Los Angeles County
START-ODS
System Transformation To Advance Recovery and Treatment

sage
SUD Electronic Information System

Guide to Claims Denial Resolution

July 2025 | Version 5.0

SAPC | Substance Abuse Prevention and Control

County of Los Angeles Public Health

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Introduction

The Guide to Claims Denial Resolution aims to assist treatment providers with identifying Local and State denials, claim denial definitions, and denial resolution steps. Claims submitted to SAPC undergo an adjudication process which results in an approval or denial of services. Approvals are paid by SAPC to the provider and then sent to the State for a second level of adjudication. Both Local and State denials are categorized by Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC). CARCs and RARCs are nationally recognized, federally standardized code sets used by U.S. health payers to report payment adjustments including denials.

The Sage Claim Denial Reason and Resolution Crosswalk (Denial Crosswalk) addresses both Local and State denials. Depending on whether a provider is a Primary or Secondary Sage User will impact how the Denial Crosswalk will be utilized.

Denial Types

1. **Local (SAPC):** Denials that occur immediately when the claim is received and adjudicated within Sage. These initial adjudication rules are based on eligibility, policy, and program standards established by Drug Medi-Cal (DMC), the SAPC Provider Manual, and the Rates Matrix.
    a. The claim status in Sage for these claims will always show as “denied,” regardless of whether the billing was resubmitted and subsequently approved.
2. **State:** Claims that were approved by SAPC but subsequently denied by the State. The State adjudication system verifies claim information against the DHCS database, which is comprised of patient information entered at Medi-Cal enrollment as well as the billing rules set by Department of Health Care Services (DHCS) and Centers for Medicaid and Medicare Services (CMS). At the State level, claims are generally denied due to eligibility, invalid information, or not following other Drug Medi-Cal (DMC) standard(s). For these denials, the provider has already been paid on the claim by SAPC and denied amounts are deducted from future payments.
    a. State denials will show with a claim status of “approved” as the reference to claim status in Sage is the Local adjudication status. Even if a claim was taken back by SAPC, the status will still show “approved” but will show a takeback amount with a State denial code in PCNX and KPI.

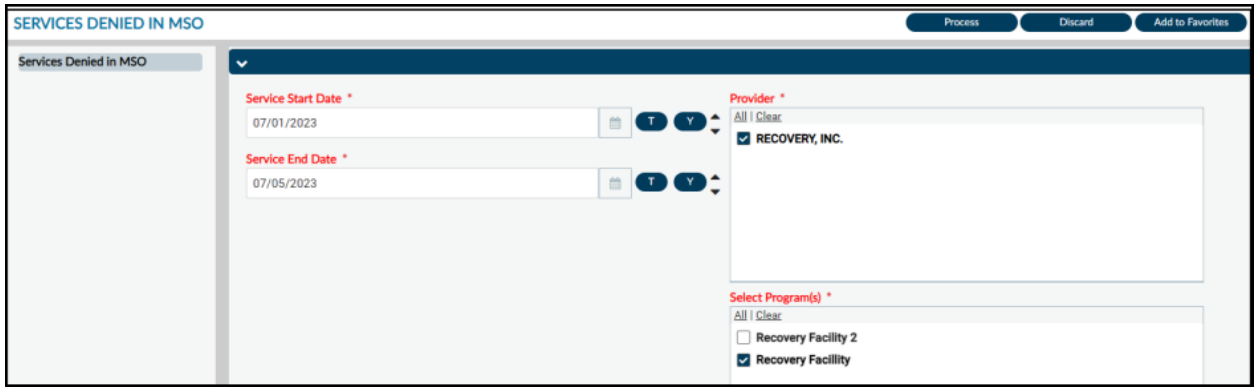
Denial Identification

The first step in denial troubleshooting is to identify which claims were denied. There are several reports, dashboards, and widgets available in Sage to review both Local and State denials. For more detailed information on how to read the reports and widgets, please refer to the PCNX Guide to Reports and PCNX Guide to Widgets located on the SAPC Sage website. The following information

provides details on the variety of reports available in PCNX and KPI that can be utilized to identify denied claims. Providers can determine the reports that fit the needs of the agency best.

Local Denials

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.



