedure mSB flag is set when a Medicare claim line has an add-on procedure and no primary procedure has been billed by the same provider on the same claim for the same date of service or when claim line has a One day Add On procedure with primary procedure billed by the same provider on the same claim for the same date of service.
112.	**mSP**	Per Medicare guidelines procedure code **XXXXX** is within the global period of history procedure code **YYYYY** performed on **mm/dd/yyyy** by the same provider. Review documentation to determine if a modifier is appropriate.	(mSP) Medicare Post-Op Surgery By Provider The mSP edit identifies claim lines that contain a date of service and a surgical procedure code that is submitted within the follow-up (global) days of surgical procedure, by the same physician.

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113.	**mSPh**	Per Medicare guidelines procedure code **XXXXX** performed on **mm/dd/yyyy** by the same provider is within the global period of **XXXXX**.	(mSPh) Medicare Post-Op Surgery By Provider The mSPh edit identifies claim lines that contain a date of service and a surgical procedure code that is submitted within the follow-up (global) days of surgical procedure, by the same physician.
114.	**mTC**	Per the Medicare Physician Fee Schedule, Procedure **XXXXX** describes only the technical portion of a service or diagnostic test. Modifier **XX** is not appropriate.	(mTC) Medicare Technical Component Only The mTC Medicare Rule identifies the claim lines which have procedure codes that represent the technical portion of selected diagnostic tests and a 26 or TC modifier is present. The PC/TC concept does not apply since these services cannot be split into professional and technical components.
115.	**mTF**	The date of service is past Medicare timely filing guidelines.	(mTF) Medicare Timely Filing The mTF timely filing rule will fire on claims when submitted past the timely filing requirements established by The Centers for Medicare and Medicaid Services (CMS).
116.	**mTH**	Per Medicare guidelines, procedure code **XXXXX** requires modifier GT or GQ.	(mTH) Medicare Telehealth The mTH edits will fire when a telehealth service is identified and a modifier GQ or GT modifier is not submitted on the detail line.
117.	**mTS**	Team Surgery is not permitted for Procedure **XXXXX**.	(mTS) Medicare Team Surgeons Not Permitted The mTS edit identifies claim lines that contain a team surgeon modifier and a procedure code that Medicare typically does not allow reimbursement for team surgeons.
118.	**mUN**	Per CCI, Procedure Code **XXXXX** has an unbundle relationship with Procedure Code **YYYYY** billed for the same date of service.	(mUN) Unbundled Procedure (as per Medicare) on Separate Claim -- (History Edit) The Medicare Unbundle System Rule verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicare. If there is another procedure in the patient's history which should not be billed with the current line's procedure code, the respective Unbundle flag is fired.
119.	**mUO**	Per CCI, Procedure Code ' **XXXXX** ' has an unbundle relationship with Procedure Code ' **XXXXX** ' billed for the same date of service. Review documentation to determine if a modifier override is appropriate.	(mUO) Unbundled Procedure (as per Medicare) on Current Line, Possible Modifier Override The mUO Medicare Unbundle System Rule verifies if the procedure code on the current line and any other procedure codes billed for the same patient on the same day by the same provider can be billed together, as per Medicare. If there is another procedure in the patient's history which should not be billed with the current line's procedure code, the respective Unbundle flag is fired.
120.	**NPD**	Dx1 **XXXXX** describes an external cause, or requires the ICD code for the first underlying disease, and should never be listed as the primary diagnosis for a procedure.	(NPD) Not a Primary Diagnosis Code The NPD System Rule identifies claim lines that contain a diagnosis code that have been identified as not appropriate as a primary diagnosis.
121.	**NPT**	This patient received care by provider **XXXX** within the last three years. An established patient E/M code should be used. Procedure code **XXXXX** was billed on **XX/XX/XXXX**.	(NPT) New Patient Code Billed for Established Patient Claim History The NPT flag identifies when the patient history indicates the patient has been seen by the same provider or a provider with the same specialty from the same group within 3 years of the current claim line's beginning date of service.
