

# The Substance Use Treatment Ecosystem



**Stampp Corbin, President**

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# Agenda



Business Development/Pre-Admission



Admission



Program Requirements/Clinical Documentation



Billing



Denial Management



Regulatory Complaints



Payments



Never forget  
**YOU**  
are the piece  
that makes  
the difference



# Business Development/ Pre-Admission

- **Business Development**

- Online/Digital
- Referrals
- Face to Face



## **ANTI-KICK BACK AND ANTI-BROKERING STATUTES**

- **Pre-Admission**

- Verification of Coverage
- Valid ID, Phone Number, Address, Emergency Contact
- Notification of Potential Admit (internal or third-party biller)

# Admission

- **Documents Must Meet:**
  - DHCS Requirements
  - State and Federal Laws
- **Authorizations**
  - Preauthorization Requirements
    - Time Constraints
    - Can Lead to Loss Revenue
  - Management of Authorization Dates
    - Time Constraints
    - Can Lead to Loss Revenue
  - ASAM Intake Assessment and Level of Care Placement
    - ASAM 3.7 Not DHCS Licensed
  - Other Assessments (CIWA, COWS)
    - Must Match Level of Care
- **Request Plan Documents**



# Program Requirements/ Clinical Documentation

- **Program Requirements “COMPLIANCE”**
  - Must Meet ASAM Requirements
  - Schedule for Each Level of Care
  - Clinical Roster
  - Clinical Documentation “IF IT IS NOT DOCUMENTED, IT DID NOT OCCUR”
    - Observation Logs
    - Start and Stop Times
    - Accurate, Timely, and Not Boilerplate
      - Client in Two Places at Once
    - Treatment Plan
      - Medication Observation vs. Administration
      - Updates
    - Review of Laboratory Testing
    - Discharge Plan on Day One
    - Signature Requirements (within 72 hours, credentials)
- **Protocols for Never Occurring Events**



# Billing

- **Internal vs. Third Party**

- Same Processes in Either

- **Process:**

- Accurate Daily Census or Testing
- Verification of Coverage
  - At Least Monthly Updates
    - Can Lead to Uncovered Days
- Understand:
  - In-Network Billing Requirements
    - Third Party Carve Outs
  - Out-of-Network Billing Requirements





# Denial Management

“NOW THE FINANCIAL WORK BEGINS”

- **Medical Record Requests**
  - AB3275 (30 Calendar Days)
- **Provider Errors**
  - Poor Documentation
  - Inaccurate Coding
  - Timely Filing
  - Termed Coverage
  - Diagnosis Code Issues
  - Authorization Lapses
- **Payer Errors**
  - Inaccurate Denials
  - Erratic Payments
  - *Compliant Clinical Hour Minimums*



**APPEALS, APPEALS, APPEALS**

# Regulatory Complaints

“FIGHTING FOR PAYMENT”



- California Department of Managed Health Care (96% of Claims)
- California Department of Insurance (4% of Claims)
- Employee Benefit Services Administration (EBSA)
  - ALL Self-Insured Plans

# Payments

“NO MISSION WITHOUT MONEY”

- Tracking Claim Receipt to Payment
  - AB3275 (30 Calendar Days)
- How Do You Know They Are Accurate?
  - Monthly Reports
  - Reviews with the Internal Billing Department or Third-Party Biller
- Do You Have Copies of Plan Documents?
- Why Are There Third-Party Negotiations?





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**AB 3275**, Health Care Coverage: Claim Reimbursement, codified in Health & Safety Code §§ 1371, 1371.34, and 1371.35:

Requires plans, by January 1, 2026, **to reimburse a complete claim or a portion thereof, whether in state or out of state**, as soon as practicable, but **no later than 30 calendar days after receipt of the claim**.

Requires plans, if a claim or portion thereof does not meet the criteria for a complete claim or the criteria for coverage under the plan contract, **to notify the claimant, in writing**, that the claim or portion thereof is contested or denied, as soon as practicable, but **no later than 30 calendar days after the receipt of the claim**.

Requires plans, **if a complete claim is not reimbursed within 30 calendar days after receipt, to pay interest at a rate of 15% per annum beginning with the first calendar day after the 30-day calendar period**. Also requires plans to **automatically include all accrued interest in its payment of the claim, without requiring the claimant to submit a request for the interest amount**. **Increases the penalty** on plans for not automatically paying the interest owed on a claim **from \$10 to \$15** or 10% of the accrued interest on the claim.

**Requires plans not to contest claims consistent with the procedure or revenue codes and services approved by prior authorization**, with appropriate documentation included on the claim. Requires plans, if a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof, **to complete reconsideration of the claim within 30 calendar days after receipt of this additional information**.

**Requires plans to treat complaints by an enrollee about a delay or denial of a payment of a claim as a grievance subject to that grievance process, whether or not the enrollee uses “grievance” as part of the complaint**.

