Error Correction Report Handbook

October 2000

Prepared by the
California Department of Mental Health
Accounting/Fiscal Systems
The ECR Team
1600 9th Street, Room 150
Sacramento, CA 95814
ecr@dmhhq.state.ca.us
(916) 654-2342

Table of Contents

Finding Help on the Internet

Department of Mental Health Web Site http://www.dmh.cahwnet.gov

Healthy Families Web Site http://www.HealthyFamilies.ca.gov

Medi-Cal Web Site http://www.medi-cal.ca.gov

I HATE ECR's

Short-Doyle/Medi-Cal Error Codes
Edit Error Correction Report
(October 2000)

What is an ECR? Claims are submitted to the California State Department of Mental Health for Short-Doyle/Medi-Cal and for SED-Healthy Families. Claims that do not meet edit/eligibility requirements are either denied or suspended. Claims that are suspended end up on the Edit Error Correction Report (ECR report). The ECR process is what a county uses to fix errors so that a corrected claim may be processed for payment.

The format of the ECR is always the same. There is a row of data that provides information on the specific claim. It includes BILLED MO/YR, PATIENT NAME, PATIENT RECORD NUMBER, SERVICE MO/YR, SERVICE DAYS, MODE OF SERVICE, SERVICE FUNCTION, UNITS/TIME, SERVICE UNITS, WELFARE ID/SSN and BILLED AMOUNT. Below this claim listing are the errors that have been identified. The listing of errors may include a box for an OVERRIDE CODE. It will always have a FIELD NUMBER, and BOXES to enter corrected information. It will also describe the FIELD IN ERROR, give the current value for that field, and an error message.

The ECR corrections received are entered by key data operators into the Medi-Cal Short-Doyle (MSD) system. The new values and/or overrides replace what is currently in suspense. The claim is then processed again going through the same edits. If it is not corrected properly, it will come out on the next ECR as an error. Corrections, when done incorrectly, may cause the process to deny the claim rather than suspend it.

The following is an alphabetical listing of error messages that may appear on the ECR. An error message can appear related to a number of fields that are incorrect. The **number in brackets** is the number of the error message as it relates to codes on the electronic EOB (Explanation of Balance). The complete listing of FIELD numbers are in the Short-Doyle/Medi-Cal Claim Record Field Names and Conditions table which is in the first Appendix of this document.

ERROR MESSAGES

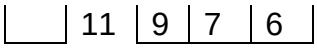
BLANK (01)
The identified field was left blank but is required for the edit process. Fill in the required information using the correct format for the specific field.

CLAIM HELD FOR THE HEALTHY FAMILIES HOLD PERIOD (17)
This error message does not require action. The claim is on "hold" pending the 60 day retroactive denial edit. Once the "hold" period has passed the claim will be processed.

CLAIM TOO OLD FOR ELIGIBILITY CHECK (18)
This message in not currently valid. For information only.

CONFLICTS WITH ELIGIBILITY FILE (10)
This happens when the incorrect SSN or Welfare ID is used. The edit tries to match SSN, name, age, and sex. The fix is to use the correct SSN or to delete the record. However, it may be an error in the YEAR OF BIRTH (Field 11), SEX (Field 12) or PATIENT NAME (Field 8) that keeps the edit from matching on the required fields.

Check the SSN. If it is correct make sure that the other items (YEAR OF BIRTH, SEX, PATIENT NAME) are correct. The YEAR OF BIRTH field must have the "century" and "year" the client was born, NOT the month and year. A client born in "1976" would be entered as "976".



DATE RANGE NOT ALLOWED (22)
This relates to TREATMENT DATE (Field 16). This indicates that days-billed are in error. If the time billed is for an inpatient stay, this can be shown as a range of days (e.g., "0520"- admit date on the 5th of the month to discharge on the 20th of the month). If the time billed is for an outpatient visit on the 5th of the month, then it should be shown as "0505", which means it is for the same day.

DUPLICATE SERVICE – NO OVERRIDE (26) [Duplicate Edit Error Report]
This indicates that the edit has found a duplicate service (either on this claim or a claim processed in the past). There are no overrides for this error. Make sure the data is correct. If it is, delete the record. If the data is in error, correct the field that is incorrect.

GREATER THAN TWO OUTPATIENT SERVICES (28) [Duplicate Edit Error Report]
See Multiple Service – Override OK error message.

INELIGIBLE IN MO/YR (09)
This error indicates the recipient was not eligible for Medi-Cal services during the billed month and year of service. This message is also used if recipient has a Share-of-Cost (SOC) obligation to meet. Provider is prohibited from billing Medi-Cal for services used to meet the beneficiary's SOC. When the SOC has been obligated, the balance above the SOC amount and all subsequent services for that month may be billed to Medi-Cal. There are two ways to correct this error:

1. If the total amount of services during the month is below the SOC amount, place an "X" in the override code to cancel the claim from Medi-Cal, or
2. If the amount of services provided during the month is above the SOC amount, the total amount of services must be SOC certified using the Proof of Eligibility (POE) machine, in order to bill Medi-Cal. Once certified, on the ECR report, enter the complete Welfare ID number in field 10.

INVALID CODE (03)
There are a number of errors related to "Invalid Code."

SERVICE FUNCTION CODE (FIELD 18).
This is an indication that an incorrect code was entered. Verify the type of service provided, and write the correct number.
Medication Support for example.

	18	6	0

ETHNIC CODE (FIELD 13)
This is an indication that an incorrect code was entered. The codes are numeric as shown below.

1 - White	4 - Asian/Pacific	8 - Other
2 - Hispanic	5 - American Indian or Alaska Native	
3 - Black	7 – Filipino	

SSN ERROR (FIELD 10)
This error indicates that there was no match found in the Medi-Cal Eligibility Determination System (MEDS). Providers are responsible for verifying that the following numbers are correct:

1. Welfare Identification (ID) (14 digits)
2. Social Security Numbers (SSN) (9 digits) (must not start with an 8 or a 9)
3. Swipe Card (first 9 digits)
4. Pseudo SSN (9 digits) (must start with an 8 or 9 and end with the letter"P")
5. Client Identification Number (CIN) (9 digits)

Note: Any groups of numbers that are different from 9 digits or 14 digits will fail the edit. Do not use the 10 digits on the swipe card nor include the check digit from the CIN.

Corrections:

1. If the SSN indicated in the report is **wrong**, write the correct SSN in the correction field. **Leave the override code space blank**. Do not include dashes. Left justify the entry.

	10	5	6	3	6	0	1	2	3	4					

2. If the **14 digit Welfare ID** indicated on the report is **wrong**, write in the correct Welfare ID. **Leave the override code space blank.**

	10	1	9	3	8	5	5	5	5	5	5	5	2	7	7

Other Messages Pertaining to Field 10:

1. Invalid Code: This message may occur because the **10**-digit number on the **swipe card** was used. Enter only the first **9** digits or the SSN in the correction field. It may be due to starting with an 8 or 9 without a "P" in the final space which means it is a pseudo SSN. Leave the override code blank.
2. Ineligible in Month/Year
3. Not On Eligibility File
4. No Secondary Match

DISCHARGE (FIELD 17)

This error indicates that a discharge code has been placed improperly. In the correction space, enter a lower case "b" with a slash through it.

	17	~~b~~

DIAGNOSTIC CODE (FIELD 14)

This is an indication that the Diagnostic Code posted was either incorrect, left blank or the field was completed it incorrectly. A valid diagnostic code is three, four or five alpha/numeric characters long. It must be left justified. Do not zero fill. Verify and post the correct Diagnostic Code. Below are some examples of the correct way to complete this. DSM codes are in the Appendix.

