



CALIFORNIA CODE OF
REGULATIONS
TITLE 22
Drug Medi-Cal
Beneficiary Record
Requirements

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PRESENTATION OUTLINE

- PSPP Review Overview
- Admission/Physical Exam
- Treatment Plan
 - Questions and Answers (10 mins)
- Counseling (Group and Individual)
- Beneficiary Contact
- Continuing Service Justification
- Discharge
 - Questions and Answers (10 mins)
- Multiple Services
- Perinatal
- Contacts/Closing
 - Questions and Answers (15 mins)

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TITLE 22 SECTIONS
Section 51159(c)

Outpatient Drug Free/ Day Care Habilitative

- Section 51341.1
- Section 51490.1
- Section 51516.1
- Section 51458.1

Perinatal

- Section 51159(c)
- Section 51516.1(a) 3
- Section 50260
- Section 50262.3(a)

Narcotic Treatment Program
Information available in a different
presentation

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DRUG MEDI-CAL SUBSTANCE ABUSE SERVICE MODALITIES

- Outpatient Drug Free (ODF)
- Day Care Habilitative (DCH)
- Perinatal Certified Substance Abuse (Outpatient)
- Perinatal Residential Substance Abuse

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PSPP AUTHORITY
Section 51341.1(k)

Department of Health Care Services (DHCS) shall conduct a postservice postpayment (PSPP) utilization review of Drug Medi-Cal (DMC) substance abuse services.

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Definition:
POSTSERVICE POSTPAYMENT
Section 51159(c)

Postservive postpayment (PSPP) audit, which is reviewed for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.

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Section 51341.1(k)

The review shall:

1. Verify that the documentation requirements of subsection (i) of this regulation are met;

Section 51341.1(i)

1. Evidence that the beneficiary met the admission criteria
2. Treatment plan(s)
3. Progress notes
4. Evidence that the beneficiary received the minimum counseling or a waiver noted, signed, and dated by the physician in the beneficiary's treatment plan

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Section 51341.1(i) cont'd...

5. Justification for continuing services
6. Discharge summary
7. Evidence of compliance with each treatment modality
8. Evidence that the beneficiary met the requirements of good cause
9. Evidence that multiple billing requirements are met

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Section 51341.1(k) cont'd...

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.

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PSPP UTILIZATION REVIEW PROCESS

- Coordinate site visit with the provider
 - Programs should not change counseling schedules due to site visit.
- Provide the program a list of beneficiary records to be reviewed
- Provide technical assistance
- Conduct an exit conference at the program or by telephone
- Inform the program of the PSPP report and the Corrective Action Timeline

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PROVIDER RESPONSIBILITIES

Section 51341.1(g)

- Provide services
- Establish, maintain and update as necessary each individual beneficiary record
- Keep group counseling sign-in sheets which must include the date and duration

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PROVIDER RESPONSIBILITIES

Section 51341.1(i)

Providers shall maintain the following documentation in the individual beneficiary record established pursuant to subsection (g)(1) for each beneficiary for a minimum of 3 years from 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.

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Definition:

ADMISSION TO TREATMENT DATE

Section 51341.1(b)(1)

The date of the first **face-to-face treatment service**

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ADMISSION CRITERIA

Section 51341.1(h)

Complete for each beneficiary:

- Personal
- Medical
- Substance abuse history
- Assessment of the physical condition of the beneficiary, by either a physical examination or, assessment
- Review of beneficiary's medical, substance abuse history, and/or within 30 calendar days of admission a physical examination
 - If the assessment is made without the benefit of a physical examination, the physician shall complete a waiver

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INTAKE / ASSESSMENT

Section 51341.1(b)(10)

Includes the evaluation or analysis of the cause or nature of:

- | | | |
|--|------------|---|
| 1. Mental | | 1. Assessment of treatment needs to provide medically necessary treatment services by a licensed physician, and |
| 2. Emotional | | |
| 3. Psychological | And | |
| 4. Behavioral and | | |
| 5. Substance abuse disorder using the DSM code | | 2. May include a physical examination and laboratory testing |

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PHYSICAL EXAM

Section 51341.1(h)(1)(A)(iii)(a)

- Admission Physical Exam – “A physical examination of the beneficiary by a **physician, registered nurse practitioner, or physician assistant** authorized by state law to perform the prescribed procedures”
- The physical exam document must be located in the beneficiary record
- The waiver must specify the basis for not requiring a physical exam

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PHYSICAL EXAM cont'd...

