COUNTY OF LOS ANGELES
Public Health

# Clinical & Utilization Management Updates

Los Angeles County Department of Public Health All Provider Meeting October 12, 2021

Substance Abuse Prevention & Control

COUNTY OF LOS ANGELES Public Health

Authorization requests should not be submitted until all appropriate documentation has been entered into Sage for review per the Sage Required Documentation Checklist 3.0

Any missing documentation causes delays and/or unnecessary denials that could have been avoided if documentation had been present.

Providers should check to ensure the fields on the authorization are correct before submitting, which will avoid unnecessary denials and NOABDs

# Common auth errors:

**Funding source submitted incorrectly.**
**If patient is not a DMC beneficiary, the funding source <u>must be Non DMC</u>**

**If patient is a DMC beneficiary, the funding source <u>must be DMC</u>, with the <u>only exception</u> being RBH authorizations are always Non DMC funding.**

**ASAM not finalized**

# Overview of Non-Residential Medical Necessity

- **SAPC has updated our utilization management (UM) processes and timelines for NON-RESIDENTIAL authorizations to align with State guidance (DHCS BHIN 21-019) related to non-residential medical necessity that changes when services can be reimbursable by Medi-Cal.**
  - See DHCS Behavioral Health Information Notice (BHIN) 21-019 for more details at: https://www.dhcs.ca.gov/Documents/BHIN-21-019-DMC-ODS-Updated-Policy-on-Medical-Necessity-and-Level-of-Care.pdf

**Specifically, initial authorizations are granted based on:**

- LA County residency and financial eligibility to allow for Medi-Cal reimbursable engagement services, even if medical necessity is not eventually established.
- However, the purpose of these services must involve engaging clients in services with the ultimate aim of establishing medical necessity, even if medical necessity is not subsequently successfully established.

**Initial authorizations for non-residential services can be approved WITHOUT YET ESTABLISHING MEDICAL NECESSITY, but with DURATION LIMITS**

**Initial authorization timeframe will vary based on age and homelessness status:**

- **Patients aged 20 and under and/or People Experiencing Homelessness (PEH)** will be granted an initial 60-day authorization while being engaged to complete the ASAM Assessment and establish medical necessity.
- **All other individuals** will be granted an initial 30-day authorization while they are being engaged to complete the ASAM Assessment and establish medical necessity.

# Authorization Periods – Patients Aged 20 and Under or PEH

For **NON-RESIDENTIAL SERVICES**, initial authorizations for patients **aged 20 and under** and **People Experiencing Homelessness (PEH)** will be set at 60 days *while they are being engaged and medical necessity is being established.*

Providers:

- Should engage patient to try to complete ASAM assessment and establish medical necessity throughout the initial 60-day authorization, but if this is not possible, the timelines for ASAM assessments and establishing medical necessity are the same as previously:
  - 7- or 14-days to complete ASAM assessment upon the end of the initial 60-day authorization period depending on clients who are 21 and over (7-days) or aged 20 and under (14-days); and
  - 30 days to submit all documentation to establish medical necessity and submit complete member authorization.

1 **Initial 60-Day Engagement Authorization Period**

- Patient must be LA County Resident
- Must meet SAPC Financial Eligibility requirements
- **Must meet age requirement of being 20 or under**
- **Documentation of homelessness status is required (if applicable)**
- Does NOT need to meet medical necessity

2 **New Authorization Request** submitted following initial 60-day authorization. In this example, the second authorization would begin Sept 6, 2021 and provider will have 7- or 14-days (depending on age of patient) to finalize the ASAM assessments and 30 days to submit all necessary documentation to establish medical necessity, as per current requirements.

