NORTHCARE NETWORK SUBSTANCE USE DISORDER SERVICES

OPERATIONS MANUAL

2018-2019

Website: www.northcarenetwork.org

NORTHCARE NETWORK SUBSTANCE USE DISORDER
PROVIDER MANUAL 2018-2019

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GENERAL INFORMATION

Purpose of the Operations Manual

The purpose of this Operations Manual is to outline the basic framework for NorthCare Network SUD processes. While every attempt has been made to be as clear and accurate as possible, omissions, ambiguities, and other imperfections may exist. In the event an error is discovered or a policy/procedure changes, contracted providers will be notified in writing. The NorthCare Network Substance Use Disorder Services Operations Manual is incorporated by reference as part of the Provider Contract agreement. As updates, clarifications, and changes are made to our Master Contracts or the Medicaid Provider Manual, this Substance Use Disorder Operations Manual will also be updated.

Organizational Chart – State Level

Michigan Department of Community Health
Behavioral Health and Developmental Disabilities Administration (BHDDA)
Substance Use Disorder Single State Authority (SSA)
Dr. George Mellos, M.D., Deputy Director

Office of Recovery Oriented Systems of Care (OROSC)

NORTHCARE NETWORK GOVERNING BOARD

Copper Country:

Michael Koskinen
Patrick Rozich (Chairperson)*
James Tervo

Gogebic:

Joe Bonovetz
Margaret Rayner
Stephen Thomas*
Dan Siirila (alternate)

Hiawatha:

Jim Moore
George Ecclesine
Dr. John Shoberg
Bob Barr (alternate)

Northpointe:

Gerald McCole
Mari Negro
Ann Martin

Pathways:

George Botbyl (Secretary)
Pat Bureau
William Davie (Vice-Chair)
Katie Carlson-Lynch (alternate)

SUD Policy Board

Chairperson: James Moore, Chippewa County

Vice-Chairperson: Craig Reiter, Schoolcraft County

Tim Palosaari, Houghton County

James Brennan III, Iron County

Stephen Adamini, Marquette County

Randy Eckloff, Keweenaw County

Jim Hill, Mackinac County

Michael Koskinen, Baraga County

Ann Martin, Dickinson County

Nancy Morrison, Luce County

John Nelson, Menominee County

Catherine Pullen, Alger County

David Rivard, Delta County

Jon Bonovetz, Gogebic County

Robert Nousiainen, Ontonagon County

NorthCare Network Governing Board and SUD Policy Board charts are on our website.

NORTHCARE STAFF

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Chief Executive Officer
Judi Brugman, SAPT Director/Contract Manager
906-225-7286
SUD Treatment Coordinator
906-225-4422
Carol Easton, SUD Assessment Specialist
906-226-0042
Kathy Lyman, SUD Access Specialist
888-333-8030 or 906-225-7254
Karena Grasso, Provider Network Administrative Support Specialist
906-225-4404

NorthCare Organizational chart

NorthCare Network

Mission, Vision, and Values

Mission

NorthCare Network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and supports through the responsible management of regional resources.

Vision

NorthCare Network envisions a full range of accessible, efficient, effective and integrated quality behavioral health services and community based supports for residents of Michigan's Upper Peninsula.

Values

• We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and a culture of gentleness.

• We also endorse effective, efficient community based systems of care based on the ready availability of a competent workforce and evidence based practices.

• We believe in services that are accessible, accountable, value based, and trauma informed.

• We support full compliance with state, federal and contract requirements, and responsible stewardship.

• The right care, at the right time, for the right cost, and with the right outcome.

Access Management

Access management consists of those responsibilities associated with determining administrative and clinical eligibility, managing resources (including demand, capacity, and access), ensuring compliance with various funding eligibility and service requirements, and assuring associated quality of care. Activities to carry out these responsibilities include appropriate referral and linkage to other community resources.

Hours of Operation

Regular office hours are 8:00 A.M. until 5:00 P.M., EST, Monday through Friday.

DIAL HELP

Dial Help trained staff answer the SUD line during non-business and holiday hours. Calls will be handled appropriately based on request and necessity.

TARGET POPULATION

While this varies somewhat according to funding source and priority status; target population is generally comprised of low-income residents with a substance use disorder residing in the fifteen counties of the Upper Peninsula of Michigan.

Residency in Region

The PIHP will not limit access to programs and services funded by this Agreement only to residents of the PIHP's region, because the funds provided by the Department under the State contract come from federal and statewide resources. Members of federal and state-identified priority populations will be given access to treatment services, consistent with the requirements of the State contract, regardless of their residency. However, for non-priority populations, the PIHP will give its regional residents priority in obtaining services funded under this agreement when the actual demand for services by those residents eligible for services exceeds the capacity of the programs. **Providers are required to determine and document client's county of residence.**

Use of Cell Phones

Legal Action Center Book – Confidentiality and Communication – A Guide to the FDA Confidentiality Law and HIPAA - 2012 Edition
Mobile telephones present some new challenges to programs. Before the use of mobile telephones, conversations about confidential matters could take place in rooms or booths where some degree of privacy could be achieved. With mobile telephones, conversations about confidential matters can take place anywhere and be overheard by anyone. Although 42 C.F.R. Part 2 does not specifically address the use of mobile telephones, a mixture of common sense and restraint will satisfy both laws. For instance, a staff member should not have a conversation about a patient in an area where there is an obvious risk of being overheard, like in a public gathering or aboard public transportation.

Some programs have also limited staff use of mobile telephones to discuss patients because there have been occasions where such conversations are inadvertently

overheard on another mobile telephone. If this is a persistent problem in an area, limitations should be imposed.

Telemedicine Legal Action Center, 2012 Edition

Telemedicine is an approach whereby, with the help of telecommunications, people receive health care without being in the same room as their health care provider. It typically occurs in rural areas where people do not have access to a full array of providers. A patient can enter the office of one provider, who hooks up via telecommunications with one or more other providers. The provider(s) and patient can communicate via any combination of computer, telephone, and video.

Naturally, telemedicine poses new challenges for maintaining confidentiality because, among other things, several providers may be involved, at different sites, with persons listening to or viewing the telemedicine session unbeknownst to the patient. In addition, communications could be intercepted or re-disclosed to unauthorized persons.

The same confidentiality principles apply to telemedicine as to in-person treatment. Moreover, if protected health information is being transmitted or stored electronically then the HIPAA electronic security standards will need to be implemented. Special care must be taken to ensure that records are available only to authorized personnel and those sessions (individual or group) with alcohol or drug patients are not witnessed by unauthorized persons. Most telemedicine sessions that involve the disclosure of alcohol or drug information will require a consent form to be in place. The consent must list all parties participating in the telemedicine conference, including technical support individuals operating the video cameras or other equipment, and of course all are prohibited from making re-disclosures without authorization. Provisions also must be made to ensure the security of the tapes after the conference is completed. This is a service that must be included in Provider Contract and can only be billed using the appropriate Telemedicine CPT code.

List of Contract Providers

Refer to the NorthCare Network Customer Handbook for the current listing of Substance Abuse Disorder providers.

FUNDING /ELIGIBILITY CRITERIA/CLINICAL NEED

12-Month Availability of Services

Contract Providers must maintain service availability throughout the fiscal year for persons who do not have the ability to pay.

Treatment Services must be based on the following:

Medical Necessity Criteria for substance use disorder supports and services

The PIHP must assure that treatment service authorization and reauthorization decisions are consistent with the following Medical Necessity Criteria. These criteria are substantively the same as the applicable criteria for substance use disorder Medicaid services.

1.0 Medical Necessity Criteria

1.1 "Medically necessary" substance use disorder services are supports, services, and treatment:
- 1.1.1 Necessary for screening and assessing the presence of substance use disorder; and/or
- 1.1.2 Required to identify and evaluate a substance use disorder; and/or
- 1.1.3 Intended to treat, ameliorate, diminish or stabilize the symptoms of a substance use disorder; and/or
- 1.1.4 Expected to arrest or delay the progression of a substance use disorder; and/or
- 1.1.5 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.

1.2 The determination of a medically necessary support, service or treatment must be:
- 1.2.1 Based on information provided by the individual, individual's family, and/or other individuals (e.g., friends, personal assistants/aide) who know the individual; and
- 1.2.2 Based on clinical information from the individual's primary care physician or clinicians with relevant qualifications who have evaluated the individual; and
- 1.2.3 Based on individualized treatment planning; and
- 1.2.4 Made by appropriately trained substance use disorder professionals with sufficient clinical experience; and
- 1.2.5 Made within federal and state standards for timeliness; and
- 1.2.6 Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- 1.2.7 Documented in the individual plan of service.

1.3 Supports, services and treatment authorized by the PIHP must be:
- 1.3.1 Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the individual; and
- 1.3.2 Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

1.3.3 Provided in the least restrictive, most integrated setting. Residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

1.3.4 Delivered consistent with, where they exist, available research findings, health care practice guidelines and standards of practice issued by professionally recognized organizations or government agencies.

1.4 Using criteria for medical necessity, a PIHP may:

1.4.1 Deny services a) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care; b) that are experimental or investigational in nature; or c) for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support, that otherwise satisfies the standards for medically-necessary services; and/or

1.4.2 Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

1.4.3 A PIHP may not deny services solely based on PRESET limits of the cost, amount, scope, and duration of services; but instead determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on industry standards and consistent with 1.3.4 above and that is provisional and subject to modification based on individual clinical needs and clinical progress.

Clinical Eligibility: DSM 5 Diagnosis

To be eligible for treatment services purchased in whole or part by state-administered funds under the agreement, an individual must be found to meet the criteria for one or more selected substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM). These disorders are listed below. This requirement is not intended to prohibit use of these funds for family therapy. It is recognized that persons receiving family therapy do not necessarily have substance use disorders.

Cannabis Related Disorders:

F12.10 Cannabis Use Disorder – Mild

F12.20 Cannabis Use Disorder – Moderate/Severe
F12.99 Unspecified Cannabis Use Disorder

Hallucinogen Related Disorders:
F16.10 Phencyclidine Use Disorder – Mild
F16.20 Phencyclidine Use Disorder – Moderate/Severe
F16.99 Unspecified Phencyclidine Related Disorder
F16.10 Other Hallucinogen Use Disorder – Mild
F16.20 Other Hallucinogen Use Disorder – Moderate/Severe
F16.99 Unspecified Hallucinogen Related Disorder

Inhalant Related Disorders:
F18.10 Inhalant Use Disorder – Mild
F18.20 Inhalant Use Disorder – Moderate/Severe
F18.99 Unspecified Inhalant Related Disorder

Opioid Related Disorder:
F11.10 Opioid Use Disorder – Mild
F11.20 Opioid Use Disorder – Moderate/Severe
F11.99 Unspecified Opioid Related Disorder

Sedative, Hypnotic, or Anxiolytic (SHA) Related Disorders:
F13.10 SHA – Mild
F13.20 SHA – Moderate/Severe
F13.99 Unspecified SHA Related Disorder

Stimulant Related Disorders:
Stimulant Use Disorders
F15.10 Amphetamine Type – Mild
F14.10 Cocaine – Mild
F15.10 Other or Unspecified Stimulant – Mild
F15.20 Amphetamine Type – Moderate/Severe
F14.20 Cocaine – Moderate/Severe
F15.20 Other or unspecified stimulant—Moderate/Severe

Alcohol Use Disorders:
F10.10 Alcohol Use Disorder – Mild
F10.20 Alcohol Use Disorder – Moderate/Severe
F10.99 Unspecified Alcohol-Related Disorder

Other (unknown) Substance Related Disorders:
F19.10 Other (unknown) Substance Use Disorder – Mild
F19.20 Other (unknown) Substance Use Disorder – Moderate/Severe
F19.99 Unspecified Other (unknown) Substance Related Disorder

Individualized Treatment Planning:

Individualized treatment planning must include the completion of a bio-psychosocial assessment which consists of current and historical information and identifies needs and strengths, along with the following:

Treatment Plan

- Mutual setting of goals and objectives
- Goals must be stated in client's words
- Each goal must be directly tied to a need identified in the assessment
- Objectives must contain the steps that need to be taken to achieve the goals
- Objectives need to be measurable
- Objectives must have target dates for completion

Treatment Interventions

- Determine the intervention(s) that will be used to assist the client in being able to accomplish the objective
- What action will the client take to achieve it and what action will the counselor take to assist the client in achieving the goal
- These actions must be mutually agreed upon to provide the best chance of success for the client

Progress Notes

- Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the treatment plan
- When progress notes are written, the note should reflect what goal(s) were addressed during a treatment session
- The progress notes are also used to document any changes made to the treatment plan

Treatment Plan Reviews

- Reviews must be documented in the case file.
- The reviews must include input from all clinicians/treatment providers involved in the care of the client as well as any other individuals the client has involved in their treatment plan
- This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client
- The client, clinician, and other relevant individuals as appropriate should sign this review

FUNDING SOURCES

All **intensive** levels of service must be screened by PIHP Access and determined appropriate for that level of care for funding to be considered. At the screening's conclusion, the screener will offer to make a 3-way call to the contracted Provider of the client's choice to set up an admission date to enter the determined Level of Care. The

client must give the screener permission to make the 3-way call and to disclose the level of care that was determined by the screening to the Provider chosen by the client.

