Short-Doyle / Medi-Cal Claim Payment/Advice (835) NOTES: Drug Medi-Cal Services

Please also see the official CARC/RARC descriptions on the X12 website Link to CARC
Definitions

Link to RARC Definitions

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| CARC / RARC Changes | | | | | | | | | | | | | | | | | | | |
|--|---|----------------------------|------------------------|--------------------|--------------------|-------------------|-------------------|--------------------|--------------------|------------------------|--------------------------|----------------------------|--------------------|---------------------|---------------------|----------------------|----------------------|---------------------|-------------------|
| Drug Medi-Cal Description | Organized Delivery System Waiver/ 837l Description | Latest Update 6/22/2021 | 03/10/2014 and earlier | Updated 03/11/2014 | Updated 12/09/2014 | Updated 06/8/2015 | Updated 09/8/2015 | Updated 08/23/2016 | Updated 01/10/2017 | Updated 4/3/2017 (ODS) | Updated 3/12/2019 (837I) | Updated Before Nov 2019 | Updated 11/12/2019 | Updated 3/1/2020 | Updated 6/8/2020 | Updated 8/11/2020 | Updated 10/6/2020 | Updated 3/9/2021 | Updated 5/11/2021 |
| Medicare must be billed prior to the submission of this claim (Medi-Medi). | | CO/22/N479 | | | | | | | | | | | | | | | | CO/22/N479 | |
| If the week begins and ends across different service months the county should split the weekly claim by the days in | s | CO/267/N74 | | | | | | | | | | | | | | | | CO/267/N74 | |
| each respective month and allocate the COB amount paid by Medicare by day. | | | | | | | | | | | | | | | | | | | |
| Beneficiary has Medicare Part B and Bundle service(s) greater than 7 days. The NPI of the billing provider(s) is deactivated NPPES or | | CO/16/M53 | | | | | | | | | | | | | | | | | |
| The NPI of the billing provider(s) is deactivated NPPES or the incorrect NPI Type for the Billing Provider NPI has been entered on the claim. | | CO/208/N257 | | | | | | | | | | | | | | | | | CO/208/N257 |
| The NPI of the attending provider is deactivated NPPES. | | CO/208/N253 | | | | | | | | | | | | | | | | | CO/208/N253 |
| The NPI of the service facility location on a claim is deactivated in NPPES or the incorrect NPI Type for the Service Facility Location NPI has been entered on the claim. | | CO/208/N77 | | | | | | | | | | | | | | | | | CO/208/N77 |
| the Claim Rendering NPI is deactivated in NPPES or the incorrect NPI Type for the Claim Rendering NPI has been entered on the claim. | | CO/208/N290 | | | | | | | | | | | | | | | | | CO/208/N290 |
| The NPI of the ordering provider is deactivated in NPPES | | CO/208/N265 | | | | | | | | | | | | | | | | | CO/208/N265 |
| The NPI of the referring provider is deactivated in NPPES | | CO/208/N286 | | | | | | | | | | | | | | | | | CO/208/N286 |
| Claim denied for Methadone dosing when the units billed on service line does not equal the number of days in the date range. | The units billed does not equal the number of days in the date range for a methadone dosing- | CO/16/N345 | CO/119/N362 | CO/16/N345 | | | | | | | | | | | | | | | |
| N/A - ODS Only | MAT services billed with fractional units must total one unit per drug type per day on a claim. | CO/16/N345 | | | | | | | | | | | | | | | | | |
| N/A - ODS 8371 only | 837I - The number of units billed exceeds the max days allowed (one unit billed per calendar day). | CO/16/N345 | | | | | | | | | CO/16/N345 | | | | | | | | |
| This service is not allowed on the same date as the previously-approved service for this beneficiary without a valid multiple service procedure modifier. | This service is not allowed on the same date as the previously-approved service for this beneficiary. | CO/96/M80 | CO/18 | CO/16/N20 | CO/96/N20 | | CO/96/M80 | | | | | | | | | | | | |
| This service is not allowed on the same date as one or more previously-approved services for this beneficiary. | | CO/96/M80 | CO/A1/M80 | CO/96/M80 | | | | | | | | | | | | | | | |
