



*Substance Use Disorder
Best Practice
Guidelines*

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MID-SOUTH SUBSTANCE ABUSE COMMISSION EXPECTATIONS

The Mid-South Substance Abuse Commission (MSSAC) is dedicated to contracting for the provision of quality substance use disorder treatment services, which considers each individual's readiness to change and works with them to discover and pursue their own recovery.

MSSAC's substance use disorder treatment expectation is to emphasize a client-centered approach, incorporating the stages of change model with appropriate interventions, appropriate levels of service and care, to improve client treatment outcomes.

MSSAC substance use disorder treatment providers are expected to utilize these guidelines for the provision of quality substance use disorder treatment and supporting services in order for our shared clients' to pursue their own recovery.

What is recovery?

The Betty Ford Institute convened a consensus conference in September 2006 to create a definition of "recovery." Fourteen experts were invited for their knowledge of research and recovery to arrive at a consensus definition of recovery for the substance use disorder treatment field to discuss and refine. Because the definition is designed to be quantifiable, the goal of the definition is to stimulate research and further discussion. MSSAC is in support of this multidimensional definition and its concepts are an integral part of this document. The definition is as follows:

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by *sobriety, personal health, and citizenship.*

Sobriety refers to abstinence from alcohol and all other non-prescribed drugs. This criterion is considered to be primary and necessary for a recovery lifestyle. Evidence indicates that for formerly dependent individuals, sobriety is most reliably achieved through the practice of abstinence from alcohol and all other drugs of abuse. *Early sobriety* = 1 – 11 months; *sustained sobriety* = 1 – 5 years; *stable sobriety* = 5 years or more.

Personal health refers to improved quality of personal life as defined and measured by validated instruments such as the physical health, psychological health, independence, and spirituality scales of the World Health Organization QOL (Quality of Life) instrument.

Citizenship refers to living with regard and respect for those around you as defined and measured by validated instruments such as the social function and environmental scales of the WHO-QOL instruments.

Criteria 2 and 3 extend sobriety into the broader concept of recovery. Personal health and citizenship are often achieved and sustained through peer support groups such as AA and practices consistent with the 12 Steps and 12 Traditions."¹

The above definition of recovery is not a substitute for specific individualized assessment, determination of level of care, and treatment planning.

¹ The Betty Ford Institute Consensus Panel. What is recovery? A working definition from the Betty Ford Institute. J Subst Abuse Treat 2007; 33:221-8.

DEFINITIONS

“Abstinence” is non-use of a specific substance. In recovery, non-use of any addictive psychoactive substance. May also denote cessation of an addictive behavior, such as gambling, over-eating, etc.

“Aftercare Planning” is a written plan of activities, what-to-do-if lists, who to contact, etc. developed by the client in conjunction with the therapist to help plan what the client will do when treatment is completed.

“Admission” is that point in an individual’s relationship with an organized treatment service when the intake process has been completed and the individual is entitled to receive services of the treatment program.

“ASAM” stands for the American Society for Addiction Medicine. It is the medical association for Addictionologists. The members developed the patient placement criteria.

“Assessment” is those procedures by which a program evaluates an individual’s strengths, weaknesses, problems and needs, and determines priorities so that a treatment plan can be developed.

“Bundling” is an approach to treatment that ties or “bundles” several treatment services together, often delivering them in a specific treatment setting. Because this approach often overlooks a client’s individual needs and can lead to inappropriate and unnecessary services, the current trend is toward “unbundled” services.

“CareNet” is the web-based data system used by MSSAC for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

“Clinically Managed Services” are directed by non-physician addiction specialists rather than medical personnel. They are appropriate for individuals whose primary problems involve emotional, behavioral or cognitive concerns, readiness to change, relapse, or recovery environment, and whose problems in Dimension 1 (intoxication/withdrawal) and Dimension 2 (biomedical concerns), if any, are minimal or can be managed through separate arrangements for medical services.

“Co-Occurring Disorders” are concurrent substance-related and mental disorders. Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.

“Continued Service Criteria” is in the process of client assessment, certain problems and priorities are identified as justifying admission to a particular level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client’s status in each of the six assessment dimensions is considered in determining the need for continued service.

“Continuum of Care” is an integrated network of treatment services and modalities, designed so that an individual’s changing needs will be met as that individual moves through the treatment and recovery process.

“Cultural Competency” is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

“Discharge Summary” is the written summary of the client’s treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician’s perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, detail those goals not accomplished with a brief statement as to why, and it should present the initial DSM-IV^{TR} Multiaxial Diagnosis and the current multiaxial diagnosis at time of discharge.

“Discharge/Transfer Criteria” is in the process of client assessment, certain problems and priorities are identified as justifying treatment in a particular level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and thus are used to determine when a client can be treated at a different level of care or discharged from treatment. Also, the appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. The level of function and clinical severity of a client’s status in each of the six assessment dimensions is considered in determining the need for discharge or transfer.

“DSM-IV^{TR}” is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision by the American Psychiatric Association. It is a practical and useful tool for clinicians with brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in diagnostic criteria.

“Early Intervention” is a specifically focused treatment program including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence. (ASAM PPC-2R Level .05 Early Intervention)

“Enabling” is any action by another person or an institution that intentionally or unintentionally has the effect of facilitating the continuation of an individual’s addictive process.

“Episode of Care” is the period of service between the beginning of a treatment service for a drug or alcohol problem and the termination of services for the prescribed treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for termination. For reporting purposes, “completion of treatment” is defined as completion of all planned treatment for the current treatment episode.

“Individualized Treatment” is treatment designed to meet a particular client’s needs, guided by a treatment plan that is directly related to a specific, unique client assessment.

“Intensity of Service” is the number, type, and frequency of staff interventions and other services (such as consultation, referral or support services) provided during treatment at a particular level of care.

“Intensive Outpatient Treatment” is an organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment consisting of regularly

scheduled sessions within a structured program, for a minimum of 9 hours of treatment for adults and 6 hours of treatment per week for adolescents.

“Length of Service” is the number of days (for residential care) or units/visits/encounters (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.

“Level of Care” as used in the *ASAM Patient Placement Criteria*, this term refers to a discrete intensity of clinical and environmental support services bundled or linked together and available in a variety of settings.

“Level of Function” is an individual’s relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.

“Level of Service” as used in the *ASAM Patient Placement Criteria*, this term refers to board categories of patient placement, which encompass a range of clinical services such as early intervention, detoxification, or opioid maintenance therapy services and levels of care such as intensive outpatient treatment or clinically managed medium-intensity residential treatment.

“Matching” is a process of selecting treatment resources to conform to an individual client’s needs and preferences, based on careful assessment. Matching has been shown to increase treatment retention and thus to improve treatment outcome. It also improves resource allocation by directing clients to the most appropriate level of care and intensity of services.

“Medically Managed Treatment” are services that involve daily medical care, where diagnostic and treatment services are directly provided and/or managed by an appropriately trained and licensed physician.

“Medically Monitored Treatment” are services that are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists and other health care professionals and technical personnel, under the direction of a licensed physician. Medical monitoring is provided through an appropriate mix of direct client contact, review of records, team meetings, 24-hour coverage by a physician, and quality assurance programs.

“Medical Necessity” means determination that a specific service is medically (clinically) appropriate, necessary to meet a client’s treatment needs, consistent with the client’s diagnosis, symptoms and functional impairments and consistent with clinical Standards of Care.

“Medically Necessary Services” means substance use disorder treatment services that are necessary for screening and assessing the presence of a substance use disorder, and/or are:

- Required to identify and evaluate a substance use disorder that is inferred or suspected and/or are;
- Intended to treat, ameliorate, diminish or stabilize the symptoms of substance abuse including impairment on functioning and/or are;
- Expected to arrest or delay the progression of a substance use disorder and to forestall or delay relapse and/or are;
- Designed to provide rehabilitation for the clients to attain or maintain an adequate level of functioning.
- Symptom alleviation alone is not sufficient for purposes of admission.

In considering the appropriateness of **any** level of care, the four basic elements of Medical Necessity should be met:

1. Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM IV^{TR} or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSSAC Provider Contract.
2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.
3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by substance use disorder or mental health professionals.
4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on the American Society of Addiction Medicine's Patient Placement Criteria-Revised Second Edition (ASAM PPC-2R).

“Modality” is a specific type of treatment (technique, method, or procedure) that is used to relieve symptoms or induce behavior change. Modalities of addiction treatment include, for example, detoxification or antagonist medication, motivational interviewing, cognitive behavioral therapy, group therapy, social skills training, vocational counseling, and self/mutual help groups.

“Modalities of Addiction Treatment” include, for example detoxification or antagonist medication, motivational interviewing, cognitive behavioral therapy, group therapy, social skills training, vocational counseling, and self/mutual help groups.

“Outpatient Service” is an organized non-residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment for substance-related disorders.

“Outpatient Treatment” is an organized service, delivered in a variety of settings, in which treatment staff provide professionally directed evaluation and treatment of substance-related disorders.

“Patient Placement Criteria” is to enhance the use of multidimensional assessments in making objective patient placement decisions for various levels of care. The criteria for consideration are considered evolutionary in nature and are intended to encourage further patient placement research.

“Peer Support/Recovery Supports” are programs designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer Recovery programs are designed and delivered primarily by individuals in recovery and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.

“PIHP” stands for the Prepaid Inpatient Health Plan dealing with Medicaid funding.

“Pre-authorization/Pre-certification” is a review of the client's treatment plan, medical necessity documentation, and Level of Care determination prior to the client receiving services. Pre-

authorization/pre-certification is to be preformed prior to beginning of services at Detoxification, residential, and medication-assisted treatment for opioid addiction (methadone).

“Program” is a generalized term for an organized system of services designed to address the treatment needs of clients.

“Pseudo-addiction” is a pattern of drug-seeking behavior of pain patients receiving inadequate pain management that can be mistaken for addiction.

“Readiness to Change” refers to an individual’s emotional and cognitive awareness of the need to change, coupled with a commitment to change. When applied to addiction treatment and particularly assessment Dimension 4, “Readiness to Change” describes the individual’s degree of awareness of the relationship between his or her alcohol or other drug use or mental health problems, and the adverse consequences of such use, as well as the presence of specific readiness to change personal patterns of alcohol and other drug use.

“Recognize, Understand and Apply” is the distinction that the criteria made between an individual’s ability to *recognize* an addiction problem, *understand* the implications of alcohol and other drug use on the individual’s life, and *apply* coping and other recovery skills in his/her life to limit or prevent further alcohol or other drug use. The distinction is in the difference between an intellectual awareness and more superficial acknowledgement of a problem (recognition) and a more productive awareness of the ramifications of the problems for one’s life (understanding); and the ability to achieve behavior change through the integration of coping and other relapse prevention skills (application).

“Recovery” is a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety. As used in the *ASAM Patient Placement Criteria*, “recovery” refers to the overall goal of helping a client to achieve overall health and well-being.

“Screening” is defined as a formal, brief process that occurs as the client requests or presents for services to determine the likelihood of a substance use disorder and a preliminary identification of other needs. This process is for whether a client walks in or telephones for substance use disorder (SUD) treatment services. The screening process results in the determination of eligibility for assessment at an initial level-of-care and an initial service authorization.

“Sobriety” is a state of complete abstinence from psychoactive substances by an addicted individual, in conjunction with a satisfactory quality of life.

“Stages of Change” refers principally to the work of Prochaska and DiClemente, who describe how individuals progress and regress through various levels of awareness of a problem, as well as the degree of activity involved in a change in behavior.

“Support Services” are those readily available to the program through affiliation, contract or because of their availability to the community at large (for example, 911 emergency response services). They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.

“Transfer” is the movement of the client from one level of service to another, within the continuum of care.

“Trauma” is the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism, and disasters. (NASMHPD, 2004) It can also be described as events/experiences that are shocking, terrifying, and/or overwhelming to the individual resulting in feelings of fear, horror, helplessness. Are interpersonal in nature: intentional, prolonged, repeated, severe, and occur in childhood and adolescence and may extend over an individual’s life span. (Teri, 1991 Giller, 1999)

“Treatment” is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

“Triage” as used by the *ASAM Patient Placement Criteria*, is decision making at the conclusion of an initial assessment process to determine the specific assignment of the client to a level of care or service.

“Unbundling” is an approach to treatment that seeks to provide the appropriate combination of specific services to match a client’s needs. The goal of unbundling is to provide an array of options for flexible individualized treatment, which can be delivered in a variety of settings. The intensity of clinical services are determined independently of the individual’s need for supportive living arrangements and other environmental supports.

**ACCESS MANAGEMENT FOR SUBSTANCE USE DISORDER TREATMENT
ACCESS, ASSESS, AND REFER**

Access, Assess, and Refer

Screening (Triage) is defined as a formal, brief process that occurs as the client requests or presents for services to determine the likelihood of a substance use disorder and a preliminary identification of other needs. This process is for whether a client walks in or telephones for substance use disorder (SUD) treatment services. The screening process results in the determination of eligibility for assessment at an initial level-of-care and an initial service authorization.

Assessment is used to collect information in a manner that will enable the provider to establish (or rule out) the presence of a substance use disorder. It is also used to determine the individual's readiness for change, identify strengths or problem areas that may affect the processes of treatment and recovery, and engage the individual in the development of a treatment relationship. The assessment serves as the basis for the treatment plan.

