Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method

(Formerly the Highmark APC Based Payment Methods Manual)

Provider Training Manual
and
Change Documentation

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Payment Policy and Reimbursement Management
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Overview of the Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method

Section 1: Highmark OPPS Based Payment Method

NOTE: Medicare billing protocol applies in this methodology except where Highmark has communicated specific billing guidelines relative to benefit and coverage determinations. Listed below are a few examples:

a. ***A routine PAP smear would be billed with revenue code 311 for Medicare, but for Highmark, due to benefit coding for preventive services, this must be billed using revenue code 923.***

b. ***Condition Code 44 should not be billed to Highmark on an Outpatient claim when the Inpatient admission has been denied. Highmark allows all Outpatient services, including observation, to be billed as long as an Inpatient bill for the same patient has not been submitted.***

Highmark has adopted the Medicare Outpatient Prospective Payment System (OPPS) that is based on the Ambulatory Payment Classification (APC) system and the use of the OPPS components in Highmark APC based payment methods.

Since its inception, CMS has made, and continues to make, changes and refinements to APCs and the entire OPPS. These changes are made every calendar quarter, with the most significant changes occurring at the start of each calendar year. As required, updates to the OPPS are published in the Federal Register for public access.

The Highmark OPPS based payment method is designed to use all of the features, values, and workings of the Medicare OPPS with the exception of select customized features. The payment method includes the APC grouper and pricer, relative weights, applicable edits and quarterly updates. Prior to implementation of any updates, Highmark evaluates the appropriateness of the new or revised components for potential modification.

OPPS was designed to pay acute hospitals for most outpatient services. Hospitals must submit claims with Type of Bill (TOB) 13x or 14x using CPT or HCPCS codes for all services, supplies and pharmaceuticals. Each line on a claim should be billed with the appropriate modifier, if applicable. Each line is then evaluated for payment or non-payment using various criteria and then assigned a Status Indicator which will determine the payment mechanism to be applied [reference **Appendix 1**].

NOTE: Highmark requires that all lines MUST be reported with the applicable charge. If no charge is submitted for any line, the line will be denied for payment stating that no charges were submitted, therefore, no payment can be made.

The changes that CMS makes to APCs and OPPS occur quarterly with the most significant changes made at the start of each calendar year. Highmark's implementation for each quarterly update is based on the timeframe in which CMS releases the quarterly change notices and Highmark's receipt of such changes via the vendor software. The date of implementation will be posted in advance via the Highmark OPPS calendar on the Provider Resource Center in Navinet. This is a rolling calendar that will list the most current 8 quarters. All claims **received** on or after the date of implementation with dates of service from the beginning of the quarter will receive the new updates. In order to make these updates, Highmark reviews CMS documents for changes in medical practice, changes in technology, new services, new cost data, and other information. This is also compared to the changes that are contained within the vendor software for each quarter.

NOTE: All updates are implemented prospectively and retroactive adjustments are not applied.

Section II. Highmark Customization of OPPS

Medicare Coverage Specific Edits:

Select edits have been deemed as coverage policy edits specific to Medicare. Highmark will default price the codes that receive some of these edits (Refer to Section III). These OCE edits include but may not be limited to such items as non-covered services, codes not recognized by Medicare, inpatient services not separately payable, non covered by statutory exclusion, code not recognized by OPPS, revenue code not recognized by Medicare, etc. For a complete listing of the OCE edits that are reimbursed by Highmark, please reference Appendix 2.

Medicare Benefit Policy Edits:

Certain edits are specific to Medicare Benefit policy therefore Highmark will process these codes to allow for payment according to Highmark specific coverage and benefit policies. These edits include such services as questionable covered procedures, same day as inpatient procedure, and services provided outside of the approval period.

Inpatient Procedure Edits:

Medicare has determined that certain services for Medicare patients should only be performed in an inpatient setting due to the fact that the aged population is at a higher risk category for significant procedures. Although most of these services are appropriate only for inpatients, there may be services that can be performed for non-Medicare patients on an outpatient basis under alternative medical management and payment

policies. There is no designated OPPS payment for these types of services, therefore, Highmark will pay for these via the default pricing logic. (Refer to Section III.)

