

BILLING & DENIAL RESOLUTION TUTORING LAB

APRIL 9, 2026



- Reminders & Announcements
- Financial Eligibility Form Overview and Requirements
- Bundles & Unbundled Services
- Tutoring Session Topics
 - CO 97 M86
 - Roll-Up Guidance
 - Replacement Claim Assignment (CMS-1500) form
- Open Q&A

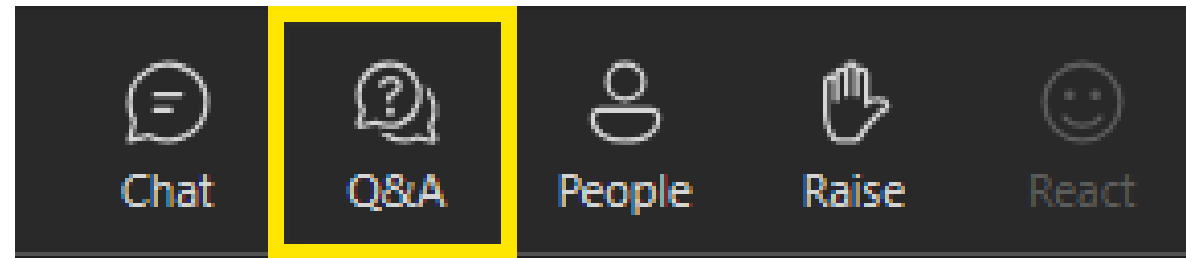
REMINDERS & ANNOUNCEMENTS

REMINDERS

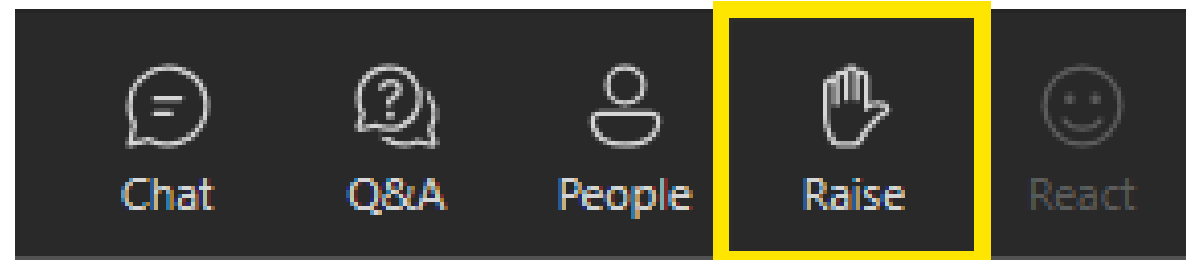
Q&A REMINDER

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

- Q&A Button

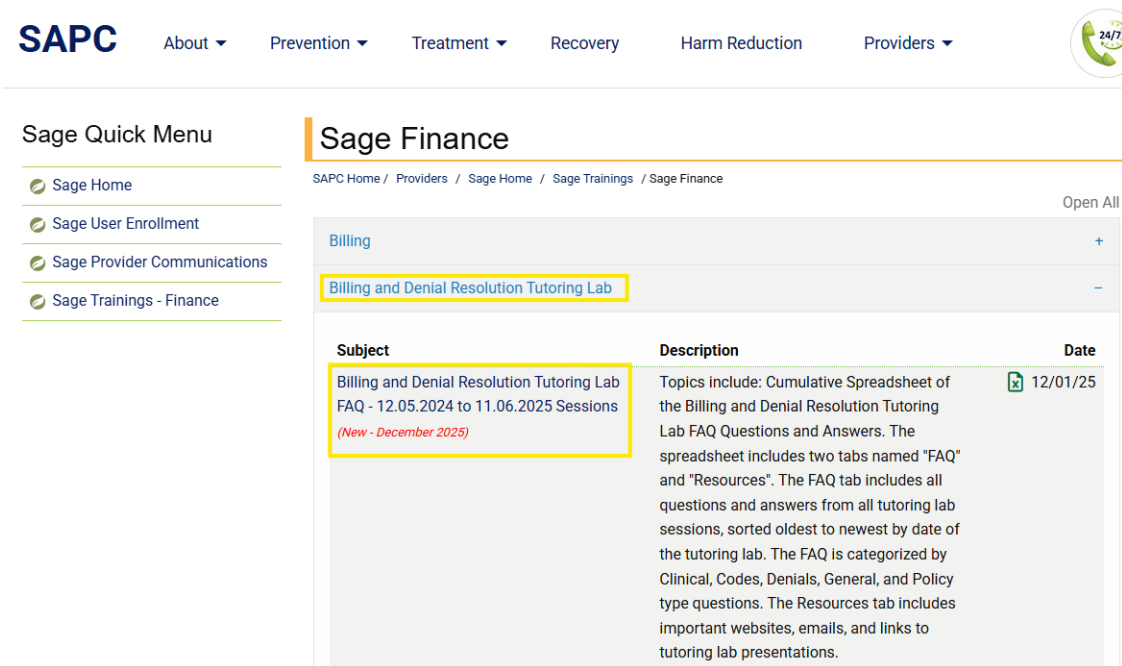


- Raise Hand Button



FAQ REMINDER

- As a reminder, FAQ are uploaded on a monthly basis. Please check to see if your question has been asked in previous tutoring labs.
 - Link: <http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm>



The screenshot shows the SAPC website's Sage Finance page. The navigation bar includes SAPC, About, Prevention, Treatment, Recovery, Harm Reduction, and Providers. A 24/7 support icon is also present. The Sage Quick Menu on the left lists Sage Home, Sage User Enrollment, Sage Provider Communications, and Sage Trainings - Finance. The Sage Finance section features a breadcrumb trail: SAPC Home / Providers / Sage Home / Sage Trainings / Sage Finance. Below this is a table with two rows: 'Billing' and 'Billing and Denial Resolution Tutoring Lab'. The 'Billing and Denial Resolution Tutoring Lab' row is highlighted with a yellow border. Below the table is a detailed description of the FAQ.

Subject	Description	Date
Billing and Denial Resolution Tutoring Lab FAQ - 12.05.2024 to 11.06.2025 Sessions <i>(New - December 2025)</i>	Topics include: Cumulative Spreadsheet of the Billing and Denial Resolution Tutoring Lab FAQ Questions and Answers. The spreadsheet includes two tabs named "FAQ" and "Resources". The FAQ tab includes all questions and answers from all tutoring lab sessions, sorted oldest to newest by date of the tutoring lab. The FAQ is categorized by Clinical, Codes, Denials, General, and Policy type questions. The Resources tab includes important websites, emails, and links to tutoring lab presentations.	12/01/25

HELP DESK TICKET FORMS

- Two different forms for Help Desk tickets
- ServiceNow Create Case Form
 - Tickets go directly to Netsmart
 - Use this form to report Sage system issues
- Request Billing Assistance Form
 - Ticket goes directly to SAPC Finance
 - Use this form to report billing-related issues
 - Link: https://netsmart.servicenow.com/plexussupport?id=sc_cat_item&sys_id=1ac545cf1b115e103001a9b6624bcb00&sysparm_category=4cb69d19c3921200b0449f2974d3ae69
- **Note:** Billing-related tickets submitted through the Create Case form will take longer to resolve

FY 24-25 BILLING DEADLINES

- Submit original and replacement claims for FY 24-25 services by the deadlines listed below:

<p><u>Dates of Service</u> 7/1/2024 - 12/31/2024</p>
<p><u>Deadline to Submit</u> Friday, January 30, 2026</p>

**DEADLINE
PASSED!**

<p><u>Dates of Service</u> 1/1/2025 - 6/30/2025</p>
<p><u>Deadline to Submit</u> Thursday, April 30, 2026</p>

**21 DAYS
LEFT TO
SUBMIT!**

FY 24-25 BILLING DEADLINES

- In preparation of the billing deadlines, we recommend:
 - Don't wait until the last week (or even the last day!) to submit claims. Submit claims at least once a month before the deadline to allow for any corrections needed for Local and State denials.
 - Review all currently denied services to ensure services have been corrected and replaced (as able).
 - Review available contract amounts and request augmentations if necessary.
 - Lastly, open a [Request Billing Assistance](#) ticket for any support needed to resolve outstanding FY 24-25 questions.

