CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

DRUG MEDI-CAL

Training Manual:

Charting Requirements
ODF/DCH/Perinatal Residential

Drug Medi-Cal Monitoring Unit

Revised March 10, 2005

Training Manual: Charting Requirements for ODF/DCH/Perinatal Residential

Introduction

Welcome to the Drug Medi-Cal (DMC) provider *Training Manual: Charting Requirements for ODF/DCH/Perinatal Residential (2004-05).* The Department of Alcohol and Drug Programs (ADP) DMC Monitoring Unit has prepared this manual to assist DMC service providers in meeting the regulations and standards required for reimbursement of services to DMC beneficiaries. The manual is a detailed guide for use by providers in fully meeting the DMC regulations and standards, for maintaining the quality of treatment services DMC beneficiaries both need and deserve, and for avoiding recoupments assessed as the result of program deficiencies.

The requirements for the provision and documentation of substance abuse services for DMC eligible beneficiaries reimbursed by DMC funds are contained in the following documents, which are located at ADP's web site at www.adp.ca.gov/dmc.asp :

- Title 22, California Code of Regulations (CCR) sections 51341.1, 51490.1 and 51516.1;
- Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Certification Standards) of July 2004; and,
- The State of California Standards for Drug Treatment Programs (Treatment Standards) of October 1981, revised September 1982. [Additional information on treatment standards is contained in the March, 2004, Alcohol and/or Other Drug Program Certification Standards (AOD Standards)].

Federal law requires all payments to providers for Medi-Cal services (funded in part by Federal Medicaid dollars) be subject to utilization controls. Utilization controls take various forms, and for DMC services the utilization control is the postservice postpayment (PSPP) utilization review conducted by analysts who are employees ADP's DMC Monitoring Unit.

Title 22, California Code of Regulations, Section 51341.1(k) defines the Drug Medi-Cal (DMC) postservice postpayment (PSPP) utilization review process. The utilization review is, for the most part, an examination of a sample of

individual patient records to insure that appropriate services of acceptable quality were provided and documented as required by Title 22 DMC regulations. The chart on the following page lists the steps of the review process and the specific sub-sections of Title 22 and Title 9 that are used to evaluate service documentation.

Review Step	ODF/DCH/Residential	NTP
Admission*	Title 22, 51341.1 (h)(1)	Title 9, 10270
DSM Code*	Title 22,51341.1 (h)(1)(D)(ii)	Same
Assessment	Title 22, 51341.1 (b)(10),(h)(1)	Title 9, 10305
Treatment Planning*	Title 22, 51341.1 (h)(2)	Title 9, 10305
Treatment Requirements	Title 22, 51341.1 (d) & (c)	same
Progress Notes	Title 22, 51341.1 (d)(2),(h)(3)	Title 9, 10345
Group Counseling Sign-in	Title 22, 51341.1 (g)(2)	same
Dosing Services	n/a	Title 9, 10255
Provider & Client Contact	Title 22, 51341.1 (h)(4)	Title 9, 10345
Continuing Services*	Title 22, 51341.1 (h)(5)	Title 9, 10410
Discharge	Title 22, 51341.1 (h)6)	Title 9, 10415
Fees Charged to Client	Title 22, 51341.1 (h)(7)	same
Good Cause Codes	Title 22, 51490.1 (a)	same
Second Service	Title 22, 51490.1 (d)	n/a
22 Fair Hearing	Title 22, 51341.1 (p)	same

*These areas establish medical necessity for treatment services and deficiencies can result in recoupment of the entire treatment episode.

This training manual is designed to assist you in understanding the charting requirements for the documentation of DMC services. While every effort has been made to insure that the information contained in this manual is accurate and up to date, it is ultimately the responsibility of the individual service provider to become familiar with and follow all applicable laws, regulations and standards when providing Drug Medi-Cal (DMC) services. Remember also that this manual is designed to assist you with understanding DMC requirements, not the additional requirements that may exist under your contract and the general requirements of other statutes and regulations. We would very much appreciate your comments and suggestions on how to improve this manual. Please contact us at DMCanswers@adp.state.ca.us with your input.

Disclaimer:
THIS TRAINING MANUAL IS NOT INTENDED TO REPLACE THE APPLICABLE LAWS, REGULATIONS AND STANDARDS FOR THE PROVISION OF DMC SERVICES. THE SPECIFIC LANGUAGE OF THE LAW, REGULATION OR STANDARD WILL BE USED TO DETERMINE WHETHER OR NOT A PROVIDER HAS MET THE REQUIREMENTS TO KEEP PAYMENTS FOR THE PROVISION OF DMC SERVICES.

I. Medical Necessity and the Medical Director

A key to complying with the charting requirements for DMC services is an understanding of the requirement that all services must be shown to be medically necessary.

> "*Substance abuse services*, as defined in this section, provided to Medi-Cal beneficiaries, *are 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."[1] *(emphasis added)*

> "For each beneficiary, the provider shall…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".[2] *(emphasis added)*

The reason for this is simple; funding. DMC services, as part of Medi-Cal, are funded approximately 50% by federal Medicaid funds, and therefore must meet Medicaid requirements. The most important of these is that services must be medically based. Many would consider treatment based on group counseling services (ODF/DCH) to be a social model modality; however, because the services are "…prescribed by a physician…"[3] and "provided by or under the direction of a physician…"[4] the modality becomes medically based and is eligible for Medi-Cal funding. Contents of the patient record that document medical necessity demonstrate that the physician was directing the provision of treatment services.

