

Clinical & Utilization Management Updates

Los Angeles County Department of Public Health
All Provider Meeting March 1, 2022
Substance Abuse Prevention & Control



Agenda

- Timeliness of Authorization Submissions
- UM Protocol for Patients with OHC
- Grievance and Appeal Forms Updates
- Provider Documentation Workgroup

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.
- Three 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. Auth that was delayed awaiting receipt of an Other Health Coverage denial
- 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>



Other Health Coverage Provider Billing Manual

<http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/ohc/SAPCOtherHealthCoverageProviderBillingManual.pdf>

Section 3: SAPC Service Authorization Requests for Patients with OHC

SAPC strongly recommends providers submit a service authorization within 30 days of upon admission, including for patients with both Drug Medi-Cal and OHC benefits. Service authorization requests for patients with OHC must adhere to and meet current standards and requirements for service authorizations. If a patient has an OHC, the provider should include a comment in the service authorization justification indicating that the patient has an OHC. However, as previously indicated, providers should not send claims to SAPC for these services until the OHC carrier has already been billed and has denied the claims or a response has not been received for 90 calendar days.

The recommendation to submit the service authorization prior to claims being denied by the patient's OHC is to support providers in obtaining a member authorization at the time that the patient receives SUD services. This allows the SAPC Utilization Management Care Manager (Care Manager) to review the authorization submission and offer providers feedback to support the provider gathering any additional required documentation and to follow-up with the patient should the Care Manager require any clarification to approve the service authorization.

Non-DMC services such as Recovery Bridge Housing or incentive services authorized through Provider Authorizations (PAuths) will not be affected by a patient having OHC and will not require providers to submit any details to SAPC regarding OHC.

Providers will be able to hold submission of a member authorization request until a claim denial from the OHC has been received, and SAPC Utilization Management will consider authorization requests submitted more than 30 days following the date of service when providers include a comment in the service authorization justification indicating that the patient has an OHC and that the provider was delayed from submitting their service authorization due to waiting for receipt of an OHC denial. However, service authorization requests for patients with OHC must adhere to and meet current standards and requirements for service authorizations. Providers are at risk for denials of authorization when documentation does not adhere to these service standards, and correcting documentation deficiencies becomes more difficult to address when there are extended durations of time between the initial date of admission and the Care Manager's review of the authorization submission.

SAPC's standard policy requires authorization requests be submitted within 30 days from the initial date of service, with narrow exceptions associated with delays in establishing financial eligibility. Even with these exceptions, SAPC requires that all authorization requests be submitted no later than 120 days from the initial date of service.

Grievance and Appeal Form Updates

- 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): <input type="checkbox"/> Standard Appeal <input type="checkbox"/> Expedited Appeal		2. Date:	
INFORMATION ABOUT MEDI-CAL BENEFICIARY FILING APPEAL			
3. Name (Last, First, and Middle): <i>(required)</i>		4. Sage PT ID#: <i>(if known)</i>	5. Authorization # <i>(if known)</i>
6. Date of Birth: <i>(required)</i>	7. Medi-Cal #: <i>(if known)</i>	8. Street Address: <i>(required if there is an address available)</i>	
9. City and Zip Code <i>(required if there is an address available)</i>	10. Phone Number and/or Email Address: <i>(required if there is a phone number or email address available)</i>	11. Do we have your permission to leave a voice message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
COMPLETE IF AUTHORIZING A REPRESENTATIVE TO FILE AN APPEAL ON YOUR BEHALF			
12. Name of Representative:		13. Agency Name/ Relationship:	14. Email:
15. Street Address:		16. City and Zip:	17. Phone:
18. If you are authorizing another person or entity to represent you in filing this appeal, please sign below:			
_____		_____	
Patient Name (Print)		Patient (Signature)	
FORM INFORMATION ABOUT THE APPEAL			
19. Did you receive an Advance Benefit Determination (NOABD) letter? <input type="checkbox"/> Yes <input type="checkbox"/> No			
20. Did anyone complete this form on your behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. Which type of NOABD did you receive:			
<input type="checkbox"/> Denial		<input type="checkbox"/> Termination	
<input type="checkbox"/> Payment Denial		<input type="checkbox"/> Timely Access to Services	
<input type="checkbox"/> Other, describe: _____		<input type="checkbox"/> 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).

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**

Provider Documentation Workgroup

- Provider Documentation Workgroup working to:
 - Update/design effective and efficient workflow process for the Care Managers as needed
 - Support providers by clarifying UM expectations and share additional instructions regarding Providers documenting FE care coordination (i.e. Medi-Cal applications)
 - Providing clear practical set of examples for providers
 - Quality of documentation
 - Timeliness of documentation

Thank You!



“As human beings, our greatness lies not so much in being able to remake the world.. as in being able to remake ourselves”

*- Mahatma Gandhi*₁₁