DMC-ODS – FAQs

How are Clinician Consultation services billed under Drug Medi-Cal Organized Delivery System (DMC-ODS)?

Reference: BHIN 24-001, BHIN 23-017, DMC-ODS Billing Manual, DMC-ODS Service Table.

Clinician Consultation is not a direct service provided to DMC-ODS members. This service allows clinicians to seek treatment advice and expertise from other licensed professionals to support the provision of care for specific DMC-ODS members.

Only the DMC-ODS providers that are seeking advice and directly rendering care to the member can bill for Clinician Consultation. The rendering DMC-ODS provider can use the Clinician Consultation procedure codes (99367, 99368, or 99451) to claim for the activity. The clinician providing advice cannot bill for Clinician Consultation.

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing Clinician Consultation services.

Is the consultation between a Licensed Professional of the Healing Arts (LPHA) and a Licensed Clinical Counselor (LCC) for determination of diagnosis and medical necessity billable using assessment codes?

Reference: BHIN 24-001, BHIN 23-068, DMC-ODS Billing Manual, DMC-ODS Service Table.

No. The assessment code would not be used to bill for the consultation. Consultation between an LPHA and a LCC that occurs during a DMC-ODS member's assessment would be billed as Clinician Consultation using a separate code.

Clinician Consultation is not a direct service provided to DMC-ODS members. This service allows clinicians to seek treatment advice and expertise from other licensed professionals to support the provision of care for specific DMC-ODS members.

Only the DMC-ODS providers that are seeking advice and directly rendering care to the member can bill for Clinician Consultation. The rendering DMC-ODS provider can use

the Clinician Consultation procedure codes (99367, 99368, or 99451) to claim for the activity. The clinician providing advice cannot bill for Clinician Consultation.

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing Clinician Consultation services.

When would a Residential Treatment Services provider bill for Recovery Services under Drug Medi-Cal Organized Delivery System (DMC-ODS)?

Reference: BHIN 24-001, BHIN 22-005, DMC-ODS Billing Manual, DMC-ODS Service Table.

The daily bundled rate for Residential Treatment Services includes:

- Assessment
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education
- Substance Use Disorder Crisis Intervention Services

Members may receive Recovery Services under DMC-ODS in three ways: as a standalone service, separately but concurrently with the other DMC-ODS levels of care listed in BHIN 24-001's "Covered DMC-ODS Services" section (including Residential Services), or as a component of these DMC-ODS levels of care.

If a member is receiving Recovery Services as a component of their Residential Treatment Services, the Residential providers should submit separate claims for the Recovery Services. Recovery Services can be claimed on the same day as Residential Treatment Services and for the same member by Outpatient Treatment Services and Residential Treatment Services providers.

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing Recovery Services.

Can the Brief Questionnaire for Initial Placement (BQuIP) tool be used to complete the multidimensional level of care (LOC) assessment?

Reference: BHIN 24-001, BHIN 23-068

No. The BQuIP tool cannot be used to complete the multidimensional level of care (LOC) assessment. Providers are required to use an American Society of Addiction Medicine (ASAM) Criteria assessment to determine DMC-ODS members' placement into the appropriate level of care.

Can Z-codes be used as the primary diagnosis for Drug Medi-Cal Organized Delivery System (DMC-ODS) services?

Reference BHIN 24-001, BHIN 22-013

Certain Z-codes may be used during a DMC-ODS member's assessment services when a diagnosis has yet to be established, per BHIN 22-013. Z-codes meet the federal requirement for claims. The medical record should support any Z-codes that are used in an assessment.

DMC-ODS claims must include clinically appropriate International Classification of Diseases, Tenth Revision (ICD-10) codes associated with each service encounter. ICD codes are required on claims in order for DHCS to receive federal financial participation.

What type of assessment is required when authorizing Drug Medi-Cal Organized Delivery System (DMC-ODS) clients for American Society of Addiction Medicine (ASAM) 3.1 and 3.5 Levels of Care?

