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DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

ASAM Frequently Asked Questions

This document replaces all level of care specific FAQ documents now located on the ASAM archive page: [ASAM Archive (pa.gov)]
Questions about the ASAM Transition? Email RA-DAASAM@pa.gov
ASAM Transition Website: [ASAM Transition (pa.gov)]

Level 1	
THERAPIES	
The group size has been limited at a total of 12 individuals. However, CCBH, per OMHSAS states groups are to be no more than 10 without a WAIVER. Please clarify.	DDAP regulations do not address group capacity. Per DHS, group size for outpatient levels of care is capped at 10. However, providers can obtain a waiver, through OMHSAS, to conduct 12 person groups. In addition, OMHSAS does not have regulations at the inpatient or residential levels of care regarding group size; therefore, a waiver to group size would not be required for these levels of care. Individual payors may have their own provisions for group size at varying levels of care. DDAP recommends that providers confirm these standards directly with those payors.
ASSESSMENT & TREATMENT PLAN REVIEW	
How frequently should ASAM Continued Stays be completed for patients receiving opioid treatment services in a Methadone Maintenance Program?	Whether or not an individual remains appropriate for the current level of care should be determined by the ongoing, clinical assessment process and whether the needs identified in the treatment plan have adequately been accomplished or can continue to be addressed at that intensity of service. Clinicians are directed to follow the guidance indicated in The ASAM Criteria pages 110 & 299 – 306.
It has been suggested that LOCA should not be "repeated" on admission and it was also stated that "review does not mean redo." So, the suggestion seems to be that OP providers should receive a LOCA from the referral source (assuming	DDAP suggests providers should be in close communication with SCAs and programs who are part of their network of referrals to ensure a smooth transition across the continuum of care and to decrease barriers to accessing treatment. ASAM Criteria provides guidance on frequency of review or re-assessment on pages 110 and 299-306 in the text. Section 5.02 of the Case Management and Clinical Services Manual states, "Once a LOCA is completed, it will be valid for a

the referral source is an SCA or another provider). This has never happened in our area. We can write a policy saying that we review the LOCA that we receive, but we have no control over whether the referring organization sends a LOCA. Likewise, within our own agency, we refer back and forth between OP and IOP, and our SCA has stated clearly that there must be two, separate LOCA when we do that, one for the discharge and one for the admission. I respectfully request clarity on this procedure.	period of six months . . . If an individual request to reinitiate services prior to the end of the six-month period, the case manager may complete a follow-up assessment in lieu of a new one; however, a new ASAM Summary and Risk Rating must be completed." Please also reference the following licensing alert which discusses Psychosocial histories: Alert 1996-04.pdf (pa.gov).
Level 2	
SUPPORT SYSTEMS	
Can you clarify the distinctions in support services between the IOP and PHP levels of care?	The main difference between IOP and PHP related to support systems include the following: IOP has psychiatric and other medical consultation services available within 24 hours by telephone and within 72 hours in person. PHP has psychiatric and other medical consultation services are available within 8 hours by telephone and within 48 hours in person. Additional information specific to IOP (p.198 - 207) and PHP (p.208 - 218) can be found in The ASAM Criteria.
STAFF	
How are staffing ratios calculated when the same counselor is responsible for clients in IOP and OP services?	The staffing ratio can be established in several ways. Either by straight designation for a counselor who sees only IOP clients, who would then have 15 clients; OR, by percentage of time served in the delivery of split services. If a counselor spends 60% of time providing IOP services and 40% in providing OP services then that counselor could have 9 IOP clients and 14 OP clients, for a total of 23 clients. See example below: 60% of 15 = 9

	40% of 35 = 14 23 total clients
Does the IOP ratio apply to NTPs that provide IOP level of care? I believe the question stems from the difference in licenses. Let's say you have an OP Maintenance and OP drug-free. So, for example, if a counselor is carrying a caseload under the OP Maintenance license and the facility runs an IOP program under the OP drug-free license, I'm guessing the mixed caseload with the formula DDAP provided is in play for that counselor/program.	Yes, the recommended IOP ratio of 1:15 applies at all levels of IOP service delivery, including NTP's. DDAP recommends a 1:15 ratio for staff to consumers in IOP based on this amount of services compared to a normal full-time equivalent work week and to assist providers in meeting the ASAM requirement of 9-19 hours of individualized treatment services per week. The staffing ratio can be established in several ways. Either by straight designation for a counselor who sees only IOP clients, who would then have 15 clients; OR, by percentage of time served in the delivery of split services. If a counselor spends 60% of time providing IOP services and 40% in providing OP services then that counselor could have 9 IOP clients and 14 OP clients, for a total of 23 clients. See example below: 60% of 15 = 9 40% of 35 = 14 23 total clients "
Are IOP counselors who also see OP clients allowed to keep 1 x monthly clients on their caseload? Does this count against their active client caseload?	IOP Counselors can maintain clients seen once a month or less on their caseloads, and this would not be included in their counselor to client ratio. Please refer the licensing alert for further guidance on this topic: Alert 2014-01.pdf (pa.gov). In addition, the definitions in the PA 701.1 define "caseload" as the following: "Caseload—The number of clients who are receiving direct counseling services on a regular basis at least twice per month. The number of clients does not include clients who are seen by a counselor only for intake evaluations."
If I have a counselor that works in two programs (D&A IOP and MH), does that counselor's MH health caseload count toward the 1:15 ratio?	While the PA 704.12 does state all clients (including MH clients) should be counted in the calculation, if the facility is able to separate the number of non-substance use disorder clients, and non-substance use disorder hours, DDAP permits this and will only use the substance use disorder information.
Please provide clarification regarding licensing vs. credentialing at time of hire, does the type of license matter?	Licensing and credentialing may vary based on position. Chapter 704 Staffing Regulations outline the qualifications required for the positions of clinical supervisor, counselor, and counselor assistant.

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	The ASAM requirement is that staff who provide clinical services must be licensed or credentialed. SUD treatment providers that hire clinical staff who do not hold a license or certification must document steps towards licensure or certification. Treatment providers may, but are not required to, begin this process during a new employee's probationary period. Once the new employee has completed the probationary period, the provider must maintain documentation in the employee file to demonstrate that the employee is working towards licensure or certification. DDAP recommends the documentation include hours worked, hours of supervision, required trainings, and educational transcripts.
Even while utilizing motivational strategies, many individuals who are appropriate for IOP may be unwilling to participate in more than 9 hours of treatment per week. How can we be sure we will not be penalized for an individual's unwillingness to engage in treatment as recommended? Won't it look like we are just offering 9 hours of IOP?	One of the goals of Dimension 4 services in this case will be to "attract" the participant into recovery, rather than to mandate services that do not match their readiness to change. It is also critical to respect patient choice and needs. If a client is not able to or not ready to participate in 9-19 hours a week of treatment, they may be more appropriate for an outpatient level of care. The documentation within the individual's record should clearly identify what is recommended for the individual and what the individual is willing to accept. In addition, progress notes should clearly document how the counselor is working to engage the individual in additional hours of treatment and explore with the individual any barriers that may exist for the individual, including non-treatment needs.
ASSESSMENT & TREATMENT PLAN REVIEW	
How often should reassessments be done for IOP and PHP levels of care?	Page 110 of The ASAM Criteria recommends re-assessment of all six dimensions every 6 sessions for outpatient levels of care. More regular re-assessment may be needed based on client progress.
OTHER	
We were told that MERCER will be developing a monitoring tool to be used by the BHMCOs for 3.5 and 2.5 Levels of Care. Is this still the case and if so, when will we be receiving that monitoring tool?	DDAP is collaborating with OMHSAS and the consulting company Mercer to develop a monitoring tool that will be used to determine alignment with the ASAM Criteria. The tool was created first for level 3.5, and there'll be similar tools created for each of the other LOC moving forward. Information about a release date will be forthcoming.

