Substance Use Disorder Information System

Communication Release

6/18/2021

Miscellaneous Note Type Value Changes

Effective 7/1/2021

On Thursday, July 1, 2021, SAPC will be implementing 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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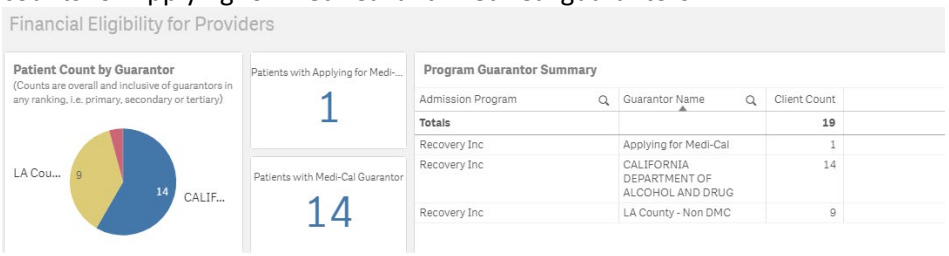
Critical Error Reports

Effective Monday, June 21, 2021, SAPC will implement an automated process that will upload the Critical Error Reports for incoming 837 files to each provider's SFTP. This process will start with new incoming files initially. However, SAPC IT is working to also upload historical Critical Error Reports for providers. In conjunction with the 277CA report, providers will have increased visibility on which claims were rejected and why they were rejected. As a reminder, rejected claims are NOT adjudicated, meaning they were not approved, denied or pended, but noted as rejected and must be resubmitted for adjudication. The Critical Error Report provides the claim level information for the rejected services, while the 277CA provides the service level information for the errored claim. For providers that submit files within one service to one claim format, these two reports will have a 1:1 claim to service ratio. However, for those with claims that have multiple services, there will be one line item on the Critical Error Report that can represent multiple rejected services on the 277CA. Please review the guidance document attached to this communication and the related section of the 6/8/2021 provider meeting found here Sage and Billing & Denial Resolution Update. For questions related to how to utilize or interpret these reports, please contact the Sage Helpdesk by phone at (855) 346-2392 or via the Sage Help Desk ServiceNow Portal: https://netsmart.service-now.com/plexussupport. For files to be re-uploaded to the SFTP, providers can complete this IT request form and email to SapcProviderReq@ph.lacounty.gov.

Financial Eligibility KPI View

To better assist providers track and follow the 30 day Applying for Medi-Cal policy outlined in SAPC IN 21-02, SAPC has developed a new KPI Financial Eligibility View on the PM KPI Dashboards. The Financial Eligibility for Providers sheet provides both summary and detailed information related to the Financial Eligibility and guarantor data for all patients enrolled at a provider agency with a submitted Financial Eligibility form. Providers can use this sheet to verify overall or specific patients with a particular guarantor for the agency or for a specific program site at the agency.

The top half of the sheet shows the overall agency counts per guarantor included on the Financial Eligibility form within Sage. If only one guarantor is selected, the pie chart will change to only show that guarantor. However, the Patients with Applying for Medi-Cal Guarantor and Patient with Medi-Cal Guarantor objects will not be affected if a particular guarantor is selected. These two objects will always show counts for Applying for Medi-Cal and Medi-Cal guarantors.



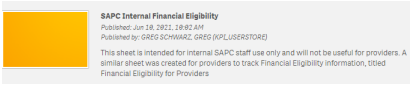
The bottom half of the sheet will display patient specific information based on any filters selected. This information is useful to see which specific patients have a certain guarantor and to verify the information needed for billing. The Client Index Number (CIN), Policy Number and County from the Financial Eligibility are listed in the table to allow for additional validation of the data. To assist with tracking Applying for Medi-Cal patients, when the Applying for Medi-Cal guarantor is selected as the filter, additional columns for dates of service are added. This will show the first date of service and last date of service billed under Applying for Medi-Cal that have been paid by SAPC. Because this is a PM KPI Dashboard sheet, the services will only populate after a check has been issued, which is different than MSO which will display claims immediately after adjudication.

