SAPC Billing Office Hours FAQ

The questions referenced in this FAQ were submitted by SAPC Contracted providers during the SAPC Billing Office Hours, held every Thursday from 1-2pm/2:30pm July 25, 2024, through October 24, 2024.

#	Question	Response
July 25, 2024		
1	Code 99367 - Is this a valid code to use when the MD is conducting a medical team conference regarding a specific client with the counseling team (AOD counselors, care coordinators)? Or would this code only be used when the meeting includes other medical professionals?	Code 99367 is used when physicians participate in a medical team conference with a minimum of three qualified health care professionals from different specialties or disciplines who provide direct care to the patient each of whom are participating in the reported team conference. Since AOD counselors and care coordinators working in SAPC contracts SUD services, they are all focused on treating SUD; this code is when there are specialists outside of the SUD program (such as physical health and mental health) who each participate in a case conference for not less than 30 min. Reporting participants shall have performed face-to face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days. Because these types of interdisciplinary conferences involving SAPC contracted physicians with qualified health care professionals working outside of SAPC programs, this code isn't used for developing plans of care with other SAPC-contractor agency practitioners.
2	Ordering/coordinating MAT medications - When the MD is ordering and coordinating with pharmacies to fill MAT medications, which code should be used? In the LPHA Medi-Cal documentation training, the slides instruct providers to use code 99213. However, in the SAP-C IN 24-01(F) (attached) it states that a care coordination code should be used. Please advise.	The 99212-99215 codes are used for the physicians (or other eligible medical clinician's) time evaluating patients, ordering medications, and if needed, coordinating directly with a pharmacy. If non-physician (or medical practitioner) staff work with patients to obtain their medications from the pharmacy, the time these non-medical practitioners spend on this coordination is billed to care coordination.
3	Progress Note for MD Services - If the MD conducts more than 1 service during a visit with a client, and each service has its own code & rate, would the MD have to document each individual service using a separate progress note? For example, during a 60-minute MD visit, MD conducts: Office Visit of New PT (99203) + Health Risk Assessment (96160) + Medication Training/Support (H0034R). Would the MD document all 3 services on the same progress note or different progress notes?	The physician should pick one code to encompass all these services described within a single progress note; so, if the physician conducts a 60 min visit, a health risk assessment and medication training/support is included under evaluation and management services and the physician should bill 99205 rather than three separate codes. Some codes (for example 99205 plus 99416 for extended services) are both billable with a single progress note. If the physician is engaging in truly distinct services billable to distinct codes, then they would need to be reflected with separate clinical notes, but the usual convention is to bill the 99202-99205 and 99212-99215 codes for the entire set of services during a medical visit.
4	Progress Note for MD Services - Progress Note #18 & #19 "start/end time", if more than 1 service was conducted at the time of the MD visit, and each service has its own code & rate (see example in question 3), would the MD have to document separate start & end times for each individual service? Or would the MD only enter a start/end time for the overall visit? How would the billers bill for each separate service as they all have different codes & rates?	See #3 above.

5	Progress Note for MD Services - Progress Note #22 "service type", is the MD able to list several service types on the same progress note if more than 1 service was conducted at the time of the visit? (See example in question 3), would all those services be documented on the same note/service type? And if so, how would the billers bill for each separate service as they all have different codes & rates?	See #3 above.
6	Service Type for MD Services - Would a MD physical conducted for the purposes of assessing the need for MAT services fall under "Assessment" service type or "Residential-Physical Health" service type?	These are covered under "Assessment / Medication Services / MAT" billable to 99202-99205 and 99212-99215 codes.
7	For code 99368, can we bill for 15 minutes only?	No, this code must meet the specific time range of 30 minutes or more.
8	Are we still doing the roll up for individual services?	Yes, roll up billing is still required for services in FY 24-25, with the exclusion of group counseling and patient education group codes.
9	Billing services for student trainees. AJ as a modifier, is this correct? Can I get direction on this process?	Guidance regarding the claiming of students and clinical trainees can be found in the DHCS DMC-ODS Billing Manual page 49 Section 5.2.20 Clinical Trainees.
10	We got guidance that MAT can be billed with H0033 or H0034, but there was a SAPC email stating we should use T1007 which is the Discharge planning code? please clarify.	Guidance regarding the billing of MAT codes H2010M, H2010N, H2010S is still in process. Providers are instructed to continue claiming these codes using current guidance. Updates regarding this guidance will be released via the Sage Communication.
