

**Office of Developmental Programs (ODP)**  
**PROMISe™ ERROR STATUS CODES (ESCs)**  
**Effective July 1, 2009**

ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
772	Dates of Service Do not Match Units on Claim Line	<p>This edit applies to all services that use a "day unit".</p> <p>This error will set and deny the claim detail line(s) when the system determines that the day units billed are <u>not</u> equal to the number of days represented by the "From" and "To" dates billed on the claim detail line(s).</p> <p>For example, a claim detail date span equal to 7/1 - 7/15 should equal 15 day units on the claim. If it does not, then ESC 772 will set and the claim detail line will deny.</p>	<p>Either the units or the date span entered on the claim is incorrect.</p> <p>Since the claim detail line was denied in this situation, a new claim will need to be submitted with the correct units or correct date span that accurately reflects the number of units entered on the claim.</p>
773	Bill Ineligible Service in Subsequent Month	<p>This edit only applies to the ineligible <b>Waiver</b>-Funded Residential services.</p> <p>This edit will set and deny the claim detail line when the system determines that the billed date (the date the claim was submitted) is in the same calendar month as the date the ineligible <b>Waiver</b>-Funded Residential service was rendered.</p>	<p>To correct this error, submit a new claim no earlier than the first day of the subsequent month after the ineligible Residential Waiver service was rendered.</p> <p>For example, do not bill July 2009 ineligible <b>Waiver</b>-Funded Residential services in July. You must wait until August 1, at the earliest, before submitting the ineligible Residential Waiver service. Remember to also enter the accompanying Individual's Room and Board contribution on the claim for the ineligible <b>Waiver</b>-Funded Residential services rendered in July.</p>

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774	Residential Services Cannot Cross Calendar Months	<p>This edit applies to all <b>Waiver</b>-Funded Residential services (eligible and ineligible).</p> <p>This edit will set and deny the entire claim when the system determines the detail "From" and "To" dates of service found on each claim line or multiple claim detail lines are <u>not</u> within the same calendar month. All claim detail lines must contain dates of service within one calendar month and reflect the same calendar month.</p>	<p>To correct this error, submit a separate claim for each calendar month in which the eligible and ineligible <b>Waiver</b>-Funded Residential service(s) was rendered.</p> <p>Please note, for claims submitted with any <b>Waiver</b>-Funded Residential services on it, all other claim detail lines also present on the claim must fall within the same calendar month or the entire claim will deny.</p>
776	Claim Cannot Span Fiscal Year	<p>This edit applies to all ODP services found in the approved Consolidated and P/FDS Waivers, as well as, Base services.</p> <p>This edit will set and deny the entire claim when the system determines that more than one State Fiscal Year is found on a single claim detail line or when more than one State Fiscal Year is represented on the entire claim across multiple claim detail lines.</p>	<p>To correct this error, submit a separate claim for each State Fiscal Year which is represented by the dates of service submitted on the claim.</p> <p>One claim should contain only dates of service for one fiscal year and the second claim should contain dates of service for the other fiscal year.</p>
778	Consumer Contribution (SSI) Missing From Claim	<p>This edit applies to the ineligible <b>Waiver</b>-Funded Residential services only. This error will set when the system finds an ineligible <b>Waiver</b>-Funded Residential service on the claim and determines there is a blank space or zero in the field on the claim where the Individual's Room and Board contribution is required.</p> <p>When this condition is found on the claim, the claim detail line with the ineligible <b>Waiver</b>-Funded Residential service will deny.</p>	<p>To correct this error, submit a new claim that includes a dollar amount equal to the amount charged to the Individual for Room and Board.</p> <p>CMS1500 (paper): "Amount Paid" field            PROMISe™ Internet: "Patient Pay Amount" field            Provider Electronic Solutions Software (PES): "Patient Pay" field.</p> <p><b>PLEASE NOTE: Discussions are underway regarding how to instruct providers to bill when the provider does not charge the individual for any Room and Board or any Room or any Board. Future communications will address these billing practices.</b></p>

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779	Consumer Contribution < or > 72% of Annual Max SSI	<p>This edit applies to ineligible <b>Waiver</b>-Funded Residential services only.</p> <p>This error is for informational purposes only and will set when the system finds that the amount entered in the Individual's Room and Board contribution (patient pay field) is <b>not equal</b> to 72% of the current maximum monthly SSI.</p> <p>Although the short description for this error code says "Annual", please ensure that the Individual's monthly Room and Board contribution amount is included on your claim.</p> <p>This edit was created primarily for internal purposes so ODP can generate reports for analysis.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>This edit will set to inform the provider/biller that the system recognizes that the amount entered as the Individual's Room and Board contribution is not equal to 72% of the annual maximum SSI.</p>
3024	The Invoice Claim Line Quantity Exceeds the Prior	<p>This edit will set and your claim detail line will deny when the units submitted on the claim are in excess of the units remaining on the PROMISE™ authorization for the Permanent Vacancy.</p>	<p>To correct this error, confirm the correct numbers of units were entered on the claim. If the units were entered incorrectly, please submit a new claim with the correct number of units.</p> <p>If the units were entered correctly, then review the units entered on the claim and compare them to the units remaining on your PROMISE™ authorization. If you do not know how many units are remaining on your PROMISE™ authorization, contact your ODP Regional Waiver Capacity Manager.</p> <p>In order to bill for units in excess of the units remaining on the PROMISE™ authorization, please contact your ODP Regional Waiver Capacity Manager.</p>

