Guidance for implementing ASAM Criteria, 3rd Edition withdrawal management standards in Minnesota's substance use disorder treatment system

Minnesota Behavioral Health Administration

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Purpose

This document is provided for guidance purposes only and summarizes key information from The ASAM criteria: Treatment criteria for addictive, substance-related and co-occurring conditions (3rd ed.) (ASAM Criteria, 3rd Edition), published in 2013. Page numbers cited in this document refer to The ASAM Criteria, 3rd Edition. The full American Society of Addiction Medicine (ASAM) criteria and Minnesota Rule 245F statutory requirements must be consulted and followed. This document is not a substitute for these official resources or requirements.

Background

The Minnesota Behavioral Health Administration (BHA) has developed this guidance document for implementing ASAM Criteria, 3rd Edition withdrawal management standards to help SUD treatment providers across the state understand how the ASAM Criteria, 3rd Edition's various levels of withdrawal management can be offered within a continuum of care. This document focuses specifically on Level 3.2, clinically managed residential withdrawal management, and Level 3.7, medically monitored inpatient withdrawal management, the two levels of care licensed under Minnesota Statute 245F.

Continuum of care in withdrawal management

Withdrawal management is more than just managing the physical symptoms of withdrawal. According to the ASAM Criteria, 3rd Edition, it is a critical opportunity to help individuals break the cycle of substance use and address related issues. For many, withdrawal management represents their first exposure to formal treatment and recovery. ASAM Criteria, 3rd Edition emphasizes that withdrawal, while often uncomfortable and risky, creates a valuable opportunity to engage clients in long-term recovery. Since modern withdrawal management techniques effectively manage withdrawal symptoms, counseling and therapy can begin during withdrawal management, rather than being delayed until it is complete[1].

Transition from detox to withdrawal management

The term "detoxification" or "detox" has historically been used in SUD treatment, including in Minnesota regulations and earlier editions of the ASAM Criteria. However, the ASAM Criteria, 3rd Edition replaces this term with "withdrawal management" (WM) to better reflect a comprehensive and medically informed approach.

WM is not just a set of services: it is a level of care that must be clinically appropriate and based on medical necessity. WM is defined as "services required for Dimension 1: Acute intoxication and/or withdrawal potential."[2] These services are only appropriate when medical necessity has

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[1] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance -Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies©; 2013.

[2] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The ASAM Criteria:

been determined through a comprehensive assessment that identifies the need for support in managing intoxication and/or withdrawal symptoms.

While the liver naturally detoxifies substances, clinicians are responsible for managing the physiological and psychological effects of withdrawal. If withdrawal symptoms are not present, or if they do not pose a significant health risk, WM services may not be medically necessary, and another level of care may be more appropriate. In cases where a person is intoxicated but not yet in withdrawal, dimension 1 services focus on monitoring and managing intoxication.

By emphasizing medical necessity and individualized care, the ASAM Criteria, 3rd Edition supports the appropriate use of WM services within a broader continuum of care.

Five levels of withdrawal management

The ASAM Criteria outlines five levels of WM services, ranging from outpatient to intensive inpatient care:

- Level 1-WM: Ambulatory WM without Extended On-Site Monitoring
- Level 2-WM: Ambulatory WM with Extended On-Site Monitoring
- Level 3.2-WM: Clinically Managed Residential WM
- Level 3.7-WM: Medically Monitored Inpatient WM
- Level 4-WM: Medically Managed Intensive Inpatient WM

Under Minnesota Statute 245F, licensed providers may currently offer only Level 3.2 WM and Level 3.7 WM.

Tools and guidance in ASAM Criteria, 3rd Edition for withdrawal management

The ASAM Criteria provides several tools and frameworks to guide providers in WM:

- **Withdrawal rating scales and flow sheets**: Located in Appendix A of The ASAM Criteria, 3rd Edition (pages 393–400), these tools help assess withdrawal severity and guide clinical decisions.
- **Variable withdrawal risk by substance**: The ASAM Criteria, 3rd Edition notes that withdrawal risk differs by substance and include specific guidance for each.
- **Risk rating matrix**: This matrix supports a multidimensional approach for matching client needs to the appropriate WM level of care. It is explained for specific substances on pages 147–173.

