06/05/2025 Billing & Denial Resolution Tutoring Lab FAQ

Open Q&A

Question	Answer
How does roll up billing work for care coordination services? Which fields need to match in order to be rolled up?	The State indicates that services with the same procedure code provided to the same beneficiary by the same practitioner on the same date of service should be rolled up. Please use the Request Billing Assistance form for State denials to open a ticket if you are following this guidance and continue to receive denials.
Are day rates and room and board rates now allowed to be billed for the date of discharge? If so, when did this take effect?	SAPC has been working to obtain clearer guidance from the State on this matter. Residential and withdrawal management providers cannot bill day rates on the date of discharge. If a patient is not staying at the facility overnight, the day rate cannot be billed. This will be published in the Provider Manual 10.0 which is to be released later this year.
What is the denial code CO A1 N421?	CO A1 N421 is related to "findings from a DHCS Post Service Post Payment (PSPP) Utilization review or SAPC Programmatic Compliance Monitoring Review." Essentially, the service was denied due to disallowance from post-service, post-payment utilization review related to an audit and the funds must be taken back.
Does SAPC allow applicants for registration as an AMFT, APCC, and ASW to provide and bill for services under the BBS 90-Day Rule?	Please email sage@ph.lacounty.gov for clarification on this question.
As the end of the fiscal year is approaching, how can we bill for clients who have inactive Medi-Cal? Do we need to wait until the client has active Medi-Cal before we can retroactively bill for previous months?	Yes, if a patient has a lapse in Medi-Cal coverage, you will need to help that patient re-establish their benefits. If you need assistance understanding the eligibility process, please reach out to DPH-SAPC-EST@ph.lacounty.gov SAPC also recommends that agencies run the 270 monthly to check Medi-Cal status and identify any patients who may need to re-establish benefits.
Our agency is receiving a lot of denials for HCPCS codes with guidance indicating that if we are using a HCPCS code, the HL modifier has been removed	The HL and GC modifiers are used to override the Medicare COB requirement for that particular service. This topic was covered in the February

and can only be used if client is Medi-Medi and the clinician is licensed. Please confirm if we must remove the HL modifier from our denied claims before replacing them.	Billing & Denial Resolution Tutoring Lab. Please click HERE for resources from past sessions.
How do we submit claims for clients previously funded under MHLA?	Please use the Request Billing Assistance form to open a ticket for each patient affected by this so that our staff can assist with updating their financial eligibility forms.
Our agency is receiving local denial CO 45, which says "charges exceed your contracted/legislated fee arrangement denials". However, we have confirmed that we do have dollars remaining on our contract but are waiting on an augmentation. Should we submit replacement claims for these denials or wait until the augmentation is processed?	This likely means that you are billing a higher amount than you should be. Please open a help desk ticket using the Request Billing Assistance form with the information so that our team can investigate these denials further.
How do secondary providers bill for H0049-N? What information is needed in PCNX and what reporting unit will it be billed under?	The guidance for this is changing soon. Moving forward, if a patient is not admitted during the time of screening for any reason, bill it as H2017 under the Recovery Services p-auth. Additionally, the Referral Connections form must be completed for any patient that was screened and not admitted.
Is a billing blackout scheduled for the beginning of the 25-26 fiscal year?	As of now, there is no billing blackout anticipated. If this changes, the update will be released in a SAPC Sage Provider communication.
Can we bill multiple group counseling services for a patient on the same day but at different times?	Yes, those services can be billed for the same day without being rolled up.
Is there a report in PCNX that allows us to track replacement claims?	Currently, there is no report that tracks replacement claims. However, you can track using your EOB or Cost of Service by Client Report.
Can we enter new authorizations for the next fiscal year early?	Yes, there is no authorization blackout for FY 25-26, so you can submit them now. As a reminder, authorizations that span across fiscal years will be split, so please ensure that you update that information in your system (secondary providers) or select the correct authorization when using the fast service entry submission form (primary providers).
If a claim is replaced because it was denied at the state level, how can we track if the claim has been resubmitted to the State?	The Patient Billing History widget in PCNX contains a column named "BilledToState" that indicates when a claim has been billed to the State. Agencies also receive a claim status report every month through the SFTP that shows all claims submitted in the last two years and includes State adjudication information.