BILLING & DENIAL RESOLUTION TUTORING LAB

JANUARY 8, 2026

- Reminders & Announcements
- Tutoring Session Topics
  - CO 97 M86
  - Roll-Up Guidance
  - Replacement Claim Assignment (CMS-1500) form
- Open Q&A

REMINDERS & ANNOUNCEMENTS

REMINDERS

Q&A REMINDER

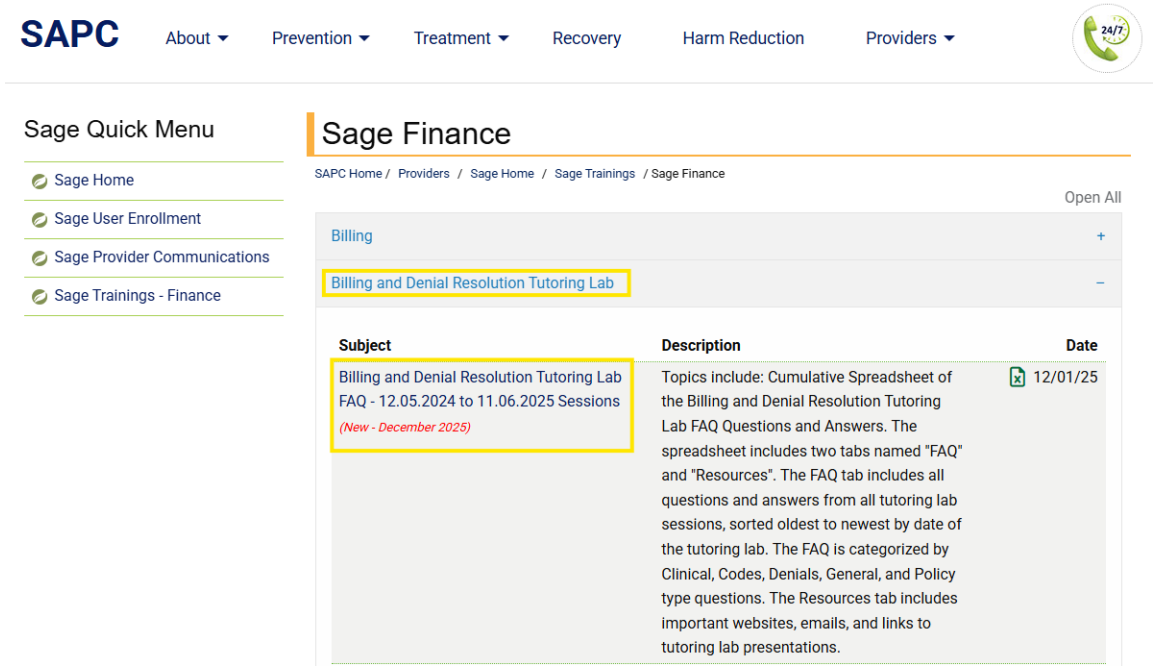
- As a reminder, to ask questions during this lab, please use one the following:

  - Q&A Button

  - Raise Hand Button

FAQ REMINDER

- As a reminder, FAQ are uploaded on a monthly basis. Please check to see if your question has been asked in previous tutoring labs.
  - *Link: http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm*



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

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.

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
1/1/2025 - 6/30/2025	Thursday, April 30, 2026

FY 24-25 BILLING DEADLINES

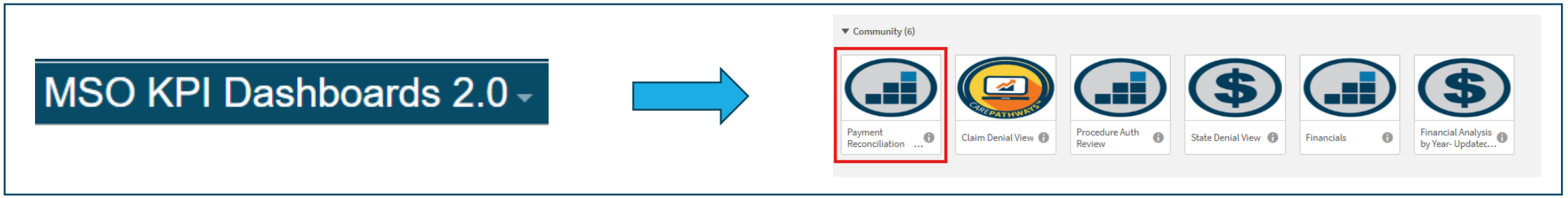
- Submit original and replacement claims for FY 24-25 services by the deadlines listed below:

FY 24-25 BILLING DEADLINES

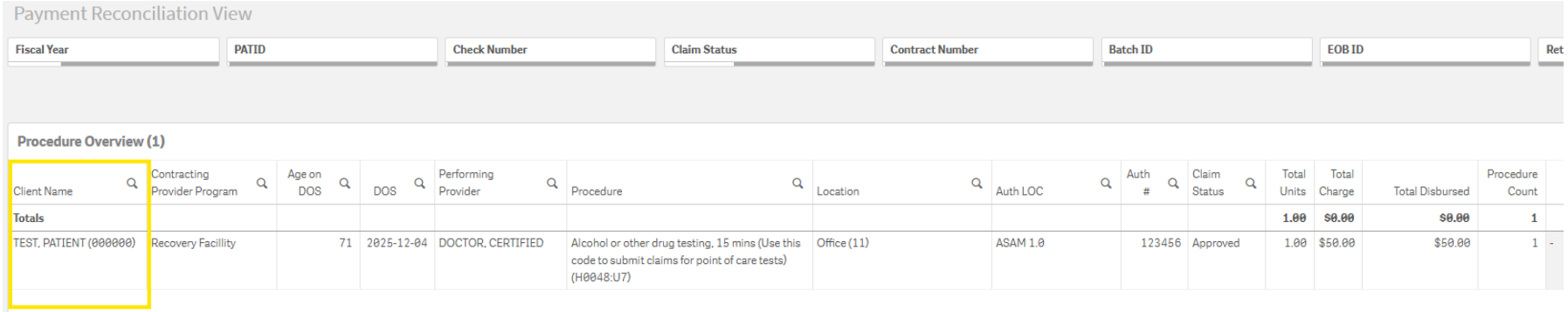
- In preparation of the billing deadlines, we recommend:

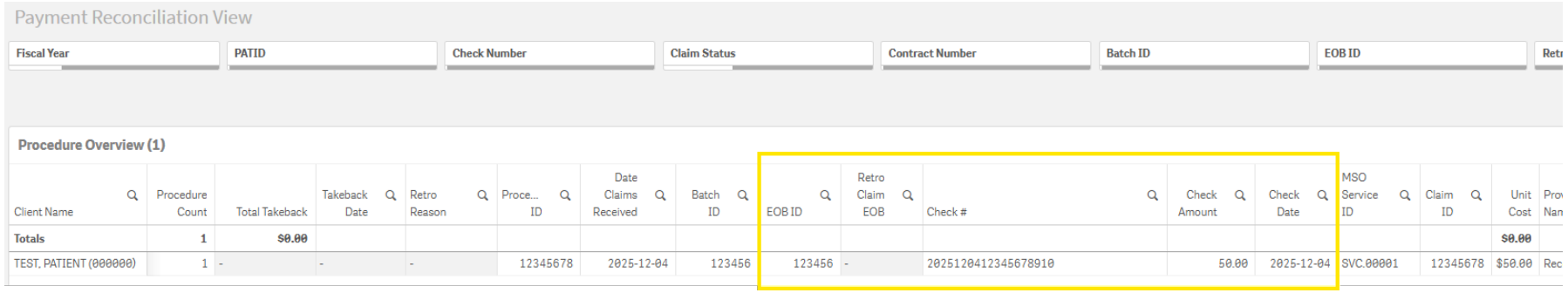
  - Don’t wait until the last week to submit claims. Submit claims at least once a month before the deadline to allow for any corrections needed for Local and State denials.
  - Review all currently denied services to ensure services have been corrected and replaced (as able).
  - Review available contract amounts and request augmentations if necessary.
  - Lastly, open a Request Billing Assistance ticket for any support needed to resolve outstanding FY 24-25 questions.