[1] Title 22, CCR, Section 51341.1(a)
[2] Title 22, CCR, Section 51341.1(h)(1)(D)(i)
[3] Title 22, CCR, Section 51341.1(a)
[4] Title 22, CCR, Section 51341.1(h)

DMC certification standards provide additional details:

> "Under the direction of a physician means a physician formulation of, approval of, or involvement in each DMC patient's plan of care. Such direction may take one of several forms, such as development or review/approval of the treatment plan of care, clinical consultation of the patient's case, medication evaluation, or involvement in the patient's case conference. Evidence of the physician's direction shall be documented by the physician's notations and signature in the patient's health record…"[5]

The Certification Standards also define the role of the medical director (physician):

> "Medical Director/Medical Responsibility
>
> 1. Each substance abuse clinic shall have a licensed physician designated as the medical director. All medical services provided by the substance abuse clinic shall be under the direction of a physician, who shall be available on a regularly scheduled basis and otherwise on call. The medical director shall assume medical responsibility for all patients. The medical director shall direct medical services, either by acting alone or through an organized medical staff.
> 2. The medical director's responsibilities, acting alone or through an organized medical staff, shall include:
>   a. Establishing, reviewing, and maintaining medical policies and standards.
>   b. Assuring the quality of medical services given to all patients.
>   c. Assuring that at least one physician practicing at the clinic shall have admitting privileges to a general acute care hospital or a plan, as approved by ADP, for ensuring needed hospital services. For narcotic treatment programs, this requirement is the responsibility of the program sponsor and shall be met by the program sponsor entering into an agreement with a hospital official to provide general medical care in accordance with Title 9, CCR, Section 10340.
>   d. Assuring that a physician has assumed medical responsibility for all patients treated by the clinic (Title 9, CCR, Section 10110).

[5] DMC Certification Standards, Section (II)(I)

3. Documentation of assumption of medical responsibility shall include, but not be limited to, written approval of the treatment plan in accordance with Title 22, CCR, Section 51341.1 (h)(2)(A), or for narcotic treatment programs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B)."[6]

In summary, the medical necessity for treatment services provided by a DMC program is established by the Medical Director (physician). The Medical Director for a DMC service provider is the physician, licensed in California, who assumes the medical responsibility for all patients treated by the program and who directs the provision of medically necessary services to patients.

II. The Treatment Process

DMC services are required to be provided as part of a formal treatment process. This process consists of:[7]

1. Intake
    a. Admission
    b. Assessment
2. Treatment planning
3. Implementing the treatment plan – treatment services and referrals
4. Treatment planning review and update
5. Justification for continuing services beyond regulatory limits
6. Discharge from treatment

There is nothing unusual or exceptional about this treatment process. In fact, the entire process reflects a logical approach that can be, and is, applied to problem solving in any area.

Solving a problem begins with the preliminary identification of the general nature of the problem, followed by a more detailed determination of the specifics of the problem. For DMC funded substance abuse services, this is the intake process of admission (identifying the problem and establishing that your program can help) and assessment (determining the various components that make up the problem). *If you are having difficulties with your car, you identify the initial problem (it won't start) and then check the various systems (electrical, fuel, mechanical, etc.) to determine what needs to be fixed so your car will start.*

[6] DMC Certification Standards, Section (IV)(A)
[7] Title 22, CCR, Section 51341.1 (h)(1-6)

Next, for substance abuse treatment, you create a treatment plan designed to deal with issues identified in the assessment process. *For your car, the shop writes up a work order detailing what work is to be performed.*

In DMC treatment the patient receives treatment and referrals. *For your car, the mechanic completes the tasks listed on the work order.*

After 90 days has passed, or additional problems are identified that relate to substance abuse, the treatment plan is updated and modified as necessary. *If the mechanic finds more problems with your car, the work order is modified.*

Substance abuse treatment services are completed, and the program determines that the patient has made sufficient progress to be discharged. *The mechanic completes his work; test drives your car, and determines that all problems appear to be fixed.*

The DMC program discharges the patient, writes up a discharge summary, and closes the patient record. *The shop gives you your car, writes up the bill and marks it "Paid in Full" when you give them your credit card.*

If a DMC provider omits one or more of these steps, the chances for a positive treatment outcome are reduced. If a mechanic skips one or more steps, it is likely that your car won't be fixed. Substance abuse services and human beings are, of course, much more complicated than cars. If your car doesn't work after you take it to the shop, you don't pay. The success or failure of substance abuse treatment is much more difficult to determine, and even the best quality treatment, provided in the most conscientious fashion, may not be successful. This is why DMC substance abuse services are paid for as long as the program provides those services in a fashion consistent with the requirements of regulations and standards, not on the "success" or "failure" of a particular treatment episode. For this reason, ***DMC services must be provided and documented as required by regulations and standards, or payment for those services will be disallowed and the funds will be recouped.***

III. Patient Record Content and Retention Requirements

Requirements for the contents of the patient record are detailed in Title 22. All DMC service providers are required to:

> "Establish, maintain, and update as necessary, an individual patient record for each beneficiary admitted to treatment and receiving services. For purposes of this regulation, "an individual patient record" means a file for each beneficiary which shall contain, but

not be limited to, information specifying the beneficiary's identifier (i.e., name, number), date 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, and all documentation relating to the beneficiary gathered during the treatment episode, including all intake and admission data, all treatment plans, progress notes, continuing service justifications, laboratory test orders and results, referrals, counseling notes, discharge summary and any other information relating to the treatment services rendered to the beneficiary."[8]

and,

"Providers shall maintain the following documentation in the individual patient record established pursuant to subsection (g)(1) for each beneficiary for a minimum of three (3) years from the date of the last face-to-face contact. If an audit takes place during the three year period, the provider shall maintain records until the audit is completed.
(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 or 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)."[9]

[8] Title 22, CCR, Section 51341.1(g)(1)
[9] Title 22, CCR, Section 51341.1(i)

The Treatment Standards also list requirements for the contents of patient records:

Contents of Records

All records must contain the following, at minimum:

A. Demographic and Identifying Data:

- client identifier (i.e. name, number, etc...);
- date of birth;
- sex;
- race/ethnic background;
- address;
- telephone number;
- next of kin, or emergency contact (include phone number);
- consent to treatment;
- referral source and reason for referral;
- date of admission; and
- type of admission (i.e., new, etc...).