Readiness to change, as defined by the ASAM PPC-2R, is "an individual's emotional and cognitive awareness of the need to change, coupled with a commitment to change. When applied to addiction treatment and particularly assessment Dimension 4, "Readiness to Change" describes the client's degree of awareness of the relationship between his or her alcohol or other drug use or mental health problems, and the adverse consequences of such use, as well as the presence of specific readiness to change personal patterns of alcohol and other drug use."

The research has determined there are six well-defined stages of change: Precontemplation, contemplation, preparation, action, maintenance, termination. An important component to the assessment process is determining what stage of change the client is in and matching the treatment strategy to the stage.

A biopsychosocial assessment tool, chosen by the SUD provider and using internally standardized forms is to gather the following information which is to become part of the client's file:

Demographic/Intake Information:

1. Name, address, and telephone number, when applicable.
2. Date of birth and gender.
3. Family and social history.
4. Educational history.
5. Occupation.
6. Legal and court-related history.
7. Present substance use disorder problem.
8. Date the information was gathered.
9. Signature of the staff member gathering the information.
10. Name of referring agency, when appropriate.
11. Address, telephone number, and name of nearest relative to contact in case of emergency.
12. History of current and past substance use disorder or other counseling services received. The agency, type of service, and the date the service was received shall be indicated.
13. Name, address, and telephone number of the most recent family or private physician.
14. Date of last physical and/or date of last doctor visit.
15. List of all medical problems inclusive of any and all pain conditions.

Substance Use/Abuse History & Biopsychosocial:

16. A substance use disorder history, including information about prescribed drugs and alcohol which

indicates, at a minimum, all of the following information:

- a. Substance used in the past, including prescribed drugs.
- b. Substances used recently, especially those used within the last 48 hours.
- c. Substance of preference; Primary, Secondary, and Tertiary.
- d. Frequency with which each substance is used.
- e. Previous occurrences of overdose, withdrawal, or adverse drug or alcohol reactions.
- f. History of previous substance use disorder treatment received.
- g. Year of first use of each substance.
- h. List of medications; prescribed and over-the-counter.
- i. Current emotional state; including any trauma related experiences.
- j. Cultural background.
- k. Vocational history.
- l. Family relationships.
- m. Educational background.
- n. Socioeconomic status.
- o. Any legal problems that may affect the treatment plan.

MSSAC's Treatment staff reserves the right to review the use of biopsychosocial assessment tools to ensure it meets the established standards. The assessment process includes the biopsychosocial component, diagnostic impression based on DSM IV^{TR}, health and infectious disease risk and referral, Level of Care determination based on the ASAM PPC-2R, and case management and ancillary needs assessment.

Service referral to the appropriate level of care and SUD treatment provider is a part of the access management process. The referral includes providing information on available programs to assist the client with informed program choice and referral to the selected program. It is critical to match treatment resources (such as the treatment provider) to conform to an individual client's needs and preferences, based on careful assessment. Matching has been shown to increase treatment retention and to improve treatment outcome. It also improves resource allocation by directing clients to the most appropriate level of care and intensity of services. The key is always to use the right strategy at the right time because even people who are not ready to act or change can begin to set the change process in motion. Clients, who are not even aware there is a problem to those who have spent years hoping to change, can benefit from appropriately timed interventions based on where they are in the Stages of Change model.

If the individual is found to be ineligible for admission, there will be documentation in the file as to the reason why, and a referral to an appropriate agency or organization will be made.

Admission into SUD Treatment

In the process of client assessment, certain problems and priorities are identified as justifying admission to a particular level of care. As stated in the MSSAC provider contract, level of care placement is to be individually determined utilizing the ASAM PPC-2R and the DSM-IV^{TR}.

During admission into treatment, it is MSSAC'S expectation that the agency staff will provide explanations to the client and documentation to confirm, of the following:

1. Client Confidentiality Rights and Protected Health Information (HIPAA): 42 CFR, Part 2 and 45 CFR Sections 160 & 164.
2. Recipient Rights for all clients and Fair Hearing Rights for Medicaid funded clients.
3. If the organization self-identifies as a faith-based or religious, clients are given notification of their right to request alternative services. Notification must be in the form of the model notice contained in the final regulations. (See MSSAC's Charitable Choice Policy for language.)
4. General nature and objectives of the program.

5. Rules that govern conduct and infractions that can lead to disciplinary action or discharge from the program.
6. Hours during services are available.
7. Costs to be borne by the client, if any.

Co-Occurring Disorders (COD)

Co-occurring disorders refers to when a client has concurrent substance use (abuse or dependence) and mental disorders. Clients are said to have co-occurring disorders when he or she have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

Integrated screening addresses both the mental health and substance use disorder, each in the context of the other disorder in order to make an appropriate placement determination.

For those individuals who have experience physical, emotional, and/or sexual trauma but do not meet the criteria for Post-Traumatic-Stress Disorder, particular consideration regarding appropriate placement determination needs to take place.

Culturally Competent SUD Treatment Services

It is the expectation of MSSAC that all SUD treatment providers have the understanding of skills and resources to deal effectively in cross cultural situations, which include the following values and principles:

1. Families will make different choices, based on cultural forces.
2. All people share common basic needs; various cultures meet their common basic needs differently.
3. Awareness and acceptance of differences is critical to successful delivery of services; and courses of action should be chosen that minimize cross-cultural barriers.
4. Remember, it is the clients that define what is culturally relevant to them, not the therapists.

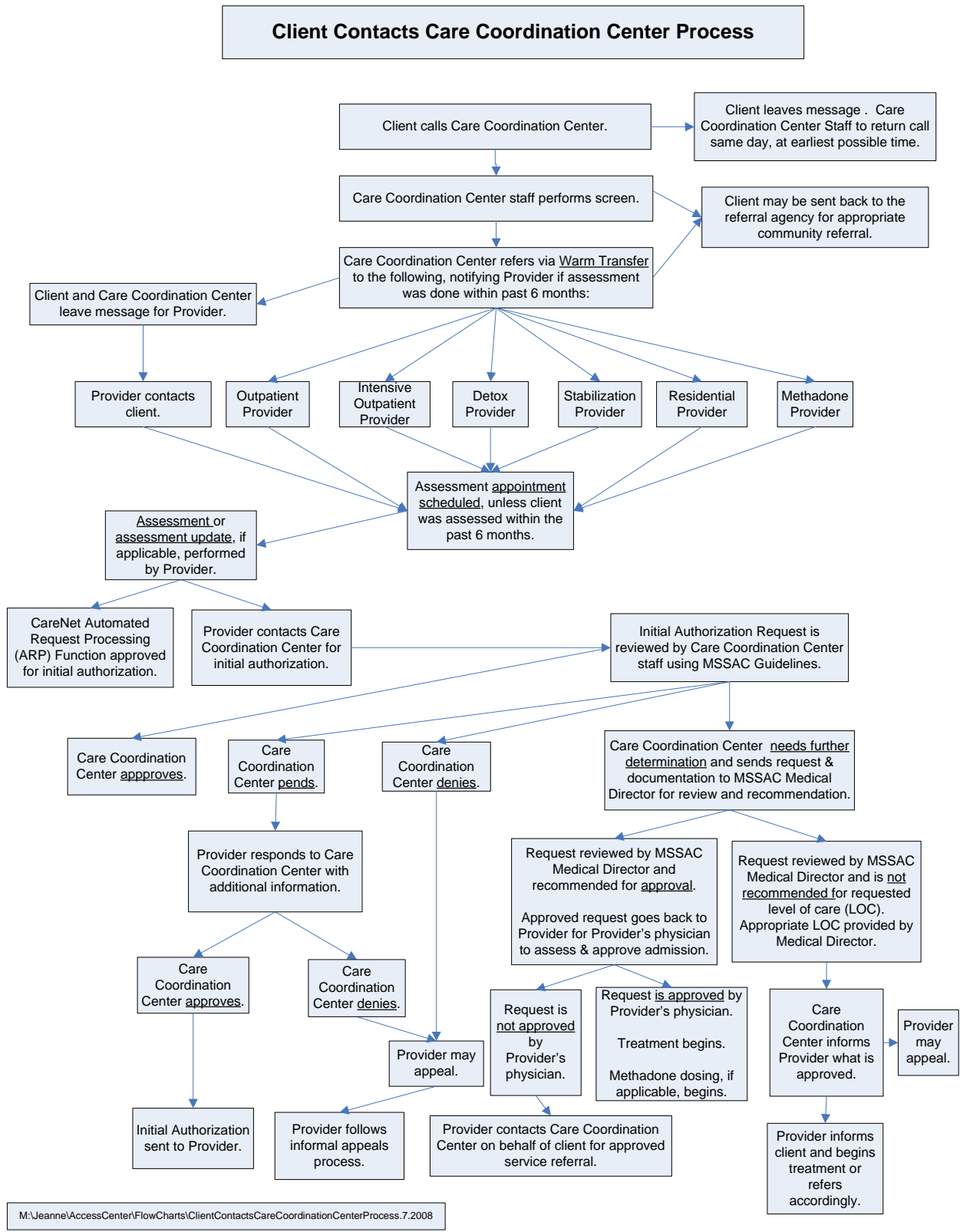
SUD treatment providers are to take into consideration cultural factors when assessing, placing, and treating their clients at all levels of care. It is important to remember specific cultural practices are to be taken into consideration during treatment, however, other's sensibilities and safety need to be taken into consideration in a group therapy setting.

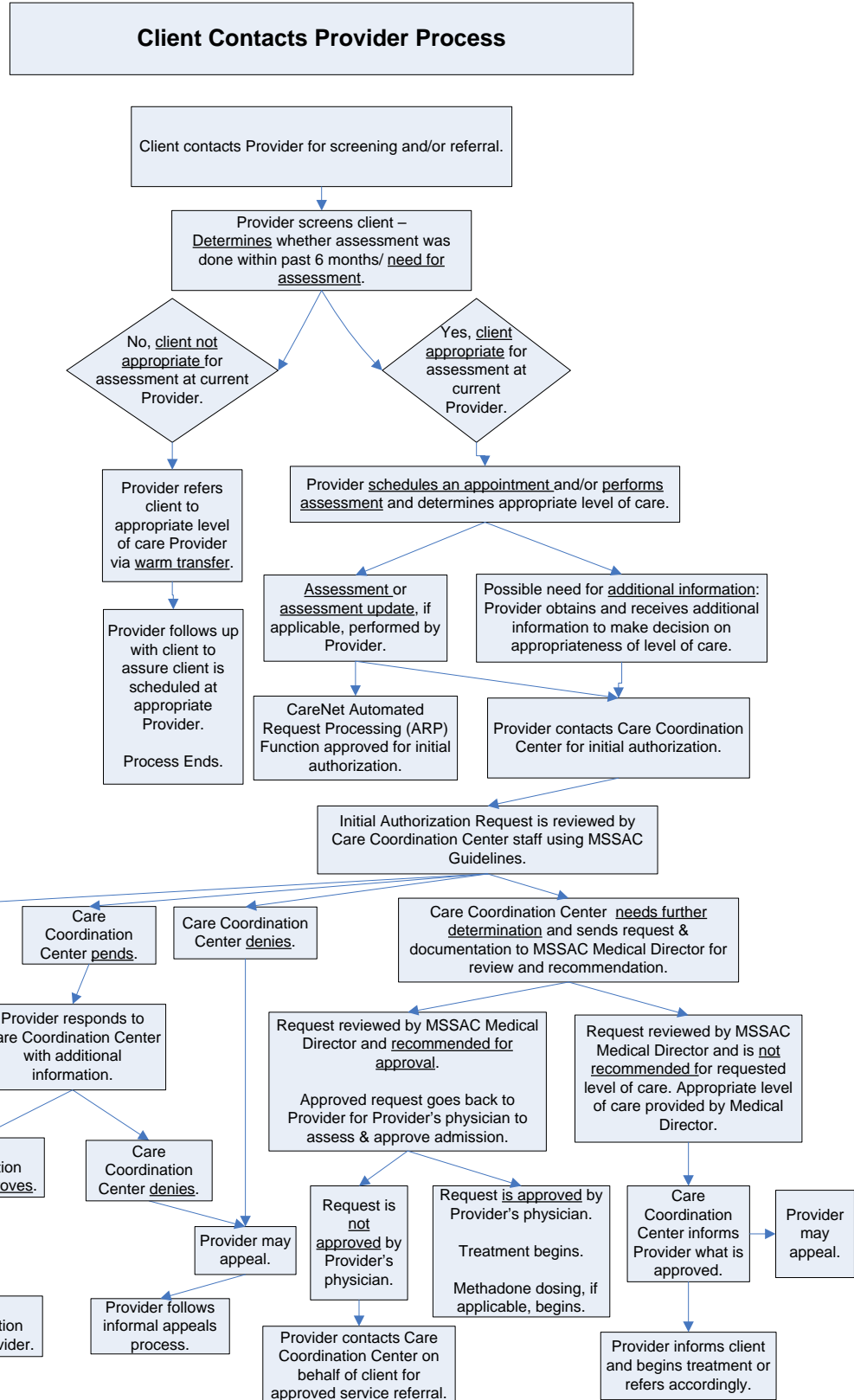
Exceptions to the ASAM PPC-2R

In making treatment placement decisions, three important factors override the client-treatment match with regard to levels of service:

1. Lack of availability of appropriate, criteria-selected care;
2. Failure of a client to progress at a given level of care, so as to warrant a reassessment of the treatment plan with a view to modification of the treatment approach. Such situations may require transfer to a specialized program at the same level of care or to a more intensive or less intensive level of care to achieve a better therapeutic response; and
3. State laws regulating the practice of medicine or licensure of a facility requiring criteria different from these.

