HEALTH CARE AUTHORITY

Medicaid Management Information System Replacement (MMISR) Project

MCO Turquoise Claims Manual

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1.0 Introduction

The purpose of this manual is to summarize all the requirements for an organization participating in New Mexico Medicaid as a Turquoise Care Managed Care Organization.

It is required that the MCO share the information included in this manual with its subcontractors if those contractors are responsible for any of the information exchanges described in this manual and provide technical assistance to ensure their systems and procedures are sufficient to enable the MCO to meet all its data and reporting obligations. Contained in this manual are the minimal MCO requirements, file layouts (or links to file layouts) and descriptions for the data provided to the MCO's by the New Mexico Medicaid Management Information System (MMIS), also referred to as "Turquoise Claims", as well as the data requirements, file layouts (or links to file layouts), data definitions, and system edits for data the MCO's are to provide to the MMIS. As any changes are made in the managed care system, the Medical Assistance Division will provide the MCO's with updates to this manual.

HCA is in the process of converting to Turquoise Claims which employs a modular approach to data management. This modular approach has a System Integrator (SI) which is responsible for transacting data exchanges between the various modules and external partners such as MCOs. Another module is Benefit Management Services (BMS), which will perform provider enrollment functions.

MCO's are responsible for maintaining management information systems sufficient to meet the requirements outlined in this manual. MCO's are further responsible for ensuring that their subcontractors and major providers also have sufficient systems capability so that the MCO's ability to meet minimal system requirements is not impaired.

MCO's will receive data related to functions they are to provide for New Mexico Medicaid. Reports and files are downloaded on the CONDUENT DMZ Moveit Server, Azure PBM Prod MOVEit Transfer. Each MCO will have their own Outbound folder from where they can download and access the documents.

The following is a summary of the files received by the MCO's. Each file is discussed in more detail in the following sections and at the end of this manual is a table that summarizes the files and frequencies.

The following **Real-time** files are produced by BMS and Financial Services (FS). The **Daily** files are produced by the Turquoise Claims, HMS (Quality Assurance) system, and ASPEN (Daily cycles do not run on the days that the monthly cycle runs).

Real-Time Application Programming Interface:

- **Enroll Provider and Update Provider APIs** - Files that contain Providers who has been enrolled in NM Medicaid as either FFS or MC provider and thus approved for participation with the MCO along with any provider's terminated or changes to the provider's record.

- **Update Member LOC API** - A file that contains all clients' nursing facility level of care, and any updates to the client's Long Term Care level of care.
- **Update Member PL API** - Any time a Health Home, Care Coordination, Long Term Care Span, PCP, or Patient Liability span is added or changed, those records will appear on the Update Member PL API file for the MCO to which the client is enrolled for dates covered by that span.

MCO's will receive the following **daily** or ***weekly*** files:

- **820 Payroll Deducted and Other Group Premium Payment for Insurance Products the HIPAA payment file showing all capitations.** The first weekly capitation file reflects all per member-per-month payments made for that enrollment month, any retroactive periods of enrollment, and any recoupments that occur as part of that week's cycle; successive weeks include any periodic recoupments made throughout the month.
- **Daily 834 Benefit Enrollment and Maintenance and Roster Supplement Files –** will have clients who have been enrolled or terminated in the night's enrollment cycle. Clients may have chosen the MCO or have been auto assigned. The Daily file will also include clients re-enrolled for the current or prior months and newborn clients newly enrolled for the current month. This file is run Monday through Saturday. A file is not produced if no new enrollment activity has been reported.
- **ASPEN to MCO and MCO to ASPEN interface files –** NFLOC and SOC assessment request and determination files exchanged with ASPEN for those members who are not otherwise eligible for Medicaid (NOMEs). Although these files are not exchanged with Turquoise Claims and any testing or communication of issues must be directed to Deloitte (ASPEN), the details for these files have been provided in these systems manual.
- **RC070 & RC072 files –** these are response files to Encounters submitted the previous day, showing whether encounters have been 'paid' (accepted) or 'denied' and why.
- **TPL Daily File –** A response file sent by the QA Module containing verified other insurance information for newly enrolled or reinstated clients. The file is in response to an inquiry file – TPL Eligibility File – received from the MCO and is sent the following business day by the QA Module. Response files are sent Monday through Friday by the QA Module. TPL Eligibility files received on weekends or holidays are considered received the next business day; if multiple files are received the response will be combined into a single file.

MCO's will receive the following **monthly** files:

- **834 Benefit Enrollment and Maintenance and Roster Supplement Files –** the HIPAA transaction will report all clients enrolled for the upcoming month. This file is generated on the third working day before the end of the month. The Roster Supplement file contains supplemental information that the 834 transaction is not equipped to handle. These files are generated on the third working day before the end of the month.
- **Provider Reconciliation file (In an MFT canonical format from BMS.)**
- **Rate and Formulary/Reference files**
- **CAV Monthly File –** a delta file of managed care program clients with changes in Other Insurance coverage. Changes are defined as adds, updates, terms and voids.

MCO's must provide to the Medical Assistance Division (MAD) information related to their Managed Care Program. This information is:

- **Encounters -** must be submitted at least weekly using HIPAA compliant formats.

- **Update Member LOC API –** a file that contains enrollee information including care coordination level, nursing facility level of care (agency directed vs self- directed community benefit or Nursing Facility), Primary Care Provider (PCP), Health Home assignment, etc.
- **Provider Network file –** the MCO is required to identify those providers who are in-network.
- **Daily TPL Eligibility file –** the MCO is required to send a file containing any newly eligible or reinstated clients on the TPL file sent to the QA Module. This is file is sent daily.

If the MCO does not have any updates to send, an empty file does not need to be sent. The MCO's should contact CONDUENT and the Medical Assistance Division Systems Bureau (SB) staff whenever there is a problem with the transmission or receipt of Turquoise Claims data or to report a problem with data validity (note: HCA is finalizing this process. Any updates will be communicated). Most data will be exchanged via website, API or FTP server. All HIPAA formats are sent through Conduent's EDI Gateway. All non-HIPAA format files or reports, except for Provider data that will come from BMS, are received/sent through APIs and FTP.

2.0 MCO System Requirements

It is required that an MCO's Management Information System (MIS) be capable of accepting, processing, maintaining, and reporting specific information necessary to the administration of the Managed Care program. The MCO's MIS must meet the following requirements.

2.1 MCO System Hardware and Software Requirements

The MCO is required to maintain system hardware, software and information systems resources sufficient to provide the capability to:

1. Accept, transmit, process, maintain and report specific information necessary to the administration of the State's Turquoise Care programs, including, but not limited to, data pertaining to Providers, Members, Claims, Encounters, Grievance and Appeals, disenrollment for other than loss of Medicaid eligibility and HEDIS and other quality measures.
2. Comply with the most current federal standards for encryption of any data that is transmitted via the internet by the CONTRACTOR or its subcontractors.
3. Conduct automated Claims processing with current National Provider Identification Number (NPI) for health care providers and FEIN/SSN numbers for atypical providers in HIPAA compliant formats.
4. Accept and maintain the State's ten (10) digit Member Medicaid identification number to be used for all communication to HCA and be cross walked to the CONTRACTOR's assigned universal Member number and which is used by the Member and providers for identification, eligibility verification, and Claims adjudication by the CONTRACTOR and all subcontractors.
5. Monitor the completeness of the encounter data being received to detect providers or subcontractors who are transmitting partial or no records.
6. Transmit data securely and electronically.
7. Maintain a website for dispersing information to providers andMembers and be able to receive comments electronically and respond when appropriate, including responding to practitioner transactions for eligibility and formulary information.

8. Disseminate enrollment information to providers and subcontractors/vendors within twenty-four (24) hours of receipt of the information or, at a minimum, ensure that current eligibility information is available to providers for eligibility verification within twenty-four (24) hours of receiving the information, via a website, automated voice response system, or other means. Providers must be able to verify eligibility on weekends, holidays and after normal business hours.
9. Receive data elements associated with identifying Members who are receiving ongoing services or from another contractor and using, where possible, the formats that HCA uses to transmit similar information to an MCO.
10. Transmit to HCA or another contractor, data elements associated with Members who have been receiving ongoing services within the CONTRACTOR's MCO; and have an automated access system for providers to obtain Member enrollment information that includes the cross-reference capability of the system to the Member's ten (10) digit Medicaid identification number designated by HCA to the Member's Social Security number as a means of identifying the Member's most current benefits such as providing the Member's category of eligibility.
11. Have systems capability to transmit to HCA/MAD or another MCO data elements associated with their clients or assignees who have been receiving ongoing services within their organization and maintain a system backup and recovery plan.
12. Maintain a system backup and recoveryplan.

2.2 MCO Provider Network Information Requirements

Every provider who participates with the MCO is required to be either enrolled with HCA as an FFS & Managed Care provider or as a Managed Care-Only provider under Turquoise Care. The MCO is required to refer providers not already enrolled to the Provider Enrollment vendor (BMS), for enrollment, (all discussed in the Provider section of this manual). The MCO's provider network capabilities must include, but not be limited to:

a. Maintenance of complete provider information for all providers contracted with the MCO and its subcontractors and any other non-contracted providers who have provided services to date.
b. MCO should ingest the Provider Taxonomy Matrix to ensure providers are applying the correct taxonomy.
c. Ability to provide automated access to clients and providers of a client's PCP assignment.

2.3 Client Information Requirements

The MCO is required to accept, maintain, and transmit Client information to include, but not be limited to:

d. Acceptance of client eligibility and demographic data as well as monthly enrollment information via electronic data transfer.
e. Monitoring newborns whose mother was enrolled in Managed Care at the time of the newborn's birth to ensure minimal lapse in time between the infant's birth and their determination of Medicaid eligibility. After eligibility is approved, newborns of Medicaid eligible MCO enrolled mothers are eligible for a period of twelve (12) months starting with the month of birth. The newborn isenrolled

retroactively to the date of birth with the same MCO the mother had during the birth month, as soon as the newborn's eligibility is approved. However, the parent or legal guardian may choose a different MCO for the newborn as early as the second month of life. In such a case, the MCO of the mother is only entitled to capitation for the birth month. If the newborn's mother is not a member of an MCO at the time of birth, the newborn is enrolled during the next applicable enrollment cycle.

f. The ability to generate client information to providers within 24 hours of receipt of the Enrollment Roster from HCA.

g. Assign as the key Medicaid client ID number, the MedicaidcardID that is sent on the Enrollment Roster file. The MCO will cross-reference this ID to the member's social security number and any internal number used in the MCO's system to identify members. The Medicaid Card ID number format is either the Medicaid System ID number preceded by a '3' or the ASPEN MCI ID preceded by a '2'.

h. Meet Federal CMS standards for release of client information (applies to subcontractors as well). These standards specify that providers may access Medicaid eligibility information only by entering the client's Medicaid identification number or two or more of the following data elements:
   - Client's full name, including middleinitial.
   - Client's date of birth.
   - Client's Social Security Number

   AND by entering date(s) of service(s). If a span of service dates is entered, you determine the length of the span that is appropriate, not to exceed a maximum of 12 months prior to the query date. If a specific date of service is requested, the date cannot be more than 12 months prior to the query date.

   The MCO, and its subcontractors, are subject to HIPAA confidentiality/privacy laws, regulations, and contractual provisions (see 42 CFR 431.306(b).) This is in addition to the requirement that restricts the use or disclosure of information to purposes directly connected with the administration of the Medicaid program (see 42 CFR 431.301). The MCO and its subcontractors are responsible for establishing appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records.

i. Tracking changesin the client's category of eligibility.

j. Accurate maintenance of client eligibility and demographic data.

k. Ability to provide automated access to providers of client eligibility and PCP assignment. The MCO must provide an automated voice response system or Web-based solution for providers to verify eligibility and PCP assignment.

l. Make client enrollment and PCP assignment information available for electronic verification systems, including swipe card systems.

m. Ability to provide electronic transmission to HCA/MAD Care Coordination assessment and level, nursing facility level of care, community long term care arrangement, PCP assignment, Health Home assignment, etc. as specified in the Update Member LOC API file.

2.4 Claims Processing Requirements

The MCO and any of its subcontractors or providers paying their own claims are required to maintain Claims processing capabilities to include, but not be limited to:

n. Accepting NPI and HIPAA-compliant formats for electronic Claims submission.
o. Assigning unique identifiers for all Claims received from providers and ensuring that any adjustments or voids either carry some part of that original Transaction Control Number (TCN) in the adjustment/void TCN or carry a related TCN field so that the original can always be linked to any adjustments and voids.
p. Standardizing protocols for the transfer of Claims information between the CONTRACTOR and its subcontractors/providers, audit trail activities, and the communication of data transfer totals and dates.
q. Date stamping all Claims in a manner that will allow determination of the calendar date of receipt.
r. Running a payment cycle to include all submitted Claims to date at least weekly.
s. Paying Clean Claims in a timely manner as follows:

- For Claims from I/T/Us, day activity providers, assisted living providers, Nursing Facilities and home care agencies including Community Benefit providers, ninety-five percent (95%) of Clean Claims must be adjudicated within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims must be adjudicated within a time period of no greater than thirty (30) Calendar Days of receipt.
- For all other Claims, ninety percent (90%) of all Clean Claims must be adjudicated within thirty (30) Calendar Days of receipt, and ninety-nine percent (99%) of all Clean Claims must be adjudicated within ninety (90) Calendar Days of receipt.

t. Paying contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current Medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall not be required to pay any interest calculated to be less than two dollars ($2.00). The interest shall be paid within 30 days of the payment of the claim. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HCA/MAD.
u. Meeting both State and federal standards for processing Claims.
v. Generating remittance advice and/or 835 to providers for all Claims submissions.
w. Participating in a committee or committees with HCA to discuss and resolve systems and data related issues, as required by HCA.
x. Accepting from providers and subcontractors only national HIPAA- compliant standard codes and editing to ensure that the standard measure of units is billed and paid for.
y. Editing Claims to ensure that services being billed are provided by providers licensed to render these services, that services are appropriate in scope and amount, that Members are eligible to receive the services, and that services are

billed in a manner consistent with HCA defined editing criteria and national coding standards.

z. Using the Daily Third-Party Liability (TPL) and Monthly Cost Avoidance (CAV) files provided by QA, the state designated TPL vendor, along with any TPL identified to the MCO outside of this file to coordinate benefits with other payers.

aa. Capturing and reporting all TPL, interest, copay, or other financial adjustments on all Claims, using HCA defined editing criteria and HIPAA standard Claim adjustment reason codes and remark codes to identify the payments and adjustments.

bb. Developing and maintaining a NPI HIPAA-compliant electronic billing system for all providers submitting bills directly to the CONTRACTOR and requiring all subcontractors to meet the same standards.

cc. Accepting and accurately paying Medicare Claims coming either as Medicare claims sent to the CONTRACTOR from the CONTRACTOR's providers or as Medicaid crossover Claims submitted by the coordination of benefits agreement ("COBA") contractor or provider, ensuring the following:

    1) All information on the Medicare or crossover Claim for the client enrolled in the MCO must be accepted, adjudicated, and stored in the MCO's system; including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules.
    2) Any Medicare claims paid by the SNP for which there is no Medicaid obligation (no coinsurance or deductible) must be adjudicated and stored complete with all Claim adjustment reason codes explaining the difference between the provider's billed charges and the MCO's allowed and paid amounts.

dd. Maintaining adequate data to the same standards of completeness and accuracy as required for proper adjudication of Fee-For-Service claims for all services, regardless of the method of payment for those services, to meet the Encounter Data requirements in the next section, including but not limited to:

    1) Services provided under sub-capitation payment arrangements.
    2) Services provided as part of a bundled rate.
    3) Services performed by CONTRACTOR staff, even where no payment is made or identified for those services, such as care coordination activities.

ee. Adhering to federal and State timely filing requirements as defined in HCA timely filing Claims exceptions detailed in the MCO Systems Manual.

ff. Configuring the CONTRACTOR's own system to meet HCA's editing criteria as detailed in the MCO Systems Manual.

gg. Acceptance from providers and subcontractors of national standard codes; using standard definitions for services and unit definitions.

hh. Systemic review and control systems, to include editing of claims to ensure services are being submitted by providers licensed to render the services being billed, that services are appropriate in scope and amount, and that enrollees are eligible to receive the service and that services are billed in a manner consistent with national coding criteria (e.g., discharge type of bill includes discharge date, rendering provider is always identified for facility and group practices, services

provided in any inpatient/residential setting are coded with an inpatient type of bill, etc.).

2.5 Encounter Reporting Requirements

The MCOs have a responsibility for the following Encounter File Submission and Reporting capabilities to include, but not be limited to:

a. Provide Encounter Data to HCA by electronic file transmission using the 5010 PACDR and NCPDP formats according to HIPAA transaction and code sets and operating rules using HCA approved, standard protocols.
b. Comply with CMS and HIPAA standards for electronic transmission, security and privacy (also applies to subcontractors).
c. Submit to HCA all Encounters in accordance with the HIPAA TechnicalGuidance, NM's Companion Guides for Encounters, HIPAA Operating Rules, EDI guidelines for successful submission of files and any specific information included in the MCO Systems Manual.
d. Make changes or corrections to any systems, processes or data transmission formats as needed to comply with HCA data quality standards as originally defined or subsequently amended.
e. Submit to HCA Encounters for all Claims or services paid by the MCO and its subcontractors.
f. Within five (5) Business Days of the end of a payment cycle the MCO shall generate Encounter Data files for that payment cycle from its Claims management system(s) and/or other sources. If the MCO has more than one (1) payment cycle within the same calendar week, the Encounter Data files may be merged and submitted within five (5) Business Days of the end of the last payment cycle during the calendar week.
g. Submit to HCA Encounters for all adjustment/void Claims of previously reported Encounters according to the same timeliness standards as required of paid original Claims, applied to the adjustment date. Adjustment and voids of previously paid Claims must be identified according to instructions in the HIPAA Technical Requirements guide and NM Companion guides, including the HCA Transaction Control Number (TCN) of the previously paid Encounter that the adjustment/void modifies.
h. Submit corrections to any encounters that are rejected by the HIPAA EDI transaction processing within 5 working days of the notice of rejection.
i. Submit to HCA Encounters for any Medicare claims for a Medicaid client sent to the MCO from the MCO's providers as well as Medicaid crossover Claims submitted by the COBA contractor or provider, ensuring the following:

(1) All information on the Medicare or Medicaid crossover Claim must be submitted as an Encounter to HCA including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim

Adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules. Instructions for the submission of Medicare Encounters will be included in the MCO Companion Guides.

(2) any Medicaid crossover Claim where the MCO either paid the Medicaid obligation or there was no payment made on the Medicaid obligation must be sent to HCA as a Medicaid crossover Encounter.

(3) Have a formal monitoring and reporting system to reconcile submission and resubmission of Encounter Data between the MCO and HCA to ensure timeliness of submissions, resubmissions and corrections and overall completeness and accuracy of data.

(4) Have a formal monitoring and reporting system to reconcile submissions and resubmissions of Encounter Data between the MCO and the subcontractors or providers who pay their own Claims to assure timeliness, completeness and accuracy of their submission of Encounter Data to the MCO.

(5) Meet HCA Encounter timeliness requirements by submitting to HCA at least ninety percent (90%) of its Claims, originals and adjustments within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accord with the specifications included in HIPAA Technical Report, the NM Companion Guide and the MCO Systems Manual, regardless of whether the Encounter is from a subcontractor, sub-capitated

(6) arrangement, or performed by the MCO. MCO may not withhold submission of Encounters for any reason.

(7) Have written contractual requirements of subcontractors or providers that pay their own Claims to submit Encounters to the MCO on a timely basis which ensures that the MCO can meet its timeliness requirements for Encounter submission.

(8) Meet Encounter accuracy requirements by submitting MCO paid Encounters with no more than a three percent (3%) error rate per invoice type (PACDRI, PACDRP,PACDRD, NCPDP), calculated for a quarter's worth of submissions. HCA will monitor the MCO corrections to New Mexico denied Encounters by random sampling. Seventy-five percent (75%) of the New Mexico denied Encounters included in the random sample must have been corrected and resubmitted by the MCO within thirty (30) Calendar Days of denial.

(9) Systematically edit Encounters prior to submission to prevent or decrease submission of duplicate Encounters and other types of Encounter errors. The edits used in the Turquoise Claims system for encounters are included in this manual and should be used to establish similar edits within the MCO's system for claims; and

(10) Where the MCO has entered into capitated reimbursement arrangements with providers, the MCO shall require submission of all utilization or Encounter Data to the same standards of completeness and accuracy as required for proper adjudication of Fee-For-Service claims, as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data.

(11) Meet encounter requirements by submitting to HCA/MAD a report of the number of denied claims by invoice type (Professional, Institutional, Pharmacy, Dental) by date of payment and date of service. This report will be compared to encounter data to evaluate the completeness of data submitted. A variance between the MCO's report and the record of encounters received cannot exceed 10% for months of payment greater than 90 days.

(12) Report all data with specific attention to the following financial information that will be used to ensure accuracy of claims payment and to set future capitation rates:

- Actual MCO Paid Amount on all claims/lines paid by the MCO or subcontractor.
- An MCO Paid Amount equivalent to any claims/lines not paid as fee for service claim/line, with a pricing process code that indicates the amount shown is an equivalent amount (e.g., sub-capitated providers/clients).
- Claim Adjustment reason codes (CAS codes) with Remark Codes as needed to designate the reasons any claim/line is not paid (e.g., bundling) and to describe any differences between billed charges and MCO payment amount.
- Any payments by any third-party payer, co-payments from the client, or adjustments to the claim/line's pricing reported with the appropriate claim adjustment reason and remark codes.
- Payment to IHS, FQHC, and RHC providers using institutional claim formats and including the encounter rate on one line of the claim but including all services rendered as part of that encounter.

MCO's must define the subcontractors' system requirements in such a way as to ensure that HCA's MCO system requirements can be met.

3.0 Enrollment Data

ASPEN is the system that determines eligibility for Medicaid and enrolls clients in Turquoise Care. ASPEN will send daily and monthly enrollment files to Turquoise Claims which processes these files, appending additional information the ASPEN system doesn't maintain (i.e., cohorts, long term care, health home, care coordination, etc.). From the daily and monthly processing, there are several files that are provided to the MCO's to expedite their enrollment of MCO eligibles. In addition to the routine Managed Care processing, Turquoise Claims creates several files that are provided to assist MCO staff to manage transition and continuity of care. This section provides a description of these various files and the file layouts. Each file is designated according to the program for which it is generated. At the end of this manual is a list of all the files that are produced and a schedule for when files are placed on the DMZ Move-it Server.

3.1 Reporting Client Demographic Updates

The Enrollment data that HCA sends to the MCOs comes from eligibility determined by one of three possible sources, ISD, SSA, or CYFD. Because the Turquoise Claims system is not the originator of the data, any changes to the client information must be made by ISD, SSA or CYFD, depending on where the eligibility originated. Most of the client eligibility originated in and is maintained by ISD in the ASPEN system. When the MCO becomes aware of a change in a client's address and the client has any Category of Eligibility (COE) other than 006, 014, 017, 037, 046, 047, 066 or 086 (these all originate from CYFD) or 001, 003, 004 (these usually originate from SSA) this information should be communicated to the local ISD office that manages the client's case.

Please remember that the MCOs are reporting as third parties. ISD must verify address change information through SSA/MVD scans or contact with the client.

3.2 Daily Client Enrollment

When a client applies for Medicaid eligibility at the local county office or via the web portal Yes NM, ISD or Yes NM informs the client that they must choose an MCO for their Medicaid services. The MCO choice made by the client is retained in ASPEN and is used to enroll the client once eligibility has been determined (using that choice if it doesn't conflict with re-enrollment requirements). ASPEN then sends the enrollment data on the daily file that comes to Turquoise Claims. In that night's managed care cycle, the enrollment roster file will be finalized and sent to the MCO.

If the client doesn't make a choice or the client's eligibility is initiated outside of the county ISD system (SSA or CYFD determines eligibility), the client will be auto assigned to an MCO the night their eligibility is received. Regardless of whether assignment is by choice or auto-assignment, the ASPEN system will send the enrolled clients an enrollment confirmation letter showing the MCO to whom they've been assigned and the effective dates of enrollment.

Clients who are eligible, and not currently enrolled, but have a prior enrollment within the last 180 days are automatically reenrolled with their prior Turquoise Care health plan if they are still eligible and have no lockout span in effect for the health plan. In the absence of prior enrollment within the last 180 days, clients will be auto assigned to the MCO that any other household member is assigned to and in the absence of that, clients are randomly assigned to an MCO.

Native Americans are not required to enroll in Turquoise Care, unless the client needs long term care or is a Dual Eligible. Native American clients can enroll in Turquoise Care using either the State's Web Portal, Yes NM (www.yes.state.nm.us) or by calling the Consolidated Call Center (1-800-283-4465).

3.2.1 Enrollment of CISC Recipients

ASPEN will mandatorily enroll all current and new CISC Recipients to the CISC MCO, Presbyterian, except for Native American CISC Recipients. The enrollment of Native American CISC into the CISC MCO shall be voluntary. Native American CISC Recipients may enroll with the CISC MCO, another MCO, or receive services through HCA's FFS program.

The effective date of enrollment in the CISC MCO shall be the first day of the month in which the child was taken into State custody.

CISC Recipients who are mandatorily enrolled in the CISC MCO shall remain enrolled in the CISC MCO while in State custody and shall not be provided with an option to select a different MCO.

Newborns of CISC Members who are not taken into State custody will be enrolled in the CISC MCO but not as a CISC Member. The mother shall have one (1) opportunity anytime during the three (3) months from the effective date of enrollment to change the newborn's MCO assignment. Enrollment of newborns of CISC who are taken into State custody will follow CISC Recipient enrollment requirements.

CISC Members enrolled with the CISC CONTRACTOR who leave State custody shall be:

- Disenrolled from the CISC program effective on the last day of the month in which the CISC Member is no longer in State custody.
- Assigned to the CISC CONTRACTOR but not as a CISC Member effective on the first day of the month following the month in which the CISC Member is no longer in State custody.
- Given the opportunity to change MCOs during the first ninety(90) Calendar Days following the effective date of enrollment.

3.3 MCO's Responsibility for New Clients

Upon receipt of new enrollment for clients on the Daily roster file, the MCO is responsible for sending the client by mail or electronically a Member handbook within thirty (30) Calendar Days of receipt of notification of enrollment in the CONTRACTOR's MCO. Upon request of a Member or Recipient, the MCO must mail or send electronically a Provider Directory, Preferred Drug List, and/or Member handbook within ten (10) Calendar Days. The MCO must give the person requesting a provider directory, Preferred Drug List, and/or Member handbook the option to get the information from the MCO's website or to receive a printed document. Each Member shall be provided with an identification card identifying the Member as a participant in the Turquoise Care program within twenty (20) Calendar Days of notification of enrollment into the MCO. The MCO shall re-issue a Member ID card within ten (10) Calendar Days of notice if a Member reports a lost card or if information on the Member ID card needs to be changed.

HCA carries several different addresses for clients, including Authorized Rep, Payee, Mailing and Residential. The MCO is instructed to mail items to the client using the address in this hierarchy; however, if the client has a CYFD Category of Eligibility ('006','014','017','037','046','047','060','061','066','086'), the Payee address is always used if present:

1) Authorized Rep,
2) Payee,
3) Mailing,
4) Residential

3.4 Initial MCO Switch

When a client is newly enrolled with a Managed Care Organization, the client has a 90-day period during which they can make a change. After exercising switching rights, a Member shall remain with the MCO until the annual choice period, unless the client is a Native American. Native American's can opt-out of Turquoise Care at any time. This switch can be made using either the State's Web Portal, Yes NM

(www.yes.state.nm.us) or by calling the Consolidated Call Center (1-800-283-4465).communicated on the client's enrollment notification letter.

3.5 Open Enrollment Reminder Letters

A client enrolled in Turquoise Care is locked in that enrollment for a period of 12 months. The ASPEN system sends an open enrollment reminder letter to enrolled clients 90 days prior to the end of each of their 12-month lock-in periods. If the clients do not choose to enroll with another MCO before the end of the lock-in period, they will continue to be locked-in to the current MCO enrollment for another 12 months. If the client chooses another MCO during the open enrollment period, they will have one opportunity anytime during the ninety (90) Calendar Day period immediately following the effective date of enrollment in the newly selected MCO to request to change MCOs. Similar to the initial switch, the client wishes to switch using either the State's Web Portal, Yes NM (www.yes.state.nm.us) or by calling the Consolidated Call Center (1-800-283-4465).

3.6 MCO's Responsibility for Client Transfers

The MCO is responsible for identifying clients who are transferring to a different MCO and clients transferring from another MCO and performing all the required transition of client data outlined in the Managed Care Transition Management Agreement. Client Transfers are identified in the Enrollment Roster by use of a Transfer ID. When a client is transferring from the MCO, the roster will include a termination record with the Transfer ID populated with the ID of the MCO the client is transferring to. When a client is transferring to the MCO the roster will include an enrollment record with the Transfer ID of the MCO the client is transferring from. The MCO is expected to reach out tothe transfer MCO to coordinate the client's care.

3.7 Managed Care Enrollment and the Enrollment Roster Files

The managed care daily cycle identifies any client who is newly eligible or whose status has changed since the previous daily cycle and creates either an enrollment or termination/recoupment record for those clients.

All Medicaid clients will be in Turquoise Care except for the following (this is primarily a list of COEs not included; where the COE is noted as not included, it is not meant to exclude clients who have one of these COEs in conjunction with an included COE):

1. Clients in ICF/MR facilities (newly namedICF/IID)
2. Children's Medical Services - COE007
3. General Assistance – COE 005
4. Out of State CYFD categories – COE's 046 and 047 5. Refugees – COE 014, 019, 049,
5. Undocumented aliens – COE 085 with fed match <> 8
6. COVID19 Uninsured – COE 085 with fed match = 8
7. Clients who have only eligibility as QMB/SLMBs, Qualified Individuals, LIS – COE's 041, 042, 044, 045, 048, 050

8. PACE – not identified by COE but by lock-in type code 'PAC'
9. Medical Management client identified as the system does currently

3.7.1 Managed Care Services

The only services outside Turquoise Care (carved out) will be:

- DD Waiver services
- Medically Fragile Waiver
- Supports Waiver services
- School Based Services
- Early Intervention

These can be defined by excluding:

- Provider type (PT 344, 345),
- Claim type W with COE 096 and 095,
- Early Intervention, excluding the procedure code/modifier codes as follows:
  - T2023/TL, T1027/TL, T1027/TLHQ, T1027/TLTT, T1027/TLTJ, H2000/TL, H2000/HA

3.7.2 Incarcerated Individuals

HCA will report when a client has been discharged from an incarceration facility to be enrolled with the MCO and when a client enrolled with an MCO is being terminated due to incarceration. The rules governing incarceration are that if the client is enrolled in managed care during the month of incarceration, the client is disenrolled effectively at the end of that month; except if the incarceration begin date is exactly the first day of the month in which case the enrollment will be terminated as of the end of the prior month. If the client is eligible for enrollment in managed care, upon their discharge, they will be enrolled into the MCO effective the month of discharge, if the discharge date isn't exactly the last day of the month. A client enrolled in managed care when they are incarcerated on 8/3/2024 will be terminated from enrollment effective 8/31/2024 and if they are discharged October 29, 2024, they will be re-enrolled effective 10/1/2024, assuming they still meet the criteria for required Turquoise Care enrollment. And a client enrolled in managed care when they are incarcerated on 8/1/2024 will be terminated from enrollment effective 7/31/2024 and if they are discharged October 31, 2024, they will be re-enrolled effective 11/1/2024, assuming they still meet the criteria required for Turquoise Care enrollment.

The monthly Supplemental Enrollment Roster file reports when a member has been incarcerated for 30 days or more at which point the client's benefits are considered suspended, and the enrollment to managed care is terminated. The monthly roster file includes the incarceration booking date, release date, and facility ID. This information is not provided timely enough for the MCOs to perform the monitoring and follow-up prescribed.

ASPEN provides incarceration data at the time it is received via the Daily Enrollment Roster file. Since the booking date doesn't affect the client's enrollment until 30 days after incarceration, there isn't necessarily any enrollment information that would trigger a record on the Daily Enrollment Roster File.

The MCOs will need to recognize that a record on the Daily file with Minor Type '6' indicates an incarceration update and shall capture this information in their own system.

- ASPEN will send an 'E' record with the member's actual booking date and the incarceration facility ID when the member enrolled to the MCO is first incarcerated using Minor Type value '6' to identify the record as an incarceration record.
- If the member is transferred to another incarceration facility while still enrolled to that MCO another "E" record will be sent on the Daily file with Minor Type '6' showing the booking date as the date the member transferred to the new facility and the new facility ID.
- If the member remains incarcerated for 30 days, their Enrollment status is suspended, and ASPEN will send a 'T' record still showing the member's actual booking date and facility ID. This would be sent on the Daily roster but would not carry the Minor Type value '6' since there's no update to the client's incarceration period. The incarceration data would also be reflected in the Monthly Roster.
- A 'T' record is sent on the Daily roster file with the Minor type '6' at any point during the member's incarceration when the member transfers from one incarceration facility to another; even though the client may have been disenrolled from that MCO for a month or more. When this happens, ASPEN will send the last T record produced for the client, reflecting the booking date of that transfer and the new facility ID.
- An 'E' record will be sent with the member's release date when the member is identified as released with the re-enrollment date to the MCO to which the member was previously enrolled; assuming the member hasn't chosen a new MCO while incarcerated.
- Depending on the notification timing of the incarceration, the MCO could get a daily record that contains both a change to enrollment as well as the incarceration data. For example, if ASPEN is not notified of an incarceration until 30 days has already passed, the MCO could get a T record that also contains the incarceration information, sent in the Daily with the Minor Type '6'.

3.7.3 HIPAA 834 Format

New Mexico will produce the 834 formats for the Enrollment roster file. The 834 format is produced from the proprietary roster file. Refer to the NM Companion Guide on the HCA website at https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/ for any explanation of NM specific mapping that has been done to the 834 format fields.

The X12N 834 Health Care Enrollment and Maintenance standard transaction does not accommodate the full range of information currently provided in New Mexico's Enrollment Roster file interface. For that reason, New Mexico will continue to produce Supplemental Member file interface which will carry some of the same data as on the 834, plus the additional data not covered by the 834. The discussion in this section primarily addresses the enrollment process and the Supplemental Roster files that are produced.

3.7.4 Daily Enrollment

A daily (Monday through Saturday) 834 Benefit Enrollment file and a daily Supplemental Roster file is generated for Turquoise Care. The MCOs should not expect to receive a roster/834 file on the day after a state holiday.

The Daily 834 Benefit Enrollment and Supplemental Roster files contain a record for every new client that has been enrolled in the nightly cycle. A new client can be added with retroactive months of enrollment. This file will also include clients who've lost eligibility for a prior month or months and have been determined eligible for those lost months and any Retroactive Newborn enrollments. The daily file will also report any terminations or recoupments.

The Daily 834 Benefit Enrollment and Supplemental Member files contain a record for each retroactive month of managed care enrollment that has been added. The different types of records other than new enrollments are:

- *Retroactive Newborn enrollments* - During both the daily and monthly cycles, the system attempts to auto-enroll newborns who would otherwise be candidates for notification of health plan eligibility. The system identifies newborns using the following criteria:
    - The client is less than 12 monthsold.
    - The client has no prior health plan enrollment or recoupment span.
    - The client's mother is on file and enrolled in a health plan on the newborn's
    - birth date.
    - The client is eligible for health plan enrollment back to the date of birth with the health plan the client's mother was enrolled in on the birth date.

The system uses the following method to locate a newborn client's mother:

If the relationship-to-head-of-household indicator on the client's highest ranked COE span indicates a child, and there is only one female designated as the case head of household, auto enroll the infant. In all other cases, do not auto-enroll the infant.

Once the system identifies a newborn to auto-enroll, the system creates a health plan enrollment span for the health plan the newborn's mother was enrolled in on the birth date. If the newborn's eligibility is not open-ended, the system creates enrollment with a closed end date. The enrollment span covers each month the newborn is eligible from the birth date through the end of the month when the first gap in the newborn's eligibility occurs.

If the system cannot link the non-Native American newborn to a mother using the criteria above, the system will auto-assign the newborn like any other Medicaid eligible client. If the newborn is Native American, the newborn will not be enrolled in Turquoise Care.

A daily record is sent for the following:

- *Terminations* - During the daily cycle, the system will terminate any clients who are not meeting enrollment criteria. If later in the month, the client's eligibility for enrollment is reestablished, a re-enrollment record will be sent.
- *Re-enrollments* – Clients who have been terminated and then re-enrolled.
- *Recoupments* – Clients whose termination is retroactive will be recorded as recoupment spans.
- *Voided Enrollment* - If the client was previously reported on a Daily 834 Benefit Enrollment and Supplemental Roster files as a new enrollment for the upcoming month and subsequently has that eligibility voided, the client will be shown on a subsequent Daily 834 Benefit Enrollment and Supplemental Roster files as a voided record.

- *Incarceration* – A minor type '6' will indicate an update to incarceration data. The **only** fields that will be updated on an Incarceration record with minor type 6 are the Facility Id and the Incarceration Booking and Release dates.

Other data included in this Incarceration record should not be allowed to update the MCO's member record.

3.7.5 Prospective Medicare Enrollment

Effective April 2023 the MCOs will be sending default enrollment notices to clients who will become Medicare eligible. This is an initiative the State is undertaking to align enrollment for full benefit dually eligible individuals, thereby streamlining Medicare enrollment for newly Medicare eligible into their existing Medicaid MCO's D-SNP with the option to opt out in favor of Original Medicare.

To enable this default enrollment, the Supplemental Enrollment Roster file will begin sending the prospective Medicare dates for clients who have not previously been enrolled in Medicare. Prior to this time, the roster file only includes Medicare spans that overlap the current enrollment month. The State obtains future Medicare spans from CMS and starting in April, will report them on the roster. There is no change to the file layout, but the following will be:

- The change applies to Medicare Parts A and B only.
- Prospective Medicare data will only be reported on current enrollment month major type E roster records.
- The Medicare coverage indicator on the roster will continue to be set only in the context of current Medicare coverage and will not be set if the client has only prospective Medicare coverage.

Upon implementation, the new process would call for the MCOs to ingest the future date spans and send default enrollment notices to their clients who have the future Medicare begin dates. Clients would have the right to opt-out, otherwise they'll be enrolled with the MCO for both their Medicaid and their D-SNP plans. The systems manual doesn't outline this process; only note that the prospective spans will be sent.

3.7.6 Monthly Enrollment Reporting

In the nightly cycle, 3 days before the end of the month, the system will generate a monthly 834 Benefit Enrollment and Supplemental Roster files. These files will show all the clients active or terminated as of the upcoming enrollment month, along with any retroactively enrolled eligible clients. It is also during this process that the system will produce open enrollment reminder letters for clients who are in the 9th month of a 12-month lock-in period.

Clients who have appeared on the Daily 834 Benefit Enrollment and Supplemental Roster files will appear again on the Monthly 834 Benefit Enrollment and Supplemental Roster files. There will be a separate record for each retro span record and ongoing span record.

Any clients added retroactively once the monthly processing is run will be reported on the next Daily 834 Benefit Enrollment and Supplemental Roster files and captured in the next monthly reporting.

3.7.7 Enrollment Roster File

The Daily Supplemental Roster file format is the same as the Monthly Supplemental Roster file. The file differentiates between new enrollees, ongoing enrollees and terminated enrollees by using a Major Enrollment Indicator as follows:

Major Enrollment Indicator	Values	Values
E	Enrolled	New Enrollee
E	Enrolled	Ongoing Enrollee
T	Terminated	Disenrolled
R	Retroactive	Retroactive Enrollment
X	Recoupment	Recoupment

Since retroactive enrollments are reported on the Supplemental Roster file, it is possible for the roster to have multiple entries for one client: one for each month of retroactive enrollment, and one for the current month enrollment. Recoupment spans are created when a client was enrolled in the MCO for the enrollment month, but ASPEN determines that a mistake in enrollment was made and either reassigns the client to Fee for Service Medicaid or determines the client as ineligible. The recoupment span notifies the MCO that the client is not considered enrolled in that MCO for the enrollment month indicated by X5 span, despite what may have been communicated on an earlier enrollment roster. If a recoupment spans multiple months, there will be an entry with X5 span for each month the recoupment is effective. This will typically only happen because of audit activity or retroactive date of death.

It is the nature of eligibility and enrollment that clients lose eligibility for enrollment which results in a recoupment span that is sent on the roster file; only to be added back retroactively later. MCOs recovering paid claims from providers based on the roster recoupment span is a premature action that places an unnecessary burden on the providers and the MCO. HCA instructs the MCOs that they must not recover claim payments from providers upon receipt of the recoupment span on the Enrollment Roster file. MCOs must wait and only be recouped from the providers if the capitation payment for the month of service that covers that claim's dates of service is voided by HCA. The capitation voids are reported on the 820, the electronic remittance.

It is possible that the enrollee’s begin date shown on the enrollment roster may change, although the enrollee has been an ongoing enrollee with that plan. The MCO should rely on the combination of the Major Enrollment Indicator and the enrollee’s begin date to identify the enrollee’s status as new or ongoing. It may happen that a new enrollee will have both a begin date and an end date, due to their having chosen to transfer to another MCO at some point in the future or perhaps due to a future loss of eligibility for managed care. The enrollee with an end date will also show up as a Terminated Enrollee on the month in which the termination takes place.

The Monthly Supplemental Roster File contains both demographic information about the enrollees as well as the capitation amount to be paid for each enrollee and that enrollee's cohort number. The file is sent through the System Integration Platform (SIP) to the MCO.

3.7.7.1 Supplemental Roster File Layout

The layout for the Supplemental Roster file is located HCA-MCO - Documents - MCO Business Manual - All Documents . The layout is the same regardless of whether the file is produced from the Daily or Monthly Cycle.

Notes:

1. All dates are formatted CCYY-MM-DD except for the month of service which is formatted YYYYMM.
2. Some fields are not required/populated for Terminations. Cohort numbers and rate types are not generated for terminations or recoupments.
3. Unless otherwise stated, information for enrollment spans and the highest ranked health plan COE span for new or ongoing enrollees is taken from the span in effect for the current enrollment month. Information from enrollment spans and the highest ranked health plan COE span for terminations is taken from the span in effect for the prior enrollment month.
4. For new plan enrollers, the transfer MCO and plan information is the plan in which the client was enrolled in the month immediately prior to the current enrollment month; otherwise, it is blank. For terminations, the transfer MCO and plan information is the plan to which the client has switched. For retro enrollments, the transfer MCO and plan number is the plan in which the client was enrolled in the month prior to the retro enrollment (if any enrollments exist and the provider/plan number is different than the retro enrollment - otherwise it contains spaces).
5. For retro enrollments and recoupments there is a separate roster record for each retroactive enrollment or recouped month. The enrollment begin and end dates (LockinBeginDate, LockinEndDate) reflect the first and last day of the month to which the retroactive enrollment or recoupment applies. The roster record's major type (MajorRecordType) is always within the context of the current capitation month (MOServiceDate). In July 2016 (RAT 3124), the State requested that we change "R" (retro enrollment rosters) to "E" (ongoing enrollments) if there was an enrollment lock-in span within the past three months preceding the begin date of the retroactive enrollment span for the same MCO provider. If there was no prior enrollment within the previous three months or the MCO provider was not the same, then the "R" is not changed and will remain an "R". The intent of this change is to ensure that the definition of the "R" record is consistent with Mercer's definition. This record type conversion activity is done after the roster has been created but before it is sent out to the MCO's and before the electronic 834's has been generated.
6. For retroactive enrollments this is the rate cohort number used to determine the physical health or behavioral health cohort capitation rate that applied during the month covered by the enrollment begin and end dates. For ongoing enrollments this is the rate cohort number used to

determine the physical health or behavioral health cohort capitation rate that applies to the current enrollment month.

7. The patient liability amounts are also referred to as the medical care credit amounts. These fields are not populated for recoupment and/or termination rosters. Patient liability information is sent from ASPEN on the roster extract.
8. Cohort rates and amounts are calculated using the rate type returned from the managed care eligibility subroutine along with demographic data. If the cohort number shown is '999', this means that the system could not assign a cohort. These are considered errors and are worked by the state and will result in either a cohort assignment which will be seen on the MCO's 820, or a recoupment of the enrollment span that was sent.
9. For current month enrollment and termination roster records (record major type codes E and T), the incarceration booking date, release date, and facility ID are populated from the non-voided COE/FM 054/3 span with the most recent booking date that overlaps the current enrollment month. For retro enrollment month and recoupment roster records (record major type codes R and X), the incarceration booking date, release date, and facility ID are populated from the non-voided COE/FM 054/3 span with the most recent booking date that overlaps the retro enrollment or recoupment month. Incarceration COE spans with contiguous end and begin dates are combined.

The Incarceration Facility IDs are as follows:

FACILITY_ID	FACILITY_NAME
100	Bernalillo County Youth Services Center
101	Bernalillo Metropolitan Detention Center
102	Catron County Detention Center
103	Chaves County Detention Center
104	Chaves Juvenile Detention Center
105	CYFD - Camino Nuevo Youth Center
106	CYFD - John Paul Taylor Center
107	CYFD - San Juan Juvenile Facility
108	CYFD - Youth Diagnostic and Development Center
109	Cibola County Correctional Center
110	Vigil Maldonado Detention Center
111	Curry County Detention Center
112	Curry County Juvenile Detention Center
113	De Baca County Detention Center
114	Dona Ana County Detention Center
115	Dona Ana Juvenile Detention Center
116	Eddy County Detention Center
117	Hidalgo County Detention Center
118	Grant County Detention Center
119	Lea County Juvenile Detention Center
120	Lea County Detention Center

121	Lincoln County Detention Center
122	Los Alamos County Detention Center
123	Luna County Juvenile Detention Center
124	Luna County Detention Center
125	McKinley County Adult Detention Center
126	McKinley County Juvenile Detention Center
127	(CNMCF) Central New Mexico Correctional Facility - Level 1
128	(CNMCF) Central New Mexico Correctional Facility
129	(GCCF) Guadalupe County Correctional Facility
130	(LCCF) Lea County Correctional Facility
131	(WNMCF) Western New Mexico Correctional Facility South
132	(NENMCF) Northeast New Mexico Correctional Facility
133	(OCPF) Otero County Prison Facility
134	(PNM) Penitentiary of New Mexico
135	(RCC) Roswell Correctional Center
136	(SNMCF) Southern New Mexico Correctional Facility
137	(SCC) Springer Correctional Facility
138	(WNMCF) Western New Mexico Correctional Facility North
139	Otero County Detention Center
140	Quay County Detention Center
141	Rio Arriba County Detention Center
142	Roosevelt County Detention Center
143	San Juan County Detention Center
144	San Juan County Juvenile Services Center
145	San Miguel County Detention Center
146	Sandoval County Detention Center
147	Santa Fe County Adult Detention Facility
148	Santa Fe County Juvenile Detention Center
149	Sierra County Detention Center
150	Socorro County Detention Center
151	Taos County Adult Detention Center
152	Taos Juvenile Detention Center
153	Torrance County Detention Facility
154	Valencia County Detention Center
155	San Juan Alternative Sentencing
160	Department of Health - Forensic Unit
165	Guadalupe County Sheriff's Office

180	Zuni Detention Center
6528	Pueblo of Laguna Detention Facility
6944	Crownpoint Department of Corrections

10. CYFD Offices are sent in the Payee Address fields. The offices are:

County	Office Manager	Address	Phone #	Fax #
Jennifer Archuleta-Earp, JenniferA.Earp@state.nm.us, NW Regional Manager, Phone: (505) 867-2373				
Cibola	Rebecca Sandoval rebecca.sandoval@state.nm.us	1019 E. Roosevelt Ave, Ste. A Grants, NM 87020	(505) 285-6673	(505) 287-7603
McKinley	Charles Reado Charles.Reado@state.nm.us	1720 East Aztec, Gallup, NM 87301	(505) 863-9556	(505) 722-6976
San Juan	Deborah Yost DeborahA.Yost@state.nm.us	2800 Farmington Ave., Farmington, NM 87401	(505) 327-5316	(505) 599-9680
Sandoval	Cantrell Mosley cantrell.mosley@state.nm.us	4359 Jager Dr., NE, Suite D, Rio Rancho, NM 87144	(505) 771-5990	(505) 867-7671
Torrance	Vacant	214 S. 5th Street, P.O. Box 348, Estancia, NM 87016	(505) 384-2745	(505) 384-2891
Valencia	Kimberly Chavez-Buie kim.chavez-buie@state.nm.us	750 Morris Road, SW, Los Lunas, NM 87031	(505) 866-2300	(505) 866-2319
Natividad Posda, Natividad.Posada@state.nm.us, NE Regional Manager, Phone: (505) 426-1020				
Colfax/Union	April Jolley April.Jolley@state.nm.us	1900 Hospital Drive, Raton, NM 87740	(575) 445-2358	(575) 445-2410
Rio Arriba/Los Alamos	Marylina Tanuz Marylina.Tanuz@state.nm.us	912 North Railroad, Española, NM 87532	(505) 753-7191	(505) 753-0433
San Miguel/Mora/ Guadalupe	Georgia Baca GeorgiaM.Baca@state.nm.us	2518 Ridge Runner Rd., Las Vegas, NM 87701	(505) 426-1020	(505) 425-5049

Santa Fe	Matthew Esquibel matthewa.esquibel@state.nm.us	1920 5th Street, Santa Fe, NM 87505	(505) 827-7450	(505) 827-7440
Taos	Melissa Montoya MelissaD.Montoya@state.nm.us	1308 Gusdorf Rd., Taos, NM 87571	(575) 758-8871	(575) 751-0719
Larry Wisecup, charles.wisecup@state.nm.us, SW Regional Manager, Phone: (575) 434-5950				
Dona Ana Perm Plan & Placement	Theresa Gonzales theresa.gonzales@state.nm.us	2805 Roadrunner Parkway, Las Cruces, NM 88007 945 Anthony Drive, Anthony, NM 88021	(575) 373-6490 (575) 882-7900	(575) 373-6415 (575) 882-7850
Dona Ana Invest & I-HS	Marianne Hernandez marianne.hernandez@state.nm.us	2805 Roadrunner Parkway, Las Cruces, NM 88007 945 Anthony Drive, Anthony, NM 88021	(575) 373-6490 (575) 882-7900	(575) 373-6415 (575) 882-7850
Grant & So. Catron	Melissa Marquez-Gonzales Melissa.Marquez-Gon@state.nm.us	3082 32nd Bypass Rd. Ste. A, Silver City, NM 88061	(575) 538-2945	(575) 388-5498
Luna/Hidalgo	Debbie Orona debbie.orona@state.nm.us	918 E. Pear, Deming, NM 88030	(575) 546-6557	(575) 546-7114
Otero	Jacquelyn Carter Jacquelyn.Carter@state.nm.us	2200 Indian Wells Rd., Alamogordo, NM 88310	(575) 434-5950	(575) 437-3084
Lincoln	Jacquelyn Carter Jacquelyn.Carter@state.nm.us	26387 US Highway 70, Ruidoso Downs, NM 88346	(575) 378-0045	(505) 841-9199
Sierra	Tina VanWinkle tina.vanwinkle@state.nm.us	161 New School Rd., T or C, NM 87901	(575) 894-3414	(575) 894-1044
Socorro/No. Catron	Tina VanWinkle	104 S. 6th Street, Socorro, NM 87801	(575) 835-2716	(575) 835-2257
George Arguello, george.arguello@state.nm.us, SE Regional Manager, Phone: (575) 461-0110				
Chaves	Matthew Rael matthew.rael@state.nm.us	#4 Grand Ave. Plaza, Suite A, Roswell, NM 88201	(575) 624-6071	(575) 624-6190

Curry	Tamara Letcher Tamara.Letcher@state.nm.us	221 W. Llano Estacado, Clovis, NM 88101	(575) 763-0014	(575) 763-0041
Roosevelt	Tamara Letcher Tamara.Letcher@state.nm.us	1500 South Avenue D, Portales, NM 88130	(505) 841-9150	(575) 356-2601
Eddy/Carlsbad	Maria Calderon maria.calderon@state.nm.us	901 DeBaca, Carlsbad, NM 88220	(575) 887-3576	(575) 887-6437
Eddy/Artesia	Maria Calderon	2215 W. Main, Artesia, NM 88210	(575) 748-1221	(575) 748-3789
Lea/Hobbs	Trish Garza Patricia.Garza@state.nm.us	907 West Calle Sur, Hobbs, NM 88240	(575) 397-3450	(575) 397-3472
Quay/Harding/DeBaca	Molly Clement Molly.Clement@state.nm.us	107 West Aber, Tucumcari, NM 88401	(575) 461-0110	(575) 461-4173
Michelle Threadgill, michelle.threadgill@state.nm.us, Metro Regional Manager, Phone: (505) 841-7800				
Metro Reg Off #1	Christina Nuanes christina.nuanes@state.nm.us	4501 Indian School Rd., NE, Bldg. 3, Alb, NM 87110	(505) 841-7800	(505) 841-7867
Metro Reg Off #2	Lisa Moore Lisa.Moore@state.nm.us	1031 Lamberton Place, NE, Albuq NM 87107	(505) 841-2911	(505) 841-2919
Metro Reg Off #3	Joaquin Morales Joaquin.Morales@state.nm.us	1031 Lamberton Place, NE, Albuq NM 87107	(505) 841-7800	(505) 841-7932
Metro Reg Off #4	Vacant	4501 Indian School Rd., NE, Bldg., 3, Suite 310, Alb NM 87110	(505) 841-2911	(505) 841-6699
Metro Reg Off #5	Anastacia VanOrman Anastacia.Rivera@state.nm.us	1031 Lamberton Place, NE, Albuq NM 87107	(505)841-7800	(505) 841-7982
Leticia Salinas, LeticiaR.Salinas@state.nm.us, SCI & REC CTR Regional Manager, Phone: (505) 841-6100				

SCI Office #1	Paul Williams paul.williams@state.nm.us	4665 Indian School Rd., NE, Bldg. 1, Alb, NM 87110	(505) 841-6100	(505) 841-6691
SCI Office #2	Jeffrey Bowerman Jeffrey.Bowerman@state.nm.us	4665 Indian School Rd., NE, Bldg. 1, Alb, NM 87110	(505) 841-6100	(505) 841-6691
Receiving Center	Dorothy Trujillo-Fierro DorothyM.Trujillo-Fi@state.nm.us	4665 Indian School Rd., NE, Bldg. 1, Alb, NM 87110	(505) 841-6100	(505) 841-6691
Statewide Central Intake Toll Free Line 1-855-333-7233 (855-333-SAFE)				

W1H29051-B-GEO-CBTY_CD Valid Values are:

County Code	County Code Description
01	Bernalillo
02	Catron
03	Chaves
04	Colfax
05	Curry
06	DeBaca
07	DonaAna
08	Eddy
09	Grant
10	Guadalupe
11	Harding
12	Hidalgo
13	Lea
14	Lincoln
15	LosAlamos
16	Luna
17	McKinley
18	Mora
19	Otero
20	Quay
21	RioArriba
22	Roosevelt
23	Sandoval
24	SanJuan
25	SanMiguel
26	SantaFe
27	Sierra
28	Socorro
29	Taos
30	Torrance
31	Union
32	Valencia
33	Cibola
88	OutofCountry
99	OutofState

W1H29051-B-ADM-OFFICE_CD Valid Values are:

01	ISD office Albuquerque
03	ISD field office Roswell
04	ISD office Raton
05	ISD field office Clovis
07	ISD field office Las Cruces
08	ISD field office Carlsbad
09	ISD field office Silver City
10	ISD field office Santa Rosa
12	ISD field office Lordsburg
13	ISD field office Hobbs
14	ISD field office Ruidoso
16	ISD field office Deming
17	ISD field office Gallup
18	ISD field office Las Vegas
19	ISD field office Alamogordo
20	ISD field office Tucumcari
21	ISD field office Espanola
22	ISD field office Portales
23	ISD field office Rio Rancho
24	ISD field office Farmington
25	ISD field office Las Vegas
26	ISD field office Santa Fe
27	ISD field office T or C
28	ISD field office Socorro
29	ISD field office Taos
30	ISD field office Moriarty
32	ISD field office Belen
33	ISD field Grants
34	ISD field office Artesia
35	ISD field office Albuquerque
36	ISD field office SW Bernalillo County
37	ISD field office Las Cruces
38	ISD field office Anthony
39	ISD field office NE Bernalillo county
40	Admin office Santa Fe
42	ISD field office Los Lunas
45	SCI North, Bernalillo
47	SCI South Las Cruces
49	Centralized units Bernalillo

3.7.8 ISD County Offices

Table 1 - ISD Country Offices

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
NE Bernalillo 7:30-5:00	01 39	222-9600		222-9652	4330 Cutler Ave., NE P.O. Box 36090 Albuquerque, NM 87176	Dennis Davis	222-9603
NW Bernalillon 7:30-5:00	01 35	841-7700		841-7757	1041 Lamberton Place NE P.O. Box 25287 Albuquerque, NM 87125	Juli A. Lindsey	841-7775
SE Bernalillo 7:30-5:00	01 01	383-2600	1-800-432-6217 COM Fax	383-2105 383-2151	1711 Randolph Rd, SE. Po Box 19310 Albuquerque, NM 87109	Rochelle Radloff	383-2661
SW Bernalillo 7:30-5:00	01 36	841-2300	COM Fax	841-2381 841-2395	3280 Bridge Blvd. SW P.O. Box 12355 Albuquerque, NM 87195	David Otero	841-2339
Catron	02	Contact Socorro County ISD Office					
Chaves 8:00-5:00	03 03	625-3000	1-800-824-8971	625-3099	1701 S. Sunset Roswell, NM 88203	Lorraine Gutierrez	625-3019
Cibola 7:00-5:00	33 33	287-8836		285-6278	900 Mount Taylor Ave. Po Box 1390 Grants, NM 87020	David Klumpenhower	287-1305

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
Colfax 8:00-5:00	04 04	445-2308		445-2218	1233 Whittier St. Raton, NM 87740	Phillip Rodriguez Cell	Ext. 108
Curry 8:00-5:00	05 05	762-4751	COM Fax	763-0493 742-1978	3316 North Main Suit A Clovis, NM 88101	Olga Aldaz Cell	762-6222
DeBaca	06	Contact Guadalupe County ISD Office					
W. Dona Ana 8:00-5:00	07 07	524-6500		524-6509	655 Utah Ave. Las Cruces, NM 88001	Dorothy Fisher	Ext: 1110
S. Dona Ana 8:00-5:00	07 38	882-5781		882-4728	220 Crosset Lane P.O. Box 4130 Anthony, NM 88021	Juan Ramos	Ext. 230
E. Dona Ana 8:00-5:00	07 37	524-6568		524-6510	2121 Summit Ct. Las Cruces, NM 88011	Richard Gil	Ext. 204
Eddy /Artesia 8:00-5:00	08 34	748-3361		746-6123	108 N. 16th St. Artesia, NM 88210	Sarah McArthur	Ext. 1008
Eddy/Carlsbad 8:00-5:00	08 08	885-8815		887-0550	3604 San Jose Blvd Carlsbad, NM 88220	Jerry Barnes Cell (Staff)	Ext. 1006 361-0319
Grant 8:00-5:00	09 09	538-2948	1-800-331-7311 COM Fax	538-0241 534-3422	3088 32nd Street Bypass Suite A Silver City, NM 88061	Corina Rivera	Ext.1023
Guadalupe 8:00-5:00	10 10	472-3459	1-800-523-6643	472-3425	620 Historic Route 66 Santa Rosa, NM 88435	Rita Romero	Ext: 124

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
Harding	11	Contact San Miguel County ISD Office					
Hidalgo 8:00-5:00	12 09	542-3562	COM Fax	542-3226 534-3422	109 Poplar St. Lordsburg, NM 88045	Corina Rivera	538-2948 Ext. 1023
Lea 8:00-5:00	13 13	397-3400	COM Fax	393-2529	2120 N. Alto-Suite D Hobbs, NM 88240	Paul Harms	397-3423
Lincoln 8:00-5:00	14 14	378-1762		378-2204	26387 Hwy-70 PO Box 606 Ruidoso Downs, NM 88346	James K McCleland	Ext.41202
Lovington	37	Contact Lea County ISD Office					
Luna 8:00-5:00	16 16	546-0467	COM Fax	546-9326	910 E. Pear P.O. Box 818 Deming, NM 88030	Rebecca Joe	Ext. 103

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
McKinley 8:00-5:00	17 17	863-9545	1-800-825-7422	722-0991	2907 E. Aztec Avenue Gallup, NM 87301	Edna Ashley	Ext. 152
Mora	18	Contact San Miguel County ISD Office					
Otero 8:00-5:00	19 19	437-9260	1-800-826-4468	437-3098	2000 Juniper Drive Alamogordo, NM 88310	Rebeca Schuyler-Avila	Ext: 104
Quay 8:00-5:00	20 20	461-4627		461-2983	421 W. Tucumcari Blvd. Tucumcari, NM 88401	Rita Romero	Ext. 109
Rio Arriba 8:00-5:00	21 21	753-2271	1-800-231-2835	753-5826	228 Paseo de Onate Street Espanola, NM 87532	Antonette Cordova	Ext: 1001
Roosevelt 8:00-5:00	22 22	356-4473		359-2142	1028 Community Way P.O. Box 1090 Portales, NM 88130	Sherry Moulder	Ext. 1027
Sandoval 7:30-5:00	23 23	383-6300	1-800-926-9425	383-6307	4363 Jager Drive Rio Rancho, NM 87144	Vacant	383-6305
San Juan 8:00-5:00	24 24	566-9600	1-800-231-6667	566-9655	101 W. Animas P.O. Box 5250 Farmington, NM 87499	Roger Burton	566-9605
San Miguel 8:00-5:00	25 25	425-6741		454-0256	3112 Hot Springs Blvd. P.O. Box 1348 Las Vegas, NM 87701	Seth Conkle	Ext. 113

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
Santa Fe 8:00-5:00	26 26	827-1932	1-800-231-8081	827-1940	2542 Cerrillos Road Santa Fe, NM 87505	Cathy Sisneros OIC	827-1911
Sierra 8:00-5:00	27 27	894-3011	1-800-560-3011	894-1021	102 Barton Street T or C, NM 87901	Lorie Medina	Ext.110
Socorro 8:00-5:00	28 28	838-8700	1-800-245-9571	835-9478	1014 N. California Str P.O. Box LL Socorro, NM 87801	Joseph Mascarena	838-8723
Taos 8:00-5:00	29 29	758-8804		758-1012	145 Roy RD Taos, NM 87571	Delfino "Del" Torres	Ext. 1002
Torrance 8:00-5:00	30 30	832-5026	1-866-335-7293	832-4882	109 Tulane Ave. P.O. Box 400 Moriarity, NM 87035	Belinda Garland	Ext. 1006
Union 8:00-5:00	31 04	374-9401		374-2853	834 Main Street Clayton, NM 88415	Phillip Rodriguez	445-2308 Ext. 108
Valencia 8:00-5:00	32 32	864-5200		864-5247	620 E. Reinken Rd P.O. Box 259 Belen, NM 87002	Dennis Salas	864-5242
Valencia North 8:00-5:00	32 42	222-0800		222-0888	445 Camino Del Rey Los Lunas, NM 87031	Robert Chavez	222-0844

County Office	Geo/Adm County Code	Main Phone #	Toll Free #	Fax #	Address	Manager	Phone
Tierra Amarillo 8:00-5:00	21 21	588-7103		588-7369	17345 Chama Highway P.O. Box 816 Tierra Amarillo, NM 87575	OIC Antonette Cordova	753-2271 Ext: 1001

Table 2 – Category of Eligibility Valid Values

COE Cd	COE Code Description
001	SSIAgedorMedicaidExt-Aged
003	SSIBlindorMedicaidExt-Blind
004	SSIDisbldorMedicaidExt-Disabled
006	FosterCareChildProtectiveSvc
014	RefugeesFosterCare
017	SubsidyAdoptionOtherStates
018	Repatriates (Cash&MedAssist)
019	Refugee (Cash&MedAssist)
027	PostClosure-Eligible4Months
028	TransitionalMedicaid
029	FamilyPlanning
030	MedicalAssist-PregnantWomen
031	Newborns
032	133%ofPovertyKids
033	AFDC-DeemedIncomeDisregard
034	SSI-DeemedIncomeDisregard
035	PregnantWomen-with Fed Match =1
036	185%ofPovertyKids
037	TitleIV-EsubsidyAdoption

COE Cd	COE Code Description
066	Foster Care TitleIV-E
071	CHIP-235%PvtyKids with Fed Match = 1
072	Non-TANF(AFDC) with Fed Match = 1
073	12MonthExtension
074	QualifiedWorkingDisabled(QWD)
081	InstitutionalCare-Aged
083	InstitutionalCare-Blind
084	InstitutionalCare-Disabled
085	EMCforUndocumentedAliens
086	FosterChildFromAnotherState
090	HCBW-AIDS
091	HCBW-Handicapped&Elderly
092	HCBW-VentilatorDependent
093	HCBW-Hndicapped&Elderly(Blind)
094	HCBW-MedHandicapped(Disabled)
095	HCBW-MedicallyFragile
096	HCBW-DevelopmentallyDisabled
097	HCBW-Non-MedicaidElderly
098	HCBW-Non-MedicaidBlind

COE Cd	COE Code Description
041	QMB-Age65andOver
044	QMB-UnderAge65
046	FCChildOutofNMTitleIV-E
047	SubsidyAdoptOutofNMTitleIV-E
048	Repatriates-(MedicalAssistOnly)
049	Refugee-(MedicalAssistanceOnly)
051	SpecialMedicalNeeds-Aged
052	Breast or Cervical Cancer
053	Special Medical Needs-Blind
059	Refugee-(MedicalAsstSpend-down)

COE Cd	COE Code Description
099	HCBW-Non-MedicaidHandicapped
100	Other Adults (133% FPL)
200	Parents/Caretaker Relatives
300	Full Medicaid for Pregnant Women (0% up to 133%)
301	Pregnancy-Related Medicaid (133% up to 185%)
400	Children's Medicaid (0% to 133% FPL)/0-5
401	Children's Medicaid (0% to 133% FPL)/6-19
402	Children's Medicaid (133% to 185% FPL)/0-5
403	Children's Medicaid (133% to 185% FPL)/6-19
420	CHIP Medicaid (185% to 235% FPL/CHIP kids)/0-5
421	CHIP 6-18 190-240% FPL

LockinAssignmentReasonCode Valid Values are:

Value	Long
AA	Auto Assignment
AE	Administrative Assignment
CC	Client Choice
FC	Family Continuity
RE	Reenroll with Previous Prov
RI	Recoupment - Ineligibility
RN	Retroactive Newborn
RO	Recoupment - Other
RP	Retroactive Enrollment
RS	Recoupment - Incarcerated
RX	Recoupment - Death

3.7.9 Disability Type

Value	Definition
BL	Blind
DF	Deaf
ME	Mental
OT	Other
PH	Physical
UN	Unknown

3.7.10Race

1	Caucasian
2	Hispanic
3	American Indian
4	Asian/Pacific Islander
5	Black/African American
6	Other
9	Unknown
A	Native Hawaiian or Other Pacific Islander
B	African American and White
C	Asian and White
D	American Indian or Alaska Native and White
E	American Indian or Alaska Native and African American

B-LCKN-CHNG-RSN-CD Valid Values are:

Value	Long
AC	Administrative Closure
CC	Client Choice
CM	Disenroll - County Move
CR	Disenroll - Client Request
DD	Disenroll – Death
DE	Disenroll – Dept Exempt
IN	Disenroll - Incarcerated
LE	Loss Of Eligibility

Value	Long
LO	Lockout
LT	Disenroll - Res In LTC/MH Fac
OS	Disenroll - Moved out of State
DL	Disenroll – Med Mgmt, Hspc,Lck
EC	Exclusion
OV	Override 12 Mo MCO Lockin
RC	RAC Audit
RD	Recoupment - Duplicate Client
RI	Recoupment - Loss of Eligibility
RO	Recoupment – Other
RS	Recoupment Incarcerated
RX	Recoupment - Death
SD	Disenroll - MCO Switch

IndianTribeCode– Client Tribal Code
This code designates the tribe to which a Native American client belongs.

Value	Long
	none
1A	Cochiti
1B	Jemez
1C	Sandia
1D	San Felipe
1E	Santa Ana
1F	Santo Domingo
1G	Zia
1H	Nambe
1I	Pojoaque
1J	San Ildefanso
1K	Tesuque
1L	Santa Clara
99	Other
1M	San Juan
1N	Acoma
1O	Laguna
1P	Picturis

Value	Long
1Q	Taos
1R	Isleta
1S	Zuni
1T	Jicarilla Apache
1U	Mescalero Apache
1V	Alamo Navajo
1W	Canoncito Navajo
1X	Ramah Navajo
1Y	Main Reservation Navajo
1Z	Checkerboard Navajo

Ethnicity

HS	Hispanic
NH	Not of Hispanic or Latino or Spanish origin
UK	Ethnicity Unknown

LanguageCode -Primary Language Code

Value	Long	Value	Long	Value	Long
00	English	32	Punjabi	66	Gujarati
01	Spanish	34	Serbian	67	Hausa
02	Vietnamese	35	Slovak	68	Hmong
03	Chinese Mandarin	36	Slovanian	69	Icelandic
04	Chinese Cantonese	37	Swahili	70	Ilocano
05	Arabic	38	Tagalog	71	Lithuanian
06	Korean	39	Taiwanese	72	Macedonian
07	Hindi	40	Thai	73	Malay
08	Farsi	41	Tigrinya	74	Malayalam
09	Urdu	42	Turkish	75	Mien
10	Russian	45	Khmer	76	Navaho
11	Bosnian	46	Greek	77	Tewa
12	Albanian	47	Italian	78	Towa
13	Somali	48	Portuguese-Creole	79	Apache
14	French	49	Aklan	80	Zuni
15	German	50	Assyrian	81	Nepali
16	Czech	51	Bambara	82	Norwegian
17	Sing Language	52	Basque	83	Pashto
18	Amharic	53	Bhojpuri	84	Romanian
19	Armenian	54	Bulgarian	85	Shanghai
20	Bengali	55	Burmese	86	Somoan

21	Croatian	56	Cambodian	87	Swedish
22	Haitian-Creole	Campuchean		88	Toishanese
23	Hebrew	57	Catalan	89	Tongan
24	Hungarian	58	Chaochow	90	Ukranian
25	Indonesian	59	Danish	91	Wolof
26	Japanese	60	Dari	92	Yiddish
27	Kurdish	61	Dutch	93	Yoruba
28	Laotian	62	Estonian	94	Keresan
29	Maltese	63	Fijian	UK	Unknown
30	Polish	64	Finnish		
31	Portuguese				
		65	Fukienese		

EligibilityTerminationReasonCode COE Termination Reason Code

101	The individual(s) listed above did not verify their social security number(s).
102	The date of birth has not been verified for the individual(s) listed above.
103	The individual(s) listed above did not verify their living arrangements.
104	The individual(s) listed above did not verify their student status.
105	The individual(s) listed above did not verify citizenship.
106	The individual(s) listed above did not verify relationship.
107	The individual(s) listed above did not provide information to verify a disability
109	The individual(s) listed above did not verify their SSI status.
113	The individual(s) listed above did not verify identity.
116	The individual(s) listed above did not verify their earnings.
130	The individual(s) listed above did not verify their unearned income.
131	The individual(s) listed above did not verify their checking account(s) amounts.
132	The individual(s) listed above did not verify their savings account(s) amounts.
133	The individual(s) listed above did not verify their resources.
134	The individual(s) listed above did not verify their life insurance.
135	The individual(s) listed above did not verify their vehicle value.
149	The individual(s) listed above did not verify New Mexico residency.
150	The date of death has not been verified for the individual(s) listed above.

202	The individual(s) listed above is not eligible to participate in the program because the individual(s) a U.S. citizen, a legal immigrant, or has not declared U.S. citizenship/legal immigrant status.
206	The individual(s) listed above do not meet program age requirements.
207	The individual(s) listed above did not meet the <PROGRAM NAME> school attendance ements.
208	The individual(s) listed above did not apply for or provide a social security number(s).
209	The individual(s) listed above do not meet the definition of refugee as defined by program policy.
210	The individual(s) listed above failed the New Mexico residency requirement.
212	The individual(s) listed above do not meet the program relationship requirements
213	Your pregnancy has not been medically verified.
217	The individual(s) listed above are participating in a strike.
219	The principal wage earner in your assistance group voluntarily quits a job without good cause. ore, the individual listed above is not eligible for a period of 3 months.
220	The individual(s) listed above do not meet the program definition of disability.
222	The individual(s) listed above do not meet the department's definition of blindness.
226	The individual(s) listed above is NOT institutionalized.
228	You did not cooperate with Child Support Enforcement Division requirements.
232	The individual(s) listed above have been disqualified for intentional violation of program rules.
239	The individual(s) listed above voluntarily quit a job or reduced their earnings.
242	The individual(s) listed above are ineligible students.
243	You are a minor unmarried parent and not living under adult supervision.
254	You have not yet been institutionalized for 30 consecutive days.
257	The member(s) listed above are ineligible for or are not receiving Medicare Part A.
257	The member(s) listed above are ineligible for or are not receiving Medicare Part A.
268	Your child was born or your pregnancy ended.
301	The total countable income of your assistance group exceeds program limits.
305	The financial assistance benefits received by your assistance group have changed.
320	The gross income of your assistance group exceeds program limits.
401	The value of your countable personal and/or real property exceeds resource limits.
402	Your assistance group knowingly transferred resources to qualify for benefits.
544	The individual(s) listed above has passed away.
557	The head of household for your assistance group has passed away.

558	The whereabouts of your assistance group is unknown.
560	The member listed above is not the primary caretaker for the assistance group member(s).
563	The individual(s) listed above walked out of the interview before it was completed.
564	The individual(s) listed above did not provide necessary information to determine eligibility.
565	You have voluntarily withdrawn your application.
566	The application was not signed.
567	The member(s) listed above did not cooperate with the Quality Assurance review.
570	The individual(s) listed above do not live in the household.
571	The individual(s) listed above requested closure of your case.
585	The individual(s) listed above refused to be available for employment.
611	The individual(s) listed above have applied for SNAP benefits in another household. 707
914	The Incapacity Review Unit (IRU) does not have enough information to support the disability claim.
CO2	The individual(s) listed above did not reapply for benefits.
CO3	The individual(s) listed above did not complete the periodic review process or recertification s.
CO4	The individual(s) listed above received Cash Assistance out of state.
MRG	Client Merge
UK	Unknown
SYS	Span Terminated by Turquoise Claims during Cut/Paste Processing

3.7.11 Monthly Cutoff Schedule

Enrollment Month	Monthly Roster Reconciliation Cycle Date
Jan-26	2025-12-25
Feb-26	2026-01-27
Mar-26	2026-02-24
Apr-26	2026-03-26
May-26	2026-04-25
June-26	2026-05-26
Jul-26	2026-06-25

Aug-26	2026-07-28
Sep-25	2026-08-26
Oct-26	2026-09-25
Nov-26	2026-10-27
Dec-26	2026-11-25
Jan-27	2026-12-26

3.7.12 Update Member PL API

Any time Health Home, Care Coordination, or Patient Liability span is added, those records will appear on the Update Member PL API file for the MCO to which the client was enrolled for dates covered by that span. The record could thus be generated for a client the MCO doesn't have currently enrolled. Unlike the Enrollment Roster file which produces data that is in effect only for the upcoming enrollment month.. Since Health Home and Care Coordination levels can be assigned for some clients by an external vendor, the MCO will need to update their files with this information to ensure the MCO doesn't erroneously assign their own care coordination or health home to these clients. Patient Liability can change during the month, so it's important for the MCO to update their records when this data is sent so that nursing facility claims can be paid correctly, deducting the correct patient liability amounts. The file will be transmitted in real time and can be sent seven (7) days a week. The file layout is located HCA-MCO - Documents - MCO Business Manual - All Documents

Notes:

1. For Health Home and Care Coordination spans, the 5 most recently added spans are reported. Any non-voided spans are reported before voided spans. Spans are reported by descending end date, then by descending begin date.
2. If the LTC patient liability span dates are contiguous and have the same amounts, they are consolidated into one span so that the three most recently updated amounts can be reported on the record. Added or updated spans with zero amount are only reported if the most recent prior span had a non-zero amount. If there is a gap between the date spans but the amounts are the same, then both spans would be reported up to 5 spans total. The 5 occurrences of patient liability data are displayed in descending date order so that the most recent amount is reported first.

4.0 **Special** services - long term care, care coordination & support broker

MCOs are responsible for certain administrative tasks that require performing client assessments and reporting the determinations from these assessments and, for long term care services, any

resulting plans of care. This section deals with the interfaces and rules regarding these special services.

4.1 Long Term Care

MCOs are responsible for determining level of care for nursing facility and community benefit services for clients already enrolled in the MCO and for clients applying for Medicaid benefits who are not otherwise Medicaid eligible (NOME) unless they meet the nursing facility level of care (NFLOC) criteria. The NOME clients who are applying for Medicaid and require NFLOC assessments are communicated by ASPEN to the MCOs, who must complete a timely NFLOC assessment and then report their determination back to ASPEN. If the client meets NFLOC and financial eligibility criteria, the client is approved for Medicaid. ASPEN sends the eligibility for the client and sends the managed care enrollment to the MCO that did the assessment on the same day eligibility is approved. The eligibility and enrollment records sent to Turquoise Claims from ASPEN do not include any long-term care information.

MCOs must communicate within 5 days of receiving the client Enrollment Roster file the client's long-term care service delivery model. This is sent on the Update Member LOC API file as a Setting of Care span that includes the begin and end dates of the SOC span, usually a maximum 12-month period. The SOC span may change based on a change in the service delivery model or periodic absences due to hospitalization or change in condition, but unless the client meets the following criteria, it must always fall within the current 12-month NFLOC period.

4.1.1 Continuous NFLOC

A continuous NF LOC is intended to eliminate the requirement for annual NF LOC assessment and determination for Community Benefit Members whose chronic condition is not expected to improve. Continuous NF LOC does not change any comprehensive needs assessment (CNA) requirements.

The Community Benefit Member (NOME and full Medicaid) must meet the following requirements:

1. The Member must have had an approved NF LOC for the prior three years.
2. The approved NF LOC must be related to the Member's primary diagnosis.
3. A continuous NF LOC status must be approved by the MCO Medical Director and documented in the Member's file.
4. The Member's PCP must annually complete and sign a form that documents the Member's ongoing ADL deficits related to the Member's primary diagnosis. The MCO must maintain this form in the Member's file.
5. The MCOs are to use the following list of conditions as a guide to determine appropriate primary diagnosis to be considered for a continuous NFLOC.
    - Cerebral Palsy
    - Chronic Obstructive Pulmonary Disease (end stage)
    - Cystic Fibrosis
    - Dementias (such as Alzheimer's, Multi-Infarct, Lewy Body)

- Developmental Disability (such as microcephaly and severe chromosomal abnormalities)
- Neurodegenerative Diseases (such as ALS, muscular dystrophy, multiple sclerosis,)
- Paralysis secondary to Cerebral Vascular Accident
- Parkinson's Disease
- Paraplegia
- Quadriplegia
- Spina Bifida
- Paralysis secondary to severe spinal cordinjury
- Ventilator Dependent

6. The MCOs will be required to regularly report to HCA the number of Members with approved continuing NF LOC status and other related information as directed by HCA through the Community Benefit Report #4.

Continuous NFLOC is to be reported on the Update Member LOC API interface by sending an end date of12/31/9999.

4.1.2 Short Term Stays in a Nursing Facility

The MCO shall authorize a payable authorization/bed days (revenue code 0190) for a Member residing in a Nursing Facility that is not requesting Long Term Care (LTC) Custodial Care. The MCO shall not complete a NFLOC determination or transmit a Setting of Care (SOC) for Short Term Stays (less than 120 days). The Member will receive their skilled care through their Medicare benefit and if the Member is approved for Medicaid and appears on the MCO Enrollment Roster and the MCO determines the Member does require long-term care placement, the MCO shall submit the NFLOC SOC via the Update Member LOC API file. The NFLOC SOC shall begin the day after the Member has exhausted their Medicare skilled care benefits (generally the first 100 days).

4.1.3 Medicaid Pending

The MCO will conduct an NFLOC determination once and only if the Member is admitted under LTC Custodial Care. The Nursing Facility must notify Income Support Division

(ISD) once the Member reverts to LTC Custodial Care. ISD/HCA shall not submit an ASPEN 112 notification to the MCO while the Member is receiving skilled/acute care through a short-term stay/skilled nursing through a Skilled Nursing Facility (SNF)/Nursing Facility. ISD/HCA will send the MCO an ASPEN 112 notification upon receipt of NFLOC packet for a Member applying for Institutional Medicaid.

The MCO will receive notification via ASPEN 112 and will have 30 calendar days to complete a NFLOC determination upon receipt of a complete NFLOC packet from the Nursing Facility. The MCO will submit a response with the NFLOC determination on the ASPEN 113 file. If an incomplete packet is received and the MCO is unable to make an NFLOC determination, the MCO should follow the Request for Information (RFI) process to obtain complete documentation. If after failed attempts the documentation is not received, an Administrative Denial can be transmitted on the ASPEN 113 file.

If the Member's NFLOC determination is approved and the Member qualifies both for financial and medical eligibility, the Member will be assigned an MCO. Once the MCO receives notification of eligibility via the Enrollment file, the MCO will determine the payable authorization and assign/transmit the Institutional Nursing Facility (INF) SOC to HCA via the Update Member LOC API file within five (5) business days.

4.1.4 LTC Custodial Care

The MCO will conduct an NFLOC determination for Members with Full or Institutional Medicaid that are residing in a Nursing Facility and accessing services through LTC Custodial Care. The MCO will assign/transmit the Institutional INF SOC to HCA via the Update Member LOC API file within five (5) business days in alignment with the payable authorization dates.

If the Member is under Institutional Medicaid (COE 081-084), the MCO will transmit the NFLOC determination on the ASPEN 113 file. ISD will send ASPEN 112 notification to the assigned MCO at 90, 45 and 30 calendar days prior to the current NFLOC expiration date.

If in the event a Member leaves the facility Against Medical Advice (AMA), prior to a Community Reintegration (CRI), or passes away prior to the 90th calendar day in an LTC Custodial Care facility, the MCO shall truncate the payable authorization and INF SOC span with the end date reflecting the discharge date/last date of the facility.

For Members that have a Community Benefit COE (090-094), the Member does not qualify for LTC Custodial Care. The Member or facility must notify ISD and/or apply for Institutional Medicaid to qualify for LTC Custodial Care. A Community Benefit Member can still access services through a short-term stay and/or through a Skilled Nursing Facility. The member should apply for Institutional Medicaid if transitioning from the community to a Nursing Facility. If the LOC is current for COE 090-094, ASPEN would not send a 112 notification for IC Medicaid and would use the current LOC in ASPEN for eligibility.

Members admitted to the Nursing Facility who are on the Medically Fragile (COE 095) Developmentally Disabilities (COE 096) and Supports Waiver (COE 096) should not be transitioned to Institutional Medicaid unless the Member plans to remain in the facility long-term. If the member is transitioned to Institutional Medicaid, their Waiver eligibility and access to Home and Community Based Services will be terminated. A Member who is under a Medically Fragile, Developmentally Disabled or Supports Waiver COE can still access skilled/acute care through a short-term stay/skilled nursing through a Skilled Nursing Facility/Nursing Facility. The member can also be approved for LTC in the Nursing Facility or Community Benefit even though they have the COE 095 or 096, but the Waiver Authorization must be end dated 1 day prior to the start of the MCO's LTC span. This data can be validated by the Update Member PL API file that has the TPA Waiver Authorization information.

4.1.5 MCO Review Type and Requirement Chart

Review Type	Nursing Facility Level of Care (NFLOC)	Setting of Care (SOC)	Payable Authorization	Revenue Code

Skilled Nursing Facility	*Not required*	*Not required*	*Payable authorization will be issued upon Member meeting medical criteria*	*Dependent on the Nursing Facility and MCO contract*
Short Term Stay	*Not required*	*Not required*	*Payable authorization will be issued upon Member meeting medical criteria*	*Short Term Stay: 0190- Subacute Care Level 1*
Long Term Custodial Care	*NFLOC must be submitted with approval or denial*	*SOC must be transmitted with an approved NFLOC and payable authorization*	*Payable authorization will be issued upon Member meeting NFLOC criteria and bed days/authorization dates will be issued to align with HCA Criteria/NFLOC timelines and is dependent on Medicaid eligibility.*	*Low Nursing Facility Level of Care: 0190- Subacute Care/LNF* *High Nursing Facility Level of Care: 0199- Subacute Care/HNF* **Reserve Bed Days (Home)-Revenue Code 0182* **Reserve Bed Days (Hospital)-Revenue Code 0185*
Hospice Care in Nursing Facility	*NFLOC must be authorized for Hospice Care in a Nursing Facility*	*SOC must be transmitted with an approved NFLOC and payable authorization.* *The dates of service billed must align with the Institutional* *Nursing Facility (INF) SOC.*	*Payable authorization will be issued upon Member meeting NFLOC criteria and bed days/authorization dates will be issued to align with HCA Criteria/NFLOC timelines and is dependent on Medicaid eligibility.*	*Hospice: 0658- Hospice Room and Board* *Hospice: 0659- Other Hospice Room and Board*

Clients with IC Restricted Coverage

Sometimes, a member may be approved for Medicaid under a restricted IC category. A client with restricted IC category is eligible for all Medicaid benefits except for long term care benefits. The restricted coverage is identified by the client having a COE 081, 083, or 084 with a fed match code of '4'. The COE and Fed match are on the MCO's enrollment roster. Only once the client's restricted

coverage is closed and ongoing Medicaid is established will the client have long term care benefits included in their Medicaid coverage.

The MCOs should always submit NF LOC determinations via the ASPEN interface. However, if the MCO receives enrollment for a member who is on IC restricted coverage "fed match code '4', even though the MCO has already determined the client to meet the NFLOC criteria, the client is not eligible for long term care benefits, and the NF LOC/SOC must not be submitted via the Update Member LOC API file until the fed match '4' has been removed. The MCO should provide all other non-long term care benefits the client needs during this period of IC Restricted coverage.

4.1.6 Completing & Reporting NF LOC and SOC Determinations

When a client who is not enrolled with an MCO applies for Medicaid for long term care benefits, the eligibility system, ASPEN, will initiate a referral to an MCO to initiate a level of care assessment. These level of care assessment requests are randomly generated unless the client has chosen the MCO as part of their eligibility application. This file will be a daily file that the MCO is expected to process and schedule a Nursing Facility level of care assessment as soon as possible for any clients on the file, not to exceed 45 days from the date of the request for assessment. These clients will not be on the MCO's Enrollment Roster file at the time the request for assessment is made.

Clients who are already enrolled with the MCO with a full Medicaid category may also request or be referred to as a level of care assessment. These clients will already have Medicaid so communicating the NFLOC determination to ASPEN is not needed. If determined to meet level of care criteria, the MCO will communicate the determination of NFLOC on the Update Member LOC API interface file as a Setting of Care span.

Once the nursing facility determination is made for a client not enrolled with the MCO, the MCO will return information about the determination to ASPEN on the MCO to ASPEN interface file. If the client is determined to be eligible for nursing facility level of care and financially eligible for Medicaid, the client will be sent by ASPEN to Turquoise Claims with their eligibility data showing the MCO Choice as the MCO who completed the NF LOC determination. Turquoise Claims will then enroll the client to the MCO, reflected in the MCO Choice field and send client data on the Enrollment Roster file.

The MCO will then submit updates to the client information via the Update Member LOC API interface to reflect the nursing facility level of care and the Setting of Care effective dates and provider information.

Sometimes, the client may request with their Medicaid application a different MCO than the one performing the NFLOC determination. When this happens, it is critical that the MCO receiving the enrollment recognize the need for submitting the long-term care SOC span to Turquoise Claims. If the MCO receives a new client on its enrollment file whohas a Category of Eligibility in an IC (081, 083, 084) or Waiver category (090 through 094), these clients should be flagged for submission of the long-term care SOC span. If the MCO has not completed a long-term care assessment, this probably means that another MCO performed the assessment, and the client is either in a nursing facility or should be receiving Community Benefit services. The MCO is instructed to immediately contact *Medical Assistance Division Allocations Manager 505-476-7258* to receive the MCO NFLOC assignment information. The MCO can then contact that MCO to obtain the NFLOC determination

information. If the client is in an 081, 083, 084 category and in a nursing home, the MCO must submit a long-term care span in the Update Member LOC API file within 10 business days of receiving the client on their enrollment roster. If the client is in a waiver category, the MCO must develop a plan of care and submit that long term care SOC span on the Update Member LOC API interface within 10 business days.

The timelines for reporting NF LOC and SOC date spans for clients for whom the MCO performed the NFLOC assessment via the ASPEN and Update Member LOC API files are outlined based on the members:

- Medicaid eligibility status.
- Service authorization level.
- Long-term care (LTC) servicemodel.

4.1.6.1 Member Not Otherwise Medicaid Eligible (NOME)

Category Of Eligibility (COE) 090, 091, 092, 093, 094:

1. **Initial approvals**
   a) The MCO shall submit the Initial NF LOC determination spans via the ASPEN interface file within 40 calendar days of receiving the Primary Freedom of Choice (PFOC) for HCA to make a final Medicaid eligibility determination.
   b) The MCO shall submit the NF LOC effective dates and applicable Setting of Care (SOC) date spans (ADB, SDB or INF) via the Update Member LOC API file within 5 business days of receiving the member's initial enrollment on the Enrollment Roster file.
2. **Initial NF LOC denials**
   a) The MCO shall submit the denial of an NF LOC via the ASPEN interface file within 5 business days of the NF LOC denial. The date span is reported as one day.
   b) **Example:** NF LOC denial was completed on 10/12/24. No later than 10/19/24, the MCO must submit the NF LOC date span as: 10/12/24 – 10/12/24 with disposition reason: Medical Denial – does not meet medical necessity.
   c) The Income Support Division (ISD) will issue a Notice of Case Action (NOCA) with denial of Medicaid eligibility.
   d) Members may request a Fair Hearing by contacting the HCA Fair Hearings Bureau (FHB) or ISD. The member is not eligible to request continuation of benefits (COB). The MCO must adhere to the New Mexico Administrative Code (NMAC) 8.308.15 and the Managed Care Policy Manual Section 16 requirements related to Appeals and Fair Hearings.
   e) The MCO shall not issue Appealrights.
   f) If the member requests a Fair Hearing, the MCO will be notified via the Fair Hearing Acknowledgement notice from the HCA/FHB.
   g) The ISD office will be the primary lead during the Fair Hearing process. The MCO is responsible for the development of the Summary of Evidence (SOE) and distribution to all interested parties. The MCO is also responsible for providing testimony during the Fair Hearing.
   The MCO will receive a copy of the final Fair Hearing decision letter from the HCA/ISD.
3. **If the Fair Hearing is found in favor of the Claimant, the MCO will comply with the final Fair Hearing decision letter and implement necessary steps to uphold the decision within three business days of receipt of the decision letter.**

- **Example**: Member does not have an existing NF LOC date span. The MCO will make the effective date of the Initial NF LOC date, the date the Primary Freedom of Choice (PFoC) is received by the MCO, and the span shall cover a 12-month period. If the PFoC is received on February 14, 2025, the NF LOC date spans would be 02/14/25 – 02/13/26.
- The MCO shall submit the NF LOC date spans via the ASPEN interface file
- The MCO shall submit the NF LOC date spans and applicable SOC date span via the Update Member LOC API file within five business days of receiving the member's initial enrollment on the enrollment roster file.
- If the Fair Hearing decision is in favor of the Department, the MCO does not have any entry/submission requirements.

Annual Recertification

The MCO shall submit the upcoming NF LOC effective date spans via the ASPEN Interface AND the MCO must submit the NF LOC effective dates and SOC applicable date spans (ADB, SDB or INF) via the Update Member LOC API file no later than 60 calendar days prior to the expiration of the existing NF LOC and SOC date spans, including denials. The MCO may begin planning for the Community Benefit reassessment as much as 120 calendar days prior to and must complete the reassessment no less than 60 days prior to the expiration of the existing NFLOC span. For SOC INF, the MCO can only request the packet required for reassessment from the nursing facility 60 days in advance. A 45- and 30-day reminder file is generated from the Income Support Division (ISD) to the MCOs if ISD has not received the next year's NF LOC determination 60 days prior to expiration.

Annual Renewal of NF LOC-denials – MCO Appeal

a) If the MCO has determined that an annual NOME member no longer meets NF LOC at annual renewal, the MCO shall send the Notice of Action (NOA) to the member with the denial of the NF LOC within five business days from the NF LOC determination and will include Appeal and Fair Hearing rights.
b) The MCO shall wait 10 business days, from the date of the NOA, to submit the ASPEN interface file denial, to allow the member opportunity to request COB from the MCO.
c) If the member requests COB within 10 business days:
    1. The MCO shall send an ASPEN interface file with 120 temporary authorization days; and
    2. The MCO shall also send the Update Member LOC API file reflecting the same period as the 120 temporary authorization days and applicable SOC, ADB or SDB.
d) If the member does not request COB within 10 business days, the MCO shall submit the denial of the NF LOC via the ASPEN interface file. The disposition reason is Medical Denial, and the NF LOC date is reported as one day.
e) After the Appeal process has been exhausted:
    1. If the MCO overturns the NF LOC denial decision and the member:
    a) **Requested COB**, the MCO shall send the new annual NF LOC dates via the ASPEN interface file. The new annual NF LOC dates should cover a 12-month period. The MCO shall also send the Update Member LOC API file reflecting the same NF LOC dates span and applicable SOC, ADB or SDB.
    b) **Example**: Current NF LOC dates are: 04/01/25 – 03/31/26. 120 temporary authorization days had previously been submitted to cover 04/01/26 – 07/31/26. The MCO submits

the remaining months to cover a 12-month period (08/01/26 – 03/31/27). There should be no gaps in the NF LOC dates from the previous year.

c) **If you do not request COB**, the MCO shall send the new annual NF LOC dates via the ASPEN interface file and ISD will re-open and approve the Waiver COE. The new annual NF LOC dates must cover the entire 12-month period (04/01/26 – 03/31/27). The MCO shall also send the Update Member LOC API file reflecting the same NF LOC dates span and applicable SOC, ADB or SDB.

1. If the MCO does not overturn the NF LOC denial decision and the member:
    a) **Requested COB**, the MCO shall NOT submit a Medical Denial via the ASPEN interface file because the 120 temporary authorization days are already in ASPEN.
    b) **Did not request COB**, the MCO shall NOT submit a Medical Denial via the ASPEN interface file as this was completed in D above.

Annual NF LOC Fair Hearings & NF LOC/ SOC Timelines

a) If the member has exhausted the MCO Appeals process and **requested COB,** he/she is eligible to request a Fair Hearing through HCA/FHB. If the member requests a Fair Hearing, the MCO will be notified via the Fair Hearing Acknowledgement notice from the HCA/FHB. If the member **did not request COB**, go to letter F of this section.

b) **ASPEN INTERFACE:** The MCO shall review existing NF LOC temporary date spans to determine if enough days have been authorized for COB during the Fair Hearing process. If not, an additional 120-day temporaryNF LOC date span must be submitted within 5 business days of receipt of the Fair Hearing acknowledgement notice.
    1. The ISD will keep the Waiver COE active to allow continuation of eligibility during the Fair Hearing process.
    2. Prior to the 90th day, the MCO shall review the Fair Hearing case status to determine if the Fair Hearing is delayed and will continue beyond the temporary NF LOC span.
    3. If the Fair Hearing is delayed, an additional 120-day temporary NF LOC span must be submitted via the ASPEN interface file by the MCO.

c) **Turquoise Claims INTERFACE:** The MCO shall send a 120-day temporary NF LOC span via the Update Member LOC API file, with the applicable SOC, ADB or SDB, for COB during the Fair Hearing process.
    1. Prior to the 90th day, the MCO shall review the Fair Hearing case status to determine if the Fair Hearing is delayed and will continue beyond the temporary NF LOC span.
    2. If the Fair Hearing is delayed, an additional 120-day temporary NF LOC span and applicable SOC must be submitted via the Update Member LOC API file by the MCO.

d) For members who are Agency Based Community Benefit (ABCB), a continued Prior Authorization (PA) must be sent to the appropriate provider(s) to continue service(s) for the 120-day period and for each subsequent temporary extension submitted during the Fair Hearing.

e) For members who are Self-Directed Community Benefit (SDCB), a partial budget and care plan for 120 days must be entered in the FOCoS System for COB during the Fair Hearing process and for each subsequent temporary extension submitted during the Fair Hearing.

f) The ISD office will be the primary lead during the Fair Hearing process. The MCO is responsible for the development of the Summary of Evidence (SOE) and distribution to all interested parties. The MCO is also responsible for providing testimony during the Fair Hearing.

g) The MCO will receive a copy of the final Fair Hearing decision letter from the HCA/ISD.
   1. If the Fair Hearing is found in favor of the Claimant, and requested COB, the MCO will comply with the final Fair Hearing decision letter and uphold the decision within three business days of receipt of the decision letter.

Example:

- Member's original NF LOC date spans were 04/01/25 to 03/31/26. MCO previously sent a temporary NF LOC span via the ASPEN interface file for 04/01/26 – 07/31/26 AND submitted an Update Member LOC API file with NF LOC and SOC date spans 04/01/26 – 07/31/26.
- Decision letter was received by MCO on 07/06/25 indicating decision is in favor of Claimant. A NF LOC span of 08/01/25 – 03/31/26 must be sent via the ASPEN interface file extending the NF LOC to the original end date so that ISD can reinstate the Waiver COE.
- An Update Member LOC API file submission is also required for NF LOC and SOC for 08/01/25 – 03/31/26.
- For an ABCB case, a PA must be sent to the appropriate provider(s) to continue service(s) through 03/31/26.
- For an SDCB case, the partial budget and care plan must be extended in FOCoS to 03/31/26.
    - If the Fair Hearing is found in favor of the Claimant, and does not request COB, the MCO will comply with the final Fair Hearing decision letter and uphold the decision within three business days of receipt of the decision letter.

