LAKESHORE
REGIONAL PARTNERS

SUD Services Provider Manual

Muskegon CMH Services

Community Mental Health of Ottawa County

West Michigan CMH System

Quick Reference

SUD Services Provider Manual
for the Muskegon, Ottawa, and West Michigan CMH Region

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SECTION 1

INTRODUCTION AND OVERVIEW

1.1 Introduction

The responsibility for managing substance abuse treatment services will transfer from the Regional Substance Abuse Coordinating Agencies (CAs) to the Prepaid Inpatient Health Plans (PIHPs) on October 1, 2014. The five (5) affiliate Community Mental Health Service Provider (CMHSP) members of the Lakeshore Regional Partnership (LRP) have been delegated the responsibility to manage the responsibilities for their respective areas. The region is comprised of 5 CMPSP: Community Mental Health of Ottawa County, Community Mental Health of Muskegon County, Network 180, Allegan County Community Mental Health, and West Michigan Community Mental Health. Within this region, Ottawa, Muskegon, and West Michigan CMHs are partnering for specific tasks and services and Network 180 and Allegan CMH are partnering. This document is the Provider Manual for the network of Substance Use Disorder Treatment Providers contracted with directly with the CMHs of Muskegon, Ottawa, and West Michigan heretofore referred to in this document as "CMHSP", referring to the specific CMH system with which the provider is contracted. This Provider Manual includes guidelines for treatment service definitions, requirements and restrictions, and is a reference source for issues relating to treatment services funded through the CMHSP. The guidelines provided within this document address both Block Grant and PA2 funding requirements. In many instances, throughout the document, it will note that the section applies only to Medicaid and Healthy Michigan Plan funded services or providers.

Block Grant Guidelines provided within this document and incorporated into contracts between the CMHSP and sub-contractors are derived from the terms of the Federal Block Grant, Public Act 368 of Michigan, the Annual Action Planning Guidelines (AAP) issued by the Michigan Department of Community Health (MDCH), and actions taken by the CMHSP.

For special purpose funds, from other funding sources, the terms set by that funding source will be provided in separate guidance specific to services funded through those funds.

Annually, MDCH publishes Action Plan Guidelines (APG) that specifies minimum requirements and terms for both the CMHSP and its sub-contractors. MDCH grants the PIHP/CMHSP authority to add further requirements germane to its own regional system so long as those additional requirements do not contradict or circumvent the Federal or State requirements.

The CMHSP will incorporate the terms of the AAP's into this provider manual and the State contract. It is the responsibility of all sub-contractors to abide by the terms of the APG as reflected in this manual and their contract with the CMHSP.

Given the wide variety of sources of requirements and changes, this operational reference manual is provided as a single point of reference and compilation of requirements. While it is our intent to make it as authoritative and accurate as possible on the date of its publication, users are cautioned that original source material takes precedence in all instances.

Amendments per MDCH, other funding sources, or the CMHSP may be made into requirements for subcontractors. Additional or new information and/or requirements may be distributed to subcontractors through a variety of methods.

1.2 Role of the CMHSP

The CMHSP serves as the coordinating agency and is responsible for comprehensive planning and reporting for substance use disorder services in the CMHSP region. Each CMHSP must ensure a continuum of substance abuse treatment services based on local determination of treatment service needs and on Federal and State requirements, as outlined in MDCH Treatment Policy #09 Outpatient Treatment Continuum of Services (See Appendices). The CMHSP is also responsible for establishing performance criteria with funded providers for audit purposes.

The CMHSP is expected to work toward a continuum of care for SUD Treatment and Recovery Services which includes: Outpatient, Residential, Detoxification, Methadone and other Medication Assisted Treatment, Case Management, Recovery Support, and Early Intervention.

1.3 CMHSP Priorities

1.3.1 Recovery Oriented System of Care (ROSC)

Michigan has defined ROSC in the following way:

> *Michigan's recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.*

Adopted by the ROSC Transformation Steering Committee, September 30, 2010.

A ROSC Integrates Strategies To:

- Prevent the development of new SUDs.
- Reduce the harm caused by addiction.
- Help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.

The following priorities have been established by MDCH for the initial implementation of a ROSC transformation.

- Behavioral health and primary healthcare integration
- Community health promotion
- Recovery support services that are peer-based
- Prevention services that are environmental and population-based
- Services and supports whose focus is expanded, including both the continuum of care (from pre-treatment services to post-treatment check-ups and support) and the content of care (beyond supporting abstinence to

promoting community health and helping people build meaningful lives in the community).

Additional information pertaining to Michigan's ROSC transformation initiative can be found in the ROSC area at the website: http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_55008-108813-,00.html

1.3.2 Individualized Treatment Planning and Integrated Care

The CMHSP acknowledges that the best client outcomes will be achieved when substance use disorder treatment services are based on the foundation of an individualized treatment/recovery plan. To achieve the best results, these plans must be a product of the client's active involvement in establishing the goals and expectations for treatment to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment.

The CMHSP is of the philosophy that in order for a client's treatment plan to effectively address a client's needs, the plan must incorporate a holistic approach to services, including; integrated care for physical and mental health needs and trauma-informed care.

1.3.3 Data Driven Quality Improvement

The CMHSP places great importance on the provider network and the coordinating agency being able to use data to inform data-driven decision making in both planning and implementation of services. The CMHSP will work to support the provider network in monitoring the provision of services to guide service improvement.

1.3.4 Community Input and Involvement

The communities served by the CMHSP are in a unique position to assist the CMHSP in the distribution and management of resources coordinated by the agency. The CMHSP will work to involve community input in decision making. The CMHSP also places great importance on the agency and provider network being actively involved in community initiatives so that resources may be coordinated effectively.

1.4 Policy and Procedure Development

Policies and supporting procedures governing the operation of the CMHSP, including its sub-contractual relationships with providers, are derived, in order of precedence, from Federal Block Grant requirements, State of Michigan requirements, and adopted policies of CMHSP Boards of Directors.

The CMHSP is charged with ensuring that funded services meet the needs, priorities, and requirements as mandated by the Michigan Department of Community Health and the U.S. Department of Health and Human Services.

Federal and State mandates are not negotiable and the CMHSP does not have the authority to waive such requirements or mandates in the contracting process. The CMHSP acceptance of such are pre-conditions of receiving resource allocations which are distributed to providers through sub-contracts.

The CMHSP Board of Directors may endorse, remain neutral with respect to, or recommend against sub-contractor initiated requests for changes in Federal or State requirements. The CMHSP Board of Directors may also initiate its own requests for changes. In neither instance does the action of the Board constitute a waiver of requirements.

1.5 Provider Network

Providers with a history of administering quality behavioral care in a cost-effective manner, and meeting the CMHSP Provider Selection Criteria are selected to participate in the CMHSP provider panel network.

The CMHSP classifies providers as network or non-network providers. For the remainder of this manual, Network providers will be referred to as Providers and non-network providers will be referred to as non-network providers.

Contracted network providers are in no way a party to any employer/employee relationship with the Michigan Department of Community Health, the CMHSPs, the Medical Services Administration, or any other such organization by virtue of contracting as a provider in the CMHSP Medicaid/Healthy Michigan Plans program.

The CMHSP's service network will contain a continuum of substance abuse care, as required and allowed by Michigan Medicaid/Healthy Michigan Plan rules. It will provide for a distribution of professionals and health service providers. The CMHSP will establish a range of services from facilities. Services will be proximal to enrollees and timely access to care available.

- Where available, public transportation will be considered in provider location. The geographic dispersal of members in urban/suburban and rural communities affects ease and time required to access treatment. Ease of access affects follow-through and follow up to treatment and, therefore, contributes significantly to positive treatment outcome.
- For these clinical reasons, a thirty (30) mile transportation radius is established from the home to be the outside parameter for outpatient treatment and ancillary services, whenever possible. No Medicaid/Healthy Michigan Plans client should have to travel more than sixty (60) miles for appropriate outpatient services. The travel radius to a qualified detoxification or other residential care facility, if provided, may be greater, because there are far fewer such facilities, and this is an allowable (optional) service under the CMHSP Medicaid/Healthy Michigan Plan.

1.6 CMHSP Contact Information

Inquiries regarding administrative functions of each CMHSP and the content covered within this document can be made by telephone, fax, or mail to the respective CMHSP:

CMH of Ottawa County
12265 James St.
Holland MI 49424
Access: 1-877-588-4357
Fax: 616-393-5653

CMH of Muskegon County
376 E. Apple Avenue
Muskegon MI 49442

Access: 1-855-795-1771
Fax: 231-724-4545

West Michigan CMH (Lake, Mason, Oceana Counties)
920 Diana St.
Ludington, MI 49431
Access: 1-800-992-2061
Fax: 231-845-7095

Claims forms should not be sent to the CMHSP. Refer to Section 6 of this manual for billing and reimbursement instructions and claim inquiries. This phone number should be used for inquiries related to the following:

- This manual and provider requirements
- Claims processing
- Reporting procedures
- Service Planning and Development

Customer Service

Inquiries in regard to client services may be directed to the Customer Service Department of the CMHSP. Customer service is available after hours and on weekends for client's seeking services.

CMH of Ottawa County
Customer Service:
Main: 1-866-710-7378
Fax: 616 393-5687
Email: cmhcustomerservices@miottawa.org

CMH of Muskegon County
1-231-720-3201

West Michigan CMH (Lake, Mason, Oceana Counties)
Toll Free: 1-800-992-2061

This number should be used for the following purposes:

- Assist persons seeking services in identifying the service provider(s) best able to meet their needs.
- Assist referring organizations in identifying the service provider(s) best able to meet the needs of the person they are referring.
- Assist SUD treatment providers in identifying available service providers when the program needs to refer a client to a level of care that they do not provide.
- Service Eligibility.
- Benefits and program information.
- Discuss authorization of client services with the provider requesting authorization.

1.7 Manual Maintenance

Periodically, the CMHSP publishes bulletins, notices, or administrative letters or memorandums to supplement and update the provider manuals. These publications provide information relating to policies, procedures and benefits. They are the official means of updating the manual between reprinting or full manual issues.

The administrative letter or memorandum is used to communicate major policy changes impacting the CMHSP, such as:

- A change in the reimbursement mechanism for a provider.
- A change in the system of communicating admission and/or claims information.
- An announcement by the Department of Community Health that affects the overall Plan.

Bulletins or notices are used to convey changes in the day-to-day operational procedures that apply to providers, to communicate changes in Medicaid/Healthy Michigan Plan coverage and to announce new provider participation.

SECTION 2

ACCESS TO SUBSTANCE USE (SUD) DISORDER SERVICES

2.1 Consumer Entrance to Services:

Persons seeking outpatient treatment services can present directly at any outpatient provider in the CMHSP Provider Network. Persons seeking residential or sub-acute detox services can present at any CMHSP contracted Outpatient Provider.

It is not required that the consumer or provider contact the CMHSP Access Management Staff prior to delivery of an assessment and initial outpatient or intensive outpatient services that result in an individualized treatment plan.

2.1.1 Outpatient Providers:

Persons seeking outpatient treatment services can present directly at any outpatient provider in the CMHSP Provider Network, including medication assisted treatment. Persons seeking residential or sub-acute detox services can now present at any CMHSP designated Outpatient Provider. Anyone who would like assistance in identifying the provider best able to meet their needs should contact CMHSP Customer Service for assistance.

Designated Outpatient Providers will conduct pre-screening to determine eligibility for CMHSP funded services, a full assessment for eligible clients, inform the person of the providers available to meet their needs, and make referrals when appropriate.

To be an designated Outpatient Provider in the CMHSP network, a provider must possesses SARF licensure and accept Block Grant and Medicaid/Healthy Michigan Plans for the CMHSP Region Counties of Lake, Mason, Oceana, Muskegon, and Ottawa. A list of Designated Outpatient Providers has been provided in the Attachments section.

Allegan or Kent County Residents should contact Network 180 at: 1-866-411-0690

2.1.2 Central Phone Support by CMHSP:

CMH of Ottawa County
1-877-588-4357

CMH of Muskegon County
1-855-795-1771

West Michigan CMH (Lake, Mason, Oceana Counties)
1-800-992-2061

The above designated phone numbers that ring directly to access management staff at each CMHSP is available 24/7 to promote access to services. This phone number will be available to:

- Assist persons seeking services in identifying the service provider(s) best able to meet their needs.

- Assist referring organizations in identifying the service provider(s) best able to meet the needs of the person they are referring.
- Assist SUD Outpatient Providers in identifying available service providers when the program needs to refer a client to a level of care that they do not provide.

During regular business hours consumers who contact the designated phone number will be provided with assistance identifying an appropriate service provider in their community. A full screening will not be completed during business hours.

When a client calls, a CMHSP Access Staff Member will briefly examine the client's condition and make a referral to an appropriate network provider.

If the referral is routine, the Access Staff Member will makes a routine referral to a designated Provider. Referrals are made based on:

- Location of the client
- Benefits Available
- Service Availability
- Client Preference

Clients who meet "urgent" or "crisis" criteria will be referred to an appropriate crisis resource such as the emergency room or local 24-hour mental health crises Access Center.

Network Providers are encouraged to include a statement in their after-hours recording that directs people to call 911 if it is an emergency or to call the CMHSP designated phone number for immediate assistance if the situation is not an emergency:

- **Urgent Situation:** A situation in which an individual is determined to be at-risk of experiencing a substance use disorder or mental health crisis in the near future, without the intervention of care, treatment, or support services. **Note**: Any priority population clients seeking substance use disorder services that meet the level of care criteria for admission to detoxification or residential services are an urgent situation.
- **Crisis Situation:** A situation in which a client seeking access is experiencing a medical or psychiatric emergency or who is suicidal or homicidal, thereby requiring an immediate referral/intervention to a provider specializing in the service most appropriate to the client's situation and needs.

Clients in need of substance use disorder services but who are not in the CMHSP region will be referred to the access center for the appropriate PIHP. Clients who are not in need of substance use disorder services will be referred to other community resources as available.

2.1.3 Pre-Screening

The outpatient provider where the client presents will be responsible for pre-screening the consumer to ensure they meet eligibility standards prior to service

provision with CMHSP funds.

Pre-screening can be done by non-clinical staff and may be done over the phone or in person if the client presents at the agency as the first contact.

Pre-screening should collect enough information to ensure eligibility and determine priority status of the client.

A client should not have to schedule an appointment to complete the pre-screen. Instead the pre-screen should occur at the initial point of contact with the client and result in an appointment for initial services. If the provider is unable to complete the pre-screening upon initial contact the provider must ensure that pregnant drug users, injecting drug users, and parents at risk of losing custody are screened within twenty-four (24) hours, and all others within two (2) business days.

The provider where the consumer presents must determine, and document, the client's admission priority status, as defined in Section 3.2.

Eligibility Criteria:

A. Residence:

- Block Grant and Medicaid/Healthy Michigan Plans: Only residents of Lake, Mason, Oceana, Allegan, Kent, Muskegon, and Ottawa Counties are eligible for CMHSP Block Grant funding. Non-CMHSP residents may apply to the CMHSP for funding assistance following the procedures provided using the *Non-Resident Service Request Form* for Block Grant only) and will be considered on a case-by-case basis.
- Residency is defined using the county of financial responsibility (COFR) guidelines. The COFR guidelines are complex, so if there is any question regarding county of residency, consult one of the CMH Access Centers. (See section 2.4.2 for more information on residency definition).

B. Financial Eligibility: The client must be eligible for CMHSP administered funds prior to service delivery, including Block Grant, Medicaid/Healthy Michigan Plans, Healthy Michigan Plan, or MIChild for residents of all counties in the CMHSP region.

C. Medical Necessity: Only services that meet medical necessity criteria will be allowable. Medical necessity does not require use in the past thirty (30) days. For detailed guidance regarding medical necessity refer to Section 2.4.1.

Priority Status: Certain priority populations must be given admission preference over any other client accessing the system. These clients are identified as a priority population under Block Grant funding requirements. Admission preference must be applied in the following order:

- Pregnant injecting drug user
- Pregnant drug user
- Injecting drug user
- Parents at-risk of losing custody of their children

Because these populations must be given admission priority, it is necessary to determine priority status during the pre-screening process. If the client is referred to another provider, the referring provider must notify the receiving provider of the priority status with appropriate releases of information.

For more details regarding priority populations and access standards refer to Section 2.3.

2.1.4 Choice of Provider

The outpatient provider where the consumer presents must inform the client of all available service provider options consistent with the appropriate level of care and resources for payment.

Client preference and choice is given high value in the placement process, and a client will not be authorized for a level or place of care that they state a firm unwillingness to attend. Prospective clients may have legal incentive to participate in treatment, but a Court-based referral does not guarantee CMHSP funding. Authorization for these clients will be based on clinical eligibility/medical necessity.

If a client indicates a preference to receive services from another provider, the pre-screening provider shall refer the client. When referring clients to another provider, the initial provider should assist the client in accessing services at the other provider. If the pre-screening was done over the phone, a three way call is encouraged. If the pre-screening was done in person, the initiation of a phone call to the new provider with the client is encouraged.

2.1.5 Initial Appointment Scheduling

If the client chooses to receive services at the pre-screening provider, an initial appointment with the client should be scheduled if it is not possible to provide services immediately.

A provider must maintain adequate facilities and sufficient personnel to provide consumers with timely access to covered services as are medically needed.

Providers must assure that preference for treatment admission is given to priority populations and meet the following Federal and/or State admission priorities.

- Pregnant and pregnant injecting drug users must be offered admission within two (2) business days. Pre-natal referral and communicable disease risk reduction information must be provided within forty-eight (48) hours.

  Pregnant Medicaid/Healthy Michigan Plans clients must receive an assessment within twenty-four (24) hours, and admission to services within twenty-four (24) hours after the assessment.

- Injecting drug user, parents at risk of losing children, and all others must be offered admission within **fourteen (14) days**.

If it is not possible to offer an appointment within the required timeframe, the provider must contact the CMHSP Access Center in the appropriate county to receive assistance in identifying an alternative provider of service and to place the client on the waiting list if appropriate.

Admission delays of more than fourteen (14) days for any level of care shall be monitored by the CMHSP, and providers must notify CMHSP if they do not have the capacity to meet service requests within this time allowance.

2.1.6 Initial Services

Once the provider has determined eligibility the CMHSP will allow up to five (5) initial hours of outpatient or two (2) days of intensive outpatient services, including the assessment, before the provider must submit an authorization request. The provider must ensure that the full bio-psychosocial assessment is conducted within a reasonable timeframe.

Recently completed assessments by Community Mental Health, a Court/corrections program, primary medical care provider, or other qualified source should be utilized to the extent possible. If the assessment is a different tool than the provider used, the content of their assessment should be used to complete the corresponding portions of the provider's assessment tool and any additionally required information would be collected from the client.

The bio-psychosocial assessment and treatment or discharge plan must be in place by the end of these initial sessions in order for the initial sessions to be eligible for reimbursement and/or authorization of additional services.

- For clients who do not need additional services a discharge plan should be in place by the end of the initial sessions to be eligible for reimbursement.
- For clients who discontinue contact prior to completion of a plan, the provider must document efforts to re-engage the client for the initial services to be eligible for reimbursement.