KPI UPDATE – PAYMENT RECONCILIATION VIEW



- This KPI update:
  - Moves and freezes Client Name to first column
  - Adds columns:
    - EOB ID
    - Retro Claim EOB
    - Check #
    - Check Amount
    - Check Date





DATE OF DISCHARGE BILLING

- Discharge Date typically falls on the last day of the patient's service authorization
- Per Provider Manual 10.0 billing on the date of discharge–
  - Allowed
    - Billing Outpatient Services
  - Not Allowed
    - Billing the Day Rate such as RBH (Page 99)

ANNOUNCEMENTS

FY24-25 CONFIGURATION UPDATES

SAPC Finance has been working with Netsmart to update the Sage configuration for minor changes. These are anticipated to be fully configured by 1/16/2026. An updated Rates Matrix will be posted to the Sage website by 1/16/2026.

- T2021 and T2024 have been updated to remove the modifiers 93 and 95 and replaced with the SC modifier (No rebilling necessary)
- 95 modifier has been removed from procedure codes 98966, 98967, and 98968
- 27 modifier has been removed from all codes
- H2010 has been updated to remove 02 and 10 location for Place of Service. The modifiers and unit max have been updated to align with FY 25-26.
- 99415 has been removed from Levels of Care 3.1 (U1), 3.3 (U2), and 3.5 (U3)
- 99202-99205, 99212-99215 and 90849 have been removed from LOC 1.0WM (U4:U7 and U4:U8)

FY24-25 CONFIGURATION UPDATES

- GC and HL modifiers have been removed from the following codes:

Change
Removed Gl and HC as an allowable modifier to codes: 90885,90887,90889,96170,96171,99367,99368,99417,99418,H0001,H0007,H0012, H0014,H0019,H0033,H0034,H0048,H0049,H0049,H1000,H2010,H2014,H2015, H2017,H2027,H2034,S9976,T1006,T1007,T1009,T1013,T1017,T2027

- Fees have been removed for Occupational Therapist & Occupational Therapist Clinical Trainee for procedure code 99368 for all Levels of Care.
- Fees have been removed for Registered Nurse and Registered Nurse Clinical Trainee for procedure code H2017 for all Levels of Care.

WOMEN'S HEALTH HISTORY FORM

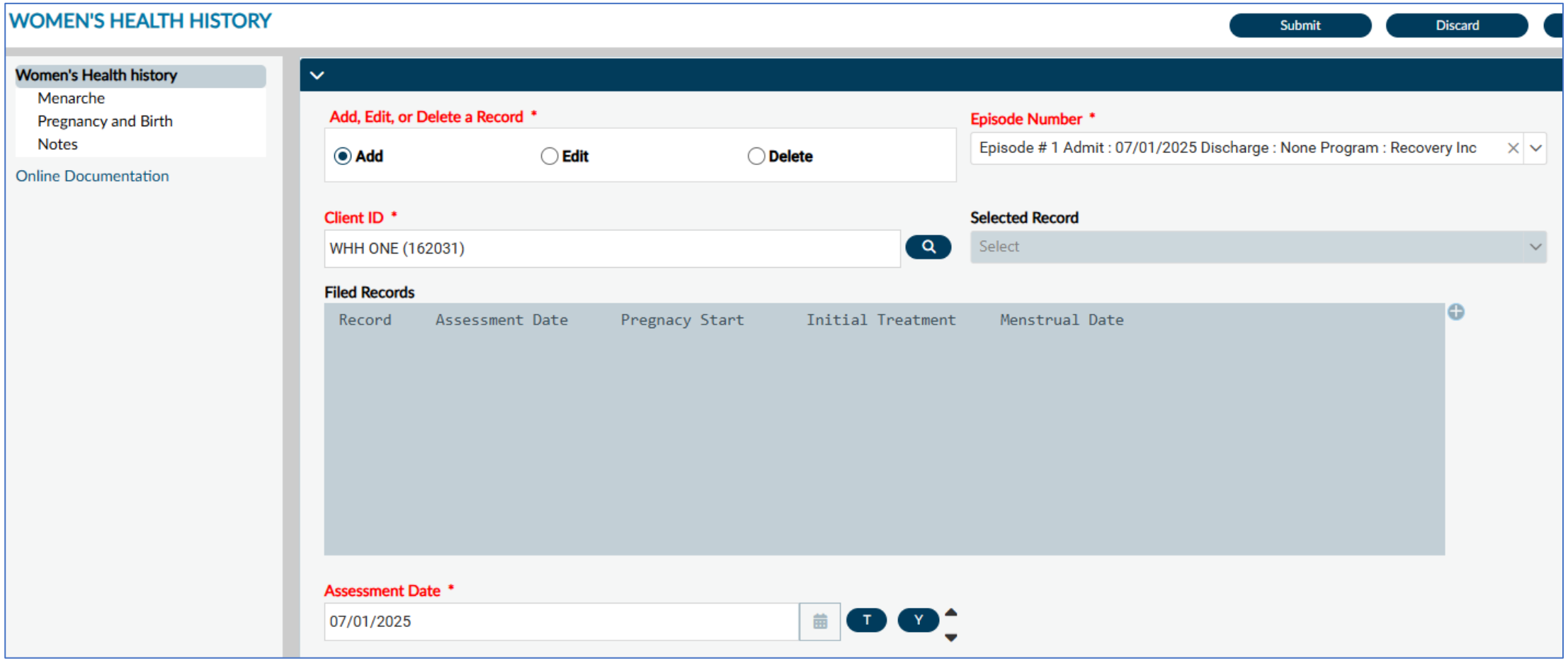
- The Women's Health History form must be filled out for pregnant and perinatal (PPW) clients. PPW clients should have an active Women's Health History record listed per episode per pregnancy.
  - For example: a client receives services at two different agencies during the same pregnancy period. If the client has an active Women's Health History record added by Agency A for the current pregnancy, then Agency B must still ADD a new active Women's Health History record for the current pregnancy.
- There cannot be overlapping pregnancy records within a single Episode. However, there may be multiple records of the same pregnancy period by different Episodes as each agency is required to have their own record.
- Agencies should NOT EDIT information on any Women's Health History records created by other agencies.
- If the Women's Health History form is not filled out and does not contain an active record for the pregnancy period, the pregnancy indicator will not appear on the claim, leading to State denials.

WOMEN'S HEALTH HISTORY FORM

- Required fields to ADD a new active record:
  - **Add**, Edit, or Delete a Record
    - DO NOT EDIT OR DELETE records from other agencies
  - **Client ID**
  - **Episode Number**
  - **Assessment Date**
  - **Pregnancy Start Date**
    - If available: **Pregnancy End Date**
  - **Note Section**
    - Enter the **Provider Agency Name** that this Women's Health History record belongs to.
      - Example: "This record belongs to Recovery Inc."
    - Entering this information will help clarify which records belong to a particular agency, as the form currently does not indicate which record belongs to which agency after filing.