- The MCO shall send the new annual NF LOC dates via the ASPEN interface file and ISD will re-open and approve the Waiver COE. **Example:** The new annual NF LOC dates must cover the entire 12-month period (04/01/26 – 03/31/27). The MCO shall also send the Update Member LOC API file reflecting the same NF LOC dates span and applicable SOC, ADB or SDB.
    - If the Fair Hearing decision is in favor of the Department:
        a) The MCO will end the NF LOC and SOC via the Update Member LOC API file effective the date the final Fair Hearing decision letter was received by the MCO (on 07/06/25 per the previous example in G.1. above).
        b) If the MCO has submitted multiple temporary NF LOC date spans, the MCO shall submit the time frame span(s) that need to be voided to John Padilla at johnh.padilla@hca.nm.gov,Tina Romero at tina.romero@hca.nm.gov and Melinda Espinoza at melindaa.espinoza@hca.nm.gov for processing.
        c) The MCO will terminate the PA(s) issued to the appropriate provider(s) effective 14 calendar days (07/20/25) from the date the decision letter was received by the MCO (07/06/25) to provide adequate notice to the providers.
        d) The MCO will develop a closed budget and care plan in FOCoS (effective 7/20/25) and inform the EOR of the closing out so the EOR can notify employees.

4.1.6.2 Members with Full Medicaid

COEs 001, 003, 004, 100, etc.:

1. Initial approvals

The MCO shall submit the NF LOC effective date spans and applicable SOC (ANW, SNW or INF) date spans via the Update Member LOC API file within 5 business days of the NF LOC determination.

2. Initial NF LOC Denials

a) The MCO shall send the NOA to the member with the denial of NF LOC and Community Benefits (CB) within five business days of the NF LOC determination and will include Appeal and Fair Hearing rights.

b) Member may request an Appeal by contacting his/her MCO. The MCO must adhere to the New Mexico Administrative Code (NMAC) 8.308.15 and the Managed Care Policy Manual Section 16 requirements related to Appeals and Fair Hearings.

c) Member is not eligible to request COB.

d) After the Appeal process has been exhausted, the MCO shall notify the MAD/PPB of the MCO Appeal decision via the CIU and include a copy of the Appeal decision letter sent to the member.

   1. If the MCO overturns the NF LOC denial decision the MCO shall send the new annual NF LOC dates via the Update Member LOC API file. The new annual NF LOC dates should cover a 12-month period.
      a. **Example**: Current NF LOC dates are: 04/01/25 – 03/31/26. 120- day temporary authorization days had previously been submitted to cover 04/01/26 – 07/31/26. The MCO submits the remainingmonths to cover a 12-month period (08/01/26 – 03/31/27). There should be no gaps in the NF LOC dates from the previous year.
   2. If the MCO does not overturn the NF LOC denial decision the MCO shall notify PPB via the CIU.

e) If the member requests a Fair Hearing, the MCO will be notified via the Fair Hearing Acknowledgement notice from the HCA/FHB.

f) The MAD/Program Policy Bureau (PPB) will work with the MCO during the Fair Hearing process and the MCO is responsible for completion of the SOE and for providing testimony during the Fair Hearing. The MCO will follow the already established process and submit the SOE via the DMZ to MAD/PPB. MAD/PPB will distribute the SOE to all interested parties.

g) The MCO will receive a copy of the Fair Hearing decision from the HCA/MAD.

3. Annual Recertification

If the client has a 12-month NFLOC determination, the MCO shall submit the NF LOC effective date spans and applicable SOC (ANW, SNW or INF) date spans via the Update Member LOC API file no later than 60 calendar days prior to the expiration of the existing NF LOC and SOC date spans. The MCO may begin planning for the Community Benefit reassessment as much as 120 calendar days prior to and must complete the reassessment no less than 60 days prior to the expiration of the existing NFLOC span. For SOC INF, the MCO can only request the packet required for reassessment from the nursing facility 60 days in advance. A 45- and 30-day reminder file is generated from the Income Support Division (ISD) to the MCOs if ISD has not received the next year's NF LOC determination 60 days prior to expiration.

4. Annual NF LOC Denials

a) The MCO shall send the NOA to the member with the denial of NF LOC and CB 60 calendar days prior to the expiration of the existing NF LOC and will include Appeal and Fair Hearing rights.

b) If the member does not request COB, the MCO does not have any entry/submission requirements until the MCO Appeal or Fair Hearing process has been completed. Please go to letter F of the belowsection.

c) If the member files a Fair Hearing after the Appeals process has been exhausted, the MAD/Program Policy Bureau (PPB) will work with the MCO during the Fair Hearing process and the MCO is responsible for completion of the SOE and for providing testimony during the Fair Hearing. The MCO will follow the already established process and submit the SOE via the DMZ to MAD/PPB. MAD/PPB will distribute the SOE to all interested parties.
d) The MCO will receive a copy of the Fair Hearing decision from the HCA/PPB.

5. Annual NF LOC Fair Hearings & NF LOC/SOC Timelines

a) If the member requests COB within 10 calendar days of the NOA, the MCO will complete the following steps:
b) **ASPEN INTERFACE:** The MCO does not send any information via the MCO to ASPEN interface.
c) **Turquoise Claims INTERFACE:** The MCO shall send a 120-day temporary NFLOC span via the Update Member LOC API file, with the applicable SOC ANW or SNW, for COB during the MCO Appeal and Fair Hearing process.
    i. Prior to the 90th day, the MCO shall review the Fair Hearing case status to determine if Fair Hearing is delayed and will continue beyond the COB temporary NF LOC span.
    ii. If delayed, an additional 120-day temporary NF LOC span and applicable SOC must be submitted via the Update Member LOC API by the MCO.
d) For members who are ABCB, a continued PA must be sent to the appropriate provider(s) to continue service(s) for the 120-day period and for each subsequent temporary extension submitted during the Fair Hearing.
e) For members who are SDCB, a partial budget and care plan for 120 days must be entered in FOCoS for COB during the Fair Hearing process and for each subsequent temporary extension submitted during the Fair Hearing.
f) The MAD/Program Policy Bureau (PPB) will work with the MCO during the Fair Hearing process and the MCO is responsible for completion of the SOE and for providing testimony during the Fair Hearing. The MCO will follow the already established process and submit the SOE via the DMZ to MAD/PPB. MAD/PPB will distribute the SOE to all interested parties.
g) The MCO will receive a copy of the Fair Hearing decision from the HCA/MAD.
    i. If the Fair Hearing decision is in favor of the Claimant, the MCO will comply with the decision and uphold the decision within three business days of receipt of the decision letter.

        Example: Member's current NF LOC date spans are 04/01/26 to 03/31/27. MCO sent a temporary NF LOC and SOC span from 04/01/26 – 07/31/26 via the Update Member LOC API interface file.

        1. A Decision letter is received by the MCO on 07/06/26 indicating decision is in favor of Claimant.
        2. An Update Member LOC API file interface submission for NF LOC and SOC is 08/01/26 – 03/31/27 is required.
        3. For an ABCB case, a PA must be sent to the appropriate provider(s) to continue service(s) through 03/31/27.
        4. For an SDCB case, the partial budget must be extended in FOCoS to 03/31/27.

    ii. If the Fair Hearing is found in favor of the Department, the MCO will:

a. End the NF LOC and SOC via the Update Member LOC API effective the date the final Fair Hearing decision letter was received by the MCO (on 07/06/26 per the previous example in G.i. above).
b. Determine if multiple temporary NF LOC date spans were submitted and need to be voided. The MCO shall submit the time frame span(s) that need to be voided to John Padilla at johnh.padilla@hca.nm.gov,Tina Romero at tina.romero@hca.nm.gov and Melinda Espinoza at melindaa.espinoza@hca.nm.gov for processing.
c. Terminate the PA(s) issued to the appropriate provider(s) effective 14 calendar days (07/20/26) from the date the decision letter was received by the MCO (07/06/26) to provide adequate notice to the providers.
d. Develop a close out budget and care plan (effective 7/20/26) and inform the EOR of the closure so the EOR can notify employees.

4.1.6.3 Medicaid Pending and Institutional Care (IC)

COE 081, 083, 084

Approvals and Denials for Medicaid Pending and Institutional Care cases should be processed as:

- Initial Approvals shall be submitted with the NF LOC determination date spans via the ASPEN interface file within 30 calendar days of receiving the NF LOC packet from the nursing facility.
- Initial denials for Medicaid Pending cases should be followed as outlined in Initial NF LOC denials above.
- IC annual denials should be followed as outlined in ***Annual NF LOC denials*** and ***Annual NF LOC Fair Hearing & NF LOC/SOC Timelines*****.**
- Initial and annual denials for residents in a NF with a Full Medicaid COE (i.e., 001, 003, 004, 100, etc.) should be followed as outlined in ***Members with Full Medicaid*** section.

4.1.6.4 Annual Comprehensive Needs Assessment and NFLOC Reassessment

The MCO is required to complete a Comprehensive Needs Assessment (CNA) annually. For a waiver client who has been approved for NFLOC, but does not meet Continuous NFLOC criteria, the MCO must complete the CNA and NFLOC reassessment no earlier than 90 calendar days and no less than 60 calendar days prior to the end of the NFLOC period for the client to continue long term care services uninterrupted. If the client continues to meet NFLOC, the reassessment should trigger a new 12-month NFLOC period and a new SOC span. We refer to the NFLOC period and SOC span separately because a client's NFLOC period is expected to remain on the original 12-month schedule whereas the client's SOC spans may open and close over time. However, SOC spans must always fit within the 12-month NFLOC period and the LTC assessment date must always be prior to the begin date of the SOC span.

For example: a client approved on 3/23/25 to begin community benefit starting 4/1/25 has a NFLOC period that runs 4/1/25-3/31/26. That client's SOC span may initially be entered with that same span. Subsequent changes have caused that span to be split into 4/1/25-6/30/25; 7/1/1/25-9/30/25 and the client now wishes to switch to a different SOC. The MCO must reassess the client's needs and plan of care, but a new LTC determination is not needed. That span would be extended as 10/1/25 but cannot exceed the current NFLOC end date of 3/31/26.

An NFLOC reassessment must be performed any time a change in the client's condition or service delivery model warrants it, but the NFLOC period will remain on its 12-month schedule.

4.1.6.5 Refusal and/or Non-Compliance with the Annual CNA Requirement

Members who do not comply with CNA requirement

a) The MCO shall make reasonable efforts to contact the member to conduct the CNA and shall document at least three attempts to contact the member.
b) Reasonable efforts shall include at least one attempt to contact the member at the phone number most recently reported by the Member and use of the member's last reported residential address.
c) Documentation of the three attempts shall be included in the members'
d) file.
e) Such attempts should occur on not less than three different calendar days, at different hours of the day, including day and evening hours and after business hours.
f) A Reminder Notice shall be sent to the members' most recently reported address indicating that the NF LOC will end and CB will not be accessible without the completion of the CNA.
g) If the member has a COE waiver, the Reminder Notice shall inform the member that not completing the CNA will result in loss of Medicaid Eligibility and shall provide information about how to contact his/her care coordinator to obtain a CNA.
h) If the member has still refused to complete the CNA within 30 days of the expiration of the existing NF LOC span, the MCO shall issue a NOA indicating that due to refusal and/or non-compliance with the annual CNA requirements, the member's services will end (including end date in NOA). The NOA shall include Appeal and Fair Hearing Rights.
i) If the member is a NOME, the MCO is required to submit an Administrative Denial (DA) via the ASPEN interface file to report the denial of the NF LOC to ISD.
j) The ISD will close the Waiver COE and issue a NOCA to the member offering Fair Hearing rights.
k) The MCO will allow the NF LOC to expire in ASPEN and/or Turquoise Claims unless the member requests COB within 10 calendar days of the NOA. If the member requests COB, the MCO shall follow the above outlined steps for annual NOMEs and full Medicaid members who request COB. The MCO must adhere to the New Mexico Administrative Code (NMAC) 8.308.15 and the Managed Care Policy Manual Section 16 requirements related to Appeals and Fair Hearings.

4.1.7 ASPEN to MCO NF LOC Request file (ASPEN 112)

ASPEN runs the 112, 113, and 114 files Monday through Friday, excluding holidays. ASPEN will send a file daily, regardless of whether there are any requests for NF LOC for that day or not. The interface files are transmitted directly between ASPEN and the MCOs using secure FTP. A client will only appear on the file once. If the MCO does not send a response for the client who is pending, that client will remain pending and a reminder record is not sent on a future file. However, for a pending client, any time that the client's eligibility is touched by the worker, this may trigger a record on the 112 files. The MCO may receive the same client NFLOC request multiple times on the 112 files.

Each time a record for a Medicaid pending client is sent it will have a Sequence Number and a request date. If the same client is sent multiple times, the MCO will have multiple sequence numbers and may have different Request Dates. The MCO is instructed to submit their 113 with the sequence number that matches the Request Date being sent. If all the Request Dates are the same, ASPEN will accept any Sequence Number submitted.

The ASPEN to MCO Level of Care interface file will contain clients applying for or being redetermined for COEs 90/91/92/93/94 or 81/83/84 where the facility type is a nursing facility or Long-Term Care.

If an individual has an approved open-ended NF LOC span, ASPEN shall not send a renewal NF LOC request to the MCOs unless the individual changes to a COE not in 90, 91, 92, 93, 94. If an individual has an End-Dated NF LOC span, ASPEN shall continue to send renewal NF LOC requests to the MCOs 90 days from LOC expiration and on the day of LOC Expiration as well as the 30 and 45 day LOC Renewal Requests. After an LOC has expired (and case remains approved), another LOC Request shall be sent to the MCO every time Mass Update on the Case or Eligibility is run and certified by a case worker.

ASPEN shall send an LOC request every 30 days for individuals in ASPEN who meet the following conditions:

a) There is no LOC response received from the MCO that received the most recent LOC Request (and)
b) The individual's eligibility is pending (and)
c) The most recent LOC request was sent 30 days ago.
d)

File names are as follows:

MCO	File Transfer Location	File Name
BCBS	BCBS Server	ABCS015
Presbyterian	PRESB Server	APRS015
United Health Care	UHC Server	AUTD01S
Molina	MOL Server	AM0L01S

The file layout for the 112 file ASPEN sends to the MCOs to assign a client for NLFOC assessment is as follows:

Data Element	Position	Type & Size	Mandatory / Optional	Description
HDR_RECORD_IND		PIC X(2)	Mandatory	HD'
HDR_FILE_NAME		PIC X(5)	Mandatory	ASPEN'
HDR_SEND_TO_FILE_NAME		PIC X(5)	Mandatory	BCBS/PRBS/TPAS/UNHH/MLNA
HDR_DATE		PIC X(8)	Mandatory	CCYYMMDD
ASPEN_CLIENT_ID	1-9	AN, 9	Mandatory	ASPEN individual (MCI) ID.
SSN	10-18	AN, 9	Mandatory	Individual SSN.
FIRST_NAME	19-48	AN, 30	Mandatory	
LAST_NAME	49-78	AN, 30	Mandatory	
MIDDLE_NAME	79-108	AN, 30	Optional	
DOB	109-116	AN 8	Mandatory	Individual date of birth. Format: MMDDYYYY
GROUP HEADER - CLIENT MAILING ADDRESS			Optional	GROUP HEADER For the 80s categories, the resident address is the facility address of an individual in a nursing home. Address will only be sent for the 80s categories (does not apply to the 90s).
MAILING_ADDR_ST_NAME	117-216	AN, 100	Optional	Mailing address street name of the client.
MAILING_ADDR_CITY	217-241	AN, 25	Optional	Mailing address city of the client.
MAILING_ADDR_STATE	242-243	AN, 2	Optional	Mailing address state of the client.
MAILING_ADDR_ZIP5	244-248	AN, 5	Optional	Mailing address zip5 of the client.
MAILING_ADDR_ZIP4	249-252	AN, 4	Optional	Mailing address zip4 of the client.
GROUP HEADER - CLIENT_RESIDENTIAL_ADDRESS				GROUP HEADER For the 80s categories, the resident address is the facility address of an individual in a nursing home. Address will only be sent for the 80s categories (does not apply to the 90s).
RESIDENTIAL_ADDR_ST_NAME	253-352	AN, 100	Optional	Residential address street name of the client.
RESIDENTIAL_ADDR_CITY	353-377	AN, 25	Optional	Residential address city of the client.

Data Element	Position	Type & Size	Mandatory / Optional	Description
RESIDENTIAL_ADDR_STATE	378-379	AN, 2	Optional	Residential address state of the client.
RESIDENTIAL_ADDR_ZIP5	380-384	AN, 5	Optional	Residential address zip5 of the client.

Data Element	Position	Type & Size	Mandatory / Optional	Description
RESIDENTIAL_ADDR_ZIP4	385-388	AN, 4	Optional	Residential address zip4 of the client.
COE	389-391	AN, 3	Mandatory	Represents the category of eligibility. COES to be transmitted: COEs 081, 083, 084, 090, 091, 092, 093, 094, 095, and/or 096. Reference the EDTOA tab for a list of values and translations.
COE_DISPOSITION	392-393	AN, 2	Mandatory	Represents the status of the EDG. Reference the EDEDGSTATUS tab for a list of values.
LOC_END_DT	394-401	AN, 8	Optional	Date is only populated if LOC is 30 days from expiration for the following categories of eligibility: 81, 83, 84, 90, 91, 92, 93, 94, 95, or 96. Format: MMDDYYYY
FACILITY_NAME	402-351	AN, 50	Optional	Name of the facility giving care to the individual.
FACILITY_TYPE	452-453	AN, 2	Optional	Type of facility the individual is being cared for in. Reference the DCFACILITYTYPE tab for a list of values.
N/A	454-461	AN,8	Optional	N/A
N/A	462-469	AN,8	Optional	N/A
ADMIN_COUNTY_CODE	470-471	AN, 2	Optional	Administrative county of the client. This is the county for which the client is being worked. Reference the COUNTY tab for a list of values.

Data Element	Position	Type & Size	Mandatory / Optional	Description
REQUEST_DATE	472-479	AN, 8	Mandatory	MCOs must return an LOC determination starting during the month of or before the 'Request Date'. The purpose of the 'Request Date' field is to ensure that the MCOs are informed of the date from when ASPEN requires LOC determination made. The MCOs are expected to return an LOC determination with the LOC Begin Date starting from on or before the month of the 'Request Date
LOC_SEQ_NUM	480-488	AN, 9	Mandatory	The 'LOC Sequence Number' shall be different for every LOC Request that ASPEN sends. Example: If ASPEN sends a 45 day and a 30-dayLOC renewal reminder to an MCO, the LOC Sequence Number shall be different for these two LOC Requests. If the MCO has received more than one LOC request for an Individual, the MCO can return the LOC Sequence Number from either LOC request that has the 'Request Date' from when the MCO has determined LOC If the MCO did not receive the initial 112 for a client (e.g., client transfer), the 113 can be sent without the LOC Seq Num populated
TRLR_RECORD_IND	PIC X(2)	TR'	Mandatory	
TRLR_RECORD_CNT	PIC 9(9)		Mandatory	

4.1.8 MCO to ASPEN NF LOC Response file (ASPEN 113)

The MCO is expected to create a file daily back to ASPEN, even if there are no assessments to be reported on for that day. The interface files are transmitted directly between ASPEN and the MCOs using secure FTP. ASPEN Batch cycle starts at 7:00 PM MT each day and the Jobs that process LOC files from MCOs and TPA are kicked off as soon as the batch cycle is started. MCO's should post files by 6:45PM MT each day to be processed on the same day.

The MCO is required to approve or deny the NF LOC within 5 business days from the completed packet. ASPEN is programmed to close all new applications if it is not disposed within 90 days (for disability-based MA categories) and 45 days (for all other MA categories). If LOC response for disability-based nursing facility or community benefit is not received by the 89th day from the application date, the case will be closed. For all other non-disability-based IC/Waiver categories that day would be 44th day from

the application. Once the MCO has made their determination of NFLOC, the MCO will send ASPEN a file that contains Level of Care (LOC) information for individuals requested on the ASPEN to MCO LOC daily send file.

The following rules apply to how the MCO submits LOC determinations:

1. The MCO must never submit 113 for a Medicaid pending client that was not on that MCO's 112. If the MCO receives a packet from a nursing facility for a client that is not already enrolled with the MCO and the client has not appeared on a 112 file, the MCO should contact LTSSB who can inquire in ASPEN to determine which MCO the NFLOC determinationhas been assigned. The MCO can then return the packet to the nursing facility with the instructions to submit to that MCO.
2. The MCO must never submit 113 for an ongoing Medicaid client that was not on that MCO's 112. It is possible, for short term approvals, due to the timing when the MCO sends the initial approval, that the MCO will be ready to submit the ongoing approval before ASPEN has generated the request on the 112. When this happens, the MCO must wait for the 112 requests. For example:
   - ASPEN sent an LOC request in 112 files to the MCO on 18-FEB-2025 with request date as 01-FEB-2025.
   - ASPEN received a LOC response in 113 files from the MCO on 19-FEB-25 with LOC approved from 01-FEB-2025 to 01-MAY-2025. This span was accepted.
   - On 12-MAR-2025, ASPEN received LOC approval in 113 files from the MCO with LOC approved from 02-MAY-2025 to 01-MAY-2026. This was rejected because the only request date currently on file in ASPEN was for February 1. ASPEN sends out the renewal requests 90 ,45 and 30 days from expiration. The first notification is sent well in advance before the MCOs must start the renewal process (60 days from the expiration). But in this scenario, the initial LOC approval from 01-FEB-2025 to 01-MAY-2026 was received on 19th FEB 2025 and the 90th day from the LOC expiration date falls on 1 FEB 2025. Because the 90-day trigger was missed, the next trigger for ASPEN to send the 112 would be on March 17 and again on April 12.
3. If the MCO receives a request from a nursing facility to change the client from low to high NF or vice versa, that change should be handled internally by the MCO but should never be sent to ASPEN.
4. The SNF/NF is required to conduct specific types of assessments and clinical documentation based on the type of admission (skilled/acute vs custodial/LTC). If the resident meets skill care upon admission, only an authorization is to be issued, no NF LOC assignment, as this is a physical health benefit.
5. The ASPEN system does not issue a 112 file for the dates the resident was receiving skilled/acute care in the SNF/NF. Once and ONLY if the resident reverts to custodial care (long term care) should the NF LOC begin, and the ASPEN should then send the 112 with the request date care switched to custodial/LTC.
6. MCOs must return a LOC determination as a continuous span starting during the month of (or) before the 'Request Date.' Please note below the instruction re: Request Date.
7. If the MCO sends a LOC denial, either administrative or medical, followed by a LOC Approval, the LOC Spans must be a continuous span. See below for examples.
8. If the MCO sends more than one LOC approval span on the same day, the LOC span must be continuous span.
9. Stand-Alone LOC Denials, either administrative or medical, must be sent as Same-Day Spans (LOC begin date same as LOC end date) starting during the month of the 'Request Date.' A Stand-Alone LOC Denial is an LOC Denial that is not sent along with an Approval in the same 113 File.

10. ASPEN shall not accept multiple LOC Spans for the same individual with overlapping LOC Dates in the same 113 File.
11. Open-Ended NF LOC Approvals can only be received when the individual is approved or pending on the below COE's:
    - 90: Medicaid Waiver - AIDS
    - 91: Medicaid Waiver – Aged
    - 92: Medicaid Waiver - Brain Injury
    - 93: Medicaid Waiver – Blind
    - 94: Medicaid Waiver – Disabled
12. There must be a prior LOC Span with an end date in the future or within the last 90 days of the Open-Ended LOC Approval Begin Date.
13. Open-Ended LOC Approvals shall be sent with a 'blank' LOC End Date.
14. End-Dated LOC Approval Spans cannot be more than 366 days.
15. The MCO must have received the most recent LOC request (if there was an LOC Request sent within 90 Days) or be the individual's enrolled/chosen MCO with the individual pending or approved on an IC/Waiver COE.
16. If the MCO sends a retroactive LOC determination, the MCO must send all other LOC Spans that start after the retroactive LOC begin date. Refer to Example J below for examples.
17. If the MCO sends a retroactive LOC determination, the MCO must send all the future LOC spans.

4.1.8.1 Request Dates and LOC Sequence Numbers

For a Medicaid Pending client, the MCO may receive multiple records for the same client on the 112. Each record will have a different LOC sequence number. When the MCO makes their LOC determination and is sending that on the 113 files, the MCO can use any of the LOC sequence numbers, it doesn't matter which one if the request dates are the same.

For a Medicaid pending client, the MCO may receive multiple records for the same client on the 112 with different Request Dates. The MCO must always respond with the earliest Request Date and should use the sequence number that was sent for that request date.

See the examples below for the 113 File validations and how MCO's must send LOC determinations:

a. The MCOs/TPA must return an LOC determination as a continuous span starting during the month of (or) before the 'Request Date.'

Example:

- Individual's eligibility is pending for LOC in ASPEN for months Jan, Feb and March. Date of Application and LOC Request triggered on 23-JAN-25.
- LOC 'Request Date' sent as 01-JAN-25 as this is the first day of the application month.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility

1	MCO/TPA Determines the individual is Approved from 1-JAN-25 to 31-DEC-25				
1a	1-JAN-25	31-DEC-25	AP	Accepted	Approved all pending months
2	MCO/TPA Determines the individual is Approved from 28-JAN-25 to 27-JAN-26				
2a	28-JAN-25	27-JAN-26	AP	Accepted	Approved all pending months
3	MCO/TPA Determines the individual is Approved from 15-FEB-25 to 14-FEB-26				
3a	1-JAN-25 15-FEB-25	14-FEB-25 14-FEB-26	DN AP	Accepted – both records must both be received in the same 113 file.	Deny Jan, Approve Feb Ongoing
3b	15-FEB-25	14-FEB-26	AP	Rejected – E13	
4	MCO/TPA Determines the individual is Approved from 15-MAR-25 to 14-MAR-26				

4a	1-JAN-25 15-MAR-25	14-MAR-25 14-MAR-26	DN AP	Accepted – both records must both be received in the same 113 file.	Deny Jan and Feb, Approve March Ongoing
4b	15-FEB-25	14-FEB-26	AP	Rejected – E13	
5	MCO/TPA Determines the individuals are Approved from 15-FEB-25 to 14-FEB-26				
5a	20-JAN-25 15-FEB-25	14-FEB-25 14-FEB-26	DN AP	Accepted – both records must both be received in the same 113 file.	Deny Jan, Approve Feb Ongoing
5b	15-FEB-25	14-FEB-26	AP	Rejected – E13	
6	MCO/TPA Determines the individual is Approved from 1-NOV-24 to 31-OCT-25. The LOC Approval Begin Date received from the MCO/TPA is 2 months prior to the 'Request Date'.				

6a	1-NOV-24	31-OCT-25	AP	Accepted	Approved all pending months
7	MCO/TPA sends spans that have a gap (not continuous) in the same 113 file.				
7a	01-JAN-25	28-JAN-25	AP or DN	Rejected – E13	
7b	02-MAR-25	01-MAR-26	AP		

b. <u>Stand-Alone</u> LOC Denials must be sent as Same-Day Spans starting during the month of the 'Request Date.'

- A Stand-Alone LOC Denial is an LOC Denial that is not sent along with an Approval in the same 113 File.

Example:

- Individual's eligibility is pending for LOC in ASPEN for months Jan, Feb and March. Date of Application and LOC Request triggered on 23-JAN-25.
- LOC 'Request Date' Sent as 01-JAN-25 as this is the 1st of the pending edg.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
8	MCO/TPA Determines the individual is Denied for Level of Care.				
8a	1-JAN-25	1-JAN-25	DN	Accepted	Deny All Months
8b	20-JAN-25	20-JAN-25	DN	Accepted	Deny All Months
8c	15-FEB-25	15-FEB-25	DN	Rejected – E14	
8d	1-DEC-24	1-DEC-24	DN	Rejected – E14	
8e	1-JAN-25	2-JAN-25	DN	Rejected – E14	
8f	1-JAN-25	12-DEC-26	DN	Rejected – E14	
8g	15-JAN-25	16-JAN-25	DN	Rejected – E14	
8h	15-FEB-25	14-FEB-26	DN	Rejected – E14	
8i	01-JAN-25	Open- Ended	DN	Rejected – E14	

Note: ASPEN is not expecting Same-Day Denials if a denial is received in the same file as an LOC Approval. Refer to examples 3, 4 and 5 for LOC Denials sent along with Approvals.

c. MCOs/TPA cannot send LOC Spans with overlapping LOC Dates in the same 113 File:

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
9	MCO sends an overlapping Open- Ended Approval Span and an End-Dated Approval Span in the same 113 File.				
9a	01-JAN-25	Open- Ended	AP	Rejected – E11	
	02-FEB-25	01-FEB-26	AP		
10	MCO/TPA sends overlapping End- Dated Approval Spans in the same 113 File.				
10a	01-JAN-25	31-DEC-25	AP	Rejected – E11	
	01-FEB-25	31-JAN-26	AP		
11	MCO/TPA sends an overlapping LOC Approval and Denial in the same 113 File.				
11a	01-JAN-25	15-MAR-25	DN	Rejected – E11	
	01-FEB-25	31-JAN-26	AP		

Note: The scenarios above are not exhaustive of all types of Overlapping LOC Spans that the MCOs/TPA could send in the 113 File.

d. LOC Span does not cover all the pending months in ASPEN. LOC is determined starting during the month of (or) before the 'Request Date.'

Example:

- Individual requires an LOC determination made for the months Jan through June. LOC was requested on 23-APR-18 with the 'Request Date' sent as 01-JAN-18 as this is the 1st of the pending EDG.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
12	MCO sends LOC Approval from 1-JAN-25 to 31-MAR-25, and the approval is sent on April 30th, 2025.				
12a	01-JAN-25	31-MAR-25	AP	Accepted	Approve the months for which LOC was received and send another LOC renewal

					request to the MCO for the remaining pending months.

Note: Even though the LOC Response is accepted, the Individual cannot receive benefits until an LOC Determination is received for all the pending months.

e. The MCO/TPA must have received the most recent LOC request (if there was an LOC Request sent within 90 Days) or be the individuals enrolled/chosen MCO with the individual pending or approved on an IC/Waiver COE.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
13	LOC Approval received from an MCO that did not receive the most recent LOC Request within the last 90 days and is not the enrolled MCO or client choice. Individuals are not currently approved in IC or Waiver.				
13a	02-JAN-25	01-JAN-26	AP	E16: Rejected	
14	LOC Approval received from an MCO that did not receive the most recent LOC Request within the last 90 days and the individual is not pending on IC or Waiver. Individuals are not currently approved in IC or Waiver.				
14a	01-JAN-25	01-JAN-25	AP	E16: Rejected	

f. Only the MCO's can send Open-Ended NF LOC Approvals:

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
15	An Open-Ended LOC Determination is received from the TPA.				
15a	1-JAN-25	Open - Ended	AP	Rejected – E12	

g. Open-Ended NF LOC Approvals shall only be accepted when individual is approved or pending on the below COE's:

- **90: Medicaid Waiver -AIDS**
- **91: Medicaid Waiver -Aged**
- **92: Medicaid Waiver - Brain Injury**
- **93: Medicaid Waiver -Blind**
- **94: Medicaid Waiver -Disabled**

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
16	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved on COE 94: Medicaid Waiver – Disabled.				
16a	1-JAN-25	Open - Ended	AP	Accepted	Approved months received
17	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved for COE 96: Medicaid Waiver - Developmentally Disabled.				
17a	1-JAN-25	Open - Ended	AP	Rejected – E12	

h. There must be a prior LOC Span with an end date in the future or within the last 90 days of the Open-Ended LOC Approval Begin Date.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
25	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved for COE 94: Medicaid Waiver – Disabled. Individuals have existing LOC approval ending in future or in the past 90 days.				
25a	1-JAN-25	Open - Ended	AP	Accepted	Approved months received
26	An Open-Ended LOC Determination is received from an MCO for an Individual that is pending or approved for COE 94: Medicaid Waiver – Disabled. Individuals do not have existing LOC approval ending in future or in the past 90 days.				
26a	1-JAN-25	Open - Ended	AP	Rejected – E12	

i. End-Dated LOC Approval Spans cannot be more than 366 days.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
26	MCO/TPA sends an End-Dated LOC Approval as a span of more than 366 days				
26a	1-JAN-268	31-MAR-26	AP	Rejected – E15	

j. If MCO/TPA sends a retroactive LOC determination, the MCO/TPA must send all other LOC Spans that start after the retroactive LOC begin date.

There are situations where a retroactive LOC determination is requested after a current LOC determination has been established.

Example:

- An Individual applies for IC/Waiver on 3/17/25. The Individual's eligibility is approved in ASPEN for months March and ongoing with an LOC approval span received from the MCO/TPA on 4/12/25 as 03/01/2025 – 2/28/2026. This individual has no other LOC spans established in ASPEN.
- Individual applies for two prior months Medicaid on 4/15/25 for the retro months January and February of 2025. The individual has no LOC determined for these months, so another LOC Request is sent on 4/15/25 to the MCO/TPA with a Request Date as 1/1/25 as this is the least of the prior Medicaid requested months.

#	LOC Auth Begin Date	LOC Auth End Date	Disposition	114 Response	Eligibility
20	MCO/TPA sends an LOC Approval for the retro months January and February 2025. The MCO/TPA does not intend to make any change to the LOC Approval for the current and ongoing span.				
20a	01-JAN-25	28-FEB-25	AP	Accepted – This is the best way for the MCO/TPA to send this LOC approval.	Approve retro months and current months remain approved
	01-MAR-2025	28-FEB-26	AP		
20b	01-JAN-25	01-MAR-25	AP	Accepted- but MCOs/TPA should send the current span as well.	Because ASPEN gives precedence to the most recent LOC, this LOC Approval should be sent along with the current LOC Approval.
21	MCO/TPA sends an LOC Denial for the retro months January and February 2025. The MCO/TPA does not intend to make any change to the LOC Approval for the current and ongoing span.				
21a	01-JAN-25	28-FEB-25	DN	Accepted – This is the best way for the MCO/TPA to	Approve retro months and current months remain approved
	01-MAR-2025	28-FEB-26	AP		

				send this LOC approval.	
21b	01-JAN-25	01-JAN-25	DN	Accepted- but MCOs/TPA should send the current span as well.	Because ASPEN gives precedence to the most recent LOC, this LOC Denial should be sent along with the current LOC Approval. If the current approval span is not sent, ASPEN shall terminate the client's eligibility by considering the denial.

Files will be submitted as follows:

MCO	File Transfer Location	File Name
BCBS	BCBS Server	ABCS01R
Presbyterian	PRESB Server	APRS01R
Molina	Molina Server	AMOL01R
United	United Server	AUTD01R

The file layout for the 113 file is as follows:

Data Element	Position	Type & Size	Mandatory/ Optional	Description
HDR_RECORD_IND		PIC X(2)	Mandatory	HD'
HDR_FILE_NAME		PIC X(5)	Mandatory	BCBS/PRBS//TPAS/UNHH/MLNA
HDR_DATE		PIC X(8)	Mandatory	CCYYMMDD
DISPOSITION DATE	1-8	DATE	Mandatory	MMDDYYYY Date the LOC was determined. Format: MMDDYYYY

Data Element	Position	Type & Size	Mandatory/ Optional	Description
DISPOSITION REASON CODE	9-10	AN, 2	Mandatory	Reason for the disposition. Values: Approved - AP Medical Denial - DM (denial because the individual does not meet their LOC - medical necessity) Administrative Denial - DA (Denied by MCO/TPA for other reasons)

Data Element	Position	Type & Size	Mandatory/ Optional	Description
LOC BEGIN DATE	11-18	DATE	Optional	MMDDYYYY LOC begin date. If the disposition is approved, start date will be populated in the file. Format: MMDDYYYY
LOC END DATE	19-26	DATE	Optional	MMDDYYYY Level of Care end date. LOC Denials sent as Same-Day Spans must show LOC begin date same as LOC end date starting using the 'Request Date.
FIRST NAME	27-56	AN, 30	Mandatory	Individual first name.
LAST NAME	57-86	AN, 30	Mandatory	Individual First name.
DOB	87-94	DATE	Mandatory	MMDDYYYY individual date of birth.
SSN	95-103	AN, 9	Mandatory	Individual SSN.
ASPEN CLIENT ID	104-112	AN, 9	Mandatory	Individual ASPEN client ID (MCI ID). ID will be sent if present in MCO/TPA system. Format: Alpha numeric.
FILLER	113-120	DATE	Optional	
FILLER	121-128	DATE	Optional	

Data Element	Position	Type & Size	Mandatory/ Optional	Description
Case Manager/consultant entity (Waiver) Address GROUP HEADER				GROUP HEADER
CASE MANAGER/CONSULTANT ENTITY	129-168	AN, 40	Optional	Field will be populated with the case manager/consultant entity. If no case manager/consultant entity exists, the value in this field should be blank. The case manager/consultant entity will be sent by MCO/TPA and received by ASPEN as text.
CASEMANAGER_ADDR_ST_NAME	169-198	AN, 30	Optional	Street name for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_CITY	199-223	AN, 25	Optional	City for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_STATE	224-225	AN, 2	Optional	State for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_ZIP5	226-230	AN, 5	Optional	ZIP5 for the address of the consultant entity/case manager.
CASEMANAGER_ADDR_ZIP4	231-234	AN, 4	Optional	ZIP4 for the address of the consultant entity/case manager.
LOC_SEQ_NUM	235-243	AN, 9	Optional	The MCO/TPA is expected to return the 'LOC Sequence Number' that was received in the 112 File as 'pass back data'
TRLR_RECORD_IND	PIC X(2)	TR'	Mandatory	
TRLR_RECORD_CNT	PIC 9(9)		Mandatory	

4.1.9 ASPEN to MCO NF LOC Exceptions Response file (ASPEN 114)

ASPEN will produce a response file to inform the MCOs of the interface level processing status of the LOC Response File (113 file). This file –the 114 File, shall be generated upon processing the 113 File and shall include processing and exception details. The 114 File shall be generated as a response to each 113-file received from the MCO. Note: If ASPEN does not receive a 113 File from the MCOs/TPA, a 114 File shall not be sent.

ASPEN shall FTP the 114 file in the same way the 112 file is sent, by placing the file in each MCO's STS folder. The File Transfer locations and File Name where ASPEN shall send the 114 File are listed below:

MCO	File Transfer Location	File Name
BCBS	/BCBS/Inbound/	ABCS03S
Presbyterian	/PRESB/Inbound/	APRS03S
Molina	/MOL/Inbound	AMOL03S
United	/UHC/Inbound	AUTD03S

The 114 file shall contain the data that was received in the LOC Response file (113 file) from the MCO, with two new fields added.

Data Element	Position	Type & Size	Mandatory/ Optional	Description
HEADER RECORD				
HDR_RECORD	1-234	VARCHAR2(234)	Mandatory	This field will contain the header as it was received on the 113 file
Filler	235-237	VARCHAR2(3)	Optional	This field will contain spaces filled in
RECORD				
RECORD_RECEIVED_FROM_MCOTPA	1-243	VARCHAR2(234)	Mandatory	This Field will contain the record as it was received on the 113 file from MCO/TPA
NA	244-294	NA	NA	
PROCESS FLAG	295	VARCHAR2(1)	Mandatory	This field indicates if the record was processed and Level of Care successfully updated: 'S' – Level of Care Updated 'E' – Error while updating Level of Care 'N' – Not Processed
EXCEPTION REASON CODE	296-297	VARCHAR2(2)	Optional	This field contains the Exception Reason Code if the record had an Exception. See 'EXCEPTION RSN CD' tab
TRAILER RECORD				
TRLR_RECORD	1-294	VARCHAR2(234)	Mandatory	This field will contain the Trailer as it was received on the 113 file
Filler	295-297	VARCHAR2(3)	Optional	This field will contain spaces filled in

Code	Process Flag
S	Level of Care Updated
E	Error while updating Level of Care
N	Not Processed

When there is an Exception, the Process flag is set to 'E'. An example of what you might see in the 114 file is 'E03'. When there is an exception, the record is considered as processed.

The exceptions described below are all critical exceptions, meaning ASPEN should reject the record and the LOC Determinations shall not be updated in the System. The MCO's are expected to correct and resend the LOC determination(s). With exception of E09 – Unexpected Technical Error, this Exception shall be monitored and investigated by the ASPEN Development Team.

Exception Reason Codes	
Code	**Exception Reason**
01	Input Data Error – Header or Trailer record is not available in the file
02	Input Data Error – Total data records in the file does not match with the Trailer record count
03	Input Data Error – Record is in incorrect format
04	Input Data Error – Individual ID and SSN are not available in the file
05	Input Data Error – Individual is not found with the Individual ID received
06	Input Data Error – Individual is not found with the SSN received
07	Input Data Error – SSN received is in invalid format
08	Input Data Error – Individual ID and SSN on the file do not belong to the same Individual ID in ASPEN
09	Unexpected Technical Error
10	Input Data Error – Invalid LOC Authorization Begin or End Date
11	Input Data Error – Overlapping LOC Spans for the same individual
12	Input Data Error – Open- Ended LOC Span not valid for this program or individual
13	Input Data Error – LOC is not determined as a continuous span starting on or before the month of the 'Request Date'.
14	Input Data Error – Stand Alone LOC Denial Record is not a Same-Day Span starting during the month of the 'RequestDate.

Exception Reason Codes	
Code	**Exception Reason**
15	Input Data Error – End- Dated LOC Approval Span is more than 366 days
16	Input Data Error – LOC Determination received from an MCO/TPA that did not receive the most recent LOC Request (within the last 90 days) or is not the enrolled/chosen MCO

4.1.10 Timeliness Requirements for Reporting NFLOC SOC Spans to Turquoise Claims

MCOs are required to complete level of care determinations for enrollees and to communicate when a NFLOC is determined and a setting of care plan is developed. MCOs are required to submit the SOC spans in advance of the start of community benefit services via the Update Member LOC API. If there is an error in the SOC span that was submitted by the MCO, the call back error API will be triggered to the MCO, and the SOC span must be corrected prior to the month in which Community Benefit services begin. Retroactive spans for clients in nursing facilities can be submitted. MAD realizesthat there are limited circumstances that may require a SOC span to be submitted for a retroactive time. For example: an existing member whose Medicaid recertification was approved retroactively to avoid a gap in a category of eligibility. The following provides clarification regarding the process for the Managed Care Organization's submission of retroactive exception requests.

Submission of Exception Requests

1 Prior to submission of retroactive exception requests, MCOs must submit the NF LOC SOC prospectively to begin the following month and only request the exception for the current or prior months. For the prospective period, MCOs should enter the SOC for the upcoming month (e.g., If the current month is August, the prospective month, and the earliest the begin date can be entered is September). In rare instances when the monthly cap cycle has run, the MCO may submit the exception request to HCA.

2 MCOs must submit retroactive exception requests to Victoria Sanchez, LTSSB Community Benefit Manager at victoriam.sanchez@hca.nm.gov and copy Theresa Griego at theresam.griego@hca.nm.gov as needed, but should not send more than one file per day. MCOs should not send more than 20 members per file. Larger files may result in a delay in approval/denial(s) beyond the seven (7) business days indicated in LOD #47. Any anticipated delay will be communicated to the MCO within the seven (7) business days.

3 MCOs should not send the same member/exception request more than once unless requested by LTSSB.

Documentation to Accompany the Request Must Include:

1. Member Information as follows:
    a. Member Name
    b. Medicaid ID
    c. DOB
    d. Date Span Requiring Retro Review
    e. SOC for Retro Span

f. Reason for Request for RetroactiveSOC

2. All the data fields in the order are outlined in the example table below.
    a. As much detail as possible related to the request, including extenuating circumstances or reason for urgency.
    b. Whether services have been provided during the requested retroactive period and include the begin date of the services.
3. Reason Code. See the table below for reason codes.

If the LTSSB reviewer has any questions regarding the request, the request will be sent back to the MCO and will delay the determination beyond the seven (7) business days.

Example of a Complete Request:

Rejection Date (if applicable le)	**Request sent** to LTSSB **Date**	**Medicaid ID**	**Member First Name**	**Member Last Name**	**DOB**	**NF LOC Begin Date**	**NF LOC End** Date	**soc**	**LTC Assessment Date**	**Reason**	**Reason** Code (see table below)
	3/30/16	11111111	Roger	Rabbit	11/11/1970	4/11/16	7/31/16	ADS	6/16/15	Member was planning to switch to SDCB, and his SOC was changed to SBD effective 4/1116. On 3/28/16, member notified his care coordinator that he changed his mind and did not want to switch to SDCB. ABCB services have continued to be provided.	4

HCA Approval/Denial of Exception Requests

HCA will approve exception requests under certain circumstances. (See table below) All approvals and denials will be made on a case-by-case basis. Once approved or denied, the MCO will be informed of the approval or denial via email.

Code	Retro NF LOC SOC Exception Reason	Retro Entry Approved
1.	MCO switches-when prior MCO did not meet NF LOC timeline	Yes
2.	Community reintegration	Yes, depending on the member's eligibility y status
3.	Continuation of benefits (COB) related to a pending appeal/fair hearing	Yes
4.	SOC switches due to change in CB model (Agency-Based to Self-Directed or vice versa)	Yes
5.	Member urgently needs services in current month (i.e., member transitioning from hospital to assisted living facility)	Yes
6.	MCO data entry error (i.e., wrong dates or wrong SOC)	No
7.	NFLOC approved or entered late	No
8.	CNA scheduling difficulty with the member	No

4.1.11 Closing NF LOC/SOC spans

The following provides direction regarding the process to close the NF LOC/SOC date spans for Not Otherwise Medicaid Eligible (NOME) members and Full-Medicaid members.

4.1.11.1 NOME members not accessing CB services for 90 consecutive calendar days or more:

The MCO shall send a Reminder Notice to the member after 30 calendar days of non-utilization of CB services. The Reminder Notice shall be sent to the member's most recently reported address. The Reminder Notice shall advise the member that in 60 calendar days (including end date) if CB services are not utilized, his/her NF LOC/SOC will be closed, and this will result in loss of Medicaid Eligibility. The member must also be notified that he/she must be approved for a waiver allocation and go through the eligibility process should they request that Community Benefits be re-established. ***Please note that cases that closed prior to May 1, 2017, do not require Reminder Notice.***

The MCO must send a Notice of Action (NOA) after 60 consecutive calendar days on non- utilization of CB services. The NOA shall advise the member that in 30 calendar days (including end date), his/her NF LOC/SOC will be closed and will include Appeal and Fair Hearing rights.

ASPEN INTERFACE: The MCO shall wait 10 business days from the date of the NOA to submit an ASPEN interface file requesting closure of the Category of Eligibility (COE), as an Administrative Denial. The Administrative Denial is reported as one day (03/01/26 - 03/01/26) and is the first date of non-utilization of CB services.

The Income Support Division (ISD) will close the Waiver COE and issue a Notice of Case Action (NOCA) to the members offering Fair Hearing rights.

Turquoise Claims INTERFACE: The MCO shall retroactively close the NF LOC/SOC date span via the Update Member LOC API.

Example: *Current NF LOC and SOC are 07/01/25 – 06/30/26.*

Members went without CB services or refused CB services from 9/12/25 through 12/17/25.

The modified NF LOC and SOC span is 07/01/25 – 09/11/25. Please note that the 9/11/25 date reflects the last day the member received CB services.

The MCO must ensure that processes are in place to terminate the Prior Authorization(s) PA(s) issued to provider(s) using appropriate dates.

The retroactive SOC date span submitted in the Update Member LOC API interface must always have the same **begin** date as the existing LTC span; that is, there can be no retroactive change to the SOC **begin** date.

If the member expresses interest in re-establishing CB services, the MCO must assist the member by placing his/her name on the Central Registry and advise the member that he/she must wait to become eligible for an allocation and complete the eligibility process.

4.1.11.2 **Full** Medicaid members not accessing community benefit services for 90 consecutive days or more:

The MCO shall send a Reminder Notice to the member after 30 calendar days of non-utilization of CB services. The Reminder Notice shall be sent to the member's most recently reported address. The Reminder Notice shall advise the member that in 60 calendar days (including end date) if CB services are not utilized, his/her NF LOC/SOC will be closed, and this will result in the member no longer being able to access CB services without the completion of a new Comprehensive Needs Assessment (CNA).

The MCO must send a NOA after 60 consecutive calendar days on non-utilization of CB services. The NOA shall advise the member that in 30 calendar days (including end date), his/her NF LOC/SOC will be closed and will include Appeal and Fair Hearing Rights.

ASPEN INTERFACE: The MCO does not send any information via the MCO to ASPEN interface.

Turquoise Claims INTERFACE: The MCO shall retroactively close the NF LOC/SOC date span via the Update Member LOC API.

Example: Current NF LOC and SOC are 07/01/25 – 06/30/26.

Members went without CB services or refused CB services from 9/12/15 through 12/17/15.

The modified NF LOC and SOC span is 07/01/25 – 09/11/25. Please note that the 9/11/25 date reflects the last day the member received services.

MCO must ensure that processes are in place to terminate the PA(s) issued to provider(s) using appropriate dates.

The retro closure span submitted on the Update Member LOC API interface must always have the same begin date as the existing LTC span; that is, there can be no retro change to the begin date.

If a member requests reinstatement of services, the MCO shall schedule and complete a CNA and conduct a medical eligibility determination.

MCOs must issue PA(s) to the appropriate provider(s) using appropriate reinstatement dates.

4.1.12Community Benefit Model Change

The MCO must never submit a Long-Term Care (LTC) span that overlaps an existing span submitted by another MCO. The existing span should be closed and a new span sent. When a client transfers to the MCO, that client continues to retain the LTC span that was in place with the previous MCO. The receiving MCO should not send any update to that LTC span just because the MCO transferred. That LTC span remains in effect until its end date, unless the receiving MCO has identified a change that needs to occur to that span due to a change in SOC or NF LOC determination.

Reminder: a client is not allowed to be approved for self-direction without having spent at least 120 days in agency directed Community Benefit services. When a member moves from ABCB to SDBC or vice versa, the MCO shall submit the updated NF LOC and SOC date spans via the Update Member LOC API file 90 calendar days prior to the effective date the member is expected to begin participating in the new service delivery model. This is done so that the Self Direction contractor can plan for the new client's needs. However, the start date of the new SOC span must be the actual planned start date of the new service delivery model. Overlap of SOC spans are not allowed. The SOC shall be changed from

1) ADB to SDB or ANW to SNW; or
2) SDB to ADB or SNW to ANW

When a change in setting of care occurs, that change must take place within the existing NFLOC period or at the beginning of a new NFLOC period. The MCO must report the SOC start date as the first day the member is expected to begin participating in the new service delivery model. The new SOC start date will usually be different than the start date of the existing 12-month NF LOC period (the new SOC could start at the beginning of a new NFLOC period); however, the SOC end date must not exceed the existing 12-month NF LOC period end date.

For example, a client receives an assessment for Community Benefit on 2/23/19 with an ADB span that began 3/1/2019. Their NF LOC period runs from 3/1/19-2/28/20. Their SOC span can have starts and stops within that period, but generally, the MCO will enter a 12-month span for 3/1/2019 – 2/28/2020. If the client wishes to switch to community benefit after 120 days, the MCO should send a long term care span in the Update Member LOC API interface in April for the switch to SDB with an effective begin date in July, That span should have the begin date of 7/1/2019 and the end date of 2/28/2020 (their existing 12 month NF LOC period) and should reflect the most recent assessment date. By no later than January 1, the MCO should have completed a reassessment and will enter a new 12-month NF LOC period and SOC span from 3/1/19- 2/28/20.

4.1.13Allowed Changes to the Community Benefit Long Term Care Span

The MCO is allowed to submit Community Benefit Long Term Care spans where the difference between the incoming begin date and end date is not more than 12 months. If the client's COE is 095 or 096, the MCO should NEVER submit a Community Benefit Long Term Care span without confirming the client does not have a Mi Via or Waiver authorization in effect. Even if the client's COE 095/096 has been closed and a different COE is reported on the roster, the MCO should still validate with the client and case manager to determine whether the COE change is temporary, or the client has left the DD/Med Frag. DD/Med Frag waiver authorizations are reported on the roster as long-term care spans with level of care 'MR0'. When an already enrolled client is newly authorized for the 'MR0' level of care, that will be communicated to the MCO in the Update Member PL API file the morning after the span is entered into Turquoise Claims. Many clients with COE 095 or 096 also have eligibility as SSI clients. There may be times when the 095 or 096 is not reestablished timely so that there may be short periods when the client reverts to the SSI COE. Usually, the 095/096 will be reinstated and no break in the DD or Med Frag waiver will occur.

The following decision tree can be used to determine under what conditions a Community Benefit span can be submitted and what the system will record in the Long-Term Care span.

Conditions	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8
Incoming span overlaps existing span	N	N	Y	Y	Y	Y	Y	Y
Incoming begin date < existing begin date	*	*	Y	N	N	N	N	N
Incoming begin date = existing begin date	*	*	*	Y	Y	Y	N	N
Incoming SOC = existing SOC	*	*	*	Y	Y	N	Y	N
Incoming end date = existing end date	*	*	*	Y	N	*	*	*
Incoming begin date < first of next month	Y	N	*	*	*	*	*	*

Actions								
No update	X		X	X				
Ignore as duplicate				X				
Post error 45 (retro)	X		X					
Void existing span						X		
Terminate existing span 1 day before incoming begin date							X	X
Add new incoming span		X				X	X	X
Update existing span with incoming end date					X			

4.1.14DD or Med Frag Waiver Change from Community Benefit

Some clients may be approved and receive Community Benefit services and are later approved for a DD or Med Frag Waiver category (095, 096). There will often be a period of overlap between their former Medicaid COE and the new Waiver COE (095 or 096), or the former Medicaid COE may terminate, and

the client only has COE 095 or 096, but waiver services have not yet been implemented. Once the MCO receives the COE 095 or 096 on the roster file, that should be the trigger this is a client who needs to transition from Community Benefit provided by the MCO to Waiver services that are not covered by the MCO. The Care Coordinator is expected to work closely with the Case Manager who is helping the client develop a plan of care and coordinate the closing of Community Benefit services prior to the start of the Waiver services authorization. The TPA entering the Waiver authorization will close the NFLOC SOC span when they open the Waiver authorization (DD Waiver) or Waiver LTC span (for MiVia and Supports Waiver). The MCO will not be paid the LTC cohort once the Waiver Prior Authorization or Mi Via/Supports Waiver LTC span is entered into Turquoise Claims. The roster file will contain the LOC/SOC for clients in the DD/Med Frag waiver programs whose services are carved out of managed care. These spans will contain LOC = MR0- and SOC MIV (Mi Via). All MR0 spans are included so the MCO is aware when LTC is authorized for these clients, in case the MCO has implemented community benefit while waiting for the client's waiver approval.

It is important that if the MCO is aware that Waiver services have started but continues to see an open NFLOC SOC span and no MR0 LTC span, that the MCO contact the client's case manager and report the situation to HCA.

4.1.15Supports Waiver

The HCBS Supports Waiver (SW) will offer an array of specified HCBS waiver services to clients with COE 096; less than is offered to clients approved through the existing DD waiver or Mi Via waiver. The intention is to provide critical services to clients who are on the DD waiver wait list until a slot in the regular waiver is available. Clients approved for SW will be able to choose to receive those services as either Self-Directed or Agency-Based (traditional) model.

DOH maintains the DD wait list and will be responsible for identifying and releasing allocation to the Supports Waiver. An Allocation packet is given to the client who is instructed to submit a Medicaid application to ISD and LOC to the TPA. The LOC request is evaluated and if approved it is entered into Turquoise Claims by the TPA.

In Turquoise Claims we will identify approvals for SW by entering long-term care spans with a Level of Care 'MR0' and new Setting of Care values. We will report these approvals to the MCOs in the roster and the Update Member PL API file using existing fields that capture LTC spans by establishing Two New Setting of Care values to be associated with MR0 Level of Care – 'SWD' Supports Waiver Self Directed and 'SWA' Supports Waiver Agency Directed. Just like regular DD Waiver services, the Support Waiver services are not provided by the MCO and when a client is approved for Supports Waiver any MCO Community Benefit service would be discontinued.

4.1.16Update Member PL API Interface File

The new process provides a streamlined and automated way for Managed Care Organizations (MCOs) to submit Update Member Level of Care (LOC) requests. When an MCO sends an LOC update, the FS system receives the request and begins processing it immediately.

FS first validates the information contained in the request to ensure it is complete, accurate, and meets all requirements for updating a member's level of care. If any part of the request fails validation, FS

sends an error response back to the MCO, indicating that the issue must be corrected before the request can be resubmitted.

If the LOC request passes validation, FS updates the member's level-of-care information in its system. Once this update is successfully applied, FS automatically initiates the Update Member Plan Level (PL) process. This means the MCO does not need to submit a second request—FS handles the plan-level update as a continuation of the LOC process.

The updated LOC information is then used to generate the PL update, ensuring that both the member's level-of-care and plan-level data remain consistent across all systems that rely on this information.

This revised workflow removes manual handoffs, reduces the chance of data misalignment, and ensures that every LOC update from an MCO results in a complete and accurate update to both the member's LOC and PL records.

HCA produces a daily Update Member PL API that reports any LTC span that was updated since the previous night's cycle. This is being done so that the MCO will have up to date information re: any LTC spans entered. The daily file is sent to show updates received but is also intended as a way for the MCO to validate what they have against what is in Turquoise Claims.

If a DD or Med Frag Waiver Prior Auth is added for a member, this authorization will be shown in the Update Member PL API file as a Long-Term Care Span so that the MCO can better coordinate. The layout is located HCA-MCO - Documents - MCO Business Manual - All Documents

Note:
1) The COE data will only appear if the recipient has a COE of 095/096 and is being reported with a Mi Via, Supports Waiver, DD Waiver or Med Frag Waiver.

4.1.17Long Term Care Claims Rules

The following rules for Community Benefit and Nursing Facility claims and encounters will serve as clarification of issues identified by HCA and/or the MCOs regarding edits that need to be in place to ensure the MCOs' correct payment of claims and submission of encounters.

COMMUNITY BENEFIT CLAIMS/ENCOUNTER RULES

Correct payment of Community Benefit services requires attention to the Provider billing the claim, the services on the claim and the client and their eligibility and approval for long term care services.

PROVIDER:

1. The ONLY provider type allowed on a Community Benefit encounter is the provider type 363 which is matched to the taxonomy 253Z00000X submitted on encounters. Provider Type 344 is the waiver provider type for clients in the

DD and Med Frag waiver or Supports waiver for which HCA pay via FFS and is not allowed to bill for services rendered under Turquoise Care. There are a small number of instances where a nursing facility is allowed to render respite services for a short period. The time frame is usually 5 or 6 days and is not commonly used.

2. Many providers who are enrolled as a Community Benefit provider (type 363) are also enrolled as other types of providers. These include provider types 324 Private Duty Nursing, 361 Home Health, 301 Physician, 211-212 Nursing Facility, 311 Clinic, OT, PT and ST Therapists (451-455), 344 Med Frag and DD waiver, 362 Hospice, etc. Because the provider may have multiple lines of business, it is possible that the provider may get confused and bill a Community Benefit service using a taxonomy that is not Community Benefit or vice versa. This means that the MCO must have in place sufficient edits that compare the taxonomy on the claim to the procedure codes on the claim to prevent payment if the procedure code is only allowed for Community Benefit and the taxonomy isn't 253Z00000X. Please refer to the list of taxonomy by viewing the Taxonomy Grid for claim submission https://www.hca.nm.gov/providers/ to see what taxonomies relate to which Turquoise Claims provider types.

EPSDT – A child in need of support services should always receive those services through EPSDT instead of Community Benefit if possible. An agency approved to render EPSDT services (additional services children under the age of 21 may receive) is NEVER a Community Benefit provider (provider type 363). Provider Type 324, Private Duty Nursing providers may bill EPSDT personal care services and nursing services as an EPSDT service. See NMAC 8.320.2 for more details about EPSDT providers and covered services. MCOs must allow reimbursement of Well Child Checks for members who have been taken into custody and have had a Well Child Check in less than 12 months before custody date. This will ensure that these visits have taken place within the 30-day period that the member is taken into custody.

SERVICES:

There should never be a community benefit service paid to a provider other than PT 363, unless that service is:

1. Respite being allowed to be billed by the nursing facility for a short term, or
2. Allowed as an EPSDT service for a client underage 21, in which case it is not Community Benefit and should not be billed by PT 363 (see #5 below).

Nor should there ever be an encounter for provider type 363 which contains any procedure not allowed on the Community Benefit procedure code list. *Any encounter claim line from a provider type 363 with a procedure that is not a Community Benefit will be denied with Omnicaid exception 0281 (Turquoise Claims code: 35505).* There are 2 lists of procedure codes allowed for Community Benefit: Agency-Based Codes and Self-Directed Codes:

4.1.18Agency-Based Services, Service Codes and Applicable Units of Service

Service type	Code	Unit increments 1 unit =
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Day
Community Transition Services	T2038	Per service
Emergency Response	S5161	Month
Emergency Response High Need	S5161 U1	Month
Environmental Modifications	S5165	1 unit per project
Behavior Support Consultation	H2019	15 minutes
Behavior Support Consultation, Clinic Based	H2019TT	15 minutes
Employment Supports	H2024	Day
Home Health Aide	S9122	Hour
Nutritional Counseling	S9470	Hour
Personal Care-Consumer Directed	99509	Hour
Personal Care-Consumer Delegated	T1019	15 minutes
Personal Care-Directed training	S5110	15 minutes
Personal Care-Directed-Administrative Fee	G9006	1 unit + 1 month
Personal Care-Directed Advertisement Reimbursement Fee	G9012	1 Advertisement

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Private Duty Nursing for Adults – RN	T1002	15 minutes
Private Duty Nursing for Adults – LPN	T1003	15 minutes
Respite RN	T1002 U1	15 minutes
Private Duty Nursing for Adults – LPN	T1003 U1	15 min

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Respite	99509 U1	Hour
Physical Therapy for Adults	G0151	15 minutes
Occupational Therapy for Adults	G0152	15 minutes
Speech Language Therapy for Adults	G0153	15 minutes

Personal Care Services (PCS) Consumer Directed Model Code Definitions

Personal Care Consumer-Directed	99509	Hour	The rate for ongoing attendant services. The rate includes both the employee's and the employer's share of Social Security withholding and the cost for worker's compensation insurance. The maximum number of hours billable is determined by the authorization issued by the MCO which must be approved by the MCO Medicaid Utilization Review Department.
Personal Care Consumer-Directed Training	S5110	15 minutes	The rate for training is provided to the consumer or their attendant at the request of the consumer. There is an annual maximum of eight (8) hours of training is allowed per consumer.

Personal Care Consumer-Directed Advertisement Reimbursement Fee	G9012	1 unit = 1 advertisement	The maximum allowable rate for advertising. Consumers are reimbursed for up to two (2) advertisements per year if seeking a new Personal Care Attendant. If the billed amount exceeds the maximum allowable rate, the billed amount will be reduced to the maximum allowable rate. The Advertising reimbursement is allowed only for actual and necessary advertising. Documentation is required in the case file.
Personal Care Consumer-Directed Administrative Fee	G9006	1 unit = 1 month	The rate for fiscal intermediary tasks such as processing payroll for the consumer's Personal Care Attendants, producing reports required by the Medical Assistance Division, processing claims for Consumer-Directed Personal Care services (including Income Tax and Social Security withholding) and submitting billings to the MCO.

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Self-Directed Personal Care	99509	99509	Hour	minimum wage - $14.60
HH Aide	S9122	S9122	Hour	$16.32
Employment Supports (includes Job Coach)	T2019	T2019	15 min.	$2.15 - $6.93
Job Developer (Per job that is developed for member)	T2019	T2019JD	Each	$100-$700
Customized Community Supports (adult day hab.)	S5100	S5100	15 min.	$1.36-$8.82
PT	G0151	G0151	15 min.	$13.51 - $24.22
OT	G0152	G0152	15 min.	$12.74 - $23.71
Speech/Language Pathology	G0153	G0153	15 min.	$16.06 - $24.22
Behavior Support Consultation	H2019	H2019	15 min.	$12.24 - $20.65
Private Duty Nursing – Adults- RN	T1002	T1002	15 min.	$10.90
Private Duty Nursing – Adults- LPN	T1003	T1003	15 min	$6.79
Nutritional Counseling	S9470	S9470	Hour	$42.83
Acupuncture	97810	97810	15 min.	$12.50-$25.00
Biofeedback	90901	90901	Visit	$50.00-$100.00
Chiropractic	98940	98940	Visit	$50.00-$100.00

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Cognitive Rehabilitation Therapy	97532	97532	15 min.	$12.50-$25.00
Hippotherapy	S8940	S8940	Visit	$50.00-$100.00
Massage Therapy	97124	97124	15 min.	$12.50-$25.00
Naprapathy	S8990	S8990	Visit	$50.00-$100.00
Native American Healers	S9445	S9445	Session	As approved by MCO

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Respite Standard (not provided by RN, LPN or HHA)	T1005	T1005SD	15 min.	$3.38
Respite RN	T1005	T1005RN	15 min.	$10.90
Respite LPN	T1005	T1005LPN	15 min.	$6.79
Respite HH Aide	T1005	T1005HHA	15 min.	$4.08
Emergency Response (monthly fee)	S5161	S5161	Each	$36.71-$40.79
Emergency Response (testing and maintenance)	S5160	S5160	Each	As approved by MCO
Environmental Modifications	S5165	S5165	Each	As approved by MCO (maximum of $5,000 every 5 years)
Transportation Mile	T2049	T2049	Per Mile	$0.34-$.40
Transportation Commercial Carrier Pass	T2004	T2004	Each	As approved by MCO
Start Up-Goods	T2028	T2028	Each	As approved by MCO
Fees and Memberships	T1999	T1999CP-I	Each	As approved by MCO
Coaching/education for parents, spouse or others (not available for paid caregivers)	T1999	T1999CE-I	Each	As approved by MCO
Coaching/education for parents, spouse or other classes only (not available for paid caregivers)	T1999	T1999CL-I	Each	As approved by MCO
Coaching/education for parents, spouse or other conferences and seminars (not available for paid caregivers)	T1999	T1999CS-I	Each	As approved by MCO

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Technology for Safety and Independence	T1999	T1999TS	Each	As approved by MCO
Cell phone service (including data/GPS)	T1999	T1999CELL	Each	$0.00-$100.00
Cell phone and related equipment	T1999	T1999CPEP	Each	As approved by MCO
Cell phone/landline	T1999	T1999CPL	Each	As approved by MCO
Internet service	T1999	T1999IS	Each	As approved by MCO
Landline service	T1999	T1999LS	Each	As approved by MCO
Internet/cell phone	T1999	T1999IC	Each	As approved by MCO

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Internet/cell phone/landline	T1999	T1999ICL	Each	As approved by MCO
Internet/landline	T1999	T1999IL	Each	As approved by MCO
Fax machine	T1999	T1999FX	Each	As approved by MCO
Computer	T1999	T1999CR	Each	As approved by MCO
Office supplies	T1999	T1999OS	Each	As approved by MCO
Printer	T1999	T1999PR	Each	As approved by MCO
Health-related equipment and supplies	T1999	T1999HR-I	Each	As approved by MCO
Adaptive equipment and supplies	T1999	T1999AE-I	Each	As approved by MCO
Exercise equipment and related items	T1999	T199EE-I	Each	As approved by MCO
Nutritional supplements	T1999	T1999NS-I	Each	As approved by MCO
OTC medications	T1999	T1999OM-I	Each	As approved by MCO
Household related goods	T1999	T1999HG-I	Each	As approved by MCO

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Appliances for independence	T1999	T1999AI-I	Each	As approved by MCO
Adaptive furniture	T1999	T1999AF-I	Each	As approved by MCO

1. Community Benefit Services must be edited to ensure that the units billed do not exceed what is reasonable based on the unit definition. For example, it is unreasonable for there to be more than 24 units of 99509 billed in a day since this is an hourly code. It is unreasonable for there to be more than 31 units of T2031 billed in a month with 31 days since this is a per diem code.
2. You may not allow providers to routinely bill units for an entire month regardless of which days service was provided. Doing this creates a problem with duplicate edits and will be disallowed by auditors. For example, a claim showing dates of service 9/1/16-9/30/16 for 20 units can create a problem if the 20 units were in fact only used between 9/1 and 9/17, for example, or if the client leaves to enter a nursing facility or hospital or hospice or dies, etc. The service should be billed only for the days service was rendered. Days can be grouped together on a claim, but only if services are rendered every day within that span. For the most part, with Community Benefit services (except for thosethat are billed on a per diem or monthly basis), you can't tell if this is the case or not, so providers should be instructed to report separately each service by the exact day or span of days it was rendered. This is regardless of whether the claim is for Agency-Based orSelf-Directed.
3. The MCO must have edits in place to deny Community Benefit claims submitted for dates of service that overlap dates the client was not in the home; either dates of hospitalization or rehab, or for dates the client was not eligible and enrolled with the MCO.
4. **EPSDT** - There are some procedure codes that are defined as both Community Benefit and EPSDT codes. These are: Home Health Aide, PT, OT and Speech services: S9122, G0151, G0152, G0153. When these services are rendered to a client under the age of 21, they must be billed by a provider other than a Community Benefit provider and the client shouldn't have a long term care span solely to receive the service (the client who receives EPSDT services, could, however, also be receiving some other Community Benefit service not available through EPSDT for which they would require a long term care span). No other Community Benefit procedure code than these 4 above should ever be billed as an EPSDT service.
5. A Private Duty Nursing Agency (PT 324) with a NM DOH Home Health agency is intended to be the default provider for skilled nursing under the EPSDT benefit,

although an FQHC is also allowed to bill EPSDT services. Private Duty Nursing services should be billed using a combination of revenue code and procedure code (if billed on the UB-04/837I) or procedure code only (if billed on the CMS1500/837P) allowed for Private Duty Nursing and FQHC providers. These revenue codes are 0550-0552 and procedure code is T1000 TDand TE. See NMAC 8.320 for more details about EPSDT covered services.

a. For clients in need of personal care type services, the appropriate procedure code under EPSDT S5125 is allowed as Attendant Care rendered by a provider type 324 and if billed on the UB-04/837I, the appropriate revenue code 0570 - 0572 HOME HEALTH AIDE must be included.
b. Providers who are required to provide electronic visit verification may bill a stipend for caregivers to utilize their personal smartphone and existing data plan. The entire stipend must be paid to the caregiver, and the agency may not retain any of it. All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT). The code G9005 is the code to be billed under EPSDT as the EVV Stipend. When billed by the Home Health Agency, bill the G9005 with the revenue code 0569 MEDICAL SOCIAL (HOME HEALTH)- OTHER MEDICAL SOCIAL SERVICES.

6. **Environmental Mods Only** – It is not a valid use of the Community Benefit to authorize a client whose only need is for Environmental Modifications. HCA is reviewing claims for clients authorized for Community Benefit where this is the only service used and will be communicating to the MCOs about actions to be taken.
7. ***CLIENT***
    1. There should never be an encounter submitted with a taxonomy 253Z00000X (provider type 363) for whom we do not already have a long-term care span showing a community benefit setting of care. *Any Community Benefit encounter submitted without a matching LTC span will be denied with* Omnicaid *exception code* 0031 (Turquoise Claims code: 29641).
    2. There should never be a community benefit setting of care entered our system by the MCO for a client for whom we don't have a community benefit encounter submitted within at least 120 days of the SOC begin date. **Note:** The: "clock" should start upon the eligibility approval for the member. The NFLOC/SOC can be in the system prior to financial eligibility from ISD and the member cannot access services until fully approved. The member is allowed 45 days per policy to provide paperwork, but there can be additional delays in some cases, such as waiting for DDU approval or if there is a ticket due to system error.

3. **EPSDT** - Members under the age of 21 are eligible for a wider range of services through the EPSDT benefit. Special Rehabilitative services such as physical therapy, speech therapy, occupational therapy, hearing and language services, behavioral health services, case management and EPSDT PCS and Private Duty Nursing services are all covered EPSDT services. A client receiving these services is not considered a client receiving Community Benefit and a long-term care span should not be extended for them, unless they are also eligible for and receiving some other Community Benefit service not covered under EPSDT.
4. **ABP Exempt** – Client with a COE 100 must always have been identified with a Disability Type Code with a begin date that is less than or equal to the date you are approving them for Community Benefit. The dates do not need to be in synch with the Community Benefit NFL SOC span, only that it is entered starting on or before the NFLOC span.

NURSING FACILITY CLAIMS/ENCOUNTER RULES

1. The ONLY provider type allowed on a Nursing Facility encounter is the provider type 211 or 212 and for the encounter to be recorded as a long-term care encounter it must have type of bill codes 65X, 66X, 69X, 86X, 89X, 21X, 22X
2. There should never be a non-crossover encounter submitted with a provider type 211, 212 for greater than a 120-day stay for a client for whom we do not already have a long-term care span showing a nursing facility setting of care. *Any Nursing Facility encounter submitted without a matching LTC span will post an* exception 0331 (Turquoise Claims code: 29641) but will not be denied.
3. There should never be a nursing facility setting of care entered our system by the MCO for a client for whom we don't subsequently receive a nursing facility encounter submitted within at least 120 days of the SOC begin date (***or Client Enrollment Add Date, if >= SOC Begin Date***). If for some reason, the client doesn't end up utilizing the nursing facility, the NFL/INF span should be voided or terminated. **Not**e: the "clock" should start upon the eligibility approval for the member. The NFLOC/SOC can be in the system prior to financial eligibility from ISD and the member cannot access services until they are fully approved. The member is allowed 45 days per policy to provide paperwork, but there can be additional delays in some cases, such as waiting for DDU approval or if there is a ticket due to a system error.
4. MCOs should not be denying nursing facility claims for timely filing based solely on the Admit date but must also compare against the date the enrollment was added. If the client's enrollment add date is after the claim's last date of service, The client's enrollment add date should be used to determine whether the claim has

been timely filed. For example, a client approved in September with retro enrollment to May, should not have their nursing facility claim denied for May and June based on a 90-day timely filing rule since the enrollment begin date didn't get added until September.

5. When a client changes nursing facility or the nursing facility has a change of ownership that changes the Provider ID from what is on the Long-Term Care Span, the MCO is responsible for sending an update to that span. *Failure to do so will result in Exception 0336 (Turquoise Claims code: 2109) denying the nursing facility claim.*
6. Nursing Facilities should not be allowed to be billed routinely at the first of the month and last of the month, but in fact the actual span of days the client was at the facility. Routinely billing the entire month of days regardless of the days covered results in errors and audit findings.
7. Clients in Hospice, provider type 362, who are in Nursing Facilities have their claims submitted by the hospice provider using revenue codes 0658/0659. The MCO must not pay the nursing facility directly since that payment is made by the Hospice provider. And there must be a long-term care span showing SOC = INF. *Any Nursing Facility encounter submitted with the Hospice Revenue Codes 0658 or 0659 without a matching LTC span will be denied with exception 0331 (Turquoise Claims code: 29641).*
8. Claims from Nursing Facilities and Hospice should not have ancillary charges in addition to the per diem codes. The per diem codes are intended to cover **all** services the NF offers.
9. **ABP Exempt** – Client with a COE 100 must always have been identified with a Disability Type Code with a begin date that is less than or equal to the date you are approving them for Nursing Facility. The dates do not need to be in synch with the Nursing Facility NFLOC SOC span, only that it is entered starting on or before the NFLOC span.

LONG TERM CARE EDITS

The following Edits will post and deny for Encounters:

The following Edits will post and deny for Encounters:

Omnicaid:0281 (CMdS: 35505) Service Not Allowed for Community Benefit Provider- this is a new edit that will be set to Deny effective March 1, 2017

Encounter Claims – Business Rules

Posting Condition 1:

If Billing Provider Type is in SL # CS-5645 (Provider Type 363) AND Billing Provider Specialty is in SL # CS-5304 (Specialty Code 078),

AND the Procedure Code on the line is NOT in system list CS-5677 (Service Allowed Community Benefit Provider),

THEN post this exception on the line.

Posting Condition 2:

If Billing Provider Type is in SL # CS-5645 (Provider Type 363) AND Billing Provider Specialty is NOT in SL # CS-5304 (Specialty Code 078),

AND the Procedure Code on the line is NOT in system list CS-5678 (Service Allowed Self-Directed Provider),

THEN post this exception on the line.

Omnicaid: 0331(CMdS:29641) No LTC Span Available for First Date of Service – this is an edit that is set to deny already.

Encounter Claims Rules for Exception 0331 (Edit #29641)

Exception 0331(Edit #29641) is posted for encounter claims when required LTC (Long-Term Care) spans are missing or misaligned based on Provider Type and Level of Care (LOC).

1. Provider Types 211 or 212 (SL # CS-4999)

- Applies only when Admit Date ≥ (Last Date of Service – 120 days).

- Post 0331 if no LTC span overlaps claim dates AND LOC = INF.

- Post 0331 if an LTC span exists but span begin date is NOT ≤ FDOS.

2. Provider Type 362 (SL # CS-5426) with Revenue Code in List 4721

- Applies when Last DOS > Admit Date + 120 days.

- Post 0331(Edit #29641) if no overlapping LTC span AND LOC = INF.

- Post 0331(Edit #29641) if LTC span exists but span begin date is NOT ≤ FDOS.

3. Provider Type 363 (SL # CS-5645)

- LOC must be ANW, SNW, ADB, or SDB (SL # CS-5805).

- Post 0331(Edit #29641) if no overlapping LTC span.
- Post 0331(Edit #29641) if LTC span exists but span begin date is NOT ≤ FDOS.

Omnicaid: 0336 (CMdS: 2109) Billing Provider Not Authorized by LTC Span or Lockin– this is an edit that is set to deny already.

> The nursing facility provider ID in the Long- Term Care span does not match the nursing facility claims billing provider ID.

4.1.18.1 Care Coordination, Administration and Support Broker

Care Coordination

The MCO registers itself as the provider of Care Coordination as provider type 222. PT 222 Care Coordination is allowed to bill the following range of codes:

98967 98968 96160 G9012 S5190 T2024

when that care coordination has been rendered by the MCO itself.

If the client is in CareLink NM, care coordination is part of the service that the CLNM provider renders and is billed to the MCO and comes to CMdS as a CareLink encounter. The MCO may not bill Care Coordination under their provider type 222 using procedure code T2024 for months the client is enrolled in CareLink NM. Clients with a category of eligibility (COE) 066/086 cannot be enrolled in Carelink NM/Health Homes and must be opted out if these COEs are identified at any time post enrollment with CareLink NM.

MCOAdministrative Services/Support Broker Services

The MCO registers itself as the provider of administrative services as provider type 223. HCA initially set this up to accommodate any administrative services rendered by MCO staff other than Care Coordination. HCA needs to know the support broker services utilized by the client but does not need to know the specific support broker who rendered the support. Therefore, any support broker services, whether rendered directly by MCO staff or contractors or by agencies contracted with the MCO, should be submitted as encounters to Conduent using the MCO's provider type 223 on the Professional claim type with procedure code T2025. Individual Support Brokers should not be enrolled with BMS. The intention of this is to allow an MCO to submit Support Broker services for its Self-Directed Community Benefit population (not the Mi Via population for whom all Mi Via and related services are handled completely outside of Turquoise Care).

Since the provider types 222 and 223 are utilized by the MCOs and the MCOs do not bill with NPI and taxonomy, the MCO provider records have been established with different zip codes since the zip code would be the only differentiation with the MCO's FEIN to map to the provider record. Please note the zip codes established for each provider type and submit encounters accordingly.

4.1.18.2 Update Member LOC API INTERFACE FILE

The Managed Care Organization is responsible for submitting the Update Member LOC API interface file to report on clients whose status has changed in any way. This includes notification of:

- Client's most recent assessment type (HRA (H), CNA (C), NTM (N), DMR (D)), level code and date.
- Client's most recent categorization status and date of categorization.
- PCP assignment.
- NF level of care and setting of care – new assignments or changes.
- Community long term care assignment orchange.
- Health Home assignment.

If the MCO does not have any changes to report, a file is not sent.

The layout for the Update Member LOC file is located HCA-MCO - Documents - MCO Business Manual - All Documents

4.2 Care Coordination Assessment and Level Data Requirements

The MCO shall adhere to all contract requirements to complete the HRA. The valid value 'N' which stands for New to Medicaid Review and valid value 'D' which stands for Data Mining Review will only be allowed when submitted with a CC Level 0, 3, 4 or 5 as outlined below. Conversely, the existing values of H (HRA) or C (CNA) can be submitted with any CC Level.

1. The MCO's use of the assessment type 'N' is intended for those instances where the client is new to Medicaid and the MCO is unable to complete the required HRA within 30 days, due to the Member being Unable to Reach (CCL0-UTR), Refused Care Coordination (CCL4-RCC) or Difficult to Engage (CCL5-DTE). The assessment date associated with the type 'N' would be the date the MCO completed all contract required attempts to complete the HRA. The MCO shall conduct data mining on Members with an assessment type 'N' after the Member has been enrolled with the MCO for one quarter. At that time, the MCO must change the Member's assessment type from 'N' to "D", "H", or "C". The assessment date associated with the new type replacing 'N' would bethe date the assessment type was performed (i.e., either the date the data mining was performed or the assessment completed).
2. The MCO's use of the assessment type D is intended for ongoing clients where the client's CC Level is '3' (General Population), '0' (Client Unable to be Reached), '4' (Client Refused Care Coordination), or '5' (Client Difficult to Engage) and there is no indication, through a Data Mining Review, of a change in the Member's condition that would require a higher CC level. The CCL0, CCL3, CCL4, or CCL5 Member would then be recategorized as CCL3 with an Assessment Type 'D'.

If the MCO submits a CC span without an assessment type and date, Turquoise Claims will look to see if there is already a span on file with a Care Coordination begin date that is greater to or equal to the incoming span that has a previously submitted assessment type and date. If so, Turquoise Claims will accept the incoming CC level and dates and copy that most recent prior existing assessment type and date into the new CC span.

There is no expiration for a CC assessment date; the system will not be edited to ensure the assessment has been completed within the past 12 months or that Data Mining is being completed every quarter. Although there are program policy requirements related to when the MCO should conduct re-assessments, the system will not try to enforce these requirements. There will be periodic reporting HCA will do to determine if the assessment requirements are being done timely.

If an incoming transaction has assessment type D (Data Mining Assessment) and incoming CC level is other than 0, 3, 4 or 5, or incoming transaction has assessment type N (New to Medicaid) and incoming CC level is other than 0, 4 or 5 an error will post to the incoming record: error 2139 ASSESS TYPE D/N NOT VALID FOR CCLEVEL

Changes to the end date of a CC span without any change in CC level will just update the end date of the existing span instead of voiding and replacing it (this doesn't affect the MCOs, is just an efficiency fix). If the incoming assessment type and/or date is different from the existing as well, the system will also accept the update of these fields in addition to the end date.

If the incoming CC span overlaps an existing span, but the begin date is greater than the existing span's begin date, the system will cut back the existing span's end date to 1 day prior to the incoming span's begin date and accept the incoming span.

The system will not allow an incoming CC effective date or assessment date to be greater than 1 month in the future from the interface date. If submitted, a new error will post error 2140 CC EFF DT/ASSESS DT > 1 MONTH IN FUTURE.

Assessment are both entered with a Care Coordination Level and Effective/End dates, the Care Coordination Effective Date must be different for the two records.

If the client changes care coordination level, the MCO can submit just the Care Coordination Level with the new effective and end dates without resending the Care Coordination Assessment date and type, unless a new assessment has in fact been done.

4.2.1 Long Term Care Data Requirements

** NOTE: Long Term Care fields are intended to be sent as a block of data. The MCO is supposed to assess clients in long-term care at least annually based on their last assessment date. When an LTC assessment is completed, the MCO is expected to

communicate the date of the assessment, the new effective date of the long-term care LOC and SOC and all those associated fields (LOC, SOC, effective date, end date, and SOC provider NPI). So, for example, if the client's current LTC information is as follows:

LTC ASSESSMENT DATE	6/11/2025
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	7/1/2025
NF LEVEL OF CARE END DATE	6/30/2026
SETTING OF CARE	SDB
SETTING OF CARE PROVIDER NPI	9999999998

The MCO would be expected to complete an NF LOC assessment **with sufficient time to enable entry of the next year's effective date** by no later than **6/30/2026**. **The Community Benefit SOC cannot be entered retroactively.** Once completed, the MCO will send the information in on the Update Member LOC API file as follows (assuming no change)

LTC ASSESSMENT DATE	5/31/2026
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	7/1/2026
NF LEVEL OF CARE END DATE	6/30/2027
SETTING OF CARE	SDB
SETTING OF CARE PROVIDER NPI	9999999998

If, for example, during this most recent assessment period, the client changes status and moves from the Community Benefit to a Nursing Home, the information would be sent as follows **(The SOC INF can be entered retroactively)**:

LTC ASSESSMENT DATE	11/17/2026
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	11/1/2026
NF LEVEL OF CARE END DATE	10/31/2027
SETTING OF CARE	INF
SETTING OF CARE PROVIDER NPI	1902804156

If, for example, during this most recent assessment period, the client leaves the nursing facility and is no longer in NF LOC, the information may look as follows:

LTC ASSESSMENT DATE	12/17/2026
NF LEVEL OF CARE	NFL
NF LEVEL OF CARE EFFECTIVE DATE	11/1/2026
NF LEVEL OF CARE END DATE	12/31/2026
SETTING OF CARE	INF
SETTING OF CARE PROVIDER NPI	1902804156

4.2.2 Managed Care Call Back API

The daily files from the MCOs are used to update the Client Detail, Health Home,Care Coordination, and Long-Term Care (LTC) tables. There are several distinct sections or types of data in the input file: demographic data to identify the client, data to update the client detail table, data to update the Care Coordination table, data to update the Health

Home table, and data to update the Long-Term Care span table. Each of these sections of data used to update Turquoise Claims are subject to their own sets of validation edits, and data that if invalid in one section will not cause valid data to be ignored in another section. For example, a client's LTC span data may be updated even if the Care Coordination dates are rejected as being invalid.

The following errors will be produced from the Update Member LOC API interface file. Edit errors encountered during the processing of the Update Member LOC API Interface will be sent back to the MCOs. Errors may be critical or non-critical. Critical errors will prevent updates from being made in Turquoise Claims.

Edit Errors produced during update:

Error Num	Critical/ Non-Critical	Error Message	Meaning
2100	Critical	CLIENT NOT FOUND	The client was not found in Turquoise Claims. The swipe card ID is used to read the B_ALT_ID_TB. If the B_SYS_ID is not found for the swipe card ID, the error will be posted. The entire record will be rejected, and no further edits will be done.
2101	Critical	CARE COORDINATION DATE INVALID	The care coordination date in the file is invalid in content or format. This edit is done only if the care coordination date is greater than spaces.
2102	Critical	INVALID CARE COORDINATION TYPE	The care coordination type, if specified, is not "C" or "H".
2104	Critical	HEALTH HOME NPI NOT ON FILE	An NPI was specified in the HLTH- HOME-NPI field of the input record, but the NPI could not be found in Turquoise Claims.
2105	Critical	INVALID HEALTH HOME TYPE	The home health level code from the input record HLTH-HOME-TY-CD) could not be found in SL BC 9027. Value'C' is not allowed - this value may be submitted only via the CareLink NM interface.
2106	Critical	INVALID CARE CORDINATION LEVEL	The care coordination level from the input file (CARE-COORD-LVL) could not be found on the System List BC 9028. Values'6', '7', '8' and '9' are not allowed - these values may be submitted only via the CareLink NM interface.
2107	Critical	CLIENT ID NAME OR DATE OF BIRTH MISMATCH	The last name through the first blank and the date of birth from the input record does not match that of the data returned from the client table. The entire record will be rejected, and no further edits will be done.

Error Num	Critical/ Non-Critical	Error Message	Meaning
2108	Critical	INVALID DISABILITY TYPE EFFECTIVE DATE	Disability Type effective date must be a valid date

Error Num	Critical/ Non-Critical	Error Message	Meaning
2109	Critical	DISABILITY TYPE CODE IS INVALID	The disability type code from the input record (DISABIL-TY-CD) cannot be found on the SL BC 9045
2110	Critical	INVALID LTC ASSESSMENT DATE	The long-term care assessment date from the input file, LTC-ASSESS-DT, is not a valid date.
2111	Critical	INVALID LVL CARE EFFECTIVE DATE	The level of care effective date from the input file, NF-LVL-CARE-EFF-DT, is not a valid date.
2112	Critical	INVALID LVL CARE END DATE	The level of care end date (NF-LVL- CARE-END-DT) is not a valid date.
2113	Critical	CARE COORDINATION EFFECTIVE DATE INVALID	The care coordination effective date from the input file (-CARE-COORD-EFF-DT) is not a valid date.
2114	Critical	INVALID CARE COORDINATION END DATE	The care coordination end date from the input file CARE-COORD-END-DT) is not a valid date.
2115	Critical	HEALTH HOME EFFECTIVE DATE IS NOT VALID	The home health effective date from the input file (HLTH-HOME-EFF-DT) is not a valid date.
2116	Critical	HEALTH HOME END DATE IS NOT VALID	The home health end date from the input file (HLTH-HOME-END-DT) is not a valid date.
2117	Critical	COORD END DATE MUST BE => BEGIN DATE	The care coordination end date from the input file (CARE-COORD-END-DT) cannot be less than the care coordination begin date from the input file (CARE- COORD-EFF-DT). The end date must be equal to or greater than the effective date.
2118	Critical	HEALTH HOME END DATE NOT > BEGIN DATE	The home health end date from the input file (HLTH-HOME-END-DT) must be greater than the home health effective date from the input file (HLTH-HOME-EFF- DT).
2119	Critical	LTC END DATE MUST BE > LTC BEGIN DATE	The long-term care end date from the input file (NF-LVL-CARE-END-DT must be greater than the long-term care end date from the input file (NF-LVL-CARE-EFF-DT).

Error Num	Critical/ Non-Critical	Error Message	Meaning
2120	Critical	PCP ASSIGN EFFECTIVE DATE INVALID	The PCP assign date from the input file (PCP-ASSIGN-EFF-DT) is not a valid date.
2121	Critical	CC ASSESS DATE REQUIRED FOR ASSESS TYPE	The care coordination type (CARE- COORD-TY) is specified on the input record, but the care coordination assessment date (CARE-COORD-DT) is not specified. Both fields are required if one of the fields is specified.

Error Num	Critical/ Non-Critical	Error Message	Meaning
2122	Critical	CC ASSESS TYPE REQUIRED FOR ASSESS DATE	The care coordination type (CARE- COORD-TY) is not specified on the input record, but the care coordination assessment date (CARE-COORD-DT) is specified. Both fields are required if one of the fields is specified.
2123	Critical	CC LEVEL, CC EFF/END DATES REQUIRED	The care coordination level (CARE- COORD-LVL – values 0-5 and A-D) is specified, but either the care coordination effective date (CARE-COORD-EFF-DT) **or** the care coordination end date (CARE- COORD-END-DT) is not specified.
2124	Critical	CC ASSESS TYPE/ASSESS DATE REQUIRED	The care coordination level (CARE- COORD-LVL – values 1, 2, 3, A-D) is specified, and the care coordination date from the input file (CARE-COORD-DT) is not specified, and no assessment date can be found on the B_CARE_COORD_TB for the client.
2125	Critical	CC LEVEL & CC END DATE REQUIRED	The care coordination effective date (CARE-COORD-EFF-DT) is specified, but either the care coordination level (CARE-COORD-LVL) or the care coordination end date (WCARE- COORD-END-DT) is not specified.

Error Num	Critical/ Non-Critical	Error Message	Meaning
2126	Critical	SETNG OF CARE PROV NOT ON FILE OR BLANK	If LTCSettingID_extn is specified and is not found in the Turquoise Claims database OR If LTCSettingID_extn is specified for LOC in SL BC 9018 and provider type is not in SL PC 9003 and provider enrollment status is not in SL PC 9004 OR LTCSettingID_extn is an NPI and the end effective date for the NPI is not greater than or equal to incoming LTC span begin date For INF providers, the provider type must be 211 (Nursing facility, private) or 212 (Nursingfacility, state), and the provider's most recent enrollment status must be Active (60) or None-MCO provider (70). If the provider number is an NPI, the NPI's end effective date must be on or after the submitted LTC begin date (NF- LVL-CARE-EFF-DT).
2127	Critical	PROVIDER NPI NOT ON FILE	The provider NPI (PROVIDER-NPI) is specified but cannot be found on the P_NPI_XMTCH_TB table.
2128	Critical	LTC ASSESS DATE REQD FOR LTC BEG/END	The LTC assessment date (LTC- ASSESS-DT) is not specified on the input file, but either the level of care effective date (-NF-LVL-CARE-EFF-DT) or the level of care end date (NF-LVL-CARE- END-DT) is specified.
2129	Critical	NO ASSESS DATE FOUND FOR COORD INSERT	No care coordination assessment date was present on the input file AND is not present in Turquoise Claims.

Error Num	Critical/ Non-Critical	Error Message	Meaning
2130	Critical	INVALID DISABILITY TYPE END DATE	Disability Type end date must be a valid date.
2131	Critical	DISABIL END DATE MUST BE => EFF DATE	Disability Type end date must be greater than the effective date.

2132	Critical	NO UPDATES MADE TO Turquoise Claims	The record was processed, but no updates were made to Turquoise Claims. Critical errors can be posted to the error file, but the error 40 may not appear on the error report. This happens when there is data for more than 1 table (ex: home health and care coordination) in the record, but edits prevented one of updates from occurring, but the data for the other passed all edits and Turquoise Claims updated.
2133	Critical	DISABIL DATE REQUIRED FOR DISABIL TYPE	If a disability type is received, disability dates must be provided as well.
2134	Critical	DISABIL TYPE REQUIRED FOR DISABIL DATE	If disability dates are provided, there must be a disability type provided.
2135	Critical	DISABIL EFF DATE MUST => CC ENROLL DATE	If the client has a disability type, then the disability begin date must be provided and it must be >= the client' s Turquoise Care first enrollment date.
2141	Critical	RETRO COMMNTY BENEFIT ENROLL NOT ALLOWED	LTC Level of Care = NFL and LTC Setting Of Care = 'ANW' or 'ADB or 'SNW' or 'SDB' and LTC Begin Date is less than first of the upcoming month.
2142	Critical	CLIENT HAS OVERLAPPING WAIVER PRIOR AUTH	Client has a DD Waiver (PA type W) or Supports Waiver (PA type = S) prior authorization with a status of Approved (A), Closed (C) or Suspended (S) with a PA effective and end date span that overlaps the LTC begin and end date span on the incoming transaction.
2138	Critical	NFL OVERLAPS EXISTING NON-NFL LOC SPAN	Client has a non-NFL level of care LTC span with begin and end dates that overlap the begin and end date span on the incoming transaction.
2139	Critical	CC ASSESS TYPE NOT VALID FOR CC LEVEL	Incoming transactions have assessment type D (Data Mining Assessment) and incoming CC level is other than 0, 3, 4 or 5, or incoming transaction has assessment type N (New to Medicaid) and incoming CC level is other than 0, 4 or 5

Error Num	Critical/ Non-Critical	Error Message	Meaning
2140	Critical	CC EFF DT/ASSESS DT > 1 MONTH IN FUTURE	Incoming transaction has a CC effective date or assessment date that is more than 1 month in the future from the current date.

*For errors 2142 and 2138, MCO is instructed to contact christina.lucero@hca.nm.gov to coordinate closure of any Waiver Prior Auths or non-NFL LTC spans prior to resubmitting the NFL LTC span

5.0 THIRD PARTY LIABILITY

Clients with other insurance are reported by HCA to the MCOs. Medicare coverage is reported separately as Medicare spans and is not included in the TPL files.

5.1 TPL Files to MCOs

TPL coverage is shared with the MCOs via two file exchanges. Daily, the MCO sends an TPL "eligibility" file to QA. The daily file contains any newly enrolled or reinstated clients. QA determines if the client has coverage, verifies the coverage with the third-party carrier, and returns a TPL file with verified coverage only. The file layouts are located HCA-MCO - Documents - MCO Business Manual - All Documents

The second method is a monthly CAV file sent to the MCOs by QA. This file reports changes in coverage including adds, terms, updates and voids.

ADDS: If QA identifies TPL that has not been reported previously, QA will submit a record that does not match existing client coverage record client id, carrier, policy number, or does match these but does not overlap the existing dates. This will be considered by the MCO as an add transaction.

UPDATES: If QA identifies some change in the existing data other than begin and end dates, a record would be submitted that matches the existing span except for a change to policy information such as coverage code, policyholder, etc.
TERMINATIONS: If QA identifies that coverage that has been reported as open is no longer active coverage, QA will submit a termination record defined as a record where an end date that is not open ended and is earlier than the end date previously reported. The span submitted by QA must match what was previously sent to the MCO as existing client coverage on client id, carrier, policy number, and begin date. The existing client coverage record will be updated with the incoming end date.