Patient Guarantor Detail
Patient Count (1)

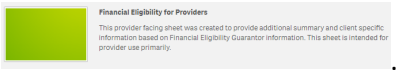
PATID	Admission Program	Guarantor Name	CIN Number	Policy Number	County on F.E.	Applying for Medi-Cal First Date of Service	Applying for Medi-Cal Last Date of Service	Service Count
Totals						-	-	**0**
212215	Recovery Inc	Applying for Medi-Cal	N/A	12345678901...	Not California County	-	-	0

In this example, Applying for Medi-Cal is set as the filter, which allows the columns outlined in red to show, however, there are no associated paid claims for that patient to populate. This could be because the provider has not yet billed, or the claims have not been paid on an actual check. Additionally, for this patient, the Financial Eligibility shows a county that is outside of CA. This column was added to help providers ensure that patients reside within LA county or have their DMC assigned to LA County. For those that are not assigned to LA County, providers should be using the Applying for Medi-Cal option if eligible.

Please note that there are two similar sheets for Financial Eligibility within PM KPI Dashboards. The sheet with an orange icon



is for SAPC internal use only and will not display any useful information for providers. Providers should be using the Financial Eligibility for Providers sheet which is indicated by a green icon



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Information on Denial Code CO 96 MA43

The State has a pending draft Information Notice with updated language related to denial code CO 96 MA43. SAPC is conferring with the State to ensure there is an understanding of circumstances which may cause this denial. SAPC has updated Sage configuration to not

automatically retro adjudicate these claims until we get clarification from the State. Providers who received claims with this denial code should resubmit/replace these claims at this time. These claims will be re-adjudicated at the local level and will not be automatically recouped if denied by the state.

End of Fiscal Year Reminders

- (**NEW**) 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.
- (Repeat) 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.
- (Repeat) Providers should not submit claims for services conducted on or after July 1, 2021 until SAPC has notified agencies that the rates and system configurations for fiscal year 2021-22 have been completed. If claims are submitted for services conducted on or after 7/1/2021 before notification of completion of the configuration, these services will be automatically denied by Sage. Providers can continue to submit claims with service dates of 7/1/2020-6/30/2021 throughout July 2021.
- (Repeat) 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.
- (Repeat) With the change in fiscal years, the KPI Dashboards will no longer contain data from January 1 – June 30, 2018 as of July 1, 2021. If there is particular data that providers would like to retain, SAPC suggests exporting the necessary data from KPI prior to June 30, 2021.

Critical Error Report Guide for 837 Files

Published: 6/18/2021

Contents

Overview

This document provides information for Secondary Sage Users only who submit claims via the 837 EDI HIPAA transaction process. This does not apply to Primary Sage Users, or those who submit claims using Sage/ProviderConnect.

Critical Error Categories

There are two categories of critical errors related to 837 files that can cause issues with the processing of an 837 file.

Functional/Structural Error (File level)

The first category is a general functional error where there are missing or invalid structural components within the file that prevent the entire file from being processed. Currently, when these errors occur, providers are notified via email by SAPC IT that the entire file was rejected and the segment containing the error must be corrected before the file can be processed. This is standard process within Sage and has not changed.

Critical Error (Claim level)

The second category of critical errors relates to the claim level within each 837 file that causes claims to be rejected, but the file to continue to process the remaining valid claims. Accepted and rejected claims are noted on the corresponding 277CA file, which is sent to providers via the SFTP. However, the actual segment and erroneous information that is missing or invalid may not be contained in the 277CA. As such, SAPC will be implementing a process, effective Monday June 21, 2021, that will automatically provide the Critical Error Report to providers via the SFTP, along with the other current files that are uploaded to the SFTP for providers to review. This new report is in addition to the current files being uploaded to the SFTP and is intended to enhance troubleshooting ability for providers.