County of Los Angeles Public Health

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

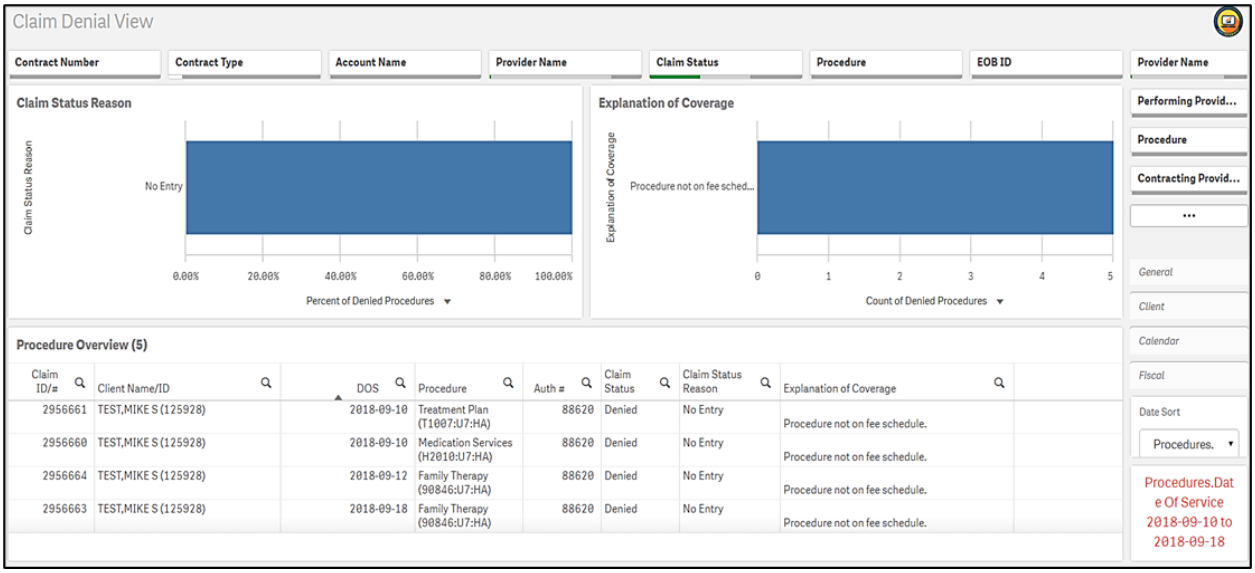
Print Date: 9/5/2023

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

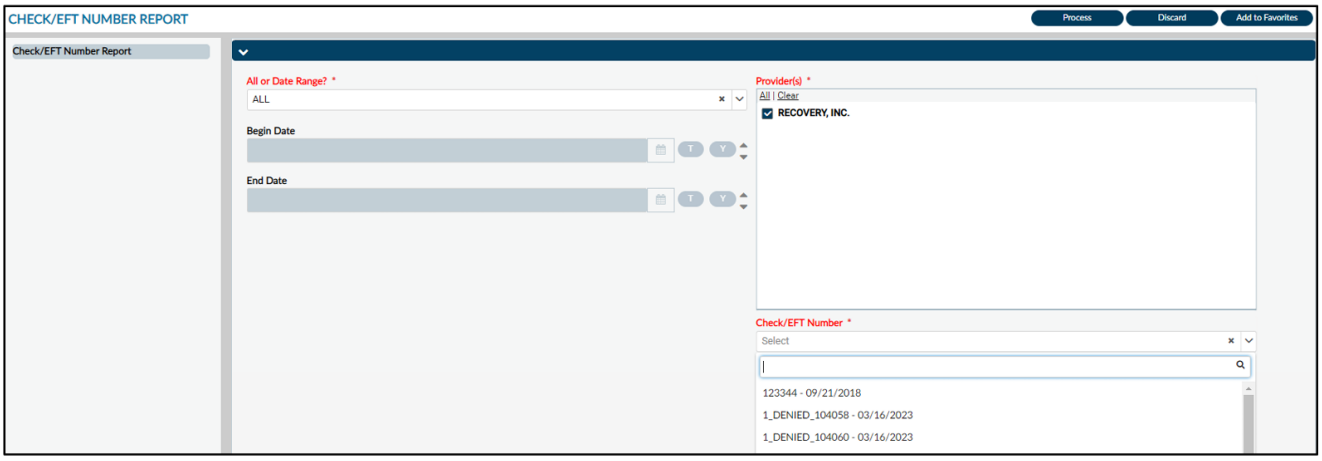
Agency	Member ID	Service Date	Reason for Denial	Service	Amount
Recovery, Inc.	161057	7/1/2023	The service was denied for the following reason: Date of Service is Outside of Authorization Date Range	Family Psychotherapy (Without the Patient Present) (90846:U7)	$ 45.61
Recovery, Inc.	161118	7/1/2023	The 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

MSO KPI Dashboard 2.0 – Claim Denial View: This sheet 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. The view is split into three sections:

- Claim Status Reason: This section provides a graph for the denial reason that is assigned to a denied claim. If a denied claim does not have a denial reason, it will have an explanation of coverage to explain the denial. Providers have the option to see Claim Status Reason graph displayed by Count of Denied, Amount Denied, or Percent of Denied.
- Explanation of Coverage: This section displays a graph by Explanation of Coverage for claims that were denied due to not meeting certain rate, treatment or contract standards that have been set by DMC and/or SAPC. Providers have the option to see Explanation of Coverage graph displayed by Count of Denied, Amount Denied, or Percent of Denied.
- Procedure Overview: This section provides detailed service/claim information for any filters selected by the user. The table is coded to only show denied services.



Check/EFT 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).



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

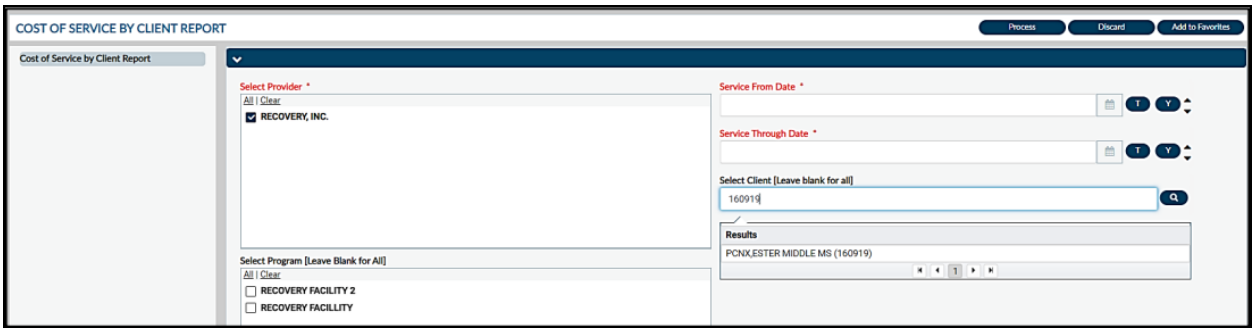
Batch #	Program	Client ID	Date of Service	CPT Code	Claim Status	Explanation of Coverage	Amount Billed	Approved Payment
22668								
	Recovery Facillity							
		160851	2/25/2023	Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used	Denied	The service was denied for the following 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

Local and State Denials

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:

A. **Local Denials:** A "D" shown in the **A/P/D** column indicates a Local denial.

- **State denials:** A denial reason code displayed in the **Retro Reason 1/Retro Reason 2** column starting with the word "Denial" indicates a State denial. The retro date, retro amount, and retro EOB ID columns provide more detail on how much was recouped, the date it was recouped, and the EOB number the recoupment can be found on.



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	Units Billed	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,ESTE R 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,ESTE R 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,ESTE R 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,ESTE R 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,ESTE R 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,ESTE R 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,ESTE R MIDDLE MS	160919	12/10/202313278	23457	H0005:U7	TEST,PRACTITIONER	4.00	A	206.32	206.32	206.32	0.00	0.00	P12275					
Recovery, Inc.	Recovery Facility	PCNX,ESTE R MIDDLE MS	160919	12/10/202313277	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

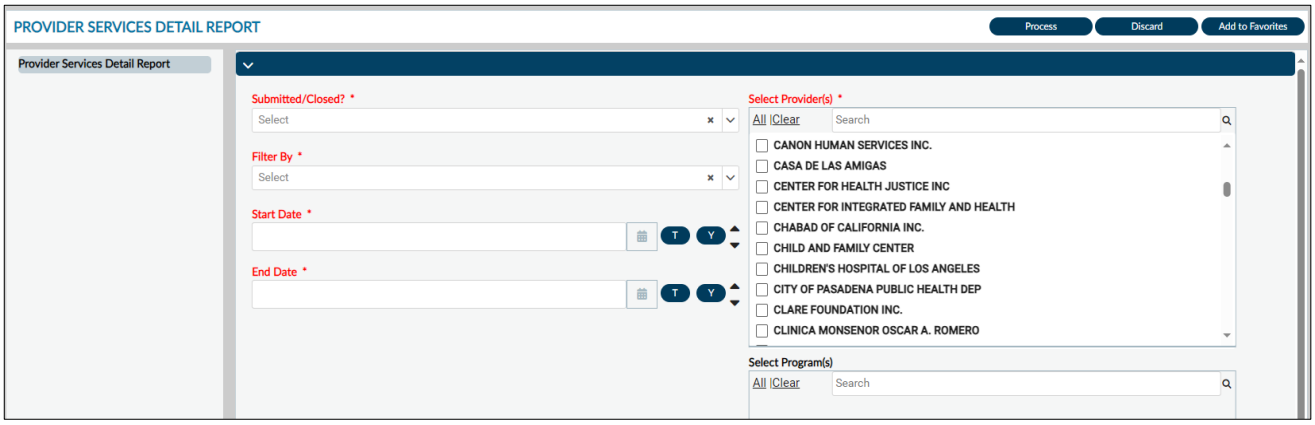
Recovery, Inc. (1) TOTALS :