14	V	6	1	1	

14	2	9	0	0	

14	3	1	1		

14	3	0	3	0	0

INVALID DRUG CODE (21)
Relates to Drug Medi-Cal only.

INVALID SERVICE FUNCTION CODE (19)
Correct the service function code.

LATE SUBMISSION (04)
There are three possible errors.
1. The billing was not timely and may be subject to a "Good Cause" code.
2. The claim was submitted more than a year after the month of service and is not subject to "Good Cause" override.
3. The date is in error and needs to be corrected.

If the date used in the initial billing is verified to be correct then you may only override this error for "Good Cause". The codes are used to explain why the claim was not sent timely. Failure to use a "Good Cause" code will result in rejection of the claim being corrected. (See "Good Cause Code" Section.)

If the claim was submitted more than one year after the month of service the "Good Cause" override code will not work as the claim is more than a year old. Place an "X" in the override box to delete the claim.

If the date is found to be incorrect, then write the correct date in the correction field.

MEDICARE COVERAGE PART ___, HIC #_____ (31)
This error message relates to the XOVER INDICATOR (Field 22). It indicates that the client is a Medicare beneficiary. Claims to Short-Doyle/Medi-Cal for services provided to a Medicare beneficiary should be claimed only after Medicare reimbursement/denial documentation has been received. There are a number of corrections and edits possible. The edits involve either deleting the claim ("X" in the override box) or a specific code in the "XOVER INDICTATOR" box and a change in the dollar amount. See "XOVER INDICATOR" table.

If a client has Medicare coverage but the claiming **provider has not been certified as a Medicare provider**, place a "**H**" in the correction space in Field 22 **(not the override space)**. In Field 21 enter the amount to bill Medi-Cal only if it is different from the amount shown.

If the claim is an **X** crossover claim, meaning the **client is eligible for Medicare**, then provider needs to verify whether or not Medicare has been billed.

If Medicare has not been billed, then **deny** the claim by putting an "**X**" in the override code. The provider must then bill Medicare. Upon receipt of Medicare payment or denial the claim may be resubmitted.

X	22	

21							.		

If Medicare has been billed but there is **no response** from Medicare, then **deny** the claim by putting an "**X**" in the override code. Upon receipt of Medicare payment or denial the claim may be resubmitted.

X	22	

21							.		

If Medicare was billed but **payment was denied** to the provider, then **bill Medi-Cal** by putting an "**X**" in Field 22 **(not the override space)**. In Field 21 change the amount only if incorrect on the ECR.

	22	**X**

21							.		

If Medicare was billed and **payment was made** to the provider, then put an "**X**" in Field 22 **(not the override space)**. In Field 21 enter the amount billed net of the Medicare payment. Example: If the amount billed was $100.20 and Medicare paid $25.50, enter $74.70 in Field 21.

	22	**X**

21					**7**	**4**	.	**7**	**0**

If the claim is a **N** crossover claim, which means **the client was Medicare eligible but the service was not**, place a "**N**" in the correction space in Field 22 **(not the override space)**. In Field 21 write in the amount to be billed to Medi-Cal only if it is different from what is on the ECR. If it is the same, leave the field blank.

	22	**N**

21							.		

MO/YR OF SERVICE GREATER THAN RECEIPT DATE (16)
The receipt date is entered by State Department of Mental Health. This error indicates that the service was provided after the claim was received. Enter the correct date.

MODE NOT AUTHORIZED (08)
Message indicates that the wrong MODE OF SERVICE (Field 6) has been used. Verify the mode of service being provided (e.g., 18 – Outpatient Services).

MODE NOT AUTHORIZED IN MO/YR (14)
Enter the correct mode.

MULTIPLE SERVICE – OVERRIDE OK (27) [Duplicate Edit Error Report]
This is similar to the "Duplicate Service – No Override" error message, but it means that it may be that a multiple service was provided and the county may override this edit. There are limits on time and amounts.

NO SECONDARY MATCH (15)
This error message usually goes with "Conflicts with Eligibility File". Since the SSN/Welfare ID/CIN is incorrect, all the related information is also incorrect. Use the correction field to enter all the correct information (i.e., name and year of birth).

NOT NUMERIC (06)
This message might appear in any of seven different fields. In some instances there could be letters instead of numbers in the field.

NOT ON ELIGIBILITY FILE (11)
This error message indicates that an incorrect Welfare ID/SSN/CIN was entered. Verify the correct SSN of the patient and if he was eligible during the month of service, leave the override code blank, and use the correction field to enter the correct SSN/Welfare ID/CIN. Do not use the check digit with the CIN.

NOT ON PROVIDER FILE (12)
This message indicates that the provider number is wrong or not on current provider listing. Provider numbers that include letters must be in upper case. Providers should contact their county mental health program to make sure the provider number is on the Medi-Cal Provider File prior to resubmission of the ECR.

NOT VALID DATE (02)
Date is not valid for the specific field. For example, Date the Claim is Submitted (Field 4) is "CCYYMM". Outpatient treatment Dates would be "First Day" (01-31) "Last Day" (01-31), for example, "0505". Inpatient would be a range of days, for example, "0615".

OTHER COVERGE IND - (32)
This indicates that other health coverage has been found on the MEDS system.

If the claim is a **P** crossover claim, meaning the **client has private insurance**, then the provider needs to verify if the private insurance has been billed.

If private insurance has not been billed, then **deny** the claim by putting an "**X**" in the override code. The provider must then bill the private insurance. Upon receipt of insurance payment the claim may be submitted again for the balance.

X	22	

21 | | | | | | | . | | |

If private insurance has been billed but there is **no response** from the insurance company, then **deny** the claim by putting an "**X**" in the override code. Upon receipt of insurance payment or denial the claim may be submitted again.

X	22	

21 | | | | | | | . | | |

If private insurance was billed but **payment was denied** to provider, then **bill Medi-Cal** by putting a "**P**" in Field 22 **(not the override space)**. In Field 21 write the billed amount only if it is different from the amount shown on the ECR.

	22	**P**

21 | | | | | | | . | | |

If private insurance was billed and **payment was made** to the provider, then put a "**P**" in Field 22 **(not the override space)**. In Field 21 enter the amount billed net of the insurance payment. Example: If the amount billed was $100.20 and insurance paid $25.50, enter $74.70 in Field 21.

	22	**P**

21					**7**	**4**	.	**7**	**0**

Other Coverage Indicator code of "**9**" means that client has **Healthy Families** coverage. Place an "X" in the override Code and resubmit as a Healthy Families claim, if SED. There is no other correction.

X	22	

21 | | | | | | | . | | |

PROGRAM NOT AUTHORIZED (13)
Enter the correct program code.

SERVICE FUNCTION NOT AUTHORIZED (29)
Enter the correct service function code.

SERVICE FUNCTION NOT AUTHORIZED IN MO/YR (30)
Enter the correct service function code.

TO DAY > FROM DAY (24)
This indicates that the end date is greater than the start date. Please enter the correct dates.

UNITS > ALLOWED (23)
This error indicates that the number of unit's claimed was greater than allowed. Place the actual number of units or 240, whichever is smaller, in the correction field. Note: The correction field must be "zero filled". If you enter 240, it must be entered as "0240".

UNITS NOT EQUAL TO DAYS (25)
Units claimed are not equal to the days claimed (Inpatient only). Please correct the dates or units.

