L.A. Care Direct Network

L.A. Care HEALTH PLAN®
For All of L.A.

Operational Changes Effective November 2022
for Prior Authorization and Care Management

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY
SINCE 1997

October 17, 2022

Welcome

Training Objectives:

- Identify what's changing and what's not changing.
- Review the updated prior authorization form and submission process.
- Refresher on checking eligibility and finding network providers.
- Review updated tools and resources on the www.lacare.org website.

What is Changing with L.A. Care?

- As of November 1, 2022, L.A. Care Health will no longer use a third party to process certain authorizations or to conduct case management (CM) activities for members assigned to the L.A. Care Direct Network.
- L.A. Care staff will perform the utilization management (UM) and care management (CM) functions for Direct Network members.
- Authorization requests must be submitted by fax or phone. The iExchange platform will no longer be available for electronic submission. Status tracking of L.A. Care authorizations in iExchange will be available until December 31, 2022.
- We will issue an updated, simpler prior authorization request form that providers must use starting November 1, 2022.

What is Not Changing?

- Validity of authorizations issued prior to and/or with end dates after November 1, 2022. ***Providers are still obligated to confirm member's eligibility status for the dates of service.***
- Phone and fax numbers for L.A. Care UM, CM, Customer Service, Provider Account Management.
- Case management referral forms.
- Prior authorization requirements or turnaround times.
- Primary Care Physician (PCP) assignments or membership within the Direct Network.
- Participating network of specialty, hospital and ancillary providers.
- L.A. Care policies for UM, CM and Claims.
- UM and CM process for members assigned to other networks or other delegated providers/vendors.

When and How Will the Termination Happen?

Case Management Overview

- The following key activities and dates are part of the transition and termination for ambulatory Case Management (CM).
  - In August 2022, L.A. Care started handling new member referrals to CM.
  - In September 2022, high risk and complex members began transitioning to L.A. Care CM staff.
    - Receipt and review of CM packets that include assessments, care plans, interdisciplinary care team documents.
    - Conducting warm hand-off case conferences to discuss members' active and pending care plan activities.
    - Informing members via outreach calls and letters.
    - Primary Care Physician notification of the new CM staff assignment.
  - Moderate/low acuity members evaluated on case-by-case basis for graduation or transition to L.A. Care CM staff.
  - All CM transitions to L.A. Care to finish by November 1, 2022.
- CM referrals https://www.lacare.org/sites/default/files/la3001_cm_referral_form_202008.pdf
- CM questions or phone referrals 1-844-200-0104.

When and How Will the Termination Happen?

General UM Changes

- L.A. Care staff will perform the UM functions starting November 1, 2022.
- L.A. Care hired and trained additional staff to handle intake, clinical review, notifications and phone calls over the past 6 months.
- As of November 1, 2022 iExchange will no longer be available for electronic submission of authorization requests.
- Starting on November 1, 2022, authorization requests must be submitted by fax or phone using an updated Prior Authorization Request Form which will be posted to www.lacare.org/priorauth by October 24, 2022.

When and How Will the Termination Happen?

iExchange Changes

- L.A. Care partnered with OptumHealth and Medecision from June 1, 2020 to December 31, 2022 to offer Direct Network providers an electronic option (a.k.a. iExchange) to request authorizations and to check on the status of authorizations.
- L.A. Care's contractual agreement with OptumHealth ends December 31, 2022 which also ends the use of iExchange/Medecision.
  - New provider registrations closed as of September 9, 2022.
  - After October 31, 2022 no new authorization requests can be submitted via iExchange.
  - The platform will still be available to registered providers for checking status and accessing historical authorizations until Saturday, December 31, 2022.
  - After December 31, 2022, Providers can contact L.A. Care at (844) 361-7272.
- There will not be an alternate submission and tracking option at the time of the iExchange termination. L.A. Care will provide a similar platform in the future which is currently in development.

The Authorization Process

How Can Providers Submit Authorization Requests without iExchange?

- All requests (pre-service/prior, admissions, concurrent review, retrospective) must be submitted by fax or phone.
- Please use the **newly updated** Prior Authorization Request Form located at www.lacare.org/priorauth.
  - Routine requests and post-service requests fax to 213-438-5777.
  - Urgent requests fax to 213-438-6100.
- Hospitals and Skilled Nursing Facilities should send face sheets, clinicals and discharge orders as follows for fastest processing.
  - Face sheet and admissions clinical info 877-314-4957.
  - Clinical review 213-438-5063.
  - Discharge orders 213-438-5066.
  - Hospital coversheet available https://www.lacare.org/sites/default/files/pl1304_hospital_block_fax_form_202205.pdf.
- Note that the fax numbers previously listed on Direct Network materials are still valid (213-438-5680 for prior/retro auth; 213-438-2203 for hospitals and skilled nursing). **Do not send the same request to multiple fax numbers** as it will create duplicates and slow down processing.

General Authorization Requirements

Provider must complete an Authorization Request Form before providing services that require authorization.

Please use the appropriate fax number listed on the Authorization Fax Request Form to ensure expediency.

When requesting an authorization, you must provide the information requested on the Authorization Form.

Please submit all required documentation for Medical Necessity.

Failure to follow instructions may result in delayed process of your authorization.

General Authorization Requirements

Please verify member's eligibility prior to submitting an Authorization request.

Please verify all service codes (ICD-10, CPT/HCPCS) requested on the Authorization Request Form are valid per Medi-Cal guidelines.

Obsolete CPT, ICD-10/HCPCS codes will not be authorized.

If an authorization is required, Claims will be paid according to the approved authorization codes.

