COUNTY OF SAN MATEO
HEALTH SYSTEM

Behavioral Health & Recovery Services

Alcohol and Other Drug Services
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BHRS AOD Information Notice: 2018-05

Date: August 17, 2018

To: SUD Treatment Providers

From: Diana Hill, AOD Manager

Subject: Use of Avatar Service Code AD58 Room and Board

Purpose

This Information Notice is to inform Residential SUD treatment contracted providers of the appropriate use of service code AD58 Room and Board.

Background

On January 4, 2018 DHCS issued MHSUDS Information Notice 18-001, Drug Medi-Cal Organized Delivery System Residential Reimbursement. Per this MHSUDS Information Notice, "in order for residential treatment to be reimbursed on a daily basis, the service provided must include a required service activity on the date of billing. The components of residential treatment are established in the DMC-ODS Waiver special terms and conditions (STC), Section 134. Including:

- Intake
- Individual
- Group Counseling
- Patient Education
- Family Therapy
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment
- Discharge Services."

Provider Requirements

When a Residential Treatment Provider uses an ODS Residential Service Code (AD312ODS, AD332 ODS, or AD352ODS) in Avatar, the provider is certifying that one of the above service activities was provided to the client on that day. The service activity shall be appropriately documented in the client's chart.

If a client did not receive one of the above service activities on a given day, but was present in the facility, a residential treatment service shall not be claimed to DMC for that day. However, the provider is still able to claim room and board costs for that client and that day. In order to claim room and board costs only for a given day in Avatar, the Residential treatment provider shall use service code AD58 Room and Board.

If you have any questions about this Information Notice, please contact your assigned AOD Program Analyst.

cc: Clara Boyden, AOD Administrator
Doreen Avery, Financial Services Manager II, MIS
Nancy Ferreira, Patient Services Specialist, MIS
BHRS AOD Program Analysts and Supervisors

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Date: November 28, 2018

To: SUD Treatment Providers

From: Diana Hill, AOD Manager

Subject: Updated Avatar Financial Registration Form and Provider Client Census Report

At the Avatar User Group Meeting on 11/26/18, provider attendees were given the updated version of the Avatar Financial Registration Form, commonly referred to as the ARF. **The updated ARF shall be used for all new admissions beginning December 1, 2018.** It is also attached to this letter.

The sections that have been updated are the Eligible Treatment Funding Sources and Recovery Residence (RR) Funding Sources. In the older version of the ARF, the SAPT/COUNTY was combined. If a client was eligible for either SAPT or County funding, providers were to select this funding source.

In the updated ARF, the SAPT and County funding sources have been separated for both the Treatment funding sources and the Recovery Residence funding sources. Providers must now identify which of the two funding sources the client is eligible for. See the SAPT and County Eligibility Grid on the next page for more information.

Additionally, BHRS needs to know which of your current/active clients are SAPT vs. County funding eligible. To determine this, **on 11/30/18, all providers shall run a Census Report in Avatar and identify which of your current clients are SAPT and which are County**, for both the primary or secondary funding source. If you need assistance in running the Census Report, please contact your AOD Program Analyst. Please send the completed report via secure email to HS_BHRS_AOD-Corrections@smcgov.org or fax it to 650-573-2110 no later than 12/5/18.

SAPT and County Eligibility Grid

SAPT	**Resident of San Mateo County, and one or more of the following apply:** • Client is medically indigent/uninsured; • Client is a US citizen and is in Recovery Residence, or is in Residential Treatment and needs funding to pay for the room and board portion; • Client has ACE Health Coverage; • Client is a Medi-Cal beneficiary, but Medi-Cal won't pay for the treatment service, possibly because their Medi-Cal is pending transfer to San Mateo County or the client has already had 2 residential episodes in the past year.
County	**Resident of San Mateo County, and one or more of the following apply:** • Client is documented but not a US citizen, or is undocumented; • Client has ACE insurance but is undocumented; • Client has private health insurance, but their benefit does not cover substance use treatment services, or their benefit has been exhausted. Provider is responsible for verifying and documenting that they have billed the private health insurance and the insurance denied the claim due to one of these two reasons; • County funding is flexible and may be used to cover other incidences, but prior authorization must first be received by BHRS AOD.

