



Perinatal Beneficiaries and the DMC-ODS Pilot Program
Frequently Asked Questions
June 2016

The following answers to frequently asked questions intend to provide clarification regarding treating perinatal women in 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 Pilot Program:

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

1. What is the term of eligibility for “perinatal” or pregnancy-related services?

A pregnant woman who was eligible for and received Medi-Cal services during the last month of pregnancy shall continue to be eligible for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy, regardless of whether the other conditions of eligibility are met. Eligibility (based on pregnancy) ends on the last day of the month in which the 60th day occurs (22 CCR §50260).

2. What are extended services for pregnant women under the broader Medi-Cal Program?

Extended services for pregnant women include pregnancy-related and postpartum services for 60 days after the pregnancy ends (or the last day of the month in which the 60th day occurs) for 60 days after pregnancy ends and services for any other medical conditions that may complicate pregnancy. Pregnancy-related and postpartum services include all antepartum (prenatal) care, care during labor and delivery, postpartum care, and family planning. Pregnancy-related services include all care normally provided during pregnancy (examinations, routine urine analyses, evaluations, counseling, and treatment) and labor and delivery (initial and ongoing assessment of maternal and fetal well-being and progress of labor, management of analgesia and local prudential anesthesia, vaginal delivery with or without episiotomy, initial assessment and, when necessary, resuscitation of the newborn

infant). Postpartum care includes those services provided 60 days after the pregnancy ends (or the last day of the month in which the 60th day occurs (e.g. hospital and scheduled office visits during the puerperium, assessment of uterine involution and, as appropriate, contraceptive counseling). Family planning services include contraceptive counseling and tubal ligation. Treatment for obstetrical complications (including preexisting or developing maternal or fetal conditions) which create a high-risk pregnancy and which may or may not be pregnancy-related is also covered.

Pregnancy-related and postpartum services may also include outpatient alcohol and other drug treatment services that ameliorate conditions that complicate pregnancy, when medically necessary. These services include women-specific treatment and recovery services.

3. Are perinatal beneficiaries eligible for DMC-ODS Pilot Program services?

Yes. In order to receive services through the DMC-ODS pilot program, the perinatal 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, meet the ASAM adolescent treatment criteria.

4. How often does medical necessity need to be verified / reauthorized for perinatal beneficiaries under the DMC-ODS Pilot Program?

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.

5. Are residential services available to perinatal beneficiaries?

Yes. Residential services are provided to both non-perinatal and perinatal beneficiaries. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. For perinatal beneficiaries, these services include women-specific treatment and recovery services. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and

apply interpersonal and independent living skills and access community support systems. The cost of room and board is not eligible for federal financial participation.

6. Is prior authorization required for perinatal residential treatment under the DMC-ODS Pilot Program?

Yes. Counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider. Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service. Counties shall have written policies and procedures for processing requests for initial and continuing authorization of services. Counties are to have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Counties are to meet the established timelines for decisions for service authorization. Counties are required to track the number, percentage of denied and timeliness of requests for authorization for all DMC-ODS Pilot services that are submitted, processed, approved, or denied.

7. Are there limitations related to length of stay in residential services for perinatal beneficiaries?

No. Whereas the length of residential services range from 1 to 90 days with a 90-day maximum for (non-perinatal) adults and a 30-day maximum for adolescents (with a one-time extension up to 30 days on an annual basis), perinatal clients may receive longer lengths of stay based on medical necessity. Perinatal clients may receive lengths of stay up to the length of the pregnancy and postpartum period (the last day of the month in which the 60th day after the end of the pregnancy).

8. Are there any unique claiming requirements related to perinatal residential services provided under the DMC-ODS Pilot Program?

Yes. The claim requires a pregnancy indicator and the appropriate perinatal modifier. The treatment plan must also establish medical necessity for the services prescribed and, as applicable, support the extended length of stay.

9. Are there different licensing requirements for perinatal residential treatment facilities under the DMC-ODS Pilot Program than existing licensing requirements for non-Pilot perinatal residential treatment facilities?

No. The licensing requirements for perinatal residential treatment facilities will remain the same under the Pilot Program.

10. Are there facility size / bed number limitations for purposes of seeking federal financial participation under the DMC-ODS Pilot Program?

No. Residential services under the DMC-ODS Pilot Program, including perinatal

residential services, can be provided in facilities of any size.

11. Do perinatal residential providers participating in the DMC-ODS Pilot Program need to have an ASAM designation?

Yes. The Centers for Medicare and Medicaid Services (CMS) requires all residential providers to meet the ASAM requirements and obtain a DHCS issued ASAM designation as part of their participation in the DMC-ODS. DHCS has developed a designation program to certify that all providers of Level 3.1 through 3.5 Residential / Inpatient Services are capable of delivering care consistent with ASAM Criteria. As part of this designation program, DHCS has developed a self-assessment questionnaire that includes the elements that define Levels 3.1 through 3.5. After completion of the DHCS ASAM designation questionnaire, each facility will be given a provisional designation. The provisional status of the DHCS ASAM designation will remain on the residential treatment facility license until verification of the designation(s) is completed during an on-site visit. Over the next several months, DHCS will also be adding the ASAM designation process to the initial licensing process, so all residential providers will eventually have an ASAM designation.