While these criteria are intended to be as specific as possible, unique clinical presentation or extenuating circumstances may dictate some flexibility in application of the criteria to ensure the safety and welfare of the client.





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**OUTPATIENT SERVICES FOR SUBSTANCE USE DISORDER TREATMENT
MODALITY: INDIVIDUAL, GROUP OR FAMILY**

of Care

Outpatient treatment is an organized delivered in a variety of settings, in which addiction treatment staff provide professionally directed evaluation and treatment for substance-related disorders. Individual, couple, group and family therapy are common modalities appropriate for substance use disorder outpatient care. Outpatient treatment is the level of care with the least amount of restriction, so it is important that clients are able to maintain a degree of safety outside of session.

Modalities of Outpatient Treatment Services:

Individual Therapy

A sixty (60) minute, face-to-face, one-on-one session between the client and the clinician; usually at the clinician's office. Application of evidenced-based practices such as motivational interviewing, are used as appropriate. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. The individual sessions may be utilized to work with the client on any issues inappropriate for disclosure in a group setting.

Group Therapy

A process in which a number of people (Best Clinical Practices: 3 minimum, 12 maximum and 15 maximum for didactic education) are involved in a therapeutic setting at the same time under the guidance of a clinician. Groups range from focusing on an individual within the context of a group, on interactions that occur among individuals in the group, or on the group as a whole.

Didactic groups are generally more educational in nature and are used to provide clients with such information as, but not limited to: impact of alcohol and drug misuse, social skill-building information, relapse prevention skill building, etc. Participation in group therapy helps people by imparting useful recovery solutions, building a pro-social support network, and beginning to understand the dynamics of enabling.

Family Therapy

Family therapy is based on family systems theory, which understands the family to be a living organism that is more than the sum of its individual members. Family therapy uses "systems" theory to evaluate family members in terms of their position or role within the system as a whole. Problems are treated by changing the way the system works rather than trying to "fix" a specific member.

The identified client in family therapy is the family member with the symptom that has brought the family into treatment. The concept of the identified client is used by the clinician to keep the family from scapegoating the client or using him or her as way of avoiding problems in the rest of the system. The identified client can be a child, or an adolescent, or an adult.

In Family therapy sessions, concepts of importance are differentiation of self and triangular relationships. Family systems theory maintains that emotional relationships in families are usually triangular. Whenever any two persons in the family have problems with each other, they will "triangle in" a third person as a way of stabilizing their own relationships. The triangling can undermine the SUD treatment of the identified client. The concept of differentiation of self refers to the ability of each family member to maintain his or her own sense of self, while emotionally connected to the family. Often in family systems impacted by addiction, differentiation has become difficult for the family members.

-Occurring Disorders (COD)

Co-occurring disorders refers to when a client has concurrent substance use (abuse or dependence) and substantiated diagnosed mental disorders. Clients are said to have co-occurring disorders when he or she have one or more substantiated mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

As per the ASAM PPC-2R, Co-Occurring substance-related and mental disorders are appropriate at an Outpatient level **if:** the client's disorders are of *mild to moderate severity* and have responded to more intensive treatment services. The mental disorders have resolved to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.

Eligibility Criteria

1. The client is experiencing a Substance Use Disorder reflected in a primary, validated DSM-IV^{TR} or ICD10 Diagnosis (not including V codes) that is identified as eligible for services in the MSSAC provider contract and the following (A or B, and C and D) manifestations is present:
 - a. The client reports or expresses a subjective level of distress and/or psychosocial problems and has been unable to maintain abstinence.
or
 - b. The client's alcohol and/or drug abuse/dependence has resulted in significant consequences and social/family impairment but not to the degree that higher levels of care are not needed to provide additional structure, nor are any life-threatening withdrawal symptoms present.
and
 - c. The client is motivated for, or amenable to, treatment and has the skills to obtain a primary support system and a good recovery environment to aid in his or her recovery.
and
 - d. While various combinations of modalities may be employed an intensive approach is not necessary to either motivate the client or to achieve the treatment objectives, nor is a multidisciplinary treatment staff required.
and
2. A reasonable expectation that the client's presenting symptoms, conditions, or level of functioning will improve through treatment.
and
3. The treatment is safe and effective according to nationally accepted standards generally recognized by substance use disorder and mental health professionals.
and
4. It is the most appropriate and cost-effective level of care that can be safely provided for the client's immediate condition based on the ASAM PPC-2R.

and Reauthorization of SUD Treatment Services

To document and explain the client's appropriateness for SUD treatment services at Level I: Outpatient Treatment, the following are questions to consider and answer as applicable:

1. What is the client's withdrawal potential only mild to moderate with no need for detoxification?
2. Is this the client's first attempt at SUD treatment?
3. For clients with a history of repeated relapses and a treatment history involving multiple treatment attempts, what evidence is there of the restorative potential for this proposed admission?
4. Have expectations for client participation in SUD treatment been articulated clearly?
5. What are the chronic physical conditions that affect treatment or would prohibit full participation at this level? (e.g., chronic pain with narcotic analgesics)
6. What are the emotional, behavioral, or cognitive conditions or complications that would distract the client from participating in development of treatment plan and recovery activities?

7. Are there chronic mental health conditions that affect treatment? (e.g., stable but chronic schizophrenia, affective or personality disorder problems? Psychotropic medications?)
8. Does the client's living environment negatively impact his or her recovery potential?
9. Has the client developed any community supports such as AA/NA, church, non-using friends?
10. Is there a reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment at this level of care?
11. Does the client have any recognition and understanding of, and skills for how to cope with his or her addiction problems and prevent relapse or continued use?
12. How aware is the client of relapse triggers, ways to cope with cravings to use and skills to control impulses to use?
13. Is the treatment safe and effective according to nationally accepted standards generally recognized by substance use disorder or mental health professionals?
14. Is it the most appropriate and cost-effective level of care that can be provided safely for the client's immediate condition based on the ASAM PPC-2R?
15. Would the client benefit from one-on-one intervention with the clinician?
16. Does the client feel coerced into treatment or actively object to receiving treatment?
17. Are there legal, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?
18. How ready is the client to change?
19. Does the client demonstrate an interest in working toward the goal of rehabilitation?
20. If willing to accept treatment, how strongly does the client disagree with others' perception that he or she has an addiction problem?
21. Is the client compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his or her alcohol or other drug use problems?

Group

22. Are the problems best treated in a social context such as group?
23. Will supportive peer group interaction enhance the effectiveness of problem solving and learning new ways of behaving?
24. Is it important for the client to create bonds and/or learn about the impact one has on others for symptom resolution and growth?

Family

25. Is the client's progress being sabotaged or the client's treatment being discontinued as influenced by the family?
26. Are the treatment objectives most efficiently achieved by working with the family?
27. Has the client failed to make expected progress—indicators include medication noncompliance, continued substance abuse or other self-harming behaviors, recurrent detox and/or hospitalizations to where the client would benefit from individual sessions?
28. Is the identified client a child/adolescent or a young adult still living at home and/or requires parental resources for appropriate functioning?

If the client **enters treatment** at this level of care, the following is the initial benefit:

One assessment session (if one has not been done within the last six (6) months) and up to 12 units of outpatient services in any combination of Individual, Family, and/or Group, Case Management will be authorized for the initial authorization. Scope, duration, and intensity need to be provided to the Care Coordination Center.

The **1st reauthorization** is up to 12 units of any combination of individual/family, group and/or case management. **2nd, 3rd**, etc., **reauthorizations** will be in increments of up to 8 units of any combination of individual/family, group and/or case management.

Note: this is not a benefit limit but the increments in which services will be authorized.

If the client is **transferred** from another level of care, number of sessions authorized will be dependent upon the information provided to the Care Coordination Center in the authorization request.

The **Initial Authorization Expiration Date** (Initial Lapse Date) for Outpatient services is **up to 4 months or 120 days**. There is no extension of the Expiration Date for the initial authorization. The provider has **up to three (3) working days from the date of the assessment** to have the initial authorization request entered into the CareNet system. If the initial authorization request is pended by the Care Coordination Center, the provider is to respond within **three (3) working days**. The Care Coordination Center is to respond to pended initial responses within **three (3) working days**. If the initial request is **not entered into CareNet within three (3) working days**, the initial authorization will be dated the date received by the Care Coordination Center on the CareNet system.

The **Re-authorization Expiration Date** (Re-authorization Lapse Date) for Outpatient services is **approved by the Care Coordination Center if clinically appropriate**. Scope, duration, and intensity need to be provided to the Care Coordination Center. If the reauthorization request is pended by the Care Coordination Center, the provider is to respond within **three (3) working days**. The Care Coordination Center is to respond to pended reauthorization responses within **three (3) working days**. If pended request is **beyond three (3) working days**, the reauthorization request will be dated the date received by the Care Coordination Center on the CareNet system.

Continued Service Criteria for Authorization

It is appropriate to retain the client at the present of level of care if:

1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;
or
2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
and/or
3. New problem(s) have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client's new problems can be addressed effectively.

To document and explain the client's continued readiness for treatment or need to transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria, below.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.
or
2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.
or

3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.

or

4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated only at a more intensive level of care.

To document and explain the client's readiness for discharge or need for transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed.** If the criteria apply to the existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

INTENSIVE OUTPATIENT SERVICES FOR SUBSTANCE USE DISORDER TREATMENT

Level of Care

Intensive Outpatient treatment (IOP) services generally provide a minimum of nine (9) or more hours of structured programming per week, consisting primarily of counseling and education about substance-related and mental health problems. Such services may include individual and group counseling provided in the scope, frequencies, and duration appropriate to the objectives of the treatment plan. Programming is a planned format of therapies, delivered on an individual and group basis and adapted to the client's developmental stage and comprehension level. Motivational enhancement and engagement strategies are used in preference to more confrontational approaches.

MSSAC recognizes it can be difficult to have sufficient client population to sustain IOP services. MSSAC is “**unbundling**” IOP services to encourage flexibility in providing the needed scope, duration and intensity of treatment by utilizing outpatient groups, didactic/educational groups, and individual therapy sessions. With “**unbundling**” IOP services, the type and intensity of treatment are based on the client's needs and not on limitations of the treatment modality.

IOP Individual Therapy

A sixty (60) minute, face-to-face, one-on-one session between the client and the clinician; usually at the clinician's office. Application of evidenced-based practices such as motivational interviewing, are used as appropriate. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. The IOP individual session may be utilized for the development and review of the client's individual treatment plan as well as to work with the client on any issues inappropriate for disclosure in a group setting.

IOP Group Therapy

A process in which a number of people (Best Clinical Practices: 3 minimum, 12 maximum and 15 maximum for didactic education) are involved in a therapeutic setting at the same time under the guidance of a clinician. Groups range from focusing on an individual within the context of a group, on interactions that occur among individuals in the group, or on the group as a whole.

IOP Didactic Group

Didactic groups are generally more educational in nature and are used to provide clients with such information as, but not limited to: impact of alcohol and drug misuse, social skill-building information, relapse prevention skill building, etc. Participation in group therapy helps people by imparting useful recovery solutions, building a pro-social support network, and begin to understand the dynamics of enabling.

-Occurring Disorders (COD)

The services of an IOP are appropriate for clients with co-occurring substance-related and substantiated diagnosed mental disorders if the mental health and addiction treatment services are integrated into IOP. Such clients require active mental health services, which should be delivered through Level II.1 Dual Diagnosis Capable or Dual Diagnosis Enhanced programs.

As per the ASAM PPC-2R, Co-Occurring substance-related and mental disorders are appropriate at an Intensive Outpatient level **if**: the client's disorders are of *mild to moderate severity* and have responded to more intensive treatment services. The mental disorders have resolved to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.

Eligibility Criteria

1. The client is experiencing a Substance Use Disorder reflected in a primary, validated DSM-IV^{TR} or ICD10 Diagnosis (not including V codes) that is identified as eligible for services in the MSSAC provider contract and **all** of the following (A, B, C,D, E, and F) manifestations is present:
 - a. The client is not demonstrating any life-threatening withdrawal symptoms that require acute inpatient detoxification.
and
 - b. The client is not suffering medical/psychiatric complications of his or her substance abuse/dependence that would inhibit the client's ability to actively participate in and benefit from participation in treatment.
and
 - c. The client is unable to maintain abstinence without a structured treatment intervention during a portion of the day.
and
 - d. The client's support system is supportive of his or her recovery such that the client can adhere to the treatment plan and service schedules. If the client has no primary support system, he or she has the skills to obtain such a support system or become involved in a self-help system.
and
 - e. The client suffers significant impairment in social, medical, family and/or work functioning secondary to substance abuse.
and
 - f. The client demonstrates an interest in working toward the goal of rehabilitation.
and
2. A reasonable expectation that the client's presenting symptoms, conditions, or level of functioning will improve through treatment.
and
3. The treatment is safe and effective according to nationally accepted standards generally recognized by substance use disorder and mental health professionals.
and
4. It is the most appropriate and cost-effective level of care that can be safely provided for the client's immediate condition based on the ASAM PPC-2R.

