Establishing Eligibility & Medical Necessity in Opioid Treatment Programs

Quality Improvement and Utilization Management Unit
Clinical Services and Analytics Branch

Substance Abuse Prevention and Control

Objectives

1. Review Eligibility Determination Process for OTP Providers

    •   Medical Necessity

    •   Financial Eligibility

    •   Residency Requirement

    •   Treatment Plan and Planning

2. Aligning of annual OTP Update with SAPC Medical Necessity.

3. Review of Provider Diagnoses for OTP

4. ASAM Continuum: Tips & Tricks to avoid pitfalls

    •   Miscellaneous Note When ASAM does not resolve to a Dx

5. Withdrawal Management in OTP Settings

6. Coordinating care with non-OTP Providers

7. Eligibility Re-Determination: What is SAPC looking for?

8. Q & A

Purpose of Establishing Eligibility and Medical Necessity

- Establishing eligibility in the SAPC network ensures the patient has appropriate access to basic services within the network and minimizes the traditional barriers of accessing care.

- Medical Necessity is the basis for determining eligibility as required by Title 22.

- Medical Necessity is the most effective way of ensuring the core principles of the START-ODS project that the patient receives the right care, at the right time, for the right duration.

  – Refer to DHCS Title 22 DMC Fact Sheet

  – http://www.dhcs.ca.gov/services/adp/Documents/Title_22_Diagnosis_Medical_Necessity_DSM.pdf

Eligibility Determination Process

1. Confirm client resides in Los Angeles County.

2. Financial eligibility form is complete
   - Indicates client has Drug MediCAL, My Health LA, is Applying for MediCAL or qualifies for another LA County Program.

3. A DSM-5 diagnosis is entered in sage

4. An ASAM assessment has been completed _and_ this assessment has been reviewed/<u>finalized</u> by a Licensed Practitioner of the Healing Arts (LPHA)

Establishing Medical Necessity
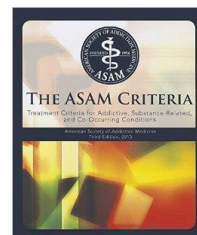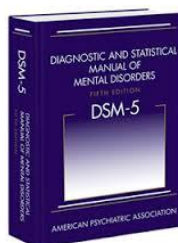
- **Medical Necessity Criteria**
    1. **DSM-5 diagnosis**
        A. **Adults (age 21+)** must have DSM diagnosis for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders
        B. **Youth (age 12-17) and Young Adults (age 18-20)** must have DSM diagnosis for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders **OR** *be assessed to be at-risk for developing substance use disorder*
    2. *FULL* **ASAM Assessment** → to determine medically necessary level of care to ensure that services are appropriate and provided in the appropriate level of care

    *Meeting medical necessity is a requirement for all populations served in the specialty SUD system, regardless of Medi-Cal or funding status** (e.g., My Health LA, AB 109 or other County programs)

Medical Necessity

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WHO Can Establish Medical Necessity?

- **Licensed LPHA must verify medical necessity** via a face-to-face or telehealth review with the individual conducting the assessment (e.g., SUD counselor)

- **License-Eligible Practitioners** (e.g., Associate Social Worker (ASW), Marriage & Family Therapy Intern (IMFT), a Professional Clinical Counselor Intern (PCCI) or Psychological Assistant) **may also establish medical necessity .**

Who is a *Licensed* LPHA

Physician
Nurse Practitioner
Physician Assistant
Registered Nurse
Registered Pharmacist
Licensed Clinical Psychologist
Licensed Clinical Social Worker
Licensed Professional Clinical Counselor
Licensed Marriage and Family Therapist

Who is Eligible for SAPC Reimbursed Services?

- Medi-Cal Eligible or Enrolled

- My Health LA Eligible or Enrolled

- Individuals enrolled in other LA County funded programs who are <u>NOT</u> Medi-Cal or My Health LA eligible or enrolled.

