ELIGIBILTY VERIFICATION AND SERVICE AUTHORIZATION PROCESS

Substance Abuse Prevention and Control
County of Los Angeles Health Agency & Department of Public Health

Outline

- **Important Network-Wide Issues**

- **Eligibility Verification vs. Service Authorizations**

- **Preauthorized vs. Authorized Services**

- **Service Request Form (Parts A and B)**

- **Required Documentation**

- **Transitions Between Different Levels of Care**

- **Bed Holds**

- **Discussion / Q&A**

WHEN QUESTIONS ARISE:
1st → **Provider Manual**
2nd → **SAPC website** (FAQ's, Timeline Factsheet, Documentation Checklist)
3rd → **Call SAPC**

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Important Network-Wide Issues

Helpful Resources
- All counselors and clinical supervisors should read the **Provider Manual**
- Refer to **Checklist for Service Authorizations** to determine what documents are needed for eligibility verifications and authorizations
- Refer to **START-ODS Informational Brief #5: Submission and Update Timelines** for the required timelines for eligibility verification and authorizations submissions
- Refer to **FAQ's** on SAPC website to answer most questions

Authorizations
- The clock for authorization submissions does not start until a preauthorization or authorization submission is COMPLETE
- Difference between eligibility verification vs. service authorizations
- To review full ASAM assessments and determine medical necessity, LPHA face-to-face with counselor is required
- Needs individualized ASAM assessments
- Need to use correct DSM diagnosis and fill out LOC grid appropriately

Important Network-Wide Issues (cont'd)

SBAT
- Few providers are updating their SBAT data on a daily basis
- Must avoid using today's availabilities on yesterday's patients
  - Need to stay disciplined with SBAT data and stick with the availabilities provided

SASH
- Provider should NOT turn away MHLA patients and those who are Medi-Cal eligible, but not yet enrolled
- SASH is NOT responsible for discharge planning – providers should use SBAT to identify appropriate referral entities; this is billable case management time
- Providers should NOT be performing their intake or doing full ASAM assessment during the SASH phone call
- When the SASH calls to make referrals, some providers are telling the SASH and patient that they will call the patient back to arrange an appointment within 2 days → inconsistent with the goal of treatment on demand
- Many providers are still not picking up their phones during business hours when the SASH attempts to make referrals

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(Managed Care)

WHY DO YOU ALWAYS COMPLICATE THINGS?!

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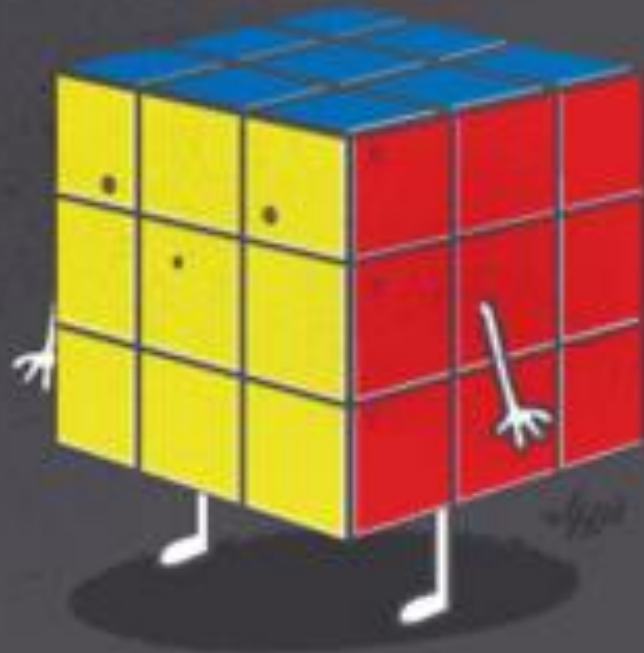
Eligibility Verification vs. Service Authorization

Eligibility Verification
- Process of verifying eligibility for specialty SUD services:
    1. Eligible for Medi-Cal, My Health LA, and/or other County funded programs

        AND

    2. County of Residence (COR) verified to be Los Angeles County (providers should be checking COR at least once per month), with Medi-Cal patients with benefits enrolled to Los Angeles County

        AND

    3. Meet medical necessity for these services, which includes a DSM-5 diagnosis for an SUD and placement at an appropriate level of care as determined by the ASAM Criteria

