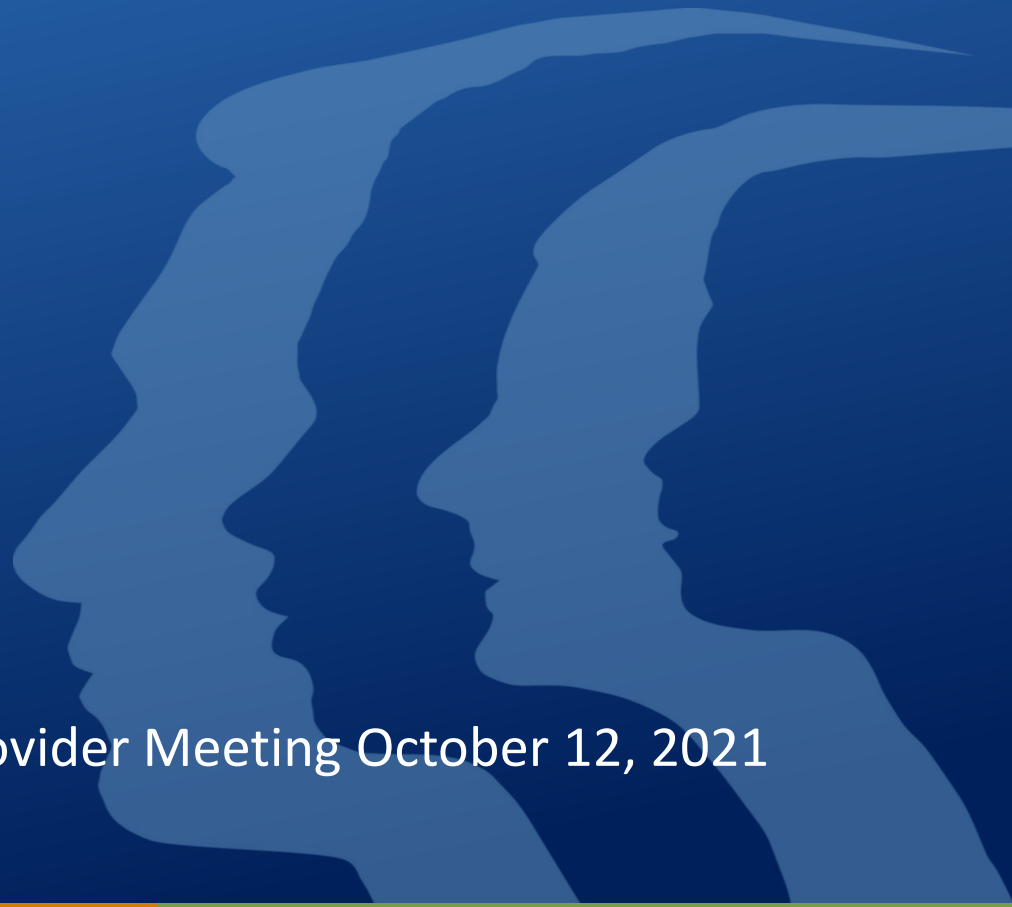
SAGE UPDATES



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

All Provider Meeting October 12, 2021

Overview

- Important Reminders
- Telehealth Modifiers Requirement
- Provider Activity Report Updates
- State Denials and Resubmissions

IMPORTANT REMINDERS

Screening- Documentation and Billing

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

AND

(2) Complete the Referral Connection Form in Sage for both admitted patients and patients who were referred out