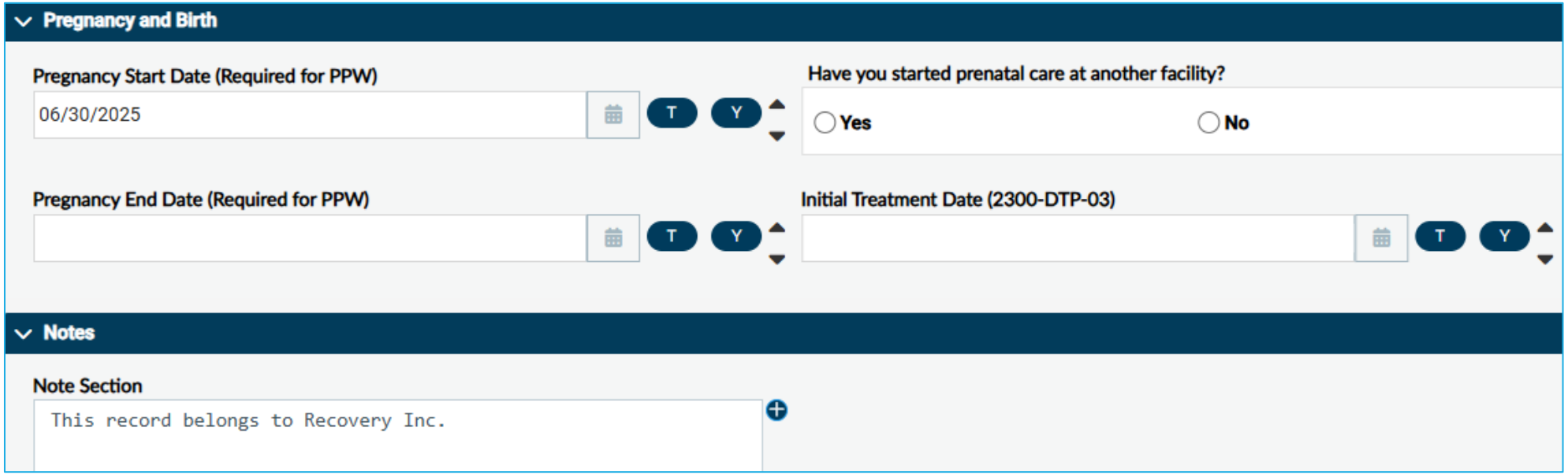
WOMEN'S HEALTH HISTORY FORM

- Required fields for adding a new record (continued on the next slide)



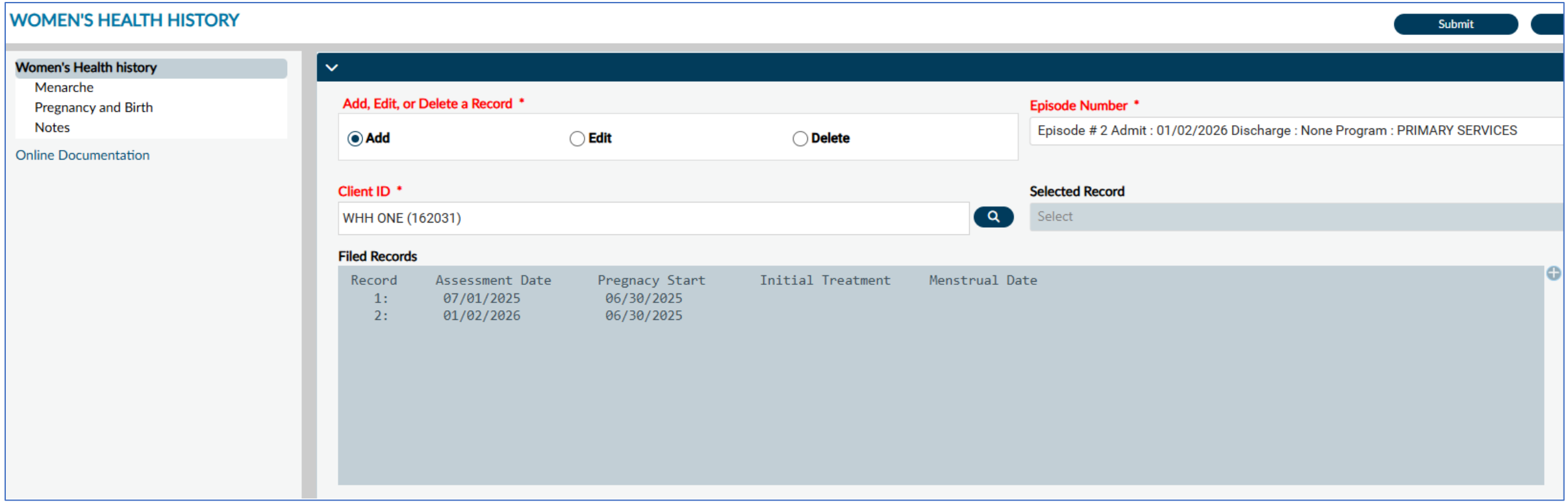
WOMEN'S HEALTH HISTORY FORM

- Required fields for adding a new record (continuation of previous slide)



WOMEN'S HEALTH HISTORY FORM

- Below is an example of how the Women's Health History form will look when two agencies file an active record for the same pregnancy.



TUTORING SESSION: PART 1 – CO 97 M86

CO 97 M86 – WHAT IS IT?

- One of the most common State denials providers receive
- What is a CO 97 M86 denial?
  - CO 97 = The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
  - M86 = Service denied because payment already made for same/similar procedure within set time frame.

CO 97 M86 – WHAT CAUSES THIS DENIAL?

- In a Nutshell:
    - Medi-Cal denied this service because it had already approved the same service provided on the same day, by the same rendering provider, to the same beneficiary on another claim.

CO 97 M86 – WHAT CAUSES THIS DENIAL?

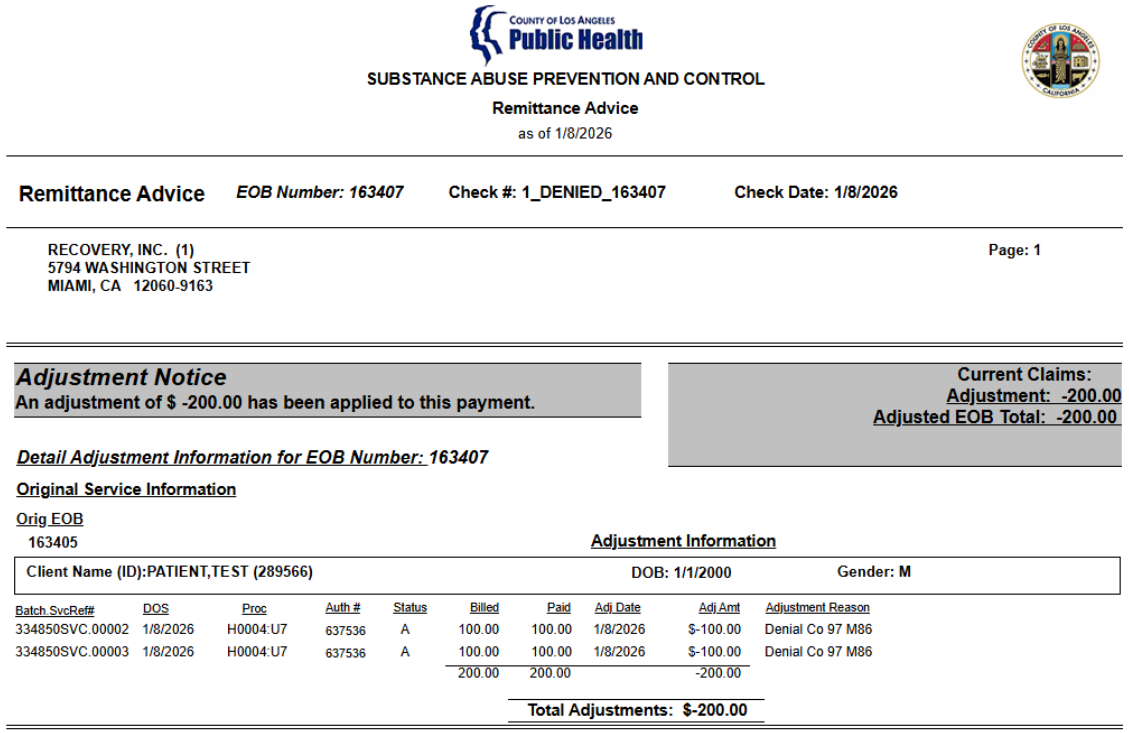
CLAIM 1	CLAIM 2	CLAIM 3
Service 1 (9AM) Test, Patient Dr. Clinician H0004:U7, POS 02 1.0 Unit 15 mins DOS: 1/8/2026	Service 2 (3PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026	Service 3 (5PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED	DENIED	DENIED
Service 1 (9AM) Test, Patient Dr. Clinician H0004:U7, POS 02 1.0 Unit 15 mins DOS: 1/8/2026	Service 2 (3PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026	Service 3 (5PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026