UNITS/SERVICE IS NOT <=UNITS/TIME (20)
UNITS OF SERVICE (Field 20) must be equal to or less than UNITS OF TIME (Field 19).

ZERO CLAIMED (07)
UNITS OF TIME (Field 19) and UNITS OF SERVICE (Field 20) must be equal to or greater than zero, depending on the service. TOTAL BILLED AMOUNT (Field 21) must be greater than zero. Enter the correct amount.

THINGS TO REMEMBER

ECR's must be corrected using **GREEN** ink.

A **signature, date** and **provider telephone number** must be on the first page of each batch. For multiple pages the signer has the option to use a stamp pad wherein the signer's name and telephone number is provided.

Welfare Identification Number has **14 digits**.

Social Security Number (SSN) has **9 digits** and is left justified in the Welfare Identification Number field. The number on the plastic swipe card is treated like a SSN. Use the first 9 digits, drop the last (10^{th}) digit. SSN's may not start with an "8" or a "9".

Client Index Number (CIN). This is **9 digits**. If this is the only number the client has on the plastic ID card, treat it as a SSN, drop the last digit, retain the alpha and left justify in the Welfare ID field.

"X" override code will delete a record for both Edit and Duplicate ECR's.

The **correction field** is used for amending **incorrect** information only. Do not recopy data that is correct.

Override codes "A" through "F" are late submission codes from Title 22. If ECR is affixed with a good cause code, a "Good Cause Certification " letter must be prepared. This letter is to remain with the provider for review by auditors. Do not send it with the ECR. Good Cause Code "D" must be approved by the SDMH before processing.

Anytime a correction is being made, leave the override code field blank.

DUPLICATE ERROR CORRECTION REPORT (DECR)

The purpose of this report is to inform the provider of line items that were suspended from payment because of duplicate/multiple errors. Duplicate errors can occur for three reasons:

1) a submitted claim is for the same service on the same day for the same recipient as an approved claim;
2) the units of time from the submitted claim in combination with the units of time from approved claims for case management exceed a total of 96 units for the same day for the same recipient;
3) the combination of the submitted claim with approved outpatient claims exceeds two outpatient services on the same day for the same recipient.

The claim in error is grouped with the approved claims that identified the error and with a correction box.

This group of information is printed as follows: The first line of each group is the suspended claim. The next line(s) is the approved claim(s) that caused the claim in the first line to suspend. The approved claim(s) is preceded or followed by two asterisks as an aid in identifying the approved claim(s) from the error claim. The suspended and approved claim lines display the same information with the exception of "Billed Amount" and "Provider". The suspended claim displays its billed amount and the approved record displays its provider number. The last item in the group is the correction boxes. These boxes are used by the providers to either override the duplicate error or to correct the claim. The first three boxes consist of:

- CLAIM ID – Supplied by the computer program. The claim id from the claim in error.
- O/R – Enter the override code "Y" to approve the claim, or "X" to delete the claim from suspense.
- FIELD – Always "99". This identifies the correction as a duplicate error correction.

The remaining correction boxes are only entered if <u>NOT</u> overriding the claim, i.e., to correct an error that made the claim appear to be a duplicate. Only those fields that are to be changed are to be entered in their appropriate boxes.

- MO/YR SERV – Month and year the recipient received the service. (enter leading zeros)
- DAYS SERV – The first and last day of treatment. (enter leading zeros)
- UNITS TIME – Units of time provided. (right justified, leading zeros not required)
- UNITS SV – Units of service provided. (right justified, leading zeros not required)
- BILLED AMOUNT – Total dollars for services provided (no cents).
- DUPLICATE ERROR MESSAGE – Supplied by the program based on the type of error.

DUPLICATE ERROR MESSAGES

There are four possible error messages.

DUPLICATE SERVICE – NO OVERRIDE

This message is displayed when the submitted claim is for the same service on the same day for the same recipient as an approved claim for a service with cannot be overridden for approval.

USER ACTION:

Verify the submitted claim information. If the claim information is correct,
1) either deny the claim with an “X” override, or
2) take no action which will age deny the claim in 96 days from when it was added to suspense.

If the claim information is incorrect, make the correction(s) in the supplied correction boxes.

MULTIPLE SERVICE – OVERRIDE OK

This message is displayed when the submitted claim is for the same service on the same day for the same recipient of an approved claim for a service which can be overridden in order to receive payment.

USER ACTION:

Verify the submitted claim information. If the claim information is correct, follow the established county procedure to obtain clinician certification of the service as appropriate and medically necessary. Upon notification of clinician certification, enter the override code “Y” in the override code field for that claim, and sign and date the DECR at the bottom. If the claim information is incorrect, make the correction(s) to the claim information in the appropriate correction boxes.

TIME GREATER THAN 96 UNITS

This message is displayed when the units of time from the submitted claim in combination with the units of time from approved claims for case management exceed a total of 96 units for the same day for the same recipient.

USER ACTION:

Verify the submitted claim information. If the claim information is correct, 1) either deny the claim with an “X” override, or 2) take no action which will age deny the claim in 96 days from when it was added to suspense.
If the claim information is incorrect, make the correction in the appropriate correction boxes.

GREATER THAN TWO O/P CLAIMS

This message is displayed when the combination of the submitted claim with approved outpatient claims exceeds two outpatient services on the same day for the same recipient.

USER ACTION:

Verify the submitted claim information. If the claim information is correct, follow the established county procedure to obtain clinician certification of the service as appropriate and medically necessary. Upon notification of clinician certification, enter the override code “Y” in the override code field for that claim, and sign and date the DECR at the bottom. If the claim information is incorrect, make the correction to the claim information in the appropriate correction boxes.

HEALTHY FAMILIES

Healthy Families Beneficiary ID

The Beneficiary ID must be 14 places on the form =BC9H99NNNNNNNA.

Where BC = Beneficiary County (two digit numeric),
9H=Healthy Families,
9 = Filler and the
CIN = 9NNNNNNNA (where N is a numeric and A is a letter).

CIN means Client Index Number and it is unique in the system.

Error Codes and Healthy Families Program (HFP) Claims

(Technical Discussion)

Only three error codes were modified by HFP.

Error Code 03 – Invalid Code. This code is set for many situations such as invalid sex code, invalid CIN, etc. For HFP this code will appear if the aid code is equal to "9H" and the CIN is not in a valid format. It would also be set if the "9H" is present but there is no county code.

Error Code 09 – Ineligible in Mo/Yr. This error code is set for the following reasons:

1) If no FFP aid code is found for the date of service.
2) If the Eligibility Status Code is not less than 500 for the primary segment or the special programs segments 1, 2, or 3 (started in fall of 1999) but the ID is found on MEDS.

For HFP this code will also be set for the following reasons:

1) HFP Date of Service period spans the HFP eligibility period.
2) No HFP or Medi-Cal eligibility was found for the Date of Service but the ID is found on MEDS.
3) The HFP claim Date of Service is older than 16 months and the Eligibility Status Code on the MMEF has a "5" or "7" in the second character.
4) The Eligibility Status code is "5" or "7" and the Date of Service is outside the start or end HFP beginning or ending date. If the Status code is "651" and the HFP Start/End date is "14", meaning that the start of HFP was on the 14th of the month and continues through the end of month. If the Service Date is the 10th, then the claim is marked as ineligible. If the Eligibility Status code is "671" then the HFP Start/End date's End date must be checked. If the field is "25", then HFP eligibility ended on the 25th of the month and if the Service Date is the 30th, then the claim is marked as ineligible.

