



Sage Billing Webinar

Los Angeles County's Electronic Substance
Use Disorder Electronic Health Record System

Substance Abuse Prevention and Control
County of Los Angeles Health Agency & Department of Public Health

1/31/2018



Housekeeping

- Please mute your phone
- Do NOT put your phone on HOLD – it plays music and does not allow the rest of us to hear
- Hold questions to the end
 - Provider-specific needs should be taken offline in a separate communication
 - Please do not ask questions by sending to the webinar ORGANIZER via the chat function
- Please ensure all issues are reported to the Netsmart Sage Help Desk



GOALS

1. Increase understanding of the process for submission of Eligibility Verification and Service Authorization requests (to understand where data 'comes from')
2. Provide clarification for key fields to complete on the Financial Eligibility Form
3. Help you ensure that your billing for Treatment Services is supported by your documentation
4. Learn how to 'Spot-check' bills prior to submittal to SAPC or to Troubleshoot Denied Claims
5. Have some time for general Questions & Answers



Client Eligibility Verification & Service Authorizations

GOALS

- Gain background knowledge for how authorization elements show up in Treatment and Billing
- Understand the difference in Authorized Services (aka Member Authorizations) and Non-Authorized Services (aka Provider Authorizations)



Client Eligibility Verification & Service Authorizations

TOPICS COVERED

- A. How to view Client Eligibility & Authorization status Information
 1. Client Eligibility Verification Report
 2. Authorization Request Status Report
- B. How to Submit an Authorization Request for Authorized Services
 1. What Sage forms do I need to submit?
 - *Clinical Contact Form*
 - *Financial Eligibility Form*
 - Complete ASAM Continuum (Adult) or Youth ASAM
 - *Provider Diagnosis (ICD-10)*
 - CAL-OMS Admission
 - *Authorizations Form*

(continued)



Client Eligibility Verification & Service Authorizations

TOPICS COVERED (continued)

2. Clinical Contact Form

Purpose:

- a. To ensure SAPC is able to contact you regarding questions on your authorization.
- b. Include: days/times worked, a back-up person to contact who can answer questions if you are not available, as well as secondary numbers to reach you.

(continued)



Client Eligibility Verification & Service Authorizations

TOPICS COVERED (continued)

3. Authorizations Form
 - a. Funding Source
 - Drug Medi-Cal (f)
 - Non-Drug Medi-Cal (Non-DMC)
 - b. Benefit Plan
 - DMC SUD Services
 - Non-DMC Services
 - c. Program
 - d. Authorization Group
 - ASAM Level of Care (LOC)
 - Age
 - Perinatal
 - e. Understanding and how to choose appropriate U code (provide descriptions for U codes)

See Rates & Standards Matrix (FY 17-18) document
 - f. Add Attachments to Authorizations as needed



Client Eligibility Verification & Service Authorizations

AUTHORIZATION TIPS

1. You should **ONLY** submit an Authorization Form for **AUTHORIZED SERVICES** (e.g. Residential, MAT for youth, RBH). If you submit an authorization form for non-authorized services, it will be denied as not necessary.
2. **DO NOT** enter a diagnosis on the Authorizations form, as this can potentially result in billing problems. You should only enter diagnosis on the Provider Diagnosis (ICD-10) form.
3. The Authorizations Form should only be submitted **AFTER** you have completed all required elements to review your authorization (e.g. Finalized ASAM, Diagnosis form, etc.)
4. *Note New Change Being Implemented:* If the Authorization has not yet been approved (e.g. is in Pending or Denied status), it will **NOT** appear on the Treatment entry screen to allow treatment services to be entered. These services cannot be billed for until Approved.



