SUBSTANCE USE DISORDER TREATMENT SERVICES

PROVIDER MANUAL
ADDENDUM

Frequently Asked Questions (FAQ)

START-ODS

System Transformation to Advance Recovery and Treatment, Los Angeles County's Substance Use Disorder Organized Delivery System

COUNTY OF LOS ANGELES Public Health
Substance Abuse Prevention and Control

Contents

FAQ document is intended to provide clarity and will be incorporated into Provider Manual and Contract Bulletin updates. Details on contractual requirements and/or treatment standards should refer to the Network Providers section of SAPC's website.

SECTION 1. GENERAL INFORMATION

1. **_SAPC Website_ _for Providers_ New**

   Click the links to access the specific pages or documents:

Provider Manual, Fact Sheets and Forms	Provider Meetings, Bulletins, Briefs and Factsheets	Sage County eHR system.
Includes Clinical & Business Standards; Policies & Procedures; And Clinical/Contract/Finance/IT Essential Forms	Includes regulatory & Contractual obligations such as Contract bulletins; recorded provider meetings and DHCS Notices	In the event of a Sage Outage, then downtime procedures should be followed
Provider Manual and Clinical Forms	Information Brief #4 Eligibility Information Brief #5 Submission Timelines	Sage Page
Checklist Authorization & Eligibility Non-Sage	040518 Provider Meeting: Avoid Billing Denials	Sage FAQ or Sage Webinars
Checklist Authorization & Eligibility Sage	Bulletin 17-06 Medical Necessity	Helpdesk: (855) 346-2392
	SAPC Residential Bulletin 18-05 Start	Suggestions (requires Log-in): Customer Service Portal

2. **_Contact Us/Training and Useful Weblinks_ New**

Topic	Weblink
General	SUDTransformation@ph.lacounty.gov
Clinical	SAPC.QI.UM@ph.lacounty.gov
Monitoring	SAPCMonitoring@ph.lacounty.gov
Systems of Care	SAPC_ASOC@ph.lacounty.gov
Training	SAPC Calendar
SBAT: SAPC Provider Online Directory	http://sapccis.ph.lacounty.gov/sbat/
Provider ASAM Training Environment: Requires "C" Number	https://sageuat.healthagency.lacounty.gov/pctrain/

SECTION 2. CLINICAL RELATED: Standards of Care, Authorization, Training

Service Authorizations and Eligibility Verification

3. *What documentation is required for service authorizations and eligibility verification?*

Please see the Substance Abuse Prevention and Control (SAPC) Website: Checklist of Required Documentation for Utilization Management.

4. *How can I ensure that my authorizations/re-authorizations are processed as quickly as possible?* NEW

There are case specific factors that make timely processing of authorizations/pre-authorizations more difficult. Providers should verify that the most common missing information is complete, which are commonly: No ASAM; ASAM not finalized; No DSM-V diagnosis; and incomplete financial eligibility. Also, providers should include updated contact information to ensure that Utilization Management (UM) staff can reach you should they have additional questions.

In Sage, first check the comments section of the Authorization Form to see if Utilization Management (UM) is waiting for any information from your agency. Lastly, you can confirm the status of any or all authorizations at your agency using the "Authorization Status Report" in Sage.

5. *What is the maximum number of participants in group activities, does this include family or significant others?*

- In non-residential settings, the maximum number of individuals in any group counseling or patient education session is 12 individuals;

- In residential settings, the maximum number is 12 individuals for group counseling and 30 individuals for patient education. This includes non-patients (e.g., family members) and private pay patients.

6. *How can providers document group size structure change for residential patient education group size?* NEW

Effective 4/29/2019, SAPC and Netsmart have updated Sage to reflect SAPC's minimum and maximum group size requirements. Providers are now able to enter the accurate number of attendees in both the billing and the progress note, consistent with guidelines in Question 5 for non-residential and residential settings.

7. *When are case consultations between a counselor and LPHA billable?*

Face-to-face consultation between the counselor who completes the American Society of Addiction Medicine (ASAM) Assessment and the License Practitioner of the Healing Arts (LPHA) who signs it is not reimbursable. Only direct patient services are reimbursable.

8. When is an LPHA co-signature required?

The Provider Manual contains detailed Provider Type descriptions under the "Workforce" header on page 159.