Block Grant

To be eligible for Block Grant funding, a client must meet income, medical necessity criteria and residency requirements (per State contract) in one of the fifteen counties in the Upper Peninsula of Michigan.

Access: Services shall be provided in the amount and for the duration and with the scope that is appropriate to reasonably achieve the desired treatment outcomes and is the least restrictive. level of Care is determined using the following tools/clinical information: NorthCare Brief Screening Tool, ASAM placement criteria, DSM 5, current and historical substance use disorder history, mental illness history, and motivation. Access requirements apply to all funding sources.

Income: Financial eligibility is determined according to a sliding fee scale based on the national poverty index. Financial eligibility must be documented by the provider. Acceptable sources of documentation include pay stubs, unemployment check stubs, most recent income tax return, or a letter from an employer attesting to an employee's income. Other reasonable forms of documentation will be considered; however, any other form **must** also be in the client chart. Annual site visits by the PIHP will check to ensure that copies of approved documentation are found in client charts. Under certain circumstances there may be conflicting income information. NorthCare reserves the right to request income documentation, prior to authorization consideration.

Generally, financial eligibility is determined by income over a 12-month period of time. Yearly income can be based on the following alternative method for a valid reason such as recent unemployment. The formula is: $(Last 3 months of income) X 4 (quarters in a year) = $(Projected 12-month income). **Exception requests (for income consideration other than discussed above) must be put into writing and directed to the PIHP CEO or designee.**

The sliding fee scale below became effective April 1, 2017 and was current at the time the Provider Manual was written. It is based on the Federal Poverty Guidelines, which are revised annually. The sliding fee scale is subject to revision by the PIHP during the year. In the event that the scale is updated, providers will be notified in writing and given an effective date for applying the new revision.

Clients who meet the sliding fee scale and other requirements but are also covered by other insurance may be eligible for Block Grant funding in coordination with the other insurance plan. Block Grant funds must be the last source of funding either in conjunction with other insurance or funding, or, after other funding sources available to the consumer have been exhausted.

Financial information needed to determine ability to pay (financial responsibility) must be **reviewed** every six months, at a change in an individual's financial status, or at time of a new admission. We strongly suggest checking with clients on a monthly basis. A simple question like "has anything changed financially" when a client checks in for their appointment would suffice for a monthly check.

NORTHCARE

Substance Use Disorder Services

Sliding Fee Scale
Effective 4/1/2017

Family Size	Income Level 200% of Poverty
1	23,760
2	32,040
3	40,320
4	48,600
5	56,880
6	65,160
7	73,460
8	**81,780**

Residency:
Priority clients will be placed according to State guidelines. NorthCare will follow the State "Admission Priority Requirements" established for non-priority clients. The PIHP will exercise a priority admission system for non-priority clients. This procedure would give non-priority regional residents the first opportunity to fill available treatment placements. All others would be considered for placement dependent on capacity of the programs funded.

Medical Necessity: Clients seeking **intensive levels** of care-other than sub-acute residential/social detox programming-must complete an SUD Access screening. Funds can only be accessed for intensive services if the screening demonstrates a medical necessity for such services. Substance use disorder services will be provided in the least restrictive, most integrated setting.

Covered Services: Refer to your contract

Medicaid

To receive substance use disorder treatment funding through this source, it is necessary to verify current Medicaid coverage that identifies the recipient as a resident within the PIHP's fifteen-county Medicaid catchment area and demonstrate "medical necessity" for the service provided. Refer to the Medicaid Provider Manual available on line at www.michigan.gov/mdhhs for a complete definition of Medical Necessity. Refer to NorthCare Network's Enrollee Rights and Protections policy.

Income: Financial eligibility for Medicaid is determined by Michigan's Department of Human Services (DHS). Clients apply at their local DHS office. A valid Medicaid card is documentation of income. Medicaid eligibility must be checked

It is essential that providers be vigilant about checking Medicaid eligibility, as clients may be eligible one month **but not the next**. **Verification must continue monthly and/or before each service.**

Residency: Medicaid recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate Regional Entity. Issues regarding county of financial responsibility should be referred to NorthCare Network.

Medical Necessity: Substance use disorder services must be medically necessary and provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when clinically appropriate.

Providers of Medicaid-covered services must accept clients referred by NorthCare Access and render medically necessary services which the provider is qualified by law to render, customarily provides, and has the capacity to provide.

Allowable Services: Medicaid covered services include:
Initial Assessment, diagnostic evaluation, referral and patient placement;
Withdrawal Management
ASAM Level 3.2 Clinically Managed Residential
ASAM Level 3.7 Medically Monitored

Residential Treatment;
Intensive Outpatient Treatment;
Outpatient Treatment; and
Methadone Treatment

Deductible: Medicaid consumers could have a monthly Spend Down (deductible) requirement.

Healthy Michigan Plan

Income: Financial eligibility for Healthy Michigan Plan (HMP) is determined by Michigan's Department of Human Services (DHS). Clients apply at their local DHS office. HMP eligibility must be checked on the MIS system.

It is essential that providers be vigilant about checking HMP eligibility, as clients may be eligible one month **but not the next**.

Residency: Healthy Michigan Plan recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate Regional Entity. Issues regarding county of financial responsibility should be referred to NorthCare Network.

Covered Services:

Initial Assessment, diagnostic evaluation, referral and patient placement;
Withdrawal Management

ASAM Level 3.2 Clinically Managed Residential
ASAM Level 3.7 Medically Monitored

Residential Treatment;
Intensive Outpatient Treatment;
Outpatient Treatment

Medical Necessity:

Substance use disorder services must be medically necessary and provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when clinically appropriate. Providers of Healthy Michigan Plan -covered services must accept clients referred by NorthCare Access and render medically necessary services which provider is qualified by law to render, customarily provides, and has the capacity to provide.

State Disability Assistance (SDA)

Income: Application is made through the Michigan Department of Human Services (MDHS). Asset limit of $3,000 (cash assets only are counted.)

Residency: Residency in substance use disorders residential treatment, Michigan residency and not receiving cash assistance from another state. U.S. citizenship or have an acceptable alien status.

Medical Necessity: To receive SDA benefits, a client must be screened by NorthCare Access as needing a residential level of care according to the current ASAM placement criteria.

MI Health Link Information: **Website:** www.uphp.com

The MI Health Link is a new program that allows individuals who have both full Medicare and full Medicaid to receive coordinated care. This means an individual, who enrolls in the MI Health Link Program, will have one plan and one card for primary health care, behavioral health care, home and community- based services, nursing home care and medications. Individuals who choose to be enrolled will be assigned a

person called an Integrated Care Coordinator who will help coordinate services by linking and coordinating with all providers involved in the individual's health care. For more information about the MI Health Link contact the Upper Peninsula Health Plan at 1-877-349-9324 (TTY: Dial 711).

LEVEL OF CARE

Medical Necessity

Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical standards of care. Medical necessity of a service must be documented in the individual plan of services.

Individual Assessment

A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan. An assessment-only option is initiated by individuals seeking to determine if their substance use is a problem. Outpatient providers on the panel provide an appropriate access point for this service. If at the time of scheduling, the individual shares information that would indicate risk (impaired driving, positive drug screen, etc.) and reports their willingness to follow through with treatment recommendations based on the assessment, this service could be reimbursed by NorthCare in one of two ways.

1. When there is a DSM 5 diagnosis, the service can be processed via ELMER
2. If there is not a DSM 5 diagnosis, the intake may be billed to NorthCare via paper invoice.

(Note: An example that NorthCare would not consider is an individual ordered to have an assessment despite no evidence of a substance use disorder and the individual is unwilling to consider treatment if recommended.)

GAIN-I Core

Per contract with MDHHS, as of October 1, 2018, it is the expectation that providers will engage in the GAIN-I Core training process with Chestnut Health Systems. Contracted providers are expected to establish and maintain a Data Use Agreement with Chestnut Health Systems for the use of the GAIN ABS. Due to the ability to transfer the GAIN-I Core among provider agencies, a GAIN-I Core is an allowable expense every 6-months. This is the maximum allowable reimbursement for this clinical function. At a minimum, re-assessment should be completed annually. If an individual has a significant change prior to the 6-month marker, the clinician can adjust the original assessment to reflect those changes and indicate as updated in the notes. This 6-month maximum allowable assessment if for the purpose of updating information and establishing the individual's current goals. Full implementation of the GAIN-I Core is scheduled for FY 2019. Transition should be fully implemented by March 30, 2019 and will be the exclusive assessment by September 30, 2019. NorthCare will direct and assist with the coordination of the implementation process.

Progress Notes

Documentation needs to be completed in a timely manner. Progress notes are required to be in client file:

- At time of service or shortly thereafter – maximum of two (2) business days
- Assessments – within five days from the date of the assessment
- Required to have a stop and start time
- Signed by clinician

Outpatient Treatment/Aftercare (Level 1.0), Block Grant, Health Michigan Plan, Medicaid

Eligibility criteria for Outpatient care are as follows:

- Meets medical necessity criteria and
- The current edition of the DSM is used to determine an initial diagnostic impression
- Is based on individualized determination of need and
- Is cost effective and
- The American Society of Addiction Medicine (ASAM) Patient Placement Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs and
- Is based on a level of care determination using the six assessment dimensions of the current ASAM Patient Placement Criteria:
    1) Withdrawal potential
    2) Medical conditions and complications
    3) Emotional, behavioral or cognitive conditions and complications
    4) Readiness to change
    5) Relapse, continued use or continued problem potential
    6) Recovery/living environment

When a client is specifically seeking outpatient services and does not indicate a desire for intensive services, the appropriate point of entry is at the client's choice of contracted outpatient providers. (Customer Handbook – on NorthCare Network's website; www.northcarenetwork.org.) Clinical staff will administer an assessment to determine appropriate services. If a potential client contacts NorthCare first, they will be offered contact numbers to access outpatient services in their area.

Intensive Level of Care – all services higher than 1.0

Intensive Outpatient (Level 2.1), Block Grant, Healthy Michigan Plan, Medicaid

Intensive outpatient (IOP) treatment is a planned and organized non-residential treatment service in which SUD trained/educated clinicians provide several SUD treatment service components to beneficiaries. Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in special residences.

Services are provided over a period of weeks. Level 2.1(IOP) programming provides essential education and treatment services while allowing the participant to apply their newly acquired skills in "real world environments". The service array would include

individual, group and family counseling as well as didactic elements regarding alcohol and drugs. Participants in this level of care would leave the treatment facility after completing their daily treatment. The focus is to allow participants to implement the skills they have gained in the program by returning to their home communities. Level of care is determined using the following tools/clinical information: NorthCare Brief Screening Tool, ASAM placement criteria, DSM V, substance use disorder history, mental illness history, and motivation.

Low-Intensity Residential (Level 3.1), Block Grant, Healthy Michigan Plan, Medicaid

Low intensity (3.1) treatment is a clinically-managed, low-intensity residential 24-hour structure with available trained personnel with at least 5 hours of clinical service per week.

Residential Treatment/Continued Care – (Level 3.3) Block Grant, Healthy Michigan Plan, Medicaid

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance use disorder specialists. Residential treatment must be staffed 24 hours-per-day.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment. Level of care is determined using the following tools/clinical information: NorthCare Brief Screening Tool, ASAM placement criteria, DSM V, substance use disorder history, mental illness history, and motivation.

All admissions and continuing stay authorizations will be based on medical necessity.

Residential Treatment – (Level 3.5) Block Grant, Healthy Michigan Plan, Medicaid

This is a 24/7 clinically monitored level of care. Clients stay at the facility while receiving services. Persons admitted to this level of care have significant social and psychological problems but are capable of benefitting from high-intensity treatment services. Clients who begin at this level of care may step down to a lower level as medical necessity permits using ASAM placement criteria, DSM V and motivation.

Withdrawal Management– Residential Setting, Block Grant, Healthy Michigan Plan, Medicaid

The need for withdrawal management is determined by qualified medical personnel. A qualification instrument such as the Clinical Institute Withdrawal Assessment (CIWA) may be used to rate the severity of symptoms related to withdrawal from alcohol and other physically addicting drugs.

Clinically Managed Residential Withdrawal Management – Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2-D). These services must be provided under the

supervision of a certified addictions counselor. Services must have arrangements for access to licensed medical personnel as needed.

Medically Managed Residential Withdrawal Management – Freestanding Detoxification Center: These services must be staffed 24-hours-per-day by a licensed physician or by the designated representative of a licensed physician (ASAM Level III.7-D).

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professional in a hospital setting. Appropriate program licensure program is required.

Authorization Requirements – Withdrawal Management – Residential Setting:

- ✓ Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current beneficiary status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- ✓ Admission to withdrawal management services must be made based on:
    - o Medical necessity criteria
    - o Level of Care determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria

Evaluation for Appropriateness of Methadone Therapy - Block Grant, Healthy Michigan Plan, Medicaid

This service is available through UP Health Systems – Marquette. NorthCare does not perform the screening, but rather funds an assessment performed by an addictionologist/physician, a behavioral health professional, and other medical staff. Clients access the service by contacting NorthCare, which directs the client to an identified staff person working in the Center for Intensive Addiction Services at UP Health System – Marquette a Duke LifePoint Hospital. Clients who are determined to be appropriate for Methadone treatment will be assisted in gaining entry to a qualified Methadone Program which is mutually agreed to by NorthCare and the client.