B. Intake Data:

All data gathered during intake (see Section II.A.2.) shall appear in the client's record.

C. Treatment Plan:

Each client shall have an individual written treatment plan which is based upon the information obtained in the intake and assessment processes. The treatment plan shall be developed within 30 days from the client's admission. There shall be periodic review and update of the treatment plan at least every 90 days. At minimum, the treatment plan shall include the following:

- statement of problems to be addressed in treatment;
- statement of goal(s) to be reached which address the problem(s);
- action steps which will be taken by program and/or client to accomplish goal(s); and
- target date(s) for accomplishment of action step(s), goal(s), and when possible, resolution of problem(s).

a. Urine Surveillance:

For those situations where drug screening by urinalysis is deemed appropriate and necessary by the program director, or supervising physician, the program shall:

- establish procedures which protect against the falsification and/or contamination of any urine sample;
- document urinalysis results in the client's files.

b. Other information required:

- The documentation of all services which show the relationship of services to treatment plans (see Section II.B.3.).
- The documentation of quality assurance procedures (see Section II.D.).
- The documentation of required discharge information (see Section II.F.).
- Progress notes which state clients' progress toward reaching goal(s).

c. Other requirements:

- Client record shall be written legibly in ink or typewritten.
- All entries shall be signed and dated.
- All significant information pertaining to a client shall be included in the client's record. A standard format shall be used for all records. These records shall be easily accessible to staff providing services to the clients.

d. Disposal and Maintenance of Records:

- Closed programs - In the case of a program closing, all client records shall be stored in an appropriate confidential manner by the County Drug Program Administrator for not less than four years.
- Closed cases - There shall be a written policy in all programs regarding the maintenance and disposal of client records. All records shall be stored in an

appropriate confidential manner for not less than four years from the date they are officially closed."[10]

Remember that the requirements for retaining records outlined here are the minimum required by DMC regulations. Other record retention requirements may exist that require you to keep records even longer.

To summarize, all DMC providers must create and maintain a patient record (also known as a chart or file, etc.) that contains almost *everything* having *anything* to do with a patient's treatment episode. ***This record must be maintained by the provider for at least three years after the date of the last face-to-face contact with the patient.***

ODF/DCH/Perinatal Residential Services Required Documentation

Admission

Title 22 defines "Intake" as "…the process of admitting a beneficiary into a substance abuse treatment program."[11] The regulations and standards divide the intake process into two areas; admission and assessment.

Title 22 requires the provider to "Develop and use criteria and procedures for the admission of beneficiaries to treatment."[12] The Treatment Standards require, at minimum, three criteria; identification of drugs of abuse, documentation of social, psychological, physical and/or behavioral problems related to drug abuse, and a statement of nondiscrimination.[13]

The Treatment Standards also list the following as the minimum process for admission:

a. An initial interview shall determine whether or not a client meets the admission criteria.

b. If a potential client does not meet the admission criteria, the client shall be referred elsewhere for treatment.

[10] Treatment Standards, Section (II)(C)(2)
[11] Title 22, CCR, Section 51341.1(b)(10)
[12] Title 22, CCR, Section 51341.1(h)(1)(A)(i)
[13] Treatment Standards, Section (II)(A)(1)

c. All clients admitted shall meet the admission criteria and this shall be documented in the client's record.

d. If a client is appropriate for treatment, the following information shall be gathered at minimum:

- social, economic and family background;
- education;
- vocational achievements;
- criminal history, legal status;
- medical history;
- drug history; and
- previous treatment

e. Only upon completion of this process and the signing of the consent form, shall the client be admitted to treatment.[14]

When reviewing admission documents in the patient record, ADP analysts will look for the following information and/or documents:

1) A personal history with, at minimum:	(T-22)
• Social, economic and family background	(Tx Stds)
• Education	(Tx Stds)
• Vocational achievements (work history)	(Tx Stds)
• Criminal history and legal status	(Tx Stds)
• Previous treatment	(Tx Stds)
2) Medical history	(T-22)
3) Substance abuse history	(T-22)
4) Clients rights document including at minimum:	
• Statement of non discrimination	(Tx Stds)
• Client rights	(Tx Stds)
• Grievance procedures	(Tx Stds)
• Discharge appeal process	(Tx Stds)
• Program rules and regulations	(Tx Stds)
• Client fees 15	(Tx Stds)
• Access to treatment files	(Tx Stds)

[14] Treatment Standards, Section (II)(A)(2)

[15] Except for share of cost, DMC beneficiaries may not be charged any fees. [Title 22, CCR, Section 51341.1(h)(7)]. References to fees in DMC beneficiary records should reflect this requirement. See "Fees for treatment services" on page 32.

5) Consent to treatment (admission agreement) (Tx Stds)

In addition, any other information or documents listed in the provider's admission procedures, must also be present in the patient record to complete the admission process and establish medical necessity for services.

Note: The Treatment Standards do not require the patient to sign or otherwise acknowledge receipt of the client's rights summary. However, unless there is a signed copy of the clients rights form, a statement on the consent to treatment form that the patient was given a copy or some other documentation in the patient record that the patient received this document, the program cannot demonstrate that this requirement was met.

