COLORADO

Department of Health Care Policy & Financing

FY 2023–2024 Inpatient and Residential Substance Use Disorder Service Denial Determination Analysis

January 2024

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary 1
Purpose 1
Findings, Conclusions, and Recommendations 2

2. Background and Methodology 4
Background 4
Methodology 5

3. Overall Results 9
Results 9
Overarching Strengths 12
Additional Findings 12
Recommendations 13

1. Executive Summary

Purpose

Pursuant to Senate Bill 21-137 and the resultant changes to the Colorado Revised Statutes (10 Code of Colorado Regulations [CCR] 25.5-5-425), Health Services Advisory Group, Inc. (HSAG) conducted an audit of 33 percent of all denials of authorization requests for inpatient and residential substance use disorder (SUD) treatment for each of Colorado's Medicaid managed care entities (MCEs). The purpose of the audit was to determine whether the MCEs properly followed the American Society of Addiction Medicine (ASAM) criteria when making denial determinations and to provide recommendations to the Department of Health Care Policy & Financing (the Department) for program improvement.

The recommendations contained within this report are a product of an audit conducted by HSAG pursuant to Senate Bill 21-137 and the resultant changes to the CCR 25.5-5-425 and should not be construed as recommendations or specific opinions of the Colorado's Governor's Office, Office of State Planning and Budgeting, the Department, or other state agencies.

During the fiscal year (FY) 2022–2023 inaugural year for this audit, HSAG used the services of a subcontractor for the clinical review portions of the audit. HSAG instructed the subcontractor to review the final denial determination by the MCEs for agreement or disagreement. For this year's audit, HSAG hired and used in-house ASAM specialists and, at the direction of the Department, used a targeted sampling technique to include 100 percent of Special Connections members, members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, and older adults (ages 65 years and older), collectively referred to as the special populations. HSAG's sampling strategy capped administrative denials at 10 percent of the total sample and continued to ensure representation of providers and the level of care requested to focus on these special populations and medical necessity cases for which ASAM criteria are applicable. An example of an administrative denial is an untimely provider request, and an example of a medical necessity denial is a case in which documentation clearly shows that a less restrictive level of care is more appropriate to meet the member's need.

In addition, in FY 2023–2024, HSAG added a review component to determine whether the proper ASAM criteria were used by the MCE (i.e., population-specific or level of care specific criteria within ASAM) and whether the specific criteria were applied properly to further evaluate the MCE's ability to effectively use the ASAM level of care criteria for prior and continued stay authorization determinations. Due to the difference in sampling and review methodologies, HSAG cautions that comparisons between FY 2023–2024 and FY 2022–2023 results should not be made.

The sample included 35 Special Connections members and four older adults. While the sample included no adolescent members (defined as 17 years of age and younger), the sample included six members ages 18 to 20 years for whom EPSDT considerations should have been applied. See Section 2 of this report for the background and methodology used for conducting the audit.

Findings, Conclusions, and Recommendations

The MCEs reported to HSAG a total of 12,835 inpatient and residential SUD service requests, of which 887 were denials, for an overall denial rate of 6.9 percent and a rate of medical necessity denials (676 denials) of 5.3 percent. HSAG noted that the number of denials the MCEs self-reported for this project was not consistent with the number of denials reported to the Department by the MCEs for additional Senate Bill 21-137 reporting. HSAG reviewed a total of 313 cases; 34 administrative denials (10.9 percent) and 279 cases that were reviewed for medical necessity (89.1 percent). Of the 279 cases reviewed for medical necessity, 97 were initial reviews and 216 were continued stay reviews, resulting in 69.0 percent of HSAG's sample being continued stay denials, while 62.7 percent of all denials statewide were continued stay denials. The slight difference in the percentage of continued denials between the statewide total percentage and the HSAG sample may be related to targeted sampling of the special populations. It is important to note that when reviewing continued stay requests, utilization review (UR) documentation submitted indicated that the MCEs frequently used the *Dimensional Admissions* criteria and *Risk Ratings* without the use of *Continued Service* or *Transfer/Discharge* criteria. Both the ASAM *Continued Service* and *Transfer/Discharge* criteria require a review of the member's treatment plan and progress made toward treatment goals; however, guidance provided by the Department to the MCEs in the summer of 2021 instructed the MCEs to consider all clinical documentation that described progress toward treatment goals in place of treatment plans, when necessary, to avoid additional administrative burden to providers. To duplicate the MCEs' process as directed by the Department, HSAG also considered any clinical documentation available in lieu of treatment plans if a treatment plan was not included in the file submission. HSAG notes that this process does not align with the use of ASAM criteria to fidelity.

