State of California
Office of Administrative Law

In re:

Department of Health Care Services

Regulatory Action:

Title 22, California Code of Regulations

Adopt sections:
Amend sections: **50090, 50260, 50262.3, 50951, 50953, 51008, 51008.5, 51015, 51159, 51200, 51303, 51341.1, 51458.1, 51476, 51490.1**
Repeal sections:

NOTICE OF APPROVAL OF CHANGES WITHOUT REGULATORY EFFECT

California Code of Regulations, Title 1, Section 100

OAL File No. 2013-1204-03 N

This action without regulatory effect makes necessary amendments to comply with recent statutory changes transferring the Drug Med-Cal Program from the Department of Alcohol and Drug Programs to the Department of Health Care Services. (AB 106, Statutes of 2011, Chapter 31 anf SB 1014, Statutes of 2012, Chapter 36)

OAL approves this change without regulatory effect as meeting the requirements of California Code of Regulations, Title 1, section 100.

Date: 12/16/2013

Original Signed

Kathleen Eddy
Senior Counsel

For: DEBRA M. CORNEZ
Director

Original: Toby Douglas
Copy: Ben Carranco

STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATION SUBMISSION

NONSUBSTANTIVE

(See instructions on reverse)

STD. 400 (REV. 01-2013)

For use by Secretary of State only

ENDORSED FILED
IN THE OFFICE OF
2013 DEC 16 PM 3:19
JOHN BURTON
SECRETARY OF STATE

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-	2013-1204-03N	

For use by Office of Administrative Law (OAL) only

2013 DEC -4 PM 2:33

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY
Department of Health Care Services

AGENCY FILE NUMBER (If any)
DHCS-13-002

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
Drug Medi-Cal	

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	
	ADOPT
	AMEND: See Attachment
TITLE(S): 22	REPEAL

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☒ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☐ Effective on filing with Secretary of State
- ☒ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Ben Carranco	(916) 440-7766	(916) 440-5748	ben.carranco@dhcs.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: Original Signed — DATE: 11/20/13

TYPED NAME AND TITLE OF SIGNATORY: Toby Douglas, Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

DEC 16 2013

Office of Administrative Law

(1) Amend Section 50090 to read:

§ 50090. Share of Cost.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Sections 14005.9, ~~and~~ 14021, 14053, 14054, 14124.24, and 14131, Welfare and Institutions Code.

(2) Amend Section 50260 to read:

§ 50260. 60-Day Postpartum Services Program.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14005.3, 14021, 14021.51, 14053, ~~and~~ 14100.1, 14124.24, 14131, 14132.21, and 14132.905, Welfare and Institutions Code; and Title 42, United States Code, Section ~~1396a (e) (5)~~1396a(e)(5).

(3) Amend Section 50262.3 to read:

§ 50262.3. Continued Eligibility Program for Pregnant/Postpartum Women and Infants.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14016.10, and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14021.51, 14053, 14124.24, and 14131, Welfare and Institutions Code; and Title 42, United States Code, Sections 1396a(e)(4), 1396a(e)(5) and 1396a(e)(6) ~~of the United States Code~~.

(4) Amend Section 50951 to read:

§ 50951. Right to State Hearing.

Amend Note as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Sections 10950-10965, 14021, 14053, 14124.24, and 14131, Welfare and Institutions Code.

(5) Amend Section 50953 to read:

§ 50953. State Hearing Procedures.

Amend Note as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, and 14124.5, Welfare and Institutions Code. Reference: Sections 10950-10965, 14001, ~~and~~ 14021, 14053, 14124.5, 14124.24, and 14131, Welfare and Institutions Code.

(6) Amend Section 51008 to read:

§ 51008. Bills for Service.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, 14115, and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14053, 14115, 14124.1, 14124.2, 14124.24, 14131, and 14133, Welfare and Institutions Code.

(7) Amend Section 51008.5 to read:

§ 51008.5. Billing Procedures for Claims Delayed by Good Causes.

Amend Note as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14053, 14115, 14124.1, 14124.2, 14124.24, 14131, and 14133, Welfare and Institutions Code; and Title 42, ~~C.F.R.~~ Code of Federal Regulations, Section 447.45(d)(4)(iv).

(8) Amend Section 51015 to read:

§ 51015. Provider Grievances and Complaints.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 14104.5 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14053, 14104.5, 14124.24, and 14131, Welfare and Institutions Code.

