Sanford Health Plan regularly updates, modifies and enhances its claim system to ensure appropriate and accurate payments.

As of February 2026, we have implemented an additional claim editing system to ensure we follow current published reimbursement policies and validate correct coding guidelines as documented in CPT, HCPCS Level II, ICD-9 and ICD-10 as well as generally accepted billing guidelines. This will help provide greater focus on identifying incorrect, inappropriate or duplicative services and/or payments.

A list of edits is provided below, including a description and remark codes. Updated 1/29/2026

Tapestry Code	Description	CARC	RARC	Appealable?	Rationale
Z00101	Ineffective or Deleted CPT/HCPCS Code.	181	N/A	No	This edit indicates using an ineffective or deleted procedure code and causes the claim line to be denied.
Z00102	Invalid CPT/HCPCS Code.	181	N/A	No	This edit indicates using a procedure code that never existed and causes the claim line to be denied.
Z00103	Missing CPT/HCPCS Code.	16	M20	No	This edit indicates the CPT/HCPCS code was not billed on the claim line and causes the claim to be denied.
Z00402	Inappropriate User of Modifier - Modifier 25	4	N/A	No	This edit indicates use of Modifier 25 with a non-E/M service and causes the claim line to be denied.
Z00402	Inappropriate User of Modifier - Modifier 50	4	N/A	No	This edit indicates use of Modifier 50 with a bilateral indicator of 0, 2, or 9 and causes the claim line to be denied.
Z00402	Inappropriate User of Modifier - Modifier 59	4	N/A	No	This edit indicates services inappropriately reported with Modifiers 59, XE, XS, XU, or XP and causes the claim line to be denied.

Z00402	Inappropriate User of Modifier - Modifier 22, 76, 77	4	N/A	No	Modifiers are two digit codes that are used to clarify the service being billed. Modifier 22 indicates services that are significantly greater than usually required, but should only be appended to procedure codes with a global period of 0, 10, or 90 days, and cannot be used for Anesthesia services, Evaluation & Management services, Unlisted Codes, or DME. Modifier 76 indicates repeat services on the same day by the same qualified healthcare professional and cannot be used for Laboratory or Pathology Codes, Evaluation & Management services. Modifier 77 indicates a service was repeated by another qualified healthcare professional in a separate encounter on the same day. This edit indicates services inappropriately appended with the corresponding modifier and causes the claim line to be denied.
Z00403	Already paid in part, or for the global amount, on another claim/provider.	234	N20	No	This edit indicates services were already billed with similar anesthesia modifiers for the same date of service and causes the claim line to be denied.
Z00501	Add-on Code. Primary procedure not found.	107	N122	No	This edit indicates an add-on code was used without a primary procedure found. Since add-on codes should never be billed as stand-alone codes the claim line will likely deny.
Z00502	Not allowed separate payment with procedure {0}.	234	N20	No	This edit indicates the services billed are already included within another billed procedure and cannot be billed separately.
Z00801	E/M Service Billed One Day Prior is Included in 90 Day Global Service.	97	N525	No	This edit indicates the procedure or service being billed **one day prior** to surgery is included within the 90 day global service. If modifier 57 is appended to the service the Global Surgical Editing with be bypassed.

Z00802	E/M Service Billed on the Same Day is Included in 90 Day Global Service.	97	N525	No	This edit indicates the procedure or service being billed on the **same day** as surgery is included within the 90 day global service. If modifier 57 or 25 is appended to the service the Global Surgical Editing with be bypassed.
Z00803	E/M Service Billed on the Same Day is Included in 10 Day Global Service.	97	N525	No	This edit indicates the procedure or service being billed on the **same day** as surgery is included within the 10 day global service. If modifier 25 is appended to the service the Global Surgical Editing with be bypassed.
Z00804	E/M Service Billed on the Same Day is Included in 0 Day Global Service.	97	N525	No	This edit indicates the procedure or service being billed on the **same day** as surgery is included within the 0 day global service. If modifier 25 is appended to the service the Global Surgical Editing with be bypassed.
Z00805	E/M Service Billed During Postop Included in 90 Day Global Service.	97	N525	No	This edit indicates the procedure or service being billed **within the 90 days postoperative** of surgery is included within the 90 day global service. If modifier 24 is appended to the service the Global Surgical Editing with be bypassed.
Z00806	E/M Service Billed During Postop Included in 10 Day Global Service.	97	N525	No	This edit indicates the procedure or service being billed **within the 10 days postoperative** of surgery is included within the global service. If modifier 24 is appended to the service the Global Surgical Editing with be bypassed.
Z00807	Secondary Procedure Included in 90 Day Primary Procedure Global Service.	97	N525	No	This edit indicates a secondary procedure or service being billed **within the 90 days postoperative** of surgery is included within the 90 day global service. If modifier 58, 78, or 79 is appended to the service the Global Surgical Editing with be bypassed.