New Error Code 17- Healthy Families Hold Period
This will be set for any HFP claim that comes in and the difference between the Current Date and Date of Service is less than the specified HFP Hold Period (currently 90 days). This is an error that cannot be corrected by the counties. This will change when the record meets the HFP hold period.

EOB and ECR Changes Related to Error Code 32 – Other Coverage Ind _

If the HFP claim was submitted as SD/MC but the person has HFP coverage there will be error code "32 – Other Coverage Ind **9**". This means that HFP coverage was found.

How to fix using EOB.

As the system is showing this as a SD/MC claim and not a HFP claim the counties can pull the information from the EOB and resubmit as a new HFP claim if the child is SED.

How to Fix Using ECR.

There is no fix using the ECR with just this error. You can "X" to have it deleted and then resubmit a new bill if the child is SED It will error out of the suspense file in 97 days. As HFP is separate from SD/MC you can resubmit as HFP without having to delete it from the SD/MC suspense file.

Short-Doyle/Medi-Cal Claim Record Field Names and Conditions

Description	Conditions	Field Number
Claim ID		
Provider code	non-blank	3
Date the claim is submitted		4
Program code	01	5
Mode of service	05, 07, 08, 09, 12, 18	6
Patient Name		8
Patient record number		
Beneficiary ID	Format controls	10
Year of Birth	numeric or blank	11
Sex code		12
Race/Ethnic code		13
DSM IV Diagnostic code	non-blank	14
Century/Year/Month that service is provided	Non-blank and numeric	15
Treatment (service) dates		16
Discharged code		17
Service Function		18
Units of Time	Numeric => zero	19
Units of Service	Numeric => zero	20
Total billed amount	Numeric => zero	21
Late billing override code		
Duplicate payment override code		
Admission Date		
County use field		
Crossover indicator		22
Total Service Charge		23
Medicare/OHC amount		

The information above shows the relationship between the elements on the claim (Description), minimum conditions and the field number shown on the ECR. For example, Provider Code must be non-blank, and the field on the ECR would be 3.

"XOVER INDICATOR " - Edit Logic Table

County	County	State	State	State	State
Recipient's Eligibility	**Tape Xover Indicator**	**Recipient's MEDS Elig.**	**Action**	**EOB Xover Error Code**	**Error Correction Report Message**
No Medicare	blank	No Medicare	Approve	--	---
No Medicare	blank	Medicare	Suspend	31	Medicare Part __, HIC#
Medicare	X	Medicare	Approve	--	---
Medicare	X	No Medicare	Approve	10	Conflicts with Eligibility.
Medicare	N	Medicare	Approve	--	---
Medicare	N	No Medicare	Approve	10	Conflicts with Eligibility.
Medicare	H	Medicare	Approve	--	---
Medicare	H	No Medicare	Approve	10	Conflicts with Eligibility.
No Other Coverage.	blank	No Other Cov	Approve	--	---
No Other Coverage.	blank	Other Cov	Suspend	32	Other Coverage __
Other Coverage	P	No Other Cov	Approve	10	Conflicts with Eligibility.
Other Coverage.	P	Other Cov	Approve	--	---
Other Coverage.	P	Medicare	Suspend	31	Medicare Part __, HIC#
-----	None Above	---	Suspend	03	Invalid Code

This shows the edit logic used in the system when matching MEDS against the claim data. For example, if the claim shows Medicare coverage and the "Xover" indicator shows "X" and MEDS shows either no eligibility or eligibility, the claim will be approved. If the claim shows "no other coverage " (field is blank), but MEDS finds other coverage, the claim is suspended with error code 32.

Staple

BATCH TRANSMITTAL FOR ERROR CORRECTION REPORTS

TO: STATE DEPARTMENT OF MENTAL HEALTH
ACCOUNTING SECTION
1600 NINTH STREET, RM. 150
SACRAMENTO, CA 95814

DATE SENT TO SDMH

_____

DATE SENT TO SDHS

_____

EDIT ECR ____
DUPLICATE ECR ____

County Code _____

BATCH NUMBER
(State Use Only)

M-___/___/___/___/

LINE COUNT
(Total Green Corrections)

___/___/___/

REPORT DATE_____ **RUN DATE**_____

INSTRUCTIONS

There may be no more than **260 corrections/line count** in a batch. (A correction is considered one revised field item including the "X" in the override bracket. Therefore, one page may contain more than one correction). In addition, no batch may have more than **30 pages**.

A **Batch Transmittal Form** must be completed and attached to the ECR with the following data elements:

DATE SENT TO SDMH – date of submission to the State Department of Mental Health
DATE SENT TO SDHS – Leave blank.
EDIT ECR/DUPLICATE ECR – Check the box. To not mix types of ECR's.
LINE COUNT – number of corrected fields/lines in a batch (no more than 260 corrections).
REPORT DATE (MM-DD-YY) – the date found in the center of the ECR.
RUN DATE/CURRENT DATE (MM-DD-YY) – the date found on the upper right hand corner of the ECR.
BATCH NUMBER – For State DMH use only.

Staple (do not paperclip) each Batch Transmittal Form on top of every ECR batch in the upper left hand corner.

The State Department of Mental Health Accounting Section must receive the batch within **60 days** of the Run Date.

GOOD CAUSE CODES FOR LATE SUBMISSION

Providers must meet one of the six situations in order to qualify for good-cause exemption. All time limits and documentation requirements for a particular situation must be adhered to.

A. Situation A (Good Cause "A") - (time limit: one year)

Failure of the patient or legal representative, due to deliberate concealment or physical or mental incapacity, to present identification as a Medi-Cal beneficiary.

1) Providers have one year from the month in which the service was rendered to identify the patient as being Medi-Cal eligible on the particular date of service.
2) Providers shall submit delayed billing not later than 60 days from the date the patient was first identified as a Medi-Cal beneficiary.
3) The delayed billings must be received by State DMH Accounting Section within the stated time limit which may not exceed one year.
4) The following documentation must be maintained by providers:
   a) Date of service.
   b) Date the patient was identified as a Medi-Cal beneficiary.
   c) Month of service documentation may be any of the following:
      i) Medi-Cal I.D. card.
      ii) MEDI label.
      iii) Proof of eligibility (POE) label
      iv) Any of the above indicating Kaiser, Ross-Loos or CHAMPUS coverage, when accompanied by denial of coverage or an explanation of the other coverage by that carrier.
5) Photocopy of the Medi-Cal card or MEDI/POE labels.

B. Situation B (Good Cause "B") - (time limit: one year or 60 days)

Billing involving other coverage, including but not limited to Medicare, Kaiser, Ross-Loos, or CHAMPUS.

1) Providers have one year after the month of service or 60 days from the date of notification that third party payment was denied, whichever is earlier, to bill State DMH for the service rendered.
2) The delayed billing must be received by State DMH Accounting Section within the stated time limit.
3) The following documentation must be maintained by the providers:
   a) Date of service.
   b) Notification of denial of payment by third party.

C. Situation C (Good Cause "C") - (time limit: one year)

Determination by the Director of the Department of Health Services that the provider was prevented from submitting bills for services within the time limitation due to circumstances beyond the provider's control; specifically, due to delay or error in the certification or determination of Medi-Cal eligibility of beneficiary by the State or county. This also applies to retroactive Medi-Cal eligibility.