In conjunction with the 277CA report, providers will have increased visibility on which claims were rejected and why they were rejected. As a reminder, rejected claims are NOT adjudicated, meaning they will not be approved, denied, or pended, but noted as rejected and must be resubmitted for adjudication. The Critical Error Report provides the claim level information for the rejected services, while the 277CA provides the service level information for the errored claim. For providers that submit files within a one service to one claim format, these two reports will have a 1:1 claim to service ratio. However, for those with claims that have multiple services, there will be one line item on the Critical Error Report that can represent multiple rejected services on the 277CA.

While investigating provider reports of “missing” claims or “missing” 835s, SAPC has identified a primary reason for “missing” claims was related to claims being rejected and not fixed and resubmitted by providers. SAPC is adding the Critical Error Report to the 837 workflow to improve providers ability to reconcile 837 files with resulting 835 files and reduce the volume of resulting 835 files.

837 Submission with Critical Error Report Workflow

The following example will outline a typical process for utilizing the Critical Error Report to investigate rejected claims for correction and resubmission.

1. 837 file submitted to SAPC via SFTP.
2. File is automatically processed.
3. Sage system validates the entire file for standard functional/structural deficits.

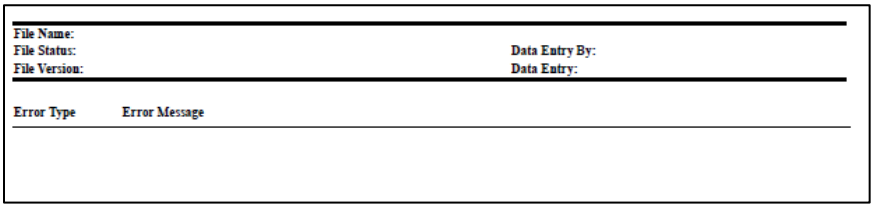
a. If functional critical errors are present, the entire file will be rejected and an email will be sent to providers to correct the specific segment that is erroring out.

b.

Notes
Missing Required Segment. Unable To Determine Loop Information.Loop: 2310B Segment: CLM. The claim is missing other segments. The file was rejected.

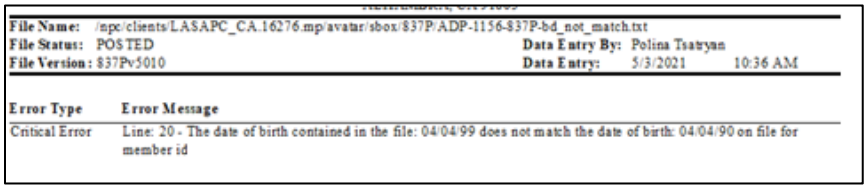
   i. In this situation, the provider would need to correct the 2310B Loop, CLM Segment to ensure all require elements are present according to the corresponding 837p or 837i companion guide.
   ii. Once corrected, the file must be renamed before it is resent.

4. If the file does not contain any functional errors, the system moves to validating at the claim level and the corresponding Critical Error Report and 277CA will be generated.
   a. If no critical errors exist, a blank report will be generated and sent to providers on the SFTP. The file name of the blank report will indicate the corresponding 837 file.



5. When critical errors are present, the Critical Error Report will provide specific information on what the error is and where in the file it was found.
6. The Critical Error Report will be sent to all Secondary Sage Users via the SFTP.
   a. The report will display the following header information to assist in locating the corresponding 837 file:
      i. File name
      ii. File status: Compiled or Posted
      iii. Data Entry time and date
   b. The Error Type and Error message will be displayed in the body of the report
      i. Critical Errors are those that prevent the claim from being adjudicated

a.



   i. This sample error indicates the date of birth in the provider's EHR does not match the date of birth in Sage.
   ii. The provider should reconcile these two dates of birth by confirming the correct date of birth and correcting it either in Sage (Must be corrected on both the Client Demographics and on the Financial Eligibility) or the provider's EHR and submit a new claim for the rejected services. (To correct the date of birth in Sage, providers must submit a Sage Helpdesk ticket)
      1. The specific rejected services will be available on the 277CA if needed. However, since this is related to the claim level, all services related to that claim will be rejected and need to be resubmitted.

