COLORADO

Department of Health Care Policy & Financing

# FY 2025–2026 Inpatient and Residential Substance Use Disorder Service Denial Determination Analysis

*January 2026*

*This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and 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 and Financing (HCPF) 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, HCPF, or other state agencies.**

HSAG used in-house ASAM specialists and, at the direction of HCPF, included 100 percent of Special Connections or pregnant/postpartum members, adolescent members (ages 17 years and younger), 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 29 cases that were Special Connections, one additional case in which the member was pregnant or postpartum (defined as less than one year post-delivery), five cases that were adolescents (ages 17 years and younger), and eight 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 fiscal year (FY) 2025–2026 Inpatient and Residential Substance Use Disorder Service Denial Determination Analysis was conducted using data from FY 2024–2025, referred to as the review period. In FY 2024–2025, the MCEs reported a total of 24,413 inpatient and residential SUD service requests, of which 1,463 were denials, for an overall denial rate of just under 6 percent (5.99 percent). While the MCEs' overall reported denial rate remained relatively stable across the previous three fiscal years (7 percent in FY 2022–2023 and 6 percent in 2023–2024), the overall number of authorization requests increased across the previous three fiscal years and led to increases in HSAG's denial sample size. **This increase in the total number of authorization requests was due to an increase in the number of**

**members accessing treatment**. Specifically, from FY 2022–2023 to FY 2023–2024, the sample increased by 23 percent (from 313 to 385). From FY 2023–2024 to FY 2024–2025, the sample increased by 27 percent (from 385 to 487).

For the FY 2024–2025 review period, HSAG reviewed 33 percent of the 1,463 total denials reported by the MCEs for a total of 487 sample cases. The 487 sample cases consisted of 66 administrative denials (14 percent). The remaining 421 sample cases were reviewed for medical necessity (86 percent). Of the 421 cases reviewed for medical necessity, 129 were initial or retrospective reviews. Additionally, 292 cases were continued stay reviews, also known as concurrent reviews, which are requests for the member to remain at a level of care that was initially authorized when the requesting provider is seeking additional days. 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. In previous years, HCPF's guidance was to consider all clinical documentation that described progress towards treatment in lieu of treatment plans. In policy transmittal 24-04, ASAM Treatment Plan Requirement for Concurrent Review, HCPF updated its ASAM training and guidance to MCEs to require treatment plans for *Continued Service* and *Transfer/Discharge* reviews as of July 1, 2024. For the FY 2025–2026 audit, HSAG applied HCPF's updated guidance on treatment plan requirements when assessing the MCEs' application of ASAM criteria.

**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 331 of the 421 medical necessity cases, or 79 percent. HSAG agreed with the denial decisions made by each MCE for 410, or 97 percent, of the medical necessity cases reviewed.**

Of 90 cases in which HSAG disagreed with the MCEs' application of ASAM criteria, 55 were specifically related to continued stay reviews that lacked a treatment plan, as required by ASAM and HCPF. For the remaining 35 cases in which HSAG disagreed with the MCEs' application of ASAM criteria, the disagreements were primarily driven by other factors, such as insufficient documentation for special population considerations or the use of incorrect criteria for the level of care. While there was slight improvement in the documentation of some of the MCEs' consideration of special population criteria in some populations, the majority of cases involving special populations lacked documentation of the consideration of special population criteria which may create a barrier to the member receiving the right care, in the right place, and at the right time.

All MCEs scored 90 percent or above for denial decisions agreement. While there were some cases in which the reviewers incorrectly documented the level of care as 3.7 when the request was for 3.7 Withdrawal Management (WM), HSAG noted improvement in the appropriate documentation of these levels of care compared to previous years. Additionally, HSAG identified a best practice in which the RAE 1 UM team worked with care coordinators to locate available beds within their provider network for administrative denials related to out-of-network providers. 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 HCPF:

- Continue to reinforce and expand HCPF's ASAM standardized training initiatives to ensure consistent selection, implementation, and documentation of the appropriate ASAM criteria across all levels of care and review types. Strengthen ongoing monitoring efforts to evaluate adherence and identify trends impacting members' access to the right care, at the right place, and at the right time. 
- Strengthen training and monitoring of MCE utilization management (UM) staff to ensure consistent application of ASAM criteria for special populations. Consider conducting periodic audits to verify accurate documentation and alignment with HCPF standards. 
- Collaborate with the MCEs to improve provider compliance with treatment plan submission requirements for continued stay reviews. 

