



Drug Medi-Cal Organized Delivery System

*Frequently Asked Questions
Revised June 2019*

The frequently asked questions intend to provide clarification on various components of the Drug Medi-Cal Organized Delivery System (DMC-ODS). Specifically, this document focuses on addressing questions that are not explicitly answered in the [Special Terms and Conditions](#), [Intergovernmental Agreement](#), and existing [MHSUDS Information Notices](#) or other official DHCS sources.

This document will be updated as necessary.

For additional information regarding the DMC-ODS:

- Visit the [DMC-ODS webpage](#).
- Contact us at [DMC Answers](#).

Fiscal

Billing

1. Can a non-perinatal provider serve a pregnant beneficiary? What is the process to claim for these services?

Yes, a pregnant beneficiary can choose to receive services from a non-perinatal provider. If the beneficiary receives eligibility through a pregnancy aid code, the claim will require the PAT 9 pregnancy indicator to be valid.

2. What is the methodology for billing group counseling services?

DMC-ODS group services should use the following methodology:
(Number of minutes for the group + travel / Number of beneficiaries in the group)
= Total minutes per beneficiary + documentation time.

Travel time can be included for the counselor's travel from facility to the community location where a group may be offered, and back to facility. Documentation time captures the time it takes for the counselor to write a progress note for each beneficiary that participated in the group.

- 3. If a beneficiary does not attend the total required number of hours for services they were supposed to, can the provider bill for the hours that the beneficiary did attend?**

The provider cannot bill for services that were not provided. However, the hours that were provided will not be disallowed as long as the provider has ensured that the minimum required hours of services were made available to the beneficiary.

- 4. If a client is transitioning between levels of care and the case managers from both organizations are meeting together with the client to facilitate the transition, can both organizations claim for the service?**

Case management for care coordination will be allowed for transitions between levels of care. Each county can structure this activity according to their policies and procedures for managing care coordination.

- 5. If the only service provided on a given day is “room and board,” would this be considered a non-billable DMC day?**

Yes. If the only service that is provided on a given day is “room and board” (SABG or other funded), it would be considered a non-billable DMC day. It would not alter the authorization period and the day would not be billable unless you document a clinical service on that date. If there is not a DMC claim for that day, it would not count toward the 90-day stay limit.

Fiscal Considerations

- 1. What inflation factors must be considered in interim rate-setting?**

DHCS has selected the “Medicare Home Health Agency Market Basket Index” as the inflation factor to be applied by counties. The current Medicare Home Health Agency Market Basket Index is available on the [CMS website](#).

- 2. What happens if a county underestimates costs in the development of the interim rate?**

Under or overpayment of federal funds to the contracting county will be addressed as a part of the settlement process.

- 3. Are revenues other than 2011 realignment funds eligible for federal match?**

Yes. Other local funds are eligible to be used as the non-federal match as long as they are non-federal public funds and are otherwise eligible to be used as match consistent with the requirements outlined in SSA §1903(w)(6) and 42 CFR §433.51.

- 4. Can travel time be claimed under the DMC-ODS Pilot Program?**

Yes. Counties and county sub-contractors may claim for staff travel time to and from providing direct services under the DMC-ODS Pilot Program. Travel and documentation time is to be included in the service time and must not be claimed separately. Travel and documentation time must be linked to the service provided, documented in the treatment notes, and subject to federal

reasonableness standards.

Quality Management

Grievances and Appeals

1. What are the county documentation requirements relating to grievances?

The county shall maintain a written record for each grievance and appeal received. The record of each grievance and appeal shall be maintained in a log and include the following information:

1. The date and time of receipt of the grievance or appeal;
2. The name of the beneficiary filing the grievance or appeal;
3. The name of the representative recording the grievance or appeal;
4. A description of the complaint or problem;
5. A description of the action taken by the Plan or provider to investigate and resolve the grievance or appeal;
6. The proposed resolution by the Plan or provider;
7. The name of the Plan provider or staff responsible for resolving the grievance or appeal; and
8. The date of notification to the beneficiary of the resolution

The written record of grievances and appeals shall be submitted at least quarterly to the county's quality improvement committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.