Co-Occurring Referral for Intensive Levels of Care

Complete the Universal Consent form MDHHS-5515 and fax to 248-406-1286. SUD Access staff will contact referral source for consultation and determine appropriateness of referral. Once a clinical decision has been made, NorthCare SUD access will proceed with access protocol.

Co-occurring-Providers

Screening/Assessments for Co-occurring Disorders

Screening for co-occurring disorders should be completed on all clients being admitted to the NorthCare network. This screening should be part of the routine intake or assessment processes on new clients.

The Co-occurring Screening Should Include

1. A diagnostic interview to determine which, if any, DSM mental disorder diagnoses is met by the client.

2. A treatment history assessing the outcome of previous treatment experiences and barriers to effective treatment.

3. An assessment of the impact of the mental disorders on the substance disorder from a longitudinal perspective.

4. An assessment of the consumer's awareness of the problem and stage of motivation to change.

Please refer to the NorthCare Website at www.northcarenetwork.org for the complete practice guidelines for Assessment of Co-occurring Disorders.

Out-of-Network Services

If a necessary service covered under the contract is unavailable within the network, the PIHP adequately and timely covers the service out-of-network for as long as the PIHP is unable to provide it.

The PIHP requires out-of-network providers to coordinate with the PIHP regarding payment and ensures that any cost to the beneficiary is no greater than it would be if the services were furnished within the network.

MANDATED ADMISSION PRIORITIES

In accordance with SAPT federal block grant regulations at CFR 96.131 and Sec 6232 of Public Act 368 of 1978, as amended, and per Medicaid Manual Bulletin (04-03) admission priorities are delivered in accordance with federal and state standards; preference for treatment admission is as follows:

Priority One

Pregnant, injecting drug user

Priority Two

Pregnant substance use disorders

Priority Three

Injecting drug user

Priority Four

Parent at risk of losing their child(ren) due to Substance Use. (Open CPS case)

Priority Five
All others

Access Timeliness Standards
The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are in *italics*: Screened and referred applies to intensive services and methadone. When a client calls an outpatient provider for services, the provider must follow the ADMISSION guidelines, not the screened and referred requirements. If a client calls an outpatient provider and requests intensive services or methadone, they must then be referred to NorthCare for further services.

Admission Priority Requirements

Population	Admission Requirement	Interim Service Requirement	Authority
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*	CFR 96.121; CFR 96.131; Treatment Policy #04 **Recommended**
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours 2) Detoxification, Methadone or Residential – Offer admission within 24 business hours Other Levels of 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*	CFR 96.121; CFR 96.131; **Recommended**
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 needle sharing c) Risks of transmission to sexual partners and infants 2. *Early Intervention Clinical Services*	CFR 96.121; CFR 96.126 **Recommended**
Parent at Risk of Losing Children (Open CPS case)	Screened and referred within 24 hours. Capacity to offer Admission within 14 days	**Begin within 48 business hours** *Early Intervention Clinical Services*	Michigan Public Health Code Section 6232 **Recommended**
All Others	Screened and referred within seven calendar days. Capacity to offer Admission within 14 days	**Not Required**	CFR 96.131(a) – sets the order of priority; MDHHS and PIHP contract

SPECIALITY PROGRAMS

Recovery Coach Support Services (RCSS)

A peer recovery coach is an individual who has lived experience in receiving services and/or supports for a substance use condition. They serve as a guide to initiate, achieve and sustain long-term recovery from addiction including medication assisted, faith based, 12 step and other pathways to recovery. Recovery coaches provide connections in navigating recovery supportive systems and resources including professional and non-professional services.

Within RCSS it is recognized that individuals in recovery, their families, and their community allies are critical resources that can effectively extend, enhance, and improve formal treatment services. RCSS are designed to assist individuals in achieving personally identified goals for their recovery by selecting and focusing on specific services, resources, and supports. These services are available within most communities employing a peer-driven, strength-based, and wellness-oriented approach that is grounded in the culture(s) of recovery and utilizes existing community resources. RCSS emphasize strength, wellness, community-based delivery, and the provision of services by peers rather than SUD service professionals. As such, these services can be viewed as promoting self-efficacy, community connectedness, and quality of life, which are important factors to sustained recovery.

Types of Peer Recovery Support Services

The placement of peers varies from recovery centers, stand-alone peer programs, traditional treatment and prevention programs, and other sites. Activities are targeted to individuals and families at all places along the path to recovery. This would include outreach to individuals who are still active in their disorder and or addiction, up to and including individuals who have been in recovery for several years. The different kinds of activities have been divided into four service categories: emotional support, informational support, instrumental support, and affiliation support (SAMHSA, 2009a). Below are examples for each support type.

Activities and Types of Support

Emotional: Demonstrate empathy, caring, or concern to bolster a person's self-esteem and confidence

Examples:

Listening to problems (identify resources to meet the need)
Leading/mentoring/coaching
Leading support groups
Peer mentoring
Relating stories
Offering hope
Validating client experience

Supporting self-assessment (identify where an individual is and where they want to go)
Walking with the individual (find out the comfort level to complete a task or attend an event)
Advocating
Empowering

INFORMATIONAL: Share knowledge and information and/or provide life or vocational skills training

Examples
Peer-led resource connector programs
Health and wellness classes and workshops
Education and career planning classes and workshops
Leadership development classes and workshops
System navigation (assisting someone to work through the layers/regulations of a system to obtain services that are needed)
One-on-one teaching
Recovery plan development
Personal (individual) development
Problem-solving
Pursuing education
Life-skills classes, workshops, and trainings including:
Dental
Mental health
Physical health
Nutrition
Legal
Child care options
Keep recovery first (the importance of working one's own recovery path needs to be of paramount importance)
Job readiness
Wellness workshops
Parenting classes

Various groups for instruction:
Parenting
12-Step Literacy
Navigating the 12-Steps
Stress management
Conflict resolution
Trauma
Job skills
Social skills in recovery
Others as needed

INSTRUMENTAL Provide concrete assistance to help others accomplish tasks.

Examples
Direct instrumental services (connections to get a person's most basic needs met, i.e.,

food banks, clothing banks, housing/shelter) Make warm connections to services and referrals (making an in-person introduction or on-sight delivery to a site for needed services/support) Open doors for an individual (making face-to-face contact with a person or organization on behalf of the individual seeking assistance) Hands-on advocating (taking responsibility to take another's banner and push for them so that systems can bend or change to meet that person's needs) Navigate community resources (teaching individuals about the who, what, where, and why of community services, so that they understand where to turn, where to go and who to talk with) Child care, transportation, health referrals Follow up on referrals Outreach – recovery checkups Arrange regular (weekly, etc.) meetings with individuals

AFFILIATIONAL: Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.

Examples
Alcohol- and other drug-free social/recreational activities
Recovery centers
Engagement centers
Drop-in centers
Recovery community connections
Social/recreational activities
Cultural activities – music, arts, theatre and poetry, picnics, networking, etc.
Faith-based recovery supports
(SAMHSA, 2009b)
(MDHHS Bureau of Substance Abuse and Addiction Services Treatment Technical Advisory #07)

Training Peer Recovery Coaches
In order to be a peer recovery coach, individuals will need to complete the current designated training approved by MDHHS and meet all current requirements.
To complete the entire scope of necessary elements, an average training would encompass approximately 40 hours. Components may include:

- Comprehensive overview of the purpose and tasks of a recovery coach.
- Tools and resources useful in providing recovery support services.
- Skills needed to link people to needed supports within the community that promote recovery.
- Basic understanding of substance use and mental health disorders, crisis intervention, and how to respond in a crisis situation.
- Skills and tools for effective communication, motivational enhancement strategies, recovery action planning, cultural competency, and recovery ethics.
- Clarity regarding the fact that recovery coaches do not provide clinical services. They do, however, work with people experiencing difficult emotions and physical states.
- Describe the roles and functions of a recovery coach.
- List the components of a recovery coach.
- Build skills to enhance relationships.
- Discuss co-occurring disorders and medication-assisted recovery.
- Describe stages of changes and their applications.

- Address ethical issues.
- Experience wellness planning.
- Practice newly acquired skills.
- How to create a safe environment.
- What recovery is (components of recovery, recovery core values, and guiding principles of recovery).
- Skills to enhance relationships.
- Listening and communication skills.
- Values and differences.
- Skills to address transference/countertransference.
- Skills to manage sexual harassment.
- Crisis intervention.
- Stigma and labels.
- How to tell your own stories.
- Issues of self-disclosure.
- Referral skills.
- Pathways to recovery.
- Stages of change.
- Motivational interviewing.
- Cultural competence.
- Privilege and power.
- Spirituality and religion.
- Resources and programs.
- Self-care.
- Boundary issues and respect.
- Recovery wellness planning.

As of January 1, 2018, training is provided by MDHHS. Links to a list of scheduled trainings and a description of the application process are provided below:

- Recovery Coach CERTIFICATION Training Application 2018
- FAQ Recovery Coach State Certification
- MSA 17-45 (003) Recovery Coach Provider Description
- Peer Recovery Coach Certification Letter
- Recovery Coach PREVIOUSLY Certified Application 2018
- Additional Information and Resources

  Following certification, a minimum of 20 hours of continuing education, with at least 10 hours being SUD specific, and 6 hours in ethics is required over a two-year period of time.

For additional information on Recovery Coach certification, contact the NorthCare Network Treatment Coordinator at 906-225-4422.

Agencies are required to contact NorthCare Network at 906-225-7222 with any updates regarding staffing changes with recovery coaches.

Unique Challenges to Recovery Coaches
Peers, because they are in recovery, may face a unique challenge that many in the SUD service workforce do not. Due to the nature of this work, peers may be placed into situations, while they are providing services, where they might encounter others from their past who were their “using friends” or “dealers.” Hence, it is important to understand how to act in situations when these negative encounters occur. Therefore, support for a peer who has a need because of these encounters should be available. Support can come from the supervisor, another more experienced peer, or other agency staff with whom the peer feels comfortable enough to discuss the issues. The same is to be said for peer recovery coaches regarding the issue of relapse. It is well-known that addiction is a relapsing, chronic brain disease. Agencies that utilize peers, whether they are paid or unpaid, are therefore urged to recognize the nature of addiction and develop a non-punitive policy in response to peer relapse. The agency is further encouraged to work with the peer to develop a recovery reengagement plan to facilitate the peer’s return to recovery.

Supervision of Peer Recovery Staff
Peer recovery coaches are to be respected as equal members of an agency’s staff. They are as much a part of an agency/organization as are support, clinical, and executive staff. Intentional and purposeful acknowledgement, role delineation, and supervision are critical to the blending of roles, rules, and regulations among staff. Peers come with a unique amount of knowledge and personal experience in addictions and other co-occurring disorders. This experience makes them a valuable part of the organization. It is important for management to orient existing staff to the roles that peers will have within the agency. This will prevent or reduce misunderstandings for all staff. Peers, because they are in recovery, may face a unique challenge that many in the SUD service workforce do not. Due to the nature of this work, peers may be placed into situations, while they are providing services, where they might encounter others from their past who were their “using friends” or “dealers.” Hence, it is important to understand how to act in situations when these negative encounters occur. Therefore, support for a peer who has a need because of these encounters should be available. Support can come from the supervisor, another more experienced peer, or other agency staff with whom the peer feels comfortable enough to discuss the issues. RCSS should be actively involved in the treatment team consultations and, as such, would receive supervision in this venue. A minimum of one hour per week of supervision is required and is to be documented. Documentation can occur as part of a treatment team note contained in a case file or documented separately.

DOCUMENTATION AND REPORTING REQUIREMENTS

Providers will maintain confidential records of client activities. For drop in activities, including groups, providers will maintain a sign in sheet of participants. For recoverees engaged in ongoing mentoring, Recovery Coaches will utilize a client self-assessment/ matrix, or other assessment tool and a recovery wellness plan. Assessments and plans are to be reviewed in a timely manner, not less than quarterly. Assessments and

reviews will be signed and dated by the recoveree and Recovery Coach. RCSS will maintain notes documenting progress, services and outreach efforts. RCSS will maintain appropriate releases for referrals. RCSS can refer to the CCAR or State approved training manual for references or develop and/or use agency documents provided they are consistent with RCSS values and goals. Unless otherwise specified, RCSS will have the ability to work in the community and to provide transportation to recoverees as clinically appropriate. For recoverees engaged in RCSS services (excluding outreach or drop-in), RCSS will provide follow up calls at 3, 6 and 12 months and document level of recovery. When a Recovery Coach is embedded in a program, the agency will determine appropriate documentation of RCSS activity. For Example, if a RCSS is working in a treatment setting, the RCSS will be included as part of the IPOS and will maintain contact notes within the case file. If the recoveree leaves the agency and the RCSS is designated to follow the recoveree, the RCSS will develop a case file independent of the agency's record.

NorthCare recognizes the uniqueness of the rural setting and acknowledges that RCSS may provide a multitude of services in their community. Recovery Support Services extend beyond the formal setting and work to create recovering oriented systems of care. During the development phase of Recovery Support Services within the region, it is the goal of NorthCare that RCSS will provide up to 25% of their time engaged in outreach services and at least 75% of their time providing direct contact with recovering persons unless otherwise specified in the agency contract.

