BILLING & DENIAL RESOLUTION TUTORING LAB

MARCH 5, 2026

- Reminders & Announcements
- Max Units Updates
- County and Aid Report Updates
- Tutoring Session Topic
- Open Q&A

REMINDERS & ANNOUNCEMENTS

REMINDERS

Q&A REMINDER

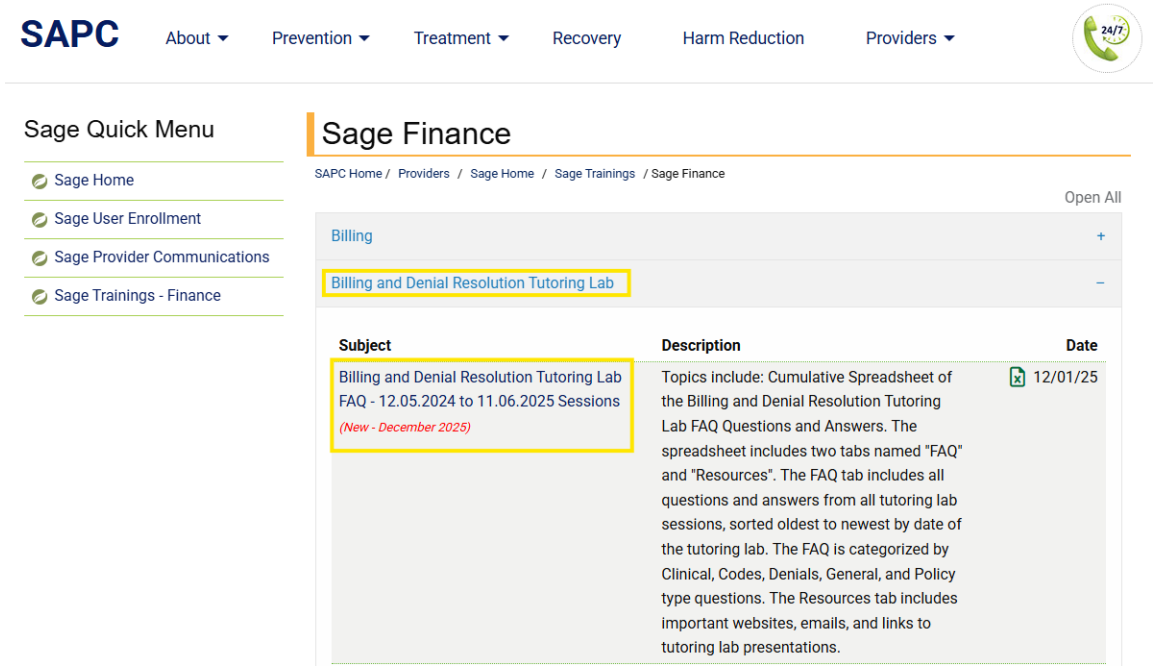
- As a reminder, to ask questions during this lab, please use one the following:

  - Q&A Button

  - Raise Hand Button

FAQ REMINDER

- As a reminder, FAQ are uploaded on a monthly basis. Please check to see if your question has been asked in previous tutoring labs.
  - *Link: http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm*



HELP DESK TICKET FORMS

- Two different forms for Help Desk tickets
- ServiceNow Create Case Form
  - Tickets go directly to Netsmart
  - Use this form to report Sage system issues
- Request Billing Assistance Form
  - Ticket goes directly to SAPC Finance
  - Use this form to report billing-related issues
  - Link: https://netsmart.service-now.com/plexussupport?id=sc_cat_item&sys_id=1ac545cf1b115e103001a9b6624bcb00&sysparm_category=4cb69d19c3921200b0449f2974d3ae69
- **Note:** Billing-related tickets submitted through the Create Case form will take longer to resolve

FY 24-25 BILLING DEADLINES

- Submit original and replacement claims for FY 24-25 services by the deadlines listed below:

DEADLINE PASSED!

Dates of Service	Deadline to Submit
7/1/2024 - 12/31/2024	Friday, January 30, 2026

Dates of Service	Deadline to Submit
1/1/2025 - 6/30/2025	Thursday, April 30, 2026

56 DAYS LEFT TO SUBMIT!

FY 24-25 BILLING DEADLINES

- In preparation of the billing deadlines, we recommend:

  - Don’t wait until the last week (or even the last day!) to submit claims. Submit claims at least once a month before the deadline to allow for any corrections needed for Local and State denials.
  - Review all currently denied services to ensure services have been corrected and replaced (as able).
  - Review available contract amounts and request augmentations if necessary.
  - Lastly, open a Request Billing Assistance ticket for any support needed to resolve outstanding FY 24-25 questions.

ANNOUNCEMENTS

CO 284 DENIALS

- Beginning February 11, 2026, claims for services billed after the service authorization has ended will be denied with **Denial CO 284**.
- This commonly occurs when a client changes providers and/or levels of care, leading to a shortened service authorization end date.
- If billing has occurred through the original end date, Sage prevents editing the end date in the Service Authorization Form, but the revised end date can be found in the **Comments** section of the form.
- For questions regarding updated service authorization dates, please contact the case manager listed in the Comments section of the Service Authorization Request form.

FIELD-BASED SERVICES UPDATES

- Field-Based Services (FBS) released Information Notice 26-01, which provides updates to the FBS Standards and Practices to expand FBS services and update documentation requirements.
- FBS requires accurate and complete documentation. Claims and progress notes should have matching Place of Service (POS) codes and accurate duration of services. Only time spent for billable service components may be included in the service duration (FBS Standards and Practices, Page 6). Time spent on non-billable activities such as documentation, waiting, or travel must not be included in the duration of service time.
- Please refer to the FBS Standards and Practices (page 11) for more details on updated documentation guidelines.

DISCONTINUATION OF FBS TRANSPORTION BENEFIT

- Field-Based Services mileage reimbursement is no longer a covered benefit, **effective 1/12/2026**. Agencies may continue to submit claims for mileage reimbursement prior to this date, but transportation will no longer be an allowable code for services provided on or after 1/12/2026. The FY 25-26 FBS Enhanced Benefit, which provides an extra 10% reimbursement of total approved claims, was designed to offset any additional costs associated with providing Field-Based Services, including transportation.
- If you have any questions, please e-mail SAPC-SOC@ph.lacounty.gov.

COUNTY AND AID CODE REPORT

COUNTY AND AID CODE REPORT

- Updated on 2/17/2026
- New Report Output Fields
  - **Share of Cost:** Indicates if a patient has a Medi-Cal Share of Cost (Yes/No)
  - **Unmet Share of Cost:** Indicates whether a patient's Medi-Cal Share of Cost has been met (Yes/No/Not Applicable)
  - **Client Index Number:** CIN is now displayed for each data line
- Other updates
  - Data Entry Date field renamed to **271 Posted Date**
  - File Status field removed
  - Report output fields reordered for clarity and ease of use

COUNTY AND AID CODE REPORT

County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Provider County and Aid Code History

Print Date: 2/9/2026

Parameters Selected: PATID: , Provider: Recovery Inc, From: 9/1/2025 to 9/30/2025

Patid-Ep	Name	Admit Date	271 Posted Date	Eligibility Period	Eligibilty Info	Client Index Number	Aid Code	County Code	Share of Cost	Unmet Share of Cost	Managed Care Plan
123456-1	TEST,PATIENT	05/30/2024	09/05/2025	09/01/2025 - 09/30/2025	Active Coverage	91234567F	M1	30	No	Not Applicable	PHP-L.A. CARE HLTH PLAN,LA CARE HLTH PLAN
654321-4	TEST,ZCLIENT	04/11/2025	09/09/2025	09/01/2025 - 09/30/2025	Active Coverage	9999999G	17	19	Yes	Yes	PHP-HLTH NET,HEALTH CARE L.A., IPA
991234-2	ZTEST,PATIENT	01/19/2024	09/12/2025	09/01/2025 - 09/30/2025	Inactive	91111111H	Inactive	Not Applicable	Yes	No	No MCP On File

Reminders:

- This report reflects patient Medi-Cal eligibility and can help identify potential coverage gaps.
- The report output is based on the Real Time Inquiry (270) Request/Eligibility Response (271) and State MEDS data.
- Providers should continue running the 270 and posting the 271 monthly for the most updated eligibility information.

FY24-25 & FY25-26 MAX UNITS UPDATES

BACKGROUND AND RATIONALE

Previous

- DHCS guidance sets max units to reflect a 24-hour treatment service window which is outside of true treatment service time.
- Overpayment due to unrealistically high max units on services billed.
- Local and State disallowances due to high units billed in error result in recoupment of overpayments.

Current

- SAPC has updated max units at the high end of expected standard service duration.
- Reduces overpayment of services due to incorrect units billed
- Decreases service disallowances during audits
- Decreases overbilling-related takebacks by SAPC

SAPC MAX UNIT UPDATE

- Effective January 12, 2026, the maximum allowable unit count **per client, per day** has been updated for the service codes on the following slides.
- The updates have been fully configured in Sage.
- The new max units apply to FY 24-25 and FY 25-26. New versions of the rates matrices that reflect these changes here:
  - FY 25-26 Rates Matrix v1.3 – Provider Facing 02.06.2026.xlsx
  - FY 24-25 Rates Matrix v4.0 – Provider Facing 01.13.2026.xlsx
- Any services billed under the previous maximum unit limit that were denied should be re-billed following the new unit limit.

