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| **Effective Date:** January 1, 2022 | **Policy Title:** Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services |
| **Original Date of Issue:** April 1, 2022 |
| **Last Revision Date:** N/A |
| **MH  SUD** | **Reference to BHIN No.:** 21-071 |

**PURPOSE**

To outline medical necessity determination requirements and the use of the American Society of Addiction Medicine (ASAM) Criteria© to determine the appropriate level of care for providing covered substance use disorder treatment services in DMC State Plan counties, as specified in Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021), and in accordance with Welfare and Institutions Code section 14184.402(i). The implementation of the ASAM Criteria© in DMC counties is in alignment with implementation by the Drug Medi-Cal Organized Delivery System (DMC-ODS) counties for the ASAM Criteria© for assessment and level of care determination purposes.

**BACKGROUND**

With the California Advancing and Innovating Medi-Cal (CalAIM) initiative,

DHCS aims to design a coherent plan to address beneficiaries’ needs across the continuum of care to ensure that all Medi-Cal beneficiaries receive coordinated services in support of improved health outcomes. The goal is to ensure access to the right care in the right place at the right time.

The ASAM Criteria©

The ASAM Criteria©, formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcomes-oriented and results-based care in the treatment of Substance Use Disorders (SUDs). The ASAM Criteria© relies on a comprehensive set of guidelines for level of care placement, continued stay, and transfer/discharge of individuals with addiction, including those with co-occurring conditions. The ASAM Criteria© uses a multidimensional assessment to direct medical management and the structure, safety, security, and intensity of treatment services. Detailed information about The ASAM Criteria© is available on the ASAM website.[[1]](#footnote-2)

**POLICY**

All medical necessity determinations for covered substance use disorder treatment services provided to beneficiaries through Drug Medi-Cal (DMC) counties shall be made in accordance with Welfare and Institution (W&I) Code section 14059.5[[2]](#footnote-3) and in accordance with the requirements set forth below.

**PROCEDURE**

1. Initial Assessment
   1. Initial assessment for all levels of care, except Narcotic Treatment Programs (NTP) may be conducted:
      * 1. Face-to-face
        2. By telephone (defined as synchronous audio-only)
        3. By telehealth (defined as synchronous audio and video)
        4. In the community
        5. In the home
   2. Initial assessment for all levels of care, except NTP. may be completed by one of the following:
      1. A Licensed Practitioner of the Healing Arts (LPHA), OR
      2. A Registered/certified alcohol and other drug counselor

An LPHA shall evaluate the assessment in consultation with the registered/certified counselor.

Consultation between LPHA and registered/certified counselor may be performed:

In person

Via telephone

Via telehealth

Documentation of the initial assessment shall reflect consultation between LPHA and registered/certified counselor.

Initial diagnosis shall be determined and documented by an LPHA.

* 1. Initial assessment for Narcotic Treatment Programs
     1. The history and physical exam conducted by an LPHA at admission qualifies for the determination of medical necessity, pursuant to state and federal regulations.
  2. Timeliness and Covered Services during the Assessment Process
     1. Beneficiaries aged 21 years of age and older:
        + 1. The initial assessment shall be completed within 30 calendar days following the first visit with an LPHA or registered/certified counselor.
          2. Covered and clinically appropriate services may be provided during the 30-day initial assessment period.
     2. Beneficiaries under 21 years of age:
        + 1. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
          2. Covered and clinically appropriate services may be provided during the 60-day initial assessment period.
     3. Adult beneficiaries experiencing homelessness:
        + 1. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
          2. The practitioner shall document that the beneficiary is experiencing homelessness and requires additional time to complete the initial assessment.
     4. All beneficiaries
        + 1. Clinically appropriate services are reimbursable up to 30 days for beneficiaries aged 21+ or up to 60 days for beneficiaries under age 21 or experiencing homelessness following a visit with an LPHA or registered/certified counselor whether or not a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. A provisional diagnosis may be used prior to establishing the diagnosis. It is permissible to use “Other Specified Mental Disorder” and “Unspecified Mental Disorder” or “factors influencing health status and contact with health services” (Z-codes).
  3. Timeliness consideration when a beneficiary withdraws from treatment prior to completion of the assessment.
     1. When beneficiary withdraws from treatment prior to completion of the assessment or establishing a diagnosis, and later returns to care, the 30-day or 60-day assessment period starts over.