VOIDS: If QA identifies that the TPL previously reported is incorrect and the client never had the coverage that is identified, QA should submit a void transaction defined as transactions where the begin date = end date. The existing span which matches the client coverage record client id, carrier, policy number, and begin date will be voided. The layout of the file is located HCA-MCO - Documents - MCO Business Manual - All Documents

Client's relationship to the policyholder (valid value):

5.1.1 Client's relationship Code

UNKNOWN	0
SELF	1

SPOUSE	2
CHILD	3
STEPCHILD	4
FOSTER-CHILD	5
GRANDPARENT	6
OTHER	9

1. State code (valid value):

State Name State Code

ALASKA	AK
ALABAMA	AL
ARKANSAS	AR
AMERICAN SAMOA	AS
ARIZONA	AZ
CALIFORNIA	CA
COLORADO	CO
CONNECTICUT	CT
WASHINGTON DC	DC
DELAWARE	DE
FLORIDA	FL
GEORGIA	GA
GUAM	GU
HAWAII	HI
IOWA	IA
IDAHO	ID
ILLINOIS	IL
INDIANA	IN
KANSAS	KS
KENTUCKY	KY
LOUISIANA	LA
MASSACHUSETTS	MA
MARYLAND	MD

MAINE	ME
MICHIGAN	MI
MINNESOTA	MN
MISSOURI	MO
NORTH-MARIANA-ISL	MP
MISSISSIPPI	MS
MONTANA	MT
NORTH CAROLINA	NC
NORTH DAKOTA	ND
NEBRASKA	NE
NEW HAMPSHIRE	NH
NEW JERSEY	NJ
NEW-MEXICO	NM
NATIONAL	NT
NEVADA	NV
NEW-YORK	NY
OHIO	OH
OKLAHOMA	OK
OREGON	OR
PENNSYLVANIA	PA
PUERTO RICO	PR
RHODE	RI
SOUTH CAROLINA	SC
SOUTH DAKOTA	SD
TENNESSEE	TN
TEXAS	TX
UTAH	UT
VIRGINIA	VA
VIRGIN ISLAND	VI
VERMONT	VT
WASHINGTON	WA
WISCONSIN	WI
WYOMING	WY

2. Client's relationship to the policyholder (valid value):

Client's relationship Code

UNKNOWN	0
SELF	1
SPOUSE	2
CHILD	3
STEPCHILD	4
FOSTER-CHILD	5
GRANDPARENT	6
OTHER	9

3. TPL coverage type code (valid value):

TPL coverage type Code

INPATIENT	01
OUTPATIENT	02
SURGERY	03
LAB	04
XRAY	05
ANESTHESIA	06
DRUG/STANDARD	07
MAJOR MEDICAL	08
DENTAL	09
VISION	10
ACCIDENT	11
CASUALTY	12
WORKMEN'S COMP	13
INDEMNITY	14
NURSING	15
HMO/DRUG	16
MEDICARE SUPPLY A	17

MEDICARE SUPPLY B	18
TRANSPORTATION	19
CANCER	20
BLACK-LUNG	21
HMO/STANDARD	22
MENTAL/AMBULATORY	23
MENTAL/INPATIENT	24
HEARING	25
MENTAL/HMO AMBULATORY	26
MENTAL/HMO IMENTAL	27
DENTAL/HMO	28
VISION/HMO	29
HEARING/HMO	30

4. **TPL policy resource code (valid value):**

Absent Parent	1
Casualty	2
EPSDT	3
Health Insurance	4
Other Insurance	5
Pregnant	6
Unassigned	7

5.2 MCO to QA Module TPL Invalid Transactions

On a daily (Monday through Friday) and monthly basis, after the MCO receives the TPL interface file from the QA Module, it returns the invalid transactions will be written to an error file. This file contains the same information as the input, but an error message is added to the end of the output record. The layout of the file is located HCA-MCO - Documents - MCO Business Manual - All Documents

1. TPL edit error list (critical errors):
   - 002-MISSING TPL DATA
   - 013-POLICY NUMBER IS REQUIRED
   - 014-POLICY BEGIN DATE IS REQUIRED

- 015-POLICY BEGIN DATE ISINVALID
- 016-POLICY END DATE ISINVALID
- 017-Policy Begin dt cannot be after Policy End dt
- 018-CLIENT COVERAGE BEGIN DATE ISREQUIRED
- 019-CLIENT COVERAGE BEGIN DATE ISINVALID
- 020-CLIENT COVERAGE END DATE ISINVALID
- 021-CL CVRG Begin dt cannot be after CL CVRG End dt
- 022-Client Coverage type code is invalid
- 023-Carrier's Address State code is invalid
- 024-Client CVRG span is not covered by Policy span
- 026-Missing CVRG Type CD, at least one is required
- 027-PLCY BEG Date more than 2 mos in future
- 028-CLNT CVRG BEG Date more than 2 mos in future

2. TPL edit error list (critical errors):
   - 102-Missing data in required fields for Carrier Required
   - 108-Medicaid ID is required

6.0 CAPITATION PAYMENT

The Monthly enrollment cycle that generates the 834 and Supplemental Roster files also generates the Capitation or Per Member Per Month (PMPM) claims for all the Medicaid Managed Care enrollees for the upcoming month.

Capitation claims are processed through the MMIS claims processing system on the first Saturday of the enrollment month with a payment date of the following Monday. For example, if the Full Enrollment cycle occurs on June 25, 2024, for the enrollment month of July 2024, the PMPM claims created will be processed on July 5, 2024, with the 820 and 834 available the morning of July 6, 2024.

The system's process for determining a client's health plan capitation rate is described in detail below. If the system is unable to determine the appropriate capitation rate for a client, it terminates the client's health plan enrollment span.

6.1 Rate Cohort Determination

The following chart describes the rate cohorts for Turquoise Care. Each member has 2 cohorts assigned, one for physical health and the other for behavioral health. The selection of a COE for cohort assignment is hierarchical if a client has more than one COE that overlaps. If a client has a waiver COE and a regular Medicaid COE, the regular Medicaid COE will always be chosen. We can therefore assume that anywhere that the COE criteria show a Waiver COE (09x), that the client does not have a regular Medicaid COE and thus the Waiver COE has been chosen. The BH Cohorts can be assigned using the corresponding physical health cohort that the client is in.

PHYSICAL HEALTH COHORTS FOR REGULAR MEDICAID BENEFIT PACKAGE

PH Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	GEO Country Code
001	2 - Newborn	TANF/AFDC, MA KIDS, CYFD 0-2 MONTHS	003, 004, 006, 017, 027, 028, 031, 032, 036, 037, 060, 061, 066, 071, 072, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 400, 401, 402, 403, 420, 421	0	0	F & M	NONE	N/A	NO	N/A
002	1- Regular	TANF/AFDC, MA KIDS 2 MOS THRU 23 YRS	027, 028, 031, 032, 052, 072, 400, 401, 036, 071, 200, 402, 403, 420, 421	0	23	F & M	NONE	N/A	NO	N/A
003	1- Regular	TANF/AFDC 19 THRU 49 FEMALE	027, 028, 052, 072, 200	19	49	F	NONE	N/A	NO	N/A
004	1- Regular	TANF/AFDC 19 THRU 49 MALE	027, 028, 072, 200	19	49	M	NONE	N/A	NO	N/A
005	1- Regular	TANF/AFDC 50+	027, 028, 052, 072, 200	50	255	F & M	NONE	N/A	NO	N/A
006	1- Regular	SSI & WAIVER 2 MOS TO 1 YEAR MALE AND FEMALE	003, 004,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	0	0	F &M	NONE	N/A	NO	N/A
007	1- Regular	SSI & WAIVER 1 YEAR THRU 20 YEARS MALE & FEMALE	003, 004, 074, 081, 083, 084, 090, 091,	1	20	F &M	NONE	N/A	NO	N/A

PH Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low _Age	High _Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	GEO Country Code
			092, 093, 094, 095, 096							
008	1- Regular	SSI & WAIVER 21 THRU 39 FEMALE	003, 004, 074,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	21	39	F	NONE	N/A	NO	N/A
009	1- Regular	SSI & WAIVER 21 THRU 39 MALE	003, 004, 074, 081, 083, 084, 090, 091, 092, 093, 094, 095, 096	21	39	M	NONE	N/A	NO	N/A
010	1- Regular	SSI & WAIVER 40+	001, 003, 004, 074,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	40	255	F &M	NONE	N/A	NO	N/A
011	1- Regular	PW/MA 15 THRU 49	030, 035, 300, 301	15	59	F	NONE	N/A	NO	N/A
012	1- Regular	CYFD 2 MONTHS THRU 26 YEARS	006, 017, 037, 060, 061	0	26	F &M	NONE	N/A	NO	N/A
012	1- Regular	CYFD 18 – 26 YEARS	066, 086	18	26	F &M	NONE	N/A	NO	N/A
013	4 – Child in State Custody	CISC Under Age 18	066, 086	0	17	F &M	NONE	N/A	NO	N/A

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	LOC	SOC	Medicare (Part A or Part B or both)	Geo County Code

300	V- Dual NFLOC	LTC - NF LOC DUALS	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	Y	01, 03, 05, 06, 08, 13, 14, 15, 17, 20, 22, 23, 24, 26, 28, 30, 32, 33
301	W - Dual MiVia	LTC - MI VIA Self Directed DUALS	090, 091, 092, 093, 094 (only the waiver COEs (090-094) are eligible for Self - Directed, however, a client could have overlapping eligibility with another regular Medicaid COE in which case the regular Medicaid COE is what will appear on the Roster file).	0	255	F & M	NFL	SNW, SDB	Y	N/A
302	X - Non-Dual NFLOC	LTC - NF LOC NON DUALS	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 090, 091, 086, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	NO	01, 03, 05, 06, 08, 13, 14, 15, 17, 20, 22, 23, 24, 26, 28, 30, 32, 33

303	Y - Non-Dual MiVia	LTC - MI VIA Self Directed NON DUALS	090, 091, 092, 093, 094 (only the waiver COEs (090-094) are eligible for Self - Directed, however, a client could have overlapping eligibility with another regular Medicaid COE in which case the regular Medicaid COE is what will appear on the Roster file).	0	255	F & M	NFL	SNW, SDB	NO	N/A
304	Z - Healthy Duals	LTC - HEALTHY DUALS	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	Not = NFL	N/A	Y	N/A

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	LOC	SOC	Medicare (Part A or Part B or both) Part B or both)	Geo County Code
310	Q - Dual NFLOC - Ph2	LTC - NF LOC DUALS PH REG2	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 0095,	0	255	F & M	NFL	INF, ANW, ADB	Y	02, 07, 09, 12, 16, 19, 27

			096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421							
312	R - Non-dual NFLOC - Ph2	LTC - NF LOC NON DUALS PHREG2	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	NO	02, 07, 09, 12, 16, 19, 27
320	U - Dual NFLOC - Ph5	LTC - NF LOC DUALS PH REG5	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071, 402, 403, 420, 421	0	255	F & M	NFL	INF, ANW, ADB	Y	04 10 11 18 21 25 29 31
322	9 - Non-dual NFLOC - Ph5	LTC - NF LOC NON DUALS PH REG5	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084,086, 090, 091, 092, 093, 094, 095, 096, 200, 300, 301, 400, 401, 036, 071,	0	255	F & M	NFL	INF, ANW, ADB	NO	04 10 11 18 21 25 29 31

			402, 403, 420, 421							

Geo County Code - (Either the INF provider's location is within the county or non-INF client's geo county)

Cohorts 006 through 010 include the clients who are not in long term care or those clients who are DD Waiver or Med Frag clients. The clients in this cohort have all their physical health needs covered in the cohort, and their DD/Med Frag waiver are paid FFS. Since it is possible for a D&E waiver client to have financial eligibility for this category without accompanying LTC span in place, any client with waiver financial eligibility but no LTC span will fall here.

BH COHORTS - CONSIDER CRITERIA SIMPLY BEING THE PHYSICAL HEALTH COHORT ASSIGNED
(Including the Certified Community Behavioral Health Clinic (CCBHC) cohort number corresponding to the behavior health cohort number)

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	Corresponding Cohort	Corresponding CCBHC Cohort
201	B - BH - Non-LTC Non-Dual Non-ABP	BH TANF/AFDC M & F	027, 028, 030, 031,032,033,034, 035, 060, 061, 072, 073, 036, 071, 402, 403, 420, 421, 200, 300, 301,400, 401	0	255	F & M	001-005, 011	701
202	B - BH - Non-LTC Non-Dual Non-ABP	BH CYFD M & F	006, 017, 037	0	26	F & M	012	702
202	B - BH - Non-LTC Non-Dual Non-ABP	BH CYFD M & F	066, 086	18	26	F & M	012	702

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	Corresponding Cohort	Corresponding CCBHC Cohort
203	B - BH - Non-LTC Non-Dual Non-ABP	BH SSI, B&D, WAIVER - 0 TO 14 YRS M & F	003, 004, 081, 083, 084,090, 091, 092, 093, 094, 095, 096	0	14	F & M	006-010	703
204	B - BH - Non-LTC Non-Dual Non-ABP	BH SSI, B&D, WAIVER - 15 TO 20 YRS M & F	003, 004, 074,081, 083, 084, 090, 091, 092, 093, 094, 095, 096	15	20			704704
205	B - BH - Non-LTC Non-Dual Non-ABP	BH SSI, B&D, WAIVER - 21 + YRS M & F	001, 003, 004, 074, 081, 083, 084, 090, 091, 092, 093, 094, 095, 096	21	255			705
206	C - BH LTC Non-dual	BH LTC NON DUAL	001, 003, 004, 006,017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066, 072, 073, 074, 081, 083, 084, 086, 036, 071, 090, 091, 092, 093, 094, 095, 096, 402, 403, 420, 421, 200, 300, 301, 400, 401	0	255	F & M	302, 303, 312, 322	706
207	S - BH LTC Dual	BH LTC DUAL	001, 003, 004, 006, 017, 027, 028, 030, 031, 032, 033, 034, 035, 037, 052, 060, 061, 066,	0	255	F & M	300, 301, 304, 310, 320	707

Cohort #	Rate Type	Cohort_Desc	COE_Cd	Low_Age	High_Age	Gender	Corresponding Cohort	Corresponding CCBHC Cohort
			072, 073, 074, 081, 083, 084, 086, 036, 071, 090, 091, 092, 093, 094, 095, 096, 402, 403, 420, 421, 200, 300, 301, 400, 401					
208	6 - BH ABP	BH ABP	COE 100	18	65	F & M	110-122	708
209		CISC	066, 086	0	17	F & M	013	709

ALTERNATIVE BENEFIT PACKAGE (ABP) POPULATION - USING SCI COHORTS REDEFINED

Cohort #	Cohort Description	COE Criteria	Min Age	Max Age	Gender
110	ABP, ages 18-20 M	COE 100	18	20	M
111	ABP, ages 18-20 F	COE 100	18	20	F
112	ABP, ages 21-29 M	COE 100	21	29	M
114	ABP, ages 21-29 F	COE 100	21	29	F
115	ABP, ages 30-39 M	COE 100	30	39	M
116	ABP, ages 30-39 F	COE 100	30	39	F
117	ABP, ages 40-49 M	COE 100	40	49	M

Cohort #	Cohort Description	COE Criteria	Min Age	Max Age	Gender
118	ABP, ages 40-49 F	COE 100	40	49	F
119	ABP, ages 50-59 M	COE 100	50	59	M
120	ABP, ages 50-59 F	COE 100	50	59	F
121	ABP, ages 60-65 M	COE 100	60	65	M
122	ABP, ages 60-65 F	COE 100	60	65	F

6.2 Enrollment Terminations – No Rate Cohort Found

If a rate cohort that matches the client's characteristics does not exist, the enrollment roster will reflect a cohort number 999, and no capitation payment is made for that month for that client. These clients are listed on the Client Capitation Error Report which is available to State staff who work to identify why the client is enrolled but not meeting any cohort definition. The MCO is expected to enroll the client, despite the cohort 999 and render services. State staff will correct whatever error is causing the cohort 999 to post and either the cohort will be assigned and paid, or the client will be determined not eligible to be enrolled. If the client is not eligible to enroll, the enrollment will be recouped. Whenever the system terminates a client's plan enrollment, it also closes the client's rate cohort history span as of the end of the month for which the last capitation payment was made.

6.3 Capitation Claim Generation

The system may generate capitation claims for only the current capitation month for each client or for one or more retroactive capitation months for each client based on the last capitation date on the lock-in span. It continues generating claims until the first of the upcoming month or the enrollment ending date, whichever is earlier. If for any reason a capitation claim cannot be made for a given month, the system stops the attempt with that month for that client and health plan provider and does not attempt to create any other claim for other months. For example, if the system determines that a capitation claim is required for October, November, and December, the process starts with October. If a successful claim is generated for October, the system attempts to generate a claim for November. If the claim cannot be generated for October, the system stops and does not attempt to generate claims for November or December.

Capitation processing will generate one capitation for each member per month, with an amount for the BH cohort and an amount for the PH cohort. The capitation claim gets generated with the two payments reflected in two lines on the same claim.

On all capitation claims, the sum of the line item submitted charges is the submitted charge on the claim record. The dates of service are the month begin and end dates. Capitation claims are passed directly into the Claims Processing Subsystem adjudication cycle. The Claims Processing Subsystem checks for duplicates to ensure no capitation claim is paid more than once and submits the claims for processing during the first payment cycle of the most recently capitated month. The Claims Processing Subsystem sets the reimbursement amount on the capitation claims to equal the submitted charge before paying the claims.

6.4 Capitation Adjustments

It is the nature of eligibility and enrollment that clients may lose eligibility and later regain it retroactively, resulting in recoupment spans appearing on the Enrollment Roster. Because these changes frequently resolve retroactively, HCA does not recover capitation payments immediately upon receiving a recoupment span. Instead, HCA applies a lag period before voiding capitations to prevent unnecessary disruption. The only exceptions are confirmed Date of Death (DOD) or Incarceration events, for which capitations are recovered beginning with the event month without applying a lag.

With the transition to the Turquoise Claims system, all capitation adjustments, including those triggered by retroactive eligibility changes, are now handled automatically by HCA. MCOs must not recoup claim payments from providers based solely on roster recoupment spans. MCOs may recoup only when the capitation for the service month has been officially voided by HCA and reported on the 820 electronic remittance.

Turquoise Claims Automatic Processing

Turquoise Claims now automatically processes the following capitation adjustments:

- Retroactive Medicare determinations
- Date of Death (DOD)
- Loss of Eligibility
- Member Record Merges
- Incarceration

- Retroactive INF (long-term care) spans
- Retroactive Newborn cohort adjustments

MCOs must reconcile capitation activity using the 820 remittance and may use the Enrollment Roster for informational reference.

Monthly Capitation Report

The only capitation report HCA continues to generate monthly is:

- Duplicate Capitation Due to Merge Report

This report identifies cases in which duplicate capitation occurred due to an eligibility merge. HCA processes recoupments for the prior month based on this report, and all voids or adjustments appear on the 820.

Adjustment Reason Codes

The following Adjustment Reason Codes will appear on the 820 electronic remittance for Turquoise Claims-driven capitation adjustments:

Code | Description

010 | Retroactive Rate Change

L013 | DMA Change in Recip Aid Category

L015 | Cap Void – Date of Death (DOD)

L016 | Cap Adjust – Retro Medicare

L020 | Long-Term Care Reconciliation

136 | Member Benefit Plan Enrollment

L101 | Cap Adjust – Retro INF

L102 | Cap Adjust – Retro Newborn

L103 | Cap Void – Incarcerated Client

Provider Recoupment Rule

MCOs may only recoup from providers when the capitation for the month of service has been voided by HCA and appears on the 820 electronic remittance.

6.5 820 Premium Payment File

Conduent will produce the 820 Premium Payment file out of each weekly payment cycle. This file contains a record of all capitations claims and capitation recoupments as well as any gross level

payments or recoveries. The Companion Guide is on the HCA website to explain any NM specific completion of data http://www.HCA.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html .

7.0 MCO Claims Payment & Reporting Special Instructions

Although the MCO has its own policies for claims processing, including prior authorization and payment rates, there are several federal requirements the MCO needs to be aware of. The purpose of this section is to share HCA's payment policies that prevent over payment and explain the process for receipt and payment of Crossover Claims. For example, the MCO may have their own rates for hospital-based reimbursement, and not use HCA's method, which happens to differ from Medicare.

HCA wants the MCO to know that there is a precedent for reducing hospital based professional services in both Medicare and Medicaid.

7.1 Services Excluded from Medicare Billing

The MCO must not require billing to Medicare for services that are not covered Medicare services. Pursuant to NMAC 8.302.3.12 and NMAC 8.302.3.12 C (2), "If a medically necessary service is excluded from Medicare and it is a MAD covered benefit, MAD will pay for the service."

HCA/MAD has determined that the following Community Benefit services are not covered by Medicare.

- Adult Day Health (S5100)
- Assisted Living (T2031)
- Community Transition Services (T2038)
- Emergency Response (S5161)
- Emergency Response High Need (S5161 U1)
- Environmental Modifications (S5165)
- Behavior Support Consultation (H2019)
- Behavior Support Consultation, clinic bases (H2019TT)
- Employment Supports (H2024)
- Home Health Aide (S9122)
- Medically Tailored Home-Delivered Meals (S5170)
- Nutritional Counseling (S9470)
- Personal Care-Consumer Directed (99509)
- Personal Care-Consumer Delegated (T1019)
- Personal Care-Directed training (S5110)
- Personal Care-Directed-Administrative Fee (G9006)

Personal Care-Directed Advertisement Reimbursement Fee (G9012) HCA/MAD has determined that the following EPSDT services are not covered by Medicare.

- Targeted Case Management (T2023)
- Attendant Care Services (S5125)

- Nursing Assessment/Evaluation (T1001)
- Qualified Physical Therapist Services(G0151)
- Qualified Occupational Therapist Services (G0152)
- Qualified Speech-Language Pathologist Services (G0153)

7.2 Crossover Claims

When Medicare Part A, B, or C has paid a claim, the MCO adjudicating the Medicaid payment cannot deny consideration of the patient responsibility (co-insurance, deductible, or copayments) based on Medicaid limitations such as program coverage of the service, medical necessity issues, or prior authorization. For this reason, payments for co-insurance, deductible, and copayments are even made on chiropractor services.

Medicare retroactive entitlement results in the original capitation payment being adjusted to pay a capitation that is appropriate for dual-eligible coverage. The MCO may recoup payments for services that can still be paid. Providers must be notified by Turquoise Care that the recoupment is due to retroactive Medicare Entitlement so they may bill Medicare timely. Supplemental instructions from Turquoise Care may be necessary regarding applicable filing limits for coinsurance, deductible, copayments, and repayment following Medicare denial.

7.2.1 Special Part B Only Instructions

When a Medicaid eligible individual only has Part B Medicare coverage and has an inpatient stay, Medicare pays on the Part B charges. Medicaid pays the OMB inpatient encounter rate less than the amount paid by Medicare, (by having the provider submit the inpatient claim showing the Medicare Part B payment), and less any Medicaid payment for the co-insurance/deductible on Part B charges that may already have been paid. Payments made to the physician by Medicare or Medicaid should not be deducted from payment to the hospital.

MCO's are instructed to do the following:

- Pay the Medicaid Inpatient Encounter rate to the provider for services provided to Medicare Part B only recipients that had an inpatient stay,
- One of the following options can beused:
    - The cross-over claim can be denied, allowing the provider to submit their claim as an inpatient claim with the Part B payment entered on the claimjust as would be customary for a commercial insurance payment. The Provider is then reimbursed at the Medicaid Inpatient rate less the Medicare Part B payment; or
    - Pay the Medicare Part B coinsurance and deductible amount and have the Provider send the inpatient claim showing the amount that Medicare paid as well as the amount Medicaid already paid towards the coinsurance and deductible. The claim is then paid at the Medicaid Inpatient OMB rate less than the Medicare Part B payment and less the co-insurance/deductible payment that was already paid by Medicaid.
- Provide written billing instructions for the claims to I.H.S. and Tribal 638 providers.

7.3 Payment of the Crossover Claim

Although the MCO should only pay coinsurance, deductible, psych amount and the patient responsibility on a Crossover claim, normal pricing logic is followed so that cost savings analysis can be performed later.

7.3.1 Institutional Crossover Pricing

a. Determine the Allowed Charge – this involves applying lower of logic (unless an exclusion is allowed)
b. **Allowed Charge =** Medicare Coinsurance Amount + Medicare Deductible Amount + Psych Amount + Patient Responsibility
c. COMPARE TO
d. MCO'S Calculated Allowed Charge – (Medicare Paid Amount + Medicare Sequestration Amount) **= New Calculation**
e. When the **New Calculation** is less than the Allowed Charge, then it is used as the MCO's allowed amount.

The lower of logic payment limitation is **bypassed** under the following circumstances:

- When the claim type is inpatient and the billing provider type is 211 through 218 (nursing facilities, ICF-MR, RTC, and TFC), or 221 (IHS).
- When the claim type is inpatient, the DRG code is 999 (ungroupable for DRG versions 25 or greater).
- When the claim type is outpatient and the billing provider type is 201 through 218, and the provider location is in-state or border.
- When the claim type is outpatient and the billing provider type is 221, 313, 314, 315 (IHS, FQHC, RHC), or 455 (rehab center).

7.3.2 Professional Crossover Pricing

1. Determine the Allowed Charge – this involves applying lower of logic (unless an exclusion is allowed)
   a) **Allowed Charge =** Medicare Coinsurance Amount + Medicare Deductible Amount
   b) COMPARED TO
   c) MCO'S Calculated Allowed Charge – (Medicare Paid Amount + Medicare Sequestration Amount) **= New Calculation**
   d) When the **New Calculation** is less than the Allowed Charge, then it is used as the MCO's allowed amount.
2. The lower of logic payment limitation is bypassed under the following circumstances:
   a) When the billing provider type is 363 (community benefit).
   b) When the line-item service area code is Anesthesia and the procedure code is 10000 – 99999 inclusive.
3. For Part B, if there is a psych amount on the claim, or if the coinsurance is within one penny of half of the Medicare allowed amount, then the claim will perform the lesser of logic.

7.4 Coordination of Benefits Agreement (COBA)

The Centers for Medicare & Medicaid Services (CMS) developed a national model contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information within a claim's crossover context is exchanged. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare paid claims data for processing supplemental insurance benefits for Medicare beneficiaries from CMS national crossover contractor, the Coordination of Benefits Contractor (COBC). Medicare contractors, courtesy of their Data Centers, submit all claims for crossover to COBC nightly via 837 flat file formats and/or NCPDP. The COBC will edit claims for required elements. Any files that fail business edits for claim structure will not be processed. Instead, the COBC will ask the contractors to re-transmit the entire file. Upon acceptance of the file, COBC will run the file through its customized claims translator to convert the file to an outbound HIPAA ANSI format and perform HIPAA validation. Then, after referencing the frequency and media type specifications established in the COBA database for the trading partner, the COBC will sort the claims by COBA IDs for transmission to the trading partners.

HCA, as the New Mexico Medicaid COBA trading partner, sends the eligibility information on a bi-weekly basis for all NM clients who are dual eligibles and receives the COBA claims files for those clients identified as FFS. The COBA contractor will send claims files for managed care clients directly to the MCOs. HCA will prepare separate files to send to COBA for clients enrolled with each MCO. COBA will then send directly to the MCO any claims for dates of service for which clients are enrolled with the MCO. MCOs must have their own trading partner agreement with the COBA contractor and are responsible for establishing their connections for COBA claims transmissions.

The COBA 5010 Companion Guide can be found at https://www.cms.gov/files/document/coordination-benefits-agreement-coba-companion-guide- health-insurance-portability-and-accountability.pdf

In addition to the Companion Guide, the following are provided:

MCOs will follow their normal encounter data rules. The following fields are additional fields that are required to identify the claim as a crossover and show the amounts allowed and paid by Medicare as well as the client's deductible and coinsurance. Our goal with this is to receive the required data that allows us to identify the claim as a crossover claim and to have correctly reflected in our system what Medicare paid and the amount of the Medicare coinsurance and deductible; in addition to the amount the MCO paid.

837 PROFESSIONALS

THE CRITICAL COMPONENT IN OUR ABILITY TO CLASSIFY THE PROFESSIONAL FORMAT AS A CROSSOVER CLAIM IS THAT A PROFESSIONAL CROSSOVER CLAIM MUST CONTAIN:

MEDICARE PAID AMOUNTS THAT ARE GREATER THAN $0 (REPORTED IN HEADER OR LINE 2430 SVD AS SHOWN BELOW) AND

LOOP 2320 SBR09 = 'MB' OR '16', AND

- CAS SEGMENTS MUST BE PRESENT AT THE LINE OR HEADER WITH AT LEAST
- CAS REASON CODE = '1' OR '2' AND ASSOCIATED AMOUNTS

Although the Medicare Allowed Amount is not captured directly on the claim, as per HIPAA 837 instructions: The Allowed amount is calculated using the prior payer's payment information coupled with adjustment information in the CAS segments. The prior payer payment + the sum total of all patient's responsible adjustment amounts = the Allowed amount. The Patient Responsible adjustments are identified by use of the Category Code PR in CAS01.

LOOP 2010BA – NM108 – 'MI'

- NM109 – Client's HIC Number (Medicare ID Number)

LOOP 2320 SBR OTHER SUBSCRIBER INFORMATION

- SBR01 = P SBR09 = MB

LOOP 2320 CAS CLAIM LEVEL ADJUSTMENTS

- If any claim level adjustments were made, these would be reported here. Otherwise, the critical Medicare Line-Item Coinsurance and Deductible amounts are shown in the Loop 2430 CAS segments.

LOOP 2320 AMT COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT

- AMT01 = D
- AMT02 = Sum of Line-Item MEDICARE PAID AMTs

LOOP 2330A NM1 OTHER SUBSCRIBER NAME

- NM101-NM103 – AS INDICATED BY THE TR3 NM108 = MI
- NM109 = CLIENT'S MEDICARE HIC NUMBER

LOOP 2330B NM1 OTHER PAYER NAME

- NM101 = PR
- NM102 = 2 NM103 = 'COBA' NM108 = PI
- NM109 = COBA [MUST BE EQUAL TO LOOP 2430, SVD01]

LOOP 2330B DTP CLAIM ADJUDICATION DATE (2430 DTP segment can be used instead)

- DTP01 = 573 DTP02 = D8
- DTP03 – Date Medicare adjudicated the claim

LOOP 2330B REF OTHER PAYER SECONDARY IDENTIFIER

- REF01 = F8
- REF02 = Medicare Claim Number

LOOP 2430 SVD SERVICE LINE ADJUDICATION

- SVD01 = COBA (MUST BE THE SAME AS REPORTED IN 2330B NM109)
- SVD02 = Amount Medicare Paid on the Line SVD03-1 = HC
- SVD03-2 = LI Procedure code
- SVD03-3-6 = Procedure Modifiers if applicable SVD05 = Number of Units Paid

LOOP 2430 CAS LINE ADJUSTMENT

- CAS02 – For every Medicare claim there MUST be at least 1 of the following CAS segments and in many cases 2 CAS segments,
- CAS02=1 (Medicare Deductible) and
- CAS05=2 (Medicare Coinsurance).
- Another frequent CAS segment used is CAS05= 122, Medicare psych amount
- ANY CAS SEGMENT REPORTED MUST HAVE AN ASSOCIATED CAS AMOUNT

The MCO would continue to report their paid amount on the 2400 HCP Segment if the claim was adjudicated on the line; otherwise, it would be reported at the header level. The MCO's Paid Amount should equal the lesser of the Medicare deductible/coinsurance amounts or the MCO's payment amount.

837 INSTITUTIONAL

THE CRITICAL COMPONENT IN OUR ABILITY TO CLASSIFY THE INSTITUTIONAL FORMAT AS A CROSSOVER CLAIM IS THAT AN INSTITUTIONAL CROSSOVER CLAIM MUST CONTAIN:

HEADER OR LINE MEDICARE PAID AMOUNTS THAT ARE GREATER THAN $0 (REPORTED IN 2320 OR 2430 AMT AS SHOWN BELOW) AND

LOOP 2320 SBR09 = 'MA' OR 'MB' OR '16', AND

LOOP 2320 (FOR INPATIENT) OR LOOP 2430 (FOR OUTPATIENT) CAS AMOUNTS SEGMENTS MUST BE PRESENT WITH AT LEAST CAS REASON CODE = '1' OR '2' AND ASSOCIATED AMOUNTS

LOOP 2010BA – NM108 – 'MI'

- NM109 – Client's HIC Number (Medicare ID Number)

LOOP 2320 SBR OTHER SUBSCRIBER INFORMATION

- SBR01 = P
- SBR09 = MA or MB

LOOP 2320 CAS CLAIM LEVEL OR LOOP 2430 CAS LINE LEVEL ADJUSTMENTS

- CAS02 – For every Medicare claim there MUST be at least 1 of the following CAS segments and in many cases 2 CAS segments,
- CAS02=1 (Medicare Deductible) and
- CAS05=2 (Medicare Coinsurance).
- Another frequent CAS segment used is CAS05= 122, Medicare psych amount
- ANY CAS SEGMENT REPORTED MUST HAVE AN ASSOCIATED CAS AMOUNT

LOOP 2320 OR LOOP 2430 AMT COORDINATION OF BENEFITS (COB) TOTAL MEDICARE PAID AMOUNT

- AMT01 = N1
- AMT02 = Sum of Line-Item MEDICARE PAID AMTs

LOOP 2330A NM1 OTHER SUBSCRIBER NAME

- NM101-NM103 – AS INDICATED BY THE IG NM108 = MI
- NM109 = CLIENT'S MEDICARE HIC NUMBER

LOOP 2330B NM1 OTHER PAYER NAME

- NM101 = PR
- NM102 = 2 NM103 = 'COBA' NM108 = PI
- NM109 = [MUST BE EQUAL TO LOOP 2430, SVD01]

LOOP 2330B DTP CLAIM ADJUDICATION DATE

- DTP01 = 573 DTP02 = D8
- DTP03 – Date Medicare adjudicated the claim

LOOP 2330B REF OTHER PAYER SECONDARY IDENTIFIER

- REF01 = F8
- REF02 = Medicare Claim Number

The MCO would continue to report their paid amount on the 2300 OR 2400 HCP Segment. The MCO's Paid Amount should equal the lesser of the Medicare deductible/coinsurance amounts or the MCO's payment amount.

7.5 Third Party Liability (TPL)

The MCO is expected to report all TPL applied to claims on the encounter in the appropriate COB and CAS segments. The MCO Paid amount must reflect the final payment by the MCO less any third-party payments received.

7.6 Long Term Care Services and Medical Care Credit/Patient Liability

Clients are approved for long-term care services once a level of care assessment is completed and the client is found to meet the nursing facility level of care (NFLOC). The MCO is responsible for communicating level of care and setting of careinformation to HCA for clients enrolled for whom the MCO has determined meet NF LOC and updating that information when a client's situation changes. The MCO is responsible for ensuring that any long-term care claims paid are for dates of service for which clients are approved for that SOC and for that provider and that services have been rendered in accordance with the client's plan of care. The revenue codes 0022, 0024 are Medicare codes that are supposed to be used in Medicare billings for short term stays and should only appear on a crossover claim. Medicare, the instructions for Inpatient Rehabilitation Facility (IRF) PPS are when the revenue center code = '0024', the total charges will be zero. Nursing Facility Charges for long-term care covered days that are not Medicare covered skilled care should be billed with the revenue codes 0190 and the submitted charges should be greater than $0. The 0190-accommodation revenue code must have total charges equal the rate times the units.

Clients who meet nursing facility level but are not eligible for Medicaid under normal financial standards of income may have eligibility determined using an institutional care standard of income. These clients will always have a Category of Eligibility of either 081, 083, or 084. Any amount of income deemed more than this institutional standard is determined to be the member's responsibility for their own care. This medical care credit (MCC), or patient liability, must be paid for any services rendered in the nursing home for which there is any Medicaid payment to be made; otherwise, the member would not be eligible under that category.

The MCC is computed by the county Income Support Division (ISD) office for the first full calendar month of NF care. The MCC amount may be $0 if that is the result of the calculation. Notice of the MCC amount is electronically sent from the ISD office to the NF and the amount is sent from ASPEN to Turquoise Claims and then to the MCOs in the Enrollment Roster and in the Update Member PL API file. Sometimes, ISD may correct an amount previously reported and communicate that in a separate MAD 200 notice of adjustment form. The medical care credit amount must be collected by the nursing facility and reported on the nursing facility claim form but, regardless, the MCO is responsible for deducting the appropriate medical care credit from the nursing facility payment.

The medical care credit is the amount of the member's income used to reduce the Medicaid payment to the institution where the member resides. A member must make this payment directly to the institution. A Medical Care Credit is not paid for stays in an acute care setting. The amount of medical care credit is always determined prospectively. The ISD worker computes a medical care credit starting with the first full month of institutional care. No medical care credit is required for the month the recipient enters the institution if [he or she is] they are admitted after the first moment of the first day of the month.

The member is not required to pay a medical care credit for the month of discharge from the institution. The medical care credit must be paid if the member is transferred to another institution or makes a short visit outside the institution. No medical care credit is charged for the month in which a member who received Medicaid institutional care services dies. This will prevent a deficit for the institution when a benefit, such as social security, must be returned due to the death of a beneficiary. No medical care credits are applied for any period of retroactive eligibility under this provision.

The MCC is deducted from a Medicare crossover claim for NF services. On crossover claims sent to the MCO for deductible and co-insurance amounts, the MCC is applied against the amount payable on the crossover. The MCC is applied to a claim if the member has been eligible for Medicare only and then becomes eligible for Medicaid if the member has been in the NF the full month. The MCC is taken from the co- insurance payment and/or the Medicaid payment.

When the member transfers from one facility to another, the MCC is taken by the facility in which the resident resided on the first day of the month. The remaining amount of the MCC for the month is applied to additional facility if not satisfied by the first facility.

Since providers often bill weekly, this requires the MCO system to keep track of the MCC still due across more than one claim, and potentially across more than one provider when the member is transferred to a different NF during the month.

The MCC is applied to a claim even though a member has used all the reserve bed days while out of the facility but not permanently discharged or expired while out of facility. When there is a re-admission the MCC is completed, unless readmit is 30 days post leave, the re-entry is considered a new admission.

The MCC is applied to the nursing facility claim regardless of which revenue codes or type of bill code is billed.

The MCC or patient liability amount applied to the nursing facility claim must be reported in the 2300 loop AMT Patient Paid Amount segment of the institutional claim and the MCO Amt Paid must be the allowed amount minus this patient liability amount.

7.7 Pricing and the Medicaid Fee Schedule

The New Mexico Fee Schedule posted on the DMZ shows pricing options identified by Factor Code (FC) and modifiers to distinguish between new equipment (use modifier NU) and rentals (use modifier RR). The state may request an invoice during the review for pricing on HCPCS with the rate of $0.00. The pricing notes “General Fee Schedule” and “General by Report” and “Manual Review Fee Schedule” are for the global or purchase rates. The pricing notes “Rental Fee Schedule” and “Rental by Report” and “Rental Manual Price-Fee Schedule” are for the rental rates. The pricing notes “26 Fee Schedule (FS)” and “26 by Report” are for the professional component rates when modifier 26 is used. The pricing notes “TC Fee Schedule” and “TC by Report” are for the technical component rates when modifier TC is used.

A procedure reflecting a FC 5 – General by Report with a Value of 0 or Outpatient Hospital pricing, FC Y - OPPS All with a Source Code of J6-OPPS NM Medicaid Price Review, does not mean the service is not covered. The MCO needs to review the service to determine a reimbursement rate to the provider.

When reviewing the HCA fee schedules, for procedures reflecting a FC 5 or FC Y, the MCO should determine the appropriate payment amount by doing the following:

Check the Medicare fee schedules to see if a rate has been established,

- If not and it is a service that you can obtain an invoice for, request the invoice (either the manufacturer or the distributors document reflecting their charges to the provider) and use the information to price the claim line
- If an invoice is not available or it is a service that is not invoice driven, such as medical or surgical procedures, identify similar procedures that are already priced and use those as a guide to come up with a reimbursement.

7.8 Gross Receipts Tax

New Mexico Medicaid services are generally subject to New Mexico Gross Receipts Tax (GRT). Only taxable providers (i.e., for-profit entities) should include GRT in their claims, and only for services identified as taxable based on the tax indicator in the reference file. The GRT is set based on billing provider physical location zip. Managed Care Organizations (MCOs) are expected to follow the current Conduent GRT table, which is updated periodically.

Providers are responsible for including GRT in their billed amounts. The system will automatically calculate and apply the appropriate tax to the final payment. The MCO-paid amount must include the GRT portion

8.0 **Provider-Managed** Care Enrollment and Provider File Interfaces

HCA requires any provider who requests participation with the MCO who is not already enrolled with Medicaid as either an FFS or Managed Care Only provider to enroll.

Regardless of whether the provider is a contract or non-contracted provider to the MCO, the provider must appear on the Enroll or Update Provider API file for an encounter to process.

The MCO is responsible for certifying any provider who participates with the MCO and maintaining complete provider information for these providers. The enrollment process for a Managed Care provider who is a non-contracted or out-of-state provider is simplified even more than the streamlined process for the MC contracted provider.

Provider enrollment is managed by the Benefit Management Services (BMS) module vendor (GDIT/Digital Harbor). BMS replaced the Conduent provider file formats with real-time API enroll/update transactions and will send a Provider Reconciliation file monthly in a canonical format. The MCOs will continue to send a Provider network file, but it will become an add/update only file that is submitted weekly). Both the current Provider File layouts and the new API and Canonical formats are shown below.

For Cause Termination means a termination, as defined in subparagraph (11) of this section by an SMA of the provider's billing privileges, of which appeal rights have been exhausted or the time for appeal has

expired. For Cause terminations are terminations related to fraud, integrity, or quality issues which run counter to the overall success of the Medicaid Program. For CMS review, for cause reasons for termination closely mirror the regulatory authorities for Medicare revocations found in 42 CFR

§ 424.535. See also MPEC 01.10.02; 01.01.02.

The provider's NPI is always the key identifier, unless the provider is an atypical provider without NPI, in which case, the identifier will be the provider's tax id (EIN) or Social Security Number (SSN), if used for tax purposes instead of an EIN. The NPI number or EIN/SSN, for atypical providers, submitted on encounters must then match a provider on file that has been added as an FFS or MC-only enrolled provider.

HCA assigns a separate Medicaid Provider ID record for each provider type on file for every combination of Provider NPI, Provider Type, and Zip Code. Thus, if a provider NPI xxxxxxxxxx has one provider type in one location and another provider type in that same location as well as in a different location, there will be 3 records present on the file; each with its own Medicaid Provider ID number. The only exception to this is that a servicing only provider who can be expected to be on a claim as a rendering, referring, attending, ordering provider should only be assigned one Provider ID based on that practitioner's primary location; in order to avoid problems with identifying the correct Medicaid ID in Turquoise Claims since the 837 doesn't contain a zip code for the rendering provider.

There should be no duplicate combinations of NPI (or EIN/SSN if the provider is an atypical), provider type and location zip code. The Turquoise Claims system uses the NPI, taxonomy code and zip code on the incoming encounter to match the correct Provider ID on the Turquoise Claims system. A file of taxonomy codes matched to provider type will be provided to the MCOs.

Codes

Value	Description
01	Term-Medicaid Authority
02	Medicare Termination
03	Term-License Revoked
04	Term-License Expired
05	Medicare Exclusion
06	Term-Change of Ownership
07	No Claims Activity
08	Term-Provider Deceased
09	Term-Pending
10	Term-Voluntary Termination
11	Terminated- MCO Authority
13	Term-No Reverification
20	Denied-Invalid License
21	Denied Two Prov Numbers
22	Denied-Prov Already Has Num
23	Denied Not Eligible
24	Denied for Other Reasons
40	Pending No Lic/Temp Lic
41	Pending Signed Agreement
42	Pending Missing Documentation
43	Pending Rate Determination
44	Pending Status Approval
45	Pending Web Application
46	Pend-License/Cert Verif
60	Active
70	None-MCO Prov-See MCO Status
99	NPI ID Missing for Provider

8.1 Provider API File Layout

MCOs will be advised of provider enrollments, updates, and terminations via an Enroll Provider or Update Provider API. The identification of enrollment and update will happen based on the endpoint for the APIs. The two APIs will have 2 separate endpoints. Based on which endpoint is called, it will determine whether the intent is to enroll or update. This file will be sent near real-time in a json format. The documentation for these interfaces is included in Appendix I.

8.1.1 Response Payload

Entity	Data Element	Data Description	Data Type	Field length	Required
ResponseMessage					
ResponseMessage	Response	Response Message	String	150	Y
ResponseMessage	Status	Status of the transaction	String	25	Y
ResponseMessage	Transaction ID	The unique transaction ID generated by SIP for every transaction.	String	50	N
ResponseMessage.ErrorMessage					
ErrorMessage	Type	Type of the error	String	50	N
ErrorMessage	Severity	Severity of the error	String	20	N
ErrorMessage	Code	Error code	String	20	N
ErrorMessage	Description	Error description	String	150	N
ResponseMessage.ErrorMessage.Entity					
Entity	entity	The name of the entity which has an error	String	25	N
Entity	DataElement	Data element name for which the error has occurred	String	50	N
Entity	DataElementValue	Data element value for which the error has occurred	String	50	N

8.2 Provider Monthly Reconciliation File Layout

BMS will send a monthly reconciliation file to the MCOs. MCOs are not to load data from this reconciliation file but use it to ensure the MCO has captured all the provider adds and updates that have come in during the month and confirm that MCOs received/processed all the APIs correctly (MCOs should begin an analysis of any differences found, possibly resulting in tickets within Cherwell if analysis with BMS, the SI or HCA is needed) (note: HCA is finalizing this process. Any updates will be communicated). The Provider Reconciliation file will follow the MFT Canonical design detailed below and will be in a JSON format.

The MMISR system allows for both real-time (API) and batch (file/MFT) forms of data transfer for a single kind of data (e.g.: Provider updates). This raises the possibility that for any given data transfer from a system-of-record, a receiving system utilizing both forms may spot a discrepancy between the two. Such a discrepancy might be the result of issues at any point from the system-of-record, through the SIP, to the receiving system.

For the two forms of data transfer to be used as a proper check on each other, two conditions must be met:

1. Both types of data must have timestamps available, consistently generated at the source, such that the aggregation of all API responses with a source timestamp prior to the file's source timestamp results in the same dataset as in the file. (Note: this condition is met for the Provider Reconciliation file and provider update APIs from BMS. Other systems of record TBD)
2. The receiving system must utilize the source timestamps correctly to make sure it compares the correct aggregation of API responses it has received with a particular matching file.

If the receiving system does find a discrepancy between the resulting API response dataset and the file dataset, the system should not replace the API response dataset with the file dataset but first check to see that the issue does not exist within its own system. If the issue is not within its own system, the operations and maintenance team for the receiving system should raise a ticket identifying the discrepancy. A multi-module/partner/SIP analysis would then be initiated to determine the root cause of the discrepancy. In addition, the receiving system may query the source system, if possible, to achieve a short-term fix that will enable continued processing within the receiving system. The receiving system should not perform only the short-term fix without also raising the ticket that initiates the root cause analysis.

Note that there are enterprise error handling capabilities that have been defined for both APIs and MFTs that are independent of those here. The process outlined in this decision should be complimentary to those capabilities, not as a replacement. The associated API documentation is in Appendix I.

8.3 Provider Web Portal

Providers who are not enrolled as Medicaid FFS providers or as MC-Only providers can submit their application for enrollment through Provider Enrollment using https://yes.nm.gov/ . BMS staff will review the application considering New Mexico and CMS requirements for the given provider type. For example, Community Based providers must be licensed to provide many services and so may have to submit additional documentation showing their licensure to be approved.

There are two types of Managed Care Only provider enrollment on the web portal:

1 HCA MC-Only Contracted – abbreviated application but for the most part, just like a FFS provider.
2 MC-Only Restricted providers – this is a streamlined application that does not include full provider information. The intention is that the MCO is completing abbreviated applications on behalf of single case agreement providers who will provide short term services to an individual member.

8.4 MC-Only Restricted Provider Enrollment

The Managed Care Organization (MCO) can enroll providers that are not in the MCO's network (i.e., Single Case Agreements) using the MCO Restricted enrollment. The allowable providers for this MCO Restricted enrollment are:

1 Medicare Only providers (these are providers who appear on a crossover claim that are not otherwise Medicaid providers).
2 Pharmacies (provider type 416) are not part of the MCO's network.
3 Dentists (provider type 421) are not part of the MCO's network.
4 Out-of-State non-network providers (except those located in TX, CO, AZ, UT).

The MCO should enter their Medicaid Provider ID and complete the information on the Web Portal as if they are the Medicaid provider the MCO is trying to enroll.

To adhere with the Center for Medicare and Medicaid Services (CMS) guidelines the following rules for out-of-network New Mexico (NM) Medicaid Providers are effective July 1, 2024.

1 MCOs submitting MCOR application must submit a copy of the provider's current/valid license.
2 A provider enrolled with a MCOR can only bill for one beneficiary for not more than 180 days using the enrolling National Provider Identifier (NPI). If claims for a single beneficiary under one NPI continue beyond 180 days, the provider must enroll with NM Medicaid.
3 Effective July 1, 2024, MCORs will be approved for 180 days from the effective enrollment date.
   - An effective enrollment date is the Date of Service requested on the application; and
   - MAD will require any MCOR provider who continues to serve members after 180 days to complete an application for enrollment.

8.5 Changes To the Provider Record

Providers and MCOs can submit concerns and requests (e.g., including duplicate providers, expedited provider registrations, and back dating) to the State's MAD Provider Enrollment email (NM.Providers@HCA.nm.gov) or to the Consolidated Call Center (1-800-299-7304) so all requests can be tracked and responded to.

If the MCO becomes aware that the effective date of the provider's enrollment is not sufficient to cover dates of service for its members, a request to back date the enrollment begin date can be made. For MCO-Only providers with enrollment status 70, the MCO can make this request themselves via the MAD Provider Enrollment email or CCSC. For FFS & MC providers with enrollment status 60, since the enrollment belongs to the provider, they need to submit the request to backdate and not the MCO.

8.6 Provider Types That Can't Coexist

The following is part of duplicate checking logic for provider enrollment to prevent enrollment of a provider more than once for a provider type that should not be allowed to coexist.

The following pairs of provider types should never coexist for the same NPI, regardless of location

211	NursFacPvt	Nursing Facility, Private	NRSNG-FAC-PR
212	NursFac St	Nursing Facility, State	NRSNG-FAC-ST
214	ICFMRPrvt	ICF MR Private	ICFMR-PRVT

215	ICF MR St	ICF MR State Owned	ICFMR-ST-OWN
216	ResTrJCAHO	Residential Trtmnt Ctr. JCAHO	RES-TR-JCAHO
217	ResTrtCtr	Residentl Trtmnt Ctr Not JCAHO	RES-TRT-CTR

The following pairs of provider types should never coexist for the same NPI, in the same location (defined as the same 9-digit zip code). These physician provider types should also not coexist for the same NPI with any other provider type between the ranges of 211- 445, regardless of location

301 - Physician M Physician, MD PHYSICIAN-MD

302 - Physician DO & NDPhysician, DO & ND PHYSICIAN-DO & ND

The provider type should only be allowed to coexist for the same NPI, in the same location (defined as the same 9-digit zip code) with the following provider types.

- 201Hospital, General Acute
- 202Hospital, Rehabilitation Unit in a General Acute Hospital 203Hospital, Rehabilitation
- 204Hospital, Psychiatric Unit in a General Acute Hospital 205Hospital, Psychiatric
- 211Nursing Facility, Private 212Nursing Facility, State 213Hospital, Swing-Bed 214ICF MR Private 215ICF MR State Owned
- 221Indian Health Services Hospital or Tribal Compacts

The following groups of provider types should never coexist for the same NPI, in the same location (defined as the same 9-digit zip code).

306	ClNursSpec	Clinical Nurse Specialist	CLINIC-NURSE-SPEC
316	Nurse CNP	Nurse, CN Practitioner	NURSE-CN-PRCT
317	Nurse RN	Nurse, RN	NURSE-RN
318	Nurse CRNA	Nurse, CRNA	NURSE-CRNA
311	ClinicDxTr	Clin Non-prft Trtmnt&Diag Ctr	CLN-NPR-TR-DG
312	ClinicFmPl	Clinic, Family Planning	CLN-FAM-PLNG
313	FQHC	Clinic Federally Qlfd Hlth Ctr	CL-FD-QLF-HCT
314	RH Clinic	Clin, Rural Hlth Med, Freestnd	CLN-RHLTH-MD
315	RHC hspbsd	Clin,Rural Hlth Med, Hosp Bsd	CL-RR-HLTH-MD
322	Midwfe Nur	Midwife, Certified Nurse	MIDWIFE-CERT-NURSE

323	Midwfe Lay	Midwife, Lay	MIDWIFE-LAY
351	LabClnical	Lab, Clinical Free Standing	LB-CLN-FR-STN
352	Radlgy Fac	Radiology Facility	RDLGY-FCLTV
353	Lab&RadFac	Lab, Clinical With Radiology	LB-CLN-RDLGY
354	LabDgnstic	Laboratory, Diagnostic	LAB-DIAG

If provider is PT and OT, make them a PT and not have both Community Benefit can only be provided by a provider type 363. If a provider is enrolled as PT 344 (Waiver provider), you must have that provider enroll as type 363 before rendering Community Benefit services.

451	OcupThrpst	Occup Therapist, Lic & Cert	OCUP-THRPST
452	OccThrpLic	Occupational Therpst Licensed	OCC-THRP-LIC
453	PhysThrpst	Physical Therapist, Lic & Cert	PHYS-THRPST
454	PhsThrpLic	Physical Therapist, Licensed	PHS-THRP-LIC
457	SpThrLicCt	SpeechTherapistChldAdltLicCert	SP-THRP-CHLD
458	SpThr Schl	Speech Therapist Child,Sch Cer	SP-THER-SC-CT
421	Dentist	Dentist	DENTIST
422	ClnRHlthDn	Clinical, Rural Health, Dental	CLN-RHLTH-DN
423	DntlHygnst	Dental Hygienist	DENTAL-HYGNST
363	Community Benefit Provider		

The following are all individual service renderers (except PT 433, but also should have only 1 licensed location), which should never exist as more than one provider type between the ranges of 211-445 per NPI regardless of location.

430	BehHealWor	Behavioral Health Worker	BEHAVR-HEALTH-WORK
431	Psychlgst	Psychologist, PHd, EdD,PsyD	PSYCHOLOGIST
433	MH DOH	Clinic, MH Center (DOH)	MNT-HLTH-CNT
435	LPCC	LPCC (Lic Prof Clinic Counslr)	LPCC

436	LMFT	LMFT (Lic Marr&Family Therap)	LMFT
437	LMSW	LMSW (Lic Mstr Lev Social Wkr)	LMSW
438	PsySchCert	Psychologist School Certified	PSYCH-SCH-CERT
439	PsyAssLisc	Psychologist Associate License	PSYCH-ASSO-LISC
440	LADAC	Lic Alchol & Drug Abuse Cnslr	LADAC
443	PsyNursCNS	Nurse Psych Nurse Specialist	NRS-PS-NRS-SP
444	LISW	LISW (Lic Indpndnt Soc Worker)	LISW
445	Cnslr Mstr	Licensed Masters Level Counsel	LC-MST-LV-CNS

8.7 Provider Type and Specialty

Provider type and specialty are assigned based on the licensure and certification of the provider. Depending on the types of services a provider's licensure/certification allows, a provider may have multiple provider records in BMS, one for each type and servicing location. The MCO must be aware of the services a given provider type may render to ensure that the appropriate taxonomy is used. For example, a provider may enroll with BMS as a Home Health provider type which has specific taxonomies associated. If the MCO and provider determine that the provider should also provide Community Benefit services, a separate provider type must be assigned by HCA which associates with a different set of taxonomies. Home Health services arebilled on an institutional claim with CMS defined revenue codes and the home health taxonomies whereas Community Benefit services are billed on a professional claim with HCPC codes defined by HCA. The same provider may also be licensed/certified as a DME provider which also bills on a professional claim with its own taxonomies. The MCO is responsible for ensuring that providers are shown on the provider file with the appropriate provider types and specialties for the services contracted with that MCO and that the MCO pays claims with the correct taxonomies for that provider type and group of services.

The following is the approved HCA provider type and specialty list. Providers may have only one type per NPI and Location but may have more than one specialty.

PROV TYPE	PROVIDER TYPE & SPECIALTY DEFINITIONS	PROVIDER SPECIALTY CODE
201	Hospital, General Acute	
	General Acute	N/A
	Mobile Resp and Stab Svcs (MRSS)	139
	Mobile Crisis Team (MBLCRSTM)	149
202	Hospital, Rehabilitation Unit in a General Acute Hospital	N/A
203	Hospital, Rehabilitation or Other Specialty	
	Children's Specialty Hospital	127
	Long Term Acute Care hospital	128
	Rehabilitation Hospital	129
	Other Specialty Hospital	134
204	Hospital, Psychiatric Unit in a General Acute Hospital	N/A
205	Hospital, Psychiatric	N/A
211	Nursing Facility, Private	N/A
212	Nursing Facility, State	N/A
213	Hospital, Swing-Bed	N/A
214	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID) - Private	N/A
215	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID) - State Owned	N/A
216	Accredited Residential Treatment Center (ARTC)	
	Juvenile ARTC for Behavioral Health	260
	Adult ARTC for SUD (In-state)	261
	Adult ARTC for SUD (Out-of-State)	261
	Qualified Residential Treatment Program (QRTP) Residential Shelter Care Facilities For Children	262
217	Residential Treatment Center, not Accredited	N/A

218	Treatment Foster Care Agency	N/A
219	Group Home, not Accredited	N/A
221	Indian Health Services (IHS) or Tribal 638 Contract Facility	
	Hospital or Outpatient Clinic	100
	Dental	102
	Multi-Systemic Therapy (MST)	131
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitizationdesensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Mobile Resp and Stab Svcs (MRSS)	139
	Mobile Crisis Team (MBLCRSTM)	149
222	Care Coordinator	MCOR ENTRY
223	MCO Administration	MCOR ENTRY
301	Physician, Medical Doctor (MD)	Required - see list below
302	Doctor of Osteopathy (DO) and Naturopathic Doctor (ND)	
	Doctor of Osteopathy (DO)	Required - see list below
	Naturopathic Doctor (ND)	300
	Specialties for types 301 (MD) and 302 (DO Only)	
	General Practice	001
	General Surgery or Other Specialized Surgery not otherwise listed	002
	Allergy	003
	ENT (Ear, Nose, Throat)	004
	Anesthesiology	005
	Cardiology	006
	Dermatology	007
	Family Practice	008
	Gastroenterology	010
	Hematology or Oncology	011
	Manipulative Therapy	012
	Neurology	013
	Neurological Surgery	014

Obstetrics	015
OB-GYN	016
Ophthalmology	018
Neonatology	019
Orthopedic Surgery	020
Emergency Medicine	021
Pathology	022
Plastic Surgery	024
Physical Medicine & Rehabilitation	025
Psychiatry, Other	026
Pain Management	027
Proctology	028
Pulmonary Disease	029
Radiology	030
Thoracic Surgery	033
Urology	034
Nuclear Medicine	036
Pediatrics	037
Geriatrics	038
Nephrology	039
Hand Surgery	040
Internal Medicine	041
Cardiology, Pediatric	042
Allergy, Pediatric	043
Public Health	044
Preventative Medicine	046
Psychiatry, Board Certified, Child/Adolescent	047
Endocrinology/Diabetes/Metabolism	048
Multiple Specialties (applicable only to a group)	049
Addictionologist	050
Cardiac or Peripheral Vascular Surgery	140
Critical Care	141
Genetic Counseling	142
Hospitalist	143
Oral & Maxillofacial Surgery	144
Rheumatology	145
Sleep Medicine	146
Sports Medicine	147

	Transplant Surgery	148
	Autism Evaluation Practitioner (AEP) (not applicable to a group)	150
305	Physician Assistant	N/A
306	Clinical Nurse Specialist, Medical	N/A
311	Clinic, Diagnostic & Treatment Center	N/A
312	Clinic, Family Planning	N/A
313	Clinic Federally Qualified Health Center (FQHC)	
	Multi-Systemic Therapy (MST)	131
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitizationdesensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Mobile Resp and Stab Svcs (MRSS)	139
	Mobile Crisis Team (MBLCRSTM)	149
	School Based Health Center	190
	Medical Only	191
	Medical and Dental	192
	Medical, Dental, and Behavioral Health	193
	Medical and Behavioral Health	194
314	Clinic, Rural Health Medical, freestanding	N/A
315	Clinic, Rural Health Medical, hospital based	N/A
316	Nurse, Certified Nurse Practitioner (CNP)	
	General	090
	Family Practice	091
	Pediatrics	092
	Obstetrical	093
	Psychiatric	097
317	Nurse, RN	
	Psychiatric RN	059
	School Nurse	094
	Other RN	096
	Home Visiting Agency	202

318	Nurse, Certified Registered Nurse Anesthetists (CRNA)	N/A
319	Anesthesiologist Assistant	N/A
320	Pharmacist Clinician	
321	School Based Health Center (Non-FQHC) NOTE: if site is certified as an FQHC, must enroll as provider type 313 - FQHC with specialty 190-SBHC	N/A
322	Midwife, Certified Nurse	N/A
323	Midwife, Licensed (Non-Nurse)	N/A
324	Nursing Agency, Private Duty	
	EPSDT Nursing Services (Medically Directed)	N/A
	EPSDT Personal Care (Non Medically Directed)	N/A
325	Podiatrist	N/A
331	Audiologist	N/A
333	Dietician/Nutritionist	N/A
334	Optician	N/A
335	Optometrist	N/A
338	Prosthetist and/or Orthotist	N/A
341	Chiropractor	N/A
342	Crisis Triage Center Licensed (CTC)	
	Mobile Resp and Stab Svcs (MRSS)	139
	Mobile Crisis Team (MBLCRSTM)	149
	CTC residential or both residential and non residential	246
	CTC Non-Residential Only	247
343	Opioid Treatment Program (OTP)	N/A
344	Home & Community Based Services (Waiver)	**FFS ONLY**
	Developmentally Disabled Waiver	070
	Supports Waiver (effective 7/1/2020)	072
	Medically Fragile Waiver	073
	DD Waiver Case Management	074

	Community Supports Coordination	076
	Medically Fragile Waiver Case Management	077
345	Schools	N/A
346	Lodging, Meals	N/A
351	Lab, Clinical Freestanding	N/A
352	Radiology Facility	N/A
353	Laboratory, Clinical with Radiology	N/A
354	Laboratory, Diagnostic, for Tests and Measurements	N/A
361	Home Health Agency	N/A
362	Hospice	N/A
363	Community Benefit Provider - MCO Only	
	Nursing Respite	173
	Behavior Support Consultation	174
	Emergency Response	175
	Employment Supports	176
	Environmental Modifications	177
	Home Health Aide	178
	Private Duty Nursing for Adults	179
	Respite	180
	Skilled Maintenance Therapy	181
	Personal Care	182
	Assisted Living	183
	Adult Day Health	184
	Community Transition Services	185
	Occupational Therapy for Adults	186
	Physical Therapy for Adults	187
	Speech Therapy for Adults	188
	Nutritional Counseling	189
364	Ambulatory Surgical Center	N/A
401	Ambulance, Air	N/A
402	Ambulance, Ground	N/A
403	Handivan	N/A
404	Taxi or MCO General Transportation Contractor (non-capitated)	N/A
405	Birth Center, Licensed	N/A

411	Pharmacist General	N/A
412	Hearing Aid Supplier	N/A
414	Medical Supply/Durable Medical Equipment provider (DME)	N/A
	Human Donor Milk Supplier (HDMS)	208
415	IV Infusion Services	N/A
416	Pharmacy	
	In-State Pharmacy	N/A
	IHS or Tribal 638 Pharmacy	N/A
	Out of State	N/A
417	Pharmacy, Rural Health Clinic	N/A
421	Dentist	
	General Dentistry	055
	Oral Surgery, Endodontics, Other Specialty	056
422	Dental Clinic, Rural Health	N/A
423	Dental Hygienist	
	Collaborative Practice	160
	Not in Collaborative Practice	161
430	Behavioral Health Worker	
	Behavior Technician (BT) Includes: Board Certified Autism Technician (BCAT) Registered Behavior Technician (RBT) or Non-Certified Behavior Technician	098
	Behavioral Management Service (BMS) Worker	113
	Peer Support Worker, Certified	114
	Family Support Worker, Certified	115
	Community Support Worker	116
	Board Certified Assistant Behavior Analyst (BCaBA)	151
	Psychiatric Nurse RN (not board certified)	248

431	Psychologist, (Ph.D., Ed.D., Psy.D.)	
	Not Certified for Prescribing	111
	Certified for Prescribing	112
	FunctionalFunctional Family Therapy (FFT)	135
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitizationdesensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Autism Evaluation Practitioner (AEP) (not applicable to a group)	150
432	Behavioral Health Agency	
	Behavioral Management Services (BMS)	081
	Day Treatment Services	082
	Comprehensive Community Support Services (CCSS)	107
	Intensive Out Patient (IOP)	108
	Assertive Community Treatment (ACT)	130
	Multi-Systemic Therapy (MST)	131
	Autism Disorder Applied Behavior Analysis (ABA) Services	132
	Functional Family Therapy (FFT)	135
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitizationdesensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Evaluation and Therapies	133
	Mobile Resp and Stab Svcs (MRSS)	139
	Mobile Crisis Team (MBLCRSTM)	149
	Crisis Services Community Provider	251
433	Clinic, Mental Health Center - DOH Certified (CMHC)	
	Adult Psychological Rehabilitation Services	080
	Behavioral Management Services (BMS)	081
	Day Treatment Services	082

	Comprehensive Community Support Service (CCSS)	107
	Intensive Out Patient (IOP)	108
	Assertive Community Treatment (ACT)	130
	Multi-Systemic Therapy (MST)	131
	Autism Disorder Applied Behavior Analysis (ABA) Services	132
	Evaluation and Therapies	133
	FunctionalFunctional Family Therapy (FFT)	135
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitizationdesensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Mobile Resp and Stab Svcs (MRSS)	139
	Mobile Crisis Team (MBLCRSTM)	149
435	Licensed Professional Clinical Counselor (LPCC)	
	LPCC	240
	Functional Family Therapy (FFT)	135
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
436	Licensed Marriage & Family Therapist (LMFT)	
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	LMFT	242
438	Psychologist School Certified	N/A
440	Substance Abuse Counselor	
	Licensed Alcohol & Drug Abuse Counselor (LADAC)	124
	Licensed Substance Abuse Associate (LSAA)	125

	Certified Alcohol and Drug Abuse Counselor (CADC)	250
441	Developmental Delay Service	
	Early Intervention Services	083
443	Psychiatric Clinical Nurse Specialist	N/A
444	Social Worker, Licensed Clinical (LCSW)	
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Licensed Clinical Social Worker (LCSW)	244
445	Counselors, Therapists, and other Social Workers	
	Licensed Associate Marriage and Family Therapist (LAMFT)	058
	Licensed Master's Level Social Worker (LMSW)	087
	Psychologist Associate	088
	Behavior Analyst Board Certified Behavior Analyst (BCBA or BCBA-D)	099
	Licensed Baccalaureate Social Worker (LBSW)	119
	Licensed Mental Health Counselor (LMHC) Licensed Professional Counselor (LPC)	122
	Licensed Professional Art Therapist (LPAT)	123
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
	Behavior Analyst approved for ABA specialty care Board Certified Behavior Analyst (BCBA or BCBA-D)	253
	Intern	254

446	Core Service Agency (CSA)	
	Adult Psychological Rehabilitation Services (PSR)	080
	Comprehensive Community Support Service (CCSS)	107
	Intensive Out Patient (IOP)	108
	Assertive Community Treatment (ACT)	130
	Multi-Systemic Therapy (MST)	131
447	Renal Dialysis Facility	N/A
451	Occupational Therapist (OT), Licensed & Certified	N/A
452	Occupational Therapist (OT), Licensed, Not Certified	N/A
453	Physical Therapist (PT), Licensed & Certified	N/A
454	Physical Therapist (PT), Licensed, Not Certified	N/A
455	Rehabilitation Facility, Comprehensive Outpatient (CORF)	N/A
457	Speech Therapist, Licensed (SLP)	N/A
458	Speech Therapist for Children, (SLP) School Certified	N/A
462	Case Management Agency	
	Case Management Medically at risk children Early Periodic Screening, Diagnostic & Treatment (EPSDT)	061
	Case Management Developmentally Disabled Children	062
	Case Management Developmentally Disabled Adults	063
	Case Management Maternal and Child Care (Families First)	064
	Case Management Traumatic Brain Injury (TBI)	065
	Certified Community Health Worker (CHW)/Community Health Representative (CHR)	230
901	Acupuncturist, Licensed or Doctor of Oriental Medicine (DOM) MCO only	N/A
904	Physical Health Enhanced Service or Enhanced Service Provider MCO only	N/A
905	Rehabilitation Center, not certified MCO only	N/A

922	Behavioral Health Enhanced Service or Enhanced Service Provider MCO only	N/A
	Functional Family Therapy (FFT)	135
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136
	Eye movement desensitization and reprocessing (EMDR)	137
	Dialectical Behavior Therapy (DBT)	138
923	Promotora or Other Traditional Healers MCO only	N/A

8.8 PROVIDER NETWORK INTERFACE – BMS

Effective November 2024, the file will be sent via the SI to the BMS vendor by all 4 Turquoise Care MCOs. The MFT file will be sent weekly in a json format. The first file sent by the MCOs will be a full file of all providers in their network. Thereafter it must only be new providers or terminations from the network. All dates and times are MT.

File names are:

BCBS_Network.MMDDYYYY.ZIP PHP_Network.MMDDYYYY.ZIP

UHP_Network.MMDDYYYY.zip MHP_Network.MMDDYYYY.ZIP

HEADER

Data Element Name	Data Description	Data Type	Field Length	Required	Start Position	End Position	Delimited postion (starts at 0)	Sample
MCOId	Provider ID assigned to the submitting MCO	String	8	Y	N/A	N/A	N/A	
FileCreatedDate	File creation date	String	10	Y	N/A	N/A	N/A	YYYY-MM-DD

DETAIL

Data Element Name	Data Description	Data Type	Field Length	Required	Start Position	End Position	Delimited postion (starts at 0)	Sample
ProviderIdentifier	A unique number that the system assigns to the provider for MMIS claims processing.	String	50	Y	N/A	N/A	N/A	

ProviderNPIId	NPI ID of the provider	String	10	N	N/A	N/A	N/A	
NetworkBeginDate	The date Provider began part of the MCO network	String	10	Y	N/A	N/A	N/A	YYYY-MM- DD
NetworkEndDate	The date signifies the termination or non renewal of the providers contract with MCO.	String	10	N	N/A	N/A	N/A	YYYY-MM- DD
ProviderName	Name the provider used when they enrolled in the medicaid system	String	130	N	N/A	N/A	N/A	

Data Element Name	Data Type	Field Length	Required	Start Position	End Position	Delimited postion (starts at 0)	Sample
RecordCount	Number	9	Y	N/A	N/A	N/A	

The json format is shown here:

{

"HeaderRecord": { "type": "object", "properties": { "MCOId": {

"type": "string", "length": 8

},

"FileCreateDate": { "type": "string", "length": 10

}

}

},

"ProviderRecords": { "Provider": { "type": "array",

"items": { "type": "object", "properties": {

"ProviderIdentifier": {"type": "string", "length": 50}, "ProviderNPIId": {"type": "string", "length": 10},

"NetworkBeginDate": {"type": "string", "length": 10},

"NetworkEndDate": {"type": "string", "length": 10},

"ProviderName": {"type": "string", "length": 130}

}

}

}

},

"TrailerRecord": { "type": "object", "properties": { "RecordCount": {

"type": "integer", "length": 9

}

}

}

}

The incoming file will be checked to ensure data is accurate and an error file will be posted back to the MCOs if the following errors are found.

Error Code	Error Description	Comment
01	PROVIDER NPI INVALID	Validate the MCO-NETWORK-NPI-ID on input file is found in the Systems' NPI match. If not found post edit.
02	MEDICAID ID INVALID	Validate the MCO-NETWORK-PROV-ID on the input file is found on the Provider table. If not found post edit.
03	NPI/MEDICAID ID MISMATCH	Validate the input file MCO-NETWORK-NPI-ID and MCO-NETWORK- PROV-ID are found on the P_NPI_XMTCH_TB. If not found post edit.
04	MCO ID INVALID	The header line MCO-NETWORK-MCO-ID is validated against an active MCO Provider ID. If not found post edit.
05	NETWORK BEGIN DT INVALID	Edit will post for any of the following: MCO-NETWORK-BEG-DT is spaces MCO-NETWORK-BEG-DT is a baddate MCO-NETWORK-BEG-DT is less than 2024-07-01 MCO-NETWORK-BEG-DT is greater than MCO-NETWORK- END-DT
06	NETWORK END DATE INVALID	Edit will post for any of the following: MCO-NETWORK-END-DT is spaces MCO-NETWORK-END-DT is a baddate MCO-NETWORK-END-DT is less than 2024-07-01
07	NETWORK DATE NOT IN NETWORK	The begin network date is greater than monthly processing date.
08	HEADER REC MISSING	

Error Code	Error Description	Comment
09	TRAILER REC INVALID	
11	Input span overlaps existing span.	Input Network date span overlaps existing Network date span in CMdS DB2.

Any errors in the Network file submission will be sent back to the MCO by the BMS vendor via the SI to the MCOs. The format is json and the file layout is as follows:

File Names are:

- ProviderNetworkErrorBCBS_YYYYMMDD_HHMMSS.ZIP ProviderNetworkErrorUHP_YYYYMMDD_HHMMSS.ZIP
- ProviderNetworkErrorPHP_YYYYMMDD_HHMMSS.ZIP ProviderNetworkErrorMHP_YYYYMMDD_HHMMSS.ZIP

HEADER

Data Element Name	Data Type	Field Length	Required	Start Position	End Position	Delimited position (starts at 0)	Sample	Data Description
RecordType	String	1	N	N/A	N/A	N/A	H	Field indicates the type of record. H - Header
OriginalFileName	String	100	Y	N/A	N/A	N/A	ProviderNetworkFile_YYYY-MM-DD	The name of the data file for which an error file is getting generated
OriginalFIleDescription	String	150	N	N/A	N/A	N/A	Provider Network File Errors	The description of the data file for which an error file is getting generated
OriginalFIleCreatedOn	String	10	Y	N/A	N/A	N/A	YYYY-MM-DD	The file created date of the data file for which an error file is getting generated
PartnerId	String	30	Y	N/A	N/A	N/A		The MCO ID submitted in the Provider Notification file header record.
	String	32	Y	N/A	N/A	N/A	YYYY-MM-DD HH:MM:SS ZZZZ	Error file created time

CreatedTimestamp								

DETAIL

Data Element	Data Description	Data Type	Field length	Required	Start Position	End Position	Delimited line position (starts at 0)	Sample Format	Reference Data
RecordType	Field indicates the type of record. E - Error	String	1	N	N/A	N/A	N/A	E	
ErrorNumber	Error code number	String	5	Y	N/A	N/A	N/A		Y
ErrorText	Error code description	String	40	Y	N/A	N/A	N/A		
ErrorDetails	Field captures one {Provider} record from the original Provider Network File where the issue is reported.	String	210	Y	N/A	N/A	N/A		

TRAILER

Data Element Name	Data Type	Field Length	Required	Start Position	End Position	Delimited postion (starts at 0)	Sample	Data Description
RecordType	String	1	N	N/A	N/A	N/A	T	Field indicates the type of record. T - Trailer
Record Count	Number	9	Y	N/A	N/A	N/A		Total number of Provider Notification detail records

The json file structure is:

```
{
"HeaderRecord": { "type": "object", "properties": { "RecordType": {
"type": "string", "length": 1
},
"OriginalFileName": { "type": "string", "length": 100
},
"OriginalFileDescription": { "type": "string",
"length": 150
},
"OriginalFileCreatedOn": { "type": "string",
"length": 10
},
"PartnerId": { "type": "string", "length": 30
},
"CreatedTimeStamp": { "type": "string", "length": 32
}

}
},
"ErrorRecords": { "ErrorRecord": { "type": "array",
"items": { "type": "object", "properties": {
"RecordType": {"type": "string", "length": 1},
"ErrorNumber": {"type": "string", "length": 5},
"ErrorText": {"type": "string", "length": 40},


"ErrorDetails": {"type": "string"}
}
}
}
},
```

"TrailerRecord": { "type": "object", "properties": { "RecordType": {
"type": "string", "length": 1
},
"RecordCount": { "type": "integer", "length": 9
}
}
}

9.0 Encounters

HCA collects encounter data to meet state and federal accountability, quality of care, performance, and rate setting objectives. HCA and other auditors and governmental agencies use encounters to assess cost-effectiveness, utilization trends, servicedelivery patterns, MCO activities and outcomes, appropriate management of client's health care needs and third-party insurance plans reimbursement, compliance with claims payment and encounter completeness, accuracy and timeliness.

Paid Encounters are always submitted by the MCO using either 837, PACDR, or NCPDP standard transaction formats. The following sections outline the procedures for these submissions. The companion guides for the Managed Care HIPAA transactions are at [5010 HIPAA - Guides, FAQs and Submission Procedures – New Mexico Health Care Authority.]

9.1 Submission of NCPDP Transactions

NCPDP files are uploaded directly to the Conduent's DMZ site as per the instructions in the DMZ instructions section of this manual. NCPDP files are transferred to the mainframe at 8 PM EDT from the DMZ, so it is recommended that the MCO submit their file no later than 7:45 PM EDT.

9.1.1 NCPDP Encounter Submission Process Timeline

DAY	TIME	ACTION
Day 1	Before 6pm MT	Upload NCPDP zip file to DMZ
Day 1	6pm MT	Uploaded files are transferred to the pharmacy claims processing system
Day 2	12am MT	Pharmacy batch jobs start
Day 2	6pm MT	Adjudicated pharmacy claims are transferred to the NM MMIS system
Day 3	8am MT	NM MMIS encounter reports are processed and placed on the DMZ

Because of the way Turquoise Claims process NCPDP claims only one (1) file may be submitted per processing day. Our processing days are Monday through Friday. The files placed on the DMZ are transmitted to PBM (Flexible Rx) for processing at 8 PM EDT on each processing day. Any file

uploaded to DMZ after 8 PM EDT would be considered the next day's file as far as determine the number submitted. If multiple files are placed on DMZ in a processing day one of the files will be overlaid when they are transferred to PBM.

The maximum number of encounters that may be submitted in a Daily Submission is 100,000 B1 or B2 claims, or 50,000 B3 claims.

9.2 MCO Trading Partner and 837 Encounter Testing Procedures

The 837 transactions are submitted to the Fiscal Agent's EDI Gateway, where they are validated for format and conformance to implementation and companion guide content. The MCO should follow the HIPAA implementation guides with the New Mexico Companion Guides for Managed Care Encounters providing any New Mexico specific instructions (both the 837 Companion Guides and NCPDP Payer Sheet) are found on the HCA Website at https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/

The steps to becoming an MCO Trading Partner and submitting production encounter files are as follows:

1. Complete a new Trading Partner Agreement (TPA) for 5010 transactions.
   a) The form is available on the New Mexico Medicaid Website at: https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/.
   b) Complete the form and send it to HIPAA.DeskNM@hca.nm.gov.

2. Once the New Mexico HIPAA Helpdesk receives your signed TPA, they will enter your information into our Trading Partner Management System (TPMS) and provide you details on submission of your PACDR transactions format validation on the test files.
   a) You will be granted access to the UAT EDI MOVEit DMZ/Transfer to perform HIPAA transaction format validation.
   a) You will also be granted access to the UAT EDI MOVEit DMZ/Transfer to perform HIPAA transaction format validation on the test files. EDI DMZ, an SFTP connection, which allows automated delivery and receipt of files.
   b) Validate your 837 files using CommerceDesk.
3. Validate your files using UAT EDI MOVEit DMZ/Transfer https://nonprodazuresftp.services.conduent.com.
4.
   a) Your files only need to pass SNIP levels 1 and 2 without errors. (That is, if you have a SNIP level 5 error, or a SNIP level 1 warning (not error), then your file is considered 'passed' for 5010 validations.)
   b) You should submit your files UAT EDI MOVEit DMZ/Transfer first to ensure they pass 5010 validations.
5. The submitter needs to submit three files of at least 10 valid claims each for each transaction type (PADCR I, PACDR D, PACDR P) you wish to submit into production.
   (That is, if you are planning to submit PACDR I, D, P transactions, you need to submit nine files in total.)

6. Once you have submitted 3 files of at least 10 valid claims each, contact the NM HIPAA Helpdesk (HIPAA.DeskNM@hca.nm.gov) to let them know you are ready to have your files reviewed by the State.
7. The claims will be reviewed by the State and once approved, you will be granted permission to submit 5010 version PACDR claims or encounters to the Production system.

If you have any questions, contact CCSC HIPAA Helpdesk 800-299-7304 or hipaa.desknm@hca.nm.gov.

9.2.1 EDI Online Instructions

The CONDUENT EDI Online tool provides healthcare providers with the ability to conduct business electronically with CONDUENT EDI.

EDI Online capability allows users to:

- Submit 5010 837 X12 transactions
- Retrieve response transactions and files, including 999s, Online confirmation reports, 277CAs and 835s.

Access to the site for New Mexico Medicaid Trading Partners is administered through the New Mexico HIPAA Helpdesk HIPAA.DeskNM@hca.nm.gov

To get started, access the Conduent EDI Login page:
https://edionline.portal.conduent.com/EDIOnline/redirect.action

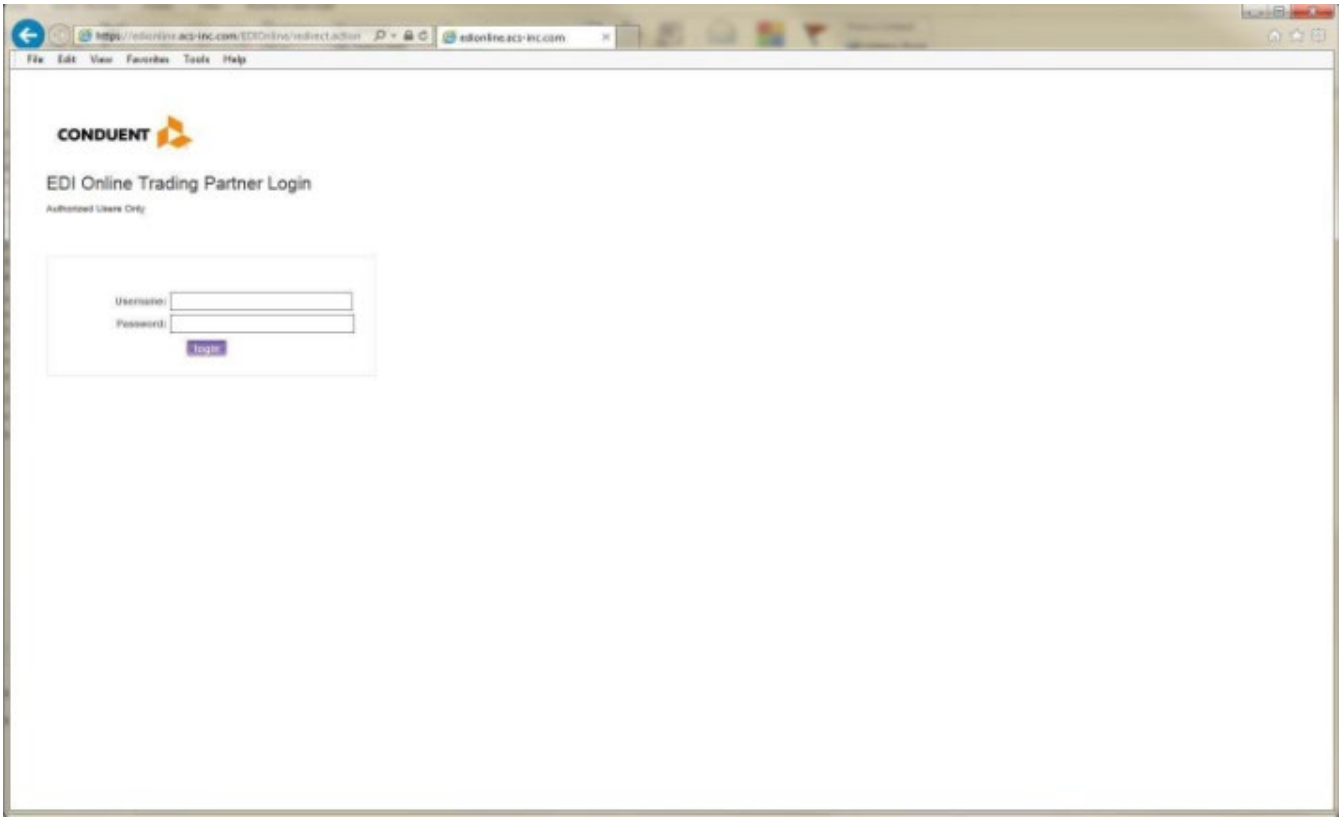

Figure 1: Conduent EDI Login Page

Enter the TPMS username and password that you were assigned when you enrolled for EDI services and click the **Log In** button.

Once you log in successfully, the next window confirms your login information was correct.

To submit files, click on **Submit Files** button.

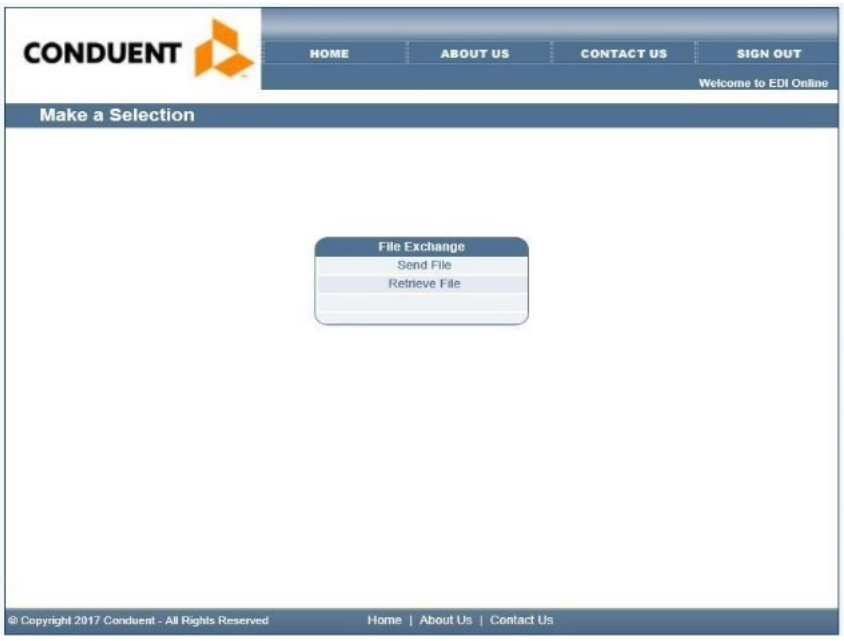

Figure 2: File Submission Page

The next window prompts you to navigate to the location of the file you wish to upload using the **Browse** button.

Figure 3: File Selection Page

Once you've used the Browse button to locate your file, you are ready to click the

Submit button.

EDI Online will return a window stating that your file was successfully submitted. There is a link to view the confirmation report. You can either click the link or click on the menu item **Retrieve Files**.

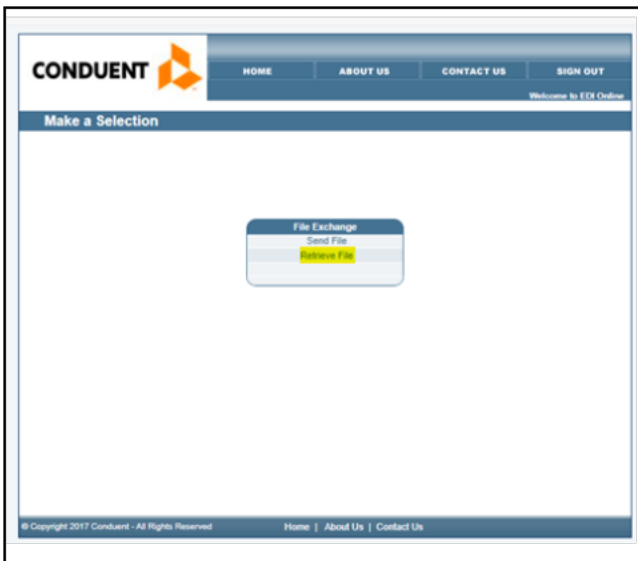

Figure 4: Retrieving Confirmation Section

Once you click on the Confirmation Report link (or Retrieve Files), the next window will display a **Reports** link under the heading **Confirmation Reports**. Click on the link to navigate to the confirmation report.

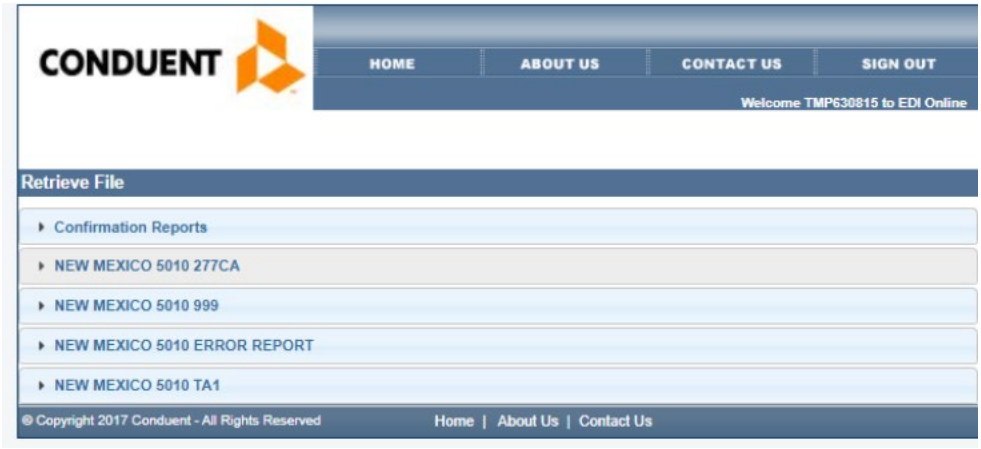

Figure 5: Confirmation Report Retrieval Page

The available confirmation report(s) will be displayed in the next window.

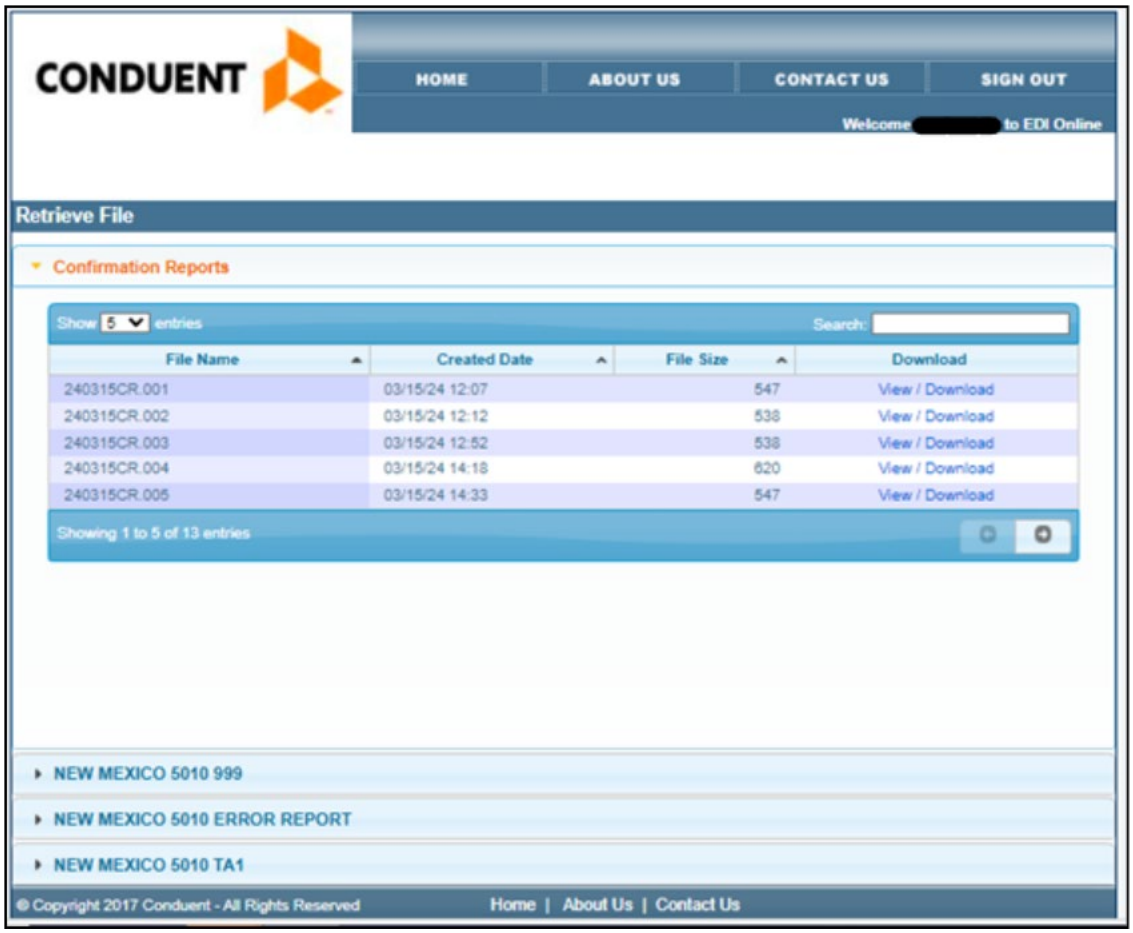

Figure 6: View Confirmation Report

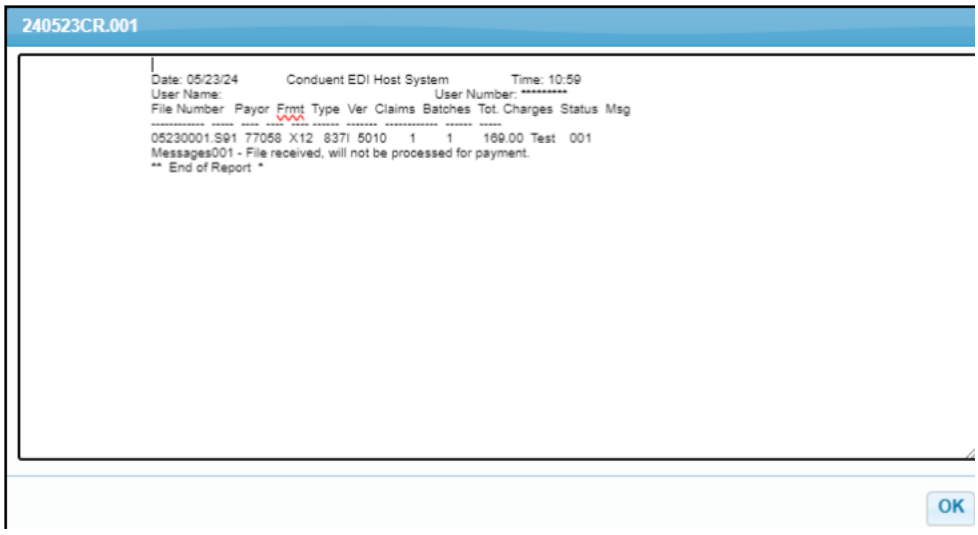

Figure 7: Confirmation report

The last report is the one from your most recent file submission. Make sure that the date coincides with the date you submitted the file.

Sometimes, there is a lag of up to 15 minutes before your report appears in the list.

If you don't see a report for your submission, then refresh the screen.

If you submit multiple files in one day, the sequence number in the file name will be increased by 1.

Click on your report.

You will be prompted to save the file. (You will not be allowed to view the report without first saving it).

Once the file is saved to a desired location, you will be prompted to Open the file.

You can use Notepad to open thereport.

If you do not receive a confirmation report after 15 minutes, contact the New Mexico HIPAA Helpdesk to report the delay.

The message, **'001 – File received, will not be processed for payment.'** indicates that your file upload was successful. The message states that it will not be processed for payment because the file that we uploaded was a **test** file.

To retrieve the HTML Confirmation Report, 277CA, and TA1 Files, Follow similar procedures as above.

9.2.2 PACDR Encounter Submission Rules and EDI & Conduent Timing and Flow

The MCO may submit one or more PACDR transaction files, however, the Maximum file size is 45 MB.

The maximum size of a batch (defined as the number of claims in a ST/SE loop) is 5000 claims and the maximum number of claims submitted per night is 50,000 on the weekdays and 100,000 on the weekend (Saturday/Sunday). MCOsmay not submit one claim per ST/SE loop because this creates a multitude of batches and there is a batch limit within Turquoise Claims. **Crossovers and non-crossovers can be submitted in the same file.**

Within 15 minutes, reports and responses are available to the trading partner on ***MOVEit DMZ/Transfer,*** including:

1. Online Confirmation Report - Verify that your file was accepted in this report. Ifthe file is rejected, you may not receive the remainder of the reports.
2. HTML Compliance Report - Your files only need to pass SNIP level 1 and 2 to be passed to the MMIS for processing.
3. 999 X12 transaction
4. TA1 X12 transaction (if requested in 837 X12 transaction)

If the expected responses do not appear after 15 minutes, the MCO should contact HIPAA.DeskNM@hca.nm.gov *with the following information:*

- TP ID
- Trading Partner Business Name

- Trading Partner's contact name, phone and/or email
- Date and Time PACDR file wassubmitted
- Any other particulars that will help with the resolution process

The HIPAA Helpdesk will troubleshoot the issue and respond within 24 hours.

Internal CONDUENT processing:

CONDUENT EDI accepts and translates the PACDR data for use by the NM MMIS.

Every 2 hours from 10am ET through 6pm ET, Monday – Friday, the NM MMIS System pulls claim/encounter data from EDI and performs front-end claims processing and claims adjudication. This process also produces 277CA files transmitted back to EDI for delivery to the trading partner via EDI Online. The claims adjudication cycle starts at 7 pm ET.

CONDUENT will run daily claims cycles at 1pm ET, Monday through Friday. In addition to daily claims reporting, the daily claims cycle also finalizes encounter voids and produces the MCO RC070-071 flat files and RC072 reports.

Within 24 hours of file submission, the resultant 277CA X12 transactions are posted to *EDI Online*. The 277CA X12 transaction reflects files which have made it from the EDI to Turquoise Claims and have gone through Turquoise Claims pre-processor. The 277CA X12 will tell the MCO whether the file has passed the pre-processor and gone on through full adjudication.

If the 277CA transaction does not appear after 24 hours, the MCO should contact HIPAA.DeskNM@hca.nm.gov with the following information:

- TP ID
- Trading Partner BusinessName
- Trading Partner's contact name, phone and/or email
- Date and Time PACDR file wassubmitted
- Any other particulars that will help with the resolution process. The Helpdesk will troubleshoot the issue and respond within 24 hours.
- Each morning, the following should be available to the MCO:
  - MCO encounter flat files and reports should be available on DMZ.

EDI assigns an internal file "Tracking ID" to each PACDR-file submitted. This is a unique number that will never be repeated for another file. The Tracking ID allows EDI to associate a claim with the file that is submitted on. EDI keeps up to 7 years of history of 837/PACDR raw data for submitted claims.

