DENY REASON CODES CHEAT SHEET v 7.49 06/20/07

OUTPATIENT

HIPAA Deny Reason Code	IS DENY SOURCE			IS DENY REASON	DESCRIPTION/RESOLUTION
	RULES	CICS	UIWEB/ FIN ADJ		
	Yes			Validate diagnosis code Inb837.Post.37	This means that the diagnosis code on the claim was not a valid diagnosis code in the Integrated System.
	Yes			Service Location does not have rate for procedure code.	Normally occurs when you are re-submitting a claim. The original procedure code on the resubmitted claim is no longer in your provider rate table. There could be various reasons why this has occurred. Use another valid procedure code. If you feel the procedure code in the original claim is valid please call the Help Desk.
	Yes			Date of Service occurs after Client's Date of Death	Only the following procedure codes can be used with the Date of Service after the client's date of death 90887, 90889, 99361 and 99362.
	yes			Cannot void a claim when service date equal discharge date	An outpatient or Day Treatment claim cannot be voided if it is equal to or greater than the episode discharge date.
	Yes			Procedure Code is required.	The procedure code was blank when you tried to submit the claim.
A1			Yes		DMH Finance Bureau denied the claim. 1. The claim had a plan that is not in the providers contract, or 2. There is no more money in the plan on the claim, or 3. MC-EPSDT or Healthy Families plans were on the claim and the claim was not sent to Medi-Cal, or 4. CalWORKs was a plan on the claim and it did go to Medi-Cal. 5. Medi-Cal denied the claim. If after you research this information you feel the claim was denied in error, contact your DMH Finance Bureau liaison.

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					Also see HIPAA Deny Reason Code 18. This has been phased out as of August 2005. You may still see this message on claims prior to August 2005.
B4	Yes			Verify LP Delay Reason Code (Inb.837.43)	The delay reason code cannot be 5, 6, 9, 11.
B7	Yes			Verify Service Location Medicare ID (Inb.837.Post.47a)	For directly operated, if Medicare claim, make sure the provider location has a Medicare ID. If Medi-Cal is the payer and can be billed, make sure the service location Medi-Cal ID is active.
B7	Yes			Verify SrvLoc MediCalID (Inb837.Post.52)	For Local Plan Providers (DO & Contract), if Medi-Cal is a payer and can be billed, ensure the service location Medi-Cal ID is active. Medi-Cal can be billed when: • All the plans in the claim allow Medi-Cal to be billed, • And the procedure code can be converted to a Medi-Cal procedure code.
B7	Yes			Medical billable claims service date (Inb837.Post.58)	Service date over 12 months old and cannot be billed to MediCal.
5	Yes			Verify ServLocProv Mode (Inb837.Post.50)	Validate mode of service location consist with proc code service type– Added 6/17/2004 Verify the hrp_provider.mode for the service loc (RU where the service took place). If mode = 10, then we need to make sure that for the proc code listed, hrp_DMHProcedure.Servicetype=O and hrp_DMHProcedure.DayTrmt = Y.
13	Yes			Verify Svc Dt - Dt of Death (Inb837.Post.15)	If client Death Date exists in the MHMIS or the IS, the Service Date must prior to or the same.
18			Yes		This has been phased out as of August 2005. You may still see this message on claims prior to August 2005. DMH Finance Bureau denied the claim. 1. The claim had a plan that is not in the providers contract, or 2. There is no more money in the plan on the claim, or 3. MC-EPSDT or Healthy Families plans were on the claim and the claim was not sent to Medi-Cal, or

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					4. CalWORKs was a plan on the claim and it did go to Medi-Cal. 5. Medi-Cal denied the claim. If after you research this information you feel the claim was denied in error, contact your DMH Finance Bureau liaison. See if these claims had EPSDT or Healthy Families. run the IS010 report, and look on that report to see if MCal = NO. If it does, these claims have been denied because you have claimed against EPSDT or Healthy Families plans, but you did not send the claim to MediCal first. You can only claim against these plans if you send the claim to MediCal first. To fix these you should do a new eligibility check for that service date/month/provider/client. Make sure MediCal is included. For EPSDT clients as long as you get a positive response from MediCal, you can go ahead and resubmit making sure that the MediCal checkbox is checked for the claim to go to MediCal on the Admin/claim/payer tab. For Healthy Family clients, you need to actually check the response which is normally negative from MediCal because you do not get an EVC number for Healthy Family clients. If the response indicates the client does have Healthy Families, make sure the client is enrolled in the healthy family plan (look at the DMH elig response). When you submit the claim out of Admin you need to force the claim to go to Medi-Cal by going to the Payer tab, make sure the Medi-Cal checkbox is checked, enter a "9" in the EVC number field, click continue, go to the Medi-Cal Id field and enter the client CIN #. Click submit.
18	Yes			Check for Dup claim (Inb837.Post.4)	The same Claim Id came in 2xs. This is somewhat common for providers who submit through EDI, but should not occur for user who submit claims from Admin. That being said, this had occurred for those that submit through Admin on certain occasions where claims got suspended and were then resubmitted. If you get this error message call the help desk at 213-351-1335.

