BILLING & DENIAL RESOLUTION TUTORING LAB

JULY 10, 2025

- Announcements and Reminders
- Tutoring Session Topics
  - Upcoming Sage Code Configuration Updates
  - Other Health Coverage Coordination of Benefits
- Open Q&A

ANNOUNCEMENTS & REMINDERS

REMINDERS

- **August 29, 2025**: FY 23-24 final billing deadline
- **FY 25-26 Treatment Billing Office Hours**
  - Starts Thursday, 7/24 through 10/16; once a month – 3rd Thursday of each month from 1-2 pm, except for July which will be on 7/24.
  - Questions can still be asked during the monthly Tutoring Lab and we will be sharing information we see in billing during each meeting as well.
  - Office Hours link has been posted to the SAPC Event Calendar and will go out in next week's Sage Provider Communication.
- **Updated Denial Crosswalk and Guide to Claim Denial Resolution** being posted to the Sage website in the coming week
- **New Fiscal Year – New Auths:** For patients whose treatment spans two fiscal years, they receive two authorizations (split auths). Please be sure to use the appropriate auth for FY 25-26 services.

FY 24-25 AND 25-26 BILLING DEADLINE CLARIFICATION

- On 7/1/2025 SAPC planned to introduce the previously announced original and replacement claim deadlines, 180-days and 365-days, respectively.
- However, due to recent system changes, SAPC did not implement these deadlines as planned.
- SAPC will be implementing them during 2025, however, the date has not yet been confirmed. The implementation date will not be before 9/30/2025.
- When SAPC implements the deadlines:
  - 1) Original services billed over 180 days from the date of service will be denied
  - 2) Replacement services billed over 365 days from the date of service will be denied

STATE DENIALS FOR CO 16 N288

- **CO 16 N288 description:** Rendering provider taxonomy code missing
- SAPC began receiving State denials for services delivered by Clinical Trainees billed to DHCS in May and June 2025 for this code.
    - Various services date are impacted
- Providers can submit replacement claims for these services while SAPC works with DHCS to resolve this. No further recoupments will occur with this denial code until the issue is resolved.

UPCOMING CODE CONFIGURATION CHANGES FOR FY 25-26

PHASE 2 CONFIGURATION – AUG/SEPT

- **Telehealth Modifiers and Places of Service**
  - DHCS aligned their telehealth guidance with Centers for Medicare and Medicaid (CMS)
  - Added the 93 and/or 95 modifiers to a variety of codes as well as place of service 02 and 10 where applicable
- **Updated Sage code descriptions**

PHASE 3 CONFIGURATION

- **Community Health Workers Codes**
  - 98960 – Individual education and training
  - 98961 – Education and training; 2-4 patients
  - 98962 – Education and training; 5-8 patients
  - Awaiting clarification from DHCS regarding level of care lockouts and maximum units before configuring in Sage.
  - Is available on the current Rates Matrix but Billing Rules will likely need to be updated. Fees will not change.

OTHER HEALTH COVERAGE COORDINATION OF BENEFITS

COORDINATION OF BENEFITS (COB)

- **What is Coordination of Benefits?**
  - A process used by insurance companies to decide how to pay for services when patients have more than one insurance plan.
  - It determines which plan pays first (primary payer) and which pays second (secondary payer).
- **Why is COB Important?**
  - Prevents duplicate payments – ensures plans don't both pay for the same service.
  - Avoids claim denials – coordination ensures the appropriate plan is billed first.

REPORTING COB ON CLAIMS

- It is critical that COB information is entered on claims submitted to SAPC.
- On claims to SAPC, COB information relays the primary payer's denial or partial payment of a service. Without this information on a claim for a patient with another insurance other than Medi-Cal, DHCS will deny the service.
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DENIAL METRICS: CO 22 N429

Fiscal Year	# Services Denied	Total Denial Amount
23-24	59,938	$2,429,444
24-25	44,593	$2,004,482

MEDICARE AS AN OHC

Non-OTP Services

- Medi-Medi patients who have **Medicare Parts A or B are not required** to be billed to Medicare first and can be billed directly to SAPC without COB information on a claim.
- Exception to this rule is Intensive Outpatient, which became billable to Medicare as of 1/1/2024 for any sites that are a Community Mental Health Center (CMHC) or Federally Qualified Health Center (FQHC).

OTP Services

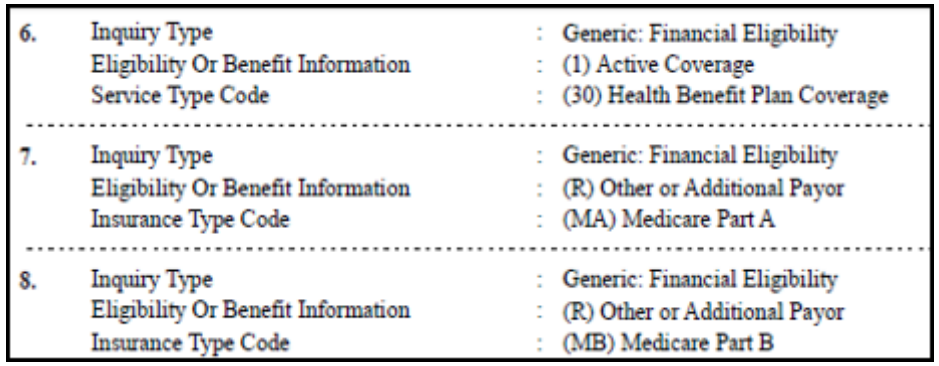
- Medi-Medi patients services are required to be billed to Medicare before Medi-Cal and COB information must be included on the claim.
- Note that Medicare Part B covers some MAT medications and the patient's plan should be consulted on what is covered.
    - DHCS has indicated that Disulfiram, Buprenorphine combination, or Naltrexone: Long-acting injection DO NOT need to be billed to Medicare first.

