



BILLING DENIALS 2.0: CLAIMS PRE-ADJUDICATION AND DENIAL TROUBLESHOOTING

Los Angeles County's Substance Abuse Prevention
and Control

Thursday February 07,
2019

Outline

1. Introduction to billing denials troubleshooting
2. In depth description of most common billing denials
3. Questions?
4. Detailed description of Pre-adjudication process
5. Demonstration of Pre-adjudication of claims
6. Application of billing denials troubleshooting to Pre-adjudication demonstration
7. Questions?



Substance Use Disorder Information System



Objectives

By the end of this training, you will be able to:

- Understand the most common denial reason codes and what triggered the denial.
- Identify next steps that are needed to address the most common denial reason.
- Describe the Pre-adjudication process and how to utilize it to reduce billing denials.
- Apply denial troubleshooting techniques to the Pre-adjudication validation errors.

Reasons for Claim Denials

- **Claims may be denied for multiple reasons, including:**
 - Incorrect/missing information (Financial Eligibility Form info, Provider Diagnosis (ICD-10) Form)
 - Service authorization errors or denials
 - Lack of funds in contract (provider would just need to request an increase in adjustable contract cap)
 - Configuration or contracting issues

**Current denial rate across SAPC providers is 19.6%.
However, we have seen a number of providers reduce this rate
through the troubleshooting process.**

**A certain proportion of denials are unavoidable in managed
care systems**



DECODING Your Denials: Finding the Denial Reason or Explanation of Coverage

Professional Treatments Form

Recovery, Inc.	1/2/2018 Delete		USERSU01,TEST	H0006:U7:HA:HD	2	30
Auth: P10 CP Program: RECV - 3250 Wilshire Blvd						

Field	Value
Claim Status	Denied
Claim Status Reason	
Explanation of Coverage	The service was denied for the following reason: F

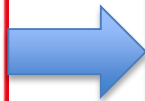
Denial Reason:

Eligibility not found/verified in Cal PM

Translation: There are one or more eligibility elements missing or incorrect on the Financial Eligibility or Provider Diagnosis (ICD-10) Forms

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 177	Denied	Eligibility not found/verified in CalPM	Blank

REQUEST DENIED



Troubleshooting



APPROVED



Denial Reason:

Eligibility Not Found/Verified in Cal PM

Troubleshooting is the same for primary or secondary users.

Possible Situation: Completed and submitted financial eligibility, but entered CIN in policy field only or entered a date after the admission date in the coverage effective date field.

Forms to check:

1. Financial Eligibility Form
2. Provider Diagnosis (ICD-10) Form

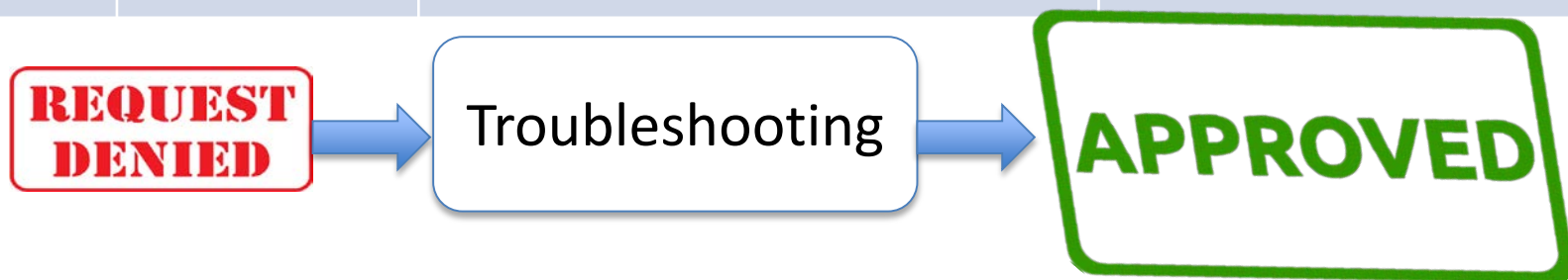
Troubleshooting steps:

1. Does the client have a financial eligibility form completed?
 - a) Was it **Saved and Submitted?**
2. If the client has a Financial Eligibility defined as Drug MediCal as the primary guarantor, are the following fields filled in:
 - a. Subscriber Client Index #
 - b. Subscriber Birth Date
 - c. Subscriber Address Line 1: State, City, Zip Code
 - d. Eligibility Verified, Coordination of Benefits and Subscriber Assignment of Benefits all must be set to 'Yes', assuming Yes is the correct response.
 - e. Coverage Effective Date must be on or before episode admission date and on or before first date of service.
 - f. Was the patient DMC eligible during the denied service date? Check the Real-Time 270 Request.
3. Does the client have an Admission Diagnosis in the Provider Diagnosis (ICD-10) form?
 1. Date of admission diagnosis must be the same date as the episode admission or prior to the service claimed date if readmission.
 2. Diagnosis ranking and billing order must match

Denial Reason: Contracting Provider Program Not Valid For Authorization

Translation: The provider program (location) that was entered on the authorization and billed against is not setup for the level of care and/or the CPT code that was billed, including modifiers.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 185	Denied	Blank	Contracted Provider Program Not Valid For Authorization





Denial Reason: Contracting Provider Program Not Valid For Authorization

What to do if you
are a Primary
Sage User
(Provider
Connect)?

Possible Scenarios:

Provider selected an incorrect Auth Grouping on the Authorization Request Form and it was approved. PPW when not a contracted PPW provider, for example.

Forms to check:

1. Professional Treatment Form (Authorization Field)
2. Service Authorization Form (if applicable, to verify location and LOC)

Troubleshooting steps:

- Authorization Request Form
 1. Ensure the Authorization grouping on the Authorization Request Form is the correct level of care, age group and PPW status that was provided.
 - If all information is correct, please contact your CPA to verify contracts and system configuration.
 2. Ensure the **Provider Program (e.g. location)** on the Service Authorization Form is correct for the service that was provided.
 3. Please contact QI/UM to request a change in the authorized program location or to deny incorrect authorization and resubmit a new authorization if a mistake is found.
- Professional Treatment Form
 1. When completing the Professional Treatment Form, did you:
 - Select the appropriate Member Auth number?
 - Verify the program listed is the program the service was rendered and is set up for that LOC, CPT and Modifier
- Run Pre-Adjudication process before submitting to verify if fixed or resubmit claim.
- Contact Helpdesk if still not resolved.



Denial Reason: Contracting Provider Program Not Valid For Authorization

What to do if
you are a
Secondary
Sage User?

Troubleshooting steps: (Similar to Primary Users)

- Authorization Request Form
 1. Ensure the Authorization grouping on the Authorization Request Form is the correct level of care, age group and PPW status that was provided.
 - Contact Helpdesk for further guidance
 2. Ensure the **Provider Program (e.g. location)** on the Service Authorization Form is correct for the service that was provided.
 3. Please contact QI/UM to request a change in the authorized program location or to deny incorrect authorization and resubmit a new authorization if a mistake is found.
- 837 File
 1. Verify the following information is correct on the 837 File
 - The Auth number matches the authorization for the intended level of care and CPT codes
 - The NPI and address for the contracting program (location) is the same as the program on the Authorization Request Form
 - The program location corresponds to the actual level of care, CPT code and modifier where the service was provided.
 - The HCPC and modifier match the approved codes found on the Authorization
- Contact the Helpdesk if not resolved.



