



Beneficiary Eligibility Criteria for the DMC-ODS Pilot
Frequently Asked Questions
Updated June 2016

The following answers to frequently asked questions intend to provide clarification regarding the determination of program medical necessity criteria and Medi-Cal eligibility for beneficiaries to receive services through the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program.

This document will be updated as necessary.

For additional information regarding the DMC-ODS

- Visit <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>
- Contact us at DMCODSWAIVER@dhcs.ca.gov

What criteria must be met by beneficiaries in order to receive services through the DMC-ODS pilot program?

In order to receive services through the DMC-ODS pilot program, the beneficiary must:

- Be Medi-Cal eligible.
- Reside in the DMC-ODS pilot county (based on the Medi-Cal Eligibility Data System file).
- Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or be assessed to be at risk for developing a SUD (for youth under 21).
- Meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
- If applicable, must meet the ASAM adolescent treatment criteria.

How must eligibility be determined?

Determination of who may receive DMC-ODS pilot benefits shall be performed as follows:

- Medi-Cal eligibility must be verified by the county, or county contracted provider. When the county contracted provider conducts the initial eligibility determination, it will be reviewed and approved by the county prior to payment for services (with an exception for tribal health programs).
- The initial medical necessity determination must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA).
- After establishing a diagnosis, the ASAM criteria will be applied to determine placement into a level of assessed services.
- Medical necessity qualification for ongoing receipt of services (except for NTP services) is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician, or LPHA to be clinically appropriate. For NTP services, reauthorization is required annually.

Who can determine medical necessity?

For counties participating in the DMC-ODS pilot program, medical necessity can be determined by a Medical Director, licensed physician, or a LPHA. For counties not participating in the DMC-ODS pilot program, medical necessity can only be determined by a licensed physician.

What is a Licensed Practitioner of the Healing Arts?

LPHA includes:

- Physician
- Nurse Practitioner (NPs)
- Physician Assistants (PAs)
- Registered Nurses (RNs)
- Registered Pharmacists (RPs)
- Licensed Clinical Psychologists (LCPs)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Licensed Marriage and Family Therapists (LMFTs)
- License-Eligible Practitioners working under the supervision of licensed clinicians

Do certified sites / facilities furnishing service under the DMC-ODS pilot program need to have a Medical Director?

Yes. In selecting providers to furnish services under this pilot, counties must select only providers that have a Medical Director who, prior to the delivery of services under this pilot, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a Medicaid provider agreement with DHCS as required

by 42 CFR 431.107.

What, if any, are the timeliness requirements for the determination of medical necessity?

The provider (Medical Director, licensed physician, or LPHA) shall evaluate each beneficiary to diagnose whether the beneficiary has a substance use disorder (or risk of developing a substance use disorder for youth under 21) within thirty (30) calendar days of the beneficiary's admission to treatment date. The provider shall document the basis for the diagnosis in the beneficiary's individual patient record.

How often does medical necessity need to be verified / reauthorized?

Medical necessity qualification for ongoing receipt of services (except for NTP services) is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician, or LPHA to be clinically appropriate. For NTP services, reauthorization is required on an annual basis.

Can assessment activities be claimed?

Services rendered to conduct the required assessment to determine medical necessity and establish a treatment plan should be documented and claimed accordingly.