Los Angeles County
START-ODS
System Transformation
To Advance Recovery
and Treatment

sage
Managed by SAPC

Guide to Claim Denial Resolution and Crosswalk

A Patient Management System
Services, Data, and Claims

May 2021 | Version 3.0

SAPC | Substance Abuse Prevention and Control

County of Los Angeles Public Health

Table of Contents

Introduction

The Claim Denial Reason and Resolution Crosswalk, hereinafter referred to as the Crosswalk, was developed to assist providers with identifying claim denial definitions and resolution steps. When claims are submitted to SAPC, they undergo an adjudication process which may result in denials categorized by Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC). CARCs and RARCs are nationally recognized, federally standardized code sets used by U.S. health payers to report payment adjustments including denials.

The Crosswalk addresses both local and State denials. Depending on whether a provider is a primary or secondary user will impact how the Crosswalk will be utilized. A glossary is located at the end to clarify specific terminology referenced in this document.

Denial Levels

For the purposes of this crosswalk and denial investigation, SAPC has separated denied services into a two-level system. These levels are meant to distinguish between "local" (SAPC) level denials and State level denials.

1. Level 1- Local (SAPC): This level consists of denials that occur immediately when the claim is initially received and adjudicated within Sage. These initial adjudication rules are based on eligibility, policy and program standards established by DMC, SAPC Provider Manual and the Rates/Standards Matrix.
    a. Unless the denied claim is voided by the provider, the Claim Status in Sage for these claims will always show as "denied," regardless if the billing was resubmitted and subsequently approved.
2. Level 2- (State related): This level consists of claims that were approved by SAPC, but subsequently denied by the State or as a result of an audit finding. Generally, these would be denied due to eligibility, invalid information, or other DMC standard(s). For these denials, the provider has already been paid on the claim by SAPC and denied amounts are deducted from future payments after additional billing is processed.
    a. DMC eligible claims are transmitted to the State for reimbursement to SAPC. The State system verifies against the DHCS database, which is comprised of patient information entered at Medi-Cal enrollment. If information entered into Sage does not match information in the State system exactly, the claims will be denied by the State and potentially recouped from the provider.
    b. State denials will show as "Void" in the treatment history "Status" section in Sage.
        i. However, the "Treatment Details" section when viewing the specific treatment information, will continue to show the "Claim Status" as "Approved." In MSO KPI claims will continue to show as "Approved" but will have an associated "Takeback" amount on the Payment Reconciliation View.
            1. The "Claim Status" in the treatment history reflects the original adjudication of the claim.

ii. If a claim has been taken back or retro adjudicated by SAPC through an audit or manual process, the claim will show with a "Void" status in Sage on both the Submitted Bills section and the Treatment sections. However, they will continue to show as "Approved" in MSO KPI but will have an associated "Takeback" amount on the Payment Reconciliation View. Claims with this Takeback amount indicate they were a Level 2 denial.

General Denial Investigation and Procedures

The process of denial investigation depends on several variables that can be different for each denied claim or each provider agency. Generally, Primary and Secondary Sage Users will have the same category of errors leading to denials, however, the investigation and correction steps will differ substantially between Primary and Secondary Sage Users.

The below categories refer to the most prevalent issues for both Primary and Secondary Sage Users. Understanding the common errors for these general categories and applying the accompanying troubleshooting steps to claims prior to being submitted to SAPC may greatly reduce errors and denials, leading to increased approval rates and improved efficiencies related to investigating claim denials.

There are several ways to investigate a denied claim to determine the source of the denial. Generally, there are five primary categories of denials with similar troubleshooting steps to resolve issues within each group:

1. Date Errors
2. Financial Eligibility
3. Diagnosis Issues
4. Authorization
5. 837 File Errors (Secondary Sage Users Only)

As most denials fall into one of these categories, providers can minimize denials and/or more easily correct denials by first verifying information in each of these areas.

Date Errors

This group of denials relates to errors in admission dates, services dates, claim submission dates, or authorization dates. Providers need to ensure the following dates are correct before submitting claims or when a claim is denied due to a date inconsistency.

A. Episode start date corresponds to the first date the patient enrolled in services for a particular agency. This date will not change if a patient discharges and readmits. For the agency, the episode date must be on or prior to the date of the first service. 'Episode' date and 'Admission' date are not the same. There is only one episode and episode date per patient at an agency.

B. Service date must be on or after the SAPC contract effective date for the agency/program site. SAPC Contract Management and Compliance will provide an effective date when providers can officially receive an approved authorization and submit claims for reimbursement. Services provided before that date will be denied.

C. Services claimed with a date of service before the date of diagnosis will be denied.

D. Authorization start and end dates must match the dates for the service period.

E. Financial Guarantor Coverage Effective Date must be either prior to or the same as the service to be reimbursable by that guarantor. Financial Guarantor Coverage Effective Date must not be after the service date.

F. Coverage expiration date is only entered for a given guarantor if the actual date the patient lost or will lose coverage for that guarantor is known. Any service occurring after the coverage expiration date for a primary guarantor will be denied.

    a. This field should only be completed:

        i. When a patient loses Medi-Cal eligibility and it is not reinstated.

        ii. For Applying for Medi-Cal when the patient becomes enrolled in Medi-Cal.

G. Date of service violates the State's Same Day Billing matrix and was either a duplicate entry or cannot be billed on the same day as another service that was already approved.

    a. This can occur for admission and discharge claims when a patient is transferring to a different level of care or provider.

