BILLING & DENIAL RESOLUTION TUTORING LAB

FEBRUARY 6, 2025

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.

Billing & Denial Resolution
Tutoring Lab Attendance

- Announcements and Reminders
- Tutoring Session Topics
  - OHC Updates & Reminders
  - EOB Updates
  - Preparations for FY 25-26
- Open Q&A

ANNOUNCEMENTS & REMINDERS

REMINDERS

- **SAPC Clinical Standards and Training Webinar: Connecting Clinical Documentation to CPT and HCPCS Medi-Cal Codes**
  - February 26, 2025 from 9:00-11:45 am
  - Registration required
- Please use the new Sage Help Desk Billing Assistance Request forms when submitting a ticket related to billing.
- Replacement Claim Training for Primary Providers is still on hold until further notice.

OHC UPDATES & REMINDERS

MEDI-MEDI BENEFICIARIES

MEDICARE BILLING CRITERIA

Generally, when determining if a service needs to be billed to Medicare prior to billing Medi-Cal, providers must confirm if the three conditions below are met. If any of the three criteria are not met, the claims can be billed to SAPC without billing Medicare first.

1. The beneficiary is actively enrolled in both Medicare and Medi-Cal.
2. The rendering service provider is a Medicare recognized provider type.
    a) Recognized Provider Types: Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialist, Licensed Clinical Social Workers, Marriage and Family Therapists (who have met Medicare's education requirements), Licensed Professional Clinical Counselors, and Psychologists
    b) Interns and clinical trainees of the licensed practitioners listed above are not Medicare recognized provider types.
3. The service is a Medicare covered service.

Medicare COB is required to be reported on the claim when all three conditions below are met:

1. The beneficiary is Medi-Medi.
2. The rendering provider is a Medicare Recognized Provider Type.
3. The service claimed is a Medicare covered service.

HL AND GC MODIFIER USAGE TO BYPASS COB REQUIREMENTS

- If the performing provider is not one of the Medicare recognized provider types listed on the prior slide, DHCS has setup the HL and GC modifiers to bypass the Medicare COB requirement.
- The HL modifier should be used on the service for a Medi-Medi patient whose service is a Medicare covered service, but the performing provider type is:
  - Intern working under clinical supervision to obtain licensure
  - License-eligible LPHA
  - Licensed Marriage and Family Therapists that do not meet Medicare's requirements
  - Psychological Associate
- The GC modifier should be used for a Medi-Medi patient whose service is a Medicare covered service, but the performing provider type is a Physician Resident.
- Clinical Trainees do not need to utilize the HL modifier as their specific modifier should also bypass the Medicare COB requirement.

MEDICARE COORDINATION OF BENEFITS

- The Rates and Standards Matrix includes the column, “Medicare COB Required” on the Billing Rules tab. This column indicates if the code is required to be billed to Medicare prior to billing DMC.
  - If the service is required to be billed to Medicare for Medi-Medi patients, this column will indicate “Yes”.
  - If the service is not required to be billed to Medicare before Medi-Cal, the column will indicate “No”.
  - Even if a patient’s OHC Code and COV indicate the OHC should be billed, if the Billing Rules tab indicates it does not, then the service can be billed directly to SAPC.

MEDI-MEDI PATIENTS IN OPIOID TREATMENT

- Opioid Treatment is a covered benefit under Medicare.
- Medi-Medi patients must have services billed to Medi-Care first, prior to billing SAPC or DMC will deny the service.
- Per SAPC Information Notice 20-01, OTPs must be enrolled as a Medicare provider and must bill Medicare first for all services delivered by the OTP to Medicare recipients.
- Medi-Medi patients who are also enrolled in Medicare Part D, Medicare must be billed first for most MAT medications, with the exception of: Disulfiram, Buprenorphine combination, or Naltrexone long-acting injection.
    - Always check the Billing Rules tab of the Rates Matrix to confirm if DMC requires Medicare billing first.
- *Use the Medicare billing criteria to determine necessity to bill Medicare prior to SAPC/DMC.*

