



New York Medicaid Fee-For-Service (FFS) Practitioner Administered Drugs (PADs): Top Edit Resource for Professional Claims

Important PAD Phone Numbers	
eMedNY - Claims billing and ePACES help	1-800-343-9000
Pended Claims & Medical Supplies and Procedure Code Limits	1-800-342-3005

General Resources	
New York State Medicaid General Billing Guidelines	www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Professional.pdf
General Remittance Guidelines	www.emedny.org/ProviderManuals/AllProviders/General_Remittance_Guidelines.pdf
NYRx, the Medicaid Pharmacy Program	health.ny.gov/nyrx
Medicaid Update (MU)	www.health.ny.gov/health_care/medicaid/program/update/main.htm
Practitioner Administered Drug Search Tool	www.emedny.org/info/pad
Policies and Billing Guidance for Practitioner Administered Drugs	www.health.ny.gov/health_care/medicaid/program/practitioner_administered/ffs_practitioner_administer.htm
Provider Manuals	www.emedny.org/ProviderManuals
Edit/Error Knowledge Base (EEKB) Search Tool	www.emedny.org/HIPAA/5010/edit_error
Health Insurance Portability and Accountability Act (HIPAA) Transaction Standard Companion Guide	www.emedny.org/hipaa/5010/transactions/eMedNY_Transaction_Information_CAQH-CORE_CG_X12_version_5010.pdf

Edit #	Edit Description	Claim Adjustment Reason Code (CARC)	Healthcare Claim Status Code	Remark Code	Information & How to Resolve
00172	Procedure Requires Manual Pricing	252: An attachment/ other document is required to adjudicate this claim/ service. 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)	306: Detailed description of service.	N729: Missing Patient Medical/ Dental Record for this service	<p>The use of certain procedures requires that the claim pend for Manual Pricing by the Department of Health. This edit will cause electronic claims to be denied and paper claims to pend.</p> <p>RESOLUTION: Check the Procedure Code used to ensure that it is correct. If it is correct and the claim was denied, then the claim must be re-submitted as a paper claim. If the claim is pending, wait for the result of the Manual Review. If there are errors in the Procedure Code that was sent, correct and re-submit.</p> <ul style="list-style-type: none"> • Pended, Denied, Rejected and Missing Claims Quick Reference • September 2024 Medicaid Update
00180	Units Greater Than Maximum	151: Payment adjusted because the payer deems the information submitted does not support this many / frequency of services	476: Missing or invalid units of service	N362: The number of days or units of service exceeds our acceptable maximum	<p>The number of units indicated on one or more service lines on the claim is more than the number of units allowed by the Department of Health.</p> <p>RESOLUTION: Please check the units that were submitted for each service line of the claim. If there were errors, correct and re-submit. If the billed units were medically necessary, resubmit the claim on paper and include relevant medical documentation. The paper claim will pend for manual review. Please contact the DOH Review Unit at: 1-800-342-3005, Option 3.</p>

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02087	Invalid Diagnosis / Procedure Combination	11: The diagnosis is inconsistent with the procedure	255: Diagnosis code	M51: Missing / Incomplete / Invalid Procedure Code(s)	<p>A HCPCS (Alphanumeric HCPCS or numeric CPT) procedure code that was billed on the claim is only payable with certain diagnosis codes that were not present on the claim. In some cases, the procedure must be payable with the primary diagnosis.</p> <p>RESOLUTION: If there were errors, correct and re-submit. Review coverage parameters if present.</p> <ul style="list-style-type: none"> • Provider Manuals • Policies and Billing Guidance for Practitioner Administered Drugs
02237	Acquisition cost is Greater than the Global Pre-designated Percentage of the ASP -- 340B Drugs	16: Claim/Service lacks information or has submission/billing error(s)	178: Submitted Charges	M79: Missing/ Incomplete/ Invalid Charge	<p>Medicaid payment for physician administered drugs under the '340B' program is limited to the lesser of the provider's acquisition cost by invoice, or a designated maximum fee on file for each drug. The maximum fee is equal to the 340B ceiling price. NYSDOH requires the reported acquisition cost to be within a set reasonability limit based on the ceiling price. If the acquisition cost exceeds the ceiling price, the edit will fail.</p> <p>RESOLUTION: The Acquisition Codes reported on the cost invoice must not exceed the 340B ceiling price. Verify the submitted units and modifiers present on the claim. Drugs not acquired through the 340B program should not be submitted with a 'UD' modifier.</p>