  – *REMEMBER: Drug MediCAL (DMC) is ALWAYS the first payor if patient is eligible and/or enrolled.*

Financial Eligibility Form

Patient ENROLLED in Drug Medi-Cal (DMC)

Scenario: Patient Enrolled in Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM

- **<u>MUST</u> complete a Financial Eligibility Form for all patients at admission.**

- **To ensure you are able to access all benefits available, you must enter 2 separate guarantors for each patient that has DMC (1).**
  - <u>DMC Medi-Cal</u>: DMC should always be listed as the 1st guarantor.
  - <u>LA County Non-DMC</u>

Scenario: Patient Enrolled in Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM

Guarantor Information

Guarantor Plan	**Customize Guarantor Plan**
Medi-Cal	○ Yes - Y ● No - N

2

3

Subscriber Information

Subscriber Policy Number	**Subscriber Medicare Number**
912345678C	
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index #	**Subscriber Branch of Service**
912345678C	-Please Choose One-

4

5

- **Selecting "DMC Medi-Cal" will auto-populate Medi-Cal as the Guarantor Plan (2):**
  - Do NOT change Guarantor Plan type or Guarantor Information
  - Customize Guarantor Plan field should always be "NO" **(3)**

- **Subscriber Client Index # (CIN):** Enter 9 digit alphanumeric CIN, assigned by Medi-Cal, in "Subscriber Policy Number" **(4)** and "Subscriber Client Index #" **(5)** fields.

Scenario: Patient Enrolled in Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM

- **Effective Date of Contract:** Should read 01/01/2000 **(6)**.

- **Coverage Effective Date:** If you know the patient's Medi-Cal Effective date, enter the known date.
    - If you are unsure of the effective date, enter 07/01/2017, as that is the launch date for DMC-ODS in LA County **(7)**.

Scenario: Patient Enrolled in Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM: LA County Non-DMC

Guarantor Information

Guarantor Plan	**2**	Customize Guarantor Plan	**3**
Insurance ▾		○ Yes - Y ⦿ No - N	

Subscriber Information

Subscriber Policy Number	**4**	Subscriber Medicare Number	
N/A			
Subscriber Medicaid #		Subscriber MEDS ID #	
Subscriber Client Index #	**5**	Subscriber Branch of Service	
		-Please Choose One- ▾	

In addition to DMC, You also need to enter LA County Non-DMC as a Guarantor
- **Selecting "LA County NON-DMC" will auto-populate "INSURANCE" as the Guarantor Plan (2):**
  - Do not change Guarantor Plan type or Guarantor Information
  - Customize Guarantor Plan field should always be "NO" **(3)**
- **Subscriber Policy Number:** Policy Number field for all LA County Non-DMC Guarantors will always be "N/A" **(4).**
- **Subscriber Client Index # (CIN):** Leave this field blank **(5).**

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Scenario: Patient Enrolled in Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM: LA County Non-DMC

- **Effective Date of Contract:** Should read 01/01/2000 **(6)**.

- **Coverage Effective Date:** Enter 07/01/2017, as that is the launch date for DMC-ODS in LA County **(7)**.

- **DON'T FORGET TO HIT SAVE + SUBMIT!**

Financial Eligibility Form

Patient APPLYING for
Drug Medi-Cal (DMC)

Scenario: Patient Applying for Drug Medi-Cal (DMC)
FINANCIAL ELIGIBLITY FORM

- **REMINDER: <u>MUST</u> complete a Financial Eligibility Form for all patients at admission.**
- **For patients who are applying for Medi-Cal or in the process of transferring their benefits to LA County, you must enter 2 separate guarantors for each patient that has DMC (1).**
  - <u>Applying for Medi-Cal</u>: DMC should always be listed as the 1st guarantor.
  - <u>LA County Non-DMC</u>

Scenario: Patient Applying for Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM

Guarantor Information

Guarantor Plan	Customize Guarantor Plan
Insurance ▼ **2**	○ Yes - Y ◉ No - N **3**

Subscriber Information

Subscriber Policy Number	Subscriber Medicare Number
Applying for Medi-CAL **4**	
Subscriber Medicaid #	**Subscriber MEDS ID #**
Subscriber Client Index # **5**	**Subscriber Branch of Service** -Please Choose One- ▼
Subscriber Military Status -Please Choose One- ▼	**Subscriber Treatment Auth** ○ Yes - Y ○ No - N
Subscriber Assignment Of Benefits ◉ Yes - Y ○ No - N	**Subscriber Release Of Information** ○ Appropriate Release Of Information On File At HCSP - A ○ Informed Consent To Release Medical Info - I ○ No, Provider Not Allowed To Release Data - N ○ On File At Payor Or At Plan Sponsor - O ○ Provider Has Limited/Restricted Ability To Release Data - M ◉ Yes, Provider Has Signed Statement Permitting Release - Y

