Los Angeles County
START-ODS
System Transformation
To Advance Recovery
and Treatment

Documenting Changes in Financial Eligibility Status

Sage Patient Management System:
Services, Data, and Claims

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SAPC | Substance Abuse Prevention and Control
County of Los Angeles Public Health

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Documenting Changes in Financial Eligibility Status

Updated August 2022

This job aid outlines the process, for both Primary and Secondary Sage Users, used to change a patient's financial eligibility status as the situation arises. This workflow depends on identifying what the current financial status is and how it will be changed. Identifying Drug Medi-Cal (DMC), My Health n(MHLA) or other select County programs eligible patients minimizes barriers to treatment. Providers are required to verify patient benefits enrollment at admission and on monthly basis; and for those who do not have current benefits assist in applying for DMC or MHLA. This job aid covers the following situations:

1. Patients who initially admitted as Applying for Medi-Cal/MHLA, then become Medi-Cal/MHLA enrolled;
2. Patients who initially admitted as Medi-Cal/MHLA enrolled, then lose their benefits during treatment;
3. Patients who are admitted as other County Funding enrolled or MHLA and;
4. Patients who initially admitted as Self-pay, then become Medi-Cal, MHLA or other County Funding enrolled.

Verifying Medi-Cal Eligibility

Providers are required to verify Medi-Cal eligibility prior to admission and at the beginning of every month. A record of this verification must be kept on file either within Sage or at the agency. All Medi-Cal certified providers can conduct this verification using one of the following processes:

1. Real-Time 270 Eligibility Request within Sage (Provider Manual Requirement)
2. Automated Eligibility Verification System (AEVS)
3. Point of Service (P.O.S.) device
4. DHCS Medi-Cal eligibility transaction

The Real-Time 270 Eligibility Request form is required per Provider Manual 5.0 and should be used as the primary method to verify initial and monthly eligibility. The Real-Time 270 request requires a DMC guarantor to be entered on the Financial Eligibility form with a Subscriber Client Index Number (CIN) entered. The CIN is listed on the Medi-Cal Beneficiary Identification Card (BIC) and is the first 9 digits of the "ID No." starting with a 9 and ending with a letter (see image of BIC below).

If providers do not have the CIN, they may need to use one of the other methods listed above to obtain the CIN and input on the DMC guarantor.

The following images are of the BICs currently in circulation, including the new BIC. All versions of the BICs below are valid.

New BIC:

For more information about obtaining access to Medi-Cal related verification systems, please call the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555 or visit https://www.medi-cal.ca.gov/.

For instructions on the Real-Time 270 Eligibility Request, please visit the SAPC website and view the January 29, 2019 Provider meeting. Click the link below to access the PowerPoint slides http://publichealth.lacounty.gov/sapc/NetworkProviders/pm/012919/SageUpdatesPresentation.pdf. Please click this link to access instructions for utilizing the Real-Time 270 Eligibility Request. http://publichealth.lacounty.gov/sapc/NetworkProviders/pm/012919/SageMediCalEligibilityVerificationRealTimeProcessUserGuide.pdf.

Patients Who Obtain Benefits During Treatment

SAPC currently allows up to 30 days of reimbursable treatment at admission only per patient per year while providers assist patients in applying for benefits. This policy does not apply to patients who lose their benefits during treatment and are working to be reinstated or to patients who have an active Medi-Cal case in another county.

> POLICY: Inter County Transfers: Patients whose current Medi-Cal is assigned to a county other than LA County <u>and</u> who have, 1) initiated an InterCounty Transfer (ICT) by contacting the DPSS eligibility worker from the originating county about the transfer request and 2) requested the change of address online through www.benefitscal.com or at a local LA County DPSS office, will be considered as having active Medi-Cal coverage in LA County. These ICT patients should be entered on the Financial Eligibility with a DMC guarantor and evidence of the transfer must be uploaded to the chart before requesting a DMC authorization.

