Edit Flag	Edit Status	Description
ACW ACW	CAUTION	**Anesthesia Crosswalk** When a surgical CPT procedure code is billed by an anesthesiologist to report the anesthesia Claims Manager for that procedure, ClaimsManager crosses the surgical procedure code to the appropriate anesthesia CPT code prior to analysis. This edit identifies instances where a surgical procedure code was crosswalked to the CPT code describing anesthesia Claims Manager for that procedure. This crosswalk occurs for claims by any provider identified in the provider database as specialty 05 (Anesthesiology) or 43 (Certified Registered Nurse Anesthetist, Anesthesia Assistant). This flag should always be set for profiling since it describes a process, not an error. The default action for this edit is Caution.
ANE ANE	REVIEW	**Anesthesia By Non-Anesthesiologist** This flag is driven by provider specialties 05 and 43 and is intended to identify improper use of anesthesia codes for postoperative pain management, local anesthesia, or sedation not requiring monitoring by an anesthesiologist.
ASD ASD	REVIEW	**Anesthesia Secondary Procedure** For a given operative session, only one anesthesia code should be billed, even when multiple surgical procedures are performed. In such cases, it is important to bill the anesthesia service with the highest value. This flag identifies when more than one anesthesia service has been billed, and invalidates the flagged line from further editing.
BDS BDS	REVIEW	**Missing or Invalid Date of Service** The beginning or ending Date of Service is invalid.
BRR BRR	REVIEW	**Anesthesia Crosswalk By Report** The system was unable to crosswalk this surgical code to an anesthesia code. The surgical CPT code is a "By Report" procedure. Review the documentation.
CAG CAG	REVIEW	**Procedure Not Typical for Age of Patient** Procedure code is not typical for the age of the patient.
CCI CCI	REVIEW	**Injection Procedure w/o Cardiac Catheterization** CPT codes 93539–93545 identify injection procedures performed during cardiac catheterization. Whenever these codes appear, the claim is searched to verify that a cardiac catheterization was also billed. If a corresponding cardiac catheterization is not found, ClaimsManager flags this and recommends reporting of the injection using the codes in the Vascular Procedures section of CPT (93501–93533) instead of the listed injection code. It is also possible, though less likely, that the cardiac catheterization has been left off the claim and should be added rather than replacing the injection code.
CCR CCR	REVIEW	**Cardiac Catheterization w/o Rad Supervision** An injection procedure for cardiac catheterization has been billed without the radiological supervision procedure.
CDL CDL	REVIEW	**Deleted Procedure Code** Procedure code has been deleted.
CPT CPT	REVIEW	**Missing or Invalid Procedure Code** Procedure code is invalid or missing.
CSX CSX	REVIEW	**Procedure Not Typical for Sex of Patient** Procedure code is not typically performed for gender of patient.
DAP DAP	REVIEW	**Deny Add on Procedure** Indicates the submitted Add On procedure code needs to be denied because the primary procedure code submitted with the Add On Code was denied.

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DLP DLP	REVIEW	**Duplicate Line by Provider** The line item may be a duplicate of another line item performed by the same provider. (without the appropriate overrides.)
GFP GFP	REVIEW	**Global Follow-up by Provider** This flag identifies an evaluation and management (E/M) code that: was billed during the global follow-up period of an earlier procedure has the same primary diagnosis as any one diagnosis for the earlier Procedure was performed by the same physician. No modifier overrides this flag so we recommend that the line be deleted from your claim before submitting it to your payer. This flag applies to non-Medicare claims. The mFP mnemonic flags the same scenario for Medicare claims. The GFP flag invalidates the line for further editing.
GSP GSP	REVIEW	**Post-Op Surgery by Provider** This flag identifies a procedure code that: was billed without an appropriate modifier during the global follow-up period of an earlier procedure has the same primary diagnosis as any one diagnosis for the earlier procedure was performed by the same physician The flag description indicates that modifier -58, -76, -78, or -79 is required. This flag applies to non-Medicare claims. The mSP mnemonic flags the same scenario for Medicare claims.
IAG IAG	REVIEW	**Diagnosis Not Typical for Patient Age** Diagnosis Code is not typical for age of this patient
ICD ICD	REVIEW	**ICD-9 CM Code Cannot be Found in Database** Diagnosis code is not listed as a valid code in the ICD-9 database.
ICM ICM	REVIEW	**Missing Diagnosis Code** The primary diagnosis is missing.