It is not required that these initial sessions be completed before an authorization request can be submitted. A provider may submit an authorization request at any point after the assessment has been completed.

This approach to initial services is designed to allow flexibility in the structuring of initial sessions and to allow the clinician to establish a relationship with the client in the initial session(s) rather than spending the first session(s) completing paperwork which has been found to reduce client retention in services.

The authorization request must be submitted within fourteen (14) days of the first date of service. It is expected that the client's individual treatment plan will be completed within fourteen (14) days of admission and must be signed by the client within fourteen (14) days of completion.

2.2 Referring to Another Provider

2.2.1 When a Referral is Necessary

A. Level of care: The provider must refer clients who want and are appropriate for a higher level of care that the outpatient provider does not offer. This may occur either before or after initial outpatient services are offered. Interim services may be provided at the lower level of care until the client is admitted to the higher level of care.

B. Client Choice: If a client indicates a preference to receive services from

another provider, the pre-screening provider shall refer the client.

C. Co-Occurring Disorders: According to SAMHSA, mental and substance use conditions often co-occur. In other words, individuals with substance use conditions often have a mental health condition at the same time and visa versus. Approximately 8.9 million adults have co-occurring disorders; and only 7.4% of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.

SAMHSA also reports that integrated treatment that addresses mental and substance use conditions at the same time is associated with lower costs and better outcomes such as reduced substance use, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests and improved quality of life. (Source: http://www.samhsa.gov/co-occurring)

It is important to ensure that clients with co-occurring mental and substance use conditions are treated by a provider capable of effectively addressing their needs. The ASAM PPC-2R and/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* provides the following guidance for determining the service needs of clients presenting with co-occurring conditions:

- Individuals whose co-occurring mental disorder best fits within the category of low/moderate severity disorder can be appropriately treated in programs designed to treat primary substance use disorders.
- Individuals with concurrent high severity mental disorders are generally best managed in dual diagnosis specialty programs that can offer integrated mental health and addiction treatment approaches.

  If a provider is not able to provide these services they should refer clients to an appropriate provider if one is available who will provide the services to the client. If no appropriate provider is available the provider should contact the CMHSP for assistance.
- Some patients may require immediate stabilization for their psychiatric symptoms before they can be engaged in ongoing addiction treatment and recovery. Depending on the severity of their symptoms, such patients may require referral to medical and/or psychiatric services outside the scope of addiction treatment. Patients whose biomedical or psychiatric disorders are so severe that stabilizing them is the highest priority are most appropriately treated in a medical or psychiatric facility before addiction treatment is initiated or continued.

2.2.2 Transferring Between Levels of Care:

CMHSP Customer Service is available to assist in referring clients by identifying available service providers:

A. Assessment: The bio-psychosocial assessment will usually be completed by the outpatient provider. In some cases the assessment will be completed by detox or residential services providers if treatment begins there.

When multiple providers are involved in providing services to an individual, every effort must be made to avoid unnecessary duplication of assessments. The initial provider shall obtain signed releases of information allowing information to be shared with the other providers who will be involved in the case, the authorizing CMH, and the LRP.

Once services are authorized, the provider who completed the assessment will share the assessment report (with the client's permission) with the secondary provider. A second assessment at the next level of care will not be an allowable expense if already billed by the previous provider.

If the assessment provided is a different tool than the provider uses, the content of the assessment completed by the initial provider should be used to complete the corresponding portions of the provider's assessment tool and any additionally required information would be collected from the client. An additional assessment would not be billed by the provider receiving an assessment already completed.

The assessment process is often time consuming, stressful, and can be traumatic for some individuals. It is important to remember that assessment can be very painful and shaming for clients who have to share their history. If the process is not undertaken with an awareness of how traditional service approaches may trigger a trauma victim, more harm can be done to an already fragile individual.

B. Authorization at Higher LOC

When the Outpatient Provider clinician determines that a referral to residential or residential sub-acute detox services at another provider is necessary, they will need to coordinate authorization of services with the Access Staff Member at the CMHSP.

The Outpatient Provider will need to submit the following so that the CMHSP can create the authorization for the client and release it to the selected residential provider:

- Residential authorization request form.
- All information required to create the Demographic and Payor records in ProviderConnect and a copy of the Declaration of Income if the Outpatient Provider has not yet created these records for the client.
- A copy of the client's full bio-psychosocial assessment- which is sent both to CMH and to the detox provider.
- A copy of the individualized treatment plan (if completed).

If approved, the CMHSP Access Staff Member will enter an initial authorization for services at the higher level of care. The Outpatient Provider should then assist the client in contacting the residential provider to schedule admission.

Once this has been done, the Outpatient Provider should notify the CMHSP of the selected provider and anticipated admission date. The CMHSP will also need:

- A signed Release of Information between the CMHSP and the

receiving residential provider. Without this release, the CMHSP will not be able to release the client's information to the residential provider.

When admitting the client, the residential provider should identify 'Other SA Program' as the referral source rather than 'AAR" when entering the client's admission record.

C. Interim Services

If the client is unable to be admitted to the higher level of care services immediately, the Outpatient Provider shall provide OP or IOP services until admission takes place at the higher level of care.

When requesting authorization for provision of interim services, the provider should note that the client is waiting for admission to a higher level of care. Refer to Section 3.1.3E for more information.

Providers must ensure that priority populations receive the required interim services as defined in Section 2.3.If the client refuses interim services, the refusal should be documented in the client file.

D. Transfer Criteria for a Higher Level of Care

According to ASAM PPC-2R and/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, each of the six dimensions should be reviewed to determine a patient's need for transfer to a higher level of care. It is appropriate to transfer the patient from the present level of care to a higher level of care if they meet the following criteria:

- Has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan; or
- Has demonstrated a lack of capacity to resolve their problem(s); or
- Has experienced an intensification of problem(s), or has developed a new problem(s) that can be addressed effectively only at a more intensive level of care.

E. Transfers from Detoxification to Next Level of Care

Medicaid/Healthy Michigan Plan clients must be admitted to the next level of care within seven (7) days of discharge from detoxification. However, it is recommended for all clients that they be admitted as soon as possible following detox services. If residential services are required, but there is not capacity to admit the client, interim services should be provided at a lower level of care until admission to residential occurs.

F. Warm Transfer

A "warm" transfer will be required if initial outpatient services have been provided and is to be encouraged in all cases. The referring provider should establish the appropriate release of information so that the provider receiving the referral can be made aware that the client is coming and ensure that information collected from the client is not duplicative. When the client arrives at the second provider they should be treated as if the transition is a

continuation of their care. A warm transfer should also be ensured when a consumer is transitioning to a lower level of care.

When a consumer is transitioning to a lower level of care and they had received interim services there should be an attempt to allow the client to return to the original provider.

If transportation is a challenge, the referring provider should assist the client in accessing community resources to assist. Some Medicaid/Healthy Michigan Plans cover transportation assistance for clients.

2.2.3 Information Sharing Between Providers

The assessment process is time consuming, stressful, and can be traumatic for some individuals. It is important to remember that assessment can be very painful and shaming for clients who have to share their history. If the process is not undertaken with an awareness of how traditional service approaches may trigger a trauma victim, more harm can be done to an already fragile individual.

Because of this, the appropriate releases of information must be collected so that any screening and/or assessment results can be shared with the CMHSP and/or another provider who will serve the client. If the client refuses to allow the release this refusal must be documented in the client's file. When the CMHSP authorizes residential services we will share the assessment results with the residential provider once the release of information from the Outpatient Provider is received.

Recently completed assessments by Community Mental Health, a Court/corrections program, primary medical care provider, or other qualified source should be utilized to the extent possible. If the assessment is a different tool than the provider used, the content of their assessment should be used to complete the corresponding portions of the provider's assessment tool and any additionally required information would be collected from the client.

The provider where the consumer presents must also determine the client's admission priority status and advise the potential admitting program of the client's admission priority status and to receive, from the potential admitting program, information on if and when admission may be expected.

When a client transitions between levels of care, whether at the same or a different provider, appropriate releases of information must be established and information regarding the assessment and treatment plan must be shared. If the client refuses to provide the release the refusal must be documented in the client's file.

A sample *Release of Information* has been provided in the Attachments section.

2.2.4 Coordination of Care with the Court System

When the Court system refers a client, the Provider must use the substance use disorder screening information provided by the District Court Probation Officer assessments when the Probation Officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP).

A release of information form must accompany the District Court Probation Officer referral. In situations where information is not adequate, the release of information should allow the Provider to contact the District Court Probation Officer for additional

information.

If the Court system refers the client to the CMHSP Access Staff Member, they will use the provided information to pre-authorize services at the provider of choice based on medical necessity, ASAM PPC-2R and/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition* and financial eligibility.

Drug Court clients must be shown to need the level of clinical care being requested, per ASAM standards. In situations where the client is "borderline" in regard to level of care, the Drug Court preference level should be honored if funding permits.

2.3 Priority Populations/Admission Standards

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements indicate that clients who are pregnant or injecting drug users have admission preference over any other client accessing the system and are identified as a priority population.

The Providers must provide services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity.

Within the admission priority status categories, the service provider has the right, responsibility, and authority to adjust admission order for cause.

When one client is jumped over another within the same admission priority category a written rationale shall be included in the record of the client given priority. A note shall also be placed in the file of the client who was passed over stating why and when the client was passed over.

Providers must conduct outreach activities for injecting drug users (IDU) and pregnant women. Clients must be recruited from women's shelters, homeless shelters, emergency rooms and other places where those likely to be in need of substance abuse services can be found.

Specific interim service requirements apply to priority populations and must be provided within the timeframe provided in the table below. When the client is found to need a higher level of care, it is expected that service at the lower level of care be provided until admission to the higher level of care. Provision of these services, or the refusal of such, must be documented for every priority client.

Refer to Section 2.2.2 for more information about providing interim services. Priority population clients must be admitted to services as follows:

Population	Admission Requirement	Interim Service Requirement*
Pregnant Injecting Drug User	1. Screened and referred within 24 hours. 2. Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. d. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1. Screened and referred within 24 hours. 2. Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred w/in 24 hours. Offer admission w/in 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
All Others	Screened and referred within seven calendar days. Capacity to offer admission w/in 14 days.	Not required.

2.4 Eligibility For CMHSP Funded Services

2.4.1 Medical Necessity: CMHSP funded treatment services, for all funding streams, must meet medical necessity criteria to be allowable. It should be noted that medical necessity does not require recent use.

Medically necessary services are supports, services, and treatment that meet at least one of the following criteria:

- Necessary for screening and assessing the presence of substance use disorder.
- Required to identify and evaluate a substance use disorder.
- Intended to treat, ameliorate, diminish or stabilize the symptoms of a SUD.

- Expected to arrest or delay the progression of a SUD.
- Designed to assist the individual to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.

In addition, determination of medical necessity must be based on all the following:

- Based on information provided by the individual, individual's family, and/or other individuals (e.g., friends, personal assistants/aids, etc.) who know the individual.
- Based on clinical information from the individual's primary care physician or clinicians with relevant qualifications who have evaluated the individual.
- Based on individualized treatment planning.
- Made by appropriately trained SUD professionals with sufficient clinical experience.
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

2.4.2 Residency

Block Grant Treatment funds administered by the CMHSP are primarily to provide services for current residents of the LRP region (Lake, Mason, Oceana, Allegan, Kent, Muskegon, and Ottawa). Residency in the area shall be established by evidence of an address within the region with stated intent to remain.

Acceptable documentation may include a Michigan driver's license, State identification card, school identification, auto registration, voter registration, a bank document, or other dated/addressed document from an official governmental unit, school, or employer.

When a person moves out of the region, residency will be considered to have ended thirty (30)days after the move, and CMHSP coverage will be discontinued unless continuation is applied for and granted by the CMHSP using the process described for non-CMHSP residents below.

Residents of all other counties with Medicaid/Healthy Michigan Plans should be referred to the appropriate PIHP Access Center for services.

Residency is defined using the county of financial responsibility (COFR) guidelines. The COFR guidelines are complex, so if there is any question regarding county of residency, consult one of the CMH Access Centers.

Key elements of the COFR guidelines include:

- The financially responsible CMHSP is the one that managed the public benefit in the county where the client last lived independently.
- Licensed AFC homes, nursing homes, and homes for the aged are not considered living independently.
- Adults living in transient settings (motels, homeless shelters, "couch surfing", etc.), on the street, or in their vehicle are considered residents of that county if they express intent to remain in that county.
- Children or adolescents in foster care are considered residents of the county whose court has jurisdiction of their case.

- Children or adolescents not in foster care are considered residents of the county where their parent or legal guardian resides.

Non-CMHSP Residents

Non-CMHSP Block Grant eligible residents may apply to the CMHSP for funding assistance using the *Non-Resident Service Request Form* and will be considered on a case-by-case basis. CMHSP funded treatment providers may admit non-residents to treatment, but must collect payment for the client from other sources, unless pre-approved by the CMHSP.

It is expected that the majority of requests will be from residents of adjacent counties, who are unable to access appropriate services within their region due to capacity, location, language and/or schedule barriers.

The CMHSP will grant approval when financially possible for MDCH Priority populations.

2.4.3 Financial Eligibility

Providers are required to use the *LRP Sliding Fee Scale* to determine financial eligibility for Block Grant funding provided in the Attachments section. Block Grant funds administered by the CMHSP are the last source of payment (Payor of Last Resort). If a client has Medicare, Medicaid, Healthy Michigan, MIChild, PA2 funding, partial insurance, or Department of Corrections (DOC) funding, all of these sources would be primary and need to be billed first. CMHSP funds may not be used to subsidize insured clients if the insured client chooses to go to a provider outside their insurance network.

Determining Financial Eligibility

In order to apply the sliding fee scale it is necessary to establish the household income and number of persons in the household. The way that this is calculated is determined by which of the following categories the person would fall under:

- **Minor Children:** For purposes of determining CMHSP financial eligibility, a child under 18 years of age will be considered a dependent; and total family income must be used unless the minor has been declared an emancipated minor, is married, or confidentiality has been formally requested by the minor for initial treatment services. During the course of treatment, once there is parental knowledge of a child's treatment, parental resources must be considered and applied.
- **Adult Dependent**: In the case of a single person 18 years of age and over who is living with his/her family and is being claimed as a dependent for income tax purposes (i.e. a student), family income should be considered in determining CMHSP financial eligibility. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.
- **Adult Independent**: Once a person turns 18, they may be legally considered an adult. Their 1040 income tax form or current payroll stub should be used to document income, and to determine financial eligibility. Parental income is not used if the 18-year-old is not claimed by a parent as a dependent. If the person

is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.

- **Married**: If married, the income of the client's spouse must also be considered.
- **Child support**: Child support paid should be deducted from an adult's income. Child support received should not be counted toward income.

SECTION 3

UTILIZATION MANAGEMENT

The CMHSP utilization management consists of the authorization of treatment services, concurrent reviews of treatment, retrospective reviews of challenging cases, random sample client file reviews, special studies, grievance and appeals procedures, review of authorization requests and service provision trends, and monitoring and assessment of operations and system trends.

During the course of the fiscal year and based on funding utilization, there may be a need for the CMHSP to institute a waiting list for Block Grant consumers. If this becomes necessary, providers will be given specific instructions.

In addition to the CMHSP Utilization Review, all Providers are expected to have internal utilization management capability. This capability must be expressed in systematic procedures which include initial assessments, concurrent review and retrospective reviews or studies. Adequate provision for staff supervision and consultation, peer review, and in-service training must be demonstrated.

3.1 Authorization Requests

Providers submit service authorization requests via ProviderConnect that will be reviewed by a CMHSP Access Staff Member. Providers will use the designated Customer Service department phone number to contact the CMHSP regarding authorization issues at respective Access Centers.

Authorization of services shall not be limited to consumers who report use within the past thirty (30) days because a restriction of services to only clients who report recent use is not in keeping with a recovery oriented system of care (ROSC).

Service authorization requests for initial services and continuation reviews must be based on the appropriate level of care as determined by medical necessity, ASAM PPC-2R criteria taking into consideration all six dimensions, not just recent use patterns and progress toward treatment goals. The initial authorization request must be submitted via the ProviderConnect system within fourteen (14) calendar days of the initial admission date.

Client preference and choice is given high value in the placement process, and a client will not be authorized for a level or place of care that they state a firm unwillingness to attend.

3.1.1 Authorization Parameters

Section 5.2 details the benefits and authorization parameters by level of care. Services authorizations will be for the entire amount within the level of care as summarized in the Authorization Parameters Matrix which is provided in the Attachments section.

Providers must discharge clients when it is clinically appropriate even if they have not used all of the approved units of service. According to ASAM PPC-2Rand/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, it is appropriate to discharge the client when they have achieved the goals articulated in their individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care.

3.1.2 Maximum Benefits and Exceptions

Within the Treatment Specifications some services under certain funding streams have established maximum service amounts for a client to receive within a twelve (12) month period. These maximum amounts are expected to meet the needs of most clients. However, when a client is in need of services beyond the maximum amount they may be authorized if clinically appropriate.

Maximum services received are determined based on the previous twelve (12) month period and within the entire CMHSP network. The CMHSP will review requests for clients who have already received the maximum amount of services within the CMHSP provider network on a case by case basis through the standard ProviderConnect authorization request process.

Information reviewed will include: the client's treatment plan goals/objectives that have been achieved/not achieved, and an explanation of why this client requires and is expected to benefit from an extension of treatment at this level of care. If necessary, the CMHSP may request additional information.

When the provider is aware that the client has used the maximum benefit, this information should be provided within the re-authorization request. When the provider is unaware that the client has used the maximum benefit, the CMHSP will notify the provider and request the additional information if necessary.

3.1.3 Authorization Request Submission

All clients seeking CMHSP-managed public funding, in whole or part, for their treatment services, must be authorized for those services by the CMHSP. A request for authorizations must be entered in ProviderConnect within fourteen (14) days of the first date a client receives services.

A. **Retroactive Authorization**

Once the provider has determined eligibility, the CMHSP will allow up to five (5) initial hours of outpatient or two (2) days of intensive outpatient services, including the assessment, before the provider must submit an authorization request. The provider must ensure that the full bio-psychosocial assessment is conducted within the five (5) hours but not to exceed fourteen (14) calendar days.

The bio-psychosocial assessment and treatment or discharge plan must be in place by the end of these initial five (5) sessions in order for the initial sessions to be eligible for reimbursement and/or authorization of additional services.

It is not required that these initial sessions be completed before an authorization request can be submitted. A provider may submit an authorization request at any point after the assessment but within fourteen (14) days of the first date client received services.

If the client participated in IOP, the authorization request must demonstrate that the client was/is clinically appropriate for that level of care to be retroactively approved.

Any additional services must be pre-approved prior to delivery.

i. **Assessment Only**

If only an assessment is completed for a client, a SARF record must be entered along with an authorization request for reimbursement of the assessment. This request will be approved retroactively as long as all eligibility criteria have been validated. An admission record should not be entered.

