# Sage Claim Denial Reason and Resolution Crosswalk (May 2020)

| Adjustment Reason Group Code | Claim Adjustment Reason Definition (CARC) | Explanation of Coverage Message/DMC Description | Original Claim Status | Denial Level<br>Level 1= Local<br>Level 2= State or SAPC Initiated Takeback | Adjudication Rule (Level 1 Denials Only) | Resolution |
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| PR1 | Deductible Amount (1)<br>Not Assigned by DHCS | Service line reimbursement adjusted due to share cost collected reported by provider. | Approved | Level 2 | The claim was approved, however the amount was reduced due to patient deductible amount, typically related to Share of Cost, that Medi-Cal shows as due for the service rendered to be paid by the patient and not the benefit plan. | Cause: The provider claimed the full amount to SAPC without collecting or reporting the Share of Cost collected from the patient for the service. The claim was adjudicated by the state and determined to have a Share of Cost that was not met at the time of the service. The claim was reduced by some or all of the charge depending on the Share of Cost amount.<br><br>Validation Steps: Verify patient's Medi-Cal eligibility via Sage Real Time 270 Request, DHCS website or AEVS system for dates of service to determine share of cost.<br><br>Primary and Secondary Sage Users: The provider is responsible for collecting this amount from the patient. The adjusted amount is not considered SAPC or DMC liability. |
| CO3 | Unable to generate (3)<br>Co-Payment Amount | N/A | Approved | Level 2 | The claim was approved, however the amount was reduced due to patient Co-Payment that was discovered after claim was approved and paid. | Cause: During a routine audit, either by the SAPC, DHCS or Auditor Controller, it was determined that the member had a Co-Payment amount that was already collected by provider and not reported to SAPC on the claim. This is typically related to Other Health Care (OHC) coverage. As such, Finance has issued a takeback for the Co-Payment amount of the claim.<br><br>Validation Steps: Verify patient's OHC via Sage Real Time 270 Request, DHCS website or AEVS system for dates of service to determine OHC liability. Contact patient's OHC to identify the Co-Payment amount if not known.<br><br>Primary and Secondary Sage Users: The Co-Payment amount is the responsibility of the provider to collect from the patient and is not considered the liability of SAPC or DMC. |
| CO4 M20 | The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (4)<br><br>Missing/incomplete/ invalid HCPCS. (M20) | Service line denied because either a youth service (with the HA modifier) was billed for a non-youth client (21 or older on any date of service) or a non-youth service (without the HA modifier) was billed for a youth client (under 21 on any date of service.) | Approved | Level 2 | N/A | Cause: Invalid HCPCS and Modifier combination. E.g. Youth HA modifier incorrectly added or left off the HCPCS code and does not match with the information on file with DHCS.<br><br>Validation:<br>1. Verify patient's legal age as on file with Medi-Cal.<br>2. Verify HCPCS code with modifier in Loop 2400, SV1 Professional Service Segment, matches approved CPT codes listed on the authorization and Rates/Standards Matrix and match the age of the patient for that date of service.<br>3. Verify approved authorization was submitted with the correct grouping, including LOC and age that matches patient's legal age. .<br><br>Resolution: Correct HCPCS code modifier on 837 or contact UM to deny incorrect authorization and submit new authorization with correct information. Submit replacement claim with corrected information.<br><br>Note: During the FY 17/18 implementation, Sage authorization groupings were listed as 21 and under or 21 and over groupings. . The correct grouping for a patient who was 21 for the date of service was to select the 21 and over grouping. Providers should replace these claims once the correct authorization grouping is in place and approved. |
| CO 5 | The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | Location's Place of Service Is Invalid For Procedure Code. | Approved | Level 2 | Place of Service on claim is not an approved place of service as listed in the Sage system, it will deny. | Cause: Place of Service is not a valid location for the service provided. This type of denial is part of an audit finding to be recouped by SAPC.<br><br>Validation steps: Verify type of location is an approved location for the type of service and matches the procedure billed.<br><br>Primary Sage User: Correct selected location type on the Add Treatment Details page, Location Field.<br><br>Secondary Sage User: Correct Place of Service code as listed on the 837 file, Loop 2400, SV1 Segment, SV105 element |

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| CO5 M77 | The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (5)<br><br>Missing/incomplete/ invalid/inappropriate place of service. (M77) | Location's Place of Service is Invalid for Procedure Code | Denied | Level 1 | Place of Service on claim is not an approved place of service as listed in the Sage system, it will deny. | Cause: Place of Service is not a valid location for the service provided.<br><br>Validation steps: Verify type of location is an approved location for the type of service and matches the procedure billed.<br><br>Primary Sage User: Correct selected location type on the Add Treatment Details page, Location Field.<br><br>Secondary Sage User: Correct Place of Service code as listed on the 837 file, Loop 2400, SV1 Segment, SV105 element |
| CO13 | The date of death precedes the date of service. (13) | The date of death in MEDS precedes the date of service. | Approved | Level 2 | If the date of service on claim is beyond the date of death on file with DHCS, the state will deny. | Cause: Service was claimed for a date of service after the official date of death as recorded in the state Medi-Cal system.<br><br>Validation steps: Confirm the date of service and the patient match. Verify the date of death on file with the state.<br><br>Primary Sage User and Secondary Sage User: If date of service was entered incorrectly or for the wrong patient on original claim, submit replacement claim with correct date. If no error is found with the date of service and patient, submit appeal to SAPC.<br><br>Please note that attempts to bill for service that were not delivered is considered fraudulent activity and subject to legal action. |
| CO13 N570 | The date of death precedes the date of service (13)<br><br>Missing/incomplete/ invalid credentialing data (N570) | The date of death in MEDS precedes the date of service. | Approved | Level 2 | If the date of service on claim is beyond the date of death on file with DHCS, the state will deny. | Cause: Service was claimed for a date of service after the official date of death as recorded in the state Medi-Cal system.<br><br>Validation steps: Confirm the date of service and the patient match. Verify the date of death on file with the state.<br><br>Primary Sage User and Secondary Sage User: If date of service was entered incorrectly or for the wrong patient on original claim, submit replacement claim with correct date. If no error is found with the date of service and patient, submit appeal to SAPC.<br><br>Please note that attempts to bill for service that were not delivered is considered fraudulent activity and subject to legal action. |
| CO16 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. | Duration Per Unit For Procedure Code Is Incorrect. | Denied | Level 1 | If the duration of the service does not match the duration per unit. | Cause: Service was submitted for a duration outside of the minimum/maximum per the Rates and Standards Matrix.<br><br>Validation Steps: Check documentation and internal records to verify duration of service. Verify actual duration of service was entered correctly on claim. If actual duration is found to be under the minimum for that service, this claim is not reimbursable and should not be resubmitted. If the claim is over the maximum, the claim can only be reimbursed up to the maximum amount noted on the Rates and Standards Matrix.<br><br>Primary Sage User: Re-submit claim with the units associated with the service on the 'Treatment' page if able and resubmit claim.<br><br>Secondary Sage User: Correct unit or minutes value on the 837 file, 2400 loop, that is associated with actual duration of service. |
| CO16 N379 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Claim level information does not match line level information.(379) | Claim Level Payment/Adjustment Information Found and No Service Level Payment/Adjustment Found. | Denied | Level 1 | If there is an AMT segment found in the 2300 loop, but no SVD/CAS segment found in the 2400 loop | Cause: The service level segment is missing on the 837 file or does not match the claim level segment.<br><br>Validation Steps: Verify service level and claim level segments are present and match on the 837 file, loop 2300 and 2400<br><br>Primary Sage User: N/A. This is only related to 837 claims.<br><br>Secondary Sage User: Ensure SVD and CAS segments of the 837 file are populated correctly and resubmit 837 with correct formatting. |
| CO16 M53 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid days or units of service.(M53) | Fractional units were billed for a service requiring billing in whole units. | Denied | Level 1 | If 'Service Units' is blank or zero it will deny. | Cause: Claim was submitted without or with invalid service units or service units qualifier on 837 file.<br><br>Validation Steps: Verify the service units listed on the 837 file, 2010BB segment were populated or valid values.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim without units entered.<br><br>Secondary Sage User: Correct missing service units information on the 837 file and resubmit claim. |

