BILLING & DENIAL RESOLUTION TUTORING LAB

NOVEMBER 6, 2025

- Reminders & Announcements
- DMC Contract Monitoring
- Replacement Claim Metrics
- Tutoring Session Topics
  - Reviewing Local Denials
- 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

BILLING CYCLE

- Billing Cycle
  - Submit claims by the 10th of each month
    - Primary: Fast Service Entry Submission & Replacement Claim Assignment (CMS-1500) forms
    - Secondary: EDI files submitted via SFTP
      - 835 files sent to Provider:
        - State denial(s)
        - Check number entered for EOB
  - SAPC's reasonable timeline for processing payments is 15 calendar days, which falls on the 25th of each month
- Provider Manual 10.0
  - Page 233, "Claim Submission and Reimbursement Process"
  - Link: http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/25-12/SAPC-IN-25-12-Provider-Manual-v10.0-Attachment-I.pdf

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

CO 96 MA43 STATE DENIALS

- 10/23/2025 Provider Communication regarding CO 96 MA43 denials:
  - Recently, recoupments with a denial code of CO 96 MA43 indicated that the client has an "unsatisfactory immigration status."
  - However, the actual reason for the recoupments was due to lack of eligibility, CO 177.
  - The most common reasons for the recoupments were:
    - The CIN number listed in the Financial Eligibility Form was incorrect when compared against the MEDS file
    - The client did not have active Medi-Cal at the time of service.
  - Additional guidance on how to resolve a CO 177 denial can be found in the "State Denials" tab of the Sage Claim Denial Reason and Resolution Crosswalk Version 5.0

RATES MATRICES UPDATED

- Please use the latest version of the rates matrix for each billable fiscal year
  - Updates to various things such as the allowable modifiers, allowable places of service, etc.
- FY 24-25 Rates Matrix (Updated October 15, 2025): Link
- FY 25-26 Rates Matrix (Updated October 15, 2025): Link

LOCKOUT CONFIGURATION ISSUES

- What will it look like to a provider:
  - Batch Status Report (A/D/P Message) & EOB:

334609SVC.000	637122	341234	DMC	08/10/2025	A	90791:U7	1.0	$1008.68	$1008.68	$0.00	$0.00	$1008.68
334609SVC.000	637122	341234	DMC	08/10/2025	D	90849:U7:XE	1.0	$312.69	$0.00	$312.69	$0.00	$0.00

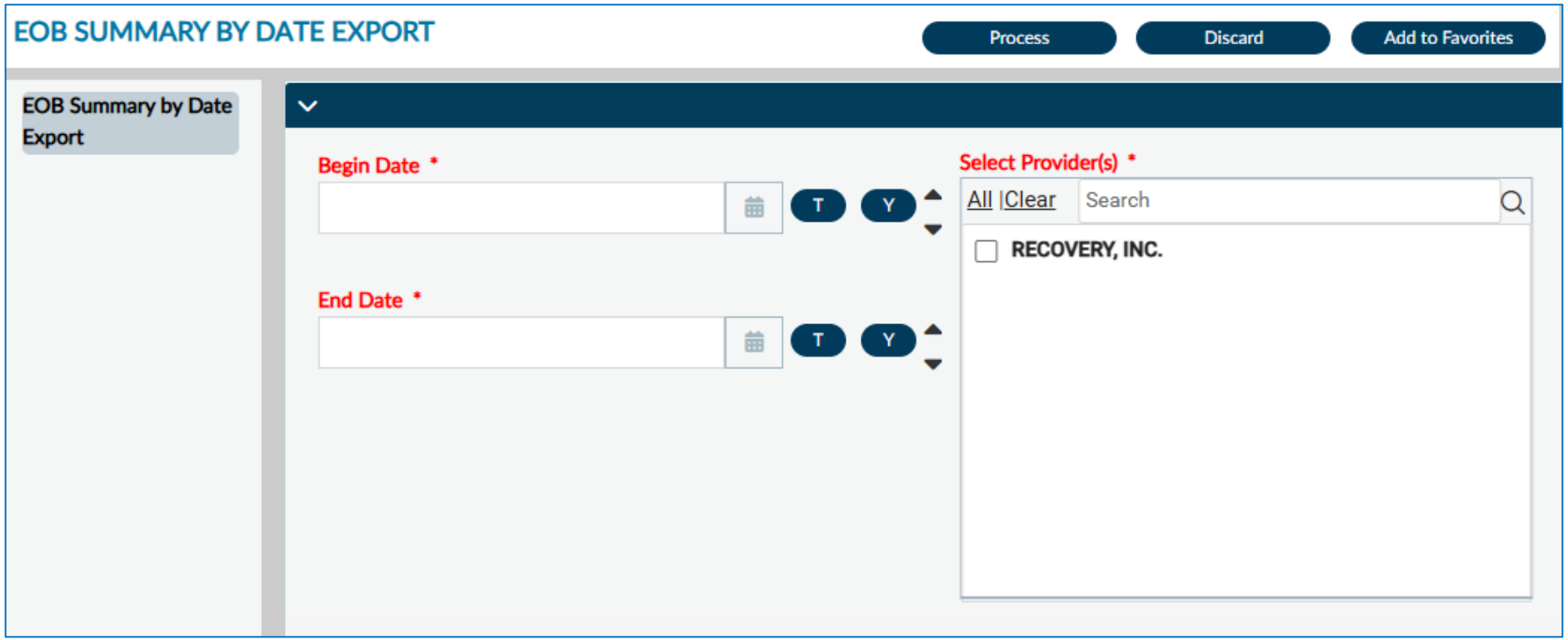
CLAIM DENIED DUE TO LOCKOUT
The service was denied for the following reason: Claim Status has been set to D because of Claim Adjudication Rule 90849_Lockout - 90849 Lockout.

- What are the next steps?
  - Open a help desk ticket using the Request Billing Assistance form, so that we can prioritize configuring the codes you are trying to bill.
  - Please hold off on billing lockouts if you are receiving these denials and wait until we configure the affected codes for you.
  - SAPC Finance is currently doing a full review of the lockout code configurations.

ANNOUNCEMENTS

EOB SUMMARY BY DATE REPORT

- New export-friendly report that summarizes data from the Provider EOB Remittance Advice
- Report Parameters (Begin Date and End Date) are based on EOB Dates



EOB SUMMARY BY DATE REPORT

- Data field "Adjust Code" features the adjustment reason from the Provider EOB Remittance Advice
  - CV = Contractor Void
  - SD = State Denial

County of Los Angeles Public Health

EOB Summary by Date Export

From 9/15/2025 to 9/15/2025

EOB ID	EOB Date	Contract Number	Fiscal Year	Expected Disburse	EOB Amount	Check Amount	Difference	Takeback	Adjust Code	Provider #	Agency	Check Number	Check Date
163108	9/15/2025	341234	FY2526	108.88	-108.88		108.88	-217.76	CV	1	Recovery, Inc.		
163109	9/15/2025	341234	FY2526	217.76	108.88		-108.88	-326.64	CV	1	Recovery, Inc.		
163111	9/15/2025	341234	FY2526	3,026.04	2,269.53		-2,269.53	-1,083.15	CV	1	Recovery, Inc.		
163105	9/15/2025	341234	FY2526	756.51	723.63	$723.63	0.00	-32.88		1	Recovery, Inc.	123Hogwarts	9/15/2025
163106	9/15/2025	H005046	FY2425		-301.04		301.04	-301.04		1	Recovery, Inc.	1_DENIED_163106	9/15/2025
163107	9/15/2025	341234	FY2425		-96.72		96.72	-96.72		1	Recovery, Inc.	1_DENIED_163107	9/15/2025

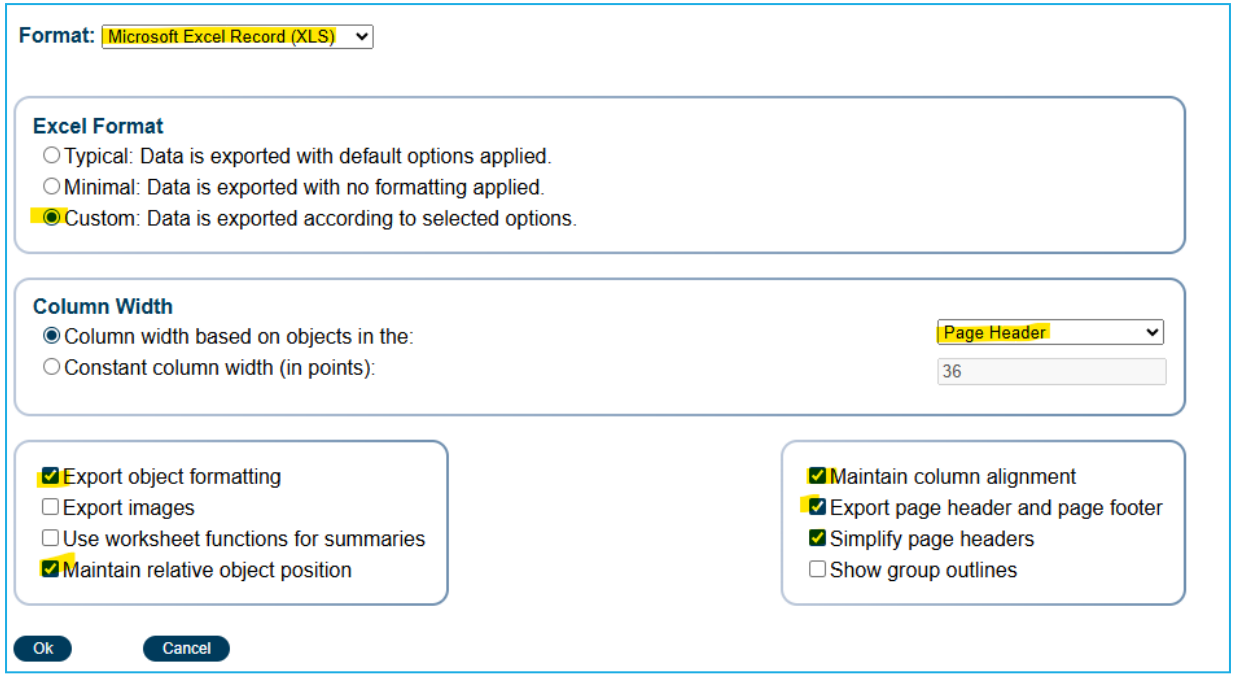
EOB Summary by Date Export

From 8/28/2025 to 8/28/2025

EOB ID	EOB Date	Contract Number	Fiscal Year	Expected Disburse	EOB Amount	Check Amount	Difference	Takeback	Adjust Code	Provider #	Agency	Check Number	Check Date
163066	8/28/2025	341234	FY2526		-156.39		156.39	-156.39	SD	1	Recovery, Inc.	1_DENIED_163066	8/28/2025

EOB SUMMARY BY DATE REPORT

- Recommended export settings:
  - **Format**: Microsoft Excel Record (XLS)
  - **Excel Format**: Custom
  - **Column width based on objects in the**: Page Header
  - **Checkboxes**: Export object formatting, Maintain relative object position, Maintain column alignment, Export page header and page footer, Simplify page headers.