- **Selecting "Applying for Medi-Cal" will auto-populate "Insurance" as the Guarantor Plan (2).**
    - Do not change Guarantor Plan type or Guarantor Information
    - Customize Guarantor Plan field should always be "NO" **(3)**

- **Subscriber's Policy Number:** Enter, "Applying for Medi-Cal" **(4)**
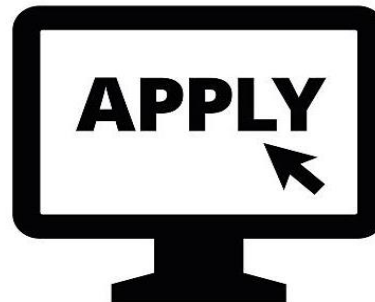
- **Subscriber Client Index # (CIN):** Leave blank **(5).**

Scenario: Patient Applying for Drug Medi-Cal (DMC) FINANCIAL ELIGIBLITY FORM

- **Effective Date of Contract:** Should read 01/01/2000 **(6).**

- **Coverage Effective Date:** Given this is a required field, enter date patient applied to Medi-Cal, as benefits will be retroactive to date of application **(7).**

- **DON'T FORGET TO HIT SAVE + SUBMIT!**

Scenario: Patient Enrolled in My Health LA (MHLA) FINANCIAL ELIGIBLITY FORM

- **<u>MUST</u> complete a Financial Eligibility Form for all patients at admission.**

- **Patients enrolled in My Health LA must only have 1 guarantor selected (1).**
  - LA County Non-DMC

Scenario: Patient Enrolled in My Health LA (MHLA) FINANCIAL ELIGIBLITY FORM

- **Selecting "LA County-NON-DMC" will auto-populate "INSURANCE" as the Guarantor Plan (2):**
  - Do NOT change Guarantor Plan type or Guarantor Information
  - Customize Guarantor Plan field should always be "NO" **(3)**
- **Subscriber Policy Number:** Policy Number field for all LA County Non-DMC Guarantors will always be "N/A" **(4).**
- **Subscriber Client Index # (CIN):** Leave this field blank **(5)**.

Scenario: Patient Enrolled in My Health LA (MHLA) FINANCIAL ELIGIBLITY FORM

Coverage Information			
Eligibility Verified ◉ Yes - Y ○ No - N		**Coverage Effective Date** 07/01/2017	7
Coverage Expiration Date		**Inhibit Billing By Mail** ○ Yes - Y ○ No - N	
Effective Date Of Contract 01/01/2000	6	**Expiration Date Of Contract**	
Is This A Managed Care Contract ○ Yes - Y ○ No - N		**Insurance Code/Medicaid Tape**	
Coordination Of Benefits ◉ Yes - Y ○ No - N		**Date Of Accident**	

- **Effective Date of Contract:** Should read 01/01/2000 **(6)**.

- **Coverage Effective Date:** If you know the patient's My Health LA Effective date, enter the known date.
  - If you are unsure of the effective date, enter 07/01/2017, as that is the launch date for DMC-ODS in LA County **(7)**.

- **You also must complete the My Health LA section of CalOMS/LACPRS.**

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Financial Eligibility- Client Address

- If the client is homeless:
  - Use the address of the Department of Public Social Services (DPSS) where the client receives benefits from
  - Do NOT use SAPC's address

Eligibility Determination Process

Eligibility Determination Process: Residency

1. Client must be a resident of **Los Angeles County**

2. No out-of-county residents should have been admitted under SAPC's jurisdiction after March 31, 2018 for OTP clients.

3. There will be no allowable billing for OTP clients who are not residents of LA county after June 30th, 2018.

Eligibility Determination Process: Treatment Plan and Planning

- Treatment planning should begin when client enters the program

- Should include short and long term goals related to the medication for addiction treatment (MAT) and necessary concurrent services (e.g., psychosocial counseling)

- This should be a "living document" (i.e., should be regularly reviewed and updated based on client progress or changing circumstances)

- Treatment plan should always indicate need for MAT

Eligibility Determination Process: Treatment Plan and Planning

- Needs to be signed by the patient before uploading to Sage.

- Needs to be reviewed/signed by physician

- Treatment plan needs to be uploaded in sage, regardless of primary electronic medical record system

  - *This is especially critical for re-verification of client eligibility*

  - *Eligibility will NOT be re-verified without a treatment plan*

Eligibility Determination Process: Treatment Plan and Planning

IMPORTANT NOTE: If an agency is using it's own forms to document, including treatment plans and progress notes, they must be approved by SAPC's Medical Director (Dr. Tsai).

