

CLAIMS REJECTED AS ERRORS

Claims identified on an Error Report must be corrected and resubmitted to the Department of Developmental Disabilities [DODD] before the claims can be submitted to the Ohio Department of Medicaid for payment approval. Error reports can be viewed online in the Medicaid Billing System [eMBS] under 'Provider Weekly Reports'.

For further assistance, please contact the DODD Provider Support Center at 800.617.6733 or DODD.support@dodd.ohio.gov

(1) DATE OF SERVICE IS MISSING OR INVALID. The date of service was not formatted correctly or was omitted.

(2) DATE OF SERVICE EXCEEDS PROCESSING DATE. The date of service was later than the date MBS processed the claim.

(3) DATE OF SERVICE PRECEEDS START-UP DATE. The date of service entered was prior to the date the service code went into effect.

(4) CLAIM SUBMITTED PAST THE ALLOWED SUBMISSION DATE. Claims must be submitted within 350 days of the date of service.

(5) SERVICE AVAILABILITY HAS EXPIRED. Services may only be available through a specific date, or may be replaced by a different service.

(6) INVOICE DATE IS MISSING OR INVALID. The Invoice Date was either missing or incorrectly formatted. The correct format is MMDDYY. Please note that if you are using Single Claim Entry the invoice date is entered for you.

(7) INVOICE DATE EXCEEDS PROCESSING DATE. The invoice date cannot be later than the date the claim was processed. Please note that if you are using Single Claim Entry the invoice date is entered for you.

(8) SVC DATE NOT FOUND IN CERTIFICATION SPAN. Failure to renew certification prior to the expiration date found in the Provider Certification Wizard will result in periods where payment may be delayed and/or denied.

(9) CLAIM DOES NOT MATCH USEABLE PAWS RECORD. Claims submitted to DODD must be authorized by the county board of developmental disabilities through the Payment Authorization for Waiver Services [PAWS] system. Providers have 'Read-Only' access to PAWS, where they can view what has been authorized. This error can mean:

- A PAWS plan has not been entered by the county board;
- The PAWS plan has not been enrolled by DODD, in which case the plan status will be 'pending';
- The provider is using an incorrect service code;
- The service date entered is not within the authorized PAWS span.

(10) RECIPIENT NUMBER IS MISSING OR INVALID. The recipient's Medicaid Recipient Number contained non-numeric data or was omitted. To correct, review the submitted information and re-enter the correct data.

(11) MEDICAID RECIPIENT NUMBER ENTERED IS INVALID. The Medicaid Recipient Number entered was not a valid number. Check the recipient's Medicaid card for the correct number.

(12) PAWS DAILY UNIT LIMIT IS EXCEEDED. This error indicates that the claim submitted is in excess of the daily unit limit authorized in PAWS.

(13) CAFS DATA NOT AVAILABLE. No longer used.

(14) TCM SERVICE IS INAPPROPRIATE. Individual is not eligible for TCM.
[Note: County board services only.]

(15) RECIPIENT LAST NAME IS MISSING. The recipient's last name is missing. To correct insert the last name in the field (First 5 letters of the recipient's last name).

(16) RECIPIENT LAST NAME IS INVALID. The recipient's Last Name contained non-alpha data (such as dashes or apostrophes) or was not entered.

(17) RECIPIENT INITIAL IS MISSING OR INVALID. The recipient's Initial contained non-alpha data (such as dashes or apostrophes) or was not entered.

(18) HOMEMAKER/PERSONAL CARE EXCEEDS 24 HOURS IN A DAY. HPC services cannot exceed a total of 24 hours (96 units) per day, whether billed by one or by several providers.

(19) CONTRACT NUMBER IS MISSING OR INVALID. No longer used.

(20) DIFFERENT HOMEMAKER/PERSONAL CARE SERVICES ON SAME DAY. HPC service shall not be based on a day billing unit when the eligible individual receives this service's from more than one waiver service provider on the same day.

(21) CONTRACT NUMBER CHECK DIGIT IS INVALID. No longer used.

(22) PAWS TOTAL UNIT LIMIT IS EXCEEDED. This error indicates that the claim submitted is in excess of the total number of units authorized by the County Board.