COVERAGE FOR CLIENTS INELIGIBLE FOR FEDERAL PROGRAMS FAQ AND SLIDES

- SAPC held an instructional webinar on February 25, 2026, providing details about the new Client Ineligible for Federal Programs (CIFP) guarantor/funding.
- This funding is specifically for clients of LA County in need of SUD treatment who no longer qualify for Medi-Cal or other Federal funding under the new Federal regulations due to immigration status.
- CIFP Training FAQ: [Coverage for Clients Ineligible for Federal Programs \(CIFP\) FAQs](#)
- CIFP training PowerPoint Slides: [Coverage for Clients Ineligible for Federal Programs \(CIFP\) Training PowerPoint Slides](#)

KPI DASHBOARDS OFFICE HOURS

- SAPC is hosting KPI Dashboards Office Hours for contracted providers with KPI accounts
- This is a drop-in group to discuss, troubleshoot, and learn KPI functionality
- Held weekly on Thursdays at 10AM. No registration is required.

Link: [KPI Dashboards Office Hours | Meeting-Join | Microsoft Teams](#)

Meeting ID: 266 069 333 607 18

Passcode: y86dE7iu

ANNOUNCEMENTS

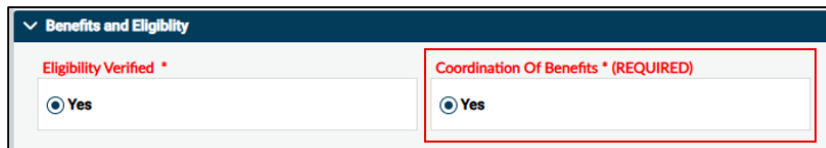
TREATMENT BILLING ADD-ON RATE REMINDER

- The Language assistance (T1013) add-on rate is available when language interpretation services are required to support effective service delivery, including sign language
- T1013 is an additional reimbursement available to providers to support meaningful communication and equitable access to care
- A claim for interpretation should be submitted when the interpretation service is delivered by a trained interpreter that is a separate person from the rendering provider
- Billing Information:
 - Billing Code: T1013
 - Units may be billed in 15-minute increments
 - Standard rate: \$31.88
 - Note: Interpretation time cannot exceed the duration of the primary service.

FINANCIAL ELIGIBILITY FORM UPDATE

- SAPC Removed the **Coordination of Benefits** field from the Financial Eligibility form in Sage
- Field is not required for billing and does not impact adjudication or benefits information when billing to DHCS
- Effective Tuesday, March 31, 2026

OLD



Benefits and Eligibility

Eligibility Verified *

Yes

Coordination Of Benefits * (REQUIRED)

Yes



NEW



Benefits and Eligibility

Eligibility Verified *

Yes

FINANCIAL ELIGIBILITY FORM

FINANCIAL ELIGIBILITY FORM

- Financial Eligibility Form Overview
- Types of Guarantor
- Financial Eligibility Required Fields for each type of guarantor
- Denials due to Financial Eligibility Form Filled out Incorrectly

FINANCIAL ELIGIBILITY SECTION

Episode Information

Social Security Number: 432-23-2814 Episode Number: 1

Admission Date: 08/15/2025

Program: Recovery Inc

Default Information From Different Episode:
 Yes No

Episode To Default From: Select

Coverage Comments:

Guarantor Order

Guarantor #1
(1) CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

Guarantor #2
(3) LA County - Non DMC

Guarantor #3
Select

Guarantor #4
Select

[Clear Previous Guarantor Order](#)

GUARANTOR SELECTION SECTION

Guarantor Information

Guarantor Information

Guarantor Bundle	Guarantor #	Guarantor Name	Guarantor Plan	Customize Guarantor Plan
	DMC Medi-Cal (1)	CALIFORNIA DEPARTMENT OF ALCOHOL AND D...	2	No
	LA County - Non DMC (3)	LA County - Non DMC	1	No

[Add New Item](#) [Edit Selected Item](#) [Delete Selected Item](#)

Guarantor # *(click on the lightbulb for more details ->)* *

DMC Medi-Cal (1)

Guarantor's Name
CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

Guarantor's Address - Line 1
1700 K Street

Guarantor's Address - Line 2

Guarantor's Address - City
Sacramento

Guarantor's Address - State
CALIFORNIA

Guarantor's Address - Zip
95814-6437

Guarantor's Phone Number

Guarantor Plan *
(Non-Contract) Medi-Cal

Effective Date Of Contract (DO NOT EDIT) *
01/01/2000

Customize Guarantor Plan *
 No

Subscriber Information

Client's Relationship To Subscriber *
Self

Subscriber's Name *
PATIENT,TEST

Subscriber's Social Security # *
432-23-2814

Subscriber's Birth Date
01/01/2000

Subscriber's Sex *
 Female Male Unknown

Subscriber Release Of Info *
 Informed Consent To Release Medical Info
 Yes, Provider Has Signed Statement Permitting Release

Subscriber's Policy #
91284918A

Subscriber Client Index Number
91284918A

Subscriber's MEDS ID#

TYPES OF GUARANTORS

1. Drug Medi-Cal (DMC)
2. Applying for Medi-cal
3. LA County Non-DMC
4. Client Ineligible for Federal Programs (CIFP)

▼ PATIENT, TEST (000289566)

Age: 26, DOB: 01/01/2000, Gender: M, Gender Identity: Male, BMI: -, Height: -, Weight: -, Ep: 1 : Recovery Inc, Location: -, Age: 26, DOB: 01/01/2000 Allergies (0)

Medi-Cal Eligibility Information- Last... [↗](#)

FINANCIAL ELIGIBILITY

[Submit](#) [Discard](#) [Add to Favorites](#)

Financial Eligibility

- Episode Information
- Guarantor Order
- Guarantor Selection**
- Guarantor Information
- Subscriber Information
- Benefits and Eligibility
- Eligibility Inquiry
- Employer Information

Customize Plan

Policy Number Override

Online Documentation

▼ Guarantor Information

Guarantor Information *

Guarantor Bundle	Guarantor #	Guarantor Name	Guarantor Plan	Customize Guarantor Plan	Guarantor's Address - Line 1
	DMC Medi-Cal (1)	CALIFORNIA DEPARTMENT OF ALCOHOL...	2	No	1700 K Street
	LA County - Non DMC (3)	LA County - Non DMC	1	No	

