Substance Use Disorder Information System

Communication Release

1/14/2022

Provider Activity Report Issue Resolved

Some Primary Providers utilizing the Provider Activity Report in ProviderConnect were encountering an issue where the report was not generating data for the time selected in the report parameters. SAPC worked with Netsmart to resolve this issue and a fix has been implemented as of Thursday, 1/13/2022. When running the Provider Activity Report, SAPC recommends selecting date parameters no more than 30 days at a time. For time periods with a high volume of notes, it is possible that the parameters may need to be shortened in order for the report to successfully load. If the report is run and data is not received, shorten the time parameters selected to reduce the volume of notes on the report output.

Providers should also note that there may be a delay from when a progress or miscellaneous note is entered in Sage and when it is available to show on the Provider Activity Report. Notes entered may take until the following day to appear on the report for the time period selected. This delay should be taken into account in agency workflows to ensure all services are being accounted for when billing SAPC.

Telehealth Configuration Completed

The configuration of Sage to accommodate the new telehealth modifiers required by DHCS has been completed as of Tuesday, 1/11/2022. The modifiers were made available to be billed with an effective date of 1/1/2022.

Providers can reference the Claiming for Telehealth Using Modifiers job aid which provides information for both primary and secondary providers on how to bill for telehealth using the new modifiers. Please ensure your agency reviews this job aid and distributes it as needed to the appropriate staff.

Requirements

All Medi-Cal covered services delivered by telehealth or telephone must be claimed using the following modifiers and place of service code:

- Telehealth service: GT
- Telephone service: SC
- Place of service code: 02

SAPC will not configure residential settings for telehealth services as these services are only allowable under current emergency order through December 2022 and are not normal levels of care that would constitute telehealth or telephone services. Additionally, services via telehealth to patients in quarantine or isolation while the patient is at the residential site should continue to be billed as regular residential services.

For primary providers: Sage will be configured to include the telehealth and telephone modifiers as Procedure Code options on the Treatment screen. The Location code selected on the Treatment Details screen must be selected as Telehealth if a Procedure Code with a telephone/telehealth modifier was selected.

For secondary providers: Telephone and telehealth services included on 837P files must include the appropriate modifier with the CPT code for the service and must include the place of service code – 02 - to indicate the service was delivered via telehealth/telephone. If the 02 place of service code is not included on the claim when the telehealth or telephone modifiers are used, the service will be denied.

CPT and Modifier Combinations with Over Four Modifiers

With the addition of the telehealth/telephone service modifiers, there are certain authorization groupings where more than 4 modifiers would need to be used. All standard EDI and HIPAA transactions have a 4-modifier limit on CPT codes, where DHCS has indicated that the youth modifier – HA – should be dropped from the CPT/modifier combination to meet the 4-modifier maximum when the service is provided by telephone/telehealth and requires the new modifier. This will not impact the rate at which the service is reimbursed as all the effected codes are for PPW services, which receives the maximum allowable rate.

The authorization groupings where the youth modifier should be dropped for the new telehealth/telephone modifier are:

ASAM 1.0-WM - 12-17/Perinatal
ASAM 1.0-WM - 18-20/Perinatal
ASAM OTP - 12-17/Perinatal-PPW
ASAM OTP - 18-20/Perinatal-PPW
RSS – 12-17/Perinatal
RSS – 18-20/Perinatal

For example, a client receiving Individual Therapy (H0004) with ASAM level 1-OTP (UA + HG), age 15 (HA), pregnant (HD), and the service conducted via Telehealth (GT) would use code H0004:UA:HG:HD:GT. The youth modifier should be dropped if the Telehealth/Telephone modifier is to be used and would cause the number of modifiers to be higher than 4.

National Drug Code Requirements and Configuration

On Thursday, January 20, 2022, SAPC will implement the configuration necessary for billing MAT services with National Drug Codes (NDCs) to the State. With this configuration, claims for MAT services that do not include the required associated NDC for that HCPCS code, will be denied by SAPC.

- If no NDC is used, an invalid NDC is used, or the incorrect NDC for the HCPCS code is used, the service will be denied and the explanation of coverage message received by providers will be: "*The service was denied for the following reason: National Drug Code (837-2410-LIN-03) is not valid for this Procedure Code."*

Claims without the associated NDC codes for the medication being billed will be denied by the State with the denial code CO 96 N54 or CO 26 N650. If the NDC was correctly added to your agency's claims and you received one of these denial codes, SAPC requests providers resubmit the claims to SAPC so they can be sent to the State again for adjudication. If the claim did not include the NDC code, SAPC requests providers add the required code to the claim and resubmit the claim to SAPC.

It is important for secondary providers to ensure that their electronic health record systems are correctly configured to allow the agency to associate the correct NDC for MAT services. The NDCs for each MAT HCPCS code can be found on the SAPC Rates and Standard Matrix, which can be located on the SAPC website at: http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/21-05/StandardFY21-22RatesMatrix.pdf.

Fiscal Year 2018-19 Billing Deadline

As recently communicated in the December 21, 2022 All Provider Meeting, providers can submit claims for FY18-19 until January 31, 2022. Any resubmissions for correctable State denials must be submitted by this deadline unless otherwise communicated by SAPC. The SAPC Finance Analyst assigned to your agency will reach out if they have not seen any rebilling conducted recently for State denials that have been recouped. SAPC will be providing technical assistance to providers to assist in the successful rebilling of these claims.

Medi-Cal Online Eligibility Verification System

SAPC has recently been notified of changes to the format of the Medi-Cal Online Eligibility Verification System through the Medi-Cal website. The system traditionally provided the traffic signal light as a warning system to show if there are any potential limitations to Medi-Cal eligibility based on the combination of the traffic light, aid code and county code.

The information being reported has NOT changed; however, the formatting of the eligibility alert is no longer displayed using the traffic light. Where previously the traffic light was in the top right corner, followed by different codes with the messages on the bottom, the screen is now showing the message first followed by the corresponding code information without a traffic signal light alert graphic.

The color-coding system is now present in the message itself as the entire message section is highlighted in the corresponding color, either green, yellow or red (see figure 1). This is the same as the old traffic light, but just shown as a highlight rather than a traffic light.

In general, to verify eligibility using the Medi-Cal Online Eligibility Verification System, users should refer to the following guidance:

1. Always verify the aid code first to ensure that the aid code is DMC eligible
    a. Beneficiaries can be enrolled in a Medi-Cal program, but the program does not contain DMC benefits.
2. Check the county code to ensure the patient is assigned to LA County- 19.
3. The color-coding system can be interpreted as follows:
    a. Green signals that the are no eligibility limitations based on available benefits under the aid code
    b. Yellow signals that there may be restrictions related to Share of Cost, OHC, income requirements, emergency only, perinatal only, etc…
        i. If the message is highlighted in yellow, providers should review the message thoroughly to identify the reason for possible restrictions and contact DPSS for further clarification if needed.
    c. Red signals the patient is not eligible for any Medi-Cal benefit for the date of service
        i. This can occur if there are holds placed on the account by the DPSS eligibility worker and should be addressed directly with LA County DPSS.

Figure 1: New Eligibility Screen Format