BHRS SUD AVATAR
Financial Registration Form

☐ SUD ☐ FOP / MOP / DEJ

☐ Initial Request ☐ Update ☐Transfer	**Date:**	**Program:**
Client ID: *(for MIS use)*	**Avatar Program Code:**	**Program Contact & Phone No:**
Client SSN:	**Client Date of Birth:**	**Admission Date:**

Last Name:	**First Name:**	**M.I.**
Alias or other names used:	**Undocumented:** ☐ Yes ☐ No ☐ Declined to state	

Was this client pregnant in the past 60 days? ☐ Yes ☐ No

If yes, Pregnancy Start Date: _____ Pregnancy End Date: _____

Does Client have Medi-Cal? ☐ Yes ☐ No

Client's Medi-Cal Number ***(CIN Number)***: _____

Is client potentially eligible for Medi-Cal benefits? ☐ Yes ☐ No **Client referred to Medi-Cal?** ☐ Yes ☐ No

Signed Assignment of Benefits? ☐ Yes ☐ No

*****PLEASE ATTACH copy of Assignment of Benefits for Medi-Cal along with copy of card if available.**

Does Client have Medicare? ☐ Yes ☐ No **If yes, please check all that apply** ____Part A ____Part B ____Part D

What is the Client's Medicare Number (*HIC Number*): _____

Signed Assignment of Benefits? ☐ Yes ☐ No

*****PLEASE ATTACH copy of Assignment of Benefits for Medicare along with copy of card if available.**

Eligible *Treatment* Funding Sources *(check up to 2 funding sources for DMC clients)*

☐DMC ☐CalWORKS ☐SAPT ☐SAPT Perinatal ☐Criminal Justice Realignment (AB109, Unified Re-Entry or Pathways)
☐Measure A (youth) ☐BHRS Realignment (Drug Court) ☐County

***Recovery Residence (RR)* Funding Sources:** Recover Residence AVATAR Program Code:

☐CalWORKS ☐SAPT ☐SAPT Perinatal ☐Criminal Justice Realignment (AB109, Unified Re-Entry or Pathways)
☐ BHRS Realignment (Drug Court) ☐ County

Comments:

Responsible Party's Information:

Name: _____ **Phone:** _____

Relationship to Client: ☐ **Self** ☐ **Other:** _____

Address: _____ ☐ **Homeless**

City: _____ **State:** _____ **Zip Code:** _____

OHC (OTHER HEALTH INSURANCE) (Example: Kaiser, Blue Cross, United HealthCare, etc.) ☐Yes ☐No ☐Unknown

Insurance name: _____ **Policy Number:** _____

Insurance Co phone number: _____ **Group Number:** _____

Signed Assignment of Benefits? ☐ Yes ☐ No

*****PLEASE ATTACH copy of Assignment of Benefits along with copy of insurance card *(front and back)***

Email Securely to MIS/Billing Unit HS_BHRS_AOD-Corrections@smcgov.org or 650-573-2110

Updated 12/5/2018

SUD Treatment Services: Funding Source Priorities (ver. 11/15/18)

