Optum

Clinical Criteria Guidelines: A clinical approach to understanding medical necessity

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Agenda / Objectives

1. Overview of Medical Necessity
2. Applying Medical Necessity to Clinical Information and Translating it to Appropriate Level of Care
3. Level of Care Guidelines
4. A Closer Look at Level of Care Instruments
5. Vignettes

The Right Service at the Right Time

- Person-centered and developmentally sensitive
- Clinically effective
- Least restrictive level of care
- Accessible to individual without causing undue hardship or prolonged separation from community and family

Medical Necessity

Is used to determine what is the appropriate level of care given an individual's unique set of medical or behavioral health circumstances.

The Continuum of Care

From Least Restrictive to Most Restrictive LOC

Level of Care Guidelines

Optum Alaska will review service authorization requests using evidence-based level of care clinical guidelines approved for use by the Alaska Division of Behavioral Health:

- **ASAM:** The American Society for Addiction Medicine (ASAM) Criteria® adults and adolescents presenting with substance use disorders
- **LOCUS:** The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) by the American Association of Community Psychiatrists for adults,18 and older, with behavioral health disorders
- **CAL-LOCUS/CASI :** The Child and Adolescent Service Intensity Instrument by the American Academy of Child and Adolescent Psychiatry, for children, 6 to 18 with behavioral health disorders
- **ECSII:** The Early Childhood Service Intensity Instrument (ECSII), published by The American Academy of Child and Adolescent psychiatry for young children from birth to age 5.

Making Level of Care Determinations

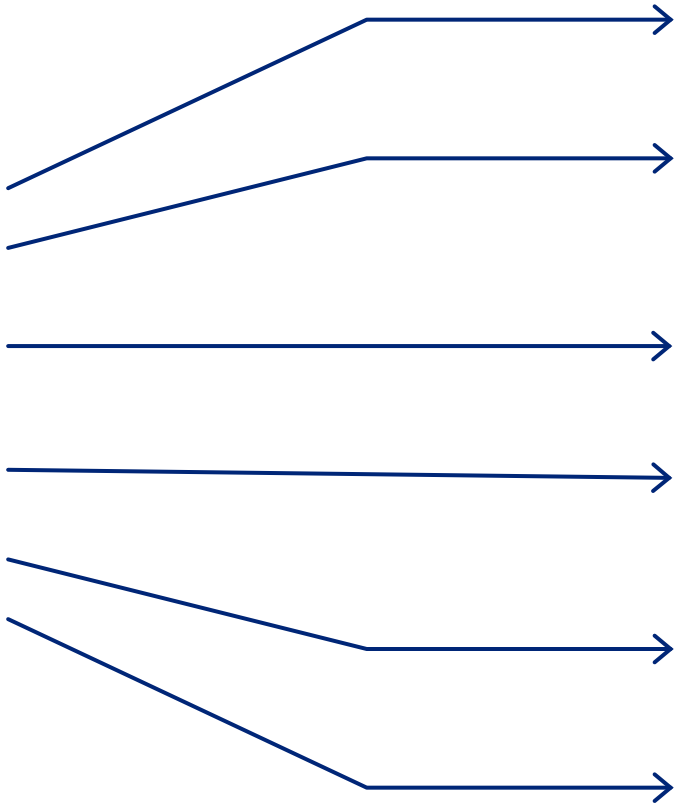
Provide the answers to questions in the Medical Necessity section of the Service Authorization Request

Optum uses clinical information provided to determine medical necessity by utilizing the appropriate level of care guideline (ASAM, LOCUS, etc.)

Optum will compare Optum's LOC determination against provider's request and seek additional information/justification if needed

What Do Level of Care Instruments Measure?

