BILLING & DENIAL RESOLUTION TUTORING LAB

SEPTEMBER 4, 2025

- Announcements and Reminders
- Tutoring Session Topics
  - Updated Billing Deadlines
  - Billing for Screening Job Aid
  - Discharge Planning
  - CO 16 N288 Rebills
  - Help Desk Ticket Trends
  - Share of Cost
  - Financial Eligibility
- Open Q&A

ANNOUNCEMENTS & REMINDERS

Q&A REMINDER

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

  - Q&A Button

  - Raise Hand Button

UPDATED BILLING DEADLINES

- Updated billing deadline for FY 23-24
  - 8/27 - Notification email sent to providers, with subject line "FY 23-24 Final Billing Deadline Partial Extension"
  - Dates of Service from **January 1, 2024** to **June 30, 2024** = **Submission deadline extended to September 12, 2025**
  - However, for Dates of Service from **July 1, 2023** to **December 31, 2023** = **Submission deadline was August 29, 2025**
- FY 24-25, FY 25-26
  - Deadlines are still pending

BILLING FOR SCREENING JOB AID

- We've added the topics based on provider feedback in the August 2025 tutoring lab, and uploaded the final job aid on 8/27 to the SAPC Website
- Let's take a look at the revisions:

Screening delivered to patients with Non-Drug Medi-Cal or Drug Medi-Cal (DMC) eligibility is reimbursable. To ensure the appropriate guarantor is assigned to the service, please note the following:

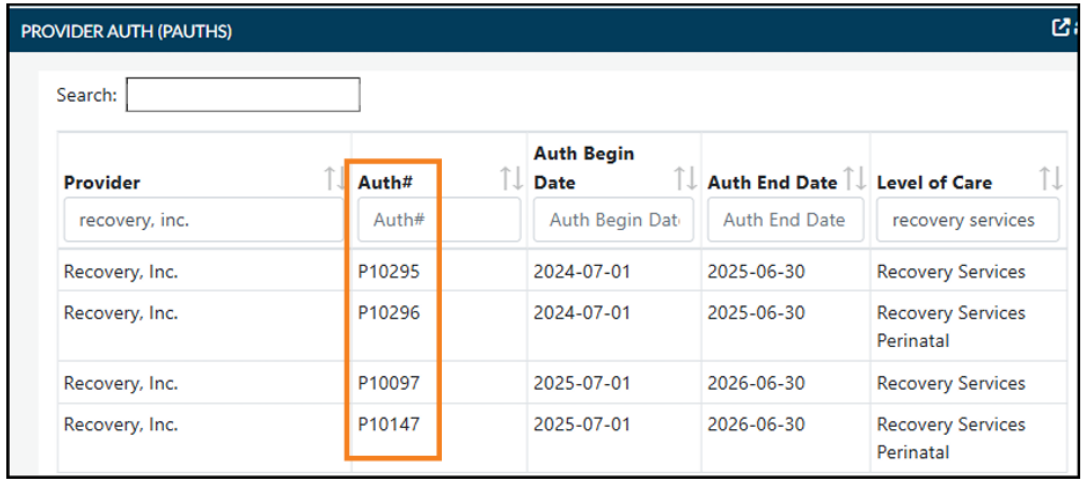
- Patients with DMC benefits must have the DMC guarantor as the first guarantor on the patient's Financial Eligibility record. This ensures SAPC is able to bill the service to DMC.
- Patients without DMC benefits should have the "LA County – Non DMC" guarantor on the patient's Financial Eligibility record.
- Primary Provider agencies billing in PCNX should choose "Drug Medi-Cal" as the funding source when using the Recovery Services PAuth to bill for screening, regardless of whether or not the patient has DMC benefits.

