

DDAP ASAM Criteria Guidance Regarding Treatment Planning, Continued Service and Transfer/Discharge Criteria
(2-28-19 rev 3-13-19)

As has historically been the practice within our system and continues to be the case with the transition to the ASAM Criteria, 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. This ongoing process is consistent with the direction provided in the ASAM Criteria, 2013¹ on pages 105 -112 regarding Service Planning and on pages 299-306 regarding 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 clients’ progress.

At this point in our transition, DDAP is purposefully NOT articulating specific time frames for treatment plans, continued stay reviews or authorization protocols. We recognize that change is a process, and we are offering this guidance in support of the principles articulated in the ASAM Criteria, and in anticipation of the time ahead when treatment plans will be written in an individualized, person-centered, stage specific way. It is also anticipated that continued stays 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.

We are working toward the day that our SCA’s, BH-MCO’s and provider organizations are able to make adaptations, adjust their policies & procedures, and can fully implement the principles outlined in the ASAM Criteria, to the benefit of the persons we serve.

¹ Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies®, 2013.

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The following items provide further guidance regarding **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. 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 ASAM 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 client 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 clients who receive direct counseling less than twice per month (see Licensing Alert 01-14).

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9. DDAP strongly recommends that providers establish and publish/maintain on file policy and procedure for the frequency of treatment plan updates with respect to the ASAM Criteria's guidance 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 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 specifically 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 timeframes 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”)
4. With the ongoing transition and more complete integration of the ASAM Criteria application, more specific timeframes for completing formal continued stay reviews may be delineated by DDAP in the future. However, until the time that such may occur, providers and SCAs/BH-MCOs should collaborate to determine a protocol that satisfies all the considerations noted in item #3 above.

The following provides guidance relative to **Authorization for Payment**:

“The ASAM Criteria 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.” (p.17, The ASAM Criteria, 3rd edition). However, the following guideline are suggested to assist with the practical utilization of continued stay determinations related to authorizations by payors.

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.

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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 timeframes as listed below:

Level of Care	Maximum Timeframe for Authorization
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)	3.7, 3.5 R (ST) 14 days initial, and every 7 days thereafter 3.7, 3.1 (HWH), 3.5 H (LT), 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

3. 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.
4. 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.