SAGE UPDATES

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

All Provider Meeting December 21, 2021

Overview

- Telehealth Modifiers Requirement- 02/01/2022
- State Denials- Reminders and Z Code Denials
- Critical Error Workflow for Secondary Sage Providers
- KPI Data Availability

Telehealth Modifier Requirements

New Telehealth Billing Procedures

Delays in Sage Configuration of Telehealth Modifiers (BHIN 21-047)

SAPC TO BEGIN IMPLEMENTATION ON 02/1/2022

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

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.
- Providers should prioritize dates of service within FY18/19

Z-Code Denials or Multiple RARCs

Denial codes that begin with "zDenial" or have multiple RARCs

These denial code combinations have been discontinued; however they may be seen with historical denials.

A majority of claims with these codes were reviewed by SAPC but could not be corrected by SAPC.

Addressing these codes:

- Ensure the CIN is correct for that patient.

Typically, only one of the RARCs is the cause of the denial.

- Start simple
  - If there are three RARCs, go with the one that is most familiar to you as that is probably the cause of the denial (N327, MA39, N424).

NOTES: Most of these type of denials were CIN related issues where there was a typo, or was the CIN for a different patient

Multiple RARC Examples

Most common denial codes with multiple RARCs:

- zDenial CO 16 N327 N570
- zDenial CO 96 N327 M20 N424

SAMPLE TROUBLESHOOTING FLOW

z = claim from previous fiscal years

Multiple RARCs = Correct the obvious issues, such as DOB or CIN

CO 16 and CO 96 are both generic for something didn't match approval criteria

N327 = Date of Birth discrepancy between Sage and DHCS

- Very common code and most likely the issue

N424 = out of county issue

- very common could also be the issue , if DOB was not.

M20 = Error with HCPCS code entered – not likely the issue

N570 = site not certified for service delivered- less likely to be the issue, investigate this last

General Workflow for Correcting State Denials

Check CIN matches on Beneficiary Identification Card or Medi-Cal system

This tends to be the most common error SAPC has found during investigation

Either a typo or wrong CIN for that patient

Verify Aid Code for date of service

Providers are required to keep records of eligibility verification at admission and monthly during treatment.

For Co 177 denials, providers should first check the eligibility record on file to verify the Aid Code is DMC eligible

Keep Calm and "Don't Underestimate the power of the Tools"

SDMC Aid Code Master Chart SAPC developed resources	Keep the eligibility records readily available for future validation