DSM Code

As part of the admission process and to establish medical necessity for treatment services, Title 22 requires that the provider "Identify the applicable Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition diagnostic code."[16]

Remember that the DSM code must be for a substance abuse issue, and the code selected must correspond to the information obtained in the intake process or a subsequent re-assessment. If the DMC code is missing, is clearly incorrect, or is different from the DSM code used in the claims for reimbursement, then all services will be disallowed and payments recouped.

Assessment

The second part of the intake process is assessment. Once admitted to the program, an assessment of the need for specific treatment services must be made. The Treatment Standards require, at minimum, an assessment for needs in the following areas:

[16] Title 22, CCR, Section 51341.1(h)(1)(D)(ii)

- Education
- Vocational counseling and training
- Job referral and placement
- Legal services
- Medical and Dental services
- Social/recreational services
- Individual and group counseling for the beneficiary as well as collateral services.[17]

Title 22 also requires that the program:

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:

> (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 abuse 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.[18]

Subsection (a) above gives the requirement for a physical exam used as an assessment of the beneficiary's physical condition. To properly document this, a copy of the actual physical exam must be placed in the patient record.

Note also that subsection (b) above incorporates two distinct requirements; the review of the beneficiary's medical history, substance abuse history, and/or the most recent physical examination documentation, and the requirement that the physician complete a waiver of the admission physical exam that states the basis for not requiring the physical. If a program admits a DMC beneficiary to treatment without documenting that both requirements were met, the admission process is not complete and medical necessity for treatment has not been established. As a result, all paid claims for treatment services for that beneficiary will be disallowed and payments recouped. Sample Forms can be seen at http://www.adp.ca.gov/dmc/sample_forms.shtml .

[17] Treatment Standards, Section (II)(B)(3)(b)
[18] Title 22, CCR, Section 51341.1(h)(1)(A)(iii)

If a provider fails to complete an assessment that, at a minimum, addresses the areas listed above, then the assessment will be considered incomplete. If the provider's admission criteria and procedures require other possible treatment needs be assessed, and the assessment is not completed for those potential needs, then the assessment is incomplete.

A treatment plan based on an incomplete assessment is not valid, and will result in recoupment of payments for all treatment services provided under that treatment plan.

On February 3, 2004, ADP issued Bulletin number 04-01 recommending that all publicly funded AOD service providers in California administer and use the Addiction Severity Index (ASI), Fifth Edition; Lite, Clinical Factors Version; University of Pennsylvania, for client assessment.[19] Additional information on the use of the ASI for assessment and treatment planning is available at the Treatment Research Institute web site, www.tresearch.org .

Treatment Planning

Title 22 requires that the treatment plan be "individualized," and that it be based "…upon information obtained in the intake and assessment process."[20] Remember that the Title 22 definition of "Intake" includes "…the assessment of treatment needs to provide medically necessary treatment services…"[21]

Title 22 also requires that the initial treatment plan include the following specific elements:

1. A statement of problems to be addressed
2. Goals to be reached which address each problem
3. Action steps which will be taken by the provider, and/or beneficiary to accomplish identified goals
4. Target dates for the accomplishment of action steps and goals
5. A description of the services, including the type of counseling, to be provided and the frequency thereof
6. The assignment of a primary counselor [22]

[19] ADP Bulletin 04-01, California Department of Alcohol and Drug Programs
[20] Title 22, CCR, Section 51341.1(h)(2)(A)
[21] Title 22, CCR, Section 51341.1(b)(10)
[22] Title 22, CCR, Section 51341.1(h)(2)(A)(i)

The initial treatment plan must include these 6 elements. In addition, all problems identified in the assessment process must be addressed on the treatment plan, either through services provided by the program, or through referrals to other service providers. ***If any of the six elements are missing or incomplete, or if a problem identified through the assessment process is not addressed by the treatment plan, then the treatment plan is invalid, and payments for all treatment services provided under the treatment plan will be recouped.***

Note that the description of services must include both the type and frequency of counseling services. This description must be specific, i.e. "two group counseling sessions a week", etc.; not "counseling as needed". The reason for this is that the treatment plan is how the provider documents that the services are "…prescribed by a physician…" and that services are "…provided by or under the direction of a physician…" as required by Title 22, not by other program staff.[23]

Crisis intervention counseling services cannot, by definition, be preplanned, and so the frequency with which they are to be provided cannot be included on a treatment plan. It is also impractical or impossible to exactly preplan other types of billable individual counseling sessions, so it is acceptable to make a blanket statement of "individual counseling sessions as necessary" on the treatment plan or update.

Note also that "action steps" which will be taken to accomplish goals may include referrals outside the program. For example, a treatment plan may include a goal for the patient to address employment issues. A number of different action steps could be taken to do this, for example enrolling in job training or registering with the Employment Development Department, either of which would meet the requirements of the regulation.

Although not currently required, *ADP strongly recommends that the DSM code also be placed on each treatment plan and update.*

Title 22 also establishes specific timelines for the completion of the initial treatment plan, as follows:

1. The counselor shall complete and sign within thirty (30) calendar days of the admission to treatment date, and
2. The physician shall review, approve, and sign within fifteen (15) calendar days of signature by the counselor.[24]

[23] Title 22, CCR, Section 51341.1(a) & (h)
[24] Title 22, CCR, Section 51341.1(h)(3)(A)(ii)

Title 22 defines the "admission to treatment date" as "…the date of the first face-to-face treatment service, as described in Subsection (d) of this regulation, rendered by the provider to the beneficiary."[25]

Treatment plans must be reviewed and updated as follows:

> (a) The counselor shall review and sign 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.
>
> (b) Within fifteen (15) calendar days of signature by the counselor, the physician shall review, approve, and sign all updated treatment plans. If the physician has not prescribed medication, a psychologist licensed by the State of California Board of Psychology may sign an updated treatment plan.[26]