"We were wondering if you could offer monitoring guidance for the following two scenarios: Monitoring 2.5 & 3.7: Scenario 1: The agency does not have a contract with the SCA or a publicly funded MCO. Who is responsible for monitoring this agency? Monitoring 2.5 & 3.7: Scenario 2: The agency is located geographically in a county managed by one publicly funded MCO, but that county's SCA, Primary Contractor, and MCO do not have a contract or relationship with that agency. However, another county SCA, Primary Contractor, and MCO do have a relationship and a contract. Who is responsible for monitoring this agency? "	In reference to both scenarios, DDAP is collaborating with OMHSAS and the consulting company Mercer to develop a monitoring tool that will be used to determine alignment with ASAM. The tool was created first for level 3.5, and there'll be similar tools created for each of the other LOC moving forward. Information about a release date and plan will be forthcoming.
"If allowed 15 IOP/ 35 OP, but only 12 group members in a session, what if more show up? Clients take public transportation to get to group. If at full capacity based on the maximum client guidelines, we will have to turn people away. Isn't this a barrier to treatment? If at maximum client capacity and we must to turn people away, will we have any repercussions for not providing treatment? "	Providers should not have to turn people away from treatment for reasons such as the one noted in the question. Providers should make every effort to understand how many patients will be attending group well in advance of that group and have a plan in place to ensure that no patient is ever turned away from a service outside of reasons noted in their policies and procedures and for refusing treatment. Please reference the Logistical Impediments section on page 19 of the ASAM text for more information. It should also be noted that the transition to ASAM Criteria does not impact regulations already in place regarding group size. DDAP does not have regulations to address group capacity. Per OMHSAS, group size for outpatient levels of care is capped at 10. However, providers can obtain an exception, through OMHSAS, to conduct 12 person groups.
Level 3	

SETTING	
Will providers need to create distinct 3.7 units to be able to treat patients or can individuals needing 3.5 and 3.7 services be treated in the same unit?	No, a provider would not be required to create a distinct level 3.7 unit, unless it was a provider decision. Individuals needing level 3.5 or 3.7 could be treated within the same physical location if they are receiving the assessed level of care specific to their needs.
Are there posted regulations in the 3.0 levels of care regarding specifics of treatments allowed in these levels of care. For instance, could we admit a patient from the hospital that needs continued IV antibiotics?	There are no DDAP regulations regarding the types of conditions treated in the 3.0 levels of care. Admission for all levels of care would be determined by the facility's policy and procedures, medical/nursing staffing, scope of practice, and overall ability to provide services either on site or through consultation or referral.
SUPPORT SYSTEMS	
If case management is a service that occurs separately from the residential service provider, can CRS services still be provided by the residential provider?	Yes, Certified Recovery Specialists may be employed by a treatment provider and serve in a supportive role while an individual is in residential services.
If a client is from a county far away, would telephone or virtual meetings meet the expectation?	If distance or circumstance precludes a case manager from meeting in person with the individual and his or her counselor, or individually while in residential services, then telehealth contacts would meet this expectation. DDAP recommends reaching out to individual payors for requirements specific to the provision of telehealth services.
3.7 Onsite Bio-Medical Services. This is a little vague. My best guess is physician and nursing services are provided on site rather than by referral to an outside provider. Also lab services and medication services are provided on site. Am I correct?	At Level 3.7, a Physician is available to assess the patient in person within 24 hours of admission and medically necessary thereafter (p. 266 of The ASAM Criteria). Nursing staff is available on site 24/7. Lab services and other specialty medical services are available on site, through consultation or referral. Medication administration is provided on site by an appropriately credentialed or licensed nurse. More information on characteristics of a level 3.7 program can be found on pages 265-279 of the ASAM Criteria and by reviewing the Service Characteristics and Self-Assessment Checklist for 3.7 located here: ASAM Transition (pa.gov)
STAFF	
What is meant by "Physician monitoring, nursing care, and observation are available." Later in the support	ASAM Criteria edition provides information regarding staffing and support systems (including Physician monitoring, nursing, and observation) for each level of care. Level 3.1: Pages 224-225

service description Higher acuity in some patients dictates the need for 24 hour nursing care and direct involvement by the physician or other qualified practitioner. Given this is a residential service am I correct there is no expectation for 24/7 physician presence on site? While it is clear the expectation of 24 hour nursing care exists for higher acuity patients, am I correct lower acuity patients would not require 24 hour nursing care? Can you describe the expectation for nursing availability and are there any nurse/patient ratio's?	Level 3.5: Pages 245 -250 Level 3.7: Pages 266-268 Level 3.7WM: Pages 139-141 The ASAM Criteria does not specify nurse/patient ratios across levels of care. Facilities must follow relevant regulations mandating a specific nurse to patient ratio. DDAP recommends organizations reach out to all payors regarding requirements specific to the provisions of nursing and physician staffing at each level of care. Additional information regarding medical staffing can be found in the Service Characteristics and Self-Assessment Checklists specific to each level of care located here: ASAM Transition (pa.gov)
Can you please cover the issue of "supervising physician" for halfway house? Many halfway houses do not have an onsite physician. It is costly. Could you please help interpret this requirement? Is it a requirement? Does the physician have to be an addiction specialist? That becomes even more problematic for there are limited specialists. Would the physician affiliated with the rehab suffice as a "supervised referral?"	At level 3.1, telephone or in-person consultation with a physician and emergency services are available 24 hours a day, 7 days a week (The ASAM Criteria p.224). If the program consults or contracts with an off-site physician, this would suffice. While the ASAM Criteria states that an "addiction physician should review admission decisions to confirm clinical necessity of services." (p.225) it does not state that physicians providing ongoing care and consultation outside of the admission decision must be addiction physicians. Further explanation regarding addiction-credentialed physicians and addiction specialist physicians' qualifications can be found on pages 411 and 412 of the ASAM Criteria. DDAP recommends that providers confirm expectations related to physician staffing with payors.
As a treatment provider, we will not be pursuing a 3.7 designation for this However, we are thinking towards the future. Can a facility be designated as a 3.7, but specifically for Co Occurring enhanced (psych clients) and not the medical aspects? Honestly, the medical	ASAM Criteria states ""The services of a Level 3.7 program are designed to meet the needs of patients who have functional limitations in Dimensions 1, 2, and/or 3 . . . Requirements for admission to a Level 3.7 indicate that at least one of the two specifications must be in Dimensions 1, 2, or 3"" (page 266). Facilities can gauge their readiness for alignments at level 3.7 by both reading the ASAM Criteria chapter regarding Level 3.7 found on pages 265-279 and referencing the Level 3.7 Self-Assessment Checklist and Service Characteristics resources found here: ASAM Transition (pa.gov) If and when facilities are ready to become aligned as a 3.7 provider,

part we already take many of the examples listed-but there are a few examples we don't think can be managed. I had feedback from an SCA in our area that could be the case but thought I would get feedback from you as I know there is an approval process to have this designation.	they can reach out to the ASAM Resource account – RA-DAASAM@pa.gov – to request additional information about the alignment and to begin thisprocess.
THERAPIES	
There is a requirement for at least 5 hours per week of professionally directed treatment (individual, group, family therapy, medication management and/or psycho- education) for the 3.1 LoC. However, there was no breakdown between individual versus group counseling per hour. What will be the specific requirement for therapy hours delivered at the halfway house level of care?	ASAM Criteria (p.225 & p.226) outlines the therapies that should be offered at Level 3.1. It also states "Planned clinical program activities (constituting at least 5 hours per week of professional directed treatment) to stabilize and maintain the stability of the patient's substance use disorder symptoms and to help him or her develop and apply recovery skills."
Can DDAP provide clarification on the statement "The Department will consider other service delivery schedules if a provider can show how appropriate, individualized, services can be provided within the residential setting. Providers were asking for more clarification on this update." This is in relation to ASAM 3.5 and 3.7.	The ASAM requirement is to provide clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision of daily clinical services appropriate to the patient's needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day. Therapies noted in ASAM Criteria for 3.5 (p.251 -22) and 3.7 (p.269) include the following: Individual therapy Group therapy Family therapy / family activities including parent/child bonding activities Medication education and management Physical Therapy