ASSESSMENT MAX UNIT UPDATES

Code	Service Description	Previous Max Units	Updated Max Units
96131	Psychological testing evaluation services by physician or other qualified healthcare professional Each additional hour	22	7
99416	Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting Each additional 30 minutes	44	8
99417	Prolonged outpatient evaluation and management service time with or without direct patient contact Each 15 minutes of total time	91	16
H0001	Alcohol and/or drug assessment 15 minutes	96	16
H0048	Alcohol and/or other drug testing Collection and handling only of specimens other than blood 15 minutes	96	16
H0049	Alcohol and/or drug screening 15 minutes	96	16
T2024	Assessment substitute 15 minutes	96	16

CARE COORDINATION/TREATMENT PLANNING MAX UNIT UPDATES

Code	Service Description	Previous Max Units	Updated Max Units
H1000	Prenatal care, at-risk assessment 15 minutes	96	32
T1017	Targeted case management 15 minutes	96	32
H2014	Skills training and development 15 minutes	96	16
H2027	Psychoeducational service 15 minutes	96	16
T1007	Treatment plan development and/or modification 15 minutes	96	16

COUNSELING MAX UNIT UPDATES

Code	Service Description	Previous Max Units	Updated Max Units
H0005	Alcohol and/or drug services Group counseling by a clinician 15 minutes	96	16
H0004	Behavioral health counseling and therapy 15 minutes	96	16
H0050	Alcohol and/or drug services Brief intervention 15 minutes (Code must be used to submit claims for Contingency Management Services)	96	16
T1006	Alcohol and/or substance abuse services Family/couple counseling 15 minutes	96	16
T2021	Therapy substitute 15 minutes	96	16

MEDICATION SERVICE/PEER SUPPORT/RECOVERY SERVICES MAX UNIT UPDATES

Code	Service Description	Previous Max Units	Updated Max Units
H0033	Medication administration Direct observation 15 minutes	96	16
H0034	Medication training and support 15 minutes	96	16
H0025	Behavioral health prevention education service (Peer support group session) 15 minutes	96	16
H0038	Self-help/peer services (individual) 15 minutes	96	16
H2015	Comprehensive community support services 15 minutes	96	16
H2017	Psychosocial rehabilitation services 15 minutes	96	16

CRISIS INTERVENTION/SUPPLEMENTAL SERVICE MAX UNIT UPDATES

Code	Service Description	Previous Max Units	Updated Max Units
H0007	Alcohol and/or drug services Crisis intervention (outpatient) 15 minutes	96	16
96171	Health behavior intervention, family (without the patient present) Face-to-face Each additional 15 minutes	94	14
T1013	Sign language or oral interpretive services 15 minutes	Variable	16
H0014	Alcohol and/or drug services Ambulatory detoxification Hourly	24	4

COMMUNITY HEALTH WORKER SERVICES MAX UNIT UPDATES

Code	Service Description	Previous Max Units	Updated Max Units
98960	Education and training for patient self-management by a qualified non-physician healthcare professional using a standardized curriculum, face-to-face with patient Individual 30 minutes	48	8
98961	Education and training for patient self-management by a qualified non-physician healthcare professional using a standardized curriculum, face-to-face with patient 2-4 patients 30 minutes	48	8
98962	Education and training for patient self-management by a qualified non-physician healthcare professional using a standardized curriculum, face-to-face with the patient 5-8 patients 30 minutes	48	8

EXCEPTIONS

In the event where services provided to a patient will exceed the maximum unit, please file an appeal before billing by completing the Complaint/Grievance Form and emailing it to SAPCMonitoring@ph.lacounty.gov.

NEW CIFP GUARANTOR

RECENT CIFP WEBINAR – MATERIALS

- The 2/25/2026 CIFP Training FAQ and PowerPoint slides can be found here: http://publichealth.lacounty.gov/sapc/providers/sage/sage-pcnx.htm

Sage-PCNX

Subject	Description	Date
Coverage for Clients Ineligible for Federal Programs (CIFP) FAQs *(New - March 2026)*	This documents covers the frequently asked questions related to coverage and Sage configurations for the Client Ineligible for Federal Programs (CIFP) guarantor available as of January 1, 2026.	03/04/26
Coverage for Clients Ineligible for Federal Programs (CIFP) Training Powerpoint Slides *(New - March 2026)*	Powerpoint slides from the CIFP webinar held on 2/25/26 that describes the new guarantor Client Ineligible for Federal Programs, including coverage, criteria and how to configure the Financial Eligibility, Cal-OMS and Service Authorizations in Sage.	03/04/26

- Webinar recording will be uploaded to the SAPC-LNC by the end of the month: http://sapc-lnc.org/

NEW CIFP GUARANTOR – WHEN TO USE

- ONLY Use the CIFP Guarantor when the Client:
  1. Has unsatisfactory immigration status AND
  2. Does not currently have Medi-Cal benefits AND
  3. Does not qualify for any other programs that are one of SAPC's Secondary Funding Sources, such as General Relief, CalWorks, AB 109.
- If the client does participate in one of the programs that SAPC receives Secondary Funding for, the new CIFP guarantor should not be used and the provider should complete the auth, Financial Eligibility, and CalOMS as usual for a Non-DMC client.

NEW CIFP GUARANTOR – SAGE REQUIREMENTS

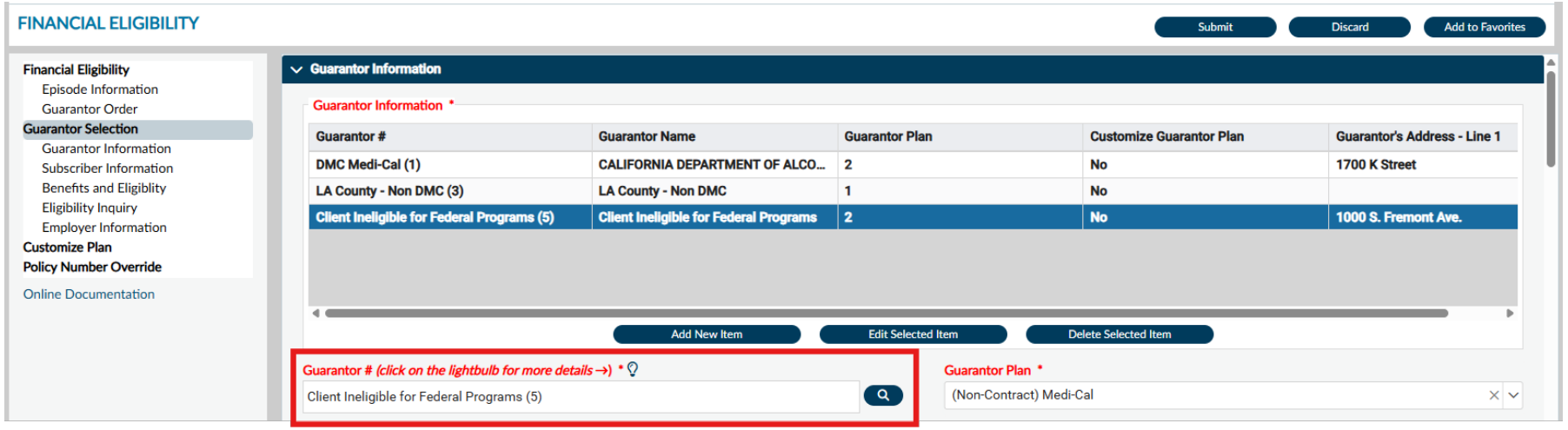
- CalOMS
  - Under "Is the client a Medi-Cal beneficiary (eligibility determined)?", select NO
  - Under "Other funding programs", select "Client Ineligible for Federal Programs"
- Service Authorization
  - Under "Funding Source Authorization is For", select "Non-Drug Medi-Cal"
- Financial Eligibility
  - Under Guarantor #, select "Client Ineligible for Federal Programs (5)"
  - In the Subscriber Policy field, enter "CIFP"

NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

Scenario A: Patient's Medi-Cal coverage expired and no longer qualifies for secondary funding (e.g AB109).