Authorization Request Process – Step by Step

- Step 1 – Check member eligibility status and assignment to the Direct Network.
- Step 2 – Determine if the service requires an authorization.
- Step 3 – Confirm provider to perform services is in-network/contracted.
- Step 4 – Complete the prior authorization form.
- Step 5 – Submit completed prior authorization form with relevant clinical documentation to appropriate fax number.
- Step 6 – Wait for follow up, such as request for additional info or notification of decision.

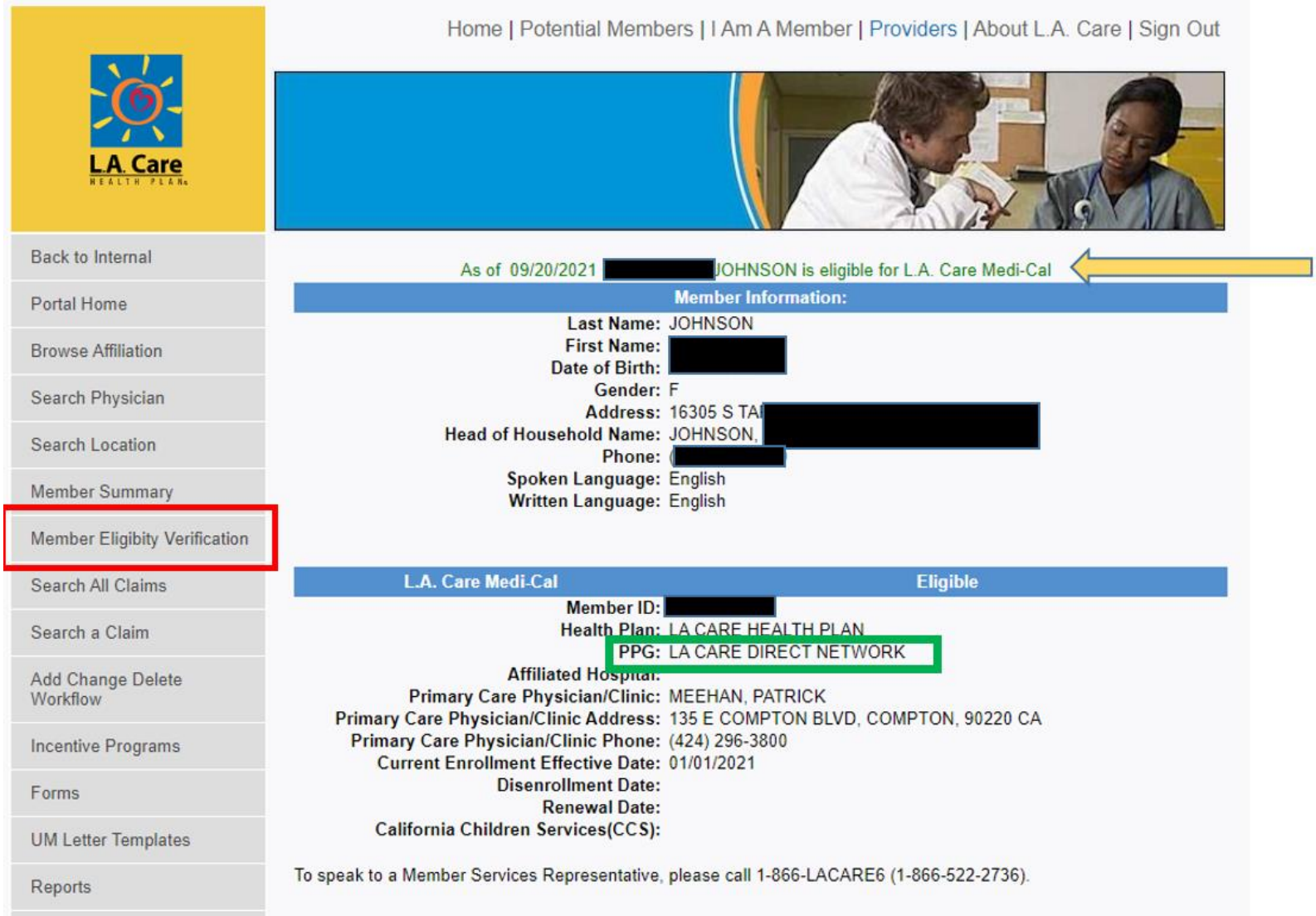
Step 1 – Check member eligibility and assignment to the Direct Network

- Option A: In our provider portal www.lacare.org.
- Option B: Via phone to the Provider Solution Center (866) 522-2736 and press 1.

*****Important Note*****

The Medi-Cal eligibility system, AEVS, **does not** provide the network assignment data. Please use one of the options listed above to identify the member's PPG/network.

