Claims Edit System (CES) – Significant Facility Edits

Code ID	Explanation Code Description	Edit Detail Reason	Code ID	Explanation Code Description	Edit Detail Reason
K01	Diagnosis and Age Conflict	Patient's age doesn't match the age indicated for this diagnosis code.	K11	Term Bilat Px or Px/Units > 1	Modifier 73 was billed with an independent or conditional bilateral procedure with mod 50 or a procedure with units >1.
K02	E-Code as Reason for Visit	A code that describes an external cause can't be a primary diagnosis code for a claim.	K12	Comprehensive Proc w/ App Mod	The procedure is part of another procedure on this claim for the same date of service with no qualifying modifier.
K03	Invalid HCPCS Procedure	The procedure code submitted is not valid for the dates of service on this claim.	K13	Invalid Revenue Code	The Revenue Code submitted is not a valid Outpatient Prospective Payment System Revenue Code.
K04	Inappropriate Bilateral Procedure	The same procedure code was used 2 or more times for the same date of service.	K14	Services are not Separately Payable	The claim contains a combination of lines that are rejected or denied as packaged.
K05	Comprehensive Proc Not Allowed	This procedure is included and part of another procedure on this claim for the same date of service.	K15	Revenue Code Req HCPC Code	The claim requires a Healthcare Common Procedure Coding System (HCPCS) code.
K06	Med Visit Same Day w/o MOD 25	One or more surgical procedures occurred on the same day as an evaluation code without modifier 25.	K16	Services Prior to FDA Approval	The item, service, or procedure on this claim was performed or provided before FDA approval.
K07	Invalid HCPCS Modifier	The modifier is not a valid Outpatient Prospective Payment System modifier.	K17	Units > 1 for MOD 50 Bilat Proc	Claim indicated that the bilateral procedure was performed more than once for the same date of service.
K08	Invalid Date	The service date is incorrect or falls outside of the range of service indicated.	K18	Rebundle Into Another Code	The originally billed code was transferred or rebundled to a more appropriate code per industry standard guidelines.
K09	Invalid Age	The member's age on this claim is less than zero or greater than 124 years.	K19	Rebundle Into Another Code - History	The originally billed code was transferred or rebundled to a more appropriate code per industry standard guidelines.
K10	Only Incidental Services Reported	All line items reported on this claim are considered incidental (status indicator N) services.	K20	Principal Diagnosis Code is Missing	The principal diagnosis code is missing.

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K21	Partial Hospital Condition Code	TOB 12X or 14X is present with condition code 41.	K31	Missing Patient ID	The claim does not contain a Patient ID.
K22	Observation Service Not Allowed	Observation "G" codes (G0243, G0244) are billed on a claim with TOB not equal to 13X.	K32	Blank Provider ID	The claim did not contain a Provider ID.
K23	Invalid Condition Code	The condition code(s) on the claim are invalid.	K33	Missing or Invalid Patient Status Code	The patient discharge status is missing or invalid.
K24	Missing or Invalid Date of Birth	The claim has a missing or invalid date of birth.	K34	Point of Origin is Missing or Invalid	The point of origin is missing or invalid.
K25	Missing or Invalid from or through Date	The from (admission) and through (discharge) date are invalid.	K35	Invalid Type of Admission	This claim contains an invalid type of admission code.
K26	Missing Principle Diagnosis	A primary diagnosis is required.	K36	Invalid Value Code	This claim contains an invalid value code.
K27	Inappropriate Diagnosis Combination	Diagnosis billed identifies two conditions that cannot be billed together.	K37	Invalid Type of Bill	This claim contains an invalid type of bill.
K28	Modifier 27 Inappropriate	Modifier 27 is inappropriate as another evaluation, and management service is not found on this claim or in history.	K38	Invalid Occurrence Date Span	The occurrence span codes on the claim are not valid.
K29	Repeat Modifier Inappropriate	A repeat lab modifier is inappropriate since another lab service without a repeat lab modifier is not found.	K39	Diagnosis Not Typical for Age	The claim line being disallowed as one of the diagnosis codes is not typical for the member's age.
K30	Maximum Daily Frequency Exceeded	The sum of units, or all lines with the same procedure code, exceeds the maximum allowed for this service.	K40	Required Modifier Invalid or Missing	The required modifier is missing or the modifier is invalid for the procedure code.

