Utilization Management-Provider Meeting

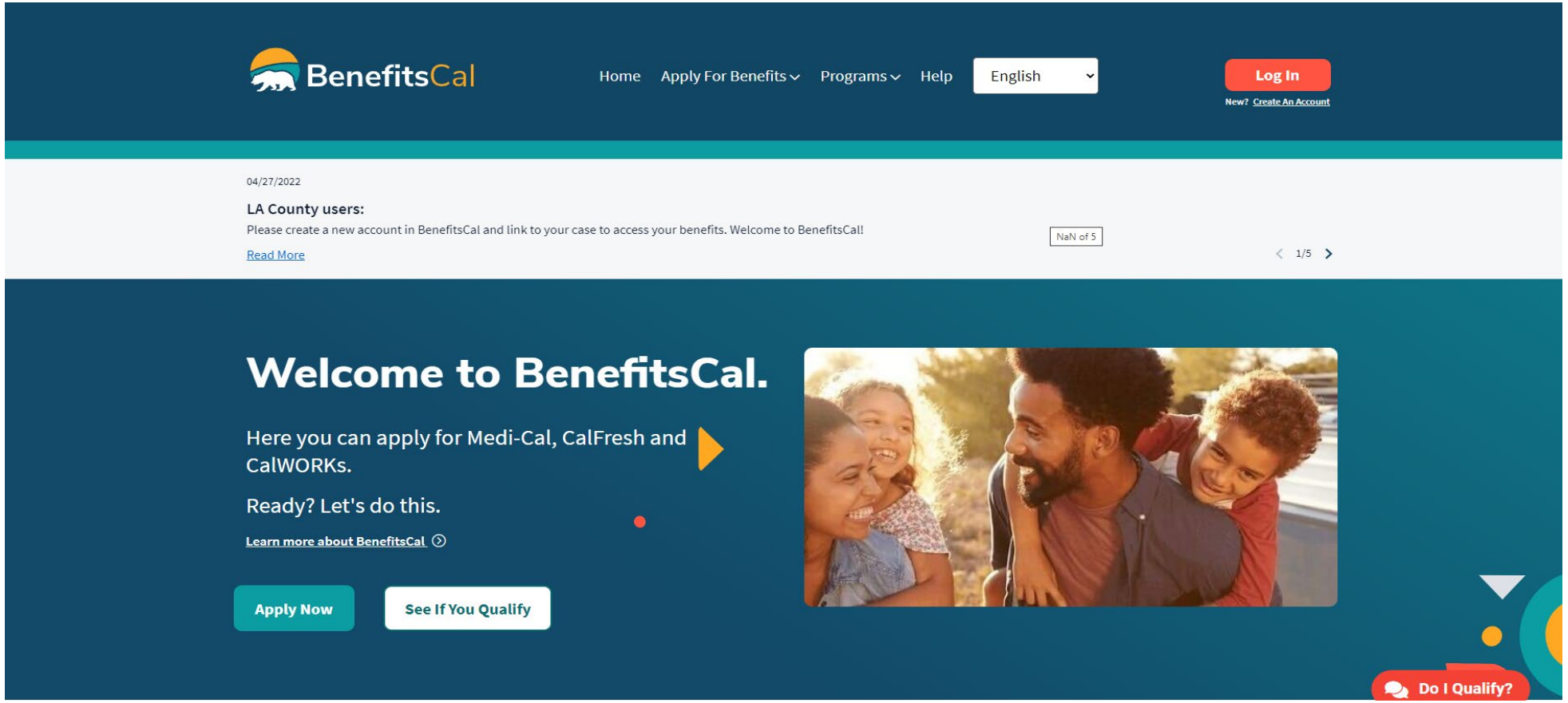
Los Angeles County Department of Public Health
June 15, 2022
Substance Abuse Prevention & Control

Agenda

- Update on Inter County Transfer of Medi-Cal Benefits (ICT)
- CalAIM Documentation Redesign
- Updating FE for MyHealthLA Enrollees now Eligible for Medi-Cal
- Reminder: New Adult Paper-Based ASAM for SAGE Downtimes
- Open Discussion

