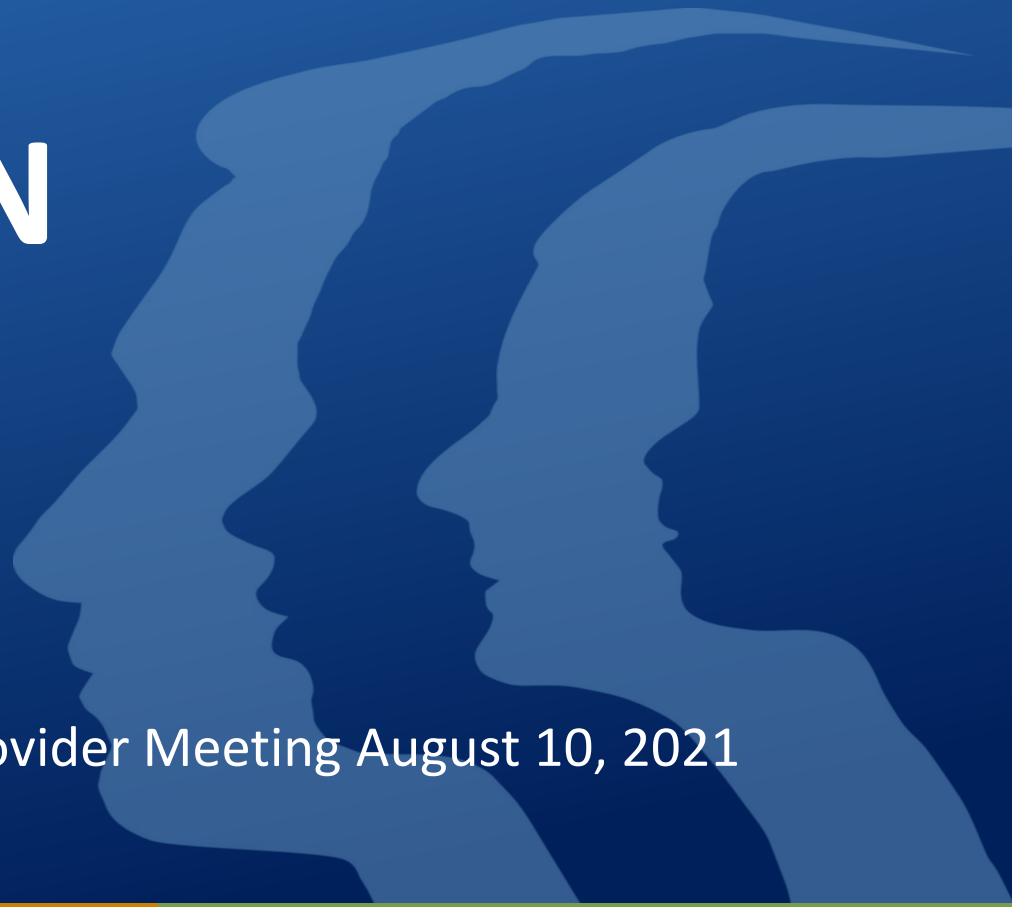
SAGE, BILLING AND DENIAL RESOLUTION UPDATES



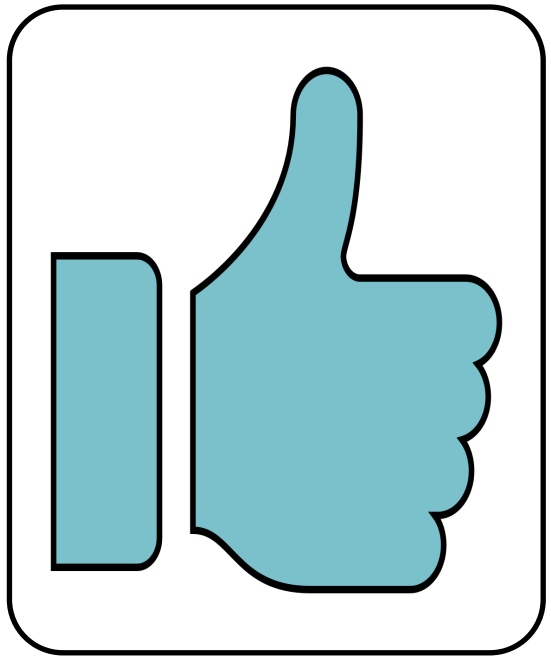
Los Angeles County Department of Public Health
Substance Abuse Prevention & Control