The 31-character EDI trace number structure is as follows: Positions 1 – 15 – file-specific Tracking I

Positions 16 – 23 – ST/SE sequence number within the file – starts at 00000001 for each file and increments by 1 for each ST/SE in the file

Positions 24 – 31 – CLM segment sequence within the file – starts at 00000001 for each file and increments by 1 for each CLM segment in the file across all ST/SEs – does not start over at 00000001 for each ST/SE

File Tracking ID allows multiple ST/SE loops within the same file to be aggregated for reporting. MCOs are encouraged to submit all their claims in one file per type within multiple ST/SE loops of 5000 claims

each. Multiple files of one type submitted on 1 day will each be recorded and reported on the RC72 as a separate file.

In Case of Questions or Problems:

Submitters with questions or problems submitting files, or with questions about their claims, should contact the HIPAA Helpdesk at 800-299-7304 or by email at HIPAA.DeskNM@hca.nm.gov. The HIPAA Helpdesk is open from 8 a.m. to 5 p.m. MST (Monday – Friday).

Submission Deadline: Files should be submitted on a weekly basis. MCO's can submit files as frequently as they wish.

Resubmission: Rejected data files must be corrected and resubmitted within 5 working days of the notice of rejection from the translator. Denied Encounters must be resubmitted within 30 days of the date of the notice of denial from HCA.

9.3 Encounter Data Submission Requirements

MCO's must collect data on every encounter between an MCO's enrollee and an MCO staff or any provider paid by the MCO, regardless of whether the provider is contracted or non- contracted. The MCO's are to transmit all paid encounters completely and timely to HCA using HIPAA standard formats and standard code sets according to the contract requirements, which vary according to program and specified in that program's contract:

An encounter is:

- Any claim adjudicated and paid by the MCO or any of its subcontractors for a client covered by NM's Turquoise Care program.
- Any record of a service provided by the MCO or any of its subcontractors or encounter between the MCO or its subcontractors and a client covered by NM's Turquoise Care program which was not adjudicated as a claim but represents a client-specific service or administrative activity for which there is an expense associated.

HCA/MAD maintains oversight responsibility for evaluating and monitoring the volume, completeness, timeliness, and quality of encounter data submitted by the MCO. If the MCO elects to contract with a subcontractor, the MCO must ensure that the subcontractor complies with all claims and encounter requirements. The MCO must submit all encounter data for all services rendered to HCA/MAD. The MCO is responsible for the quality, accuracy, and timeliness of all encounter data submitted to HCA/MAD. HCA/MAD shall communicate directly with the MCO any requirements and/or deficiencies regarding completeness, quality, accuracy and timeliness of encounter data, and not with any third party MCO. Failure to submit accurate and complete encounter data will result in financial penalties determined by HCA/MAD based upon the error, and/or the repetitive nature of the error and/or the frequency of the errors. The MCO shall submit encounter data to HCA/MAD in accordance with the following:

The MCO is required to submit to HCA the following:

- All original claims/claim lines paid or denied by the MCO.
    - This includes Medicaid payments for Medicaid clients, and it includes Medicare payments made on behalf of Medicaid clients even if there is no Medicaid payment on the Medicareclaim.

- All adjustment/void claims of previously reported paid claims, submitted according to the same timeliness standards as required of paid/denied original claims. If the original encounter was denied by Turquoise Claims, the MCO should take the following steps:
  1 Evaluate if the claim was submitted incorrectly by the provider/subcontractor
    a) If so, return the claim to the source to be corrected and resubmitted.
    b) If not, determine whether the MCO made an error in transcribing the claim to the PACDR/NCPDP encounter file.
  2 If the claim is returned to the source to be corrected and resubmitted, the MCO should submit this correction as an adjustment reflecting the original Denied TCN and showing the received date and paid date of the resubmitted claim.
  3 If the claim is corrected by the MCO as a transcription error, the MCO should:
    a) If the original claim was submitted in error (i.e., claim had been previously submitted and wasn't paid twice or claim was not the last paid in chain claim for that client and that service), resubmit the encounter as a void reflecting the original Denied TCN
    b) If the original claim was submitted because of an error made by the MCO in its transmission, resubmit as an original with the original received and paid dates.

Adjustments and voids of previously submitted claims must be identified as such according to instructions in the HIPAA Technical Requirements guide and NM Companion guides, including the Turquoise Claims TCN of the previously paid encounter that the adjustment/void modifies.

9.3.1 Encounter Timeliness Requirement

HCA/MAD encountered timeliness requirements attempt to ensure that the MCO submits to HCA all its encounters within a reasonable period of its final adjudication. The MCO must submit to HCA/MAD at least ninety percent (90%) of its Claims, originals and adjustments within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication, regardless of whether the encounter is from a subcontractor, sub-capitated arrangement, or performed by the MCO. It is not acceptable to withhold submission of encounters because the MCO believes the encounters may not pass NM encounter edits

The MCO is expected to have written contractual requirements of subcontractors or providers that pay their own claims to submit encounters to the MCO on a timely basis which ensures that the MCO can meet its timeliness requirements for encounter submission.

9.3.2 Encounter Accuracy Requirement

The MCO meets accuracy requirements by submitting MCO paid encounters with no more than a three percent (3%) error rate per invoice type (INPT, Pharmacy, Dental, and Non-INPT/Professional), calculated for a quarter's worth of submission. This calculation is performed by collecting all the original encounters processed by Turquoise Claims during the quarter (i.e., pulling all claims with a Turquoise Claims paid date within the quarter) and evaluating the paid vs denied by invoice type and claim type. This evaluation excludes any denials which have subsequently been paid during the quarter, any denials which are duplicates (multiple denials during a quarter will only be counted once), and any denials which were voided during the quarter. HCA will provide the MCO with both summary level and detail level data on their Encounter Accuracy rates.

HCA/MAD will monitor the MCO corrections to NM denied encounters by random sampling. Seventy-five percent (75%) of the NM denied encounters included in the random sample with 75% that must have been corrected and resubmitted by the MCO within thirty (30) days of denial by HCA

The MCO is expected to edit encounters prior to submission to prevent or decrease submission of duplicate encounters and other types of encounter errors. The edits applied by HCA for encounters are in a later section of this manual for use by the MCO's to perform their own edits to ensure optimum accuracy and completeness.

9.3.3 Encounter Completeness Requirement

The MCO must meet completeness requirements by submitting to HCA/MAD a report of the amount of MCO payment for all MCO paid claims by date of payment and date of service, including a tally of any IBNR clams, according to a format specified by HCA/MAD; referred to as the Lag Report. This report will be compared to encounter data to evaluate the completeness of data submitted. A variance between the MCO's report and the record of encounters received cannot exceed 10% for months of payment greater than 90 days. In other words, for example, for the payment month of July, 90% of encounters paid in the months of April and before should be completed in the Turquoise Claims system.

The Lag Report

Each month, the MCO is to complete an excel workbook with 5 spreadsheets that show all paid claims amounts broken down by the following categories:

- Institutional Inpatient
- Institutional Outpatient
- Professional
- Pharmacy
- Combined

The definition for the different categories is as follows:

- **Institutional Inpatient** – Any claims paid on an 837I (or UB92 paper claim) where TOB = 11x, 12x, 65x, 66x, 69x, 89x, 21x, 22x
- **Institutional Outpatient** - Any claims paid on an 837I (or UB92 paper claim) where TOB Is Not = 11x, 12x, 65x, 66x, 69x, 89x, 21x, 22x
- **Professional** – Any claims paid on an 837P (or HCFA1500 paper claim)
- **Pharmacy** – Any claim paid on the NCPDP claim format
- **Combined** – All Claims paid

A copy of the Lag Report is on the following page. The report is to be run and submitted no later than the first Friday of each month for the payments made by the end of the preceding month. The sample on the next page only shows one year of data, but the report is not an annual, it keeps running with prior months of data included.

MCO TURQUOISE CLAIMS MANUAL

HCA-25HCA/MAD Medicaid Lag Report Funding: Medicaid Turquoise Care Services

ServiceDate:01/01/2012 to 12/31/2012

PaidDate:01/01/2012 to 12/31/2012 ReportRunDate:01/06/2013

	MONTHS OF SERVICE												
Months OF Payment	**1/1/2012**	**2/1/2012**	**3/1/2012**	**4/1/2012**	**5/1/2012**	**6/1/2012**	**7/1/2012**	**8/1/2012**	**9/1/2012**	**10/1/2012**	**11/1/2012**	**12/1/2012**	**Total**
1/1/2012	$8,428,185		$-	$-	$-	$-	$-	$-	$-	$-	$-		**$18,474,003**
2/1/2012	$7,595,548	$8,673,015		$-	$-	$-	$-	$-	$-	$-	$-		**$17,147,591**
3/1/2012	$1,294,401	$7,556,501	$9,126,158		$-	$-	$-	$-	$-	$-	$-		**$18,424,929**
4/1/2012	$195,661	$1,032,529	$7,719,737	$7,477,142		$-	$-	$-	$-	$-	$-		**$16,194,500**
5/1/2012	$45,096	$152,625	$1,178,479	$7,995,501	$8,249,387		$-	$-	$-	$-	$-		**$17,651,552**
6/1/2012	$12,695	$17,172	$147,259	$1,545,312	$8,005,005	$7,298,632	$-	$-	$-	$-	$-		**$17,272,118**
7/1/2012	$31,741	$28,160	$37,947	$132,708	$1,682,731	$7,733,263	$6,559,713		$-	$-	$-		**$16,327,602**
8/1/2012	$3,136	$1,799	$28,238	$57,519	$165,400	$1,390,752	$8,692,051	$7,682,252		$-	$-		**$18,117,903**
9/1/2012	$8,709	$9,145	$9,435	$26,819	$79,446	$205,429	$906,527	$8,146,087	$6,957,044	$-	$-		**$16,378,982**

10/1/2012	$7,029	$5,080	$15,752	$15,820	$78,006	$73,408	$115,381	$1,107,833	$7,368,573	$7,625,397	$-		**$16,411,130**
11/1/2012	$7,289	$6,203	$12,854	$13,407	$10,758	$12,887	$23,942	$335,557	$1,086,079	$7,990,749	$6,968,280		**$16,551,897**
12/1/2012	$391	$779	$886	$1,833	$2,067	$(1,187)	$40,280	$75,658	$370,181	$1,799,546	$8,129,876	$6,398,412	**$16,781,303**
Summary by MOS	**$17,626,503**	**$17,480,234**	**$18,275,366**	**$17,263,897**	**$18,271,769**	**$16,713,220**	**$16,334,306**	**17,378,302**	**$15,875,272**	**$17,648,909**	**$16,410,788**	**$13,499,856**	**$743,759,549**

The MCO is responsible to report all data noted as "required" in the HIPAA Technical Reports, and HCA/MAD's Encounter Companion Guides with specific attention to the following financial information that will be used to ensure accuracy of claims payment and to set future capitation rates:

1. Actual MCO Paid Amount on all claims/lines paid by the MCO or subcontractor. This amount must be the amount paid minus any third party or client copay collected.
2. An MCO Paid Amount equivalent to any claims/lines not paid as fee for service claim/line, with a pricing process code that indicates the amount shown is an equivalent amount (e.g., sub-capitated providers/clients).
3. Claim Adjustment reason codes (CAS codes) with Remark Codes as needed to designate the reasons any claim/line is not paid at the provider's billed charge (e.g., bundling).
4. Any payments by any third-party payer, co-payments from the client, or adjustments to the claim/line's pricing reported with the appropriate claim adjustment reason and remark codes.
5. Payment to IHS, FQHC, and RHC providers using institutional claim formats and including the encounter rate paid on one line of the claim, but including all services rendered as part of that encounter.
6. Any services provided to clients directly by MCO staff (e.g., care coordination, assessments, etc.) must be submitted to HCA/MAD as encounter data using agreed upon coding and meeting all HIPAA transaction standards

9.3.4 PACDR Encounter Adjustments/Voids

The MCO can adjust or void an encounter that has been previously adjudicated in Turquoise Claims by using the HIPAA PACDR adjustment transaction. Pharmacy encounters submitted via NCPDP format are adjusted/voided using the same NCPDP format as outlined earlier in this manual. Please refer to the New Mexico Companion Guides for Managed Care Encounters (both the PACDR Companion Guides and NCPDP Payer Sheet) for specific instructions re: how to submit a void or adjustment encounter. The companion guides are found on the HCA web portal at https://www.hca.nm.gov/providers/hipaa-standard-companion-guides/.Adjustment and Void encounters must match the original encounter on the following data elements:

- Billing Provider NPI (or Tax ID if the original was submitted for an atypical provider),
- Client ID, and
- The Turquoise Claims TCN of the original paid encounter that must be entered on the adjustment encounter.

The PACDR-transaction file can only contain encounters of one format type. Thus, all PACDR Ps must be submitted to one file, all PACDR Is must be submitted on a separate file, and all PACR Ds must be submitted on another separate file. Furthermore, crossover encounters should always be batched separately from other, non-crossover encounters. However, the MCO may submit original encounters, adjustments and voids in thesame batch. The encounters will continue through the regular encounter system edits and will appear on the RC070/071 and on the RC072.

If an encounter is accepted, it will appear on RC070/071 and on RC072 with any exceptions that apply. Any adjustment/void encounters submitted that don't match the required fields or which are found to have been previously adjusted, will also be shown on the RC070/071 report as denied with any of the following exception codes:

- 0842 (CMdS 1893) Client ID Match Not Found - The client ID on the adjustment or void request does not match the client ID on the encounter that is being adjusted or voided.
- 0843 (CMdS 1905) Bill Prov Match Not Found - The billing provider number on the adjustment or void request does not match the billing provider number on the encounter that is being adjusted or voided.
- 0844 (CMdS 1905) Blng NPI Match Not Found - The NPI on the adjustment or void must result in a match to the Turquoise Claims Medicaid ID number submitted on the original encounter. The taxonomy is not needed for matching purposes on the adjustment or void request.
- 0845 (CMdS 1894) Clm Already Cred or Replcd - The encounter that is being adjusted or voided has already been adjusted or voided. An encounter can only be voided once. Adjustments to previously adjusted encounters may be made but any such requests must be submitted with the TCN assigned to the most recent adjudicated adjustment, not the TCN of the original encounter. This is considered a duplicate encounter and is set to Deny and Report.
- 0850 (CMdS 1895) ADJ/VOID Req Not Processed - The original Turquoise Claims TCN to adjust or void is missing or invalid. OR the original Turquoise Claims TCN to adjust or void does not match a previously paid encounter.
- 0856 (CMdS 1897) A Credit May Not Be Adjusted (CMdS a Void May Not Be Replced)

If an adjustment or void request cannot be processed for any of these reasons, it will be denied and the original encounter will remain in its original status. If an adjustment is submitted and the credit is accepted but the debit is denied for any reason other than the above, the credit side of the claim is accepted but the replacement or debit side is denied.

Adjustment Processing

An adjustment allows the MCO to correct a previously submitted encounter. In Turquoise Claims, when the adjustment claim is adjudicated, Turquoise Claims marks the original encounter as having been credited. It then creates a credit, or negative of the original encounter, and a replacement debit that reflects the 'new' or adjusted encounter. Here are some special considerations regarding encounter adjustments:

1. If the reason for the encounter adjustment is to correct the NPI of the provider or the original claim was paid with a different client ID than was originally submitted, the MCO must instead void the original encounter and then resubmit the claim as an original encounter. **It is critical that the voids be submitted in a separate cycle from the 'new' claim submission.**
2. If the reason for the encounter adjustment is that some, but not all, lines on the claim have since been denied by the MCO, the encounter adjustment should include only the lines that should now correctly reflect paid. As stated above, Turquoise Claims will create a negative of the original claim and the adjustment claim will in essence, replace that original. For example, if an encounter was submitted originally and paid in Turquoise Claims with 5 lines and one of those lines has since been recouped by the MCO, the adjustment encounter will contain only the 4 lines that are now considered by the MCO as valid; Turquoise Claims will void the 5 line encounter and process the 4-line encounter.

Void Processing

A void is submitted to nullify **all** individual lines originally submitted on an encounter without supplying additional corrected data. It works at the claim header level and all services originally accepted on that TCN will be voided. When the MCO submits a void, the original encounter is credited, and a credit encounter is created (but without the replacement debit encounter that is created for an adjustment).

Turquoise Claims System-Generated Adjustments

HCA has the capability to mass adjust encounters, whether in a paid or denied status in Turquoise Claims. A mass adjustment request could be made to override edits that are posting to encounters that the State wishes to bypass or to void encounters that are in a paid status that audit has determined to be invalid or for other reasons that would be explained to the MCO prior to action taken.

9.4 NPI and Taxonomy Specific Instructions

All encounters must be submitted with an NPI number for any provider other than an atypical provider. Only "Atypical" providers (non-healthcare providers) may continue to file claims without an NPI Number. These include:

- Community Benefit providers (PT363),
- Handivans, taxis, and
- Meals and lodging providers.
- Schools and behavioral health providers are not exempt and must obtain NPI numbers. Atypical provider claims must be submitted with the provider's Tax ID number. Of course, if the provider has an NPI, that should be used.

Every encounter submitted for a healthcare provider with an NPI number must also include that provider's taxonomy number, ***if that provider has more than one Turquoise Care provider type associated with that NPI.*** Provider type 344 (DD/Med Frag Waiver provider) is **not** a Turquoise Care provider type. **The MCO should not require a taxonomy to be submitted on a claim if the provider has only 1 Turquoise Care provider type under that NPI.** The provider who only has 1 Turquoise Care provider type enrolled in BMS under 1 NPI number will always have a single match to a provider ID in BMS, and taxonomy is not used.

Taxonomy is a 10-digit number that enables providers to indicate their type of practice and specialty on an encounter form. Use of taxonomy and the NPI is mandatory on healthcare encounters ***if needed to adjudicate the claim***. The MCO must never deny payment to a provider for not submitting a taxonomy or the 'right' taxonomy if that provider has only 1 line of business for Turquoise Care.

BMS provider enrollment vendor assigns one or more taxonomy for each provider record it enrolls and communicates this on the Provider Monthly and Daily files. ***The MCO is cautioned not to rely solely on the taxonomy found on the NPI registry for a New Mexico provider, but rather to use the Taxonomy to Provider Type crosswalk that we provide.*** The NPI registry records the taxonomy self-chosen by the provider, often at a corporate level and does not always reflect the licensure/certification under which the provider is operating in New Mexico. New Mexico assigns the provider types based on the specific program the provider is requesting on its application and the provider's licensure/certification for that

program. The possible taxonomy codes for a given provider type are then identified by General Dynamics (KYP) on the crosswalk based on all the applicable taxonomies that relate to that provider's New Mexico licensure/certification. Verify with the Provider Enrollment Matrix that can be found at https://www.hca.nm.gov/providers/.

- CONDUENT will use the NPI number, and the taxonomy as reported on the encounter to determine the Medicaid ID number of the provider to whom payment is to be made.
- Taxonomy is required on the encounter when the NPI is used for the billing, rendering, and attending providers if any of those providers has more than one type associated with that NPI. Providers must state the taxonomy when registering for the NPI number.
- Taxonomy will be used by CONDUENT to locate the appropriate Medicaid ID number when the provider has one NPI ID number for two or more lines of business. For example, if a home health agency also has a hospice Medicaid ID number and a private duty nursing number, and the provider chooses to apply for only one NPI, different taxonomies are used by the provider to indicate when the encounter is for home health, hospice, or private duty nursing.

Selecting a Taxonomy for an Encounter –The MCO must require its providers with two or more lines of business to submit their claims with taxonomy codes and institute some editing between the provider type assigned by HCA and the taxonomy coming in on the claim. In the event the MCO pays a claim without a taxonomy code from a healthcare provider, the MCO can use the file of taxonomy to provider type crossmatch to assign a taxonomy code that will match the provider type of the provider in BMS.

The following tips for validating taxonomy on claims are provided:

- Providers which have more than 1 line of business for one NPI must use the correct taxonomy for each provider type/specialty assigned as per the following crosswalk.
- For some providers, there may be both Level II and Level III taxonomy available and whichever provider submits is acceptable.
- Community Based providers are Atypical and so do not need to use NPI or taxonomy unless they are part of a health care provider that uses the same NPI with different provider types. Community Benefit providers, when using an NPI number, must use the taxonomy appropriate for that provider type but cannot use that same taxonomy on a non-community benefit service encounter. This distinction is very important for encounters to be processed appropriately.
- Hospitals must use the hospital taxonomy for both their inpatient and outpatient departments. They cannot use the clinic taxonomies for outpatient hospital services.
- IHS hospitals do not have a special IHS taxonomy and therefore will use the acute care hospital taxonomy. There is a special taxonomy for an IHS pharmacy.
- Pharmacy providers who do not have a separate DME/Medical Supply provider number who are submitting Professional (HCFA1500) encounters for medical supplies must still use the pharmacy taxonomy even if the encounter is not a pharmacy encounter.

9.5 Provider Type/Specialty to Taxonomy Crosswalk

PROVIDER TYPE	PROVIDER TYPE & SPECIALTY DEFINITIONS	PROVIDER SPECIALTY CODE	LEVEL II TAXONOMY	LEVEL III AREA OF SPECIALIZATION TAXONOMY
201	Hospital, General Acute	N/A	282N00000X	
	Mobile Resp and Stab Svcs (MRSS)	139		
	Mobile Crisis Team (MBLCRSTM)	149		
	Rural Emergency Hospital (REH)	N/A	261Q00000X	261QE0002X
202	Hospital, Rehabilitation Unit in a General Acute Hospital	N/A	273Y00000X	
203	Hospital, Rehabilitation or Other Specialty			
	Children's Specialty Hospital	127	281P00000X	281PC2000X
	Children's Specialty Hospital	127	282N00000X	282NC2000X
	Children's Specialty Hospital	127	283X00000X	283XC2000X
	Long Term Acute Care hospital	128	282E00000X	
	Rehabilitation Hospital	129	283X00000X	
	Other Specialty Hospital	134	284300000X	
204	Hospital, Psychiatric Unit in a General Acute Hospital	N/A	273R00000X	
205	Hospital, Psychiatric	N/A	283Q00000X	
211	Nursing Facility, Private	N/A	313M00000X	
212	Nursing Facility, State	N/A	313M00000X	
213	Hospital, Swing-Bed	N/A	275N00000X	
214	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID) - Private	N/A	315P00000X	
215	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID) - State Owned	N/A	315P00000X	
216	Accredited Residential Treatment Center (ARTC)			
	Juvenile ARTC for Behavioral Health	260	322D00000X	
	Adult ARTC for SUD (In-state)	261	324500000X	
	Adult ARTC for SUD (Out-of-State)	261		

PROVIDER TYPE	PROVIDER TYPE & SPECIALTY DEFINITIONS	PROVIDER SPECIALTY CODE	LEVEL II TAXONOMY	LEVEL III AREA OF SPECIALIZATION TAXONOMY
			324500000X	
	Qualified Residential Treatment Program (QRTP)	262	322D00000X	
217	Residential Treatment Center, not Accredited	N/A	320600000X	
217	Residential Treatment Center, not Accredited	N/A	320700000X	
217	Residential Treatment Center, not Accredited	N/A	320900000X	
217	Residential Treatment Center, not Accredited	N/A	323P00000X	
217	Residential Treatment Center, not Accredited	N/A	324500000X	
217	Residential Treatment Center, not Accredited	N/A	324500000X	3245S0500X
218	Treatment Foster Care Agency	N/A	253J00000X	
219	Group Home, not Accredited	N/A	320800000X	
221	Indian Health Services (IHS) or Tribal 638 Contract Facility		282N00000X	
	Hospital or Outpatient Clinic	100		
	Dental	102	122300000X	
	Mobile Resp and Stab Svcs (MRSS)	139		
	Mobile Crisis Team (MBLCRSTM)	149		
301	**Physician, Medical Doctor (MD)**	Required - see specialty list below	N/A	N/A
302	**Doctor of Osteopathy (DO) and Naturopathic Doctor (ND)**			
	Doctor of Osteopathy (DO)	Required - see specialty list below	N/A	N/A
	Naturopathic Doctor (ND)	300	175F00000X	
	Specialties for types 301 (MD) and 302 (DO Only)			
	General Practice	001	208D00000X	
	General Surgery or Other Specialized Surgery not otherwise listed	002	208600000X	

	Allergy	003	207K00000X	
	ENT (Ear, Nose, Throat)	004	207Y00000X	
	Anesthesiology	005	207L00000X	
	Cardiology	006	207RC0000X	
	Dermatology	007	207N00000X	
	Family Practice	008	207Q00000X	
	Gastroenterology	010	207R00000X	207RG0100X
	Hematology or Oncology	011	207R00000X	207RH0003X
	Manipulative Therapy	012	204D00000X	
	Neurology	013	N/A	2084N0400X
	Neurological Surgery	014	207T00000X	
	Obstetrics	015	207V00000X	207VX0000X
	OB-GYN	016	207V00000X	
	Ophthalmology	018	207W00000X	
	Neonatology	019	208000000X	2080N0001X
	Orthopedic Surgery	020	207X00000X	
	Emergency Medicine	021	207P00000X	
	Pathology	022	N/A	207ZP0102X
	Plastic Surgery	024	208200000X	
	Physical Medicine & Rehabilitation	025	208100000X	
	Psychiatry, Other	026	N/A	2084P0800X
	Pain Management	027	N/A	208VP0000X
	Proctology	028	208C00000X	
	Pulmonary Disease	029	207R00000X	207RP1001X
	Radiology	030	N/A	2085B0100X
	Radiology	030	N/A	2085D0003X
	Radiology	030	N/A	2085R0202X
	Radiology	030	N/A	2085U0001X
	Radiology	030	N/A	2085H0002X
	Radiology	030	N/A	2085N0700X

	Radiology	030	N/A	2085N0904X
	Radiology	030	N/A	2085P0229X
	Radiology	030	N/A	2085R0001X
	Radiology	030	N/A	2085R0205X
	Radiology	030	N/A	2085R0203X
	Radiology	030	N/A	2085R0204X
	Thoracic Surgery	033	208G00000X	
	Urology	034	208800000X	
	Nuclear Medicine	036	207U00000X	
	Pediatrics	037	208000000X	
	Geriatrics	038	207R00000X	207RG0300X
	Geriatrics	038	207Q00000X	207QG0300X
	Nephrology	039	207R00000X	207RN0300X
	Hand Surgery	040	208600000X	2086S0105X
	Hand Surgery	040	208200000X	2082S0105X
	Hand Surgery	040	207X00000X	207XS0106X
	Internal Medicine	041	207R00000X	
	Cardiology, Pediatric	042	208000000X	2080P0202X
	Allergy, Pediatric	043	208000000X	2080P0201X
	Public Health	044	251K00000X	
	Preventative Medicine	046	N/A	2083A0100X
	Preventative Medicine	046	N/A	2083C0008X
	Preventative Medicine	046	N/A	2083T0002X
	Preventative Medicine	046	N/A	2083B0002X
	Preventative Medicine	046	N/A	2083X0100X
	Preventative Medicine	046	N/A	2083P0500X
	Preventative Medicine	046	N/A	2083P0901X
	Psychiatry, Board Certified, Child/Adolescent	047	N/A	2084P0804X
	Endocrinology/Diabetes/Metabolism	048	207R00000X	207RE0101X
	Multiple Specialties (applicable only to a group)	049	193200000X	
	Addictionologist	050	207L00000X	207LA0401X

	Addictionologist	050	207Q00000X	207QA0401X
	Addictionologist	050	207R00000X	207RA0401X
	Addictionologist	050	N/A	2083A0300X
	Addictionologist	050	N/A	2084A0401X
	Cardiac or Peripheral Vascular Surgery	140	208600000X	2086S0129X
	Critical Care	141	207R00000X	207RC0200X
	Genetic Counseling	142	N/A	207ZP0007X
	Hospitalist	143	208M00000X	
	Oral & Maxillofacial Surgery	144	122300000X	1223S0112X
	Rheumatology	145	207R00000X	207RR0500X
	Sleep Medicine	146	207R00000X	207RS0012X
	Sleep Medicine	146	207Q00000X	207QS1201X
	Sleep Medicine	146	207Y00000X	207YS0012X
	Sleep Medicine	146	208000000X	2080S0012X
	Sleep Medicine	146	N/A	2084S0012X
	Sports Medicine	147	207Q00000X	207QS0010X
	Sports Medicine	147	208000000X	2080S0010X
	Sports Medicine	147	207P00000X	207PS0010X
	Sports Medicine	147	207R00000X	207RS0010X
	Sports Medicine	147	207X00000X	207XX0005X
	Sports Medicine	147	208100000X	2081S0010X
	Sports Medicine	147	N/A	2083S0010X
	Sports Medicine	147	N/A	2084S0010X
	Transplant Surgery	148	204F00000X	
	Autism Evaluation Practitioner (AEP) (not applicable to a group)	150	208000000X	2080P0008X
	Autism Evaluation Practitioner (AEP) (not applicable to a group)	150	N/A	2084P0005X
305	**Physician Assistant**	N/A	363A00000X	
306	**Clinical Nurse Specialist, Medical**	N/A	364S00000X	364SM0705X
311	**Clinic, Diagnostic & Treatment Center**	N/A	261Q00000X	261QM2500X
312	**Clinic, Family Planning**	N/A	261Q00000X	261QF0050X

313	**Clinic Federally Qualified Health Center (FQHC)**		261Q00000X	261QF0400X
	Mobile Resp and Stab Svcs (MRSS)	139		
	Mobile Crisis Team (MBLCRSTM)	149		
	School Based Health Center	190		
	Medical Only	191		
	Medical and Dental	192		
	Medical, Dental, and Behavioral Health	193		
	Medical and Behavioral Health	194		
314	**Clinic, Rural Health Medical, freestanding**	N/A	261Q00000X	261QR1300X
315	**Clinic, Rural Health Medical, hospital based**	N/A	261Q00000X	261QR1300X
316	**Nurse, Certified Nurse Practitioner (CNP)**			
	General	090	363L00000X	363LP2300X
	Family Practice	091	363L00000X	363LF0000X
	Pediatrics	092	363L00000X	363LP0200X
	Obstetrical	093	363L00000X	363LX0001X
	Psychiatric	097	363L00000X	363LP0808X
317	**Nurse, RN**			
	Psychiatric RN	059	163W00000X	163WP0808X
	School Nurse	094	163W00000X	163WS0200X
	Other RN	096	163W00000X	
	Home Visiting Agency	202	251J00000X	
318	**Nurse, Certified Registered Nurse Anesthetists (CRNA)**	N/A	367500000X	
319	**Anesthesiologist Assistant**	N/A	367H00000X	
320	**Pharmacist Clinician**	N/A	183500000X	1835P0018X
321	**School Based Health Center (Non-FQHC)** **NOTE: if site is certified as an FQHC, must enroll as provider type 313 - FQHC with specialty 190-SBHC**	N/A	261Q00000X	261QS1000X
322	**Midwife, Certified Nurse**	N/A	367A00000X	
323	**Midwife, Licensed (Non-Nurse)**	N/A	176B00000X	

324	**Nursing Agency, Private Duty**		251J00000X	
	EPSDT Nursing Services (Medically Directed)	N/A		
	EPSDT Personal Care (Non Medically Directed)	N/A		
325	**Podiatrist**	N/A	213E00000X	
331	**Audiologist**	N/A	231H00000X	
333	**Dietician/Nutritionist**	N/A	133V00000X	
333	**Dietician/Nutritionist**	N/A	133N00000X	
334	**Optician**	N/A	156F00000X	156FX1800X
335	**Optometrist**	N/A	152W00000X	
338	**Prosthetist and/or Orthotist**	N/A	224P00000X	
338	**Prosthetist and/or Orthotist**	N/A	222Z00000X	
341	**Chiropractor**	N/A	111N00000X	
342	**Crisis Triage Center Licensed (CTC)**		261Q00000X	261QM0801X
	Mobile Resp and Stab Svcs (MRSS)	139		
	Mobile Crisis Team (MBLCRSTM)	149		
	CTC residential or both residential and non residential	246		
	CTC Non-Residential Only	247		
343	**Opioid Treatment Program (OTP)**	N/A	261Q00000X	261QM2800X
344 (Note: FFS only)	**Home & Community Based Services (Waiver)**		261Q00000X	261QC1500X
	Developmentally Disabled Waiver	070		
	Supports Waiver (effective 7/1/2020)	072		
	Medically Fragile Waiver	073		
	DD Waiver Case Management	074		
	Community Supports Coordination	076		
	Medically Fragile Waiver Case Management	077		
345	**Schools**	N/A	251300000X	
346	**Lodging, Meals**	N/A	177F00000X	
346	**Lodging, Meals**	N/A	174200000X	
351	Lab, Clinical Freestanding	N/A	291U00000X	

352	Radiology Facility	N/A	261QR0200X	
353	Laboratory, Clinical with Radiology	N/A	291U00000X	
354	Laboratory, Diagnostic, for Tests and Measurements	N/A	293D00000X	
361	Home Health Agency	N/A	251E00000X	
362	Hospice	N/A	251G00000X	
362	Hospice	N/A	315D00000X	
363	Community Benefit Provider - MCO Only		253Z00000X	
	Nursing Respite	173		
	Behavior Support Consultation	174		
	Emergency Response	175		
	Employment Supports	176		
	Environmental Modifications	177		
	Home Health Aide	178		
	Private Duty Nursing for Adults	179		
	Respite	180		
	Skilled Maintenance Therapy	181		
	Personal Care	182		
	Assisted Living	183	310400000X	
	Adult Day Health	184		
	Community Transition Services	185		
	Occupational Therapy for Adults	186		
	Physical Therapy for Adults	187		
	Speech Therapy for Adults	188		
	Nutritional Counseling	189		
364	Ambulatory Surgical Center	N/A	261Q00000X	261QA1903X
401	Ambulance, Air	N/A	341600000X	3416A0800X
402	Ambulance, Ground	N/A	341600000X	3416L0300X
403	Handivan	N/A	343900000X	
403	Handivan	N/A	343800000X	
404	Taxi or MCO General Transportation Contractor (non-capitated)	N/A	344600000X	

405	Birth Center, Licensed	N/A	261Q00000X	261QB0400X
406	Reproductive and Child Health Para Professional	207	174N00000X	
411	Pharmacist General		183500000X	
412	Hearing Aid Supplier	N/A	332S00000X	
414	Medical Supply/Durable Medical Equipment provider (DME)	N/A	332B00000X	
	Human Donor Milk Supplier (HDMS)	208		
415	IV Infusion Services	N/A	251F00000X	
416	Pharmacy		333600000X	
	In-State Pharmacy	N/A		
	IHS or Tribal 638 Pharmacy	N/A		
	Out of State	N/A		
417	**Pharmacy, Rural Health Clinic**	N/A	333600000X	3336C0002X
421	**Dentist**			
	General Dentistry	055	122300000X	1223G0001X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223D0001X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223D0004X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223E0200X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223P0106X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223X0008X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223S0112X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223X2210X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223X0400X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223P0221X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223P0300X
	Oral Surgery, Endodontics, Other Specialty	056	122300000X	1223P0700X
422	**Dental Clinic, Rural Health**	N/A	261Q00000X	261QD0000X
423	**Dental Hygienist**			
	Collaborative Practice	160	124Q00000X	
	Not in Collaborative Practice	161	124Q00000X	
430	**Behavioral Health Worker**			

	Behavior Technician (BT) **Includes: Board Certified Autism Technician (BCAT) Registered Behavior Technician (RBT)** **or**	098	106S00000X	
	Non-Certified Behavior Technician			
	Behavioral Management Service (BMS) Worker	113	172V00000X	
	Peer Support Worker, Certified	114	175T00000X	
	Family Support Worker, Certified	115	175T00000X	
	Community Support Worker	116	172V00000X	
	Board Certified Assistant Behavior Analyst (BCaBA)	151	106E00000X	
	Psychiatric Nurse RN (not board certified)	248	163W00000X	163WP0808X
431	**Psychologist, (Ph.D., Ed.D., Psy.D.)**		103T00000X	
	Not Certified for Prescribing	111		
	Certified for Prescribing	112	103T00000X	103TP0016X
	Functional Family Therapy (FFT)	135		
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
	Autism Evaluation Practitioner (AEP) (not applicable to a group)	150		
432	**Behavioral Health Agency**		251S00000X	
	Behavioral Management Services (BMS)	081		
	Day Treatment Services	082		
	Comprehensive Community Support Services (CCSS)	107		
	Intensive Out Patient (IOP)	108		
	Assertive Community Treatment (ACT)	130		
	Multi-Systemic Therapy (MST)	131		
	Autism Disorder Applied Behavior Analysis (ABA) Services	132		

	Functional Family Therapy (FFT)	135		
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
	Evaluation and Therapies	133		
	Mobile Resp and Stab Svcs (MRSS)	139		
	Mobile Crisis Team (MBLCRSTM)	149		
	Crisis Services Community Provider	251		
433	**Clinic, Mental Health Center - DOH Certified (CMHC)**		261Q00000X	261QM0801X
	Adult Psychological Rehabilitation Services	080		
	Behavioral Management Services (BMS)	081		
	Day Treatment Services	082		
	Comprehensive Community Support Service (CCSS)	107		
	Intensive Out Patient (IOP)	108		
	Assertive Community Treatment (ACT)	130		
	Multi-Systemic Therapy (MST)	131		
	Autism Disorder Applied Behavior Analysis (ABA) Services	132		
	Evaluation and Therapies	133		
	Functional Family Therapy (FFT)	135		
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
	Mobile Resp and Stab Svcs (MRSS)	139		
	Mobile Crisis Team (MBLCRSTM)	149		
435	**Licensed Professional Clinical Counselor (LPCC)**		101Y00000X	101YP2500X
	LPCC	240		

	Functional Family Therapy (FFT)	135		
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
436	**Licensed Marriage & Family Therapist (LMFT)**		106H00000X	
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
	LMFT	242		
438	**Psychologist School Certified**	N/A	103T00000X	103TS0200X
440	**Substance Abuse Counselor**		101Y00000X	101YA0400X
	Licensed Alcohol & Drug Abuse Counselor (LADAC)	124		
	Licensed Substance Abuse Associate (LSAA)	125		
	Certified Alcohol and Drug Abuse Counselor (CADC)	250		
441	**Developmental Delay Service**		222Q00000X	
	Early Intervention Services	083		
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0808X
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0809X
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0807X
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0810X
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0811X
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0812X
443	**Psychiatric Clinical Nurse Specialist**	N/A	364S00000X	364SP0813X
444	**Social Worker, Licensed Clinical (LCSW)**		104100000X	
	Functional Family Therapy (FFT)	135		
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		

	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
	Licensed Clinical Social Worker (LCSW)	244	104100000X	1041C0700X
445	**Counselors, Therapists, and other Social Workers**		101Y00000X	101YM0800X
	Licensed Associate Marriage and Family Therapist (LAMFT)	058	106H00000X	
	Licensed Master's Level Social Worker (LMSW)	087	104100000X	
	Psychologist Associate	088	103T00000X	
	Behavior Analyst Board Certified Behavior Analyst (BCBA or BCBA-D)	099	103K00000X	
	Licensed Baccalaureate Social Worker (LBSW)	119	104100000X	
	Licensed Mental Health Counselor (LMHC) Licensed Professional Counselor (LPC)	122		
	Licensed Professional Art Therapist (LPAT)	123	221700000X	
	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
	Behavior Analyst approved for ABA specialty care Board Certified Behavior Analyst (BCBA or BCBA-D)	253	103K00000X	
	Intern	254		
446	**Core Service Agency (CSA)**		251S00000X	
	Adult Psychological Rehabilitation Services (PSR)	080		

447	**Renal Dialysis Facility**	N/A	261Q00000X	261QE0700X
451	**Occupational Therapist (OT), Licensed & Certified**	N/A	225X00000X	
452	**Occupational Therapist (OT), Licensed, Not Certified**	N/A	225X00000X	
453	**Physical Therapist (PT), Licensed & Certified**	N/A	225100000X	
454	**Physical Therapist (PT), Licensed, Not Certified**	N/A	225100000X	
455	**Rehabilitation Facility, Comprehensive Outpatient (CORF)**	N/A	261Q00000X	261QR0400X
457	**Speech Therapist, Licensed (SLP)**	N/A	235Z00000X	
458	**Speech Therapist for Children, (SLP) School Certified**	N/A	235Z00000X	
462	**Case Management Agency**		251B00000X	
	Case Management Medically at risk children **Early Periodic Screening, Diagnostic & Treatment** **(EPSDT)**	061		
	Case Management Developmentally Disabled Children	062		
	Case Management Developmentally Disabled Adults	063		
	Case Management Maternal and Child Care (Families First)	064		
	Case Management Traumatic Brain Injury (TBI)	065		
	Certified Community Health Worker (CHW)/Community **Health Representative (CHR)**	230		
901	**Acupuncturist, Licensed or Doctor of Oriental Medicine (DOM)** **MCO only**	N/A	171100000X	
904	**Physical Health Enhanced Service or Enhanced Service Provider** **MCO only**	N/A	261Q00000X	
905	**Rehabilitation Center, not certified MCO only**	N/A	261Q00000X	261QR0400X
922	**Behavioral Health Enhanced Service or Enhanced Service Provider** **MCO only**	N/A	251S00000X	
	Functional Family Therapy (FFT)	135		

	Trauma-focused cognitive behavioral therapy (TF-CBT)	136		
	Eye movement desensitization and reprocessing (EMDR)	137		
	Dialectical Behavior Therapy (DBT)	138		
923	**Promotora or Other Non-Traditional Healers MCO only**	N/A	174H00000X	

Use Of Location Zip Code

When an individual provider has more than one location, special procedures apply.

If it is not possible for the provider to obtain different NPI numbers for each location, the best alternative for a provider may be to work with the NM Taxation and Revenue Department to see if the business qualifies for one tax rate. Refer to the publication FYI 200 at https://www.tax.newmexico.gov/forms-publications/ on the NM Tax and Rev web site or call a NM Tax and Rev district office.

If the above alternatives are not possible, the billing provider ZIP code on the encounter must be the ZIP code for the physical location which matches the Medicaid ID number for that location. For example, if an individual provider were an optometrist who has individual Medicaid ID numbers for practices in Santa Fe and Taos but only one NPI for both locations, the optometrist's encounter must contain the NPI, taxonomy, and the ZIP code for either the Santa Fe or Taos location, depending at which location the service took place. CONDUENT will then associate the NPI and zip code with the correct Medicaid ID number and make payment at the correct tax rate.

When the multiple Medicaid ID numbers are for locations that are individually certified or

licensed, such as hospitals and nursing facilities, the Medical Assistance Division expects the provider to have separate NPI for each location.

9.6 Reporting of MCO Paid Amount

The MCO Paid Amount is reported on the 837 in the HCP01 segment and on the NCPDP in the Gross Amount Due field. The pricing process code in the 837 HCP02 is used to describe the payment being reported. The NCPDP amount must always be the amount paid to the Pharmacy. The following guidelines are to be followed in reporting the paid amount on the 837. The MCO should make every effort to report an amount of payment for the service, including providing an FFS equivalent if the service was capitated. Only the conditions that meet pricing process, code 00 and 04, will be allowed to reflect a $0 Paid Amount ***and must always reflect a $0 payment***.

00 Zero Pricing (Not Covered Under Contract)	Use online pricing to indicate line(s) not priced because service has been reimbursed through other means. Vaccines are the best example of this. They are a service rendered but may have

	been paid through DOH vaccines program. MCO Paid Amt will be expected to be zero on the line, but the line is not considered to be denied.
01 Priced as Billed at 100%	
02 Priced at the Standard Fee Schedule	
03 Priced at a Contractual Percentage	
04 Bundled Pricing	Use online pricing to indicate line(s) not priced individually but included in bundled payment amount shown on another line. MCO Allowed Amt will be expected to be zero on the line, but the line is not considered to be denied.
05 Peer Review Pricing	
07 Flat Rate Pricing	
08 Combination Pricing	
09 Maternity Pricing	
10 Other Pricing	Use if MCO Allowed Amount reflects an FFS equivalent. MCO and subcontractor have not paid this amount as the service is capitated and only a PMPM has been paid for the services reflected on the claim or the service has been rendered by an employee of the MCO and thus hasn't incurred a direct payment amount. The MCO Allowed Amount must not be 0.
11 Lower of Cost	
12 Ratio of Cost	
13 Cost Reimbursed	
14 Adjustment Pricing	

9.7 Report of COB and CAS on Encounters

Exception 0162 (CMdS 64110) is the edit that will be posted if an out of balance situation exists for claims with COB and CAS reported. The exception balances header to header and line to line as shown here:

Edit 0162 (CMdS 64110) will postwhen:

- If line Level COB is present, the sum of the 2400 SVC203 loop (C-TOT-CHRG-AMT) must equal the sum amounts in loop 2430 CAS Service Line Adjustments (C-CAS-AMT) + Sum of amounts in loop 2430 SVD02 Service Line Paid Amount (C-LI-PYR-PYMT- AMT)
- If only header level COB is present, the header amounts must balance (PLEASE NOTE: if line COB is present, even if the header amounts balance, the edit will still post if the line levels don't balance).

- Loop 2300 CLM02 Total claim Charge Amount (C-TOT-CHRG-AMT) must equal Sum amounts in Loop 2320 CAS Header Service Adjustments (C-CAS-AMT) + Loop 2320 AMT Claim Paid Amount (C-COB-PYR-PYMT-AMT)

9.8 Reporting of Interest payments

The requirement for Interest payments is stated in the MCO's contract which refers to New Mexico Administrative Code.

4.19.1.7 Paying interest as required in Paragraph (1) of subsection 8.308.20.9 (E) of NMAC;

NMAC says:

The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current Medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HCA/MAD.

As clarification of this, Interest is calculated on the amount due or paid (not the amount billed). Prompt Pay interest begins to accrue on an untimely paid clean claim on the first day after the deadline for payment and ends on the date of payment. Thus, interest in the electronic clean claims starts to accrue on the 31st calendar day following receipt without payment. Interest in manual clean claims starts to accrue on the 46th day following receipt without payment.

The MCO shall not be required to pay any interest calculated to be less than two dollars ($2.00). The interest shall be paid within 30 days of the payment of the claim

1 MCOs are instructed to report on the encounter of any interest paid on a claim or claim line by using a CAS segment. The CAS reason code for Interest payment is 225 Interest Payment by Payer. On the encounters, interest is to be reported at the header level. If reporting interest payment without any other third-party payment (amount the MCO paid is not a third-party payment), enter SBR segments as follows based on the number of payers on the claim, using the 2320 Payer code 'ZZ' for the interest payment.

SBR values when paid interest		
SINGLE PAYER		
2000B	S	MC
2320	P	ZZ
TWO PAYER MEDICARE		
2000B	T	MC
2320 1st	S	ZZ
2320 2nd	P	MB
TWO PAYER COMMERCIAL		
2000B	T	

		MC
2320 1st	S	ZZ
2320 2nd	P	CI
THREE PAYER 2000B		
	A	MC
2320 1st	T	ZZ
2320 2nd	P	MB
2320 3rd	S	CI

1 The MCO reports the interest payment in the 2320 Loop like this:
   - CAS*OA*225*3.00 (example interest amount) AMT* D*0
2 The MCO must include the 2330A NM1 and N4 spans for the claim to pass EDI edits.
3 If reporting interest payment where there is also some other third-party payment, the balancing rules must be followed which means that all the third-party payments must be included on the claim, along with CAS segments that fully balance up to the Billed Charges (either Total Billed Charges at the header or lines balance with billed charges at the line).

The interest payment is to be included in the overall MCO Payment Amount reported in the HCP segment. For claims where the payment amount HCP02 segment is only reported at the line level, add the interest amount on the first service line.

9.9 ENCOUNTER EDITING

The MMIS checks for duplicates and validates the encounter input against the Client Eligibility, Provider, and Procedure Formulary File, appending critical information to the individual encounters. The duplicate checking process compares the MCO ICN of the next record to the previous record within the same file and to any in-history MCO ICN. If MCO ICN is the same, the duplicate record is denied. Duplicate checking also checks the in process encounter to history encounters checking the Dates of Service, Provider, Client, and service information to identify duplicates of encounters previously paid.

The first step in Encounter adjudication involves assigning a claim type to the encounter. This claim type assignment is integral to the editing of the claim. The procedure and revenue reference files all contain a table of allowed claim types and as you can see from the chart below, only certain provider types are allowed for certain claim types:

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
I	UB-04	Inpatient	Batch Type U – UB-04 (OR)========== Batch Type A – UB-04 Crossover	Type of Bill = 11X 12X 621 AND Provider Type = 201-205, 216, 221 (OR)========== Type of Bill = 11X 12X AND Provider Type = 201-205 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) (OR)========== Type of Bill = 12X AND Batch Document Type Code not equal “E” (Encounter) (OR)========== Type of Bill = 11X or 12X AND Provider Type = 922 or 904 AND Batch Document Type Code equal “E” (Encounter)	General Hospital Mental Hospital (OR)========== (for X12N-ADJ, X12N and type of bill code digits 1-2 = 12) AND Batch Document Type Code not equal “E” (Encounter) OR Value Code = XO AND Type of Bill – 11X 12X AND Batch Document Type Code not equal “E” (Encounter)

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
O	UB-04	Outpatient Note: This is	Batch Type U – UB-04	Type of Bill = 13X 71X 72X	Outpatient Hospital Rural Health Clinic Freestanding Dialysis Center

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
		the default code for UB-04's.	(OR)========== === Batch Type A – UB-04 Crossover	73X 74X 75X 76X 77X 84X AN D Provider Type = 201-205, 221, 313, 314,315, 455, 447 OR Claim Type not previously assigned as CT 1, N, V or H. Provider type 364 and 218 would fall into this category. (OR)========== Type of Bill = 13X 71X 72X 73X 74X 75X 76X 77X 84X AND Provider Type = 201-205, 315 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND	Freestanding FQHC Outpatient Rehabilitation Facility Ambulatory Surgery Center Freestanding Birthing Center

				There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
N	UB-04	Long Term Care	Batch Type U – UB-04 (OR)========== ===	Type of Bill = 11X 65X 66X 69X 86X 89X AND Provider Type = 211-215, 216-217, 219, 221 (OR) Batch Document Type Cd = “E” (Encounter) AND Type of Bill = 11X 65X 66X 69X 86X 89X 21X 22X AND Provider Type = 211-215, 18, 219, 221	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
			Batch Type A – UB-04 Crossover	(OR)========== Type of Bill = 11X 65X 66X 69X 86X 89X AND Provider Type = 216 AND	
				Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	
P	CMS-1500	Practitioner/Physician Note: This is the default code for CMS-1500's.	Batch Type H – CMS- 1500 (OR)========== == === Batch Type B – HCFA Crossover	Claim Type not previously assigned as CT L, S, T, W, or X. (OR)========== Claim Type not previously assigned as CT L, S, T, W, or X. AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	Edit 0032 (Provider Type/Claim Type Conflict) posts if default is assigned.
D	ADA Dental	Dental	Batch Type D – ADA Dental		

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
L	CMS-1500	Independent Laboratory, X- Ray	Batch Type H – CMS- 1500 (OR)========== === Batch Type B – HCFA Crossover	Provider Type = 351-354 (OR)========== Provider Type = 351-354 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	
S	CMS-1500	Medical Supply	Batch Type H – CMS- 1500 (OR)========== === Batch Type B – HCFA Crossover	Provider Type = 336-338, 411, 414-417 (OR)========== Provider Type = 336-338, 411, 414-417 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
V	UB-04	Home Health	Batch Type U – UB-04 (OR)========== === Batch Type A – UB-04 Crossover	Type of Bill = 32X (Discontinued as of 02/27/14) 33X 34X AND Provider Type = 361 (OR) Batch Document Type Cd = “E” (Encounter) AND Type of Bill = 32X (Discontinued as of 02/27/14) 33X 34X AND Revenue Code '0550' THRU '0559', '0570' THRU '0579', '0580' THRU '0589', '0590' THRU '0599'. OR Provider Type = 361 (OR)========== Type of Bill = 32X (Discontinued as of 02/27/14) 33X 34X AND	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
				Provider Type = 361 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an IHS Facility AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	
T	CMS-1500	Transportation	Batch Type H – CMS- 1500 (OR)========== Batch Type B – HCFA Crossover	Provider Type = 401-405 (OR)========== Provider Type = 401-405 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND There is no Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
A	UB-04	Mcare Part A Crossover	Batch Type A – UB-04 Crossover	Type of Bill = 110-118 180-188 210-218 280-288 410-418 510-518 61X AND Header Medicare Allowed Amount is greater than 0 OR Provider Billing Code is not Unrestricted or Billing Only OR Provider Billing Type is 211-215, 217-218, 221 OR An IHS Facility OR There is an Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	
B	CMS-1500	Mcare Part B Crossover	Batch Type B – CMS- 1500 Crossover	Header Medicare Allowed Amount is greater than 0 OR Provider Billing Code is not Unrestricted or Billing Only OR There is an Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810) AND Provider Billing Type is not 341, 344, 363, 447, 705, 463-999	
C	UB-04	Mcare UB-04 Part B	Batch Type A– UB-04 Crossover	Type of Bill =120-128 131-135	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
		Crossover		137-138	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments
		Note: This is the default code for UB-04 Crossover's.		13P 13I 141 145 147-148 22X 231 235 237-238 241 245 247-248 331-335 337-338 341-344 62X 711-715 717-718 721-725 727-728 741-745 747-748 75X 76X 811-815 817-818 821-825 827-828 831-835 837-838 AND Header Medicare Allowed Amount is greater than 0 OR Provider Billing Code not Unrestricted or Billing Only OR Provider Billing Type is 221, 313-314, 455 OR An IHS Facility OR	

				There is an Administrative Claim Adjustment Segment (CAS) for the Medicare Payer. (system list 4810)	

Claim Type	Claim Form	Claim Type Description	Batch/Invoice Type	Assignment Criteria	Other Criteria/Comments

H	UB-04	Hospice	Batch Type U – UB-04 (OR)========== == === Batch Type A – UB-04 Crossover	Type of Bill = 81X 82X AND Provider Type = 362 (OR) Batch Document Type Cd = “E” (Encounter) AND Type of Bill = 81X 82X AND Revenue Code '0650' THRU '0658' (OR)========== Type of Bill = 81X 82X AND Provider Type = 362 AND Header Medicare Allowed Amount = 0 AND Provider Billing Code is Unrestricted or Billing Only AND Not an HIS Facility AND There is no Administrative Claim Adjustment Segments (CAS) for the Medicare Payer. (system list 4810)	Hospice

Once the claim type is assigned, the system attempts to match the NPI, taxonomy and zip code on the claim to the correct provider record in Turquoise Claims. See section **NPI Specific Instruction** for more information on this. Further editing ensures the client is eligible and enrolled with the MCO on the dates of service and that the service is allowed for that claim type and provider type and type of bill (if it’s an institutional claim). The reference files listed in the Reference File section can be used by the MCOs to ensure their own edits are in synch with how Turquoise Claims is edited. **However, please note,** these tables simply show all provider types allowed for all codes and all claim types allowed for all codes. But the system is only going to allow if the claim type, provider type and service code all agree. So, for

example, the revenue code file that shows allowed type of bill codes will show ALL allowed type of bill codes but based on the provider who is billing and the claim type that's been assigned, only certain type of bill codes is allowed for that given combination.

The validation process includes edits that are set to "Pay and Report", "Deny and Report", and "Deny". "Pay and Report" edit exceptions post when there is an error in the information in a field, but the error is not determined to be critical to the acceptance of the line item/encounter, so the encounter/line is accepted. Only those encounter line items that receive a "Pay" status or a "Pay and Report" edit exception are accepted as Paid by HCA's system. The "Deny and Report" status is set for adjustment rejection edits and services such as Abortion that can't be paid with federal funds.

The errors are accumulated and if the batch has denied errors, the MCO is required to correct the encounters reported as "Deny" errors and resubmit them within 30 days of the error report. If the error represents what the MCO believes is an accurate payment, the claim should be sent to HCA for evaluation.

9.9.1 Duplicate Processing and the Use of Modifiers

Duplicate processing is the same for all encounter claim types. An encounter is denied as a duplicate when the conditions on the Duplicate Editing Chart that follows are met. Duplicate processing will not record as a duplicate when these fields match within the same encounter (i.e., ICN.). When an encounter denies because of a duplicate, the error message on the Denied Encounter Adjudication Cycle Detail Report will show the MCO's ICN # that the encounter duped against.

To avoid having encounters that the MCO considers valid denying as duplicates, (i.e., the MCO is submitting a second claim for the same client, same date of service, same provider and same procedure code but the MCO has allowed the service but our system will deny as a duplicate) the MCO can use a valid modifier to differentiate the service as a non-duplicate service for any HCPC procedure. Whenever possible, the differentiating modifier should be specific to the procedure and those modifiers allowed for that procedure code. And the differentiating modifier would not be needed for the first occurrence of a service but would be used for the second occurrence of the service code for the same dates of service, same provider, and same enrollee (e.g., U1). The non-specific series U1-U9 can be used to differentiate, except for Dental procedures which don't allow these modifiers. A third occurrence of the same procedure code would thus require use of a different modifier (e.g., U2), and so on. If the service is already defined using one of these modifiers, the MCO could use a second modifier to further differentiate the services. For example, the service is defined by the procedure and modifier U1, the MCO would submit the second occurrence of this service for the same client, same day, same provider with a U1 and a U2 modifier.

Effective June 15, 2026, MCOs are no longer allowed to make claim corrections when a healthcare provider sends a claim with incorrect or incomplete information, the MCO cannot fix the claim on behalf of the provider any longer.

9.9.2 Duplicate Encounter Edit Table

The following charts define how Encounter Exceptions work for different claim types: **Note:** The following service versus same service edits must be turned on for either FFS or Encounter to post. If they

are not turned on, they will not post. However, the system supports all service versus same service edits for both FFS and Encounter.

Table 3 – Duplicate Encounter Edit Table

Claim Type = I (Inpatient) and none of the lines of the claim contains revenue code = 0169

Same Provider – Exception 1361 (CMdS 6600)	Same Provider – Exception 1362 (CMdS 65011)
Same client ID. (B_SYS_ID) Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) The New Mexico Turquoise Claims MMIS does not post this exception if only one of the claim's revenue codes is between 0810 and 0819 or between 0890 and 0899	Same client ID. (B_SYS_ID) Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371(CMdS 65017,6604)	**Different Provider – Exception 1372 (CMdS 65018)**
Same client ID (B_SYS_ID) Same or overlapping dates of service; see Note 3 (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID)	Same client ID. (B_SYS_ID) Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different from dates. (C_HDR_SVC_FST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) The claim with the earliest from date does not have the same admission date and through date. (C_HDR_ADMIT_DT C_HDR_SVC_LST_DT) The claim with the earliest from date has a hospital pay mode of "C" (DRG).

	(C_BSE_AMT_SRC_CD) The claim with the earliest from date does not have a patient status of "02" (discharge/ transferred to another short-term general hospital for inpatient care). (C_PAT_STAT_CD)

Claim Type = I (Inpatient) and one of the lines of the claim contains revenue code = 0169 = Awaiting Placement Edits Post to Header

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)
Same client ID. (B_SYS_ID) Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)	Same client ID. (B_SYS_ID) Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371(CMdS 65017,6604)	**Different Provider – Exception 1372(CMdS 65018)**
Same client ID. (B_SYS_ID) Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = O (Outpatient) and Type of Bill NOT 71x, 72x, 73xor 79x	**Edits Post to Line**
Same Provider – Exception 1361(CMdS 65010,6600)	
Same client ID.(B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code or modifier; see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R-PROC-MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology. The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim, The system will bypass the edit If the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim, bypass exception. For Outpatient claims, bypass if rendering providers are not equal and either rendering provider is BH OR attending providers are not equal and either attending provider is BH AND Billing Provider Type = 221, 313, 314, or 315 No AND one of the following is true: TOB 73X or 79X TOB 71X and Billing Prov Type 314 or 315 TOB NOT 71X, 72X, 73X or 79X BH is defined as provider type: '204' '205', '216' THRU '219', '304',	