FY 24-25 BILLING DEADLINES

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

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

FY 24-25 BILLING DEADLINES

- In preparation of the billing deadlines, we recommend:

  - Don’t wait until the last week 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.

RECENTLY PUBLISHED GUIDANCE

- CENS DMC Services
  - Supports CENS provider agencies in billing for CENS services billable to DMC
  - Includes the following topics:
    - Identifying billable codes on the Rates Matrix
    - Services covered under the CENS billable codes
    - Identifying CENS PAuth numbers in Sage
    - Billing CENS services in Sage-PCNX (primary Sage users)
    - Billing CENS services via 837 (secondary Sage users)
  - The guide is available for download here: LINK

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SAGE BILLING QUICK GUIDE
CENS DMC Services

OVERVIEW

This quick guide provides information to support CENS provider agencies in billing for CENS services billable to Drug Medi-Cal (DMC). The information in this document is applicable for patients who have Medi-Cal. For Non-DMC patient services, provider agencies should bill the CENS staff hour rate as outlined in the CENS Standards and Practices. CENS DMC billable services do not require a service authorization and are instead billed using the CENS Provider Authorization (PAuth) assigned to the agency.

This job aid includes the following sections:

- Identifying Billable Codes on The Rates Matrix
- Services Covered Under the CENS Billable Codes
- Identifying CENS PAuth Numbers in Sage
- Billing CENS Services In Sage-PCNX (Primary Sage Users)
- Billing CENS Services via 837 (Secondary Sage Users)

Additional information regarding CENS DMC billing and service requirements can be found in SAPC Information Notice 23-13. Information regarding billing via PAuth can be found in the Sage Billing Quick Guide: Provider Authorizations (PAuths).

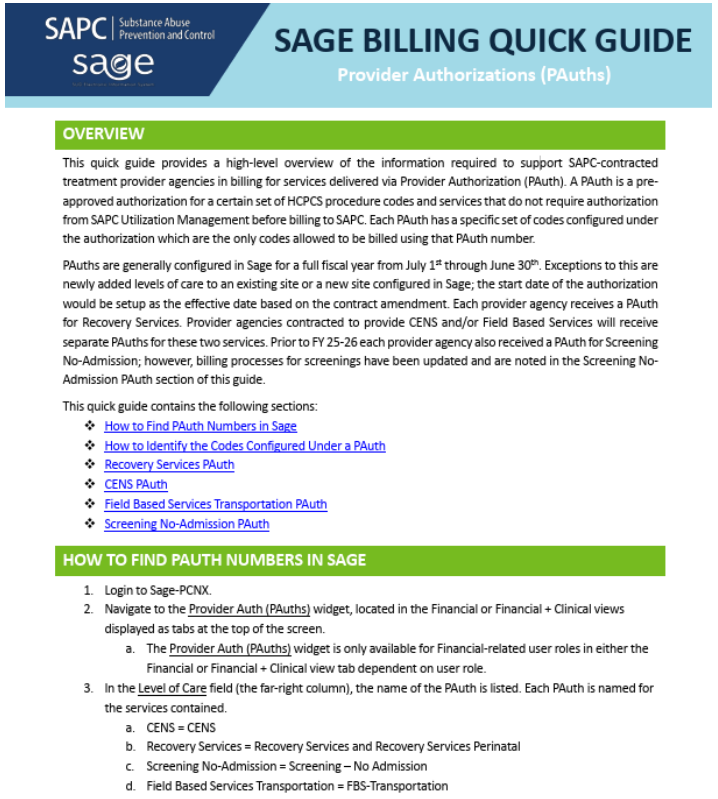
IDENTIFYING BILLABLE CODES ON THE RATES MATRIX

1. Download the Rates Matrix from the SAPC website.
   a. Hover over the Providers menu tab on the SAPC homepage.
   b. Click on Manuals, Bulletins and Forms under the Treatment sub-menu.

   c. Click on the Bulletins tab.

RECENTLY PUBLISHED GUIDANCE

- Provider Authorizations (PAuths)
  - Provides a high-level overview of the information required in billing for services delivered via PAuth
  - Includes the following topics:
    - How to find PAuth Numbers in Sage
    - How to identify the codes configured under a PAuth
    - Recovery Services PAuth
    - CENS PAuth
    - Field Based Services Transportation PAuth
    - Screening No-Admission Pauth
  - The guide is available for download here: LINK



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SAGE BILLING QUICK GUIDE
Provider Authorizations (PAuths)

OVERVIEW

This quick guide provides a high-level overview of the information required to support SAPC-contracted treatment provider agencies in billing for services delivered via Provider Authorization (PAuth). A PAuth is a pre-approved authorization for a certain set of HCPCS procedure codes and services that do not require authorization from SAPC Utilization Management before billing to SAPC. Each PAuth has a specific set of codes configured under the authorization which are the only codes allowed to be billed using that PAuth number.

PAuths are generally configured in Sage for a full fiscal year from July 1st through June 30th. Exceptions to this are newly added levels of care to an existing site or a new site configured in Sage; the start date of the authorization would be setup as the effective date based on the contract amendment. Each provider agency receives a PAuth for Recovery Services. Provider agencies contracted to provide CENS and/or Field Based Services will receive separate PAuths for these two services. Prior to FY 25-26 each provider agency also received a PAuth for Screening No-Admission; however, billing processes for screenings have been updated and are noted in the Screening No-Admission PAuth section of this guide.

This quick guide contains the following sections:

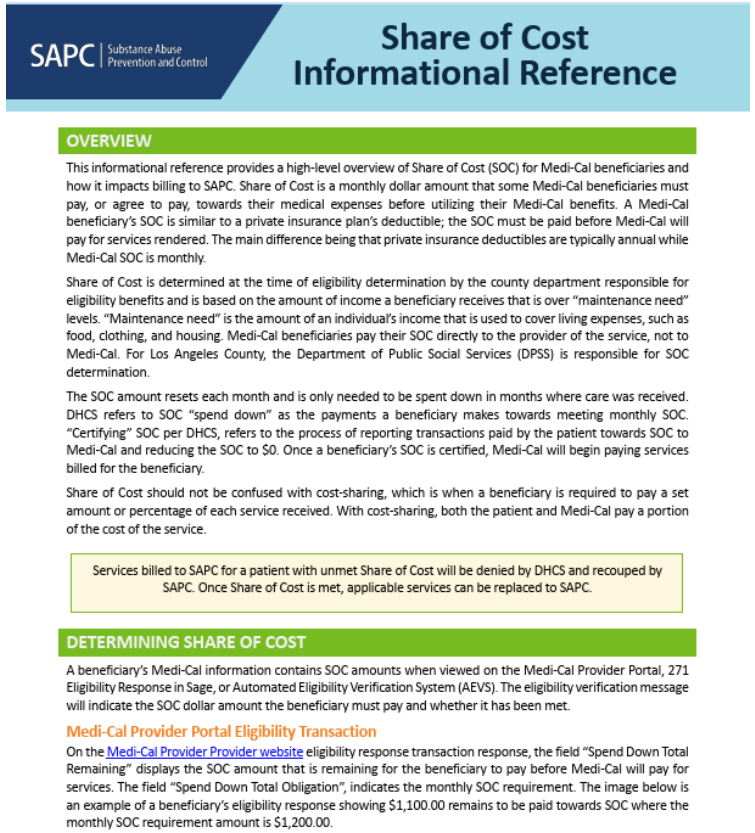
- How to Find PAuth Numbers in Sage
- How to Identify the Codes Configured Under a PAuth
- Recovery Services PAuth
- CENS PAuth
- Field Based Services Transportation PAuth
- Screening No-Admission PAuth

HOW TO FIND PAUTH NUMBERS IN SAGE

1. Login to Sage-PCNX.
2. Navigate to the Provider Auth (PAuths) widget, located in the Financial or Financial + Clinical views displayed as tabs at the top of the screen.
   a. The Provider Auth (PAuths) widget is only available for Financial-related user roles in either the Financial or Financial + Clinical view tab dependent on user role.
3. In the Level of Care field (the far-right column), the name of the PAuth is listed. Each PAuth is named for the services contained.
   a. CENS = CENS
   b. Recovery Services = Recovery Services and Recovery Services Perinatal
   c. Screening No-Admission = Screening – No Admission
   d. Field Based Services Transportation = FBS-Transportation

RECENTLY PUBLISHED GUIDANCE

- Share of Cost
  - Provides a high-level overview of Share of Cost (SOC) for Medi-Cal beneficiaries and how it impacts billing to SAPC
  - Includes the following topics:
    - Determining Share of Cost
    - Meeting Share of Cost
    - Certifying Share of Cost
  - The informational reference is available for download here: LINK



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Share of Cost Informational Reference

OVERVIEW

This informational reference provides a high-level overview of Share of Cost (SOC) for Medi-Cal beneficiaries and how it impacts billing to SAPC. Share of Cost is a monthly dollar amount that some Medi-Cal beneficiaries must pay, or agree to pay, towards their medical expenses before utilizing their Medi-Cal benefits. A Medi-Cal beneficiary's SOC is similar to a private insurance plan's deductible; the SOC must be paid before Medi-Cal will pay for services rendered. The main difference being that private insurance deductibles are typically annual while Medi-Cal SOC is monthly.