(9) Amend Section 51159 to read:

§ 51159. Utilization Controls.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14053, 14088.16, 14105, 14106, 14124.24, 14131, 14132, 14133, and 14133.25, Welfare and Institutions Code.

(10) Amend Section 51200 to read:

§ 51200. Basic Requirement for Program Participation.

Amend Note as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14021, 14043.1, 14043.36, 14043.75, 14053, 14123, 14124.24, 14131, and 14132, Welfare and Institutions Code; Sections 101150-101160, Health and Safety Code; and Sections 1200-1327, Business and Professions Code.

(11) Amend Section 51303 to read:

§ 51303. General Provisions.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; Chapter 1066, Statutes of 1977; Section 57(c), Chapter 328, Statutes of 1982; and Sections 14059.5, 14105, 14105.44, and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14053, 14059.5, 14105.44, 14124.5, 14124.24, 14131, 14132, and 14133.3, Welfare and Institutions Code.

(12) Amend Section 51341.1 to read:

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

(a) Substance ~~abuse~~use disorder services, as defined in this section, provided to Medi-Cal beneficiaries, are 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.

(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) of this regulation, rendered by the provider to the beneficiary.

~~(2) "ADP" means the State of California Department of Alcohol and Drug Programs which is authorized to administer Drug Medi-Cal substance abuse services through an interagency agreement with the State of California Department of Health Services. Whenever ADP contracts for Drug Medi-Cal substance abuse services directly with a provider, ADP shall also assume the role and responsibilities assigned to the county under this section.~~

(~~3~~2) "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.

(~~4~~3) "County" means the department authorized by the county board of supervisors to administer alcohol and substance ~~abuse~~use disorder programs, including Drug Medi-Cal substance ~~abuse~~use disorder services.

(~~5~~4) “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.

(~~6~~5) “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 ~~abuse~~use disorder diagnoses, who are pregnant or in the postpartum period, and/or to Early and Periodic Screening Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized in this Chapter.

(~~7~~6) “~~DHS~~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.

(~~8~~7) “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. For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than ~~10~~ten clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

(~~9~~8) “Individual counseling” means face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of service.

(~~10~~9) “Intake” means the process of admitting a beneficiary into a substance ~~abuse~~use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance ~~abuse~~use disorders; the diagnosis of substance ~~abuse~~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 licensed to practice medicine in the State of California. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance ~~abuse~~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.

(~~11~~10) “Medical psychotherapy” is a type of counseling service that has the same meaning as defined in Section 10345 of Title 9, CCR.

(~~12~~11) “Medication Services” means the prescription or administration of medication related to substance ~~abuse~~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.

(~~13~~12) “Naltrexone treatment services” means an outpatient treatment service directed at serving detoxified opiate addicts who have substance ~~abuse~~use disorder diagnosis by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

(~~14~~13) “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 ~~abuse~~use disorder diagnoses. For the purposes of this section, “narcotic treatment program” does not include detoxification treatment.

(~~15~~14) “Outpatient drug free treatment services” means an outpatient service directed at stabilizing and rehabilitating persons with substance ~~abuse~~use disorder diagnoses.

(~~16~~15) “Perinatal certified substance ~~abuse~~use disorder program” means a Medi-Cal certified program which provides substance ~~abuse~~use disorder services, as specified in Subsection (c)(4) of this regulation, to pregnant and postpartum women with substance ~~abuse~~use disorder diagnoses.

(~~17~~16) “Perinatal residential substance ~~abuse~~use disorder services program” means a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with substance ~~abuse~~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.

(~~18~~17) “Postpartum” means individuals who meet the criteria specified in Sections 50260 or 50262.3(a).

(~~19~~18) “Postservice postpayment utilization review” has the same meaning as Section 51159(c).

(~~20~~19) “Provider” means the legal entity certified pursuant to Section 51200 to provide Drug Medi-Cal substance ~~abuse~~use disorder services to eligible beneficiaries at its certified location(s).

(~~21~~20) “Substance ~~abuse~~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.

(~~22~~21) “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.

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

(1) Any of the substance ~~abuse~~use disorder services listed in subsection (d) of this regulation 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 ~~abuse~~ 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).