Eligibility Verification vs. Service Authorization

Service Authorization
- Process of approving certain services that either require:
  - **Preauthorization**
    - Residential Treatment (3.1, 3.3., 3.5)
    - Intensive Inpatient Treatment* (3.7, 4.0)
      - *Does <u>NOT</u> refer to withdrawal management (3.7-WM or 4-WM)

      Preauthorized **services require preauthorization for <u>every episode</u>**

    <u>OR</u>

  - **Authorization**
    - Withdrawal Management for youth
    - Medication-Assisted Treatment for youth
    - Recovery Bridge Housing

    Authorized **services only require authorization when eligibility needs to be verified or re-verified**

Eligibility Verification vs. Service Authorization (cont'd)

- **When a patient enters the specialty SUD treatment system for the first time:**
  - **Services that do NOT require authorization (outpatient treatment, intensive outpatient treatment, withdrawal management for adults, & OTP) <u>STILL REQUIRE submission of Service Request Forms and accompanying required documentation in order to verify eligibility status</u>** → Because medical necessity is a component of both eligibility status and service authorizations

- **Eligibility verification is required whenever a patient enters the specialty SUD system for the first time, and needs to be renewed at the end of the eligibility period for the respective funding source**

Eligibility Verification vs. Service Authorization (cont'd)

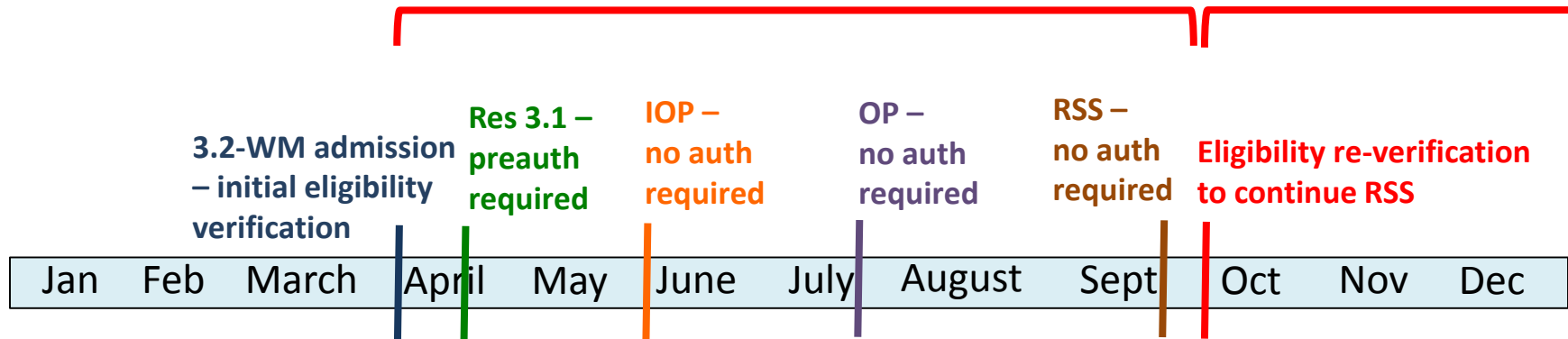**Eligibility renewal time periods**
- **Drug Medi-Cal** → every 6 mo for non-OTP services, and every 12 mo for OTP services
- **My Health LA** → annually
- **Qualified County programs (e.g., AB 109)** → varies based on participation in these qualified County programs

- **Once someone is determined to be eligible, services that do NOT require authorization (OP treatment, IOP treatment, all levels of withdrawal management *for adults*, & OTP) do NOT require submission of Service Request Form _within_ these eligibility periods. Eligibility must be renewed at timeframes listed above.**

- **SAPC is exploring how eligibility information can be transmitted to all its network providers via Sage so that all providers are aware of the eligibility periods of shared patients to maximize efficiencies**

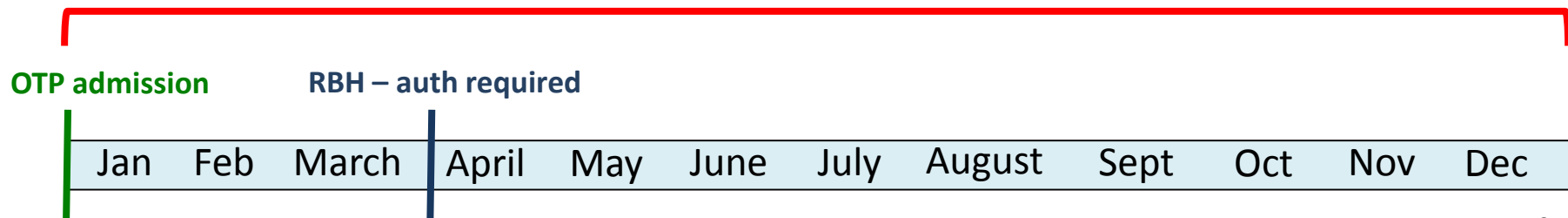SUMMARY: Eligibility Verification vs. Service Authorization