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| CO16 M53 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid days or units of service. (M53) | Service (other than NTP counseling) was billed with a number of units different from the number of days billed. | Approved | Level 2 | N/A | Cause: There is a mismatch between the service claimed and the date or date range used to identify date of service. Only certain services can be billed using a date range format. Typically, these are services with a maximum of 1 unit per day.<br>Additionally, when reporting units, the calculated units for the service were reported with fractional units, instead of whole numbers. Only group and patient education can support fractional units due to the 1 unit = 1 minute ratio.<br><br>Validation steps: Verify service/HCPCS code allows for a date range or fractional units to be submitted. Verify the structure of 837 is One Service-One Claim.<br><br>Primary Sage User: Replace any non day rate or max 1 unit/day claims that were submitted using the date range function when entering 'Treatments'.<br><br>Secondary Sage User: On the 837 file in Loop 2400, correct units in SV103 and SV104 elements or date format qualifier in DTP02 element for D8 or RD8 values. Submit replacement claims when corrected. |
| CO16 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16) | Submitted charge is blank. | Denied | Level 1 | If there is no 'Total Charge' it will deny. | Cause: Claim was submitted without or with invalid charge amounts values.<br><br>Validation Steps: Verify the total charge on the 837 file, charge segment was populated and valid values.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim without valid charges.<br><br>Secondary Sage User: Correct missing or invalid charges information on the 837 file and resubmit claim. |
| CO16 MA31 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid beginning and ending dates of the period billed.(MA31) | 837I: Service line Date of Service (DOS) "from" and "to" dates are not within the admission and discharge date range. | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br>Cause: Date range submitted does not fall within the admission and discharge dates on file with the state system.<br><br>Validation steps: Verify dates of service match admission and discharge dates reported to the state on Cal-OMS, DATAR or other admission data.<br><br>Secondary Sage User: : Correct and submit new Cal-OMS, DATAR or other admission data sources if error is found in reporting data. Correct dates of service if error is found in claim for date of service. Replace claim if error is found. |
| CO16 MA39 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid gender.(MA39) | Beneficiary identified as perinatal-eligible (Loop 2000B PAT09 is "Y"), but MEDS indicates the beneficiary is not female per FAME response.<br><br>837I: Claim level pregnancy indicator is present and the beneficiary is not female per FAME response. | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br>Cause: Indicated the patient is pregnant, where the state system shows the patient is not female.<br><br>Validation steps: Verify gender in Sage is correct and matches gender on claim. Verify pregnancy status indicator on claim should be on the claim. Verify authorization grouping is correct and should include perinatal codes.<br><br>Primary Sage User: Not applicable. This is only for providers who offer 3.7WM or 4.0WM levels of care.<br><br>Secondary Sage User: Correct any error found in client demographics for gender by contacting Sage Helpdesk. Correct errors found in authorization by submitting new authorization and contacting QI.UM inquiry line to deny incorrect authorization.<br>Additionally, correct Subscriber Gender Code on 837 file- 2010B Loop- DMG Segment- DMG03 element if incorrect. |
| CO16 MA39 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid gender.(M39) | Missing/incomplete/invalid gender. Gender submitted on 837 is not equal to gender received in FAME response. | Approved | Level 2 | N/A | Cause: Claim indicated the patient is pregnant, where the state system shows the patient is not female.<br><br>Validation steps: Verify gender in Sage is correct and matches gender on claim. Verify pregnancy status indicator on claim should be on the claim. Verify authorization grouping is correct and should include perinatal codes.<br><br>Primary Sage User: Correct any error found in client demographics for gender by contacting Sage Helpdesk. Correct errors found in authorization by submitting new authorization and contacting QI.UM inquiry line to deny incorrect authorization.<br><br>Secondary Sage User: Correct any error found in client demographics for gender by contacting Sage Helpdesk. Correct errors found in authorization by submitting new authorization and contacting QI.UM inquiry line to deny incorrect authorization.<br>Additionally, correct Subscriber Gender Code on 837 file- 2010B Loop- DMG Segment- DMG03 element if incorrect. |

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| CO16 N50 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid discharge information.(N50) | 837I: Missing/incomplete/invalid discharge information. Claim Frequency Type Code (CLM03) equals '2' (interim first claim) or '3' (interim continuing claim) and DTP01 equals '096' (i.e. discharge hour is indicated). | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br>Cause: Discharge information is missing or invalid on 837i file based on the claim information.<br><br>Validation steps: Verify on 837 file, Loop 2300-CLM05-03 segment has correct frequency code for the service provided and DTP-Discharge-DTP01 has the correct values for the service.<br><br>Primary Sage User: Not applicable.<br><br>Secondary Sage User: Correct information on 837I file if errors are found and submit replacement claim. |
| CO16 N259 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid billing provider/supplier secondary identifier. (N259) | Billing Provider EIN Submitter EIN does not match per DMC provider records. | Approved | Level 2 | N/A | Cause: Provider EIN as reported to SAPC contracts and entered into Sage does not match EIN on file with the state DMC certification.<br><br>Validation steps: Contact CPA to verify EIN on file and as entered into Sage matches EIN on state documents. Contact state analyst to verify EIN listed in state system matches EIN in Sage.<br><br>Primary Sage User: If error is found in Sage, contact Helpdesk to correct EIN. If error is found in state system, follow steps to correct EIN with state analyst.<br><br>Secondary Sage User: Correct EIN as listed on the 837 file under Loop 2010AA-N4 Billing Provider Segment-Ref02 element for EIN, if error was on 837 file. If error is found in Sage, contact Helpdesk to correct EIN. If error is found in state system, follow steps to correct EIN with state analyst. |
| CO16 N301 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid procedure date(s). (N301) | Service line denied because a service that is not methadone dosing was billed with a date range rather than a single date of service.<br><br>Service line denied because service "to" date proceeds "from" date. | Approved | Level 2 | N/A | Cause: Date range used on claim for service that does not allow for date range qualifier to be used.<br><br>Validation steps: Verify service claimed is not methadone and date qualifier is D8 or if service was methadone, verify date qualifier was RD8 on 837 file.<br><br>Primary Sage User: N/A. Billing through Provider Connect will prevent this error.<br><br>Secondary Sage User: Correct service in Loop 2400 or date format qualifier in DTP02 segment to correspond with the service provided. |
| CO16 N327 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid other insured birth date.(N327) | Missing/incomplete/invalid date of birth. Date of birth on 837 file does not match date of birth in FAME response. | Approved | Level 2 | N/A | Cause: Date of birth in Sage or as reported on 837 file does not match DMC secondary verification system, FAME. Date of birth may have matched MEDS file prior to billing to the state, however the state runs secondary check in FAME system to confirm date of birth.<br><br>Validation steps: Verify date of birth in Sage is correct and matches date of birth on 837 file, if billed using 837. Contact DHCS to verify date of birth in state system if Sage date of birth appears correct.<br><br>Primary Sage User: Correct any error found in client demographics for date of birth by contacting Sage Helpdesk. If Sage has correct DOB, work with DHCS/DPSS to correct date of birth on file with the state.<br><br>Secondary Sage User: Correct any error found in client demographics for date of birth by contacting Sage Helpdesk. If Sage has correct DOB, work with DHCS/DPSS to correct date of birth on file with the state.<br>Additionally, correct Subscriber Birth Date on 837 file- 2010B Loop- DMG Segment- DMG02 element if incorrect. |
| CO16 N345 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. (16)<br><br>Date range not valid with units submitted. (N345) | MAT services billed with fractional units must total one unit per drug type per day on a claim. | Approved | Level 2 | N/A | Cause: Secondary User only. 837 file service line units for MATsvcs were entered with a partial unit rather than a whole unit. MATsvcs should always be entered as 1 unit per day per patient.<br><br>Validation steps: Verify units on 837 file for date of service and drug type should be 1 unit per day using UN qualifier.<br><br>Primary Sage User: N/A. Primary Sage Users cannot enter fractional units.<br><br>Secondary Sage User: Correct units on the 837 file 2400 loop- SV1 Segment- SV103 and SV104 elements to UN and 1 unit if service is MATsvcs. |

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| CO16 N345 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. (16)<br><br>Date range not valid with units submitted. (N345) | 837I - The number of units billed exceeds the max days allowed (one unit billed per calendar day). | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br>Cause: More than one unit was billed per day per patient.<br><br>Validation steps: Verify unit(s) entered on 837I file.<br><br>Primary Sage User: N/A Primary Providers are not currently providing Institutional Services.<br><br>Secondary Sage User: Correct the units and/or dates of service on 2400 loop- SV2 segment- SV204 and SV205 elements |
| CO16 N345 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. (16)<br><br>Date range not valid with units submitted. (N345) | The units billed does not equal the number of days in the date range for a methadone dosing. | Approved | Level 2 | N/A | Cause: Methadone claim using day range but units do not equal number of days in range.<br><br>Validation steps: Verify date range and actual number of units based on services provided.<br><br>Primary Sage User: N/A. Billing through Provider Connect will prevent this error.<br><br>Secondary Sage User: Correct service units in Loop 2400 or date range segment to correspond with the service provided. |
| CO16 N521 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Mismatch between the submitted provider information and the provider information stored in our system. | Claim denied because Billing Provider EIN and NPI combination is not valid per DMC provider records. | Approved | Level 2 | N/A | Cause: Provider EIN and NPI as reported to SAPC contracts and entered into Sage does not match EIN and/or NPI on file with the state DMC certification.<br><br>Validation steps: Contact CPA to verify EIN and NPI on file and as entered into Sage matches EIN and NPI on state documents. Contact state analyst to verify EIN and NPI listed in state system matches EIN and NPI in Sage.<br><br>Primary Sage User: If error is found in Sage, contact Helpdesk to correct EIN or NPI. If error is found in state system, follow steps to correct EIN or NPI with state analyst.<br><br>Secondary Sage User: Correct EIN as listed on the 837 file under Loop 2010AA-N4 Billing Provider Segment-Ref02 element for EIN, if error was on 837 file. If error is found in Sage, contact Helpdesk to correct EIN. If error is found in state system, follow steps to correct EIN with state analyst. |
| CO16 N379 | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Claim level information does not match line level information. (N379) | Claim Level Payment/Adjustment Information Found and No Service Level Payment/Adjustment Found. | Denied | Level 1 | If there is an AMT segment found in the 2300 loop, but no SVD/CAS segment found in the 2400 loop | Cause: The service level segment is missing on the 837 file or does not match the claim level segment.<br><br>Validation Steps: Verify service level and claim level segments are present and match on the 837 file, loop 2300 and 2400<br><br>Primary Sage User: N/A. This is only related to 837 claims.<br><br>Secondary Sage User: Ensure SVD and CAS segments of the 837 file are populated correctly and resubmit 837 with correct formatting. |
| CO22 N479 | This care may be covered by another payer per coordination of benefits. (22)<br><br>Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).(N479) | Third Party Payer Does Not Exist in Client Financial Eligibility Record | Denied | Level 1 | If the Third Party Payer information is missing or invalid, it will deny. | Cause: Financial eligibility, MEDS file and/or 837 file indicate patient has OHC, but claim did not indicate adjudication or payment by OHC.<br><br>Validation Steps: Verify medi-cal eligibility though Real-Time 270 Request in Sage, AEVS, DHCS eligibility website to confirm if patient has third party coverage or OHC for the time period of the service. If patient has OHC, the OHC must be billed before sending claim to SAPC. A valid adjudication code must be included on the claim.<br><br>Primary Sage User: Include OHC information on the Financial Eligibility Guarantor section in Sage and enter any payments received on the Treatment Details page.<br><br>Secondary Sage User: Include OHC information on the Financial Eligibility Guarantor section in Sage and enter payments or adjudication code on 837 file in the Line Adjudication Information Loop 2430- OHC/Medi-Cal Claims, SVD, CAS and DTP segments. |

