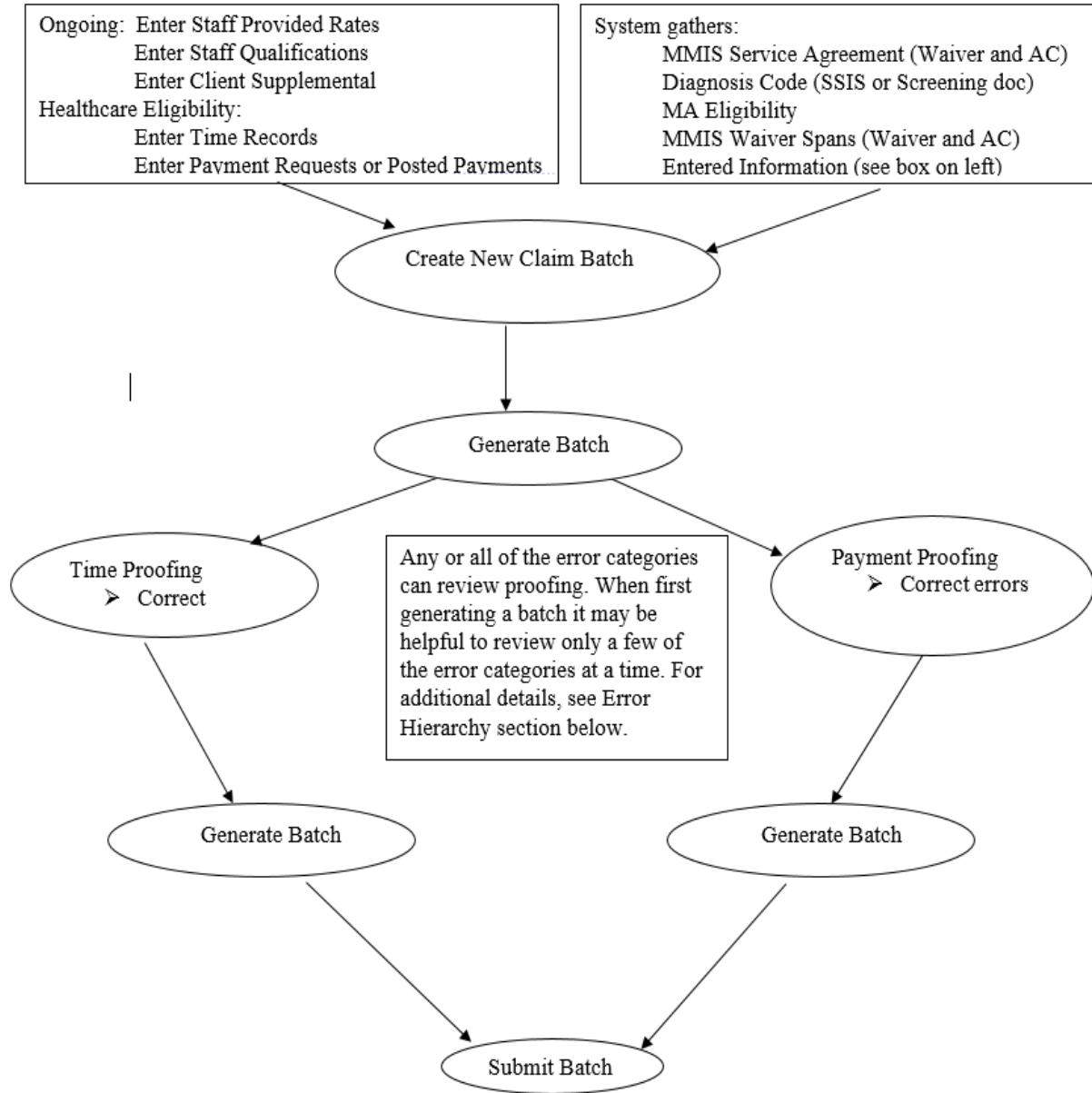


SSIS Claiming Helpful Hints and Proofing Messages

Claim Batch Flow Chart



Error Hierarchy

The resolution of one proofing message can produce another. For example, a client must have PMI to claim. If you have a potential claim, but the client for the Time Record does not have a PMI. Proofing message 1018 – Missing PMI# displays. Perhaps the client was never cleared to SWNDX to get that PMI. You clear the client to the state. If that client is not on MA you would now get proofing message 2010 – Client must be MA eligible to claim. Without having the PMI, there is no way to know if the person has MA eligibility.