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  '342' THRU '343',
  '430' THRU '433',
  '435' THRU '441',
  '443' THRU '446',
  '922'.
OR C-BLNG-SPECL-CD:
  '026' '047' '050' '058' '059',
  '062' '063',
  '080' THRU '084',
  '086' THRU '089',
  '097' THRU '099',
  '103' '107' '108'
  '111' THRU '117',
  '119'
  '122' THRU '125',
  '130' THRU '133',
  '150' THRU '151',
  '193' THRU '194',
  '240' THRU '248',
  '250' THRU '251',
  '253' THRU '256',
  '260' THRU '262
```

For Outpatient claims, bypass the edit if the PROVIDER TYPE is (221, 313, 314, OR 315) AND The primary diagnosis on the in process is different from the primary diagnosis on the history claim

Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372(CMdS 65018)
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code or modifier; see Notes 5a, 5b. (R_REV_CD or R_PROC_CD or R-PROC-MOD) Same billed charge. (C_LI_SUBM_CHRG_AMT) The servicing provider type (P_TY_CD from C_LI_TB) on both claims is not “221” (Indian health services hospital).	Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code or modifier; see Notes 5a, 5b and 16. (R_REV_CD or R_PROC_CD or R-PROC-MOD) Same billed charge. (C_LI_SUBM_CHRG_AMT) The servicing provider type (P_TY_CD from C_LI_TB) on both claims is “221” (Indian health services hospital).

Claim Type = O (Outpatient) and Type of Bill = 73x and 79X = Federally Qualified Health Center (FQHC) Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology. The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim. The system will bypass the edit If the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim, bypass. Exception 1361(CMdS 65010,6600)	
Different Provider – Exception 1371(CMdS 65017,6604)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD)	

Claim Type = O (Outpatient) and Type of Bill = 72x = Renal Dialysis	**Edits Post to Line**
Same Provider – Exception 1361(CMdS 65010,6600)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Same enterprise provider number.	

(C_BLNG_NTRPRS_ID) 4. Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology.

Different Provider – Exception 1371(CMdS 65017,6604)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD, or R_PROC_MOD)	

Claim Type = O (Outpatient) and Type of Bill = 71x and NM Prov. Type = 315 = Rural Health Clinic – Free Standing Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD, or R_PROC_MOD The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology.	
Different Provider – Exception 1371(CMdS 65017,6604)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim,	

Claim Type = O (Outpatient) and Type of Bill = 71x and NM Prov. Type = 314 = Rural Health Clinic – Hospital Based Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD) The system will bypass the edit if one of the claims has a modifier 76 or 77 and the other doesn't. The system will bypass the edit if one of the claims has a modifier 59 and the Service area is Pathology. The system will bypass the edit if the Billing Provider Type is 221, 313, 314, 315 and the rendering provider on the in process is different from the rendering provider on the history claim.	
Different Provider – Exception 1371(CMdS 65017,6604)	
Same client ID. (B_SYS_ID) Same date of service. (C_LI_FST_DOS_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16. (R_REV_CD or R_PROC_CD or R_PROC_MOD)	

Claim Type = N (Long Term Care) Edits Post to Header

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)

Same client ID. (B_SYS_ID) Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)	Same client ID. (B_SYS_ID) Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371(CMdS 65017,6604)	
Same client ID (B_SYS_ID) Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = P (Practitioner/Physician) and NM Prov. Type NOT = (364, 324, 342-343, 346, 441, 462, 363, 901, 431-433, 435-437, 443-446, 451-455, 457-458, 904-906, 331, 334-335, or 412) **Edits Post to Line**

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1363(CMdS 65012)	Same Provider – Exception 1364(CMdS 65013)	Same Provider – Exception 1365(CMdS 65014)	Same Provider – Exception 1366(CMdS 65015)
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT _CD)	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number Same procedure code; see Note 16. (R_PROC_CD) Same service component code.	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number Same procedure code; see Note 16. (R_PROC_CD) Same service component code.	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number Same procedure code; see Note 16. (R_PROC_CD) Same service component code.	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number The paid claim's service component code is "2" (surgery) and the in- process claim's service component code is "8" (assistant surgery).	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number The in-process claim's service component code is "2" (surgery) and the paid claim's service component code is "8" (assistant surgery).

The history and in-process claims' lines have the same modifiers The New Mexico Turquoise Claims MMIS does not post this exception if one of the following conditions occurs; see Notes 10, 11, 12, 13 and 14.	(C_SVC_COMPONENT_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does not post this exception if one of the following conditions occurs; see Notes 10, 11, 12, 13 and 14.	(C_SVC_COMPONENT_CD) The claims meet the conditions in Note 11b. The history and in-process claims' lines have the same modifiers The New Mexico Turquoise Claims MMIS does not post this exception if one of the following conditions occurs; see Notes 10,12 and 13.	(C_SVC_COMPONENT_CD) The claims meet the conditions in Note 13. The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does not post this exception if one of the following conditions occurs; see Notes 10, 12 and 14.	(C_SVC_COMPONENT_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does not post this exception if the servicing provider is a group. (PROV_INDIV_GRP_IND)	(C_SVC_COMPONENT_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does not post this exception if the servicing provider is a group. (PROV_INDIV_GRP_IND)
Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372(CMdS 65018)	Different Provider – Exception 1373(CMdS 65019)	Different Provider – Exception 1374 (CMdS 65030)	Different Provider – Exception 1375(CMdS 65020)	
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	

Different servicing provider number. (C_RNDR_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) Same Billed Charge. The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does **not** post this exception if one of the following conditions occurs; see Notes 9, 10, 11, 13, 14 and 17.	Different servicing provider number. (C_RNDR_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The claims meet the conditions in Note 11b. Same Billed Charge. The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does **not** post this exception if one of the following conditions occurs; see Notes 9, 10, 12, 13 and 14.	Different servicing provider number. (C_RNDR_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The claims meet the conditions in Note 13. Same Billed Charge. The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does **not** post this exception if one of the following conditions occurs; see Notes 9, 10 and 12.	Different enterprise provider number. (C_BLNG_PROV_ID) Same servicing provider number. (C_RNDR_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) Same Billed Charge. The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does **not** post this exception if one of the following conditions occurs; see Notes 10, 11 and 14.	Different servicing provider number. (C_RNDR_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) Same bill charged. (C_LI_SUBM_CHRG_AMT) Same servicing provider specialty. (P_SPECL_CD) The claims meet the conditions in Note 9. The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does **not** post this exception if the claims meet the conditions in Note 10.	

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 364 = Ambulatory Surgical Center Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers on.
Different Provider – Exception 1371(CMdS 65017,6604)	**Different Provider – Exception 1372(CMdS 65018)**
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.	

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 324, 342-343, 346, 441, 462, 363, or 901= Misc/Enhanced EPSDT Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1369(CMdS 65019)
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number.	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number.

(C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers. New Mexico Turquoise Claims does not post this exception if the following condition occurs; see note 14.	(C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.	C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.
Different Provider – Exception 1371(CMdS 65017,6604)		Different Provider – Exception 1379(CMdS 65021)
Same clientID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same Billed Charge The history and in-process claims' lines have the same modifiers. New Mexico Turquoise Claims does not post this exception if the following condition occurs; see note 14.		Same clientID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_ DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_RNDR_NTRPRS_ID FROM C_LI_HCFA1500_TB) Same procedure code, see Note 16. (R_PROC_CD) Same Billed Charge. The HIS claim and the IP claim's lines have the same modifiers.

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 431-433, 435-437, or 443-446 = Psychiatric Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1369(CMdS 65016)
Same clientID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number	Same clientID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number	Same clientID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same Servicing Prov Number or IP Servicing Prov Number equals I Billing Prov Number or IP Billing Prov Number equals I Servicing Provider Number

Same procedure code; see Note 16.(R_PROC_CD) The history and in-process claims' lines have the same modifiers.	Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.	Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.
Different Provider – Exception 1371(CMdS 65017,6604)		Different Provider – Exception 1379(CMdS 65021)
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different enterprise provider number. (C_RNDR_NTRPRS_ID from C_LI_TB) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.		Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different enterprise provider number. (C_RNDR_NTRPRS_ID FROM C_LI_HCFA1500_TB) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 451-455, 457-458, or 904-906 = Rehabilitation Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1369(CMdS 65016)
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers
Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372(65018)	Different Provider – Exception 1379(65021)

Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.		Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers

Claim Type = P (Practitioner/Physician) and NM Prov. Type = 331, 334-335, or 412 = Vision and Hearing Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1369(65016)
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billingprovider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing providernumber. C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers.
Different Provider – Exception 1371(CMdS 65017,6604)		**Different Provider – Exception 1379(65021)**
1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. (C_BLNG_PROV_ID) 4. Same procedure code; see Note 16. (R_PROC_CD)		1. Same client ID. (B_SYS_ID) 2. Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Different billing provider number. C_BLNG_PROV_ID) 4. Same procedure code, see Note 16. (R_PROC_CD)

5. The history and in-process claims' lines have the same modifiers.		The history and in-process claims' lines have the same modifiers

Claim Type = D (Dental) **Edits Post to Line**

Same Provider – Exception 1361(CMdS 65010)
Same client ID. (B_SYS_ID)
Same date of service.
(C_LI_FST_DOS_DT)
Same billing provider number or same servicing provider or IP billing provider equal I servicing provider or IP servicing provider equal I billing provider.
(C_BLNG_PROV_ID)
Criteria to fail exception:
Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is the same on both claims.
Criteria to fail exception:
Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is blank on both claims.
Criteria to bypass the exception:
Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is different on both claims.
Criteria to fail the exception:
Procedure code is the same on both claims and Oral cavity is the same on both claims and Tooth number is blank on one claim and valued on the other.
Criteria to fail the exception:
Procedure code is the same on both claims and Oral cavity is blank on both claims and Tooth number is the same on both claims.
Criteria to fail the exception:
Procedure code is the same on both claims and Oral cavity is blank on both claims and Tooth number is blank on both claims.
Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is different on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is blank on one claim and valued on the other.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is the same on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims.

Criteria to bypass the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on one claim and valued on the other.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is the same on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is different on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on one claim and valued on the other.

Different Provider – Exception 1371(CMdS 65017,6604)

Same client ID. (B_SYS_ID)

Same date of service.

(C_LI_FST_DOS_DT)

Different enterprise provider number.

(C_RNDR_NTRPRS_ID from C_LI_TB)

Criteria to fail exception:

Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is the same on both claims.

Criteria to fail exception:

Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is blank on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is different on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is the same on both claims and tooth number is blank on one claim and valued on the other.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is the same on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is blank on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is different on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on both claims and tooth number is blank on one claim and valued on the other.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is the same on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on both claims.

Criteria to bypass the exception: Procedure code is the same on both claims and oral cavity is different on both claims and tooth number is blank on one claim and valued on the other.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is the same on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on both claims.

Criteria to bypass the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is different on both claims.

Criteria to fail the exception:

Procedure code is the same on both claims and oral cavity is blank on one claim and valued on the other and tooth number is blank on one claim and valued on the other.

Claim Type = L (Independent Laboratory, X-Ray) **Edits Post to Line**

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1363(65012)	Same Provider – Exception 1364(65013)	Same Provider – Exception 1369(65016)

Old – New	Old – 0752	Old – New	Old – New	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number.
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number.	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number.	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	
(C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does <u>not</u> post this exception if one of the following conditions occurs; see Notes 11, 13.	(C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does <u>not</u> post this exception if one of the following conditions occurs; see Notes 11, 13.	(C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The claims meet the conditions in Note 11b. The history and in-process claims' lines have the same modifiers The New Mexico Turquoise Claims MMIS does <u>not</u> post this exception if the claims meet the conditions in Note 13.	Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The claims meet the conditions in Note 13. The history and in-process claims' lines have the same modifiers.	(C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does <u>not</u> post this exception if one of the following conditions occurs; see Notes 11 and 13.
Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372			Different Provider – Exception 1379
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)			Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT)

Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) Different billed charge. (C_LI_SUBM_CHRG_AMT) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does <u>not</u> post this exception if the claims meet the conditions in Notes 11.	Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) Same billed charge. (C_LI_SUBM_CHRG_AMT) The claims meet the conditions in Note 11b. The history and in-process claims' lines have the same modifiers.			Different billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) Same service component code. (C_SVC_COMPONENT_CD) Different billed charge. (C_LI_SUBM_CHRG_AMT) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does **<u>not</u>** post this exception if the claims meet the conditions in Note 11.

Claim Type = S (Medical Supply) **Edits Post to Line**

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1369
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD)	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD)	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD)

The history and in-process claims' lines have the same modifiers The New Mexico Turquoise Claims MMIS does not post this exception if the procedure code modifier on one claim is "LT" (left side of the body) and the procedure code modifier on the other claim is "RT" (right side of the body). (C_PROC_MOD_XXX_CD where XXX = 1^{ST} or 2^{ND} or 3^{RD} or 4^{TH}). Or meets the criteria in Note 14.	The history and in-process claims' lines have the same modifiers. The New MexicoTurquoise Claims MMIS does not post this exception if the procedure code modifier on one claim is "LT" (left side of the body) and the procedure code modifier on the other claim is "RT" (right side of the body). (C_PROC_MOD_XXX_CD where XXX = 1^{ST} or 2^{ND} or 3^{RD} or 4^{TH}). Or meets the criteria in Note 14.	The history and in-process claims' lines have the same modifiers The New Mexico Turquoise Claims MMIS does not post this exception if the procedure code modifier on one claim is "LT" (left side of the body) and the procedure code modifier on the other claim is "RT" (right side of the body). (C_PROC_MOD_XXX_CD (WHERE XXX = 1^{ST} OR 2^{ND} OR 3^{RD} OR 4^{TH})).
Different Provider – Exception 1371(CMdS 65017,6604)		Different Provider – Exception 1379(65021)
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same billed charge. (C_LI_SUBM_CHRG_AMT) The history and in-process claims' lines have the same modifiers		Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD Same billed charge. (C_LI_SUBM_CHRG_AMT) The history and in-process claims' lines have the same modifiers.

Claim Type = V (Home Health) **Edits Post to Line**

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)
Same client ID. (B_SYS_ID) Same datesof service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number.

(C_BLNG_NTRPRS_ID) Same revenue code, see Notes 5b and 16. (R_REV_CD)	(C_BLNG_NTRPRS_ID) 4. Same revenue code, see Note 5b and 16. (R_REV_CD)
Different Provider – Exception 1371(CMdS 65017,6604)	
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code, see Notes 5b and 16. (R_REV_CD)	

Claim Type = T (Transportation) **Edits Post to Line**

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1369(CMdS 65016)
Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) 6. The history and in-process claims' lines have the same modifiers	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers	Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) The history and in-process claims' lines have the same modifiers. The New Mexico Turquoise Claims MMIS does <u>not</u> post this exception if the procedure code is in the additional miles system list (4725)
Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1379	

Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code; see Note 16. (R_PROC_CD) Same billed charge. (C_LI_SUBM_CHRG_AMT) The history and in-process claims' lines have the same modifiers.	Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16. (R_PROC_CD) Same billed charge. (C_LI_SUBM_CHRG_AMT) The history and in-process claims' lines have the same modifiers The New Mexico Turquoise Claims MMIS does **not** post this exception if the procedure code is in the additional miles system list (4725)	

Claim Type = A (Medicare Part A Crossover) and Type of Bill = 11x, 12x, 81x, or 82x = Institutional Part A Crossover Edits Post to Header

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)
Same client ID. (B_SYS_ID) Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)	Same client ID. (B_SYS_ID) Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371(CMdS 65017,6604)	**Different Provider – Exception 1372(CMdS 65018)**
Same client ID. (B_SYS_ID) Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID)	

Claim Type = A (Medicare Part A Crossover) and Type of Bill = 18x, 21x, 22x, 25x, 26x, 27x, 28x, 62x, 65x, 66x, 67x, or 68x = Medicare Long Term Care Part A Crossover Edits Post to Header

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)
1 Same client ID. (B_SYS_ID) 2 Same dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3 Same enterprise provider number. (C_BLNG_NTRPRS_ID)	1 Same client ID. (B_SYS_ID) 2 Overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3 Same enterprise provider number. (C_BLNG_NTRPRS_ID)
Different Provider – Exception 1371(CMdS 65017,6604)	**Different Provider – Exception 1372(CMdS 65018)**
1 Same client ID. (C_BLNG_NTRPRS_ID) (B_SYS_ID) 2 Same or overlapping dates of service; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3 Different enterprise provider number.	

Claim Type = B (Medicare Part B Crossover) Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)	Same Provider – Exception 1363 (CMdS 65012)-Post to Header		

Same client ID. (B_SYS_ID) Same dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, See Note 16b. (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. Same billed amount. The history and in-process claims' lines have the same modifiers.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, See Note 16b. (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. The history and in-process claims' lines have the same modifiers.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Same billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16b (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. The history and in-process claims' lines have the same modifiers. Both claims have the same header deductible.

Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372(CMdS 65018)	Different Provider – Exception 1373 (CMdS 65019)- Post to Header
Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code, See Note 16b. (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. Same billed amount. The history and in-process claims' lines have the same modifiers.		Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) Different billing provider number. (C_BLNG_PROV_ID) Same procedure code, see Note 16b (R_PROC_CD). Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code. The history and in-process claims' lines have the same modifiers. Both claims have the same header deductible amount.

Claim Type = C (Medicare UB92 Part B Crossover) **Edits Post to Header**

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)

Same client ID. (B_SYS_ID) Same dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16b. (R_REV_CD or R_PROC_CD) Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code or the Revenue Code.	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16b. (R_REV_CD or R_PROC_CD) Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code or the Revenue Code.
Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372(CMdS 65018)
. Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code or procedure code, see Notes 5a, 5b, and 16b. (R_REV_CD or R_PROC_CD) Note: If the paid date of the history claim is on or before the date in system parameter 4660, the allowed amount (Medicare Co-Insurance plus Medicare Deductible for the entire claim) is used for duplicate check comparison rather than the Procedure Code or the Revenue Code.	

Claim Type = H (Hospice) Edits Post to Line

Same Provider – Exception 1361(CMdS 65010,6600)	Same Provider – Exception 1362(CMdS 65011)
Same client ID. (B_SYS_ID) Same dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code; see Notes 5b and 16. (R_REV_CD)	Same client ID. (B_SYS_ID) Overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Same enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code; see Notes 5b and 16. (R_REV_CD)
Different Provider – Exception 1371(CMdS 65017,6604)	Different Provider – Exception 1372(65018)

Same client ID. (B_SYS_ID) Same or overlapping dates of service. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) Different enterprise provider number. (C_BLNG_NTRPRS_ID) Same revenue code; see Notes 5b and 16. (R_REV_CD)	

The encounter edits below compare claims of different types where there are either crossover and non-crossover claims for the same/overlapping dates of service or where there are inpatient/residential and outpatient for the same/overlapping dates of service. Turquoise Claims always pays the crossover and denies the non-crossover, pays the inpatient and denies the outpatient. Turquoise Claims will system-adjust the encounter that is determined to be denied due to the duplicate condition, and we will report these on a separate batch of RC reports to the MCO.

Exception	Title and Description
0600 (65000)	**Suspect Duplicate Professional or Technical Component, Covered by Complete Service** **Description (posts to line for all claim types below):** The New Mexico Turquoise Claims MMIS posts this exception when it compares a paid claim line for one of the claim types listed below to an in-process claim line for one of the claim types listed below. For example, the New Mexico Turquoise Claims MMIS compares physician claim lines to psychiatric claim lines or physician claim lines to physician claim lines or outpatient claim lines to vision and hearing claim lines, etc. **Claim types that the New Mexico Turquoise Claims MMIS compares to each other: Form Claim Type** CMS-1500Lab/Radiology (L) CMS-1500 Misc/Enhances EPSDT (P and Prov. Ty. = 324, 342-343, 346, 441, 462, 363, or 901) UB-04 Outpatient (O and Type of Bill NOT 71x, 72x, or 73x) CMS-1500Physician (P and Prov. Ty. NOT (364, 324, 342-343, 346, 441, 462, 363, 901, 431-433, 435-437, 443-446, 331, 334-335, 412, 451-455, 457-458, or 904-906)) CMS-1500Psychiatric (P and Prov. Ty. = 431-433, 435-437, or 443-446) CMS-1500 Vision and Hearing (P and Prov. Ty. = 331, 334-335, or 412) **If the New Mexico Turquoise Claims MMIS is comparing two HFCA-1500 claim types, it uses these criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claim lines have the same dates of service or the dates of service overlap. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Both claim lines have a service area and is one of these: "LAB" (laboratory) "RAD" (radiology). (R_SVC_AREA_CD) 1. Both claims have the same procedure code. See note 16c (R_PROC_CD) 2. The service component code on one claim is "C" (complete) and the service component code on the other

Exception	Title and Description
	claim is "T" (technical component) or "P" (professional). (C_SVC_COMPONENT_CD) **If the New Mexico Turquoise Claims MMIS is comparing a HFCA-1500 claim to a UB-04 claim type, it uses these criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap. (C_LI_FST_DOS_DT C_LI_LAST_DOS_DT) 3. Both claims have the same service area, and the service area is one of these: "LAB" (laboratory) "RAD" (radiology). (R_SVC_AREA_CD) 3. Both claims have the same procedure code. See note 16c (R_PROC_CD) 4. The HFCA-1500 claim's service component code is "C" (complete) or "T" (technical component) or "P" (professional component). (C_SVC_COMPONENT_CD) 5. The HFCA-1500 claim's place of service is "22" (on-campus outpatient hospital) or "19" (off-campus outpatient hospital) or 05 IHS Free Standing Facility or 06 IHS Provider-based Facility or 07 Tribal 638 FreeStnding Fclty or 08 Tribal 638 Prov-based Facility or 23 Emergency Room Hospital or 24 Ambulatory Surgical Center or 20 Urgent Care Facility. (R_PL_OF_SVC_CD) If the edit posts, the system will generate a replacement request for the related history if the in-process claim is outpatient and the paid claim is not.
0652(65001)	**Suspect Duplicate Service, Covered by Inpatient DRG Claim** **Description (posts to the header of the in-patient, Awaiting Placement, and Long-Term Care claim; posts to line for all other claim types listed below):** The New Mexico Turquoise Claims MMIS posts this exception when it compares either: 1. An in-process inpatient claim to a paid claim line for one of the claim types listed below, or 2. An in-process claim line for one of the claim types listed below to a paid inpatient claim. **Claim types that the New Mexico Turquoise Claims MMIS compares to the inpatient claim:** Ambulatory Surgical Center (P and NM Prov. Ty. = 364) Awaiting Placement (I and at least one line with revenue code = 0169) Medical Supply (S) +

Exception	Title and Description
	Wai ver (W) Hom e Heal th (V) Hos pice (H) Lab/ Radi olog y (L) Long Term Care (N) Outpati ent (O) Misc/Enhanced EPSDT (P and Prov. Ty. = 324, 342-343, 346, 441, 462, 363, or 901) + Rehabilitation (P and Prov. Ty. = 451-455, 457-458, or 904-906) + Transportation (T) + + The New Mexico Turquoise Claims MMIS does not post this exception if the claim's procedure code is listed in Notes 2 or 4. * The New Mexico Turquoise Claims MMIS does not post this exception if either claim's provider type is 313, 314, 315 or 346. See Note 1. **The two claims that the New Mexico Turquoise Claims MMIS compares meet all the following criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT C_LI_LAST_DOS_DT depending on the claim type) 3. The inpatient claim has a Base Amount Source Code is 'DO', DS', or 'DT' (DRG) (C_BSE_AMT_SRC_CD) 4. For the claim types listed below, the New MexicoTurquoise Claims MMIS performs these additional edits: **Medical Supply or Waiver:** The New Mexico Turquoise Claims MMIS does **not** post this exception if:

Exception	Title and Description
	1. The line DOS is within 3 days of the Inpatient Claim Admit or Discharge Date. **Lab/Radiology:** 1. The lab/Radiology claim's service component code is **not** "P" (professional component). (C_SVC_COMPONENT_CD) **Long Term Care:** See Note 6. **Transportation:** The New Mexico Turquoise Claims MMIS does **not** post this exception if: 1. The transportation claim's servicing provider type (P_TY_CD) is "401" (air ambulance), or
	2. The transportation claim's servicing provider type (P_TY_CD) is "403" (handivan) and the recipient's age (C_HDR_CLNT_AGE) at the time of service is less than 18, or 3. The transportation claim's servicing provider type (P_TY_CD) is "404" (taxi) and the recipient's age (C_HDR_CLNT_AGE) at the time of service is less than 18. 4. The transportation claim's servicing provider type (P_TY_CD) is "402" (ground ambulance) and the inpatient claim's admission date is greater than or equal to claims line's FDOS on transportation claims. **Outpatient:** The New Mexico Turquoise Claims MMIS does **not** post this exception if: 1. The outpatient claim has only one line and the revenue code (R_REV_CD) on that line is "0545" (air ambulance). 2. The outpatient claim's revenue code (R_REV_CD) is in the bone marrow transplant revenue codes system list (4724) or the donor charge revenue codes system list (4723). 3. The outpatient claim contains one of the "donation" diagnosis codes (V59-V59.9 plus the equivalent ICD-10 diagnosis codes of Z52-Z52.999. **The outpatient claim procedure code is on general system list 4824.**
0653(65002,6602))	**Suspect Duplicate Service, Covered by Inpatient Non-DRG Claim** **Description (posts to the header of the in-patient claim; posts to line for all other claim types listed below):** The New Mexico Turquoise Claims MMIS posts this exception when it compares either: 1. An in-process inpatient claim to a paid claim line for one of the claim types listed below, or 2. An in-process claim line for one of the claim types listed below to a paid inpatient claim.

Exception	Title and Description
	Claim types that the New Mexico Turquoise Claims MMIS compares to the inpatient claim: Ambulatory Surgical Center (P and NM Prov. Ty. = 364) Awaiting Placement (I and at least one line has revenue code = 0169) Medical Supply (S) + Waiver (W) Home Health (V) Lab/Radiology (L) Long Term Care (N) Misc/Enhanced EPSDT (P and Prov. Ty. = 324, 342-343, 346, 441, 462, 363, or 901) + Rehabilitation (P and Prov. Ty. = 451-455, 457-458, or 904-906) + + The New Mexico Turquoise Claims MMIS does not post this exception if the claim's procedure code is listed in Notes 2 or 4. * The New Mexico Turquoise Claims MMIS does not post this exception if either claim's provider type is 313, 314, 315 or 346. See Note 1. **The two claims that the New Mexico Turquoise Claims MMIS compares meet all of the following criteria:** 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT C_LI_LAST_DOS_DT depending on the claim type) 3. The inpatient claim does **not** have a Base Amount Source Code is 'DO', DS', or 'DT' (DRG) (C_BSE_AMT_SRC_CD) 4. For the claim types listed below, the New Mexico Turquoise Claims MMIS does these additional edits: **Medical Supply:** The New Mexico Turquoise Claims MMIS does **not** post this exception if:

Exception	Title and Description
	1. The line DOS is within 3 days of the Inpatient Claim Admit or Discharge Date. **Lab/Radiology:** 1. The lab/Radiology claim's service component code (C_SVC_COMPONENT_CD) is **not** "P" (professional component). **Long Term Care:** See Note 6.
0686 (65004)	**Suspect Duplicate, Medicare Part A Claim Overlaps with Another Service** Description (this edit posts to the header of all claim types listed below): The New Mexico Turquoise Claims MMIS posts this exception when it compares either: 1. An in-process Medicare institutional Part A crossover to a paid claim for one of the claim types listed below, or 2. An in-process claim for one of the claim types listed below to a paid Medicare institutional Part A crossover. Claim types that the New Mexico Turquoise Claims MMIS compares to the Medicare institutional Part A crossover: Home Health (V) Hospice (H) Inpatient (I) Long Term Care (N) Medicare Long Term Care Part A Crossover (A and Type of Bill = 18x, 21x, 22x, 25x, 26x, 27x, 28x, 62x, 65x, 66x, 67x, or 68x) Renal Dialysis Center (O and Type of Bill = 72x) Outpatient (O) Ambulatory Surgical Center (P and NM Prov Type = 364) Medical Supply (S) Waiver (W) Lab/Radiology (L) Misc/Enhanced EPSDT (P and Prov Type = 324, 342, 343, 346, 363, 441, 462, or 901) Rehabilitation (P and Prov Type = 451-455, 457, 458, or 904-906) Transportation (T) The New Mexico Turquoise Claims MMIS does not post this exception if the claim's procedure code is listed in Note 2. See Notes 1 and 2. The two claims that the New Mexico Turquoise Claims MMIS compares meet all the following criteria: 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT depending on the claim type)

Exception	Title and Description
	3. For the claim types listed below, the New Mexico Turquoise Claims MMIS does these additional edits. Long Term Care: See Note 6. Lab/Radiology: 1. The lab/radiology claim's service component code is not "P" (professional component). (C_SVC_COMPONENT_CD) Outpatient: The New Mexico Turquoise Claims MMIS does not post this exception if: 1. The outpatient claim has only one line and the revenue code (R_REV_CD_ on that line is "0545" (air ambulance). 2. The outpatient claim's revenue code is in the bone marrow transplant revenue codes system list (4724) or the donor charge revenue codes system list (4723). Transportation: The New Mexico Turquoise Claims MMIS does not post this exception if: 1. The transportation claim's servicing provider type (P_TY_CD) is "401" (air ambulance), or 2. The transportation claim's servicing provider type is "403" (handivan) and the client's age (C_HDR_CLNT_AGE) at the time of service is less than 18, or 3. The transportation claim's servicing provider type is "404" (taxi) and the client's age at the time of service is less than 18.

0779(65037)	**Suspect Duplicate Service, Covered by Hospice Claim** Description (posts to the header of Awaiting Placement, Inpatient, and Long-Term claims and posts to the line of all other claim types listed below): The New Mexico Turquoise Claims MMIS posts this exception when it compares either: 1. An in-process hospice claim to a paid claim for one of the claim types listed below, or 2. An in-process claim for one of the claim types listed below to a paid hospice claim. Claim types that the New Mexico Turquoise Claims MMIS compares to the hospice claim: Medical Supply (S) Home Health (V) Physician (P and Billing Prov. Ty. = 363) See Note 1. The two claims that the New Mexico Turquoise Claims MMIS compares meet all the following criteria: Both claims have the same client ID. _ID) Both claims have the same dates of service or the dates of service overlap; see Note 3.

	R_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT depending on the claim type)
0782(65006)	**Suspect Duplicate Service, Covered by Medicare Professional Part B Crossover** Description (this edit posts to the line of all claim types listed below): The New Mexico Turquoise Claims MMIS posts this exception when it compares either: 1. An in-process Medicare professional crossover to a paid claim for one of the of the claim types listed below, or 2. An in-process claim for one of the claim types listed below to a paid Medicare professional crossover claim. Claim types that the New Mexico Turquoise Claims MMIS compares to the Medicare Professional Part B crossover: Ambulatory Surgical Center (P and NM Prov. Ty. = 364) Dental (D) Medical Supply (S) Lab/Radiology (L) Physician (P and Prov. Ty. NOT (364, 324, 342-343, 346, 441, 462, 363, 901, 431-433, 435-437, 443- 446, 331, 334-335, 412, 451-455, 457-458, or 904-906)) Psychiatric (P and Prov. Ty. = 431-433, 435-437, or 443-446) Transportation (T) Vision and Hearing (P and Prov. Ty. = 331, 334-335, or 412) See Note 1. The two claims that the New MexicoTurquoise Claims compare meet all the following criteria: 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap. (C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT) 3. Both claims have the same enterprise provider number. (C_BLNG_NTRPRS_ID) 4. Both claims have the same procedure code; see Note 16. (R_PROC_CD)
0783(65007)	**Suspect Duplicate Long-Term Care, Waiver, or Personal Care Options Claim** The New Mexico Turquoise Claims MMIS posts this exception when it compares either an in-process long term care claim to a paid Waiver claim or Personal Care Option claim, or an in-process Waiver claim or Personal Care Option claim to a paid long term care claim, and the two claims meet all the following criteria: This edit posts to the header. Claim types that the New Mexico Turquoise Claims MMIS compares to each other: Long Term Care (N) Waiver (W) Personal Care (P and Prov Type = 363) 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT or C_LI_FST_DOS_DT_C_LI_LAST_DOS_DT depending on the claim type)

1384(65023)	**Suspect Duplicate Medicare Institutional Part A Crossover and Medicare Institutional Part B Crossover** The New Mexico Turquoise Claims MMIS posts this exception when it compares either an in-process Medicare institutional Part A crossover to a paid Medical institutional Part B crossover, or an in-process Medical institutional Part B crossover claim to a paid Medicare institutional Part A crossover claim, and the two claims meet all the following criteria: This edit posts to the header. Claim types that the New Mexico Turquoise Claims MMIS compares to each other: Medicare Institutional Part A Crossover (A and Type of Bill = 11x, 12x, 81x, or 82x) Medicare UB-04 Part B Crossover (C) 1. Both claims have the same client ID. (B_SYS_ID) 2. Both claims have the same dates of service or the dates of service overlap; see Note 3. (C_HDR_SVC_FST_DT C_HDR_SVC_LST_DT) 3. Both claims have the same Medicare allowed amount. (C_MCARE_ALLOW_AMT)

Note	Description
1	The New Mexico Turquoise Claims MMIS contains a system list for this exception that allows MAD to list the claim types that the New Mexico Turquoise Claims MMIS will automatically replace. When the New Mexico Turquoise Claims MMIS compares the two claims, the New Mexico Turquoise Claims MMIS automatically replaces the paid claim if it is for a claim type on the system list (4731).
2	The New Mexico Turquoise Claims MMIS does not post this exception if the claim's procedure code is listed in the System List (4729).

Note	Description
3	Before the New Mexico Turquoise Claims MMIS compares the dates, it does the following: Inpatient and Long-Term Care Claims: 1. If the claim's last digit of the type of bill is "1" (admit through discharge claim) or "4" (last bill of a series of bills), the New Mexico Turquoise Claims MMIS subtracts one day from the claim's last date of service (C_HDR_SVC_LST_DT). (The last date of service becomes one day earlier than what the provider billed because the provider does not get paid for the last day.) If the New Mexico Turquoise Claims MMIS is comparing an **inpatient** claim to a **Medical Supply** claim, the New Mexico Turquoise Claims MMIS subtracts three days from the inpatient claim's last date of service (C_HDR_SVC_LST_DT). (MAD does not care whether these claims overlap during this time because they assume that the Medical Supply services are related to the client's discharge.) If the New Mexico Turquoise Claims MMIS is comparing an **inpatient** claim to an **Administrative Fee** claim (claim type = M and NM Prov. Ty. Not 701-704), the New Mexico Turquoise Claims MMIS subtracts 31 days from the inpatient claim's last date of service (C_HDR_SVC_LST_DT). (MAD does not care whether these claims overlap during this time because they assume that the administrative fee services are related to the client's discharge.) 2. If the claim's last digit of the type of bill is "1" (admit through discharge) or "2" (first bill of a series of bills), the New Mexico Turquoise Claims MMIS adds one day to the claim's first date of service (C_HDR_SVC_FST_DT). (The first date of service becomes one day later than what the provider billed because any other service that the client receives the same day that they enter the hospital or nursing home, MAD assumes, was rendered before the client entered the facility.) For UB-92 claims the New Mexico Turquoise Claims MMIS uses the C_TY_OF_BLL_1_2_CD/C_TY_OF_BILL_3_CD. Medicare Institutional Part A and Long-Term Care Part A Crossovers: 1 The New Mexico Turquoise Claims MMIS subtracts one day from the claim's last date of service (C_HDR_SVC_LST_DT). (MAD does not care whether the last date of service overlaps another claim by one day.) 2 The New Mexico Turquoise Claims MMIS adds one day to the claim's first date of service (C_HDR_SVC_FST_DT). (MAD does not care whether the last date of service overlaps another claim by one day.)
4a	If both claim lines being compared have a procedure code that is non-spaces, then use procedure code for the comparison; otherwise use revenue code for the comparison.
4b	The program does **not** compare the lines when the in-process claim's line item non-covered amount (C_NN_CVRD_CHRG_AMT) equals the in-process claim's line item submitted revenue amount (C_LI_SUBM_CHRG_AMT). The program stops the comparison when the line-item revenue code (R_REV_CD) on either claim is "0001."

Note	Description
5	The New Mexico Turquoise Claims MMIS determines the covered period between the inpatient claim and the long-term care claim. The covered period begin date is the earliest first date of service (C_HDR_SVC_FST_DT) on the two claims. The covered period end date is the most recent last date of service (C_HDR_SVC_LST_DT) on the two claims. The New Mexico Turquoise Claims MMIS calculates the **covered number of days** (covered period end date minus covered period begin date plus 1). Next, the New Mexico Turquoise Claims MMIS calculates the number of days covered by each claim (last date of service minus first date of service plus 1). The New Mexico Turquoise Claims MMIS calculates the **total claim days** by adding the LTC claim, and the inpatient claim covered days together. The New Mexico Turquoise Claims MMIS subtracts the total reserve days on the LTC claim from the total claim days. The New Mexico Turquoise Claims MMIS posts the exception if the total claim days are more than the covered period days. Please note that the New Mexico Turquoise Claims MMIS uses the dates of service that it calculates according to Note 3.
6	Both claims have the same service area (R_SVC_AREA_CD) and the service area is one of these: "RAD" (Radiology) "LAB" (Laboratory) "EM" (evaluation/management consultation) OR Both claims have the same procedure code (R_PROC_CD), which is in one of these ranges: "36400" through "36425" OR "36600" through "36660."
7	The service area (R_SVC_AREA_CD) on both claims is "ANE" (anesthesia) and the first, second, third or fourth modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) on one claim is: "QX" (CRNA with medical direction physician) AND The first, second, third or fourth modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) on the other claim is one of these: "AA" (anesthesiologist personally performs service or directs only one anesthetist CRNA) "QK" (direction of 2, 3, 4 CRNAs) "QY" "QZ" "P1" "P2" "P3" "P4" "P5" "P6"

Note	Description
8	The Service Area Code on the two lines are equal, and the service area (R_SVC_AREA_CD) is one of these: "ANE" (anesthesia) "DEN" (dental) "LAB" (laboratory) "MED" (medicine) "RAD" (radiology) "SUR" (surgery)AND The first, second, third or fourth modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) on one claim is one of these: "76" (repeat procedure by same physician) OR "77" (repeat procedure by a different physician).
9	Both claims have the same service area (R_SVC_AREA_CD) and the service area is one of these: "ANE" (anesthesia) "DEN" (dental) "LAB" (laboratory) "MED" (medicine) "RAD" (radiology) "SUR" (surgery) AND Both claims have the same modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3rd OR 4th)) and the modifier is one of these: "76" (repeat procedure by same physician) OR "77" (repeat procedure by different physician).
10	The place of service(R_PL_OF_SVC_CD) on both claims is one of these: "21" (inpatient hospital) "51" (inpatient psychiatric facility) OR "61" (comprehensive inpatient rehabilitation facility) AND The billing provider type (P_TY_CD) on both claims is "303" (physician component for hospital) and the procedure code (R_PROC_CD) is in one of these ranges: "70000" through "79999" (radiology) OR "R0000" through "R0000" (radiology).

Note	Description
11	The place of service (R_PL_OF_SVC_CD) on both claims is one of these: "21" (inpatient hospital) "51" (inpatient psychiatric facility) "61" (comprehensive inpatient rehabilitation facility) AND The service component code (C_SVC_COMPONENT_CD) on both claims is "P" (professional component).
12	When comparing a History claim to an In-process claim and both claims' billing provider type is 363 (personal care), either claim's line has a modifier on system list 4801.
13	The New Mexico Turquoise Claims MMIS does **not** post this exception if it occurs on the same claim and the service's duplicate check indicator (C_LI_DUPL_CHK_IND) is "Y" (allow duplicate lines on the same claim).
14	The New Mexico Turquoise Claims MMIS does **not** post this exception if it occurs on the same claim.
15	The modifier (C_PROC_MOD_XXX_CD (WHERE XXX = 1ST OR 2ND OR 3RD OR 4TH)) on both claims is one of these: "62" (twosurgeons) "66" (surgicalteam) "AK" (nurse practitioner, team member, rural) "AL" (nurse practitioner, team member, non-rural) "AM" (physician, team member) "AU" (PA services, other than assistant surgery, team member).

9.9.3 Outputs of Encounter Processing

In addition to the outputs from EDI for files submitted to it, there are output files/reports from Turquoise Claims once the encounters are adjudicated. For every encounter file that is processed, there are three possible outputs:

- *ENCOUNTER ADJUDICATION CYCLE SUMMARY REPORT* RC-072 – This report summarizes by type of claim within batch the total number of claims errors along with a summary of the total unduplicated paid and denied. The exception codes are listed according to Deny, Deny & Report, Pay & Report status. Since some exceptions post to the header and some to the line, a column for number of claims with error and a column for number of lines with error are shown. If the error is posted to the header, it is considered to post to all the lines on the claim. This report also lists the percentage of submitted encounters paid and denied in a file. Abortion encounters that are not eligible for federal funds, and encounters submitted as void or adjustment that the State can't void or adjust all post the Deny & Report status and are not considered as part of either denied or paid claims, and are subtracted from the number submitted as well, so are not counted as part of the overall error rate.

- Institutional Inpatient encounters are adjudicated at the claim level and thus will be accepted or denied in their entirety. Thus, if there is an error in any line item on an Institutional Inpatient encounter, the entire encounter claim will be denied.
- Professional and Institutional Non-Inpatient encounters will be accepted or denied on a line-item basis. Header level edits will cause the entire encounter to deny.
- Professional and Institutional Non-Inpatient encounters could have some lines accepted and some denied. Each line item on a Drug encounter is assigned its own claim number.
- Thus, each line is treated as a claim and will be accepted or denied on its own. The error calculation for Professional and Institutional Non-Inpatient encounters is performed as the number of encounter lines denied divided by the number of encounter lines submitted; less any Deny & Report lines. The Institutional Inpatient and Drug encounter error calculation is performed as the number of claims denied divided by the number of encounter claims submitted.

- RC70/71 *FLAT FILE* – The RC070 and RC071 flat files are produced daily for Drug and Non-Drug Encounter Claims and contain detail information for all claims submitted in a batch. The claims data is extracted from Turquoise Claims tables and processed to produce a flat file with the batches sent from EDI and PDCS sorted by batch type 837I or 837P or Drug or 837D or INPT. The file contains a Header record with the Batch information, Detail records of line items both paid and denied with both header level and line level exceptions that would cause the claim to be denied and a Trailer record that has total record counts.
- PDCS FAILED REVERSAL – RC073 – Reversal claims that are sent to PDCS which PDCS cannot match to a paid claim in their system are referred to as a failed reversal and are reported on this report.

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9.9.3.1 Encounter Outcome Reports

Encounter Adjudication Cycle Summary Report – RC072

1 NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM PROCESSING DATE: 04/05/2013

REPT: NMMC0040-RC072 HUMAN SERVICES DEPARTMENT PROCESSING TIME: 16:02:11

PAGE: 1

ENCOUNTER ADJUDICATION CYCLE SUMMARY REPORT – MANAGED CARE HEALTH PLAN

BATCH NUMBER: 000000000216033
MCO NUMBER: 000XXXXX
BATCH TYPE: INST-INPT
AS OF: 04/05/2013

PERCENTAGE OF EXCEPTION AFFECTED	EXCEPTION	# EXC POSTED @ CLM	CLAIMS/LINES WITH EXCEPTION CODE	EXCEPTION DESCRIPTION	POSTED AT LINE	ALL LINES
1152	HEALTH PLAN PROVIDER NOT AUTHO	2	0.50 %	DENY		
0850	ADJ/VOID REQ NOT PROCESSED	5	1.24 %	DENY RPT		
1371	E -POSS DUP-DIFFERENT PROVIDER	1	0.25 %	DENY RPT		
0051	E-SUM OF ACCM DYS NOT=TOT DYS	4	0.99 %	PAY RPT		
0058	E - PAT STAT/ TYPE BILL CONFLI	3	0.74 %	PAY RPT		
0182	E-MISS/INVALID CVD/NON DAYS	4	0.99 %	PAY RPT		
0303	E - ATTENDING # IS MISS/INVAL	21	5.20 %	PAY RPT		
0310	ATTEND NPI NOT FOUND	21	5.20 %	PAY RPT		
0315	ATTEN NPI MATCH MULTI MCAIDID	97	24.01 %	PAY RPT		
0325	TRAUMA/ACCIDENT CLAIM	30	7.43 %	PAY RPT		
0750	E-CLNT HAS TPL RESUB W/TPL EOB	4	0.99 %	PAY RPT		

	# CLAIMS
# PAY & REPORT (POSSIBLY DUPLICATEDCOUNT)	184
# DENY (POSSIBLY DUPLICATEDCOUNT)	2

# DENY & REPORT (POSSIBLY DUPLICATEDCOUNT)	6	
# UNDUPLICATED PAID	396	99.50 %
# UNDUPLICATED DENY	2	0.50 %
TOTAL PAID AND DENIED	398	
# UNDUPLICATED DUPLICATES AND FAILED REVERSALS (DENY & REPORT STATUS)	6	
GRAND TOTAL SUBMITTED	404	

BATCH NUMBER: 000000000216033
MCO NUMBER: 000XXXXX
BATCH TYPE: INST-NON-INPT

EXCEPTION CODE	EXCEPTIONDESCRIPTION	# EXCEPTION POSTED ATLINE	# EXC POSTED @CLM ALL LINES	AFFECTED PERCENTAGE OF CLAIMS/LINES	WITH EXCEPTIONS EXCEPTION DISPOSITION
0141	E-CLIENT ID NOT ON FILE		1	0.01 %	DENY
0189	E- SUB UNITS OF SERVMISSING	1		0.01 %	DENY
0296	BILLING NPI NOT FOUND		2	0.01 %	DENY
0424	E-BILL PROV NOT ENROLL ON DOS		2	0.01 %	DENY
1152	HEALTH PLAN PROVIDER NOTAUTHO	13		0.07 %	DENY
0850	ADJ/VOID REQ NOT PROCESSED		76	0.43 %	DENY RPT
1361	E - EXACT DUPLICATE	11		0.06 %	DENY RPT
1362	E - POSSIBLE DUP-SAMEPROVIDER	39		0.22 %	DENY RPT
0182	E-MISS/INVALID CVD/NON DAYS		3	0.02 %	PAY RPT
0325	TRAUMA/ACCIDENT CLAIM		590	3.33 %	PAY RPT
0435	E - PROC/SEX CNFL	1		0.01 %	PAY RPT
0454	E-PRINCIPAL DIAG/AGE CONFLICT		1	0.01 %	PAY RPT
0750	E-CLNT HAS TPL RESUB W/TPL EOB		51	0.29 %	PAY RPT

	# LINES
# PAY & REPORT (POSSIBLY DUPLICATEDCOUNT)	646
# DENY (POSSIBLY DUPLICATEDCOUNT)	19

# DENY & REPORT (POSSIBLY DUPLICATEDCOUNT)	126	
# UNDUPLICATED PAID	17,619	99.95 %
# UNDUPLICATED DENY	8	0.05 %
TOTAL PAID AND DENIED	17,627	
# UNDUPLICATED DUPLICATES AND FAILED REVERSALS (DENY & REPORT STATUS)	87	
GRAND TOTAL SUBMITTED	17,714	

BATCH NUMBER: 000000001162360

MCO NUMBER: 000XXXXX BATCHTYPE: PROF

EXCEPTION CODE	EXCEPTION DESCRIPTION	# EXCEPTION POSTED AT LINE	# EXC POSTED @ CLM ALL LINES	CLAIMS/LINES WITH AFFECTED EXCEPTIONS	PERCENTAGE OF EXCEPTION	EXCEPTION DISPOSITION
0141	E-CLIENT ID NOT ON FILE		117	0.24 %		DENY
0189	E- SUB UNITS OF SERVMISSING	1		0.00 %		DENY
0296	BILLING NPI NOT FOUND		1,081	2.26 %		DENY
0299	BLNG NPI MATCH MULTI MCAIDID		234	0.49 %		DENY
0306	BILLING NPI REQUIRED		250	0.52 %		DENY
0424	E-BILL PROV NOT ENROLL ON DOS	2,476		5.18 %		DENY
0430	E-PROCEDURE NOT ON FILE	8		0.02 %		DENY
0519	NDC NOT VALID	16		0.03 %		DENY
0520	HCPCS CODE REQ NDC	22		0.05 %		DENY
0671	ABORTION REQUIRES REVIEW	2		0.00 %		DENY
1151	LOCKIN ENDS BEFORE ENCTR LDOS	7		0.01 %		DENY
1152	HEALTH PLAN PROVIDER NOTAUTHO	142		0.30 %		DENY
1253	E-CLAIM DOS/CLIENT DOD CONFL	5		0.01 %		DENY
0850	ADJ/VOID REQ NOT PROCESSED		3,251	6.80 %		DENY RPT
1361	E - EXACT DUPLICATE	92		0.19 %		DENY RPT
1362	E - POSSIBLE DUP-SAMEPROVIDER	8		0.02 %		DENY RPT
0294	SVC FACI REQUIRES NPI	6,006		12.57 %		PAY RPT
0312	BLNG NPI FOUND-TXNMY NOMATCH		358	0.75 %		PAY RPT
0325	TRAUMA/ACCIDENT CLAIM	2,434		5.09 %		PAY RPT

9.9.3.2 RC70/71 RECORD LAYOUTS

The RC070 and RC071 file layout is located HCA-MCO - Documents - MCO Business Manual - All Documents

Network to Provider ID Crosswalk:

000M1814	Presbyterian	814
16785851	United HealthCare	826
42101522	Blue Cross Blue Shield	873
000M1808	Molina	808

9.9.4 Exception Edit Error Codes

The exception edit codes shown here are only those used by the Turquoise Claims system once the claims have cleared EDI. There are additional edits within EDI that are documented in the CMS Implementation Guide and the State's Companion Guide; both of which are on the State's website and the HIPAA Desk Website.

The encounters with errors will be reported on the DENIED ENCOUNTER ADJUDICATION CYCLE DETAIL FILE RC70/71 using exception edit error codes. The description of each error is provided on the next page.

Exception Edit Error codes are set to either "Pay and Report", "Deny and Report" or "Deny". A line or header can have multiple exceptions that post. Regardless, any deny exception will cause that line/header to deny.

9.9.4.1 Claims Exception Errors for Non-Drug Claims

Exception codes may carry a different disposition per claim type. Each claim type set to Deny or Deny and Report for an Encounter is shown below.

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0032/4933	E-PROVIDER/CLAIM TYPE	Long Term Care	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
	CONFLICT		
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	Outpatient	DENY
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	Practitioner/Physician	DENY
0051/4626	E-SUM OF ACCM DYS NOT=TOT DYS	Hospice	DENY
0051/4626	E-SUM OF ACCM DYS NOT=TOT DYS	Inpatient	DENY
0051/4626	E-SUM OF ACCM DYS NOT=TOT DYS	Long Term Care	DENY
0072/1620	E - ACCOM REV CODE MISSING	Mcare Part A Crossover	DENY
0072/1620	E - ACCOM REV CODE MISSING	Inpatient	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Mcare Part A Crossover	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Mcare Part B Crossover	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Mcare UB Part B Crossover	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Dental	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Hospice	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Inpatient	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Laboratory and Xray	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Long Term Care	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Outpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0097/19627	PLAN PAYMENT MISSING/INVALID	Practitioner/Physician	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Medical Supply	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Transportation	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	Home Health	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	HCBS Waiver	DENY
0097/19627	PLAN PAYMENT MISSING/INVALID	HCBS Case Mgmt Assmt (CMA)	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Mcare Part A Crossover	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Mcare Part B Crossover	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Mcare UB Part B Crossover	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Dental	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Hospice	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Inpatient	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Laboratory and Xray	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0100/1962	MCO PAID DATE MISSING/INVALID	Long Term Care	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Outpatient	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Practitioner/Physician	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Medical Supply	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Transportation	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	Home Health	DENY
0100/1962	MCO PAID DATE MISSING/INVALID	HCBS Waiver	DENY
0117/1350	E - MODIFIER 1 INVALID	Laboratory and Xray	DENY
0117/1350	E - MODIFIER 1 INVALID	Practitioner/Physician	DENY
0117/1350	E - MODIFIER 1 INVALID	Medical Supply	DENY
0117/1350	E - MODIFIER 1 INVALID	Transportation	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Mcare Part A Crossover	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Mcare Part B Crossover	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Mcare UB Part B Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0120/1030	E- BILLING PROVIDER IS MISSIN	Dental	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Hospice	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Inpatient	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Laboratory and Xray	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Long Term Care	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Outpatient	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Practitioner/Physician	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Medical Supply	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Transportation	DENY
0120/1030	E- BILLING PROVIDER IS MISSIN	Home Health	DENY
0121/1351	E - MOD 2 INVALID	Laboratory and Xray	DENY
0121/1351	E - MOD 2 INVALID	Practitioner/Physician	DENY
0121/1351	E - MOD 2 INVALID	Medical Supply	DENY
0121/1351	E - MOD 2 INVALID	Transportation	DENY
0124/1131	E - FROM DOS IS MISSING	Mcare Part A Crossover	DENY
0124/1131	E - FROM DOS IS MISSING	Mcare Part B Crossover	DENY
0124/1131	E - FROM DOS IS MISSING	Mcare UB Part B Crossover	DENY
0124/1131	E - FROM DOS IS MISSING	Dental	DENY
0124/1131	E - FROM DOS IS MISSING	Hospice	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0124/1131	E - FROM DOS IS MISSING	Inpatient	DENY
0124/1131	E - FROM DOS IS MISSING	Laboratory and Xray	DENY
0124/1131	E - FROM DOS IS MISSING	Capitation (MC)	DENY
0124/1131	E - FROM DOS IS MISSING	Long Term Care	DENY
0124/1131	E - FROM DOS IS MISSING	Outpatient	DENY
0124/1131	E - FROM DOS IS MISSING	Practitioner/Physician	DENY
0124/1131	E - FROM DOS IS MISSING	Medical Supply	DENY
0124/1131	E - FROM DOS IS MISSING	Transportation	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Practitioner/Physician	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Transportation	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Long Term Care	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Laboratory and Xray	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Outpatient	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Home Health	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Mcare Part A Crossover	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Hospice	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Mcare UB Part B Crossover	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Inpatient	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Mcare Part B Crossover	DENY
0126/1150	From DOS Aftr Through-Clm Hdr	Medical Supply	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0126/1151	From DOS After Thru DOS-Clm LI	Practitioner/Physician	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Home Health	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Medical Supply	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Mcare Part B Crossover	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Transportation	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Inpatient	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Hospice	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Long Term Care	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Outpatient	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Laboratory and Xray	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Mcare UB Part B Crossover	DENY
0126/1151	From DOS After Thru DOS-Clm LI	Mcare Part A Crossover	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Laboratory and Xray	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Mcare UB Part B Crossover	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Hospice	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Mcare Part A Crossover	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Home Health	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Transportation	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Medical Supply	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Practitioner/Physician	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Inpatient	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Long Term Care	DENY
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	Outpatient	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Transportation	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Laboratory and Xray	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Long Term Care	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Hospice	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Mcare UB Part B Crossover	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Home Health	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Practitioner/Physician	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Medical Supply	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Mcare Part A Crossover	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Inpatient	DENY
0127/1161	Thru DOS After Rcpt Dt-Clm Ll	Outpatient	DENY
0129/1320	Member ID is Missing	Inpatient	DENY
0129/1320	Member ID is Missing	Mcare Part B Crossover	DENY
0129/1320	Member ID is Missing	Laboratory and Xray	DENY
0129/1320	Member ID is Missing	Medical Supply	DENY
0129/1320	Member ID is Missing	Outpatient	DENY
0129/1320	Member ID is Missing	Long Term Care	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0129/1320	Member ID is Missing	Practitioner/Physician	DENY
0129/1320	Member ID is Missing	Hospice	DENY
0129/1320	Member ID is Missing	Mcare UB Part B Crossover	DENY
0129/1320	Member ID is Missing	Mcare Part A Crossover	DENY
0129/1320	Member ID is Missing	Dental	DENY
0129/1320	Member ID is Missing	Home Health	DENY
0129/1320	Member ID is Missing	Transportation	DENY
0129/1911	Member ID Invalid	Outpatient	DENY
0129/1911	Member ID Invalid	Transportation	DENY
0129/1911	Member ID Invalid	Medical Supply	DENY
0129/1911	Member ID Invalid	Practitioner/Physician	DENY
0129/1911	Member ID Invalid	Dental	DENY
0129/1911	Member ID Invalid	Mcare UB Part B Crossover	DENY
0129/1911	Member ID Invalid	Laboratory and Xray	DENY
0129/1911	Member ID Invalid	Hospice	DENY
0129/1911	Member ID Invalid	Home Health	DENY
0129/1911	Member ID Invalid	Long Term Care	DENY
0129/1911	Member ID Invalid	Mcare Part B Crossover	DENY
0129/1911	Member ID Invalid	Mcare Part A Crossover	DENY
0129/1911	Member ID Invalid	Inpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0130/1340	E - CLIENT DOB IS MISS/INVAL	Mcare Part A Crossover	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Mcare Part B Crossover	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Mcare UB Part B Crossover	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Dental	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Hospice	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Inpatient	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Laboratory and Xray	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Long Term Care	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Outpatient	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Practitioner/Physician	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Medical Supply	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Transportation	DENY
0130/1340	E - CLIENT DOB IS MISS/INVAL	Home Health	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Mcare Part A Crossover	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Mcare Part B Crossover	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Mcare UB Part B Crossover	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Dental	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Hospice	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0141/2003	E-CLIENT ID NOT ON FILE	Inpatient	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Laboratory and Xray	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Long Term Care	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Outpatient	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Practitioner/Physician	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Medical Supply	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Transportation	DENY
0141/2003	E-CLIENT ID NOT ON FILE	Home Health	DENY
0148/1490	E - REV CODE IS MISSING	Mcare Part A Crossover	DENY
0148/1490	E - REV CODE IS MISSING	Mcare UB Part B Crossover	DENY
0148/1490	E - REV CODE IS MISSING	Hospice	DENY
0148/1490	E - REV CODE IS MISSING	Inpatient	DENY
0148/1490	E - REV CODE IS MISSING	Long Term Care	DENY
0148/1490	E - REV CODE IS MISSING	Outpatient	DENY
0148/1490	E - REV CODE IS MISSING	Home Health	DENY
0150/1360	E - PLACE SERV MISS/INVALID	Mcare Part B Crossover	DENY
0150/1360	E - PLACE SERV MISS/INVALID	Dental	DENY
0150/1360	E - PLACE SERV MISS/INVALID	Laboratory and Xray	DENY
0150/1360	E - PLACE SERV MISS/INVALID	Practitioner/Physician	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0150/1360	E - PLACE SERV MISS/INVALID	Medical Supply	DENY
0150/1360	E - PLACE SERV MISS/INVALID	Transportation	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Mcare Part A Crossover	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Long Term Care	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Outpatient	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Transportation	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Laboratory and Xray	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Mcare Part B Crossover	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Hospice	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Practitioner/Physician	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Home Health	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Medical Supply	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Inpatient	DENY
0155/1140	Thru Svc Dt Invald on Clm Hdr	Mcare UB Part B Crossover	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Hospice	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Long Term Care	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Mcare Part B Crossover	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Transportation	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Mcare UB Part B Crossover	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Inpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0155/1141	Thru Svc Dt Invalid on Clm LI	Mcare Part A Crossover	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Medical Supply	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Laboratory and Xray	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Practitioner/Physician	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Outpatient	DENY
0155/1141	Thru Svc Dt Invalid on Clm LI	Home Health	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Mcare Part A Crossover	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Mcare Part B Crossover	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Mcare UB Part B Crossover	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Dental	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Hospice	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Inpatient	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Laboratory and Xray	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Long Term Care	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Outpatient	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Practitioner/Physician	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Medical Supply	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Transportation	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	Home Health	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	HCBS Waiver	DENY
0162/64110	OTHER PYR PYMT DOES NOT BALANC	HCBS Case Mgmt Assmt (CMA)	DENY
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Mcare Part A Crossover	DENY
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Mcare UB Part B Crossover	DENY
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Hospice	DENY
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Inpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Long Term Care	DENY
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Outpatient	DENY
0163/1500	E-LINE DOS OUT FROM/THRU DATE	Home Health	DENY
0166/1471	CLM ADM DT GT THE DISCHARG DT	Mcare Part A Crossover	DENY
0166/1471	CLM ADM DT GT THE DISCHARG DT	Inpatient	DENY
0167/1460	E - ADMIT DATE IS MISSING	Mcare Part A Crossover	DENY
0167/1460	E - ADMIT DATE IS MISSING	Inpatient	DENY
0172/19645	E - PROCEDURE CODE MISSING	Mcare Part B Crossover	DENY
0172/19645	E - PROCEDURE CODE MISSING	Mcare UB Part B Crossover	DENY
0172/19645	E - PROCEDURE CODE MISSING	Dental	DENY
0172/19645	E - PROCEDURE CODE MISSING	Laboratory and Xray	DENY
0172/19645	E - PROCEDURE CODE MISSING	Practitioner/Physician	DENY
0172/19645	E - PROCEDURE CODE MISSING	Medical Supply	DENY
0172/19645	E - PROCEDURE CODE MISSING	Transportation	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0182/19656	E-MISS/INVALID CVD/NON DAYS	Mcare Part A Crossover	DENY
0182/19656	E-MISS/INVALID CVD/NON DAYS	Inpatient	DENY
0182/19656	E-MISS/INVALID CVD/NON DAYS	Long Term Care	DENY
0188/1521	E - PATIENT STATUS INVALID	Hospice	DENY
0188/1521	E - PATIENT STATUS INVALID	Inpatient	DENY
0188/1521	E - PATIENT STATUS INVALID	Long Term Care	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Mcare Part A Crossover	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Mcare Part B Crossover	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Mcare UB Part B Crossover	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Hospice	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Inpatient	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Laboratory and Xray	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Long Term Care	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Outpatient	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Practitioner/Physician	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Medical Supply	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Transportation	DENY
0189/1240	E- SUB UNITS OF SERV MISSING	Home Health	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Mcare Part A Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0201/1891	CRED/REPLCMT TCN MIS OR INV	Mcare Part B Crossover	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Mcare UB Part B Crossover	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Dental	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Financial Transaction	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Hospice	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Inpatient	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Mcare Pharm Part B Crossover	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Laboratory and Xray	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Capitation (MC)	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Long Term Care	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Outpatient	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Practitioner/Physician	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Pharmacy (RX)	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Medical Supply	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Transportation	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Home Health	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	HCBS Waiver	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	HCBS Case Mgmt Assmt (CMA)	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0201/1891	CRED/REPLCMT TCN MIS OR INV	Replacement Request	DENY
0201/1891	CRED/REPLCMT TCN MIS OR INV	Credit Request	DENY
0222/2015	Member Name Mismatch	Home Health	DENY
0222/2015	Member Name Mismatch	Practitioner/Physician	DENY
0222/2015	Member Name Mismatch	HCBS Waiver	DENY
0222/2015	Member Name Mismatch	Medical Supply	DENY
0222/2015	Member Name Mismatch	Dental	DENY
0222/2015	Member Name Mismatch	Mcare Part A Crossover	DENY
0222/2015	Member Name Mismatch	Mcare UB Part B Crossover	DENY
0222/2015	Member Name Mismatch	HCBS Case Mgmt Assmt (CMA)	DENY
0222/2015	Member Name Mismatch	Long Term Care	DENY
0222/2015	Member Name Mismatch	Transportation	DENY
0222/2015	Member Name Mismatch	Hospice	DENY
0222/2015	Member Name Mismatch	Inpatient	DENY
0222/2015	Member Name Mismatch	Mcare Part B Crossover	DENY
0222/2015	Member Name Mismatch	Laboratory and Xray	DENY
0222/2015	Member Name Mismatch	Outpatient	DENY
0222/2040	DOB Doesn't Match DOB on file	Laboratory and Xray	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0222/2040	DOB Doesn't Match DOB on file	HCBS Case Mgmt Assmt (CMA)	DENY
0222/2040	DOB Doesn't Match DOB on file	Mcare UB Part B Crossover	DENY
0222/2040	DOB Doesn't Match DOB on file	Dental	DENY
0222/2040	DOB Doesn't Match DOB on file	Outpatient	DENY
0222/2040	DOB Doesn't Match DOB on file	Transportation	DENY
0222/2040	DOB Doesn't Match DOB on file	Home Health	DENY
0222/2040	DOB Doesn't Match DOB on file	Mcare Part B Crossover	DENY
0222/2040	DOB Doesn't Match DOB on file	Hospice	DENY
0222/2040	DOB Doesn't Match DOB on file	Mcare Part A Crossover	DENY
0222/2040	DOB Doesn't Match DOB on file	HCBS Waiver	DENY
0222/2040	DOB Doesn't Match DOB on file	Practitioner/Physician	DENY
0222/2040	DOB Doesn't Match DOB on file	Medical Supply	DENY
0222/2040	DOB Doesn't Match DOB on file	Inpatient	DENY
0222/2040	DOB Doesn't Match DOB on file	Long Term Care	DENY
0253/4120	Diag Not Valid For Hdr DOS	Mcare UB Part B Crossover	DENY
0253/4120	Diag Not Valid For Hdr DOS	Practitioner/Physician	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0253/4120	Diag Not Valid For Hdr DOS	Mcare Part B Crossover	DENY
0253/4120	Diag Not Valid For Hdr DOS	Transportation	DENY
0253/4120	Diag Not Valid For Hdr DOS	Long Term Care	DENY
0253/4120	Diag Not Valid For Hdr DOS	Inpatient	DENY
0253/4120	Diag Not Valid For Hdr DOS	Mcare Part A Crossover	DENY
0253/4120	Diag Not Valid For Hdr DOS	Medical Supply	DENY
0253/4120	Diag Not Valid For Hdr DOS	Hospice	DENY
0253/4120	Diag Not Valid For Hdr DOS	Laboratory and Xray	DENY
0253/4120	Diag Not Valid For Hdr DOS	Home Health	DENY
0253/4120	Diag Not Valid For Hdr DOS	Outpatient	DENY
0253/4121	Diag Not Valid For Line DOS	Mcare Part A Crossover	DENY
0253/4121	Diag Not Valid For Line DOS	Medical Supply	DENY
0253/4121	Diag Not Valid For Line DOS	Mcare UB Part B Crossover	DENY
0253/4121	Diag Not Valid For Line DOS	Long Term Care	DENY
0253/4121	Diag Not Valid For Line DOS	Home Health	DENY
0253/4121	Diag Not Valid For Line DOS	Outpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0253/4121	Diag Not Valid For Line DOS	Hospice	DENY
0253/4121	Diag Not Valid For Line DOS	Inpatient	DENY
0253/4121	Diag Not Valid For Line DOS	Transportation	DENY
0253/4121	Diag Not Valid For Line DOS	Practitioner/Physician	DENY
0253/4121	Diag Not Valid For Line DOS	Laboratory and Xray	DENY
0253/4121	Diag Not Valid For Line DOS	Mcare Part B Crossover	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Mcare Part A Crossover	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Mcare Part B Crossover	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Mcare UB Part B Crossover	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Hospice	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Inpatient	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Laboratory and Xray	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Long Term Care	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Outpatient	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Practitioner/Physician	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Medical Supply	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Transportation	DENY
0260/4115	DIAGNOSIS CODE NOT SPECIFIC	Home Health	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0281/35505	SVRC NT ALLW COMM BENEFIT PRV	Practitioner/Physician	DENY
0284/49317	TRANSITION SVCS> 90 DAYS	Practitioner/Physician	DENY
0285/49307	MODIFIER TN BILLED FOR NON- RUR	Practitioner/Physician	DENY
0295/3616	INVALID BILLING NPI	Mcare Part A Crossover	DENY
0295/3616	INVALID BILLING NPI	Mcare Part B Crossover	DENY
0295/3616	INVALID BILLING NPI	Mcare UB Part B Crossover	DENY
0295/3616	INVALID BILLING NPI	Dental	DENY
0295/3616	INVALID BILLING NPI	Hospice	DENY
0295/3616	INVALID BILLING NPI	Inpatient	DENY
0295/3616	INVALID BILLING NPI	Laboratory and Xray	DENY
0295/3616	INVALID BILLING NPI	Long Term Care	DENY
0295/3616	INVALID BILLING NPI	Outpatient	DENY
0295/3616	INVALID BILLING NPI	Practitioner/Physician	DENY
0295/3616	INVALID BILLING NPI	Medical Supply	DENY
0295/3616	INVALID BILLING NPI	Transportation	DENY
0295/3616	INVALID BILLING NPI	Home Health	DENY
0296/3000	BILLING NPI NOT FOUND	Mcare Part A Crossover	DENY
0296/3000	BILLING NPI NOT FOUND	Mcare Part B Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0296/3000	BILLING NPI NOT FOUND	Mcare UB Part B Crossover	DENY
0296/3000	BILLING NPI NOT FOUND	Dental	DENY
0296/3000	BILLING NPI NOT FOUND	Hospice	DENY
0296/3000	BILLING NPI NOT FOUND	Inpatient	DENY
0296/3000	BILLING NPI NOT FOUND	Laboratory and Xray	DENY
0296/3000	BILLING NPI NOT FOUND	Long Term Care	DENY
0296/3000	BILLING NPI NOT FOUND	Outpatient	DENY
0296/3000	BILLING NPI NOT FOUND	Practitioner/Physician	DENY
0296/3000	BILLING NPI NOT FOUND	Medical Supply	DENY
0296/3000	BILLING NPI NOT FOUND	Transportation	DENY
0296/3000	BILLING NPI NOT FOUND	Home Health	DENY
0296/3000	BILLING NPI NOT FOUND	HCBS Waiver	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Mcare Part A Crossover	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Mcare Part B Crossover	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Mcare UB Part B Crossover	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Dental	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Hospice	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Inpatient	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Laboratory and Xray	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Long Term Care	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Outpatient	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Practitioner/Physician	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Medical Supply	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Transportation	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	Home Health	DENY
0299/3002	BLNG NPI MATCH MULTI MCAID ID	HCBS Waiver	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Mcare Part A Crossover	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Mcare Part B Crossover	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Mcare UB Part B Crossover	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Dental	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Hospice	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Inpatient	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Laboratory and Xray	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Long Term Care	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Outpatient	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Practitioner/Physician	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Medical Supply	DENY
0300/3000	E-BILLING PROV NOT ON FILE	Transportation	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0300/3000	E-BILLING PROV NOT ON FILE	Home Health	DENY
0302/3400	ATTENDING PROV # NOT ON FILE	Mcare Part A Crossover	DENY
0303/1590	E - ATTENDING # IS MISS/INVAL	Mcare Part A Crossover	DENY
0303/1590	E - ATTENDING # IS MISS/INVAL	Hospice	DENY
0303/1590	E - ATTENDING # IS MISS/INVAL	Inpatient	DENY
0303/1590	E - ATTENDING # IS MISS/INVAL	Long Term Care	DENY
0303/1590	E - ATTENDING # IS MISS/INVAL	Home Health	DENY
0306/3615	BILLING NPI REQUIRED	Mcare Part A Crossover	DENY
0306/3615	BILLING NPI REQUIRED	Mcare Part B Crossover	DENY
0306/3615	BILLING NPI REQUIRED	Mcare UB Part B Crossover	DENY
0306/3615	BILLING NPI REQUIRED	Dental	DENY
0306/3615	BILLING NPI REQUIRED	Hospice	DENY
0306/3615	BILLING NPI REQUIRED	Inpatient	DENY
0306/3615	BILLING NPI REQUIRED	Laboratory and Xray	DENY
0306/3615	BILLING NPI REQUIRED	Long Term Care	DENY
0306/3615	BILLING NPI REQUIRED	Outpatient	DENY
0306/3615	BILLING NPI REQUIRED	Practitioner/Physician	DENY
0306/3615	BILLING NPI REQUIRED	Medical Supply	DENY
0306/3615	BILLING NPI REQUIRED	Transportation	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0306/3615	BILLING NPI REQUIRED	Home Health	DENY
0309/3623	INVALID ATTEND NPI	Mcare Part A Crossover	DENY
0309/3623	INVALID ATTEND NPI	Hospice	DENY
0309/3623	INVALID ATTEND NPI	Inpatient	DENY
0309/3623	INVALID ATTEND NPI	Long Term Care	DENY
0309/3623	INVALID ATTEND NPI	Home Health	DENY
0310/3400	ATTEND NPI NOT FOUND	Mcare Part A Crossover	DENY
0310/3400	ATTEND NPI NOT FOUND	Hospice	DENY
0310/3400	ATTEND NPI NOT FOUND	Inpatient	DENY
0310/3400	ATTEND NPI NOT FOUND	Long Term Care	DENY
0310/3400	ATTEND NPI NOT FOUND	Home Health	DENY
0315/3402	ATTEN NPI MATCH MULTI MCAID ID	Mcare Part A Crossover	DENY
0315/3402	ATTEN NPI MATCH MULTI MCAID ID	Hospice	DENY
0315/3402	ATTEN NPI MATCH MULTI MCAID ID	Inpatient	DENY
0315/3402	ATTEN NPI MATCH MULTI MCAID ID	Long Term Care	DENY
0315/3402	ATTEN NPI MATCH MULTI MCAID ID	Home Health	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0317/3622	ATTENDING NPI REQUIRED	Mcare Part A Crossover	DENY
0317/3622	ATTENDING NPI REQUIRED	Hospice	DENY
0317/3622	ATTENDING NPI REQUIRED	Inpatient	DENY
0317/3622	ATTENDING NPI REQUIRED	Long Term Care	DENY
0317/3622	ATTENDING NPI REQUIRED	Home Health	DENY
0318/3621	BLNG SSN/TAX ID NOT FOUND	Practitioner/Physician	DENY
0319/3621	BLNG SSN/TAX MATCH MULTI MCAID	Mcare Part B Crossover	DENY
0319/3621	BLNG SSN/TAX MATCH MULTI MCAID	Practitioner/Physician	DENY
0319/3621	BLNG SSN/TAX MATCH MULTI MCAID	Transportation	DENY
0319/3621	BLNG SSN/TAX MATCH MULTI MCAID	HCBS Waiver	DENY
0331/29641	NO LTC SPAN AVAIL FOR FRST DOS	Hospice	DENY
0331/29641	NO LTC SPAN AVAIL FOR FRST DOS	Long Term Care	DENY
0331/29641	NO LTC SPAN AVAIL FOR FRST DOS	Practitioner/Physician	DENY
0332/4101	E- Diag Code Missing	Mcare Part A Crossover	DENY
0332/4101	E- Diag Code Missing	Laboratory and Xray	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0332/4101	E- Diag Code Missing	Inpatient	DENY
0332/4101	E- Diag Code Missing	Mcare UB Part B Crossover	DENY
