



# Claim Denial Investigation and Resolution

Los Angeles County Department of Public Health  
Substance Abuse Prevention & Control

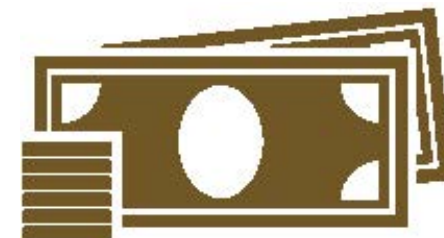


## Overview

- **Key Terms**
- **Claim Denial Reason and Resolution Crosswalk v1.0**
- **Additional Resources for Denial Identification**
- **Recommended process for denial resolution**
  - Primary Sage Users
  - Secondary Sage Users



AND



- **Primary Sage User-** A provider agency that uses Sage-ProviderConnect as its sole Electronic Health Record (EHR); completing all documentation and billing within Sage.
  - For the purposes of denial resolution, agencies that submit claims directly in Sage-ProviderConnect, but document in a different EHR systems, will follow Primary Sage User troubleshooting steps.
- **Secondary Sage User-** A provider agency that has purchased and uses an entirely different EHR system. The majority of clinical documentation is completed within their EHR and billing is sent to SAPC via an electronic data interchange process.
- **Managed Services Organization (MSO)-** This refers to an organization that manages a network of providers or agencies. SAPC is the Managed Services Organization (MSO) for the SUD network. In Sage, when MSO is used, it references transactions between SAPC and the provider network only.

# Claim Denial Crosswalk

1. Find the Denial Code

2. Go to the associated Denial Reason

3. Is there a Remark Code?

4. Find the “Denial Message in Sage”

5. Identify the Adjudication Rule

6. View the Resolution Steps

# Where to Find the Crosswalk



1. Go to: <http://publichealth.lacounty.gov/sapc/>

2. Click Network Providers

3. Click Provider Manual and Forms

4. Scroll to Finance Related Forms and Documents



If you or someone you know has a substance use disorder, also known as

**PROVIDER MANUAL AND FORMS**  
Expectations and requirements of substance use disorder network providers, including clinical and business standards, policies and procedures, and essential forms

**CAPACITY BUILDING AND TRAINING RESOURCES**  
Tools and resources available to support substance use disorder providers in building and maintaining an effective workforce and business, and achieving patient outcomes

**STAKEHOLDER COLLABORATION AND ENGAGEMENT**  
Opportunities to contribute to the development and refinement of the system of care, and learn what occurred in previous workgroup meetings

**PROVIDER MEETINGS, BULLETINS, BRIEFS AND FACTSHEETS**  
Information on contract updates and changes at the County, State and Federal levels, and other documents that outline programmatic, financial, information technology and contracting changes and requirements

**CONTRACT UPDATES, REQUESTS AND INQUIRIES**  
Electronic submission of documents and change requests related to the SAPC substance use disorder contract and contacting SAPC representatives

**RESEARCH, TRENDS AND DATA REPORTS**  
New research and resources on substance use disorder treatment best practices, and local data on substance use, service utilization and patient outcomes

## *Finance Related Forms and Documents*

- [Claim Denial Reason and Resolution Crosswalk for Providers \(New - January 2020\)](#)
- [Denial Crosswalk Instructions Version 1.0 \(New - January 2020\)](#)
- [Cost Report Forms and Instructions](#)
- [Treatment Rates and Standards Matrix](#)

## Denial Categories

### “Denial Reason”

- Denial Reason refers to the first check of eligibility requirements set by DMC and SAPC
- Claims that have a Denial Reason populated are denied due eligibility standards or SAPC contractual restrictions

### Explanation of Coverage

- Refers to claims that passed initial eligibility and contractual rules, but are now subject to additional requirements
- Claims that do not have a Denial Reason populated, but show an Explanation of Coverage, are denied due to authorizations issues, budget amounts, configuration issues and policy/treatment standard rules

## Treatment History

- Provides patient level history of claim status per fiscal year and fiscal month or all existing claims for the patient

## Services Denied in MSO Report

- Filtered by any date range and/or available Provider Program
- Provides list of all DENIED claims for parameters

# Treatment History and Details



## Treatment History display on the Treatment screen

- This display will show an individual patient's denied services for a given timeframe. By selecting the date of a denied claim, the denial reason will display on a separate window. An example of using this report would be to troubleshoot denials by patient.