MEDICARE AS AN OHC

If all three of the criteria below are met, the patients service is required to be billed to Medicare before Medi-Cal (and SAPC).

1. The beneficiary is actively enrolled in both Medicare and Medi-Cal.
2. The rendering service provider is a Medicare recognized provider type.
    a) Recognized Provider Types: Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialist, Licensed Clinical Social Workers, Marriage and Family Therapists (who have met Medicare's education requirements), Licensed Professional Clinical Counselors, and Psychologists
    b) Interns and clinical trainees of the licensed practitioners listed above are not Medicare recognized provider types.
3. The service is a Medicare covered service.

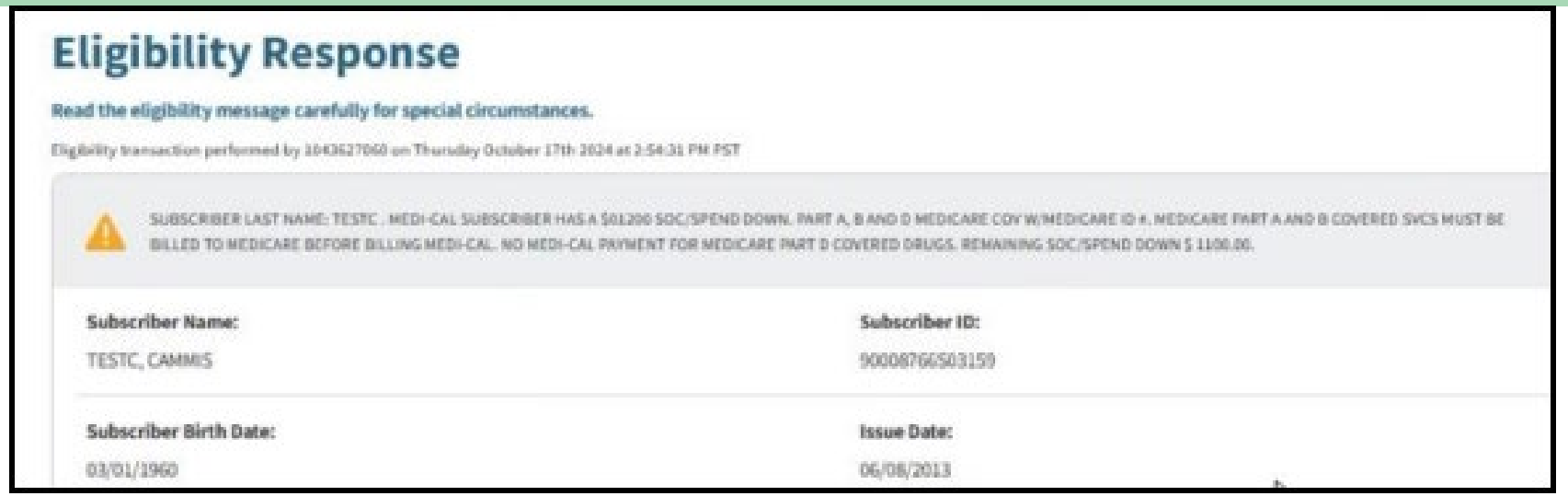
271 ELIGIBILITY RESPONSE: MEDICARE



6.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(1) Active Coverage
	Service Type Code	:	(30) Health Benefit Plan Coverage
7.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(R) Other or Additional Payor
	Insurance Type Code	:	(MA) Medicare Part A
8.	Inquiry Type	:	Generic: Financial Eligibility
	Eligibility Or Benefit Information	:	(R) Other or Additional Payor
	Insurance Type Code	:	(MB) Medicare Part B

- In Sage, after running the Real Time (270) Inquiry Request, the 271Eligibility Response will display the patient's eligibility information.
- In the response, if the patient has Medicare, it will list the Insurance Type Code as Medicare and include what type of Medicare the patient has.

MEDI-CAL PROVIDER PORTAL ELIGIBILITY RESPONSE



- The color-coded informational ⚠ on a patient's eligibility response indicates there are special circumstances for the patient.
- Read the message next to the yellow icon as it should indicate if the patient has Medicare. It will also include which type of Medicare the patient has.

PRIMARY PROVIDER CLAIMS

- The **Client Other Health Coverage form** must be completed for the patient, including for patients with Medicare, if the services are required to be billed to the OHC first.
  - The form needs to be completed for each plan the patient is enrolled in.
  - If the required guarantor is not in the drop down, please open a Sage Help Desk ticket using the Request Billing Assistance form.
- Follow the SAPC OHC Billing Manual instructions, which outlines which fields to fill in on the Client Other Health Coverage form and during Fast Service Entry to submit COB information on the patient's claim.

SECONDARY PROVIDER CLAIMS

- Not required to complete the Client Other Health Coverage form, as the information is contained in the 837 submitted to SAPC.
- Refer to SAPC's 837 Companion Guides for the required loops and segments with COB information.


OPEN Q&A