Share of Cost is determined at the time of eligibility determination by the county department responsible for eligibility benefits and is based on the amount of income a beneficiary receives that is over "maintenance need" levels. "Maintenance need" is the amount of an individual's income that is used to cover living expenses, such as food, clothing, and housing. Medi-Cal beneficiaries pay their SOC directly to the provider of the service, not to Medi-Cal. For Los Angeles County, the Department of Public Social Services (DPSS) is responsible for SOC determination.

The SOC amount resets each month and is only needed to be spent down in months where care was received. DHCS refers to SOC "spend down" as the payments a beneficiary makes towards meeting monthly SOC. "Certifying" SOC per DHCS, refers to the process of reporting transactions paid by the patient towards SOC to Medi-Cal and reducing the SOC to $0. Once a beneficiary's SOC is certified, Medi-Cal will begin paying services billed for the beneficiary.

Share of Cost should not be confused with cost-sharing, which is when a beneficiary is required to pay a set amount or percentage of each service received. With cost-sharing, both the patient and Medi-Cal pay a portion of the cost of the service.

Services billed to SAPC for a patient with unmet Share of Cost will be denied by DHCS and recouped by SAPC. Once Share of Cost is met, applicable services can be replaced to SAPC.

DETERMINING SHARE OF COST

A beneficiary's Medi-Cal information contains SOC amounts when viewed on the Medi-Cal Provider Portal, 271 Eligibility Response in Sage, or Automated Eligibility Verification System (AEVS). The eligibility verification message will indicate the SOC dollar amount the beneficiary must pay and whether it has been met.

Medi-Cal Provider Portal Eligibility Transaction

On the Medi-Cal Provider Provider website eligibility response transaction response, the field "Spend Down Total Remaining" displays the SOC amount that is remaining for the beneficiary to pay before Medi-Cal will pay for services. The field "Spend Down Total Obligation", indicates the monthly SOC requirement. The image below is an example of a beneficiary's eligibility response showing $1,100.00 remains to be paid towards SOC where the monthly SOC requirement amount is $1,200.00.

H0049 REMOVED FROM CENS PAUTH

- Effective 11/10/2025, H0049 will be removed as a billable service from the CENS PAuth
- Providers should rebill only if H0049 was denied by DHCS as either a duplicate (CO 96 M80) or lockout.
- SAPC is currently investigating and will notify impacted providers via email.
- Also, CENS providers are advised to instead bill/rebill for screening using H2017.
    - For guidance on how to bill for H2017, please review the Billing for Screening Job Aid

MISSING DIAGNOSIS RECOUPMENTS

- The Department of Health Care Services (DHCS) requires services to contain the beneficiary's admission diagnosis. Services billed to SAPC that do not contain the admission diagnosis cannot be billed to DHCS.
- As of this week, services billed to SAPC that do not contain an admission diagnosis will be:
  - Denied automatically upon submission with a "Eligibility Not Found/Verified in CalPM" denial reason or
  - Recouped manually by SAPC with a "No Admission Diagnosis Present"/CO 16 MA65 denial reason
- Currently, the DMC Fiscal Operations Section staff are working with provider agencies who have not completed the Sage Diagnosis form appropriately to report the client's admission diagnosis.
- Reminder: when entering the Admission diagnosis, the primary diagnosis must be a diagnosis applicable to SUD

MISSING DIAGNOSIS RECOUPMENTS

- Admission Diagnosis SAPC Resources:

  - QI & UM Checklist of Required Documentation: Provides information on what documents and forms are required when submitting a request for a service authorization. **Note that the document indicates the Sage form name as "Provider Diagnosis (ICD-10)", however, the name in Sage-PCNX is "Diagnosis".*
  - DSM-5 Substance Use Diagnosis: Provides a simplified table of diagnoses applicable for SUD and the appropriate ICD-10 code to use for billing purposes.
  - Provider Manual v10.0: Contains multiple references regarding allowable diagnoses.
  - FY 25-26 DMC-ODS Billing Manual (Pages 111-122): Contains reference to covered diagnoses per DHCS.
  - Correcting Diagnosis Errors in Sage: Instructions on how to correct common data entry or date errors for the Diagnosis form in Sage.

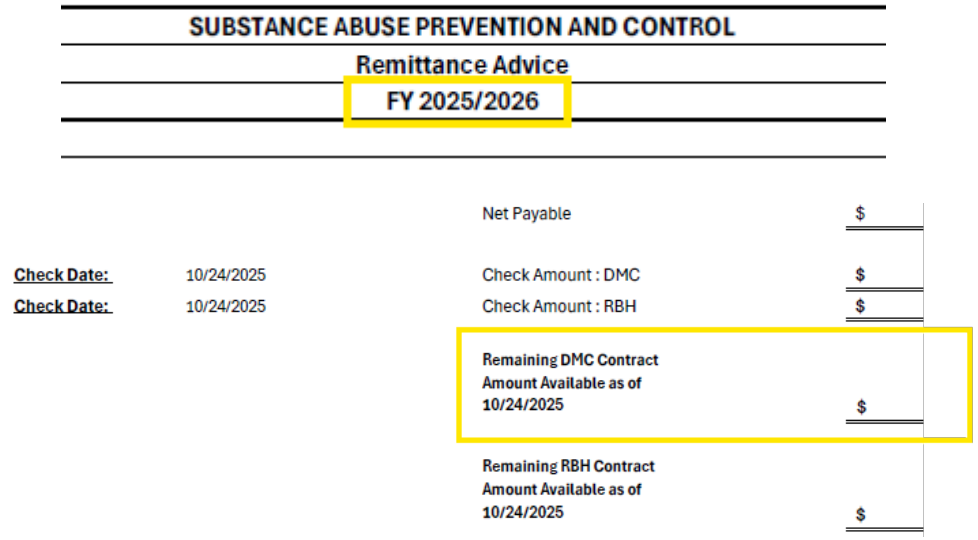
DMC CONTRACT MONITORING

DMC CONTRACT MONITORING – KEEP IN MIND

- Keep in mind - along with services billed for a fiscal year, if an agency participates in additional programs, these activities are paid out through their fiscal year DMC contract.
- These programs can include:
  - Value-Based Incentives
  - Courtesy Dosing
  - R95 Enhanced Activities
  - RYSE Initiative – Pillar I
  - Field Based Enhanced Benefit
  - Child-Friendly Environments
  - ASAM IV Residential Capacity Building Pilot
- Currently, payments for participation in these programs does not reflect in Sage.

DMC CONTRACT MONITORING – STAYING AHEAD

- So how do you stay ahead of potentially running out of funds in your DMC contract?
  - Monitor your Remittance Advice (RA)
    - The RA will show a line for remaining funds available for the RA's indicated fiscal year



SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

FY 2025/2026

		Net Payable	$
Check Date:	10/24/2025	Check Amount : DMC	$
Check Date:	10/24/2025	Check Amount : RBH	$
		Remaining DMC Contract Amount Available as of 10/24/2025	$
		Remaining RBH Contract Amount Available as of 10/24/2025	$

  - RA is uploaded to your SFTP and available to download for 2 weeks

DMC CONTRACT MONITORING – STAYING AHEAD

- Incorporate into your workflow:
  - Regularly monitor your SFTP for Remittance Advice (RA) and track your remaining DMC contract amounts
  - If another department within your agency (i.e. accounts receivables) is responsible for downloading the RA from the SFTP, make sure to coordinate with them so you're aware of how much is left in your DMC contract when attempting to bill
    - When there is no more money available in your DMC contract, you'll start receiving "**Total expected disbursement exceeds current account level amount**" local denials

DMC CONTRACT MONITORING – AUGMENTATION

- Services billed against DMC contracts with no more available funding will continue receiving "**Total expected disbursement exceeds current account level amount**" local denials until funds become available
- Running low on DMC contract funds?
  - Request a Contract Augmentation through your SAPC CPA
  - A Contract Augmentation typically takes up to 3 months to process
  - Plan ahead and submit these augmentation requests early so that you have funding available when needed!
- SAPC currently strategizing on how to make it easier for providers to monitor

REPLACEMENT CLAIM METRICS

REPLACEMENT CLAIM METRICS

- Primary Providers (Using the Replacement Claim Assignment (CMS-1500) form)
  - # of providers who've submitted replacement claims: 25
  - # of providers who haven't replaced any claims: 25
  - Total batches submitted: 783
  - Total claims submitted: 16,975
  - Total charged: $2.99 Million
  - Total disbursed: $2.84 Million

REPLACEMENT CLAIM METRICS

- Secondary Providers (Using their own EHR)
  - # of providers who've submitted replacement claims: 22
  - # of providers who haven't replaced any claims: 9
  - Total batches submitted: 2,536
  - Total claims submitted: 54,315
  - Total charged: $8.05 Million
  - Total disbursed: $7.03 Million

REPLACEMENT CLAIM METRICS

- Top 5 replacement claim Local denials
  1. Eligibility not found/verified in CalPM
  2. Authorization is blank
  3. Invalid authorization number
  4. Procedure not on fee schedule
  5. Funding source not eligible on date of service for member
- Top 5 replacement claim State denials
  1. CO 97 M86
  2. CO 96 M30
  3. CO 208 N297
  4. CO 177
  5. CO 96 N362