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3025	DOS is Before or After the PA Date	This edit will set and your claim detail line will deny when the dates of service submitted on the claim are not equal to the dates of service on the PROMISE™ authorization for the Permanent Vacancy.	<p>To correct this error, confirm the correct dates of service were entered on the claim. If the dates of service were entered incorrectly, please submit a new claim with the correct dates of service.</p> <p>If the dates of service were entered correctly, then review the dates of service entered on the claim and compare the dates to those on your PROMISE™ authorization. If you do not know what dates are on your PROMISE™ authorization, contact your ODP Regional Waiver Capacity Manager.</p> <p>In order to bill for dates of service other than what is indicated on your PROMISE™ authorization, please contact your ODP Regional Waiver Capacity Manager first to have the dates of service updated.</p>
4020	Units Billed exceed allowable units for Procedure	<p>This edit will set, cutback the units and the PROMISE™ allowed amount to the maximum allowable unit or dollar limitation, and pay the claim detail line when either of the following conditions are found on the claim:</p> <ol style="list-style-type: none"> <li>1. The daily unit limitation is exceeded.</li> <li>2. The weekly unit limitation is exceeded.</li> <li>3. The State Fiscal Year unit or dollar limitation is exceeded.</li> </ol>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>When this error sets, no additional payment will be made for units submitted in excess of the unit or dollar limitation.</p>

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4036	Procedure Code/Modifier vs. POS Restriction	<p><b>(CONTINUED FROM PREVIOUS PAGE)</b></p> <p>This edit is set to deny the claim detail line.</p> <p>The following conditions cause ESC 4036 to set:</p> <p><b>Reason #1:</b> The Place of Service (POS) code was billed incorrectly on the claim.</p>	<p><b>(CONTINUED FROM PREVIOUS PAGE)</b></p> <p><b><u>Claim Correction for Reason #1 (to the left):</u></b></p> <ol style="list-style-type: none"> <li>1. Identify the correct POS code that is valid for the provider type/specialty and procedure code/modifier combination submitted on your claim. This can be done by reviewing the Place of Service (POS) Matrix located on <a href="http://odpconsulting.net">odpconsulting.net</a> under the Provider Information Center (PIC) "Breaking News" section.</li> <li>2. The Place of Service (POS) Matrix is large document which is sorted in ascending order by procedure code. To easily locate the procedure code (service) you are interested in viewing, go to the top of screen to the "Find" box and enter the procedure code you are interested in viewing. Next hit the "Enter" key on your keyboard.</li> <li>3. Once you have located the procedure code you are interested in on the POS matrix, you will see many instances where there are multiple POS codes associated with the same procedure code. Locate the procedure code/provider type/specialty combination and modifier, if applicable, associated with the rendering provider's 13-digit MPI and service location that was billed on the claim and use the POS code found in the same row when billing.</li> <li>4. Resubmit your claim using the correct Place of Service code found in the Place of Service (POS) Matrix.</li> </ol>

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4036	Procedure Code/Modifier vs. POS Restriction	<p><b>(CONTINUED FROM PREVIOUS PAGE)</b></p> <p><b>Reason #2:</b> Edit 4036 may also set with, and as a result of, ESC 4044. The short description found on your Remittance Advice for ESC 4044 is "Proc Code Not Compensable for Prov Type/Spec".</p> <p>When both 4036 and 4044 set together on your claim, the system is unable to find the provider type/specialty code combination in the rendering provider's PROMISe™ enrollment file that is associated with the procedure code submitted on the claim. As a result, the system assumes the POS code entered on the claim is invalid.</p>	<p><b>(CONTINUED FROM PREVIOUS PAGE)</b></p> <p><b><u>Claim Correction for Reason #2 (to the left):</u></b></p> <ol style="list-style-type: none"> <li>1. The electronic Provider Enrollment Automation Project (ePEAP) allows you to view all your PROMISe™ provider enrollment data. Go into ePEAP, which can be accessed from the "PA PROMISe™ Internet" hyperlink, which is located at <a href="http://promise.dpw.state.pa.us/">http://promise.dpw.state.pa.us/</a>, and look up the provider types and specialties associated with the rendering provider's 13-digit MPI number and service location indicated on the claim.</li> <li>2. Compare the provider type/specialty combination that is stored on your PROMISe™ provider enrollment file with the provider type/specialty combination that is associated with the procedure code found on the ODP Place of Service (POS) Matrix.</li> <li>3. Both ESC 4036 and ESC 4044 set on a claim at the same time when either the provider type or specialty or both are not present on your PROMISe™ provider enrollment file.</li> </ol> <p>Do the following to correct this error:</p> <p><b>A. Adding a specialty to your PROMISe™ provider enrollment file:</b> Fax a letter (on company letterhead) to the ODP PROMISe™ Provider Enrollment unit, (717)783-5141, stating your 9-digit MPI #, 4-digit service location code, site address, effective date of the new specialty and the specialty code you would like added. –or–</p>