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22	Yes			Verify Medicare Claims (Inb837.Post.46)	For directly operated, make sure Medicare is specified as a payer if all conditions are met. The service location is Medicare certified. The service is Medicare reimbursable. The client has Medicare The service is not via telephone.
29	Yes			Verify Late Claims for Delay R (Inb837.Post.19)	If a claim is filed more than 6 months after the service date, there must be a delay reason code.
31	Yes			Verify Subscriber Enrollment (Inb837.Post.10)	Verify the subscriber (client) is enrolled with DMH and is a person. Note that the value in the claim is the client's DMH ID. Also may be related to client's death date.
38	Yes			Verify Submitter (Inb837.Post.3)	The submitter last or Organization Name and Submitter Identifier must be a registered provider found on the IS database. The provider must also be active on the date of service.
38	Yes			Reject Corrected and Replacement (Inb837.Post.2)	The IS will process only original (1) or voided claims (8). 05/20/2004: Replacement (7) claim are also valid. Only corrected (6) are not accepted.
38	Yes			Ensure LP Service Location has Rate for Claim Plans and Procedure Code (Inb837.Post.5.2.E3)	If the CPT code in the claim is not billable under the Plan (i.e. Crisis Intervention is not allowed under AB3632) the claim will be denied, even if there is another Plan in the claim.
45			Yes		DMH Financial Adjudication. The DMH Finance Bureau denied the claim. The Finance Bureau typically denies the claim when the claim has a plan not in the contract or funds for a plan on the contract have run out or **Medi-Cal denied the claim.** Contact your provider liaison at **http://dmh.lacounty.info/hipaa/downloads/FINANCE_BUREAU_CONTACT_LIST.pdf**

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47	Yes			Verify Diagnosis Code (Inb837.Post.37)	Ensure the ICD-9 diagnosis code converts to a DSMIV code. There may be a problem with the ICD-9 – DSMIV crosswalk. Call the help desk at 213-351-1335.
52	Yes			Ensure LP Rendering Provider has a Taxonomy (Inb837.Post.5.2.E4)	If the claim is from Local Plan provider, ensure the rendering provider's taxonomy can perform the service. If you receive this error, resubmit -- This edit has been suspended.
52	Yes			Verify Rend Provider Medicare ID (Inb837.Post.42) or (Inb837.Post.47)	For Directly Operated providers the system checks to see if the rendering provider has a Medicare ID in the IS system. If you believe the rendering provide is a Medicare certified provider then call the help desk at 213-351-1335.
96	Yes			Validate Client Plans (Inb837.Post.5.2.E1)	For all claims (LP and FFS), ensure the client is actively enrolled and approved for all the plans specified in the claim. To enroll a client in a plan (add a plan) you must do an update enrollment. For instructions on how to do an update enrollment go to **http://dmh.lacounty.info/hipaa/do_UsingtheIS.htm**
107	Yes			Verify Void Claim (Inb837.Post.5)	The voided claim must have a matching original claim. This happens when you try to unlock the voided claim and you try to submit/resubmit. Call the help desk at 213-351-1335.
107	Yes			Prior ClaimID for Void/Resubmit (Inb837.Post.5a)	For example if the original (claim A) was denied and then resubmitted as Claim B. To void the claim, Claim B must be voided, not Claim A.
107	Yes			For Void, Validate Original or last Resubmitted Status (Inb837.Post.5b)	The last approved claim for a service can be voided. A single service may be submitted multiple times if it is denied multiple times.
107	Yes			Prev Resub Status For Resub (Inb837.Post.5c)	Attempted to Re-Submit a transaction that was not in DENIED status.

