

§ 51341.1. Drug Medi-Cal Substance Use Disorder Services.

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Title 22. Social Security

Division 3. Health Care Services

Subdivision 1. California Medical Assistance Program

Chapter 3. Health Care Services

Article 4. Scope and Duration of Benefits (Refs & Annos)

EMERGENCY REGULATIONS ENACTED

JULY 1, 2014

22 CCR § 51341.1

§ 51341.1. Drug Medi-Cal Substance Use Disorder Services.

DMC BENEFICIARY ELIGIBILITY DEFINED

(a.) Substance use disorder services, as defined in this section, provided to a Medi-Cal beneficiary, shall be covered by the Medi-Cal program when determined medically necessary in accordance with Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Section 51159.

DEFINITION OF TERMS:

(b) For the purposes of this Section, the following definitions and requirements shall apply:

- (1) “Admission to treatment date” means the date of the first face-to-face treatment service, as described in Subsection (d), rendered by the provider to the beneficiary.
- (2) “Beneficiary” has the same meaning as in Section 51000.2.
- (3) “Calendar Week” means the seven (7) day period from Sunday through Saturday.
- (4) “Collateral services” means face-to-face sessions with therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
- (5) “Counselor” means any of the following:
 - (A) A “Certified AOD Counselor,” as defined in Section 13005(a)(2) of Title 9, CCR.
 - (B) A “Registrant,” as defined in Section 13005(a)(8) of Title 9, CCR.
- (6) “County” means the department authorized by the county board of supervisors to administer alcohol and substance use disorder programs, including Drug Medi-Cal substance use disorder services.
- (7) “Crisis intervention” means a face-to-face contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.
- (8) “Day care habilitative services” means outpatient counseling and rehabilitation services provided at least three (3) hours per day, three (3) days per week to persons with substance use disorder diagnoses, who are pregnant or postpartum, and/or to Early and Periodic Screening Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized in this Chapter.

(9) “Department” means the State of California Department of Health Care Services which is authorized to administer Drug Medi-Cal substance use disorder services. Whenever the Department contracts for Drug Medi-Cal substance use disorder services directly with a provider, the Department shall also assume the role and responsibilities assigned to the county under this section.

(10) “Face-to-face” means occurring in person, at a certified facility. Telephone contacts, home visits, and hospital visits shall not be considered face-to-face.

(11) “Group counseling” means face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served. Group counseling shall be conducted in a confidential setting, so that individuals not participating in the group cannot hear the comments of the group participants, therapist or counselor. A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

****Amendment SB1045 7/7/14: ODF Group Size is Minimum 2 & Maximum 12 Starting 1/1/15**

(A) For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than ten clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

(B) For day care habilitative services, group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

(12) “Individual counseling” means face-to-face contacts between a beneficiary and a therapist or counselor. Individual counseling shall be conducted in a confidential setting, so that individuals not participating in the counseling session cannot hear the comments of the beneficiary, therapist or counselor.

(13) “Intake” means the process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; the diagnosis of substance use disorders utilizing the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association; and the assessment of treatment needs to provide medically necessary treatment services by a physician. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.

(14) “Medical psychotherapy” means a type of counseling service that has the same meaning as defined in Section 10345 of Title 9, CCR.

(15) “Medication Services” means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.

(16) “Naltrexone treatment services” means an outpatient treatment service directed at serving detoxified opiate addicts who have substance use disorder diagnosis by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

(17) “Narcotic treatment program” means an outpatient service using methadone and/or levoalphacetylmethadol (LAAM), directed at stabilization and rehabilitation of persons who are opiate addicted and have a substance use disorder diagnoses. For the purposes of this section, “narcotic treatment program” does not include detoxification treatment.

(18) “Outpatient drug free treatment services” means an outpatient service directed at stabilizing and rehabilitating persons with substance use disorder diagnoses.

- (19) “Perinatal certified substance use disorder program” means a Medi-Cal certified program which provides substance use disorder services, as specified in Subsection (c)(4), to pregnant and postpartum women with substance use disorder diagnoses.
- (20) “Perinatal residential substance use disorder services program” means a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnoses. Each beneficiary shall live on the premises and shall be supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services for pregnant and postpartum women. Supervision and treatment services shall be available day and night, seven days a week.
- (21) “Physician” means a person licensed as a physician by the Medical Board of California or the Osteopathic Medical Board of California.
- (22) “Postpartum” means within the eligibility period specified in Section 50260.
- (23) “Postservic postpayment utilization review” has the same meaning as Section 51159(c).
- (24) “Provider” means the entity certified pursuant to Section 51200 to provide Drug Medi-Cal substance use disorder services to eligible beneficiaries at its certified location(s).
- (25) “Relapse” means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.
- (26) “Relapse trigger” means an event, circumstance, place or person that puts a beneficiary at risk of relapse.
- (27) “Substance use disorder diagnoses” are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association.
- (28) “Support plan” means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.
- (29) “Therapist” means any of the following:
- (A) A psychologist licensed by the California Board of Psychology.
 - (B) A clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences.
 - (C) An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences.
 - (D) A physician.
- (30) “Unit of service” means:
- (A) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services, a face-to-face contact on a calendar day.
 - (B) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with Section 10000 of Title 9, CCR.

