# Communication Release

7/1/2021

## Historical Critical Error Reports

In the June 18, 2021 Sage Provider Communication, SAPC notified treatment providers that the Critical Error Reports for incoming 837 files would be uploaded to each provider's SFTP beginning on 6/21/2021. In addition to providing the Critical Error Reports for files submitted as of 6/21/2021, SAPC has been working on compiling historical Critical Error Reports for providers for 837s received between 12/1/2017-6/21/2021. The reports will be uploaded to each provider's SFTP in the: Compile_Report/Archive folder. SAPC IT will notify provider SFTP contacts via email when the reports have been uploaded to the SFTP and are ready for download. Due to technical limitations, the Critical Error Report files will be available for only **7 days** to download before they are deleted from the SFTP. As such, providers are encouraged to retrieve these files as soon as possible after receiving notification of their availability.

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## New Fiscal Year Blackout Period

***Effective 7/1/2021***

With the new fiscal year here, it is important to note that Sage will be undergoing configuration updates to align the system rates to the new rates and standards matrix. Similar to last fiscal year, SAPC is expecting a shorter claiming blackout period than providers have previously experienced. **The claiming blackout for FY21-22 will begin on Thursday, July 1, 2021**. Providers should not submit any claims to SAPC for FY21-22 but can continue to submit billing for FY20-21 (please be aware of the deadlines in the EOY Fiscal Year Reminders section of this communication). If FY21-22 claims are received prior to SAPC announcing the blackout has been removed, the claims will be denied and these claims will have to be resubmitted by the provider when the blackout is lifted. SAPC anticipates that the claiming blackout should be released by August 1, 2021 and will notify providers when it has been removed. However, SAPC will work to minimize this timeframe if possible.

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## SAPC Verification of Medi-Cal Eligibility

***Effective 7/1/2021***

Due to the large number of State denials across the network, SAPC has been investigating causes and solutions to assist providers in preventing State denials. SAPC has identified client Medi-Cal eligibility as one of the largest preventable denials. These denials are seen under the various CARC/RARC combinations of CO 177. In an effort to minimize these denials, **effective 07/01/2021**, SAPC will implement a two-step process that will verify Medi-Cal Eligibility at the authorization level and the claim level. These two new processes will give providers immediate denial information that can be used to better manage their given programs. Traditionally, providers may wait weeks to months before knowing if a claim was denied by the State due to Medi-Cal eligibility.

**Authorization Level Verification:** Starting 7/1/2021, all newly submitted DMC authorizations will be verified against the current Medi-Cal Eligibility Data Set (MEDS), which contains eligibility on file at DHCS. For those patients submitted as DMC eligible by providers, QI & UM Care Managers will be checking for valid aid codes, county codes, and eligibility status based on similar information given to providers through the AEVS, Real-Time 270 Eligibility Request, and Medi-Cal eligibility portal. If there is a discrepancy in what the provider submitted and what the MEDS file shows, providers will be given the opportunity to resolve the issue before the authorization is denied.

Providers should take the following steps to resolve situations in which the patient is showing as ineligible on the current MEDS file:

1. Ensure the CIN listed on the DMC guarantor is the correct CIN for that patient.
2. Run the Real-Time 270 Eligibility Request in Sage for the date of authorization.
3. Upload the printout from Medi-Cal system that was used to verify eligibility via the Attachments in Sage.
4. If patient is deemed ineligible for DMC, but is enrolled in another county funding program, correct the Financial Eligibility and submit a new authorization under Non-DMC and request to deny the DMC authorization.

Additionally, authorization dates may be modified based on the eligibility dates within the MEDS file. If the patient is eligible for other county funding, Applying for Medi-Cal coverage, or later gets retroactive Medi-Cal, providers may be able to submit for the remainder of the authorization dates.