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125	Yes			Verify min UOFS data (Inb837.Post.12)	The data was missing when the claim was sent. This is an internal problem and you should be able to resubmit the claim.
125	Yes			Client Ineligible for Service	You are claiming against a plan that the client is not enrolled in You are claiming against a plan that the client's effective date was after the service date of the claim You are claiming against a plan that the service location does not have in their contract with DMH You added a plan in the Payer tab when submitting the claim. You must do an Update Enrollment to add a Plan. In order to correctly enroll the client in a plan (add a plan) you must do an Update Enrollment. For instructions on how to do an Update Enrollment go to **http://dmh.lacounty.info/hipaa/do_UsingtheIS.htm**
125	Yes			Verify Service Time (Inb837.Post.45)	Other and Face-to-Face time are zeroes.
125	Yes			Verify Staff time limits (Inb837.Post.16)	The staff time has exceeded the limit for the procedure code or minutes not to exceed 8 hours per staff person. See Procedure Codes manual at **http://dmh.lacounty.info/hipaa/index.html**
125	Yes			Plans Need Medi-Cal as a payer (Inb837.Post.54) or **Validate Medi-Cal as a payer if plan is EPSDT/HF (Inb837.Post.54)**	The claim has MC-EPSDT or Healthy Families as a plan and the claim was not sent to Medi-cal. Check out the training film at **http://dmh.lacounty.info/hipaa/co_ISMovies.htm**. Select movie called Medi-Cal Eligibility and Denied Claims.
125	Yes			Verify Medicare and Insurance (Inb837.Post.17)	For contract providers, Medicare and Insurance claims are submitted before submitting through the IS. Make sure there is an amount paid even if it is $0.00. For directly operated providers Medicare amount paid should equal $0.00. For Other Insurance, both directly operated providers and contract providers may enter an amount received.
125	Yes			Verify Subscriber Info (Inb837.Post.36)	Subscriber (client) address, City, State and Zip and demographic information should be in the claim.

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125	Yes			Verify Billing and Pay To Prov (Inb837.Post.7)	The billing provider must exist in the IS and be active on the service date of the claim. The help desk needs to look up the provider information (not the rendering provider but the provider legal entity and verify that it is correct. The user may have to submit paperwork to update provider info.
125	Yes			Verify Svc Dt - Current Dt (Inb837.Post.28)	Ensure the service date is not more that a year before the current date.
125	Yes			Verify Receiver (Inb837.Post.6)	The receiver of all claims must be DMH.
125	Yes			Verify Payer (Inb837.Post.11)	Verify the payer referenced on the inbound 837 claim is DMH.
125	Yes			Verify FFS 2 Plan (Inb837.Post.30)	If the claim is from FFS 2 provider, ensure only MCF is sent as plan in the other payer loop. Note that a plan does not have to be present in the transaction.
125	Yes			Verify Directly Operated Prov (Inb837.Post.8)	Claims from Directly Operate providers must have DMH as the pay to provider and an organization as the billing provider.
125	Yes			Verify Birth Dt - Dt of Death (Inb837.Post.23)	Ensure the subscriber's birth date is not after the date of death.
136	Yes			Verify Insurance Type Code (Inb837.Post.49)	REMOVED 12/15/2004 If an Other payer in Medi-Cal or Medicare, ensure the Insurance type code is valid. • Medical = 'MC' • Medicare = 'MB' • Insurance = Anything other than MC or MB. Typically is set to 'CI'.
147	Yes			Ensure LP service location (RU) has a rate table (Inb837.Post.5.2.E1)	If the CPT code in the claim is not billable under the Plan (i.e. Crisis Intervention is not allowed under AB3632) the claim will be denied, even if there is another Plan in the claim with the same CPT code that is billable to Medi-Cal (CI is billable under EPSDT).