(23) SERVICE CODE IS MISSING OR INVALID. The Service Code was not entered correctly or was left blank.

(24) UNITS DELIVERED ARE MISSING OR INVALID. The Units of Service Delivered were not entered or the information entered could not be processed. Check this field; make the necessary corrections and resubmit.

(25) PAWS TOTAL COST LIMIT IS EXCEEDED. This error indicates that the claim submitted is in excess of the total cost limit authorized by the County Board.

(26) UNITS DELIVERED ARE EXCESSIVE. Claims for any Service Code with quarter-hour (15 minutes) units are restricted to 96 units per day. Claims for any Service Code with hourly units are restricted to 24 units per day. Daily rate codes are restricted to one (1) unit per day.

(27) OTHER SOURCE OF PAYMENT IS INVALID. You should only use the Other Source Code field in eMBS if you are reporting patient liability [1] or third party liability [S]. Otherwise, this field should be left blank.

(28) SERVICE DUPLICATED FOR RECIPIENT AND DATE. If a provider enters two or more claims in the same billing cycle for the same recipient, service code, and service date, MBS will process the first claim entered and error any subsequent duplicates. An example would be a provider billing APC [homemaker/personal care] with a group size of '1' for 24 units, and then entering the same claim for 36 units. The second claim would error.

(29) OTHER SOURCE CODE AND PAYMENT AMOUNT DISAGREE. If you enter a '1' into the Other Source Code field in eMBS, indicating that you are reporting patient liability, then the Other Source Amount field cannot be left blank.

(30) PAWS MONTH UNIT LIMIT IS EXCEEDED. This error indicates that the claim submitted is in excess of the monthly unit limit authorized in PAWS.

(31) SERVICE IS LIMITED TO ONE PROVIDER PER DAY. Services such as Adult Foster Care [AFO/AFA] and Adult Family Living [AFL], which are daily units, cannot be billed by more than one provider per day. This error indicates another provider has billed for this service. If you believe the other provider billed in error, please see your local County Board for assistance in coordinating the billing.

(32) SERVICE IS IDENTICAL TO PRIOR BILLING. The claim entered duplicates a claim that was paid in a previous billing cycle.

(33) SERVICE IS INAPPROPRIATELY DELIVERED. No longer used.

(34) PAWS WEEK UNIT LIMIT IS EXCEEDED. This error indicates that the claim submitted is in excess of the weekly unit limit authorized in PAWS.

(35) LAST NAME DIFFERS FROM RECIPIENT FILE The information entered in the Recipient Last Name field in eMBS must match the name associated with the Medicaid Recipient Number as it appears on the individual's Medicaid card. The name associated with the Medicaid Recipient Number appears along with this error.

(36) INITIAL DIFFERS FROM RECIPIENT FILE. The information entered in the Recipient First Initial field in eMBS must match the name associated with the Medicaid Recipient Number as it appears on the Ohio Department of Medicaid recipient file. The name associated with the Medicaid Recipient Number appears along with this error.

(37) RECIPIENT NOT FOUND ON RECIPIENT FILE. The Medicaid Recipient Number entered into eMBS is not on the Ohio Department of Medicaid recipient file. Please check the individual's Medicaid card to ensure you have entered the correct number, or contact your local county board of developmental disabilities for assistance.

(38) WAIVER RECIPIENT INELIGIBLE FOR CAFS SERVICES. No longer used.

(39) LEVEL ONE SERVICE EXCEEDS WAIVER SPAN LIMIT. Homemaker/Personal Care, Respite, and Transportation services are limited to \$5,000 per waiver year on the Level 1 waiver.

(40) LEVEL ONE SERVICE EXCEEDS WAIVER SPAN LIMIT. LV1 errors when specialized medical equipment/ emergency response system costs exceed \$2,000.00 in the waiver span or when environmental adapt (FAA, FVN) is greater than \$2,000.00 and associated services are greater and \$6,000.00 during the waiver span or emergency services exceeds \$8,000.00 during waiver span.

(41) GROUP SIZE IS MISSING OR INVALID. This error occurs when the group size is missing or zero has been placed into this field.