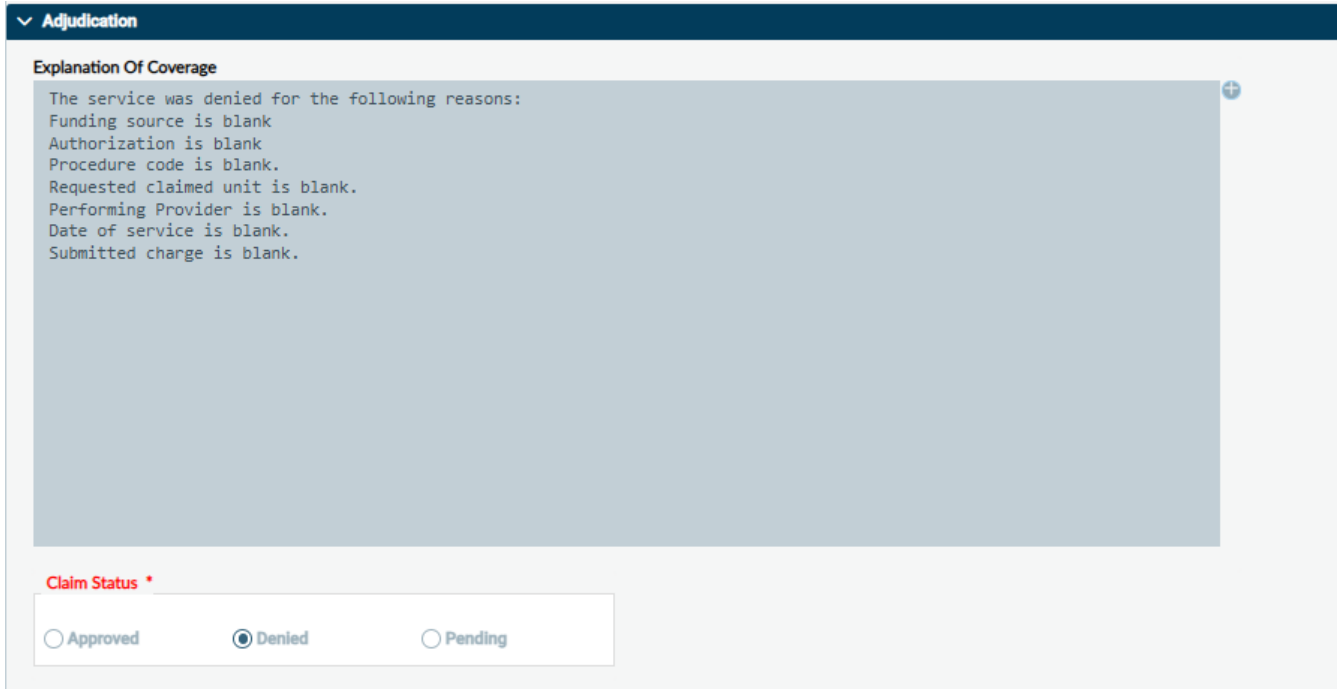
TUTORING SESSION: REVIEWING LOCAL DENIALS

REVIEWING LOCAL DENIALS

- Overview
  - Pre-adjudication
  - Adjudication
  - Reports and tools available to identify local denials
  - Available resources to resolve local denials

REVIEWING LOCAL DENIALS – PRE-ADJUDICATION

- Pre-adjudication - Primary Sage Users
  - **Explanation of Coverage** field in the Fast Service Entry Submission Form



REVIEWING LOCAL DENIALS – PRE-ADJUDICATION

- Pre-adjudication - Secondary Sage Users

277CA

Accepted/Rejected claims due to formatting

```
ISA*00*          *00*          *30*951234567      *30*680290013      *171107*0939*^*00501*000000003*1*T*:~
GS*HC*951234567*68029013*20171107*093907*3*X*005010X222A1~
ST*277*0003*005010X214~
BHT*0085*08*3*20171107*093907*TH~
HL*1**20*1~
NM1*AY*2*Los Angeles County SAPC*****FI*68290013~
TRN*1*20171107093907~
DTP*050*D8*20171107~
DTP*009*D8*20171107~
HL*2*1*21*1~
NM1*41*2*RECOVERING, INC.*****46*951234567~
TRN*2*12345H~
STC*A2:20*20171107*WQ*60~
QTY*90*1~
AMT*YU*60~
HL*3*2*19*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
TRN*1*0~
STC*A2:20**WQ*60~
QTY*QA*1~
AMT*YU*60~
HL*4*3*PT~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
TRN*2*36044~
STC*A2:20*20171107*WQ*60~
REF*1K*1~
DTP*472*D8*20170911~
SE*26*0003~
GE*1*3~
IEA*1*000000003~
```

2200B Loop - Information Receiver Application Trace ID

- TRN01 – Provider Reference ID from the 837P -- BHT03
- STC01 – Claim Status Category Code*
- QTY01 – 90=Acknowledged Quantity /AA=Unacknowledged Quantity
- AMT01—YU=Total Accepted Amount / YY= Total Rejected Amount

2200D Loop – Claim Status Tracking

- TRN02 – Provider's Claim ID from the 837P - CLM01
- STC02 – Claim Status Category Code*
- REF02 – Claims Reference Assigned by Sage.
- DTP03 – Claim Level Service Date

Critical Error Report

Provides claim level information for the rejected services

File Name: /npc/clients/LASAPC_CA.16276.mp/avatar/sbox/837P/ADP-1156-837P-bd_not_match.txt
File Status: POSTED **Data Entry By:** Polina Tsaryan
File Version: 837Pv5010 **Data Entry:** 5/3/2021 10:36 AM

Error Type	Error Message
Critical Error	Line: 20 - The date of birth contained in the file: 04/04/99 does not match the date of birth: 04/04/90 on file for member id

- 837P Companion Guide: Link
- Critical Error Report Guide for 837 Files: Link

REVIEWING LOCAL DENIALS – ADJUDICATION

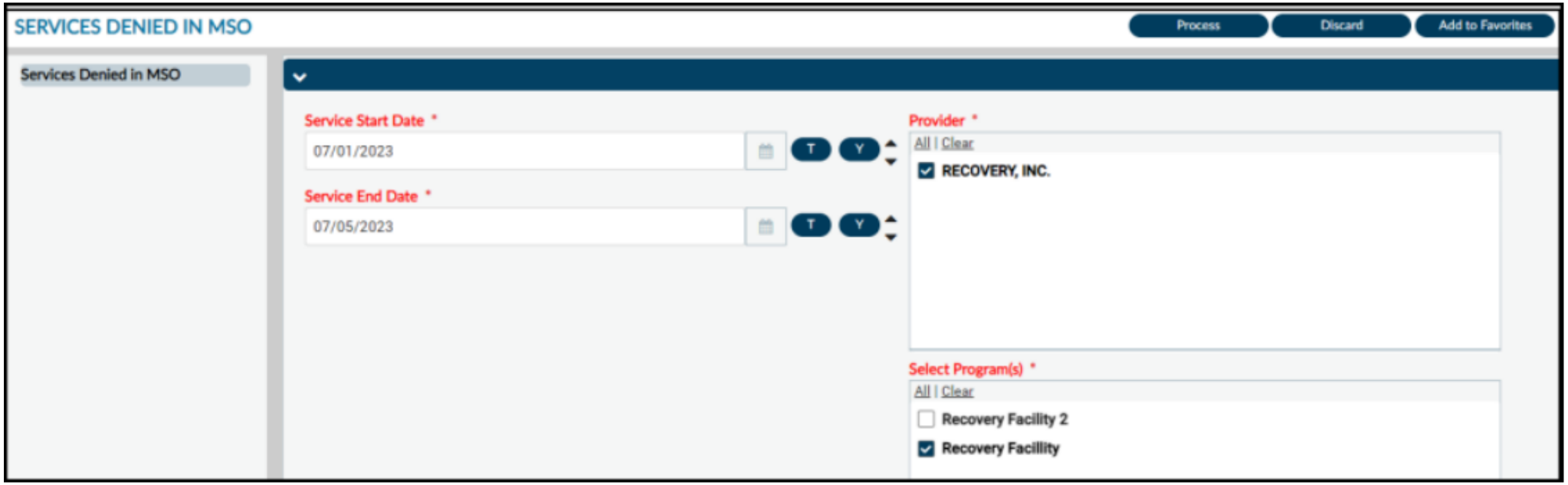
- Next, there are two levels of adjudication:
  - 1st – at the Local level
  - 2nd – at the State level
- Local denials occur after claims are submitted and are adjudicated at the 1st level in Sage

REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Reports and Tools
    1. Services Denied in MSO Report
    2. Check/EFT Number Report
    3. Cost of Service By Client Report
    4. Provider EOB Remittance Advice
    5. MSO KPI Dashboard 2.0 – Claim Denial View
    6. MSO KPI Dashboard 2.0 – Payment Reconciliation View
    7. Patient Billing History Widget

REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Services Denied in MSO Report
  - This report provides a listing of services that were denied Locally by SAPC. The report can be run for a duration up to one year. This report shows Local denial reasons across the entire agency or a specific site for a given period based on the parameters selected.



REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

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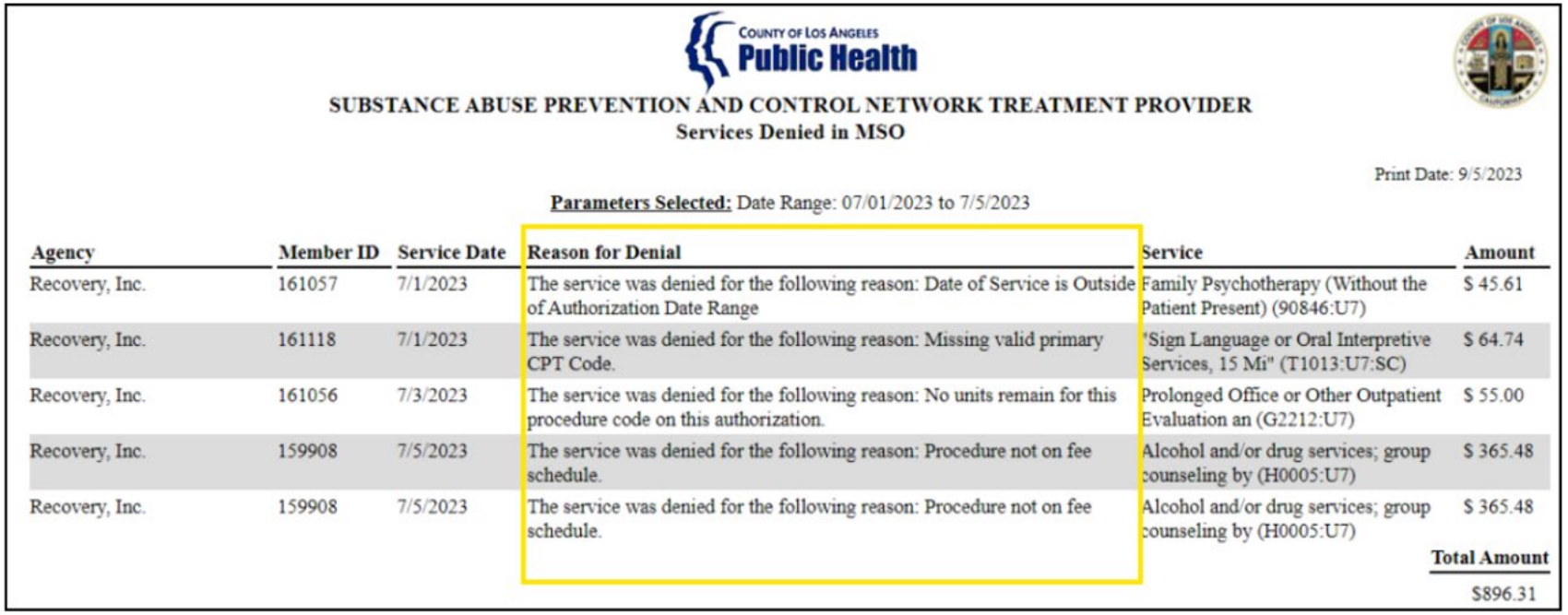


County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL NETWORK TREATMENT PROVIDER
Services Denied in MSO

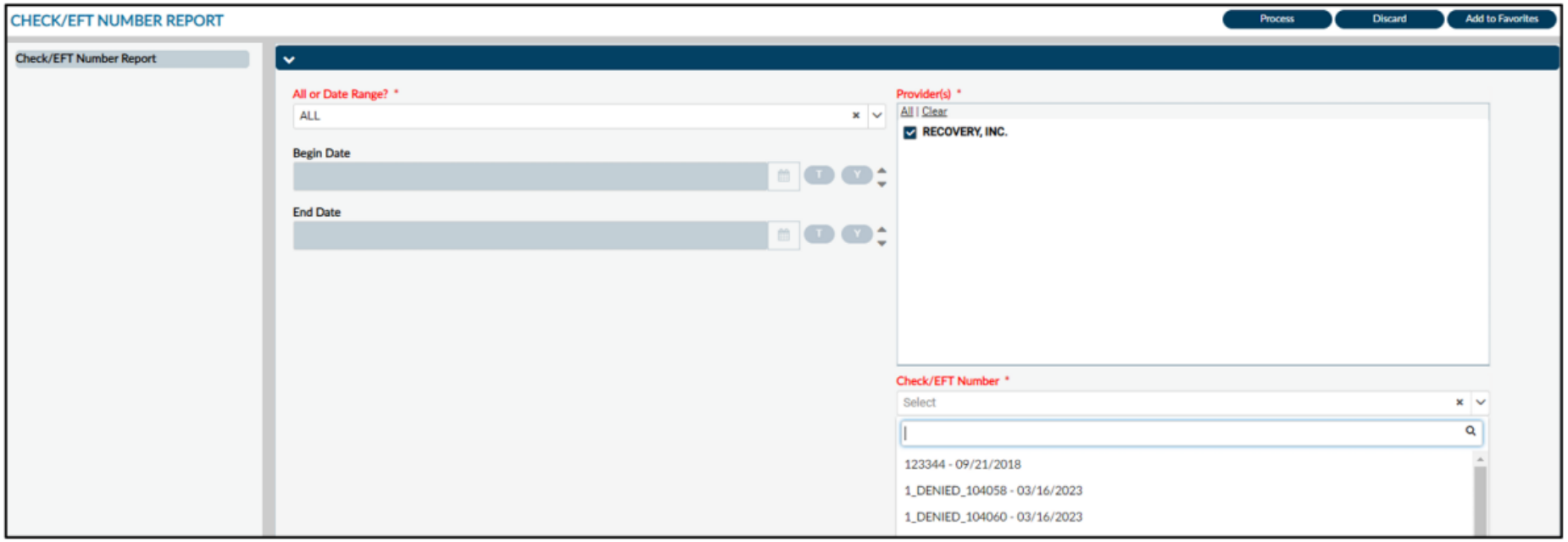
Print Date: 9/5/2023

Parameters Selected: Date Range: 07/01/2023 to 7/5/2023

Agency	Member ID	Service Date	Reason for Denial	Service	Amount
Recovery, Inc.	161057	7/1/2023	The service was denied for the following reason: Date of Service is Outside of Authorization Date Range	Family Psychotherapy (Without the Patient Present) (90846:U7)	$ 45.61
Recovery, Inc.	161118	7/1/2023	The service was denied for the following reason: Missing valid primary CPT Code.	"Sign Language or Oral Interpretive Services, 15 Mi" (T1013:U7:SC)	$ 64.74
Recovery, Inc.	161056	7/3/2023	The service was denied for the following reason: No units remain for this procedure code on this authorization.	Prolonged Office or Other Outpatient Evaluation an (G2212:U7)	$ 55.00
Recovery, Inc.	159908	7/5/2023	The service was denied for the following reason: Procedure not on fee schedule.	Alcohol and/or drug services; group counseling by (H0005:U7)	$ 365.48
Recovery, Inc.	159908	7/5/2023	The service was denied for the following reason: Procedure not on fee schedule.	Alcohol and/or drug services; group counseling by (H0005:U7)	$ 365.48
					Total Amount
					$896.31

REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Check/EFT Number Report
  - Shows all Local denied services and the associated denial reasons for a selected check number. This report can be used to identify denials by check number/payment (checks may cover multiple bills).



REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Check/EFT Number Report
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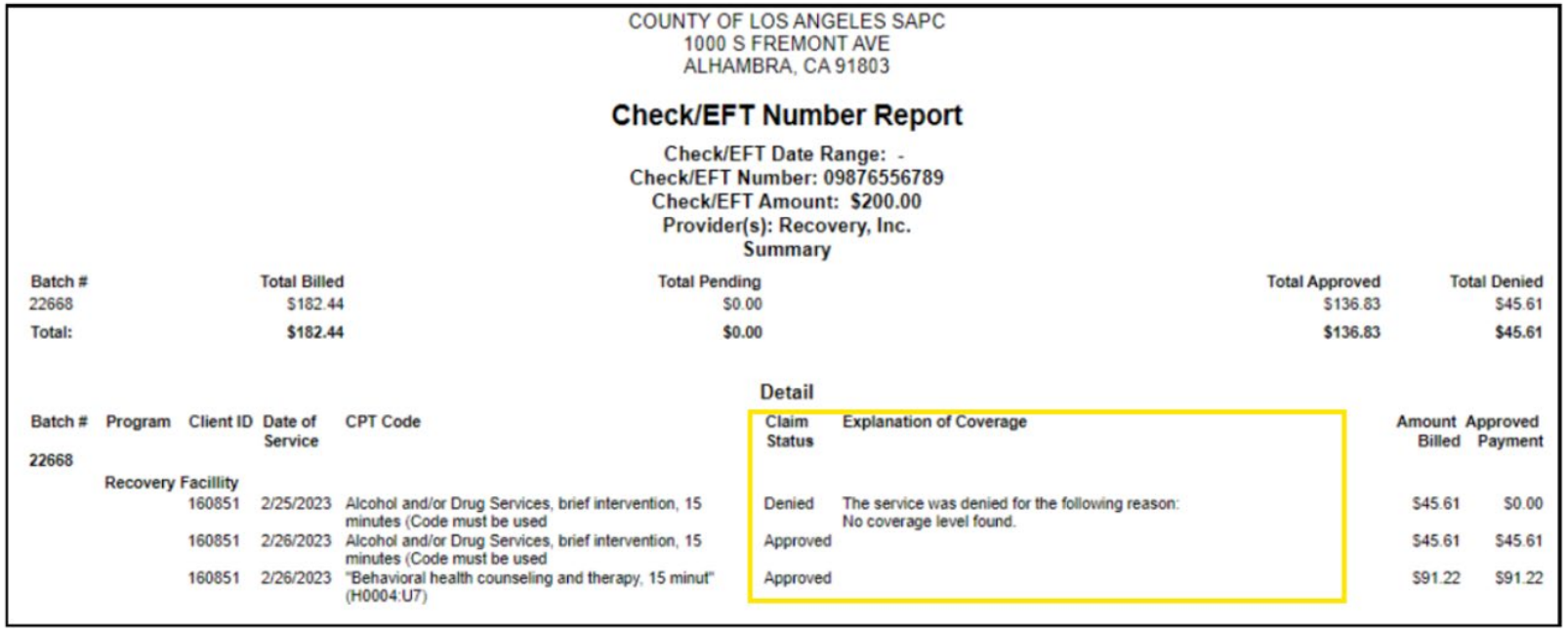


COUNTY OF LOS ANGELES SAPC
1000 S FREMONT AVE
ALHAMBRA, CA 91803

Check/EFT Number Report

Check/EFT Date Range: -
Check/EFT Number: 09876556789
Check/EFT Amount: $200.00
Provider(s): Recovery, Inc.
Summary

