



County of Los Angeles
Department of Mental Health

Contract Providers Transition Project
(CPTP)

HIPAA 5010 EDI Deny Reason Cheat Sheet

Version 1.2

October 2012

DOCUMENT REVISION HISTORY

Version	Release Date	Revised by	Comments/Indicate Sections Revised
HIPAA 5010 V 1.0	04/02/2012	Karen Bollow	New 5010 EDI Deny Reason Cheat Sheet
HIPAA 5010 V 1.1	05/01/2012	Karen Bollow	Add Error Code 208 Description and Link
HIPAA 5010 V 1.2	10/01/2012	Karen Bollow	New rules for Telephone, Tele-Psychiatry and Client Address.

HIPAA 5010 EDI DENY REASON CHEAT SHEET

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.1) Validate Date Type & Value	Ensure the date string sent is consistent with the date qualifier selected. Ensure date is greater or equal to 1/1/1753
(Inb837P.Post.2) Validate Receiver	The receiver of all claims must be DMH
(Inb837P.Post.3) Validate Payer	The payer of all claims must be DMH
(Inb837P.Post.4) Duplicate Claim	Each claim from a submitter must have a unique claim id.
(Inb837P.Post.5) Validate Dependent	For DMH the subscriber is always the patient. Therefore, there will not be a dependent loop even when the subscriber is a dependent for 3rd Party Insurance. In this case, there will be a 2330A loop containing the subscriber for 3rd Party Insurance.
(Inb837P.Post.6) Validate Single Service	Ensure just one service line is in the claim
(Inb837P.Post.7) Validate Service Date	Ensure service date is a single date and is not in the future.
(Inb837P.Post.8) Validate Submitter	Ensure the submitter exists and is active on the date of service.
(Inb837P.Post.9) Validate Diagnosis	Ensure the diagnosis codes are valid and active for the service date. Also ensure there are no gaps between diagnosis values (e.g. if the third diagnosis exists, there must be a first and second diagnosis)

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.10) Validate Plan	Each claim requires a valid DMH plan that is active for the service date
(Inb837P.Post.11) Validate Unit Type	Ensure the unit type is Units ('UN').
(Inb837P.Post.12) Validate Service Time	Ensure service time is not less than zero and is a whole number (no decimals are allowed).
(Inb837P.Post.13) Validate Provider Signature Indicator	Ensure provider signature = 'Y'
(Inb837P.Post.14) Validate Provider Accepts Assignment Code	Ensure Provider Accept Assignment code = 'A'
(Inb837P.Post.15) Validate Client DMH ID	Ensure subscriber primary ID is a valid DMH ID.
(Inb837P.Post.16) Ensure Client Not Cross Referenced	Ensure client id in Subscriber Primary ID field is not cross referenced.
(Inb837P.Post.17) Validate Client Gender for Pregnancy Claims	If Pregnancy is indicated in the claim and client is not female claim will be denied. • For LP & FFS EDI claims Pregnancy is found in 2000B PAT09 Pregnancy Indicator = 'Y'
(Inb837P.Post.18) Validate Client Information	Subscriber address, City, State and Zip information and the Demographic information must be present in Claim
(Inb837P.Post.19) Validate Client Address	Ensure client Address1, City, State and Postal Code, are not empty

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.20) Validate Client Birth Against Death Date	Ensure the client's birth date is not after the death date
(Inb837P.Post.21) Validate Service Date Against Death Date	Ensure the client's death date is not before the service date
(Inb837P.Post.22) Validate Service Location Address	Ensure Service Facility, if sent, Address 1, City and State are not empty and do not contain ampersand ('&').
(Inb837P.Post.23) Validate Zip Code	Ensure the 9 digit zip code is sent for the billing and service facility address.
(Inb837P.Post.24) Validate Procedure Code	Ensure procedure code is a valid DMH value, its service type is outpatient or day treatment, and is active for the service date.
(Inb837P.Post.25) 2.1.25. Validate Minimum Procedure Service Time	Ensure the service time is not less than the minimum service time allowed for the procedure.
(Inb837P.Post.26) Validate Maximum Procedure Service Time	Ensure the service time is not greater than the maximum service time allowed for the procedure.
(Inb837P.Post.27) Validate Billing Provider	Ensure NPI value in 2010AA_NM109 is assigned to one LP or FFS billing provider. Also ensure the billing provider is active for the service date
(Inb837P.Post.28) Validate LP Billing Provider Service Rate	Ensure the LP Billing Provider has a service rate for the fiscal year of the service.
(Inb837P.Post.29) Validate Claim Type	For claims from LP providers, only allow original (1), replacement (7) or void (8) claims. For claims from FFS providers only allow original (1) claims.
(Inb837P.Post.30) Validate Provider Organization Type	Ensure the claim is not from LP Directly Operated or FFS 1 Provider
(Inb837P.Post.31) Validate Release of Information Code	For claims from LP providers, Release of Information code must be 'Y' or 'I'. For claims from FFS providers Release of Information code must be 'Y'