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148	Yes			Verify Med-Cal and Medicare ID (Inb837.Post..39)	If Medi-Cal is specified as a payer the Medi-Cal ID must be in the CIN format – 8 digits and a capital letter. Cannot use all 9's and a letter. If Medicare is specified as a payer, ensure the clients Medicare ID is in the format a minimum of 9 and max of 12 (such as A12345678XYZA). MHMIS EPI2 screen format.
148	Yes			Validate Client Medicare Eligibility **(Inb837.Post.46A)**	If the client had Medi-Cal and deleted the Medicare ID on the clinical tab the user may receive error message "VALIDATE CLIENT MEDICARE ELGIBILITY" the user received message in error and should resubmit claim. Issue fixed 09/2005. If Medicare is listed on the Financial Tab, Medicare needs to be included as a payer if the Medi-Cal eligibility check also shows Medicare.
148	Yes			Verify Insurance Rendering Prov (Inb837.Post.21)	If a payer is 3rd party insurance and a rendering provider for insurance exists, it must be of type "Commercial Identifier". In addition there can only be one rendering provider of type commercial identifier.
	Yes			Validate Medicare and Insurance Paid Amount (Inb837.Post.54)	Ensure Medicare and/or Other Third Party Insurance paid amounts do not exceed the total claim amount.
	Yes			Validate Data Like bad data in address line (Inb837.Post.61)	Resubmit Claim.

INPATIENT

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	RULES	CICS	UIWEB/ FIN ADJ		
18	Yes			Check for Dup Transaction (Inb837I.Post.3)	Checking for duplicates in general: if a claim comes in with the same claim number, it is considered a duplicate regardless of whether it's an original, resubmit or void. NOTE: The void claim will have it's own unique claim id and the original claim id will be referenced.
18	Yes			Reject Corrected/Replacemt Clm (Inb837I.Post.1)	The IS will process only original (1) or voided claims (8). If a corrected (6) or replacement (7) claim is received, the claim is rejected.
29	Yes			Verify Late Claims (Inb837I.Post.15)	If a claim is filed more than 6 months after the service end date, there must be a delay reason code.
38	Yes			Ensure LP Service Location has Rate for Claim Plans and Procedure Code (Inb837i.Post.5.2.E3)	If the claim is from Local Plan provider, ensure the service location's rate table contains the claim plans and procedure code. If the claim does not contain any plans check rate table for CGF. Either "trash can" the plan when submitting the claim or do an Update Enrollment. Instructions for doing an Update Enrollment are at **http://dmh.lacounty.info/hipaa/do_UsingtheIS.htm**
52	Yes			Ensure LP Rendering Provider has a Taxonomy (Inb837i.Post.5.2.E4)	If the claim is from Local Plan provider, ensure the rendering provider's taxonomy can perform the service. If you receive this error, resubmit – This edit has been suspended.
64	Yes			Validate Medicare and Insurance Amount Paid	Either a Medicare paid amount or Other Insurance Paid amount was entered on the Payer tab and the amount entered was more than the amount of the claim.

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96	Yes			Validate Client Plans (Inb837i.Post.5.2.E1)	For all claims (LP and FFS), ensure the client is actively enrolled and approved for all the plans specified in the claim.
107	Yes			Original/Resub Status For Void (Inb837I.Post.4b)	If there is only an original claim it cannot be denied. If there is an original and one or more resubmitted claims, the last resubmitted claim cannot be denied and all the others must have been denied. In addition, if the last resubmitted claim is a Void, it must be denied due to rules.
125	Yes			Verify Svc Dt <= Curr Date (Inb837I.Post.21)	Ensure the service date is not more than a year before the current date. REMOVED 12/15/2004
125	Yes			Client Cross Referenced (Inb837I.Post.28)	Verify the Client ID has not been cross referenced with another Client ID.
125	Yes			Verify Subscriber Info (Inb837I.Post.22)	Ensure the subscriber's Address, Zip and demographic exist in the transaction.
125	Yes			Verify Procedure Code (Inb837I.Post.20)	It appears that the user may be modifying the procedure code, by deleting the modifiers which is causing the problem, or modifying the procedure code when submitting the claim on the Administrative side.
125	Yes			Verify Attending Provider (Inb837I.Post.7)	Ensure that the rendering provider associated with the inpatient claim is current and not expired.
125	Yes			Verify Srv Dt Range (Inb837I.Post.23)	This is caused by an inpatient episode running across 2 months and then a service is submitted where the service date range crosses from one billing month to the next. Services must remain within a month. (So split the service into two,submit one claim for one month and then another for the next.)