	The interventions also include nonclinical therapeutic interventions such as: Health education Activities related to relapse prevention, exploring interpersonal choices, daily living, and personal responsibility Relapse Prevention Educational and skill building groups Vocational Rehabilitation Art, music, and movement therapies Other therapeutic recreational activities and interventions
How, within residential programs, does case management fit into schedule? Can it be provided as part of the 6-8 hours, or outside?	Providers are encouraged to review the therapies section under each Level of Care in the ASAM Criteria edition. Case Management is not listed under the therapies section in Level 3.5 or 3.7; therefore, it should not be included as part of the recommended 6-8 hours of daily clinical services. Further, the definition of skilled treatment services on page 429 of the ASAM Criteria does not include Case Management as an intervention that can counted as clinical service hours. While Case Management cannot be counted towards clinical service hours, it is an important service which can be offered by program staff on site, or through an outside source. Case Management can also be noted as an intervention on the client's treatment plan when appropriate. The provider would need to discuss with the MCO to determine if CM is a billable service while in residential treatment.
Has there been a decision yet with regard to 7 days per week clinical presence/counseling for July 2021 roll out for level 3.5 and 3.7?	The ASAM requirement is to provide clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision of daily clinical services appropriate to the patient's needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day.
I had a question from a 3.5 provider which I wanted to forward to DDAP. The provider was asking for the clinical hours for 3.7/3.5 if DDAP could define "family activities" as well as provide some examples of what would be considered	SUD treatment providers have the flexibility to provide the required daily clinical/therapeutic services in a way that best meets the needs of the individual. There is no requirement that residential treatment providers provide two 2-hour group therapy sessions per day. The ASAM requirement is to provide clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision

“family activities.”? Can DDAP define and provide examples for "family activities" in a residential setting?	of daily clinical services appropriate to the patient’s needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day.
Does the 3.1 LOC require 10 clients per group? Can residents in the 3.1 LOC miss clinical groups due to work?	DDAP regulations do not address group capacity. Per DHS, group size for outpatient levels of care is capped at 10. However, providers can obtain a waiver, through OMHSAS, to conduct 12 person groups. In addition, OMHSAS does not have regulations at the inpatient or residential levels of care regarding group size; therefore, a waiver to group size would not be warranted for these levels of care. Other individual payors may have their own provisions for group size at varying levels of care. DDAP recommends that providers confirm these standards directly with those payors. If treatment is provided according to the treatment plan DDAP will consider the program in compliance with that regulation. If a resident misses a clinical session for any reason it must be documented in the client record. If the scheduling conflict is persistent, consider altering the client's treatment schedule to accommodate the work schedule and allow for more consistent attendance. Check with the client’s funding source and other agencies who may have expectations for how these missed sessions are documented and managed. "
I am wondering about the service delivery model and the requirement of 6-8 hours of service daily for LOC 3.5. One obstacle I am facing is the weekday schedules where our kids are in school most of the day. I have read in descriptions in the ASAM manual that discusses education but by the verbiage seems like they are referencing groups to discuss the importance of education and preparing them to engage in "productive daily activity" (ASAM Manual, p. 251). I would like to clarify if the hours our clients are in school count towards daily	The ASAM requirement for adults - **not adolescents** -- at level 3.5 and 3.7 for adults is daily clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision of daily clinical services appropriate to the patient’s needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day. Adolescent SUD treatment providers have always utilized the ASAM Criteria for level of care assessments and continued stay reviews. Beginning in November 2021, DDAP will collaborate with adolescent providers, public payers, and other stakeholders in preparation for ensuring adolescent providers are fully aligned with the ASAM Criteria. DDAP will address the special considerations for adolescents to ensure providers are implementing the Criteria for adolescents throughout the delivery of treatment services across the entire continuum of care. Please reference pages 251-252 in the ASAM Criteria for additional information regarding approved therapies at this level of care. In addition, please note the Adolescent-specific Considerations: Therapies at the bottom of page 252 which addresses educational services.

service amounts required by ASAM. In addition, we operates our own Privately Licensed School on-site which may or may not help to determine the answer.	
I have a question about two community groups we would like to conduct and whether they count towards the ASAM clinical hours. The first community group would take place at a local farm for equine activities. The owner runs equine programs for local veterans as part of their trauma recovery work. The second community group would take place at a local art school where the staff of the school would be working with our clients on various art and craft activities. Here are my questions: Would these groups count towards the ASAM requirement of 4 hours of group therapy each day 7 days per week? Would these groups count towards the ASAM requirement of 6 hours of clinical programming each day, 7 days per week?	The ASAM requirement is to provide clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision of daily clinical services appropriate to the patient's needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day. Therapies noted in ASAM Criteria for 3.5 (p.251 -22) and 3.7 (p.269) include the following: Individual therapy Group therapy Family therapy / family activities including parent/child bonding activities Medication education and management Physical Therapy The interventions also include nonclinical therapeutic interventions such as: Health education Activities related to relapse prevention, exploring interpersonal choices, daily living, and personal responsibility Relapse Prevention Educational and skill building groups Vocational Rehabilitation Art, music, and movement therapies Other therapeutic recreational activities and interventions
I am seeking clarity about what counts towards the six to eight hours of programming daily for the ASAM alignment for level 3.5? Do medication times count towards the time?? A great majority of the population being treated	The ASAM Criteria, pages 251-252, under the section titled "Therapies" states "Monitoring of the patient's adherence in taking any prescribed medications, and/or any permitted over the counter medications or supplements" along with several other interventions. The ASAM requirement is to provide clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision

are co-occurring and medication blocks need to be established throughout the day.?	of daily clinical services appropriate to the patient's needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day.
How, within residential programs, does case management fit into schedule? Can it be provided as part of the 6-8 hours, or outside?	Providers are encouraged to review the therapies section under each Level of Care in the ASAM Criteria. Case Management is not listed under the therapies section in Level 3.5 or 3.7. With that said, Case Management is almost always a vital part of the treatment plan. Case Management may be provided by the treatment provider or through the SCA. Case management services should be provided based on the individual's needs identified in the multidimensional assessment and if warranted, should be included in the patient's treatment plan. CM can be provided concurrently while in residential treatment and after discharge, regardless of who provides the service. Case Management must be a separate and distinct service from individual therapy sessions. The provider would need to discuss with the MCO to determine if CM is a billable service while in residential treatment. The provider would need to discuss with the MCO to determine if CM is a billable service while in residential treatment.
I am looking for as much information as possible to better understand the expectations on facilitators for small group therapy within the ASAM transition. I know ASAM transition requires 2 hours daily, does it have to be 2 consecutive hours? Would 1 in the am and 1 in the pm meet standards? Also information I have seen reads that small group therapy cannot be facilitated by a BHA level employee. However, what if BHA has a degree in the SUD field, CRS, and or CAAC credentials from Pennsylvania Certification Board? Would that BHA be eligible?	The ASAM requirement is to provide clinical services 7 days per week in accordance with individualized treatment plans. To assist residential providers in ensuring the required provision of daily clinical services appropriate to the patient's needs at the residential level of care, DDAP recommends clinical services are provided 6-8 hours per day. SUD treatment providers have the flexibility to provide the required daily clinical/therapeutic services in a way that best meets the needs of the individual. There is no requirement that residential treatment providers provide two 2-hour group therapy sessions per day. Therapies noted in ASAM Criteria for 3.5 (p.251-52) and 3.7 (p.269) include the following: Individual therapy Group therapy Family therapy / family activities including parent/child bonding activities Medication education and management Physical Therapy The interventions also include nonclinical therapeutic interventions such as: Health education