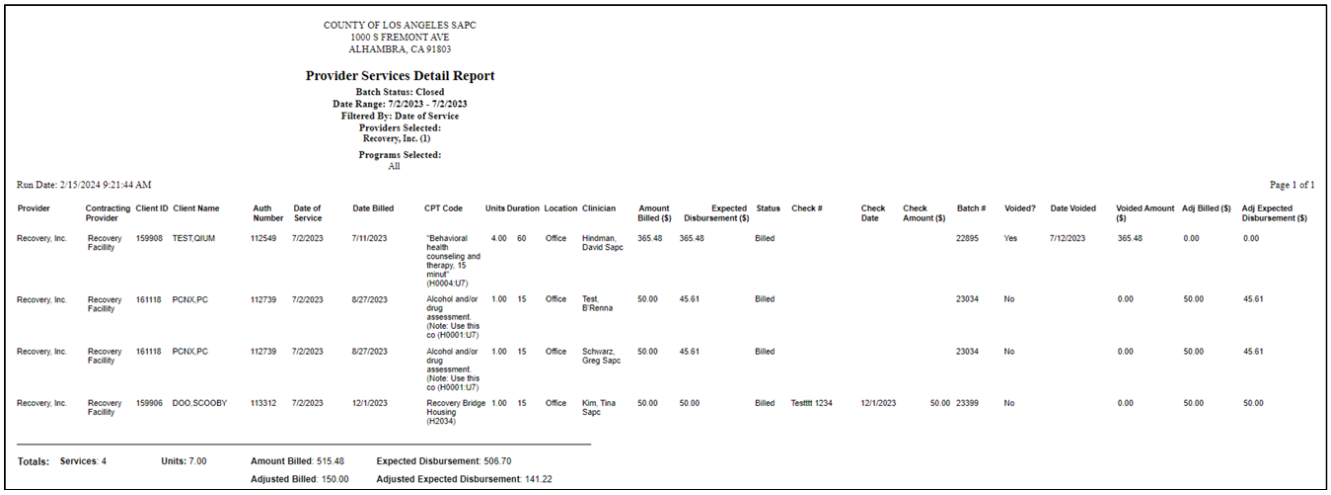
Total Amount Billed: $2,160.46

Original Expected Disbursement: 2,160.46

Updated Expected Disbursement: 219.14

Provider Services Detail Report: This report lists billed services for a given period including the amount billed, expected disbursement, and if a check number is associated with a service. This report can be used to determine how much was billed, paid, and denied for a given data range of service, as well as to track how much billing is submitted within a given period.





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

Provider Services Detail Report

Batch Status: Closed
Date Range: 7/2/2023 - 7/2/2023
Filtered By: Date of Service
Providers Selected:
Recovery, Inc. (1)
Programs Selected:
All

Run Date: 2/15/2024 9:21:44 AM

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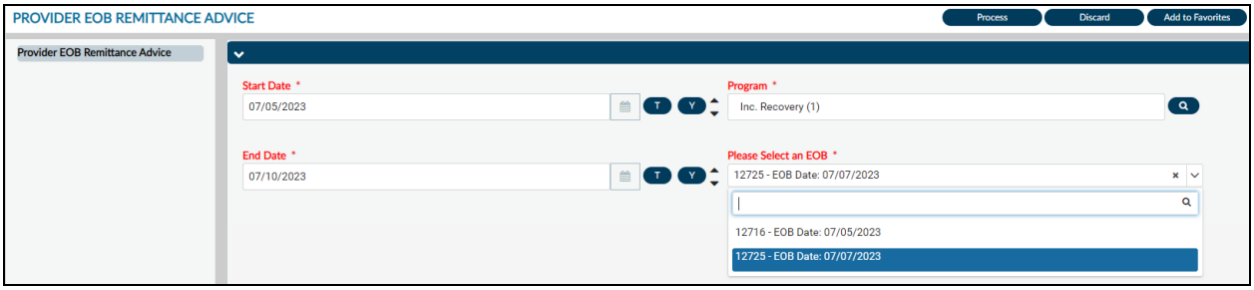
Provider	Contracting Provider	Client ID	Client Name	Auth Number	Date of Service	Date Billed	CPT Code	Units	Duration	Location	Clinician	Amount Billed ($)	Expected Disbursement ($)	Status	Check #	Check Date	Check Amount ($)	Batch #	Voided?	Date Voided	Voided Amount ($)	Adj Billed ($)	Adj Expected Disbursement ($)
Recovery, Inc.	Recovery Facility	159908	TEST,QIUM	112549	7/2/2023	7/11/2023	"Behavioral health counseling and therapy, 15 minut" (H0004:U7)	4.00	60	Office	Hindman, David Sapc	365.48	365.48	Billed				22895	Yes	7/12/2023	365.48	0.00	0.00
Recovery, Inc.	Recovery Facility	161118	PCNX,PC	112739	7/2/2023	8/27/2023	Alcohol and/or drug assessment. (Note: Use this co (H0001:U7)	1.00	15	Office	Test, B Renna	50.00	45.61	Billed				23034	No		0.00	50.00	45.61
Recovery, Inc.	Recovery Facility	161118	PCNX,PC	112739	7/2/2023	8/27/2023	Alcohol and/or drug assessment. (Note: Use this co (H0001:U7)	1.00	15	Office	Schwarz, Greg Sapc	50.00	45.61	Billed				23034	No		0.00	50.00	45.61
Recovery, Inc.	Recovery Facility	159906	DOO,SCOOBY	113312	7/2/2023	12/1/2023	Recovery Bridge Housing (H2034)	1.00	15	Office	Kim, Tina Sapc	50.00	50.00	Billed	Testttt 1234	12/1/2023	50.00	23399	No		0.00	50.00	50.00

Totals: **Services**: 4 **Units**: 7.00 **Amount Billed**: 515.48 **Expected Disbursement**: 506.70
Adjusted Billed: 150.00 **Adjusted Expected Disbursement**: 141.22

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.

