Clinical & Utilization Management Updates

Los Angeles County Department of Public Health
All Provider Meeting May 3, 2022
Substance Abuse Prevention & Control

Agenda

- **Documentation Requirements**
  - Applying to Medi-Cal (currently in effect)
  - DHCS BHIN 22-019 (starts 7/1/2022)
- **Care Coordination and MyHealthLA**
- **Notice of Adverse Benefit Determination (NOABD) Letters**
  - Assisting patients with filing appeals
- **Resubmission Timeline Reminder**
- **New Adult Paper-Based ASAM for SAGE Downtimes**

Applying for Medi-Cal Documentation Requirement

- Case management note for assisting patient with services related to applying for Medi-Cal can include:

1) Collaborating with patient on entering information into application electronically
2) Communicating with DPSS personnel to initiate application
3) Assist patient with follow up on progress of application
4) Assisting patient with securing documentation required for the application process and transmitting the documentation to DPSS
5) Resolving barriers to pt qualifying for Medi-Cal (i.e. errors in income reporting by others, etc.) and provide examples of each time of note:

Applying for Medi-Cal Documentation Requirement (Continued)

Reasonable documentation verifying that the patient has Medi-Cal:

1) DPSS mobile app screen shot of the approval and the case number(L number), this proof is required along with provider attestation that the screenshot belongs to the patient as a misc note.
2) Or calling DPSS with assistance of the provider requesting a written document (DPSS letter) as proof of Medi-Cal approval.

- **DPSS contact info:**

Toll Free (866) 613-3777

Local Numbers

(310) 258-7400
(626) 569-1399
(818) 701-8200

Forthcoming Documentation Requirements

DHCS BHIN 22-019 effective 7/1/2022

- New required element: Problem List
  - List of symptoms, conditions, diagnoses, and/or risk factors updating in an ongoing basis when there is a change in the patient's condition
- Phases out Treatment Plan for non-OTP LOCs
  - Treatment plans still required for OTPs and for (in the future) peer support services
- Progress Notes
  - Required for each service
  - Required each day a service is delivered (a weekly summary is not permitted)
  - Required to be documented within 3 days of the date of service
- Additional guidance forthcoming from SAPC in preparation for a 7/1/2022 start

Care Coordination and Applying for My Health LA

- Job Aid: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/UpdatingFinancialEligibilityAdmittedUnderOtherCountyFundingMHLA.pdf
- LA County Non-DMC guarantor used when the patient is enrolling in for MHLA; do NOT use Applying for Medi-Cal when the patient is in the process of enrolling in MHLA.
- When completing CalOMS, if you select MHLA as the funding, you will be required to enter a number in that section, which must be a 13 digit numerical ID.
- If there is no ID number you can use, please document via a miscellaneous notes you are assisting the patient with MHLA enrollment and please be sure to update the CalOMS with the MHLA enrollment number once obtained.
- Patients applying for My Health LA **cannot** use the **30 day Applying for Medi-cal benefit**.

Care Coordination and Applying for My Health LA (continued)

- Case management note or miscellaneous note documenting that the patient is enrolling in My Heath LA:

1) Helping the patient enter information into application electronically or by calling the local clinic based on the patient's zip code
2) Communicating with local clinic personnel to initiate application and getting an application number
3) Assist patient with follow up on progress of application
4) Assisting patient with securing documentation required for the application process and transmitting the documentation to the MHLA clinic for enrollment
5) Resolving barriers to pt qualifying for My Health LA (i.e. errors in income reporting by others, ID card etc.).

Grievance and Appeal Form

The Appeal Form is available via the Clinical Forms and Documents section of our Provider Manual and Forms Page:

http://publichealth.lacounty.gov/sapc/NetworkProviders/ClinicalForms/AQI/AppealForm.pdf
Email: SAPCmonitoring@ph.lacounty.gov
Phone: (626) 299-4532
Fax: (626) 458-6692

Appeal Update

- Appeals filed without the patient's involvement, including appeal forms filed without the patient's written consent, must include a written justification for why the patient was unable to be involved with filing the appeal. Appeals filed without the patient's involvement will be processed as a complaint/grievance in accordance with SAPC complaint/grievance protocols (SAPC Provider Manual Page 189).