Authorization Request Form Program Selection

- The program on the Authorization request form corresponds to the provider agency where treatment is being delivered.
 - If an agency has multiple sites, be sure to select the correct program where this patient is being treated.

Funding Source & Benefit Plan Information

Funding Source:

Drug Medi-Cal ▼

Benefit Plan:

DMC SUD Services ▼

Program:

- Please Choose One - ▼ *

- Please Choose One -

Recovery Facility

Authorization Group

Leave blank for individual CPT Codes requests.



Professional Treatment Form

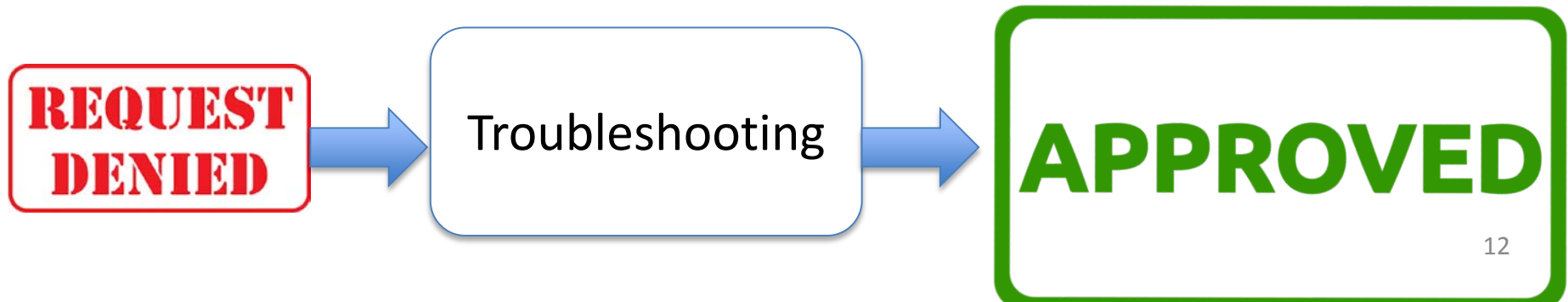
- Each Auth # corresponds to a Funding Source, Dates of Service, Age Group, ASAM LOC, PPW status and Treatment Location.
 - It is possible that an agency may have more than one approved authorization for a given time period (Patient left and came back, OTP aligning with continuous treatment date, etc...)
 - Providers need to ensure they are selecting (primary user) or inputting (secondary user) the correction authorization when billing.
 - Authorization numbers that are numbers ONLY and DO NOT start with a “P” correspond to all levels of care, RBH and treatment services.
 - Any authorization number that begins with a “P” (e.g. Provider Authorizations) corresponds to Incentives ONLY for any claim 7/01/2018 and beyond.
 - Pauths still exist for prior fiscal year 17/18 for late claims and replacement claims for outpatient, withdrawal management and RSS services.

Denial Reason:

Missing/Invalid or Denied Authorization Number

Translation: 837 File was submitted with an incorrect authorization, invalid, denied or missing authorization number. This can be a “Member Authorization” or “Provider Authorization” (Denial Reason experienced only by Secondary Sage Users).

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 15	Denied	Blank	Invalid/Missing or Denied Authorization Number





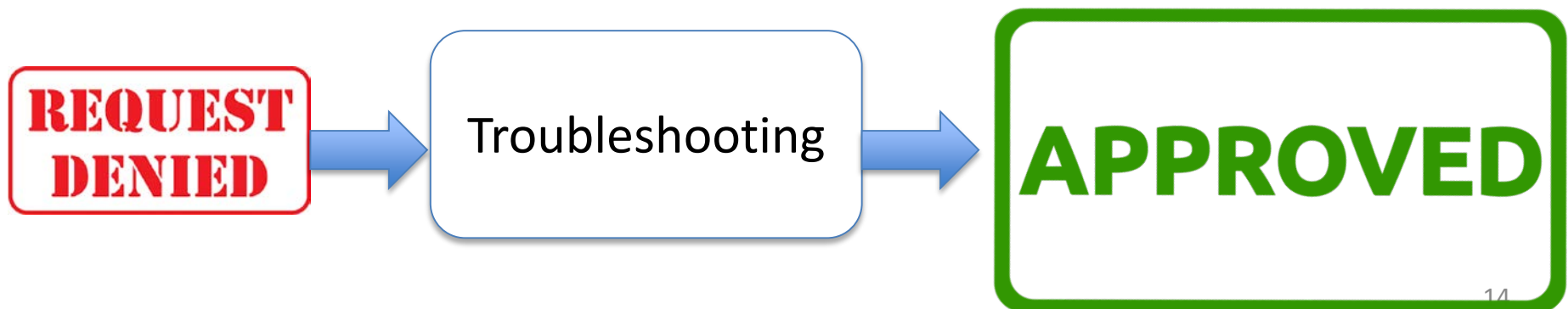
Denial Reason: Missing, Invalid or Denied Authorization Number

<p>What to do if you are a <u>Primary Sage User</u>?</p>	<p><u>Troubleshooting steps:</u> Not Applicable. This is a denial reason that applies to secondary providers only.</p>
<p>What to do if you are a <u>Secondary Sage User</u>?</p>	<p><u>Possible Situation:</u> Provider entered auth number on 837 from a pending or denied auth and billed without confirming it was approved. Provider forgot to enter the auth number before billing.</p> <p><u>Forms to check:</u></p> <ol style="list-style-type: none">1. Authorization Request Form2. Ref*G* on SV1 segment, loop 2400 on 837 File <p><u>Troubleshooting steps:</u></p> <ol style="list-style-type: none">1. Confirm that you have an authorization number for your client in PCONN2. Before submitting the claim, confirm the authorization was approved.2. Confirm that you are using the correct Authorization Number or Provider Authorization number and resubmit billing.3. Verify the Auth number on the 837 File in the Ref*G* loop is the same number from the Authorization Request Form4. Ensure your system for entering Auth Numbers into your EHR is accurate

Denial Reason: Procedure not on Fee schedule.

Translation: The service you are claiming is not associated with the program location or your agency.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 181	Denied	Blank	Procedure not on fee schedule.





Denial Reason: Procedure not on Fee schedule.

What do you do if you are a Primary Sage User (Provider Connect)?

Possible Situation: Provider selected the wrong authorization grouping by accident and it was approved. I.e. PPW when not a PPW provider. Or 837 provider billed the wrong HCPC code by accident.

Forms to check:

1. Authorization Form

Troubleshooting steps:

1. Verify the authorization group on the authorization is correct.
 - If it is correct, contact helpdesk to verify you are configured to that level of care.
 - If incorrect, contact UM to deny the authorization and resubmit an authorization with the correct information.
2. If you discover that you used the incorrect code or code with incorrect modifier, resubmit claim with new authorization using the correct code and modifier (Note: You must have a corrected authorization to rebill).
3. If unable to resolve, contact Help Desk.

What do you do if you are a Secondary Sage User?