- **Local Denials:** The "D" in the Status column indicates that the service was denied at the Local level and the denial reason is indicated below the service line. The second image below shows examples of how Local denials display on an EOB.
- **State Denials:** An Adjustment Reason column will display with a denial code for claims denied by the State resulting in a retro adjudication. This EOB is often referred to as a retro EOB and will have an "Adjustment Notice," banner that includes the adjustment amount and adjusted EOB total on the first page. The Status column will still reflect an "A" for approved, as this claim was approved at the Local level. The third image below shows how State denials appear on an EOB.



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

Adjustment Notice
An adjustment of $ -4068.85 has been applied to this payment.

Current Claims:
Adjustment: -4068.85
Adjusted EOB Total: -4068.85

Detail Adjustment Information for EOB Number: 17282

Original Service Information

Orig EOB
14430

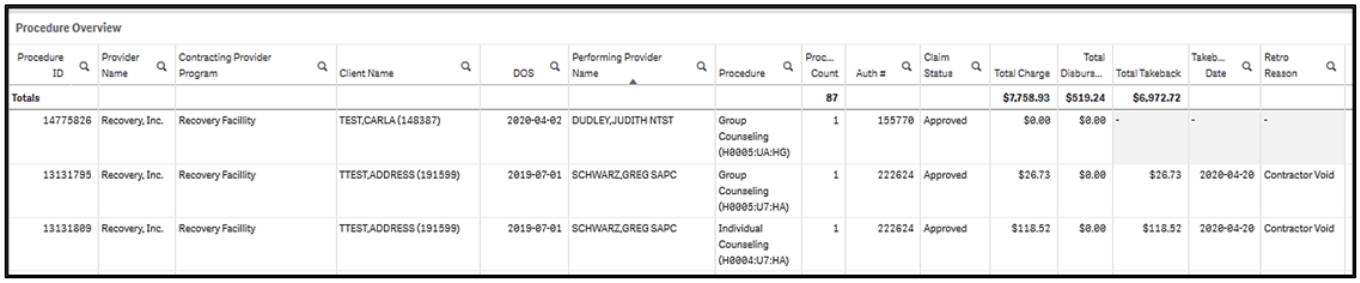
Adjustment Information

Client Name (ID):TEST,NEWYEAR (162341) **DOB: 1/1/1980** **Gender: F**

Batch.SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
24653SVC.00001	6/2/2024	H0005:U7	115028	A	14.83	14.83	10/15/2024	$-14.78	Denial Co 167 N30
					14.83	14.83		-14.78	
Batch.SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
24670SVC.00001	6/1/2024	H0025:U8	115029	A	12.45	12.45	10/15/2024	$-12.45	Denial Co 167 N30

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

- **Local Denials**: A "Denied" in the **Claim Status** column indicates a Local denial.
- **State Denials:** A denial reason code, for example – "Denial CO 177", listed in the Retro Reason column indicates a State denial. The Total Take Back, Takeback Date, and Retro EOB ID columns will also be populated when a State denial has occurred.



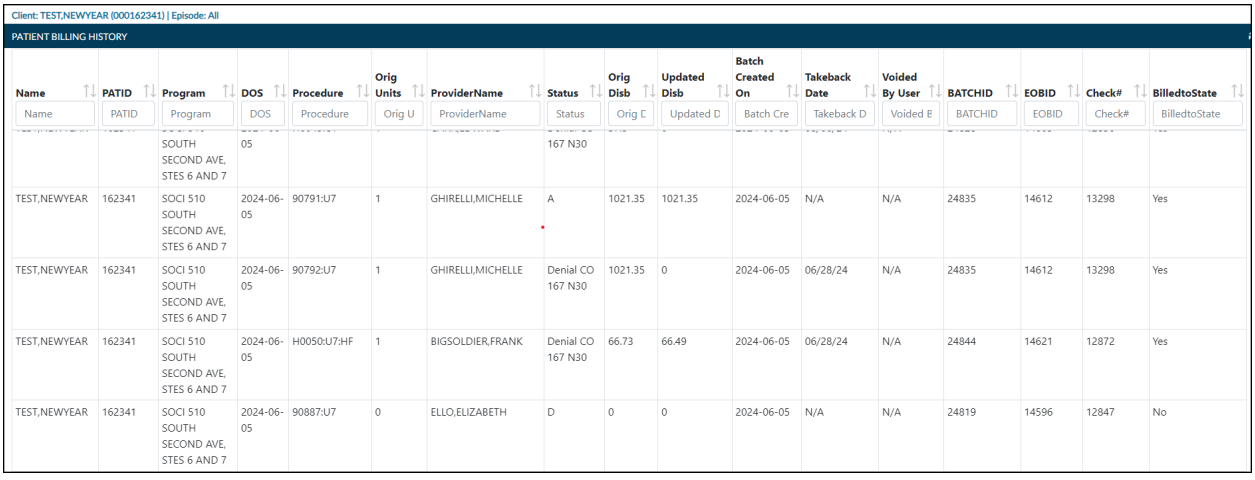
Procedure Overview

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	155770	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

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

B. **Local Denials:** A "D" shown in the **Status** column indicates a Local denial.

- **State Denials:** A Denial Reason code (example - Denial CO 177) displayed in the **Status** column indicates a State denial. The **Updated Disbursement** (Updated Disb) column should be 0, and the takeback date is listed for when the payment was recouped. Batch ID, EOBID, Check ID columns will not update with the State denial information and will only show information related to the Local claim approval.