Behavioral Health:
Highmark does not pay for behavioral health services not performed in conjunction with an emergency room visit under the OPPS based payment method. Facilities which provide outpatient mental health services must bill Highmark under a distinct and separate provider number from the acute number. For example, if a partial hospitalization claim is submitted to Highmark with condition code 41, the entire claim will be denied.

Durable Medical Equipment (DME):
Under the Highmark OPPS based payment method, determinations with respect to allowable DME services will be made in accordance with the Health Plan's payment policies, product design and provider contracts. Highmark will pay for these claims using either a fee schedule or via the default pricing using the hospital specific Outpatient Ratio of Cost to Charge (ORCC) calculation if no fee exists. The fee schedule used is the same that is used by the regional carrier (DMERC).

Medically Unlikely Edits (MUE):
Under the Highmark OPPS based payment method, CMS Date of Service (Adjudication Indicators 2 and 3) and Line level (Adjudication Indicator 1) MUE edits are all applied at the line level, not at a date of service or claim level.

Section III. Claim Pricing Detail

1. **Status Indicators:**
   The line level Status Indicator is one outcome of the OCE assignment process. These indicators identify how a HCPCS code is to be paid. A payment amount (including zero payment) is then calculated for each line on the claim. A summary listing and description of the current set of Status Indicators are contained in **Appendix 1**.

2. **Customization:**
   Highmark has made certain adjustments to the pricing components of OPPS. This customization falls into two types: a) changes to payment calculations that are the result of customized edits and b) additional pricing features that are required by Highmark payment policy.

   a. **Default Pricing Logic:** In the absence of a price for a procedure under the Highmark based OPPS method, Highmark may calculate payment for the procedure by using what Highmark Health Services refers to as default

pricing. The calculation is performed by multiplying the line covered charge times the hospital specific Outpatient Ratio of Cost to Charge (ORCC).

When a significant procedure that is device dependent falls under the default pricing logic, the device that is reported utilizing revenue code 278 will also receive default pricing.

Refer to Appendix 2 for a listing of all customized edits and how they are handled by Highmark Health Services

b. Contractual Adjustments: Once all line payments have been calculated including lines that have been default priced, any and all contractual adjustments will be applied.

a. For lines that default price, the payment category percent will be applied based on the Payment Status Indicator that is assigned to the line. For example, if the Status Indicator is "A" but no Medicare fee exists, the line is default priced, the Fee Schedule Percent multiplier will be applied, not the Default Percent multiplier.

Claim Pricing Example (for illustrative purposes only):
The following represents a claim for multiple services showing the Highmark OPPS based method pricing for all service lines. The line pricing is driven by the status indicator assigned to each line.

Line 3 is an Inpatient Only procedure that Medicare does not pay, but Highmark reimburses as explained in Section II. This line is priced by multiplying the hospital specific Outpatient Ratio of Cost to Charge (ORCC) against the covered charge for the line. For this example, we are using an ORCC value of .3125.

Pricing for line 3 is calculated as follows: $680.00 x .3125 = $212.50.

All other lines price as Medicare. Two lines map to an APC, and receive the wage adjusted APC Payment amount. Line 2 receives a status indicator of **A** which designates that a fee schedule was used to price the line, and two lines receive a status indicator of **N** which designates services are packaged and no separate payment is made.