Z00808	Secondary Procedure Included in 10 Day Primary Procedure Global Service.	97	N525	No	This edit indicates a secondary procedure or service being billed **within the 10 days postoperative** of surgery is included within the global service. If modifier 58, 78, or 79 is appended to the service the Global Surgical Editing with be bypassed.
Z00901	Patient is Not New to This Provider.	B16	N/A	No	This edit indicates the patient has received services from this provider in the previous 3 years.
Z013	Other office visit ({0}) on same service date.	97	M86	No	This edit indicates the billed procedure or service by the same provider on the same day exceeds the Physician Visit Frequency.
Z021X	Rebundled with other procedure(s) into procedure {0}.	97	M15	No	This edit indicates the individual procedures could be encompassed within a single CPT code and are not to be billed separately.
Z027X	Rebundled with other procedure(s) into procedure {0}.	16	N657	No	This edit indicates the individual tests make up a panel or are components of the same procedure and are not to be billed separately.
Z041	Procedure not compatible with diagnosis.	11	N/A	Yes	This edit indicates the procedure or service is not compatible with the diagnosis.
Z04501	Unspecified Laterality Diagnosis Code.	16	N769	No	This edit indicates the diagnosis code does not indicate laterality and requires whether the condition occurs on the left, right, or bilateral.
Z04502	Incomplete diagnosis code.	16	M76	No	This edit indicates the diagnosis code was incomplete and did not include all applicable digits.
Z04503	Manifestation Dx Code Billed as Primary Diagnosis.	16	M76	No	This edit indicates the diagnosis code could be used for conditions for underlying etiology and body system manifestation and are not in the proper sequencing order of codes.
Z04504	Ineffective or Deleted Diagnosis Code.	16	M76	No	This edit indicates the diagnosis code is ineffective or deleted and is not effective for the claim line date(s) of service.
Z04505	Invalid Diagnosis Code.	16	M76	No	This edit indicates the diagnosis code is not recognized by CMS and is not valid for the claim line.

Z04506	External Cause of Morbidity Dx Code Billed as Principal Dx.	16	MA63	No	This edit indicates use of a external morbidity code listed as principal (listed first in non-inpatient settings) when the appropriate injury code should be sequenced before any external cause codes.
Z04507	Sequela Dx Code Billed as Primary Dx.	16	MA63	No	This edit indicates a sequela code sequenced before a condition or nature code when a sequela code has to be second on a professional claim.
Z04508	Sequela Dx Code Billed as Primary Dx.	16	MA63	No	This edit indicates a sequela code sequenced before a condition or nature code when a sequela code has to be second on a facility claim.
Z04509	Mutually Exclusive Excludes1 Diagnosis Codes.	16	M76	Yes	This edit indicates use of diagnosis codes that are mutually exclusive being used together.
Z04510	Inappropriate Sequencing Order for Code First Diagnosis	16	MA63	No	This edit indicates a manifestation code is sequenced before an underlying condition code on a professional claim line.
Z04511	Inappropriate Sequencing Order for Code First Diagnosis.	16	MA63	No	This edit indicates a manifestation code is sequenced before an underlying condition code on a facility claim line.
Z04512	Missing Code First Diagnosis Code.	16	MA63	No	This edit indicates a manifestation code is without a first code diagnosis on a professional claim line.
Z04513	Missing Code First Diagnosis Code.	16	MA63	No	This edit indicates a manifestation code is without a first code diagnosis on a facility claim line.
Z04514	Diagnosis Laterality Grouping (Professional & Facility)	16	M76	No	This edit indicates multiple laterality codes from the same subcategory are being used together on a professional claim.
Z04515	Diagnosis Laterality Grouping (Professional & Facility)	16	M76	No	This edit indicates multiple laterality codes from the same subcategory are being used together on a facility claim.
Z04603	Procedure inconsistent with the place of service.	5	N/A	No	This edit indicates the place of service is inappropriate for the DME item reported.
Z04701	Inappropriate Use of Modifier.	4	N/A	No	This edit indicates a telehealth modifier was used on a procedure or service that is not eligible for telehealth.
Z04702	Procedure inconsistent with the place of service.	5	N/A	No	This edit indicates a telehealth place of service was used on a non-telehealth service.