CO 97 M86 – WHAT DOES IT LOOK LIKE TO A PROVIDER?

- Retro EOB



County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 1/8/2026

Remittance Advice *EOB Number: 163407* Check #: 1_DENIED_163407 Check Date: 1/8/2026

RECOVERY, INC. (1)
5794 WASHINGTON STREET
MIAMI, CA 12060-9163

Page: 1

Adjustment Notice
An adjustment of $ -200.00 has been applied to this payment.

Current Claims:
Adjustment: -200.00
Adjusted EOB Total: -200.00

Detail Adjustment Information for EOB Number: 163407

Original Service Information

Orig EOB
163405

Adjustment Information

Client Name (ID):PATIENT,TEST (289566) DOB: 1/1/2000 Gender: M

Batch.SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
334850SVC.00002	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	$-100.00	Denial Co 97 M86
334850SVC.00003	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	$-100.00	Denial Co 97 M86
					200.00	200.00		-200.00	

Total Adjustments: $-200.00

KPI

CO 97 M86 – HOW DO WE FIX IT?

ROLL-UPS!

TUTORING SESSION:
PART 2 - GUIDE TO ROLLUPS

ROLL-UPS – OVERVIEW - WHAT ARE THEY?

- Roll-up services refer to the consolidation of multiple identical claims into a single billed service that contain the same:
    1. Patient
    2. Rendering Performing Provider
    3. Procedure Code and
    4. Date of Service
- This process ensures compliance with Department of Health Care Services (DHCS) guidelines to prevent duplicate billing for outpatient services. Per the DHCS DMC-ODS Billing Manual, duplicate services are not allowed for outpatient services with minimal exceptions.

ROLL-UPS – OVERVIEW - WHEN DO THEY APPLY?

- Roll-ups are required for:
  - All outpatient services (except for code exceptions noted below)
- Roll-ups are not required for:
  - There are some code exceptions per DHCS, where roll-ups are not required:
    - Sign language or Oral Interpretive services (T1013)
    - Interactive complexity (90785)
    - Health behavior interventions for the family without the patient present (96170 and 96171)
    - Group Counseling (H0005)
    - Group services using the HQ modifier (H0034, H2017, T2021)
    - Patient Education services using the HQ modifier (H2014)

ROLL UPS – OVERVIEW – WHAT NOT TO DO

CLAIM 1

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 2

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 3

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

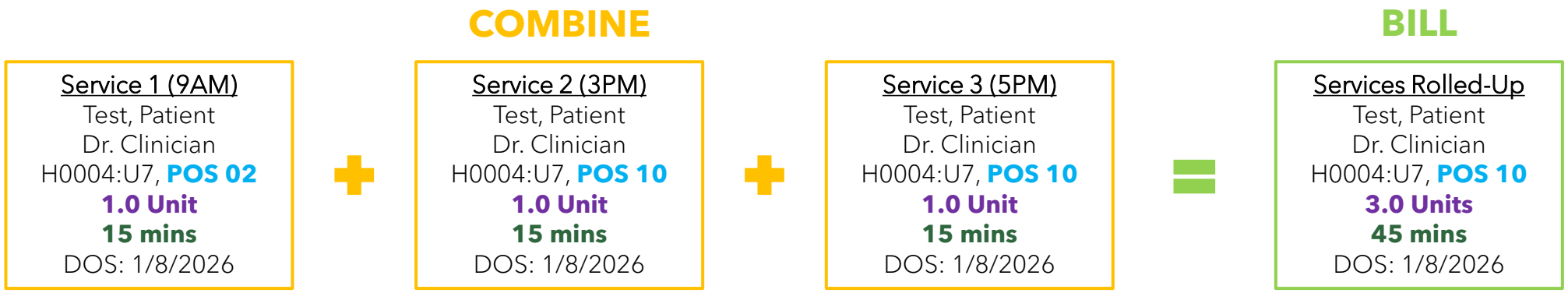
Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

ROLL UPS – OVERVIEW – WHAT TO DO

COMBINE

Service 1 (9AM)	+	Service 2 (3PM)	+	Service 3 (5PM)	=	**BILL** Services Rolled-Up
Test, Patient		Test, Patient		Test, Patient		Test, Patient
Dr. Clinician		Dr. Clinician		Dr. Clinician		Dr. Clinician
H0004:U7, **POS 02**		H0004:U7, **POS 10**		H0004:U7, **POS 10**		H0004:U7, **POS 10**
1.0 Unit		**1.0 Unit**		**1.0 Unit**		**3.0 Units**
15 mins		**15 mins**		**15 mins**		**45 mins**
DOS: 1/8/2026		DOS: 1/8/2026		DOS: 1/8/2026		DOS: 1/8/2026

ROLL UPS – HOW TO ROLL UP – THINGS TO CONSIDER



- Parts of the claim to think about when rolling-up services. These can potentially change after rolling-up:
  - **Place of Service**
  - **Duration (Minutes) and the Midpoint Rule**
  - **Units**

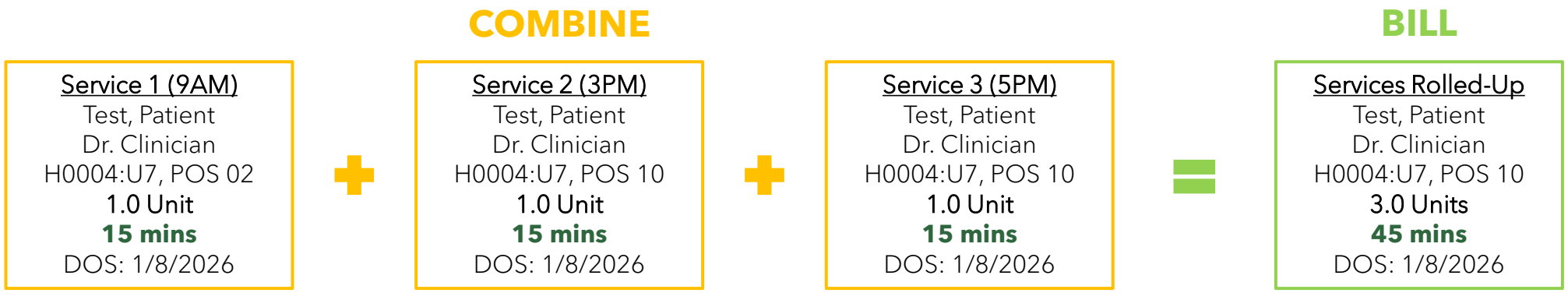
ROLL UPS – THINGS TO CONSIDER – PLACE OF SERVICE

COMBINE **BILL**

Service 1 (9AM)	+	Service 2 (3PM)	+	Service 3 (5PM)	=	Services Rolled-Up
Test, Patient Dr. Clinician H0004:U7, **POS 02** **1.0 Unit** **15 mins** DOS: 1/8/2026		Test, Patient Dr. Clinician H0004:U7, **POS 10** **1.0 Unit** **15 mins** DOS: 1/8/2026		Test, Patient Dr. Clinician H0004:U7, **POS 10** **1.0 Unit** **15 mins** DOS: 1/8/2026		Test, Patient Dr. Clinician H0004:U7, **POS 10** **3.0 Units** **45 mins** DOS: 1/8/2026