PERINATAL PROGRAM DESCRIPTIONS

(c) Drug Medi-Cal substance use disorder services for pregnant and postpartum women:

- (1) Any of the substance use disorder services listed in Subsection (d) shall be reimbursed at enhanced perinatal rates pursuant to Section 51516.1(a)(3) only when delivered by providers who have been certified pursuant to Section 51200 to provide perinatal Medi-Cal services to pregnant and postpartum women.
- (2) Only pregnant and postpartum women are eligible to receive residential substance use disorder services.

(3) Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

(4) Perinatal services shall include:

- (A) Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792);
- (B) Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);
- (C) Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and
- (D) Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

TYPES OF DMC SERVICES PROGRAMS

(d) Drug Medi-Cal substance use disorder services shall include all of the following:

(1) Narcotic treatment program services, utilizing methadone and/or levoalphacetylmethadol (LAAM) as narcotic replacement drugs, including intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance use, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone and/or LAAM, as prescribed by a physician to alleviate the symptoms of withdrawal from opiates, rendered in accordance with the requirements set forth in Chapter 4 commencing with Section 10000 of Title 9, CCR.

(2) Outpatient drug free treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure, subject to all of the following:

(A) Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month.

(B) Individual counseling shall be limited to intake, crisis intervention, collateral services, and treatment and discharge planning.

(3) Day care habilitative services including intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure. Day care habilitative services shall be provided only to pregnant and postpartum women and/or to EPSDT-eligible beneficiaries as otherwise authorized in this Chapter. The service shall consist of regularly assigned, structured, and supervised treatment.

(4) Perinatal residential substance use disorder services including intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide and/or order these services within the scope of their practice or licensure.

(A) Perinatal residential substance use disorder services shall be provided in a residential facility licensed by the Department pursuant to Chapter 5 (commencing with Section 10500), Division 4, Title 9, CCR.

(B) Perinatal residential substance use disorder services shall be reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents [In accordance with 42 CFR Section 435.1009, Medicaid reimbursement is not allowed for individuals in facilities with a treatment capacity of more than 16 beds].

(C) Room and board shall not be reimbursable through the Medi-Cal program.

(5) Naltrexone treatment services including intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance use, body specimen screens, individual and group counseling, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure. Naltrexone treatment services shall only be provided to a beneficiary who meets all of the following conditions:

(A) Has a confirmed, documented history of opiate addiction.

(B) Is at least (18) years of age.

(C) Is opiate free.

(D) Is not pregnant.

DHCS RESPONSIBILITIES:

(e) The Department shall do all of the following:

(1) Provide administrative and fiscal oversight, monitoring, and auditing for the provision of statewide Drug Medi-Cal substance use disorder services.

(2) Ensure that utilization review is maintained through on-site postservice postpayment utilization review.

(3) Demand recovery of payment in accordance with the provisions of Subsection (m).

COUNTY RESPONSIBILITIES:

(f) The county shall do all of the following:

(1) Implement and maintain a system of fiscal disbursement and controls over the Drug Medi-Cal substance use disorder services rendered by providers delivering services within its jurisdiction pursuant to an executed provider agreement.

(2) Monitor to ensure that billing for reimbursement is within the rates established for services.

(3) Process claims for reimbursement.

PROVIDER RESPONSIBILITIES:

(g) In addition to the requirements of Section 51476 and the regulations set forth in this chapter, the provider shall:

(1) Establish, maintain, and update as necessary, an individual patient record for each beneficiary admitted to treatment and receiving services. Each beneficiary's individual patient record shall include documentation of personal information as specified in Paragraph (A) and beneficiary treatment episode information as specified in Paragraph (B) below.

(A) Documentation of personal information shall include all of the following:

- (i) Information specifying the beneficiary's identifier (i.e., name, number).
- (ii) Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, beneficiary's next of kin or emergency contact.
- (iii) For pregnant and postpartum women, medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy.