122.	**p004F**	**XXXXX** does not meet medical necessity. Please review.	(p004F) Non-covered Diagnosis Code - Rabies Vaccine The p004F edit fires when a non-covered diagnosis code is submitted
123.	**p008L**	Per NCD 110.4, the diagnosis code submitted is non-covered. Please review	(p008L) Non-covered Diagnosis Code - NCD 110.4 The p008L edit fires when a covered diagnosis is not submitted on the detail line
124.	**p011D**	Place of Service **XX** is non-covered for this procedure. Please review	(p011D) Non-covered Place of Service - NCD 110.4 The p011D edit identifies detail lines submitted with a non-covered place of service.

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125.	**p018F**	p018F: **XXXXX** is missing a required modifier. Please review the submission	(p018F) Modifier Required for some PET Scans The p018F edit fires when certain PET Scan procedure codes are submitted without a necessary modifier.
126.	**p019L**	Per NCD 190.11, the service is not deemed a medical necessity. Please review	(p019L) Non-Covered Diagnosis - NCD 190.11 The p019L edit fires when a covered diagnosis is not submitted on the detail line
127.	**p029D**	The system is unable to calculate the special pricing applied to services when Modifiers 50 & 78 are submitted on the same detail line. Please split the detail line in to two lines, one line with Modifiers 78/RT and one line with Modifiers 78/LT.	(p029D) Modifiers 50 & 78 The p029D edit identifies detail lines submitted with Modifiers 50 & 78.
128.	**p043L**	Per NCD 190.1, **XXXXX** has not been deemed a medical necessity. Please review.	(p043L) Histocompatibility Testing - NCD 190.1 The p043L edit fires on claim lines where a covered diagnosis is not submitted.
129.	**p045L**	Per NCD 190.5, **XXXXX** has not been deemed a medical necessity. Please review.	(p045L) Sweat Test - NCD 190.5 The p043L edit fires on claim lines where a covered diagnosis is not submitted.
130.	**p048L**	Per NCD 210.4.1, Code **XXXXX** does not meet medical necessity requirements, please review claim.	(p048L) Smoking & Tobacco-Use Cessation Counseling – NCD 210.4.1 This edit fires when an applicable service is submitted without a covered diagnosis.
131.	**p065M**	The submitted prior authorization may be valid; however, it does not apply to **XXXXX**.	(p065M) Prior Authorization Submitted for Services not Requiring a Prior Authorization Number The p065M edit identifies detail lines submitted with a Prior Authorization when a Prior Authorization is not required.
132.	**p070D**	Procedure Code **XXXXX** may require additional documentation for processing. Review to determine if additional documentation should be submitted.	(p070D) Service Requires Documentation for Processing The p070D edit fires when a code requires documentation for processing and documentation is not submitted.
133.	**p072L**	Per NCD 20.33, a required modifier is missing. Please review	(p072L) Missing Modifier - NCD 20.33 The p072L edit fires when a required modifier is not submitted on the detail line
134.	**p073L**	The service has not been deemed a medical necessity. Please review.	(p073L) Non-covered Diagnosis Code - NCD 20.33 The p073L edit identifies detail lines submitted with a non-covered diagnosis code.
135.	**p078B**	**XXXXX** has not been deemed a medical necessity. Please review.	(p078B) Non-covered Diagnosis Code - LCD L33449 The p078B edit identifies detail lines submitted with a non-covered diagnosis code.
136.	**p098L**	Per NCD 210.6, Code **XXXXX** does not meet medical necessity. Please review code(s).	(p098L) Hepatitis B Infection Screening (NCD 210.6) The p098L edit fires on claim lines where the viral disease screening diagnosis is submitted without meeting the requirement of submitting an additional covered ICD-10 Diagnosis.
137.	**p102B**	JM & JJ: p102B - **XXXXX** is deemed not medically necessary per LCD L33447 so please review the submission	(p102B) Special EEG LCD (Diagnosis portion) The p102B edit fires when a procedure code in this LCD is submitted without an approved diagnosis code.
138.	**p130L**	Per NCD 30.3.3, **XXXXX** does not meet medical necessity. Please review.	(p130L) Acupuncture for Chronic Lower Back Pain - NCD 30.3.3 The p130L edit fires on claim lines where a covered diagnosis is not submitted.
139.	**p132B**	Per NCD 110.3 and Article A56065, **XXXXX** has not been deemed a medical necessity. Please review.	(p132B) Non-covered Diagnosis Code The p132B edit identifies detail lines submitted with a non-covered diagnosis code.