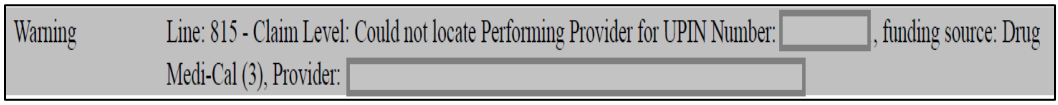
(Sample 277CA)

Claims Accepted:	0	Charges:	0.00
Claims Rejected:	1	Charges:	25.00

#	Policy Num	Patient Name	Service Date (From - Thru)	Charges	Status
1	MSO160406	OHC,TEST	7/18/2020 - 7/18/2020	25.00	A7:0

2. In this situation, once the DOB is corrected, it will apply to all services under that claim and allow them to be accepted once resubmitted.

ii. Warning messages display on the Critical Error Report as well, but will not result in a rejected claim and will proceed to adjudication. However, they will likely be denied at adjudication.

a. 

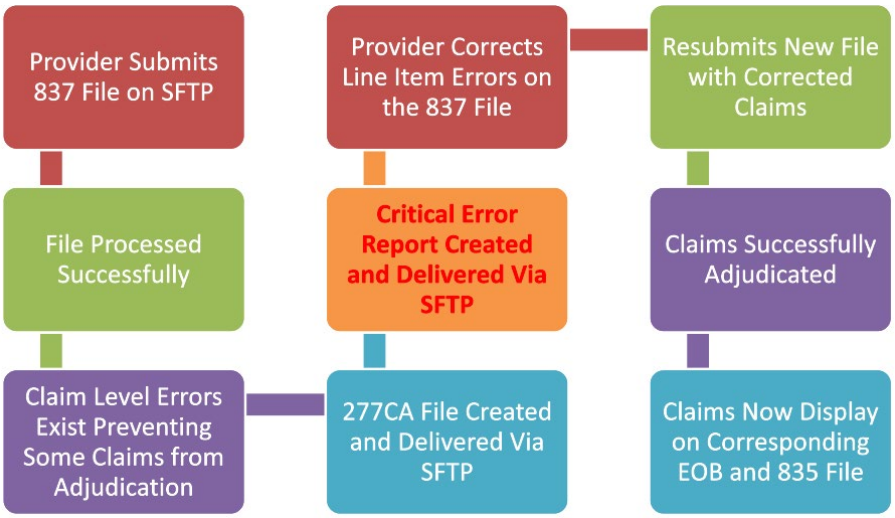
i. This message indicates the performing provider NPI was either missing or invalid (does match a performing provider for that agency configured in Sage).

ii. Warning messages will relate directly to denial reasons on a resulting EOB/835.

7. Rejected claims will not appear on the EOB as they were not adjudicated, however, may appear on the resulting 835 for informational purposes only since there is no adjudication.
   a. When present on an 835, the rejected claim will have a corresponding Claim Adjustment Reason Code (CARC) Group of OA or Other Adjustment and a CARC code.
      i. This has historically been transmitted as OA D6, OA 16 or OA 17
         a. OA 18 and OA 109 are the only current Other Adjustments that represent an actual denial. All other OAs that display on an 835 file likely relate to a rejected claim.
   b. When rejected claims display on the 835, the NM108 segment will contain the original PATID formatting including the 'MSO' portion.
      i. Accepted claims on 835 only show the number portion without the 'MSO' prefix.
      ii. Rejected claims may also show in Sage/ProviderConnect on the "Services Denied in MSO" report, also showing with a PATID with the 'MSO' prefix.