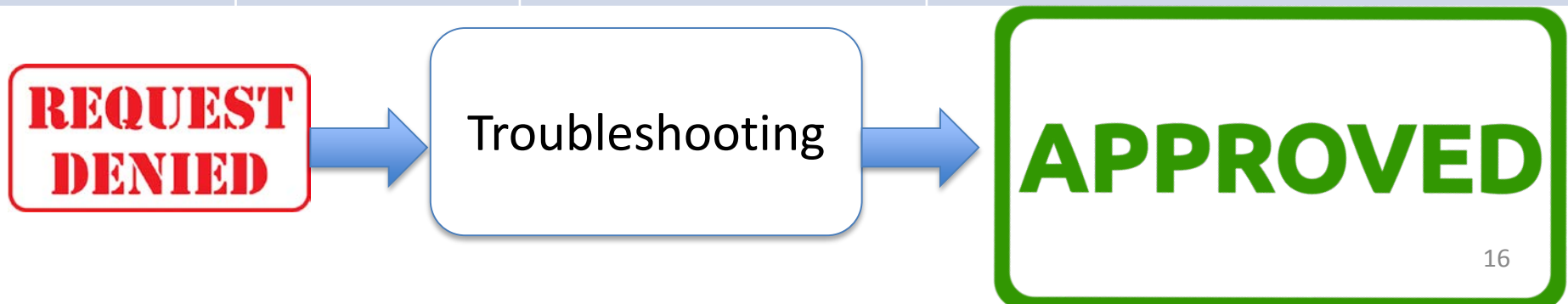
Troubleshooting steps:

1. Same as above
2. Verify HCPC code and modifier on 837 file is on the approved Authorization Request Form and you are configured for that service.
3. Contact Helpdesk if you believe you were using the correct information.

Denial Reason: Missing Episode for Date of Service

Translation: Your are attempting to bill for a service that occurred before the admission date.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO A1 MA40	Denied	Blank	Missing Episode for DOS





Denial Reason: Missing Episode for Date of Service

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. Provider Admission Form

Troubleshooting steps:

1. Verify that the date attempting to bill services for falls on or after the date of admission on Provider Admission Form.
2. If you discover the admission date is incorrect, contact the help desk to request assistance for options in adjusting this date.
3. If the date of service occurred on or after the admission date, resubmit billing with this correct date.
4. Contact Help Desk if not resolved.

What to do if you are a Secondary Sage User?

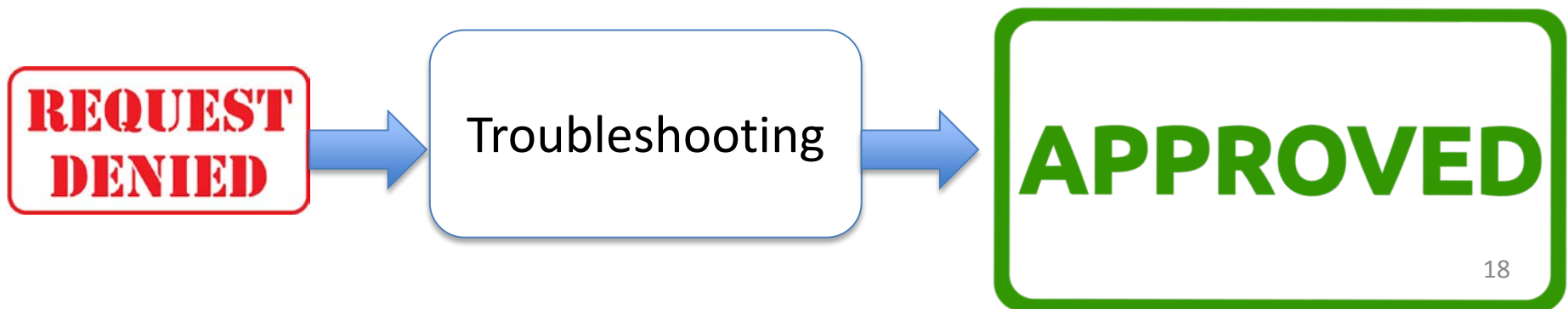
Troubleshooting steps:

1. Same as above.
2. Correct date on 837 File and resubmit if date of service is on or after episode admission date.

Denial Reason: Performing Provider Is Not Registered On Date of Service

Translation: Clinician who provided the service has an enrollment date in Sage after the date of service.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO B7	Denied	Blank	Performing provider is not registered on date of service.





Denial Reason:

Performing Provider Is Not Registered On Date of Service

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. SAGE HelpDesk User Creation Form

Troubleshooting steps:

1. Verify the date of hire on newest version of form (registration date on older version).
2. Verify if date of hire (registration date on older version) is before or after service delivery date
3. Verify the correct provider was entered on the billing.
4. Contact Helpdesk to assist in resolution if unable to correct.

What to do if you are a Secondary Sage User?

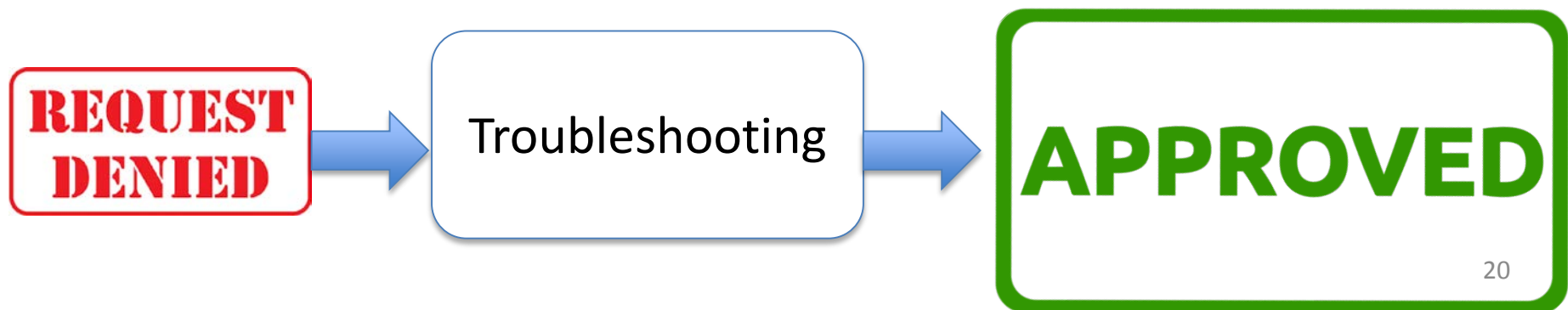
Troubleshooting steps:

1. Same as above

Denial Reason: Exceeded Number of Days to Bill

Translation: You are attempting to bill for services that occurred greater than 365 days prior to billing date.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 29	Denied	Blank	Service Exceeded Allowed Number Of Days Prior to Date Of Claim.





Denial Reason:

Exceeded Number of Days to Bill

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. Billing

Troubleshooting steps:

- 1 Confirm in the Submitted Bill that the Date of Service is not more than 365 days before the Bill Date. NOTE: Typically this is a typo error (ex: 2018 vs. 2019).
2. If date of service was less than 365 days before the billing date, resubmit with correct dates.
* If this does not resolve issue, contact Help Desk.
3. If date of service was more than 365 days before the billing date, you will not be permitted to bill for these services.

What to do if you are a Secondary Sage User?

Troubleshooting steps:

1. Confirm the Date of Service is correct.
2. If date of service was less than 365 days before the billing date, resubmit with correct dates.
* If this does not resolve issue, contact Help Desk.
3. If date of service was more than 365 days before the billing date, you will not be permitted to bill for these services.