0332/4101	E- Diag Code Missing	Mcare Part B Crossover	DENY
0332/4101	E- Diag Code Missing	Practitioner/Physician	DENY
0332/4101	E- Diag Code Missing	Outpatient	DENY
0332/4462	E- Diag Code Missing	Mcare Part B Crossover	DENY
0332/4462	E- Diag Code Missing	Inpatient	DENY
0332/4462	E- Diag Code Missing	Outpatient	DENY
0332/4462	E- Diag Code Missing	Mcare Part A Crossover	DENY
0332/4462	E- Diag Code Missing	Laboratory and Xray	DENY
0332/4462	E- Diag Code Missing	Practitioner/Physician	DENY
0332/4462	E- Diag Code Missing	Mcare UB Part B Crossover	DENY
0336/2109	Prov Not Authd by Nurs Hme Spn	Long Term Care	DENY
0336/2110	Prov Not Authd by Nurs Hme Spn	Long Term Care	DENY
0336/2111	Prv Not Authd by Skl Nrs Fc Sp	Long Term Care	DENY
0336/2112	Prv Not Authd by Skl Nrs Fc Sp	Long Term Care	DENY
0347/4316	E - REV CODE NOT ON FILE	Mcare UB Part B Crossover	DENY
0347/4316	E - REV CODE NOT ON FILE	Hospice	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0347/4316	E - REV CODE NOT ON FILE	Long Term Care	DENY
0347/4316	E - REV CODE NOT ON FILE	Outpatient	DENY
0347/4316	E - REV CODE NOT ON FILE	Home Health	DENY
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Mcare Part A Crossover	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Mcare Part B Crossover	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Mcare UB Part B Crossover	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Dental	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Hospice	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Inpatient	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Laboratory and Xray	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Long Term Care	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Outpatient	DENY&REPORT

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Practitioner/Physician	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Medical Supply	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Transportation	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Home Health	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	HCBS Waiver	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	HCBS Case Mgmt Assmt (CMA)	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Replacement Request	DENY&REPORT
0350/1889	CLAIM AUDITED NO ADJUST ALLOW	Credit Request	DENY&REPORT
0358/39143	WAIVER CLM PROV SPECL CONFLICT	HCBS Waiver	DENY
0358/39143	WAIVER CLM PROV SPECL CONFLICT	HCBS Case Mgmt Assmt (CMA)	DENY
0361/4270	E-TOOTH/QUADRANT # REQUIRED	Dental	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Mcare Part B Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0367/49299	PROV REVIEW FOR TYPE/PROC	Dental	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Hospice	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Laboratory and Xray	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Long Term Care	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Outpatient	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Practitioner/Physician	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Medical Supply	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Transportation	DENY
0367/49299	PROV REVIEW FOR TYPE/PROC	Home Health	DENY
0368/4322	BILL PROV REVIEW FOR TYPE/REV	Hospice	DENY
0368/4322	BILL PROV REVIEW FOR TYPE/REV	Inpatient	DENY
0368/4322	BILL PROV REVIEW FOR TYPE/REV	Long Term Care	DENY
0368/4322	BILL PROV REVIEW FOR TYPE/REV	Outpatient	DENY
0368/4322	BILL PROV REVIEW FOR TYPE/REV	Home Health	DENY
0372/4420	E- PROC/CLM TYPE CNFL	Dental	DENY
0372/4420	E- PROC/CLM TYPE CNFL	Laboratory and Xray	DENY
0372/4420	E- PROC/CLM TYPE CNFL	Practitioner/Physician	DENY
0372/4420	E- PROC/CLM TYPE CNFL	Medical Supply	DENY
0372/4420	E- PROC/CLM TYPE CNFL	Transportation	DENY
0373/4324	E-REV/TYPE OF BILL CNFL	Hospice	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0373/4324	E-REV/TYPE OF BILL CNFL	Inpatient	DENY
0373/4324	E-REV/TYPE OF BILL CNFL	Long Term Care	DENY
0373/4324	E-REV/TYPE OF BILL CNFL	Outpatient	DENY
0373/4324	E-REV/TYPE OF BILL CNFL	Home Health	DENY
0377/9090	Fund Code defaulted paid susp	Credit Request	DENY
0377/9090	Fund Code defaulted paid susp	Mcare Part B Crossover	DENY
0377/9090	Fund Code defaulted paid susp	HCBS Case Mgmt Assmt (CMA)	DENY
0377/9090	Fund Code defaulted paid susp	Inpatient	DENY
0377/9090	Fund Code defaulted paid susp	Home Health	DENY
0377/9090	Fund Code defaulted paid susp	Dental	DENY
0377/9090	Fund Code defaulted paid susp	Capitation	DENY
0377/9090	Fund Code defaulted paid susp	Pharmacy	DENY
0377/9090	Fund Code defaulted paid susp	Replacement Request	DENY
0377/9090	Fund Code defaulted paid susp	Mcare UB Part B Crossover	DENY
0377/9090	Fund Code defaulted paid susp	Financial Transaction	DENY
0377/9090	Fund Code defaulted paid susp	Laboratory and Xray	DENY
0377/9090	Fund Code defaulted paid susp	HCBS Waiver	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0377/9090	Fund Code defaulted paid susp	Practitioner/Physician	DENY
0377/9090	Fund Code defaulted paid susp	Transportation	DENY
0377/9090	Fund Code defaulted paid susp	Long Term Care	DENY
0377/9090	Fund Code defaulted paid susp	Medical Supply	DENY
0377/9090	Fund Code defaulted paid susp	Outpatient	DENY
0377/9090	Fund Code defaulted paid susp	Mcare Part A Crossover	DENY
0377/9090	Fund Code defaulted paid susp	Hospice	DENY
0377/9095	Fund Code defaulted denied	Laboratory and Xray	DENY
0377/9095	Fund Code defaulted denied	Long Term Care	DENY
0377/9095	Fund Code defaulted denied	Medical Supply	DENY
0377/9095	Fund Code defaulted denied	Mcare Part A Crossover	DENY
0377/9095	Fund Code defaulted denied	Financial Transaction	DENY
0377/9095	Fund Code defaulted denied	Dental	DENY
0377/9095	Fund Code defaulted denied	Home Health	DENY
0377/9095	Fund Code defaulted denied	Mcare UB Part B Crossover	DENY
0377/9095	Fund Code defaulted denied	Inpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0377/9095	Fund Code defaulted denied	Transportation	DENY
0377/9095	Fund Code defaulted denied	Practitioner/Physician	DENY
0377/9095	Fund Code defaulted denied	HCBS Case Mgmt Assmt (CMA)	DENY
0377/9095	Fund Code defaulted denied	Hospice	DENY
0377/9095	Fund Code defaulted denied	Capitation	DENY
0377/9095	Fund Code defaulted denied	Pharmacy	DENY
0377/9095	Fund Code defaulted denied	Credit Request	DENY
0377/9095	Fund Code defaulted denied	Replacement Request	DENY
0377/9095	Fund Code defaulted denied	HCBS Waiver	DENY
0377/9095	Fund Code defaulted denied	Outpatient	DENY
0377/9095	Fund Code defaulted denied	Mcare Part B Crossover	DENY
0380/19657	SERVICE NOT COVERED BY DIAG	Long Term Care	DENY
0392/4116	SURGICAL PROC CD NOT SPECIFIC	Mcare Part A Crossover	DENY
0392/4116	SURGICAL PROC CD NOT SPECIFIC	Mcare UB Part B Crossover	DENY
0392/4116	SURGICAL PROC CD NOT SPECIFIC	Inpatient	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Mcare Part A Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Mcare Part B Crossover	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Mcare UB Part B Crossover	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Dental	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Hospice	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Inpatient	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Laboratory and Xray	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Long Term Care	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Outpatient	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Practitioner/Physician	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Medical Supply	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Transportation	DENY
0424/3005	E-BILL PROV NOT ENROLL ON DOS	Home Health	DENY
0430/4424	E-PROCEDURE NOT ON FILE	Mcare Part B Crossover	DENY
0430/4424	E-PROCEDURE NOT ON FILE	Dental	DENY
0430/4424	E-PROCEDURE NOT ON FILE	Laboratory and Xray	DENY
0430/4424	E-PROCEDURE NOT ON FILE	Practitioner/Physician	DENY
0430/4424	E-PROCEDURE NOT ON FILE	Medical Supply	DENY
0430/4424	E-PROCEDURE NOT ON FILE	Transportation	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Mcare Part A Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Hospice	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Inpatient	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Laboratory and Xray	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Long Term Care	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Outpatient	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Practitioner/Physician	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Medical Supply	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Transportation	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	Home Health	DENY
0440/4145	E - 6TH (F) DIAG NOT ON FILE	HCBS Waiver	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Hospice	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Inpatient	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Laboratory and Xray	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0446/4148	E-7TH (G) DIAG NOT ON FILE	Long Term Care	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Outpatient	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Practitioner/Physician	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Medical Supply	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Transportation	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	Home Health	DENY
0446/4148	E-7TH (G) DIAG NOT ON FILE	HCBS Waiver	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Hospice	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Inpatient	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Laboratory and Xray	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Long Term Care	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Outpatient	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Practitioner/Physician	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Medical Supply	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Transportation	DENY
0450/4112	E-1ST (A) DIAG NOT ON FILE	Home Health	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0453/19650	NON-RELATED DIAG CODE INVALID	Mcare Part B Crossover	DENY
0453/19650	NON-RELATED DIAG CODE INVALID	Laboratory and Xray	DENY
0453/19650	NON-RELATED DIAG CODE INVALID	Practitioner/Physician	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Hospice	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Inpatient	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Laboratory and Xray	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Long Term Care	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Outpatient	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Practitioner/Physician	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Medical Supply	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Transportation	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	Home Health	DENY
0458/4151	E-8TH (H) DIAG NOT ON FILE	HCBS Waiver	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Mcare Part B Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Hospice	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Inpatient	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Laboratory and Xray	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Long Term Care	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Outpatient	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Practitioner/Physician	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Medical Supply	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Transportation	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	Home Health	DENY
0460/4133	E - 2ND (B) DIAG NOT ON FILE	HCBS Waiver	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Hospice	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Inpatient	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Laboratory and Xray	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Long Term Care	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Outpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0470/4136	E -3RD (C) DIAG NOT ON FILE	Practitioner/Physician	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Medical Supply	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Transportation	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	Home Health	DENY
0470/4136	E -3RD (C) DIAG NOT ON FILE	HCBS Waiver	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Hospice	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Inpatient	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Laboratory and Xray	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Long Term Care	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Outpatient	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Practitioner/Physician	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Medical Supply	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Transportation	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	Home Health	DENY
0472/4154	E-9TH (I) DIAG NOT ON FILE	HCBS Waiver	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Mcare Part A Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Hospice	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Inpatient	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Laboratory and Xray	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Long Term Care	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Outpatient	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Practitioner/Physician	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Medical Supply	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Transportation	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	Home Health	DENY
0480/4139	E - 4TH (D) DIAG NOT ON FILE	HCBS Waiver	DENY
0488/4130	E - ADM DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0488/4130	E - ADM DIAG NOT ON FILE	Hospice	DENY
0488/4130	E - ADM DIAG NOT ON FILE	Inpatient	DENY
0488/4130	E - ADM DIAG NOT ON FILE	Long Term Care	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Mcare Part B Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Hospice	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Inpatient	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Laboratory and Xray	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Long Term Care	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Outpatient	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Practitioner/Physician	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Medical Supply	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Transportation	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	Home Health	DENY
0490/4144	E - 5TH (E) DIAG NOT ON FILE	HCBS Waiver	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Mcare Part A Crossover	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Mcare Part B Crossover	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Mcare UB Part B Crossover	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Dental	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Hospice	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Inpatient	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Laboratory and Xray	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Long Term Care	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Outpatient	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Practitioner/Physician	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Medical Supply	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Transportation	DENY
0496/99014	E-CLM NOT SUB W/IN 2 YR LIMIT	Home Health	DENY
0519/19653	NDC NOT VALID	Outpatient	DENY
0519/19653	NDC NOT VALID	Practitioner/Physician	DENY
0520/19652	HCPCS CODE REQ NDC	Outpatient	DENY
0520/19652	HCPCS CODE REQ NDC	Practitioner/Physician	DENY
0520/19652	HCPCS CODE REQ NDC	Medical Supply	DENY
0550/4578	E - PRIN.SURG PROC NOT ON FILE	Mcare Part A Crossover	DENY
0550/4578	E - PRIN.SURG PROC NOT ON FILE	Mcare UB Part B Crossover	DENY
0550/4578	E - PRIN.SURG PROC NOT ON FILE	Inpatient	DENY
0550/4578	E - PRIN.SURG PROC NOT ON FILE	Outpatient	DENY
0598/4228	Prin Diag POA Missing Invalid	Inpatient	DENY
0598/4230	1st Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4231	2nd Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4232	3rd Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4233	4th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0598/4234	5th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4235	6th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4236	7th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4237	8th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4238	9th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4239	10th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4240	11th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4241	12th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4242	13th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4243	14th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4244	15th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4245	16th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4246	17th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4247	18th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4248	19th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4249	20th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4250	21st Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4251	22nd Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4252	23rd Sec(BF/ABF)Dx POA M/I	Inpatient	DENY
0598/4253	24th Sec(BF/ABF)Dx POA M/I	Inpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0652/65001	SUSPECT DUP, COVERED BY INPT	Mcare Part B Crossover	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Hospice	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Laboratory and Xray	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Long Term Care	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Practitioner/Physician	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Medical Supply	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Transportation	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	Home Health	DENY
0652/65001	SUSPECT DUP, COVERED BY INPT	HCBS Waiver	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Mcare Part A Crossover	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Mcare Part B Crossover	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Mcare UB Part B Crossover	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Dental	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Hospice	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Laboratory and Xray	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Long Term Care	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Outpatient	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Practitioner/Physician	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Medical Supply	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0653/65002	SUSPECT DUP, COVERED BY INPT	Transportation	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	Home Health	DENY
0653/65002	SUSPECT DUP, COVERED BY INPT	HCBS Waiver	DENY
0671/4433	Abr Prc Rq Ct Of Nec Fm-No Att	Outpatient	DENY&RPT
0671/4433	Abr Prc Rq Ct Of Nec Fm-No Att	Mcare UB Part B Crossover	DENY&RPT
0671/4433	Abr Prc Rq Ct Of Nec Fm-No Att	Mcare Part A Crossover	DENY&RPT
0671/4433	Abr Prc Rq Ct Of Nec Fm-No Att	Inpatient	DENY&RPT
0671/4433	Abr Prc Rq Ct Of Nec Fm-No Att	Mcare Part B Crossover	DENY&RPT
0671/4433	Abr Prc Rq Ct Of Nec Fm-No Att	Practitioner/Physician	DENY&RPT
0671/4434	Abr Prc Rq Ct Of Nec Frm-w/Att	Mcare UB Part B Crossover	DENY&RPT
0671/4434	Abr Prc Rq Ct Of Nec Frm-w/Att	Inpatient	DENY&RPT
0671/4434	Abr Prc Rq Ct Of Nec Frm-w/Att	Outpatient	DENY&RPT
0671/4434	Abr Prc Rq Ct Of Nec Frm-w/Att	Mcare Part B Crossover	DENY&RPT
0671/4434	Abr Prc Rq Ct Of Nec Frm-w/Att	Practitioner/Physician	DENY&RPT
0671/4434	Abr Prc Rq Ct Of Nec Frm-w/Att	Mcare Part A Crossover	DENY&RPT
0686/65004	SUSPECT DUPE PART A CLM OVER	Hospice	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Inpatient	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Laboratory and Xray	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Long Term Care	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Outpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0686/65004	SUSPECT DUPE PART A CLM OVER	Practitioner/Physician	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Medical Supply	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Transportation	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	Home Health	DENY
0686/65004	SUSPECT DUPE PART A CLM OVER	HCBS Waiver	DENY
0690/49330	PROVIDER NOT APPROVED FOR HFW	Practitioner/Physician	DENY
0691/49324	PROV NOT AUTH CCBHC CLAIM	Practitioner/Physician	DENY
0691/49324	PROVIDER NOT AUTHORIZED TO BILL CCBHC CLAIM	Mcare Part B Crossover	DENY
0702/2030	E - DOS IS BEFORE DOB	Mcare Part A Crossover	DENY
0702/2030	E - DOS IS BEFORE DOB	Mcare Part B Crossover	DENY
0702/2030	E - DOS IS BEFORE DOB	Mcare UB Part B Crossover	DENY
0702/2030	E - DOS IS BEFORE DOB	Dental	DENY
0702/2030	E - DOS IS BEFORE DOB	Hospice	DENY
0702/2030	E - DOS IS BEFORE DOB	Inpatient	DENY
0702/2030	E - DOS IS BEFORE DOB	Laboratory and Xray	DENY
0702/2030	E - DOS IS BEFORE DOB	Long Term Care	DENY
0702/2030	E - DOS IS BEFORE DOB	Outpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0702/2030	E - DOS IS BEFORE DOB	Practitioner/Physician	DENY
0702/2030	E - DOS IS BEFORE DOB	Medical Supply	DENY
0702/2030	E - DOS IS BEFORE DOB	Transportation	DENY
0702/2030	E - DOS IS BEFORE DOB	Home Health	DENY
0702/2030	E - DOS IS BEFORE DOB	HCBS Waiver	DENY
0702/2030	E - DOS IS BEFORE DOB	HCBS Case Mgmt Assmt (CMA)	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Mcare Part A Crossover	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Mcare Part B Crossover	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Mcare UB Part B Crossover	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Dental	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Hospice	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Inpatient	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Long Term Care	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Outpatient	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0707/49312	E-PROC NOT PREGNANCY RELATED	Practitioner/Physician	DENY
0707/49312	E-PROC NOT PREGNANCY RELATED	Home Health	DENY
0718/19626	NO DED/CO-INS ON X-OVER CLM	Mcare Part A Crossover	DENY
0718/19626	NO DED/CO-INS ON X-OVER CLM	Mcare Part B Crossover	DENY
0718/19626	NO DED/CO-INS ON X-OVER CLM	Mcare UB Part B Crossover	DENY
0779/65037	SUSPECT DUP COV BY HOSPICE CL	Long Term Care	DENY
0779/65037	SUSPECT DUP COV BY HOSPICE CL	Practitioner/Physician	DENY
0779/65037	SUSPECT DUP COV BY HOSPICE CL	Medical Supply	DENY
0779/65037	SUSPECT DUP COV BY HOSPICE CL	Home Health	DENY
0782/65006	SUSP DUP COVERED BY MCARE PT B	Dental	DENY
0782/65006	SUSP DUP COVERED BY MCARE PT B	Laboratory and Xray	DENY
0782/65006	SUSP DUP COVERED BY MCARE PT B	Practitioner/Physician	DENY
0782/65006	SUSP DUP COVERED BY MCARE PT B	Medical Supply	DENY
	SUSP DUP COVERED BY MCARE PT B		

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0782/65006		Transportation	DENY
0812/1647	8TH CONDITION CODE INVALID	Hospice	DENY&REPORT
0812/1647	8TH CONDITION CODE INVALID	Inpatient	DENY&REPORT
0812/1647	8TH CONDITION CODE INVALID	Long Term Care	DENY&REPORT
0812/1647	8TH CONDITION CODE INVALID	Outpatient	DENY&REPORT
0812/1647	8TH CONDITION CODE INVALID	Home Health	DENY&REPORT
0813/1648	9TH CONDITION CODE INVALID	Hospice	DENY&REPORT
0813/1648	9TH CONDITION CODE INVALID	Inpatient	DENY&REPORT
0813/1648	9TH CONDITION CODE INVALID	Long Term Care	DENY&REPORT
0813/1648	9TH CONDITION CODE INVALID	Outpatient	DENY&REPORT
0813/1648	9TH CONDITION CODE INVALID	Home Health	DENY&REPORT
0814/1649	10TH CONDITION CODE INVALID	Hospice	DENY&REPORT
0814/1649	10TH CONDITION CODE INVALID	Inpatient	DENY&REPORT
0814/1649	10TH CONDITION CODE INVALID	Long Term Care	DENY&REPORT
0814/1649	10TH CONDITION CODE INVALID	Outpatient	DENY&REPORT
0814/1649	10TH CONDITION CODE INVALID	Home Health	DENY&REPORT
0840/1892	REPLCMT OR CRED IS IN PROCESS	Mcare Part A Crossover	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Mcare Part B Crossover	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Mcare UB Part B Crossover	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0840/1892	REPLCMT OR CRED IS IN PROCESS	Dental	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Financial Transaction	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Hospice	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Inpatient	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Mcare Pharm Part B Crossover	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Laboratory and Xray	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Capitation (MC)	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Long Term Care	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Outpatient	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Practitioner/Physician	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Pharmacy (RX)	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Medical Supply	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Transportation	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Home Health	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	HCBS Waiver	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	HCBS Case Mgmt Assmt (CMA)	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Replacement Request	DENY
0840/1892	REPLCMT OR CRED IS IN PROCESS	Credit Request	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0841/19665	MCO PROV ID MUST MATCH ORIG	Mcare Part A Crossover	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Mcare Part B Crossover	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Mcare UB Part B Crossover	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Dental	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Financial Transaction	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Hospice	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Inpatient	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Mcare Pharm Part B Crossover	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Laboratory and Xray	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Capitation (MC)	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Long Term Care	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Outpatient	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Practitioner/Physician	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Pharmacy (RX)	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Medical Supply	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Transportation	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Home Health	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	HCBS Waiver	DENY

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0841/19665	MCO PROV ID MUST MATCH ORIG	HCBS Case Mgmt Assmt (CMA)	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Replacement Request	DENY
0841/19665	MCO PROV ID MUST MATCH ORIG	Credit Request	DENY
0845/1894	CLM ALREADY CRED OR REPLCD	Mcare Part A Crossover	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Mcare Part B Crossover	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Mcare UB Part B Crossover	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Dental	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Financial Transaction	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Hospice	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Inpatient	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Mcare Pharm Part B Crossover	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Laboratory and Xray	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Capitation (MC)	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Long Term Care	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Outpatient	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Practitioner/Physician	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Pharmacy (RX)	DENY&REPORT

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0845/1894	CLM ALREADY CRED OR REPLCD	Medical Supply	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Transportation	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Home Health	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	HCBS Waiver	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	HCBS Case Mgmt Assmt (CMA)	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Replacement Request	DENY&REPORT
0845/1894	CLM ALREADY CRED OR REPLCD	Credit Request	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Mcare Part A Crossover	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Mcare Part B Crossover	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Mcare UB Part B Crossover	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Dental	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Financial Transaction	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Hospice	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Inpatient	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Mcare Pharm Part B Crossover	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Laboratory and Xray	DENY&REPORT

0850/1895	ADJ/VOID REQ NOT PROCESSED	Capitation (MC)	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Long Term Care	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Outpatient	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Practitioner/Physician	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Pharmacy (RX)	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Medical Supply	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Transportation	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Home Health	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	HCBS Waiver	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	HCBS Case Mgmt Assmt (CMA)	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Replacement Request	DENY&REPORT
0850/1895	ADJ/VOID REQ NOT PROCESSED	Credit Request	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Mcare Part A Crossover	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Mcare Part B Crossover	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Mcare UB Part B Crossover	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Dental	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Financial Transaction	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Hospice	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Inpatient	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Mcare Pharm Part B Crossover	DENY&REPORT

0856/1897	A CREDIT MAY NOT BE ADJUSTED	Laboratory and Xray	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Capitation (MC)	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Long Term Care	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Outpatient	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Practitioner/Physician	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Pharmacy (RX)	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Medical Supply	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Transportation	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Home Health	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	HCBS Waiver	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	HCBS Case Mgmt Assmt (CMA)	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Replacement Request	DENY&REPORT
0856/1897	A CREDIT MAY NOT BE ADJUSTED	Credit Request	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Mcare Part A Crossover	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Mcare Part B Crossover	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Mcare UB Part B Crossover	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Dental	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Hospice	DENY&REPORT

0857/1904	CANNOT ADJ DENIED REPLACEMENT	Inpatient	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Laboratory and Xray	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Long Term Care	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Outpatient	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Practitioner/Physician	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Medical Supply	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Transportation	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Home Health	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	HCBS Waiver	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	HCBS Case Mgmt Assmt (CMA)	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Replacement Request	DENY&REPORT
0857/1904	CANNOT ADJ DENIED REPLACEMENT	Credit Request	DENY&REPORT
0868/1400	E-TOOTH NUMBER INVALID	Dental	DENY

0870/1420	E-TYPE OF BILL IS MISS OR INV	Mcare Part A Crossover	DENY
0870/1420	E-TYPE OF BILL IS MISS OR INV	Mcare UB Part B Crossover	DENY
0870/1420	E-TYPE OF BILL IS MISS OR INV	Hospice	DENY
0870/1420	E-TYPE OF BILL IS MISS OR INV	Inpatient	DENY
0870/1420	E-TYPE OF BILL IS MISS OR INV	Long Term Care	DENY
0870/1420	E-TYPE OF BILL IS MISS OR INV	Outpatient	DENY
0870/1420	E-TYPE OF BILL IS MISS OR INV	Home Health	DENY
0930/19666	SURG PROCEDURE NOT VALID	Mcare Part A Crossover	DENY
0930/19666	SURG PROCEDURE NOT VALID	Mcare UB Part B Crossover	DENY
0930/19666	SURG PROCEDURE NOT VALID	Inpatient	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Mcare Part A Crossover	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Mcare Part B Crossover	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Mcare UB Part B Crossover	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Dental	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Hospice	DENY
	NO HP ENTRY FOR DOS FOR CC		

1160/35513	PLA	Inpatient	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Laboratory and Xray	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Long Term Care	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Outpatient	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Practitioner/Physician	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Pharmacy (RX)	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Medical Supply	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Transportation	DENY
1160/35513	NO HP ENTRY FOR DOS FOR CC PLA	Home Health	DENY
1186/1480	E - ADMIT HOUR INV	Mcare Part A Crossover	DENY
1186/1480	E - ADMIT HOUR INV	Mcare UB Part B Crossover	DENY
1186/1480	E - ADMIT HOUR INV	Hospice	DENY
1186/1480	E - ADMIT HOUR INV	Inpatient	DENY
1186/1480	E - ADMIT HOUR INV	Long Term Care	DENY

1186/1480	E - ADMIT HOUR INV	Outpatient	DENY
1186/1480	E - ADMIT HOUR INV	Home Health	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Mcare Part A Crossover	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Mcare Part B Crossover	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Mcare UB Part B Crossover	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Dental	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Financial Transaction	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Hospice	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Inpatient	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Mcare Pharm Part B Crossover	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Laboratory and Xray	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Capitation (MC)	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Long Term Care	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Outpatient	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Practitioner/Physician	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Pharmacy (RX)	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Medical Supply	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Transportation	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Home Health	DENY
1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Replacement Request	DENY

1253/2020	E-CLAIM DOS/CLIENT DOD CONFL	Credit Request	DENY
1361/65010	E - EXACT DUPLICATE	Mcare Part A Crossover	DENY
1361/65010	E - EXACT DUPLICATE	Mcare Part B Crossover	DENY
1361/65010	E - EXACT DUPLICATE	Mcare UB Part B Crossover	DENY
1361/65010	E - EXACT DUPLICATE	Dental	DENY
1361/65010	E - EXACT DUPLICATE	Hospice	DENY
1361/65010	E - EXACT DUPLICATE	Inpatient	DENY
1361/65010	E - EXACT DUPLICATE	Laboratory and Xray	DENY
1361/65010	E - EXACT DUPLICATE	Long Term Care	DENY
1361/65010	E - EXACT DUPLICATE	Outpatient	DENY
1361/65010	E - EXACT DUPLICATE	Practitioner/Physician	DENY
1361/65010	E - EXACT DUPLICATE	Medical Supply	DENY
1361/65010	E - EXACT DUPLICATE	Transportation	DENY
1361/65010	E - EXACT DUPLICATE	Home Health	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Mcare Part A Crossover	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Mcare Part B Crossover	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Hospice	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Inpatient	DENY
	E - POSSIBLE DUP-SAME		

1362/65011	PROVIDER	Laboratory and Xray	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Long Term Care	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Practitioner/Physician	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Medical Supply	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Transportation	DENY
1362/65011	E - POSSIBLE DUP-SAME PROVIDER	Home Health	DENY
1363/65012	POSSIBLE DUP - SAME PROVIDER	Mcare Part B Crossover	DENY
1363/65012	POSSIBLE DUP - SAME PROVIDER	Laboratory and Xray	DENY
1363/65012	POSSIBLE DUP - SAME PROVIDER	Practitioner/Physician	DENY
1371/65017	E -POSS DUP-DIFFERENT PROVIDER	Mcare Part A Crossover	DENY
1371/65017	E -POSS DUP-DIFFERENT PROVIDER	Inpatient	DENY
1371/65017	E -POSS DUP-DIFFERENT PROVIDER	Long Term Care	DENY
1384/65023	SUSP DUP MCARE PT A & B X- OVER	Mcare UB Part B Crossover	DENY
-/1505	MCO denied claim or claim line	Dental	Deny&Rpt
-/1505	MCO denied claim or claim line	Inpatient	Deny&Rpt

-/1505	MCO denied claim or claim line	Practitioner/Physician	Deny&Rpt
-/1505	MCO denied claim or claim line	Long Term Care	Deny&Rpt
-/1505	MCO denied claim or claim line	Outpatient	Deny&Rpt
-/1505	MCO denied claim or claim line	Mcare Part A Crossover	Deny&Rpt
-/1505	MCO denied claim or claim line	Mcare UB Part B Crossover	Deny&Rpt
-/1505	MCO denied claim or claim line	Mcare Part B Crossover	Deny&Rpt
1900/4158	10TH (J) DIAG NOT ON FILE	Mcare Part A Crossover	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Mcare Part B Crossover	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Mcare UB Part B Crossover	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Hospice	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Inpatient	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Long Term Care	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Outpatient	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Practitioner/Physician	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Medical Supply	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Transportation	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	Home Health	DENY
1900/4158	10TH (J) DIAG NOT ON FILE	HCBS Waiver	DENY
6158/81112	REFRACTION LMT 1 YR FOR CHILD	Mcare Part B Crossover	DENY
6158/81112	REFRACTION LMT 1 YR FOR CHILD	Practitioner/Physician	DENY
6159/81113	RP/REFIT EYEWEAR 1/60 DAYS	Mcare Part B Crossover	DENY

6159/81113	RP/REFIT EYEWEAR 1/60 DAYS	Practitioner/Physician	DENY
6172/81125	ULTRAFILTRATION VS DIALYSIS	Outpatient	DENY
6172/85046	ULTRAFILTRATION VS DIALYSIS	Outpatient	DENY
6195/81130	CLRCTL GNE TEST ONC 3 YRS	Laboratory and Xray	DENY
6201/81129	CARELINK CO/CARE FEE MONT	Practitioner/Physician	DENY

Exception codes may carry a different disposition per claim type. Each claim type set to Pay-and-Report for an Encounter can be found in Appendix D.

Claim Types:

OC Claim Type Code	OC Claim Type Desc	CMdS Claim Type Code	CMdS Type Desc
M	CAPITATION	C	Capitation
D	DENTAL	D	Dental
F	FINAL TRANSACTION	F	Financial Transaction
I	INPATIENT	I	Inpatient
L	INDEPENDENT LAB	L	Laboratory and Xray
P	PRACTITIONER	M	Practitioner/Physician
S	MEDICAL SUPPLY	S	Medical Supply
T	TRANSPORTATION	T	Transportation
W	HCBS WAIVER	G	HCBS Waiver
X	HCBS CMA WAIVER	U	HCBS Case Mgmt Assmt (CMA)
N	LONG TERM CARE	N	Long Term Care
H	HOSPICE	H	Hospice
O	OUTPATIENT	O	Outpatient
V	HOME HEALTH	V	Home Health
R	PHARMACY	P	Pharmacy
Y	REPLACEMENT REQUEST	R	Replacement Request
A	MEDICARE PART A XOVER	W	Mcare Part A Crossover

C	MEDICARE PART B XOVER	X	Mcare UB Part B Crossover
B	MEDICARE PART B XOVER	Y	Mcare Part B Crossover
Z	CREDIT REQUEST	Z	Credit Request

9.9.4.1.1 Most Frequent Medicaid Exceptions

NM Medicaid manages appropriate payment of services by assigning provider types and specialties to specific service codes. There are two primary edits that apply specifically to the provider type allowed for a procedure and the rendering provider type when the Rendering provider is required. The edit 0367 (CMdS 49299) **Prov Requires Review for Proc/Type Combo** will post if the provider billing or rendering the service is not one of the allowed provider types as per the procedure reference file; except that the State uses a system list to allow exceptions to the provider types shown on the procedure code file. Edit 0412 (CMdS 3300) **Rendering Provider Required** will deny claims that are submitted for codes that require a rendering provider if the rendering provider is not submitted; again, with an exception allowed based on provider types on a system list. There are additional edits that will be posted if the rendering provider on the claim is not enrolled and/or not allowed for that procedure.

The referring provider required indicator on the procedure code file that specifies when a rendering is required is intended to ensure for certain procedures that when a billing provider is a group, the individual practitioner gets reported on the claim as the rendering. The procedure code file also contains which provider types are allowed for that procedure. Generally, for encounters we apply the edit 0367(CMdS 49299) a bit more broadly than for FFS by looking also at the rendering provider when the billing provider type isn't one of the allowed for that procedure, and if the rendering provider is one of the allowed types on the procedure code file, the edit will not post. The edit 0412 (CMdS 3300) simply says that the rendering provider indicator is S or B, the rendering provider must be on the claim and on our provider master database. However, the system bypasses this exception if the billing provider type is equal to the billing provider type on system list "4542" (Billing Provider Types). So, for example: H0001 has the referring provider required indicator on the reference database associated with the line-item procedure code on the claim equal to 'S' (Rendering) and H0001 allows PT 313 and 343. Since both PTs are on system list 4542, this means that the rendering provider is not required to be on the claim.

The state will supply the system list to the MCOs for their use in editing. Changes to these lists occur very infrequently.

The description for the following exceptions is provided for the MCO's reference as these errors are the most frequently experienced. Refer to above chart to see if the exception is set to deny or just pay and report.

Claim Exception Cd	Exception Short Desc	Exception Description
0032 (4932,4933)	E-PROVIDER/CLAIM TYPE CONFLICT	The claim has been assigned a claim type of Practitioner, but the Billing Provider Type Code is not on system list 4960 (Provider Types allowed on Clm Ty P) (Note: this condition occurs when a claim with a Batch Type of HCFA is assigned a claim type of Practitioner by default). OR The claim has been assigned a claim type of Outpatient ('O')_ or MCARE Part B Xover ('C'), first Date Of Service (DOS) is greater than or equal to the Turquoise Care Implementation date (PARM 0100 Subsystem H) and Billing Provider Type is not one of the Outpatient provider types (201, 202, 203, 204, 205, 221, 313, 314, 315, 364, 447). OR The claim has been assigned a claim type of Long-Term Care (N'), first Date of Service (DOS) is greater than or equal to the Turquoise Care Implementation date (PARM 0100 Subsystem H) and Billing Provider Type is not one of the LTC provider types (211, 212, 213, 214, 215, 216, 217, 218, 219).
0051(4626)	E-SUM OF ACCM DYS NOT=TOT DYS	The sum of the submitted units for all the claim revenue codes that match the revenue codes on system list "4490" (Accommodation Revenue Codes) does not equal the covered days. The system uses the first date of service to access the correct list of accommodation revenue codes. If the provider rate type is DRG, the system uses the last date of service instead of the first date of service. A rate type of DRG is identified by the base rate source code of "DO" (Outlier), "DS" (Standard,) or "DT" (Transfer). The system bypasses this exception if a revenue code of "720" – (Labor Room/Delivery General Classification) is present on any of the claim lines and the

Claim Exception Cd	Exception Short Desc	Exception Description
		sum of the claim line submitted units for the accommodation revenue codes is less than the covered days.
0058(1520)	E – PAT STAT/ TYPE BILL CONFLI	The claim header patient status code conflicts with the claim header type of bill as follows: The last character of type of bill is “1” (Admit Thru Discharge Claim) or “4” (Interim Billing – Last Claim) and the patient status is “30” (Still a Patient), “31” (Still a Patient, State- Assigned) or “32” (Still a Patient, Waiting Placement). OR The last character of type of bill is “2” (Interim Billing – First Claim) or “3” (Continuing Claim) and the patient status is not “30” (Still a Patient), “31” (Still a Patient, State- Assigned) or “32” (Still a Patient, Waiting Placement).
0072(1620)	E – ACCOM REV CODE MISSING	The claim does not contain a line item with a revenue code equal to any of the revenue codes found on system list “4490” (Accommodation Revenue Codes). The system bypasses this exception when the revenue code is equal to “0720” (Labor Room/delivery General Classification) and the last date of service minus the first date of service equals one.
0077(4914)	E –SERV DATE SPAN MORE ONE DOS	The procedure span days indicator is set to “N” (No) indicating the dates of service cannot span days. AND The claim line first date of service does not equal the claim line last date of service.

Claim Exception Cd	Exception Short Desc	Exception Description
0097(19627)	Plan Payment Missing/Invalid	The encounter claim or line has an MC paid amount = zero and the procedure pricing code is not “00” (Zero Pricing (Not Covered)) or 04 Bundled Pricing. Bypass edit 0097 for Turquoise Care encounter if: Header Pricing Methodology code (C-PRCNG-PROCESS-CD) is ‘00’ or ‘04’, or Billing Provider Type (C-BLNG-PROV-TY-CD) equal to 211 or 212 and (Value Code (W1C40521-C-VALU-CD (n)) = ‘23’ and Value Code Amt (W1C41521-C-UB92-VALU-CD-AMT (n)) > $0;) or 4. Line Item Prior Payment Amount (C-COB-PYR-PYMT-AMT (n)) is > $0 OR c.d. if the Copay, NF Patient Liability or TPL reported in the claim exceeds 25% of the billed charges.

Claim Exception Cd	Exception Short Desc	Exception Description
0105(19659)	E-DUPE INPATIENT/OUTPATIENT	This edit is posted at the header level of inpatient claims and at the line level of outpatient claims when the client IDs are equal, the billing provider numbers are equal, and the line first date of service or line last date of service of the outpatient claim equals the first date of service of the inpatient claim or the line first date of service or the line last date of service of the outpatient claim equals the last date of service of the inpatient claim and the last digit of the type of bill on the inpatient claim is 1 (admit) or 4 (last claim). This edit is posted to all outpatient claims in process (if the above criteria are met). The edit is posted to Inpatient claims only when the associated outpatient claim already has been paid. During the adjudication cycle, the system performs special processing for each inpatient claim that has exception 0105 posted. An adjustment request is generated for the conflict outpatient claim with an adjustment reason = “550” resulting in a claim credit to the outpatient claim. We are requesting that the ‘550’ process (process that recoups an earlier paid outpatient claim based on the setting of certain dupe exceptions) work for encounters also. Secondly, we want to add a bypass exception to the edit as follows: Bypass If the Outpatient encounter claim revenue code is between 0300 and 0349 and diagnosis code on the outpatient claim is different from the admitting diagnosis on the inpatient claim.
0109(6553)	E- SURGERY FOLLOW- UP CVRS SVC	The follow-up service billed should have been part of the surgery billing. The following conditions must be true when comparing the current and previously paid claim: This edit posts when a medical procedure code for a follow-up office visit per system list “4599” is billed within the span of days between the first date of service and the follow-up date of another claim with a surgical procedure, the rendering provider numbers are equal, and the first three digits of the primary diagnosis codes are equal (practitioner claims only). The follow-up date is calculated by adding the post-op days from the Reference database to the line item procedure’s first date of service.

Claim Exception Cd	Exception Short Desc	Exception Description
0112(1180)	E- DOS CANNOT SPAN MONTHS	The claim header first date of service month is not equal to the claim header last date of service month. OR The claim header first date of service year is not equal to the claim header last date of service year. Only the following billing provider types apply to this edit: "211" (Nursing Facility, Private) "212" (Nursing Facility, State) "213" (Hospital, Swing Bed) "214" (ICF MR Private) "215" (ICF MR State Owned) "216" (Residential Treatment Center – JCAHO) "217" (Residential Treatment Center – Not JCAHO) "218" (Treatment Foster Care Services) "362" (Hospice) "705" (PACE) For hospice claims (claim type = "H"), the system bypasses this exception unless one of the claim's revenue codes is "0658" or "0659."
0113(19639)	E – ADMIT/FROM DATE CONFLICT	The admission date is greater than the first date of service.
0114(1430)	E- ADMIT SOURCE MISSING/ INVAL	The source of admission is missing from the claim. OR The source of admission is present on the claim, but it is not a valid value.

Claim Exception Cd	Exception Short Desc	Exception Description
0132(1250)	E – SUBD CHARGE IS MISSING	The line item submitted charge is missing. The edit is bypassed if the procedure code is on system list 4751 (Bypass Procs for Edit 0132(1250)). The edit posts to the line for all claim types.
0147(1440)	E – ADMIT TYPE INVALID	Inpatient Claims: The admit type is not a valid value or is equal to spaces. Outpatient Claims: The admit type is greater than spaces and is not a valid value.
0157(14363)	E-LINE COUNT IS INVALID	The claim line item count is zero or the claim line item count is greater than maximum number of line items on the claim.
0160(1260)	E – TOTAL CLAIM CHARGE CONFLIC	The sum of the line item submitted charges is not equal to the total submitted charges or the sum of the line item non-covered charges is not equal to the total non-covered charges. The total submitted charges and total non-covered charges are keyed on the line item of the claim associated with revenue code “0001.” The sum of the line item submitted charges does not add up to the total claim charge
0182(19656)	E-MISS/INVALID CVD/NON-DAYS	The through date of service minus the from date of service must be within three days of the covered days plus the non-covered days – if patient status equals 30 one day is added, otherwise the edit will post. If it’s an Encounter claim with Claim Type N, Billing Provider Type ‘211’ or ‘213’, and if any claim line contains a therapy revenue code of 0420-0449, then the exception will be bypassed. This applies to both inpatient claims and long term

Claim Exception Cd	Exception Short Desc	Exception Description
		care claims (in our system claim types I or N. If you see the claim type assignment chart, you'll see the TOB 86x is classified as long term care
0185(1510)	E- HOSPICE SUB UNT GRT TOT DYS	The patient status on the claim is equal to “30” (Still patient) and the line item submitted units of service associated with revenue code “0658” or “0659” is greater than the statement through coverage date minus statement from coverage date plus one. OR The patient status on the claim is NOT equal to “30” (Still patient) and the line item submitted units of service associated with revenue code “0658” or “0659” is greater than the statement through coverage date minus statement from coverage date
0188(1521)	Patient Status Invalid	Patient status is missing or not a valid value for the claim type
0201(1891)	Void/Repl TCN Missing/Invalid	The Requested Void or Replacement TCN is Missing or Invalid. The Request cannot be processed. Please correct and resubmit.
0205(3629(	E – REFERRING PROV REQUIRED	The referring provider required indicator on the reference database associated with the line item procedure code on the claim is equal to “Y” (Yes) and the line item referring provider on the claim is blank

Claim Exception Cd	Exception Short Desc	Exception Description
0222(2015)	Member Name Mismatch	Member information on the member database does not match the information keyed on the claim.
0239(49316)	OPPS OBSERV STAY 23 HOUR LIMIT	The claim is an OPPS claim, the procedure code = G0378 (HOSPITAL OBSERVATION SERVICE, PER HOUR) and the submitted units are greater than the service maximum allowed units on the OPPS procedure pricing span. The OPPS procedure pricing spans are identified as those on the Procedure Pricing Span table which has a Factor Code = 'Y'. An OPPS claims is defined as: Header Date of service greater than or equal to the OPPS effective start date on parameter 4840 for FFS claims or parameter 4841 for Encounter claims. Claim Type = 'O' or 'C' Type of Bill = '13X' or '83X' Provider Type = '201' or '203
0260(4115)	Diagnosis Code Not Specific	The Diagnosis Code submitted on the claim is not specific enough by itself and requires an additional Diagnosis Code. Please correct and resubmit claim.
0263(6140,6150,6160)	Crossover Claim – No Medicare on File	Post 6140: Claim Type = Inpatient Crossover and member.medicare Coverage Type <> Medicare Part A A crossover claim was submitted; however, the member is not indicated to have the appropriate Medicare coverage for that claim Post 6150: Claim Type = Outpatient Crossover and member.medicare Coverage Type <> Medicare Part B A crossover claim was submitted; however, the member is not indicated to have the appropriate Medicare coverage for that claim Post 6160:

Claim Exception Cd	Exception Short Desc	Exception Description
		Claim Type = Professional Crossover and member.medicare Coverage Type <> Medicare Part B A crossover claim was submitted; however, the member is not indicated to have the appropriate Medicare coverage for that claim
0261(29631)	CLIENT IS MEDICARE PART C ELIGIBLE	The client database indicates that the client has Medicare Part C coverage for the claim dates of service and there is no attachment code “59.” This edit is bypassed for the following reasons: If attachment code “74” is present on the claim, or the claim contains a CAS Reason that is present on system list 4811 for the Medicare payor (MA, MB or 16). The claim type is “S” (Medical Supply) AND the POS is “21” (Inpatient), “31” (Skilled Nursing Facility), “32” (Nursing Facility), “55” (Residential Substance Abuse Treatment Center), or “56” (Psychiatric Residential Treatment Center). The provider type on the claim is “313” (FQHC) and the procedure code is “YE010,” “YE011,” “YE012,” “YE013,” “YE014,” or “YE015.” 4. Provider type “435” (LPCC), “436” (LMFT), “443” (CNS), or “444” (LISW). 5. Note for Outpatient claims: This edit is bypassed for a line, if the revenue code on that line is present on the system list (“4733”). Edit revision to bypass if the Medicare coverage code on the procedure formulary file doesn’t indicate the code is covered. Edit needs revision for encounters – For Encounters. The client database indicates the client has Medicare Part C coverage for the claim dates of service but the C-COB- FLN-IND-CD IS NOT EQUAL TO MA, MB OR MI

Claim Exception Cd	Exception Short Desc	Exception Description
0264(29634)	E-CLIENT IS MCARE PT A ELIGIBL	The client database indicates that the client has Medicare Part A coverage for the claim dates of service and there is no attachment code “59.” The edit is bypassed if attachment code “74” is present on the claim, or the claim a CAS Reason that is present on system list 4811 for the Medicare payor The client database indicates that the client has Medicare Part A coverage for the claim dates of service, but the C-COB-FLN-IND-CD IS NOT EQUAL TO MA OR MI
0265(29630)	E-CLIENT IS MCARE PT B ELIGIBL	The client database indicates the client has Medicare Part B coverage for the claim dates of service and the procedure code has Medicare Part B coverage, but there is NO attachment code “59.” OR The claim is an outpatient claim and the client database indicates the client has Medicare Part B coverage for the claim dates of service, but there is NO attachment code “59.” Note for Outpatient claims: This edit is bypassed for a line, if the revenue code on that line is present on the system list (“4733”) of revenue codes that are to bypass edit 0265(CMdS 29630). OR The claim is an inpatient Part B only non-crossover claim and the client does – have Medicare Part B coverage and the type of bill is NOT equal to “121,” “122,” “123,” “124,” “821,” “823,” or “824.” This edit is bypassed for the following reasons: 1) The claim type is “S” (Medical Supply) AND the POS is “21” (Inpatient), “31” (Skilled Nursing Facility), “32” (Nursing Facility), “55” (Residential Substance Abuse Treatment Center), or “56” (Psychiatric Residential Treatment Center). 2

Claim Exception Cd	Exception Short Desc	Exception Description
		3) Provider type “435” (LPCC), “436” (LMFT), “443” (CNS), or “444” (LISW). Attachment code “70” or “74” is present on the claim. Claim contains a CAS Reason that is present on system list 4811 for the Medicare payor. Edit needs revision for encounters – For Encounters, The client database indicates the client has Medicare Part B coverage for the claim dates of service and the procedure code has Medicare Part B coverage, but the C- COB-FLN-IND-CD IS NOT EQUAL TO MB OR MI This edit is bypassed for a line, if the revenue code on that line is present on the system list (“4733”) of revenue codes that are to bypass edit 0265. OR The claim is an outpatient claim and the client database indicates the client has Medicare Part B coverage for the claim dates of service, but the C-COB-FLN-IND-CD IS NOT EQUAL TO MB OR MI This edit is bypassed for a line, if the revenue code on that line is present on the system list (“4733”) of revenue codes that are to bypass edit 0265. OR The claim is an inpatient Part B only non-crossover claim and the client does have Medicare Part B coverage and the type of bill is NOT equal to “121,” “122,” “123,” “124,” “821,” “823,” or “824.” RETAIN ADDITIONAL BYPASS CRITERIA.
0281(35505)	Svrc Nt Allw Comm Benefit Prv	Service Not Allowed For Community Benefit Provider

Claim Exception Cd	Exception Short Desc	Exception Description
0284(49317)	Transition Svcs> 90 Days	Transition Services Grtr 90 Days From Start Of Comm Ben Services
0299(3002)	Multiple Billing P_SYS_ID	More than one P_SYS_ID was found for the Billing provider in the P_ALT_ID table for the submitted provider ID & ID Type combination. Could not resolve to a unique P_SYS_ID
0310(3400)	Attending Prov ID Not on DB	The Attending Provider ID submitted on the claim is not on file. Please correct and resubmit claim.
0313(3600)	CAT OF SERV CANNOT BE DETERMIN	Inpatient, Medicare Part A Crossover, Long Term Care Claims: The claim category of service cannot be determined from the rules in the category of service determination table. All Other Claim Types: The line item category of service cannot be determined from the rules in the category of service determination table.
0314(29638)	Inpatient Services Not Payable for Presumptive Eligibility	Inpatient Claim Types: The client's category of eligibility is equal to "035" (Preg WM FM 3 Presumptive Elig), and the Federal Match code is equal to "3" (100% FFP, Preg Presmpt, SCHIP). Physician ClaimTypes:

Claim Exception Cd	Exception Short Desc	Exception Description
		The client's category of eligibility is equal to "035" (Preg WM FM 3 Presumptive Elig), and the Federal Match code is equal to "3" (100% FFP, Preg Presmpt, SCHIP), and the place of treatment is equal to "21" (Inpatient). Modify to add COEs 300 and 301 where fed match = 3
0315(3402)	Multiple Attending P_SYS_ID	More than one P_SYS_ID was found for the Attending provider in the P_ALT_ID table for the submitted provider ID & ID Type combination. Could not resolve to a unique P_SYS_ID
0322(39145)	Servicing Facility NPI for School Based Health Centers Missing/Invalid	The new edit would deny a claim where the billing provider type is 321 and a Servicing Facility NPI id has not been submitted on the claim, or the Servicing Facility NPI ID has been submitted but does not match an enrolled provider with a status of '60' or '70' and dates that cover the dates of service on the claim/encounter.
0331(29641)	NO LTC SPAN AVAIL FOR FRST DOS	If the Provider Type is 211 or 212 and the admit date is greater than 120 days less than the last date of service. If not true, then bypass edits 0331(29641, 0709(29640) and 0336(2109,2110,2111,2112) since LTC spans are not required for these claims If true, then check for a non-voided LTC span where the span begin date is

Claim Exception Cd	Exception Short Desc	Exception Description
		<= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'INF' (WV-B0457-C- NURSING-FACILITY). If not found, then post the exception 0331.(29641) If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331(29641). If the span begin date is <= FDOS, then continue to exception 0709(29640). If the Provider Type is 362 and Revenue Code is 0658 or 0659 and the admit date is greater than 120 days less than the last date of service If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'INF'. If not found, then post the exception 0331(29641). If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709(29640). If the Provider Type is 363 If true, then check for a non-voided LTC span where the span begin date is <= the Claim LDOS and the span end date >= claim FDOS where the Level of Care of 'NFL' and Setting of Care of 'ANW', SNW', ADB', or 'SBD'. If not found, then post the exception 0331(29641).

Claim Exception Cd	Exception Short Desc	Exception Description
		If the client's Setting of Care is 'INF' that covers the dates of service and procedure code is T2038 or S5165 then bypass posting exception edit 0331. If found, then confirm that the span begin date <= FDOS. If not, then post exception 0331. If the span begin date is <= FDOS, then continue to exception 0709. For hospice claims, the system bypasses this exception unless the revenue code is "0658" or "0659."

Claim Exception Cd	Exception Short Desc	Exception Description
0338(4307)	Service Not Payable For LTC Client	The procedure code LTC indicator is "Y" (indicating that the service is covered by LTC). AND The client LTC span covers the claim line item dates of service (indicating that the client was in an LTC facility during the service period). AND The provider's level of care on the client LTC span is equal to "HNF," "LNF," "MR1," "MR2," or "MR3" (the other additional LOC values indicate that the client is in a Treatment Care Facility and for which the edit should NOT post). AND The procedure code modifiers do not equal "U1". Modify to read "AND The provider's level of care on the client LTC span is equal to "NFL" with

Claim Exception Cd	Exception Short Desc	Exception Description
		Setting of Care = 'INF" or LOC is "MR1," "MR2," or "MR3"
0340(35507)	PT NOT ELIG FOR LTC DUE TO TRA	The claim's primary category of eligibility is "001", "003", "004", "081", "083", "084" and the associated federal match code is equal to "X" or "4" (Restricted SSI).

Claim Exception Cd	Exception Short Desc	Exception Description
0350(1889)	Claim Cannot be adjusted	Claim Cannot be adjusted due to Adjustment restriction indicator set to "Yes".

Claim Exception Cd	Exception Short Desc	Exception Description
0363(4406)	E - PROC/MOD 1 CONFLICTING	The procedure code modifier include/exclude code on the reference database is equal to “I” (Include) and the claim's first procedure code modifier on the line item does not match any of the procedure code modifiers listed on the reference database. OR The procedure code modifier include/exclude code on the reference database is equal to “E” (Exclude) and the claim's first procedure code modifier on the line item matches a procedure code modifier listed on the reference database. If the reference database does not contain a procedure code modifier, then this exception is bypassed. If the modifier value on the claim matches a modifier on system list “4651” (Bypass Procedure Modifiers), this edit is bypassed. If the claim is an OPPS claim, then this exception is bypassed. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X, Billing Provider Type ‘201’ or ‘203’, and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims. The procedure code modifier include/exclude code on the reference database is equal to “I” (Include) and the claim's first procedure code modifier on the line item does not match any of the procedure code modifiers listed on the reference database. OR the procedure code modifier include/exclude code on the reference database is equal to “E” (Exclude) and the claim's first procedure code modifier on the line item matches a procedure code modifier listed on the reference database. If the reference database does not contain a procedure code modifier, then this exception is bypassed. If the modifier value on the claim matches a modifier on system list “4651”

Claim Exception Cd	Exception Short Desc	Exception Description
		(Bypass Procedure Modifiers), this edit is bypassed. If the claim is an OPPS claim, then this exception is bypassed. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims.
0341(3632)	REFERRING NPI REQUIRED	The Referring NPI is not present on the claim, and the Medicaid provider's "Healthcare Provider" flag is equal to 'Y'.

Claim Exception Cd	Exception Short Desc	Exception Description
		If the Referring Provider Medicaid ID is spaces, the edit is bypassed
0362(4272)	E-TOOTH SURFACE REQUIRED	The tooth surface required indicator on the procedure record is equal to tooth surface required, and none of the six tooth surfaces on the line item have a value other than spaces. OR The tooth surface required indicator on the procedure record is equal to tooth surface required, the procedure code is equal to D1351, and the tooth surface is not O-Occlusal, OB (Occlusal-Buccal) or OL (Occlusal-Lingual).
0364(4274)	E- PROC/TOOTH/QUAD NBR CNFL	The tooth number include/exclude code on the reference database associated with the line item procedure code on the claim is equal to “I” (Include) and the line item tooth number on the claim is not equal to any of the tooth numbers included on the reference database. OR The tooth number include/exclude code on the reference database associated with the line item procedure code on the claim is equal to “E” (Exclude) and the line item tooth number on the claim is equal to one of the tooth numbers excluded on the reference database.
0367(49299)	BILL PROV REVIEW FOR TYPE/PROC	All Claim Types: This edit will be bypassed for all encounter claims whose procedure code is found on general system list 4774. This edit will also be bypassed if the procedure code modifier is ‘AS’, the rendering provider type is ‘305’, 306’, 316’, ‘320’, ‘322’ or ‘323’, and the procedure code is within range 11000-69999. All Non-Inpatient UB-04 Claim Types:

Claim Exception Cd	Exception Short Desc	Exception Description
		The provider type include/exclude code on the reference procedure code database is equal to "I" (Include) and the billing provider type on the claim does NOT match any of the provider types listed on the reference procedure code database. OR The provider type indicator on the reference procedure code database is set to "E" (Exclude) and the billing provider type on the claim matches a provider type listed on the reference procedure code database. This edit is not executed for Inpatient Claims Note: If the reference database does not contain a provider type, this exception is bypassed. The edit will also be bypassed for OPPS claims. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X or 851, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims. In addition, the edit will be bypassed when Outpatient (Claim Type O) and the Billing Provider Type is 313 (FQHC). All Other Claim Types: The provider type include/exclude coded on the reference procedure code database is equal to "I" (Include) and the rendering provider type on the claim does NOT match any of the provider types listed on the reference procedure code database. OR

Claim Exception Cd	Exception Short Desc	Exception Description
		The provider type include/exclude code on the reference procedure code database is equal to “E” (Exclude) and the rendering provider type on the claim matches a provider type listed on the reference procedure code database. Note: If the reference procedure code database does not contain a provider type, this exception is bypassed. Note: For All HCFA (Professional) Claim Types: The rendering provider’s type is used first for this edit. If edit would post based on the rendering provider’s type, then the billing provider’s type code is used, if the procedure code is found on system list “4547” (Procedures that can use either Rendering or Billing Provider Type/Specialty). Note: For All CMS-1500 Claim Types: The edit is bypassed if the billing provider is found on system list 4775 and the procedure code is found on system list 4776 (H0043 AND H0044). **Note:** For All Encounter HCFA (Professional) and Encounter Dental Claim Types: The rendering provider’s type is used first for this edit. If edit would post based on the rendering provider’s type, then the billing provider’s type code is used. For All Encounters: The edit is bypassed when the provider type is 221, 314, 315 and the MCO Paid Amount on the line is 0.

Claim Exception Cd	Exception Short Desc	Exception Description
0368(4322)	BILL PROV REVIEW FOR TYPE/REV	The provider type include/exclude code on the reference revenue code database is equal to "I" (Include) and the billing provider type on the claim does NOT match any of the provider types listed on the reference revenue code database. OR The provider type indicator on the reference revenue code database is set to "E" (Exclude) and the billing provider type on the claim matches a provider type listed on the reference revenue code database. Note: If the reference revenue code database does not contain a provider type, this exception is bypassed.
0372(4420)	E- PROC/CLM TYPE CNFL	The procedure claim type include/exclude code on the reference database is equal to "I" (Include) and the claim type on the claim does not match any of the claim types listed on the reference database. OR The procedure claim type include/exclude code on the reference database is equal to "E" (Exclude) and the claim type on the claim matches a claim type listed on the reference database. If the reference database does not contain a claim type, then this exception is bypassed. The edit will also be bypassed for OPPS claims. An OPPS claim has the following attributes: Claim Type O or C, Type of Bill 013X or 083X, Billing Provider Type '201' or '203', and Header First Date of Service on or after Date Value on System Parameter 4840 for FFS and System Parameter 4841 for Encounter claims.

Claim Exception Cd	Exception Short Desc	Exception Description
0373(4324)	E-REV/TYPE OF BILL CNFL	The revenue type of bill include/exclude code on the reference database is equal to “I” (Include) and the type of bill on the claim does not match any of the type of bill values listed on the reference database. OR The revenue type of bill include/exclude code on the reference database is equal to “E” (Exclude) and the type of bill on the claim matches a type of bill value listed on the reference database. If the reference database does not contain a type of bill, then this exception is bypassed.
0376(4422)	E-PROC REQUIRES MODIFIER	The procedure code modifier required indicator on the reference database is equal to “Y” (Yes) and both line item procedure code modifiers on the claim are equal to spaces or zeroes
0377(9090, 9095)	Fund Code defaulted paid susp, Fund Code defaulted denied	A fund code could not be determined for a to be paid or suspended claim and was defaulted. A fund code could not be determined for a to be denied claim and was defaulted.
0386(35512)	Proc Code Exists on ABP System List 4755	post to the claim line, if the procedure code is included in system list 4755 – PROC CODES INCLUDED IN ABP - LIST TWO. The edit will bypass: If the claim’s primary COE is equal to “100” and the recipient’s disability indicator is set to <spaces> OR If the claim’s primary COE is equal to “030”, “035”, “300” or “301” OR If the recipient is under 21
0388(4473)	E-FQHC PROV CANT BILL X-OVER	The billing provider type is “313” (Clinic Federally Qualified Health Center). Note: Only applies to crossover claims (Controlled via Exception Disposition Table).

Claim Exception Cd	Exception Short Desc	Exception Description
0412(3300)	E-REND/DEST NOT ON DATA BASE	If the referring provider required indicator on the reference database associated with the line item procedure code on the claim is equal to 'S' (Rendering) or 'B' (Both); the rendering provider is required on the claim. This edit posts if the rendering provider number if present on the claim does not have a corresponding row on the provider master database. The system bypasses this exception if the billing provider type is equal to the billing provider type on system list "4542" (Billing Provider Types).
0422(3305)	RENDERING PROV NOT ENROLLED	The edit posts if both of the following conditions are NOT true: The line item last date of service is encompassed by the rendering provider enrollment span dates. The rendering provider enrollment status is equal to "60" (Active). This edit logic is bypassed if the billing provider type is equal to the billing provider type on system list "4542" (Billing Provider Types). Add that the rendering provider enrollment status can be = '70' or '60' for encounters
0425(3015)	E-PROV NOT A VALID BILL PROV	This edit determines if the billing provider is not allowed to submit claims. The edit posts if the Billing Provider Code is equal to "S" (Service Only – No Claims).
0496(99014)	CLAIM NOT SUBMITTED WITHIN THE TWO-YEAR FILING PERIOD	Remove Encounter bypass logic
0497(99015)	TIMELY FILING-RVW GRACE PERIOD	The adjustment or resubmission claim was not received within the filing grace period. For adjustments, the edit will post when the replacement claim was not received within 90 days of the replaced TCN's paid date and the replaced TCN was timely as defined in edit 0815(99013)/0820(99016).
0519(19653)	NDC Not Valid	NDC Not Valid

Claim Exception Cd	Exception Short Desc	Exception Description
0520(19652)	HCPCS Code Req NDC	HCPCS Code Requires NDC
0596(1370)	E – DIAGNOSIS RELATED CODE INV	The line item first, second, third, fourth, fifth, sixth, seventh, or eighth diagnosis related code is not a valid value, references a diagnosis code that is equal to spaces or is repeated in another related diagnosis field on the same line.
0652(65001)	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Drg Claim
0653(65002)	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim
0686(65004)	Suspect Dupe Part A Clm Over	Suspect Duplicate, Medicare Part A Claim Overlaps With Another Service

Claim Exception Cd	Exception Short Desc	Exception Description
0690(49330)	Provider Not Approved For HFW	Provider Not Approved For High Fidelity Wrap Around
0691(49324)	Prov Not Auth CCBHC Claim	Provider Not Authorized To Bill CCBHC Claim
0694(49327)	Proc Code Inv For CCBHC Claim	Procedure Code Invalid For CCBHC Claim
0709(29640)	LTC SPAN ENDS BEFORE LAST DOS	The LTC end date is before the claim last date of service or the LTC discharge date (date associated with occurrence code “42”) is before the claim last date of service. The system bypasses this exception if the discharge date or LTC end date one day prior to the last date of service and the claim frequency code is “1” (Admission Through Discharge) or “4” (Interim Billing – Discharge Clm). For hospice claims, the system bypasses this exception unless the revenue code is “0658” or “0659.” (Rev Codes 0658/0659 should only be used with clients who have a NFL/INF span in place)

Claim Exception Cd	Exception Short Desc	Exception Description
0778(65009)	Suspect Duplicate Home Health and Waiver Claim	For Turquoise Care, modify this exception to post for encounters when claim type V compares to claim with Provider Type 363 where 1. Both claims have the same client ID. (C_HDR_TB.B_SYS_ID) 5. Both claims have the same dates of service or the dates of service overlap. (C_HDR_TB.C_HDR_SVC_FST_DT C_HDR_TB.C_HDR_SVC_LST_DT). 3. The Community Benefit claim's procedure code is the Waiver system list (4728)
0840(1892)	Replacement/Void is in Process	The Requested Void or Replacement is already in process for this Claim. The Request cannot be processed.
0900(1071)	MCARE DENIED FOR ADMIN RSNS	Medicare denied because the amount paid was zero and one of the following administration reasons are on system list 4810
0901(1072)	NON MCARE DENIED FOR ADMIN RSN	Other (non-Medicare payer) denied because the amount paid was zero and one of the following administrative reasons is on system list 4810
0905(6140)	Inpatient crossover claim and no Medicare Part A coverage on file	A crossover claim was submitted; however, the member is not indicated to have the appropriate Medicare coverage for that claim
0956(1401)	ORAL CAVITY REQUIRED	If the procedure code indicates that an oral cavity is required and the field is spaces or not a valid value (please refer to Turquoise Claims for a list of the valid values), the exception 'Oral cavity required' is posted
0957(4275)	PROC/ORAL CAVITY CONFLICT	The oral cavity include/exclude code on the reference database associated with the line item procedure code on the claim is equal to "I" (Include) and the line item oral cavity on the claim is not equal to any of the oral cavity values included on the reference database. OR The oral cavity include/exclude code on the reference database associated with the line item procedure code on the claim is equal to "E" (Exclude) and the line item oral cavity on the claim is equal to one of the oral cavity values excluded on the reference database.

Claim Exception Cd	Exception Short Desc	Exception Description
1160(35513)	No Health Plan Entry for DOS for CC Plan	DOS are not covered by a lockin span for the MCO submitting the encounter. Encounter edit that replaces edits 1150, 1151, and 1152I
1253(2020)	Clm DOS/Client DOD Cnfl	Claim end date of service is after the member's date of death.
1274(2025)	PATIENT STATUS CLIENT DATE OF DEATH CONFLICT	The patient status on the claim is equal to “20” (Expired), and the date of death on the client master database is not present

[Placeholder for systems list]

9.9.4.2 Pharmacy Claims Exception Errors

The following codes are all set to deny for encounters.

Exception Code	Edit Disposition	NCPDP Reject Code	Short Description	Long Description
4001	Deny	01	M/I BIN	"THE BIN NUMBER IS MISSING OR DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED BELOW. 610084 OR 007060 OR 009555 OR 007912"
4002	Deny	02	M/I VERSION NUMBER	THE VERSION NUMBER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD

4003	Deny	02	M/I VERSION NUMBER	THE VERSION NUMBER IS NOT ONE OF THE VERSIONS THAT THE CUSTOMER ACCEPTS FOR PROCESSING.
4004	Deny	03	M/I TRANSACTION CODE	THE TRANSACTION CODE IS MISSING (ZEROS) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD IN VERSION 3.2.
4005	Deny	03	M/I TRANSACTION CODE	THE TRANSACTION CODE IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD IN VERSION 5.1.
4006	Deny	03	M/I TRANSACTION CODE	THE TRANSACTION CODE IS NOT ONE OF THE TRANSACTION CODES IN VERSION 3.2 OR 5.1 THAT THE CUSTOMER ACCEPTS FOR PROCESSING.
4007	Deny	04	M/I PROCESSOR CONTROL NUMBER	"M/I PROCESSOR CONTROL #DRRXTEST = TESTDRRXPROD = PRODUCTIONDRRXACCP = ACCEPTANCE"
4009	Deny	05	M/I PHARMACY NUMBER	THE PHARMACY PROVIDER ID DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4010	Deny	07	M/I CARDHOLDER ID	THE MEMBER ID IS MISSING OR EQUAL SPACES.
4012	Deny	09	M/I BIRTHDATE	NA
4013	Deny	09	M/I BIRTHDATE	NA
4014	Deny	09	M/I BIRTHDATE	"NOT USEDDOB ON CLAIM MUST BE WITHIN ONE YEAR OF

				PARTICIPANT'S ACTUAL DOBBE/MA"
4019	Deny	13	M/I OTHER COVERAGE CODE	THE OTHER COVERAGE CODE IS MISSING OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4023	Deny	15	M/I DATE OF SERVICE	ANYTHING ELECTRONIC IS DENIED. ANY PAPER CLAIM IS REVIEWED.
4025	Deny	16	M/I PRESCRIPTION/SERVICE REFER	IF PRESCRIPTION NUMBER IS MISSING (ZEROS) OR NOT NUMERIC - THEN POST THE ERROR.
4027	Deny	17	M/I FILL NUMBER	"IP REFILL INDICATOR (FILL NUMBER) IS EQUAL TO ZEROS OR (IP REFILL INDICATOR (FILL NUMBER) IS GREATER THAN ZEROS AND IP PROVIDER NUMBER EQUALS HISTORY PROVIDER NUMBER AND IP PRESCRIPTION NUMBER EQUALS HISTORY PRESCRIPTION NUMBER AND IP GSN EQUALS HISTORY GSN AND IP DATE PRESCRIBED EQUALS HISTORY DATE PRESCRIBED)"
4028	Deny	17	M/I FILL NUMBER	THE PRESCRIPTION REFILL NUMBER (FILL NUMBER) IS NOT NUMERIC.
4030	Deny	19	M/I DAYS SUPPLY	M/I DAYS SUPPLY

4033	Deny	20	M/I COMPOUND CODE	"EDIT POSTED IF NOT 0 - 1 - 2NOTE: COMPOUNDS (VALUE 2) ACCEPTED IN 5.1"
4034	Deny	21	M/I PRODUCT/SERVICE ID	THE NATIONAL DRUG CODE (NDC) IS MISSING - NON-NUMERIC - OR ALL ZEROS.
4037	Deny	22	M/I DISPENSED AS WRITTEN CODE	THE DISPENSE AS WRITTEN DAW/PRODUCT SELECTION CODE DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4039	Deny	25	M/I PRESCRIBER IDENTIFICATION	THE PRESCRIBER ID IS MISSING (SPACES).
4042	Deny	25	M/I PRESCRIBER IDENTIFICATION	MISSING OR INVALID PRESCRIBER IDENTIFICATION
4043	Deny	28	M/I DATE RX WRITTEN	THE DATE PRESCRIPTION WRITTEN IS MISSING OR INVALID
4045	Deny	28	M/I DATE RX WRITTEN	THE DRUG IS A SCHEDULE II DRUG AND THE NUMBER OF DAYS SINCE THE DATE PRESCRIBED IS MORE THAN 30 DAYS PRIOR TO THE FIRST DATE OF SERVICE
4067	Deny	33	M/I PRESCRIPTION ORIGIN CODE	MEDICAID DOES NOT ACCEPT THE DEFAULT ORIGIN CODE
4074	Deny	4C	M/I COORDINATION OF BENEFITS/O	"MISSING/INVALID COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT - 5.1 ONLY A COB SEGMENT IS PRESENT AND THE

				COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT IS MISSING (ZEROS)."
4075	Deny	40	PHARMACY NOT CONTRACTED WITH P	PHARMACY NOT ON FILE - PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE. FOR ENROLLMENT OR STATUS ISSUES REFER PHARMACY TO CONDUENT ALBUQUERQUE AT 800-299-7304 EXT 193.
4078	Deny	5C	M/I OTHER PAYER COVERAGE TYPE	THE OTHER PAYER COVERAGE TYPE (COB HEIRARCHY) IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4079	Deny	5E	M/I OTHER PAYER REJECT COUNT	A COB SEGMENT IS PRESENT AND THE OTHER PAYER REJECT COUNT IS MISSING.
4081	Deny	50	NON-MATCHED PHARMACY NUMBER	THE SERVICE PHARMACY PROVIDER ID DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4081	Deny	50	NON-MATCHED PHARMACY NUMBER	THE SERVICE PHARMACY PROVIDER ID DOES NOT EXIST ON THE PROVIDER MASTER TABLE.
4082	Deny	51	NON-MATCHED GROUP ID	B - GROUP RECORD NOT ON FILE

4083	Deny	51	NON-MATCHED GROUP ID	ACS REQUIRED A - 1ST DATE OF SVC NOT IN RANGE OF THE PLAN ON THE GROUP FILE
4085	Deny	51	NON-MATCHED GROUP ID	C - MAIL ORDER CLAIM: MAIL ORDER PRICING ID NOT ON THE GROUP FILE.
4086	Deny	52	NON-MATCHED CARDHOLDER ID	NON-MATCHED MEMBER ID. MEMBER NOT FOUND ON ELIGIBILITY FILE.
4089	Deny	54	NON-MATCHED NDC #	NON-MATCHED NDC (NOT ON DRUG FILE)
4090	Deny	56	NON-MATCHED PRESCRIBER IDENTIF	PHYSICIAN LIC# NOT ON FILE (LOCKIN)
4092	Deny	60	DRUG NOT COVERED FOR PATIENT A	"POST IF MINIMUM AGE ON CUSTOM RECORD AND PATIENT IS BELOW THAT AGE AND NO PA EXISTS.11/26 EOB EDIT MOVED FROM EDIT 88"
4094	Deny	61	DRUG NOT COVERED FOR PATIENT G	DRUG NOT COVERED FOR PATIENT GENDER. IF THE DRUG IS SPECIFIED FOR A PARTICULAR GENDER ON THE CUSTOM RECORD AND THE PATIENT IS NOT THAT GENDER AND NO PRIOR AUTHORIZATION ON THE MEDICAL PROFILE; THEN POST THE ERROR.

4097	Deny	65	PATIENT IS NOT COVERED	PATIENT NOT COVERED - CHECKS THE COVERAGE DATA ON THE ELIGIBILITY FILE TO SEE IF THE CLAIM FDOS IS IN RANGE. ALSO CHECKS THE RELATIONSHIP TO DETERMINE IF THE MEMBER IS COVERED AND CHECKS TO SEE IF IT IS A COVERED MEMBER ID. IF NOT COVERED FOR ANY OF THESE REASONS; THEN POST THE ERROR.
4097	Deny	65	PATIENT IS NOT COVERED	PATIENT NOT COVERED - CHECKS THE COVERAGE DATA ON THE ELIGIBILITY FILE TO SEE IF THE CLAIM FDOS IS IN RANGE. ALSO CHECKS THE RELATIONSHIP TO DETERMINE IF THE MEMBER IS COVERED AND CHECKS TO SEE IF IT IS A COVERED MEMBER ID. IF NOT COVERED FOR ANY OF THESE REASONS; THEN POST THE ERROR.
4102	Deny	70	NO REBATE FOR NDC PER CMS	NO REBATE FOR NDC PER CMS
4103	Deny	66	PATIENT AGE EXCEEDS MAXIMUM AG	POST IF DRUG HAS A MAXIMUM AGE SPECIFIED ON A CUSTOMER RECORD AND THE AGE OF THE MEMBER EXCEEDS THIS MAXIMUM

4110	Deny	7E	M/I DUR/PPS CODE COUNTER	THE DUR/PPS CODE COUNTER IS MISSING (ZEROS).
4113	Deny	70	PRODUCT/SERVICE NOT COVERED	"A =DESI DRUG (LESS THAN EFFECTIVE DRUG) - NON-REIMBURSABLE"
4114	Deny	70	PRODUCT/SERVICE NOT COVERED	"IF THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS A NDC ANDTHE NDC IS A PLAN NON-COVERED DRUG FROM THE BENEFIT LIMIT RANGE TABLEANDNO PREVIOUS PRICING EDITS HAVE BEEN SET FOR THIS CLAIM ANDTHE PLAN BENEFIT LIMIT OVERRIDE PA IS NOT EQUAL TO I (OVERRIDE INITIAL RX)."
4115	Deny	70	PRODUCT/SERVICE NOT COVERED	I= DEFAULT CODE - NOT COVERED ON PLAN
4116	Deny	70	PRODUCT/SERVICE NOT COVERED	"NDC NOT COVERED - REASON CODES: A =DESI DRUG B =NO REBATE C = NOT COVERED ON PLAN FILED =NO VALID PRICING CATEGORY ON GROUP FILE FOR DOS E =NO PRICING ON DRUG FILE FOR DATE OF CLAIM F =NO MAIL-ORDER SERVICE FOR CLIENT G =MAIL-ORDER FOR MAINTENANCE DRUGS ONLY I= DEFAULT CODE - NOT COVERED ON PLAN "