- **Place of Service (POS)**
  - Notice in the example above you have: POS 02, POS 10, POS 10
  - For simplicity, select the POS that occurs the most
  - In the example above, POS 10 occurs two times, while POS 02 occurs once
  - So, when rolling-up, we selected POS 10 because it occurred more often than POS 02

ROLL UPS – THINGS TO CONSIDER – MIDPOINT



- **Duration (Minutes) and the Midpoint Rule**
  - What is the Midpoint Rule?
    - The minimum time needed to claim 1 unit
    - If the service duration is less than the minimum time = cannot claim 1 unit
    - If the service duration is at least the minimum time = can claim at least 1 unit
  - **Before a roll-up, you'll consider the midpoint on an individual service basis**
  - Let's take a look at the FY25-26 Rates Matrix > Billing Rules Tab > H0004

ROLL UPS – THINGS TO CONSIDER – MIDPOINT

- **Duration (Minutes) and the Midpoint Rule**
  - Next, go to the "**Minimum Time Needed to Claim 1 Unit**" column
    - This will tell you the minimum service duration needed to claim 1 unit of H0004
    - For H0004, the minimum time needed to claim 1 unit is 8 minutes
    - If your service duration for H0004 is 7 minutes or less, you cannot claim 1 unit
    - *If trying to see if service duration long enough to claim 1 unit:*
      - If your service duration for H0004 is 8 minutes or more, you can claim 1 unit
    - *If trying to claim a higher duration beyond the duration in the service description:*
      - Use the following calculation

Code	Code Type	Service Description	Minimum Time Needed to Claim 1 Unit	Minimum Time When Add-On Code or Next Code in Series Can Be Claimed	Can This Code Be Extended with an Add-on or Prolonged Code?	Example Calculation
H0004	Individual Counseling	Behavioral health counseling and therapy 15 minutes.	8 Min	23 Min	No. Claim multiple units of this code as appropriate up to the maximum units per day.	If 100 minutes of service was provided: 100 minutes of service / 15 minutes time for code = 6.6667 units. 6 units accounts for 90 minutes of service. For the remaining 10 minutes of service, 1 additional unit of H0004 can be claimed. Therefore for 100 minutes of service, claim 7 units of H0004.

Example Calculation

For a 100 minute service -

100 minutes of service/15 minutes time for code = 6.6667 units

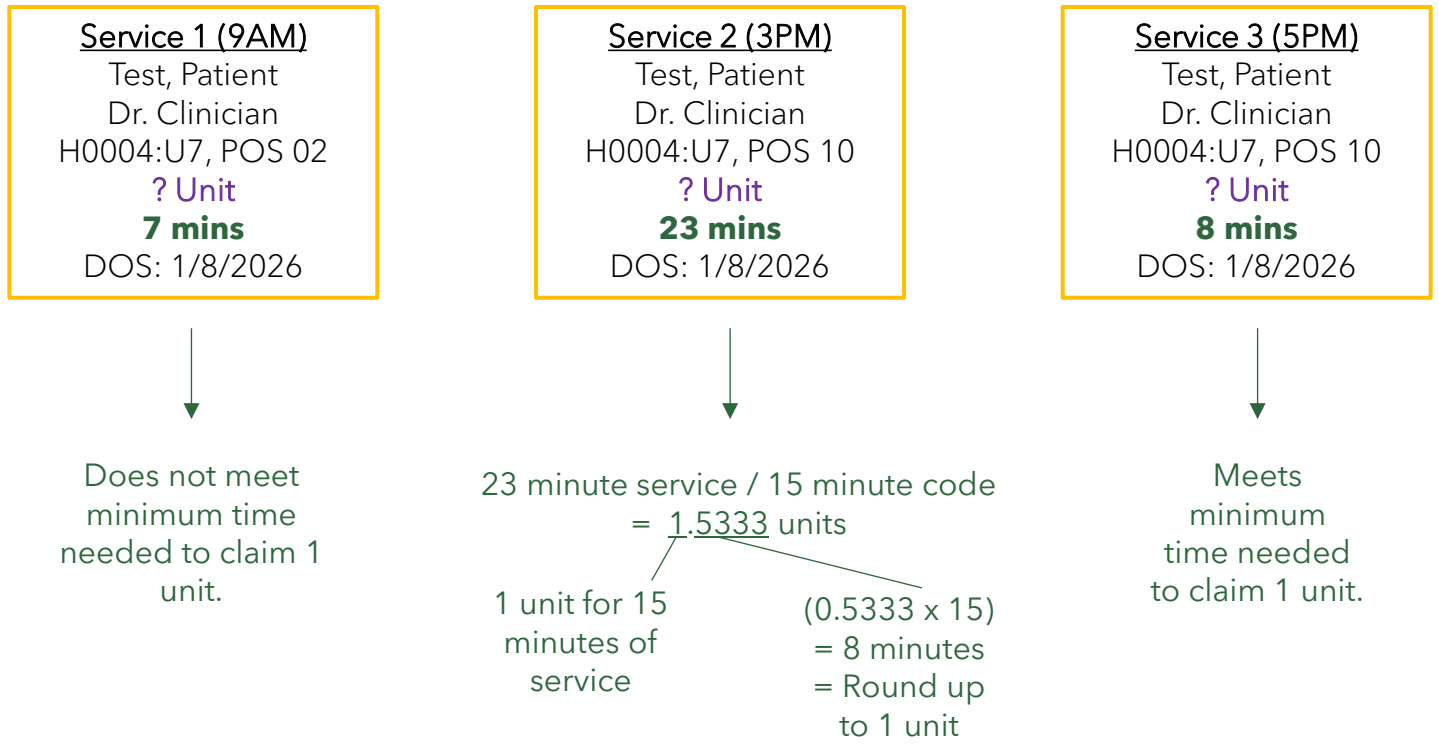
6 units accounts for (6 x 15) = 90 minutes of service.