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| CO22 N479 | This care may be covered by another payer per coordination of benefits. (22)<br><br>Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). (N479) | Missing valid Third Party Guarantor. | Denied | Level 1 | If the Payer's Primary Identification Number of the Third Party Payor indicated is not associated to a Guarantor on the Financial Eligibility form, it will deny. | Cause: Financial eligibility, MEDS file and/or 837 file indicate patient has OHC, but claim did not indicate adjudication or payment by OHC.<br><br>Validation Steps: Verify medi-cal eligibility though Real-Time 270 Request in Sage, AEVS, DHCS eligibility website to confirm if patient has third party coverage or OHC for the time period of the service. If patient has OHC, the OHC must be billed before sending claim to SAPC. A valid adjudication code must be included on the claim.<br><br>Primary Sage User: Include OHC information on the Financial Eligibility Guarantor section in Sage and enter any payments received on the Treatment Details page.<br><br>Secondary Sage User: Include OHC information on the Financial Eligibility Guarantor section in Sage and enter payments or adjudication code on 837 file in the Line Adjudication Information Loop 2430- OHC/Medi-Cal Claims, SVD, CAS and DTP segments. |
| CO26 N52 | Expenses incurred prior to coverage. (26)<br><br>Patient not enrolled in the billing provider's managed care plan on the date of service.(N52) | Date Of Service Is Prior To Plan Effective Date. | Denied | Level 1 | If Date Of Service' is prior to 'Date Plan Offered Effective Date' in 'Plan Definition', it will deny. | Cause: Date of service claimed is prior to Coverage Effective Date for primary guarantor in Financial Eligibility or prior to Effective Date of Contract on Financial Eligibility for the primary guarantor.<br><br>Validation Steps: Coverage effective date for the primary guarantor must be on or before the date of service if patient admitted to program already enrolled in DMC. If provider assisted patient enroll in DMC or the effective date is known, then that date should be entered in the Coverage Effective Date field. Effective Date of Contract should not be changed by provider and should always be 01/01/2000. Verify the above information on the Financial Eligibility form.<br><br>Primary Sage User: Correct any date information on the Financial Eligibility form in Sage to match the actual coverage dates for the patient.<br><br>Secondary Sage User: Correct any date information on the Financial Eligibility form in Sage to match the actual coverage dates for the patient. |
| CO27 N52 | Expenses incurred after coverage terminated. (27)<br><br>Patient not enrolled in the billing provider's managed care plan on the date of service. (N52) | Member Not Eligible On Date Of Service. | Denied | Level 1 | Eligibility is verified against the MEDS file provided monthly by DHCS. If the service date does not fall within the eligibility period, it will deny. | Cause: Date of service claimed after the primary guarantor's coverage has expired. The patient lost DMC or other county funding benefits or was not covered on that date of service. This is generally an error where a date was entered into the Coverage Expiration Date field instead of the Coverage Effective Date field for the primary guarantor on the Financial Eligibility form.<br><br>Validation Steps: Verify medi-cal eligibility though Real-Time 270 Request in Sage, AEVS, DHCS eligibility website to confirm patient has active DMC eligibility for the date of service claimed. Verify the Coverage Expiration Date field on the primary guarantor in Financial Eligibility form is either blank or after the date of service if known.<br><br>Primary Sage User: Correct any date information on the Financial Eligibility form in Sage to match the actual coverage dates for the patient. Refer to most recent SAPC Provider Manual for claiming for services rendered if a patient loses DMC coverage during treatment.<br><br>Secondary Sage User: Correct any date information on the Financial Eligibility form to match the actual coverage dates for the patient. Refer to most recent SAPC Provider Manual for claiming for services rendered if a patient loses DMC coverage during treatment. |
| CO27 | Expenses incurred after coverage terminated. (27) | Member not enrolled on date of service.<br><br>Member not eligible on date of service - no plan identified. | Denied | Level 1 | If the 'Require Member Enrollment' registry setting is enabled and member is not enrolled on 'Date Of Service' for 'Funding Source' it will deny. | Cause: When patient policy was termed at the time of service.<br><br>Validation Steps: First check eligibility to confirm policy effective and termination date. If come across patient policy is active, send claim back for reprocessing.<br><br>Primary and Secondary Sage User: Correct any date information on the Financial Eligibility form in Sage to match the actual coverage dates for the patient. Refer to most recent SAPC Provider Manual for claiming for services rendered if a patient loses DMC coverage during treatment. |

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| CO29 | The time limit for filing has expired. (29) | Service Exceeded Allowed Number Of Days Prior to Date Of Claim. | Denied | Level 1 | If difference between 'Date Claims Received' and 'Date Of Service' is greater than 'Maximum Number of Days Prior to 'Date Claims Received' Date of Service is Permitted'. | Cause: The actual date of service for the claim was more than 365 days from the date of submission to SAPC. For replacement claims, more than 720 days from date of service.<br><br>Validation Steps: Verify the date of service for the claim was within the time frame or not. If date of service was beyond 365 for an original claim, it cannot be processed under normal conditions.<br><br>Primary Sage User: Correct date of service if it was entered incorrectly. If date of service was beyond 365 contact your agency's financial analyst for additional guidance.<br><br>Secondary Sage User: Correct date of service if it was entered incorrectly. If date of service was beyond 365 contact your agency's financial analyst for additional guidance. |
| CO29 | The time limited for filing has expired. (29) | Services in the Claim span the EOB Fiscal year. | Denied | Level 1 | If the services in the claim spans fiscal years, the claims will be pended for manual adjudication | Cause: The 837 file contained claims from multiple fiscal years. Only the current fiscal year's claims were processed. The previous fiscal year claims were separated out and denied.<br><br>Validation Steps: Verify 837 contained claims spanning an EOB fiscal year which are always 07/01/XX-06/30/XX.<br><br>Primary Sage User: N/A. Primary users cannot submit claims that cross a fiscal year as Sage will not populate an authorization for that time frame.<br><br>Secondary Sage User: Resubmit claims for only one fiscal year per 837 file. |
| CO29 | The time limited for filing has expired. (29) | Claim denied for late submission. | Approved | Level 2 | N/A | Cause: The claim was submitted more than 6 months from the date of service without a delay reason code, or more than 365 days from date of service. This could also be triggered if the replacement claim was submitted beyond 730 days from original date of service.<br><br>Validation: SAPC to verify if a late code was added to the 837/837I sent to the state. Providers to verify if the claim is an original claim or a resubmission/replacement. Verify the date of service entered on the claim was correct without a data entry error.<br><br>Primary and Secondary Sage Users: If the claim was legitimately denied due to being outside of DMC set time frames, contact the agency's Financial Analyst for more information if claim is reimbursable. If there was a data entry error, replace claim with correct information. |
| CO31 N382 | Patient cannot be identified as our insured. (31)<br><br>Missing/incomplete/invalid patient identifier. (N382) | Member ID is blank. | Denied | Level 1 | If there is no 'Member Name Or ID' it will deny. | Cause: Member name or ID on the 837 file is missing or in an invalid format.<br><br>Validation Steps: Verify the member name is present on the 837 file and the member ID is formatted correctly starting with MSO then the Sage ID.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim with a blank or invalid member ID.<br><br>Secondary Sage User: Ensure the name or ID is present and formatted correctly, then resubmit claim. |
| CO45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (45) | Charges reduced because they exceed the maximum allowed given the established rate and the billed units of service. | Denied | Level 1 | If charged amount is greater than the contracted fee schedule amount, claim will pay at the fee schedule. If the charged amount is lower than the fee schedule amount, the claim will be paid at the fee schedule higher than the charge amount. | Cause: Charged amount on claim is different than the fee schedule amount, which is configured based on the rates and standards matrix for the service provided, level of care and population specifiers.<br><br>Validation Steps: Verify amount charged is equal to the rate listed for that service from the rates and standards matrix available on the SAPC website. Note: Providers contracted to provider services to either youth or PPW populations have a separate rates and standards matrix with rates specific to contracted specialty population providers.<br><br>Primary Sage User: As the claim was paid at the contracted rate for the service, no action is needed, unless the service was incorrectly billed or the authorization was for the wrong grouping. Correct authorization, void claim and resubmit under new authorization if appropriate. Void and replace claim if the service billed was incorrect or not paid at the amount indicated on the rates and standards matrix.<br><br>Secondary Sage User: Charge amount is found on Loop 2400-SV1 segment-SV102 element. As the claim was paid at the contracted rate for the service, no action is needed, unless the service was incorrectly billed or the authorization was for the wrong grouping. Correct authorization, void claim and resubmit under new authorization if appropriate. Void and replace claim if the service billed was incorrect or not paid at the amount indicated on the rates and standards matrix. |

