05/01/2025 Billing & Denial Resolution Tutoring Lab FAQ

FY 25-26 Changes

Question	Answer
Does the discontinuation of $0 billing for next fiscal year apply to primary and secondary providers?	Yes, it applies for both primary and secondary providers.
Do the $0 services being discontinued include intake and discharge planning notes?	Yes, any of the services that would be bundled into the day rate and billed to SAPC normally are being discontinued.
Are we still required to complete documentation for $0 services since they are no longer being billed?	Yes, you must always document your services as normal, they just will not be billed to SAPC.
How should we bill for Non-Admission Screenings if H0049-N is being removed?	Instead of H0049-N, please bill with H2017 using your agency's Recovery Services P-auth. You will bill a non-admission with the lowest level of care certified for that site. Please ensure to roll these services up to avoid state denials.
If $0 billing is no longer required, does this mean that SAPC will accept and pay all day rates and room and board claims without proof that the client received qualifying DMC services for any given day?	Yes. However, services must still be delivered and documented. This will be confirmed when your agency's CPA conducts monitoring or if your agency is audited by DHCS. The requirements for residential day rates have not changed, only the billing for $0 services.
May we begin omitting $0 services this fiscal year or is this new policy beginning next fiscal year.	You may discontinue $0 billing now.
Since agencies are being instructed to bill only 1 unit of H2010M and H2010N, do we need to include the service duration in the billing?	No, the service duration is not necessary to include. Please note that starting FY 25-26, the maximum allowable units for both services will be changed to 1.

Open Q&A

Question	Answer
We received guidance from SAPC stating that agencies should be using H2014 rather than T1007. We have never received a denial for this code. Can you please clarify if both are allowable?	Please email sage@ph.lacounty.gov for clarification.
How can I distinguish whether a denial is local or from the state?	There are multiple ways of determining whether a denial is local or state denial. On the Sage website, in the Denial Troubleshooting section of the Sage Trainings-Finance page, there is a document called Quick Guide to Identifying Denials. It goes over an example of what denials look like in KPI. In Payment Reconciliation View, if the Claim Status column says "denied", it is a local denial. If it says "approved", that means it was approved locally. If the service was denied by the state, that column will still say "approved", but information will populate in the takeback fields to the right, showing that there was an amount taken back and the denial reason. On the EOB, if you see a "D" status, that is a local denial, and the denial reason will be underneath. For state denials, the status will be "A". On both the EOB and KPI, the state denial reason starts with "CO" followed by a string of numbers. As a secondary provider, instead of looking at the EOB, you may only receive an 835. This can be confusing because local denials also follow the "CO" code format and different loop segments can look similar. As each EHR is different, you may want to consult your vendor to help you identify what is a local or state denial.
As patients in ASAM 3.1 and 3.5 levels of care must reach a minimum number of treatment hours per week and must attend at least one 15-minute clinical session per day to bill for the day rate, can we still bill the day rate if the client has an excused absence (i.e. doctor's appointment)?	Even if the absence is excused, the day rate cannot be billed if no service was delivered on that day.
Does the money from late billing apply to the month we billed or to the month we are billing for?	There is a general billing deadline of the 10th of the month to receive payment by the 25th of the same month.

