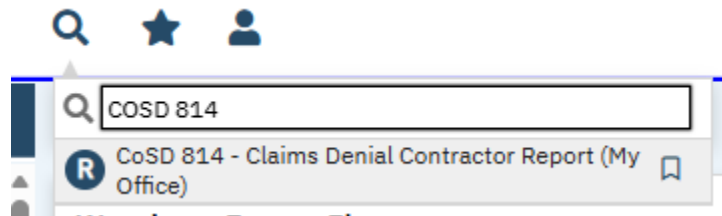


The **COSD 814 – Claims Denial Contractor Report** provides information regarding the different reasons why Medi-Cal would deny a service/claim.

BHS Billing Unit has always handled majority of the claims that were denied by Medi-Cal, however, there were instances where copies of the denials (i.e., clients not Medi-Cal eligible, missing EOB from primary payer, etc.) were sent to the programs for further review and guidance (i.e., whether claims should be replaced/resubmitted or accept denial). Please refer to the following guidelines when reviewing the report.

NOTE: There are various billing activities (i.e., charge creation, claim generation, electronic remittance processing, EOB posting, claim replacements, etc.) that occur at any given time there, the report will only be as current as the day you run it.

1. Search for CalMHSA 814 – Claims Denial Contractor Report or simply type in 814.



2. System prompts you for a service “Start Date”, “End Date” and “Program Code”. Use DOS (Date of Service) denials that are still considered billable based on SD/MC (Short-Doyle Medi-Cal) timely filing guidelines (15 months from DOS).

A screenshot of a form with three input fields. The first field is labeled 'Start Date' and contains the text '7/1/2025'. The second field is labeled 'End Date' and contains the text '7/31/2025'. The third field is labeled 'Program Code' and is currently empty. Each date field has a small calendar icon to its right. The 'Program Code' field has a dropdown arrow to its right.

3. Report displays the services in ascending order by DOS. Report can be exported using either Excel or CSV if you wish to sort or filter other than the default. Once you export the report, please add a column at the end and label it “PROGRAM

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ANALYSIS”. Use this column to make notes of your findings and instructions for BHS BU whether claim should be replaced or not.

Start Date

7/1/2025

End Date

7/31/2025

Select Programs

CRF CROSSROADS

Find

Next

Word

Excel

PowerPoint

Excel

PDF

Program Name	Client Id	Date Of Service	Clinician First Name	Clinician Last Name	Clinician Taxonomy Code	Clinician Degree	Charge Amount	Paid Amount	Charge Status	First Denial Adj Group Code	Adj Reason Code Desc	RARCode Short Desc
Program Name	123456789	07/01/2025	Doctor	Quinn	Counselor: Mental Health (101YM0800X)		\$291.99	\$0.00	Denied	CO	16 - Claim Lacks Info	N288 - Taxonomy
		07/01/2025			Counselor: Mental Health (101YM0800X)		\$291.99	\$0.00	Denied	CO	16 - Claim Lacks Info	N288 - Taxonomy
		07/16/2025			Counselor: Professional (101YP2500X)	APCC Associate Professional Clinical Counselor	\$97.33	\$0.00	Denied	CO	177 - CIN Doesn't Match	NoRARData
		07/17/2025			Student in an Organized Health Care Education/Training Program (390200000X)		\$389.33	\$0.00	Denied	CO	22 - Payer COB	NoRARData
		07/18/2025			Counselor: Professional (101YP2500X)	APCC Associate Professional Clinical Counselor	\$324.44	\$0.00	Denied	CO	177 - CIN Doesn't Match	NoRARData
		07/18/2025			Counselor: Professional (101YP2500X)	APCC Associate Professional Clinical Counselor	\$389.33	\$0.00	Denied	CO	177 - CIN Doesn't Match	NoRARData
		07/21/2025			Child and Adolescent Psychiatry (2084P0804X)	MD Medical Doctor	\$1171.84	\$0.00	Denied	CO	96 - Non Covered Charge	M80 - Same Day Service

Program Name	Client Id	Date Of Service	Clinician First Name	Clinician Last Name	Clinician Taxonomy Code	Clinician Degree	Charge Amount	Paid Amount	Charge Status	First Denial Adj Group Code	Adj Reason Code Desc	RARCode Short Desc	Program Analysis
Program Name	123456789	05/02/2025	Justin	Thyme	Student in an Organized Health Care Education/Training Program (390200000X)		\$283.25	\$0.00	Denied	CO	177 - CIN Doesn't Match	NoRARData	8/4/2026; Verified CIN in provider portal; client not eligible on DOS; DO NOT REPLACE
Program Name	987654321	05/02/2025	Justin	Thyme	Counselor: Professional (101YP2500X)	APCC Associate Professional Clinical Counselor	\$377.66	\$0.00	Denied	CO	177 - CIN Doesn't Match	NoRARData	8/4/2026: Please update CIN in coverage plan to 98765432A; PLEASE REPLACE
Program Name	876543219	05/29/2025	Justin	Thyme	Counselor: Mental Health (101YM0800X)	APCC Associate Professional Clinical Counselor	\$1416.30	\$0.00	Denied	CO	22 - Payer COB	NoRARData	8/4/2026: Please add Aetna as primary. Insured id is 12345 effective 04/01/2025; PLEASE REPLACE