MEDI-MEDI PATIENTS IN INTENSIVE OUTPATIENT

- As of January 1, 2024, Medicare has added Intensive Outpatient (IOP) as a covered benefit for patients served at a Community Mental Health Center (CMHC), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC).
- Services for Medi-Medi patients receiving IOP at a site not certified as one of the centers listed above do not have to be billed to Medicare first.
- *Use the Medicare billing criteria to determine necessity to bill Medicare prior to SAPC/DMC.*

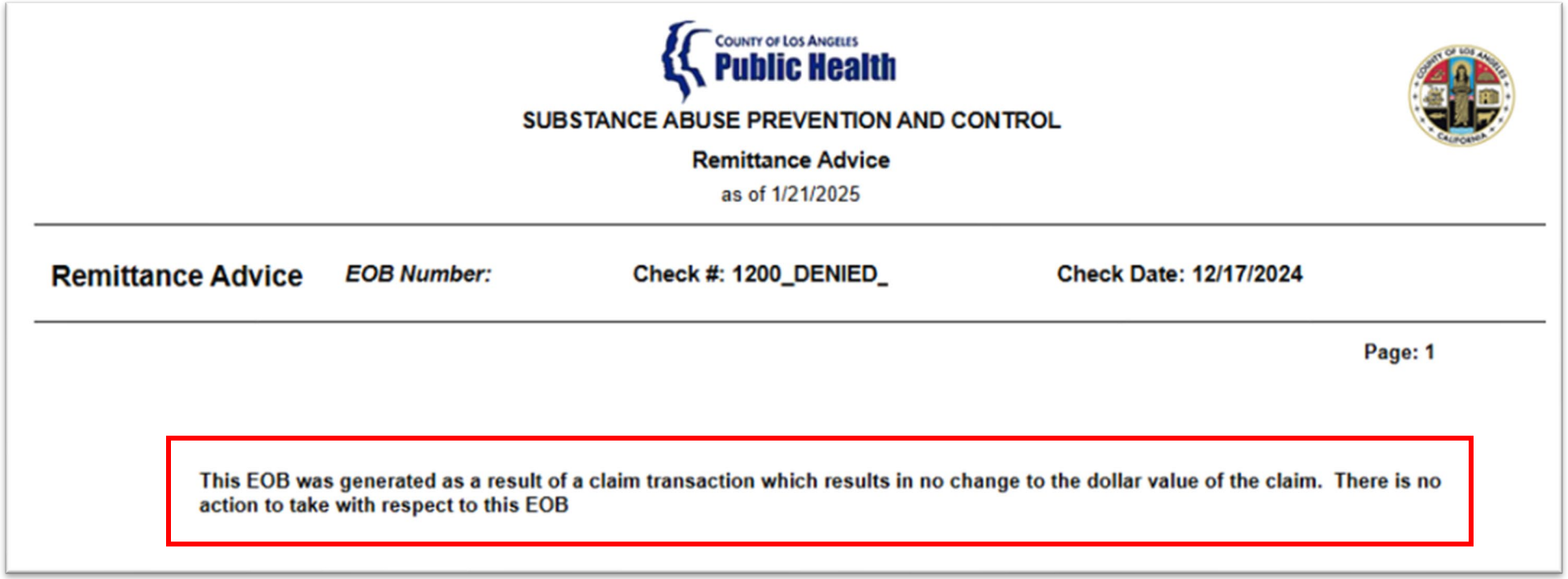
MEDI-MEDI PATIENTS IN NON-OTP OR IOP

- Patients with Medicare Part A or B AND Medi-Cal are not required to have services billed to Medicare prior to SAPC/DMC.
- Patients with Medicare Part C or Medicare Advantage (MA) plans must be billed to the MA first before billing SAPC.
- *Use the Medicare billing criteria to determine necessity to bill Medicare prior to SAPC/DMC.*

EOB UPDATES

CHANGE TO EOB PRODUCTION TIMING

- SAPC Finance made a change to the timing of daily EOB production in Sage at the beginning of the calendar year (2025)
- EOBs are now generating at 9:00 PM instead of 6:00 PM
- The aim was to increase the volume of claims on the daily EOBs for Secondary Providers in the event that a high volume of 837s were received by SAPC
    - We were finding that on heavy billing days, not all files were finished processing by 6:00 PM.
    - This caused claims submitted on one file to be potentially split between an EOB produced on the day the file is posted and the remaining claims to appear on the EOB the next day.
    - While this may still occur, it should decrease the volume of this occurrence and make reconciliation easier.



