SALISH BHO

UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

Policy Name: SUBSTANCE USE DISORDER SERVICE DESCRIPTIONS **Policy Number:** 7.07

Reference: WAC 388-877, Contract requirements
DSM-5, ASAM (3rd edition),

Effective Date: 4/2016

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Approved by: SBHO Executive Board

Definitions

American Society of Addiction Medicine (ASAM): Supports the use of multidimensional assessments in developing individualized service plans, and to guide clinicians, counselors, and care managers in making objective decisions about admission, continuing care, and transfer/discharge criteria regarding individuals with addictive, substance-related, and cooccurring conditions.

Levels of Care (LOC): Referral to a specific level of care must be based on a comprehensive assessment of an individual with a substance use disorder. A primary goal underlying ASAM criteria is for an individual to be placed in the most appropriate level of care.

Substance Use Disorder (SUD): A condition in which the use of one or more substances leads to a clinically significant impairment or distress.

SBHO maintains standard level of care (LOC) guidelines for all services. These LOC guidelines incorporate contract requirements, American Society of Addiction Medicine (ASAM) criteria, and Washington Administrative Codes. SBHO contracts with an Administrative Service Organization (ASO), CommCare, to facilitate service authorization requests for Residential SUD treatment. CommCare utilizes these Level of Care guidelines for supporting decisions about scope,

duration, intensity and continuation of services. Decisions regarding Substance Use Disorder treatment services must abide by these guidelines.

1. **Determining Medical Necessity for Enrollment in Services**

A. Evaluating ASAM Level of Care Criteria**:** Prior to enrollment in SUD treatment services, the following must be accomplished to determine "medical necessity":

1) The individual has received a comprehensive Substance Use Disorder Bio-Psycho-Social assessment from an appropriately credentialed professional. The assessment process includes the administration of the GAIN-SS.
2) A substance use disorder diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and included in the statewide ACS as a covered diagnosis has been assigned based on information gathered from the assessment. The DSM-5 diagnosis is identified by an ICD-10 code.
3) ASAM level of care requirements (medical necessity), sufficient to meet the individual's needs, have been determined by an appropriately credentialed professional, through evaluation of ASAM criteria.
4) The individual is expected to benefit from the recommended intervention.
5) The individual's unmet needs cannot be more appropriately met by another intervention.
6) There are no restrictions as to the number or frequency of assessments an individual can receive.

2. **Outpatient Substance Use Disorder Services**

A. Agency provider assessment determines enrollment for the following levels of outpatient treatment based on access to care standards and medical necessity: ASAM Level 1.0 Outpatient and ASAM Level 2.1 Intensive Outpatient

B. Service Expectations

1) Individuals will be able to receive medically necessary outpatient services at their current ASAM level. Services provided must include at least the following:

a. ASAM Level 1: Outpatient Treatment Services

i. Provides up to nine contact hours per week for adults and up to six hours per week for adolescents. ii. Available Services:

a) Case Management
b) Opiate Substitution Treatment
c) Group and Individual counseling

b. ASAM Level 2.1: Intensive Outpatient Treatment Services

i. Provides 9-19 hours of structured programming per week for adults, and, 6-19 hours per week for adolescents.

ii. Available Services:

a) Case Management

b) Group and Individual counseling
c) Chemical dependency outpatient treatment services that provide a concentrated program of individual and group counseling, education, and activities, including at least one individual session each month.

C. Continuing Care Criteria

An individual may remain in care as long as medical necessity criteria continue to be met and treatment is reviewed on an on-going basis.

D. Discharge Criteria

Individuals are appropriate for discharge when they no longer meet medical necessity requirements determined by a review of ASAM criteria. Discharge criteria will be determined by a CDP or a CDPT under the supervision of a CDP supervisor.

E. Authorization Request Denials

If a provider agency determines an individual does not meet access to care or medical necessity criteria they will submit a denial request to SBHO. SBHO will review all denial requests. If SBHO agrees with the denial request, SBHO will send a Notice of Adverse Benefit Determination (NOABD) for Medicaid individuals and services or a Notice of Determination for non-Medicaid individuals and services as well as provide a peer clinical review. The purpose of the peer clinical review is to allow the treating provider a chance to discuss UM determinations before the initiation of the appeal process. If a peer to peer conversation or review of additional information does not result in resolution, SBHO informs the provider and the individual of the right to initiate an appeal and the procedure to do so.