– Agencies must use the forms from SAPC's website until individual forms have been approved. This will result in significant delays in the eligibility verification process.

– This includes agencies that are utilizing it's own Electronic Records outside of Sage.

– Please email request to review forms to SAPC.QI.UM@ph.lacounty.gov

Eligibility Determination Process:
Aligning of annual OTP update with SAPC medical necessity review

- Regardless of when SAPC initially reviewed the eligibility/medical necessity, the re-verification process timeline will be aligned with the annual OTP update
  - This will help to streamline the process for providers and reduce redundancies in the process for providers.
- Therefore, SAPC will review and make determinations of eligibility re-verification on the client's *annual admission date*
  - *For example:*
    - *If a client entered treatment in August, 2017 and SAPC established eligibility in March, 2018*
    - *Re-verification documents need to be entered by August, 2018*

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Diagnostic Considerations

Diagnostic Considerations

Diagnosis: Diagnostic Statistical Manual, 5th Edition (DSM-5) Criteria For Substance Use Disorder			

Please check off any symptoms that have occurred in the past 12 months.

	Substance Use Disorder Criteria (DSM-5)	Name of Substance(s)		
		#1:	#2:	#3:
1	Substance often taken in larger amounts or over a longer period than was intended.	☑	☐	☐
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☑	☑
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	☐	☐	☐
4	Craving, or a strong desire or urge to use the substance.	☑	☐	☐
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐	☐	☐
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	☑	☑	☑
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	☐	☐	☐
8	Recurrent substance use in situations in which it is physically hazardous.	☑	☐	☐
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	☐	☑	☑
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same amount of the substance.	☐	☐	☐
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.	☐	☐	☐
	Total Number of Criteria			

Establishing medical necessity requires the presence of a <u>DSM-5 substance use disorder diagnosis</u>

* The presence of <u>at least 2</u> of these criteria indicates a substance use disorder.

** The severity of the substance use disorder is defined as:

- Mild: Presence of <u>2-3 criteria</u>
- Moderate: Presence of <u>4-5 criteria</u>
- Severe: Presence of <u>6 or more criteria</u>

Typical Diagnoses in OTP Settings When Patient Continues to Actively Use

- **305.50 (F11.10) Opioid Use Disorder, Mild, On Maintenance Therapy**
  – Presence of 2-3 substance use disorder criteria

- **304.00 (F11.20) Opioid Use Disorder, Moderate, On Maintenance Therapy**
  – Presence of 4-5 substance use disorder criteria

- **304.00 (F11.20) Opioid Use Disorder, Severe, On Maintenance Therapy**
  – Presence of 6 or more substance use disorder criteria

Medical Necessity (cont'd)

- What if Medications for Addiction Treatment (MAT – e.g., methadone, buprenorphine, etc.) are working and the client is no longer exhibiting symptoms?

- Does the client still meet medical necessity?

Medical Necessity (cont'd)

- YES!

- Think about how the client would be doing _without_ the assistance of the MAT being used.

- Would they likely return to using/meeting criteria for a substance disorder?
  - Therefore, in essence, the client is in remission due to the effects of the MAT being used and maintenance therapy → The justification for need for ongoing services should focus on explaining why this is the case in each individual case.

Remission Specifiers

Specify if:

- **In early remission:** After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).

- **In sustained remission:** After full criteria for opioid use disorder were previously met, none of the criteria for opioid use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC

Remission Specifiers (cont'd)

Specify if:

- **On maintenance therapy:** This additional specifier is used if the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). This category also applies to those individuals being maintained on a partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC
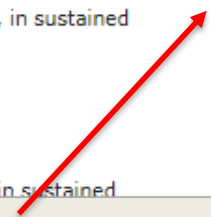
Eligible Substance Use Disorders (when client is not actively using)

- Examples:
  - **305.53 (F11.10) Opioid Use Disorder, Mild, In Early Remission, *On Maintenance Therapy***
  - **304.00 (F11.20) Opioid Use Disorder, Moderate, In Sustained Remission, *On Maintenance Therapy***
  - **304.00 (F11.20) Opioid Use Disorder, Severe, In Early Remission, *On Maintenance Therapy***

Searching For A Diagnosis in Sage

- Search using DSM IV language to narrow your search results

Title 22 requirements for Justification of Diagnosis

- According to Title 22, the diagnosis is essential in verifying Medical Necessity. As such there are certain requirements that must be met to satisfy Title 22 criteria for documenting how providers arrived at Diagnosis:
  - The diagnosis must be documented separately from the treatment plan and should include:
    - Date
    - Beneficiary first and last name
    - Date of admission
    - Sign and dated by physician or LPHA
    - DSM 5 Diagnosis

Title 22 requirements for Justification of Diagnosis

Recently clarified by DHCS, a narrative summary describing the basis for the diagnosis must be included in the medical record written by either the Physician or the LPHA.