11	What is the code that will replace any billing for MAT or MAT education?	
12	For MAT Services, do we bill using T1007?	
13	Can you clarify what is H2010M & H2010N, are those billed as a zero-dollar amount, so 2 notes needed, then do we need 1 note billing the services under T1007 or are there 2 notes required under T1007 for each service?	
14	Is there an ETA when the billing blackout will be lifted?	The claiming blackout will be lifted by August 1, 2024. There is no blackout when submitting authorizations this fiscal year.
15	Is S9976-C specifically for PPW?	Yes, HCPCS code S9976-C is available specifically for Perinatal and Parenting Women (PPW) providers. This code is used to claim for the room and board rate of up to 5 children accompanying a mother into treatment. It must be claimed with the S9976 room and board rate for the patient in treatment.
16	If a patient is transferring to a different location, can we continue to use the same service authorization?	No, authorizations are provider site/agency specific. Providers should submit a new Service Authorization request.
17	When we rebill denied services, the amount doesn't go away from the denied amount. Is there a way to change that?	There is not a way to remove the denied amount from the system even if the service is rebilled as they are two distinct and separate submissions in Sage.
18	Are we going to get transitional payments for July and August claims?	Transitional payments will not be issued for July and August claims as the blackout is to be lifted at the beginning of August. This should allow providers time to claim for July's billing by the deadline for payment which is the 10th of the following month.
19	Are groups billed separately for the new FY [24-25]?	The HCPCS code H0005 is set specifically for group counseling billing, HCPCS Codes H0034, H0034R, H2014, H2017, H2034, and T2021 are available for group counseling billing when using the HQ modifier. Group services continue to be billed as individual services and are not required to be rolled up.
20	Are we completely done with receiving state denials?	SAPC continues to bill DMC for fiscal years currently open for billing, as such, providers will continue to receive State denials for past fiscal years currently open for billing. Only when a fiscal year is deemed closed will

		providers no longer receive new recoupments for State denials for that year.
21	Can outpatient bill for discharge services?	Yes, code T1007 is claimable for both outpatient and intensive outpatient providers.
22	Regarding the roll up billing, what if the services have different locations?	In instances where services are submitted via roll-up, providers will choose only one place of service code. (i.e., roll up services delivered both onsite vs telehealth will be submitted using one place of service code)
August 1, 2024		
23	Please show how to void a claim?	The process can be found on the SAPC website: http://publichealth.lacounty.gov/sapc/providers/sage/sage-pcnx.htm The training is called ***PCNX for Primary Sage Users: Finance and Billing Recording.***
24	The following HCPCS combo H0004:U7: AJ is not working in PCNX.	In any instance where you see a code is missing, SAPC recommends running the following report in Sage: MSO Provider Config Report FY 2023+ for the appropriate fiscal year. If the code is missing from this report, then there is an issue with your configuration and a Help Desk ticket will need to be initiated to add the missing HCPCS code combination.
25	Can 90885 only be billed as a single unit or multiple units? Is there an add on code to bill multiple units?	This code can only be billed for 1 unit (31mins - 68mins). For service time of 68 minutes or more, claim the appropriate units of T2024 (assessment substitute).
26	Which code is used for Family Therapy for Recovery Services?	Code H2017 would be used, if it were a group session you would bill H2017 with the HQ modifier. Please refer to the crosswalk on the following Sage Communication: SAPC-Sage-Provider-Communication-092223.pdf (lacounty.gov)
27	The rates we are enter are not matching the tier that I have been assigned.	Please submit a Sage Help Desk Ticket, Netsmart will confirm the appropriate tier has been assigned. Sage Help Desk Phone Number: (855) 346-2392 Sage Help Desk ServiceNow Portal: https://netsmart.service-now.com/plexussupport
28	Regarding the ASAM 3.2 WM level of care patients, since the patient is in detox and does not participate in groups during the first two weeks, but is still receiving individual counseling services, we can still bill the daily rate & room and board, correct? Also, I would use "U9" for all ASAM 3.2 WM claims, correct?	Yes, if the patient is receiving some clinical services the day rate can be billed. If no clinical services are received, then the provider would only bill the room and board rate. All ASAM 3.2 WM claims are submitted using the U9 modifier.
29	To bill for MAT Services at 3.1 & 3.5 or MAT education at the zero amount to reach the specific incentive.... What note type am I looking for under the client to find when those services were provided to them to bill?	You would be looking in the content of the progress notes to confirm that MAT education was provided. We are reviewing our PCNX documentation interface to consider options practitioners can use to indicate that an individual or group session addressed MAT in accordance with the permitted patient education materials described within SAPC Information Notice 24-01. Prior to this functionality being established, you would use the content of the documentation to indicate when MAT education was provided.