140.	**p136L**	Code **XXXXX** should be submitted with 1 unit. Please review	(p136L) Services Submitted With More Than 1 Unit The p136L edit identifies detail lines submitted with units greater than 1.
141.	**p152D**	Procedure Code **XXXXX** should be submitted with a charge greater than $0.00.	(p152D) Submitted Charge $0.00 The p152D edit identifies detail lines submitted with a charge of $0.00.
142.	**p158B**	Per NCD 110.24, Code **XXXXX** is not covered by Part B. Please review and submit to Part A.	(p158B) Part A Services Submitted to Part B The p158B edit identifies detail lines submitted with a Part A code.

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143.	**p159B**	Per LCD L38737, **XXXXX** has not been deemed a medical necessity. Please review	(p159B) Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) Diagnosis Coverage The p159B edit will fire when a non-covered diagnosis code is submitted.
144.	**p216D**	Per NCD 20.33, Code **XXXXX** is non-covered when performed in Place of Service XX. Please review.	(p216D) Place of Service Coverage - NCD 20.33 The p216D edit fires when a service is performed in an inappropriate place of service.
145.	**p250D**	Code **XXXXX** may require additional documentation for processing. Review to determine if additional documentation should be submitted.	(p250D) Service Requires Documentation for Processing The p250D edit will fire when a code requires documentation for processing and documentation is not submitted.
146.	**p252L**	Per NCD 110.4, a required diagnosis or modifier is missing. Please review.	(p252L) Missing Diagnosis or Modifier - NCD 110.4 The p252L edit fires when a required diagnosis or modifier is not submitted on the detail line
147.	**p292D**	Per NCD 110.21, **XXXXX** should not be submitted with Modifier EB. Please review	(p292D) Modifier EB - NCD 110.21 The p292D edit fires when Modifier EB is submitted with an inappropriate procedure code.
148.	**p306A**	Codes J0881, J0885 and Q5106 require Modifier EA, EB or EC. In addition, Codes J0881, J0882, J0885, Q4081 and Q5106 require Hematocrit (HCT) and/or Hemoglobin (HGB) test results be submitted in the HCT or HBG claims fields.	(p306A) ESA Modifier & HGB/HCT Results The p306A edit fires when the code/modifier combination is non-covered or the HGB/HCT results are not submitted.
149.	**p317A**	Z-Code **XXXXX** requires a drug name be submitted. Please review.	(p317A) Z-Code Requires a Drug Name be Submitted The p317A edit will fire when a Z-Code is submitted and a requires drug name is missing
150.	**p320D**	Code **XXXXX** has been deemed a non-covered service based on a local policy so please review claim	(p320D) Non-Covered Services included in LCD The p320D edit fires when the submitted procedure code is deemed as not covered per Local Coverage Determinations of Medical Affairs.
151.	**p331D**	**XXXXX** is not covered when submitted in Place of Service **XX**. Please review.	(p331D) Rehabilitation Services - Place of Service The p331D edit will fire when a non-covered place of service is submitted.
152.	**p348D**	**XXXXX** requires an invoice be submitted for processing. Please review.	(p348D) Service Requires an Invoice for Processing The p348D edit will fire when a service requiring an invoice is submitted and an invoice is missing
153.	**p355D**	Per NCD 270.3, **XXXXX** is not covered in Place of Service '**XX**'. Please review.	(p355D) NCD 270.3 - Place of Service The p355D edit will fire when a non-covered place of service is submitted.
154.	**p366D**	**XXXXX** should be submitted with a charge greater than $0.01.	(p366D) Submitted Charge $0.01 The p366D edit identifies detail lines submitted with a charge of $0.01.
155.	**p369A**	p369A – Code **XXXXX** does not meet medical necessity in this case per LCD L37636 so please review the submission	(p369A) Non-OB Pelvic Ultrasound LCD The p369A edit fires when a procedure code is submitted without an approved diagnosis code.
156.	**p374D**	Service may be covered by another payer. Please review the submitted place of service and/or modifiers.	(p374D) Global Service or TC Component Billed in a Facility Setting The p374D edit fires when a global service or a technical component is submitted in a facility setting.
157.	**p397D**	When billing **XXXXX**, "1" should be entered in the quantity billed / number of services field and enter the total amount of the drug or biological actually administered (in mg or mcg) in Block 19 or the electronic equivalent.	(p397D) Biologicals Quantity Billed Greater 1 The p397D edit fires when NOC Code J3490, J3590 or J9999 is submitted and the quantity billed is greater than 1.