Reference BHIN 24-001, Exhibit A of BHIN 21-001, BHIN 23-068

DMC-ODS ASAM 3.1 and 3.5 Levels of Care require a multidimensional assessment to be conducted and completed within 72 hours following the member's admission to the program, per Exhibit A of BHIN 21-001.

Members receiving detoxification services upon admission are exempt from the multidimensional assessment requirement if a pre-assessment is completed within 72 hours of admission to the detoxification services and there are contingency plans to transfer the member to a Level of Care where a full assessment will be conducted.

Is prior authorization required for Drug Medi-Cal Organized Delivery System (DMC-ODS) Residential Treatment and Inpatient Services?

Reference: BHIN 24-001

Yes. DMC-ODS plans shall provide independent review of authorization requests for residential and inpatient services (excluding withdrawal management services) and notify the provider of the plan's decision within 24 hours of the submission of the request by the provider.

Please note that DMC-ODS plans may not impose prior authorization for non-residential and non-inpatient assessment and treatment services, which includes withdrawal management services.

Is a comprehensive American Society of Addiction Medicine (ASAM) Criteria assessment required for members to receive Recovery Services?

Reference: BHIN 24-001, BHIN 22-005, BHIN 23-068

Recovery Services do not require a comprehensive ASAM assessment for members to receive services, regardless of the mode of delivery.

Members may receive Recovery Services based on self-assessment or a provider's assessment of relapse risk. Members do not have to be diagnosed as being in remission in order to access Recovery Services.

Recovery Services under DMC-ODS can be delivered in three ways: as a standalone service; separately but concurrently with the other DMC-ODS levels of care listed in BHIN 24-001's “Covered DMC-ODS Services" section; or as a component of these DMC-ODS levels of care. DMC-ODS providers should use their clinical expertise, in accordance with each member's clinical needs and generally accepted standards of practice, to determine the appropriate delivery method of Recovery Services for their members.

Please note that a comprehensive ASAM assessment is not required for a member to begin receiving DMC-ODS services.

What are the length of stay requirements for Medi-Cal members in residential substance use disorder (SUD)

treatment programs? Do these requirements differ for pregnant and postpartum members?

Reference BHIN 21-021; BHIN 24-001

Medi-Cal members, including pregnant and postpartum members, can stay in residential SUD treatment programs for as long as clinically appropriate as determined by a Licensed Practitioner of the Healing Arts (LPHA). While the statewide goal for the average length of stay for residential treatment services provided by Drug Medi-Cal Organized Delivery System (DMC-ODS) counties is 30 days or less, there is no limitation on the maximum number of days a member can reside in residential treatment.

Please see BHIN 21-021 for additional information on the removal of a former length of stay requirement.

If a member is stepping down from residential to outpatient Drug Medi-Cal Organized Delivery System (DMC-ODS) services, can the outpatient provider and the residential provider bill for Care Coordination while the member is still technically enrolled in residential services?

Reference: BHIN 24-001, DMC-ODS Billing Manual, DMC-ODS Service Table

The Residential Treatment Services bundled rate does not include Care Coordination services. Thus, the Residential Treatment or the Outpatient provider may bill and be reimbursed for Care Coordination as an unbundled service separately from billing for the Residential Treatment or Outpatient services.

If the Residential Treatment provider is certified to provide the Outpatient Services, that provider may claim for Care Coordination as an outpatient service (using modifier U7 or U8) and would be reimbursed for the service on the outpatient rate. The Residential Treatment provider may also claim for Care Coordination through the Residential program certification (i.e. modifier U1) instead of Outpatient and be entitled to the same outpatient rate.

The Residential Treatment Services bundled rate includes the following components:

- Assessment
- Counseling

- Family Therapy
- Medication Services
- Patient Education

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing Care Coordination services.

For Drug Medi-Cal Organized Delivery System (DMC-ODS), are discharge plans and discharge summaries still required?