Claim Line	CPT/HCPCS		APC	Status Indicator	Charges	Payment
1	78451	Cardiac Imaging	377	S	$2,400.00	$695.70
2	84484	Lab		A	$50.00	$14.57
3	**21366**	**Inpatient Only procedure**		**C**	**$680.00**	**$212.50**
4	A9500	Radiolabeled		N	$600.00	$ 0.00
5	J3490	Drugs		N	$25.00	$ 0.00
6	93005	EKG	99	S	$259.00	$24.02
Total					$4,014.00	$946.79

Appendix 1

Ambulatory Payment Classification [APCs]
Payment Status Indicators

A – Paid on fee schedule [Fee schedule or other]	G – Pass-through drugs & biologicals [APC including pass through amount]	M – Items and services not billable to the Fiscal Intermediary [Not paid under OPPS]	R – Blood and blood products [APC]
B – Codes not recognized by OPPS [Not paid under OPPS]	H – Pass-through device categories [Cost]	N – Packaged items and services [No Pay]	S – Procedure or Service, not discounted when multiple [APC]
C – Inpatient only procedure [Not paid under OPPS]	J1 – Hospital Part B Services Paid Through a Comprehensive APC [APC]	Q1 – STV packaged codes [No Pay] or [APC]	T – Procedure or Service, multiple reduction applies [APC]
E1 - Non- Allowed Item or Service [No Pay]	J2 – Hospital Part B Services Paid Through Comprehensive Observation APC [APC]	Q2 – T packaged codes [No Pay] or [APC]	U – Brachytherapy sources [APC]
E2 - Items and Services for which pricing information and claims data are not available [No Pay]	K – Non pass-through drugs and Non-implantable biologicals, including therapeutic radiopharmaceuticals [APC]	Q3 – Codes may be paid through a composite APC [No Pay] or [APC]	V – Clinic or Emergency Department visit [APC]
F – Corneal tissue acquisition; certain CRNA services; Hepatitis B vaccines [Cost]	L – Influenza vaccine; Pneumococcal Pneumonia vaccine [Cost]	Q4 - J1, J2, S, T, V, Q1, Q2, Q3 Packaged Lab Codes [No Pay] or [Fee Schedule]	Y – Non-implantable Durable Medical Equipment [Fee]

[ ] Represents Medicare payment application; certain status indicators may be customized to align with Highmark payment policies or product benefit design

Appendix 1

Ambulatory Payment Classification [APCs]
Payment Status Indicators

Status indicators ***A*** and ***Y*** indicate that the line was paid from a fee schedule. A number of different Medicare fee schedules are used, including ambulance, laboratory, DME and others.

Status indicators ***B, C, E1, E2, M*** and ***N*** indicate that no payment was made for the line. Each indicator reflects a distinct reason such as codes not recognized by Medicare, discontinued codes, non-covered services or services that are packaged into the payment covered by another APC payment line.

Status indicators ***F, G, H, K*** and ***L*** indicate that the payment was made at a fixed payment rate. This may be an acquisition cost or an additional payment not subject to adjustment factors such as the wage index.

Status indicators **Q1**, **Q2, Q3** and **Q4** are for services that are either packaged or paid as a separate APC or Fee payment, depending on the services that are billed with them.

Status indicators ***J1, J2, S, T*** and ***V*** indicate that the line was paid according to an APC pricing calculation. The CPT/HCPCS code on the claim line is mapped to an APC code with an associated relative weight. The standard conversion factor is then multiplied by this weight and the specific wage index of the submitting hospital to yield the base APC line payment. This base payment may be further adjusted for an outlier payment.

Status indicator ***T*** indicates that payment for more than one procedure would be subject to multiple procedure discounting.

Status indicator **R** is for blood and blood products, and is paid an APC payment.

Status Indicator **U** for all brachytherapy sources is paid based on prospective payment rates.

****Please note that these are the Medicare definitions for the status indicators. Please refer to Appendix 2 and Appendix 3 for how Highmark handles the edits associated with the non-covered status indicators.**