Categories of RISK & RESILIENCE



- Risk of Harm
- Functional/Developmental Status
- Co-occurring Disorders
- Home and Recovery Environment
- Treatment and Recovery History
- Treatment Engagement

Dimension 1
Evaluating Risk of Harm

No Risk	Low Risk	Moderate Risk	Serious Risk	Extreme Risk
No evidence of SI or HI and/or Able to care for self	History of self-neglect, but not currently present Passive thoughts of suicide, homicide or intense distress in the past; or There has been some self harm or self neglect in the past but none currently	Significant SI or HI w/out current plan or intent Extreme distress with history of harmful behavior Hx of chronic impulsive SI or HI without change in usual behavior; or Some evidence of self-neglect	Current SI or HI with intent; or History of chronic, impulsive SI/HI with indications of escalation Clearly unable to care for self	Current SI with intent, plan and means to act Command hallucinations to engage in SI/HI with a history of acting on them, or Extremely compromised ability to care for self; Neglecting needs entirely

Risk of Harm

Safety and/or Withdrawal Potential

Is there a current risk of harm to self or other?

☐ Yes ☐ No ☐ No Update

- If yes, describe any current risk of harm to self or others.
- Specify if there is any active intent or plan to commit suicide or homicide.
- Note whether these thoughts are always present, or specific to a situation or event that has occurred recently:

Is there any indication that the person may harm self or others?

- Ideation, intent, plan/method, means to do harm to self or others
- Self-injurious behavior
- Severe neglect of self-care or safety due to intoxication, or psychiatric status
- Acute intoxication and/or dangerous withdrawal potential

Dimension 2

Activities of Daily Living/Functional Status

Minimal Impairment	Mild Impairment	Moderate Impairment	Serious Impairment	Severe Impairment
May have a passing struggle to cope with work, school or relationships due to a known stressor	Some problems in relationships with increase in distress or conflict Some disruption in ability to care for self, work, parent or go to school	Fighting, break-up, etc. but with control of impulsive, aggressive, abusive behavior Less care for hygiene and appearance Disruption to sleep, eating habits, activity level or sexual appetite without impact on health	Conflicts escalate to violence or social withdrawal Often failing to care for hygiene, appearance Serious sleep deficits, weight change, etc.. Frequently unable to attend to work, school, parenting	Threatening others, minimal control of aggression, abusiveness Neglect of hygiene Dangerous lack of sleep, nutrition, activity Complete inability to attend to work, school or parenting, etc..

Functional Developmental Status

Self-Care, Social-Emotional and Developmental Abilities

Are there any deficiencies in the participants ability to (select all applicable):

- ☐ Fulfill obligations (home, work, school)
- ☐ Interact with others
- ☐ Care for themselves (ADLs, health/medical, etc.)
- ☐ Utilize support systems either through lack of or inability to engage (family, church, community supports, tec.)
- ☐ Other
- ☐ No Update

Describe:

How able is this person to meet their basic needs relative to others their age?

- Ability to perform like same age peers at school, home or on their job
- Ability to communicate and interact with others
- Ability to participate in activities of daily living (ADL's) appropriate for their age

Dimension 3
Co-Occurring Conditions

None	Minor Co-Morbidity	Significant Co-Morbidity	Serious Co-Morbidity	Severe Co-Morbidity
No evidence of medical illness, substance use disorders or psychiatric disorders apart from the BH problem Past illnesses are stable and pose no threat to stability of the current condition	Medical/cognitive problems which aren't debilitating and do not impact the presenting BH problem Occasional episodes of substance misuse, not escalating, not impacting BH problem	Medical condition may adversely impact BH problem Ongoing or episodic SU despite negative impact on BH problem Cognitive disorder is adversely impacting ability to cope with BH problem	Medical condition clearly worsens or is worsened by BH problem Uncontrolled SU, posing serious barrier to recovery from BH problem Cognitive disorder is disabling and impedes ability to recover from BH problem	Medical condition, poorly controlled and potentially life-threatening Severe SU with inability to control use or severe withdrawal symptoms Cognitive disorder seriously impairs ability to function and prevents recovery

Co-Occurring Conditions

Mind, Body, Spirit

Are there comorbid medical issues?

☐ Yes ☐ No ☐ No Update

If yes, describe current comorbid medical issues:

Are there co-occurring issues of cognition (i.e., dementia, traumatic brain injury, FASD, developmental disabilities, etc.)?