Add Professional Treatment

This page defaults to treatments with services that occur during the current fiscal year.

VIEW ALL VIEW ALL view

Treatment History									
Agency	Tx Date <small>click to view details</small>	Status	Therapist	Procedure Code	Units	Duration	Billing		
							Bill Date	Status	Expected Disbursement
Recovery, Inc.	12/6/2017		SMITH,JOHN	H0004:U7	2			Denied	\$0.00
Auth #. P2872 CP Program: Recovery Facility Batch #: 4									
Recovery, Inc.	12/5/2017		SMITH,JOHN	H0004:U7	2			Denied	\$0.00
Auth #. P2872 CP Program: Recovery Facility Batch #: 4									
Recovery, Inc.	12/4/2017		SMITH,JOHN	H0004:U7	2			Denied	\$0.00
Auth #. P2872 CP Program: Recovery Facility Batch #: 4									
Recovery, Inc.	12/3/2017		SMITH,JOHN	H0004:U7	2			Approved	\$58.00
Auth #. P2872 CP Program: Recovery Facility Batch #: 4									
Recovery, Inc.	12/2/2017		SMITH,JOHN	H0004:U7	2			Approved	\$58.00
Auth #. P2872 CP Program: Recovery Facility Batch #: 4									
Recovery, Inc.	12/1/2017		SMITH,JOHN	H0004:U7	2			Approved	\$58.00
Auth #. P2872 CP Program: Recovery Facility Batch #: 3									

Field	Value
Procedure Code	H00
Revenue Code	
Units	
Approved Units	0
Service Date	
Start Time	
End Time	
Funding Source	Drug Medi-Cal
Authorization Number	
Claim Status	Denied
Claim Status Reason	
Explanation of Coverage	The service was denied for the following reason: Authorization is denied.
Duration	
Private Pay Amount Add/Edit	\$0.00
Billed Amount	\$
Expected Disbursement	\$0.00
Fee Table Amount	\$0.00
Check Number	
Check Date	
Check Amount	
Diagnosis Code #1	
Comments	
Service Comments	
Voided	No





## Services Denied in MSO Report in Provider Connect (PCONN)

Services Denied in MSO					
Agency	Member ID	Service Date	Reason for Denial	Service	Amount
Recovery, Inc.	159952	8/23/2019	The service also has the following Denial notice: Procedure not on fee schedule.	Individual Counseling (H0004:U2)	\$ 0.00
Recovery, Inc.	159952	8/23/2019	The service also has the following Approval notice: Limited by co-payment	Individual Counseling (H0004:U7)	\$ 59.26
Recovery, Inc.	8162	10/1/2019	The service was denied for the following reason: This member's authorization is for a different funding source.	Group Counseling (H0005:U7)	\$ 51.98
Recovery, Inc.	159913	11/1/2019	The service was denied for the following reason: Performing Provider is not registered on date of service.	Methadone (H0020:UA:HG)	\$ 100.00

- Shows all denied claims with the denial reason/explanation of coverage for all claims in the date range and/or contracting provider program selected
- If “Reason for Denial” is blank on this report, it indicates the claim was voided or is pending.

## Check/EFT Report

- Lists claim status and amount paid for adjudicated claims for a specific Check/EFT transaction.
- Report can provide valuable service level information, but not for check reconciliation
  - Report does not include takebacks or retro adjudications

## Audit Log Report

- Provides submission status of any form produced in ProviderConnect to be submitted to SAPC
- Useful to verify authorizations “not reviewed” were successfully submitted
- Useful to check on “Bill Enums” that are pending (Primary Sage Users only)

## Check/EFT Report

### Detail

Bill Enum	Program	Client ID	Date of Service	Procedure Code	Claim Status	Explanation of Coverage	Billed Amount	Approved Amount
				H2010:UA:HG - Medication Services	Approved	None Given	####	####
				H0001:U7 - Intake/Assessment	Denied	Authorization is denied.	####	####

- This report will show all denied services and the associated denial reasons for a selected check number.
  - An example of using this report would be to identify denials by check number/EFT payment (checks may cover multiple bills or 837's).
  - Report does not display takebacks or retro adjudications that may result in difference between Approved amount and the check amount. For this information, use MSO KPI Payment Reconciliation view.

