County of Los Angeles
Department of Mental Health

Contract Providers Transition Project (CPTP)

How to Correct Denied Claims

Version 1.3

August 2010

DOCUMENT REVISION HISTORY

Version	Release Date	Revised by	Comments/Indicate Sections Revised
Version 1.1	04/14/2009	Karen Bollow	New Link for EDI Error Messages
Version 1.2	08/13/2009	Marta Ghazarian	Minor Updates
Version 1.3	08/10/2010	Karen Bollow	Update links to EDI Deny Rule Cheat Sheet

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1 Introduction

This document describes the process to identify problems throughout the production Electronic Data Interchange (EDI) claiming cycle. There are numerous points of failure from the time the EDI batch is submitted to DMH until the final remittance advice is received from the State. It is important to have a clear understanding of the process and potential error situations in order to resolve problems quickly and receive payment for claims.

2 Production Claim Cycle

The following table describes the step-by-step process for each EDI transaction. The contract agency must complete the EDI Certification process and testing process prior to submitting production EDI transactions.

The contract agency and/or the trading partner must install a Production Digital Certificate prior to submitting EDI production transactions. (Refer to the EDI Security and Access document for information on loading digital certificates)

At each step in the process, the results are either positive or negative. If there are errors, the appropriate error code table should be referenced in order to correct the error.

Process Description	Form or Input	Error Code Table
1. Upload file thru Secure File Transfer (SFT) using the following website: http://sft.dmhis.co.la.ca.us. Send an email notification of upload to: IS_EDI_Prod@sierrasystems.com stating the following: submitter name (your name), ISA06 (15 digit ISA number), total number of claims, total dollar value of claims and BHT04 (file upload date in ccyymmdd format)	Results are stored in the EDI File Status (access to EDI file limited to CIOB EDI Support Unit). Timing: Next Day	IS File Validation Edit Table
2. Perform Integrated System (IS) file validation.	Must pass IS file validation to proceed further or process will end. Timing: Next Day	IS File Validation Edit Table
3. Perform HIPAA file validation.	See Response folder for Positive or Negative TA1 Interchange Acknowledgment.	Negative TA1 Error Codes

Process Description	Form or Input	Error Code Table
	Timing: Next Day	
4. Perform HIPAA Structure Validation (syntax).	See Response folder for Positive or Negative 997 Functional Acknowledgment. Timing: Next Day	Negative 997 Error Codes
5. Create 277u (Unsolicited Status Response) with individual claims	277u individual claims with IS Claim Number. Assigned to each Submitter Claim ID (See files in Response Folder). Timing: Two days after file upload	
6. Perform IS Business Rules Validation on Each Claim	If claim fails the IS Business Rules, claim status is denied and a negative 835 Remittance Advice is put in response folder. Timing: Two days after file upload	IS Deny Reason Codes Cheat Sheet
7. If this is a FFS2 claim, proceed to step 13. Otherwise, for all other claims, perform CICS Rules validation for outpatient and day treatment claims only.	If claim fails the CICS Rules, claim status is denied and negative 835 Remittance Advice is put in response folder. Timing: Two days after file upload claims are available through IS Reports	IS Deny Reason Codes Cheat Sheet
8. Perform check for other payers on the claim. If there are other payers, proceed to step 9. Otherwise, if there are no other payers on the claim, claim is “Approved”.	Create positive 835 Remittance Advice and put in the response folder. Timing: Three to four days after file upload	
9. Batch claims for Medi-Cal and send to Medi-Cal.	Send claims to State. Timing: Weekly on Thursday	

Process Description	Form or Input	Error Code Table
10. State performs validation of business rules based on the State Companion Guide.	If claim fails the State Business Rules, claim status is denied and a negative 835 Remittance Advice is put in response folder. Timing: One to Two Weeks	835 Claim Adjustment Reason Code 835 Claim Status Code 835 Claim Group Code 835 Remittance Advice Remark Code
11. State approves Medi-Cal claim for local plan agency.	Create positive 835 Remittance Advice and put in the response folder. Timing: Three to Four Days after receipt of 835 from the State	
12. FFS2 Medi-Cal claim approved by the State.	Process FFS Checkwrite and process approved 835 Remittance Advice. Timing: One to Two Weeks	
13. FFS2 (continued from Step 7) Create 106 File and perform FFS legacy processing. Process approved Remittance Advice (RAD) claims only. Return to step 9.	Timing: Unknown	