30	According to the rates matrix Medical Assistants, **363AM (363AM0700X)** is set as the taxonomy code to bill with. However, in the NPI registry, this taxonomy populates a description of "**Physician Assistant Clinical Trainee**" I want to confirm the taxonomy code for Medical Assistants before submitting.	Please refer to DHCS DMC ODS Billing Manual Page 87 and the FY 24-25 Rates and Standards Matrix Taxonomy Codes Tab which confirms this Taxonomy Code for Medical Assistants. The State only adjudicates using the first 4 characters of the taxonomy code and the recommendations from DHCS may not always align with the actual taxonomy codes when registering someone through the NPPES registry. DHCS has indicated they will only be looking at

		NPPES to verify the NPI number on a claim is active during the service dates, they will not be comparing the NPI to what is associated with a user's NPI as listed in NPPES. Providers can register staff with the appropriate taxonomy code in NPPES. Providers can use this website to see the available taxonomies as of July 2024: https://taxonomy.nucc.org/.
31	T1017 – Should we hold off on billing for Nurse Practitioner?	Yes, there is currently pending configuration with this code and the associated performing provider type. An update will be made via the Sage Communications once this has been completed.
32	Place of Service Code, if a patient doing telehealth in a car, should we use code 02 or 10?	Place of service refers to the location where the patient is receiving treatment. In the example presented the place of service code would be 02 unless the patient notes that they are living in their car, in which case it would be place of service code 10.
33	Question about Recovery Services, if the SIRP was submitted using H0004 can we bill it as H2017?	If an individual service was provided to a patient enrolled in recovery services, H2017 is an appropriate billing code. Please refer to the following provider communication regarding RSS crosswalk of services. SAPC-Sage-Provider-Communication-092223.pdf (lacounty.gov)
34	For H0025, is this a peer educational group code only? Does it require a HQ modifier?	Yes, per the Provider Manual, the two billable services for peer support and are billed with H0025 and H0038. SAPC-Provider-Manual-8.0.pdf (lacounty.gov) (page 67) H0025 is used for Behavioral Health Prevention Education Services. Per the Provider Manual this code is used for Educational Skill Building Groups: Providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills to help beneficiaries achieve desired outcomes. These groups promote skill building for beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services. The code does not require an HQ modifier as it is used for a group service only.
35	Is there a min/max number of participants for group services?	Group size limits are relegated to the following: FAQNetworkProviders.pdf (lacounty.gov) (Item 5) The minimum number of participants for a group service is two. In non-residential settings, the maximum number of individuals in any group counseling or patient education session is 12 individuals. In residential settings, the maximum number is 12 individuals for group counseling and 30 individuals for patient education. This includes non-patients (e.g., family members) and private pay patients.
36	Is there an updated aid code chart to show the allowable codes?	The most updated version of the Aid Code Master Chart is found on DHCS's website: MedCCC - Library (ca.gov) The direct link to the aid code chart is located here: https://www.dhcs.ca.gov/provgovpart/Documents/SDMC-Aid-Code-Chart.xlsx
August 8, 2024		

37	Is there a statute of limitations regarding the state denials?	For State denials, you can continue to work and rebill any services for all fiscal years currently open for billing; FY 22-23, 23-24, and 24-25. A Sage Communication will be released notifying providers when the fiscal years above have been closed for billing.
38	Certain codes were requested to not be transmitted due to SAPC system issues (e.g., H0050, etc.). Any update when you will accept those claims?	This will be communicated via a Sage Communication once these issues have been resolved.