Z04704	Inappropriate or invalid Place of Service.	5	N/A	No	This edit indicates an inappropriate telehealth place of service.
Z04707	Q3014 was submitted with an inappropriate type of bill.	282	N/A	No	This edit indicates an inappropriate bill type on a telehealth originating site facility claim.
Z04708	Q3014 was Submitted with an Inappropriate Revenue Code.	199	N/A	No	This edit indicates an inappropriate revenue code on a telehealth originating site facility claim.
Z04709	Inappropriate Use of Modifier.	4	N/A	No	This edit indicates an inappropriate audio-only 93 modifier on a telehealth code.
Z04710	Inappropriate Use of Modifier.	4	N/A	No	This edit indicates an inappropriate audio-only FQ modifier on a telehealth code.
Z04901	Therapy code was received with more than 1 therapy modifier.	4	N/A	No	This edit indicates use of multiple therapy modifiers on the same claim line.
Z04902	Always or Sometimes therapy code submitted without modifiers GN, GO or GP	16	N822	No	This edit indicates billed services from a therapy assistant without GP or GO modifier on the claim line(s).
Z04903	Assistant therapy code requires additional modifier.	16	N822	No	This edit indicates billed services from a therapy assistant with a CO modifier but without GO modifier on the claim line(s).
Z04904	Always therapy code missing required modifier.	16	N822	No	This edit indicates billed services without a specified physical, occupational, or speech therapy modifier on the claim line.
Z04905	Always ST code missing required modifier.	16	N822	No	This edit indicates speech therapy code without GN modifier on the claim line.
Z04906	Always OT code missing required modifier.	16	N822	No	This edit indicates occupational therapy code without GO modifier on the claim line.
Z04907	Always PT code missing required modifier.	16	N822	No	This edit indicates physical therapy code without GP modifier on the claim line.
Z04908	Always therapy REV code with inappropriate modifier pairing.	4	N/A	No	This edit indicates billed services without the proper combination of physical, occupational, or speech therapy modifier and revenue code on the claim line.
Z04909	Always ST code with inappropriate modifier/REV code pairing.	16	N823	No	This edit indicates speech therapy codes without the proper combination modifier GN and revenue code 44x on the claim line.

Z04910	Always OT code with inappropriate modifier/REV code pairing.	16	N823	No	This edit indicates occupational therapy codes without the proper combination modifier GO and revenue code 43x on the claim line.
Z04911	Always PT code with inappropriate modifier/REV code pairing.	16	N823	No	This edit indicates physical therapy codes without the proper combination modifier GP and revenue code 42x on the claim line.
Z04912	Sometimes therapy mod and REV code pairing is missing or inappropriate.	16	N823	No	This edit indicates billed services without the proper combination of physical, occupational, or speech therapy modifier and revenue code on the claim line.
Z05202	Ineffective or Deleted Place of Service.	16	M77	No	This edit indicates an ineffective or deleted place of service on the claim line(s).
Z05203	Invalid Place of Service.	16	M77	No	This edit indicates a place of service that does not exist on the claim line(s).
Z05204	Missing Type of Bill Required on Claim.	16	MA30	No	This edit indicates the type of bill is missing on the claim.
Z05205	Ineffective or Deleted Type of Bill.	16	MA30	No	This edit indicates the type of bill is ineffective or deleted.
Z05206	Invalid Type of Bill.	16	MA30	No	This edit indicates the type of bill does not exist in the code set and is invalid.
Z05501	Inappropriate Place of Service for Emergency Department CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05502	Inappropriate Place of Service for Critical Care Transport CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05503	Inappropriate Place of Service for Critical/Intensive Care CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05504	Inappropriate Place of Service for Hospital Care CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05505	Inappropriate Place of Service for Facility Consultation CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05506	Inappropriate Place of Service for Hospital Care CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05507	Inappropriate Place of Service for Hospital Observation CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.