HELPFUL HINTS

Do Not Claim

When adding a Do Not Claim record it is optional to enter a Reason code. Examples of Reason codes include TPL, No MA eligibility and Other. Entry of a Reason code clarifies why the record is being added.

Examples of when you might add a Do Not Claim record:

- The clients Medical Assistance is covered by a Managed Care Organization (MCO) so the MCO will need to be billed rather than MMIS.
- The client will likely never be MA eligible (select No MA eligibility).
- Submitting a claim would require the family to pay a MA spenddown. (Select Other and enter a Comment if appropriate.)
- The client is an MSHO client and the medical plan needs to be billed. (Select MSHO.)
- The client has reached the MMIS Service Agreement cap to be paid. (Select Other and enter a Comment if appropriate.)
- The client has other insurance that must be billed before submitting to MMIS. (Select TPL.)

CW-TCM

- TEFRA Override - Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) option provides MA eligibility to some disabled children who live with their families. TEFRA covers the same services provided by MA. Eligibility is determined based on a child's qualifying disability, determined by SMRT (State Medical Review Team), regardless of parental income and assets. Parents may, however, be assessed a parental fee for services based on income. Enter TEFRA override dates to indicate that CW-TCM should be claimed for a TEFRA child.

MH-TCM

- Claims for clients in a MA Funded Facility are limited to 180 days for VA/DD-TCM, MH-TCM and RSC-TCM combined. The beginning of the 180 days is the Service Date of the first paid claim for VA/DD-TCM, MH-TCM, or RSC-TCM. MMIS enforces this rule and no editing is done in SSIS.

MH-Rule 5

- Children's Residential Mental Health Treatment payment rates are set at the end of a quarter. Claims must be submitted after the end of the quarter.
- Children receiving MNCare may be eligible for Rule 5. MNCare does not list a Rule 5 living arrangement and does not include an out-of-home provider in the client's living arrangement record. The out-of-home provider number (sent to MMIS as a Rendering provider) is required for Rule 5 claims. Submit Rule 5 claims for clients receiving MNCare through MN-ITS.

RSC-TCM

- Claims for clients in a MA Funded Facility are limited to 180 days for VA/DD-TCM, MH-TCM and RSC-TCM combined. The beginning of the 180 days is the Service Date of the first paid claim for VA/DD-TCM, MH-TCM, or RSC-TCM. MMIS enforces this rule and no editing is done in SSIS.
- Social Services can bill via SSIS and Public Health Nursing (PHN) can bill using MN-ITS and the claims will not be denied as duplicates.

VA/DD TCM

- Claims for clients in a MA Funded Facility are limited to 180 days for VA/DD-TCM, MH-TCM and RSC-TCM combined. The beginning of the 180 days is the Service Date of the first paid claim for VA/DD-TCM, MH-TCM, or RSC-TCM. MMIS enforces this rule and no editing is done in SSIS.
- VA/DD-TCM cannot be provided to a person in an institution unless it is for the purposes of transitioning/relocating from the institution to the community. Institutions are defined as hospitals, nursing facilities (including Certified Board and Care Facilities), and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD).

Waiver

- Waiver claims are not edited for remaining units of a MMIS service agreement line item. While remaining units are known at the time of the last interface of MMIS data to SSIS, claims could have been submitted during the interim using MN-ITS.