1) Providers have one year from the date of service to bill State DMH for services rendered.
2) The delayed billings must be received by State DMH Accounting Section within the stated time limit.
3) The following documentation must be maintained by the providers:
   a) Date of service.
   b) Copy of application of Medi-Cal benefits (e.g., SSI/SSP); copy of re-determination of eligibility.

D. Situation D* (Good Cause "D") - (time limit: one year) STATE USE ONLY

Determination by the Director of the Department of Health Services that the provider was prevented from submitting bills for services within the time limitation due to the following circumstances that were beyond the provider's control:

1) Damage to or destruction of the provider's business office or records by a natural disaster, including fire, flood or earthquake; or circumstances involving such disaster have substantially interfered with processing bills in a timely manner.
2) Theft, sabotage or other deliberate, willful acts by an employee.
3) Circumstances involving the retroactive certification/re-certification of the provider to participate in the SD/MC program by the state, or delays by DHS in enrolling a provider.
   a) The date of eligibility for new providers to participate in the Medi-Cal program is the date of certification/re-certification by DHS Provider Participation Section.
   b) Certified SD/MC providers who feel that the date of participation in the SD/MC program should be earlier than the date of certification may request retroactive certification from DHS Performance Monitoring Section through the County Operation Chief.
4) Other circumstances that are clearly beyond the control of the provider and have been reported to the appropriate law enforcement or fire agency when applicable.
   a) Providers have one year from the date of service to bill DMH for services rendered.
   b) The delayed billings must be received by State DMH Accounting Section within the stated time limit.
   c) Documentation to be forwarded to State DMH Accounting Section by the county/provider through the services Area Chief.
      i) Date of service.
      ii) Insurance claim reports, newspaper clippings, photographs of damages, etc.

***** Circumstances that shall not be considered beyond the control of the provider include, but are not limited to:

1) Negligence by employees.
2) Misunderstanding of or unfamiliarity with Medi-Cal regulations.
3) Illness or absence of any employee trained to prepare bills.

4) Delays caused by U.S. Postal Service or any private delivery service.

E. Situation E (Good Cause "E") - (time limit: two months)

Special circumstances that cause a billing delay such as a court decision or fair hearing decision.

1) Providers have two months after the date of resolution of the circumstance to bill State DMH.
2) The delayed billings must be received by State DMH Accounting Section within the stated time limit.
3) Documentation to be maintained by the providers:
   a) Cause of the delay.
   b) Resolution of the delay, including the date of resolution.

F. **Situation F (Good Cause "F") - (time limit: one year)**

Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code.

1) The provider shall have one year in which to submit the bill after the month in which services have been rendered.
2) A copy of the pleadings shall be conclusively presumed to be sufficient evidence of commencement of a legal proceeding.
3) Documentation to be maintained by the provider:
   a) Date of service.
   b) Notification of denial of payment by a liable third party.
   c) Copy of the preceding.

STATE OF CALIFORNIA — SHORT-DOYLE / MEDI-CAL CLAIM REIMBURSEMENT AUDIT SYSTEM — CURRENT DATE: 03/31/00
DEPARTMENT OF HEALTH SERVICES — DEPARTMENT OF MENTAL HEALTH — PAGE NO. : 4,311
REPORT NO: MR-MSD130-R011 — PROGRAM CODE 01 – MENTAL SERVICES
EDIT ERROR CORRECTION REPORT

MARCH 24, 2000

COUNTY: 70 EUREKA

EXAMPLE
INELIGIBLE IN MO/YR

PROVIDER: 9999

BATCH NUMBER	BILLED MO/YR	PATIENT NAME	PATIENT RECORD NUMBER	SERVICE MO/YR	SERVICE DAYS	MODE SRVC	SVC FC	UNITS TIME	SCV UNITS	WELFARE ID/SSN	BILLED AMOUNT
702000020401	02/00	DOE	1065555	02/00	09-09	18	09	65	1	563601234	$ 94.25

CLAIM ID	OVERRIDE CODE	FIELD NO.	********CORRECTI0N********** FIELD IN ERROR	VALUE	ERROR MESSAGE
H999904840		10	WELFARE ID/SSN	563601234	*INELIGIBLE IN MO/YR
H999904840		15	MO/YR OF SERVICE	0799	*INELIGBILE IN MO/YR

This error means that the MSD system has found a match on the Medi-Cal Eligibility Determination System (MEDS) but that the system says that the person is not eligible during that month and year.

There can only be two solutions.

The first solution is that the date is incorrect. Enter the correct date to fix.

CLAIM ID	OVERRIDE CODE	FIELD NO.	********CORRECTI0N********** FIELD IN ERROR	VALUE	ERROR MESSAGE
H999904840		15	MO/YR OF SERVICE	**0809**	*INELIGBILE IN MO/YR

The other solution is that the date is correct and the person is not eligible. Delete the claim.

CLAIM ID	OVERRIDE CODE	FIELD NO.	********CORRECTI0N********** FIELD IN ERROR	VALUE	ERROR MESSAGE
H999904840	**X**	10	WELFARE ID/SSN	563601234	*INELIGIBLE IN MO/YR

STATE OF CALIFORNIA — SHORT-DOYLE / MEDI-CAL CLAIM REIMBURSEMENT AUDIT SYSTEM — CURRENT DATE: 03/31/00
DEPARTMENT OF HEALTH SERVICES — DEPARTMENT OF MENTAL HEALTH — PAGE NO. : 4,311
REPORT NO: MR-MSD130-R011 — PROGRAM CODE 01 – MENTAL SERVICES

EDIT ERROR CORRECTION REPORT

MARCH 24, 2000

COUNTY: 70 EUREKA

EXAMPLE – MEDICARE COVERAGE - CROSSOVER

PROVIDER: 9999

BATCH NUMBER	BILLED MO/YR	PATIENT NAME	PATIENT RECORD NUMBER	SERVICE MO/YR	SERVICE DAYS	MODE SRVC	SVC FC	UNITS TIME	SCV UNITS	WELFARE ID/SSN	BILLED AMOUNT
702000020401	02/00	DOE D	1065555	02/00	09-09	18	09	65	1	563601234	$ 94.25

CLAIM ID	OVERRIDE FIELD CODE	NO.	********CORRECTI0N**********	FIELD IN ERROR	VALUE	ERROR MESSAGE
H999914181		22		XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B
H199914181		21		TOTAL AMOUNT	94.25	M/CARE COV.AB HIC#4492423452B

These two errors go together.
The first error message means that no crossover code was used on the claim and that Medicare coverage was found.
The second error message for field 21 is to be used to put in the corrected or net amount of billing to Medi-Cal.
Possible Solutions:
Provider has not been certified **as a Medicare provider. Enter an "H" in the correction box for field 22.**

H999914181		22	H	XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B

The client was Medicare eligible but the service was not. **Enter an "N" in the correction space for field 22.**

H999914181		22	N	XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B

Medicare has not been billed. **Enter an "X" in the override code box for field 22 to delete claim.**

H999914181	X	22		XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B

Medicare was billed but there has been no response. **Enter an "X" in the override code box for field 22 to delete claim.**

H999914181	X	22		XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B

Medicare was billed but payment was denied **Enter an "X" in field 22 correction box. Medi-Cal pays.**

H999914181		22	X	XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B

Medicare was billed and paid. **Enter a "X" in the correction box for field 22 and enter the new Medi-Cal amount in field 21.**

H999914181		22	X	XOVER INDICATOR		M/CARE COV.AB HIC#4492423452B
H199914181		21	7 2 1 0	TOTAL AMOUNT	94.25	M/CARE COV.AB HIC#4492423452B