Treatment Criteria for Addictive, Substance -Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies©; 2013.

Importance of a holistic, client-centered approach

The ASAM Criteria, 3rd Edition emphasizes a client-centered strategy that considers all dimensions of a client's needs. This approach ensures individuals receive the right level of care while addressing their unique risks and challenges during withdrawal.

Included below is a detailed chart with specific page references from the ASAM Criteria, 3rd Edition text.

Substance	Variable Withdrawal Risk	Risk Rating Matrix	Dimensional Admission Criteria Rules
Alcohol	145-146	147-154	165, 171-173, 166 (examples)
Sedative/Hypnotics	154-155	155-161	165, 171-173, 167 (examples)
Opioids	161 - 162	162	165, 171-173, 168 (examples)
Tobacco	163	N/A	165, 171-173, 170 (examples)
Marijuana	163	N/A	165, 171-173
Stimulant (and Dissociative Anesthetics)	163	N/A	169 (examples)
All substances	N/A	N/A	170 (examples)
More than one substance used at the same time	164	N/A	N/A

Across all levels of WM, the ASAM Criteria, 3rd Edition emphasizes the need for services to be provided under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

Withdrawal management programs and detoxification programs in Minnesota

History

Minnesota has been a leader in addiction treatment, especially through the creation of the

Minnesota Model[3]. This model, which combines the self-help methods of Alcoholics Anonymous (AA) with a medical approach, has been key in shaping how addiction is treated in the state. Traditionally, Minnesota's focus has been on alcohol dependency, reflecting its largely white population, even as the rest of the country faced waves of addiction to various substances.

Over time, national advances in addiction treatment, driven by brain research and new evidence-based psychosocial therapies, have shifted towards treating addiction as a chronic disease. This new approach integrates withdrawal management services with mental and physical healthcare.

Legislative frameworks and challenges

In Minnesota, detoxification programs and withdrawal management programs are governed by different regulations. Minnesota Rules Chapter 9530 regulates detoxification programs, while Minnesota Statutes Chapter 245F regulates withdrawal management programs. This distinction can sometimes lead to confusion, but both sets of regulations ensure proper licensing and require standards for these services.

Chapter 245F governs comprehensive withdrawal management programs with medical oversight. It includes medical necessity requirements for admission and continuing care and aligns closely with ASAM's multidimensional assessment model, ensuring thorough evaluation of medical, psychological and social factors. ASAM level of care 3.2 and 3.7 are covered benefits under both Medicaid and commercial insurance plans, making these services more widely accessible to individuals in need of medically monitored or managed detoxification.

In contrast, Chapter 9530 (Rule 32) is funded through counties with an emphasis on client and community safety. It sets minimum standards for detox programs based on observable symptoms, without the same level of detailed medical oversight and documentation. A summary of the differences is outlined in Appendix A.

ASAM Criteria, 3rd Edition for withdrawal management programs

This section summarizes key content from the ASAM Criteria, 3rd Edition, pages 137–143, for Level 3.2-WM and Level 3.7-WM. It outlines expectations for the setting, staffing, services, assessment, documentation and discharge to support safe, appropriate placement and transition to ongoing care.

[3] Hazelden Betty Ford Foundation. (n.d.). History of the Hazelden Betty Ford Foundation

Level 3.2-WM: Clinically managed residential withdrawal management

Level 3.2-WM, often called “social detoxification,” is designed for people experiencing moderate withdrawal symptoms who need 24-hour support and monitoring. This level of care focuses on providing peer and social support rather than medical or nursing care. Programs at this level follow clinical protocols to identify clients who may need medical services that go beyond what the facility can provide and ensure they are transferred to a higher level of care if necessary. Some facilities at this level are also equipped to supervise the self-administration of medications to help manage withdrawal symptoms.