Measures:

- Number of individuals formally enrolled in long term Recovery Coaching.
- Number of participants who receive direct recovery support, indirect recovery support and /or educational services.
- Number of 12 month follow up interviews successfully completed.
- Percent of participants with reduced and/or abstinence use during the past 30 days at 12 months follow up interview compared to their past 30-day substance use at enrollment into Recovery Coaching. (75% target)
- Percent of participants involved in any recovery activities during the past 30 days and at 12 months follow up.
- Self-help groups
- Met with Recovery Coach
- Served as Recovery Coach or volunteer
- Served as sponsor affiliate with self-help group.

Contact SUD Treatment Coordinator for document templates or consultation. (906) 225-4422.

Additional Peer Recovery Coach resource links:

- Additional Information and Resources
- Narcotics Anonymous
- Dual Recovery Anonymous
- Self-Management and Recovery Training (SMART Recovery)

- Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Integrated Health Solutions (CIHS)
- Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)

RECOVERY HOUSING

Recovery Housing

The goal of providing recovery housing services is to provide a supportive recovery environment to help reduce the incidence of drug and alcohol abuse and dependency, prevent relapse, and support individuals in their recovery.

II. PROCEDURES

A. Eligibility Screening Requirements

1. Individual meets the criteria for NorthCare funding (income, residency, and substance use disorder diagnosis).
2. Individual is actively engaged in NorthCare funded services.
3. Individual is in need of a highly structured and monitored living environment where recovery support is available.
4. Individual has experienced a history of unsuccessful recovery attempts, which have resulted in a return to chronic use.
5. Individual has significant negative factors in the areas of family, social, work, or environment that places him/her at-risk for relapse.

B. Admission Requirements

The following admission criteria pertain to recovery homes:

- Individual has completed or does not need medical or sub-acute detoxification.
- Individual has successfully completed long or short-term Residential treatment, as applicable.
- Individual does not present with a severe medical or psychiatric condition that would interfere in his/her ability to function in a supervised supportive living environment.
- Individual adheres to the requirement of attending an appropriate funded treatment service while residing in the Recovery Home which will be documented in the client's file.
- Individual demonstrates active motivation for recovery and a desire to work towards self-sufficiency.

C. Recovery House Admission Procedure

- Recovery Home Provider will screen client according to provider's criteria and determine if client is appropriate.
- Recovery Home Provider will complete the admission packet with the client.
- Recovery Home Provider will ensure a signed Release of Information is completed for each client.
- Recovery Home Provider will assist the client in developing an individualized recovery plan or if currently receiving Peer Services, obtain a copy of the plan.

D. Continued Stay Requests

- If a client meets eligibility requirements, NorthCare Network will fund the first 60 days of recovery housing. If a client is still in need of recovery home services after sixty days and not able to independently secure financial resources to pay for housing due to extraordinary circumstances, the Recovery Home Provider may request a reauthorization for continued stay seven (7) days prior to the expiration date of the initial authorization. Contact NorthCare Network (906-225-7222) for request to extend payment beyond 60 days.
- Eligibility for continued stay requires demonstration that client is making progress towards recovery goals, is participating in a NorthCare treatment program and is actively involved in the recovery process, as well as an explanation of the need for additional length of stay.
- If the criteria for continued authorization is met, NorthCare will approve up to an additional thirty (30) days of service.

F. Reporting Requirements

Recovery Home Provider shall submit their bill to NorthCare by the 10th of every month.

H. NorthCare Reviews

1. Recovery Home Provider will be included in NorthCare Provider site reviews.
2. The Recovery Home Provider will receive an on-site review annually.
3. NorthCare will review client and program records including source documentation to support eligibility and program activities.

I. Records

The Recovery Home Provider will maintain adequate program, and fiscal records and files, including source documentation, to support program activities and all expenditures made under the terms of this agreement, as required.

- A sign in registry for each billable date of service will be kept separately for each client served.
- All client specific information will be kept in a secure location and the Recovery Home Provider will adhere to confidentiality requirements.
- Consent forms will be obtained before sharing client information with outside entities.
- Documentation of attendance and coordination with approved outpatient treatment provider (minimum once per month).

Contact SUD Treatment Coordinator for document templates or consultation. (906) 225-4422.

All clients are screened for specialty programs and if they are applicable, clients are offered specialty programs based on client's choice and need. NorthCare will refer and coordinate services for clients based on specialty qualifications.

In cases where clients do not meet criteria for SUD treatment services, referrals to other types of services are offered as appropriate.

Women's Specialty Services

Providers **must** screen and/or assess pregnant women, women with dependent children, and women attempting to regain custody of their children to determine whether these women or their children could benefit from the defined federal services listed below – if found appropriate, the client should be referred to a program designated to deliver the specialty services listed below:

Designated treatment programs receiving funding for pregnant women and women with dependent children must *provide or arrange* for the following:

1. Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care;
2. Primary pediatric care for their children, including immunizations.
3. Gender specific substance use disorder treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare while the women are receiving these services;
4. Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect; and
5. Sufficient case management and transportation to ensure that women and their dependent children have access to the above-mentioned services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children.

The above five types of services, especially including primary medical care, can only be covered when **no other source** of support is available and when **no other source** is financially responsible.

This same population must be screened by all Providers for ancillary services (child care and transportation assistance) and pre-screened for **Fetal Alcohol Syndrome**. Ancillary services can be accessed through the PIHP and children found to need further FAS services need to be referred to UP Health System Specialty Clinic in Marquette @ (906)225-4777 for an FAS diagnostic evaluation. (FAS pre-screen form can be found on the NorthCare Network Substance use disorder Services website under “Screening Forms.”)

Training Requirements for designated Women’s Specialty Programs:

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, of gender specific substance use disorder training or 2080 hours of supervised gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the

requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Bureau of Substance Abuse and Addiction Services (BSAAS) Women's Treatment Coordinator.

Pregnant women are given preference in admission to treatment facilities.

PHILOSOPHY:
Women's services are developed around a relational model; the recognition that, for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. A model of empowerment and collaboration are essential treatment components. Treatment is specifically designed to be gender competent to address the specific needs of the family.

ACCESS TO WSS TREATMENT
Eligible women are defined as "pregnant women and women with dependent children, including women who are attempting to regain custody of their children. Michigan law extends priority population status to men whose children have been removed from the home or are in danger of being removed from the home under the child protection laws. Men who are shown to be the primary caregivers for their children are eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care." When completing an admission in ELMER, enroll the consumer in the Women's Specialty Program.

ASSESSMENT
Upon determining that an individual is eligible for WSS, designated sites will complete a Women's and Family Assessment that will be the basis for a collaborative treatment plan that includes the needs of the children and family. Providers may bill for the agency's assessment in addition to the WSS assessment. Both assessments can be completed at the same time and billed at the same time. Since there is an extensive amount of information required, continued assessment over time will lend more information as the family and clinician gain trust. It is the expectation that each child in the family system will be assessed and appropriate referrals made. The clinician should be asking about each child's needs regardless of whether the child is physically present. Health care needs of both the mother and child(ren) will be addressed including coordination of care with physicians and pediatricians. The assessment allows the clinician to determine a true family-based plan. Completing the assessment also promotes an educational opportunity for the parent to learn about such issues as FASD, NAS and other community resources for the child(ren). H0001 HD is the authorization code for a WSS assessment. When requesting authorization, you will be asked to enter the number of children's referrals made. For the initial authorization, put "zero" in the appropriate boxes and for each subsequent authorization, record the number of referrals made for children.

FASD ASSESSMENT:
Substance use disorder treatment programs are in a unique position to have an impact on the FASD problem. It is required that all SUD programs include FASD prevention within the treatment regimen. All treatment programs that have contact with the children born to women who have used alcohol are required to screen these children for FASD

and, if appropriate, refer for further diagnostic services.
http://www.michigan.gov/documents/mdch/P-T-11_FAS_Pre-Screen_Form_402802_7.pdf
http://www.michigan.gov/documents/mdch/TX_Policy_11_FASD_295506_7.pdf

TREATMENT PLANNING
Individual plans of service will be family centered, strength based, culturally competent and collaborative across systems with a culture of unconditional care. Plans should include an emphasis on safety, self-sufficiency and be outcome oriented. Consumers should be offered care coordination and access to a Recovery Coach where available. A well conducted assessment will also identify barriers and needs. Child care, transportation and referrals for women and children's services will be addressed through an appropriate goal and objective in the IPOS. Women's health and reproductive needs should be explored and addressed. Parenting issues, employment, children's mental and physical health needs will be addressed with appropriate services and referrals provided. The intensity of services will vary according to the IPOS and needs of the client and family.

SERVICES:
Once it is determined that the individual qualifies for WSS, the HD modifier will be used for authorization of services. Non-gender-specific services identified in the IPOS but not provided by a WSS Specialist, may be coded with the HD modifier. These services should be reviewed with the primary counselor to assure they are appropriate. For example, a woman may choose to attend a co-occurring, co-ed, non-gender specific group as part of her treatment plan. A progress note reflecting a discussion between the consumer and the counselor would be expected.

ANCILLARY SERVICES

Care Coordination:
At times, the clinician can perform the function of both the care coordinator and counselor. Care coordination can be provided by para-professionals and interns. Care coordination contacts (15-minute units), should be scheduled to benefit the client and may vary in length depending on the IPOS and needs of the client. Recovery Coaches can be used to support the overall plan. Care coordination conducted by phone may be billed but should not be used as a substitute for face to face contacts. It is the expectation that the majority of the care coordination will be face to face. Authorization code: H0050HD Brief intervention/ Care Coordination (15-minute unit).

Transportation:
All Women's Specialty Services will provide access to transportation for women, children and eligible men. This can be in the form of bus tickets, transport by a Recovery Coach, gas cards, etc. Use the T2002 HD in the ELMER system when gas cards are being provided. When requesting authorization for transportation, request one unit per day for the date that transportation (most often gas card) will be used. For example, client comes weekly for 3 months (12 sessions) and has a treatment plan that has the stated goal need for transportation. Request authorization for 12 (T2002 HD) units. If client is given $10 in gas cards per one counseling session, bill 1 unit of T2002 for that date, then bill the amount ($10). (T2002 can only be billed once per day.)

Maximum of 1 unit /$40 per day. Use S0215 when requesting mileage – typically to reimburse a provider for transporting a client out of region, etc.

Child Care:
Since child care is a barrier to treatment, funds are available to pay for licensed and kin care. All WSS programs are encouraged to provide on-site child care whenever possible. When child care is provided on site, it is not necessary that the site be licensed as a day care provider. Besides removing a significant barrier for the family, onsite child care allows the clinician to evaluate the child(ren) for health and safety needs as well as mental health issues. To request reimbursement for child care, complete the WSS Ancillary Services Request Form and submit for payment as instructed on the form.

Discretionary Funds:
As women and families work towards becoming self-sufficient, additional material needs may be identified. The clinician should first help the client identify community resources, when appropriate and in collaboration with the Women's Treatment Team, up to $200 of discretionary funds are available, without prior approval when other resources have been exhausted. For discretionary funds exceeding $200, complete the Ancillary Services Request form and submit it to NorthCare SUD (FAX: 248-406-1286) Authorization of ancillary services requires a goal that addresses the need in the IPOS. To request reimbursement for discretionary funds, complete the WSS Ancillary Services Request Form and submit payment as instructed on the form.

The following website contains a wealth of information regarding FASDs – www.cdc.gov/ncbddd

Provider Qualifications

Funded programs must be nationally accredited, and State licensed per contract. In the event that a provider loses accreditation or licensure, the agency must notify the PIHP within two business days.

Accessibility & Accommodation Policy
Substance use disorder Providers must have an accommodation policy-refer to "Accessibility & Accommodation Policy" on the NorthCare website.

1. Access and accommodation of persons with limited English proficiency-the following website may be helpful: https://www.languageline.com.

2. Sensitivity and accommodation of diverse ethnic and cultural backgrounds (e.g., Native Americans).

3. Accommodations for those with visual impairments or mobility challenges.

4. Accommodations for individuals with communication impairments (including persons who do not use verbal language to communicate or who use alternative forms of communicating (e.g., TTY).

5. Staff education on the importance of each individual's diverse needs and the necessity to utilize person-centered thinking to create individual plans of service and actions to meet those needs. This training will recognize the disabilities affecting members may not be visible to the naked eye and may require accommodations in areas such as recognizing the effects of medications, adjusting meeting schedules and the length of meetings.

6. A commitment to remove any barrier that may not be currently addressed. This may be accomplished by a variety of means: e.g. focus groups, consumer complaints, consumer surveys.

Providers will be monitored for appropriate compliance during annual site reviews.

Using a Sign Language Interpreter

Considerations for the Mental Health/Substance Use Disorder Clinician Using a Sign Language Interpreter

By James Tresh, MA, MS CSC, LMHC
Founder, President and CEO of National Deaf Academy, an exclusively Deaf residential facility located on twenty acres in Florida, serving the mental health needs of Deaf and Hard of Hearing children, adolescents and adults. For more information, please call: 353-735-9500 V/TTY or 352-735-9570 TTY. **Language Line - 1-888-808-9008**

Background Check
It is the policy of NorthCare Network that appropriate background and exclusion checks be completed on all potential employees, students, interns, volunteers, contractors and board members as part of their screening process. Criminal background checks are required prior to hire and every other year after the initial check. Refer to the NorthCare Network Background and Exclusion Check policy for complete details on the process that must be followed. **Providers must conduct criminal background checks on all active substance use disorder employees periodically after the initial check.**

Cultural Competence
All providers must have a written cultural competency plan implemented at their Agency - the plan must include:

1. Identification and assessment of the cultural needs of potential and active clients based on population served.
2. Identification of how ongoing staff training needs in cultural competency will be assessed and met and the evidence that staff members receive training.
3. Process for ensuring that panel providers comply with all applicable requirements concerning the provision of culturally competent services.
4. Process for annually assessing compliance with the cultural competence plan.