Step 1 – Provider Portal Eligibility Example



Step 2- Determine if the service requires an authorization

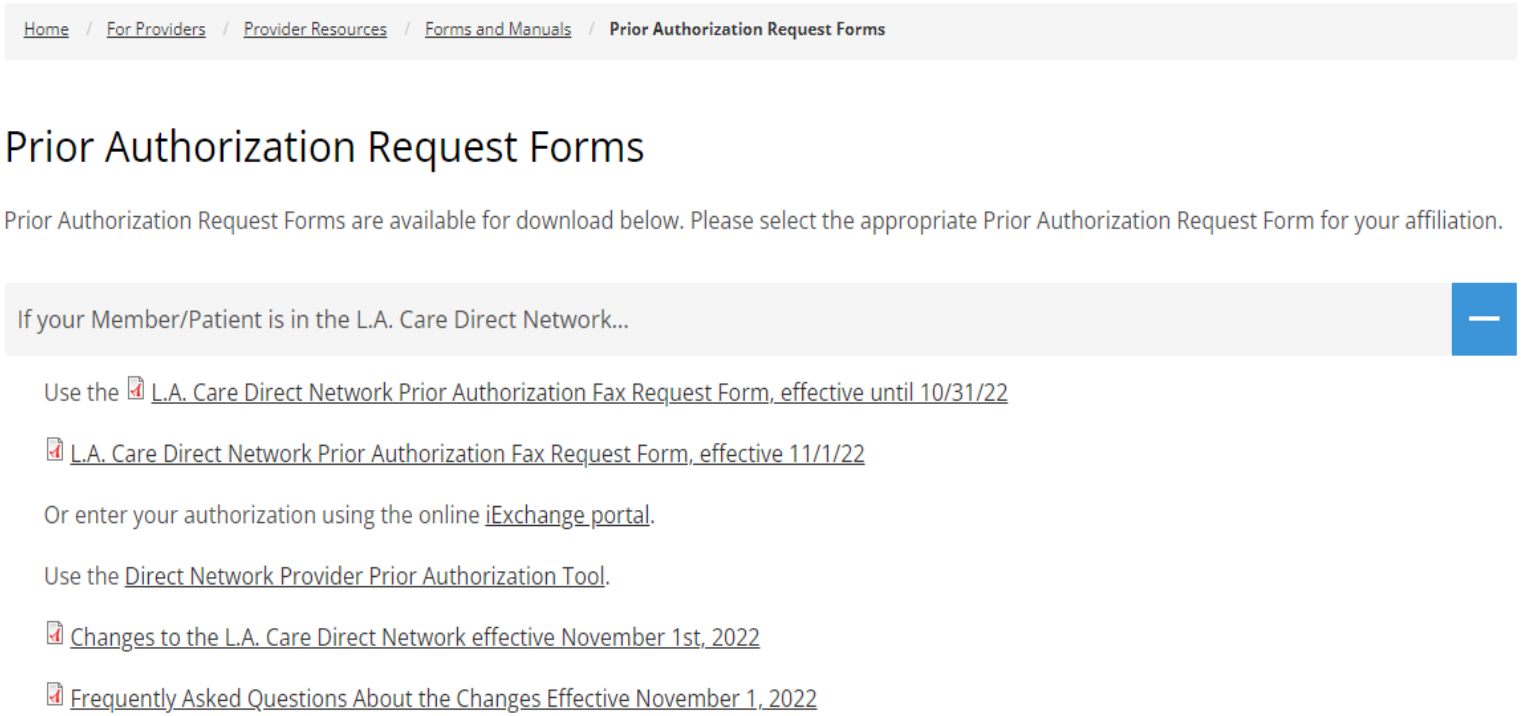
Services that ***DO NOT*** Require Prior Authorization

Note: This is not an all-inclusive list. Other restrictions may apply.

- Referral to an in-network medical specialist/provider.
- Emergency medical screening and stabilization services as allowable under applicable rules and regulations and evidence of coverage.
- Preventive health services (including immunizations, influenza, and pneumococcal vaccinations).
- Well women care (including annual cervical cancer screening, pelvic exams, and mammography screening) at intervals specified in the U.S. Preventive Services Task Force Guidelines.
- Dialysis, both in network and out of area.
- Urgent care visits.
- Routine lab services, preparations and tests: CBC, metabolic panels.
- Non-Medical Transportation (NMT).

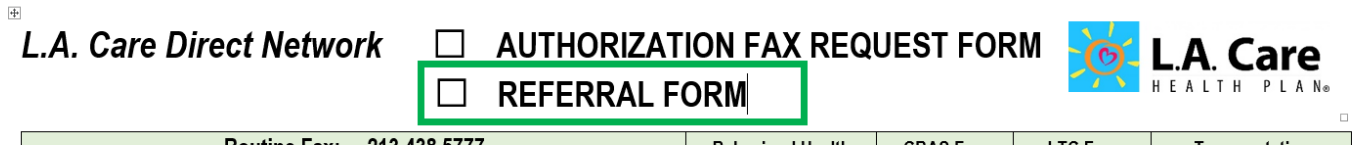
Step 2 (continued) - Determine if the service requires an authorization

- Visit www.lacare.org/priorauth to find Direct Network resources.
- Use the tool (see below) to look up services by code to determine if an authorization is required.