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

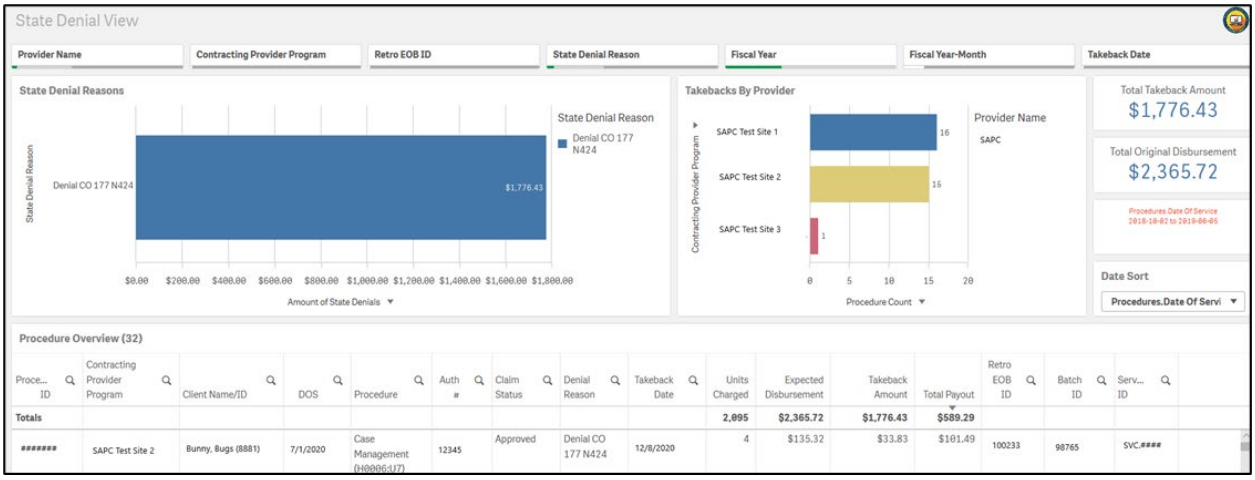
PATIENT BILLING HISTORY

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

State Denials

MSO KPI Dashboard 2.0 - State Denial View: This sheet provides information for claims that were denied by the State. There are 3 main sections: State Denial Reason, Takebacks by Provider, and Procedure Overview.

- State Denial Reasons: This graph provides a summary of the amount of services and dollars based on the State denial codes. Providers have the option to see State Denial Reason by Count of State Denials or Amount (dollars) of State Denials.
- **Takebacks By Provider:** This section summarizes the takebacks by program sites. Providers have the option to view Takebacks by Procedure Count or Takeback Amount.
- **Procedure Overview:** This section provides a detailed listing of the specific procedures that were denied by the State. The **Denial Reason** column will display the State denial code. Other relevant fields to note are Takeback Date, Takeback Amount, Total Payout and Retro EOBID. The Takeback Amount is the dollar amount that was taken back by SAPC due to the claim being denied by State; this could be the full disbursement amount or a partial takeback. The Total Payout is the difference between disbursement and takeback amounts.



Secondary Sage Users

Secondary Sage Users can access all of the above PCNX reports and KPI views. Secondary Sage Users also receive denial information through the 835 file received from SAPC via the SFTP. After 837P/I files are adjudicated in Sage an Explanation of Benefits (EOB) is created. Once the EOB is paid by SAPC, the check number is entered in Sage which triggers an 835 file to generate. The 835 file contains the denial code (for Local and State). The denial reasons in descriptive format are not included on an 835 but can be viewed in PCNX, KPI, or EOBs. Secondary Sage Users can use the Denial Crosswalk to identify the denial reason and needed resolution steps to resubmit or replace the claim. For more detailed information on to view denial reasons on an 835 file for both Local and State denials, please review the HIPAA 837P Companion Guide located on the SPAC website.

Common Denials and Correction Procedures

The below categories refer to the most prevalent denial reasons for both Primary and Secondary Sage Users. Understanding the common errors that cause denials for these broad categories and applying the accompanying troubleshooting steps to claims prior to being submitted to SAPC may greatly reduce errors and denials, leading to increased approval rates and improved efficiencies related to investigating claim denials.

Common Local Denial Categories	Common State Denial Categories
• Financial Eligibility	• Medi-Cal Eligibility
• Agency/Site/Performing Provider Configuration Issues	• Medicare / Medi-Cal Patients
• Authorization	• Performing Provider Taxonomy
• Date Error	• Duplicate Service
• Diagnosis	
• 837 File Formatting and Submission Errors (Secondary Sage Users Only)	

Most claims denied at the Local and State level can be corrected and replaced. This section will review the most common denials at the Local and State levels, how to fix the denials, and new/updated State denial information. As most denials fall into one of these categories, providers can minimize denials and/or more easily correct denials by first verifying information in each of these areas. Generally, Primary and Secondary Sage Users will have the same category of errors leading to denials, however, the investigation and correction steps will differ substantially between Primary and Secondary Sage Users.

Eligibility

Common Local Denial Reasons: Eligibility Not Found/Verified in CalPM

Common State Denial Codes: CO 177, CO 22 N479

Local Denials

Local denials related to eligibility are due to errors on the Financial Eligibility form for the patient and are most often received as a Local denial for “Eligibility Not Found/Verified in CalPM”. Both Primary and Secondary Sage Users must complete the Financial Eligibility Form in Sage, which is how SAPC determines financial liability for services rendered. Additionally, for

Medi-Cal beneficiaries, the information entered on the Financial Eligibility form is sent on the claim to DHCS and if errors are made on the form, the State will likely deny the service. The following areas of the Financial Eligibility Form will result in denials if not completed correctly:

A. Verify that the patient's Financial Eligibility Form is complete and has been submitted.
B. For the Drug Medi-Cal Guarantor, ensure that form includes:
    a. Subscriber Client Index # (for the correct patient)
    b. Subscriber Sex (The State will only accept Male or Female).
    c. Subscriber Date of Birth (that matches the DOB on file with the State)
    d. Subscriber Address Line 1, State, City, Zip Code
        i. For patients who are experiencing homelessness, the Local Department of Public Social Services (DPSS) office address should be used.
    e. Eligibility Verified: Providers must verify eligibility prior to accepting a patient.
        i. Select “Yes”.
    f. Coordination of Benefits, select “Yes”
    g. Subscriber Assignment of Benefits, select “Yes”
    h. Coverage Effective Date must be on or before episode admission and on or before first date of service.
    i. Coverage Expiration Date is either blank or must be after the date of service billed.

C. Use the CALPM Eligibility Check widget to confirm if any errors were made on the form. This widget populates the most common errors found in Sage, including if:
    a. Eligibility Verified is marked No
    b. Coverage Expiration Date is prior to the date of service
    c. Missing CIN on the DMC guarantor

    If any of the issues that lead to eligibility denials are met, the patient will show on the widget, indicating the claim will deny. It is best practice to review this widget before submitting billing.

State Denials

The most frequent State denials encountered for the treatment network are related to Medi-Cal eligibility. Most often, these denials are caused by one of the following issues:

- Incorrect information on the patient’s Financial Eligibility DMC guarantor, such as:
    - Wrong CIN
    - Date of birth doesn’t match Medi-Cal
- Patient’s aid code does not cover DMC-ODS services
- Patient did not have eligibility for the dates of service and/or had a gap in coverage

To avoid DMC eligibility issues related to outdated information, providers are required to run the Real-Time 270 Eligibility Request upon admission and monthly while the patient is receiving services. Running the Real-Time 270 Eligibility Request updates the MEDS file, which is the primary file of Medi-Cal eligibility to show the most current eligibility information.

A significant portion of State denials are related to incorrect or invalid DMC eligibility. This may have been related to a patient having an OHC, out of county Medi-Cal, or there was a data entry error with the CIN, so the State would be comparing the Financial Eligibility information against the wrong CIN.