Denial Reason: Contracting Provider Program Not Active

Translation: Program you are attempting to bill to is not currently active in the SAGE system.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 147	Denied	Blank	Contracting Provider Program is Not Active.

**REQUEST
DENIED**

Troubleshooting

APPROVED



Denial Reason: Contracting Provider Program Not Active

What to do if you are a Primary Sage User (Provider Connect)?

Possible Situation: Provider had an emergency move and selected the wrong program location on the authorization before it was removed from Sage.

Forms to check:

1. None.

Troubleshooting steps:

1. Contact Help Desk to confirm that the treatment program and location you are attempting to bill to is active in Sage.
2. If program is not active, Help Desk will escalate ticket to SAPC-Contracts and Compliance Division (CCD).
3. Follow-up with SAPC-CCD as needed.

What to do if you are a Secondary Sage User?

Forms to Check:

1. None.

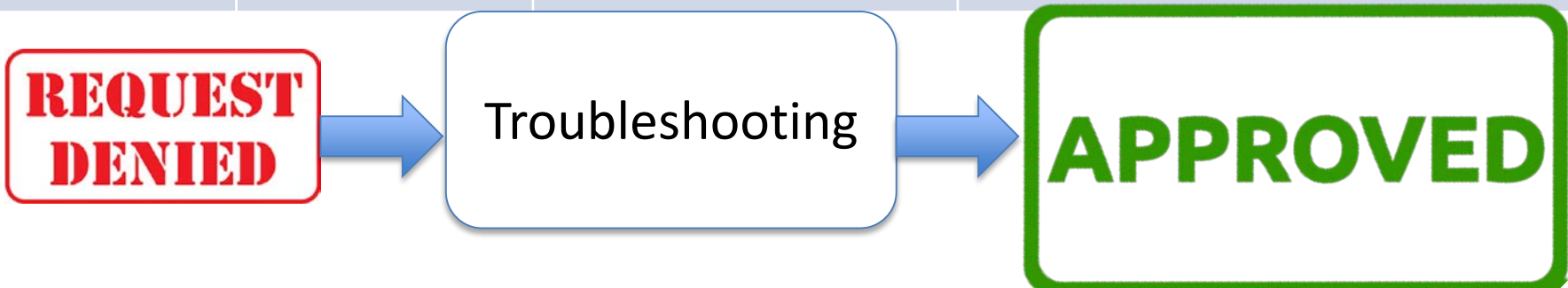
Troubleshooting steps:

Same as above.

Denial Reason: Group Duration Limit

Translation: Historical error and should no longer be encountered

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 177	Denied	Eligibility and/or Standards not Met	Claim Status has been set to D because of Claim Adjudication Rule 4 - H0005:U1 Group Counseling 90 min limit.





Denial Reason: Group Duration Limit

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. Clinical Documentation
2. Professional Treatment Entry

Troubleshooting steps:

1. Verify the duration of group you are attempting to bill for is between 60 and 90 minutes in duration.
2. This is a historical error. Should not be encountered if you resubmit your billing.
2. If not resolved with resubmission, contact Help Desk.

What to do if you are a Secondary Sage User?

Troubleshooting steps:

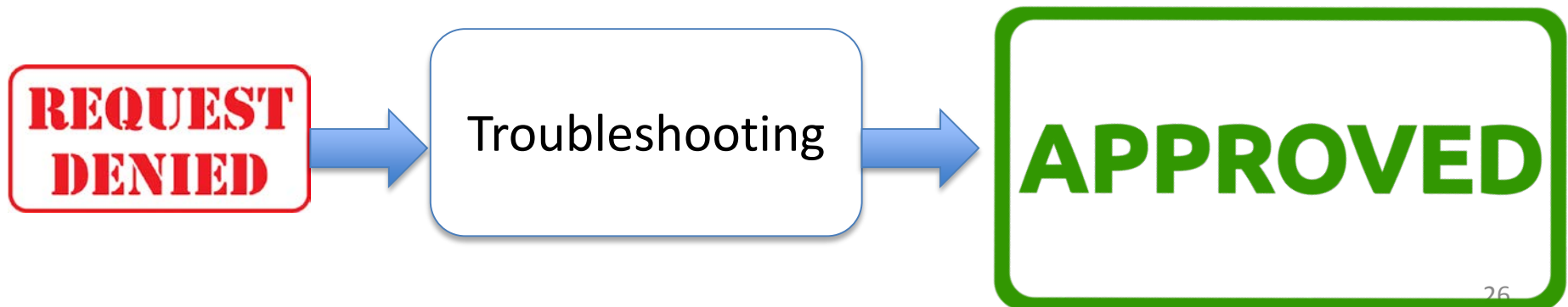
1. Same as above.

Denial Reason:

Number of Services per Claim Allowed Exceeded

Translation: You have attempted to submit a claim on an 837 with too many services associated with it.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 16	Denied	Blank	Number of services per claim allowed exceeded





Denial Reason:

Number of Services per Claim Allowed Exceeded

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. None.

Troubleshooting steps:

1. Not Applicable. This denial reason applies only to secondary Sage users submitting billing via the 837 process.

What to do if you are a Secondary Sage User?

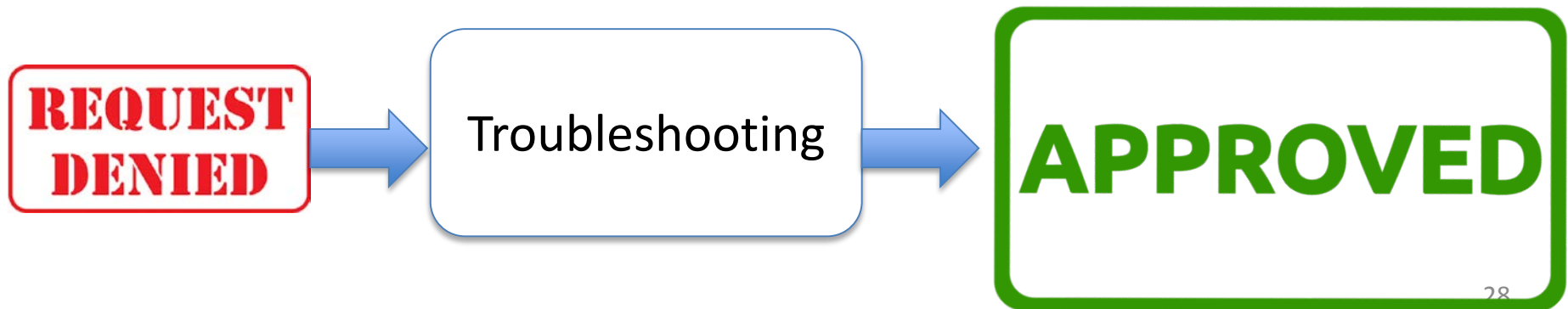
Troubleshooting steps:

1. Resubmit claims with correct formats.
 1. There should only be one service per claim
2. Contact Help Desk if not resolved.

Denial Reason: No Coverage Level Found

Translation: The particular type of service that you are attempting to bill for may not be associated with this benefit plan

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 181	Denied	Blank	No coverage level found.





Denial Reason: No Coverage Level Found

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. Professional Treatment

Troubleshooting steps:

Not applicable to Primary Users.

What to do if you are a Secondary Sage User?

