

SAPC Provider Utilization Management Meeting

Los Angeles County Department of Public
Health

December 18th, 2024

Substance Abuse Prevention & Control



Agenda

- **Update: Processing RBH Authorizations**
- **Update: RI-CM Auth review**
- **Intercounty Transfer (ICT) Reminders**
- **Updated Contact Email for Appeal/Grievances**
- **Essential Contact Info/SAPC Referrals Process**
- **Residential Re-Authorizations for Patients Experiencing Homelessness**
- **Discussions/Questions**
- **Adjourn**

Update: Processing RBH Authorizations

- The core goal of RBH is to provide a safe living space that is supportive of recovery for clients who are receiving OP/IOP/OTP/OP-WM treatment for their SUD. RBH is available for young adults (ages 18-20) and adults (ages 21+) who are:
 1. In need of a stable, safe living environment to best support their recovery from SUD
 2. Concurrently enrolled in Initial Engagement/0.5/OP/IOP/OTP/OP-WM treatment settings.

Update: Processing RBH Authorizations

- Clients who are discharged from treatment in OP/IOP/OTP/OP-WM settings are no longer eligible to receive reimbursement for RBH. However, RBH providers may hold beds for up to seven (7) days for clients who need to leave the housing facility for reasons such as hospitalization, therapeutic pass, or return to treatment after discharging against medical advice.
- Young adult and adult PPW and Non-PPW beneficiaries may be authorized and reimbursed for 90 days, and reauthorized for three additional 90 days if needed, for a maximum stay of 360 days while they are in concurrent treatment and the RBH eligibility criteria specified above.

- The 360 days are not required to be continuous and may be used throughout a 12-month period starting from the date of initial RBH admission. Providers should continue to request for specific services (*RBH, RBH Perinatal PPW or RBH Parenting PPW*) as appropriate. SAPC would continue to review for specific information per our checklist of required documentation according to the selected Benefit Plan. Once an individual has resided in RBH for a total of 360 calendar days within the past 12 months or has met the 12-month period since the first day of RBH admission, whichever occurs first, the benefit period ends and cannot restart until 30 days after the most recent discharge date.

- Clients who are transitioning from residential treatment to RBH + OP/IOP have **seven (7) days** grace period to enroll in OP/IOP. If client failed to enroll in OP/IOP within seven days after enrolling in RBH, the RBH authorization shall start on the same day of the OP/IOP admission date. *For example: If the initial RBH was approved from 1/1/24-3/30/24 but client didn't enroll in OP until 1/9/24. The RBH authorization will be modified to 1/9/24-3/30/24.*

CM-READMISSION-AUTHS

i. Extended Absence and Readmission Throughout CM Protocol

A member shall be considered a readmission if they leave CM services for more than 30 days. At readmission, the member shall have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.7) and confirm the member meets the medical necessity criteria for CM. If the member has remained engaged in other services, such as residential treatment, during their absence from CM, an update to the most recent ASAM assessment is sufficient, and the member does not require a new diagnostic assessment. Based on the assessment, a provider may offer other treatments as alternatives to CM if there is strong clinical evidence that CM is unlikely to produce the intended results. However, if the determination from the new assessment is that CM is an appropriate course of treatment for that member, the member may receive CM services and the incentive structure would restart at Week 1. If the member resumes CM services, they may earn incentives starting at the Week 1 scheduled incentive amount up to a maximum of \$599 per year inclusive of all incentives earned that year, including previous Recovery Incentives Program participation.



InterCounty Transfers (ICT):
Medi-Cal (MC) transfer of benefits from one county to their new county of residence ensuring no interruption or overlap of MC benefits



Are you struggling with processing InterCounty Transfers (ICT)?

Contact Nancy (ncrosby@ph.lacounty.gov) for help!

- A training is available including:
 - How to complete a Medi-Cal ICT for a new admission
 - Selection of Guarantor
 - Documentation supporting transfer to Los Angeles County effective date
 - Change Report Summary
 - Notice of Action
 - Electronic methods of verification of Residency
 - What is available to providers vs SAPC
 - [BenefitsCal](#)
 - When it can and cannot be used
 - Department of Health Care Services (DHCS) Information Notices pertaining to ICT

What is an ICT?

