

**Pennsylvania Guidance for  
Applying  
*The ASAM Criteria, 2013*  
Revised August 2019**



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## INTRODUCTION

This document is to be utilized in applying *The American Society of Addiction Medicine (ASAM) Criteria, 2013* within Pennsylvania's Treatment System when conducting a Level of Care Assessment for initial referral into services or for continued stay and discharge considerations after treatment engagement. Because Pennsylvania's robust treatment system has some nuances that are not addressed within *The ASAM Criteria, 2013*, specifically related to the Halfway House and Residential levels of care, the information contained herein will further assist in determining placement into those services. The crosswalk of the levels of care as they have historically been referenced versus the corresponding level of care identified in *The ASAM Criteria, 2013* are also included.

This document serves to further assist the assessor by providing supplemental information for determining the treatment needs of special populations when making a referral for services. Additionally, guidance on treatment planning, continued stay reviews and Single County Authority (SCA) authorization for services is included herein to provide clarification on these clinical processes as outlined in the Pennsylvania regulations, in comparison to that which is outlined in the criteria.

*The ASAM Criteria, 2013* does not supersede Pennsylvania regulations, applicable statutes, and contractual agreements established by the Department of Drug and Alcohol Programs.

### **INTRODUCTION TO TREATMENT LEVELS OF SERVICE (*The ASAM Criteria, 2013*, pp. 106-107)**

### **ADULT LEVELS OF CARE 6-DIMENSIONAL OVERVIEW (*The ASAM Criteria, 2013*, pp. 175-176)**

### **ADOLESCENT LEVELS OF CARE 6-DIMENSIONAL OVERVIEW (*The ASAM Criteria, 2013*, pp. 177-178)**

### **WITHDRAWAL MANAGEMENT (*The ASAM Criteria, 2013*, pp 127 – 173)**

There are various assessment considerations for determination of withdrawal management needs including the individual's personal withdrawal history, course of illness, substances being used, current withdrawal symptoms, medical and mental health complications, etc.; therefore, assessors should be well-acquainted with the specific details outlined in *The ASAM Criteria, 2013* (pp. 127 – 173), including the Dimensional Admission Criteria Decision Rules by substance, the Risk Rating Matrix (*The ASAM Criteria, 2013*, pp. 73 - 104), Immediate Need and Imminent

Danger Profile (*The ASAM Criteria, 2013, p. 66*), as well as the Withdrawal Management Instruments found in the Appendix A (*The ASAM Criteria, 2013, pp. 393 – 400*).

**1 WM (*The ASAM Criteria, 2013, pp. 132-134*) Ambulatory Withdrawal Management  
And**

**2 WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring (*The ASAM Criteria, 2013, pp. 134 – 136*)**

Ambulatory withdrawal management exists within our treatment delivery system; however, since this activity is not indicated on the license of providers who deliver this level of care, it is difficult to determine Pennsylvania’s current capacity for these services and individuals’ access to these services. Work will continue to identify and expand ambulatory withdrawal management services, as appropriate. Until then, clients should continue to use the existing ambulatory services offered by providers. Such services may be provided by licensed SUD providers, including outpatient providers with appropriate medical staff and services and primary care physicians.

**3.2 WM: Clinically-Managed Residential Withdrawal Management (*The ASAM Criteria, 2013, pp. 137 – 139*)**

Since all licensed residential withdrawal management facilities must have healthcare staff as a regulatory requirement, there are no licensed residential treatment providers within the Commonwealth of Pennsylvania that provide only a “social setting detoxification” that is characterized by peer and social support. While licensed residential withdrawal management programs may support individuals in progressing through withdrawal symptoms without any use of medication, this is done as a service within a 3.7 WM service and not as a separate 3.2 level of care. The provision of this service as a definitive 3.2 level of care will need to be explored as a future enhancement to the system of care.

## **PENNSYLVANIA LICENSED CLINICAL SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES**

The following are *The ASAM Criteria, 2013* text references for Level of Care (LOC) not specifically addressed in this document:

**Early Intervention (EI) – Level .5 (*The ASAM Criteria, 2013*, pp. 179 - 183) \*not licensed**

**Outpatient (OP) Services – Level 1 (*The ASAM Criteria, 2013*, pp. 184 - 196)**

**Intensive Outpatient (IOP) Services – Level 2.1 (*The ASAM Criteria, 2013*, pp. 196 – 207)**

**Partial Hospitalization (PHP) Services – Level 2.5 (*The ASAM Criteria, 2013*, pp. 208 – 218)**

**Opioid Treatment Services (OTS) – (*The ASAM Criteria, 2013*, pp. 290 – 298)**

## Clinically-Managed Low-Intensity Residential Services, i.e., Halfway House (HWH) – Level 3.1 (*The ASAM Criteria, 2013, pp. 222 -234*)

