Substance Use Disorder Information System

Communication Release

9/23/2022

Recovery Monitoring & Recovery Prevention State Denials

SAPC recently became aware of an issue with Recovery Monitoring and Recovery Prevention services being denied by DHCS for services conducted on or after 1/1/2022. This issue is due to the T1012 code being deactivated by DHCS as of 1/1/2022. Guidance from the State had indicated T1012 being deactivated for Substance Abuse Assistance, however, the code was also previously identified by DHCS as being the code to use for Recovery Monitoring. Although providers utilize H0038-R and H0038-P for these two services, SAPC was cross-walking those codes to T1012 per State guidance. As of last week, DHCS notified counties that the T1012 code cannot be used for Recovery Monitoring in addition to Substance Abuse Assistance. SAPC will update the configuration in Sage for H0038-R and H0038-P to avoid future State denials. In the meantime, if agencies have received State denials for these two codes for services delivered on or after 1/1/2022, please wait to resubmit the services until SAPC indicates this issue is resolved. An announcement will be sent to providers when this has been resolved and denials can be resubmitted.

InterCounty Transfers and DPSS Contact Information

Providers are encouraged to contact the local DPSS offices at the numbers below to receive assistance with resolving any eligibility or InterCounty Transfer (ICT) related issues. According to DPSS, it can take a few days to update the county of residence from the time a DPSS office is called to initiate the ICT, which will update the eligibility information at the State.

In situations where the MEDS file or other eligibility verification indicates a patient is ineligible during a given month based on either an aid code or eligibility status, or county code, providers should contact DPSS directly to identify the specific reason a patient was deemed ineligible or begin the ICT process. SAPC does not have any information on what triggered the patient's ineligibility or how to resolve the issue as that is managed entirely by DPSS and Medi-Cal. The DPSS Customer Service Center, is the most appropriate resource to identify issues related to eligibility, can be reached at the following phone numbers:

Toll Free: (866) 613-3777
Local Numbers:
(310) 258-7400
(626) 569-1399
(818) 701-8200

If providers are working on their State denials related to CO 177 and related eligibility codes, where the reason for ineligibility is not fully understood, DPSS might be able to assist with understanding the eligibility status at the time of service; especially for older denials.

Additionally, in an effort to better understand the barriers that providers continue to experience in processing InterCounty Transfers under DMC, SAPC is requesting that providers who are having challenges or complex ICT cases e-mail Nancy Crosby at ncrosby@ph.lacounty.gov and share the nature of the issue by providing the following information:

- Name of Agency
- Contact Person
- Description of the challenge or complexity

- Length of time without transfer
- Any remedies that have been or could be helpful

SAPC will use this information to help identify strategies for resolving the overall ICT issue. Providers **must** use secured email when sending PHI via email. Unsecured emails containing PHI will be deleted immediately.

Community Based Organization Designation for BenefitsCal

SAPC aims to clarify what it means to be a Community Based Organization (CBO) within BenefitsCal. When providers sign up for CBO access, it will allow the provider to submit and track benefits applications on behalf of the patient they assisted with applying. This can be very helpful if providers are following up on an application as they can log in as the CBO and check the status of any of the applications without the patient present.

Additionally, a CBO can assist a patient with changing their address within BenefitsCal to an LA county address if necessary. When changing an address within BenefitsCal, there is a mailing address and a county of residence field. Both fields must be changed to LA County. Please note that this is only when updating an address, this does NOT initiate an Intercounty Transfer. Patients **must** contact DPSS, with or without the provider, to request an ICT from the old county to the new county. At which point, providers can print the Change Summary Report to show that the address is now an LA county address.

Providers can only access patient accounts in counties that are enrolled in BenefitsCal. Most counties in CA are utilizing BenefitsCal at this time, however, counties such as Orange and Ventura have not yet been enrolled but are expected to by 2023. Please contact LA County DPSS directly to assist patients whose benefits are assigned to those counties not using BenefitsCal, using the contact information provided in this communication or in-person with the patient present.