☐ Yes ☐ No ☐ No Update

If yes, describe co-occurring issues of cognition:

Are there co-occurring substance abuse issues?

☐ Yes ☐ No ☐ No Update

If yes, describe co-occurring substance abuse issues:

Does this person have any co-occurring conditions?

- Medical
- Developmental Disability
- Cognitive Impairment
- Psychiatric and/or Substance Use Disorder
- Prescription Medications

Dimension 4a

Recovery Environment - Stress

Low Stress	Mildly Stressful	Moderately Stressful	Highly Stressful	Extremely Stressful
Life circumstances are stable No recent break-ups or alienation Money, Food, Housing stable No risk to safety No pressure to perform/care for others beyond capacity	Some challenges w/family- partner Transition to a new role (job/school/fam) Concern about money, housing, food. Performance pressure at school/job/home	Significant discord with family/partner Big transitions - loss of job/move Decrease in income/threats to housing and food Pressure to perform in one area impact's ability to meet obligations in another	Serious illness, death, divorce, separation from children, relational mistreatment Severe transition - jail, loss of housing Unable to meet needs for food, housing Overwhelmed by demands to meet obligations	Acute trauma, witness to or victim of extreme or repeated violence/natural disaster/abuse Incarceration or homelessness Severe pain or imminent loss of life due to illness or injury Sustained inability to meet basic needs

Dimension 4b

Recovery Environment - Support

Highly Supportive	Supportive	Limited Support	Minimal Support	No Support
Ample resources: family, friends and/or partner who provide time, interest, affection and support; or Intensive professional supports (structured programs) are effectively engaged	Support may not be abundant, but people willing to provide support in times of need There are family, friends or partner who will participate in treatment; or Professional supports are effectively engaged	Few natural resources may be capable of providing help as needed; or Usual supports may have become alienated or less able to provide support; or Limited involvement with professional sources of support	Very few actual or potential sources of support are available; or Usual supports are not able or willing to help and/or feel hostile toward person; or Individual is on bad terms or unwilling to use professional supports	There are no sources in this person's life for emotional or material assistance

Home and Recovery Environment

Caregivers, Partners, Family, Friends

Are there any concerns related to home/living environment?

☐ Yes ☐ No ☐ No Update

If yes, describe any current home/living environment, including supports and areas of concern:

Describe this person's home/living environment

- Parental or Caregiver Relationship (if child)
- Strengths and support for recovery within the home, family or social network
- Stressors and challenges to recovery within the home, family or social network

Dimension 5

Treatment and Recovery History

Fully Responsive	Significant Response	Moderate Response	Poor Response	Negligible Response
No prior experience with treatment; or Treatment efforts have been helpful in controlling the presenting problem	Treatment experience (past and present) has been successful in controlling most symptoms, but intensive or repeated exposures may have been required.	Treatment (past and present) has not achieved complete remission of symptoms; Unclear response to treatment; Partial recovery with strong professional/peer support	Treatment has not achieved optimal control of symptoms even *with intensive, repeated efforts*. Attempts to step-down LOC has had limited success.	Minimal response to treatment (past or present) with persisting symptoms even with intensive, structured med managed care for extended periods of time;

Treatment and Recovery History

Resilience

Has the participant had any recent treatment history, including psychiatric or substance abuse hospitalizations?

☐ Yes ☐ No ☐ No Update

If yes, describe, including time periods, interventions that the participant has identified as successful or non-helpful treatment interventions:

Describe history of treatment, trauma and recovery

- Recent treatment history, including hospitalizations
- Relapse or continued use potential
- Interventions that helped
- Interventions that did not help
- Known history of trauma or adverse childhood events

Dimension 6

Recovery Status (Stage of Change)