Patients who are "Applying for Medi-Cal" need to have this indicated on their Financial Eligibility with a primary guarantor of "Applying for Medi-Cal" and a secondary guarantor of LA County-Non DMC as seen in Figure 1 below. SAPC has noted a large number of state denials related to providers entering DMC as the primary guarantor for patients with out of county Medi-Cal. To avoid unnecessary denials, it is very important to utilize "Applying for Medi-Cal" for all patients whose Medi-Cal is assigned to another county.

Guarantor Selection	
Change Order	Guarantor Name
⬇ ⬆	Applying for Medi-Cal
⬇ ⬆	LA County - Non DMC
-- Guarantors --	Add Guarantor

Figure 1: Applying for Medi-Cal

During the course of treatment, providers must assist the patient in applying for Medi-Cal, either in person at a local DPSS office, through the Customer Service Center 899-613-3777, or via the https://benefitscal.com/ portal.

When providers become aware that the Medi-Cal benefits were approved with an official effective date, providers should:

1. Bill all remaining services covered under Applying for Medi-Cal as soon as possible, before adding the DMC guarantor.
2. Wait for all claims to be appropriately adjudicated under Applying for Medi-Cal and Verify claims were appropriately denied or approved using Provider Connect, EOBs, KPI or 835s.
3. When the provider has received all expected approvals, the DMC guarantor can be entered with the correct Coverage Effective Date
    a. Providers must DELETE the "Applying for Medi-Cal" guarantor once the DMC guarantor has been added to prevent billing errors.
    b. In the Coverage Comments section of the Financial Eligibility, providers should enter the dates the patient qualified under the SAPC Applying for Medi-Cal policy (See Figure 3 below)
4. Billing will only be approved for dates of service that fall within the DMC coverage effective dates once the DMC guarantor is entered.
    a. If providers need to bill for any previous Applying for Medi-Cal claims, the DMC guarantor would have to be deleted and Applying for Medi-cal re-entered to claim for dates of service prior to the Medi-Cal effective date.

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 BenefitsCal portal so that any needed information can be accessed online easily.

Figure 3: Benefits Acquired During Treatment

Coverage Comments	Patient was originally entered as Applying for Medi-Cal for dates 6/01/2022- 6/30/2022. Medi-Cal became effective on 7/1/2022.

Guarantor Selection

Change Order	Guarantor Name
↓ ↑	1 CALIFORNIA DEPARTMENT OF ALCOHOL AND D
↓ ↑	2 LA County - Non DMC

-- Guarantors -- | Add Guarantor

Submit | Cancel

Figure 4: DMC guarantor Coverage Effective Date - Reflects first date of active coverage

Coverage Information	
Eligibility Verified (•) Yes - Y ( ) No - N	Coverage Effective Date 07/01/2022

Additionally, DMC guarantors must have a policy number AND a Subscriber Client Index Number (CIN) listed on the guarantor details page (figure 5). SAPC recommends using the CIN for both the policy number and CIN fields.

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

Figure 5: Policy and CIN#- Guarantor Details

Patients may also enter treatment as other County Funding enrolled (AB 109, JJCPA, Drug Court, etc.) or eligible for MHLA benefits and apply at the time of admission similar to Applying for Medi-Cal. However, since there is no Applying for MHLA option as a guarantor, providers should list this as LA County-Non DMC only and enter MHLA (or the other county funding) in the Subscriber Policy Number field.

MHLA applications are typically processed much quicker than DMC applications, sometimes within a few days of application. Providers may decide to wait before entering the Financial Eligibility or submitting an authorization until the application is approved and an MHLA number is assigned. This could avoid having multiple authorizations for the same treatment episode.

Providers must identify and update the Cal-OMS Admission information as needed to include the relevant Funding Program information (see figure 6).

