COLORADO

Department of Health Care Policy & Financing

FY 2024–2025 Inpatient and Residential Substance Use Disorder Service Denial Determination Analysis

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

HSAG HEALTH SERVICES ADVISORY GROUP

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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.

HSAG used in-house ASAM specialists and, at the direction of the Department, included 100 percent of Special Connections or pregnant/postpartum members, adolescent members (ages 17 years and younger) 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 ensured representation of providers, initial and continued authorization requests, and the level of care (LOC) 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 shows that a less restrictive LOC is more appropriate to meet the member's need.

This sample included 25 cases that were Special Connections, three additional cases that were pregnant or postpartum (defined as less than one year post-delivery), three cases that were adolescents (ages 17 years and younger), eight cases that were Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible (ages 20 years and younger), and no cases in the denial universe or sample that were older adults (ages 65 years and older). See Section 2 of this report for the background and methodology used for conducting the audit.

Findings, Conclusions, and Recommendations

The MCEs reported a total of 18,019 inpatient and residential SUD service requests, of which 1,148 were denials, for an overall denial rate of 6.4 percent and a rate of medical necessity denials (1,043 denials) of 5.8 percent. HSAG reviewed a total of 385 cases, of which 21 were administrative denials (5.5 percent) and 364 cases were reviewed for medical necessity (94.5 percent). Of the 364 cases reviewed for medical necessity, 79 were initial or retrospective reviews and 285 were continued stay reviews, resulting in 78 percent of HSAG's medical necessity sample being continued stay denials,

while 69 percent of all denials statewide were continued stay denials. It is important to note that the ASAM third edition criteria require a review of the member's treatment plan and progress made toward treatment goals for both the ASAM *Continued Service* and *Transfer/Discharge* determinations. While the Department updated its ASAM training and guidance to MCEs to require treatment plans for *Continued Service* and *Transfer/Discharge* reviews during FY 2024–2025, the review period included records from FY 2023–2024 when the Department guidance to the MCEs was to consider all clinical documentation that described progress toward treatment goals in place of treatment plans, when necessary, to avoid additional administrative burden on 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 recognizes the Department's efforts over the past year to align the MCE's implementation 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 329 of the 364 medical necessity cases, or 90.4 percent. HSAG agreed with the denial decisions made by each MCE for 329, or 90.4 percent, of the medical necessity cases reviewed.

Several of the MCEs demonstrated inconsistencies in documenting denial determinations for 3.7 (Medically monitored intensive inpatient, adult) and 3.7WM (Medically monitored inpatient withdrawal management) levels of care, using the terms interchangeably in these instances. HSAG cautions the MCEs that did not clearly and consistently document these levels of care correctly as the criteria for each level of care vary greatly from the other. Additionally, of the 27 medical necessity determinations reviewed for pregnant and parenting members, HSAG reviewers only agreed with 12 of the MCE denials, or 44 percent. Moreover, clinical documentation of the members' pregnancy or parenting situation, or evidence that the MCEs requested additional information relevant to the Special Connections population, was not present in 26 of the 27 denials. See Section 3 for additional detailed findings.

HSAG uses the following icons to identify opportunities related to quality (), timeliness (), and access ().

Overall, HSAG recommends that the Department:

- Require MCEs to complete the Department-provided ASAM standardized training related to the selection, implementation, and documentation of the appropriate ASAM criteria for the specific population level of care and type of review, 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.
- Provide additional training for all MCE utilization management (UM) staff related to the selection, implementation, and documentation of the appropriate ASAM criteria for the specific population, level of care, and type of review.

- Consider increased oversight and monitoring (e.g., clinical review) of 3.7 and 3.7WM service requests and decisions to ensure the appropriate criteria are being used and documented appropriately for these levels of care.
- Provide the MCEs with ongoing training to clarify expectations for the utilization and documentation of ASAM's population-specific criteria for pregnant and parenting members, including the Special Connections population to ensure the safety and wellbeing of both the mothers seeking treatment and their children.
- 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,"[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 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

[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 2023–2024), with the following minimum data fields:

- MCE identifier number
- Date of adverse benefit determination
- Extension
- Denial type (e.g., administrative, medical necessity, or technical)
- Denial reason (e.g., not medically necessary, out-of-network provider, insufficient information)
- First-level UM staff (first and last name)
- First-level UM staff credentials
- UM staff who made the final determination (first and last name)
- UM final decision-maker credentials

