Service Authorization Requests:
Tips and Troubleshooting

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

QI & UM Provider Meeting: February 26, 2019
Objectives

- Identify common challenges that occur when reviewing service authorization requests
- Highlight tips for documentation submission that can facilitate review for approval
- Review documentation examples with audience input
Review: What is the QI & UM Team?

- QI & UM Team is part of the Clinical Services and Data Analytics Branch
- QI & UM Team includes licensed practitioners from a variety of disciplines, including:
  - Addiction Psychiatrists
  - Clinical Psychologists
  - Mental Health Registered Nurses
  - Registered Nurses
  - Licensed Clinical Social Workers
Multidisciplinary Clinical Team

• QI & UM staff are licensed clinicians with experience treating patients
• QI & UM serves as a “gateway” to SUD services for DMC, MHLA and other eligible patients seeking SUD services in Los Angeles County
• Every request for SUD services for all levels of care are reviewed by QI & UM staff
• QI & UM staff use their clinical experience and skills to evaluate and facilitate appropriate services for SUD patients, including confirming:
  – Patient has at least one DSM-5 SUD diagnosis
  – Patient meets medical necessity for level of care requested
Common Challenges

What are some common challenges that come up when we are reviewing authorization service requests?
Challenge #1: Missing provider staff contact information

- Remember to provide the following in the clinical contact section:
  - Staff name
  - Treating Facility Address
  - Phone number
Challenge #2: Incomplete documentation

• Submit service requests when:
  – ALL documents are included
  – ALL documents are finalized

• Remember to review the “Checklist of Required Documentation for Utilization Management” on the SAPC website
  (http://publichealth.lacounty.gov/sapc/NetworkProviders/ClinicalForms/TSSageVersion-ChecklistEligibilityVerificationServiceAuthorizations.pdf)
Challenge #3: Responding to requests for additional information

- Sometimes, we see resubmissions of the same information as before
- Remember: you have 3 business days to submit missing information once we request it
Challenge #4: Submitting authorization request for services not in agency’s contract

• Authorization requests should only be submitted for services approved in agency’s contract with SAPC
  – Ex: If you are treating a pregnant woman, make sure you are contracted to provide Perinatal PPW services before submitting an authorization request
  – If you are not sure if you are contracted to provide these services, please call your Contract Program Auditor
Why does documentation matter to QI & UM?

- Why document?
- What is considered documentation that will help justify your service authorization request?
- How should it look?
What is clinical documentation?

• “anything in the patient’s health record that describes the care provided to that patient, and its rationale. It is observational and narrative in content and is written by counselors and clinicians to analyze the process and contents of patient encounters.”
Why document?

• Ensure comprehensive and quality care

• Ensure efficient way to organize and communicate with other providers

• Protect against risk and minimize liability

• Comply with legal, regulatory, & institutional requirements

• Facilitate quality improvement & application of utilization management
Why is documentation important for QI & UM?

• Standardized documentation by counselors, clinicians, and staff helps with
  – treatment consistency
  – improves quality of care
  – success rate for approving service authorization requests
What documentation does QI & UM review?

- Service Authorization Request Form
- ASAM Assessment
- Financial Eligibility
- DSM-5 Diagnosis
- Treatment plan and future updates
- Miscellaneous Notes
- Cal-OMS admission/discharge data
- Information related to special populations (e.g. PPW, criminal justice)
- Discharge and Transfer forms
- Additional clinical documentation as needed
Why is documentation so important?

- With documentation you are **telling the story of the patient and their treatment** - Auditors, UM, Supervisors, are not in the session.

- Your choice of words influences how others “read” or interpret the patient.

- You are also **reflecting** on the work you have done with the patient and determining what the plan is moving forward.
Where does QI & UM look for medical necessity?

- ASAM Assessment
- DSM-5 Diagnosis
- Treatment plan and future updates
- Miscellaneous Notes
What goes into justifying a level of care when writing a miscellaneous note?

