Substance Use Disorder Information System

Communication Release

10/22/2021

Telehealth Modifier Configuration Updated Guidance

Overview

The California Department of Health Care services (DHCS) published Behavioral Health Information Notice 21-047 regarding new telehealth modifiers required to be included on all claims for services provided via telehealth and telephone along with the corresponding place of service code no later than 11/1/2021. This is intended to allow DHCS to track access to services and measure the proportion of services delivered by telehealth, telephone or in person services.

SAPC has been working with Netsmart to configure Sage to support these requirements from DHCS and the changes will be released prior to the November 1st deadline. A job aid has been developed to support providers in understanding the requirements and will be posted to the SAPC Sage website within the next 1-2 weeks and is attached to this communication for review and reference. The job aid provides information for both primary and secondary providers on how to bill for telehealth using the new modifiers.

Requirements

All Medi-Cal covered services delivered by telehealth or telephone must be claimed using the following modifiers and place of service code, effective November 1, 2021:

- 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.

Companion Guide Updates
The SAPC 837P Companion Guide has been updated to include additional information regarding the modifiers and place of service code. These changes add information regarding the order of the modifiers on the code and where the place of service code should be on the claim. Email sapc_support@ph.lacounty.gov for questions or support on the companion guide changes.

Rates & Standards Matrix Updates
The Rates & Standards Matrix and SAPC Information Notice have been updated to reflect the telehealth requirements. The documents can be found on the SAPC website under the SAPC Start-ODS Contract Bulletins section of the Provider Meetings, Bulletins, Briefs and Factsheets page.

Effective July 1, 2021, the treatment standards for Recovery Support Services (RSS) was increased to 0-9 hours per week/0-36 units. This is a substantial increase from the previous monthly standard. The provider manual will be updated to reflect this change in the upcoming version 6.0.

FY18-19 State Denials

SAPC has been in the process of recouping claims that were denied by the State so providers can correct and resubmit/replace where appropriate. There will be some State denials that cannot be corrected due to the patient being ineligible for DMC at the time of service. With the cost reporting period approaching, SAPC recommends providers prioritize FY18-19 State denial corrections and subsequent resubmission/replacement instead of focusing on more recent State denials. This will help to make cost reporting more accurate and include all possible services in the cost report. Please note that cost reporting for FY17-18 has been closed and settled. No further action is required for FY17-18.

Please note when fixing State denials, the claims have already been voided and recouped once you receive indication that a claim has been State denied. When resubmitting claims, there is no need to void them first before resubmitting as the system will not post the void. Primary Sage Users only need to resubmit the claim as a new claim. Whereas Secondary Sage Users should replace the claim only and should not void it using the claim frequency code of '8.' If a State denial is voided by a Secondary Sage User, the provider will not receive an 835 or EOB for that void as this would create a negative balance for the provider. The only options for submitting fixed State denied claims is either Replacement (Secondary Providers) or Resubmission (Primary Providers).

Eligible Providers Under DMC-ODS

SAPC sought and received verification that Licensed Professional Clinical Counselors (LPCCs) are considered LPHAs and Associate Professional Clinical Counselors (APCCs) and are considered Licensed-Eligible LPHAs in the DMC-ODS system. This was welcome news as it clarified the expanded potential LPHA workforce for the specialty SUD system and addressed questions submitted by SAPC network providers who wished to consider LPCC and APCC potential employees. These LPHAs and Licensed-Eligible LPHAs should go through regular hiring and onboarding processes for both provider agencies as well as for Sage onboarding.

10/12/2021 Provider Meeting Sage Updates

On October 12, 2021, SAPC held a Provider Meeting that included Sage Updates. The slides for the Sage updates can be found on the SAPC website here.

Topics under the Sage update section included:

- Reminders related to the ASAM CO-TRIAGE screening requirement as well as how to document and billing for screening
- How to locate Provider Authorization numbers (PAUTHs)
- Avoiding duplicate patient records

- Tips for writing progress notes
- Telehealth Modifier Requirements
- Upcoming updates to the Provider Activity Report
- Information on State denial upcoming recoupments and resolution of State denials
- Update on Other Health Coverage configuration
- National Drug Code reminders

National Drug Codes for Medication Assisted Treatment

The Department of Health Care Services (DHCS) indicated in MHSUDS Information Notice 17-045 that Medication Assisted Treatment (MAT) claims are required to include the NDC Code for medications administered in the NTP setting. When billing for MAT services, it is required that the claim includes the National Drug Code (NDC) for the associated medication. For example, when billing CPT code S5000A for Naltrexone Generic, the required NDC code is 65757030001. SAPC has identified a high number of claims submitted by providers that did not include the required NDC 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.