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| CO45 N640 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (45)<br><br>Exceeds number/frequency approved/allowed within time period. (N640) | This service occurs during a claim processing blackout. | Denied | Level 1 | If the service date occurs during a blackout period for the selected authorization, it will deny | Cause: A claims processing blackout was placed on this patient due to eligibility requirements not being met or the entire agency due to a fiscal year configuration. Blackouts are placed on all agencies at the beginning of a fiscal year to prevent premature billing. If an agency bills prior to receiving the official approval from Contracts, all claims will be denied for this reason. Blackouts placed by UM due to incomplete eligibility information will result in the claim being pended.<br><br>Validation Steps: Verify you have received an official communication from SAPC that you are able to submit claims if this is related to a fiscal year configuration. Contact QI.UM at 626.299.3531 if the claim is pended due to missing eligibility information to determine what information was missing. These claims will only be for FY 2017/18 claims. Individual blackouts were not placed after FY 17/18, however may still be in place for dates of service up to 06/30/18.<br><br>Primary Sage User: Contact the agency's CPA for fiscal year blackouts and QI.UM at 626.299.3531 for individual claims blackouts.<br><br>Secondary Sage User: Contact the agency's CPA for fiscal year blackouts and QI.UM at 626.299.3531 for individual claims blackouts. |
| CO45 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) (45) | Charges reduced because they exceed the maximum allowed given the established rate and the billed units of service. | Approved | Level 2 | N/A | Cause: Partial payment was approved as the amount charged exceeded the established rate/billed UOS.<br><br>Validation Steps: Verify if charged amount was in accordance to established rates at the time of service.<br><br>Primary and Secondary Sage Users: Submit replacement claim for service with the correct rate per the SAPC rates and standards. |
| CO96 M80 | Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>Not covered when performed during the same session/date as a previously processed service for the patient. (M80) | This service is not allowed on the same date as one or more previously-approved services for this beneficiary. | Approved | Level 2 | N/A | Cause: This may occur when there is a duplicate service or if a service like an admission was completed on the same day as a discharge across different programs or different providers. This code applies to both 837P and 837I claims.<br><br>Validation Steps: Review dates of service being claimed are accurate and do not violate the DHCS Same Day Billing Matrix from MHSUDS 17-039.<br><br>Primary and Secondary Sage Users: If the service was delivered on the same day as another service marked as not reimbursable on the DHCS Same Day Billing Matrix, then the claim should not be replaced as it is not reimbursable. However, if there was a mistake found on the date of service, then providers should submit a replacement claim.<br><br>If a patient is being discharged from a residential or inpatient level of care to any other level of care, only one site or provider can bill on the discharge date. For example, if a patient is discharged on 04/01/2020 an OTP provider and admitted to another OTP provider on 04/01/2020, only one provider should be claiming for Methadone as the patient should not be receiving Methadone from 2 providers on the same day. The discharging provider should use 3/31/2020 as the discharge date to correspond with the last Methadone dose. |
| CO96 M114 | Non-covered charge(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor. (M114) | 837I: Beneficiary is 21 years of age or more on the service "start date" and youth indicator is reported on the claim *or* beneficiary is less than 21 years of age on the service "end date" and youth indicator is not reported on the claim. | Approved | Level 2 | N/A | This applies to only 837I claims and services.<br>Cause: Invalid HCPCS and Modifier combination. E.g. Youth HA modifier incorrectly added or left off the HCPCS code and does not match with the information on file with DHCS.<br><br>Validation:<br>1. Verify patient's legal age as on file with Medi-Cal.<br>2. Verify HCPCS code with modifier in Loop 2400, SV1 Professional Service Segment, matches approved CPT codes listed on the authorization and Rates/Standards Matrix and match the age of the patient for that date of service.<br>3. Verify approved authorization was submitted with the correct grouping, including LOC and age that matches patient's legal age. .<br><br>Resolution: Correct HCPCS code modifier on 837 or contact UM to deny incorrect authorization and submit new authorization with correct information. Submit replacement claim with corrected information. |

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| CO96 N30 | Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>Patient ineligible for this service. (N30) | 837I: The claim level pregnancy indicator is not present for a perinatal service. | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br>Cause: For 837I file, the service is for a perinatal service, with the HD modifier, however the patient is not listed as being pregnant in the CLM subscriber information.<br><br>Validation steps: Verify if patient is pregnant or if claim was mistakenly entered with HD modifier. Verify authorization is correct for either PPW or non PPW.<br><br>Primary Sage User: Correct authorization after confirming pregnancy status by contacting QI.UM. Submit new authorization with correct information.<br><br>Secondary Sage User: Correct either the 837I file to include the correct information or correct the authorization by contacting QI.UM, after submitting a new authorization. |
| CO96 N129 | Non-covered charge(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>Not eligible due to the patient's age. (N129) | Beneficiary is 21 years of age or more on the service “start date” and "HA" modifier is reported on the claim *or* beneficiary is less than 21 years of age on the service “end date” and "HA" modifier is not reported on the claim. | Approved | Level 2 | N/A | Cause: Modifier was not properly incorporated.<br><br>Validation Steps:<br>Verify patient's age at the time of service. Verify which modifier, if any, is appropriate and compare if it matches the claim. Verify authorization is for the correct age grouping.<br><br>Primary Sage User: Replace claim with modifier for the date of service.<br><br>Secondary Sage User: Replace claim with correct modifier for the date of service. |
| CO96 N216 | Non-covered charge(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. (N216) | Procedure codes and modifiers and/or National Drug Code service combination do not identify an allowable Drug Medi-Cal Organized Delivery System (ODS) service. | Approved | Level 2 | N/A | Cause: Patient may not be enrolled in DMC. Service type entered is not DMC reimbursable.<br><br>Validation steps: SAPC to validate if non-DMC claims were submitted to the State. Provider to verify patient eligibility. Verify financial eligibility, MEDS file and/or 837 file, provider name, birth date make sure provider was certified/eligible to be paid for this service.<br><br>Primary Sage Users and Secondary Sage Users: Replace the claim if patient was Medi-Cal enrolled and approved for procedure on the date of service. |
| CO96 N216 | Non-covered charge(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package. (N216) | 837I: The Revenue Code, Procedure<br>Coding System Code and/or Demonstration Project Identifier combination is not a valid DMC institutional service combination. | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br><br>Cause: Patient may not be enrolled in DMC. Service type entered is not DMC reimbursable.<br><br>Validation steps: SAPC to validate if non-DMC claims were submitted to the State. Provider to verify patient eligibility. Verify financial eligibility, MEDS file and/or 837 file, provider name, birth date make sure provider was certified/eligible to be paid for this service.Validate Revenue Code on 2400 Loop- SV2 Segment- SV201 element. Validate Procedure Coding on 2110 Loop- SVC Segment.<br><br>Secondary Providers: Replace the claim if patient was Medi-Cal enrolled and approved for procedure on the date of service. |
| CO96 N362 | Non-covered charge(s). ) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>The number of Days or Units of Service exceeds our acceptable maximum. (N362) | Service line denied because the units billed are greater than 1, excluding ODS NTP Dosing services or services that have either a 10 minute or 15 minute increment unit of measure. | Approved | Level 2 | N/A | Cause: Service with maximum units per day as 1 claimed using more than 1 unit. .<br><br>Validation steps: Verify service and HCPCS code match and correct number of units is 1 per day.<br><br>Primary Sage User: Replace claim with correct number of units per service.<br><br>Secondary Sage User: Replace claim with correct number of units on the 837 file. |

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| CO96 N424 | Non-covered charge(s). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (96)<br><br>Patient does not reside in the geographic area required for this type of payment.(N424) | The billing county is not the county of responsibility for the beneficiary. | Approved | Level 2 | N/A | Cause: the patient's Medi-Cal is associated with a different county.<br><br>Verify: Verify when the Medi-Cal transfer process began. If Medi-Cal transferred occurred was the transfer date effective when the request was made. Verify if there is an MOU or contract for an LA County Provider to accept patients with out of county Medi-Cal. Review authorization/ financial eligibility/client address is correct. Check the patient address, bill under the Non-DMC if the client in the process of changing address<br><br>Primary and Secondary Sage Users: Void original approved claim and resubmit claim under non-DMC fund. |
| CO109 N480 | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. (109)<br><br>Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).(N480) | The total third party payment amounts exceed the total third party amount provided. | Denied | Level 1 | If the total of the third party amounts is greater than the 'Third Party Amount Paid'. | Cause: Total charges and total services provided are not equal and considered out of balance for third party payments and charges.<br><br>Validation Steps: Verify the number of services listed on the claim match the total amount paid listed on the claim.<br><br>Primary Sage User: N/A. Although primary users enter OHC payments, it is entered one service at a time. This cannot be out of balance through Sage.<br><br>Secondary Sage User: Correct OHC payments and services information are in balance. Total amount paid by a third party must equal the total number of services. |
| CO110 | Billing date predates service date. | Service date cannot be later than submission date. | Approved | Level 2 | N/A | Cause: Billing occurred prior to Episode admission.<br><br>Validation Steps: Validate the Episode Start date is not after the first service billed. If it is submit a helpdesk ticket to correct the Episode Start date.<br><br>Primary and Secondary Sage Users: replace the claim once the service and or episode date are corrected. |
| CO119 N362 | Benefit maximum for this time period or occurrence has been reached. (119)<br><br>The number of Days or Units of Service exceeds our acceptable maximum. (N362) | Service exceed the applicable (youth or adult) non-perinatal residential stay limit for the calendar year. | Approved | Level 2 | N/A | Cause: Patient exceeded their number and/or length of stay at a residential facility for a calendar year. Services that exceed the limit are denied. DMC only covers 2 admissions per calendar year. SAPC uses other funding to cover any services outside of the 2 admissions.<br><br>Validation steps: Verify number of residential admissions and length of stay. Verify if this was a resubmitted claim vs a corrected replaced claim.<br><br>Primary and Secondary Sage Users: Contact your Financial Analyst for additional assistance. |
| CO143 | Portion of payment deferred. | Portion of payment for approved services deferred due to insufficient contract balances. Claim is older than 700 days, payment deferred through Cost Settlement. | Approved | Level 2 | N/A | Cause: Claim(s) exceed State threshold and payment is deferred through Cost Settlement.<br><br>Please contact your Financial Analyst for resolution steps for this denial. |
| CO150 N362 | Payor deems the information submitted does not support this level of service. (150)<br><br>The number of Days or Units of Service exceeds our acceptable maximum. | Approved units limited to fee definition maximum. | Denied | Level 1 | If the total amount of units in the system is over the maximum for that date of service, it will deny. | Cause: The procedure code is restricted to a unit per day maximum, such as methadone as one unit per day. The denied claim was submitted for more than the maximum units or there is already an approved claim in the system that has satisfied the per day maximum.<br><br>Validation Steps: Verify the number of units billed is correct based on the service provided and does not exceed the maximum per day limit. Additionally, cross check any approved claims for the same service on the same date of service.<br><br>Primary Sage User: Resubmit claim using correct units/day billed on the 'Professional Treatment' page in Sage. If claim has already paid out, then no further action is need as this is a duplicate service.<br><br>Secondary Sage User: Resubmit claim ensuring units billed on the 837 file, 2400 loop, SV1, segment, SV104 element does not exceed the maximum for the procedure. If claim has already been paid out, then no further action is needed as this is a duplicate service. |