0.6667 units accounts for (0.6667 x 15) = 10 minutes of service. **Round up to 1 unit, since it meets the 8 minutes minimum**

= **7 Units**

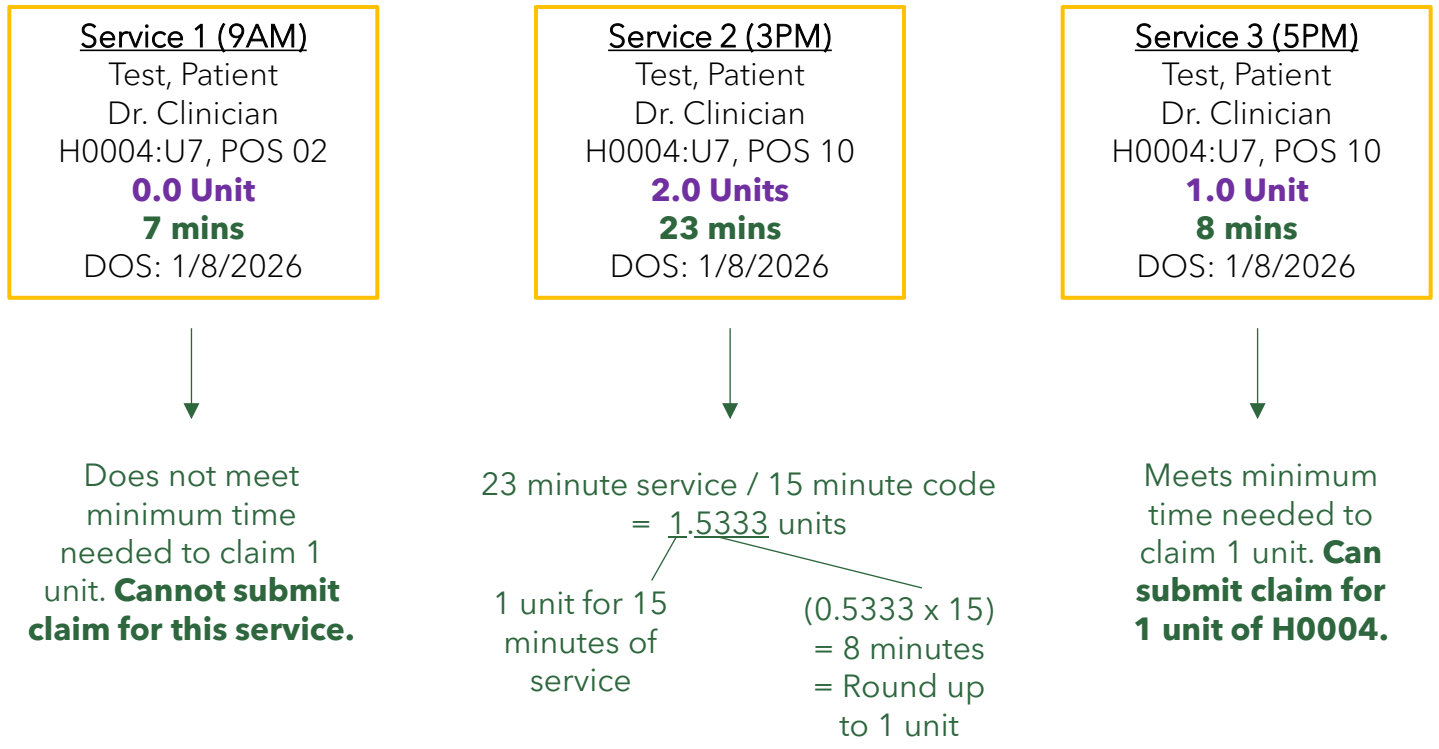
ROLL UPS – MIDPOINT RULE IN ACTION

"**Minimum Time Needed to Claim 1 Unit**" of H0004 is 8 minutes. Code is 15 minutes per the service description. Below are examples of how to determine units when the service duration varies.



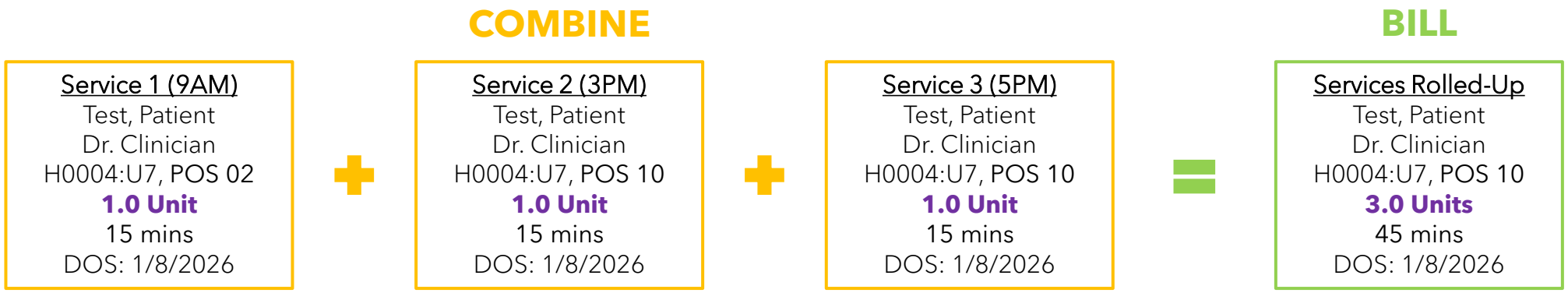
ROLL UPS – MIDPOINT RULE IN ACTION

"**Minimum Time Needed to Claim 1 Unit**" of H0004 is 8 minutes. Code is 15 minutes per the service description. Below are examples of how to determine units when the service duration varies.



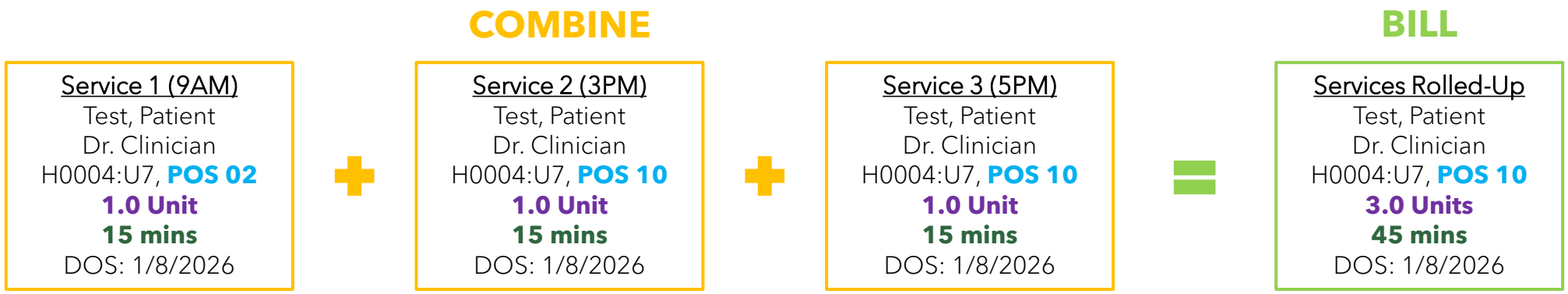
2 units total for 23 minutes of H0004

ROLL UPS – THINGS TO CONSIDER - UNITS



- **Units**
  - Units are calculated based on the billing rules for the code and the midpoint rule
  - Before a roll-up, you'll consider the units on an **individual service basis**
  - Combine all identical service units into one rolled up service
  - Note: Services with a unit maximum of 1 unit cannot be rolled up

ROLL UPS – END RESULT



- End results of rolling up:
  - **Place of Service = POS 10**
  - **Duration (Minutes) and the Midpoint Rule = 45 mins**
  - **Units = 3.0 units**

ROLL-UPS – HOW DO WE BILL THEM?