Reference: BHIN 19-003; BHIN 23-068, BHIN 24-001

DMC-ODS plans and providers should follow documentation requirements set forth in BHIN 23-068, which does not include discharge plans and discharge summaries. Discharge planning is a component of Care Coordination services for DMC-ODS and should be provided based on member need. Discharge planning can include coordination with substance use disorder (SUD) treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. For certified only programs, discharge plans and summaries are required per Alcohol and/or other Drug (AOD) Certification Standard 7120.

Further, licensed residential programs shall update resident records as necessary to ensure current accuracy and include data and reason for termination of services, per CCR Title 9, Chapter 5, Section 10568. Additionally, BHIN 19-003 updates H&S Code 11834.26(d) to include resident discharge and continuation of care as part of the required written plan to address resident relapse.

Can homelessness be a justification for extending substance use disorder (SUD) treatment or even increased level of care (LOC)?

Reference: BHIN 24-001

Members must meet the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) to access SUD services through the DMC/DMC-ODS program. The American Society of Addiction Medicine (ASAM) Criteria is used to determine placement into the appropriate LOC for all members receiving services through the DMC or DMC-ODS. Dimension 5 (Recovery Environment Interactions) of the

multidimensional ASAM assessment includes factors that can impact recovery, such as homelessness, to help determine the appropriate placement. Member placement and LOC determinations shall ensure that members are able to receive care in the least intensive LOC that is clinically appropriate to treat their condition.

Can the requirement to offer naloxone at a Narcotic Treatment Program (NTP) / Opioid Treatment Program (OTP) be met by offering a form of buprenorphine (Suboxone®) that contains both buprenorphine and naloxone?

Reference: BHIN 24-001, BHIN 23-064

No. While NTPs/OTPs may offer formulations of buprenorphine that contain naloxone, this is not a replacement for naloxone. Naloxone (by itself) is used to reverse an opioid-involved overdose. The inclusion of naloxone in the combination buprenorphine/naloxone product is intended to prevent diversion and misuse of the buprenorphine medication; it is not intended to reverse an opioid-involved overdose.

How can Drug Medi-Cal Organized Delivery System (DMC-ODS) providers leverage Medi-Cal for prescribing and dispensing naloxone to patients?

Reference: BHIN 24-001 , BHIN 23-064

DMC-ODS providers have flexibility to provide or arrange for naloxone to be prescribed and provided to each DMC-ODS member by leveraging Medi-Cal Rx. Medi-Cal Rx is the outpatient pharmacy benefit for all Medi-Cal members. Medi-Cal Rx covers prescription and over-the-counter outpatient drugs, including naloxone.

DMC-ODS providers that are authorized to prescribe the medication can prescribe naloxone to each member who is under their care and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of the members, as a best practice overdose prevention measure. DMC-ODS providers can also coordinate delivery of the naloxone from a pharmacy to the member's location or refer members to pharmacies that will dispense naloxone directly to the member. Furthermore, DMC-ODS counties may cover drug product costs for treatment when the medications are purchased and administered or dispensed in a nonclinical setting (e.g., criminal justice settings or street-based outreach). Finally, medical directors and prescribing clinicians of DMC-ODS

providers are also able to establish a standardized protocol that authorizes designated staff working in a DMC-ODS provider agency to issue prescriptions on behalf of the medical directors or prescribing clinicians to a local pharmacy for naloxone.

The Naloxone Distribution Project (NDP) is a project DHCS established in 2018 to reduce opioid-related overdose deaths through the provision of free naloxone, directly shipped to eligible entities. The NDP supports eligible entities, including, but not limited to, law enforcement, schools, tribal entities, county public health and behavioral health departments, and community organizations. The NDP is not the primary source for naloxone in California and other available funding sources should be used to obtain naloxone prior to utilizing the NDP.

How can Medi-Cal members access Medications for Addiction Treatment (MAT)?