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| CO152 M53 | Payer deems the information submitted does not support this length of service (152)<br><br>Missing/incomplete/invalid days or units of service. (m53) | Specified Duration is not valid for Procedure Code. | Denied | Level 1 | If the duration exceeds the 'Maximum Duration' or is lower than the 'Minimum Duration', it will deny. | Cause: Service was submitted for a duration outside of the minimum/maximum per the Rates and Standards Matrix.<br><br>Validation Steps: Check documentation and internal records to verify duration of service. Verify actual duration of service was entered correctly on claim. If actual duration is found to be under the minimum for that service, this claim is not reimbursable and should not be resubmitted. If the claim is over the maximum, the claim can only be reimbursed up to the maximum amount noted on the Rates and Standards Matrix.<br><br>Primary Sage User: Re-submit claim, with the corrected units associated with the service, on the 'Treatment' page if able and resubmit claim.<br><br>Secondary Sage User: Correct unit or minutes value on the 837 file, 2400 loop, SV1 segment, SV104 element, that is associated with actual duration of service. |
| CO167 N30 | This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (167)<br><br>Patient ineligible for this service. (N30) | Service line did not contain a valid Drug Medi-Cal diagnosis code. | Approved | Level 2 | N/A | Cause: Principle diagnosis is not a covered SUD diagnosis.<br><br>Validation steps: Verify the principle diagnosis is an SUD approved diagnosis. Check the ICD and DSM Crosswalk from the SAPC website: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/ICD10DSM5Crosswalk.pdf<br><br>Primary and Secondary Users: Void the diagnosis in Sage and submit a new "update' diagnosis type with the correct diagnosis, then replace the claim. |
| CO177 N59 | Patient has not met the required eligibility requirements. (177) Please refer to your provider manual for additional program and provider information. (N59) | This client is not eligible for this service. Avatar Financial Eligibility Record check failed. Changing claim status to Denied and the reason to Eligibility not found/verified in CalPM. | Denied | Level 1 | If criteria used to submit the claim to the state is missing or incorrect, it will deny. | Cause: Patient information or guarantor information as entered on the Financial Eligibility form, and the Provider Diagnosis (ICD-10) is missing, or does not meet the standard eligibility requirements for specialty SUD services.<br><br>Validation: Verify that Patient's Financial Eligibility form is complete, saved and submitted. For DMC Guarantor, ensure that form includes:<br>-CIN, DOB, address (Line 1, State, City, Zip Code),<br>-Eligibility Verified, coordination of benefits, Subscriber Assignment of Benefits all must be set to "Yes"<br>-Coverage Effective date must be on or before episode admission . Verify the client was Medi-Cal eligible for service date billed using the Real-Time 270 Request (This will update the internal MEDS file if outdated)<br>-The Provider Diagnosis (ICD-10) must have a valid, DMC approved SUD diagnosis and an admission diagnosis.<br>-Date of admission diagnosis must be the episode admission or prior to the service claimed date if readmission.<br>-Diagnosis ranking and billing order must match.<br><br>Primary Sage User: Correct the above information and resubmit claim.<br><br>Secondary Sage User: Correct/update the above information and ensure the diagnosis on the 837 file, 2010B loop, HI Diagnosis Pointer segment, HI101 element matches the diagnosis as entered into the Sage system. |
| CO177 | Patient has not met the required eligibility. (177) | Beneficiary aid code is "restricted to pregnancy services" and the client is not identified as perinatal-eligible (Loop 2000B PAT09 is "Y" not provided).<br><br>Long Term Care aid code "13", "23", "63" are only allowed for NTP services.<br><br>Claim denied due to no valid aid code for month of service.<br><br>MEDS indicates this client has non-Medicare other health coverage, and the claim does not indicate that coverage has been billed first. | Approved | Level 2 | N/A | Cause: Patient does not have active coverage for the date of service claimed, the proper aid code was not used or the patient has other health coverage that was not billed first.<br><br>Validation Steps: Verify patient's Medi-Cal eligibility via Sage Real Time 270 Request, DHCS website or AEVS system for dates of service. Verify correct Aid Code was entered on the Financial Eligibility Form. Verify Long Term Care aid code is only included for patients in OTP.<br><br>If patient has OHC, demonstrate OHC was billed first.<br><br>Primary Sage User: Drug Medi-Cal is identified as the secondary insurance and the primary guarantor is identified as a commercial insurance plan on the Financial Eligibility. If patient was not eligible, or has OHC that was billed and payment was received, please contact your finance analyst for individual support.<br><br>Secondary Sage User: Drug Medi-Cal is identified as the secondary insurance and the primary guarantor is identified as a commercial insurance plan in SBR01. Verify a primary insurer is listed on the 837 file and any coordination of benefits payments made from primary insurer is indicated on the AMT segment. If patient was not eligible, please contact your finance analyst for individual support. |

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| CO181 | Procedure code was invalid on the date of service (181) | Procedure code type is blank. | Denied | Level 1 | If there is no 'Procedure Code Type' it will deny. | Cause: The 837 file was submitted without a procedure code type or an invalid procedure code type.<br><br>Validation Steps: Verify the procedure code type is present, in the correct format and a valid type for the procedure code according to the most recent SAPC Companion Guide.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim with a blank or invalid procedure code type.<br><br>Secondary Sage User: Enter or correct the procedure code type as shown on the 837 file, 2400 loop, SV1 segment, SV101 elements and resubmit claim. |
| CO181 MA66 | Procedure code was invalid on the date of service (181)<br><br>Missing/incomplete/invalid principal procedure code. (MA66) | Procedure code is blank. | Denied | Level 1 | If there is no 'Procedure Code' it will deny. | Cause: The 837 file was submitted without a procedure code or an invalid procedure code.<br><br>Validation Steps: Verify the procedure code is present, in the correct format and a valid procedure code as listed on the rates and standards matrix and on the approved authorization.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim with a blank or invalid procedure code.<br><br>Secondary Sage User: Enter or correct the procedure code that is associated to the service, as shown on the 837 file, 2400 loop, SV1 segment, SV101 elements and resubmit claim. |
| CO197 M62 | Precertification/ authorization/notification/pre-treatment absent. (197)<br><br>Missing/incomplete/invalid treatment authorization code. (M62) | Authorization is blank | Denied | Level 1 | If there is no 'Authorization Number' it will deny. | Cause: The 837 file was submitted without an authorization number in the correct loop-segment-element.<br><br>Validation Steps: Verify the authorization number is present, in the correct format and a valid authorization equal to the same number showing in Sage on the Authorization Request.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim with a blank authorization number.<br><br>Secondary Sage User: Enter or correct the authorization number, that is the same as the authorization in Sage, as shown on the 837 file, 2400 loop, REF segment, REF01,02 elements and resubmit claim. |
| CO197 N521 | Precertification/ authorization/notification/pre-treatment absent (197)<br><br>Mismatch between the submitted provider information and the provider information stored in our system. | Authorization number unknown to system. | Denied | Level 1 | If entered 'Authorization Number' is not found in MSO it will deny. | Cause: The authorization number used does not exist in Sage for any patient.<br><br>Validation Steps: Verify the authorization number is populated, in the correct format and a valid authorization equal to the same number showing in Sage on the Authorization Request.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim with a blank authorization number.<br><br>Secondary Sage User: Enter or correct the authorization number, that is the same as the authorization in Sage, as shown on the 837 file, 2400 loop, REF segment, REF01,02 elements and resubmit claim. |
| CO197 N362 | Precertification/authorization/notification/pre-treatment absent. (197)<br><br>The number of Days or Units of Service exceeds our acceptable maximum. (N362) | No units remain for this procedure code on this authorization. | Denied | Level 1 | If the units within the authorization for the 'Procedure Code' are exhausted it will deny. | Cause: This is a historical denial from FY 17/18 and part of 18/19. Each authorized CPT code on the authorization was assigned a maximum number of units to bill, which was subsequently raised so this denial would not activate.<br><br>Validation Steps: Verify the units authorized for the procedure code on the authorization used is 99999 on the Authorization Request display in Sage.<br><br>Primary Sage User: No edits or changes are needed to resolve as long as the units authorized is showing as 99999. Resubmit claim once verified.<br><br>Secondary Sage User: No edits or changes are needed to resolve as long as the units authorized is showing as 99999. Resubmit claim once verified. |