Reports

Several reports are available and can be run to resolve proofing messages prior to claims generation. These reports are available in the application and do not require the Admin Security function of Create Health Care Claims. Reports that can be run include:

- **Do Not Claim Detail Report** – identifies clients who have a Do Not Claim record that may have been entered because the client was not receiving MA/MN Care but who have since started receiving MA/MN Case services. This report can also be used to monitor claimable services provided to a person with a Do Not Claim record.
- **CW-TCM Eligibility** – lists all CW-TCM Supplemental Healthcare Eligibility entered. This report includes TEFRA Override dates and can be reviewed as needed.
- **DD Screening Detail Report** – lists all MMIS DD screenings and includes Diagnosis and screening.
- **LTC Screening Detail Report** – lists all MMIS LTC screenings and includes Diagnosis and screening information.
- **MH Rule 5 Eligibility** – lists all MH Rule 5 eligibility entered.
- **MH-TCM Eligibility** – lists all MH-TCM Supplemental Healthcare Eligibility.
- **VA/DD-TCM Eligibility** – lists all VA/DD TCM Supplemental Healthcare Eligibility entered.

PROOFING

Users with the security function of Fiscal Default Activities can view and work with claims proofing messages.

A general note about MMIS changes: the type of staff member (fiscal, social worker, or other) who does these changes in MMIS varies by county. Social work and fiscal staff may need to coordinate changes with MAXIS/MMIS workers in the county. Any changes needed to resolve messages related to MMIS or MAXIS or must be done in MAXIS or MMIS.

Claims Proofing Error Check Boxes

The screenshot shows a web application interface with three tabs: "Waiver and AC (Draft) 02/01/2009 - 02/28/2009", "Claims", and "Payment Proofing". The "Claims" tab is active. The interface contains a grid of checkboxes for error types: "Time Record", "Attempted Contact", "Diagnosis", "Duplicate Claim", "MA Eligibility", "MMIS Service Agreement", "Client", "Do Not Claim", "Staff Not Qualified", and "Exclusions". On the right side, there are four buttons: "Search", "Clear All", "Select All", and "Restore Defaults".

The screenshot shows the same web application interface, but with the "Time Proofing" tab selected. The checkboxes for error types are: "Payment", "Diagnosis", "Duplicate Claim", "MA Eligibility", "MMIS Service Agreement", "Client", "Do Not Claim", and "Exclusions". The "Search", "Clear All", "Select All", and "Restore Defaults" buttons are also present on the right.

Depending on the scope of proofing being done, or the role of the person doing the proofing, all or some of the Proofing check boxes can be selected to view claims not being generated because of possible data errors. Clicking on a proofing message displays the time or payment record in question. If additional client details are needed, clicking the Tree tab enables you to navigate to additional details of the message without exiting proofing.

Error description and number by Category

Attempted Contact:

Attempted Contact is not claimable (2202)

Client:

Estimated DOB (107)

Missing PMI # (1018)

Client Age:

Client must be 18 or over (2201)

Client must be under 21 (2205)

Client must be under 21 (2501)

Phone contact – client must be 18 or over (2211)

Diagnosis:

Diagnosis required (2019)

MH Diagnosis required (2020)

Do Not Claim:

Client marked "Do Not Claim" (2008)

Duplicate Claim:

Claim would be a duplicate (2017)

Exclusions:

Exclusion Exists – Payments (2050)

Exclusion Exists – Time Records (2051)

MA Eligibility:

Service Dates not within a single Living Arrangement (2005)

Service Dates not within a single Eligibility Span (2006)

Client must be MA eligible to claim (2010)

Invalid Major Program (2011)

Client cannot be on a waiver (2012)

Invalid Living Arrangement (2013)

No MMIS Eligibility Information (2021)

No Living Arrangement (2022)

Client must be on a Waiver (2302)

Service Dates not within a single Waiver span (2303)

Major Program not Valid for Waiver Type (2308)

Missing NPI/UMPI (2503)

MMIS Service Agreement:

- No MMIS Service Agreement (2304)
- Service Dates not within a single Service Agreement (2305)
- County is not the service provider on the Service Agreement (2306)
- Service Agreement status is not valid (2307)