Funder By Priority	Funding Source or Coverage Name	Examples of Funders Or Coverage Type	Description	Funding Restrictions
1st priority	Other Health Coverage* **BHRS does not provide or pay for these services-please refer to OHC insurer*	Blue Shield, Aetna, Kaiser Medicare (Noridian)	Another entity has responsibility to provide and pay for these services to the individual – refer to insurer.	See Explanation of Benefits (EOB) for coverage and restrictions specific to OHC
2nd Priority	MediCal (Medicaid) Cal Medi-Connect /Dual Eligibles	SMC MediCal (HPSM) EPSDT funds individuals age 20 and under Kaiser MediCal (through HPSM) Cal Medi-Connect – also know as dual MediCal/Medicare coverage	MediCal and other public coverage for which San Mateo County BHRS AOD is responsible for providing to eligible beneficiaries. These are services in which we obtain reimbursement/federal financial participation (FFP) for providing services to beneficiaries.	Medicare shall be billed first, Medical pays what Medicare doesn't pay. Out of County Residents (OOC) are not covered. OOC must transfer MediCal to SMC/HPSM or be referred back to home county.
3rd Priority	Specialty Federal or State Funded Grants/Programs/Services	CalWORKs	Provide services to CalWORKs population transitioning from welfare to work where SUD and MH needs are employment barriers	May not supplant MediCal funding May not provide "match" for FFP draw down.
4th Priority	SAPT Block Grant	Medically Indigent SAPT Perinatal SAPT Youth Room and Board & Recovery Residences are permitted for MediCal beneficiaries while in Tx. (not comprehensive list) ACE Health Coverage okay	Designated as the funder of last resort. If MediCal or another specialty program is responsible, services shall not be paid by SAPTBG. Priorities for funding include eligible individuals who are pregnant and/or IV drug users and medically indigent.	Funds targeted to specific populations and services SAPTBG may not supplant MediCal funding May not provide "match" for FFP draw down.
5th Priority	Local funds for restricted to Specialty Services/Population specific	AB 109 - Criminal Justice/Re-entry Measure K – youth services MHSA - co-occurring disorders BH Realignment Subaccount	Local funding for services to specific populations/programs. Funds can be used as match for FFP draw down or to pay for service not reimbursed by MediCal (room & board)	May be used for match for FFP draw down.
Last Resort	County General Funds	Net County Cost County General Funds	These unrestricted local funds are our most flexible funding.	May be used for match for FFP draw down.

SUD Treatment Services: Funding Source Priorities (ver. 11/15/18)

Coverage Status	Has MediCal or Likely Eligible	Client has Medi-Cal..BUT	Uninsured/Medically Indigent	Other Health Coverage
Service Status	SUD Tx Services ARE billable & covered by Medi-Cal	Services NOT billable to Medi-Cal	No health coverage and NOT eligible for Medi-Cal	Other Health Coverage ALWAYS is provider & funder of FIRST resort
Examples	Covered Services Include: Outpatient, Intensive OP, Res Treatment, NTP/OTP, MAT services, case management, recovery services	- Out of County with M/Cal pending transfer to SMC - Provider not yet DMC Certified (Palm) - Room and Board costs - Recovery Residence	- May be undocumented - ACA eligible but has not enrolled.	When CAN SERVE those w/OHC* - ACE -does not cover SUDS. - Private benefit does not cover medically necessary SUDS or has been exhausted *must be verify and document with EOB
Fees	No fees permitted, unless benefit requires a share of costs	Sliding scale fees may apply - M/C billable service = no fee - If services not paid by M/C, such as room and board, client shall pay a portion of fees, typically through client benefits (GA, CalFresh, Disability) to pay portion of costs	Sliding scale fees apply - Client shall pay a portion of cost based on income - may include a portion of client benefits (GA, CalFresh, Disability) to pay portion of costs	Sliding scale fees apply - Client shall pay a portion of cost based on income - may include a portion of client benefits (GA, CalFresh, Disability) to pay portion of costs
SOURCE BY PRIORITY (must verify eligibility for funder and service)				
	SMC MediCal (HPSM)			
	*If Eligible – enroll ASAP	CalWORKs		
	*If M/C in another county, refer to home county OR request M/C transfer to SMC (if appropriate)	SAPT BG	SAPT BG	SAPT BG
		AB109/CJ Realignment/Re-entry	AB109/CJ Realignment/Re-entry	AB109/CJ Realignment/Re-entry
		Measure K- youth services	Measure K- youth services	Measure K- youth services
		MHSA	MHSA	MHSA
		County General Funds	County General Funds	County General Funds

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BHRS AOD Information Notice: 2018-06

Date: November 29, 2018

To: SUD Treatment Providers

From: Diana Hill, AOD Manager DH

Subject: Residential SUD Treatment 60-Day Plans and One-Time Extension Requests

Rescinds: BHRS AOD Information Notice 2018-02

Purpose

This Information Notice rescinds BHRS AOD Information Notice 2018-02.

This Information Notice is to clarify that it is the responsibility of residential SUD treatment contracted providers to submit individualized 60-Day Plans, and One-Time Extension Requests where indicated.

Background

The Department of Health Care Services (DHCS) requires counties implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot to authorize residential services, to ensure clients receive care consistent with the American Society of Addiction Medicine (ASAM) treatment criteria, and to conduct utilization management activities to evaluate the appropriateness and medical necessity of SUD treatment services. 60-Day Plans and One-Time Extension Requests are part of the County's process to meet these requirements.