Financial Eligibility Form Issues

This group of denials relates to errors or missing information that is used to determine financial eligibility. Both Primary and Secondary Sage Users must complete the Financial Eligibility Form in Sage, which is how SAPC determines financial liability for services. As such, certain information and criteria are required on the Financial Eligibility Form in order to establish financial eligibility. The following areas of the Financial Eligibility Form will result in denials if not completed correctly or if the patient does not meet that financial standard:

A. Verify that the patient's Financial Eligibility Form is complete and has been submitted.

B. For Drug Medi-Cal (DMC) Guarantor, ensure that form includes:

    a. Subscriber Client Index # (for the correct patient).

    b. Subscriber Sex (The State will only accept Male or Female).

    c. Subscriber Date of Birth (that matches the DOB on file with the State).

    d. Subscriber Address Line 1, State, City, Zip Code.

        i. For patients who are homeless, the local Department of Public Social Services (DPSS) office address is used.

e. Eligibility Verified- Providers must verify eligibility prior to accepting a patient.
    i. Select "Yes" if eligibility has been verified.
    ii. If provider has not verified eligibility prior to completing the financial eligibility, then "No" should be selected, which would result in denials until eligibility has been verified.
f. Coordination of Benefits = Yes
g. Subscriber Assignment of Benefits = Yes
h. Coverage Effective Date must be on or before episode admission and on or before first date of service.
i. Coverage Expiration Date is either blank or must be after the date of service billed.

C. To avoid DMC eligibility issues related to outdated information, providers are required to run the Real-Time 270 Eligibility Request on admission and monthly while the patient is receiving services. Running the Real-Time 270 Eligibility Request updates the MEDS file, which is the master file of Medi-Cal eligibility to show the most current eligibility information.
    a. A significant portion of State denials are related to incorrect or invalid DMC eligibility. This may have been related to a patient having out of county Medi-Cal or there was a data entry error with the CIN, so the State would be comparing the FE information against the wrong CIN.

Diagnosis Issues

This group of denials is related to errors, invalid entries, or unsupported diagnoses on the Provider Diagnosis (ICD-10) Form in Sage, which is required to be completed for both Primary and Secondary Sage Users. The following items must be present and correct, or the claim will be denied:

A. All patients must have an admission Type of Diagnosis on the Provider Diagnosis (ICD-10) form in the system. If there are only "update" diagnosis types in the system, this will cause a denial.

B. The admission diagnosis date must be on or before the date of service. When providers enter an admission diagnosis, it will automatically populate the date as the episode start date.
    1. If provider changes the admission diagnosis date to a date after the date of service, the claim will be denied.
    2. If the admission diagnosis date and the episode start date match, but are after the service date, the episode must be corrected before the claim can be resubmitted.

C. The principal diagnosis must be a DMC approved diagnosis. A list is available on the SAPC website and DHCS publishes approved diagnosis through MHSUDS Information Notices.

D. Diagnosis ranking and billing order must match. This means that each of the primary, secondary, or tertiary diagnoses listed must have the same billing order of 1, 2, or 3. The primary diagnosis must be a substance use related diagnosis.

Authorization Issues

As of July 1, 2018, all services must have a valid member authorization to be reimbursed. Additionally, provider authorizations (PAUTH) are issued for incentive payments and screening services. Many authorizations are submitted with incorrect information related to dates, contracting provider program (program address), authorization groupings, or funding source. Errors on the Authorization Request Form may result in various denial reasons, depending on if the error was a data entry error or an issue with services not being contracted with SAPC.

Issues related to authorizations can be resolved by contacting the SAPC Quality Improvement and Utilization Management (QI & UM) directly at (626) 299-3531. Providers should contact the Sage Helpdesk at (855) 346-2392 for system issues that cannot be corrected by QI & UM.

Common errors to be validated on the Authorization Request Form are as follows:

A. Funding source is incorrect for the patient and provider.
    1. DMC Funding Source option must be selected for all DMC enrolled patients receiving DMC reimbursable services at a DMC certified/licensed program location.
    2. Non-DMC Funding source option must be selected for all patients who are either applying for DMC or do not have DMC at the time of authorization regardless of the service or provider. This must be changed to the DMC Funding Source option once the patient is enrolled in DMC. A new authorization is required if changing the funding source.
        i. Non-DMC Funding source must also be selected for My Health LA patients or for patients enrolled in a County program such as AB109, CalWORKs, and General Relief that are not enrolled in DMC.
    3. Recovery Bridge Housing (RBH) authorizations must be entered using the Non-DMC Funding Source option, regardless of patient DMC eligibility or provider DMC status.
    4. If the service was delivered at a non-DMC certified site, this will trigger a state denial for ineligible provider.

B. Start and end dates are inconsistent with dates of service and information on the Financial Eligibility Form. Providers must verify that the start and end dates on the authorization are consistent with the actual dates of services being billed.

C. Contracting Provider Program on the Authorization is different than the actual address where the service was rendered. The program address on the authorization must match the service delivery address.
    1. If the address is blank on an approved authorization, providers should check with their Contract Program Auditor (CPA) to verify if they are an approved campus provider. This is the only circumstance when the address will remain blank.

2. If the Contracting Provider Program field is blank and the provider is not an approved campus provider, this will result in a claim denial. If this field is left blank in error, contact the SAPC QI & UM Care Manager assigned to the authorization to update this field on your behalf.

D. Authorization grouping does not match the level of care where the patient was admitted, or the provider is not contracted for that level of care.

E. Authorization grouping was selected for a special population that does not apply to the patient or the provider is not contracted to deliver specialized services for that population. This refers specifically to Pregnant and Parenting Women (PPW) and age specific groupings. System errors where the authorization information (e.g., funding source, contracting provider program, and authorization grouping) was correct, however the Current Procedural Terminology (CPT) codes on the authorization did not match or populate correctly. In this situation, providers will need to resubmit the authorization and contact the SAPC QI & UM Care Manager to deny the errored authorization and approve the new authorization.