Step 2 (continued) - Determine if the service requires an authorization

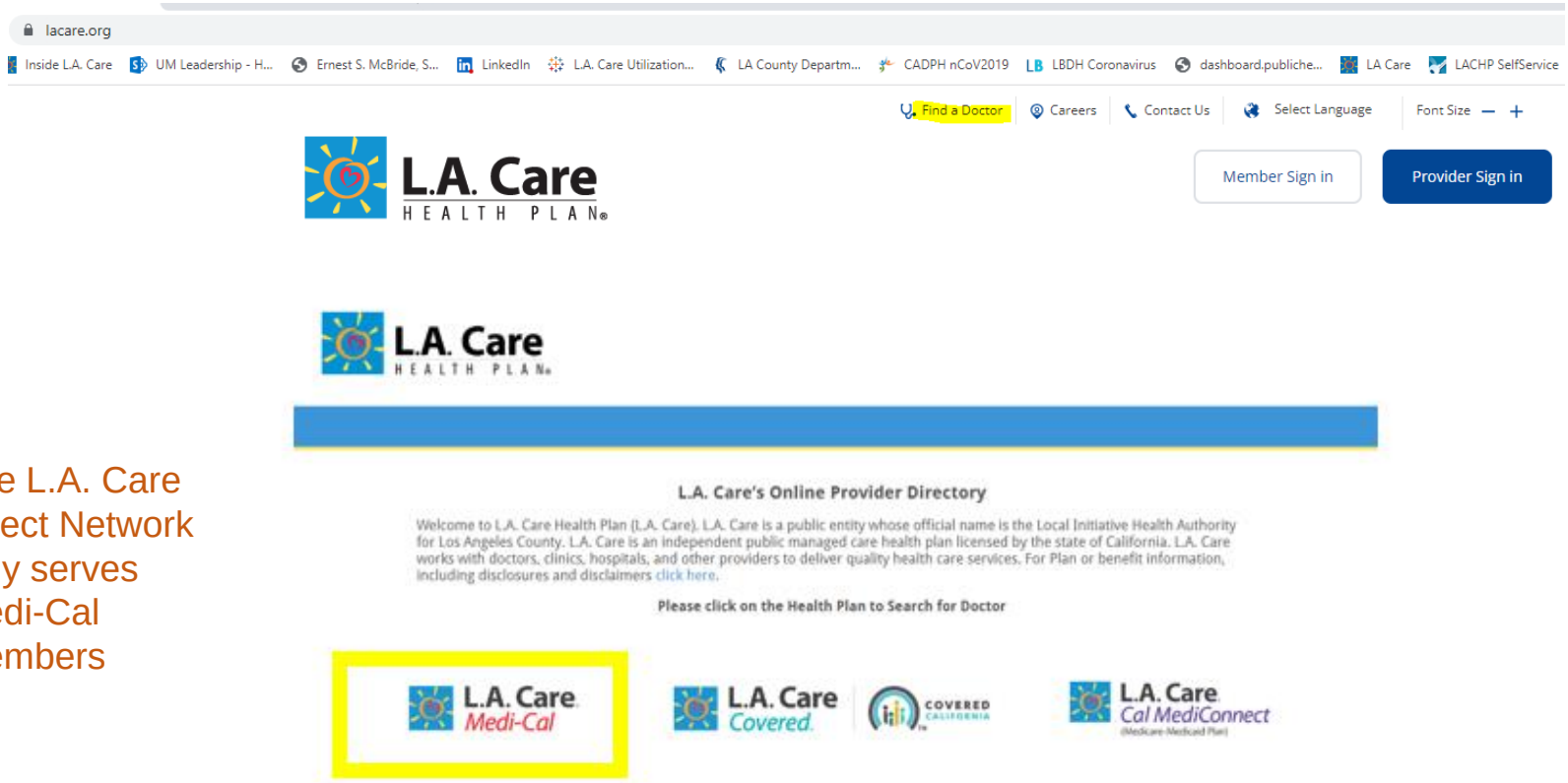
- Most out-of-network care requires prior authorization* (see Step 3 for validating network status or finding in-network providers).
- If services requested do not require prior authorization according to the look-up tool AND the provider is in-network, the member can be referred directly. The Prior Authorization form can be used to make the referral.
  - Send form with relevant clinical notes to in-network provider.
  - Give copy of form to member so they can call for scheduling.


L.A. Care Direct Network ☐ AUTHORIZATION FAX REQUEST FORM ☐ REFERRAL FORM L.A. Care HEALTH PLAN

* Excludes certain out-of-network care such as emergent/urgent, dialysis, sensitive services.

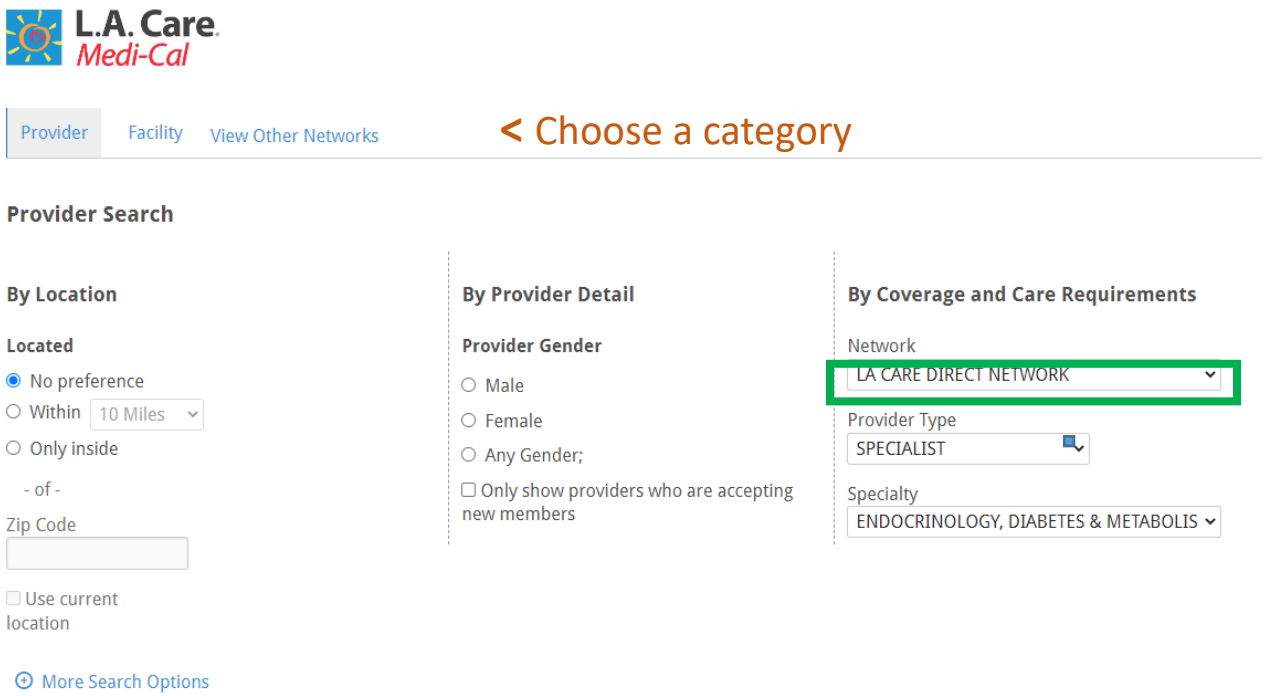
Step 3 – Confirm Provider to perform services is in-network/contracted