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.32) Validate Evidence Based Practice Code	If claim is from LP provider, ensure one to three valid EBP codes are in the claim. In addition the EBP codes cannot be duplicated. EBP codes are separated by a dash '-'
(Inb837P.Post.33) Validate Void/Replace Previous Claim	For Void and Replacement claims ensure a prior claim number is sent and ensure that it is valid.
(Inb837P.Post.34) Validate Void/Replace Previous Claim Deny Source	Ensure the Void or Replacement claim references the most recently submitted claim that was not denied by DMH business rules (i.e. RULES, DTA or CICS)
(Inb837P.Post.35) Validate Replacement Previous Claim Status	Replacement claims are only allowed if all previous claims for the service (original and replacements) are denied. Also the referenced claim cannot be a void.
(Inb837P.Post.36) Validate Replacement Procedure for DTA MHS Original Claim	Ensure a resubmitted claim has a DTA MHS procedure if the denied parent claim was also for a DTA MHS procedure.
(Inb837P.Post.37) Validate Void Service Not Voided	Services that have already been voided, cannot be voided again
(Inb837P.Post.38) Validate LP Service Location – School/Satellite	For LP claims, ensure the Satellite or School Service Location exists, is active on the service date, and is associated to the billing provider.
(Inb837P.Post.39) Validate LP Service Location Service Rate – School/Satellite	For LP claims, ensure the Satellite or School Service Location has a service rate.
(Inb837P.Post.40) Validate LP Service Location – Non School/Satellite	For LP providers, if the Satellite or School NPI is not sent, ensure a single service location can be determined. The Billing provider and service rate information (determined by using the procedure, service date and plan) is used to determine the service location.
(Inb837P.Post.41) Validate FFS Service Location	For claims from FFS provider, ensure the service location is active on the service date.
(Inb837P.Post.42) Validate Rendering Provider	Ensure the Rendering Provider NPI is assigned to one provider for the service location of the claim, the provider is active for the service date, and the provider record is complete and not retired. Given that the NPI can only be assigned to one rendering provider per service location, this validation also ensures that the rendering provider is associated to the service location of the claim and that the association is active on the

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
	service date.
(Inb837P.Post.43) Validate LP Rendering Provider Taxonomy	For LP providers, ensure the Rendering Provider's taxonomy is always sent and is a valid DMH value.
(Inb837P.Post.44) Validate FFS2 Rendering Provider Taxonomy	If the claim is from FFS 2 provider, ensure the rendering provider has one and only one taxonomy. Note the taxonomy in the claim is not used for this validation. Only the taxonomy that DMH has recorded for the rendering provider is used.
(Inb837P.Post.45) Validate FFS Pre-Authorization	If the claim is from FFS 2 provider ensure the authorization number is 11 digits (if authorization number is sent).
(Inb837P.Post.46) Validate FFS Rate Conversion	For claims from FFS 2 providers, ensure the procedure code in the claim can be converted to a valid FFS procedure code.
(Inb837P.Post.47) Validate FFS Service Quantity	For claims from FFS 2 providers, ensure the FFS service quantity is less than 999.
(Inb837P.Post.48) Validate FFS Late Claims	For claims from FFS 2 providers, ensure a late code is sent in the claim if the claim is more than 6 months late.
(Inb837P.Post.49) Validate LP Procedure Code Mode of Service	For claims from LP providers ensure the mode for the service location matches the procedure code type. <ul style="list-style-type: none"> • If Service Location is mode = 10 (day treatment), ensure procedure code type is day treatment. • If Service Location is mode = 15 (outpatient), ensure procedure code type is outpatient.
(Inb837P.Post.50) Validate LP Outpatient Service Time	For claims from LP providers if Service Location is mode = 15 (outpatient), ensure service time is greater than zero.
(Inb837P.Post.51) Validate LP Episode	Ensure there is a valid episode for claims from LP providers. NOTE: DMH allows episodes to cross admit and discharge dates. Therefore the most recently created episode will be used should more than one matching episode be found. NOTE: DMH allows multiple episodes with the same admit date, if this occurs and the procedure code requires an open episode, ensure an open episode exists. - NOTE: An example is Crisis Stabilization, where the service occurs twice in one day. For this case providers open an episode for the first service. For the second service they close the episode and then open another episode on the same day. This is done because within a same episode MHMIS does not allow Crisis Stabilization to occur more than once