Non-OTP Settings

Eligibility Period: 6 months

Eligibility Renewal

3.2-WM admission – initial eligibility verification

Res 3.1 – preauth required

IOP – no auth required

OP – no auth required

RSS – no auth required

Eligibility re-verification to continue RSS

| Jan | Feb | March | April | May | June | July | August | Sept | Oct | Nov | Dec |

OTP Settings

Eligibility Period: 12 months

OTP admission

RBH – auth required

| Jan | Feb | March | April | May | June | July | August | Sept | Oct | Nov | Dec |

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Preauthorization vs. Authorization

Preauthorization – Provider must request approval from SAPC before beginning treatment, unless they accept financial risk if medical necessity is ultimately unable to be established, in which case they can choose to deliver these services prior to SAPC approval

– Residential treatment
– Intensive Inpatient treatment

These are the ONLY services that require preauthorization by SAPC

Authorization – Services may be provided prior to approval from SAPC

– Medication-Assisted Treatment for youth
– Withdrawal Management for Youth
– Recovery Bridge Housing

Example

- A provider admits a Medi-Cal patient for their first treatment episode in Los Angeles County on 8/1/17.
- IOP treatment is determined to be most appropriate.
  - **Drug Medi-Cal eligibility period is 6 mo from admission date for non-OTP services** (would be 12 mo if OTP services) → **8/5/17 – 1/31/18**

- **All treatment services that do NOT require AUTHORIZATION (e.g., OP, IOP, WM for adults, OTP) can be provided during this patient's 6 mo DMC eligibility period WITHOUT submitting any documents to SAPC because they do NOT require authorization*.**

- **Services that require PREAUTHORIZATION (e.g., residential and intensive inpatient treatment) still require submission of Service Request Form and supporting clinical documentation within this patient's 6 mo DMC eligibility period*.**

  *The Discharge and Transfer Form is still required once patients are eventually discharged from ALL levels of care.
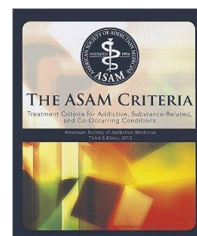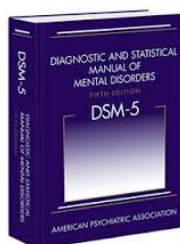
Establishing Medical Necessity

- ## 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

<u>WHO</u> 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)

- Service Request Form **MUST INCLUDE:**
  1. Signature of the Licensed LPHA verifying medical necessity
     AND
  2. Signature of the SUD counselor or License-eligible LPHA who conducted the in-person assessment, if assessment was not done by the Licensed LPHA

- **License-Eligible Practitioners** (e.g., Associate Social Worker (ASW), Marriage & Family Therapy Intern (IMFT), a Professional Clinical Counselor Intern (PCCI) or Psychological Assistant) **are considered LPHA's, but are NOT considered *Licensed* LPHA's**, and must work under the supervision of a licensed LPHA and obtain a **<u>co-signature</u>** on the work completed by the license-eligible practitioner

Who is a *<u>Licensed</u>* 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

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<u>WHEN</u> Medical Necessity Needs to be Established

- **NEW patients AFTER launch of START-ODS**
  - Eligibility – including medical necessity – needs to be established **within 7 calendar days** for **all new patients entering treatment in Los Angeles County's specialty SUD system AFTER July 1, 2017**

- **OLD patients from BEFORE launch of START-ODS**
  - Patients being treated in Los Angeles County's specialty SUD system BEFORE July 1, 2017 will be transitioned to the new system gradually (outlined in subsequent slides)
  - **Reauthorizations need to be submitted 7 calendar days prior to the end of the transition deadline (see Table 17 of Provider Manual)**

OLD <u>Residential</u> Cases that were Active Prior to START-ODS Launch (July 1, 2017)

- For clients already in residential treatment as of 6/30/2017, SAPC automatically authorized residential cases for **60 calendar days from July 1st at the residential 3.1 rate**

- For these pre-launch cases, the **automatic residential authorization period will expire on 8/30/17**

  - Patients who do not require longer lengths of residential stay should be discharged earlier, per clinical need