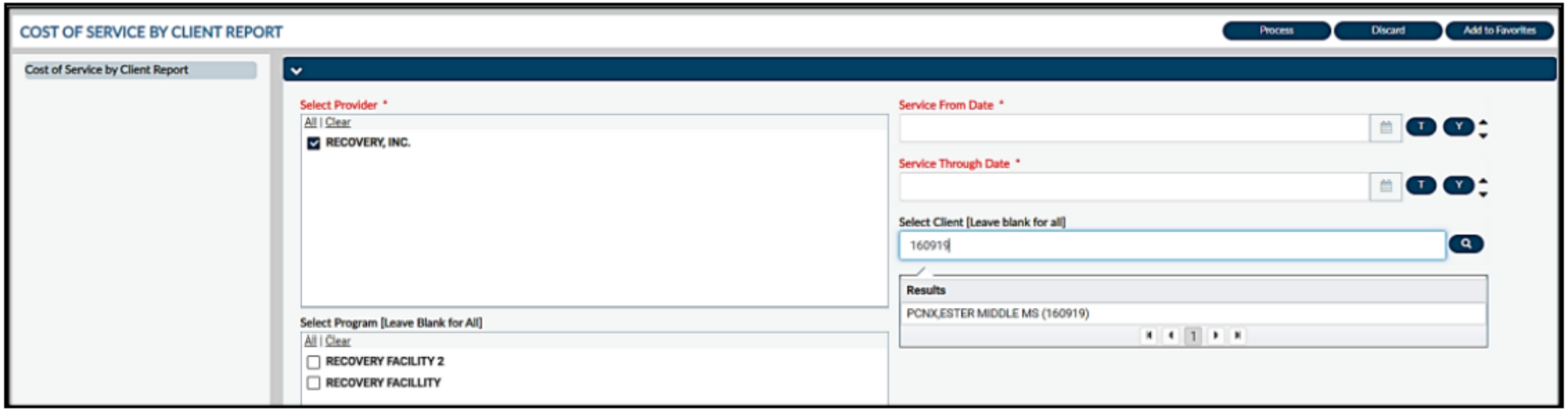
Batch #	Total Billed	Total Pending	Total Approved	Total Denied
22668	$182.44	$0.00	$136.83	$45.61
Total:	**$182.44**	**$0.00**	**$136.83**	**$45.61**

Detail

Batch #	Program	Client ID	Date of Service	CPT Code	Claim Status	Explanation of Coverage	Amount Billed	Approved Payment
22668								
	Recovery Facillity							
		160851	2/25/2023	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used	Denied	The service was denied for the following reason: No coverage level found.	$45.61	$0.00
		160851	2/26/2023	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used	Approved		$45.61	$45.61
		160851	2/26/2023	"Behavioral health counseling and therapy, 15 minut" (H0004:U7)	Approved		$91.22	$91.22

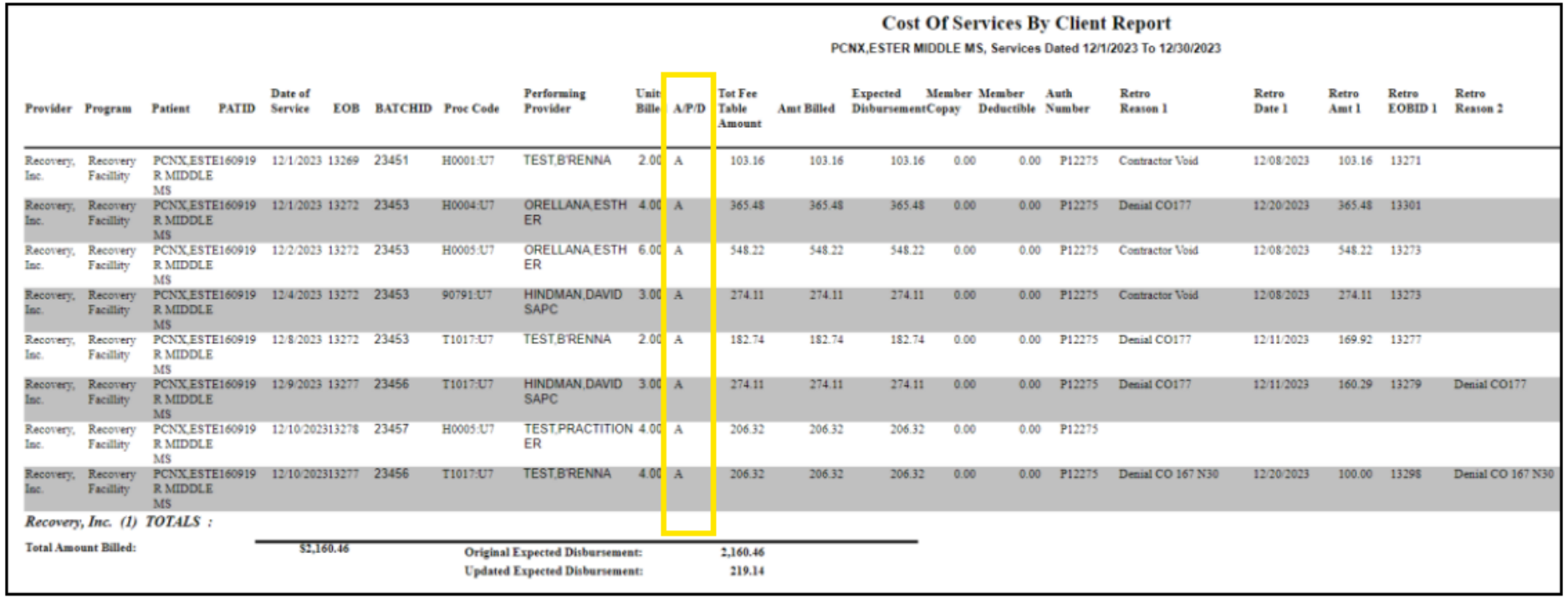
REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Cost of Service by Client Report
  - This report provides a listing of billed services that can be limited by a specific client. When viewing the report output, providers will be able to see the Local and State denials by looking at specific columns in the report



REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Cost of Service by Client Report
  - This report provides a listing of billed services that can be limited by a specific client. When viewing the report output, providers will be able to see the Local and State denials by looking at specific columns in the report



Cost Of Services By Client Report

PCNX,ESTER MIDDLE MS, Services Dated 12/1/2023 To 12/30/2023

Provider	Program	Patient	PATID	Date of Service	EOB	BATCHID	Proc Code	Performing Provider	Unit Bille	A/P/D	Tot Fee Table Amount	Amt Billed	Expected Disbursement	Member Copay	Member Deductible	Auth Number	Retro Reason 1	Retro Date 1	Retro Amt 1	Retro EOBID 1	Retro Reason 2
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/1/2023	13269	23451	H0001:U7	TEST,B'RENNA	2.00	A	103.16	103.16	103.16	0.00	0.00	P12275	Contractor Void	12/08/2023	103.16	13271	
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/1/2023	13272	23453	H0004:U7	ORELLANA,ESTHER	4.00	A	365.48	365.48	365.48	0.00	0.00	P12275	Denial CO177	12/20/2023	365.48	13301	
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/2/2023	13272	23453	H0005:U7	ORELLANA,ESTHER	6.00	A	548.22	548.22	548.22	0.00	0.00	P12275	Contractor Void	12/08/2023	548.22	13273	
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/4/2023	13272	23453	90791:U7	HINDMAN,DAVID SAPC	3.00	A	274.11	274.11	274.11	0.00	0.00	P12275	Contractor Void	12/08/2023	274.11	13273	
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/8/2023	13272	23453	T1017:U7	TEST,B'RENNA	2.00	A	182.74	182.74	182.74	0.00	0.00	P12275	Denial CO177	12/11/2023	169.92	13277	
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/9/2023	13277	23456	T1017:U7	HINDMAN,DAVID SAPC	3.00	A	274.11	274.11	274.11	0.00	0.00	P12275	Denial CO177	12/11/2023	160.29	13279	Denial CO177
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/10/2023	13278	23457	H0005:U7	TEST,PRACTITIONER	4.00	A	206.32	206.32	206.32	0.00	0.00	P12275					
Recovery, Inc.	Recovery Facility	PCNX,ESTER MIDDLE MS	160919	12/10/2023	13277	23456	T1017:U7	TEST,B'RENNA	4.00	A	206.32	206.32	206.32	0.00	0.00	P12275	Denial CO 167 N30	12/20/2023	100.00	13298	Denial CO 167 N30

Recovery, Inc. (1) TOTALS :

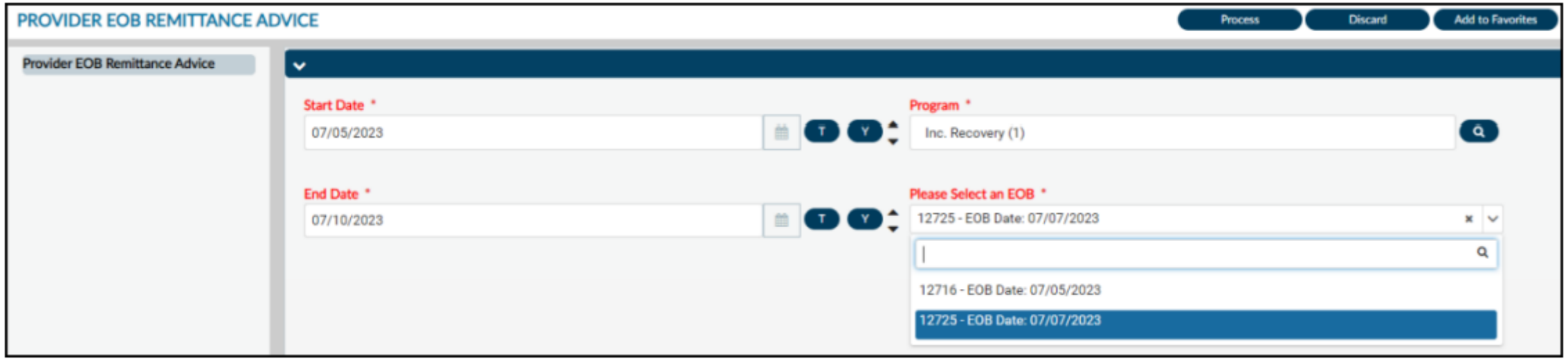
Total Amount Billed: $2,160.46

Original Expected Disbursement: 2,160.46

Updated Expected Disbursement: 219.14

REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Provider EOB Remittance Advice
  - This report provides adjudication details of claims submitted and includes the service information, adjudication status, and amount paid. The EOBs produced from this report match the EOBs sent via the SFTP.



REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Provider EOB Remittance Advice
  - This report provides adjudication details of claims submitted and includes the service information, adjudication status, and amount paid. The EOBs produced from this report match the EOBs sent via the SFTP.

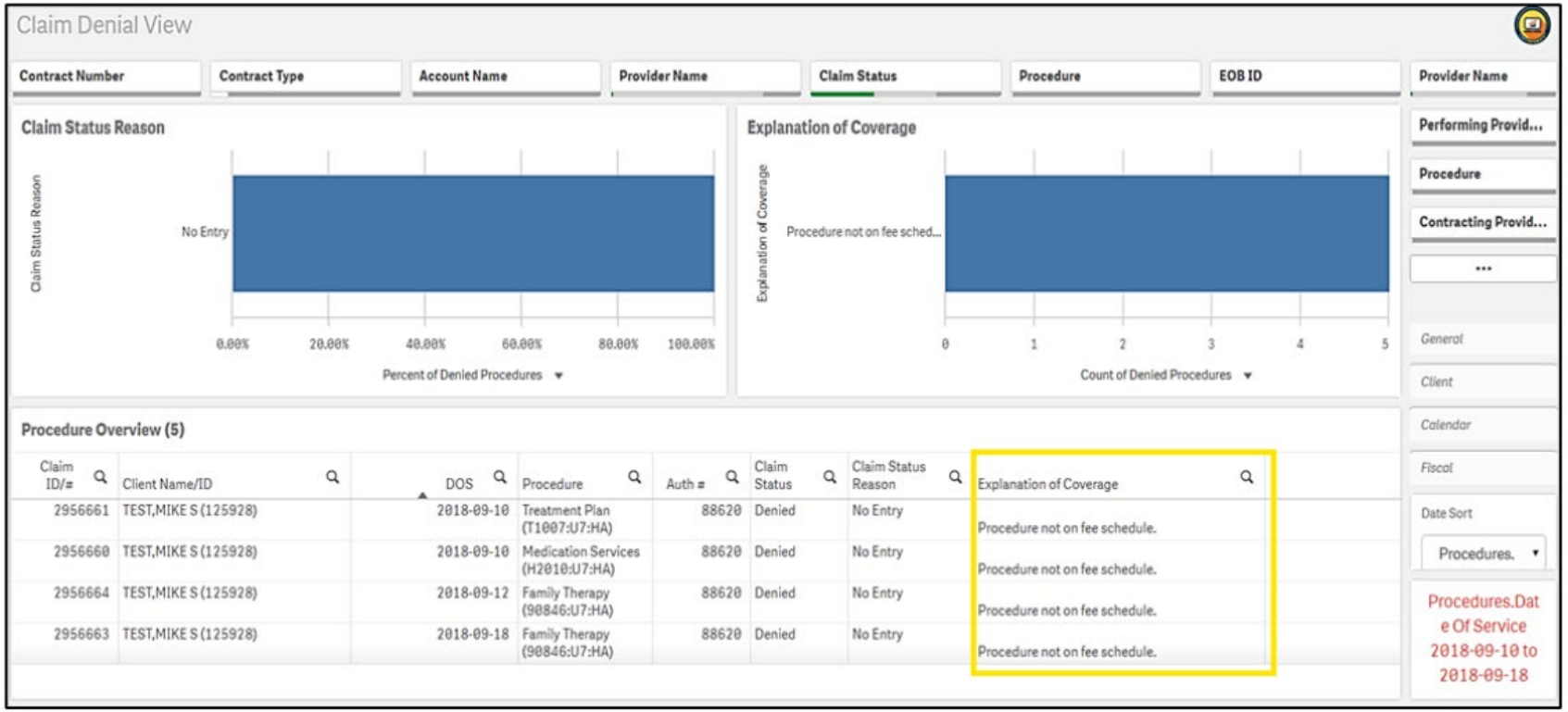
Client Name (ID): TEST,NEWYEAR (162341) **DOB: 01/01/1980** **Gender: F**

Date Claim Received: 06/04/2024

Batch.SvcRef#	Auth #	Contract #	Contract Type	Date of Service	Status	CPT Code	Claimed Units	Claimed Amount	Allowed Amount	Denied/ Adjusted	Member Co-pay	Amount Paid
24670SVC.0000	115029	PH003868	DMC	06/01/2024	A	H0025:U8	1.0	$12.45	$12.45	$0.00	$0.00	$12.45
24670SVC.0000	115029	PH003868	DMC	06/01/2024	A	H2014:U8:HQ	1.0	$15.86	$15.86	$0.00	$0.00	$15.86
24670SVC.0000	115029	PH003868	DMC	06/01/2024	A	H2014:U8:SC	1.0	$71.38	$71.38	$0.00	$0.00	$71.38
24670SVC.0000	115029	PH003868	DMC	06/01/2024	D	H2014:U8:SC	1.0	$71.38	$0.00	$71.38	$0.00	$0.00
The service was denied for the following reason: Location's Place of Service Is Invalid For Procedure Code.												
24670SVC.0000	115029	PH003868	DMC	06/02/2024	A	H0025:U8	1.0	$12.45	$12.45	$0.00	$0.00	$12.45
24670SVC.0000	115029	PH003868	DMC	06/02/2024	A	H0038:U8	1.0	$56.04	$56.04	$0.00	$0.00	$56.04
24670SVC.0000	115029	PH003868	DMC	06/02/2024	D	H0038:U8	1.0	$56.04	$0.00	$56.04	$0.00	$0.00
The service was denied for the following reason: Procedure not on fee schedule.												
							7.0	$295.60	$168.18	$127.42	$0.00	$168.18

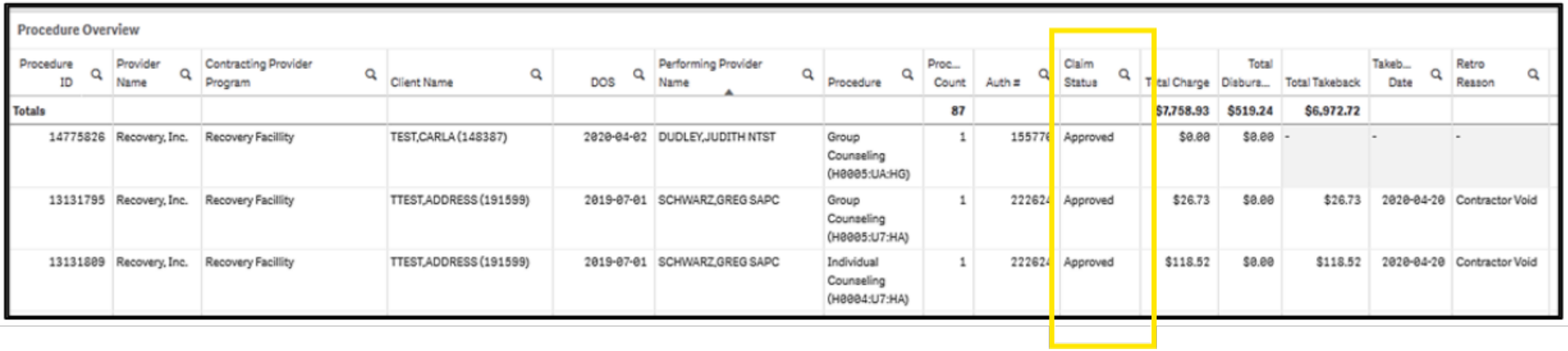
REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- MSO KPI Dashboard 2.0 – Claim Denial View
  - This view provides visibility on Local denials. A claim status of "Denied" can have either a Denial Reason and/or an Explanation of Coverage that explains the reason for denial.



REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- MSO KPI Dashboard 2.0 – Payment Reconciliation View
  - This view provides detailed information and summaries of service adjudications, EOBs, Retro EOBs, and check numbers. The Procedure Overview section displays client, service, and adjudication information.

