
Remittance Advice Details (RAD) Examples: Outpatient Services

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This section explains the *Remittance Advice Details* (RAD) fields and shows examples of the various types of reimbursement data received during a payment period. Refer to the *Remittance Advice Details (RAD)* section in this manual for details about the RAD.

RAD codes appear in the far right column for each claim line and their full explanation appears at the bottom of the RAD. The RAD includes a maximum of three denial code messages. Codes with the prefix "9" indicate a free-form error message, which allows Medical claims examiners to return unique free-form messages that more accurately describe claim submittal errors and denial reasons.

CA MEDI-CAL													TO: ABC PROVIDER P.O. BOX 999 ANYTOWN, CA 99999-1234		
REMITTANCE ADVICE DETAILS													REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES		
18 PROVIDER NUMBER 0123456789		19 CLAIM TYPE OUTPATIENT		20 WARRANT NO 39248026		16 CS SEQ. NO. 99999999		21 DATE 01/01/08		22 PAGE: 1 of 1 pages					
1 RECIPIENT NAME	2 RECIPIENT MEDI-CAL ID NO.	3 CLAIM CONTROL NUMBER	4 SERVICE DATES FROM TO MMDDYY MMDDYY		5 PROC CODE	6 PATIENT CONTROL NUMBER	7 QTY	8 TOTAL CHARGES	9 NON COVERED	10 PAYABLE CHARGES	11 RATE	12 PAID AMOUNT	13 RAD CODE		
APPROVES (RECONCILE TO FINANCIAL SUMMARY)															
SMITH DAVID	90000000A95001	5079410418401	031707	031707	XXXXX	39830	20	1730.00	310.00	1420.00			0417		
			031707	031707	XXXXX			442.80		442.80					
			031707	031707	XXXXX			282.20		282.20					
			031707	031707	XXXXX			28.90		28.90					
			031707	031707	XXXXX			173.80		173.80					
			031707	031707	XXXXX			24.50		24.50					
			031707	031707	XXXXX			126.00		126.00					
			031707	031707	XXXXX			142.00		142.00					
			031707	031707	XXXXX			2222.00		2222.00					
			031707	031707	XXXXX			655.00	60.00	595.00					
			****TOTALS FOR APPROVES					10	5827.20	370.00	5457.20	0.57	3110.60	0417	
												3110.60	AMT PAID		
DENIES (DO NOT RECONCILE TO FINANCIAL SUMMARY)															
DAVIS MARY	90000000A95001	5030412005101	011107	011107	XXXXX	39186		598.10							
			011107	011107	XXXXX			1094.00							
			011107	011107	XXXXX			85.40							
			011107	011107	XXXXX			213.10							
			011107	011107	XXXXX			18.40							
			011107	011107	XXXXX			10.60							
			011107	011107	XXXXX			30.90							
			TOTALS NUMBER OF DENIES					7	2050.50					0036	
SUSPENDS (DO NOT RECONCILE TO FINANCIAL SUMMARY)															
JOHNSON M	90000000A95001	5030412006701	090907	090907	XXXXX	37089	180	8520.00							
			090907	090907	XXXXX			9999.99							
			090907	090907	XXXXX			5403.80							
			090907	090907	XXXXX			788.05							
			090907	090907	XXXXX			175.35							
			090907	090907	XXXXX			4509.20							
			090907	090907	XXXXX			633.60							
			090907	090907	XXXXX			373.10							
			090907	090907	XXXXX			142.50							
			090907	090907	XXXXX			806.40							
			090907	090907	XXXXX			711.00							
			090907	090907	XXXXX			161.00							
			090907	090907	XXXXX			1304.41							
			090907	090907	XXXXX			2963.00							
			090907	090907	XXXXX			282.00							
			090907	090907	XXXXX			932.00							
			PAT LIAB	OTH	COVG	0.00	SALES TX						0602		
			TOTALS NUMBER OF SUSPENDS					15	36773.40						
14 EXPLANATION OF DENIALS/ADJUSTMENT CODES															
0417 BILLED AMOUNT IS CUTBACK TO ALLOWED PER THE ACCOMMODATION RATE FILE OR TO DISALLOW PAYMENT FOR DAY OF DISCHARGE/DEATH															
0036 RTD WAS EITHER NOT RETURNED OR WAS RETURNED UNCORRECTED; THEREFORE YOUR CLAIM IS FORMALLY DENIED															
0602 PENDING ADJUDICATION.															
17 OHC CARRIER NAME AND ADDRESS															
15															
NO49 123 NATIONAL LIFE 100 MAIN STREET ANYTOWN MN 99999															