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4036	Procedure Code/Modifier vs. POS Restriction	<b>(CONTINUED FROM PREVIOUS PAGE)</b>	<p><b>B. Adding a provider type to your PROMISE™ provider enrollment file:</b> Only one provider type is permitted per service location on the PROMISE™ system. In order to obtain a new 13-digit MPI and service location for the new provider type, complete a PROMISE™ Provider Enrollment Base Application which can be downloaded at <a href="http://www.dpw.state.pa.us/omap">www.dpw.state.pa.us/omap</a> by clicking "Provider Information", located on the list on the left hand side of the screen. Next, click the "Provider Enrollment Information" hyperlink. Completed application and change request forms may be faxed to (717)783-5141, or mailed to the ODP PROMISE™ Provider Enrollment Unit located at 413 Health and Welfare Building, Harrisburg, PA 17101.</p>

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4044	PROC CODE NOT COMPENSABLE FOR PROVIDER TYPE/SPECIALTY	<p>An interpretation of the short description is as follows:            The procedure code (service) submitted on the claim is not permitted to be rendered by the provider type/specialty combination of the provider who rendered the service.</p> <p>This edit will set and the claim detail line will <b>deny</b> when the system determines that the provider type/specialty combination associated with the service submitted is invalid for the <b>rendering</b> provider.</p> <p>The system determines whether the rendering provider is permitted to render the service being billed. The system only checks the PROMISE™ enrollment file to make this determination; therefore, it is imperative that your PROMISE™ enrollment file is accurate. This error will set when the rendering provider's PROMISE™ enrollment file does not contain the correct provider type/specialty combination on file.</p>	<p>To correct this error do the following:</p> <ol style="list-style-type: none"> <li>1. Go into ePEAP, which can be accessed from the PROMISE™ Internet, and look up the provider types and specialties associated with the 13-digit MPI number indicated on the claim.</li> <li>2. It is likely that either the specialty associated with the service billed is not on your rendering provider file, is incorrect on your provider file, or the provider type is incorrect.</li> <li>3. <b>If a specialty needs to be added specialty to your PROMISE™ provider enrollment file:</b> Fax a letter (on company letterhead) to the ODP PROMISE™ Provider Enrollment unit, (717)783-5141, stating your 9-digit MPI #, 4-digit service location code, site address, effective date of the new specialty and the specialty code you would like added.</li> <li>4. <b>If a new provider type is needed:</b> Only one provider type is permitted per service location on the PROMISE™ system. In order to obtain a new 13-digit MPI and service location for the new provider type, complete a PROMISE™ Provider Enrollment Base Application which can be downloaded at <a href="http://www.dpw.state.pa.us/omap">www.dpw.state.pa.us/omap</a> by clicking "Provider Information", located on the list on the left hand side of the screen. Next, click the "Provider Enrollment Information" hyperlink. Completed application and change request forms may be faxed to (717)783-5141, or mailed to the ODP PROMISE™ Provider Enrollment Unit located at 413 Health and Welfare Building, Harrisburg, PA 17101.</li> </ol>

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5446	Follow SC Exception Process	This edit will set and your claim will suspend when the accumulated allowed units per detail from the current claim and/or paid claims history for P/FDS Waiver Supports Coordination Services has exceeded the 200 unit State Fiscal Year limitation.	<p>To correct this error, please follow the "Supports Coordination Services Exception Process" outlined in Informational Packet # 002-09, which is found on the <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets".</p> <p><b>PLEASE NOTE:</b> Although the Individual's ISP may contain approved units for Supports Coordination in excess of the fiscal year unit limitation, this <u>does not guarantee</u> that PROMISE™ will approve the Supports Coordination claim for payment if the system determines the fiscal year unit limitation has been exceeded.</p> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p>
5447	Follow SC Exception Process	This edit will set and your claim will suspend when the accumulated allowed units per detail from the current claim and/or paid claims history for Consolidated Waiver Supports Coordination Services has exceeded the 300 unit State Fiscal Year limitation.	<p>To correct this error, please follow the "Supports Coordination Services Exception Process" outlined in Informational Packet # 002-09, which is found on the <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets".</p> <p><b>PLEASE NOTE:</b> Although the Individual's ISP may contain approved units for Supports Coordination in excess of the fiscal year unit limitation, this <u>does not guarantee</u> that PROMISE™ will approve the Supports Coordination claim for payment if the system determines the fiscal year unit limitation has been exceeded.</p> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p>