BILLING FOR SCREENING JOB AID

- Identifying PAuths Numbers in Sage

IDENTIFYING PAUTH NUMBERS IN SAGE

1. Login to PCNX.
2. Navigate to the Provider Auth (PAuths) widget.
    a. The Provider Auth (PAuths) widget is only available for Financial-related user roles.
3. In the Level of Care field, type in "Recovery Services". This will filter the results in the widget to just the Recovery Services PAuths.
4. To identify the appropriate PAuth number to utilize for billing based on the fiscal year, view the dates in the Auth Begin Date and Auth End Date fields.
    a. New PAuths are issued for each fiscal year. It is important to ensure the appropriate authorization number is being utilized for billing.
5. Once the appropriate row is identified, the PAuth number to use for billing screening is under the Auth# column.



BILLING FOR SCREENING JOB AID

- Available to download at the link below:

http://www.ph.lacounty.gov/sapc/docs/providers/sage/finance/Billing-for-Screening-Job-Aid.pdf

DISCHARGE PLANNING

WHAT IS DISCHARGE PLANNING

- What is discharge planning?
  - An ongoing discussion between providers and patients on how and when treatment should end.
- When does discharge planning occur?
  - Provider can start discussing discharge planning as early as the intake and continue throughout the treatment.
- What can the end of treatment (discharge) look like?
  - Referral to another level of care (LOC), post treatment return, or re-entry into the community, and/or linkage of the patient to essential community treatment, housing, and human services.

RATES MATRIX – CODE TYPE UPDATE

FY 24-25

Code Type	Service (Brief Definition)	Code
Discharge Services	Alcohol and/or substance abuse services, treatment plan development and/or modification. 15 minutes	T1007

FY 25-26

Code Type	Service Description	Code
Treatment Planning	Alcohol and/or substance abuse services, treatment plan development and/or modification. 15 minutes	T1007

WHAT TO BILL?

Reminder:

A Provider can start discussing discharge planning as early as the intake and it can continue throughout the treatment.

So with that in mind, for billing, instead focus on services provided throughout the treatment:

It is recommended to use codes for services provided throughout discharge planning:

- During discharge planning, you did treatment planning, then bill treatment planning
- During discharge planning, you did care coordination, so bill care coordination

Specific codes for discharge?

Still discussing internally, in terms of code recommendations. So please keep an eye out for those in the future.

CO 16 N288 REBILLS

CO 16 N288 REBILLS

- A recent configuration error in Sage led to an increase in the State Denial CO 16 N288 (claim did not include the rendering provider's taxonomy code)
- This error only impacted services performed by clinical trainees, that were billed to the state in May 2025 and later.
- The configuration error has been corrected, and the impacted services can be rebilled immediately.

HELP DESK TICKET TRENDS

HELP DESK TICKETS – THINGS WE'RE NOTICING

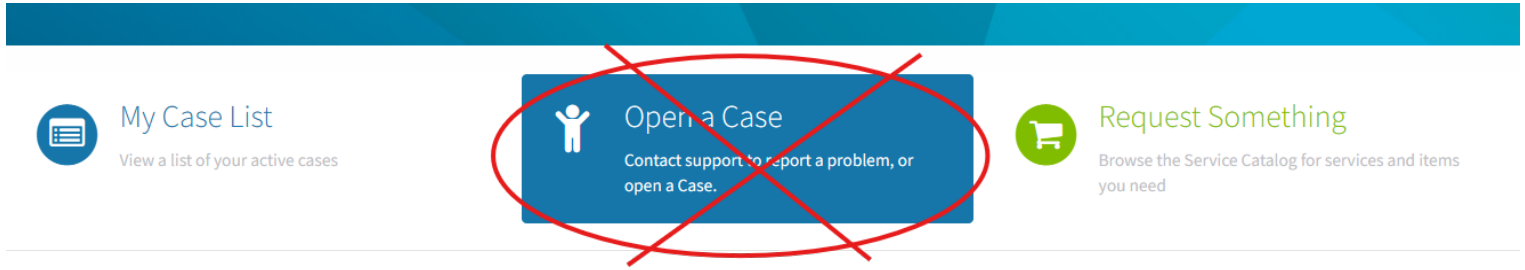
- Overridable lockouts

Units	Amt Billed	Total Fee Table Amt	Expected Disbursement	A/D/P	A/D/P Message
1.00	0.00	0.00	0.00	Denied	The service was denied for the following reason: Claim Status has been set to D because of Claim Adjudication Rule 96130_Lockout - 96130 Lockout.