Through SAPC's investigation of these State denial codes, it was identified that an issue with Sage was preventing claims submitted with an NDC code to be properly sent to the State with all required information. Sage is currently being updated to resolve this issue so the information will be appropriately sent to the State. If your agency received the two noted denial codes for MAT services, SAPC recommends validating if the claims sent to SAPC included the required NDC code. If the NDC code was correctly added to the claim 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 also important for secondary providers to ensure that their electronic health record systems are correctly configured to allow the agency to add the associated NDC code for MAT services. Without these codes being included on claims, these claims will continue to be denied by the State and recouped by SAPC. The NDC codes for each MAT CPT 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.

Claims for Patients with Other Health Coverage

SAPC has been working to update Sage to allow Primary Users to enter Other Health Coverage (OHC) on services for patients who have OHC. It is anticipated that the configuration of Sage for primary users should be completed within the next 2-3 months. SAPC will provide a more specific release date when able. SAPC asks that primary users continue to identify but hold the submission of claims for patients where OHC information would need to be added until the configuration has been completed and SAPC has provided training and resources on how to submit claims with OHC information included.

For secondary providers, Sage is currently configured to accept 837 files with OHC information included and for the information to be transmitted to the State. To align your agency's electronic health record with requirements for including OHC information on an 837 file, refer to SAPC's 837 Companion Guides which can be found on SAPC's Sage website at: http://publichealth.lacounty.gov/sapc/providers/sage/system-guides.htm.

SAPC has planned a webinar for secondary providers to review the OHC claiming information required in the SAPC 837 Companion Guide. The details of the webinar are below. Please be sure to register and attend! In preparation for the secondary provider OHC webinar, SAPC recommends providers review the SAPC 837 Companion Guide section on OHC on page 24 and come prepared with any questions. There will be a forthcoming webinar for primary providers when the configuration in Sage for primary providers has been completed.

- Date: Wednesday, November 3, 2021
- Time: 11:00 am-12:00 pm
- Registration Link: https://sapccis.ph.lacounty.gov/Registration/registration.aspx?id=171

State denials for OHC will likely fall under two denial codes: CO 22 N479 or CO 177 (possibly with accompanying RARC). For secondary providers, SAPC recommends reviewing the OHC information that was submitted on the claim if these denial codes were received, correcting any errors, and then submitting a replacement claim to SAPC. For primary providers, SAPC requests agencies continue to identify but hold resubmitting these denials with the OHC information until Sage has been fully configured to support primary provider entry of OHC information on claims.

Claiming for Telehealth Using Modifiers

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Table of Contents

Introduction to Telehealth/Telephone Configuration Changes

The California Department of Health Care services (DHCS) published Behavioral Health Information Notice 21-047 regarding new telehealth modifiers required to be included on all claims for services provided via telehealth and telephone along with the corresponding place of service code no later than 11/1/2021. This is intended to allow DHCS to track access to services and measure the proportion of services delivered by telehealth, telephone or in person services.

Sage has been configured to support these requirements from DHCS. This job aid will walk through the claiming process for providers who bill directly through Sage and those who utilize the 837 process for billing. The following changes have been implemented per the DHCS telehealth and telephone service reporting requirements. The configuration allowed for the new HCPCS and modifier combinations to be associated with all existing and new authorizations, without having to modify any approved authorizations or groupings.

Providers will not see the new HCPCS and modifier combinations on the list of codes on approved authorizations as normally indicated (Figure 1). The new codes are applied in the background and will be available when entering the CPT/HCPCS on the Treatment page (Figure 2) for Primary Sage Users.