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02238	Acquisition cost is Greater than the Specific Pre-designated Percentage of the ASP -- 340B Drugs	16: Claim/ Service lacks information or has submission/ billing error(s)	178: Submitted Charges	M79: Missing/ Incomplete/ Invalid Charge	<p>Medicaid payment for physician administered drugs under the '340B' program is limited to the lesser of the provider's acquisition cost by invoice, or a designated maximum fee on file for each drug. The maximum fee is equal to the 340B ceiling price. NYSDOH requires the reported acquisition cost to be within a set reasonability limit based on the ceiling price. If the acquisition cost exceeds the ceiling price, the edit will fail.</p> <p>RESOLUTION: The Acquisition Codes reported on the cost invoice must not exceed the 340B ceiling price. Verify the submitted units and modifiers present on the claim. Drugs not acquired through the 340B program should not be submitted with the 'UD' modifier.</p> <ul style="list-style-type: none"> • 340B Drug Pricing Program
02275	Invalid Codes Submitted for 340B Pharmacy Drugs	16: Claim/ Service lacks information or has submission/ billing error(s)	216: Drug Information	N823: Incomplete/ Invalid Procedure Modifier(s)	<p>The Procedure Code modifiers used on this Practitioner Administered Drug (PAD) claim has flagged it as a 340B claim. The J-code and the NDC on the claim are not a match for a 340B claim.</p> <p>RESOLUTION: Review the procedure codes and modifiers submitted on this claim; correct and resubmit the claim if there is an error.</p> <ul style="list-style-type: none"> • 340B Drug Pricing Program
02276	Submitted Ingredient Cost Exceeds Ceiling Price	16: Claim/ Service lacks information or has submission/ billing error(s)	216: Drug Information	M79: Missing/ Incomplete/ Invalid Charge	<p>The Procedure Code modifiers used on this Practitioner Administered Drug (PAD) claim has flagged it as a 340B claim. The ingredient cost submitted for this 340B drug claim exceeds the ceiling price.</p> <p>Review the ingredient cost; correct and resubmit the claim if there is an error.</p> <p>RESOLUTION: Verify the submitted units and modifiers present on the claim. Drugs not acquired through the 340B program should not be submitted with a 'UD' modifier.</p> <ul style="list-style-type: none"> • 340B Drug Pricing Program

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02280	Procedure Code and Drug Code not Associated	16: Claim/ Service lacks information or has submission/ billing error(s)	216: Drug Information	N846: National Drug Code (NDC) Supplied Does Not Correspond to the HCPCS/ CPT Billed	The claim included a service line with a HCPCS and an NDC number that cannot be billed together. RESOLUTION: Check the NDC against the PAD Formulary Search Tool to verify NDC-HCPCS combination. <ul style="list-style-type: none"> • Practitioner Administered Drug (PAD) Search Tool
02304	Zero fill Pend Status Criteria Met	22: This care may be covered by another payer per coordination of benefits	596: Non-Covered Charge Amount	N36: Claim must meet primary payer's processing requirements before we can consider payment	The claim reported a Coordination of Benefits Total Non-covered Amount but according to information on file the services billed should have been billed first to the primary payer. RESOLUTION: Submit the charges to the primary payer. Upon receipt of a remittance advice send a Coordination of Benefits claim to NYS Medicaid. <ul style="list-style-type: none"> • Edit 02304
02365	Claim Charge is Greater Than WAC Times Percentage	16: Claim/ Service lacks information or has submission/ billing error(s)	178: Submitted Charges	M79: Missing/ Incomplete/ Invalid Charge	The claim has a procedure code modifier billed that flags this drug as a 340B drug and the claim line charge amount is greater than the Wholesale Acquisition Cost (WAC). RESOLUTION: Review the charge amount, units, procedure codes and modifiers submitted on this claim; correct and resubmit the claim if there are errors with any of these entries.

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00152	RECIPIENT FILE INDICATES MEDICARE/ NO MEDICARE PRESENT	22: This care may be covered by another payer per coordination of benefits	85: Entity Not Primary	MA04: Secondary Payment Cannot Be Considered Without the Identity of or Payment Information From the Primary Payer. The Information Was Either Not Reported or Was Illegible.	<p>Verify the patient's Medicare eligibility, ensure proper coordination of benefits, and correct the claim to reflect accurate payer information. Confirm that the claim has been billed to Medicare and a remittance advice has been received. The adjudication information from the remittance advice must be reported in the Coordination of Benefits claim to NYS Medicaid.</p> <p>Edit 00152 will fail if the Medicaid file indicates the beneficiary has Medicare, but the "Medicare Paid" amount is blank. To avoid failing Edit 00152 on electronic claim submissions, providers should enter Medicare information in either the claim level or service level segments of the 837-transaction. If Medicare has denied payment, then enter '0FILL' to indicate that a prior payer has denied the claim or has paid zero.</p> <ul style="list-style-type: none"> • eMedNY HIPAA Support