- Secondary Providers
  - 837 Files
    - Follow the correct naming convention using this guide: http://ph.lacounty.gov/sapc/NetworkProviders/ITForms/Inbound837FileNamingConventions.pdf
    - Do not create additional folders in the SFTP for Originals, Replacements, and Voids
    - Guide is currently being updated by SAPC IT to reflect this

HELP DESK TICKETS – THINGS WE'RE NOTICING

- Denial Crosswalk 5.0
  - Please use the denial crosswalk to try to resolve local/state denials before opening a help desk ticket
  - Link: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/DenialCrosswalk/Sage-Claim-Denial-Reason-and-Resolution-Crosswalk-V5.0.xlsx
- Request Billing Assistance Form
  - DON'T click this link to submit billing tickets:



  - However, DO Use this Link: https://netsmart.service-now.com/plexussupport?id=sc_cat_item&sys_id=1ac545cf1b115e103001a9b6624bcb00&sysparm_category=4cb69d19c3921200b0449f2974d3ae69

SHARE OF COST

SHARE OF COST OVERVIEW

- Some Medi-Cal beneficiaries must pay or agree to pay a monthly dollar amount toward their medical expenses before Medi-Cal will pay for services rendered.
  - This dollar amount is called Share of Cost (SOC) and is similar to a private insurance plan's out-of-pocket deductible.
- SOC is determined upon Medi-Cal eligibility determination based on the amount of the individual's income that is over "maintenance need" levels.
  - "Maintenance need" refers to the amount of the individual's income that is used to cover living expenses such as food, clothing, and housing.
- Medi-Cal beneficiaries pay their SOC directly to the provider of their services, not to the State.
- SOC resets each month and is only needed to be spent down in months where care was received.

WHY IS THIS IMPORTANT?

- Services billed to SAPC for a beneficiary with unmet Share of Cost will be denied by DHCS and recouped by SAPC.
- Provider agencies must work with the patient to collect SOC payments for services rendered and report them to Medi-Cal, otherwise, services billed to DHCS will continue to be denied.
- Once SOC is met, services can be replaced to SAPC and the services should no longer deny with DHCS related to unmet SOC.
- SAPC will be releasing a Share of Cost Informational Reference to support providers in understanding and reporting Share of Cost.

DETERMINING SHARE OF COST

- A beneficiary's Medi-Cal information contains SOC amounts when viewed on the Medi-Cal Provider Portal, 271 Eligibility Response in Sage, or Automated Eligibility Verification System (AEVS).
    - The eligibility verification message will indicate the SOC dollar amount the beneficiary must pay and whether it has been met.