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.52) Validate LP Void Minimum Match Criteria	For void claims from LP providers, ensure void claim information matches DMH specified claim information of the parent claim.
(Inb837P.Post.53) Validate LP Void Service Date	For claims from LP providers, ensure the service date of the claim being voided does not match the discharge date of its episode.
(Inb837P.Post.54) Validate LP Replacement Claim Episode	For replacement claims from LP providers, ensure the episode for the replacement claim is the same episode as its parent claim.
(Inb837P.Post.55) Validate LP Duplicate Crisis Stabilization Claim	For claims from LP providers, if the claim is for crisis stabilization, ensure a non-voided claim does not already exist with the same client, episode and service date.
(Inb837P.Post.56) Validate LP Duplicate Outpatient Claim	For claims from LP providers that do not have duplicate override specified, ensure non-voided claim does not already exist with the same client, service location, rendering provider, procedure, service date and service time.
(Inb837P.Post.57) Validate Other Payer Occurrence	If a payer other than DMH is in the claim ensure the payer only occurs a specified number of times. <ul style="list-style-type: none"> • If Medicare or Medi-Cal are payers in the claim they can only occur once. • If Private Insurance is in the claim, they can only occur up to 5 times.
(Inb837P.Post.58) Validate Jail Payers	If the Place of Service is Jail, ensure Medi-Cal and/or Medicare are not payers in the claim.
(Inb837P.Post.59) Validate FFS Medi-Cal Payer	For claims from FFS 2 providers, ensure Medi-Cal is sent as a payer in the claim
(Inb837P.Post.60) Validate FFS Rendering Provider Medi-Cal ID	For claims from FFS 2 providers, ensure the rendering provider has a Medi-Cal ID for the service location of the claim.
(Inb837P.Post.61) Validate Medi-Cal Client ID	If Medi-Cal is a payer, ensure the Client's Medi-Cal ID format is correct.

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.62) Validate Procedure Code for Medi-Cal Claims	If Medi-Cal is a payer in the claim, ensure the procedure code in the claim can be billed to Medi-Cal and can be converted to a valid Medi-Cal procedure code.
(Inb837P.Post.63) Validate Plan for Medi-Cal Claims	If Medi-Cal is a payer in the claim, ensure the plan in the claim is billable to Medi-Cal
(Inb837P.Post.64) Validate LP Service Location for Medi-Cal Claims	For claims from LP providers, if Medi-Cal is a payer in the claim, ensure the service location Medi-Cal effective dates are active for the claim service date.
(Inb837P.Post.65) Validate FFS Delay Reason Code	<p>For claims from FFS 2 Providers, if a delay reason code is sent it must be a valid DMH value as follows:</p> <ul style="list-style-type: none"> • Late code 1,3,8,9 and 11 - Late code 11 can only be sent <ul style="list-style-type: none"> - If a TAR (Prior Authorization Number) is sent in the claim - Or if the Med-Cal is a billable payer and the service date and submit date are within DMH SD II allowable date range for FFS claims. - Late code 3 can only be sent if DMH is allowing late code 3 to be sent, Medi-Cal is a payer and the client has a Medicare ID recorded with DMH.
(Inb837P.Post.66) Validate LP Delay Reason Code	<p>For claims from LP providers, if a delay reason code is sent it must be a valid DMH late code value as follows:</p> <ul style="list-style-type: none"> • Late code 1,3,7,8,9 or 11 - Late code 3 can only be sent if DMH is allowing late code 3 to be sent, Medi-Cal is a payer and the client has a Medicare ID recorded with DMH. - Late code 11 can only be sent for the following conditions: <ul style="list-style-type: none"> - Claim is a Replacement - Or claim is not billable to Medi-Cal - Or claim is Original and Med-Cal is a billable payer and the service date and submit dates are within DMH allowable date range for the provider type of the claim.
(Inb837P.Post.67) Validate 12 Months Late for Medi-Cal Billable Claims	<p>If Medi-Cal is a billable payer in the claim, ensure the service date is not more than 12 months late. Number of months is determined by using the claim service month and the month the claim is processed by DMH. For example, if a claim is Medi-Cal billable and the service date is 3/10/2011 then the claim must be submitted by 4/30/2012 (i.e. Within the service month & year + 12 months). If the claim is submitted after 4/30/2012 (i.e. May 2012 or later), the claim will be denied.</p>

