Substance Use Disorder Information System

Communication Release

2/17/2022

Funding Source Screen When Entering Treatments in ProviderConnect

SAPC would like to provider further instruction related to the recent changes to the claiming procedures in ProviderConnect/Sage for Primary Sage Users. Effective Wednesday 2/16/2022, additional screens were added to the Treatment page when entering Professional Treatments. To accommodate Other Health Coverage (OHC) entry, these fields were required due to the need to add Claim Level information for OHC claims.

The first screen providers will encounter after selecting "Add Professional Treatment," is the Professional Claim Details page. On this page users are required to select a Funding Source for the claim. The Funding Source selection on the Professional Claim Details page **MUST** match the Funding Source for the authorization, which is entered in the Add-Treatment Setup/Enter Treatment Criteria page, as was previously required.

Patients with only LA County Non-DMC guarantors and/or Applying for Medi-Cal (e.g. MHLA), RBH claims, and "Screening- No Admission" claims will **ALWAYS** be Non-DMC for both the Claim Level funding source and the Service Level funding source on the Treatment entry page.

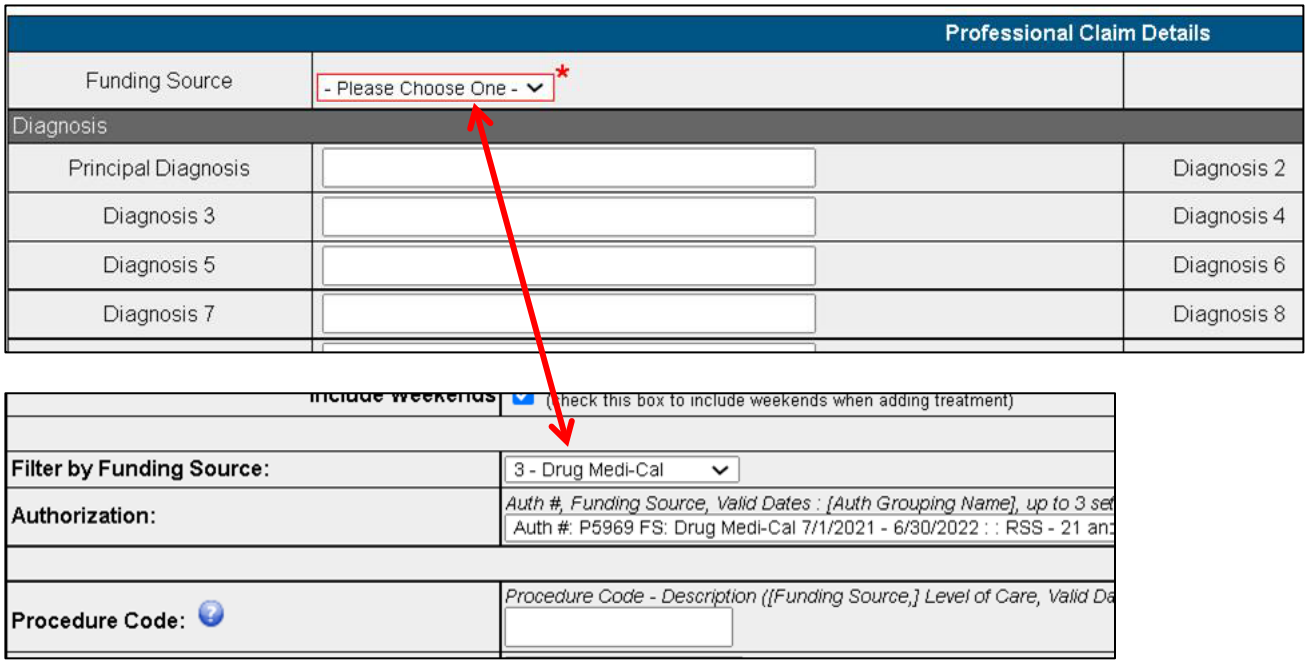
Once you select a Claim Level funding source, providers must only enter treatments that match that funding source until a new claim is added. For example, if DMC is selected on the Professional Claim Details page, then the services and authorizations must have DMC selected as the funding source when entering treatments onto the claim.

If billing for a patient with both DMC and Non-DMC services (such as outpatient and RBH), separate claims must be submitted using the Professional Claim Details page. The example below walks through how to separate the DMC and non-DMC services on two separate claims.

Example:

1. The provider would first bill the DMC services by clicking Treatment on the left-hand menu bar to go to the Treatment History page
2. Click "Add Professional Claim" on the Treatment History page
3. Select "Drug Medi-Cal" as the Funding Source on the Professional Claim Details page
4. Click "Add Professional Service" on the Professional Claim Details page
5. Enter the DMC services on the Treatment entry page using the DMC Funding Source and DMC authorization
6. When the DMC services were entered to the DMC claim and the provider is ready to enter the Non-DMC claims, providers would then go back through the same process, starting by clicking Treatment on the left-hand menu bar, but will then choose "Non-Drug Medi-Cal" on the Professional Claim Details page and then enter the non-DMC treatments using "Non-DMC" as the funding source and selecting the non-DMC authorization

Should a provider select one funding source on the claim level, but enter the opposite funding source authorization, the claim will show as failed-edit on the pre-adjudication with the message of, "This service was denied for the following reason: This member's authorization is for a different funding source." Providers need to delete the treatments and re-enter under the correct funding source when this message is received. Please make sure to run the pre-adjudication for all services prior to billing to avoid unnecessary denials. The same denial reason will show on the EOB or within Sage or KPI should the claim be submitted without correcting the error.


Professional Claim Details
Funding Source
- Please Choose One -
*
Diagnosis
Principal Diagnosis
Diagnosis 2
Diagnosis 3
Diagnosis 4
Diagnosis 5
Diagnosis 6
Diagnosis 7
Diagnosis 8

(check this box to include weekends when adding treatment)
Filter by Funding Source:
3 - Drug Medi-Cal
Authorization:
Auth #, Funding Source, Valid Dates : [Auth Grouping Name], up to 3 set
Auth #: P5969 FS: Drug Medi-Cal 7/1/2021 - 6/30/2022 : : RSS - 21 an
Procedure Code:
Procedure Code - Description ([Funding Source,] Level of Care, Valid Da