

Los Angeles County

## **START-ODS**

System Transformation  
To Advance Recovery  
and Treatment



# **CLAIMING FOR SCREENING JOB AID**

Sage Patient Management System:  
Services, Data, and Claims

February 2023 | Version 2.0

## SCREENING PROCESS FOR PRIMARY AND SECONDARY SAGE USERS

*Updated 02/07/2023*

Screening for the appropriate level of care placement is an essential component of the treatment process and a requirement within the SAPC network for most providers. As stated in the Provider Manual, direct to provider referrals at provider sites that do not offer the full continuum of care (i.e. all levels of care available under DMC ODS), a screening tool (Youth Engagement Screener or ASAM CO-Triage) must be completed before a full ASAM Continuum or Youth Assessment is completed. If the patient has been referred by SASH, CENS or CORE, a screening is not required, and the provider may initiate a full assessment immediately.

To assist providers with meeting this requirement, SAPC worked closely with DHCS to include screening, H0049, as a DMC reimbursable service for FY 19/20 and beyond. While in prior years, this service was considered a “zero billing”, as of September 1, 2019, providers are eligible for a \$30 flat rate for most screenings, with some exceptions discussed in this job aid.

To bill for screening, providers must complete all required documentation prior to claiming. The following documentation **must be** completed within Sage for both Primary and Secondary Sage Users. The forms cannot be replicated into a secondary medical record system.

### Documentation

Providers must use one of the approved screening tools in Sage.

1. For youth patients 12-17 y/o, complete the **Youth Engagement Screener** in Sage
2. For patients 18 and older, complete the **ASAM Co-Triage** in Sage

Screenings may be completed by registered or certified SUD counselors, Licensed Eligible LPHA or LPHA. After the screening is completed, providers must complete the **Referral Connection Form**. This is to be completed for all screenings, whether the patient was admitted, referred out or screened negative.

### General Claiming Procedures

There are two processes providers can utilize to bill for a completed screening depending on the outcome of the screening. The screening and referral outcome determine if a provider will bill using a Provider Authorization (PAuth) or a Member Authorization to claim for the service.

1. **Provider Authorizations (PAuth)** are used to bill for instances where the patient was not admitted to the provider site. Providers will use the PAUTH to bill for screening under the following three situations:
  - a. Patient screens negative
  - b. Patient is not admitted on the same day as the screening
  - c. Patient is referred out to another provider or another site from the same provider

Each provider is configured to have a PAuth that is associated with the lowest level U-code in which each provider site is DMC certified for the entire agency. This PAuth number will be used for all patients who meet the above

criteria. The PAuth is pre-approved for all screenings that meet the criteria and does not need to be approved on a per patient basis by the UM unit.

The associated HCPCS code for the PAuth is H0049-N with the lowest level U-code in which the provider site is DMC certified. If using the PAuth number, which corresponds to one of the above three scenarios, providers should only use H0049-N along with the lowest level U-Code in which each provider site is DMC certified.

**2. Member Authorizations** are the primary form of authorization for services within SAPC and are processed by the Utilization Management unit. The screening HCPCS code H0049 is already included at all levels of care and all authorizations, however it has traditionally been a non-reimbursed zero-dollar service.

- a. SAPC has updated the member authorizations to include a \$30 flat rate for HCPCS H0049 on each **Outpatient 1.0, Intensive Outpatient 2.1 and OTP** member authorizations, which will be retroactive to September 1, 2019.
  - i. **Outpatient 1.0 and 2.1** providers will be allowed one (1) unit of service for \$30 maximum per screening.
  - ii. **OTP** providers should bill two (2) units of service at \$15/unit to total \$30 maximum per screening.
- b. **Residential and Withdrawal Management levels of care**, which are billed using a bundled day rate, will remain a ‘zero-dollar’ service as screening is included in the bundled day rate reimbursement amount.
  - i. In situations where the patient will be admitted to the provider, but on a different day from the screening or to a different site than where the screening occurred, the provider would bill the screening under the PAuth using H0049-N, and request the member authorization for the day of admission, and not claim the screening on the member auth.

**Primary Sage Users**

When billing HCPCS H0049-N for a negative or not admitted screening, enter the date of the screening on the Treatments page, then select the appropriate PAuth from the authorization dropdown. For any date of service 9/01/2019 and beyond, there will be two PAuths to choose from, one is for incentives and the other is for screening.

After selecting the screening PAuth, enter H0049-N in the Procedure Code field with the lowest level U-code in which the provider site is DMC certified. Enter the clinician name and credentials who completed the screening, and the program where the screening was administered. Screenings will always be 1 unit. Entering any other unit will result in a denied claim.

Authorization:	Auth #, Funding Source, Valid Dates : [Auth Grouping Name], up to 3 sets Procedure Code - Description from Auth Auth # P12183 FS: Drug Medi-Cal 11/1/2022 - 6/30/2023 : Screening - No Admission - H0049-N - Screening - No Admission, H0049-N:U1 - Screening - No Admission, H0049-N:U7 - Screening - No Admission
Procedure Code:	Procedure Code - Description ([Funding Source], Level of Care, Valid Dates) H0049-N:U7 H0049-N:U7 - Screening - No Admission (, 11/1/2022 - 6/30/2023)
Clinician:	ABRANTES PATRICIA (7/1/2018 -)
Performing Provider License Type:	10 - Registered SUD Counselor/Other Provider
Program:	- Please Choose One -
Units / Day:	1 Warning! Group based service units have a one minute duration

On the Treatment Details, enter the actual duration for the entire screening process. This will not impact billing, however it will help SAPC track the actual time screenings are taking which will help to inform later policy. There are no current restrictions on where a screening can take place in the location field.