There are two scenarios where this may occur:

- Clients who are referred immediately to a residential program and no interim services are provided.
- Clients who are found not to have a substance use disorder diagnosis and are therefore not eligible for additional services.

ii. **Initial Services Only**

- **Initial Services Adequate:**

  When a client is not in need of additional services beyond the assessment and initial outpatient or IOP services, an authorization request must be submitted for an assessment and any initial session(s) that were provided. These services will be approved retroactively as long as all eligibility criteria have been validated and discharge planning has been completed. If an assessment was not necessary because a recent assessment was available, the authorization request should only include the initial outpatient or IOP services.

- **Client Discontinues Services:**

  When a client has discontinued care during initial services, a request must be submitted for authorization of the services that were provided. At least one attempt to re-engage the client in services must be documented and detailed in the authorization request.

iii. **Initial Services plus Additional:**

When the client is in need of services beyond the initial services, an authorization request should be submitted for the assessment, initial services, and the additional services. The initial services will be approved retroactively and the additional services will be pre-approved.

B. **Prior Authorization**

- **Residential, methadone, and sub-acute detoxification services** must be pre-approved before admission to residential services, including State Disability Assistance (SDA) room and board, and medication supported treatment services with the exception of pregnant clients presenting for methadone.

  When pregnant clients present for methadone, an authorization request must be submitted within twenty-four (24) hours of admission to ensure eligibility and provide retroactive authorization for that first day and

any subsequent days. Proof of pregnancy must be collected by the Provider prior to admission and documentation placed in the client's records. All requirements as specified in the MDCH Treatment Policy #5 "Criteria for Using Methadone for Medication Assisted Treatment and Recovery" must be followed.

- **Outpatient and Intensive Outpatient:** All services in excess of the initial five (5) hours of Outpatient or two (2) days of Intensive Outpatient must have prior authorization.

C. Requesting a Lower Level of Care (LOC) than Client Qualifies to Receive

If OP or IOP is being requested instead of residential services because a client has indicated that they prefer to receive the lower level of care, documentation of client choice of this level of care instead of residential should be documented and noted in the authorization request.

When clients who are receiving OP or IOP services while waiting for admission to residential services the Provider should note the anticipated date of admission to residential and that the request for OP or IOP are being provided as interim services in the authorization request.

3.2 Authorization Review

Service authorization approval will be determined based on ASAM PPC-2Rand/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, medical necessity, and validation of eligibility. The CMHSP will review each request by the end of the business day following submission, barring unusual circumstances.

After the initial authorization, concurrent reviews will be based on the criteria as the initial review and also take into consideration the Service Continuation Criteria as detailed in Section 3.2.5.These reviews will occur at each subsequent point where re-authorizations, extensions of treatment or change in the level of care are requested.

Patient progress toward criteria for discharge shall be considered in the decision process as defined in the Service Continuation Criteria detailed in Section 3.2.5.

3.2.1 Approval Baseline Parameters

In order to improve consistency in authorizations the CMHSP has established parameters for service requests for each level of care. These parameters provide the anticipated ASAM criteria and standard authorization of service amounts. This guidance is summarized in the Authorization Parameters Matrix, provided in the Attachments section and detailed in Section 5.2.

The CMHSP understands that in order to provide individualized treatment and respect client preference, not all requests will fall within established parameters. Providers must ensure that authorization requests are based on individualized treatment planning per MDCH Treatment Policy #06 "Individualized Treatment Planning" available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html

3.2.2 Automated Approval

Approval of initial, non-complex Outpatient requests that fall within the approval baseline parameters will be automated unless:

- The client has utilized more than forty (40) units of Outpatient across all providers in the CMHSP network in the past twelve (12) months.

3.2.3 Manual Review

For requests that do not meet the criteria for automated approval and for residential, methadone, and sub-acute detox service requests, the client record and/or assessment will be reviewed for approval determination. If additional information is needed to process the request, the Access Management Staff will contact the requesting provider. Refer to Section 2.2.2 for more information.

A copy of the full assessment must be submitted to the CMHSP Access Staff Member with authorization requests for methadone, and residential services, including detox. The CMHSP may also contact the clinician for more information.

3.2.4 Length of Authorization

Standard authorizations will be active for one hundred and eighty (180) days from date of approval. Authorization dates may be extended with justification that the level of care is still appropriate for the client. Providers should submit an extension of the authorization dates to the CMHSP through one of several secure communication methods such as secure email, fax, phone, in ProviderConnect comments within and authorization and provide justification for the extension in a brief narrative summary explaining why the extension is clinically necessary. An authorization end date will not be extended beyond twelve (12) months from the begin date.

Authorizations for methadone will reflect the required timelines established by MDCH and provided in the BSAAS policy #05, *Criteria for Using Methadone for Medication-Assisted Treatment and Recovery* available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html

3.2.5 Concurrent Review (Re-Authorization)

A concurrent review shall occur at each subsequent point after the initial authorization where extensions of treatment or change in the level of care are requested.

Just as with initial requests, re-authorization requests for client continuation must be based on medical necessity, ASAM criteria, continuation indicators, and updated clinical indicators for the client. Treatment planning and level of service/intensity of care shall be reviewed and adjusted as necessary with consideration to length of stay, use of appropriate resources, involvement and participation of significant others in the treatment process, etc.

- Length of stay shall be initially assigned based upon medical necessity and length of stay norms and reviewed for continued stay or extended stay based upon medical necessity.
- The use of appropriate resources in the treatment process and other medical considerations shall be reviewed.

- If the provider or client does not agree with the CMHSP Access determination he/she may initiate the Appeal and Grievance Procedure.
- Continued patient progress toward criteria for discharge shall be considered in the decision process.

Service Continuation Criteria: According to the ASAM PPC-2R and/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, it is appropriate to retain the patient at the present level of care if:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue work toward his or her treatment goals; **or**
- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; **and/or**
- New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the new problems can be addressed effectively.

Medication Assisted Treatment Services: State-administered funds, except Medicaid/Healthy Michigan Plans as covered under the Addendum, are limited for methadone to two (2) years per eligible client. This may be extended if the client meets the continued stay criteria specified in the MDCH Treatment Policy #05, *Criteria for Using Methadone for Medication Assisted Treatment and Recovery*" available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html

3.2.6 Pended Authorizations

CMHSP funded treatment services, for all funding streams, must meet medical necessity criteria to be authorized. If additional information is needed to process the request, the CMHSP's Access Management Staff (AMS) will send the authorization request back to the provider indicating what documentation or information is required to process the authorization. The provider shall have five (5) business days to respond to the request for information by resubmitting the authorization. The CMHSP's Access Staff Member will review the Request for Authorization with additional information within one (1) business day. If the information sent is insufficient or inadequate, the CMHSP's Access Staff Member shall contact the provider directly to indicate what information is still required. The requested information shall be sent to the CMHSP's Access Staff Member within one (1) business day. Failure to provide requested information in a timely manner may jeopardize approval of the requested authorization.

3.3 Grievance and Appeals Procedure

3.3.1 Notification of Rights

Providers must notify all clients of their rights, including the procedure for filing a grievance and appeal. Medicaid/Healthy Michigan Plan clients must receive an adequate notice prior to the submission of an authorization request for services. In addition, Medicaid/Healthy Michigan Plan recipients must be notified through advance notice prior to any action to reduce or terminate current authorized services. Medicaid/Healthy Michigan Plan clients must receive Adequate or Advance Notices of their services and rights in accordance with sections of Federal Law 42 CFR 440-230(d), 42 CFR Chapter IV, Subpart F, Sections 438.402 to 424, MDCH/MSA Policy Bulletin: Medicaid/Healthy Michigan Plans Eligibility Manual – Beneficiary.

3.3.2 Filing a Grievance

Clients may file a grievance and request an appeal by contacting the CMHSP Recipient Rights Advisor. The Recipient Rights Advisor may be reached at the general CMHSP office at CMH of Ottawa County 1-877-588-4357, CMH of Muskegon County 231-720-3201, or West Michigan CMH (Lake, Mason, Oceana Counties) 1-800-992-2061. The Recipient Rights Advisor role will not be assigned to an Access Staff Member.

3.3.3 Advocacy on Behalf of Client

Provider agencies may advocate for services on behalf of a client by contacting a CMHSP Access Staff Member. If after speaking with Access staff they still feel that additional consideration is required, they may contact a CMHSP Access Supervisor for further discussion/consideration.

If the provider feels the matter has not been satisfactorily resolved after speaking with the CMHSP Access Supervisor, they may submit a *Request for Review of Authorization Decision* to initiate a peer review of the decision. The request form is provided in the Attachments section.

3.4 Capacity Management

The CMHSP is responsible for monitoring availability of services and adjusting the service array as necessary to meet needs and must ensure that services are available year-round.

3.4.1 IDU Providers

Upon reaching 90 percent of capacity to admit individuals to the program, a Provider that serves IDUs must notify the CMHSP immediately. The CMHSP is required to notify the State within twenty four (24) hours.

3.4.2 Waiting List

If it is not possible to offer an appointment within the required timeframe the provider must contact a CMHSP Access Staff Member. If an alternative provider that can admit the client within the required timeframe is available they may be admitted with that Provider. If the client wishes to wait for an opening with the original Provider, that Provider must notify the client when an opening becomes available.

The CMHSP will contact the client every thirty (30) days, at a minimum, to determine continued interest in services, continued necessity of services, and

whether the client might be appropriate for services from another provider with capacity to provide the services. This does not prohibit the service provider from contacting the client directly.

3.4.3 Mid-Year Adjustment to Allowable Benefits

It may be necessary for the CMHSP to implement a waiting list for Block Grant clients in order to ensure service availability year-round. If this is necessary, the CMHSP will notify each provider in the network by email, fax, and will also post a notice on the established website.

SECTION 4

CLIENT RIGHTS AND REQUIRED NOTIFICATIONS

4.1 Choice of Provider

The outpatient provider, where the consumer presents, must inform the client of all available service provider options consistent with the appropriate level of care and resources for payment. Refer to Section 2.1.4 for more information.

4.2 Recipient Rights

A recipient may not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, mental or physical handicap, marital status, sexual preference, or political beliefs. All clients must receive notification of these rights. The Know Your Rights brochure is available in both English and Spanish. Copies are available upon request from your local CMHSP.

Records of the identity, of any recipient of services which are maintained in connection with the performance of any drug abuse prevention function conducted shall be confidential and be disclosed only for the purposes and under the circumstances described below:

1. The content of any record referred to above may be disclosed in accordance with the prior written consent of the recipient.
2. Whether or not a recipient gives written consent the content of any record referred to above may be disclosed as follows:
   - To medical personnel to the extent necessary to meet a bona fide medical emergency.
   - To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual recipient in any report of such research, audit or evaluation, or otherwise disclose recipient identities in any manner.
   - If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefore.

When maintaining records that include both the recipient's name and information regarding his or her substance use or abuse, the recipient shall be provided with both a summary of recipient rights and written notification that states:

> "Recipients of substance abuse services have rights protected by State and Federal law and promulgated rules. For information contact (staff name, address, phone) or the Bureau of Health Systems, Division of Licensing and Certification, Substance Abuse Licensing Section, Recipient Rights Coordinator, P.O. Box 30664, Lansing, Michigan 48909."

Any program announcement, brochure, or other written communication that describes the program's services shall also include this statement.

For more information and full details regarding recipient rights for substance abuse services refer to Section XV of the MDCH Substance Abuse Licensing Rules, Recipients

Rights and Licensing Applications available at http://www.michigan.gov/lara/0,1607,7-154-27417_30419---,00.html.

4.3 Grievance and Appeal

Medicaid/Healthy Michigan Plan clients will receive Adequate and Advance Notices of their services and rights in accordance with sections of Federal Law 42 CFR 440-230(d), 42 CFR Chapter IV, Subpart F, Sections 438.402 to 424, MDCH/MSA Policy Bulletin: Medicaid/Healthy Michigan Plans Eligibility Manual – Beneficiary Hearings.

Grievance and appeal procedures for Medicaid/Healthy Michigan Plan clients must comply with the LBHA Policy 20-054, available at http://www.co.muskegon.mi.us/cmh/providermanual/section3/04-023.pdf.

Providers must notify all clients of their rights to file a grievance and appeal in relation to the authorization request for their services. Notification must occur prior to submission of an authorization request or an action that would result in a reduction or termination of services. Refer to Section 3.2 for more information.

4.4 Charitable Choice Procedures

In order for the CMHSP to comply with 42CFR Parts 54 and 54a, and 45 CFR Parts 96, 260, and 1050, pertaining to the final rules for the Charitable Choice Provisions and Regulations, Providers must also comply.

Providers must identify themselves as religious (or faith-based), if applicable, and ensure that clients are notified of their right to request alternative services.

Unless a written request to use an alternate, but equivalent notice is made and approved by the CMHSP, the language below is required.

> *"No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.*
>
> *If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization."*

If a client objects to the religious character of a program, the Provider and the CMHSP's customer services department must work to refer the client and ensure connection to alternative services within the standards of timeliness, capacity, accessibility, and equivalency.

Documentation must be in each client's file that they were given, and received this "charitable choice" notice.

4.5 HIPAA Notification

Providers must provide clients with formal notice of their rights regarding privacy of protected health information, as required by the Federal Health Insurance Portability and Accountability Act of 1996. This notice is in addition to the HIPAA compliant privacy

notice required to be given by your agency itself, and will not meet your obligations, as a treatment provider.

The *CMHSPHIPAA Privacy Brochure*, provided in the Attachments section and available upon request from the local CMHSP, shall be given to all newly admitted or re-admitted clients using CMHSP funding, as they come into the program. Documentation of this provision must be documented. The notice should be given to all clients who are receiving services funded in whole or in part by any source of funds managed by the CMHSP. The CMHSP privacy notice does not need to be given to clients whose services are in no way covered by any funding source managed by the CMHSP.

The provider is not required to collect a separate acknowledgement from each client that they have received this notice.

4.6 Communicable Disease

Given the increased risk of contracting HIV/AIDS, hepatitis, and other communicable diseases for those with a substance use disorder, it is important to recognize the role of communicable disease in the development of substance abuse treatment plans for clients.

There are requirements that all substance abuse treatment agencies receiving MDCH/ODCP funds must meet in regard to communicable disease screening, information provision and referrals. These requirements must be met regardless of whether the provider receives a communicable disease allocation.

All publicly funded substance abuse treatment providers must assure that the following services are provided:

- Treatment providers are required to screen **all** substance abuse clients entering treatment for risk of HIV/AIDS, STDs, TB, and hepatitis, and to provide basic information about risk.
- All clients entering residential treatment and residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid the potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.
- All pregnant women presenting themselves for treatment must be informed of available STD and HIV-testing resources.
- All clients with a history of injecting drug use (IDU) must be referred for Hepatitis C testing, unless documentation is provided affirming and existing positive Hepatitis C diagnosis.
- All persons receiving substance abuse services who are determined to be infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The agency's responsibility extends to ensuring that the agency to which the client is referred has the capacity to provide these medical services or to make these services available, based on ability to pay. If no such agency can be identified locally (within reasonable distance), the agency must notify the CMHSP.
- Provide basic information on HIV/AIDS, Tuberculosis, Hepatitis, and STDs to all clients entering treatment.
- For those clients entering or already active in substance abuse treatment who are identified with high-risk behaviors:

- Each treatment agency must provide additional information about the resources available and referral to testing and treatment (with follow-up).
- Each treatment agency is required to assure that communicable disease related health education and risk reduction activities are available, and that appropriate medical referrals are made when indicated.

For full details on communicable disease requirements please refer to the MDCH Policy #2 found at: http://www.michigan.gov/documents/mdch/P-P-02_Comm_Disease_w-form_enabled_372455_7.pdf

4.7 Adequate Notice to Medicaid/Healthy Michigan Plans Clients

Adequate Notice requires that all clients be made aware of their right to appeal authorization decisions related to their services. Adequate notice must be provided to all Medicaid/Healthy Michigan Plan clients at the beginning of a new service episode or service level by the Provider. A copy of the signed Adequate Notice form must be kept in the client's file for all Medicaid/Healthy Michigan Plan clients.

4.8 Advance Directives to Medicaid/Healthy Michigan Plan Clients

The rights of Medicaid/Healthy Michigan Plan clients to make choices and decisions about their future medical and/or behavioral health care are respected by the CMHSP. Medicaid/Healthy Michigan Plan clients may make their choices known by completing an Advance Directive for medical and/or mental health care, also known as a Durable Power of Attorney. This is a document in which a client appoints another individual to make future medical and/or mental health decisions should their ability to make decisions become impaired. An Advance Directive is voluntary and it is against the law for health care providers or insurance companies to require one as a condition of treatment coverage.

Providers must offer all adult Medicaid/Healthy Michigan Plans clients information on Advance Directive laws and record in the client record if a client provides the Provider with an Advance Directive.

- Comply with all provisions for advance directives, described in Federal Code 42CFR 422.128, as required under 42CFR 438.6,
- Must have in effect written policies and procedures for the use and handling of advance directives written for any adult individual receiving treatment services by or through the Provider.
- Provide adults information regarding their rights to have and exercise advance directives under the law of the State of Michigan: MCL 700.5506 – 700.5512 and MCL 333.1051 – 333.1064.
- Update policies within 90 days of any changes to State law.
- Describe Provider procedures for respecting patient advance directives rights, including any limitations if applicable.

The CMHSP shall monitor compliance with this policy. External review will be conducted during site visit reviews.

References:

- Michigan Advance Directive for Mental Health Care: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_41752---,00.html

- Advance Directives: Planning for Medical Care in the Event of Loss of Decision-Making Ability: www.michbar.org/elderlaw/adpamphlet.cfm
- Advance Directive – FAQs: http://www.bcbsm.com/member/establishing_advance_directive/advance_directive_faq.shtml
- 42 C.F.R. 422.128

4.9 Corporate Compliance Plan

The CMHSP is committed to conducting itself as a good organizational citizen by promoting an organizational culture that encourages a commitment to compliance with the law. For more information refer to Section 7.2.2 and the Corporate Compliance Plan available at https://lakeshoreregionalentity-public.sharepoint.com/Pages/Policies.aspx.

The Corporate Compliance Plan shall be provided to all Medicaid/Healthy Michigan Plans Covered Individuals, and the Providers must obtain and retain (subject to review by the CMHSP) signed certifications that each such individual has received, has read, and understands the Code of Ethics and agrees to abide by the requirements of the LRP Corporate Compliance Program.

4.10 Lakeshore Regional Partnership Handbook

Providers must offer all Medicaid/Healthy Michigan Plans clients the Lakeshore Regional Partnership Handbook upon admission and annually thereafter for treatment episodes that exceed one (1) year in length. Copies are available upon request from your CMHSP or on-line at the Lakeshore Regional Partner website: http://lakeshoreregionalpartners.lsre.org.

SECTION 5

BENEFIT INFORMATION

5.1 Public Funding Sources

5.1.1 Block Grant

Federal Substance Abuse Services Block Grant (BG) funds are administered by the State of Michigan, and distributed through MDCH-designated Regional Entities. Often referred to as "community grant," there is a 10% local (county) match required of the PIHP region, the CMHSP may limit benefits due to availability of funds.