[Add New Item](#) [Edit Selected Item](#) [Delete Selected Item](#)

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR DMC

Client's Relationship To Subscriber * Self	Subscriber Release Of Info * <input type="radio"/> Informed Consent To Release Medical Info <input checked="" type="radio"/> Yes, Provider Has Signed Statement Permitting Release
Subscriber's Name * PATIENT,TEST	Subscriber's Policy # 91284918A
Subscriber's Social Security # * 432-23-2814	Subscriber Client Index Number ? 91284918A
Subscriber's Birth Date 01/01/2000	Subscriber's MEDS ID#
Subscriber's Sex * <input type="radio"/> Female <input checked="" type="radio"/> Male <input type="radio"/> Unknown	Subscriber's Group Name
Subscriber's Address - Street Line 1 * 1000 S FREMONT AVE	Subscriber's Group # (Only use for Sobering Services)
Subscriber's Address - Street Line 2	Subscriber's Medicare #
Subscriber's Address - City * ALHAMBRA	
Subscriber's Address - State * CALIFORNIA	
Subscriber's Address - County Los Angeles	
Subscriber's Address - Zip * 91803-1323	
Subscriber's Phone Number	
Subscriber Mobile Phone Number	

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR DMC

Benefits and Eligibility

Eligibility Verified *

Yes

Coverage Effective Date *

07/01/2017



T

Y



Coverage Expiration Date



T

Y



Subscriber Assignment Of Benefits *

Yes

No

Maximum Covered Dollars *

9999999.99

Subscriber's Covered Days *

9999

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR DMC


Eligibility Inquiry (270) Status

- Request Inquiry
- Inquiry Sent
- None
- Inquiry Requested
- Response Received

Effective Date Of Medi-Cal Eligibility



Eligibility Code




Aid Code




Date Benefits Denied




Denial Code



Date Benefits Terminated



Eligibility Response (271) Reject Reason Code



EVC Tracking Number

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR LA COUNTY NON-DMC


Client's Relationship To Subscriber * Self	Subscriber Release Of Info * <input type="radio"/> Informed Consent To Release Medical Info <input checked="" type="radio"/> Yes, Provider Has Signed Statement Permitting Release
Subscriber's Name * PATIENT,TEST	Subscriber's Policy #
Subscriber's Social Security # * 432-23-2814	Subscriber Client Index Number ?
Subscriber's Birth Date 01/01/2000	Subscriber's MEDS ID#
Subscriber's Sex * <input type="radio"/> Female <input checked="" type="radio"/> Male <input type="radio"/> Unknown	Subscriber's Group Name
Subscriber's Address - Street Line 1 * 1000 S FREMONT AVE	Subscriber's Group # (Only use for Sobering Services)
Subscriber's Address - Street Line 2 	Subscriber's Medicare #
Subscriber's Address - City * ALHAMBRA	
Subscriber's Address - State * CALIFORNIA	
Subscriber's Address - County Los Angeles	
Subscriber's Address - Zip * 91803-1323	
Subscriber's Phone Number 	
Subscriber Mobile Phone Number 	

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR LA COUNTY NON-DMC


Eligibility Verified *

Yes

Coverage Effective Date *

07/01/2017  ▲ ▼


Coverage Expiration Date

 ▲ ▼

Subscriber Assignment Of Benefits *

Yes No

- Subscriber Policy Number
 - Enter the Other County Funding source name, such as Drug Court, AB109, GR etc..

Subscriber's Policy #
Drug Court
Subscriber Client Index Number 
<input type="text"/>

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR APPLYING FOR MEDI-CAL

▼ Episode Information

Social Security Number	Episode Number
432-23-2814	1

Admission Date
08/15/2025

Program
Recovery Inc

Default Information From Different Episode

Yes No

Episode To Default From
Select

Coverage Comments

Date of application
Source of application: In person at DPSS, BenefitsCal
Application number
Eligibility worker, if applicable

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR APPLYING FOR MEDI-CAL

Client's Relationship To Subscriber * Self	Subscriber Release Of Info * <input type="radio"/> Informed Consent To Release Medical Info <input checked="" type="radio"/> Yes, Provider Has Signed Statement Permitting Release
Subscriber's Name * PATIENT,TEST	Subscriber's Policy # Applying for MediCal
Subscriber's Social Security # * 432-23-2814	Subscriber Client Index Number ?
Subscriber's Birth Date 01/01/2000	Subscriber's MEDS ID#
Subscriber's Sex * <input type="radio"/> Female <input checked="" type="radio"/> Male <input type="radio"/> Unknown	Subscriber's Group Name
Subscriber's Address - Street Line 1 * 1000 S Fremont Ave	Subscriber's Group # (Only use for Sobering Services)
Subscriber's Address - Street Line 2	Subscriber's Medicare #
Subscriber's Address - City * Alhambra	
Subscriber's Address - State * CALIFORNIA	
Subscriber's Address - County Los Angeles	
Subscriber's Address - Zip * 91803-8800	
Subscriber's Phone Number	
Subscriber Mobile Phone Number	

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR APPLYING FOR MEDI-CAL

Eligibility Verified *

Yes

Coverage Effective Date *

06/01/2017

Coverage Expiration Date

06/30/2017

Subscriber Assignment Of Benefits *

Yes

No

Maximum Covered Dollars *

99999999.99

Subscriber's Covered Days *

9999

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR CIFP

Client's Relationship To Subscriber * Self	Subscriber Release Of Info * <input type="radio"/> Informed Consent To Release Medical Info <input type="radio"/> Yes, Provider Has Signed Statement Permitting Release
Subscriber's Name * PATIENT,TEST	Subscriber's Policy # CIFP
Subscriber's Social Security # * 432-23-2814	Subscriber Client Index Number
Subscriber's Birth Date 01/01/2000	Subscriber's MEDS ID#
Subscriber's Sex * <input type="radio"/> Female <input checked="" type="radio"/> Male <input type="radio"/> Unknown	Subscriber's Group Name
Subscriber's Address - Street Line 1 * 1000 S Fremont Ave	Subscriber's Group # (Only use for Sobering Services)
Subscriber's Address - Street Line 2	Subscriber's Medicare #
Subscriber's Address - City * Alhambra	
Subscriber's Address - State * CALIFORNIA	
Subscriber's Address - County Los Angeles	Subscriber's Address - Zip * 91803-8800
Subscriber's Phone Number	Subscriber Mobile Phone Number

Eligibility Verified * <input checked="" type="radio"/> Yes	
Coverage Effective Date * 04/08/2026	
Coverage Expiration Date	
Subscriber Assignment Of Benefits * <input checked="" type="radio"/> Yes <input type="radio"/> No	
Maximum Covered Dollars * 9999999.99	Subscriber's Covered Days * 9999

FINANCIAL ELIGIBILITY REQUIRED FIELDS FOR CIFP

CIFP ONLY

Eligibility Verified *

Yes

Coverage Effective Date *

04/08/2026

Coverage Expiration Date

Subscriber Assignment Of Benefits *

Yes

No

Maximum Covered Dollars *

9999999.99

Subscriber's Covered Days *

9999

DMC AND NON-DMC BENEFITS AND ELIGIBILITY

Eligibility Verified *

Yes

Coverage Effective Date *

07/01/2017

Coverage Expiration Date

04/07/2026

Subscriber Assignment Of Benefits *

Yes

No

Maximum Covered Dollars *

9999999.99

Subscriber's Covered Days *

9999

FINANCIAL ELIGIBILITY FORM FILLED OUT INCORRECTLY

Local Denials:

- Eligibility not found/verified in CalPM (Primary)
- CO 177 (Secondary)

- Denial Crosswalk:

<http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/DenialCrosswalk/Sage-Claim-Denial-Reason-and-Resolution-Crosswalk-V5.0.xlsx>



END OF YEAR (EOY) PREPARATIONS

EOY PREPARATION

- The end of the 2025-2026 fiscal year is approaching on June 30, 2026.
- What can agencies do to prepare
 - I. Work on resolving and rebilling all denials (as appropriate) as soon as possible
 - II. Secondary Providers
 - I. Connect with your vendor to fix any configuration issues
 - II. Rates Matrix for FY26-27 - it is currently under review, but hopefully will be released soon, more updates to come
 - III. EOY Cleanup
 - I. Make sure all FY25-26 claims are submitted ASAP
 - II. Augmentations
 - I. Double check if you need an augmentation
 - II. If you have an existing augmentation, make sure to follow up with your CPA for the latest updates
 - IV. Sage "Network Practitioner Report"
 - I. Make sure your practitioners are up to date and accurate before billing
 - II. Make sure whoever is responsible in your agency for managing practitioners is monitoring this report

BUNDLED VS. UNBUNDLED SERVICES

OVERVIEW

- What is a day rate?
- What is a bundled rate?
- What is an unbundled service?
- Closer look at the following levels of care:
 - Residential (U1, U2, U3)
 - 1.0 WM (U4:U7, U4:U8)
 - 3.2 WM (U9)
 - 3.7 WM (:37) & 4.0 WM (:40)
 - OTP (UA:HG)

WHAT IS A DAY RATE?

For Residential, 3.7 WM and 4.0 WM - A day rate indicates that a service spans 24-hours and includes various bundled services within that rate based on level of care and code type.

WHAT IS A BUNDLED RATE?

A bundled rate is a group of services that is paid with one rate, based on code type.

WHAT IS AN UNBUNDLED SERVICE?

An unbundled service is a service that is billed separately from the bundled rate, based on code type.

CLOSER LOOK - RESIDENTIAL (U1, U2, U3)

- Billing the bundled day rate for residential treatment services at ASAM 3.1, 3.3, 3.5 using code H0019
- Bundled services (included in the day rate) by Code Type in the Rates Matrix:
 - Assessment
 - Individual & Group Counseling
 - Family Therapy
 - Medication Services
 - Patient Education
 - SUD Crisis Intervention Services
- Unbundled services (billed separately from the day rate) by Code Type in the Rates Matrix:
 - Care Coordination
 - Peer Support Specialist Services
 - MAT for OUD (billed via H0033 or H0034)
 - MAT for AUD (billed via H0033 or H0034)
- Source (Page 40, DMS-ODS Billing Manual 3.0): <https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf>

CLOSER LOOK - 1.0 WM (U4:U7, U4:U8)

- Billing the extended day service rate for withdrawal management using code H0014.
- Bundled services (included in the extended day service rate) by Code Type in the Rates Matrix:
 - Assessment
 - Individual Counseling & Group Counseling
 - Family Therapy
 - Patient Education
 - SUD Crisis Intervention
- Unbundled services (billed separately from the extended day service rate) by Code Type in the Rates Matrix:
 - Additional MAT (billed via H0033 or H0034)
 - Care Coordination / Clinical Consultation
 - Peer Support Specialist Services
 - Contingency Management
- Source (Page 43, DMS-ODS Billing Manual 3.0): <https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf>

CLOSER LOOK - RESIDENTIAL WM (U9)

- Billing the day rate for residential withdrawal management treatment services at ASAM 3.2 using code H0012.
- Bundled services (included in the day rate) by Code Type in the Rates Matrix:
 - Assessment
 - Individual Counseling & Group Counseling
 - Family Therapy
 - Patient Education
 - SUD Crisis Intervention
- Unbundled services (billed separately from the day rate) by Code Type in the Rates Matrix:
 - Additional MAT (billed via H0033 or H0034)
 - Care Coordination / Clinical Consultation
 - Recovery Support Services
 - Peer Support Specialist Services
- Source (Page 43, DMS-ODS Billing Manual 3.0): <https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf>

CLOSER LOOK - 3.7 WM & 4.0 WM

- Billing the day rate for inpatient withdrawal management treatment services at ASAM 3.7 & 4.0 using code 0953
- Bundled services (included in the day rate) by Code Type in the Rates Matrix:
 - All services are bundled
- Unbundled services (billed separately from the day rate) by Code Type in the Rates Matrix:
 - None
- Source (Page 43, DMS-ODS Billing Manual 3.0): <https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf>

CLOSER LOOK - OTP/NTP (UA:HG)

- Bundled medication service (H0020, S5000, etc) by Code Type in the Rates Matrix:
 - Assessment
 - Family Therapy
 - MAT for OUD
 - MAT for AUD
 - Patient Education
 - SUD Crisis Intervention
- Unbundled services by Code Type in the Rates Matrix:
 - Medication Administration (under the Medication Service Code Type)
 - Individual Counseling & Group Counseling
 - Care Coordination
 - Recovery Services
- Source (Page 41, DMS-ODS Billing Manual 3.0): <https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf>

TUTORING SESSION - 3 PARTS

**TUTORING SESSION:
PART 1 - CO 97 M86**

CO 97 M86 - WHAT IS IT?

- One of the most common State denials providers receive
- What is a CO 97 M86 denial?
 - CO 97 = The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - M86 = Service denied because payment already made for same/similar procedure within set time frame.

CO 97 M86 - WHAT CAUSES THIS DENIAL?

- In a Nutshell:
 - Medi-Cal denied this service because it had already approved the same service provided on the same day, by the same rendering provider, to the same beneficiary on another claim.

CO 97 M86 - WHAT CAUSES THIS DENIAL?

CLAIM 1

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 2

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 3

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026


DENIED

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026



CO 97 M86 - WHAT DOES IT LOOK LIKE TO A PROVIDER?


- Retro EOB



**COUNTY OF LOS ANGELES
Public Health**

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice
as of 1/8/2026



Remittance Advice *EOB Number: 163407* Check #: 1_DENIED_163407 Check Date: 1/8/2026

RECOVERY, INC. (1)
5794 WASHINGTON STREET
MIAMI, CA 12060-9163

Page: 1

Adjustment Notice
An adjustment of \$ -200.00 has been applied to this payment.

Current Claims:
Adjustment: -200.00
Adjusted EOB Total: -200.00

Detail Adjustment Information for EOB Number: 163407

Original Service Information

Orig_EOB
163405

Adjustment Information

Client Name (ID):PATIENT,TEST (289566)		DOB: 1/1/2000		Gender: M					
Batch_SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj.Date	Adj.Amt	Adjustment Reason
334850SVC.00002	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	\$-100.00	Denial Co 97 M86
334850SVC.00003	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	\$-100.00	Denial Co 97 M86
					200.00	200.00	-200.00		
Total Adjustments: \$-200.00									

KPI

Retro Reason

-

Denial CO 97
M86

CO 97 M86 - HOW DO WE FIX IT?