SAPC UM-Provider Meeting 6/15/2022

Inter County Transfer of Medi-Cal Benefits (ICT) Follow Up


BenefitsCal
Home
Apply For Benefits
Programs
Help
English
Log In
New? Create An Account
04/27/2022
LA County users:
Please create a new account in BenefitsCal and link to your case to access your benefits. Welcome to BenefitsCal!
Read More
NaN of 5
1/5
Welcome to BenefitsCal.
Here you can apply for Medi-Cal, CalFresh and CalWORKs.
Ready? Let's do this.
Learn more about BenefitsCal
Apply Now
See If You Qualify
Do I Qualify?

- Create a benfit CAL account and link the San Bernardino case to the account, and
- Report the change, and
- Click on the information link and update the address

Reasonable Proof

BenefitsCal

Submit Date

Submit Time

Case Number

Change Report Summary

Programs

Food (CalFresh)

Health Coverage (Medi-Cal)

Your Information

Case Discussion

- ***Sample #1:*** No info for County of Responsibility and County of Residence. There's no previous eligibility info prior to 5/1/2022 on MEDs Report. Provider reported that client was transferring from Orange County to LA.
- UM Recommendation

TO REQUEST RETROACTIVE AUTHORIZATION FOR ICT:

- UM will accept retroactive requests from dates of service 7/1/2021 and beyond that are new authorization requests or previously submitted service authorizations that were denied under service request rescinded.
- If there was a previously submitted authorization that was denied due to the county of responsibility not being assigned to LA (in many cases, the county eligibility file will show LA county residence from 1-3 months prior to the completion date of the LA County as the county of responsibility), then provider can appeal this denial for a secondary review.
  - Provider run 270/271 form to update MEDS and upload any documentation from DHCS or DPSS that indicates changes to the county of residence or when an ICT was initiated as the eligibility file may not show the expected changes.
  - Once the documentation is uploaded or you have confirmed the dates of the ICT, providers can submit the authorization for the corresponding dates of service.
    - Include miscellaneous note on your actions taken to transfer benefits
  - UM will verify the dates against the county's eligibility file and/or attached supporting documentation and miscellaneous note on actions taken to determine the retroactive authorization period.

Case Discussion

- ***Sample #2:*** Client is transferring to San Bernardino County to LA County. There is Los Angeles County code but patient's address is still showing an address in in San Bernardino County.
- UM Recommendation

Case Discussion

- ***Sample #3:*** Provider reported that client is transferred the Medi-Cal from Santa Barbara County to LA.
- Provided L number and a document called “Single Subscriber Response”
- UM Recommendation

ICT Appeal Case Discussion (1)

- Initial auth for 3.1 LOC 2/15-3/16 , provider submitted documentation of assisting patient with intercounty transfer process. The authorization was approved under 30 day “Applying for Medi-Cal funding”.
- Auth for remainder of the initial 60 days 3/17-4/15 was partially denied. 4/1-4/15 was approved, MEDS files showed county of responsibility LA County effective 4/1/22.
- New MEDS file upgrade was implemented, county of residence now listed in MEDS file, state has agreed to accept claims based on county of residence.
- After our ICT process update, provider submitted expedited appeal. The appeal was processed timely; the partial denial was overturned. Authorization for dates 3/17-3/31 was approved because new MEDS file upgrade shows county of residence established as LA County effective 2/1/22.

ICT Appeal Case Discussion (2)

- Dates requested 1/20/22-1/26/22 3.7 WM
- A grievance was processed on 3/8/22, the denial was upheld. Pt's benefits were assigned to Fresno County. Pt has previously received one time Applying for medi-cal benefit during the fiscal year.
- A 2nd Grievance was submitted and processed on 5/27/22. The **new MEDS file** revealed that **County of residence** has transitioned to **LA County** as of **1/1/22**. The denial was overturned, the authorization was approved.