(42) ICD-9 CODE IS MISSING (837 FORMAT). No longer used.

(43) SERVICE DATE NOT FOUND IN ELIGIBILITY SPAN No longer used.

(44) SERVICE COUNTY IS MISSING OR INVALID. The Service County was not entered or was incorrectly formatted.

(45) STAFF SIZE IS MISSING OR INVALID. Staff size is missing or was entered as zero.

(46) STAFF SIZE AND SERVICE CODE DISAGREE. The staff size entered must match the service code as applicable.

(47) STAFF SIZE EXCEEDS MAXIMUM ALLOWED. Staff size cannot be more than 5.

(48) INPUT RATE IS MISSING OR INVALID. The Usual Customary Rate is missing or non-numeric data was entered into this field.

(49) SERVICE DATE EXCEEDS ALLOWED ADJUSTMENT SPAN. Adjustments that are submitted more than two years beyond the service date cannot be processed through the Medicaid Information Technology System [MITS].

(50) INDIVIDUAL AGE INAPPROPRIATE FOR FOSTER CARE. An Individual receiving adult foster care services (AFA or AFO) must be 18 years of age or older.

(51) SERVICE CODE AND PROVIDER TYPE DISAGREE. Contact the DODD Provider Support Center at 800.617.6733 or at DODD.support@dodd.ohio.gov.

(52) HOMEMAKER/PERSONAL CARE AND FOSTER CARE CONFLICT. An individual may not receive homemaker/personal care services on the same day as adult foster care services. In the event of simultaneous submissions, adult foster care services will receive precedent.

(53) HIPAA BILLING CODE RECEIVED IS INVALID. No longer used.

(54) NET CLAIM AMOUNT IS LESS THAN ZERO. Other source amount entered exceeds the amount billed for the individual claim. Resubmit, making certain the amount entered into the other source amount is equal to or less than the total claim. If necessary, report the remainder of the patient liability on the following day(s) claim.

(55) DBU CLAIM OVER CEILING REJECTED BY DODD. No longer used.

(56) CLAIM NOT MATCHED WITH ACUITY TABLE. The claim did not match against the current acuity table, and the billing rate could not be calculated without an acuity value. Contact your local County Board for assistance.

(57) INDIV SUSPENDED FROM PAWS ON THIS DATE. The individual's PAWS was suspended on the date of service. Please contact your local County Board for assistance.

(58) INVALID # OF UNITS FOR COMMUNITY RESPITE SERVICES. The community respite daily billing code [ARN] must be used if more than 7 hours [28 units] of service is provided, and the individual stays overnight at the service delivery location. The partial day billing code [ARD] must be used when between five and seven hours [20- 28 units] are of service is provided, and the individual does not stay overnight at the service delivery location. The 15 minute unit code [ARF] must be used for all other scenarios.

(59) MAXIMUM # OF UNITS FOR RESPITE SERVICES EXCEEDED. Community respite is limited to sixty calendar days of service per waiver span, and residential respite is limited to ninety calendar days per waiver span.

(60) CLAIM NOT ELIGIBLE FOR ADJUSTMENT AT THIS TIME. No longer used.

(61) CLAIM IS OVER MEDICAID MAX. Non-medical transportation claims [ATT, FTT, STT] are limited to \$100 per unit. If the actual cost of the claim is over \$100, the PAWS plan will have to authorize two or more units per span. Please contact your CBDD for assistance.

(62) ON-SITE/ON-CALL LIMITED TO 8 HOURS PER DAY. [AOC/FOC] claims are limited to 32 units [8 hours] of service per individual per day, whether billed by one provider or by multiple providers.

(63) ADULT DAY SERVICES 15 MIN/DAY UNIT CONFLICT. When a single agency provider provides less than 5 hours or more than seven hours of adult day services during 1 calendar day to the same individual, the provider shall use 15 minute units. You cannot bill a daily unit and 15-minute unites on the same day.

(64) ADULT DAY SERVICES DAILY UNIT CONFLICT. When a single agency provider provides less than 5 hours or more than seven hours of adult day services during 1 calendar day to the same individual, the provider shall use 15-minute units. You cannot bill 2 daily units on the same day.

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