ICR ICR	REVIEW	**Anesthesia Crosswalk Individual Consideration** Procedure code requires crosswalking to one of several appropriate anesthesia codes before pricing. Review the documentation for correct code.
IDL IDL	REVIEW	**Deleted ICD9-CM Code** Diagnosis code has been deleted.
IDX IDX	REVIEW	**Non Specific Diagnosis Code** Diagnosis code is a non-specific diagnosis code and requires a fourth and/or fifth digit to provide the proper specificity.
IMC IMC	REVIEW	**Inappropriate Modifier Combination** Identifies modifiers that cannot be used together on the same claim line.
IMO IMO	REVIEW	**Invalid Modifier** This edit identifies a line containing a modifier that cannot be found in the table of valid CPT, Medicare, or user-defined modifiers.

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INJ INJ	REVIEW	**Injection Administration w/o Supply** When an injection is performed in an office setting, the claim is searched for the presence of CPT code 99070 or a HCPCS Level II "J" code to verify that the arterial injection has been reported. If no such code is found, the flag is set and recommends adding this billable item to the claim.
ISX ISX	REVIEW	**Diagnosis Not Typical for Patient's Gender** Diagnosis code is not typical for patient gender.
LNM LNM	REVIEW	**No initial lab procedure to repeat** Lab procedure billed with a 59 or 91 modifier. No other lab billed on the same date of service.
LPR LPR	REVIEW	**Repeat lab procedure** Lab procedure code has been billed more than once for the date of service without a repeat modifier (59 or 91).
M26 M26	REVIEW	**Modifier –26 Required** This flag identifies line items that do not contain a modifier -26 for a procedure with a PC/TC split when the procedure was performed in a hospital inpatient or outpatient place of service. When a procedure that has both a professional and technical component is performed in an inpatient or hospital outpatient setting, the physician should bill only the professional component because the technical component is typically billed by the facility. To identify the professional component, the physician should apply modifier -26 or -PC following the CPT code, or use "Q" as the type of service indicator. The list of procedures with PC/ TC splits is not always consistent with the Medicare list and use of this flag is not recommended for analysis of Medicare claims. Other flag address PC/TC issues for Medicare claims.
MFD MFD	REVIEW	**Typical Daily Frequency Exceeded** Line item may be a duplicate of one on another claim or the typical allowed daily frequency for this procedure is exceeded.
M51 M51	REVIEW	**Modifier –51 required** This flag identifies line items that do not contain a modifier –51 for multiple procedures. However, this edit works in conjunction with the N51 and NOT flag the procedure with the highest RVU – nor will this edit flag subsidiary codes that should not billed with a –51 in the first place.
MOD MOD	REVIEW	**Modifier Not Appropriate** Modifier is inappropriate with listed CPT code.
N51 N51	REVIEW	**Modifier –51 Not Allowed on Primary Procedure** This flag identifies line items where modifier –51 is appended to either the only procedure code billed on one claim or the primary procedure
NPD NPD	REVIEW	**Not a Primary Diagnosis** Diagnosis Code describes an external cause, underlying disease, or unacceptable and should never be listed as the primary diagnosis for a procedure.
PCM PCM	REVIEW	**Invalid Professional Component Modifier** Modifier –26 or PC is invalid with the procedure code billed.
PRO PRO	REVIEW	**Prolonged Service without E&M Procedure** Prolonged service procedure has been billed without a corresponding E&M procedure.

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PRS PRS	REVIEW	**Missing or Invalid Provider Specialty** Provider's specialty is missing or invalid.
PSX PSX	REVIEW	**Missing Patient Gender** The gender for this patient is either empty or an invalid.
RDL RDL	REVIEW	**Repeat Radiology** Radiology procedure code has been billed more than once for the date of service without a repeat modifier (76,77 or 59).
REB REB	REVIEW	**Re-bundle to Appropriate Procedure Code** When two or more billed Claims Manager are more appropriately reported using a single code, the lines is playing these CPT codes are flagged. In the flag description, the code to which these Claims Manager rebundle is displayed. An REB flag is set for each line of service involved in the rebundle process. This means, for example, that a single coding mistake involving rebundling of three Claims Manager into one service is reported as three REB flags. The TRA flag and the REB flag describe two steps in the rebundle process. The REB flag invalidates the line for further editing.
RNM RNM	REVIEW	**Inappropriate use of Repeat Modifier** Radiology procedure billed with a 76, 77 or 59 modifier. The same radiology code has not been billed on the same date of service.