1. Access Criteria AFTER Initial Assessment Process
2. To qualify for DMC services after the initial assessment process, beneficiaries aged 21 and older must meet the following criteria:
   * 1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders,

OR

* + 1. At least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

1. Beneficiaries under the age of 21:
   * 1. Receive covered services that are appropriate, and medically necessary to correct and ameliorate health conditions (pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)[[3]](#footnote-4) under the federal statutes and regulations).
     2. Services provided need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.
2. Diagnosis
3. Diagnostic determination shall be made by an LPHA.
4. Provisional diagnoses:
   1. Provisional diagnoses are used prior to the determination of a diagnosis. It is permissible to use “Other Specified Mental Disorder” and “Unspecified Mental Disorder” or “factors influencing health status and contact with health services” (Z-codes).
   2. Provisional diagnosis shall be updated by an LPHA to accurately reflect the beneficiary’s needs.
5. Additional Clarification
6. Services for covered services are reimbursable[[4]](#footnote-5) even when:
   1. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.[[5]](#footnote-6)
   2. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan;[[6]](#footnote-7) or
   3. The beneficiary has a co-occurring mental health condition.
      1. Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the beneficiary has a co- occurring mental health disorder.
      2. Reimbursement for covered DMC provided to a beneficiary who meets DMC criteria and has a co-occurring mental health condition shall not be denied as long as DMC criteria and requirements are met.
7. Level of Care Determination
8. Practitioners shall use the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service[[7]](#footnote-8). The treatment service must be both medically necessary and clinically appropriate to address the beneficiary’s presenting condition.
   1. For beneficiaries aged 21 year and over
      1. A full assessment using the ASAM Criteria© shall be completed within 30 calendar days of the beneficiary’s first visit with an LPHA or registered/certified counselor.
   2. For beneficiaries under the age of 21 or adult beneficiaries experiencing homelessness
      1. A full assessment using the ASAM Criteria© shall be completed within 60 calendar days of the beneficiary’s first visit with an LPHA or registered/certified counselor.
9. Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the beneficiary’s condition.
10. A full ASAM assessment shall be repeated when a beneficiary’s condition changes.
11. DMC State Plan Counties shall receive assurance from DMC providers that ASAM Criteria will be used to determine the appropriate level of care.
12. Additional Clarifications
13. Clinically necessary services are permissible prior to completion of a full ASAM assessment.
14. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.
15. Clarification on reimbursement of covered and clinically appropriate services
16. Services provided during the *initial or full* ASAM Criteria© assessment
    1. Beneficiaries aged 21 years of age or older, services up to 30 calendar days form first visit with LHPA or certified/registered counselors
    2. Beneficiaries under age 21 years, services up to 60 calendar days from date of first visit with LHPA or certified/registered counselor
    3. All adult beneficiaries experiencing homelessness, services up to 60 calendar days from first visit with LPHA or certified/registered counselor
17. Services provided prior to determination of SUD diagnosis
18. Services provided, even when later determined beneficiary did not meet SUD criteria for continued services

**DEFINITIONS**

None

**FORMS/ATTACHMENTS**

None

**REVISION HISTORY**

N/A (First Version)

1. www.asam.org [↑](#footnote-ref-2)
2. [Law section (ca.gov)](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14059.5.&lawCode=WIC#:~:text=(a)%20For%20individuals%2021%20years,or%20to%20alleviate%20severe%20pain.) [↑](#footnote-ref-3)
3. Section 1396d(r) of Title 42 of the United States Code. [↑](#footnote-ref-4)
4. W&C Code 14184.402(f) [↑](#footnote-ref-5)
5. All Medi-Cal claims for reimbursement continue to require the inclusion of a CMS approved ICD-10 diagnosis code. [↑](#footnote-ref-6)
6. Per BHIN 21-071, DHCS anticipates providing additional guidance for this item. [↑](#footnote-ref-7)
7. W&I Code 14184.402(e) [↑](#footnote-ref-8)