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.68) Validate 6 Months Late for Medi-Cal Billable Claims	If Medi-Cal is a billable payer in the claim and the service date is more than 6 months late, ensure a delay reason code is sent. Number of months is determined by using the claim service month and the month the claim is processed by DMH. For example, if a claim service date is 3/10/2011 and is Medi-Cal billable, then the claim must be submitted by 9/30/2011 (Service Month & Year + 6 months). If the claim is submitted after 9/30/2011 (i.e. October 2011 or later), then the claim must have a late code
(Inb837P.Post.69) Validate LP Maximum Service Time for Medi-Cal Billable Claims	For claims from LP providers, if Medi-Cal is a billable payer in the claim ensure the service time does not exceed the allowable Medi-Cal maximum service time.
(Inb837P.Post.70) Validate Net Remaining for Medi-Cal Claim	For Medi-Cal billable claims ensure remaining amount to be paid is not zero or less.
(Inb837P.Post.71) Validate SD II Replacement for Medi-Cal Billable Claim	Replacement type claims are only allowed for SD II LP provider claims that are billable to Medical and previously denied by Medi-Cal. SD I claims cannot be replaced.
(Inb837P.Post.72) Allow One Replacement for LP Medi-Cal Billable Claims	For LP replacement claims where Medi-Cal is a billable payer in the claim, ensure a replacement claim has not been previously sent to Medi-Cal.
(Inb837P.Post.73) Validate Replacement Claim CIN for Medi-Cal Billable Claims	For LP replacement claims where Medi-Cal is a billable payer in the claim and a claim has been previously sent to Medi-Cal, ensure the client's Medi-Cal ID in the claim matches the Medi-Cal Client ID sent in the previous claim to Medi-Cal.
(Inb837P.Post.74) Validate Other Payer Adjudication Date	If Medicare or Private Insurance are payers in the claim, the adjudication date for the payer must be sent. The adjudication date must be on or after the service date and must be before or equal to the date that DMH processes the claim. If Medi-Cal is a payer in the claim an adjudication date cannot be sent.
(Inb837P.Post.75) Validate Medicare and Private Insurance Paid Amount	If Medicare or Private Insurance are payers in the claim, the payer paid amount value must be sent.
(Inb837P.Post.76) Validate Medicare Insurance Type Code	If Medicare and Other Insurance are payers in the claim ensure value Medicare Insurance Type code is sent. If Medicare is a payer, but Other Insurance is not, ensure Medicare Insurance Type code is not sent For Medi-Cal and Other Insurance ensure the Insurance Type code is not sent

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.77) Validate Claim Benefits Assignment Certification Indicator	Ensure a valid value for Benefits Assignment Certification Indicator is sent for the claim.
(Inb837P.Post.78) Validate Other Payer Benefits Assignment Certification Indicator	For each other payer sent in the claim ensure a valid value for Benefits Assignment Certification Indicator is sent.
(Inb837P.Post.79) Validate FFS Other Payer Release of Information Code	For each other payer sent in the claim ensure a valid value for Benefits Assignment Certification Indicator is sent.
(Inb837P.Post.80) Validate Payer Responsibility	For DMH and each other payer sent in the claim ensure a valid payer responsibility is sent
(Inb837P.Post.81) Validate Adjustment Group is Not Repeated	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Group Codes are not repeated across multiple claim level CAS segments.
(Inb837P.Post.82) Validate Adjustment Group Code is Active	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Group Codes are active for the payer's payment date.
(Inb837P.Post.83) Validate Adjustment Reason Code is Active	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Reason Codes are active for the payer's payment date.
(Inb837P.Post.84) Validate Adjustment Amount Format	For LP Contract original and replacement claims, ensure Medicare and Private Insurance adjustment amount is a monetary value.
(Inb837P.Post.85) Validate Adjustment Amount Exists	For LP Contract original and replacement claims, ensure Medicare and Private Insurance ensure every Adjustment Reason has an Adjustment Amount.
(Inb837P.Post.86) Validate Adjustment Amount Quantity	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Quantity is an integer with maximum of 2 decimals.

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.87) Validate Adjustment Reason Gaps	For LP Contract original and replacement claims, ensure each Medicare and Private Insurance Adjustment group has no gaps between each of its Adjustment Reasons. For example if Adjustment Reason 4 exists, Adjustment Reason 1, 2 and 3 must also exist.
(Inb837P.Post.88) Ensure Medi-Cal Adjustments Do Not Exist	For LP Contract original and replacement claims, ensure there is no Adjustment information for Medi-Cal.
(Inb837P.Post.89) Ensure COB Information Balances	For LP Contract original and replacement claims, ensure Medicare and Private Insurance COB payments and adjustment balance to the Claim Amount. For each payer the calculation is Claim Amount = Payer's Payment Amount + Sum of Payer's Adjustment Amounts.
(Inb837P.Post.90) Validate Medicare and Private Insurance Remaining Patient Liability Amount	If Medicare or Private Insurance are payers in the claim, remaining patient liability amount value must be sent.
(Error Code 208) NPI Errors	To correct claims that were denied due to error code 208, you must first correct the Rendering Provider's NPI in the IS. This NPI may be corrected by submitting an electronic Rendering Provider update. A copy of the Rendering Provider update should also be e-mailed to the Compliance Program and Audit Services Bureau at the following address: NPIVRPF@dmh.lacounty.gov
(Inb837P.Post.91) Validate LP Telephone and Tele-Psychiatry Modifier	For LP Contract original and replacement claims, do not allow both Telephone ('SC') and Tele-Psychiatry ('GT') modifiers in the claim.
(Inb837P.Post.92) Validate LP Telephone Procedure Code	For LP Contract original and replacement claims, if the Telephone ('SC') modifier is in the claim ensure the procedure code can be performed via Telephone.