Figure 1: Available codes visible on authorization

Authorization Group	
294 - ASAM 2.1 - 21 and Over	
PROCEDURE CODE	**DESCRIPTION**
90846:U8	Family Therapy
D0001:U8	Discharge Services
H0001:U8	Intake/Assessment
H0004:U8	Individual Counseling
H0005:U8	Group Counseling
H0006:U8	Case Management
H0048:U8	Alcohol/Drug Testing
H0049:U8	Screening
H2010:U8	Medication Services
H2011:U8	Crisis Intervention
MATSvc:U8	Med for Addiction Treatment Services
T1006:U8	Collateral Services
T1007:U8	Treatment Plan
T1012:U8	Patient Education

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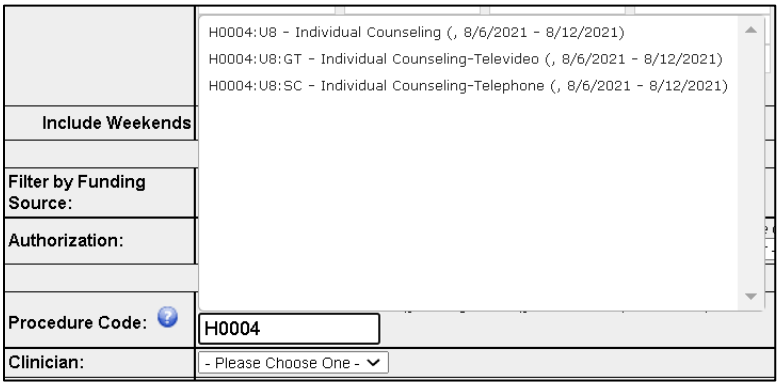
Figure 2: Additional available codes when entering procedure code



Effective November 1, 2021, all Medi-Cal covered services have been configured as noted and must be claimed using the following modifiers and place of service code if delivered via telehealth, :

- Telehealth service: GT
- Telephone service: SC
- Place of service code: 02 (Same for both Telehealth and Telephone services)

Secondary Sage Users (agencies that bill using the 837 process) should configure their systems to include these modifiers on all DMC covered CPT/HCPCS codes, with the exception of residential and inpatient levels of care (3.1, 3.3, 3.5 and WM 3.2, WM 3.7, WM 4.0).

To further clarify, 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. An updated SAPC 837 companion guide will be published for specific information on the loop and segment for the place of service code. **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 by SAPC.** The denial will show on the Pre-adjudication within Sage (Figure 3):

Pre-Adjudication Edit Failed Reason	Status	Units	Procedure Code
The service was denied for the following reason:Location's Place of Service Is Invalid For Procedure Code.	Failed Edit	4	Individual Counseling-Televideo (H0004:U8:HD:GT)

Exceptions and Alternate Configurations

SAPC did not configure residential settings for telehealth services as these services are only allowable under current emergency order through December 2021 and are not normal levels of care that would constitute telehealth or telephone services. Additionally, services delivered 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.

In some rare instances, there are services within particular authorization groupings where more than four (4) modifiers would need to be used as a result of the new modifiers. All standard EDI and HIPAA transactions have a 4-modifier limit on CPT codes. In the following authorization groupings, the telehealth and telephone services would exceed the 4-modifier limit:

- 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

Each of these authorization groupings correspond specifically to the perinatal youth population. DHCS has indicated that the youth modifier – "HA" – should be removed from the HCPCS/modifier combination to meet the 4-modifier maximum when the service is provided by telephone/telehealth. 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. For example, a client receiving Individual Counseling (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 HA modifier was removed to meet the transaction standard requirement. Sage has been configured in this manner already for Primary Sage Users. Secondary Sage Users should configure their EHR systems to reflect this as well for those who are contracted for those levels of care and populations.

Telehealth/Telephone Procedures for Primary Sage Users/Providers Who Bill Directly in Sage

Before utilizing telehealth services, please ensure that a consent for telehealth services form has been discussed and signed or verbally consented to by the patient, if unable to obtain physical signature when implementing. Additionally, providers should be using a HIPAA compliant telehealth platform when conducting telehealth.

SAPC has redeveloped the Provider Activity Report to better assist providers in billing for telehealth/telephone services. The updated Provider Activity Report will include the "Method of Service Delivery" selections directly from the progress notes (Figure 4) in Sage. This will allow billers to easily identify which services should be claimed as telehealth or telephone.

Figure 4: Progress note method of service delivery

Reminder: Method of Service Delivery refers to how a session was conducted. Select the appropriate method.