Z05509	Inappropriate Place of Service for Urgent Care CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05510	Inappropriate Place of Service for Home Service CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05511	Inappropriate Place of Service for Home Health CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05512	Inappropriate Place of Service for Newborn Care CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05513	Inappropriate Place of Service for Nursing Facility CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05514	Inappropriate Place of Service for Office or Other Outpatient CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05515	Inappropriate Place of Service for Outpatient Consultation CPT/HCPCS.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05517	Inappropriate Place of Service for Single Dialysis Services.	5	M77	No	This edit indicates a conflict between the CPT/HCPCS and the Place of Service code billed.
Z05701	Inappropriate CPT/HCPCS Billed with Modifier 26 for Prof Component.	4	N/A	No	This edit indicates codes with PC/TC indicators of 0, 2, 3, 4, 5, 7, or 9 and a modifier 26 on a professional claim.
Z05702	Inappropriate CPT/HCPCS Billed with Modifier TC for Tech Component.	4	N/A	No	This edit indicates codes with PC/TC indicators of 0, 2, 3, 4, 5, 6, 7, 8, or 9 and a modifier TC on a professional claim.
Z05704	Professional and/or Technical Component Billed with Global Service.	97	N/A	No	This edit indicates a provider group billed a PC/TC indicator 1 code on the same day in the same non-facility Place of Service on separate claim lines and is included in the global service.
ZR5704	Professional and/or Technical Component Billed with Global Service.	97	N/A	No	This edit indicates a provider group billed a PC/TC indicator 1 code on the same day in the same non-facility Place of Service on separate claim lines and is included in the global service. This results in the global service code claim line(s) being reduced by the allowed amount of the component code line(s).
Z05705	CPT/HCPCS Prof and Tech Component Billed and Requires Global Service.	234	N390	No	This edit indicates multiple codes billed with a PC/TC indicator 1 in the same non-facility setting on separate claim lines.

Z05706	Inappropriate Global Service Billed in a Hospital Setting.	171	M97	No	This edit indicates an inappropriate Place of Service billed with a PC/TC indicator 1 code.
Z05707	Inappropriate Technical Component Billed in a Hospital Setting.	171	M97	No	This edit indicates an inappropriate Place of Service billed with a PC/TC indicator 1 code and TC modifier.
Z05801	Drug Waste Billed Without Identical HCPCS Code.	B15	N/A	No	This edit indicates modifier JW reports the amount of drug discarded but there's no report of the amount administered.
Z05802	Drug Waste Billed and HCPCS Code for Amount Administered Not Payable.	B15	N/A	No	This edit indicates modifier JW reports the amount of drug discarded but there's no payable administered amount for the same date of service.
Z05803	Inappropriate Drug Waste Submitted for Drug or Biological.	4	N/A	No	This edit indicates modifier JW reports the amount of drug discarded but with the specific drug it is inappropriate to have waste on a professional claim.
Z05804	Inappropriate Drug Waste Submitted for Drug or Biological.	4	N/A	No	This edit indicates modifier JW reports the amount of drug discarded but with the specific drug it is inappropriate to have waste on a facility claim.
Z06201	Exact Duplicate of a Facility Claim.	18	N/A	No	This edit indicates a previous, duplicate facility claim has already been received.
Z06203	Exact Duplicate of a Facility Claim Line.	18	N/A	No	This edit indicates a previous, duplicate facility claim line has already been received.
Z06301	Exact Duplicate of a Professional Claim.	18	N/A	No	This edit indicates a previous, duplicate professional claim has already been received.
Z06303	Exact Duplicate of a Professional Claim Line.	18	N/A	No	This edit indicates a previous, duplicate professional claim line has already been received.
Z06305	Exact Duplicate of an Assistant Surgeon Professional Claim Line.	18	N/A	No	This edit indicates a previous, duplicate assistant surgeon claim has already been received.
Z06401	Units of Service Exceed Medicare DME MUE Value.	151	N362	Yes	This edit indicates the number of units billed exceeds the Medicare DME MUE Value for the claim line.
Z06402	Units of Service Exceed Medicare Practitioner MUE Value.	151	N362	Yes	This edit indicates the number of units billed exceeds the Medicare practitioner MUE Value for the claim line.