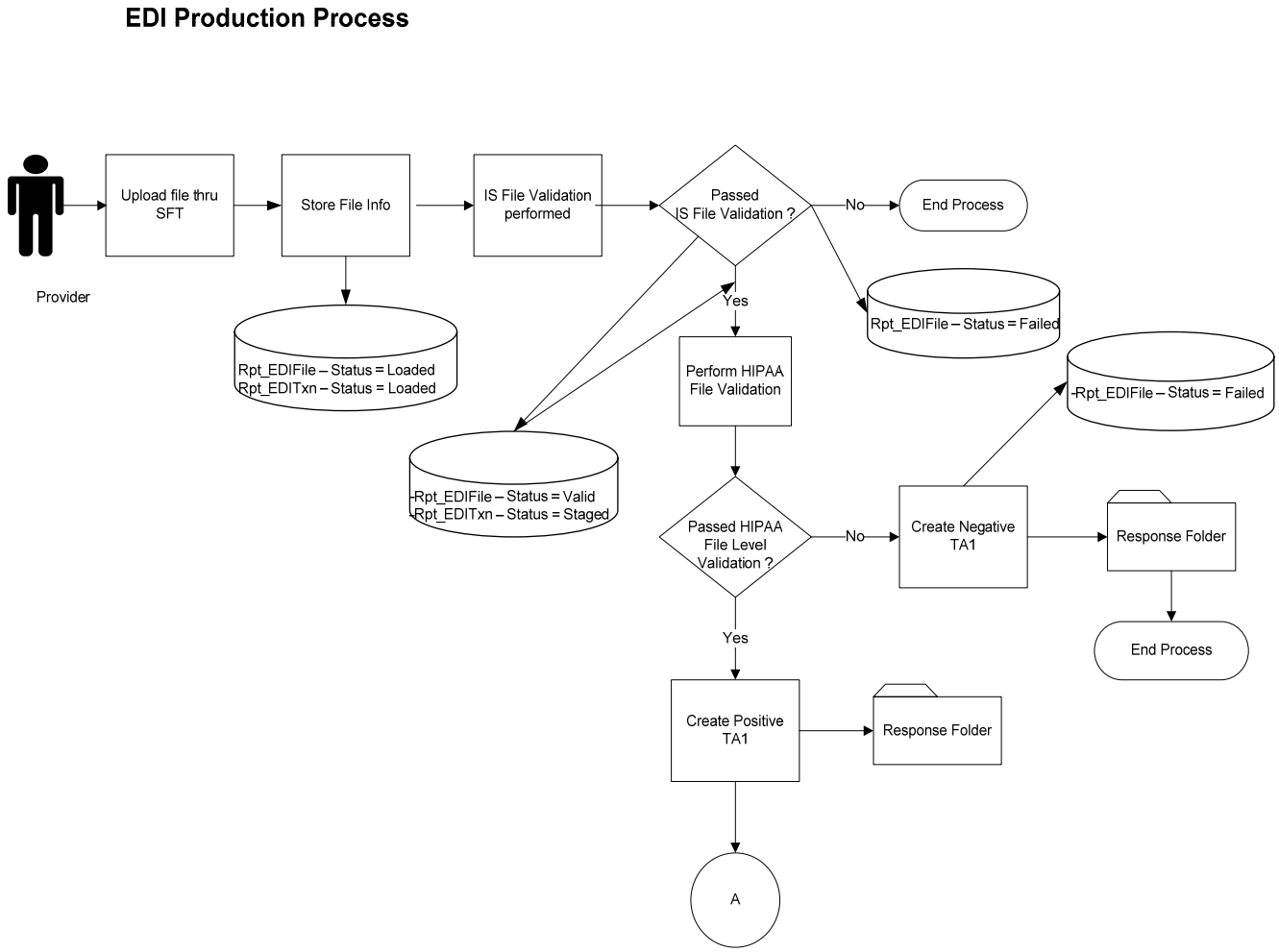
3 Production Claim Cycle Process Flow

The following charts show the process flow described above. For each step in the process, there is a result. Based on the result, there is information sent to each contract agencies Response Folder. The Response Folder should be reviewed daily by each agency to monitor the progress of the claim processing.

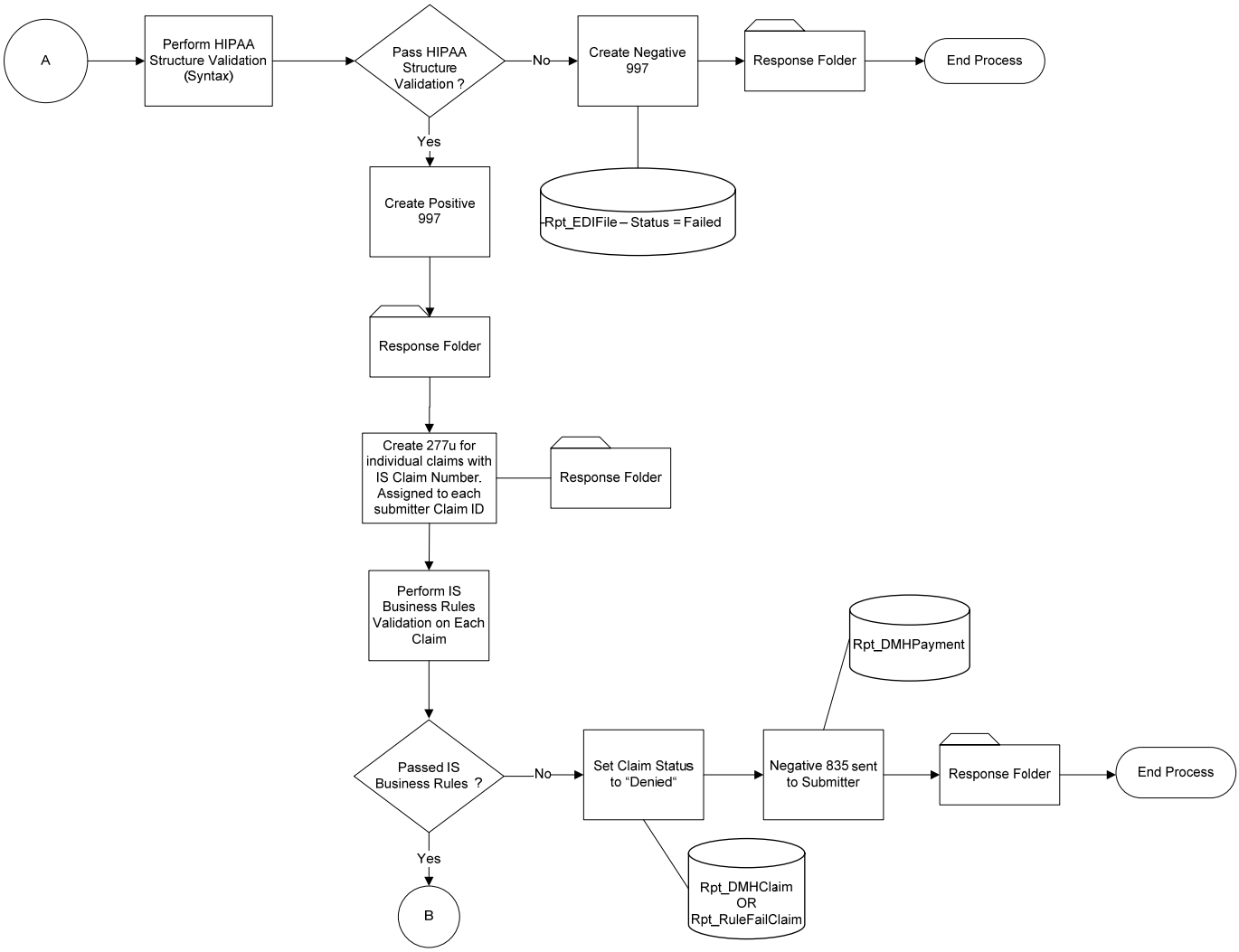
Information is also stored in various tables that are available via the Secure Internet File Transfer (SIFT) data that is updated on a weekly basis for EDI contract agencies. The tables reference error conditions.

