

Title 22 Drug Medi-Cal Frequently Asked Questions (FAQs)

INTAKE

1. Is there specific wording that is required when developing a Medical necessity statement?

The Medical Director is responsible for developing and implementing medical policies and standards for the provider. Please refer to these regulations for any specific language regarding medical necessity that he/she requires.

22 CCR § 51341.1. (b)(28)(A)(i)(c)

**See (b)(28)(A)(i) for all SUD Medical Director responsibilities*

2. Does the DSM code need to be on the intake note, the treatment plan or both? (In addition to the ICD 10 Code)

Currently, Title 22 only requires the diagnosis to be listed on the treatment plan.

22 CCR § 51341.1. (h)(2)(A)(i)(g)

3. Is the certified counselor permitted to record the appropriate DSM diagnosis on the intake diagnosis form and treatment plan, then put into our Electronic Health Record (EHR) prior to the physician's review/signature?

Title 22 does allow a therapist, physician assistant, or nurse practitioner, acting within the scope of their respective practice, to evaluate each beneficiary for a substance use disorder. The individual who performs the diagnosis shall document the basis for the diagnosis in the beneficiary's record. The physician shall document approval of the diagnosis by signing and dating the treatment plan.

22 CCR § 51341.1. (h)(1)(A)(v)(b)

22 CCR § 51341.1. (h)(1)(A)(vi)

4. Can the physician review all the documents associated with admission to treatment and make the determination regarding medical necessity without face to face contact?

Yes, Title 22 does not mandate that a beneficiary have a face to face session with the doctor prior to admission into treatment. Title 22 only requires that the physician review each beneficiary's personal, medical and substance use history within thirty (30) calendar days of the beneficiary's admission to treatment date.

22 CCR § 51341.1 (h)(1)(A)(iii)

5. Does Title 22 specify a length of time or number of sessions allowed to complete the admission/intake process? Can the service provider complete the ASI on the same day the admission/intake process is completed?

No, Title 22 does not specify how long the intake process should last, as intake is based on the provider's policies and the needs of the beneficiary. Also, a provider cannot request reimbursement for the same service on the same day.

22 CCR § 51341.1 (b)(13)

22 CCR § 51490.1 (b)

6. Are we still supposed to use the Health Questionnaire?

There is no regulatory requirement in Title 22 that mandates use of a specific Health Questionnaire form. The AOD Program Certification Standards refer to the Health Questionnaire form ADP 10100 A-E, which is now DHCS 5103. Providers may use DHCS 5103 as part of the admission process, or develop a health questionnaire to meet the required admission components from Title 22. If AOD-certified, the provider's health questionnaire must contain at minimum the information in the DHCS 5103.

22 CCR § 51341.1. (h)(1)(A)(ii) & (iii)

AOD Alcohol and Drug Certification Standards Section 12020:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5103.pdf

TREATMENT PLANNING

1. Do you list all of the "problems" identified through the intake process as goals on each treatment plan?

All issues identified during the intake and assessment process must be listed as a problem statement on the treatment plan. However, some problem statements can be deferred as determined appropriate by the treatment staff.

22 CCR § 51341.1. (h)(2)(A)(i)(a)

2. Do treatment plans need to have a certain number of goals/problems/etc.?

Title 22 does not require a specific number of problem statements or goals. The problem statements should reflect what was identified through the intake and assessment process.

22 CCR § 51341.1. (h)(2)(A)(i)(a)(b)

3. On the treatment plan, is two times per week for the frequency of group adequate or does it need more specificity?
It depends on the modality of treatment and level of care needed. Title 22 only speaks to the minimum number of interactions required.

22 CCR § 51341.1(d)(2)(A)

22 CCR § 51341.1. (h)(2)(A)(i)(e)

22 CCR § 51341.1. (h)(4)(A)

22 CCR § 51341.1. (h)(4)(B)

4. Can "target dates" be greater than the 90 days the treatment plan is valid for?

The treatment plan must reflect the individualized needs of the beneficiary. Therefore, Title 22 does not require a specific duration for goals.

22 CCR § 51341.1. (h)(2)(A)(i)(d)

5. Must collateral services be listed as well as individual and groups?

Collateral and group services (including frequency) must be documented on the beneficiary's treatment plan. Intake, treatment planning, crisis, and discharge planning are not required to be documented on the treatment plan.

22 CCR § 51341.1. (h)(2)(A)(i)(e)

6. Is the indication of "Primary Counselor" on the signature line enough to meet DMC requirements of "assignment of primary counselor" on treatment plans?

Yes.

22 CCR § 51341.1 (h)(2)(i)(f)

7. Can the Medical Director sign the Treatment Plan via Electronic Health Record (EHR) without a face to face if the SUD counselor gathered appropriate information necessary to develop a thorough treatment plan?