Z06403	Units of Service Exceed Medicare Outpatient Hospital MUE Value.	151	N362	Yes	This edit indicates the number of units billed exceeds the Medicare outpatient hospital MUE Value for the claim line.
Z06501	Units of Service Exceed Unit Threshold.	151	N362	Yes	This edit indicates the number of units billed exceeds the allowed units within a specific timeframe on a professional claim.
Z06502	Units of Service Exceed Unit Threshold.	151	N362	Yes	This edit indicates the number of units billed exceeds the allowed units within a specific timeframe on a facility claim.
Z07001	CPT/HCPCS Inconsistent with Patient's Age	6	N/A	No	This edit indicates the age range on the service code of a professional claim is inconsistent with the age of the patient.
Z07002	CPT/HCPCS Inconsistent with Patient's Age	6	N/A	No	This edit indicates the age range on the service code of a facility claim is inconsistent with the age of the patient.
Z07003	Diagnosis Inconsistent with Patient's Age.	9	N/A	No	This edit indicates the age range on the diagnosis code of a professional claim is inconsistent with the age of the patient.
Z07004	Diagnosis Inconsistent with Patient's Age.	9	N/A	No	This edit indicates the age range on the diagnosis code of a facility claim is inconsistent with the age of the patient.
Z07401	Billed Charges Inconsistent with Zero Units of Service.	16	M53	No	This edit indicates changes greater than $0.00 are inconsistent with zero units billed on professional claims.
Z07402	Billed Charges Inconsistent with Zero Units of Service.	16	M53	No	This edit indicates changes greater than $0.00 are inconsistent with zero units billed on facility claims.
Z07801	Inappropriate Use of Co-Surgeon Modifier.	54	N/A	No	This edit indicates a 62 modifier was used with procedure code that does not require a co-surgeon and the claim line(s) will be denied.
Z07803	Inappropriate Use of Assistant Surgeon Modifier.	54	N/A	No	This edit indicates a modifiers 80, 81,92, or AS was used with procedure code that does not require an assistant surgeon and the claim line(s) will be denied.

Z07804	Inappropriate Use of Co- or Team and Assistant Surgeon Modifiers.	4	N519	No	This edit indicates use of assistant surgeon modifiers (80, 81, 82, or AS) and 62 (co-surgeon) or 66 (team surgeon) modifiers on the **same date of service and same provider** when only modifiers 62 or 66 are appropriate.
ZR7804	Inappropriate Use of Co- or Team and Assistant Surgeon Modifiers.	4	N519	No	This edit indicates multiple claim lines using assistant surgeon modifiers (80, 81, 82, or AS) and 62 (co-surgeon) or 66 (team surgeon) modifiers on the **same date of service and same provider** when only modifiers 62 or 66 are appropriate. This results in the co- or team surgeon claim line(s) being reduced by the allowed amount of the assistant surgeon claim line(s).
Z07805	Inappropriate Use of Co- or Team and Assistant Surgeon Modifiers.	4	N823	No	This edit indicates use of assistant surgeon modifiers (80, 81, 82, or AS) and 62 (co-surgeon) or 66 (team surgeon) modifiers on the **same date of service and different provider** when only modifiers 62 or 66 are appropriate.
ZR7805	Inappropriate Use of Co- or Team and Assistant Surgeon Modifiers.	4	N823	No	This edit indicates multiple claim lines using assistant surgeon modifiers (80, 81, 82, or AS) and 62 (co-surgeon) or 66 (team surgeon) modifiers on the **same date of service and different provider** when only modifiers 62 or 66 are appropriate. This results in the co- or team surgeon claim line(s) being reduced by the allowed amount of the assistant surgeon claim line(s).
Z07806	Inappropriate Use of Co-Surgeon Modifier.	4	N519	No	This edit indicates multiple claim lines for the **same date of service and same rendering provider** without indicating a 62 or 66 modifier consistently across all the claim lines.