The CMHSP sets service limits and authorization parameters for funds that they manage which are provided in the Authorization Parameters Matrix, provided in the Attachments section. Priority for use of these funds is assigned to selected populations as defined in Section 2.3. The CMHSP will consider extensions for service limits on a case-by-case basis.

A. **Covered Services:** Assessment, Outpatient therapy, Co-Dependent Outpatient Therapy, Opiate Replacement Therapy, Intensive Outpatient, Partial Hospitalization Enhanced IOP, Short and Long-Term Residential, Residential room and board, and Sub-Acute Detox.

B. **Additional Requirements**

All clients seeking Block Grant fund coverage must also apply for Medicaid/Healthy Michigan Plan/MIChild programs unless they can show recent ineligibility. Providers may need to assist clients in this process.

Community Grant consumers are assessed a co-pay for services based on the most recent CMHSP Sliding Fee Schedule. The co-pay is a client's share of cost based on a sliding fee scale calculation or other agreement and must be applied to Block Grant funded clients.

5.1.2 Medicaid/Healthy Michigan Plans/Healthy Michigan Plans

Medicaid/Healthy Michigan Plan are the Department of Community Health programs for medical assistance established under Section 105 of Act No. 280 of the Public Acts of 1939, as amended, MCLA 400.105, and Title XIX of the Federal Social Security Act, 42. U.S.C. 1396, et.seq.

The LRP administers Medicaid/Healthy Michigan Plan funding for Substance Use Treatment Services in Allegan, Kent, Lake, Mason, Ocean, Muskegon and Ottawa County enrollees.

A. **Services**:

Covered: Assessment, Outpatient Therapy, Intensive Outpatient, Methadone, Partial Hospitalization Enhanced IOP.

Optional: Short and Long-Term Residential, Sub-Acute Detox

Not covered: The following services are excluded from coverage:

- Medical services or medication, with the exception of opiate replacement therapy and sub-acute detox services.
- Co-Dependent Outpatient Therapy, levo-alpha-acetyl-methadol (LAAM), Suboxone Buprenorphine, Residential Room and Board, Acute inpatient detoxification;
- Emergency Medical Care;
- Emergency or Routine transportation;
- Substance abuse prevention and treatment which occurs routinely in the context of providing primary health care;
- Room, board, custodial, and domiciliary care which is primarily for the purpose of maintaining the enrollee's basic needs for food, clothing, shelter, and cleanliness;
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM);
- Pharmacy services (with the exception of methadone and LAAM within methadone addiction treatment);
- Court related services, such as pretrial or court testimony and the preparation of court related reports. Treatment requested by an enrollee may be provided at a clinically appropriate level of care as determined by medical necessity and ASAM criteria; however, specific Court ordered evaluations, reports, and other related activities are not covered benefits;
- Services that are covered by another health benefit or third party payer such as:
  - Services covered by another health benefit plan or insurer;
  - Care rendered under Coordination of Benefits, workers compensation or any non-coordinated no-fault automobile policy;
  - Services covered by a contract with the Michigan Department of Corrections or Community Corrections.
- Non-medically necessary services except as defined in the benefit coverage certificate are not a covered benefit.
- **Medicaid/Healthy Michigan Plans Benefits Not Managed by the LRP:** Some Medicaid/Healthy Michigan Plan services are funded through the Medical Services Administration and are not managed by the CMHSP. Medicaid/Healthy Michigan Plan covered substance abuse services and ancillary services which are not the responsibility of the CMHSP, include:
  - Acute detoxification: This is a hospital provided service, billed directly to Medical Services Administration and subject to MSA criteria for reimbursement.
  - Laboratory services: Laboratory services related to substance abuse (with the exception of lab services required for Methadone

and LAAM) should be billed directly to Medical Services Administration by the laboratory.

Pharmacy services: Medications prescribed as a support to substance abuse treatment are paid for either or a fee-for-service basis by Medical Service Administration (for recipients who are not in a capitated health plan) or through the recipient's health plan (with prior authorization from the plan).

B. **Requirements**

- Medicaid/Healthy Michigan Plan consumers may ***not*** be charged a co-pay for Medicaid/Healthy Michigan Plan covered services.
- Coverage continuation: It is a client's responsibility to maintain their Medicaid/Healthy Michigan Plan coverage as long as they meet eligibility criteria. Clients who fail to complete periodic communications with DHS to maintain their coverage will not be eligible for continuing CMHSP BlockGrant coverage as an alternative.
- Transfer to CMHSP BlockGrant funding will require review by the CMHSP, and documentation from DHS that client was no longer eligible for reasons other than failure to provide necessary information to DHS. Provider assistance to help the client maintain coverage may be appropriate.
- Medicaid/Healthy Michigan Plan enrolled clients who move out of Lake, Mason, Oceana, Muskegon or Ottawa County must transfer to new home Medicaid/Healthy Michigan Plans PIHP coverage within thirty (30) days of a permanent move.

5.1.3 PUBLIC ACT 2 (PA2)

PA2 funds are county-assigned liquor taxes which are distributed by the State to the counties. Fifty (50) percent of the county liquor tax funding must be used for substance abuse services. Use of PA2 is locally determined but services must be provided by a licensed substance abuse service provider to benefit the population of the county from which the tax was collected.

For counties that have assigned oversight of PA2 funds to the CMHSP, the Block Grant requirements and conditions shall be applied to PA2 funds through specific Provider Agreements.

5.1.4 MICHILD

MIChild is the low cost health insurance provided through the State of Michigan for children whose families do not qualify for Medicaid/Healthy Michigan Plans/Healthy Kids. Families pay a premium to the State each month.

The following substance abuse services are covered through specific Provider Agreements with the CMHSP or MIChild consumers: Outpatient Therapy, Intensive Outpatient Treatment, Residential Substance Abuse Services, Inpatient Treatment (Hospital based services, less costly services outside the hospital may be substituted if they meet the medical needs of the individual), Laboratory and Pharmacy (applies only when a subcontracted physician writes a prescription for

pharmacy items or lab).

MIChild consumers may not be charged a co-pay for MIChild covered services.

5.1.5 STATE DISABILITY ASSISTANCE (SDA) SERVICES

The State Disability Assistance (SDA) program funds cover room and board expenses for clients eligible for public assistance benefits while in residential or domiciliary care. These funds are extremely limited for the CMHSP region so they are restricted to clients admitted to long-term residential treatment at OAR.

Covered Service: Residential Room and Board

Eligibility: To be eligible for SDA funding for room and board services in a substance use disorder treatment program, a person must be:

- Determined to meet Michigan Department of Human Services' (DHS) eligibility criteria;
- Determined to be in need of residential treatment services;
- Authorized for residential treatment when the CMHSP expects to reimburse the provider for the treatment;
- At least 18 years of age or an emancipated minor; and
- In residence in a residential treatment program each day that SDA payments are made.

5.1.6 MEDICARE

Medicare is a federally funded health insurance program, often held by elderly persons or those determined to be permanently disabled. Medicare is not managed by the CMHSP but Medicare and Medicaid/Healthy Michigan Plans benefits should be coordinated. Non-elderly clients who have Medicare are likely to be eligible for Medicaid/Healthy Michigan Plans.

Specific Conditions:

- Medicare benefits must be used prior to billing CMHSP for client's care.
- Other funding sources may be requested to cover substance abuse treatment services not covered by a Medicare plan.

5.2 Treatment Specifications by Level of Care

Client co-pays apply to some services and funding categories. Where CMHSP co-pays apply, providers may selectively waive the co-pay for a client but may not bill the CMHSP or the co-pay amount. No co-pays may be assessed for services covered, approved, and billed to Medicaid/Healthy Michigan Plan, unless specifically allowed in the State of Michigan Medicaid/Healthy Michigan Plan Manual policies.

Clients who have private insurance co-pays, and meet CMHSP block grant eligibility criteria, may be assisted with CMHSP funding for a portion of their care costs. All group insurance plans for employers with over fifty (50) employees must now offer parity coverage of addiction and mental health services, comparable to coverage for other medical conditions. Clients with separate health insurance should be asked to bring in their benefits summary, so coverage can be verified.

Providers may charge clients a nominal "therapeutic fee" for expenses not covered by the CMHSP. They may also specifically charge clients for extra reporting functions if client progress reports are asked to be prepared for Court personnel, employers, or other non-clinical parties requesting information. Such fees may not be billed to the CMHSP if not paid by the client. Providers frequently providing such reports to outside parties should show how they are covering the costs of these services. Failure of a client to pay such fees cannot bar public-funding eligible clients from participating in medically necessary treatment services. However, the provider is not obligated to provide unpaid reports to outside sources.

5.2.1 Initial Assessment

If an assessment was conducted by a different provider it should be requested and an update completed as a part of the clients therapeutic services (e.g., individual session of outpatient). A provider may request an exception to the limit if they are unable to acquire the assessment due to the client not signing a release of information or because the other provider does not provide the assessment within a timely manner.

An assessment does not need to be pre-approved when provided by an outpatient provider designated as a point of entry for CMHSP funded services. Assessments provided by out-of-region providers must be pre-approved.

The DSM IV must be used for diagnostic evaluations; and the ASAM Patient Placement Criteria (2-R)/The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions must be used for determination of admission, continued stay and discharge/transfer.

A full bio-psycho-social assessment tool must be completed which collects sufficient information to address the six dimensions of the ASAM Patient Placement Criteria, identify needs and strengths of the client, and initiate treatment planning. Providers may use alternative tools, but the concluding results and summary submitted for prior authorization must match the Addiction Severity Index (ASI) tool in content and order.

It is allowable for providers to use client self-administered tools as part of their intake process, with subsequent professional staff review with the consumer.

The initial assessment is reimbursed as an event rather than an hourly rate and does ***not*** count against initial OP treatment hours authorized services. Assessment updates shall be conducted as a part of the time approved for therapeutic services.

5.2.2 Outpatient Treatment

5.2.2.1 Individual, Family Counseling, Group Counseling, and Case Management

Outpatient care may cover a range from one (1) hour to twenty (20) hours per week. Care plans must be individualized for each client, and there may be considerable variation in the mix of individual and group sessions to meet individual client needs. Prior authorization is ***not*** required before initiation of outpatient services. Authorization must be requested before services may exceed five (5) hours. A client's Outpatient Therapy schedule may overlap into the time frames considered to meet "Intensive

Outpatient" levels when clinically justified for the client.

See Section 5.2.8 B for a full description and program requirements related to Case Management.

Benefits

Up to twenty (20) outpatient hours may be requested in the initial request. An additional twenty (20) hours may be requested in a re-authorization request.

Initial services that are allowed to be retroactively approved count against these hours. Services may include a mix of individual, family/marital, and group sessions as appropriate for the client.

There is no overall limit on the number of outpatient sessions covered under current Medicaid/Healthy Michigan Plan or MIChild agreements. Re-authorizations with continuing care justification is still required.

Block Grant and PA2 outpatient services are limited to forty (40) total hours per twelve (12) month period in the provider network. Additional services will be considered on a case-by-case basis.

5.2.2.2 Co-Dependent Outpatient Services

Adults, adolescents and children who are currently living with, or have lived with a substance abuser within the past six months (who is receiving services), are eligible for outpatient treatment with a specific focus on co-dependency, enabling and self-help involvement. The family member with the SUD diagnosis is not present.

Benefits

Up to four (4) sessions of outpatient services may be requested under Block Grant or PA2. These services may include a mix of individual and group sessions. No extension of co-dependent, non-user treatment will be covered by CMHSP payment.

This service is not payable with MIChild or Medicaid/Healthy Michigan Plan funding.

Additional Considerations

- If a co-dependent family member is found to have an active substance use disorder diagnosis, they should be treated as a regular SUD client and referred for admission in their own right.
- Joint family/client sessions do not count against co-dependent sessions. Instead they would be billed under the client's approved outpatient services.

5.2.3 Medication Supported Services

Methadone dosing services as an adjunct to therapeutic services may be provided when clinically appropriate and methadone is medically/clinically indicated. Therapeutic services provided in coordination with Methadone dosing will be authorized under the benefits detailed under the appropriate level of care.

The client may receive methadone for the purposes of medication detoxification or maintenance:

- **Medication detoxification**: The dispensing of drugs in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug. It is also used as a method of bringing the individual to a narcotic-free state within a specified period. There are two types of medication detoxification: 1) short-term detoxification is for less than thirty (30) days; and 2) long-term detoxification is for between 30 and 180 days.
- **Medication maintenance**: The stabilization of patients on chemotherapy and ongoing medication.

Clients should be strongly encouraged to try other treatment modalities first (with the exception of pregnant opiate dependent women). Treatment planning must include efforts to gain independence from methadone when therapeutic methadone use is established.

CMHSP funding for methadone is limited and may not be sufficient to pay for all clients eligible for services, or for the full amount of all authorized services. It may be necessary to implement a waiting list for Block Grant and PA2 funded methadone. Providers are expected to work with the CMHSP to manage available funds.

Admission and continuation is subject to physician evaluation and approval based on established medical criteria. Exceptional criteria must be met for persons under age 18.

Authorization

Prior authorization is required for medication supported services with the exception of pregnant clients presenting for methadone.

When pregnant clients present for methadone an authorization request must be submitted within twenty four (24) hours of admission to ensure eligibility and provide retroactive authorization for that first day and any subsequent days. Proof of pregnancy must be collected by the Provider prior to admission and documentation placed in the client's records.

All CMHSP-sponsored review and funding authorizations will follow the MDCH *Enrollment Criteria for Methadone Maintenance and Detoxification Program (updated 2005)* and MDCH *Technical Advisory: Counseling Requirement for Clients receiving Methadone* (8/10/2007) guidelines, in addition to ASAM PPC2 and DSM-IV assessment and diagnosis criteria.

Meeting admission criteria does not ensure funding approval. The CMHSP will determine eligibility based on likelihood of successfully meeting the criteria and no other complicating factors that would indicate the need for a more intensive level of treatment.

Benefits

- **Methadone:** Block Grant, Medicaid/Healthy Michigan Plan, MIChild, and PA2: Up to sixty (60) visits plus four (4) hours of OP treatment hours may be requested

in the initial authorization request. Up to six (6) month increments may be requested in re-authorization request. An annual physician evaluation is required for continued authorization.

A client may be authorized to receive additional therapeutic services at another provider when appropriate based on ASAM criteria. Additional therapeutic services may be requested up to the amount allowable under the appropriate level of care. The client may receive therapeutic services at another provider when necessary. Coordination of Care will be required if multiple providers are serving a client.

Due to limited funding new methadone clients will only be approved under Block Grant and PA2 funding if they are a priority population as detailed in Section 2.3.

Block Grant and PA2 clients will be limited to a maximum period of two (2) years for daily dose and related counseling services benefits; clients beyond the 2-year period may be authorized as Methadone Maintenance clients, up to twelve (12) months at a time, if meeting the requirements of the program, and no contraindicated findings on periodic drug tests, or treatment attendance problems.

Methadone funding extensions beyond two (2) years are subject to physician and the CMHSP re-review based on documented withdrawal attempts or other medical need, lack of other alternatives, and compliance with OTC rules.

Provision of Methadone must comply with procedures and requirements as detailed in the following MDCH guidance documents available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html

- Treatment Recovery Policy #05, *Criteria for Using Methadone for Medication-Assisted Treatment:* Clarifies the process for the use of methadone in medication-assisted treatment and recovery for opioid dependence.
- Recovery and Treatment Policy #04, *Off-Site Dosing Requirements for Medication Assisted Treatment*: Clarifies the rules and procedures pertaining to off-site dosing of opioid treatment medication by clients in an opioid treatment program.
- Technical Advisory #06, *Counseling Requirement for Clients Receiving Methadone Treatment*: Clarifies the substance abuse administrative rule specific to the counseling requirements for clients receiving methadone as part of their substance abuse treatment.

- **Suboxone Buprenorphine**
  Medicaid/Healthy Michigan Plans clients must use the Medicaid/Healthy Michigan Plans pharmacy benefit and procedures for the Suboxone® dose and the prescribing physician must be approved as a qualified prescriber. This benefit is not coordinated by the CMHSP.

  Block grant: Requests will be considered on a case-by-case basis.

  Provision of Suboxone Buprenorphine must comply with procedures and requirements as detailed the following MDCH/BSAAS guidance documents:

  - Treatment Policy #04, *Off-Site Dosing Requirements for Medication*

Assisted Treatment: Clarifies the rules and procedures pertaining to off-site dosing of opioid treatment medication by clients in an opioid treatment program.

- Treatment Policy #03, Buprenorphine: Establishes standards for the use of buprenorphine as adjunct therapy in the treatment of opioid addiction.

Requirements

- Priority shall be given to clients evidencing drug injection who are pregnant.
- Services may be performed only under the care of a licensed physician in programs approved by the Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA).
- Public, non-Medicaid/Healthy Michigan Plan, support for ongoing methadone maintenance is limited, so long term clients may be held financially responsible for the future costs of this service, even if clinical need continues. Continued CMHSP funding support is not guaranteed.
- Clients must be active in professional concurrent treatment.
- THE CMHSP-funded Suboxone® will need to be dispensed by the prescribing provider, with "take out" of seven (7) days maximum.
- With the exception of pregnant, opiate dependent clients, new methadone clients must show long term (≥ 2 immediate past years), confirmed heroin/opiate addiction pattern, and at least one previous, documented, drug-free treatment attempt within past two (2) years. Attempt must include at eight (8) or more outpatient treatment sessions or residential days beyond opiate detox. Opiate replacement therapy clients are expected to be linked by the program to other medical, occupational, and social service resources with the objective of achieving drug-free status and/or independence from public assistance for the ORT services within the two (2) year period unless they have permanent disabilities that keep them from any sort of paid employment.
- Continued use of other illicit or non-prescribed drugs and alcohol is not allowed, for medical reasons, and this is to be enforced via periodic drug testing. Drug tests showing non-compliance with methadone dose levels or evidence for other alcohol or drug use may result in CMHSP funding discontinuation, despite provider allowances.
- This benefit is not intended for clients with physical dependency to prescribed pain medications, or with short, infrequent, or low level opiate use histories.
- Hospital inpatient services cannot be purchased using MDCH funding.

Funding Limitations: Community Grant funding may not be sufficient to support client demand for methadone services. Providers are expected to use due diligence in delivering services with overall costs in mind.

The CMHSP cannot guarantee full payment if the amount of Block Grant

services billed exceed the available funds.

5.2.4 Intensive Outpatient Treatment (IOP)

5.2.4.1 IOP (II.2)

IOP for adults must consist of at least three (3) hours of planned therapeutic activities for one IOP day/unit of service, on three (3) or more days per calendar week for at least nine (9) hours of scheduled therapeutic activity.

Adolescent IOP services require a minimum of two (2) hours per day, three (3) to five (5) days per week for a minimum of eight (8) hours scheduled therapeutic activity.

Prior authorization is ***not*** required before initiation of IOP services. Authorization must be requested before services may exceed six (6) hours. However, retroactive approval will only be granted when client meets criteria for IOP level of care per ASAM criteria.

Therapeutic time within IOP may include a mix of group counseling, individual counseling, evaluation, didactic lectures, acupuncture therapy, and treatment/discharge planning.