(B) Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, as specified in Subsections (b), (c), (d) and (h), including but not limited to all of the following:

- (i) Intake and admission data, including, if applicable, a physical examination.
- (ii) Treatment plans.
- (iii) Compliance with Subsection (h)(4).
- (iv) Progress notes.
- (v) Continuing services justifications.
- (vi) Laboratory test orders and results.
- (vii) Referrals.
- (viii) Counseling notes.
- (ix) Discharge plan.
- (x) Discharge summary.
- (xi) Compliance with the multiple billing requirements specified in Section 51490.1(b).
- (xii) Any other information relating to the treatment services rendered to the beneficiary.
- (xiii) Evidence of compliance with requirements for the specific treatment service as described in Subsection (d).

(2) Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:

- (A) The typed or legibly printed name and signature of the therapist(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet the therapist(s) and/or counselor(s) certify that the sign-in sheet is accurate and complete.
- (B) The date of the counseling session.
- (C) The topic of the counseling session.
- (D) The start and end time of the counseling session.
- (E) A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

(3) Provide services.

(4) Submit claims for reimbursement and maintain documentation specified in Section 51008.5 supporting good cause claims where the good cause results from provider-related delays.

PROVIDER REIMBURSEMENT UNDER DIRECTION OF PHYSICIAN :

(h) For a provider to receive reimbursement for Drug Medi-Cal substance use disorder services, those services shall be provided by or under the direction of a physician and all of the following requirements shall apply:

Admission Criteria and Medical Necessity

(1) Admission criteria and procedures.

(A) For outpatient drug free, Naltrexone treatment, day care habilitative, and perinatal residential treatment services each of the following requirements shall be met:

- (i) The provider shall develop and document procedures for the admission of beneficiaries to treatment; and

(ii) The provider shall complete a personal, medical, and substance use history for each beneficiary upon admission to treatment.

(iii) The physician shall review each beneficiary's personal, medical and substance use history within thirty (30) calendar days of the beneficiary's admission to treatment date.

(iv) Physical examination requirements

(a) If a beneficiary had a physical examination within the twelve (12) month period prior to the beneficiary's admission to treatment date, the physician shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

(b) As an alternative to complying with Paragraph (a) or in addition to complying with Paragraph (a) above, the physician, a registered nurse practitioner or a physician's assistant, may perform a physical examination of the beneficiary within thirty (30) calendar days of the beneficiary's admission to treatment date.

(c) If the physician has not reviewed the documentation of the beneficiary's physical examination as provided for in Paragraph (a) or the provider does not perform a physical examination of the beneficiary as provided for in Paragraph (b), then the provider shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met.

(v) The physician shall evaluate each beneficiary to diagnose whether the beneficiary has a substance use disorder, within thirty (30) calendar days of the beneficiary's admission to treatment date. The diagnosis shall be based on the applicable diagnostic code from the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association. The physician shall document the basis for the diagnosis in the beneficiary's individual patient record.

(vi) The physician shall determine whether substance use disorder services are medically necessary, consistent with Section 51303 within thirty (30) calendar days of each beneficiary's admission to treatment date.

Beneficiary Eligibility Requirements:

(B) In addition to the requirements of Subsection (h)(1)(A), for Naltrexone treatment services, for each beneficiary, all of the following shall apply:

(i) The provider shall confirm that the beneficiary meets all of the following conditions:

(a) Has a documented history of opiate addiction.

(b) Is at least eighteen (18) years of age.

(c) Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.

(d) Is not pregnant and is discharged from the treatment if she becomes pregnant.

(ii) The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results; and (iii) The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

(C) For narcotic treatment programs, the provider shall adhere to the admission criteria specified in Section 10270, Title 9, CCR.

Treatment Plans

(2) Treatment plan for each beneficiary.

(A) For each beneficiary admitted to outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services the provider shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process. The provider shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

(i) The initial treatment plan and updated treatment plans shall include all of the following:

- (a) A statement of problems to be addressed.
- (b) Goals to be reached which address each problem.
- (c) Action steps which will be taken by the provider, and/or beneficiary to accomplish identified goals.
- (d) Target dates for the accomplishment of action steps and goals.
- (e) A description of the services, including the type of counseling, to be provided and the frequency thereof.
- (f) The assignment of a primary therapist or counselor.
- (g) The beneficiary's diagnosis as required by Subsection (h)(1)(A)(v).
- (h) If a beneficiary has not had a physical examination within the twelve month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.

