

SUBSTANCE USE, GAMBLING & EPIDEMIOLOGY TREATMENT POLICY #10

SUBJECT: Residential Treatment Continuum of Services

ISSUED: May 3, 2013, December 1, 2017, May 1, 2025

EFFECTIVE: October 1, 2025

PURPOSE:

The purpose of this policy is to establish the requirements for residential services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to ensure that services are individualized services that maintain cultural, age and gender appropriateness.

SCOPE:

This policy impacts the Prepaid Inpatient Health Plan (PIHP) and its adult residential LOC service provider network.

BACKGROUND:

Residential treatment includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They do indicate, however, that ten hours of scheduled activities, with two of those hours being formalized counseling, must take place each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Criteria Third Edition (ASAM Criteria), and the stages-of-change models that have been developed. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential care.

Throughout the current residential level of services assessment, treatment planning, and recovery support preparations are required, and must be included in the authorized treatment services. Historically, residential services have been defined by length-of-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services:

- Short-term residential: less than 30 days in a program.
- Long-term residential: 30 days or more in a program.

This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted

into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

DEFINITIONS:

Core Services – Treatment basics, therapeutic interventions, and interactive education/counseling. See the chart in the “Covered Services” section for further information.

Counseling – An interpersonal helping relationship that begins with the individual exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the individual to set the goals that pave the way for positive change to occur. Also, a face-to-face intervention (by non-professional staff) with a client, for the purpose of goal setting and achievement and skill building.

Co-Occurring Disorder – The coexistence of both a mental illness and substance use disorder (SUD) is known as a co-occurring disorder. The term can also be used with co-occurring SUD and physical health conditions.

Crisis Intervention – A service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

Face-to-Face – This interaction not only includes in-person contact, but it may also include real-time video and audio linkage between a client and provider, if this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation – Assist the client, potential client, or referral source in arranging transportation to and from treatment.

Family Counseling – Face-to-face intervention with the client and their significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy – Face-to-face, insight-oriented interventions with the client and their significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Habilitative Services – Healthcare services that aim to help people learn skills necessary for maintaining health and functioning, including those necessary for managing daily life activities and social relationships.

Individual Assessment – Face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning – Direct and active involvement by the individual in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the individual's motivation to participate in treatment. Treatment planning requires an understanding that everyone is unique, and each treatment plan must be developed based on the individual's needs, goals, desires, and strengths and be specific to the diagnostic impression and assessment.

Medical Necessity – Treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

Medication Assisted Treatment (MAT) – The use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Medications used are approved by the Food and Drug Administration (FDA) and are clinically driven and tailored to meet each patient's needs.

Medications for the Treatment of Opioid Use Disorder (MOUD) – Providing medications to achieve and sustain clinical remission of signs and symptoms of OUD and support the individual process of recovery without a specific endpoint (as with the typical standard of care in medical and psychiatric treatment of other chronic illnesses).

Peer Support – Individuals who have shared experiences of addiction and recovery and offer support and guidance to one another in a treatment setting.

Psychoeducational groups – Groups formed to educate clients about substance use, related behaviors, and the behavioral, medical, and psychological consequences of use, abuse, and dependency; psychoeducational groups provide information important for maintaining recovery.

Psychotherapy – An advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

Psychotherapy (or therapy) groups – Groups formed to reduce or eliminate substance use or other problematic behaviors by changing long-standing relational and intrapsychic difficulties. Psychotherapy groups differ from other groups traditionally used for substance use treatment, such as problem-solving or support groups, in that the group (1) has a relatively long-term contract; (2) focuses more on psychodynamic issues (rather than

education, support, or problem solving); (3) begins in later stages of readiness for treatment and recovery; (4) tolerates the expression of more emotion; and (5) stresses process over content.

Recovery – Process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Recovery Planning – Purpose is to highlight and organize a person’s goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation – Services designed to support and promote recovery through development of knowledge and skills necessary for an individual’s recovery.

Referral/Linking/Coordination of Services - Office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

Return to Use – Process in which a person with an SUD/ODU who has been in remission experiences a single incident of use.

Relapse - Process in which a person with SUD/ODU who has been in remission experiences a return of symptoms or loss of remission. A relapse is different from a return to use in that it involves more than a single incident of use. Relapses occur over a period of time and can be interrupted. Relapse need not be long lasting.