AND

(3) Enter Diagnosis code

LPHA's established Dx

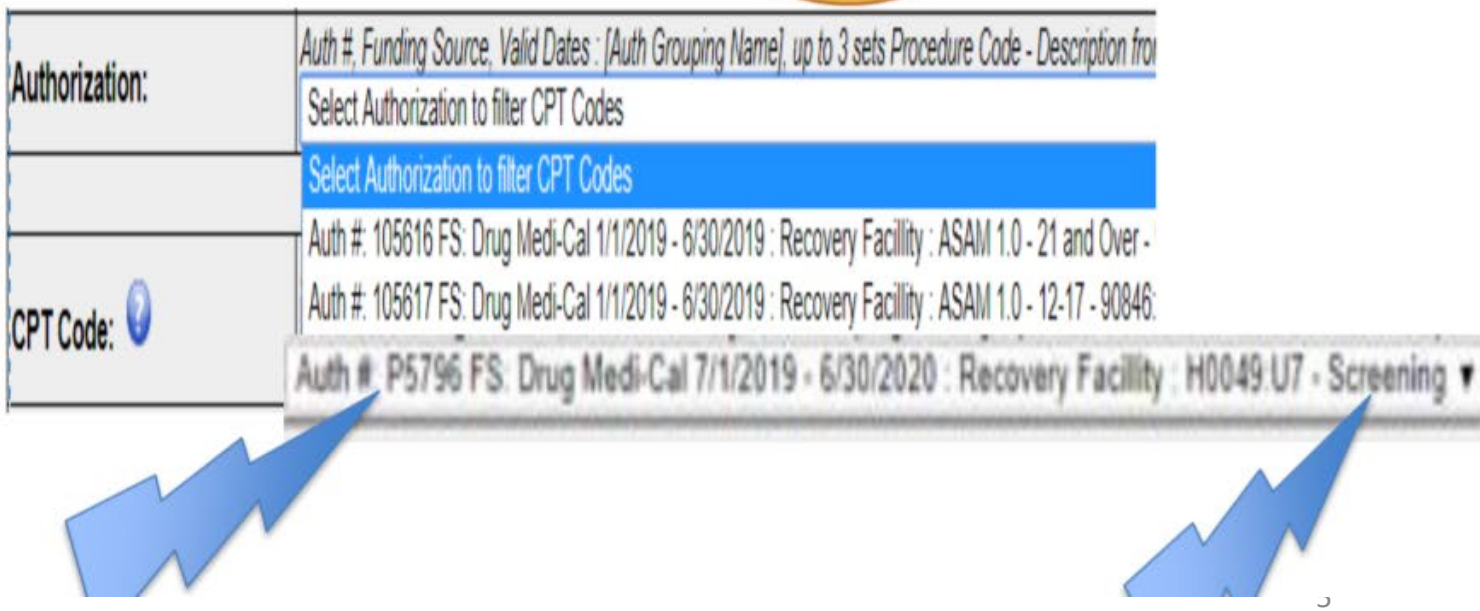
If no dx (e.g. new patient): use Z03.89 in Sage and in Provider's EHR to reflect screening

(4) Submit a claim using the either a Pauth (for patients not admitted) or Member Auth (for admitted patients) when (1), (2) and (3) are completed.

Training on How to Do Screening: http://publichealth.lacounty.gov/sapc/providers/sage/other-training-resources.htm

Where Can Providers Find Their PAuth's?

- For providers that claim through Sage: Pauths are listed on the Treatment page along with all member auths when entering a treatment.
  - Pauths all start with a "P" followed by a number
  - Screening should only be billed using the Pauth, not the member auth.
- For secondary providers who claim using the 837 process: if you do not know your Pauth number, please contact the HelpDesk or your CPA to get that information.
- Billing for screening is similar to billing for incentives.



Avoiding Duplicate Patient Records

- When searching for a patient in Sage, verify social security number, date of birth and name are all entered correctly. You should search for patients prior to creating a new admission.
- Do not enter 999-99-9999 as the search SSN if patient does not have a social security number. Use 222-22-2222, 777-77-7777, 333-33-3333 etc.
- The rank score is heavily weighted on the social security #. Given frequency of use, 999-99-9999 will make it less likely to identify your patient.
- Be careful of similar or same name situations. Always check SSN and DOB for common names before creating the record (and when documenting in a chart).

SAPC processes on average 400-500 progress note modifications per week

Primary Issue:

- Staff are starting the notes before group, but patient doesn't show for group
- Contracts Unit has noticed full notes written for patients that did not attend the group that are being requested to be Final to Drafted to void the note
- ***Please do not write documentation until after service is delivered***.

Secondary Issue:

- Dates are entered incorrectly
- Typically, if notes are written on a different date than the service, the counselor enters the documentation date rather than the service date.
- Dates cannot be modified, the entire note must be rewritten
  - This can lead to duplicate billing since the new note will show on the Provider Activity Report

Ticket Submission Process:

- Submit one ticket per progress note needing correction
- Include all the following information on the ticket:
  - PATID
  - Date of Service
  - Performing Provider
  - Type of Service
  - Duration
  - Note Type (BIRP/GIRP/SIRP/SOAP/MISC)
  - Type of Miscellaneous note, if applicable

Telehealth Modifier Requirements

New Telehealth Billing Procedures

DHCS released telehealth bulletin featuring new modifiers (BHIN 21-047)

EFFECTIVE 11/1/2021

Telehealth and Telephone services must be documented and claimed with specific codes to indicate the correct method of service delivery.