39	CPT Code 99215 states the minimum for the add-on code is 84 min to use 99416, but the service definition has a range of 40 - 54 min. Also, the example uses 54 minutes not 84 minutes. Is it supposed to be 84 min or 54 min?	At 83 minutes, while the maximum service time for 99215 would have been reached (54 minutes), the minimum service time for the add-on code 99415 (30 minutes) would not have been reached. Minutes between 55 and 83 would go unclaimed or not reimbursed. Once 84 minutes of 99215 has been provided, as the minimum service time for the add-on code has been reached as well, counties can claim 1 unit of 99215 and 1 unit of 99415
40	We are using the AJ modifier in conjunction with the Clinical Trainees. For the EDI files, where should the AJ modifiers be in the modifier sequence?	Please refer to the 837P companion Guide: http://publichealth.lacounty.gov/sapc/Sage/Documentation/CompanionGuideHIPAA837P.pdf (page 9-10) 9. Procedure Code Modifier Order For a transaction to be HIPAA-compliant, a procedure code cannot use more than four modifiers. The following modifier order must be used when submitting claims to SAPC. A. Specified Modifier Order • ASAM Level of Care (LOC) • Special Population (Youth, Perinatal) • Place of Service (Telehealth) • Lockout (XU, XE, 59, 27) • Clinical Trainee/Student Run the MSO PROVIDER CONFIG REPORT FY2023+ in PCNX to see a listing of the complete HCPC/CPT code set with relevant modifiers that your site has been configured to claim. This report will support your agency in identifying the code and modifier combinations to use for services. B. Trainee Modifiers Specifics 1. Clinical Trainee/Student Modifier will always be the last modifier and if a modifier needs to be dropped to accommodate it, the place of service (telehealth 93 ,95, SC, GQ) modifier will be dropped. 2. HL/GC will not be used in conjunction with Clinical/Student Trainee Modifiers C. Modifiers to Drop if Needed. In rare situations that a service would exceed four modifiers per procedure code in each transaction, do not use telehealth modifiers. If not using telehealth modifiers is not enough to keep transaction under four modifiers, do not to include modifiers HL (Intern) and GC (Resident). If more modifiers need to be dropped, remove modifiers that do not affect payment determination. For a complete listing of modifiers please refer to the modifier's subtab located on the http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-andforms.htm?tm#bulletins
41	We accidentally submitted July 2024 claims before the blackout was lifted. We will be resubmitting these claims	They would be resubmitted as original services or Claim Type 1.

	once we receive the 835 denials. Do we resubmit these as Claim Type 1? Or do they have to be resubmitted as Claim Type 7?	
42	The new matrix and under ASAM 1.0 H2015 states that comprehensive community support services, per 15 minutes. My question is are we only able to bill 15 minutes or it just means 15 minutes increments?	Time is tracked in 15-minute increments, and H2015 has a maximum limit of 96 units. The billing rules tab on the rates matrix provides information on the maximum units that can be billed for all codes.
43	What is the time frame when we can change the guarantor after claims have been submitted?	It is recommended that providers confirm that all services have been billed under the guarantor before making changes to a guarantor in a patient's Financial Eligibility record. In most scenarios, a guarantor should not be deleted from the record. Providers should refer to and utilize SAPC's job aid – Documenting Changes in Financial Eligibility Status for more guidance.
44	Can claims that were denied under MHLA be rebilled?	Yes, providers are allowed to resubmit claims that have been denied for MHLA.
45	Can T2024 be used for other assessments, like ASAM?	No, that would not be used for ASAM. ASAM Assessment would use H0001.
46	How many years can back in time can the state deny services? How far back?	SAPC is still actively submitting billing to the State for claims for services from FY22-23 to the current fiscal year.
47	When viewing the 270 Inquiry in the Client Dashboard it only shows the date the inquiry was submitted. How can we verify the month the inquiry was submitted for?	Follow up
48	For State denial code 177, how can we prevent these?	A State denial for CO 177 indicates that the patient is not eligible for DMC. There are many potential causes for this denial. SAPC's Denial Crosswalk provides guidance to providers on how to resolve local and State denials. To prevent denials for CO 177, it is important to validate the patient's DMC eligibility every month to confirm their DMC benefits. The patient's aid code should be reviewed to confirm it is covered by DMC, that the patient's DMC benefits County of Residence or County of Responsibility are 19 (LA County), the patient's other insurance was billed first and the denial or partial payment was included on the claim to SAPC (if applicable), and that the correct CIN is on the patient's DMC guarantor in the Financial Eligibility.
49	Any intention /plan to allow nursing staff (LVN, Psychiatric Technician, Medical Assistants) to submit billing directly?	Currently, only users with a Finance role can submit billing. To request a Finance role for a user, please email us at Sage@ph.lacounty.gov with the individual's details, and we will configure their access accordingly.
50	Until when do we have for the [FY]22-23 to be closed out?	There is not a final date yet set, SAPC will notify providers via a Sage Communication when the deadline to submit for FY 22-23 occurs.