Payment:

- No HCPCS/Modifier on Payment (2007)
- Original Payment for a Modification already claimed (2016)
- Location must be "Inpatient Hospital" with Living Arrangement of "Community" (only applies to Payments)(2101)

Staff Not Qualified:

- Staff Qualifications, Qualified = No (2018)

Supplemental Eligibility:

- No Supplemental Eligibility (2015)
- Annual Review needed (2206)
- No TEFRA override (2207)
- MH Rule 5 Level of Care = No (2502)

Time Record:

- No Staff Qualification (2003)
- No Staff-provided Rate for the HCPCS/Modifiers (2004)
- Duration less than half a unit (2009)
- County of Service not in the region (2014)
- No Staff-provided Rate on the Screening Date (2024)
- First claimable contact must be "Face to face" (2203)
- "Face to face" contact required every 3 months (2204)
- Location must be "Inpatient Hospital" with Living Arrangement of "Community" (only applies to Time records)(2102)
- Activity not valid for client's waiver (2301)

Claims Proofing Messages

Common proofing messages are messages used by more than one claim category.

Message #	Category	Short Message	Long Message
Proofing message resolution			
107	Common	"Est. date of birth".	The client has an estimated date of birth. The client must have an actual date of birth.
Clients must have an Actual DOB to claim. Making changes to a client's DOB changes the status of the client to Uncleared Client and adds them to the Clearing Log.			
1018	Common	No PMI #.	The client does not have a Person Master Index (PMI) number in SSIS. Client must have a PMI #.
Clients must have a PMI # to claim. Either the client needs to be cleared in SSIS, or if changes are necessary, they must be done in MAXIS.			
2003	Common	No Staff Qualifications for the worker on the activity date.	The staff person on the Time record must have a Staff Qualification record for the appropriate Claim Category in effect on the activity date of the Time record.
Note the staff person's name is included in the proofing message. Staff qualifications are entered in the Admin module. Because Admin is a different executable, the proofing process cannot take you directly to that screen. You will need to add the Staff Qualifications for this worker in Admin. It is not necessary to close Admin and Worker to apply these updates in Worker.			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2004	Common	No Staff-provided Rate for the "HCPCS/Modifier" on the activity date.	A Staff-provided Rate for the "HCPCS/Modifier" must exist and be in effect on the activity date of the Time record.
<p>This information is entered in the Admin module. Because Admin is a separate executable, the proofing process cannot take you directly to that screen. You will need to add the Staff-provided rate for this procedure. It is not necessary to close Admin and Worker to apply these updates in Worker, but be sure to save your changes.</p>			
2005	Common	The service dates span more than one Living Arrangement.	The service dates on the Payment must be completely within a single Living Arrangement.
<p>The Service Start Date through the Service End Date must be completely within the Living Arrangement effective dates. If changes are necessary, they must be done in MMIS.</p>			
2006	Common	The service dates are not completely within an Eligibility Span.	The service dates on the Payment must be completely within an Eligibility Span.
<p>The Service Start Date through the Service End Date must be completely within the dates of a single Eligibility span. Also, the status of the Major Program must be Active or Closed. If changes are necessary, they must be done in MMIS.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2007	Common	No "HCPCS/Modifiers" for a claimable "Service".	The "Service" is claimable and no "HCPCS/Modifiers" was selected on the Payment.
<p>Payments must have a HCPCS/Modifier to claim the payment.</p> <p>NOTE: In some counties, social workers may enter the HCPCS/Modifiers on the SSIS Service Arrangement because they also enter MMIS Service Agreements. In other counties, accounting staff will enter the HCPCS/Modifier when entering the payment request.</p>			
2008	Common	A Do Not Claim Determination is in effect on the service dates.	The Service is claimable but the client is marked "Do Not Claim" for Claim Category during the service dates.
<p>The client has a Do Not Claim Determination record in effect during the service dates of the Time or Payment record. If message 2008 displays, you will not get any other proofing messages.</p> <p>NOTE: Counties should decide who will set up Do Not Claim records in their county – fiscal or social work staff or a team that works together. The person who enters this into SSIS will need the security function, Enter Supplemental Eligibility.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2009	Common	Duration for Client is less than half a unit.	The Duration for the client in the Regarding section of the time record is less than half a unit. Duration must be at least half a unit to round up to one unit.
<p>The Duration of a time record must be at least half a unit to submit a claim. For example, when a message shows the unit is a 15 minute unit. The time record must be eight or more minutes to claim.</p> <p>**Best practice is to generate a batch first to reduce the number of Duration less than half a unit proofing messages that display. The combining of time records happens during claim generation. Therefore, time records that are individually less than half a unit will display if proofing is viewed before claim generation.</p>			