# ProviderConnect Resources for All Providers



- **Explanation of Benefits (EOB) Remittance Advice Report sent to all providers via SFTP**
  - Each bill or 837 file submitted to SAPC has a corresponding EOB Remittance Advice Report that details approved and denied claims with corresponding reasons, contract billed against, total approved payments and line item information for each claim.

## Remittance Advice

EOB Number: 302

Check #:

Check Date:

RECOVERY, INC. (1)  
3250 WILSHIRE BLVD #1709  
LOS ANGELES, CA 90010-9998

Amount Approved: \$116.00

Page: 1

Client Name (ID): TEST,MIKE S (125928)

DOB: 08/20/1999

Gender: M

Date Claim Received: 12/08/2017

<u>Batch.SvcRef#</u>	<u>Auth #</u>	<u>Contract #</u>	<u>Contract Type</u>	<u>Date of Service</u>	<u>CPT Code</u>	<u>Status</u>	<u>Claimed Amount</u>	<u>Allowed Amount</u>	<u>Denied/ Adjusted</u>	<u>Member Co-pay</u>	<u>Amount Paid</u>
4.00001	P2872			12/02/2017	H0004:U7	A	\$58.00	\$59.26	\$0.00	\$0.00	\$58.00
4.00002	P2872			12/03/2017	H0004:U7	A	\$58.00	\$59.26	\$0.00	\$0.00	\$58.00
4.00003	P2872			12/04/2017	H0004:U7	D	\$58.00	\$0.00	\$58.00	\$0.00	\$0.00
<i>ELIGIBILITY AND/OR STANDARDS NOT MET</i>											
<i>The service was denied for the following reason: This service occurs during a claim processing blackout.</i>											
4.00004	P2872			12/05/2017	H0004:U7	D	\$58.00	\$0.00	\$58.00	\$0.00	\$0.00
<i>ELIGIBILITY AND/OR STANDARDS NOT MET</i>											
<i>The service was denied for the following reason: This service occurs during a claim processing blackout.</i>											
4.00005	P2872			12/06/2017	H0004:U7	D	\$58.00	\$0.00	\$58.00	\$0.00	\$0.00
<i>ELIGIBILITY AND/OR STANDARDS NOT MET</i>											
<i>The service was denied for the following reason: This service occurs during a claim processing blackout.</i>											
									\$174.00		
										12	\$116.00

## View Claim Status:

Approved

Pending

Denied

## Patterns or Trends in the Claim Status

- Look for patterns of denials for a group of denied claims.
  - Missing performing provider
  - All claims for a certain auth or provider program are denied, etc.

## Payment Reconciliation View

Missing Information that might have triggered denial (Ex. Performing Provider not identified)

Claim based Takebacks/Retro Adjudications after claim was approved.

Visibility on original claim EOB and Retro Claim EOB



# Denial Troubleshooting- Primary Sage User



# Denial Investigation Overview for Primary Sage Users

- **Look for patterns**
  - ***Large number of denied services with the same Denial Reason/Explanation of Coverage***
    - May indicate a configuration issue, agency specific issue, performing provider issue
  - ***All claims for one or a few patients are denied***
    - May indicate missing or incorrect DMC eligibility information or authorization issue.
  - ***All claims for a specific authorization are denied***
    - May indicate issues with the authorization (Wrong authorization used, issue with auth grouping, contracting provider program issue)
- **Fiscal Year (FY) trends**
  - During FY crossovers, there tend to be additional opportunities for denials if a provider bills during a blackout period, or before configurations are completed
  - Denials related contract amounts exceeded can result when contract augmentations were not submitted timely or at all.

## Submitted Bills from Billing Display

- Provides total amounts of Approved/Pending/Denied/Void claims on each bill submitted
- Bill Enum provides detailed patient level claim status

## Denied Services Report

- Available for each Bill Enum in Billing Section
- Displays claim status for each service claimed on the specific submitted bill



# Claim Pre-Adjudication for Primary Sage Users



- Providers should perform a check on claims prior to submission to identify possible denials by selecting the “Submit Bill for Pre-adjudication” function.