	For example, if a service was delivered in March, but not billed until early May (before May 10th), it would be included in your agency's payment on May 25th.
My agency has been receiving denial CO 97 M86 for services that are not duplicates and do not meet the criteria for rolling up? Could this be due to another State configuration issue?	There are no known configuration issues for duplicates currently. Please open a help desk ticket so that the SAPC finance team can investigate the denial.
Where can I find training resources for the KPI dashboard and the SFTP process?	On the Sage trainings page, there is a section for KPI resources that contains guides in pdf format, which can be found here: http://publichealth.lacounty.gov/sapc/providers/sage/kpi.htm . We currently do not have KPI training videos available. However, there are a lot of guides that contain guidance on how to use KPI for billing-related applications. If you need assistance with something specific on KPI, please ask our team for training on how to navigate to what you need. The SAPC Finance team does not have access to the SFTP and is therefore unable to provide training for the SFTP. You will need to contact SAPC-IT for this.
When I receive State denial CO 97 M86, do I need to void the original claim and resubmit it with the total number of units?	For secondary providers, please submit a replacement claim for the original service billed to SAPC that was not denied by DHCS. Replace the service with the multiple services rolled up into one service with the units totaled. For primary providers, use the Replacement Claim Assignment (CMS-1500) from in PCNX.
Should the HQ modifier be removed from H2014 for patient education services?	The HQ modifier is only used for group services and can be removed for individual services.
Can the residential day rate still be billed if a patient only receives a face-to-face care coordination service but no group sessions?	Care coordination is billed in addition to the day rate. To determine whether a service is part of the bundled rate or not, please refer to the DMC-ODS Levels of Care section of the DHCS DMC-ODS Billing Manual. If a service was provided to the patient that is listed as part of the bundled day rate, you may bill the day rate. However, if the patient only received care coordination, you cannot bill the day rate because it is not included in that list.
What is a partial takeback? How is this calculated and why was the second part taken back many months later?	There are some services where SAPC reimburses providers at a higher rate than the State reimburses SAPC. When that happens, the recoupment amount is the State amount, leaving a remaining payment for the Provider. To correct this, the remainder is taken back manually by SAPC. We are working to try to improve the speed with which we complete the manual process.

Why do all denials and takebacks appear on the billing history widget?	All denials and takebacks that affect you should be visible on the patient billing history widget. If there is something that you believe is missing, please open a Sage help desk ticket using the Request Billing Assistance form and provide examples.
Can we bill for the day rate on the date of discharge?	According to the State, you can bill for the day rate on the date of discharge. However, they did not address cases where the patient is admitted to another level of care on the same day. Currently, if a patient has billing for discharge and admission on the same day, one of the claims will be denied. SAPC is currently working with the State to make both allowable.
Are room and board and RBH billable on the date of discharge as well as the date of intake?	Room and Board and RBH should not be billed on the date of discharge.
Please clarify whether 99415 is a billable code for psychiatry assessment services under ASAM 3.1? If so, does it apply only to the initial assessment or are follow-up appointments also billable?	99415 is one of the codes that have been deactivated for residential levels of care because it is part of the bundled day rate.
Where in PCNX can we check if the women's health form has been entered?	Simply navigate to the Women's Health History form in PCNX to see if there is an existing record. Click edit record and enter the client ID and episode number. If there are any records, they will appear in the dropdown list in the Selected Record field.
If a Medi-Medi patient's services are denied with CO 177 for a date of service in FY 23-24, can we resubmit these claims directly to SAPC based on the new guideline if the services do not have "Medicare COB required" in the Matrix?	This will depend on what level of care the patient is in. On the billing rules tab of the matrix, there is a field that says, "Medicare COB required". This field indicates whether the service must be billed to Medicare first. If it says no, you should be able to bill it to Medi-Cal without receiving a denial related to Medicare billing. Please note that if the person is in ASAM OTP, the service must be billed to Medicare first. Medi-Medi denials are often sent with a different denial reason than CO 177, so there may be something else that is incorrect in the Medi-Cal record. Please open a Sage Help Desk ticket using the Request Billing Assistance form.
For Medi-Medi patients, how can we request a denied COB response?	For specific billing questions and questions about claims, medical records, or expenses, call Medicare at 1-800-MEDICARE. For questions about Medicare Enrollment in order to bill Medicare services, please reach out to a Medicare Administrative Contractor (MAC). To find a designated MAC, go to: https://www.cms.gov/medicare/enrollment-

	renewal/providers-suppliers/chain-ownership-system-pecos/medicare-enrollment-assistance-contacts and click on the "Find and contact your MAC (PDF)" link.
When a client is enrolled in an outpatient level of care and receiving recovery services, what level of care modifiers should I choose?	The U6 modifier indicates that the service is a recovery service. The second U code is dependent on the kind of certification the site has. You would bill the U code associated with what level of care your site is able to deliver for.
What is location code 57?	Place of service code 57 indicates a "Non-residential Substance Abuse Treatment Facility". Specifically, place of service 67 is "A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing." For a full list of place of services code and their descriptions, please refer to the Place of Service tab in the Rates and Standards Matrix.
When my agency had MyHealthLA, we were instructed to bill clients with MyHealthLA coverage under Medi-Cal upon transferring to a recovery services level of care. Is this correct?	Incorrect, continue to bill under the Non-DMC guarantor.