

overrides Bolder

Code	Description	Code	Description	Code	Description
100 A	B Too early to bill on waiver	315 A	B Missing primary ICD-9 code	412 A	B Invalid RUGs score
105 A	B Too early to bill off waiver	316 A	B Invalid primary ICD-9 code	413 A	B Invalid HIPPS modifier
110 A	B Invalid provider number	317 A	B Invalid 4th ICD9 code	414 A	B HIPPS modifier code 00 requires RUGs = AAA
115 A	B Interim rate not received	318 A	B Invalid 5th ICD9 code	415 A	B Assessment date required
120 A	B Patient in uncertified bed	319 A	B Invalid 6th ICD-9 code	416 A	B Modifier codes out of sequence
125 A	B Missing provider number	320 A	B Invalid 2nd ICD-9 code	417 A	B Assessment date invalid
130 A	B Claim totals to less than \$1.00	321 A	B Invalid 3rd ICD-9 code	418 A	B Invalid coverage begin date
135 A	B No days or rate on claim	322 A	B Trauma code - potential MSP claim	419 A	B Invalid coverage end date
200 A	B Missing SNF loc attachment	323 #	B End of Month admit - removed Jan 2002 close	420 A	B Duplicate HIPPS modifier on stay
205 A	B Missing PT attachment	324 A	B Trauma code may be needed (MSP claim)	421 B	B Therapy code/Modifier mismatch
210 A	B Missing OT attachment	325 A	B Missing or invalid sex code	422 A	B 00 HIPPS modifier on claim
215 A	B Missing ST attachment	326 A	B Invalid 7th ICD9 code	423 A	B Duplicate assessment dates
216 A	B Missing Med Supply attachment	327 A	B Invalid 8th ICD9 code	424 #	B Invalid To date of Service on assessment change
217 A	B Missing MSP attachment	328 A	B Invalid 9th ICD9 code	425 B	B Ambulance code requires 1 modifier
219 A	B Missing other attachments	330 A	B Invalid admit date	426 A	B HIPPS modifier days > than allowable days
220 A	B Missing various attachments	345 A	B Invalid occurrence code	427 A	B Case mix with Pre PPS admit on 01/99 claim
221 A	B Pending Central Medicare review	350 A	B Invalid occurrence date	428 A	B Override 427 - Case Mix with Pre PPS admit on 01/99 claim
223 A	B Missing prior claim attachments	351 B	B Therapy claim - need occurrence code 11 and begin date	429 #	B Override 433 - 08 or 38 HIPPS modifier found on claim
224 A	B Need copy of medicare card	352 B	B Old occurrence dates	430 B	B Therapy codes require 1 modifier
225 A	B Hold per CMR - reason unknown	353 #	B Very high therapy units	431 A	B R & B days do not equal Revenue Code 022 days
226 A	B Hold per CMR	355 A	B Missing occurrence span	432 #	B Therapy RUGs missing therapy charges
227 A	B Hold per facility	356 A	B 3 day qualifying stay not met	433 #	B 08 or 38 Hipps modifier found on claim
228 A	B DPNA corp Hold	357 A	B 30 day transfer not met	434 B	B Exceeds Occupational Therapy cap
229 A	B System DPNA Corp Hold	358 A	B End date more than 3 days after UR	435 B	B Exceeds Physical Therapy & Speech Therapy cap
230 A	B Claims for prior dates of service not billed	359 A	B Invalid UR date or thru date	436 #	B Assessment date after discharge date
231 B	B Blood Glucose for Patient in Certified bed	360 A	B Same day transfer indicated	437 A	B Override 422 - 00 HIPPS modifier on claim
233 A	B Missing or invalid UPIN #	361 A	B Invalid condition code	438 B	B Modifiers appear without HCPCs code
235 A	B Claim pending deletion	365 A	B Invalid condition code #2	439 B	B Blood Glucose with no service date
236 A	B Claim pending change	370 A	B Invalid condition code #3	440 A	B 14-day Comprehensive assessment missing
237	B Smushed ancillary charge	388 #	B Very high ancillary amount	441 A	B Assessment date must match coverage day 1
238 A	B Claim contains pen supplies	385 A	B 05 occurrence code/no trauma code (no override)	442 A	B Duplicate RUGs found for change modifier
