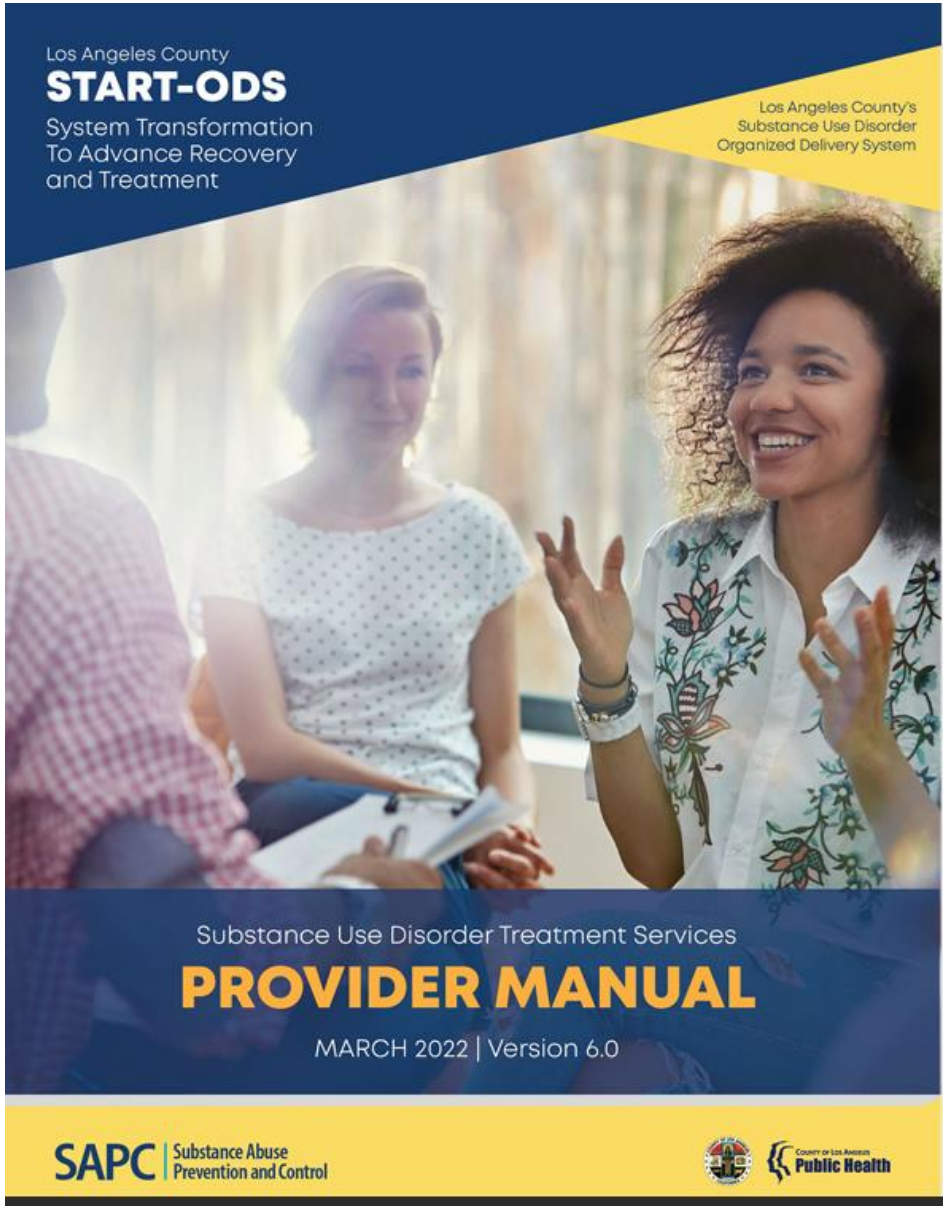
Utilization Management-Provider Meeting

Los Angeles County Department of Public Health
May 18, 2022
Substance Abuse Prevention & Control

Agenda

- Reminder: Provider Manual Version 6.0
- Update on Inter County Transfer of Medi-Cal Benefits (ICT)
  - Case Examples
- Applying for Medi-Cal Documentation Requirements
- Care Coordination and MyHealthLA
- Resubmission Timeline Reminder
- Reminder: New Adult Paper-Based ASAM for SAGE Downtimes
- Open Discussion



http://publichealth.lacounty.gov/sapc/NetworkProviders/Privacy/SAPCProviderManual6.0.pdf