Troubleshooting steps:

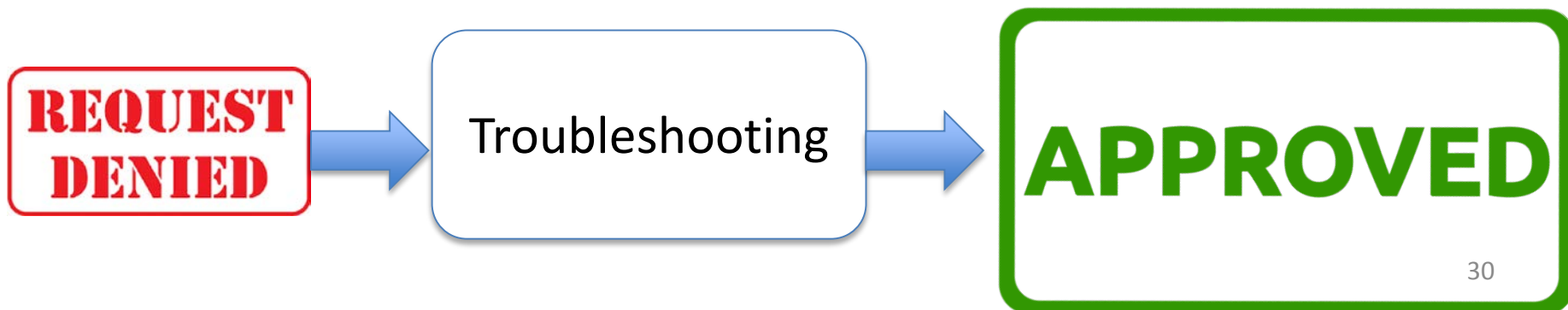
1. Review HCPC code you were using to ensure it is part of the benefit plan, as indicated by the SAPC Rates & Standards Matrix.
2. If you have confirmed HCPC code is correct, contact Help Desk for assistance.

Denial Reason:

Funding source not eligible on date of service for member.

Translation: Date of Service is before the admission date.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 166	Denied	Blank	Funding source not eligible on date of service for member.





Denial Reason:

Funding source not eligible on date of service for member.

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check:

1. Financial Eligibility Form

Troubleshooting steps:

1. Verify that the date of service billed falls on or after the coverage effective date listed for each Guarantor on the Financial Eligibility Form.
2. There should only be a date in “Coverage Expiration Date” if patient lost DMC benefits and is no longer eligible.
 - If this occurs, the service date must be before the expiration date in order for the service to be reimbursable.
3. Correct and resubmit if error is found.
4. Contact Help Desk if not resolved.

What to do if you are a Secondary Sage User?

Troubleshooting steps:

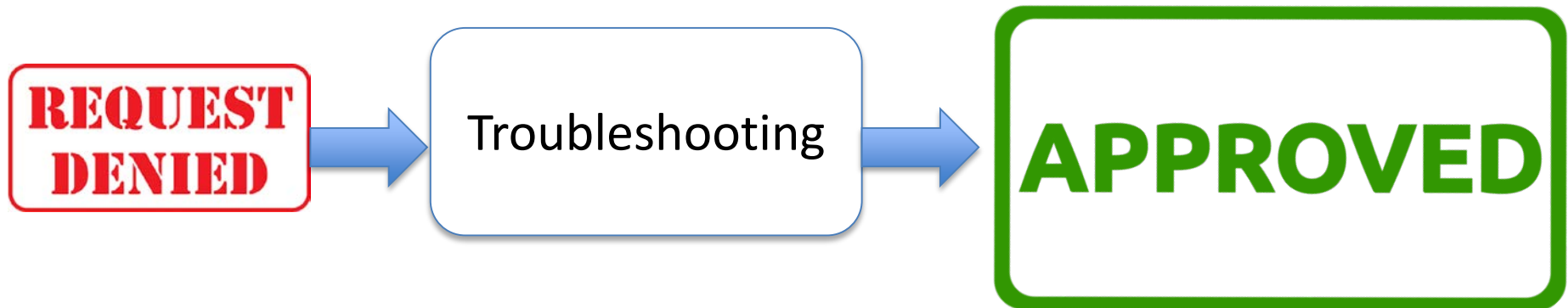
1. Same as Above

Denial Reason:

Diagnosis For Authorization is Not Found On Claim

Translation: There is a diagnosis on the Authorization Request Form that does not perfectly match what is on the Provider Diagnosis (ICD-10) Form or diagnosis on 837 file does not match diagnosis in chart.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 197	Denied	Blank	Diagnosis For Authorization Is Not Specified On Claim





Denial Reason:

Diagnosis For Authorization is not Found On Claim

What to do if you are a
Primary Sage User
(Provider Connect)?

Forms to check:

1. Authorization Request Form
2. Professional Treatment Form

Troubleshooting steps:

1. Does the Authorization Request Form have a diagnosis?
 - If you find a diagnosis on this form, please contact SAPC QI & UM Staff Member who assisted with your authorization who will assist in removing the diagnosis from the Authorization Request Form.
2. Resubmit your claim.
3. Does the Professional Treatment form contain a diagnosis?
 - If Yes, then remove diagnosis and resubmit your claim.

What to do if you are a
Secondary Sage User?

Troubleshooting steps:

1. Same as above
2. Ensure the HI*ABK segment has a valid diagnosis code that matches the diagnosis entry in Sage.
3. Resubmit your claim.



Authorization Request Form



- Do **NOT** enter a diagnosis on the Authorization Request Form.

Authorization Request

Client Information		
CLIENT NAME Monster Child	MEMBER ID 11	PROVIDER NAME Recovery, Inc.
Authorization Dates		
Authorization Requested Start Date:	<input type="text"/>	Set authorization for <input type="text"/> days <input type="button" value="Set"/>
Authorization Requested End Date:	<input type="text"/>	
Care Manager		
CARE MANAGER ASSIGNED:		DATE ASSIGNED:
Authorization Information		
AUTHORIZATION NUMBER:	CURRENT AUTHORIZATION STATUS:	CURRENT AUTHORIZATION STATUS REASON:
AUTHORIZED LEVEL OF CARE:	TYPE OF AUTHORIZATION:	PERFORMING PROVIDER TYPE:
PLANNED ADMIT DATE:	INITIAL OR CONTINUING AUTH:	NEXT REVIEW DATE:
Diagnosis		
Primary Diagnosis	<input type="text"/>	Do NOT enter diagnosis in this field.
Secondary Diagnosis	<input type="text"/>	



Professional Treatment Form

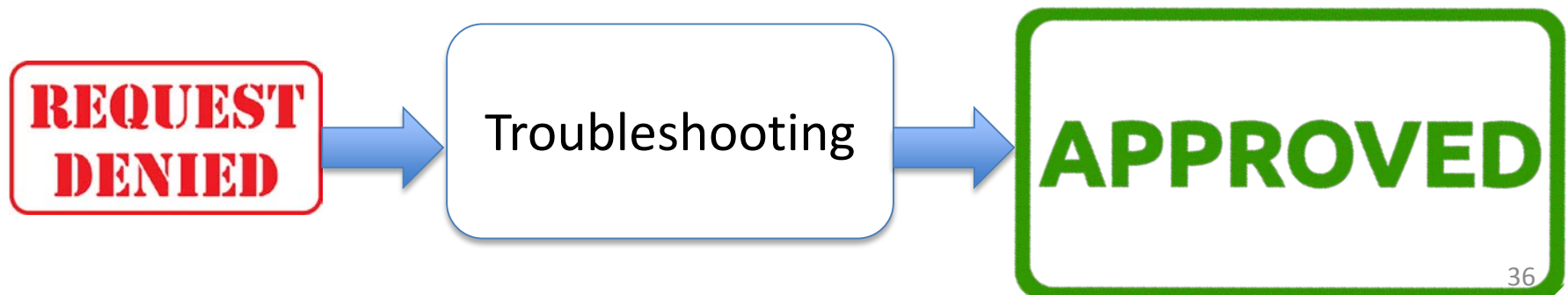
- Do **NOT** enter a diagnosis on the Professional Treatment Form → may cause billing errors.