All Provider Meeting August 10, 2021

Overview

- Review of Key Process & System Changes
- State Denial Updates and Workflow
- 837 File Critical Error Report Workflow

Review of Key Process & Sage System Changes



Medi-Cal Eligibility

- Effective 7/1/2021, SAPC implemented new eligibility verification checks during the authorization and claiming processes:
  - UM is validating patients, who are indicated as being Medi-Cal enrolled, against the Medi-Cal Eligibility Data Set (MEDS) to confirm county code, aid code and status code
  - Claims are being validated against the status code on the MEDS file.
    - Status code relates to the traffic light on the eligibility printout where green and yellow correspond to codes that are likely eligible and red corresponds to status codes that indicate not eligible.
  - **Real-Time 270 Eligibility Request Presentation** published to the main SAPC webpage (under Network Providers, Provider Manual and Forms)
  - Providers can upload the Medi-Cal eligibility printout along with the authorization if there are any discrepancies. UM may ask for additional evidence to support eligibility if provider disagrees with eligibility from MEDS file.

Process Change Reminders

Sage Processes

- Updated documentation guidance in SAPC IN 21-05 to clarify that RSS levels of care are eligible to be reimbursed for documentation time of one extra unit for individual services.
- Document Modification Request Workflow published on the Sage page under Sage Help Desk to assist in expediting requests for final to draft helpdesk tickets.
- New 837 file naming convention guide to help with better tracking of 837 files (published on both the main SAPC Network Providers page and the Sage page under Sage System Guides).
- Sage Critical Error Reports uploaded to SFTP for all Secondary Sage Users to assist in reconciling claims on 835s.
- One rate across all discipline levels providing services- As previously announced, SAPC is no longer using staffing level for rate structure

Notable Enhancements and Improvements From FY 20-21

County of Los Angeles Public Health

New Miscellaneous Note Options to Improve Documentation

- Added several new types of Misc notes that are more specific to services rendered and removed unnecessary note types

Rate Increases Across Levels of Care

- Rates finalized before the fiscal year cutover, including OTP and MAT

Operationalized Recovery Support to Improve Access to Care

- Patients now permitted to enter directly into RSS without previous level of care
- PAuths issued for all RSS services to improve access to treatment
- Clarification of previous level of care U code to avoid State denials.

Notable Enhancements and Improvements From FY 20-21

Claims Blackout Lifted 7/27/21

- Earliest lifting of blackout of all Fiscal Years since Sage

Proactive Monitoring of Billing Issues to Improve Timely and Correct Payments

- Verification of Medi-Cal with MEDS
  - At the UM level and claims processing level
- Financial Eligibility KPI Views
- County and Aid Code Report
- SAPC staff monitoring new claims across the network for denial patterns or irregularities in billing

Out with the Old, In with the New!

- Using member auths to bill RSS
- Using last years rates when submitting 837 claims
- Using old authorizations ending on 6/30 (Secondary Sage Users)
- Not billing for RSS documentation time
- Not verifying Medi-Cal Eligibility using aid code and county code and skipping the Real-Time 270 Request

- ✓ **Use Pauths for all RSS claims with dates of service 7/1/2021 and beyond**
- ✓ **Configure provider EHR with new rates per the current Rates and Standards Matrix (Standard, Perinatal and Youth)**
- ✓ **Update authorizations that cross fiscal years to new auth numbers before billing**
- ✓ **1 unit added to individual services at 1.0, 2.1 and RSS LOCs**
- ✓ **Check aid code, county code and eligibility status at admission and monthly before billing**
  - ✓ **Upload your MCAL/FE Verification and run the 270 before submitting an authorization**

Additional RSS Configuration Updates

- REMINDER: When billing RSS, do not use previous level of care as the secondary U code starting 7/1/2021
  - Secondary U code for RSS should reflect the lowest level of care certified at the service site where RSS is being delivered.
  - Do NOT use a withdrawal management U code as the secondary U code

Prior RSS Configuration

RSS provider bills RSS with the U6 RSS code and the previous LOC code of U1 for residential

RSS provider is only certified for U7 Outpatient, not Residential

Old HCPCS: H0004:U6:U1

New RSS Configuration

RSS provider is only certified for U7 Outpatient and RSS, therefore, secondary U code is U7 regardless of where the patient was previously treated.