Client ID	Date		Cost	
	From	To	Unbilled	Billing
	8/1/2019	8/1/2019	\$0.00	\$0.00
			Total:	\$0.00
<a href="#">&lt;&lt; Cancel/Delete Bill</a>		<a href="#">Save, But Not Submit</a>	<a href="#">Submit Bill for Pre-adjudication</a>	<a href="#">View Bill Summary &gt;&gt;</a>

- The Failed result lets the provider know this claim would likely be denied if submitted for adjudication.
- Many reasons can be corrected by the provider, however some may require Netsmart/SAPC support.

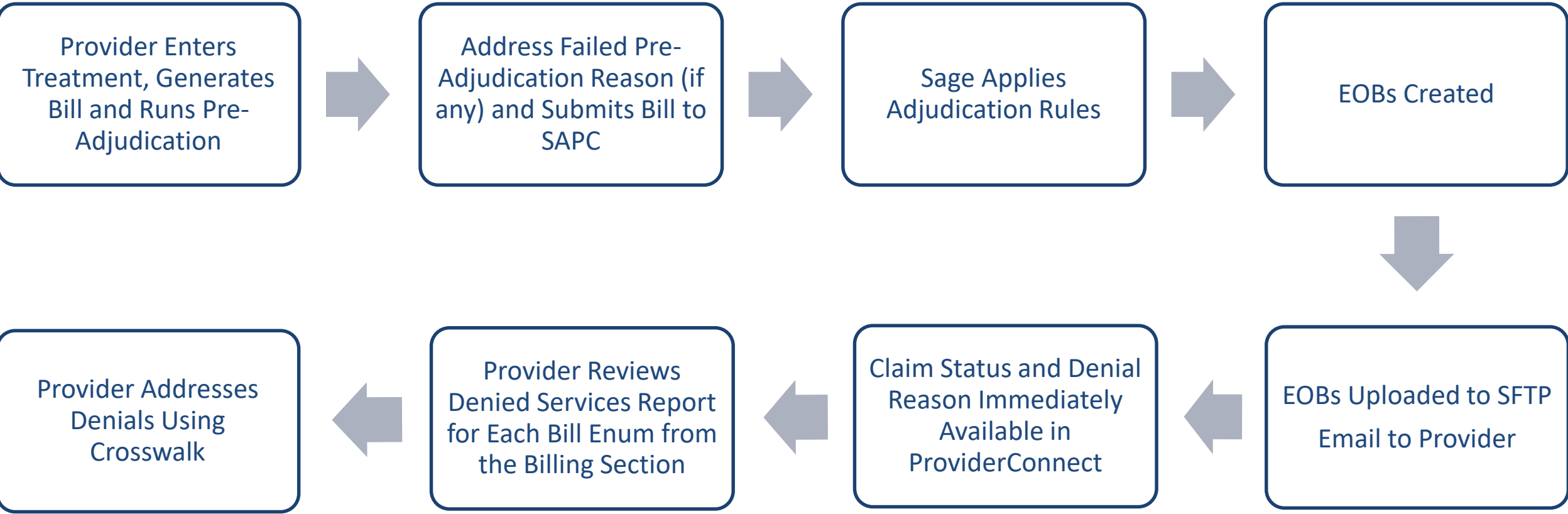
Bill Pre-adjudication Submission Date	Submitted By
12/27/2019 12:31:17 PM	EOrellana2 (Esther Orellana)

<a href="#">Refresh Bill Pre-adjudication Results</a>	<a href="#">Resubmit Bill For Pre-adjudication</a>	Filter Results By Status <span>All</span> ▼ Filter Results <span>All</span> ▼	<a href="#">Return to Bill Summary</a>
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[Mark All Passed As Reviewed](#)

Bill Pre-Adjudication Results							
Mark Service As Reviewed	Member ID	Service Date	Pre-Adjudication Edit Failed Reason	Status	Units	Procedure Code	Cost
<input type="checkbox"/>		8/1/2019 <a href="#">Delete</a>	The service was denied for the following reason:Procedure not on fee schedule.	Failed Edit	1	Individual Counseling (H0004:U7)	\$0.00