STATE OF CALIFORNIA — SHORT-DOYLE / MEDI-CAL CLAIM REIMBURSEMENT AUDIT SYSTEM — CURRENT DATE: 03/31/00
DEPARTMENT OF HEALTH SERVICES — DEPARTMENT OF MENTAL HEALTH — PAGE NO. : 4,311
REPORT NO: MR-MSD130-R011 — PROGRAM CODE 01 – MENTAL SERVICES

EDIT ERROR CORRECTION REPORT

MARCH 24, 2000

COUNTY: 70 EUREKA

EXAMPLE
NOT ON ELIGIBILITY FILE

PROVIDER: 9999

BATCH NUMBER	BILLED MO/YR	PATIENT NAME	PATIENT RECORD NUMBER	SERVICE MO/YR	SERVICE DAYS	MODE SRVC	SVC FC	UNITS TIME	SCV UNITS	WELFARE ID/SSN	BILLED AMOUNT
702000020401	02/00	DOE	1065555	02/00	09-09	18	09	65	1	563601234	$ 94.25

CLAIM ID	OVERRIDE CODE	FIELD NO.	********CORRECTI0N**********	FIELD IN ERROR	VALUE	ERROR MESSAGE
H999904840		10		WELFARE ID/SSN	563601234	*NOT ON ELIGIBILITY FILE

This error means that the MSD system has not found a match on the Medi-Cal Eligibility Determination System (MEDS).

There can only be two solutions.

The first solution is that the SSN/Welfare ID/CIN is in error. The correct fix is to enter the correct SSN/Welfare ID/CIN.

CLAIM ID	OVERRIDE CODE	FIELD NO.	********CORRECTI0N**********	FIELD IN ERROR	VALUE	ERROR MESSAGE
H999904840		10	**5 6 3 6 0 3 4 5 6**	WELFARE ID/SSN	563601234	*NOT ON ELIGIBILITY FILE

The other solution is that the SSN is correct but the person is not eligible. Delete the claim.

CLAIM ID	OVERRIDE CODE	FIELD NO.	********CORRECTI0N**********	FIELD IN ERROR	VALUE	ERROR MESSAGE
H999904840	**X**	10		WELFARE ID/SSN	563601234	*NOT ON ELIGIBILITY FILE

STATE OF CALIFORNIA — SHORT-DOYLE / MEDI-CAL CLAIM REIMBURSEMENT AUDIT SYSTEM — CURRENT DATE: 03/31/00
DEPARTMENT OF HEALTH SERVICES — DEPARTMENT OF MENTAL HEALTH — PAGE NO. : 4,311
REPORT NO: MR-MSD130-R011 — PROGRAM CODE 01 – MENTAL SERVICES
EDIT ERROR CORRECTION REPORT

MARCH 24, 2000

COUNTY: 70 EUREKA

EXAMPLE – OTHER HEALTH COVERAGE

PROVIDER: 9999

BATCH NUMBER	BILLED MO/YR	PATIENT NAME	PATIENT RECORD NUMBER	SERVICE MO/YR	SERVICE DAYS	MODE SRVC	SVC FC	UNITS TIME	SCV UNITS	WELFARE ID/SSN	BILLED AMOUNT
702000020401	02/00	DOE	1065555	02/00	09-09	18	09	65	1	563601234	$ 94.25

CLAIM ID	OVERRIDE FIELD CODE	NO.	********CORRECTI0N**********	FIELD IN ERROR	VALUE	ERROR MESSAGE
H999914181		22		XOVER INDICATOR		OTHER HEALTH COVERAGE CODE K
H199914181		21		TOTAL AMOUNT	94.25	OTHER HEALTH COVERAGE CODE K

These two errors go together.
The first error message means that no crossover code was used on the claim and that other health coverage was found.
The code at the end of the message tells what kind of coverage was found:

- **"C" CHAMPUS**
- **"F" Medicare HMO**
- **"K" Kaiser**
- **"P" PHP/HMO or EPO**
- **"V" Variable – other than above**
- **"9" Healthy Families Program (Only solution is to "X" claim and resubmit if HFP-SED.)**

The second error message for field 21 is to be used to put in the corrected or net amount of billing to Medi-Cal.
Possible Solutions:

Private insurance has not been billed. Enter an "X" in the override code box for field 22 to delete claim.

H999914181	X	22		XOVER INDICATOR	OTHER HEALTH COVERAGE CODE K

Private insurance billed but no response. Enter an "X" in the override code box for field 22 to delete claim.

H999914181	X	22		XOVER INDICATOR	OTHER HEALTH COVERAGE CODE K

Private insurance billed but payment was denied. Enter a "P" in the correction box for field 22.

H999914181		22	P	XOVER INDICATOR	OTHER HEALTH COVERAGE CODE K

Private insurance billed and made payment. Enter a "P" in the correction box for field 22 and enter the net amount billed in field 21 boxes for the net amount.

H999914181		22	P	XOVER INDICATOR		OTHER HEALTH COVERAGE CODE K
H199914181		21	7 2 1 0	AMOUNT	94.25	OTHER HEALTH COVERAGE CODE K

Diagnostic Codes Listing (Alpha/Numeric – Left Justify)

V1581	2938	29581	29666	30082	30390	30540	30750	31233	6250
V611	29381	29582	2967	30089	30391	30541	30751	31234	6258
V6110	29382	29583	2968	3009	30392	30542	30752	31235	78009
V6112	29383	29584	29680	3010	30393	30543	30753	31239	78052
V6120	29384	29585	29681	3011	30400	30550	30754	3124	78054
V6121	29389	29590	29682	30110	30401	30551	30759	3128	78059
V618	2939	29591	29689	30111	30402	30552	3076	31281	7809
V619	2940	29592	2969	30112	30403	30553	3077	31282	7876
V622	2941	29593	29690	30113	30410	30560	3078	31289	7999
V623	2948	29594	29699	3012	30411	30561	30780	3129	9952
V624	2949	29595	2970	30120	30412	30562	30781	3130	9955
V6281	29500	29600	2971	30121	30413	30563	30789	3131	99552
V6282	29501	29601	2972	30122	30420	30570	3079	3132	99553
V6283	29502	29602	2973	3013	30421	30571	3080	31321	99554
V6289	29503	29603	2978	3014	30422	30572	3081	31322	99581
V652	29504	29604	2979	3015	30423	30573	3082	31323	99583
V7101	29505	29605	2980	30150	30430	30580	3083	3133	
V7102	29510	29606	2981	30151	30431	30581	3084	3138	
V7109	29511	29610	29810	30159	30432	30582	3089	31381	
2900	29512	29611	2982	3016	30433	30583	30890	31382	
2901	29513	29612	2983	3017	30440	30590	3090	31383	
29010	29514	29613	2984	3018	30441	30591	3091	31389	
29011	29515	29614	2988	30181	30442	30592	3092	3139	
29012	29520	29615	2989	30182	30443	30593	30921	3140	
29013	29521	29616	29900	30183	30450	3060	30922	31400	
2902	29522	29620	29901	30184	30451	3061	30923	31401	
29020	29523	29621	29910	30189	30452	3062	30924	3141	
29021	29524	29622	29911	3019	30453	3063	30928	3142	
2903	29525	29623	29980	3020	30460	3064	30929	3148	
2904	29530	29324	29981	3021	30461	3065	3093	3149	
29040	29531	29625	29990	3022	30462	30650	3094	3150	
29041	29532	29626	29991	3023	30463	30651	3098	31500	
29042	29533	29630	3000	3024	30470	30652	30980	31501	
29043	29534	29631	30000	3025	30471	30653	30981	31502	
2908	29535	29632	30001	30250	30472	30659	30982	31509	
2909	29540	29633	30002	30251	30473	3066	30983	3151	
2910	29541	29634	30009	30252	30480	3067	30989	3153	
2911	29542	29635	3001	30253	30481	3068	3099	31531	
2912	29543	29636	30010	3026	30482	60680	3100	31532	
2913	29544	29637	30011	3027	30483	6069	3101	31539	
2914	29545	29640	30012	30270	30490	6070	3102	3154	
2915	29550	29641	30013	30271	30491	3071	3108	3155	
2918	29551	29642	30014	30272	30492	3072	3109	3158	
29181	29552	29643	30015	30273	30493	30720	311	3159	
29189	29553	29644	30016	30274	30500	30721	31200	316	
2919	29554	29645	30019	30275	30501	30722	31201	317	
2920	29555	29646	3002	30276	30502	30723	31202	3180	
2921	29560	29650	30020	30279	30503	3073	31203	3181	
29211	29561	29651	30021	3028	30510	3074	31210	3182	
29212	29562	29652	30022	30281	30511	30740	31211	319	
2922	29563	29653	30023	30282	30512	30741	31212	3321	
2928	29564	29654	30029	30283	30513	30742	31213	3331	
29281	29565	29655	3003	30284	30520	30743	31220	3337	
29282	29570	29656	3004	30285	30521	30744	31221	33382	
29283	29571	29660	3005	30289	30522	30745	31222	33390	
29284	29572	29661	3006	3029	30523	30746	31223	33392	
29289	29573	29662	3007	30300	30530	30747	3123	33399	
2929	29574	29663	3008	30301	30531	30748	31230	347	
2930	29575	29664	30080	30302	30532	30749	31231	60784	
2931	29580	29665	30081	30303	30533	3075	31232	60889	