The current Information System (IS) allows report requests to view or download reports containing denied claim information such as the IS010 (Claim Status Report) and the IS080, the download version of the IS010.

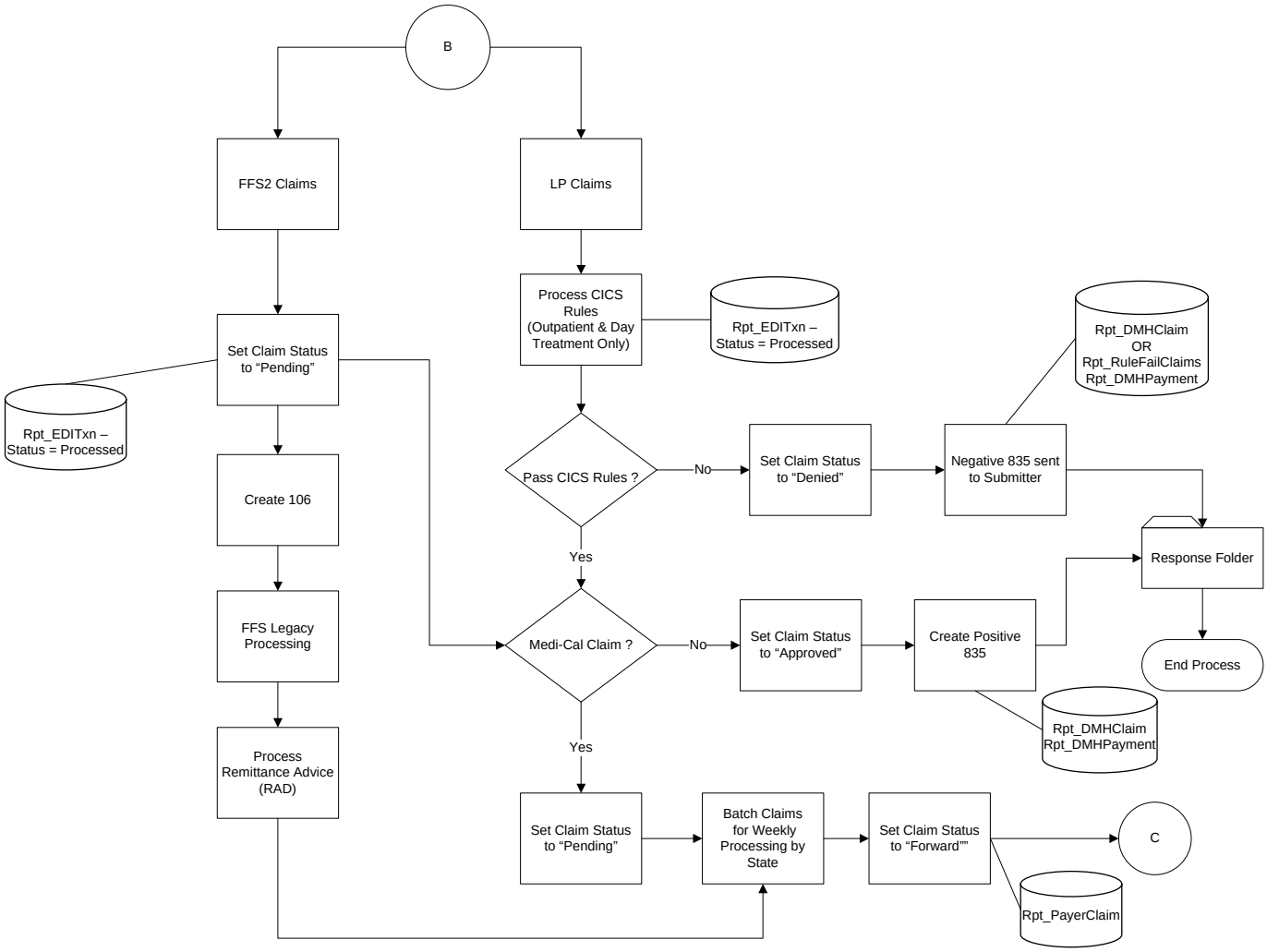
EDI Production Process – Page 1



EDI Production Process – Page 2 (Continued)