Setting/service delivery (p. 137)

- Social setting WM program

Support systems (p. 137)

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems
- Since level 3.2-WM is managed by clinicians, not medical or nursing staff, protocols are in place should a client's condition deteriorate and appear to need medical or nursing interventions. These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include determining the conditions under which nursing and physician care is warranted and/or when transfer to a medically monitored facility or an acute care hospital is necessary. The protocols are developed and supported by a physician knowledgeable in addiction medicine.
- Affiliation with other levels of care
- Ability to conduct or arrange for appropriate laboratory and toxicology testing

Staffing (p.137 & p.138)

Physician/Physician Assistant/Nurse Practitioner	• Level 3.2-WM is a clinically managed service designed explicitly to safely assist clients through withdrawal without the need for ready on-site access to medical and nursing personnel • Medical evaluation and consultation are available 24 hours a day in accordance with treatment/transfer practice protocols and guidelines • Required: physician approved protocols for client observation and supervision, determination of appropriate level of care and facilitation of the client’s transition to continuing care

Registered Nurse or other licensed and credentialed nurse	• Level 3.2-WM is a clinically managed service designed explicitly to safely assist clients through withdrawal without the need for ready on-site access to medical and nursing personnel • Medical evaluation and consultation are available 24 hours a day in accordance with treatment/transfer practice protocols and guidelines
Interdisciplinary team of appropriately trained clinicians (counselors, social workers and psychologists)	• Level 3.2-WM programs are staffed by appropriately credentialed personnel who are competent to implement physician-approved protocols for client observation and supervision, determination of appropriate level of care and facilitation of the client's transition to continuing care. • All clinicians who assess and treat clients can obtain and interpret information regarding the needs of these clients. Such knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. • Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law. • Staff assures that clients are taking medications according to the physician prescription and legal requirements

Therapies (p. 138)

- Daily clinical services to assess and address the needs of the client. Services may include medical services, individual and group therapies and withdrawal support.
- Therapies provided as clinically necessary:
    - A range of cognitive, behavioral, medical, mental health and other therapies are administered to the client on an individual or group basis. These are designed to enhance the client's understanding of addiction, the completion of the WM process and referral to an appropriate level of care for continuing treatment.
    - Interdisciplinary individualized assessment and treatment
    - Health education services
    - Services to families and significant others

Assessment and treatment plan review (p.138)

- Addiction-focused history obtained as part of the initial assessment and reviewed by the

physician or physician extender during the admission process

- Physical examination by a physician, physician assistant or nurse practitioner as part of the initial assessment if self-administered WM medications are to be used
- Sufficient biopsychosocial screening assessments to determine the level of care in which the client should be placed and for the individualized care plan to address treatment priorities identified in dimensions 2 through 6
- Individualized treatment plan, including problem identification in dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives
- Daily assessment of client progress through WM and any treatment changes
- Discharge/transfer planning, beginning at admission
- Referral arrangements made as needed

Documentation (p.138)

- Progress notes reflect implementation of the treatment plan
- Progress notes indicate client's response to treatment and interventions
- Changes to the treatment plan should be documented in the progress notes and within the treatment plan
- Withdrawal scales (examples can be found in ASAM Criteria, 3rd Edition, pgs. 393-400) and flow sheets are used as needed

Length of service/continued service/discharge criteria (p. 138-139)

- Discharges: Signs and symptoms of withdrawal are sufficiently resolved that the client can be sufficiently managed at a less intensive level of care
- Referral to a higher level of WM: Signs and symptoms of withdrawal have failed to respond to treatment and have intensified as evidenced by higher scores on the CIWA-Ar other comparable standardized scoring system) such that transfer to a more intensive level of WM service is indicated
- Referral to a higher level of care: Unable to complete Level 3.2-WM despite an adequate trial. For example, they are experiencing increasing depression and suicidal impulses complicating cocaine withdrawal and indicating the need for transfer to a more intensive level of care or the addition of other clinical services (such as intensive counseling).