NOTES:

I HATE ECR's

Short-Doyle/Medi-Cal Error Codes
Edit Error Correction Report

BLANK (01)
The identified field has been left blank but is required for the edit process. Fill in the required information using the correct format for the specific field.

CLAIM HELD FOR THE HEALTHY FAMILIES HOLD PERIOD (17)
This error message does not require action. It merely indicates that the claim is on "hold" pending the 60 day retroactive denial edit. Once the "hold" period has passed the claim will be processed.

CLAIM TOO OLD FOR ELIGIBILITY CHECK (18)
This message in not currently valid.

CONFLICTS WITH ELIGIBILITY FILE (10)
This happens when the incorrect SSN or Welfare ID is used. The edit tries to match SSN, name, age, and sex. The fix is to use the correct SSN or to delete the record. However, it may be an error in the YEAR OF BIRTH (Field 11), SEX (Field 12) or PATIENT NAME (Field 8) that keeps the edit from matching on the required fields.
Check the SSN. If this is correct make sure that the other items (YEAR OF BIRTH, SEX, PATIENT NAME) are correct. The YEAR OF BIRTH field must have the "century" and "year" the client was born, NOT the month and year. A client born in "1976" would be entered as "976".

DATE RANGE NOT ALLOWED (22)
This relates to TREATMENT DATE (Field 16). This indicates that days-billed are in error. If the time billed is for an inpatient stay, this can be shown as a range of days (e.g., "0520"- admit date on the 5th of the month to discharge on the 20th of the month). If the time billed is for an outpatient visit on the 5th of the month, then it should be shown as "0505", which means it is for the same day.

DUPLICATE SERVICE – NO OVERRIDE (26)
This indicates that the edit has found a duplicate service (either on this claim or a claim processed in the past). There are no overrides for this error. Make sure the data is correct, if it is, delete the record.

GREATER THAN TWO OUTPATIENT SERVICES (28)
See Multiple Service – Override OK error message.

INELIGIBLE IN MO/YR (09)
This error indicates the recipient was not eligible for Medi-Cal services during the billed month and year of service. This message is also used if recipient has a Share-of-Cost (SOC) obligation to meet. Provider is prohibited from billing Medi-Cal for services used to meet the beneficiary's SOC. When the SOC has been obligated, the balance above the SOC amount and all subsequent services for that month may be billed to Medi-Cal. There are two ways to correct this error:

3. If the total amount of services during the month is below the SOC amount, place an "X" in the override code to cancel the claim from Medi-Cal, or
4. If the amount of services provided during the month is above the SOC amount, the total amount of services must be SOC certified using the Proof of Eligibility (POE) machine, in order to bill Medi-Cal. Once certified, on the ECR report, follow the correction process of Welfare ID/SSN (Field 10).

INVALID CODE (03)
There are a number of errors related to "Invalid Code."

SERVICE FUNCTION CODE (FIELD 18).
This is an indication that an incorrect code was entered. Verify the type of service provided, and write the correct number.

ETHNIC CODE
This is an indication that an incorrect code was entered. The codes are:

1 - White	4 - Asian/Pacific	8 - Other
2 - Hispanic	5 - American Indian or Alaska Native	
3 - Black	7 - Filipino	

SSN ERROR (FIELD 10)
This message may occur because the 10-digit number on the swipe Medi-Cal card was used. Only use the first 9 digits. Leave blank the override code and use the correction field to enter the correct SSN.

DISCHARGE (FIELD 17)
This error indicates that a discharge code has been placed improperly. In the correction space, enter a lower case "b" with a slash through it.

DIAGNOSTIC CODE (FIELD 14)
This is an indication that the Diagnostic Code posted was either incorrect or left blank. Verify and post the correct Diagnostic Code.

INVALID DRUG CODE (21)
Relates to Drug Medi-Cal only.

INVALID SERVICE FUNCTION CODE (19)
Correct the service function code.

LATE SUBMISSION (04)
There are three possible errors. 1. The billing was not timely and may be subject to a "Good Cause" 2. The claim was submitted more than a year after the month of service. 3. The date is wrong. If the billing is correct then you may override this error for "Good Cause". Failure to use a "Good Cause" code will result in rejection of the claim being corrected. (See "Good Cause Code" Section.) If the date is found to be incorrect, write the correct date in the correction field. If it is more than a year late, delete the claim.

MEDICARE COVERAGE PART ___, HIC #_____ (31)
This error message relates to the XOVER INDICATOR (Field 22). It indicates that the client is a Medicare beneficiary. Claims to Short-Doyle/Medi-Cal for services provided to a Medicare beneficiary should be claimed only after Medicare reimbursement/denial documentation has been received. There are a number of corrections and edits possible. The edits involve either deleting the claim ("X" in the override box) or a specific code in the "XOVER INDICTATOR" box and a change in the dollar amount (and don't forget to zero fill). See "XOVER INDICATOR".

MO/YR OF SERVICE GREATER THAN RECEIPT DATE (16)
The receipt date is entered by SDMH. This error indicates that the service was provided after the claim was received. Enter the correct date.

MODE NOT AUTHORIZED (08)
Message indicates that the wrong MODE OF SERVICE (Field 6) has been used. Verify the mode of service being provided (e.g., 12 – Outpatient Hospital Services).

MODE NOT AUTHORIZED IN MO/YR (14)
Enter the correct mode.

MULTIPLE SERVICE – OVERRIDE OK (27)
This is similar to the "Duplicate Service – No Override" error message, but it means that it may be that a multiple service was provided and the county may override this edit.