EDI Production Process – Page 3 (Continued)



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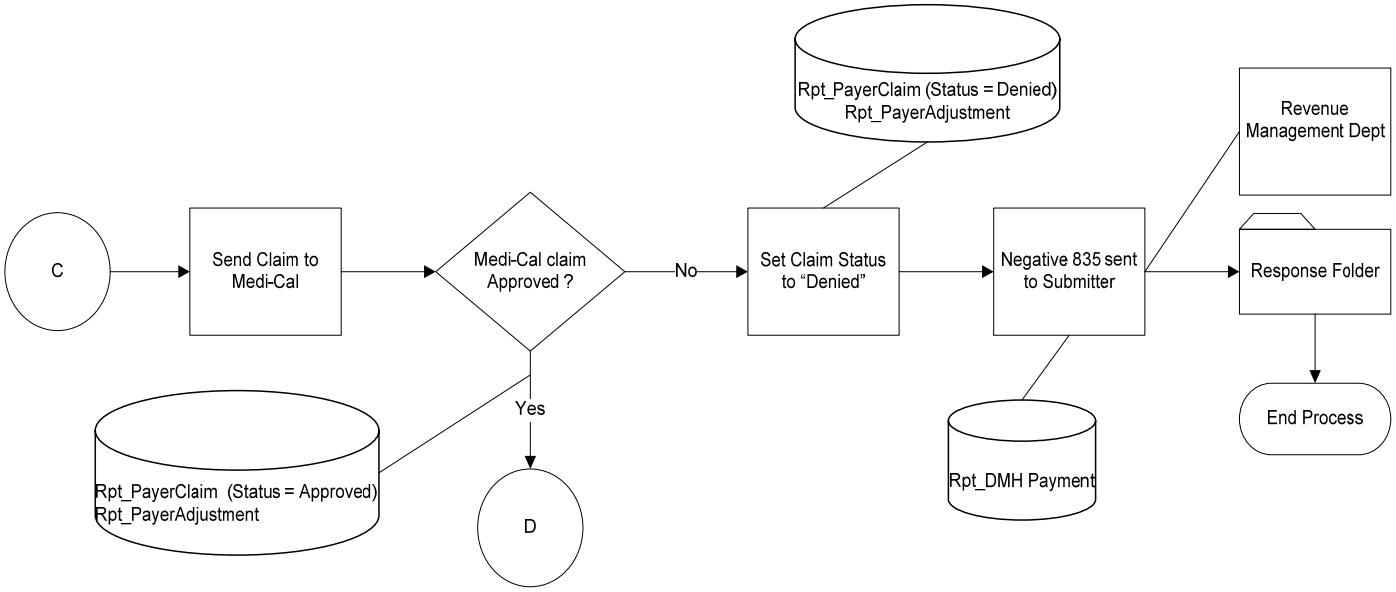
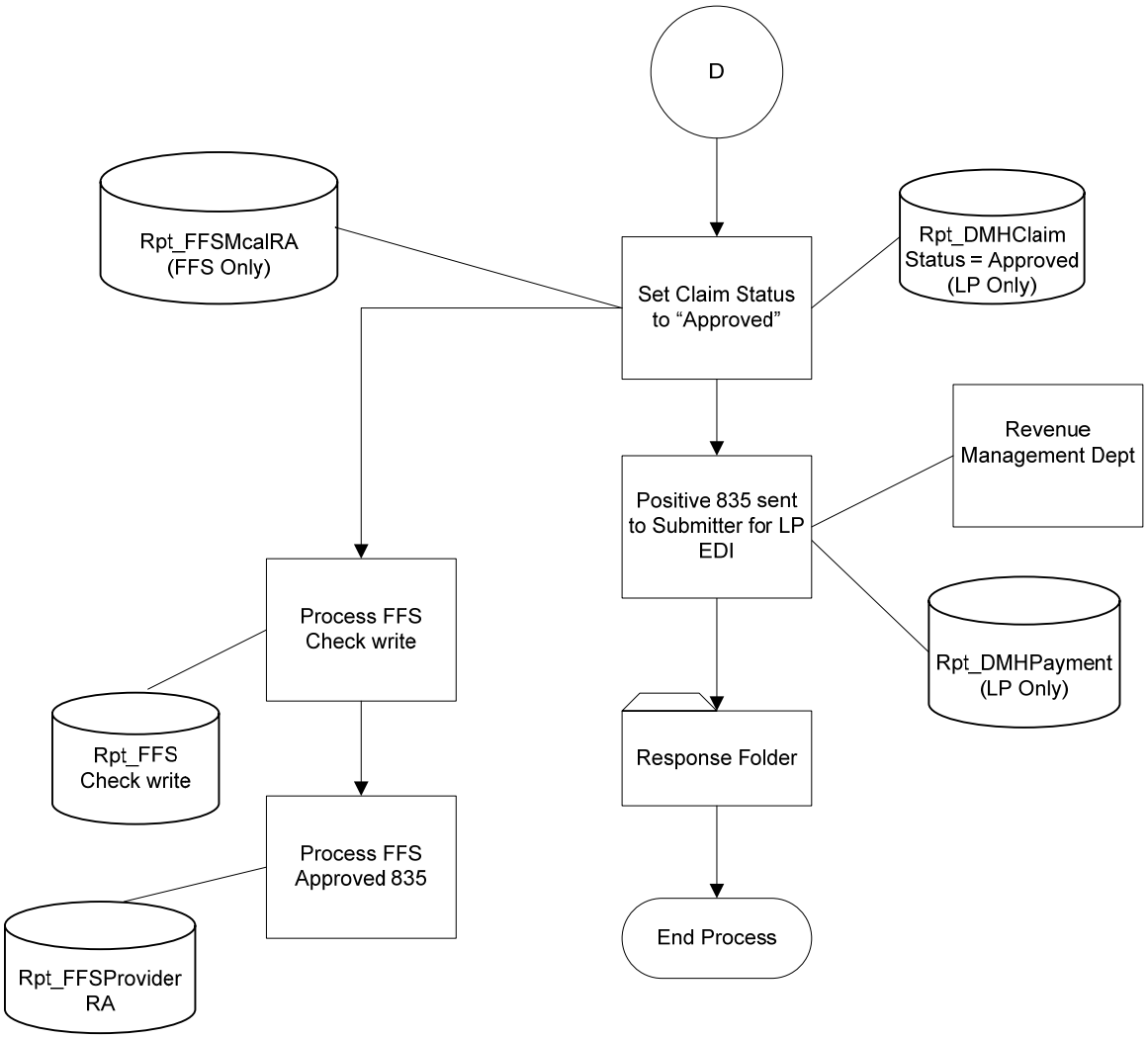


