State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: February 10, 2014

MHSUDS INFORMATION NOTICE NO.: 14-001

TO: COUNTY ALCOHOL AND DRUG PROGRAM ADMINISTRATORS
COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: SHORT-DOYLE/MEDI-CAL DENIED CLAIM ADJUSTMENT CODE CHANGES

REFERENCE: ADMINISTRATIVE SIMPLIFICATION: ADOPTION OF STANDARDS FOR HEALTH CARE ELECTRONIC FUNDS TRANSFERS AND REMITTANCE ADVICE (45 CFR PART 162)

This Information Notice describes changes to the adjustment codes for denied claims reported on claim payment/advice transactions (835) from the Short-Doyle/Medi-Cal (SDMC) system. These changes are part of the Committee on Operating Rules for Information Exchange (CORE) Rule 360, are federally mandated as part of the Affordable Care Act, and have an implementation date of January 1, 2014.

Background

The Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) Rule establishes data content rule requirements for conducting the v5010 X12 835 transaction. The current use of the CARCs, RARCs, and Claim Adjustment Group Codes (CAGCs) can cause confusion throughout the healthcare industry due to non-uniform use of the codes. Therefore, CORE determined that operating rules would be required for the consistent and uniform use of CARCs and RARCs. The federal government released the regulations related to these operating rules on August 10, 2012.

When providers do not receive the same uniform and consistent CARC and RARC combinations for the same or similar business scenarios from all health plans, they are unable to automatically post claim payment adjustments and claim denials accurately and consistently. The CORE Rule 360 remediates this by providing four CORE-defined Claim Adjustment/Denial Business Scenarios and specific combinations of CARC/RARC/CAGC codes that can be applied to convey details of the claim denial or payment within each business scenario. However, when a specific CORE-defined

business scenario is not applicable to meet the health plan's business needs, the health plan may develop additional business scenarios and code combinations for them.

Changes to SDMC CARCs and RARCs

To implement the CORE Rule 360 requirements for Drug Medi-Cal Services, the Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and Remittance Advice Remarks Codes will be changed according to Enclosure 1, effective January 1, 2014. For certain claim denials, the description of the circumstance of claim denial is revised from the previously published descriptions to clarify the circumstance or to reflect changes since the description was previously published.

Questions regarding the content of this information notice or its enclosure may be directed to Mary Furuhashi at (916) 323-1861.

Sincerely,

Karen Baylor

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health and Substance Use Disorder Services

Enclosure

Description	Revised/New Description (where applicable)	Old Group/ Reason/ Remark	New Group/ Reason/ Remark
Beneficiary identified as perinatal-eligible (Loop 2000B PAT09 is "Y"), but MEDS indicates this client is male.		CO/10/_	CO/16/MA39
	Deny claim when billing for Perinatal service when beneficiary is not perinatal-eligible (Loop 2000B PAT09 is "Y").	CO/10/_	CO/96/N30
Perinatal service billed prior to 1/1/2014, but beneficiary is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided), or Daycare Rehabilitative service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided.)		CO/11/_	
	The date of death precedes the date of service.		CO/13/_
The claim (Original/Void/Replacement) is an invalid bridge submission claim.		CO/16/N354	
	Deny service lines with zero dollar net charge.		M54
This service is not allowed on the same date as a previously-approved service for this beneficiary without a valid multiple service procedure modifier.		CO/18/_	CO/16/N20
MEDS indicates this client has non-Medicare other health coverage, and the claim does not indicate that coverage has been billed first.		CO/22/_	CO/16/N479
Coordination of benefits adjustment.		CO/23/_	
Claim denied for late submission.		CO/29/_	CO/29/N30
Beneficiary aid code(s) do not indicate eligibility for Drug Medi-Cal services.		CO/31/_	
Charges reduced because they exceed the maximum allowed given the established rate and the billed units of service.		CO/45/_	
Administrative Fees retained by State.		CO/89/_	
	DMC denies the post-adjudicated file that contains duplicate claims as another submitted file.		CO/97/M86