HIPAA 5010 INBOUND 837 PROFESSIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837P.Post.93) Validate DMH Client Address	<p>For original and replacement claims, if Medi-Cal is a billable payer in the claim ensure the DMH client address is valid. Valid address must meet all of the following criteria:</p> <ul style="list-style-type: none"> • Client Address 1 is not empty and contains valid DMH characters, • If Client Address 2 is not empty, it contains valid DMH characters • Client City has at least 2 characters and contains valid DMH characters • Client State is not empty is contains only 2 alphabetic values • Client Zip is 5 or 9 digits <p>NOTE: DMH valid characters are limited to the following:</p> <ul style="list-style-type: none"> • A thru Z (upper & lowercase) • 0 thru 9 • ! • (•) • + • , (comma) • . (period) • ? • = • (space) • - (hyphen) • /

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.1) Validate Date Type & Value	Ensure the date string sent is consistent with the date qualifier selected. Ensure date is greater or equal to 1/1/1753
(Inb837I.Post.2) Validate Receiver	The receiver of all claims must be DMH.
(Inb837I.Post.3) Validate Payer	The payer of all claims must be DMH
(Inb837I.Post.4) Check Duplicate Claim	Each claim from a submitter must have a unique claim id.
(Inb837I.Post.5) Validate Dependent	For DMH the subscriber is always the patient. Therefore, there will not be a dependent loop even when the subscriber is a dependent for 3rd Party Insurance. In this case, there will be a 2330A loop containing the subscriber for 3rd Party Insurance.
(Inb837I.Post.6) Validate Single Service	Ensure just one service line is in the claim
(Inb837I.Post.7) Validate Admit Date	Ensure Admit Date is sent in the claim.
(Inb837I.Post.8) Validate Service Date	Ensure service date is in a valid from-to date range format and is not in the future. <ul style="list-style-type: none"> • Service From Date portion must be equal or before the To Date portion • Service From and To date must be within the same year and month • Admit Date cannot be after service dates Also ensure the number of units matches the number of days for the service date range
(Inb837I.Post.9) Validate Submitter	Ensure the submitter exists and is active on the date of service.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.10) Validate Diagnosis	Ensure the primary diagnosis is valid and active for the service date.
(Inb837I.Post.11) Validate Plan	Each claim requires a valid DMH plan that is active for the service date
(Inb837I.Post.12) Validate Provider Accept Assignment code	Ensure Provider Accept Assignment code = 'A'
(Inb837I.Post.13) Validate Client DMH ID	Ensure subscriber primary ID is a valid DMH ID.
(Inb837I.Post.14) Validate Client is Not Cross Referenced	Ensure client id in Subscriber Primary ID field is not cross referenced.
(Inb837I.Post.15) Validate Client Gender for Pregnancy Claims	If Pregnancy is indicated in the claim and client is not female claim will be denied.
(Inb837I.Post.16) Validate Client Information	Subscriber address, City, State and Zip information and the Demographic information must be present in Claim
(Inb837I.Post.17) Validate Service Location Address	Ensure Service Facility, if sent, Address 1, City and State are not empty and do not contain ampersand ('&').
(Inb837I.Post.18) Validate Facility Code	Ensure a valid DMH facility code value is sent.
(Inb837I.Post.19) Validate Type of Admission	Ensure a valid DMH type of admission code value is sent.
(Inb837I.Post.20) Validate Point of Origin for Admission	Ensure a valid DMH point of origin for admission value is sent.
(Inb837I.Post.21) Validate Patient Status Code	Ensure a valid DMH patient status code value is sent.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.22) Validate Zip Code	Ensure the 9 digit zip code is sent for the billing and service facility address.
(Inb837I.Post.23) Validate Procedure Code	Ensure procedure code is a valid DMH value, its service type is inpatient, and is active for the service date.
(Inb837I.Post.24) Validate Service Unit Type	Ensure the unit type matches the appropriate unit type for the procedure
(Inb837I.Post.25) Validate Minimum Procedure Service Time	Ensure the service time is not less than the minimum service time allowed for the procedure.
(Inb837I.Post.26) Validate Maximum Procedure Service Time	Ensure the service time is not greater than the maximum service time allowed for the procedure.
(Inb837I.Post.27) Validate Billing Provider	Ensure NPI value in 2010AA_NM109 is assigned to one LP billing provider. Also ensure the billing provider is active for the service date
(Inb837I.Post.28) Validate LP Billing Provider Service Rate	Ensure the LP Billing Provider has a service rate for the fiscal year of the service
(Inb837I.Post.29) Validate Claim Type	For claims from LP providers, only allow original (1), replacement (7) or void (8) claims.
(Inb837I.Post.30) Validate Provider Organization Type	Ensure the claim is from LP Contract provider only
(Inb837I.Post.31) Validate Client Address	Ensure client Address1, City, State and Postal Code, are not empty and do not contain ampersand ('&').
(Inb837I.Post.32) Validate Evidence Based Practice Code	If claim is from LP provider, ensure one to three valid EBP codes are in the claim. In addition the EBP codes cannot be duplicated. EBP codes are separated by a dash '-'
(Inb837I.Post.33) Validate Void/Replace Previous Claim	For Void and Replacement claims ensure a prior claim number is sent and ensure that it is valid.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.34) Validate Void/Replace Previous Claim Deny Source	Ensure the Void or Replacement claim references the most recently submitted claim that was not denied by DMH business rules (i.e. RULES, DTA or CICS)
(Inb837I.Post.35) Validate Replacement Previous Claim Status	Replacement claims are only allowed if all previous claims for the service (original and replacements) are denied. Also the referenced claim cannot be a void.
(Inb837I.Post.36) Validate Void Service Not Voided	Services that have already been voided, cannot be voided again
(Inb837I.Post.37) Validate LP Service Location – School/Satellite	For LP claims, ensure the Satellite or School Service Location exists, is active on the service date, and is associated to the billing provider.
(Inb837I.Post.38) Validate LP Service Location Service Rate – School/Satellite	For LP claims, ensure the Satellite or School Service Location has a service rate.
(Inb837I.Post.39) Validate LP Service Location – Non School/Satellite	For LP providers, if the Satellite or School NPI is not sent, ensure a single service location can be determined. The Billing provider and service rate information (determined by using the procedure, service date and plan) are used to determine the service location.
(Inb837I.Post.40) Validate Attending Provider	Ensure the Attending Provider NPI is assigned to one LP provider for the service location of the claim, the provider is active for the service date, and the provider record is complete and not retired. Given that the NPI can only be for one LP provider in the service location, this validation also ensures that the rendering provider is associated to the service location of the claim and that the association is active on the service date.
(Inb837I.Post.41) Validate LP Rendering Provider Taxonomy	For LP providers, ensure the Rendering Provider's taxonomy is always sent and is a valid DMH value.
(Inb837I.Post.42) Validate LP Procedure Code Mode of Service	For claims from LP providers ensure the mode for the service location matches the procedure code type. • If Service Location is mode = 05 (inpatient), ensure procedure code type is inpatient.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.43) Validate LP Episode	<p>Ensure there is a valid episode for claims from LP providers. NOTE: DMH allows episodes to cross admit and discharge dates. Therefore the most recently created episode will be used should more than one matching episode be found. NOTE: DMH allows multiple episodes with the same admit date, if this occurs and the procedure code requires an open episode, ensure an open episode exists. - NOTE: An example is Crisis Stabilization, where the service occurs twice in one day. For this case providers open an episode for the first service. For the second service they close the episode and then open another episode on the same day. This is done because within a same episode MHMIS does not allow Crisis Stabilization to occur more than once</p>