(i) If documentation of a beneficiary's physical examination, which was performed during the prior twelve months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

(ii) The provider shall ensure that the initial treatment plan meets all of the following requirements:

(a) The therapist or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date.

(b) The beneficiary shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within (30) calendar days of the admission to treatment date. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

(c) The physician shall review the initial treatment plan to determine whether the services are medically necessary. This determination shall be consistent with Section 51303. If the physician determines the services in the initial treatment plan are medically necessary, the physician shall type or legibly print their name, and sign and date the treatment plan within fifteen (15) calendar days of signature by the therapist or counselor.

(iii) The provider shall ensure that the treatment plan is reviewed and updated as described below:

(a) The therapist or counselor shall complete, type or legibly print their name, sign and date the updated treatment plan no later than ninety (90) calendar days after signing the initial treatment plan, and no later than every ninety (90) calendar days thereafter, or

when a change in problem identification or focus of treatment occurs, whichever comes first.

(b) The beneficiary shall review, approve, type or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of signature by the therapist or counselor. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

(c) The physician shall review each updated treatment plan to determine whether the services are medically necessary. This determination shall be consistent with section 51303. If the physician determines the services in the updated treatment plan are medically necessary, the physician shall type or legibly print their name and, sign and date the updated treatment plan, within fifteen (15) calendar days of signature by the therapist or counselor. If the physician has not prescribed medication, a psychologist licensed by the State of California Board of Psychology may review for medical necessity, type or legibly print their name and sign and date an updated treatment plan.

(B) For narcotic treatment programs, providers shall complete initial and updated treatment plans in accordance with the requirements specified in Section 10305, Title 9, CCR.

Progress Notes:

(3) Progress notes shall be legible and completed as follows:

(A) For outpatient drug free or Naltrexone treatment services, for each individual and group counseling session, the therapist or counselor who conducted that counseling session shall record a progress note for each beneficiary who participated in the counseling session; and type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the counseling session. Progress notes are individual narrative summaries and shall include all of the following:

(i) The topic of the session.

(ii) A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.

(iii) Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session.

(B) For day care habilitative and perinatal residential treatment services, the therapist or counselor shall record at a minimum one (1) progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions. The therapist or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. Progress notes are individual narrative summaries and shall include all of the following:

(i) A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.

(ii) A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.

(C) For narcotic treatment programs, the therapist or counselor shall record progress notes in accordance with the requirements of Section 10345, Title 9, CCR.

Minimum Beneficiary contact:

(4) Minimum provider and beneficiary contact.

(A) For outpatient drug free, day care habilitative, perinatal residential, or Naltrexone treatment services, a beneficiary shall be provided a minimum of two (2) counseling sessions per thirty (30) day period except when the physician determines that either of the following apply:

- (i) Fewer beneficiary contacts are clinically appropriate.
- (ii) The beneficiary is progressing toward treatment plan goals.

(B) Narcotic treatment program providers shall provide counseling in accordance with Section 10345, Title 9, CCR. A beneficiary shall receive a minimum of fifty (50) minutes of counseling per calendar month. Waivers of this requirement shall be in accordance with Section 10345, Title 9, CCR.

Justification for Continuing Services:

(5) Continuing services shall be justified as shown below:

(A) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services:

(i) For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the therapist or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services.

(ii) For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the physician shall determine whether continued services are medically necessary, consistent with Section 51303. The determination of medical necessity shall be documented by the physician in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

- (a) The beneficiary's personal, medical and substance use history.
- (b) Documentation of the beneficiary's most recent physical examination.
- (c) The beneficiary's progress notes and treatment plan goals.
- (d) The therapist or counselor's recommendation pursuant to Paragraph (i) above.
- (e) The beneficiary's prognosis.

(iii) If the physician determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment.

(B) For narcotic treatment program services, the review to determine continuing need for services shall be performed in accordance with Section 10410, Title 9, CCR.

Discharge from Treatment Requirements:

(6) Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. In addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Subsection (p).

(A) A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.

- (i) The discharge plan shall include, but not be limited to, all of the following:
 - (a) A description of each of the beneficiary's relapse triggers and a plan to assist the beneficiary to avoid relapse when confronted with each trigger.
 - (b) A support plan.

(ii) The discharge plan shall be prepared within thirty (30) calendar days prior to the date of the last face-to-face treatment with the beneficiary.

(iii) During the therapist or counselor's last face-to-face treatment with the beneficiary, the therapist or counselor and the beneficiary shall type or legibly print their names, sign

and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary.