	Activities related to relapse prevention, exploring interpersonal choices, daily living, and personal responsibility Relapse Prevention Educational and skill building groups Vocational Rehabilitation Art, music, and movement therapies Other therapeutic recreational activities and interventions These non-clinical therapeutic interventions may be facilitated by staff other than therapists, such as counselor aides, behavioral health technicians, certified recovery specialists, or case managers. Programs should consider the following when determining the appropriateness of staff working within their scope of practice when facilitating any of the above therapies: the therapy/intervention itself, the level of skill and formal training required to correctly employ the intervention, the overall group milieu, individual patient problem areas and symptoms, the likelihood of the therapy resulting in a challenging emotional response, and individual payor guidelines regarding who can and cannot facilitate certain types of programming. DDAP recommends reaching out to individual payors for information specific to credentialing requirements for facilitators of group and individual clinical/therapeutic interventions.
ASSESSMENT & TREATMENT PLAN REVIEW	
Does an ASAM Summary sheet need to be completed for clients at the residential and detox level of care?	Yes, the ASAM Summary Sheet does need to be completed in all levels of care, including residential and withdrawal management (WM).
Treatment plan reviews will now be required weekly instead of 15 days as previously allowed for 3.5 level of care?	Pennsylvania regulation 709.52 indicates individual treatment plans and outlines the frequency at which treatment plans must be reviewed at the residential level of care. "(a) An individual treatment and rehabilitation plan shall be developed with a client. (b) Treatment and rehabilitation plans shall be reviewed and updated at least every 30 days. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update shall occur at least every 15 days." ASAM Criteria states "Residential levels of care should formally review progress once a week and more often if the

	person is quite unstable" (page 110). Providers need to consider minimum requirements of the regulations and the ASAM criteria emphasis of individualized and patient centered care. Please refer to the definitions of both patient centered care (P. 425) and individualized treatment (p.420) of the ASAM Criteria.
OTHER	
What is the expectation for 1 on 1 supervision of a client when off premises? Is the expectation that staff are present when off premises for doctor appointments, etc.	There are no DDAP regulations that address individuals going offsite during a residential stay. A provider should refer to their internal policies regarding appointments and may want to check with their MCOs to determine if they have any requirements around offsite appointments. If an individual can be off site individually, it might be a clinical question whether that client is appropriate for the 3.0 Level of Care.
Also, we were told that MERCER will be developing a monitoring tool to be used by the BHMCOs for 3.5 and 2.5 Levels of Care. Is this still the case and if so, when will we be receiving that monitoring tool?	DDAP is collaborating with OMHSAS and the consulting company Mercer to develop a monitoring tool that will be used to determine alignment with ASAM. The tool was created first for level 3.5, and there'll be similar tools created for each of the other LOC moving forward. Information about a release date will be forthcoming.
Some of our 3.7 LOC Providers have asked how they go about receiving that same designation in the ASAM alignment process. I did see that you have posted a list of providers with that designation on your website. Is there a form for a provider to complete to request that LOC designation and if not, how do they go about requesting it and receiving it?	Providers interested in being aligned for ASAM Level 3.7 should reach out to the ASAM email account at ra-daasam@pa.gov to express their intentions. DDAP staff will work with the provider to schedule a time to meet with the provider's interdisciplinary team, including medical staff, to review a series of questions related to services and staffing related to 3.7. In addition, the provider will be asked to submit policies and procedures related to Level 3.7. DDAP staff will review information gathered during the meeting and by reviewing policies and procedures to assess the providers readiness for alignment for 3.7. If a provider is assessed as being aligned for 3.7, the provider will be added to the 3.7 alignment list located on DDAP's website. If providers are assessed as not being ready to provide services at ASAM 3.7, DDAP staff will continue to work with the provider to prepare them for alignment.
Level 4	
STAFFING	
In order to meet the 16 hrs. of counseling services, could a nurse be utilized to do counseling to fill in any staffing gap?	An RN does meet staffing regulations for counseling positions. Alert 1996-06.pdf (pa.gov). If the nurse is counseling on a somewhat regular basis or is officially filling a portion of the 16 hours of required therapeutic availability, DDAP would expect to see an updated job description reflecting

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	both nursing and counseling duties and the nurse would also need to meet the annual training requirements for counselor.
Does the requirement of a Physician being available 24-hours a day include the option of utilizing a Physician's Assistant?	The ASAM Criteria for Level 4 indicates an interdisciplinary team of appropriately credentialed clinical staff (including addiction-credentialed physicians, nurse practitioners, physician assistants, nurses, counselors, psychologists, and social workers) who assess and treat patients with severe substance use disorders.... (page 252).
Does the physical exam conducted by the Emergency Care Center physician qualify for the physical requirement OR would tele-psych be ok if the RN does the physical and the Physician charts it?	ASAM Criteria provides an overview of all that is included in an assessment at this level of care on page 284. "In Level 4 programs, the assessment and treatment plan review include: a " a) A comprehensive nursing assessment, conducted at the time of admission. b) Physician approval of admission. c) A comprehensive history and physical examination, performed by a physician within 12 hours of admission . . . " In addition, ASAM Criteria states that at Level 4, "Physicians provide medical management 24 hours a day . . . "(page 282). A psychiatric evaluation via telehealth would not take the place of the physical examination requirement for admission at Level 4. ASAM Criteria does not indicate that RN's can conduct the history and physical examination.
THERAPIES	
Regarding 16 hours of counseling, are counseling services needed to be delivered in the building for a 16-hour period on a daily basis? If I work 2 therapists' daylight, does that meet this requirement? Or does this have to be 16 hours a day 7am to 11pm example?	ASAM Criteria (p.282) states that "A team of appropriately credentialed professionals who provide medical management by physicians 24 hours a day, primary nursing care 24 hours a day, and professional counseling services 16 hours a day." This means that professional counseling must be available at least 16 hours during each 24-hour day. Having two counselors working the same 8-hour shift, or overlapping 8-hour shifts, does not meet this requirement.
Could the 16 hours of counseling be met by using "on call" or PRN staff?	Counseling can be provided by "on call" or PRN if they meet the following minimum METs indicated by §704.7 of the PA licensing regulations. In addition, all new staff must hold a professional license through the Department of State (LPC, LMFT, LSW, LCSW) or be credentialed by PCB or by a statewide certification body which is a member of a National certification body or be certification by another state government's substance abuse counseling certification board or be actively working towards Department of State licensure or certification through the PCB or by a statewide certification body which is a member of a national certification body or by another state government's substance abuse counseling certification board.

In order to meet the 16 hrs. of counseling services, could a nurse be utilized to do counseling to fill in any staffing gap?	Yes, an RN could be utilized for counseling services and does meet the qualifications in Chapter 704 for the position of counselor. Alert 1996-06.pdf (pa.gov). If the nurse is counseling on a somewhat regular basis or is officially filling a portion of the 16 hours of required therapeutic availability, DDAP would expect to see anupdated job description reflecting both nursing and counseling duties and the nurse would also need to meet the annual training requirements for counselor.
ASSESSMENT & TREATMENT PLAN REVIEW	
Does an ASAM Summary sheet need to be completed for clients at the residential and detox level of care?	Yes, the ASAM Summary Sheet does need to be completed in all levels of care, including residential and withdrawal management (WM).
I was wondering if you could help as far as how to handle admissions ASAM that states a patient needs one level of care (4.0WM) and then our doctor does the assessment and determines that 3.7WM is more appropriate. Based on what I am reading we are not to repeat the ASAM, but if we do not, we will have an ASAM with a different level of care. Do you have any suggestions?	Providers are encouraged to not complete the entire assessment all over again, rather to update the one provided upon admission – this update can be documented on the ASAM summary sheet. The admitting provider needs to document why they are recommending a different LOC than the one that was determined during the LOCA. According to the DDAP Case Management and Clinical Services Manual, “If the level of care received is different than the level recommended, the ASAM Summary as well as the case notes must document attempts to engage the individual into clinically appropriate services.” In addition, an assessor/clinician should follow the policies and procedures outlined by their agency for referring or admitting individuals who are best served at a different level of care. Case Management and Clinical Services Manual.pdf (pa.gov).
DOCUMENTATION	
What are the requirements regarding clinician and supervisory sign off/signature on the ASAM Summary sheet?	Section 5.07 of the Case Management and Clinical Services Manual states, "In the event the Case Manager has not completed all required trainings, the case management supervisor must document close supervision and review of written documentation, to include the LOCA and ASAM Summary Sheet, until the case manager has received all required trainings."
All Levels of Care	