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147	Yes			Ensure LP service location (RU) has a rate table (Inb837i.Post.5.2.E1)	If the claim is from Local Plan provider, ensure the service location has rate table.
B7	Yes			Medical billable claims service date (Inb837.Post.58)	Service date over 12 months old and cannot be billed to MediCal.
	Yes			Validate Medicare and Insurance Coverage (Inb837i.Post.13)	Ensure Medicare and/or Other Third Party Insurance paid amounts do not exceed the total claim amount.
	Yes			Validate Client Medicare Eligibility (Inb837i.Post.38)	If the client had Medi-Cal and deleted the Medicare ID on the clinical tab the user may receive error message "VALIDATE CLIENT MEDICARE ELGIBILITY" the user received message in error and should resubmit claim. Issue fixed 09/2005. If Medicare is listed on the Financial Tab, Medicare needs to be included as a payer if the Medi-Cal eligibility check also shows Medicare.

MHMIS (CICS)

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	RULES	CICS	UIWEB/ FIN ADJ		
OA		Yes		IS100000 - CLNT TRANSIENT MEDICARE CANNOT BE PAYER	Transient clients cannot be billed to Medicare.
		Yes		LAMH0011- RECORD NOT FOUND	The Client ID (MHMIS ID) cannot be found in the MHMIS. There may be an out-of-sync problem between the IS and MHMIS. Call the help desk.
				LAMH0011 EPISODE NOT FOUND	There was a problem with the rendering provider association for these services and has been fixed for Nov. 2004 claims. Please resubmit from Clinical. If this problem re-occurs please report it to the Help Desk.
31		Yes		LAMH0295-CLIENT HAS XREF ID	The Client ID (MHMIS ID) is a xref number. There is more than one Id for this client and this one has been disabled. Use the correct ID.
52		Yes		LAMH0337 CANT"T USE INACTIVE PROV NUM	The rendering provider has expired in the MHMIS Staff tables. If this rendering provider should not be expired, contact the help desk so that it can be updated.
		Yes		LAMH0339 - SFPR NOT ASSIGNED TO PROV NUM	**08/25/06 This error message is no longer used! If you have claims with this error—you can resubmit.** The staff code for the SFPR for this client is not in the MHMIS Reporting Unit of the SFPR. If the SFPR is in your Reporting Unit, you can go the Client Info/Other tab and remove and/or replace the SFPR name. If the SFPR is for another Reporting Unit, you must contact the other reporting unit and ask them to remove and/or change the SFPR name.

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52		Yes		LAMH0339 - SFPR NOT ASSIGNED TO PROV NUMUSER SPECIAL IAL	Look in Client Info, Other tab. You will see the SFPR name and reporting unit for that SFPR. The SFPR may need to be updated. When the claim is submitted the data in the claim is used to update MHMIS. When the SFPR is inactive in MHMIS this error could occur. 1.If the staff person should be in that reporting unit, call the help desk so that the rendering provider can be added to the correct reporting unit in the MHMIS. 2. If you have access to the reporting unit for this clinician, remove the clinicians name by clicking on the SFPR drop down and selecting the blank space.
		Yes		LAMH0361-DISCHARGE lt LAST TREATMENT DATE USER SPECIAL	You are trying to close an episode with a discharge date that does not match the last UOFS on the MHMIS. Sometimes it is caused by a claim that was voided in the IS but was not removed from the MHMIS. Call the Help Desk to investigate.
		Yes		LAMH0378-TREATMENT AUTHORIZATION MISSING (EPIS:LAMH0378)	
		Yes		LAMH0404-UNAUTHORIZED ACT CODE IN RU	When the claim was sent to the MHMIS, the procedure code is translated into an activity code. The MHMIS does not have the translated activity code in its table for the Reporting Unit. Either your reporting unit is not authorized to use this procedure code/activity code or there is an problem and the tables need to be updated. If you feel that it is in error, call the help desk.
		Yes		LAMH0411- ACT DATE < ADMIT DATE	The Date of Service is before the admit date on the episode.