New HCPCS: H0004:U6:U7

State Denials Updates

SAPC Interventions on behalf of Providers

SAPC has implemented several ongoing processes for State Denials, including monitoring, investigation, rebilling, replacement on behalf of our network and timely notification of state denied state . This has involved:

Continuous communication with the State on several State denial codes to ensure denials were valid and CARC/RARC codes had clear instructions on how to resolve.	Successfully correcting and rebilling hundreds of thousands of claims that were State denied without having to recoup them from providers.	Establishing processes for the regular and timely processing of claims and provider notification of denials to enable expeditious correction and resubmission.

State Denials to be Recouped

Despite SAPC's efforts, there is still a backlog of historical state denied claims that were unable to be corrected by SAPC and will be recouped from providers.

- **These historical state denials will require correction, resubmission, and/or replacement, where appropriate.**
- **SAPC expects these recoupments to begin over the course of the next few weeks.**

These historical denials include claims that span across FYs 18/19, 19/20, & 20/21.

- **Providers <u>WILL BE</u> permitted to resubmit/replace all correctable denied claims beyond the 6-month DMC claiming policy for a limited time.**
- **FY 17/18 has been closed and those claims have been settled. No further action is required.**

State Denials to be Recouped

The primary codes to be recouped are as follows:

CO 177 denials for ineligibility and out of county	CO 16 MA39 for incorrect or mismatch on sex between F.E. and Medi-Cal	CO 16 N327/CO 96 N327 for incorrect/mismatch on date of birth	CO 167 N30 for non covered diagnosis

State Denials to be Recouped

Claim issues related to sex, date of birth and some eligibility denials that could not be fixed by SAPC

- Providers entered the wrong CIN on the Financial Eligibility in Sage.
- The State billing system uses the CIN to identify the patient and matches the sex and DOB against the file based on CIN.
  - Example: DOB and/or Sex value may be correct for the patient. However, but the DOB/Sex value for the CIN entered may be significantly different.

SAPC highly recommends making a copy of the Patient's MCAL Card and uploading it to Sage

- Significant number of denials related to Incorrect Sex and DOB on F.E.
- MCAL card shows the information the State has on file to be entered on the claim
  - Example: If the MCAL card incorrectly shows Male, then the claim must show male until the State database has been corrected

Top Denials and How to Resolve Them

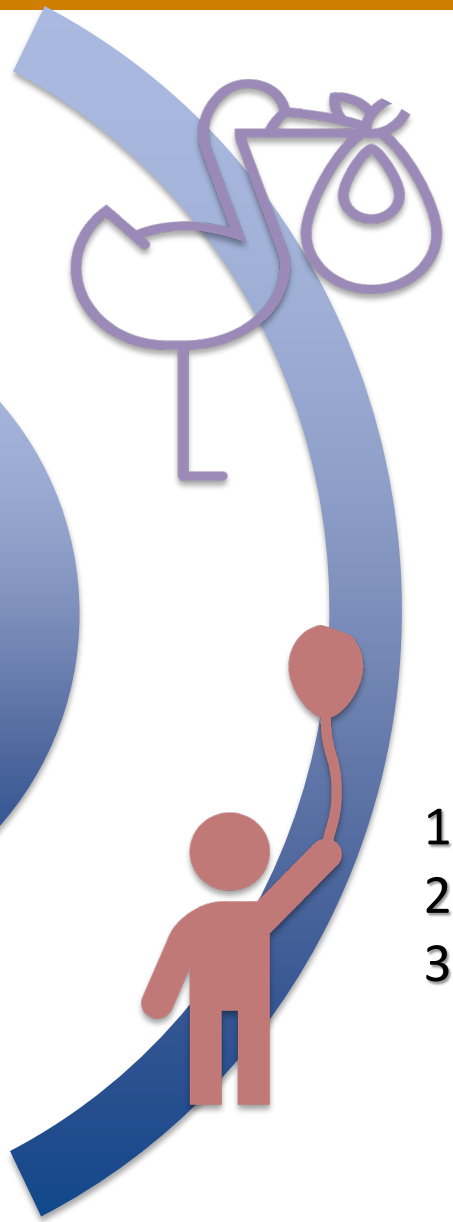
Sex Value Discrepancy- CO 16 MA39

Sex (M/F/U) on Financial Eligibility does not match state eligibility file

Top Reasons for Discrepancy:

1. Wrong CIN listed on F.E.
2. Data entry error on F.E.
3. State only uses Male and Female where Sage can have an 'Unknown' option

Top Denials and How to Resolve Them



Incorrect Date of Birth- CO 16 N327

Date of Birth on Financial Eligibility does not match state eligibility file (FAME system)

Top Reasons for Discrepancy:

1. Wrong CIN listed on F.E.
2. Typo on F.E.
3. DMC has different DOB

Top Denials and How to Resolve Them

Patient Eligibility- CO 177 (N424)/CO 96 N424

Patient is not Eligible for DMC Services- Does not have full scope Medi-Cal or benefits not assigned to LA County

Providers MUST verify the patients aid code and county code to ensure they are DMC eligible

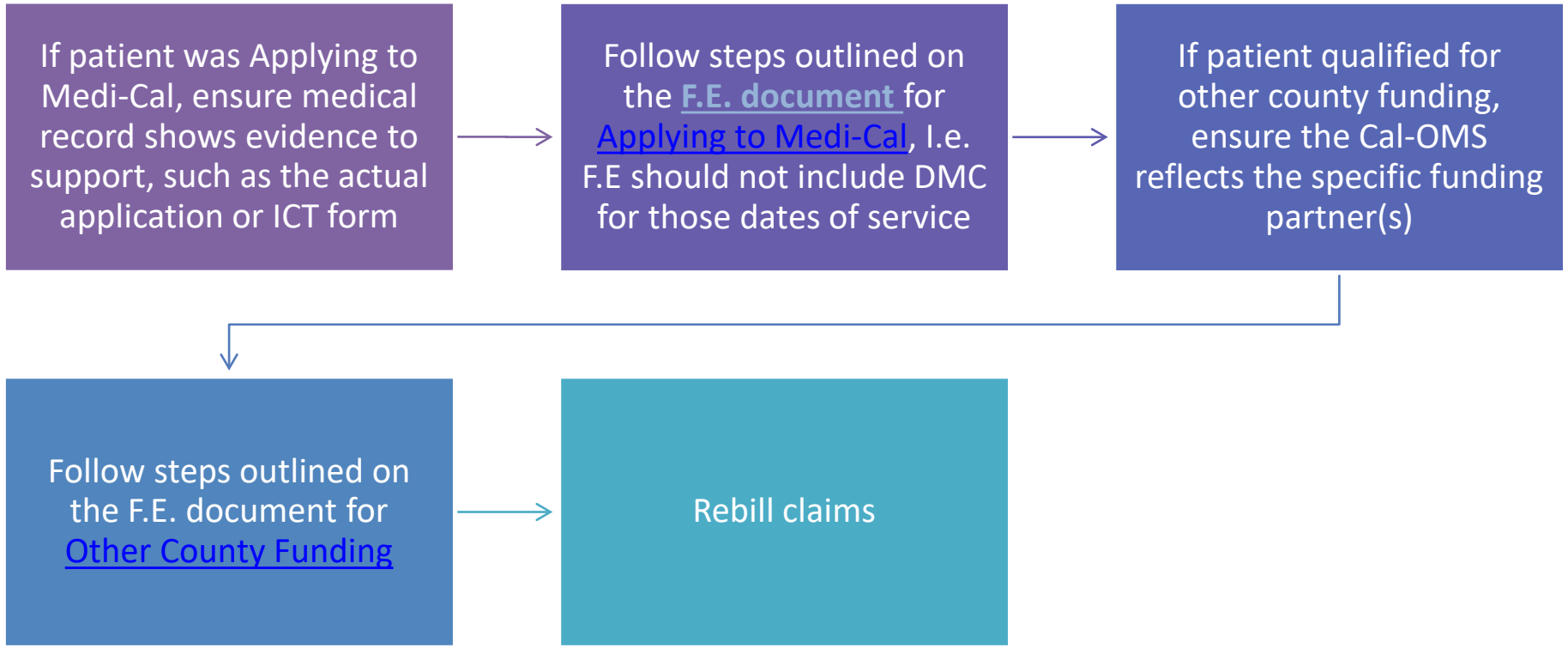
***Some aid codes are Medi-Cal eligible but not for DMC services (M2, HPE codes are for participating 3.7WM, 4.0WM and hospitals only) and may not be eligible for replacement