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5564	Service Prgm Conflict. Bill Base Svcs Separately	<p>This error code applies to all ODP services (Waiver and Base).</p> <p>This error code will set when the system determines that one of the claim detail lines is for Base services and the other claim detail line is for Waiver covered services.</p>	<p>When this condition is found on the claim, PROMISe™ will pay only the Waiver service listed on the claim and will deny all Base services listed on the claim.</p> <p>To get paid for the remaining denied services, the provider should submit a separate claim for the Base services.</p>
5565	Svc Prg Conflict. VOID Orig Claim & Rebill.	<p>This edit will set when the initial claim submitted was paid for under Waiver eligibility but the eligibility was changed to Base before the adjustment was submitted, or vice versa.</p> <p><b>For example:</b> Individual A has a Base eligibility for services rendered and billed from July 1 through July 10, 2009. After the initial claim was billed and paid, the Individual's eligibility changed to Waiver. The provider realizes the wrong number of units were submitted on the original paid claim and tries to adjust the original units on the original claim. Error Code 5565 will set during this condition because the original claim paid to the County Payment File but the adjustment would have to be paid through Treasury. PROMISe is unable to process an adjustment with conflicting funding streams; therefore, the entire claim adjustment will deny.</p>	<p>To correct this error do the following:</p> <ol style="list-style-type: none"> <li>1. The Provider should void the original paid claim in history that the Provider was attempting to adjust.</li> <li>2. Determine if the Individual should be receiving Base or Waiver services and confirm the eligibility dates for the Individual's service program do not overlap.</li> <li>3. Once you determine which service program should be associated with the Individual, contact Individual's SCO and request that the Individual's eligibility dates be corrected so the overlapping eligibility dates are accurately reflected in HCSIS and CIS.</li> <li>4. Do not submit a new claim until you are sure the Individual's eligibility dates have been updated properly.</li> </ol>

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5576	Respite Days > 30 Days in a State Fiscal Year	<p>This edit will set and suspend the claim detail line when PROMISE™ determines that the accumulated allowed units per detail from the current claim and/or paid claims history for Medical Leave has exceeded the 30 day State Fiscal Year unit limitation.</p> <p>DO NOT ATTEMPT TO ADJUST OR RESUBMIT A SUSPENDED CLAIM. When a claim is set to suspend, staff at ODP will manually review the claim, then make a determination whether to "pay" or "deny" the claim detail line (service line).</p>	<p>In order to receive payment for the units submitted in excess of the 30 day fiscal year limitation, a provider should do the following:</p> <ol style="list-style-type: none"> <li>1. Contact the Individual's Supports Coordination Organization (SCO).</li> <li>2. The SCO will complete the draft "REQUEST FOR EXCEPTION TO THE ESTABLISHED SERVICE LIMITS OR MAXIMUM NUMBER OF SERVICE UNITS" form (DP 1023) and submit it to their Administrative Entity (AE).</li> <li>3. The AE will review the request and forward it to their ODP Regional Program Manager (RPM).</li> <li>4. If the exception request is approved by the RPM, then the RPM will send an approval form to the ODP Claim's Resolution Section via e-mail and cc: the AE.</li> </ol> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p> <p>For more detailed information concerning the draft exception process, Please review Informational Packet 010-09 located on <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets", which is located on the left side of the main web page.</p> <p>To confirm that your Exception Request was approved by the Regional Program Office and is on file with the ODP Claim's Resolution Unit, please call: 1-866-386-8880, Mon – Thurs 8:30-12:00 and 1:00 - 3:30</p>

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5577	More Than 1,040 Units billed in State FY	<p>This edit will set for informational purposes only when the accumulated allowed units per detail from the current claim and/or paid claims history for Supports Broker services has exceeded 1040 units in the State Fiscal Year.</p> <p>When this edit sets, any units in excess of 1040 units on the claim within a State Fiscal Year will be cutback to 1040 units and the claim detail line will pay. The allowable units and the payment will reflect the unit reduction.</p>	<p><b>NO CLAIM RESOLUTION IS NEEDED FOR THIS EDIT.</b></p> <p>This edit sets to inform the provider/biller that the system recognizes that more 1040 accumulated units for Supports Broker service were submitted in a State Fiscal Year.</p> <p>This edit was created primarily for internal purposes so ODP can generate reports for analysis purposes.</p>
5578	Funding Conflict. Bill units > 30 on separate claim	<p>This edit was developed so the system can determine when the funding source changes from Federal to State funding.</p> <p>This edit will set when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds 30 day units for Eligible Medical Leave or Eligible Therapeutic Leave or a combination of both Eligible Medical and Eligible Therapeutic Leave during a State Fiscal Year.</p> <p>When this edit sets, any units in excess of 30 day units on the claim will be cutback to 30 and the claim detail line will pay.</p>	<p>The claim will pay using Federal Funding Participation (FFP) up to 30 day units in a State Fiscal Year. The remaining units submitted in excess of 30 day units should be submitted on a separate claim in order to receive payment. The 31st and subsequent day units for Eligible Medical and Therapeutic Leave are paid from a State Funding source. This edit was created because the system is unable to process a claim when a change in funding source is found on the claim.</p> <p>After the funding source has officially changed and been recognized by the system, any additional units submitted during the State Fiscal Year for either Therapeutic Leave or Medical Leave can be billed as they were before the 30 unit limitation was exceeded.</p> <p>Fiscal year unit limitation for Therapeutic Leave is 48 day units. There is no fiscal year limitation for Medical Leave.</p>
5579	Paid service exceeds 12 consecutive months	This edit is currently under development	This edit is currently under development