IOP therapy programs may include limited auricular acupuncture services if the service is physician directed, provider has been approved by CMHSP to provide this service, and the client meets accepted criteria for this service.

Benefits: Block Grant, Medicaid/Healthy Michigan Plans, and MIChild

Up to twenty one (21) days of IOP, and two (2) hours of individual (that exceed the nine (9) hours) may be requested in the initial request. Initial services that are allowed to be retroactively approved count against these hours.

Up to twenty one (21) additional IOP days, and two (2) hours of individual may be requested in re-authorization requests.

There is no overall limit on the number of IOP sessions covered under current Michigan Medicaid/Healthy Michigan Plans, and MIChild.

Domiciliary: IOP services may have domiciliary, room and board, services provided in association with the IOP program. These services, if approved by the CMHSP, must be pre-approved and may need to be separately billed. Medicaid/Healthy Michigan Plan and MIChild funds cannot be used for per diem room and board fees.

5.2.5 Residential Substance Abuse Services

The client must be present on all days billed as residential services and must receive at least four (4) hours of therapeutic services per day. Treatment time may include a mix of group counseling, individual counseling, evaluation, didactic lectures, acupuncture therapy, and treatment/discharge planning. Authorization is required prior to admission.

Benefits

Long-Term Residential:

- Block Grant, PA2, and MIChild: Up to twenty-two (22) days may be requested in the initial request. Up to twenty-two (22) days may be requested in re-authorization requests. Block Grant and PA2 residential services are limited to one hundred and eighty (180) total days per twelve (12) month period in the provider network. Additional services will be considered on a case-by-case basis.
- Medicaid/Healthy Michigan Plans: Up to twenty-two (22) days may be requested in the initial request. Up to twenty-two (22) days may be requested in re-authorization requests. The room and board portion of residential services may not be billed to Medicaid/Healthy Michigan Plans.

Short-Term Residential (Intensive):

- Block Grant, PA2 and MIChild: Up to seven (7) days may be requested in the initial request. Up to seven (7) days may be requested in re-authorization requests. Block Grant and PA2 outpatient services are limited to sixty (60) total days per twelve (12) month period in the provider network. Additional services will be considered on a case-by-case basis.
- Medicaid/Healthy Michigan Plans: Up to seven (7) days may be requested in the initial request. Up to seven (7) days may be requested in re-authorization requests.

  The room and board portion of residential services may not be billed to Medicaid/Healthy Michigan Plans. If available, Block Grant, PA2 or SDA may be used for per diem room and board for Medicaid/Healthy Michigan Plans eligible clients. Pre-authorization is required prior to confirmation of funded admission days.

Special Considerations

- Client must be present and receive documented therapeutic services on all dates for which clinical rates are billed. Any day without at least four (4) hours of therapeutic/clinical/skill-building services may not be billed at full rate on a per diem basis. Consumer-directed AA/NA support groups may not be counted toward service requirement or billed as a clinical service, even if they occur at the residential site.
- Step-down to a lower intensity treatment service is expected immediately following any residential stay. This may be at the same or at a different provider location. It is **required** that clients will have contact with their next care provider and a scheduled appointment prior to discharge from any level of residential care.

5.2.6 Sub-Acute Detoxification

Detoxification services are defined as medically supervised care provided in a sub-acute residential setting for the purpose of managing the effects of withdrawal from alcohol and/or other drugs. A detoxification program must be staffed twenty-four (24) hours per day, seven (7) days per week, by a licensed physician or by the

designated representative of a licensed physician.

Benefits

Block Grant, PA2, Medicaid/Healthy Michigan Plan, and MIChild: Up to five (5) days, re-authorized in increments of three (3) days. Longer increments may be authorized for some clinical conditions when accompanied with attending physician request. Authorization is required prior to admission.

Services are limited to six (6) total days per twelve (12) month period in the provider network. Additional services will be considered on a case-by-case basis.

Special Considerations

Step-down to a lower intensity treatment service is expected immediately following any sub-acute detox residential stay. This may be at the same or at a different provider location. It is **required** that clients will have contact with their next care provider and a scheduled appointment prior to discharge from any level of residential care. Medicaid/Healthy Michigan Plans clients must be admitted to the next level of care within seven (7) days of discharge from detoxification.

5.2.7 Acute Detoxification

Inpatient, acute care treatment, such as in an emergency or acute-care facility, are not covered through CMHSP funding, with the exception of MIChild for hospital-based detoxification. Hospital-based detoxification for MIChild enrollees will be approved on a case-by-case basis.

All other clients should be referred to their primary care physician, the hospital or their Medical Health Plan. Inpatient acute care may be covered for Medicaid/Healthy Michigan Plan clients through their medical care plans, or direct State payment. Medicaid/Healthy Michigan Plans Mental Health plan benefits may include inpatient psychiatric care admissions, via local CMH/PIHP authorization.

5.2.8 Specialty Services

The following Michigan licensed secondary service categories may be covered by some CMHSP funding sources when funding is available. Providers are expected to provide these adjunct services, as appropriate to the needs of their clients, or to refer clients to other sources of these services.

Some of these services are not billed as a fee-for-service.

5.2.8.1 Women and Families Specialty Services (WFSS)

The SAPT Block Grant requires states to spend a set minimum amount each year for treatment and ancillary services for pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

To be eligible for WFSS funds a provider must be designated as a Women and Family Specialty Provider or as gender-competent. For more information regarding this specialty service please refer to the Women's Specialty Services Guidance Document, provided in the Attachments section.

5.2.8.2 Specialized Case Management / Care Coordination Services

A substance use disorder case management program coordinates, plans, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the treatment team and as guided by the individualized treatment planning process.

To be eligible for CMHSP funding the service must be a distinct case management and service coordination function provided to clients currently in or recently in treatment services.

The rules and procedures established for these services are provided in the MDCH Treatment Policy #8- *Substance Abuse Case Management Program Requirements* which is available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html

5.2.8.3 Intervention Services

Professional counseling services to bring a person with indications of a substance use disorder to an acceptance of treatment participation; often initiated by third party such as family member, employer, or Court.

5.2.8.4 Specialized Integrated Dual Diagnosis Services

Specialty services for clients diagnosed with a co-occurring substance use disorder and mental illness diagnoses. These services may be provided in coordination with mental health services provided by the Community Mental Health or other mental health provider.

5.2.8.5 Peer Recovery/Recovery Support Services

Peer recovery and recovery support services are designed to support and promote recovery and prevent relapse through supportive services that result in increased knowledge and skills necessary for an individual's recovery. Peer recovery programs and designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery.

The rules and procedures established for Early Intervention services are provided in MDCH Technical Advisory #7- Peer Recovery/Recovery Support Services which is available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html .

To be eligible for CMHSP funding, relapse prevention and support services must be provided for clients who formerly participated in treatment and are determined to be at immediate risk of relapse. Services may be professionally and/or peer led.

5.2.8.6 Acupuncture

Acupuncture may be used as adjunct therapy for substance abuse treatment with costs built into the therapeutic service. A description of the services provided by any funded program which includes acupuncture as adjunct therapy must be provided to CMHSP prior to service delivery.

The rules and procedures established for acupuncture services are provided in MDCH Treatment Policy #02, Acupuncture, which is available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html . All contractors providing this service must follow guidelines as provided in this policy.

5.2.8.7 Early Intervention

According to the ASAM PPC-2R and/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*, early intervention services explore and address any problems or risk factors that appear to be related to the use of alcohol and other drugs and that help the individual to recognize the harmful consequences of inappropriate use.

Early intervention services must be appropriate for the individual and their stage of change, as well as access to clinical services and may be provided in a group or individual setting.

Clients must be screened on an individual level, and a diagnosis is required, at least on a provisional basis. Intervention plans participation goals are developed for this level of service. Participants are not required to meet abuse or dependence thresholds for early intervention services.

The rules and procedures established for Early Intervention services are provided in the MDCH Technical Advisory #9- *Early Intervention* which is available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html .

SECTION 6

CMHSP FINANCIAL AND REPORTING PROCEDURES

6.1 Financial Policies and Procedures

A Fee Schedule indicating a payment profile, specified services, and rates for those services is part of the contract and will be attached to the CMHSP Provider Agreement. Providers are expected to utilize the payment rates for services rendered and to hold Medicaid/Healthy Michigan Plans and MIChild members harmless from additional charges for those services (in keeping with the agreements). Specific reimbursement and finance issues are addressed in the CMHSP Medicaid/Healthy Michigan Plan Provider Agreement and CMHSP Block Grant Agreement.

6.1.1 Authorization

All CMHSP area clients seeking CMHSP-managed public funding, in whole or part, for their treatment services, must be authorized for those services by the CMHSP. Requests for authorizations must be entered in ProviderConnect within fourteen (14) days of first client contact. For more information refer to Section 3.1.

6.1.2 Clean Claim

Clean Claim means a claim which is properly completed and contains all data elements necessary for processing in accordance with Provider Agreement and policy including submissions on the CMHSP ProviderConnect system, as agreed and appropriate, with all required data fields completed.

6.1.3 Sliding Fee Scale

Providers are required to use the uniform sliding fee scale adopted by the LRP to determine financial eligibility. Calculate the LRP Sliding Fee Scale using the Excel file provided at contract initiation. Refer to Provider Connect manual Contact Information page if you need to obtain a copy of the Excel file.

The sliding fee scale does *not* apply to Medicaid/Healthy Michigan Plan or MIChild clients.

Calculating Household Income

In order to apply the sliding fee scale it is necessary to establish the household income and number of persons in the household. The way that this is calculated is determined by which of the following categories the person would fall under:

- **Minor Children:** For purposes of determining CMHSP financial eligibility, a child under 18 years of age will be considered a dependent; and total family income must be used unless the minor has been declared an emancipated minor, is married, or confidentiality has been formally requested by the minor for initial treatment services. During the course of treatment, once there is parental knowledge of a child's treatment, parental resources must be considered and applied.
- **Adult Dependent**: In the case of a single person 18 years of age and over who is living with his/her family and is being claimed as a dependent for income tax purposes (i.e., a student), family income should be considered in

determining CMHSP financial eligibility. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.

- **Adult Independent**: Once a person turns 18, they may be legally considered an adult. Their 1040 income tax form or current payroll stub should be used to document income, and to determine financial eligibility. Parental income is not used if the 18-year-old is not claimed by a parent as a dependent. If the person is covered by family health insurance, the available health insurance benefits must be used prior to using CMHSP Block Grant funds.
- **Married**: If married, the income of the client's spouse must also be considered.
- **Child support**: Child support paid should be deducted from an adult's income. Child support received should not be counted toward income.

6.1.4 Fee Collection

It is recommended that programs use at least three distinct attempts to collect fees assessed. At that point, if the fee still is not paid, the debt may be turned over to a collection agency. This is not applicable to Medicaid/Healthy Michigan Plans, or MIChild clients.

6.1.5 Co-Pays

A co-pay is a client's share of cost based on a sliding fee scale calculation or other agreement. A co-pay must be applied to block grant per the LRP Sliding Fee Scale. It may apply to some PA2 funded clients.

Medicaid/Healthy Michigan Plan or MIChild clients may not be charged co-pays for therapy, counseling, or medications unless they are structured into the State plan.

Fees assessed based on application of the sliding fee scale but not collected, cannot be billed to the CMHSP.

6.1.6 Insurance Coverage

If an individual has insurance, they must use the benefits provided, and they must use approved providers associated with that insurance.

If an individual has partial insurance, the CMHSP cannot be billed until the insurance payment has been received. After partial insurance payment has been received, public funds may be used to reimburse the portion of the CMHSP rate that the insurance does not cover as determined by the sliding fee scale. CMHSP funds may not be used to subsidize insured clients if the insured client chooses to go to a provider outside their insurance network.

6.1.7 Verification of Income

Medicaid/Healthy Michigan Plan eligibility and income verification shall be verified at least every six months or at a significant financial event, and proof of verification kept in the client record.

All Other Funding: Client income must be substantiated either by a current payroll

stub, a 1040 Federal or State income tax form, or an unemployment pay stub, whenever possible.

Any person determined to be qualified for full CMHSP Block Grant payment must show application for Medicaid/Healthy Michigan Plans or MIChild, as appropriate or recent documentation of ineligibility.

Income should be verified and/or updated at least every six months or at a significant financial event, and proof of verification kept in the client record.

The *CMHSP Declaration of Income Application for Benefits* form, provided in the Attachments section, or one that contains the same information must be in the case record and signed by the client.

6.1.8 Coordination of Benefits

It is the policy of the CMHSP to promote the utilization of all insurance and other benefit coverage a consumer may have in a systematic way, as well as to assure coordination between Substance Abuse services and CMH, for the benefit of their clients.

Providers shall notify the CMHSP, via ProviderConnect, of any known Coordination of Benefits information which applies to a claim when it is submitted.

6.1.9 Financial Audits

- All CMHSP Providers are subject to audit to determine the validity of claims paid.
- Charges for improperly documented or inappropriate services are disallowed.
- Disallowed charges are deducted from future payments to the provider from CMHSP.

6.1.10 Medicaid/Healthy Michigan Plans Specific Billing Procedures

A. Time Limit For Filing Medicaid/Healthy Michigan Plan Claims: Medicaid/Healthy Michigan Plan claims should be generated within sixty (60) days of the date of service on the ProviderConnect System, unless a Covered Person/Member is retrospectively enrolled, or other primary insurance billing is in process. If the Covered Person/Member is retrospectively enrolled, claims should be generated within sixty (60) days of notice of Medicaid/Healthy Michigan Plan enrollment approval.

B. Do Not Bill a Medicaid/Healthy Michigan Plan Enrollee: A provider should not bill or otherwise collect payment for services from a Medicaid/Healthy Michigan Plan enrollee except for spend-down deductibles, the CMHSP-approved co-payments, and non-covered or non-authorized services.

C. Billable and Maximum Payments:

A schedule of the CMHSP-approved covered or allowable services and the maximum payments provided by CMHSP to the contracted provider are issued to each provider as an attachment to the Provider Agreement.

Assignment of payment to a participating Network Provider or Facility Provider must be done as part of the Provider contracting process and attached to the assignee's formal agreement.

Providers must not bill, charge, collect from, seek compensation from, or have any recourse against Medicaid/Healthy Michigan Plan enrollees/members for services covered under the Michigan Medicaid/Healthy Michigan Plan Program (as defined in the Medicaid/Healthy Michigan Plan Provider Agreement).

Services provided must be pre-authorized by the CMHSP.

D. Non-Network Provider Reimbursement: Non-network providers will be reimbursed for authorized services, provided that an authorization request is made as required supporting the rendered service.

Non-network providers shall coordinate with the CMHSP regarding payment and to ensure that any cost to the beneficiary is no greater than it would be if the services were furnished within the network.

E. Medicaid/Healthy Michigan Plan Reimbursement Requirements:

Providers are contracted to provide services on a fee-for-service basis. Direct payment is made for services provided by credentialed and contracted providers when the following conditions are met:

- Services are provided as a result of an authorization from the CMHSP.
- Services provided are a covered substance abuse Medicaid/Healthy Michigan Plan benefit, identified on the CMHSP-approved Medicaid/Healthy Michigan Plan fee schedule.
- Services provided are in compliance with the requirements of the utilization management program.
- Services provided are within the scope of the provider's license and credentials.
- Services are performed in an approved setting as indicated in the Provider Agreement.
- Services are provided on or after the effective date of the Member's eligibility for covered services by the Plan.

F. Medicaid/Healthy Michigan Plan Spend-Down Deductible Procedures:

Medicaid/Healthy Michigan Plan clients who have a monthly spend down deductible amount may be served with CMHSP Block Grant funds if it is known or likely that the monthly deductible amount will not be incurred by the planned treatment services or other medical care they are receiving.

Clients whose planned treatment will meet the spend-down deductible within the month should be assisted in documenting eligible expenditures (incurred, but not necessarily paid by client) to DHS, to obtain active Medicaid/Healthy Michigan Plan coverage going forward. For such clients, CMHSP BlockGrant may fund up to the deductible amount for the month.

There are cases when a client has medical need for behavioral coverage but DHS has determined that they have excess income for full Medicaid/Healthy Michigan Plan eligibility, and therefore have an ability to pay some of their own medical care costs. These clients are known as or enrolled in a spend-down program. Spend-down means that the client must incur medical expenses each month equal to, or in excess of, an amount determined by the local DHS office to qualify for Medicaid/Healthy Michigan Plans coverage. Once their spend-down amount has been met each month, they become eligible for Medicaid/Healthy Michigan Plan benefits for the remainder of the month

Bills for service rendered prior to the effective date of Medicaid/Healthy Michigan Plan eligibility are the client's responsibility. The Provider may bill CMHSP Medicaid/Healthy Michigan Plans for any covered services (in excess of the client's liability) rendered during the eligible period.

Because bills have to be incurred before the spend-down deductible amount is met, there will often be a period of retroactive eligibility. This may be several days or up to a period of three months from the current month.

There may be one service that is partly the client's responsibility and partly CMHSP Medicaid/Healthy Michigan Plans funded. If the provider of service chooses to bill for this service and the client has no other insurance, the information entered or submitted must indicate the correct shares for each party involved.

If the client has other insurance the information entered must indicate the appropriate shares or amounts for each responsible party, including the client, and correct dates of effective coverage.

The client may be held responsible for payment of expenses that were incurred to meet the spend-down amount. Payment by client does not have to be made before Medicaid/Healthy Michigan Plan eligibility is approved. Consult with the CMHSP if other public funds are being sought to assist client in meeting the financial obligations of the spend-down deductible or co-pay.

G. Medicaid/Healthy Michigan Plan Third Party Claims:

Enrollee coverage may not exceed 100 percent of the established CMHSP established Medicaid/Healthy Michigan Plan fee for covered service when other insurers including Medicare are also providing coverage for the service. Medicaid/Healthy Michigan Plan under this plan will always be considered secondary, except in relation to CMHSP Block Grant funds. When coordination of benefits occurs the maximum fee screen will not be exceeded in making secondary payment.

In the event a service is covered by Medicaid/Healthy Michigan Plan as well as another plan, CMHSP determines primary versus secondary coverage for the service and eligibility determination purposes. When an Enrollee is enrolled in Medicare, Medicare will be the primary payer ahead of Medicaid/Healthy Michigan Plan in this plan, (or any plan contracted by the State). Other health plans include, but are not limited to, any group or

individual plan providing substance abuse care through insurance coverage, group practice or other prepaid coverage; Worker's Compensation; disability; or under a labor-management trustee plan, union welfare plan, employer organization plan, employee benefit organization plan, or employer self-insurance plan, Medicare, automobile insurance, or other commercial carrier. Enrollees for whom Medicaid/Healthy Michigan Plan (under this plan) is secondary coverage are required to follow pre certification processes (Section II, 2.13) identical to those for whom coverage is primary. Enrollees must follow standard pre certification guidelines in order for services to be eligible for reimbursement and benefit coordination.