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

SUPPORT SYSTEMS	
Should Case Management services be pro vided by the Single County Authority and not the treatment providers?	Case Management Services may be provided by an SCA or a treatment provider, as separate and distinct services. Please see the Case Management and Clinical Services Manual issued by DDAP effective 7/1/2020 for more information. Section 5.00, Case Management Overview indicates: "The SCAs and its contracted providers must offer case management as a separate and distinct service from treatment that addresses all relevant aspects of an individual's path to recovery... If the SCA contracts with a treatment provider to perform case management, the two services must be conducted either by two separate staff members or at two separate times. The treatment provider may not perform both treatment and case management services during a therapy session."
Should SCAs provide Case Management services to all clients or only SCA funded clients?	Best practice is for Case Management services to be offered to all individuals engaging in SUD treatment.
Are the Case Managers hired at the SCA held to the case manager qualifications and training requirements found in the PA Addendums?	Yes, Case Managers hired at the SCA after July 1, 2021, are required to be licensed by the Department of State as a Social Worker, Professional Counselor, Clinical Social Worker or Marriage and Family Counselor or hold certification as a CAAC with the PCB or by another statewide certification body which is a member of a national certification body or certification by another state government's substance abuse counseling certification board or be working toward credentialing. In addition, Case Management must meet the requirements set forth by the DDAP Case Management and Clinical Services Manual.pdf (pa.gov). Staff who were hired in theircurrent positions within the same project or organization on or before July 1, 2021, are grandfathered and not subject to credentialing or licensure.
Are the facilities responsible for providing case management services internally or are they responsible for coordinating with external providers in order to offer case management services? What will it look like post discharge? Will this look similar to a Certified Recovery Specialist (CRS)?	DDAP continues to work with SCAs to increase the availability of case management services at the county level as a separate and distinct service from clinical care. Where separate and distinct case management services exist at the home/referring county, they should be utilized. Coordination with case management services that are provided through the referring county will allow for seamless, continuity of care upon discharge and allow the case manager to follow through with the provision of services as the individual transitions back to their community. If separate case management services do not exist, then the provider should coordinate services as best as possible.

STAFF	
Who is qualified to conduct an ASAM level of care assessment?	ASAM Criteria states that a "credentialed counselor or clinician, a certified addiction registered nurse, a psychologist, or a physician may gather diagnostic and multidimensional assessment data relevant to the six ASAM criteria dimensions."(p.42) In addition, the Case Management and Clinical Services Manual Section 5.02 states that Case Managers are allowed to conduct ASAM level of care assessments.
Is the state going to align with the PA Specific addendums and licensing requirements or will providers have to meet both expectations, have limited, and not always experienced certified counselors, because they have an unacceptable degree?	The regulations and the ASAM Guidance document are in sync. Minimum requirements for counselors can be found in 28 Pa. Code § 704. Once hired, a person can work toward certification. This allows individuals with lived experience the opportunity for job entry and an avenue for professional growth as they pursue on the job training and formal educational opportunities. Staff who were hired in their current positions within the same project or organization on or before July 1, 2021, are grandfathered and not subject to credentialing or licensure. Please also reference this licensing alert regarding which compiles a list of acceptable degrees that meet the requirements outlined in 28 Pa. Code §§ 704.5(c) - 704.8(c). Alert 2021-03.pdf (pa.gov).
Is there a curriculum approved for MI at this point and is there a process to get an established curriculum approved by DDAP? Will this training be a 6 hour requirement?	DDAP's "Motivational Interviewing, Advancing the Practice" is currently a required training for case managers hired on or after 7/1/21 and is the "DDAP-approved" MI training. Clinical supervisors are recommended to take this course by 7/1/23 and other clinicians are recommended to take the course by 7/1/26.
Do social workers need to be licensed if they are operating as internal case managers?	Case Managers hired at the SCA after July 1, 2021, are required to be licensed by the Department of State as a Social Worker, Professional Counselor, Clinical Social Worker or Marriage and Family Counselor or hold certification as a CAAC with the PCB or by another statewide certification body which is a member of a national certification body or certification by another state government's substance abuse counseling certification board or be working toward credentialing. In addition, Case Managers must meet the minimum METs indicated by the State Civil

	Service Commission and meet all other training requirements set forth by the DDAP Case Management and Clinical Services Manual.pdf (pa.gov).Staff who were hired in theircurrent positions within the same project or organization on or before July 1, 2021, are grandfathered and not subject to credentialing or licensure.
With the change in employment requirements (i.e., staffing ratio, supervision ratio, and education/certification requirements), will this require additional supervision of the staff? Some facilities may not be able to meet the employment requirements initially, will they have a specific amount of time to transition?	Staffing ratios remain consistent as noted in the regulation. Supervision required for counselors is determined by the program (see § 709.26. Personnel management). In delivering quality services, especially by those with minimal experience, there should be regular, ongoing individualized and group supervision and case consultation. PCB defines "Supervision as a formal or informal process that is evaluative, clinical, and supportive. It can be provided by more than one person, it ensures quality of clinical care, and extends over time. Supervision includes observation, mentoring, coaching, evaluating, inspiring, and creating an atmosphere that promotes self-motivation, learning, and professional development." DDAP concurs with this definition.
Regarding PCB Certification for new staff after 7-1-21. Can we hire a Clinical supervisor that doesn't have experience, a license, or PCB Certificate after 7-1-21? After reading the: ADDENDUM: PA – SPECIFIC EXPECTATIONS FOR CONTRACTUAL COMPLIANCE – OUTPATIENT 1.0, I'm still a bit confused.	All Clinical Supervisors hired after July 1, 2021 must meet the minimum education and training requirements established via §704.6 of the PA Licensing Regulations and hold a clinical license through the Department of State or be certified by the PCB or hold full certification as an addictions counselor by a statewide certification body which is a member of a National certification body or certification by another state government's substance abuse counseling certification board. Since all the MET requirements for Clinical supervisor require some level of clinical experience you would not be able to hire a clinical supervisor who did not meet this requirement either before or after July 1, 2021. See the link below for clarification on the METs for Clinical supervisor: 28 Pa. Code § 704.6. Qualifications for the position of clinical supervisor. (pacodeandbulletin.gov)
The Change Company lists out 3 e-trainings for ASAM training: Module 1: Multidimensional Assessment; Module 2: From Assessment to Service Planning and Level of Care; Module 3: Introduction to The ASAM Criteria. My question is if all 3 of these modules are required to meet	The ASAM Update from January 2020 specifies that Modules 1 and 2 offered by The Change Companies can be completedto satisfy the training requirements. Module 3 is not required. In February 2022, DDAP announced an additional online option from ASAM was added to the approved online ASAM trainings. Please reference the DDAP Training Website for updated

DDAP ASAM training requirements per the CM & Clinical DDAP Manual? The Change Company lists out 5 e-training modules for Motivational Interviewing to include: The Spirit of MI; Engagement; Focusing; Evoking; Planning. My questions is if these trainings meet the requirement for MI training as listed as “Motivational Interviewing, Advancing the Practice” in the CM & Clinical DDAP Manual? Also, do providers need to take all of these trainings to meet these requirements?	information on approved trainings. ASAM Transition (pa.gov) The only Motivational Interviewing training that satisfies the requirement is the one offered by DDAP, Motivational Interviewing: Advancing the Practice.
For new hires that have not completed ASAM 3rd trainings, Is there a time requirement. Something on the order of “within 1 year of hire ASAM training must be completed?”? I cannot find this info anywhere.? Also, it looks like the only way to obtain this training is paying Train for Change hundreds of dollars.? Is this true?? I have contacted quite a few of our area providers and they are not interested in cost sharing.?	Section 5.09 of the CMCS Manual indicates the SCA is required to ensure that staff providing case management services and their supervisors complete all case management core trainings within 365 days of hire, which includes the trainings of Motivational Interviewing, Advancing the Practice and The ASAM Criteria. The ASAM Update from January 2020 specifies that Modules 1 and 2 offered by The Change Companies can be completed to satisfy the training requirements. In February 2022, DDAP announced an additional online option from ASAM was added to the approved online ASAM trainings. Please reference the DDAP Training Website for updated information on approved trainings. ASAM Transition (pa.gov) The only Motivational Interviewing training that satisfies the requirement is the one offered by DDAP, Motivational Interviewing: Advancing the Practice. DDAP encourages providers to reach out to the SCA since they may be able to coordinate on-site trainings.
THERAPIES	
How would recreational interventions be documented? Would para-professional staff (tech staff) be able to document?	Recreational interventions must be tied to a specific need identified in the assessment and addressed through a particular goal on the individualized treatment plan. The progress note, charted for a group or for each person, should be individualized to reflect the progress of the treatment plan and can be noted by the person overseeing the intervention. Providers should follow their policies and procedures regarding documentation standards and reach out to payors