Medi-Cal transfer of benefits that allows uninterrupted coverage as the beneficiary moves from one County to their new County of Residence within California.

*For step-by-step instructions on updating Financial Eligibility in Sage for ICT process, visit:

<http://publichealth.lacounty.gov/sapc/NetworkProviders/FinanceForms/FinancialEligibility/DocumentingChangesFinancialEligibilityStatus.pdf>



ICT through Benefits CAL

Agency
&
Patient

- If coming from a County that is available in [BenefitsCal](#), assist patient with creating an account, change the patient address to LAC
- Agency writes a Miscellaneous Note for the steps taken

DPSS

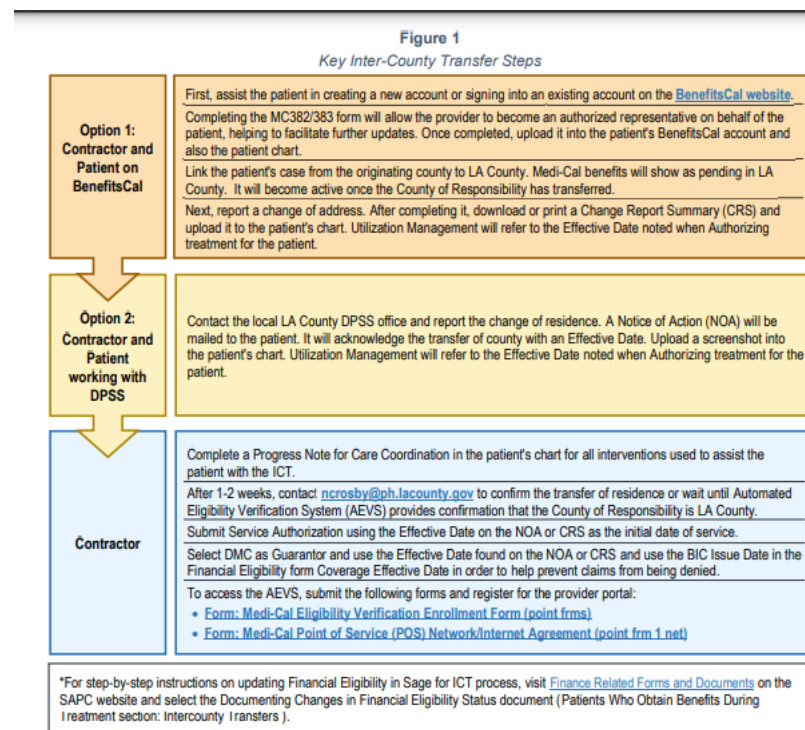
- Once DPSS processes this change (approximately 1-7 days) a Change Report Summary will be uploaded to the patient's [BenefitsCal](#) account including a benefit Effective Date

Agency

- Agency screenshots the Change Report Summary and uploads to patient chart under Attachments and writes a MISC note for steps taken, updates FE, and bills for Care Coordination
- Take note of ELIGIBILITY Date and submit Treatment Authorization (they will be approved starting on the date the patients benefit became active in LAC)

[BenefitsCal](#) link

- ALL COUNTIES are currently in benefitscal. Please review Figure 1 (page 16 of Provider Manual 9.0)



For individuals seeking care who are eligible for Medi-Cal but whose benefits are not active at the time of assessment and intake, SAPC providers should enroll eligible patients in Medi-Cal and/or applicable financial eligibility programs. **Eligible individuals may NOT be denied services pending the establishment of Medi-Cal participation. Sliding scale fees or flat fees are not allowable for Medi-Cal-eligible patients or those who qualify for applicable County-funded programs.**



Updated Contact Email for Appeal/Grievances



sapc_appeal@ph.lacounty.gov





Manuals & Guides	Bulletins	Clinical	Beneficiary	Contracts & Compliance	Finance	CRLA
------------------	-----------	----------	--------------------	------------------------	---------	------

Beneficiary

Subject	Date
Appeal Form <i>(Updated - October 2024)</i>	 10/31/24
Complaint and Grievance Form <i>(Updated - October 2024)</i>	 10/31/24

Email: sapc_appeal@ph.lacounty.gov	Mail: Substance Abuse Prevention and Control, Contracts and Compliance Branch, 1000 South Fremont Avenue, Building A9 East, 3rd floor, Box 34, Alhambra, California 91803
Phone: (626) 299-4532	
Fax: (626) 458-6692	
If you need this form in alternate format (e.g., large print, braille, or audio), call 888-742-7900 press 7.	