Providers are required to complete the authorization procedures in instances of secondary coverage in precisely the same manner as for coverage deemed primary. This requirement applies to both pre authorization and continuation (concurrent) review activities. Providers are also required to hold enrollees financially harmless once combined primary coverage and secondary coverage reimbursements total the CMHSP contracted rates for Medicaid/Healthy Michigan Plans in effect at the time.

6.2 Submission of Billing

CMHSP treatment providers must submit bills for Medicaid/Healthy Michigan Plans, Block Grant, PA2, and MIChild funded services through Netsmart Technologies, Inc. ProviderConnect System. Billing will be primarily done via the ProviderConnect system.

Instructions and details of this process are found within the CMHSP ProviderConnect Operations Manual.

Billing is expected to be done by the 10th of the month following the month of service via the ProviderConnect system except in special cases. Type or imprint to complete non-ProviderConnect paper billing forms.

Billing through ProviderConnect System

Medicaid/Healthy Michigan Plans, Block Grant, MIChild, and PA2 services must be billed through the ProviderConnect System, unless otherwise instructed.

- **Bills are to be generated within sixty (60) days of the date of service**, unless there is pending insurance. In cases where other insurance is to be billed and CMHSP Block Grant payment needs are uncertain, client record, admissions, authorization requests, and treatment services can be entered however treatment services (billing) should not be entered on the ProviderConnect system until the contractual agency is ready to bill.
- **Bills should be generated no more than bi-weekly**

  Treatment records can be entered more frequently, but bill generation should be done no more than bi-weekly to reduce administrative burden.

6.2.1 Financial Status Report

A Financial Status Report (FSR) is required only for performance-based reimbursement contracts with CMHSP and is due by the 10th of the month following the month for which services are being billed. FSRs are not required for

services billed through ProviderConnect since an FSR can be generated on the ProviderConnect system.

All costs submitted on the FSR for performance-based reimbursement contracts must be pre-approved by the CMHSP through the submission of the CMHSP Budget Cost-Detail and Supporting Narrative. The *Financial Status Report* and *Budget Cost-Detail and Supporting Narrative* are provided in the Attachments section.

6.2.2 Billing Adjustments

If additional services are being billed, they should be entered into the ProviderConnect system in accordance with the ProviderConnect manual.

If a service was billed in error, the details of the service should be submitted via email so a credit for the over payment can be issued against a future payment.

If the amount billed/paid for a service was incorrect, the details of the difference in rates should be submitted via email so a credit for overpayment or additional payment can be made.

Contract information for submitting billing adjustments can be found in the ProviderConnect manual.

6.3 Payments

Payment for approved services will be issued by check in the name and to the address of the contracted Provider or Electronic Funds Transfer (EFT). Payments will be made for CMHSP covered services only.

Payments for covered services (in accordance with the Providers Agreement) will be made within thirty (30) days following the receipt of a clean claim (approved bill transmittal to CMHSP on ProviderConnect).

Retrospective Medicaid/Healthy Michigan Plans Eligibility: Retrospective monthly adjustments of Medicaid/Healthy Michigan Plan eligible enrollees by the Department of Community Health and/or the Medical Services Administration may affect the status of a client's eligibility. CMHSP will reduce future payments if consumer is determined to have a sliding fee scale pay amount.

SECTION 7

PROVIDER SELECTION, QUALIFICATIONS AND SERVICE REQUIREMENTS

The CMHSP develops and maintains a network of substance abuse health care service providers through a formal provider application review and provider selection process.

Provider applicants shall complete a formal credentialing process which determines participation based on the standards adopted by Lakeshore Regional Partnership. Providers within the CMHSP network must maintain these standards once accepted as a Provider.

The standards guide the selection of facilities and (individual providers) and achieve compliance with the administrative rules of the HMO Act as amended and filed on January 5, 1988 for Medicaid/Healthy Michigan Plans providers.

7.1 Selection Review Process: A Provider may apply for, and be granted permission to deliver more than one type of service. To help ensure demonstrated competence, applicants will be asked to share references with the CMHSP that speak to the applicant's relevant experience. Also, the applicant's professional staff must provide individual professional credentials to assist the CMHSP in the credentialing process. Refer to Section 7.9 for more information about the credentialing process.

A Provider is notified of the approval or denial of application and (if approved) is given a standard formal contract. The signed and returned contract is retained in a Provider file and by the CMHSP.

As part of the on-going credentialing and review process, the CMHSP will review information about the provider from internal and external sources including; admission/discharge information or studies, client complaints and grievances, Client Satisfaction Information, Utilization Management Reports, and Quality Improvement Reports. This data will be combined with the Facility Provider's reapplication materials and presented to the CMHSP Board and/or appointed credentialing committee.

Information provided to the CMHSP by a provider or a provider applicant must be accurate and complete. Any falsification of such information may result in termination from participation.

7.2 Provider Standards Required

7.2.1 Credentialing: It is the policy of the CMHSP that all contracted Providers meet the standards for practice and satisfy the requirements of the Credentialing Processes established by the Lakeshore Regional Partnership. All substance abuse service providers must be qualified to perform services consistent with CMHSP's goals and objectives and State and community standards.

Provider Credential Reviews: The CMHSP will review the credentials of all facilities and professionals applying for affiliation with the CMHSP, and reexamine provider credentials every two (2) years. Specific criteria shall apply to all facilities seeking affiliation or are being re-credentialed for continued affiliation.

Criteria are evaluated in the following areas:

A. Licensure: Providers must possess licensure by the State of Michigan Department of Licensing and Regulatory Affairs to provide each type of

substance abuse services for which Provider is delivering services or seeking to provider under CMHSP funding.

B. Accreditation: Providers must maintain accreditation as an alcohol and/or drug abuse program or broader behavioral health program by one of five national accreditation bodies; The Joint Commission (TJC)*, Commission on Accreditation of Rehabilitation Facilities (CARF)*, American Osteopathic Association (AOA), Council on Accreditation of Services for Families and Children (COA), or National Committee on Quality Assurance (NCQA) or other approved accreditation body.

*Methadone providers must meet additional specific national accreditation standards from these accrediting organizations.

C. Practice Organization and History:

- Providers must maintain liability insurance in amounts specified by the CMHSP.
- Convictions of a crime other than a misdemeanor of traffic offense will be evaluated on an individual basis by the CMHSP.
- Providers must have a history of acceptable participation in Medicaid/Healthy Michigan Plans, Medicare, and substance abuse block grant funding programs, as applicable.
- Providers must have an 'acceptable' report, if available from the National Practitioners Data Bank.
- The Provider must not currently be involved in a disciplinary process or have pending disciplinary actions by a hospital, or other such facility, licensing board, third party payer, or peer review entity.
- Provider must have no significant history of malpractice claims or adverse malpractice experience.
- Providers must maintain acceptable levels of malpractice insurance as identified by Lakeshore Regional Partnership.

D. **Service Delivery**

- Providers must maintain a clinical services system that provides assessment, diagnosis (utilizing DSM IV), patient placement (ASAM-PPC2Rand/or the new release of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Condition*), and referral.
- Providers must have the capability to integrate the ASAM Patient Placement Criteria for admission, continued stay and discharge/transfer.
- Providers must provide a welcoming environment for individuals with co-occurring disorders. Providers who do not possess integrated licensure must refer clients to a qualified provider when appropriate. Refer to Section 2.2.1C for more information.

  Providers with appropriate integrated licensure must utilize a comprehensive, continuous, integrated system of care in accordance with the following policy adopted by the CMHSP:

- MDCH Treatment Technical Advisory #05, *Welcoming*.

- Providers must maintain accessible and adequate office hours and meets the provisions of Act 230 of the Public Acts of 1972 as amended to allow access by enrollees with handicaps.
- Providers must maintain services in a geographical location convenient to the CMHSP area eligible persons, appropriate to the levels of care offered.
- Providers must comply with CMHSP Medicaid/Healthy Michigan Plan Provider Agreement and/or Block Grant Provider Agreement as applicable.
- Providers' client satisfaction must meet Lakeshore Regional Partner's expectations for Medicaid/Healthy Michigan Plan clients and for clients funded under other CMHSP managed funds.
- Providers must ensure the rights of clients to privacy and dignity while waiting for and receiving care.
- Providers shall not engage in or conduct research which involves inconvenience or risk to clients.

E. **Quality Improvement**: Providers must have active quality improvement programs. These programs should adequately identify problems, establish plans for improvement, and show problems corrected or improved. Utilization review and quality improvement activities must produce data as a basis for ongoing service maintenance, development, refinement, and management.

F. **Quality of Care**

To continue as a CMHSP Provider, providers must achieve and maintain the following standards:

- Qualities of Care performance indicators meet acceptable Lakeshore Regional Partner levels.
- Complaint/grievance activity is not excessive for the Lakeshore Regional Partner region.
- Outcome indicators, if applied, meet acceptable CMHSP levels and parameters.
- Cooperate with quality improvement programs.
- Meet acceptable facility review expectations.

G. Utilization

- Meet CMHSP expectations for utilization performance, per staff productivity.
- Cooperate with CMHSP Utilization Management requests.
- Meet CMHSP expectations for ancillary service referrals.

H. **Physical Location Requirements**

- Provider locations may not be moved without the approval of the

CMHSP.

- Treatment and other services shall be provided in a facility which is appropriate for the services provided and which is comfortable, safe, convenient, handicap accessible, and private.
- Grounds have (or have made available) adequate parking, including specially designated handicapped spaces close to entrances.
- Regular and effective snow and ice removal must be provided.
- The facility building must comply with all local fire and safety codes and meets the facility standards of an appropriate national accrediting body.
- Handicap-equipped rest rooms must be available to clients and those accompanying them.

I. **Disclosure:** Providers must provide full disclosure of ownership, affiliations, and organizational structure.

J. **Reputation:** Maintain an acceptable professional reputation in the community.

7.2.2 Corporate Compliance

The CMHSP is committed to conducting itself as a good organizational citizen by promoting an organizational culture that encourages a commitment to compliance with the law. This commitment extends to every aspect of our business as well as every work-related activity of our employees, contractors, and individuals with responsibility pertaining to the ordering, provision, marketing, documentation, billing or services reimbursable by Federal Health Care Programs. The commitment further extends to the preparation of claims, reports or other requests for reimbursement for such items or services with the statutes, regulations, and written directives of Medicare, Medicaid/Healthy Michigan Plan, and all other Federal Health Care Programs (as defined in 42 U.S.C. ξ 13201-7b (f), hereinafter collectively referred to as the "Federal Health Care Programs." CMHSP is also committed to ensuring that it complies with the requirements of all Federal and State programs from which it receives funding above and beyond "Federal Health Care Programs."

The CMHSP Corporate Compliance Plan provides standards of conduct and internal control systems that are reasonably capable of reducing the likelihood of violations of law. The Corporate Compliance Program, which is an outgrowth of the Plan, seeks to prevent violations of any law, whether criminal or non-criminal for which CMHSP is, or would be, liable. Refer to the *Corporate Compliance Plan* available at https://lakeshoreregionalentity-public.sharepoint.com/Pages/Policies.aspx.

Therefore, CMHSP requires that contracted providers:

- Acknowledge the CMHSP's Compliance Program and Code of Ethics.
- The Corporate Compliance Plan is provided to all Covered Individuals.
- The Providers obtain and retain (subject to review by the CMHSP) signed certifications that each such individual has received, has read, and

understands the CMHSP Code of Ethics and agrees to abide by the requirements of the CMHSP Corporate Compliance Program.

7.2.3 Conflict of Interest

All Providers within the CMHSP network must ensure a conflict of interest as defined under Executive Order 12549, Title XVIII or XIX does not exist. Providers within the CMHSP network must ensure that their employees are not engaging in activities with other organizations which may result in personal benefit to them at the expense of CMHSP or its provider members or which may influence their decisions on matters involving the CMHSP.

A conflict of interest exists when a workforce member's personal, family, or financial activities adversely influence the judgment required to perform ones duties. If a conflict of interest exists, or even the appearance of a conflict exists, the workforce member must report the potential conflict to their local Compliance Officer and the CMHSP's Compliance Officer.

7.3 Provider Reporting Requirements

All Data Reporting requirements and due dates are found in the Provider Agreement. Continued failure of providers to submit required reports to CMHSP may result in a financial penalty being imposed and serve as cause for termination of the CMHSP's contractual relationship with the Provider.

7.3.1 ProviderConnect User Permissions and Data Entry

Access to the ProviderConnect system is restricted to individuals granted permission to access the system by the CMHSP.

Adding a New User: Each new user must complete and submit the *ProviderConnect Request for New User Account* form to their CMHSP to become activated and provided a username and password for the system.

Deactivating an Existing User: Providers are required to notify their CMHSP of individuals requiring deactivation by completing and submitting *ProviderConnect Request for New User Account form* and selecting 'user deletion' under request type. This is to be completed when a staff with permission to access the ProviderConnect system has terminated employment or has been reassigned duties within the agency and no longer has need to access information on the ProviderConnect system. Notification may occur in advance of the actual date of termination or reassignment of job responsibilities with the agency. The CMHSP will de-activate the user's permission on the date specified. In the event employment is terminated unexpectedly, the Provider shall notify the CMHSP immediately of the need to de-activate the user's permission.

Full procedures for data entry using the ProviderConnect System are provided in the *Provider-Connect Operations Manual* which is downloadable on the ProviderConnect system.

A ProviderConnect admission and discharge form must be completed for Block Grant, Medicaid/Healthy Michigan Plan, MIChild, and PA2 funded clients receiving services through a Fixed Unit Reimbursement Rate under the CMHSP. Providers must create these records in the ProviderConnect System. A hard copy

of these records must be included in the client's case record.

Providers must follow the current Data Definitions, Coding, and instructions issued by MDCH. Providers must ensure that records are accurate and supporting documentation is on file. If errors are discovered, providers must immediately notify CMHSP by completing the *ProviderConnect Information System Data Correction Form* provided in the Attachments section.

7.3.2 Census Logs: Providers of residential and/or detoxification services must maintain a daily client census log that contains a listing of each individual client in treatment. This listing can be made in client name or using the client identification number. Census must be taken at approximately the same time each day, such as when residents are expected to be in bed. MDCH and/or CMHSP will review the daily client census logs in data auditing site visits.

7.3.3 Sentinel Event Reporting Requirement

All residential service providers must report, review, investigate, and act upon sentinel events for persons living in 24-hour specialized settings and those living in their own homes receiving ongoing and continued personal care services.

Providers must immediately contact the CMHSP located in the Provider's county as well the CMHSP in the county of the client's residence, if different using the Sentinel Events Incident Report provided in the Attachments section.

A Sentinel Event is defined as an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)

Any of the following should be reviewed to determine whether it meets the criteria for sentinel event.

- Death of a recipient which is not by natural cause or does **not** occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.
- Serious illness requiring admission to hospital, n**ot** including planned surgeries, whether inpatient or outpatient. It also does **not** include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.
- Alleged cause of abuse or neglect.
- Accident resulting in injury to recipient requiring emergency room visit or hospital admission.
- Behavioral episode: Serious challenging behaviors are those not already addressed in a treatment plan and include significant (in excess of $ 100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence that result in death or loss of limb or function to the individual or risk thereof. All unauthorized leaves from residential treatment are not sentinel events in every instance. Serious

physical harm is defined by the Administrative Rules for Mental Health (330.7001) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient."

- Arrest and/or conviction.
- Medication error means a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage which resulted in death or loss of limb or function or the risk thereof. It does not include instances in which consumers have refused medication.

The Provider and CMHSP shall review all incidents to determine if the incidents meet the criteria and definitions above and if they are related to practice of care. The CMHSP shall ensure that persons involved in the review of sentinel events have the appropriate credentials to review the scope of care. The outcome of this review is a classification of incidents as either a) sentinel events, or b) non-sentinel events.

An "appropriate response" to a sentinel event "includes a thorough and credible root cause analysis, implementation of improvements to reduce risk, and monitoring of the effectiveness of those improvements." (JCAHO, 1998) A root cause analysis (JCAHO) or investigation (per CMS approval and MDCH contractual requirement) is "processes for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance." (JCAHO, 1998)

Following completion of a root cause analysis or investigation, the CMHSP will develop and implement either.

- A plan of action (JCAHO) or an Intervention (per CMS approval and MDCH contractual requirement) to prevent further occurrence of the sentinel event. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated.

  Or

- Presentation of a rationale for not pursuing a plan of action or an intervention.

Reporting is **not required** for:

- Accidents treated at medi-centers and urgent care clinics/centers should be included in the accident reporting along with those treated in emergency rooms. In many communities in the state where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of emergency rooms.
- Planned surgeries, whether outpatient or inpatient, are not considered unexpected occurrences and therefore are not included in the reporting of illnesses requiring admissions to hospitals.
- Report arrests and convictions as separate incidents.

7.3.4 Consumer Satisfaction Survey Collection Procedures

A sample of clients receiving substance abuse services funded in whole or part by CMHSP managed funds shall be surveyed. The CMHSP will provide detailed instruction for the collection process for client satisfaction surveys for FY 14/15.

7.3.5 Medication Supported Treatment Logs: Providers of pharmacologic support services (either methadone or suboxone-buprenorphine) must maintain a log that contains a listing of each client in treatment, and their daily dosages of these medications provided by the program. MDCH and/or CMHSP will review these logs in data auditing site visits.

7.3.6 Communicable Disease: Proof of staff communicable disease training must be recorded on the staff training log. Providers will be required to submit the *HIV/AIDS Policy and Procedure Questionnaire and Training Log* within thirty (30) days of receipt of a new contract. This report is provided in the Attachments section.

Providers must complete and submit the *Annual Supplemental Cost Information*. Instructions for completing this form are provided on the form which is provided in the Attachments section. The method used to calculate the percent of administrative and support staff time attributable to substance abuse must be provided in support of this form.

This report is due by April 30th for the previous fiscal year, or with submission of the organization's financial audit.

7.3.7 Annual Equipment Inventory Report: This form must be completed annually by all performance reimbursement providers and submitted to the CMHSP within thirty (30) days of the new contract. The required form is provided in the Attachments section.

Equipment is defined as a tangible, nonexpendable, personal property having a useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit, and purchased in whole or part with MDCH funds under an expenditure reimbursement contract with the CMHSP.

7.4 Provider Site Visit Reviews and Billing Verification

Site visits will consist of clinical audits as well as a review of Provider policies, procedures, staff credentialing, and compliance with CMHSP requirements. Each treatment provider in the CMHSP network will receive one annual site visit where CMHSP will review case files using the *Treatment Site Visit Case Review Form* and meet with administration to review the *Treatment Site Visit Evaluation Protocol*. Both forms are provided in the Attachments section.

For Designated Women's Providers and Gender-Competent providers an additional protocol, the W*FSS Site Visit Evaluation Protoco*l, provided in the Attachments section, will be reviewed during the annual visit.

7.4.1 Purpose: To ensure:

- Each Provider is qualified to provide offered services.
- A high level of performance throughout the CMHSP network.

- Delineation of specific service areas and to ensure that specific standards and access objectives are met.
- Periodic assessment of the performance of CMHSP contracted Providers.
- Each provider has met achieved and maintained appropriate Accreditation as defined in Section 7.2.3.
- Each provider has met achieved and maintained appropriate Staff Credentialing as defined in Section 7.9.2.
- Each Provider meets all other requirements established in this manual and not monitored another way.

