7.3.1 Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services

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References: BHIN No.: 21-071; W&I Code, Section 14184.402(a)(e)(f)(i); Section 14059.5;

Policy Owner: Behavioral Health/QAPI/SUD QA, QA Manager

Director Signature: Signature on File

I. Policy Statement

This Policy and Procedure outlines medical necessity determination requirements and the use of the American Society of Addiction Medicine (ASAM) Criteria© to determine the appropriate level of care for providing covered substance use disorder treatment services in DMC State Plan counties, as specified in Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), and in accordance with Welfare and Institutions Code section 14184.402(i). The implementation of the ASAM Criteria© in DMC counties is in alignment with implementation by the Drug Medi-Cal Organized Delivery System (DMC-ODS) counties for the ASAM Criteria© for assessment and level of care determination purposes.

II. Scope

This policy applies to all Sonoma County DHS-BHD staff who provide Drug Medi-Cal (DMC) treatment program services to Sonoma County Medi-Cal beneficiaries.

III. Definitions

A. Drug Medi-Cal (DMC): Drug Medi-Cal is a treatment funding source for eligible Medi-Cal members. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program. SUD services funded by Drug Medi-Cal are listed in Title 22, California Code of Regulations (CCR), Section 51341.1. (d)(1-6). Title 9 and Title 22, CCR govern DMC treatment.

B. Homelessness: The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

C. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): A benefit of the Medi-Cal program as specified in Title 19 of the Social Security Act (SSA), Section 1905(r)(5), Title 42 of the United States Code, Section 1396d(r). The benefits covered under EPSDT provide comprehensive and preventive health care services for individuals younger than 21 years of age who are enrolled in Medi-Cal. These services are key to ensuring children and youth receive appropriate preventive medical, dental, vision, hearing, mental health, substance use disorder, developmental and specialty services, as well as all necessary services to address any defects, illnesses or conditions identified. All of these services are at no-cost to individuals under age 21 who have full-scope Medi-Cal.

IV. Policy

All medical necessity determinations for covered substance use disorder treatment services provided to beneficiaries through Drug Medi-Cal counties shall be made in accordance with Welfare and Institution (W&I) Code section 14059.5 and in accordance with the requirements set forth below.

V. Procedures

A. Initial Assessment

1. Initial assessment for all levels of care, except Narcotic Treatment Programs (NTP), may be conducted:

   a. Face-to-face

b. By telephone (defined as synchronous audio-only)

c. By telehealth (defined as synchronous audio and video)

d. In the community

e. In the home

2. Initial assessment for all levels of care, except NTP, may be completed by one of the following:

   a. A Licensed Practitioner of the Healing Arts (LPHA), OR

   b. A registered/certified alcohol and other drug counselor

      i. An LPHA shall evaluate the assessment in consultation with the registered/certified counselor.

      ii. Consultation between an LPHA and registered/certified counselor may be performed:

         (1) In person

         (2) By telephone

         (3) By telehealth

      iii. Documentation of the initial assessment shall reflect consultation between an or the LPHA and registered/certified counselor.

      iv. Initial diagnosis shall be determined and documented by an LPHA.

3. Initial assessment for Narcotic Treatment Programs

   a. The history and physical exam conducted by an LPHA at admission qualifies for the determination of medical necessity, pursuant to state and federal regulations.

4. Timeliness and Covered Services during the Assessment Process

   a. Beneficiaries aged 21 years of age and older:

      i. The initial assessment shall be completed within 30 calendar days following the first visit with an LPHA or registered/certified counselor.

      ii. Covered and clinically appropriate services may be provided during the 30-day initial assessment period.

b. Beneficiaries under 21 years of age:

i. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.

ii. Covered and clinically appropriate services may be provided during the 60-day initial assessment period.

c. Adult beneficiaries experiencing homelessness:

i. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.

ii. The practitioner shall document that the beneficiary is experiencing homelessness and requires additional time to complete the initial assessment.

iii. Covered and clinically appropriate services may be provided during the 60-day initial assessment period.

d. All beneficiaries

i. Clinically appropriate services are reimbursable up to 30 days for beneficiaries aged 21+ or up to 60 days for beneficiaries under age 21 or experiencing homelessness following a visit with an LPHA or registered/certified counselor whether or not a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. A provisional diagnosis may be used prior to establishing the diagnosis. It is permissible to use "Other Specified Mental Disorder" and "Unspecified Mental Disorder" or "factors influencing health status and contact with health services" (Z-codes).