**Claim Level Verification:** In addition to authorization level checks, SAPC will implement a system level verification when claims are submitted for local adjudication. For DMC claims submitted via Sage and 837 files, the system will cross check the patient eligibility against the current MEDS file. If the patient has a valid aid code and no other restrictions, such as Share of Cost/Spenddown, the claim will be adjudicated as normal. However, if the aid code is not a valid DMC aid code or the patient has other restrictions that make the patient ineligible for the dates of service being claimed, the claim will be denied for the following Claim Status Denial Reason: "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." This is the message that will appear on the Pre-Adjudication screen in Sage for Primary Sage Users and the EOB Remittance Advice, as well as the Claim Denial View in MSO KPI. This denial reason will correspond with the CARC/RARC combination of CO 177 N59 on the subsequent 835 file.

When this denial occurs, providers should take the following resolution steps to validate if the claim can be resubmitted:

1. Ensure the CIN listed on the DMC guarantor is the correct CIN for that patient.
2. Run the Real-Time 270 Eligibility Request in Sage to ensure the MEDS file has the most updated information.
    a. If the patient has a Share of Cost, the MEDS file will show the patient as ineligible at the beginning of the month. When the Share of Cost/Spenddown amount has been reached, the only way to update that information on the MEDS file for the given month is running the 270 Eligibility Request in Sage. Otherwise the information for the current month will not be updated until the following month's MEDS file is loaded.
3. Check the AEVS, Medi-Cal eligibility website, or POS machine to verify current eligibility status for the date of service.
    a. If eligibility from DMC shows eligible, contact the agency's Finance Analyst at SAPC to confirm MEDS file information before resubmitting the claim.
4. If the issue is related to a delay in the Medi-Cal system updating current status, providers should wait until the following month for the next MEDS file to update the patient's status and run the 270 Eligibility Request for the dates of service that were denied.

With these processes in place, providers will have much higher confidence that the claims will not be denied by the State. However, all SAPC approved claims are still subject to State denials for several other reasons outside of SAPC's control. While these processes should limit the risk of a State denial, they will not eliminate that risk completely. To further minimize the risk, providers must check eligibility with the State systems at admission and every subsequent month during treatment, including verifying the aid code is eligible for DMC benefits and the patient's Medi-Cal is assigned to LA County. Additionally, providers should ensure patient information is correct in Sage and matches the provider's EHR, if applicable.

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## Miscellaneous Note Type Value Changes

***Effective 7/1/2021***

(**NEW**) An issue has been identified in the configuration of the Miscellaneous Note Type values in ProviderConnect. For users with the Financial + Clinical (LPHA) access group, an error is occurring where these users will not see the Type values when using the Chrome browser. If users under this access group are experiencing this error using Chrome, the Type values should be visible by using Internet Explorer or Microsoft Edge. If users are unable to see the updated Type values using these browsers, a Sage Help Desk ticket should be submitted either via phone at (855) 346-2392 or through the ServiceNow Portal at https://netsmart.service-now.com/plexussupport.

(Repeat) On Thursday, July 1, 2021, SAPC implemented updated Miscellaneous Note Type values to better support Primary Sage Users in documenting services provided to patients. The changes to the Miscellaneous Note Type values are noted below. SAPC has created a job aid for providers to support understanding of when to use each Miscellaneous Note Type value which is attached to this communication and will be posted on the Sage website at: http://publichealth.lacounty.gov/sapc/providers/sage/resources.htm.

**Important!** Miscellaneous Notes entered prior to these changes will retain the value that was selected when entering the note in ProviderConnect. If Miscellaneous Notes exist with note types from the list of values that will be removed or changed, the note will retain the note type value.

The following values will be **removed** from the dropdown value list:

- Care Coordination
- Disciplinary Actions
- Miscellaneous Note
- Six/Twelve Month Justification
- Skills Development

The following values will be **added** to the dropdown value list:

- Medical Necessity Justification
- Other
- Residential-Physical Health Services
- Residential-Support Services
- Residential-Therapeutic Services
- Residential-Mental Health Services

The following additional **change** will be made:

- Case Conference and Case Review are combined into the new type value: Case Conference/Review

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## ASAM CONTINUUM Update

On Wednesday, July 7, 2021, the American Society of Addiction Medicine will be releasing updates to the ASAM CONTINUUM. Details about the updates made in this version of the software can be found below and on the **ASAM CONTINUUM website**. Updates to the ASAM CONTINUUM are not controlled by SAPC and are implemented directly by ASAM.