F. Authorization numbers were not updated in the Secondary Sage Users electronic health record (EHR) system, therefore, an old authorization number was used for the service date resulting in denials for associated claims. This is most often found for fiscal year split authorizations. Providers will be denied for "procedure code not found in authorization" or "invalid authorization number" because there is a discrepancy between the Healthcare Common Procedure Coding System (HCPCS) code and the authorization number.

837 File Formatting and Submission Errors

This group of denials only applies to Secondary Sage Users who submit claims via an 837 Electronic Data Interchange (EDI) file transaction. In addition to the above general denial themes for all providers, denials related to this category have two additional primary reasons that are not related to contractual or benefit issues: 1) file formatting errors; and 2) missing/invalid information entered.

The main issue related to the file format relates to extraneous characters or spaces pulled from the EHR system of Secondary Sage Users or the default system configuration where the file does not conform to the requirements in SAPC's Companion Guide. This may occur when the system is used for multiple payors, funding streams, county agencies, etc. where each may have variations on the formatting requirements. The file format is specific to each managed care organization and needs to be formatted according to the specific guidelines in the companion guide for that organization.

The 837P and 837I companion guides were created to inform Secondary Sage Users how to create the 837P/837I file with the correct format to avoid these errors. Generally, the 837 files are compiled from the EHR itself with information entered into the patient's medical record and provider billing information. There are certain defaults that can be added to each 837 file that may contain errors or if information is missing from the medical record, it will not populate to the required Loop-Segment-Element on the file.

Many denials for Secondary Sage Users will show as "CO 16," which is defined as "claim/service lacks information which is needed for adjudication." This may also be accompanied by a remark reason of "missing/incomplete/invalid" required value. This likely occurs as Secondary Sage Users must manually enter information from Sage into their own system, as well as communicate certain information to be in the Sage system. This includes authorization information, contact information, and the National Provider Identifier (NPI) number(s) associated with the performing or billing provider. If any of this information is not entered, entered for the wrong patient, or mistyped in either system, it will result in denials. Any discrepancies between information in Sage and information on the claim will lead to these denials.

It is important for Secondary Sage Users to check for authorization updates (which can be done in Sage using the Authorization Request Status Report) during fiscal year cutovers and for reauthorizations as these will create new authorization numbers. These new authorization numbers must be manually entered in the EHR system of Secondary Sage Users before submitting the 837 file. Providers should use their error reports, if available in their EHR, when creating an 837 file to identify these errors in advance of submitting.

Additionally, if there are inconsistencies between the FE in Sage and the Secondary Sage Users' EHR, this may result in denials.

Resources for Denial Investigations

Although Primary and Secondary Sage Users have similar categories of errors leading to claim denials, the process by which providers are informed of the denial reason differs slightly. Once the denial reason(s) is/are known, the Crosswalk will aid providers in identifying resolution steps that can be taken to correct the error so the claim can be resubmitted or replaced. The following are methods by which providers may identify denials, denial reasons, and/or denial codes.

Identifying Denial Reasons

Identifying Denials with Key Performance Indicator (KPI) Dashboards 2.0

- **MSO KPI Dashboard 2.0 Payment Reconciliation Sheet** – Published to the network on 10/1/2020, this sheet providers detailed information on services, EOBs, Retro EOBs, and Check Numbers. The Procedure Overview object has two main areas to determine the type of denial. The Claim Status column is associated with Level 1 adjudications. If it is Denied, the claim did not get paid by SAPC. If the Claim Status column indicates Approved, the claim was paid by SPAC. If the last three columns are populated (Total Takeback, Takeback Date, and Retro Reason), this indicates a Level 2 denial. Specifically, if the Retro Reason Column begins with "Denial CO" this would indicate a State Denial. It may also be an audit related retro and would have a description of why the service was recouped from the provider.