Authorization and Reauthorization of SUD Treatment Services

To document and explain the client's appropriateness for SUD treatment services at Level II: Intensive Outpatient Treatment, the following are questions to consider and answer as applicable:

1. What is the client's withdrawal potential only mild to moderate with no need for detoxification?
2. Have expectations for client participation in SUD treatment been articulated clearly?
3. What are the medical conditions or problems that would prohibit full participation at this level of care?
4. Are there chronic physical conditions that affect SUD treatment? (e.g., chronic pain with narcotic analgesics?)
5. What are the emotional, behavioral, or cognitive conditions or complications that would distract the client from participating in development of treatment plan and recovery activities?
6. Are there chronic mental health conditions that affect SUD treatment? (e.g., stable but chronic schizophrenia, affective or personality disorder problems? Psychotropic medications?)
7. Has motivational interventions at another level of care failed and are not likely to succeed at a lower level?
8. For clients with a history of repeated relapses and a treatment history involving multiple treatment attempts, is there evidence of the restorative potential for this proposed admission?
9. Does the client's perspective inhibit his or her ability to make behavioral changes without motivational interventions requiring minimally nine (9) hours plus individual attention?

10. Does the client have difficulty in suspending use as determined by his or her recent use pattern?
11. Does the client have a high likelihood of relapse or continued use or continued problems despite active participation in a less intensive level of care and modification of the treatment plan?
12. Does the client's living environment negatively impact his or her recovery potential?
13. Has the client developed any community supports such as AA/NA, church, non-using friends?
14. Does the client feel coerced into treatment or actively object to receiving treatment?
15. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance motivation for engagement into treatment?
16. How ready is the client to change?
17. Is there a reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment at this level of care?
18. Does the client have any recognition and understanding of, and skills for how to cope with his or her addiction problems and prevent relapse or continued use?
19. How aware is the client of relapse triggers, ways to cope with cravings to use and skills to control impulses to use?
20. If willing to accept treatment, how strongly does the client disagree with others' perception that he or she has an addiction problem?
21. Is the client compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his or her alcohol or other drug use problems?
22. Does the client demonstrate an interest in working toward the goal of rehabilitation?
23. Is the treatment safe and effective according to nationally accepted standards generally recognized by substance use disorder and mental health professionals?
24. Is it the most appropriate and cost-effective level of care that can be provided safely for the client's immediate condition based on the ASAM PPC-2R?

If the client **enters treatment** at this level of care, the following is the initial benefit:

One assessment session (if one has not been done within the last six (6) months) and a minimum of 9 hours up to a maximum of 19 hours per week of any combination of group, didactic, individual, family sessions and/or case management will be authorized for the initial authorization for up to 30 days of services. Scope, duration, and intensity need to be provided to the Care Coordination Center.

The 1st reauthorization will be increments of up to nine (9) hours per week for up to 14 days of service in any combination of group, didactic, individual, family sessions, and/or case management. Additional reauthorization requests will be determined on medical necessity. **Note:** this is not a benefit limit but the increments in which services will be authorized.

If the client is **transferred** from another level of care, number of sessions authorized will be dependent upon the information provided to the Care Coordination Center in the authorization request.

The **Initial Authorization Expiration Date** (Initial Lapse Date) for Intensive Outpatient (IOP) services is **1 months or 30 days**. There is no extension of the Expiration Date for the initial authorization. The provider has **up to three (3) working days from the date of the assessment** to have the initial authorization request entered into the CareNet system. If the initial authorization request is pended by the Care Coordination Center, the provider is to respond within **three (3) working days**. The Care Coordination Center is to respond to pended initial responses within **three (3) working days**. If the initial request is **not entered into CareNet within three (3) working days**, the initial authorization will be dated the date received by the Care Coordination Center on the CareNet system.

The **Re-authorization Expiration Date** (Re-authorization Lapse Date) for IOP services is **approved by the Care Coordination Center if clinically appropriate**. Scope, duration, and intensity need to be provided to the Care Coordination Center. If the reauthorization request is pended by the Care Coordination Center, the provider is to respond within **three (3) working days**. The Care Coordination Center is to respond to pended reauthorization responses within **three (3) working days**. If pended request is **beyond three (3) working days**, the reauthorization request will be dated the date received by the Care Coordination Center on the CareNet system.

Continued Service Criteria for Authorization

It is appropriate to retain the client at the present of level of care if:

1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;
or
2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
and/or
3. New problem(s) have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client's new problems can be addressed effectively.

To document and explain the client's continued readiness for treatment or need to transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria, below.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.
or
2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.
or
3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.
or
4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated only at a more intensive level of care.

To document and explain the client's readiness for discharge or need for transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

**RESIDENTIAL SERVICES FOR SUBSTANCE USE DISORDER TREATMENT
STABILIZATION (Short-Term)
Pre-authorization Review Required**

of Care

Stabilization is short-term treatment used to reduce the risk of immediate relapse so that structured activities may be applied. It is provided in a residential setting which includes overnight stay(s). Stabilization allows various methods of continued detoxification to occur depending upon substance used, including but not limited to monitoring vital signs, if necessary, 3 meals a day, access to fluids, taking care of personal needs, and allowing rest. Primary activities of Stabilization are physical stabilization, introduction of recovery concepts, development of initial treatment plan, and discharge planning to the next level of care.

Expectations:

1. Prior to admission, alternative, less restrictive levels of care should be considered and attempted as appropriate. A more restrictive level of care should not be considered solely on a “convenience” basis or automatically considered when presented as an alternative to incarceration.
2. The expectation for clients in stabilization is to attend treatment programming to their ability to participate but for full participation to begin **no later** than the third day of admission. If it is determined the client is not medically stable by the third day, the client is to follow the medical clinician’s recommendation. Motivational enhancement and engagement strategies are used in preference to more confrontational approaches.
3. Stabilization treatment **MUST** include a **MINIMUM** of **six (6) hours** of structured activities per day. Within the 6 hours of programming, there **MUST** be **three (3) hours of group therapy and didactic groups**. Individual sessions are to be included in the treatment modality mix.
4. The defining characteristic of Residential/Stabilization treatment is that individuals are served who, because of specific functional deficits, need safe and stable living environments in order to develop their recovery skills.
5. Some of these functional deficits are problems in the application of recovery skills, lack of personal responsibility, or lack of connection to the worlds of work, education or family life. They can also include cognitive problems which can be permanent or temporary, as well as problems with interpersonal relationships or emotional skills, criminal activity, psychological problems, disaffiliation from mainstream values, limited vocational skills, inadequate anger management skills, and extreme impulsivity. Their mental disorders may involve serious and persistent Axis I disorders and Axis II disorders.
6. For adolescents face-to-face family meetings are a critical part of the treatment plan. The frequency of these meetings is to be determined from the clinical presentation of a given case but not less than once per week. (Multi-family therapy does not take the place of individual family therapy.)

Co-Occurring Disorders (COD)

Level III programs that treat individuals with substantiated co-occurring mental and substance-related disorders typically integrate mental health and addiction treatment services and incorporate mental health professionals into the treatment staff. Such programs generally are more flexible, more individualized and less confrontational than the typical Level III program. There is considerable variation in program activities, as well as in the duration of program stages. The intensity of interpersonal encounters is considerably reduced, reliance on educational and skill-building approaches is increased, and the

programs are more closely tailored to address the specific mental and substance-related problems of individual clients. The mental health component of treatment is not focused on intensive psychiatric, medical or nursing care, but rather on support for reshaping coping skills and mental functioning.

Eligibility Criteria

1. Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM IV^{TR} or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSSAC CA Provider Contract and all of the following (A, B, C, D and E) manifestations are present:
 - a. The client is medically stable so that withdrawal symptoms if present are not life threatening and can be safely monitored at this level of care. The client is not experiencing medical complications that would preclude active participation in treatment. The client is mentally competent and cognitively stable to benefit from admission to a stabilization treatment program.
and
 - b. The client demonstrates an interest in working toward the goal of rehabilitation as evidenced by his/her willingness and ability to engage in treatment programming.
and
 - c. The client exhibits a pattern of severe substance use disorder/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.
and
 - d. Despite recent (e.g., past treatment history, history of treatment failure) appropriate, professional outpatient intervention, the client is continually unable to maintain abstinence and recovery,
and
 - E. For clients with a history of repeated relapses and a treatment history involving multiple treatment attempts, there must be evidence of the restorative potential (willingness and ability to engage in treatment programming) for the proposed admission.
and
2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.
and
3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder professionals.
and
4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on the American Society Of Addiction Medicine's Patient Placement Criteria.

and Reauthorization of SUD Treatment Services

To document and explain the client's appropriateness for SUD treatment services at Level III.5: Stabilization, the following are questions to consider and answer as applicable:

1. What alternative, less restrictive levels of care, been considered or attempted as appropriate?
2. Have expectations for client participation in SUD treatment been articulated clearly?
3. Does the client need a safe and stable living environment in order to develop his/her recovery skills, due to specific functional deficits?
4. Is the client medically stable so that withdrawal symptoms, if present, are not life threatening and can be safely monitored at this level of care?
5. Is the client mentally competent and cognitively stable to benefit from this level of treatment?
6. What are the chronic physical conditions that affect treatment? (e.g., chronic pain with narcotic analgesics?).

7. What are the chronic mental health conditions that affect treatment? (e.g., stable but chronic schizophrenia, affective or personality disorder? Psychotropic medications?)
8. Does the client have any recognition and understanding of, and skills for how to cope with his or her addiction problems and prevent relapse or continued use?
9. Does the client exhibit a pattern of severe substance use disorder/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning?
10. Despite recent (e.g., past treatment history, history of treatment failure) appropriate, professional outpatient intervention, is the client continually unable to maintain abstinence and recovery?
11. For client with a history of repeated relapses and a treatment history involving multiple treatment attempts, is there evidence of the restorative potential for this proposed admission?
12. Is there a reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment at this level of care?
13. Is the treatment safe and effective according to nationally accepted standards generally recognized by substance use disorder or mental health professionals?
14. Is it the most appropriate and cost-effective level of care that can be provided safely for the client's immediate condition based on the ASAM-PPC-2R?
15. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance motivation for engagement into treatment?
16. How ready is the client to change?
17. Does the client feel coerced into treatment or actively object to receiving treatment?
18. Does the client demonstrate an interest in working toward the goal of rehabilitation?
19. If willing to accept treatment, how strongly does the client disagree with others' perception that he or she has an addiction problem?
20. Is the client compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his or her alcohol or other drug use problems?

If the client **enters treatment** at this level of care, the following is the initial benefit:

One assessment session (if one has not been done within the last six (6) months) and up to 7 days will be authorized for the initial authorization. Scope, duration, and intensity need to be provided to the Care Coordination Center.

The **1st reauthorization is up to 7 days**. The 2nd, 3rd, etc. reauthorizations will be in increments of up to 4 days. **Note:** this is not a benefit limit but the increments in which services will be authorized

If the client is **transferred** from another level of care, number of sessions authorized will be dependent upon the information provided to the Care Coordination Center in the authorization request.

The **Initial Authorization Expiration Date** (Initial Lapse Date) for Stabilization service is **1 month or 30 days**. There is no extension of the Expiration Date for the initial authorization. The provider has **up to two (2) working days after the date of the** assessment to have the initial authorization request entered into the CareNet system. If the initial authorization request is pending by the Care Coordination Center, the provider is to respond within **two (2) working days**. The Care Coordination Center is to respond to pending initial responses within **two (2) working days**. If initial request is **not entered into CareNet within two (2) working days**, the initial authorization will be dated the date received by the Care Coordination Center on the CareNet system.

The **Re-authorization Expiration Date** (Re-authorization Lapse Date) for Stabilization services is **approved by the Care Coordination Center if clinically appropriate**. Scope, duration, and intensity need to be provided to the Care Coordination Center.

If the reauthorization request is pended by the Care Coordination Center, the provider is to respond within **two (2) working days**. The Care Coordination Center is to respond to pended reauthorization responses within **two (2) working days**. If pended request is **beyond two (2) working days**, the reauthorization request will be dated the date received by the Care Coordination Center on the CareNet system.

Continued Service Criteria for Authorization

It is appropriate to retain the client at the present of level of care if:

1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;
or
2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment as the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
and/or
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client's new problems can be addressed effectively.

To document and explain the client's readiness for discharge or need to transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria, below.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.
or
2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.
or
3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.
or
4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated only at a more intensive level of care.

To document and explain the client's readiness for discharge or need for transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

RESIDENTIAL SERVICES FOR SUBSTANCE USE DISORDER TREATMENT
RESIDENTIAL (Long-Term)
Pre-Authorization Review Required

of Care

Long-term residential is defined as professionally-supervised program that includes planned individual and group therapeutic and rehabilitative counseling, didactics, peer therapy, and rehabilitative care. These services are provided in a residential setting and include an overnight stay. The goals of residential/long-term are to continue with stabilizing the physical, emotional, and mental health of the client. To build recovery tools. To develop discharge plan/aftercare plan to next appropriate level of care and to facilitate transfer. Motivational enhancement and engagement strategies are used in preference to more confrontational approaches.

Expectations:

1. Prior to admission, alternative, less restrictive levels of care should be considered and attempted as appropriate. A more restrictive level of care should not be considered solely on a “convenience” basis or automatically considered when presented as an alternative to incarceration.
2. The defining characteristic of Long-term residential treatment is that individuals are served who, because of specific functional deficits, need safe and stable living environments in order to develop their recovery skills after receiving detoxification services if necessary, and stabilization.
3. Some of these functional deficits are problems in the application of recovery skills, lack of personal responsibility, or lack of connection to the worlds of work, education or family life. They can also include cognitive problems which can be permanent or temporary, as well as problems with interpersonal relationships or emotional skills, criminal activity, psychological problems, disaffiliation from mainstream values, limited vocational skills, inadequate anger management skills, and extreme impulsivity. Their mental disorders may involve serious and persistent Axis I disorders and Axis II disorders.
4. For adolescents face-to-face family meetings are a critical part of the treatment plan. The frequency of these meetings is to be determined from the clinical presentation of a given case but not less than once per week. (Multi-family therapy does not take the place of individual family therapy.)