Essential Contact Info

- For a specific authorization question, contact the care manager named in SAGE
- UM General number: **(626) 299-3531** and email: SAPC.QI.UM@ph.lacounty.gov
- Netsmart Helpdesk for SAGE technical problems/questions: **(855) 346-2392**
- To file an appeal: sapc_appeal@ph.lacounty.gov
 - Grievance and Appeal Follow-Up: **(626) 293-2846/** sapc.qi.um@ph.lacounty.gov
 - The Grievance and Appeal Follow-Up Phone Number is for providers or patients who have questions or concerns after receiving a Grievance and Appeals (G&A) Resolution Letter

UNIT/BRANCH/CONTACT	EMAIL/Phone Number	Description of when to contact
Sage Help Desk	Phone Number: (855) 346-2392 ServiceNow Portal: https://netsmart.service-now.com/plexussupport	All Sage related questions, including billing, denials, medical record modifications, system errors, and technical assistance
Sage Management Branch (SMB)	SAGE@ph.lacounty.gov	Sage process, workflows, general questions about Sage forms and usage
QI and UM	SAPC.QI.UM@ph.lacounty.gov UM (626)299-3531- (No Protected Health Information PHI)	All authorizations related questions, Questions about specific patient/auth, questions for the office of the Medical Director , medical necessity, secondary EHR form approval
Systems of Care	SAPC_ASOC@ph.lacounty.gov	Questions about policy, the provider manual, bulletins, and special populations (youth, PPW, criminal justice, homeless)
Contracts	SAPCMonitoring@ph.lacounty.gov	Questions about general contract, appeals, complaints, grievances and/or adverse events. Agency specific contract questions should be directed to the agency CPA if known.
Strategic and Network Development	SUDTransformation@ph.lacounty.gov	DHCS policy, DMC-ODS general questions, SBAT
Clinical Standards and Training (CST)	SAPC.cst@ph.lacounty.gov	Clinical training questions, documentation guidelines, requests for trainings
Phone Number to file an appeal	(626) 299-4532	
Grievance and Appeals (G&A)	(626)293-2846	Providers or patients who have questions or concerns after receiving a Grievance and Appeals Resolution Letter or follow up with an appeal.
CalOMS	HODA_CalOMS@ph.lacounty.gov	CalOMS Questions
Finance Related Topics	SAPC-Finance@ph.lacounty.gov (626) 293-2630	For questions regarding Finance related topics that are not related to billing issues
Out of County Provider	Nancy Crosby (ncrosby@ph.lacounty.gov)	Out of county provider requesting assistance in submitting authorization for LA County beneficiary & resident Intercounty Transfer / Medi-cal eligibility (MEDS- acceptable aid codes) / Applying for Medi-cal general questions
SASH	(844) 804-7500	Patients calls requesting for service

Residential Treatment for Patients Experiencing Homelessness (reminder)

- SAPC criteria for approval of authorization requests for continued residential admissions for patients experiencing homelessness who do not have a place to stay includes the following:
 - The patient’s homelessness status is appropriately documented in CalOMS, on a current problem list finalized/signed by an LPHA (required every 30 days) and documented within the clinical record.
 - The patient agrees to ongoing residential admission and treatment.
 - The provider has documented their efforts to establish a post-discharge housing plan for the patient.
 - The above is documented within a Miscellaneous Note/Progress Note that is submitted alongside the request for residential level of care reauthorization.

Discussions/Questions



“The opposite of addiction is not sobriety; the opposite of addiction is **connection.”**

- Johann Hari