Procedure Overview

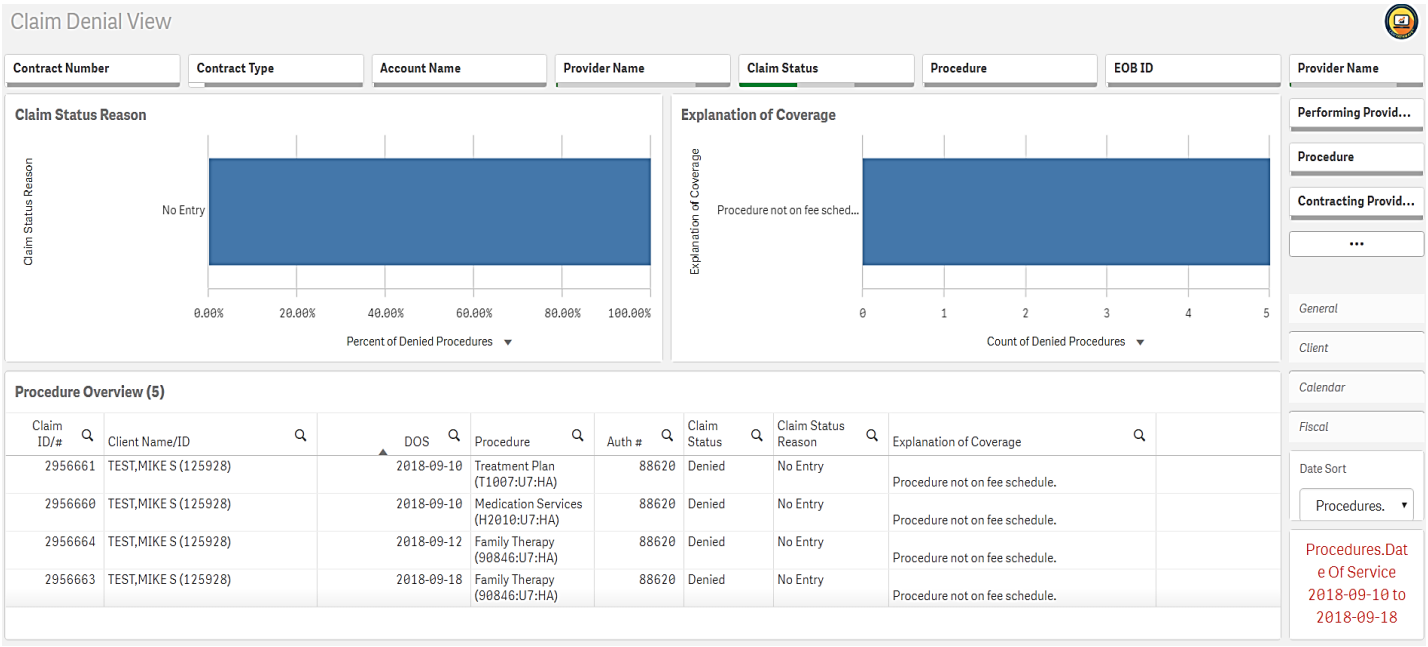
Procedure ID	Provider Name	Contracting Provider Program	Client Name	DOS	Performing Provider Name	Procedure	Proc... Count	Auth #	Claim Status	Total Charge	Total Disbure...	Total Takeback	Takeb... Date	Retro Reason
Totals							**87**			**$7,758.93**	**$519.24**	**$6,972.72**		
14775826	Recovery, Inc.	Recovery Facility	TEST,CARLA (148387)	2020-04-02	DUDLEY,JUDITH NTST	Group Counseling (H0005:UA:HG)	1	155770	Approved	$0.00	$0.00	-	-	-
13131795	Recovery, Inc.	Recovery Facility	TTEST,ADDRESS (191599)	2019-07-01	SCHWARZ,GREG SAPC	Group Counseling (H0005:U7:HA)	1	222624	Approved	$26.73	$0.00	$26.73	2020-04-20	Contractor Void
13131809	Recovery, Inc.	Recovery Facility	TTEST,ADDRESS (191599)	2019-07-01	SCHWARZ,GREG SAPC	Individual Counseling (H0004:U7:HA)	1	222624	Approved	$118.52	$0.00	$118.52	2020-04-20	Contractor Void

- **MSO KPI Dashboard 2.0 Claim Denial Sheet** – Published to the network on 03/3/2020, this sheet gives providers visibility on Level 1 Local denials. Level 1 denials, with a claim status of "Denied" can have either a Denial Reason and/or an Explanation of Coverage that explains the reason for denial. The view is split into three sections:

  Claim Status Reason: This refers to the 'Denial Reason' that is assigned to a denied claim. These reasons correspond to the "Denial Reason or Explanation of Coverage Message from Sage " column on the crosswalk. Denial Reasons are populated when the claim does not include basic eligibility standards for the system to check against, such as missing CIN number. If a denied claim does not have a denial reason, it will have an explanation of coverage to explain the denial. Percentage and Procedure Counts selections at the bottom of the object refer only to the percentage/counts of claims that were denied for that reason and do not refer to percentage of all claims. For example, if Eligibility not found/verified in CalPM is showing at 35% on the bar graph, that means of only denied claims, 35% were related to that denial reason. Count of Denied Procedures works in the same manner; it only shows the count of claims denied for that particular reason.

  - *Explanation of Coverage*: This refers to claims that were denied for reasons outside of eligibility; they were denied for a different reason related to rate, treatment or contract standards. These explanations also correspond to the "Denial Reason or Explanation of Coverage Message from Sage " column on the crosswalk as they are Level 1 denials.

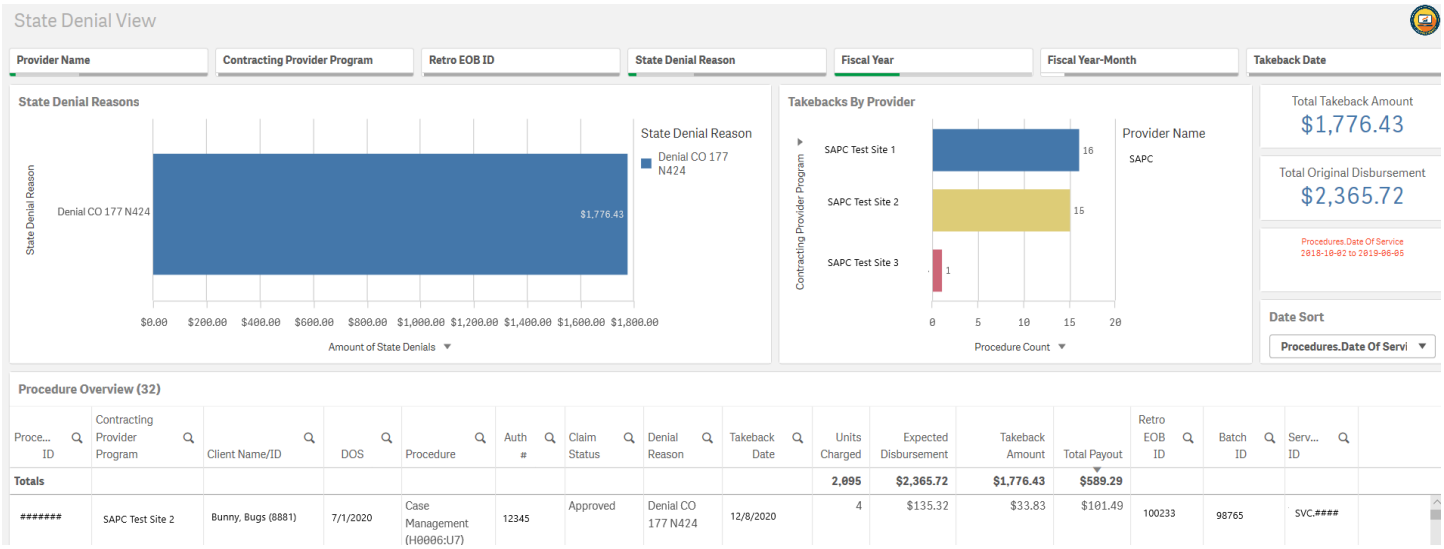
  - *Procedure Overview section*: Provides detailed service/claim information for any filters selected by the user. For instance, if a user wanted to see all the claims denied for "Eligibility not found/verified in CalPM," they would select that in the Claim Status Reason object. This will then populate all claims with that denial reason on the bottom Procedures Overview section of this view. The term "No Entry" is best understood as not applicable and should not be interpreted as 'something is missing.' As seen in the screen shot, Claim Status Reason of "No Entry" means there is no assigned denial reason because it is not applicable. The patient met basic eligibility criteria and requires further processing for final adjudication. In the below screen shot example, the patient was eligible for the service (therefore did not have a denial reason), however, the provider billed for a service that was not contracted or configured, leading to an explanation of coverage of "Procedure not on fee schedule."



