BILLING & DENIAL RESOLUTION TUTORING LAB

DECEMBER 5, 2024

ATTENDANCE SURVEY

While you wait for today's lab to begin, please complete the brief form linked on this slide (use the QR code) to indicate your attendance.

https://forms.office.com/g/pNNsNMndrg

Billing & Denial Resolution Tutoring Lab Attendance

HOUSEKEEPING

- Today's session will be recorded and posted to the Sage website along with the presentation slides.
- If you have questions during the session, please enter them into the Q&A and not the chat.
  - We will try to answer questions from the Q&A as we go through the tutoring session if they are applicable to the topic, otherwise, they will be answered at the end as time permits.
  - An FAQ will be produced following each tutoring lab and posted to the Sage website.
- If you have a question on the topic being discussed, you can also use the "Raise Hand" feature.

- Announcements and Reminders
- Tutoring Session Topics
  - Guidance on H2010M/N/S
  - Using the Denial Crosswalk
- Open Q&A

ANNOUNCEMENTS & REMINDERS

UPCOMING DEADLINES

- **December 31, 2024:** FY 22-23 final billing deadline
- ~~**December 31, 2024**~~ **January 14, 2025:** FY 23-24 June through December services final billing deadline
- **March 31, 2025:** FY 23-24 January-June services final billing deadline (original services)
  - Replacement services for these service dates (January-June 2024) is 365 days from the date of service.

REMINDERS FROM 11/22/2024 SAGE COMMUNICATION

- **State Denial Updates**
  - CO 107 – Sage configuration issue found and should be resolved within the next week; services can be resubmitted to SAPC now
  - CO 177 – For patients who are undocumented with Medi-Cal, services should be resubmitted to SAPC; working with DHCS to resolve receiving this denial code for these beneficiaries
  - CO 97 M86 for H2010M/N/S – Sage configuration issue was found and corrected; services can be resubmitted to SAPC
- **Claim Status Report** – October and November 2024 reports were delayed in posting to the SFTP; resolved and posted to the SFTP on 11/15/2024
- **P-Auths for Field Based Service transportation mileage (A0080-F)** for FY 24-25 available for approved FBS agencies
- **T1013 – Interpretive Services** rate adjustment to $30.92 for all provider tiers and allowable performing provider license types; services can be replaced to receive new rate

PCNX REPLACEMENT CLAIM PROCESS COMING SOON

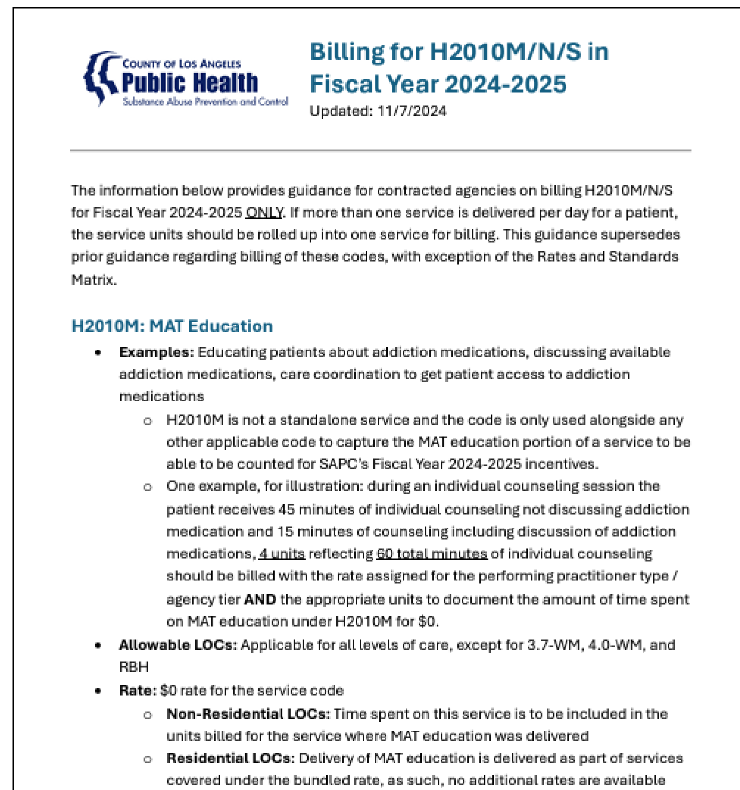
- For Primary Sage Users, the SAPC Finance team is preparing to train agencies and launch new PCNX functionality that will allow users to submit replacement claims soon.
- If you are interested in becoming a pilot provider, please reach out to SAPC-Finance@ph.lacounty.gov and we will reach out to schedule training. We are looking for at least two more pilot providers to test within the next couple of weeks.
- We are hoping to launch the new functionality in very late December/early January and this will include a webinar to introduce the process and a guide on how to use the functionality and other supporting information.