	for requirements regarding staff qualifications and documentation for specific interventions. Additional guidance is located on the ASAM Monthly TA Call provided on this topic located here: ASAM TA_12.06.pdf (pa.gov).
I had a question which may be related to ASAM but it may be cited in another regulation or area. We are curious if in the ASAM Criteria or in any regulation about the length of therapeutic sessions specifically the standard practice that a therapeutic sessions should as minimum 50 minutes to 1 hour.	The ASAM Criteria does not speak to or recommend specific lengths of time for individual counseling sessions. ASAM Criteria is focused on providing treatment that is tailored to the needs of the individual, guided by an individualized, multidimensional assessment and treatment plan, and developed in consultation with the patient. DDAP Regulations do not speak to length of therapeutic sessions. DDAP recommends providers confirm expectations related to therapy session length directly with payors.
ASSESSMENT & TREATMENT PLAN REVIEW	
Can providers continue to complete assessments?	Yes, if providers are contracted by the SCA or MCO to conduct level of care assessments. However, providers must demonstrate evidence of neutrality in their process of completing the LOCA and referring the client to the most appropriate level of care. This includes offering the client a choice and documentation that individuals have been referred to alternate programs other than the one conducting the level of care assessment.
Regulations recently changed to allow mental health providers to extend the due dates of treatment plans to 90 days. Will this change move its way to substance use?	It is DDAP's understanding that this MH regulation change was a temporary modification due to COVID-19. There is no effort currently underway for a change to drug and alcohol regulation. The current timeframes for treatment plan reviews noted in the 28 Pa. Code Ch. 709 are considered minimum standards for aligning with the ASAM Criteria and if changes are needed more frequently than noted in the regulation, they should be done. Clinicians should frequently reassess each individual and update the treatment plan as appropriate or when changes for the individual dictate such, documenting on the treatment plan and a progress note.
What is "evidence of neutrality" when conducting a Level of Care Assessment (LOCA) and how will it be monitored?	In some cases, SCAs or their contracted providers are conducting assessments and then making a referral. In other cases, LOCA is completed by a potential treating provider. In those cases, evidence of neutrality will include, but not be limited to: evidence demonstrating appropriate application of the ASAM admission criteria, evidence of client choice, data demonstrating enough referrals to alternate treatment providers, etc.

How is the ASAM criteria used to conduct a discharge for someone completing the program?	The Continued Service and Transfer/Discharge Criteria are found on pages 299 – 306 of The ASAM Criteria. There are conditions listed for the appropriateness of transfer or discharge of a patient from the present level of care (p. 303). When the condition for discharge has been met as outlined in the ASAM text, on pages 303-306, a contracted provider would then complete a discharge ASAM Summary Sheet in PA-WITS using the information presented in the discharge criteria and specific to the individual.
Are facilities able to complete their own transition of care or "step downs" to continued care or would we need an approved assessor to complete these?	Providers should be completing ongoing clinical assessments while an individual is in treatment to determine appropriateness for continued stay, transfer or discharge. Only the LOCA is done by an independent assessor. Treating clinicians/providers should be a part of the referral process when transitioning an individual to another level of care.
Our understanding is that we are required to have a written procedure that a clinician will review all admission decisions to confirm clinical necessity. Is this indicating that a counselor sign off on the assessors recommended level of care?	The review by the provider is to confirm the appropriateness to the recommended level of care. The facility should have a policy and procedure in place to indicate how this is done. Consider any BHMCOs/Managed care requirements around signatures and your current procedure for admitting an individual into treatment at your facility.
We get referrals from prisons and jails that have the ASAM completed. It may be up to 3 months old as they are preparing for d/c and they come directly to us from the prison. The level of care is correct on the ASAM and nothing has changed due to them being incarcerated. Can we use those as the admissions ASAM or do they need to be repeated?	Once a LOCA is completed, it will be valid for a period of six months. In this situation a new ASAM Summary and Risk Rating should be completed. Please reference the DDAP Case Management and Clinical Services Manual Section Chapter 5.02, Section I which includes guidance on LOCA for individuals who have been incarcerated. [Case Management and Clinical Services Manual.pdf (pa.gov).]
DOCUMENTATION	
What aspects of the ASAM Criteria can be incorporated into other documentation, such as progress notes and assessments?	All 6 Dimensions of the ASAM Criteria should be incorporated throughout the patient record. This concept is often referred to as the "Golden Thread." Starting at the assessment, the golden thread refers to the thread of connection and consistency of information woven throughout the patient's record. ASAM Assessments should not remain separate and distinct parts of the patient

Do ASAM assessments need to remain separate and distinct documents?	record. It should also be noted that the ASAM Criteria is copyrighted material. A provider that is looking to incorporate portions of the ASAM Criteria text into an EHR should reference the Fair Use Guidelines issued by ASAM, which can be found on their webpage Copyright & Permissions (asam.org) or seek the advice of its legal counsel. Additional guidance is located on the ASAM Monthly TA Call provided on this topic located here: ASAM TA_12.06.pdf (pa.gov).
What are the requirements regarding clinician and supervisory sign off/signature on the ASAM Summary sheet?	Section 5.07 of the Case Management and Clinical Services Manual states, "In the event the Case Manager has not completed all required trainings, the case management supervisor must document close supervision and review of written documentation, to include the LOCA and ASAM Summary Sheet, until the case manager has received all required trainings.
How would recreational interventions be documented? Would para-professional staff (tech staff) be able to document?	Recreational interventions must be tied to a specific need identified in the assessment and addressed through a particular goal on the individualized treatment plan. The progress note, charted for a group or for each person, should be individualized to reflect the progress of the treatment plan and can be documented by the person overseeing the intervention. Providers should follow their policies and procedures regarding documentation standards and reach out to payors for requirements regarding staff qualifications and documentation for specific interventions. It is also important to note that ASAM Criteria identifies recreational therapy as a skilled treatment service (page 429). Additional guidance is located on the ASAM Monthly TA Call provided on this topic located here: ASAM TA_12.06.pdf (pa.gov).
For documentation of life skills and therapeutic recreation do these need to be done in DAP format?	DDAP does not specify the format the provider must use, but it is the expectation that the life skills or recreational activity relates to an individual's need based on the treatment plan, and this should be clear in the clinical documentation of this service. DDAP recommends that providers confirm expectations related to documentation for these kind of interventions with payors. Additional guidance is located on the ASAM Monthly TA Call provided on this topic located here: ASAM TA_12.06.pdf (pa.gov).
OTHER	
What is the 1115 Waiver?	In short, the 1115 waiver, is an application process that DHS/ OMHSAS submitted to the Centers for Medicare and Medicaid Services (CMS) to address the admission limitations created by the

	IMD exclusion. The waiver required the use of an evidence based nationally recognized admission tool and service delivery practice of which Pennsylvania chose the ASAM Criteria.
I would like to inquire if DDAP is requiring providers to obtain ASAM level of care certification.	DDAP is currently not requiring providers to obtain ASAM level of care certification by accreditation organizations (CARF, Joint Commission, etc.). DDAP recommends that providers confirm expectations related to ASAM accreditation with payors.
I have been following the news of the ASAM Alignment and I just received a copy of the "ASAM Clarification and Flexibility 4/28/21" document.? I was surprised to see that one of the headings for ASAM alignment for Adolescent Services read: "Current efforts for aligning services with ASAM do not apply to adolescent services."? That reads pretty clear to me, but I just need some more assurance.? If we are an adolescent facility, then we do not need to be concerned with any regulations or requirements that apply to the ASAM/DDAP alignment?	Adolescent SUD treatment providers have always utilized the ASAM Criteria for level of care assessments and continued stay reviews. Beginning in November 2021, DDAP will collaborate with adolescent providers, public payers, and other stakeholders in preparation for ensuring adolescent providers are fully aligned with the ASAM Criteria. DDAP will address the special considerations for adolescents to ensure providers are implementing the Criteria for adolescents throughout the delivery of treatment services across the entire continuum of care.