Using the case documentation furnished by the providers to the MCEs, HSAG agreed that the MCEs selected and appropriately implemented the proper ASAM criteria in 235 of the 279 medical necessity cases, or 84 percent. However, HSAG found that in many cases documentation by providers was inadequate. HSAG agreed with the denial decisions made by each MCE for 243, or 87 percent, of the medical necessity cases reviewed. See Section 3 for additional detailed findings.

Overall, HSAG recommends that the Department:

- Encourage standardized training for the MCEs, continue its provider stakeholder meetings that offer ongoing technical assistance, and enhance monitoring to ensure adherence to the ASAM criteria, which may impact appropriate access to services for the right care, at the right place, and at the right time.
- Encourage training for MCE UM staff members and providers regarding the appropriate ASAM criteria (e.g., admissions or continued stay, older adult, and adolescent) and minimum documentation required based on the type of review, level of care, and special population considerations.
- Revise its guidance to the MCEs regarding allowing denials without requesting treatment plans for continued stay reviews. The use of treatment plans in continued stay, transfer, and discharge determinations is an important component of using the ASAM level of care placement criteria to fidelity.

- Provide the MCEs with a universal definition of administrative denials and medical necessity denials to use for all projects and deliverables to the Department and its vendors. Included in this definition should be a defined set of administrative and medical necessity denial reasons, and a time frame for what constitutes a late submission that may lead to an administrative denial.

2. Background and Methodology

Background

Beginning January 2021, the Department added SUD inpatient hospital and residential state plan benefits to the Regional Accountable Entity (RAE) and Medicaid managed care organization (MCO) capitated contracts. Pursuant to Senate Bill 21-137 Section 11, which states, "No later than July 1, 2022, the State Department shall contract with an independent third-party vendor to audit 33 percent of all denials of authorization for inpatient hospital and residential SUD treatment for each MCE,"[2-1] the Department contracted with HSAG, an external quality review organization (EQRO), to conduct the required audit. The requested scope of work was to overread a sample of UR denial determinations for SUD inpatient hospital and residential levels of care (LOCs), using ASAM LOCs, made by Colorado's seven RAEs and one MCO providing behavioral health services (collectively referred to as "MCEs"), for which the determinations resulted in a denial or partial denial of the requested service.

The eight MCEs consist of the seven RAEs (RAE 1, Rocky Mountain Health Plans [RMHP]; RAE 2, Northeast Health Partners [NHP]; RAE 3, Colorado Access [COA]; RAE 4, Health Colorado, Inc. [HCI]; RAE 5, COA; RAE 6 and RAE 7, Colorado Community Health Alliance [CCHA]) and the one MCO (Denver Health Medical Plan [DHMP]).

Table 2-1 displays the ASAM LOC, title, and description for each LOC reviewed during the audit.

Table 2-1—ASAM LOCs

LOC	Title	Description
3.1	Clinically managed low-intensity residential	24-hour structure with available trained personnel; at least five hours of clinical service/week
3.2WM	Clinically managed residential withdrawal management (WM)	Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery
3.5	Clinically managed high-intensity residential (adult criteria)	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment; able to tolerate and use full active milieu or therapeutic community

[2-1] Senate Bill 21-137. Section 11, 25.5-5-425, page 8. Available at: https://leg.colorado.gov/sites/default/files/2021a_137_signed.pdf. Accessed on: July 20, 2023.

LOC	Title	Description
3.5	Clinically managed medium-intensity residential (adolescent criteria)	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment; able to tolerate and use full active milieu or therapeutic community
3.7	Medically monitored intensive inpatient (adult criteria)	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3; 16 hours/day counselor availability
3.7	Medically monitored high-intensity inpatient (adolescent criteria)	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3; 16 hours/day counselor availability
3.7WM	Medically monitored inpatient WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring

Methodology

HSAG's assessment occurred in four phases:

1. Document request
2. Targeted sampling
3. UR over-read
4. Analysis and report development

Document Request

HSAG requested a data file from each MCE to obtain a list of all denials for inpatient hospital and residential levels of SUD treatment among MCE members. HSAG requested that the data file include one record per denial during the measurement period (FY 2022–2023), with the following minimum data fields:

- Member name
- Member date of birth (DOB)
- Member identification (ID) number
- Date of service request
- Date of determination
- MCE identifier number
- Requesting facility (provider) name
- Requesting facility National Provider Identifier (NPI) number
- ASAM LOC requested

- Length of stay (LOS) requested
- Determination (e.g., denied, partial denial)
- ASAM LOC approved (if an alternate LOC was approved)
- Denial type (e.g., administrative, medical necessity, or technical)
- Denial reason (e.g., not medically necessary, out-of-network provider, insufficient information)
- Whether or not the denial was appealed, went to a State fair hearing, and the outcome

Sampling Plan

Upon receiving the list of all denials from the MCEs, HSAG reviewed key data fields to assess potential duplication; data completeness; and the distribution of denials by MCE, facility, and ASAM LOC. HSAG used the listing of all denied services for inpatient hospital and residential SUD treatment as a sample frame from which to generate a sample list of cases for each MCE for the over-read activities.

HSAG used a random sampling approach to select no less than 33 percent of denials that occurred per MCE, based on the number of unique denials for inpatient hospital and residential SUD treatment in the sample frame for each MCE. HSAG ensured that the sample cases reflected the widest possible array of denials among facilities, ASAM LOCs, and members. In FY 2023–2024, special sampling parameters were added to focus on adolescent, older adult, and Special Connections members. Special Connections is a program for pregnant and parenting members (within one year after delivery). Administrative denials were included but capped at 10 percent of each sample while ensuring all ASAM levels of care were represented. Administrative denials were capped to allow for an in-depth review of medical necessity cases, as ASAM criteria agreement is not applicable to administrative denials. HSAG noted slight variance in how the MCEs defined administrative denials, which could result in an unintended variation in the percentages of medical necessity cases among the MCEs. Comparisons of the MCEs' percentages of medical necessity and administrative denials should be approached with caution.

Before sampling, HSAG counted the number of denials by MCE for inpatient hospital and residential SUD treatment and determined the number of cases needed to meet the 33 percent requirement. Fractional numbers were rounded up to the nearest whole number of cases to ensure a minimum of 33 percent of denials were reviewed.

HSAG then randomly selected a representative sample of denials for each MCE using the number of sample cases identified in the sample size determination. Cases were then proportionately distributed based on the number of denials within each LOC. For example, if 28 percent of an MCE's denials were attributed to the 3.1 ASAM LOC, 28 percent of the MCE's cases chosen for over-read reflected denials attributed to the 3.1 ASAM LOC.

After compiling all sampled cases into a single sample denial list per MCE, HSAG assessed the distribution of sampled facilities by MCE, LOC, and members to ensure that sampled denial cases represented the requesting facilities and members present in the sample frame. When necessary, HSAG drew oversample denial cases during the sampling phase and replaced initially sampled cases with oversample cases to ensure representation from the greatest possible number of SUD treatment facilities.

Utilization Review Documentation

HSAG provided the sample denial lists to each MCE and requested a complete file for each case that included:

- Documentation of when the request for service was received, description of the request, member status, and need.
- Documentation of when the denial determination was made.
- Result of the review (i.e., denied, partial, or limited approval).
- When verbal and/or written notice of adverse benefit determination (NABD) was provided to the member and to the provider.
- Copies of written NABD.
- Copies of information the MCE used to make the UR denial determination, including notes from each reviewer; dates of each review; system notes associated with each point of the review; and documentation of telephonic and/or written communication between reviewers and UR staff, providers, members, and/or authorized representatives.
- Copies of all medical records and related documents used for making the determination.
- Documentation of how the MCE considered each ASAM dimension using the most recent edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* when determining medical necessity. The third edition was used for this review due to the FY 2022–2023 time frame of denial samples.
- Documentation as to whether medication-assisted treatment (MAT) was provided as part of the treatment provided.
- Credentials of the MCE reviewer who made the denial determination.

HSAG Review Elements

Using the documentation provided by the MCEs, HSAG determined:

- Whether the MCE reviewer selected the appropriate criteria for the level of care and population (e.g., admissions or continued stay, adult-specific criteria, adolescent-specific criteria, and population-specific criteria for older adults or Special Connections members). Based on the Department's direction, HSAG reviewed for treatment plans or equivalent documentation.
- Whether the MCE reviewer applied the chosen criteria correctly (e.g., following the level-specific criteria or considering interdimensional interactions and comorbidities).
- Whether the information found in the medical records and related documents was sufficient to make an independent UR determination regarding the appropriateness of the prior-authorization request and the accuracy of the MCE determination.
- Whether the UR determination was made within the required time frame.
- Whether the HSAG reviewer agreed/disagreed with the MCE denial determination.