Provider Type	Able to Provide Reimbursable Services	Co-Signature Required
LPHA	Y	N
Licensed Eligible LPHA	Y	N
Student Trainee or Intern	N	N/A
Certified SUD Counselor /Registered SUD Counselor	Y	Y (ONLY ASAM Assessments, LOC justifications & treatment plans require co signature)
Student Trainee or Intern Registered as a SUD Counselor	Y	Y (by an LPHA)

9. Does an LPHA have to finalize the Miscellaneous Note for extension justification?

Yes. An LPHA must finalize the Miscellaneous Note that justifies the need for ongoing services. Document in Sage, in a Miscellaneous Note, using the Six/Twelve Month Justification Note Type.

Additionally, per the Department of Health Care Services (DHCS), the initial justification of medical necessity and the justification of need for ongoing services must include the following information: (a) The beneficiary's personal, medical and substance use history; (b) Documentation of the beneficiary's most recent physical exam (within the last twelve [12] months); (c) The beneficiary's progress notes and treatment plan goals; (d) The recommendation for continued services; and e) the Physician or LPHA signature and date.

10. Are there income criteria for patients to be eligible for RBH? New

Recovery Bridge Housing (RBH) is available at no cost for patients. Patients qualify for RBH when they (1) meet RBH housing eligibility requirements; (2) are eligible for Medi-Cal or MHLA or qualify for another county funded program (such as AB 109, PSSF-TLFR, JJCPA, and/or Title IV-E) ; and (3) are concurrently enrolled in outpatient (ASAM 1.0), intensive outpatient (ASAM 2.1), ambulatory withdrawal management (ASAM 1-WM, 2-WM) and/or opioid treatment programs (1-OTP) services.

11. Since RBH is abstinence-based, how should we handle relapses that occur during RBH stay?

SAPC funded RBH facilities must have a policy and procedure (P&P) that support patients who relapse but are willing to reestablish sobriety –either allow patients to remain in the RBH location if appropriate or provide access to withdrawal management services or an appropriate alternate living location to support abstinence and treatment goals thereby limiting the negative impact of their relapse. This activity could be fulfilled by the RBH house manager or outpatient provider as long as the responsible party is clear and outlined in the

P&P. This may also involve increasing support at RBH, coordinating with the patient's outpatient provider (RBH and outpatient provider need to have a release of information to coordinate care), providing support/encouragement that although a relapse occurred, personal treatment goals should not be abandoned. Additionally, it is important to note that "abstinence-based" does not include Medications for Addiction Treatment (MAT), meaning that RBH facilities are encouraged to have policies that accommodate residents who may require MAT to support their recovery.

12. Can an RBH provider perform drug testing (UA) to its clients? New

No. Urine analysis (UA) or alcohol/drug testing (UA) is not an allowable billing service under RBH. Per the Rates & Standards Matrix, the RBH rate only covers the cost of the bed. Moreover, UA testing is considered a treatment service which is not allowed in RBH settings. The RBH provider can coordinate with the treating provider, and request that the test be conducted for the patient. However, patient consent must be secured to release the test result to the RBH provider.

13. Are we able to have private pay individuals in the same group as Medi-Cal and My Health LA participants?

Yes. Group sign-in sheets need to include all patients in the group, so it is clear who is, and is not, reimbursed by SAPC. Participating family members also need to sign-in and contribute to the maximum group size (See #4). However, family members would not be entered into the California Outcomes Measurement System (CalOMS), also known locally as the Los Angeles County Participant Reporting System (LACPRS).

14. Can a patient be enrolled in an Opioid Treatment Program (OTP) and a Residential Care facility concurrently?

Yes. A client can receive OTP services while in Residential Care. See the MH-SUDS Information Notice 17-039 and accompanying Same Day Billing Matrix Enclosure for concurrently covered services.

15. When are CalOMS admissions and discharges required to be completed?

Site Changes: All levels of care, require CalOMS/LACPRS entries for any transition in site location, including intra-agency transitions to different site locations.

Level of Care Changes: CalOMS/LACPRS entries are required for transitions between different levels of care, excluding transitions between residential levels of care.

