SAPC Utilization Management Meeting

February 16, 2022

Agenda

- Grievance and Appeal Forms and Process
- Notice of Adverse Benefit Determination (NOABD) Letters
  - Assisting patients with filing appeals
- Resubmission Timeline Reminder
- Other Health Coverage Guidance
- Provider Documentation Requirements

NOABD

- **Jan 24th**: SAPC began issuing state required **Notice of Adverse Benefit Determination (NOABD)** letters to Medi-Cal beneficiaries following denials of authorization for residential levels of care (LOC 3.1, 3.3, or 3.5) not associated with withdrawal management (WM).
  - These letters are being mailed to the patient's mailing address and copies are mailed to the relevant provider agency
  - SAPC-generated NOABD letters will not be issued for denials of 3.2-WM and 3.7-WM LOC authorization requests
- UM care managers **continue to notify providers** on all denials by phone.

Denial Reasons Associated With NOABD

- SAPC generates NOABD letters when denials of authorization are made for non-WM residential services in the following circumstances:

1. Does Not Meet Medical Necessity Criteria
2. Patient not residing in LA County
3. Patient's benefits not assigned to LA County
4. 30-day timely documentation submission deadline not met*
5. Insufficient Documentation
6. Partial Approvals (authorizations with modified start dates due to late medical necessity documentation and/or late authorization submission)

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.
- Two 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
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

sage Managed by SAPC

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 Update

- 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**): ☐Standard Appeal ☐Expedited Appeal			2. Date:
INFORMATION ABOUT MEDI-CAL BENEFICIARY FILING APPEAL			
3. Name (Last, First, and Middle): *(required)*		4. Sage PT ID#: *(if know*	5. Authorization # *(if known)*
6. Date of Birth: *(required)*	7. Medi-Cal #: *(if known)*	8. Street Ad *(required if s as an a ilable)*	
9. City and Zip Code *(required if there is an address available)*	10. Phone Number and/or Em Address: *(required if there is a phone numbe l address a lable)*		11. Do we have your permission to leave a voice message? ☐Yes ☐No
COMPLETE IF AUTHORIZING A REPRESENTATIV AL ON YOUR BEHALF			
12. Name of Representative:	13. Agency Name/ Re hip:		14. Email:
15. Street Address:	16. Ci d Z		17. Phone:
18. **If you are authorizing another n or enti esent you in filing this appeal, please sign below:**			
Patient Name (Print)		Patient (Signature)	
ORMA ABOUT THE APPEAL			
19. Did you receiv Adve efit Determination (NOABD) letter? ☐Yes ☐No			
20. Did anyon plete this n you alf? ☐Yes ☐No			
21. Which type OABD did y eceive: ☐ Denial ☐ Payment Den ☐ Other, describe._____ ☐ Termination ☐ Timely Access to Services ☐ 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).

Narrowing Criteria for Authorization Resubmissions

Currently 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

Starting Jan 24th, we narrowed the criteria where we will **only review 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

Provider Documentation Requirements

- To update/design effective and efficient workflow process for the Care Mangers as needed
- To support providers by clarifying UM expectations and share additional instructions regarding Providers documenting their client support for Medi-Cal or Non DMC applications as needed
- Providing clear practical set of examples for providers
  - Quality of documentation
  - Timeliness of documentation
- Financial liability of accepting a patient without coverage or without transferring Medi-Cal coverage to Los Angeles county rests with the provider.

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**

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