Highmark OPPS Customized Edits			Appendix 2
OCE EDIT #	**DESCRIPTION**	**Highmark Health Services REACTION**	**COMMENT**
5	E-Code as Reason for Visit	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
6	Invalid HCPCS Procedure	Default Price	Allows for payment for HCPCS codes not recognized due to the quarterly implementation delay.
9	Non-Covered Service	Default Price	The following codes will not default price as they are non covered services by Highmark - A0888, A9270, 80050, C1890, 99429 and all Performance Measurement Codes
12	Questionable Covered Procedure	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
13	Separate Payment for Services not Provided by Medicare	Default Price	Edit deactivated to allow for line to process according to Highmark benefit and policy. This edit is for codes that are not reportable to Medicare but may be reportable to Highmark. If eligible, line will be default priced.
15	Service Unit Out of Range for Procedure	Process Claim	CMS Date of Service (Adjudication Indicators 2 and 3) and Line level (Adjudication Indicator 1) MUE edits are only applied at the line level. Highmark does not apply MUE edits with a Rationale of CMS Policy.
18	Inpatient Procedure	Default Price	
28	Code Not Recognized by Medicare, Alternate Code for Same Service may be Available	Default Price	The following codes will not default price as there are alternate codes that should be billed for these services - 80055, 80101, 90281, 90283, 90287, 90291, 90386 and 90399. The following code is non covered by Highmark - S2900. Performance Measurement Codes will not default price.
49	Same Date as Inpatient Procedure	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
50	Non-Covered by Statutory Exclusion	Default Price	The following codes will not default price as they are non covered services by Highmark - V2787 and V2788
55	Not Reportable for this Site of Service	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
60	Use of Modifier CA With More Than One Procedure is Not Allowed	Process Claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
61	Service Can Only Be Billed to the DMERC	Fee Schedule or Default Price	

Highmark OPPS Customized Edits			Appendix 2
OCE EDIT #	**DESCRIPTION**	**Highmark Health Services REACTION**	**COMMENT**
62	Code Not Recognized by OPPS; Alternate Code May Be Available	Default Price	This edit is default priced with the following exceptions: observation CPT codes 99217 - 99220 and 99234 - 99236, 99201 - 99205 and 99211 - 99215 and codes G0168, Q0081, Q0083, Q0084, 27096, 52441, 52442, 61796 - 61800, 63620, 63621, 71555, 72198, 73725, 74185, 77048, 77049, 77058, 77059, 93015, 88187, 88188, 88189, 93040, 99183, 86153, G0339, G0340, 0537T, 0538T, 0539T, 0540T
66	Code Requires Manual Pricing	Default Price	
67	Service Provided Prior to FDA Approval	Default Price	
68	Service Provided Prior to Date of National Coverage Determination	Default Price	
69	Service Provided Outside of Approval Period	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
70	CA Modifier Requires a transfer discharge status or Patient Status Code 20	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
72	Service Not Billable to Fiscal Intermediary	Default Price	Only codes 90649, 90650, 90716, 90723, 90733, 90734, 90736, 90477, 90585, 90620, 90621, 90644, 90651, 90681, 90697, 90750, 99446, 99447, 99448, 99449 will be default priced, all other codes will be denied. Refer to Appendix 3
73	Billing of Blood and Blood Products	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
79	Incorrect billing of revenue code with HCPCS Code	Process claim	Edit deactivated to allow for line to process according to Highmark benefit and policy. If eligible, line will be priced at either OPPS pricing or default pricing.
83	Service provided on or after the end date of NCD coverage	Default Price	

Highmark OPPS Line Rejection Codes and Messages

Appendix 3

OCE EDIT #	DESCRIPTION	Highmark REJECTION	TEXT	835 REMARKS CODE	835 REMARKS CODE DESCRIPTION	GROUP CODE	REASON CODE	REASON CODE DESCRIPTION
10	Service Submitted for Denial (CC 21)	R6007	Claim contains all non-covered services. Therefore, no payment can be made.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service	CO	204	This service/equipment/drug is not covered under the patient's current benefit plan
11	Services Submitted for FI/MAC Review (CC 20)	R6008	Claim contains all non-covered services. Therefore, no payment can be made.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service	CO	204	This service/equipment/drug is not covered under the patient's current benefit plan
15	Service Unit Out of Range for Procedure	CMS Date of Service (Adjudication Indicators 2 and 3) and Line level (Adjudication Indicator 1) MUE edits are only applied at the line level. Will deny R6012 if exceed line level edit. Highmark does not apply MUE edits with a Rationale of CMS Policy.	The number of services/units reported are out of range for the procedure billed. Please resubmit the claim with the correct information. Electronically enabled providers should resubmit electronically.	M53	Missing/incomplete /invalid days or units of service.	CO	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
17	Inappropriate Specification of Bilateral Procedure	R6014	There are more than one conditional bilateral services reported for the same date of service and all or some of these are reported with a modifier 50. Please resubmit the claim with the correct information. Electronically enabled providers should resubmit electronically.	N400	Electronically enabled providers should submit claims electronically.	CO	4	The procedure code is inconsistent with the modifier used or a required modifier is missing