ZR7806	Co-Surgeon/Team Surgeon With and Without Modifiers 62 or 66 Same Provider	4	N519	No	This edit indicates multiple claim lines for the **same date of service and same rendering provider** without indicating a 62 or 66 modifier consistently across all the claim lines. This results in the co- or team surgeon claim line(s) being reduced by the allowed amount of the claim line(s) without 62 modifier, or denial of the claim line.
Z07807	Inappropriate Use of Co- or Team Surgeon Modifiers.	4	N823	No	This edit indicates multiple claim lines for the **same date of service and different rendering provider** without indicating a 62 or 66 modifier consistently across all the claim lines.
ZR7807	Inappropriate Use of Co- or Team Surgeon Modifiers.	4	N823	No	This edit indicates multiple claim lines for the **same date of service and different rendering provider** without indicating a 62 or 66 modifier consistently across all the claim lines. This results in the co- or team surgeon claim line(s) being reduced by the allowed amount of the claim line(s) without 62 modifier, or denial of the claim line.
Z07808	Inappropriate Use of Assistant Surgeon Modifier.	4	N519	No	This edit indicates multiple claim lines for the **same date of service and same rendering provider** without indicating a 80, 81, 82, or AS modifier consistently across all the claim lines.
ZR7808	Inappropriate Use of Assistant Surgeon Modifier.	4	N519	No	This edit indicates multiple claim lines for the **same date of service and same rendering provider** without indicating a 80, 81, 82, or AS modifier consistently across all the claim lines. This results in the assistant surgeon claim line(s) being reduced by the allowed amount of the claim line(s) without 80, 81, 82, or AS modifiers, or denial of the claim line.
Z07901	ASC Service Is Not Payable With Another Service On The Same Day.	236	N20	No	This edit indicates multiple PTP codes (usually for Ambulatory Surgery Centers) being reported together on the same date of service on professional claims.

ZR7901	ASC Service Is Not Payable With Another Service On The Same Day.	236	N20	No	This edit indicates multiple PTP codes (usually for Ambulatory Surgery Centers) being reported together on the same date of service on professional claims. When another claim has already been received and paid this edit results in the PTP code claim line(s) being reduced by the allowed amount of the claim line(s) already paid, or denial of the claim line.
Z07902	NCCI PTP - Medicare Practitioner Services on Professional Claims	236	N20	No	This edit indicates multiple NCCI PTP codes being reported together on the same date of service on Medicare professional claims.
ZR7902	Service Is Not Payable With Another Service On The Same Day.	236	N20	No	This edit indicates multiple NCCI PTP codes being reported together on the same date of service on Medicare professional claims. When another claim has already been received and paid this edit results in the NCCI PTP code claim line(s) being reduced by the allowed amount of the claim line(s) already paid, or denial of the claim line.
Z07903	NCCI PTP - Medicare Practitioner Services: Ambulatory Surgical Center on Facility Claims	236	N20	No	This edit indicates multiple NCCI PTP codes (usually for Ambulatory Surgery Centers) being reported together on the same date of service on Medicare facility claims.
ZR7903	ASC Service Is Not Payable With Another Service On The Same Day.	236	N20	No	This edit indicates multiple NCCI PTP codes (usually for Ambulatory Surgery Centers) being reported together on the same date of service on Medicare facility claims. When another claim has already been received and paid this edit results in the NCCI PTP code claim line(s) being reduced by the allowed amount of the claim line(s) already paid, or denial of the claim line.
Z07904	Hospital Service Is Not Payable With Another Service On The Same Day.	236	N20	No	This edit indicates multiple NCCI PTP codes (usually for hospitals) being reported together on the same date of service on Medicare facility claims.