County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 1/21/2025

Remittance Advice *EOB Number:* **Check #: 1200_DENIED_** **Check Date: 12/17/2024**

Page: 1

This EOB was generated as a result of a claim transaction which results in no change to the dollar value of the claim. There is no action to take with respect to this EOB

EOB INDICATING NO ACTION NECESSARY

"NO ACTION" EOBS

- Why were providers receiving EOBs with this message?
  - Often State denials from DHCS are received with more than one denial code.
  - There are certain denial codes that SAPC fixes on behalf of providers issue and rebill to DHCS without the provider needing to take action.
    - SAPC Finance does not recoup these denial codes and providers don't see them in Sage.
  - In the scenario that:
    1. A set of denial codes for a service was received from DHCS, and
    2. The primary denial code is NOT recouped from the provider, but
    3. A secondary denial code was received that is set to produce a recoupment
    - An EOB was produced with a $0 takeback for the secondary denial code and resulted in EOBs with this message.
  - Providers and SAPC did not have visibility into what these $0 recoupments were

CHANGE MADE TO EOBS

- SAPC Finance worked with Netsmart to move this message to the last page of the EOBs and display the service information.
- Providers will now be able to see the secondary denial reason with the $0 takeback to address the denial reason.
- Technically, no recoupment of actual funds has occurred.
- These $0 recoupments are not available in KPI.

County of Los Angeles Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 2/6/2025

Remittance Advice ***EOB Number:*** **Check #:** **Check Date: 2/3/2025**

Adjustment Notice

An adjustment of $ 0.00 has been applied to this payment.

Current Claims:
Adjustment: 0.00
Adjusted EOB Total: 0.00

Detail Adjustment Information for EOB Number:

Original Service Information

Orig EOB

Adjustment Information

Client Name (ID) **DOB:** **Gender:**

Batch.SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
	8/3/2023	T1007:U7		A	280.90	280.90	12/17/2024	$0.00	Denial Co 96 N95
					280.90	280.90		0.00	

Client Name (ID) **DOB:** **Gender:**

Batch.SvcRef#	DOS	Proc	Auth #	Status	Billed	Paid	Adj Date	Adj Amt	Adjustment Reason
	8/2/2023	T1006:U7		A	224.72	224.72	12/17/2024	$0.00	Denial Co 96 N95
					224.72	224.72		0.00	

Hope, Wellness and Recovery... connecting people, ideas and resources...

COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Remittance Advice

as of 2/6/2025

Remittance Advice ***EOB Number:*** **Check #:** **Check Date: 2/3/2025**

Total Adjustments: $0.00

Adjustments

Contract #

This EOB was generated as a result of a claim transaction which results in no change to the dollar value of the claim. There is no action to take with respect to this EOB

WHAT TO DO WITH $0 STATE DENIALS

- Nothing at this time.
- Until you see a State denial with a recoupment amount greater than $0, no action is necessary.

PREPARING FOR FY 25-26

RATES AND STANDARDS MATRIX

- SAPC Finance is starting to prepare for FY 25-26 and we want your feedback on the Rates and Standards Matrix.
- What aspects of the Rates and Standards Matrix FY 24-25 do you find most beneficial or effective?
- What aspects of the Rates and Standards Matrix FY 24-25 do you find difficult to understand or use?
- What specific changes or improvements would you recommend SAPC to make for the future version of the Rates and Standards Matrix?

Rates and Standards Matrix Feedback Survey


OPEN Q&A