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00131	THIRD PARTY INDICATED/ OTHER INSURANCE AMT NOT SUBMITTED	22: This care may be covered by another payer per coordination of benefits	85: Entity Not Primary	MA04: Secondary Payment Cannot Be Considered Without the Identity of or Payment Information From the Primary Payer. The Information Was Either Not Reported or Was Illegible.	<p>The patient has TPL (Third Party Liability) coverage on file in the NYS Medicaid system, but the claim does not include payment information from the TPL payer. edit indicating that other insurance coverage exists, but the claim did not report the payment amount or a denial from that insurer.</p> <p>RESOLUTION:</p> <p>Confirm that the claim has been billed to the TPL payer and remittance advice has been received. The adjudication information from the remittance advice must be reported in the Coordination of Benefits claim to NYS Medicaid.</p> <p>If it is known that the TPL payer does not cover these services, NYSDOH Cost Avoidance policy permits claim submission to that payer to be bypassed. The AMT- Coordination of Benefits (COB) Total Non-covered Amount segment must be sent in the iteration of Loop 2320 for that payer. This will trigger the adjudication system process previously known as 'Zero Fill'.</p> <p>Documentation that the TPL payer does not cover the services must be kept on file.</p> <ul style="list-style-type: none"> • HIPAA Transactions Standard Companion Guide • Edit 02304: Zero Fill
02066	DRUG CODE MISSING	16: Claim/ Service lacks information or has submission/ billing error(s)	218: NDC Number	M119: Missing/ Incomplete/ Invalid/ Deactivated/ Withdrawn National Drug Code (NDC).	<p>The procedure code on the claim is for a Practitioner Administered Drug (PAD). All claims for PADs are required to be submitted with an NDC code.</p> <p>RESOLUTION:</p> <p>If the procedure code to be billed is for a Physician Administered Drug, ensure the NDC is entered.</p> <ul style="list-style-type: none"> • PAD Search Tool

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02078	DRUG SUBMITTED NOT REBATEABLE	96: Non-covered Charge(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).	218: NDC Number	N448: This Drug/ Service/ Supply is Not Included in the Fee Schedule or Contracted/ Legislated Fee Arrangement.	<p>The submitted NDC of the drug is not for a drug that has a rebate. The NDC of drugs with no rebate must not be reported.</p> <p>RESOLUTION: Check the NDC code to ensure the correct code was entered. If there are errors correct the NDC and re-submit.</p> <ul style="list-style-type: none"> • Drug Manufacturer Contacts • PAD Search Tool
00705	DUPLICATE CLAIM IN HISTORY	97: The Benefit for This Service is Included in the Payment / Allowance for Another Service / Procedure That Has Already Been Adjudicated.	54: Duplicate Of A Previously Processed Claim / Line	M86: Service Denied Because Payment Already Made for Same / Similar Procedure Within Set Time Frame.	<p>There is a claim in the paid history file for this patient and this provider for this date of service and procedure or rate code. The claim was previously paid to the provider or group, which caused the denial.</p> <p>If multiple NPIs are linked by the tax ID, the conflicting claim could be paid to one of the linked NPIs.</p> <p>RESOLUTION: Please review the current and past remittance statements. Even if a claim was paid at a zero-dollar amount, it is still considered paid in the Medicaid claim history files and a replacement (adjustment) may be necessary to correct your payment.</p> <p>Practitioner: If billing for two or more of the same services rendered on the same date, resubmit an adjustment, on paper with medical notes. Enter the procedure code on one line, with multiple units.</p> <ul style="list-style-type: none"> • Edit 00705

Edit #	Edit Description	Claim Adjustment Reason Code (CARC)	Healthcare Claim Status Code	Remark Code	Information & How to Resolve
02114	ZERO PAYMENT ON MEDICARE CROSSOVER CLAIM	23: The Impact of Prior Payer(s) Adjudication Including Payments and/ or Adjustments.	104: Processed According to Plan Provisions (Plan Refers to Provisions That Exist Between the Health Plan and the Consumer or Patient).	N/A	<p>This edit is only applied to Medicare Crossover claims. The edit will be hit when the claim has a zero payment from Medicare and the Patient Responsibility amount is zero. It is also applied when the Medicare payment was greater than the amount that Medicaid would pay as primary payer.</p> <p>RESOLUTION: This claim is not payable.</p>

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00204	PROCEDURE CODE INACTIVE ON SERVICE DATE	181: Procedure Code Was Invalid on the Date of Service	486: Principal Procedure Date.	N56: Procedure Code Billed is Not Correct / Valid for the Services Billed or the Date of Service Billed.	<p>The Procedure Code that was submitted is not valid for the Date of Service indicated.</p> <p>RESOLUTION: Resubmit bill with a Procedure Code that was available on the Date of Service.</p> <p>Consult the applicable Fee Schedule if necessary. Correct and re-submit.</p>