MEETING SHARE OF COST

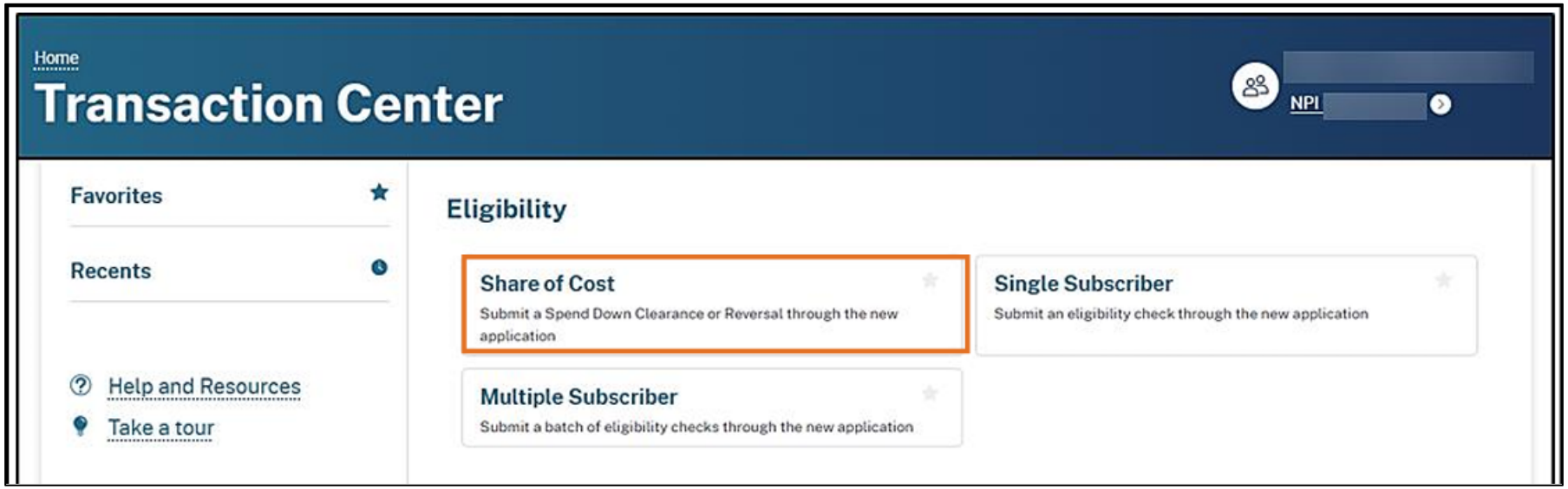
- Patients can meet SOC through healthcare expenses including medical equipment, prescription and over-the-counter drugs prescribed by a physician, medical services, and health supplies.
    - These services are not required to be Medi-Cal covered in order to meet SOC. It is also possible that unpaid medical bills can be used to lower a future month's SOC.
- Unpaid Medical Bills
    - DHCS recommends the patient contacts the Department of Public Social Services (DPSS) to determine if their scenario is allowable to be reported for SOC spend down. DPSS has also issued a Share of Cost Flyer that outlines more information about how to meet SOC.

REPORTING SHARE OF COST TRANSACTIONS

- Medi-Cal providers are required to perform a SOC clearance transaction immediately upon receiving payment or accepting obligation of payment directly from the beneficiary for services they provide.
- Obligating payment means that the provider is allowing the beneficiary to pay for services at a later date or through a payment plan, as designated by the provider.
- Provider agencies must keep a record of the transactions reported to Medi-Cal on behalf of the patient along with the supportive documentation, should it be needed in an audit.
- Once the patient's SOC has been certified, i.e. the SOC has been spent down, services for the patient can be billed to SAPC. Services paid by the patient to spend down their SOC should not be billed to SAPC as they were already paid by the patient.

MEDI-CAL PROVIDER PORTAL

- Beneficiary SOC can be viewed and reported via the Medi-Cal Provider Portal.
- The process for reporting SOC clearance transactions can be found on the DHCS Medi-Cal Provider Portal Eligibility Transactions User Guide, beginning on page 8 and on the DHCS AEVS Transactions guide, beginning on page 6.



271 ELIGIBILITY RESPONSE

- On the 271 Eligibility Response in Sage, SOC information will appear with "(Y) Spend Down" in the row for "Eligibility or Benefit Information" and the SOC amount will be indicated as the "Benefit Amount". In the example image below, the patient has a SOC of $1,034.

Inquiry Type	:	Generic: Financial Eligibility
Eligibility Or Benefit Information	:	(Y) Spend Down
Benefit Amount	:	1034