- **MSO KPI Dashboard 2.0 State Denial View Sheet** - Published to the network on 7/22/2020, this sheet gives visibility to providers on Level 2 (State) related denials.
    - *State Denial Reasons*-This object lists the dollar amount or procedure count associated with a Level 2 code. These codes use the naming convention "Denial CO" followed by a CARC. The object can be changed by they user by selecting the the prefered amount or count view at the bottom of the object.

    - *Takebacks by Provider*- This object lists the total dollar amount or total count associated with Level 2 denials by provider sites or an agency as a whole.

    - *Procedure Overview*- This object provides a detailed listing of the specific procedures that were denied by the state. Claim Status will be listed as "Approved" because SAPC initially approved and paid this claim. There are three dollar amount related fields: Expected Disbursement, Takeback Amount, and Total Payout. Expected Disbursement is what SAPC initially paid the provider. The Takeback Amount is the dollar amount that was taken back by SAPC due to the claim being denied by State; this could be the full disbursement amount or a partial takeback. The Total Payout is the amount the provider is the difference between disbursement and takeback. Many of these Denial Reasons may be corrected. Please see the Crosswalk for replacement resolution steps.

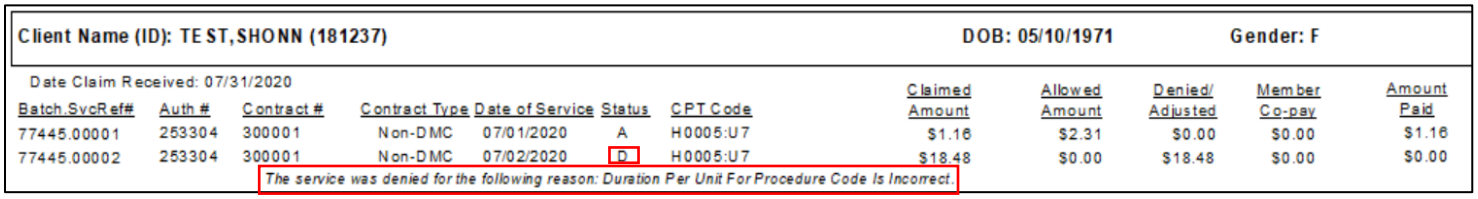


Identifying Denials with Explanation of Benefits (EOB) Remittance Advice

The EOB Remittance Advice is furnished to providers via the SFTP. An EOB will give a listing of claims, their status, and an explanation for denials.

Local Denials

When a claims is denied at the local level, the EOB will give service information including a description of the denial reason. This will be similar to the Explanation of Coverage message in KPI. The "D" in the Status column indicates that service was denied.



Client Name (ID): TEST,SHONN (181237) **DOB: 05/10/1971** **Gender: F**

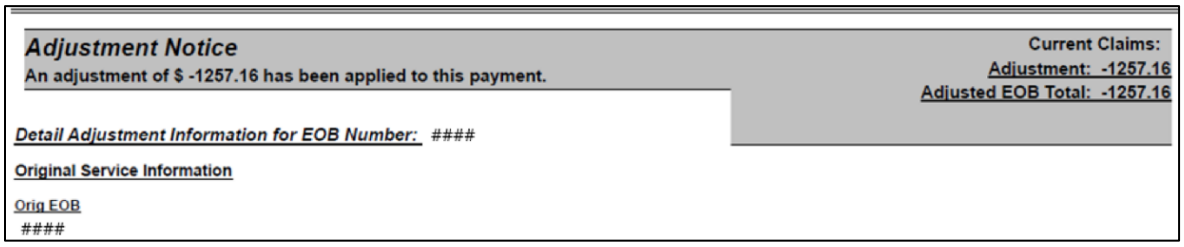
Date Claim Received: 07/31/2020

Batch.SvcRef#	Auth #	Contract #	Contract Type	Date of Service	Status	CPT Code	Claimed Amount	Allowed Amount	Denied/ Adjusted	Member Co-pay	Amount Paid
77445.00001	253304	300001	Non-DMC	07/01/2020	A	H0005:U7	$1.16	$2.31	$0.00	$0.00	$1.16
77445.00002	253304	300001	Non-DMC	07/02/2020	D	H0005:U7	$18.48	$0.00	$18.48	$0.00	$0.00

The service was denied for the following reason: Duration Per Unit For Procedure Code Is Incorrect.