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| CO197 N41 | Precertification/authorization/notification/pre-treatment absent. (197)<br><br>Authorization request denied. | Authorization is denied. | Denied | Level 1 | If the 'Current Authorization Status' is 'Denied' for the 'Authorization Number' it will deny. | Cause: Provider submitted claim before verifying the authorization was approved or did not update their system to reflect the approved authorization number. At times, UM will need to subsequently deny a previously approved authorization and create a new approved authorization due to a nonclinical reason.<br><br>Validation Steps: Verify the authorization number used to claim is approved by checking the Authorization Request for the specific patient or the Authorization Request Status Report for a group of authorizations in Sage. If the authorization is denied, there will be comments explaining why it was denied. UM attempts to contact providers for all denied authorizations.<br><br>Primary Sage User: Primary users cannot submit a claim if the authorization was denied. If a primary user receives this denial and the authorization is actually denied, it was likely approved initially and subsequently denied. Contact QI.UM at 626.299.3531 for further information and instruction.<br><br>Secondary Sage User: Before submitting claims, ensure all authorizations on the 837 form are approved using the Authorization Request Status Report in Sage. Update any denied authorization numbers on the 2400 loop, REF segment, REF02 elements, with an approved authorization for that patient and service and resubmit claim. |
| CO197 N581 | Precertification/authorization/notification/pre-treatment absent. (197)<br><br>Investigation of coverage eligibility is pending. (N581) | Authorization is pending. | Denied | Level 1 | If the 'Current Authorization Status' is 'Pending' for the 'Authorization Number' it will pend. | Cause: Provider submitted claim before verifying the authorization was approved or did not update their system to reflect the approved authorization number.<br><br>Validation Steps: Verify the authorization number used to claim is approved by checking the Authorization Request for the specific patient or the Authorization Request Status Report for a group of authorizations in Sage. If the authorization is denied, there will be comments explaining why it was denied. UM attempts to contact providers for all denied authorizations.<br><br>Primary Sage User: Primary users cannot submit a claim if the authorization was denied. If a primary user receives this denial and the authorization is actually denied, it was likely approved initially and subsequently denied. Contact QI.UM at 626.299.3531 for further information and instruction.<br><br>Secondary Sage User: Before submitting claims, ensure all authorizations on the 837 form are approved using the Authorization Request Status Report in Sage. Update any denied authorization numbers on the 2400 loop, REF segment, REF02 elements, with an approved authorization for that patient and service and resubmit claim. |
| CO198 N510 | Precertification/ authorization exceeded. (198)<br><br>Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing. (N510) | No dollars remain for this authorization. | Denied | Level 1 | If all liability has been used for the authorization, it will deny | Cause: This is a historical error that occurred in FY 17/18. This occurred due to a configuration issue that has been resolved that limited the liability per authorizations, primarily on Provider Auths.<br><br>Validation Steps: Verify with the agency's CPA that the provider or member auth in question has been updated to the correct liability values for the agency. Or if a new authorization was created to correct the error.<br><br>Primary Sage User: Resubmit claim using the corrected authorization or a new authorization.<br><br>Secondary Sage User: Resubmit claim using the corrected authorization or a new authorization. |
| CO198 | Precertification/authorization exceeded. (198) | The remaining liability of the Contracting Provider Authorization linked to this Authorization is $0 | Denied | Level 1 | If a Member Authorization is used and it is linked to a Contracting Provider Authorization with $0 remaining liability, it will deny. | Cause: This is a historical error that occurred in FY 17/18. This occurred due to a configuration issue that has been resolved that limited the liability per authorizations, primarily on Provider Auths.<br><br>Validation Steps: Verify with the agency's CPA that the provider or member auth in question has been updated to the correct liability values for the agency. Or if a new authorization was created to correct the error.<br><br>Primary Sage User: Resubmit claim using the corrected authorization or a new authorization.<br><br>Secondary Sage User: Resubmit claim using the corrected authorization or a new authorization. |

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| CO198 | Precertification/authorization exceeded. (198) | No dollars and or visits remain for this procedure code on this authorization. | Denied | Level 1 | if there are no units left for the CPT code on the authorization, it will deny. | Cause: This is a historical error that occurred in previous years. This occurred due to a configuration issue that has been resolved that limited the available units per authorized CPT code. The units per CPT have been increased to avoid this denial.<br><br>Validation Steps: Verify the authorization shows 99999 units available for each CPT code.<br><br>Primary Sage User: Resubmit claim using the corrected authorization or a new authorization.<br><br>Secondary Sage User: Resubmit claim using the corrected authorization or a new authorization. |
| CO200 MA129 | 200-Expenses incurred during lapse in coverage (200)<br><br>This provider was not certified for this procedure on this date of service. (MA129) | Funding source not eligible on date of service for member. | Denied | Level 1 | If admission date is after the date of service, it will deny. | Cause: Date of service is prior to episode start date for the provider. Episode start dates reflect the first ever admission by the patient to the provider. This date will not change if the patient discharges and re-admits. Treatment admissions are tracked through the Cal-OMS admission and discharges. If the episode start date was manually entered for a date after the admission, this will result in a denial.<br><br>Validation Steps: Verify the episode start date in Sage on the Provider Admission Form matches the actual date of admission for first time patients at the agency. If the patient is a re-admit, verify the episode start date matches the original admission date. Verify date of service is on or after the episode start date.<br><br>Primary Sage User: If the date of service was incorrect, resubmit claim with actual date of service. If the episode start date is incorrect, submit a helpdesk ticket and attach documentation showing the correct episode date. Once episode date is corrected, resubmit claim.<br><br>Secondary Sage User: If the date of service was incorrect on the 2400 loop, DTP segment, DTP03 element, resubmit claim with actual date of service. If the episode start date is incorrect, submit a helpdesk ticket and attach documentation showing the correct episode date. Once episode date is corrected, resubmit claim. |
| CO200 | Expenses incurred during lapse in coverage (200) | No coverage level found.<br><br>Plan not found. | Approved | Level 2 | If there is no plan level for plan ('Plan Definition' form, 'Plan Coverage Definition' tab) it will deny. | Cause: Patient does not have Medi-Cal on record with the State.<br><br>Validation Steps: Verify patient's Medi-Cal eligibility via Sage Real Time 270 Request, DHCS website or AEVS system for dates of service. Verify the patient's information in Sage, matches their Medi-Cal information.<br><br>Primary and Secondary Sage Users: If patient lost DMC coverage during date of service, contact agency Financial Analyst to determine if claim is eligible for replacement. If patient has been verified to have active coverage during the dates claimed, submit replacement claim. |
| CO204 | This service/equipment/drug is not covered under the patient's current benefit plan (204) | Procedure code not found in authorization. | Denied | Level 1 | | Cause: The procedure code and associated date of service claimed does not match the approved HCPCS code on the authorization number listed.<br><br>Validation Steps: Verify the procedure code and date of service are valid for the authorization number used. Verify the authorization in Sage has the all expected approved HCPCS codes listed.<br><br>Primary Sage User: N/A- Primary users can only select valid HCPCS codes that are listed on the authorization selected when entering a treatment.<br><br>Secondary Sage User: Correct the procedure code listed on the 837 file, Loop 2400, SV1 Professional Service Segment, SV101 element and/or authorization number as listed on the 837 file, Loop 2400- REF-Prior Authorization Required Segment, REF01 element. Ensure there are no extraneous spaces or special characters in the element.<br><br>A claim will also be denied if the patient has multiple authorization numbers, likely due to a fiscal year split or extended services, and the old authorization number was used. Secondary users must update their systems when a new authorization is assigned. |

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| CO208 | National Provider Identifier - Not matched. (208) | NPI out of date range for this claim.<br><br>NPI is incorrect.<br><br>Provider shares NPI with another location and DMC accounting system cannot currently issue payment for this type of claim. | Approved | Level 2 | N/A | Cause: There is an issue with the supplied NPI number<br><br>Validation steps: Verify Agency and rendering practitioner's NPI number, associated address, and effective date. Provider may need to consult with Contracts Unit to verify information is correct in Sage.<br><br>Primary and Secondary Users: replace claim with correct NPI number. |
| CO222 N362 | Exceeds the contracted hours/days/units. (222)<br><br>The number of Days or Units of Service exceeds our acceptable maximum. (N362) | Maximum Number Of Units Of Procedure Code Per Day Exhausted. | Denied | Level 1 | If 'Maximum Units Per Day' entered for 'Procedure Code', and units per day exceeds that value in total units for the Client, Date, Procedure Code, Funding Source, Provider, Performing Provider, License Type, and Level Of Care that are approved and not taken back, it will deny. | Cause: The service claimed has a set maximum number of units/day allowable, where the units on the claim exceeded that value or the service has already been paid in the system. This is often accompanied by "A potential Duplicate Service Found" denial reason in Sage.<br><br>Validation Steps: Verify the number of units entered for the procedure do not exceed the maximum amounts allowable. Verify the service does not have a prior approval and payment using Treatment History in Sage, Payment Reconciliation view in KPI and Remittance Advice Reports by Finance to ensure payment was made for the approved claim.<br><br>Primary Sage User: Determine if services was already paid, if so, no further action is required. Otherwise correct claim information and resubmit or contact helpdesk for further guidance.<br><br>Secondary Sage User: Determine if services was already paid, if so, no further action is required. Otherwise correct claim information on 837 file, 2400 loop, SV1 segment, elements SV103 and 104 and resubmit or contact helpdesk for further guidance. |
| CO222 N627 | Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. (222)<br><br>Service not payable per managed care contract. (N627) | Overall Account Dollars Exceeded. | Denied | Level 1 | | Cause: This results when the Fiscal Year contract amount has been reached. No further claims will be approved or paid once the contract has been exceeded until an augmentation is approved and processed by Contracts.<br><br>Validation Steps: Verify contract amounts per agency's contract matches what was billed for the fiscal year. Contact finance for additional reports/numbers of billed amounts. Verify in Sage under Provider Billing Reports and KPI Financials and Operations views to view amounts claimed for the fiscal year.<br><br>Primary Sage User: Providers should monitor contract amounts throughout the year and submit for an augmentation to the assigned CPA prior to exceeding contract amounts. Do not submit any additional claims until augmentation is processed or all claims will be denied.<br><br>Secondary Sage User: Providers should monitor contract amounts throughout the year and submit for an augmentation to the assigned CPA prior to exceeding contract amounts. Do not submit any additional claims until augmentation is processed or all claims will be denied. |
| CO226 | Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. (226) | Performing provider is blank. | Denied | Level 1 | If performing provider is missing, invalid or not registered, it will deny. | Cause: Claim was submitted without the performing/rendering provider NPI on the 837 file. The NPI number is correct, however it is not associated to the provider agency submitting the claim.<br><br>Validation Steps: Verify the performing provider was entered correctly, with the correct NPI number and corresponds with the staff who delivered the service. If this information is correct, verify the agency submitted a user creation form for the performing provider to be associated to the agency with the correct hire date and NPI number. This can be verified by contacting the Sage Help Desk.<br><br>Primary Sage User: This is an unlikely denial for primary users as a treatment cannot be entered without a performing provider. If the performing provider is not showing in the field on the 'Treatment' page, then contact the Helpdesk and/or submit a user creation form to sageforms@ph.lacounty.gov<br><br>Secondary Sage User: Correct the 837 file, 2010BB Loop Payer Information- NM1 Rendering Provider Name (2310B) segment, to show the correct rendering provider name and NPI number. If this is correct, contact Helpdesk to determine if performing provider is registered in the system to the billing provider. Submit claim once corrected. |