TUTORING SESSION

BILLING GUIDANCE ON H2010M/N/S

NEW BILLING GUIDANCE DOC FOR H2010M/N/S FOR FISCAL YEAR 24-25

- Billing guidance for FY 24-25 H2010M/N/S posted to the Sage website
- Provides examples of the services included as part of the codes and how to bill it



County of Los Angeles Public Health Substance Abuse Prevention and Control

Billing for H2010M/N/S in Fiscal Year 2024-2025

Updated: 11/7/2024

The information below provides guidance for contracted agencies on billing H2010M/N/S for Fiscal Year 2024-2025 ONLY. If more than one service is delivered per day for a patient, the service units should be rolled up into one service for billing. This guidance supersedes prior guidance regarding billing of these codes, with exception of the Rates and Standards Matrix.

H2010M: MAT Education

- **Examples:** Educating patients about addiction medications, discussing available addiction medications, care coordination to get patient access to addiction medications
  - H2010M is not a standalone service and the code is only used alongside any other applicable code to capture the MAT education portion of a service to be able to be counted for SAPC's Fiscal Year 2024-2025 incentives.
  - One example, for illustration: during an individual counseling session the patient receives 45 minutes of individual counseling not discussing addiction medication and 15 minutes of counseling including discussion of addiction medications, 4 units reflecting 60 total minutes of individual counseling should be billed with the rate assigned for the performing practitioner type / agency tier **AND** the appropriate units to document the amount of time spent on MAT education under H2010M for $0.
- **Allowable LOCs:** Applicable for all levels of care, except for 3.7-WM, 4.0-WM, and RBH
- **Rate:** $0 rate for the service code
  - **Non-Residential LOCs:** Time spent on this service is to be included in the units billed for the service where MAT education was delivered
  - **Residential LOCs:** Delivery of MAT education is delivered as part of services covered under the bundled rate, as such, no additional rates are available

H2010M: MAT EDUCATION

Clarification: H2010M is not a standalone service and the code is only used alongside any other applicable code to capture the MAT education portion of a service to be able to be counted for SAPC's Fiscal Year 2024-2025 incentives.

Allowable LOCs: Applicable for all levels of care, except for 3.7-WM, 4.0-WM, and RBH

Rate: $0 rate for the service code

- Non-Residential LOCs: Time spent on this service is to be included in the units billed for the service where MAT education was delivered
- Residential LOCs: Delivery of MAT education is delivered as part of services covered under the bundled rate, as such, no additional rates are available

H2010M EXAMPLES

Examples of MAT Education

Educating patients about addiction medications, discussing available addiction medications, care coordination to get patient access to addiction medications

Example Scenario

During an individual counseling session, the patient receives 45 minutes of individual counseling not discussing addiction medication and 15 minutes of counseling including discussion of addiction medications.

4 units reflecting 60 total minutes of individual counseling should be billed with the rate assigned for the performing practitioner type / agency tier AND the appropriate units to document the amount of time spent on MAT education under H2010M for $0.

H2010N: NALOXONE HANDLING/DISTRIBUTION

Clarification: H2010N is not a standalone service and the code is only used alongside any other applicable code to capture that Naloxone education and/or distribution was delivered to be able to be counted for SAPC's Fiscal Year 2024-2025 incentives.