August 15, 2024		
51	When an LPHA conducts a family counseling session without the patient present for 30 mins or (90846) should we be also using the patient's substance use disorder diagnosis? Or would we utilize an ICD-10 Code, such as Z71.52 (counseling for family members of drug abuser)?	The provider should use the SUD dx. If the family session occurred prior to establishing an SUD (for example an initial engagement auth) then the provider can use an applicable Z code such as the one noted.
52	For MA rates, do we need them be MAT certified or just having a diploma is enough?	Pending response.
53	The Rates and Standards Matrix FY24-25 – DRAFT document currently has the -CN suffix present for H2015-CN and H0049-CN. However, these two codes do NOT exist under the Billing Rules tab. Our understanding was	The billing rules tab has been corrected in the current version of the rates matrix and is posted online. -CN denotes codes that are available for billing of the CENS locations.

	that the -CN suffix was not in use for FY 24-25. Is its inclusion in the Tier 1-3 tabs an overlooked typo?	
54	We currently offer Patient Education to groups under our CENS program? How would we bill that? Can the HQ modifier be applied to group activities under CENS?	Patient Education to groups for the CENS program would bill with H2017-CN using the HQ modifier. This is currently pending configuration as it was omitted from the Rates Matrix this year. Please track Sage Communications on updates when this will be available.
55	Is there a mechanism where we can view all the associated CPT and HCPCS codes associated with a specific P-Auth? (e.g., CENS P-Auth P9914)	Provider sites can see all CPT code combinations associated with the CENS and all other levels of care by running the MSO Provider Config Report 2023+ for the current Fiscal Year (7/1/2024-6/30/2035).
August 22, 2024		
56	For the 837 EDI files for July 2024 submitted before 8/10, can we still expect to receive the corresponding 835 files on (or around) the 25th of August?	You will receive something between now to the end of August 2024.
57	Where can we find the slides and recordings to these meetings?	Billing FAQs, PowerPoint Slides, and Video Recordings are available at the following location of the SAPC website: http://publichealth.lacounty.gov/sapc/providers/sage/finance.htm
58	How do we bill A0080 (Perinatal Transportation)?	This benefit is available to all Perinatal Treatment Network Providers. Please follow the steps shown here for billing this HCPCS code: https://lacounty-my.sharepoint.com/:v:/g/personal/eorellana_ph_lacounty_gov/EWcCvuu8atdAtOPEU6ZUa6QBQHjCfCbHsnVBEl8N5NsE5A?e=0VZhqw
59	What is the reason H2010S & M are now zero dollar? Or was this a state mandate and if so, can you say what the justification is/was?	Guidance regarding the billing of MAT codes H2010M, H2010N, H2010S is still in process. Providers are instructed to continue claiming these codes using current guidance. Updates regarding this guidance will be released via the Sage Communication.
60	Any update on when H0050 and the other codes that weren't ready can be billed?	There are no new updates regarding this service, updates regarding this guidance will be released via the Sage Communication.
61	For 837 files, what happens to claim if the auth in PCNX is pending? Does SAPC hold the claims and if yes, will we see this in the 277 files?	Providers are requested not to submit services when the Service Authorization is pending. While the claim may appear as accepted on the 277 report, it will show as pending on the 837 posted report. Please note that any claims submitted with a pending Service Authorization will be denied.
62	How long do we need to wait after we submit billing to run the provider services detail report for accuracy information?	The Provider Services Detail Report will be generated based on the parameters you select when running the report. If you wish to run the report immediately after submitting claims please select 'submitted' in the parameters. This will display all submitted claims, regardless of whether the batches are open or closed, as the batches are generally not immediately closed.
63	Is FY 22/23 still open for Billing, if so when is the due date.	Please refer to the 9/6/2024 Sage Communication: **Fiscal Year 2022-2023:** The final date for treatment billing for FY 22-23 services is set as Tuesday, December 31, 2024. **Fiscal Year 2023-2024:** A phased approach will be taken for services delivered in FY 23-24. • Services delivered July-December 2023 must be submitted by Tuesday, December 31, 2024 • Services delivered January-June 2024 must be submitted by Monday, March 31, 2025
64	Is Naloxone distribution H2010N:U7 billable for ASAM 1.0 Outpatient?	Yes, please refer to the Rates and Standards Matrix for FY 24-25. This service is paid out at zero dollars and is used for tracking in the incentives initiative.

65	I have a service of 60 minutes for Family Therapy (90847) to bill, but The Rate and Standard Matrix says 58 minutes or more, claim T2021 (Therapy substitute). I am unsure what to bill for this service. Do I bill the T2021 for the extra 2 minutes?	No, you would bill the full 60 minutes using the T2021 substitute code.