IMPORTANT! If patient has prior DMC and Non-DMC coverage, DO NOT DELETE these guarantors

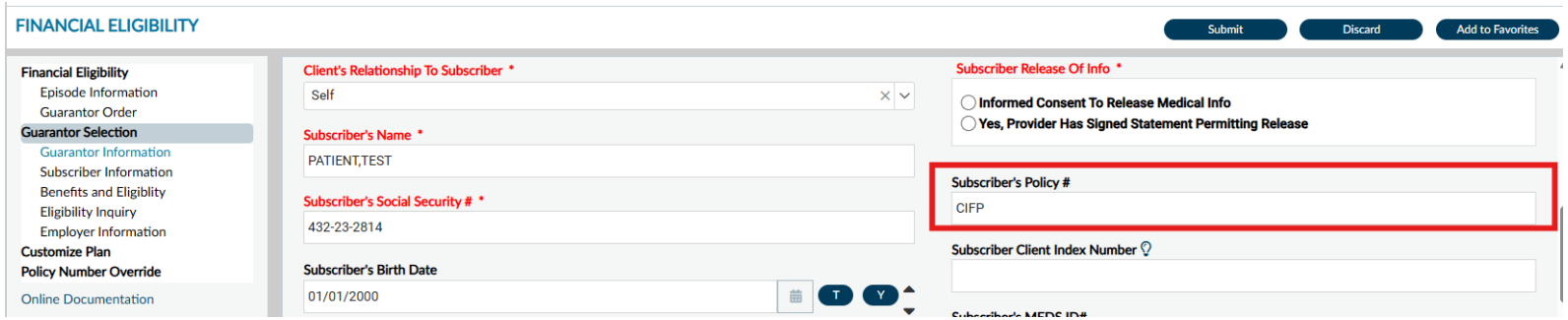
- Step 1: Add a new **Client Ineligible for Federal Programs (5)** guarantor to the patient's **Financial Eligibility** form



NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

Scenario A: Patient's Medi-Cal coverage expired and no longer qualifies for secondary funding (e.g AB109).

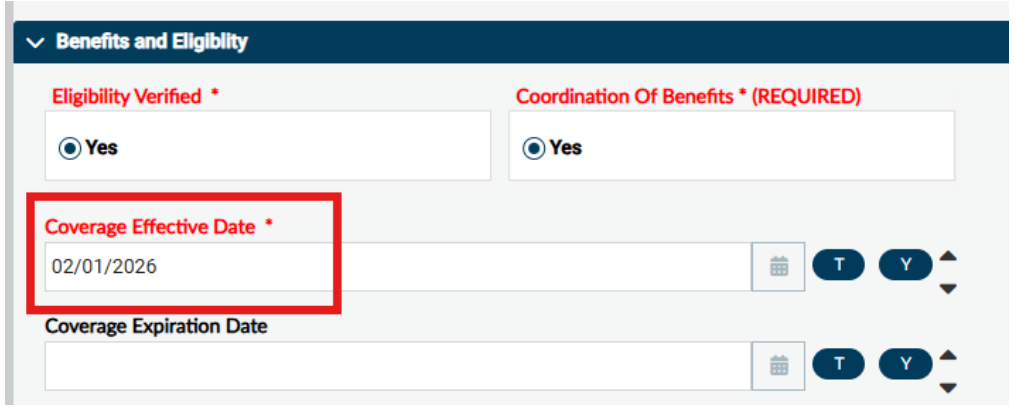
- Step 2: Enter CIFP in the Subscriber's Policy # field



NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

Scenario A: Patient's Medi-Cal coverage expired and no longer qualifies for secondary funding (e.g AB109).

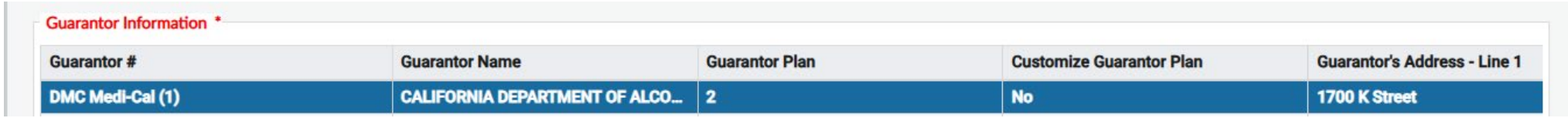
- Step 3: Fill out all Required Fields, then for the Coverage Effective Date enter a date that is after when the patient was no longer eligible for DMC and Non-DMC coverage. In the example below, the patient's DMC and Non-DMC coverage expired on 1/31/2026, so we entered 02/01/2026.

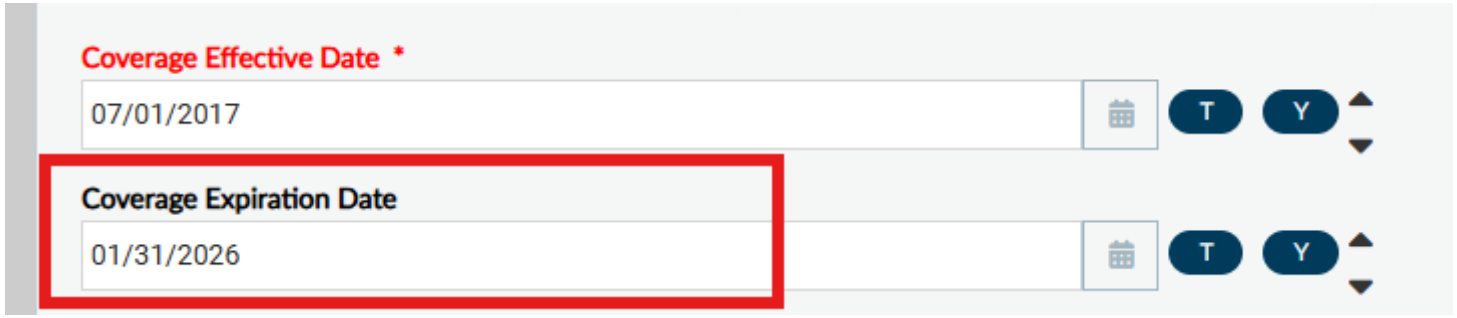


NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

Scenario A: Patient's Medi-Cal coverage expired and no longer qualifies for secondary funding (e.g AB109).

- Step 4: Next, select the **DMC Medi-Cal (1)** guarantor, then enter the **Coverage Expiration Date**





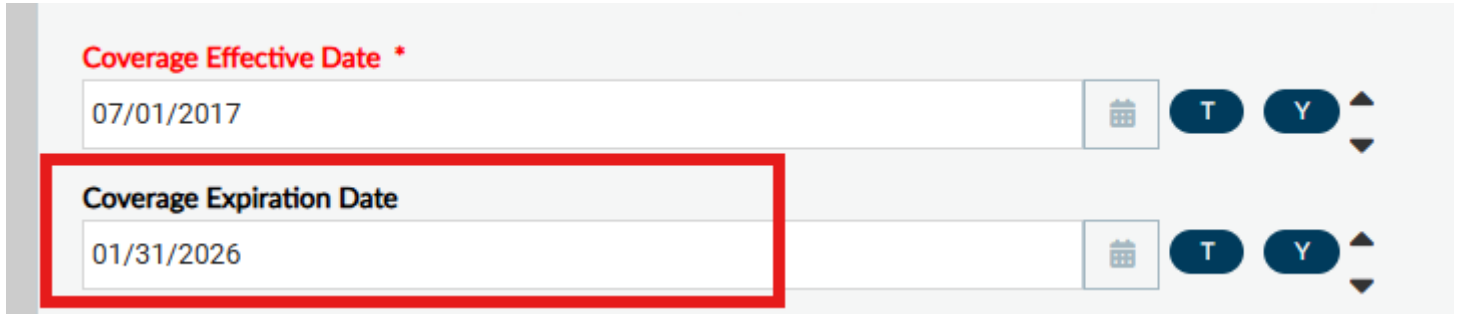
NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

Scenario A: Patient's Medi-Cal coverage expired and no longer qualifies for secondary funding (e.g AB109).

- Step 5: Next, select the **LA County – Non DMC (3)** guarantor, then enter the **Coverage Expiration Date**

Guarantor Information *

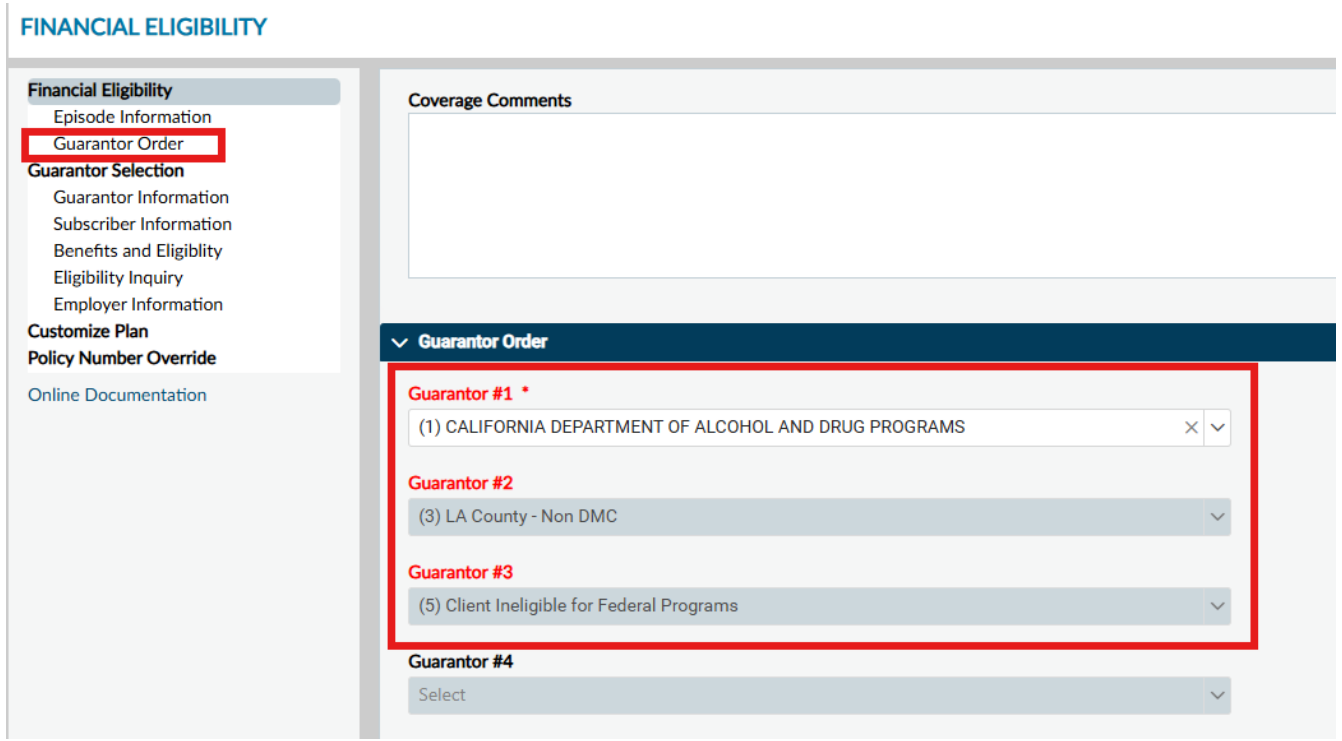
Guarantor #	Guarantor Name	Guarantor Plan	Customize Guarantor Plan	Guarantor's Address - Line 1
DMC Medi-Cal (1)	CALIFORNIA DEPARTMENT OF ALCO...	2	No	1700 K Street
LA County - Non DMC (3)	LA County - Non DMC	1	No	



NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

Scenario A: Patient's Medi-Cal coverage expired and no longer qualifies for secondary funding (e.g AB109).

- Step 6: Lastly, update the **Guarantor Order**, then click the **SUBMIT** button:



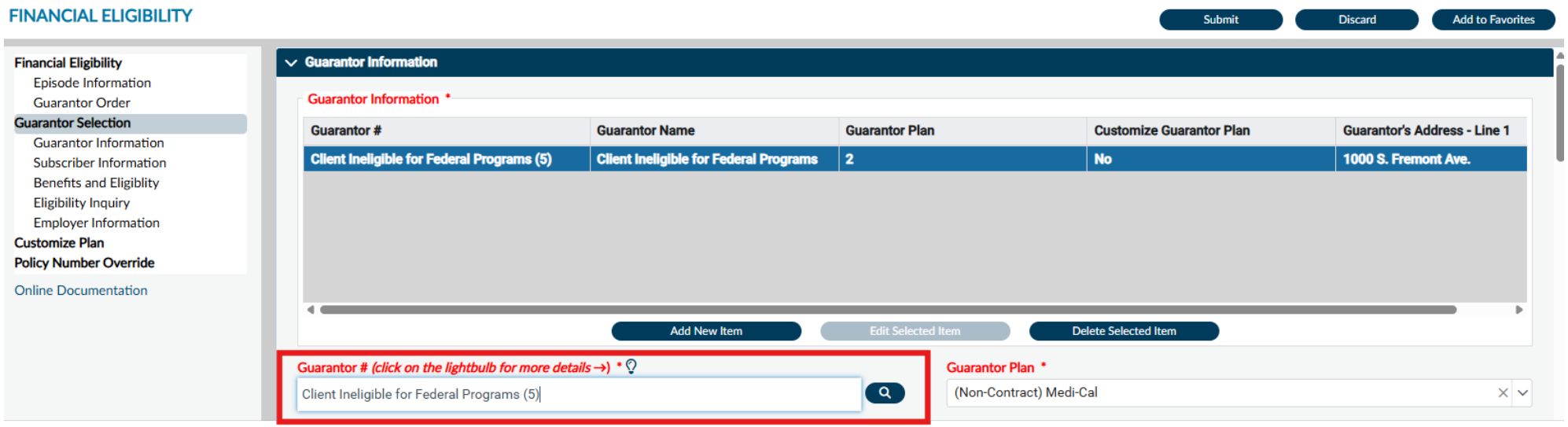
NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO A

- Important notes for Scenario A (Patient's Medi-Cal coverage expired and no longer qualifies for Non-DMC secondary funding (e.g AB109)).
  - Failure to enter an appropriate **Coverage Expiration Date** (e.g. a date before the CIFP guarantor's **Coverage Effective Date**) for both the **DMC Medi-Cal (1)** and **LA County – Non DMC (3)** guarantors will lead to denials.
    - This is because Sage will continue attempting to bill against DMC and Non-DMC funding sources first before the CIFP guarantor.

NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO B

Scenario B: Patient has no prior Medi-Cal coverage and does not qualify for Non-DMC secondary funding sources (e.g. AB 109).

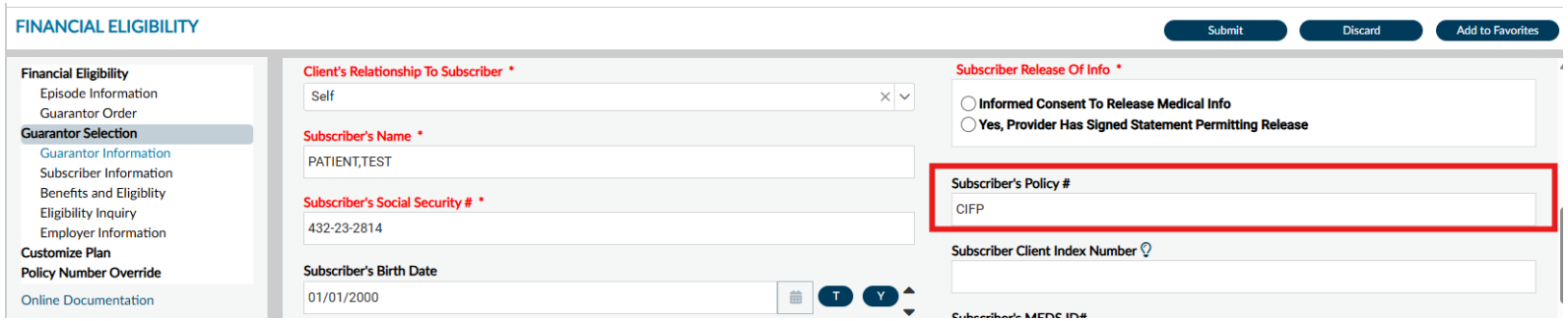
- Step 1: Add a new **Client Ineligible for Federal Programs (5)** guarantor to the patient's **Financial Eligibility** form



NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO B

Scenario B: Patient has no prior Medi-Cal coverage and does not qualify for Non-DMC secondary funding sources (e.g. AB 109).

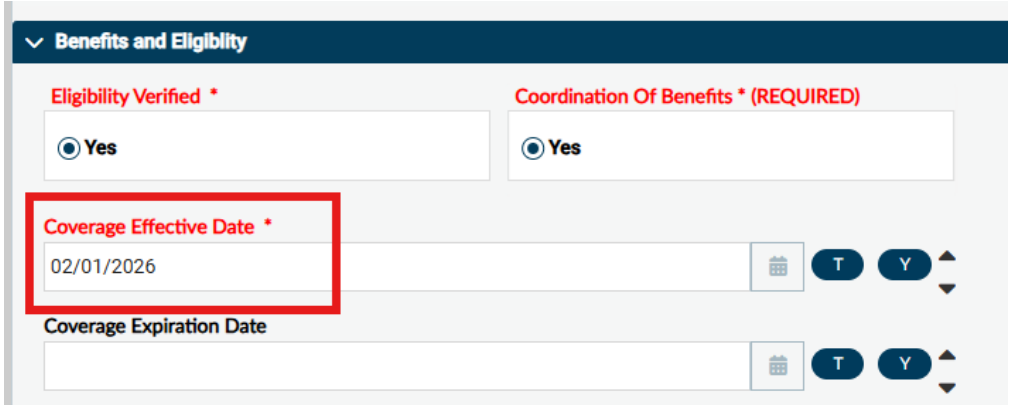
- Step 2: Enter CIFP in the Subscriber's Policy # field



NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO B

Scenario B: Patient has no prior Medi-Cal coverage and does not qualify for Non-DMC secondary funding sources (e.g. AB 109).