# Billing Workflow for Primary Sage User



## Eligibility Not Found Verified in Cal PM

- Basic eligibility information required to continue to process claim
- About 3x # of denials for this than next highest
- Populated as a “Denial Reason” in Sage

## Maximum Number of Units Procedure Code/Day Exhausted

- Residential day rates, Room and Board, RBH claims primarily impacted by this denial.
- This is usually a duplicate submission where the claim was already paid. Sometimes related to waiting on voided claims from the State.
- Shows as Explanation of Coverage in Sage

## Procedure not on Fee Schedule

- Generally a data entry error on the authorization in the grouping or provider program selected or performing provider on claim.
- Signals the claimed service is not contracted for
- Fees are only configured to reflected contracted services
- Shows as Explanation of Coverage in Sage



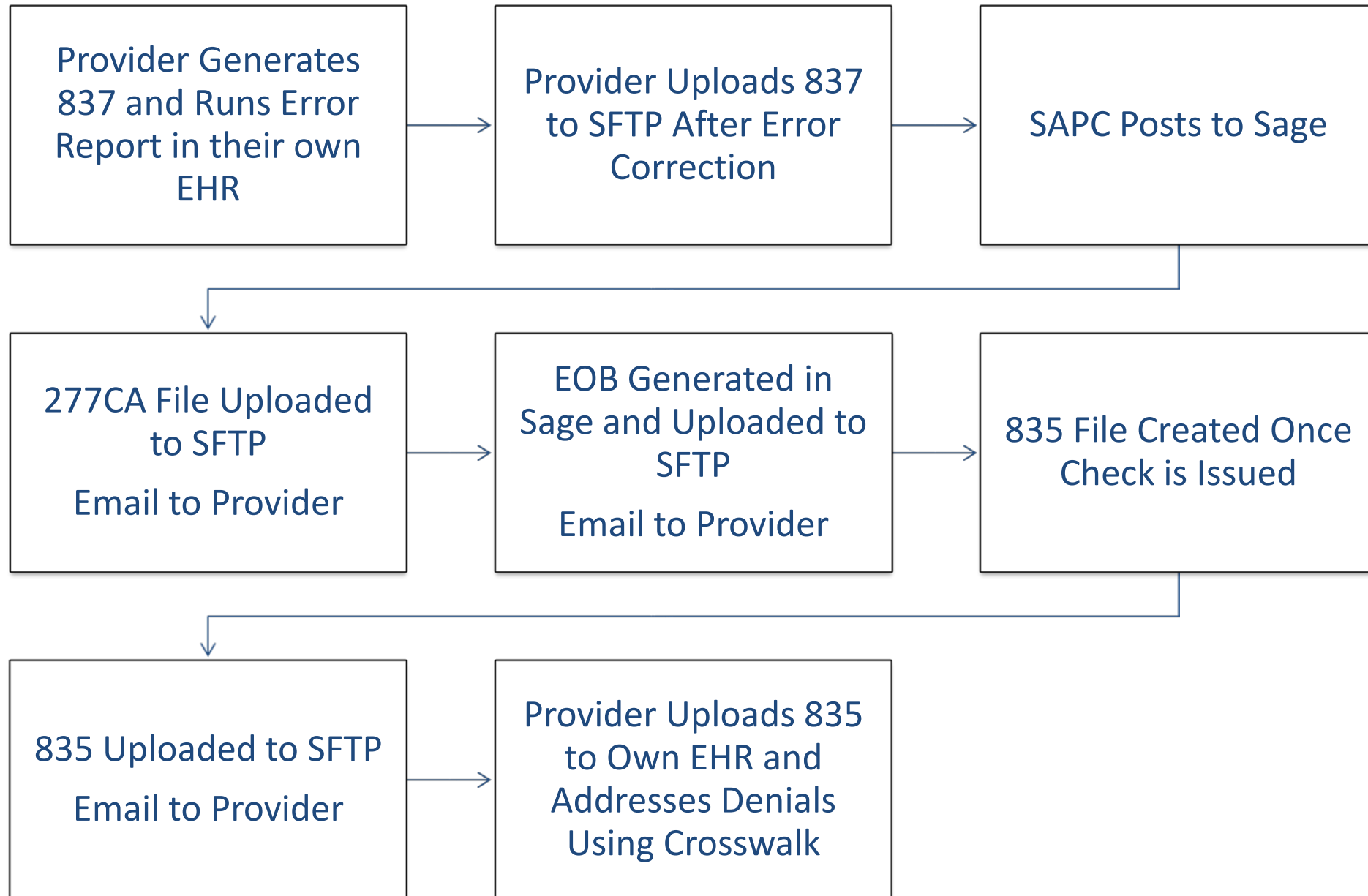
# Denial Troubleshooting- Secondary Sage User



