BILLING & DENIAL RESOLUTION TUTORING LAB

JUNE 5, 2025

- Announcements and Reminders
- Tutoring Session Topics
  - Lockout Override Modifier Usage
  - OTP Billing Clarifications
- Open Q&A

ANNOUNCEMENTS & REMINDERS

REMINDERS

- June 30, 2025: FY 22-23 final billing deadline
- June 30, 2025: FY 23-24 final billing deadline
- July 1, 2025: Claim adjudication rules for billing timeliness will be implemented
  - Original claims: 180 days
  - Replacement claims: 365 days
    - Submit local and State denial resubmissions as replacements as applicable

REMINDER ON REPLACEMENT CLAIMS

Need to resubmit a local or State denied service?

Submit a REPLACEMENT claim

- Previous SAPC guidance may have differed, however, recent instruction has changed this guidance
- Providers (Primary and Secondary) should submit REPLACEMENT claims to resubmit both local and State denials
- Submitting a replacement claim ensures:
  - Easier tracking of changes to the original service
  - Easier reconciliation
  - Decreased State denials for lockouts/duplicates & less recoupments

REPLACEMENT CLAIM ASSISTANCE

Primary Providers: Review replacement claim training materials on the Sage website

Secondary Providers: Review the SAPC Companion Guide

Open a Sage Help Desk ticket using the Request Billing Assistance form to request technical assistance

Email SAPC-Finance@ph.lacounty.gov to request a technical assistance meeting

REQUEST BILLING ASSISTANCE FORM: REQUEST TYPES

General Billing Question

- Policy clarifications
- Code usage questions
- Billing process clarifications
- 835/277/RA/EOB reupload requests

Local Denial

- Denial cause investigation and resolution for locally denied claims
- For example:
  - Claim appears in KPI Claim Denial View
  - In EOB, claim is denied and has claim status reason
  - Denial message appears in Explanation of Coverage field in Fast Service Entry Submission
  - Critical Errors

State Denial

- Denial cause investigation and resolution for State denied claims
- For example:
  - Claim appears in KPI State Denial View
  - In EOB, claim is approved but has a takeback and CARC/RARC

Payment Inquiry

- Understanding payment amounts
- Understanding takebacks and withholdings from checks
- Check or Remittance Advice ETA

837 FILE PROCESSING DELAYS

- SAPC has been working with Netsmart very closely and following up daily to resolve the system issue leading to untypical processing time for 837 files.
- Many files are processing within standard processing times (within 24 hours), however, some files are taking long to be processed (over one week).
    - These files contain a high volume of claims which are slowing down the processing of the file.
- Netsmart has indicated to SAPC they recommend that files contain no more than 2,000 claims to ensure they process timely.

FAST SERVICE ENTRY SUBMISSION FORM ERRORS

- SAPC Finance and the Sage Management Division are working closely together with Netsmart to resolve the issues encountered by some Primary Providers who are getting kicked out of PCNX or encountering errors when attempting to enter services on the Fast Service Entry Submission form.
- There is no known resolution at this time.
- Providers are encouraged to open Sage Help Desk tickets (do not use the Request Billing Assistance form) when encountering issues and to update current tickets each time they encounter the issue.

LOCAL DENIALS FOR: "TOTAL EXPECTED DISBURSEMENT EXCEEDS ACCOUNT LEVEL AMOUNT"

- **Cause:** If your agency receives this local denial, it indicates that the contracted budget amount in Sage has been reached.
- **Resolution**: Reach out to your agency's Contract Program Auditor (CPA) to request a contract budget augmentation.
- Additional information: Agencies who have pending augmentations for FY 24-25 have had their Sage contract budget amounts increased early, to allow providers to bill for services prior to the 7/1/2025 billing timeline implementation.
  - IMPORTANT! Approved services **WILL NOT** be paid until the augmentation is executed. Providers will receive EOBs and potentially 835s, however, they cannot be paid until amendment execution is final.