(Inb837I.Post.44) Validate Overlapping Service Date	Ensure there is not another non-voided claim that has not been denied by DMH business rules with overlapping service dates for the same client and service location.
(Inb837I.Post.45) Validate LP Void Minimum Match Criteria	For void claims from LP providers, ensure void claim information matches DMH specified claim information of the parent claim.
(Inb837I.Post.46) Validate LP Void Service Date	For claims from LP providers, ensure the service end date of the claim being voided does not match the discharge date of its episode.
(Inb837I.Post.47) Validate LP Replacement Claim Service Date & Episode	For replacement claims from LP providers, ensure the service date and episode are the same as the parent claim
(Inb837I.Post.48) Validate Other Payer Occurrence	<p>If a payer other than DMH is in the claim ensure the payer only occurs a specified number of times.</p> <ul style="list-style-type: none"> • If Medicare or Medi-Cal are payers in the claim they can only occur once. • If Private Insurance is in the claim, they can only occur up to 5 times.
(Inb837I.Post.49) Validate Medi-Cal Client ID	If Medi-Cal is a payer, ensure the Client's Medi-Cal ID format is correct.
(Inb837I.Post.50) Validate Procedure Code for Medi-Cal Claims	If Medi-Cal is a payer in the claim, ensure the procedure code in the claim can be converted to a valid Medi-Cal procedure code.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837i.Post.51) Validate Plan for Medi-Cal Claims	If Medi-Cal is a payer in the claim, ensure the plan in the claim is billable to Medi-Cal
(Inb837I.Post.52) Validate LP Service Location for Medi-Cal Claims	For claims from LP providers, if Medi-Cal is a payer in the claim, ensure the service location Medi-Cal effective dates are active for the claim service date.
(Inb837I.Post.53) Validate LP Delay Reason Code	<p>For claims from LP providers, if a delay reason code is sent it must be a valid DMH late code value as follows:</p> <ul style="list-style-type: none"> • Late code 1,3,7,8,9 or 11 - Late code 3 can only be sent if DMH is allowing late code 3 to be sent, Medi-Cal is a payer and the client has a Medicare ID recorded with DMH. - Late code 11 can only be sent for the following conditions: <ul style="list-style-type: none"> - Claim is a Replacement - Or claim is not billable to Medi-Cal - Or claim is Original and Med-Cal is a billable payer and the service date and submit dates are within DMH allowable date range for the provider type of the claim.
(Inb837I.Post.54) Validate 12 Months Late for Medi-Cal Billable Claims	<p>If Medi-Cal is a billable payer in the claim, ensure the service date is not more than 12 months late.</p> <p>Number of months is determined by using the claim service month and the month the claim is processed by DMH. For example, if a claim is Medi-Cal billable and the service date is 3/10/2011 then the claim must be submitted by 4/30/2012 (i.e. Within the service month & year + 12 months). If the claim is submitted after 4/30/2012 (i.e. May 2012 or later), the claim will be denied.</p>
(Inb837I.Post.55) Validate 6 Months Late for Medi-Cal Billable Claims	<p>If Medi-Cal is a billable payer in the claim and the service date is more than 6 months late, ensure a delay reason code is sent.</p> <p>Number of months is determined by using the claim service month and the month the claim is processed by DMH. For example, if a claim service date is 3/10/2011 and is Medi-Cal billable, then the claim must be submitted by 9/30/2011 (Service Month & Year + 6 months). If the claim is submitted after 9/30/2011 (i.e. October 2011 or later), then the claim must have a late code</p>
(Inb837I.Post.56) Validate LP Maximum Service Time for Medi-Cal Billable Claims	For claims from LP providers, if Medi-Cal is a billable payer in the claim ensure the service time does not exceed the allowable Medi-Cal maximum service time.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.57) Validate Net Remaining for Medi-Cal Claim	For Medi-Cal billable claims ensure remaining amount to be paid is not zero or less.
(Inb837I.Post.58) Validate SD II Replacement for Medi-Cal Billable Claim	Replacement type claims are only allowed for SD II LP provider claims that are billable to Medical and previously denied by Medi-Cal. SD I claims cannot be replaced.
(Inb837I.Post.59) Allow One Replacement for LP Medi-Cal Billable Claims	For LP replacement claims where Medi-Cal is a billable payer in the claim, ensure a replacement claim has not been previously sent to Medi-Cal.
(Inb837I.Post.60) Validate Replacement Claim CIN for Medi-Cal Billable Claims	For LP replacement claims where Medi-Cal is a billable payer in the claim and a claim has been previously sent to Medi-Cal, ensure the client's Medi-Cal ID in the claim matches the Medi-Cal Client ID sent in the previous claim to Medi-Cal.
(Inb837I.Post.61) Validate Other Payer Adjudication Date	If Medicare or Private Insurance are payers in the claim, the adjudication date for the payer must be sent. The adjudication date must be on or after the service date and must be before or equal to the date that DMH processes the claim. If Medi-Cal is a payer in the claim an adjudication date cannot be sent
(Inb837I.Post.62) Validate Medicare and Private Insurance Paid Amount	If Medicare or Private Insurance are payers in the claim, the payer paid amount value must be sent.
(Inb837I.Post.63) Validate Claim Benefits Assignment Certification Indicator	Ensure a valid value for Benefits Assignment Certification Indicator is sent for the claim.
(Inb837I.Post.64) Validate Other Payer Benefits Assignment Certification Indicator	For each other payer sent in the claim ensure a valid value for Benefits Assignment Certification Indicator is sent.
(Inb837I.Post.65) Validate Payer Responsibility	For DMH and each other payer sent in the claim ensure a valid payer responsibility is sent
(Inb837I.Post.66) Validate Residential Medi-Cal Place of Service	For residential claims that are billable to Medi-Cal, ensure the corresponding Medi-Cal procedure code has a place of service specified.
(Inb837I.Post.67) Validate Adjustment Group is Not Repeated	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Group Codes are not repeated across multiple claim level CAS segments.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Inb837I.Post.68) Validate Adjustment Group Code is Active	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Group Codes are active for the payer's payment date.
(Inb837I.Post.69) Validate Adjustment Reason Code is Active	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Reason Codes are active for the payer's payment date.
(Inb837I.Post.70) Validate Adjustment Amount Format	For LP Contract original and replacement claims, ensure Medicare and Private Insurance adjustment amount is a monetary value
(Inb837I.Post.71) Validate Adjustment Amount Exists	For LP Contract original and replacement claims, ensure Medicare and Private Insurance ensure every Adjustment Reason has an Adjustment Amount.
(Inb837I.Post.72) Validate Adjustment Amount Quantity	For LP Contract original and replacement claims, ensure Medicare and Private Insurance Adjustment Quantity is an integer with maximum of 2 decimals.
(Inb837I.Post.73) Validate Adjustment Reason Gaps	For LP Contract original and replacement claims, ensure each Medicare and Private Insurance Adjustment group has no gaps between each of its Adjustment Reasons. For example if Adjustment Reason 4 exists, Adjustment Reason 1, 2 and 3 must also exist.
(Inb837I.Post.74) Ensure Medi-Cal Adjustments Do Not Exist	For LP Contract original and replacement claims, ensure there is no Adjustment information for Medi-Cal.
(Inb837I.Post.75) Ensure COB Information Balances	For LP Contract original and replacement claims, ensure Medicare and Private Insurance COB payments and adjustment balance to the Claim Amount. For each payer the calculation is Claim Amount = Payer's Payment Amount + Sum of Payer's Adjustment Amounts.
(Inb837I.Post.76) Validate Medicare and Private Insurance Remaining Patient Liability Amount	If Medicare or Private Insurance are payers in the claim, remaining patient liability amount value must be sent.