Co-Occurring Disorders (COD)

Level III programs that treat individuals with co-occurring mental and substance-related disorders typically integrate mental health and addiction treatment services and incorporate mental health professionals into the treatment staff. Such programs generally are more flexible, more individualized and less confrontational than the typical Level III program. There is considerable variation in program activities, as well as in the duration of program stages. The intensity of interpersonal encounters is considerably reduced, reliance on educational and skill-building approaches is increased, and the programs are more closely tailored to address the specific mental and substance-related problems of individual clients. The mental health component of treatment is not focused on intensive psychiatric, medical or nursing care, but rather on support for reshaping coping skills and mental functioning.

Eligibility Criteria

1. Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM IV^{TR} or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSSAC CA Provider Contract and **all** of the following (A, B, C, D and E) manifestations are present:
 - a. The client is medically stable so that withdrawal symptoms if present are not life threatening and can be safely monitored at this level of care. The client is not experiencing medical

complications that would preclude active participation in treatment. The client is mentally competent and cognitively stable to benefit from admission to a stabilization treatment program.

and

- b. The client demonstrates an interest in working toward the goal of rehabilitation as evidenced by his/her willingness and ability to engage in treatment programming.

and

- c. The client exhibits a pattern of severe substance use disorder/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning.

and

- d. One (1) of the following must be met to satisfy criterion D:

- 1. Despite recent (e.g., past treatment history, history of treatment failure) appropriate, professional outpatient intervention, the client is continually unable to maintain abstinence and recovery.

or

- 2. The client is residing in a severely dysfunctional living environment which would undermine effective IOP or Outpatient treatment.

or

- 3. There is evidence for, or clear and reasonable inference of, serious imminent physical harm to self or others directly attributable to the continued abuse of substances, which would prohibit treatment in an outpatient setting.

or

- e. For clients with a history of repeated relapses and a treatment history involving multiple treatment attempts, there must be evidence of the restorative potential (willingness and ability to engage in treatment programming) for the proposed admission.

and

- 2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.

and

- 3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder professionals.

and

- 4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on the American Society Of Addiction Medicine's Patient Placement Criteria.

and Reauthorization of SUD Treatment Services

To document and explain the client's appropriateness for SUD treatment services at Level III.3: Residential/long-term, the following are questions to consider and answer as applicable:

- 1. What alternative, less restrictive levels of care been considered or attempted as appropriate?
- 2. Have expectations for client participation in SUD treatment activities been articulated clearly?
- 3. Does the client need a safe and stable living environment in order to develop his/her recovery skills, due to specific functional deficits?
- 4. Is the client medically stable so that withdrawal symptoms, if present, are not life threatening and can be safely monitored at this level of care?
- 5. Is the client mentally competent and cognitively stable to benefit from this level of treatment?
- 6. What are the chronic physical conditions that affect SUD treatment? (e.g., chronic pain with narcotic analgesics)
- 7. What are the chronic mental health conditions that affect SUD treatment? (e.g., stable but chronic schizophrenia, affective or personality disorder problems? Psychotropic medications?)

8. How does the client exhibit a pattern of severe substance use disorder/dependency as evidenced by significant impairment in social, familial, scholastic or occupational functioning?
9. Despite recent (e.g., past treatment history, history of treatment failure) appropriate, professional outpatient, IOP, or stabilization interventions, is the client continually unable to maintain abstinence and recovery?
10. For client with a history of repeated relapses and a treatment history involving multiple treatment attempts, is there evidence of the restorative potential for this proposed admission?
11. Is there a reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment at this level of care?
12. Is the treatment safe and effective according to nationally accepted standards generally recognized by substance use disorder or mental health professionals?
13. Is it the most appropriate and cost-effective level of care that can be provided safely for the client's immediate condition based on the ASAM-PPC-2R?
14. Does the client feel coerced into treatment or actively object to receiving treatment?
15. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance motivation for engagement into treatment?
16. How ready is the client to change?
17. Does the client demonstrate an interest in working toward the goal of rehabilitation?
18. If willing to accept treatment, how strongly does the client disagree with others' perception that he or she has an addiction problem?
19. Is the client compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his or her alcohol or other drug use problems?
20. Does the client have any recognition and understanding of, skills for how to cope with his or her addiction problems and prevent relapse or continued use?
21. How aware is the client of relapse triggers, ways to cope with cravings to use and skills to control impulses to use?

If the client **enters treatment** at this level of care, the following is the initial benefit:

One assessment session (if one has not been done within the last six (6) months) and up to 14 days will be authorized for the initial authorization. Scope, duration, and intensity need to be provided to the Care Coordination Center.

The 1st reauthorization is up to 30 days. The 2nd, 3rd, etc. reauthorizations will be in increments of up to 10 days. **Note:** this is not a benefit limit but the increments in which services will be authorized

If the client is **transferred** from another level of care, number of sessions authorized will be dependent upon the information provided to the Care Coordination Center in the authorization request.

The **Initial Authorization Expiration Date** (Initial Lapse Date) for Residential service is **1 month or 30 days**. There is no extension of the Expiration Date for the initial authorization. The provider has **up to two (2) working days from the date of the** assessment to have the initial authorization request entered into the CareNet system. If the initial authorization request is pending by the Care Coordination Center, the provider is to respond within **two (2) working days**. The Care Coordination Center is to respond to pending initial responses within **two (2) working days**. If initial request is **not entered into CareNet within two (2) working days**, the initial authorization will be dated the date received by the Care Coordination Center on the CareNet system.

The **Re-authorization Expiration Date** (Re-authorization Lapse Date) for Residential services is **approved by the Care Coordination Center if clinically appropriate**. Scope, duration, and intensity need to be provided to the Care Coordination Center. If the reauthorization request is pending by the Care

Coordination Center, the provider is to respond within **two (2) working days**. The Care Coordination Center is to respond to pended reauthorization responses within **two (2) working days**. If pended request is **beyond two (2) working days**, the reauthorization request will be dated the date received by the Care Coordination Center on the CareNet system.

Continued Service Criteria for Authorization

It is appropriate to retain the client at the present of level of care if:

1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;
or
2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment as the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
and/or
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client's new problems can be addressed effectively.

To document and explain the client's readiness for discharge or need to transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria, below.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.
or
2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.
or
3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.
or
4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated only at a more intensive level of care.

To document and explain the client's readiness for discharge or need for transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

**CLINICALLY MANAGED RESIDENTIAL DETOXIFICATION
&
MEDICALLY MONITORED DETOXIFICATION SUBSTANCE USE DISORDER
TREATMENT - SUB-ACUTE DETOX
Pre-authorization Review Required**

Level of Care

ASAM PPC-2R defines Clinically Managed Residential Detoxification Level III.2-D as an organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. Clinically managed residential detoxification is characterized by its emphasis on peer and social support. This level provides care for clients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. However, the full resources of a Level III.7-D, medically monitored inpatient detoxification service is not necessary.

ASAM PPC-2R defines Medically Monitored Inpatient Detoxification Level III.7-D as an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent setting. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. Sub-acute detoxification provides services to clients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour monitoring; however, the full resources of an acute care hospital are not necessary. This level of care is not justified by simple intoxication or fear of relapse.

Expectations:

1. Sub-acute detoxification is one component of a comprehensive treatment strategy; detoxification is the beginning phase of treatment.
2. Sub-acute detoxification will be authorized as part of a planned treatment episode, with the clinical pathway detailed in the authorization of services and explained to the client prior to admission into detoxification services.
3. The sub-acute detoxification provider will facilitate the client's transfer to the next level of care by following the MSSAC Continuum of Care Policy and Procedure.
4. The sub-acute detoxification provider is to provide a safe withdrawal from the drug(s) of dependence and enable the client to become drug free.
5. The sub-acute detoxification is to be provided in a supportive environment, with caring staff, sensitivity to cultural issues, confidentiality, and selection of appropriate detoxification medication (if needed) in order that the withdrawal is humane and protects the client's dignity.
6. The sub-acute detoxification provider is to prepare the client for ongoing treatment of his or her substance use disorder by emphasizing detoxification is the beginning **phase of treatment**, not a treatment modality in itself. Detoxification is an opportunity to offer clients information and to motivate them for longer term treatment.
7. Clients in sub-acute detoxification may begin to attend treatment programming depending on their ability to participate. If the sub-acute detoxification provider will continue SUD treatment in either stabilization or Long-term residential, full participation to begin **no later** than the third day of admission. If it is determined the client is not medically stable by the third day, the client is to follow the medical clinician's recommendation.

Pregnant Women

Pregnant women (IDU or not) need to be offered admission into detoxification services within twenty-four (24) hours after the initial screening. It is **highly recommended** pregnant women whose primary drug(s) of choice are alcohol, benzodiazepines, and/or barbiturates (Sedatives-Hypnotics) be referred to an acute care medical hospital where the stress of detoxification on the pregnancy will be appropriately monitored until her need for detoxification or stabilization while pregnant is no longer needed, she can then be safely treated in a less intensive level of care.

Co-Occurring Disorders (COD)

For those individuals admitted into sub-acute detoxification already on prescribed non-addictive psychotropic medications for such diagnoses as depression, schizophrenia, anxiety, or bi-polar, it is advisable to keep them on those medications while being detoxed from alcohol and/or other drugs (legal or illegal).

If an individual is admitted into sub-acute detoxification and is on prescribed addictive medications, it is recommended that those medications be on hold during detox. The detox protocol will cover the withdrawal from these medications. The goal is to move the client from addictive prescribed medications to non-addictive medications while in SUD treatment.

For those individuals not on any prescribed psychotropic medications and if indicated, they may be started on the appropriate non-addictive psychotropic medications.

Eligibility Criteria

1. Client is experiencing a Substance Use withdrawal and meets the criteria for a substance-specific withdrawal diagnosis reflected in a primary, validated, DSM IV^{TR} or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSSAC CA Provider Contract and the following (A and B, or C) manifestations are present:
 - a. The client is must score a ten (10) or greater on the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar) or the equivalent for a standardized scoring system.
and/or
 - b. The client is experiencing signs and symptoms of severe withdrawal, or there is evidence (based on history of substance intake, age, gender, previous withdrawal history, present symptoms, physical condition, and/or emotional, behavioral or cognitive condition) that a severe withdrawal syndrome is imminent. The severe withdrawal symptom is assessed as manageable at this level of service.
or
 - c. There is a strong likelihood the client (who requires medication) will not complete detoxification at another level of care and enter into continuing treatment or self-help recovery, as evidenced by one (1) of the following:
 - a. The client requires medication and has a recent history of detoxification at a less intensive level of care, marked by past and current inability to complete detoxification and enter into continuing addiction treatment. The client continues to have insufficient skills or supports to complete detoxification.
or
 - b. The client has a recent history of detoxification at less intensive levels of service that is marked by inability to complete detoxification or to enter into continuing addiction treatment, and the client continues to have insufficient skills to complete detoxification.
or
 - c. The client has co-morbid physical, emotional, behavioral, or cognitive condition (such as chronic pain with active exacerbation or post-traumatic stress disorder with

brief dissociative episodes) that is manageable in this setting, but which increases the clinical severity of the withdrawal and complicates detoxification.

and

2. A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.

and

3. The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder professionals.

and

4. It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on the American Society Of Addiction Medicine's Patient Placement Criteria.

and Reauthorization of SUD Treatment Services

To document and explain the client's appropriateness for SUD treatment services at Level III.2-D or III.7D: Sub-Acute Detoxification, the following are questions to consider and answer as applicable:

1. What risk is associated with the client's current level of acute intoxication? **Low, Medium, or High?**
2. What is the serious risk of severe withdrawal symptoms or seizures based on the client's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? **(If yes, III.7-D is required.)**
3. What are the current signs of withdrawal?
4. What supports does the client have to assist in ambulatory detoxification if medically safe?
5. What are the current physical illnesses other than withdrawal, that need to be addressed or which complicate treatment? Such as: COPD – asthma, bronchitis, emphysema; diabetes; hypertension; moderate to severe chronic pain issues. **(If yes, III.7-D is required.)**
6. What are the chronic conditions that affect treatment? (e.g., chronic pain with narcotic analgesics).
7. What are the current psychiatric illnesses or psychological, behavioral, or emotional problems that need to be addressed or which complicate treatment?
8. What are the chronic conditions that affect treatment? (e. g., stable but chronic schizophrenia, affective or personality disorder problems? Psychotropic medications?)
9. What, if any addictive or non-addictive psychotropic medications is the client on, that could negatively impact detox?
10. Do any emotional/behavioral problems appear to be an expected part of addiction illness or do they appear to be separate? Even if connected to addiction, are they severe enough to warrant specific mental health treatment?
11. Is the client in immediate danger of continued severe distress and drinking/drugging behavior?
12. Does the client have any recognition and understanding of, and skills for how to cope with his or her addiction problems and prevent relapse or continued use?
13. What severity of problems and further distress will potentially continue or reappear, if the client is not successfully engaged into treatment at this time?
14. How aware is the client of relapse triggers, ways to cope with cravings to use and skills to control impulses to use?
15. Are there any dangerous family, significant others, living or school/working situations threatening treatment engagement and success?
16. Does the client have supportive friendship, financial or educational/vocational resources to improve the likelihood of successful treatment?
17. Are there legal, vocational, social service agency or criminal justice mandates that may enhance motivation for engagement into treatment?
18. Does the client demonstrate an interest in working toward the goal of rehabilitation by agreeing to begin SUD treatment at the appropriate level of care after detox?