Transition From	Discharge CalOMS Required	Transition To	Admission CalOMS Required
Outpatient Level of Care	Y	New Site -Outpatient / Intensive Outpatient/ Opioid Treatment Program / Residential / Withdrawal Management	Y
	Y	Same Site Intensive Outpatient / Opioid Treatment Program / Residential / Withdrawal Management	Y
Intensive Outpatient Level of Care	Y	New Site -Outpatient / Intensive Outpatient / Opioid Treatment Program / Residential / Withdrawal Management	Y
	Y	Same Site- Outpatient / Opioid Treatment Program / Residential / Withdrawal Management	Y

Opioid Treatment Program	Y	New Site -Outpatient / Intensive Outpatient / Opioid Treatment Program / Residential / Withdrawal Management	Y
	Y	Same Site-Outpatient / Intensive Outpatient / Withdrawal Management	Y
Residential Level of Care	Y	New Site-Outpatient / Intensive Outpatient / Opioid Treatment Program / Residential / Withdrawal Management	Y
	Y	Same Site-Outpatient / Intensive Outpatient / Opioid Treatment Program / Withdrawal Management	Y
	N	Same Site- Residential	N
Withdrawal Management	Y	New Site-Outpatient / Intensive Outpatient/ Opioid Treatment Program / Residential / Withdrawal Management	Y
	Y	Same Site- Outpatient / Intensive Outpatient / Opioid Treatment Program / Residential	Y

16. **When discharging in CalOMS/LACPRS, what codes should we use for individuals without a Social Security Number (SSN)?**

Code	Reason
99900	Client declined to state SSN
99901	Unknown/Unsure SSN
99902	No SSN
99903	Other
99904	Unable to answer (reserved for the developmentally disabled or individuals undergoing detoxification services that are not stabilized

Note: in Sage for MHLA patients without SSN the following is used: 999-99-9999.

17. **Can patients enrolled in Recovery Support Services (RSS) attend residential groups?**

No. Individuals enrolled in RSS cannot attend residential group sessions. However, they can attend outpatient and intensive outpatient groups.

18. **See SAPC Residential Bulletin 18-05 for standards for calculating residential weekly treatment hours. OTP services must still adhere to minimum (5 units/50 minutes) and maximum (20 units/200 minutes) monthly treatment standards as well. Is Safeguarding Medications (facilitating client self-administration of medications) considered a treatment service?**

No. Although Safeguarding Medications is included in the "Treatment Service Hours", it is not considered a "therapeutic service". Therefore, though it does count towards the Residential Service Hour requirements, it does not count as a therapeutic service required to bill for the day rate if that is the only service provided on a given day. The day rate can only be claimed if a therapeutic service, as defined in SAPC Residential Bulletin 18-05, has been delivered on that day. Otherwise, only room and board may be claimed.

Health Coverage: Medi-Cal, MHLA, Private Insurance

19. *How do I serve someone with share-of-cost Medi-Cal?*

Individuals who are required to pay a share-of-cost before services are fully covered by Medi-Cal, must pay out-of-pocket until the share-of-cost (deductible) is met. This is also known as a "spend down" which is a clearance of patient's share-of-cost liability. The patient must "spend down" an amount towards medical expenses prior to receiving Medi-Cal benefits for that month.

Providers may collect share-of-cost (SOC) payments from patients on the date that services are rendered or clear/ "obligate" the SOC and make a payment arrangement for the amount. The payment must be cleared/certified through a Medi-Cal transaction using Point of Service (POS) device or Automated Eligibility Verification System (AEVS) online immediately upon receiving payment or obligating. See www.medi-cal.ca.gov - References Tab, click "More" Click User Guides for either "AEVS" or "POS" User Guides.

20. *Do I need to serve individuals whose Medi-Cal application is incomplete or pending?*

Yes. Individuals who are eligible for Medi-Cal or My Health LA, but whose benefits are not yet established cannot be turned away or have their admission/intake appointment delayed (e.g., waitlisted) while their benefits are being established. Network providers need to screen individuals and, if treatment services are determined to be needed, assist individuals in acquiring benefits and establish medical necessity via the assessment process. Time spent to acquire benefits may be reimbursed through the case management benefit. SAPC has also implemented incentive payments for providers who successfully work to assist patients in acquiring benefits in addition to what can be billed for case management.

Providers will also be reimbursed for delivered treatment services for up to 60 days after admission and completion of CalOMS/LACPRS for: (1) patients who are likely eligible for Medi-Cal and whose complete Medi-Cal application is submitted with a CIN number assigned but whose application was ultimately denied by the State; and (2) patients who need current Medi-Cal benefits re-assigned to Los Angeles County due to a permanent move. Once Medi-CAL benefits are established, providers can submit subsequent authorizations to Utilization Management for additional services, as clinically appropriate and consistent with the SAPC benefit package.

See the Provider Manual Establishing Benefits Resources, page 21/Table 28, page 196/Case Management Appendix, page 216 and/or Provider Incentive Pilot Program Bulletin 18-06.