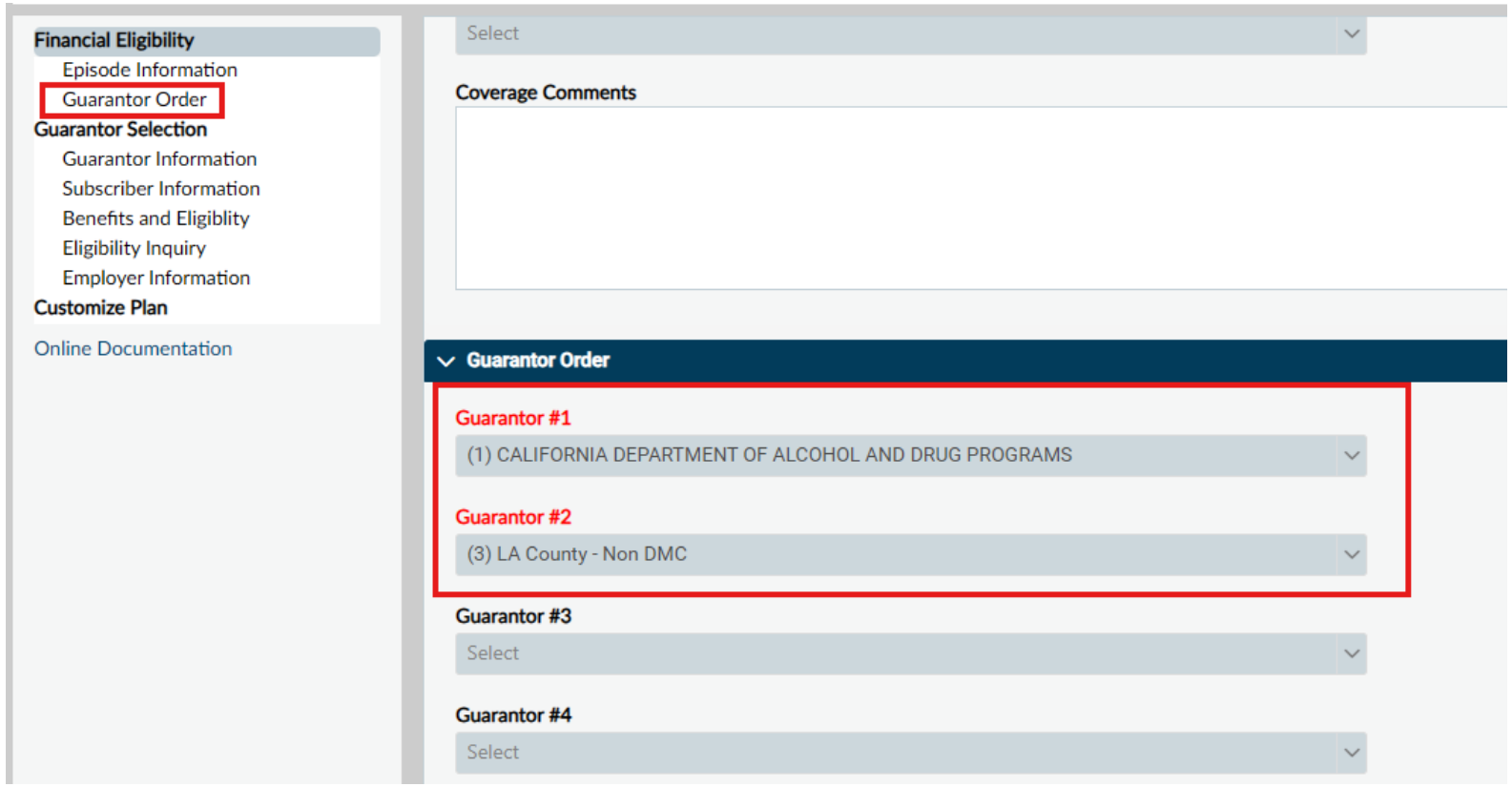
AUTOMATED ELIGIBILITY VERIFICATION SYSTEM (AEVS)

- The Department of Health Care Services (DHCS) AEVS is an interactive voice response system that allows provider agencies to access beneficiary eligibility information and clear SOC liability via telephone.
- Providers must have a valid Provider Identification Number (PIN) to access AEVS.
- AEVS verifies beneficiary eligibility for the current and prior 12 months and will provide information on SOC.
- Provider agencies can also use AEVS to report SOC spend down transactions. Refer to the DHCS AEVS General Instructions guide and DHCS AEVS Transactions guide for information on accessing AEVS and how to receive and transmit SOC information via the telephone system.

