03/06/2025 Billing & Denial Resolution Tutoring Lab FAQ

Open Q&A

Question	Answer
Should County and State denials with $0.00 value services be resubmitted?	No. SAPC has recently unsuppressed some information regarding $0 service denials, so providers may receive EOBs with a message "This EOB is a result of adjudications that have a $0 value." This is for better visibility, but providers do not need to resubmit the denials unless they are for services that are tied to incentives (for example, H2010M/N/S codes).
Can you please review the process for rebilling the CO 96 N362 denials from Fiscal Year 22-23? Specifically, the formula to calculate the rate for group counseling.	The formula for the group counseling rate for Fiscal Year 22-23 can be found at the bottom of the rates matrix for that year. The formula is as follows: {[(# minutes in the group + travel time)/ # participants in the group] = Total treatment minutes per beneficiary} + documentation time per beneficiary. Our guidance to providers for that fiscal year was to round up to the nearest unit. Please open a help desk ticket if you need further assistance.
PCNX is not allowing me to add the CIN on the Financial Eligibility form. There is no error message.	SAPC Finance is not yet aware of this issue. It is most likely a technical issue. Please open a help desk ticket if you encounter this again.
Do another financial eligibility and progress note need to be added for each service rendered to the same patient?	Financial eligibility and diagnosis do not need to be redone unless there is a change, but a progress note does need to be created for each service delivered. However, the 270 eligibility check should still be performed monthly.
As a CENS provider, we were previously using T1017-CN for targeted case management, but we received a message that CENS codes can no longer be billed for 2024. Should T1017-CN be substituted by H2015 for community service screening?	Yes, T1017-CN should now be billed as H2015. There is a table in a Sage Provider Communication from September 2022 that shows a list of codes that crosswalk into H2015 and H2017. This includes those for assessment, group counseling, individual counseling, and family therapy for H2017 and care coordination, recovery monitoring, and relapse prevention for H2015. This applies to fiscal year 23-24 and 24-25.

	In the rates matrix, you can navigate to the appropriate tier's tab for your agency and filter the Code Type column for "CENS" and all applicable CENS codes will display. Most CENS codes also have a -CN at the end.
For recovery services, are two different providers who render two different H2017 services, such as family counseling and individual counseling, to the same client on the same day able to bill for each service?	Yes. Additionally, like any service that is required to be rolled up, if the services are delivered by different performing providers, they can be billed as two separate services without rolling up.
If a client lost DMC coverage during treatment but qualifies for a non-DMC program such as JJCPA, does a new authorization under non-DMC funding need to be requested to rebill denied claims with denial code CO 177?	You can update the financial eligibility without a new authorization. On the Sage Finance webpage under Billing, there is a guide titled "Documenting Changes in Financial Eligibility Status" that covers multiple scenarios for patients who either lose or obtain benefits. Please note that the Drug Medi-Cal guarantor should **never** be deleted from a patient's Financial Eligibility Form. SAPC still needs this guarantor to establish dates of eligibility for billing to the State. In this instance, utilize the coverage expiration date field in the Drug Medi-Cal guarantor in the Financial Eligibility form and enter the date that the patient lost benefits. This tells the system that any service after that date should be applied to the next guarantor. Please ensure that there is another non-DMC guarantor in the financial eligibility.
What are the codes for ASAM 1.0 Outpatient Recovery Services for MAT and Naloxone?	H2010N-CN is the code for naloxone handling and distribution. This is used to track incentives, but it must be accompanied by another service, usually H2015 or H2017 depending on what kind of service was being delivered when naloxone was being distributed to that patient. H2010M for MAT education would be billed similarly.
Why am I receiving a local denial for 90791 (extended with 99204 and 99205) for a 60-minute service? Is there a code that I can use to bill for the entire duration of the service?	On the billing rules tab of the rates and standards matrix, 99204 and 99205 are listed as "Outpatient Overridable Lockouts with Appropriate Modifiers" (column K). If these codes were billed without either the 59, XE, XP, or XU modifier, they would deny because they are technically locked out. If you would like for SAPC Finance to look over the denials before you resubmit these claims, please open a help desk ticket.
Can residential levels of care bill H2010M on top of the daily rate or added to a group conducted in	For residential levels of care, H2010M codes have a $0 service fee attached because agencies are