Recovery Inc,	MSOXXXXX	3/8/2021	The date of birth contained in the file does not match the date of birth on file for member id	Individu Counsel
Recovery Inc,	MSOXXXXX	3/15/2021	The date of birth contained in the file does not match the date of birth on file for member id	
Recovery Inc,	MSOXXXXX	3/15/2021	The date of birth contained in the file does not match the date of birth on file for member id	Individu Counsel

8. Once critical errors are fixed, providers can then resubmit the previously rejected claims in a new 837 file.
   a. Note: Providers should contact their EHR vendors to ensure rejected claims on the 277CA are able to be processed in the provider's EHR.
   b. If correctly resolved, the claims should now be accepted after being resubmitted and pushed to the adjudication stage.



Types of Critical Errors with Resolution

Below is a list of the most frequent critical errors that cause claim rejections. The list is arranged by highest to lowest occurring errors. Errors that have never occurred or occur in less than 1% of claims are excluded from the list.

Error Type	Error Explanation/Resolution
The date of birth contained in the file does not match the date of birth on file for member ID	This critical error is the most frequently occurring error within the system. Date of birth in the primary EHR, used to create the 837 file, does not match the DOB for that patient in the Demographics form Sage. Provider needs to ensure the DOB in both system matches.
Member does not exist in the MSO System	Member ID on 837 file does not include the MSO prefix or the PATID itself is invalid and does not match a PATID within Sage for that provider.
An 'Original Reference Number' (2300-REF*F8) is required for claims marked as a void or replacement	The claim frequency code for the claim is entered as 7 for replacement or 8 for void, but the PCCN field is invalid or missing.
Unbalanced Claim	The sum of the services within the claim do not equal the total claim amount. Providers need to ensure all services are listed for the claim and that the corresponding charge amounts equal the total charge amount on the claim level.
A valid 'Original Reference Number' (2300-REF*F8) is required for claims marked as a void or replacement	The Original Reference Number listed on the void or replacement claim must match the exact PCCN listed on the corresponding 835 file for that claim.
Procedure Code Not Defined In MSO CPT Code Table	Procedure code listed on the claim or services does not match a valid procedure code configured within Sage. Sage is configured to only include HCPCS codes listed on the Treatment Rates and Standards Matrix for that fiscal year.
Invalid diagnosis code	Diagnosis code on the 837 is in an invalid format. A claim will **NOT** be rejected due to including a non-DMC reimbursable diagnosis. This error is only related to the formatting of the diagnosis code if it does not match the parameters set forth in the companion guide.

The 'Original Reference Number' (2300-REF*F8) provided is for a claim for a different member Id.	The Original Reference Number listed on the replacement or void claim matches a known PCCN in the system but does not match the PCCN from the original 835 file for that patient and claim.
Cannot determine member through name and policy number	The member name and policy number (“MSO”+PATID) is not in the correct format or does not match a patient within the Sage system.
A void or replacement has already been filed for this Payer Claim Control Number.	The Original Reference Number listed in 2300-REF*F8 is valid but has already been utilized for another replacement or void claim. The PCCN is unique for each claim or service and is not duplicated.
Invalid 'Principal Procedure Code (2300-HI01-2)'.	The Principal Procedure Code used does not match a current HCPCS code in the system, either due to invalid format or the code is not a reimbursable code.
Invalid Diagnosis Reference	This occurs when the diagnosis code pointer does not correspond with the correct diagnosis or is not in the correct order. The diagnosis reference is related to 2400-SV1-07
Revenue Codes Not Defined In MSO REV Code Table	Occurs for 837i claims only. Revenue code listed on the claim or services does not match a valid revenue code configured within Sage. Sage is configured to only include revenue codes listed on the Treatment Rates and Standards Matrix for that fiscal year.
Invalid date range.	Claims submitted with a date range, much indicate the appropriate Date Time Period Format Qualifier in DTP02 of RD8. If the claim is submitted with a date range for D8 qualifier, this will cause an error. Or if the claim is submitted as a single date with the RD8 qualifier, this will also result in an error.
Missing Admitting Diagnosis	This error refers a process within Sage where a valid Admission Type of Diagnosis must be entered on the Provider Diagnosis (ICD-10) form for a claim to be successfully processed. If the diagnosis on the claim does not correspond with the admission diagnosis in Sage, an error will occur.