(d) Drug Medi-Cal substance ~~abuse~~use disorder services shall include:

(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 ~~abuse~~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 the following:

(A) Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance ~~abuse~~use or a return to substance

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

(B) Perinatal residential substance ~~abuse~~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 USC Section 1396d(a)(25)(B) and Section 1396(i) and~~ 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 ~~abuse~~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:

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

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

(C) Is opiate free; and

(D) Is not pregnant.

(e) ~~ADP~~The Department shall:

(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; and

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

(f) The county shall:

(1) Implement and maintain a system of fiscal disbursement and controls over the Drug Medi-Cal substance ~~abuse~~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; and

(3) Process claims for reimbursement.

(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. For purposes of this regulation, “an individual patient record” means a file for each beneficiary which shall contain, but not be limited to, information specifying the beneficiary's identifier (i.e., name, number), 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, and all documentation relating to the beneficiary gathered during the treatment episode, including all intake and admission data, all treatment plans, progress notes, continuing services justifications, laboratory test orders and results, referrals, counseling notes, discharge summary and any other information relating to the treatment services rendered to the beneficiary.

(2) Maintain group counseling sign-in sheets which indicate the date and duration of the session;

(3) Provide services; and

(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.

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

(1) Admission criteria and procedures

(A) For outpatient drug free, Naltrexone treatment, day care habilitative, and perinatal residential treatment services, the provider shall perform all of the following:

(i) Develop and use criteria and procedures for the admission of beneficiaries to treatment.

(ii) Complete a personal, medical, and substance ~~abuse~~use history for each beneficiary upon admission to treatment.

(iii) Complete an assessment of the physical condition of the beneficiary within thirty (30) calendar days of the admission to treatment date. The assessment shall be completed by either:

(a) A physical examination of the beneficiary by a physician, registered nurse practitioner, or physician assistant authorized by state law to perform the prescribed procedures; or

(b) A review of the beneficiary's medical history, substance ~~abuse~~use history, and/or the most recent physical examination documentation. If the assessment is made without benefit of a physical examination, the physician shall complete a waiver which specifies the basis for not requiring a physical examination.

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

(i) The provider shall confirm that the beneficiary:

(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; and

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

(ii) The physician shall certify beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results; and

(iii) The physician shall advise beneficiaries of the overdose risk should they 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.

(D) For each beneficiary, the provider shall:

(i) Establish medical necessity consistent with Section 51303. For purposes of these regulations, medical necessity is established by the physician's admission of each beneficiary pursuant to Subsection (h)(1) of this regulation, the physician's review and signature of each beneficiary's treatment plan and updates pursuant to Subsection (h)(2) of this regulation, and the physician's determination to continue services pursuant to Subsection (h)(5) of this regulation; and

(ii) Identify the applicable Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition diagnostic code.

(2) Treatment plan for each beneficiary

(A) For a beneficiary admitted to outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services the provider shall prepare an individualized

written treatment plan, based upon the information obtained in the intake and assessment process.

(i) The initial treatment plan shall include:

(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; and

(f) The assignment of a primary counselor.

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

(a) The counselor shall complete and sign within thirty (30) calendar days of the admission to treatment date, and

(b) The physician shall review, approve, and sign within fifteen (15) calendar days of signature by the counselor.

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

(a) The counselor shall review and sign 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) Within fifteen (15) calendar days of signature by the counselor, the physician shall review, approve, and sign all updated treatment plans. If the physician has not prescribed medication,

a psychologist licensed by the State of California Board of Psychology may sign an updated treatment plan.

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

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

(A) For outpatient drug free or Naltrexone treatment services, the counselor shall record a progress note for each beneficiary participating in an individual or group counseling session. Progress notes are individual narrative summaries and shall include:

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

(ii) Information on a beneficiary's attendance including the date (month, day, year) and duration in minutes of individual or group counseling sessions.

(B) For day care habilitative and perinatal residential treatment services, the counselor shall record a progress note, at a minimum, once a week. The progress notes are individual narrative summaries and shall include:

(i) The time period covered by the summary. The period shall be no more than seven (7) days.

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

(iii) A record of the beneficiary's attendance at each counseling session including the date (month, day, year) and duration of the counseling session.

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

(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 provider determines that:

(i) Fewer beneficiary contacts are clinically appropriate; and

(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.