66	Do CENS staff need to submit a patient authorization for an assessment/screening for FY 24-25? I am having trouble submitting billing because there is no patient authorization on file. I've submitted a Sage Helpdesk ticket, but they are also unaware why this is happening and suggested I reach out to QUIM. Before the new fiscal year started CENS staff did not need to submit an authorization it just auto populated.	No providers have been configured with provider authorization to bill for CENS Services. The Pauth will show in the authorization area with a P-followed by a number. If you are still having issues locating your Pauth please submit your helpdesk ticket number to Finance and we can provide assistance.
67	Do we submit the T2021 and T2024 codes with the telephone or telehealth modifiers?	Yes, you will use the 93 or 95 telehealth modifiers when using these codes to substitute CPT Codes. This is not currently configured in Sage or SDMC, it is expected to be deployed sometime in October.
68	if a provider billed for 90847 & 90846 on the same day and both are 60min, would I just bill 120min on T2021?	90846, 90847, 90849 In addition, the lockout rules of the CPT code being substituted will be in effect. Therefore, if a therapy CPT code cannot be reported with another service code, then T2021 should also not be reported with that code.
69	When we get a denial reason that reads "Maximum number of units of procedure code per day exhausted" is that a duplicate denial?	The service claimed has a set maximum number of units/day allowable, where the units on the claim exceeded that value or the service has already been paid in the system. This is often accompanied by "A potential Duplicate Service Found" denial reason in Sage.
August 29, 2024		
70	How do we bill Contingency Management - UDT Stimulant Positive? Is the code H0050?	All Services for Contingency Management must be billed using H0050. For specifics regarding Contingency Management Billing please refer to SAPC IN 23-06.
71	For ASAM 1.0 outpatient do CENS need to submit a patient authorization even if the patient is refusing treatment? I have a Sage Helpdesk ticket open, but the helpdesk was unsure and referred me to QUIM. I did not hear back from QUIM, so I then asked in last week's meeting. You asked me to forward the ticket to sapc finance so you can investigate but they also referred by back to QUIM. For FY 23-24 we did not need to submit an authorization but instead it would auto populate. Can you please advise on how we can find this out?	No providers have been configured with provider authorization to bill for CENS Services. The Pauth will show in the authorization area with a P-followed by a number. If you are still having issues locating your Pauth please submit your helpdesk ticket number to Finance and we can provide assistance.
72	This widget has always shown "no data in table" what am I missing? Do I need to "activate"?	Need to clarify issue with the group.
73	We are a Secondary provider as of 7/1/24. We have some services that need to be voided from June-24. How do we void last year claims?	The process for voiding claims as a primary provider can be found in the following presentation: https://lacounty-my.sharepoint.com/:v:/g/personal/eorellana_ph_lacounty_gov/EWcCvuu8atdAtOPEU6ZUa6QBQHjCfCbHsnVBEl8N5NsE5A?e=0VZhqw
74	In the last meeting, we inquired about the T2021 and T2024 codes, were you able to find out if it needs the telephone/telehealth modifiers?	Yes, you will use the 93 or 95 telehealth modifiers when using these codes to substitute CPT Codes. This is not currently configured in Sage or SDMC, it is expected to be deployed sometime in October.
75	If we have a resident that programmed the whole day in residential, attended multiple groups had an individual service but discharges at the end of the day would we be able to bill any services?	Pending Response

76	Going back to my question where can I find step by step to bill CENS and navigate the Provider Auth (PAuths) Widget?	Pending Response
77	UA testing H0048 for this FY now states N/A for certified, registered, and LE/ LPHA instead of $- Does this mean we no longer have to process our UA testing through the billing system?	NA designates that the service is not allowable for that performing provider type. $- designates the service as allowable for the performing provider type but is paid out with a zero-dollar billing.
78	Could you provide guidance on how we can bill MAT Services for RS Clients? I understand that we cannot bill them as MAT directly, but could we process them as Care Coordination?	Need to clarify with group as to what is referred to as RS.