Essential Phone Numbers

- UM General number: **(626) 299-3531**
- Netsmart Helpdesk: **(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**

Timeliness of Authorization Submissions

- Member authorizations and reauthorizations must be submitted to the SAPC Quality Improvement and Utilization Management Unit within thirty (30) calendar days of admission or within thirty (30) calendar days of the first date of service.
- Four exceptions to the 30 days rule – authorization submissions should be held pending the establishment of financial eligibility in the following circumstances:

1. Outside Los Angeles county beneficiary pending transfer
   - *Prospective policy change if LA County Residency following transfer is sufficient*
2. An individual who applied for Medi-Cal but has not established DMC benefits yet
3. Awaiting receipt of an Other Health Coverage denial
4. Pending resolution of SAGE technical issue that prevented authorization submission (providers must document SAGE Help Desk Ticket Number related to the technical issue)

- All service authorization requests, including those delayed due to establishment of financial eligibility, must adhere to and meet Medi-Cal standards and requirements for timelines of clinical assessment.

30d Timeliness of Authorization are required as of 11/1/2020:
http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/20-11/SAPCIN20-11MemberAuthorizationSubmission.pdf

Criteria for Authorization Resubmissions

Authorization resubmissions are not accepted when an authorization is denied due to lack of medical necessity, and SAPC providers will be directed to file an appeal to request reconsideration of an authorization request denied by SAPC due to lack of medical necessity.

SAPC UM only accepts authorization resubmissions in these circumstances:

1. Authorization that was submitted in error and withdrawn by the provider
2. Re-authorization that was submitted prior to 30d before the end of the current authorization
3. Resubmission to correct the treatment funding source

ASAM American Society of Addiction Medicine

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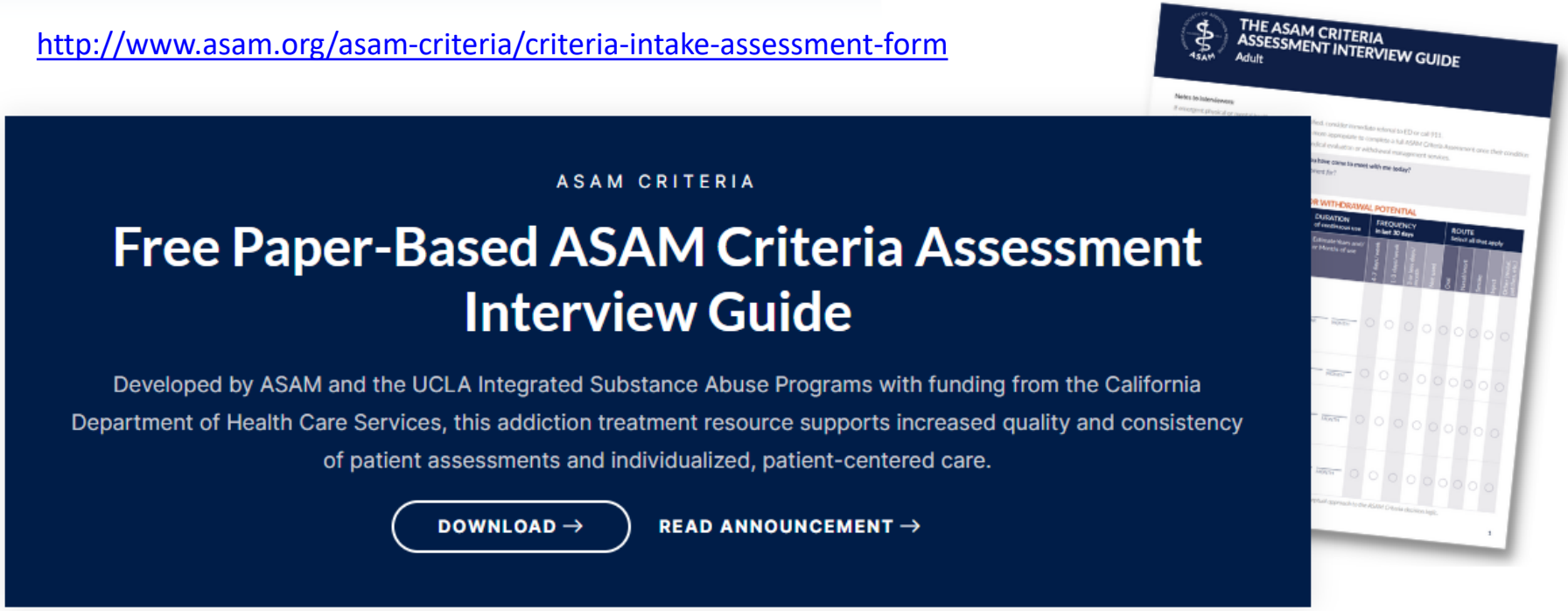
http://www.asam.org/asam-criteria/criteria-intake-assessment-form



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