POLICY: MEDICAL NECESSITY

I. PURPOSE:

The purpose of this policy is to ensure that beneficiaries enrolled in Marin County’s continuum of substance use services meet medical necessity for the appropriate American Society of Addiction Medicine (ASAM) level of care at admission and throughout treatment and recovery services, and is clearly documented in the beneficiary’s file.

II. REFERENCES:

Title 22 Regulations, CCR § 51303, 22 CCR § 51341.1
Title 9, CCR
State-County Intergovernmental Agreement, Exhibit A, Attachment 1
Policy BHRS-SUS-21 Residential Authorization
Drug/Medi-Cal Organized Delivery System (DMC-ODS) Standard Terms and Conditions (STCs)
DHCS Information Notice 16-044: Clarifying the Meaning of Face-to-Face Review from the STCs from the DMC-ODS

III. POLICY:

It is the policy of County BHRS to ensure beneficiaries receiving services as part of the continuum of substance use services, whether as a Marin Medi-Cal beneficiary or low income uninsured Marin resident, meet medical necessity criteria for the enrolled level of care. Beneficiaries will be assessed for medical necessity and ASAM Criteria through either the BHRS Access Line or directly with ASAM-trained DMC-ODS service providers.

Medical necessity for an adult (an individual age 21 and over) is determined using the following criteria:

a. The individual must have received at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders;
b. The individual must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

Medical necessity for an adolescent individual (an individual under the age of 21) is determined using the following criteria:

a. The adolescent individual must be assessed to be at risk for developing a SUD; and
b. The adolescent individual must meet the ASAM adolescent treatment criteria.

Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.

IV. AUTHORITY/RESPONSIBILITY:

Alcohol and Drug Administrator
BHRS Director
BHRS Quality Management
Contract Managers

V. PROCEDURE:

1. The initial medical necessity determination for an individual to receive services must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in the DMC-ODS STCs and DHCS Information Notice 16-044. After establishing a diagnosis, the American Society of Addiction Medicine (ASAM) Criteria shall be applied to determine placement into the appropriate level of care.

2. If the entity screening or assessing the beneficiary determines that the medical necessity criteria has not been met and that the beneficiary is not entitled to the particular level of care being sought or any substance use disorder treatment services from the Marin County DMC-ODS, then a written Notice of Adverse Benefit Determination (NOABD) will be issued in accordance with 42 CFR 438.404.

3. For an individual to receive ongoing DMC-ODS services in the same level of care, the Medical Director, licensed physician, or LPHA shall reevaluate that individual’s medical necessity qualification at least every six months (through the reauthorization process). Continuing services justification, as defined in CFR Title 22, Section 51341.1, is required no sooner than five months and no later than six months from the
admission date. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director, licensed physician, or LPHA reauthorization is required annually.


5. The Medical Necessity determination shall be documented in accordance with the timeframes and requirements outlined in the applicable sections of Title 22, Title 9 and DMC-ODS STCs.

Contractor compliance with this policy shall be achieved through:
1. Distribution of the Contractor Manual, which includes information about Policies, Procedures and contract requirements, annually at contract renewal
2. Approval of contract as to form and legal affect by county counsel, signature of Contractor on contract agreeing to all conditions set forth in the contract, and approval and execution of contract by the County Board of Supervisors or County Administrative Officer.
3. BHRS Quality Management staff performs a utilization review on a monthly basis prior to upload and payment of services for all new beneficiary admissions to treatment. Staff will review documentation demonstrating that the beneficiary meets medical necessity criteria, is in the appropriate ASAM level of care, and that the interventions are appropriate for the diagnosis(es) and level of care.
4. If BHRS Quality Management identifies deficiencies related to medical necessity, claims will not be submitted to DHCS and the Provider will be required to submit a Plan of Correction to BHRS.
5. At annual Site Visit, Contract Manager shall review contractor policy and procedures regarding medical necessity, as well as shall review beneficiary files for evidence of meeting medical necessity, and Continuing Services Justifications and NOABDS, if applicable. Employee files and training logs will be reviewed in order to ensure ASAM and Title 22 training requirements are being met within the appropriate timeframe, and policies and procedures are being followed in accordance with regulations.

County-operated service compliance shall be achieved through:
1. Approval of State-County Intergovernmental Agreement by Board of Supervisors or authorized designee agreeing to all conditions set forth in the contract.
2. BHRS Quality Management staff performs a utilization review on a monthly basis for all new beneficiary admissions to treatment prior to upload of claims to DHCS. Staff will review documentation demonstrating that the beneficiary meets medical necessity criteria, is in the appropriate ASAM level of care, and that the interventions are appropriate for the diagnosis(es) and level of care.
3. If BHRS Quality Management identifies deficiencies related to medical necessity, claims will not be submitted to DHCS and a Plan of Correction will be required.

4. Annual completion of Self Audit, including County Alcohol & Drug Administrator’s signed attestation of adherence to all laws and regulations.

5. At annual Site Visit, Quality Management staff shall review contractor policy and procedures regarding medical necessity, as well as shall review beneficiary files for evidence of meeting medical necessity, and Continuing Services Justifications and NOABDs, if applicable. Employee files and training logs will be reviewed in order to ensure ASAM and Title 22 training requirements are being met within the appropriate timeframe, and policies and procedures are being followed in accordance with regulations.