The ASAM Criteria “do not purport to set medical or legal standard of care and may not encompass all the levels of service options that may be available in a changing health care field or within any particular state”, (*The ASAM Criteria, 2013, p. ix*). Additionally, the descriptions are intended to provide a more comprehensive understanding of each LOC; and “are not intended to replace or supersede the relevant statutes, licensure, or certification requirements of any state or federal jurisdiction” (*The ASAM Criteria, 2013, p. 19*). **Therefore, application guidance as it pertains to Pennsylvania’s Halfway House LOC is set forth in this document and reflects and adaptation of the criteria as it applies to the 3.1 LOC as delivered in Pennsylvania.**

1. In PA, the HWH LOC is licensed as a non-hospital residential facility providing, structured, regulated, professionally staffed services focused on developing self-sufficiency through counseling, employment and other services. Within the criteria, the term halfway house is not synonymous with the term halfway house as designed and delivered in Pennsylvania.
2. The ASAM Criteria’s Level 3 placements include a continuum of residential services, including levels 3.1, 3.3, 3.5 and 3.7. Within Pennsylvania’s system of care, HWHs focus on community reintegration including work, volunteer and educational activities most appropriately described by *The ASAM Criteria, 2013* Level 3.1, with guidance for applying the criteria to PA’s system of care and regulatory requirements.
3. *The ASAM Criteria, 2013* indicate that clinical services in this 3.1 LOC are usually provided in an outpatient setting (*The ASAM Criteria, 2013, p. 223*); however, in Pennsylvania, HWH’s are licensed, clinical providers that deliver onsite substance use disorder treatment, with referrals to an appropriate off-site mental health provider unless a provider is also credentialed to provide such services within the facility.
4. The HWH LOC has been and continues to be a 24-hour post stabilization service rather than a service meant for those in the “discovery process” as described in the criteria or for those just initiating the recovery process.
5. As always, it is essential that assessors are aware of all the service providers to which they make referrals so that individuals are appropriately matched to the provider/facility that can best meet the needs of the individual.
6. *The ASAM Criteria, 2013* is person-centered, rather than program-focused. It is DDAP’s expectation that individuals, in any LOC, will be treated as warranted, and if a service is needed, the provider will ensure that the individual’s needs are met within the program’s structure or through a referral to a specialized provider.

7. Even though there has been legislation passed to certify or license recovery residences, recovery houses are not authorized to provide clinical services. While housing may be an ancillary need that can be met while an individual is participating in one of the outpatient levels of care, the appropriate clinical service would be *The ASAM Criteria, 2013* 1.0, 2.1, or 2.5 LOCs, with an ancillary referral to an approved recovery residence, but NOT an *ASAM Criteria, 2013* level 3 placement. The need for housing and a safe recovery environment cannot be the sole driver for placement into HWH/residential services, rather an individual must meet the admission criteria of the other dimensions as well (*The ASAM Criteria, 2013*, pp. 228 -231).

8. DDAP is providing clarification to the Level 3.1 Adult Dimensional Admission Criteria, Dimension 3, All Programs statement located on pages 228 – 229, *The ASAM Criteria, 2013*:

All Programs: The patient may not have any significant problems in this dimension. However, if any of the Dimension 3 conditions are present, the patient must be admitted to a co-occurring capable or co-occurring enhanced program (depending on his or her level of function, stability, and degree of impairment). In Pennsylvania, these admission criteria can be satisfied by an admission into a co-occurring capable, a co-occurring enhanced program, a program with a Certificate of Approval as meeting the criteria in the co-occurring disorder competent bulletin, or through an individual referral to a mental health provider. As noted in *The ASAM Criteria, 2013*, p.45: **“If the emotional, behavioral or cognitive signs and symptoms are part of addiction (e.g., mood swings because the individual is using “uppers” and “downers”), then Dimension 3 needs may be safely addressed as part of addiction treatment.”**

10. An individual is not required to have a co-occurring issue to use the 3.1 LOC, nor does having a co-occurring condition negate placement in this LOC. Rather, the criteria are inclusive of those individuals who may have co-occurring conditions in Level 3.1 (and all LOCs).



## Clinically Managed Population-Specific High-Intensity Residential Services – Level 3.3 (Adult Criteria Only) (*The ASAM Criteria, 2013, pp. 234 – 243*)

1. Some providers may have a DDAP Non-Hospital Program license and have a Mental Health license to address persons with severe co-occurring disorders (COD) and therefore are equipped to serve individuals with significant cognitive dysfunction, developmental delays and/or debilitating CODs. Currently, it is uncertain if or where such population-specific programs exist in Pennsylvania; they are mostly unavailable. Clinicians/assessors need to be mindful of available services and programming done by providers.
2. While there are some providers that are equipped with the level of specialty staff to serve individuals with severe cognitive impairments or co-occurring disorders, there are no SUD treatment programs that are licensed to serve **only** individuals with these specialized needs.
3. In such instances where an individual is assessed as having cognitive impairments that require services that are adapted to fit the level of impairment and staffing requirement, assessors and clinicians should make every effort to identify programs that can better deliver such services, even though the facility patient population is not limited to these specialized services or specific individuals, or concurrent referrals for specialized care should be made.
4. Where functionality is so impaired that the physical or mental health issue is primary or supersedes the SUD need, appropriate referral to a therapeutic rehabilitation program or a traumatic brain injury program is required, followed by SUD referral upon stabilization, as appropriate.
5. In those instances where the 6-dimensional assessment and individual needs warrant a 3.3 LOC placement, but such services do not exist or cannot be accessed, identification of that need should be made at the time of referral to the payor; SCAs and BH-MCOs should track the cumulative need for this LOC. While an individual should be referred to the next available higher level of care as indicated by *The ASAM Criteria, 2013, p. 111*, tracking the need for this LOC assists Pennsylvania in assessing gaps and needed services.

