Clinical & Utilization Management Updates

Los Angeles County Department of Public Health
All Provider Meeting December 21, 2021
Substance Abuse Prevention & Control

Agenda

- Authorization Submission Deadlines
- Timeframe for Medical Necessity for Non-Residential Services
- Notice of Adverse Benefit Determination (NOABD)
- Update to SAPC Appeals and Grievance/Complaint Process

Authorization Submission Deadlines

- 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 start date of reauthorization.
- Two exceptions to the 30 days rule – authorization submissions delayed pending the establishment of financial eligibility in the following circumstances:

1. Outside Los Angeles county beneficiary pending transfer
2. An individual who applied for Medi-Cal but has not established DMC benefits yet

Fiscal Year 2020-2021 Rates and Payment Policy Updates (pages 8-9) published 7/1/2020:
http://publichealth.lacounty.gov/sapc/bulletins/START-ODS/20-10/SAPCIN20-10RatesFY20-21.pdf

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

Authorization Periods – Patients Aged 20 and Under or PEH

July 8, 2021 — Sept 5, 2021

Initial Engagement Authorization Period
60 days

New Authorization Period – Approval Process Remains the Same

ASAM

Medical Necessity

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.

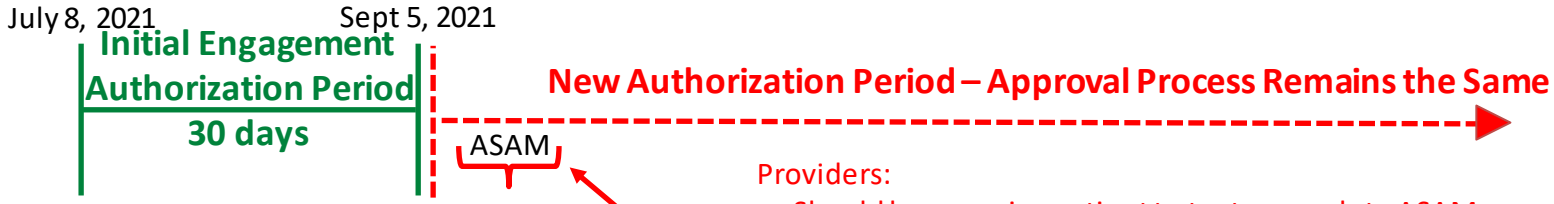
Total Authorization Length

- **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



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.*

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

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.

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

NOABD

- In the future (date TBD), SAPC will begin issuing state required **Notice of Adverse Benefit Determination (NOABD)** letters to Medi-Cal beneficiaries following denials of authorization for residential levels of care (LOC 3.1, 3.3, or 3.5) not associated with withdrawal management (WM).
  - These letters will be mailed to the patient's mailing address and copies will also be mailed to the relevant provider agency
  - SAPC-generated NOABD letters will not be issued for denials of 3.2-WM and 3.7-WM LOC authorization requests

Denial Reasons Associated With NOABD

- SAPC will generate NOABD letters when denials of authorization are made for non-WM residential services in the following circumstances:

1. Does Not Meet Medical Necessity Criteria
2. Patient not residing in LA County
3. Patient's benefits not assigned to LA County
4. 30-day timely documentation submission deadline not met*
5. Insufficient Documentation
6. Partial Approvals (authorizations with modified start dates due to late medical necessity documentation and/or late authorization submission)

TYPE OF ACTION	NOTIFICATION REQUIREMENTS	RESPONSIBLE PARTY FOR NOTIFICATION	APPEALS Beneficiary/provider/authorized representative MUST file within 60 days of NOABD[2]				STATE HEARING Beneficiaries must exhaust the appeal process prior to requesting
			Written Acknowledgement of Receipt	Appeal Resolution (Standard)	Appeal Resolution (Expedited)	Extension (max. 14 calendar days)	
1) Termination Suspension or Reduction of previously authorized service	PATIENT in writing at least 10 days <u>before action</u> using NOABD[1] Template & attachments (exceptions 42 CFR 431.213 and 431.214)	NETWORK PROVIDERS	Postmarked within 5 calendar days of appeal receipt. • Date received • Contact Info of County staff patient may contact (Date received/Name/Phone/Address	May not exceed 30 calendar days from receipt of appeal. Notice of Appeal Resolution & attachments (NAR) template 1) Upheld NAR OR 1) Overturned NAR** **Plans must authorize/ provide services (not furnished during appeal process) no later than 72 hours from date it reverses the determination	Resolved as expeditiously as health condition requires, but no longer than 72 hours after request 1) <u>Request Denied</u> • Prompt Oral notice • Written Notice within 2 calendar days of decision. Applicable NOABD; reverts to standard resolution time (30 days) 1) Request Approved Resolve within 72 hours or request 14-day extension. • Upheld NAR[3] • Overturned NAR** • if resolved wholly in favor of beneficiary. **Plans must authorize/provide services (not furnished during appeal process) no later than 72 hours from date it reverses the determination	1) Initiated by Beneficiary 2) Initiated by County ONLY due to need for more information <u>AND</u> in best interest of patient: County must provide: • Prompt Oral Notice • NOABD Grievance/ Appeal Delay Resolution template & attachments sent in 2 calendar days of decision to extend. NOTE: If plan fails to adhere to notice/timing requirements, the beneficiary is deemed to have "exhausted" appeal process and may initiate a State Hearing	Beneficiary must request w/in 120 days of NAR or County failure to adhere to requirements <u>Standard Hearing:</u> County notify beneficiaries that the State must reach its decision within 90 calendar days of date of request for hearing. <u>Expedited Hearing:</u> County must notify beneficiary that the State must reach its decision within 3 days of the request <u>Overturned Hearings:</u> County shall authorize/provide disputed services as expeditiously as health condition requires, but no later than three working days.
1) Failure to Provide Services in Timely Manner	PROVIDER via fax/phone within 24 hours of decision. PATIENT in writing within 2 business days of the <u>decision</u> NOABD[1] Template & attachments	SAPC and NETWORK PROVIDERS					
1) Denial of authorization (residential) 2) Denial of Payment 3) Failure to resolve grievance/ appeals 4) Denial of request to dispute financial liability		SAPC					