CIN	Other Funding Programs (Choose all that apply) Juvenile In Custody Probation Camp My Health LA None Perinatal Service Private Pay Probation / Day Reporting Center Probation JJCPA Probation Title IV E Prop 47 Prop 57 Ctrl+click to choose multiple items If Medi-Cal beneficiary is "Yes" or "Pending", My Health LA cannot be selected
Probation PDJ Number	CalWorks Case Number
Please select camp: -Please Choose One-	Other Camp (Specify):
General Relief Case Number	DCFS Case Number
Drug Court Case Number	AB 109 Case Number
AB 109 PB Number	CalWORKs Recipient No
Substance Abuse Treatment Under CalWORKs No	What is your My Health LA Participant ID (13 digits)?
Please select MHLA medical home provider/clinic: -Please Choose One- *	Is the client in or being admitted to Recovery Bridge Housing? No

Figure 6: Entering Other Funding Programs or MHLA Information on Cal-OMS Admission

Patients Whose Benefits Expired During Treatment

Throughout treatment, providers may encounter situations where the patient was admitted to treatment with active DMC, MHLA or other county funding, which was verified at admission, but lose coverage during treatment.

Providers should NOT discharge these patients once they become aware of the loss of benefits. Providers should make every effort to assist the patient with regaining their benefits. If that is not possible, providers must make appropriate referrals and ensure, to the best of their ability, the patients are transferred to an appropriate treatment provider.

Please refer to the most current Provider Manual on situations in which SAPC may be able to reimburse providers, when patients lose either DMC, MHLA or other county funding. The 30-day applying for benefits policy does not apply to losing benefits and reapplying during treatment. Providers are only eligible to utilize this policy upon admission to a program.

After it is confirmed that a patient has lost their benefits, providers must immediately update the Financial Eligibility form before submitting any additional claims. Providers will do this by entering a "Coverage Expiration Date" in the DMC guarantor details page (see figure 7).

Coverage Information	
Eligibility Verified (●) Yes - Y ( ) No - N	Coverage Effective Date 12/01/2017
Coverage Expiration Date 06/30/2020	Inhibit Billing By Mail ( ) Yes - Y ( ) No - N
Effective Date Of Contract 01/01/2000	Expiration Date Of Contract

Figure 7: Adding Coverage Expiration Date for DMC Guarantor with Last Date of Active Coverage

If Medi-Cal was the only available funding (patient does not qualify for other county funding), only adding the “Coverage Expiration Date” would be necessary. Please note the provider will not be reimbursed for services rendered during the time the patient is without benefits.

However, if the patient has additional funding sources through Other County partners (other than MHLA), such as AB 109, Drug Court, JJCPA, or PSSF-TLFR, providers would need to ensure the Cal-OMS Admission form includes all necessary information for all applicable county partners (see figure 8).

Admission Data	
Proposition 36 Participant? No	Source of Referral 12 Step Mutual Aid
Days Waited to Enter Treatment 1	Number of Prior Episodes 1
Is the client a Medi-Cal beneficiary (eligibility determined)? No	Application Submit Date
CIN	Other Funding Programs (Choose all that apply) AB109 Adult Drug Court CalWORKS CalWORKS (API) CalWORKS Detox CalWORKS Family Solution Center DCFS-PSSF (TLFRG) Family Dependency Drug Court General Relief Juvenile In Custody Probation Camp Ctrl+click to choose multiple items If Medi-Cal beneficiary is "Yes" or "Pending", My Health LA cannot be selected
Probation PDJ Number	CalWorks Case Number
Please select camp: -Please Choose One-	Other Camp (Specify):
General Relief Case Number	DCFS Case Number

Figure 8: Cal-OMS Admission Fields Reflecting Other County Funding Partners

For patients who lost their DMC coverage and whose services will now be claimed to a county partner, the Financial Eligibility form should be updated as well to change the order of the guarantors. LA County-Non DMC should now be the primary guarantor until Medi-Cal is reactivated as seen in Figure 9. Once reactivated, providers should follow the steps above related to when benefits are established during treatment.

Guarantor Selection	
Change Order	Guarantor Name
↓ ↑	LA County - Non DMC
↓ ↑	CALIFORNIA DEPARTMENT OF ALCOHOL AND DRU
-- Guarantors --	Add Guarantor

Figure 9: Correcting Primary and Secondary Guarantors order when patient loses DMC.

For patients who lose their MHLA coverage, there will only be one guarantor listed. If there is no other county funding partner to claim to, the same process should occur where the "Coverage Expiration Date" (see figure 10) is entered in the guarantor details page to reflect the known expiration date. Providers should contact the patient's medical home or visit the DHS website at http://dhs.lacounty.gov/wps/portal/dhs/mhla to assist the patient with reinstating their MHLA coverage. Please note the provider will not be reimbursed for services rendered during the time the patient is without benefits.