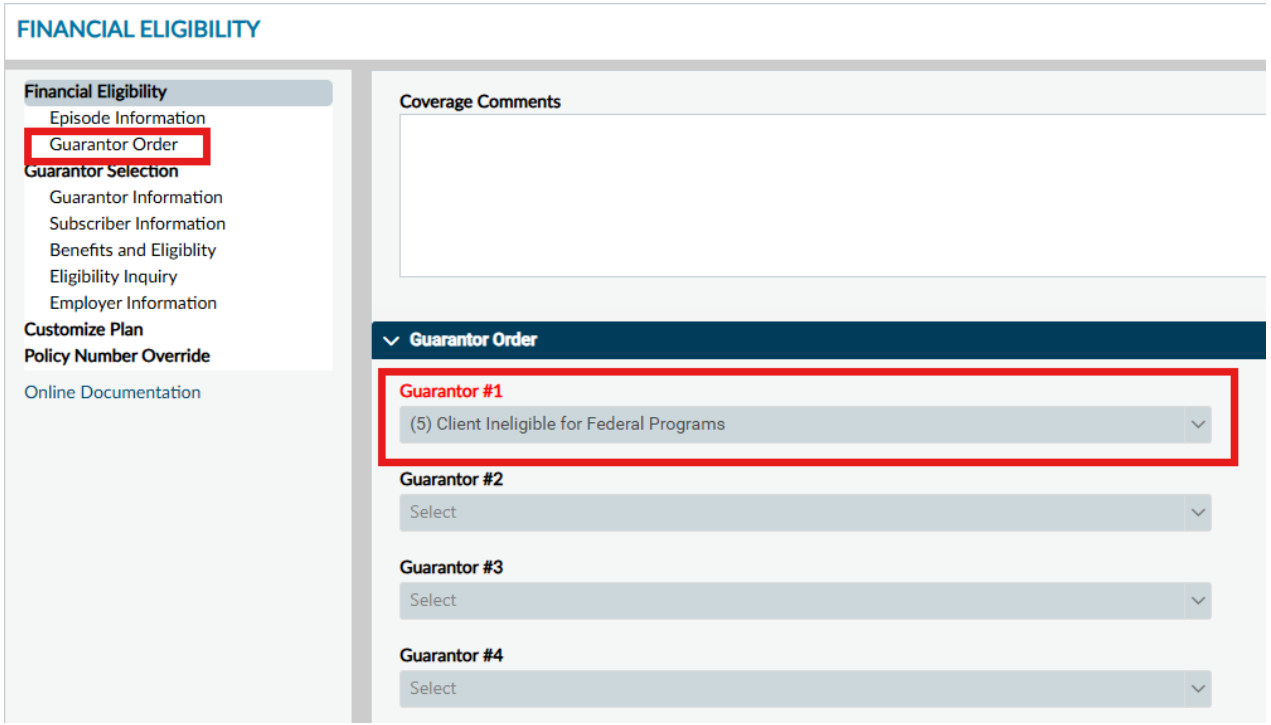
- Step 3: Fill out all Required Fields, then enter the **Coverage Effective Date.** This date should be on or before the first date of service using the CIFP guarantor.



NEW CIFP GUARANTOR – FINANCIAL ELIGIBILITY FORM – SCENARIO B

Scenario B: Patient has no prior Medi-Cal coverage and does not qualify for Non-DMC secondary funding sources (e.g. AB 109).

- Step 4: Lastly, update the **Guarantor Order**, then click the **SUBMIT** button:



TUTORING SESSION: DIAGNOSIS

DIAGNOSIS – SESSION AGENDA

- Diagnosis Background
- Where to find the diagnoses
- Sage Diagnosis form
- Sage Diagnosis form access
- Local Denials
- State Denials
- Example of error-free diagnosis form
- Takeaways before billing
- Other considersations

DIAGNOSIS – BACKGROUND

- Diagnoses must be established and updated as clinically appropriate by an LPHA, within their scope of practice, when a client's condition changes to accurately reflect the client's needs.
- During the initial assessment period (ranging from 30 to 60 days, depending on the population), provisional diagnoses are used prior to the determination of a definitive diagnosis or in cases where a suspected SUD has not yet been confirmed.
- Agencies are encouraged to document diagnosed co-morbidities – only as secondary, tertiary diagnoses and so forth (never as a primary diagnosis)

DIAGNOSIS – BACKGROUND

- Providers may use the following provisional ICD-10 diagnosis options during the assessment phase of a client's treatment when an SUD diagnosis has yet to be established:
  - ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances," may be used by all practitioners during the assessment period prior to diagnosis and do not require certification as, or supervision of, an LPHA. For a list of applicable diagnosis codes that can be documented by any DMC-ODS practitioner, see Appendix D.
  - ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during a member's treatment assessment phase when a diagnosis has yet to be established.
  - LPHAs may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services."

DIAGNOSIS – WHERE TO FIND DIAGNOSES

- Provisional Diagnoses
  - SAPC Provider Manual 10.0, Pages 260-262: http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/25-12/SAPC-IN-25-12-Provider-Manual-v10.0-Attachment-I.pdf

Appendix D. ICD-10 Clinical Modification Codes Z55-Z65

Persons with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances

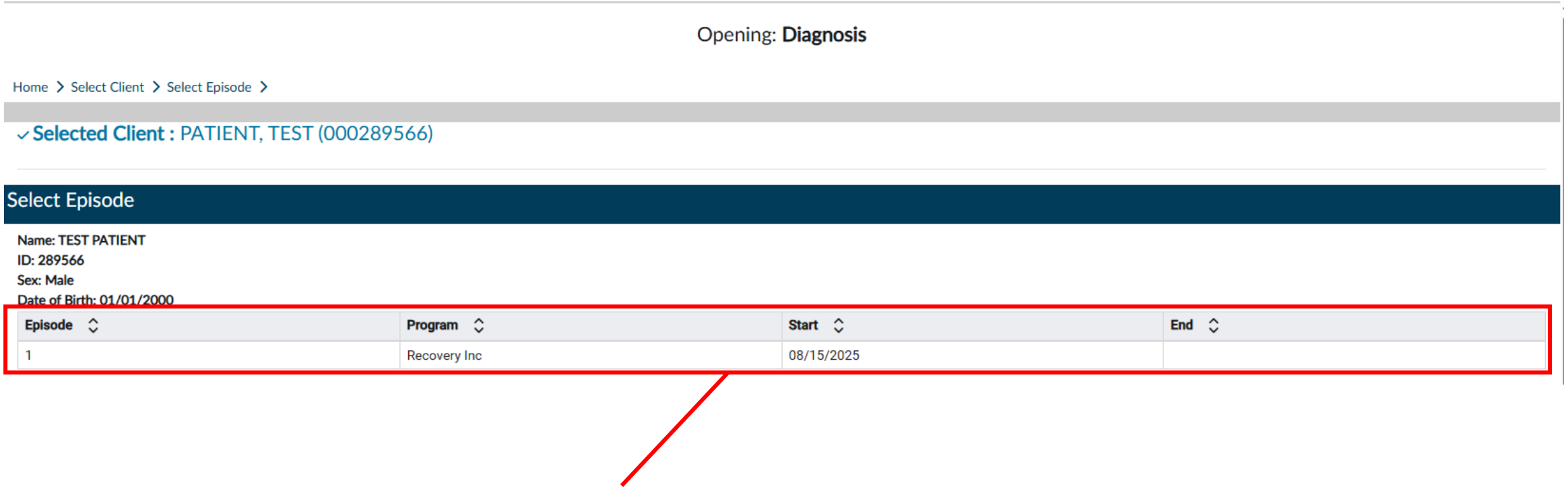
Category	Code	Description
Problems related to education & literacy (8)	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in school

- SUD Covered Diagnoses
  - FY25-26 DMC-ODS Billing Manual, Pages 111-122: https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf

Appendix 5- Covered Diagnoses

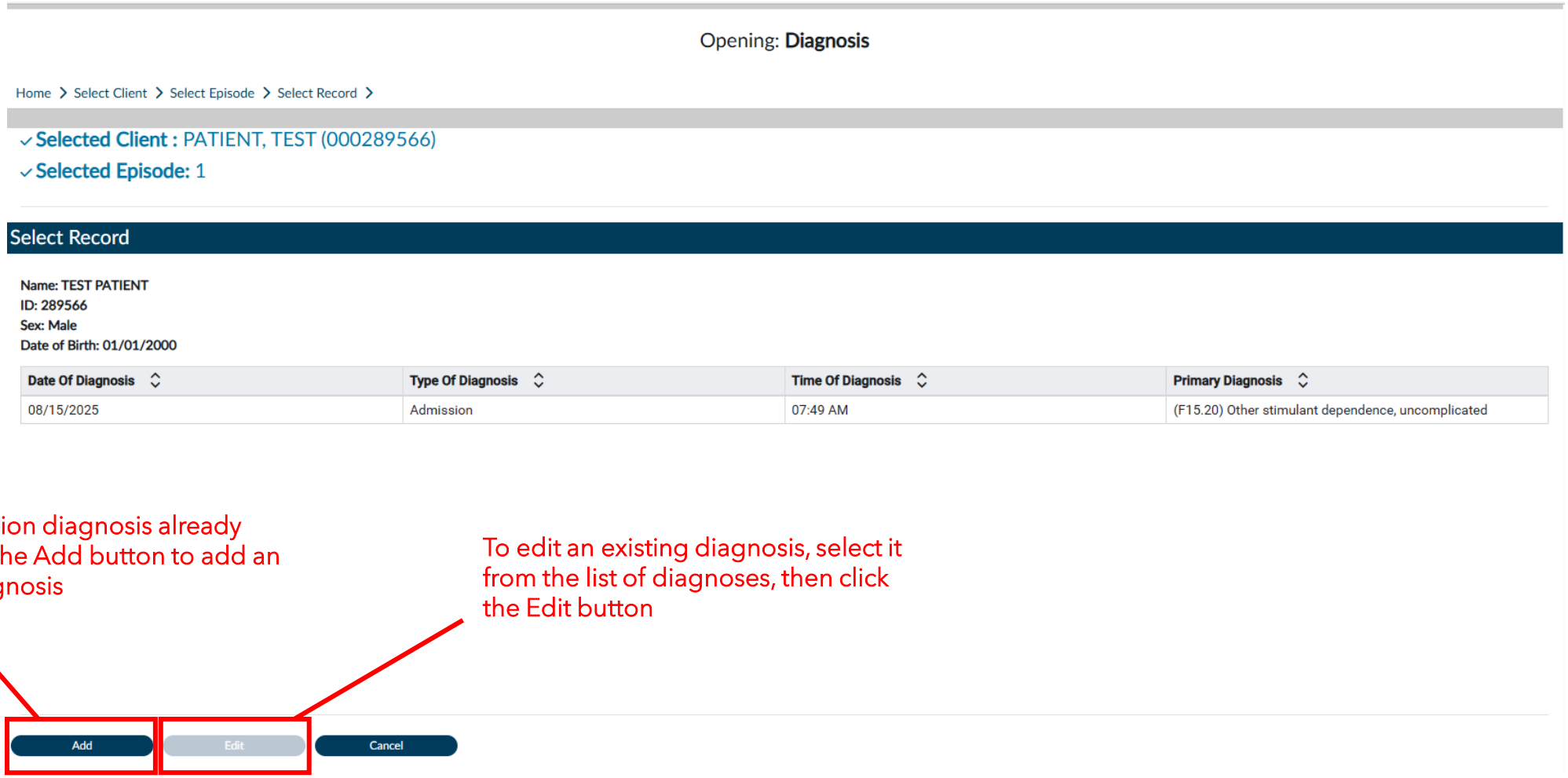
ICD-10 Code	Code Description
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium

DIAGNOSIS – SAGE FORM



To begin, select your agency from the Episode list.

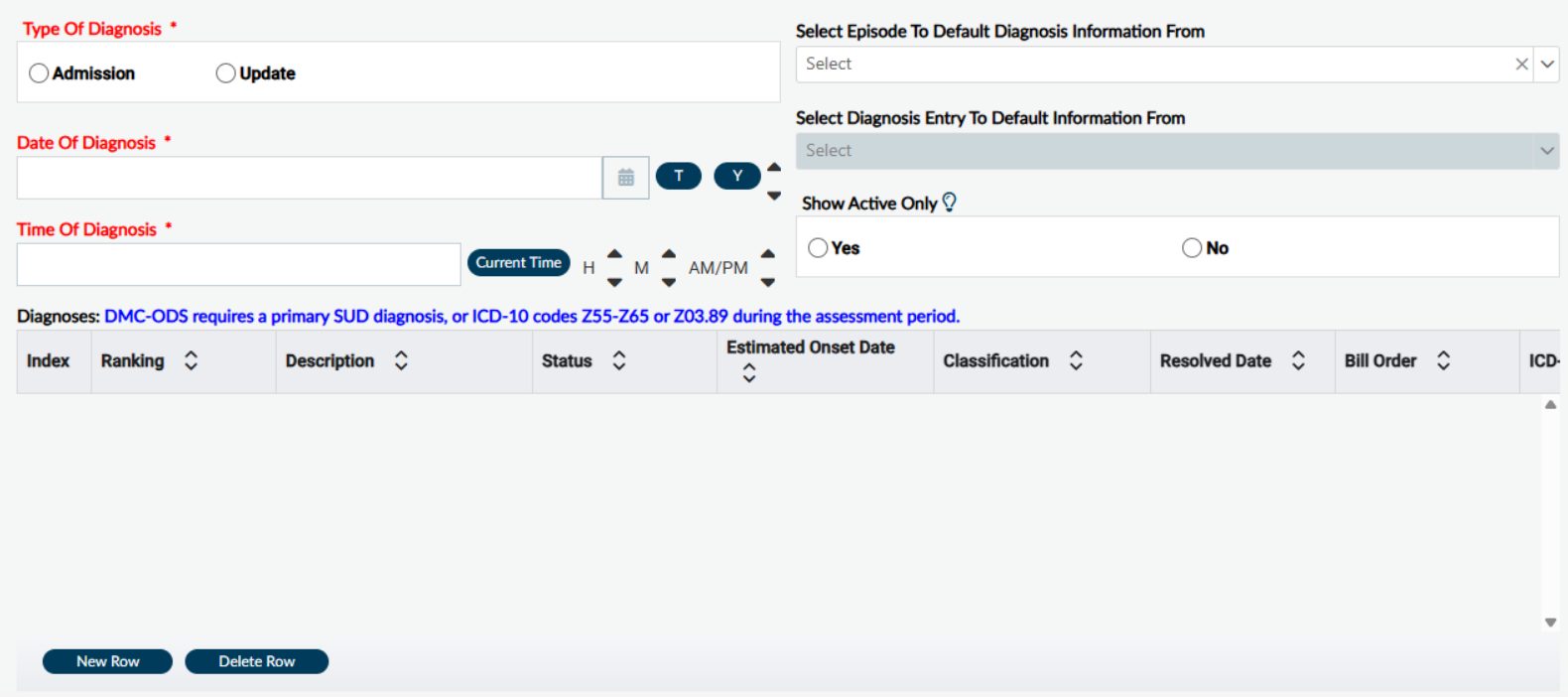
DIAGNOSIS – SAGE FORM



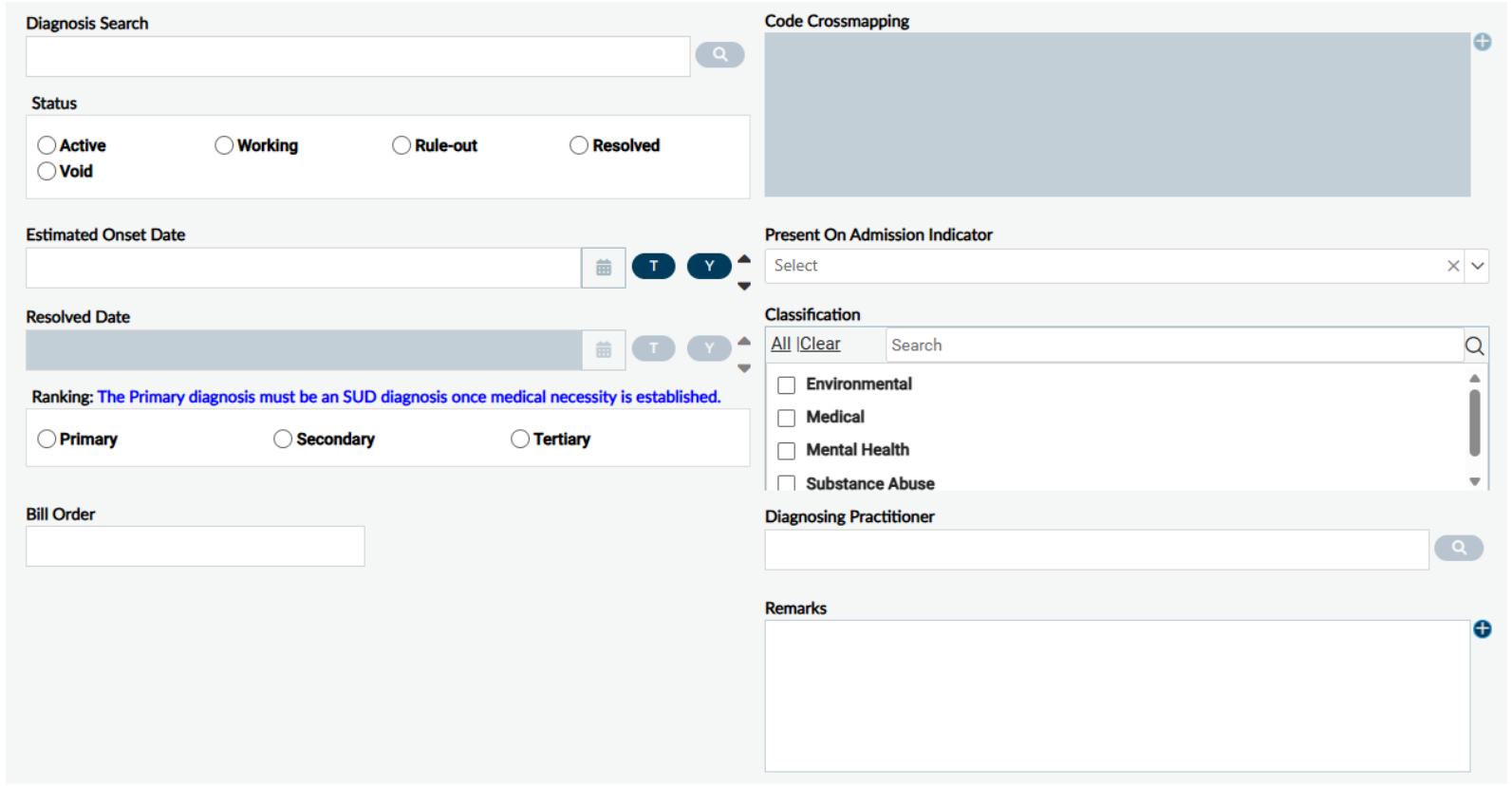
If an Admission diagnosis already exists, click the Add button to add an Update diagnosis

