Communication Release

09/12/2025

Real Time (270) Inquiry Request Form Update

SAPC would like to clarify how to properly run and read the results of the 270/271. The Real Time Inquiry (270) Request form provides valuable eligibility information for patients with Drug Medi-Cal coverage. Providers should run the 270 Request at admission and then monthly to verify the patient's most up-to-date eligibility information, including Aid Code, County of Responsibility Code, Other HealthCare Coverage, and Share of Cost information.

Providers must enter the patient's name and the Drug Medi-Cal guarantor for the 270 to work properly. Additionally, the language for the "From Date" and Through Date" has been updated to clarify what the dates mean and their intended use.

- "From Date (First day of eligibility month)": First day of the month that eligibility information is being requested.
- "Through Date (Last day of eligibility month)": Last day of the same month for the eligibility information.

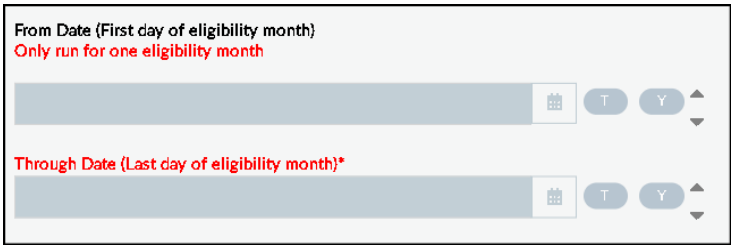
The date range must be within the same month. If multiple months are run then the system will display only the current month's eligibility, regardless of the date range entered.

Only eligibility information from one (1) year prior to the current date is available on the 270 from DHCS. If entering dates beyond one (1) year prior, the eligibility will always show as ineligible because the request is invalid.

Additionally, both date fields must be completed for the results to populate accurately. If the "Through Date" is blank, the results will only be for the current month and not for the month being requested, if different. The results from DHCS appear to default to the current date when there is a missing date field or multiple months date range; as such, SAPC has made the "Through Date" a required field.

For example:

- If the "From Date" is 07/01/2025 and the "Through Date" is 09/10/2025, the results will be for the current month of September 2025 regardless of the "From Date".
- To pull information for July 2025, the "From Date" and "Through Date" must both be within the month of July 2025, e.g. 7/1/2025 through 7/31/2025.



Appointment and Referral Disposition Workflow

As a reminder: Per the requirements outlined in SAPC-IN 25-11 Requirements for Appointment and Referral Dispositions, the Referral Connections form was updated and changes were implemented on 9/1/2025. Additionally, the Appointment and Referral Disposition form was developed and implemented on 9/1/2025. This process is required and implemented to better track appointments made for our patients to ensure they are receiving timely access to care.

To meet the requirements of the IN, and for the forms to function properly, providers must follow these steps for direct-to-provider referrals or referrals from SASH, CENS or CORE:

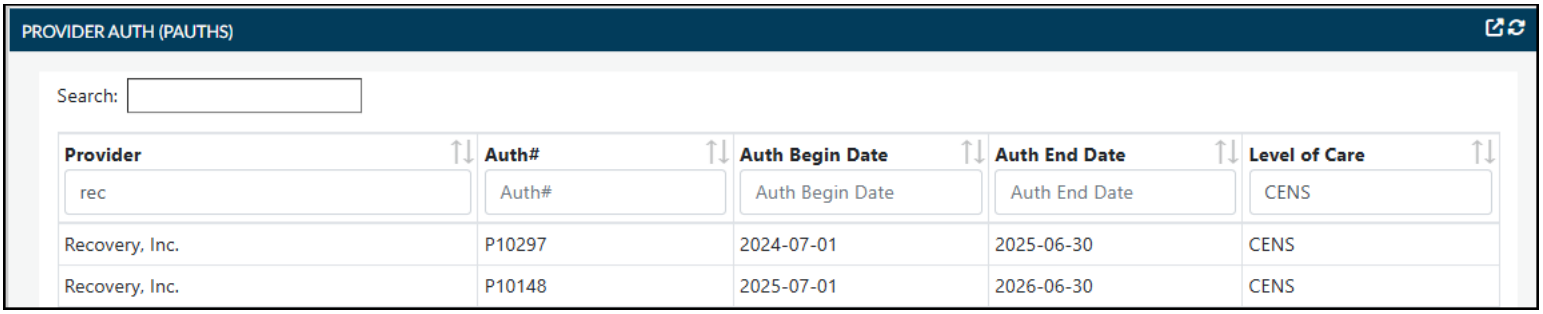
1. **ASAM CO-Triage or Youth and Young Adult Screening**: Must be completed first.
2. **Referral Connections form:** Must be completed after the screening is submitted.
    a. Providers who are accepting a patient from SASH, CENS or CORE, or another treatment provider, do not need to complete the Referral Connections form or a screening tool.
3. **Appointment and Referral Disposition:** Must be completed when a patient was given an appointment to any provider, including the provider who screened the patient.
    a. If an appointment is made or the intake was completed by the screening provider, that provider must still complete the form.
    b. Additionally, if the patient was referred to a different provider, the provider who is receiving the patient must complete the Appointment and Referral Disposition. The provider who referred out, does not need to complete the form.