Relapse Prevention Groups - Groups formed to help clients maintain recovery or minimize the impact and duration of relapse.

Remission – Medical term meaning a disappearance of signs and symptoms of the disease. DSM-5TR defines remission as present in people who previously met OUD criteria but no longer meet any OUD criteria (with the possible exception of craving). Remission is an essential element of recovery.

Substance Use Disorder – A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli (DSM-5-TR).

Telehealth - Face-to-face encounter that includes a dual audio/visual platform, in compliance with Section 1834(m) of the Social Security Act. Providers must ensure the privacy of the beneficiary and the security of any information shared via telehealth.

Telemedicine – The use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services.

Toxicology Screening – Screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program (this may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

Withdrawal Management – Monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

REQUIREMENTS:

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short and long-term descriptors will no longer be used to describe residential services. PIHPs will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels 3.1, 3.5, and 3.7. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care and are described as follows.

Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include age, gender, culture and development. Authorization decisions regarding length of stay (including continued stay), change in LOC and discharge, must be based on the ASAM patient placement criteria. A person's participation in referral and continuing care planning must occur prior to transfer or discharge.

ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Treatment

These services are directed toward applying structure, support to build practice recovery and coping skills, recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to outpatient services focused on improving the individual's functioning and coping skills in Dimension 2 and 3.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, lack of connection to employment, education, or family life, developmental disorders, co-occurring conditions, greater than average susceptibility of peer influence or significant others, or lack of impulse control. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community. This type of programming can be beneficial to individuals who do not acknowledge a substance use

problem, and services would be focused on engagement and continuing treatment. Treatment at this level is sometimes necessary to due to deficits in the individual's recovery environment and length of stay in clinically managed Level 3.1 programs is generally longer than that of the more intensive levels of residential care. This allows the individual to practice and master the application of recovery skills.

Additionally, level 3.1 services must include:

- An individualized treatment plan, developed within 72 hours of admission.
- Formal assessment and treatment plan, updated monthly and signed by clinical staff.
- A medical examination, conducted within 24 hours of admission, or sooner as needed based on the patient's medical presentation, by a physician or advanced practice provider, and include assessment for addiction medication needs.
- Interdisciplinary treatment team, convening at least weekly.
- Weekly progress note, added to the individual's file discussing any changes, progress or other incidents of note.
- Nine (9) to nineteen (19) hours of structured clinical services per week, available seven (7) days a week. These are selected by master's level clinical staff and support recovery and co-occurring conditions. Number of hours per week are based on individual need and based on the assessment and treatment plan.

Patient Supervision

Individuals in 3.1 settings should be provided with 24-hour structure and support. Whereabouts and wellness of each individual should be documented at least once an hour. For structured services, this would be documented by progress notes that may cover multiple hours. Unstructured activities, including those when individual is working independently, must be indicated in a consistent manner in the individual's chart. Overnight hours should reflect if individual is awake and needs assistance, otherwise identified as sleeping time. Policies and procedures regarding individuals off-site should be in place as well.

Support Systems

Necessary support systems include telephone or in-person consultation with a physician and emergency services, available 24 hours a day, and seven days a week. There also must be direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services. Programs should have the ability to arrange for needed procedures as appropriate to the severity, urgency of the individual's condition and be individually driven. These programs should also have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. They should also have direct affiliations with other levels of care or close coordination through referral to more and less intensive levels of care and other services such as literacy training and adult education.

Staff Requirements

Staff within a 3.1 setting should be interdisciplinary and acting within their scope of practice. These individuals should include (but are not limited to): program director, clinical staff (i.e., psychologists, clinical social workers, SUD and mental health counselors), and allied health staff (i.e., certified peer support specialists, patient navigators, health educators, counselor aids and group living workers). The director of programming, the individual responsible for the design and development of the program, should have at a minimum, a master's degree in a field related to clinical behavioral health and at least five (5) years of documented experience in combined SUD and mental health treatment to oversee the clinical and behavioral aspects of the program.

Co-occurring Enhanced Programs

These should be staffed by credentialed mental health professionals that have the ability to treat co-occurring disorders with the capacity to involve addiction-trained psychiatrists. These professionals should also have sufficient cross-training in addiction and mental health to understand the signs and symptoms of mental disorders, be able to understand and explain to the individual the purposes of different psychotropic medications and how they interact with substance use.