- **For patients who require longer residential lengths of stay, residential reauthorizations need to be submitted <u>at least 7 calendar days</u> prior to the expiration of the current authorization (see Table 17 of Provider Manual)**

  - When medically necessary, reauthorizations for these pre-launch residential cases need to be submitted to SAPC by **8/23/17**

OLD <u>Non-Residential</u> Cases that were Active Prior to START-ODS Launch (July 1, 2017)

- **Intensive Outpatient (ASAM 2.1)**
  - Eligibility needs to be verified by SAPC *within* <u>3 months</u> of DMC-ODS launch (by 10/1/17)
- **Outpatient (ASAM 1.0)**
  - Eligibility needs to be verified by SAPC *within* <u>4 months</u> of DMC-ODS launch (by 11/1/17)
- **OTP**
  - Eligibility needs to be verified by SAPC *within* <u>6 months</u> of DMC-ODS launch (by 1/1/18)

- **Need to submit eligibility verification documents (Service Request Form and documentation outlined in Checklist on SAPC website) <u>at least 21 calendar days</u> prior to the expiration of the current ELIGIBILITY period listed above (see Table 15 of Provider Manual)**

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Service Request Form

- Used to establish eligibility and **must be submitted to SAPC within 7 calendar days of initiation of treatment** for all new patients after 7/1/17

- **Required for all ASAM levels of care whenever a patient enters the specialty SUD system for the first time, and needs to be renewed at the end of the eligibility period for the respective funding source**

- Must fill out all the mandatory fields in red
  - If the mandatory fields are incomplete or incorrectly filled out, providers will be contacted directly by QI & UM staff or CSD staff.

- **Pre- and Post-Sage Process**
  - Prior to Sage, providers need to fax the Service Request Forms to (323)-725-2045 → **Please fax <u>one service request at a time</u> and <u>include cover sheet</u>**
  - Once Sage is launched, providers can submit the Service Request Form electronically and:
    - For Sage users, SAPC will have access to necessary clinical documentation via Sage directly
    - For non-Sage users, providers will have to upload required clinical documents to Sage portal

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Service Request Form – Part A

- **Part A** of the Service Request Form:
  – Patient info
  – Provider info
  – Eligibility info
  – Medical necessity info

- Part A must be completed for all ASAM levels of care whenever a patient enters the specialty SUD system for the first time, or when their eligibility period ends and needs to be renewed

- **Signature/Date is required** on page 2.

Part A	PART A – MUST BE COMPLETED FOR ALL LEVELS OF CARE

PATIENT INFORMATION		
3. Name: (Last, First, Middle)	4. Date of Birth: (MM/DD/YY)	5. Medi-Cal or MHLA Number:
6. Address:		
7. Phone Number: Okay to Leave a Message? ☒ Yes ☒ No		8. Gender:
9. Perinatal Patient ☒ Yes ☒ No If yes, provide verification	10. Criminal Justice Involved Patient ☒ Yes ☒ No If yes, provide Criminal Justice Identification Number:	11. Race/Ethnicity (Optional):

PROVIDER INFORMATION	
12. Provider Agency Name:	
13. Address:	
14. Name of Contact Person:	15. Email Address of Contact Person:
16. Phone Number of Contact Person:	17. Fax Number:

ELIGIBILITY REQUIREMENTS FOR SPECIALTY SUBSTANCE USE DISORDER SERVICES IN LOS ANGELES COUNTY

18. Is the patient a resident of Los Angeles County? ☒ Yes ☒ No

19. Is the patient Medi-Cal Eligible? ☒ Yes ☒ No. If yes, please go to question 20. If no, please go to question 21.

20. Are the beneficiary's Medi-Cal benefits assigned to Los Angeles County? ☒ Yes ☒ No.

21. Is the patient a participant in the My Health LA (MHLA) program or other qualified county funded benefits? (e.g. AB 109) ☐ Yes ☒ No

MEDICAL NECESSITY FOR ALL LEVELS OF CARE

22. DSM-5 Diagnosis for Substance Use Disorder or Substance Use Diagnosis At Risk For:

23. Level of Care Determination:

24. Printed Name of Licensed LPHA from the ASAM Assessment Form:

25. Discipline:	26. Licensed LPHA License Number:

Service Request Form – Part B

- **Part B** of the Service Request Form:
  - Check off the preauthorized or authorized service being requested
  - **Signature/Date is required** on page 2