79	As 3.1 LOC and 3.5 LOC, is there a way that an LPHA can bill code 90885 for reviewing the discharge paperwork given from an outpatient psychiatric evaluation? Or is that only for psychiatrists/MD, etc.? and would it be care coordination?	Pending Response
80	We discussed H2010N last week and I understand the service can be documented even if the patient is in RS or provided by peers. What code should we use for billing? There was a bulletin about this recently to use code T1007, but I don't think they can be used by peers or in RS	Pending Response
81	I realized CM H0050 were to be held from billing a couple days ago. I bill for another agency in the evenings and have billed CM since the blackout was lifted. Are those going to be denied or am I ok?	Pending Response
82	Is Plan of Care billable? is it billable under H0038?	Pending Response
83	Is there a guidance on the residential day billing rules? If a client is on-site from the 1st to the 30th if they receive services on the 30th but that is the discharge date, we cannot bill the 30th?	Pending Response
84	Are Peer Support Services allowed in Recovery Services?	Recovery services are not reimbursable when provided by a Peer Support Specialist.
85	Is the MSO Denial Report the same for county and state? Once the resolution has been done how long does it take to update in the MSO Report? Can the MSO Report be generated with actual code and description vs description?	Pending Response
86	How do you all recommend a quick way for billers to know which date is the discharge date? Or will it just take some research on the biller's end? Anyone else want to share what they do to recognize that date?	Pending Response
September 05, 2024		
87	Is the 180 days deadline for original claims a state issue or this applies just to SAPC?	Refer to Section 5.2.14 Claim Timeliness of the DMC ODS Billing Manual – Original Claims The timeline for initial submission of DMC-ODS claims is critical. Original claims must be submitted within 12 months of the month of services (W&I Code, Section WIC 14021.6(g)). An original claim submitted after 6 months from the month of service without a DHCS approved Delay Reason Code (DRC) will be denied. Please see section 5.2.368 for more information about requesting a DRC. Please refer to Appendix 6 for a list of DRCs.
88	Where do I see the steps for modification and creating PCNX access?	The process is covered in the Sage User Onboarding/Offboarding and Privilege Management Guide.
89	Will the RBH and RH sites have the same naming conventions for the "fake" NPI? Such as "RBHT"	Pending Response

90	Are the bed claims for RBH requiring a principal DX attached to the claims? We had our 837 test claims rejected for RBH because of the missing DX.	All RBH claims require a diagnosis, the diagnosis should match the diagnosis code used from admission for the RBH claim. RBH participants must be concurrently enrolled in OP (ASAM 1.0), IOP (ASAM 2.1) OTP (ASAM 1-OTP), or Ambulatory Withdrawal Management (ASAM 1-WM, 2-WM) services for providers to receive RBH reimbursement. See Page 91 of the SAPC Provider Manual.
91	How do you bill a CENS 1.0 outpatient step by step. I'm having difficulty submitting billing and have it on hold because I do not know how to work the PAuth's.	Please follow the steps shown here for billing: https://lacounty-my.sharepoint.com/:v:/g/personal/eorellana_ph_lacounty_gov/EWcCvuu8atdAtOPEU6ZUa6QBQHjCfCbHsnVBEl8N5NsE5A?e=0VZhqw
92	What is the last day of service/ walk away date /discharge. I understand that we are unable to bill the daily rate and room & boards out, but what if they have a full day of activities done and then for example walk out of the facility at 9pm? Can we still bill the entire day?	Pending Response
93	Last discussion it was stated that the discharge day could not be billed for H0019 and S9976 is this correct? Also, for RBH H2034 should not be billed on the discharge date?	Pending Response
94	With financial eligibility not found denials, I know there are sometimes several things that may need to be "fixed" is there any kind of "if this then do this, if not this then..." etc.? and is there a way to know ahead of time if I've found the right "fix"? I've rebilled for one client twice now, thinking I'd gotten the issues fixed only to have it come again as denial.	Pending Response
95	When billing services I've had a few authorizations that were approved the same day I was billing but when selecting that approved auth it gives a denial message. Do we need to wait a certain amount of time before billing or is PCNX in real time?	PCNX is in real time, the auth should approve once it is available. If there are issues with your auth please reach out to QIUM.
96	I'm trying to sift through the EOBs with state denials. Is there or could there be a report that would allow us to download all data by client that would let us easily see billed to denied to rebilled to either paid or denied again?	KPI Dashboards provides refreshed views for clinical, financial, and operational data of select Key Performance Indicators (KPIs), as well as the ability to filter aggregated data by program, service type, patient and more. (Payment Reconciliation Report)
97	What's the time in which providers must submit notes? I remember it being 3 days, but do we count the day in which services were delivered as day 1.	Pending Response
98	Can we add the Denial Code on the description of the denial on the "Services Denied in MSO" report it would help us identify the Denial code faster. Also, can we add the word "report" at the end of "Services Denied in MSO", so it pops up when we type in report into the search bar in PCNX	All enhancement requests can be made using the Sage HelpDesk. Please visit the Sage Helpdesk to register any enhancement request as it will be vetted through the SAPC business section.