Section 51341.1(h)(1)(A)(iii)(b)

A review of the beneficiary's medical history, substance abuse history, and/or 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.**

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COMMON DEFICENCIES FOR PHYSICAL EXAM/PHYSICAL EXAM WAIVER

- Missing physical or physical exam waiver
- Late physical exam waiver
- Physical exam waiver signed but not dated by program physician
- Documentation does not specify the basis for not requiring a physical exam

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ESTABLISHING MEDICAL NECESSITY

Section 51341.1(h)(D)(1)

- Physician admission of each beneficiary pursuant to subsection (h)(1) of this regulation
- Physician review and signature of each beneficiary treatment plan and updates pursuant to subsection (h)(2) of this regulation
- Physician determination to continue services pursuant to subsection (h)(5) of this regulation

And

- The provider shall identify the applicable DSM code as part of the admission criteria

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COMMON DEFICIENCIES FOR INTAKE AND ASSESSMENT/ ADMISSION

- Beneficiary information is inconsistent throughout the intake and assessment documentation
- Inconsistent admission dates
- Missing beneficiary information
- Prior intake and assessment is utilized for current admission

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COMMON DEFICIENCIES FOR ADMISSION cont'd...

The admission process, taken as a whole in its entirety, constitutes the basis for establishing medical necessity. As a result, any incorrect or missing information means that medical necessity has not been established and all claims for services for that treatment episode will be disallowed.

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TREATMENT PLANNING

Section 51341.1(h)(2)

- The initial treatment plan must be:
 - **Individualized**
 - Based on the information obtained during the intake and assessment process

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TREATMENT PLANNING cont'd...

Section 51341.1(h)(2)(A)(i)

It must include the following 6 elements:

1. A statement of the problems to be addressed
2. Goals to be reached which address each problem
3. Action steps which will be taken by the provider, and/or beneficiary to accomplish identified goals

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TREATMENT PLANNING cont'd...

Section 51341.1(h)(2)(A)(i)

4. Target dates for the accomplishment of actions steps and goals
5. A description of the services, including the type of counseling, to be provided and the frequency thereof. Group counseling must be a specific number of sessions per unit of time – individuals can be "as needed", but must be on the treatment plan
6. The assignment of a primary counselor

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TREATMENT PLAN TIMELINES

Section 51341.1(h)(2)(A)(ii)

- The initial treatment plan must be completed by the counselor within **30 calendar days** of the admission to treatment date
- The physician must review, approve and sign within **15 calendar days** of the signature by the counselor

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TREATMENT PLANNING

Updated Treatment Plan Timelines

Section 51341.1(h)(2)(A)(iii)(a)

“The counselor shall review and sign the updated treatment plan no later than 90 calendar days after signing the initial treatment plan and no later than every 90 calendar days thereafter, **or when a change in problem identification or focus of treatment occurs, whichever comes first.**”

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TREATMENT PLANNING

Updated Treatment Plan Timelines

Section 51341.1(h)(2)(A)(iii)(b)

“Within 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.”

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COMMON DEFICIENCIES TREATMENT PLANNING

- Late treatment plans
- Late signatures by either the counselor or physician
- Missing type and frequency of services
- Missing target dates
- Documentation of the primary counselor missing

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Questions & Answers



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Definition GROUP COUNSELING

Section 51341.1(b)(8)

- Face-to-face contact
- One or more therapists or counselors
- Focused on the needs of the individuals
- ODF – must be from 4 to 10 in the group
- In order to bill DMC, one of the 4 to 10 participants must be a DMC beneficiary

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BENEFICIARY CONTACT

Section 51341.1(h)(4)

- A minimum of two counseling sessions per 30-day period

Section (d)(2)(A)

- Minimum of two group counseling sessions

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BENEFICIARY CONTACT

Section 51341.1(h)(4)

Requirement may be waived by the provider if:

1. Fewer contacts are clinically appropriate;
2. The beneficiary is making progress towards treatment plan goals

Section 51341.1(i)(4)

- "Exceptions or waivers must be noted, **signed and dated by the physician in the beneficiary's treatment plan.**"

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COMMON DEFICIENCIES FOR GROUP COUNSELING

- Missing group note
- Missing sign-in sheet
- Missing beneficiary signature on sign-in sheet
- More than 10 or less than 4 documented on sign-in sheet
- Missing date and duration of counseling in progress note
- The program staff signing on behalf of the beneficiary

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INDIVIDUAL COUNSELING IN ODF

Section 51341.1(d)(2)(B)

- ODF is a group counseling modality
- Individual counseling is limited to five exceptions:
 - Intake and Assessment
 - Treatment Planning
 - Discharge Planning
 - Crisis Intervention
 - Collateral Services

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INDIVIDUAL COUNSELING cont'd...