7.4.2 Out-of-Region Providers: The CMHSP will make every attempt to establish reciprocal agreements with the governing coordinating agencies and/or PIHPs for the geographic location of out-of-region providers. The intention of establishing these agreements is to allow the CMHSP to rely on the site visit findings conducted by those organizations. For Medicaid/Healthy Michigan Plans providers, the CMHSP will continue to conduct billing verification and any other Medicaid/Healthy Michigan Plan specific review requirements during each six-month period.

7.4.3 Case File Selection: The CMHSP selects at least ten (10) cases for review from the current fiscal year. The selection shall include both active and closed cases, as well as both Medicaid/Healthy Michigan Plan and Block Grant funded clients (where applicable). Within these respective categories, the selection will be random. Providers will be provided with the list of case files that will be reviewed 24 hours prior to the site visit. Medicaid/Healthy Michigan Plans reviews will consist of verification of at least twenty five (25) treatment units semi-annually.

7.4.4 Corrective Action

Providers who are out-of-compliance with standards must take corrective action and re-establish compliance with standards or risk loss of provider status.

Depending on the nature and significance of errors or deficiencies noted, up to two (2) errors or deficiencies out of ten (10) records would result in a corrective action plan. More than two errors result in a recommendation. A recommendation could, in rare cases, be issued based on a single deficiency.

7.4.5 Report of Findings:

Providers will receive communication regarding the results of the site visit within 30 days of the site visit. The CMHSP will provide a summary of the findings for each visit that identifies any corrective action required. If any finding reaches the threshold of less than 75%, the corrective action plan will include a follow-up visit by CMHSP within ninety (90) days to assure that changes have been implemented to eliminate the problem.

For Medicaid/Healthy Michigan Plans providers, a summary report will be compiled for the LRP for their respective PIHP area. For more information refer to the LRP Medicaid/Healthy Michigan Plan Claims Verification Policy adopted by the CMHSP.

7.5 Individualized Treatment Planning

The Administrative Rules for Substance Abuse Programs in Michigan promulgated under PA368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

MDCH, as well as accreditation standards require evidence of client participation in the treatment planning process. Evidence of client participation includes goals and objectives in the client's own words, goals and objectives based on needs the client identified in the assessment, and evidence the client was in attendance when the plan was developed. Each treatment plan must also contain the amount, scope and duration of treatment and the date service is to commence within the plan or review.

All providers will develop an individualized treatment plan for eligible clients obtaining services, with client participation in the plan. The provider will maintain a documented procedure for treatment planning.

Full guidelines and requirements are provided in the Treatment Policy #06, *Individualized Treatment and Recovery Planning*, available at http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html .

Monitoring of Compliance: The CMHSP will monitor compliance with individualized treatment and recovery planning requirements during Provider site visits. These review findings will be made available to the Bureau of Substance Abuse and Addiction Services during their site visit to the CMHSP. MDCH will also review for individualized treatment and recovery planning requirements during selected provider site visits. Reviews of plans will occur in the following manner:

A. A review of the bio-psychosocial assessment to determine where and how the needs and strengths were identified.

B. A review of the plan to check for:
   - Matching goals to needs – Needs from the assessment are reflected in the goals on the plan.
   - Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients.
   - Measurable objectives – The ability to determine if and when an objective will be completed.
   - Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan.
   - Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
   - The amount, scope and duration of treatment within the plan.
   - Signatures – client, counselor, and involved individuals, or documentation as to why no signature.
   - Recovery planning activities are taking place during the treatment episode.

C. A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

D. An audit of the treatment and recovery plan progress review to check for:

- Progress note information matching what is in review.
- Rationale for continuation/discontinuation of goals/objectives.
- New goals and objectives developed with client input.
- Client participation/feedback present in the review.
- Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

7.6 Cultural Competency

Contracted providers are required to participate in programs and training to enhance sensitivity to cultural and ethnic diversity. Providers must have a written and implemented cultural competency plan that includes:

- Identification and assessment of the cultural needs of potential and active clients based on population served.
- Identification of how access to services is facilitated for persons with diverse cultural backgrounds and limited English proficiency.
- Identification standards for the recruitment and hiring of culturally competent staff members.
- Identification of how ongoing staff training needs in cultural competency will be assessed and met and the evidence that staff members receive training.
- An annual assessment of compliance with its cultural competency plan.

7.7 Limited English Proficiency

The CMHSP and its contracted providers shall provide accurate and timely language assistance and effective communication to limited-English-proficient (LEP) persons at no cost to the client. Including current and prospective patients/clients, family, and other interested persons to ensure them equal access to services. The procedures outlined in the Limited-English-Proficient (LEP) Persons Policy ensures that information is communicated to LEP persons in a language that they understand and maintains standards that insure compliance with the Title VI Civil Rights Act of 1964.

For more information refer to the full LEP policy provided in the Attachments section.

7.8 Service Availability

A Provider must assure that service availability will be maintained regardless of a Consumer's ability to pay.

A Provider must provide notification in writing to the CMHSP within three (3) days of any action that would require or result in significant modification, reductions, or elimination of the provision of service availability.

7.8.1 Access Standards

If it is not possible to offer an appointment within the required timeframe the provider must contact the CMHSP utilization review specialists to receive assistance in identifying an alternative provider of service and to place the client on the waiting list if appropriate.

Admission delays of more than fourteen (14) days for any level of care shall be

monitored by the CMHSP, and providers must notify the CMHSP if they do not have the capacity to meet service requests within this time allowance.

Providers must have the capacity to accept Medicaid/Healthy Michigan Plan clients without waiting periods beyond set standards as defined in the Michigan's Mission-Based Performance Indicator System manual. Network Providers must provide assessments within twenty-four (24) hours and treatment admissions following assessment within twenty-four (24) hours for urgent situations. Assessments for non-urgent situations must be within fourteen (14) days, and treatment admissions following Assessment for non-urgent situations within fourteen (14) days.

Providers shall maintain adequate provision for referral resources to address other client needs identified.

Upon reaching 90 percent of capacity to admit individuals to the program, a Provider that serves IDUs must notify the CMHSP immediately. The CMHSP is required to notify the State within twenty-four (24) hours.

No individual may be denied treatment because of race, color, creed, national origin, sex, religion, age, ancestry, marital status, sexual preference, or physical or mental handicap.

7.9 Staff Requirements

7.9.1 Staff Composition: Providers' **s**taff composition should generally include a balance of disciplines appropriate to the institution and the treatment methods utilized. Staff levels and composition will be reviewed against the programmatic goals of the facility to determine adequacy and depth for the intended effort.

7.9.2 Treatment Staff Credentialing

The State of Michigan currently uses credentialing services and standards managed through the Michigan Certification Board of Addiction Professionals (MCBAP). MCBAP administers the Michigan Addictions Fundamentals Examination (MAFE), and International Certification and Reciprocity Consortium (IC&RC) tests as part of the credentialing-process. MCBAP also administers the approval of professional development plans for staff in the process of upgrading their qualifications to meet certification-level standards. MAFE study guide materials are available from IAODAPCA, 401 E. Sangamon Ave. Springfield, IL 62702, FAX: (217) 698-8234. To register for the MAFE contact MCBAP at: www.mcbap.com.

Staff providing services within the CMHSP network must meet the current requirements stated in the *Michigan Department of Community Health – Credentialing and Staff Qualifications Requirements for the CA (Coordinating Agency) Provider Networks* available at http://www.michigan.gov/documents/mdch/Credential__Staff_Qualif_Require_Sep2011_431435_7.pdf; and the *Michigan PIHP/CMHSP Provider Qualifications Per Medicaid/Healthy Michigan Plans Services & HCPCS/CPT Codes* available at http://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf.

These standards apply to employee and contractual staff serving clientele whose

care is funded through any categories of funding administered by or for which the CMHSP is otherwise responsible.

The State of Michigan currently uses credentialing services and standards managed through the Michigan Certification Board of Addiction Professionals (MCBAP) www.mcbap.org. MCBAP administers the Michigan Addictions Fundamentals Examination (MAFE) and IC & RC (International Certification and Reciprocity Consortium) tests as part of the credentialing-process. MCBAP also administers the approval of professional development plans for staff in the process of upgrading their qualifications to meet certification-level standards.

The *New Hire Verification Form* should be completed for each staff person and should be the first document in the credential section of their personnel file. The form is provided in the Attachments section. Staff credentials will be reviewed during the annual site visit.

A. Requirements by Job Function as of July 2012:

1. **Treatment Supervisor:** Commonly described as Supervisors, Managers or Clinical Supervisors. This represents an individual directly supervising staff, including all levels of clinical services.

   Certification Requirement: Must possess either a Certified Clinical Supervisor– Michigan (CCS-M) or a Certified Clinical Supervisor-IC&RC (CCS-R) or be on a Developmental Plan for one of these certifications.

   Supervision Requirement: Professional licensure requirements may apply depending on the nature of the work duties and scope of practice.

2. **Substance Abuse Treatment Specialist (SATS):** Commonly described as clinicians, therapists, or counselors. This represents direct clinical treatment service provider staff not identified as specifically focused.

   Certification Requirements: In order to qualify as a SATS an individual must meet the criteria detailed in **any one of** the following three categories.

   - Possesses one of the following certifications from the Michigan Certification Board of Addiction Professionals: CADC, CADC-M, CAADC, CCJP-R, CCDP, or CCDP-D.
   - Individual has a development plan with MCBAP **and** possesses one of the following licensures: MD/DO, PA, NP, RN, LPN, LP, LLP, TLLP, LPC, LLPC, LMFT, LLMFT, LMSW, LLMSW, LBSW, or LLBSW
   - Individual possesses one of the following alternative certifications: American Society of Addiction Medicine (ASAM), American Psychological Association (APA) specialty in addiction, or Certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD).

   Supervision Requirement: Must be supervised by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

3. **Substance Abuse Treatment Practitioner (SATP**): Commonly described as treatment staff providing direct service to clients like education and support; or they may be new to the field.

   Certification Requirements: In order to qualify as a substance abuse treatment practitioner, an individual must have a MCBAP development Plan in place and be supervised by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   Supervision Requirement: Must be supervised by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

4. **Specifically Focused Treatment Staff:** This category includes Case Managers, Recovery Support Staff as well as staff who provide ancillary health care services such as nurses, occupational therapists, psychiatrists and children's services staff in women's specialty programs. Licensing requirements may apply depending on the nature of the work duties and scope of practice.

   Certification Requirements: No certification requirements. Education and training may apply depending on the role of the staff.

   Supervision Requirement: Must be supervised by an individual with MCBAP certification.

5. **Treatment Adjunct Staff:** Adjunct staff is involved with the client but not at a clinical treatment services level. It is recognized that some treatment adjunct staff provide didactic or skill development services. Commonly described as Resident Aides, Pharmacy Techs or Childcare Aides, or program aides/techs. Licensing requirements may apply to adjunct staff depending on the nature of the work duties and scope of practice.

   Certification Requirements: No certification requirements. Education and training may apply depending on the role of the staff.

   Supervision Requirement: Must be supervised by an individual with MCBAP certification.

7.9.3 Staff Certification Recommendations

A. Staff possessing a "Michigan-only" level of certification is encouraged to work towards achieving the ICRC credential.

B. Personnel certified at the Substance Abuse Treatment Practitioner level are encouraged to work towards the Substance Abuse Treatment Specialist level.

7.9.4 Additional Staff Requirements

A. Providers must ensure that criminal background checks are conducted as a condition of potential employment for all employees hired after 10/1/2003. This requirement is not intended to imply that a criminal record should necessarily bar employment.

B. Providers receiving Medicaid/Healthy Michigan Plans funds must review the

Medicaid/Healthy Michigan Plans Sanctioned Provider List, http://exclusions.oig.hhs.gov/ annually to assure no staff in employment or contracting with the Provider is listed. Pursuant to Section 1128 and Section 1902(a)(39) of the Social Security Act, the Medicaid/Healthy Michigan Plans Program will not reimburse a provider for any services rendered or that were ordered/prescribed by a sanctioned (e.g. suspended, terminated, excluded, etc.) provider. The effect of the provider's exclusion precludes them from furnishing, ordering, or prescribing items or services to any Medicaid/Healthy Michigan Plans member.

C. For clinical staff with less than 2,000 hours of substance use disorder treatment experience, the CMHSP requests completion of the MAFE (Michigan Addictions Fundamentals Examination) within ninety (90) days of hire in addition to the minimal MDCH credentialing requirements. Program may request a waiver by submitting information on the person's relevant experience and the type of clinical supervision that is being provided.

7.9.5 Clinical Billing Code Allowed Based on Qualifications

Clinical staffs are those individuals providing the following clinical services: individual counseling, group counseling and/or didactic services in an outpatient or residential setting.

7.9.5.1 Block Grant, PA2, or MIChild Funded Treatment Services

For Substance Abuse Treatment Specialist (SATS) and Substance Abuse Treatment Practitioner (SATP) allowable billing codes, refer to page 13 and 14 of the *MDCH Credentialing and Staff Qualification Requirements for the CA Provider Network.*

7.9.5.2 Medicaid/Healthy Michigan Plans Funded Treatment Services

For Substance Abuse Treatment Specialist (SATS) and Substance Abuse Treatment Practitioner (SATP) allowable billing codes refer to page 15 through 18 of the *Michigan PIHP/CMHSP Provider Qualifications Per Medicaid/Healthy Michigan Plans Services & HCPCS/CPT Codes* and *MDCH Medicaid/Healthy Michigan Plans Provider Manual*, Mental Health/Substance Abuse, Section 2.4, "Staff Provider Qualifications".

Providers are responsible for ensuring they comply with future updates to the Medicaid/Healthy Michigan Plans Manual.

7.9.6 Credential Files and Verification

Providers are required to establish and maintain a credentials file on all employees or contractual staff providing clinical services. Providers must conduct primary source verification of education and licensure, registration and/or certification prior to employment and maintain proof of the primary source verification in the credentials file.

Providers must conduct primary source verification of licensure, registration and/or certification on all clinicians and maintain proof of verification in the credential file annually.

A. **Credential File**: The credentials file must include, at minimum:

- A written application that is completed, signed and dated by the clinician that attests to:
    - a lack of present illegal drug use,
    - any history of loss of license,
    - felony convictions,
    - any history of loss or limitation of privileges or disciplinary action,
    - five (5) year history of professional liability claims resulting in judgment or settlement, and,
    - attestation by the applicant of the correctness of and completeness of the application.
- Academic history with proof of completion.
- Employment experience in the form of a resume.
- Copies of professional licenses, certifications and registrations.
- Current list of "in-service" trainings completed, including other professional training experiences pertinent to clinical practice. The credentials file must also include an evaluation of the clinician's work history for the prior five (5) years.
- Proof of the criminal background check for all employees hired after 10/1/2003.
- Proof of annual review of the Medicaid/Healthy Michigan Plans Sanctioned Provider List, http://exclusions.oig.hhs.gov/ to assure no staff in employment or contracting with the Provider is listed.
- A list of clinical privileges practiced by date granted.
- Proof of annual primary source verification of licensure, registration and/or certification on all clinicians and maintain in the credential file.
- Intern files must also contain the practicum and clinical experience supervised, with the areas of clinical practice, age group, and/or special skills learned. See the CMHSP Student Intern Policy section for more information.

B. **Verification of Credentials**

The *Confirmation of Credentials Form*, provided in the attachment section, must be submitted annually upon request to the CMHSP. During the annual provider site visit, the CMHSP will review the credential files for accuracy and thoroughness. A sampling methodology may be used to verify the information contained in these forms and that annual primary source verification has been completed and documented in the credential file.

Clinical services rendered by staffs who do not meet credentialing requirements as detailed in Section 7.9.2 shall not be reimbursed by the CMHSP.

The CMHSP reserves the right to recognize and accept the credentialing activities and application of another RE/PIHP. A provider may submit a written request for such consideration.

C. **Provider Responsibility**: Prior to the delivery of services, it is the Provider's responsibility to ensure that all staff slated to provide direct treatment service funded in whole or in part with CMHSP funds meet the qualifications and to maintain credential files on all clinical staff.

Within fourteen (14) days of hire, the Provider must submit the New Employee Verification Form to the CMHSP for all employees who provide direct substance use disorder treatment services to CMHSP funded clients.

Annually, Providers must conduct primary source re-verifications of licensure, registration and/or certification on all clinicians and maintain proof of verification in the credential file.

7.9.7 Clinical Staff Approval Process

A *New Hire Verification Form* must be submitted for each treatment service staff providing CMHSP funded services within fourteen (14) days of hire. This form is provided in the Attachments section.

Forms will be reviewed internally at CMHSP who will conduct a review to verify the licensure, credentials, and checks for Federal Exclusionary Listing. Primary source verification does not need to be submitted to the CMHSP.

Based on the staff person's individual experience and preparation, the CMHSP may request completion of the Michigan Addictions Fundamentals Examination (MAFE) in addition to the minimal credentialing requirements.

7.9.8 Staff Training Requirements

In addition to meeting staff credentialing requirements, the CMHSP requires the following training requirements for all employees, volunteers, student interns, and persons under contract providing services to CMHSP funded clients.

The Confirmation of Trainings form, provided in the Attachments section, documenting provider and staff compliance must be submitted annually, upon request, for all professional staff whose scope of services provided is impacted by the topic(s) listed

A. Communicable Disease

To ensure that treatment program staff meets contractual requirements for training and knowledge on HIV/AIDS, MDCH mandates that all staff with client contact at a licensed treatment provider have at least a basic knowledge of HIV/AIDS, TB, Hepatitis, and STD, and the relationship to substance abuse.

MDCH provides a web-based training that will cover minimal knowledge standards necessary to meet this **Level 1** requirement. However, if a Provider desires to provide this training through other mechanisms, the following information must be included:

- Basic orientation on HIV/AIDS
    - HIV/AIDS, TB, Hepatitis (especially A, B, and C) and STD/Is, as they relate to the agency target population.
    - Modes of transmission (risk factors, myths and facts, etc.).
    - Linkage between substance abuse and these CDs.

- Overview of treatment possibilities.
- Local resources available for further information/screening.

- Basic training on agency policies and procedures.

All new hires must receive the required communicable disease training on communicable diseases within six (6) months of hire by a certified MDCH/HAPIS trainer or the online training provided by MDCH at www.MI-PTE.org.

Proof of staff communicable disease training must be recorded on the staff training log. Providers will be required to submit the *HIV Policy and Procedure Questionnaire and Training Log* annually, within thirty (30) days of the new contract each year. This report is provided in the Attachments section.

B. Advance Directives Training

Medicaid/Healthy Michigan Plan providers must annually, and within the first thirty (30) days of hire, educate its staff by a professionally credentialed authority on Advance Directive regulations, new regulations, forms, and related issues. CMHSP providers must log attendance at the annual training. For more information refer to Section 4.8.