2. What are the requirements for appeals?

The beneficiary or their authorized representative may file an appeal in-person, orally, or in writing. If they request expedited resolution, the beneficiary or representative must follow an in-person or oral filing with a written, signed appeal. The appeal must not count against the beneficiary or authorized representative in any way. Individuals deciding on the appeals resolution must be qualified to do so and not involved in any previous level of review or decision-making.

Beneficiaries and / or their authorized representative must:

- Have the right to examine their case files, including their medical record and any other documents or records considered during the appeal process, before and during the appeal process.
- Have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Be allowed to have a legal representative and / or legal representative of a deceased member's estate included as parties to the appeal.
- Be informed that their appeal is being reviewed using written confirmation.

- Be informed of their right to request a State Fair Hearing, following the completion of the appeal process.
3. **What are the requirements and timeframes for State Fair Hearings?**
 Beneficiaries may request a State Fair Hearing only after receiving notice that the county is upholding an adverse benefit determination.
 Beneficiaries have 120 days to request a State Fair Hearing, beginning from the date that the county gave the decision to the beneficiary in person, or the day after an appeal decision is postmarked. If the beneficiary did not receive a NOABD, they may file for a State Fair Hearing at any time.
 The Department of Social Services will conduct an independent review within 90 days of receiving the request. Beneficiaries may request an expedited State Fair Hearing. If a request qualifies for an expedited State Fair Hearing, the decision will be issued within three working days from the date that the request is received by the State Hearings Division.
 4. **Can counties update the NOABDs? If not, will DHCS be issuing a NOABD that is specific to SUD services?**
 NOABD template language cannot be amended or modified. All templates must be used with the approved language and approved font. The section of each NOABD pertaining to the availability of large font, braille or electronic formats must be in 18-point font; the rest of the NOABD should be in 12-point font.
 The #4 Delivery System NOABD does not apply to SUD services. All of the other NOABDs apply to SUD services and should be used accordingly.
 5. **Should network providers send NOABDs when discharging clients for noncompliance? Do providers issue NOABD letters or only counties?**
 A NOABD must be sent to the beneficiary when discharging for non-compliance. The county is ultimately responsible for ensuring that the NOABD letters appropriately reach the beneficiary. However, if they choose to make it a requirement of their providers, the county must have a mechanism in place to be notified of their occurrences to ensure compliance.
 6. **What happens if a beneficiary never shows up for treatment after admission or never returns to treatment?**
 The county would be responsible for issuing a NOABD to the beneficiary, specifically a termination notice for non-compliance.
 7. **If a beneficiary's treatment plan is modified by the provider (e.g., change in level, frequency or type of service) must a Modification of Requested Service NOABD be issued to the beneficiary?**
 Outpatient DMC-ODS treatment services are not required to be authorized by the Plan. If the provider determines a change in level of care or frequency of services is appropriate, they do not need to receive authorization from the Plan. Because the provider is modifying the services, and not the Plan, a modification notice is not required.

Quality Management

1. **If my county has an integrated behavioral health department (i.e., mental health and substance use disorder [SUD] treatment services are overseen by a single director), can I combine some of the same requirements of the DMC-ODS QI Plan with the Mental Health Plan (MHP) QI Plan?**

Yes, for counties that have an integrated behavioral health department, the DMC-ODS QI Plan may be combined with MHP QI Plan.

2. **What grievance and appeal information must be in the QI Plan?**

The QI Plan must include information on how beneficiary complaints data will be collected, categorized, and assessed for monitoring. At a minimum, the QI Plan must include information on:

- How to submit a grievance, appeal, and request for a state fair hearing;
- The time frame for resolution of appeals;
- The content of an appeal resolution;
- Record keeping;
- Continuation of benefits; and
- Requirements of state fair hearings.

3. **If my county has an integrated behavioral health department, can I use the same QI Committee required by the MHP contract to fulfill the DMC-ODS QI Committee requirements?**

Yes, for counties with an integrated behavioral health department, the county may use the same committee, with SUD participation.