a residential setting for the purpose of incentive tracking?	paid through the incentive. However, please continue to bill H2010M codes for tracking purposes. You can also bill H2010M under H0034R so that you can receive a regular payment for medication services delivered to a person. If you are performing medication services as part of a group service, use H0034R with the HQ modifier to signify that this was a group service in residential.
Why am I receiving multiple CO 96 N362 State denials for 1 unit of 96160 for a 30-minute service?	The denial code CO 96 N362 indicates that the service was denied because the units billed are greater than one, excluding NTP dosing. It is possible that these services were accidentally submitted twice. Additionally, since primary providers do not have the ability to replace claims yet, it is possible that as a primary provider, a void was attempted before a new claim was submitted. If the void was not yet sent to the State, the new service would be denied. Please open a help desk ticket for further investigation.
Following past billing instruction, I was billing H2010N with T1007 to receive incentives for services but was unaware that H2010M could be billed with T1007 as well, so I was billing H2010M by itself. I recently received instruction to bill H0004 to receive incentives for both H2010N and H2010M. Can H0004 be billed for past H2010M services that were not billed for incentives? If so, should the H2010M services be voided so that they can be billed together?	The guidance changed because in fiscal year 23-24, there were rates attached to H2010M and N, but in 24-25 there are not. Please bill H2010M and N so that they will count toward your agency's incentive metrics. The code that they are billed with will depend on what service was being provided. For example, if you distributed naloxone during an individual counseling session, then you would bill H2010N with H0004. There is a guide on how to bill for H2010 codes for this fiscal year on the Sage Trainings website, as well as a recording of a previous Tutoring Lab session where this was discussed. The Sage team also provided additional guidance for documentation in the Sage Provider Communication from 02/14/2025.
Should H0004 and H2010M/H2010N be rolled up if they are performed by the same provider on the same day?	No. Because they are distinct codes, they do not need to be rolled up. Only services with identical codes need to be rolled up when provided to the same patient on the same day by the same provider.
What is the difference between MAT codes 99212 and H0034?	99212 is specifically for license types MD/DO, PA, and NP, for a 10-19 minute service duration in an office or other outpatient visit of an established patient. H0034 is for license types MD, DO, PA, NP, pharmacist, RN, MA, LPTs and LVNs for medication training and support, per 15 minutes.

	The rates and standards matrix will include more specific differences between the two codes.
Are H2015 and H2017 still being used for Recovery Services billing?	Yes, the crosswalk in the Sage Provider Communication from September 2022 shows H2015 and H2017 as the two main codes for Recovery Services. Additionally, the rates matrix can be filtered for codes associated with Recovery Services in the Code Type column.
Does the patient need to be physically present to bill H2010S for medication handling and safeguarding? For example, if a clinician is documenting information in a medication log based on instructions from a specific patient's pharmacist.	
Can agencies bill H0034R in order to receive payment for H2010M while billing H2010M to count toward incentives?	Yes, because incentive tracking focuses primarily on H2010M or N, not H0034 or H0034R.
Does the SFTP report tie into State denials?	One of the SFTP reports uploaded is for State denials that were received from DHCS regarding 992 assessment codes. These were denied because they are not billable to the State. SAPC has already recouped these amounts and has an alternate way for agencies to bill for MAT services (H0034R). The other spreadsheet that was uploaded to the SFTP was a list of erroneous CO 96 N54 denials that were recouped due to a State system error. Both reports are pertaining to State denials but serve the purpose of allowing SAPC to take back denied amounts preemptively in order to allow agencies to resubmit claims.
How can agencies track the entire cycle of a claim from local adjudication to final payment or denial by the State?	There are multiple reports on PCNX that can help track your claims. On the Sage Training webpage, there is a helpful guide to reports in PCNX. MSO KPI is recommended for viewing local approvals and denials and is great for identifying denial trends. The Services Denied in MSO report will show only an agency's denied services. The Cost of Service by Client report will display claims for specific clients. Provider Services Detail and Summary Reports are also useful for tracking claims. The Patient Billing History widget shows local adjudication for a claim as well as whether the

	claim has been sent to the State. It will also indicate if the claim was denied by the State, along with the denial code and the amount that was taken back.
Will H0050 be denied if the recovery incentives diagnosis is not included on the claim?	Yes, for H0050 (contingency management), one of the two approved diagnoses must be on the claim, or it will be denied.

Open Q&A (not answered due to time)

Question	Answer
How should we document the Coverage Effective End Date in the Financial Eligibility Form if a patient loses DMC benefits, but recovers them at a later date?	
How should we bill 99205 for a 120-minute service? Would it be 1 unit of 99205 and 1 unit of 99415?	
A client's authorization was approved for an outpatient level of care. However, their Medi-Cal indicates that Kaiser is their primary insurance. We have been billing under Medi-Cal since August 2024 and have received no denials. Should we stop billing for this client?	