ROLL-UPS!

**TUTORING SESSION:
PART 2 - GUIDE TO ROLLUPS**

ROLL-UPS - OVERVIEW - WHAT ARE THEY?

- Roll-up services refer to the consolidation of multiple identical claims into a single billed service that contain the same:
 1. Patient
 2. Rendering Performing Provider
 3. Procedure Code and
 4. Date of Service
- This process ensures compliance with Department of Health Care Services (DHCS) guidelines to prevent duplicate billing for outpatient services. Per the [DHCS DMC-ODS Billing Manual](#), duplicate services are not allowed for outpatient services with minimal exceptions.

ROLL-UPS - OVERVIEW - WHEN DO THEY APPLY?

- Roll-ups are required for:
 - All outpatient services (except for code exceptions noted below)
- Roll-ups are not required for:
 - There are some code exceptions per DHCS, where roll-ups are not required:
 - Sign language or Oral Interpretive services (T1013)
 - Interactive complexity (90785)
 - Health behavior interventions for the family without the patient present (96170 and 96171)
 - Group Counseling (H0005)
 - Group services using the HQ modifier (H0034, H2017, T2021)
 - Patient Education services using the HQ modifier (H2014)

ROLL UPS - OVERVIEW - WHAT NOT TO DO



CLAIM 1

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 2

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 3

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026



ROLL UPS - OVERVIEW - WHAT TO DO



COMBINE

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026



Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

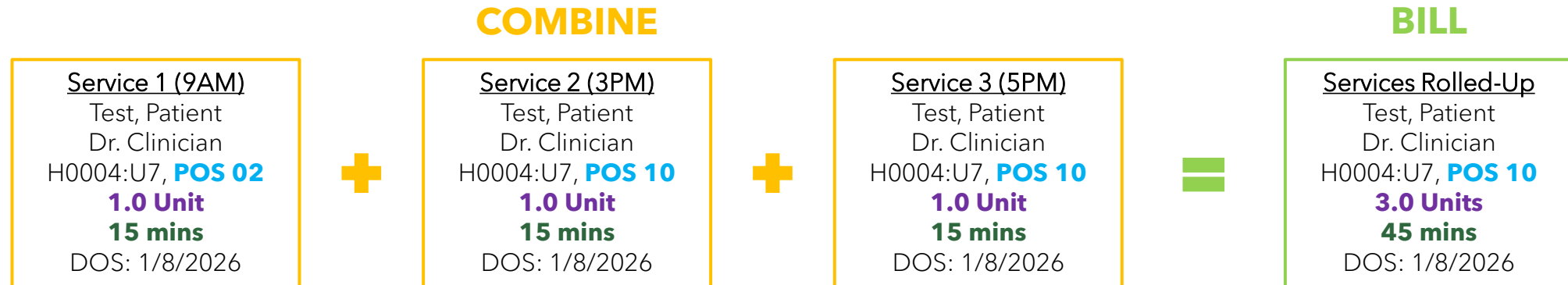


Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026



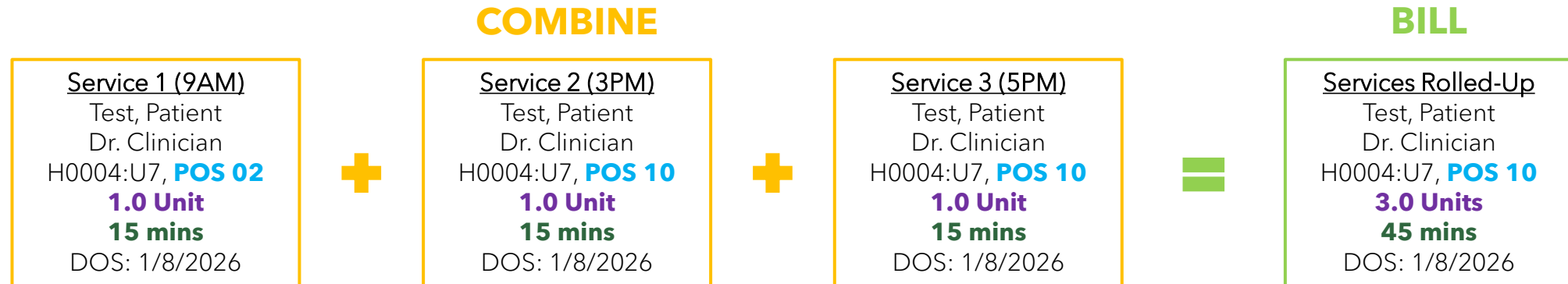
Services Rolled-Up
Test, Patient
Dr. Clinician
H0004:U7, POS 10
3.0 Units
45 mins
DOS: 1/8/2026

ROLL UPS - HOW TO ROLL UP - THINGS TO CONSIDER



- Parts of the claim to think about when rolling-up services. These can potentially change after rolling-up:
 - **Place of Service**
 - **Duration (Minutes) and the Midpoint Rule**
 - **Units**

ROLL UPS - THINGS TO CONSIDER - PLACE OF SERVICE



- **Place of Service (POS)**

- Notice in the example above you have: POS 02, POS 10, POS 10
- For simplicity, select the POS that occurs the most
- In the example above, POS 10 occurs two times, while POS 02 occurs once
- So, when rolling-up, we selected POS 10 because it occurred more often than POS 02

ROLL UPS - THINGS TO CONSIDER - MIDPOINT

COMBINE

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026



Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026



Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026



BILL

Services Rolled-Up
Test, Patient
Dr. Clinician
H0004:U7, POS 10
3.0 Units
45 mins
DOS: 1/8/2026

- **Duration (Minutes) and the Midpoint Rule**

- What is the Midpoint Rule?
 - The minimum time needed to claim 1 unit
 - If the service duration is less than the minimum time = cannot claim 1 unit
 - If the service duration is at least the minimum time = can claim at least 1 unit
- **Before a roll-up, you'll consider the midpoint on an individual service basis**
- Let's take a look at the [FY25-26 Rates Matrix](#) > Billing Rules Tab > H0004

ROLL UPS - THINGS TO CONSIDER - MIDPOINT

- **Duration (Minutes) and the Midpoint Rule**

- Next, go to the “**Minimum Time Needed to Claim 1 Unit**” column
 - This will tell you the minimum service duration needed to claim 1 unit of H0004
 - For H0004, the minimum time needed to claim 1 unit is 8 minutes
 - If your service duration for H0004 is 7 minutes or less, you cannot claim 1 unit
 - *If trying to see if service duration long enough to claim 1 unit:*
 - If your service duration for H0004 is 8 minutes or more, you can claim 1 unit
 - *If trying to claim a higher duration beyond the duration in the service description:*
 - Use the following calculation

Code	Code Type	Service Description	Minimum Time Needed to Claim 1 Unit	Minimum Time When Add-On Code or Next Code in Series Can Be Claimed	Can This Code Be Extended with an Add-on or Prolonged Code?	Example Calculation
H0004	Individual Counseling	Behavioral health counseling and therapy 15 minutes.	8 Min	23 Min	No. Claim multiple units of this code as appropriate up to the maximum units per day.	If 100 minutes of service was provided: 100 minutes of service / 15 minutes time for code = 6.6667 units. 5 units accounts for 90 minutes of service. For the remaining 10 minutes of service, 1 additional unit of H0004 can be claimed. Therefore for 100 minutes of service, claim 7 units of H0004.