(B) The provider shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

(i) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services, the provider shall complete the discharge summary within thirty (30) calendar days of the date of the provider's last face-to-face treatment contact with the beneficiary. The discharge summary shall include all of the following:

- (a) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
- (b) The reason for discharge.
- (c) A narrative summary of the treatment episode.
- (d) The beneficiary's prognosis.

(ii) For narcotic treatment program services, the discharge summary shall meet the requirements of Section 10415, Title 9, CCR.

DMC Beneficiary Benefit =Full Payment:

(7) Except where share of cost, as defined in Section 50090, is applicable, providers shall accept proof of eligibility for Drug Medi-Cal as payment in full for treatment services rendered. Providers shall not charge fees to a beneficiary for access to Drug Medi-Cal substance use disorder services or for admission to a Drug Medi-Cal treatment slot.

MAINTAIN CLIENT RECORDS:

(i) For each beneficiary, providers shall maintain all of the documentation in the beneficiary's individual patient record established pursuant to Subsection (g)(1) for a minimum of three (3) years from the date of the last face-to-face contact between the beneficiary and the provider. In addition providers shall maintain documentation that the beneficiary met the requirements for good cause specified in Section 51008.5, where the good cause results from beneficiary-related delays, for a minimum of three (3) years from the date of the last face-to-face contact. If an audit takes place during the three year period, the providers shall maintain records until the audit is completed.

REIMBURSEMENT FOR SUD SERVICES

(j) Reimbursement for Drug Medi-Cal Substance Use Disorder Services.

(1) The Department shall not reimburse a provider for services not rendered or received by a beneficiary.

(2) In order to receive and retain reimbursement for services provided to a beneficiary, the provider shall comply with the requirements listed in Subsection (i).

(3) When a beneficiary receives services from more than one provider, the Department shall reimburse only one provider for a single unit of service provided at a single certified location on a calendar day.

(4) For outpatient drug free, day care habilitative, and Naltrexone treatment services, the Department may reimburse the provider for an additional unit of service on a calendar day under either of the circumstances listed below. The additional unit of service shall be reimbursed pursuant to Section 51490.1(b) and shall be documented in the individual patient record as a separate unit of service in accordance with Subsection (h)(3).

- (A) Outpatient drug free and Naltrexone for crisis intervention or collateral services; or
- (B) Day care habilitative for crisis intervention.

(5) The Department shall reimburse a narcotic treatment program for services based on Section 51516.1. If the beneficiary receives less than a full month of services, the Department

shall prorate reimbursement to the daily rate per beneficiary, based on the annual rate per beneficiary and a 365-day year pursuant to Section 14021.51(g) of the Welfare and Institutions Code.

POST SERVICE UTILIZATION REVIEW

(k) The Department shall conduct a postservice postpayment utilization review of Drug Medi-Cal substance use disorder services. The review shall do all of the following:

- (1) Verify that the documentation requirements of Subsection (i) are met.
- (2) Verify that each beneficiary meets the admission criteria, including the use of an appropriate Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association diagnostic code, and medical necessity for services is established pursuant to Subsection (h)(1)(A)(vi).
- (3) Verify that a treatment plan exists for each beneficiary and that the provider rendered services claimed for reimbursement in accordance with the requirements set forth in Subsection (h).
- (4) Establish the basis for recovery of payments in accordance with Subsection (m).

DHCS POST SERVICE FINDINGS

(l) The Department shall base its postservice postpayment utilization review findings and the amount of provider overpayments on a sampling of beneficiary and other provider records. These records shall be provided while Department personnel are on the provider's premises conducting the postservice postpayment utilization review for that site. In determining provider compliance or the amount of provider overpayments, the Department shall not consider records provided after Department personnel have left the provider's premises.

DHCS RECOVERY OF PAYMENTS

(m) In addition to the provisions of Section 51458.1(a), the Department shall recover overpayments to providers for any of the following reasons:

- (1) For all providers who:
 - (A) Claimed reimbursement for a service not rendered.
 - (B) Claimed reimbursement for a service at an uncertified location.
 - (C) Failed to meet the requirements of Subsections (b), (c), (d), (g), (h), and (i).
 - (D) Used erroneous, incorrect, or fraudulent good cause codes and procedures specified in Sections 51008 and 51008.5.
 - (E) Used erroneous, incorrect, or fraudulent multiple billing codes and certification processes specified in Section 51490.1(b).
- (2) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services if the provider received reimbursement in excess of the limits set forth in Section 51516.1(a).
- (3) For narcotic treatment programs, because the provider failed to meet any of the following:
 - (A) The admission criteria time frames specified in Section 10270, Title 9, CCR.
 - (B) The time frames for treatment plan completion and for review specified in Section 10305, Title 9, CCR.
 - (C) The continuing treatment time frames specified in Section 10410, Title 9, CCR.
- (4) For all providers who received reimbursement for an ineligible narcotic treatment program individual or group counseling session. For purposes of this subsection, "ineligible narcotic treatment program individual or group counseling session" means any of the following:

- (A) The counseling session does not meet the minimum requirements set forth in Section 10345, Title 9, CCR;
- (B) The counseling session is not the type specified in the treatment plan required by Section 10305, Title 9, CCR; or
- (C) The frequency of counseling exceeds that specified in the treatment plan required by Section 10305, Title 9, CCR.

(5) For all providers who received reimbursement for an ineligible individual counseling session. For purposes of this subsection “ineligible individual counseling session” means an individual counseling session which does not meet the requirements specified in Subsection (b)(12) and, for outpatient drug free treatment services as specified in Subsection (d)(2)(B).

(6) For all providers who received reimbursement for an ineligible group counseling session. For purposes of this subsection, “ineligible group counseling session” means a group counseling session which does not meet the requirements specified in Subsection (b)(11) and, for outpatient drug free treatment services as specified in Subsection (d)(2)(A).

(7) For all providers who received reimbursement for an ineligible day care habilitative unit of service. For purposes of this subsection, “ineligible day care habilitative unit of service” means a unit of service that was less than three hours of service on the calendar day billed or provided to a non-pregnant, non-postpartum or non-EPSDT eligible beneficiary.

DHCS DEMAND FOR RECOVERY PROCEDURES

(n) The Department shall utilize the procedures contained in Section 51458.2 to determine the amount of the demand for recovery of payment.

PROVIDER NON-COMPLIANCE WITH REQUIREMENTS:

(o) Provider noncompliance with other requirements set forth in this section shall be noted as programmatic deficiencies. The Department shall issue a report to the provider documenting any demand for recovery of payment and/or programmatic deficiencies and the provider shall submit a corrective action plan within sixty (60) calendar days of the date of the report. The plan shall do all of the following:

- (1) Address each demand for recovery of payment and/or programmatic deficiency.
- (2) Provide a specific description of how the deficiency shall be corrected.
- (3) Specify the date of implementation of the corrective action.

FAIR HEARING RIGHTS

(p) Providers shall inform each beneficiary of the right to a fair hearing related to denial, involuntary discharge, or reduction in Drug Medi-Cal substance use disorder services as it relates to their eligibility or benefits, pursuant to Section 50951.

(1) Providers shall advise the beneficiary in writing at least ten (10) calendar days prior to the effective date of the intended action to terminate or reduce services. The written notice shall include all of the following:

- (A) A statement of the action the provider intends to take.
- (B) The reason for the intended action.
- (C) A citation of the specific regulation(s) supporting the intended action.
- (D) An explanation of the beneficiary's right to a fair hearing for the purpose of appealing the intended action.
- (E) An explanation that the beneficiary may request a fair hearing by submitting a written request to:

(F) An explanation that the provider shall continue treatment services pending a fair hearing decision only if the beneficiary appeals in writing to the Department of Social Services for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.

(2) All fair hearings shall be conducted in accordance with Section 50953.

APPEALS PROCESS-DEMANDS FOR RECOVERY OF PAYMENT

(q) County and Provider Administrative Appeals

A provider and/or county may appeal Drug Medi-Cal dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims.

(1) Requests for first-level appeals, grievances, and complaints will be managed as follows:

(A) The provider and/or county shall initiate action by submitting a letter to:

DEPARTMENT OF SOCIAL SERVICES
STATE HEARING DIVISION
P.O. BOX 944243, MS 9-17-37
SACRAMENTO, CA 94244-2430
1 (800) 952-5253 TDD 1 (800) 952-8349

(i) The provider and/or county shall submit the letter on the official stationery of the provider and/or county and it shall be signed by an authorized representative of the provider and/or county.

(ii) The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim.

(B) The letter shall be submitted to the address listed in Subsection (q)(1)(A) within ninety (90) calendar days from the date the provider and/or county received written notification of the decision to disallow claims.

(C) The Substance Use Disorders Prevention, Treatment, and Recovery Services Division (SUDPTRSD) shall acknowledge the letter within fifteen (15) calendar days of its receipt.

(D) The SUDPTRSD shall inform the provider and/or county of the SUDPTRSD's decision and the basis for the decision within fifteen (15) calendar days after the SUDPTRSD's acknowledgement notification. The SUDPTRSD shall have the option of extending the decision response time if additional information is required from the provider and/or county. The provider and/or county will be notified if the SUDPTRSD extends the response time limit.