- The following information must be included in the narrative summary:
  - Substance Use History
  - Personal History
  - Medical History
  - DSM Criteria
  - Physician recommendation for treatment
  - Recommended level of care based on ASAM
- This information can be written by the LPHA in a <u>Miscellaneous Note</u> under the *Assessment Note Type*

ASAM Continuum
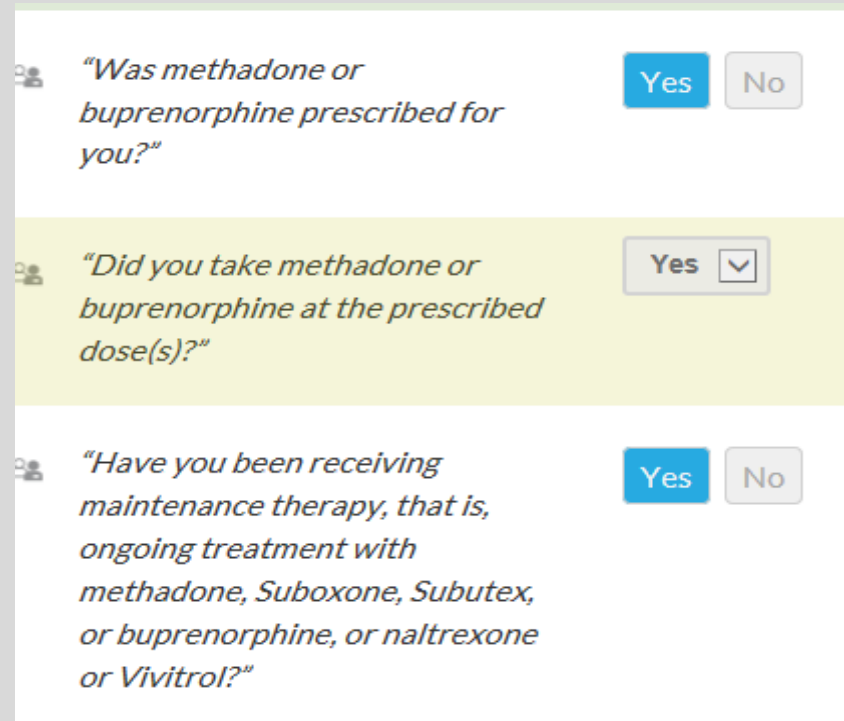
ASAM CONTINUUM Tips for OTP Providers

- **In the Drug and Alcohol section of the ASAM CONTINUUM:**
  - When asking the questions in the subsection of the ASAM related to the client's drug of choice:
    - Remember to <u>use all information available to you, including your clinical judgment!</u>
      - Use your clinical skills to probe the client for more information.
      - Even if the client denies that their drug used caused problems, but you know from the records that it did, answer the question according to your clinical judgment.
      - Patient responses should be filtered through clinical judgment to ensure accuracy in response and a proper assessment via the ASAM CONTINUUM.

ASAM CONTINUUM Tips for OTP Providers (cont'd)

- **In the Drug and Alcohol section of the ASAM CONTINUUM:**
  - In the Methadone and Buprenorphine Use section
    - Carefully answer the questions related to whether methadone or buprenorphine was prescribed and whether the client was receiving maintenance therapy

ASAM CONTINUUM Tips for OTP Providers (cont'd)

- **In the Drug and Alcohol section of the ASAM CONTINUUM:**
  - In the Opioid Treatment services section of the ASAM
    - "Will the patient be treated using an opioid withdrawal protocol" if the client will be treated using any form of Medication for Addiction Treatment, select the medication type from the drop down menu

If you do not expect the patient to enter Opioid Treatment Services (e.g., Methadone Maintenance, Buprenorphine Maintenance, or Extended-Release Naltrexone injection), enter "NO" for each of the following questions.