# 2. Background and Methodology

## Background

Beginning January 2021, HCPF 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] HCPF contracted with HSAG, an external quality review organization (EQRO), to conduct the required audit. The requested scope of work was to over-read a sample of UM denial determinations for SUD inpatient hospital and residential LOCs, using ASAM LOCs, made by Colorado's seven RAEs and one Medicaid 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 one Medicaid MCO (Denver Health Medical Plan [DHMP]). During the review period, DHMP delegated its behavioral health utilization management to COA.

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 |
| 3.5 | Clinically managed medium-intensity residential (adolescent criteria) | 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare |

[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, 2025.

| LOC | Title | Description |
|---|---|---|
| | | 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. UM 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 row of data per denial during the measurement period (FY 2024–2025), with the following minimum data fields:

- MCE identifier number
- Date of adverse benefit determination (ABD)
- Date of member notice of adverse benefit determination (NABD)
- Date of provider notification
- Provider notification method
- Extension
- Type of ABD (e.g., administrative, medical necessity, or technical)
- Reason for ABD (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)
- Initial or continued stay review
- ASAM criteria used
- ASAM LOC requested
- Authorized alternative LOC (if an alternate LOC was authorized)
- 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 and FY 2025–2026 reporting years. 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 Management 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 UM 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 HCPF uses when determining medical necessity. The third edition was used for this review as it is the edition HCPF used during FY 2024-2025.
- 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 HCPF's direction, HSAG reviewed for treatment plan inclusion in continued stay reviews.
- 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 UM determination regarding the appropriateness of the prior-authorization request and the accuracy of the MCE determination.
- Whether the UM 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 eight 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 a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor (LMHC), and 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 HCPF.

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.
- Appropriate credentials of both first- and second-level reviewers.
- Potential overutilization, underutilization, or QOC concerns.

This report contains the results of the analysis.

# 3. Overall Results

Of 24,413 inpatient and residential SUD service requests from all MCEs, 1,463 were denials. HSAG reviewed a total of 487 cases, of which 66 were administrative denials, leaving 421 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 421 medical necessity sample denial determinations for SUD inpatient hospital and residential services. Of 421 medical necessity sample denial determinations, 129 were initial reviews and 292 were continued stay reviews. This sample included 29 cases that were Special Connections, one additional case in which the member was pregnant or postpartum (defined as less than one year post-delivery), five cases that were adolescents (ages 17 years and younger), 11 cases that were Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible, and eight 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 | 97 | 90 | 79 | 88% |
| RAE 2 | 35 | 32 | 24 | 75% |
| RAE 3 | 83 | 66 | 62 | 94% |
| RAE 4 | 90 | 85 | 51 | 60% |
| RAE 5 | 37 | 27 | 26 | 96% |

| 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 6 | 70 | 60 | 43 | 72% |
| RAE 7 | 46 | 39 | 27 | 69% |
| DHMP | 29 | 22 | 19 | 86% |
| **Total** | **487** | **421**[1] | **331** | **79%** |

[1] 66 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 421.

Based on the documentation provided by the MCEs, HSAG reviewers determined that in 79 percent of applicable sample denials the MCEs followed HCPF'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). Of eight MCEs, RAE 5 demonstrated the highest level of adherence to ASAM criteria (96 percent agreement), whereas RAE 4 demonstrated the lowest adherence to ASAM criteria (60 percent agreement).

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. In previous years, HCPF's guidance was to consider all clinical documentation that described progress towards treatment in lieu of treatment plans. In policy transmittal 24-04, ASAM Treatment Plan Requirement for Concurrent Review, HCPF updated its ASAM training and guidance to MCEs to require treatment plans for *Continued Service* and *Transfer/Discharge* reviews as of July 1, 2024. HSAG followed HCPF guidance when making determinations regarding appropriate implementation of ASAM criteria. For the FY 2025-2026 audit, HSAG applied HCPF's updated guidance on treatment plan requirements when assessing the MCEs' application of ASAM criteria.

Of 90 cases in which HSAG disagreed with the MCEs' application of ASAM criteria, 55 were specifically related to the continued stay reviews that lacked a treatment plan, as required by ASAM and HCPF. For the remaining 35 cases in which HSAG disagreed with the MCEs' application of ASAM criteria, the disagreements were primarily driven by other factors, such as insufficient documentation for special population considerations or the use of incorrect criteria for the level of care.

While there were some cases in which the reviewers incorrectly documented the level of care as 3.7 when the request was for 3.7WM, HSAG noted improvement in the appropriate documentation of these levels of care compared to previous years.

### 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 | 90 | 90 | 100% |
| RAE 2 | 32 | 29 | 91% |
| RAE 3 | 66 | 66 | 100% |
| RAE 4 | 85 | 81 | 95% |
| RAE 5 | 27 | 27 | 100% |
| RAE 6 | 60 | 56 | 93% |
| RAE 7 | 39 | 39 | 100% |
| DHMP | 22 | 22 | 100% |
| **Total** | **421**[1] | **410** | **97%** |

[1] 66 samples were administrative denials and were not applicable for medical necessity review; therefore, the total medical necessity sample was 421.