Staffing

1. **Are student interns or trainees considered LPHAs?**

No. To be considered “license-eligible,” the individual must be registered with the appropriate state licensing authority for his or her respective field. Interns who have not yet received their advanced degree within their specific field and / or have not registered with the appropriate state board are not considered LPHAs.

2. **Are co-signatures required for license-eligible practitioners?**

Co-signing assessments is not required for license-eligible practitioners as part of the required supervision. To be considered a “licensed-eligible practitioner,” an individual must be registered with the appropriate state licensing authority for his or her respective field in order to obtain supervised clinical hours for licensure. The individual must also be working under the supervision of a licensed clinician. The terms of supervision are governed by the scope of practice statutes and the California Board of Behavioral Sciences and the California Board of Psychology professional boards. Please refer to the [California Board of Behavioral Sciences](#) or the [California Board of Psychology](#) for more information on licensing and registration requirements.

3. **What does it mean to be a “registered” counselor?**

According to Title 22 [9 CCR 130059(a)(8)], “registrant” means an individual registered with any certifying organization to obtain certification as an AOD counselor.

Levels of Care

Case Management

1. **What are the certification requirements to offer case management services?**

A site / facility offering case management services must be a certified DMC provider. However, this does not mean that services must be provided at the certified site / facility. Alternatively, services may be provided in the community.

2. **What requirements must be met for case management services to be eligible for reimbursement?**

- The beneficiary is Medi-Cal eligible.
- The beneficiary resides in the pilot county.
- The beneficiary meets established medical necessity criteria. The initial medical necessity determination must be performed by a medical director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA).
- Services are delivered by a qualified provider and linked to a DMC-certified site / facility.

Medication Assisted Treatment

1. **Can the requirement to offer naloxone at an NTP / OTP be met by offering a form of buprenorphine (suboxone) that contains both buprenorphine and naloxone in the formula?**

No. While Narcotic Treatment Programs (NTPs) / Opioid Treatment Programs (OTPs) may offer forms of buprenorphine that contain naloxone in the formula, this is not a replacement for naloxone. Naloxone (by itself) is used to treat a narcotic overdose in an emergency situation. Naloxone utilized as a combo product with buprenorphine is utilized to prevent diversion of the medication.

2. **What are the differences between NTP / OTP MAT services and non-NTP / OTP MAT services?**

NTP / OTP MAT services include methadone dosing, buprenorphine dosing, disulfiram dosing, and naloxone dispensing, along with counseling services. Non-NTP / OTP MAT services are identified as “Additional MAT” and are optional services for the DMC-ODS. Additional MAT has a component for medication management – which reimburses the MD for medication management and prescribing. The prescription would be filled by a pharmacy and shall be

reimbursed through the pharmacy benefit. There is the option for the DMC-ODS County to propose a dosing rate for five categories of FDA approved medications, including buprenorphine, disulfiram, naltrexone (Vivitrol), acamprosate, and naloxone. These rates would go through the same approval process as the Interim Rates.

3. **Are MAT services available outside of DMC-ODS?**

Yes. Medi-Cal beneficiaries may access MAT services outside of DMC-ODS under certain circumstances. SUD treatment providers may offer certain MAT services through an enrollment of physicians as Fee-For-Service (FFS) providers and adherence to the requirements as outlined below. See the [Medi-Cal provider manual](#) posted online for more detailed information about the coverage available under the FFS program.