LEP – Limited English Proficient

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or

"LEP." These individuals may be entitled language assistance with respect to a particular type or service, benefit, or encounter. The following website may be helpful: www.LanguageLine.com

Charitable Choice

Treatment clients and prevention service recipients are required to be notified of their right to request alternative services if the provider is faith based. The faith-based provider must provide notice. Notification must be in the form of a model notice contained in the final regulations. The model notice contained in the federal regulations is:

"No provider of substance use disorder services receiving Federal funds from the U.S. Substance use disorder and Mental Health Services Administration, including this organization, may discriminate against you based on 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 use disorder 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 use disorder 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."

Providers and clients should contact the PIHP at 1-888-333-8030 with any questions, concerns or alternate referral related to Charitable Choice.

Americans with Disabilities Act

All contractors must comply with applicable provisions of the Americans with Disabilities Act (the ADA.) Further information may be found at:

Nondiscrimination on the Basis of Disability in State and Local Government Services: United States Code of Federal Regulations, Title 28, Part 35, Washington, D.C. (1991.)

Compliance/Program Integrity

Providers that make or receive annual payments under the contract of at least $5,000,000, will have written policies that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. Providers meeting this threshold must also comply with Section 6032 of The Deficit Reduction Act (DRA) of 2005.

All Providers, including those not meeting the $5,000,000 threshold for a formal Compliance Program, are expected to have written policies and follow principles that promote ethical health care, and uphold the integrity of ethical business practice. Failure to do so will result in remediation effort attempts and/or contract action, if needed. NorthCare has the responsibility of regulating, overseeing and monitoring the Medicaid processes of business conducted throughout its service area and to support business

practices conducted with integrity and in compliance with the requirements of applicable laws and sound business practices. The NorthCare Compliance Plan, standards, and policies referenced herein are not exhaustive or all inclusive. All Network Providers are required to comply with all applicable laws, rules and regulations including those that are not specifically addressed in the Compliance Plan. NorthCare will monitor compliance efforts of Network Providers during annual site reviews, at minimum.

The Provider reports to NorthCare Network within 30 calendar days when it has identified payments more than amounts specified in the contract. Recoveries of overpayments due to fraud, waste, or abuse shall be reported by the Provider to NorthCare Network.

The Provider will provide prompt notification to NorthCare Network when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including, changes in the enrollee's residence and the death of an enrollee.

PRIMARY CARE COORDINATION

All appropriate steps must be taken to assure that substance use disorder treatment services are coordinated with service providers as well as primary health care.

Treatment case files must include, **at a minimum**, the primary care physician's name and address, a signed waiver release of information for purposes of coordination, or a statement that the client has refused to sign this waiver.

Care coordination agreements or joint referral agreements, by themselves, are not sufficient to show that the Provider has taken all appropriate steps related to coordination of care. Client case file documentation is also necessary.

NON-SUBSTANCE USE REFERRAL

If a client is found to not need substance use disorder services, based on results of the Access screening, staff will make appropriate referrals based on client need. Examples are as follows: LSS Welcome Home Homelessness program, Local DHS, Local Police Departments, and Local Emergency Departments.

OUTSIDE SCREENINGS

NorthCare will accept qualified screenings from certified District Court Probation Officers, as well as other Regional Entities as part of determining an appropriate level of care (LOC).

NorthCare will accept qualified screenings from Project Rehab Hispanic Program and Monroe Harbor Light Deaf/Hard of Hearing programs as part of determining an appropriate LOC.

HYPODERMIC NEEDLES

Block Grant or State funds shall not be used to provide individuals with hypodermic needles or syringes.

INCARCERATED PERSONS

To ensure a timely screening for individuals who are at high risk for relapse and overdose, incarcerated individuals may be screened prior to release when assisted by a probation officer. The Universal Consent MDHHS-5515 is required and may be obtained by calling 906-225-5722. Once received and it is verified that it is appropriately completed, a pre-screening phone interview (906-225-5722) will occur with either the client, if available, or the authorized person on the release of information. Insurance and income information will be requested. A phone screening will then be scheduled. The probation officer must be available to assure that the incarcerated individual is available for the phone screening with NorthCare. Additionally, the probation officer/ liaison will be responsible for communication with the treatment provider and for assuring that the incarcerated individual has appropriate transportation to treatment when it becomes available. Please consult NorthCare when designating a court liaison to ensure coordination of care. Residential placement is not a guarantee and providers do not hold beds. Client must be available for treatment when an appropriate placement is determined.

INFORMATIONAL FACT SHEETS

Informational Fact Sheets can be obtained from the following Website for such topics as: HIV/AIDS, TB, Hepatitis C, etc. at www.cdc.gov then click “health topic A-Z”. Another helpful sight is: www.healthymichigan.com – telephone number: 1-800-353-8227 (clearing house).

NOTICE OF PRIVACY PRACTICE

Protecting client health information is very important. The Federal Government has issued a set of regulations to guide the medical community in this area. The notice of privacy practices is sent out by NorthCare Network Substance Use Disorder Services to all funded recipients. The notice of privacy will describe the rights a client has about their medical record. The client has a right to inspect and copy their records; the right to request an amendment to their record; the right to a list of the disclosures and the right to inspect the information used or disclosed; and the right to request confidential communication with their health providers.

POINTS OF ENTRY FOR FUNDED SERVICES

Welcoming/Customer Service – Training Component on Website:

A welcoming philosophy is based on the core belief of dignity and respect for all people while in turn following good business practice. It is important for the system to understand and support the client in seeking treatment by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

Welcoming is conceptualized as an accepting attitude and understanding of how people "present" for treatment and a capacity on the part of that location to address their needs in a manner that accepts and fosters a service and treatment relationship that meets the needs and interests of the service recipient. Welcoming is also considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders. A comprehensive pre-screen should take place with the person calling so they can be directed to the appropriate next step. Questions like: are you currently seeing a mental health provider, are you interested in outpatient or intensive services, income, available for treatment immediately (example of our pre-screening form is in this document and on our website.) Answers to these questions will get this client to the appropriate next step, without adding an unnecessary phone call or visit by the caller.

General Principles Associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry and on-going services.
- Welcoming applies to all "clients" of an agency. Beside the individual seeking services and their family, a client also includes the public seeking services; other providers seeking access for their clients; agency staff; and the community in which the service is located, and/or the community resides.
- Welcoming is comprehensive and evidences throughout all levels of care, all systems and service authorities.
- A welcoming system is "seamless". It enables service regardless of original entry point, provider and current services.
- In a welcoming system, when resources are limited, or eligibility requirements are not met, the provider ensures a connection is made to community supports.
- A welcoming system is culturally competent and able to provide access and services to all individuals seeking treatment.

Welcoming – Service Recipient

- There is openness, acceptance and understanding of the presenting behaviors and characteristics of persons with substance use disorders.
- And, for persons with co-occurring mental health problems, there is an openness, acceptance and understanding of their presenting behaviors and characteristics.
- Welcoming is recipient based and incorporates meaningful client participation and "client satisfaction" that includes consideration to the family members/significant others.
- Services are provided in a timely manner to meet the needs of the individual and/or their families.
- Clients must be involved in the development of their treatment plans and goals**.**

Welcoming – Organization

- The organization demonstrates an understanding and responsiveness to the variety of help seeking behaviors related to various cultures and ages.
- All staff within the agency incorporates and participates in the welcoming philosophy.

- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the client repeat it at each provider.
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient.
- Consideration is given to administrative details such as sharing paperwork across providers, ongoing review to streamline paperwork to essential and necessary information.
- A welcoming system can provide follow-up and assistance to an individual as they navigate the provider and the community network(s).
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a client receive training and develop skills that improve engagement in the treatment process.
- All paperwork has purpose and represent added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient process, transmission and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space and consideration to privacy, a drinking fountain and/or other "amenities" to foster and accepting, comfortable environment.
- The service location is considered regarding public transportation and accessibility.
- Waiting areas include consideration for family members or others accompanying the individual seeking services.

APPLICATION PROCESS

Screening Process

1. Clients seeking outpatient services would contact the treatment provider directly
    - A substance use disorder clinician from the provider agency conducts a comprehensive assessment which includes biopsychosocial elements, diagnostic impression, and application of the ASAM criteria.
    - Substance use disorder treatment must be based on medical necessity.
    - Demographic data, financial information, and an Initial Authorization Request is entered into the appropriate online forms and electronically transmitted to the PIHP.
2. The following information must be obtained via a pre-screening to determine client's priority status:
    - **Admission Priority – Pregnant/Injecting Drug User, Pregnant Substance use disorders, Injecting Drug User, Parent at Risk of Losing Children and All Others**
    - **Potential Funding Source – This should be verified and**

documented using the PIHP MIS system

- **Other Insurance or benefit that may cover Substance use disorder treatment (Coordination of Benefits)**
- **Annual household income**
- **Current Community Mental Health client**
- **Type of service requesting**
- **Treatment History (Current and historical)**
- **Name, Phone number, Social Security #, DOB**
- **County of Residence**

The client must be given a choice of provider. On the Provider side, this choice must be documented on a "choice of provider" form and kept in the client's file. The client must sign-off that they received the "choice of provider" form – this is required for all levels of care. Once the PIHP obtains an appropriate release of information; the Brief screening is available to the SUD provider listed.

Providers

In all cases, the provider is responsible for entering demographic, financial, insurance, admission and authorization data into the PIHP MIS.

Initial Authorization Requests

- ✓ Initial authorization requests must be submitted and **approved** within 17 calendar days of the client's admission or the entire request may be denied. If you miss submitting and receiving an approved authorization within the 17calendar day window, you can still file a new request; however, approved authorization can only be backdated 17 calendar days once it is approved. For example, John Doe presents for OP treatment at the provider agency. The provider submits an initial authorization request to NorthCare on June 21 (this day counts as day 1 in counting.) If the authorization is requested to begin on June 5th it may be authorized (**if the entire request/documentation is properly completed**.) If the authorization is requested to begin on June 1st, the entire request may be denied. Remember, requests can be backdated a maximum of 17 days.

Pended Requests

- ✓ Problems (pended authorization requests) that are not resolved within (17 days Initial and 14 days Reauthorization) from the date of **admission** may result in a denial. Following a denial, you are eligible to resubmit the authorization request. Remember - filling a whole new request means typing in all the information over again and adhering to the above 17/14-day administrative rule. In other words, read **all** the comments the NorthCare reviewer is making and address **all the errors at once** - not one at a time.

- ✓ Outpatient Reauthorization requests must be filed 14 days prior to the begin date. Residential Reauthorization requests must be filed 48 business hours prior to the begin date. If this procedure is not followed, there is the possibility that the begin date will be adjusted to the date NorthCare staff are able to review and approve

the request. Motivation for treatment will also be reviewed at this time.

- ✓ Discharge planning, including housing and mental health issues must be addressed at admission

- ✓ Utilization Management staff will review cases for clients who repeatedly access treatment without showing significant improvement.

- ✓ Financial Eligibility must be verified at time of telephone prescreening, authorization, at time of service and monthly. Applicable changes must be documented within the MIS system.

Client who transitions from social detox into residential treatment at the same facility will be admitted into social detox and discharged from residential treatment. A separate referral from social detox into residential treatment is not necessary.

Consent to Share Behavioral Health Information for Care Coordination Purposes-Universal Consent MDHHS-5515 form

- https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686-,00.html
- The properly completed Universal Consent MDHHS-5515 must be faxed to NorthCare in order for the referral process to begin in ELMER.

Certification of Eligibility

The certification of eligibility form must be completed for all clients to be put through the NorthCare Network Substance Use Disorder Services. For **Intensive services,** the form must be faxed to the NorthCare along with the Universal Consent MDHHS-5515 prior to an authorization request being considered. Outpatient services must have the form completed by the client and kept in the client chart.

USING THE ELMER SYSTEM

System Authentication/Data Encryption

The ELMER system requires user authentication. Base credentials are a username and password. All user passwords must be changed at least every 90 days and are required to be at least 6 characters and should contain a combination of letters and numbers. All data transmitted over the internet is SSL encrypted. In order to access the ELMER system, username and passwords must be assigned. **Supervisors** must contact the PIHP to request a username/password for an employee. Contact NorthCare Network, Karena Grasso 225-4404 or Joan Tappy 226-0020, to have username and passwords established or reset. Usernames/passwords will be given to the employee via confidential email or over the telephone **only**. Employees are strictly prohibited from sharing their username and/or passwords. Off-site accessing of the ELMER system is also strictly **prohibited**. You may only access the ELMER system from the approved, licensed Provider site – this practice allows the system to be HIPAA and 42 C.F.R. Part

2 compliant. Notify NorthCare Network **immediately** to have a username disabled when an employee leaves your Agency. This should be done **without delay** so that continued access is not possible. Any issues with the ELMER system should be reported to the PIHP staff at 1-888-333-8030.