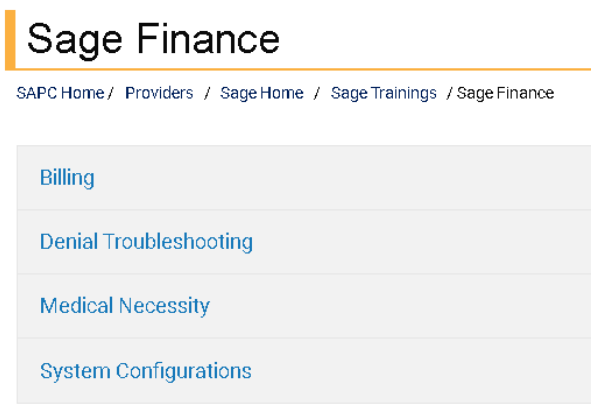
SAPC Resources

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

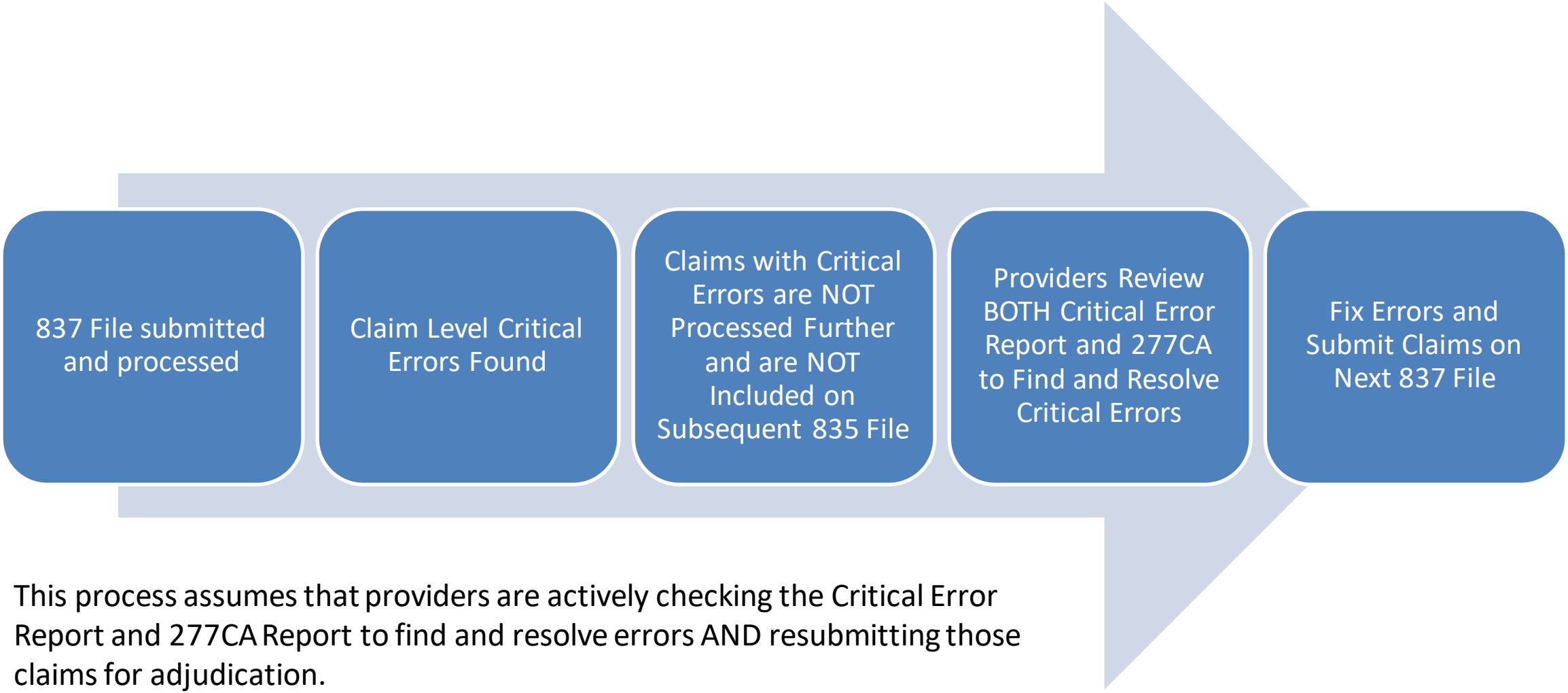
Sage Website→Sage Trainings→Finance

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



Critical Error Workflow For Secondary Sage Users

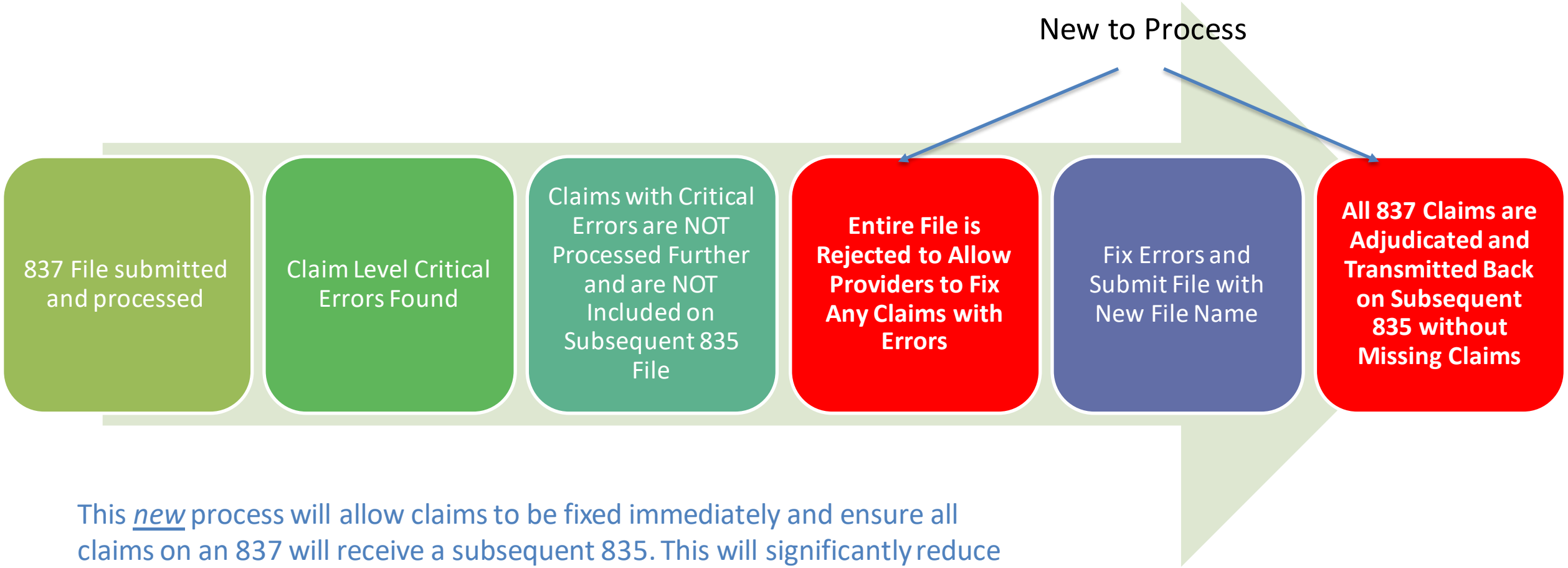
Critical Errors- Current Process



This process assumes that providers are actively checking the Critical Error Report and 277CA Report to find and resolve errors AND resubmitting those claims for adjudication.

835 files will not contain claims with critical errors as they were not processed. Therefore, these claims can remain unbilled if providers are not reviewing, fixing and resubmitting those claims.

Critical Errors- Proposed Process



This *new* process will allow claims to be fixed immediately and ensure all claims on an 837 will receive a subsequent 835. This will significantly reduce the number of 'missing claims.'

Additionally, 277CA files will only be created for files without critical errors and will display only accepted claims to be adjudicated.

Please note: This is only a proposed workflow. No imminent changes to processes will be made prior to discussion with providers

Comparison of Critical Error Processes

Current Process

- All files are processed regardless of errors
- Claims with errors will not be adjudicated or found on 835s
- Providers must review both Critical Error Report and 277CA to fully resolve critical errors
- Must create a second 837 file for the same claim
- Only staff with access to the SFTP who receive the Critical Error Report will know there were issues to be corrected

Proposed Process

- **Entire file will be rejected if file contains any critical error to reduce 'missing' claims**
- **Email will be sent to designated staff alerting that the file was rejected**
- **Critical Error Report will show what and where the error is for preventative correction**
- **Providers will only need to review Critical Error Report and not the 277CA to find and correct errors.**
- **Once corrected, the file must be resubmitted with a different file name**
- **All claims on an accepted file will show on subsequent 277CA, EOBs and 835s.**

Please review the Critical Error Report Guide for 837 Files for more details

KPI Data Availability

KPI Claiming/Billing Data

On January 1, 2022, KPI data will be truncated to ensure performance of KPI

All claims data for FY 18/19 to the present will remain intact

- KPI will no longer show claims/billing information for FY 17/18

***Providers are encouraged to export any data needed for FY 17/18 by 12/31/2021.
To download data: Right click on a particular table or graph and select “Download As” then select the data type to download. (Selecting download as “Data” will result in an Excel spreadsheet***