- Member name
- Member date of birth (DOB)
- Member identification (ID) number
- Member's race and ethnicity
- Special Connections status
- Pregnant/postpartum status
- Member's diagnosis code
- Member's diagnosis description
- Date of service request
- Requesting facility (provider) name and address
- Requesting facility National Provider Identifier (NPI) number
- Initial or continued stay review
- ASAM criteria used
- ASAM LOC requested
- ASAM LOC approved (if an alternate LOC was approved)
- Length of stay (LOS) requested
- LOS approved
- Medication-assisted treatment (MAT) provided
- 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, initial or continued stay reviews, 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). The special population sampling parameters continued in the FY 2024–2025 reporting year. Administrative denials were included but capped at 10 percent of each sample while ensuring all ASAM LOCs 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 initial or continued stay review) 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 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 same edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* that the Department uses when determining medical necessity. The third edition was used for this review as it is the edition the Department used during FY 2023–2024.
- Documentation as to whether 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 LOC 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 seven 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 experience working with ASAM criteria in a variety of settings. All reviewers had clinical experience treating SUD and utilizing the ASAM criteria for UM determinations. HSAG chose the review team based on specific experience conducting UM prior-authorization reviews in other states 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 18,019 inpatient and residential SUD service requests from all MCEs, 1,148 were denials. HSAG reviewed a total of 385 cases, of which 21 were administrative denials, leaving 364 medical necessity cases that were applicable to determine proper use of ASAM criteria and agreement with the denial decision. The results in this section provide an overview across the eight MCEs and 364 medical necessity sample denial determinations for SUD inpatient hospital and residential services. Of the 364 medical necessity sample denial determinations, 79 were initial reviews and 285 were continued stay reviews. This sample included 25 cases that were Special Connections, three additional cases that were pregnant or postpartum (defined as less than one year post-delivery), three cases that were adolescents (ages 17 years and younger), eight cases that were EPSDT eligible, and no cases that were older adults (ages 65 years and older). These special populations require utilization of population-specific criteria. The results below will provide an overview of whether the:

1. MCEs selected and properly utilized appropriate ASAM criteria for the population and LOC 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	31	30	27	90%
RAE 2	48	47	36	77%
RAE 3	61	55	53	96%
RAE 4	109	107	91	85%
RAE 5	32	28	26	93%
RAE 6	53	51	51	100%

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 7	34	31	31	100%
DHMP	17	15	14	93%
Total	**385**	**364**[1]	**329**	**90%**

[1] 21 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 364.

Based on the documentation provided by the MCEs, HSAG reviewers determined that in 90 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 LOC 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 6 and RAE 7 demonstrated the highest level of adherence with ASAM criteria (100 percent agreement), whereas RAE 2 demonstrated the lowest adherence with ASAM criteria (77 percent agreement).

The Department updated its ASAM training and guidance to MCEs to require treatment plans for *Continued Service* and *Transfer/Discharge* reviews during FY 2024–2025, however, the review period included records from FY 2023–2024 when the Department guidance to the MCEs was 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. HSAG followed the Department's previous guidance related to considering treatment plans or equivalent clinical documentation when determining if the ASAM criteria were selected and implemented. While this did not impact HSAG's determination regarding the appropriate ASAM criteria, it was noted that the majority of continued stay reviews did not include treatment plans.

Several of the MCEs demonstrated inconsistencies in documenting denial determinations for 3.7 and 3.7WM levels of care, using the terms interchangeably in these instances. HSAG cautions the MCEs that did not clearly and consistently document these levels of care correctly as the criteria for each level of care vary 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	30	28	93%
RAE 2	47	35	74%
RAE 3	55	54	98%
RAE 4	107	91	85%
RAE 5	28	26	93%
RAE 6	51	50	98%
RAE 7	31	31	100%
DHMP	15	14	93%
Total	**364**[1]	**329**	**90%**

[1] 21 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 364.

HSAG reviewers agreed with the denial decisions made by the MCEs for 90 percent of denials. HSAG agreed most frequently with RAE 7 and least frequently with RAE 2.

Overarching Strengths

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

- RAE 7 demonstrated the most consistent application of ASAM criteria with 100 percent agreement and 100 percent agreement with denial decisions.
- RAE 6 demonstrated consistent application of ASAM criteria with 100 percent agreement.
- DHMP, RAE 1, RAE 3, RAE 5, RAE 6, and RAE 7 were all high in HSAG reviewer agreement at 90 percent or above.
- RAE 6 and RAE 7 exhibited best practices by regularly processing extensions to allow more time for the provider to submit appropriate documentation or for a peer-to-peer review to occur. Examples of cases with extensions include members with neurocognitive concerns, high Clinical Institute Withdrawal Assessment (CIWA) scores, elevated vitals and possible heart failure, and history of

seizures. HSAG recognizes that allowing for additional time for providers to submit appropriate documentation, when it is in the member's best interest, is a best practice.