Level 3.7-WM: Medically monitored inpatient WM

Level 3.7-WM programs provide 24-hour observation, evaluation, monitoring and treatment for individuals whose withdrawal signs and symptoms are severe enough to warrant round-the-clock inpatient care. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

Setting/service delivery (p.139)

- Freestanding WM center
- Does not require the full resources of an acute care general hospital or medical managed intensive inpatient treatment program

Support systems (p.139)

- Availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems
- Availability of medical nursing care and observation as warranted, based on clinical judgement
- Direct affiliation with other levels of care
- Ability to conduct or arrange for appropriate laboratory and toxicology tests

Staffing (p.139-140)

Physician/Physician Assistant/Nurse Practitioner	• Available 24 hours a day by telephone • Available to assess the client within 24 hours of admission or earlier • Available to provide on-site monitoring of care and further evaluation daily
Registered Nurse or other licensed and credentialed nurse	• Available upon admission to conduct a nursing assessment • Oversees the monitoring of client's progress and medication administration, on an hourly basis, if needed • Available to administer medications in accordance with physician orders • Level of nursing care is appropriate to the severity of individual client needs
Licensed, certified or registered clinicians	• Provide planned regimen of 24-hour professionally directed evaluation, care and treatment services for clients and their families

Interdisciplinary team of appropriately trained clinicians (physicians, nurses, counselors, social workers and psychologists)	• Available to assess and treat the client and to obtain and interpret information regarding client needs • The number and disciplines of team members are appropriate to the range and severity of the individual client's problems

Therapies (p.140)

- Daily clinical services to assess and address the needs of each client; may include appropriate medical services, individual and group therapies and withdrawal support
- Hourly nurse monitoring of the client's progress and medication are available, if needed.
- Provided as clinically necessary:
    - A range of cognitive, behavioral, medical, mental health and other therapies are administered to the client on a group and individual basis. These are designed to enhance the client's understanding of addiction, the completion of WM process, and referral to an appropriate level of care for continuing treatment.
    - Multidisciplinary individualized assessment and treatment
    - Health education services
    - Services to families and significant others

Assessment and treatment plan review (p.140)

- Addiction-focused history obtained as part of the initial assessment and reviewed by the physician during the admission process
- Physical examination by a physician, physician assistant or nurse practitioner within 24 hours of admission and appropriate laboratory and toxicology tests: if level 3.7-WM services are a stepdown from 4-WM, records of the physical exam from the preceding seven days are evaluated by a physician within 24 hours of admission
- Sufficient biopsychosocial screening assessments to determine the level of care in which the client should be placed and for the individualized care plan to address treatment priorities identified in dimensions 2 through 6
- Individualized treatment plan, including problem identification in dimensions 2 through 6 and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives
- Daily assessment of client progress through WM and any treatment changes

- Discharge/transfer planning, beginning at admission
- Referral arrangements made as needed

Documentation (p.140)

- Progress notes reflect implementation of the treatment plan
- Progress notes indicate client's response to treatment and interventions
- Changes to the treatment plan should be documented in the progress notes and within the treatment plan
- Withdrawal Scales (examples can be found in ASAM Criteria, 3rd Edition, pgs. 395-40)
- Flow sheets (vital signs, etc.)

Length of service/continued service/discharge criteria (p.142)

- Discharge: Signs and symptoms of withdrawal are sufficiently resolved that they can be safely managed at a less intensive level of care.
- Referral to a higher level of care: Signs and symptoms of withdrawal are not responding to treatment and are intensifying

Level of care (LOC) determination for withdrawal management

This guidance supports timely LOC decisions for individuals needing WM by helping providers gather key clinical information at admission. It is designed for use with adults who may need Level 3.2 (Clinically Managed Residential Withdrawal Management) or Level 3.7 (Medically Monitored Inpatient Withdrawal Management), as defined in the ASAM Criteria, 3rd Edition.