To edit an existing diagnosis, select it from the list of diagnoses, then click the Edit button

DIAGNOSIS – SAGE FORM FIELDS



DIAGNOSIS – SAGE FORM FIELDS



DIAGNOSIS – ACCESS

- Which Provider user roles have access to the Diagnosis form?
  - Read (Can only view the Sage Diagnosis form)
    - PCNXAuditUser
    - PCNXCertPeerFinClin
    - PCNXClerical
    - PCNXFinancialOnly
    - PCNXOperations
  - Read Write (Can view and edit the Sage Diagnosis form)
    - PCNXCENS
    - PCNXClinicalOnlyCounselor
    - PCNXClinicalClinicalOnlyLPHA
    - PCNXFinClinCounselor
    - PCNXFinClinLPHA
    - PCNXFinRNLVNLPTMA
    - PCNXRNLVNLPTMA
    - PCNXStudentIntern

DIAGNOSIS – COMMON DX RELATED DENIALS

- Local Denials
    - *Eligibility not found/verified in CalPM*
    - *This client is not eligible for this service. Avatar Financial Eligibility Record check failed. Changing claim stat to Denied and the reason to Eligibility not found/verified in CalPM.*
- State Denials
    - CO 167 N30
        - Denial description
            - *Service line did not contain a valid Drug Medi-Cal diagnosis code*
- Link to Denial Crosswalk v5.0: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/DenialCrosswalk/Sage-Claim-Denial-Reason-and-Resolution-Crosswalk-V5.0.xlsx

DIAGNOSIS – DIAGNOSIS DENIALS

- Local Denials
    - Denial description
        - *Eligibility not found/verified in CalPM*
        - *This client is not eligible for this service. Avatar Financial Eligibility Record check failed. Changing claim stat to Denied and the reason to Eligibility not found/verified in CalPM.*
    - What issues with the Diagnosis may have caused this denial?
        - The Provider Diagnosis (ICD-10) must have a valid, DMC approved SUD diagnosis and an admission diagnosis
        - Date of admission diagnosis must be the episode admission or prior to the service claimed date if readmission
        - Diagnosis ranking and billing order must match

DIAGNOSIS – DIAGNOSIS DENIALS – CLOSER LOOK

- **Cause:** The Provider Diagnosis (ICD-10) must have a valid, DMC approved SUD diagnosis and an admission diagnosis
  - In the example below, the primary diagnosis is not a valid DMC approved SUD diagnosis

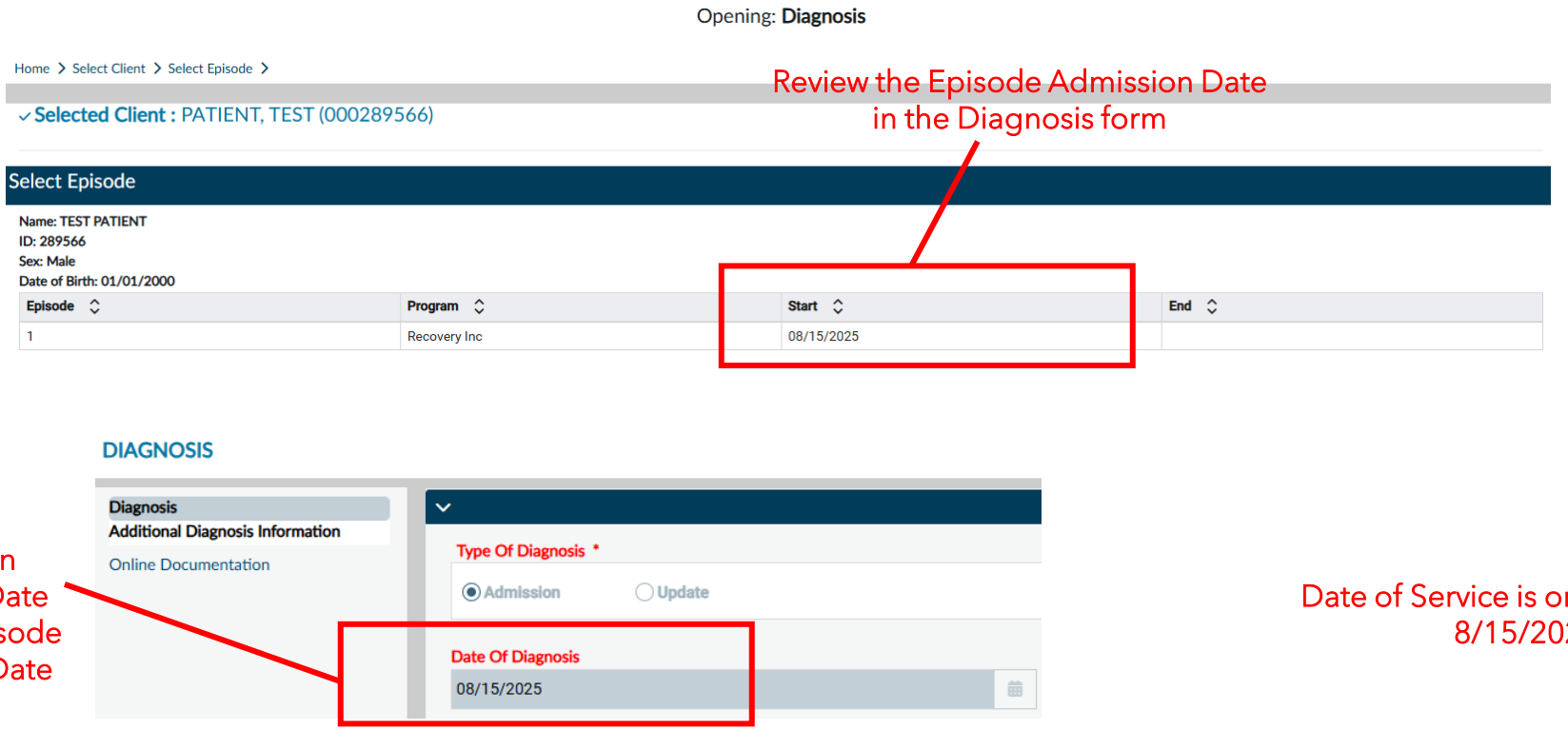
Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	(F43.0) Acute stress reaction

  - In the example below, the primary diagnosis is a valid DMC approved SUD diagnosis

Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	(F15.20) Other stimulant dependence, uncomplicated

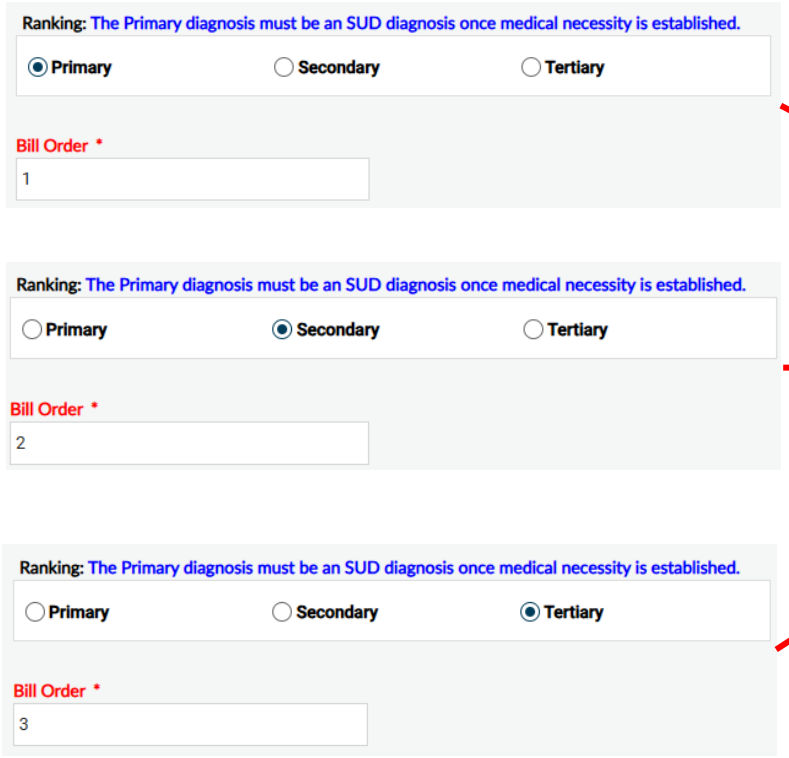
DIAGNOSIS – DIAGNOSIS DENIALS – CLOSER LOOK

- **Cause:** Date of admission diagnosis must be the episode admission or prior to the service claimed date if readmission
- Resolution:



DIAGNOSIS – DIAGNOSIS DENIALS – CLOSER LOOK

- **Cause:** Diagnosis ranking and billing order must match
- Resolution:



Index = Bill Order

Index	Ranking	Description	Status	Estimated Onset Date
1	Primary (1)	Other stimulant dependence,...	Active (1)	08/15/2025
2	Secondary (2)	Alcohol abuse, uncomplicated	Active (1)	08/15/2025
3	Tertiary (3)	Alcohol abuse, in remission	Active (1)	08/15/2025