21. *Do I need to serve individuals whose My Health LA application is pending or incomplete?*

Yes. Like with Medi-Cal, providers are expected to assist MHLA eligible participants enroll in the program upon intake and within 60 days of first service. If individuals are undocumented and refuse to participate in MHLA, a Miscellaneous Note must be completed that outlines multiple efforts taken to encourage participation given advantages such as covered physical health services, and details on the patient's refusal reasons. In general, this will not be an audit exception provided the vast majority of eligible participants do attempt to enroll.

22. Can I serve Medi-Medi patients?

Individuals with full-scope Medicaid (Medi-Cal) and Medicare can be served under the Drug Medi-Cal (DMC) program, if medical necessity requirements are met, and are billed to DMC.

23. Can individuals who are ineligible for Medi-Cal or My Health LA be served under SAPC?

In certain situations. If an individual is a participant in any of the following County-funded programs that provide additional funding to SAPC, an individual can be admitted and served even if ineligible for Medi-Cal or My Health LA. The full benefit package is available to these patients at no-cost: AB 109, Drug Court, Juvenile Justice Crime Prevention Act, Promoting Safe and Stable Families Time Limited Family Reunification, Title IV-E (this does not apply to other programs such as CalWORKs and General Relief).

24. What can Residential Providers do when Department of Social Services (DPSS) is denying General Relief (GR) patients for not attending assessments with "CASC"?

The Client Engagement and Navigation Service (CENS) replaced the Community Assessment Service Centers (CASC) and are co-located at various County partner sites to support vulnerable populations in connecting with treatment. For tracking and funding purposes, all admission information for GR patients must be logged in DPSS' case management and eligibility system, LEADER Replacement System (LRS). Currently patients are referred to the CENS staff because of their user access to LRS. This process allows for DPSS to monitor the individual's participation

SAPC will work in partnership with DPSS to make modifications to current DPSS policy and reporting expectations so as not to negatively impact patient benefits.

For assistance, please contact SAPC_ASOC@ph.lacounty.gov.

SECTION 3. FINANCE RELATED: Reimbursement, Budget, Cost Report

Claims Submissions

25. When can food costs be included in the budget?

Meal costs are only allowable in residential and inpatient programs (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4.0-WM); snack costs are only allowable when provided to minors (ASAM 1.0-AR, 1.0, 2.1). Non-SAPC funds must be used for all other food purchases. Food costs must be reported under the "Food and Snacks" line item under "Services and Supplies" category and be clearly tracked and managed.

26. Do we still need to complete the Same Day Billing form?

No. MH-SUDS Information Notice 17-039 provides information on how same day billing requirements changed for Drug Medi-Cal Organized Delivery System (DMC-ODS) participating counties. The Same Day Billing Matrix Enclosure provides information on what services in what levels of care can and cannot be provided on the same day. A multiple billing code form is no longer required because regulations articulate when a same day service, and any associated claim, can and cannot occur.

27. *What is the guarantor entity for RBH patient?* *New*

Authorizations: For the purposes of submitting RBH service authorizations the "Funding Source" on the Authorization request will always be Non-DMC.

Billing: For the purposes of submitting billing, the financial eligibility of the patient will determine the guarantor information.

- If the patient has DMC, then DMC will be primary guarantor and a secondary guarantor of LA County Non-DMC MUST be entered.

- If the patient does not have DMC, then only the LA County Non-DMC guarantor should be entered, and the Cal-OMS MUST reflect the county program or MHLA that is covering the services.

28. *If LA County Non-DMC is selected as guarantor, what address should RBH providers indicate for that guarantor?* *New*

Providers do not need to select an address when selecting Non-DMC as guarantor.

29. *Can RBH providers bill for at least the residential room and board while the patient has yet transitioned into RBH pending outpatient enrollment?* *New*

No. The Room and Board rate cannot be charged on the same day as the RBH day rate.

30. *What is the responsibility of the RBH provider to either supplement and/or provide nutritional support to RBH clients who have no means of financial support? Will there be legal liabilities for not providing this?* *New*

There are no SAPC policies preventing RBH providers from offering nutritional support to its residents. The outpatient treatment provider also needs to use the case-management benefit to ensure access to eligible benefits such as General Relief or CalFresh, or other non-profit organizations such as food pantries that provide no-cost services.

31. *Do RBH providers need to follow the Outpatient 10-mile radius rule if the patient is staying in the RBH provider's facility?* *New*

No. RBH is a non-DMC billable benefit and is therefore not subject to the DMC-ODS Waiver distance requirement. However, the best practice is to refer patients to the RBH provider within close proximity to the site where they are receiving concurrent SUD treatment. Their needs and preferences should also be considered when selecting RBH providers with bed availability.