At admission, providers must assess dimension 1 (acute intoxication and/or withdrawal potential) and obtain as much clinically relevant information as possible for dimensions 2 and 3 (biomedical and emotional/behavioral conditions) to identify imminent needs. These dimensions are essential for determining the appropriate initial level of care, particularly in WM settings.

When imminent needs are identified and a full multidimensional assessment is not feasible, a provisional LOC determination can be made based on dimensions 1–3. If the individual is in crisis, the assessment should be paused, and the person referred to emergency services.

Trained admitting staff may complete the assessment of dimensions 1–3 and recommend a provisional LOC, but final decisions must be reviewed and confirmed by a qualified professional. A provisional LOC does not replace the requirement for a full biopsychosocial and multidimensional assessment, which should follow as soon as the patient is clinically stable.

Risk-rating boxes are included to support utilization management (UM) processes. These ratings

should reflect the provider's clinical judgment and be used to justify LOC recommendations. All decisions must align with ASAM guidelines and meet clinical and regulatory standards.

Step 1: Assess Dimension 1: Acute intoxication and/or withdrawal potential

Dimension 1 forms the clinical foundation for initiating withdrawal management. Begin by:

- Identifying current substance(s) used, frequency and last use
- Screening for withdrawal symptoms and risk severity
- Using validated withdrawal scales (see below)
- Urine drug screen and/or breathalyzer
- Assign initial risk rating (Appendix B)

Common Screening Tools.

Tool	Substance	When to Use
CIWA-Ar (Clinical Institute Withdrawal Assessment – Alcohol)	Alcohol	Score ≥15 suggests need for medical monitoring (Level 3.7)
COWS (Clinical Opiate Withdrawal Scale)	Opioids	Score ≥13 indicates moderate/severe withdrawal
SOWS (Subjective Opioid Withdrawal Scale)	Opioids	Useful self-report in combination with COWS

*Programs are not limited to these tools but should use a validated screening tool to assist in determining level of care.

Step 2: Gather available dimension 2 and dimension 3 information at admission

While a full ASAM assessment can be deferred until after stabilization, some essential information from dimensions 2 and 3 can and should be collected at admission, as it may influence the LOC decision and safety planning.

Dimension 2: Biomedical Conditions and Complications

Document vital signs and other observable physical health characteristics at time of admission

Ask and observe for:

- Chronic medical conditions (e.g., diabetes, hypertension, liver disease)

- Current symptoms or concerns (e.g., chest pain, seizures, infection)
- History of complicated withdrawal (e.g., seizures, delirium tremens)
- Pregnancy status

Example: A client with a seizure history or active chest pain may require Level 3.7 due to the need for 24-hour medical monitoring.

Dimension 3: Emotional, behavioral or cognitive conditions and complications

Screen for:

- History of or current mental health diagnoses (e.g., bipolar disorder, PTSD, psychosis)
- Current mental health symptoms (e.g., suicidal ideation, hallucinations, anxiety)
- Cognitive impairments (e.g., confusion, inability to follow instructions)
- Current use of psychiatric medications

Example: A client with active suicidal ideation or hallucinations may require Level 3.7 for medical and psychiatric monitoring.

Simple tools that may be used to support rapid dimension 3 screening at intake:

- Columbia Suicide Severity Rating Scale (C-SSRS)
- PHQ-9 or GAD-7 (if client can participate)
- Mental status exam by admitting nurse or clinician

Step 3: Make a preliminary level of care determination

Use findings from dimension 1, supported by any available dimension 2 and 3 information, to determine the appropriate level of WM.