The physician is responsible for reviewing the treatment plan and determining if treatment is medically necessary. It is not required for the physician to do a face to face with the beneficiary.

Note: See 22 CCR § 51341.1(h)(1)(A)(v) for diagnosis requirements, which includes *the requirement that the basis for the diagnosis be documented in the beneficiary record. A physician's signature on the treatment plan, which includes the beneficiary's diagnosis, does not fulfill the requirement of the physician (or alternatively a therapist, physician assistant or nurse practitioner) documenting the basis for the diagnosis.*

22 CCR § 51341.1. (h)(2)(A)(ii)(c)

8. Can a psychologist, LCSW, MFT or Intern sign an updated treatment plan?

If the physician has not prescribed medication, a psychologist may sign the updated treatment plan in lieu of the physician to document medical necessity. LCSWs, MFTs, and interns may sign the treatment plan in the role of therapist or counselor, but not in lieu of the physician's role of determining medical necessity.

22 CCR § 51341.1 (h)(2)(A)(iii)(c)

COUNSELING

1. How many crisis and collateral sessions can be billed to Drug Medi-Cal?

Title 22 does not specify a maximum number of individual counseling sessions that can be billed to DMC. However, to be eligible to bill DMC, crisis intervention and collateral services must meet the Title 22 definitions.

22 CCR § 51341.1 (b) (4)

22 CCR § 51341.1 (b) (7)

2. Can you still bill for IOT services if a beneficiary misses one group as long as IOT services were offered 3 days/3 hours?

IOT services are billed at a daily bundled rate. As long as a minimum of 3 hours of services are provided each day and a minimum of 3 days are offered in one week, providers may bill DMC for the services provided.

3. Is the 3 hours, 3 days per week requirement the same for adolescent IOT services?

Yes, there is no distinction made in Title 22 in reference to Youth Programs regarding IOT (Intensive Outpatient Treatment- formerly known as Day Care Habilitative) therefore the 3 hours, 3 days per week does apply to Youth Programs.

4. How do you prorate a group session less than 90 minutes or a beneficiary's attendance in a group session less than 90 minutes?

Please see 22 CCR § 51516.1 (a)(3)(A)(1)(2) for requirements for prorating and the DMC billing manual for instructions for prorating.

http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/DMC_Billing_Manual%20FINAL.pdf

5. Can we bill for an individual session for intake, another individual session for assessment, and for my time writing progress notes on the same day?

Multiple service billings for the same day for individual counseling services are permissible if the second service is not a duplicate, and/or the same as the service previously provided to the beneficiary on the same day. Assessments are considered part of the intake process and two intake sessions cannot take place on the same day. Time used for writing progress notes is not a billable DMC service.

22 CCR § 51341.1 (b)(13)

22 CCR § 51341.1 (d)(2)(B)

22 CCR § 51490.1 (b)

6. Can a provider prorate individual counseling sessions for beneficiaries receiving treatment through ODF or IOT modalities or only for group?

- Yes, an ODF provider may prorate both individual and group counseling services. If less than 50 minutes is provided for an individual and/or less than 90 minutes is provided for a group counseling session, the provider must prorate services as defined in *22 CCR § 51516.1 (a) (3) (A) (1) (2)*.
- IOT session days cannot be prorated as it is a bundled rate. A minimum of 3 hours of group must be provided and made available 3 days a week for the provider to bill for IOT services.

22 CCR § 51516.1 (a)(3)(A)(1)(2)

7. Can an individual session with a youth and his/her teacher be billed as a collateral service?

No, the significant person must have a personal relationship with the beneficiary. Teachers are considered "official" or "professional" per Title 22.

22 CCR § 51341.1. (b)(4)

8. What are the requirements when a youth beneficiary turns 18 while in treatment? Is it more clinically appropriate to transfer the beneficiary into our adult program, or continue to serve the beneficiary under our youth program? How is billing affected? What are the best practices?

Title 22 does not address best practices or whether services are clinically appropriate. In this instance, the provider can only bill for group counseling services when services are provided on a certified school site.

22 CCR § 51341.1 (b)(11)

9. If a beneficiary changes treatment modalities, for example from ODF to IOT, does the provider have to discharge the beneficiary and complete a discharge plan?

If the beneficiary changes from ODF to IOT within the same provider/facility, you must update the treatment plan. Discharging the beneficiary is only required when the beneficiary is moving to a different certified site or moving to a different certified provider.

22 CCR § 51341.1 (h)(2)(iii)(a)

10. When switching a beneficiary from perinatal ODF to a non-perinatal ODF program, do we need to discharge or just revise or develop a new treatment plan if attending the same provider/facility?

A beneficiary going from perinatal ODF to non-perinatal ODF within the same provider/facility does not require an updated treatment plan unless there is a change in problem identification or focus of treatment. However, if the change from perinatal to non-perinatal is strictly due to the beneficiary no longer qualifying for the enhanced perinatal rate and treatment focus is not changing, an updated treatment plan is not necessary.