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5580	Respite Services > 28 days in State Fiscal year.	This edit will set and your entire claim will suspend when the accumulated allowed units per detail from the current claim and/or paid claims history for Base Respite services has exceeded the 28 days State Fiscal Year unit limitation.	<p>In order to receive payment for the units submitted in excess of the 28 day fiscal year limitation, a provider should do the following:</p> <ol style="list-style-type: none"> <li>1. Contact the Individual's Supports Coordination Organization (SCO).</li> <li>2. The SCO will complete the draft "REQUEST FOR EXCEPTION TO THE ESTABLISHED SERVICE LIMITS OR MAXIMUM NUMBER OF SERVICE UNITS" form (DP 1023) and submit it to their County MH/MR Program.</li> <li>3. The County MH/MR Program will review the request and forward it to their ODP Regional Program Manager (RPM).</li> <li>4. If the exception request is approved by the RPM, then the RPM will send an approval form to the ODP Claim's Resolution Section via e-mail and cc: the County MH/MR Program.</li> </ol> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p> <p>For more detailed information concerning the draft exception process, please review Informational Packet 010-09 located on <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets", which is located on the left side of the main web page.</p>

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5581	Limited to 480 units per Fiscal Year	<p>This edit will set when the accumulated allowed units per detail from the current claim and/or paid claims history for 15-minute Respite services has exceeded the 480 units State Fiscal Year unit limitation.</p> <p>When the system determines this condition exists, it will suspend the claim for ODP review.</p> <p>DO NOT ATTEMPT TO ADJUST OR RESUBMIT A SUSPENDED CLAIM. When a claim is set to suspend, staff at ODP will manually review the claim, then make a determination whether to "pay" or "deny" the claim detail line (service line).</p>	<p>This edit sets to alert the provider/biller that the system recognizes that more than 480 15-minute units were submitted in a State Fiscal year. In order to receive payment for the units submitted in excess of the 480 15-minute unit fiscal year limitation, ODP authorization is needed. To obtain authorization, please do the following:</p> <ol style="list-style-type: none"> <li>1. Contact the Individual's Supports Coordination Organization (SCO).</li> <li>2. The SCO will complete the draft "REQUEST FOR EXCEPTION TO THE ESTABLISHED SERVICE LIMITS OR MAXIMUM NUMBER OF SERVICE UNITS" form (DP 1023) and submit it to their Administrative Entity (AE).</li> <li>3. The AE will review the request and forward it to their ODP Regional Program Manager (RPM).</li> <li>4. If the exception request is approved by the RPM, then the RPM will send an approval form to the ODP Claim's Resolution Section via e-mail and cc: the AE.</li> </ol> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p> <p>For more detailed information concerning the draft exception process, please review Informational Packet 010-09 located on <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets", which is located on the left side of the main web page.</p> <p>To confirm that your Exception Request was approved by the Regional Program Office and is on file with the ODP Claim's Resolution Section, please call: 1-866-386-8880 Mon - Thurs 8:30-12:00 and 1:00 - 3:30</p>

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5582	Limited to \$10,000 in 5-year Period.	<p>This edit will set and the claim detail line will suspend when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds \$10,000 over 5 fiscal years for the same Individual.</p> <p>DO NOT ATTEMPT TO ADJUST OR RESUBMIT A SUSPENDED CLAIM. When a claim is set to suspend, staff at ODP will manually review the claim, then make a determination whether to "pay" or "deny" the claim detail line (service line).</p> <p>This edit applies to Vehicle Accessibility Adaptations for Waiver and Base.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>The RPM will analyze the paid claim's history related to the claim, then make a determination to approve or deny it.</p>
5583	NO ADDITIONAL PMT IS DUE FROM ODP	<p>This edit will set, and the claim detail line will deny, when a claim is submitted after the unit or dollar limitation has been exhausted.</p> <p>Typically, ESC 5583 "Units Billed Exceed Allowable Units for Procedure" sets with an audit that cuts a detail line back to zero.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>When this error code sets, the claim detail line will deny, Allowed Units will equal zero, and the Allowed Amount will show a zero dollar amount.</p>

