Communication Release

2/16/2024

State Denial CO 97 M86

Providers may have started to receive State denials with code CO 97 M86 for services delivered for FY 23-24. The Department of Health Care Services' (DHCS) description for this denial is, "Short-Doyle Medi-Cal denied this service because it had already approved the same service provided on the same day, by the same rendering provider, to the same beneficiary." DHCS's denial description is referring to their policy on Outpatient Services that requires providers to submit one service that incorporates two or more services (as allowed) into one claim for FY 23-24. This is different than how providers should continue to bill for FY 22-23 services. SAPC Finance's investigations into this denial code have confirmed that some providers are continuing to bill SAPC with two separate services/claims for, for example, claiming two individual counseling services instead of rolling up the two services into one. The information regarding this denial will be added to the next version of SAPC's Denial Crosswalk.

Resolution

- **Primary Sage Users:** Void the original service billed to SAPC that was not denied by DHCS. Resubmit the service with the two (or more) services rolled up into one service with the units totaled.
- **Secondary Sage Users:** Submit a replacement claim for the original serviced billed to SAPC that was not denied by DHCS. Resubmit the service with the two (or more) services rolled up into one service with the units totaled.

Below is the information from the DHCS Billing Manual, a clarification email from 8/1/2023 from SAPC on Roll-Up Services, and an update from the Sage Provider Communication from 9/29/2023 which provides an update on roll-up services and group counseling/patient education.
https://admin.govdelivery.com/accounts/CALACOUNTY/campaigns
DHCS DMC ODS CalAIM Billing Manual, page 32, section 5.2.12 on Duplicate Services – Outpatient Services
"Outpatient services are listed in service tables 1-13. Except for Sign language or Oral Interpretive services (T1013), Interactive complexity (90785), and health behavior interventions for the family without the patient present (96170 and 96171), a claim is considered a duplicate if all of the following data elements are the same as another service approved in history:

- The beneficiary's CIN
- Rendering provider NPI
- Procedure code(s)/modifier(s)
- Date of service

Duplicate services are not allowed.

If a provider renders the same service to the same beneficiary on the same day more than once, the provider should submit the claim as one service rather than two services. For example, a provider may render 60 minutes of recovery services in the morning and an additional 30 minutes of recovery services in the evening to the same beneficiary. In this particular scenario, the county would submit one claim for 90 minutes of recovery services."

SAPC Email to Providers on 8/1/2023
"For FY 23-24, providers are required to submit same services (those with the same HCPCS or CPT Code), occurring on the same day, and performed by the same performing provider to the same patient as a consolidated single claim. This is known as a roll up service. For example, a performing provider who provides 30 minutes of care coordination in the morning (onsite) and 30 minutes of care coordination

(via telephone) in the afternoon to the same patient on the same day, must claim this as one claim of 60 minutes of care coordination for the day. Providers who fail to do this will receive a denial on the claim once adjudicated by the State."

Sage Provider Communication on 9/29/2023

"Updated DHCS Policy on Roll-Up Services for Groups: After successfully advocating for our providers with DHCS, the State has removed the requirement for multiple group services/patient education groups delivered to the same patient on the same day to be "rolled up" or combined into one service for billing. Providers can once again bill each service separately as in previous fiscal years. The requirement is still in effect for all individual services and must be rolled up into one total service, such as for multiple individual counseling, assessments, or care coordination, etc. delivered to the same patient in the same day by the same provider."

Midpoint Rule and Billing Rolled Up Services

DHCS has provided additional clarification regarding the midpoint rule as it applies to rolled up services. When multiple services are provided to the same patient, on the same day, by the same practitioner, with the same service code, these should be rolled up and billed as one service to SAPC.

DHCS uses AMA rules, which states that each service must meet the midpoint rule independently to qualify to be **included in the billing** as a roll up. Units billed should not be based on the combined total duration time but on each individual service duration time meeting the midpoint rule.

Example 1:	Service 1 = 18 mins (meets midpoint rule) Service 2 = 7 mins (*does not* meet midpoint rule)	Combined Total Duration: 25 mins **Allowable Units Billed: 1 unit**
Example 2:	Service 1 = 9 mins (meets the midpoint rule) Service 2 = 8 mins (meets the midpoint rule)	Combined Total Duration: 17 mins **Allowable Units Billed: 2 units**

Peers Support Specialist Scholarship Availability

SAPC has released a Certified Peer Support Specialist Scholarship Application and scholarship manual for interested Peer candidates. Scholarships are limited and available until all funds are exhausted or December 31, 2025, whichever comes first. Applications will be reviewed on a rolling basis. Refer to the scholarship manual for application cycle dates. Please distribute this information widely to your agency staff, volunteers, program alumni and community members. Direct any questions to SAPC_ASOC@ph.lacounty.gov.

Certified Medi-Cal Peer Support Specialists access to the Problem List

Effective Monday 2/19/2024, Certified Medi-Cal Peer Support Specialists (CMPSS) will be given access to edit a patient's Problem List/Treatment Plan form in Sage; however, it is still required to be finalized by an (LE)LPHA. For additional resources on what can be entered into a Problem List, please refer to the CalAIM Documentation Reform section of the SAPC Sage website.

CMPSSs are still required to document a Plan of Care for peer related services on a Progress Note. Documenting problems on the Problem List/Treatment Plan form is not a substitute for a Plan of Care.