Example Calculation
 For a 100 minute service -
 100 minutes of service / 15 minutes time for code = 6.6667 units

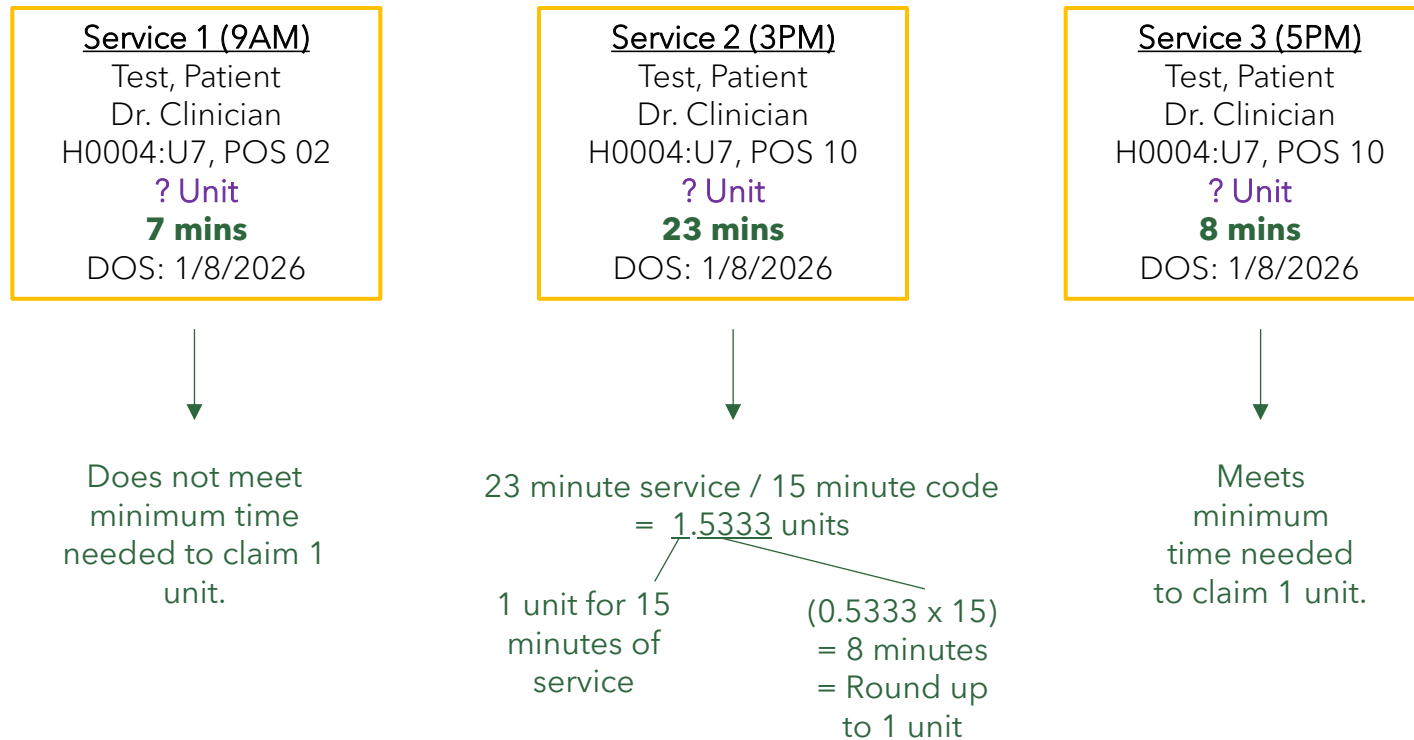
6 units accounts for
 $(6 \times 15) =$
 90 minutes of service.

0.6667 units accounts for
 $(0.6667 \times 15) = 10$
 minutes of service.
Round up to 1 unit, since it meets the 8 minutes minimum

7 Units

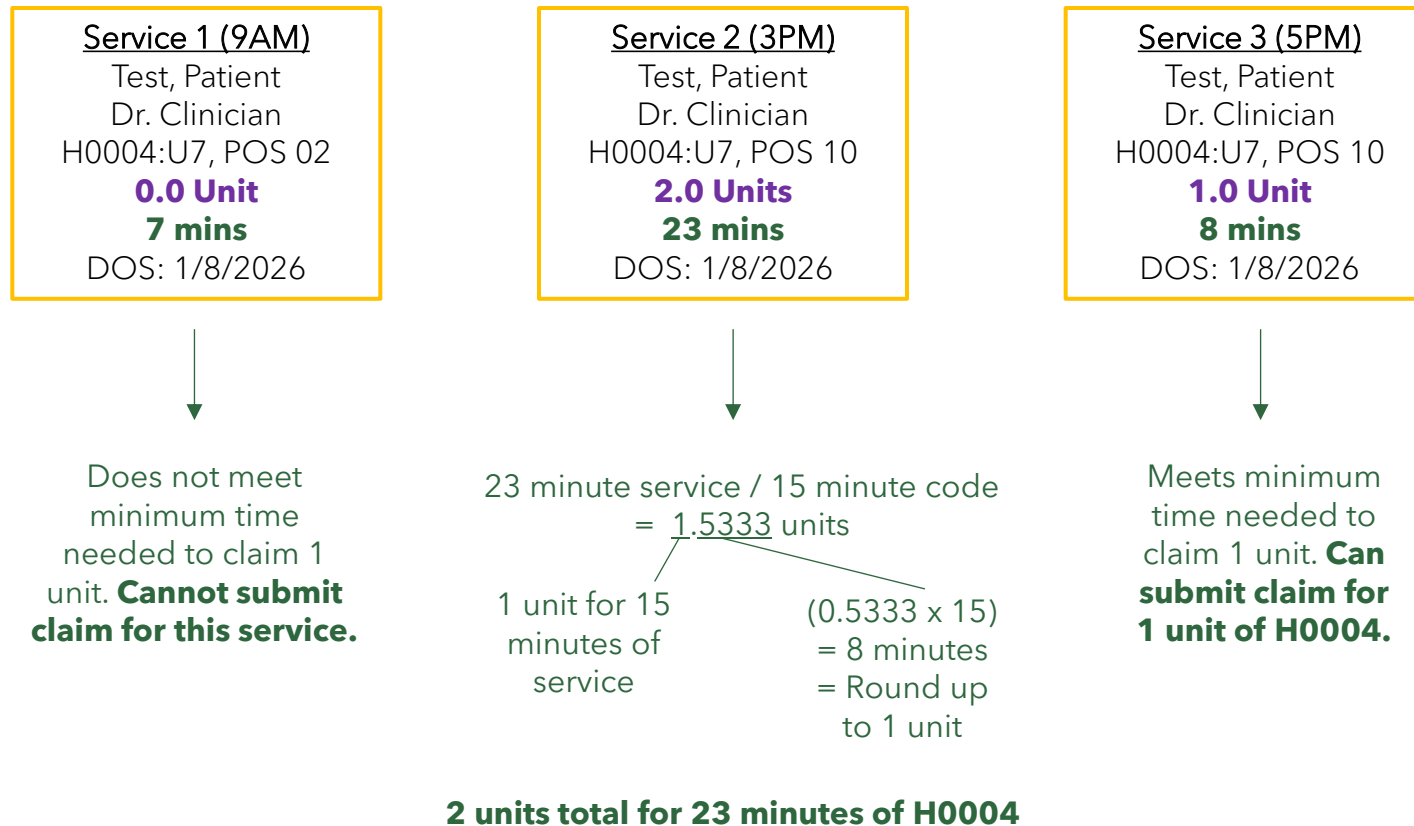
ROLL UPS - MIDPOINT RULE IN ACTION

“**Minimum Time Needed to Claim 1 Unit**” of H0004 is 8 minutes. Code is 15 minutes per the service description. Below are examples of how to determine units when the service duration varies.