32. *What is the procedure for RBH providers needing to move a patient from one site to another?* *New*

RBH residents who move to a different site address (excluding residents who move between apartments or rooms at the same street address) require: 1) a discharge from the original RBH address; and 2) submission of a new authorization request that includes the new site address for approval by SAPC's Utilization Management Unit. For claims purposes, when a resident moves to a different address, providers must submit the day rate for the new location and not the original location.

33. What is SAPC's bed hold policy for RBH and residential? New

SAPC's bed hold policy (RBH and Residential) states that providers may hold and bill beds for up to seven (7) days for patients who need to leave the housing facility for reasons such as hospitalization, therapeutic pass, flash incarceration, and return to treatment after discharging against medical advice.

In a Residential setting, transitioning to another level of care (e.g. withdrawal management) is not an allowable reason for a bed hold. Only Room and Board is reimbursable during bed hold days since no Clinical Services are provided while patients are temporarily absent from the facility.

34. What HCPCS code can we use to account for services (i.e., psychotherapy) provided, but under another funding stream (for example, DMH) towards a client's weekly treatment services requirement?

SAPC is in process of adding Healthcare Common Procedure Code System (HCPCS) codes to address the addition of physical and mental health services within residential treatment settings. In the meantime, please complete a Miscellaneous Note that details the number of hours and a brief description of the allowable off-site services. This can be referenced in an audit. Providers will be notified when HCPCS codes are available.

35. Are group sessions less than 60 minutes or more than 90 minutes reimbursable?

No. According to the Rates & Standards Matrix, groups must be a minimum of 60 minutes and a maximum of 90 minutes. Groups billed below or above these limits, will be denied.

36. Is Medication Services (H2010) appropriate to use for coordination with pharmacy for client medications (refills, coordinate pick-up)?

No. This is a case management function and needs to be documented and billed accordingly. See Provider Manual page 217 for Case Management billable services.

37. Is the ASAM and Treatment Plan review and finalization done by the LPHA or LPHA-eligible person reimbursable?

Reviewing and co-signature of documents by a LPHA for required roles and supervision is not a billable activity as they are considered supervisory/administrative and do not directly service the patient. Although these reviews are very important to ensure the patient is being appropriately served.

Review of the treatment plan, however, is a billable service **if** it is completed with the counselor and LPHA present.

38. In a residential facility, what can providers do if the minimum treatment service hours cannot be met?

Under limited circumstances, a patient's clinical or medical needs may prevent participation in the standard weekly Treatment Service hours. Providers must complete a Miscellaneous Note detailing the circumstances that prevented the completion of hours. Justifications must detail the obstacles that prevented full participation in therapeutic services and how the individual's recovery goals are being met. SAPC will review justifications on a case by case basis.

If less than 10 (ASAM 3.1), 12 (ASAM 3.3) or 11 (ASAM 3.5) hours of Treatment Services Hours are provided per week, for more than two (age 12-20) or three (age 21+) weeks, the patient needs to step down to a lower level of care, and further reimbursement will be disallowed unless otherwise approved by SAPC. Providers will be alerted via Sage if service unit minimums are not met.

Budget and Budget Modifications

39. *Are there any additional processes RBH providers need to follow to obtain the additional reimbursements given the change in RBH rates effective July 1, 2017? New*

No. SAPC will process rate adjustments internally and send payment to providers. There is no additional documentation for additional reimbursements.

40. *Do I need to do a budget modification if I move funds between cost categories or line items?*

Yes. A budget modification is required when an agency wants to move funds from one funding line to another. This process remains the same as in past years with the 10% rule applied. Modifications can be made between line items of 10% or less without prior approval from the SAPC Division Director. All modifications above 10% must be approved by the SAPC Division Director.

41. *Can residential programs charge fees such as GR/CalFresh?*

Clients who are on Medi-Cal or My Health LA cannot be charged fees for room and board and/or treatment services. however, SAPC is reviewing DPSS policy on the transfer of General Relief (GR) and/or CalFresh benefits to a residential provider and will make a final determination on whether to grant an exception. While this policy is under review, SAPC providers may continue to collect GR/CalFresh benefits from residential clients and those fees must be reported to SAPC on the year-end cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

SECTION 4. PROGRAM ADMINISTRATION RELATED: Staffing, Operations, Facility, Management

42. *We are a female RBH site and were told to just leave the "male" section at zero (0). Is this correct? New*

The Service and Bed Availability Tool (SBAT) has now been updated to display only the gender populations that an RBH site services.

