Edit Flag	Edit Status	Description
ACW ACW	CAUTION	**Anesthesia Crosswalk** The surgical procedure code has been crosswalked to an anesthesia procedure code for analysis of the claim.
ANE ANE	REVIEW	**Anesthesia By Non-Anesthesiologist** A Procedure was billed by a provider not listed as an Anesthesiologist or a Nurse Anesthetist (Specialty type of 05 or 4 appropriateness.
ASD ASD	REVIEW	**Anesthesia Secondary Procedure** Only allow the anesthesia code with the highest base unit value per operative session.
BAG BAG	REVIEW	**Procedure Not Typical for Patient Sex** The gender billed on the claim does not meet the policy requirements per LCD Part A guidelines.
BAG BAG	REVIEW	**Inappropriate Age for LCD Part B** The age billed on the claim does not meet the policy requirements per LCD Part B guidelines.
BCD BCD	REVIEW	**Missing or Invalid Dx for Code to code** The diagnosis code required for the procedure to procedure relationship is either missing from the claim line or has been disabled.
BCM BCM	REVIEW	**Missing or Invalid Mod for C2C in LCD B** The modifier code required for the procedure to procedure relationship is either missing from the claim line/history line.
BCP BCP	REVIEW	**Missing or Invalid Additional Procedure** The procedure code billed requires an additional procedure to be billed per LCD Part B guidelines.
BDS BDS	REVIEW	**Missing or Invalid Date of Service** The beginning or ending Date of Service is invalid.
BFR BFR	REVIEW	**LCD Part B Typical Frequency Exceeded** The maximum allowed frequency for the procedure has been exceeded per LCD Part B guidelines.
BPO BPO	REVIEW	**Missing required LCD Place of Service** The place of service code billed on the claim does not meet the policy requirements per LCD Part B guidelines.
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.
BSX BSX	REVIEW	**Procedure Not Typical for Patient Sex** The gender billed on the claim does not meet the policy requirements per LCD Part B guidelines.
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** An injection procedure for cardiac catheterization has been billed without the primary cardiac catheterization procedure.

Edit Flag	Edit Status	Description
CCR 	REVIEW	**Cardiac Catheterization w/o Rad Supervision** An injection procedure for cardiac catheterization has been billed without the radiological supervision procedure.
CDL 	REVIEW	**Deleted Procedure Code** Procedure code has been deleted.
CPT 	REVIEW	**Missing or Invalid Procedure Code** Procedure code is invalid or missing.
CSX 	REVIEW	**Procedure Not Typical for Sex of Patient** Procedure code is not typically performed for gender of patient.
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
IAG 	REVIEW	**Diagnosis Not Typical for Patient Age** Diagnosis Code is not typical for age of this patient
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 	REVIEW	**Missing Diagnosis Code** The primary diagnosis is missing.
ICR 	Caution	**Anesthesia Crosswalk Individual Consideration** Procedure code requires crosswalking to one of several appropriate anesthesia codes before pricing. Review the documentation for correct code.
IDL 	REVIEW	**Deleted ICD9-CM Code** Diagnosis code has been deleted.
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 	REVIEW	**Inappropriate Modifier Combination** Identifies modifiers that cannot be used together on the same claim line.
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.
INJ 	REVIEW	**Injection Administration w/o Supply** Injection administration procedure has been bill without the drug or supply administered.