Program Discharge Policy

All Programs must have a policy that details their Client Discharge Policy. Clients must be given this information upon admission and must sign a document showing they received and understand the Discharge Policy. The use of behavioral contracts related to client relapse and continued use during treatment is not clinically appropriate. This practice is not supported by research and fails to comply with the Substance Abuse and Mental Health Services Administration guidelines.

The Program Discharge Policy must include the following components:

1. A recipient shall be informed if a program has a policy for discharging recipients who fail to comply with program rules and shall receive, at admission and thereafter upon request, a notification form that includes written procedures which explain all the following:
    a. The types of infractions that can lead to discharge
    b. Who has the authority to discharge recipients
    c. How and in what situations prior notification is to be given to the recipient who is being considered for discharge
    d. The mechanism for review or appeal of a discharge decision
2. A copy of the notification form signed by the recipient shall be maintained in the recipient's case file.

AUTHORIZATION PROCESS

A current release must be on file with the PIHP prior to the client being "referred" to a specific SUD Provider. A current release is one that covers the current authorization period being requested. An authorization becomes invalid once it is connected with an admission that has been or should be discharged. The release or consent must be faxed or scanned to the ELMER system.

While obtaining a copy of a client's Medicaid card is good practice, monthly documentation in the client file must reflect that funding eligibility was checked.

The next step is to fill out the authorization request itself. It represents a snapshot of the client, so it is important to fully complete the form including an individualized treatment plan. NorthCare will approve units of service based on medical necessity, ASAM, DSM-V and treatment plan.

As stated at the bottom of the ELMER Authorization form: "This clinical authorization does not guarantee payment. "The authorization is considered a part of the whole billing process. A Final payment decision is made at time of payment.

Question on authorizations contact: SUD Treatment Coordinator, 906-225-4422 or SUD Assessment Specialist, 906-226-0042.

Authorization Requirements:

- A service meets medical necessity criteria
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) is used to determine an initial diagnostic impression.
- The service is based on individualized determination of need.
- The service is cost effective
- The American Society of Addiction Medicine (ASAM) Patient Placement Criteria are used to determine substance use disorder treatment placement/admission and/or continued stay needs.

    - ✓ Withdrawal potential
    - ✓ Medical conditions and complications
    - ✓ Emotional, behavioral or cognitive conditions and complications
    - ✓ Readiness to change
    - ✓ Relapse, continued use or continued problem potential
    - ✓ Recovery/living environment

Re-Authorization Requirements:

Reauthorization requests may be approved when authorization requirements continue to be met. The request must:

- Document evidence of progress in achieving treatment plan goals
- Document continued medical necessity
- Document reauthorization request is essential due to cognitive and behavioral impairments
- The following tools must be utilized and documented: DSM-V, ASAM Criteria, Individualized determination of need, cost effective and readiness for change

Outpatient services will be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment, but additional covered services are needed for the beneficiary to be able to sustain recovery independently.

Reauthorization of services can be denied in situations where the beneficiary has:

- not been actively involved in their treatment despite active outreach efforts on the part of the provider, as evidenced by repeatedly missing appointments;
- not been participating/refusing to participate in treatment activities;
- behaviors that are deemed to violate the rules and regulations of the program providing the services.

Beneficiaries may also be terminated from treatment services based on these violations.

Providers

Provider Appeal

Providers may request an “internal review” to potentially appeal what they consider an adverse determination that concerns utilization and/or quality management issues. This may include medical necessity determination, level of care authorized, number of units approved, etc.

- The provider who disagrees with a PIHP decision **must** first discuss the situation with the Utilization Management (UM) staff person who made the adverse determination. The discussion between provider and PIHP UM staff person must occur within five business days of the disputed action.
- If provider does not feel the situation has been satisfactorily resolved, they may submit a written appeal to the NorthCare Network. The written request should clearly outline the specific issue to be reviewed, why it should be reviewed, and the desired outcome. The written request must be submitted within 14 days of the considered adverse determination. NorthCare Network staff will follow the procedures outlined in the NorthCare Network Service Authorization Policy.

While prior authorization is not required for detox clients, an authorization request via the ELMER system must be filed and approved within 17 days of a client’s admission.

Access

Provider agrees to fully cooperate with NorthCare by:

1. Securing prior payment authorization for all treatment rendered except for situations as described in the NorthCare Network Substance Use Disorder Provider Manual
2. Accepting screenings, concurrent reviews and retrospective review findings by NorthCare to determine Medical Necessity for payment of benefits subject to the applicable appeal procedures as described in the NorthCare Network Substance Use Disorder Provider Manual
3. Following the procedures outlined for the filing of an appeal or grievance related to the determination of Medical Necessity for payment of benefits as described in the NorthCare Network Substance Use Disorder Provider Manual. Provider acknowledges that the failure to follow the terms of NorthCare policies and procedures may result in a reduction in the amount of payments to Provider.

CUSTOMER SERVICE

1-888-333-8030

CREDENTIALING

In the interest of continued quality improvement, we have developed the capacity to keep certifications and licenses in our electronic record. Any new or renewals to certifications or licenses will be requested along with the development plans for counselors and supervisors with MCBAP.

Staff Qualifications and Professional Development – Refer to Contract

MCBAP Development Plan Requirement - Development Plan must be completed and submitted to MCBAP within **30** business days of beginning employment. **It is the responsibility of the provider/staff to meet requirement.**

NorthCare Network Credentialing Policy - Refer to NorthCare Network Credentialing Privileging Policy and NorthCare Network Credentialing Program Policy on NorthCare website as well as the Medicaid Manual and Provider contract.

Providers must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network. Appropriate and timely credentialing is the Provider's responsibility.

Clinician's Development Plan must be **valid and on file at** MCBAP **prior** to consideration to be added as a qualified clinician to the NorthCare Provider panel.

IC&RC Exam
Completion 6 months before applying for certification is highly recommended. If you fail the exam, you must wait 60 days before taking it again.

Expiration of Licenses
Any Provider who has not renewed their license or certification prior to its expiration will be immediately suspended/terminated from the provider network. Services are not reimbursed during periods of lapsed license/certification. This can be monitored on the license and regulatory affairs (LARA) website.

Upper Midwest Indian Council on Addictive Disorders (UMICAD)
Tribal providers get their certification from UMICAD, they have 3 levels of certification: ADC I, ADC II, ADC III. The IC&RC has a residency rule called "the 51% rule" on where a person can apply to take the ADC Written Exam and/or certification.

Credentialing Updates

Programs are required to notify NorthCare of any updates/changes to any existing clinician's credentials when the information is available to the clinician and/or program. All newly hired (or transferred between internal programs) clinicians' credentialing information, along with hire date, must be submitted to NorthCare **within 2 weeks of hire** (or transfer.) This notification will ensure the clinician is properly credentialed to provide substance use disorder services to NorthCare funded clients. Termination dates of all clinicians and ELMER users must be submitted immediately to NorthCare Network – Provider Network Administrative Support Specialist, Karena Grasso via email kgrasso@northcarenetwork.org so that they can be removed from the ELMER system.

License Exclusion Check

The following website can be used to check any exclusions for licensed providers. The PIHP will check all contracted providers and clinicians through this website regularly:

- Department of Health & Human Services (HHS) sanctioned provider information is available on the following website: http://exclusions.oig.hhs.gov.
- MDHHS licensing sanctions for health facilities and professionals are available at http://michigan.gov/healthlicense

PROVIDER BILLING

General Information

Treatment providers will bill for services via the NorthCare Management Information Systems (MIS). In order to accomplish billing, all services must be prior authorized.

Treatment services should be billed to NorthCare Network on a monthly basis. Providers are encouraged to bill for services by the 10th of the month following the month treatment was provided.

All services must be billed within 60 days of treatment. An exception will be automatic for those clients with 3rd party insurance. This will allow the treatment provider the opportunity bill the 3rd party insurance prior to billing NorthCare. Once 3rd party payment has been received, the amount paid can be included when the treatment is entered into the ELMER system.

Do not combine fiscal years in a batch.
Example: September 2017 dates of service should not be processed in the same batch as November 2017 dates of service. Create and submit a separate batch.

Providers can expect reimbursement from NorthCare Network within 45 days for clean claims **received** by the 10th of each month. Bills processed can be viewed and printed at the provider level.

Claims Processing

Refer to the How to Guides in ELMER – click on "Help" at the top of the Elmer Provider page

- SUD Provider Claims Entry Quick Reference
- SUD Provider Claims Submission User Manual

MEDICAID ADMINISTRATIVE HEARING PROCESS

See NorthCare Website in the Customer Handbook

RECIPIENT RIGHTS

Substance use disorder recipient rights complaints are handled at the provider level by the recipient rights officer at that agency (list of current Provider Recipient Rights on NorthCare website.)

CONFIDENTIALITY/CONSENT

Confidentiality is expected to be maintained in accordance with Federal law and regulations (42 C.F.R. Part 2.) In keeping with this, appropriate written consent must be obtained from a client in order for NorthCare Network Substance Use Disorder Services and providers to share information. Listed below are essential items in ensuring appropriate confidentiality standards are followed:

- Providers are to use the Consent to Share Behavioral Health Information for Care Coordination Purposes Universal Consent MDHHS-5515 as the Release submitted to the PIHP to obtain authorization.
- *RELEASES* are good for the time period noted on the Health Information Release Authorization form – with some exceptions. Exceptions permitting limited disclosures without written consent are as follows:
  1. Internal Communications
  2. Anonymous Disclosures
  3. Qualified Service Organization Agreements (QSOAs)
  4. Medical Emergency
  5. Research
  6. Audit & Evaluation
  7. Authorizing Court Order
  8. Patient Threat/Crime on program premises or against program personnel
  9. Reporting Suspected Child Abuse and Neglect
- There is no age limit for consent. Children and adolescents receiving substance use disorder treatment services must sign any release they choose to give; parental signatures are **NOT** required. Public Health Code, MCL 333.6121.

QUALITY MANAGEMENT

Quality Improvement

NorthCare's Quality Assessment and Performance Improvement Program (QAPIP) is structured to facilitate and ensure an objective and systematic performance improvement program that monitors and evaluates the quality of care provided to clients identified to have any one or more of the following: mental illness, developmental disabilities, or substance use disorder. The QAPIP emphasizes the use of consumer and other stakeholder involvement to improve services. Quality management stresses the self-worth of employees; cooperation between employees; team building; and a partner relationship between the PIHP, CMHSPs, and advocacy groups and other human service agencies. Quality management seeks prevention over remediation. A basic principle of quality management is that it is less expensive in the long run to build quality into an organization's services (prevention) than it is to expend additional resources on rework and dissatisfied customers (remediation).

Each Substance use disorder Provider is strongly encouraged to implement a Quality Assessment and Performance Improvement Program within their provider organization that addresses:

- Structure and Accountability for the QI Program
- Active Participation by Stakeholders
- Components and Activities
- Process for Review and Follow-Up of Sentinel Events
- Evaluation of Members Experiences with Services
- Practice Guidelines
- Qualifications for Scope of Practice (Credentialing and Privileging)
- Verification of Service Delivery
- Utilization Management Activities
- Procedures for Adopting & Communicating Process & Outcome Improvements

Utilization Management

Utilization management is a set of functions and activities focused on ensuring that clients receive services with the appropriate frequency and duration which are delivered according to practice guidelines for obtaining the best possible outcomes. Refer to NorthCare website: www.northcarenetwork.org for the complete Utilization Management policy. Although NorthCare is responsible for authorizing services, providers are required to review the effectiveness of interventions and adjust accordingly.

1. To assure an accessible and appropriate set of services for plan members
2. To maximize cost-effectiveness
3. To assure Uniform Benefit-Customers with similar needs will receive similar services regardless of where they obtain services within catchment area
4. Medicaid services must comply with the standards within the MDHHS current Medicaid Provider Manual
5. Substance Use Disorder services must utilize DSM-V for diagnosis and ASAM criteria for level of care (placement)/admission, continued stay and discharge/transfer.
6. Performance measures are expected to meet or exceed industry standards.

Site Visits

Annual site reviews will be conducted using an overall quality management plan. The Site Visit Protocol areas of review will include but not be limited to: organizational policies and contractual requirements; claims management; client chart review; data collection; performance indicator timeliness, reporting; licensing and accreditation; staff credentials and professional training; clinical practices and recipient rights. All requirements along with the site visit date will be sent to the Providers in advance of the proposed date. Portions of the Annual Site Visits will be conducted via desk audit. This is meant to reduce the time spent at each provider site and allows provider staff flexible time to submit contractual requirements.

Desk Audit

Desk audits are considered part of the Annual site review for each Provider. An email will be sent out to Program Directors/Supervisors requesting various contractual agency information; along with a due date for when the information must be returned to the PIHP. Desk Audit data must be submitted to the PIHP prior to the on-site review.

NorthCare Training

NorthCare Network Substance use disorder providers can utilize the www.improvingmipractices.com for contractual training requirements to be completed within 30 days of hire and annually thereafter.