(2) A provider and/or county may initiate a second level appeal, grievance or complaint to the Office of Administrative Hearings and Appeals.

(A) The second level process may be pursued only after complying with first-level procedures and only when:

(i) The SUDPTRSD has failed to acknowledge the grievance or complaint within fifteen (15) calendar days of its receipt, or

(ii) The provider and/or county is dissatisfied with the action taken by the SUDPTRSD where the conclusion is based on the SUDPTRSD's evaluation of the merits. The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within thirty (30) calendar days from the

date the SUDPTRSD failed to acknowledge the first-level appeal or from the date of the SUDPTRSD's first-level appeal decision.

(B) All second-level appeals made in accordance with this section shall be directed to:
OFFICE OF ADMINISTRATIVE HEARINGS AND APPEALS
1029 J STREET, SUITE 200
SACRAMENTO, CA 95814

(C) In referring an appeal, grievance, or complaint to the Office of Administrative Hearings and Appeals, the provider and/or county shall submit all of the following:

- (i) A copy of the original written grievance or complaint sent to the SUDPTRSD.
- (ii) A copy of the SUDPTRSD's report to which the appeal, grievance, or complaint applies.
- (iii) If received by the provider and/or county, a copy of the SUDPTRSD's specific finding(s), and conclusion(s) regarding the appeal, grievance, or complaint with which the provider and/or county is dissatisfied.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14021, 14021.3, 14021.5, 14021.6, 14021.30, 14021.51, 14043.75, 14124.1, 14124.24, 14124.26 and 14124.5, Welfare and Institutions Code; Statutes of 2011, Chapter 32, and Statutes of 2012, Chapter 36. Reference: Sections 14021, 14021.3, 14021.5, 14021.6, 14021.33, 14021.51, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.20, 14124.21, 14124.24, 14124.25, 14124.26, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code; Sections 436.122, 456.21, 456.22 and 456.23, Title 42, Code of Federal Regulations; Statutes of 1996, Chapter 162, Items 4200-101-0001 and 4200-102-0001; and Statutes of 2011, Chapter 32, and Statutes of 2012, Chapter 36.

HISTORY

1. New section filed 12-14-95 as an emergency; operative 12-14-95 (Register 95, No. 50). A Certificate of Compliance must be transmitted to OAL by 4-12-96 or emergency language will be repealed by operation of law on the following day.
2. Repealed by operation of Government Code section 11346.1 (Register 96, No. 16).
3. New section filed 4-16-96 as an emergency; operative 4-16-96 (Register 96, No. 16). A Certificate of Compliance must be transmitted to OAL by 8-14-96 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 4-16-96 order transmitted to OAL 8-13-96 and filed 9-25-96 (Register 96, No. 39).
5. Amendment of section and Note filed 5-12-97 as an emergency; operative 5-12-97 (Register 97, No. 20). A Certificate of Compliance must be transmitted to OAL by 9-9-97 or emergency language will be repealed by operation of law on the following day.
6. Amendment of section heading, section and Note filed 6-30-97 as an emergency; operative 7-1-97 (Register 97, No. 27). A Certificate of Compliance must be transmitted to OAL by 10-29-97 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 5-12-97 order transmitted to OAL 8-13-97 and filed 9-23-97 (Register 97, No. 39).
8. Amendment of section heading, section and Note refiled 10-6-97 as an emergency; operative 10-29-97 (Register 97, No. 41). A Certificate of Compliance must be transmitted to OAL by 2-26-98 or emergency language will be repealed by operation of law on the following day.
9. Amendment of section heading, section and Note refiled 1-14-98 as an emergency; operative 2-26-98 (Register 98, No. 3). A Certificate of Compliance must be transmitted to OAL by 6-26-98 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 1-14-98 order, including further amendment of section heading, section and Note, transmitted to OAL 6-11-98 and filed 6-29-98 (Register 98, No. 27).

11. Change without regulatory effect amending subsection (p)(1)(E) filed 5-17-2006 pursuant to section 100, title 1, California Code of Regulations (Register 2006, No. 20).
12. Change without regulatory effect amending section heading, section and Note filed 12-16-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 51).
13. Amendment of section and Note filed 6-25-2014 as an emergency; operative 6-25-2014 (Register 2014, No. 26). A Certificate of Compliance must be transmitted to OAL by 12-22-2014 or emergency language will be repealed by operation of law on the following day.
This database is current through 8/29/14 Register 2014, No. 35
22 CCR § 51341.1, 22 CA ADC § 51341.1

AMMENDMENT ENFORCEMENT DATE: JANUARY 1, 2015

TITLE 22 SENATE BILL 1045 CHAPTER 80 APPROVED JULY 7, 2014

THIS BILL INSTEAD REQUIRE A GROUP TO CONSIST OF A MIMUM OF 2 AND A MAIXMUM OF 12 INDIVIDUALS FOR ODF.