Edit Flag	Edit Status	Description
ISX ISX	REVIEW	**Diagnosis Not Typical for Patient's Gender** Diagnosis code is not typical for patient gender. ☒ Review ☐ Caution ☐ Off
LBI LBI	REVIEW	**Missing required LCD Part B diagnosis** None of the diagnosis billed on the claim line supports medical necessity as specified by the LCD guidelines.
LBM LBM	REVIEW	**Missing LCD Part B modifier** The modifier required for this policy is missing or disabled.
LBN LBN	REVIEW	**LCD Part B diagnosis is not in the Primary Position** A diagnosis code on the claim meets medical necessity, but the diagnosis was not billed in the primary position as specified in the LCD Part B policy.
LBP LBP	REVIEW	**Missing or invalid sequence of LCD Part B primary diagnosis** The primary diagnosis billed on the claim is not an LCD specified diagnosis code or the primary diagnosis code is missing.
LBS LBS	REVIEW	**Missing or invalid sequence of LCD Part B secondary diagnosis** The secondary diagnosis billed on the claim is not an LCD specified diagnosis code or the secondary diagnosis code is missing.
LBT LBT	REVIEW	**Missing or invalid sequence of LCD Part B tertiary diagnosis** The tertiary diagnosis billed on the claim is not an LCD specified diagnosis code or the tertiary diagnosis code is missing.
M26 M26	CAUTION	**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.
M51 M51	REVIEW	**Modifier –51 Required** This flag identifies line items that do not contain modifier –51 for multiple procedures. However, this edit works in conjunction with the N51 and will NOT flag the procedure with the highest RVU – nor will this edit flag subsidiary codes that should not be billed with a modifier –51.
mAP mAP	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.
mAS mAS	REVIEW	**Assistant Surgeon not Permitted** No payment allowed for surgical assistant.

Edit Flag	Edit Status	Description
mB2 	CAUTION	**Bilateral Payment Adjustment is not Applicable** This flag is an advisory edit that does not identify a coding error. Instead, it notifies you of procedures for which the typical payment adjustments are not applicable. The default action for this flag is Caution. This flag allows you to monitor or spot check claims to verify that appropriate Medicare payment rules are being followed. There are four possible ways in which bilateral procedures are reimbursed. Please see User's guide for details.
mBC 	REVIEW	**Bundled Code** Payment is not considered. Procedure code has no RVU's assigned.
mBI 	REVIEW	**Bundled Item or Service** This flag identifies items or Claims Manager that are covered as incident to a physician service. These items or Claims Manager are bundled into the payment for that physician service if provided on the same date and will not be separately reimbursed. An example is an elastic bandage furnished by a physician incident to a physician service such as treatment of an ankle sprain.
mCO 	REVIEW	**Co-surgeons not Permitted** Medicare has identified CPT codes for which no reimbursement may be made for co-surgeons. When one of these codes is billed with a modifier - 62, the line is flagged by this flag. This does not include those procedures for which co-surgery is reimbursed if documentation is submitted to establish medical necessity; these CPT codes are flagged with the documentation flag mD2..
mD1 	CAUTION	**Document Assistant at Surgery** Surgical assistant payment may be allowed if documentation supports medical necessity.
mD2 	CAUTION	**Document Co-surgeons** Co-surgery payment may be allowed if documentation supports medical necessity.
mD3 	CAUTION	**Document Team Surgery** Team surgery payment may be allowed if documentation supports medical necessity.
mDP 	REVIEW	**Post-op Unrelated Service by Provider** E&M procedure with a different diagnosis, without an appropriate modifier, is within the global period of another procedure performed by the same provider.
mDT 	REVIEW	**Diagnostic Test in Hospital Setting** Procedure code requires a modifier -26 when billing for the professional component in an inpatient or outpatient hospital setting.
mEM 	REVIEW	**Surgical Procedure with E&M** E&M code has been billed by the same provider on the same day or previous day as a surgical procedure. Modifier –25 or –57 is required.
mFP 	REVIEW	**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 Medicare claims. The GFP edit flags the same scenario for non-Medicare claims. The global period for this edit is defined by CMS's Physician Fee Schedule.