Section 51341.1(b)(9)

- Face-to-face contact
- Telephone contacts, home visits and hospital visits do not qualify – services must be provided at the certified location.

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DAY CARE HABILITATIVE

Section 51341.1(b)(6)

- Outpatient counseling and rehabilitation services
- **Minimum of three hours a day, three days a week**
- Limited to **pregnant or postpartum** women, and/or
- Early and Periodic Screening, Diagnosis and Treatment (**EPSDT**) eligible beneficiaries

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COMMON DEFICENCIES FOR INDIVIDUAL COUNSELING

- Missing individual progress note
- Individual counseling session does not meet one of five exceptions (ODF)
- Billed an individual counseling session for one of the five exceptions but the progress note does not reflect a counseling focus that meets the criteria of one of the five exceptions
- Collateral held with professional(s)

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CRISIS INTERVENTION COUNSELING

Section 51341.1(b)(5)

- Face-to-face contact with a beneficiary in crisis
- Crisis is an **actual relapse**, or
- **Unforeseen event or circumstance causing an imminent threat of relapse**
- Services shall:
 - Focus on **alleviating crisis** problems, and
 - Limited to **stabilization** of the emergency

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COMMON DEFICENCIES FOR CRISIS COUNSELING

- The progress note did not reflect a crisis
- Continuous counseling regarding the same crisis
- Lack of documentation regarding how beneficiary was stabilized

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COLLATERAL SERVICES COUNSELING

Section 51341.1(b)(3)

- Face-to-face session
- With persons **significant** in the life of the beneficiary
- **Personal**, not professional, relationships
- Focusing on the **treatment needs** of the beneficiary
- **Supporting the achievement** of the beneficiary's treatment goals.

Section 51490.1(d)(1)(C)

Collateral services shall be documented in the beneficiaries treatment plan in accordance with the beneficiaries short/long term goals.

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COMMON DEFICENCIES FOR COLLATERAL COUNSELING

- Progress note does not describe a collateral service
- Person present is not a significant person identified in the beneficiary's life
- As documented, session does not focus on the beneficiary treatment needs

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DOCUMENTING TREATMENT

Section 51341.1(h)(3)(B)

- Progress notes for DCH:
 - Must be legible
 - Must be individual narrative summaries
 - **May cover up to seven days**
 - Must include attendance information including full date (month, day, year), session duration and type of counseling for each counseling session
 - Must include a description of beneficiary progress on treatment plan goals, etc.

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DOCUMENTING TREATMENT cont'd...

Section 51341.1(h)(3)(A)

- Progress notes for ODF:
 - Must be legible
 - Must be individual narrative summaries
 - **Must be completed for each counseling session**
 - Must include attendance information including full date (month, day, year), session duration in minutes and type of counseling
 - Must include a description of beneficiary progress on treatment plan goals, etc.

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CONTINUING SERVICES JUSTIFICATION

Section 51341.1(h)(5)(A)(i)

- No sooner than 5 months and no later than 6 months from admission or the date the last justification was completed
- Counselor must review progress and eligibility of beneficiary to continue services

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CONTINUING SERVICES JUSTIFICATION cont'd...

Section 51341.1(h)(5)(A)(ii)

- The physician must determine the need for continuing services based on:
 - The counselor's recommendation
 - The beneficiary's prognosis
 - The medical necessity of continued treatment

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CONTINUING SERVICES JUSTIFICATION cont'd...

Section 51341.1(h)(5)(A)

- The beneficiary must be discharged from Drug Medi-Cal if the physician determines that there is no medical necessity to continue treatment
- If the justification to continue services is missing from the beneficiary record, all billings submitted from the due date until applicable (treatment ends or another justification is due) will be disallowed
- If the justification to continue services is signed late, all billings submitted from the due date until the day the justification to continue services was completed will be disallowed

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COMMON DEFICIENCIES FOR CONTINUING JUSTIFICATION

- The physician signs prior to the 5th month time period
- The physician signs after the 6th month due date
- The physician signs but does not date the justification
- No prognosis
- Missing continuing service justification
- Physician signature missing
- Counselor recommendation missing
- Missing statement by physician of how medical necessity was met

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DISCHARGE PLANNING

- Actions to be completed by the beneficiary post treatment
- Progress note must document planning for continued recovery following discharge from the program

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COMMON DEFICIENCIES FOR DISCHARGE PLANNING

- Discharge planning session does not reflect discussion of discharge plan
- Unnecessary discharge planning sessions

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DISCHARGE

Section 51341.1(h)(6)(A)