## **Clinically-Managed High Intensity Residential Services (Adult) Rehabilitative Residential Services – Level 3.5R and Clinically-Managed High Intensity Habilitative Residential Services 3.5H – (*The ASAM Criteria, 2013, pp. 244 – 264*)**

While neither the short or long-term LOC have been eliminated with the use of *The ASAM Criteria, 2013*, references to what have historically been known as: 3B: “Medically Monitored Short-Term (ST) Residential” and 3C: “Medically Monitored Long-Term (LT) Residential” will now be regarded as: “**Clinically-Managed High Intensity Rehabilitative Residential Services” 3.5R and “Clinically-Managed High Intensity Habilitative Residential Services” 3.5H to more accurately reflect *The ASAM Criteria, 2013* principles of person-centered treatment planning. Because of the multiplicity of services that exist in Pennsylvania for the 3.5 LOC, an adaptation has been made to appropriately reflect the delivery of services. (*The terms high and highest as published in the 2018 version of this document were changed to rehabilitative and habilitative in response to feedback from the field*).**

### **Clinically-Managed High Intensity Residential Services (Adult) High Intensity Rehabilitative Residential Services – Level 3.5R (*The ASAM Criteria, 2013, pp. 244 – 264*)**

1. While the distinction in delivery of services between these two types of 3.5 service exists, it is not delineated within the PA licensing regulations. Both types of care are licensed under the Chapters 709 & 711 Standards for Licensure of Freestanding Treatment Facilities. Furthermore, although programs licensed under the 709 & 711 regulations may have medical staff or access to medical staff, since the licensing regulations do not specify the requirement for medical professionals to be employed within these LOCs, both LOCs are best defined as “Clinically Managed” Residential Services as opposed to the previously defined “medically monitored”.
2. When an individual meets the admission criteria for the 3.5 LOC, the additional placement considerations that follow specifically for Pennsylvania should be made in determining the distinction between “Clinically-Managed High Intensity Rehabilitative Residential Services” (Short-Term) and “Clinically-Managed High Intensity Habilitative Residential Services” (Long-term) LOCs.
3. To be designated as a 3.5 Co-Occurring Enhanced provider (3.5E), such a designation must be assigned to a provider by virtue of being licensed as a mental health Residential Treatment Facility for Adults (RTF-A), in addition to their drug and alcohol license. Such designations have been verified and issued through the Departments of Human Services (DHS) and Drug and Alcohol Programs (DDAP).

4. For Clinically-Managed **High-Intensity Rehabilitative** Residential Services (3.5R) to be appropriate, the individual *must need rehabilitation services, rather than habilitation services* (see *The ASAM Criteria, 2013*, pp. 419 & 427 for definitions of habilitation and rehabilitation). Many persons start stabilization/treatment in High-Intensity Rehabilitative services, but after careful monitoring and further comprehensive assessment, transition to High-Intensity Habilitative services may be necessary.

### **Clinically-Managed High Intensity Habilitative Residential Services – Level 3.5H** **(*The ASAM Criteria, 2013*, pp. 244 – 264)**

1. For Clinically-Managed **High-Intensity Habilitative** Residential Services (3.5H) to be appropriate, the individual must need habilitation services, rather than rehabilitation services. (see *The ASAM Criteria, 2013*, pp. 419 & 427 for definitions of habilitation and rehabilitation). “Habilitation” as referenced and delivered within an adult SUD treatment program primarily addresses those life-skill issues identified in dimension three below and not instruction or interventions related to daily living skills such as bathing, toileting, dressing, etc.

2. While placement in the most appropriate LOC should be determined by clinical assessment and judgment, there may be court-ordered appointments to the Clinically Managed High-Intensity Habilitative Residential LOC or designated specialized “Criminal Justice” placement/residential service. Please refer to the text to more fully understand how to approach and document mandated treatment episodes. (*The ASAM Criteria, 2013*, p. 20).

3. For either LOC, Clinically Managed High-Intensity Rehabilitative or Habilitative Residential Services, when an individual has both SUD and Mental Health conditions and where there are co-occurring capable, or co-occurring enhanced services available, such would be the more appropriate type of service/referral. See “Co-Occurring SUD and MH Disorders,” p. 16 of this document.