Providers are encouraged to apply for CBO status within the BenefitsCal website to assist their patients with benefits application and status updates.

Submitting Authorizations for Pending Merge Cases

SAPC and Netsmart are continuing to work the merge case backlog and expect all older merge cases to be completed within the next few months. However, if an authorization is needed prior to the merge being processed, providers can follow these steps:

1. Identify the Source ID (Record that will no longer exist after the merge) and Target ID (Correct record that will remain)
2. Ensure all required documentation is present on the Target ID that is needed by UM to review the case
    a. Comprehensive ASAM Assessment, and ASAM Summary Report, which may need to be printed from the Source and attached to the Target
        i. If printing the ASAM Assessment, please ensure the LPHA has signed and dated the printed copy if the ASAM Assessment form in Sage is missing or not finalized by the LPHA.
    b. Diagnosis
    c. Financial Eligibility
    d. Miscellaneous Assessment, Medical Justification, and/or Treatment Plan Review/Update notes
    e. Problem List or Treatment Plan related as needed for reauthorization
    f. Clinical Contact
3. If all the above documentation is present on the Target ID, then providers can submit the Service Authorization while waiting for the merge to process.
    a. Once the merge has been processed, the documentation and attachments will still be on the Target ID as entered.

UM can only process authorizations where all the required documentation is on the same ID as the authorization.

Merge Case Next Steps

Currently, the Sage Help Desk resolves approximately 100-200 backlog merge cases per week. Once a case is merged, providers will be notified via the Help Desk ticket in the portal. Providers will not receive a call if the ticket was created over the phone. Please make sure you have access to the online portal to receive the notifications. To view the instructions for accessing the online portal, click the following link: Sage Help Desk Service Now Portal.

Once the case is resolved and communicated to the person who reported the merge, please verify the new record is accurate and your agency continues to have access to the record, including all previously documented notes, forms, and attachments under the new PATID.

Providers should communicate the new PATID to their staff who are associated with the patient and ensure that the new PATID is used for all future documentation and billing. If staff typically search for a patient using the PATID, they will no longer see the old PATID in the system and may attempt to create a new patient. It is very important to communicate the correct ID to use and to always call the Help Desk first if there are any issues finding a patient.

Please also refer all staff who admit patients into Sage to review the Provider Meeting presentation for 09/06/2022, starting on slide 27, which reviews the admission process in Sage to avoid future duplicate cases.

Documentation for Care Coordination is Disallowed for Fiscal Years Prior to 22-23

This notice serves to reiterate that documentation time for care coordination is not allowable for fiscal years prior to and including FY 21-22, per SUD Treatment Services Provider Manuals versions 4.0 and 6.0. This aligns with previous SAPC guidance stating documentation time for care coordination, formerly case management, was not allowable for reimbursement.

For FY 22-23, care coordination is a reimbursable service to allow providers to claim time required to document in Sage(SAPC IN 22-13). DHCS stipulates that documentation of the activity must be included in a Progress Note or Miscellaneous Note.

> Service-Based LOC: For ASAM 1.0 and 2.1, up to 10-minutes of documentation time per patient for group services using 1-minute increments and up to 15-minutes for individual services in 15-minute increments. This includes care coordination, Peer Support Services and Recovery Services.
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> Day Rate-Based LOC: For ASAM 3.1, 3.3, 3.5, 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM, SAPC incorporated the cost of documentation into the daily rate. Separate claim submissions are not permitted. Daily or per service notes are now required for these levels of care; the weekly note allowance has been discontinued effective July 1, 2022

KPI FY 22-23 Data Issues

SAPC has been notified that several providers are unable to view non-telehealth services despite receiving EOBs and payments. SAPC is working with the Netsmart KPI team to resolve this issue as quickly as possible. At this time to verify the claim status of services you may use the Treatment page in Sage, the provider billing reports in Sage, EOBs provided by SAPC, and/or 835s (Secondary Sage Users only). We apologize for the inconvenience and will notify the network when the issue is resolved.