4117	Deny	70	PRODUCT/SERVICE NOT COVERED	"NO SIGNED REBATE AGREEMENT (REASON CODE B). "
4118	Deny	70	PRODUCT/SERVICE NOT COVERED	F =NO MAIL-ORDER SERVICE FOR CLIENT
4119	Deny	70	PRODUCT/SERVICE NOT COVERED	G =MAIL-ORDER FOR MAINTENANCE DRUGS ONLY
4120	Deny	70	PRODUCT/SERVICE NOT COVERED	D =NO VALID PRICING CATEGORY ON GROUP FILE FOR DOS
4123	Deny	70	PRODUCT/SERVICE NOT COVERED	"REASON CODE E: NO PRICE ON DRUG FILETHE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS A NDC AND NO DRUG PRICING DATA FOR THE DRUG WAS IN EFFECT FOR THE CLAIM DATE OF SERVICE. "
4125	Deny	75	PRIOR AUTHORIZATION REQUIRED	"STEP CARE IF THE CUSTOMER PARTICIPATES IN STEP CARE AND THE DRUG IS NOT COVERED BY THE PLAN OR BY A PA AND THE REJECT CODE ON THE STEP CARE RECORD IS 75 AND THE NUMBER OF AGENTS TAKEN IS LESS THAN THE NUMBER OF AGENTS REQUIRED OR THE AMOUNT OF TIME THE DRUGS WERE TAKEN WAS LESS THAN THE THERAPY SPAN REQUIRED.

4132	Deny	75	PA REQUIRED - STATE	PA REQUIRED
4133	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE DUR AMOUNT LIMIT ACCUMULATOR EQUALS 'ALL'AND THE DUR AMOUNT LIMIT TOTAL (A CALCULATED FIELD) IS GREATER THAN THE DUR AMOUNT LIMIT FROM THE PLAN BENEFITS LIMIT TABLE AND THE DUR AMOUNT LIMIT STATUS ON THE PLAN'S BENEFITS LIMIT TABLE EQUALS 'P' AND THERE IS NO PRIOR AUTHORIZATION INDICATED ON THE CLAIM."
4134	Deny	75	PRIOR AUTHORIZATION REQUIRED	THE PRIOR AUTHORIZATION USED UNITS PLUS THE CLAIM DRUG QUANTITY IS GREATER THAN THE PRIOR AUTHORIZATION APPROVED UNITS AMOUNT
4140	Deny	75	PRIOR AUTHORIZATION REQUIRED	PRIOR AUTHORIZATION REQUIRED

4141	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CUSTOM PLAN MAX UNITS ACCUM EQUALS A (ALL DOSES) AND THE CLAIM SUBMITTED QUANTITY IS GREATER THAN CUSTOM PLAN MAX UNITS ANDTHE CUSTOM PLAN MAX UNITS' STATUS EQUALS P (PA REQUIRED) AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED). "
4142	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CUSTOM PLAN MAX NUMBER OF REFILLS IS NOT EQUAL TO UNLIMITED (999) AND THE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS I (OVERRIDE INITIAL RX) AND THE CLAIM REFILL INDICATOR GREATER 0 ANDTHE CUSTOM PLAN MAX NUMBER OF REFILLS LESS THAN (<) THE CLAIM REFILL INDICATOR ANDTHE PRIOR AUTHORIZATION INDICATOR IS
4143	Deny	75	PRIOR AUTHORIZATION REQUIRED	"THE PLAN BENEFIT LIMITS INDICATE NOT COVERED AND THE CLAIM PA TYPE CODE NOT = '8' (PA OVERRIDE) ANDTHE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS I (OVERRIDE INITIAL RX) AND THE CLAIM REFILL INDICATOR IS EQUAL TO 0 AND THE PLAN BENEFIT LIMT MED

				CERT INDICATOR = 'Y' (OVERRIDE) ANDTHE CLAIM PA INDICATOR NOT = P
4144	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CUSTOM PLAN MAX NUMBER OF REFILLS IS NOT EQUAL TO UNLIMITED (999) AND THE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS Y (OVERRIDE) AND THE CUSTOM PLAN MAX NUMBER OF REFILLS LESS THAN CLAIM REFILL INDICATOR AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED). “
4145	Deny	75	PRIOR AUTHORIZATION REQUIRED	PA REQUIRED. CALL CONDUENT TECHNICAL DESK AT 800-365-4944. DRUG REQUIRES PA PER PLAN.
4146	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE PLAN BENEFIT LIMIT OVERRIDE PA EQUALS I (OVERRIDE INITIAL RX) ANDTHE CLAIM REFILL INDICATOR EQUALS 0 AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED). “

4148	Deny	75	PRIOR AUTHORIZATION REQUIRED	CLIENT SPECIFIC (MA) PA REQUIRED FOR TELEPHONE PRESCRIPTION SCHEDULE II DRUG (ALSO HANDLES OXYCONTIN LIMITS EXCEEDED EDIT) IF THE PRESCRIPTION ORIGINATED BY TELEPHONE FOR A SCHEDULE II DRUG AND IT IS NOT AN EMERGENCY SERVICE LEVEL ANDIT IS NOT A PAPER CLAIM
4149	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE DAILY DOSE (DERIVED BY TAKING CLAIM SUBMITTED QUANTITY / CLAIM DAYS SUPPLY) GREATER THAN CUSTOM PLAN MAINTENANCE CLAIM DOSE AND THE CUSTOM PLAN MAINTENANCE INDICATOR EQUALS PAY AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED). “
4150	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CUSTOM PLAN MAXIMUM DAILY DOSE UNITS IS NOT EQUAL TO 0 ANDTHE DAILY DOSE (DERIVED BY TAKING CLAIM SUBMITTED QUANTITY / CLAIM DAYS SUPPLY) GREATER THAN CUSTOM PLAN MAXIMUM DAILY DOSE AND CLAIM DOSE INDICATOR EQUALS 'PAY' ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO

				(PRIOR AUTHORIZED OR COVERED
4151	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CUSTOM PLAN MINIMUM DAILY DOSE UNITS IS NOT EQUAL TO 0 AND THE DAILY DOSE (DERIVED BY TAKING CLAIM SUBMITTED QUANTITY / CLAIM DAYS SUPPLY) IS LESS THAN THE CUSTOM PLAN MINIMUM DAILY DOSE ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED). “
4152	Deny	75	PRIOR AUTHORIZATION REQUIRED	"THE CLAIM PARTICIPANT AGE IS NOT LESS THAN THE CUSTOM PLAN DRUG MAXIMUM AGEAND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED) AND THE CUSTOM PLAN AGE EDIT STATUS EQUALS PA REQUIRED AND THE CLAIM'S PRIOR AUTHORIZATION TYPE CODE NOT = PA OVERRIDE ('8')."

4153	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CLAIM PARTICIPANT AGE IS NOT GREATER THAN THE CUSTOM PLAN DRUG MINIMUM AGE AND THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED) AND THE CUSTOM PLAN AGE EDIT STATUS EQUALS PA REQUIRED ANDTHE CLAIM'S PRIOR AUTHORIZATION TYPE CODE NOT = PA OVERRIDE ('8')."
4154	Deny	75	PRIOR AUTHORIZATION REQUIRED	"THE (CUSTOM PLAN DAYS SUPPLIED ACCUM IS NOT EQUAL TO N (NONE) AND THE CUSTOM PLAN DAYS SUPPLIED IS NOT EQUAL TO WORK DEFAULT DAYS (999)) AND THE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS C (ACUTE DOSE ONLY) AND THE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN THE WORK DEFAULT DOSE (9999.999) AND THE DAILY DOS
4155	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF THE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS A (ALL DOSES) AND THE CLAIM SUBMITTED DAYS IS GREATER THAN THE CUSTOM PLAN DAYS SUPPLIED AND THE CUSTOM PLAN DAYS SUPPLIED STATUS EQUALS P (PA REQUIRED) AND

				THE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED). “
4156	Deny	75	PRIOR AUTHORIZATION REQUIRED	"AN ENTRY ON THE CUSTOM RECORD EXISTS ANDTHE DUR UNITS’ ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N ANDTHE DUR UNITS AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0.000 AND LESS THAN +99999.999 AND ((THE DUR UNITS ACCUMULATOR CODE ON THE CUSTOM RECORD EQUALS C (ACUTE) AND (IP DAILY DOSE IS GREATER T
4157	Deny	75	PRIOR AUTHORIZATION REQUIRED	"AN ENTRY EXISTS ON THE CUSTOM RECORDANDDUR DAYS SUPPLY ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N ANDDUR DAYS SUPPLY AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0 AND LESS THAN +999 AND (DUR DAYS SUPPLY ACCUMULATOR CODE ON THE CUSTOM RECORD EQUALS C (ACUTE) AND (IP

				DAILY DOSE IS GREATER THAN THE CUSTOM PLAN DAYS SUPPLY LIMIT AND CUSTOM PLAN UNIT STATUS CODE = P AND CLAIM PA INDICATOR In (A-MATCHED,C_COVERED)
4158	Deny	75	PRIOR AUTHORIZATION REQUIRED	"AN ENTRY EXISTS ON THE CUSTOM RECORD AND DUR MAX RX ACCUMULATOR CODE ON THE CUSTOM RECORD IS NOT EQUAL TO N AND DUR MAX RX AMOUNT ON THE CUSTOM RECORD IS GREATER THAN +0 AND LESS THAN +999 AND (DUR MAX RX ACCUMULATOR CODE ON THE CUSTOM RECORD EQUALS C (ACUTE) AND IP DAILY DOSE IS GREATER THAN THE MAINTENANCE CL
4160	Deny	76	PLAN LIMITATIONS EXCEEDED	H =CUSTOM REC; DAILY DOSE > MAINTENANCE CLAIM DOSE
4161	Deny	76	PLAN LIMITATIONS EXCEEDED	"THE NUMBER OF SCRIPTS ON THE PLAN RECORD IS GREATER THAN ZERO AND LESS THAN 999.ANDTHE SCRIPT LIMIT TOTAL IS GREATER THAN THE NUMBER OF SCRIPTS ON THE PLAN RECORD.ANDPRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO 1 OR 3 ANDTHE

				PRESCRIPTION LIMIT EXEMPT INDICATOR ON THE CUSTOM RECORD IS NOT EQUAL TO Y "
4162	Deny	76	PLAN LIMITATIONS EXCEEDED	"(THE CUSTOM PLAN DAYS SUPPLIED ACCUM IS NOT EQUAL TO N (NONE) OR THE CUSTOM PLAN DAYS SUPPLIED IS NOT EQUAL TO WORK DEFAULT DAYS (999) AND THE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS C (ACUTE DOSE ONLY) AND THE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN WORK DEFAULT DOSE (9999.999) AND THE DAILY DOSE IS GREATE
4163	Deny	76	PLAN LIMITATIONS EXCEEDED	G =CUSTOM REC; ACUTE DOSE - SUBMITTED DAYS > MAX DAYS SUP FOR SPEC CLAIM

4164	Deny	76	PLAN LIMITATIONS EXCEEDED	"(THE CUSTOM PLAN MAX UNITS ACCUM IS NOT EQUAL TO N (NONE) ANDTHE CUSTOM PLAN MAX UNITS IS NOT EQUAL TO WORK DEFAULT MAX UNITS (99999.999) ANDTHE CUSTOM PLAN MAX UNITS ACCUM EQUALS C (ACUTE DOSE ONLY) AND THE CUSTOM PLAN MAINTENANCE CLAIM DOSE LESS THAN WORK DEFAULT DOSE (9999.999) AND THE DAILY DOSE IS GREATER
4165	Deny	76	PLAN LIMITATIONS EXCEEDED	D =CUSTOM REC; ALL DOSES - SUBMITTED UNITS > MAX UNITS FOR SPEC CLAIM
4166	Deny	76	PLAN LIMITATIONS EXCEEDED	O =PLAN FILE MAX SCRIPTS EXCEEDED FOR A SPECIFIC DURATION
4167	Deny	76	PLAN LIMITATIONS EXCEEDED	INVALID PLAN LIMITATIONS EXCEEDED
4168	Deny	76	PLAN LIMITATIONS EXCEEDED	F =CUSTOM REC; ALL DOSES - SUBMITTED DAYS > MAX DAYS SUPP FOR SPEC CLAIM

4169	Deny	76	PLAN LIMITATIONS EXCEEDED	I =CUSTOM REC; ALL DOSES - MAX NUM OF SCRIPTS EXCEEDED FOR SPEC DUR
4171	Deny	76	PLAN LIMITATIONS EXCEEDED	M =CUSTOM REC; ALL DOSES - SUBMITTED UNITS > MAX UNITS FOR SPEC DUR
4172	Deny	76	PLAN LIMITATIONS EXCEEDED	N =CUSTOM REC; ACUTE DOSE - SUBMITTED UNITS > MAX UNITS FOR SPEC DUR
4173	Deny	77	DISCONTINUED PRODUCT/SERVICE I	DISCONTINUED NDC NUMBER - HCFA
4177	Deny	79	REFILL TOO SOON	REFILL TOO SOON
4184	Deny	81	CLAIM TOO OLD	IF CLAIM IS OLDER THAN THE FILING LIMIT ESTABLISHED ON THE GROUP FILE; THEN THE ERROR IS POSTED.
4185	Deny	83	DUPLICATE PAID/CAPTURED CLAIM	"THE HISTORY CLAIM'S PHARMACY PROVIDER EQUALS IN PROCESS CLAIM'S PHARMACY PROVIDER ANDTHE HISTORY CLAIM'S PARTICIPANT ID EQUALS IN PROCESS CLAIM'S PARTICIPANT ID AND THE HISTORY CLAIM'S FIRST DATE OF SERVICE (FDOS) EQUALS IN PROCESS CLAIM'S FDOS ANDTHE HISTORY CLAIM'S MEMBER NUMBER EQUALS IN PROCESS CLAIM'S MEMBER

4186	Deny	83	DUPLICATE PAID/CAPTURED CLAIM	DUPLICATE PAID / CAPTURED CLAIM
4187	Deny	85	CLAIM NOT PROCESSED	"THE MAXIMUM NUMBER OF ENTRIES FOR THE RELATED HISTORY TABLE HAVE BEEN MET OR EXCEEDED.
4188	Deny	85	CLAIM NOT PROCESSED	CLAIM NOT PROCESSED - REJECT CODE NOT FOUND ON REJECT CONTROL TABLE OR TOO MANY REJECT CODES ARE POSTED TO CLAIM OR RELATED HISTORY ENTRIES EXCEEDED FOR CLAIM OR PARTICIPANT
4189	Deny	87	REVERSAL NOT PROCESSED	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED HAS ALREADY BEEN CREDITED.
4190	Deny	87	REVERSAL NOT PROCESSED	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED IS IN THE PROCESS OF BEING CREDITED.
4191	Deny	87	REVERSAL NOT PROCESSED	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED WAS DENIED.

4192	Deny	84	CLAIM HAS NOT BEEN PAID/CAPTUR	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED WAS NOT FOUND OR IS A CREDIT.
4192	Deny	84	CLAIM HAS NOT BEEN PAID/CAPTUR	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE ADJUSTED/CREDITED WAS NOT FOUND OR IS A CREDIT.
4193	Deny	84	CLAIM HAS NOT BEEN PAID/CAPTUR	THE ORIGINAL CLAIM THAT IS ATTEMPTING TO BE CREDITED IS A MAIL ORDER CLAIM
4206	Deny	AB	DATE WRITTEN IS AFTER DATE FIL	THE DATE PRESCRIPTION WRITTEN IS GREATER THAN THE DATE OF SERVICE.
4207	Deny	AC	PRODUCT NOT COVERED NON-PARTIC	"THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS A NDC AND (DRUG REBATE DATA IS FOUND FOR THE CLAIM'S NDC AND DATE OF SERVICE ON THE DRUG REBATE TABLE AND THE DRUG REBATE CODE FOR THE NDC = NO REBATE ('0') AND THE NDC IS NOT A REBATE EXEMPT NDC (HARD-CODED TABLE - MAS
4208	Deny	AF	PATIENT ENROLLED UNDER MANAGED	NA

4209	Deny	AG	DAYS SUPPLY LIMITATION FOR PRO	"EXCEEDS CUSTOM DAYS SUPPLIED LIMITS - 5.1 ONLYTHE CUSTOM PLAN DAYS SUPPLIED ACCUM EQUALS A (ALL DOSES) ANDTHE CLAIM SUBMITTED DAYS GREATER THAN CUSTOM PLAN DAYS SUPPLIEDANDTHE CUSTOM PLAN DAYS SUPPLIED STATUS EQUALS D (DENY)ANDTHE PRIOR AUTHORIZATION INDICATOR IS NOT EQUAL TO (PRIOR AUTHORIZED OR COVERED
4212	Deny	AM	M/I SEGMENT IDENTIFICATION	THE SEGMENT IS A MANDATORY SEGMENT AND THE SEGMENT IDENTIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD
4213	Deny	A9	M/I TRANSACTION COUNT	THE TRANSACTION COUNT IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4214	Deny	BE	M/I PROFESSIONAL SERVICE FEE S	THE PRODUCT/SERVICE ID QUALIFIER IS NOT NDC AND THE PROFESSIONAL SERVICE FEE SUBMITTED IS MISSING (ZEROS).
4215	Deny	B2	M/I SERVICE PROVIDER ID QUALIF	THE SERVICE PROVIDER ID QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF

				THE VALID VALUES SPECIFIED FOR THE FIELD.
4227	Deny	DU	M/I GROSS AMOUNT DUE	MCO PAID AMT IS INVALID. MCO PD AMT MUST BE > ZERO
4229	Deny	DV	M/I OTHER PAYER AMOUNT PAID	"MISSING DENY DATE (IF THE OTHER COVERAGE CODE IS 3 (OTHER COVERAGE EXISTS - THIS CLAIM NOT COVERED) OR 4 (OTHER COVERAGE EXISTS - PAYMENT NOT COLLECTED)) ANDTHE PAYERID DATE IS NOT NUMERIC OR THE PAYERID DATE IS NOT GREATER THAN ZEROS OR THE PAYERID PAID AMOUNT IS GREATER THAN ZEROS."
4231	Deny	DV	M/I OTHER PAYER AMOUNT PAID	"CLAIM REQUIRES TPL REVIEW (MASSACHUSETTS SPECIFIC) IF THE OTHER COVERAGE CODE IS 2 (OTHER COVERAGE EXISTS - PAYMENT COLLECTED) AND THE PAYERID PAID AMOUNT IS MISSING (ZERO). ORIF THE OTHER COVERAGE CODE IS '0' (NOT SPECIFIED) OR '1' (NO OTHER COVERAGE IDENTIFIED) '3' (OTHER COVERAGE EXISTS - THIS CLAM NOT COVERED)
4236	Deny	EC	COMPOUND ING COMPONENT COUNT	A COMPOUND SEGMENT IS PRESENT AND THE COMPOUND INGREDIENT COMPONENT COUNT IS ZEROS.

4237	Deny	ED	COMPOUND ING QUANTITY	THE COMPOUND INGREDIENT QUANTITY IS MISSING (ZEROS).
4239	Deny	EM	M/I PRESCRIPTION/SERVICE REFER	THE PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4240	Deny	EN	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER IS MISSING (ZEROS) ON A REVERSAL FOR COMPLETION TRANSACTION.
4241	Deny	EP	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE DATE IS MISSING (ZEROS) ON THE REVERSAL OF A COMPLETION TRANSACTION
4243	Deny	ET	M/I QUANTITY PRESCRIBED	THE QUANTITY PRESCRIBED IS MISSING (ZEROS).
4244	Deny	EU	M/I PRIOR AUTHORIZATION TYPE C	"THE PRIOR AUTHORIZATION TYPE CODE DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD ORTHE PRIOR AUTHORIZATION TYPE CODE IS MISSING AND THE PRIOR AUTHORIZATION NUMBER IS PRESENT."
4247	Deny	EZ	M/I PRESCRIBER ID QUALIFIER	"THE PRESCRIBER ID QUALIFIER IS MISSING AND A PRESCRIBER ID EXISTS ORor IT DOES NOT MATCH ONE OF THE VALID

				VALUES SPECIFIED FOR THE FIELD"
4256	Deny	E7	M/I QUANTITY DISPENSED	EDIT IGNORED
4263	Deny	E9	PROVIDER ID	THE PHARMACY PROVIDER ID IS MISSING AND THE PHARMACY PROVIDER ID QUALIFIER IS PRESENT.
4267	Deny	HB	M/I OTHER PAYER AMOUNT PAID CO	A COB SEGMENT IS PRESENT AND THE OTHER PAYER AMOUNT PAID COUNT IS MISSING (ZEROS).
4268	Deny	HB	M/I OTHER PAYER AMOUNT PAID CO	THE OTHER PAYER AMOUNT PAID COUNT DOES NOT MATCH THE NUMBER OF OTHER PAYER AMOUNT PAID FIELDS RECEIVED ON A COB/OTHER PAYMENTS SEGMENT.
4269	Deny	HC	M/I OTHER PAYER AMOUNT PAID QU	THE OTHER PAYER AMOUNT PAID QUALIFIER IS MISSING (SPACES) AND THE OTHER PAYER AMOUNT PAID IS GREATER THAN ZEROS.
4270	Deny	HC	M/I OTHER PAYER AMOUNT PAID QU	THE OTHER PAYER AMOUNT PAID QUALIFIER DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD

4271	Deny	HD	M/I DISPENSING STATUS	"IF THE DISPENSING STATUS IS MISSING (SPACES) ANDTHE QUANTITY INTENDED TO BE DISPENSED IS GREATER THAN ZEROS OR THE DAYS SUPPLY INTENDED TO BE DISPENSED IS GREATER THAN ZEROS."
4272	Deny	HD	M/I DISPENSING STATUS	THE DISPENSING STATUS DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4274	Deny	HF	M/I QUANTITY INTENDED TO BE DI	THE QUANTITY INTENDED TO BE DISPENSED IS MISSING (ZEROS) AND THE DISPENSING STATUS INDICATES A PARTIAL FILL ('P') OR 'C'.
4275	Deny	HF	M/I QUANTITY INTENDED TO BE DI	THE QUANTITY INTENDED TO BE DISPENSED IS GREATER THAN ZEROS BUT THE DISPENSING STATUS DOES NOT INDICATE A PARTIAL FILL ('P').
4276	Deny	HG	M/I DAYS SUPPLY INTENDED TO BE	THE DAYS SUPPLY INTENDED TO BE DISPENSED IS MISSING (ZEROS) AND THE DISPENSING STATUS INDICATES A PARTIAL FILL (P').
4293	Deny	M2	MEMBER LOCKED INTO SPECIFIC PR	"PARTICIPANT/PROVIDER LOCKIN MISMATCH THE CLAIM FIRST DATE OF SERVICE FELL WITHIN THE DATE RANGE OF ONE OF THE PROVIDERS IN THE LOCKIN TABLE BUT THE CLAIM PROVIDER NUMBER IS NOT

				EQUAL TO THE PROVIDER NUMBER IN THE LOCKIN TABLE. "
4297	Deny	PB	INVALID TRANSACTION COUNT FOR	THE TRANSACTION COUNT IS GREATER THAN 4 FOR A BILLING - REVERSAL - OR REBILL REQUEST.
4298	Deny	PC	M/I CLAIM SEGMENT	A CLAIM SEGMENT WAS NOT RECEIVED WITH A BILLING REQUEST.
4299	Deny	PC	M/I CLAIM SEGMENT	A CLAIM SEGMENT WAS RECEIVED WITH AN ELIGIBILITY REQUEST.
4300	Deny	PD	M/I CLINICAL SEGMENT	A CLINICAL SEGMENT WAS RECEIVED WITH AN ELIGIBILITY, A REVERSAL, A PRIOR AUTHORIZATION REVERSAL, OR A PRIOR AUTHORIZATION INQUIRY REQUEST.
4302	Deny	PE	M/I COB/OTHER PAYMENTS SEGMENT	NA
4303	Deny	PE	M/I COB/OTHER PAYMENTS SEGMENT	A COB/OTHER PAYMENTS SEGMENT WAS RECEIVED WITH AN ELIGIBILITY - A REVERSAL - OR A PRIOR AUTHORIZATION REVERSAL REQUEST.
4304	Deny	PF	M/I COMPOUND SEGMENT	NA

4305	Deny	PF	M/I COMPOUND SEGMENT	A COMPOUND SEGMENT WAS RECEIVED WITH AN ELIGIBILITY OR A REVERSAL REQUEST.
4307	Deny	PH	M/I DUR/PPS SEGMENT	NA
4308	Deny	PH	M/I DUR/PPS SEGMENT	"DUR/PPS SEGMENT INVALID WITH ELIGIBILITY REQUEST - 5.1 ONLYA DUR/PPS SEGMENT WAS RECEIVED WITH AN ELIGIBILITY REQUEST."
4309	Deny	PJ	M/I INSURANCE SEGMENT	NA
4310	Deny	PJ	M/I INSURANCE SEGMENT	NA
4312	Deny	41	SUBMITTED TO OTHER PROCESSOR	PART D COPAYS ARE MEMBERS RESPONSIBILITY. MEDICAID (PLAN 140) ONLY PAYS FOR QUALIFYING OTCS WHEN ALL SSI ELIGIBILITIES ARE ON FILE.
4312	Deny	PK	M/I PATIENT SEGMENT	NA
4315	Deny	PN	M/I PRESCRIBER SEGMENT	NA
4316	Deny	PN	M/I PRESCRIBER SEGMENT	"PRESCRIBER SEGMENT INVALID WITH REQUEST TYPE - 5.1 ONLY A PRESCRIBER SEGMENT WAS RECEIVED WITH AN ELIGIBILITY OR A REVERSAL REQUEST."
4317	Deny	PP	M/I PRICING SEGMENT	NA

4318	Deny	PP	M/I PRICING SEGMENT	"PRICING SEGMENT INVALID WITH ELIGIBILITY REQUEST - 5.1 ONLYA PRICING SEGMENT WAS RECEIVED WITH AN ELIGIBILITY REQUEST"
4319	Deny	PR	M/I PRIOR AUTHORIZATION SEGMEN	NA
4320	Deny	PR	M/I PRIOR AUTHORIZATION SEGMEN	"PRIOR AUTHORIZATION SEGMENT INVALID WITH REQUEST TYPE - 5.1 ONLYA PRIOR AUTHORIZATION SEGMENT WAS RECEIVED WITH AN ELIGIBILITY OR A REVERSAL REQUEST."
4321	Deny	PS	M/I TRANSACTION HEADER SEGMENT	"MISSING MANDATORY TRANSACTION HEADER SEGMENT - 5.1 ONLYAN ELIGIBILITY - BILLING - REVERSAL - OR RE-BILL REQUEST WAS RECEIVED WITHOUT A MANDATORY TRANSACTION HEADER SEGMENT."
4322	Deny	04	INV PROCESSOR CONTROL NUMBER	N/A. EXCEPTION CODE DELETED AND REPLACE WITH 4321

4325	Deny	PV	NON-MATCHED ASSOCIATED PRESCRI	"ASSOCIATED PRESCRIPTION/SERVICE DATE DOES NOT MATCH DOS - 5.1 ONLYTHE ASSOCIATED PRESCRIPTION/SERVICE DATE ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C (COMPLETION FILL) DID NOT MATCH THE DATE OF SERVICE ON THE MATCHING PARTIAL FILL TRANSACTION. "
4326	Deny	P1	ASSOCIATED PRESCRIPTION/SERVIC	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C (COMPLETION FILL) DID NOT MATCH THE REFERENCE NUMBER ON THE MATCHING PARTIAL FILL TRANSACTION
4328	Deny	P3	COMPOUND INGREDIENT COMPONENT	THE COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH THE NUMBER OF COMPOUND PRODUCT ID'S RECEIVED ON A COMPOUND SEGMENT.
4329	Deny	P4	COORDINATION OF BENEFITS/OTHER	THE COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT DOES NOT MATCH THE NUMBER OF COB/OTHER PAYMENT SEGMENTS RECEIVED.
4330	Deny	P6	DATE OF SERVICE PRIOR TO DATE	"DOS LESS THAN DOB - 5.1 ONLYTHE CLAIM DATE OF

				SERVICE IS LESS THAN THE CLAIM DATE OF BIRTH. "
4331	Deny	P7	DIAGNOSIS CODE COUNT DOES NOT	THE DIAGNOSIS CODE COUNT DOES NOT MATCH THE NUMBER OF DIAGNOSIS CODES ON A CLINICAL SEGMENT.
4332	Deny	P8	DUR/PPS CODE COUNTER OUT OF SE	THE SETS OF DUR/PPS INFORMATION WERE RECEIVED OUT OF NUMERICAL SEQUENCE.
4333	Deny	P9	FIELD IS NON-REPEATABLE	IS THIS USED IN COMBINATION WITH OTHER INVALID REJECT CODES SO THAT THE FIELD IS IDENTIFIED?
4334	Deny	RB	MULTIPLE PARTIALS NOT ALLOWED	MORE THAN ONE PARTIAL FILL TRANSACTIONS WERE RECEIVED FOR THE SAME PRESCRIPTION/SERVICE ID.
4335	Deny	RC	DIFFERENT DRUG ENTITY BETWEEN	THE PRODUCT/SERVICE ID AND/OR QUALIFIER ON THE COMPLETION TRANSACTION (DISPENSING STATUS OF C) DOES NOT MATCH THE PRODUCT/SERVICE ID AND/OR QUALIFIER ON THE ASSOCIATED PARTIAL FILL TRANSACTION (DISPENSING STATUS OF P).

4336	Deny	RD	MISMATCHED CARDHOLDER/GROUP ID	THE MEMBER ID AND THE GROUP ID ON THE INSURANCE SEGMENT OF A COMPLETION TRANSACTION (DISPENSING STATUS OF C) DOES NOT MATCH THE MEMBER ID AND GROUP ID ON THE INSURANCE SEGMENT OF THE ASSOCIATED PARTIAL FILL TRANSACTION (DISPENSING STATUS OF P).
4337	Deny	RE	M/I COMPOUND PRODUCT ID QUALIF	THE COMPOUND PRODUCT ID QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4338	Deny	RF	IMPROPER ORDER OF 'DISPENSING	"COMPLETION WITH NO PARTIAL - 5.1 ONLYA CLAIM SEGMENT WITH A DISPENSING STATUS OF C WAS RECEIVED BUT NO MATCHING PARTIAL FILL TRANSACTION (DISPENSING STATUS OF P) COULD BE FOUND"
4339	Deny	RG	M/I ASSOCIATED PRESCRIPTION/SE	THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C IS MISSING (ZEROS).
4340	Deny	RH	M/I ASSOCIATED PRESCRIPTION/SE	"THE ASSOCIATED PRESCRIPTION/SERVICE DATE ON A CLAIM SEGMENT WITH A DISPENSING STATUS OF C IS

				MISSING (ZEROS) OR IT IS NOT A VALID DATE."
4342	Deny	RN	PLAN LIMITS EXCEEDED ON INTEND	"INTENDED QUANTITY EXCEEDS PLAN LIMITS THE QUANTITY INTENDED TO BE DISPENSE RECEIVED ON A CLAIM SEGMENT WITH A P DISPENSING STATUS EXCEEDS THE MAXIMUM DISPENSED QUANTITY LIMITS ON THE PLAN FOR WHICH THE PARTICIPANT IS ELIGIBLE."
4343	Deny	RN	PLAN LIMITS EXCEEDED ON INTEND	"INTENDED DAYS SUPPLY EXCEEDS PLAN LIMITS - 5.1 ONLYTHE DAYS SUPPLY INTENDED TO BE DISPENSE RECEIVED ON A CLAIM SEGMENT WITH A P DISPENSING STATUS EXCEEDS THE MAXIMUM SUBMITTED DAYS LIMITS ON THE PLAN FOR WHICH THE PARTICIPANT IS ELIGIBLE."
4344	Deny	RP	OUT OF SEQUENCE 'P' REVERSAL O	"PARTIAL REVERSED BEFORE COMPLETION REVERSED - 5.1 ONLYA REVERSAL FOR A PARTIAL FILL TRANSACTION WAS SUBMITTED BEFORE THE COMPLETION TRANSACTION WAS REVERSED. THE REPLACEMENT TCN NUMBER ON THE MATCHING COMPLETION TCN IS ZEROS. SEE PAGE 7 OF NM

				BLUEPRINT.NOTE: 5.1 SAME DAY INSPECT DISPENSING STATUS IN ORDER TO REVE
4345	Deny	RS	M/I ASSOCIATED PRESCRIPTION/SE	"THE ASSOCIATED PRESCRIPTION/SERVICE DATE IS MISSING (ZEROS) OR IS AN INVALID DATE WHEN A CLAIM SEGMENT WITH A DISPENSING STATUS OF P WAS RECEIVED.ASSOCIATED FIELDS ARE NOT REQUIRED ON PARTIAL TRANSACTION."
4346	Deny	RT	M/I ASSOCIATED PRESCRIPTION/SE	"THE ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER IS MISSING (ZEROS) AND THE DISPENSING STATUS IS P. ASSOCIATED FIELDS ARE NOT REQUIRED ON PARTIAL TRANSACTION. THIS EDIT DOES NOT MAKE SENSE."
4347	Deny	RU	MANDATORY DATA ELEMENTS MUST O	"OPTIONAL FIELDS PRECEDE MANDATORY FIELDS A SEGMENT OF ANY TYPE WAS RECEIVED WITH AN OPTIONAL FIELD OR FIELDS PRECEDING THE MANDATORY FIELDS."

4348	Deny	R1	OTHER AMOUNT CLAIMED SUBMITTED	THE OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH THE NUMBER OF OTHER AMOUNT CLAIMED SUBMITTED FIELDS RECEIVED ON A PRICING SEGMENT.
4349	Deny	R2	OTHER PAYER REJECT COUNT DOES	THE OTHER PAYER REJECT COUNT DOES MATCH THE NUMBER OF OTHER PAYER REJECT CODES RECEIVED ON A COB/OTHER PAYMENTS SEGMENT
4350	Deny	R3	PROCEDURE MODIFIER CODE COUNT	THE PROCEDURE MODIFIER CODE COUNT DOES NOT MATCH THE NUMBER OF PROCEDURE MODIFIER CODES RECEIVED ON A CLAIM SEGMENT
4351	Deny	R4	PROCEDURE MODIFIER CODE INVALI	NA
4352	Deny	R5	PRODUCT/SERVICE ID MUST BE ZER	THE PRODUCT/SERVICE ID ON THE CLAIM SEGMENT WAS NOT ZEROS WHEN THE PRODUCT/SERVICE ID QUALIFIER INDICATED THAT THE CLAIM WAS FOR DUR/PROFESSIONAL PHARMACY SERVICE.
4353	Deny	R6	PROD/SVC NOT APPROPR FOR LOC	PROD/SVC NOT APPROPR FOR LOC

4354	Deny	R7	REPEATING SEGMENT NOT ALLOWED	AN IDENTICAL SEGMENT WAS SUBMITTED ON A SINGLE TRANSACTION.
4355	Deny	R9	VALUE IN GROSS AMOUNT DUE DOES	"GROSS AMOUNT DUE FOR RX = INGREDIENT COST SUBMITTED + DISPENSING FEE SUBMITTED + FLAT SALES TAX AMOUNT SUBMITTED + PERCENTAGE SALES TAX SUBMITTED
4356	Deny	SE	M/I PROCEDURE MODIFIER CODE CO	THE PROCEDURE MODIFIER CODE COUNT IS MISSING (ZEROS) AND A PROCEDURE MODIFIER IS PRESENT.
4357	Deny	TE	M/I COMPOUND PRODUCT ID	THE COMPOUND PRODUCT ID IS MISSING (SPACES).
4359	Deny	VE	M/I DIAGNOSIS CODE COUNT	THE DIAGNOSIS CODE COUNT IS MISSING (ZEROS) AND A DIAGNOSIS CODE IS PRESENT.
4360	Deny	WE	M/I DIAGNOSIS CODE QUALIFIER	THE DIAGNOSIS CODE QUALIFIER IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
4361	Deny	XE	M/I CLINICAL INFORMATION COUNT	THE CLINICAL INFORMATION COUNTER IS MISSING (ZEROS) OR IT DOES NOT MATCH THE NUMBER OF SETS OF MEASUREMENT FIELDS ON A CLINICAL SEGMENT.
4362	Deny	ZE	M/I MEASUREMENT DATE	THE MEASUREMENT DATE IS MISSING (ZEROS).

4363	Deny	85	CLAIM NOT PROCESSED	THIS EDIT WILL POST IF THE HEADER-LEVEL OVERRIDE EXCEPTION LOCATION CODE DOES NOT HAVE A MATCHING CODE ON THE REFERENCE TEXT LOCATION DATABASE
4364	Deny	85	CLAIM NOT PROCESSED	"THIS EXCEPTION CAN BE POSTED TO THE CLAIM IF A LOGIC ERROR - SUCH AS A MISSING REPLACED TCN NUMBER FOR A CREDIT TRANSACTION - OR A CREDIT WITH A CLAIM STATUS OF TO-BE-DENIED - OCCURS. IN SOME INSTANCES - IT CAN BE USED TO DENOTE UNEXPECTED SQL CODES.
4369	Deny	52	NON-MATCHED CARDHOLDER ID	THE PARTICIPANT ID ON THE REPLACEMENT OR CREDIT REQUEST DOES NOT MATCH THE PARTICIPANT ID ON THE CLAIM THAT IS BEING REPLACED OR CREDITED.
4374	Deny	84	CLAIM HAS NOT BEEN PAID/CAPTUR	"A CREDIT CLAIM CANNOT BE ADJUSTED. THE REPLACEMENT CLAIM OF AN ADJUSTMENT CAN BE VOIDED OR REPLACED - BUT THE CREDIT CLAIM OF AN ADJUSTMENT CAN NEVER BE VOIDED OR REPLACED.THIS EDIT CAN POST TO PROVIDER SUBMITTED CREDIT REQUESTS -

				PROVIDER SUBMITTED REPLACEMENT CLAIMS.
4375	Deny	85	CLAIM NOT PROCESSED	THIS EXCEPTION CAN BE USED TO SUSPEND THE CLAIM IF A LOGIC ERROR.
4376	Deny	87	REVERSAL NOT PROCESSED	THE ADUSTMENT REASON CODE ENTERED ON THE REQUEST IS MISSING OR INVALID (NOT NUMERIC OR NOT ON VALID VALUES TABLE). SEE THE DATA DICTIONARY FOR A LIST OF VALID VALUES.
4379	Deny	85	CLAIM NOT PROCESSED	THE MEMBER ID NUMBER ON THE CLAIM OR ADJUSTMENT BEING PROCESSED IS CURRENTLY BEING UPDATED BY ANOTHER USER OR SYSTEM PROCESS. (THIS SITUATION SHOULD RARELY OCCUR. SIMPLY TRYING TO PROCESS AGAIN NORMALLY RESULTS IN THIS EXCEPTION NOT OCCURRING AGAIN).

4385	Deny	19	M/I DAYS SUPPLY	"THE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS) AND A CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE AND (THE CUSTOM PLAN ACCUMULATION CODE = 'NO EDIT' OR THE CUSTOM PLAN'S D
4386	Deny	19	M/I DAYS SUPPLY	If the Plan Benefit Accumulated Code is Edit- Acute AND maintenance Dose Number < Default Daily dose AND current claim daily Dose > Maintenance Dose Number AND Submitted Day Supply Amount (from Claim) > Plan benefit day submitted number edit posts.
4387	Deny	19	M/I DAYS SUPPLY	"THE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS) AND A CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE AND THE CUSTOM PLAN

				ACCUMULATION CODE = 'EDIT ALL DRUGS' AND THE CLAIM'S
4388	Deny	19	M/I DAYS SUPPLY	"THE PLAN'S MAX UNITS LIMIT < UNLIMITED UNITS (9999.999) AND THE CLAIM'S DRUG SUBMITTED QUANTITY > PLAN'S MAX UNITS LIMIT AND NO CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE "
4389	Deny	19	M/I DAYS SUPPLY	"THE PLAN'S MAX UNITS LIMIT < UNLIMITED UNITS (9999.999) ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > PLAN'S MAX UNITS LIMIT ANDA CUSTOM PLAN BENEFIT LIMIT RECORD EXISTS FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE ANDTHE CUSTOM PLAN MAX UNITS' ACCUMULATION CODE = 'NO EDIT' ANDTHE CUSTOM PLAN'S UNITS LIM

4390	Deny	19	M/I DAYS SUPPLY	"THE CUSTOM PLAN MAX UNITS' ACCUMULATION CODE = 'EDIT ACUTE ONLY' ANDTHE CUSTOM PLAN'S MAINTENANCE DOSE < DEFAULT DAILY DOSE (9999.999) ANDTHE CLAIM'S CALCULATED DAILY DOSE > CUSTOM PLAN'S MAINTENANCE DOSE ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > PLAN'S MAX UNITS LIMIT"
4391	Deny	19	M/I DAYS SUPPLY	"THE CUSTOM PLAN MAX UNITS' ACCUMULATION CODE = 'EDIT ALL DRUGS' ANDTHE CLAIM'S DRUG SUBMITTED QUANTITY > CUSTOM PLAN'S MAX UNITS LIMIT"
4400	Deny	19	M/I DAYS SUPPLY	EDIT IGNORED
4401	Deny	19	M/I DAYS SUPPLY	EDIT IGNORED
4403	Deny	19	M/I DAYS SUPPLY	"A CUSTOM PLAN BENEFIT LIMIT RECORD DOES NOT EXIST FOR THIS CUSTOMER - PLAN - AND BENEFIT LIMIT TYPE ANDTHE CLAIM'S SUBMITTED DAYS SUPPLY AMOUNT (DAYS SUPPLY) > PLAN HEADER DAYS SUPPLY LIMIT (OR MAINTENANCE DAYS SUPPLY LIMIT FOR MAINTENANCE DRUGS)"

4404	Deny	85	CLAIM NOT PROCESSED	"FORMULARY TYPE CODE FOR THE PLAN NOT = 'N' (NO FORMULARY) AND NO FORMULARY IS FOUND ON THE DRUG FORMULARY TABLE"
4411	Deny	70	COMPOUND NOT COVERED	SUBMISSION CLARIFICATION CODE = 08 IS NOT ALLOWED FOR MEDICARE PART D DUAL ELIGIBLE PARTICIPANTS
4414	Deny	85	CLAIM NOT PROCESSED	THE PHARMACY'S PHYSICAL ADDRESS INFORMATION COULD NOT BE FOUND.
4415	Deny	85	CLAIM NOT PROCESSED	IF THE LOADED EXCEPTION COUNT IS 0.
4416	Deny	HD	M/I DISPENSING STATUS	COMPOUND CODE IS EQUAL TO '2' AND THE DISPENSING STATUS IS GREATER THAN SPACES.
4417	Deny	RH	M/I ASSOCIATED PRESCRIPTION/SE	"PARTIAL AND COMPLETION NOT ALLOWED ON SAME DAY 5.1 ONLYFIRST DATE OF SERVICE EQUAL ASSOCIATED PRESCRIPTION/SERVICE DATE."
4420	Deny	82	CLAIM IS POST DATED	BATCH DATE LESS THAN FIRST DATE OF SERVICE
4421	Deny	56	NON-MATCHED PRESCRIBER IDENTIF	PRESCRIBER ID NOT FOUND ON PROVIDER ENROLLMENT ELIGIBILITY TABLE. PRESCRIBER ID NOT VALID FOR THIS CLIENT
4429	Deny	65	PATIENT IS NOT COVERED	IF THE PARTICIPANT IS PRODUCTION AND THE CLAIM WAS MARKED AS A TEST CLAIM

				BECAUSE IT CONTAINED A TEST PROVIDER
4430	Deny	E4	M/I REASON FOR SERVICE CODE	"DUR OVERRIDE CONFLICT THE REASON FOR SERVICE IS MISSING AND THE DUR INTERVENE CODE OR DUR OUTCOME CODE IS PRESENT."
4439	Deny	87	REVERSAL NOT PROCESSED	AN ADJUSTMENT REQUEST RECORD HAS TARGETED A HISTORY RECORD FOR ADJUSTMENT - BUT THE HISTORY RECORD HAS BEEN SUSPENDED
4441	Deny	87	REVERSAL NOT PROCESSED	AN ADJUSTMENT REQUEST RECORD HAS TARGETED A HISTORY RECORD FOR ADJUSTMENT - BUT THE HISTORY RECORD HAS BEEN VOIDED
4443	Deny	87	REVERSAL NOT PROCESSED	AN ADJUSTMENT REQUEST RECORD HAS TARGETED A HISTORY RECORD FOR ADJUSTMENT - BUT THE KEYED REPLACED NUMBER (TCN) ON THE ADJUSTMENT REQUEST RECORD THAT IDENTIFIES THE HISTORY RECORD IS EQUAL TO ZEROS.
4445	Deny	85	CLAIM NOT PROCESSED	"CLAIMS IS SYSTEM GENERATED AND (TRANSACTION TYPE IS VOID OR TRANSACTION TYPE IS DEBIT OF ADJUSTMENT) AND CYCLE NUMBER EQUAL ZERO AND BATCH NUMBER IS LESS

				THAT SYSTEM GENERATED BATCH NUMBER "
4446	Deny	75	PRIOR AUTHORIZATION REQUIRED	DUR EDIT POSTED WITH A CONFLICT CODE OF HD (HIGH DOSE) - PA REQUIRED
4447	Deny	75	PRIOR AUTHORIZATION REQUIRED	"THE IN-PROCESS BILLING PROVIDER ID NOT EQUAL HISTORY BILLING PROVIDER ID AND FIRST DATE OF SERVICE ON THE CURRENT CLAIM MUST BE AFTER THE FIRST DATE OF SERVICE ON THE HISTORY CLAIM. AND FIRST DATE OF SERVICE ON THE CURRENT CLAIM MUST BE BEFORE THE DATE CALCULATED TO BE THE HISTORY CLAIM'S FIRST DATE OF SERVICE PL
4448	Deny	75	PRIOR AUTHORIZATION REQUIRED	DRUG TO DRUG INTERACTION
4449	Deny	75	PRIOR AUTHORIZATION REQUIRED	"IF MEDICAL PROFILE OVERRIDE INDICATOR SET TO NO AND (HISTORY FDOS IS GREATER THAN IP FDOS OR AFTER PROCESSING THROUGH ALL OF HISTORY CLAIMS) AND THE DOSE FORM ON THE DRUG RECORD FROM THE IP NDC MUST EQUAL 'EACH' OR

				'MILLILITER' AND CALCULATED DAILY DOSE MUST BE MORE THAN THE MAXIMUM DAILY DOSE ON THE DRUG RE
4450	Deny	21	M/I PRODUCT/SERVICE ID	"THE PRODUCT/SERVICE ID QUALIFIER INDICATES THE PRODUCT/SERVICE ID IS AN NDC AND THE NDC IS MISSING OR NON-NUMERIC."
4464	Deny	70	PRODUCT/SERVICE NOT COVERED	CLIENT IS IN NURSING HOME - PLEASE TRY MEDICARE D
4465	Deny	70	PRODUCT / SERVICE NOT COVERED	CVG FOR MEDICARE XO OR WAIVER SVC ONLY
4629	Deny	##	RESERVED FOR FUTURE USE	RESERVED FOR FUTURE USE
4665	Deny	28	M/I DATE RX WRITTEN	- POST IF DATE WRITTEN IS LESS THAN 1/1/1750 OR GREATER THAN 12/31/2150 - POST IF DATE WRITTEN IS MORE THAN 5 YEARS PRIOR TO THE FDOS- POST IF DATE WRITTEN IS GREATER THAN DOS
4681	Deny	HA	INV FLAT SALES TAX AMT SUBM	SUBMITTED SALES TAX IS EQUAL TO OR GREATER THAN U&C, SILK TICKET 988
4682	Deny	GE	INV PCNT SALES TAX AMT SUBM	PERCENTAGE SALES TAX AMOUNT SUBMITTED IS EQUAL

				TO OR GREATER THAN U&C, SILK TICKET 988
4683	Deny	AC	NON-COV NDC - NOT REBATEABLE	THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS AN NDC & DRUG REBATE DATA IS FOUND FOR THE CLAIM'S NDC & DATE OF SERVICE ON THE DRUG REBATE TABLE & THE DRUG REBATE CODE FOR THE NDC = NO REBATE ('0') AND THE NDC IS NOT A REBATE EXEMPT NDC**5.1 EDIT ONLY-SEE 4684 FOR 3.2 EDIT**
4684	Deny	70	PROD NOT COV-NOT REBATEABLE	THE PRODUCT/SERVICE ID QUALIFIER INDICATES THAT THE PRODUCT/SERVICE ID FIELD CONTAINS AN NDC & DRUG REBATE DATA IS FOUND FOR THE CLAIM'S NDC & DATE OF SERVICE ON THE DRUG REBATE TABLE & THE DRUG REBATE CODE FOR THE NDC = NO REBATE ('0') AND THE NDC IS NOT A REBATE EXEMPT NDC**3.2 EDIT ONLY-SEE 4683 FOR 5.1 EDIT**
4728	Deny	67	FILLED BEFORE COV EFFECTIVE	THIS EXCEPTION POSTS WHEN THERE IS NO ELIGIBILITY AND OVERRIDE CODE "2" IS SUBMITTED
4751	Deny	06	M/I GROUP ID	M/I GROUP ID

4756	Deny	32	M/I LEVEL OF SERVICE	"POST EDIT IF NOT VALID VALUE: 00=NOT SPECIFIED 01=PATIENT CONSULTATION 02=HOME DELIVERY03=EMERGENCY04=24 HOUR SERVICE05=PATIENT CONSULTATION ABOUT GENERIC PRODUCT SELECTION2-10-03 CHANGED PDCS DESCRIPTION AND MOVED EOB 0207 TO NEW EXCEPTION CODE 4961 - SPECIFIC TO ILLEGAL ALIEN"
4764	Deny	5C	INVALID OTHER PAYER COV TYPE	INVALID OTHER PAYER COVERAGE TYPE
4765	Deny	62	PATIENT/CARD HOLDER ID NAME MI	MEMBER NAME & NUMBER DISAGREE
4775	Deny	7K	OTHER CVRG- PAYER AMT DISCREP	SUM OF SUBMITTED OTHER PAYER PATIENT RESPONSIBILITY AMOUNTS MUST BE GREATER THAN ZERO WHEN OCC = 4
4777	Deny	5E	M/I OTHER PAYER REJECT COUNT	OTHER PAYER REJECT COUNT MUST BE GREATER THAN OR EQUAL TO 1 WHEN OCC = 3
4778	Deny	6E	M/I OTHER PAYER REJECT CODE	AT LEAST ONE OTHER PAYER REJECT CODE IS REQUIRED TO BE SUBMITTED WHEN OCC = 3
4779	Deny	7K	OTHER CVRG- PAYER AMT DISCREP	SUM OF SUBMITTED OTHER PAYER AMOUNT PAID AMOUNTS MUST BE GREATER THAN ZERO WHEN OCC = 2

4780	Deny	NR	INV PAYER-PAT RESP AMT COUNT	M/I OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT
4781	Deny	NP	M/I PAYER-PAT RESP AMT QUAL	M/I OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER
4782	Deny	CX	INV PATIENT ID QUALIFIER	M/I PATIENT ID QUALIFIER
4786	Deny	99	HOST PROCESSING ERROR	EDIT IGNORED
4787	Deny	CA	M/I PATIENT'S FIRST NAME	FIRST NAME NOT EDITED SEPARATELY. IF THE FIRST NAME IS MISSING ON THE CLAIM; SYSTEM RETURNS COB 0238. THIS EDIT HAS BEEN MAPPED TO CB; M/I PATIENT'S LAST NAME.
4787	Deny	CA	M/I PATIENT'S FIRST NAME	FIRST NAME NOT EDITED SEPARATELY. IF THE FIRST NAME IS MISSING ON THE CLAIM; SYSTEM RETURNS COB 0238. THIS EDIT HAS BEEN MAPPED TO CB; M/I PATIENT'S LAST NAME.
4789	Deny	CB	M/I PATIENT'S LAST NAME	MEMBER NAME MISSING
4791	Deny	75	PRIOR AUTH REQUIRED	RESERVED FOR FUTURE USE
4798	Deny	12	M/I PATIENT LOCATION CODE	NURSE FACILITY PT. IND. INVLD
4799	Deny	13	M/I OTHER COVERAGE CODE	MEMBER COVERED BY PRIVATE INS
4800	Deny	15	M/I DATE OF SERVICE	DATE DISP. EARLIER THAN PRSCRBD

4801	Deny	15	M/I DATE OF SERVICE	DATE DISP. AFTER BILLING DATE
4802	Deny	82	CLAIM IS POST DATED	DATE BILLED AFTER ADJUDICATION DATE
4803	Deny	21	M/I PRODUCT/SERVICE ID	NDC INVALID FORMAT
4808	Deny	65	PATIENT IS NOT COVERED	POST EDIT IF SPENDDOWN DATE IS SAME AS DATE OF SERVICE. IF EDIT FAILS - ALSO POST EDIT M5 (REQUIRES MANUAL CLAIM).
4810	Deny	65	PATIENT IS NOT COVERED	MEMBER ENROLLED W/MCO ON DOS
4811	Deny	65	PATIENT IS NOT COVERED	MEMBER ELIG IN SLMB & QDWI
4813	Deny	65	PATIENT IS NOT COVERED	MEMBER HAS OTHER INSURANCE BUT NO OTHER PAYOR AMT OR OTHER PAYOR DATE SUBMITTED ON THE CLAIM
4823	Deny	76	PLAN LIMITATIONS EXCEEDED	"PLAN LIMITATIONS EXCEEDED - PRIOR AUTHORIZATION REQUIRED.
4824	Deny	SH	OTHER PYR PT RESP CNT ERR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
4825	Deny	MX	M/I BENEFIT STAGE COUNT ERROR	BENEFIT STAGE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
4826	Deny	SG	SUB CLARIF CD COUNT ERROR	SUBMISSION CLARIFICATION CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS

4827	Deny	NX	M/I SUB CLARIFICATION CD CNT	M/I SUBMISSION CLARIFICATION CODE COUNT
4828	Deny	2G	INV COMPOUND INGRED MOD CNT	M/I COMPOUND INGREDIENT MODIFIER CODE COUNT
4831	Deny	76	PLAN LIMITATIONS EXCEEDED	"PLAN LIMITS EXCEEDED - SEE BELOW REASON CODES: B =CUSTOM REC; ALL DOSES - MAX $ LIMIT EXCEEDED FOR SPEC DUR"
4832	Deny	76	PLAN LIMITATIONS EXCEEDED	C =CUSTOM REC; ACUTE DOSE - MAX $ LIMIT EXCEEDED FOR SPEC DURATION
4833	Deny	76	PLAN LIMITATIONS EXCEEDED	P= PATIENT EXCEEDS MONTHLY REFILL LIMIT
4834	Deny	84	CLAIM HAS NOT BEEN PAID	CLAIM HAS NOT BEEN PAID OR CAPTURED. ADJUSTMENT CLAIM IS REJECTED CREDIT WILL COMPLETE
4835	Deny	87	REVERSAL NOT PROCESSED	REVERSAL NOT PROCESSED - IF THE MATCHING HISTORY CLAIM WAS FOUND AND WAS ALREADY CREDITED; OR WAS TO-BE-CREDITED; OR THE ORIGINAL CLAIM WAS DENIED; THEN THE ERROR IS POSTED.
4842	Deny	DQ	M/I USUAL & CUSTOMARY CHARGE	SUSPEND A CLAIM IF BILLED AMOUNT IS > THAN OR EQUAL TO 500% OF ALLOWED AMOUNT OR IF BILLED AMOUNT IS < LESS THAN OR EQUAL TO 20% OF ALLOWED AMOUNT. SUSPEND TO LOCATION CODE 40.

4843	Deny	DQ	M/I USUAL & CUSTOMARY CHARGE	590 CLAIMS UNDER $150 SHOULD DENY WITH NCPDP REJECT DQ AND EOB 0429
4847	Deny	E7	M/I QUANTITY DISPENSED	NA
4852	Deny	19	M/I DAYS SUPPLY	EDIT WILL CHECK FOR BOTH MISSING AND INVALID CONDITIONS
4854	Deny	83	DUPLICATE PAID/CAPTURED CLAIM	DUP CHECK: SEARCHES HISTORY. IF A CLAIM WITH THE SAME FDOS AND 1ST 5 CHARACTERS OF THE GCN'S ARE EQUAL; THEN DUP CHECK CONTINUES. IF PRIOR AUTHORIZATION IS REQUIRED; OR THE PRESCRIBING PHYSICIAN DEA NUMBERS ARE EQUAL; OR THE PRIOR AUTH MED CERT CODE INDICATES MEDICAL CERTIFICATION; OR THE DENIAL OVERRIDE IS SET TO M
4857	Deny	M2	MEMBER LOCKED INTO SPECIFIC PR	MEMBER LOCKED TO SPECIFIC DR
4858	Deny	81	CLAIM TOO OLD	THE ENCOUNTER CLAIM IS GREATHER THAN TWO (2) YEARS FROM THE FIRST DATE OF SERVICE.
4859	Deny	15	M/I DATE OF SERVICE	DATE DISPENSED IS INVALID
4861	Deny	40	PHARMACY NOT CONTRACTED WITH P	PROV. INELIG. TO BILL FOR DOS

4862	Deny	28	INV DATE PRESCRIPTION WRITTEN	THE NUMBER OF DAYS SINCE DATE RX WRITTEN HAS BEEN EXCEEDED BASED ON THE DEA CONTROL SCHEDULE
4864	Deny	65	PATIENT IS NOT COVERED	"EDIT POSTED IF DOS IS BEFORE SPENDDOWN DATE.EDIT ALSO POSTED FOR OTHER NON-SPENDDOWN RELATED ELIGIBILITY."
4865	Deny	65	PATIENT IS NOT COVERED	FILLED AFTER COVERAGE EXPIRED
4866	Deny	65	PATIENT IS NOT COVERED	FILLED AFTER COVERAGE TERMINATED
4867	Deny	76	PLAN LIMITATIONS EXCEEDED	E =CUSTOM REC; ACUTE DOSE - SUBMITTED UNITS > MAX UNITS FOR SPEC CLAIM
4868	Deny	76	PLAN LIMITATIONS EXCEEDED	J =CUSTOM REC; ACUTE DOSE - MAX NUM SCRIPTS EXCEEDED FOR SPEC DUR
4869	Deny	76	PLAN LIMITATIONS EXCEEDED	K =CUSTOM REC; ALL DOSES - SUBMITTED DAYS > MAX DAYS SUPP FOR SPEC DURATION
4870	Deny	76	PLAN LIMITATIONS EXCEEDED	L =CUSTOM REC: ACUTE DOSE - SUBMITTED DAYS > MAX DAYS SUPP FOR SPEC DURATION
4871	Deny	82	CLAIM IS POST DATED	CLAIM POST DATED
4873	Deny	E7	M/I QUANTITY DISPENSED	EDIT WILL CHECK FOR BOTH MISSING AND INVALID CONDITIONS
4874	Deny	##	RESERVED FOR FUTURE USE	RESERVED FOR FUTURE USE

4876	Deny	26	INV UNIT OF MEASURE	THE UNIT OF MEASURE CODE IS NOT EQUAL TO THE VALID VALUES
4910	Deny	07	M/I CARDHOLDER ID	MEMBER ID NOT IN VALID FORMAT
4911	Deny	65	PATIENT IS NOT COVERED	FILLED BEFORE COVERAGE EFFECTIVE - IF THE CLAIM'S FDOS FALLS BEFORE THE OLDEST COVERAGE BEGINNING DATE IN THE COVERAGE TABLE (ELIGIBILITY FILE); THEN THE ERROR IS POSTED.
4913	Deny	76	PLAN LIMITATIONS EXCEEDED	GREATER THAN 34 DAYS SUPPLY FOR NON-MAINT. DRUG PRIOR AUTHORIZATION REQUIRED.
4914	Deny	75	PRIOR AUTHORIZATION REQUIRED	NON-PDL DRUG - PRIOR AUTHORIZATION REQUIRED (TCP PROGRAM)
4916	Deny	75	PRIOR AUTHORIZATION REQUIRED	12-11 ADDED NEW EXCEPTION CODE FOR START/END DATE FOR IRDP PROGRAM (CSR 60)
4918	Deny	1C	M/I SMOKER/NON-SMOKER CODE	NA
4919	Deny	1E	M/I PRESCRIBER LOCATION CODE	NA
4929	Deny	AA	PATIENT SPENDDOWN NOT MET	NEW EDIT FOR 5.1 - ACTIVE IN BASE
4931	Deny	AE	QMB (QUALIFIED MEDICARE BENEFI	NA

4933	Deny	EA	M/I ORIGINALLY PRESCRIBED PROD	NA
4934	Deny	EB	M/I ORIGINALLY PRESCRIBED QUAN	NA
4935	Deny	EF	M/I COMPOUND DOSAGE FORM DESCR	THE COMPOUND DOSAGE FORM DESCRIPTION CODE DOES NOT MATCH ONE OF THE NCPDP VALID VALUES
4936	Deny	EG	M/I COMPOUND DISPENSING UNIT HAS AN ERROR	NA
4937	Deny	EH	COMPOUND ROUTE OF ADMINISTRATION	THE COMPOUND DISPENSING UNIT FORM INDICATOR DOES NOT MATCH ONE OF THE NCPDP VALID VALUES
4938	Deny	EJ	M/I ORIGINALLY PRESCRIBED PROD	NA
4951	Deny	RA	PA REVERSAL OUT OF ORDER	NA
4952	Deny	RK	PARTIAL FILL TRANSACTION NOT S	NA
4953	Deny	RM	COMPLETION TRANSACTION NOT PER	NA
4954	Deny	R8	SYNTAX ERROR	NA
4956	Deny	M5	REQUIRES MANUAL CLAIM	"EDIT POSTED WHEN SPENDDOWN DATE IS SAME AS DATE OF SERVICE.SHOULD ACCOMPANY EDIT 65 (PATIENT NOT COVERED) - EXCEPTION CODE 4808 - EOB 0385

				(SPENDDOWN DATE SAME AS DOS)."
4958	Deny	65	PATIENT IS NOT COVERED	PATIENT NO LONGER COVERED BECAUSE DECEASED
4959	Deny	DV	M/I OTHER PAYER AMOUNT PAID	EDIT NEEDED TO CREATE ADDITINOAL REPORTS FOR PA SUBSYSTEM (CSR 14).
4960	Deny	85	CLAIM NOT PROCESSED	"SET IF ATTEMPTING TO ROLL OFF OLD HISTORY AND WS-010-NO-ROLL-OFFPROGRAM: PDDC8622 / S560 ROLL-OFF-HIST-SECTION"
4961	Deny	32	M/I LEVEL OF SERVICE	EDIT POSTED FOR: 1) ILLEGAL ALLIENS; 2) NON-ALIENS - OVERRIDE RESTRICTED CARD (LOCKIN) AND 3) NON-ALIENS - EMERGENCY FILLS [03 & < 5 DAYS SUPPLY]
4964	Deny	M2	MEMBER LOCKED INTO SPECIFIC PR	IF PARTICIPANT IS LOCKED IN TO A PHYSICIAN AND THE CLAIM HAS AN OUT OF STATE PROVIDER; DENY THE CLAIM WITH NCPDP REJECT M2
4965	Deny	75	PRIOR AUTHORIZATION REQUIRED	590 CLAIMS IN EXCESS OF $500 REQUIRE PA. IF THERE IS NO PA, THE CLAIM SHOULD DENY FOR NCPDP EDIT 75 AND EOB 3002.
4967	Deny	70	PRODUCT/SERVICE NOT COVERED	MCO PARTICIPANTS MUST SUBMIT TO THE MCO (MANAGED CARE ORG.)

4968	Deny	76	PLAN LIMITATIONS EXCEEDED	NON-PDL DRUG - SUPPLY LIMITED (TCP PROGRAM)
4970	Deny	76	PLAN LIMITATIONS EXCEEDED	STEP CARE - GREATER THAN 90 DAYS IN 180 DAYS OF RANITIDINE OR NIZATIDINE > 150 MG/DAY; FAMOTIDINE > 20MG/DAY; CIMETIDINE > 400MG/DAY PA REQUIRED.
4971	Deny	75	PRIOR AUTHORIZATION REQUIRED	STEP CARE - PRAVACHOL IS NON-PDL IF PATIENT NOT RECEIVING ANTIVIRAL THERAPY; TXCL W5B OR W5C. ARBS REQUIRE PREVIOUS TX WITH ACEIS WITHIN LAST 365 DAYS; OTHERWISE, PRIOR AUTH REQUIRED (TCP PROGRAM)
4972	Deny	M5	REQUIRES MANUAL CLAIM	COMPOUND CLAIMS EXCEEDING $200 REQUIRE PAPER CLAIM
4977	Deny	56	NON-MATCHED PRESCRIBER IDENTIF	PHYSICIAN LIC# NOT ON FILE
4978	Deny	70	PRODUCT/SERVICE NOT COVERED	MEDICAL SUPPLIES NOT COVERED AT POS EFFECTIVE 3/17/03 AND NUTRITIONALS NOT COVERED EFFECTIVE 4/3/03
4979	Deny	25	M/I PRESCRIBER IDENTIFICATION	PRESCRIBER WRITING PRESCRIPTION FOR SCHEDULE II DRUG MUST HAVE A VALID DEA# ON FILE

4983	Deny	75	PA REQUIRED	CONTACT ACS CLINICAL DESK AT 866-506-4379EDIT HISTORY: 4-1 CREATED EDIT 4984 AND 4983 TO BREAK OUT UNIQUE LOGIC PREVIOUSLY UNDER THE 4132 EXCEPTION CODE (DRUG PROGRAM); AS REQUESTED BY MARGARET AND PATTY
4984	Deny	75	PA REQUIRED	PA REQUIRED.
4985	Deny	65	PATIENT NOT COVERED	EDIT WILL POST IF MEMBER IS NOT COVERED BY MEDICAID EVEN IF ELIGIBLE UNDER A SPECIFIC PLAN

9.9.4.2.1 PHARMACY DENIALS DUE TO NDC NOT ON FILE

Since HCA uses First Databank and the MCOs use Medispan, there is the possibility that the MCO's will recognize an NDC code that is not on the State's formulary. If the MCO has an NDC code that is denied as not being on the State's formulary, the MCO is instructed to submit the following spreadsheet containing the list of NDCs denied to Conduent who will then work with our FDB representative at PDCS to add those NDC codes that can be added. Once the adds are done, the MCO can resubmit the denied encounters.

The following template should be used and sent to: lorin.meskin@conduent.com

MCO TURQUOISE CLAIMS MANUAL

FIRST DATABANK

ADD PRODUCT/IMAGE REQUEST FORM

NDC #	Manufacturer Name	Label Name Product Description	UPC #	Package Size	OTC/RX	NDC/UPC	IMAGE

9.9.5 Submission of Corrections to Encounter Files

If the MCO receives a 997 or an HTML Error report from TIE, or fails to receive a balancing report from TIE, the MCO will know that the Encounter file was rejected in its entirety and must be corrected and resubmitted. The naming convention for the resubmission of this file should follow that shown in Encounter Submission Procedures section of this manual.

The MCO is expected to resubmit any encounters that are denied. A pattern of errors on the *ENCOUNTER ADJUDICATION CYCLE SUMMARY REPORT* (RC-072) that exceeding 3% denied may result in a corrective action request. Corrections to denied encounters may be resubmitted in a separate resubmission file or combined with the next batch of encounters being submitted.

837I (Institutional) inpatient and NCPDP (Drug) encounters will be accepted or denied in their entirety. Thus, if there is an error in any line item on an inpatient 837I or Drug claim, the entire encounter claim will be denied. 837I non-inpatient, 837P and 837D (Professional/Dental) encounters will be accepted or denied on a line-item basis.

Header level edits will cause the entire encounter to deny. Otherwise, the 837I non- inpatient, 837P and 837D encounter could have some lines accepted and some denied. The error calculation for 837I non-inpatient, 837P and 837D encounters is performed as the number of encounter lines denied divided by the number of encounter lines submitted (minus duplicates and failed reversals). The 837I Inpatient and Drug encounter error calculation is performed as the number of claims denied divided by the number of encounter claims submitted (minus duplicates and failed reversals).

The *DENIED ENCOUNTER ADJUDICATION CYCLE DETAIL FLAT FILE* RC70/71 will include all encounters that are denied at the header level and any line items that were denied. The MCO should submit the entire claim as an adjustment so that lines previously submitted don't error off as duplicates if resubmitted on the claim.

10.0 Supporting Files

10.1Reference Files

To support various functions of the Managed Care Organization, HCA makes available monthly a variety of Provider, Rates, and Formulary files. These files are sent via the SIP in the morning of the second day of each month. The Rate and Formulary files included are:

File Detailed Description	File Name	Legacy File Name (Ref Only)
Interface record layout for diagnosis related group relative weights	DRGRELATIVEWEIGHTS_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRDRGRW.CSV
Interface record layout for procedure code formulary file with indicators	PROCEDURECODEFORMULARY_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPCFRM.CSV

File Detailed Description	File Name	Legacy File Name (Ref Only)
Interface record layout for place of service codes by procedure code	PLACEOFSERVICEBYPROCEDURECODE_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPLSVC.CSV
Interface record layout for revenue code formulary file with indicators	REVENUECODEFORMULARY_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRRVFRM.CSV
Interface record layout for revenue code by provider rates	REVENUECODEBYPROVIDERRATES_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRRCPRV.CSV
Interface record layout for procedure code pricing spans	PROCEDURECODEPRICINGSPAN_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPCPRC.CSV
Interface record layout for procedure rates.	RATEPROCEDUREPROVIDER_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRSPPRC.CSV
Interface record layout for procedure rates by Provider Specialty.	RATEPROCEDUREPROVIDERSPECIALTY_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRSPPRC.CSV
Interface record layout for procedure rates by Provider types.	RATEPROCEDUREPROVIDERTYPE_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRSPPRC.CSV
Interface record layout for procedure pricing	PROCEDUREPRICING_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRSPPRC.CSV
Interface record layout for procedure rates.	RATEPROCEDUREAGE_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRSPPRC.CSV
Interface record layout for procedure matrix file	PROCEDUREMATRIX_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPMTRX.CSV
Interface record layout for institutional pricing file	INSTITUTIONALPRICING_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPRCNG.CSV
Displays for all active procedure codes whether provider type, provider specialty or claim type is specified and if it is (indicator = 'I'), displays all valid provider type/claim types.	PROCEDURECLAIMTYPESANDPROVIDERTYPESALLOWED_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPRPRT.ZIP
Displays for all active revenue codes by revenue type whether provider type or type of bill code is specified and if it is (indicator = 'I'), displays all valid provider type/type of bill codes	REVENUECODEWITHTYPEOFBILL_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRRVTOB.ZIP
Provider type taxonomy crosswalk	PROVIDERTYPETAXONOMYCROSSWALK_NM035401_M_YYYYMMDD_HHMMSSmmm.csv	MRPTXNY.ZIP

The details of these file layouts is located [HCA-MCO - Documents - MCO Business Manual - All Documents](#).

Notes: The special pricing procedure is used when a procedure is not paid across the board at the same pricing, or perhaps not paid to any but a select group of providers. The Rate type has the following values which are used to specify which combination of factors is used to evaluate the pricing. For the most part, the type isn't all that necessary since the fields themselves will indicate what is being used. For instance, if the type is A, the only field populated will be provider; if rate type is F, the provider type and COE will be populated, etc.:

Field: R-RT-TY-CD R-Reference

Rate Modifier type field. Table r_rt_proc_specl_tb will contain 8+ ways of modifying a rate on a procedure. This identifies the type of rate modifier (Blng/Rend type, Rend-Ty/COE, Rend-Ty, etc.)

Value	Long
A	Provider
B	Billing, Rendering Type
C	Rendering Type, COE
D	Rendering Type
E	Rendering Specialty
F	Billing Type, COE
G	Billing Type
H	Billing Specialty
I	Procedure Code

Rate Source Code	
Value	Long
AI	Appropriated Increase
AR	Audited Rate
BP	Baseline Price
CA	CPI Adjustment
CC	Cost to Charge Ratio
CP	Capitation
CS	Comparable Service
CT	Contract
EC	Equipmnt and/or Supply Catalog
FP	Federal Pricing
HA	OPPS Always Packaged
HP	OPPS HCPCS Pricing
J1	OPPS Price Mcare APC St Ind Q1
J2	OPPS Price Mcare APC St Ind Q2
J3	OPPS Price Mcare APC St Ind Q3
J5	OPPS NM Mcaid Pay Price Revw
J6	OPPS NM Medicaid Price Review
J7	OPPS NM Medicaid Not Covered
J8	OPPS NM Medicaid Special Revw
J9	OPPS NM Medicaid Covered
JA	OPPS NM Fee Sched APC St Ind A
JB	OPPS Not Payable APC St Ind B
JC	OPPS NotCvrd Inpt APC St Ind C
JE	OPPS Not Covered APC St Ind E
JF	OPPS Price Mcare APC St Ind F
JG	OPPS Price Mcare APC St Ind G
JH	OPPS Price Mcare APC St Ind H
JK	OPPS Price Mcare APC St Ind K
JL	OPPS Price Mcare APC St Ind L
JM	OPPS Not Payable APC St Ind M
JN	OPPS PackagdServ APC St Ind N
JP	OPPS Price Mcare APC St Ind P
JR	OPPS Price Mcare APC St Ind R
JS	OPPS Price Mcare APC St Ind S
JT	OPPS Multi Reduct APC St Ind T
JU	OPPS Price Mcare APC St Ind U
JV	OPPS Price Mcare APC St Ind V
JX	OPPS Price Mcare APC St Ind X
JY	OPPS Not Payable APC St Ind Y
LM	Legislative Mandate
MB	Medicare BC\BS
MR	Manufacturers Retail Price
PM	Percent of Medicare
RV	Relative Value
SD	State Determined (default)
TP	Third Party
WA	AWP + Administration
WC	Wholesale Cost
WD	Average Wholesale Price (AWP)
WP	Average Wholesale Price
ZZ	Not Applicable

FACTOR CODES

Value	Long
0	ASC Not Covered
1	General Fee Schedule
2	General Relative Value Scale
3	Manual Review Fee Schedule
4	Manual Review RVS
5	General by Report
6	General Not Covered
8	ASC Manual Review Fee Schedule
9	ASC By Report
A	26 Fee Schedule (FS)
B	26 Relative Value Scale (RVS)
C	26 Manual Review Fee Schedule
D	26 Manual Review RVS
E	26 by Report
F	26 Not Covered
G	TC Fee Schedule

H	TC Relative Value Scale
I	TC Manual Review Fee Sched
J	TC Manual Review RVS
K	TC by Report
L	TC Not Covered
M	Rental Fee Schedule
N	Rental Relative Value Scale
O	Rental Manual Price-Fee Sched
P	Rental Manual Price-RVS

R	Rental Not Covered
S	Anesthesia Fee Schedule
T	Anesthesia Relative Value Scal
U	Anesthesia Manual Review Fee
V	Anesthesia Manual Review RVS
W	Anesthesia by Report
X	Anesthesia Not Covered
Y	Outp Prospective Pmt System

Field: R-INST-CHRG-MOD-CD

Pricing control code used to "Rate" (by provider number) price Inpatient claims, along with certain Outpatient claims, including Long Term Care (LTC) claims.

Value *Long*

Inpatient Percent of Charge

Outpatient Percent of Charge

Inpatient Per Diem

LTC Per Diem

IHS Per Diem

Diagnostic Related Group (DRG)

Outp Prosp Pmt Sys Pct of Base

.

Displays for all active revenue codes by revenue type (inpat, outpt or long-term care) whether provider type or type of bill code is specified and if it is (indicator = 'I'), displays all valid provider type/type of bill codes. DX code updates will be made per HCA request.

11.0 DMZ Schedule and User Guide

Table 4- DMZ Schedule

Interface Name	Inbound / Outbound	Frequency	Sender	File Name	Receiver/Target	Days of the week (M,T,W,Th,F,S,Sun)*	Delivery Time *
RC 072 Drug - BCBS	Outbound	Daily	FS	RC072BCBS_NMMC0041_D_{timestamp}.xlsx	MCO-BCBS	M to Sun	8:00 AM MT

Interface Name	Inbound / Outbound	Frequency	Sender	File Name	Receiver/Target	Days of the week (M,T,W,Th,F,S,Sun)*	Delivery Time *
RC 072 Drug - MHP	Outbound	Daily	FS	RC072MHP_NMMC0041_D_{timestamp}.xlsx	MCO-MHP	M to Sun	8:00 AM MT
RC 072 Drug - PHP	Outbound	Daily	FS	RC072PHP_NMMC0041_D_{timestamp}.xlsx	MCO-PHP	M to Sun	8:00 AM MT
RC 072 Drug - UHP	Outbound	Daily	FS	RC072UHP_NMMC0041_D_{timestamp}.xlsx	MCO-UHP	M to Sun	8:00 AM MT
RC 072 Non-Drug - BCBS	Outbound	Daily	FS	RC072BCBS_NMMC0041_{timestamp}.xlsx	MCO-BCBS	M to Sun	8:00 AM MT
RC 072 Non-Drug - MHP	Outbound	Daily	FS	RC072MHP_NMMC0041_{timestamp}.xlsx	MCO-MHP	M to Sun	8:00 AM MT
RC 072 Non-Drug - PHP	Outbound	Daily	FS	RC072PHP_NMMC0041_{timestamp}.xlsx	MCO-PHP	M to Sun	8:00 AM MT
RC 072 Non-Drug - UHP	Outbound	Daily	FS	RC072UHP_NMMC0041_{timestamp}.xlsx	MCO-UHP	M to Sun	8:00 AM MT

12.0 New Mexico MoveIt DMZ User Guide

User Guide

12.1Overview

The New Mexico MOVEit DMZ is a secure file transfer facility being used to transfer files and reports between Conduent, New Mexico State Departments, New Mexico MCOs, and Third Parties designated by the state of New Mexico. The files and reportsto be transferred between entities are uploaded by the transmitting entity into a designated folder that the receiving entity has the authority to read and/or download the file or report from. The access security in MOVEit DMZ is controlled at the folder level. Users are granted Read, Write, Delete, List, and/or Notify access to each folder that they need, to perform their duties. Administrators in MOVEit DMZ may also be granted Sub and/or Admin authority so that they may create folders and/or administer the user's folder access rights.

Each folder in MOVEit DMZ has several retention days associated with it. The number of retention days controls how long a file or report will remain in that folder before they are automatically deleted from that folder and MOVEit DMZ. The number of retention days is expressed in calendar days and not on workdays. As a rule, folders that contain daily or weekly files have a 10-day retention period and folders for monthly files have a 45-day retention period. There are exceptions to the number of days on certain folders. If you have a question about the retention for a specific folder, please contact one of the New Mexico MOVEit DMZ administrators.

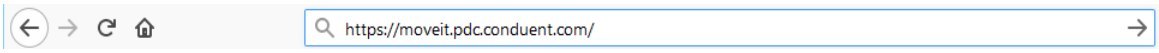
The New Mexico MOVEit DMZ is **NOT** a file storage area.

12.2The Website

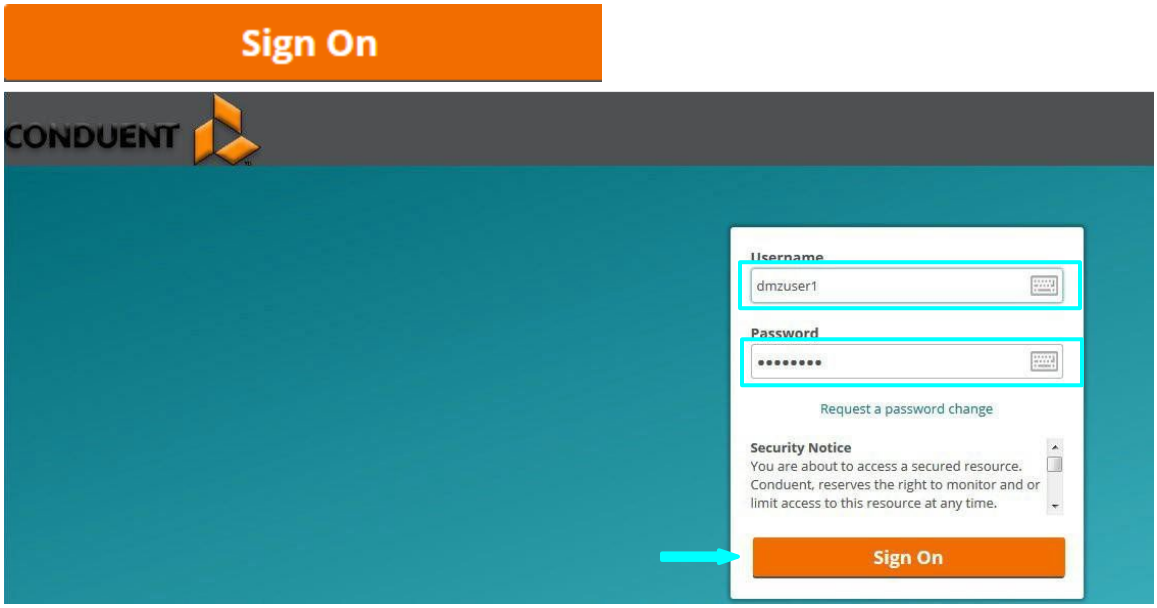
The New Mexico MOVEit DMZ is access via the World Wide Web and may be accessed from any computer with one of the major web browsers installed. The URL of the New Mexico MOVEit DMZ is Azure PBM Prod MOVEit Transfer. This is a secure website and may only be accessed by an authorized user.

12.3Logging On

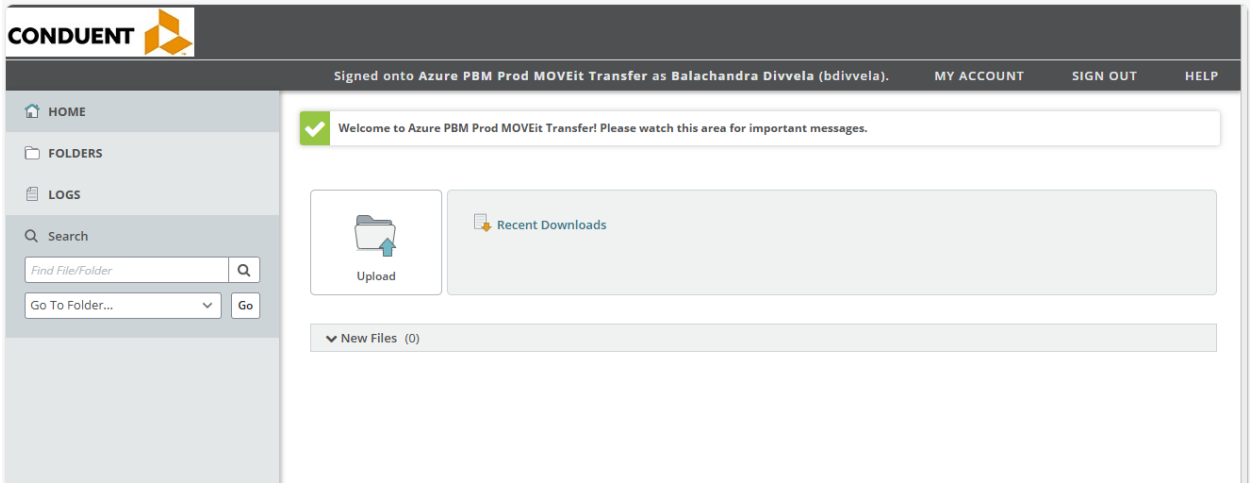
Enter the New Mexico MOVEit DMZ URL in your browsers address bar. Azure PBM Prod MOVEit Transfer



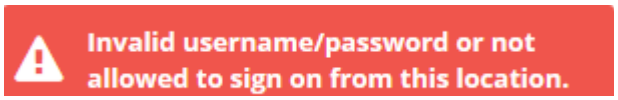
You will receive the Sign On screen. Enter your User ID and Password, and then click “**Sign On**”



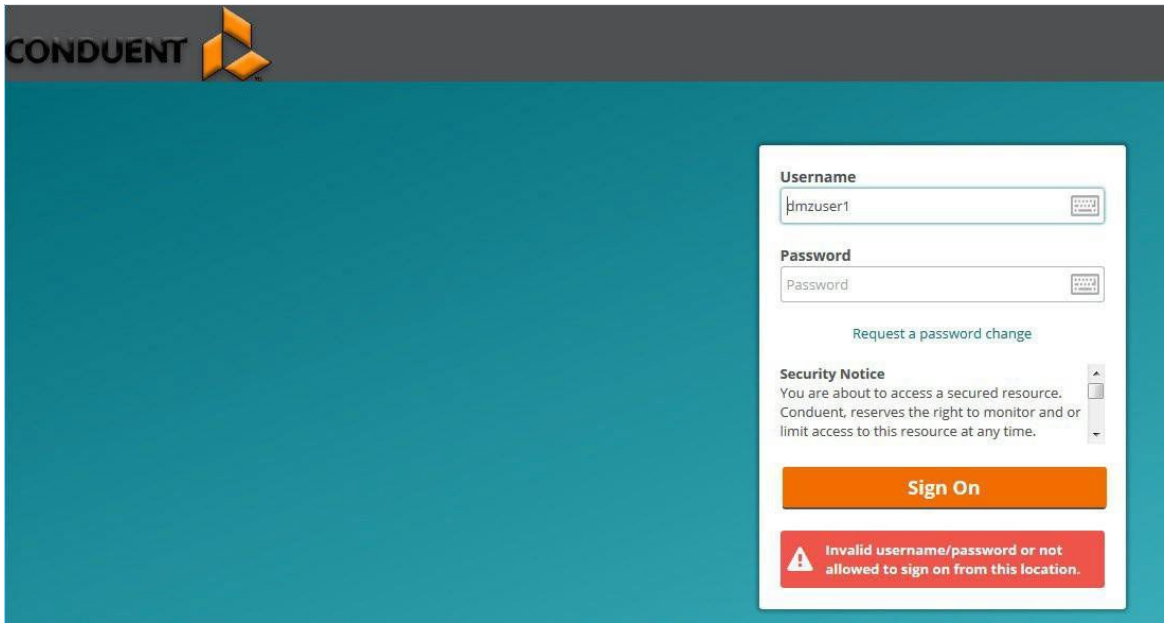
If the Sign On is successful you will be taken to your Home folder.



If the Sign On failed, you will receive the Sign On screen with the following message:



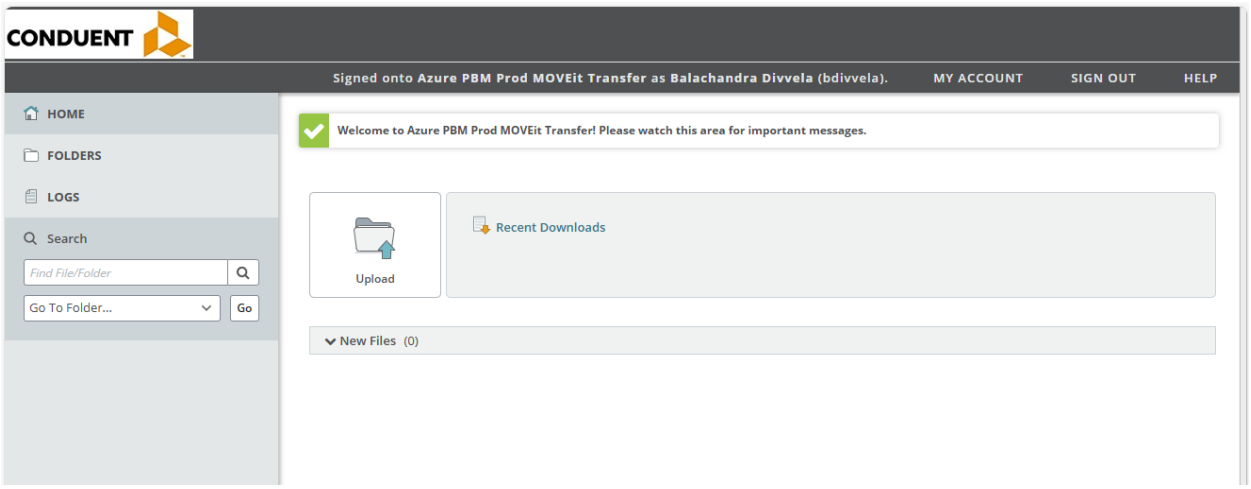
This message is generic to help prevent unauthorized access to the New Mexico MOVEit DMZ.

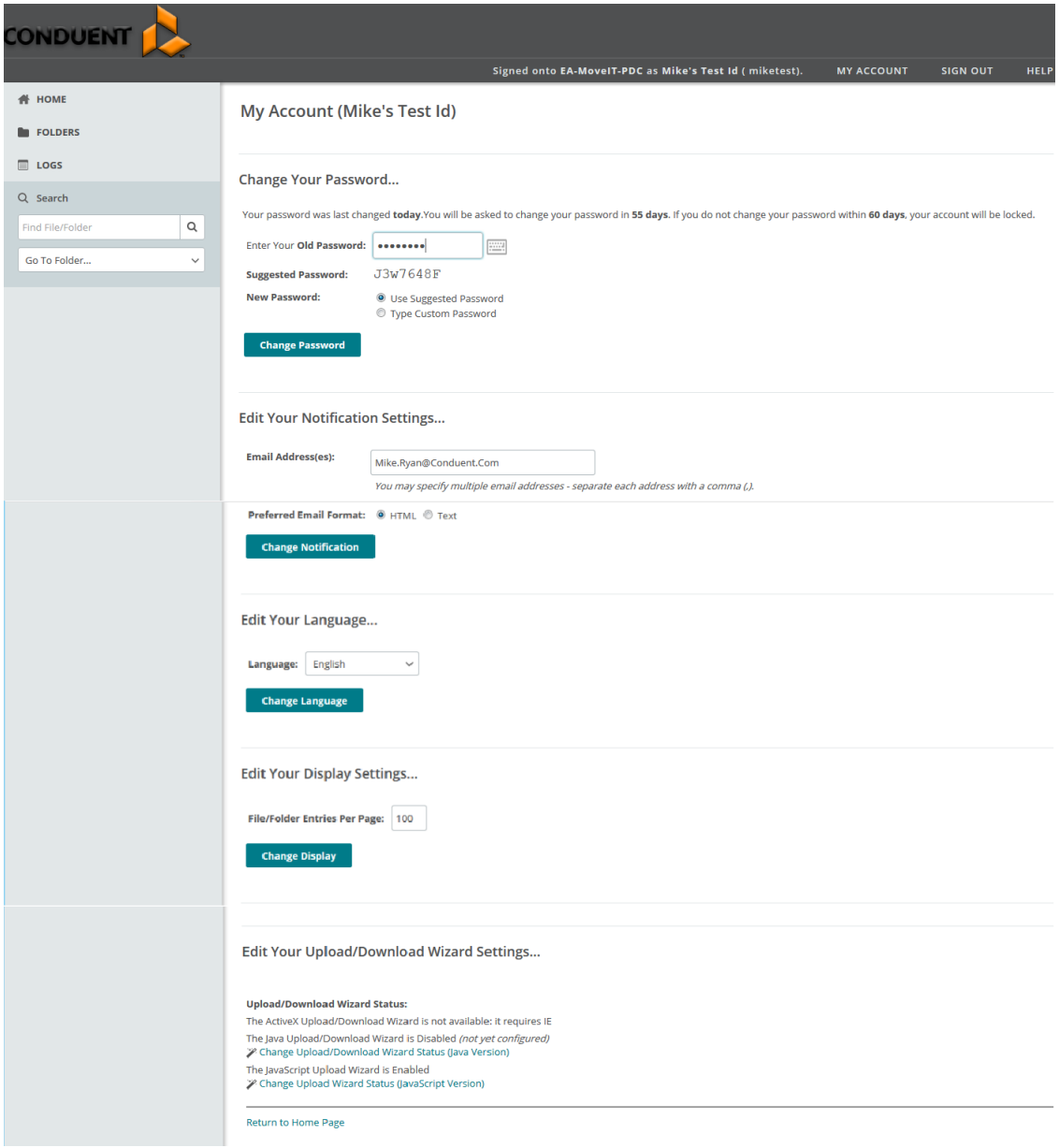


Remember that the Username is not case sensitive, but the Password is. If you receive this screen, try to reenter your information. If you continue to receive this screen, please contact one of New Mexico MOVEit DMZ administrators to have a new password assigned and to verify your Username.

12.4Your Account Options

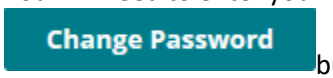
To modify your account options, click on My Account at the top of the home page. A list of options will be displayed for you to change.


CONDUENT
Signed onto Azure PBM Prod MOVEit Transfer as Balachandra Divvela (bdivvela).
MY ACCOUNT
SIGN OUT
HELP
HOME
FOLDERS
LOGS
Search
Find File/Folder
Go To Folder...
Go
Welcome to Azure PBM Prod MOVEit Transfer! Please watch this area for important messages.
Upload
Recent Downloads
New Files (0)

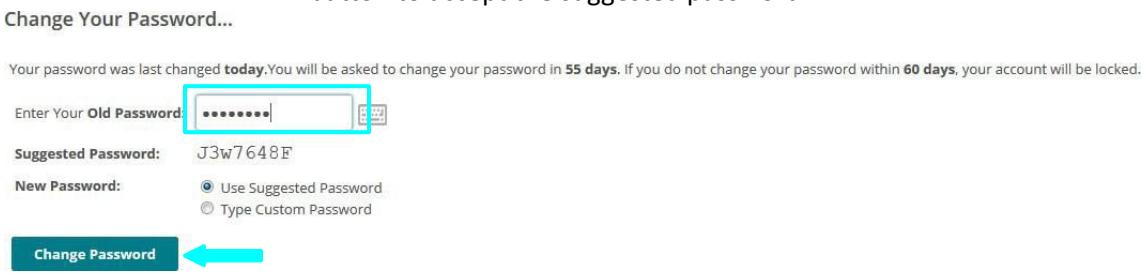


12.5Changing Your Password

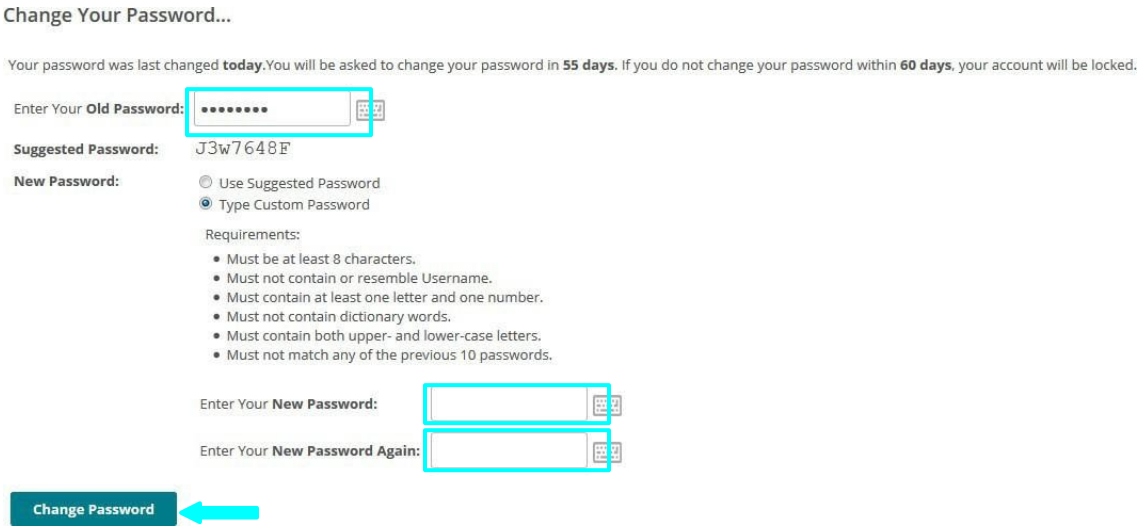
You will need to enter your existing password in the space provided and then click on the



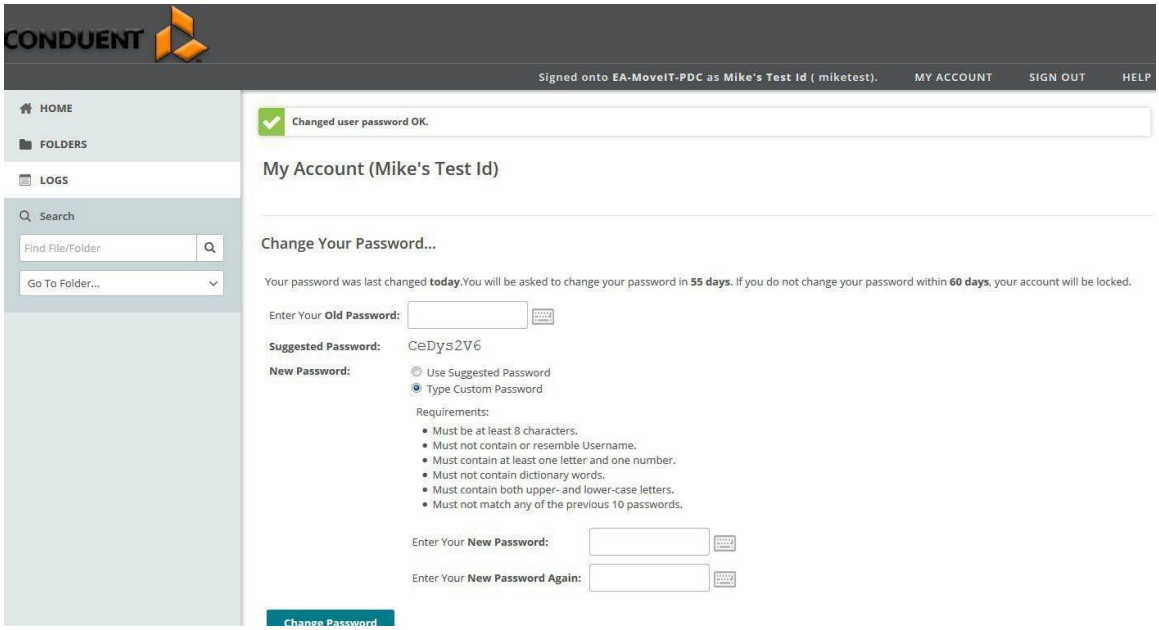
button to accept the suggested password.



If you want to enter a custom password, First click on the **Type Custom Password** button, and the screen will change to allow you to enter your custom password. If your new password is acceptable to MOVEit DMZ you should get the next screen with the

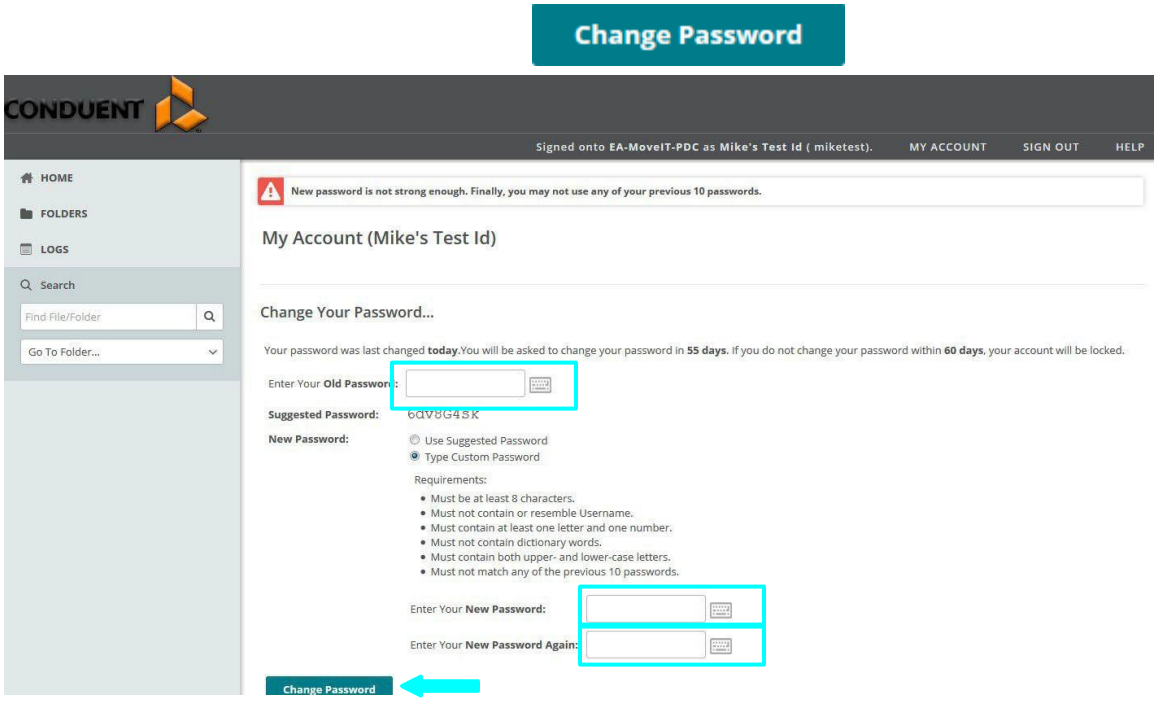


If your new password is acceptable to MOVEit DMZ you should get the next screen with the **Changed User Password Ok** button.



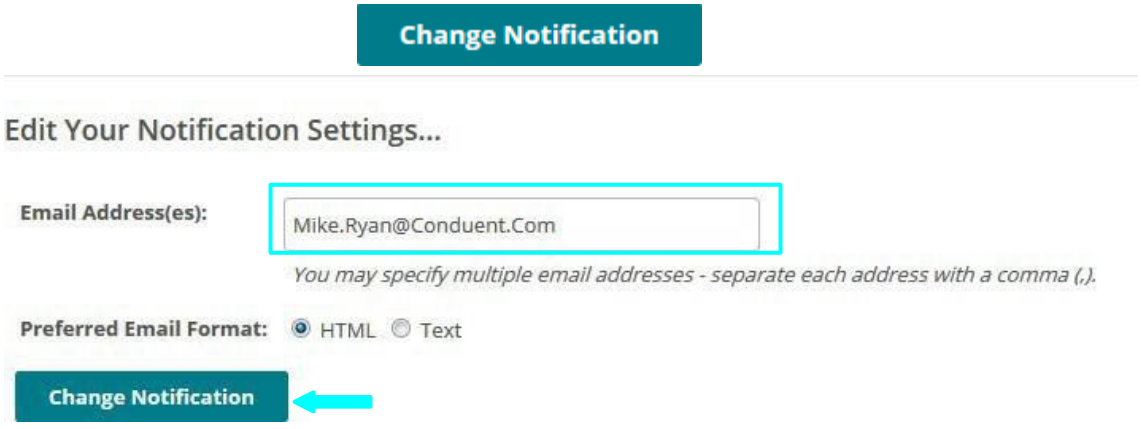
If your new password is not acceptable to MOVEit DMZ you will get this screen and the rejected message:

Re-enter your information and correct your new password to meet the requirements below.

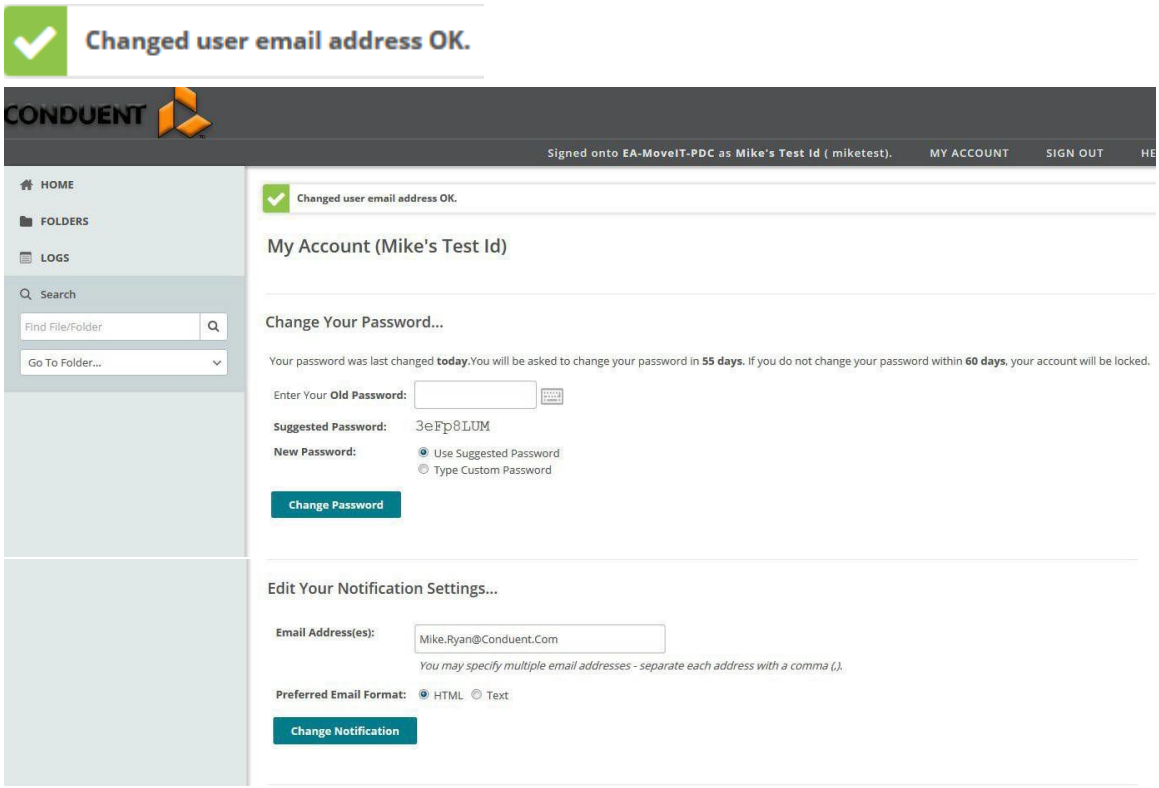


12.6Your Notification Settings

To change your 'Notification Setting' just over type the current values with your updated email and click the **change notification** button

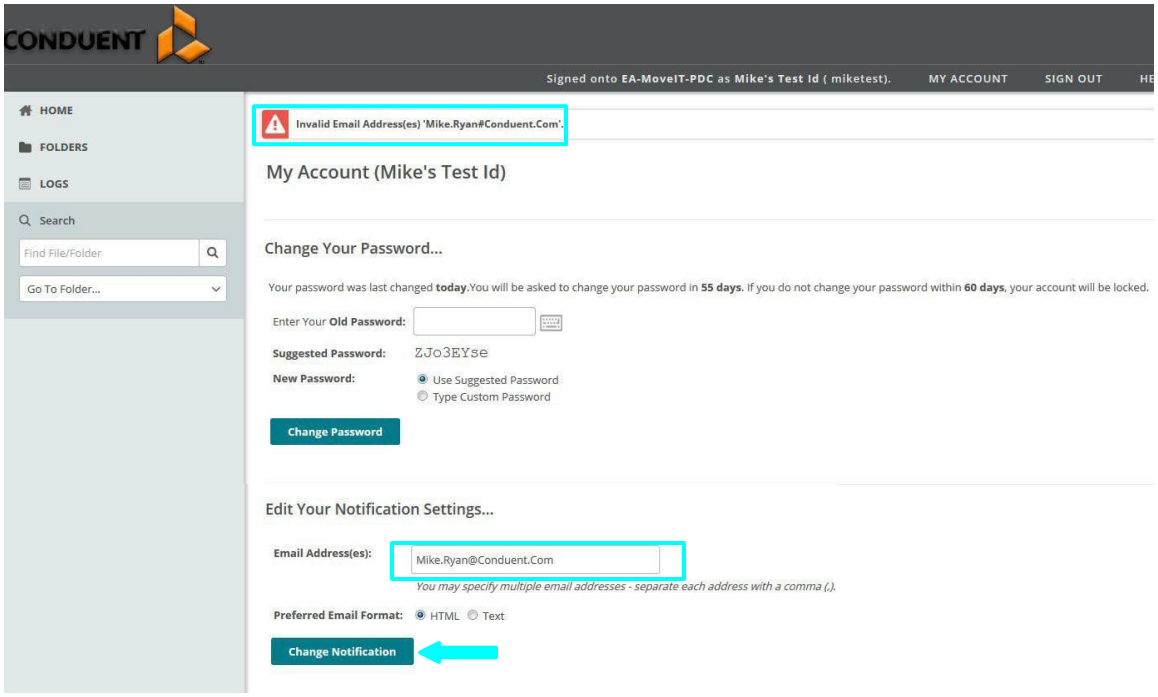


If your changes are accepted, you will get this OK message



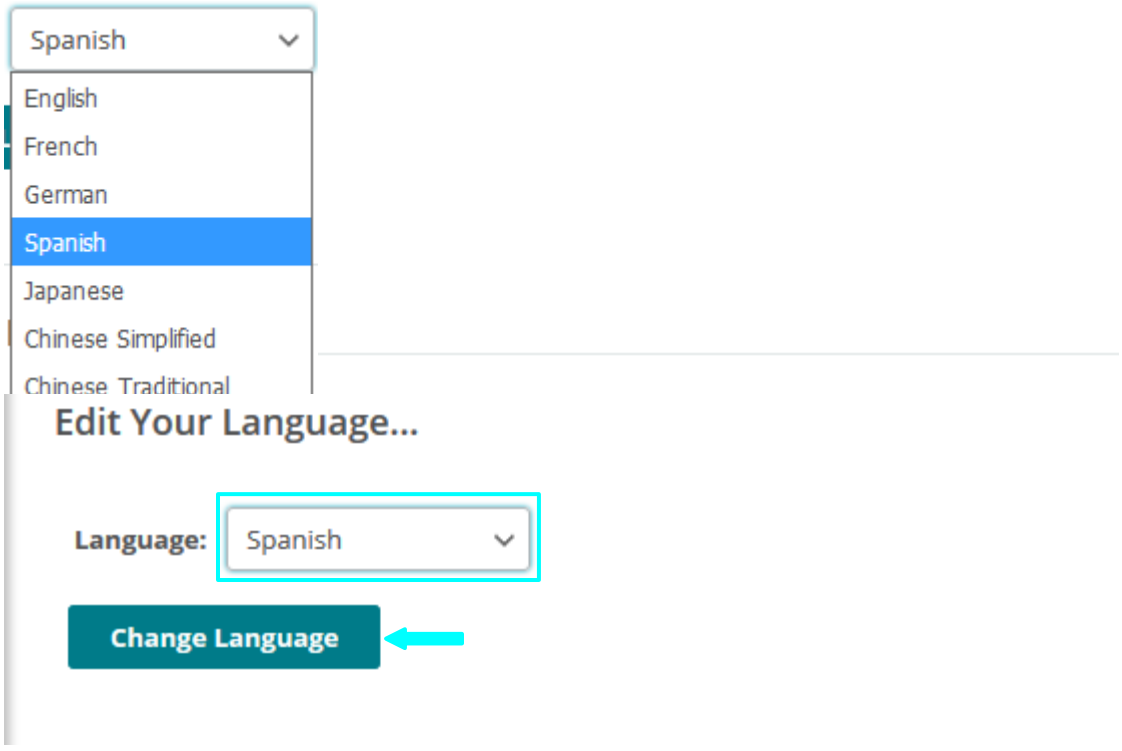
If you enter an invalid email address, you will get this message

showing the invalid address. The screen will be redisplayed with the original email address redisplayed. Enter a valid email address and resubmit if you still need to make the change.



12.7Your Language Setting

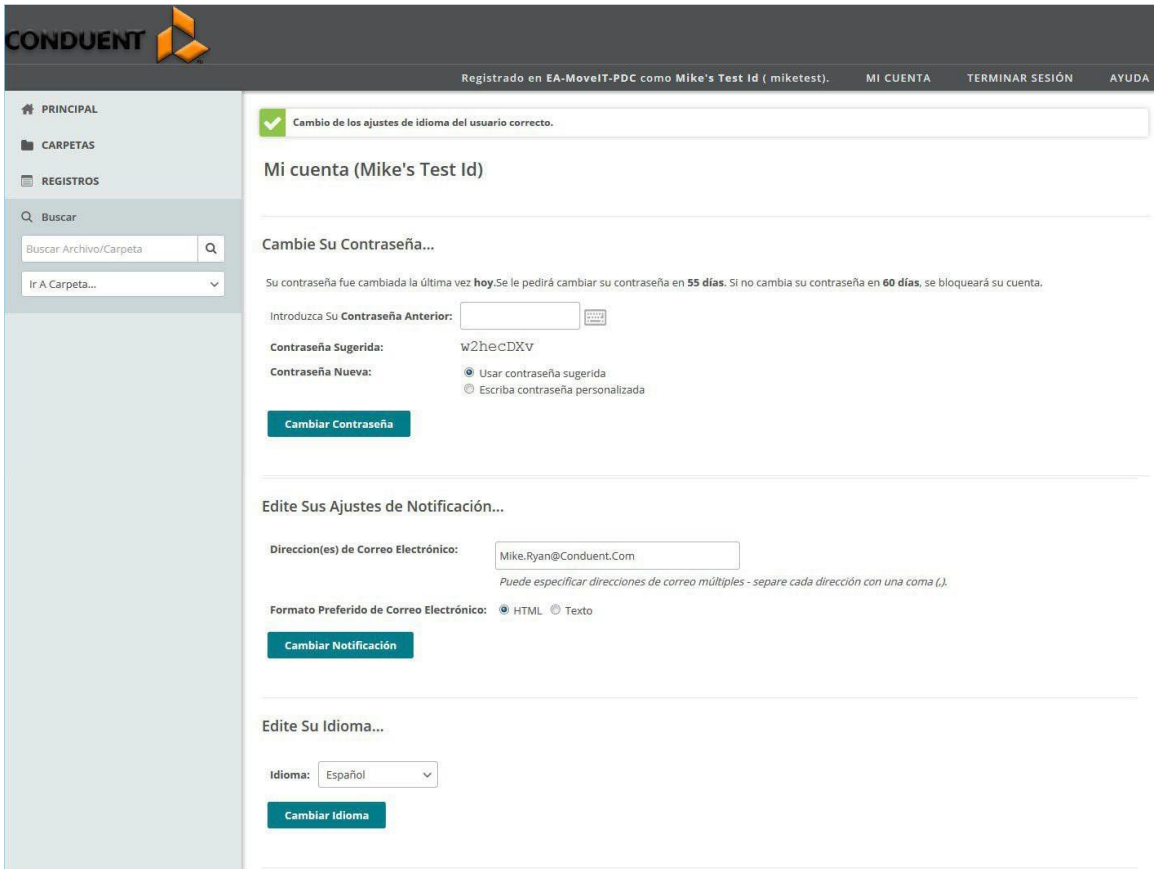
Here you can adjust the language that the screens are displayed in from the dropdown menu by selecting the language you want and then click the **Change Language** button.



You will receive the OK message in the language selected

Cambio de los ajustes de idioma del usuario correcto. a

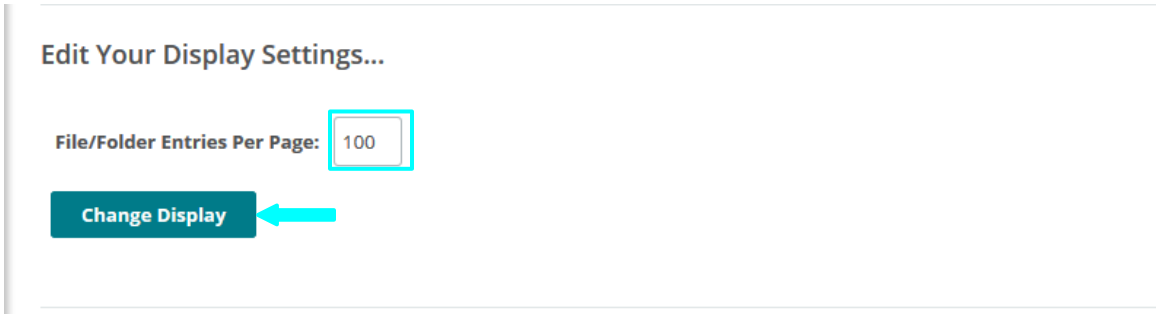
And the screen will then be displayed in that language



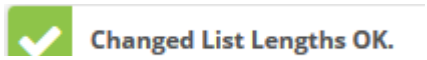
12.8Your Display Setting

Here you can adjust the number of folders or files that will be displayed on any given page. The valid values for the number of entries on a page are between 5 and 200. If you enter a value outside of this range, you will get an error message.

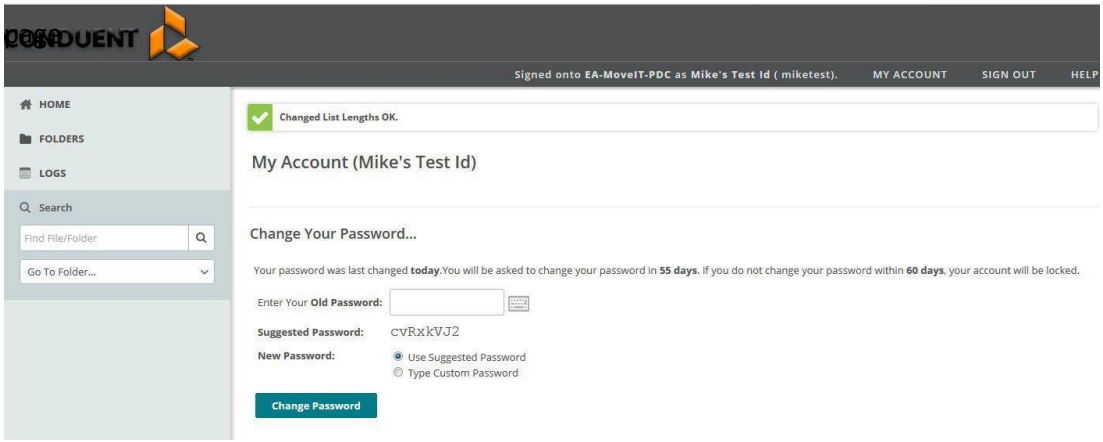
Enter the number of entries you want on a page and then click the **Change Display** button.



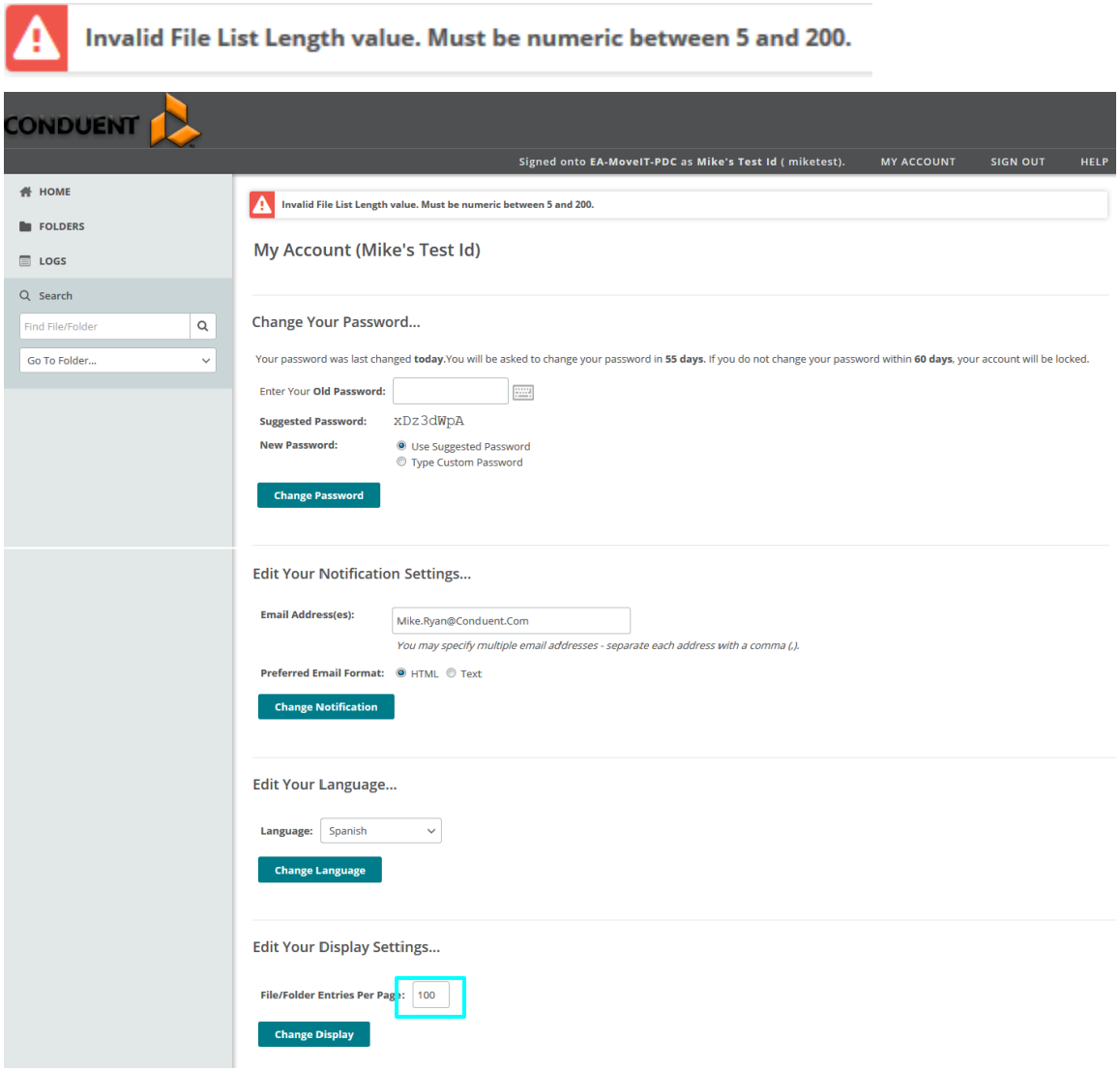
If you entered a valid value, you would get the **Changed List**



Lengths OK message and returned to top of the Account Options



If you enter an invalid value, you will receive an invalid value message and be returned to the top of the Account Options page, with the original value restored in the Entries per Page field.

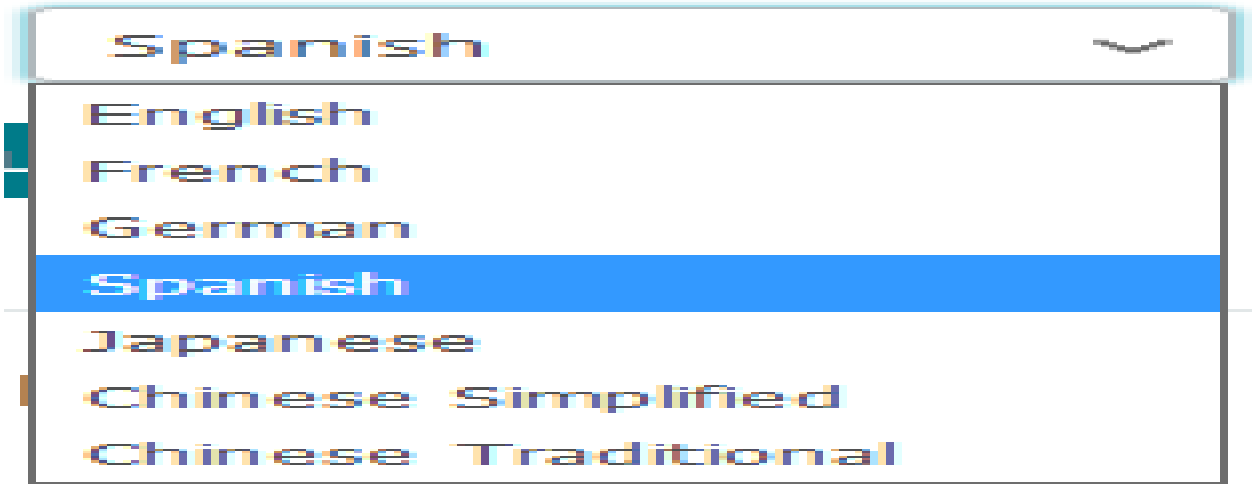


12.9Navigation

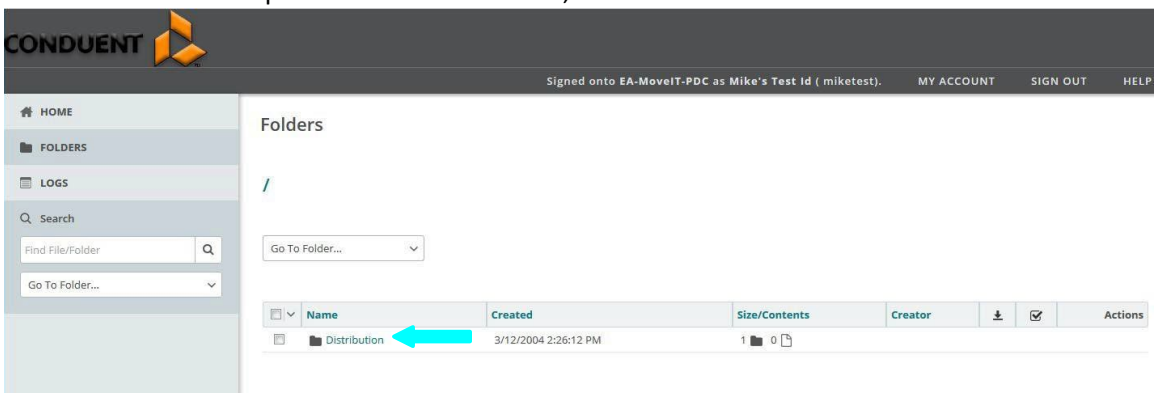
In general navigation in MOVEit DMZ is as simple as point and click. On any of the DMZ screens when you see an underlined word you may click on that word and you will be taken to that screen. The next two sections will show you two ways to navigate to the file or folder that you want to work with.

12.9.1The Step-Down Method

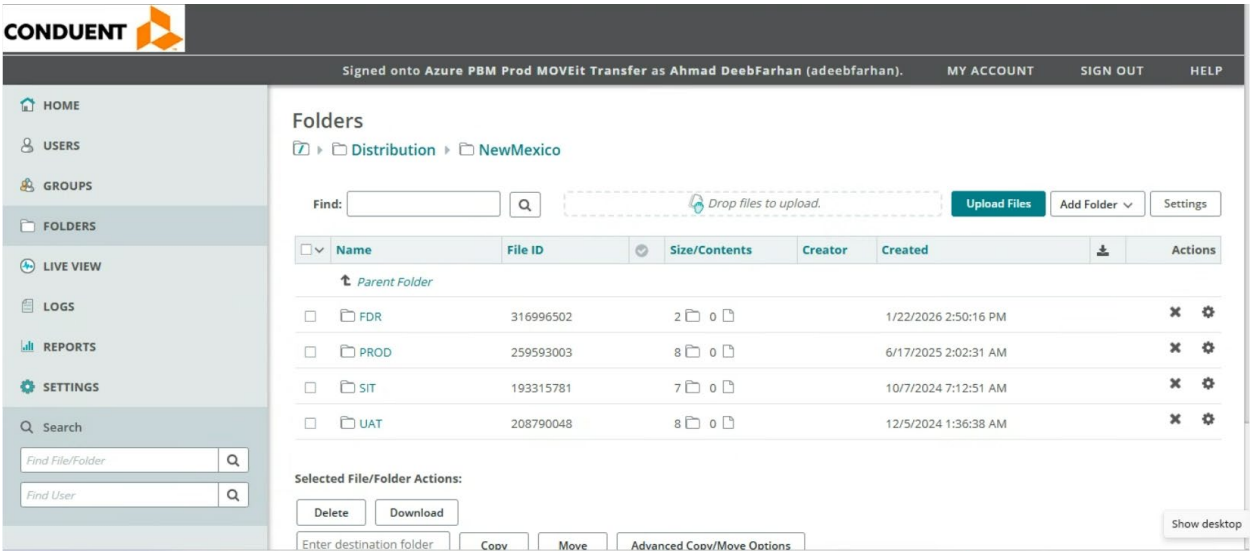
The Step-Down Method will take you one level deeper into the folder structure each time you select the next folder in the chain. Once you are signed on and are on your home page start the process by clicking on the FOLDERS icon on the upper left of the screen.



You will be taken to the first level to which you have access, which in most cases will be the Distribution level. To proceed to the next level, click on Distribution

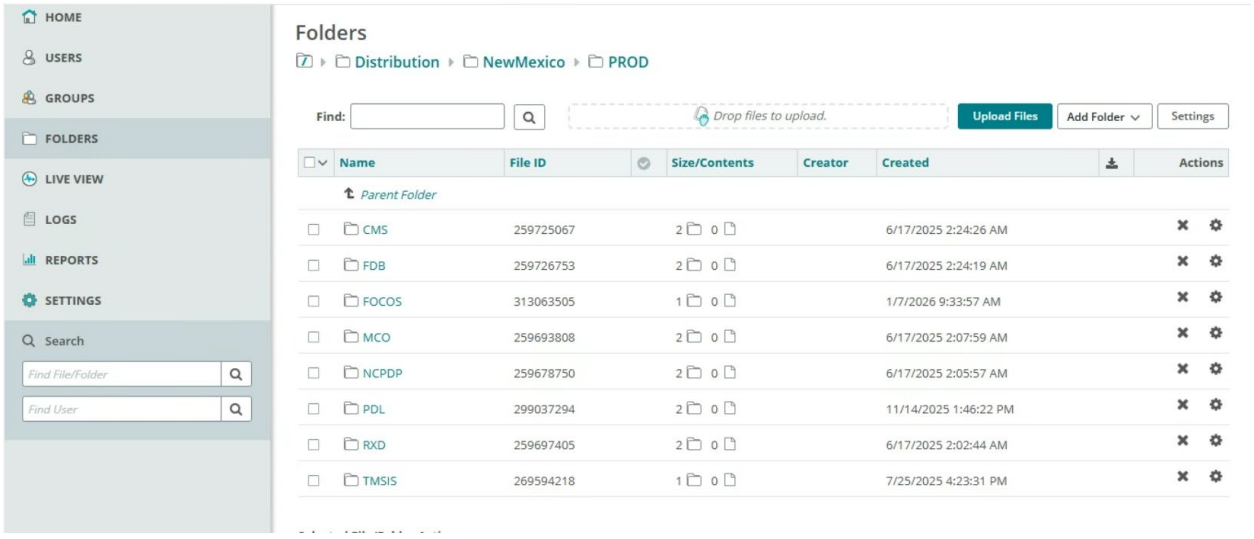


The next level will be displayed as seen below. Note that the 'New Mexico' folder shows that there are 30 sub folders to this one. To see the next level, click on the 'NM Operations' folder name.

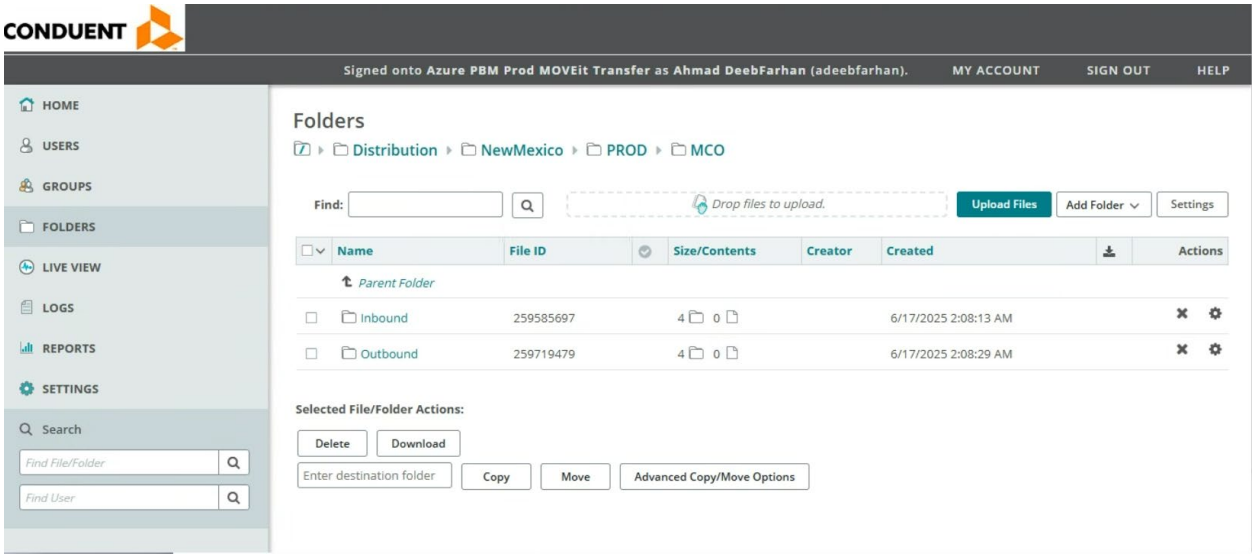


This next screen will vary, depending on the number of files to which you have access, at each level as you continue to drill down to the various levels. You continue to drill down, by clicking on the name of the folder you want, to reach the next level.

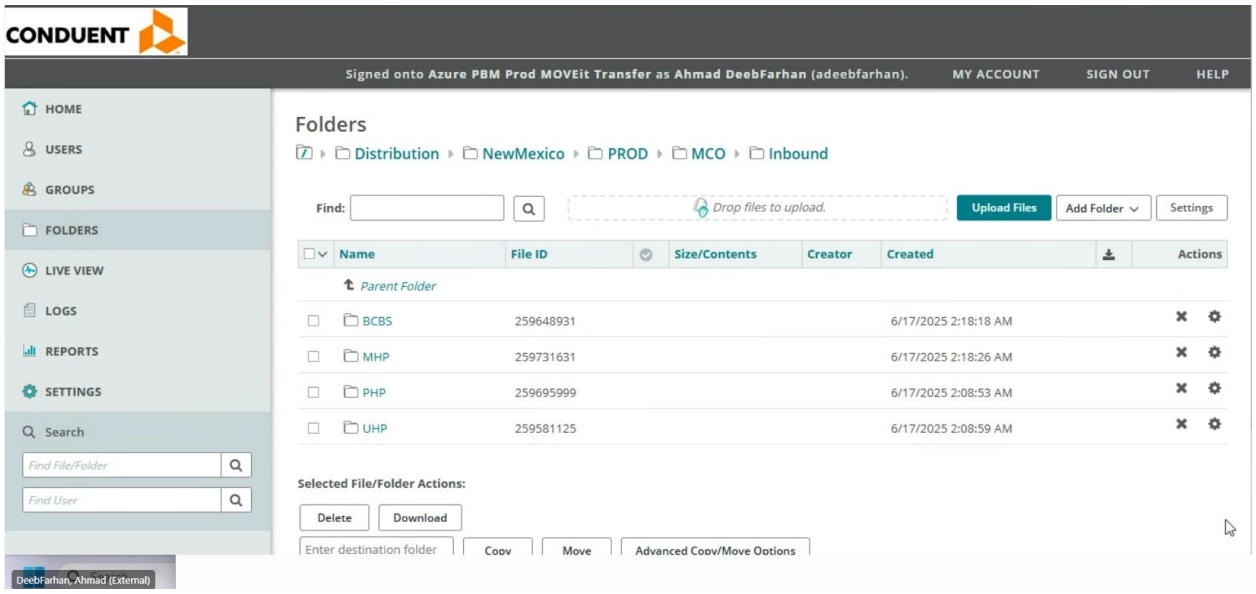
The results from the above selection are shown below. You will notice that the column titled 'Size/Contents' shows 2 values. The number before the folder icon indicates the number of sub folders to this folder and the number before the sheet of paper icon is the number of files contained in this folder.

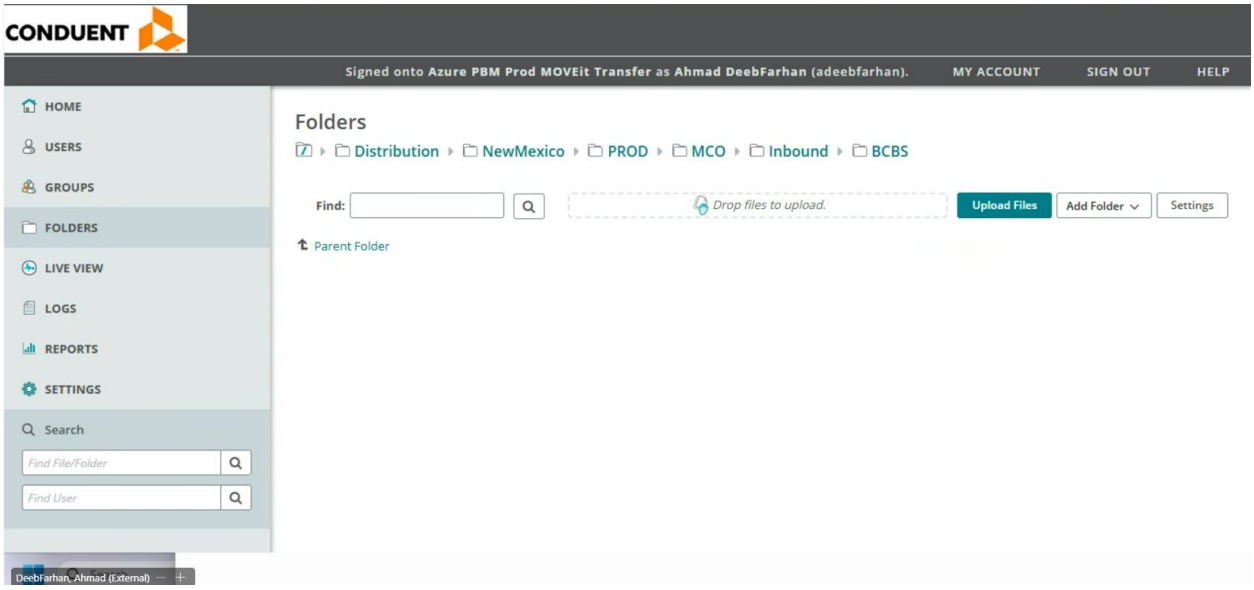


The selection of the 'PROD' folder will display an MCO folder. Within the MCO folder, there will be an 'Inbound' and 'Outbound' folder.



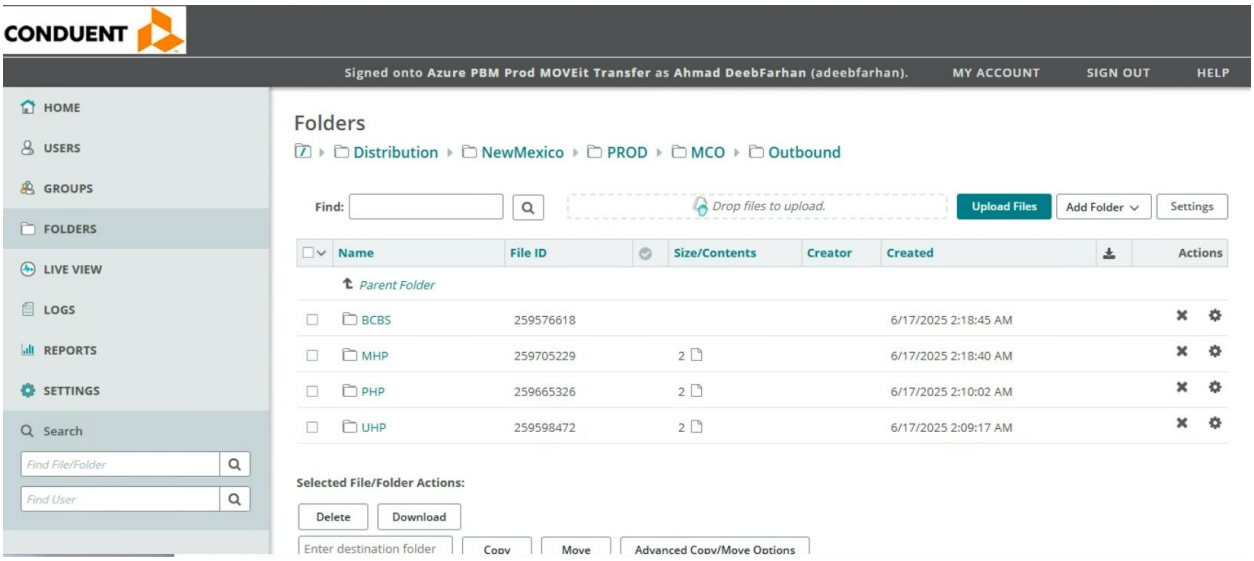
Within each 'Inbound' and 'Outbound' folder will be folders for each individual MCO. Here is an example of navigating in the 'Inbound' folder:

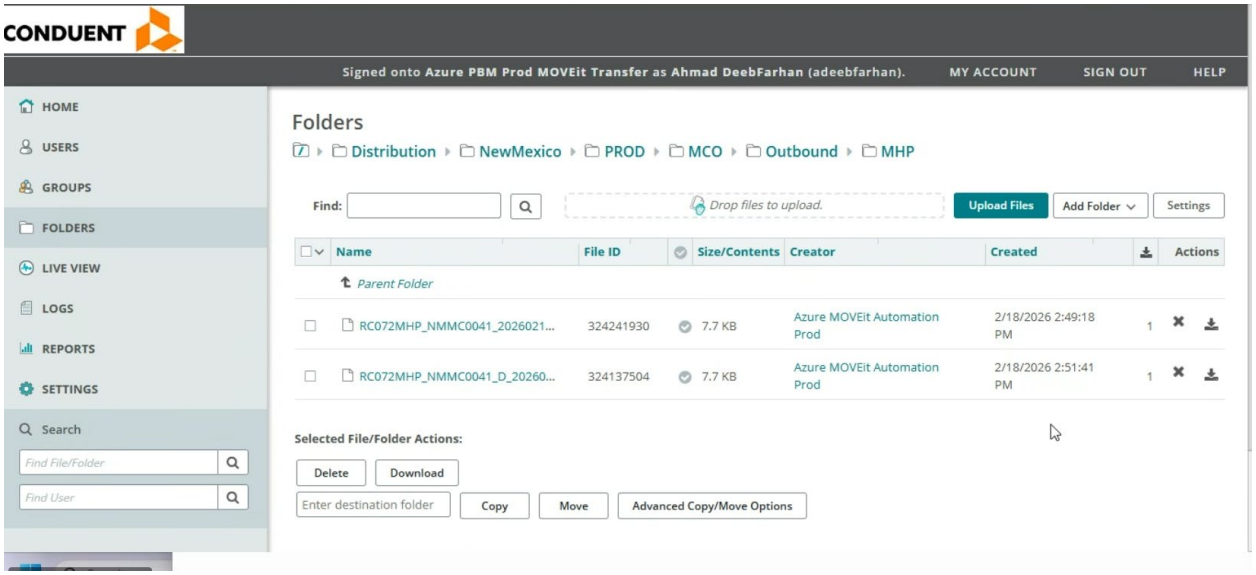




You will now have the details on this file. This is the lowest level for any chain. The screen received will show you the Actions that you can take against this file, File Information such as the entity that uploaded the file, the file size, how many time it has been downloaded, and if it was verified when it was uploaded. You will also get a Log of the activity on this file.

Here is an example of navigating in the 'Outbound' folder:



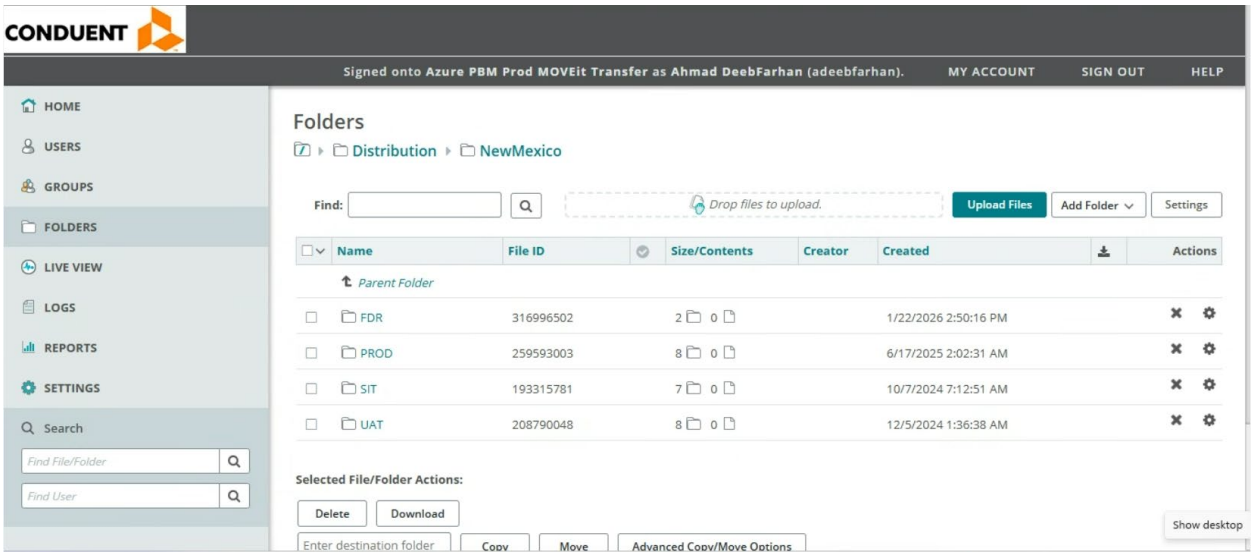


This screen shows when the files were placed in this folder, the size of the file, the entity that placed the files there, the number of times the file has been downloaded, an option to delete the file (if you have that permission for this folder) and the download button.

You can now select a single file to get further details on the file by clicking on the file you want the details for.

To find the next file you want to work with, you can click on 

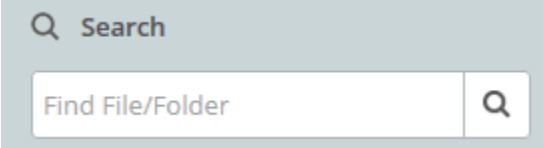
to start the process over or you can go directly to any of the levels displayed at the top of the screen by clicking on the level you want. To go directly to 'NewMexico', just click on it. You will be back to New Mexico level and can proceed as needed.



12.9.2The File/Folder Search Method

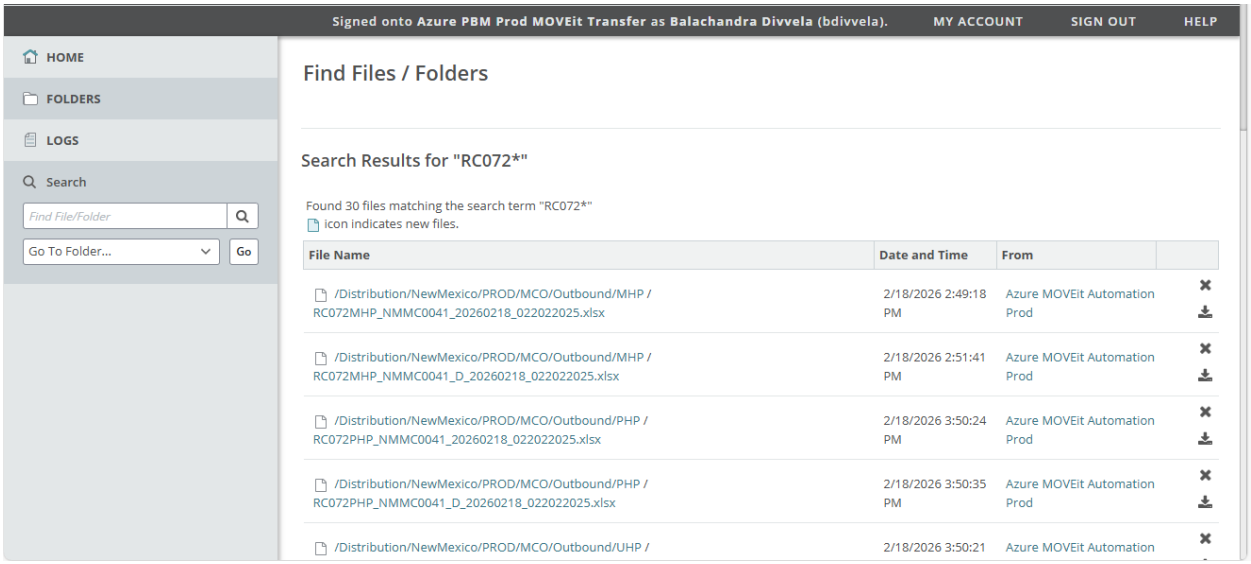
The File/Folder Search Method will allow you to enter a file or folder name or partial name, and it will return a list of matches to which you have access. From the list you just need to click on the one you want, and you will be taken there.

The File/Folder Search box is displayed on all pages.



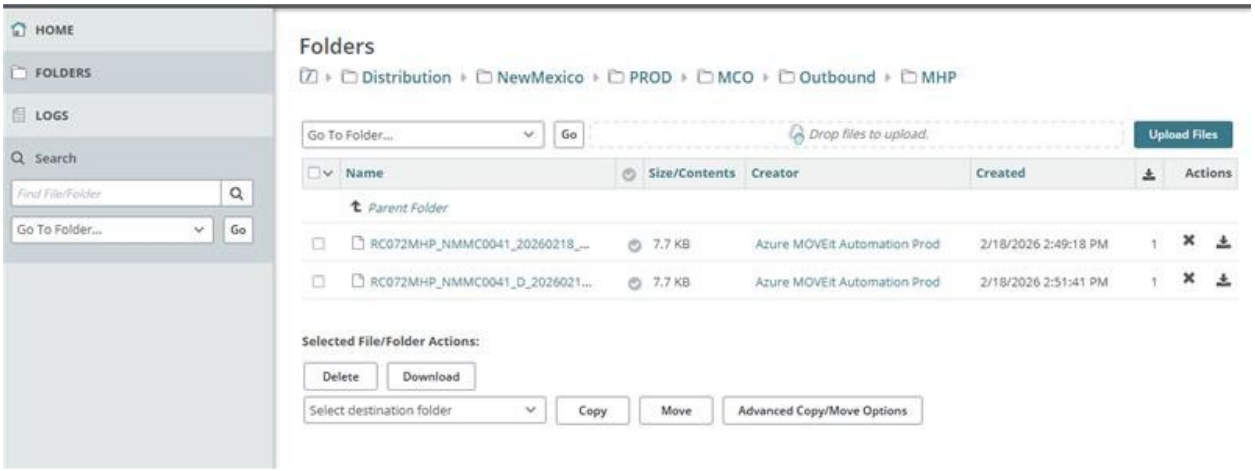
This box is displayed in the upper left quadrant of each page.

Let's find the RC072MHP_NMMC0041_20260218_022022025.xlsx file for MHP since we know we have access to that file. We will enter 'RC072' in the Find File/Folder Box and clickon .



This user has access to 30 File/Folders that contain RC072* in the name and we are presented with the list.
ow just scroll down until we find the file we are looking for. Once found just click on the path for that file.

You will be taken to the folder that contains that file. You can now perform any action on the file for which you have authority.

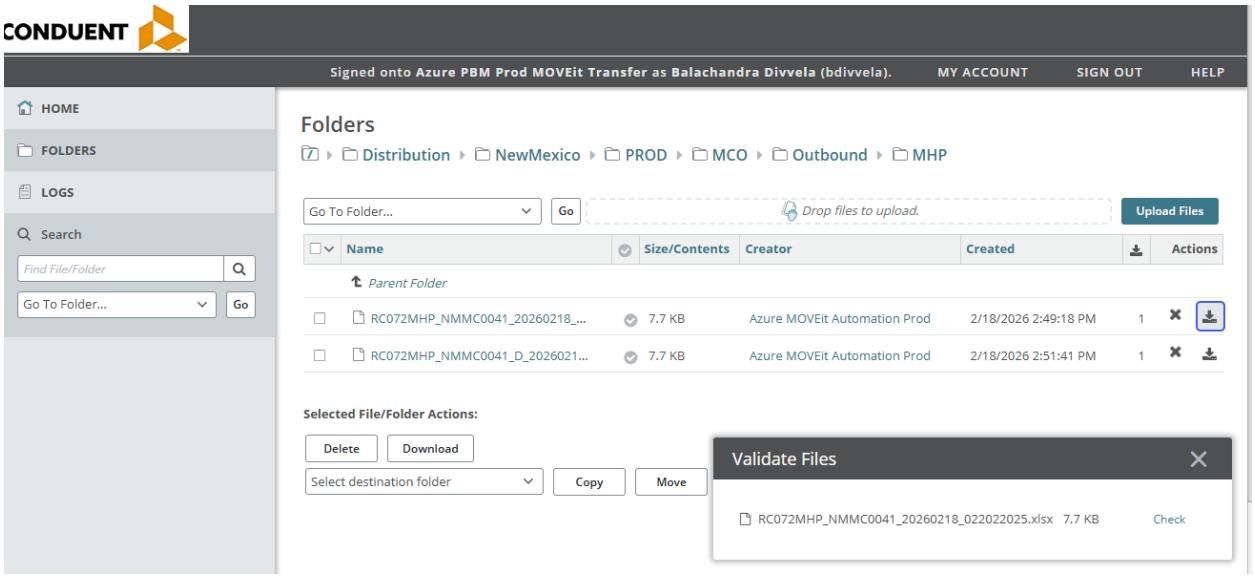


12.10 File Activities

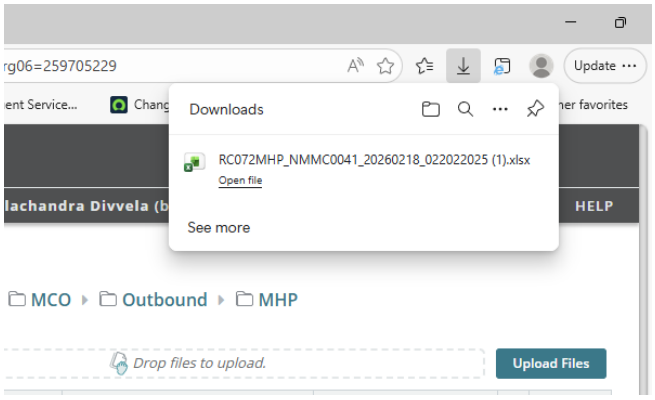
12.10.1 Downloading Files

To download a file from MOVEit DMZ, you must first locate the file using one of the methods described in the previous section. Additionally, you must have the necessary permission for that file. Generally, if you can view a file, you will also be able to download it.

Once you have identified the file, click the Download button on the right and the file will be downloaded to your computer.



The file will be downloaded into your browsers download area.



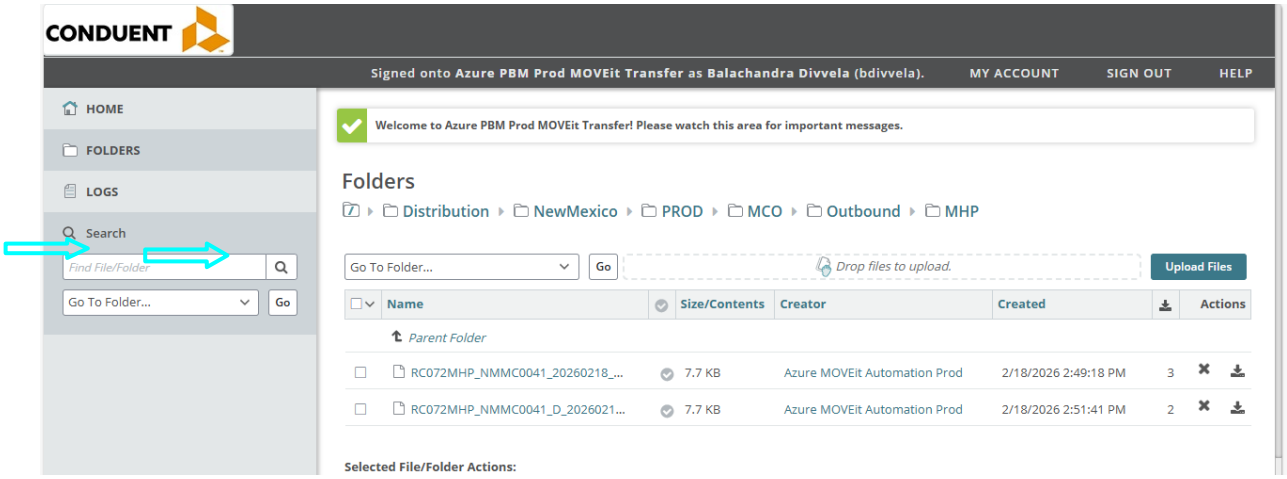
12.11 Uploading Files

Please refer to the '**File Naming Convention for DMZ Procedures'** document if you are uploading a file that will be processed by Conduent.

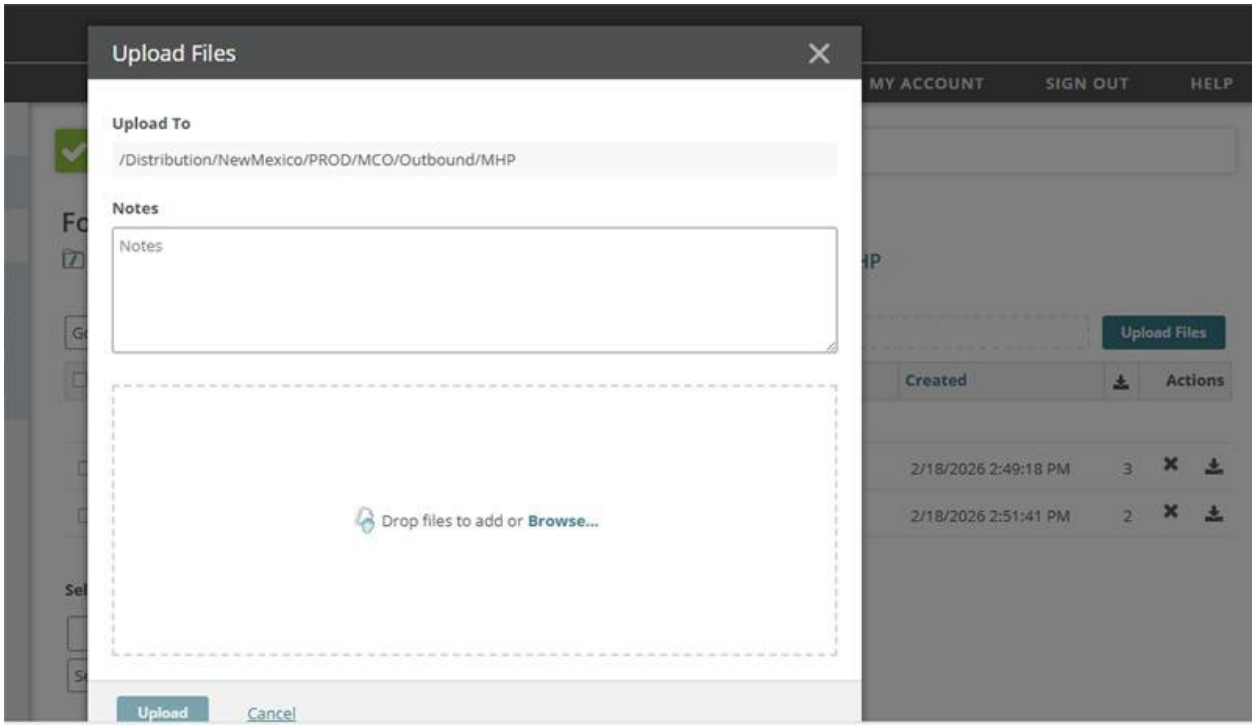
12.11.1 Using the Upload Files button

The easiest way to upload files is by using the MOVEit '**Upload Files**' button. This tool allows you to upload multiple files simultaneously. The files will be named on the DMZ as they appear in the 'Upload' Files window.

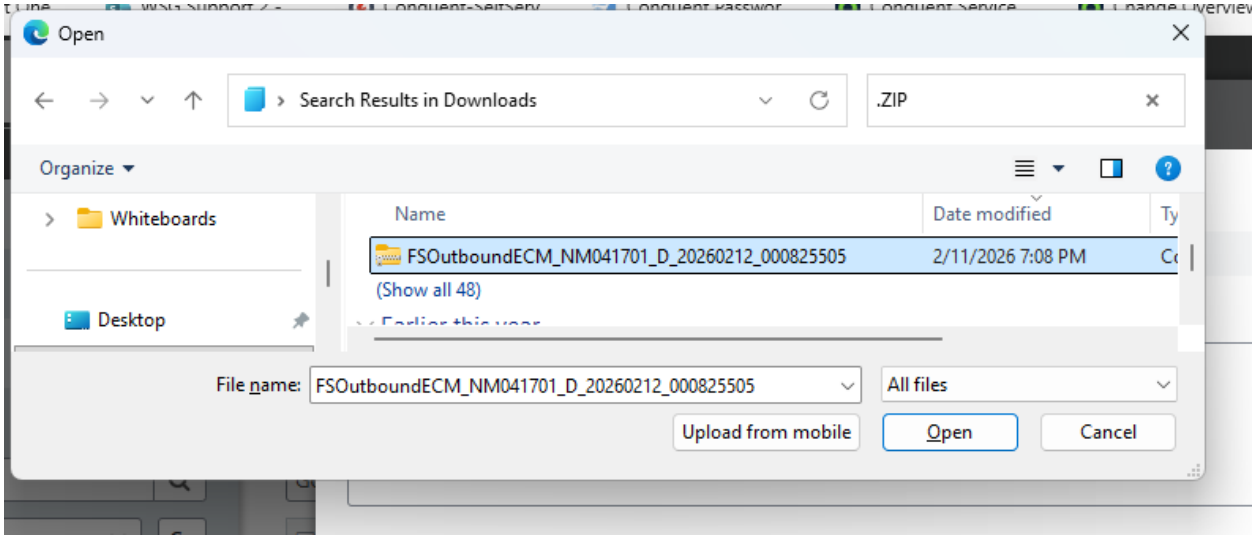
To start, you will need to navigate to a folder where you have permission to upload files. Once you're there, your page will display a layout similar to this. Take note of the '**Upload Files**' button; this button will appear on any page where you have uploading authority for that folder.



The next step is to activate the Upload by clicking on the '**Upload Files'** button. The Upload Files dialogue box will be displayed next:



Select the file you want to upload, and it will be placed in the dialogue box, using the standard window selection process.



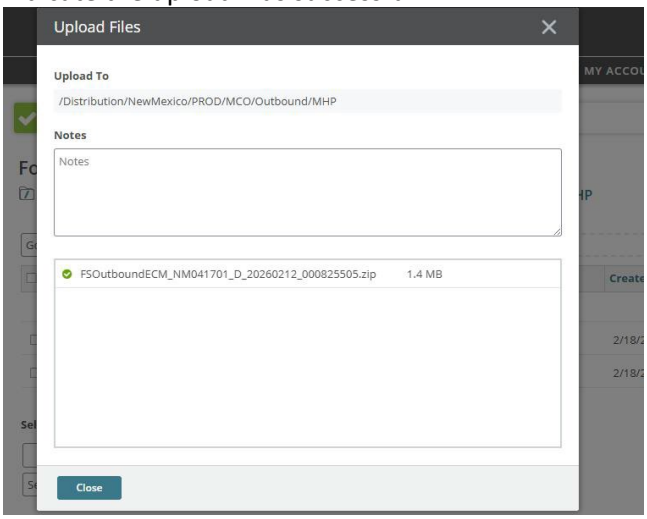
You can repeat the above process if you want to upload multiple files to the same folder.

Once you have selected the file or files to upload, click on the **Upload** button to continue the process.

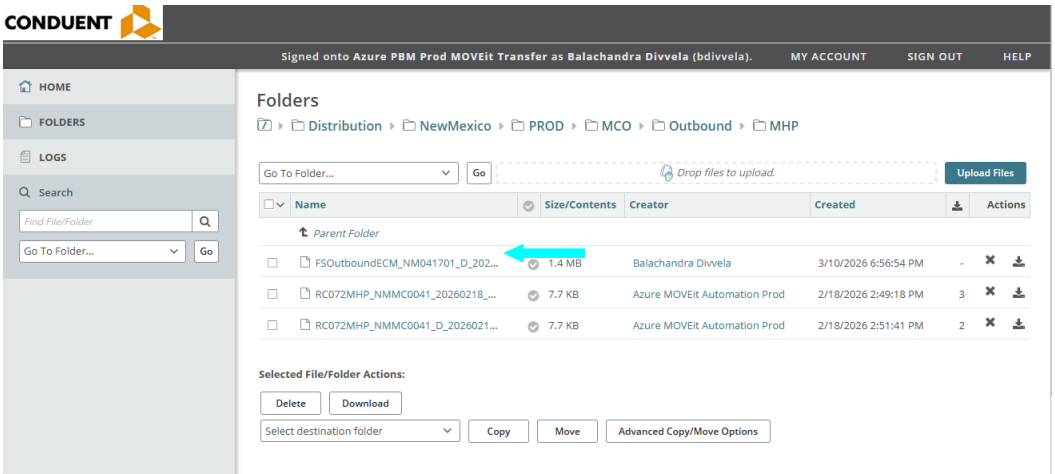
Our standard is that all files placed on DMZ will be in the **ZIPPED** format. This will require you to transfer a file that is already zipped. The 'Upload file/s' must already have the correct DMZ name associated with it.

Click the 'Upload" button and you will receive the progress box showing that the file/s are being uploaded to DMZ.

When the transfer is complete, you will see a green check mark to the left of the file name to indicate the upload was successful.

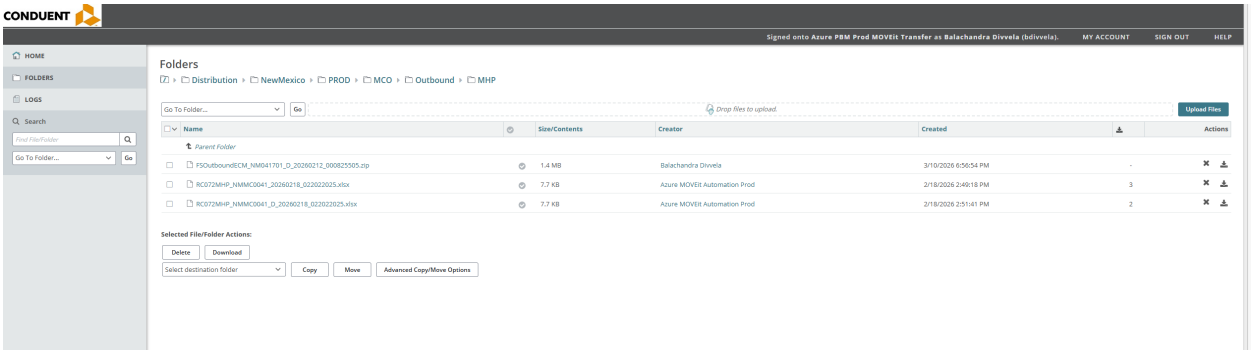


You can now close the upload window. After closing it, navigate to the folder where you need to access or upload files. You should see the file you uploaded in the folder you were viewing. Please note that the file verification indicator is visible since the Upload File button was used for the upload.



If a file is not verified upon upload, it will show an unchecked box before the file name and will lack a checkbox after the file name. In this case, the file should be deleted and re-uploaded. This situation only occurs when the Upload File button is used to upload a file.

12.11.2 Basic View

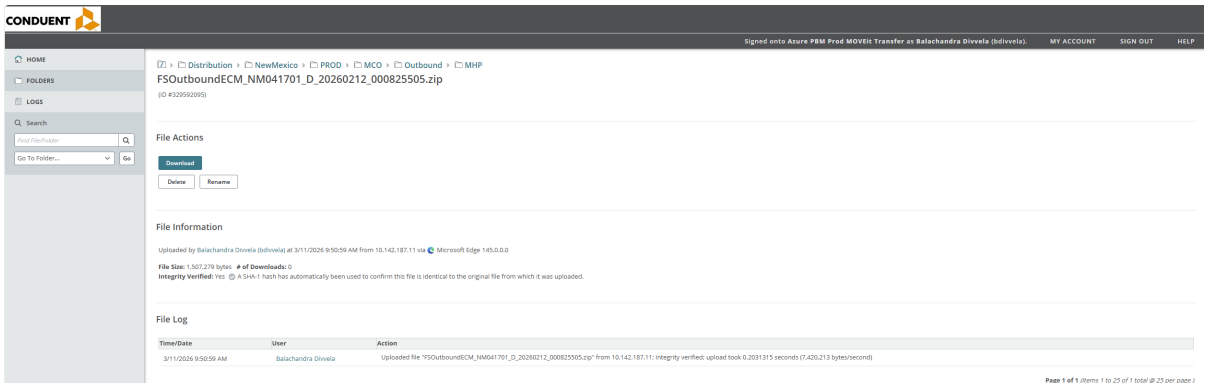


RENAMING

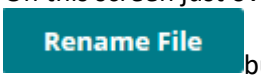
If you have upload authority to a folder, you will be able to rename the files in that folder. The Rename function should only be used if necessary. If you upload a file and then discover that it is not named correctly this function can save you time by allowing, you to just change the name and not having to delete and upload the file again under the correct name.

First you will need to navigate to the folder containing the file to be renamed. We will use the file just uploaded in the previous section. Now click on the name of the file that you want to rename.

You will receive the File Detail screen. Under the ‘File Actions’ heading you will have the Rename option. Click on ‘**Rename’** to get the file rename screen.

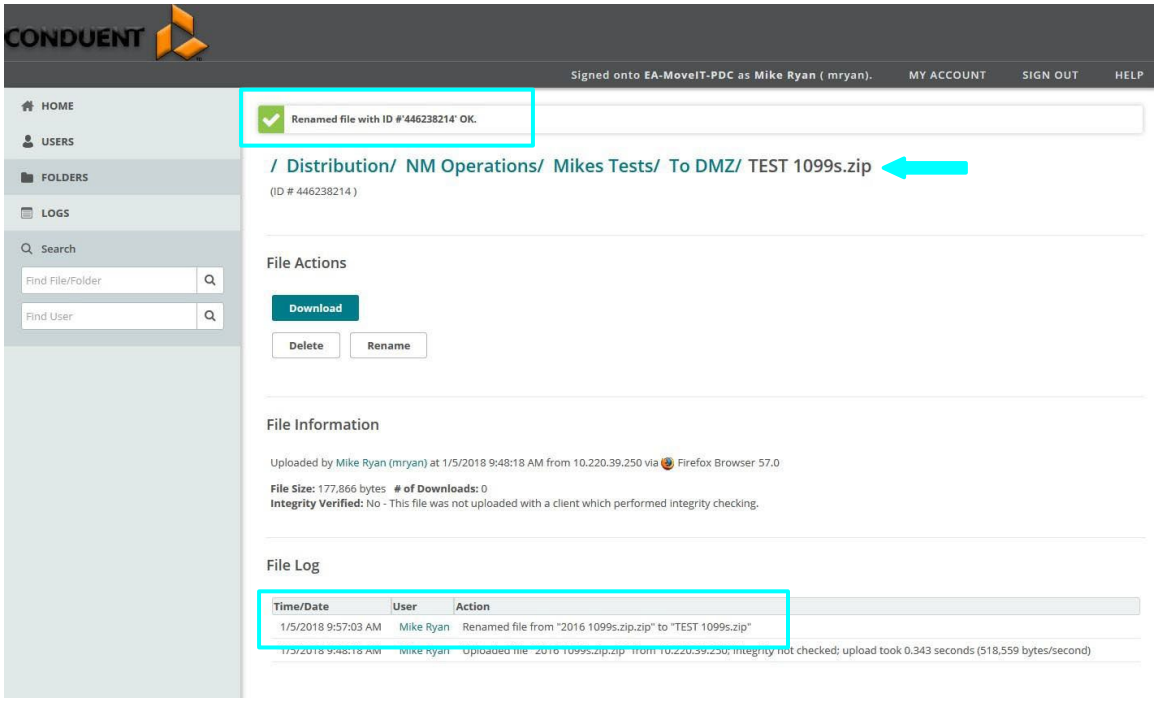


On this screen just over type the file name to the correct name and then click the



button. We changed the date of 2016 to TEST and removed the extra ‘.ZIP’ from the file name.

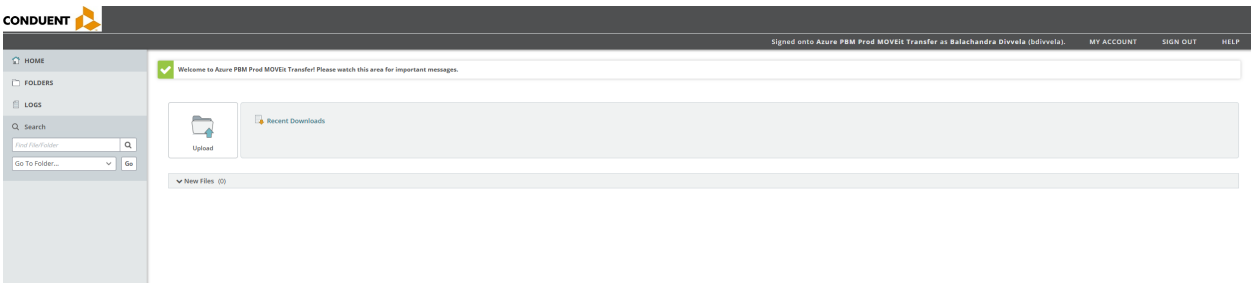
You will receive the File Detail screen back, with a message at the top showing if the rename process was successful or not. The new file name will be displayed after the folder path and the ‘File Log’ will have the rename documented.



12.11.3 Without the Upload Files button

You will also be able to upload files using the following process. Remember that the file to be uploaded should be in zipped format and if it is to be processed by Conduent the file name will have to be set to the proper DMZ name prior to the upload.

The screens where you have upload authority will have a different look than the **Upload File** button discussed above. Navigate to the 'Home' page and click the **Upload** button.



You will now be able to upload a file to this folder. The next step is to select the file to be uploaded by clicking on the **browse** button. You will get the standard window browse window.

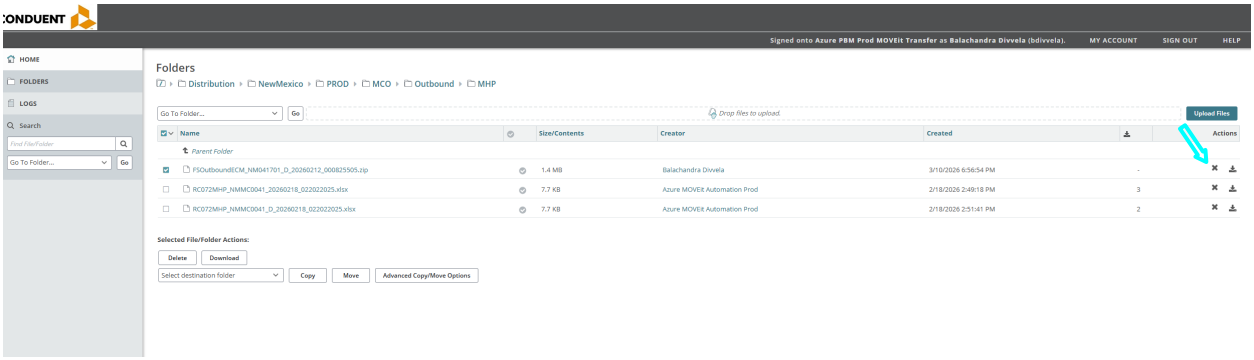
Select the file you want to upload using the standard window selection process. This will place the file name in the upload area.

Now, just clickon the **Upload** button to upload the file. You will get your starting screen back, with a message showing the outcome of the upload at the top of the screen and the uploaded file listed.

12.12 Deleting Files

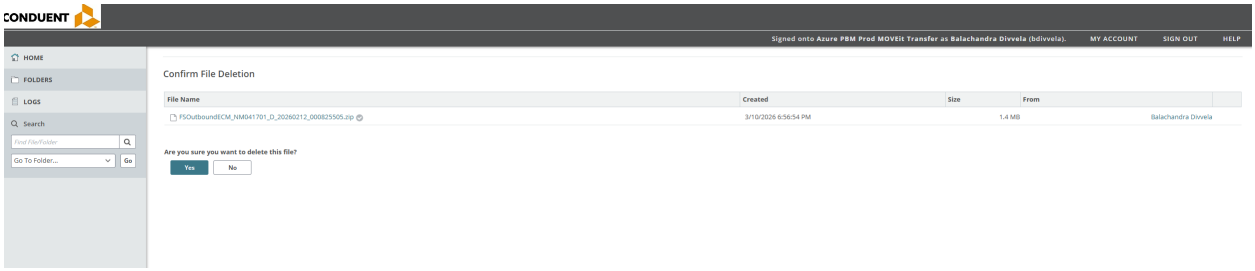
To delete a file from MOVEit DMZ, you must have Delete authority for the folder that contains the file. Generally, if you have upload authority for a folder, you will also have delete authority; however, there may be cases where you possess one type of authority without the other.

To delete a file from DMZ, begin by navigating to the folder that contains the file you wish to delete. For this example, we will delete the file that we just renamed. Use one of the navigation methods described earlier in this document to go to the following folder: /Distribution/ NewMexico/PROD/MCO/Outbound/MHP.



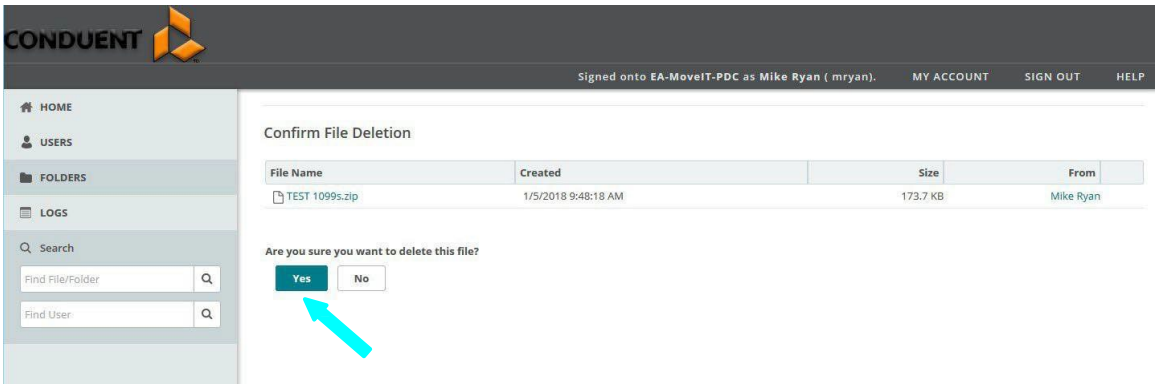
We now want to click on the Delete icon  under the '**Actions'** column across from the name of the file to be deleted.

You will now be asked to confirm the delete. If you want to process the delete, then click on **YES**, if you want to cancel the delete then click on **NO**.

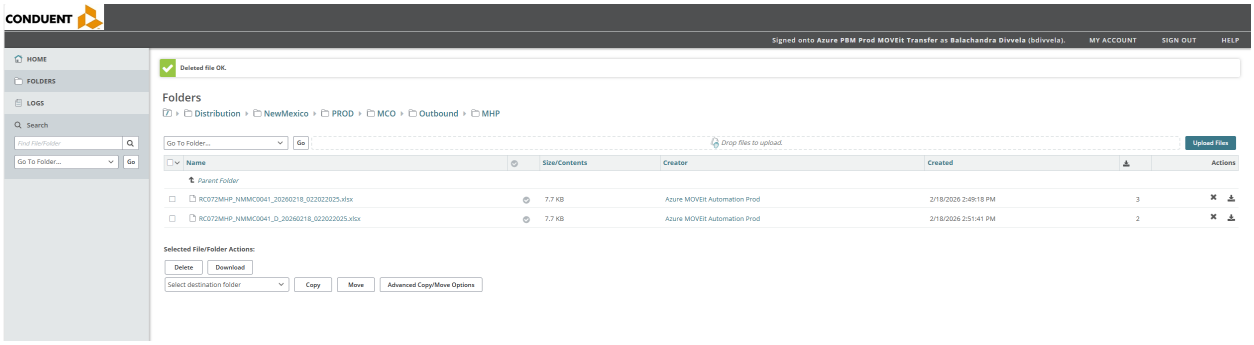


To view the activity and details of this file before deleting it, simply click on the file name. This will take you to the file details screen. If you decide to delete the file, just click the delete button.

You will now be asked to confirm the delete. If you want to process the delete, then click on **YES**, if you want to cancel the delete then click on **NO**. In this case we will click on **YES**.

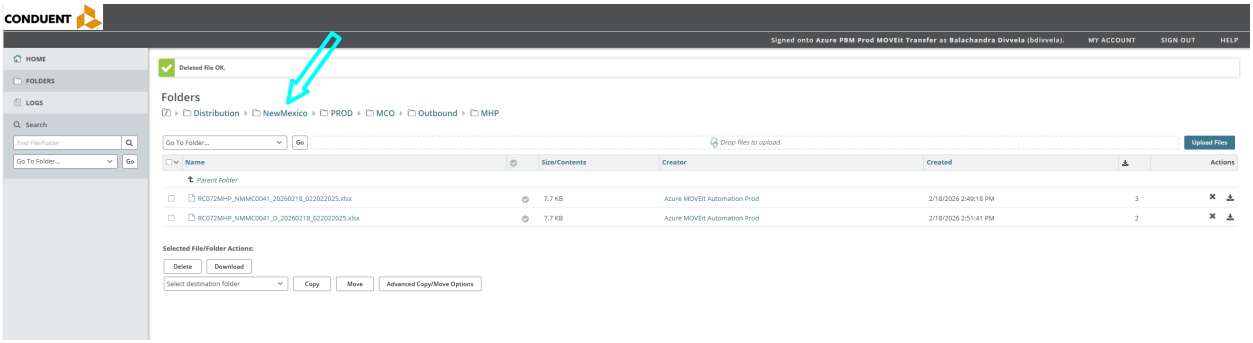


Once you have confirmed the delete, you will be returned to the screen showing the files (if any) still in the folder, from which this file was deleted.

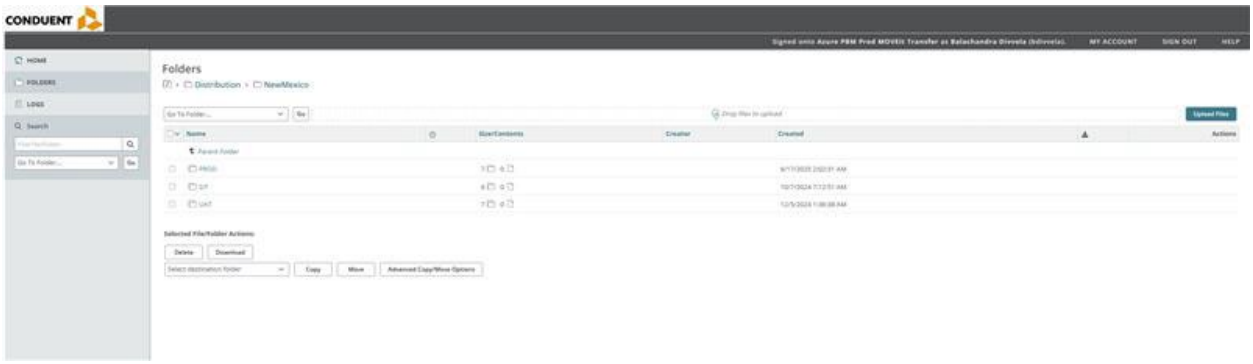


To navigate away from this screen, you can go directly to any level in the path shown by just clicking on the level, you want.

If you click on '**New Mexico**' you will be taken to that level.



You are now back to the '**New Mexico**' level



13.0 Appendices

13.1Appendix A: Deliverable Record of Changes

Table 5 - Deliverable Record of Changes

Version No.	Date	Owner	Description of Change
V1.1	6/21/24	Chris Pruett	Turquoise Care Systems Manual
V1.2	7/29/24	Vivian Ulibarri	Updated Setting of Care Provider ID - 27238016
V1.3	8/22/24	Vivian Ulibarri	Removed "If Care Coordination Assessment Date is present, CC Assessment type is required" from Care Coordination Assessment Type Specifications
V1.4	9/4/24	Vivian Ulibarri	▪ Removed "attempts or" from C Assessment Date Specifications o "*This is filled in any time the MCO ~~attempts or~~ completes a Health Risk Assessment (HRA) or a Comprehensive Needs Assessment (CNA)*" ▪ Removed *"All Care Coordination Levels must have an assessment type and date on file."* from Care Coordination Assessment and Level Data Requirements ▪ Removed "*An incoming CC span without an assessment type and date where there is no prior assessment type and date in an existing CC span will be rejected with error 32: CC ASSESS TYPE/DATE REQUIRED*" from Care Coordination Assessment and Level Data Requirements ▪ Removed "*When submitting a CC span for any level (including levels 0, 3, 4 or 5) for a client, an MCO must submit a CC assessment type of 'N' (NMA), 'D' (DMA), 'H; (HRA) or 'C' (CNA) along with an assessment date if an assessment type and assessment date is not already on file in Omnicaid.*" from Care Coordination Assessment and Level Data Requirements ▪ Removed "*NOTE: Care Coordination assessments performed by the MCO must always be entered with all 5 fields populated: Assessment Date, Assessment Type, Care Coordination Level and Care Coordination Effective and End dates. If the Health Risk assessment and* ▪ *Comprehensive*" from Care Coordination Assessment and Level Data Requirements

Version No.	Date	Owner	Description of Change
V1.5	11/5/24	Vivian Ulibarri	▪ Added "Clients with a category of eligibility (COE) 066/086 cannot be enrolled in CareLink NM/Health Homes and must be opted out if these COEs are identified at any time post enrollment with CareLink NM." to the Care Coordination Section on page 99.
V1.6	12/16/24	Vivian Ulibarri	Removed "CC BEG/END, CC ASSESS DATE REQUIRED" from error 32 and replaced with "CC ASSESS TYPE/DATE REQUIRED" on page 109.
V1.7	12/17/24	Vivian Ulibarri	Updated the Monthly Cutoff Schedule to reflect 2025 dates on page 47.
V1.8	1/29/25	Vivian Ulibarri	▪ Page 42- 43 Removed (CF, CK, MA, MT, RD, RM, CL, CN, CO, DC, EX, JJ, MB, ME, MT, NF, NP, NR, DH, DM, DN, DO, DP, DR, DT, PC, RG, RM, RN, & XT) values ▪ Page 43 Added value RS Recoupment – Incarcerated ▪ Page 134-137 Added Certified Community Behavioral Health Clinic (CCBHC) cohort number corresponding to the physical health cohort number ▪ Page 138 Added Certified Community Behavioral Health Clinic (CCBHC) cohort number corresponding to the Alternative Benefit Package (ABP) cohort number ▪ Page 231 Added Provider Type 216 ▪ Page 233 Added Type of Bill 11X
V1.9	2/26/25	Vivian Ulibarri	▪ Page 161 Corrected the 2nd sentence to state data instead of date. ▪ Page 161 Added MCOs are not to load data from this reconciliation file but use it to ensure the MCO has captured all the provider adds and updates that have come in during the month and "confirm that MCOs received/processed all the APIs correctly (MCOs should begin an analysis of any differences found, possibly resulting in tickets within Cherwell if analysis with BMS, the SI or HCA is needed)."
V1.10	3/3/25	Vivian Ulibarri	▪ Page 132-133 Added Certified Community Behavioral Health Clinic (CCBHC) cohort number corresponding to the behavior health cohort ▪ Page 134-138 Removed Certified Community Behavioral Health Clinic (CCBHC) cohort number corresponding to the physical health cohort number ▪ Page 139 Removed Certified Community Behavioral Health Clinic (CCBHC) cohort number corresponding to the Alternative Benefit Package (ABP) cohort number
V1.11	4/10/25	Vivian Ulibarri	▪ Page 88 Replaced 3747P1801X with 253Z00000X and updated where to locate the list of taxonomy to provider type crosswalk "**by viewing the Taxonomy Grid for claim submission https://www.hca.nm.gov/providers/"**. ▪ Page 95 Replaced 3747P1801X with 253Z00000X ▪ Page 99 Added "Currently Provider type 222 and 223 are Omnicaid only. GDIT will addthe provider types later." to the MCO Administrative Services/Support Broker Services

Version No.	Date	Owner	Description of Change
V1.12	10/27/25	Vivian Ulibarri	▪ Renamed Manual from “TURQUOISE CARE SYSTEMS MANUAL” to “MCO TURQUOISE CLAIMS MANUAL” ▪ Replaced HSD with HCA throughout the document ▪ Page 1-7, 52, 54, 147-172, & 186 BMS Updates ▪ Page 46 Updated the Monthly Roster Reconciliation Cycle Dates ▪ Page 137 Added recoupment schedule ▪ Page 216, 219, 221, & 224 Updated the Provider Type/Specialty to Taxonomy Crosswalk ▪ Page 240 & 241 Added Outpatient claims bypass (pg. 240 added “OR attending providers are not equal and either attending provider is BH”) ▪ Page 301 Added Exception Code 0691 PROVIDER NOT AUTHORIZED TO BILL CCBHC CLAIM ▪ Page 456 Updated Enroll Provider, Update Provider, Inquire Provider, Search Provider, and Callback API Functional Specifications embedded in the Appendix
V1.13	2/1/25	Vivian Ulibarri	▪ Page 46 Updated the Monthly Roster Reconciliation Cycle Dates ▪ Page 101 Removed Care Coordination Level 9
V1.14	2/9/26	Vivian Ulibarri	▪ Page 46 Updated the Monthly Roster Reconciliation Cycle Date for January 2026 and removed December 2025. ▪ Page 356 Added Values H-AARTC Per Diem Tier 1, I-AARTC Per Diem Tier 2, & J-AARTC Per Diem Tier 3
V1.15	3/11/26	Kristie Abraham	▪ All sections Made formatting and verbiage updates ▪ All sections Replaced file layouts with links ▪ Page 405, Section 3 Updated MoveIT screenshots to reflect new system ▪ Page 464 Added Appendix B-C
V1.16	3/26/26	Kristie Abraham	▪ Page 9 Updated the TPL Daily File Description

13.2Appendix B: API Functional Specifications

Table 6 - API Functional Specifications

API Functional Specifications	Link
Enroll Provider API	Enroll Provider API Functional Specifica
Update Provider API	Update Provider API Functional Specifica
Search Provider API	Search Provider API Functional Specificatic

Inquire Provider API	 Inquire Provider API Functional Specificatic
Callback Provider API	 Callback API Functional Specificatic

13.3Appendix C: Interface Delivery Schedule

Integration Number	Interface Name	File Name	Source	Source Path	Target	Target Path	File Delivery Frequency	Days of the week (M,T,W,Th,F,S,Sun)	Delivery Time
NM1317	Provider Network File	BCBS_Network.MMDDYYYY.ZIP	MCO - BCBS		BMS		Weekly	Friday	7 PM MT
NM1318	Provider Network File	PHP_Network.MMDDYYYY.ZIP	MCO - PHP		BMS		Weekly	Friday	7 PM MT
NM1319	Provider Network File	UHP_Network.MMDDYYYY.zip	MCO - UHP		BMS		Weekly	Friday	7 PM MT
NM1320	Provider Network File	MHP_Network.MMDDYYYY.ZIP	MCO - MHP		BMS		Weekly	Friday	7 PM MT
NM2310	QA Daily Eligibility MCO1 - BlueCross BlueShield Interface	QAEligBCBS_NM231001_D_YYYYMMDD_HHMMSSmmm.txt	MCO - BCBS		QA		Daily	M - Sunday	Morning
NM2311	QA Daily Eligibility MCO2 - Molina Health Plan Interface	QAEligMHP_NM231101_D_YYYYMMDD_HHMMSSmmm.txt	MCO - MHP		QA		Daily	M - Sunday	Delivery time can be anytime during the day
NM2313	QA Daily Eligibility MCO3 - United Health Interface	QAEligUHC_NM231301_D_YYYYMMDD_HHMMSSmmm.txt	MCO - UHP		QA		Daily	M - Saturday	Delivery time can be anytime during the day
NM2312	QA Daily Eligibility MCO4 - Presbyterian Health Plan	QAEligPHP_NM231201_D_YYYYMMDD_HHMMSSmmm.txt	MCO - PHP		QA		Daily	M - Saturday	8 AM - 5 PM MT
NM2331	Monthly CAV Error Return File MCO1-	QACAVBCBSERROR_NM233101_M_YYYY	MCO - BCBS	/Staging	QA	/tohms	Monthly	Dependent on the delivery of	24-48hrs after CAV File

Integration Number	Interface Name	File Name	Source	Source Path	Target	Target Path	File Delivery Frequency	Days of the week (M,T,W,Th,F,S,Sun)	Delivery Time
	BlueCross BlueShield	MMDD_HHMMSSmmm.txt						the Monthly CAV File	
NM23332	Monthly CAV Error Return File MCO2 - Molina Health Plan	QACAVMHPError_NM233201_M_YYYYMMDD_HHMMSSmmm.txt	MCO - MHP	/Staging	QA	/tohms	Monthly	Dependent on the delivery of the Monthly CAV File	24-48hrs after CAV File
NM23333	Monthly CAV Error Return File MCO3 - United Health Plan	QACAVUHPError_NM233301_M_YYYYMMDD_HHMMSSmmm.txt	MCO - UHP	/Staging	QA	/tohms	Monthly	Dependent on the delivery of the Monthly CAV File	24-48hrs after CAV File
NM23334	Monthly CAV Error Return File MCO4 - Presbyterian Health Plan	QACAVPHPError_NM233401_M_YYYYMMDD_HHMMSSmmm.txt	MCO - PHP	/Staging	QA	/tohms	Monthly	Dependent on the delivery of the Monthly CAV File	24-48hrs after CAV File
NM2337	QATPL.MCO1.MMDDYYYY Response Error	QA-TPL-BCBS-ErrorResp_NM233701_D_YYYYMMDD_HHMMSSmmm.txt	MCO - BCBS	/Staging	QA	/tohms	Daily	M - Saturday	TBD/Dependent on TPL Response from QA
NM2338	QATPL.MCO2.MMDDYYYY Response Error	QA-TPL-MHP-ErrorResp_NM233801_D_YYYYMMDD_HHMMSSmmm.txt	MCO - MHP	/Staging	QA	/tohms	Daily	M - Saturday	TBD/Dependent on TPL Response from QA
NM2339	QATPL.MCO3.MMDDYYYY Response Error	QA-TPL-UHP-ErrorResp_NM233901_D_YYYYMMDD_HHMMSSmmm.txt	MCO - UHP	/Staging	QA	/tohms	Daily	M - Saturday	TBD/Dependent on TPL Response from QA

Integration Number	Interface Name	File Name	Source	Source Path	Target	Target Path	File Delivery Frequency	Days of the week (M,T,W,Th,F,S,Sun)	Delivery Time
NM2340	QATPL.MCO4.MMDDYYYY Response Error	QA-TPL-PHP-ErrorResp_NM234001_D_YYYYMMDD_HHMMSSmmm.txt	MCO - PHP	/Staging	QA	/tohms	Daily	M - Saturday	TBD/Dependent on TPL Response from QA
NM1324	Provider Network Error File	ProviderNetworkErrorBCBS_YYYYMMDD_HHMMSS.ZIP	BMS		MCO - BCBS		Weekly	Immediately after receiving the Provider Network File	
NM1326	Provider Network Error File	ProviderNetworkErrorPHP_YYYYMMDD_HHMMSS.ZIP	BMS		MCO - PHP		Weekly	Immediately after receiving the Provider Network File	
NM1327	Provider Network Error File	ProviderNetworkErrorMHP_YYYYMMDD_HHMMSS.ZIP	BMS		MCO - MHP		Weekly	Immediately after receiving the Provider Network File	
NM0358	RC070 Drug-BCBS Interface	RC070BCBS_NM035801_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - BCBS	/Outbound	Daily	M - Sun	8 AM MT
NM0359	RC070 Drug-Molina Health Plan Interface	RC070MHP_NM035901_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - MHP	/Outbound	Daily	M - Sun	8 AM MT
NM0360	RC070 Drug-Presbyterian Interface	RC070PHP_NM036001_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - PHP	/Outbound	Daily	M - Sun	8 AM MT
NM0362	RC071 Non-Drug-BCBS Interface	RC071BCBS_NM036201_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - BCBS	/Outbound	Daily	M - Sun	8 AM MT

Integration Number	Interface Name	File Name	Source	Source Path	Target	Target Path	File Delivery Frequency	Days of the week (M,T,W,Th,F,S,Sun)	Delivery Time
NM0363	RC071 Non-Drug-Molina Health Plan Interface	RC071MHP_NM036301_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - MHP	/Outbound	Daily	M - Sun	8 AM MT
NM0364	RC071 Non-Drug-Presbyterian Interface	RC071PHP_NM036401_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - PHP	/Outbound	Daily	M - Sun	8 AM MT
NM0350	RC 073 BCBS Interface	RC073BCBS_NM035001_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - BCBS	/Outbound	Daily	M - Sun	5 AM MT
NM0351	RC 073 MHP Interface	RC073MHP_NM035101_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - MHP	/Outbound	Daily	M - Sun	5 AM MT
NM0352	RC 073 PHP Interface	RC073PHP_NM035201_D_YYYYMMDD_HHMMSSmmm.txt	FS	/Staging	MCO - PHP	/Outbound	Daily	M - Sun	5 AM MT
NM0411	Supplemental Daily Roster-BCBS Interface	SuppRosterBCBS_NM041101_D_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - BCBS	/Outbound	Daily	M - Sat	7 AM MT
NM0412	Supplemental Daily Roster-Molina Health Plan Interface	SuppRosterMHP_NM041201_D_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - MHP	/Outbound	Daily	M - Sat	7 AM MT
NM0413	Supplemental Daily Roster-Presbyterian Interface	SuppRosterPHP_NM041301_D_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - PHP	/Outbound	Daily	M - Sat	7 AM MT
NM0387	Supplemental Monthly Roster-BCBS Interface	SuppRosterBCBS_NM038701_M_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - BCBS	/Outbound	Monthly	Dates will align with TC manual (screenshot to the right)	11 PM MT
NM0388	Supplemental Monthly Roster-Molina Health Plan Interface	SuppRosterMHP_NM038801_M_YYYYM	FS	/Staging	MCO - MHP	/Outbound	Monthly	Dates will align with TC manual	11 PM MT

Integration Number	Interface Name	File Name	Source	Source Path	Target	Target Path	File Delivery Frequency	Days of the week (M,T,W,Th,F,S,Sun)	Delivery Time
		MDD_HHMMSSmmm.zip							
NM0389	Supplemental Monthly Roster-Presbyterian Interface	SuppRosterPHP_NM038901_M_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - PHP	/Outbound	Monthly	Dates will align with TC manual	11 PM MT
NM2302	QATPL.MCO1.MMDDYYYY	QATPLBCBS_NM230201_D_YYYYMMDD_HHMMSSmmm.txt	QA	/fromhms	MCO - BCBS	/Outbound	Daily	Monday - Friday	Within 24 hours of receiving the QA Daily Eligibility Interface
NM2303	QATPL.MCO2.MMDDYYYY	QATPLMHP_NM230301_D_YYYYMMDD_HHMMSSmmm.txt	QA	/fromhms	MCO - MHP	/Outbound	Daily	Monday - Friday	Within 24 hours of receiving the QA Daily Eligibility Interface
NM2305	QATPL.MCO4.MMDDYYYY	QATPLPHP_NM230501_D_YYYYMMDD_HHMMSSmmm.txt	QA	/fromhms	MCO - PHP	/Outbound	Daily	Monday - Friday	Within 24 hours of receiving the QA Daily Eligibility Interface
NM2323	NMCAV.QATPL.MCO1.MMDDYYYY	QACAVTPLBCBS_NM232301_M_YYYYMMDD_HHMMSSmmm.txt	QA	/fromhms	MCO - BCBS	/Outbound	Monthly	20th day of the month (if delivery day is a Saturday, Sunday, or Holiday, file will be sent on the next business day)	Delivery time can be anytime during the day
NM2324	NMCAV.QATPL.MCO2.MMDDYYYY	QACAVTPLMHP_NM232401_M_YYYYM	QA	/fromhms	MCO - MHP	/Outbound	Monthly	20th day of the month (if delivery	Delivery time can be anytime

Integration Number	Interface Name	File Name	Source	Source Path	Target	Target Path	File Delivery Frequency	Days of the week (M,T,W,Th,F,S,Sun)	Delivery Time
		MDD_HHMMSSmmm.txt						day is a Saturday, Sunday, or Holiday, file will be sent on the next business day)	during the day
NM2326	NMCAV.QATPL.MCO4.MMDDYYYY	QACAVTPLPHP_NM232601_M_YYYYMMDD_HHMMSSmmm.txt	QA	/fromhms	MCO - PHP	/Outbound	Monthly	20th day of the month (if delivery day is a Saturday, Sunday, or Holiday, file will be sent on the next business day)	Delivery time can be anytime during the day
NM0354	Rate and Formulary Interface	RateFormMCOs_NM035401_M_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - BCBS MCO - UHP MCO - PHP MCO - MHP	/Outbound	Monthly	2nd day of the Month	7 AM MT
NM0426	Incarceration Daily File - BCBS Interface	BCBSIncarceration_NM042601_D_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - BCBS	/Outbound	Daily	Monday - Saturday	
NM0427	Incarceration Daily File - MHP Interface	MHPIncarceration_NM042701_D_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - MHP	/Outbound	Daily	Monday - Saturday	