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02195	DENY DUE TO PRIOR PAYER ADJUDICATION	136: Failure To Follow Prior Payer's Coverage Rules	286: Other Payer's Explanation of Benefits / Payment Information.	N/A	<p>This edit is applied to Coordination of Benefits claims with data showing that a prior payer denied the claim and adjusted the balance using a Claim Adjustment Group Code and Claim Adjustment Reason Code combination that is not reimbursable per NYS Medicaid Third Party Liability rules.</p> <p>RESOLUTION: If the information send was accurate, the claim is not payable. Do not re-submit.</p> <p>Due to ongoing Health Care industry initiatives, it sometimes occurs that claims that were previously payable are denied when the codes sent in the Coordination of Benefits areas of the claim change. If you are experiencing claim denials that were paid previous to the prior payer's changing their Remittance Advice codes, or if you otherwise feel that the claim is payable, please send an email to eMedNYHIPAASupport@GDIT.com, including the 16-digit Medicaid TCN (the claim reference number from the Medicaid Remit).</p> <p>Do not include any Patient Identifiable Information or Protected Health Information in your email.</p>

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00068	CLAIM SUBMISSION DATE NOT WITHIN REQUIRED TIME LIMITS	29: The Time Limit For Filing Has Expired	718: Claim / Service Not Submitted Within the Required Timeframe (Timely Filing).	N/A	<p>The claim was submitted with a date of service that was over 90 days old on the receipt date of the claim, and there was no delay indicator on the claim.</p> <p>RESOLUTION: Check the date of service to ensure that the correct date is entered. NYSDOH requires that any claim that has passed the 90-Day timely filing requirements must include a Delay Reason Code. The NYSDOH filing requirement is 90 days. Therefore, all claims for which more than 90 days has lapsed since the Date of Service must include one of the following Delay Reason Codes in order to be considered for payment.</p> <p>Please note that Delay Reason Codes 5 and 6 are not valid per NYS Medicaid policy. Note also that Delay Reason Code 7 is only applicable for Coordination of Benefits claims.</p> <p>If the delay reason is for interrupted maternity care or an IPRO denial/reversal, it is permitted to use code 11- Other.</p> <p>New York Medicaid's policy and procedures for timely submission of claims can be found in the Provider Manuals Select the specific manual for your provider type. Select 'Information for All Providers' and click on 'General Billing'.</p> <ul style="list-style-type: none"> • Guide to Timely Billing
00218	PROVIDER NOT APPROVED FOR SERVICE	8: The Procedure Code is Inconsistent With the Provider Type/ Specialty (Taxonomy).	454: Procedure Code For Services Rendered.	N95: This Provider Type/ Provider Specialty May Not Bill This Service.	<p>The procedure indicated on the claim cannot be billed with the Category of Service assigned to the claim. The provider is not authorized to bill under the Category of Service as of the date of service.</p> <p>RESOLUTION: If the information on the claim is correct the claim is not payable. If there are errors, correct and re-submit.</p>

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00036	AMOUNT CHARGED IS MISSING OR INVALID	16: Claim/ Service lacks information or has submission/ billing error(s)	178: Submitted Charges	M79: Missing/ Incomplete/ Invalid Charge	<p>The claim included at least one service line with a zero charge. Medicaid requires a charge amount greater than zero for the type of service billed. This applies to certain claim types for which payment is calculated as a percentage of charge, and to claims that show Medicare payment on the line that has a zero charge.</p> <p>RESOLUTION: Verify the amount for the service line with the zero charge. If the charge is zero, remove the line item from the claim. If the charge for the service line is missing, update the value and then resubmit.</p>
01172	PREPAID CAPITATION RECIPIENT - SERVICE COVERED WITHIN PLAN (DENY)	24: Charges Are Covered Under a Capitation Agreement / Managed Care Plan.	97: Patient Eligibility Not Found With Entity.	N/A	<p>One of the following eligibility types results in this edit:</p> <ul style="list-style-type: none"> • The patient is in a Medicaid Managed Care Plan and the service billed is covered by the plan. • The patient is enrolled in the Health Home Program. <p>RESOLUTION: Providers can verify the information on the card by using one the Medicaid Eligibility Verification System (MEVS) methods described in this document:</p> <ul style="list-style-type: none"> • If the patient eligibility shows they are with a Managed Care Plan or the Health Home program, then the claim/s must be billed to one of those. Generally, unless the service is 'carved out', when the plan/program does not pay, neither will Medicaid. • The patient's eligibility message will notate what, if any, 'carve out' services can be billed to Medicaid. Please see the MEVS Manual for information on eligibility messaging. • If you believe the service should be carved out, contact the Managed Care office at (800) 206-8125 or email to: managedcarecomplaint@health.ny.gov for policy and general questions on managed care plans. If you know the client is in an MLTC (Managed Long Term Care) plan please call (518) 474-6065.