2010	Common	No Eligibility Span exists for the service dates.	The client must have an Eligibility Span in effect on the service dates and the "Status" must be "Active" or "Closed."
<p>The client must have a valid MMIS eligibility span in effect from the Service Start Date through the Service End Date. Also, the status of the Major Program must be Active or Closed. If information needs to be changed, it must be done in MMIS.</p>			
2011	Common	The "Major Program" is not valid for Claim Category.	The Eligibility Span in effect for the client must have a "Major Program" that is valid for the claim category.
<p>The Major Program on the Recipient Eligibility Span in effect during the Service Dates must be valid for the Claim Category. If changes are necessary, they must be done in MMIS.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2012	Common	Cannot claim – client is on a Waiver.	The client cannot have a Waiver span in effect on the service dates.
<p>The Claim Category does not allow a client to be on a waiver any time during the Service Dates. Waiver type Y or Z are not considered waivers. Y= LTC CSG Conversion Z= LTC CSG Diversion</p> <p>If changes are necessary, they must be done in MMIS.</p>			
2013	Common	Living Arrangement is not valid for Claim Category	The MMIS Living Arrangement in effect on the service dates must be valid for the claim category.
<p>The Living Arrangement in effect during the Service Dates must be valid for the Claim Category. If changes are necessary, they must be done in MMIS.</p>			
2014	Common	County of Service is not in the region.	The County of Service must match the Claiming County on the Claim Batch. Record is not valid for any county in this region.
<p>Note in the Data Clean-up proofing message lists the county of service. This message can only happen in SWHHS, DVHHS or F/M counties. The county of service for the client must be a county in the region. County of service is edited on the Workgroup setup screen. If incorrect, the county of service is changed on the WG screen. Once corrected, the time record must be deleted and re-entered in order for the change to be reflected on this time record.</p>			
2015	Common	No Supplemental Eligibility exists for the service dates.	The client must have a Supplemental Eligibility record in effect on the service dates.
<p>Displays when the client does not have a supplemental eligibility record entered in SSIS for the service dates of the time or payment and supplemental eligibility is required for the claim category (TCMs and Rule 5).</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2016	Common	The original payment for this Payment Type has a Claim.	Claims for a negative amount cannot be submitted. The claim for the original payment must be replaced or voided.
<p>The original payment for a modification has already been claimed. Claims cannot have a negative amount. If a claim has been submitted for a payment and a modification subsequently entered, the original claim must be replaced or voided. Note the original claim number is included in the message.</p> <p>NOTE: Fiscal workers will likely enter payment modifications. It is not likely that social workers would enter this type of information.</p>			
2017	Common	One or more claims already exist during the service dates.	Only one claim can be submitted for a "HCPCS/Modifiers" for a given date range. The existing claim(s) must be voided and resubmitted to include this record.
<p>This claim would be a duplicate of a claim previously submitted. A claim with the same HCPCS/Modifiers and the same or an overlapping date range already exists for the client. The existing claim(s) must be voided and resubmitted to include this record.</p> <p>If the claim has already been submitted, the claim must be voided and resubmitted to include this record. If the duplicate claim is draft, regenerating the batch will include it in the claim. When navigating to the duplicate claim node, claims for other claim categories may display along with the duplicate claim.</p> <p>NOTE: Most social workers will not have access to this screen. Fiscal staff will likely contact the social worker to help resolve the duplicate.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2018	Common	"Qualified" = "No" on the Staff Qualifications for the worker on the activity date.	The Service is claimable, but the staff person is not qualified to claim for Claim Category.
<p>Note the staff name of the person on the time record is in the error message. The Qualified to claim field = No on the Staff Qualification record is in effect for the Worker on the Time record. If a staff qualification needs to be changed you will need to go to the Admin module of SSIS. It is not necessary to exit Admin and Worker for updates to be included. If message #2018 displays, no other proofing messages will display.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2019	Common	A diagnosis is required.	A billable diagnosis code was not found for the client. A billable diagnosis code is required to claim.
Displays when the client does not have a billable diagnosis and the HCPCS/Modifiers requires one. From the Action button a new Diagnosis can be added.			