5/14 SAGE COMMUNICATION: END OF YEAR EOB AND 835 PROCESSING FOR SECONDARY PROVIDERS

- As the end of FY 24-25, and the June 30th billing deadline for FY 22-23 and 23-24 approaches, SAPC Finance is temporarily adjusting our internal processes slightly to decrease the timeframe that it takes for Secondary Providers to receive 835s. SAPC Finance will begin producing 835s prior to the services being paid to enable Secondary Providers more time to resolve denials prior to the billing deadline. This process will be in place through the end of June. As of July 2025, regular processing of EOBs and 835s will occur.
- A temporary check number will be entered into Sage for EOBs containing services for FY 22-23 and 23-24, which will trigger production of an 835. The temporary check number will be in the following format, "EOY_[EOB #]", where the [EOB #] will be the EOB #, for example, "EOY_16545".
- Receipt of 835s with these temporary check numbers does not indicate payment of the services, as services will still be paid on the standard payment schedule. The true check number will be updated in Sage once payment is issued and can be viewed in KPI on the Payment Reconciliation View at the end of the month and will also be seen on the agency's check Remittance Advice outlining the EOBs paid on the monthly payment.

CLINICAL TRAINEE REMINDERS

- **Use the Clinical Trainee Modifiers when applicable when billing the service code**
  - Examples: AJ for an LCSW, MFT, or LPCC Clinical Trainee or AH for a Psychological Clinical Trainee > H0005:U7:AJ or H0005:U7:AH
  - The modifiers can be found on the Modifiers tab of the Rates Matrix
- **DHCS requires the Clinical Trainee's supervisor's NPI to be listed on the claims or they will be denied**
  - Providers must provide this information to SAPC for Clinical Trainees. The Sage Help Desk is responsible for configuring the information in Sage so it can be added to claims sent to DHCS.
  - Your agency's Sage Liaison should submit a Sage Help Desk ticket using the SAPC Sage User Creation Form to add the supervisor's information into Sage for the Clinical Trainee.

FY 25-26 RATES MATRIX

- Initial Rates Matrix sent out to agencies via GovDelivery email notification along with a document outlining the changes and the Rates Information Notice.
  - Minor updates have been made to both documents after requesting feedback. It is expected that the final IN and documents should be published within the next week or two.
- Errors/Updates on Rates Matrix that will be corrected in the final version posted to the SAPC website:
  - H0033 should not contain rates for Peer Support Specialists
  - Added allowable override modifiers for codes 90792 and 96131
  - Incorrected indicators on the CPT Add-on Codes tab, mainly for T1013.
  - Updates to the Allowable Modifiers for non-DMC codes when billed for perinatal (A0080, childcare, etc.)
- Phase 2 changes coming in August/September
  - Adding Community Health Worker performing provider license type and associated 3-code series. More information will be coming from the SAPC Sage team on user role and form/report access. See this DHCS Guide on Community Health Workers for more information on the services.
  - Updated code descriptions in Sage to match the Rates Matrix
  - Updating/adding telehealth modifiers and places of service to some CPT codes

PERFORMING PROVIDER INFORMATION

- SAPC Finance cannot update or change information for performing providers in Sage.
- Please contact the Sage Help Desk for the following:
    1. To confirm the information configured for a performing provider.
    2. To make changes to a performing provider's record.
        - This requires the SAPC Sage User Creation Form ticket to be submitted with the changes needed.
- Please do not submit a Request Billing Assistance form for either of these situations.

ERRONEOUS STATE DENIALS

- DHCS has provided SAPC a list of FY 23-24 services that were erroneously denied due to various system issues with codes CO 177, CO 96 N362, and CO 96 N54.
  - The CO 177 State denials mainly impacted service codes H2014, H2015, H2017, and T1017, for patients that have active OHC. These service codes are exempt from OHC requirements, but the state system did not recognize them as such.
  - The CO 96 N362 state denials inaccurately denied 3.7/4.0 WM services with more than 1 unit, when the denial rule should only apply to non-inpatient claims.
  - The CO 96 N54 denials also only impacted 3.7/4.0 WM services, where the state system was unable to map a rate for those services.
- For the impacted services, SAPC has placed the list of claims that still need to be rebilled in the SFTP folder for each provider under “Files\06-02-2025". They are available on the SFTP through 06/09/2025. Providers can resubmit these services at anytime prior to the June 30, 2025, deadline.

LOCKOUT OVERRIDE MODIFIER USAGE

IMPORTANT!

- SAPC Finance cannot provide clinical guidance on the information we will be reviewing today.
- We will review the DHCS rules and billing process for using lockout override modifiers.
- However, we cannot provide clarifications on what makes two similar clinical services distinct to justify using the lockout override modifiers.
- SAPC Finance recommends emailing SAPC.QI.UM@ph.lacounty.gov and SAPC.CST@ph.lacounty.gov for assistance in understanding the difference between different services and determining if they are distinct.