ZR7904	Hospital Service Is Not Payable With Another Service On The Same Day.	236	N20	No	This edit indicates multiple NCCI PTP codes (usually for hospitals) being reported together on the same date of service on Medicare facility claims. When another claim has already been received and paid this edit results in the NCCI PTP code claim line(s) being reduced by the allowed amount of the claim line(s) already paid, or denial of the claim line.
Z08301	Drug Units of Service Exceed the Daily Maximum.	151	N362	Yes	This edit indicates that the maximum number of units for the HCPCS has been exceeded per industry, pharmaceutical and drug standards or literature.
Z08304	Drug Units of Service Exceed the Daily Maximum.	151	N362	Yes	This edit indicates that the maximum number of units for the HCPCS has been exceeded per industry, pharmaceutical and drug standards or literature.
Z08306	Drug Frequency of Service Limit Exceeded.	151	N640	Yes	This edit indicates that the HCPCS was billed earlier than expected per industry, pharmaceutical and drug standards or literature.
Z08307	Drug Frequency of Service Limit Exceeded.	151	N640	Yes	This edit indicates that the HCPCS was billed earlier than expected per industry, pharmaceutical and drug standards or literature.
Z08308	Administration Code Inconsistent with Drug(s) Billed.	16	N56	No	This edit indicates that the administration code is inconsistent with the drug code per CMS and CPT guidelines.
ZR8308	Administration Procedure Inconsistent with Drug(s) Billed for professional claims	16	N56	No	This edit indicates that the administration code is inconsistent with the drug code per CMS and CPT guidelines.
Z08309	Administration Code Inconsistent with Drug(s) Billed.	16	N56	No	This edit indicates that the administration code is inconsistent with the drug code per CMS and CPT guidelines.
ZR8309	Administration Code Inconsistent with Drug(s) Billed.	16	N56	No	This edit indicates that the administration code is inconsistent with the drug code per CMS and CPT guidelines.

Z08310	Administration Code Billed Without Drug.	B15	N349	No	This edit indicates that the administration code was billed without a drug code or that the drug code was not payable.
Z08311	Administration Code Billed Without Drug.	B15	N349	No	This edit indicates that the administration code was billed without a drug code or that the drug code was not payable.
Z08312	Unconventional Use of Drug.	188	N/A	Yes	This edit indicates a conflict between the drug and the diagnosis code billed per industry, regulatory, pharmaceutical, drug standards and literature.
Z08313	Unconventional Use of Drug.	188	N/A	Yes	This edit indicates a conflict between the drug and the diagnosis code billed per industry, regulatory, pharmaceutical, drug standards and literature.
Z08401	The Procedure Was Submitted With An Inappropriate Anatomical Modifier.	4	N/A	No	This edit indicates that the anatomical modifier is inappropriate to the CPT or HCPCS code billed.
Z08402	The Procedure Was Submitted With An Inappropriate Modifier.	4	N/A	No	This edit indicates that the anatomical modifier is inappropriate to the CPT or HCPCS code billed.
Z08501	Inappropriate Place of Service for Ambulance, Professional	5	M77	No	This edit indicates ambulance mileage or transportation service code billed with an inappropriate place of service on a professional claim.
Z08502	Inappropriate Type of Bill Ambulance, Facility	282	N/A	No	This edit indicates ambulance mileage or transportation service code billed with an inappropriate place of service on a facility claim.
Z08503	Inappropriate Revence Code Ambulance, Facility	199	N/A	No	This edit indicates ambulance mileage or transportation service code billed with an inappropriate revenue code on a facility claim.
Z08506	Ambulance Supplies Without Ambulance Transportation Services	234	N390	No	This edit indicates ambulance supplies are being billed without ambulance transportation services from the same provider on the same date of service on professional claims.
Z08507	Ambulance Supplies Without Ambulance Transportation Services	234	N390	No	This edit indicates ambulance supplies are being billed without ambulance transportation services from the same provider on the same date of service on facility claims.