Agency/Site/Performing Provider Configuration Issues

Common Local Denial Reasons: Procedure Not on Fee Schedule; Performing Provider is Blank

Common State Denial Codes: CO 208 N290, CO 208 N297, CO 96 N54

These types of denials are related to performing providers or sites not having the correct configuration or authorizations to perform the service. At the performing provider level, this occurs because the performing provider type does not have the correct license type to perform the service. For example, a provider other than a Certified Peer Support Specialist tries to bill for H0025 which is only deliverable by a Certified Peer Support Specialist. At the program site level, this denial occurs because Sage is not configured to allow the provider agency or site to perform that service. For example, a program with multiple sites, bills the service to an incorrect site that is not on the patient's authorization. For Secondary Sage Users this denial can also occur from submitting an 837 file with an invalid or missing procedure code. The resolutions for each type of denial are below.

A. **Performing Provider**
    a. Confirm on the Rates Matrix that the performing provider is allowed to bill for the service.
    b. Contact the Sage Help Desk to confirm the discipline/license type listed in Sage for the performing provider as it may need correction.

B. Program/Site
    a. Use the site listed on the authorization or submit a corrected authorization if incorrect.
    b. Campus Providers: Use an NPI from a site in the agency that provides the same level of care.
    c. RBH sites: Contact your CPA to use your "fake" NPI since site is not DMC certified.

d. Contact your CPA to confirm contract includes that level of care and/or type of service.

C. Secondary Providers

a. Enter or correct the procedure code type as shown on the 837 file, 2400 loop, SV1 segment, SV101 elements.

Rate Not Identified for Procedure: CO 96 N54

DHCS uses CO 96 N54 for services that that do not have a rate in their system based on the procedure code, and modifiers or provider type. This code is commonly related to issues with the taxonomy of the performing provider. To resolve CO 96 N54 denials, review the rates matrix to confirm the service code has a rate for the performing provider type. Call the Sage Help Desk to confirm that performing provider has the appropriate license type and taxonomy listed in the system.

Authorization Errors

Many authorizations are submitted with incorrect information related to dates, contracting provider program (program address), benefit plan, or funding source. Errors on the Service Authorization Request form may result in various denial reasons, depending on if the error was a data entry error or an issue with services not being contracted with SAPC.

Issues related to authorizations can be resolved by contacting the SAPC Quality Improvement and Utilization Management (QI & UM) directly at (626) 299-3531. Providers should contact the Sage Help Desk at (855) 346-2392 for system issues that cannot be corrected by QI & UM.

Common errors to be validated on the Service Authorization Request form are as follows:

A. Funding Source is incorrect.

a. "Drug Medi-Cal" must be selected for all DMC enrolled patients receiving DMC reimbursable services at a DMC certified/licensed program site.

b. "Non-Drug Medi-Cal" must be selected for patients who are applying for Medi-Cal or do not have Medi-Cal at the time of authorization.

i. Once a patient is enrolled in Medi-Cal, a new authorization must be requested.

ii. This source must be selected for patients enrolled in a County program such as AB109, CalWORKS, and General Relief that are not enrolled in DMC.

iii. This source must be selected for authorizations for Recovery Bridge Housing, regardless of the patient's DMC status.

B. Start and End Dates inconsistent with billing.

a. Providers must verify that the start and end dates on the authorization are consistent with the actual dates of service being billed.

C. **Incorrect Contracting Provider Program.**
    a. If the program site on the authorization is different than the program site on the service claim, the service will deny.
    b. This field will be blank on an approved authorization for agencies configured as an approved campus provider. This is allowable only for campus providers. If the agency is not a campus provider and the field is blank, contact SAPC QI UM for assistance.

D. **Incorrect benefit plan.**
    a. If the level of care modifier billed on the service does not match the benefit plan on the patient's authorization, the service will deny.
    b. If the benefit plan on the authorization is not an approved and contracted level of care for the agency, the services will deny and a new authorization must be requested for the patient with the correct level of care.

E. **Incorrect authorization number used for billing.**
    a. **Primary Sage Users:** If the incorrect authorization number was entered in PCNX when billing, the services may deny. The services can be replaced and the correct authorization selected.
    b. **Secondary Sage Users:** It is important for Secondary Sage Users to ensure their electronic health record (EHR) system contains accurate authorization numbers. This is particularly of concern for patient authorizations that cross fiscal years as two separate authorizations will be issued for the patient.

Date Errors

This group of denials relates to errors in admission dates, services dates, claim submission dates, or authorization dates. Providers need to ensure the following dates are correct before submitting claims or when a claim is denied due to a date inconsistency.

A. Service date must be on or after the SAPC contract effective date for the agency/program site. SAPC Contract Management and Compliance will provide an effective date when providers can officially receive an approved authorization and submit claims for reimbursement. Services provided before that date will be denied.
B. Services claimed with a date of service before the date of diagnosis will be denied.
C. Authorization start and end dates must match the dates for the service period.
D. Financial Guarantor Coverage Effective Date must be either prior to or the same as the service to be reimbursable by that guarantor. Financial Guarantor Coverage Effective Date must not be after the service date.
E. Coverage expiration date is only entered for a given guarantor if the actual date the patient lost or will lose coverage for that guarantor is known. Any service occurring after the coverage expiration date for a primary guarantor will be denied.

a. This field should only be completed:
    i. When a patient loses Medi-Cal eligibility, and it is not reinstated.
    ii. For Applying for Medi-Cal when the patient becomes enrolled in Medi-Cal.

F. Date of service violates the State's Same Day Billing matrix and was either a duplicate entry or cannot be billed on the same day as another service that was already approved.
    a. This can occur for admission and discharge claims when a patient is transferring to a different level of care or provider.

Diagnosis

This group of denials is related to errors, invalid entries, or unsupported diagnoses on the Provider Diagnosis (ICD-10) Form in Sage, which is required to be completed for both Primary and Secondary Sage Users. The following items must be present and correct, or the claim will be denied:

A. All patients must have an admission Type of Diagnosis on the Provider Diagnosis (ICD-10) form in the system. If there are only "update" diagnosis types in the system, this will cause a denial.
B. The admission diagnosis date must be on or before the date of service. When providers enter an admission diagnosis, it will automatically populate the date as the episode start date.
    1. If the provider changes the admission diagnosis date to a date after the date of service, the claim will be denied.
    2. If the admission diagnosis date and the episode start date match, but are after the service date, the episode must be corrected before the claim can be resubmitted.
C. The principal diagnosis must be a DMC approved diagnosis. A list is available on the SAPC website and DHCS publishes approved diagnosis through MHSUDS Information Notices.
D. Diagnosis ranking and billing order must match. This means that each of the primary, secondary, or tertiary diagnoses listed must have the same billing order of 1, 2, or 3. The primary diagnosis must be a substance use related diagnosis.