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4. Please refer to **the DMC-CARC-RARC-CalAIM** or **MH-CARC-RARC-CalAIM** documents for a full version of the CARC (Claim Adjustment Reason Code) and RARC (Remittance Advice Remark Code) description. There are differences in the descriptions and usage of the denial code based on the service program (MH or SUD) of the client.

Below are the list of denial codes/denial reasons that programs should focus on when reviewing the report.

CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
CO/16/N288	SD/MC denied this service because the claim did not include the rendering provider's taxonomy.	- Rendering clinicians' taxonomy at time of service does not match their information in NPPES or the State's database or information is missing. - If rendering clinician was a CT (Clinical Trainee) at time of service, taxonomy 390200000X should still be listed as one of their taxonomies in NPPES. All taxonomy codes tied to the clinician's license/degree should remain in NPPES even though it is not indicated as their current taxonomy. To avoid claims from getting denied by SD/MC, please DO NOT delete the taxonomy in NPPES.	- Remark code N288 indicates that the payer's adjudication system found the rendering provider's taxonomy code to be missing, incomplete, or invalid in the 837 electronic claim file. - To address the issue, verify the clinician's taxonomy code and ensure that it matches the payer's taxonomy database or NPPES and valid for the time of service being billed. - Inform BHS_EHRAccessRequest.HSA@sdcounty.ca.gov (MIS Access) and SUDBillingUnit.BHS@sdcounty.ca.gov (SUD BU)

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CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
		Notify BHS/MIS and MHBU once information has been updated in NPPES.	immediately upon NPPES data updates. If anything appears correct based on your review and requires additional assistance, please contact BHS MIS and cc SUD BU.
CO/16/N327	SD/MC denied this claim because the beneficiary's date of birth (month and year) on the claim did not match the date of birth (month and year) in the eligibility system.	- Go to Client Information in SmartCare and verify client's DOB against record in DHCS Provider Portal/Medi-Cal eligibility system. - Please complete and submit the BHS-025 Form to the Health Management Information (HIM) team with correlating documents to help support change requests. Please contact MHBU if you need assistance. - Notify SUD BU once DOB has been corrected in the system. - In some cases, the N327 denial stems from an invalid CIN (Client Identification Number / Client Index	- Go to Client Information in SmartCare and verify client's DOB against record in DHCS Provider Portal/Medi-Cal eligibility system. - Please complete and submit the BHS-025 Form to the Health Management Information (HIM) team with correlating documents to help support change requests. Please contact the SUD BU if you need assistance. - Notify SUD BU once DOB has been corrected in the system. - In some cases, the N327 denial stems from an invalid CIN (Client Identification Number / Client Index

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CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
		Number), but the DOB is correct. Please verify the CIN and contact SUD BU if you need further assistance.	Number), but the DOB is correct. Please verify the CIN and contact SUD BU if you need further assistance.
CO/16/N479	SD/MC denied this Medicare-eligible service because the beneficiary has either traditional FFS Medicare or Medicare Advantage (Medicare Part C) and there is no evidence the MHP tried to bill Medicare before billing SD/MC.	- Verify if client has Medi-Medi coverage or OHC-Medi-Cal or OHC-Medicare-Medi-Cal coverage. - If your program has already billed Other Healthcare Coverage or Medicare, please forward a copy of the EOB (Explanation of Benefits) to MHBUS. - If no response is received from OHC or Medicare within 90 days, after claims are billed, notify MHBUS and provide proof of billing.	- To resolve or prevent N479 denial: - Verify if client has Medi-Medi coverage. Dual-eligible (Medi-Medi) beneficiaries can choose to get their Medicare coverage through Original Medicare or a Medicare Advantage (Part C) plan. - NTP programs must bill Medicare (B or C) as the primary payer. Medicare EOB must be submitted by the program to the SUDBillingUnit.BHS@sdcounty.ca.gov. Note: SUD BU will use NTP's 7-day weekly bundle format to replace the claims denied. - For non-NTP programs, billing to Medicare Part C is mandatory when they are the primary payer, except if
CO/22/N479	- SD/MC denied this claim because the beneficiary is covered by Medicare and there is no evidence that the MHP billed Medicare before billing SD/MC. - SD/MC denied this Medicare-eligible outpatient, 24 -hour or day service because the beneficiary is covered by traditional Medicare Part B or Medicare Advantage and there is no evidence the MHP tried to bill Medicare before billing SD/MC		