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

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

(i) No sooner than five (5) months and no later than six (6) months the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the counselor shall review the progress and eligibility of the beneficiary to continue to receive treatment services.

(ii) If the counselor recommends that the beneficiary requires further treatment, the physician shall determine the need to continue services based on the following factors:

(a) The medical necessity of continuing treatment;

(b) The prognosis; and

(c) The counselor's recommendation for the beneficiary to continue receiving services.

(iii) The provider shall discharge the beneficiary if the physician determines there is no medical necessity to continue 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.

(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) of this regulation. The provider shall complete a discharge summary for each beneficiary in accordance with the following requirements:

(A) 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 last face-to-face treatment contact with the beneficiary. The discharge summary shall include:

(i) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment;

(ii) The reason for discharge;

(iii) A narrative summary of the treatment episode; and

(iv) The beneficiary's prognosis.

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

(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 beneficiaries for access to Drug Medi-Cal substance ~~abuse~~use disorder services or for admission to a Drug Medi-Cal treatment slot.

(i) Providers shall maintain the following documentation in the individual patient record established pursuant to subsection (g)(1) for each beneficiary 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 provider shall maintain records until the audit is completed.

(1) Evidence that the beneficiary met the admission criteria specified listed in Subsection (h)(1) of this regulation;

(2) Treatment plan(s) as described in Subsection (h)(2) of this regulation;

(3) Progress notes as described in Subsection (h)(3) of this regulation;

(4) Evidence that the beneficiary received counseling as described in Subsection (h)(4) of this regulation with exceptions of waivers noted, signed, and dated by the physician in the beneficiary's treatment plan;

(5) Justification for continuing services as described in Subsection (h)(5) of this regulation;

(6) Discharge summary as described in Subsection (h)(6) of this regulation;

(7) Evidence of compliance with requirements for the specific treatment service as described in Subsection (d) of this regulation;

(8) Evidence that the beneficiary met the requirements for good cause specified in Section 51008.5 where the good cause results from beneficiary-related delays; and

(9) Evidence that the provider complied with the multiple billing requirements specified in Section 51490.1(d).

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

(1) ~~ADP~~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) of this regulation.

(3) When a beneficiary receives services from more than one provider, ~~ADP~~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, ~~ADP~~the Department may reimburse the provider for an additional unit of service on a calendar day under the circumstances listed below. The additional unit of service shall be reimbursed pursuant to Section 51490.1(d) and shall be documented in the individual patient record as a separate unit of service in accordance with Subsection (h)(3) of this regulation.

(A) Outpatient drug free and Naltrexone for crisis intervention or collateral services; or

(B) Day care habilitative for crisis intervention.

(5) ~~ADP~~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, ~~ADP~~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 ~~11758.42~~14021.51(g) of the ~~Health and Safety~~ Welfare and Institutions Code.

(k) ~~ADP~~The Department shall conduct a postservice postpayment utilization review of Drug Medi-Cal substance ~~abuse~~use disorder services. The review shall:

(1) Verify that the documentation requirements of Subsection (i) of this regulation 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 diagnostic code, and medical necessity for services is established pursuant to Subsection (h)(1)(D) of this regulation;

(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) of this regulation; and

(4) Establish the basis for recovery of payments in accordance with Subsection (m) of this regulation.

(l) In determining compliance and demand for recovery of payment actions, ~~ADP~~the Department shall base its findings on a sampling of beneficiary records and other records of the provider.

(m) In addition to the provisions of Section 51458.1(a), ~~ADP~~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 Subsection (h)(1)(D) of this regulation.

(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(d).

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

(A) The provider failed to meet the time frames of Subsections (h)(1)(A)(iii), (h)(2)(A)(ii), (h)(2)(A)(iii), or (h)(5)(A) of this regulation.

(B) 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:

(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) The provider 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:

(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) The provider 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)(9) and, for outpatient drug free treatment services, Subsection (d)(2)(B) of this regulation.

(6) The provider 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)(8) of this regulation.

(7) The provider 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.

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

(o) Provider noncompliance with other requirements set forth in this section shall be noted as programmatic deficiencies. ~~ADP~~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:

(1) Address each demand for recovery of payment and/or programmatic deficiency;

(2) Provide a specific description of how the deficiency shall be corrected; and

(3) Specify the date of implementation of the corrective action.