LOCKOUT RULES BACKGROUND

The State's adjudication system enforces two types of lockout rules:

1. CA Code of Regulations (CCR) prohibits some services from being provided to a patient on the same day.
2. Centers for Medicare and Medicaid Services (CMS) requires states to implement the National Correct Coding Initiative (NCCI). This initiative identifies codes that should not be billed on the same day for the same patient unless certain conditions are met.

OVERRIDABLE OUTPATIENT LOCKOUTS

- Some outpatient codes that have lockouts due to CCR and CMS regulations can be overridden using the modifiers 59, XE, XP, or XU.
- Override modifiers such as 59, XE, XP, and XU are used in Medicare billing to indicate that procedures or services, which might otherwise be denied as a lockout, are actually distinct and separately billable based on the clinical scenario.
- The Billing Rules tab of the Rates Matrix provides information for each code on non-overrideable (column J) and overridable lockouts (column K). The Allowable Modifiers column (AA) provides additional information on which of the override modifiers are applicable to use with the code.

NON-APPLICABLE SCENARIOS

- The override modifiers are **not** applicable for:
  - Overriding outpatient lockouts for bundled services
    - For example, if the day rate has been billed for a patient in 3.1, the override lockouts cannot be used to bill separately for individual counseling, assessment, etc.
  - Overriding lockouts between levels of care
    - For example, if an OTP service is shown on the Billing Rules as locked out against residential, the override modifiers cannot be used to allow the OTP service to be billed the same day as residential.
  - Overriding services required to be rolled-up
    - For example, if two individual counseling sessions are provided to the patient on the same day, using an override modifier on the second service does not apply. The services must continue to be rolled up.

KEY POINTS FOR COMPLIANCE

- Use modifier 59 only when no more specific modifier applies (XE, XP, XU).
- Documentation must clearly support the distinct nature of each service billed with an override modifier.
- Never use these modifiers simply to bypass claim lockout rules; use only when clinical circumstances justify separate billing.

A	B	C	J	K	AA
Code	Code Type	Service Description	Outpatient Non-Overridable Lockout Codes	Outpatient Overridable Lockouts with Appropriate Modifiers *(Overridable Modifiers for codes with * are: 59, XE, XP or XU Overridable Modifiers for codes with ** are: 27, 59, XE, XP or XU)*	Allowable Modifiers
90792	Assessment	Psychiatric diagnostic evaluation with medical services, 60 minutes	90846, 90847, 96170, 96171	90791*, 90849*, 90865*, 90882*, 90885*, 90887*, 90889*, 96160*, 99202**, 99203**, 99204**, 99205**, 99212**, 99213**, 99214**, 99215**, 99234**, 99235**, 99236**, 99238**, 99239**, 99304**, 99305**, 99306**, 99307**, 99308**, 99309**, 99310**, 99341**, 99342**, 99344**, 99345**, 99347**, 99348**, 99349**, 99350**, 99367**, 99368**, 99408**, 99409**, 99415**, 99416**, 99418**, 99424**, 99441**, 99442**, 99443**, 99451**, 99491**, 99495**, 99496**, G0396*, G0397*, G2011*	59, 93, 95, AH, AJ, GC, HD, HG, HP, U7, U8, UA, XE, XP, XU
99214	Medication Assessment / MAT Service	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 30-39 minutes total time on the date of the encounter.	99238, 99451	96130*, 99212**, 99213**, 99408**, 99409**, G0396*, G0397*, G2011*, H0049*, H0050*	59, 95, GC, HD, HL, HP, U7, U8, XE, XP, XU

“TARGET” CODE

- If a modifier is used to override a lockout the modifier must be used with the **“target”** code or the code that would otherwise not be able to be billed with the primary service (codes in column K on the Rates Matrix).
- Please note that HCPCS (alpha) modifiers can be used with CPT and HCPCS codes, but CPT (numeric) modifiers can only be used with CPT codes.
  - For example, the **59** override modifier can only be used with CPT codes. Please be sure to review the Allowable Modifiers column (AA) on the Billing Rules tab.
- The target code is the code in column K on the Billing Rules tab that needs to be billed along with the primary service. “Primary service” is not the same meaning as “primary code” when referring to add-on code usage.
- The billing order of the codes is important. The primary service needs to be billed first and then the target code service.