| N/A - ODS 837I only | 837I: When comparing the service line with a previously approved line for the same date of service, if both service lines are from 837I claims, then the deny service line. | CO/96/M80 | | | | | | | | | CO 96 M80 | | | | | | | | |
| N/A - ODS 8371 only | 837: When comparing the service line with a previously approved service line in history for the same date of service, if non service line is an institutional service (8377) and the other service is a professional service AND the service date of the professional service (8377) is not the admit date of the institutional service then deny service line. | CO/96/M80 | | | | | | | | | CO 96 M80 | | | | | | | | |
| Beneficiary aid code is "restricted to pregnancy services" and the client is not identified as perinatal-eligible (Loop | | CO/177 | | | CO/96/N216 | | | CO/177 | | | | | | | | | | | |
| 2000B PAT09 is "Y" not provided). MEDS indicates this client has non-Medicare other health coverage, and the claim does not indicate that coverage | | CO/177 | CO/22 | CO/16/N479 | CO/177 | | | CO/177 | | | | | | | | | | | |
| has been billed first. Beneficiary aid code(s) do not indicate eligibility for Drug | | CO/177 | CO/31 | | | | | CO/177 | | | | | | | | | | | |
| Medi-Cal services. Long Term Care aid code "13", "23", "63" are only allowed | | CO/177 | | | | | | | | | | | | | | | | | |
| for NTP services. Claim denied because client is ineligible per MEDS. | | CO/177 | CO/177 | | | | | | | | | | | | | | | | |
| Claim denied due to no valid aid code for month of service (all aid codes are eliminated or no eligible aid codes present on FAME response) | | CO/177 | | | | | | CO/177 | | | | | | | | | | | |
| N/A - ODS 837I only | 837l: Service line denied because the Service Facility Location is not authorized to provide the service (identified by the Revenue Codes. PCS codes and DPI) for the | CO/B7/N570 | | | | | | | | | CO/B7/N570 | | | | | | | | |
| Missing/incomplete/invalid date of birth. Date of birth on 837 file does not match date of birth in FAME response. | | CO/16/N327 | | | | | | | CO/16/N327 | | | | | | | | | | |
| Service date submitted prior to the service effective date. Example - Non-perinatal residential services for EPSDT beneficiaries. | Claim does not include authorized services or no interim rate for service type. | CO/26/N650 | | | | | | | | | | CO/96/N54 | | | | CO/26/N650 | | | |
| Procedure codes and modifiers provided do not identify a Drug Medi-Cal service. | Procedure codes and modifiers and/or National Drug Code service combination do not identify an allowable Drug Medi-Cal Organized Delivery System (ODS) service. | CO/96/N216 | CO/A1/M51 | CO/96/N216 | | | | | | | | | | | | | | | |
| N/A - ODS Only | Billing override code was used on a DMC- ODS claim | CO/96/N216 | | | | | | | | | | | | | | | | | |

| | Table | | | | | | | | , | | | | | | |
|---|---|-------------|-----------------------|------------|------------|--|------------|-------------|------------|--|---------------------------------|--|-----------|------------|---|
| N/A - ODS 837I only | 837I: The Revenue Code, Procedure Coding System Code and/or Demonstration Project Identifier combination is not a valid DMC institutional | CO/96/N216 | | | | | | | CO/96/N216 | | | | | | |
| | service combination. The billing county is not the county of | | | | | | | | | | | | | | |
| N/A - ODS Only | responsibility for the beneficiary. | CO/96/N424 | | | | | | CO/96/N424 | | | | | | | |
| Beneficiary identified as perinatal-eligible (Loop 2000B PAT09 is "Y"), but MEDS indicates the beneficiary is not female per FAME response. | 837I: Claim level pregnancy indicator is present and the beneficiary is not female per FAME response. | CO/16/MA39 | CO/10 | CO/16/MA39 | | | | | | | | | | | |
| Missing/incomplete/invalid gender. Gender submitted on 837 is not equal to gender received in FAME response. | | CO/16/MA39 | | | | | CO/16/MA39 | | | | | | | | |