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		Yes		LAMH0412- ACT DATE > DISCHARGE DATE	The Date of Service is after the discharge date on the closed episode.
		Yes		LAMH0415-ACT DATE OUTSIDE STAFF EMP DATE	The date of service is after the rendering provider's termination date for that reporting unit. If you feel this is in error the tables in the MHMIS must be updated. Contact the help desk.
		Yes		LAMH0418-ACT DATE > TERMINATION DATE	The procedure/activity date cannot be after the termination date of the rendering provider in the MHMIS. If you believe this in error, call the help desk. A rendering provider form may have to be submitted.
B4		Yes		LAMH0436-LATE CODE REQUIRED	Re-submit this claim using a late code at the time of submission. The MHMIS counts six months from the monthly billing cycle, For example if we are in the April 2005 billing cycle any claim with a May 2004 - October 2004 date of service requires a late code. Once we run the April claims (on May 6, 2005) the system will require a late code for claims with service dates of June 2004 - November 2004 because the current billing cycle is May 2005. See the website for a detailed explanation and valid late (delay reason) codes http://dmh.lacounty.info/hipaa/index.html
		Yes		LAMH0437-VALID LATE CODES ARE A THRU D	There was a mismatch between the IS and MHMIS late codes. This has been corrected and you can resubmit the claim. The list of valid late codes is on the dmh website. http://dmh.lacounty.info/hipaa/index.html
		Yes		LAMH0459 TIME > THAN 23 HRS 59 MINS	The total face-to-face and other time cannot be greater than 24 hours.

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		Yes		LAMH0469 TIME > THAN 19 HRS 59 MINS	Face-to-face and Other time cannot be greater than 20 hours.
		Yes		LAMH0927-VALID LATE CODES ARE A THRU D	There was a mismatch between the IS and MHMIS late codes. This has been corrected. The list of valid late codes is on the dmh website **http://dmh.lacounty.info/hipaa/index.html**
148		Yes		LAMH0931-CIN # W/A-Z OR MEDI-CAL # ONLY USER SPECIAL IAL	The user has put the social security number of the client into the CIN number. The issue is that the CIN number is not formatted correctly.
		Yes		LAMH0995 NO VALUE ALLOWED IN AMOUNT PAID FIELDS	If the Medicare box is checked on the Payer tab, the Medi-Cal box must also be checked.
				LAMH0998 MCAL/MCARE=Y CODES(B,E,H,N,P,X):	A cross over code is needed to create this UOFS in the MHMIS. This should be reported to the Help Desk at 213-351-1335.
		Yes		LAMH4072-MEDICARE(N) NO AMT ALLOWED	If the Medicare box is checked on the Payer tab, the Medi-Cal box must also be checked. Either check the Medi-Care box when entering a Medi-Care paid about greater than zero, or remove the Medi-Care paid amount and do not check the Medi-Care box.
		Yes		LAMH4090-STAFF CODE/REPT UNIT UNMATCHED	The MHMIS does not show the staff persons ID in the reporting unit in which the service is being provided. The help desk must update the information in the MHMIS. A rendering provider form may have to be submitted.
52		Yes		LAMH4091-STAFF CODE REPT UNIT EXPIRED	In the MHMIS, the rendering provider is assigned to a Reporting Unit that shows expired in the MHMIS Staff Table. If this is in error, call the help desk.

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18		Yes		LAMH6019 - DUPLICATE DAY TREATMENT	A Day Treatment service cannot be submitted if there is already a service with the same date in the MHMIS. Verify that you have the correct date of service.
				LAMH0931-CIN # W/A-Z OR MEDI-CAL # ONLY USER SPECIAL IAL	The user has put the social security number of the client into the CIN number. The issue is that the CIN number is not formatted correctly.
				LAMH4076-XOVR(H) NO MEDICARE AMT ALLOWED	Call the Help Desk at 213-351-1335.
				LAMH4084-XOVR(E) CANNOT BE CHANGED	I Call the Help Desk at 213-351-1335.
				LAMH0998 MCAL/MCARE=Y CODES(B,E,H,N,P,X)	Call the Help Desk at 213-351-1335.
52		Yes		LAMH9110-SRVC NOT BILLABLE TO MEDICARE (or Staff Not Medicare Cert)	Call the Help Desk at 213-351-1335.
38		Yes		LAMH9112- NOT A MEDICARE REIMBURSED SRVC	Call the Help Desk at 213-351-1335.
		Yes		LAMH9113 - INVALID MEDICARE SERVICE LOC	If you are sending the claim to Medicare, the Place of Service entered on the Clinical/Service is not billable to Medicare.
62		Yes		LAMHDT01-NO TBS AUTHORIZATION FOUND	You must obtain prior authorization from the Day Treatment website. https://dmhdowney1.co.la.ca.us/DayTreatment.htm This service was entered for an outpatient service, for a client that had a day treatment episode open at the same time. The user should make sure they have prior authorization entered in the "DayTreatment and TBS