Recovery Support Services

Recovery support services should be provided to increase prosocial, and community living skills and provide support, structure and consistency.

ASAM Level 3.5 – Clinically Managed High-Intensity Residential Treatment

These programs are designed to treat clients who require a safe and stable living environment to develop and practice their recovery skills to avoid experiencing immediate recurrent or continuing use in a manner that poses significant risk for serious harm or destabilizing loss upon transition to a less intensive LOC. Programs provide at least 20 hours of structured clinical services per week consisting primarily of psychotherapy, counseling, and psychoeducation to address addiction and co-occurring mental health conditions. These programs also provide a high-intensity clinically planned and managed therapeutic milieu that encourages development and internalization of prosocial attitudes and behaviors using community support to reinforce recovery skills.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

Support Systems

Programs in this LOC should have telephone or in-person consultation with a physician, or a physician assistant or nurse practitioner in state where they are licensed as physician extenders and may perform the duties designated here for a physician; emergency services, available 24 hours a day, seven (7) days a week. They must also have direct affiliations with other levels or close coordination through referral to more and less intensive levels of care and other services. They must also have arranged medical, psychiatric, psychological, laboratory, and toxicology services as appropriate to the severity and urgency of the individual's condition.

Staff Requirements

Level 3.5 programs staffed by licensed or credentialed clinical staff such as addiction counselors and other professional staff who work with the allied health staff in interdisciplinary approach working under the oversight of a medical director. Professional staff should be onsite 24-hours a day, or per license regulations. 24-hour on-call medical support to address urgent or emergent medical issues and on-call support allows programs to care for ongoing biomedical and/or withdrawal-related needs is required. Clinical staff should be knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, able to identify the signs and symptoms of acute psychiatric conditions and have specialized training in behavior management techniques. Staffing for this level must take into consideration the requirement of hourly wellness checks. Whereabouts and wellness of each individual should be documented at least once an hour. For structured services, this would be documented by progress notes that may cover multiple hours. Unstructured activities, including those when individual is working independently, must be indicated in a consistent manner in the individual's chart. Overnight hours should reflect if individual is awake and needs assistance, otherwise identified as sleeping time. Policies and procedures regarding individuals off-site should be in place as well.

Co-occurring Enhanced Programs (COE)

Level 3.5 COE must offer psychiatric services, medication evaluation and laboratory services. These services should be available by telephone within eight (8) hours and on-site or closely coordinated off-site staff within 24 hours, as appropriate by severity and urgency of the individual's mental health condition. These programs should be staffed by credentialed mental health professionals, including addiction psychiatrists who are able to assess and treat the co-occurring mental health disorder and have specialized training in behavior management. They should also have cross-training to understand the signs and symptoms of co-occurring mental health disorders and be able to explain to the individual, the purpose of psychotropic drugs and how they interact with substance use.

ASAM Level 3.7 – Medically Managed Residential Treatmentⁱ

These programs provide medically managed residential services for patients experiencing intoxication, withdrawal, biomedical and/or psychiatric concerns or require initiation or titration of addiction medication who require 24-hour observation, monitoring, and treatment but not the full resources of a hospital. They offer a structured regime of professional 24-hour nurse monitoring and residential support. This LOC is for individuals who are intoxicated, experiencing withdrawal, have biomedical or psychiatric concerns and require initiation or continuation of addiction medication. This LOC has the capacity to deliver psychosocial services equivalent to those provided in Level 3.5.

Support Systems

This LOC requires physician monitoring, nursing care, and observation made available to the individual. The following staffing is required for this LOC: a physician must be available to assess the individual in person within 24 hours of admission and thereafter as medically necessary; a registered nurse to conduct alcohol and other drug-focused nursing assessment at time of admission; and an appropriately credentialed nurse responsible for monitoring the individual's progress and for medication administration. There must be additional medical specialty consultation, psychological consultation, laboratory and toxicology services available on-site through consultation or referral. There also must be coordination of necessary services or other levels of care available through direct affiliation, a referral process or transition to another LOC. Psychiatric services should be available on-site through consultation or referral when presenting an issue that could be attended to at a later time. These services should be available within eight (8) hours by telephone or 24-hours in person.