Our online Provider Directory is at www.lacare.org - “Find a Doctor”.



The L.A. Care Direct Network only serves Medi-Cal members

Step 3 – Confirm Provider to perform services is in-network/contracted



< Select L.A. Care Direct Network

< Choose Provider Type: Specialist, Ancillary, etc.

Reminder: Nearly all out-of-network care requires prior authorization.

Step 4 – Complete the Prior Authorization Form

- Complete all required fields in the form – fields with bold/asterisk (*.)
- Avoid common delays by providing.
  - Your fax number for follow-up, including delivering the determination notice.
  - Service codes.
  - Attached records of all relevant clinical information that demonstrates medical necessity for the specific service(s) requested.
- Please submit your authorization to the fax number associated with the type of request shown at the top of the prior authorization form. This can avoid unnecessary delays in processing.

- NOTE: Submit claims only after you receive authorization/determination to avoid claim denials and disputes.

Step 5 – Submit the Completed Prior Authorization Form

Fax numbers by category of service

Member info

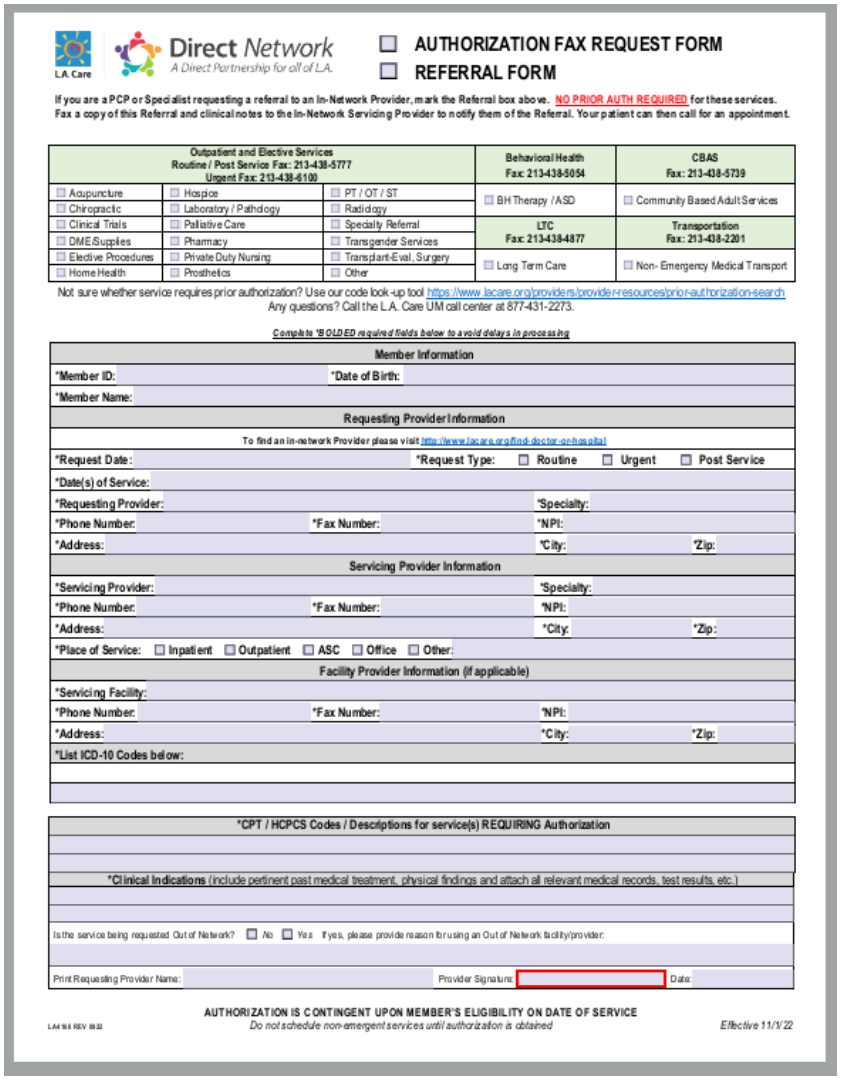
Requesting Provider info

Servicing Provider info

Diagnosis codes

Service codes

Clinical indications
attach supporting records



L.A. Care | Direct Network — A Direct Partnership for all of L.A.

☐ AUTHORIZATION FAX REQUEST FORM
☐ REFERRAL FORM

If you are a PCP or Specialist requesting a referral to an In-Network Provider, mark the Referral box above. NO PRIOR AUTH REQUIRED for these services.
Fax a copy of this Referral and clinical notes to the In-Network Servicing Provider to notify them of the Referral. Your patient can then call for an appointment.