On August 17, 2018, BHRS AOD issued Information Notice 2018-02, Residential SUD Treatment 60-Day Plans and One-Time Extension Requests. That IN is now rescinded and is null and void.

Provider Requirements

At the 45th day of the residential treatment stay, providers shall use the ASAM Level of Care (LOC) Reassessment Tool to reassess each client's medical necessity of continued treatment, severity rating, and level of care needs. The ASAM LOC Reassessment Tool results shall also be incorporated into the client's 60-Day Plan when the provider is requesting authorization for the client to receive residential treatment services beyond the initial 60-day authorization. The 60-Day Plan shall also include the following information:

- the client's continuing care plan post discharge (lower level of care)
- the client's housing plan post discharge (home, shelter, SLE, Recovery Residence, or another plan)
- the client's financial stability plan
- the provider's modified interventions and client's goals for up to the next 30 days. This shall show how the treatment interventions were adjusted to help the client make progress on the goals that were not reached

during the first 60 days, and how the client's goals were modified to reflect current rating severity of the ASAM LOC Reassessment Tool.

One-Time Extensions may be available to clients that were unable to make enough progress on their treatment goals to transfer to a lower level of care and allow for a client to extent their residential stay beyond the 90th day, up to 120 days. One-Time Extensions are only available to Medi-Cal beneficiaries one time per 365-day period. At the 75th day of the residential treatment stay, providers shall use the ASAM LOC Reassessment Tool to reassess each client's medical necessity of continued treatment, severity rating, and level of care needs. The ASAM LOC Reassessment Tool results shall also be incorporated into the client's One-Time Extension when the provider is requesting authorization for the client to receive residential treatment services beyond the 90th day. The One-Time Extension request shall also include the following information:

- the client's continuing care plan post discharge (lower level of care)
- the client's housing plan post discharge (home, shelter, SLE, Recovery Residence, or another plan)
- the client's financial stability plan
- the provider's modified interventions and client's goals for up to the next 30 days. This shall show how the treatment interventions were adjusted to help the client make progress on the goals that were not reached during the first 90 days, and how the client's goals were modified to reflect current rating severity of the ASAM LOC Reassessment Tool.

The following documents shall be submitted by the residential provider to the RTX Team in accordance to the timeline specified below when submitting a 60-Day Plan and requesting a One-Time Extension for a client. ASAM Level of Care (LOC) Reassessment Tools are required with both the 60-Day Plan and the One-Time Extension Request.

Documents	Due Date
60 Day Plan and ASAM LOC Reassessment Tool	45-50 days after client's admission date
One-Time Extension Request and ASAM LOC Reassessment Tool	75-80 days after client's admission date

Submission of One-Time Extension Requests or 60-Day Plans after the current authorization has expired will result in denial of authorization for the period between the expiration date and date of BHRS AOD approval of the One-Time Extension or 60-Day Plan. If the One-Time Extension or 60-Day Plan does not indicate medical necessity criteria was met, it will be denied. Expired authorizations and denied authorizations are not eligible for Drug Medi-Cal (DMC) or BHRS payments. The residential provider shall be responsible for

covering the cost of unauthorized or denied services. The residential provider shall not request the beneficiary or client to pay for services that were unauthorized or denied by BHRS due to the provider's failure to submit the required documents in accordance with the specified timelines.

For example:

A residential service authorization expires on the 15th of the month, but the 60-Day Plan or One-Time Extension was due on the 1st. The provider submits the 60-Day Plan or One-Time Extension on the 19th of the month, and the RTX case manager approves it on the 20th. The provider is financially responsible for the cost of services from the 16th of the month through the 19th.

A residential service authorization expires on the 15th of the month, but the 60-Day Plan or One-Time Extension was due on the 1st. The provider submits the 60-Day Plan or One-Time Extension on the 19th of the month, and the RTX case manager denies it (due to not meeting medical necessity criteria) on the 20th. The provider is financially responsible for the cost of services from the 16th forward to the end of the residential stay.

If you have any questions about this Information Notice, please contact your assigned AOD Program Analyst.

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