Client Eligibility Verification & Service Authorizations

TOPICS COVERED (continued)

4. Add Financial Eligibility

a. Add Guarantor

- DMC – California Department of Alcohol and Drug
- LA County – Non DMC
- Applying for Medi-Cal
- Self Pay (Can use for other lines of business as well)

b. Handling of Multiple Guarantors

- Ex. Client is Medi-Cal and AB109

(continued)



Client Eligibility Verification & Service Authorizations

TOPICS COVERED (continued)

- c. DMC Requirements
 - Policy Number
 - Client Index Number (CIN) [REQUIRED FOR BILLING MEDI-CAL]
 - Subscriber Assignment of Benefits = Always should answer “YES”
 - Assignment of Benefits identify that the Client authorizes Medi-Cal to forward payment for a covered treatment directly to SAPC and not to the client when claimed to the State
 - Subscriber Release of Information = Yes, Provider Has Signed Statement Permitting Release
 - Eligibility Verified = Y
 - Provider is required to verify Medi-Cal eligibility of the client either through Point-of-Service device or by phone
 - If client is verified to have Medi-Cal, then “Y” is checked. If Provider does not know if the client has Medi-Cal, then “N” is utilized. If “N” is entered, claims cannot be paid.

(continued)



Client Eligibility Verification & Service Authorizations

TOPICS COVERED (continued)

c. DMC Requirements (continued)

- Coverage Effective Date = Must be completed
 - Generally will be 7/1/2017 for persons who have had ongoing Medi-Cal since launch of ODS
 - Note: Medi-Cal benefits are active until the end of the specified month
- Effective Date of Contract = Must be completed
- Coordination of Benefits (COB) = Always should answer “YES”
 - COB is a process to agree to identify the health benefits available to the client and coordinate the payment process to prevent mistaken payment of a client’s benefits

Example: Client has Other Health Coverage (BCBS) and Medi-Cal. COB is required so that BCBS is billed first and pays for services. The residual is then claimed to Medi-Cal.



Client Eligibility Verification & Service Authorizations

FINANCIAL ELIGIBILITY TIPS

1. If the admission is not filled out correctly, then Financial Eligibility fields do not pre-populate for you
2. If the admission date is filled out incorrectly so that it falls after treatment services have been provided, it will create billing errors
3. CIN is a required field for billing
4. Do not forget to scroll over to see the Coverage Effective Date
5. Do not forget to click SAVE and, on the next screen, select SUBMIT
If the SUBMIT button is not selected, the Financial Eligibility will not be sent to SAPC



How to Enter Treatment Services

TOPICS COVERED

1. Provider Activity Report

- a. This report identifies services that you have documented
- b. You will only enter claims for services you have documentation to support

2. Treatment Form

- a. Treatment History
- b. Add Professional Treatment (add new treatments)
 - Single date, Date Range or Multiple dates
Note: You can bill for repeated services (e.g. attending a daily group) using 'date range' (if service occurred each day without interruption) or 'multiple dates' (if services occurred with some interrupted dates (such as weekends)).
 - Funding Source
 - How to identify the correct CPT codes
- c. Add Claim information under "Enter Treatment Criteria"

Treatments have been entered. Treatments still require billing to SAPC for payments.



How to Enter Treatment Services

TIPS

1. Ensure to set the Treatment (click bottom right button)
2. Diagnosis should appear on the Provider Diagnosis (ICD-10) form. While it is possible to select a diagnosis in the Treatment form, it is not the diagnosis needed for billing.



How to Spot-Check Prior to Claim Submittal

1. Validate Authorization
 - a. Member Authorization or Provider Authorization (PAuth)
 - b. Are Treatment Service dates within the Authorization dates?
 - c. Is the “correct” Provider Authorization (PAuth) selected?
Ex. Was Perinatal chosen when client is Male?
Ex. Age of client is different than what is shown on the Provider Authorization
 - d. Status of Authorization – is it Denied or in Pending state?
2. Financial Eligibility CIN # vs Policy #
3. Provider Diagnosis – Have you completed Provider Diagnosis (ICD 10) form?
4. Are Group Counseling or Patient Education units correctly entered? (Rule: 1 Unit = 1 Minute)



How to Generate a Bill to SAPC

TOPICS COVERED

1. Select Billing from Main Menu
2. Generate New Bill
 - a. This step will compile all treatments entered (but not yet submitted) into one bill.
 - b. A pre-display screen will show any items that have yet to be submitted for billing
3. View Bill Summary
 - a. This step will open the Treatment billing page which includes a summary of the bill
4. Submit Bill
 - a. This action will send the bill to SAPC for processing.



How to Troubleshoot a Denied Claim

1. Review the checklist above in how to “Spot-Check”
2. If you cannot find any data out of alignment, enter a Sage Help Desk ticket.
 - a. The Sage Help Desk can check other factors – such as Contract set up



Questions?