Highmark OPPS Line Rejection Codes and Messages								Appendix 3
OCE EDIT #	**DESCRIPTION**	**Highmark REJECTION**	**TEXT**	**835 REMARKS CODE**	**835 REMARKS CODE DESCRIPTION**	**GROUP CODE**	**REASON CODE**	**REASON CODE DESCRIPTION**
20	Code 2 of Column 1/Column 2 Correct Coding Edit Not Allowed	R6017	Component of comprehensive procedure not allowed. Therefore, no payment can be made for this service.	N20	Service not payable with other service rendered on the same date.	CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
21	Medical Visit on Same Day as Procedure Without Modifier 25	R6018	Medical visit on same day as procedure without a modifier 25. Therefore, no payment can be made.	None shown		CO	4	The procedure code is inconsistent with the modifier used or a required modifier is missing
23	Invalid Date	R6020	In order to process the claim, additional information is required. Please resubmit the claim with the correct service dates. Electronically enabled providers should resubmit electronically.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
27	Only Incidental Services Reported	R6025	This service is considered to be part of another service reported on another line of this claim. Therefore, no payment can be made.	N20	Service not payable with other service rendered on the same date.	CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
29	Partial Hospitalization Service for Non-Mental Health Diagnosis	R6094	Partial Hospitalization claims are not reimbursable under this Reimbursement method.	M53	Missing/incomplete /invalid days or units of service.	CO	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

Highmark OPPS Line Rejection Codes and Messages								Appendix 3
OCE EDIT #	**DESCRIPTION**	**Highmark REJECTION**	**TEXT**	**835 REMARKS CODE**	**835 REMARKS CODE DESCRIPTION**	**GROUP CODE**	**REASON CODE**	**REASON CODE DESCRIPTION**
30	Insufficient Services on Day of Partial Hospitalization	R6094	Partial Hospitalization claims are not reimbursable under this Reimbursement method.	M53	Missing/incomplete /invalid days or units of service.	CO	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
35	Only Mental Health Education and Training Services Provided	R6033	Outpatient Hospital Psych claim where activity therapy and/or Occupational Therapy are the only services reported. Therefore, no payment can be made.	N30	Patient ineligible for this ser	CO	205	Pharmacy discount card processing fee
37	Terminated Bilateral Procedure or Terminated Procedure With Units >1	R6035	Terminated bilateral procedure (modifier 50) or terminated procedure with units greater than 1. Therefore, no payment can be made.	None shown		CO	115	Procedure postponed, canceled, or delayed.
38	Inconsistency Between Implanted Device and Implantation Procedure	R6036	Claim contains an Implanted Device, but does not have an appropriate matching Implantation Procedure Code. Please resubmit the claim with the correct information. Electronically enabled providers should resubmit electronically.	M51	Missing/incomplete/invalid procedure code(s).	CO	181	Procedure code was invalid on the date of service.
40	Code 2 of Column 1/Column 2 Correct Coding Edit, Would Be Allowed With Appropriate Modifier	R6038	Component of Comprehensive Procedure would be allowed with Appropriate Modifier. For further consideration, please resubmit the claim with the Appropriate Modifier. Electronically enabled providers should resubmit electronically.	N400	Electronically enabled providers should submit claims electronically.	CO	4	The procedure code is inconsistent with the modifier used or a required modifier is missing