4. Additionally, for either LOC, the length of service in treatment should be variable, and based on the continued assessment of the individual’s symptom severity and level of functioning.

5. When determining placement in a Women’s with Children Program as 3.5H (see *The ASAM Criteria, 2013*, pp. 318 – 339). Specific considerations should be evaluated as delineated on pages 15 - 17 of this guidance document.

**The distinguishing factors between 3.5R and 3.5H apply when an individual meets criterion for 3.5R, but ALSO demonstrates the following specifications:**

- **DIM 3:** The individual must meet *at least 2 of the following*:
  - a) Disordered Living Skills, i.e., lacking socially acceptable norms/coping skills; history of inability to internalize social responsibility; history of significant, consistent substance use before early adolescence.
  - b) Disordered Social Adaptiveness, i.e., history of repetitive antisocial or criminal behavior with or without incarceration; history of rebellion/denigration of acceptable societal values with disregard of authority and basic rules.
  - c) Disordered Self-Adaptiveness, i.e., persecutory fear, poor sense of self-worth, self-hatred; history of chronic external focus/seeking of external stimuli to the exclusion of developing internal supports; inability to develop supportive relationships; blaming others and difficulty/unwillingness to make decisions to effect positive changes in the circumstances that the individual regards as undesirable.
  - d) Disordered Psychological Status: i.e., history of early onset (pre-adolescence) of emotional blunting or impairment, or developmental disorders as exemplified by: lack of geographical roots, lack of healthy role-modeling opportunities, little or no opportunity for parental bonding or guidance, a pervasive history of parental enabling, gang membership, dysfunction parental modeling (such as long-term criminal behavior or other antisocial lifestyles) OR a history of significant impulsivity without due regard for potential negative consequences.
- **DIM 4:** The individual has little to no recognition that his or her SUD use is a problem or is causing a problem; requires 24-hr, directed motivational interventions to gain insight into the SUD to make behavioral changes.
- **DIM 5:** Must meet one of the following: 1) The individual demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to addiction or mental health problems and recidivism to criminal behavior. Imminent danger of relapse is accompanied by an uninterrupted cycle of relapse-reoffending-incarceration-release-relapse without the opportunity for treatment, 2) Individual is assessed to be in danger of substance use with attendant severe consequences, and is in need of 24-hour professionally directed clinical interventions and support, or 3) individual has attempted to reduce or control substance use, but has been unable to do so in his/her immediate environment.
- **DIM 6:** Must meet one of the following: 1) Individual lives in an environment which undermine his/her efforts to change or in which treatment is unlikely to succeed or 2) There is danger of physical, sexual, and/or severe emotional victimization in the individual's current environment.

### **Medically Monitored Intensive Inpatient Services – Level 3.7 (*The ASAM Criteria, 2013, pp. 265 -279*)**

1. Because of the medical staffing requirement of this LOC, Medically Monitored Residential Providers licensed under the 710 or 711 regulations will most likely qualify to deliver 3.7 services, i.e., residential treatment provided in a healthcare facility, a hospital capable of monitoring; a psychiatric hospital.
2. However, in such instances where a program licensed under the 709 regulations has the required medical staffing (most likely those that also provide withdrawal management services) and has been designated as a 3.7 by the process established by DDAP/DHS it would also meet the requirements to provide Medically Monitored Intensive Inpatient Services.
3. Designations for 3.7 may be for physical health (PH) or mental health (MH). To be designated as a 3.7 PH provider, physician access and nursing care must be available around the clock. To be designated as a 3.7 MH provider, Mental Health Professionals must be on staff around the clock in addition to medical staff and a provider must have dual licensure in SUD and mental health (inpatient or RTF-A). Such designations have been verified and issued through the Departments of Human Services (DHS) and Drug and Alcohol Programs (DDAP).

### **Medically Managed Intensive Inpatient Services – Level 4.0 (*The ASAM Criteria, 2013, pp. 280 – 289*)**

Designations for 4.0 may be for physical health (PH) or mental health (MH). To be designated as a 4.0 PH provider, physician access and nursing care must be available around the clock within a healthcare facility. To be designated as a 4.0 MH provider, the provider must have a mental health inpatient license in addition to a drug and alcohol license. Such designations have been verified and issued through the Departments of Human Services (DHS) and Drug and Alcohol Programs (DDAP).

## OTHER ASSESSMENT CONSIDERATIONS / SPECIAL POPULATIONS

### Assessment Upon Re-Entry From Incarceration (*The ASAM Criteria, 2013, pp. 350 – 356*)

1. Forced abstinence resulting from a period of incarceration does not equate to recovery and therefore an individual's SUD condition should be assessed based upon the 6 months prior to incarceration as well as in light of any clinical services received while incarceration, along with present motivation and current stage of change. While incarceration should never be a substitution for needed treatment, assessors must do a clinical assessment based on ALL 6 dimensions.