Staff Requirements

These programs are staffed by an interdisciplinary staff (including physicians, nurses, addiction counselors, and behavioral health specialists) who can assess and treat the individual and obtain and interpret information regarding the individual's psychiatric and substance use or addictive disorders. Staff should be knowledgeable about the biological and psychosocial dimensions of addictions and other behavioral health disorders. The staff should have training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care and treatment services. A licensed physician should oversee the treatment process and assure quality of care. Physicians perform physical examinations for all admitted to this LOC. These staff should have specific training in addiction medicine or addiction psychiatry and experience with addiction medicine. Individuals should receive pharmacotherapy integrated with psychosocial therapies.

Co-occurring Enhanced Programs

Level 3.7 COE programs at this level should offer appropriate psychiatric services, medication evaluation and laboratory services. A psychiatrist should assess the individual within four hours

of admission by telephone and within 24 hours following admission in person, if not sooner, as appropriate by individual's behavioral health condition. A registered nurse or licensed mental health clinician should conduct a behavioral health-focused assessment at the time of admission. If not done by a registered nurse, a separate nursing assessment must be done. The nurse is responsible for monitoring the individual's progress and administering or monitoring the individual's self-administration of psychotropic medications. These must also be staffed by addiction psychiatrists and credentialed behavioral health professionals who can assess and treat co-occurring psychiatric disorders and who have specialized training in behavior management. These programs are ideally staffed by a certified addiction specialist physician, or a physician certified as an addiction psychiatrist. Some, if not all, treatment professionals should have sufficient cross-training to understand signs and symptoms of psychiatric disorders and be able to explain to the individual the purpose of psychotropic medication and how they interact with substance use. The intensity and care should meet the individual's needs.

ASAM Level 3.7 – BIO Medically Managed Biomedically Enhanced Residential Treatment

Universal medically managed standards state that patients and staff should be able to alert each other at all times. Patients should be able to alert staff to an issue immediately and staff should be able to respond immediately to assess patient's needs.

Staff Requirements

Within the 3.7 BIO, there is to be a medical director who develops, approves and regularly reviews program's admission criteria and protocols. They also direct patient care and ensures the adequacy of individual treatment plans. Physicians and advanced providers review admission decisions within 24 hours, perform physical examinations and medical histories, monitor patient response to treatment, and provide clinical consultation and supervision for co-occurring biomedical, psychiatric, and cognitive conditions. Nursing and medical support staff should be available during program hours of operation to conduct nursing assessments upon admission, provide primary nursing care and observation, and monitor patient progress. The level of nursing care provided should be appropriate to the severity of patient needs. Clinical staff, with the appropriate training and scopes of practice should deliver planned regimens of professionally directed psychosocial services, assess and support the management of co-occurring mental health conditions, support coordinated treatment planning, and care coordination, and coordinate the delivery of recovery support services. Medically managed levels of care may have allied health staff who support the delivery of recovery support services including peer recovery coach services, health education services, and transition support.

Determining Level of Care

ASAM LOCs describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC assessment

dimensions' determination and is client driven. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision, with placement of an individual in the lowest LOC they qualify for, while taking client preference into consideration. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record. Clients may also be transitioned between LOC as their needs change and their disease warrants.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery and sustain remission.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

Level of Care	Level 3.1 Clinically Managed Low-Intensity Residential	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.7 Medically Managed Residential
Dimension 1 Intoxication, Withdrawal, and Addiction Medications.	Patient has no withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level 1.7 - WM or Level 2.7 - WM.	Patient is at minimal risk of severe withdrawal or showing mild symptoms of intoxication. If withdrawal is present, needs can be managed clinically without medication intervention.	Approach "unbundled" withdrawal management for adults. Patient is showing moderately or severe symptoms of intoxication or withdrawal and need an IV. Patient experiencing or is anticipated to imminently experience severe signs and/or symptoms of intoxication or withdrawal. Initiation or titration of addiction medication is anticipated to be complex requiring daily medical management and nursing care including after hours.