Treatment Details	Additional Information
Funding Source: Drug Medi-Cal CPT Code: H0004:U7:HA:HD - Individual Counseling Num of Days: 1 Units/Day: 4 Total Units: 4 Cost/Unit: \$0.00 Cost/Day: \$0.00 Total Cost: \$0.00 Treatment Date(s): 03/07/2018	Start Time: <input type="text"/> End Time: <input type="text"/> Duration (minutes per service): <input type="text" value="60"/> Location: <input type="text" value="Office"/>
Diagnosis Details	
Primary Diagnosis: <input type="text"/>	
Second Diagnosis: <input type="text"/>	
Third Diagnosis: <input type="text"/>	
Fourth Diagnosis: <input type="text"/>	

Denial Reason: Service Occurs During a Claims Blackout

Translation: The service you are attempting to bill for occurs during a period where a claims blackout is actively in place. This is a historical error that is not likely to be seen by providers

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
OA 133	Denied	Blank	This service occurs during a claim processing blackout.





Denial Reason: Service Occurs During a Claims Blackout

What to do if you are a
Primary Sage User
(Provider Connect)?

Forms to check:

1. Client Eligibility Verification Report

Troubleshooting steps:

1. Run the Client Eligibility Verification Report.
2. Does the client have their eligibility established for the dates of service that you are requesting?
 - If Yes, contact the help desk to determine if a claims blackout is in place.
 - If No, then:
 1. Verify all needed medical necessity components are in the chart.
 2. Contact your SAPC UM Staff Person or SAPC UM 626-299-3531.

What to do if you are a
Secondary Sage User?

Troubleshooting steps:

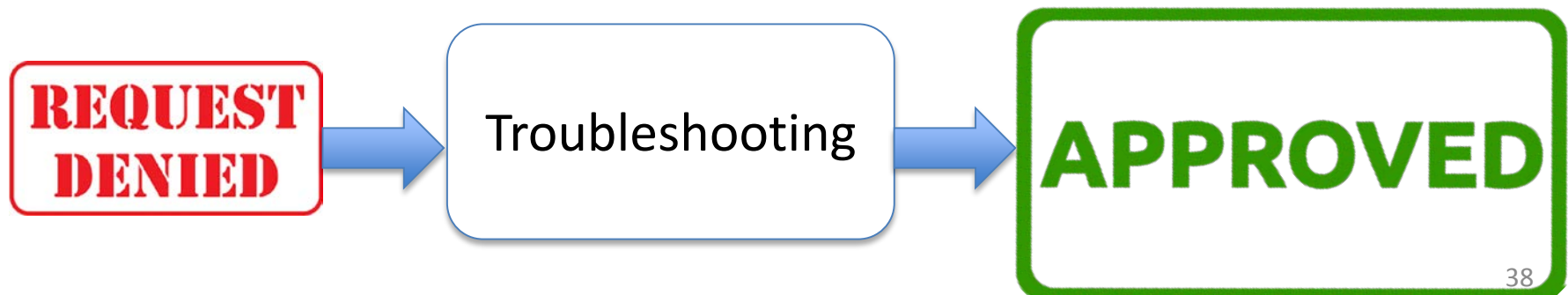
1. Same as above.

Common Denial Reason:

Group time on Treatment is more than 90 minutes

Translation: You are attempting to bill for a group service that is more than 90 minutes in length.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 177	Denied	Eligibility and/or Standards not Met	Claim Status has been set to Denied because of Claim Adjudication Rule 16 - Limit group/pt 90 min.





Denial Reason:

Group time on Treatment is more than 90 minutes

What to do if you are a
Primary Sage User
(Provider Connect)?

Forms to check:

1. Clinical Documentation
2. Professional Treatment Entry

Troubleshooting steps:

1. Verify duration of group on the clinical documentation.
 - If group lasted longer than 90 minutes, you can only bill for a maximum of 90 minutes of service.
2. Resubmit claim using corrected duration of group, as specified in 1.

What to do if you are a
Secondary Sage User?

Troubleshooting steps:

1. Verify the group duration.
 - If group lasted longer than 90 minutes, you can only bill for a maximum of 90 minutes of service.
2. Resubmit 837 using correct duration of group, as specified in 1.

Denial Reason:

Claim Level Adjustment was submitted without a corresponding Service Level Adjustment

Translation: The claim on an 837 is formatted incorrectly. Identified a previous payment/adjustment and the service level did not.

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
OA 23	Denied	Blank	Claim Level Payment/Adjustment Information Found and No Service Level Payment/Adjustment Found.

**REQUEST
DENIED**



Troubleshooting



APPROVED



Denial Reason: Claim Level Adjustment was submitted without a corresponding Service Level Adjustment

What to do if you are a
Primary Sage User
(Provider Connect)?

Forms to check:

1. None

Troubleshooting steps:

1. Not Applicable. This is an denial reason that applies to secondary providers

What to do if you are a
Secondary Sage User?

Forms to Check:

1. 837 File

Troubleshooting steps:

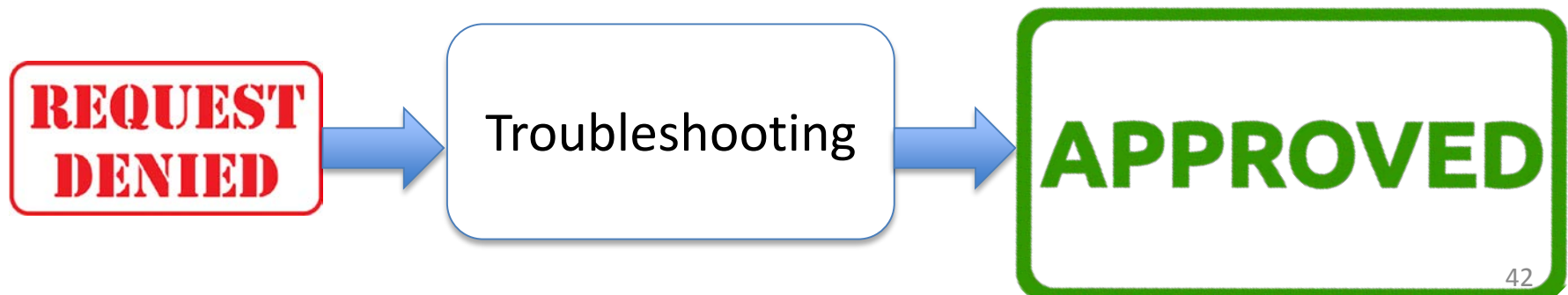
1. Resend 837 with corresponding Service Level Adjustment for the Claim Level Adjustment

Denial Reason:

Group Time is Too Short and Outside Minimum Limit

Translation: You are attempting to bill for a group that too short (e.g. <60 mins).