22 CCR § 51341.1 (h)(2)(iii)(a)

PROGRESS NOTES

1. What are the signature requirements when a provider is transitioning from hard copy files to Electronic Health Record (EHR)? For example, counselors forget to finalize notes within seven days during the first month of being trained on the EHR.

Signature guidelines are addressed in Title 22, and must be met regardless of documentation method.

22 CCR § 51341.1. (h)(3)(A)

22 CCR § 51341.1. (h)(3)(B)

2. Does Title 22 require counselors to write a full note for the treatment plans? Is the treatment plan sufficient documentation?

The counselor must write a progress note with the required components for every individual and group counseling session.

22 CCR § 51341.1. (h)(3)(A)

22 CCR § 51341.1. (h)(3)(B)

3. Does each progress note need to reference each and every problem that is on the Treatment plan?

No, the progress notes must reflect progress or lack of progress towards the treatment plan problems, goals, action steps, objectives and/or referrals; however, regulations do not require every problem statement be addressed in each progress note.

22 CCR § 51341.1. (h)(3)(A)

22 CCR § 51341.1. (h)(3)(B)

GROUP SIGN-IN SHEETS

1. Will you recover if a beneficiary signs into group using pencil?

No, the regulations only specify that the name must be legibly typed or printed along with a signature of the participant.

22 CCR § 51341.1. (g)(2)(E)

2. Title 22 requires a sign-in sheet though Title 42 CFR Part 2 prohibits the "incidental disclosures" that by definition, occur during the sign-in process. Do you have a recommendation on how to reconcile the conflict?

Standard procedure at admission should include a release of confidentiality and an agreement to keep information confidential.

CONTINUING SERVICES JUSTIFICATION

1. On the Justification to Continue Treatment document, who is responsible for determining the beneficiary's prognosis? Is it the counselor or the physician?

The therapist or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services and recommend whether or not the beneficiary should continue to receive services. While the counselor may submit a suggested prognosis to the physician, the physician is ultimately responsible for reviewing and making the final determination on the beneficiary's prognosis.

22 CCR § 51341.1. (h)(5)(A)(i)(ii)(e)

2. If a doctor does not approve the continuing services justification at 6 months, how can we do a 30-day discharge plan? Completion of the continuing services justification between five and six months provides 30 days for completion of the discharge plan.

22 CCR § 51341.1. (h)(5)(A)(i)(ii)(e)

22 CCR § 51341.1. (h)(6)(A)

DISCHARGE

1. Is it considered a successful discharge if the beneficiary has met all goals; however, never submits a copy of the required physical exam, which is an identified goal on the treatment plan?

Title 22 does not address "Successful Discharge." For more information about CalOMS Tx, call DHCS's IT Service Desk at (916) 440-7000 or send an email to ITServiceDesk@dhcs.ca.gov.

FAIR HEARING

1. How is the Fair Hearing requirement enforced when a beneficiary is discharged for safety reasons, i.e., beneficiary threatened to harm another beneficiary, and you cannot provide a 10-day notice (based on safety)?

The fair hearing requirement refers to eligibility and benefits, therefore does not apply to a discharge due to safety reasons.

22 CCR § 51341.1. (p)

MISCELLANEOUS

1. If we use an Electronic Health Record (EHR), will DHCS require hardcopies of documents during their reviews?

DHCS may require a hard copy of any documentation during a review.

State/County Contract – Special Terms and Conditions (7)(c)

2. Can we bill DMC for UA (drug testing)?

The cost for body specimen screening is not a billable service as it is included as part of the administrative costs providers can bill for.

3. Can an "Administrative fee" be charged to DMC beneficiaries? For example: Beneficiaries are responsible to submit timely requests for treatment status reports. On occasion, a beneficiary might demand for a report 1-hour before court. To help beneficiary stay responsible, can a small "fee" be charged? A fee can be \$1 or \$5?

Providers must accept eligibility for DMC services as payment in full. No fees of any kind can be charged to the beneficiary.

22 CCR § 51341.1. (h)(7)

4. Are counties required to audit a specific period of time when performing annual program/fiscal audits of our service providers?

Counties are required to monitor DMC providers at least annually; either fiscal year or calendar year is acceptable, however, it must be consistent.

State/County Contract: Exhibit A, Part V, Section 4.B.1.b

5. Does O.D.F. require abstinence only goals for beneficiaries? Can we apply harm reduction in treatment?

Treatment should be individualized and in the best interest of the beneficiary. Title 22 does address abstinence or harm reduction.

[DMC Title 22 Power Point Presentation](#)

Questions E-mail: DMCAnswers@dhcs.ca.gov

For Download:

[California Code of Regulations \(CCR\) DMC Title 22 Revisions FAQ](#)

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