Substance Use Disorder Information System

Communication Release

3/25/2021

Webinar Announcement
CIBHS Focus on Finance: How to Bill OHC (Other Health Coverage)

Summary: CIBHS will be facilitating a presentation followed by a discussion, on how to properly submit claims for patients who present with OHC attached to their Medi-Cal record. The timing is critical as SAPC is currently incorporating OHC into SAGE, which should be fully implemented soon. Providers are required to submit claims to a patient's OHC prior to submission for DMC reimbursement and provide SAPC/DHCS the EOB's or denial letters. As we are gearing up for CalAIM, it is critical that LA County Network Providers understand the difference between full scope Medi-Cal and Medi-Cal with OHC or Medicare Advantage.

Objectives:

- Recognize patient Medi-Cal response "Other Health Coverage" (OHC) and differentiate between full scope Medi-Cal and Medi-Cal with special circumstances.
- Design a system for managing patients with OHC and when appropriate, execute administrative functions to submit claims or obtain denial letters.
- List steps needed to satisfy SAPC and DHCS requirements for obtaining reimbursement for claims submitted when patient has OHC on their Medi-Cal record.

Date and Time:
April 7th, 2021
12:00pm to 1:00pm – CIBHS Presentation
1:00pm to 1:30pm – Optional Q & A

Audience:
All program leadership, billers, finance professionals, operations, other key staff involved with benefits acquisition and eligibility.

Registration Link: http://bit.ly/cibhs0407

Remapping CO45 for Level 1 Denial Codes on 835 files

Sage was recently updated to include new denial reasons on 835s for claims adjudicated from 837P and 837I files. The denial reason/explanation of coverage values in Sage for this new 837P denial is "Claim Submitter ID Already Successfully Processed." For existing 835 files, this code will continue to show as CO 45. SAPC has worked to remap this code to a more specific CARC/RARC combination that will assist in denial troubleshooting. All claims received (regardless of date of service) on 03/23/2021 and after, if denied for this reason will be reported as **OA 18 M47** on the 835 and "**Claim Submitter ID Already Successfully Processed"** in the KPI Claim Denial View and the EOBs.

For 837I files and resulting 835s, CO 45 was used to indicate the denial "No Admitting Diagnosis on or Before Admission Date." SAPC has determined that this denial is no longer necessary and has been deactivated so that the system no longer looks for that denial in the adjudication process. Any claims that were previously denied for this reason can be resubmitted for adjudication and should not receive this denial after resubmission. However, these claims may be denied for other reasons that were not noted on previous adjudication. Should this denial be reactivated, it has been remapped as **CO 146 MA65**, with a Sage explanation of coverage reason of **"No Admitting Diagnosis on or Before Admission Date"** as seen in KPI and EOBs.

Reminder: Claiming for Screening

As a reminder regarding the screening process, providers must utilize the ASAM CO-TRIAGE or Youth Screener in Sage in addition to the Referral Connection Log for any patient who was not referred by SASH, CENS, or CORE (unless the site offers the full continuum of care available). There are two different procedures for claiming for the screening depending on if the patient is admitted the day of the screener or another day.

1. If the **patient is admitted on the same day the screener was completed**, providers would request a member authorization as they normally would and claim the H0049 code that is attached to the authorization.
    a. All non-residential levels of care are eligible to receive the $30 flat rate for the screening.
    b. For residential levels of care or levels of care that bill a day rate, screening is incorporated into that day rate already.
2. If the **patient is not admitted on the same day or to the same provider site** that completed the screening, providers would use the Provider Authorization (PAuth) that is preassigned and preapproved for all patient screeners. Providers use the same PAuth number for any patient that they are billing a screener. PAuths are assigned for the entire fiscal year and a new PAuth is issued at the beginning of each fiscal year (this is the same for incentives as well).
    a. This will be billed prior to the member auth date. Providers will admit the patient into Sage or create an episode for their agency, but not submit a member authorization until the day the patient is actually admitted.
    b. The CalOMS admission date should reflect the first day of treatment, not screening if they are different.
    c. For questions related to CalOMS admission dates, please contact your assigned HODA (Health Outcomes and Data Analytics) CalOMS team member.

For more information, please see the Sage Webinar Trainings page http://publichealth.lacounty.gov/sapc/Sage/SageWebinars.htm and view the September 25, 2019 recorded webinar on the Referral Connection process. Additionally, Secondary Sage Users may contact the Sage Helpdesk or their assigned CPAs if they do not know the current PAuth number.