FINANCIAL ELIGIBILITY

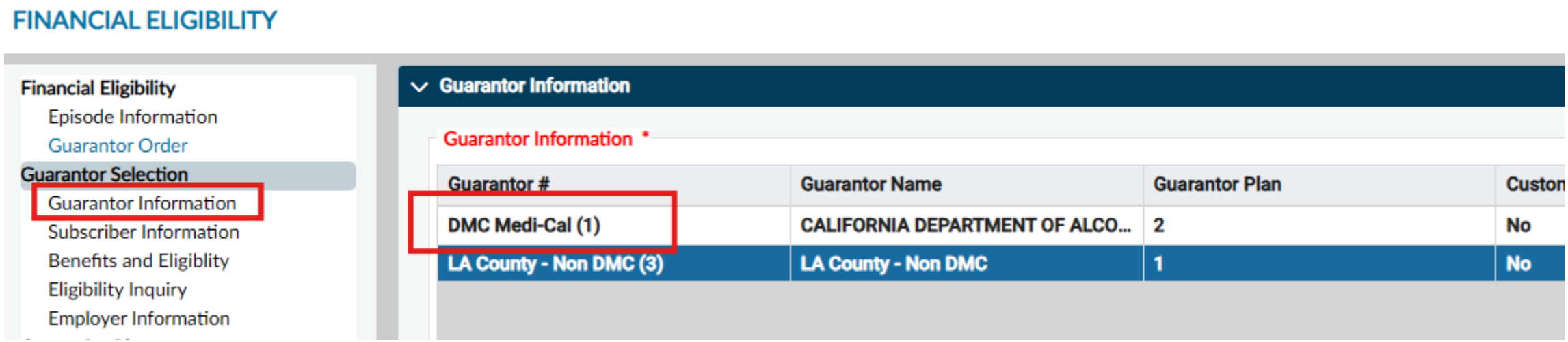
GUARANTORS

- The guarantors must be in the correct order



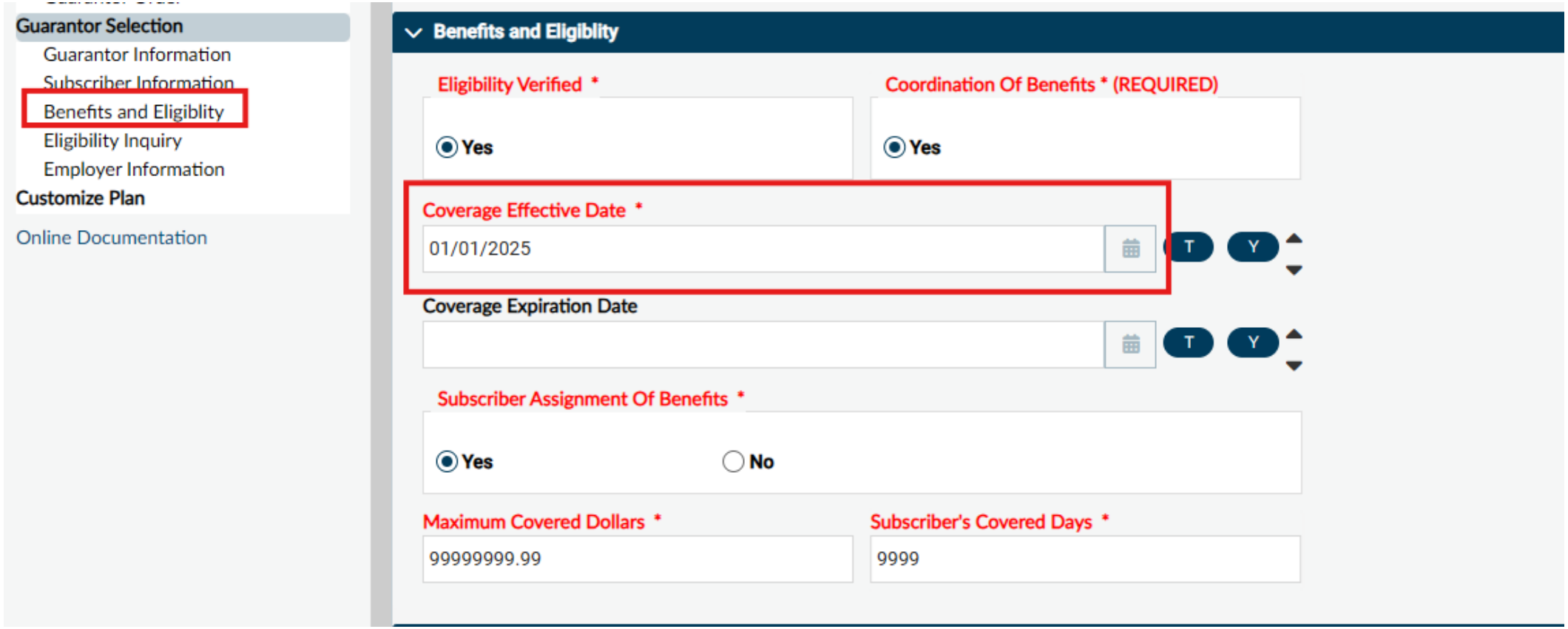
GUARANTORS

- DO NOT DELETE the DMC Medi-Cal Guarantor



GUARANTORS

- If a patient leaves and comes back at a later date, or if they lose then gain back Medi-Cal eligibility, DO NOT CHANGE the Coverage Effective Date field



GUARANTORS

- Remember to check the 271 response and to use the Automated Eligibility Verification System (AEVS)
- Link to "Sage Medi-Cal Eligibility Verification: 270/271 Real-Time Request": http://publichealth.lacounty.gov/sapc/NetworkProviders/pm/012919/SageMediCalEligibilityVerificationRealTimeProcessUserGuide.pdf

HELPFUL RESOURCES

HELPFUL RESOURCES

- Denial Crosswalk: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/DenialCrosswalk/Sage-Claim-Denial-Reason-and-Resolution-Crosswalk-V5.0.xlsx
- Replacement Claim Job Aid: http://publichealth.lacounty.gov/sapc/docs/providers/sage/finance/Job-Aid-Replacement-Claim-Assignment-CMS-1500-Provider-Training.pdf
- Guide to PCNX Reports: http://publichealth.lacounty.gov/sapc/docs/providers/sage/pcnx/PCNX-Guide-Reports.pdf
- Guide to Widgets: http://publichealth.lacounty.gov/sapc/docs/providers/sage/pcnx/PCNX-Guide-Widgets.pdf
- The entire catalog of SAPC Finance Billing Aids: http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm

HELPFUL CONTACTS

HELPFUL CONTACTS

UNIT/BRANCH Contact	EMAIL *Do not send Protected Health Information (PHI) to any SAPC email*	Description of when to contact