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5584	More than 4 Sessions are billed in a calendar month	<p>This edit will set when the system determines that the accumulated allowed days per detail from the current claim and/or paid claims history exceeds 4 days of <b>Base</b> Family Aid services within the same calendar month. This edit is applied to <b>Base</b> Family Aid services Individually and in combination with one another.</p> <p>Only <b>Base</b> Family Aid Services is subject to this edit. The service is captured and counted during a calendar month even if the service resides in history.</p> <p><b>Base</b> Family Aid procedure codes that are subject to this edit Individually or in combination with each other: W7310 - W7312, W7314, W7324 - W7326 (REGARDLESS OF MODIFIERS)</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>When the system recognizes this condition has occurred, then the PROMISe™ allowed amount will be cutback to the 4 day calendar month limitation. The allowable units and payment will be adjusted to reflect the cutback.</p> <p>No additional payment will be made for units submitted in excess of the 4 day unit calendar month limitation.</p>
5586	Paid claims > \$500 in state fiscal year.	<p>This edit will set when the system determines that the accumulated allowed dollars per detail from the current claim and/or paid claims history for Specialized Supplies has exceeded the \$500 fiscal year dollar limitation.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>When the system recognizes this condition has occurred, the PROMISe™ allowed amount will be cutback to reflect the \$500 fiscal year limitation. The allowable units and payment will be adjusted to reflect the cutback.</p> <p>No additional payment will be made for dollars submitted in excess of the \$500 fiscal year limitation.</p>

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs						
5587	<p>Home &amp; Comty Hab &amp; Companion Svc &gt; 672 units/wk</p> <p>(This description currently says "Home and Comty Hab &amp; Companion Svc &gt; 96 units per day but will be changed to the above)</p>	<p>This edit will set and cutback the units to the maximum allowable weekly units when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds 672 units per calendar week.</p> <p>This edit applies to Companion services and Home and Community Habilitation unlicensed services (listed below) when they are billed Individually or in combination with each other. When this edit sets, the claim detail line will pay.</p> <p>The following procedure codes are subject to this edit: W1724 - W1727 (Companion Services), W7057 - W7061 (Home and Community Habilitation unlicensed), W7068 - W7069 (Home and Community Habilitation unlicensed), (REGARDLESS OF MODIFIERS)</p>	<p>Bill all services that apply to this edit within a calendar week. Do not span calendar weeks.</p> <p>The PROMISE™ financial cycle occurs Friday evening. Calendar week billing prevents you from receiving a record of the entire week span on your Remittance Advice (RA)/Payment File/Trade Files unless you wait until Sunday, at the earliest, to bill for the entire previous week.</p> <p><b>PLEASE NOTE:</b> Another edit is under development that will deny the claim detail line when the system determines that the dates of service submitted on the claim detail line spans (overlaps) calendar weeks. Calendar week spanning refers to when a claim detail line contains dates of service that are more than one calendar week. (Calendar week is Sunday through Saturday)</p> <p><b>PLEASE NOTE:</b> You are permitted to bill more than one calendar week on one claim by using different claim detail lines as long as your dates of service on each claim detail line are within a calendar week. For example:</p> <p>A single claim with multiple claim detail lines:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">Claim Detail Line #1: August 2 - August 8</td> <td style="text-align: right; padding-right: 20px;">100 units</td> </tr> <tr> <td style="padding-left: 20px;">Claim Detail Line #2: August 9 - August 13</td> <td style="text-align: right; padding-right: 20px;">75 units</td> </tr> <tr> <td style="padding-left: 20px;">Claim Detail Line #3: August 16</td> <td style="text-align: right; padding-right: 20px;">25 units</td> </tr> </table>	Claim Detail Line #1: August 2 - August 8	100 units	Claim Detail Line #2: August 9 - August 13	75 units	Claim Detail Line #3: August 16	25 units
Claim Detail Line #1: August 2 - August 8	100 units								
Claim Detail Line #2: August 9 - August 13	75 units								
Claim Detail Line #3: August 16	25 units								

**PLEASE NOTE:** Other ESCs may set that are not included on this listing. This list applies to all new PROMISE™ ESCs only and excludes Financial Management Service ESCs.