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CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
			the Medicare Advantage plan has the required Fee-for-Service equivalent certification and is permitted to bill directly to Medi-Cal. • Non-NTP program's requirement to bill Medicare Part B with COB (Coordination of Benefits) depends on the program's eligibility and the service provided. Please use the ODS-DMC Service Table to determine which procedure is marked as COB Medicare "YES". • Both NTP and non-NTP programs must follow the after 90-day OHC/Medicare rule. Submit Medicare's Proof of Billing (POB) to SUD BU if no response is received from the primary plan after 90 days to bill Medi-Cal while waiting for the program to submit the final OHC/Medicare claim for adjudication.

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CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
CO/96/MA43	- Medi-Cal denied the service because it was for a beneficiary with unsatisfactory immigration status and the county is responsible for paying for 100% of the cost of service. - Immigration status is tied to the Medi-Cal CIN# of the client. It's possible that client's CIN# in the BHS system is incorrect and needs to be updated.	- The DHCS Medi-Cal Provider Portal does not display or allow user access to the beneficiary immigration status directly. This data is part of the CMS reporting system, not a feature within the Provider Portal's transactional interface. BHS programs and BHS BU do not have access to it. - CO/96/MA43 denial is a true denial. No service replacement is necessary for the denied claim. - The funding is shifted to 100% County. Please check with your BHS Fiscal Analyst for confirmation.	- The DHCS Medi-Cal Provider Portal does not display or allow user access to the beneficiary immigration status directly. This data is part of the CMS reporting system, not a feature within the Provider Portal's transactional interface. BHS programs and BHS BU do not have access to it. - CO/96/MA43 denial is a true denial. No service replacement is necessary for the denied claim. - The funding is shifted to 100% County. Please check with your BHS Fiscal Analyst for confirmation.
CO/96/M80	- SD/MC denied this service because more than one inpatient or 24-hour service was claimed for the same time period for the same beneficiary. - SD/MC denied this outpatient service because	MH programs should run the "CoSD Little y Suspense Report" on a frequent basis and follow QA guidance on resolving items listed on the report.	For SUD NTP, "it could be due to MAT duplicate billing, or two different medications were provided to the same beneficiary on the same day. The two medications cannot be provided to the same beneficiary on the

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CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
	it may not be claimed on the same day as an approved 24-hour or inpatient service. SD/MC denied the service because it was provided to the same beneficiary on the same day as another service previously approved and the two services cannot be provided to the same beneficiary on the same day (i.e., they are locked out) without an over-ridable modifier. Please consult the SMHS Service Table for those services that cannot be provided to the same beneficiary on the same day as well as the modifiers that will over-ride the lock out.	- Please be advised that there is “no” claim it anyway process in SmartCare. - MHBU reviews this denial on a regular basis and do extensive analysis on reason why it was denied as duplicate before we determine whether denial is correct or if replacement is needed.	same day (i.e., Methadone and MAT services are not allowed on the same day)." If you're unable to find any invalid duplicate service or lockout, it is possible that the client is seen at an outside facility on the same date the client was seen on your program. Given the inability to verify due to HIPAA restrictions, please notify the SUD BU and we will treat this as a valid or true denial.
CO/177/NoRARCDData	- SD/MC denied this claim because the Client Index Number or CIN on the claim did not match the beneficiary's CIN in MEDS. - SD/MC denied this claim because the Date	- Verify client's eligibility in DHCS Provider Portal. - If CIN# changed, please provide the new/correct info on the report. - If eligibility expires prior to the DOS and client is no longer Medi-Cal eligible,	Verify the client's Medi-Cal eligibility in the DHCS Provider Portal to determine coverage at the time of service. Check as well if the client has Other Health Coverage as primary.

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CARC/RARC/Health Remark Code	CARC RARC Description	MH PROGRAMS	SUD PROGRAMS
	of Service must be greater than or equal to the Date of Eligibility. - SD/MC denied this claim because Beneficiary aid code is “restricted to pregnancy services” and the client is not identified as perinatal-eligible. - If aid code is not Medi-Cal billable. - SD/MC denied this claim because Long Term Care aid code “13”, “23”, “63” are only allowed for NTP services. - A client/beneficiary may have other health coverage as a primary plan.	please indicate on the report. If client is incarcerated, please indicate on the report.	- Using the DHCS Aid Code Master Chart, verify if the aid code is billable to DMC. - If CIN# changed, please provide the new/correct info on the report. - If eligibility expires prior to the DOS and client is no longer Medi-Cal eligible, please indicate on the report. - If client is incarcerated, please indicate on the report.
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