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Owner	Matthew Yascolt: Director of Substance Use Disorder
Policy Area	Substance Use Disorders
Applicability	Detroit Wayne Integrated Health Network

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SUD Intake, Eligibility Verification, Level of Care Validation, and Level of Care Change

PROCEDURE PURPOSE

To define the process of service providers to review, validate, or appeal the Level of Care (LOC) determinations made by the Access Call Center.

EXPECTED OUTCOME

Ensure that every member receives the clinically appropriate level of care through a rigorous, two-tier validation process. By empowering the service provider to verify or challenge the initial screening, Detroit Wayne Integrated Health Network minimizes risk of under-treating high-risk individuals or over-utilizing restricted resources.

PROCEDURE

1. **Initial Referral Receipt** The process beings when the Access Call Center completes an initial screening and refers a member to a service provider.
    a. The Access Call Center determines the initial LOC.

b. The provider receives the referral and must conduct a comprehensive clinical assessment and drug screen.

c. With the goal to confirm that the members clinical presentation matches the referred LOC.

2. **Provider Determination Options** Upon completion of the provider-level assessment, the clinician must select one of the following three pathways

Option	Action	Requirement
Agreement with call center LOC	Accept the referral as-is	The assessment matches the Access Center's LOC determination
Disagreement with call center LOC	Submit a Change in LOC Request to accesscenter@dwihn.org with clinical justification	The provider determines a different level of care is medically necessary (higher of lower)
Clinical Justification	Retain referred LOC via justification in Utilization Management Authorization	The LOC seems incongruent at face value, but specific clinical nuances justify the placement

3. **Clinical Justification Protocols** In cases where the data appears inconsistent with standard LOC criteria, providers must justify the placement in the Notes Section of the authorization. Key Justification Scenarios:

a. **Incarceration/Hospitalization:** If a member reports low usage (e.g., 6 out of 30 days) due to being in jail or a hospital, this does not count as "sober time." Service providers must document the duration of controlled environment stays to justify a higher LOC.

b. **Inconsistent Reporting:** If the member provides different information to the provider than they gave to the Access Call Center, the provider's assessment takes precedence but must be detailed in the notes or change in level of care request.

c. **Negative Toxicology:** If a member's urine drug screen is negative despite a history of high-risk use, the clinician must document the risk of relapse or withdrawal history to justify the stay.

4. **Appeal**: When a provider acting on a member's behalf disagrees with a UM authorization decision, they have the right to appeal and request a formal review. All appeals must be submitted through appeals@dwihn.org.
The appeal must include the following information:

a. Member ID: Mental Health Wellness Information Network (MHWIN) Member ID.

b. Authorization Number: From denied authorization.

c. Provider Information: Contact information for additional questions or follow up.

d. Clinical Justification: Reasoning to support appeal.

5. **Eligibility Verification:** In addition to eligibility verification in MHWIN providers will conduct the following verification workflow

a. Primary ID Collection: Request a valid, government issued photo ID (Driver's license, passport, state ID).

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b. Multi-Factor Check: Cross-reference the ID with MHWIN and a secondary source.

c. Knowledge-Based Auth: Ask out-of-wallet questions (e.g. what is your address on file, phone, email).

d. Visual/Physical Audit: Inspect physical documents for tampering, inconsistent fonts, or expired dates.

e. Providers must ensure insurance verification occurs in MHWIN and if a member has insurance that is transferring from another county or has an open application. The medicaid tracking number must be included in all authorization for services.

6. **Documentation Requirements** To ensure seamless authorization from Utilization Management, all notes must include:

    a. Document discrepancies in member reporting

    b. Specific dates of incarceration or hospitalization

    c. Rationale why the Access Call Center's LOC is appropriate despite “face value” data points (e.g. the ASAM states a member should be in a different level of care but due to member's high risk in certain areas the service provider believes another level of care is appropriate)

7. **Same-Day Residential Departure Processing** When a member admits to a residential treatment program but discharges the facility prior to spending the night, because residential per-diem rates require an overnight stay, this ensures the facility can accurately transition the member's tier and secure authorization/billing for all specific services rendered during their single-day stay.

    a. Identify Same-Day Departure

        1. Condition: A member completes the residential intake process but leaves the facility against medical advice, is discharged, or otherwise departs before the overnight census is taken.

        2. Impact: The per-diem residential bed day cannot be billed

    b. Contact the Access Call Center

        1. Action: Immediately contract the Access Call Center and initiate a level of care change to outpatient programming citing discharge status of the member

    c. Document the Admission Record

        1. Action: In the members admission record enter a comprehensive progress/administrative note detailing the same-day departure. The exact time of admission and discharge, the reason for pre-mature departure, and a statement confirming that the access call center was notified and this is an admission for a level of care change that was originally residential but is now outpatient.

    d. Submit Authorizations for Rendered Services

        1. Action: Compile all clinical documentation for services actually delivered during the day (e.g., intake assessments)

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2. Submission: Submit authorization requests for the outpatient line-item services

8. **Medical Necessity and Clinical Criteria** An extension of withdrawal management services beyond the initially authorized length of stay must be justified by ongoing medical necessity. Continued stay criteria include but are not limited to:
    a. **Persistent Acute Withdrawal Symptoms:** Standardized rating scales indicate moderate-to-severe active withdrawal
    b. **Medical / Psychiatric Instability:** Uncontrolled vital signs, persistent nausea/vomiting, severe tremors, acute agitation, or co-occuring physiatric distress requiring clinical monitoring.
    c. **Inadequate Risk Mitigation:** High risk for severe withdrawal complications that cannot yet be safely managed at a lower level of care.
        1. Conduct an ongoing clinical assessment:
            i. Reevaluate the individual using the appropriate standardized objective tool:
                a. COWS (Clinical Opiate Withdrawal Scale) for opioid withdrawal
                b. CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol, Revised) for alcohol or sedative/hypnotic withdrawal.
            ii. Assessments must be administered and scored by a qualified clinical or nursing professional within 24 hours prior to the expiration of the current authorization.
        2. Compile supporting clinical documentation: prepare a concurrent review packet including:
            i. Updated COWS or CIWA-Ar score sheet (must reflect current clinical status)
            ii. Current Vital Signs (blood pressure, heart rate, temperature, respiratory rate)
            iii. Provider Progress notes and Medication Administration Record: showing current pharmacological management and response to treatment
            iv. Brief Clinical Justification: Clear narrative articulating why the patient cannot be safely transitioned to a lower level of care at this time.
            v. Revised Discharge and Step-Down Plan: Target discharge date and scheduled outpatient/ASAM step-down plan
        3. Submit Extension Request
            i. Transmit the complete documentation packet via additional authorization request for additional days

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ii. Email Subject Line Format: Extension Request: [MhWIN Member ID Number]

MONITORING STEPS

Who monitors this procedure:	DWIHN and Service Providers
Department:	SUD Department, Access Call Center, UM Department
Frequency of monitoring:	Daily
Reporting provided to:	UMC Committee
Comments: This is associated with Eligibility and Screening Policy	

Attachments

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SUD Intake Workflow (1).pdf

Approval Signatures

Step Description	Approver	Date
Clinical Officer Review	Stacey Sharp: Associate Vice President of Clinical Operatio	Pending
Unit Review and Approval	Matthew Yascolt: Director of Substance Use Disorder	08/2026

Applicability

Detroit Wayne Integrated Health Network

Standards

No standards are associated with this document