Diagnosis Codes Used

Claim Category	Source, In order of precedence	Default if no <i>Billable Diagnosis Code</i>	
		ICD-9 (Service End Date <= 09/30/2105)	ICD-10 (Service Start Date >= 10/01/2015)
CW-TCM	N/A – always use the default	V68.9	Z60.9
DD Screening	Screening document See Diagnosis Code	None	None
LTCC	Screening document See Diagnosis Code	None	None
MH-TCM	See Diagnosis Code	None	None
RSC-TCM	Screening document See Diagnosis Code	V68.9	Z60.9
Rule 5	See Diagnosis Code	None	None
VA/DD-TCM	Screening document See Diagnosis Code	V68.9	Z60.9
Waiver and AC	Screening document See Diagnosis Code	None	None

Message #	Category	Short Message	Long Message
Proofing message resolution			
2020	Common	A Mental Health diagnosis is required.	A billable mental health diagnosis was not found for the client.
Displays when the client does not have a billable mental health diagnosis			
2021	Common	The client has no Healthcare Eligibility from MMIS.	The client must have Healthcare Eligibility from MMIS in SSIS to verify eligibility. No eligibility information has been received from MMIS.
<p>The client must have MMIS eligibility information to claim.</p> <p>NOTE: The client may not have been cleared, SSIS may not have yet received PMI through the monthly SWNDX upload, or the client may not yet have been entered into MAXIS, MMIS by Income Maintenance staff. A client could have a PMI and no eligibility. If a client has no PMI, message 1018 – missing PMI # is displayed.</p>			
2022	Common	Client must have a Living Arrangement record.	The client must have a Living Arrangement record to verify client has a valid Living Arrangement. No Living Arrangement records have been received from MMIS for this client.
The client must have a MMIS Living Arrangement record. If changes are needed, they must be done in MMIS.			
2024	Common	No Staff-provided Rate for the "HCPCS/Modifiers" on the "Screening Date".	A Staff-provided Rate for the "HCPCS/Modifiers" must exist and be in effect on the "Screening Date" of the Supplemental Screening.
This information is entered in the Admin module. Because Admin is a separate executable, the proofing process cannot take you directly to that screen. You will need to add the Staff-provided rate for this procedure. It is not necessary to close Admin and Worker to apply these updates in Worker, but be sure to save your changes.			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2051	Common	An Exclusion for Healthcare Claiming exists.	Claims are not created for a client selected on a time record when an Exclusion record for Healthcare Claiming exists for that client and time record.
Exclusion records are added to time records as a way to prevent individual records from generating a claim or to remove a record from Time Proofing that has been researched and should not generate a claim.			
2101	RSC-TCM	"Location" on the Payment must be "Inpatient Hospital" because the Living Arrangement for the client is "Community".	Clients living in the community are only eligible for RSC-TCM services during an inpatient hospital stay of less than 30 days. MMIS requires "Inpatient Hospital" as the place of service.
When the client's Living Arrangement during the Service Dates is Community, the Location on the Payment must be Inpatient Hospital.			
Note: This is also true for time records, which is message 2102.			
Note: A social worker probably wouldn't enter this on the Payment Request screen.			
2102	RSC-TCM	"Location" on the Time record must be "Inpatient Hospital" because the Living Arrangement for the client is "Community".	Clients living in the community are only eligible for RSC-TCM services during an inpatient hospital stay of less than 30 days. MMIS requires "Inpatient Hospital" as the place of service.
When the clients Living Arrangement on the Activity Date is Community, the Location on the Time record must be Inpatient Hospital.			
Note: This is also true for payment records, which is message 2101.			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2201	VA/DD TCM	Age on the service date must be 18 or over.	The client must be 18 or over on the dates of service to claim VA/DD-TCM services.