NM0429	Incarceration Daily File - PHP Interface	PHPIncarceration_NM042901_D_YYYYMMDD_HHMMSSmmm.zip	FS	/Staging	MCO - PHP	/Outbound	Daily	Monday - Saturday	

13.4 Appendix D: Pay/Report Codes

Exception_Cd (Omnicaid/CMdS)	Exception_Short_Desc	Exception_long_Desc	Claim_Type_Desc	Exception_Disp_ Cd
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Capitation	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Dental	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Financial Transaction	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	HCBS Waiver	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Hospice	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Inpatient	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Laboratory and Xray	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Pharmacy	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Replacement Request	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Medical Supply	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Transportation	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Home Health	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0032/4932	Claim type not determined	Claim type cannot be determined. Please refer to billing manual and resubmit claim.	Credit Request	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Capitation	Pay-and-Report

0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Dental	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Financial Transaction	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	HCBS Waiver	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Hospice	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Inpatient	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Laboratory and Xray	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Pharmacy	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Replacement Request	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Medical Supply	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Transportation	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Home Health	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Mcare Part A Crossover	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Mcare UB Part B Crossover	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Mcare Part B Crossover	Pay-and-Report
0032/4933	E-PROVIDER/CLAIM TYPE CONFLICT	PROVIDER TYPE/CLAIM TYPE CONFLICT	Credit Request	Pay-and-Report

0051/4626	Accom Dys not eql to Covd Dys	The Sum of the Accommodation Days Does Not Equal the Total Covered Days on the Claim.	Hospice	Pay-and-Report
0051/4626	Accom Dys not eql to Covd Dys	The Sum of the Accommodation Days Does Not Equal the Total Covered Days on the Claim.	Inpatient	Pay-and-Report
0051/4626	Accom Dys not eql to Covd Dys	The Sum of the Accommodation Days Does Not Equal the Total Covered Days on the Claim.	Long Term Care	Pay-and-Report
0051/4626	Accom Dys not eql to Covd Dys	The Sum of the Accommodation Days Does Not Equal the Total Covered Days on the Claim.	Mcare Part A Crossover	Pay-and-Report
0058/1520	Patient Stat and Freq conflict	The Patient Status conflicts with billing frequency. Please refer to billing manual and resubmit claim.	Hospice	Pay-and-Report
0058/1520	Patient Stat and Freq conflict	The Patient Status conflicts with billing frequency. Please refer to billing manual and resubmit claim.	Inpatient	Pay-and-Report
0058/1520	Patient Stat and Freq conflict	The Patient Status conflicts with billing frequency. Please refer to billing manual and resubmit claim.	Long Term Care	Pay-and-Report
0072/1620	E - Accom Rev Code Missing	Accommodation Revenue Code Is Missing	Inpatient	Pay-and-Report
0072/1620	E - Accom Rev Code Missing	Accommodation Revenue Code Is Missing	Mcare Part A Crossover	Pay-and-Report
0075/4500	Rev Cd requires Surg Proc Cd	The Revenue Code on the claim must be billed with a Surgical Procedure Code. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0077/4914	Dates of Svc Cannot Span Days	The Dates of Service on the Claim cannot Span more than One Day of Service.	Dental	Pay-and-Report
0077/4914	Dates of Svc Cannot Span Days	The Dates of Service on the Claim cannot Span more than One Day of Service.	Laboratory and Xray	Pay-and-Report
0077/4914	Dates of Svc Cannot Span Days	The Dates of Service on the Claim cannot Span more than One Day of Service.	Practitioner/ Physician	Pay-and-Report
0077/4914	Dates of Svc Cannot Span Days	The Dates of Service on the Claim cannot Span more than One Day of Service.	Medical Supply	Pay-and-Report
0077/4914	Dates of Svc Cannot Span Days	The Dates of Service on the Claim cannot Span more than One Day of Service.	Transportation	Pay-and-Report
0077/4914	Dates of Svc Cannot Span Days	The Dates of Service on the Claim cannot Span more than One Day of Service.	Mcare Part B Crossover	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Dental	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Hospice	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Inpatient	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Laboratory and Xray	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Practitioner/ Physician	Pay-and-Report

0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Long Term Care	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Outpatient	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Medical Supply	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Transportation	Pay-and-Report
0092/49320	Allowed Amount Missing/Invalid	Allowed Amount Missing/Invalid	Home Health	Pay-and-Report
0105/19659	E-Dupe Inpatient/Outpatient	Duplicate - Inpatient/Outpatient	Inpatient	Pay-and-Report
0105/19659	E-Dupe Inpatient/Outpatient	Duplicate - Inpatient/Outpatient	Outpatient	Pay-and-Report
0105/65000	Suspect Dup Prof Or Tech Comp	Suspect Duplicate - Proffesional Or Technical Component - Covered By Complete Service	Laboratory and Xray	Pay-and-Report
0105/65000	Suspect Dup Prof Or Tech Comp	Suspect Duplicate - Proffesional Or Technical Component - Covered By Complete Service	Practitioner/ Physician	Pay-and-Report
0105/65000	Suspect Dup Prof Or Tech Comp	Suspect Duplicate - Proffesional Or Technical Component - Covered By Complete Service	Mcare Part B Crossover	Pay-and-Report
0109/6553	Postop E/M w/Hist Surg Clm	The Postop Evaluation and Management services are included in the Surgery Services and the Surgery has already been paid.	Practitioner/ Physician	Pay-and-Report
0109/6553	Postop E/M w/Hist Surg Clm	The Postop Evaluation and Management services are included in the Surgery Services and the Surgery has already been paid.	Mcare Part B Crossover	Pay-and-Report
0112/1180	DOS Cannot Span Across Months	Date of Service Cannot Span Across Months. Please submit one claim per calendar month.	Hospice	Pay-and-Report
0112/1180	DOS Cannot Span Across Months	Date of Service Cannot Span Across Months. Please submit one claim per calendar month.	Long Term Care	Pay-and-Report
0113/19639	E - Admit/From Date Conflict	Admit Date/From Date Conflict	Inpatient	Pay-and-Report
0114/1430	Source of Admission Invalid	The source of admission is missing or invalid. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0118/19625	E -Medicare Allowed Amnt Confl	Medicare Allowed Amount Conflict	Mcare Part A Crossover	Pay-and-Report
0118/19625	E -Medicare Allowed Amnt Confl	Medicare Allowed Amount Conflict	Mcare UB Part B Crossover	Pay-and-Report
0118/19625	E -Medicare Allowed Amnt Confl	Medicare Allowed Amount Conflict	Mcare Part B Crossover	Pay-and-Report
0119/1410	1st Tooth Surface Invalid	Line item 1st tooth surface on the claim is not a valid value.	Dental	Pay-and-Report
0119/1411	2nd Tooth Surface Invalid	Line item 2nd tooth surface on the claim is not a valid value.	Dental	Pay-and-Report

0119/1412	3rd Tooth Surface Invalid	Line item 3rd tooth surface on the claim is not a valid value.	Dental	Pay-and-Report
0119/1413	4th Tooth Surface Invalid	Line item 4th tooth surface on the claim is not a valid value.	Dental	Pay-and-Report
0119/1414	5th Tooth Surface Invalid	Line item 5th tooth surface on the claim is not a valid value.	Dental	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Dental	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Hospice	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Inpatient	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Laboratory and Xray	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Practitioner/ Physician	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Long Term Care	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Outpatient	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Medical Supply	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Transportation	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Home Health	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Mcare Part A Crossover	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Mcare UB Part B Crossover	Pay-and-Report
0123/19628	Wrong Recipient Proc Body Part	The Modifier Billed Indicates That A Provider Performed The Incorrect Procedure Or Performed It On The Wrong Recipient Or Body Part - A Never Event Occurred.	Mcare Part B Crossover	Pay-and-Report
0127/1160	Thru DOS Aftr Rcpt Dt-Clm Hdr	The Through Date of Service on Claim Header is after Receipt Date of the Claim. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0127/1161	Thru DOS After Rcpt Dt-Clm LI	The Through Date of Service on Claim Line is after Receipt Date of the Claim. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Dental	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Hospice	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Inpatient	Pay-and-Report

0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Laboratory and Xray	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Long Term Care	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Outpatient	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Medical Supply	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Transportation	Pay-and-Report
0132/1250	Submitted Charge is Missing	The Submitted Charge is missing. Please add Submitted Charge and resubmit claim.	Home Health	Pay-and-Report
0147/1440	Admission Type Invalid	The Admission Type is invalid. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Dental	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Hospice	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Inpatient	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Laboratory and Xray	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Long Term Care	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Outpatient	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Medical Supply	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Transportation	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Home Health	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
0160/1260	Total Submitted Chrg Conflict	The sum of the line item(s) billed charges is not equal to the total submitted charges. Please refer to billing manual and resubmit claim.	Mcare Part B Crossover	Pay-and-Report

0172/19645	E - Procedure Code Missing	Procedure Missing	Outpatient	Pay-and-Report
0176/29636	Tobacco Cess Sess Nt Allwd	Tobacco Cessation Sessions Not Allowed	Dental	Pay-and-Report
0176/29636	Tobacco Cess Sess Nt Allwd	Tobacco Cessation Sessions Not Allowed	Practitioner/ Physician	Pay-and-Report
0176/29636	Tobacco Cess Sess Nt Allwd	Tobacco Cessation Sessions Not Allowed	Outpatient	Pay-and-Report
0176/29636	Tobacco Cess Sess Nt Allwd	Tobacco Cessation Sessions Not Allowed	Medical Supply	Pay-and-Report
0182/1510	Inv Covd-NonCovd Dys w/pat st	Missing or Invalid Covered Days and/or Non-Covered Days conflicts with patient status indicated on the claim. Please refer to billing manual and resubmit claim.	Hospice	Pay-and-Report
0182/19656	E-Miss/Invalid Cvd/Non Days	Missing Or Invalid Covered/Non-covered Days	Inpatient	Pay-and-Report
0182/19656	E-Miss/Invalid Cvd/Non Days	Missing Or Invalid Covered/Non-covered Days	Long Term Care	Pay-and-Report
0182/19656	E-Miss/Invalid Cvd/Non Days	Missing Or Invalid Covered/Non-covered Days	Mcare Part A Crossover	Pay-and-Report
0185/1510	Inv Covd-NonCovd Dys w/pat st	Missing or Invalid Covered Days and/or Non-Covered Days conflicts with patient status indicated on the claim. Please refer to billing manual and resubmit claim.	Hospice	Pay-and-Report
0205/3629	Proc Prov Role/OR/RF is Reqd	Procedure Provider Role code is not matching the claim line provider role code or Ordering or Referring Provider is required and was not submitted. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0205/3629	Proc Prov Role/OR/RF is Reqd	Procedure Provider Role code is not matching the claim line provider role code or Ordering or Referring Provider is required and was not submitted. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0205/3629	Proc Prov Role/OR/RF is Reqd	Procedure Provider Role code is not matching the claim line provider role code or Ordering or Referring Provider is required and was not submitted. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0205/3629	Proc Prov Role/OR/RF is Reqd	Procedure Provider Role code is not matching the claim line provider role code or Ordering or Referring Provider is required and was not submitted. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0239/49316	OPPS Observ Stay 23 Hour Limit	OPPS Observation Stay 23 Hour Limit	Outpatient	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Hospice	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Inpatient	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Laboratory and Xray	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Practitioner/ Physician	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Long Term Care	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Outpatient	Pay-and-Report

0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Medical Supply	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Transportation	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Home Health	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Mcare Part A Crossover	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Mcare UB Part B Crossover	Pay-and-Report
0261/29631	Client Is MCARE Part C Eligibl	Client Is Medicare Part C Eligible	Mcare Part B Crossover	Pay-and-Report
0263/6150	OP Csvr w/No Mdcr Pt B on file	An Outpatient Crossover claim was submitted; however, the Member does not have Medicare Part B coverage on file for the Dates of Service indicated on the claim.	Mcare Part A Crossover	Pay-and-Report
0263/6150	OP Csvr w/No Mdcr Pt B on file	An Outpatient Crossover claim was submitted; however, the Member does not have Medicare Part B coverage on file for the Dates of Service indicated on the claim.	Mcare UB Part B Crossover	Pay-and-Report
0263/6150	OP Csvr w/No Mdcr Pt B on file	An Outpatient Crossover claim was submitted; however, the Member does not have Medicare Part B coverage on file for the Dates of Service indicated on the claim.	Mcare Part B Crossover	Pay-and-Report
0263/6160	Prof Csvr w/No Md Pt B on file	A Professional Crossover claim was submitted; however, the Member does not have Medicare Part B coverage on file for the Dates of Service indicated on the claim.	Mcare Part A Crossover	Pay-and-Report
0263/6160	Prof Csvr w/No Md Pt B on file	A Professional Crossover claim was submitted; however, the Member does not have Medicare Part B coverage on file for the Dates of Service indicated on the claim.	Mcare UB Part B Crossover	Pay-and-Report
0263/6160	Prof Csvr w/No Md Pt B on file	A Professional Crossover claim was submitted; however, the Member does not have Medicare Part B coverage on file for the Dates of Service indicated on the claim.	Mcare Part B Crossover	Pay-and-Report
0264/29634	Client Is MCARE Pt A Eligible	Client Is Medicare Part A Eligible	Inpatient	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Hospice	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Inpatient	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Laboratory and Xray	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Practitioner/ Physician	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Outpatient	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Medical Supply	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Transportation	Pay-and-Report
0265/29630	E-Client Is Mcare Pt B Eligibl	Client Is Medicare Part B Eligible	Mcare Part B Crossover	Pay-and-Report

0286/1920	Medicare Paid Date Invalid	The Medicare Paid Date is missing or invalid. Please add Date and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0286/1920	Medicare Paid Date Invalid	The Medicare Paid Date is missing or invalid. Please add Date and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
0286/1920	Medicare Paid Date Invalid	The Medicare Paid Date is missing or invalid. Please add Date and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0289/3612	Operating prov NPI Invalid	Operating Provider NPI Invalid. Performs check digit routine on NPI ID	Inpatient	Pay-and-Report
0289/3612	Operating prov NPI Invalid	Operating Provider NPI Invalid. Performs check digit routine on NPI ID	Outpatient	Pay-and-Report
0290/3626	Referring Provider NPI Invalid	The Referring Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0290/3626	Referring Provider NPI Invalid	The Referring Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0290/3626	Referring Provider NPI Invalid	The Referring Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0290/3626	Referring Provider NPI Invalid	The Referring Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Transportation	Pay-and-Report
0290/3626	Referring Provider NPI Invalid	The Referring Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0293/3611	Serv Facil prov NPI Invalid	Servicing Facility Provider NPI Invalid. Performs check digit routine on NPI ID	Laboratory and Xray	Pay-and-Report
0293/3611	Serv Facil prov NPI Invalid	Servicing Facility Provider NPI Invalid. Performs check digit routine on NPI ID	Practitioner/ Physician	Pay-and-Report
0293/3611	Serv Facil prov NPI Invalid	Servicing Facility Provider NPI Invalid. Performs check digit routine on NPI ID	Medical Supply	Pay-and-Report
0293/3611	Serv Facil prov NPI Invalid	Servicing Facility Provider NPI Invalid. Performs check digit routine on NPI ID	Transportation	Pay-and-Report
0294/39138	Svc Faci Requires NPI	An NPI Is Not Present On The Claim For The Service Facility, But It Is Required Because Of The Place Of Service Code.	Laboratory and Xray	Pay-and-Report
0294/39138	Svc Faci Requires NPI	An NPI Is Not Present On The Claim For The Service Facility, But It Is Required Because Of The Place Of Service Code.	Practitioner/ Physician	Pay-and-Report
0294/39138	Svc Faci Requires NPI	An NPI Is Not Present On The Claim For The Service Facility, But It Is Required Because Of The Place Of Service Code.	Medical Supply	Pay-and-Report
0294/39138	Svc Faci Requires NPI	An NPI Is Not Present On The Claim For The Service Facility, But It Is Required Because Of The Place Of Service Code.	Transportation	Pay-and-Report
0308/3617	Rendering Provider NPI Requird	The Rendering NPI Is Not Present On The Claim.	Dental	Pay-and-Report
0308/3617	Rendering Provider NPI Requird	The Rendering NPI Is Not Present On The Claim.	Practitioner/ Physician	Pay-and-Report
0308/3617	Rendering Provider NPI Requird	The Rendering NPI Is Not Present On The Claim.	Mcare Part B Crossover	Pay-and-Report

0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Dental	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Hospice	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Inpatient	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Laboratory and Xray	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Practitioner/ Physician	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Long Term Care	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Outpatient	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Medical Supply	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Transportation	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Home Health	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Mcare Part A Crossover	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Mcare UB Part B Crossover	Pay-and-Report
0313/3600	Cat of Svc Cant be Determined	The Category of Service cannot be determined from the information on the claim.	Mcare Part B Crossover	Pay-and-Report
0314/29638	Inpatient Not Payable For PE	Inpatient Services Not Payable For Presumptive Eligibility	Inpatient	Pay-and-Report
0314/29638	Inpatient Not Payable For PE	Inpatient Services Not Payable For Presumptive Eligibility	Practitioner/ Physician	Pay-and-Report
0314/29638	Inpatient Not Payable For PE	Inpatient Services Not Payable For Presumptive Eligibility	Long Term Care	Pay-and-Report
0314/29638	Inpatient Not Payable For PE	Inpatient Services Not Payable For Presumptive Eligibility	Mcare Part B Crossover	Pay-and-Report
0316/39146	Attnd NPI Found-Txnmy No Match	Attnd NPI Found-Txnmy No Match	Hospice	Pay-and-Report
0316/39146	Attnd NPI Found-Txnmy No Match	Attnd NPI Found-Txnmy No Match	Inpatient	Pay-and-Report
0316/39146	Attnd NPI Found-Txnmy No Match	Attnd NPI Found-Txnmy No Match	Outpatient	Pay-and-Report
0316/39146	Attnd NPI Found-Txnmy No Match	Attnd NPI Found-Txnmy No Match	Home Health	Pay-and-Report

0322/39145	Svc Fac NPI Req For SBHC	Servicing Facility NPI Required For School Base Health Center	Practitioner/ Physician	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Capitation	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Dental	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Hospice	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Inpatient	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Laboratory and Xray	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Practitioner/ Physician	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Long Term Care	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Outpatient	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Medical Supply	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Transportation	Pay-and-Report
0325/4102	Trauma / Accident Claim	The Claim is Trauma / Accident related.	Home Health	Pay-and-Report
0330/3202	Multiple Referring P_SYS_ID	More than one P_SYS_ID was found for the Referring provider in the P_ALT_ID table for the submitted provider ID and ID Type combination. Could not resolve to a unique P_SYS_ID	Laboratory and Xray	Pay-and-Report
0330/3202	Multiple Referring P_SYS_ID	More than one P_SYS_ID was found for the Referring provider in the P_ALT_ID table for the submitted provider ID and ID Type combination. Could not resolve to a unique P_SYS_ID	Practitioner/ Physician	Pay-and-Report
0330/3202	Multiple Referring P_SYS_ID	More than one P_SYS_ID was found for the Referring provider in the P_ALT_ID table for the submitted provider ID and ID Type combination. Could not resolve to a unique P_SYS_ID	Medical Supply	Pay-and-Report
0330/3202	Multiple Referring P_SYS_ID	More than one P_SYS_ID was found for the Referring provider in the P_ALT_ID table for the submitted provider ID and ID Type combination. Could not resolve to a unique P_SYS_ID	Transportation	Pay-and-Report
0330/3202	Multiple Referring P_SYS_ID	More than one P_SYS_ID was found for the Referring provider in the P_ALT_ID table for the submitted provider ID and ID Type combination. Could not resolve to a unique P_SYS_ID	Mcare Part B Crossover	Pay-and-Report
0340/35507	Pt Not Elig For Ltc Due To Tra	Client Not Eligible For Ltc Due To Resource Transfer	Hospice	Pay-and-Report
0340/35507	Pt Not Elig For Ltc Due To Tra	Client Not Eligible For Ltc Due To Resource Transfer	Long Term Care	Pay-and-Report
0341/3632	Referring Prov NPI Required	The Referring Provider ID must be an NPI. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0341/3632	Referring Prov NPI Required	The Referring Provider ID must be an NPI. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report

0341/3632	Referring Prov NPI Required	The Referring Provider ID must be an NPI. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0341/3632	Referring Prov NPI Required	The Referring Provider ID must be an NPI. Please correct and resubmit claim.	Transportation	Pay-and-Report
0341/3632	Referring Prov NPI Required	The Referring Provider ID must be an NPI. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0347/4316	Revenue Code not on File	The Revenue Code on the Claim is not on File. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0347/4316	Revenue Code not on File	The Revenue Code on the Claim is not on File. Please correct and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0351/19647	E - High Variance	High Variance	Dental	Pay-and-Report
0351/19647	E - High Variance	High Variance	Hospice	Pay-and-Report
0351/19647	E - High Variance	High Variance	Inpatient	Pay-and-Report
0351/19647	E - High Variance	High Variance	Laboratory and Xray	Pay-and-Report
0351/19647	E - High Variance	High Variance	Practitioner/ Physician	Pay-and-Report
0351/19647	E - High Variance	High Variance	Long Term Care	Pay-and-Report
0351/19647	E - High Variance	High Variance	Outpatient	Pay-and-Report
0351/19647	E - High Variance	High Variance	Medical Supply	Pay-and-Report
0351/19647	E - High Variance	High Variance	Transportation	Pay-and-Report
0351/19647	E - High Variance	High Variance	Home Health	Pay-and-Report
0351/19647	E - High Variance	High Variance	Mcare Part B Crossover	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Dental	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Hospice	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Inpatient	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Laboratory and Xray	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Practitioner/ Physician	Pay-and-Report

0352/19648	E - Low Variance	Low Variance	Long Term Care	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Outpatient	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Medical Supply	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Transportation	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Home Health	Pay-and-Report
0352/19648	E - Low Variance	Low Variance	Mcare Part B Crossover	Pay-and-Report
0362/4272	Tooth Surface Required	The Procedure Code submitted on the claim requires a Tooth Surface. Please correct and resubmit claim.	Dental	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Dental	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Transportation	Pay-and-Report
0363/4406	Procedure/ Mod 1 Conflicting	There is a conflict between the Procedure Code and Modifier 1 submitted on the claim. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0364/4274	Procedure Cd/Tooth Num Requird	The Procedure Code conflicts with the Tooth Number and/or Tooth Quadrant on the claim. Please correct and resubmit claim.	Dental	Pay-and-Report
0368/4322	Revenue/Provider Type Conflict	There is a conflict between the Provider Type and Revenue Code submitted on the Claim.	Hospice	Pay-and-Report
0368/4322	Revenue/Provider Type Conflict	There is a conflict between the Provider Type and Revenue Code submitted on the Claim.	Inpatient	Pay-and-Report
0368/4322	Revenue/Provider Type Conflict	There is a conflict between the Provider Type and Revenue Code submitted on the Claim.	Long Term Care	Pay-and-Report
0368/4322	Revenue/Provider Type Conflict	There is a conflict between the Provider Type and Revenue Code submitted on the Claim.	Outpatient	Pay-and-Report
0368/4322	Revenue/Provider Type Conflict	There is a conflict between the Provider Type and Revenue Code submitted on the Claim.	Home Health	Pay-and-Report
0368/4322	Revenue/Provider Type Conflict	There is a conflict between the Provider Type and Revenue Code submitted on the Claim.	Mcare Part A Crossover	Pay-and-Report

0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Dental	Pay-and-Report
0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Transportation	Pay-and-Report
0371/4409	Procedure/ Mod 2 Conflicting	There is a conflict between the Procedure Code and Modifier 2 submitted on the claim. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Dental	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Hospice	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Long Term Care	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Transportation	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Home Health	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
0372/4420	Procedure/Claim Type Conflict	There is a conflict between the Claim Type and the Procedure Code submitted on the claim. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0373/4324	Revenue/Type Of Bill Conflict	There is a conflict between the Type of Bill and Revenue Code submitted on the Claim.	Hospice	Pay-and-Report

0373/4324	Revenue/Type Of Bill Conflict	There is a conflict between the Type of Bill and Revenue Code submitted on the Claim.	Inpatient	Pay-and-Report
0373/4324	Revenue/Type Of Bill Conflict	There is a conflict between the Type of Bill and Revenue Code submitted on the Claim.	Long Term Care	Pay-and-Report
0373/4324	Revenue/Type Of Bill Conflict	There is a conflict between the Type of Bill and Revenue Code submitted on the Claim.	Outpatient	Pay-and-Report
0373/4324	Revenue/Type Of Bill Conflict	There is a conflict between the Type of Bill and Revenue Code submitted on the Claim.	Home Health	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Dental	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Transportation	Pay-and-Report
0376/4422	Procedure Requires Modifier	The Procedure Code submitted on the claim requires a Modifier for billing. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Capitation	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Dental	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Financial Transaction	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	HCBS Waiver	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Hospice	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Inpatient	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Laboratory and Xray	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Practitioner/ Physician	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Long Term Care	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Outpatient	Pay-and-Report

0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Pharmacy	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Replacement Request	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Medical Supply	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Transportation	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Home Health	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Mcare Part A Crossover	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Mcare UB Part B Crossover	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Mcare Part B Crossover	Pay-and-Report
0384/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Credit Request	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Capitation	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Dental	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Financial Transaction	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	HCBS Waiver	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Hospice	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Inpatient	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Laboratory and Xray	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Practitioner/ Physician	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Long Term Care	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Outpatient	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Pharmacy	Pay-and-Report

0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Replacement Request	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Medical Supply	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Transportation	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Home Health	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Mcare Part A Crossover	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Mcare UB Part B Crossover	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Mcare Part B Crossover	Pay-and-Report
0385/35511	Proc Cd Incl In ABP - List One	Proc Cd Incl In Abp - List One	Credit Request	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Capitation	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Dental	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Financial Transaction	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	HCBS Waiver	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Hospice	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Inpatient	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Laboratory and Xray	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Practitioner/ Physician	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Long Term Care	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Outpatient	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Pharmacy	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Replacement Request	Pay-and-Report

0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Medical Supply	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Transportation	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Home Health	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Mcare Part A Crossover	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Mcare UB Part B Crossover	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Mcare Part B Crossover	Pay-and-Report
0386/35512	Proc Cd Incl In Abp - List Two	Proc Cd Incl In Abp - List Two	Credit Request	Pay-and-Report
0412/3300	Rendering Prov ID Not on DB	The Rendering Provider ID submitted on the claim is not on file. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0412/3300	Rendering Prov ID Not on DB	The Rendering Provider ID submitted on the claim is not on file. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0412/3300	Rendering Prov ID Not on DB	The Rendering Provider ID submitted on the claim is not on file. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0420/3618	Rendering Provider NPI Invalid	The Rendering Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Dental	Pay-and-Report
0420/3618	Rendering Provider NPI Invalid	The Rendering Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0420/3618	Rendering Provider NPI Invalid	The Rendering Provider NPI is not a valid NPI number format. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0422/3305	Rndrng Prov Not Enrolld on DOS	The Rendering Provider does not have an active Enrollment Span that covers the Dates of Service on the claim.	Dental	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Dental	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Hospice	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Long Term Care	Pay-and-Report

0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Transportation	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Home Health	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
0425/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Dental	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Hospice	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Long Term Care	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Medical Supply	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Transportation	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Home Health	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
0426/3015	Prov Not a Valid Billing Prov	The Billing Provider ID on the Claim is not an authorized Billing Provider. Please correct and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Dental	Pay-and-Report

0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Hospice	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Inpatient	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Laboratory and Xray	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Practitioner/ Physician	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Long Term Care	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Outpatient	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Medical Supply	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Transportation	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Home Health	Pay-and-Report
0434/4402	Procedure / Age Conflict	The Member's Age conflicts with the age range indicated on file for the Procedure Code or Surgical Procedure Code submitted on the claim. Please correct and resubmit.	Mcare Part B Crossover	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Dental	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Hospice	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Inpatient	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Laboratory and Xray	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Practitioner/ Physician	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Long Term Care	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Outpatient	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Medical Supply	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Transportation	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Home Health	Pay-and-Report
0435/4425	Procedure / Gender Conflict	The Member's Gender conflicts with the Procedure Code submitted on the claim. Please correct and resubmit.	Mcare Part B Crossover	Pay-and-Report

0454/4111	Principle Diag/Age Conflict	The Member's Age conflicts with the Principle Diagnosis submitted on the claim. Please correct and resubmit.	Dental	Pay-and-Report
0454/4111	Principle Diag/Age Conflict	The Member's Age conflicts with the Principle Diagnosis submitted on the claim. Please correct and resubmit.	Inpatient	Pay-and-Report
0454/4111	Principle Diag/Age Conflict	The Member's Age conflicts with the Principle Diagnosis submitted on the claim. Please correct and resubmit.	Laboratory and Xray	Pay-and-Report
0454/4111	Principle Diag/Age Conflict	The Member's Age conflicts with the Principle Diagnosis submitted on the claim. Please correct and resubmit.	Practitioner/ Physician	Pay-and-Report
0454/4111	Principle Diag/Age Conflict	The Member's Age conflicts with the Principle Diagnosis submitted on the claim. Please correct and resubmit.	Outpatient	Pay-and-Report
0455/4110	Principle Diag/Gender Conflict	The Member's Gender conflicts with the Principal Diagnosis submitted on the claim. Please correct and resubmit.	Dental	Pay-and-Report
0455/4110	Principle Diag/Gender Conflict	The Member's Gender conflicts with the Principal Diagnosis submitted on the claim. Please correct and resubmit.	Inpatient	Pay-and-Report
0455/4110	Principle Diag/Gender Conflict	The Member's Gender conflicts with the Principal Diagnosis submitted on the claim. Please correct and resubmit.	Laboratory and Xray	Pay-and-Report
0455/4110	Principle Diag/Gender Conflict	The Member's Gender conflicts with the Principal Diagnosis submitted on the claim. Please correct and resubmit.	Practitioner/ Physician	Pay-and-Report
0455/4110	Principle Diag/Gender Conflict	The Member's Gender conflicts with the Principal Diagnosis submitted on the claim. Please correct and resubmit.	Outpatient	Pay-and-Report
0472/4158	9th Sec(BF/ABF)Dx NOF	The 9th Secondary (BF or ABF) Diagnosis is not on file. Please correct and resubmit claim.	Dental	Pay-and-Report
0472/4158	9th Sec(BF/ABF)Dx NOF	The 9th Secondary (BF or ABF) Diagnosis is not on file. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
0472/4158	9th Sec(BF/ABF)Dx NOF	The 9th Secondary (BF or ABF) Diagnosis is not on file. Please correct and resubmit claim.	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Dental	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Hospice	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Inpatient	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Laboratory and Xray	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Practitioner/ Physician	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Long Term Care	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Outpatient	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Medical Supply	Pay-and-Report

0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Transportation	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Home Health	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Mcare Part A Crossover	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Mcare UB Part B Crossover	Pay-and-Report
0497/99015	Timely Filing-Rvw Grace Period	Timely Filing Limit Grace Period Requires Review For An Adjustment Claim Or Attached Proof Of Timely Filing Documentation.	Mcare Part B Crossover	Pay-and-Report
0521/4512	3rd Oth(BQ/BBQ)Surg Proc NOF	The 3rd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0521/4512	3rd Oth(BQ/BBQ)Surg Proc NOF	The 3rd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0521/4515	4th Oth(BQ/BBQ)Surg Proc NOF	The 4th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0521/4515	4th Oth(BQ/BBQ)Surg Proc NOF	The 4th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0526/4515	4th Oth(BQ/BBQ)Surg Proc NOF	The 4th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0526/4515	4th Oth(BQ/BBQ)Surg Proc NOF	The 4th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0526/4518	5th Oth(BQ/BBQ)Surg Proc NOF	The 5th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0526/4518	5th Oth(BQ/BBQ)Surg Proc NOF	The 5th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Capitation	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Dental	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Financial Transaction	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	HCBS Waiver	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Hospice	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Inpatient	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Laboratory and Xray	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Practitioner/ Physician	Pay-and-Report

0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Long Term Care	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Outpatient	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Pharmacy	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Replacement Request	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Medical Supply	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Transportation	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Home Health	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Mcare Part A Crossover	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Mcare UB Part B Crossover	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Mcare Part B Crossover	Pay-and-Report
0530/35502	Proc Code Excl From ABP	Procedure Code Excluded From ABP	Credit Request	Pay-and-Report
0550/4506	1st Oth(BQ/BBQ)Surg Proc NOF	The 1st Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0550/4506	1st Oth(BQ/BBQ)Surg Proc NOF	The 1st Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0552/4518	5th Oth(BQ/BBQ)Surg Proc NOF	The 5th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0552/4518	5th Oth(BQ/BBQ)Surg Proc NOF	The 5th Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0555/81000	EPSDT SCREEN TWICE IN 11 MNTHS	EPSDT SCREENING PERFORMED TWICE IN 11 MONTHS.	Practitioner/ Physician	Pay-and-Report
0555/81000	EPSDT SCREEN TWICE IN 11 MNTHS	EPSDT SCREENING PERFORMED TWICE IN 11 MONTHS.	Outpatient	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Capitation	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Dental	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Financial Transaction	Pay-and-Report

0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	HCBS Waiver	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Hospice	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Inpatient	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Laboratory and Xray	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Practitioner/ Physician	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Long Term Care	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Outpatient	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Pharmacy	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Replacement Request	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Medical Supply	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Transportation	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Home Health	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Mcare Part A Crossover	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Mcare UB Part B Crossover	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Mcare Part B Crossover	Pay-and-Report
0557/49314	Client Read Wi 2 Days-Diff Drg	Client Readmitted Within 2 Days Of Discharge - Different Drg - Same Provider	Credit Request	Pay-and-Report
0558/49315	Client Readmin W/In 2 Days	Client Readmitted Within 2 Days Of Discharge - Same Drg	Inpatient	Pay-and-Report
0560/4506	1st Oth(BQ/BBQ)Surg Proc NOF	The 1st Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0560/4506	1st Oth(BQ/BBQ)Surg Proc NOF	The 1st Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0560/4509	2nd Oth(BQ/BBQ)Surg Proc NOF	The 2nd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report

0560/4509	2nd Oth(BQ/BBQ)Surg Proc NOF	The 2nd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0570/4509	2nd Oth(BQ/BBQ)Surg Proc NOF	The 2nd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0570/4509	2nd Oth(BQ/BBQ)Surg Proc NOF	The 2nd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0570/4512	3rd Oth(BQ/BBQ)Surg Proc NOF	The 3rd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report
0570/4512	3rd Oth(BQ/BBQ)Surg Proc NOF	The 3rd Other (BQ or BBQ) Surgical Procedure Code is not on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
0584/4702	E-No DRG In MDC For Prin Dx	DRG Return Code 2 - No DRG In MDC For Principal Diagnosis	Inpatient	Pay-and-Report
0587/4732	E-DRG RC 3 - Inv Client Age	DRG Return Code 3 - Invalid Client Age	Inpatient	Pay-and-Report
0589/4733	E-DRG RC 4 - Inv Client Sex	DRG Return Code 4 - Invalid Client Sex	Inpatient	Pay-and-Report
0590/4734	E-DRG RC 5 - Inv Disch Stat	DRG Return Code 5 - Invalid Discharge Status	Inpatient	Pay-and-Report
0596/1370	Diagnosis Related Code Invalid	The Diagnosis Related Code is missing or invalid. Please refer to billing manual and resubmit claim.	Dental	Pay-and-Report
0596/1370	Diagnosis Related Code Invalid	The Diagnosis Related Code is missing or invalid. Please refer to billing manual and resubmit claim.	Laboratory and Xray	Pay-and-Report
0596/1370	Diagnosis Related Code Invalid	The Diagnosis Related Code is missing or invalid. Please refer to billing manual and resubmit claim.	Practitioner/ Physician	Pay-and-Report
0596/1370	Diagnosis Related Code Invalid	The Diagnosis Related Code is missing or invalid. Please refer to billing manual and resubmit claim.	Mcare Part B Crossover	Pay-and-Report
0600/65000	Suspect Dup Prof Or Tech Comp	Suspect Duplicate - Proffesional Or Technical Component - Covered By Complete Service	Laboratory and Xray	Pay-and-Report
0600/65000	Suspect Dup Prof Or Tech Comp	Suspect Duplicate - Proffesional Or Technical Component - Covered By Complete Service	Practitioner/ Physician	Pay-and-Report
0600/65000	Suspect Dup Prof Or Tech Comp	Suspect Duplicate - Proffesional Or Technical Component - Covered By Complete Service	Mcare Part B Crossover	Pay-and-Report
0600/65001	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Drg Claim	Inpatient	Pay-and-Report
0600/65001	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Drg Claim	Mcare Part B Crossover	Pay-and-Report
0637/1381	Patient Condition Cd 2 Invalid	The Code for Patient's Condition or Treatment Related to Auto Accident is not valid. Please refer to billing manual and resubmit claim.	Dental	Pay-and-Report
0652/65001	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Drg Claim	Inpatient	Pay-and-Report
0652/65001	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Drg Claim	Mcare Part B Crossover	Pay-and-Report

0652/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Dental	Pay-and-Report
0652/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Inpatient	Pay-and-Report
0652/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Mcare Part A Crossover	Pay-and-Report
0652/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Mcare UB Part B Crossover	Pay-and-Report
0652/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Mcare Part B Crossover	Pay-and-Report
0653/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Dental	Pay-and-Report
0653/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Inpatient	Pay-and-Report
0653/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Mcare Part A Crossover	Pay-and-Report
0653/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Mcare UB Part B Crossover	Pay-and-Report
0653/65002	Suspect Dup, Covered By Inpt	Suspect Duplicate, Covered By Inpatient Non-Drg Claim	Mcare Part B Crossover	Pay-and-Report
0653/65003	Suspect Dup Physician And Lab/	Suspect Dup Physician And Lab/Radiology Claim	Laboratory and Xray	Pay-and-Report
0653/65003	Suspect Dup Physician And Lab/	Suspect Dup Physician And Lab/Radiology Claim	Practitioner/ Physician	Pay-and-Report
0686/65004	Suspect Dupe Part A Clm Over	Suspect Duplicate, Medicare Part A Claim Overlaps With Another Service	Mcare Part A Crossover	Pay-and-Report
0692/49325	CCBHC PPS Proc Code Not Found	CCBHC PPS Procedure Code Not Found On CCBHC Claim	Practitioner/ Physician	Pay-and-Report
0692/49325	CCBHC PPS Proc Code Not Found	CCBHC PPS Procedure Code Not Found On CCBHC Claim	Mcare Part B Crossover	Pay-and-Report
0693/49326	CCBHC Proc Code Is Non-Pay	CCBHC Procedure Code Is Non-Pay	Practitioner/ Physician	Pay-and-Report
0693/49326	CCBHC Proc Code Is Non-Pay	CCBHC Procedure Code Is Non-Pay	Mcare Part B Crossover	Pay-and-Report
0695/49328	CCBHC Cost-Only Code	CCBHC Cost-Only Code	Practitioner/ Physician	Pay-and-Report
0695/49328	CCBHC Cost-Only Code	CCBHC Cost-Only Code	Mcare Part B Crossover	Pay-and-Report
0704/1290	Medical Diagnosis Required	A Medical Diagnosis is required.	Inpatient	Pay-and-Report
0704/1290	Medical Diagnosis Required	A Medical Diagnosis is required.	Laboratory and Xray	Pay-and-Report

0704/1290	Medical Diagnosis Required	A Medical Diagnosis is required.	Practitioner/ Physician	Pay-and-Report
0704/1290	Medical Diagnosis Required	A Medical Diagnosis is required.	Outpatient	Pay-and-Report
0704/1290	Medical Diagnosis Required	A Medical Diagnosis is required.	Mcare Part B Crossover	Pay-and-Report
0709/29640	Ltc Span Ends Before Last Dos	Ltc Span Ends Before Last Date Of Service	Long Term Care	Pay-and-Report
0713/1560	IP Adm<24 Hr-Rebill As OP Obs	Inpatient Admission is Less Than 24 Hours- Rebill As Outpatient Observation	Inpatient	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Dental	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	HCBS Waiver	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Hospice	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Inpatient	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Laboratory and Xray	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Practitioner/ Physician	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Long Term Care	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Outpatient	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Medical Supply	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Transportation	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Home Health	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Mcare Part A Crossover	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Mcare UB Part B Crossover	Pay-and-Report
0748/64103	TPL Att - No Resource/Payment	TPL Attachment - No Resource, No Payment Amount	Mcare Part B Crossover	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Capitation	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Dental	Pay-and-Report

0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Hospice	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Inpatient	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Laboratory and Xray	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Practitioner/ Physician	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Long Term Care	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Outpatient	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Medical Supply	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Transportation	Pay-and-Report
0749/64104	TPL Att/Payment - No Resource	TPL Attached And Payment Is Indicated On Claim But There Is No Tpl Resource On File	Home Health	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Capitation	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Dental	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Hospice	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Inpatient	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Laboratory and Xray	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Practitioner/ Physician	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Long Term Care	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Outpatient	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Medical Supply	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Transportation	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Home Health	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Mcare Part A Crossover	Pay-and-Report

0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Mcare UB Part B Crossover	Pay-and-Report
0750/64000	E-Clnt Has TPL Resub W/TPL EOB	Client Has Primary Insurance Coverage - Resubmit With TPL EOB	Mcare Part B Crossover	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Capitation	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Dental	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Hospice	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Inpatient	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Laboratory and Xray	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Practitioner/ Physician	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Long Term Care	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Outpatient	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Medical Supply	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Transportation	Pay-and-Report
0757/64105	TPL Indicated On Claim Form	TPL Other Insurance Indicator Checked As A Yes On Claim Form	Home Health	Pay-and-Report
0777/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Laboratory and Xray	Pay-and-Report
0777/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Practitioner/ Physician	Pay-and-Report
0777/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Medical Supply	Pay-and-Report
0777/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Transportation	Pay-and-Report
0778/65006	Susp Dup Covered By Mcare Pt B	Suspect Dup, Covered By Medicare Part B Crossover	Mcare Part B Crossover	Pay-and-Report
0778/65009	Home Health Vs Ccic Dupe	Suspect Duplicate Home Health And Waiver Claim	Home Health	Pay-and-Report
0779/65037	Suspect Dup Cov By Hospice Cl	Suspect Duplicate, Covered By Hospice Claim	Hospice	Pay-and-Report
0780/65003	Suspect Dup Physician And Lab/	Suspect Dup Physician And Lab/Radiology Claim	Laboratory and Xray	Pay-and-Report

0780/65003	Suspect Dup Physician And Lab/	Suspect Dup Physician And Lab/Radiology Claim	Practitioner/ Physician	Pay-and-Report
0780/65007	Dupe - Ltc And Ccic Claim	Suspect Duplicate, Long Term Care And Waiver Claim	Practitioner/ Physician	Pay-and-Report
0780/65007	Dupe - Ltc And Ccic Claim	Suspect Duplicate, Long Term Care And Waiver Claim	Long Term Care	Pay-and-Report
0781/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Laboratory and Xray	Pay-and-Report
0781/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Practitioner/ Physician	Pay-and-Report
0781/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Medical Supply	Pay-and-Report
0781/65005	Suspect Dupe Hcfa - 1500	Suspect Dup Hcfa - 1500 Services	Transportation	Pay-and-Report
0782/65006	Susp Dup Covered By Mcare Pt B	Suspect Dup, Covered By Medicare Part B Crossover	Mcare Part B Crossover	Pay-and-Report
0782/65009	Home Health Vs Ccic Dupe	Suspect Duplicate Home Health And Waiver Claim	Home Health	Pay-and-Report
0783/65007	Dupe - Ltc And Ccic Claim	Suspect Duplicate, Long Term Care And Waiver Claim	Practitioner/ Physician	Pay-and-Report
0783/65007	Dupe - Ltc And Ccic Claim	Suspect Duplicate, Long Term Care And Waiver Claim	Long Term Care	Pay-and-Report
0784/65034	Home Health Vs Comm Benefit	Suspect Duplicate Home Health And Communtiy Benefit Claim	HCBS Waiver	Pay-and-Report
0784/65034	Home Health Vs Comm Benefit	Suspect Duplicate Home Health And Communtiy Benefit Claim	Practitioner/ Physician	Pay-and-Report
0784/65034	Home Health Vs Comm Benefit	Suspect Duplicate Home Health And Communtiy Benefit Claim	Home Health	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Dental	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Hospice	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Inpatient	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Laboratory and Xray	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Practitioner/ Physician	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Long Term Care	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Outpatient	Pay-and-Report

0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Medical Supply	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Transportation	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Home Health	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Mcare Part A Crossover	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Mcare UB Part B Crossover	Pay-and-Report
0823/1280	TPL Amount is Invalid	The claim header total TPL amount is greater than the claim header total charge.	Mcare Part B Crossover	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Dental	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Hospice	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Inpatient	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Laboratory and Xray	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Practitioner/ Physician	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Long Term Care	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Outpatient	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Medical Supply	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Transportation	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Home Health	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Mcare Part A Crossover	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Mcare UB Part B Crossover	Pay-and-Report
0900/1071	Mcare Denied Clm For Admin Rsn	Medicare denied claim for administrative reasons. Medicare paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Mcare Part B Crossover	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Dental	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Hospice	Pay-and-Report

0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Inpatient	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Laboratory and Xray	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Practitioner/ Physician	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Long Term Care	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Outpatient	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Medical Supply	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Transportation	Pay-and-Report
0901/1072	OthPyr Denied Clm For Admn Rsn	Claim denied by other payor for administrative reasons. TPL paid amount = $0.00 and at least one claim adjustment reason code is present in system list C3-1071.	Home Health	Pay-and-Report
0905/6140	IP Csvr w/No Mdcr Pt A on file	An Inpatient Crossover claim was submitted; however, the Member does not have Medicare Part A coverage on file for the Dates of Service indicated on the claim.	Inpatient	Pay-and-Report
0905/6140	IP Csvr w/No Mdcr Pt A on file	An Inpatient Crossover claim was submitted; however, the Member does not have Medicare Part A coverage on file for the Dates of Service indicated on the claim.	Outpatient	Pay-and-Report
0905/6140	IP Csvr w/No Mdcr Pt A on file	An Inpatient Crossover claim was submitted; however, the Member does not have Medicare Part A coverage on file for the Dates of Service indicated on the claim.	Mcare Part A Crossover	Pay-and-Report
0905/6140	IP Csvr w/No Mdcr Pt A on file	An Inpatient Crossover claim was submitted; however, the Member does not have Medicare Part A coverage on file for the Dates of Service indicated on the claim.	Mcare UB Part B Crossover	Pay-and-Report
0905/6140	IP Csvr w/No Mdcr Pt A on file	An Inpatient Crossover claim was submitted; however, the Member does not have Medicare Part A coverage on file for the Dates of Service indicated on the claim.	Mcare Part B Crossover	Pay-and-Report
0956/1401	Quadrant Number Invalid	The Quadrant is not valid. Please correct and resubmit claim.	Dental	Pay-and-Report
0957/4275	Proc Code/Oral Cavity Reqd	The Procedure Code conflicts with the Oral Cavity on the claim. Please correct and resubmit claim.	Dental	Pay-and-Report
1050/4876	Proc Fctr Code without OP	Proc Fctr Code without OP	Outpatient	Pay-and-Report
1050/4876	Proc Fctr Code without OP	Proc Fctr Code without OP	Mcare UB Part B Crossover	Pay-and-Report
1100/49313	Hospice Rev/Proc Code Conflict	Hospice Rev/Proc Code Conflict	Hospice	Pay-and-Report
1101/49308	Hospice Allowed At End Of Life	Hospice Allowed At End Of Life	Hospice	Pay-and-Report
1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Hospice	Pay-and-Report
1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Inpatient	Pay-and-Report

1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Long Term Care	Pay-and-Report
1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Outpatient	Pay-and-Report
1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Home Health	Pay-and-Report
1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Mcare Part A Crossover	Pay-and-Report
1274/2025	Pat Stat/Mbr Dt of Dth Conflct	The Patient Status on the claim conflicts with the Member Date of Death on file. Please correct and resubmit claim.	Mcare UB Part B Crossover	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Dental	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Hospice	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Inpatient	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Laboratory and Xray	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Practitioner/ Physician	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Long Term Care	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Outpatient	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Medical Supply	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Transportation	Pay-and-Report
1351/49298	Tot Chrg Exceed Threshold Revw	Services Require Review When Total Charges Exceed Threshold.	Home Health	Pay-and-Report
1355/39147	Indiv Render Prov Not On Claim	For A Group Practice, Institution, Or Facility, The Individual Rendering Provider'S Medicaid Number Must Be Placed In The Appropriate Block.	Laboratory and Xray	Pay-and-Report
1355/39147	Indiv Render Prov Not On Claim	For A Group Practice, Institution, Or Facility, The Individual Rendering Provider'S Medicaid Number Must Be Placed In The Appropriate Block.	Practitioner/ Physician	Pay-and-Report
1355/39147	Indiv Render Prov Not On Claim	For A Group Practice, Institution, Or Facility, The Individual Rendering Provider'S Medicaid Number Must Be Placed In The Appropriate Block.	Mcare Part B Crossover	Pay-and-Report
1363/65013	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Laboratory and Xray	Pay-and-Report
1363/65013	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Practitioner/ Physician	Pay-and-Report
1363/65013	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Mcare Part B Crossover	Pay-and-Report

1364/65013	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Laboratory and Xray	Pay-and-Report
1364/65013	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Practitioner/ Physician	Pay-and-Report
1364/65013	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Mcare Part B Crossover	Pay-and-Report
1364/65014	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Practitioner/ Physician	Pay-and-Report
1365/65014	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Practitioner/ Physician	Pay-and-Report
1365/65015	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Practitioner/ Physician	Pay-and-Report
1366/65015	Possible Dup - Same Provider	Possible Duplicate - Same Provider	Practitioner/ Physician	Pay-and-Report
1366/65016	Possible Dupe Same Provider	Possible Duplicate Same Provider	Practitioner/ Physician	Pay-and-Report
1369/65016	Possible Dupe Same Provider	Possible Duplicate Same Provider	Practitioner/ Physician	Pay-and-Report
1371/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Inpatient	Pay-and-Report
1371/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Laboratory and Xray	Pay-and-Report
1371/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Practitioner/ Physician	Pay-and-Report
1371/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Outpatient	Pay-and-Report
1372/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Inpatient	Pay-and-Report
1372/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Laboratory and Xray	Pay-and-Report
1372/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Practitioner/ Physician	Pay-and-Report
1372/65018	Poss Dup - Different Provider	Possible Dup - Different Provider	Outpatient	Pay-and-Report
1372/65019	Poss Dup - Different Provider	Possible Duplicate - Different Provider	Practitioner/ Physician	Pay-and-Report
1372/65019	Poss Dup - Different Provider	Possible Duplicate - Different Provider	Mcare Part B Crossover	Pay-and-Report
1373/65019	Poss Dup - Different Provider	Possible Duplicate - Different Provider	Practitioner/ Physician	Pay-and-Report
1373/65019	Poss Dup - Different Provider	Possible Duplicate - Different Provider	Mcare Part B Crossover	Pay-and-Report

1374/65021	Poss Dupe Diff Provider	Possible Duplicate Different Provider	Practitioner/ Physician	Pay-and-Report
1375/65022	Sus Dup-Ltc And Rehab Clm	Suspect Duplicate Long Term Care And Rehab Claim	Practitioner/ Physician	Pay-and-Report
1375/65022	Sus Dup-Ltc And Rehab Clm	Suspect Duplicate Long Term Care And Rehab Claim	Long Term Care	Pay-and-Report
1376/65023	Susp Dup Mcare Pt A & B X-Over	Suspect Duplicate Medicare Part A And Medicare Part B Crossover	Mcare Part A Crossover	Pay-and-Report
1376/65023	Susp Dup Mcare Pt A & B X-Over	Suspect Duplicate Medicare Part A And Medicare Part B Crossover	Mcare UB Part B Crossover	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Dental	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Hospice	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Inpatient	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Laboratory and Xray	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Practitioner/ Physician	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Long Term Care	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Outpatient	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Medical Supply	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Transportation	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Home Health	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Mcare Part A Crossover	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Mcare UB Part B Crossover	Pay-and-Report
1376/65031	Poss Dup - Different Provider	Possible Dup - Different Provider	Mcare Part B Crossover	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Dental	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Hospice	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Inpatient	Pay-and-Report

1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Laboratory and Xray	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Practitioner/ Physician	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Long Term Care	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Outpatient	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Medical Supply	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Transportation	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Home Health	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Mcare Part A Crossover	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Mcare UB Part B Crossover	Pay-and-Report
1377/99012	Units Or Charge Too Large	Units Or Charge Too Large	Mcare Part B Crossover	Pay-and-Report
1379/65021	Poss Dupe Diff Provider	Possible Duplicate Different Provider	Practitioner/ Physician	Pay-and-Report
1380/65033	Dup Anesthesia Service	Duplicate Anesthesia Service	Practitioner/ Physician	Pay-and-Report
1383/65022	Sus Dup-Ltc And Rehab Clm	Suspect Duplicate Long Term Care And Rehab Claim	Practitioner/ Physician	Pay-and-Report
1383/65022	Sus Dup-Ltc And Rehab Clm	Suspect Duplicate Long Term Care And Rehab Claim	Long Term Care	Pay-and-Report
1384/65023	Susp Dup Mcare Pt A & B X-Over	Suspect Duplicate Medicare Part A And Medicare Part B Crossover	Mcare Part A Crossover	Pay-and-Report
1384/65023	Susp Dup Mcare Pt A & B X-Over	Suspect Duplicate Medicare Part A And Medicare Part B Crossover	Mcare UB Part B Crossover	Pay-and-Report
1471/4500	Rev Cd requires Surg Proc Cd	The Revenue Code on the claim must be billed with a Surgical Procedure Code. Please correct and resubmit claim.	Inpatient	Pay-and-Report
1701/4330	Revenue Cd Must Be Laboratory	Lab Procedure Codes and High Tech Radiology Procedure Codes must be Billed with the Revenue Code specific to Lab or High Tech Radiology. Please correct and resubmit claim.	Outpatient	Pay-and-Report
1900/4158	9th Sec(BF/ABF)Dx NOF	The 9th Secondary (BF or ABF) Diagnosis is not on file. Please correct and resubmit claim.	Dental	Pay-and-Report
1900/4158	9th Sec(BF/ABF)Dx NOF	The 9th Secondary (BF or ABF) Diagnosis is not on file. Please correct and resubmit claim.	Laboratory and Xray	Pay-and-Report
1900/4158	9th Sec(BF/ABF)Dx NOF	The 9th Secondary (BF or ABF) Diagnosis is not on file. Please correct and resubmit claim.	HCBS Case Mgmt Assmt (CMA)	Pay-and-Report

6000/81001	PHYSICAL MEDICINE > 3/MO	PHYSICAL MEDICINE MORE THAN 3 PER MONTH	Practitioner/ Physician	Pay-and-Report
6001/81002	MODALITIES MORE THAN 3/MO	MODALITIES EXCEED MORE THAN 3 PER MONTH	Practitioner/ Physician	Pay-and-Report
6002/81003	RENTAL EXCEEDS PURCHASE	RENTAL EXCEEDS PURCHASE (13 MONTHS)	Medical Supply	Pay-and-Report
6003/81004	ACTIVITIES EXCEED 3 PER MONTH	ACTIVITIES EXCEED 3 PER MONTH	Practitioner/ Physician	Pay-and-Report
6004/81005	MANIPULATION EXCEEDS 3/MO	MANIPULATION EXCEEDS 3 PER MONTH	Practitioner/ Physician	Pay-and-Report
6005/81006	TESTS EXCEED 1 PER MONTH	TESTS EXCEED 1 PER MONTH	Practitioner/ Physician	Pay-and-Report
6006/81007	NEW PATIENT VISIT MORE THAN 1	NEW PATIENT VISIT MORE THAN ONCE	Practitioner/ Physician	Pay-and-Report
6009/81010	LTC VISITS EXCEED 2/DAY	LTC VISITS EXCEED 2 PER DAY	Practitioner/ Physician	Pay-and-Report
6011/81012	INTRAORAL XRAY > EVERY 5/YRS	INTRAORAL XRAY MORE THAN EVERY 5 YEARS	Dental	Pay-and-Report
6012/81013	PANORAMIC XRAY > EVERY 5/YRS	PANORAMIC XRAY MORE THAN EVERY 5 YEARS	Dental	Pay-and-Report
6014/85003	STERIL INCIDENTAL TO CSECTION	STERILIZATION INCIDENTAL TO C SECTION	Practitioner/ Physician	Pay-and-Report
6016/81015	SVC 1/MO EXCEEDED	SERVICE 1/MO UNIT EXCEEDED FOR CALENDAR MONTH	Practitioner/ Physician	Pay-and-Report
6016/81015	SVC 1/MO EXCEEDED	SERVICE 1/MO UNIT EXCEEDED FOR CALENDAR MONTH	Outpatient	Pay-and-Report
6020/81019	TONSILLECTOMY > ONCE IN LIFE	TONSILLECTOMY MORE THAN ONCE IN A LIFETIME	Practitioner/ Physician	Pay-and-Report
6020/81019	TONSILLECTOMY > ONCE IN LIFE	TONSILLECTOMY MORE THAN ONCE IN A LIFETIME	Outpatient	Pay-and-Report
6021/81020	ADENOIDECTOMY MORE ONE LIFETIM	ADENOIDECTOMY MORE THAN ONCE IN A LIFETIME	Practitioner/ Physician	Pay-and-Report
6021/81020	ADENOIDECTOMY MORE ONE LIFETIM	ADENOIDECTOMY MORE THAN ONCE IN A LIFETIME	Outpatient	Pay-and-Report
6024/81023	APPENDECTOMY MORE THAN ONCE IN	APPENDECTOMY MORE THAN ONCE IN LIFETIME	Practitioner/ Physician	Pay-and-Report
6024/81023	APPENDECTOMY MORE THAN ONCE IN	APPENDECTOMY MORE THAN ONCE IN LIFETIME	Outpatient	Pay-and-Report
6025/81024	HYSTERECTOMY MORE THAN ONCE	HYSTERECTOMY MORE THAN ONCE IN A LIFETIME	Practitioner/ Physician	Pay-and-Report
6025/81024	HYSTERECTOMY MORE THAN ONCE	HYSTERECTOMY MORE THAN ONCE IN A LIFETIME	Outpatient	Pay-and-Report

6026/81025	CIRCUMCISION MORE THAN ONCE	CIRCUMCISION MORE THAN ONCE IN A LIFETIME	Practitioner/ Physician	Pay-and-Report
6026/81025	CIRCUMCISION MORE THAN ONCE	CIRCUMCISION MORE THAN ONCE IN A LIFETIME	Outpatient	Pay-and-Report
6027/81028	CHOLECYSTECTOMY MORE THAN ONCE	CHOLECYSTECTOMY MORE THAN ONCE IN A LIFETIME	Practitioner/ Physician	Pay-and-Report
6027/81028	CHOLECYSTECTOMY MORE THAN ONCE	CHOLECYSTECTOMY MORE THAN ONCE IN A LIFETIME	Outpatient	Pay-and-Report
6034/81035	STERLIZATION INCID TO C SECTIO	STERLIZATION INCIDENTAL TO C SECTION	Practitioner/ Physician	Pay-and-Report
6034/81035	STERLIZATION INCID TO C SECTIO	STERLIZATION INCIDENTAL TO C SECTION	Outpatient	Pay-and-Report
6034/85007	STERLIZATION INCID TO C SECTIO	STERLIZATION INCIDENTAL TO C SECTION	Practitioner/ Physician	Pay-and-Report
6034/85007	STERLIZATION INCID TO C SECTIO	STERLIZATION INCIDENTAL TO C SECTION	Outpatient	Pay-and-Report
6043/81044	PERSONAL CARE LIMIT 1/YEAR	PERSONAL CARE LIMIT ONE TIME PER YEAR PER CONSUMER	Practitioner/ Physician	Pay-and-Report
6048/85016	BITEWINGS CONFLICT WITH INTRAO	BITEWINGS CONFLICT WITH INTRAORAL	Dental	Pay-and-Report
6051/81051	PROPHY EXCEEDS LIMIT - CHILD	PROPHY EXCEEDS LIMIT - CHILD	Dental	Pay-and-Report
6052/81052	FLUORIDE EXCEEDS LIMIT ADULT	FLUORIDE EXCEEDS LIMIT- ADULT	Dental	Pay-and-Report
6053/81053	FLUORIDE EXCEEDS LIMIT - CHILD	FLUORIDE EXCEEDS LIMIT - CHILD	Dental	Pay-and-Report
6054/85015	DENTAL FLUORIDE INCLUDES PROPH	DENTAL FLUORIDE INCLUDES PROPHY	Dental	Pay-and-Report
6055/81057	DENTAL RESTORATIVE PROCEDURE	DENTAL RESTORATIVE PROCEDURE ON SAME DAY	Dental	Pay-and-Report
6056/81058	DENTAL EXAM MORE THAN ONCE PER	DENTAL EXAM MORE THAN ONCE PER DAY	Dental	Pay-and-Report
6057/85043	CDT4 VS CPT CODE ON THE SAME D	CDT4 VST CPT CODE BILLED ON THE SAME DAY BY THE SAME PROVIDER	Dental	Pay-and-Report
6057/85043	CDT4 VS CPT CODE ON THE SAME D	CDT4 VST CPT CODE BILLED ON THE SAME DAY BY THE SAME PROVIDER	Practitioner/ Physician	Pay-and-Report
6058/81062	ONE EXTRACTION ALLOWED/TOOTH	ONE EXTRACTION ALLOWED PER TOOTH	Dental	Pay-and-Report
6058/85044	ONE EXTRACTION ALLOWED/TOOTH	ONE EXTRACTION ALLOWED PER TOOTH	Dental	Pay-and-Report

6059/81059	PERSONAL CARE LIMIT 8 HRS/YEAR	PERSONAL CARE LIMIT OF WC245 LIMIT OF 8 HOURS PER YEAR	Practitioner/ Physician	Pay-and-Report
6060/81060	PERSONAL CARE LIMIT 2 / YEAR	PERSONAL CARE LIMIT FOR WC247 MAXIMUM OF TWO TIMES PER YEAR	Practitioner/ Physician	Pay-and-Report
6061/81061	PERSONAL CARE LIMIT 1/YEAR	PERSONAL CARE LIMIT WC240 LIMITED TO ONE PER YEAR PER CONSUMER	Practitioner/ Physician	Pay-and-Report
6063/81063	RESIN-ONE SURFACE ONCE/TOOTH	RESIN-ONE SURFACE ONCE/TOOTH	Dental	Pay-and-Report
6064/81064	RESIN-BASED COMPOSITE ONCE/TTH	RESIN-BASED COMPOSITE ONLY ALLOWED ONCE PER TOOTH	Dental	Pay-and-Report
6065/81065	RESIN-BASED COMPOSITE 1/TOOTH	RESIN-BASED COMPOSITE ONLY ALLOWED ONCE PER TOOTH	Dental	Pay-and-Report
6075/81127	E-TRANSPORTATION OVER $200	TRANSPORTATION OVER $200	Transportation	Pay-and-Report
6076/81054	RESIN-BASED COMPOSITE 1/TOOTH	RESIN-BASED COMPOSITE ONLY ALLOWED ONCE PER TOOTH	Dental	Pay-and-Report
6077/85045	E-LAB LIMITED BY MD W/E&M CODE	LABORATORY CLAIMS FOR PHYSICIANS ARE LIMITED WHEN PROVIDING EVALUATION AND MANAGEMENT VISITS	Practitioner/ Physician	Pay-and-Report
6080/81043	DENTAL SERVICE REQUIRES PA	DENTAL SERVICE REQUIRES PA	Dental	Pay-and-Report
6081/85039	DENTAL NOT PAYABLE ON THE SAME	DENTAL PROCEDURE CODES NOT PAYABLE ON THE SAME DATE OF SERVICE, SAME PROVIDER	Dental	Pay-and-Report
6082/81075	FITTING OF SPECTACLES LIMITED	FITTING OF SPECTACLES LIMITED TO UNDER 21 YEARS OF AGE	Practitioner/ Physician	Pay-and-Report
6083/81079	TRANSPORTATION EXCEEDS $100	TRANSPORTATION EXCEEDS $100	Transportation	Pay-and-Report
6085/81048	DENTAL LIMIT 2/YEAR	DENTAL LIMIT TWO PER YEAR	Dental	Pay-and-Report
6086/85030	DENTAL SERVICE LIMIT	DENTAL SERVICE LIMIT	Dental	Pay-and-Report
6087/81049	CANNOT EXCEED 2 REPAIRS/YEAR	CANNOT EXCEED 2 REPAIRS PER YEAR	Dental	Pay-and-Report
6088/81076	DENTAL SVC ONLY 1 PER 3 YRS	DENTAL SERVICE ONLY ALLOWED ONCE EVERY THREE YEARS	Dental	Pay-and-Report
6089/85020	PROSTHESIS VS RELINE W/IN 3 YR	PROSTHESIS VS RELINE WITHIN 3 YR PERIOD	Dental	Pay-and-Report
6090/81077	E-DENTAL SERVICE NOT A BENEFIT	DENTAL SERVICE NOT A BENEFIT FOR CLIENTS 21 YEARS OF AGE OR OLDER	Dental	Pay-and-Report
6091/81081	E-PRE-MOLAR SEALANTS NOT CVD	PRE-MOLAR SEALANTS NOT COVERED	Dental	Pay-and-Report
6093/85006	RAD PARTIAL VIEW INCL COMPL	RADIOLOGY PARTIAL VIEW INCLUDED IN COMPELTE VIEW	Laboratory and Xray	Pay-and-Report

6093/85006	RAD PARTIAL VIEW INCL COMPL	RADIOLOGY PARTIAL VIEW INCLUDED IN COMPELTE VIEW	Practitioner/ Physician	Pay-and-Report
6101/81083	EYEGLASS LENS ONLY 2 EVERY 2 Y	EYEGLASS LENS ONLY 2 EVERY 2 YRS FOR ADULTS (21 YRS AND OLDER)	Practitioner/ Physician	Pay-and-Report
6103/85027	OBSTETRIC PANEL INCL INDIVIDUA	OBSTETRIC PANEL INCLUDES INDIVIDUAL LAB CODES	Laboratory and Xray	Pay-and-Report
6103/85027	OBSTETRIC PANEL INCL INDIVIDUA	OBSTETRIC PANEL INCLUDES INDIVIDUAL LAB CODES	Practitioner/ Physician	Pay-and-Report
6105/85029	METABOLIC PANEL INCLUDES INDIV	METABOLIC PANEL INCLUDES INDIVIDUAL LAB CODE	Laboratory and Xray	Pay-and-Report
6105/85029	METABOLIC PANEL INCLUDES INDIV	METABOLIC PANEL INCLUDES INDIVIDUAL LAB CODE	Practitioner/ Physician	Pay-and-Report
6106/85005	AUDIOLOGY TEST CODES CONFLICT	AUDIOLOGY TEST CODES CONFLICT	Practitioner/ Physician	Pay-and-Report
6107/85033	LAPAROSCOPY INCLUDED SUGICAL	LAPAROSCOPY INCLUDED IN SURGICAL PROCEDURE	Practitioner/ Physician	Pay-and-Report
6114/85001	SURGICAL PROCEDURES OVERLAP	SURGICAL PROCEDURES OVERLAP	Practitioner/ Physician	Pay-and-Report
6115/81128	DIALYSIS EXCEEDS 3 MONTHS	DIALYSIS EXCEEDS 3 MONTHS WITHOUT MEDICARE CERTIFICATION	Outpatient	Pay-and-Report
6116/81131	DENTAL EXAM EXCEES LIMIT - CHI	DENTAL EXAM EXCEEDS LIMIT- CHILD	Dental	Pay-and-Report
6117/81132	DENTAL EXAM EXCEEDS LIMIT-ADUL	DENTAL EXAM EXCEEDS LIMIT-ADULT - AGE 21-99	Dental	Pay-and-Report
6118/81133	DENTAL EXAM EXCEEDS LIMIT-CHIL	DENTAL EXAM EXCEEDS LIMIT - CHILD - DIFFERENT PROVIDERS	Dental	Pay-and-Report
6119/81134	DENTAL EXAM MORE THAN 1/YEAR	DENTAL EXAM MORE THAN ONCE IN A YEAR - SAME PROVIDER	Dental	Pay-and-Report
6122/81138	PULPOTOMY ALREADY PERFORMED	PULPOTOMY ALREADY PERFORMED ON TOOTH	Dental	Pay-and-Report
6123/81137	PURCHASE REQUIRES PRIOR AUTH	PURCHASE REQUIRES PRIOR AUTHORIZATION	Medical Supply	Pay-and-Report
6124/81084	HEARING AIDS ONLY 1 PER 4 YRS	HEARING AIDS AND DISPENSING FEE ONLY 1 PER 4 YRS EACH	Practitioner/ Physician	Pay-and-Report
6124/81084	HEARING AIDS ONLY 1 PER 4 YRS	HEARING AIDS AND DISPENSING FEE ONLY 1 PER 4 YRS EACH	Medical Supply	Pay-and-Report
6125/81078	EYE EXAM 1 EVERY 2 YRS	EYE EXAM 1 EVERY 2 YRS FOR ADULTS (21 YEARS AND OLDER)	Practitioner/ Physician	Pay-and-Report
6126/81085	DISP GLOVES ONLY 200 PER MONTH	DISPOSABLE GLOVES (STERILE OR NON-STERILE) LIMITED TO 200 PER MONTH.	Practitioner/ Physician	Pay-and-Report
6126/81085	DISP GLOVES ONLY 200 PER MONTH	DISPOSABLE GLOVES (STERILE OR NON-STERILE) LIMITED TO 200 PER MONTH.	Medical Supply	Pay-and-Report

6127/81086	DISP DIAPERS LIMIT 200 A MONTH	DISPOSABLE DIAPERS LIMITED TO 200 PER MONTH	Practitioner/ Physician	Pay-and-Report
6127/81086	DISP DIAPERS LIMIT 200 A MONTH	DISPOSABLE DIAPERS LIMITED TO 200 PER MONTH	Medical Supply	Pay-and-Report
6128/81087	PROSTH/ORTH LIMIT 1 PER 3 YRS	CUSTOM FABRICATED PROSTHETIC/ORTHOTIC DEVICES ARE LIMITED TO ONE EVERY THREE YEARS.	Practitioner/ Physician	Pay-and-Report
6128/81087	PROSTH/ORTH LIMIT 1 PER 3 YRS	CUSTOM FABRICATED PROSTHETIC/ORTHOTIC DEVICES ARE LIMITED TO ONE EVERY THREE YEARS.	Medical Supply	Pay-and-Report
6129/81088	TRANSPORTATION EXCEEDS $200	TRANSPORTATION EXCEEDS $200	Transportation	Pay-and-Report
6130/81089	EYEGLASS DISP LIMIT 1 EVERY 2	EYEGLASS DISPENSING LIMIT 1 EVERY 2 YEARS FOR CLIENTS AGE 21 AND OLDER	Practitioner/ Physician	Pay-and-Report
6131/81090	EYEGLASS FRAMES LIMIT 1 EVERY	EYEGLASS FRAMES LIMIT 1 EVERY 2 YEARS FOR CLIENTS AGE 21 AND OLDER	Practitioner/ Physician	Pay-and-Report
6139/81098	REPAIR/ REFIT AND SPECTACLE PR	REPAIR/ REFITING AND SPECTACLE PROSTHESIS CODES BILLED ON SAME DOS	Practitioner/ Physician	Pay-and-Report
6139/81098	REPAIR/ REFIT AND SPECTACLE PR	REPAIR/ REFITING AND SPECTACLE PROSTHESIS CODES BILLED ON SAME DOS	Medical Supply	Pay-and-Report
6140/85018	MOTION TEST CODE CONFLICT	MOTION TEST CODE CONFLICT	Laboratory and Xray	Pay-and-Report
6140/85018	MOTION TEST CODE CONFLICT	MOTION TEST CODE CONFLICT	Practitioner/ Physician	Pay-and-Report
6140/85018	MOTION TEST CODE CONFLICT	MOTION TEST CODE CONFLICT	Outpatient	Pay-and-Report
6140/85018	MOTION TEST CODE CONFLICT	MOTION TEST CODE CONFLICT	Mcare Part A Crossover	Pay-and-Report
6140/85018	MOTION TEST CODE CONFLICT	MOTION TEST CODE CONFLICT	Mcare UB Part B Crossover	Pay-and-Report
6140/85018	MOTION TEST CODE CONFLICT	MOTION TEST CODE CONFLICT	Mcare Part B Crossover	Pay-and-Report
6141/81099	REFRACTION LIMIT 1 EVERY 2 YRS	REFRACTION LIMITED TO 1 EXAM EVERY TWO YEARS	Practitioner/ Physician	Pay-and-Report
6143/85031	SERVICE NOT ALLOWED IN SAME MO	SERVICE NOT ALLOWED IN SAME MONTH	Practitioner/ Physician	Pay-and-Report
6144/85037	SERVICE NOT ALLOWED TOGETHER	SERVICE NOT ALLOWED TOGETHER	Medical Supply	Pay-and-Report
6145/81101	PROPHY EXCEEDS LIMIT - ADULT	PROPHY EXCEEDS LIMIT- ADULT	Dental	Pay-and-Report
6146/85009	SERVICE CANNOT BE BILLED	SERVICE CANNOT BE BILLED IN CONJUCTION WITH ANOTHER SERVICE	Practitioner/ Physician	Pay-and-Report
6147/81102	DENTAL EXAM EXCEEDS LIMIT-CHIL	DENTAL EXAM EXCEEDS LIMIT - CHILD - DIFFERENT PROVIDERS	Dental	Pay-and-Report

6148/81103	TRANSPORTATION EXCEEDS $115	TRANSPORTATION EXCEEDS $115	Transportation	Pay-and-Report
6149/81104	E-TRANSPORTATION OVER $230	TRANSPORTATION OVER $230	Transportation	Pay-and-Report
6150/81105	PROPHY EXCEEDS LIMIT - ADULT	PROPHY EXCEEDS LIMIT - ADULT	Dental	Pay-and-Report
6151/81106	EARLY INTERV CM 1/MO EXCEEDED	EARLY INTERVENTION CM 1/MO UNIT EXCEEDED FOR CALENDAR MONTH	Practitioner/ Physician	Pay-and-Report
6160/81114	NEW PATIENT VISIT MORE THAN 1	NEW PATIENT VISIT MORE THAN ONCE	Practitioner/ Physician	Pay-and-Report
6161/81115	EVAL TWICE IN 10 MONTH PERIOD	EVALUATION BILLED TWICE IN A 10 MONTH PERIOD	Practitioner/ Physician	Pay-and-Report
6164/81117	EYE EXAM 1 EVERY 3 YRS	EYE EXAM 1 EVERY 3 YRS FOR ADULTS (21 YEARS AND OLDER)	Practitioner/ Physician	Pay-and-Report
6164/81117	EYE EXAM 1 EVERY 3 YRS	EYE EXAM 1 EVERY 3 YRS FOR ADULTS (21 YEARS AND OLDER)	Mcare Part B Crossover	Pay-and-Report
6165/81118	REFRACTION LIMIT 1 EVERY 3 YRS	REFRACTION LIMITED TO 1 EXAM EVERY THREE YEARS	Practitioner/ Physician	Pay-and-Report
6165/81118	REFRACTION LIMIT 1 EVERY 3 YRS	REFRACTION LIMITED TO 1 EXAM EVERY THREE YEARS	Mcare Part B Crossover	Pay-and-Report
6166/81119	EYEGLASS LENS ONLY 2 EVERY 3 Y	EYEGLASS LENS ONLY 2 EVERY 3 YRS FOR ADULTS (21 YRS AND OLDER)	Practitioner/ Physician	Pay-and-Report
6166/81119	EYEGLASS LENS ONLY 2 EVERY 3 Y	EYEGLASS LENS ONLY 2 EVERY 3 YRS FOR ADULTS (21 YRS AND OLDER)	Mcare Part B Crossover	Pay-and-Report
6167/81120	EYEGLASS FRMES LMT 1 EVERY 3 Y	EYEGLASS FRAMES LIMIT 1 EVERY 3 YEARS FOR CLIENTS AGE 21 AND OLDER	Practitioner/ Physician	Pay-and-Report
6167/81120	EYEGLASS FRMES LMT 1 EVERY 3 Y	EYEGLASS FRAMES LIMIT 1 EVERY 3 YEARS FOR CLIENTS AGE 21 AND OLDER	Mcare Part B Crossover	Pay-and-Report
6168/81121	EYEGLASS DISP LIMIT 1 EVERY 3	EYEGLASS DISPENSING LIMIT 1 EVERY 3 YEARS FOR CLIENTS AGE 21 AND OLDER	Practitioner/ Physician	Pay-and-Report
6168/81121	EYEGLASS DISP LIMIT 1 EVERY 3	EYEGLASS DISPENSING LIMIT 1 EVERY 3 YEARS FOR CLIENTS AGE 21 AND OLDER	Mcare Part B Crossover	Pay-and-Report
6169/81122	CHILD VACCINE PRICING LIMIT	CHILD VACCINE PRICING LIMIT	Practitioner/ Physician	Pay-and-Report
6169/81122	CHILD VACCINE PRICING LIMIT	CHILD VACCINE PRICING LIMIT	Outpatient	Pay-and-Report
6271/85032	DIAPERS NOT ALLOWED WITH 26DAY	DIAPERS NOT ALLOWED WITHIN 26 DAYS	Medical Supply	Pay-and-Report
6501/6519	NCCI: Comprhnsv/Compnent Proc	NCCI Exception: Correct Coding Initiative - PTP Comprehensive / Component Procedure	Laboratory and Xray	Pay-and-Report
6501/6519	NCCI: Comprhnsv/Compnent Proc	NCCI Exception: Correct Coding Initiative - PTP Comprehensive / Component Procedure	Practitioner/ Physician	Pay-and-Report

6501/6519	NCCI: Comprhnsv/Component Proc	NCCI Exception: Correct Coding Initiative - PTP Comprehensive / Component Procedure	Outpatient	Pay-and-Report
6501/6519	NCCI: Comprhnsv/Component Proc	NCCI Exception: Correct Coding Initiative - PTP Comprehensive / Component Procedure	Medical Supply	Pay-and-Report
6502/6520	CP:CCI Mutually Exclusive Proc	Bloodhound ConVergence Point Exception: Correct Coding Initiative - CCI Mutually Exclusive Procedure	Laboratory and Xray	Pay-and-Report
6502/6520	CP:CCI Mutually Exclusive Proc	Bloodhound ConVergence Point Exception: Correct Coding Initiative - CCI Mutually Exclusive Procedure	Practitioner/ Physician	Pay-and-Report
6502/6520	CP:CCI Mutually Exclusive Proc	Bloodhound ConVergence Point Exception: Correct Coding Initiative - CCI Mutually Exclusive Procedure	Outpatient	Pay-and-Report
6502/6520	CP:CCI Mutually Exclusive Proc	Bloodhound ConVergence Point Exception: Correct Coding Initiative - CCI Mutually Exclusive Procedure	Medical Supply	Pay-and-Report
6503/6533	MUE Unit Of Service Max Exceed	Daily Submitted Units Exceed The Medically Unlikely Edits Units-Of-Service Maximum Value - Practitioner Claims	Laboratory and Xray	Pay-and-Report
6503/6533	MUE Unit Of Service Max Exceed	Daily Submitted Units Exceed The Medically Unlikely Edits Units-Of-Service Maximum Value - Practitioner Claims	Practitioner/ Physician	Pay-and-Report
6503/6533	MUE Unit Of Service Max Exceed	Daily Submitted Units Exceed The Medically Unlikely Edits Units-Of-Service Maximum Value - Practitioner Claims	Outpatient	Pay-and-Report
6503/6533	MUE Unit Of Service Max Exceed	Daily Submitted Units Exceed The Medically Unlikely Edits Units-Of-Service Maximum Value - Practitioner Claims	Medical Supply	Pay-and-Report