Reference BHIN 24-001, BHIN 23-064, BHIN 23-054, BHIN 22-011, and the MCP Contracts.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

DMC-ODS providers can administer medications for Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD). All FDA-approved medications and biological products to treat these disorders are covered, including buprenorphine and naltrexone. MAT is covered, reimbursable, and can be provided in most DMC-ODS levels of care, including outpatient treatment, intensive outpatient treatment, partial hospitalization, residential treatment[1], inpatient treatment, and withdrawal management. MAT is also covered, reimbursable, and can be provided by DMC-ODS providers in non-clinical settings (such as mobile clinics and street medicine teams) and when provided as a standalone service outside of these levels of care. Methadone maintenance treatment must be provided by a Narcotic Treatment Program (NTP).

Members needing or utilizing MAT must be served. Members cannot be denied DMC-ODS treatment services, be required to decrease dosage, or be tapered off medications as a condition of receiving or continuing DMC-ODS services. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a member who declines counseling services.

As described in BHIN 24-001, DMC-ODS plans shall ensure that all DMC-ODS providers, at all levels of care, either offer MAT services directly or have an effective referral process in place to the most clinically appropriate MAT services, pursuant to the requirements set forth in BHIN 23-054. An effective referral process shall include an established relationship with a MAT provider and transportation to appointments for MAT,

regardless of whether the provider seeks reimbursement through DMC-ODS. Simply providing a member with the contact information for a MAT provider does not meet the requirement of an effective referral.

MAT may also be offered to Medi-Cal members in various settings outside of DMC-ODS, including:

- **Medi-Cal Managed Care Plans (MCPs).** Medi-Cal members can receive clinically appropriate and covered SUD services delivered by MCP network providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment) via primary care, community clinics, Federally Quality Health Centers (FQHCs), inpatient hospital, emergency departments, and other contracted medical settings, per BHIN 22-011 and the MCP Contracts, MCPs must also arrange for the provision of MAT provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- **Emergency departments (EDs) and hospitals.** EDs can be a stabilization point for members with OUD. Any hospital or ED provider may administer buprenorphine according to the CA Bridge Treatment Protocols to relieve acute withdrawal symptoms and facilitate patient referral to treatment. Over 240 EDs in California offer MAT through onsite MAT induction in the ED and short-term prescriptions of buprenorphine to bridge the member until their first follow-up visit. Please visit the California Bridge Program website to find resources, tools, and EDs that offer MAT throughout California.
- **Pharmacies.** Medi-Cal members can receive medications for the treatment of substance use disorders similar to any other maintenance medication from a Medi-Cal enrolled pharmacy. All medications and biological products utilized to treat SUDs, including long-acting injectables, are available through Medi-Cal Rx without prior authorization. Medications can also be delivered directly to provider offices for onsite administration. Medi-Cal Rx pharmacies can be found by visiting the Medi-Cal Rx website, and provider training resources can be found on the Medi-Cal Rx Education & Outreach website. The complete list of approved medications for the Medi-Cal Rx program can be found on the Medi-Cal Rx Contract Drugs List website.

Additional Resources to Access MAT

- The **DHCS Opioid Response** aims to increase access to MAT, reduce unmet treatment needs, and reduce opioid overdose related deaths through programs focused on prevention, treatment, and recovery activities. Many primary care providers, FQHCs, specialty SUD treatment providers and other organizations are

receiving funds though the project, which can help cover the cost of medications and services for individuals who are uninsured or underinsured.

- The **Tribal MAT Project** is a unified response designed to meet the specific opioid use disorder prevention, treatment, and recovery needs of California's Tribal and Urban Indian communities. The Tribal MAT Project promotes opioid safety, improves the availability and provision of MAT, and facilitates wider access to naloxone with special consideration for Tribal and Urban Indian values, culture, and treatments.
- **Treatment Locators:** Please visit http://choosemat.org/ for a list of providers and facilities offering MAT in your area. The organization Shatterproof has also created a treatment locator with questions to help individuals and families access treatment that is suited to their needs, via the ATLAS platform.