Will the patient be treated using an opioid withdrawal protocol?

No
Opioid antagonist (multi-day naltrexone induction)
Opioid antagonist rapid detoxification (i.e. with sedation or anesthesia)
Non-opioid substitution (i.e. withdrawal management with drugs other than opioids)
Opioid substitution (i.e. withdrawal management with methadone, Suboxone, Subutex, buprenorphine)

ASAM Continuum Report

If questions regarding Medications for Addiction Treatment are answered correctly, the following should appear on the ASAM CONTINUUM Report:

On maintenance therapy (for opioids, including antagonist therapies)

Establishing Medical Necessity When the ASAM CONTINUUM Report Does Not Indicate a Substance Use Disorder

DSM-5 DIAGNOSIS: SUBSTANCE USE DISORDER(S)

Dependence

Drug	☑ Criteria Met with severity based on 11 criteria	⊕ Last Use	△ Imminent Risk Of Withdrawal
None			☐

- If the ASAM CONTINUUM report <u>does not</u> indicate that the client meets DSM-5 criteria for a substance use disorder, there needs to be a Miscellaneous Note in the client's chart addressing why the client still requires treatment.

Establishing Medical Necessity When the ASAM CONTINUUM Report Does Not Indicate a Substance Use Disorder (cont'd)

- This Miscellaneous Note should indicate:
  - The diagnosis (e.g., opioid use disorder – mild/moderate/severe/in early remission/in sustained remission),
  - An explanation, based on your knowledge and clinical judgement, as to why the diagnosis in the ASAM Continuum is not accurate (due to the therapeutic effects of maintenance therapy?).

- *The note also needs to be reviewed/finalized by an LPHA*.

Withdrawal Management in OTP Settings

Withdrawal Management in OTP Settings

- Withdrawal Management in OTP Settings = OTP

- Therefore, there is no need for a separate service authorization
  - DO NOT bill for ASAM LOC 1.0-WM.

Coordinating Care with non-OTP Providers

- Many OTP clients would likely benefit from additional substance abuse treatment services
  - Especially, consider referring clients with co-occurring mental health difficulties or clients who are having MAT adherence issues
  - SBAT is a good resource for identifying other providers
- If client *is* receiving concurrent treatment with a non-OTP provider
  - Regular communication and collaboration among providers is key to optimizing the client's success
  - Make sure you have proper consents in place.

Eligibility Re-Determination:
What is SAPC looking for?

Eligibility Re-Determination

- Reminder: the eligibility re-determination process will depend on the client's *annual admission date* (regardless of when the initial eligibility verification occurred)

- ***The client's chart will need to include:***

  – The <u>most current treatment plan</u> that MUST be updated at least within the last 30 days

    - MUST EXPLAIN THE NEED FOR ONGOING SERVICES

    - Must include:

      – Signature of the prescriber of MAT

      – Counselor Signature (if applicable)

      – Patient Signature

- "It is important to note, when medications are included in the treatment plan, LPHAs who sign off on treatment plans must be licensed prescribers, whether in the OTP setting or non-OTP settings." Provider Manual 3.0, Page 159

Eligibility Re-Determination

- Also include laboratory/drug testing results (if applicable)
- SAPC may also request additional documentation, as needed, in order to facilitate appropriate clinical determination
- Reminder: The treatment plan is a "living document." It can be modified at any time to match the current treatment needs of the patient.
- Treatment plans should be reviewed with corresponding documentation every 30 days
- Treatment Plans should be updated and documented every 90 days
  - This can be documented in Sage in a Miscellaneous Note, using the Treatment Plan Review/Development note type for both Review and Update

Title 22 requirements for Justifying Need for Ongoing Services

As part of the re-verification process to establish continued Medical Necessity, a Justification for Ongoing Services must be established.

- Justification for Ongoing Services is due annually and will now be in line with the Title 9 justification OTP providers are currently completing.
- Per DHCS, the justification of need for ongoing services must include the following information
    - The beneficiary's personal, medical and substance use history.
    - Documentation of the beneficiary's most recent physical examination.
    - The beneficiary's progress notes and treatment plan goals.
    - The recommendation for continued services
    - The physician's signature and date
- This can be documented in Sage in a _Miscellaneous Note_, using the _Six/Twelve Month Justification_ Note Type.

Questions?

Thank you for all your hard work!