Miscellaneous Note Type Value Definitions

Published: 6/18/2021

Misc. Note Type	Used to Document
Assessment	The assessment process or procedure was completed. An assessment is the process for defining the nature of an issue, determining a diagnosis, and developing specific treatment recommendations for addressing the problem and/or diagnosis. This miscellaneous note type is used to document initial intake procedures/forms were completed and the initial assessment or any subsequent assessments during the treatment episode.
Case Conference/Review	A meeting or discussion with the patient and treatment team/health care team to assess and monitor the patient's treatment and/or chart to ensure the appropriateness and effectiveness of the quality of treatment and to ensure adherence to all treatment standards.
Case Management	Activities to assist patients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, and/or other community services.
Collateral Contact	Sessions between one (1) clinical treatment provider, one (1) patient (unless clinically inappropriate for the patient to be present), and significant person(s) in the patient's life.
Discharge Planning/Summary	The development of the patient's **planned** discharge. The Discharge Plan shall include, but not be limited to, the following: • A description of each of the beneficiary's relapse trigger(s) • A plan to assist the beneficiary to avoid relapse(s) • A support plan
Family Therapy	Psychotherapy, involving both the patient and their family members, that uses specific techniques and evidence-based practices (e.g., family systems theory, structural therapy, etc.). These treatment services must be provided by a Licensed Practitioner of the Healing Arts (LPHA) level therapist.
Medical Necessity Justification	Explanation establishing and justifying how a patient meets medical necessity for the requested Level of Care. The note should demonstrate appropriate placement in a substance use disorder Level of Care that is consistent with recommended treatment services and medical necessity based on the current edition of the American Society of Addiction Medicine (ASAM) Criteria. The note should be finalized by the LPHA. Additionally, this note type should be used for medical necessity justification of ongoing treatment services.
No Shows	Any instance where a patient does not attend a planned activity.
Others	Any other activities that not covered in this table. Examples of other activities include non-billable services that need to documented, including but not limited to administrative paperwork, administrative discharge, document messages left for the patient, and unplanned discharges.
Residential-Mental Health Services	Residential activities related to the assessment, diagnosis, treatment, and/or counseling by a licensed mental health professional to assist a patient in alleviating mental or emotional illness, symptoms, conditions, or disorders. This note type is used to document service hours included in the weekly requirements.
Residential-Physical Health Services	Residential activities related to the assessment, diagnosis, treatment, and/or counseling by a licensed medical professional to assist a patient's physical health. This note type is used to document service hours included in the weekly requirements.

Miscellaneous Note Type Value Definitions

Published: 6/18/2021

Residential-Support Services	Residential activities related to: • Alcohol and/or drug testing to detect the presence of specific drugs and determine prior drug use. In general, the testing should not exceed more than twice a week. • Safeguarding Medications means facilities will store all residents' medication(s) and facility staff members may assist with residents' self-administration of medication(s). • Schooling for up to ten (10) hours per week (youth patients only) • Non-Emergency Transport provisions of or arrangement for transportation to and from medically necessary treatment. This note type is used to document service hours included in the weekly requirements.
Residential-Therapeutic Services	Organized residential program activities that are designed to meet treatment goals and objectives for increased social responsibilities, self-motivation, and integration into the larger community. Such activities would include participation in the social structure of the residential and/or outpatient program(s). This will also include the patient's progression with increasing levels of responsibilities and independence. This note type is used to document service hours included in the weekly requirements.
Treatment Plan(s) Review/ Development	This activity is associated with the review and development of the patient's Treatment Plan(s) in accordance with the guidance provided in the Substance Abuse Prevention and Control's Provider Manual for Substance Use Disorder Treatment Services.