Definitions

American Society of Addiction Medicine (ASAM): Enhances the use of multidimensional assessments to develop patient-centered service plans and to guide clinicians, counselors, and care managers in making objective decisions about patient admission, continuing care, and transfer/discharge for various levels of care for addictive, substance-related, and co-occurring conditions.

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

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

SBHO maintains standard level of care (LOC) guidelines for all authorized services. These LOC guidelines incorporate contract requirements, American Society of Addiction Medicine (ASAM) criteria, and Washington Administrative Codes. SBHO contracts with an Administrative Service Organization (ASO), CommCare, to facilitate service authorization requests. CommCare utilizes these Level of Care guidelines for making decisions about scope, duration, intensity and continuation of services. Decisions regarding initial authorizations for Substance Use Disorder treatment services or authorizations for extensions of services must abide by these guidelines.
1. **Determining Medical Necessity for the Authorization Process**
   A. **Evaluating ASAM Level of Care Criteria:** Prior to authorizing a request for SUD treatment services, the following must be accomplished to determine "medical necessity":
      1) The individual has received a comprehensive Substance Use Disorder Bio-Psycho-Social assessment from a Washington State certified Chemical Dependency Professional (CDP) or a CDP-Trainee under the supervision of a Chemical Dependency Professional. The assessment process includes the administration of the GAIN-SS.
      2) A substance use disorder diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and included in the statewide ACS as a covered diagnosis has been assigned based on information gathered from the assessment. The DSM-5 diagnosis is identified by an ICD-10 code.
      3) ASAM level of care requirements (medical necessity), sufficient to meet the individual’s needs, have been determined by a CDP, or a CDPT under supervision of a CDP supervisor, through evaluation of ASAM criteria.
      4) The individual is expected to benefit from the recommended intervention.
      5) The individual’s unmet needs cannot be more appropriately met by another intervention.
      6) There are no restrictions as to the number or frequency of assessments an individual can receive.

2. **Outpatient Substance Use Disorder Services**
   A. CommCare administers authorization determinations for the following levels of outpatient treatment based on medical necessity:
      1) ASAM Level 1.0 Outpatient
      2) ASAM Level 2.1 Intensive Outpatient

   B. **Service Expectations**
      1) Individuals will be able to receive medically necessary outpatient services at their current ASAM level. Services provided must include at least the following:
         a. **ASAM Level 1: Outpatient Treatment Services**
            i. Provides up to nine contact hours per week for adults and up to six hours per week for adolescents.
            ii. Available Services:
               a) Case Management
               b) Opiate Substitution Treatment
               c) Group and individual counseling
         b. **ASAM Level 2.1: Intensive Outpatient Treatment Services**
            i. Provides 9-19 hours of structured programming per week for adults, and, 6-19 hours per week for adolescents.
            ii. Available Services:
a) Case Management
b) Group and individual counseling
c) Chemical dependency outpatient treatment services that provide a concentrated program of individual and group counseling, education, and activities, including at least one individual session each month.

C. Who May Request an Authorization
Requests for outpatient authorization are accepted from SUD agencies that are licensed by Washington State and have a contract with SBHO for outpatient services.

D. Authorization Period
CommCare may approve an initial authorization request for Level 1.0 and Level 2.1 Outpatient treatment services for a period of up to nine months. When an ongoing assessment indicates that the individual no longer needs the authorized level of care, it is expected that the outpatient provider will transition the individual to a lower level of care.

E. Continuing Care Criteria
If the outpatient provider determines the individual needs outpatient services longer than 9 months, an authorization request for continuing care must be submitted to CommCare. Submissions to CommCare must include an evaluation of the effectiveness of services provided during the initial nine month authorization and a justification for continuation of services. Any extensions beyond 9 months will be for a 3 month period.
In those cases where an individual was authorized for outpatient care but then required residential treatment, the amount of time the individual was in residential treatment will be added to the initial outpatient authorization period. Requests for extended Outpatient services must be received by CommCare a minimum of seven days prior to the expiration of the benefit period.