| Claim denied for late submission. | | CO/29 | CO/29 | CO/29/N30 | CO/29 | | | | | | | | | | |
| N/A - ODS 837I only | 837I: The claim level pregnancy indicator is not present for a perinatal service. | CO/96/N30 | | | | | | | CO/96/N30 | | | | | | |
| N/A - ODS only | Service exceed the applicable (youth or adult) non-perinatal residential stay limit for the calendar year. (Rule relaxed due to COVID-19 Pandemic on March 1st, 2020). | CO/119/N362 | | | | | | CO/119/N362 | | | Rule relaxed due to Covid-19 | | | | |
| Perinatal service billed prior to January 1, 2014, but beneficiary is not identified as perinatal-eligible (Loop 20008 PAT09 of "Yn otp provided), or Daycare Rehabilitative service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible (Loop 20008 PAT09 of "Y" not provided). | | CO/96/N30 | CO/10 <u>or</u> CO/11 | CO/96/N30 | | | | | | | | | | | |
| State Funded Immigrants: Beneficiary is full scope eligible but ineligible for Federal Fianancial Partipication due to immigration status | | CO/96/MA43 | | | | | | | | | | | CO/96/N30 | CO/96/MA43 | |
| Medi-Medi NTP/OTP Claims: Claim is denied if the coordination of benefits is entered at the Service Line level, or a combination of the Claim Line and Service Line level. | | CO/95 | | | | | | | | | | | | | |
| N/A - ODS only | Fractional units were billed for a service requiring billing in whole units. | CO/16/M53 | | | | | | CO/16/M53 | | | | | | | |
| Service (other than NTP counseling) was billed with a number of units different from the number of days billed. | requiring billing in whole drits. | CO/16/M53 | CO/119/N345 | CO/96/M86 | CO/16/M53 | | | | | | | | | | |
| N/A - ODS Only | ODS: Beneficiary is 21 years of age or more on the service "start date" and "HA" modifier is reported on the claim or beneficiary is less than 21 years of age on the service "end date" and "HA" modifier is not reported on the claim. | CO/96/N129 | | | | | | | | | | | | | |
| of service for ODF, IOT (Intensive Outpatient Treatment), RES (Residential) or NAL (Naltrexone) beneficiary. | Service line denied because the units billed are greater than 1, excluding ODS NTP Dosing services or services that have either a 10 minute or 15 minute increment unit of measure. | CO/96/N362 | CO/119/N362 | CO/96/N362 | | | | | | | | | | | |
| Service line did not contain a valid Drug Medi-Cal diagnosis code. | | CO/167/N30 | CO/167/M76 | CO/167/N30 | | | | | | | | | | | ĺ |
| N/A - ODS only | Either a youth service (with the HA modifier) was billed for a non-youth client (21 or older on date of service) or a non- youth service (without the HA modifier) was billed for a youth client (under 21 on date of service) | CO/4/M20 | | | | | | CO/4/M20 | | | | | | | |
| The date of death in MEDS precedes the date of service. | | CO/13 | | CO/13 | | | | | | | | | | | |
| The submitted Void or Replacement claim is not eligible to be Voided or Replaced. Missing/incomplete/invalid Payer Claim Control Number. | | CO/16/M47 | CO/129 | CO/16/M47 | | | | | | | | | | | |
| Service lines with zero dollar net charge. | | CO/16/M54 | | CO/16/M54 | | | | | | | | | | | |
| N/A - ODS 837I only | Service line Date of Service (DOS) "from" and "to" dates are not within the admission and discharge date range. 8371: MISSING/INCOMPLETE/INVAIIG DISCHARGE | CO/16/MA31 | | | | | | | CO/16/M431 | | | | | | |
| N/A - ODS 837I only | oszi. wissing/incomplete/invalid discharge | CO/16/N50 | | | | | | | CO/16/N50 | | | | | | |
| Perinatal and non-perinatal services are billed together. Re- bill perinatal and non-perinatal services on separate claims. | | CO/16/N61 | CO/109 | CO/16/N63 | CO/16/N61 | | | | | | | | | | |
| Void/Replacement claim denied, the original claim is an invalid resubmission claim. | | CO/16/N152 | CO/A1/N142 | CO/16/N152 | | | | | | | | | | | |
| Billing Provider EIN Submitter EIN does not match per DMC provider records. | | CO/16/N259 | CO/A1/N257 | CO/16/N259 | | | | | | | | | | | |
