Communication Release

12/30/2021

ProviderConnect Pre-Adjudication Process Error

SAPC identified an issue with the Pre-Adjudication process in ProviderConnect for claims submitted to Pre-Adjudication on 12/20/2021 or later, where the claims were not being processed in the queue. This issue was resolved on Tuesday 12/28/2021 and all services that remained in the queue were processed and pre-adjudicated correctly. Providers should not experience additional delays in pre-adjudication at this time.

Provider Activity Report Update

SAPC and Netsmart have been working to improve the functionality and workability of the Provider Activity Report to enhance billing efficiency for providers and to support primary provider billing of services provided via telehealth. It is anticipated that the report updates will be effective on Tuesday, January 4, 2022. A notification will be posted to the ProviderConnect Newsfeed if that date will be changed due to any unforeseen circumstances.

The following items have been updated on the report:

- The report will no longer be viewable in a pop-up window but will instead be available via a CSV export file. The format has changed to improve usage of the report by having the report in Excel format without the extra rows and columns that were present in the pop-up version of the report.
- Addition of a column for Method of Service Delivery as selected on the progress note. This is an important addition that will support the billing of services provided via telehealth.
- Addition of columns to include the documentation and travel dates and times from the progress note for field-based services.

When running the updated Provider Activity Report, after selecting parameters, the user will encounter a screen that indicates, “Preparing data for export, please wait…” and will display a loading icon under the message. When the report is ready for download, the message will change to “Data prepared for export. Please save CSV file to view full report” and a red button will appear under the message saying, “Export Provider Activity Report.” The red button must be clicked to download the CSV file to the user’s computer. The file can then be opened in Excel to view the data.

SAPC recommends that providers wait 24 hours from the time of progress note entry to the time of the report being run to ensure that all notes are captured for the dates of service desired for the report output.

Telehealth Configuration Update

During the December Provider Meeting, SAPC announced that the telehealth configuration was delayed and expected to be released on 2/1/2022. SAPC has been working with Netsmart to move up the implementation date for telehealth. It is anticipated that the telehealth configuration will be fully configured on Tuesday, January 11, 2022. SAPC previously provided the job aid, Claiming for Telehealth Using Modifiers, 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. Secondary providers should ensure their EHR is ready to submit claims with the telehealth modifiers on 1/11/2022.

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.

State Denial Error for OTP Claims

SAPC received notification from DHCS reporting an error in the adjudication of OTP dosing claims resulting in claims erroneously being denied for CO 96 M80. This typically signals the claim was already paid and the denied claim is a duplicate. The reported error occurred on claims SAPC submitted to Medi-Cal between September 16, 2021 and October 18, 2021. This appears to impact only dosing claims and was not dependent on date of service but claim date. If your agency received a State denial for CO 96 M80 between September 16 and October 19, and after investigation, there was no previous payment for that claim (i.e. that was the first submission), please replace those claims as soon as possible so SAPC can resubmit the claims to the State for appropriate adjudication.

These claims would show only on 835s received between September 16, 2021 and October 18, 2021. Providers can also filter the State Denial View in KPI to show only takeback dates in that date range and show only Denial CO 96 M80 to compile of list of potential claims meeting criteria for this error.

277CA Filename Convention Change

Based on feedback providers, SAPC is making a change to the 277CA file naming convention. Effective Tuesday, January 4, 2022, the agency abbreviation will move from the file name extension to the file name. An example of how this change will appear is below. SAPC believes that this will resolve an issue some providers were experiencing when trying to load the files into their EHR or view the data on the file in a text file reader. If you have any questions regarding this change, please contact SAPC IT at sapc_support@ph.lacounty.gov.

Current File Name Extension	New File Name

277CAv5010x837Pv5010x20210504x1516268830.txt_didi	277CAv5010x837Pv5010x20210504x1516268830_didi.txt
277CAv5010x837Pv5010x20200323x1303500015.txt_crc	277CAv5010x837Pv5010x20200323x1303500015_crc.txt

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Admission Diagnosis Requirement

Sage requires that all claims have an admission diagnosis that begins on the original admission date or precedes the dates of service billed. This requirement is met when entering a diagnosis in Sage via ProviderConnect on the Provider Diagnosis (ICD-10) form. Upon admission, the first diagnosis record should always be 'Admission' in the Type of Diagnosis field. Providers may then add other Types of Diagnosis records once the Admission Type of Diagnosis is entered. Although a patient can be admitted to a program multiple times, only one admission diagnosis should be maintained to match the date of the episode admission.

If providers are receiving eligibility denials or pre-adjudication fails for *"Eligibility not found/verified in CalPM," or "This client is not eligible for this service. Avatar Financial Eligibility Record check failed. Changing claim status to Denied and the reason to Eligibility not found/verified in CalPM,"*, please make sure to check the diagnosis record to ensure there is a valid Admission Type of Diagnosis that covers the dates of service billed. It is recommended to enter the Date of Diagnosis for the Admission Type of Diagnosis as the episode start date if adding the admission diagnosis retroactively.