Updated Assessment Claiming Guidance

SAPC has received recent clarification from DHCS and Medi-Cal regarding the assessment codes H0001, 90791, and G2212 prolonged service code. As part of payment reform, LPHAs were able to bill more specific CPT codes that match the service and discipline type. CPT code 90791 was initially understood as an LPHA assessment code to be billed along with G2212 to claim for the full length of service. However, G2212 was recently clarified to be only allowable for services delivered by medical professionals under those designated Evaluation & Management or other assessment CPT codes and cannot be billed with 90791 when utilized by non-medical LPHAs. As such, SAPC recommends use of H0001 for all assessments completed by non-medical LPHAs and discontinue use of 90791 with the G2212 add on code. The rate for each of these codes is identical where providers will be paid the same amount for H0001 and will no longer require use of G2212. H0001 does not have the 1-unit max per day restriction and will allow the full service time in units on the same claim.

Medical LPHAs, such as MDs/DOs/PAs, etc. will continue to use G2212 as needed if the primary CPT code does not cover the full duration of the service.

Sage-PCNX Form, Report, and Widget Updates

The SAPC Sage Team would like to announce the following form updates:

Form	Changes	Environment	Date Available
Youth and Young Adult Screener	Fixed form from defaulting from previous iteration as it creates an increased risk for error of skipped fields.	LIVE	Friday 2/16/2024
Progress Note	A **Service Duration (minutes)** field was added to capture the direct patient service time which may be less than the total difference of the Service End/Start time. Please click on the light bulb next to the field on the form for additional information.	TRAIN	Week of 2/19/2024
Provider Services Detail Report	New fields were added per provider enhancement request: **Date Billed, Voided?, Date Voided, Voided Amount ($), Adj Billed ($), Adj Expected Disbursement ($).** Please see the updated Report Guide for explanation of added fields.	LIVE	Friday 2/16/2024
270 Inquiry Widget	Updated to populate the most recent data first to ensure the current information is showing. The widget captures up to twelve 271 responses based on the most recent Submission Date field that were run in the last 12 months.	LIVE	Friday 2/16/2024

For questions regarding using the updated forms, reports, and/or widgets, please email Sage@ph.lacounty.gov.

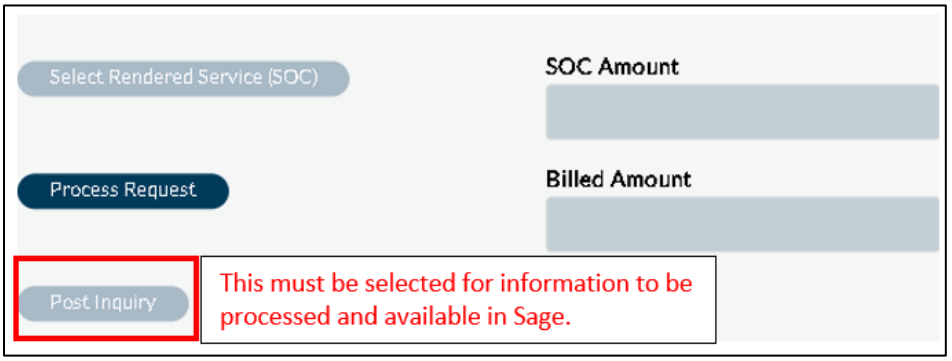
Extended: Sage Help Desk Survey

The bi-annual Sage Help Desk Feedback Survey will be emailed to users who submitted a Sage Help Desk ticket within the last six months. The survey has been extended an additional week to allow more time to respond. The survey will be open from 2/5/2024 to 2/26/2024. The survey helps SAPC and the Sage Help Desk to determine if users are receiving the support they need from the Help Desk and identify any areas for improvement.

The survey responses and feedback are an important part of our ongoing process improvement efforts to serve you better. We encourage all Sage users that receive the survey to please complete it within the designated three-week period.

Reminders From Prior Sage Provider Communications:

Real Time Eligibility 270 Inquiry Workflow: SAPC has identified a workflow issue where providers are not posting the results of the Real Time Eligibility 270 Inquiry form in Sage after viewing the report. Failure to post results prevents the data from being available to populate the reports and widgets used to view the aid and county codes from the 271 results. Previously, in ProviderConnect-Classic, posting was required before the report would populate; however, in PCNX posting is not required for the report to display, which allows the user to leave the page before posting without receiving a warning message. It is very important to post the file to ensure the data is available for all subsequent providers and available to you on the widgets and reports. Specifically, by using the 270 Eligibility report to post the results, the County and Aid Code Report and/or the 270 Inquiry widget, which is viewable on the Client Dashboard, will help to determine DMC eligibility.



SAPC does not have an update for when the issue related to the error on the eligibility report will be resolved. However, the data is being transmitted and available after posting on the widget and the County and Aid Code report in PCNX for providers who post the inquiry results.

Submission of Suggested Sage Enhancement Requests: To make suggestions, new or updates to forms, reports, and/or widgets, the SAPC Sage Team encourages you to please submit a Sage Helpdesk ticket. In the "Please describe your issue" field begin with "Enhancement Request:" and indicate the item you would like to suggest changes to. This will assist in directing the ticket to the appropriate group for review. In the "Additional Details" fields you can specify the requested changes, such as adding new fields. If possible, please attach a mockup of what you envision the changes to look like. If it is a new field, where should that field be added? If it is a report, what are all the fields you would like to see on report? The more specific you can be when making your suggestions for enhancement requests, the more likely it will be able to be considered for inclusion.

Patient Handbook Acknowledgement form went Live on January 15, 2024: Providers and patients now have the option of documenting in PCNX that a patient has viewed the patient orientation video and/or been provided with the Patient Handbook as is required per DHCS Behavioral Health Information Notice 23-048.