Sage Helpdesk	Phone Number: (855) 346-2392 ServiceNow Portal: https://netsmart.service-now.com/plexussupport	All Sage related questions, including billing, denials, medical record modifications, system errors, and technical assistance
Sage Management Division (SMD)	SAGE@ph.lacounty.gov	Sage process, workflow, general questions about Sage forms and usage
QI and UM	SAPC.QI.UM@ph.lacounty.gov UM (626)299-3531- Questions about a specific patient/auth QI (626)-293-2846- Complaints and Appeals	All authorization related questions, questions for the office of the Medical Director, medical necessity, secondary EHR form approval
Systems of Care	SAPC_ASOC@ph.lacounty.gov	Questions about policy, the provider manual, bulletins, and special populations (youth, PPW, criminal justice, homeless)
Health Outcomes and Data Analytics (HODA)	hoda_caloms@ph.lacounty.gov	All questions regarding Sage CalOMS: CalOMS submission guidelines, issues related to CalOMS forms and submissions in Sage, Data Quality Report, and requests for trainings.
Contracts	SAPCMonitoring@ph.lacounty.gov	Questions about general contracts, amendments, appeals, complaints, grievances and/or adverse events. Agency specific contract questions should be directed to the agency CPA if known.
Strategic and Network Development	SUDTransformation@ph.lacounty.gov	DHCS policy, DMC-ODS general questions, SBAT
Clinical Standards and Training (CST)	dsapc.cst@ph.lacounty.gov	Clinical training questions, documentation guidelines, requests for trainings
Finance	sapc-finance@ph.lacounty.gov	General questions related to billing, denials, tier allocation for payment reform. For specific denial questions, please open a Sage Helpdesk Ticket.

Greg Schwarz


OPEN Q&A