Is there a new ASAM Crosswalk available for guidance?? We have the August 2019-ASAM Crosswalk now, but wondered if there was an updated version with recent changes.	DDAP has not published an updated ASAM Crosswalk, however, please be sure to check the DDAP ASAM Transition Website for regular updates. ASAM Transition (pa.gov)
I'm reaching out regarding ASAM transition policies. Our facility currently offers Level 1 and Level 2.1 services. When addressing the service characteristics self-assessment checklist there are numerous policies that need to	DDAP does not specify where ASAM policies should fall within providers' policy and procedure manuals. Providers must decide where and how ASAM changes fit within policy and procedures manuals based on their own operations and other factors relevant to their organization, level of care provided, etc.

be created. From our interpretation some of these policies can fall within chapters of the departments licensing regulations and others do not. Can we receive clarification as to where these new ASAM policies should occur within our own Policy and Procedure Manuel?	
Is alignment required to maintain a DDAP license if we do not accept County funded or Medicaid/Medicare patients?	ASAM alignment is not required to maintain DDAP licensure. DDAP and DHS are requiring use of the ASAM Criteria, as provided for under Act 70, only for providers who receive funding for treatment services under agreements with SCAs and/or MCOs.
Additional Guidance	
STAFF	
Is there a curriculum approved for MI at this point and is there a process to get an established curriculum approved by DDAP? Will this training be a 6 hours requirement?	DDAP's "Motivational Interviewing, Advancing the Practice" is a required training for case managers hired on or after 7/1/21 and is the "DDAP-approved" MI training. DDAP recommends clinical supervisors should take this course by 7/1/23 and other clinicians by 7/1/26. Updates on approved trainings can be found on the DDAP Training webpage: DDAP Training Announcements (pa.gov).
Must a clinical supervisor hold a specific type of licensure, such as Licensed Clinical Social Worker or can they be a Licensed Social Worker?	In addition to meeting the basic, standard minimum education and training requirements established via §704.6 of the PA Licensing Regulations 28 Pa. Code § 704.6. Qualifications for the position of clinical supervisor. (pacodeandbulletin.gov), all clinical supervisors must be a licensed clinician by the Pennsylvania Department of State (DOS)* or be fully certified as an addiction's counselor. Please reference the Staffing Section of the Guidance for the Application of the American Society of Addiction Medicine, 3rd edition, 2013 located on the DDAP ASAM Alignment website: ASAM Transition (pa.gov)
Do social workers need to be licensed if they are operating as internal case managers?	Yes, if a social worker hired after July 1, 2021 is acting as an internal case manager and completing level of care assessments, they need to be licensed or credentialed or working towards licensure or certification. They also need to meet the METs indicated by the State Civil Service Commission. SUD treatment providers that hire clinical staff who do not hold a license or certification must

	document steps towards licensure or certification. Treatment providers may, but are not required to, begin this process during a new employee's probationary period. Once the new employee has completed the probationary period, the provider must maintain documentation in the employee file to demonstrate that the employee is working towards licensure or certification. DDAP recommends the documentation include hours worked, hours of supervision, required trainings, and educational transcripts.
What are the Staffing Credentialing Requirements?	Please reference the Staffing Section of the Guidance for the Application of the American Society of Addiction Medicine, 3rd edition, 2013 located on the DDAP ASAM Alignment website: [ASAM Transition (pa.gov).]
When DDAP refers to "approved MI training for clinical supervisors and counselors", does this mean that DDAP will require a specific DDAP facilitated MI training for staff, or will providers need to submit to DDAP our intended MI training curriculum and training materials for DDAP review and approve?	DDAP's "Motivational Interviewing, Advancing the Practice" is currently a required training for case managers hired on or after 7/1/21 and is the "DDAP-approved" MI training. DDAP recommends clinical supervisors take this course by 7/1/23 and other clinicians by 7/1/26." Updates related to approved trainings can be found on the DDAP Training website [DDAP Training Announcements (pa.gov)].
During annual licensing reviews, will DDAP review all employee HR files to ensure that the staff have all the required trainings?	During Annual Licensing reviews, licensing will not be reviewing employee HR files to ensure that staff have completed the required ASAM training. Monitoring for ASAM alignment will be completed by the various payers and SCAs. Please note that licensing will continue to monitor providers for regulatory requirements, including all staff training requirements laid out in PA 704.11.
I work for a County Department of Drug and Alcohol Services which is also the County SCA. We provide "case management" services (assessments, case coordination…) but are not a licensed treatment provider. I am in the process of working with my Human Resources Department and others to hire two case management specialist	Case Managers hired after July 1, 2021, need to meet the METs indicated by the State Civil Service Commission and if they are conducting level of care assessments, they must be licensed by the Department State or certified by a statewide certification body which is a member of a National certification body or certification by another state government's substance abuse counseling certification board or be actively working towards licensing or certification. SUD treatment providers that hire clinical staff who do not hold a license or certification must document steps towards licensure or certification. Treatment providers may, but are not required to, begin this process during a new employee's probationary period. Once the new employee has completed the probationary period, the provider must maintain documentation in the employee file to

positions and am looking for an ASAM specific document that specifies the credentials required for someone to be hired as a case manager. I've reviewed (I think) all the ASAM documents on the DDAP website and know there are specific credentials noted in the Addendums for case managers in each level of care, but haven't found the criteria in writing that specifies staffing requirements applicable to my positions to share with our HR Department. I'd appreciate your help with identifying the credentialing criteria so any modifications to our job descriptions can be made and we can get the jobs posted.	demonstrate that the employee is working towards licensure or certification. DDAP recommends the documentation include hours worked, hours of supervision, required trainings, and educational transcripts.
For the required Motivational Interviewing training, can we create and provide our own training internally? And if so, what is the process to get non-DDAP trainings approved? Or does it have to be the DDAP approved 2-day training within the TMS portal?	Foundational knowledge of the Stages of Change and Motivational Interviewing went into effect July 1, 2021. Foundational knowledge does not have to be through a DDAP approved training and can be gained through online trainings, independent readings, provider developed inhouse guidance or instruction. The only Motivational Interviewing training that satisfies the formal instruction for Motivational Interviewing (beyond the foundational awareness) requirement is the one offered by DDAP, Motivational Interviewing: Advancing the Practice. Providers cannot create and provide their own trainings. The ASAM Update from January 2020 specifies that Modules 1 and 2 offered by The Change Companies can be completed to satisfy the training requirements. Please note that DDAP's training division is happy to assist providers in requesting a DDAP trainer to come on site to provide trainings. Please reach out to RA-DATraining@pa.gov for assistance in requesting a trainer to come on site to your facility.

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DEPARTMENT OF DRUG AND
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Miscellaneous	
THERAPIES	
What is the difference between client ratio and group size?	Group size is the maximum number of individuals that may be served in any one therapy group. Client ratio is how many clients an individual counselor is permitted to have on his or her caseload and this is used as a determination that all individuals being served by the program can be adequately cared for as per regulation. In most instances, caseload is determined by those individuals for whom a counselor is responsible for personally directing care and services, i.e., establishing the treatment plan, conducting re-assessments, providing individual therapy. In the course of duty, this same counselor may conduct a group session in which there are clients for whom he is not the primary therapist.
Will all residential levels of care, halfway house as well as 3.5 and 3.7 be required to accept all forms of FDA approved MAT in order to receive funding?	Yes, the Section 4.04 of the Case Management and Clinical Services Manual states "DDAP will identify state or federal funds that are available only to providers that permit use of FDA-approved medications in the treatment of SUD. Contracted providers that restrict admission based upon medication use may not receive those funds to treat any individual or provide any type of prevention, intervention, treatment, or treatment related service.
Will the facilities be able to make the decision to taper an individual off of MAT or will they need to maintain them since all forms of MAT need to be offered in order to receive funding? What will this look like since we know all forms of MAT should be offered and people should not be discriminated against, or forced to taper off of MAT?	The Case Management and Clinical Manual states that providers receiving state or federal funds are not allowed to restrict admissions based upon medication use. "DDAP will identify state or federal funds that are available only to providers that permit use of FDA-approved medications in the treatment of SUD. Contracted providers that restrict admission based upon medication use may not receive those funds to treat any individual or provide any type of prevention, intervention, treatment, or treatment related service." Whether or not an individual should taper from MAT is a decision that must be made between the prescriber and the patient. If an individual and their prescriber make the decision to taper off MAT, the facility is still allowed to receive federal or state funds. However, if the facility forces a person from MAT to admit or continue treatment, they would be violating this requirement.
Can you provide an example of what is looks like for a residential facility providing the 3.5 level of care to be required to accept clients on methadone? Short of being an OTP, are	A residential provider can accept an individual on methadone and the medication can be provided in several ways: An NTP/OTP can deliver medication to the residential/treatment provider consistent with DDAP and CSAT regulations and guidelines. A residential provider could opt to transport an individual to the NTP/OTP, if within a reasonable distance. A residential/treatment patient can use take home medication provided by the NTP the client is enrolled in. The client could guest dose at another NTP while enrolled in a residential/treatment facility. In this scenario,