A mistake often made by providers is only to update treatment plans on a 90-day cycle, ignoring the requirement that the treatment plan be updated "…when a change in problem identification or focus of treatment occurs…". It is common for additional problems to be revealed during the counseling process that the patient may not have been willing to disclose during intake. Also, life goes on while a patient is in treatment; significant health changes (pregnancy, physical injury, discovery of a chronic health problem), changes in relationships, loss of housing or income, etc.; all could be new problems impacting treatment or require a change in treatment focus. When this happens, the treatment plan must be updated, because the physician's signature on the update demonstrates that the physician is aware of changes and is continuing to direct the treatment process. *If in doubt, update the treatment plan – the physician is directing treatment and an updated treatment plan documents their continued participation in the treatment process.*

The specific format for an updated treatment plan is left to individual providers. However, any changes made as part of the update must be clearly documented and the physician's review and approval of the update must also be clear. An initial treatment plan with cryptic notes and a second signature block for the counselor and physician will not be accepted as an update if there is any

[25] Title 22, CCR, Section 51341.1(b)(1)
[26] Title 22, CCR, Section 51341.1(h)(3)(A)(iii)

question about when and what changes were made. It is strongly recommended that a fresh treatment plan form be used for updates, even if it is primarily a copy of the initial plan.

Treatment Services – ODF

Outpatient drug free treatment services are defined as "…an outpatient service directed at stabilizing and rehabilitating persons with substance abuse diagnoses."[27]

Specific treatment services detailed in Title 22 include:

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 the following:

> (A) Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance abuse or a return to substance abuse. 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, crisis intervention, collateral services, and treatment and discharge planning.[28]

Group Counseling

Note that subsection "A" above includes three elements; the allowable focus of group counseling sessions, the fact that group sessions must be attended by

[27] Title 22, CCR, Section 51341.1(b)15)
[28] Title 22, CCR, Section 51341.1(d)(2)

appointment (no drop in sessions) and that each beneficiary must receive at least two group counseling sessions each month. ODF is a group counseling modality, and individuals who are not able to participate in group sessions should not be admitted to this modality.

Title 22 defines group counseling as:

> …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. For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than 10 clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.[29]

Group counseling sign in sheets:

Documenting group counseling sessions in all treatment modalities requires the use of group counseling sign-in sheets. These sheets must include the date of the counseling session, the duration of the counseling session, and the signatures of all clients attending the session.[30] These sheets are "sign-in sheets", not attendance sheets, so initials or check marks on preprinted lists, or an attendance list written by program staff, are not acceptable. The use of original signatures also enables auditors to verify that the minimum and maximum participant limits were met during the session.

Programs are free to include additional information on the sign-in sheet (group topic, pre-printed list of those scheduled to attend, etc.). It is recommended that these sheets be stored in chronological order by session date (not by counselor or group topic) for ease of retrieval during an audit.

Individual Counseling

Also, note that subsection "B" above limits individual counseling sessions in ODF programs to five types or exceptions: intake, crisis intervention, collateral services, treatment planning and discharge planning.

[29] Title 22, CCR, Section 51341.1(b)(8)
[30] Title 22, CCR, Section 51341.1(g)(2)

Individual counseling is defined by Title 22 as:

> …face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of service.[31]

The first of the five individual counseling exceptions in ODF is intake. These are counseling sessions (remember, a face-to-face contact between a therapist or counselor and the beneficiary) that take place as part of "…the process of admitting a beneficiary into a substance abuse treatment program."[32] There are no limits on the amount of time or the number of sessions used to admit a person to treatment, other than the limit on the number of services in a calendar day (see page 32 below). However, each intake individual counseling session must be documented by a progress note, and that note must clearly document the intake (admission and/or assessment) activities that took place. As a practical matter, the more sessions it takes to complete an intake, the more closely auditors will look at the documentation of services provided.

The second of the five individual counseling exceptions is crisis intervention. Title 22 defines crisis intervention as:

> …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.[33]

Note that there are several elements that make up this definition. All must be present, and documented in the progress note, to claim reimbursement for an individual counseling service.

The session must be:

- A face-to-face contact between a therapist or counselor and a beneficiary in crisis.
- Services provided must focus on alleviating crisis problems.
- The "Crisis" must be:

[31] Title 22, CCR, Section 51341.1(b)(9)
[32] Title 22, CCR, Section 51341.1(b)(10)
[33] Title 22, CCR, Section 51341.1(b)(5)

    - An actual relapse, **or**
    - An event or circumstance which is unforeseen, **and**
    - Presents to the beneficiary an imminent threat of relapse
- Crisis services must be limited to the stabilization of the beneficiary's **emergency** situation.

Remember, all the elements listed above must be present and documented in the progress note.

Common reasons for disallowance of crisis sessions are:

- Failure to document the imminent threat of relapse, or
- Documentation that shows services being provided beyond stabilization of the beneficiary's emergency situation.

An incident or situation triggering a crisis may result in the need for additional treatment services; however, these should be provided through changes in counseling or referrals that are documented in an updated treatment plan, not through a series of individual counseling sessions labeled as crisis sessions.

The third of the five individual counseling session exceptions in ODF is collateral services. Title 22 defines collateral services as:

> …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.[34]

Collateral services are a method of bringing friends and family and other significant individuals in the life of the beneficiary into the treatment process. Collateral sessions are <u>not</u> family or couples counseling. Note the required elements of the service and remember that the progress note must clearly document their presence:

- Face-to-face session
- Person or persons significant in the life of the beneficiary
- Focused on the treatment needs of the beneficiary
- Supporting the achievement of the beneficiary's treatment goals

[34] Title 22, CCR, Section 51341.1(b)(3)

- The significant persons must have a personal, not professional, relationship with the beneficiary

Common reasons for disallowances are:

- Counseling sessions that are clearly family counseling or couples counseling, and
- Sessions that are with persons having a professional relationship with the beneficiary (probation or parole officers, CPS workers, etc.).