Optimal Engagement	Positive Engagement	Limited Engagement	Minimal Engagement	Unengaged – Stuck
Actively maintains changes made in the past *(Maintenance)* Enthusiasm for recovery Understands illness & effect on function Takes personal responsibility for recovery	Willing to change, is actively working toward it *(Action)* Positive attitude in treatment, capable of trust Uses resources independently when necessary Takes some responsibility for recovery	Limited desire or confidence to change despite intentions to do so *(Preparation)* Struggles with trust in treatment Does not use resources independently Has limited ability to take responsibility for recovery	Limited desire/fear of adjusting behavior but recognizes need to do so *(Contemplation)* Limited ability to trust, relates poorly to treatment Does not accept responsibility for recovery or feels powerless to do so	No awareness or understanding of illness and disability *(Pre-contemplation)* No capacity to relate to another or trust in tx Extremely avoidant/guarded Does not understand that personal choices contribute to recovery

Engagement in Services

Readiness for Change

Is the participant/Guardian willing to engage in services and/or motivated to change?

☐ Yes ☐ No ☐ No Update

Describe:

The Stages of Change model, at the core of Motivational Interviewing, helps identify how aware a person is that they have a problem, how willing and motivated they are to make changes.

Describe willingness to engage in services

- Individual's participation in treatment
- Caregiver/Family participation in treatment
- Readiness for Change

Trauma Dimension

History of Adverse Experiences

Minimal Exposure	Some Exposure	Moderate Exposure	Significant Exposure	Extreme Exposure
ACE* score ≤ 1	ACE score = 2	ACE score = 3	ACE score = 4	ACE score ≥ 5

***Adverse Childhood Experiences**

- ✓ Parents or guardians separated or divorced
- ✓ Household member served time in jail
- ✓ Household member was depressed, mentally ill or attempted suicide
- ✓ Witness to household members hurting or threatening to hurt one another
- ✓ Household member swore at, insulted, humiliated, or put you down in a way that scared your OR a household member acted in a way that made you afraid you might be physically hurt
- ✓ Someone touched you sexually against your will or in a way that made you feel uncomfortable
- ✓ More than once, you went without food, clothing, a place to live or had not one to protect you
- ✓ Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- ✓ You lived with someone who had a problem with drinking or using drugs
- ✓ You often felt unsupported, unloved and/or unprotected

Trauma Dimension

History of Adverse Experiences

Is there a history with trauma / ACE?

☐ Yes ☐ No ☐ No Update

If yes, briefly describe any history of trauma (include for initial request only, or if new or relevant information has been revealed):

This Dimension is unique to Alaska Medicaid. It does not contribute to the LOCUS score. Trauma history does contribute to LOC decisions for children and families receiving 1115 BH Waiver services. It helps establish eligibility for children who are at risk for developing behavioral health disorders.

Any information you provide in this dimension for your adult clients does help depict the unique clinical needs of an individual but do keep in mind that Optum is not scoring it.

Vignettes

Vignette 1

Initial assessment: Admission to a Mental Health Treatment Facility

Client is a 31-year-old female who presented to the mental health treatment facility as a transfer from a detoxification facility due to depression.

She reported that over the past couple of months, she has had worsening problems with her mood and outlook, as well as increasing use of alcohol and cocaine.

She reported for the past few weeks her mood has been depressed with trouble falling asleep, frequent awakenings, fatigue and anhedonia. She has been unmotivated with poor concentration, low self-esteem and poor appetite. She reported that she has been drinking an average of 2-3 drinks on most days over the past year or so, and perhaps up to twice that amount on average over the past few weeks.

She notes that she can go without a drink if she must (like when she had to show up for a court appointment recently), but she feels very anxious on those days.

She has also used cocaine intermittently when she has access to it, most recently about 2 weeks ago.

She has had a number of adverse consequences related to her substance use and mental health problems.

Vignette 1 *Continued*

She says she feels she has been “depressed most of my life, as far back as I can remember, but up until the past several months she has been “better able to fake being OK”.

She had one prior psychiatric hospitalization when she was 20, which was precipitated by a suicidal attempt (overdose on valium) while intoxicated.

She reported her boyfriend left her for her best friend, so she no longer wanted to live. Her roommate found her to be lethargic, helped get her to ER, where her stomach was “pumped" (no serious medical consequences); she was “admitted to the psych unit for a few days” and started on antidepressant medications (citalopram) for the first time, which she took inconsistently for a few months with unclear benefit.