Denial Code	Claim Status	Claim Status Reason	Explanation of Coverage
CO 177	Denied	Eligibility and/or Standards not Met	Claim Status has been set to Denied because of Claim Adjudication Rule 15 - Limits Groups/Patient Education.





Denial Reason:

Group Time is Too Short and Outside Minimum Limit

What to do if you are a
Primary Sage User
(Provider Connect)?

Forms to check:

1. Clinical Documentation
2. Professional Treatment Entry

Troubleshooting steps:

1. Verify duration of group on the clinical documentation.
 - If group lasted less than 60 minutes, you cannot bill for the group.
2. Correct Group duration of 60+ mins (if applicable) and resubmit claim using correct duration of group, as specified in 1.

What to do if you are a
Secondary Sage User?

Troubleshooting steps:

1. Verify the group duration.
 - If group lasted less than 60 minutes, you cannot bill for the group.
2. Correct Group duration of 60+ mins (if applicable) and resubmit claim using correct duration of group, as specified in 1.



The Take Away

Initial Troubleshooting Steps Prior to Resubmission of Denied Claims

What to do if you are a Primary Sage User (Provider Connect)?

Forms to check for Both Primary and Secondary Users:

1. Financial Eligibility Form
2. Treatments Form
3. Authorization Request Form

Troubleshooting steps:

1. Search for Patient treatments that were denied
2. Click on “Tx Date” under Treatment History to view details of claim/treatment
3. View Claim Status Reason and Explanation of Coverage for details of denial reason
4. Follow steps for that specific Explanation from following slides

What to do if you are a Secondary Sage User?

Troubleshooting steps:

1. Review 835 for denial codes.
2. Follow steps for that specific Explanation from following slides
3. Verify information was entered correctly on the 837 File



Helpful Reminders Prior to Generating New Bill

1. Verify Financial Eligibility Form is completed correctly
2. Verify Diagnosis meets requirements
3. Confirm the authorization was completed with the correct Authorization Grouping and Program Address
4. Confirm the authorization is approved
5. If secondary user, confirm the correct authorization number is entered into your EHR
6. Confirm that the service meets minimum standards and requirements per the Provider Manual and Rates and Standards Matrix
 - Groups must be between 2 and 12 participants
 - Groups must be between 60 and 90 minutes
 - Claim information must match the service rendered
 - Must enter a claim for all billable services provided, including each member of a group.



“Big Picture” – Billing Status

- SAPC & Netsmart are acutely aware of billing challenges providers are experiencing and have been working with urgency to reduce denial rates... and will need your help as well!
- **Key Interventions**
 - Internal dashboard to help track various Sage-related metrics and progress.
 - Identification and contacting of providers with high rate of denials and low billing to assist with resolution.
 - **Billing Denials Webinar will be recorded and posted to the website for ongoing training**
 - **Pre-adjudication functionality!!!**
 - **Need providers to communicate this information to staff!**



Questions?



PROVIDER CONNECT PRE- ADJUDICATION FUNCTIONALITY:

SAVING PROVIDERS HOURS OF EXTRA WORK

February 07, 2019

Claims Pre-Adjudication

- **Purpose**: To explain and demonstrate the Pre-Adjudication process in Sage to determine potential billing issues.
- **Goals**:
 1. Define what Pre-Adjudication is and how to use it.
 2. Demonstrate how to effectively use Pre-adjudication functionality in Sage.
 3. Discuss potential workflows for providers to utilize this process

Claims Adjudication vs. Claims Pre-Adjudication

- **Claims Adjudication:**
 - The term used when SAPC processes claims that have been officially submitted to SAPC for review and payment.
- **Claims Pre-Adjudication:**
 - A new process available to primary users of Sage that will check claims ***before*** they are submitted to SAPC to allow providers to fix potential denial reasons.
 - Providers will be able to view which treatment/services will be approved or denied prior to submitting.
 - The denial reason will display along with the claim itself
 - Providers will have the ability to fix the “Treatment” or chart information prior to submitting, which can prevent the need to void and replace claims.



Pre-Adjudication Steps

1. After generating a new bill on the Billing page, click “Submit Bill Pre-adjudication”
 - Note: Providers do not have to utilize this function to submit claims. Pre-adjudication is optional.
2. This will send the bill to the Pre-adjudication queue for processing
 - The results can take up to 30 minutes from submission to post given the processes that need to occur to check the claims rules.
 - It will also depend on how many bills are in the queue.

Client ID	Date		Cost	
	From	To	Unbilled	Billing
159904	1/1/2019	1/17/2019	\$0.00	\$0.00
Total:			\$0.00	\$0.00
<< Cancel/Delete Bill	Save, But Not Submit	Submit Bill for Pre-adjudication		View Bill Summary >>



Pre-Adjudication Steps

3. Select the bill that you ran the Pre-adjudication process for

Unsubmitted Bills	
Billing Generation Date	Generated By
1/24/2019 3:42:29 PM	NTSTuser (ntst user)
1/26/2019 2:42:29 PM	AMSRW (Rachael Westhead)
1/26/2019 2:45:03 PM	AMSRW (Rachael Westhead)
2/4/2019 9:20:54 AM	GSchwarz2 (Greg Schwarz)
2/4/2019 9:29:35 AM	GSchwarz2 (Greg Schwarz)

4. Click “View Pre-adjudication Results” to see the results

Client ID	Date		Cost	
	From	To	Unbilled	Billing
159905	1/1/2019	1/17/2019	\$1,950.00	\$1,950.00
Total:			\$1,950.00	\$1,950.00
<< Cancel/Delete Bill	Save, But Not Submit		View Pre-adjudication Results	View Bill Summary >>



Pre-Adjudication Steps

5. Review each service to verify if “Passed” or “Failed” pre-adjudication check.
 - Reminder: This is not a bill yet, and has not been submitted to SAPC. This is only a validation measure.

Bill Pre-Adjudication Results							
Mark Service As Reviewed	Member ID	Service Date	Pre-Adjudication Edit Failed Reason	Status	Units	Procedure Code	Cost
<input type="checkbox"/>	159905	1/2/2019		Passed Edit	1	Family Therapy (90846:U8)	\$150.00
<input type="checkbox"/>	159905	1/3/2019		Passed Edit	1	Family Therapy (90846:U8)	\$150.00

6. For tracking purposes, check the service as reviewed to avoid reviewing again.

Bill Pre-Adjudication Results							
Mark Service As Reviewed	Member ID	Service Date	Pre-Adjudication Edit Failed Reason	Status	Units	Procedure Code	Cost
<input type="checkbox"/>	159904	1/10/2019 Delete	The service was denied for the following reason:Procedure not on fee schedule.	Failed Edit	6	Intake/Assessment (H0001:U7:HA)	\$0.00
<input type="checkbox"/>	159904	1/13/2019 Delete	The service was denied for the following reason:Procedure not on fee schedule.	Failed Edit	6	Intake/Assessment (H0001:U7:HA)	\$0.00



Pre-Adjudication Steps

7. Certain errors can be fixed immediately from this form directly by selecting the blue hyperlink service date on each claim.
 - This will take providers directly to the edit treatment function in that patients chart.
 - The following information can be changed without additional steps:
 - Provider Name and Role
 - Treatment/Service details
 - The program location is populated from the authorization, this will not have a different option unless the address is changed on the authorization itself.