The fourth of the five individual counseling session exceptions in ODF is treatment planning:

Although this counseling session is not specifically defined in regulation, it is clear that its place in the treatment process is to plan treatment services, i.e. the development of initial and updated treatment plans. Other than general guidelines, the specifics of a program's treatment planning process are left to the clinical judgment of the program's medical director and other staff. *However, for sessions identified as treatment planning in claims for reimbursement by DMC, a treatment plan or update must result from the session or sessions.*

There is no limit on the number of sessions that the development of a treatment plan or update can require, but claims will be disallowed if it is not clearly documented what was being done to develop the treatment plan or update, or if the treatment plan or update was not completed. *Treatment planning is not the same thing as a case conference or treatment plan review, and claims for these services will be disallowed.*

The most common reason for the disallowance of claims for treatment planning is when claimed sessions do not result in a treatment plan or update.

The last of the five individual counseling session exceptions in ODF is discharge planning:

This counseling service is also not defined in regulation; however, the Treatment Standards require that the discharge summary include the patient's discharge plan[35] and this type of individual session allows the program to submit a claim for the session or sessions that took place to create the discharge plan.

[35] Treatment Standards, Section (II)(F)(2)(f)

The discharge plan is developed by the counselor and the patient, and represents the patient's plan to continue recovery and maintain sobriety after discharge. Common elements included in a discharge plan are activities and referrals that will help the patient continue to work on long term goals identified in the treatment plan.

The most common reason for disallowances of claims for discharge planning counseling sessions is for sessions (at which the beneficiary may not even be present) that are actually an attempt to bill DMC for the completion of the discharge summary.

Treatment Services – DCH

Day care habilitative services (DCH) (also knows as 'rehabilitative') are defined in Title 22 as:

> …outpatient counseling and rehabilitation services provided at least three (3) hours per day, three (3) days per week to persons with substance abuse diagnoses, who are pregnant or in the postpartum period, and/or to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized in this Chapter.[36]

A more detailed description of this treatment modality:

> 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.[37]

[36] Title 22, CCR, Section 51341.1(b)(6)
[37] Title 22, CCR, Section 51341.1(d)(3)

Notice that the DCH and ODF modalities are almost identical in terms of the components of treatment. This is not surprising, given that both are outpatient (non-residential) treatment services. The differences between the two modalities are:

- Intensity of treatment – ODF can be as little as two group sessions a month while DCH is a minimum of three hours a day at least three days a week
- Eligible population – ODF treatment is available to any Medi-Cal eligible beneficiary while DCH treatment is only available to pregnant or postpartum women and EPSDT eligible Medi-Cal beneficiaries.

Postpartum is defined as:

> A pregnant woman who was eligible for and received Medi-Cal 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 for this program ends on the last day of the month in which the 60th day occurs.*[38] *(emphasis added)*

EPSDT stands for early and periodic screening, diagnosis and treatment.

EPSDT is a federally mandated Medicaid program for full-scope Medi-Cal beneficiaries under age 21. Under this program, the State pays for any medically necessary procedure or treatment to correct to ameliorate a defect, physical illness, mental illness, or a condition even if the service or item is not otherwise included in the State's Medicaid program.[39]

Treatment Services – Perinatal Residential

Treatment Services – Perinatal residential services programs are defined as:

[38] Title 22, CCR, Section 50260
[39] DMC EPSDT Fact Sheet, Department of Alcohol and Drug Programs, December 2003

> …a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with substance abuse 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.[40]

In addition, the services to be offered by this modality are:

> Perinatal residential substance abuse 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, prescribe and/or order these services within the scope of their practice or licensure.
>
> (A) Perinatal residential substance abuse services shall be provided in a residential facility licensed by ADP pursuant to Chapter 5 (commencing with Section 10500), Division 4, Title 9, CCR.
> (B) Perinatal residential substance abuse 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 USC Section 1396d (a)(25)(B) and Section 1396(i) and 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.

Notice that residential services in DMC are limited to pregnant and postpartum women only.

[40] Title 22, CCR, Section 51341.1(b)(17)

Perinatal Services – Pregnant and postpartum women only:

ODF and DCH substance abuse treatment services can be designed for and provided specifically to pregnant or postpartum women; providers may then submit claims for reimbursement at an enhanced perinatal rate. However, there are a number of requirements that the provider must also meet:

- The provider must be certified to provide perinatal services
- Services must address treatment and recovery issues specific to pregnant and postpartum women, such as:
    - Relationships
    - Sexual and physical abuse
    - Development of parenting skills

- Perinatal services must include:
    - 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);
    - Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);
    - Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and
    - 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).[41]

During PSPP reviews, ADP analysts will review the patient record of women for whom perinatal rate claims were submitted to verify that these services were provided. If the patient record does not document provision of these services, all payments for claims submitted at the enhanced rate will be recouped.

Progress Notes

In general, notations should be made in the patient record to document all activity associated with the patient's treatment episode. Carefully documenting the treatment process can be time consuming, and often tedious, but it is critical to

[41] Title 22, CCR, Section 51341.1(c)

quality treatment. Progress notes are the single most important component in this documentation process.