Essential Contact Info

- For a specific authorization question, contact the care manager named in SAGE
- UM General number: **(626) 299-3531** and email: SAPC.QI.UM@ph.lacounty.gov
- Netsmart Helpdesk for SAGE technical problems/questions: **(855) 346-2392**
- Phone Number to file an appeal: **(626) 299-4532**
- Providers or patients who have questions or concerns after receiving a Grievance and Appeals (G&A) Resolution Letter should contact the **G&A number** at (**626) 293-2846**

Clarification

- Phone Number to follow-up with an appeal after receiving a resolution letter: **(626) 293-2846**

SAPC UM-Provider Meeting 6/15/2022

CalAIM Documentation Redesign

CalAIM Documentation Redesign (BHIN 22-019)

- DHCS will remove the requirement to have a point-in-time treatment plan and the requirement that each chart note tie to the treatment plan.
- DHCS will also remove the requirement for clients to sign the treatment plan.
- Instead, DHCS will use problem lists to allow active and ongoing updates of a client's evolving clinical picture, with progress notes reflecting the care given, aligning with the appropriate billing codes.
- Reference: https://www.calmhsa.org/wp-content/uploads/CalMHSA-DMC_DMC-ODS-LPHA-Documentation-Guide-05302022.pdf

Documenting Medical Necessity

The assessment will include the provider's determination of medical necessity and recommendation for services.

The details within the problem list and progress notes will also support medical necessity.

Problem List

- Will include, but is not limited to:
  - Diagnoses identified by a provider acting within their scope of practice, if any.
  - Problems identified by a provider acting within their scope of practice, if any.
  - Problems identified by other providers acting within their respective scopes of practice, if any.
  - Problems identified by the beneficiary and/or significant support person, if any.
  - The name and title of the provider that added or removed the problem, and the date the problem was added or removed.
- The problem list will be updated on an ongoing basis.

Elements of a Progress Note

- Includes:
  - The type of service rendered.
  - A narrative describing how the service addressed the beneficiary's behavioral health need.
  - The date of the service.
  - Duration of the service, including travel and documentation time.
  - Location of the beneficiary at the time of receiving the service.
  - A typed or legibly printed name, signature of the service provider and date of signature.
  - ICD 10 code, and CPT, or HCPCS code.
  - Next steps, including, but not limited to, planned action steps by the provider or by the beneficiary.

Progress Note Timing

- Progress notes must be completed within **3 business days** of the service, except for crisis services, which must be completed within 24 hours.
- Providers must complete a daily progress note for services that are billed daily.
  - Additional weekly summaries are no longer required for day rehabilitation and day treatment intensive.

Updating FE for MyHealthLA Enrollees now Eligible for Medi-Cal

http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/DocumentingChangesFinancialEligibilityStatus.pdf

Updating FE for MyHealthLA Enrollees now Eligible for Medi-Cal

sage
Substance Use Disorder Information System

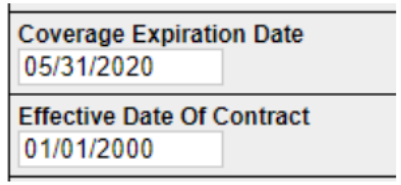


Figure 2: Coverage Expiration Date for Applying for Medi-Cal After Benefits Acquisition

The "DMC Medi-Cal" guarantor must be added and set as the primary guarantor using the "Change Order" arrows to move "California Department of Alcohol and Drugs" to the top of the list order (Figure 3). Providers must ensure the ***"Coverage Effective Date"*** (Figure 4) within the guarantor details corresponds to the same date the Medi-Cal benefits became effective. This information is available on the benefits card or the notification sent to the patient. It is recommended that the patient apply online through the YBN portal so that any needed information can be accessed online easily.