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99	Is there still a hold on billing for H0049-N: Screening Non-Admission?	Guidance should be released soon. Please refer to the Sage Communication website for the most up to date information regarding Sage.
100	Is there somewhere I can find more information on Naloxone distribution documentation and billing? What is the Service Type supposed to be? And what would be the correct way to bill it?	Pending response.
101	Will there be rates for Mat Education/Naloxone Handling for residential? Or will it be bundled with the day rate?	Guidance regarding H2010 M/N/S billing will be updated shortly, for now please continue to bill H2010N for Mat Education Naloxone Handling. This HCPCS is available outside of the day rate and can be billed as a

		separate service with a $0 dollar billing that is used for incentives tracking.
102	For clarification a PCNX denial does not require being voided in the system?	Denied claims do not require voiding in the system.
103	When would be the appropriate time to use the Void claim function?	Only approved services need to be voided. We will provide guidance soon on when to void and when to replace a claim.
104	It was my understanding we do not void State denials, but we do void Sage denials otherwise the service might be denied when we resubmit.	If a service was denied locally, voiding the service is not necessary.
105	To bill contingency management, the client must be enrolled in an OP program, correct?	The client must be enrolled in Medi-Cal and receiving services at a non-residential level of care to qualify for Contingency Management Services. Refer to SAPC Bulletin 93-06 for complete guidance for Contingency Management Services
106	If I accidently entered the wrong duration, used 1440 instead of 30, but on the Provider Detail Report it shows it's paying at correct expected disbursement, do I need to void those services and rebill?	You do not need to void the services as long as you are billing the correct units for the services provided.
107	Do Initial Engagements need a CalOMS admission?	Pending Response
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108	What is the billing code used for peer support - plan of care H0025 or H0038?	Pending Response
109	Can you show how to bill 99215 for 75 minutes?	Please refer to the following Billing Office Hours Recording at 1:14:00 where the case study presented goes over this process.
110	Could you please go over billing for the first 30 days when someone is entered with guarantor of “applying for MC” Will authorizations be approved under that circumstance or are they kept pending until MIC is fully active?	Pending Response
111	When is H2010S rate for Residential coming out?	The H2010S rate for MAT Safeguarding Medications at Residential treatment providers is already out, providers are allowed to claim for this service as a zero-dollar billing which is then used for tracking for incentive payment purposes.
112	We are adding Contingency Management to our OP/IOP clients. Can you please help us with details regarding that billing?	Instructions on the requirements need to bill for Contingency Management can be found in SAPC Bulletin 23-06.
113	Question about interpretation services, what is the proper documentation, meaning does it need to be a separate note each time they are used or for instance if it’s a group note and mentioned there that the interpreter was present, is that sufficient documentation? What is correct code, is it 90887? What is the rate, I don’t see any dollar amount in tier 3 rates?	Questions regarding progress notes and other required documentation can be answered by our Clinical Standards Team. Please contact our CST team at dsapc.cst@ph.lacounty.gov. They can provide guidance on documentation. Please bill the primary service and include the add-on code for the interpretative service that was provided.
114	Who would I contact to change the log in info on the SFTP website?	Please send an e-mail to SAPC-Finance@phlacounty.gov .
115	Are Contingency Management services (H0050) still on hold for billing?	No, Contingency Management services are now able to be billed.
116	At any point will MAT Education & Naloxone Distributions be billable with a dollar amount for [Residential Treatment Providers]?	H2010N is allowable as a service along with T1007, these codes will be used for the tracking of incentive payments. There is currently only a rate for Outpatient providers.
117	To open a client in Recovery Support Services, do they need an Auth? I looked at the Checklist SAPC has but could not find a checklist for Recovery Support Services only.	These are provided as Pauths, you would not need to submit a member auth. So the authorization is already available for the provider to utilize with a pre-approval.

118	For intake processes I have a question: If our intake staff meet with a client one day then finish the intake process the following day. Can I bill intake time on 2 different days?	Clinical Question. Pending Response.
119	For FY 23-24 H0049-N, I do not see the Pauths listed, and I am not able to bill these non admits. Do I need to create a ticket?	These Pauths have already been configured and should be available for you to use, if you are not seeing this in the system please open a Sage Help Desk Ticket.