S51 S51	REVIEW	**Subsidiary code with modifier –51** Subsidiary code was billed with a modifier 51. These codes are usually exempt from modifier 51 guidelines.
SAS SAS	REVIEW	**Typically no Surgical Assistant Required** Procedure Code typically requires no Surgical Assistant.
SUB SUB	REVIEW	**Add On Code w/o Primary Procedure** Subsidiary or Add on code was billed without the primary procedure code. *Use mSB for Medicare subsidiary codes.*
TRA TRA	REVIEW	**Transfer to Appropriate CPT** Transfers to a more appropriate CPT code when applicable. This flag works in conjunction with the REB flag.
UED UED	REVIEW	**Coding Relationship Error, Deny** This flag identifies a procedure that has an appropriate relationship with another procedure on the same claim. The line flagged identifies the procedure that would be denied if both were submitted. The UED flag invalidates the line for further editing. *Use mUN and mUO for Medicare unbundling.*
UES UES	REVIEW	**Coding Relationship Error, Secondary** This flag identifies a procedure that has an inappropriate relationship with another procedure on the same claim. The line flagged identifies the procedure that would be denied if both were submitted. In practice, this flag is identical to UED. Differences in the types of unbundling relationships between CPT codes require two flags to provide the appropriate result and flag description. The UES flag invalidates the line for further editing. *Use mUN and mUO for Medicare unbundling.*

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UID UID	REVIEW	**Incidental Procedure, Deny** This flag identifies a minor procedure that is performed during the same session as a related major procedure (for example, meatotomy performed during the same session as a cystourethroscopy with biopsy). These procedures are considered incidental and are included in the payment for the major procedure and are denied if billed separately. The UID flag invalidates the line for further editing. . *Use mUN and mUO for Medicare unbundling.*
UIS UIS	REVIEW	**Incidental Procedure, Secondary** This flag identifies a minor procedure that is performed during the same session as a related major procedure (for example, removal of a foreign body in the ear at the time of a surgical ear exploration). The foreign body removal is considered included in the payment for the major procedure and is denied if billed separately. In practice, this flag is identical to UID. Differences in the types of incidental relationships between CPT codes require two flags to provide the appropriate result and flag description. The UIS flag invalidates the line for further editing. *Use mUN and mUO for Medicare unbundling.*
UNL UNL	CAUTION	**CPT Code Unlisted** This flag identifies CPT-4 codes that are used for procedures or Claims Manager that have no CPT code that adequately describes them (for example, 94799 *Unlisted pulmonary service or procedure*). Documentation is required to describe the unlisted service.
UOE UOE	REVIEW	**Unbundled E&M Procedure** Evaluation and management (E/M) Claims Manager cannot be billed on the same day as surgical procedures, with the exception of some minor diagnostic procedures. They are considered to be included in the payment for the procedure. The exception is when the E/M service is for an unrelated condition (i.e., “a significant, separately identifiable E/M service”) or when the E/M service results in the initial decision to perform the surgery. These conditions should be identified by using modifiers -25 or -57 respectively. The list of procedures for which an E/M service can be billed on the same date is derived from two sources. For private payers, it is derived from Ingenix's Claims Edit System database. For Medicare payers, it is derived from CMS’s Correct Coding Initiative (CCI). The UOE flag invalidates the line for further editing. *Use mEM for Medicare E&M unbundling.*
UUD UUD	REVIEW	**Unbundled Procedure, Deny** This flag identifies a procedure that is considered an essential part of another procedure performed on the same date, such as intermediate repair performed with an exploratory laparotomy. The line flagged identifies the procedure that would be denied if both were submitted. The UUD flag invalidates the line for further editing. *Use mUN and mUO for Medicare unbundling.*
UUS UUS	REVIEW	**Unbundled Procedure, Secondary** This flag identifies a procedure that is considered an essential part of another procedure performed on the same date, such as introduction of needle or catheter billed with administration of chemotherapy. The line flagged identifies the procedure that would be denied if both were submitted. In practice, this flag is identical to UUD. Differences in the types of unbundling relationships between CPT codes require two flags to provide the appropriate result and flag description. The UUS flag invalidates the line for further editing. *Use mUN and mUO for Medicare unbundling.*
VEN VEN	REVIEW	**Venipuncture Not Billed** Procedure code which requires a venipuncture was billed without the corresponding venipuncture code.