Outpatient and Elective Services Routine / Post Service Fax: 213-438-5777 Urgent Fax: 213-438-6100			Behavioral Health Fax: 213-438-5054	CBAS Fax: 213-438-5739
☐ Acupuncture	☐ Hospice	☐ PT / OT / ST	☐ BH Therapy / ASD	☐ Community Based Adult Services
☐ Chiropractic	☐ Laboratory / Pathology	☐ Radiology		
☐ Clinical Trials	☐ Palliative Care	☐ Specialty Referral	LTC Fax: 213-438-4877	Transportation Fax: 213-438-2201
☐ DME/Supplies	☐ Pharmacy	☐ Transgender Services		
☐ Elective Procedures	☐ Private Duty Nursing	☐ Transplant-Eval, Surgery	☐ Long Term Care	☐ Non- Emergency Medical Transport
☐ Home Health	☐ Prosthetics	☐ Other		

Not sure whether service requires prior authorization? Use our code look-up tool https://www.lacare.org/providers/provider-resources/prior-authorization-search
Any questions? Call the L.A. Care UM call center at 877-431-2273.

Complete "BOLDED required fields below to avoid delays in processing

Member Information

*Member ID: | *Date of Birth:
*Member Name:

Requesting Provider Information

To find an in-network Provider please visit http://www.lacare.org/find-doctor-or-hospital

*Request Date: | *Request Type: ☐ Routine ☐ Urgent ☐ Post Service
*Date(s) of Service:
*Requesting Provider: | *Specialty:
*Phone Number: | *Fax Number: | *NPI:
*Address: | *City: | *Zip:

Servicing Provider Information

*Servicing Provider: | *Specialty:
*Phone Number: | *Fax Number: | *NPI:
*Address: | *City: | *Zip:
*Place of Service: ☐ Inpatient ☐ Outpatient ☐ ASC ☐ Office ☐ Other:

Facility Provider Information (if applicable)

*Servicing Facility:
*Phone Number: | *Fax Number: | *NPI:
*Address: | *City: | *Zip:
*List ICD-10 Codes below:

*CPT / HCPCS Codes / Descriptions for service(s) REQUIRING Authorization

*Clinical Indications (include pertinent past medical treatment, physical findings and attach all relevant medical records, test results, etc.)

Is the service being requested Out of Network? ☐ No ☐ Yes If yes, please provide reason for using an Out of Network facility/provider:

Print Requesting Provider Name: | Provider Signature: | Date:

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE
Do not schedule non-emergent services until authorization is obtained

LA-1111 REV 0122 | *Effective 11/1/22*

Step 6 – *Wait for follow up, such as request for additional info or notification of decision*

- If additional information is needed to make a decision, we will fax and/or call to request it
- Once a decision is made, provider and member notifications are sent.
  - Provider notifications are faxed (*please provide best fax number on prior authorization form!*).
  - Provider notifications are mailed to your address on file.
    - When fax attempts fail.
    - When no fax number is given or found in our provider database.
- PLEASE DO NOT call to check on status of your authorization immediately after sending

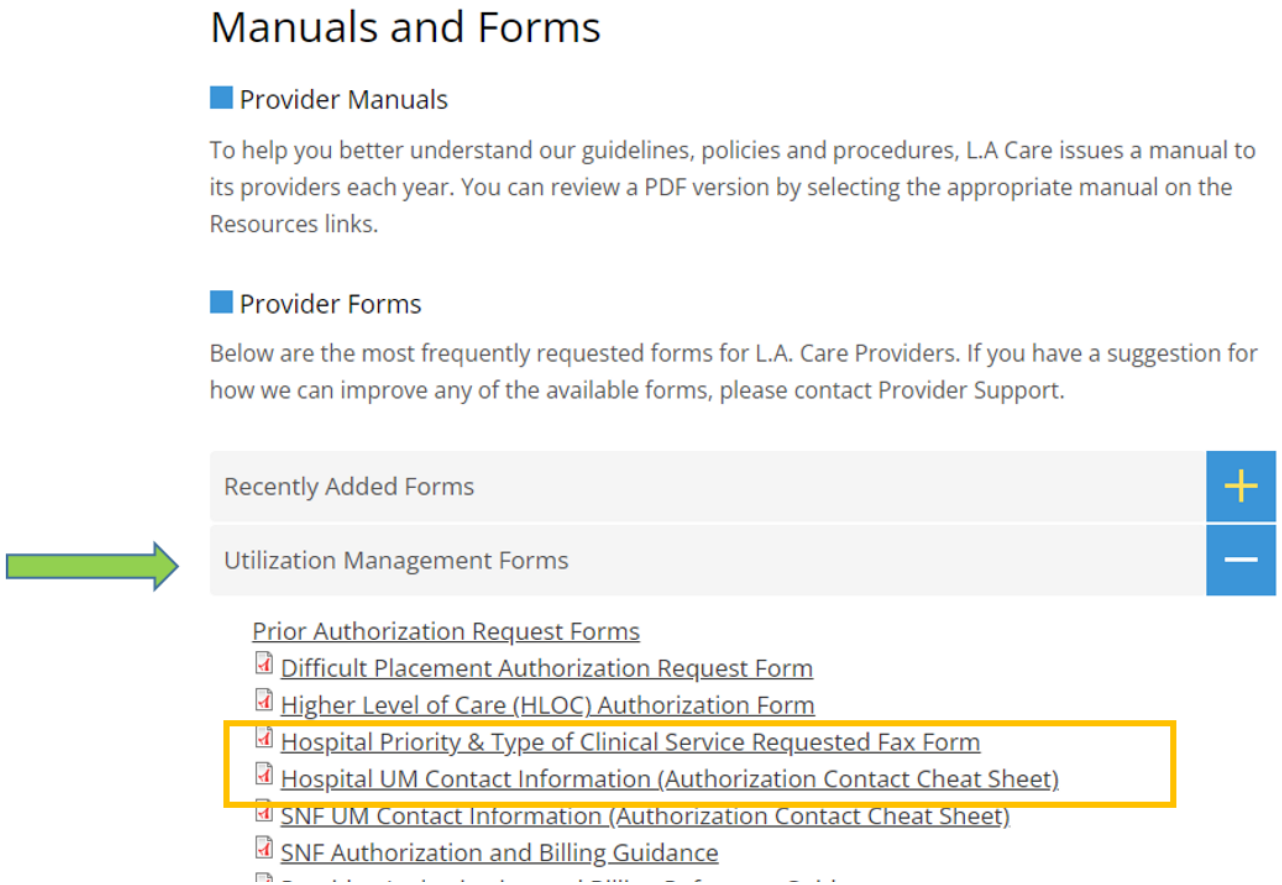
Step 6 – *Wait for follow up, such as request for additional info or notification of decision*