- Cultural Competency
- Deficit Reduction Act (DRA)
- HIPAA/Confidentiality
- Customer Service (Welcoming)
- Communicable Diseases
- Recipient Rights

The training site will provide a certificate of completion for the trainings and NorthCare will monitor this at time of site review in the employee HR files. Recommendation for a tracking system to be in place to ensure that all staff have the required training.

COMMUNICABLE DISEASE

- ✓ A check box for clients who are identified as high risk for communicable disease
- ✓ IF box is checked then must be in progress notes that client had appropriate health education – (directly related to communicable disease)
- ✓ Provider Policy for referral process for testing – TB, Hepatitis, STD and HIV when appropriate
- ✓ Provider Policy assuring all pregnant women presenting for treatment are offered referral for or provided STD and HIV testing
- ✓ HIV/Health education for all clients (chart review)
- ✓ RESIDENTIAL ONLY – All clients must have TB test at admission (if clients do not have by the time they come in – the test will be done the 1st day of admit – must have documentation (chart review)
- ✓ Protocol for residents and staff if suspicion of contagious diseases is evidenced upon client admission and prior to actual test being conducted
- ✓ Provider policy/protocol for making clients aware of available resources if already infected with TB, Hepatitis, STD or HIV
- ✓ Utilization of state funds is prohibited for the distribution of sterile needles for injection of any illegal drugs.
- ✓ Provider Policy – ALL staff (including clerical, janitorial, etc.) must have minimal knowledge of HIV/AIDS, TB – training logs documentation
- ✓ All new hires into system have received a minimum 3 hours of training on communicable disease within 6 mos. of hire,
- ✓ Clinicians receive an expanded level of training relevant to their positions within 6

mos. of hire
- ✓ Updates are provided at least every two years
- ✓ Screening tool to identify high risk clients.

DEFINITION – for Communicable Disease Training

Level 1 – Minimal standards for ALL employees:

- HIV/AIDS, TB, Hepatitis (especially A, B and C) and STDs as they relate to the agency target population
- Modes of transmission (risk factors, myths and facts, etc.)
- Linkage between substance use disorder and these communicable diseases
- Overview of treatment possibilities
- Local resources available for further information/screening
- Universal precaution procedures-basic knowledge of universal precautions for blood borne and body fluids transmission of pathogens

It is anticipated that the above could be adequately covered in a two-hour session, with update trainings every year, and may be provided by agency staff that have completed Level 2 training. **New employees must have this training within 60 days of hire.**

Deficit Reduction Act (DRA) – Included in Website Training Center:

- Provider must educate all staff on the DRA and provide up-to-date information to staff on a regular basis.

Audit - Fiscal Year (FY) 2010 marked the second full year of the national Medicaid provider audit program. CMS awarded task orders in all regions for contractors to review provider claims, conduct provider audits, and initiate the provider education activities required by Section 1936 of the Act. Through the end of FY 2010, 947 audits were underway in 45 of the states and MIG efforts identified an estimated $10.7 million in overpayments, through both direct provider audits and automated reviews of state claims.

- Medicaid Integrity Program (MIP)
- False Claims Act – Federal/Michigan
- Whistleblower's Act
- Education Requirements
- Compliance Program

NorthCare Policies:

Full list of NorthCare policies/procedures in their entirety are available on the following website: www.northcarenetwork.org

Data Entry

Refer to the "Help" section of ELMER to view referral guides.

Outpatient Treatment Discharge Data Changes and Clarification

Discharge Date Extensions: Discharge Data must be submitted when no treatment services have been provided to the client in the last ***60 Days and previous Authorization has expired.*** Please note: This is an increase from the previous 45 Day rule and is intended to give a longer window for a client to return to services without having to Discharge and re-admit.

- Discharge Date is **not** the date the discharge information is entered into ELMER.
- Discharge Date is **not** the date the client passed away, if client is deceased.
- Discharge Date **is** the date of last billable treatment service.

Residential Treatment "Reason for Discharge"

Do **not** use "Completed Treatment" for Residential Treatment Discharge Reason when additional treatment is planned or ***expected*** as part of the current treatment episode. In the Episode of Care model, Residential SA Treatment is not considered to be the ideal "end" of treatment. While a client at discharge from residential treatment may have "successfully completed that ***level of care***", it is generally expected the client will be stepped down, or referred to a lower level of care, i.e. outpatient SA treatment, for follow-up care. Therefore, the guideline is to reserve "Completed Treatment" for an Outpatient SA Discharge Reason.

Importance of Discharge Data and Keeping Discharges "Up-to-Date"

SUD Treatment Discharge Data is used to measure outcomes of Treatment, from each Admission to the corresponding Discharge. Outcomes, in turn, help determine State and Federal funding. NOMS (National Outcome Measures) specifically look at changes in frequency of use, employment status and housing status, as well as "how many days did it take client to access treatment" and "how long did client engage in outpatient treatment".

If a client in outpatient treatment needs to enter detox for example, the outpatient provider must discharge the client before the detox provider can admit him/her. Although the client may be returning to the outpatient program following a two-day detox stay, a courtesy discharge, followed by a new admission, is required**.**

A **discharge**, from ANY level of care, may be requested of a provider by the PIHP. This will be done in writing via **email** to the Program Supervisor/Director. The format used will be **client initials and MCO#**. This discharge is expected to be completed within **2 business days**.

BH-TEDS Admission & Discharge Coding Structures

Needing Particular Attention on Elmer System

Note: Some information is collected both at time of Admission and at time of Discharge and should reflect current status.

*** Date of Request / First Contact, with Treatment Provider (Performance Indicator reporting) –** Date Client, **or, NORTHCARE SUD SERVICES, Screener and Client,** contacted ***Admitting Treatment Provider*** to request **this Treatment Admission**. *The Elmer system uses Date of First Contact to calculate* **Time to Treatment.**

* **Type of Treatment Service Setting** – for both treatment Admission and Discharge:
02 Residential Detox – non-hospital 24-hour setting providing safe withdrawal
04 Residential Rehab – Short Term (typically 30 days or less)
05 Residential Rehab – Long Term (typically more than 30 days)
06 Ambulatory Intensive OP– Treatment lasts at least 3 hours/day, 3 or more days/week
07 Ambulatory Outpatient – OP setting may include individual, family, group case mgt.

*** Prior Treatment Episodes** – Indicates an attempt to answer the question: "How many times have you tried to address this problem at any treatment provider?" Only include treatment admissions, not assessment only services.
0 - 0 previous episodes
1 - 1 previous episodes
2 - 2 previous episodes
3 - 3 previous episodes
4 - 4 previous episodes
5 - 5 or more previous episodes
7 - Unknown.

***Codependent/Collateral Person Served –** indicates the client has no alcohol or drug problem but is formally receiving substance use treatment to address problems arising from his/her relationship with an alcohol or drug user.

*** Designations**

I/DD Designation – Intellectual/ Developmental Disability
1 - Yes
2 - No
3 - Not Evaluated

MI or SED Designation – Serious Mental Illness or Severe Emotional Disturbance
1 - Yes
2 - No
3 - Not Evaluated

Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment

1 - Yes, client with co-occurring SU and MH problems is being treated with an integrated treatment plan by an integrated team
2 - No, client does NOT have a co-occurring SU and MH problem and is NOT being treated with integrated treatment plan by integrated team
3 - Client with co-occurring SU and MH problems is NOT currently receiving integrated treatment

*** Currently in Mainstream Special Education –** Identifies whether or not the individual is currently in mainstream education with Special Education Status
1 – Yes
2 – No
6 – Not Applicable – Individual is not school age

School Attendance Status** - only applies to school-age (3-17 years old) or, individuals in Special Education (0 – 26 years old). ***Always choose 6 - Not applicable for a person who is older than 26 years old.
1 - Yes
2 - No
6 - Not applicable

* **Living Arrangements –** Identifies whether an individual is homeless or describes the individual's current residential situation or arrangement.
01 – Homeless – Individual having no fixed address and includes homeless shelters.
02 – Dependent Living – Individual living in a supervised setting such as a residential institution,
halfway house, transitional housing, recovery housing, a group home, **OR** children (under
age18) living with parents, relatives or guardians, **OR** SUD individuals in foster care.
03 – Independent Living - Individual with a fixed address living alone or with others in a private
residence independently. Includes adult children (18 and older) living with parents and
adolescents living independently. Also includes individuals living independently with case management or supported housing support

***Employment Financial**
Employment Status – Describes the individuals' current employment status
1 – Full Time Competitive, Integrated Employment
2 – Part-time Competitive, Integrated Employment
3 – Unemployed – ***Individual who has looked for work during the past 30 days or on a layoff from a job***
4 – Not in Competitive, Integrated Labor Force
98 – Not Applicable – ***Individual is under 16 years of age; always use 98***
Detailed 'Not in Competitive, Integrated Labor Force'
Total Annual Income – Specifies the individuals' current Annualized Income utilized in calculating his/her Ability to Pay
Number of Dependents – Number of dependents utilized in calculating ATP

Enrolled in SDA SSI or SSDI – Identifies whether the individual is enrolled in SDA, SSI, and/or SSDI or if an individual who ***otherwise qualifies for SDA is having his/her room and board at a substance use facility being paid by SDA funds***
Work/Task Hours
Earnings per Hour

* **Corrections Related Status**
01 - In prison
02 – In jail
03 – Paroled from a state or federal correctional facility
04 – Probation
05 – Tether
06 – Juvenile detention center
07 – Pre-trial (Adult) OR Preliminary Hearing (Youth)
08 – Pre-sentencing (Adult) OR Pre-disposition (Youth)
09 – Post booking-diversion
10 – Booking diversion
11 – Not under the jurisdiction of corrections or law enforcement program

Arrests in Past 30 Days –** Specifies the number of separate arrests ***(Not Charges) in the past 30 days, or since Service Start/Most recent Update, whichever is sooner. ***Never calculate further back than the Service Start Date***

Veteran Military Information –** ***Fields left blank in this section will cause the record to reject.

*** Substance Use Problem –** The following coding applies to Primary, Secondary and Tertiary Substances. The same drug cannot be used for more than one category. If Primary Substance - 00 at Admission, client must have Co-Dependent - "Yes" and/or 2, 3, or 9 must be coded in Other Factors.

01 None - If None, all related fields (Route of Admin., Frequency of Use, and Age of First Use) must be N/A
02 Alcohol
03 Cocaine/Crack
04 Marijuana/Hashish – Includes THC and any other cannabis sativa preparations
05 Heroin
06 Non-prescription Methadone (illicit use)
07 Synthetic Opiates & Other Opiates – Includes buprenorphine, butorphanol, codeine, hydrocodone,
hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol,
and other narcotic analgesics, opiates or synthetics
08 PCP – Phencyclidine
09 Hallucinogens – Includes LSD, DMT, mescaline, peyote, psilocybin, STD, and other hallucinogens
10 Methamphetamine/Speed
11 Other Amphetamines – Includes amphetamines, MDMA, 'bath salts', phenmetrazine, and other

amines and related drugs
12 Other Stimulants – Includes methylphenidate and any other stimulants
13 Benzodiazepines – Includes alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam,
flunitrazepam, flurazepam, halazepam, lorazepam, oxazepam, prazepam, temazepam, triazolam, and other benzodiazepines
14 Other Tranquilizers – Includes meprobamate, and other non-benzodiazepine tranquilizers
15 Barbiturates – Includes amobarbital, pentobarbital, phenobarbital, secobarbita, etc.
16 Other Sedatives or Hypnotics – Includes chloral hydrate, ethchlorvynol, glutehimide, methaqualone,
and other non-barbiturate sedatives and hypnotics
17 Inhalants – Includes aerosols, chloroform, ether, nitrous oxide and other anesthetics, gasoline, glue,
nitrites, paint thinner and other solvents, and other inappropriately inhaled products
18 Over-the-Counter Medications – Includes aspirin, dextromethorphan and other cough syrups,
Diphenhydramine, and other anti-histamines, ephedrine, sleep aids, and any other legally obtained,
non-prescription medication
20 Other Drugs – Includes diphenylhydantoin/phenytoin, GHB/GBL, ketamine, “spice”, carisoprodol, and
other drugs

***Medication-Assisted Opioid Therapy** – Identifies whether the use of opioid medications such as Methadone, buprenorphine, vivotrol, suboxone, or naltrexone will be part of the individual’s treatment plan
1 – Yes
2 - No
6 – N/A Used if the individual is not in treatment for an opioid problem. ***Cannot be reported if the individual has Heroin, Non-prescription Methadone or Other Opiates and Synthetics reported as Primary, Secondary or Tertiary Substance Use problem***

* **Attendance at Substance Use or Co-dependent Self-help Groups in Past 30 Days** Indicates the frequency of attendance at a self-help group in the past 30 days or since Service Start/Most recent Update, whichever is sooner.

01 – No Attendance
02 – Less than once a week (1-3 times in the past 30 days)
03 – About once a week (4-7 times in the past 30 days)
04 – 2 to 3 times per week (8-15 times in the past 30 days)
05 – At least 4 times per week (16 – 30 or more times in the past 30 days)

*** Discharge Date** – **Date of last treatment service** client received and usually matches last billable treatment.

*** Reason for Discharge/Service End –** Most significant reason for client’s discharge:
01 - Treatment Completed – Substantially all parts of the Treatment plan or program were

Completed.
02 - Dropped Out of Treatment – Individual chose not to complete treatment program, or with
whom contact has been lost.
03 - Terminated by Facility – Generally because of non-compliance with treatment or violation of
rules, laws, policies or procedures.
04 – Transferring to Another Program or Facility/Completed Level of Care – Individual will transfer
to another level of care, program, provider, or facility.
05 – Incarcerated or Released by Courts – Individual's treatment is terminated because s/he has
been subject to jail, prison, or house confinement or s/he has been released by or to the
courts.
06 – Death – The death of the individual receiving SUD services.
07 – Other – Individual transferred or discontinued treatment because of change in life
circumstances, like extended illness, hospitalization, or, change of residence out of the PIHP
SUD Treatment region.
96 – N/A – Update Record – Utilized for Update records, only.