The claim must match on the telehealth/telephone modifier and place of service code to avoid State (and Local) denials. Claim will be denied If modifier is present, but wrong place of service or if modifier is missing and place of service is correct.

Telephone Services

All services provided via telephone must include the SC modifier.

All telephone services must use the Place of Service code 02 on the service line for 837 or select **telehealth (same for both telephone and telehealth)** for location in Sage.

Telehealth (on a HIPAA certified synchronous telehealth platform)

All services provided using telehealth, must include the GT modifier

All telehealth services must use the Place of Service code 02 (same code for telephone) on the service line for 837 or select **telehealth (same Place of Service as telephone)** for location in Sage.

Documenting Telehealth Services

Method of Service Delivery is required to be selected on the progress note in Sage

Secondary Sage Users: please make sure to update your EHR to include this information on the progress note and submit to SAPC.QI.UM@ph.lacounty.gov for approval by the Medical Director's Office

SAPC is updating the 837 P companion guide to include telehealth requirements for 837 files.

With the addition of the Method of Service Delivery field, providers are no longer required to state the method in the body of the note.

Provider Activity Report

New and Improved Provider Activity Report

SAPC and Netsmart have been working to improve the functionality and workability of the Provider Activity Report to enhance billing efficiency for providers.

The expected release date for productive use is: 10/31/2021

The report will only download when run currently, however Netsmart is updating Sage to allow for it be viewable as a pop-up report

Full functionality is anticipated for mid November.

Several updates have been made to the report, including:

- Formatting to easily export to excel without extra rows or columns
- Updated to include Method of Service Delivery (to help bill for telehealth services)
- Updated to include documentation time and travel time and date for field-based services
- All other fields remain the same, with improved formatting all around.

State Denials and Resubmissions

State Denials to be Recouped

As previously reported, SAPC is retro-ing historical state denials for resolution by providers

- **These historical state denials will require correction, resubmission, and/or replacement, where appropriate.**
- **Providers should expect some denials that cannot be corrected due to patient being ineligible for DMC at the time of service.**

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 and will not be recouped.**
- **Resubmission of claims will aid providers in improving your data for Cost Reporting.**

State Denials to be Recouped

County of Los Angeles Public Health

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

Primary Steps To Resolve Denials:

Check the CIN on the Financial Eligibility in the Subscriber CIN field, not the Policy field.

Significant number of denials related to wrong CIN

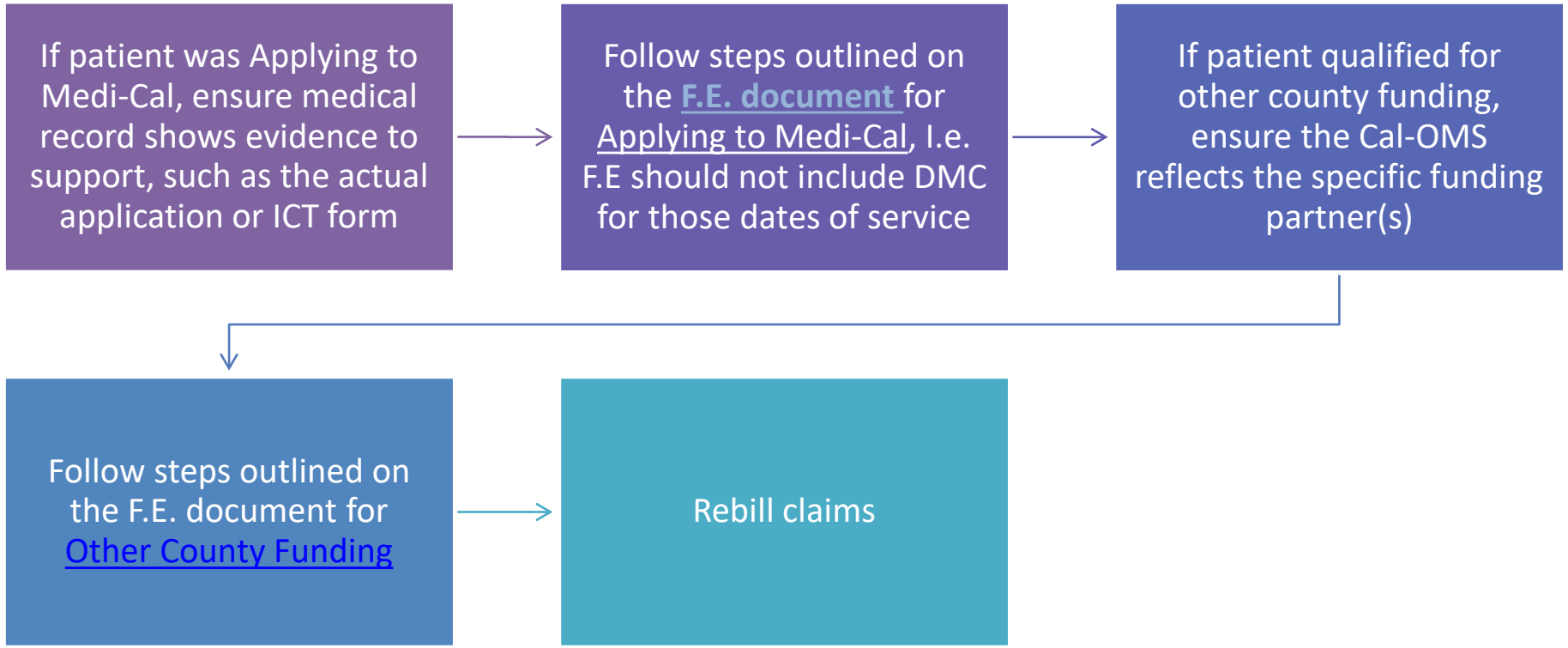
The State billing system uses the CIN to identify the patient and matches the sex and DOB against the MEDS system based on CIN.