- RAE 1 included specific member recommendations for alternative treatment locations in its NABDs.
- DHMP, RAE 3, and RAE 5 used *The ASAM Criteria Navigator* from InterQual in some of their cases, which HSAG recognizes as a best practice. *The ASAM Criteria Navigator* is a utilization management tool developed by InterQual in collaboration with ASAM to increase consistency and streamline the utilization management process.
- RAE 1 consistently documented multiple outreaches to the requesting provider to conduct peer-to-peer reviews and obtain additional documentation, when necessary. HSAG recognizes this as a best practice.
- In multiple cases, RAE 1 documented the SUD care coordinator outreached the provider to assist with providing resources to aid with continuation of care. In one specific case, RAE 1's SUD care coordinator outreached facilities to find placement for the member at the appropriate level of care. HSAG recognizes this as a best practice.
- Chart documentation referenced RAE 1's "Contingency Management Award Program" for members who reached certain milestones in recovery and treatment, encouraging members to remain engaged in long-term treatment. HSAG recognizes this as a best practice and creative strategy for member engagement.

Additional Findings

- Out of the denial cases reviewed, nine cases indicated potential quality of care concerns that included, but were not limited to, the following:
  - Two cases indicated possible quality of care concerns; both cases were from the same facility, noting a pattern of failure to meet the ASAM standard of care regarding availability of a physician or psychiatric appointment within eight hours by telephone or 24 hours in person.[2]
  - Three instances involved a Special Connections or pregnant/postpartum member at risk for harm due to premature discharge.
  - Two cases that involved a denied request for withdrawal management were referred to outpatient treatment when documentation indicated that the member was actively intoxicated; however, the member's withdrawal symptoms were anticipated to be severe due to the amount of substances used and/or length of time using substances. Failure to approve withdrawal

[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: 267.

management in these instances when it is clearly indicated puts the member at risk for adverse outcomes related to withdrawal and/or relapse.

- Out of the cases reviewed, 18 cases indicated potential overutilization or underutilization.
  - 15 cases indicated overutilization. Two cases that indicated possible overutilization were from the same provider who initially requested 14 days at the 3.7 level of care (when the MCE's contract requirement for prior authorization at 3.7 was seven days). The provider's documentation stated the 14-day stay was being requested because that is the length of the provider's program. ASAM guidelines indicate that programs should not be for a fixed length of stay, stating "length of stay must be individualized, based on the severity of the patient's illness and the patient's level of functioning at the point of service entry, as well as based on their response to treatment, progress, and outcomes."[3]
  - Two cases indicated potential underutilization. In one of the cases, the MCE approved only 10 days at 3.1, despite the MCE's contract requirements requiring an initial approval of a minimum of 14 days at this level of care at the time of the denial.
- For pregnant or parenting individuals up to one year postpartum, which includes the Colorado Special Connections members, ASAM has developed specific dimensional admissions criteria to be used when assessing the most appropriate level of treatment for individuals in this population. Of the 27 medical necessity denial determinations reviewed for pregnant and parenting members, HSAG reviewers only agreed with 12 of the MCE denials, or 44 percent. Moreover, clinical documentation of the members' pregnancy or parenting situation, or evidence that the MCEs requested additional information relevant to the Special Connections population, was not present in 26 of the 27 denials. It is important that providers submit information referencing the impact of the members' pregnancy and/or parenting status on the members' need for treatment. Additionally, it is important for MCEs to engage providers and obtain sufficient population-specific information to ensure the safety of members and the appropriate level of care.
- One provider that was prominent in the denial sample was noted to have failed to submit adequate prior authorization request documentation in most denial samples reviewed across multiple MCEs. The continued failure of the provider to submit this documentation could put the member at risk for premature discharge, withdrawal complications, relapse, and inadequate discharge planning.

[3] 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: 4.

Recommendations

Related to adherence to ASAM criteria, HSAG suggests that the Department require MCEs to complete the Department-provided training regularly and augment training and oversight of UM staff members and providers regarding:

- The appropriate criteria to use based on type of review, level of care, and special population considerations.
- 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.
- 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.
- 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).
- When applicable and in the member's best interest, implementing the use of an extension to ensure the appropriate determination is made.

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.
- 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.
- Encourage the MCEs to review facilities with a high volume of denials and identify opportunities for improvement regarding timeliness and/or appropriateness of submission, and consider additional checklists and training for facilities if documentation is lacking to determine medical necessity.
- Require MCEs to include specific UM system documentation regarding the implementation of EPSDT criteria prior to issuing a denial determination.