Title 22 requires that progress notes be legible, and (for ODF services):

> …the counselor shall record a progress note for each beneficiary participating in an individual or group counseling session. Progress notes are individual narrative summaries and shall include:
>
> > (i) A description of the beneficiary's progress on the treatment plan problems, goals, actions steps, objectives, and/or referrals; and
> >
> > (ii) Information on a beneficiary's attendance including the date (month, day, year) and duration in minutes of individual or group counseling sessions.[42]

There are slightly different requirements for DCH and perinatal residential programs:

> For day care habilitative and perinatal residential treatment services, ***the counselor shall record a progress note, at a minimum, once a week***. The progress notes are individual narrative summaries and shall include:
>
> > (i) ***The time period covered by the summary. The period shall be no more than seven (7) days.***
> >
> > (ii) A description of the beneficiary's progress on the treatment plan problems, goals, actions steps, objectives, and/or referrals; and
> >
> > (iii) A record of the beneficiary's attendance at each counseling session including the date (month, day, year) and duration of the counseling session.[43] ***(emphasis added)***

The most common problem with progress notes, other than being missing or dated incorrectly, is that the beneficiary's progress on treatment plan problems, goals, etc. is incomplete or missing altogether. ***When documenting a counseling session it is necessary to indicate what treatment plan goal (or***

[42] Title 22, CCR, Section 51341.1(h)(3)(A)
[43] Title 22, CCR Section 51341.1(h)(3)(B)

goals), etc. the session relates to. However, the note must also describe the beneficiary's progress toward the treatment goal. If a treatment plan goal is that the beneficiary learns about the recovery process, and the counseling session addresses relapse triggers, then the note must indicate that the beneficiary has (or has not – no progress toward a goal is a valid description of the progress made) demonstrated some progress towards understanding the concept.

Phrases like "good participation," "participated actively", etc. do not document progress or lack of progress, only that the individual was there and talking. Even a statement that the beneficiary "shared their triggers with the group" does not provide enough detail to evaluate progress or lack of progress. A far better note would state "Patient demonstrated an understanding of relapse triggers by sharing that rainy days and Mondays (or whatever) always brings them down and makes them feel like using."

In addition, it is important to remember that the purpose of progress notes is <u>not</u> to keep supervisors and auditors happy; the primary purpose is to improve and enhance the treatment process by helping the counselor track the patient's progress in treatment and stay focused on the treatment plan, and to allow other program staff to participate intelligently in the treatment process. If the primary counselor is not available to provide support to the patient, the chance that another counselor will be able to provide meaningful assistance may be dependant on the quality of documentation in the patient record. A series of progress notes reporting the patient's attendance at group counseling sessions and indicating only that they had "good participation" does not meet the requirements of the regulation and are clinically useless.

One way to evaluate the usefulness of progress notes for a group session is to compare the individual note written for each person attending the session. If the notes are so similar that the patient names could be interchangeable, then they are not "individual narrative summaries" and will not be accepted.

Progress notes tell the story of the treatment episode. As with any story, there must be enough detail to make the patient come to life as a unique individual making a journey that may be saving his/her life.

Minimum provider and beneficiary contact:

Title 22 establishes minimum contact between the provider and beneficiary:

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 provider determines that:

> (i) Fewer beneficiary contacts are clinically appropriate; and
>
> (ii) The beneficiary is progressing toward treatment plan goals.[44]

If the provider makes a determination that fewer contacts are appropriate, then the patient record must contain "…exceptions or waivers noted, signed, and dated by the physician in the beneficiary's treatment plan…"[45]

Justification for Continuing Services

DMC regulations place a 6 month limit on the provision of substance abuse services in ODF/DCH/Residential perinatal modalities unless the physician determines that additional treatment is required.

Continuing services shall be justified as shown below:

> (A) For outpatient drug free, day care habilitative, perinatal residential, and Naltrexone treatment services:
>
> > (i) No sooner than five (5) months and no later than six (6) months from the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the counselor shall review the progress and eligibility of the beneficiary to continue to receive treatment services.
> > (ii) If the counselor recommends that the beneficiary requires further treatment, the physician shall determine the need to continue services based on the following factors:

[44] Title 22, CCR, Section 51341.1(h)(4)(A)
[45] Title 22, CCR, Section 51341.1(i)(4)

(a) The medical necessity of continuing treatment;
(b) The prognosis; and
(c) The counselor's recommendation for the beneficiary to continue receiving services.

(iii) The provider shall discharge the beneficiary if the physician determines there is no medical necessity to continue treatment.[46]

Although the regulation does not specifically require the physician's dated signature on a document recording the physician's decision to continue services, as a practical matter there is no other way to document that the physician did approve the continuation of treatment services within the time limits of the regulation. A progress note, preprinted form, etc., signed and dated by the physician, may be used to document the approval to continue services. A sample form to document the justification for and approval of continuing services is included on the ADP web site at www.adp.ca.gov/dmc/sample_forms.shtml.

Documenting the physician's decision to continue treatment services is critical, because without this approval the medical necessity for treatment services established by admission and the initial treatment plan and updates expires. If the justification for continuing services is missing, incomplete or incorrect, all treatment services beyond six months following the admission to treatment date (or the last valid justification for continuing services) will be disallowed and payments recouped.