SAPC UM-Provider Meeting 5/18/2022

Inter County Transfer of Medi-Cal Benefits (ICT) UPDATE and Case Discussion

BHIN 21-032

1. *County of Responsibility:* the field in MEDS that indicates the county that has control of the case record in MEDS and is the county that can make eligibility and demographic information updates to the MEDS record. This county has financial responsibility for behavioral health services, consistent with the county contract with DHCS. Providers can verify Medi-Cal eligibility in three ways: POS system (BIC Card reader), Automated Eligibility Verification system (AEVS) 1 or the Medi-Cal website.
2. *County of Residence*: the field in MEDS and MEDSLITE indicating the county in which the beneficiary resides

http://www.dhcs.ca.gov/Documents/BHIN-21-032.pdf

BHIN 21-032

Short-Doyle has been modified so claims from DMC and DMC-ODS counties are no longer denied, as long as the beneficiary's County of Responsibility or County of Residence matches the submitting county.

BHIN 21-075

If a beneficiary moves to a new county and initiates an inter-county transfer***, the new county is immediately responsible for DMC-ODS treatment services and can claim reimbursement from DHCS through the Short Doyle Medi-Cal System, as of the date of the inter-county transfer initiation.*** Please see BHIN 21-032 for policy clarifications on DMC-ODS County of Responsibility.

http://www.dhcs.ca.gov/Documents/BHIN-21-032.pdf
http://www.dhcs.ca.gov/Documents/BHIN-21-075-DMC-ODS-Requirements-for-the-Period-2022-2026.pdf

http://publichealth.lacounty.gov/sapc/NetworkProviders/pm/050322/InterCountyTransfers.pdf

Resolving Intercounty Transfer of Benefit Delays

- DHCS intention behind BHIN 21-032 is a response to County/Provider identified concerns:
- Patients are being turned away because their Medi-Cal benefits are assigned elsewhere.
- Delays impact patients receiving not just SUD entitlement services but also as applicable mental health and physical health services.
- Providers are at financial risk when the ICT process takes so long.

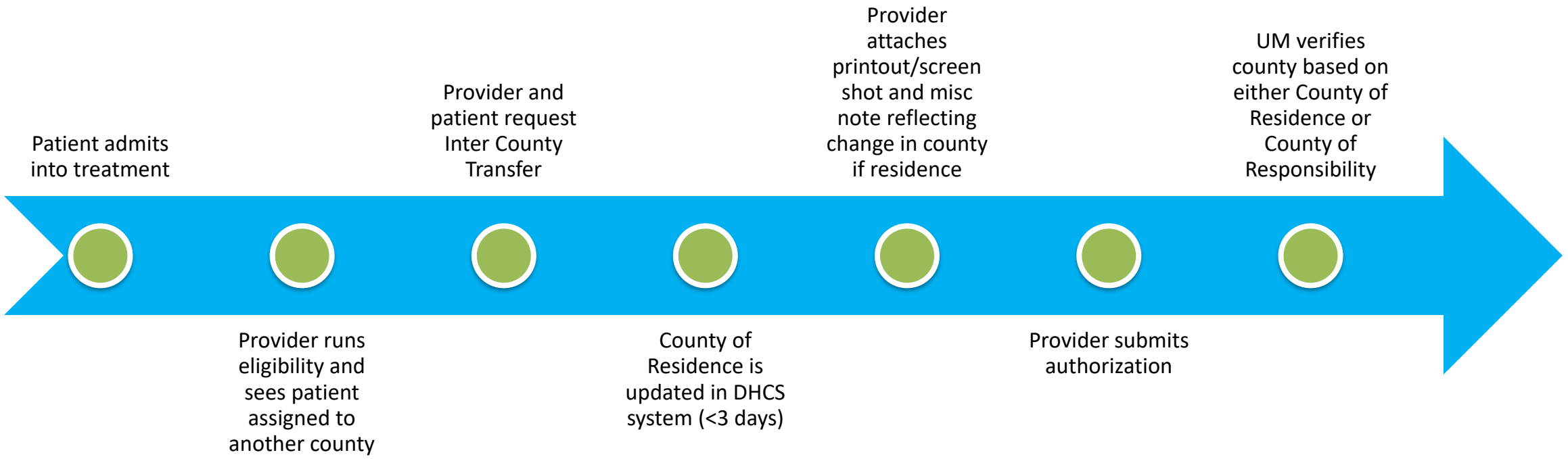
SAPC Utilization Management Verification of Medi-Cal Eligibility for ICT

