COUNTY OF LOS ANGELES
Public Health

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SAPC BULLETIN NO. 17-14-START

February 26, 2018

TO: Los Angeles County Substance Use Disorder Contracted Treatment Providers

FROM: Wesley L. Ford, M.A., M.P.H., Division Director
Substance Abuse Prevention and Control

SUBJECT: **COUNTY OF RESIDENCE MODEL**

The Department of Public Health, Substance Abuse Prevention and Control's (SAPC) substance use disorder (SUD) treatment benefit package is available at no-cost to Medi-Cal, My Health LA, and other County-funded program (e.g., AB 109) participants who reside in Los Angeles County. This benefit was effective July 1, 2017 (Bulletin 17-01) for all levels of care except Opioid Treatment Programs (OTP) who may enroll non-County residents through March 31, 2018 provided individuals are transferred to their County of residence on or before June 30, 2018 for continued services.

COUNTY OF RESIDENCE / RESPONSIBILITY

The Los Angeles County specialty SUD benefit package follows a County of residence model of service delivery which means only individuals with established residency, and who meet eligibility requirements, can receive these publicly funded services. SAPC network providers that render SUD services to individuals who reside outside of Los Angeles County will not be reimbursed for services delivered on or after July 1, 2017, except for: (1) OTP services/patients; and (2) Medi-Cal transfers as described herein. Network providers who intend to deliver services to non-County residents need to contract with the County where those beneficiaries reside to be reimbursed.

PROVIDER RESPONSIBILITIES

If Network Providers receive referrals from individuals who reside out-of-County that do not intend to move, and the Network Provider does not have a contract with the County of residence, provide the County phone number available at: http://www.dhcs.ca.gov/individuals/Pages/DMC-CountyNumbersDirectory.aspx. OTP providers must follow this process beginning April 1, 2018.

In situations where the individual resides in Los Angeles County but Medi-Cal benefits are assigned to another County, Network Providers conduct the screening/assessment and admit the patient for medically necessary services while Medi-Cal benefits are being transferred. Admission cannot be delayed or denied for eligible (i.e., Medi-Cal, My Health LA, AB 109) Los Angeles County residents due to an incomplete or pending application and/or if Medi-Cal benefits are assigned to another County.

It is the Network Provider's responsibility to facilitate the process of transferring, initiating, completing, and renewing Medi-Cal and My Health LA applications with potential and current patients using the case management benefit (at time of publication $33.83 per 15 minutes, up to 7 hours per month). SAPC also guarantees payment for services for up to 60 days during the Medi-Cal application and transfer process for individuals who meet income and other eligibility criteria and with proof of continuous effort by the Network Provider (e.g., proof of application, Medi-Cal Client Index Number (CIN), progress notes) to complete the process in a timely manner.

The *Provider Manual for Substance Use Disorder Treatment Services* includes additional guidance on claims reimbursement while a Medi-Cal, My Health LA application, or transfer is pending.

OTP COURTESY DOSING

OTP patients who are Medi-Cal beneficiaries and have traveled to Los Angeles County for business or leisure, and who do not qualify for, or are unable to bring enough take-home doses for the trip duration, are eligible for SAPC reimbursed courtesy dosing of methadone and buprenorphine for up to 30 days. The Los Angeles County clinic must receive a courtesy dosing order from the home clinic which is signed by the medical director or program physician, and at minimum outlines the dose, duration, and any other special instructions, such as take-home doses. Compliance with relevant Title 9 regulations is required.

For claims to be approved, the invoice must include all information contained within the *Courtesy Dosing Reimbursement Form*, including the name and date of birth of the patient, Social Security Number, Medi-Cal CIN, County/State of residence, home clinic, dates of service, medication type, health care procedure coding system, amount billed, and courtesy dosing reason. Individuals receiving courtesy doses are not entered as new admissions into Sage and data collection is not required. Claims must be submitted after the last dose is administered or distributed to the patient, by completing the attached *Courtesy Dosing Reimbursement Form* and sending securely to cruiz@ph.lacounty.gov or via fax at (626) 299-7225 (Attention: DMC Unit).

EFFECTIVE PERIOD

Reimbursement claims will be denied for non-County residents receiving treatment at American Society of Addition Medicine (ASAM) level of care as follows (excluding patients served under the 60-day Medi-Cal application/transfer policy):

- July 1, 2017: Non-County residents receiving ASAM 1.0, 2.1, 3.1, 3.3, 3.5, 1-WM (withdrawal management), 3.2-WM, 3.7-WM, and 4.0-WM services on or after this date.
- April 1, 2018: New non-County resident admissions to ASAM 1-OTP on or after this date.
- July 1, 2018: OTP patients who received services on or after this date, and who were not transferred to the County of residence for continued services.

For additional information related this bulletin, please contact Yanira Lima, Systems of Care Branch, at ylima@ph.lacounty.gov or (626) 299-3202.

Attachment

WLF:mg

NOTE:
This document contains client Protected Health Information and must be submitted securely in compliance with Code of Federal Regulations - Title 45, Section 164 Subpart E.

LOS ANGELES COUNTY - DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
COURTESY DOSING REIMBURSEMENT FORM - OPIOID TREATMENT PROGRAMS

PROVIDER NAME: _____
ADDRESS: _____
CITY: _____
CONTACT PERSON: _____

CONTRACT #: _____
CLAIM PERIOD: _____
DATE PREPARED: _____
PROVIDER #: _____
PHONE: _____

CLIENT NAME		DATE	SSN	CIN	RESIDENCE		HOME CLINIC		DATES OF SERVICE		MEDICATION TYPE	HCPCS	AMOUNT BILLED		COURTESY
LAST	FIRST	OF BIRTH	#	#	COUNTY	STATE	AGENCY NAME	ADDRESS	START DATE	END DATE	METHADONE/BUPRENORPHINE	CODE	UNITS	AMOUNT	DOSING REASON

I hereby certify to the best of my knowledge and belief, this claim and statement are true, correct, complete and prepared from the books and records of provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of federal and state alcohol and drug program funds and that the services and cost identified in this claim were provided in compliance with such laws and regulations including the Code of Federal Regulations - Title 45, Section 96.135.

_____ Authorized Signature

_____ Date