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

(1) Providers shall advise beneficiaries 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:

(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:

Department of Social Services

State Hearings Division

P.O. Box 944243, MS ~~19-37~~ 9-17-37

Sacramento, CA 94244-2430

1 (800) ~~925-5253~~ 952-5253

TDD 1(800) 952-8349

(F) An explanation that the provider shall continue treatment services pending a fair hearing decision only if the beneficiary appeals in writing to ~~ADP~~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.

(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. Such appeals shall be handled pursuant to Section 51015 ~~in accordance with the Interagency Agreement between ADP and DHS~~.

(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:

~~Deputy Director~~ Division Chief

~~Program Operations Division~~Substance Use Disorders Prevention, Treatment, and Recovery Services Division

Department of ~~Alcohol and Drug Programs~~Health Care Services

~~1700 K Street~~PO Box 997413, MS-2621

Sacramento, CA ~~95814-4037~~95899-7413

(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 specify that it is being submitted in accordance with Section 51015.

(iii) 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) of this regulation within ninety (90) calendar days from the date the provider and/or county received written notification of the decision to disallow claims.

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

(D) ~~ADP~~The SUDPTRSD shall inform the provider and/or county of ~~ADP's~~ the SUDPTRSD's decision and the basis for the decision within fifteen (15) calendar days after ~~ADP's~~ the SUDPTRSD's acknowledgement notification. ~~ADP~~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 ~~ADP~~ the SUDPTRSD extends the response time limit.

(2) A provider and/or county may initiate a second level appeal, grievance or complaint to ~~DHS~~ 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) ~~ADP~~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 ~~ADP~~the SUDPTRSD where the conclusion is based on ~~ADP's~~the SUDPTRSD's evaluation of the merits. The second-level appeal shall be submitted to ~~DHS~~ the Office of Administrative Hearings and Appeals within thirty (30) calendar days from the date ~~ADP~~the SUDPTRSD failed to acknowledge the first-level appeal or from the date of the ~~ADP~~SUDPTRSD's first-level appeal decision.

(B) All second-level appeals made in accordance with this section shall be directed to:

~~Chief~~

~~Medi-Cal Policy Division~~

~~Department of Health Services~~ Office of Administrative Hearings and Appeals

~~714 P Street, Room 1561~~ 1029 J Street, Suite 200

~~Sacramento, CA 95814~~ Sacramento, CA 95814

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

(i) A copy of the original written grievance or complaint sent to ~~ADP~~the SUDPTRSD;

(ii) A copy of ~~ADP's~~the SUDPTRSD's report to which the appeal, grievance, or complaint applies; and

(iii) If received by the provider and/or county, a copy of ~~ADP's~~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, 14124.1, ~~and~~ 14124.5 and 14124.24, Welfare and

Institutions Code; ~~Section 11758.41, Health and Safety Code; and Statutes of 1996, Chapter 1027~~ 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, ~~14132.90~~14132.905, ~~and~~ 14133 and 14133.1, Welfare and Institutions Code; ~~Sections 11758.42, 11758.46 and 11758.47, Health and Safety 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 1996, Chapter 1027~~Statutes of 2011, Chapter 32, and Statutes of 2012, Chapter 36.

(13) Amend Section 51458.1 to read:

§ 51458.1. Cause for Recovery of Provider Overpayments.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14005, 14005.1, 14005.4, 14005.8, 14018, 14019, 14021, 14024, 14026, 14053, 14103.2, 14103.6, 14105, 14107, 14110.1, 14117, 14123, 14124.1, 14124.2, 14124.24, 14124.5, 14131, 14132, 14133, 14133.1, 14170, 14176, and 14177, Welfare and Institutions Code.

(14) Amend Section 51476 to read:

§ 51476. Keeping and Availability of Records.

Amend Note only as follows:

Note: Authority cited: Section 20, Health and Safety Code; and Sections 10725, 14105, and 14124.5, Welfare and Institutions Code. Reference: Sections 14021, 14043.341, 14053, 14105.35, 14107, 14124.1, 14124.2, 14124.24, 14131, 14133, 14133.3, and 14170, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Sections 483.40(e) and 485.631(b)(iv).

(15) Amend Section 51490.1 to read:

§ 51490.1. Claim Submission Requirements for Counties and Providers of Drug Medi-Cal Substance ~~Abuse~~Use Disorder Services.