**RISE Updates**

- Clinicians administering RISE assessments can now change their selection for controlled environment type (Jail, Prison, etc.) prior to submission without having to create a new assessment.

**Response Updates**

- In the Psychological History Section, the response options regarding the level of severity for "Trouble controlling violent behavior" (ASp07L, ASp07M, ASp07D) and "Serious thoughts of suicide" (ASp08L, ASp08M, ASp08D) have been updated along with the blue circle "i"nformation icon guidance for enhanced clinical accuracy.

**Narrative Report Updates**

- Report output clarity has been improved for "Not sure or possibly" responses to the question, "Does the patient currently have symptoms or signs of intoxication?" (ASm06a). The output, which appears in the *Alcohol & Drug Section* of the Narrative Report, now reads, "It is not clear if the patient has symptoms or signs of intoxication."
- Output in the *Interviewer Impressions and Recommendations – Alcohol and Drugs* sub-section has been updated. It previously read, "It is my belief that [e.g., barbiturates] are [his] most significant substance use problem." The updated sentence reads, "Currently, [barbiturates] are [his] most significant substance use problem."
- The Narrative Report has been streamlined to improve readability: When a patient has never used a substance and therefore answers no questions about alcohol treatment history, we have eliminated repetitive statements about all the drug categories that have never been used from the *Alcohol & Drug Section*.

**Summary Report Updates**

- Language has been updated and streamlined in the *Final Level of Care Recommendations* Specific changes include: (453389, 463687)
    - Dimension 1 Withdrawal Management (WM) and Opioid Treatment Services/Opioid Treatment Program (OTS/OTP) recommendations now appear first, before other Levels of Care that may also be recommended to address patients' needs in Dimensions 2 through 6.
    - If the patient did not meet criteria for BIO, but the interviewer selected "Not sure or possibly" for certain medical assessment questions, there will be a recommendation for additional medical evaluation.
    - Recommendations for OTS and OTP have been edited to improve clarity and avoid redundancy.

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## End of Fiscal Year Reminders

The following are items that were included in prior Sage communications that we are resending due to being relevant to end of fiscal year activities:

- RSS services will not require submission of a member authorizations to SAPC Utilization Management in FY21-22. Billing for these services will be accomplished user Provider Authorizations (aka PAUTH) that will issued to provider agencies during the fiscal year cut over period. Once implemented, providers will be able to bill for RSS services using the same appropriate PAUTH number across multiple patients. While this is intended to aid in implementing the state's new standards for delivery of RSS services, Providers are reminded that they still need to document the rationale and for determining that RSS is the most appropriate level of care for the patient.
- On Thursday, June 3, 2021, SAPC sent out a memo to treatment providers, advising that Thursday, July 8, 2021 is the deadline for submitting all outstanding reimbursement claims for fiscal year 2020-2021 to receive payments by July 23, 2021. Claims received or submitted between July 9-July 31, 2021 will be processed by August 13, 2021. Any claims received or submitted for fiscal year 2020-2021 after July 31, 2021 will be incorporated into the year-end cost report settlement. Questions regarding reimbursement claims can be directed to Edith Mendoza at emendoza@ph.lacounty.gov or (626) 299-3206.
- For secondary providers, please note that authorizations spanning the current fiscal year and the new fiscal year are referred to as "split authorizations." This means that the authorization for the client will have two different authorizations and different authorization numbers for the different fiscal years. When preparing billing for the new fiscal year, please ensure your EHR is updated with the new authorization numbers for the 2021-22 fiscal year for these split authorizations. New auth numbers for split authorizations are already available for providers to access via ProviderConnect.
    - If the prior fiscal year's authorization number is submitted for the client for the new fiscal year, providers will receive local denials with the coverage denial reason "Invalid authorization number" and denial code CO284 M62.

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