Coverage Information	
Eligibility Verified (•) Yes - Y ( ) No - N	Coverage Effective Date 12/01/2017
Coverage Expiration Date 06/30/2020	Inhibit Billing By Mail ( ) Yes - Y ( ) No - N
Effective Date Of Contract 01/01/2000	Expiration Date Of Contract

Figure 10: MHLA Guarantor Selection and "Coverage Expiration Date" for Loss of MHLA Benefit

Patients Who Are Admitted Under Other County Funding or MHLA

Patients are eligible for full scope of the SUD treatment benefits if they are enrolled in either MHLA or other county funding partners. These partners include, but are not limited to, AB 109, JJCPA, PSSF-TLFR, DHCS WCRTS (Residential Service providers only), Drug Court, and Title IV-E. Providers must include any relevant case numbers, or policy numbers for each corresponding program(s) on the Cal-OMS admission form. As such, providers should accept these patients into treatment the same as those patients with Drug Medi-Cal.

For those patients, enrolled in one or more of the above-mentioned programs or MHLA, providers should complete the Financial Eligibility using only the LA County-Non DMC guarantor as shown in figure 11 below.

Guarantor Selection	
Change Order	Guarantor Name
⬇ ⬆	LA County - Non DMC
-- Guarantors --	Add Guarantor

Figure 11: LA County-Non DMC as sole guarantor

Additionally, when completing the guarantor information, SAPC has previously instructed providers to use "N/A" in the policy field when LA County-Non DMC is the only guarantor. When applicable, providers are also able to enter the name of the primary program the patient is enrolled in, such as "MHLA", "AB109", "JJCPA" etc. as seen in figure 12 below. Providers may also utilize the comments section on the Financial Eligibility main page for additional information on eligible programs.

Subscriber Policy Number
MHLA
Subscriber Medicaid #
Subscriber Client Index #

Figure 12: Program Name Entered in Policy Field for Non-DMC Programs

If providers are assisting the patient obtain DMC benefits, then providers should also include the "Applying for Medi-Cal" guarantor. This would follow the section in this aid, or the separate document titled "Updating Financial Eligibility for Patients Who Obtain Benefits During Treatment."

Patients Who Are Admitted as Self-Pay and Later Establish Benefits

Providers are able to accept patients who were initially admitted to an agency under Self-Pay, where the patient is fully responsible for payment to the provider for services rendered. These patients cannot be eligible for Medi-Cal or any other county funding at the time of admission to be considered for Self-Pay. For these patients, providers are not required to enter anything other than a Cal-OMS Admission and Discharge into Sage. SAPC is not responsible for authorizations or overseeing the care of any patients who are fully Self-Pay. However, if during the course of treatment, the patient becomes Medi-Cal, MHLA or other County funding partner enrolled, the patient then needs to be fully entered into Sage with a corresponding authorization.

Providers will need to complete the Financial Eligibility, Provider Diagnosis (ICD-10), Authorization Request, and other forms/documentation as any other SAPC patient. Additionally, in some cases the Medi-Cal is retroactive, where patients may have already paid for those services. Providers must refund the self-paid amounts that can be billed to Medi-Cal and upload the receipt that the funds have been refunded prior to billing SAPC. Providers should follow the same steps as above for updating the Financial Eligibility when patients establish benefits during treatment.

For accuracy in the record, the Self-Pay guarantor should be added with the exact "Coverage Effective Date" and "Coverage Expiration Date" that corresponds to the period of self-pay as the last guarantor. If the patient enrolls in Medi-Cal, then the primary guarantor would be DMC, followed by LA County-Non DMC, then followed by Self-Pay. If enrolling in MHLA or other county funding, then the primary guarantor would be LA County-Non DMC, followed by Self-Pay.

The dates for the primary guarantor should not overlap with the dates of Self-Pay. Meaning, the Self-Pay guarantor should end prior to the effective date of the primary guarantor.