ROLL UPS - MIDPOINT RULE IN ACTION

“**Minimum Time Needed to Claim 1 Unit**” of H0004 is 8 minutes. Code is 15 minutes per the service description. Below are examples of how to determine units when the service duration varies.



ROLL UPS - THINGS TO CONSIDER - UNITS

COMBINE

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026



Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026



Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

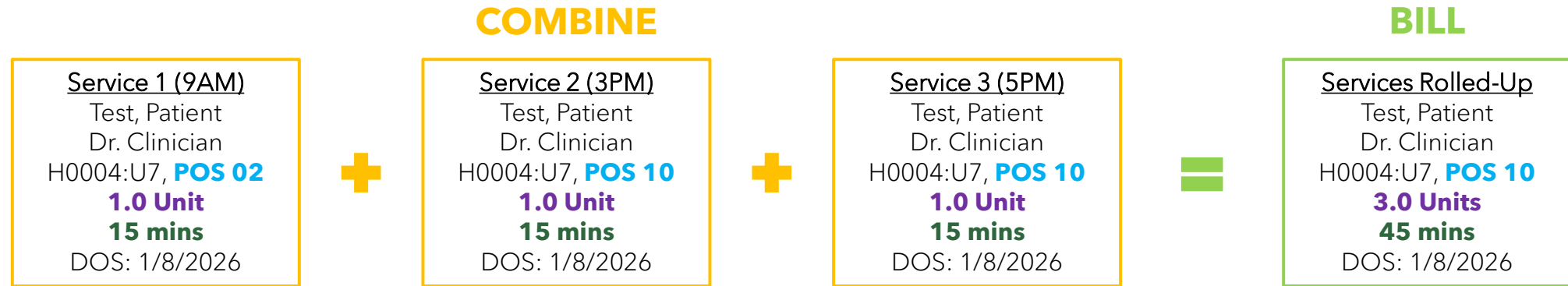


BILL

Services Rolled-Up
Test, Patient
Dr. Clinician
H0004:U7, POS 10
3.0 Units
45 mins
DOS: 1/8/2026

- **Units**
 - Units are calculated based on the billing rules for the code and the midpoint rule
 - Before a roll-up, you'll consider the units on an **individual service basis**
 - Combine all identical service units into one rolled up service
 - Note: Services with a unit maximum of 1 unit cannot be rolled up

ROLL UPS - END RESULT



- End results of rolling up:
 - **Place of Service = POS 10**
 - **Duration (Minutes) and the Midpoint Rule = 45 mins**
 - **Units = 3.0 units**

ROLL-UPS - HOW DO WE BILL THEM?

- If roll-ups are calculated before submitting original claims:
 - Primary
 - Submit originals rolled-up using the Sage Fast Service Entry Submission Form
 - Secondary
 - Submit originals rolled-up using your EHR
- If roll-ups are calculated after receiving a CO 97 M86 denial:
 - Primary
 - Submit a replacement claim using the Sage Replacement Claim Assignment (CMS-1500) form
 - Secondary
 - Submit a replacement claim using your EHR

**TUTORING SESSION:
PART 3 - PRIMARY REPLACEMENT
CLAIMS**

REPLACEMENT CLAIMS - SCENARIO

CLAIM 1

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 2

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CLAIM 3

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

DENIED

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/8/2026

CO 97 M86

CO 97 M86

REPLACEMENT CLAIMS - EOB

- Your EOB will show all claims billed



SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 1/8/2026



Remittance Advice EOB Number: 163405 Check #: Check Date:

RECOVERY, INC. (1)
5794 WASHINGTON STREET
MIAMI, CA 12060-9163

Amount Approved: \$300.00

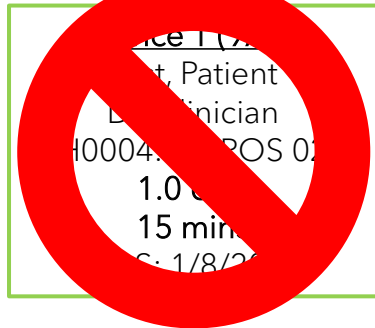
Page: 1

Client Name (ID): PATIENT,TEST (289566)							DOB: 01/01/2000		Gender: M			
Date Claim Received: 01/08/2026							Claimed	Claimed	Allowed	Denied/	Member	Amount
Batch.SvcRef#	Auth #	Contract #	Contract Type	Date of Service	Status	CPT Code	Units	Amount	Amount	Adjusted	Co-pay	Paid
334850SVC.000	637536	341234	DMC	01/08/2026	A	H0004:U7	1.0	\$100.00	\$252.17	\$0.00	\$0.00	\$100.00
334850SVC.000	637536	341234	DMC	01/08/2026	A	H0004:U7	1.0	\$100.00	\$252.17	\$0.00	\$0.00	\$100.00
334850SVC.000	637536	341234	DMC	01/08/2026	A	H0004:U7	1.0	\$100.00	\$252.17	\$0.00	\$0.00	\$100.00
							3.0	\$300.00	\$756.51	\$0.00	\$0.00	\$300.00

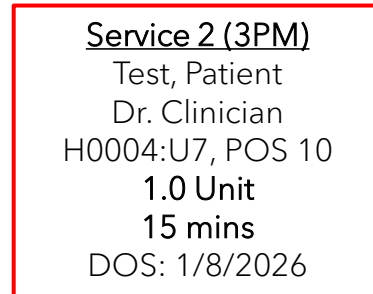
REPLACEMENT CLAIMS - RETRO EOB

- Your retro EOB will only show denied claims

APPROVED

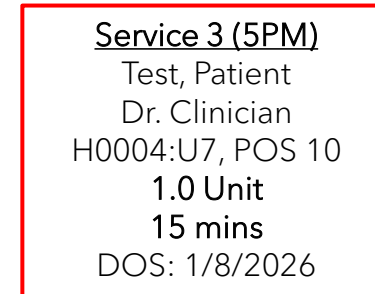


DENIED



CO 97 M86


DENIED



CO 97 M86

REPLACEMENT CLAIMS - RETRO EOB

- Your retro EOB will only show denied claims


 COUNTY OF LOS ANGELES
Public Health
 SUBSTANCE ABUSE PREVENTION AND CONTROL
 Remittance Advice
 as of 1/8/2026



Remittance Advice *EOB Number: 163407* *Check #: 1_DENIED_163407* *Check Date: 1/8/2026*

RECOVERY, INC. (1)
 5794 WASHINGTON STREET
 MIAMI, CA 12060-9163

Page: 1

Adjustment Notice
 An adjustment of \$ -200.00 has been applied to this payment.