[1] Licensed residential treatment programs that are authorized to provide incidental medical services (IMS) may also offer MAT.

How are collateral services covered under Drug Medi-Cal Organized Delivery System (DMC-ODS)?

Reference: BHIN 24-001, DMC-ODS Billing Manual, DMC-ODS Service Table

A collateral is a family member or other person supporting the DMC-ODS member. “Collateral services" is no longer defined as a unique service component of the DMC-ODS service modalities. As described in BHIN 24-001, the concept of including a collateral in a member's substance use disorder treatment has been incorporated into assessment services, individual counseling, Medi-Cal Peer Support Services, and family therapy. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member.

Assessment services may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Individual counseling services and Medi-Cal Peer Support Services can also include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

Family therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member's recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved one to remain in treatment.

BHIN 24-001 and the DMC-ODS Medi-Cal Billing Manual detail which DMC-ODS service modalities include assessment services, individual counseling services, Medi-Cal Peer Support Services and family therapy as billable service components.

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing services involving a member's collaterals.

To offer partial hospitalization services through the Drug Medi-Cal Organized Delivery System (DMC-ODS) program, what certification requirements must be met by the DMC-ODS plan?

Reference: BHIN 24-001

Partial Hospitalization Services are optional for DMC-ODS plans. There is no DMC certification category specific to partial hospitalization. In order to provide Partial Hospitalization Services through DMC-ODS, the DMC-ODS plan, or DMC-ODS contracted providers must:

1. Be certified as DMC Intensive Outpatient Treatment (IOT) providers;
2. Be able to offer 20 or more hours of clinically intensive programming per week; and
3. Demonstrate the ability to facilitate access to the psychiatric, medical, and laboratory services, as needed.

What are the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan documentation requirements relating to grievances?

Reference: BHIN 24-001, July 1, 2022 – July 1, 2027 DMC-ODS Contract

As specified in the Intergovernmental Agreement (DMC-ODS contract), each DMC-ODS plan shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.

The record of each grievance or appeal shall contain, at a minimum, all of the following information:

- General description of the reason for the appeal or grievance.

- Date received.
- Date of each review or, if applicable, review meeting.
- Resolution at each level of the appeal or grievance, if applicable.
- Date of resolution at each level, if applicable.
- Name of the covered person for whom the appeal or grievance was filed.

Each record shall be accurately maintained in a manner accessible to the Department of Health Care Services (DHCS) and available upon request to the Centers for Medicare and Medicaid Services (CMS). The written record of grievances and appeals shall be submitted at least quarterly to the plan's quality improvement committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.

What are the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan requirements for appeals?

Reference: BHIN 24-001, July 1, 2022 – July 1, 2027 DMC-ODS Contract

As specified in the Intergovernmental Agreement (DMC-ODS contract), the member or a provider and/or authorized representative may file an appeal in-person, orally, or in writing. If they request expedited resolution, the member or representative must follow an in-person or oral filing with a written, signed appeal. The appeal must not count against the member or authorized representative in any way. Individuals deciding on the appeals resolution must be qualified to do so and not involved in any previous level of review or decision-making.

Members and/or their authorized representative must:

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

What are the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan requirements and timeframes for State Hearings?

Reference: BHIN 24-001, July 1, 2022 – July 1, 2027 DMC-ODS Contract

As specified in the Intergovernmental Agreement (DMC-ODS contract), members may request a State Hearing only after receiving notice that the plan is upholding an adverse benefit determination.

Members have 120 days to request a State Hearing, beginning from the date that the plan gave the decision to the member in person, or the day after an appeal decision is postmarked. If the member did not receive a Notice of Adverse Benefit Determination (NOABD), they may file for a State Hearing at any time.

The California Department of Social Services will conduct an independent review within 90 days of receiving the request. Members may request an expedited State Hearing. If a request qualifies for an expedited State Hearing, the decision will be issued within three working days from the date that the request is received by the State Hearings Division.