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K41	Patient Discharge Status Inconsistent w/ TOB	This edit occurs when the patient discharge status code submitted is inconsistent with the type of bill frequency of 2 or 3.	K51	Add-On Procedure Without Primary Procedure	This edit occurred because the Add-on procedure code has been submitted without an appropriate primary procedure code.
K42	Discharge Date is Missing	This edit occurred because the discharge date is missing.	K52	Procedure Not Typical for Age of Patient	This edit identifies claim lines that contain a patient's age that is not typical for the procedure code.
K43	Principle Procedure Code Required	This edit occurred because a principle procedure is required when a procedure is found in the other procedure code field.	K53	ICD-9 / ICD-10 Split Claim	This edit occurs when the claim is being disallowed because the dates of service spans ICD9 and ICD10 dates of service.
K44	ICD-10 Code Billed Prior to October 2015	This edit occurred because ICD10 code types cannot be billed for date of service before September 30, 2015.	K54	New Patient Code for Established Patient	This edit identifies when the patient has received care by the same facility within the last 3 years.
K45	ICD-10 Code Billed After October 2015	This edit occurred because ICD9 code types cannot be billed for date of service greater than September 30, 2015.	K55	Unbundled Procedure - Robotic Assisted Surgery	This edit identifies when a Robotic Assisted Surgery code has been submitted and denies it.
K46	Occurrence Code is Invalid	This edit occurred because an occurrence code submitted on the claim is invalid.	K56	Inpatient Admitting Diagnosis Code is Required	This edit occurs when an inpatient claim is disallowed because the National Uniform Billing Committee, an admitting diagnosis is required.
K47	Type of Admission Invalid	This edit occurred because the type of admission 4 (newborn) cannot be billed more than once in a lifetime.	K57	Incomplete Diagnosis	This edit occurs when a claim is being disallowed because the Admitting, Principle or Other diagnosis code submitted is incomplete.
K48	Multiple Medical Visits Without Condition Code G0 (zero)	This edit occurred because multiple medical visits on the same day, same revenue code were billed without condition code G0 (zero).	K58	Invalid Procedure Code	This edit occurs when a claim is being disallowed because the Principle or Other procedure code submitted is invalid.
K49	Device Dependent Procedure Reported without Device Code	This edit occurred because a device-dependent procedure requires that a device HCPCS code be submitted on the same day.	K59	Duplicate Procedure Code	This edit occurs when a claim is being disallowed because a duplicate procedure has been submitted.
K50	Claim with Drug or Biological Lacks Payable Procedure	This edit occurred because a drug or biologic HCPC code was submitted without an associated payable procedure on the same claim.	K60	Inappropriate Age for Diagnosis	This edit occurs when a claim is being disallowed because one or more of the diagnosis codes submitted is not typical for the patients age.

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K61	Questionable Obstetric Admission	This edit occurs when a claim is being disallowed because a delivery procedure code is billed without an outcome of delivery	K65	Reason for Visit Required	This edit occurs when a claim line is being disallowed because a patient reason for visit (FL 70) diagnosis code is required.
K62	Missing or Invalid Patient Discharge Code	This edit occurs when a claim is being disallowed because the Patients Discharge Status is missing or invalid.	K66	Invalid Admitting Diagnosis	This edit identifies when an admitting diagnosis billed is considered invalid for the dates of service submitted. Code must be valid and effective based on the claim "through" date.
K63	Reason for Visit Required	This edit occurs when a claim is being disallowed because per the National Uniform Billing Committee, the patient's reason for visit is required.	K67	Manifestation Code as Principal Diagnosis	This edit identifies when a principal diagnosis code submitted is considered a Manifestation code and is not acceptable as a principal diagnosis.
K64	Critical Care Code without appropriate Revenue Code	This edit identifies when a claim is being disallowed because the procedure submitted is inconsistent with the revenue code submitted.	K68	Unacceptable Principal Diagnosis	This edit identifies when a principal diagnosis submitted is considered unacceptable as a principal diagnosis code.

If you have questions about this list, contact your Premera Provider Network Representative.