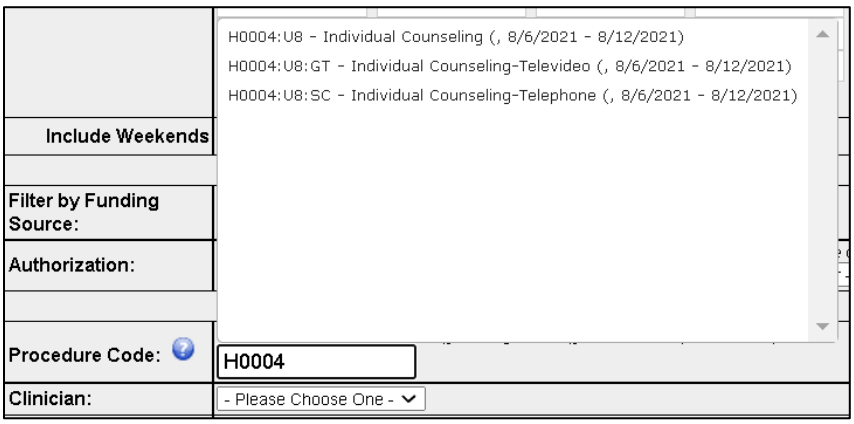
i. **Face-to-Face** is for in person session.
ii. **Field Based** is related to providers who are contracted to deliver services at certified field based locations.
iii. **Not Applicable** refers to if an informational type note is added to a patient's chart but did not involve contact of any type with another person.
iv. **Telehealth** refers to services delivered using a synchronous audio/video interaction on a HIPAA compliant platform
v. **Telephone** is NOT the same as telehealth. Telephone is stictly for audio/TTY/TDD.

Billing for Telehealth Through Sage

The billing workflow has not changed with this configuration. Primary Sage Users will continue to follow the normal billing workflow when entering Treatments/services. For telehealth or telephone services, enter the HCPCS code as normally done and the additional associated codes will display in the smart search results. Providers can enter the HCPCS code with or without the modifiers. In the example below (Figure 5), H0004 was entered, which

populated all available codes associated to H0004 on the authorization selected. The dates in paratheses are the dates of the authorization that was selected.

Figure 5: Listed and associated codes available to bill

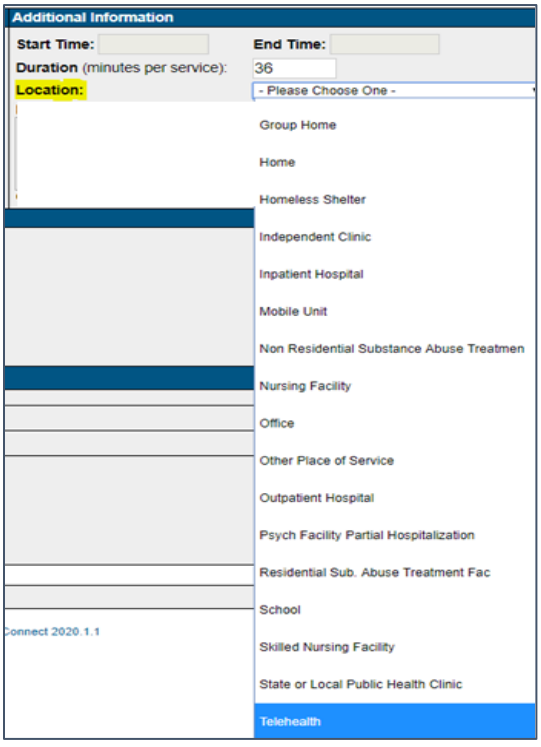


After entering all the initial information for the service, providers would click 

to proceed to the Treatment Details page, where the Location/Place of Service (Figure 6) for service will be selected. This should correspond to the Method of Service Delivery noted on the progress note or Provider Activity Report.

For telehealth AND telephone services, providers should select the “Telehealth” location option. All other fields are entered as usual. As a reminder, if telehealth or telephone services are billed without the location as Telehealth, the claim will be denied as “Location’s place of service is invalid for procedure code.”

Figure 6: Location selection on Treatment Details



Billing Telehealth for Secondary Sage Users

The new configuration for telehealth will not change the 837 process for billing. However, Secondary Sage Users must ensure they have configured their EHR systems to include the new HCPCS code and modifier combinations for all available services the agency and each site is contracted to provide. For example, if the agency is contracted for outpatient 1.0, 2.1 and RSS, each of the corresponding CPT/HCPCS, with the current modifiers, the system should now be updated to add both the telehealth: GT and telephone: SC modifiers to each of the existing procedure codes in their systems.

Additionally, when populating telehealth and telephone services on the 837, providers must ensure that the Place of Service segment (Loop 2400, SV105) is entered as '02' to correspond to telehealth or telephone method of service delivery. Submitting a telehealth or telephone HCPCS code with the incorrect corresponding place of service, which should be 02, will result in the claim being denied by SAPC as CO 5 M77 and explanation of coverage denial "Location's place of service is invalid for procedure code."