- a) While Dimension 1, Acute Intoxication and Withdrawal Potential may be low, accurate clinical assessment of the remaining Dimensions will be especially important.
- b) In assessing all dimensions, clinical attention should be in Dimension 4: "Readiness to Change", as is indicated in the criteria, the "...assessment of state of change is designated from the clinician's point of view on what the individual needs to change and accept as a condition requiring treatment."
- c) In assessing Dimension 5, "Relapse, Continued Use, or Continued Problem Potential": The clinician should "assess the need for relapse prevention services. If the person has not achieved a period of recovery from which to relapse (see definition of relapse and expanded constructs (*The ASAM Criteria, 2013, p. 52*), this dimension assesses the potential for continued use for SUD, or continue problem potential..." If an individual was untreated or undertreated during incarceration, it is clinically unlikely that forced abstinence resulted in recovery. *The ASAM Criteria, 2013* glossary defines abstinence and recovery as follows:
  - Abstinence is "intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors." (*The ASAM Criteria, 2013, p. 411*)
  - Recovery is "a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance, and surrender are useful in this process." (*The ASAM Criteria, 2013, p. 427*)

2. While it is not specifically noted in the criteria, it is implied by the information cited above, that assessors will adhere to the premise that jail time should not replace the need for clinical or support services. Rather, clinical judgment must be utilized about substance use and difficulties experienced prior to incarceration (individual history) with consideration given to

clinical interventions that may or may not have been received while incarcerated and how this impacts the assessment of risk.

3. Otherwise, *The ASAM Criteria, 2013* (pp. 350 – 356) includes consideration for SUD treatment for those who are currently incarcerated which can be utilized by assessors in the settings described.

### **Co-Occurring Substance Use and Mental Health Disorders**

1. **There is no LOC in PA that will be restricted to only individuals who have a co-occurring condition;** however, there may be *providers* that specifically serve only those with a co-occurring condition. Such programs would likely be dually licensed.

2. DDAP has historically required the assessment of co-occurring needs and appropriate referral by the SUD assessor, and follow up by the case manager. Whenever possible, individuals were to have been referred to integrated services. The transition to The ASAM Criteria brings this assessment and referral requirement to the forefront. While it may be the case that individuals who have a SUD may not have a mental health (MH) condition, and individuals who have a MH condition may not have a SUD, co-morbidity often exists and when it does, it is important that they are treated concurrently.

3. DDAP and OMHSAS recognizes that the availability of integrated services is frequently a gap in our service-delivery system and that prior efforts in strengthening co-occurring integrated care will need to be resurrected to improve services overall. Until this occurs, co-occurring disorders must be considered as part of the assessment process and referrals made accordingly: when available to a provider able to offer integrated services, to a provider that can offer co-occurring capable or co-occurring enhanced services, or to a separate behavioral health provider as individual need and available services dictates.

4. While the criteria's primary focus in DIM 3 is to assess the need for mental health services, *The ASAM Criteria, 2013* recognizes that thought disorders, anxiety, guilt and/or depression may be related to SUD problems, that are currently stable but may lead to relapse if not in a structured environment. "If the emotional, behavioral or cognitive signs and symptoms are part of addiction (e.g., mood swings because the individual is using "uppers" and "downers"), then Dimension 3 needs may be safely addressed as part of addiction treatment." (*The ASAM Criteria, 2013*, p. 45)

### **Parents or Prospective Parents Receiving Addiction Treatment Concurrently with Their Children or "Pregnant Women, Women with Children" (PWWWC), (*The ASAM Criteria, 2013*, pp. 318 – 339)**

1. As per PA Act 65 of 1993 and by way of federal substance abuse block grant (SABG) requirements, Pennsylvania has a robust system of services for pregnant women and women with children, including specialized providers offering care to these individuals. While *The ASAM Criteria, 2013* broadens the scope to include the parenting individual, Pennsylvania has few, if

any, programs that admit parenting men with their children. Nevertheless, regardless of gender, the needs of the parenting individual with a SUD should be considered at the time of assessment and recommendations/referral for treatment and appropriate supports for the individual and child should be considered, referrals made, and appropriate follow up conducted for any LOC.

2. When assessing women and women with children particular placement, considerations should be taken into account including:

- a) Parenting– as noted above. For those women in need of residential services, care should be made in referring to a program than can provide appropriate support and services for her children, including those programs that can accommodate women with their children, as well as address parenting issues.
- b) Trauma – The prevalence of trauma is very high in this population; therefore, referral should be made with consideration of this history and where trauma-informed care can be received.
- c) Medical – in addition to co-occurring issues that should be assessed as determined by the criteria, physical/health conditions, especially relevant to women, should be assessed and addressed, including by not limited to: sexually transmitted infection, obstetrical and gynecological issues (high-risk and un-intended pregnancy, abortion, rape, etc.), eating disorders, etc.

3. Many of the considerations regarding parenting or pregnant women noted above, are discussed in the Admission Criteria for Parenting or Pregnant Women (*The ASAM Criteria, 2013*, pp. 318 – 339) and in such instances, the clinician should refer to these specialized services. (Note: pregnant women and individuals who use intravenous drugs/women remain a priority population to receive services as determined by the federal SABG).