Medi-Cal Managed Care Review Timeframes

- **Pre-Service Routine/Standard**
  - 5 business days from receipt of the information necessary to make the decision, not to exceed 14 calendar days from receipt of the request.
- **Pre-Service Expedited / Urgent**
  - 72 hours from the receipt of the request for service.
  - An expedited authorization is justified when the routine/standard timeframe could jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.
- **Retrospective/Post-Service**
  - Within 30 calendar days of the request.
  - Service occurred without prior authorization (limits apply).

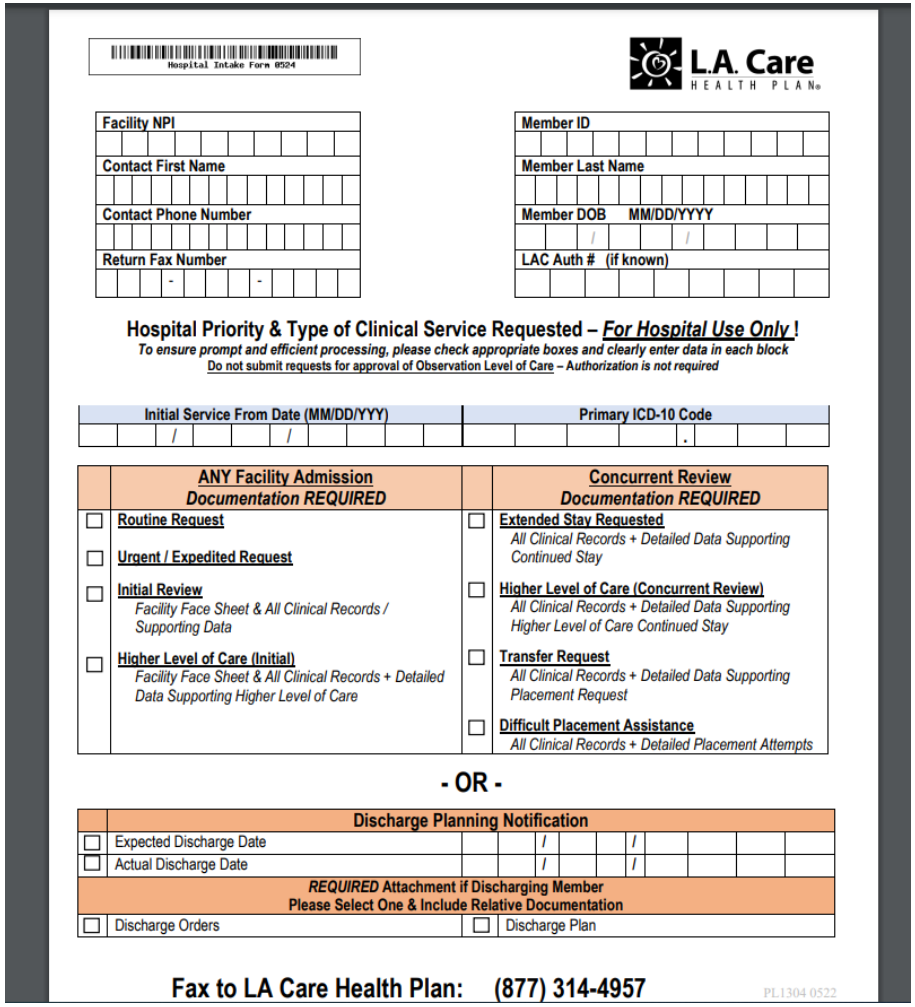
Hospital Information

- https://www.lacare.org/providers/provider-resources/forms-manuals



Hospital Coversheet

https://www.lacare.org/sites/default/files/pl1304_hospital_block_fax_form_202205.pdf



Hospital Intake Form 0524

L.A. Care HEALTH PLAN

Facility NPI	Member ID
Contact First Name	Member Last Name
Contact Phone Number	Member DOB MM/DD/YYYY
Return Fax Number	LAC Auth # (if known)

Hospital Priority & Type of Clinical Service Requested – *For Hospital Use Only* !

To ensure prompt and efficient processing, please check appropriate boxes and clearly enter data in each block

Do not submit requests for approval of Observation Level of Care – *Authorization is not required*

Initial Service From Date (MM/DD/YYY)	Primary ICD-10 Code
/ /	.