- *Buprenorphine* is a covered benefit and is available to all Medi-Cal beneficiaries who demonstrate a medical necessity for the use of the medication. Physicians at SUD facilities need to enroll as FFS providers to prescribe or administer and bill for buprenorphine.
 - FFS Medical Benefit: Any DATA 2000 waived (X number) Medi-Cal physician can order, stock, and administer buprenorphine for treatment of opioid addiction. Such medications may be prescribed and / or dispensed in the office / clinic setting. The provider bills the medical service just as any other medical service provided by their provider type. Physicians at SUD facilities who have enrolled as FFS providers would also need to obtain a federal DATA 2000 waiver (X number). In terms of counseling, a Medi-Cal provider may be a physician, psychiatrist, psychologist, nurse practitioner, or physician assistant.
 - Pharmacy Benefit: If buprenorphine is not administered directly to the patient, and the physician writes a prescription for the patient to pick up at a pharmacy for self-administration, the drug cost is covered under the FFS Pharmacy Benefit. The rate of reimbursement for the drug cost may be found in the [Affordable Care Act Federal Upper Limit Reimbursement List](#).
- *Injectable Naltrexone*, a long-acting injection, is a covered benefit of the Medi-Cal program and is available to all Medi-Cal beneficiaries who demonstrate a medical necessity for the use of the drug. It may be billed as either a FFS medical claim or a pharmacy claim. Naltrexone long-acting injection always requires a treatment authorization request (TAR), whether billed as a medical claim by physicians / clinics or as a pharmacy dispensed benefit. In order for the onsite physician to prescribe or administer long-acting injectable naltrexone, the physician at the SUD facility would need to be enrolled as a FFS provider.
 - FFS Medical Benefit: An SUD physician may become a FFS provider to prescribe and / or administer injectable naltrexone. The CPT codes 99205 and 99215 are then used to report the physician's time for naltrexone management. If the FFS physician

administers the drug in the office, this is termed a “physician administered drug.” The physician is reimbursed for the drug and the administration directly. The policy for naltrexone long-acting injection, when provided as a FFS medical benefit, can be found in the Injections: Drugs N – R section of the Medi-Cal Part 2 provider manual. It is billed under Healthcare Common Procedure Coding System (HCPCS) code J2315 (injection, naltrexone, depot form, 1 mg).

- Pharmacy Benefit: If the FFS physician does not administer the drug and instead writes a prescription for the medication, the injection would be administered at a pharmacy. The drug cost would then be paid for as a Pharmacy Benefit.
- Naloxone is a covered benefit of the Medi-Cal program and is available to all Medi-Cal beneficiaries who are at risk of opioid overdose. Naloxone does not require a TAR. In order for the onsite SUD physician to prescribe naloxone, the physician would need to become enrolled as a FFS provider. The drug cost is paid for through the Pharmacy Benefit.
 - Pharmacy Benefit: All authorized Medi-Cal providers can write a prescription for naloxone and provide the prescription to the patients. The patient can fill the prescription at any Medi-Cal provider pharmacy. Since the drug is administered at the time and place of the overdose, the medication would remain in possession of the patient (or caregiver), and would not remain at the SUD setting.

Partial Hospitalization

1. What certification requirements must be met in order for a county to offer Partial Hospitalization services through the DMC-ODS Pilot Program?

Pilot counties, or contracted network providers in pilot counties, must be certified as DMC Intensive Outpatient Treatment (IOT) providers and must demonstrate the ability to facilitate access to the psychiatric, medical, and laboratory services that might be identified as needs in the beneficiary’s treatment plan. There is no DMC certification category specific to partial hospitalization.

Recovery Services

1. Are beneficiaries receiving ongoing, long-term medication assisted treatment eligible for recovery services given that they may not “complete” their course of treatment (i.e., opioid replacement therapy)?

If a beneficiary is receiving medication assisted treatment services through a Narcotic Treatment Program (NTP) / Opioid Treatment Program (OTP), they should access any related counseling services through the NTP / OTP provider since counseling and other supports are included as part of the NTP / OTP program. For beneficiaries receiving medication assisted treatment in non-NTP / OTP settings, such as primary care settings, they may access recovery services

as necessary through certified DMC providers after their course of treatment (other than ongoing medication support) has been completed.

2. What are recovery residence services?

Recovery residences offer safe, stable, and supportive living environments that are essential to individuals recovering from SUD. Counties entering into a state-county intergovernmental agreement to participate in the DMC-ODS pilot program may offer recovery residence services as an ancillary component of the DMC-ODS waiver in adherence with the following guidance:

- Recovery residences do not provide SUD services or require licensure by DHCS.
- All recovery residence residents must be receiving medically necessary SUD treatment services, which may include recovery services, from a certified provider.
- Each county should develop guidelines for contracted recovery residence providers and provide monitoring and oversight.