837 File Formatting and Submission Errors

This group of denials only applies to Secondary Sage Users who submit claims via an 837 Electronic Data Interchange (EDI) file transaction. In addition to the above general denial themes for all providers, denials related to this category have two additional primary reasons that are not related to contractual or benefit issues: 1) file formatting errors; and 2) missing/invalid information entered.

The main issue related to the file format relates to extraneous characters or spaces pulled from the EHR system of Secondary Sage Users or the default system configuration where the file does not conform to the requirements in SAPC's Companion Guide. This may occur when the system is used for multiple payors, funding streams, county agencies, etc. where each may have variations on the formatting requirements. The file format is specific to each managed care organization and needs to be formatted according to the specific guidelines in the companion guide for that organization.

The 837P and 837I companion guides were created to inform Secondary Sage Users how to create the 837P/837I file with the correct format to avoid these errors. Generally, the 837 files are compiled from the EHR itself with information entered into the patient's medical record and provider billing information. There are certain defaults that can be added to each 837 file that may contain errors or if information is missing from the medical record, it will not populate to the required Loop-Segment-Element on the file.

Many denials for Secondary Sage Users will show as "CO 16," which is defined as "claim/service lacks information which is needed for adjudication." This may also be accompanied by a remark reason of "missing/incomplete/invalid" required value. This likely occurs as Secondary Sage Users must manually enter information from Sage into their own system, as well as communicate certain information to be in the Sage system. This includes authorization information, contact information, and the National Provider Identifier (NPI) number(s) associated with the performing or billing provider. If any of this information is not entered, entered for the wrong patient, or mistyped in either system, it will result in denials. Any discrepancies between information in Sage and information on the claim will lead to these denials.

It is important for Secondary Sage Users to check for authorization updates (which can be done in Sage using the Authorization Request Status Report) during fiscal year cutovers and for reauthorizations as these will create new authorization numbers. These new authorization numbers must be manually entered in the EHR system of Secondary Sage Users before submitting the 837 file. Providers should use their error reports, if available in their EHR, when creating an 837 file to identify these errors in advance of submitting.

Additionally, if there are inconsistencies between the Financial Eligibility in Sage and the Secondary Sage Users' EHR, this may result in denials.

Roll Up Services: CO 97 M86

Beginning FY 23-24, providers are required to submit services (those with the same HCPCS or CPT Code), occurring on the same day, and performed by the same performing provider to the same patient as a consolidated single service. This is known as a roll up service. Each service must meet the midpoint rule independently to qualify to be included in the billing as a roll up. Units billed should not be based on the combined total duration time but on each individual service duration time meeting the midpoint rule.

For example, a performing provider who provides 30 minutes of care coordination in the morning (onsite) and 30 minutes of care coordination (via telephone) in the afternoon to the same patient on the same day, must claim this as one claim of 60 minutes of care coordination for the day. Providers who fail to do this will receive a CO 97 M86 denial on the claim once adjudicated by the State.

To correct these denials, Primary Sage Users should submit a replacement claim using the Replacement Claim Assignment (CMS-1500) form in PCNX for the original service billed to SAPC that was not denied by DHCS. For each date of service, combine the total units of the two (or more) service lines, into one service, and resubmit. Secondary Sage Users should submit a replacement claim for the original serviced billed to SAPC that was not denied by DHCS. Resubmit the service with the two (or more) services rolled up into one service with the appropriate number of units.

Add-On Service Issues: CO 107

For add-on services, providers are required to bill the primary service code before adding the add-on service code. The Sage system will deny the add on code if billed separately from the primary code. Secondary providers are required to have add-on claims added to the secondary service line segment (LX) with its associated primary code on service line segment (SV1). The dependent code must be on the same claim number as the primary code. The secondary service cannot exceed the duration of the primary code.

To resolve this issue, Primary Sage Users must submit a replacement claim using the Replacement Claim Assignment (CMS-1500) form in PCNX, replacing the primary service code that was approved and add the add-on service code to the claim. Secondary Sage Users should submit a replacement claim for the original serviced billed to SAPC that was not denied by DHCS and include the add-on service code in the replacement claim. If the resolution listed above does not work or does not apply, open a Sage Help Desk ticket to request assistance.

Taxonomy Related Issues: CO 96 N95, CO 16 N288, CO 208 N297

Starting in FY 23-24, DHCS is requiring the taxonomy code of the performing provider who delivered the service to be on the claim. Taxonomy codes are unique 10-character codes that are used by healthcare providers to self-identify their specialty. A few examples of issues related to performing provider taxonomy are:

A. A claim will be denied with CO 96 N95 if the rendering provider's taxonomy does not match the first four alpha-numeric characters of a taxonomy code allowed for that service code.
B. If the taxonomy code is not added to the providers profile within Sage the claim will be denied with CO 16 N288.
C. For services performed by clinical trainees, the supervisors NPI must be included in the clinical trainee's Sage profile or the claims will get denied with CO 208 N297.
D. DHCS often sends denial CO 95 N54 , as the primary denial code in combination with one of the codes listed above as the secondary denial.

To resolve taxonomy related denials, first call the Sage Help Desk to confirm the correct performing provider type and taxonomy is associated to the performing provider. If incorrect, update the provider's Sage profile using the SAPC Sage User Creation Form on the Sage Help Desk online portal. For more detailed information on creating or modifying a user's profile, review the 07/19/24 Sage Communication or reach out to your programs associated CPA.

Critical Eligibility-Related State Denials

Medi-Cal Eligibility: CO 177

Medi-Cal eligibility denials, CO 177, occur when beneficiary has not met eligibility criteria as required by DHCS. Reasons for the denial code are:

A. The patient did not have active Medi-Cal for the month of service(s)
B. The Aid Code does not cover DMC services
C. There is Other Healthcare Coverage (OHC) that should have been billed first
D. The County Code is not Los Angeles County (19), pre 7/1/2021
E. The County of Residence or County Code is not Los Angeles County, effective 7/1/2021
F. The Client Index Number is incorrect on the Financial Eligibility (usually an inverted number)

Providers are required to verify Medi-Cal eligibility prior to admission and at the beginning of every month. A record of this verification must be kept on file either within Sage or at the agency. All Medi-Cal certified providers can conduct this verification using one of the following processes:

i. Real-Time 270 Eligibility Request within Sage

ii. Automated Eligibility Verification System (AEVS)
iii. DHCS Medi-Cal eligibility transaction

For services covered by both an OHC and Drug Medi-Cal (DMC), the patient's OHC must be billed prior to billing DMC in the majority of cases. Medi-Cal is a payor of last resort, which means that Medi-Cal beneficiaries with an active OHC that covers SUD services are required to exhaust their OHC benefits prior to using their DMC benefits. Providers are not allowed to deny Medi-Cal beneficiaries health services based on their potential third-party liability.