you required to transport them daily, allow take home in the facility?	the client would remain enrolled in the NTP and the residential treatment program. The residential provider could also have a licensed NTP/OTP on the same campus which would allow easy access to care between types of service or care. Please see the ASAM Monthly Technical Assistance Call with on this topic for additional information: ASAM TA Series November 2021 (pa.gov).
What if there is no methadone clinic in the area (rural). Would setting up one or more of the agency's 3.5 facilities, local to a methadone clinic meet the requirement for the entire agency if others could not, due to lack of access to a methadone clinic?	PA regulation regarding take-home privileges indicates "§ 715.16. Take-home privileges (e) With an exception granted under subsection (d), a narcotic treatment program may not permit a patient to receive more than a 2-week take-home supply of medication." In such cases where distance would be prohibitive for the residential provider to obtain the take-home medication every two weeks, two options could be considered: If the individual is in agreement and the provider has an alternate facility in proximity to an NTP that can provide guest dosing, a referral to the other location can be made; or the residential provider could also have a licensed NTP/OTP on the same campus which would allow easy access to care between types of service or care. Please see the ASAM Monthly Technical Assistance Call from November 2021 for additional guidance on this topic. SAMHSA is pre-emptively granting OTPs an exemption, effective upon the expiration of the COVID-19 Public Health Emergency, and subject to the conditions identified below, from the unsupervised take-home medication requirements of 42 C.F.R. § 8.12(i) that are necessary to (1) dispense up to 28 days of take-home doses of opioid use disorder medication to stable patients if the OTP believes the patient can safely handle this amount of take-home medication and (2) dispense up to 14 days of take-home doses of opioid use disorder medication to less stable patients if the OTP believes the patient can safely handle this amount of take-home medication. SAMHSA is also considering mechanisms to make this flexibility permanent.
How are we supposed to handle methadone on the weekends when clients are given a dose to take home? We are a 3.5 that monitors medication. We do not administer.	There is nothing in PA Regulations prohibiting a 3.5 facility from storing take home doses of Methadone provided your facility has up to date policies and procedures outlining medication management in accordance with PA 709.32 Drug Storage Areas and Security of Drugs. Please discuss this option with your clinical team. DDAP Licensing would be happy to provide technical assistance to assist your facility with troubleshooting this specific

	concern. Please email licensing at for requests for technical assistance related to this topic at RA-licensuredivision@pa.gov.
OTHER	
Is Case Management a reimbursable service?	Yes, case management can be a reimbursable service depending on the service delivery model for each SCA and requirements for the BH-MCOs. Providers will need to work with these payors for additional information.
I was in a meeting this morning and it was suggested that full ASAM alignment would be finalized in 2026. Can you tell me if you have any sense of where that date might have come from? The only thing I can guess is that the addendum requires the credentialing of staff who are hired after 7/1/2021. If most have a total of three years for that to happen, many of them may not complete that process until 2024 or 2025. So maybe it won't be until 2026 until all the dust settles.	In Pennsylvania, Act 70 of 2021 required SUD treatment providers to substantially align service delivery conditions with The ASAM Criteria, 3rd Edition, 2013 by July 1, 2021. DDAP was directed to develop a process to allow providers to apply requesting an extension in substantially aligning with service delivery conditions until December 31, 2021. DDAP and DHS are requiring use of the ASAM Criteria, as provided for under Act 70, only for providers who receive funding for treatment services under agreements with SCAs and/or MCOs.
Is the "Pa license issued by the Department of State" the same as the certification from DDAP for the 30 hour Clinical Supervisor Training?	The 30-hour core curriculum offered by DDAP for clinical supervisors is not that same as the Certified Clinical Supervisor certification offered by the Pa Certification board. More information can be found on their website here: Certifications | Pennsylvania Certification Board. 28 Pa. Code § 704.6. Qualifications for the position of clinical supervisor (pacodeandbulletin.gov) outlines the experience, education, and training requirements for Clinical Supervisors.

I am wondering if virtual ASAM trainings are accepted by DDAP? I am registered for one online, but I read something briefly on the DDAP site suggesting in-person trainings might be required?	Yes, the virtual sessions by The Change Companies and ASAM are acceptable. DDAP Training Announcements (pa.gov). In February 2022, DDAP announced an additional online option from ASAM was added to the approved online ASAM trainings. Please reference the DDAP Training Website for updated information on approved trainings.
I have a question. I don't see if there is a level of education (BA, MA etc.) requirement one most have first before they are eligible to take the 2-day ASAM training or if there is any. Can anybody take this training and conduct ASAM assessment? If so, it does not make sense to me. Shouldn't there be a level of clinical experience or education one most have before they can conduct an ASAM assessment? Please let me know when you can. I have several organizations in Philadelphia who are inquiring.	There are no pre-requisites for who can take the ASAM training. Staff administering the LOCA must meet the METS specified for their positions. Please reference the Staffing Qualifications Section 5.08 in the Case Management and Clinical Services Manual CMCS manual: Case Management and Clinical Services Manual.pdf (pa.gov).
I have a therapist that resigned from her counseling position and stayed on as a prn program worker. She will be returning to her counseling position October 1. Is she grandfathered into this position?	If a "Program Worker" is a Counselor or Clinical Supervisor, then yes, grandfathering would apply. Individuals continuously employed by the facility or project are considered grandfathered as they are promoted through these clinical positions. If there is any question about this or additional guidance is needed please contact the ASAM email account at RA-DAASAM@pa.gov.
What are the ASAM alignment requirements for documentation of non-clinical groups?	DDAP regulations require the presence of progress notes in the client record, however they do not detail the content of progress notes. DDAP Bureau of Program Licensure does review progress notes during inspections. DDAP Bureau of Program Licensure compares the record of service entry with the corresponding progress note (i.e. if a record of service documents an individual

	session was conducted on October 10, DDAP will verify there is an individual progress note for October 10.) DDAP Bureau of Program Licensure reviews the progress notes to confirm the therapy is being conducted according to the treatment plan. (i.e. if the treatment plan states type and frequency of treatment is 3 groups a week and 1 individual per week, DDAP verifies there are 3 group notes per week and one individual session per week.) 709.92(c) The project shall assure that counseling services are provided according to the individual treatment and rehabilitation plan, and 709.92(d) Counseling shall be provided to a client on a regular and scheduled basis. ASAM Criteria states that programs should include individualized progress notes in the patient record that clearly reflect the implementation of the treatment plan and the patient's response to therapeutic interventions. In addition, the intervention chosen should relate to the individual's need as documented in their 6-dimensional biopsychosocial assessment. DDAP does not specify the format the provider must use, but it is the expectation that the life skills or recreational activity relates to an individual's need based on the treatment plan, and this should be clear in the clinical documentation of this service. DDAP recommends that providers confirm expectations related to documentation with payors. Additional guidance is located on the ASAM Monthly TA Call provided on this topic located here: ASAM TA_12.06.pdf (pa.gov).