Level 3.2: Clinically managed residential WM

- Mild-to-moderate withdrawal
- No serious biomedical or emotional complications
- Client requires 24-hour structured support but does not require 24-hour medical monitoring

Level 3.7: Medically monitored inpatient WM

- Moderate-to-severe withdrawal or risk of complications
- Presence of unstable biomedical or psychiatric symptoms
- Requires 24-hour medical monitoring and structured clinical interventions

Step 4: Document medical necessity

Your documentation should:

- Justify the chosen level of care based on ASAM dimensions
- Reference symptoms, tool scores, preliminary risk ratings and clinical risks
- Note that the remaining ASAM dimensions will be completed post-stabilization

Step 5: Complete full comprehensive assessment

Once the client is considered medically and cognitively stable enough to participate in and complete the full comprehensive assessment (typically within 24–72 hours):

- Complete full comprehensive assessment of dimensions 2–6
- Reconfirm or adjust the level of care if new information emerges
- If client refuses assessment, clearly document the reason for refusal in the client record.

Guidance on transitioning between levels of care (3.2 and 3.7)

Clients may initially present at either Level 3.2 (Clinically managed residential withdrawal management) or Level 3.7 (Medically monitored inpatient withdrawal management) based on the severity of withdrawal symptoms, biomedical conditions and co-occurring behavioral health needs identified in ASAM dimensions 1–3. As withdrawal symptoms progress or stabilize, it is necessary to reassess the client's condition and determine whether a transition to a different level of care is clinically appropriate**.**

For example, if a client at Level 3.2 develops moderate to severe withdrawal symptoms, requires ongoing medication monitoring or presents with emerging biomedical or emotional/behavioral complications, transition to Level 3.7 should be considered. Conversely, if a client at Level 3.7 stabilizes and no longer requires 24-hour medical monitoring, a step-down to Level 3.2 may be appropriate.

All transitions between levels of care must be supported by updated clinical information and a new level of care determination. This determination should be documented in the client file and reflect changes in risk, function and treatment needs, and must be consistent with ASAM Criteria and medical necessity standards.

Appendix A: Rule 32 and MN 245F side by sides

Note: This table includes a summary of differences between MN Rule 32 and MN 245F. See statute and rule chapters for full details.

	Detoxification Programs (MN 9530 or Rule 32)	Withdrawal Management Programs (MN 245F)
Funding/Eligibility	County contracts	Medicaid service
Purpose of admission	Primarily focused on providing a safe environment and stabilization for individuals experiencing acute intoxication or withdrawal.	Provides withdrawal management services with medical oversight, withdrawal medication and stabilization services.
Assessment for admission	Admission is based on visible signs of intoxication or withdrawal symptoms requiring supervision.	More rigorous, requiring detailed evaluation at intake, including an assessment of withdrawal symptoms and medical needs before admission.
	Can admit individuals who are intoxicated, experiencing withdrawal issues, held under specific statutory orders or need temporary placement due to a substance use disorder crisis, with some admissions requiring a county request.	The program must determine that the services are medically necessary, and the individual meets the current ASAM standards for the appropriate level of withdrawal management.
Medical criteria	Minimal medical criteria: admission is determined largely by observable behaviors and self-reporting of substance use.	Prioritizes clinical and medical assessment framework. Emphasizes medical criteria, including vital signs and severity of withdrawal symptoms (e.g., CIWA or COWS scores).
Behavioral criteria	Focuses on ensuring safety, particularly if the individual poses a risk to themselves or others due to intoxication or withdrawal.	Includes behavioral and psychological criteria, such as agitation, suicidal ideation or co-occurring mental health disorders.
Readiness to change	No explicit criteria for evaluating readiness to engage in treatment	Aligns more closely with the ASAM dimension of readiness to

	or recovery services.	change. May assess readiness to change as part of the intake process but does not make it a barrier to admission.
Co-occurring disorders	Limited guidance on managing individuals with co-occurring mental health conditions.	Addresses co-occurring mental health conditions as part of the assessment and care plan.
Documentation	Minimal documentation; focuses on observable need for supervision.	Requires detailed documentation of medical and psychosocial assessments demonstrating medical necessity. Includes stabilization plan.
Continuing care continuum	Primarily covers the initial detox phase with less emphasis on transitioning patients to further treatment and recovery services.	A more integrated and continuous approach to care including transition planning and emphasizes referrals to other services or levels of care in the continuum.
Utilization review	No utilization reviews.	Post admission review of documentation to verify appropriate level of care was determined. Looks for continuing care recommendations.