SECTION 1 14021.6 OF WELFARE AND INSTITUTIONS ACT IS AMMENDED

ITEM d The maximum allowable rate for group outpatient drug fee services shall be set on a per person basis. A group shall consist of a minimum of 2 and a maximum of 12 individuals, at least one of which shall be a Medi-Cal eligible beneficiary.

ITEM e. The department shall develop individual and group rates for extensive counseling for outpatient drug free treatment based on a 50-minute individual and a 90 minute group hours. See full Senate Bill next page

Senate Bill No. 1045

CHAPTER 80

An act to amend Section 14021.6 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor July 07, 2014. Filed with Secretary of State July 07, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1045, Beall. Medi-Cal Drug Treatment Program: group outpatient drug free services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions.

Existing law also provides for the Medi-Cal Drug Treatment Program (Drug Medi-Cal), under which each county enters into contracts with the State Department of Health Care Services to provide various drug treatment services to Medi-Cal recipients, or the department directly arranges to provide these services if a county elects not to do so. For purposes of Drug Medi-Cal, existing law requires that the maximum allowable rate for group outpatient drug free services be set on a per person basis and requires that a group consist of a minimum of 4, and a maximum of 10, individuals, at least one of which must be a Medi-Cal eligible beneficiary.

This bill would instead require a group to consist of a minimum of 2 and a maximum of 12 individuals, at least one of which is a Medi-Cal eligible beneficiary. The bill would also require, if one of the individuals in a 2-member group is ineligible for Medi-Cal, that the individual who is ineligible for Medi-Cal be receiving outpatient drug free services for a substance abuse disorder diagnosed by a physician.

DIGEST KEY

Vote: MAJORITY Appropriation: NO Fiscal Committee: NO Local Program: NO

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

Section 14021.6 of the Welfare and Institutions Code is amended to read:

14021.6.

(a) For the fiscal years prior to fiscal year 2004–05, and subject to the requirements of federal law, the maximum allowable rates for the Medi-Cal Drug Treatment Program shall be determined by computing the median rate from available cost data by modality from the fiscal year that is two years prior to the year for which the rate is being established.

(b) (1) For the fiscal year 2007–08, and subsequent fiscal years, and subject to the requirements of federal law, the maximum allowable rates for the Medi-Cal Drug Treatment Program shall be determined by computing the median rate from the most recently completed cost reports, by specific service codes that are consistent with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(2) For the fiscal years 2005–06 and 2006–07, if the State Department of Health Care Services and the State Department of Alcohol and Drug Programs determine that reasonably reliable and complete cost report data are available, the methodology specified in this subdivision shall be applied to either or both of those years. If reasonably reliable and complete cost report data are not available, the State Department of Health Care Services and the State Department of Alcohol and Drug Programs shall establish rates for either or both of those years based upon the usual, customary, and reasonable charge for the services to be provided, as these two

departments may determine in their discretion. This subdivision is not intended to modify subdivision (h) of Section 14124.24, which requires certain providers to submit performance reports.

(c) Notwithstanding subdivision (a), for the 1996–97 fiscal year, the rates for nonperinatal outpatient methadone maintenance services shall be set at the rate established for the 1995–96 fiscal year.

(d) Notwithstanding subdivision (a), the maximum allowable rate for group outpatient drug free services shall be set on a per person basis. A group shall consist of a minimum of 2 and a maximum of 12 individuals, at least one of which shall be a Medi-Cal eligible beneficiary. For groups consisting of two individuals, if one of the individuals is ineligible for Medi-Cal, the individual who is ineligible for Medi-Cal shall be receiving outpatient drug free services for a substance abuse disorder diagnosed by a physician.

(e) The department shall develop individual and group rates for extensive counseling for outpatient drug free treatment, based on a 50-minute individual or a 90-minute group hour, not to exceed the total rate established for subdivision (d).

(f) The department may adopt regulations as necessary to implement subdivisions (a), (b), and (c), or to implement cost containment procedures. These regulations may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of these emergency regulations shall be deemed an emergency necessary for the immediate preservation of the public peace, health and safety, or general welfare.