| Service line denied because service "to" date proceeds "from" date. | | CO/16/N301 | CO/A1/M59 | CO/16/M59 | CO/16/N301 | | | | | | | | | | |
| Service line denied because a service other than NTP Methadone Dosing was billed with a date range rather than a single date of service. | Service line denied because a service that is not methadone dosing was billed with a date range rather than a single date of service. | CO/16/N301 | CO/A1/N63 | CO/16/M59 | CO/16/N301 | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

| Coordination of Benefits (COB) information provided is not | | | | | | | | | | | | | | | |
|---|--|-------------|----------------------|--------------|------------|--------------|---|---|-----------|------------|---|--|---|--|--|
| balanced. At the claim level, the Total Claim Charge | | | | | | | | | | | | | | | |
| Amount provide in the Loop 2300 Claim Information (CLM) | | | | | | | | | | | | | | | |
| segment must equal the Other Payer Paid Amount reported | i | | | | | | | | | | | | | | |
| in Loop 2320 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 | | CO/16/N480 | CO/A1/N480 | CO/16/N480 | | | | | | | | | | | |
| other payer. At the service line level, the Line Item Charge | | CO/10/14400 | CO/A1/19400 | CO/ 10/14400 | | | | | | | | | | | |
| 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 the Line Adjustment (CAS) segments in Loop | | | | | | | | | | | | | | | |
| 2430. | | | | | | | | | | | | | | | |
| Claim denied because Billing Provider EIN and NPI | | CO/16/N521 | CO/208/N257 | CO/16/N521 | | | | | | | | | | | |
| combination is not valid per DMC provider records. Coordination of benefits adjustment. | | | | CO/10/14321 | | | | | | | | | | | |
| Coordination of benefits adjustment. | KI 6 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | CO/23 | CO/23 | | | | | | | | | | | | |
| N/A - ODS PUPM claims only | If the Service Line Approved Amount is not | CO/24 | | | | | | | | | | | | | |
| Charges reduced because they exceed the maximum | equal to the Submitted Charge Amount, a | | | | | | | | | | | | | | |
| allowed given the established rate and the billed units of | | CO/45 | CO/45 | | | | | | | | | | | | |
| | | CO/43 | CO/43 | | | | | | | | | | | | |
| service. Administrative Fees retained by State. | | CO/89 | CO/89 | | | | | | | | | | | | |
| | 937l. Panafisian, is 31 | | | | | | | | | | | | | | |
| | 837I: Beneficiary is 21 years of age or more on the service "start date" | | | | | | 1 | | | | | | | | |
| | and youth indicator is reported on the | | | | | | | | | | | | | | |
| N/A - ODS 837I only | | CO/96/M114 | | | | | | | | CO/96/129 | | | | | |
| | claim or beneficiary is less than 21 years of age on the service "end date" and youth | | | | | | 1 | | | | | | | | |
| | | | | | | | 1 | | | | | | | | |
| | indicator is not reported on the claim. | | | | | | | 1 | | | | | | | |
| | Services span both ODS (including | | | | | | | | | | | | | | |
| N/A - ODS Only | Partnership PUPM claims) and non-ODS | CO/96/N52 | | | | | | | CO/96/N52 | | | | | | |
| DMC desired and advantage of the second control of | periods for the billing county. | | | | | | | | | | | | | | |
| DMC denies the post-adjudicated file that contains | | CO/97/M86 | | CO/97/M86 | | | | | | | | | | | |
| duplicate claims as another submitted file. Service date cannot be later than submission date. | | CO/110 | CO/110/M52 | CO/110 | | | | | | | | | | | |
| | | CO/110 | CO/110/M32 | CO/110 | | | | | | | | | | | |
| The Non-Federal portion of approved services to be paid | | CO/137 | CO/137 | | | | | | | | | | | | |
| with county Behavioral Health Subaccount (BHS) Funds. | | | CO/15/ | | | | | | | | | | | | |
| Portion of payment for approved services deferred due to | | | | | | | | | | | | | | | |
| insufficient contract balances. | | CO/143 | CO/143 | | | | | | | | | | | | |
| Claim is older than 700 days, payment deferred through | | CO/ 143 | CO/ 143 | | | | | | | | | | | | |