5. Timeliness consideration when a beneficiary withdraws from treatment prior to completion of the assessment.

a. When a beneficiary withdraws from treatment prior to completion of the assessment or establishing a diagnosis, and later returns to care, the 30-day or 60-day assessment period starts over.

B. Access Criteria AFTER Initial Assessment Process

1. To qualify for DMC services after the initial assessment process, beneficiaries aged 21 and older must meet the following criteria:

a. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders,

OR

b. At least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

2. Beneficiaries under the age of 21:

a. Receive covered services that are appropriate, and medically necessary to correct and ameliorate health conditions, pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations.

b. Services provided need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

C. Diagnosis

1. Diagnostic determination shall be made by an LPHA.

2. Provisional diagnoses:

a. Provisional diagnoses are used prior to the determination of a diagnosis. It is permissible to use "Other Specified Mental Disorder" and "Unspecified Mental Disorder" or "factors influencing health status and contact with health services" (Z-codes).

b. Provisional diagnosis shall be updated by an LPHA to accurately reflect the beneficiary's needs.

D. Additional Clarification

1. Services for covered services are reimbursable (per W&C Code 14184.402 (f)) even when:

a. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met. All Medi-Cal claims

for reimbursement continue to require the inclusion of a CMS approved ICD-10 diagnosis code.

b. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or

c. The beneficiary has a co-occurring mental health condition.

i. Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the beneficiary has a co-occurring mental health disorder.

ii. Reimbursement for covered DMC provided to a beneficiary who meets DMC criteria and has a co-occurring mental health condition shall not be denied as long as DMC criteria and requirements are met.

E. Level of Care Determination

1. Practitioners shall use the ASAM to determine the appropriate level of SUD treatment service (W&I Code 14184.402(e)). The treatment service must be both medically necessary and clinically appropriate to address the beneficiary's presenting condition.

a. For beneficiaries aged 21 years and over:

i. A full assessment using the ASAM Criteria© shall be completed within 30 calendar days of the beneficiary's first visit with an LPHA or registered/certified counselor.

b. For beneficiaries under the age of 21 or adult beneficiaries experiencing homelessness:

i. A full assessment using the ASAM Criteria© shall be completed within 60 calendar days of the beneficiary's first visit with an LPHA or registered/certified counselor.

2. Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the beneficiary's condition.

3. A full ASAM assessment shall be repeated when a beneficiary's condition changes.

4. DMC State Plan counties shall receive assurance from DMC providers that ASAM Criteria will be used to determine the appropriate level of care.

F. Additional Clarifications

1. Clinically necessary services are permissible prior to completion of a full ASAM assessment.

2. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

G. Clarification on reimbursement of covered and clinically appropriate services

1. Services provided during the initial or full ASAM Criteria© assessment

   a. Beneficiaries aged 21 years of age or older, services up to 30 calendar days from first visit with LHPA or certified/registered counselors

   b. Beneficiaries under age 21 years, services up to 60 calendar days from date of first visit with LHPA or certified/registered counselor

   c. All adult beneficiaries experiencing homelessness, services up to 60 calendar days from first visit with LPHA or certified/registered counselor

2. Services provided prior to determination of SUD diagnosis

3. Services provided, even when later determined beneficiary did not meet SUD criteria for continued services.

VI. Forms

None

VII. Attachments

None