Primary Service

Target Code

A	B	C	J	K	AA
Code	Code Type	Service Description	Outpatient Non-Overridable Lockout Codes	Outpatient Overridable Lockouts with Appropriate Modifiers *(Overridable Modifiers for codes with * are: 59, XE, XP or XU Overridable Modifiers for codes with ** are: 27, 59, XE, XP or XU)*	Allowable Modifiers
90792	Assessment	Psychiatric diagnostic evaluation with medical services, 60 minutes	90846, 90847, 96170, 96171	90791*, 90849*, 90865*, 90882*, 90885*, 90887*, 90889*, 96160*, 99202**, 99203**, 99204**, 99205**, 99212**, 99213**, 99214**, 99215**, 99234**, 99235**, 99236**, 99238**, 99239**, 99304**, 99305**, 99306**, 99307**, 99308**, 99309**, 99310**, 99341**, 99342**, 99344**, 99345**, 99347**, 99348**, 99349**, 99350**, 99367**, 99368**, 99408**, 99409**, 99415**, 99416**, 99418**, 99424**, 99441**, 99442**, 99443**, 99451**, 99491**, 99495**, 99496**, G0396*, G0397*, G2011*	59, 93, 95, AH, AJ, GC, HD, HG, HP, U7, U8, UA, XE, XP, XU
99214	Medication Assessment / MAT Service	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 30-39 minutes total time on the date of the encounter.	99238, 99451	96130*, 99212**, 99213**, 99408**, 99409**, G0396*, G0397*, G2011*, H0049*, H0050*	59, 95, GC, HD, HL, HP, U7, U8, XE, XP, XU

Note: Not all overridable lockouts are reciprocal on the Billing Rules but still apply if one code is locked out against the other.

MODIFIER 59: DISTINCT PROCEDURAL SERVICE

CMS Definition: Identifies procedures/services that are not normally reported together but are appropriate under the circumstances.

- If XE, XP, or XU is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
- It may be used for two timed codes provided sequentially but the documentation must support that the two services were distinct.

MODIFIER 59: SCENARIO EXAMPLE

SCENARIO

An established patient received an office visit (99214) in the morning and returned in the afternoon for a diagnostic evaluation with medical services (90792).

However, 99214 is locked out against being billed the same day as 90792.

HOW TO BILL

1. Bill code 90792 first – does not need to be on a separate batch or file of services, just needs to be prior to the target code on the claim.
2. Then bill code 99214 with the 59 modifier variation. For example, 99214:U7:59.

MODIFIERS XE, XP, AND XU

XE

CMS Definition: a service that is distinct because it occurred during a separate encounter.

XP

CMS Definition: a service that is distinct because it was performed by a different practitioner.

XU

CMS Definition: the use of a service that is distinct because it does not overlap usual components of the main service.

RESOURCES

- https://www.cms.gov/files/document/proper-use-modifiers-59-xe-xp-xs-xu.pdf

OTP BILLING CLARIFICATIONS

MEDICATION BUNDLE

- The H0020, S5000 and S5001 codes are technically a bundled service.
- Includes the following services in the bundled code:
  - Assessment
  - Family Therapy
  - Medical psychotherapy
  - Medication services
  - MAT for OUD/AUD
  - Patient Education
  - SUD Crisis Intervention Services
- Can bill separately
  - Counseling (individual and group)
  - Care Coordination
  - Peer Support Services

FINDINGS FROM STATE DENIAL REVIEW

- If billing H0020 (methadone), S5000, or S5001, don't also bill H0033 or H0034.
  - H0033 and H0034 for medication services are part of the medication bundled service.
- The order of which services are billed matters.
  - Services that are technically part of the medication bundle are getting approved when billed first; but then the medication denied when both are submitted.
- If the medication was delivered, do not bill the services that are part of the bundle. However, you can still bill the unbundled services (i.e. Care Coordination, counseling, and Peer Support).

If medication was delivered on the date of service:

- Bill the medication first (H0020, S5000, S5001)
- Then additional non-bundled services

If no medication was delivered on the date of service:

- Bill any of the allowable services, including medication services.
- Do not bill a medication code (H0020, S5000, S5001)


OPEN Q&A