<p>The Clients age must be greater than or equal to 18 on the Service Dates.</p> <p>Note: Editing DOB will unclear a client. Client will need to be recleared for claiming.</p>			
2202	COMMON	"Contact Status" (Attempted) is not claimable.	Attempted contacts are not claimable. Contact Status must be "Completed" to claim.
<p>The Contact Status for Activities of Client contact or Collateral contact must be Completed to claim.</p> <p>NOTE: This is true for non-TCM contacts as well as TCM contacts per Waiver and AC policy staff.</p> <p>**Best practice is to generate a batch first to reduce the number of "Contact Status [Attempted] is not claimable" proofing messages that display. Generating the batch first will allow a completed contact within the month to create a claim and all "Contact Status [Attempted] is not claimable" messages for this client would no longer display.</p>			
2203	COMMON	First claimable contact must be "Face to face".	No prior claims have been created during the Supplemental Eligibility span. A claim for a "Phone" contact cannot be created.
<p>For TCM claim categories the first claimable time record contact must be Face to face. A Phone contact exists where no prior Face to face contacts have been submitted during the Supplemental Eligibility Span.</p> <p>**Best practice is to generate a batch first to reduce the number of "First claimable contact must be Face to face" proofing messages that display.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2204	COMMON	"Face to face" contact required at least once every 3 months.	Claims in the prior 2 months are for "Phone" contacts. Another claim for a "Phone" contact cannot be submitted.
<p>For TCM claim categories a Face to face contact is required every three months. No Face to face time record contact exists for the month of service and no claims in either of the prior two months are for a Face to face contact for the same claim category.</p> <p>**Best practice is to generate a batch first to reduce the number of "Face to face contact required at least once every three months" proofing messages that display.</p>			
2205	CW-TCM	Age as of the first of the month for the service date must be under 21.	The client must be under 21 to claim CW-TCM services. Age is calculated as of the first of the month.
<p>The Clients age must be under 21 as of the first of the month of the Service Dates. If the date of birth is changed, the client will need to be recleared to SWNDX.</p>			
2206	CW-TCM	An Annual Review is needed prior to the service date.	Initial CW-TCM Eligibility determination is valid for one year, after which Annual Reviews are required to continue claiming.
<p>The CW-TCM Eligibility determination is valid for one year, after which an Annual Review must be completed. If an Annual Review is late, any time records during the time period that the Annual Review was overdue cannot be claimed, even when the new review is added.</p> <p>A report listing CW-TCM reviews due can be generated clicking on Tools/General Reports/Eligibility and selecting CW-TCM Eligibility Review entering date parameters desired.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2207	CW-TCM	TEFRA override not in effect on the service date.	If the client is eligible for TEFRA at any time during the month of service, a TEFRA override must be in effect to claim CW-TCM.
If the client is eligible for TEFRA at any time during the month of service, a TEFRA override must be in effect to submit a claim.			
2211	MH-TCM	"Contact Method" (Phone) requires Age on the service date to be 18 or over.	The client must be 18 or over to claim a phone contact for MH-TCM services. Age is calculated as of the service date.
Phone contacts can only be claimed for clients age 18 or over. Making a change to the date of birth removes the PMI and the client must again be cleared to SWNDX.			
2301	Waiver/AC	Service and Activity are not claimable for the Waiver "Type".	Some Service and Activity combinations are only valid for certain waiver types or AC only.