Staffing	Detoxification Programs (MN 9530 or Rule 32)	Withdrawal Management Programs (MN 245F)
Program director	Required on a full-time basis, responsible for all aspects of the facility and services.	Required on a full-time basis, responsible for all aspects of the facility and services.
Responsible staff person	Must be present and awake during all hours of operation, with decision-making authority over day-to-day operations. Cannot be a technician.	Must be present and awake during all hours of operation, with decision-making authority over day-to-day operations. 3.2 – Minimum requirement of LPN

		3.7 – Minimum requirement of RN, program director or physician
Technician	One technician per 10 clients, awake and on duty at all times	One technician per 10 patients, awake and on duty at all times
Registered Nurse (RN)	Must be available 24/7 for consultation; responsible for health monitoring, medication control and handling emergencies	Responsible for health monitoring, medication control and handling emergencies 3.2 – Must be available by telephone or in person for consultation 24 hours a day 3.7 – Must be on site 24/7, must conduct initial health assessments at admission and have continuous availability for medical evaluation and consultation
Medical director	Required for medical supervision, ensuring safe provision of health-related services. A licensed physician in Minnesota (per Chapter 147)	Required for medical supervision, ensuring safe provision of health-related services. A licensed physician, physician assistant or advanced practice registered nurse.
Clinical	One full-time assessor for every 15 clients served by the program	One full-time alcohol and drug counselor for every 16 clients

Appendix B – Risk rating summary information

Withdrawal management risk rating guide

This summary with limited and brief examples is based on ASAM Criteria, 3rd Edition, pages 147–162. See the ASAM Criteria, 3rd Edition for full risk rating details.

Dimension 1 – Acute Intoxication and/or Withdrawal Potential

Risk Level	Alcohol	Opioids	Stimulants
0 – No Risk	No recent use or withdrawal symptoms; fully stable	No opioid use or withdrawal risk; stable	No intoxication, withdrawal or post-use crash symptoms
1 – Mild Risk	Mild tremor, anxiety, stable vitals; no history of seizures or DTs	Mild flu-like symptoms (e.g., yawning, runny nose), no impairment	Mild fatigue, insomnia or mild depression without behavioral risk
2 – Moderate Risk	Moderate withdrawal (e.g., elevated BP, sweats); may need meds but no seizure/DT history	Moderate withdrawal (e.g., cramping, chills); some interference with functioning	Moderate "crash" (e.g., agitation, low mood); some risk of relapse or distress
3 – Significant Risk	History of DTs or withdrawal seizures; unstable vitals or hallucinations; high risk without 24-hour care	Severe symptoms (vomiting, diarrhea, body aches); risk of complications or past overdose	Severe agitation, hallucinations, paranoia or suicidal ideation; risk of harm
4 – Severe Risk	Current delirium tremens, seizures or alcohol hallucinosis; requires immediate 24-hour medical management	Incapacitating withdrawal; medically unstable; high risk of overdose or death	Psychosis, suicidality or violent behavior requiring immediate medical/psychiatric care

Dimension 2 – Biomedical Conditions

Risk Level	Examples	Impact on WM Care
0 – None	No health issues	No interference
1 – Mild	Controlled chronic conditions (e.g., mild asthma)	Can manage in routine setting
2 – Moderate	Active but manageable conditions (e.g., hypertension, recent injury)	May need additional medical monitoring
3 – Significant	Unstable condition (e.g., recent stroke, uncontrolled diabetes)	Requires access to medical oversight specific to condition
4 – Severe	Life-threatening (e.g., active heart failure, uncontrolled seizures)	Needs 24/7 hospital-level care