- Whether clinical denial determinations were made by an MCE reviewer with appropriate credentials (i.e., doctor of medicine [MD], doctor of osteopathic medicine [DO], or PhD) and expertise in treating the member's condition.
- Whether potential quality of care (QOC) concerns were documented in the case file.

The HSAG review team was led by a licensed professional counselor (LPC), with over six years of direct clinical experience in addiction treatment settings, who is a current PhD candidate in the field of counselor education and supervision with a specialization in addiction counseling as well as a trained ASAM Implementation Leader.

The physician reviewer who completed the second level reviews is an MD ASAM Fellow, is board certified by the American Board of Psychiatry and Neurology, and is an American Board of Addiction Medicine Diplomate. The physician reviewer's experience includes more than 30 years in the health care field directing large-scale health system addiction medicine treatment programs across eight states, working as a staff addiction psychiatrist and chief medical officer, and founding an addiction outreach and recovery clinic.

The review team consisted of LPCs with extensive training and at least eight years of experience working with ASAM criteria in a variety of settings. All reviewers had clinical experience treating SUD and were trained by ASAM and The Change Company in using ASAM LOC criteria for UR determination. HSAG chose the review team based on specific experience conducting UM prior-authorization reviews in another state using ASAM LOC criteria. HSAG reviewers used a two-step process; if the HSAG reviewer disagreed with the MCE's use of ASAM criteria or the final denial determination, the reviewer referred the case to the MD for a final determination of agreement or disagreement with the MCE's proper use of the ASAM criteria and agreement or disagreement with the MCE's denial determination. HSAG reviewers documented results of each review in a format approved by the Department.

Using an interrater reliability process, HSAG sampled 10 percent of the total sample records reviewed to ensure 95 percent overall accuracy was maintained throughout the audit.

Analysis and Report Development

HSAG analyzed the sample record review findings to determine if trends existed for each MCE as well as across the eight MCEs. Topics considered in this analysis included:

- Rate of HSAG reviewer agreement with the use of ASAM criteria.
- Rate of HSAG reviewer agreement with MCE denial determinations.
- Potential QOC concerns.

This report contains the results of the analysis.

3. Overall Results

Out of the 12,835 inpatient and residential SUD service requests from all MCEs, 887 were denials. The results in this section provide an overview across the eight MCEs and 313 sample denial determinations for SUD inpatient hospital and residential services. Of the 313 sample denial determinations, 97 were initial reviews and 216 were continued stay reviews. Of the 313 sample denial determinations, 279 cases were medical necessity denials that were reviewed for adherence to ASAM criteria and agreement with denial determinations. This sample included 35 cases that were Special Connections, six were EPSDT eligible, and four were older adults (ages 65 years and older). These special populations require utilization of population-specific criteria, which resulted in disagreement determinations by HSAG. The results below will provide an overview of whether the:

1. MCEs selected and properly utilized appropriate ASAM criteria for the population and level of care requested (e.g., admissions or continued stay, adult, adolescent, older adult, or pregnant and parenting) when making denial determinations for SUD inpatient hospital and residential LOCs.
2. HSAG reviewers agreed with the denial decision made by each MCE.

Results

1. Adherence to ASAM Criteria for Denial Determinations

Table 3-1 shows the number of MCE denials in the sample and the adjusted number of denials in the sample compared to the number of the denials for which the MCE appropriately applied ASAM criteria.

Table 3-1—MCE Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
RAE 1	40	40	36	90%
RAE 2	26	22	15	68%
RAE 3	40	35	32	91%
RAE 4	92	83	61	73%
RAE 5	25	20	19	95%
RAE 6	42	38	34	89%
RAE 7	35	29	27	93%
DHMP	13	12	11	92%

MCE	Number of MCE Denials in Sample	Number of Medical Necessity Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Appropriately Applied ASAM Criteria
Total	**313**	**279**[1]	**235**	**84%**

[1] 34 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 279.