State Denials

State denials resulting in a retro adjudication will be listed on the EOB Remittance Advice. This EOB is often referred to as a retro EOB, will begin with an "Adjustment Notice," and note the adjustment amount and adjusted EOB total on the first page of the EOB.



Adjustment Notice

An adjustment of $ -1257.16 has been applied to this payment.

Current Claims:
Adjustment: -1257.16
Adjusted EOB Total: -1257.16

Detail Adjustment Information for EOB Number: ####

Original Service Information

Orig EOB
####

State denials are identifiable by their naming convention, which starts with "Denial CO…" followed by a CARC and possibly a RARC in the Adjustment Reason Column. Similar to KPI and Sage the "Status" column will reflect an "A" for approved, as this claim was approved at the local level.

BatchID	SvcRef	DOS	Proc	PatID	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
####	####	####	H0004:UA	####	A	78.70	78.70	1/29/2020	$-78.70	Denial Co177

Identifying Denials in Sage

- **Services Denied in MSO Report** – This report shows local denials reason across the entire agency or a specific site for a given timeframe based on the parameters set. This report can be used to identify patterns of denials or general denials for a specified time frame.
    - This report will **not** show services denied by the state. It is only met for local level denials.

Services Denied in MSO					
Agency	Member ID	Service Date	Reason for Denial	Service	Amount
			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.	Residential -Alcohol and/or Drug Service (H0019:U3)	$

- **Check/EFT Report** – This report shows all local denied services and the associated denial reasons for a selected check number. This report can be used to identify denials by check number/payment (checks may cover multiple bills).

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.		$###	$###

- **Treatment History display on the Treatment screen** – This display shows an individual patient's local denied services for a given timeframe. By selecting the date of a denied claim, the denial reason will display on a separate window. This report can be used to troubleshoot denials by patient.

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

- **Bill Enum and View Denied Service Report** (Primary Sage Users Only)– To access these reports, click on Billing from the Main Menu. Click on a Bill Enum under the Submitted Bills section, scroll to the bottom of the screen, and click on the red View Denied Service Report button. This will lead to the View Denied Service Report. This shows local denied services by submitted bills. This report can be used to identify why which services of a specific bill were denied or paid.

Secondary Sage Users

Secondary Sage Users may also access denial codes through the 835-file received from SAPC in addition to utilizing Sage and KPI. When SAPC uploads the 837P/I submitted by the provider into Sage, it processes the file. Once adjudicated and an Explanation of Benefits (EOB) is created, an 835 file is generated by SAPC. The 835 file is limited to one denial code and due to the specific formatting of this standardized file, the denial reason cannot be included. Use the Crosswalk to identify the denial reason and needed resolution steps to resubmit or replace the claim.

The Companion Guide - HIPAA 837P (revised July 2019) and Companion Guide – HIPAA 837I (January 2020) are available under the Sage section on the SAPC website. This guide outlines requirements for 837P/I file claim submission as well as how to interpret the 835 file. Although SAPC may accept the 837P/I file, it does not mean that the file is without error. For example, if there is an extra space/character in each claim, the system will accept the file, but deny claims due to this data entry error.

Additionally, once the 837P/I file is adjudicated within Sage, it will make the following resources available to Secondary Users (these are available immediately while the 835 file is pending creation):

- **Services Denied in MSO Report**
- **Check/EFT Report**
- **Treatment History display in the Treatment screen**

Crosswalk

The Crosswalk was developed to assist providers in understanding denial codes/reasons and how to resolve the issues(s) which led to the denial so the claim can be resubmitted/replaced. Version 3.0 reflects a streamlined format where State Denials and Local Denials are on separate spreadsheets. Additionally, the number of columns were consolidated from Version 2.0 to only include the essential information to allow providers to quickly identify the cause and resolution steps for specific denials. Version 3.0 is limited to only include the most relevant or common Local and State denials.

The first step in denial troubleshooting is to identify what claims were denied. This can be done with one of the various resources discussed in the previous section. Denials may appear sporadic or without a clear pattern (e.g., error happens with some patients or within levels of care and not others). This is when individual investigation of the denials is warranted as the resolution may be different for each service. On the other hand, you may notice a pattern of denials (e.g., denials for only a specific patient, service type, performing provider (staff), or date range). In general, when there are patterns in denials, the reason code is likely the same for denied claims. As such, they will follow a similar resolution process.

> *Disclaimer - Given that there are thousands of CARC and RARC combinations, only the most common codes were included in the crosswalk. If you encounter an unlisted code, you may refer to X12.org to obtain a description of the CARC and/or RARC. Often the resolution steps for RARCs are similar regardless of the CARC.*

Resubmitting or Replacing a Denied Claim

Once providers research the denied claim, identify the issue, and correct the problem, the claim can either be resubmitted or replaced. If a claim was appropriately denied because the service itself was not allowable by SAPC or DMC, then the claim should not be resubmitted or replaced. For example, if a service was claimed at a provider program that was not certified by DMC at the time of the service, that claim is appropriately denied by the State because it is not reimbursable by DMC.

Resubmitting a Denied Claim

Resubmissions refer to the process of submitting a new claim for the same service. Once a claim is denied, the claim remains denied unless it is voided or replaced by the provider. Claims that are denied at the Level 1/Local level are generally resubmitted. Providers can choose to void a level 1 denial, which will remove the denied service from subsequent Sage reports and only count the final approved service. Claims that are resubmitted will result in the service being billed twice; the first will remain as denied and the second should be approved, unless the denied service is voided.