- Discharge may be voluntary or involuntary
- A discharge summary must be completed within 30 calendar days of the last face-to-face treatment contact
- The summary must include:
 - The duration of the treatment episode
 - The reason for discharge
 - A narrative summary of the treatment episode
 - The beneficiary's prognosis

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COMMON DEFICIENCIES FOR DISCHARGE PLANNING/SUMMARY

- No discharge summary
- The discharge date is not the last face-to-face treatment date
- The discharge summary is not within 30 calendar days of the last face-to-face
- No duration of treatment episode documented
- No prognosis documented

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DISCHARGE – FAIR HEARING

Section 51341.1(p)

- Any action taken to terminate or reduce services to a Medi-Cal beneficiary can be appealed by the beneficiary through a fair hearing process
- This fair hearing is in addition to any program or county level fair hearing process

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DISCHARGE – FAIR HEARING

Section 51341.1(p)

At least 10 calendar days prior to the effective date of the intended action the provider must give the beneficiary a written notice that includes:

- A statement of the action the provider intends to take
- The reason for the intended action
- A citation of the specific regulation(s) supporting the intended action

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DISCHARGE – FAIR HEARING

Section 51341.1(p)

Written notice (cont'd):

- Informs the beneficiary of his/her right to a fair hearing for the purpose of appealing the intended action
- The notice must include the address where the request for a fair hearing must be submitted
- Informs the beneficiary that the provider must continue treatment only if the beneficiary appeals in writing within 10 days of the notice

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COMMON DEFICENCIES FOR FAIR HEARING

- No documentation in the record that the beneficiary was informed of their fair hearing rights
- Provider did not implement the fair hearing process due to involuntary discharge
- The address to the Dept. of Social Services is outdated

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Questions & Answers



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MULTIPLE SERVICES ON THE SAME DAY

Section 51490.1(d)

- For ODF services...
 - Return visit shall not create a hardship on beneficiary
 - Progress note shall clearly reflect that an effort to provide all services was made in one visit **and** the return visit was unavoidable;
- Or**
 - The return visit shall clearly document a crisis or collateral service
 - Provider must complete the ADP 7700 form and place in beneficiary record

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MULTIPLE SERVICES cont'd...

Section 51490.1(d)(2)

- For DCH services...
 - The return visit shall clearly document a crisis service
 - Crisis services shall be documented in the progress notes
 - Provider must complete the ADP 7700 form and place in beneficiary record

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MULTIPLE SERVICES cont'd...

Section 51490.1(d)

Intake, treatment planning, discharge planning and group sessions you must also show...

- Time of day of each visit
- The leave and return requirement does not apply to crisis and collateral session

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COMMON DEFICIENCIES FOR MULTIPLE SERVICES

- Missing ADP 7700 forms
- Billing for the same service (ODF)
 - For example: Two treatment plan sessions
- Treatment services are documented as being conducted at the same time
- DCH billed for an ineligible second service
- Missing signature of the authorized person on the ADP 7700 form
- Using an incorrect form; such as, "Same day service form" in lieu of ADP 7700 form

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PERINATAL DOCUMENTATION

In order to receive the perinatal enhanced rate the following documentation will be reviewed:

- Pregnancy verification must be from a medical office and/or licensed physician
- Confirmation of child birth. This information will determine the start of the postpartum period

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POSTPARTUM SERVICES

Section 51341.1(b)(18)

- For women who were eligible for and received Medi-Cal during the last month of pregnancy
- Available for 60-day period beginning on the last day of pregnancy
- Eligibility ends on the last day of the month in which the 60th day occurs

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COMMON DEFICIENCIES FOR PERINATAL BENEFICIARIES

Not having the required documentation to determine pregnancy or postpartum timeline. Verbal verification or visual verification does not meet the verification requirement.

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DOCUMENTING TREATMENT FOR PERINATAL

Section 51341.1(h)(3)(B)

- In Perinatal Residential, progress notes:
 - Must be legible
 - Must be individual narrative summaries
 - May cover up to seven days
 - Must include attendance information including full date (month, day, year), session duration and type of counseling for each counseling session
 - Must include a description of beneficiary progress on treatment plan goals, etc.

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ADDITIONAL PROGRAM REQUIREMENTS


- Contact DHCS if program is planning to relocate
- Contact DHCS if program is closing

DHCS Application Unit:
916-322-2911

To access applications go to:
www.dhcs.ca.gov
Select the Providers & Partners tab
Under Substance Use Disorders select More
Select Drug Medi-Cal Certification

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Questions & Answers



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If additional questions arise after today's presentation, please indicate in the e-mail subject line "Webinar Training" and send e-mail to

DMCAAnswers@DHCS.ca.gov

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