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| CO273 | Coverage/program guidelines were exceeded. (273) | Procedure Code/day maxed. | Denied | Level 1 | If units entered exceed the procedure code per day limit, it will deny. | Cause: Units entered for this procedure exceed the maximum allowed for the procedure. The service was already claimed and approved based on patient ID, procedure code, date of service, rendering provider.<br><br>Validation Steps: Verify the service has not been previously approved and paid. Verify the units claimed match the service and do not exceed the maximum as outlined by SAPC and DMC regulations for that service.<br><br>Primary Sage User: If service was a duplicate and already paid, no additional steps are required. Otherwise, correct any errors found in the claim for the procedure code and total units in 'Treatment Details' and resubmit.<br><br>Secondary Sage User: If service was a duplicate and already paid, no additional steps are required. Otherwise, correct any errors found in the claim for the procedure code and total units on the 837 file, Service Line Number 2400 loop- SV1 Professional Service Segment- SV101 and SV104 elements and resubmit. |
| COA1 N421 | Claim/Service denied. At least one Remark Code must be provided. (A1)<br><br>Claim payment was the result of a payer's retroactive adjustment due to a review organization decision. (N421) | Service line denied due to disallowance from post-service, post-payment utilization review. | Approved | Level 2 | N/A | Cause: As a result of auditing, the State denied a service.<br><br>Validation steps: Verify all documentation related to the service is accurate and complete to match claims submitted to the state.<br><br>Providers may appeal the disallowance. If claims can be corrected to make the service claim valid, providers may replace the claim. |
| COB7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. (B7) | Provider is not registered on date of service. | Denied | Level 1 | If there is no 'Provider Registration' for the 'Date Of Service' and 'Funding Source' (or "All" funding sources) it will deny. | Cause: The date of service was prior to or after the effective date of the contract for the agency.<br><br>Validation Steps: Verify with agency's CPA effective date of contract and date allowed to start billing on contract. Verify date of service falls within the provider contract period. If date of service is prior to effective or after termination date of contract, this service is not reimbursable by SAPC.<br><br>Primary Sage User: Correct date of service on Treatment form if error was found or contact CPA for contract information.<br><br>Secondary Sage User: Correct date of service on 837 file, 2400 loop, DTP-Date- Service Date segment, DTP03 element, if error was found or contact CPA for contract information. |
| COB7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (B7) | Performing Provider is not registered on date of service. | Approved | Level 2 | If the Performing Provider has a registration date after the date of service it will deny. This is defined in the 'Performing Provider Registration' Form | Cause: The date of service was before the hire date of the performing provider or after the termination date of performing provider. This issue is typically an error on the creation form or the claim date.<br><br>Validation Steps: Verify date of hire entered on User creation form for the performing provider by contacting the helpdesk. If the date of hire was incorrect on this form, then submit a new user creation form with modification type as the form type to Sageforms@ph.lacounty.gov. Verify date of service falls within the employment period for the performing provider.<br><br>Primary Sage User: Resubmit claim once hire date is corrected in Sage or with correct date of service on the claim from the Treatment form.<br><br>Secondary Sage User: Resubmit claim once hire date is corrected in Sage or with correct date of service on 837 file, 2400 loop, DTP-Date- Service Date segment, DTP03 element |
| COB7 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (B7) | Contracting Provider Program is Not Active. | Approved | Level 2 | If the Date of Service is before or after the active dates of the Contracting Provider Program, it will deny. This is set in the 'Contracting Provider Registration' Form | Cause: The date of service was prior to or after the effective date of the specific program location address (contracting provider program).<br><br>Validation Steps: Verify with agency's CPA effective date of contract and date allowed to start billing on contract for that particular address/provider program. Verify date of service falls within the provider program contract period. If date of service is prior to effective or after termination date of contract, this service is not reimbursable by SAPC.<br><br>Primary Sage User: Correct date of service on Treatment form if error was found or contact CPA for contract information.<br><br>Secondary Sage User: Correct date of service on 837 file, 2400 loop, DTP-Date- Service Date segment, DTP03 element, if error was found or contact CPA for contract information. |

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| COB7 N570 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (B7)<br><br>Missing/incomplete/invalid credentialing data. (N570) | 837I: Service line denied because the Service Facility Location is not authorized to provide the service (identified by the Revenue Codes, PCS codes and DPI) for the billing county on the date(s) of service. | Approved | Level 2 | N/A | 3.7 WM and 4.0 WM Providers Only<br><br>Cause: Service line denied because the Service Facility Location is not authorized to provide the service (identified by the Revenue Codes, PCS codes and DPI) for the billing county on the date(s) of service.<br><br>Validation steps: Verify date type of service is authorized at the specific location.<br><br>Secondary Sage User: If service date was on or after site was authorized for this level of care contact your financial representative for assistance. |
| COB7 N570 | This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (B7)<br><br>Missing/incomplete/invalid credentialing data. (N570) | Service line denied because the Service Facility Location is not authorized to provide for the identified service for the billing county on the date(s) of service. | Approved | Level 2 | N/A | Cause: Provider is not authorized to provide a service in this county. This is related to the provider site not being DMC certified at time of service.<br><br>Validation steps: Verify date and type of service is authorized at the specific location. Providers may need to consult the Contracts Unit or their CPA. Verify the county the patient's Medi-Cal is from. Verify location on authorization is the correct location where the service was delivered. Verify on the 837 file, the location NPI is certified and where the service was delivered.<br><br>Primary and Secondary Sage Users: If facility location was correct on billing and authorization and DMC certified on date of service, replace claims. If authorization was incorrect, contact QI.UM inquiry line at 626.299.3531 to correct contracting provider program field on authorization. Replace claim with correct information. |
| COB15 | This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (B15) | MAT services for the same drug type and day of services billed with fractional units on a claim must all either be approved together or denied together. | Approved | Level 2 | N/A | Cause: Not all services on a claim were uniformly approved or denied together for MAT services of the same drug type on the same day.<br><br>Validation steps: Verify eligibility, authorization, and rendering practitioner information is correct.<br><br>Primary Sage User: Validate the claim information is correct and replace.<br><br>Secondary Sage Users: Validate the claim information is correct and replace. See Loop 2110. |

## DEACTIVATED CODES

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| CO15 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15) | This contracting provider does not have this authorization number. | Denied | Level 1 | If entered 'Authorization Number' is a 'Contracting Provider Service Authorization' and is not for the 'Provider' it will deny. | Cause: The provider authorization number (PAuth) exists in the system, but not for the provider claiming the service.<br><br>Validation Steps: Verify the PAuth number and dates of service for that PAuth number are correct and match the patient and provider claiming.<br><br>Primary Sage User: Primary users should contact helpdesk for resolution if they encounter this denial.<br><br>Secondary Sage User: Correct authorization number as listed on the 837 file, Loop 2400- REF-Prior Authorization Required Segment, REF01 element |
| CO15 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15) | This member's authorization is for a different funding source. | Denied | Level 1 | If entered 'Authorization Number' is not for "All" funding sources and is not for the selected 'Funding Source' it will deny. | Cause: Authorization number exists in the system, but is restricted to only DMC or NonDMC funding source.<br><br>Validation Steps: Verify the authorization number and funding source match the information on the approved authorization in Sage. Verify the funding source on the authorization is correct based on the service or HCPCS code claimed. E.g. All RBH authorizations must be under NonDMC funding source on the authorization.<br><br>Primary Sage User: Submit new authorization with correct funding source. Contact QI.UM at 626.299.3531 to deny the incorrect authorization.<br><br>Secondary Sage User: Submit new authorization with correct funding source. Contact QI.UM at 626.299.3531 to deny the incorrect authorization. |