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs						
5588	Day & Employment Services billed > 160 units/week	<p>This edit sets when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds 160 units within a calendar week. This edit accumulates the number of units based on one of the services or any combination of the services (procedure codes) that are listed below.</p> <p>The following procedure codes are subject to this edit: W7035, W7036, W7072 - W7076, W7087 - W7094, W7235, W7237, W7239, W7241, W7245</p> <p><b>PLEASE NOTE:</b> Another edit is under development that will deny the claim detail line when the system determines that the dates of service submitted on the claim detail line spans (overlaps) calendar weeks. Calendar week spanning refers to when a claim detail line contains dates of service that are more than one calendar week. (Calendar week is Sunday through Saturday)</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT</b></p> <p>When this edit sets, the units billed will be cutback to 160 units per calendar week on the claim detail line, which are the maximum allowable calendar week units. The claim detail line will <b>pay</b>.</p> <p><b>PLEASE NOTE:</b> You are permitted to bill more than one calendar week on one claim by using different claim detail lines as long as your dates of service on each claim detail line are within a calendar week (calendar week is Sunday through Saturday). For example:</p> <p>A single claim with multiple claim detail lines:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">Claim Detail Line #1: 8/2/09 – 8/8/09</td> <td style="text-align: right;">100 units</td> </tr> <tr> <td>Claim Detail Line #2: 8/9/09 – 8/13/09</td> <td style="text-align: right;">75 units</td> </tr> <tr> <td>Claim Detail Line #3: 8/16/09</td> <td style="text-align: right;">25 units</td> </tr> </table>	Claim Detail Line #1: 8/2/09 – 8/8/09	100 units	Claim Detail Line #2: 8/9/09 – 8/13/09	75 units	Claim Detail Line #3: 8/16/09	25 units
Claim Detail Line #1: 8/2/09 – 8/8/09	100 units								
Claim Detail Line #2: 8/9/09 – 8/13/09	75 units								
Claim Detail Line #3: 8/16/09	25 units								

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5589	Ineligible Med Leave >30 days in Fiscal Year	<p>This edit pays the claim detail line and applies a cutback when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds 30 units in a State Fiscal Year for the ineligible portion of Medical Leave.</p> <p>This edit sets because the ineligible Medical Leave days submitted in excess of 30 days are paid at 60% of the ineligible Residential Habilitation rate.</p>	In order to receive payment for the units submitted in excess of 30 day units, please submit the 31st and subsequent days on a separate claim transaction.

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5590	Therapeutic days > 48 days in a State Fiscal year	This error code will set and your claim will suspend when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history for the eligible portion of Therapeutic Leave has exceeded the 48 day unit limitation for the State Fiscal Year.	<p>This edit is set to suspend. DO NOT ATTEMPT TO ADJUST OR RESUBMIT A SUSPENDED CLAIM. When a claim is set to suspend, staff at ODP will manually review the claim, then make a determination whether to "pay" or "deny" the claim detail line (service line).</p> <p>In order to receive payment for the units submitted in excess of the 48 day fiscal year limitation, a provider should:</p> <ol style="list-style-type: none"> <li>1. Contact your Supports Coordination Organization (SCO).</li> <li>2. The SCO will complete the draft "REQUEST FOR EXCEPTION TO THE ESTABLISHED SERVICE LIMITS OR MAXIMUM NUMBER OF SERVICE UNITS" form (DP 1023) and submit it to their Administrative Entity (AE).</li> <li>3. The AE will review the request and forward it to their ODP Regional Program Manager (RPM).</li> <li>4. If the exception request is approved by the RPM, then the RPM will send an approval form to the ODP Claim's Resolution Section via e-mail and cc: the AE.</li> </ol> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p> <p>For more detailed information concerning the draft exception process, please review Informational Packet 010-09 located on <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets", which is located on the left side of the main web page.</p> <p>To confirm that your Exception Request was approved by the Regional Program Office and is on file with the ODP Claim's Resolution Unit, please call: <b>1-866-386-8880, Mon-Thurs 8:30-12:00 &amp; 1:00 - 3:30</b></p>

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5591	> 40 Hours in State Fiscal Year	<p>This edit will set and the claim detail line will cutback to the unit maximum allowed when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds 40 hours in State Fiscal Year. The claim detail line will show a paid status.</p> <p>This edit applies to Temporary Homemaker Chore services for Waiver and Base (W7283 UA).</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>No additional payment will be made for units submitted in excess of the 40 hour unit State Fiscal Year limitation.</p>
5593	Exceeded \$20,000 in 10-Yr Period Limit/ Consumer	<p>This edit will set and the claim detail line will suspend when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds \$20,000 over 10 fiscal years for the same Individual.</p> <p>DO NOT ATTEMPT TO ADJUST OR RESUBMIT A SUSPENDED CLAIM. When a claim is set to suspend, staff at ODP will manually review the claim, then make a determination whether to "pay" or "deny" the claim detail line (service line).</p> <p>This edit applies to Home Accessibility Adaptations for Waiver and Base.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>The RPM will analyze the paid claim's history related to the claim, then make a determination to approve or deny it.</p>