• Description of the level of care in which patient will receive treatment
• Other levels of care considered
• Specific reasons why level of care requested was selected
Template for level of care justification

Given the patient’s history and condition, the patient is determined to be appropriate for ___ [INSERT APPROPRIATE LEVEL OF CARE IN WHICH PATIENT WILL BE PLACED]. While the other level(s) of care of ___ [ENTER OTHER CONSIDERED LEVEL(S) OF CARE] were considered, the patient was ultimately determined to be most appropriate for ___ [ENTER LEVEL OF CARE PATIENT WAS REFERRED TO] because ___ [DESCRIBE THE SPECIFIC REASONS WHY THE REFERRED TO LEVEL OF CARE IS BEST FOR THE PATIENT, INCLUDING IF AND WHY PATIENT IS BEING STEPPED UP/DOWN LEVEL OF CARE].
Brief clinical scenario

• 32-year old single man who is unemployed and at risk of losing his housing
• 5-year history of a methamphetamine use disorder
• ASAM Assessment recommends residential treatment
Miscellaneous note justification example #1

Scenario:
• 32-year old single man who is unemployed and at risk of losing his housing
• 5-year history of a methamphetamine use disorder
• ASAM Assessment recommends residential treatment

Note:
• “The client requested residential treatment and is appropriate for these services”
Miscellaneous note justification example #2

Scenario:
• 32-year old single man who is unemployed and at risk of losing his housing
• 5-year history of a methamphetamine use disorder
• ASAM Assessment recommends residential treatment

Note:
• “The patient is at risk of relapse if they do not receive these services”
Miscellaneous note justification example #3

Scenario:
• 32-year old single man who is unemployed and at risk of losing his housing
• 5-year history of a methamphetamine use disorder
• ASAM Assessment recommends residential treatment

Note:
• “The ASAM indicates that the client needs residential treatment, but we do not provide this level of care at this site. Therefore, he is placed in outpatient services (ASAM 1.0)”
Miscellaneous note justification example #4

Scenario:
• 32-year old single man who is unemployed and at risk of losing his housing
• 5-year history of a methamphetamine use disorder
• ASAM Assessment recommends residential treatment

Note:
• “Based on the patient’s ASAM assessment and clinical history, we recommend residential services. While outpatient services were considered, residential services were most appropriate due to his high-risk of relapse in the community and his identification of several community stressors.”
Top Miscellaneous Note Challenges

• Unclear why client needs requested level of care (e.g. request for WM management but no discussion of withdrawal symptoms)

• Justification notes are not individualized to the patient

• Provider indicates that miscellaneous note not needed because information is located elsewhere (e.g. ASAM Assessment or Treatment Plan)
Documentation for treatment plans

• Treatment plans should be individualized and should include:
  – SUD-specific treatment goals
  – Address the needs identified in the clinical assessment
  – Support medical necessity for treatment
  – Have specific timeframes for goal/objective completion
Treatment Plan and Medical Necessity

• Medical Necessity on the treatment plan is determined by how the goals, problems and objectives address the areas of need identified on the ASAM, by the patient, counselor and LPHA.
• Problems and Objectives that are too broad or limited might not demonstrate the true intent of the medically necessary service.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Objective</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My life is bad because I use cocaine”</td>
<td>I want to stop using cocaine</td>
<td>Stop using cocaine</td>
<td>1 month</td>
</tr>
<tr>
<td>“I am in danger of losing my job because of my cocaine use”</td>
<td>I want to keep my job and stop using cocaine</td>
<td>Reduce cocaine use from 5 times per week to 0 times per week</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>
When updating the treatment plan:

• Review whether previous objectives are still relevant or should be closed (add date of completion)
• Provide updated goals, objectives and time frames after reviewing potential challenges:
  – Barriers
  – Motivation difficulties
  – Treatment resistance
Top challenges identified in treatment plans

- No SUD-related treatment goals
- Goals/objectives do not change at each treatment plan update
- No specific timeframes listed for goal/objective completion
- Provide no information about outcomes or progress toward meeting goals/objectives
Summary

• QI & UM supports your efforts to provide care
• Making minor adjustments to your submission routine can help to avoid authorization pitfalls
• Documentation quality can support your efforts to get your services authorized
Important SAPC Contact Information

• QI & UM general line: 626-299-3531
• Billing: 626-299-4175
• Contracts: 626-299-4532
• Netsmart Helpdesk: 1-855-346-2392
• SASH: 844-804-7500
Future CST Trainings

Clinical Standards and Training Unit is conducting a series of documentation trainings. For more information, please go to the Training section of the SAPC webpage and look for the Training Calendar at:

http://publichealth.lacounty.gov/sapc/Event/event.htm