4. Additionally, it is recommended that individuals receive training in those issues that are unique to women to better assess and treat this population. SAMHSA’s Tip 51: “[Addressing the Specific Needs of Women](https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426)” (<https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426>) is a helpful resource in making placement determinations and for guiding treatment services.

### **Medication Assisted Treatment (MAT)**

1. Historically, while Pennsylvania has had licensed Narcotic Treatment Programs (NTPs, also known as Opioid Treatment Programs/OTPs), this was delivered primarily as a separate service and not embedded within the full continuum of care. In keeping with the true intent of medication as an assistance to treatment, *The ASAM Criteria, 2013* recognizes the use of medications in all levels of care across the continuum, even if the treatment provider is not the prescriber of the medication. This ensures/encourages the coordination of care between therapeutic and pharmaceutical interventions.



2. For referral to an NTP using methadone, per federal regulations (with certain exceptions), an individual must be 18+ years of age and be opioid dependent for over one year.

3. The criteria are guided by an individualized, person-centered approach to services rather than a program-driven, fixed length-of-stay model. It is DDAP's expectation that individuals will be treated according to their needs, and if medication is warranted, that the provider will ensure that the individuals' needs are met. It is imperative that providers licensed as "drug-free providers" understand the expectation that medications that are being used to address an individual's SUD be regarded similarly to other medication (insulin, beta blockers, etc.) that are not prescribed by them and do not preclude the admission of individuals on MAT into services.

4. Clinicians and programs are encouraged to reference SAMHSA's TIP 63, "[Medications for Opioid Use Disorder](https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA19-5063FULLDOC)" (<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA19-5063FULLDOC>) as well as "[The ASAM National Practice Guideline For the Use of Medication in the Treatment of Addiction Involving Opioid Use](https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf)" (<https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>).

### **Other Populations/Considerations**

1. It is of utmost importance that assessors and clinicians be appropriately trained in and aware of issues that may present with specific populations. This is true of those populations addressed above, as well as, but not limited to others such as veterans, LGBTQ individuals, adolescents, Hispanic/Latino or other cultural and language diversities that may present in the assessment or clinical setting. Such considerations may impact referrals, i.e., the most appropriate setting in which to receive care, how services should be delivered, etc.

2. In instances where there is a multiplicity of identified needs, assessors should be mindful of the need for case management services and/or recovery support services. While these may not directly impact the application of *The ASAM Criteria, 2013* such services may enhance the treatment and recovery process and facilitate the clinical experience.

3. Trauma has been experienced by many people and therefore should be a consideration in the assessment and treatment process through a trauma-informed approach.

## Guidance for Treatment Planning, Continued Stay Reviews and Discharge Planning

Intake and level of care determination is based on a comprehensive assessment of the individual to be served. It is from this initial “Level of Care Assessment” that a recommendation for treatment is made. In Pennsylvania, there have been several different strategies utilized across counties for conducting this initial assessment. Sometimes the assessment is conducted by a case management unit; elsewhere, it is completed by an independent assessment center or treating clinician within a licensed treatment facility. In all cases, once admitted to services, a therapist will build upon the initial information obtained in the Level of Care Assessment to complete a full, bio-psychosocial evaluation, upon which the treatment plan/service plan is established.

Therapeutic interventions, including counseling sessions, are based upon the treatment plan goals and objectives, which are reviewed during each counseling session and adjusted according to the individual’s progress and/or emerging treatment needs. The treatment planning process is fluid (i.e., goals and objectives are completed, adjusted, and/or added), based upon the individual’s progress or lack thereof and upon ongoing 6-dimensional assessment utilizing *The ASAM Criteria, 2013*. This ongoing process is consistent with the direction provided in the text on pages 105 -112 on Service Planning and Placement and on pages 299-306 on Continued Stay/Discharge criteria. Progress and changes to the treatment plan should be noted accordingly.

While the treatment plan should be consistently utilized and evaluated to determine ongoing appropriateness/need for services, PA regulation establishes minimum standards for formalized treatment plan updates. These regulatory minimums for treatment plan reviews remain intact, although treatment plan updates can occur more frequently than the regulations require to accurately reflect the individual’s progress.

Because of the need for clinical judgement and individualized care, DDAP is purposefully NOT articulating specific timeframes for treatment plans, continued service reviews or authorization protocols. Instead, this guidance is provided in support of the principles articulated in *The ASAM Criteria, 2013* and in anticipation of treatment plans being written in an individualized, person-centered, stage specific way. It is also expected that continued service in treatment will be clearly justified in the medical record and reflective of treatment that matches the individual’s level of functioning while meeting their needs in an effective and timely manner, regardless of the authorization process.