EDI Production Process – Page 5 (Continued)



4 Reference Tables for Error Conditions

4.1 IS File Validation Edit Table

The IS File Validation Edit Table contains the error messages received when the EDI file submitted to the IS does not pass basic file format edits.

4.1.1 IS File Validation Edit Table

EDIT	Error Message
Login ID cannot be empty	'Login ID not appended to final name'
Login ID must exist only once in user table (hrp_user)	'Login ID not found'
Sender ISA cannot be empty	'Sender ISA does not exist in file'
Receiver ISA cannot be empty	'Receiver ISA does not exist in file'
Ensure Sender ISA is found as an alternate ID	'Sender ISA not found'
Ensure Receiver ISA is for DMH	'Receiver ISA does not match DMH ISA'
Ensure Login ID is valid for the Sender ISA	'Sender ISA not valid for Login ID'
Ensure ISA13 for the submitter is unique	'Duplicate Control ID for the Sender ISA'
Ensure file has only one ISA segment	'More than one ISA Envelope Header segment'

4.2 HIPAA File Validation Process – Negative TA1 Table

The following table describes the negative TA1 responses produced during the HIPAA File Validation process. The TA1 is returned to the Response Folder.

4.2.1 TA1 Interchange Acknowledgment Error Codes

Syntax Error Code	Code	Definition
TA1 Segment **Transaction Set Acknowledgment Code** A = The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors E = The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data. R = The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.	001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment
	002	This Standard as Noted in the Control Standards Identifier is Not Supported
	003	This Version of the Controls is Not Supported
	004	The Segment Terminator is Invalid
	005	Invalid Interchange ID Qualifier for Sender
	006	Invalid Interchange Sender ID
	007	Invalid Interchange ID Qualifier for Receiver
	008	Invalid Interchange Receiver ID
	009	Unknown Interchange Receiver ID
	010	Invalid Authorization Information Qualifier Value
	011	Invalid Authorization Information Value
	012	Invalid Security Information Qualifier Value
	013	Invalid Security Information Value
	014	Invalid Interchange Date Value
	015	Invalid Interchange Time Value
	016	Invalid Interchange Standards Identifier Value
	017	Invalid Interchange Version ID Value
	018	Invalid Interchange Control Number Value
	019	Invalid Acknowledgment Requested Value

Syntax Error Code	Code	Definition
	020	Invalid Test Indicator Value
	021	Invalid Number of Included Groups Value
	022	Invalid Control Structure
	023	Improper (Premature) End-of-File (Transmission)
	024	Invalid Interchange Content (e.g., Invalid GS Segment)
	025	Duplicate Interchange Control Number
	026	Invalid Data Element Separator
	027	Invalid Component Element Separator
	028	Invalid Delivery Date in Deferred Delivery Request
	029	Invalid Delivery Time in Deferred Delivery Request
	030	Invalid Delivery Time Code in Deferred Delivery Request
	031	Invalid Grade of Service Code

4.3 HIPAA Structure Validation Process – Negative 997

The following table describes the negative 997 responses produced during the HIPAA Structure Validation process. The negative 997 is returned to the Response Folder.

4.3.1 997 Error Codes

Syntax Error Code	Code	Definition
AK3 Segment	1	Unrecognized segment ID
	2	Unexpected segment
	3	Mandatory segment missing
	4	Loop Occurs Over Maximum Times
	5	Segment Exceeds Maximum Use
	6	Segment Not in Defined Transaction Set
	7	Segment Not in Proper Sequence
	8	Segment Has Data Element Errors
AK4 Segment	1	Mandatory data element missing
	2	Conditional required data element missing
	3	Too many data elements
	4	Data element too short
	5	Data element too long
	6	Invalid character in data element
	7	Invalid code value
	8	Invalid Date
	9	Invalid Time
	10	Exclusion Condition Violated
	12	Too Many Repetitions