Highmark OPPS Line Rejection Codes and Messages								Appendix 3
OCE EDIT #	DESCRIPTION	Highmark REJECTION	TEXT	835 REMARKS CODE	835 REMARKS CODE DESCRIPTION	GROUP CODE	REASON CODE	REASON CODE DESCRIPTION
42	Multiple Medical Visits on the Same Day, Same Revenue Code Without Condition Code GO	R6040	Multiple Medical visits are billed for the same UB-92 Revenue Code and date of service. Therefore, no payment can be made for this service.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
43	Blood Transfusion or Exchange Without Specification of Appropriate Blood Product	R6041	Blood transfusion or blood service is coded without the associated blood products. Please resubmit claim with the correct information. Electronically enabled providers should resubmit electronically.	N400	Electronically enabled providers should submit claims electronically.	CO	107	The related or qualifying claim/service was not identified on this claim.
44	Observation Room Revenue Code Without Observation HCPCS Code	R6042	Line contains an Observation Room Revenue Code but does not contain a HCPCS code indicating an appropriate Observation Room service. Please resubmit the claim with the correct information. Electronically enabled providers should resubmit electronically.	M51	Missing/incomplete/invalid procedure code(s).	CO	181	Procedure code was invalid on the date of service.
45		R6043	Inpatient separate procedure is not paid. Therefore, no payment can be made.	N20	Service not payable with other service rendered on the same date.	CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
46	Partial Hospitalization Condition Code (41) Not Appropriate for Type of Bill	R6044	A condition code 41 is coded with a Bill Type that is not appropriate for partial hospitalization services. Therefore, no payment can be made.	MA30	Missing/incomplete/invalid type of bill.	CO	5	The procedure code/bill type is inconsistent with the place of service.

Highmark OPPS Line Rejection Codes and Messages								Appendix 3
OCE EDIT #	**DESCRIPTION**	**Highmark REJECTION**	**TEXT**	**835 REMARKS CODE**	**835 REMARKS CODE DESCRIPTION**	**GROUP CODE**	**REASON CODE**	**REASON CODE DESCRIPTION**
47	Service is Not Separately Payable	R6045	This service is considered to be part of another service and is not separately payable. Therefore no payment can be made.	N20	Service not payable with other service rendered on the same date.	CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
48	Revenue Center Requires HCPCS	R6046	In order to process the claim, additional information is required. Since the Revenue Code(s) is considered to be non-packaged, a HCPCS code is required to receive payment. Please resubmit claim with the correct information. Electronically enabled providers should resubmit electronically.	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
53	Observation Service Code Only Allowed on Bill Type 13X	R6071	Observation Service Code Allowed Only on Bill Type 13x. Therefore, no payment can be made.	MA30	Missing/incomplete/invalid type of bill.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
54	Multiple Codes for the Same Site of Service	R6072	Multiple Codes for the Same Site of Service. Therefore, no payment can be made.	None shown		CO	204	This service/equipment/drug is not covered under the patient's current benefit plan
57	Observation Service E&M Criteria Not Met, Service Date 12/31 or 1/1	R6075	Observation Service E&M / Ancillary Criteria not Met, and Date is 12/31 or 1/1. Therefore, No payment can be made.	None shown		CO	204	This service/equipment/drug is not covered under the patient's current benefit plan
58	G0379 Only Allowed With Payable G0378	R6076	Appropriate HCPCS codes must be billed together for observation.	N20	Service not payable with other service rendered on the same date.	CO	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.