Based on the documentation provided by the MCEs, HSAG reviewers determined that in 84 percent of applicable sample denials the MCEs followed the Department's guidance related to the selection and implementation of the ASAM criteria for the population and level of care requested. For example, use of admissions versus continued stay criteria and considerations for special populations (e.g., adult, adolescent, older adult, or pregnant and parenting). Out of the eight MCEs, RAE 5 demonstrated the highest level of adherence with ASAM criteria (95 percent agreement), whereas RAE 2 demonstrated the lowest adherence with ASAM criteria (68 percent agreement).

When reviewing continued stay requests, UR documentation submitted indicated that the MCEs frequently used the *Dimensional Admissions* criteria and *Risk Ratings* without the use of *Continued Service* or *Transfer/Discharge* criteria. Both the *Continued Service* and *Transfer/Discharge* criteria require a review of the member's treatment plan and progress made toward treatment goals. Although treatment plans were not submitted by the providers or requested by the MCEs in a majority of cases reviewed, the Department's guidance allowed for equivalent documentation that shows progress toward the member's goal(s) to be considered acceptable in the place of a treatment plan.

Several of the MCEs demonstrated inconsistencies in documenting denial determinations for 3.7 and 3.7WM levels of care, often using the terms interchangeably. HSAG cautions the MCEs that did not clearly and consistently document these levels of care correctly as the criteria for each level of care varies greatly from the other.

2. Agreement With MCE Denial Determination

Table 3-2 displays the number of MCE denials in the sample compared to the number of denials for which HSAG agreed with the MCE decision.

Table 3-2—MCE Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of Medical Necessity Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
RAE 1	40	36	90%
RAE 2	22	16	73%
RAE 3	35	34	97%
RAE 4	83	62	75%
RAE 5	20	20	100%
RAE 6	38	36	95%
RAE 7	29	28	97%
DHMP	12	11	92%
Total	**279**[1]	**243**	**87%**

[1] 34 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 279.

HSAG reviewers agreed with the denial decisions made by the MCEs for 87 percent of denials. In many cases, HSAG reviewers agreed with the MCEs' denials due to the lack of adequate clinical documentation to prove medical necessity as opposed to agreeing with a denial determination in which the clinical documentation clearly proved that appropriate care could be provided at a lower level of care. HSAG agreed most frequently with RAE 5 and least frequently with RAE 2.

In many instances where HSAG reviewers disagreed with the MCE's denial determination, the MCE's UM reviewers did not consistently consider interdimensional interactions and co-occurring problems when making determinations. While the *Dimensional Admissions* criteria are foundational to the ASAM criteria, in order to truly implement the spirit and content of the ASAM criteria, it is important to consider the individual needs of each member to "amplify the criteria with their clinical judgement, their knowledge of the patient, and their knowledge of the available resources" to ensure the most appropriate determination for each individual member.[3-1]

UM reviewers often justified denial of 3.1 and 3.5 levels of care by stating that members were stabilized in Dimensions 1–3 and should be transferred to a lower level of care. However, according to the *Dimensional Admissions* criteria for each of these levels of care in the third edition of *The ASAM Criteria*, stabilization in those dimensions is an admissions requirement for these levels. In these instances, MCE UM reviewers did not appropriately consider the member's risk in Dimensions 4–6, resulting in HSAG disagreement with the MCE's denial determinations.

[3-1] Mee-Lee D, Shulman GD, Fishman MJ, et al., eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. American Society of Addiction Medicine; 2013: 17.

Overarching Strengths

HSAG identified the following overarching strengths in processing denials for inpatient hospital and residential SUD services across the MCEs:

- RAE 5 demonstrated the most consistent application of ASAM criteria with 95 percent agreement and 100 percent agreement with denial decisions.
- RAE 1, RAE 3, RAE 5, RAE 7, and DHMP were all high in HSAG reviewer agreement at 90 percent or above.
- RAE 1 included specific member recommendations for alternative treatment locations within its NABDs.
- RAE 1 was the most consistent MCE to document approved alternative levels of care. HSAG recognizes this as a best practice.
- RAE 6 and RAE 7 clearly communicated the definition of an administrative denial and the time frame for submission for prior-authorization requests in their policies and procedures, as well as in their provider manuals.
- RAE 3 and RAE 5 used *The ASAM Criteria Navigator* from InterQual in some of their cases, which HSAG recognizes as a best practice.
- RAE 3 and RAE 5 exhibited best practices with review criteria that included the individual member's needs.