- If roll-ups are calculated **before** submitting original claims:
  - Primary
    - Submit originals rolled-up using the Sage **Fast Service Entry Submission** Form
  - Secondary
    - Submit originals rolled-up using your **EHR**

- If roll-ups are calculated **after** receiving a **CO 97 M86** denial:
  - Primary
    - Submit a replacement claim using the Sage **Replacement Claim Assignment (CMS-1500)** form
  - Secondary
    - Submit a replacement claim using your **EHR**

TUTORING SESSION:
PART 3 – PRIMARY REPLACEMENT CLAIMS

REPLACEMENT CLAIMS - SCENARIO

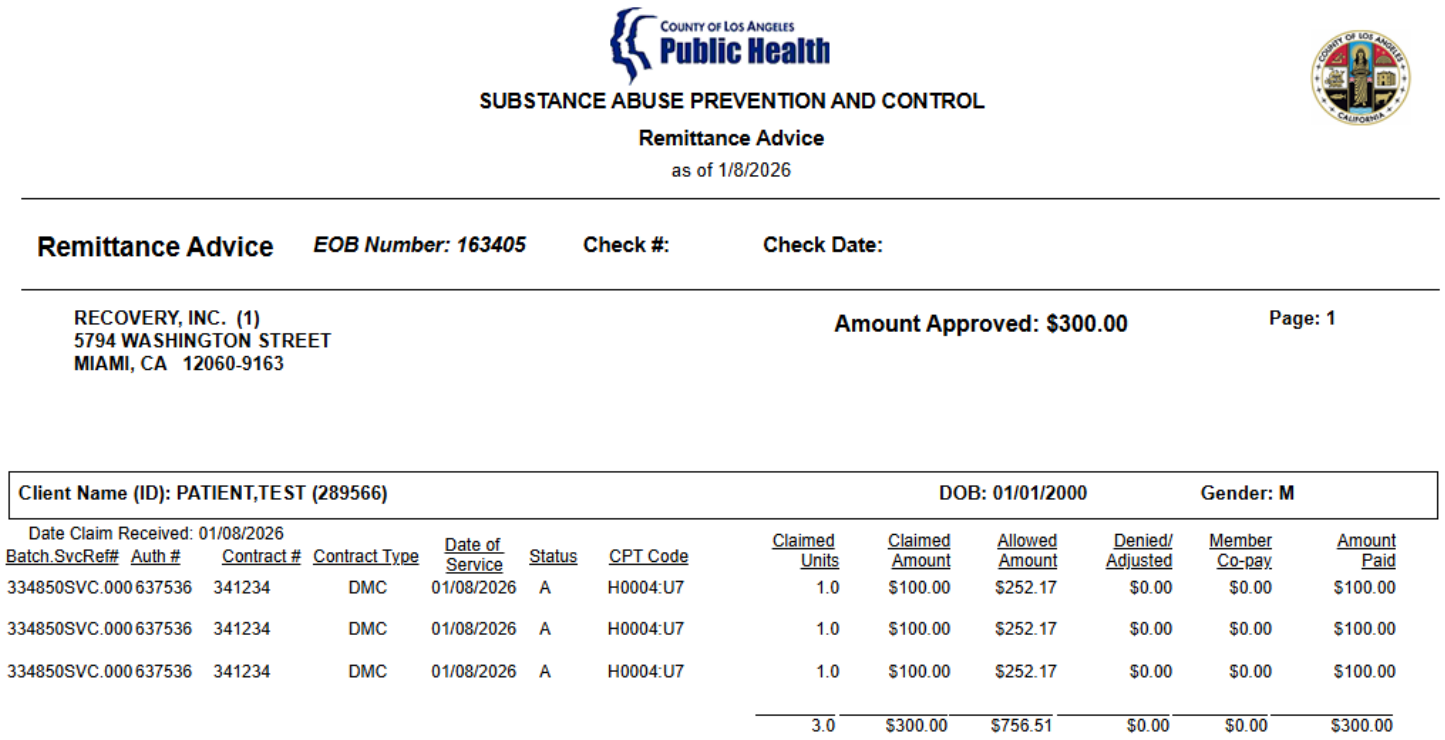
CLAIM 1	CLAIM 2	CLAIM 3
Service 1 (9AM) Test, Patient Dr. Clinician H0004:U7, POS 02 1.0 Unit 15 mins DOS: 1/8/2026	Service 2 (3PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026	Service 3 (5PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED	DENIED	DENIED
Service 1 (9AM) Test, Patient Dr. Clinician H0004:U7, POS 02 1.0 Unit 15 mins DOS: 1/8/2026	Service 2 (3PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026	Service 3 (5PM) Test, Patient Dr. Clinician H0004:U7, POS 10 1.0 Unit 15 mins DOS: 1/8/2026
	CO 97 M86	**CO 97 M86**

REPLACEMENT CLAIMS – EOB

- Your EOB will show all claims billed



County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 1/8/2026

Remittance Advice ***EOB Number: 163405*** **Check #:** **Check Date:**

RECOVERY, INC. (1)
5794 WASHINGTON STREET
MIAMI, CA 12060-9163

Amount Approved: $300.00

Page: 1

Client Name (ID): PATIENT,TEST (289566) **DOB: 01/01/2000** **Gender: M**

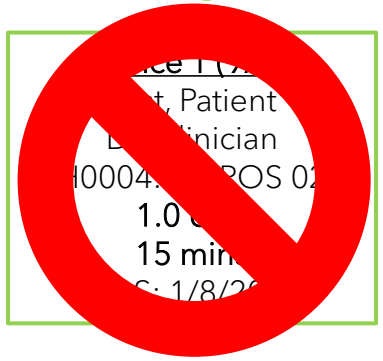
Date Claim Received: 01/08/2026

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
334850SVC.000	637536	341234	DMC	01/08/2026	A	H0004:U7	1.0	$100.00	$252.17	$0.00	$0.00	$100.00
334850SVC.000	637536	341234	DMC	01/08/2026	A	H0004:U7	1.0	$100.00	$252.17	$0.00	$0.00	$100.00
334850SVC.000	637536	341234	DMC	01/08/2026	A	H0004:U7	1.0	$100.00	$252.17	$0.00	$0.00	$100.00
							3.0	$300.00	$756.51	$0.00	$0.00	$300.00

REPLACEMENT CLAIMS – RETRO EOB

- Your retro EOB will only show denied claims

APPROVED



DENIED

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CO 97 M86

DENIED

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CO 97 M86

REPLACEMENT CLAIMS – RETRO EOB

- Your retro EOB will only show denied claims

County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 1/8/2026

Remittance Advice ***EOB Number: 163407*** **Check #: 1_DENIED_163407** **Check Date: 1/8/2026**

RECOVERY, INC. (1)
5794 WASHINGTON STREET
MIAMI, CA 12060-9163

Page: 1

Adjustment Notice
An adjustment of $ -200.00 has been applied to this payment.