Figure 1: Completed Sample Outpatient Remittance Advice Details (RAD). Actual size is 8½ by 11 inches.

Explanation of Form Items

«Form Item Definitions Table»

Item	Description
1.	Recipient Name. Listed last name first.
2.	Recipient Medi-Cal I.D. No. The recipient Medi-Cal identification number.
3.	Claim Control Number. A unique 13-digit number assigned by the California MMIS Fiscal Intermediary to track each claim line or CIF. See <i>Figure 2</i> on a following page for a detailed description. This number will appear on the RAD accompanying a warrant. Use this number when submitting a <i>Claims Inquiry Form</i> (CIF) or <i>Appeal Form</i> (90-1) to request adjustments to paid claims or reconsideration of denied claims. Refer to the <i>Claim Submission and Timeliness Overview</i> section in the Part 1 manual for an illustration of a Claim Control Number (CCN).
4.	Service Dates. Date(s) that service was rendered to a recipient.
5.	Proc. Code. HCPCS or CPT® procedure code.
6.	Medical Record Number. Provider's internal financial number for a patient.
7.	Qty. Quantity billed.
8.	Total Charges. Corresponds to the gross amount billed on the claim.
9.	Non-Covered. Total of non-allowed charges.
10.	Payable Charges. Allowable amount for the line item billed (total charges less non-covered charges).
11.	Rate. Reimbursement rate will be shown as a percentage of payable charges.
12.	Paid Amount. Amount paid. When reconciling the amount paid to the warrant amount, add the line amounts, not the claim summary amount. Payment appears on the warrant on the same page where the line amount appears.

«Form Item Definitions Table (continued)»

Item	Description
13.	RAD Code. Denial code that appears beside each claim line billed.
14.	RAD Message. Code and abbreviated message appear on the first line. If the claim is an adjustment or a denial due to duplicate billing, the warrant number of the original claim appears on the second line.
15.	Denial Codes and Messages. Denial codes with their full explanation appear at the bottom of the RAD under a summary header.
16.	ACS Sequence Number. An eight-digit sequence number that appears on the RAD and warrant. This number serves as an additional tracking device on the warrant along with the State Controller's Office (SCO's) warrant number.
17.	Other Health Coverage Billing Message. This includes name and address of recipient's insurance carrier and the policyholder's SSN. This information is included on the RAD when the claim has been denied because proof of Other Health Coverage billing was required and did not accompany the claim. (RAD code 657 is used to indicate this denial.)
18.	Provider Number. A National Provider Identifier (NPI).
19.	Claim Type. The type of claim submitted for reimbursement.
20.	Warrant No. An eight-digit number assigned by the SCO.
21.	Date. SCO issue date of the RAD.
22.	Page. Number of pages of the RAD.
23.	Patient Liability/Other Coverage. A patient's copay, coinsurance, Share of Cost or Other Health Coverage.
	Note: Sales tax applies to Allied Health, Medical Services, Outpatient, Pharmacy and Vision Care providers.