The recording of the training and workflow was made available in Sage, rather than in SAPC Learning Network Connection (SAPC-LNC). SAPC temporarily restored the PCNX Training Videos View directly in Sage to users who will be utilizing this workflow. Providers will be notified when the training is available in SAPC-LNC in future Sage Communications. If you are unable to access the PCNX Training Video View or cannot complete one of the forms, please contact the Sage Helpdesk for assistance.

If you have questions about the workflow, please email Sage@ph.lacounty.gov for assistance.

CENS PAuth Naming Update

To support provider agencies in providing CENS services and reduce confusion, the CENS PAuth label as shown in Sage will now be “CENS” instead of “CENS FBS-C”. This change is effective as of Friday, September 12, 2025. This change will be seen when viewing PAuths in the “Provider Auth (PAuths)” widget and on the Fast Service Entry Submission form when selecting an authorization.


PROVIDER AUTH (PAUTHS)

Search:

Provider	Auth#	Auth Begin Date	Auth End Date	Level of Care
rec	Auth#	Auth Begin Date	Auth End Date	CENS
Recovery, Inc.	P10297	2024-07-01	2025-06-30	CENS
Recovery, Inc.	P10148	2025-07-01	2026-06-30	CENS

Highlights from Previous Communications

Progress Note Status Report: SAPC has received reports of performance issues with the Progress Note Status Report. Some users reported longer processing times, the report not generating, or the report populating with no data, while other users are able to generate the report without issue. Netsmart is currently investigating the issue and will provide an update to affected users who created Sage Helpdesk tickets. For the time being, the Draft/Final Parameter has been removed to increase processing speed.
SAPC requests that if you are experiencing this issue that you submit a Sage Help Desk ticket to receive support for resolution and to help ensure SAPC understands the full scope of the issue.
**Tip: The Progress Note Status Report runs the fastest when only the required parameters are selected. Once exported, users can sort, and filter as needed.*

Billing on Date of Discharge: The updated Provider Manual v10.0 includes guidance to provider agencies that operate sites with 24-hour services, such as 3.1, 3.3, 3.5, and 3.2-WM, regarding billing the bundled day rate on the date of discharge. As noted in the Residential Services section, on page 76, the residential bundled day rate and Room and Board rate are not billable on the patient's date of discharge. Unbundled services such as Care Coordination, Peer Support Services, and Medication Services remain billable on the client's date of discharge.

Service Authorization Request Comments Widget Reminder: In the "Authorization Status – Last 3 Months" widget, the Comments field reflects comments from the authorization from the UM care manager which includes reason for denial and any additional information required from the provider. This widget contains embedded logic that will highlight the comment by bolding and changing the font to red for authorizations that have been updated by UM within the last seven (7) days. This will alert users to any updates from the UM care managers on the widget without users having to manually check the authorizations via the form, allowing users to make requested changes immediately and then inform the UM care manager to avoid authorization delays or denials. This widget is accessible in the "Financial Only" and "Financial + Clinical" Views.

Eligibility Verification Widget Reminder: The "Client's Current Eligibility Verification" widget quickly displays the service(s) for which the patient is currently eligible to receive. There are four (4) columns: Service, Last Verified Date, Expiration Date and Filed By. Only dates in the past will display as red, indicating the eligibility has expired and needs to be reverified by UM. For additional information regarding eligibility period see: Eligibility Verification Member Authorizations (PDF)

Running Reports in Sage: When SAPC releases or updates reports in Sage, users may notice the first time they run the report that it may take a while to populate. Typically, the more often the report is run, the faster the report data will populate. However, SAPC has identified some situations where a report may fail to load. These failures to load may occur when 1) several reports are being run simultaneously, or 2) when a report that is still processing is abruptly closed then re-run. If the top of the report browser window says "about:blank", this is an indication that there has been an

error and the report will fail to load. To address this issue, users need to clear their cache then re-run the report. Instructions for clearing the cache vary by browser, so it is recommended users search for instructions for their respective browser. The top left of the report browser should read “Avatar NX Report Viewer” if the report is running properly. If clearing your cache does not resolve your issue with running a report, please open a Sage Help Desk ticket at the Sage Help Desk ServiceNow Portal and include a snip of your browser as well as the exact parameters that were used to run the report. This information will be critical to investigating and assisting you.

County and Aid Code Report: The County and Aid Code Report has been updated in LIVE. Managed Care Plan (MCP) information has been added to the report, and the Segment and File Index fields have been removed. The MCP has been added to allow providers to quickly identify the MCP for a given patient. The MCP information is displayed as the primary MCP first, followed by the partner plan if different than the primary MCP. For instance, LA Care partners with Blue Shield of California Promise Health. The MCP column may show as L.A. Care, Blue Shield Promise. If there is no partner plan, the MCP column will list the primary MCP twice. The County and Aid Code Report allows providers to have the most up-to-date information regarding Medi-Cal enrollment. The data in the report is contingent upon providers running and posting the Real Time Inquiry (270) Request monthly for patients. This report is intended to easily access eligibility information, such as Aid Code, County Code, and now MCP, which will be updated each time the 270 is run and posted. This report can also be used to verify gaps in coverage should the eligibility data change.