She has been on and off various antidepressants and mood stabilizers ever since then, (more off than on), with diagnoses including major depressive disorder and bipolar II disorder. She says that she has never been convinced that any of the medications or her experiences with counseling have been particularly helpful.

She notes that she did have a period lasting at least 3 years during her late 20’s when she was doing fairly well in terms of her mood and overall functioning. During that time, she was on Wellbutrin, and was taking it fairly regularly. She notes that this coincided with a period in which she had been able to maintain sobriety for a few years while attending AA. She states she is uncertain whether it was the medication or her sobriety that contributed to her improved mood and functioning during this period of time.

She has seen several different psychiatrists and counselors over the years on an outpatient basis but doesn’t feel that she has “had a real connection” with most of them, including the team at the CMPC she had been “assigned to” most recently. She admits that she had been very inconsistent with meds and mental health appointments over the past few months but says she hasn’t completely given up hope that someone might be able to help.

Vignette 1 *Continued*

She has a history of asthma when she was 10. She recently had some problems with bronchitis and urinary tract infections. She is currently taking antibiotics. Apart from these problems, she denies any other significant medical problems. She denies any history of seizures or DT's.

She has used alcohol on a daily basis on and off since her late teens and notes that this has always been her substance of choice. She reports her last drink was about one week ago.

She admits to also using cocaine, typically in a binge fashion with runs of several days at a time when she has access to it. Her latest cocaine use was approximately two weeks ago.

Client reported that she noticed every time she drank or used cocaine her feelings of depression elevate.

She has had several attempts at traditional outpatient substance use treatment, but typically doesn't follow through after the first few appointments.

She has found AA to be helpful, and at one point in her late 20's she was going to AA meetings on a regular basis and was able to stay sober for almost 3 years continuously.

She reports that she does have several family members who are involved with substances, some of whom are in recovery and some of whom are active.

She reports the use of cigarettes, about 2 packs per day, and is not willing to discontinue her use of nicotine at this time.

Vignette 1 *Continued*

She currently lives with a boyfriend who is a support. She states that he's very supportive and he's always there for her when she needs him.

The client stated that he's been in recovery now for over 20 years, so she feels he understands how she feels.

She stated that she would like to rejoin AA.

She has no relationship with her parents, who live in Florida, and has no other current relationships with any extended family.

The client mentioned 3 women from her old AA group that support her who also have Bipolar D/O.

She works as a nursing assistant in several different nursing homes but currently reports job jeopardy due to frequent absences and showing up late. She added her manager stated her work performance has been suffering lately which she reports is really stressing her out.

She also reported recently completing probation for possession of cocaine.

She reports that she has few recreational interests and that she has personal religious beliefs but no religious involvement.

She reports a history of unhappiness dating back to the time of her childhood when she felt neglected by her alcoholic mother.

She also reports being sexually abused by a 17-year-old stepbrother at the age of 8.

Vignette 1 *Continued*

MENTAL STATUS EXAMINATION:

Adequate grooming and hygiene; fidgety, intermittent eye contact; cooperative with interview process, but seems only superficially engaged. Speech is soft but clear. Thought processes are logical and goal directed. Affect is constricted to anxious and dysphoric and consistent with ideation and mood. Mood is anxious and depressed. She reports still feeling overwhelmed at times. She denies any current suicidal/homicidal ideation. No evidence of delusional ideas or hallucinatory experiences. On cognitive exam, she was intact to short term and long-term memory, attention and concentration. Her intelligence was average. Her insight and judgment were fair.

Review Vignette 1

Placement Criteria: LOCUS

I. Risk of Harm

Risk Rating 3

- Rationale: Client denies current suicidal/homicidal ideation; however, she does have a history of a suicide attempt by overdosing on Valium when she was 20 years old.