**Total Authorization Length**

- **Outpatient Services* → 2 months for the initial authorization period for those aged 20 and under and PEH, and then 4 months for the new authorization once medical necessity is established** (in this example, it would end on Jan 31, 2022)
- **OTP Services** → 2 months for the initial authorization period for those aged 20 and under and PEH, and then 10 months for the new authorization once medical necessity is established** (in this example, it would end on July 31, 2022)

*Total time will equal 6 months for outpatient services
**Total time will equal 12 months for OTP services

# Authorization Periods – All Other Patients Aged 21 and Over that are Not Homeless

Medical Necessity

For **NON-RESIDENTIAL SERVICES**, initial authorizations for patients aged 21 and over who are not homeless will be set at 30 days *while they are being engaged and medical necessity is being established.*

Providers:

- Should be engaging patient to try to complete ASAM assessment and establish medical necessity throughout the initial 30-day authorization, but if this is not possible, the timelines for ASAM assessments and establishing medical necessity are the same as previously:
  - 7- or 14-days to complete ASAM assessment upon the end of the initial 60-day authorization period depending on clients who are 21 and over (7-days) or aged 20 and under (14-days); and
  - 30 days to submit all documentation to establish medical necessity and submit complete member authorization.

1 **Initial 30-Day Engagement Authorization Period**

- Patient must be LA County Resident
- Must meet SAPC Financial Eligibility requirements
- Does NOT need to meet medical necessity

2 **New Authorization Request** submitted following initial 30-day authorization. In this example, the second authorization would begin August 7, 2021 and provider will have 7- or 14-days (depending on age of patient) to finalize the ASAM assessments and 30 days to submit all necessary documentation to establish medical necessity, as per current requirements.

**Total Authorization Length**

- **Outpatient Services* → 30 days for the initial authorization period for those aged 21 and over who are not homeless, and then 5 months for the new authorization once medical necessity is established** (in this example, it would end on Jan 31, 2022)
- **OTP Services** → 30 days for the initial authorization period for those aged 21 and over who are not homeless, and then 11 months for the new authorization once medical necessity is established** (in this example, it would end on July 31, 2022)

*Total time will equal 6 months for outpatient services

**Total time will equal 12 months for OTP services

# Reminders: Non-Residential Medical Necessity

- **Submit a Full (Standard) Authorization When Medical Necessity Has Been Established**
  - No need to wait 30/60d before submitting a full authorization request
- **For initial engagement authorizations prior to establishing medical necessity**
  - Make this explicit via a miscellaneous note
  - Treatment plan should include conducting an ASAM assessment within the initial authorization period timeframe

See DHCS Behavioral Health Information Notice (BHIN) 21-019: https://www.dhcs.ca.gov/Documents/BHIN-21-019-DMC-ODS-Updated-Policy-on-Medical-Necessity-and-Level-of-Care.pdf

# Recovery Support Services (RSS)

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# All providers have been issued pre-approved Provider Authorizations (PAuths) that cover all individuals seeking RSS services at the provider agency for FY21-22

PAuths are agency wide and not limited to a specific program as all programs within SAPC have RSS included

PAuths have been issued by age group and PPW status, with all available LOCs for the agency included in those PAuths.

- I.e. Providers who have 12-17, 18-20 and 21 and over programs will have 3 PAuths, one for each age group
- Providers with all age groups and are PPW providers, will have 6 PAuths, one for each age group and PPW status…
  - for exampleASAM1.0 12-17 PPW (H0004:U6:U7:HA:HD) and ASAM 1.0 12-17 Non PPW (H0004:U6:U7:HA)

# Previous level of care U code should no longer reflect the previous level of care, which will eliminate barriers to treatment

**When billing, providers should always use the lowest level of care *contracted* for to represent the previous level of care U code on the claim. (U6:U7, U6:U8, U6:U1)**

**If you are not contracted for residential levels of care, then be careful not to select U1, U2 or U3 as the second U code on the claim.**

# Providers should not submit member authorizations for RSS services beginning 7/1/2021 or later

- UM will deny any RSS member auths submitted
- Providers will be solely responsible for ensuring medical necessity is met, including financial eligibility
- UM will not be verifying medical necessity or financial eligibility for RSS services
- Providers must document medical necessity as is the current requirement and maintain the record for audits
  —An assessment and treatment plan should be on file
- Medical necessity will be validated through audits only post service, post payment by CPAs and DHCS through normal audit procedures

# Recovery Support Services (RSS)

- **What services are covered through RSS?**
  - Individual/group counseling
  - Recovery coaching
  - Relapse prevention
  - Education/job skills
  - Family support
  - Support groups
  - Ancillary services
  - Case Management

- **Helpful for when:**
  - Providing care for patients following discharge
  - Patients intermittently participatory in care
  - Coordinating care when patient is in another facility/program