Allowable LOCs: Applicable for all levels of care, except for 3.7-WM, 4.0-WM, and RBH

Rate: $0 rate for the service code

- Non-Residential LOCs: Time spent on this service is to be included in the units billed for the service where naloxone was discussed and distributed
- Residential LOCs: Handling and distribution of naloxone and other medication is billable under the H2010S rate, but if care coordination involving staff working with a pharmacy to coordinate the patient receiving pharmacy-dispensed naloxone, care coordination units can be billed instead of H2010S for care coordination services that include naloxone.

H2010N EXAMPLES

Examples of Naloxone Handling/Distribution

Discussing naloxone with a patient and distributing naloxone to the patient. Simply providing the patient naloxone does not count towards billing this code, must include discussion of naloxone with the patient.

Example Scenario

A patient is handed naloxone on their way out of the door from a group counseling session that did not include discussion of naloxone. The provider cannot bill for H2010N simply for providing the naloxone.

H2010S: MEDICATION HANDLING/SAFEGUARDING

Clarification: H2010S is a standalone service.

Allowable LOCs: Applicable for residential LOCs only

Rate: Flat rate per service delivered to the patient. This is billable per service (handling episode) regardless of the number of medications involved per episode.

H2010S EXAMPLES

Examples of Medication Handling/Distribution

Handling medications for patient self-administration, documenting medication information in a medication log, securing medication, locking storage cabinets, securing climate-controlled environments, distributing medications (allowed for any legitimately prescribed medications not restricted to addiction medications)

Example Scenario

If an eligible practitioner handles 2 medications for Patient A and 10 medications for Patient B during a morning pill-call, there would be one H2010S service billed for each patient. If that same practitioner handles an evening pill-call service for these same patients, there would an additional H2010S service billed for each patient.

H2010 FOR CENS AND RECOVERY SERVICES

- The units for the time spent delivering the service billed under H2010M or N can be rolled up into either H2015 or H2017 based on the service where the MAT education or naloxone handling/distribution was delivered.
  - For example, if MAT education was delivered during group counseling, the associated units would be billed under H2017.

Allowable RS/CENs Codes	Pre FY 23-24 Code
H2015: Comprehensive Community Support Services	H0038-R: Recovery Monitoring H0038-S: Relapse Prevention T1017: Care Coordination
H2017: Psychosocial Rehabilitation	90846/90847: Family Therapy H0001: Assessment H0004: Individual Counseling H0005: Group Counseling

DOCUMENTING H2010M/N SERVICES

- SAPC is working on guidance for providers on how to document services where MAT education and naloxone handling/distribution occurs.
- Until updated guidance has been issued, providers should continue to document these services as they currently have been.
- For guidance and support on documenting these services, please reach out to SAPC.QI.UM@ph.lacounty.gov and SAPC.CST@ph.lacounty.gov.