For State Denied claims, Primary Sage Users must resubmit claims as Sage prevents replacement for these claims.

Replacing a Denied Claim

The replacement process is used when a provider disagrees with the denial reason or the denial amount or finds a mistake in the claim that needs to be corrected. Primary Sage Users may replace level 1 denials only. For Secondary Sage Users, the PCCN transmitted on the 835 file and must be used on subsequent 837 files that include the replacement claim. Additionally, Secondary Sage Users must mark the claim as a replacement using the code value '7' in the CLM05-3 segment of the 837 file. Failure to enter the correct PCCN and indicate the replacement status may result in a rejection and/or denial.

Voiding Claims

If there was an error on the original claim but it was still approved, such as wrong patient or wrong date of service, then claim should be voided for both Primary and Secondary Sage Users. This type of error is not replaceable. Once voided, a new claim should be submitted with the correct information. Additionally, Secondary Sage Users must mark the claim as a void using the code value '8' in the CLM05-3 segment of the 837 file. Failure to enter the correct PCCN and indicate the void status may result in a rejection and/or denial or the original claim not actually being voided.

Single Denial Reason/Code

In the situation where you find a single denial reason for a claim, such as when using the Services Denied in MSO or Check EFT Reports to view denials, compare the reason to the Crosswalk. The denial reason will coincide most with column C on the Crosswalk. A quick way to cross reference the denial reason without scrolling through each row is by using the Ctrl+F keys to find a word/phrase on the crosswalk.

For Secondary Sage Users using the 835 file, the specific CARC and RARC codes are included for denied claims. When the CARC/RARC code is identified on the 835, use the Crosswalk to find the denial reason and associated resolution steps by following the information below. Find the CARC and RARC on the Crosswalk to get the explanation of what that code combination means.

To address the denial, go to column D - Resolution. This column describes in plain language the reason for the denial in addition to the validation steps and resolution steps for providers to resubmit/replace.

> *Note: Since the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS), the requirements for medical necessity and billing changed. If a claim does not fall within the specified requirements, there would not be a resolution as the denial is valid. An example may be if a registered or certified Substance Use Disorder Counselor staff member billed for a service only a Licensed Practitioner of the Healing Arts (LPHA) is authorized to provide.*

The resolution steps in column D point to forms, reports and/or displays in Sage and the 837 file (for Secondary Users) that may show where the errors exist. As each Secondary User has separate processes for correcting the missing/invalid/incomplete/errored data in the Secondary Users EHR system, this crosswalk can only point to the Loop-Segment-Element in the 837 file of where to view the information.

> *Note: Since 835 files can only list one denial code, it is recommended Secondary Users utilize Sage denial related reports to ensure additional denial reasons are also addressed prior to resubmission.*

Multiple Denial Reasons

Sage allows for the listing of multiple local denial reasons if there are multiple issues with a claim. Though it is less common to have multiple denial reasons, each of these reasons would need to be cross referenced with the Crosswalk. The validation and resolution steps would need to be taken for all applicable denial codes and/or reasons, otherwise the claim may be denied when resubmitted.

For State Denials, if there is a secondary denial code, it would only be available on the Retro Explanation of Benefits (EOB).

Repeated Denial After Resubmission/Replacement

If resubmission/replacement of claims results in a different denial reason/denial code, please follow the appropriate resolution steps outlined above. The initial submission may have only yielded some of the denial reasons.

If a provider follows the validation step, resubmits/replaces the claim(s), and the claim(s) is denied for the same reason code, please contact the Sage Helpdesk. This will alert Netsmart and/or SAPC to further investigate to determine if there is a system issue and ways to correct it. The Helpdesk investigation process can be expedited by submitting supporting documentation of the validation steps taken by the provider. This may include providing screenshots or a list of the denial(s) including patient name, date of service, service type, site location and other appropriate data points related to validation steps.

Glossary

Adjudication – Applies appropriate eligibility and benefit plan rules to determine financial liability of the service. Claims have three adjudication outcomes: Approved, Pended and Denied.

Note: Claims are pended for two primary reasons.

1. Pending re-submission for adjudication: This refers to claims that have an error in communication between two systems where an attempt to submit was made, however there was an error and the information was not delivered as intended. Providers can verify if claims were successfully submitted using the Audit Log for Primary Sage users or the 277CA file for Secondary Sage users.
2. Pending manual adjudication process: This refers to claims that have been successfully submitted, however, require additional review by the payer to determine final outcome of either approved or denied status.

Adjustment – Refers to any adjudication of a claim where the payer pays none or any amount less than the charged amount.

Adjustment Reason Group – This refers to the category of adjustment and relates to the entity ultimately liable for payment if the initial payer denies the claim or pays less than what is charged. There are four types of Adjustment Reason Groups that associate liability:

- CO - Contractual Obligation: Typically indicates the claim is denied and provider is financially liable.
- OA - Other Adjustment: Indicates the provider is financially liable for the difference in amounts or denial.
- PR - Patient Responsibility: Patient is financially liable.
- PI - Payer Initiated Reduction: Patient is not liable, however, there is no contractual obligation by the provider to be financially liable.

Advanced Billing Rule – These are rules applied to a claim prior to SAPC sending the claim to DMC for reimbursement that verify the claim has the necessary components for DMC to reimburse. However, if the claim is determined ineligible for reimbursement by DMC, SAPC will attempt to correct any missing or invalid information by working with the provider. If the claim is ultimately deemed non-reimbursable, SAPC issues a takeback or “retro” for this claim.