- **Part B must be completed for preauthorized and authorized services**

Initial Eligibility or Preauthorization Request – Required Documentation

- **Review Checklist on SAPC website that outlines the documentation needed for initial eligibility verifications or preauthorizations, and re-verifications or reauthorizations.**
- **Required documents:**
  - Service Request Form (recommend including cover sheet)
  - Completed full ASAM assessment
    - **Substantiating perinatal & criminal justice involvement**
      - Documentation is required to substantiate perinatal and criminal justice status.
      - SAPC can approve residential services prior to receiving documentation verifying perinatal or criminal justice status, but will NOT approve residential reauthorizations until this documentation is submitted to approve longer length of stay available to these populations.
    - **Substantiating MAT & Withdrawal Management (WM) for Youth**
      - For MAT and WM for youth, providers need to submit documentation justifying the prescribed medication and WM, respectively, as well as written parental consent for treatment, as applicable.

Re-verifying Eligibility or Reauthorizations – Required Documentation

- **Required documents**
  - Service Request Form (recommend including cover sheet)
  - Current treatment plan
  - Two (2) most recent Progress Notes
  - Pertinent laboratory/drug testing results

- **When a new full ASAM assessment is required for eligibility re-verification:**
  - Non-OTP settings – <u>at least every 6 months</u>
  - OTP settings – <u>at least every 12 months</u>

- **Services for which reauthorizations are N/A**
  - **Withdrawal Management** – limited to 14 calendar day episodes
  - **Intensive Inpatient Treatment (3.7 & 4.0)** – limited to 14 calendar day episodes
  - **Recovery Bridge Housing** – limited to 90 calendar day episodes

Transferring to Preauthorized or Authorized Services

- **Examples:**
  - Seeking placement in residential (3.1, 3.3, 3.5) or intensive inpatient (3.7, 4.0) treatment from any other LOC (ASAM 1.0, 2.1, 1-WM, 3.2-WM, OTP, RSS)
  - Stepping up from a lower level of residential treatment (e.g. 3.1) to a higher level of residential treatment (e.g. 3.5), or from residential to intensive inpatient treatment
  - Youth transferring into any withdrawal management LOC or receiving MAT/OTP services

- **For patients who are already in the specialty SUD system and transitioning between LOC's into a preauthorized or authorized service:**
  - See Checklist on SAPC website for the level or care patient is being transferred to for required documentation (*Service Request Form* and new *full ASAM assessment*)
  - Additionally, *Discharge and Transfer Form* is required for all LOC discharges and transitions

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Transferring to Non-Authorized Services

- A *Discharge and Transfer Form* is required for all LOC discharges and transitions

- A *Service Request form* **is NOT required** for patients transitioning between LOC's when:
  - Stepping down into non-residential levels of care (ASAM 1.0, 2.1, 1-WM, 3.2-WM, OTP) when the individual has already been in the specialty SUD system
  - Stepping down into Recovery Support Services

NOTE:
- All patients who are **new to the START-ODS system** and referred into non-residential LOC's are new patients → *Service Request Form* and new **full ASAM assessment** are REQUIRED

Bed Holds

- **Instances in which bed holds may be necessary for patients in residential treatment:**
  - **Flash incarceration** → may hold bed for a <u>maximum of 7 calendar days</u>
  - **Brief hospitalization** → may hold bed for a <u>maximum of 7 calendar days</u>
  - **Weekend pass** → may hold bed for a <u>maximum of 3 calendar days</u>
- Bed holds will not be reimbursed at the full residential day rate since treatment services are not being provided, and **will only be reimbursed for room and board**.
- As opposed to holding the bed, providers may also choose to discharge patients from residential treatment if they are not expected to return within 7 calendar days. In these instances, the provider would discharge the patient from LACPRS, and submit a *Discharge and Transfer Form* to SAPC.

Don't Forget Documentation

- **What is "purposeful and thorough" documentation?**
  - **SUMMARY of the unique biopsychosocial details of a case**
  - **WHAT services are being provided**
  - **WHY are the services being provided**
    - Provide care rationale and mindset of the counselor or LPHA providing the service
    - After when considering the unique biopsychosocial circumstances of a case, describe why a particular service is being provided.

  - **"If it's not written down, it didn't happen"**
    - SAPC Utilization Management staff will make service authorization decisions, which will ultimately impact reimbursement, based on what is and is not included in clinical documentation by counselors and clinicians.

Discussion / Q&A

WHEN QUESTIONS ARISE:
1st → Provider Manual
2nd → SAPC website (FAQ's, Timeline Factsheet, Documentation Checklist)
3rd → Call SAPC