Treatment Details	Additional Information
Funding Source: Non-Drug Medi-Cal Procedure Code: H0049-N - Screening - No Admission Num of Days: 1 Units/Day: 1 Total Units: 1 Cost/Unit: \$30.00 Cost/Day: \$30.00 Total Cost: \$30.00 Treatment Date(s): 09/02/2019	Start Time: <input type="text"/> End Time: <input type="text"/> Duration (minutes per service): 30 Location: Non Residential Substance Abuse Treatment

For screenings that are admitted on the same day to any level of care, providers will select the member authorization and follow the same procedures as above. For Residential and Withdrawal Management levels of care, who bill using a bundled day rate, the screening will show as \$0 for the service, but will still be billed using the member authorization for patients admitted on the same day. Outpatient 1.0, Intensive Outpatient 2.1 and OTP levels of care will now have a \$30 flat rate fee for screenings associated to all member authorizations retroactive to dates of service 09/01/2019 and later. OTPs will need to claim two (2) units to equal the \$30 rate.

Authorization:	Auth #, Funding Source, Valid Dates : [Auth Grouping Name], up to 3 sets Procedure Code - Description from Auth Auth #, P12183 FS: Drug Medi-Cal 11/1/2022 - 6/30/2023 : Screening - No Admission - H0049-N - Screening - No Admission, H0049-N U1 - Screening - No Admission, H0049-N U7 - Screening - No Admission
Procedure Code:	Procedure Code - Description ([Funding Source] Level of Care, Valid Dates) H0049-N:U7 H0049-N:U7 - Screening - No Admission (, 11/1/2022 - 6/30/2023)
Clinician:	ABRANTES PATRICIA (7/1/2018 - )
Performing Provider License Type:	10 - Registered SUD Counselor/Other Provider
Program:	- Please Choose One -
Units / Day:	1 <small>Warning! Group based service units have a one minute duration</small>

Treatment Details	Additional Information
Funding Source: Drug Medi-Cal Procedure Code: H0049:U7 - Screening Num of Days: 1 Units/Day: 1 Total Units: 1 Cost/Unit: \$30.00 Cost/Day: \$30.00 Total Cost: \$30.00 Treatment Date(s): 12/01/2019	Start Time: <input type="text"/> End Time: <input type="text"/> Duration (minutes per service): 25 Location: Non Residential Substance Abuse Treatment

### Secondary Sage Users

For those providers using the 837 billing process, it is important to configure the agency's billing systems and work with billing vendors to reflect these changes to the screening process. SAPC will communicate to each Secondary Sage User the PAuth number to use for claiming. This information can also be obtained by calling the Sage Helpdesk.

The agency's electronic health record system should be configured for the H0049-N HCPCS code with a \$30 rate for a maximum of 1 unit per patient per day. This code will only be allowed using a PAuth number that will be

provided to the agency as they are created. Additionally, the \$30 rate for screenings within Outpatient 1.0 and Intensive Outpatient 2.1 levels of care should be updated with the effective date of 09/01/2019 for each H0049 code per level of care and specialty population. For example, H0049:U7 and H0049:U7:HA should each be configured with an associated \$30 rate. This code and fee should be a maximum of one (1) unit per patient per day.

OTP providers using their own electronic health record system should configure their systems to include H0049-N with the lowest level U-code in which the provider site is DMC certified and H0049:UA:HG as \$15 per unit with a maximum of two (2) units per patient per day. This will allow the provider to claim the full \$30 screening rate.

### DMC Eligible Patients

In order to maximize allowable DMC reimbursement, providers are instructed to enter the lowest level of care U-code in which the provider site is DMC certified and for those who are DMC eligible, ensure the patient’s Financial Eligibility is set to DMC as the primary guarantor.

As a reminder, all network treatment providers are required to:

1. Complete either an ASAM Co-Triage or Youth Engagement Screener for each person who comes to the facility requesting treatment services if not referred by SASH, CENS, or CORE.
2. Complete the Referral Connection Form in Sage for both admitted patients and patients who were referred out.
3. Enter diagnosis code:
  - a. Enter diagnosis code Z03.89 in Sage and in provider’s EHR, if applicable, for non-admitted screenings
    - i. Enter the lowest level of care U-code in which the provider site is DMC certified
    - ii. For DMC eligible patients ensure their financial eligibility is set to DMC
  - b. If the screening led to an admission at the same agency, providers should use the LPHA established diagnosis
4. Submit a claim using either:
  - a. Provider authorization (PAuth) for patients not admitted, OR
  - b. Member authorization for admitted patients
5. To obtain the PAuth numbers for your agency, providers can utilize the following resources:
  - a. PAuths start with a “P” and are followed by a number.
  - b. Primary providers: When entering a service on the Treatment page, the PAuth is seen in the Authorization field dropdown.
  - c. Secondary providers: Contact the Sage Help Desk or your agency’s assigned CPA to obtain the PAuth numbers.