- 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.
- Sex value for State claims can only be M or F and must match the value on the BIC
- Check the DOB on the Financial Eligibility for typos and that it matches the State system- Providers can call the helpdesk to verify DOB

Correcting Financial Eligibility Errors Causing State Denials

Correctable 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…

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 prioritize 'working' 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	Check the CIN

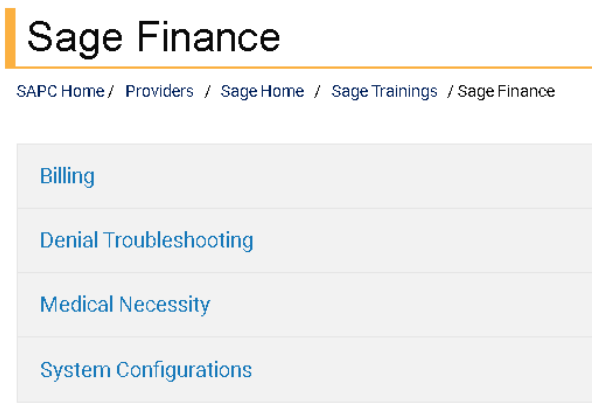
SAPC Resources

Primary SAPC Website→Provider Network→Provider Manual and Forms

- Interpreting the Real Time 270 Results
- Interpreting the Real Time 270 Results Presentation
- Correcting Diagnosis Errors in Sage
- Documenting Changes in Financial Eligibility Status
  - Updating Financial Eligibility for Patients Who Obtain Benefits During Treatment
  - Updating Financial Eligibility for Patients Whose Benefits Expired During Treatment
  - Updating Financial Eligibility Admitted Under Other County Funding or MHLA
  - Updating Financial Eligibility for Self-Pay Patients Who Establish Benefits
- Claiming for SUD Screening Instructions
- Claim Denial Reason and Resolution Crosswalk for Providers *(Updated - May 2021)*
- Denial Crosswalk Instructions Version 3.0 *(Updated - May 2021)*
- Quick Guide to Identifying Denials

Sage Website→Sage Trainings→Finance

- http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm



Other Health Care (OHC)

OHC Updates

Netsmart and SAPC continue to configure and validate Sage to allow direct entering of OHC information for Primary Sage Users

- At this time, Primary Sage Users should continue to hold any claims where the OHC information needs to be entered.
- These claims WILL be denied by the State without the OHC information.

Secondary Sage Users are fully able to enter OHC information and should continue to do so with the structure according to the current 837P and 837I companion guides

SAPC has validated that when entered correctly on the 837 files from Secondary Providers, OHC claims are being approved by Sage and by the State.

- During investigation, it was found that many claims were incorrectly formatted on the 837 files that caused denials or prevented claims from being sent to the State.
  - For example, OHC information was placed in the wrong segment in the loop.
  - Other issues were related to claim totals and service totals were not equal.

National Drug Code (NDC)

Claims Requiring National Drug Code (NDC)

SAPC will be recouping any claims that were missing NDCs where required.

- NDCs are only required for OTP providers for Buprenorphine, Disulfiram, Naloxone and Naltrexone medications.
  - Methadone does not require an NDC

Claims recouped related to NDC will be associated to:

- Denial 96 N54 as the primary denial
- Denial CO 26 N650 as a potential code used by the State for these denials