CA MEDI-CAL				TO: ABC PROVIDER P.O. BOX 999 ANYTOWN, CA 99999-1234				REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES				
PROVIDER NUMBER 0123456789		CLAIM TYPE MCARE CROSSOVER		WARRANT NO 39248026		ACS SEQ. NO. 99999999		DATE 01/01/08		PAGE: 1 of 1 pages		
RECIPIENT NAME	RECIPIENT MEDI-CAL ID NO.	CLAIM CONTROL NUMBER	SERVICE DATES		ACCOM/ PROC CODE	PATIENT CONTROL NUMBER	DAYS	MEDICARE ALLOWED	MEDI-CAL ALLOWED	COMPUTED MEDICARE AMOUNT	PAID AMOUNT	RAD CODE
			FROM MMDDYY	TO MMDDYY								
APPROVES (RECONCILE TO FINANCIAL SUMMARY)												
DAVIS JANE	90000000A95001	5079171505699	060107	061107		039634		716.00				
BLOOD DEDUCT	0.00	DEDUCTIBLE	716.00	COINSUR	0.00	CUTBACK	716.00		SALES TAX	INCL		0469
DENIES (DO NOT RECONCILE TO FINANCIAL SUMMARY)												
JOHNSON MA	90000000A95001	5006170703899	040307	040307		039305		696.00				0036
BLOOD DEDUCT	0.00	DEDUCTIBLE	696.00	COINSUR	0.00	CUTBACK	696.00					
SUSPENDS (DO NOT RECONCILE TO FINANCIAL SUMMARY)												
JONES DAVID	90000000A95001	5033172401899	041607	042307		039357		696.00				0602
BLOOD DEDUCT	0.00	DEDUCTIBLE	696.00	COINSUR	0.00	CUTBACK	696.00					
EXPLANATION OF DENIALS/ADJUSTMENT CODES												
0469	PAYMENT REDUCED TO ZERO AS MEDI-CAL'S MAX REIMBURSEMENT MAY NOT EXCEED MEDICARE'S PAYMENT. CUTBACK IS IN NON-COVERED COLUMN.											
0036	RTD WAS EITHER NOT RETURNED OR WAS RETURNED UNCORRECTED; THEREFORE YOUR CLAIM IS FORMALLY DENIED.											
0602	PENDING ADJUDICATION.											

Figure 2: Completed Sample Medicare Crossover *Remittance Advice Details* (RAD). Actual form is 8½ by 11 inches.

Crossover Payments

The following items appear on RADs for crossover payments only. (See *Figure 2* above.) Refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section in the appropriate Part 2 manual for additional information.

«Form Item Definitions Table»

- | Item | Description |
|------|---|
| 5. | Accommodation/Procedure Code. CPT® or HCPCS procedure code. |
| 8. | Medicare Allowed. Amount allowed by Medicare. |
| 9. | Medi-Cal Allowed. Amount allowed by Medi-Cal or the amount allowed by Medicare, whichever is less. |
| 10. | Computed Medicare Amount. Amount paid by Medicare. |

Claim Status

The following figures illustrate how adjudicated claims appear on the RAD. Refer to the *Remittance Advice Details (RAD)* section in this manual for additional information about these RAD codes.

CA MEDI-CAL													TO: ABC PROVIDER P.O. BOX 999 ANYTOWN, CA 99999-1234	
REMITTANCE ADVICE DETAILS													REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES	
PROVIDER NUMBER 0123456789		CLAIM TYPE OUTPATIENT		WARRANT NO 39248026		ACS_SEQ. NO. 99999999		DATE 01/01/08		PAGE: 1 of 1 pages				
RECIPIENT NAME	RECIPIENT MEDI-CAL ID NO.	CLAIM CONTROL NUMBER	SERVICE DATES		PROC CODE	PATIENT CONTROL NUMBER	QTY	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE	
			FROM MMDDYY	TO MMDDYY										
ADJUSTMENTS (RECONCILE TO FINANCIAL SUMMARY)														
SMITH JO	90000000A95001	5079171505699	031007	031007	XXXXX	98892	31	6.00		6.00		6.00	0572	
***** TOTALS FOR ADJUSTMENTS								-8.00		-8.00		-8.00	0572	
								-2.00		-2.00		-2.00		

Figure 3: Adjustment Code 572.