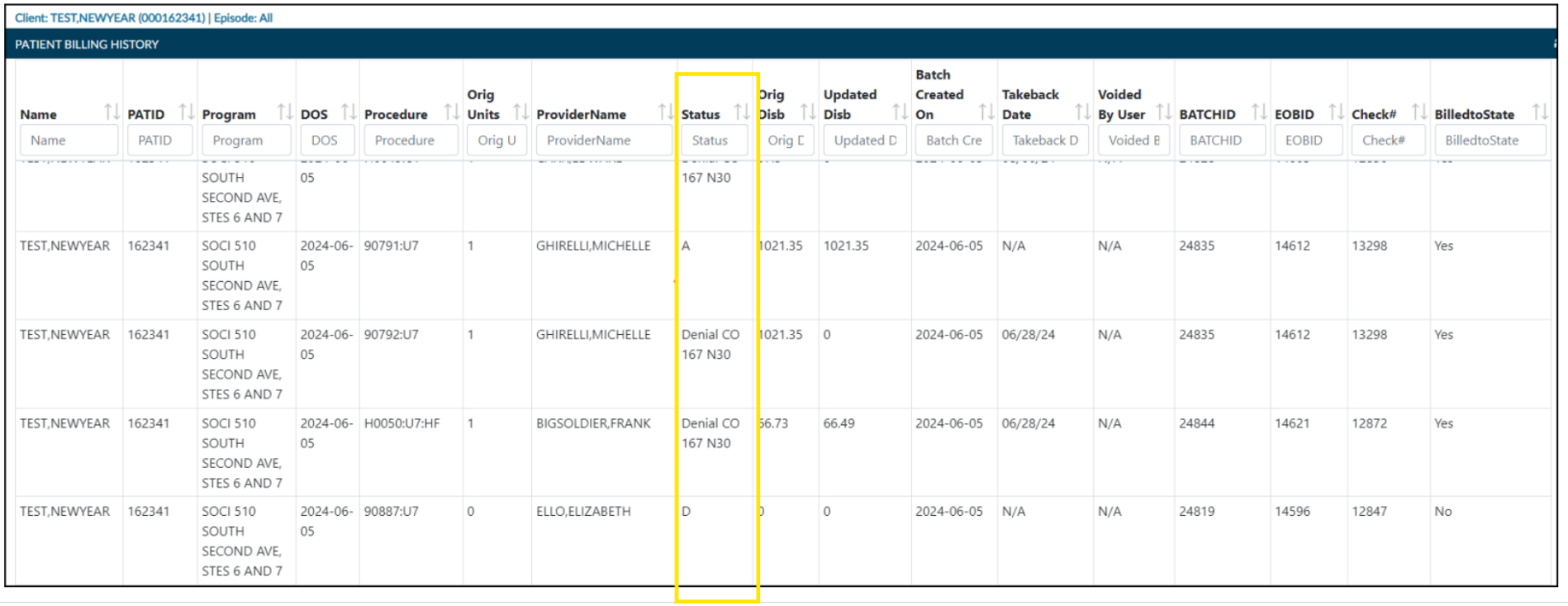


Procedure Overview

Procedure ID	Provider Name	Contracting Provider Program	Client Name	DOS	Performing Provider Name	Procedure	Proc... Count	Auth #	Claim Status	Total Charge	Total Disbura...	Total Takeback	Takeb... Date	Retro Reason
Totals							**87**			**$7,758.93**	**$519.24**	**$6,972.72**		
14775826	Recovery, Inc.	Recovery Facility	TEST,CARLA (148387)	2020-04-02	DUDLEY,JUDITH NTST	Group Counseling (H0005:UA:HG)	1	155776	Approved	$0.00	$0.00	-	-	-
13131795	Recovery, Inc.	Recovery Facility	TTEST,ADDRESS (191599)	2019-07-01	SCHWARZ,GREG SAPC	Group Counseling (H0005:U7:HA)	1	222624	Approved	$26.73	$0.00	$26.73	2020-04-20	Contractor Void
13131809	Recovery, Inc.	Recovery Facility	TTEST,ADDRESS (191599)	2019-07-01	SCHWARZ,GREG SAPC	Individual Counseling (H0004:U7:HA)	1	222624	Approved	$118.52	$0.00	$118.52	2020-04-20	Contractor Void

REVIEWING LOCAL DENIALS – REPORTS AND TOOLS

- Patient Billing History Widget
  - This widget in PCNX provides a patient level billing history



Client: TEST,NEWYEAR (000162341) | Episode: All

PATIENT BILLING HISTORY

Name	PATID	Program	DOS	Procedure	Orig Units	ProviderName	Status	Orig Disb	Updated Disb	Batch Created On	Takeback Date	Voided By User	BATCHID	EOBID	Check#	BilledtoState
		SOUTH SECOND AVE, STES 6 AND 7	05				167 N30									
TEST,NEWYEAR	162341	SOCI 510 SOUTH SECOND AVE, STES 6 AND 7	2024-06-05	90791:U7	1	GHIRELLI,MICHELLE	A	1021.35	1021.35	2024-06-05	N/A	N/A	24835	14612	13298	Yes
TEST,NEWYEAR	162341	SOCI 510 SOUTH SECOND AVE, STES 6 AND 7	2024-06-05	90792:U7	1	GHIRELLI,MICHELLE	Denial CO 167 N30	1021.35	0	2024-06-05	06/28/24	N/A	24835	14612	13298	Yes
TEST,NEWYEAR	162341	SOCI 510 SOUTH SECOND AVE, STES 6 AND 7	2024-06-05	H0050:U7:HF	1	BIGSOLDIER,FRANK	Denial CO 167 N30	66.73	66.49	2024-06-05	06/28/24	N/A	24844	14621	12872	Yes
TEST,NEWYEAR	162341	SOCI 510 SOUTH SECOND AVE, STES 6 AND 7	2024-06-05	90887:U7	0	ELLO,ELIZABETH	D	0	0	2024-06-05	N/A	N/A	24819	14596	12847	No

REVIEWING LOCAL DENIALS – RESOLUTION

- Denial Crosswalk Version 5.0
  - Refer to the "Local Denials" tab for denial causes and resolution steps

SAPC | Substance Abuse Prevention and Control

Sage Claim Denial Reason and Resolution Crosswalk 5.0 (Last updated July 2025)
*** Updated information will be indicated in RED**

County of Los Angeles Public Health

Denial Code (Secondary Providers)	CARC/RARC Description per X12.org	DMC Description *Claim Status Reason (D) on EOB or Explanation of Coverage Message from PCNX*	Cause and Resolution (Primary & Secondary Providers)
		Performing provider does not have any License Types that match the CPT Code's allowed license types.	**Cause:** The performing provider's discipline is not configured for the CPT code. **Primary/Secondary Sage User Resolution:** Please open a help desk ticket for further guidance.
		Total expected disbursement exceeds current account level amount.	**Cause:** This results when the Fiscal Year contract amount has been reached. No further claims will be approved or paid once the contract has been exceeded until an augmentation has been approved and funding is available. **Primary/Secondary Sage User Resolution:** Providers should monitor contract amounts throughout the year and request an augmentation through their assigned CPA prior to exceeding contract amounts. Do not submit any additional claims until augmentation is approved and funding is available, or all claims will be denied.
		24-hour service on discharge date.	**Cause:** This results when a 24-hour service is billed on the date of discharge. **Primary/Secondary Sage User Resolution:** No action needed. 24-hour services cannot be billed on the discharge date at this time.
		Limited by allowed amount.	**Cause:** The Total Charge entered exceeds the configured rate for the procedure code/practitioner. **Primary/Secondary Sage User Resolution:** No action needed at this time. Sage will automatically adjust the total charge to the rate configured for the procedure code.
			Cause: The patient's date of service is outside the performing provider's registration start and

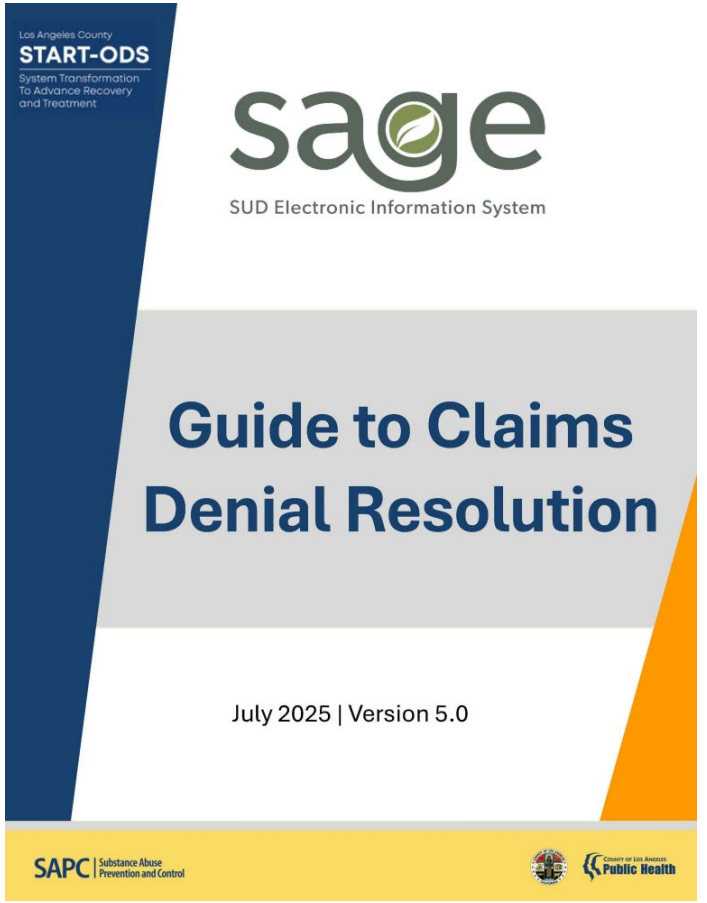
STATE DENIALS | LOCAL DENIALS

ady Accessibility: Investigate

- Link to download the Denial Crosswalk Version 5.0: HERE

REVIEWING LOCAL DENIALS – MORE INFORMATION

- Guide to Claims Denial Resolution
  - Link to download: HERE



WE WOULD LOVE TO HEAR FROM YOU!

- Agencies with high local approval rates, what are your best practices for making sure that services are approved at the local level?
- Agencies not satisfied with your local approval rates, what gaps in billing knowledge can SAPC assist with?

Let's connect! Please send an email to SAPC-Finance@ph.lacounty.gov

HELPFUL RESOURCES

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	All Sage related questions, including billing, denials, medical record modifications, system errors, and technical assistance
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 UM (626)299-3531- Questions about a specific patient/auth QI (626)-293-2846- Complaints and Appeals	All authorization related questions, questions for the office of the Medical Director, medical necessity, secondary EHR form approval
Systems of Care	SAPC_ASOC@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 submission 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 if known.
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 trainings
Finance	sapc-finance@ph.lacounty.gov	General questions related to billing, denials, tier allocation for payment reform. For specific denial questions, please open a Sage Helpdesk Ticket.

Greg Schwarz


OPEN Q&A