158.	**p413D**	Code **XXXXX** is a non-covered service so please review the claim	(p413D) Non-Covered Integumentary Codes The p413D edit fires when the submitted procedure code is deemed as not covered per Medical Affairs.

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159.	**p451A**	Per Article A53066, this drug has been deemed to be excluded from payment "incident-to" the physicians service as it is usually self-administered by the patient.	(p451A) Self-Administered Drugs The p451A edit identifies drug codes excluded from payment.
160.	**p55**	The beginning and ending date of service should equal the date of the surgery.	(p55) MOD 55 DATE SPAN The p55 edit identifies services that are submitted with the 55 modifier and have different beginning and ending dates of service.
161.	**p518A**	Per NCD 230.18 Code **XXXXX** does not meet medical necessity. Please review the claim.	(p518A) Sacral Nerve Stimulation – NCD 230.18 This edit fires when an applicable service is submitted without a covered diagnosis.
162.	**p644A**	Procedure Code **XXXXX** is not allowed when performed by an optometrist. Exception: For post-operative care only, review our CPT Modifier 55 website article to determine if it is appropriate for this procedure.	(p644A) Optometrist Cannot Bill Service without 55 Modifier Determines when an Optometrist (NPI) bills certain services without a 55 modifier.
163.	**p650A**	Code **XXXXX** has not been deemed a medical necessity. Please review the diagnosis for coverage requirements.	(p650A) Implant Glucose Monitor Diagnosis Coverage The p650A edit will fire when a non-covered diagnosis code is submitted.
164.	**p672A**	Per NCD 210.3, the Patient's age, **XX**, does not meet the age criteria for procedure **XXXXX**. Please review.	(p672A) Screening for Colorectal Cancer (CRC) - Age 50-85 - NCD 210.3 The p672A edit identifies claims with codes submitted for patients outside the age criteria
165.	**p686A**	**XXXXX** has not been deemed a medical necessity. Please review LCD L38747 for the diagnosis coverage requirements.	(p686A) “Additional ‘POEM LCD’ Coverage” This Local Coverage Determination p686A edit sets on claim lines where a covered diagnosis is not submitted.
166.	**p705A**	**XXXXX** has not been deemed a medical necessity. Please review.	(p705A) Pulmonary Rehabilitation Diagnosis Coverage The p705A edit will fire when a non-covered diagnosis code is submitted.
167.	**p906A**	U0005 requires a primary service be submitted on the same claim.	(p906A) Primary Code Not Submitted with U0005 The p906A edit will fire when U0005 is submitted without a primary code.
168.	**p918A**	Per LCD L37031, Code **XXXXX** has not been deemed a medical necessity. Please review.	(p918A) Diagnosis Coverage – LCD L37031 The p918A edit will fire when a non-covered diagnosis is submitted.
169.	**p99**	Modifier 99 requires additional modifiers be submitted with the claim. Modifier 99 is only necessary if more than 4 modifiers are applicable to a detail. Please review to determine the correct information has been submitted.	(p99) Modifier 99 submitted The p99 system rule identifies claim lines submitted with Modifier 99 and no other modifiers.
170.	**pAP**	A prior authorization request is required for these transports. See http://www.PalmettoGBA.com. For dates of service prior to April 1, 2016, ignore this message if the patient has a Legal Representative Payee and resubmit without changes.	(pAP) AMBULANCE TRANSPORT PREAUTH LRP The pAP edit identifies a non-emergency, repetitive service submitted without a prior authorization/UTN.
171.	**pAT**	Per Medicare guidelines, Modifier AT is required when billing Procedure Code **XXXXX** for active treatment. Medicare does not pay for maintenance therapy.	(pAT) AT Modifier for Chiropractic Services The pAT system rule identifies claim lines for chiropractic services submitted without an AT modifier
172.	**pATGA**	Per Medicare guidelines, Modifiers AT & GA cannot be submitted together for Procedure Code **XXXXX**.	(pATGA) Modifiers AT & GA Submitted Together The pATGA edit fires when Modifiers AT & GA are submitted on the same detail line.