Level of Care	Level 3.1 Clinically Managed Low-Intensity Residential	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.7 Medically Managed Residential
Dimension 2 Biomedical Conditions.	None or very stable; or receiving concurrent medical monitoring.	None or stable; or receiving concurrent medical monitoring.	<p>Patient is experiencing severe physical health problems and requires IV mediations or wound vacuum-assisted closure (VAC). Patient's home environment cannot meet the daily monitoring and medical management of their physical health problems.</p> <p>Pregnancy-Related Concerns: The patient requires after-hours monitoring but lacks sufficient monitoring in their current home environment to adequately support safety after-hours and effective participation in intensive outpatient addiction treatment.</p> <p>2.7 The patient is pregnant and requires daily or near-daily medical management and nursing care for pregnancy complications that are not life-threatening and do not require fetal monitoring.</p> <p>1.7 Patient is pregnant with low to average risk of experiencing pregnancy complications and requires on-site provision of prenatal care because they are unwilling or unable to</p>

Level of Care	Level 3.1 Clinically Managed Low-Intensity Residential	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.7 Medically Managed Residential
Dimension 2 Biomedical Conditions			reliably access care from an external provider.
Dimension 3 Psychiatric and Cognitive Conditions	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Applies to Co-Occurring Enhanced LOC: Patient is experiences mental health signs and/or symptoms at a level of acuity and/or complexity impacting safety and/or function that requires intensive skilled mental health-focused interventions and/or readily available access to psychiatric oversight and requires residential support or supervision to monitor for changes in status and rapidly respond to mental health concerns that may arise, but they have sufficient control to not require an acute or medically managed psychiatric setting and their medication regimen (if any) does <i>not</i> require frequent (i.e., more than weekly) or urgent	Patient is experiencing psychiatric signs and symptoms at any level of acuity and complexity that requires active psychiatric management, requiring after-hours psychiatric management and nursing care to rapidly respond to changes in mental health status. Patient is experiencing psychiatric signs and symptoms that would otherwise meet criteria for a subacute psychiatric residential treatment setting. Patient's signs and symptoms are anticipated to be exacerbated by concerns in Dimensions 1 or 2 such that the patient requires after-hours medical monitoring or nursing care with potential need to rapidly adjust psychiatric medications. Patient lacks sufficient support in their current home environment to enable effective participation in intensive outpatient addiction treatment and lacks sufficient skills and readiness to effectively participate in a recovery residence. Individual must be admitted

Level of Care	Level 3.1 Clinically Managed Low-Intensity Residential	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.7 Medically Managed Residential
Dimension 3 Psychiatric and Cognitive Conditions		medial management and/or nursing care. Or the patient lacks sufficient support in their current home environment and/or adequate functional skills to enable effective participation in clinically managed outpatient addiction treatment and lacks sufficient skills and/or readiness to effectively participate in a recovery residence.	into co-occurring capable or co-occurring enhanced program, depending on level of function or degree of impairment.
Dimension 4 Substance Use-Related Risks	Patient has a <i>moderate</i> likelihood of engaging in substance use with <u>significant risk of serious harm or destabilizing loss</u> and is assessed as able to develop relapse prevention skills and prevent substance use with residential structure and 24-hour clinically managed support while practicing recovery-sustaining skills safely on a limited basis in the community. Or the patients who have high rated issues in Dimensions 2, 3 or 5 who would otherwise	Patient has a <i>high likelihood</i> of engaging in substance use with <u>significant risk of serious harm or destabilizing loss</u> and requires 24-hour clinical support and supervision to prevent substance use while developing recovery-sustaining skills. Patients who have high rated issues in Dimensions 2 or 3 who would otherwise be appropriate for a Level 3.1 and requires 24-hour	Does not accept or relate the addictive disorder to severity of existing problems; need intensive motivating strategies; need 24-hour monitoring and clinical monitoring to assure follow through with treatment plan.