Dimension 3 – Emotional/Behavioral/Cognitive

Risk Level	Examples	Impact on WM Care
0 – None	No mental health issues	Fully stable
1 – Mild	Mild anxiety/depression	Does not interfere with WM
2 – Moderate	Moderate anxiety, depression, trauma; stable psych meds	Needs support; may complicate detox
3 – Significant	Active suicidal thoughts, psychosis, cognitive impairment	High risk: close monitoring needed
4 – Severe	Immediate danger to self/others, severe psychosis	Needs psych-medical stabilization, hospital-level care

Summary of admission criteria decision rules for WM 3.2 and 3.7

See ASAM Criteria, 3rd Edition, pages 164-173 for full details and other WM levels of care.

Criteria	WDM 3.2	WDM 3.7
General Withdrawal Condition	Mild-to-moderate withdrawal or risk of imminent withdrawal that does not require medical management	Severe withdrawal or imminent severe withdrawal requiring medical monitoring
Alcohol	CIWA-Ar < 8 and stable with monitoring; no medication required	CIWA-Ar ≥ 19 after Level 2-WM; history of severe withdrawal or altered consciousness
Opioids	Moderate symptoms manageable without medication; impulsive use risk present	Daily use > 2 weeks with failed outpatient attempts; needs meds or antagonist induction (e.g., naltrexone)
Stimulants	Lethargy, hypersomnolence, paranoia or mild psychosis persisting after Level 2-WM; no need for meds	Same symptoms + poor impulse control or coping, creating risk of continued use
Sedatives/Hypnotics	Not specified	Daily use > 4 weeks at non-therapeutic levels; with or without alcohol or other drugs; moderate withdrawal not stabilized at Level 2-WM
Intoxication Symptoms (Alcohol/Sedatives)	Not specified	Marked lethargy/hypersomnolence with history of severe withdrawal or non-stabilized altered consciousness post-Level 2-WM
Support Needs / Environment	Needs structure due to lack of safe/supportive environment; meets at least one of the following: [1] Poor recovery environment + inadequate coping skills [2] Failed previous lower-level WM with poor coping [3] Inability to complete WM at lower level with continued use	Needs structure and medical care; meets at least one of the following: [1] Requires medication and failed past WM attempts [2] Same as 3.2 [2] [3] Comorbid conditions increasing withdrawal severity (e.g., chronic pain + PTSD)

Appendix C - Additional Resources

Legislation

- 245F MN Statutes
- 9530 - MN Rules Chapter
- 254B.19 MN Statutes

MN Webpages

- Substance use disorder treatment / Minnesota Department of Human Services
- Direct Access / Minnesota Department of Human Services
- ASAM Resources for Minnesota SUD treatment providers / Minnesota Department of Human Services

Guides/Informational Documents

- American Medication Association's (AMA) Definitions of "Screening" and "Medical Necessity"
- ASAM Third Edition - THE ASAM CRITERIA ASSESSMENT INTERVIEW GUIDE, Adults
- The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management
- The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management: Pocket Guide
- The ASAM Criteria®, Fourth Edition Level of Care Assessment Guide
- The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use
- TIP 45 Detoxification and Substance Abuse Treatment (samhsa.gov)
- SAMHSA Evidence-Based Practices Resource Center

Standardized Instruments

- Clinical Opiate Withdrawal Scale (COWS)
- Columbia-Suicide Severity Risk Scale (C-SSRS)
- Generalized Anxiety Disorder -7 (GAD-&)

- Guidelines for the Treatment of Alcohol Problems – Includes CIWA-Ar
- Patient Health Questionnaire-9 (PHQ-9)
- Subjective Opiate Withdrawal Scale (SOWS)
- The Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool