



Residential Treatment Services in the DMC-ODS Pilot Program
Frequently Asked Questions
September 2016

The following answers to frequently asked questions intend to provide clarification regarding residential treatment services available to Medi-Cal beneficiaries in Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Program counties.

This document will be updated as necessary.

For additional information regarding residential treatment services:

- Information Notice 15-035
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_15-035_ASAM_Designation_8.27.pdf
- Information Notice 16-037
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_16-037.pdf
- Information Notice 16-042
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_IN_16-042.pdf

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 residential treatment?

Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan. Residential treatment services are provided in a continuum as per the five levels of American Society of Addiction Medicine (ASAM) residential treatment (3.1, 3.3, 3.5, 3.7, and 4).

2. Is residential treatment a required service in all counties that contract to participate in the DMC-ODS Pilot Program?

Yes. Residential treatment services are required in all counties that contract to participate in the DMC-ODS Pilot Program. At least one level of residential treatment is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services 3.1, 3.3, and 3.5 within three years of Centers for Medicare and Medicaid (CMS) approval of the county implementation plan and state-county intergovernmental agreement. The county must describe coordination for ASAM levels 3.7 and 4.0.

3. What are the ASAM levels of residential care?

Levels 3.1 through 4 are described in the table below:

| ASAM Level of Care | Service Name | Description of Care |
|---------------------------|--|---|
| 3.1 | Clinically Managed Low-Intensity Residential Services | 24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment. |
| 3.3 | Clinically Managed Population-Specific High-Intensity Residential Services | 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for outpatient treatment. (Note: this level is not designated for adolescents). |
| 3.5 | Clinically Managed High-Intensity Residential Services | 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community. |
| 3.7 | Medically Monitored Intensive Inpatient Services | 24-hour nursing care with physician availability for significant problems. 16 hour/day counselor availability. |

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| 4 | Medically Managed Intensive Inpatient Services | 24-hour nursing care with daily physician care for severe, unstable problems. Counseling available to engage patient in treatment. |
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4. What are the required levels of residential treatment for counties contracting to participate in the DMC-ODS Pilot Program?

At least one level of residential treatment is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of residential treatment services 3.1, 3.3, and 3.5 within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement.

5. Can a participating county elect to cover additional levels of residential treatment, such as 3.7 or 4?

Yes. Participating pilot counties may elect to offer medically monitored and/or managed intensive residential treatment services (levels 3.7 and 4) at Chemical Dependency Recovery Hospitals (CDRHs) or freestanding psychiatric hospitals through the DMC-ODS Pilot Program. Counties electing to offer inpatient residential treatment services at CDRHs or freestanding psychiatric hospitals must establish interim rates for the optional mode of service. Funding for these facilities will be paid for under the DMC-ODS pilot program.

CDRHs and freestanding psychiatric hospitals must hold a current, valid license from the Department of Public Health (DPH). Drug Medi-Cal (DMC) certification is required for all providers under the DMC-ODS Pilot Program, including CDRHs and freestanding psychiatric hospitals. A valid license from DPH is acceptable for Drug Medi-Cal certification. For more information about the Drug Medi-Cal certification process, go to: <http://www.dhcs.ca.gov/provgovpart/Pages/DMC-Forms.aspx>.

6. Who is eligible for residential treatment under the DMC-ODS Pilot?

Residential treatment services are available, based on medical necessity and the individualized treatment plan, to all beneficiaries residing in a participating DMC-ODS county who meet the established medical necessity criteria. Residential treatment services are provided to both non-perinatal and perinatal beneficiaries. This includes both adults and adolescents.

7. What are the components of residential treatment services?

The components of Residential Treatment Services include:

- Intake: The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- Individual and Group Counseling: Contacts between a beneficiary and a therapist or counselor. Services are provided in-person, by telephone, or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction
- Patient Education: Provide research-based education on addiction, treatment, recovery, and associated health risks
- Family Therapy: The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
- Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
- Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused 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.
- Crisis Intervention Services: 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 the stabilization of the beneficiary's emergency situation.

- Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. The treatment plan must include:
 - A statement of problems to be addressed,
 - Goals to be reached which address each problem
 - Action steps which will be taken by the provider and/or beneficiary to accomplish identified goals,
 - Target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof.
 - Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment.
 - The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration.
 - The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or Licensed Practitioner of the Healing Arts.

- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.

- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

8. What are the daily regimen and activities available for beneficiaries in a residential treatment environment?

In the residential treatment environment, an individual's functional cognitive deficits may require treatment that is primarily slower paced, more concrete, and repetitive in nature. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. 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. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

9. Where can residential treatment services be provided under the DMC-ODS Pilot Program?

Clinically-managed levels of residential treatment services (3.1, 3.3, and 3.5) must be provided by DHCS-licensed and DMC-certified residential facilities. Facilities serving adolescents are licensed by the Department of Social Services. Residential levels of care requiring medically monitored or managed intensive inpatient services (3.7 and 4) must be provided in a chemical dependency recovery hospital (CDRH), freestanding psychiatric hospital, or a general acute care hospital. Facilities serving adolescents are licensed by the Department of Social Services. Residential treatment facilities offering levels 3.1, 3.3, and 3.5 must also receive an ASAM designation from DHCS. See [Information Notice 15-035](#) for more information regarding the DHCS ASAM designation process.

Counties may also elect to offer residential levels 3.1, 3.3, or 3.5 at CDRHs and freestanding psychiatric hospitals. CDRHs and freestanding psychiatric hospitals must hold a current, valid license from the Department of Public Health (DPH). Drug Medi-Cal certification is required for all providers under the DMC-ODS Pilot Program, including CDRHs and freestanding psychiatric hospitals. A valid license from DPH is acceptable for Drug Medi-Cal certification. If a CDRH or freestanding psychiatric hospital is contracted with a county to offer residential services for levels 3.1-3.5, the facilities must obtain an ASAM designation for each level of residential service provided. For more information about the Drug Medi-Cal certification process, go to: <http://www.dhcs.ca.gov/provgovpart/Pages/DMC-Forms.aspx>.

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

No. Residential treatment services under the DMC-ODS Pilot Program can be provided in facilities of any size.

11. Are there limitations related to length of stay in residential treatment under the DMC-ODS Pilot Program?

Yes. The length of residential treatment services range from 1 to 90 days with a 90-day maximum for adults and a 30-day maximum for adolescents; unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. The average length of stay for residential treatment services is 30 days.

Residential treatment services for adults may be authorized for up to 90 days in one continuous period. Reimbursement will be limited to two non-continuous regimens for adults in any one-year period (365 days). One extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous length of stay in a one-year period (365 days).

Residential treatment services for adolescents may be authorized for up to 30 days in one continuous period. Reimbursement will be limited to two non-continuous 30-day regimens in any one-year period (365 days). One extension of up to 30 days beyond the maximum length of stay may be authorized for one continuous length of stay in a one-year period (365 days).

12. Can the length of stay in residential treatment be extended for perinatal clients under the DMC-ODS Pilot Program?

Yes. Perinatal clients may receive a longer length of stay based on medical necessity. Perinatal clients may receive lengths of stay up to the length of the pregnancy and postpartum period (up to the last day of the month in which the 60th day after the end of pregnancy occurs).

13. Are there treatment authorization requirements for residential treatment services covered 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.