HOW TO USE THE DENIAL CROSSWALK

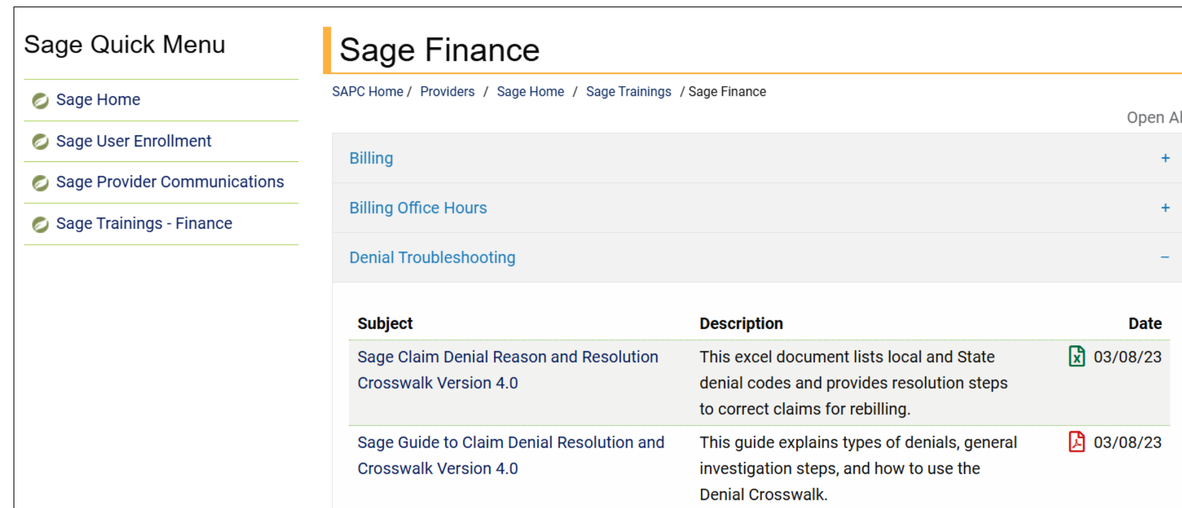
DENIAL CROSSWALK

What is the Denial Crosswalk?

- An Excel document that identifies various local and State denial codes/reasons received for denied services, what the cause of the denial is, and how to resolve it.

Where is it located?

- On the Sage website under the Sage Trainings – Finance page, then under the Denial Troubleshooting section.



HOW TO USE THE DENIAL CROSSWALK

- Identify if the denial is a local or State denial, then click on the appropriate tab – "State Denial" or "Local Denial"
  - "Local Denial" is for denials received from SAPC upon submission to SAPC
    - Primary Sage Users: EOBs will show the local denial reason under the service line

Contract #	Contract Type	Date of Service	Status	CPT Code
	DMC	11/10/2024	D	H2014:U1

The service was denied for the following reason: Performing Provider is blank.

    - Secondary Sage Users: EOBs will show the local denial reason under the service line & the denial code will be on the 835
  - "State Denial" is for denials received from SAPC upon submission to DHCS
    - These show as retros (aka takebacks) on EOBs, 835s, and in KPI; the denial reason will start with "Denial CO…)

Adj Amt	Adjustment Reason
$-73.56	Denial Co 16 N327
$-73.56	Denial Co 16 N327
$-810.74	Denial Co 16 N327
-957.86	

READING THE DENIAL CROSSWALK

- On the appropriate tab of the Denial Crosswalk, identify the row for the denial received and review the cause and resolution.
  - **Column A: Denial Code**
    - For Local denials, this is used by Secondary Sage Users to review denial codes received on 835s. For Primary Sage Users, these codes are not viewable and column C would be used to find the appropriate row of information to review.
    - For State denials, this column would be used to find the code received on an EOB and/or 835.
  - **Column B: Claim Adjustment Reason Code (CARC)-Remittance Advice Reason Code (RARC) Definition per X12.org**
    - Definition of the code based on the standard X12.org descriptions used for EDI transactions
  - **Column C: DMC Description (State Denial tab) / Denial Reason or Explanation of Coverage Message from Sage (Local Denial tab)**
    - Local Denial tab: This is the denial message on the EOB and what's viewed in KPI as the denial reason.
    - State Denial tab: This is the description from the State's CARC/RARC description list of the denial reason.
  - **Column D: Resolution**
    - Identifies known causes of the denial and provides resolutions to resolve the denial.

RESOLVE AND REBILL

- Once the resolution is identified, make corrections on the claim and/or patient record and then rebill the service.
  - Primary Sage Users: Currently, only submission of a new service is currently available until the replacement claim process is enabled.
  - Secondary Sage Users: Replace the service via 837.
  - The resubmission of a State denial does not need an associated void of the original service.

EXAMPLE

- Local denial received: "Funding source not eligible on date of service for member."