Current Claims:
Adjustment: -200.00
Adjusted EOB Total: -200.00

Detail Adjustment Information for EOB Number: 163407

Original Service Information

Orig EOB
 163405

Adjustment Information

Client Name (ID):PATIENT,TEST (289566)					DOB: 1/1/2000		Gender: M		
Batch_SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
334850SVC.00002	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	\$-100.00	Denial Co 97 M86
334850SVC.00003	1/8/2026	H0004:U7	637536	A	100.00	100.00	1/8/2026	\$-100.00	Denial Co 97 M86
					200.00	200.00		-200.00	
					Total Adjustments: \$-200.00				

REPLACEMENT CLAIMS - KPI

- To identify claims with the CO 97 M86 denials per the Retro EOB, in KPI only filter for :
 - PATID
 - Date of Service
 - Procedure
- Make note of the following columns:
 - Retro Reason
 - The row with CO 97 M86 was denied
 - We will not be replacing these rows!
 - The row where Retro Reason is blank was approved at the Local and State Level
 - This approved service is the one we're replacing!
 - MSO Service ID
 - Claim ID

REPLACEMENT CLAIMS - KPI - BATCH # & CLAIM ID

- For primary providers
 - One batch # creates one claim ID # in KPI
 - Only services can be loaded into the Replacement Claim Assignment (CMS-1500) form one Claim ID # at one time
- For secondary providers
 - One batch # may contain multiple unique claim ID #s
 - Replacement occurs in your own EHR

REPLACEMENT CLAIMS - KPI SORT ORDER

- Things to note before performing a replacement claim:
 - By Default, services listed in KPI are inverse to how their listed in the "Select Service(s) To Replace" popup - from highest to lowest
 - Remember to click the "MSO Service ID" column header to sort the services from lowest to highest, so that it matches the order in the "Select Service(s) To Replace" popup
 - Keep note of where the "approved" service is, this is the one that needs to be replaced. This line will not have a "Retro Reason" of "Denial CO 97 M86".

UNSORTED

MSO Service ID	Claim ID
SVC.00003	19854684
SVC.00002	19854684
SVC.00001	19854684

3

2

1

SORTED

MSO Service ID	Claim ID
SVC.00001	19854684
SVC.00002	19854684
SVC.00003	19854684

1

2

3

MATCHES ORDER OF THE SORTED

1	<input type="checkbox"/>	334850	2026-01-08	19854684	H0004:U7
2	<input type="checkbox"/>	334850	2026-01-08	19854684	H0004:U7
3	<input type="checkbox"/>	334850	2026-01-08	19854684	H0004:U7

REPLACEMENT CLAIMS - SCENARIO + DEMO

CLAIM 1

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/6/2026

CLAIM 2

Service 2 (3PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/6/2026

CLAIM 3

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/6/2026

SEPARATE IDENTICAL CLAIMS BILLED TO THE STATE

APPROVED

Service 1 (9AM)
Test, Patient
Dr. Clinician
H0004:U7, POS 02
1.0 Unit
15 mins
DOS: 1/6/2026

DENIED

Service 2 (3PM)
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1.0 Unit
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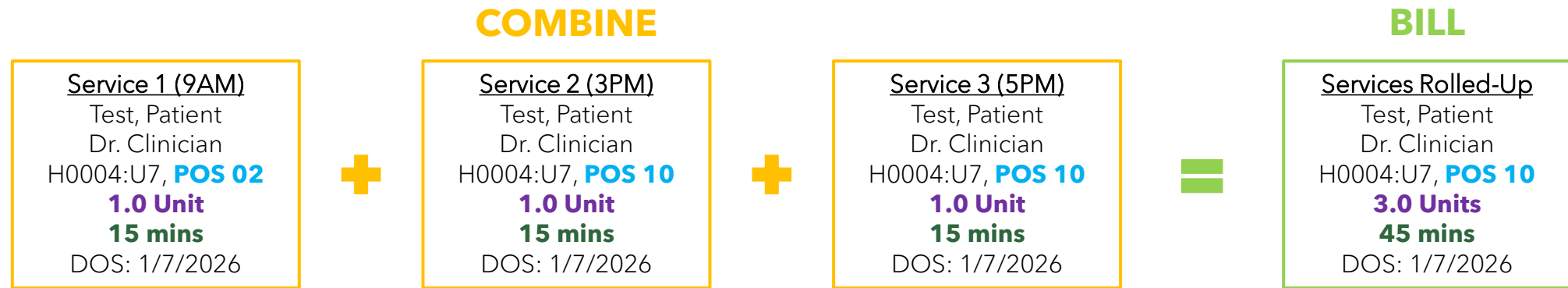
DENIED

Service 3 (5PM)
Test, Patient
Dr. Clinician
H0004:U7, POS 10
1.0 Unit
15 mins
DOS: 1/6/2026

CO 97 M86

CO 97 M86

REPLACEMENT CLAIMS - SCENARIO + DEMO



- **Demo Parameters**

- **Service:** H0004:U7
- **DOS:** 1/6/2026
- **Place of Service:** Mixed, 02 and 10 without SC modifier
- **Batch #:** 335181
- **Claim #:** 19855162
- **Scenario:** Same service billed 3 times. 2 were denied, the first was approved. Agency needs to roll up 2 denied services into the 1 approved service.
- **KPI Assumption:** After sorting by MSO Service ID column, the service in the first row is the approved service.

ADDITIONAL CONSIDERATIONS FOR ROLL-UPS

- Modifiers
 - When billing telehealth HCPCS codes and using the SC modifier
 - Place of service must be 02 or 10
 - Service code billed with SC modifier = Audio Only
 - Service code billed without the SC modifier = Audio/Video
 - When billing HL modifiers, please be consistent
 - HL modifier is used to override Medicare COB requirements for applicable codes
 - In the Billing Rules tab of the Rates Matrix, the “Medicare COB Require” column will say “Yes”
 - If you’re going to use it for one service for a practitioner, use it for the rest of the services

LOOKING AHEAD

- Currently being written
 - Roll-Up Reporting and Billing Guide
 - Will include detailed guidance on roll-ups and how to use the Replacement Claim Assignment (CMS-1500) form to bill them

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 <i>Do not send Protected Health Information (PHI) to any SAPC email</i>	Description of when to contact
Sage Helpdesk	Phone Number: (855) 346-2392 ServiceNow Portal: https://Netsmart.service-now.com/plexussupport	Sage related questions, including system errors, medical record modifications
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	All authorization related questions, questions for the office of the Medical Director, medical necessity, secondary EHR form approval
Systems of Care (SOC)	SAPC-SOC@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 submissions 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
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 clinical trainings
Finance	Sapc-Finance@ph.lacounty.gov	General questions related to billing. For specific questions related to billing denials, payments, and technical assistance, please open a ticket with the Request Billing Assistance form
Eligibility	DPH-SAPC-EST@ph.lacounty.gov	For any eligibility related questions such as for assistance identifying County of residence, help with the intercounty transfer (ICT) process, applying for Medi-Cal benefits



OPEN Q&A