ANY Facility Admission *Documentation REQUIRED*	Concurrent Review *Documentation REQUIRED*
☐ Routine Request	☐ Extended Stay Requested *All Clinical Records + Detailed Data Supporting Continued Stay*
☐ Urgent / Expedited Request	
☐ Initial Review *Facility Face Sheet & All Clinical Records / Supporting Data*	☐ Higher Level of Care (Concurrent Review) *All Clinical Records + Detailed Data Supporting Higher Level of Care Continued Stay*
☐ Higher Level of Care (Initial) *Facility Face Sheet & All Clinical Records + Detailed Data Supporting Higher Level of Care*	☐ Transfer Request *All Clinical Records + Detailed Data Supporting Placement Request*
	☐ Difficult Placement Assistance *All Clinical Records + Detailed Placement Attempts*

- OR -

	Discharge Planning Notification	
☐	Expected Discharge Date	/ /
☐	Actual Discharge Date	/ /
	***REQUIRED* Attachment if Discharging Member** **Please Select One & Include Relative Documentation**	
☐	Discharge Orders	☐ Discharge Plan

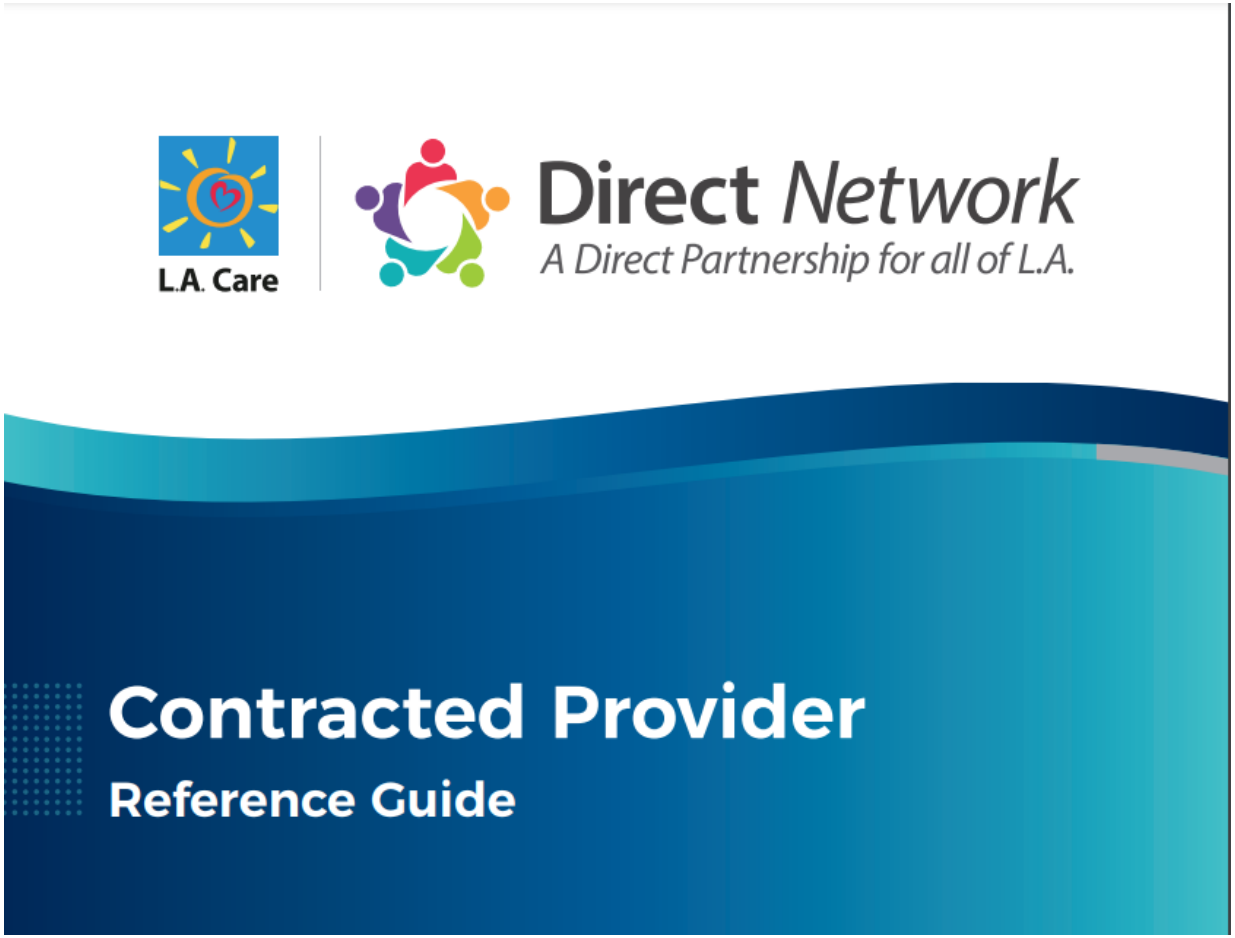
Fax to LA Care Health Plan: (877) 314-4957

PL1304 0522

Additional Resources

The Direct Network Provider Resource Guide

https://www.lacare.org/providers/provider-resources/forms-manuals



Important Contact Information

Resource	Contact Information
Ambulatory Case Management	(844) 200-0104 CMReferral@lacare.org
Customer Solution Center (Member Services)	(888) 839-9909
Direct Network – Provider Services & Information	(844) 361-7272 DirectNetwork@lacare.org
Provider Solution Center	(866) 522-2736 Option 1 for Eligibility Option 2 for Claims
Transportation - Call The Car	(626) 817-9211
Utilization Management	(844) 917-7272 Prior Authorization Request Form (lacare.org/priorauth)

Q & A