2/6/2025 Billing & Denial Resolution Tutoring Lab FAQ

EOB Updates

Question	Answer
Are agencies going to receive 835 files that are associated with “blank denials”? If so, will the files be blank?	Yes, agencies will receive an 835 file for these denials, but they may receive CARCs without a remark code in the LQ segment. SAPC is working on compiling additional resources from Netsmart to understand how these files are generated.
For secondary providers, should “blank denial” 835 files be uploaded into the other eHR system?	The answer is dependent on how the other eHR will process it. If there is a specific example you would like SAPC to investigate, please open a help desk ticket and attach the 835.

Open Q&A

Question	Answer
What is the procedure to resolve State denial CO 96 N54 for H2014?	SAPC received communication from the State shortly before this meeting informing that they have been issuing erroneous CO 96 N54 denials for the following set of codes: G2212, H0034, H2017, and H2014. The State’s system has been issuing these denials due to their system inaccurately reading the fee table for these services. These denied claims can most likely be resubmitted. SAPC will send out a communication regarding these denials.
Do providers have to enter billing codes to the services being submitted? For instance, does a group note that is entered need to include the code under the “Procedure Codes (CPT/HCPCS)” section?	The "Procedure Codes (CPT/HCPCS)" field in the Progress Note is an optional field. The person completing the Progress Note is not required to choose a CPT/HCPCS code. However, entering a CPT/HCPCS code can assist the biller to select the right code for billing. Here is a link to the Sage-PCNX Progress Note Guide:http://publichealth.lacounty.gov/sapc/docs/providers/sage/pcnx/Sage-PCNX-Progress-Note-Guide-4-4-2024.pdf
What is the guidance for resolving State denial code CO107 for G2212:U7 (medical necessity notes)?	For code CO 107, there was a Sage configuration issue where some codes were being incorrectly cross walked, meaning that they were billed to

	the State with a different code than what was originally billed. This denial primarily affected H2017 and G2212, and possibly other codes with a denial description "Short-Doyle denied the add-on or dependent service because the primary service was not valid", where the code was not an add-on. This error was resolved, so these denied claims can be resubmitted without making changes. Guidance for this denial was included in a Sage communication from 11/08/2024. Sage provider communications can be found on the Sage website by navigating to Sage Provider Communications, clicking "Open All", and using Ctrl+F to search for the procedure code (without modifiers) or denial code.
How should we address remittances received for dates in 2023 since they are from a closed fiscal year?	Billing for Fiscal Years 22-23 and 23-24 is still open until 06/30/2025, so these denials can still be corrected and resubmitted to SAPC.
For the Recovery Services level of care, is it required to provide at least 2 hours of clinical services per month?	The Clinical Standards Team is in the process of verifying the exact number of hours for a clinical service.
What is the procedure for resubmitting H2017 claims that have already been recouped?	Please rebill them without voiding the original claims. Another payment will be disbursed.
Our agency received CO 96 N362 denials for codes T1012 and H0005, many of which are not available to void. Should these claims be resubmitted?	Any State denials that resulted in payment being taken back do not need to be voided. Primary providers should submit new claims. Secondary providers should replace the claims.
What is denial code CO 97 M86?	The State denial code CO 97 M86 is not yet on the Denial Crosswalk. Denial CO 97 M86 indicates a duplicate service. This is commonly caused by failure to roll up multiple services. Services should be rolled up if they were delivered more than once a day for the same person by the same performing provider. The exceptions to the roll-up rule are T1013, 96170, 96171, group counseling, and group patient education. Please see this Sage communication which provides details and resolutions for this State denial. http://publichealth.lacounty.gov/sapc/Sage/Com

	munication/SAPC-Sage-Provider-Communication-101124.pdf. If you need additional assistance, please open a help desk ticket with our new Billing Inquiry form: Billing Inquiry Form
Is there a "Master List" of all erroneous denials caused by system setup issues at either SAPC or the State that includes applicable date ranges that would be affected by each of these situations?	SAPC is currently working on publishing this list. In the meantime, please refer to Sage Provider Communications, which list details for erroneous denials and configuration issues.
Where can I find matrix for fiscal year 2023-2024?	The FY23-24 Rates Matrix can be downloaded from the SAPC website here: http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/23-07/RatesStandardsMatrixFY23-24.xlsx
Are there any updates on the void and resubmission for Evaluation and Management codes (99202-99205, 99212-99215)?	Since the last tutoring lab, SAPC has been working on completing recoupments for all services that had not yet been recouped. Agencies will start receiving lists of rebillable services within the next two weeks in the SFTP along with an email notification to their agency finance contacts. Anything that has been recouped can be resubmitted.
Since fiscal year 23-24 is still open, can agencies still correct denials from November 2023?	Yes, the end date for billing FY22-23 & FY23-24 services is June 30th, 2025.
I have verified the information on a patient's record is correct, according to the denial crosswalk for State Denial CO 177. How should I proceed?	Please open a help desk ticket with the SAPC Billing Inquiry form: Billing Inquiry Form Tickets created using this form are routed directly to SAPC Finance.
What is the guidance for resolving CO 177 denials?	Eligibility denials are the most common denials because they can cover so many different reasons. Possible causes include the reasons in the crosswalk as well as the following: • The patient may have had a lapse in medical coverage, which would not be detected if agencies are not performing eligibility checks every month for each DMC-patient. • The wrong CIN was entered in the financial eligibility record. • The patient had OHC that was not billed first. • Patient does not have Medi-Cal, or the patient's aid code does not cover DMC services (DHCS Aid Code Chart:

	https://www.dhcs.ca.gov/provgovpart/Documents/SDMC-Aid-Code-Chart.xlsx). • The patient's County Code indicates a county other than LA County.
Can you please clarify which fiscal years are still open for billing and corrections? What are the deadlines for each fiscal year.	The original deadlines for FY 22-23 and FY 23-24 were extended to 06/30/2025. Please continue to bill, make corrections, and submit help desk tickets until the end of this fiscal year.
Because medical necessity notes had add-on codes last fiscal year, how should agencies address a denial for add-on code G2212:U7 and not for the primary code?	If you are receiving a denial for the add-on code, but not the primary code, it could be part of the aforementioned configuration issue that caused erroneous CO 96 N362 denials. If there is a specific example you are inquiring about, please open a Sage help desk ticket.
Can the day rate be billed for both the date of intake and date of discharge or only one of the dates? How is that determined?	In an ongoing discussion with the State, the general guidance they have provided is that agencies can bill the day rate for both dates as long as at least one of the bundled services for the day rate has been delivered. Examples of these bundled services include assessment, individual counseling, group counseling, and discharge services. However, if a patient was discharged and admitted to another level of care and both agencies or programs are trying to bill for the patient on the same date, it may cause a denial despite previous guidance from the State that this would be allowed. The corresponding denial code is CO 96 M80. SAPC has stopped recouping these denials until we have received clear guidance from the State on how this scenario can be billed appropriately, but agencies can still submit claims to SAPC.
Can CO 96 N54 denials for H2014 be rebilled without receiving another denial?	Agencies can and should rebill these claims. The listed codes were incorrectly denied by the State and are almost fixed. Once agencies' claims are ready for SAPC to bill to the State, it will have been resolved.