METHOD OF INDICATING CHANGES

This Accessible PDF version of the emergency regulation text for readoption includes the phrase [begin underline] at the beginning of each addition, [end underline] at the end of each addition, [begin strikeout] at the beginning of each deletion, and [end strikeout] at the end of each deletion.

A standard PDF version of this emergency regulation text for readoption is also available on the Department's Office of Regulations Internet site.

Amend Section 51341.1 as follows:

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

(a) Substance use disorder services, as defined in this section, provided to [begin underline] a [end underline] Medi-Cal [begin underline] beneficiary [end underline] [begin strikeout] ~~beneficiaries~~, ~~are~~ [end strikeout] [begin underline] shall be [end underline] 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) [begin strikeout] ~~of this regulation~~ [end strikeout], rendered by the provider to the beneficiary.

[begin underline] (2) "Beneficiary" has the same meaning as in Section 51000.2.

(3) "Calendar Week" means the seven (7) day period from Sunday through Saturday. [end underline]

([begin underline] 4 [end underline] [begin strikeout] ~~2~~) [end strikeout] "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.

[begin underline] (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. [end underline]

([begin strikeout] ~~3~~ [end strikeout] [begin underline] 6 [end underline]) “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.

([begin strikeout] ~~4~~ [end strikeout] [begin underline] 7 [end underline]) “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.

([being strikeout] ~~5~~ [end strikeout] [begin underline] 8 [end underline]) “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 [begin strikeout] ~~in the~~ [end strikeout] postpartum [begin strikeout] ~~period~~ [end strikeout], and/or to Early and Periodic Screening Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized in this Chapter.

([begin strikeout] ~~6~~ [end strikeout] [begin underline] 9 [end underline]) “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.

[begin underline] (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. [end underline]

([begin underline] 11 [end underline] [begin strikeout] ~~7~~ [end strikeout]) "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. [begin underline] 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. [end underline]

[begin underline] (A) [end underline] 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.

[begin underline] (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. [end underline]

([begin underline] 12 [end underline] [begin strikeout] ~~8~~ [end strikeout]) "Individual counseling" means face-to-face contacts between a beneficiary and a therapist or counselor. [begin strikeout] ~~Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of service.~~ [end strikeout] [begin underline] 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. [end underline]

([begin underline] 13 [end underline] [begin strikeout] ~~9~~ [end strikeout]) "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 [begin strikeout] ~~licensed to practice medicine in the State of California~~. [end strikeout] 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.

([begin underline] 14 [end underline] [begin strikeout] ~~10~~ [end strikeout]) "Medical psychotherapy" [begin strikeout] ~~is~~ [end strikeout] [begin underline] means [end underline] a type of counseling service that has the same meaning as defined in Section 10345 of Title 9, CCR.

([begin underline] 15 [end underline] [begin strikeout] ~~11~~ [end strikeout]) "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.

([begin underline] 16 [end underline] [begin strikeout] ~~12~~ [end strikeout]) "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.

([begin underline] 17 [end underline] [begin strikeout] ~~13~~ [end strikeout]) "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.

([begin underline] 18 [end underline] [begin strikeout] ~~14~~ [end strikeout]) "Outpatient drug free treatment services" means an outpatient service directed at stabilizing and rehabilitating persons with substance use disorder diagnoses.

([begin underline] 19 [end underline] [begin strikeout] ~~15~~ [end strikeout]) "Perinatal certified substance use disorder program" means a Medi-Cal certified program which provides substance use disorder services, as specified in Subsection (c)(4) [begin strikeout] ~~of this regulation~~ [end strikeout], to pregnant and postpartum women with substance use disorder diagnoses.

([begin underline] 20 [end underline] [begin strikeout] ~~16~~ [end strikeout]) "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.

[begin underline] (21) "Physician" means a person licensed as a physician by the Medical Board of California or the Osteopathic Medical Board of California. [end underline]

([begin underline] 22 [end underline] [begin strikeout] ~~17~~ [end strikeout]) "Postpartum" means [begin underline] within the eligibility period [end underline] [begin strikeout] ~~means individuals who meet the criteria~~ [end strikeout] specified in Section 50260 [begin underline]. [begin strikeout] ~~or 50262.3(a).~~ [end strikeout]

([begin underline] 23 [end underline] [begin strikeout] ~~18~~ [end strikeout]) "Postservice postpayment utilization review" has the same meaning as Section 51159(c).

([begin underline] 24 [end underline] [begin strikeout] ~~19~~ [end strikeout]) "Provider" means the [begin strikeout] ~~legal~~ [end strikeout] entity certified pursuant to Section 51200 to provide Drug Medi-Cal substance use disorder services to eligible beneficiaries at its certified location(s).

[begin underline] (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. [end underline]

([begin underline] 27 [end underline] [begin strikeout] ~~20~~ [end strikeout]) "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.

[begin underline] (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. [end underline]

([begin underline] 30 [end underline] [begin strikeout] ~~21~~ [end strikeout]) "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 use disorder services for pregnant and postpartum women:

(1) Any of the substance use disorder services listed in [begin strikeout] ~~s~~ [end strikeout] [begin underline] S [end underline] ubsection (d) [begin strikeout] ~~of this regulation~~ [end strikeout] 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).

(d) Drug Medi-Cal substance use disorder services shall include [begin underline] all of the following [end underline]:

(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 [begin underline] all of [end underline] 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 [begin underline], [end underline] 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 [begin underline] meets all of the following conditions [end underline]:

(A) Has a confirmed, documented history of opiate addiction [begin strikeout] ~~;~~ [end strikeout] [begin underline]. [end underline]

(B) Is at least (18) years of age [begin strikeout]~~;~~ [end strikeout] [begin underline]. [end underline]

(C) Is opiate free [begin strikeout]~~; and~~ [end strikeout] [begin underline]. [end underline]

(D) Is not pregnant.

(e) The Department shall [begin underline] do all of the following [end underline]:

(1) Provide administrative and fiscal oversight, monitoring, and auditing for the provision of statewide Drug Medi-Cal substance use disorder services. [begin strikeout]~~;~~ [end strikeout]

(2) Ensure that utilization review is maintained through on-site postservice postpayment utilization review [begin underline]. [end underline] [begin strikeout]~~; and~~ [end strikeout]

(3) Demand recovery of payment in accordance with the provisions of Subsection (m) [begin strikeout] ~~of this regulation~~ [end strikeout].

(f) The county shall [begin underline] do all of the following [end underline]:

(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 [begin underline] . [end underline] [begin strikeout]~~;~~ [end strikeout]

(2) Monitor to ensure that billing for reimbursement is within the rates established for services [begin underline]. [end underline] [begin strikeout]~~; and~~ [end strikeout]

(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. [begin underline] 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. [end underline] [begin strikeout] ~~For purposes of this regulation, "an individual patient record" means a file for each beneficiary which shall contain, but not be limited to,~~ [end strikeout]

[begin underline] (A) Documentation of personal information shall include all of the following: [end underline]

[begin underline] (i) [end underline] [begin strikeout] ~~i~~ [end strikeout] [begin underline] I [end underline] nformation specifying the beneficiary's identifier (i.e., name, number) [begin strikeout]~~,~~ [end strikeout] [begin underline]. [end underline]

[begin underline] (ii) D [end underline] [begin strikeout] ~~d~~ [end strikeout] ate 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 [begin strikeout]~~,~~ [end strikeout] [begin underline]. [end underline] [begin strikeout] ~~and all documentation relating to the beneficiary gathered during the treatment episode,including all~~ [end strikeout]

[begin underline] (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: [end underline]

[begin underline] (i) I[end underline] [begin strikeout] i [end strikeout] ntake and admission data, [begin underline] including, if applicable, a physical examination. [end underline] [begin strikeout] all [end strikeout]

[begin underline] (ii) T [end underline] [begin strikeout] t [end strikeout] reatment plans [begin strikeout], [end strikeout] [begin underline]. [end underline]

[begin underline] (iii) Compliance with Subsection (h)(4). [end underline]

[begin underline] (iv) P [end underline] [begin strikeout] p [end strikeout] rogress notes [begin strikeout], [end strikeout] [begin underline]. [end underline]

[begin underline] (v) C [end underline] [begin strikeout] c [end strikeout] ontinuing services justifications [begin strikeout], [end strikeout] [begin underline]. [end underline]

[begin underline] (vi) L [end underline] [begin strikeout] l [end strikeout] aboratory test orders and results [begin strikeout], [end strikeout] [begin underline]. [end underline]

[begin underline] (vii) R [end underline] [begin strikeout] r [end strikeout] eferrals [begin strikeout], [end strikeout] [begin underline]. [end underline]

[begin underline] (viii) C [end underline] [begin strikeout] c [end strikeout] ounseling notes [begin strikeout], [end strikeout] [begin underline]. [end underline]

[begin underline] (ix) Discharge plan. [end underline]

[begin underline] (x) D [end underline] [begin strikeout] d [end strikeout] ischarge summary [begin underline]. [end underline] [begin strikeout] and [end strikeout]

[begin underline] (xi) Compliance with the multiple billing requirements specified in Section 51490.1(d). [end underline]

[begin underline] (xii) A [end underline] [begin strikeout] a [end strikeout] ny other information relating to the treatment services rendered to the beneficiary.

[begin underline] (xiii) Evidence of compliance with requirements for the specific treatment service as described in Subsection (d). [end underline]

(2) [begin strikeout] Maintain group counseling sign-in sheets which indicate the date and duration of the session; [end strikeout] [begin underline] 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. [end underline]

(3) Provide services [begin underline]. [end underline] [begin strikeout]; and [end strikeout]

(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 use disorder services, those services shall be provided by or under the direction of a physician and [begin underline] all of [end underline] the following requirements shall apply:

(1) Admission criteria and procedures [begin underline]. [end underline]

(A) For outpatient drug free, Naltrexone treatment, day care habilitative, and perinatal residential treatment services [begin underline] each of the following requirements shall be met: [end underline] [begin strikeout],the provider shall perform all of the following: [end strikeout]

(i) [begin underline] The provider shall [end underline] [begin strikeout] D [end strikeout] [begin underline] d [end underline] evelop and [begin underline] document [end underline] [begin strikeout] use criteria and [end strikeout] procedures for the admission of beneficiaries to treatment [begin underline]; and [end underline] [begin strikeout]. [end strikeout]

(ii) [begin underline] The provider shall [end underline] [begin strikeout] C [end strikeout] [begin underline] c [end underline] omplete a personal, medical, and substance use history for each beneficiary upon admission to treatment.

[begin strikeout] (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: [end strikeout]

[begin underline] (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. [end underline]

[begin strikeout] ~~(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 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.~~ [end strikeout]

[begin underline] (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. [end underline]

(B) In addition to the requirements of Subsection (h)(1)(A) [begin strikeout] ~~of this regulation~~ [end strikeout], for Naltrexone treatment services, [begin underline] for each beneficiary, all of [end underline] the following shall apply:

(i) The provider shall confirm that the beneficiary [begin underline] meets all of the following conditions [end underline]:

(a) Has a documented history of opiate addiction [begin strikeout]~~;~~ [end strikeout] [begin underline]. [end underline]

(b) Is at least eighteen (18) years of age [begin strikeout]~~;~~ [end strikeout] [begin underline]. [end underline]

(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 [begin strikeout]~~; and~~ [end strikeout] [begin underline]. [end underline]

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

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

(iii) The physician shall advise [begin underline] the [end underline] beneficiary [begin strikeout] ~~ies~~ [end strikeout] of the overdose risk should the [begin strikeout] ~~y~~ [end strikeout] [begin underline] beneficiary [end underline] 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.

[begin strikeout] ~~(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.~~ [end strikeout]

(2) Treatment plan for each beneficiary [begin underline]. [end underline]

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

(i) The initial treatment plan [begin underline] and updated treatment plans [end underline] shall include [begin underline] all of the following [end underline]:

(a) A statement of problems to be addressed [begin underline]. [end underline] [begin strikeout] ~~;~~ [end strikeout]

(b) Goals to be reached which address each problem [begin underline]. [end underline] [begin strikeout] ~~;~~ [end strikeout]

(c) Action steps which will be taken by the provider, and/or beneficiary to accomplish identified goals [begin underline]. [end underline] [begin strikeout] ~~;~~ [end strikeout]

(d) Target dates for the accomplishment of action steps and goals [begin underline]. [end underline] [begin strikeout] ~~;~~ [end strikeout]

(e) A description of the services, including the type of counseling, to be provided and the frequency thereof [begin underline]. [end underline] [begin strikeout];and [end strikeout]

(f) The assignment of a primary [begin underline] therapist or [end underline] counselor.

[begin underline] (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. [end underline]

(ii) The provider shall ensure that the initial treatment plan meets [begin underline] all of [end underline] the following requirements:

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

(b) [begin underline] 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. [end underline]

[begin underline] (c) [end underline] The physician shall review [begin strikeout], approve, and [end strikeout] [begin underline] 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 [end underline] sign [begin underline] and date the treatment plan [end underline] within fifteen (15) calendar days of signature by the [begin underline] therapist or [end underline] counselor.

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

(a) The [begin underline] therapist or [end underline] counselor shall [begin underline] complete, [end underline] [begin strikeout] review [end strikeout] [begin underline] type or legibly print their name, [end underline] [begin strikeout] and [end strikeout] sign [begin underline] and date [end underline] 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.

[begin underline] (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. [end underline]

([begin underline] c [end underline] [begin strikeout] b [end strikeout]) [begin underline] 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 [end underline], [begin strikeout] W [end strikeout] [begin underline] w [end underline] ithin fifteen (15) calendar days of signature by the [begin underline] therapist or [end underline] counselor [begin strikeout], the physician shall review, approve, and sign all updated treatment plans. [end strikeout] If the physician has not prescribed medication, a psychologist licensed by the State of California Board of Psychology may [begin underline] review for medical necessity, type or legibly print their name and [end underline] sign [begin underline] and date [end underline] an updated treatment plan.

(B) For narcotic treatment programs, providers shall complete [begin underline] initial and updated [end underline] 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, [begin underline] for each individual and group counseling session, [end underline] the [begin underline] therapist or [end underline] counselor [begin underline] who conducted that counseling

session [end underline] shall record a progress note for each beneficiary [begin underline] who [end underline] participat [begin underline] ed [end underline] [begin strikeout] ~~ing~~ [end strikeout] in [begin underline] the [end underline] [begin strikeout] ~~an individual or group~~ [end strikeout] counseling session [begin underline]; and type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the counseling session. [end underline] Progress notes are individual narrative summaries and shall include [begin underline] all of the following [end underline]:

(i) [begin underline] The topic of the session. [end underline]

[begin underline] (ii) [end underline] A description of the beneficiary's progress on the treatment plan problems, goals, action [begin strikeout] ~~s~~ [end strikeout] steps, objectives, and/or referrals [begin underline].[end underline] [begin strikeout]~~;and~~ [end strikeout]

[begin strikeout] ~~(ii)~~ [end strikeout] [begin underline] (iii) [end underline] Information on [begin strikeout] ~~a~~ [end strikeout] [begin underline] the [end underline] beneficiary's attendance [begin underline], [end underline] including the date [begin strikeout] ~~(month, day, year)~~ [end strikeout] [begin underline], start and end times of each [end underline] [begin strikeout] ~~and duration in minutes of~~ [end strikeout] individual [begin strikeout] ~~or~~ [end strikeout] [begin underline] and [end underline] group counseling session [begin strikeout] ~~s~~ [end strikeout].

(B) For day care habilitative and perinatal residential treatment services, [begin underline] 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. [end underline] [begin strikeout] the counselor shall record a progress note, at a minimum , once a week. The p [end strikeout] [begin underline] P [end underline] rogress notes are individual narrative summaries and shall include [begin underline] all of the following [end underline]:

[begin strikeout] (i) The time period covered by the summary. The period shall be no more than seven (7) days. [end strikeout]

(i [begin strikeout] i [end strikeout]) A description of the beneficiary's progress on the treatment plan problems, goals, action [begin strikeout] s [end strikeout] steps, objectives, and/or referrals [begin underline].[end underline] [begin strikeout]; and [end strikeout]

(ii [begin strikeout] i [end strikeout]) A record of the beneficiary's attendance at each counseling session including the date [begin strikeout] (month, day, year) [end strikeout] [begin underline], start and end times and topic [end underline] [begin strikeout] and duration [end strikeout] of the counseling session.

(C) For narcotic treatment programs, [begin underline] t [end underline] he [begin underline] therapist or [end underline] counselor shall record progress notes in accordance with the requirements of Section 10345, Title 9, CCR.

(4) Minimum provider and beneficiary contact [begin underline]. [end underline]

(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 [begin underline]

physician [end underline] [begin strikeout] ~~provider~~ [end strikeout] determines that [begin underline] either of the following apply [end underline]:

(i) Fewer beneficiary contacts are clinically appropriate [begin strikeout]~~; and~~ [end strikeout] [begin underline]. [end underline]

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

(ii) [begin strikeout] ~~If the counselor recommends that the beneficiary requires further treatment, the physician shall determine the need to continue services based on the following factors:~~ [end strikeout] [begin underline] 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: [end underline] [begin strikeout]

~~(a) The medical necessity of continuing treatment;~~

~~(b) The prognosis; and~~

~~(c) The counselor's recommendation for the beneficiary to continue receiving services~~. [end strikeout]

[begin underline] (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. [end underline] [begin strikeout] ~~The provider shall discharge the beneficiary if the physician determines there is no medical necessity to continue treatment.~~ [end strikeout]

(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) [begin strikeout] ~~of this regulation~~ [end strikeout].

[begin underline] (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. [end underline]

[begin underline] (B) [end underline] The provider shall complete a discharge summary [begin underline], [end underline] for [begin strikeout] ~~each~~ [end strikeout] [begin underline] any [end underline] beneficiary [begin underline] with whom the provider lost contact, [end underline] in accordance with [begin underline] all of [end underline] the following requirements:

[begin strikeout] (A [end strikeout] [begin underline] i [end underline]) 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 [begin underline] provider's [end underline] last face-to-face treatment contact with the beneficiary. The discharge summary shall include [begin underline] all of the following [end underline]:

([begin strikeout] i [end strikeout] [begin underline] a [end underline]) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment [begin strikeout]; [end strikeout] [begin underline]. [end underline]

([begin strikeout] ii [end strikeout] [begin underline] b [end underline]) The reason for discharge [begin strikeout]; [end strikeout] [begin underline]. [end underline]

([begin strikeout] iii [end strikeout] [begin underline] c [end underline]) A narrative summary of the treatment episode [begin strikeout]; and [end strikeout] [begin underline]. [end underline]

([begin strikeout] iv [end strikeout] [begin underline] d [end underline]) The beneficiary's prognosis.

([begin strikeout] B [end strikeout] [begin underline] ii [end underline]) 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 [begin underline] a [end

underline] beneficiar [begin underline] y [end underline] [begin strikeout] ies [end strikeout] for access to Drug Medi-Cal substance use disorder services or for admission to a Drug Medi-Cal treatment slot.

(i) [begin underline] For each beneficiary, [end underline] [begin strikeout] P [end strikeout] [begin underline] p [end underline] roviders shall maintain [begin underline] all of [end underline] the [begin strikeout] following [end strikeout] documentation in the [begin underline] beneficiary's [end underline] individual patient record established pursuant to [begin strikeout] s [end strikeout] [begin underline] S [end underline] ubsection (g)(1) [begin strikeout] for each beneficiary [end strikeout] for a minimum of three (3) years from the date of the last face-to-face contact [begin underline] 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. [end underline] If an audit takes place during the three year period, the provider [begin underline] s [end underline] shall maintain records until the audit is completed.

[begin strikeout] (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).~~ [end strikeout]

(j) Reimbursement for Drug Medi-Cal Substance Use Disorder Services [begin underline]. [end underline]

(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) [begin strikeout] ~~of this regulation~~. [end strikeout]

(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 [begin underline] either of [end underline] 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) [begin strikeout] ~~of this regulation~~ [end strikeout].

(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.

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

(1) Verify that the documentation requirements of Subsection (i) [begin strikeout] ~~of this regulation~~ [end strikeout] are met [begin strikeout] ~~;~~ [end strikeout] [begin underline] . [end underline]

(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, [begin underline] published by the American Psychiatric Association [end underline] diagnostic code, and medical necessity for services is established pursuant to Subsection (h)(1)([begin strikeout] ~~D~~ [end strikeout] [begin

underline] A)(vi) [end underline] [begin strikeout] ~~of this regulation;~~ [end strikeout] [begin underline] . [end underline]

(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) [begin strikeout] ~~of this regulation; and~~ [end strikeout] [begin underline] . [end underline]

(4) Establish the basis for recovery of payments in accordance with Subsection (m) [begin strikeout] ~~of this regulation~~.

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

[begin underline] (*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. [end underline]

(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 Subsection [begin underline] s (b), (c), (d), (g), [end underline] (h) [begin underline], and (i) [end underline] [begin strikeout] ~~(1)(D)of this regulation~~. [end strikeout]

(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 [begin strikeout]~~:~~

~~(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) T~~ [end strikeout] [begin underline] if t [end underline] he 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 [begin underline] any of the following [end underline]:

(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) [begin strikeout] ~~The provider~~ [end strikeout] [begin underline] For all providers who [end underline] 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 [begin underline] any of the following [end underline]:

(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) [begin strikeout] ~~The provider~~ [end strikeout] [begin underline] For all providers who [end underline] 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)([begin strikeout] ~~9~~ [end strikeout] [begin underline] 12 [end underline]) and, for outpatient drug free treatment services [begin underline] as specified in [end underline] [begin strikeout] ~~,~~ [end strikeout] Subsection (d)(2)(B) [begin strikeout] ~~of this regulation~~. [end strikeout]

(6) [begin strikeout] ~~The provider~~ [end strikeout] [begin underline] For all providers who [end underline] 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)([begin strikeout] ~~8~~ [end strikeout] [begin underline] 11) and, for outpatient drug free treatment services as specified in Subsection (d)(2)(A) [end underline] [begin strikeout] ~~of this regulation~~ [end strikeout].

(7) [begin strikeout] ~~The provider~~ [end strikeout] [begin underline] For all providers who [end underline] 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) 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. 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 [begin underline] do all of the following [end underline]:

(1) Address each demand for recovery of payment and/or programmatic deficiency~~;~~ [begin underline] . [end underline]

(2) Provide a specific description of how the deficiency shall be corrected [begin strikeout]~~; and~~ [end strikeout] [begin underline] . [end underline]

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

(p) Providers shall inform [begin underline] each [end underline] [begin strikeout] ~~all~~ [end strikeout] beneficiar [begin underline] y [end underline] [begin strikeout] ~~ies~~ [end strikeout] of the [begin strikeout] ~~ir~~ [end strikeout] right to a fair hearing related to denial, involuntary discharge, or reduction in Drug Medi-Cal substance use disorder services as

it relates to the [begin strikeout] ir [end strikeout] eligibility or benefits, pursuant to Section 50951.

(1) Providers shall advise [begin underline] the [end underline] beneficiar [begin underline] y [end underline] [begin strikeout] ies [end strikeout] 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 [begin underline] all of the following [end underline]:

(A) A statement of the action the provider intends to take; [begin underline]. [end underline]

(B) The reason for the intended action [begin strikeout] ; [end strikeout] [begin underline] . [end underline]

(C) A citation of the specific regulation(s) supporting the intended action [begin strikeout] ; [end strikeout] [begin underline] . [end underline]

(D) An explanation of the beneficiary's right to a fair hearing for the purpose of appealing the intended action [begin strikeout] ; [end strikeout] [begin underline] . [end underline]

(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 9-17-37

SACRAMENTO, CA 94244-2430

1 (800) 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 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. [begin strikeout] ~~Such appeals shall be handled pursuant to Section 51015.~~ [end strikeout]

(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:

DIVISION CHIEF

SUBSTANCE USE DISORDERS PREVENTION, TREATMENT AND RECOVERY SERVICES DIVISION

DEPARTMENT OF HEALTH CARE SERVICES

P.O. BOX 997413, MS-2621

SACRAMENTO, CA 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.

[begin strikeout] ~~(ii) The letter shall specify that it is being submitted in accordance with Section 51015.~~ [end strikeout]

(ii [begin strikeout] ~~i~~ [end strikeout]) 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) [begin strikeout] ~~of this regulation~~ [end strikeout] 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 [begin underline] all of the following [end underline]:

(i) A copy of the original written grievance or complaint sent to the SUDPTRSD [begin strikeout] ~~;~~ [end strikeout] [begin underline]. [end underline]

(ii) A copy of the SUDPTRSD's report to which the appeal, grievance, or complaint applies~~;~~ [begin underline] . [end underline] [begin strikeout] ~~and~~ [end strikeout]

(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, [begin underline] 14043.75, [end

underline] 14124.1, [begin strikeout] ~~14124.5 and~~ [end strikeout] 14124.24, [begin underline] 14124.26, and 14124.5 [end underline], 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.