Discharge from Treatment

The Treatment Standards require programs to have written procedures for patient discharge that includes a definition of:

- discharge upon successful completion of the program,
- unsuccessful discharge,
- involuntary discharge and
- transfers and referrals.[47]

Patients may be discharged on a voluntary or involuntary basis, although DMC patients discharged involuntarily (even if they simply stop showing up for treatment) must be advised of their Title 22 Fair Hearing rights (see below).[48]

[46] Title 2, CCR, Section 1341.1(h)(5)(A)
[47] Treatment Standards, Section(II)(F)

The Treatment Standards and Title 22 both require that a discharge summary be completed upon discharge of the beneficiary. This summary must be completed within 30 days of the last face-to-face treatment service (Title 22) and include:

- The duration of the beneficiary's treatment based on the admission and discharge dates (Title 22)
- The reason for discharge (Title 22)
- A narrative summary of the treatment episode (Title 22)
- The beneficiary's prognosis (Title 22)
- Current drug usage (Treatment Standards)
- Vocational/educational achievements (Treatment Standards)
- Criminal activity (Treatment Standards)
- Beneficiary's discharge plan (Treatment Standards)
- Referrals (Treatment Standards)[49]

It is critical that a discharge summary meeting the above requirements be completed and placed in the patient record, because Title 22 requires the disallowance of claims and recovery of all payments for a treatment episode if the discharge summary is incomplete or missing.[50]

Fees for Treatment Services

DMC beneficiaries may not be charged any fees for treatment services, except when a share of cost requirement exists.[51] Share of cost is analogous to a co-payment in private insurance. The amount due for share of cost must be paid or obligated before Medi-Cal begins paying for any services (including DMC).[52] Providers should contact their county's eligibility office or their assigned Fiscal Management and Accountability Branch (FMAB) analyst at ADP for more information.

Good Cause Codes

[48] Title 22, CCR, Section 51341.1(h)(6)
[49] Title 22, CCR, Section 51341.1(h)(6)(A) and Treatment Standards, Section (II)(F)(2)
[50] Title 22, CCR, Section 51341.1(j)(2) & (i)(6)
[51] Title 22, CCR, Section 51341.1(h)(7)
[52] Title 22, CCR, Section 50090

Providers are required to submit claims for services within 30 days following the end of the month in which services are provided. Under certain circumstances this deadline is extended, i.e. for 'good cause'.[53] Documentation of the circumstances that meet the good cause requirements must be maintained in the individual patient record for several of the good cause codes (reasons). See FMAB's DMC Provider Billing Manual for more details.

Second Service on a Calendar Day

In general, DMC will pay for only one service on a calendar day in ODF and DCH. However, there are limited circumstances under which a provider may submit a claim and be paid for a second service on a single calendar day. Second service is not an issue for residential perinatal treatment because the claim submitted is for all services for a 24 hour day.[54]

For both ODF and DCH:

- The service must be provided during a return visit; that is, the beneficiary must leave and return to the program. There are no specific requirements for how long the beneficiary must be gone, or how far away they must go.
- The service cannot be a duplicate of the first service, i.e. the two services cannot be two group counseling sessions, two intake sessions, two crisis counseling sessions, etc. It can be a group and an individual session, or two different types of individual session.

For ODF:

- The return visit must not create a hardship on the beneficiary. There no any specific guidelines as to what constitutes a hardship, although hardship is not the same as inconvenient.
- The return visit must be clearly documented and the time of day of each service must be included in the progress note.

For a second service in ODF that is a group counseling session, an intake session, a treatment planning session or a discharge planning session, the progress note must document that an effort was made to provide all services during a single visit and that the return visit was unavoidable.

[53] Title 22, CCR, Sections 51008 and 51008.5
[54] Title 22, CCR, Section 51490.1(d)

If the second service in ODF is for a crisis or collateral service it is not necessary to document an attempt to provide all services during a single visit. Note, however, that the collateral service must be included on the treatment plan as part of the documentation of type and frequency of counseling to be provided. For any second service, the progress note must document how the service was related to meeting the goals of the patient's treatment plan.[55]

The only second service that can be billed in DCH is a crisis counseling session.[56]

Remember that a copy of the ADP Form 7700 must be completed and placed in the individual patient record. If there is more than one beneficiary name on the 7700 (which may happen if more than one beneficiary receives a second service on a given calendar day) the other names must be redacted (blacked out) to maintain patient confidentiality.[57]

Title 22 Fair Hearing Rights

In addition to any other appeal process that may be required by the Treatment Standards or their contract to provide services, providers of DMC services must advise DMC beneficiaries of their Medi-Cal fair hearing rights upon the denial, reduction or termination of DMC benefits.

The regulations require the following:[58]

1) Providers shall advise beneficiaries 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:

i. A statement of the action the provider intends to take;
ii. The reason for the intended action;
iii. A citation of the specific regulation(s) supporting the intended action;
iv. An explanation of the beneficiary's right to a fair hearing for the purpose of appealing the intended action;

[55] Title 22, CCR, Section 51490.1(d)(1)(C)
[56] Title 22, CCR, Section 51490.1(d)(2)
[57] Title 22, CCR, Section 51490.1(d)
[58] Title 22, CCR, Section 51341.1(p)

v. An explanation that the beneficiary may request a fair hearing by submitting a request to:

Department of Social Services
P.O. Box 944243, M.S. 19-37
Sacramento, California 94244-2430
Telephone: 1-800-952-5253
TDD: 1-800-9528349

b. An explanation that the provider shall continue treatment services pending a fair hearing decision only if the beneficiary appeals in writing to ADP for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.

1) All fair hearings shall be conducted in accordance with Section 50953 of Title 22.

This notification of fair hearing rights must be provided even if the beneficiary is being discharged for failure to attend the program. One good way to do this is to include the fair hearing information on a last letter attempting to make contact with a patient that has stopped attending a program.

A provider is not obligated to continue to provide services to a beneficiary who has committed or threatened to commit an act of violence, although the beneficiary still cannot be discharged until the fair hearing process is completed. In the event that a provider has a question about continuing to provide treatment services pending the completion of the fair hearing process, the provider should contact:

Department of Social Services
P.O. Box 944243, M.S. 19-37
Sacramento, California 94244-2430

Oral requests should be made by calling:

Telephone: 1-800-952-5253
TDD: 1-800-9528349

If you have any questions or comments regarding this manual or any questions about DMC in general, email DMCanswers@adp.state.ca.us. The Drug Medi-Cal

Monitoring Staff would be happy to answer any questions you may have.