Highmark OPPS Line Rejection Codes and Messages								Appendix 3
OCE EDIT #	**DESCRIPTION**	**Highmark REJECTION**	**TEXT**	**835 REMARKS CODE**	**835 REMARKS CODE DESCRIPTION**	**GROUP CODE**	**REASON CODE**	**REASON CODE DESCRIPTION**
59	Clinical Trial Requires Diagnosis Code V70.7 as Other Than Primary Diagnosis	R6077	Clinical Trial requires Diagnosis Code V707 as Other than Primary Diagnosis. Please resubmit claim with the correct information. Electronically enabled providers should resubmit electronically.	N314	Missing/incomplete/invalid diagnosis date.	CO	11	The diagnosis is inconsistent with the procedure.
62	Code Not Recognized by OPPS; Alternate Code May Be Available	HCPCS codes 99217 - 99220 and 99234 - 99236, 99201 - 99205 and 99211 - 99215 and codes G0168, Q0081, Q0083, Q0084, 27096, 52441, 52442, 61796 - 61800, 63620, 63621, 71555, 72198, 73725, 74185, 77048, 77049, 77058, 77059, 88187, 88188, 88189, 93015, 93040, 99183, 86153, 99201, 99202, 99203, 99204, 99205, 00211, 99212, 99213, 99214, 99215, G0173, G0251, G0339, G0340, 0537T, 0538T, 0539T, and 0540T reject R6081	The HCPCS procedure code is not recognized by Medicare. Therefore, no payment can be made for this service.	M20	Missing/incomplete/invalid procedure code(s).	CO	181	Procedure code was invalid on the date of service.
63	Occupational Therapy Code Only Billed on Partial Hospitalization Claims	R6082	Occupational therapy services billed on non-partial hospitalization claim. Therefore, no payment can be made.	M44	Missing/incomplete/invalid condition code.	CO	5	The procedure code/bill type is inconsistent with the place of service.
64	Activity Therapy Not Payable Outside the Partial Hospitalization Program	R6083	Activity therapy services on a non-partial hospitalization claim. Therefore, no payment can be made.	N34	Incorrect claim form/format for this service.	CO	125	Submission/billing error(s). At least one Remark Code must be provided

Highmark OPPS Line Rejection Codes and Messages								Appendix 3
OCE EDIT #	**DESCRIPTION**	**Highmark REJECTION**	**TEXT**	**835 REMARKS CODE**	**835 REMARKS CODE DESCRIPTION**	**GROUP CODE**	**REASON CODE**	**REASON CODE DESCRIPTION**
65	Revenue Code Not Recognized by Medicare	R6084	Revenue Code not recognized by Medicare. Please resubmit claim with the appropriate Revenue Code. Electronically enabled providers should resubmit electronically.	M50	Missing/incomplete/invalid revenue code(s).	CO	181	Procedure code was invalid on the date of service.
72	Service Not Billable to Fiscal Intermediary (codes 90649, 90650, 90716, 90723, 90733, 90734, 90736, 90477, 90585, 90620, 90621, 90644, 90651, 90681, 90697, 90750, 99446, 99447, 99448, 99449 will be default priced, see Appendix 2)	R6091	This service is not billable in an outpatient setting. Therefore, no payment can be made.	N428	Not covered when performed in this place of service.	CO	171	Payment is denied when performed/billed by this type of provider in this type of facility.
74	Units Greater Than One for Bilateral Procedure Billed with Modifier 50	R6097	The units of service are greater than one for bilateral procedure billed with modifier 50. Please resubmit claim with correct information. Electronically enabled providers should resubmit electronically.	M53	Missing/incomplete /invalid days or units of service.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
76	Trauma Response Critical Care Without Revenue Code 068X and CPT 99291	R6099	Claims contain trauma response code G0390, but does not contain revenue code 068X and CPT code 99291. Please resubmit claim with the correct information.	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided

Highmark OPPS Line Rejection Codes and Messages — Appendix 3

OCE EDIT #	DESCRIPTION	Highmark REJECTION	TEXT	835 REMARKS CODE	835 REMARKS CODE DESCRIPTION	GROUP CODE	REASON CODE	REASON CODE DESCRIPTION
80	Mental Health Code Not Approved for Partial Hospitalization Program	R6094	Partial Hospitalization claims are not reimbursable under this Reimbursement method.	M53	Missing/incomplete /invalid days or units of service.	CO	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
81	Mental Health not payable outside the partial hospitalization program	R6094	Partial Hospitalization claims are not reimbursable under this Reimbursement method.	M53	Missing/incomplete /invalid days or units of service.	CO	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
82	Charge exceeds token charge	R6106	Charge exceeds token charge.	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
84	Claim Lacks Required Primary Code (RTP)	R6111	Claim lacks Required Primary Code (RTP). Therefore, no payment can be made.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
85	Claim Lacks Required Device Code or Required Procedure Code	R6110	Claims lacks Required Device Code or Required Procedure Code (RTP). Therefore, no payment can be made.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
86	Manifestation Code not Allowed as Principal Diagnosis	R6507	Invalid diagnosis code used as principal diagnosis code. Therefore, no payment can be made.	MA63	Missing/incomplete/invalid principal diagnosis	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
87	Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code	R6817	Skin Substitute Application Procedure Without Appropriate Skin Substitute Product Code. Please resubmit with correct information	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided

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92	Device-Dependent Procedure Code Billed Without Device Code	R6090	Claim Lacks Required Device Code. Therefore, No payment can be made.	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
93	Corneal Tissue Processing Reported without Corneal Transplant Procedure	R6828	Corneal Tissue Processing Reported Without Corneal Transplant Procedure. Pelase Resubmit Claim With Correct Information	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
94	Biosimilar HCPCS Reported without Biosimilar Modifier	R6829	Biosimilar HCPCS Reported without Biosimilar Modifier. Please Resubmit Claim With Correct Information.	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
98	Claim with pass-through device lacks required procedure.	R6110	Claim with pass-through device lacks required procedure. Please resubmit with correct information.	M20	Missing/incomplete/invalid HCPCS.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
99	Claim with Pass-Through or Non-Pass Through drug or biological lacks required procedure.	R6833	Claim with Pass-Through or Non-Pass Through device, drug or biological lacks required procedure.	M20	Missing/incomplete.invalid HCPC	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
100	Claim for HSCT Allogeneic Transplantation Lacks Required Revenue Code Line for Donor Acquisition Services.	R6834	Claim for HSCT Allogeneic Transplantation Lacks Required Revenue Code Line for Donor Acquisition Services. Please resubmit claim with correct information.	M50	Missing/incomplete/invalid revenue code(s).	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
101	Item or Service With Modifier PN Not Allowed Under PFS.	R6835	Item or Service With Modifier PN Not Allowed Under PFS	N657	This should be billed with the appropriate code for these services	CO	4	The procedure code is inconsistent with the modifier used or a required modifier is missing

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Appendix 3

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102	Modifiers PO/PN not allowed on the same line.	R6856	Modifiers PO/PN not allowed on the same line. Please resubmit claim with correct information.	N519	Invalid combination of HCPCS modifiers	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
103	Modifier reported prior to FDA approval date.	R6119	Modifier reported prior to FDA approval. Therefore, no payment can be made.	N657	This should be billed with the appropriate code for these services	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
105	Claim reported with pass-through device prior to FDA approval for the procedure	R6086	Service provided prior to FDA approval. Therefore, no payment can be made.	N657	This should be billed with the appropriate code for these services	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
109	First diagnosis present without mental health diagnosis as first secondary diagnosis	R6124	First diagnosis present without mental health diagnosis as first secondary diagnosis. Therefore, no payment can be made.	N314	Missing/incomplete/invalid diagnosis.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
110	Service provided prior to initial marketing date	R6125	Service provided prior to initial marketing date. Therefore, no payment can be made.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided
111	Service cost is duplicative; included in cost of associated biological.	R6128	Service cost is duplicative; included in cost of associated biological. Therefore, no payment can be made.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO	234	The procedure is not paid separately.

Note: Only active Medicare edits are listed. The following edits are not listed as they are handled via up-front systematic claim edits and do not reach the OPPS program: 1, 2, 3, 8, 22, 25, 26 and 41.

Review/Revision Record

Revision #	Date	Author(s)	Revision Notes
Revision	August 8/2019	Cori Rudy	3rd Quarter update - new edit added
Revision	October 10, 2019	Cori Rudy	Added explanation of how payment percent category is determined for default pricing.