### **The following items provide further guidance on Treatment Plans/ Updates:**

1. Establishing a treatment plan should be in direct correlation with the needs identified by the individual being served, his or her stage of change, and be reflective of the 6-dimensional assessment utilizing *The ASAM Criteria, 2013*. Treatment plan

goals should be individualized and determined in collaboration with the person in treatment. Additionally, it is expected that goals will be developed in a manner that would assist the individual in taking measurable, specific, progressive steps through a change process.

2. Individuals should have a copy of their treatment plan and it should be referenced/reviewed as a part of the individual counseling session/therapeutic process.
3. Clinical evaluation and monitoring should be an ongoing part of the therapeutic process from admission/level of care determination through discharge and should encompass the 6 dimensions of the criteria.
4. As indicated in *The ASAM Criteria, 2013*, page 110, progress in all the dimensions should be assessed at regular intervals to ensure comprehensive and appropriate treatment. This may or may not be done as a formal update as indicated by regulation, depending upon the individual's presenting circumstances.
5. Progress and case consultation notes should reflect the current treatment plan and circumstances impacting the completion or non-completion of the individual's treatment goals and any newly identified needs—including crises.
6. Changes to the content of the treatment agenda for each individual should, at a minimum, be noted within progress notes or case consultation notes within an individual's chart. The significance of the issue should be a determining factor in making a formal update to the treatment plan.
7. When such needs and issues warrant a revision to the goals or objectives of the treatment plan, the clinician should indicate this immediately, since treatment plans are to be a fluid process to address individual needs. Formal treatment plan updates conducted with the treatment team and/or medical director may not exceed the time established by regulation specific to each type of service.
8. The requirements for conducting a formal treatment plan update are outlined in the Pennsylvania Regulations, Chapters 709.52(b), 709.82(b), 709.92(b), 709.123 (b)(2), 710.42(c), 711.52(d), 711.82(d), 711.92(d) 715.23 (d)(2), and 715.24(5)(iii). *These are minimum standards for conducting an update.*  
While Narcotic Treatment Standards for outpatient (not withdrawal management) indicate that treatment plans must be reviewed and updated as required by standards established by Chapters 709, 710 and 711, an outpatient NTP may request an exception to the timeframe for stable individuals who receive direct counseling less than twice per month (see Licensing Alert 01-14).
9. DDAP strongly recommends that providers establish and publish/maintain on file policy and procedure for the frequency of treatment plan updates reflective of *The ASAM Criteria, 2013* and in accordance with Pennsylvania regulation as noted above.

## The following provides guidance relative to formalized Continued Stay Reviews:

1. Whether or not an individual remains appropriate for the current level of care should be determined by the ongoing, clinical assessment process noted above and whether the needs identified in the treatment plan have adequately been accomplished or can continue to be addressed at that intensity of service. Clinicians are directed to follow the guidance indicated in *The ASAM Criteria, 2013*, pages 299 – 306.
2. While the treatment planning and progress noted should be the “road map” for the therapeutic process and in determining continued stay, transfer or discharge, Pennsylvania regulations do not indicate a timeline for conducting official continued stay reviews.
3. Such formal reviews as would be especially necessary for payors (SCAs, BH-MCOs, third party payors) should be dictated by clinical/medical necessity as determined by clinical assessment utilizing all 6-dimensions of the ASAM Criteria. Formal reviews should be at intervals that provide appropriate time frames to a) support meeting the needs of the individual; b) do not create an administrative burden for the clinician substantiating the need for ongoing service; and c) provide the payor with timely enough information to responsibly manage resources. (see section below on “Authorization for Payment”)

## The following provides guidance relative to Authorization for Payment by the SCA:

“Clinicians who make placement decisions are expected to amplify the criteria with their clinical judgement, their knowledge of the patient, and their knowledge of the available resources. *The ASAM Criteria, 2013* is not intended as a reimbursement guideline, but rather as a clinical guideline for making the most appropriate treatment and placement recommendation for an individual patient with a specific set of signs, symptoms, and behaviors.” (*The ASAM Criteria, 2013*, p. 17). However, the following guidelines are suggested to assist with the practical utilization of continued stay determinations related to authorizations by payors, especially SCAs.

1. DDAP understands that treatment planning and continued stay reviews should be based on the individual’s progress in treatment or lack thereof and that while this is true, authorization for payment of services using public funds has often been tied to this process.
2. In order that the authorization for payment process not be cumbersome for the provider or payor and to allow for proper fiscal management for payors, DDAP is recommending that such authorizations be issued according to the following maximum time frames as listed below:

<b>Level of Care</b>	<b>Maximum Timeframe for Authorization</b>
Outpatient (1.0)	6 months
IOP (2.0)	10 weeks
Partial Hospitalization (2.5)	10 weeks
Residential Treatment/Inpatient Non-hospital (3.1, 3.5, 3.7)	3.5 R, 3.7: 14 days initial, and every 7 days thereafter 3.1 (HWH), 3.5 H: up to 30 days initial, 30 days secondary, and every 15 days thereafter
Non-hospital Residential WM (3.7 WM) Inpatient WM (4.0)	Up to 5 days initial, and daily thereafter
NTP OP	OP- 6 months for bundled authorization OP-IOP-Fee-for-service/unbundled 6 mos. OP, 10 weeks IOP, 10 weeks PHP

2. It remains the provider's responsibility to notify the payor in a timely fashion if the clinical treatment plan update or clinical continued stay review as previously outlined in this document necessitates an extension or reduction/discontinuation of authorized payment time for service or a change in level of care.
  