173.	**pCHEMO**	Per Article A56141, a covered diagnosis code has not been submitted. Please review to determine medical necessity.	(pCHEMO) Chemotherapy Billing Guidelines The pCHEMO edit identifies claim lines not containing a covered diagnosis code.
174.	**PCM**	Modifier -26 is not appropriate with Procedure Code **XXXXX** because that procedure is defined as 100% professional or 100% technical.	(PCM) Invalid Professional Component Modifier The PCM edit identifies claim lines that contain a procedure code that is considered 100% technical and modifier 26 is appended.
175.	**pCO**	The submitted modifier for an occupational therapist assistant requires the outpatient therapy plan of care modifier.	(pCO) Plan of Care Modifier is Missing The pCO edit identifies claim lines containing Modifier CO but does not include Modifier GO.

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176.	**pCQ**	The submitted modifier for a physical therapist assistant requires the outpatient physical therapy plan of care modifier.	(pCQ) Plan of Care Modifier is Missing The pCQ edit identifies claim lines containing Modifier CQ but does not include Modifier GP.
177.	**pDOA**	Code **XXXXX** does not meet the requirements for the controlled substance monitoring and drugs of abuse coding guidelines. Please review to determine if a correction is needed.	(pDOA) Monitoring of Drugs of Abuse Codes The pDOA edit fires on services when a Drug of Abuse code is submitted and the text-string submitted in the SV101-7 field is blank or invalid.
178.	**pDOA1**	Code **XXXXX** does not meet the requirements for the controlled substance monitoring and drugs of abuse coding guidelines. The units submitted are greater than '1'. Please review to determine if a correction is needed.	(pDOA1) Monitoring of Drugs of Abuse Codes with a Quantity Billed Greater Than 1 The pDOA1 edit fires on services when a Drug of Abuse code is submitted and the units submitted if greater than 1
179.	**pDOA7**	More than 7 Drug of Abuse codes have been billed on this claim. This does not meet the requirements for the controlled substance monitoring and drugs of abuse coding guidelines. Please review to determine if a correction is needed.	(pDOA7) Monitoring of Drugs of Abuse Codes The pDOA7 edit fires on services when more than 7 Drug of Abuse services are submitted on the same claim.
180.	**pDOAF**	Procedure codes G0431 and G0434 can only be billed once per day, per rendering provider. Code **XXXXX** was found in history for the same DOS and rendering provider.	(pDOAF) Monitoring of Drugs of Abuse Codes The pDOAF edit fires when G0431 and G0434 are submitted on the same date of service by the same provider.
181.	**pDOAFS**	Drug of Abuse Code **XXXXX** was billed on the same date of service as another Drug of Abuse code in the same group, on the same claim.	(pDOAFS) Monitoring of Drugs of Abuse Codes The pDOAFS edit fires when Drug of Abuse code within the same group is submitted on the same date of service.
182.	**pLAT**	This service requires laterality HCPCS Modifier RT or LT. If bilateral, use CPT Modifier 50 if appropriate/valid.	(pLAT) Service Submitted without Laterality Modifier The pLAT edit will set when a service is submitted without a Laterality Modifier.
183.	**pMPOS**	pMPOS – Code **XXXXX** is not typically performed in Place of Service **XX**. Please review claim.	(pMPOS) MolDx Place of Service The pMPOS edit fires when an applicable procedure code is submitted as rendered in an unapproved MolDx Place of Service.
184.	**POS**	Procedure Code **XXXXX** is not typically performed by a physician at Place of Service **XX**.	(POS) Place of Service Not Typical with Procedure The POS System Rule identifies claim lines that contain a place of service that the specified procedure is not typically performed in.
185.	**pPDP**	The PD Modifier should not be billed with the TC Modifier.	(pPDP) Modifier PD when Modifier TC is submitted The pPDP System Rule identifies claims lines submitted with the PD and TC Modifiers.
186.	**pPOS**	**XXXXX** is not typically performed in place of service **XX.**	(pPOS) Place of Service Not Typical with Procedure The pPOS System Rule identifies claims lines submitted with a place of service the procedure is not typically performed in.
187.	**pSTIM**	Per NCD 160.7, the billing guidelines for Code L8679 have not been met. Please review.	(pSTIM) Electro-acupuncture Devices Inappropriately Submitted as an Implantable Neurostimulator The pSTIM edit fires when an electro-acupuncture device is inappropriately submitted as an implantable neurostimulator.