HSAG reviewers agreed with the denial decisions made by the MCEs for 97 percent of denials. HSAG agreed with RAE 1, RAE 3, RAE 5, RAE 7, and DHMP in 100 percent of the cases. HSAG agreed least frequently with RAE 2's denial decisions at 91 percent agreement.

## Strengths

Based on the SUD audit activities in FY 2025–2026, HSAG found the following strengths:

- All MCEs scored 90 percent or above for denial decisions agreement.
- Similar to FY 2024-2025, HSAG continued to agree with 100 percent of RAE 7's denial decisions.
- RAE 3 and RAE 5 demonstrated consistent application of ASAM criteria with agreement of 94 percent and 96 percent, respectively.
- Most of the administrative denials in RAE 1's sample were due to out-of-network requests. RAE 1's UM team worked with care coordinators to locate an available bed with a provider in RAE 1's network. HSAG recognizes this as a best practice.

- RAE 1's UM documentation clearly detailed the ASAM criteria used, including considerations for Special Connections members and criminally involved populations.
- Two of the RAE 1 sample denials reviewed were eligible for EPSDT and in both cases, the UM reviewers appropriately documented consideration of EPSDT criteria.
- Most of the MCEs documented multiple outreaches to the requesting provider to obtain additional clinical information or conduct peer-to-peer reviews, when necessary.
- When working with providers to request additional clinical information, RAE 5 educated providers regarding the HCPF requirement to include the treatment plan as a part of continued stay reviews.
- RAE 6 and RAE 7 exhibited best practices by processing extensions, when in the best interest of the member, to allow more time for the provider to submit appropriate documentation or for a peer-to-peer review to occur

## Assessment and Opportunities for Improvement

Based on the FY 2025–2026 SUD audit activities, HSAG found the following opportunities for improvement:

- Of 90 cases in which HSAG disagreed with the MCEs' application of ASAM criteria, 55 were specifically related to continued stay reviews that lacked a treatment plan, as required by ASAM and HCPF.
- Of five medical necessity cases related to older adults (ages 65 years and older), none included documentation of consideration of population-specific criteria.
- Of five medical necessity cases related to adolescent members, HSAG agreed with one case, however, four cases did not include documentation of consideration of the population specific criteria.
- 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 use when assessing the most appropriate level of treatment for individuals in this population. Of 28 medical necessity denial determinations reviewed for pregnant and parenting members, 21 cases did not include documentation of consideration of the populations specific criteria.
- Of nine medical necessity cases related to EPSDT-eligible members, seven did not include documentation of consideration of EPSDT criteria.
- Similar to FY 2024–2025 findings, none of the cases that RAE 3, RAE 5, and DHMP MCO documented as administrative denials included NABDs to members.

- At least two sample denial cases included documentation that the UM reviewer used ASAM 4th edition instead of ASAM 3rd edition, as required by HCPF at the time of the review period.
- Of 97 sample cases reviewed for RAE 1, 23 NABDs were sent on July 30, 2025. Documentation in 23 sample files stated that RAE 1 did not initially send NABDs to members due to a system error.

## Additional Findings

- None of the denial cases indicated potential overutilization or underutilization concerns.
- Of the denial cases reviewed, two indicated potential quality of care concerns including:
  - One case indicated a member was experiencing ongoing suicidal and self-harm ideations, but no documentation of a safety plan was included with the submitted clinical documentation.
  - One case included a member who voiced suicidal ideations with plan and intent when admitted to 3.7WM, but there was no indication of a safety plan in the provider's clinical documentation.

## Recommendations

**Related to adherence to ASAM criteria**, HSAG suggests that HCPF continue to reinforce and expand HCPF-provided training and also augment training and oversight of UM staff members and providers regarding:

- Consistent selection, implementation, and documentation of appropriate ASAM criteria across all levels of care, review types, and special populations.
- The requirement to include treatment plans with all continued stay reviews to improve compliance with HCPF requirements and ASAM criteria.
- Appropriate application of the HCPF-required ASAM 3rd edition.
- 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 HCPF consider these additional opportunities for improvement:**

- 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.
- Collaborate with the MCEs to improve provider compliance with treatment plan submission requirements for continued stay reviews.
- Require MCEs to include specific UM system documentation regarding the implementation of EPSDT criteria prior to issuing a denial determination.

- Utilize available denial data from MCEs to more frequently monitor deny trends, member notification compliance, and appropriate ASAM implementation. Additionally, provide MCEs with targeted feedback or technical assistance where deficiencies are identified.