Description	Revised/New Description (where applicable)	Old Group/ Reason/ Remark	New Group/ Reason/ Remark
Claim denied because perinatal and non-perinatal services are billed together. Re-bill perinatal and non-perinatal services on separate claims.		CO/109/_	CO/16/N63
Claim denied because service dates on claim include more than one calendar month. Re-bill in separate claims for each calendar month of service.		CO/138/_	
Service date cannot be later than submission date.		CO/110/M52	CO/110/_
Service line denied because a service (other than NTP counseling) was billed with a number of units different from the number of days billed.		CO/119/N345	CO/96/M86
Service denied because it would exceed limit of 20 units of NTP counseling service per month or it exceeds 1 unit of service for ODF, IOT (Intensive Outpatient Treatment), RES (Residential) or NAL (Naltrexone) beneficiary.	Deny service line for a Methadone dosing when the units billed on service line does not equal the number of days in the date range.	CO/119/N362	CO/16/N345
Service denied because it would exceed limit of 20 units of NTP counseling service per month or it exceeds 1 unit of service for ODF, IOT (Intensive Outpatient Treatment), RES (Residential) or NAL (Naltrexone) beneficiary.		CO/119/N362	CO/96/N362
The submitted Void or Replacement claim is not eligible to be Voided or Replaced.		CO/129/_	CO/16/M47
	Deny DMC Void claim received on Bridge Resubmission.	CO/129/N59	CO/16/M47
The Non-Federal portion of approved services to be paid with realignment funds.		CO/137/_	
Portion of payment for approved services deferred due to insufficient contract balances. Or payment deferred through Cost Settlement.		CO/143/_	
Claim denied because it was submitted late, a delay reason code requiring certification was provided and a certification attachment was referenced in the claim, but the certification attachment either was not received or did not cover this		CO/163/_	

Description	Revised/New Description (where applicable)	Old Group/ Reason/ Remark	New Group/ Reason/ Remark
claim.			
Service line denied because no diagnosis pointer provided in SV107 references a covered diagnosis code for Drug Medi-Cal services.		CO/167/M76	CO/167/N30
Claim denied because Billing Provider EIN and NPI combination is not valid per DMC provider records.		CO/208/N257	CO/16/N521
	DMC denies the post-adjudicated file because the submitter does not have a valid contract to bill for DMC services.		CO/242/M115
	DMC denied the Post adjudicated file because the required Certification of Public Expenditure form was not received.		CO/252/N59
Service line denied because the procedure codes and modifiers provided do not identify a Drug Medi-Cal service.		CO/A1/M51	CO/96/N216
Service line denied because service "to" date proceeds "from" date.		CO/A1/M59	CO/16/M59
Service line denied because a service other than NTP Methadone Dosing was billed with a date range rather than a single date of service.		CO/A1/N63	
This service is not allowed on the same date as one or more previously-approved services for this beneficiary.		CO/A1/M80	CO/96/M80
Void/Replacement claim denied because the original claim is an invalid resubmission claim.		CO/A1/N142	CO/16/N152
	Claim denied because Billing Provider EIN Submitter EIN does not match per DMC provider records.	CO/A1/N257	CO/16/N259
Service line denied due to disallowance from post-service, post-payment utilization review.		CO/A1/N421	
Claim or service line denied because COB information provided is not balanced. At the claim level, the Total Claim Charge Amount provided in the Loop 2300 Claim Information (CLM) segment must equal the Other Payer Paid Amount reported in Loop 2320		CO/A1/N480	CO/16/N480

Description	Revised/New Description (where applicable)	Old Group/ Reason/ Remark	New Group/ Reason/ Remark
plus the sum of all adjustment amounts reported in Claims Adjustment (CAS) segments in Loops 2320 and Line Adjustment (CAS) segments in 2430 for this other payer. At the service line level, the Line Item Charge Amount provided in the Loop 2400 Professional Service (SVC) segment must equal the Service Line Paid Amount provided in the Loop 2430 Line Adjudication Information (SVD) segment, plus the sum of all Adjustments Amounts reported in Line Adjustment (CAS) segments in Loop 2430.			
Service line denied because the Service Facility Location was not a Drug Medi-Cal certified site for the identified service on the date(s) of service.		CO/B7/_	CO/B7/N570 Old codes are combined
Service line denied because the Service Facility Location is not one for which the Billing Provider may submit claims for the date(s) of service. If Service Facility Location provider type is 'Sole Proprietor' and the zip code +4 of SFL provider on claim/service line does not equal zip code +4 in DMC's provider file then deny service line.		CO/B7/MA114	
Lien and levy recovery.		OA/223/_	
Recoupment of State General Fund (SGF) due to realignment.		PI/223/_	
Service line reimbursement adjusted due to share of cost collected reported by provider.		PR/1/_	