188.	**PTAN**	Need a Railroad Medicare PTAN? Use our Railroad Medicare PTAN Lookup And Request Tool at www.PalmettoGBA.com/RR/PTAN.	(PTAN) PTAN Lookup and Inquiries An informational message received when a submitter calls the Provider Contact Center for information that can be obtained via PalmettoGBA.com.
189.	**PVN1**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment.	(PVN1) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.

Palmetto GBA Smart Edits

As Returned on the 277CA - Highlighted row indicates edit has been added or updated since last publication.

Line Number	Smart Edits #	Smart Edits Message	Smart Edits Description
190.	**PVN1**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment. Your Medicare ambulance license is due for update. Failure to provide an updated license may result in a hold on payments.	(PVN1) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
191.	**PVN2**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment.	(PVN2) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
192.	**PVN2**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment. Your Medicare ambulance license is due for update. Failure to provide an updated license may result in a hold on payments.	(PVN2) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
193.	**PVNE**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment.	(PVNE) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
194.	**PVNE**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment. Your Medicare ambulance license is due for update. Failure to provide an updated license may result in a hold on payments.	(PVNE) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
195.	**PVNF**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment.	(PVNF) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
196.	**PVNF**	Your Medicare enrollment record is due for revalidation. Failure to respond may result in a hold on payments and possible deactivation of your enrollment. Your Medicare ambulance license is due for update. Failure to provide an updated license may result in a hold on payments.	(PVNF) Enrollment Record Revalidation An informational message the submitter will receive when your Medicare enrollment record is due to revalidation.
197.	**pWS**	Modifier PA, PB or PC was submitted for Procedure Code **XXXXX**. Please verify this modifier is correct as it is a wrongful surgery modifier.	(pWS) Wrongful Surgery Modifier The pWS edit fires when a wrongful surgery modifier is submitted.
198.	**PXRM**	Per Medicare, HCPCS Code R0075 was billed without the required UN, UP, UR or US Modifier.	(PXRM) Portable X-ray Modifiers The PXRM edit fires when code R0075 is submitted without a required modifier.
199.	**QB**	When billing **XXXXX**, "1" should be entered in the quantity billed/number of services field and enter the total amount of the drug or biological actually administered (in mg or mcg) in Block 19 or the electronic equivalent.	(pQB) Biologicals Quantity Billed Greater 1 The pQB edit fires when NOC Code J3490, J3590 or J9999 is submitted and the quantity billed is greater than 1.
200.	**RDL**	Repeat radiology procedure **XXXXX** may require a repeat procedure modifier.	(RDL) Repeat Radiology Requires Repeat Modifier The RDL System Rule identifies claim lines with a repeat radiology procedure that does not have the appropriate modifier appended. The modifier 76 should be used if the same provider is performing the procedure and the modifier 77 should be used if a different provider. This rule first looks at the unmodified radiology procedure and then compares the current line provider.

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Line Number	Smart Edits #	Smart Edits Message	Smart Edits Description
201.	**RDLS**	Repeat radiology procedure **XXXXX** may require a repeat procedure modifier.	(RDLS) Same Claim Repeat Radiology Requires Repeat Modifier The RDLS System Rule identifies claim lines with a repeat radiology procedure that does not have the appropriate modifier appended. The modifier 76 should be used if the same provider is performing the procedure and the modifier 77 should be used if a different provider. This rule first looks at the unmodified radiology procedure and then compares the current line provider.
202.	**RED**	Check the status of your Redeterminations without having to call - Palmetto GBA has a Redetermination Status Tool. Check the progress of your appeal at https://www4.palmettogba.com/pgx-partBredeterminations.	(RED) Redetermination Status Tool This edit prompts the sending of an informational message on claim submissions of the provider(s) NPI associated with an individual who calls the “Provider Contact Center” for information which otherwise he or she might obtain via PalmettoGBA.com
203.	**ZCODE**	Code **XXX** requires a Z-Code be submitted. Please see the MolDX website: https://www.PalmettoGBA.com/moldx.	(ZCODE) Procedure Code Requires a ZCode The ZCODE System Rule identifies MolDX-related procedure codes. The procedure code requires a MolDX Z-Code be submitted along with the procedure code.