(a) Claims from counties and providers for reimbursement of outpatient drug free, day care habilitative, narcotic treatment program, Naltrexone treatment, and perinatal residential treatment services shall be presented to ~~ADP~~the Department no later than thirty (30) calendar days after the month of service, unless the county or provider has good cause, as specified in Sections 51008 and 51008.5. The county or provider shall produce, upon request by ~~ADP~~the Department for audit or monitoring purposes, documentation to substantiate the good cause.

~~(b) ADP shall present such claims to DHS no later than sixty (60) calendar days after the month of service, or thirty (30) calendar days after the date ADP receives such claims, if the requirements of Subsection (a) of this regulation have been met.~~

~~(c) ADP shall resubmit claims, which have been returned by DHS for correction or additional information, within 97 calendar days from the current date (i.e., computer run date) shown on the Error Correction Reports from DHS.~~

(~~d~~b) An additional unit of service, or a multiple service billing, provided to a beneficiary on the same day may be claimed up to the maximum amount allowable if the beneficiary's return visit is to the same provider and the return visit service is not a duplicate to, or the same as, the service previously provided to the beneficiary on the same day.

“Multiple billing” means a claim is being made for a return, face-to-face visit, which is for an additional service to a previously provided service on that same day. ~~Documentation shall include a “Multiple billing override code”. “Multiple billing override code” means the code, designated by the prefix “Y”, that is entered on the Drug Medi-Cal Eligibility Worksheet (Form ADP 1584, revised June 6, 1996) or an error correction report from DHS, to indicate that~~

~~a valid return visit was provided.~~ The county and/or provider shall prepare and retain, in the beneficiary's patient record, a Multiple Billing Override Certification (Form ~~ADP 7700~~DHCS MC 7700 (Rev.10/12)~~Revised 5/97)~~, hereby incorporated by reference, certifying that a review of the client's record substantiated the multiple service. The form shall be signed by the person authorized to represent the county and/or provider.

(1) For outpatient drug free and Naltrexone treatment services:

(A) The return visit shall not create a hardship on the beneficiary; and

(B) The return visit shall be clearly documented in the beneficiary's progress notes with the time of day each visit was made. The progress notes shall clearly reflect that an effort was made to provide all necessary services during one visit and the return visit was unavoidable; or,

(C) The return visit shall be a crisis or collateral service. Collateral services shall be documented in the beneficiary's treatment plan in accordance with the beneficiary's short/long-term goals. The beneficiary's progress notes shall specifically reflect the steps taken to meet the goals defined in the beneficiary's treatment plan.

(2) For day care habilitative services, the return visit shall be a crisis service. Crisis services shall be documented in the progress notes.

(3) The county and/or provider shall prepare and keep on file a statement which documents the reason the beneficiary required a return visit. This statement shall be produced upon request by ~~ADP~~the Department for audit or monitoring purposes.

Remove Image 1 – "Multiple Billing Override Certification, ADP 7700 (Rev. 5/97)"

~~Image 1 (6.14" X 8.17") Available for Offline Print~~

Remove Image 2 – "Drug/Medi-Cal Eligibility Worksheet, ADP 1584 (Rev. 06/96)"

~~Image 2 (5.16" X 8.45") Available for Offline Print~~

Remove Image 3 – "Complete Instructions – Drug/Medi-Cal Eligibility Worksheet—ADP 1584 (For Submission of Federal Drug/Medi-Cal Claims Only) (Revised 6/96) Alcohol/Drug and Perinatal"

~~Image 3 (5.04" X 7.48") Available for Offline Print~~

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14021.5, 14021.30, 14021.33, 14124.26 and 14124.5, Welfare and Institutions Code; ~~Section 11758.41, Health and Safety Code; and Statutes of 1996, Chapter 1027~~. Reference: Sections 14021, 14021.5, 14021.6, 14021.51, 14043.7, 14053, 14107, 14124.1, 14124.2, 14124.20, 14124.21, 14124.24, 14124.25, 14131, 14132.21, 14132.905, 14133 and 14133.1, Welfare and Institutions Code; ~~Sections 11758.42 and 11758.46, Health and Safety Code; and Statutes of 1996, Chapter 1027~~and Statutes of 2011, Chapter 32; and Statutes of 2012, Chapter 36.