Claims Adjudication Rule – These are rules applied to a claim upon initial receipt by SAPC that determine if the claim should be approved, pended, or denied. Denials or pended claims at this level result in the claim not being paid.

Claims Adjustment Reason Code (CARC) – These codes communicate a reason for a payment adjustment that describes why a claim or service line was paid differently than it was billed. These are typically relayed in a two- or three-digit numeric code with an associated definition. (https://x12.org/codes/claim-adjustment-reason-codes)

Contracting Provider- This is the agency, including all individual programs and locations, contracted with SAPC to provide services or recovery bridge housing. Can also be referred to as: Provider or Agency.

Contracting Provider Program- This refers to the specific site address contracted with SAPC for the agency. Contracting provider programs can be contracted for multiple levels of care depending on the contract with SAPC and DHCS certifications.

Current Procedural Terminology (CPT) – The code set providers use to report medical procedures and professional services furnished in ambulatory/outpatient settings, including physician visits to inpatients. These are always represented in a five-digit number without any letters present and are considered Level I Healthcare Common Procedural Coding System (HCPCS) codes. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD9-10CM-ICD10PCS-CPT-HCPCS-Code-Sets-Educational-Tool-ICN900943.pdf

Denial Reason- Part of a Level 1 denial, claims that have an associated 'Denial Reason', were denied due to not meeting basic eligibility or contractual checks for the service.

Electronic Data Interchange (EDI) – The automated transfer of data in a specific format following specific data content rules between a health care provider and the managed care organization or managed services organization. https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index

Electronic Funds Transfer (EFT)- Electronic transfer of funds from one financial institution to another without the need for a manual check writing process. SAPC reimburses its providers using EFT transactions for approved services.

Explanation of Coverage- Part of a Level 1 denial, claims that have an associated 'Explanation of Coverage' were denied due to not meeting certain rate, treatment or contract standards that have been set by DMC and/or SAPC.

Financial Liability – The monetary obligation that an entity is required to make as a result of past transactions or service under DMC waiver guidelines.

Healthcare Common Procedural Coding System (HCPCS) – For Medicare and other health insurance programs to ensure that claims are processed in an orderly and consistent manner, standardized coding systems are essential. The Healthcare Common Procedure Coding System (HCPCS) Level II Code Set is one of the standard national medical code sets specified by the Health Insurance Portability and Accountability Act (HIPAA) for this purpose.

https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf

> **Note:** HCPCS Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT code set jurisdiction, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

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.

Other Health Coverage (OHC) – Refers to private health insurance. However, for Opioid Treatment Programs who will start accepting Medicare for methadone services, Sage will recognize Medicaid as an OHC. When there is an OHC for all other treatment services, Medi-Cal is the payer of last resort.

Performing Provider/Rendering Provider – The person who delivered the service being claimed.

Place of Service – The type of location where the service was delivered. This is not the specific address or agency name, but the general location, such as office, hospital, residential or nonresidential substance abuse treatment facility.

Primary Sage User/Primary User – A provider agency that uses Sage as its sole Electronic Health Record (EHR), completing all documentation and billing within Sage.

Remittance Advice Remark Code (RARC) – Used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing. Each RARC identifies a specific message as shown in the Remittance Advice Remark Code List. There are two types of RARCs, supplemental and informational. (https://x12.org/codes/remittance-advice-remark-codes)

> **Note:** The majority of the RARCs are supplemental; these are generally referred to as RARCs without further distinction. Supplemental RARCs provide additional explanation for an adjustment already described by a CARC.
>
> **Note:** The second type of RARC is informational; these RARCs are all prefaced with "**Alert"** and are often referred to as Alerts. Alerts are used to convey information about remittance processing and are never related to a specific adjustment or CARC.

Replacement Claim- Refers to the process when a provider either disagrees with the claim adjudication or needs to correct an error that resulted in a denial. Providers submit replacement claims when they need to submit the claim for re-adjudication or needs to correct a data entry error or missing information that resulted in a denial. If a claim was approved and paid, but later an error is found with that claim, providers must enter it as a "replacement" to correct the error. Providers are able to void claims without replacing them if it is determined the claim was a duplicate or not

eligible for reimbursement. When a claim is replaced, it is automatically voided, therefore, it is not needed to void first then replace.

> **Note:** For Secondary Sage Users, providers must follow the correct procedures, as outlined in the companion guide, for voids and replacements. If the incorrect values are used or missing, the replacement claim will be denied.

Resubmitted Claim- Any denied claim can be resubmitted by creating a 'new' claim and submitting the same as any other claim.

> **Note:** Since each claim is treated as a separate claim, with its own unique identifier, denied claims will show multiple times on certain reports and KPI. When calculating denial summaries, it should be noted that claims with multiple denials will show multiple 'charged amounts' for the same service. Accurate summaries of charged versus paid amounts should only include one denied charge.

Secondary Sage User/Secondary 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. Claims are sent to SAPC using an EDI/HIPAA transaction in the form of an 837P file that is uploaded to Sage for processing. SAPC provides an 835 file with the adjudication results for each claim, including approved and denied claims.

> **Note**: There are a limited number of contracted agencies within the SAPC network who utilize an EHR other than Sage for clinical documentation, however, submit claims via the billing components of Sage. For denial troubleshooting and this crosswalk, these providers will utilize the same steps as a primary sage user.

Takeback or Retro Claim Adjudication – If after a claim has been adjudicated, approved and paid, it is determined that the claim should not have been paid, a takeback or "retro" will be initiated by SAPC, which would void the claim resulting in the monies paid being taken back on the next check issued to the provider. These actions can be the result of SAPC audits, State audits, Financial Audits or if the provider notices an error in the claim.