Aid Code Master Chart- Updated 12/20/2020
https://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Aid-Code-Master-Chart.pdf

Correcting Financial Eligibility Errors Causing State Denials

CO177 denials are typically related to errors on the Financial Eligibility in Sage, such as:

1. Wrong CIN for the patient
2. Patient was applying for Medi-Cal/out of county, but F.E. showed as active Medi-Cal
3. Related to OHC for denials prior



***Please Note: If providers did not verify or incorrectly verified aid and county code, where the patient was NOT eligible for DMC, these claims are not eligible for replacement, unless the patient was enrolled in another county program such as AB109, DCFS etc…

Financial Eligibility Scenarios: Applying for MCAL

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Patients who initially admitted as Applying for Medi-Cal/MHLA

Applying for Medi-Cal Guarantor	LA County- Non DMC Guarantor

Patient is approved for DMC during treatment

Enter New Primary Guarantor of DMC	Move Applying for Medi-Cal to Tertiary Guarantor

Update Coverage Effective Dates and Expiration Dates

Enter Coverage Effective Date for DMC as the effective date assigned by DMC	Enter Coverage Expiration Date for Applying for Medi-Cal as the date before DMC was effective

CO 167 N30- Non-Covered Diagnosis

Diagnosing To Do's

Accuracy

- Ensure diagnosis is correct and consistent between Sage and provider EHR

Primary diagnosis must be a substance use disorder

Primary diagnosis must be included on the approved diagnosis list per MHSUDS 20-043

Correct the diagnosis for the denied claim if entered in error and resubmit

Enclosure 1 - ICD-10 Inpatient/Outpatient Diagnosis Codes and Descriptions

Enrolling in Medi-Cal Verification Systems

County of Los Angeles Public Health

VERIFICATION ACTIONS YOU CAN COMPLETE ONLINE	HOW TO ACCESS MCAL VERFICATION SYSTEMS
• **Eligibility** • **Batch Eligibility** • **Automated Provider Services** • **Medi-service reservations (limited MCAL services)** • **Medicare Drug Pricing** • **PDF RAD/Medi-Cal Financial Summary** • **Share of Cost**	Must have a Medi-Cal provider number and PIN, and have either an electronic or paper Medi-Cal Point of Service (POS) Network/Internet Agreement form on file: **Required forms to gain access to activate automated systems** Electronic POS/Internet form- Electronic Docusign Version Paper POS/Internet form- Printable version **For information about Provider Enrollment:** Visit the Provider Enrollment page. • Please call the Telephone Service Center (TSC) at 1-800-541-5555 for more information **Automated Eligibility Verification System (AEVS)**: 1-800-456-AEVS(2387) • DO NOT need enrollment; DO need a PIN to access.

How can I receive or reset my PIN #?

- **Providers received their initial Provider Identification Number (PIN) as part of their program enrollment.**
- **Methods for PIN Confirmation or Replacement: Medi-Cal fee-for-service providers with seven-character Provider Identification Numbers (PINs) may request a Telephone Service Center (TSC) agent at 1-800-541-5555 to confirm or reset their PIN.**

Take Away Messages for Providers

Providers should prepare their staff to expect a number of historical state denials to be posted in Sage

These will include claims from FY18/19 through FY20/21

Providers should 'work' these denials, make corrections, and resubmit/replace where appropriate.

SAPC will allow resubmission/replacement of claims >6mo old for limited period of time to allow providers to address these historical state denials.

Use the tools you have to understand and correct state denials!