Where can Drug Medi-Cal Organized Delivery System (DMC-ODS) plans and providers find guidance on Notice of Adverse Benefit Determination (NOABD) grievance and appeals requirements?

Reference: MHSUDS IN 18-010E

Please refer to MHSUDS IN 18-010E: Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates for clarification and guidance regarding the application of revised federal regulations for processing grievances and appeals.

What grievance and appeal information must be in the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan's Quality Improvement (QI) Plan?

Reference: BHIN 24-001

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

- How to submit a grievance, appeal, and request for a state hearing
- Time frame for resolution of appeals;
- Content of an appeal resolution;
- Record keeping;
- Continuation of benefits; and
- Requirements of State Hearings.

If a Drug Medi-Cal Organized Delivery System (DMC-ODS) plan has an integrated behavioral health department, can it use the same Quality Improvement (QI) Committee required by the Mental Health Plan contract to fulfill the DMC-ODS QI Committee requirements?

Reference: BHIN 24-001

Yes. The DMC-ODS plan may use the same committee, with substance use disorder participation, for counties with an integrated behavioral health department.

Are student interns or trainees considered Licensed Practitioners of the Healing Arts (LPHAs)?

Reference: BHIN 24-001, SPA 23-0026

No. A Licensed Practitioner of the Healing Arts (LPHA) includes any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Registered CSW, Licensed Professional Clinical Counselor (LPCC), Registered PCC, Licensed Marriage and Family Therapist (LMFT), Registered MFT, Licensed Vocational Nurse (LVN), Licensed Occupational Therapist (LOT), and Licensed Psychiatric Technician (LPT).

A clinical trainee is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as an LPHA; is participating in a practicum, clerkship, or internship

approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship, or internship and provide substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements.

SPA 23-0026 allows CSW, MFT, and PCC candidates to provide DMC-ODS services if the candidate:

1. Submitted their application for associate registration to Board of Behavioral Sciences (BSS) within 90 days of their master's program degree award date,
2. Is completing supervised hours towards their licensure, and
3. Acts within their scopes of practice under California law.

The BSS' "90 Day Rule" allows CSW, MFT, and PCC candidates who have submitted their applications for associate registration within 90 days of the degree award date to count supervised experience gained during the window of time between the degree award date and the issue date of the associate registration number toward their licensure.

Can a non-perinatal provider serve a pregnant Drug Medi-Cal Organized Delivery System (DMC-ODS) member? What is the process to claim for these services?

Reference: Perinatal Practice Guidelines

Yes. A pregnant member can choose to receive services from a non-perinatal provider. If the DMC-ODS member receives eligibility through a pregnancy aid code, the claim must include the Patient Information, also known as PAT, 9 pregnancy indicator to be valid. Please refer to the Perinatal Practice Guidelines for providers working with pregnant and parenting people seeking or referred to substance use disorder treatment.

How is billing for Drug Medi-Cal Organized Delivery System (DMC-ODS) group counseling services calculated?

Reference: BHIN 24-001, DMC-ODS Billing Manual, DMC-ODS Service Table

Units for DMC-ODS group counseling services should be calculated using the following formula: (Number of minutes for the group counseling session/15-minute increments =

total units to submit using procedure code H0005. DMC-ODS Plans should submit claims separately for each member receiving group counseling.

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing group counseling services.

Can you submit a claim for a member's “room and board" during residential treatment if the member received no residential treatment covered services on the date of service for the claim?

Reference: BHIN 24-001, DMC-ODS Billing Manual, DMC-ODS Service Table

No. “Room and board" cannot be claimed separately. In order to claim for residential treatment, a member must receive at least one residential treatment covered service (i.e. required structured activity) on the date of service for the claim. BHIN 24-001 outlines the services covered under Residential Treatment.

Please see the DMC-ODS Billing Manual and separate DMC-ODS Service Table for directions on billing Residential Services.

Are revenues other than 2011 realignment funds eligible for federal match?

Reference: SSA § 1903(w)(6); 42 CFR § 433.51.

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