DOCUMENTATION WITHIN THE SPECIALTY SUD SYSTEM

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

• Important Network-Wide Issues

• Review
  • Eligibility Verification vs. Service Authorization
  • Preauthorized vs. Authorized Services
  • Justification of Medical Necessity

• Documentation

WHEN QUESTIONS ARISE:
1st → Provider Manual
2nd → SAPC website (FAQ’s, Timeline Factsheet, Documentation Checklist)
3rd → Call SAPC
Important Network-Wide Issues

Helpful Resources
- Provider Manual
- Checklist of Required Documentation* (updates coming soon)
- START-ODS FAQs
- *NEW* Weekly SAPC QI and UM FAQ Provider Call

Reminders Regarding Authorizations
- If you have questions regarding a submission, please call SAPC and do NOT re-fax the materials → we are getting up to 7 duplicate faxes per patient, which is leading to significant inefficiencies
- The 24-hour clock for residential preauthorization approvals BEGINS when the preauthorization submission is COMPLETE
- To review full ASAM assessments and determine medical necessity, **LPHA must have a face-to-face discussion with counselor conducting assessment** to review case (if LPHA did not conduct assessment)
- Must include individualized ASAM assessments (no copy and pasting without modifications), correct DSM diagnosis, and fill out LOC grid appropriately
Important Network-Wide Issues (cont’d)

Reminders Regarding SBAT
- While many providers are now updating their SBAT data on a daily basis, some still are not → this is a contractual requirement
- Must avoid using today’s availabilities on yesterday’s patients
  - Need to stay disciplined with SBAT data and stick with the availabilities provided

Reminders Regarding Case Management
- Providers should NOT turn away MHLA individuals and those who are Medi-Cal eligible, but not yet enrolled → use case management
- Providers should be using the billable case management benefit for things such as discharge planning, planning level of care transitions, exploring housing options, etc → SASH/CENS/WPC is NOT responsible for these case management functions

Reminders Regarding SASH/CENS
- Many providers are still not picking up their phones during business hours when the SASH attempts to make referrals
- Providers should NOT be performing their intake or doing full ASAM assessment during the SASH phone call
- When the SASH/CENS 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
SUMMARY: Eligibility Verification vs. Service Authorization

Non-OTP Settings

- Eligibility Period: 6 months
  - 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

OTP Settings

- Eligibility Period: 12 months
  - OTP admission
  - RBH – auth required
Eligibility Verification

1. Determine eligibility for Medi-Cal, My Health LA, and/or other County-funded programs
   \textbf{AND}

2. Verify County of Residence (COR) is Los Angeles County (providers should be checking COR at least once per month); benefits need to be assigned to Los Angeles County for Medi-Cal beneficiaries
   \textbf{AND}

3. Establish \textit{medical necessity} which includes a DSM-5 diagnosis for an SUD, and placement at an appropriate level of care as determined by the ASAM Criteria
Audience Participation

• What is the difference between an Eligibility Verification and Service Authorization?
Eligibility Verification vs. Service Authorization

- 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
  - **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 these qualified County programs

- 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) still require submission of Service Request Forms and accompanying required documentation in order to verify eligibility status → Because medical necessity is a component of both eligibility status and service authorizations

- After eligibility is verified, 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, and are only required at the time of first treatment episode and when renewal is due.
Audience Participation

• What is the difference between Preauthorized and Authorized Services?
Preauthorization vs 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 NOT refer to withdrawal management (3.7-WM or 4-WM)

OR

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

Preauthorized services require preauthorization for every episode

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

• Review of Medical Necessity
  o *How/what is needed* to establish medical necessity?
  o *Who* can establish medical necessity?
  o *When* does medical necessity need to be established?
Medical Necessity

• How/What is needed to establish medical necessity?

  +  =  Medical Necessity

• 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) are considered LPHA’s, but are NOT considered Licensed LPHA’s, and must work under the supervision of a licensed LPHA and obtain a co-signature on the work completed by the license-eligible practitioner

• When does medical necessity need to be established?
  – Within 7 calendar days
Documentation
Case Formulation

• What is a Case Formulation?
  – A case formulation is a conceptual framework of a patient that incorporates all the key factors of that patient’s case into a working idea of how best to help that person.
  – Case formulations both describe and explain how a person’s problem has developed and how it is maintained so that treatment can target those core, influencing factors.
    • The “story” of a patient that underlies case formulations should be what guides the treatment and care provided by counselors and clinicians.
Justifying Medical Necessity

- Justifying medical necessity is similar to the strategies you use when asking someone for something, and attempt to explain why they should give you what you want
  - For example:
    - Asking your boss for a raise.
    - Asking your parents to let you go out with friends.
    - Convincing your spouse why you need a larger TV/new car/new handbag/etc.

2 Simple Steps:
1. Present relevant circumstances of the case
2. Present reasons why it’s important for the other person to let you do what you’re asking
How to Document/Justify Medical Necessity

• Justifying medical necessity involves describing how the counselor/clinician’s case formulation informs a patient’s specific treatment, including the ASAM level of care.

• Tell the patient’s story, describing the **WHAT** and **WHY**.
  – Provide a brief summary of the case that describes:
    • History of SUD treatment
      – Substance(s) used
      – Route of administration (eg. IV use)
      – Duration
      – Frequency
      – Consequences of use
      – Readiness to change
    • Co-occurring physical or mental health conditions
    • Psychosocial/environmental factors
      – Relationships
      – Living situation

• Use the 6 ASAM dimensions to guide your rationale
Sample Notes

• Please see handouts* for documentation examples of the following:
  – Service Request Form
  – Progress Note
  – Treatment plan
  – Discharge/Transfer Form
  – Miscellaneous Note Options (for case management, etc)

*Focus of these examples was on the sections that are most relevant for documenting medical necessity, as opposed to demographic information.
Important Reminders Regarding Documentation

• Documentation is of *key importance* in our managed SUD care model.

• Documentation is needed not only for QI and UM purposes, but also to ensure providers get paid for the services they deliver.

• Missing signatures, incorrect documentation, or conflicting documentation (e.g., different diagnoses for same patient) will slow down processing.

• **Documentation for medical necessity must be individualized**, meaning:
  – Using the same assessment/plan/rationale for multiple patients is not appropriate or beneficial.
  – Documentation should be unique to the patient and reflect treatment based on the clinical features of the individual patient based on socio-cultural environment, the medical necessity criteria, and the resources available.
  – Treatment should be **needs-based** and patients should be treated in the **least restrictive environment** appropriate.
Important Reminders Regarding Documentation (cont’d)

- ASAM assessments/grids need to be filled out correctly and consistently to demonstrate need for services.
  - **Diagnoses** should be consistent across the ASAM assessment, Service Request Form, and other documentation.
  - **Level of care information** should be consistent across the Service Request Form, ASAM assessment, and other documentation.

- When faxing documentation:
  - **Fax one service request at a time** (do not include multiple patients in one fax)
  - **Only submit one fax**; if you have questions or want to follow up on your submission, call SAPC and **DO NOT re-fax documents to avoid duplication**
  - Include **cover sheet**
Provider Resources/Support

1. Read the Provider Manual as your primary reference for questions.

2. Consult the resources available on SAPC website:
   • FAQs
   • Checklist of Required Documentation
   • Timelines Factsheet
   • Documentation Examples

3. Call SAPC
   • *NEW* Weekly QI and UM FAQ Provider Call—Wednesdays 11:30-12:30pm. Questions submitted in advance by 5pm on Mondays to sapc-qi.um@ph.lacounty.gov. Additional details coming soon.