HIPAA 5010 INBOUND 837 INSTITUTIONAL IS BUSINESS RULES	
DenyRuleFailure	Corrective action to be taken
(Error Code 208) NPI Errors	To correct claims that were denied due to error code 208, you must first correct the Rendering Provider's NPI in the IS. This NPI may be corrected by submitting an electronic Rendering Provider update. A copy of the Rendering Provider update should also be e-mailed to the Compliance Program and Audit Services Bureau at the following address: NPIVRPF@dmh.lacounty.gov
(Inb837I.Post.77) Validate Provider Signature on File	For Residential services, ensure provider signature on file is sent in the claim.
(Inb837I.Post.78) Validate DMH Client Address	<p>For original and replacement claims, if Medi-Cal is a billable payer in the claim ensure the DMH client address is valid. Valid address must meet all of the following criteria:</p> <ul style="list-style-type: none"> • Client Address 1 is not empty and contains valid DMH characters, • If Client Address 2 is not empty, it contains valid DMH characters • Client City has at least 2 characters and contains valid DMH characters • Client State is not empty is contains only 2 alphabetic values • Client Zip is 5 or 9 digits <p>NOTE: DMH valid characters are limited to the following:</p> <ul style="list-style-type: none"> • A thru Z (upper & lowercase) • 0 thru 9 • ! • (•) • + • , (comma) • . (period) • ? • = • (space) • - (hyphen) • /