Level of Care	Level 3.1 Clinically Managed Low-Intensity Residential	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.7 Medically Managed Residential
Dimension 4 Substance Use-Related Risks	be appropriate for level 2.1 but require 24-hour clinically managed structure and support for additional stability or the patient requires residential support to reliably participate in care and is assessed as unable to safely or effectively engage in outpatient care with recovery residence support.	supervision. Patients who have high rated Dimensions 3 or 5 and would otherwise be appropriate for level 2.5 but require 24-hour support and supervision to promote safety and stability or the patient requires residential support.	
Dimension 5 Recovery Environment Interactions	Patient has moderately severe functional impairment in life activities or social relationships and to further develop the basic interpersonal skills or skills of independent living necessary to support sustained recovery, the patient requires 24-hour structure and support with a therapeutic milieu and opportunities to practice learned skills in the community on a limited basis. Or the patient otherwise meets <i>Ability to Function Effectively in Current Environment</i> criteria for treatment at Level 2.1 but lacks a safe	Patient has very severe functional impairment in life activities and social relationships and to learn the basic interpersonal skills or skills of independent living necessary to support sustained recovery. The patient requires therapist-led rehabilitative services with a high-intensity therapeutic milieu and the patient is assessed as unable to safely and effectively learn these skills in a less intensive treatment setting. The patient otherwise meets <i>Ability to Function</i>	Experiencing acute psychiatric/substance use disorder marked by intensification of maladaptive behaviors and lacks sufficient interpersonal skills to effectively connect with others and requires 24-hour nursing and physician oversight.

Level of Care	Level 3.1 Clinically Managed Low-Intensity Residential	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.7 Medically Managed Residential
Dimension 5 Recovery Environment Interactions	<p>and sufficiently supportive after-hours environment or requires an after-hours therapeutic milieu to effectively address functional impairment. Patient is unable to effectively participate in the rules-based milieu of a recovery residence, or a recovery residence milieu is unlikely to provide sufficient support. The patient otherwise meets criteria for outpatient treatment, but, due to interactions in Dimensions 1, 2, 3 or 4, their recovery environment will <i>not</i> provide sufficient support or daily structure to allow for safe and effective participation in outpatient addiction treatment.</p>	<p><i>Effectively in Current Environment</i> criteria for treatment at Level 2.5 but lacks a safe and sufficiently supportive after-hours environment or requires an after-hours therapeutic milieu to effectively address functional impairment and unable to effectively participate in the rules-based milieu of a recovery residence. Or the patient otherwise meets <i>Ability to Function Effectively in Current Environment</i> criteria for treatment at Level 2.5 but is assessed as unlikely to reliably attend outpatient services.</p>	
Dimension 6 Person-Centered Considerations	<ul style="list-style-type: none"> • Patient preferences. • Barriers to care. • Need for motivational enhancement. 		

PROCEDURE:

Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
 1. Intoxication, withdrawal, and addiction medications.
 2. Biomedical conditions.
 3. Psychiatric and cognitive conditions.
 4. Substance use-related risks.
 5. Recovery environment interactions.
 6. Person-centered considerations.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As an individual's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Individual participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

SERVICE REQUIREMENTS:

The following chart details the required number of services that have been established for residential treatment in the three (3) levels of care. Documentation of all core services, and the response to them by the client, must be found in the client's chart. Core Services must take place on all days of the week, there are no "off" days within the residential services framework. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

Level of Care	Minimum Weekly Clinical Services	Minimum Weekly Support Services
ASAM 3.1 Clients with lower impairment or lower complexity of needs.	Between 10 and 19 hours per week.	At least five hours per week.
ASAM 3.5 Clients with a significant level of impairment or very complex needs.	Not less than 20 hours per week.	Not less than 20 hours per week.
ASAM 3.7 Clients with significant level of impairment or very complex needs.	Not less than 20 hours per week.	Not less than 20 hours per week.

Covered Services

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
Basic Care	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery oriented.
Treatment Basics <u>Core Service</u>	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions <u>Core Service</u>	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
Interactive Education /Counseling <u>Core Service</u>	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.

Type	Residential Services Description
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/reintegration, development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, self-care, education, working to the betterment of the program (i.e., tending to a garden), peer support, recreation/exercise, leisure activities, family visits, treatment coordination, support groups, drug/alcohol free campus, spirituality, function prosocially within a well-functioning community, ask for and accept help, create a daily structure that is supportive of recovery, and build a positive social support network.
Medical Services <u>Core Service</u>	Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available on-site or via Telehealth.

Treatment Planning/Recovery Planning

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider arranges for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria

Re-authorization or continued treatment should be based on ASAM Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

REFERENCES:

Waller RC, Boyle MP, Daviss SR, et al, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-occurring Conditions, Volume 1: Adults. 4th ed. Hazelden Publishing; 2023.

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ⁱ 3.7 Withdrawal Management is in a separate policy with separate requirements.