How to correctly match bill order and ranking

Bill Order 1 = Primary Ranking
Bill Order 2 = Secondary Ranking
Bill Order 3 = Tertiary Ranking
Bill Order 4 = Tertiary Ranking
Bill Order 5 = Tertiary Ranking

DIAGNOSIS – CO 167 N30 DENIALS

- State Denials
  - CO 167 N30
    - Denial description
      - *Service line did not contain a valid Drug Medi-Cal diagnosis code*
    - What issues with the Diagnosis may have caused this denial?
      - An active diagnosis is missing
      - The principle diagnosis on the admission form and/or the subsequent update diagnosis is not a DMC approved diagnosis
      - The date of the diagnosis is after the date of service
      - A diagnosis was not entered until after billing

DIAGNOSIS – CO 167 N30 DENIALS – CLOSER LOOK

- Cause: An active admission diagnosis is missing

Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Update	07:49 AM	(F10.11) Alcohol Abuse, in remission

Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	()

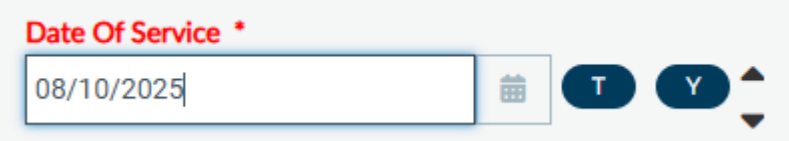
Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	(F15.20) Other stimulant dependence, uncomplicated

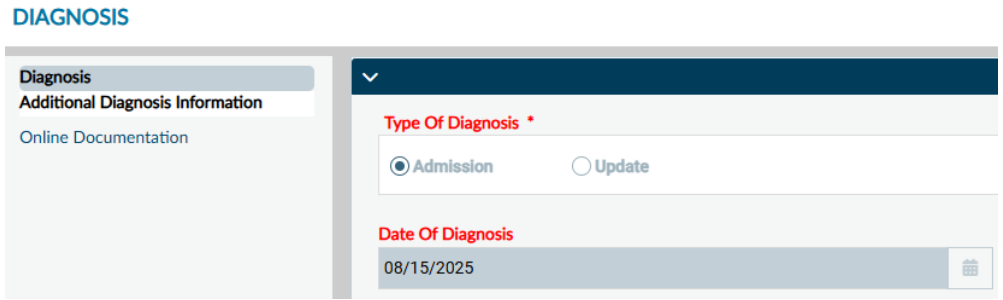
DIAGNOSIS – CO 167 N30 DENIALS – CLOSER LOOK

- Cause: The principle diagnosis on the admission form and/or the subsequent update diagnosis is not a DMC approved diagnosis
- Resolution: Make sure the primary diagnosis are DMC approved diagnoses

DIAGNOSIS – CO 167 N30 DENIALS – CLOSER LOOK

- Cause: The date of the diagnosis is after the date of service





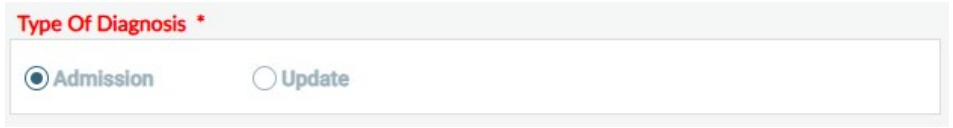
- Resolution: Verify that the date of service and the Date of Diagnosis are correct, and fix accordingly.

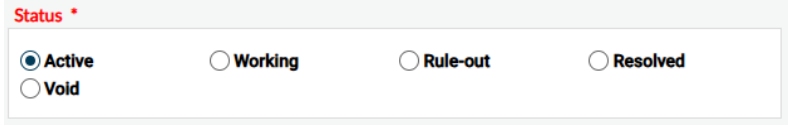
DIAGNOSIS – CO 167 N30 DENIALS – CLOSER LOOK

- Cause: A diagnosis was not entered until after billing
- Resolution: Rebill the denied services as a replacement claim.

DIAGNOSIS – OVERALL GOOD EXAMPLE - FORM

- What does a correctly filled out Sage Diagnosis form look like?
  - Active primary SUD admission diagnosis



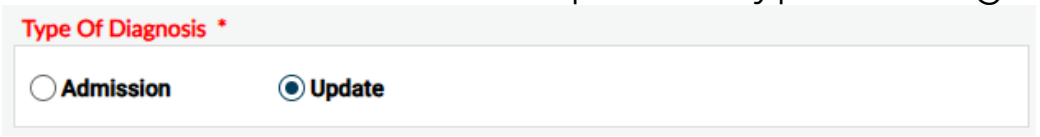


Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	(F15.20) Other stimulant dependence, uncomplicated

  - Billing order and ranking MUST match

Index	Ranking	Description	Status
1	Primary (1)	Other stimulant dependence, uncomplicated	Active (1)
2	Secondary (2)	Other stimulant abuse, uncomplicated	Active (1)
3	Tertiary (3)	Alcohol abuse, uncomplicated	Active (1)

  - Subsequent diagnoses are entered as an “Update” Type of Diagnosis



Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	(F15.20) Other stimulant dependence, uncomplicated
08/16/2025	Update	10:43 AM	(F10.11) Alcohol abuse, in remission

DIAGNOSIS – TAKEAWAYS BEFORE BILLING

- What are some considerations before submitting claims as it related to the diagnosis?
    - Make sure there is an active admission SUD covered diagnosis, and that subsequent diagnosis updates are SUD covered diagnoses
    - Make sure the date of the diagnosis is before the patient's date of service
    - Make sure a valid SUD covered admission diagnosis is entered before billing
    - There should only be ONE admission diagnosis
    - Admission diagnosis date should match the Episode admission date

DIAGNOSIS – OTHER CONSIDERATIONS

- Other Considerations
  - What do voided diagnoses look like?

Select Record

Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	()
03/05/2026	Update	12:27 PM	()

  - How do I enter an SUD diagnosis if the admission diagnosis was provisional?

Select Record

Date Of Diagnosis	Type Of Diagnosis	Time Of Diagnosis	Primary Diagnosis
08/15/2025	Admission	07:49 AM	(Z03.89) Encounter for observation for other suspected diseases and conditions ruled out
08/15/2025	Update	10:43 AM	(F10.11) Alcohol abuse, in remission

  - What if the patient was admitted prior the use of Sage?
    - If the admission diagnosis date is known, enter the actual date
    - If the admission diagnosis date is unknown, use 12/1/2017

HELPFUL RESOURCES

- Denial Crosswalk: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/DenialCrosswalk/Sage-Claim-Denial-Reason-and-Resolution-Crosswalk-V5.0.xlsx
- Replacement Claim Job Aid: http://publichealth.lacounty.gov/sapc/docs/providers/sage/finance/Job-Aid-Replacement-Claim-Assignment-CMS-1500-Provider-Training.pdf
- Guide to PCNX Reports: http://publichealth.lacounty.gov/sapc/docs/providers/sage/pcnx/PCNX-Guide-Reports.pdf
- Guide to Widgets: http://publichealth.lacounty.gov/sapc/docs/providers/sage/pcnx/PCNX-Guide-Widgets.pdf
- The entire catalog of SAPC Finance Billing Aids: http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm

HELPFUL CONTACTS

HELPFUL CONTACTS

Unit/Branch Contact	Email *Do not send Protected Health Information (PHI) to any SAPC email*	Description of when to contact
Sage Helpdesk	**Phone Number:** (855) 346-2392 **ServiceNow Portal:** https://Netsmart.service-now.com/plexussupport	Sage related questions, including system errors, medical record modifications
Sage Management Division (SMD)	SAGE@ph.lacounty.gov	Sage process, workflow, general questions about Sage forms and usage
QI and UM	SAPC.QI.UM@ph.lacounty.gov	All authorization related questions, questions for the office of the Medical Director, medical necessity, secondary EHR form approval
Systems of Care (SOC)	SAPC-SOC@ph.lacounty.gov	Questions about policy, the provider manual, bulletins, and special populations (youth, PPW, criminal justice, homeless)
Health Outcomes and Data Analytics (HODA)	hoda_caloms@ph.lacounty.gov	All questions regarding Sage CalOMS: CalOMS submissions guidelines, issues related to CalOMS forms and submissions in Sage, Data Quality Report, and requests for trainings
Contracts	SAPCMonitoring@ph.lacounty.gov	Questions about general contracts, amendments, appeals, complaints, grievances and/or adverse events. Agency specific contract questions should be directed to the agency CPA
Strategic and Network Development	SUDTransformation@ph.lacounty.gov	DHCS policy, DMC-ODS general questions, SBAT
Clinical Standards and Training (CST)	Dsapc.cst@ph.lacounty.gov	Clinical training questions, documentation guidelines, requests for clinical trainings
Finance	Sapc-Finance@ph.lacounty.gov	General questions related to billing. For specific questions related to billing denials, payments, and technical assistance, please open a ticket with the Request Billing Assistance form
Eligibility	DPH-SAPC-EST@ph.lacounty.gov	For any eligibility related questions such as for assistance identifying County of residence, help with the intercounty transfer (ICT) process, applying for Medi-Cal benefits


OPEN Q&A