Displays when the Service & Activity are not valid for the clients Waiver Type. Change must be made to the time record in order to submit a claim.			
2302	Waiver/AC	No Waiver span or "Major Program" of "AC" on the service dates.	Client must have a Waiver span or an Eligibility span with a "Major Program" of "AC" in effect on the service dates.
Client must be on a waiver or an AC recipient span during the Service Dates. Changes to waiver or AC eligibility must be made in MMIS.			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2303	Waiver/ AC	The service dates are not completely within a Waiver span.	The service dates on the Payment must be completely within a single Waiver span.
<p>The Service Start Date through the Service End Date must be completely within the effective dates of a single Waiver span. Changes to waiver eligibility must be made in MMIS.</p> <p>Note: This message is for waiver only. Message #2006 is for AC.</p>			
2304	Waiver/ AC	No MMIS Service Agreement Line Item exists for the "HCPCS/Modifiers" for the service dates.	The client must have a MMIS Service Agreement with a Line Item that is in effect on the service dates for the "HCPCS/Modifiers" to be claimed.
<p>Client must have a MMIS Service Agreement in effect for the Service Dates with that HCPCS/Modifier on the line item. Changes to/ adding of MMIS Service Agreements must be made in MMIS.</p>			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2305	Waiver/ AC	The service dates are not completely within the dates of a MMIS Service Agreement Line Item.	The service dates on the Payment must be completely within a single Line Item for the "HCPCS/Modifiers."
The Service Start Date through the Service End Date must be completely within the dates of a single MMIS Service Agreement Line item. Changes to MMIS service agreements must be made in MMIS.			
2306	Waiver/ AC	County is not the provider on the MMIS Service Agreement Line Item.	The county must be the provider on the Service Agreement Line Item to claim.
County is not the Provider on the MMIS Service Agreement line item. The Provider on the Service Agreement Line Item must match the county's MMIS Provider number or NPI/UMPI on the county claim control record in Admin. Changes to MMIS service agreements must be made in MMIS.			
2307	Waiver/ AC	The Service Agreement "Status" or Line Item "Status" is not valid.	The Service Agreement "Status" must be "Approved" or "Partially suspended". The Line Item "Status" must be "Approved."
The header of the MMIS Service Agreement must be the status of Approved or Partially Suspended. Line item status must be Approved. Changes to MMIS service agreements must be made in MMIS.			
2308	Waiver/ AC	The "Major Program" is not valid with Waiver "Type".	"Major Program" is only valid with Waiver "Type." The "Major Program" must be "UN" if the Waiver "Type" is [Waiver "Type"].
Client must have a Major Program of UN to be on this Waiver Type. Changes to Major Program must be made in MMIS.			

Message #	Category	Short Message	Long Message
Proofing message resolution			
2501	MH Rule 5	Age as of the first of the month for the service dates must be under 21.	The client must be under 21 to claim Mental Health Rule 5 services. Age is calculated as of the first of the month.
The client's age must be under 21. Making changes to a client's DOB changes the status of the client to Uncleared Client and adds them to the clearing log.			
2502	MH Rule 5	"MH Rule 5 level of care" is "No".	The "Client meets the needs for MH Rule 5 level of care and meets the legal criteria for SPMI or SED" on the Rule 5 Supplemental Eligibility in effect on the service dates must be "Yes" to claim.
MH Rule 5 Level of Care must be Yes in order to generate a claim.			
2503	MH Rule 5	The "Facility" on the Living Arrangement does not have an "NPI/UMPI."	The "Facility" on the MMIS Living Arrangement in effect on the Service dates must have a "NPI/UMPI" to claim for Mental Health Rule 5.
The NPI/UMPI is blank and another valid Living Arrangement record with a NPI/UMPI for the service dates does not exist. Changes to this information must be done in MMIS.			