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# Financial Eligibility

# Financial Eligibility Review

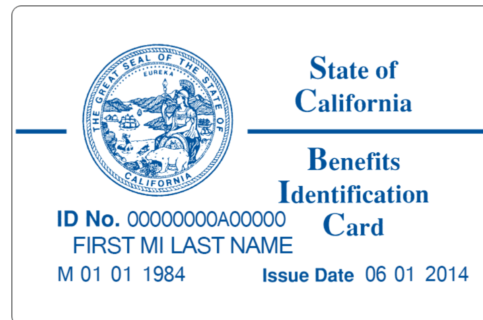
- Effective 7/1/21, SAPC began to verify Medi-Cal eligibility at the authorization and claim level by checking the MEDS file.
- Providers need to confirm the patient's financial eligibility by checking AVES and take the following steps to resolve discrepancies when the patient is ineligible based on SAPC's MEDS file review:
  - Ensure the CIN listed on the DMC guarantor is the correct CIN for the patient
  - Run the Real-Time 270 Eligibility Request in Sage for the date of authorization
  - Upload the printout from Medi-Cal system that was used to verify eligibility via the Attachments in Sage
  - If patient is ineligible for DMC but is in another county program: (1) correct the Financial Eligibility Form in Sage; (2) submit NEW authorization under Non-DMC guarantor; and (3) request to DENY the DMC authorization.

# Financial Eligibility Review

- Providers need to verify and update the Financial Eligibility Form within Sage both initially AND whenever a patient's financial eligibility changes (e.g., patient enrolls in Medi-Cal, patient loses Medi-Cal eligibility).
  - Example: Converting patient from non-DMC Applying to Medi-Cal to enrolled Medi-Cal beneficiary
- SAPC may modify authorization dates based on eligibility within the MEDS file, as verified by SAPC.
- For more details, see Financial Eligibility Guidelines at: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/DocumentingChangesFinancialEligibilityStatus.pdf

# Financial Eligibility Review

- During the course of treatment, **providers must assist the patient in applying for and verifying Medi-Cal**, either in person at a local DPSS office, through the Customer Service Center 899-613-3777, or via the Your Benefits Now (YBN) portal.




- **For patients who obtain Medi-Cal benefits during treatment, it is critical that the provider updates the financial eligibility (FE). This will help monitor ongoing eligibility for patients and AVOID authorization and billing denials.**

# Updating Financial Eligibility

- Once the patient is officially enrolled in Medi-Cal, **providers must immediately update their Financial Eligibility in Sage**
  - Add the DMC guarantor with the effective date of Medi-Cal.
  - Update the "Applying for Medi-Cal" guarantor with the "Coverage Expiration Date" to the day before Medi-Cal was effective
  - **The "DMC Medi-Cal" guarantor must be added and set as the primary guarantor and Update** "Coverage Effective Date" to the same date the Medi-Cal benefits became effective

Coverage Expiration Date
05/31/2020
Effective Date Of Contract
01/01/2000

| Guarantor Selection | |
|---|---|
| Change Order | Guarantor Name |
| ⬇ ⬆ | CALIFORNIA DEPARTMENT OF ALCOHOL AND DRU |
| ⬇ ⬆ | LA County - Non DMC |
| ⬇ ⬆ | Applying for Medi-Cal |
| -- Guarantors -- | Add Guarantor |

Coverage Effective Date
06/01/2020

# Updating Financial Eligibility

- **DMC guarantors must have a policy number AND a Subscriber Client Index Number (CIN) listed on the guarantor details page.**
  - Use the CIN for both the policy number and CIN fields within SAGE.
- **Providers must update the Cal-OMS Admission information**

| Field | Value |
|---|---|
| Subscriber Policy Number | 90000000A |
| Subscriber Medicaid # | |
| Subscriber Client Index # | 90000000A |

- For more details, please see Updating Financial Eligibility for Patients who Obtain Benefits During Treatment: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/UpdatingFinancialEligibilityPatientsWhoObtainBenefitsDuringTreatment.pdf

# Discussion / Q&A

**“The opposite of addiction is not sobriety; the opposite of addiction is connection.”**

*- Johann Hari*