F. Covered Individuals

The following individuals may be authorized for SUD Outpatient treatment services if the requirements of this section are met:

a) Medicaid enrollees
b) Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage) who have no other SUD insurance benefit and were referred to treatment from:
    i. The criminal justice system
    ii. A withdrawal management facility
    iii. A residential treatment facility

These services may be funded by CJTA, SABG, or the agency's state funded contract. If an agency does not have any of these funding sources available at the time the individual applies for services the individual should be referred to an alternative agency.

3. **Residential Substance Use Disorder Services**

A. CommCare administers authorization determinations for the following levels of residential treatment based on medical necessity:

1) Level 3.1 Clinically Managed, Low Intensity Residential Services (Recovery House)
2) Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential services 3) Level 3.5 Clinically Managed, High Intensity Residential Services

B. Enrollees cannot be required to relinquish custody of minor children in order to access residential SUD treatment services.

C. Who May Request an Authorization?

Requests for authorization of residential services should be made by an SBHO contracted outpatient, residential, or local Tribal SUD provider. The authorization request follows an assessment by a CDP, or a CDPT under supervision of a CDP supervisor, and is based on ASAM criteria. The referring provider first arranges a bed date at a residential facility, requests authorization from CommCare, then forwards the authorization information to the residential facility. Refer to the residential treatment services authorization process in SBHO P&P 7.09.

D. Authorization Period

Initial authorizations for residential treatment are for up to 30 days (90 days for PPW), based on an assessment of the individual's needs and appropriateness of placement. CommCare may contact the residential facility for more information as needed. It is expected that the individual will be transferred to a lower level of care when clinically indicated.

E. Continuing Care Criteria

If the residential provider determines that the individual needs services in excess of the initial authorization, an additional authorization request for continued residential care must be submitted to CommCare. Requests for extended residential treatment must be based on medical necessity determined by a CDP's review of ASAM criteria. Determination of medical necessity must include an evaluation of the effectiveness of services provided during the initial benefit period and justification for continuation of services. Extension requests for residential services may be made for up to 30 days per request (90 days for PPW). Requests for extended Residential services must be received by CommCare a minimum of five days in advance of the expiration of the benefit period. CommCare has up to three days to respond.

F. Discharge Criteria

Individuals are appropriate for discharge from residential treatment services when they no longer meet medical necessity requirements determined by a review of ASAM by a CDP or a CDPT under supervision of a CDP supervisor.

G. Denials

If CommCare denies a request for authorization of Residential treatment services, CommCare will send a Notice of Adverse Benefit Determination (NOABD) for Medicaid individuals and services or a Notice of Determination for non-Medicaid individuals and services as well as provide a peer clinical review. The purpose of the peer clinical review is to allow the treating provider a chance to discuss UM determinations before the initiation of the appeal process. If a peer to peer conversation or review of additional information does not result in resolution, CommCare informs the provider and the individual of the right to initiate an appeal and the procedure to do so.

H. Authorization Protocol

Refer to "Substance Use Disorder Residential Treatment Authorization Request" and instructions.

I. Covered Individuals

The following individuals may be authorized for SUD Residential treatment services if the requirements of this section are met:

1) Medicaid enrollees
2) Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage) who have no other SUD insurance benefit and were referred to treatment from:
   i. The criminal justice system
   ii. A withdrawal management facility
3) Those entering residential treatment through the Designated Crisis Responder (DCR) process

4. **<u>Withdrawal Management Services</u>**

A. Withdrawal management services are considered a crisis service and are available to covered individuals.

B. Authorization Request Protocol

No authorization is required to crisis services.

C. Covered Individuals

1) The following individuals may receive this service if the requirements of this section are met:
   i. Medicaid enrollees
   ii. Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage) who have no other SUD insurance benefit.