WSC04	DTI/DR Duplicate Claim
WSC05	Resub claims are not allowed for DTI/DR claims. Void and submit an original. (Terminated 02/17/11)
WSC07	The original claim being voided is not found. Please call the Help Desk at (213) 351-1335
WSDT01	No DTI/DR Authorization Found
WSDT02	No DTI/DR days left for original claim. No DTI/DR days used for void claim.
WSDT04	DT/DR Replacement Error. Please call the Help Desk at (213) 351-1335
WSDT05	DTI/DR Replacement Validation Error. Void and submit an original claim
WSMHS01	No MHS Authorization Found
WSMHS02	Original claim not enough MHS hours left. Void claim no hours used for the week. (Display # of Hours Left)
WSMHS04	MHS re-sub hours must be less than or equal to remaining hours.
WSMHS05	MHS re-sub validation error. Void and submit an original claim
WSMHS09	MHS re-sub error. Please call the Help Desk at (213) 351-1335

Other UOFS error codes that have been changed to IS rule:

LAMH0089	LAMH0089-INVALID DATE
LAMH4090	LAMH4090-STAFF CODE/REPT UNIT UNMATCHED
LAMH6019	LAMH6019 - DUPLICATE DAY TREATMENT
LAMHDT01	LAMHDT01-NO TBS AUTHORIZATION FOUND