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

G. Authorization Request Denials
If CommCare denies a request for authorization of outpatient treatment services, CommCare will send a Notice of Adverse Benefit Determination (NOABD) for Medicaid individuals and services (SBHO P&P 6.05) or a Notice of Determination for non-Medicaid individuals and services (SBHO P&P 7.01) as well as provide a peer clinical review. The goal of the peer clinical review is to allow the treating provider a chance to discuss UM determinations before the initiation of the appeal process. If a peer to peer conversation
or review of additional information does not result in resolution, CommCare informs the provider and the individual of the right to initiate an appeal and the procedure to do so.

H. Authorization Request Protocol
   Refer to the “Substance Use Disorder, Outpatient Treatment Authorization Request” (SBHO P&P 7.09a) and instructions (SBHO P&P 7.09).

I. Covered Individuals
   The following individuals may be authorized for SUD Outpatient treatment services if the requirements of this section are met:
   a) Medicaid enrollees
   b) Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage) who have no other SUD insurance benefit and were referred to treatment from:
      i. The criminal justice system
      ii. A withdrawal management facility
      iii. A residential treatment facility

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

3. Residential Substance Use Disorder Services
   A. CommCare administers authorization determinations for the following levels of residential treatment based on medical necessity:
      1) Level 3.1 Clinically Managed, Low Intensity Residential Services (Recovery House)
      2) Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential services
      3) Level 3.5 Clinically Managed, High Intensity Residential Services

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

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

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

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

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

G. Denials
If CommCare denies a request for authorization of Residential treatment services, CommCare will send a Notice of Adverse Benefit Determination (NOABD) for Medicaid individuals and services (SBHO P&P 6.05) or a Notice of Determination for non-Medicaid individuals and services (SBHO P&P 7.01) as well as provide a peer clinical review. The goal of the peer clinical review is to allow the treating provider a chance to discuss UM determinations before the initiation of the appeal process. If a peer to peer conversation or review of additional information does not result in resolution, CommCare informs the provider and the individual of the right to initiate an appeal and the procedure to do so.

H. Authorization Protocol
Refer to “Substance Use Disorder Residential Treatment Authorization Request” (SBHO P&P 7.09b) and instructions (SBHO P&P 7.09).

I. Covered Individuals
The following individuals may be authorized for SUD Residential treatment services if the requirements of this section are met:
1) Medicaid enrollees
2) Individuals without Medicaid who meet the state definition of low income (including those with Medicare only coverage) who have no other SUD insurance benefit and were referred to treatment from:
   i. The criminal justice system
   ii. A withdrawal management facility
3) Those entering residential treatment through the CD-ITA process
4. **Withdrawal Management Services**
   A. CommCare administers authorization determinations for Withdrawal Management services based on medical necessity

   B. **Who May Request an Authorization**
      Authorization requests for Withdrawal Management Services are accepted from appropriately credentialed facilities licensed to provide Withdrawal Management services in compliance with ASAM.

   C. **Authorization Period**
      1) Initial authorizations, determined by the admitting provider, are limited to the following:
         i. Alcohol detoxification: 3 days
         ii. Drug detoxification: 5 days

   D. **Extension Requests**
      Withdrawal Management providers may request an extension to services if needed. Provider will forward request for additional services to CommCare. CommCare has up to 24 hours to make a continuing care determination decision.

   E. **Discharge Criteria**
      Individuals are ready for discharge from withdrawal management services when they no longer meet medical necessity requirements as determined by appropriately credentialed staff.

   F. **Denials**
      If CommCare denies a request for withdrawal management services, CommCare will send a Notice of Adverse Benefit Determination (NOABD) for Medicaid individuals and services (SBHO P&P 6.05) or a Notice of Determination for non-Medicaid individuals and services (SBHO P&P 7.01) as well as provide a peer clinical review. The goal of the peer clinical review is to allow the treating provider a chance to discuss UM determinations before the initiation of the appeal process. If a peer to peer conversation or review of additional information does not result in resolution, CommCare informs the provider and the individual of the right to initiate an appeal and the procedure to do so.

   G. **Authorization Request Protocol**
      Refer to the “Substance Use Disorder Withdrawal Management Treatment Authorization Request” (SBHO P&P 7.09d) and instructions (SBHO P&P 7.09).

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