19. For clients with a history of repeated relapses and a SUD treatment history involving multiple treatment attempts, is there evidence of the restorative potential for this proposed admission and continuum of care plan?
20. Is the treatment safe and effective according to nationally accepted standards generally recognized by substance use disorder or mental health professionals?
21. Is it the most appropriate and cost-effective level of care that can be provided safely for the client's immediate condition based on the ASAM-PPC-2R?

If the client **enters treatment** at this level of care, the following is the initial benefit:

1 assessment session (if one has not been done within the last six (6) months) and up to 72 hours/3 days will be authorized for the initial authorization. Scope, duration, and intensity need to be provided to the Care Coordination Center.

The reauthorization is up to 2 days. **Note:** this is not a benefit limit but the increments in which services will be authorized

If the client is **transferred** from another level of care, number of sessions authorized will be dependent upon the information provided to the Care Coordination Center in the authorization request.

The **Initial Authorization Expiration Date** (Initial Lapse Date) for sub-acute detox service is **1 month or 30 days**. There is no extension of the Expiration Date for the initial authorization. The provider has **up to one (1) working day from the date of the** assessment to have the initial authorization request entered into the CareNet system. If the initial authorization request is pended by the Care Coordination Center, the provider is to respond within **one (1) working day**. The Care Coordination Center is to respond to pended initial responses within **one (1) working day**. If initial request is **not entered into CareNet within one (1) working day**, the initial authorization will be dated the date received by the Care Coordination Center on the CareNet system.

The **Re-authorization Expiration Date** (Re-authorization Lapse Date) for sub-acute detox services is **approved by the Care Coordination Center if clinically appropriate**. Scope, duration, and intensity need to be provided to the Care Coordination Center. If the reauthorization request is pended by the Care Coordination Center, the provider is to respond within **one (1) working day**. The Care Coordination Center is to respond to pended reauthorization responses within **one (1) working day**. If pended request is **beyond one (1) working day**, the reauthorization request will be dated the date received by the Care Coordination Center on the CareNet system.

Continued Service or Discharge/Transfer Criteria for Authorization

It is appropriate to retain the client at the present of level of care if:

1. The client continues in sub-acute detoxification until withdrawal signs and symptoms are sufficiently resolved that the client can be managed at a less intensive level of care
- or**
2. Alternatively, the client's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of care is indicated.

To document and explain the client's readiness for continued SUD treatment and the need to transfer to another level of care, **each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed**. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria, below.

**PHARMACEUTICAL INTERVENTION SUBSTANCE USE DISORDER TREATMENT
SERVICES
MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION
Opioid Replacement/Maintenance SUD Treatment Services
Pre-Authorization Review Required**

Level of Care

Opioid replacement and maintenance therapy is an organized addiction treatment service for opioid-addicted clients. It is delivered by addiction-trained personnel or addiction-credentialed clinicians, who provide individualized treatment, case management, and health education (including education about HIV, tuberculosis, and sexually transmitted diseases). Opioid replacement and maintenance therapy is provided under a defined set of policies and procedures, including admission, discharge, and continued service criteria stipulated by state law and regulation and the federal regulations at FDA 21 CFR Part 291. For the complete policy and procedure regarding Opioid/Methadone treatment refer to the MSSAC Medication-Assisted Treatment for Opioid Addiction Policy located on the website at [.mssac.com](http://mssac.com).

MSSAC believes methadone dosing **is a tool** that provides for an improved quality of life conducive to establishing and maintaining a drug-free lifestyle. It is a **medication** that prevents withdrawal symptoms, prevents opioid cravings and blocks the euphoric effects of opioid drugs. Methadone is designed to address the physiological problems **as an adjunct to** counseling and/or other substance use disorder treatment.

Expectations

1. It is an expectation that it is understood that methadone dosing is a pharmacological tool for the treatment of opiate addiction. **It is the expectation that treatment modalities involved, as reflected in the Treatment Plan, will identify and address clients' multiple substance use and addictive behaviors in general.** This will occur at the appropriate level of care and may include multiple providers.
2. It is an expectation that **most** clients will have met their treatment goals in two (2) years; however, this timeframe is not to restrict access to ongoing methadone treatment when medically necessary.
3. It is an expectation that clients disclose the names of all prescribing/treating physicians (including dentists) for the past year. It is also the expectation clients sign releases for communication with all treatment programs including health care, emergency rooms, dentists, and prescribing/treating physicians and provide a complete list of all prescribed medications and pharmacies. It is suggested program physicians access the Michigan Automated Prescription System (MAPS) to determine an accurate list of medications being prescribed for clients. *(According to Federal Regulations, substance use disorder treatment community grant funds are not to be utilized for methadone dosing of chronic pain. A clear diagnosis of opiate addiction must be present prior to any MSSAC funds being utilized for chronic pain clients.)*
4. It is an expectation that providers **make a good faith effort** to obtain all necessary releases. If a client is unwilling to fully cooperate with this expectation, the provider must document this lack of cooperation in the client's file. The client's willingness or unwillingness to comply may be a factor taken into consideration as a whole, as the Care Coordination Center reviews the client's readiness to change.
5. **Chronic Pain:** It is the fundamental expectation for clients, whose primary purpose of seeking methadone dosing is for chronic pain issues, will be referred to any/all primary care physicians. *According to Federal Regulations, substance use disorder treatment community grant funds are not*

to be utilized for methadone dosing of chronic pain. A clear diagnosis of opiate addiction must be present prior to any MSSAC funds being utilized for chronic pain clients.

6. **Consent for All Prescribing/Treating Physicians:** It is an expectation all clients disclose the names of all prescribing/treating physicians (including dentists) for the past year. It is also an expectation that clients sign releases for communication with all treatment programs including health care, emergency rooms, dentists, and prescribing/treating physicians and provide a complete list of all prescribed medications and pharmacies. The client's willingness or unwillingness to comply may be a factor taken into consideration as a whole, as the Care Coordination Center reviews the client's readiness to change.
7. It is an expectation that providers **make a good faith effort** to obtain all the necessary releases. For the purposes of coordination of care, the client must be informed of the importance to disclose the names of all prescribing physicians, treating physicians, dentists and any other health care provider over the past year. If a client is unwilling to fully cooperate with this expectation, the provider must document this lack of cooperation in the client's file. This does not validate discharge or non-acceptance into the OTP program, but may be considered an indicator of the client's readiness to change.

Pseudo Addiction

Pseudo-addiction is a pattern of drug-seeking behavior of pain patients receiving inadequate pain management that can be mistaken for addiction. The methadone treatment goal for those clients with pain inadequately treated is to get them on an adequate regimen to begin working with pain management medical staff, while working to control pain with non-opioid medication and physical therapy.

Co-Occurring Disorders (COD)

For those clients identified with COD, it is important to initiate and have participation in treatment of mental disorder(s) as well as receiving methadone and SUD treatment. A full treatment plan with clients engaging in optimally involving not only pharmaceutical interventions for the mental disorder(s) but individual and group as necessary would be appropriate.

and Reauthorization of SUD Treatment Services

For complete requirements for authorization of OMT: Methadone services refer to the MSSAC Medicated-Assisted Treatment for Opioid Addiction Policy located on the website mssac.com.

To document and explain the client's appropriateness for SUD treatment services at Level OMT: Methadone, each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed. The following are questions to consider and answer as applicable:

1. What are the current signs of opiate withdrawal?
2. Is there documentation of history of at least 1 year of continuous opiate use or at least 2 years of opiate addiction?
3. Have there been 1 or more prior confirmed attempts at drug-free SUD treatment within a 12-month period?
4. For clients with a history of repeated relapses and a SUD treatment history involving multiple treatment attempts, what is the evidence of the restorative potential for this proposed admission and continuum of care plan?
5. Is the client under 18 years of age?
6. Is the client a pregnant woman?
7. What are the current physical illnesses other than withdrawal, that need to be addressed or which complicate treatment?

8. What are the chronic physical conditions that affect treatment? (e.g., chronic pain with narcotic analgesics?)
9. Does the client need further evaluation regarding his or her chronic pain situation to determine if this is a pseudo-addiction vs. addiction?
10. What are the chronic mental health conditions that affect treatment? (e.g., stable but chronic schizophrenia, affective or personality disorder problems? Psychotropic medications?)
11. Do any emotional/behavioral problems appear to be an expected part of addiction illness or do they appear to be separate? Even if connected to addiction, are they severe enough to warrant specific mental health treatment?
12. Does the client meet the ASAM PPC-2R criteria for outpatient individual and/or group, or would a more intensive, and frequent level of care be more appropriate?
13. What is the reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through SUD treatment at this level of care?
14. Does the client feel coerced into treatment or actively object to receiving treatment?
15. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance motivation for engagement into treatment?
16. How ready is the client to change?
17. What has the client done to developed any community supports such as AA/NA, church, non-using friends?
18. How does the client demonstrate an interest in working toward the goal of rehabilitation by participating in all SUD treatment activities besides methadone dosing?
19. Does the client have any recognition and understanding of, and skills for how to cope with his or her addiction problems and prevent relapse or continued use of drugs, including alcohol, other than opiates?
20. How aware is the client of relapse triggers, ways to cope with cravings to use and skills to control impulses to use?
21. If willing to accept treatment, how strongly does the client disagree with others' perception that he or she has an addiction problem?
22. Is the client compliant to avoid a negative consequence, or internally distressed in a self-motivated way about his or her alcohol or other drug use problems?
23. If the client participated in illegal activities to obtain drugs or money for drugs, has this criminal behavior stopped?
24. Is the treatment safe and effective according to nationally accepted standards generally recognized by substance use disorder or mental health professionals?

If the client **enters treatment** at this level of care, the following is the initial benefit:

1 assessment session (if one has not been done within the last six (6) months) and up to 48 outpatient units (a combination of individual, group, case management, and family) and 180 units of daily dosing (6 months) will be authorized for the initial authorization. Scope, duration, and intensity need to be provided to the Care Coordination Center.

The **1st reauthorization is up to 90 units of daily dosing and up to 24 units of any combination of outpatient services.** The 2nd, 3rd, etc. reauthorizations will be up to 90 days of daily dosing and up to 12 units of outpatient services. More than 12 units of outpatient services may be requested during the 2nd, 3rd, etc reauthorizations if it can be appropriately documented to the Care Coordination Center. The additional units requested are to further the client's ability to achieve the treatment plan goals and objectives. **Note:** this is not a benefit limit but the increments in which services will be authorized

If the client is **transferred** from another level of care, number of sessions authorized will be dependent upon the information provided to the Care Coordination Center in the authorization request.

The **Initial Authorization Expiration Date** (Initial Lapse Date) for medication assisted treatment for opioid addiction service is **6 months or 180 days**. There is no extension of the Expiration Date for the initial authorization. The provider has **up to three (3) working days from the date of the** assessment to have the initial authorization request entered into the CareNet system. If the initial authorization request is pended by the Care Coordination Center, the provider is to respond within **three (3) working days**. The Care Coordination Center is to respond to pended initial responses within **three (3) working days**. If initial request is **not entered into CareNet within three (3) working days**, the initial authorization will be dated the date received by the Care Coordination Center on the CareNet system.

The **Re-authorization Expiration Date** (Re-authorization Lapse Date) for medication assisted treatment for opioid addiction daily dosing services is **approved by the Care Coordination Center if clinically appropriate**. Scope, duration, and intensity need to be provided to the Care Coordination Center. If the reauthorization request is pended by the Care Coordination Center, the provider is to respond within **three (3) working days**. The Care Coordination Center is to respond to pended reauthorization responses within **three (3) working days**. If pended request is **beyond three (3) working days**, the reauthorization request will be dated the date received by the Care Coordination Center on the CareNet system.

Phases Leading to Denial of Request for OMT Re-authorization

There are three (3) phases that may lead to denial from the Care Coordination Center when requesting Re-authorization. They are: Concern, Jeopardy, and Denial.

1. During the **Concern** phase, the client's therapist and the Care Coordination Center discuss concerns about the client's progress or lack of progress when requesting Re-authorization. The therapist notifies the client of the **Concern** status.
2. Examples of **Concern** phase are:
 - a. Positive urine screens
 - b. Poor treatment attendance
 - c. Lack of progress on goals/objectives

At the beginning of the **Jeopardy** phase, a letter (copy sent to the client and the therapist) is mailed to the client informing him/her of the opportunity for a case conference to inform of OMT services being in the **Jeopardy** status.

1. MSSAC staff, the Care Coordination Center staff, Provider therapist and the client meet to discuss the concerns in a Case Conference.
2. If there is agreement between the Provider and the Care Coordination Center regarding the **Jeopardy** status, the client is given specific instructions by his/her therapist about what is expected of him/her to move out of this stage.
3. If there is disagreement between the Provider and the Care Coordination Center regarding the Jeopardy status, the case will be sent to MSSAC's Medical Director for review.
4. MSSAC's Medical Director will review the case and/or discuss the case with the Provider Physician.
5. The MSSAC's Medical Director's recommendation is sent to MSSAC and the Care Coordination Center.
6. The Care Coordination Center informs the provider therapist of the disposition of the authorization.
7. The Provider physician may call MSSAC's Medical Director to discuss recommendations.