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5595	Ineligible Medical Days Cutback 30 in State FY	<p>This edit sets for informational purposes only.</p> <p>This edit will set when the 31st and subsequent ineligible Medical Leave days are submitted on a claim within one State Fiscal Year.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p> <p>This edit sets to inform the provider/biller that the system has determined that the ineligible Medical Leave days submitted on the claim have exceeded 30 day units within the State Fiscal Year. As a result, the system will pay 60%, instead of 100%, of the ineligible Residential Habilitation rate to the provider.</p>
5596	Ineligible Thera Leave >48 days in State Fiscal Yr	<p>This edit will set and your claim will suspend when the system determines that the accumulated allowed units per detail from the current claim and/or paid claims history exceeds 48 units in a State Fiscal Year for the ineligible portion of Therapeutic Leave.</p> <p>This edit is set to suspend. <b>DO NOT ATTEMPT TO ADJUST OR RESUBMIT A SUSPENDED CLAIM.</b> When a claim is set to suspend, staff at ODP will manually review the claim, then make a determination whether to "pay" or "deny" the claim detail line (service line).</p>	<p>In order to receive payment for the units submitted in excess of the 48 day fiscal year limitation, ODP approval is needed. To obtain approval, please do the following:</p> <ol style="list-style-type: none"> <li>1. Contact your Supports Coordination Organization (SCO).</li> <li>2. The SCO will complete the draft "REQUEST FOR EXCEPTION TO THE ESTABLISHED SERVICE LIMITS OR MAXIMUM NUMBER OF SERVICE UNITS" form (DP 1023) and submit it to their Administrative Entity (AE).</li> <li>3. The AE will review the request and forward it to their ODP Regional Program Manager (RPM).</li> <li>4. If the exception request is approved by the RPM, then the RPM will send an approval form to the ODP Claim's Resolution Section via e-mail and cc: the AE.</li> </ol> <p>The ODP Claim's Resolution Section must have an approval on file from the ODP Regional Office before a claim with excess units can be approved for payment. The approval form communicates to the ODP Claim's Resolution staff that the excess units have been approved for payment.</p> <p>For more detailed information concerning the draft exception process, please review Informational Packet 010-09 located on <a href="http://odpconsulting.net">odpconsulting.net</a> website under the link titled "Informational Packets", which is located on the left side of the main web page.</p>

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ESC #	ESC Short Description Seen on Remittance Advice (RA)	REASON(S) ESCs WILL SET	HOW TO CORRECT ESCs
5599	Cannot bill Medical & Therapeutic on the same day	<p>This edit will post and deny the claim detail line when:</p> <p><b>Reason #1:</b> The system finds on the current claim or in claim's history that both Medical Leave and Therapeutic Leave have been billed for the same dates of service and the same Individual, regardless of provider.</p> <p><b>Reason #2:</b> The system determines that the same Residential Habilitation service is billed for the same dates of service and the same Individual as a Therapeutic Leave or Medical Leave procedure code and modifier (UC or UD) combination. When this condition occurs, PROMISe™ will only pay the first submitted Residential Habilitation service found, regardless if it is found on the same claim or in paid claim's history.</p>	<p>This edit is set to deny.</p> <p><b>If your claim detail line denied for reason #1</b> listed to the left, then one of three conditions were found:</p> <ol style="list-style-type: none"> <li>1. The information entered on the claim was entered on the claim incorrectly (i.e. invalid dates of service, invalid RID, invalid services etc.). Submit a new claim with the correct information. or ...</li> <li>2. The system found a service that cannot be billed at the same time as the service billed in paid claims history for the same dates of service and Individual. An example of when this scenario would occur is when you are currently billing for Medical Leave but paid claim's history shows that you were already paid for Therapeutic Leave. If paid claim history is correct, do nothing because the current claim denied correctly. If history is wrong, void the claim from paid claim's history.</li> </ol> <p><b>If your claim detail line denied for reason #2</b>, then the system found that both a Residential Habilitation service and a Residential Habilitation service with a modifier was billed for the same Individual and the same dates of service either on the current claim denial or in paid claim's history.</p> <p>Residential Habilitation and Residential Habilitation with a Medical Leave or Therapeutic Leave modifier can not be billed together for the same dates of service and the same Individual. Determine which service should have been billed for the dates of service and Individual. Was only Residential Habilitation rendered on that date? Was only Medical Leave utilized on that date? Was only Therapeutic Leave utilized on that date? If a claim in history was billed incorrectly, you will need to void the claim in paid claims history to correct the issue.</p>

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5670	Limited to \$10,000 Per Claim Detail (Service Line)	<p>This edit will set and pay the claim detail line when <b>Base</b> Home Rehabilitation is submitted and is found to exceed \$10,000 in a State Fiscal Year.</p> <p>When the system determines this condition exists, it will cutback the billed amount to \$10,000 and pay the claim detail.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b> This edit sets for informational purposes only.</p> <p>No additional payment will be made for dollars submitted in excess of the \$10,000 State Fiscal Year limitation.</p>
9019	Total Amount Cutback Due To SSI Payment	<p>This edit sets for informational purposes only to inform the provider that their total claim payment was reduced by the Individual's monthly Room and Board contribution entered in the "Patient Pay" field on the claim transaction.</p> <p>This edit will set every time a claim is submitted and approved for payment for ineligible Waiver-Funded Residential services.</p>	<p><b>NO CORRECTION IS NEEDED FOR THIS EDIT.</b></p>