Z08510	Ambulance Transportation Billed Without Origin and Destination Modifier	16	N822	No	This edit indicates ambulance transportation being billed without appropriate origin and destination modifiers on a professional claim.
Z08511	Ambulance Transportation Billed Without Origin and Destination Modifier	16	N822	No	This edit indicates ambulance transportation being billed without appropriate origin and destination modifiers on a Facility claim.
Z08514	Required Modifier for Ambulance Transportation Services, Facility	16	N822	No	This edit indicates ambulance transportation being billed without QM or QN vehicle modifiers on a Facility claim.
Z08515	Air Ambulance Transportation Billed With Destination Other Than Hospital or Site of Transfer	96	N157	No	This edit indicates ambulance transportation being billed when the destination is not a hospital on a professional claim.
Z08516	Air Ambulance Transportation Billed With Destination Other Than Hospital or Site of Transfer	96	N157	No	This edit indicates ambulance transportation being billed when the destination is not a hospital on a facility claim.
Z08517	Emergency Ambulance Transportation Billed With Destination Other Than Hospital or Site of Transfer	96	N157	No	This edit indicates BLS/ALS emergency ambulance transportation being billed when the destination is not a hospital on a professional claim.
Z08518	Emergency Ambulance Transportation Billed With Destination Other Than Hospital or Site of Transfer	96	N157	No	This edit indicates BLS/ALS emergency ambulance transportation being billed when the destination is not a hospital on a facility claim.
Z08519	Ambulance Mileage Billed for Wrong Ambulance Transportation Services	16	N657	No	This edit indicates ambulance milage being billed with the incorrect transportation service (ground/air) on a professional claim.
Z08520	Ambulance Mileage Billed for Wrong Ambulance Transportation Services	16	N657	No	This edit indicates ambulance milage being billed with the incorrect transportation service (ground/air) on a facility claim.
Z08521	Ambulance Mileage Billed Without Ambulance Transportation Services	16	M51	No	This edit indicates ambulance milage is being billed without ambulance transportation services on the same date of service on professional claims.
Z08522	Ambulance Mileage Billed Without Ambulance Transportation Services	16	M51	No	This edit indicates ambulance milage is being billed without ambulance transportation services on the same date of service on facility claims.

Z08523	Ambulance Transportation Services for Deceased Patients	150	N/A	No	This edit indicates ambulance transportation services above basic life support are being billed for patients who are deceased after the ambulance was called. CMS will only reimburse basic life support services with a QL Modifier on a professional claim.
Z08524	Ambulance Transportation Services for Deceased Patients	150	N/A	No	This edit indicates ambulance transportation services above basic life support are being billed for patients who are deceased after the ambulance was called. CMS will only reimburse basic life support services with a QL Modifier on a facility claim.
Z08525	Ambulance Mileage for Deceased Patients	96	N56	No	This edit indicates ambulance milage being billed for a deceased patient on a professional claim.
Z08526	Ambulance Mileage for Deceased Patients	96	N56	No	This edit indicates ambulance milage being billed for a deceased patient on a facility claim.
Z08801	Neonatal or Pediatric Critical Care Exceeds Daily Maximum Units	B14	N666	Yes	This edit indicates too many units of critical care being billed on the same date of service.
Z08802	Neonatal or Pediatric Intensive Care Exceeds Daily Maximum Units	B14	N666	Yes	This edit indicates too many units of intensive care being billed on the same date of service.
Z08901	Evaluation and Management Billed with Critical Care on Same DOS by Same Provider	234	N20	No	This edit indicates E/M codes billed the same day as Critical Care codes by the same provider in the same place of service.
ZR8901	Evaluation and Management Billed with Critical Care on Same DOS by Same Provider	234	N20	No	This edit indicates E/M codes billed the same day as Critical Care codes by the same provider in the same place of service. This results in the critical care code claim line(s) being reduced by the allowed amount of the claim line(s) E/M codes or denial of the claim line.