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| CO15 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15) | This contracting provider's authorization is for a different funding source. | Denied | Level 1 | If entered 'Authorization Number' is a 'Contracting Provider Service Authorization' and is not for the 'Funding Source' it will deny. | Cause: Provider authorization number exists in the system, but is restricted to only DMC or NonDMC funding source.<br><br>Validation Steps: Verify the Provider authorization number and funding source match the information on the approved Provider authorization in Sage. Verify the funding source on the PAuth is correct based on the service or HCPCS code claimed. E.g. All RBH authorizations must be under NonDMC funding source on the authorization.<br><br>Primary Sage User: Submit helpdesk ticket for SAPC to create a new Provider Authorization. PAuths are managed by SAPC Contracts and Compliance Division, not QI.UM.<br><br>Secondary Sage User: Submit helpdesk ticket for SAPC to create a new Provider Authorization. PAuths are managed by SAPC Contracts and Compliance Division, not QI.UM. |
| CO15 M62 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15)<br><br>Missing/incomplete/invalid treatment authorization code. (M62) | This member's authorization is for a different provider. | Denied | Level 1 | If entered 'Authorization Number' is not for the selected 'Provider' it will deny. | Cause: The member authorization number exists in the system, but not for the provider claiming the service.<br><br>Validation Steps: Verify the authorization number is correct and match the patient and provider claiming.<br><br>Primary Sage User: Primary users should contact helpdesk for resolution if they encounter this denial.<br><br>Secondary Sage User: Correct authorization number as listed on the 837 file, Loop 2400- REF-Prior Authorization Required Segment, REF01 element |
| CO15 M62 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15)<br><br>Missing/incomplete/invalid treatment authorization code. (M62) | This member does not have this authorization number. | Denied | Level 1 | If entered 'Authorization Number' is found but is not for the member it will deny. | Cause: Authorization number exists in the system, but not for the patient that was claimed.<br><br>Validation Steps: Verify the authorization number and dates of service for that authorization number are correct and match the patient claimed.<br><br>Primary Sage User: Primary users should contact helpdesk for resolution if they encounter this denial.<br><br>Secondary Sage User: Correct authorization number as listed on the 837 file, Loop 2400- REF-Prior Authorization Required Segment, REF01 element |
| CO15 M62 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15)<br><br>Missing/incomplete/invalid treatment authorization code. (M62) | Invalid authorization number. | Denied | Level 1 | If no valid authorizations found for 'Procedure Code' or any associated codes it will deny. | Cause: The authorization number claimed does not contain the HCPCS code that was claimed.<br><br>Validation Steps: Verify the authorization in Sage has the all expected approved HCPCS codes listed.<br><br>Primary Sage User: Primary users should contact helpdesk for resolution if they encounter this denial.<br><br>Secondary Sage User: Correct the authorization number as listed on the 837 file, Loop 2400- REF-Prior Authorization Required Segment, REF01 element. Ensure there are no extraneous spaces or special characters in the element. |
| CO15 M51 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15)<br><br>Missing/incomplete/invalid procedure code(s). (M51) | Procedure code not found in authorization. | Denied | Level 1 | If entered 'Procedure Code' or any associated codes are not in the authorization it will deny. | Cause: The procedure code and associated date of service claimed does not match the approved HCPCS code on the authorization number listed.<br><br>Validation Steps: Verify the procedure code and date of service are valid for the authorization number used. Verify the authorization in Sage has the all expected approved HCPCS codes listed.<br><br>Primary Sage User: N/A- Primary users can only select valid HCPCS codes that are listed on the authorization selected when entering a treatment.<br><br>Secondary Sage User: Correct the procedure code listed on the 837 file, Loop 2400, SV1 Professional Service Segment, SV101 element and/or authorization number as listed on the 837 file, Loop 2400- REF-Prior Authorization Required Segment, REF01 element. Ensure there are no extraneous spaces or special characters in the element.<br><br>A claim will also be denied if the patient has multiple authorization numbers, likely due to a fiscal year split or extended services, and the old authorization number was used. Secondary users must update their systems when a new authorization is assigned. |

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| CO15 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15) | This funding source does not have this authorization number. | Denied | Level 1 | If entered 'Authorization Number' is a 'Funding Source Service Authorization' and is not for the 'Funding Source' it will deny. | Cause: Member authorization number exists in the system, but is restricted to only DMC or NonDMC funding source.<br><br>Validation Steps: Verify the Provider authorization number and funding source match the information on the approved Provider authorization in Sage. Verify the funding source on the PAuth is correct based on the service or HCPCS code claimed. E.g. All RBH authorizations must be under NonDMC funding source on the authorization.<br><br>Primary Sage User: Submit helpdesk ticket for SAPC to create a new Provider Authorization. PAuths are managed by SAPC Contracts and Compliance Division, not QI.UM.<br><br>Secondary Sage User: Submit helpdesk ticket for SAPC to create a new Provider Authorization. PAuths are managed by SAPC Contracts and Compliance Division, not QI.UM. |
| CO15 M62 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15)<br><br>Missing/incomplete/invalid treatment authorization code. (M62) | This authorization is associated to an inactive account. | Denied | Level 1 | If the authorization is associated to an inactive account, it will deny. | Cause: Authorization was assigned an inactive account due to a system error.<br><br>Validation Steps: Contact helpdesk to determine which account the authorization was assigned to or check in MSO KPI Dashboards 2.0 Payment Reconciliation Sheet.<br><br>Primary Sage User: Submit replacement authorization and contact QI.UM at 626.299.3531 to deny errored authorization.<br><br>Secondary Sage User: Submit replacement authorization and contact QI.UM at 626.299.3531 to deny errored authorization. |
| CO15 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15) | Service Date Prior To Authorization Begin Date (Allowed Days). | Denied | Level 1 | If the 'Service Date' is a number of days past 'Days Permitted Prior to Authorization Begin Date'. This is set in 'Approve/Pend/Deny Rules Definition' | Cause: Claim was submitted with a service date outside of the approved start and end dates on the authorization.<br><br>Validation Steps: Verify dates of service match the authorization number that was billed.<br><br>Primary Sage User: Primary users should contact helpdesk for resolution if they encounter this denial.<br><br>Secondary Sage User: Correct dates of service or authorization number on the 837 file, Loop 2400, SV1 segment |
| CO15 (Deactivated 5/1/2018) | Authorization number is missing, invalid, or does not apply to the billed services or provider. (15) | Service Date After Authorization End Date (Allowed Days). | Denied | Level 1 | If the 'Service Date' is a number of days after 'Days Permitted Beyond Authorization Begin Date'. | Cause: Claim was submitted with a service date outside of the approved start and end dates on the authorization.<br><br>Validation Steps: Verify dates of service match the authorization number that was billed.<br><br>Primary Sage User: Primary users should contact helpdesk for resolution if they encounter this denial.<br><br>Secondary Sage User: Correct dates of service or authorization number on the 837 file, Loop 2400, SV1 segment |
| OA15 (Deactivated 5/1/2018) | 18-Exact duplicate claim/service | A potential duplicate service was detected. | Denied | Level 1 | A potential duplicate is found based on 'Procedure Code', 'Date Of Service', member, and 'Provider' it will deny. When looking for duplicates it only considers approved services. | Cause: A claim was submitted that matches an already approved claim in the system. A service is duplicated when there is an approved service that matches the procedure code, date of service, member ID and performing/rendering provider. This denial reason is generally paired with services that have a maximum number of units per day that have been billed after already approved.<br><br>Validation Steps: Verify the denied service has a matching approved claim that has been paid. This can be verified in Provider Connect under the Treatment History display or in KPI Payment Reconciliation Sheet. If an approved claim for that service exists in the system, then the claim was appropriately denied and should not be resubmitted. Also, verify this service was intended to be claimed.<br><br>Primary Sage User: Contact helpdesk if a matching approved claim is not found in the system. Otherwise, no further action is required.<br><br>Secondary Sage User: Contact helpdesk if a matching approved claim is not found in the system. Otherwise, no further action is required. |

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| CO185 MA129<br><br>(MA129 deactivated) | The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (185)<br><br>This provider was not certified for this procedure on this date of service. (MA129) | Contracting Provider Program Not Valid For Authorization. | Denied | Level 1 | If Contracting Provider Program on an authorization does not match Contracting Provider Program on a claim. If Contracting Provider Program is not configured for the service claimed, it will deny. | Cause: This is specific to the agency site, not the rendering provider. Provider/Agency is contracted for the procedure, but not at the address/provider program listed on the authorization.<br><br>Validation Steps: Verify the procedure code matches the service and/or special population the service was provided. Verify the authorization grouping on the authorization is the correct grouping with the correct approved codes, and confirm the contracting provider program field on the authorization is the address where the service was delivered. Verify the service is a contracted service at the address it was delivered.<br><br>Primary Sage User: Contact QI.UM to deny the auth if there is an error found, then submit a replacement authorization. If no error is found and provider believes they are contracted for that service at that location, contact agency's CPA to verify and possibly update the contract.<br><br>Secondary Sage User: Contact QI.UM to deny the auth if there is an error found, then submit a replacement authorization. . Verify the correct NPI and address were used for that location on the 837 file, 2310C loop, NM101, and N3 segment and resubmit if error found. If no error is found and provider believes they are contracted for that service at that location, submit Helpdesk ticket to verify configuration, which will be escalated to SAPC if a configuration update is needed. |
| CO181 MA129<br><br>(MA129 deactivated) | Procedure code was invalid on the date of service (181)<br><br>This provider was not certified for this procedure on this date of service. | Procedure not on fee schedule. | Denied | Level 1 | If no fee is found in 'Provider Fee Definition' it will deny. | Cause: The provider is not contracted for the claimed procedure. The procedure code is listed on the approved authorization, however, the system was not configured to allow that procedure for the provider agency. Additionally, a performing provider was used that is not correctly set up in the system for the procedure code. E.g. billed an SUD counselor for Methadone dispensing.<br><br>Validation Steps: Verify the authorization grouping on the authorization is the correct grouping, including age and PPW modifiers. Verify the approved HCPCS codes on the authorization match the authorization grouping. Verify the correct HCPCS code was used on the 837 file. If the error is not related to the authorization or the 837 file, verify with the agency's CPA if the procedure code, specialty population and/or level of care are contracted for that agency. Verify the performing provider is authorized to deliver the service by cross checking the most current staffing guidelines bulletin on the SAPC website.<br><br>Verify the performing provider and staffing level indicator match and that performing provider has been updated in Sage if necessary. Staffing levels rate adjustment categories are included in the fee schedule and must match the staffing level entered into Sage for that NPI/performing provider.<br><br>Primary Sage User: Submit corrected authorization, and/or Contact CPA to determine if agency should be contracted for the particular service and modifiers. Contact the helpdesk to verify the performing provider was configured and updated in Sage.<br><br>Secondary Sage User: Enter corrected procedure code on the 837 file, 2400 loop, SV1 segment, SV101 elements. Submit corrected authorization, and/or Contact CPA to determine if agency should be contracted for the particular service and modifiers. Contact the helpdesk to verify the performing provider was configured and updated in Sage. |
| CO16 MA102<br>(MA102 deactivated) | Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.(16)<br><br>Missing/incomplete/ invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.(MA102) | Provider is blank. | Denied | Level 1 | If there is no 'Provider' it will deny. | Cause: Claim was submitted without billing provider, or performing/rendering provider information, including name and/or NPI number. Or the NPI number is invalid.<br><br>Validation Steps: Verify NPI and name of the billing provider or performing/rendering provider is populated and correctly entered on 837 file.<br><br>Primary Sage User: N/A. Primary users cannot submit a claim without a performing or billing provider listed on the treatment.<br><br>Secondary Sage User: Correct missing information on the 837 file and resubmit claim. |