Denial Code	Claim Adjustment Reason Code (CARC)-Remittance Advice Reason Code (RARC) Definition Per X12.org	Denial Reason or Explanation of Coverage Message from Sage	Resolution
CO200 MA129	Expenses incurred during lapse in coverage (200) This provider was not certified for this procedure on this date of service. (MA129)	Funding source not eligible on date of service for member.	**Causes:** - Date of service is outside of the service authorization start and end dates - Date of service is prior to episode start date for the provider. Episode start dates reflect the first ever admission by the patient to the provider. This date will not change if the patient discharges and re-admits. Treatment admissions are tracked through the Cal-OMS admission and discharges. If the episode start date was manually entered for a date after the admission, this will result in a denial. **Resolutions:** - Validate the start and end dates of the authorization billed against and if the appropriate authorization was billed against; if the wrong authorization was selected, resubmit the service with the correct authorization number. If a new authorization is needed, submit a Service Authorization request. - If the episode start date was incorrect: a) **Primary Sage User Resolution:** If the date of service was incorrect, resubmit claim with actual date of service. If the episode start date is incorrect, submit a helpdesk ticket and attach documentation showing the correct episode date. Once episode date is corrected, resubmit claim. b) **Secondary Sage User Resolution:** If the date of service was incorrect on the 2400 loop, DTP segment, DTP03 element, resubmit claim with actual date of service. If the episode start date is incorrect, submit a helpdesk ticket and attach documentation showing the correct episode date. Once episode date is corrected, resubmit claim.

EXAMPLE

- Resolution: Review Service Authorization Form

Opening: **Service Authorization**

Home > Select Client >

✓ **Selected Client :** CARLA, TEST (000148387)

Select Record

Provider	Auth #	Begin Date	End Date	Authorization Status	Auth Grouping	Benefit Plan
1-Recovery, Inc.	110922	06/01/2022	06/10/2022	Pending	ASAM 1.0 - 21 and Over	2-Non-DMC Services
1-Recovery, Inc.	110831	12/01/2017	06/30/2018	Approved		1-DMC SUD Services
1-Recovery, Inc.	110745	01/01/2022	01/30/2022	Approved	ASAM 1.0 - 21 and Over	1-DMC SUD Services
1-Recovery, Inc.	110744	07/01/2021	07/30/2021	Approved	ASAM 1.0 - 21 and Over	1-DMC SUD Services
1-Recovery, Inc.	110655	01/01/2022	06/30/2022	Approved	ASAM 1.0 - 21 and Over	1-DMC SUD Services
1-Recovery, Inc.	110230	07/01/2020	06/30/2021	Approved		1-DMC SUD Services
1-Recovery, Inc.	109984	08/11/2021	10/09/2021	Approved	ASAM 2.1 - 21 and Over	1-DMC SUD Services
1-Recovery, Inc.	109481	01/01/2021	06/30/2021	Approved		1-DMC SUD Services
1-Recovery, Inc.	109446	07/01/2020	06/30/2021	Approved	Screening - No Admission	1-DMC SUD Services
1-Recovery, Inc.	109379	07/01/2020	06/30/2021	Approved	ASAM 2.1 - 21 and Over	1-DMC SUD Services
1-Recovery, Inc.	96395	09/01/2018	10/30/2018	Approved	ASAM 3.3 - 21 and Over	2-Non-DMC Services

EXAMPLE

- State denial received: CO 96 N30 : The claim level pregnancy indicator is not present for a perinatal service.

Denial Code	Claim Adjustment Reason Code (CARC)-Remittance Advice Reason Code (RARC) Definition Per X12.org	DMC Description	Resolution
CO 96 N30	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) (96) Patient ineligible for this service. (N30)	Perinatal service billed prior to January 1, 2014, but beneficiary is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided), or Daycare Rehabilitative service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided). N/A - ODS Only 837I: The claim level pregnancy indicator is not present for a perinatal service.	**Cause:** The Women's Health History Form was not completed for the patient. The patient's Medi-Cal Aid code is not for full scope Medi-Cal and only covers DMC services for pregnant women. For 837I, if on Loop 2300 the Demonstration Project Identifier- REF02 notes WM37P, WM37PY,WM40P, or WM40PY then Loop 200B PAT09 is required. **Resolution:** For PPW billing, ensure the Women's Health History Form is completed. Provider Communication 12/21/2020 providers instruction as to the required fields. If the denial was related to the aid code and the provider was attempting to obtain full scope Medi-Cal in the first 30 days of service, ensure the Financial Eligibility was completed correctly. For 837I, if the claim is not a PPW service, ensure Loop 2300 REF02 does not denote 'P.'