In addition to the Medi-Cal verification eligibility methods previously listed above, Availity, a free website used to verify patient benefits, claim submissions, claim status, and authorizations, can be used to determine if a patient as on OHC that's required to be billed first. When verifying eligibility using AEVS, the Eligibility message sections will include OHC information in the form of OHC codes which indicate if OHC will need to be billed first.

If claims are denied by the OHC, or there has not been a response after 90 calendar days from the billing date, then claims can be billed to SAPC and must include a COB from the OHC Medicare. For more information on billing for patients who have OHC, read the Other Health Coverage Provider Billing Manual located on the SAPC website.

To resolve CO 177 denials, ensure the eligibility criteria has been met for the beneficiary. Review the patient's aid codes, CIN, and bill to the OHC if applicable. Verifying eligibility using one of the three previously mentioned processes should prevent CO 177 denials. Oftentimes the updates between DPSS and DHCS can be slow, so it is critical that the eligibility is verified before billing the claims.

Medicare and Medi-Cal Patients: CO 22 N479

Denials for CO 22 N479 occur specifically beneficiaries who have both Medicare and Medi-Cal, but services were not billed to Medicare first as required. If the patient has coverage under Medicare Part C or Medicare Advantage (MA) plans, then all services must be billed to the MA carrier first, before billing to SAPC. Medicare Part D covers medications for Opioid Treatment Program (OTP) services. For more information on billing for patients who have Medicare and Medi-Cal read the Other Health Coverage Provider Billing Manual located on the SAPC website.

To resolve CO 22 N479 denials, bill services to Medicare first. If denied by Medicare, or there has not been a response after 90 calendar days from the billing date, then claims can be billed to SAPC and must include a COB from Medicare.

Using the Denial Crosswalk

The Denial Crosswalk was developed to assist providers in understanding denial codes/reasons and their resolutions.

The Denial Crosswalk has four main columns:

A. Column A - Denial Code
B. Column B - CARC RARC Description from X12.org
C. Column C - Denial Reason or DMC Description
D. Column D – Cause and Resolution

Local Denials Tab

For Local denials, Column A - Denial Code, is most useful for Secondary Sage Users. The codes listed in column A correspond to the CARC/RARC denial codes included on 835s. Column B is a description of the CARC/RARC from the x12.org website. Column C, "Denial Reason or Explanation of Coverage Message from Sage", will display the denial message as seen in Sage. For both Primary and Secondary Sage users, Column D, "Resolution" explains the reason and how to correct the denial. It also provides information on the forms/reports/displays in Sage where the errors can be found.

State Denials Tab

For State denials, Column A, Denial Code, lists the denial code response from the State. Column B is the CARC/RARC description from the x12.org website. Column C, DMC description, provides the DHCS description of the denial code. Column D, Cause and Resolution, explains the denial reason and how to correct the denial for primary and secondary sage users. Similarly, to the Local Resolutions columns, it also provides information on the forms, reports and/or displays in Sage where the errors can be found.

General Usage

To use the crosswalk, first identify if the denial is Local or State and go to the appropriate tab. Find the denial code or Denial reason/DMC Description to get the explanation of the denial. A quick way to find the denial reason or code without scrolling through each row is by using the Ctrl+F keys to find a word/phrase on the crosswalk. Additionally, using the filters located on the columns, and typing in the denial code in Column A or the key words from the denial phrase in Column C is an easy way to locate the specific denial. After finding the correct denial, review the cause and steps for resolution in column D. For secondary users, the Resolution Column also includes the location of the Loop-Segment-Element on the 837 file where the issue or errors exist.

Given that there are thousands of CARC and RARC combinations, only the most common codes, and the ones provided by DHCS were included in the crosswalk. If you encounter an unlisted code, you may refer to X12.org to obtain a description of the CARC and/or RARC. Often the resolution steps for RARCs are similar regardless of the CARC.

Rebilling State Denials

Resubmitting or Replacing a Denied Claim

Once providers research the denied claim, identify the issue, and correct the problem, the claim can either be resubmitted or replaced. If a claim was appropriately denied because the service itself was not allowable by SAPC or DMC, then the claim should not be resubmitted or replaced. For example, if a service was claimed at a provider program that was not certified by DMC at the time of the service, that claim is appropriately denied by the State because it is not reimbursable by DMC.

In general, SAPC recommends treatment providers replace both Local and State denials. This assists with easier reconciliation in Sage and decreased State denials.

Resubmitting a Denied Claim

Resubmissions refer to the process of submitting a new original claim for the same service. Once a claim is denied, the claim remains denied unless it is voided or replaced by the provider. SAPC recommends that treatment providers only resubmit a new original claim for a service if the corrections to the replacement claim do not meet DHCS's requirements on replacement claims. DHCS requires that two of the following four data elements must match the corresponding service lines of the original claim:

1. Procedure code or revenue code
2. Date of service
3. Place of service
4. Service facility NPI

If more than two of the above data elements must be corrected, a new original claim must be submitted. Otherwise, the service should be replaced.

Replacing a Denied Claim

SAPC encourages both Primary and Secondary Sage Users to replace both Local and State denials. For Secondary Sage Users, the Payer Claim Control Number (PCCN) transmitted on the 835 file and must be used on subsequent 837 files that include the replacement claim. Additionally, Secondary Sage Users must mark the claim as a replacement using the code value

'7' in the CLM05-3 segment of the 837 file. Failure to enter the correct PCCN and indicate the replacement status may result in a rejection and/or denial.

Primary Sage Users must use the Replacement Claim Assignment (CMS-1500) form in PCNX to submit replacement claims. The Sage website contains a job aid, training slides, and recorded training to support form usage.

Repeated Denial After Resubmission/Replacement

If resubmission/replacement of claims results in a different denial reason/denial code, please follow the appropriate resolution steps outlined above. The initial submission may have only yielded some of the denial reasons.

If a provider follows the validation steps, resubmits/replaces the claim, and the claim is denied for the same reason code, please contact the Sage Help Desk. This will alert Netsmart and/or SAPC to further investigate to determine if there is a system issue and ways to correct it. The Help Desk investigation process can be expedited by submitting supporting documentation of the validation steps taken by the provider. This may include providing screenshots or a list of the denial(s) including patient name, date of service, service type, site location and other appropriate data points related to validation steps.