Either County of Residence or Responsibility can be LA County (Code 19) to be eligible for Medi-Cal funded SAPC services

MEDS file is not real-time and may not reflect county of resident at time of initial authorization

SAPC Providers need to show verification LA County (Code 19) is county of residence OR responsibility if there is discrepancy

Workflow


Patient admits into treatment
Provider runs eligibility and sees patient assigned to another county
Provider and patient request Inter County Transfer
County of Residence is updated in DHCS system (<3 days)
Provider attaches printout/screen shot and misc note reflecting change in county if residence
Provider submits authorization
UM verifies county based on either County of Residence or County of Responsibility

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. No info for County code.
- 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”
- Recommendation

ICT Appeal Case Discussion

- 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.

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**

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:

1.If time allows I will quickly review when it is appropriate to use “Applying fore Medi-Cal”.

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

Care Coordination and Applying for My Health LA

- See this Job Aid under the provider manual and forms section of our website: http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/UpdatingFinancialEligibilityAdmittedUnderOtherCountyFundingMHLA.pdf
- Use the LA County Non-DMC guarantor if 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.).

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
   - Such as retroactive auth for ICT if LA County of residence was in place even if LA County's assignment as the County of responsibility was pending from 7/1/2021 onward

ASAM American Society of Addiction Medicine

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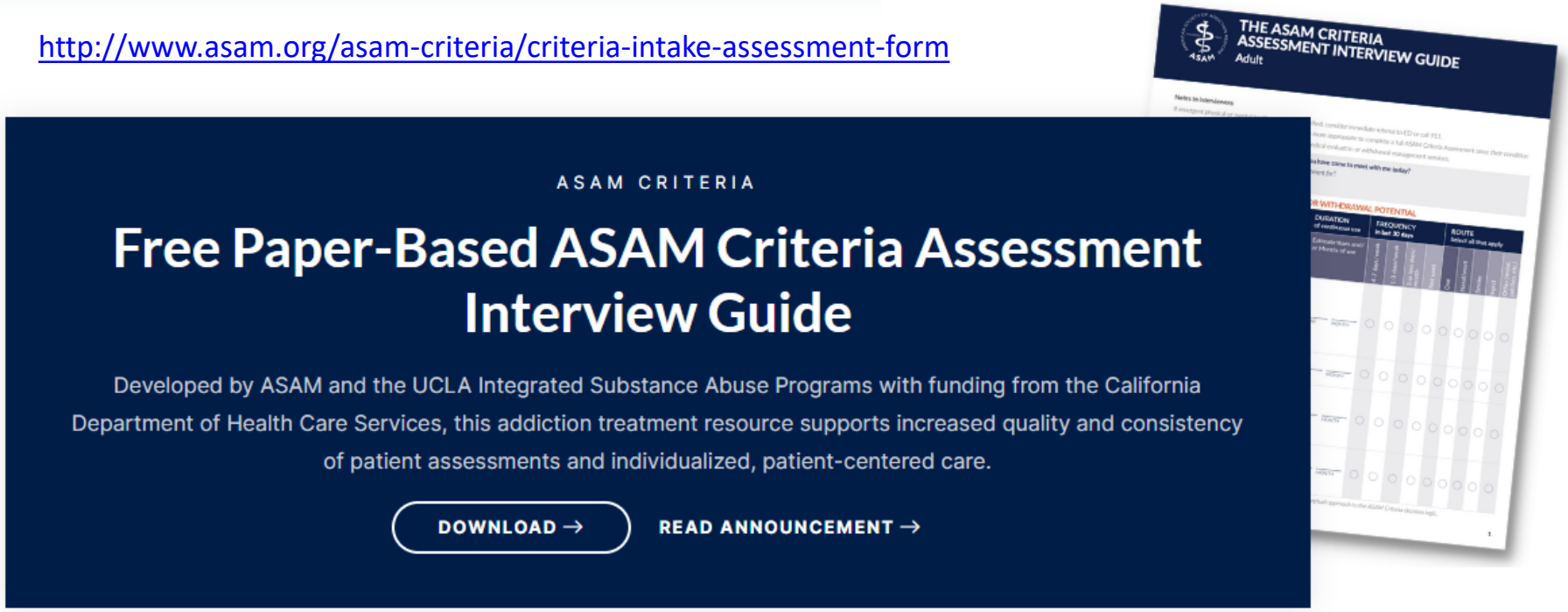
http://www.asam.org/asam-criteria/criteria-intake-assessment-form



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