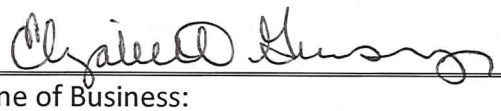
Section: Substance Abuse Treatment & Prevention	Policy Name: **Substance Abuse Service Authorization Guidelines**	Policy Number: **11.13**
Owner: **Manager of UM & Call Center**	Reviewed By: **Beth Guisinger**	Total Pages: **4**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☒ **Other (please specify): SARF Licensing**	Final Approval By: 	Date Approved: 10/30/2019
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **8/22/2019**

Policy: It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) to assure that Substance Use Disorder (SUD) Authorization processes meet the contractual and regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) contract and Center for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR) and the Public Health Code and advance the recovery of SWMBH customers. In cases where there are inconsistencies, SWMBH will follow the stricter of the two guidelines.

Purpose: SWMBH will provide guidelines to SUD Providers regarding the amount of services that may be requested and authorized at any given time. These guidelines are intended to provide a process for continued stay and ongoing service utilization review and are not intended to provide a service limit.

Scope: This policy is applicable to SWMBH's Care Management Specialists, Community Mental Health Service Providers (CMHSP), and SUD Providers that are requesting and approving authorization requests for substance abuse treatment provided under the funding sources of Medicaid, Healthy Michigan Plan, and Block Grant.

Responsibilities: SWMBH Utilization Management (UM) are responsible for collecting necessary clinical documentation to make appropriate medical necessity determination in the authorization of initial and ongoing substance abuse treatment.

CMHSPs are responsible for providing clinically appropriate services, while completing necessary supporting documentation to support initial and ongoing substance abuse treatment.

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Substance Abuse Treatment providers are responsible for providing appropriate care for customers, while completing necessary clinical documentation supporting ongoing substance abuse treatment.

Definitions: None

Standards and Guidelines:

A. These listed service guidelines are to be utilized when establishing an initial authorization or requesting additional authorizations. They are to be used in conjunction with Medical Necessity Criteria. It is important to remember that there are no pre-set limits to an individual's benefit. All authorizations are to be prior authorized to the service requested. The exception to prior authorization includes emergency services.

B. If the customer continues to meet criteria for the service, providers may request additional units accompanied by clinical rationale indicated by completing a current American Society of Addiction Medicine (ASAM) criteria assessment. The ASAM should be recent, completed within the last 30 days, to indicate the customer's continued need for ongoing treatment at the appropriate level of care.

C. All authorizations for service are expected to be based on Medical Necessity Criteria and documentation must demonstrate the need for initial or on-going services.

1. Assessment is an ongoing process and evolutionary changes should be reflected in the clinical record. It is expected that customers will have a current assessment on file. Transfers from various levels of care within an organization should contain at minimum an addendum to the assessment identifying rationale for the change in level of care and the treatment needed to remediate the identified diagnosis. Typically, assessments are authorized on an initial and annual basis. Providers may request a new assessment if it has been determined that there have been marked changes in status and the current assessment is older than 6 months.
2. Example rationale for providers to request authorization of an assessment:
    a. An identified need for a change in the level of care
    b. Annual assessment update
    c. A change in the customer's status (diagnosis, living situation, employment, presentation)
    d. A customer returning to treatment after recent service termination whose presentation has changed.

D. It is expected that the treatment plan will be present in the chart, will contain measurable goals with progress notes in the chart, and will be reviewed every 120 days at minimum or as indicated in the plan. It is expected that there are sufficient goals, objectives and interventions to support the amount of treatment being requested.

E. The policy attachment details what is average utilization throughout the Southwest Michigan Behavioral catchment area of the listed services to achieve the statutory requirement of uniform benefit across the region. This can be used by clinical supervision to monitor over or underutilization in ASAM service categories to ensure all customers are receiving the appropriate amount of service for their identified levels of need.

F. It should be noted that Level II Intensive Outpatient (IOP) is to be delivered at 9-19 hours a week per the American Society of Addiction Medicine Recommendation. As indicated above, SWMBH follows

the stricter Federal Guidelines which indicate IOP is a 3 hour a day service. Therefore, it is the policy of Southwest Michigan Behavioral Health that this service is a bundled rate to be delivered at no less than three hours a day as many clients will need more than the minimum service threshold. However, it is understood that due to variability in need amongst the client population, some clients may not be able to maintain for the full three hours a day and will need to attend more days a week for less time. For short durations based on clinical rationale. If the 9 hours a week is met in any combination with approval of UM staff, this is acceptable.

G. It should further be noted that you cannot bill for the IOP code during weeks that the client does not attend the minimum of nine hours. However, requests may be submitted for outpatient services to be reimbursed for the outpatient codes for each daily occurrence.

References: None

Attachments: 11.13A Level of Care Service Utilization Guideline

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Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	4/2/2019	III.B. Standards and Guidelines	Clarifies that recent current ASAM completed should be included within the past 30 days	E. Guisinger
1	8/22/2019	Standards and Guidelines, D.	Revision timeline changed from 90 to 120 days per LARA	E. Guisinger