State Resources	SAPC developed resources

Helpful State Resources for Providers

- **Online Medi-Cal Provider Manual**
  - https://files.medi-cal.ca.gov/pubsdoco/manual/man_query.aspx?wSearch=*_*z00*+OR+*_*z01*&wFLogo=Part1+%23+Medi-Cal+Program+and+Eligibility&wPath=N
- **AEVS transaction log- Useful to keep a record of eligibility inquires (can be uploaded to Sage)**
  - https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/aevtrn1form.pdf –
- **Where to find answers**
  - https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/0Cgetstart.pdf
- **Eligibility Benefits Instructions:**
  - https://filesacceptttest.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part1/eligrec.pdf
- **Printable versions of the POS and Eligibility Enrollment forms**
  - Form: Medi-Cal Point of Service (POS) Network/Internet Agreement (point frm1 net) (Revision Date Oct 16, 2020) | (167KB)
  - Form: Medi-Cal Eligibility Verification Enrollment Form (point frms) (Revision Date Oct 16, 2020) | (120KB)

Helpful SAPC Resources for Providers

See the *Finance Related Forms & Documents* section of the Network Provider Forms page on SAPC website.

- http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm

- **Interpreting the Real Time 270 Results**
  - http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/InterpretingRealTime270Results.pdf
- **Correcting Diagnosis Errors in Sage**
  - http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/CorrectingDiagnosisErrorsSage.pdf
- **Documenting Changes in Financial Eligibility Status**
  - http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/DocumentingChangesFinancialEligibilityStatus.pdf
- **Claim Denial Reason and Resolution Crosswalk for Providers**
  - https://filesacceptttest.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part1/eligrec.pdf
  - Denial Crosswalk Instructions Version 3.0: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/DenialCrosswalk/SAGEGuideClaimsDenialResolutionCrosswalk3.0.pdf

Critical Error Reports for Secondary Sage Users

What is a critical error and why does it matter?

Critical Errors are issues related to the 837 file that either cause the entire file to be rejected or claims within a file to be rejected.

If the entire file is rejected, IT will notify the provider and a file will be uploaded to the SFTP renamed to include the word “invalid” in the 837 file name.

For files that are accepted, there may still be issues at the claim level that prevent certain claims from be adjudicated.

This will result in the claims not showing on an EOB or included in resulting 835s.

Additionally, these claims and services will not be visible in KPI because they were not adjudicated and they cannot be manually adjudicated by Finance as they do with pending claims.

If claims are rejected for critical errors, they **must** be resubmitted on a new file after the critical error has been corrected.

These are not eligible for replacement or voiding as they were not adjudicated. Resubmitting means new Claim Submitter ID and submitted as an original claim

Utilizing the Critical Error Report

Information in the Report

- Error report gives the line number from the 837 dump file report and exact issue that needs to be corrected in the provider's EHR/corresponding 837 file.
- Provider should identify the loop and segment with the issue that corresponds with the field in their own EHR used to populate the 837.
- Correcting this error must be done before resubmitting the claim and future claims to prevent rejections.

Sample Report

File Name:	/npc/clients/LASAPC_CA.16276.mp/avatar/live/837P/InProcess/ADP·
File Status:	POSTED
File Version:	837Pv5010

Error Type	Error Message
Critical Error	Line: 20 - Cannot determine member through name and policy number: MSO

Top 5 Critical Errors

The date of birth contained in the file does not match the date of birth on file for member id	• Common error: Date of birth on 837 file does not match date of birth in Sage on Patient demographics • Usually related to a typo in Sage. Providers must submit a helpdesk ticket to correct the DOB in Sage
Member does not exist in the MSO System	• Common error: Typo or placeholder used “MSOXXXXXXX” or CIN or internal medical record number used as the PATID instead of Sage PATID
An 'Original Reference Number' (2300-REF*F8) is required for claims marked as a void or replacement	• Common error: PCCN is missing or invalid on void or replacement claims

Top 5 Critical Errors

Unbalanced Claim	• Common error: The sum of the services within the claim do not equal the total claim amount for files that contain more than one service per claim.
A valid 'Original Reference Number' (2300-REF*8) is required for claims marked as a void or replacement	• Common error: The Original Reference Number listed on the void or replacement claim was not the PCCN from the claim being voided or replaced sent on the 835 file
Procedure Code Not Defined in MSO CPT Code Table	• Common error: Typo in the 837 file populated from the provider's EHR. Usually occurring during configuration for the fiscal year or when new codes are added.