NO SECONDARY MATCH (15)
This error message usually goes with the "Not On Eligibility File" message. Since the SSN/Welfare ID/CIN is incorrect, all the related information is also incorrect. Use the correction field to enter all the correct information (i.e., name and year of birth).

NOT NUMERIC (06)
UNITS OF SERVICE (FIELD 20)
This is an indication that the field has letters.
This will also apply to UNITS OF TIME (Field 19), TOTAL BILLED AMOUNT (Field 21), TOTAL SERVICE CHARGE (Field 23).

NOT ON ELIGIBILITY FILE (11)
This error message indicates that an incorrect Welfare ID/SSN/CIN was entered. Verify the correct SSN of the patient and if he was eligible during the month of service, leave the override code blank, and use the correction field to enter the correct SSN/Welfare ID/CIN. Do not use the check digit with the CIN.

NOT ON PROVIDER FILE (12)
This message indicates that the provider number is wrong or not on current provider listing. Provider numbers that include letters must be in upper case.

NOT VALID DATE (02)
Date is not valid for the specific field. For example, Date the Claim is Submitted (Field 4) is "CCYYMM". Treatment Dates would be "First Day" (01-31) "Last Day" (01-31), for example, "0506".

OTHER COVERGE IND - (32)

1. If the service has not yet been billed to private insurance, or if it has been billed but a response has not been received (Payment or Denial Letter) prior to the deadline for submission of the ECR then place an "X" in the Override Code, this will cancel the Medi-Cal claim. Upon receipt of insurance payment or denial, provider must re-bill.
2. If the service has already been billed to private insurance and a response (payment or denial) is received prior to the deadline for submission of the ECR then place "XOVER INDICATOR" code "P" in the Error Field and post new Medi-Cal billed amount on the ECR (total value if denied or net value after deducting payment received if paid).
3. Other Coverage Indicator code of "9" means that client has Healthy Families coverage. Place an "X" in the override Code and resubmit as a Healthy Families claim, if SED. There is no other correction.
4. See "XOVER INDICATOR".

PROGRAM NOT AUTHORIZED (13)
Enter the correct program code.

SERVICE FUNCTION NOT AUTHORIZED (29)
Enter the correct service function code.

SERVICE FUNCTION NOT AUTHORIZED IN MO/YR (30)
Enter the correct service function code.

TO DAY > FROM DAY (24)
This indicates that the end date is greater than the start date. Please enter the correct dates.

UNITS > ALLOWED (23)
This error indicates that the number of unit's claimed was greater than allowed. Place the actual number of units or 240, whichever is smaller, in the correction field.

UNITS NOT EQUAL TO DAYS (25)
Units claimed are not equal to the days claimed. Please correct the dates or units.

UNITS/SERVICE IS NOT <=UNITS/TIME (20)
Units of service have to be equal to or less than the units of time claimed.

ZERO CLAIMED (07)
UNITS OF TIME (Field 19) and UNITS OF SERVICE (Field 20) must be equal to or greater than zero, depending on the service. Enter the correct amount.

GOOD CAUSE OVERRIDE CODES

Late Submissions of SD/MC Claims
(Codes refer to Good Cause Certification Letter)

A. Patient or legal representatives failure to present Medi-Cal identification.
B. Billing involving other coverage, including but not limited to Medicare, Kaiser or Champus.
C. Circumstances beyond the control of the county/provider regarding delay or error in the certification of Medi-Cal eligibility of beneficiary by the state or county.
D. Circumstances beyond the control county/provider regarding delays caused by natural disaster and willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency when applicable. This is for STATE USE ONLY.
E. Special circumstances that cause a billing delay such as a court decision or fair hearing decision.
F. Initiation of legal proceedings to obtain payment of a liable third party pursuant to section 14115 of the Welfare and Institutions Code.

HEALTHY FAMILIES BENEFICIARY ID

The Beneficiary ID must be 14 places on the form =BC9H99NNNNNNNA. Where BC = Beneficiary County (two digit numeric), 9H=Healthy Families, 9 = Filler and the CIN = 9NNNNNNNA (where N is a numeric and A is a letter).

Short-Doyle/Medi-Cal Claim Record Field Names and Conditions

Description	Conditions	Field Number
Claim ID		
Provider code	non-blank	3
Date the claim is submitted		4
Program code	01	5
Mode of service	05, 07, 08, 09, 12, 18	6
Patient Name		8
Patient record number		
Beneficiary ID	Format controls	10
Year of Birth	numeric or blank	11
Sex code		12
Race/Ethnic code		13
DSM IV Diagnostic code	non-blank	14
Century/Year/Month that service is provided	Non-blank and numeric	15
Treatment (service) dates		16
Discharged code		17
Service Function		18
Units of Time	Numeric => zero	19
Units of Service	Numeric => zero	20
Total billed amount	Numeric => zero	21
Late billing override code		
Duplicate payment override code		
Admission Date		
County use field		
Crossover indicator		22
Total Service Charge		23
Medicare/OHC amount		

"XOVER INDICATOR " - Edit Logic Table

County		State System				
Recipient's Eligibility	**Tape Xover Indicator**	**Recipient's MEDS Elig.**	**Action**	**Subject to SMA**	**EOB Xover Error Code**	**Error Correction Report Message**
No Medicare	blank	No Medicare	Approve	Yes	--	---
No Medicare	blank	Medicare	Suspend	---	31	Medicare Part __, HIC#
Medicare	X	Medicare	Approve	No	--	---
Medicare	X	No Medicare	Approve	Yes	10	Conflicts with Eligibility.
Medicare	N	Medicare	Approve	Yes	--	---
Medicare	N	No Medicare	Approve	Yes	10	Conflicts with Eligibility.
Medicare	H	Medicare	Approve	Yes	--	---
Medicare	H	No Medicare	Approve	Yes	10	Conflicts with Eligibility.
No Other Coverage.	blank	No Other Cov	Approve	Yes	--	---
No Other Coverage.	blank	Other Cov	Suspend	---	32	Other Coverage __
Other Coverage	P	No Other Cov	Approve	Yes	10	Conflicts with Eligibility.
Other Coverage.	P	Other Cov	Approve	Yes	--	---
Other Coverage.	P	Medicare	Suspend	---	31	Medicare Part __, HIC#
-----	None Above	---	Suspend	---	03	Invalid Code

THINGS TO REMEMBER

ECR's must be corrected using **GREEN** ink.

A **signature, date** and **provider telephone number** must be on each page of the ECR. For multiple pages the signer has the option to use a stamp pad wherein the signer's name is provided.

Welfare Identification Number has 14 digits.

Social Security Number (SSN) has 9 digits and is left justified in the Welfare Identification Number field. Treat the number on the new plastic swipe card as a SSN. Use the first 9 digits, drop the last (10^{th}) digit.

Client Index Number (CIN). If this is the only number the client has on the plastic ID card, treat it as a SSN, drop the last digit, retain the alpha and left justify in the Welfare ID field.

"X" override code will delete a record for both Edit and Duplicate ECR's.

When information is correct, there should **NOT** be an entry in the correction field. The correction field is used for amending **incorrect** information only.

Override codes "A" through "F" are late submission codes from Title 22. If ECR is affixed with a good cause code, a "Good Cause Certification " letter must be prepared and kept with the provider for review by auditors.

Anytime a correction is being made, leave the override code bracket blank.

A **Batch Transmittal Form** is required for all ECR's There can be nor more than 260 corrections/line count in a batch. There can be no more than 30 pages in a batch.