43. *If a counselor has completed their education and has a certificate of completion from an approved alcohol and other drug (AOD) school and is working to acquire 3000 hours so they can become certified, will they have to provide proof of additional 45 continuing education (CE) credits from the certifying body between their renewals on an ongoing basis to meet the SAPC requirement? New*

The registered counselor education policy outlines a **one-time** minimum education/training requirement. For providers that have completed their education requirements for Certification, they have far exceeded SAPC's minimum standard. Yes, they will still need to complete 45 hours of CEs by 6/30/2019 (only once, not annually).

If providers become certified prior to June 30, 2019, the registered counselor education/training requirements no longer apply.

44. *If the Registered Alcohol and Drug Technician (RADT) (in the same scenario above) was employed prior to 7/1/18 these hours will be due by 6/30/19 and can be CE credits not formal classroom education? New*

Yes, if the RADT have completed their education for certification and continue to acquire their hours, continuing education requirement can be met with CEs and they must be completed by 6/30/19.

45. *If the RADT has not attended an approved AOD school, will they need to take a more formal education by enrolling in an approved AOD school? Issues arise as schools typically enroll on a semester basis. Would proof of enrollment despite not completing hours be enough by June 30, 2019? New*

Counselors must show a good faith effort to enroll and complete required education. However, if education requirements cannot be met by 6/30/2019, proof of enrollment with a start date prior to 6/30/2019 must be submitted to SAPC.

SAPC will review these submissions on a case-by-case basis.

If adequate proof of enrollment is not submitted to SAPC, counselors will be unable to provide SAPC reimbursed treatment services; and services delivered by these employees and claims to SAPC is subject to recoupment.

46. *Schools do not like releasing transcripts prior to being "paid in full" which also delays some counselor's ability to test in a timely manner. What would be acceptable to prove their education requirements are met? New*

Unofficial transcripts, proof of course enrollment, and course syllabi are acceptable forms of proof when an official transcript is not available.

47. *For those counselors who are Registered with a certifying body, and are concurrently enrolled in a Master's Program for Social Work (MSW), Marriage and Family Therapy (MFT), Licensed Professional Clinical Counselor (LPCC), but may not have attended or completed AOD school, will these classes satisfy the education requirements? New*

Yes, they would satisfy the education requirement if they meet the following: 1) retain active enrollment in their graduate program, 2) register with a certifying body, and 3) complete both ASAM A and ASAM B trainings.

Additionally, students will not need to complete the additional 45 hours of CE's.

48. *Does SAPC have a requirement of double the CE hours per registered counselor? For example, Registered Counselors need 45 Hours (CE's) per calendar year once they are out of school. Certified Counselors need 50 hours every 2 years. New*

The 45 hours of education and 45 hours of CE training is a minimum education training requirement, particularly for staff that are relatively new to the SUD field and/or have minimal SUD knowledge and/or experience. The expectation is not for providers to meet these requirements on an annual basis.

49. *What is the Service and Bed Availability Tool (SBAT), how long does it take to obtain User registration and how do agencies update it? New*

The SBAT is one of the main tools that the general public, Substance Abuse Service Helpline (SASH), and Client Engagement and Navigation Services (CENS) will use to identify referral sites. Therefore, it is important to keep your information current, including updating appointment/bed availability on a daily-basis per SAPC requirements. Instructions are included on the SBAT Update Instructions document or enter information here: http://sapccis.ph.lacounty.gov/SBAT/Account/Login.aspx

The SBAT only includes DMC-certified locations listed in your SAPC contract. For this reason, it is important to notify SAPC_Compliance@ph.lacounty.gov as soon as a DMC location is certified to include it in your contract and then eventually the SBAT.

Log-in credentials should be provided within two (2) business days of receipt of the SBAT User Registration Form.

50. *What steps should community referrals take when providers indicate they have a "waitlist"?*

Ensuring timely access to care is essential to accomplishing the aim of improving outcomes of the specialty SUD system. If a provider is unable to meet Timely Access to Care requirements as outlined in page 25 Table 4 of the Provider Manual, the patient needs to be provided with an alternate referral within 48 hours. If the individual declines the referral, this should be clearly documented in the patient record.

Any instances of a waitlist should also be reported to SAPC_Compliance@ph.lacounty.gov.