During the **Denial** phase,

1. The Care Coordination Center will inform the Provider of the denial status; however, will authorize at least 12 days (per Medicaid Fair Hearing Policy) plus an appropriate tapering period based upon established methadone tapering guidelines with the expectation the client will be off methadone at the end of that period.

2. An Administrative Notification letter is mailed to the Medicaid-funded client and a copy is faxed to the provider, informing of the decision. The Provider is responsible for distributing the courtesy copies.
3. Tapering of the client may be appealed within 12 days from the date of the notification. If appealed within 12 days, tapering will be placed on hold. If appealed after 12 days, tapering will continue even though the Medicaid-funded client has the right to appeal for up to 90 days after the date of action.
4. The **Denial** decision may be rescinded at any time during this process.

Continued Service Criteria for Authorization

For complete requirements for continued service criteria, refer to the MSSAC Medicated-Assisted Treatment for Opioid Addiction Policy located on the website [.mssac.com](http://mssac.com).

It is appropriate to retain the client at the present of level of care if:

1. The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;
or
2. The client is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment as the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals.
and/or
3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client's new problems can be addressed effectively.

To document and explain the client's readiness for discharge or need to transfer to another level of care, each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed. If the criteria apply to the client's existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer criteria, below.

Discharge/Transfer Criteria

For complete requirements for discharge/transfer criteria, refer to the MSSAC Medicated-Assisted Treatment for Opioid Addiction Policy located on the website [.mssac.com](http://mssac.com).

It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care.
or
2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated.
or
3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated.
or
4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated only at a more intensive level of care.

To document and explain the client's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM PPC-2R criteria are to be reviewed. If the criteria apply to the

existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

2 Year Review for Continuation of Methadone Dosing Services and Funding

For complete requirements for the 2 year review process, refer to the MSSAC Medicated-Assisted Treatment for Opioid Addiction Policy located on the website [.mssac.com](http://mssac.com).

The Care Coordination Center will evaluate each client who is due for review to approve or deny the program's request for continuation of Methadone dosing funding and SUD treatment funding within two (2) years after such Methadone dosing has begun. Clients are due for their 2 year justification review **four (4) months prior to the two (2) year anniversary date (20 months post admission)**.

Programs must not rely on the Care Coordination Center to inform them when OMT clients are due for their 2 year review, as this is the programs' responsibility. Delay in submitting the required documentation, submitting incomplete or insufficient documentation, may impact clients' notification of approval or denial of methadone dosing in a timely manner. This will be considered a provider delinquency under the MSSAC Delinquency Policy located on the website [.mssac.com](http://mssac.com).

**SUBSTANCE USE DISORDER TREATMENT ADDITIONAL SERVICES
WOMEN and FAMILIES' SPECIALTY SERVICES**

Eligibility

Pregnant women, post-partum women, women with dependent children and for women whose children have been removed from the home or are at risk of being removed, because of substance abuse, according to the Protective Services Laws of Michigan.

The **five** federal requirements providers are either to provide or arrange the following:

1. Primary **medical** care for women who are receiving substance use disorder treatment.
2. Primary **pediatric** care for their children including immunizations.
3. **Gender specific** substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.
4. **Child care** while the women are receiving these services, therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
5. Sufficient **case management and transportation** services to ensure that women and children have access to the services provided in the first four requirements.

Levels of Care

Women and Families' specialty services are available at all levels of care. SUD Treatment is to be gender specific.

Gender Competent Treatment

Definition: Capacity to identify where difference on basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender competence can be a characteristic of anything from individual knowledge and skills, to teaching, learning and practice environments, literature and policy. Wherever present, gender competence promotes equality in treatment and outcomes for men and women. Those treatment programs engaged in the practice of gender competence will be providing specialized programming. Focused not only on substance use disorder, but also, for example, on trauma, relationships, self esteem, and parenting. Staff serving this population should have training in women's issues relating to the previously mentioned programming areas, as well as HIV/STDs, family dynamics, and potentially child welfare.

Ancillary Services for Women & Families Case Management

While developing a case management plan as to the ancillary services your program will provide, **keep in mind mandated services must be provided to clients and available throughout the entire fiscal year.** The **mandated** services for Women & Families Case Management are the following: **Childcare, Transportation and Primary health/physicals for the woman and/or her children.**

1. **The expectation regarding Primary health/physicals for the client and her children is for the women's case manager to facilitate accessing appropriate services.** For most women, either her Medicaid or local health department funds should cover most of this cost. If you have a woman who cannot access any other resources to pay for her physical, **ancillary services funds of up to \$90.00** may be used.
2. If a child does not have Medicaid, other insurance and/or is not eligible for MICHild funds, **ancillary services funds of up to \$70.00** may be used.

3. MSSAC has determined the following to be **allowable** services for reimbursement:

| | |
|--|---|
| Meals/snacks | (Maximum allowable is \$6.00 per meal) |
| Dental for Women | (Maximum allowable is \$90.00) |
| Dental for Children | (Maximum allowable is \$70.00) |
| Prescription Drug Co-pay Coverage | (Maximum allowable is \$30.00 co-pay) |

4. MSSAC has determined Drug Testing/Screening to be a **limited allowable** service for reimbursement within the following guidelines:

- a. It will be limited in use as not all women funded for case management will be automatically drug tested and ancillary services funds can be utilized only when all other sources of payment have been exhausted, i.e., courts, probation, DHS, Child Welfare, etc.
- b. Supporting documentation for the ancillary services is to be kept on site in the client file, available for review during the annual financial and Quality Assurance/Women's Case Management site review.

HCPCS: Definition

A0110HD: Non-emergency transportation and bus, intra or interstate carrier.
H0048HD: Collection and handling only; specimens other than blood.
T1009HD: Child sitting services for children of individual receiving services.
T2003HD: Non-emergency transportation; encounter/trip.

Established Rate:

\$1.50 per Token
\$7.00/ Urine Test
\$3.00/hr per Child
\$5.00/Gas Card

H0006HD: Case Management will be requested and entered into the CareNet system in order to track usage. Reimbursement will be made according to contractual arrangements.

Request for Authorizations & Reimbursement

A0110HD: One (1) \$1.50 Token = one (1) unit (A two-way trip would require 2 tokens, so request 2 units of A0110.)

H0048HD: One \$7.00 Urine test = one (1) unit. Documentation of testing is required in the client file.

T1009HD: One (1) hour for one (1) child is \$3.00 = one (1) unit. For example: total of 3 hours with child care provider for 1 child = 3 hours = 3 units. If it is a total of 3 hours with child care provider for 2 children it = 3 hours x 2 children = 6 units.

T2003HD: One (1) encounter/trip is defined as one \$5.00 Gas Card. One (1) encounter = 1 \$5.00 gas card.

**SUBSTANCE USE DISORDER TREATMENT ADDITIONAL SERVICES
CASE MANAGEMENT SERVICES**

Philosophy

Case Management is an effective enhancement to intervention in and treatment of substance use disorders. This is especially true for clients with other disorders, who may not benefit from traditional substance use disorder treatment, who require multiple services over extended periods of time, and who face difficulty gaining access to those services.

Such an intervention can establish a stronger foundation for clients' recovery, reduce costs and enhance long term recovery for clients who have addictive disorders, by assuring they have access to all needed services.

Case Management Expectations

1. Case management services are those services which will assist clients in gaining access to needed medical, social, educational/vocational and other services. Core elements of case management include assessment; planning; linkage, coordination and monitoring to assist clients in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and supports developed through the individualized treatment planning process.
2. Services are provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.
3. Case managers may follow clients as they progress through the continuum of care. Case management services may continue after discharge from treatment services for up to six (6) months.
4. Case management services are not a case-finding activity as funded by MSSAC but rather supportive activities to enhance the clients' long term recovery from their addictive disorder.
5. MSSAC treatment providers may determine the need for case management services during their assessment process or at any time during the treatment planning process. All case management encounters need to be authorized by the Care Coordination Center prior to the provision of such services.
6. MSSAC treatment providers may determine and utilize a case management needs assessment of their own choosing as long as it meets the following guidelines:
 - a. It must be in a written format (electronic is accepted.);
 - b. The needs assessment is to be kept in the client files; and,
 - c. Incorporated into the client's treatment plan.
7. It is MSSAC's expectation that **at a minimum one (1) encounter per month is to be face-to-face** with the client. The frequency of case management encounters is to be determined by the individualized needs of the client based on the results of a needs assessment.
8. Once a client is **discharged from treatment**, case management services may **continue for up to six (6) months**. The case management encounters can be requested as a stand alone but still must meet the **minimum requirement of one (1) encounter per month to be face-to-face**.

9. Case management services will be available to **only** clients in MSSAC funded substance use disorder treatment who **are not eligible or serviced** in this manner through mental health, public health, other community human service agencies and/or DHS agencies.
10. Case management services will be guided by clients' Treatment Plans which will incorporate case management goals and outcomes and are consistent with the rest of the clients' individualized, coordinated, comprehensive treatment plan of service.
11. Case management service providers will established linkages with other agencies in the human services network for referral to ensure continued case management services beyond the six (6) months after discharge, if necessary for the client.

Authorization of Case Management Services

Authorization for case management services are to be requested through the Care Coordination Center by the treatment provider either at the time of the initial authorization or at any time during the treatment episode if the need for such services arises.

To document and explain the client's appropriateness for SUD case management services, the following are questions to consider and answer as applicable:

1. Does the client have a level of vulnerability which interferes with a successful treatment outcome as evidenced by multiple treatment attempts?
2. Does the client have multiple systems involvement, such as Department of Human Services/Protective Services or Foster Care, Probation, and/or Drug/Sobriety SUD Treatment Courts?
3. Does the client have risk factors which exceed the capacity for traditional SUD treatment?
4. For clients with a history or repeated relapses and a treatment history involving multiple treatment attempts, is there evidence of the restorative potential for this proposed admission if case management services were part of the treatment plan?
5. Are there chronic physical conditions that affect treatment? (e.g., chronic pain with narcotic analgesics?)
6. Are there chronic mental health conditions that affect treatment? (e.g., stable but chronic schizophrenia, affective or personality disorder problems? Psychotropic medications?)
7. Would the client benefit from supportive case management services in addition to SUD treatment? How?
8. Would supportive case management services for this client improve the possibility of positive SUD treatment outcomes? How?
9. Would this client benefit from on-going case management services for up to 6 months beyond the completion of formal SUD treatment? How?

The process for requesting case management services is:

The clinician/case manager is to complete a **Case Management Needs Assessment** to substantiate the need for case management services. The clinician is to indicate the reasons why case management is being requested in the comment section of the **Request for Initial Authorization**, on the CareNet system and how many encounters are requested.

The Care Coordination Center will review the comments in the comment section of the Request for Initial Authorization to authorize the level of care and case management encounters.

Case management will be authorized as an **encounter**. An encounter is **defined** as any case management activity which is **a minimum of twenty (20) minutes in duration**. Case management services are to be authorized under **CPT H0006**.

For the **Initial Benefit, up to a maximum of 8 encounters** may be authorized with a lapse date set for 4 months (120 days) from date of authorization.

The encounter minimum of twenty (20) minutes is counted as: **at least** twenty (20) minutes of **continuous** activity, for example: a phone call that lasts twenty minutes, a face-to-face session lasting sixty (60) minutes, a wraparound session lasting four hours, etc. The minimum is **not** counted as an accumulation of less time to equal twenty minutes. Documentation of each encounter is to be in the client's file as stated above. This documentation will be reviewed during the annual Claims/Billing site review.

Billable services **would include**, but not limited to, face-to-face contact with the client, telephone contact with the client of a minimum of 20 minute duration, wrap-around meetings, and collateral family contact of a minimum of 20 minute duration (collateral family contact is defined as any contact that are not direct treatment services), collateral professional contact of a minimum of 20 minute duration, in-home visits, transportation and referrals to other needed services.

If a **Request for Re-Authorization of Services** is needed for case management, progress regarding the case management issues must be indicated on the re-authorization request. The case management activities are to be incorporated into the Treatment Plan and updated as the Treatment plan is reviewed every ninety (90) days.

There is a **maximum of two (2) case Management encounters per day**. For example, if the case manager has phone contact regarding a client for at least 20 minutes or more in the morning and sees the client face-to-face for at least 20 minutes or more in the afternoon, that can be counted as two (2) encounters. It is to be documented in the client file as two (2) separate encounters.

Documentation for Client File

The treatment file of clients' receiving case management services must contain documentation for the determination of need for case management services, and case management activity notes indicating the following information:

1. Date of contact and/or service;
2. Duration of case management contact/services;
3. Name of agency and/or person being contacted;
4. Nature of case management services requested and extent of services requested; and/or
5. Nature of case management services provided and extent of services provided;
6. Place of service and/or referral.

Specialized Case Management Services

Co-Occurring Case Management:

MSSAC has made specific arrangements with local Community Mental Health Boards to co-fund case management and treatment services for co-occurring clients. Those services **do not** come under this policy. Programs which have had MSSAC's Board of Commissioners approve a performance based case management contract; **do not** come under this policy. Those programs are to refer to their individual contract with MSSAC for specific information on reporting and reimbursement.

If a treatment provider does not fall under any of the above categories, this case management policy is in effect.