For guidance, providers may follow the questions and answers in the *Michigan Advance Directive for Mental Health Care; Planning for Mental Health Care in the Event of Loss of Decision-Making Ability* located at www.michbar.org/elderlaw/adpamphlet.cfm and/or the BCBS Advance Directive – FAQs located at: http://www.bcbsm.com/member/establishing_advance_directive/advance_directive_faq.html.

C. Limited English Proficiency (LEP) Training

All providers must educate their staff within the first six (6) months of hire to ensure that information is communicated to LEP persons in a language that they understand. Limited-English-Proficient Person (LEP) is a person whose primary language or dialect is one other than English, and who has difficulty speaking and/or comprehending the English language such that it limits his/her ability to participate in, and benefit from, services communicated in English.

Trainings shall ensure staff compliance with the laws under Title VI Civil Rights Act of 1964, which prohibits discrimination against persons with LEP, and the CMHSP's LEP Policy. Ongoing staff trainings must be provided in accordance to the provider policy.

D. Cultural Competency Training

All providers are required to participate in programs and training to enhance sensitivity to cultural and ethnic diversity. New hires must be trained in the areas of cultural competence within the first six (6) months of hire. Ongoing staff training needs in cultural competency must be assessed, met, and documented according to each provider's Cultural Competency Plan.

E. Corporate Compliance & Deficit Reduction Act (DRA) Training

Medicaid/Healthy Michigan Plan providers must educate its staff upon hire regarding its Corporate Compliance Plan and the requirements of the Deficit

Reduction Act to ensure compliance with the statutes, regulations, and written directives of Medicare, Medicaid/Healthy Michigan Plan, and all other Federal Health Care Programs (as defined in 42 U.S.C. ξ 13201-7b (f). Detailed information about the False Claims Act, Whistleblower protections, and policies and procedures for detecting and preventing fraud, waste, and abuse must be covered. Ongoing staff training needs shall be provided as needed, in accordance to the provider policy.

F. Recipient Rights Training

All providers must ensure staff is trained within thirty (30) days of hire to protect client rights in accordance with the rules under PA 368 of 1978, as amended. Specifically, the Administrative Rules for Substance Abuse Service Programs in Michigan, Section 3 – Recipient Rights (effective January 9, 1982). Ongoing staff training needs shall be provided, in accordance to the provider policy.

G. Medicaid/Healthy Michigan Plans Fair Hearings Training

Medicaid/Healthy Michigan Plan providers must ensure staff possess current working knowledge, or know where in the organization detailed information can be obtained regarding the steps and actions to be taken when a Medicaid/Healthy Michigan Plan client does not agree with the scope, duration, or intensity of services authorized. Agency staff must receive training in this area within the first thirty (30) days of hire and thereafter according to provider policy.

H. Confidentiality & Health Insurance Portability and Accountability Act (HIPAA) Training

All providers must review their written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements with new staff and ensure training on all applicable Federal and State requirements of the HIPAA 45 CFR and Confidentiality Rules of 42 CFR Part 2 within the first fifteen (15) days of hire. Ongoing trainings shall be provided, as needed, in accordance to the provider policy.

7.9.9 Patient Advocacy

A health care professional, who is acting within their lawful scope of practice, is not prohibited or restricted from advising or advocating for his or her patients in any of the following areas:

- The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the beneficiary needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

7.9.10 False Claims Act

Providers must establish written policies that address and comply with the False Claims Act and ensure their employees are made aware of their rights under the Whistleblowers Provisions of the False Claims Act. For more information visit http://www.whistleblowers.gov/

7.9.11 Use of Student Interns

The CMHSP encourages the provider network to provide opportunities to support prospective addiction professionals. However, it is important to ensure that interns are involved in ways consistent with accepted standards and compatible with patient rights and needs.

It should be assumed that a new intern is unqualified to independently deliver any service to a client. Depending on the intensity of the learning situation, four (4) to eight (8) weeks should elapse before an intern can begin to function on his/her own in such critical areas as assessment, treatment planning, treatment, or prevention education. Four to eight weeks is optimal and should be extended when appropriate for the individual intern.

Billable activity or direct service credit should not be submitted under an intern's staff number until his/her supervisor has reviewed the performance after four to eight weeks and has certified, in writing, that the intern is able to work quasi-independently in specific areas without jeopardizing patients and will contribute to patient progress.

An Internship form must be completed and approved by the CMHSP prior to submitting treatment activity provided by the intern. The *Internship Form* is provided in the Attachments section.

Criminal background checks must be completed for interns prior to interaction with clients or access to protected health information.

A. Roles and Responsibilities

1. Responsibilities of the Studentship/Practicum Agency

The agency agreeing to accept a student must:

- Provide assurance the student is covered by adequate liability insurance.
- Assign a supervisor who has:
  - Capacity to provide adequate supervision and instruction to meet the sending school's requirements, and
  - A Michigan Certification Board of Addiction Professionals treatment credential.
- Ensure compliance with all Federal labor laws if the internship is unpaid.
- Ensure the student has basic protections in the work setting consistent with Federal and State laws, ethical considerations, and sound business practices.
- Ensure the student abides by all Federal confidentiality and privacy laws.

- Submit a completed New Employee Verification form to CMHSP for the student prior to direct contact with clients who are receiving services funded in whole or part by CMHSP managed funds.
- Submit other contractual items as required by CMHSP contract.

2. Responsibilities of Studentship/Practicum Supervisor

- Provide a documented orientation to the student, which minimally addresses:

  a. Federal Confidentiality and Privacy Laws
  b. CMHSP Student Intern Policy
  c. Michigan Certification Board for Addiction Professional's *Code of Ethics*
  d. Sponsoring Agency Policy and Procedures
  e. ASAM Patient Placement Criteria
  f. DSM IVR
  g. CMHSP Authorization Process
- Provide one (1) hour of formal scheduled direction supervision on a weekly basis.
- Review and sign-off on all written documentation for independent clinical activity, including but not limited to progress notes, treatment plans, initial authorization requests, reauthorization requests and correspondence.
- Utilizing the privileging process outlined in the Clinical Practicum /Studentship Criteria listed in this policy, assure that the student is prepared to engage in the level of clinical practice assigned.
- Assist student in preparing an educational plan based on the Clinical Practicum/Studentship Criteria appropriate for the length of the practicum placement, and in consideration of the education and prior experience of the student.
- Review all clinical assignments.

3. Responsibility of the Student

- Provide written assurance of understanding of and adherence to the Federal Confidentiality and Privacy Laws;
- Provide written assurance of understanding of and adherence to the Michigan Certification Board of Addiction Professionals *Code of Ethics;*
- Provide services only as approved and directed by supervisor;
- Develop an appropriate educational plan with assistance of the supervisor.

B. **Clinical Practicum/Studentship Criteria**

Documentation of all activities and progressions made toward providing clinical services must be tracked, kept in the student's file, and available

for CMHSP review.

It is the responsibility of the supervisor to document compliance and, through his/her signature, verify competence prior to allowing the student to progress to another level of activity.

C. Reimbursement for clinical Services

1. A Provider may only invoice the CMHSP for independent clinical services provided by a student intern when services meet all contractual requirements as stated in the Michigan Medicaid/Healthy Michigan Plan Manual and the CMHSP Contract.
2. **For services provided to Medicaid/Healthy Michigan Plan and MIChild clients, the student intern must meet the following requirements:**
    - New Employee Verification form submitted to the CMHSP.
    - Meet credentialing requirements for a Substance Abuse Treatment Practitioner (SATP) or a Substance Abuse Treatment Specialist (SATS) as verified by the Provider.

    For services provided to Block Grant and PA2 clients, the student intern must meet the following requirements:
    - New Employee Verification form submitted to the CMHSP.
    - Pass the Michigan Addictions Fundamentals Examination (MAFE) Test, as verified by the Provider.
    - Have a certified MCBAP Addictions Counselor supervise, review and co-sign all progress notes, treatment plans, communication, authorization requests, and other clinical documentation of the student intern.
3. The Provider must assure compliance with the Federal Fair Labor Standards Act and have documentation that the intern has progressed to being able to provide the level of service and activity billed.

7.10 Service Standards and Guidelines

7.10.1 Mental Health Practice Guidelines

All Medicaid/Healthy Michigan Plans funded services through the CMHSP must comply with appropriate mental health requirements as established by the MDCH.

- Self-Determination http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4900-264686--,00.html
- Person Centered Planning (In substance use disorder treatment the individualized treatment planning is used to ensure person-centered planning) http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_4900-264670--,00.html
- Recovery Philosophy

http://www.michigan.gov/documents/mdch/March12007MemofromPatrick_188884_7.pdf

- Mental Health Evidence-Based Practices:
  - Assertive Community Treatment: http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_38495_38496_38504---,00.html
  - Family Psycho-education: http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_38495_38496_38504---,00.html
  - Improving Practices: http://www.michigan.gov/documents/mdch/Practice_Improvement_Steering_Committee_Meeting_11_9_09_302903_7.pdf
  - Supported Employment: http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_38495_38496_38505---,00.html

7.10.2 LRP Policies and Procedures

As an affiliated member of the Lakeshore Regional Partners, all Medicaid/Healthy Michigan Plans funded services through CMHSP must comply with appropriate LRP policies and procedures that govern the Medicaid/Healthy Michigan Plans benefit. The LRP policies and procedures can be found at the website http://lakeshoreregionalpartners.lsre.org

1.0 General Management and Administration
1.1 Conflict of Interest
1.2 Asset Protection
2.0 Financial Management
3.0 Information Systems Management
4.1 Procurement of Service
4.2 Contract Management
4.3 Network Policy Development
4.4 Credentialing and Privileging
5.0 Utilization Management
6.0 Customer Services
6.1 Grievance and Appeals
6.2 Consumer Empowerment and Involvement
6.3 Community Benefit
7.1 QAPIP
7.2 Quality Management Committee
7.3 Critical Incidents and Sentinel Events
7.4 External Review Process
7.5 Conducting Research
7.6 Corporate Compliance
7.7 CMHSP Member Monitoring

7.10.3 MDCH Best Practice Guidelines

The CMHSP is committed to following all guidelines provided by the MDCH as detailed in their Treatment Policies and Technical Advisories. All CMHSP funded services must comply with these guidelines. The CMHSP will communicate

requirements as established by these policies and technical advisories through this manual, contract requirements, and supplemental communications.

The Michigan Department of Community Health/Bureau of Substance Abuse and Addiction Services policies and technical advisories for substance use disorder services can be found at:

http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html

7.10.4 CMHSP Policies and Procedures

The following CMHSP Policies govern the Medicaid/Healthy Michigan Plan benefit and can be found on the CMHSP website:

- Medicaid/Healthy Michigan Plans Mission, Vision, Values and Ethics Statement
- Completion of Competency Based Evaluation
- Hiring Process
- Screening, Orientation and Supervision of potential employees
- Screening, Orientation and Supervision of Staff
- Financial Tracking of Contract Payments
- Billing Audit
- Recipient Rights Policies
- Staff Development
- Substance Abuse Services: Admission, Assessment, Discharge,
- Confidentiality, Credentialing Standards, Agency Discontinuation
- Services and Program Direction and Oversight
- Documentation Standards
- CMHSP Anti-Harassment Policy
- Quality Assessment and Performance Improvement
- LRP Corporate Compliance Plan

SECTION 8

PROVIDER AGREEMENT & NEGOTIATIONS

Negotiation as herein used refers to sub-contractor initiated requests for changes in the terms of their contract with the CMHSP. Normally such requests are received and acted upon as part of the Annual Action Planning process, although the possibility of extenuating circumstances that make a mid-year request appropriate is recognized.

Issues between the Provider and CMH involving contractual terms will be addressed by their respective designated representatives. All decisions to authorize, continue, or discontinue CMH payments for services to consumers will be those of CMH's Executive Director or designee. If disputes as to essential terms of this contract are not resolved by the Executive Director for the CMH, these issues will be referred for dispute resolution to the Executive Board of CMH and the Provider's governing body. If the disputes cannot be resolved, either party may seek any available legal and/or equitable remedy.

SECTION 9

CASE RECORD CONFIDENTIALITY

The CMHSP is responsible for ensuring the maintenance of all clinical records for covered benefits in accordance with accepted and prevailing standards for professional substance abuse care practice.

Confidentiality is a major professional and administrative component of clinical records management. Confidentiality is protected by a system of record control that ensures security of written and computer-based information and prescribes specified managed protocols for release of privileged information in keeping with all of Michigan Managed Care Providers policies and procedures.

The CMHSP and providers shall comply with Federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1990 (HIPAA), 45 C.F.R. Parts 160 and 164, effective April 2003.

9.1 Privileged Communication

A privacy notice is required of all providers serving publicly funded clients and a CMHSP privacy notice must be given to all clients upon their initial admission to a program that will be accessing CMHSP funding. Refer to the HIPPA Privacy Brochure provided in the Attachments section.

"Duty to warn" considerations as identified from landmark litigations like the California "Tarasoff" decision and the Michigan "Davis vs. Yong-oh-Lhern" decision shall also be considered. These considerations arise when dealing with an enrollee who may be dangerous to self or others. The referenced legal decisions uphold the position that a physician owes a duty of reasonable care to a person who is in foreseeable danger from a patient. These decisions have been interpreted to extend to any clinician who stands in a professional position to a patient.

9.2 Clinical Recordkeeping Procedures

Confidentiality shall be maintained for all enrollee records. Open records should be kept in secured files. Each file cabinet or other storage area containing such client records should be locked and maintained in a decentralized location. All keys should be kept in the possession of the Executive Director or other designee who is responsible for security. Records are not to be removed from the premises except through formal transfer to another approved custodian. When providing services at alternative location, client files must be stored at the licensed provider site and transported securely, as necessary, for service provision.

9.3 Procedures for Release of Confidential Information

A specific release of information is required to release treatment specific information to any source except to the CMHSP to review and verify services for which it is responsible for payment. Consent to any releases of information is obtained in writing, specifying the purpose of the disclosure, the quality and quantity of information to be released, and to whom it may be released. An authorization for the release of information shall become part of the client's permanent case record. Such releases must be on a corporate form or facsimile.

Cases involving treatment of substance abuse require all releases to be originals and must

comply with regulations outlined in Section 18 of Public Act 56 of 1973. Criminal justice releases may be specifically tailored to allow ongoing sharing of information to comply with court requirements, provided that the specific criminal justice release form is utilized.

Releases of information are adequate for these purposes when they contain the following provisions:

- Release specifies the purpose of the disclosure, the quality and quantity of information to be released, and to whom it may be released.
- Separate releases should be used for each family member when multiple members are involved.
- Provisions in releases for criminal justice purposes should allow for ongoing sharing of information relevant to court proceedings.
- Release should prohibit release to third party of the information contained therein.

9.4 Office Procedures for Confidentiality

The following shall be maintained as described to help ensure confidentiality:

- Word Processors shall remain covered if confidential material is left in them during breaks or lunch. Confidential material must be cleared from the desks and placed in a locked file at the end of the work day. No records should be left unoccupied on desks. Visitors should not be allowed to wander behind desks for any reason. Confidential material not immediately being used should be protected from a visitors casual glance by turning folders over so that identifying information such as names are not visible.
- Computers should have password protection to restrict access. Confidentiality standards which apply to records apply equally to computer information, tape back-ups, and hard copy print outs. Administrative and support staff have access to case or client information only as necessary to complete assignments. Computer services used by the corporation sign qualified service agreements which bind them to the confidentiality policies.
- Mailboxes are cleared of confidential material by the staff before leaving for the work day and are not in, or accessible from the reception area.
- Confidential and identifying client information should never be included in an email transmission unless it is a password protected encrypted email and the password is not included within the communication.
- No information regarding any enrollee is to be released over the telephone without a signed release form from that enrollee. Also, verification of services to enrollees cannot be given over the telephone without a signed release. Staff are not to reveal confidential information by enrollee name when others are using the telephone.
- After-hours or in social environments, no enrollee issues are discussed. In situations such as an employee meeting an enrollee in public, the employee acknowledges the enrollee only if the enrollee first acknowledges the employee. If introductions to companions are necessary, the employee does not reveal the relationship of the enrollee.

- No enrollee records are to be taken home for any reason by Provider staff.
- A specific release of information is required to provide enrollee-specific treatment information to any other source except to those institutions and individual practitioners that are network providers and/or have a contract to provide services or to organizations with which CMHSP has a qualified service agreement.
- Enrollee consent to release information is obtained in writing specifying the purpose of the disclosure, the quality and quantity of the information to be released, and to whom it may be released. Releases are on approved forms or facsimiles.
- Separate releases are required for family members in the same treatment episode.
- For SA cases, all releases are originals and comply with Federal Confidentiality Rules and Regulation 42 C.F.R. Part 2 and HIPAA Act of 1990, 45 C.F.R. Parts 160 and 164. Criminal justice releases are specifically tailored to allow ongoing sharing of information to comply with Court requirements provided that a specific criminal justice release form is utilized.
- All clinical records should be maintained at least seven (7) years following closure. Records of minors should be maintained for seven (7) years following attainment of the minor's age of minority. At that time, the records are transferred to microfiche, microfilm, or kept in storage.

9.5 Computerized Records

- All computerized systems should have password protection to allow access to information only on a "required information" basis.
- Confidentiality rules applicable to case records apply equally to computerized clinical records and information.
- All computer vendors are required to enter into qualified service agreements which bind them to confidentiality provisions.
- Tape back-ups and hard copy print-outs that are enrollee specific are treated with the same confidentiality restraints as clinical records and other materials.

9.6 Provider Record Availability

- Primary documentation of all episodes of care is the responsibility of the facility or other provider in which the substance abuse care is provided. If the care is provided by a sole proprietor, then documentation is the responsibility of the individual. Such records are maintained in a manner consistent with the CMHSP requirements and available for authorized representatives or agents of the CMHSP, the Department of Community Health and the Clinical Service Administration for examination, investigation and review.
- HIPAA rules require that programs retain records of former clients for a minimum of six (6) years.

9.7 Transfer of Clinical Records and Information

Information requested by the CMHSP or otherwise obtained or given to providers shall follow the following procedures:

- Facsimile transmission should occur using the following procedure. First place a telephone call to the person to receive the confidential transmission to verify that they are immediately available to receive the fax and to verify the fax number by sending a test message. Then immediately transmit to facsimile.
- Receipt of referrals to providers is confirmed by the provider by telephone when concurrent review is initiated with the provider.
- Written reports of enrollee progress and discharge summaries may be requested from providers.
- Reports are specifically requested by the CMHSP Utilization Review Specialists and mailed or faxed directly to them at their worksite.
- After review, reports are filed in the case management record.
- Clinical records of the enrollees may be requested from the provider for the purpose of concurrent or retrospective review of care, provider appeals or enrollee grievance processing, or for other legitimate clinical or management purposes.
- Providers are required to secure a proper release of information for all records which contain information transferred from another provider or unrelated to the episode of care.
- Records are reviewed only by those with assigned responsibility in the process.
- Records while on-site are stored in keeping with protocols for internally generated records.
- Providers who are treating enrollees in common are requested to secure proper releases of information in order to share clinical information, that comply with Federal Confidentiality Rules and Regulation 42 C.F.R. Part 2 and HIPAA, 45 C.F.R. Parts 160 and 164.