# Denial Investigation Overview for Secondary Sage Users

- Look for patterns
  - Large number of denied services with the same Denial Reason/Explanation of Coverage
    - May indicate a configuration issue, agency specific issue, performing provider issue
  - All claims for one or a few patients are denied
    - May indicate missing or incorrect DMC eligibility information or authorization that is approved.
  - All claims for a specific authorization are denied
    - May indicate issues with the authorization (Wrong authorization used, issue with auth grouping, contracting provider program issue)
- Fiscal Year (FY) trends
  - You need to be sure to update your systems!
  - During FY crossover there tend to be additional opportunities for denials by claiming to the **wrong authorization** when there is a split auth, when a **provider bills during a blackout period**, or when **provider is onboarding**
  - If a provider bills during a blackout period, or before configurations are completed
  - Denials related contract amounts exceeded are usually the result of contract augmentations not submitted timely or prior to augmentations being approved.

# Billing Workflow for Secondary Sage User



## Eligibility Not Found Verified in Cal PM

- Basic eligibility information required to continue to process claim
- Populated as a “Denial Reason” in Sage

## Performing Provider is Blank

- Performing provider is required on all claims from 7/1/2019 on.
- As of 09/01/19, nurses/others dispensing Methadone/other medications must have an NPI and be listed as the performing provider on the claim.
- Populated as Explanation of Coverage

## Duplicate Service

- Service has already been claimed and paid
- Possibly related to submitting 837 file multiple times or unclear if service had been paid (MSO KPI can be used to verify payment)
- Populated as Explanation of Coverage

## 837 File Error(s)

- File is rejected outright due to formatting or missing critical information
- Denials related to missing required information
- Providers should work with their EHR company to configure the system based on the SAPC 837 Companion Guide
- Most EHR's have an error report to validate the 837 before sending.

## Authorization Related denials

- Patients may have multiple authorizations due to Fiscal Year, reauthorizations, re-admissions etc...
- Authorizations must be updated in the Secondary User's EHR any time there is a change.
- All patients have a new authorization # for fiscal year cutovers that must be updated before claiming.



## Denial Code/Denial Reason

- Message in Sage: Eligibility Not Found/Verified in CalPM
- 835: Adjustment Reason  
Group Code: CO- contractual  
Obligation
- 835: Claim Adjustment Reason  
Code: 177

## Resolution- Per Crosswalk

- Provider should be able to correct this issue by ensuring the Financial Eligibility for patient is completed properly.
  - Guarantor is in correct order
  - CIN entered (if applicable)
  - Coordination of Benefits and Eligibility Verified are marked “Yes”
  - Dates correspond with Dates of Service (DOS)
  - Admission diagnosis entered
  - Real Time 270 is run and posted
- Additional steps on 837, if applicable: ensure the diagnosis on the 837 file, (2010B loop, HI Diagnosis Pointer segment, HI101 element) matches the diagnosis as entered into the Sage system.

## Even More Visibility Coming Soon...

- New views being created in MSO KPI to provide increased visibility on denials with an emphasis on analysis for resolution
- SAPC-Finance will be sending Explanation of Benefits (EOB's) to every provider as they are generated to provide increased visibility.
- Claim Denial Crosswalk version 2.0 with Other Adjustment (OA) groups, State denial codes and resolution steps for state denial codes.

## Sometimes It's Complicated...

- If a provider completes the validation steps for resolution provided in the Claim Denial Reason and Resolution Crosswalk and are still receiving the same error message, they should submit a Sage Help Desk ticket
- Ticket submission is important for tracking of trends which may impact various providers.
- Tickets provide a mechanism for providers and SAPC staff to communicate regarding efforts to address denial issues.

**Need Sage Help?**



**Frequently Asked Questions**

**855-346-2392** | <https://netsmart.service-now.com/plexussupport>