Drug Treatment/Sobriety Court Staffing:

MSSAC supports the concept of drug treatment courts and realizes the importance of the participant's substance use disorder treatment provider attending the drug court team meeting process. MSSAC

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considers the on-going drug court team meetings as case management encounters and providers may submit for reimbursement at the current case management encounter rate.

The provider is to submit the “Billing Log for Drug Treatment Court Team Meetings”. The **completed billing log itself is considered one (1) encounter, not by each participant listed on the log.** The billing log is to be submitted to the Finance Assistant by the 2nd business day of the next month after services were delivered.

**SUBSTANCE USE DISORDER TREATMENT ADDITIONAL SERVICES
EARLY INTERVENTION SERVICES
PEER SUPPORTS/RECOVERY SUPPORT SERVICES**

Best Practice Guidelines will be developed for both Early Intervention and Peer Support/Recovery Supports during Fiscal Year 2008/2009 with SUD provider input.

APPENDIX A: CPT/HCPCS and REIMBURSEMENT RATE

| CODE | DESCRIPTION/LEVEL OF CARE | BLOCK GRANT & MEDICAID PAYMENT | Co-Occurring Payment (HH only) |
|--|--|---|---|
| H0001 H0001HA H0001HD H0001HH | Initial Assessment (Encounter 1 hr minimum): Individual face-to-face alcohol and/or drug assessment at the licensed provider level for the purpose of identifying functional and treatment needs and to formulate the basis for the individualized treatment plan. | \$115.00 | N/A |
| H0005 H0005HA H0005HD H0005HH | Group Therapy (90 minutes): Alcohol and/or drug services; group counseling by a clinician. | \$35.00 | \$40.00 |
| H2027 H2027HA H2027HD H2027HH | Psychoeducational Services: per 15 minute; Didactic/educational groups. | \$6.25 | \$7.50 |
| H0005.2 H0005HA.2 H0005HD.2 H0005HH.2 | Group Therapy (120 minutes): Alcohol and/or drug services; group counseling by a clinician. | \$45.00 | \$50.00 |
| H0006 H0006HA H0006HD H0006HH | Case Management Services per Encounter: services provided to link clients to other essential medical, educational, social and/or other services. | \$60.00 | N/A |
| H0010 H0010HH | Medically Monitored Residential Detox: Alcohol and/or drug services; Subacute detoxification; (ASAM Level III.7-D). | \$265.00 | N/A |
| H0012 H0012HH | Clinically Managed Residential Detox: Alcohol and/or drug services; (ASAM Level III.2-D) | \$200.00 | N/A |
| N/A | Intensive Outpatient per Chair Day: Alcohol and/or drug services; intensive outpatient; from 9 to 19 hours of structured programming per week based on an individualized treatment plan. Request for didactic, group, and individual sessions as determined by individualized treatment plan. | Unbundled for Authorization and Payment | Unbundled for Authorization and Payment |
| H0018 H0018HA H0018HH | Residential Therapy Stabilization per Day: Alcohol and/or drug services; short-term residential (non-hospital residential treatment program). | \$142.00 | N/A |
| H0019 H0019HH | Residential Therapy Long-Term per Day: Alcohol and/or drug services; long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days). | \$87.00 | N/A |
| H0019HA | Adolescent Residential Therapy Long-Term per Day: Alcohol and/or drug services; long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days). | \$255.00 | N/A |
| H0020 H0020HH | Methadone Daily Dosing: Alcohol and/or drug services; Methadone administration and/or service (provision of the drug by a licensed program). | \$7.00 per day | N/A |
| S9976 | Residential Room and Board: Lodging, per diem, not otherwise specified. Block Grant Only. | \$24.00 | N/A |
| H0043 | Supplemental Disability Assistance Only/Room & Board: Lodging, per diem, not otherwise specified. | \$24.00 | N/A |
| A0110HD | Non-emergency transportation and bus: intra or interstate carrier. For Women's Specialty Programs only. | \$1.50 per bus token | N/A |
| T2003HD | Non-emergency transportation: encounter/trip. For Women's Specialty Programs only. | \$5.00 Gas Card | N/A |
| H0048HD | Drug Testing; Collection and Handling only: specimens other than blood. For Women's Specialty Programs only. | \$7.00/Urine Test | N/A |

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| CODE | DESCRIPTION/LEVEL OF CARE | BLOCK GRANT & MEDICAID PAYMENT | Co-Occurring Payment (HH only) |
|--|---|---------------------------------|--------------------------------|
| T1009HD | Child Care: Child sitting services for children of individual receiving services. For Women's Specialty Programs only. | \$3.00 per hour per child | N/A |
| 90804 90804HA 90804HD 90804HH | Individual Therapy (30 minutes): Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 30 minutes face-to-face with the client. | \$37.50 | \$42.50 |
| 90806 90806HA 90806HD 90806HH | Individual Therapy (60 minutes): Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 60 minutes face-to-face with the client. | \$80.00 | \$85.00 |
| 90808 90808HA 90808HD 90808HH | Individual Therapy (90 minutes): Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, 90 minutes face-to-face with the client. | \$112.50 | \$117.50 |
| 90847 90847HA 90847HD 90847HH | Family/Couple with the Client Present Therapy (60 minutes): Family psychotherapy (conjoint psychotherapy with client present). | \$80.00 | \$85.00 |
| 90853 90853HA 90853HD 90853HH | Group Therapy (60 minutes): Group psychotherapy (other than of a multiple-family group). | \$25.00 | \$30.00 |
| 90801HH 90801HH,HA | Psychiatric Evaluation: Diagnostic interview examination. (Approved programs only.) | \$100.00 | \$100.00 |
| 90862HH 90862HH,HA | Medication Review: Review of current medications. (Approved programs only.) | \$40.00 | \$40.00 |
| H0001H9 H0018H9 H0019H9 | House of Commons only approved codes: mutual clients with Ingham County Office of Community Corrections. Reimbursement rates remain the same. | \$115.00 \$142.00 \$87.00 | N/A |

**Modifiers for Substance Abuse HCPCS Codes
FY 2008/2009**

| Modifier | Description |
|-----------|---|
| HA | Child-Adolescent Program: services designed for persons under the age of 18. |
| HB | Adult Program – Non-Geriatric: services designed for persons age 18-64. |
| HC | Geriatric Program: services designed for adults age 65 and older. |
| HD | Women's Specialty Services: Pregnant/Parenting Women Program: services provided in a program that treats pregnant or women with dependent children. HD is required for all qualified Women's Specialty Services. |
| HG | Opioid Addiction Treatment Program: program specifically designed to provide opioid-treatment services; including but not limited to the provision of methadone. |
| HH | Integrated Substance Abuse/Mental Health Program: program specifically designed to provide integrated services to persons who need both substance abuse and mental health services, as planned in an integrated, individualized treatment plan. HH modifier is required for qualifying Integrated Substance Abuse/Mental Health services. Providers will be assigned the use of HH modifiers with submission of documentation of licensure for Integrated Substance Abuse & Mental Health Services. |
| HR | Family/Couple with Client Present: services provided to more than one client in a single treatment event, such that persons served share familial or significant other relationships. |
| H9 | Court-ordered: indicates that services were ordered by a court, probation officer and/or parole officer. This modifier is assigned only to the House of Commons for the mutual clients between MSSAC and the Ingham County Office of Community Corrections. |

1. Providers will be assigned the use of appropriate modifiers with the submission of program descriptions and documentation of any necessary licensure.

Modifiers may be used in combination with each other, such as H0001HH, HA.

Appendix B: Treatment Plan; Progress Notes; Treatment Plan Review Guidelines

It is the expectation that client Treatment Plans must be individualized, reflect all dimensions of the ASAM Patient Placement Criteria and be developed with the full and active participation of the client. All substances of abuse, including alcohol, must be included in the treatment plan (State Enrollment Criteria, August 2005, pg. 3 of 7).

Treatment Plans:

1. It is an expectation: Treatment Planning begins at the time the client enters treatment, evolving over the first or second session when required documentation has been completed. (Treatment Policy #06/Individualized Treatment Planning, 2006, p.2 of 4)
2. It is an expectation: the client's needs and strengths identified in the assessment are used in establishing the goals and objectives that will be focused on in treatment.
3. It is an expectation: Treatment Plan goals are stated in the client's words. Each goal written down should be directly tied to a need that was identified in the assessment (Treatment Policy #06/Individualized Treatment Planning, 2006, p.2 of 4).
4. It is an expectation: Treatment Plan objectives need not be recorded in the client's exact words but are written in a manner in which they can be measured for progress toward completion along with targeted completion dates.
5. It is an expectation: that treatment interventions will be identified on the client's Treatment Plan, explaining what action the client and counselor will take to achieve the goal/objective.
6. It is an expectation: Treatment Plan targeted achievement dates are realistic to the client and not just routine dates put in for completion of the plan. (Treatment Policy #06/Individualized Treatment Planning, 2006, p.3 & 4 of 4)
7. It is an expectation: once a goal has been identified, the objectives (steps that need to be taken to achieve the goal) are recorded.
8. It is an expectation: any individual or group sessions that the client participates in must address or be related to the goals and objectives in the treatment plan (Treatment Policy #06/Individualized Treatment Planning, 2006, p.3 of 4)
9. It is an expectation: throughout the treatment process, as the client's needs change, the treatment plan will be revised to meet the new needs of the client.
10. It is an expectation: Treatment Plans and Progress Notes reflect the clinical status of the client, such as compliance contracts initiated, extra sessions or specialized groups provided, and off-site dosing privileges rescinded or reduced (State Enrollment Criteria, August 2005, pg. 4 of 7 & ODCP Policy #4-Revised / Off-Site Dosing of Opioid Treatment Medication-Methadone, 2005, pg. 2 of 22)

Treatment Progress Notes:

11. It is an expectation: progress notes reflect what goal(s)/objectives(s) were addressed during a treatment episode.

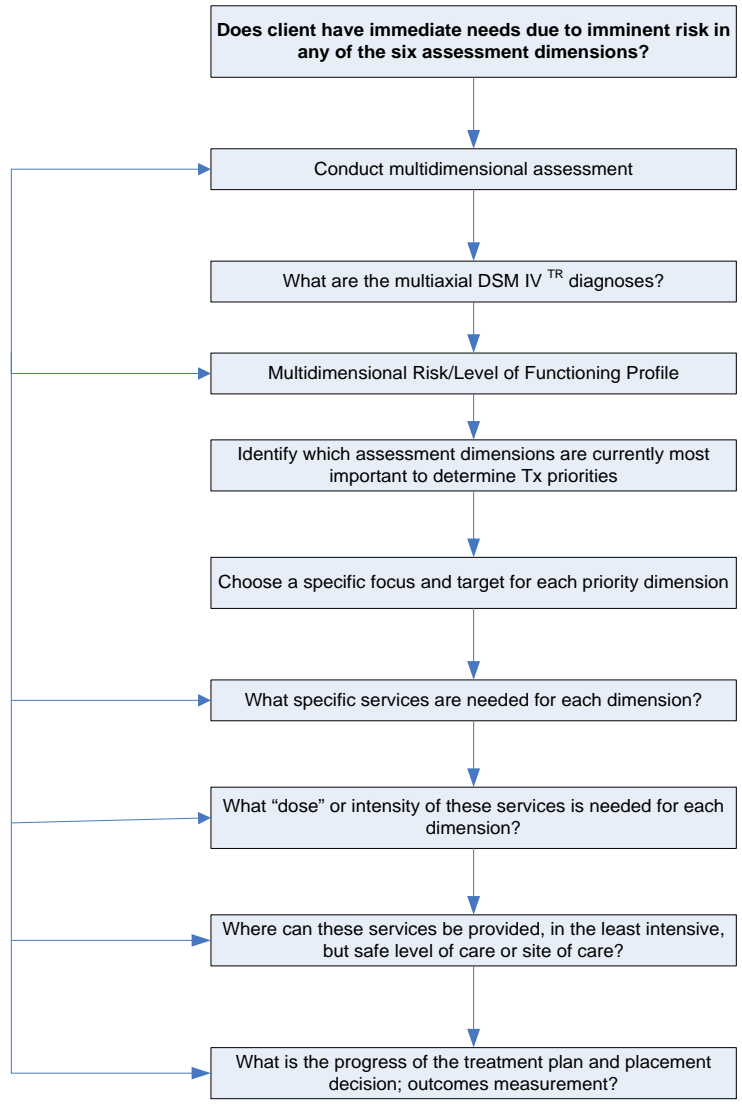
12. It is an expectation: any adjustments/changes to the treatment plan are documented in the progress notes. Once a change is decided on, it should then be added to the treatment plan in the format described above.

Treatment Plan Reviews:

13. It is an expectation: Treatment Plan Reviews are documented in the client's file^(Treatment Policy #06/Individualized Treatment Planning, 2006, p.3 of 4)
14. It is an expectation: Treatment Plan Reviews include input from all clinicians/treatment providers involved in the care of the client as well as any other individuals the client has involved in his/her treatment plan.
15. It is an expectation: Treatment Plan Reviews reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client.
16. It is an expectation: the client, clinician, and other relevant individuals should sign the Treatment Plan Review.

Appendix C:

Decision Tree to Match Assessment and Treatment/Placement Assignment



Mee-Lee, D, Shulman GD, Fishman M, Gastfriend DR, and Griffith JH, eds (2001). ASAM Patient Placement Criteria for the treatment of Substance – Related Disorders, Second Edition, Revised (ASAM PPC – 2R).

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