EXAMPLE

- Resolution: Complete Women's Health History Form

WOMEN'S HEALTH HISTORY

Submit | Discard | Add to Favorites

Women's Health history
- Menarche
- Pregnancy and Birth
- Notes

Online Documentation

Add, Edit, or Delete a Record *

(•) Add ( ) Edit ( ) Delete

Episode Number *

Select

Client ID *

MRCOOL,JANE (162334)

Selected Record

Select

Filed Records

Record	Assessment Date	Pregnacy Start	Initial Treatment	Menstrual Date
1:	04/01/2024	01/01/2024		

Assessment Date *

12/04/2024

T Y

Menarche

Date Of Last Menstrual Period (2300-DTP-03)

10/30/2024

T Y

OPEN Q&A

QUESTIONS RECEIVED VIA EMAIL

- How I am supposed to document and bill if I have provided billable services to an individual multiple times in one day. For example, " between 11-11:15 am on 11/26/24 I helped John Doe check in and complete his registration packet at the doctor's office. Then at 11:45 am I collaborated with the resident and his doctor regarding the needs of our mutual client. Upon completion of john doe's appointment, between 12:10 pm and 12:25pm myself, resident and scheduling personnel collaborate on the best day to return for a follow up appointment."
  - Is this 3 different care coordination progress notes, for each coordination involvement and is it billed at 15 minutes each (3 separate units)? Or am I supposed to place all the above information into 1 care coordination note and bill it at 45 minutes for 3units.?
  - IF I am supposed to place all the above information into 1 care coordination note and bill it at 45 minutes (3 units), then what time frame would I be using on the actual care coordination progress note form for "Service start time" and "Service End time". Would it be from 11:00 am – 12:25 pm. If so then, that time frame of an hour and 25 minutes does not match my 45 minutes I will be billing for….is this ok?
- ANSWER:
  - Per SAPC Clinical staff, there is no policy regarding the number of notes for this scenario, other than that the services need to be documented. It could be three separate notes or one note from 11-12:25 with a shorter duration. Documentation questions should be send to DSAPC.CST@ph.lacounty.gov.
  - These separate services would be rolled up into one claim. Keeping in mind the mid-point rule and minimum number of minutes to be able to bill for a service. Each service is determined separately.
    - As this is a 15-minute service, the minimum time of the service to be billable is 8 minutes. Service 1 from 11-11:15 am would be billable for 1 unit; Service 2 at 11:45 am would need to be at least 8 minutes to be billed for another 1 unit; and Service 3 from 12:10-12:25 pm would be billable for 1 unit. For this scenario, one service with 3 units would be billed.

QUESTIONS RECEIVED VIA EMAIL

- Once a claim has been resubmitted and approved at the local level, but denied at the state level, is there anything further we can do? Would we have to submit a help desk ticket?
  - Scenario: Patient has active Medi-Cal. Initial batch was denied at the local level. Claims were voided and resubmitted and the second batch got approved at the local level. The State denied the claims due to Eligibility Issues. What is next?
  - Answer: Providers can use the Denial Crosswalk to review known causes and resolutions to the State denial and if able to resolve the issue, fix the patient record or service and then rebill it to SAPC. A Help Desk ticket can be submitted if assistance is needed as the resolution cannot be determined based on what is provided on the crosswalk.
- On the SAPC website there is a "State Denial Investigation and Resolution Presentation Print out" from 2020 that guides us through SAGE. Is there something like this for PCNX?
  - Answer: The majority of the information in the State Denial and Crosswalk Investigation Guide remains the same, except for the screenshots from PConn and a couple of reports/widgets now available in PCNX. SAPC Finance is in the process of updating the guide and will be releasing an updated guide in January.