Enter Treatment Criteria

Procedure Code - Description (Authorization, Level of Care, Valid Dates)

H0004:U1 - Individual Counseling (96838, , 11/11/2018 - 12/10/2018)

HALYALKAR, JONATHAN (12/11/2017 -) ▼

- Please Choose One - ▼

CRIH 11027 Burbank Blvd ▼

4 *Warning! testing Group based service units have a one minute duration*

11/16/2018

Pre-Adjudication Steps

8. Providers can decide to completely delete the treatment from the pre-adjudication report AND from the patients chart if they need to rebill due to an error.
 - Selecting delete will remove the treatment from the patients record. It will need to be re-entered to be included in the bill.

Bill Pre-Adjudication Results							
Mark Service As Reviewed	Member ID	Service Date	Pre-Adjudication Edit Failed Reason	Status	Units	Procedure Code	Cost
<input type="checkbox"/>	159904	1/10/2019 Delete	The service was denied for the following reason:Procedure not on fee schedule.	Failed Edit	6	Intake/Assessment (H0001:U7:HA)	\$0.00
<input type="checkbox"/>	159904	1/13/2019 Delete	The service was denied for the following reason:Procedure not on fee schedule.	Failed Edit	6	Intake/Assessment (H0001:U7:HA)	\$0.00

- In this case, an adult provider selected a youth authorization grouping. This treatment must be deleted.
 - If this is the first billing for this authorization, will need to contact UM to correct the authorization grouping.
 - If this authorization has been billed against, then authorization needs to be denied and a new one created with the correct grouping.



Pre-Adjudication Steps

8. Provider can de-select a specific patient on the claim from being submitted, but not delete the treatment from the record.
 - This is completed on the “Unsubmitted Bills” screen, the same way providers are currently using this functionality.
 - Click Return to Bill Summary

Note: All services must be billed together

No.	Date	CPTCode	Units	Billing		
				As	Bill (this bill)	Cost
1.	11/2/2018	C-H0004:U1	4.00		<input checked="" type="checkbox"/>	\$0.00
2.	11/9/2018	C-H0004:U1	4.00		<input checked="" type="checkbox"/>	\$0.00
3.	11/27/2018	C-H0004:U1	4.00		<input checked="" type="checkbox"/>	\$0.00
4.	11/16/2018	C-H0004:U1	4.00		<input checked="" type="checkbox"/>	\$0.00
Total: (does not include copay and third party)						\$0.00
Set Details						



Pre-Adjudication Steps

- 9. The billing process is the same from this step forward.
 - Providers view the Bill Summary and can either continue to edit or can submit the bill to SAPC for the Full Adjudication process.
 - Reminder: There may be additional denials that occur once the claim has been adjudicated due to additional validations that can only occur after adjudication.

Summary By Client									
Client	Dates		Total Units	Paid Units	Cost				
	From	To			Total	Pending	Paid	Denied	Void
159904	2/4/2019	2/4/2019	4.00	0.00	\$118.52	\$118.52	\$0.00	\$0.00	\$0.00
159906	1/1/2019	1/21/2019	270.00	0.00	\$66.83	\$66.83	\$0.00	\$0.00	\$0.00
Total:			274.00	0.00	\$185.35	\$185.35	\$0.00	\$0.00	\$0.00

Summary By CPT Code									
CPT Code	Dates		Total Units	Paid Units	Cost				
	From	To			Total	Pending	Paid	Denied	Void
C-H0004:U7:HA	2/4/2019	2/4/2019	4.00	0.00	\$118.52	\$118.52	\$0.00	\$0.00	\$0.00
C-H0005:U7	1/1/2019	1/21/2019	270.00	0.00	\$66.83	\$66.83	\$0.00	\$0.00	\$0.00
Total:			274.00	0.00	\$185.35	\$185.35	\$0.00	\$0.00	\$0.00

<< Edit Bill

Submit Bill >>

What You Need to Know About Pre-Adjudication

- **Claims are validated against most billing rules in Sage**
 - More advanced rules can only be validated once submitted to SAPC.
 - For example, a duplicate claim will pass pre-adjudication, but once submitted to Sage, it will validate against previous claims.
- **Only validates against information at the time when provider elects to process**
 - If anything changes in the chart after submission of claim, it can still be denied based on changes that occurred after initial passing of pre-adjudication.
 - For example, validates information based on current Financial Eligibility, but provider changes that information before actually submitting the claim.
- **Bottom Line: Once providers have submitted the claim for actual adjudication, additional denial reasons are still possible**
 - However, most are accounted for in this process.



Things to Consider...

- **What is an acceptable approval rate before submitting claims?**
 - **Consider the following questions:**
 - **What is the denial reason? Can I fix it or do I need assistance from Netsmart?**
 - **How much time will it take to fix the issue before submitting?**
 - **If we submit this claim, knowing it is denied, how much time will it take to fix and resubmit later? (Void and Replace process)**
 - **Should we submit only the approvals, while we work on the denials?**
 - **Case Example: It's the 10th of the month and billing is due. Will we have time to submit before the deadline if we attempt to fix identified errors?**



Things to Consider...

- SAPC suggests a minimum 80% approval rate before submitting a bill.
 - However, depending on the denial issues, you may consider waiting and fixing if they are simple fixes, which will increase the approval rate.
- Each agency needs to decide exactly how they want to incorporate this process into their billing workflow, including:
 - When to officially submit the claim and how much time to devote to fixing before adjudication.
 - Who will be responsible for running the Pre-Adjudication?
 - Who will be responsible for investigating denial reasons?



Example Workflow for Primary Sage User

1. Biller runs provider activity report and enters all appropriate treatments (This can and should be done as often as feasible to avoid backlog and last minute entering)
2. Finance department compiles claim information and runs pre-adjudication process
3. Finance reviews pre-adjudication report and checks for any issues.
4. Finance categorizes issues into sections to be investigated by specific departments and disseminates reports accordingly
 - I.e. Authorization issues go to Clinical or Program director
 - Eligibility issues go to admissions
 - Configuration issues go to Operations or Clinical Director

Example Workflow

5. Each assigned department is tasked to investigate and attempt to resolve by a particular day.
6. Communicates with Finance with results and whether item has been fixed.
7. Finance runs pre-adjudication again, decides which claims should be submitted and which need to be removed from the claim.
8. Uses second pre-adjudication results to begin fixing claims for eventual resubmission before waiting for official denial from SAPC.
9. Receives official claims status in PCONN and reviews for additional denials and approvals.
 - Compare against what has already been fixed to avoid duplicate work.
10. Agency celebrates and rejoices for a great coordinated effort to prevent extra work. YAY!! (This step is optional, but recommended)



To Pre-Adjudicate or Not to Pre-Adjudicate?

- Providers should consider how to incorporate this process into their workflows.
 - Including timeframes and deadlines for corrections
- While this is a wonderful new tool to assist in the battle against denials, it does not solve the problem. It only shines a light on the issues.
- SAPC and Netsmart are here to help.
 - Contact the Helpdesk for any questions regarding denials, pre-adjudication and billing.
 - Netsmart will forward SAPC specific questions to the appropriate unit at SAPC.



Questions?