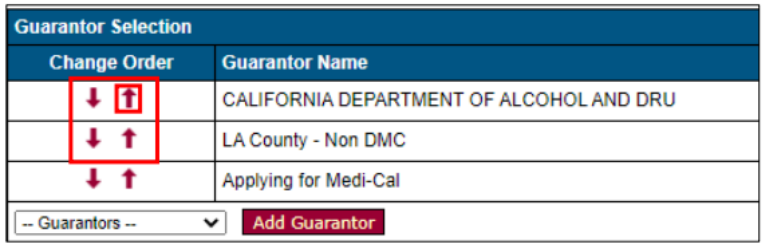


Figure 3: Benefits Acquired During Treatment

http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/DocumentingChangesFinancialEligibilityStatus.pdf

ASAM American Society of Addiction Medicine

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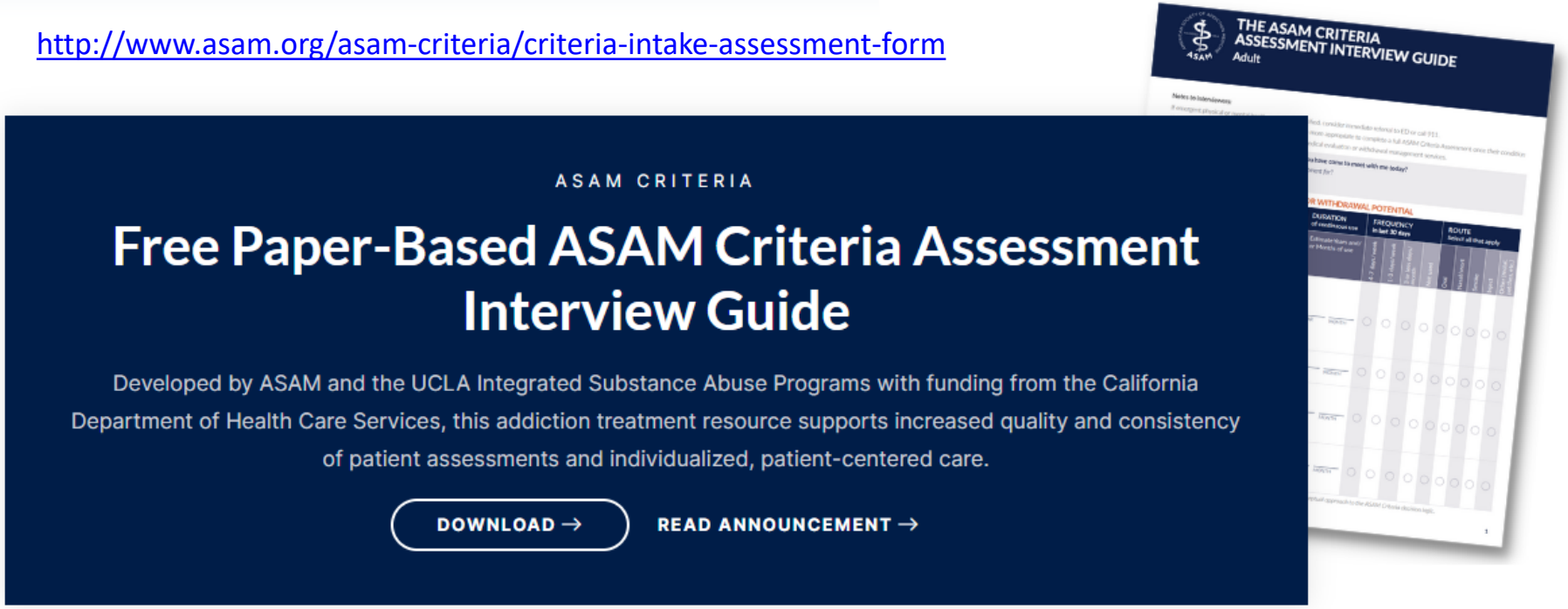
http://www.asam.org/asam-criteria/criteria-intake-assessment-form



The ASAM Criteria® Assessment Interview Guide is the first publicly available standardized version of the *ASAM Criteria* assessment. With this release, ASAM and UCLA hope to increase the quality and consistency of patient assessments and treatment recommendations. This resource can also help assist states looking to facilitate continuity and consistency in substance use disorder (SUD) treatment delivery and coverage.

Because it is paper-based, offered **free to all clinicians**, and can be used in many different clinical contexts, the Guide enhances the public utility of *The ASAM Criteria's* multidimensional assessment approach for the addiction treatment community.

Q&A / Discussion