PROVIDER NUMBER 0123456789													CLAIM TYPE OUTPATIENT		WARRANT NO 39248026		ACS_SEQ. NO. 99999999		DATE 01/01/08		PAGE: 1 of 1 pages			
RECIPIENT NAME	RECIPIENT MEDI-CAL ID NO.	CLAIM CONTROL NUMBER	SERVICE DATES		PROC CODE	PATIENT CONTROL NUMBER	QTY	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE											
			FROM MMDDYY	TO MMDDYY																				
APPROVES (RECONCILE TO FINANCIAL SUMMARY)																								
SMITH JO	90000000A95001	5079171505699	061407	061407	XXXXX	13938	0001	832.00	793.00	39.00	1.00	39.00	0401											
***** TOTALS FOR APPROVES								832.00	793.00	39.00		39.00	AMT PAID											
												39.00												

Figure 4: Approve Reason Code 401.

PROVIDER NUMBER 0123456789													CLAIM TYPE OUTPATIENT		WARRANT NO 39248026		ACS_SEQ. NO. 99999999		DATE 01/01/08		PAGE: 1 of 1 pages			
RECIPIENT NAME	RECIPIENT MEDI-CAL ID NO.	CLAIM CONTROL NUMBER	SERVICE DATES		PROC CODE	PATIENT CONTROL NUMBER	QTY	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE											
			FROM MMDDYY	TO MMDDYY																				
DENIES (DO NOT RECONCILE TO FINANCIAL SUMMARY)																								
JONES JOHN	90000000A95001	5079171505699	041107	041107	XXXXX	13654		1163.15					0009											
DAVIS DAVE	90000000A95001	5079173305699	061507	061507	XXXXX	14197		8.00					0037											
***** TOTALS NUMBER OF DENIES								1171.15																

Figure 5: Denial Reason Code 009.

CA MEDI-CAL												TO: ABC PROVIDER P.O. BOX 999 ANYTOWN, CA 99999-1234	
REMITTANCE ADVICE DETAILS												REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES	
PROVIDER NUMBER 0123456789		CLAIM TYPE OUTPATIENT		WARRANT NO 39248026		ACS SEQ. NO. 99999999		DATE 01/01/08		PAGE: 1 of 1 pages			
RECIPIENT NAME	RECIPIENT MEDI-CAL ID NO.	CLAIM CONTROL NUMBER	SERVICE DATES		PROC CODE	PATIENT CONTROL NUMBER	QTY	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE
			FROM MMDDYY	TO MMDDYY									
SUSPENDS (DO NOT RECONCILE TO FINANCIAL SUMMARY)													
SMITH JO	90000000A95001	5079171505698 5079171505699	041907 041907	041907 041907	XXXXX XXXXX	13715 13715	0001 0001 TOTAL	95.00 2567.00 2662.00					0601 0601
DAVIS MARY	90000000A95001	5079171505700 PAT LIAB	052807 932.00	052807 OTH	XXXXX COVG	13564 0.00	0001 0003	314.00 2976.00					0601
		TOTALS		NUMBER OF SUSPENDS									

Figure 6: Suspended Reason Code 601.

PROVIDER NUMBER 0123456789		CLAIM TYPE OUTPATIENT		WARRANT NO 39248026		ACS_SEQ. NO. 99999999		DATE 01/01/08		PAGE: 1 of 1 pages			
RECIPIENT NAME	RECIPIENT MEDI-CAL ID NO.	CLAIM CONTROL NUMBER	SERVICE DATES		ACCOM CODE	PATIENT CONTROL NUMBER	DAYS OR VISITS	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE
			FROM MMDDYY	TO MMDDYY									
A/R TRANS. NO.	90000000A95001		DO NOT RECONCILE TO FINANCIAL SUMMARY										
												156.76	0730

Figure 7: Accounts Receivable (A/R) Transaction Code 730.

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.