Edit Flag	Edit Status	Description
mGT mGT	REVIEW	**Global Test Only** Modifier –26 or –TC is not appropriate to be billed with a stand-alone diagnostic test.
mIM mIM	REVIEW	**Inappropriate Modifier** Procedure has been billed with a modifier considered irrelevant by Medicare. See User's Guide for detail
mIN mIN	REVIEW	**Injection Service** Injections service is bundled into any other Claims Manager payable under the fee schedule.
mLP mLP	REVIEW	**Laboratory Physician Interpretation** Laboratory code for which separate payment may be made. Modifier TC is not applicable.
mNS mNS	REVIEW	**Non-covered Service** Claims Manager that are not covered by Medicare and the patient may be billed.
mNV mNV	REVIEW	**Not Valid for Medicare Purposes** Procedure code is not valid for Medicare purposes, an alternate procedure code should be used.
MOD MOD	REVIEW	**Modifier Not Appropriate** Modifier is inappropriate with listed CPT code.
mOG mOG	REVIEW	**Medicare Outside Global Period** This flag indicated that the procedure code submitted with 99024 (post operative follow-up visit, included in global service) is outside the global follow-up period and a separately billable E/M code can be billed instead of 99024.
mPC mPC	REVIEW	**Professional Component Only** A stand-alone code for the professional component of a diagnostic service has been billed. Modifier –26 or –TC is not applicable.
mPI mPI	REVIEW	**Physician Interpretation code** This flag identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for a hospital inpatient. No billing of the technical component is recognized because payment for the underlying clinical laboratory test is made to the hospital.
mPS mPS	REVIEW	**Physician Service Code** Professional/technical component split does not apply to certain procedure codes. Modifier –26 or –TC is not applicable.
mPT mPT	REVIEW	**Physical Therapy Service** Physical therapy Claims Manager are not reimbursed to a physician in an inpatient or outpatient hospital setting.
mSB mSB	REVIEW	**Add on Code w/o Primary Procedure** Subsidiary or Add on code was billed without the primary procedure code.
mSP mSP	REVIEW	**Post-op Surgery by Provider** Surgical procedure Code is within the global period of another procedure performed by the same physician. It should not be billed without modifier -58 for Staged, -76 for Repeat, -78 for Complication, or -79 for Unrelated.

Edit Flag	Edit Status	Description
mTS 	REVIEW	**Team Surgeons not Permitted** No payment allowed for team surgeons.
mUN 	REVIEW	**Unbundled Code** Medicare Unbundling rules will search out in history for Comprehensive, Component, and Mutually Exclusive codes. The mUN flag will be issued when the current claim line unbundles to another line on the current claim or to a claim line in history. The mUN flag is similar to the mUH flag. However, it is raised when a component of the primary procedure is billed—either on the same claim or on a later claim for the same patient. The mUN flag invalidates the line from further editing.
mUO 	REVIEW	**Unbundled Code Modifier Override** Procedure code unbundles to another procedure code on the same claim for which an appropriate modifier override is allowed.
mUP 	REVIEW	**Unrelated Surgery by Provider** This flag identifies a procedure code that has been billed, without the appropriate modifier, during the global follow-up period of an earlier procedure, and was performed by a physician in the same department, but with a different diagnosis. The flag description indicates that modifier -79 is required. However, the system is unable to make an absolute determination of the relationship between procedures. So that the appropriate modifiers can be applied once the reviewer makes the final determination, the following modifiers have been included to suppress the mUP flag: -58, -76, -78, or -79. This flag applies to Medicare claims. The GUP edit flags the same scenario for non-Medicare claims. The global period for this flag is defined by CMS's Physician Fee Schedule
mVM 	REVIEW	**Ventilator Management** Ventilator management codes are not allowed for the same date of service as E&M Claims Manager.
mVP 	REVIEW	**Medicare Venipuncture** Procedure code which requires a venipuncture was billed without the corresponding venipuncture code.
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 the claim or to the primary procedure.
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.
PAT 	REVIEW	**Missing Patient ID** The Patient ID is blank or cannot be located. No further analysis could be performed.
PAY 	REVIEW	**Missing or Invalid Payer ID** The Payer ID is blank or cannot be located. No further analysis could be performed.
PCM 	REVIEW	**Invalid Professional Component Modifier** Modifier –26 or PC is invalid with the procedure code billed.
PRO 	REVIEW	**Prolonged Service without E&M Procedure** Prolonged service procedure has been billed without a corresponding E&M procedure.
PRS 	REVIEW	**Missing or Invalid Provider Specialty** Provider's specialty is missing or invalid.

Edit Flag	Edit Status	Description
PSX 	REVIEW	**Missing Patient Gender** The gender for this patient is either empty or an invalid.
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.
UNL 	CAUTION	**CPT Code Unlisted** Procedure code is an unlisted procedure for which there is no applicable CPT procedure code. Documentation may be required.