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					authorization program". Contact Mina Hernandez **213-738-3378** for further assistance.
62		Yes		LAMHDT02 – **NO DR AUTHORIZATION FOUND**	You must obtain prior authorization from the Day Treatment website. https://dmhdowney1.co.la.ca.us/Day Treatment.htm Contact Mina Hernandez 213-738-3311 for further assistance.
62		Yes		LAMHDT03-NO DTI AUTHORIZATION FOUND	You must obtain prior authorization from the Day Treatment website. https://dmhdowney1.co.la.ca.us/Day Treatment.htm . Contact Mina Hernandez **213-738-3378** for further assistance.
42		Yes		LAMHDT04 -NO MHS AUTHORIZATION FOUND	This client is currently in a Day Treatment or Day Treatment Intensive Program therefore any MHS services require authorization. Request authorization from the Day Treatment website https://dmhdowney1.co.la.ca.us/Day Treatment.htm . Contact Mina Hernandez **213-738-3378** for further assistance.
42		Yes		LAMHDT05-NO MORE HOURS LEFT FOR TBS AUTH	The Integrated System has been changed to accept the authorization of days within a predefined period of time (from - to) rather than hours/minutes within a predefined period of time (from - to). This change affects services beginning January 1, 2005, however the system change was deployed on March 9th. Denied claims with service dates of January 1, 2005 and greater should be resubmitted if the claim has this reason. Please Note: This change in the Integrated System only affects authorization and not reimbursement. The reimbursement rate for TBS remains per minute. Therefore when entering the service, users will continue to enter hours/minutes. Contact Mina Hernandez **213-**

HIPAA Deny Reason Code	IS DENY SOURCE			IS DENY REASON	DESCRIPTION/RESOLUTION
	RULES	CICS	UIWEB/ FIN ADJ		
					738-3378 for further assistance.
42		Yes		LAMHDT06-NO MORE HOUR LEFT FOR MHS AUTH	You can ask for authorization at the website: https://dmhdowney1.co.la.ca.us/Day Treatment.htm. Contact Mina Hernandez **213-738-3378** for further assistance.
62		Yes		LAMHDT07- NO MORE DAY LEFT FOR TBS AUTH	As of 01/01/05 Therapeutic Behavioral Services (TBS) are based on number of days (Not Hrs.). There is no authorization for the Activity Date you entered. You can ask for authorization at the website: https://dmhdowney1.co.la.ca.us/Day Treatment.htm. The Integrated System has been changed to accept the authorization of days within a predefined period of time (from - to) rather than hours/minutes within a predefined period of time (from - to). This change affects services beginning January 1, 2005, however the system change was deployed on March 9th. Denied claims with service dates of January 1, 2005 and greater should be resubmitted if the claim has this reason. Please Note: This change in the Integrated System only affects authorization and not reimbursement. The reimbursement rate for TBS remains per minute. Therefore when entering the service, users will continue to enter hours/minutes. Contact Mina Hernandez **213-738-3378** for further assistance.
62		Yes		LAMHDT08 – NO MORE DAYS LEFT FOR DR AUTH	The authorization days have been used. Contact Mina Hernandez **213-738-3378** for further assistance.
62		Yes		LAMHDT09-NO MORE DAY LEFT FOR DTI AUTH	The days allowed for that week are already used. Contact Mina Hernandez **213-738-3378** for further assistance.

HIPAA Deny Reason Code	IS DENY SOURCE			IS DENY REASON	DESCRIPTION/RESOLUTION
	RULES	CICS	UIWEB/ FIN ADJ		
42		Yes		LAMHDT18 – 4:00 HR(s) LEFT FOR TBS AUTH	TBS hours are almost used. You need to request additional days for TBS. https://dmhdowney1.co.la.ca.us/Day Treatment.htm. Contact Mina Hernandez **213-738-3378** for further assistance.
62		Yes		LAMH0378 – TREAT AUTH MISSING	You must receive prior authorization. Request authorization through this website. https://dmhdowney1.co.la.ca.us/Day Treatment.htm. Contact Mina Hernandez **213-738-3378** for further assistance.
42		Yes		LAMH0468 – MAX HOURS ALLOWED PER DAY IS 8	For procedures codes entered as Units, you need to be careful not to enter too many units for a single day of service
		Yes		LAMH9115 - INVALID ADDRESS	It is a Medicare claim and the client is transient.