II. Functional Status

Risk Rating 3

- Rationale: Client reports within the past few weeks her mood has been depressed with trouble falling asleep, frequent awakenings, fatigue and anhedonia. She has been unmotivated with poor concentration, low self-esteem and poor appetite. Also, client reports job jeopardy due to frequent absences and showing up late. She added her manager stated her work performance has been suffering lately.

Review Vignette 1

Placement Criteria: LOCUS

III. Co-Morbidity

Risk Rating 3

- Rationale: The client presented to this facility as a transfer (step down) from a detox facility. Due to the structured treatment environment client was able to temporarily stop substance use. Please note that the client's last use of alcohol was 1 week ago, and cocaine use was 2 weeks ago. The client also reported every time she drank or used cocaine her feelings of depression elevate.

IV. Recovery Environment

Risk Rating 2

- Rationale: The client reported job jeopardy due to frequent absences and showing up late. She added her manager stated her work performance has been suffering lately which she reports is really stressing her out.

Risk Rating 2

- Rationale: The client stated her current boyfriend is very supportive and will be a support if she needs him. Also, 3 additional women from her old AA group that have similar issues. The client would like to rejoin AA.

Review Vignette 1

Placement Criteria: LOCUS

V. Treatment and Recovery History

Risk Rating 3

- Rationale: The client reported a period of 3 years during her late 20's when she was doing fairly well in terms of her mood and overall functioning. She reported taking Wellbutrin regularly and she also maintained sobriety while attending AA meetings. ** Although the client doesn't know if the medication contributed to her improved mood or if it was her sobriety, she was still under professional care i.e., a psychiatrist because she was being prescribed medications and she had peer support, i.e., "AA", that contributed to her sobriety.

VI. Engagement

Risk Rating 3

- Rationale: The client stated she is very inconsistent with meds and mental health appointments over the past few months. She also stated she typically doesn't follow through after the first few appointments for her traditional outpatient treatment.

Review Vignette 1

Placement Criteria: LOCUS

Recommendation: IOP

Description

Structured outpatient treatment for individual with intensive support and treatment needs who is living independently

Combined outpatient clinical, rehab and 1115 services (Loc 1-2) typically in the range of 9-20 hours/week

Low-moderate impairment (2s and 3s) averaged across dimensions, risk measures may vary across dimensions

LOCUS – 17-19
CAL-LOCUS/CASI – 17-19
ECSII: 18-22

Examples of Relevant Alaska Medicaid Services

State Plan Services

- Combined outpatient clinical and rehab services up to 20 hours/week

1115 SUD Services

- ASAM 2.1 IOP
- SUD Care Coordination
- Intensive Case Management

1115 BH Services

- BH IOP
- Intensive Case Management
- Home Based Family Treatment Level 3

Vignette 2

Initial assessment: Admission to an Adolescent Substance Abuse Treatment Facility

Client is an 18-year-old male who presented to an adolescent substance abuse treatment facility as a direct transfer from a pediatric hospital.

Currently his father is an active alcoholic, and his mother is addicted to opiates and other drugs.

His family has been investigated many times by child protective services (OCS).

When he was 10, he was removed from his parent's home because of chronic neglect and abuse and placed in a foster home.

He was subsequently removed from the foster home and placed with a relative who was granted guardianship. Two weeks ago, prior to turning 18, guardianship was rescinded, and OCS was granted custody.

OCS brought him to the pediatric hospital for treatment of abscesses on his arm, severe malnutrition and active drug use.

His abscesses were believed to have been caused by intravenous drug use.

He disclosed that he had also been using heroin. At first, he attempted to downplay the amount and frequency of his drug use and said that he primarily snorted heroin, cocaine and drank alcohol.

Vignette 2 *Continued*

Later, he disclosed that he was using drugs and drinking alcohol on a daily basis and using heroin intravenously when possible.

He was also diagnosed with hepatitis C. He received treatment including detox for all his conditions in the hospital.

OCS attempted to engage his parents while he was in the hospital. Although they acknowledged his need for treatment, they were not willing to make changes in their own lives.

Current vital signs are slightly elevated– Blood pressure and pulse rate.