Narrowing Criteria for Authorization Resubmissions

Currently 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

Once SAPC's NOABD process launches, we plan to align with NOABD standards and narrow the criteria where we will **only review authorization resubmissions in these circumstances:**

1. Authorization that was submitted in error and withdrawn by the provider
2. Authorization that was submitted prior to the acceptable time frame for authorization submissions
3. Resubmission to correct the treatment funding source

Examples of Acceptable Authorization Resubmissions

2. Authorizations that was submitted prior to the acceptable time frame for authorization submissions:
   A. Any submissions more than 30 days prior to the end of an authorization will be considered too early.
   B. For residential re-auths, UM requires submission before 7 days prior the end of the current authorization but not more than 30 days prior to the end of current authorization.
   C. For outpatient authorizations, UM cannot extend the EV if there are more than 30 days on the EV. UM can accept 30 days and under from reauth date. For example, for a reauth that begins on 12/1/21 and provider submits it on 10/25/21, UM will consider it as too early.
3. Resubmission to correct the treatment funding source:
   a. For example: SAPC denied an authorization request due to the provider listing DMC as the primary funder when SAPC confirmed that the patient does not have Medi-Cal; the provider may re-submit an authorization request reflecting accurate non-DMC financial eligibility
   b. Additional example: a provider authorization is denied due to incorrect non-DMC funding; the provider may re-submit an authorization request reflecting accurate non-DMC financial eligibility

Appeal Update

- 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

1. **(Check One)**: ☐Standard Appeal ☐Expedited Appeal			2. Date:
INFORMATION ABOUT MEDI-CAL BENEFICIARY FILING APPEAL			
3. Name (Last, First, and Middle): *(required)*		4. Sage PT ID#: *(if know*	5. Authorization # *(if known)*
6. Date of Birth: *(required)*	7. Medi-Cal #: *(if known)*	8. Street Ad *(required if s an ad ilable)*	
9. City and Zip Code *(required if there is an address available)*	10. Phone Number and/or Em Address: *(required if there is a phone numbe l address a able)*		11. Do we have your permission to leave a voice message? ☐Yes ☐No
COMPLETE IF AUTHORIZING A REPRESENTATIV AL ON YOUR BEHALF			
12. Name of Representative:	13. Agency Name/ Rel hip:		14. Email:
15. Street Address:	16. Cit d Z		17. Phone:
18. **If you are authorizing another p n or enti esent you in filing this appeal, please sign below:**			
Patient Name (Print)		Patient (Signature)	
ORM ABOUT THE APPEAL			
19. Did you receiv Adve efit Determination (NOABD) letter? ☐Yes ☐No			
20. Did anyon plete this n you alf? ☐Yes ☐No			
21. Which typ OABD did y eceive: ☐ Denial ☐ Payment Den ☐ Other, describe._____		☐ Termination ☐ Timely Access to Services ☐ Notice of Grievance/Appeal Resolution	
22. Addition information on your appeal of the NOABD. Attach pages and documentation, if needed.			

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 187).

Grievance and Appeal (G&A) Phone Number

- Effective November 1, 2021, those with questions or concerns after receiving a Grievance and Appeals (G&A) Resolution Letter should contact the **G&A number** at (**626) 293-2846**

- If the SAPC's LPHA Reviewer is unable to address your questions or concerns, providers/individuals may request to speak with the Quality Improvement Supervisor at the same G&A's number at (**626) 293-2846**

Reminder

- Phone Number to file an appeal: **(626) 299-4532**
- Phone Number to follow-up with an appeal after receiving a resolution letter: **(626) 293-2846**

Thank You!

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

- Johann Hari