Additional Findings

- Out of the cases reviewed, 15 cases indicated potential quality of care concerns that included, but were not limited to, the following:
  - One case lacked consideration of co-occurring disorders that have a high risk for harm to the member, specifically an untreated eating disorder.
  - Three instances in which members had significant biomedical concerns, including severely elevated blood pressure, and were still denied coverage at a medically managed level of care.
  - Three issues related to safety planning and possible suicide or other harmful mental health concerns.
  - Lack of documentation regarding the provision of or accommodation for disability.
  - Potential harm to a child when discharging a mother and child with an active child services investigation.
- Out of the cases reviewed, 11 cases indicated potential overutilization or underutilization.
  - Seven of those cases noted possible overutilization.
  - Four cases indicated a potential for underutilization.
- MAT was documented in 176 of the sample cases and not used in 97 of the cases; and the 40 remaining cases were unknown if MAT was used. While this information was requested from the

MCEs in the desk request, the information was supplemented for RAE 6 and RAE 7 by HSAG reviewers as these RAEs were not able to provide these details from their UM system.

- While no adolescent members (e.g., ages 18 years and younger) were included in the denial universe, it should be noted that there are specific criteria to be used when making level of care determinations for this population.
- Special Connections members (pregnant and parenting individuals up to one year postpartum) have specific *Dimensional Admissions* criteria to be considered alongside the level of care specific criteria to make the most appropriate determination for this population. These considerations were not applied in 15 of the 18 medical necessity cases reviewed for Special Connections members in the denial samples. Not implementing these population-specific criteria not only put the members at risk, but also put their children at risk.

Recommendations

Related to adherence to ASAM criteria, HSAG suggests that the Department provide standardized training for the MCEs, continue its provider stakeholder meetings which offer ongoing technical assistance, enhance monitoring to ensure adherence to the ASAM criteria and ASAM best practices, and identify any issues that need to be addressed with individual MCEs that impact appropriate access to services for the right care, at the right place, and at the right time. Specifically, HSAG suggests that the Department encourage MCEs to provide training to UM staff members and providers regarding:

- The appropriate criteria to use based on type of review, level of care, and special population considerations.
- The implementation of adolescent criteria, when appropriate.
- The use of the *Older Adult Dimensional Admissions* criteria to ensure proper placement of the aging population.
- How to incorporate the *Dimensional Considerations for Parents or Prospective Parents Receiving Addiction Treatment Concurrently with Their Children* in order to reduce the risk for harm to members and their dependents. When training, the MCEs should place additional emphasis on the importance of provider documentation regarding Special Connections members and MCE considerations.
- The importance of making placement decisions which "amplify the criteria with their clinical judgement, their knowledge of the patient, and their knowledge of the available resources" to ensure the most appropriate determination for each individual member.[3-2]
- Increased attention to detail and consistency for requests at 3.7 and 3.7WM levels of care to ensure proper criteria are used for decision making.

[3-2] Mee-Lee D, Shulman GD, Fishman MJ, et al., eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. American Society of Addiction Medicine; 2013: 17.

- When applicable, emphasizing the best practice of seeking additional information from the requesting provider to document treatment plans or equivalent clinical documentation that demonstrates the member's progress toward the member's treatment goal(s).

HSAG recommends that the Department consider these additional opportunities for improvement:

- Provide the MCEs with a universal definition of administrative denials and medical necessity denials as well as a defined subset of administrative denial and medical necessity denial reasons. This update would improve data analysis and trending capabilities across MCEs and align with the Department's efforts to develop a denial dashboard.
- Set a standard timeline for the provider to submit an authorization request and define what constitutes a late submission that may lead to an administrative denial. This update would reduce confusion among providers who interface with multiple MCEs.
- Encourage the MCEs to use extensions if additional information is needed from the requesting provider, when it is in the best interest of the member.
- Require the MCEs to use treatment plans as a part of the continued service reviews to improve compliance with ASAM criteria and best practices.
- Encourage the MCEs to review facilities with a high volume of denials and identify opportunities for improvement regarding timeliness of submission (if administrative denials are high) and consider additional checklists and training for facilities if documentation is lacking to determine medical necessity.
- If a member is continuing MAT after discharge, consider referral to care managers to help coordinate follow-up care to provide continuity of care and reduce potential relapse triggers.
- Encourage MCEs to consider the member's interdimensional interactions and member-specific concerns in level of care determinations.
- Require MCEs to include specific UM system documentation regarding the implementation of EPSDT criteria prior to issuing a denial determination.