239 B	B Claim contains catheter or ostomy supplies	390 A	B No ancillary charges	443 A	B Assessment date out of sequence
240 A	B Claim DOS does not match attachment	392 A	B Missing guarantor zip code	444 #	B FDOS must match Assessment date
245 A	B Override 357 - 30 day transfer	395 A	B Net credit item	445 B	B Override 410 - More than 50 detail records
246 A	B Override 510 - 83 facility hold	396 A	B Ancillary detail line equals 0.00	446 A	B Therapy Rugs discontinued with wrong mod
250 A	B Override 360 - same day transfer	397 A	B Ancillary unit(s) less than 1	447 A	B Override 446 - Therapy Rugs discontinued with wrong mod.
255 A	B Override 390 - no ancillary charges	398 A	B Invalid revenue code	448 B	B Blood Glucose with no Diabetes diagnosis code
260 A	B Override 322 - not MSP claim	399 A	B Additional or other reason(s)	449 B	B Override 448 - Blood Glucose with no Diabetes Diag code
265	B Override 352 - old occurrence dates	400 A	B Unit has attachments	501 B	B Revenue code requires HCPC code
270 #	B Override 353 - very high units	401 A	B Waiting for remittance on original claim	502 B	B Part B claim with therapy suspended
275 #	B Override 388 - very high ancillary amount	402 A	B Manual hold for unmatched remittance	503 A	B Claim held by corporate
280 A	B Override 900 - prior claim not processed	403 A	B Assessment information changed since last AU close	505 A	B D4 Condition code error
285	B Override 231 - Lab billed for certified bed	404 A	B Manual hold for pre-PPS adjustments	504 A	B XX7 adjusted claim without a D condition code
290 A	B Override 233 - UPIN edit	405 A	B Potential program problem	510 A	B 83 facility corp claim hold
291 A	B Override 324 - Trauma Code may be needed	406 A	B A previous cancelled claim not sent	511 A	B Override 311 - MSP claim (will bill MSP electronically)
292 A	B Override 441 - Assessment date must match coverage day	407 A	B Denial code on last RA for #7 claim	800 #	B Span information has changed due to admit date
295 #	B Not Used	408 A	B Claim held for manual review code G	801 #	B Span information has changed due to condition code 16
299 A	B Other reason	409 A	B Claim held for manual review code V	802 A	B Bill type has changed
300 A	B Missing medicare number	410 B	B More than 50 detail records	850 A	B User Image Error - Deleted from Resend file
305 A	B Invalid medicare number	411 A	B RUGs score required	851 A	B Adjustment of an Adjustment (Edit received with F)
309 A	B Prior claim not yet billed			852 A	B Claim overlaps existing User Input claim
310 A	B Claim to be moved to pending			900 A	B Prior Part A Claim not processed on R/A
311 A	B MSP patient				

potential changes underlined and italicized

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105 A	B Too early to bill off waiver	316 A	B Invalid primary ICD-9 code	413 A	B Invalid HIPPS modifier
110 A	B Invalid provider number in AR	317 A	B Invalid 4th ICD-9 code	414 A	B HIPPS modifier code 00 requires RUGs = AAA
115 A	B Interim rate not received in AR	318 A	B Invalid 5th ICD-9 code	415 A	B Assessment date required
120 A	B Patient in uncertified bed	319 A	B Invalid 6th ICD-9 code	416 A	B Modifier codes out of sequence
125 A	B Missing provider number in AR	320 A	B Invalid 2nd ICD-9 code	417 A	B Assessment date invalid or outside range
130 A	B Claim total is less than \$1.00	321 A	B Invalid 3rd ICD-9 code	418 A	B Begin date of assessment period invalid
135 A	B No days or rate on claim	322 A	B Trauma code - potential MSP claim	419 A	B End date of assessment period invalid
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