Current symptoms includes irritable, agitation, nervousness, headache, slight muscle and body aches, cravings 10/10, intermittent abdominal cramps

He mentioned when abstained from substances, he states has experienced sweats, internal tremors, and nausea. However, he has never hallucinated or experienced D.T.'s

Vignette 2 *Continued*

Client reports a history of seizures and multiple overdoses. Most recent overdose was 2 1/2 weeks ago

He was evaluated by a child psychiatrist. He stated prior to OCS obtaining custody he was living on the streets, associating with fellow substance users, and committing illegal activities to survive. He mentioned that he ran away a lot.

He said that every other day he has feelings of hopelessness when he doesn't care if he lives or dies. He denied current suicidal intent or plan.

He attended multiple outpatient treatment in the past, but he said that he did not trust therapists or foster parents and did not want treatment.

Client denies taking any medications currently

He was diagnosed with opioid use disorder, stimulant (cocaine) use disorder, cannabis use disorder, unspecified depressive disorder, personal history (past history) of physical abuse and neglect in childhood, malnutrition, and hepatitis C

Review Vignette 2

Placement Criteria: ASAM Criteria 6 Dimensions

I. Acute Intoxication and/or Withdrawal Potential

Risk Rating 3

- Rationale: The client was detoxed prior to admitting into the current level of care. Although the client still shows residual symptoms, with continuation of withdrawal management the client will be able to tolerate and cope with his withdrawal discomfort.

II. Biomedical Conditions and Complications

Risk Rating 3

- Rationale: He has medical conditions (hepatitis C and malnutrition) that have been affected by his presenting substance use disorders. Client has a history of seizures and stated he had multiple overdoses with most recent 2 ½ weeks ago. Vital signs are slightly elevated.

Review Vignette 2

Placement Criteria: ASAM Criteria 6 Dimensions

III. Emotional/Behavioral/Cognitive Conditions

Risk Rating 4

- Rationale: He has mental illness (unspecified depressive disorder) that makes it more difficult for him to stop abusing drugs. He neglects and is unable to attend to self-care. He was malnourished while leaving on the street. Client has intermittent thoughts of passive suicidal thoughts, no current SI.

IV. Readiness to Change

Risk Rating 4

- Rationale: He repeatedly demonstrates inability to follow through with treatment, he continues to use alcohol and drugs and he acts impulsive in a runaway behavior. He attended multiple outpatient treatment in the past that did not result in remission od substance use.

Review Vignette 2

Placement Criteria: ASAM Criteria 6 Dimensions

V. Relapse/Continued Use/Continued Problem Potential

Risk Rating 4

- Rationale: He has no skills to stop using substances or to prevent future relapses. His continued addictive behavior places him in imminent danger.

VI. Engagement

Risk Rating 4

- Rationale: He has been around drug abuse by his parents and others in the community. He was removed from his parents' home and placed in foster care. When he ran away, he lived primarily on the street and did not have enough money for food. He was placed with a relative who recently loss custody. Also, he does not have any attachment to anyone who can support him.

Review Vignette 2

Level of Care Recommended

Recommendation: ASAM 3.5
H0047 CG, V1, HA, TF

Description

Structured intensive treatment for adolescents requiring 24-hour structure support. Adolescence in need of these services requires a complex array of intensive services.

Highly impaired consisting of the majority of 4's averaged across dimension, risk measures may vary across dimensions

LOCUS – 24 or higher
CAL-LOCUS/CASI – 23-27
ESCII – 27-30

Examples of Relevant Alaska Medicaid Services

State Plan Services

- 24-hour structured treatment and intensive support

1115 SUD Services

- ASAM 3.5
- SUD Care Coordination
- Intensive Case Management
- Integral involvement by a psychiatrist, or nurse practitioner
- Wraparound Service planning
- Therapeutic mentoring
- Medical and Medication management
- 12-step and other substance use treatment

1115 BH Services

- BH
- Wraparound services, Crisis plan
- Intensive Case Management
- Formal, Intensive, integrated, and individualized plan
- Therapeutic Foster home
- Family home with intensive supports
- Medication Management

Q&A

Thank you!