Syntax Error Code	Code	Definition
	13	Too Many Components
AK5 Segment **Transaction Set Acknowledgment Code** A = Accepted, ADVISED E = Accepted But Errors Were Noted M = Rejected, Message Authentication Code (MAC) Failed R = Rejected, ADVISED W = Rejected, Assurance Failed Validity Tests X = Rejected, Content After Decryption Could Not Be Analyzed	1	Transaction Set Not Supported
	2	Transaction Set Trailer Missing
	3	Transaction Set Control Number in Header and Trailer Do Not Match
	4	Number of Included Segments Does Not Match Actual Count
	5	One or More Segments in Error
	6	Missing or Invalid Transaction Set Identifier
	7	Missing or Invalid Transaction Set Control Number
	8	Authentication Key Name Unknown
	9	Encryption Key Name Unknown
	10	Requested Service (Authentication or Encrypted) Not Available
	11	Unknown Security Recipient
	12	Incorrect Message Length (Encryption Only)
	13	Message Authentication Code Failed
	15	Unknown Security Originator
	16	Syntax Error in Decrypted Text
	17	Security Not Supported
	23	Transaction Set Control Number Not Unique within the Functional Group
	24	S3E Security End Segment Missing for S3S Security Start Segment
	25	S3S Security Start Segment Missing for S3E Security End Segment
	26	S4E Security End Segment Missing for S4S Security Start Segment
	27	S4S Security Start Segment Missing for S4E Security End Segment

Syntax Error Code	Code	Definition
AK9 Segment **Transaction Set Acknowledgment Code** A = Accepted, ADVISED E = Accepted But Errors Were Noted M = Rejected, Message Authentication Code (MAC) Failed P = Partially Accepted, At Least One Transaction Set Was Rejected, ADVISED R = Rejected, ADVISED W = Rejected, Assurance Failed Validity Tests X = Rejected, Content After Decryption Could Not Be Analyzed	1	Functional Group Not Supported
	2	Functional Group Version Not Supported
	3	Functional Group Trailer Missing
	4	Group Control Number in the Functional Group Header and Trailer Do Not Agree
	5	Number of Included Transaction Sets Does Not Match Actual Count
	6	Group Control Number Violates Syntax
	10	Authentication Key Name Unknown
	11	Encryption Key Name Unknown
	12	Requested Service (Authentication or Encryption) Not Available
	13	Unknown Security Recipient
	14	Unknown Security Originator
	15	Syntax Error in Decrypted Text
	16	Security Not Supported
	17	Incorrect Message Length (Encryption Only)
	18	Message Authentication Code Failed
	23	S3E Security End Segment Missing for S3S Security Start Segment
	24	S3S Security Start Segment Missing for S3E End Segment
	25	S4E Security End Segment Missing for S4S Security Start Segment
	26	S4S Security Start Segment Missing for S4E Security End Segment

4.4 Integrated System (IS) Business Rules Validation Process

The IS Business Rules edits are described in the EDI Deny Reasons Cheat Sheet document on the IS Website and the EDI CPTP Website. The link to the document is:

http://dmh.lacounty.gov/hipaa/documents/DenyRuleCheatSheet.pdf

4.5 CICS Business Rules Validation Process

The CICS Business Rules edits are described in the EDI Deny Reasons Cheat Sheet document on the IS Website and the EDI CPTP Website. The link to the document is:

http://dmh.lacounty.gov/hipaa/documents/DenyRuleCheatSheet.pdf

The CICS Business Rules edits are only performed the Local Plan (LP) providers for outpatient and day treatment claims.

4.6 Medi-Cal Claims Validation Process

For Medi-Cal claims, the State performs edits on the claims based on the State DMH Companion Guide business rules. The State DMH Companion Guide is located at:

http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

If business rule errors are encountered, the State transmits a negative 835 Remittance Advice transaction to County DMH. The negative 835 is returned to the Response Folder.

The following tables are from the State DMH Companion Guide from June 2007. Please refer to the latest version of the State DMH Companion Guide when you review any errors.

The IS maintains a document that lists typical Medi-Cal errors. This document can also be used as a reference to any Medi-Cal specific errors. The document is found at:

http://dmh.lacounty.gov/hipaa/downloads/MEDI-CAL_DENIAL_CHEAT_SHEET.pdf

4.6.1 835 Claim Adjustment Group Code

Code	Definition
CO	**Contractual Obligations** - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment
CR	**Correction and Reversals** - Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment
OA	**Other adjustments**
PI	**Payor Initiated Reductions** - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e. medical review or professional review organization adjustments).
PR	**Patient Responsibility**

4.6.2 835 Claim Status Code

CLAIM STATUS CODE - SEE 835, PG. 90-91 - THIS MUST BE PLACED AT THE CLAIM LEVEL.	
Code	**Description**
4	Denied
13	Suspended
25	Predetermination Pricing Only - No Payment

4.6.3 835 Claim Adjustment Reason Code

HEALTH CARE CLAIM ADJUSTMENT REASON CODES - THESE CODES CAN BE USED MULTIPLE TIMES UNDER A GIVEN CLAIM ADJUSTMENT GROUP CODE	
Code	**Description**
11	Diagnosis inconsistent with procedure
16	Claim lacks info for adjudication. See Remarks Codes.
17	Unidentified Error
18	Duplicate claim/service
26	Expenses incurred prior to coverage
29	The time limit for filing has expired
31	Claim denied as patient cannot be identified as our insured

HEALTH CARE CLAIM ADJUSTMENT REASON CODES - THESE CODES CAN BE USED MULTIPLE TIMES UNDER A GIVEN CLAIM ADJUSTMENT GROUP CODE	
42	Charges exceed our fee schedule or maximum allowable amount
110	Billing date predates service date
119	Benefit maximum for this time period has been reached.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
A1	Claim Denied charges
A2	No error, but it reduces the total amount billed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.

4.6.4 835 Remittance Advice Remark Codes

REMITTANCE ADVICE REMARK CODES - USED IN REMITTANCE ADVICE TO RELAY INFORMATIONAL MESSAGES THAT CANNOT BE EXPRESSED WITH A CLAIMS ADJUSTMENT REASON CODE.	
Code	**Description**
M16	Please see the letter of (date) for further information. (The letter number and date must be supplied).
M51	Missing/incomplete/invalid procedure code(s) and/or rates.
M53	Did not complete or enter the appropriate number (one or more) of days or unit(s) of service.
M54	Did not complete or enter the correct charges for services rendered.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	Patient's diagnosis code(s) is truncated, incorrect, or missing; you are required to code to the highest level of specificity
MA21	SSA records indicate mismatch with name and sex
MA31	Incomplete/invalid beginning and ending dates of the period billed
MA39	Incomplete/invalid patient's sex
MA40	Incomplete/invalid admission date
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number
MA63	Incomplete/invalid principle diagnosis code
MA66	Incomplete/invalid principle procedure code and/or date
MA92	Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information

REMITTANCE ADVICE REMARK CODES - USED IN REMITTANCE ADVICE TO RELAY INFORMATIONAL MESSAGES THAT CANNOT BE EXPRESSED WITH A CLAIMS ADJUSTMENT REASON CODE.	
Code	**Description**
MA130	Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount. This Remark Code will be deactivated October 1, 2007.
N20	Service not payable with other service rendered on the same date.
N50	Missing/incomplete/invalid discharge information.
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N59	Please refer to your provider manual for additional program and provider information.
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month

4.6.5 Transaction Code Denial Reason Error Code Crosswalk

A. ORIGINAL CLAIMS					
SD/MC CODES AND MESSAGES		**HIPAA ADJUSTMENT REASON AND REMARKS CODES**			
SD/MC Error Code	**SD/MC Error Message**	**Adj. Group CAS01**	**Adj. Reason CAS02**	**Remarks Code LQ02**	**Comments**
C	Unprocessable, invalid claim ID	CO	16	MA130	
D	Unprocessable, duplicate claim ID	CO	18	MA130	
F	Failed Edits (Approve/Deny) County Option	CO	A1	MA130	
N	Deny claim with non-Title XIX determination	CO	31	MA130	
O	Unprocessable, invalid override code	CO	138	MA130	
R	Unprocessable, Receipt date error		n/a		Will be generated by state.
S	Unprocessable, duplicate claim ID on Suspense	CO	18	MA130	

A. ORIGINAL CLAIMS					
SD/MC CODES AND MESSAGES		**HIPAA ADJUSTMENT REASON AND REMARKS CODES**			
T	Deny claim with tape submission error		n/a		Not applicable to HIPAA transactions.
X	County requested denial of claim on suspense	OA	A1	MA130	
Blank	Claim denied after 97 days on suspense	CO	B5	MA130	

B. VOID TRANSACTIONS					
SD/MC CODES AND MESSAGES		**HIPAA ADJUSTMENT REASON AND REMARKS CODES**			
SD/MC Error Code	**SD/MC Error Message**	**Adj. Group CAS01**	**Adj. Reason CAS02**	**Remarks Code LQ02**	**Comments**
A	Void error – Duplicate (original claim already voided)	CO	18		
B	Void error – Received date of void is prior to VCR inception	CO	138		
E	Void error – Edit failed	CO	16	MA130	This code appears when error type does not match any other code.
I	Void error – No match on secondary fields (Beneficiary ID/Service Date)	CO	A1		
L	Void error – Original claim older than 18 months from month of service)	CO	29		
P	Void error – Invalid date format	CO	16		
U	Void error – No match on primary fields (unique ID/County Code).	CO	A1		
M	Void Transaction – Match found, void successful	n/a	n/a	n/a	Not applicable to HIPAA transactions.

4.6.6 SD/MC Error Code Crosswalk

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
01	Data element is BLANK	203-204 Gender	CO	31	MA39	
01	Data element is BLANK	205-206 DOB year	CO	31		