| Cost Settlement. | | | | | | | | | | | | | | | |
| No Perinatal Contract exists. | | CO/143 | | | | | | | | | | | | | |
| Expired Contract - No contract amendment. Contract not | | | | | | | | | | | | | | | |
| renewed and claim submitted late for previous Fiscal Year. | | CO/143 | | | | | | | | | | | | | |
| | | CO/143 | | | | | | | | | | | | | |
| Contract out of money. Claim denied due to late submission, a delay reason code | | CO/ 143 | | | | | | | | | | | | | |
| requiring certification was used and a certification | | | | | | | | | | | | | | | |
| attachment was referenced in the claim, but the | | CO/163 | CO/163 | | | | | | | | | | | | |
| certification attachment either was not received or did not | | , | CO/ 103 | | | | | | | | | | | | |
| cover this claim. | | | | | | | | | | | | | | | |
| NPI out of date range for this claim. | | CO/208 | | | | | | | | | | | | | |
| Provider shares NPI with another location and DMC | | | | | | | | | | | | | | | |
| accounting system cannot currently issue payment for this | | CO/208 | | | | | | | | | | | | | |
| type of claim. | | | | | | | | | | | | | | | |
| NPI is incorrect. | | CO/208 | | | | | | | | | | | | | |
| The submitter does not have a valid contract to bill for Drug | | CO/242/M115 | | CO/242/M115 | | | | | | | | | | | |
| Medi-Cal services. | | | | 22,2.2, | | | | | | | | | | | |
| Certification of Public Expenditure form was not received. | | CO/252/N59 | | CO/252/N59 | | | 1 | | | | | | | | |
| Claim denied because service dates on claim include more | | | | | | | | | | | | | | | |
| than one calendar month. Re-bill in separate claims for | | CO/267/N74 | CO/138 | CO/16/N63 | CO/16/N61 | CO/267/N74 | | | | | | | | | |
| | | 20,20,, | CO/130 | CO/10/1403 | CO/10/1401 | CO/201/14/14 | | | | | | | | | |
| each calendar month of service. | 837I: Service line dates in 1 claim must be | | | | | | | | | | | | | | |
| | in the same calendar month unless there is | CO/267/N74 | | | | | 1 | | | CO/267/N74 | 1 | | 1 | | |
| N/A - ODS 837I only | a discharge date that is the first day of the | CO/267/N/4 | | | | | | | | CO/26//N/4 | | | | | |
| | following month. | | | | | | | | | | | | | | |
| Service line denied due to disallowance from post-service, | | CO/A1/N421 | CO/A1/N421 | | | | | | | | | | | | |
| post-payment utilization review. | | CO/A1/14421 | CO/A1/19421 | | | | | | | | | | | | |
| | MAT services for the same drug type and | | | | | | | | | | | | | | |
| N/A - ODS Only | day of services billed with fractional units | CO/B15 | | | | | 1 | | | | | | | | |
| 1971 000 0119 | on a claim must all either be approved | , | | | | | 1 | | | | | | | | |
| The Contine Facility Leasting | together or denied together. | | | | | | | | | | | | | | |
| The Service Facility Location was not a Drug Medi-Cal- | Service line denied because the Service | | | | | | | | | | | | | | |
| certified site for the identified service on the date(s) of | Facility Location is not authorized to | CO/B7/N570 | CO 07 CO 070/1111 | CO/B7/N570 | | | | | | | | | | | |
| service. Service line denied because the Service Facility | provide for the identified service for the | CO/B7/N570 | CO/B7 or CO/B7/MA114 | | | | | | | | | | | | |
| Location is not one for which the Billing Provider may | billing county on the date(s) of service. | | | | | | | | | | | | | | |
| submit claims for the date(s) of service. | | PI/223 | PI/223 | | | | | | | | | | | | |
| Lien and levy recovery. Recoupment of State General Fund (SGF) due to | | | | | | | | | | | | | | | |
| realignment. | | PI/223 | PI/223 | | | | | | | | | | | | |
| Service line reimbursement adjusted due to share cost | | | | | | | | | | | | | | | |
| collected reported by provider. | | PR/1 | PR/1 | | | | | | | | | | | | |
| Service line is submitted with a \$0 Line Item Charge | | | | | | | | | | | | | | | |
| service line is submitted with a 30 time item charge | | | | | | | | | | | | | | | |
| Amount. | | -/-/M54 | | | | | | | | | | | | | |