Current Claims:
Adjustment: -200.00
Adjusted EOB Total: -200.00

Detail Adjustment Information for EOB Number: 163407

Original Service Information

Orig EOB
163405

Adjustment Information

Client Name (ID):PATIENT,TEST (289566) **DOB: 1/1/2000** **Gender: M**

Batch.SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
334850SVC.00002	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	$-100.00	Denial Co 97 M86
334850SVC.00003	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	$-100.00	Denial Co 97 M86
					200.00	200.00		-200.00	

Total Adjustments: $-200.00

REPLACEMENT CLAIMS – KPI

- To identify claims with the CO 97 M86 denials per the Retro EOB, in KPI only filter for :
  - PATID
  - Date of Service
  - Procedure
- Make note of the following columns:
  - Retro Reason
    - The row with CO 97 M86 was denied
      - We will not be replacing these rows!
    - The row where Retro Reason is blank was approved at the Local and State Level
      - This approved service is the one we're replacing!
  - MSO Service ID
  - Claim ID

REPLACEMENT CLAIMS – KPI

- For primary providers
  - One batch # creates one claim ID # in KPI
  - Only services can be loaded into the Replacement Claim Assignment (CMS-1500) form one Claim ID # at one time
- For secondary providers
  - One batch # may contain multiple unique claim ID #s
  - Replacement occurs in your own EHR

REPLACEMENT CLAIMS – KPI SORT ORDER

- Things to note before performing a replacement claim:
  - By Default, services listed in KPI are inverse to how their listed in the "Select Service(s) To Replace" popup – from highest to lowest
  - Remember to click the "MSO Service ID" column header to sort the services from lowest to highest, so that it matches the order in the "Select Service(s) To Replace" popup

UNSORTED

MSO Service ID	Claim ID	
SVC.00003	19854684	3
SVC.00002	19854684	2
SVC.00001	19854684	1

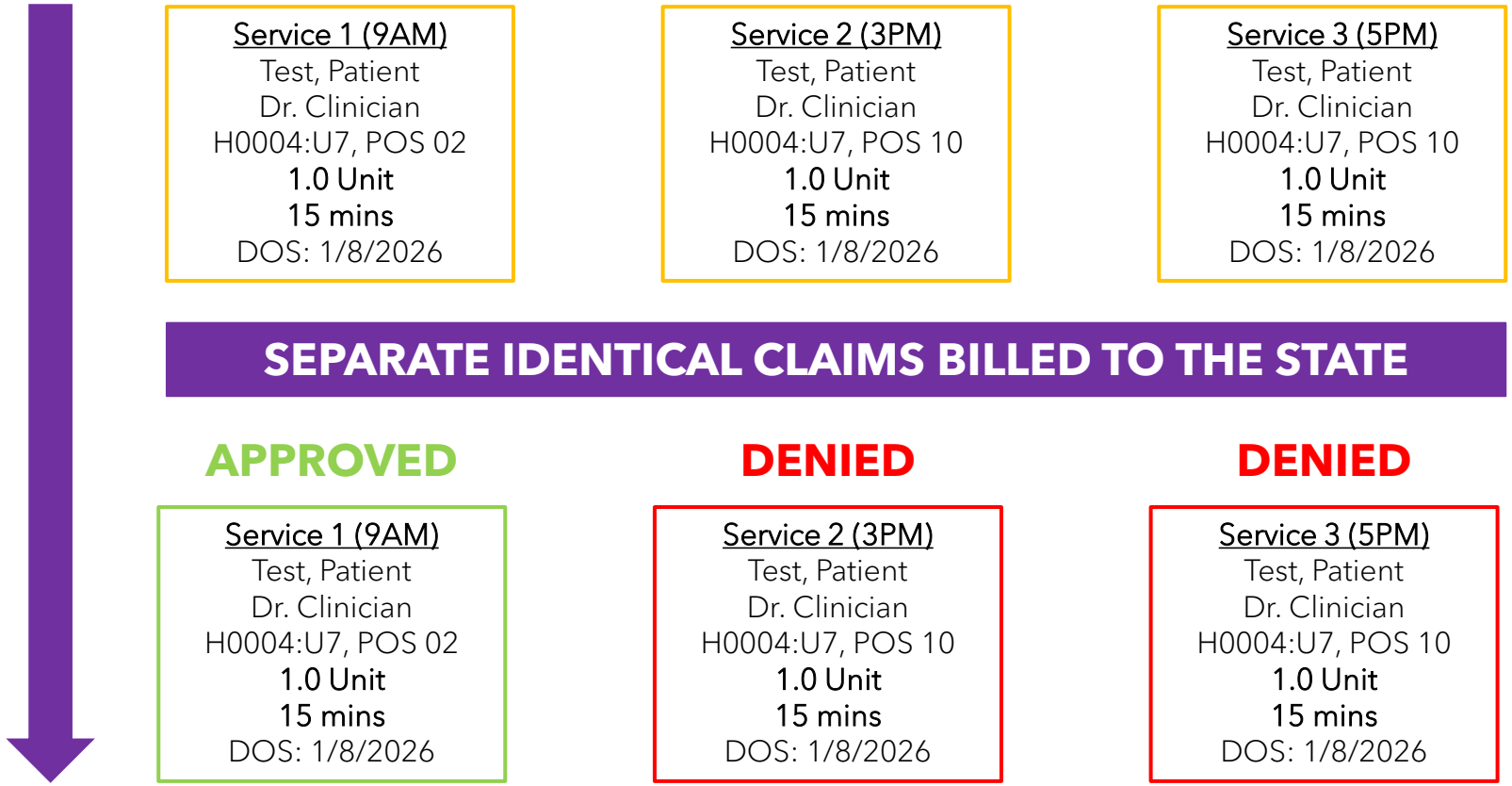
SORTED

MSO Service ID	Claim ID	
SVC.00001	19854684	1
SVC.00002	19854684	2
SVC.00003	19854684	3

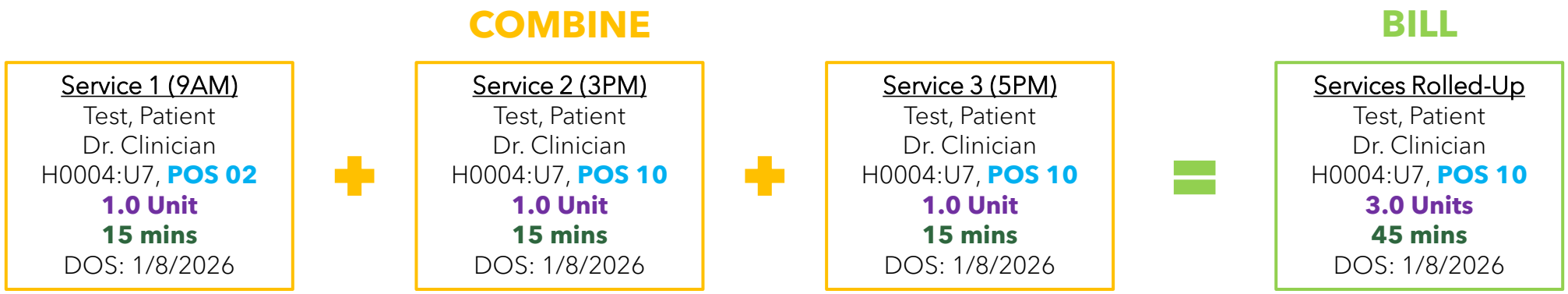
MATCHES ORDER OF THE SORTED

1	☐	334850	2026-01-08	19854684	H0004:U7
2	☐	334850	2026-01-08	19854684	H0004:U7
3	☐	334850	2026-01-08	19854684	H0004:U7

REPLACEMENT CLAIMS – SCENARIO + DEMO



REPLACEMENT CLAIMS – SCENARIO + DEMO



- End result of rolling up:
  - **Place of Service = POS 10**
  - **Duration (Minutes) and the Midpoint Rule = 45 mins**
  - **Units = 3.0 units**

HELPFUL RESOURCES

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- 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	Sage related questions, including system errors, medical record modifications
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	All authorization related questions, questions for the office of the Medical Director, medical necessity, secondary EHR form approval
Systems of Care (SOC)	SAPC-SOC@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 submissions 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
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 clinical trainings
Finance	Sapc-Finance@ph.lacounty.gov	General questions related to billing. For specific questions related to billing denials, payments, and technical assistance, please open a ticket with the Request Billing Assistance form
Eligibility	DPH-SAPC-EST@ph.lacounty.gov	For any eligibility related questions such as for assistance identifying County of residence, help with the intercounty transfer (ICT) process, applying for Medi-Cal benefits


OPEN Q&A