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
01	Data element is BLANK	207-208 Service YYYYMM	CO	B18	MA66	
01	Data element is BLANK	211-212 Mode of Service	CO	B7	M51	
01	Data element is BLANK	2 15-216 Service Function	CO	B7	M51	
01	Data element is BLANK	221-222 Total Billed Amount	CO	16	M54	
01	Data element is BLANK	223-224 Claim For Date Claim Submitted	CO	16		
01	Data element is BLANK	229-230 Race/Ethnicity				N/A. Value will be populated from MEDS.
02	Not a valid date	205-206 DOB year	CO	31		
02	Not a valid date	207-208 Service YYYYMM	CO	16	MA66	
02	Not a valid date	231-232 Service/Treatment Date	CO	16	MA66	
03	Invalid code	199-200 Crossover Indicator	CO	16		
03	Invalid code	201-202 Welfare ID	CO	31	MA61	
03	Invalid code	203-204 Gender	CO	31	MA39	
03	Invalid code	209-210 Provider Code	CO	B7		
03	Invalid code	211-212 Mode of Service	CO	B7	M51	
03	Invalid code	215-216 Service Function	CO	B7	M51	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
03	Invalid code	229-230 Race/Ethnicity				N/A
03	Invalid code	233-234 Discharge Indicator	CO	16	N50	
03	Invalid code	235-236 Diagnosis	CO	16	M81	
04	Late submission	207-208 Service YYYYMM	CO	29		
05	Not valid day	231-232 Service/Treatment Date	CO	16	MA66	
06	Not numeric	205-206 DOB year	CO	31	MA66	
06	Not numeric	207-208 Service YYYYMM	CO	16	MA66	
06	Not numeric	209-210 Provider Code	CO	B7		
06	Not numeric	211-212 Mode of Service	CO	B7	M51	
06	Not numeric	217-218 Units of Time	CO	16	N59	
06	Not numeric	219-220 Units of Service	CO	16	N59	
06	Not numeric	221-222 Billed Amount	CO	16	M54	
06	Not numeric	227-228 Admit Date	CO	16	MA40	
06	Not numeric	231-232 Service/Treatment Date	CO	16	MA66	
07	Zero Claimed	217-218 Units of Time	CO	16	M53	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
07	Zero Claimed	221-222 Billed Amount	CO	16	M54	
08	Mode not authorized	211-212 Mode of Service	CO	B7	N65	
08	Mode not authorized	209-210 Provider Code	CO	B7		
09	Ineligible in month and year	201-202 Welfare ID	PR	26	N59	
09	Ineligible in month and year	207-208 Service YYYYMM	PR	26	N59	
09	Ineligible in month and year	209-210 Provider Code	CO	B7		
10	Conflicts with eligibility file	199-200 Crossover Indicator	CO	16		
10	Conflicts with eligibility file	203-204 Gender	CO	31	MA2 1	
10	Conflicts with eligibility file	205-206 DOB year	CO	31		
10	Conflicts with eligibility file	225-226 Name	CO	31	MA21	
11	Not on eligibility file.	201-202 Welfare ID	PR	31	N59	
12	Not on DHS provider file	209-210 Provider Code	PI	B7		
13	Program not authorized in month and year	207-208 Service YYYYMM	CO	B7	N56	
13	Program not authorized in month and year	209-2 10 Provider Code	CO	B7		
13	Program not authorized in month and year	211-212 Mode of Service	CO	B7	N56	
14	Mode not authorized in month and year	207-208 Service YYYYMM	CO	B7	N56	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
14	Mode not authorized in month and year	209-210 Provider Code	CO	B7		
14	Mode not authorized in month and year	211-212 Mode of Service	CO	B7	N56	
15	No secondary match	201-202 Welfare ID	CO	31	N59	
16	Service date greater than receipt date.	207-208 Service YYYYMM	CO	110	N59	
17	Healthy Families hold period.	201-202 Welfare ID	CO	16	M16	
17	Healthy Families hold period.	207-208 Service YYYYMM	CO	16	M16	Counties receiving this combination should review DMH Information Letter 98-14 for additional information.
18	Claim too old for eligibility check	201-202 Welfare ID	CO	31	N1	
19	Invalid Service Function Code	215-216 Service Function	CO	B7	N65	
20	Units of service are not less than or equal to the units of time	217-218 Units of Time	CO	16	M53	
20	Units of service are not less than or equal to the units of time	219-220 Units of Service	CO	16	M53	
21	Invalid drug code	235-236 Diagnosis	CO	11	MA63	
22	Date range not allowed	231-232 Service/Treatment Date	CO	16	N74	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	197-198 Duplicate	CO	119	M86	
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	217-218 Units of Time	CO	119	M53	
23	Units of service are greater than allowed (in Duplicate Error Column - Duplicate service, in ADP Error Column - Units are greater than allowed, and Units of Service Error Column - number of service units greater than allowed).	219-220 Units of Service	CO	119	M53	
24	To date is greater than from date.	231-232 Service/Treatment Date	CO	16	MA31	
25	Units not equal to days.	217-218 Units of Time	CO	16	M53	
25	Units not equal to days.	219-220 Units of Service	CO	16	M53	
25	Units not equal to days.	221-222 Billed Amount	CO	42	M54	

SD/MC ERROR	SD/MC MESSAGE	ERROR FIELD INDICATORS	Adj. Group CAS01	Adj. Reason CAS02	REMARK CODE LQ02	COMMENTS
25	Units not equal to days.	233-234 Discharge Indicator	CO	16	M53	
26	Duplicate Service - No Override	197-198 Duplicate	CO	18	M86	
27	Multiple Service - Override OK	197-198 Duplicate	CO	18	M80	
28	Greater than two outpatient services	197-198 Duplicate	CO	119	N59	
29	Service Function Not Authorized	215-216 Service Function	CO	B7	N65	
30	Service Function Not Authorized in month and year	215-216 Service Function	CO	B7	N65	
31	Medicare Coverage Part ____, HIC #	199-200 Crossover Indicator	CO	16		
31	Medicare Coverage Part ____, HIC #	221-222 Billed Amount	CO	16		
32	Other Coverage Indicator ____	199-200 Crossover Indicator	CO	16	MA92	
32	Other Coverage Indicator ____	221-222 Billed Amount	CO	16	MA92	
33	Claims less than two days of LAAM dose	197-198 Duplicate	CO	B5	N14 Inactive as of 10-1-07	
34	Dollars greater than allowed	197-198 Duplicate	CO	18	N20	
34	Dollars greater than allowed	217-218 Units of Time	CO	42	N14 Inactive as of 10-1-07	
34	Dollars greater than allowed	219-220 Units of Service	CO	42	N14 Inactive as of 10-1-07	
34	Dollars greater than allowed	221-222 Billed Amount	CO	42	N14 Inactive as of 10-1-07	
35	Two doses in one day not allowed	197-198 Duplicate	CO	119	M86	