3. For SCA payors: Continued stay/utilization review to substantiate authorization for payment of services may be completed by a case manager when the review is restricted to a clinical decision made by the case manager and where fund-management and the actual authorization of funds being issued is being managed by a separate person, such as a fiscal officer or SCA Administrator. If the function of utilization review is conducted by the same SCA staff doing fund-management, the restrictions of 4 Pa. Code §255.5 apply and content of the review is restricted to the 5 elements permissible by the regulation.

## ASAM Crosswalk with PA's System of Care - August 2019

	LOC ASAM Criteria	Adult ASAM LOC Name	ASAM Program Description Summary for Adults	ASAM Adol LOC Services	PA Service Equivalent Adult	Licensed Program/Regulation	PCPC
WITHDRAWAL MANAGEMENT	1 WM Withdrawal Management p. 132 <sup>i</sup>	Ambulatory Withdrawal Management (WM)	Outpatient WM: without extended on-site monitoring	p. 128	OBOTs; OTP/NTP - See Application Guidance Document	715; 709	N/A
	2 WM p. 134	Ambulatory WM	Outpatient WM: with extended on-site monitoring	p. 128	OBOTs; OTP/NTP - See Application Guidance Document	715, 709	N/A
	3.2 WM p. 137	Clinically Managed Residential WM	Clinically Managed "Social setting program"; Managed by clinicians; NOT medical staff	p. 128	See Application Guidance Document	709	N/A
	3.7 WM p. 139	Medically Monitored Inpatient WM	"Freestanding WM center"; 24-hour observation and availability of medical staff	p. 128	Non-hospital residential detoxification	709; 711	3A
	4 WM p. 141	Medically Managed Intensive Inpatient WM	Acute care or psychiatric hospital unit; Availability of specialized medical consultation; full medical acute care; ICU as needed	p. 128	Hospital-based detoxification	710	4A
LEVELS OF CARE	0.5 p. 179	Early Intervention	An intervention program for individuals who do not meet diagnostic criteria of a SUD	.5	Early intervention	N/A	.5
	1 p. 184	Outpatient Services	<9 hours regularly scheduled sessions per week	1	OP	709; 711	1A
	2.1 p. 196	IOP Services	9 to 19 hours of structured programming per week	2.1	Intensive OP	709; 711	1B
	2.5 p. 208	PHP Services	20+ hours of clinically intensive programming per week	2.5	Partial hospitalization programs	709; 711	2A
	3.1 p. 222	Clinically Managed Low-intensity Residential	Halfway house, group home or other supportive living environment w/24-hour staff and integration with clinical services	3.1	Halfway house (see Application Guidance Doc)	709	2B
	3.3 p. 234	Clinically Managed, Population-specific, High-intensity Residential	Therapeutic rehab or TBI program; combination of low-intensity rehab services to meet (primarily cognitive) functional limitations so great to prohibit participation in OP or other LOCs	--	See Application Guidance Document	--	--
	3.5 p. 244	Clinically Managed, High-intensity Residential Services	24-hour supportive treatment environment	3.5	Non-hospital residential Tx or Tx offered in criminal justice-related (See Application Guidance Document)	709; 711	3B; 3C
	3.7 p. 265	Medically Monitored Intensive Inpatient Services	Inpatient treatment within an acute hospital, psych center, or freestanding residential facility; designed to meet functional limitations in Dim 1, 2, 3 (w/d, asthma, diabetes, etc., i.e. admission based on co-morbidity of medical or psych); physician monitoring; nursing care; additional medical specialty; psych services; clinical staff & daily clinical services; co-occurring enhanced program	3.7	Res Tx provided in a healthcare facility or hospital capable of medical monitoring, or psych hospital with D&A license, or free-standing psych hospitals	709 <sup>ii</sup> ; 710; 711	3B
	4 p. 280	Medically Managed Intensive Inpatient Services	Services delivered in an acute care inpatient setting; for patients whose biomedical, emotional, behavioral, cognitive problems are so severe that they require primary medical and nursing care	4	Hospital-based residential inpatient	710	4B
	Opioid Treatment Services (OTS) p. 290	OTS (Opioid Treatment Services)	Agonist and antagonist meds in OTP and OBOT setting	--	NTPs; OBOTs-See Application Guidance Document	ALL LOCs	--

<sup>i</sup> Page numbers are found in the American Society of Addiction Medicine (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Carson City, NV: The Change Companies<sup>®</sup>.  
<sup>ii</sup> in some instances where appropriate medical staffing exists (as per Licensing Alert 3-02), these services may be provided by a program licensed as a 709.