- **Diagnosis – *Must have at least one SUD Diagnosis; if co-occurring treatment is provided must also have a secondary diagnosis for the MH problem***

Note: Outpatient Discharges: Discharge must be submitted when no treatment services have been provided to client in last ***60 Days and/or previous Authorization has expired.*** Discharge Date is the date of the last billable service.

Note: Detox Discharges: Document the Treatment Referral Plan to follow Detox Discharge. In the Discharge Notes box include the Name of Follow-up Treatment Provider client is being referred to after Detox and the Date planned for follow-up Treatment Admission. IF client will not make the 7 Day Timeliness Standard (from Detox Discharge to Follow-up Treatment), List Appointment DATES offered, refused, accepted and check reason for Delay following Detox Discharge.

STATE-REQUIRED REPORTING

The Michigan Department of Community Health (MDHHS) requires periodic reporting by **NorthCare Network SUD Services** of information specific to the regional Panel of Treatment Providers and Clients they serve. In order for **NorthCare Network SUD Services** to compile accurate regional data, it is essential that reliable information from individual Providers be submitted on a timely basis. In addition to the data entered on Elmer, Providers are required to submit the following Report forms:

***Monthly Provider Report* - 90% Capacity Management Report**

The purpose of this report is to show which SUD Treatment Providers reach 90% *capacity* during the reported month. It provides another way to look at our region's capacity to serve Federal Priority Populations: IV Drug Users and Pregnant Women. Whereas many Residential SUD Treatment Providers reach 90% capacity in a specific month, Outpatient SUD Treatment Providers, according to the State, seldom hit 90% full capacity on any given day. Please refer to "How to Complete Monthly Capacity Management Report" for Outpatient and Residential Methods for calculating 90% capacity. Submit this report by the 15th of the Month following the Reported Month.

***Monthly Provider Report* - Federal Priority Populations Waiting List Exception Report**

This monthly report is used for **NorthCare Network SUD Services** certification that federal block grant Priority clients (Pregnant drug user and/or IV drug users) are served according to Timeliness guidelines specified in Public Law 102-321. *Monthly* Federal Priority Populations Waiting List Exception Report form was designed for electronic submission via email or faxing of this information to the NORTHCARE SUD SERVICES. Information required on this monthly report:

1. Name of Reporting **SUD** Treatment Program
2. Reporting Month, Year
3. "Yes" or "No"? Did **SUD** Treatment Program have the capacity to serve all Clients with Federal Priority Codes 1, 2 or 3 within the Specified Number of Days?
4. ***If "No" to #3:*** Provide date deficiency occurred, date NORTHCARE SUD SERVICES notified by telephone and complete the additional report, ***Documentation* when Federal Priority Populations Waiting List Exception Occurs.**
5. Person Submitting Report
6. Date of Certification

Report is due within 15 days of the end of every report month. Electronic submission (email completed form) is preferred. The following are definitions and timeliness guidelines to be used for this report:

Federal Priority Codes:

1 – Pregnant injecting drug user 2 – Pregnant non-injecting drug user 3 – Injecting drug user

Timeliness Guidelines:

1923(a)(2) Treat Within Specified Number of Days. - Each individual who requests and is in need of treatment for intravenous drug abuse must be admitted to a program of such

treatment not later than (A) 14 days after making the request for admission to such a program; or (B) 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.
1927(b)(2) Treat Within Specified Number of Days. Each pregnant woman who seeks and would benefit from substance abuse treatment services must be admitted to such program that (A) has the capacity to provide treatment services to the woman; or (B) if no program has the capacity to admit the woman, make interim services available to the woman not later than 48 hours after such request.

Provider must contact the NorthCare Network SUD Services by telephone whenever a Federal Priority Populations Waiting List Exception occurs, as noted above. If Provider is unable to locate/provide interim services, the NorthCare SUD SERVICES will assist in this process. Documentation of the specific Waiting List Exception must also be submitted to the NORTHCARE SUD SERVICES via Confidential FAX (use reporting form entitled *Documentation* when Federal Priority Populations Waiting List Exception Occurs).

Client BH-TEDS Data Uploads (Admissions and Discharges) – generated from Elmer data

The NorthCare Network SUD Services submits batches of regional client SA Treatment admissions and discharges to the State, monthly. These files are used by MDHHS for the Federal BH-TEDS (Treatment Episode Data Set). Admission and Discharge information is used for Performance Indicators and NOMS (National Outcome Measures), as well. This data is used to help determine treatment funding needs. It is essential that providers enter this information into the Elmer website in a timely, accurate manner so that the NorthCare Network SUD Services can submit reliable data to the State. Providers are asked to regularly check accuracy of data and run the Elmer ***Open Client Summary*** to keep Discharges up-to-date. This information forms the basis for statistics related to our region and reflects trends in Michigan.

Client Satisfaction Surveys

Providers are required, on an ongoing basis, to survey anonymously their open and/or closed clients regarding client satisfaction.

Treatment Providers distribute their own Client Satisfaction Surveys, which must include one "Over-All Satisfaction" question. The Provider must be able to interpret the answer to this "Over-All Satisfaction" question as either "Satisfied" or "Not Satisfied", over-all, with the Treatment Provider's Program. Another way to ask this question is, "Would client refer family or friends for Treatment with this Treatment Provider". Treatment Provider should ***survey*** an individual client only once in a Fiscal Year to avoid duplication of respondents in summary to NORTHCARE SUD SERVICES.

Note: for *Medicaid* Funded Clients, only:

In addition to Treatment Provider surveys of all clients: In FY2006 the NorthCare SUD SERVICES began mailing Client Satisfaction Surveys required by NorthCare Network. These surveys are mailed annually to unduplicated NorthCare funded Medicaid Clients in Substance Abuse Treatment.

***Immediate Provider Report* - EVENT Notification:**

NorthCare SUD Treatment Providers are required to report Event Types #2, #3 and #4, when SUD clients are involved or affected. Providers must fax the Event Notification

report form, via confidential fax, to the NorthCare SUD services, **within 3 business days of the Event's occurrence**. The following are brief descriptions of the 3 Event Types which SUD Services must report, via the NORTHCARE SUD SERVICES, to MDHHS:

#2. Relocation of consumer's placement due to licensing issues
#3. An occurrence that requires the relocation of any PIHP Regional Entity or Provider Panel service site, governance, or administrative operation for more than 24 hours

#4. The conviction of a PIHP Regional Entity, or Provider Panel Staff member for any offense related to the performance of their job duties or responsibilities.

Residential Provider Required Event Reporting:
Residential SUD Treatment Providers are to report immediately**, within 24 business hours**, any critical incident via the NorthCare SUD Immediate Notification Report form. NorthCare requires a complete Root Cause Analysis report in the event of a Sentinel Event, except for most Arrests and/or Convictions. Refer to the NorthCare website for the entire Sentinel Events Policy: www.northcarenetwork.org.

The following are examples of Critical Incidents, which may be determined to be Sentinel Events:

- Death of a recipient.
- Serious illness requiring admission to hospital.
- Alleged cause of abuse or neglect.
- Accident resulting in injury to recipient requiring emergency room visit and/or admission to hospital.
- Behavioral episode.
- Arrest and/or conviction. (Note: always count each as a Sentinel Event, but typically not required to do Root Cause Analysis.)
- Medication error.

Any Critical Incident falling into the categories listed above, **except** typically not an Arrest and/or Conviction, should be thoroughly reviewed to determine whether it meets the criteria for a Sentinel Event (defined below) and if it is also related to practice of care.
A ***Sentinel Event*** is 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)

Other Reporting
On occasion, the NorthCare Network SUD Services may survey its providers on substance abuse related issues or request specialized information. Providers' cooperation in these instances is essential in order to insure quality programming that is responsive to clients.

Please note that the inadvertent omission of a required report in this provider manual does not relieve providers of the responsibility for completing requirements previously, or subsequently, requested by the NorthCare Network SUD Services.

NorthCare Network Substance Use Disorder Services

200 W. Spring Street, Suite #2, Marquette, MI 49855

Phone: (906) 225-7222 Toll-Free: (800) 305-6564 Fax: (906) 225-7352

Reporting Requirements & Deadlines for NorthCare Regional SUD Treatment Providers

Report and Frequency	*Annual:* Report Month and Due Date											
	1st 6 Months						*2nd 6 Months*					
	1st Qtr.			*2nd Qtr.*			*3rd Qtr.*			*4th Qtr.*		
	Oct. due Nov 15	**Nov. due Dec 15**	**Dec. due Jan 15**	**Jan. due Feb 15**	**Feb. due Mar 15**	**Mar. due Apr 15**	**Apr. due May 15**	**May due June 15**	**June due July 15**	**July due Aug 15**	**Aug. due Sept 15**	**Sept. due Oct 15**
Immediate: Please report immediately to the NorthCare Network SUD Services any of these 3 events:	**Immediate reporting to the NorthCare Network SUD Services is required for the following:** *1.* Immediate **(24 business hours)** Notification Report for Sentinel Event or Critical Incident: *Residential Providers, only* 2. Immediate phone call to NorthCare Network SUD Services when Federal Priority Populations Waiting List Exception occurs 3. Immediate Event Notification (NorthCare "newsworthy" Event)											
Monthly: ***1. "Federal Priority Pops Waiting List Exception Report"*** ***2. "90% Capacity Mgt. Rpt."***	√	√	√	√	√	√	√	√	√	√	√	√

NorthCare Network Substance Use Disorder Services

200 W. Spring Street, Suite #2, Marquette, MI 49855

Phone: (906) 225-7222 Toll-Free: (800) 305-6564 Fax: (906) 225-7352

Out-of-Region SUD Treatment Providers: Reporting Requirements for NorthCare

Report and Frequency	*Annual:* Report Month and Due Date											
	1st 6 Months						*2nd 6 Months*					
	1st Qtr.			*2nd Qtr.*			*3rd Qtr.*			*4th Qtr.*		
	Oct. due Nov. 15	Nov. due Dec. 15	Dec. due Jan. 15	Jan. due Feb. 15	Feb. due Mar. 15	Mar. due Apr. 15	Apr. due May 15	May due June15	June due July15	July due Aug. 15	Aug. due Sept.15	Sept. due Oct. 15
Immediate: *Provide notice to NorthCare Network by calling 1-800-305-6564*	**Immediate reporting to the NorthCare Network SUD Services is required for the following:** **1. Immediate Notification Report for Sentinel Event or Critical Incident. *Residential Providers, only.*** **2. Immediate phone call when Federal Priority Populations Waiting List Exception occurs or 90% Capacity reached.** **3. Immediate Event Notification (NorthCare "newsworthy" Event)**											
Monthly: *"Federal Priority Pops Waiting List Exception Report" and "Capacity Management Report"*	**MDHHS required Monthly reports are done thru the PIHP Regional Entity where Facility is located. *However*,** please contact **NorthCare Network SUD Services immediately if your program does not have the capacity to serve a NorthCare Network funded SUD client according to timeliness Standards.** The NorthCare Network SUD Services (NORTHCARE SUD SERVICES) may be able to assist in meeting client's request to see another Provider within timeliness guidelines.											

List of Definitions

Access system-Provides prompt, responsive, timely and easy access to specialty services and supports for all beneficiaries. The access system functions as the front door for obtaining behavioral health services and they provide an opportunity for callers with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood and provided with options including treatment and provider options. The Access system is available, accessible and welcoming to all individuals on a telephone and walk-in basis.

Admission – is that point in an individual's relationship with an organized treatment service when the intake process has been completed and the individual is determined eligible to receive services of the treatment program.

ASAM – refers to the American Society for Addiction Medicine. It is the medical association for Addictionologists. The members developed the patient placement criteria.

Care coordination – is the deliberate organization of client care activities between two or more providers/agencies/participants involved in a client's care to collaboratively facilitate the appropriate delivery of clinically necessary services.

Case management – refers to a substance use disorder case management program that coordinates, plans, provides, 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 working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

CMHSP – stands for Community Mental Health Service Program. There are 5 in the Upper Peninsula; Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health.

Continued Service Criteria – is when, in the process of client assessment, certain problems and priorities are identified as justifying admission to a particular level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for continued service.

Co-occurring-Individuals who have at least one mental disorder as well as an alcohol or drug use disorder (SAMSHA). Use of the term carries no implication as to which disorder is primary and which is secondary, which disorder occurred first, or whether one disorder caused the other.

Critical Incident-Examples to be reported by residential providers: death of a recipient, injury requiring emergency room visit and/or admission to hospital, serious illness requiring admission to hospital, alleged case of abuse or neglect, serious challenging behavior, arrest and/or conviction, and medication error (MDHHS)

Cultural Competency – is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. It refers to the ability to honor and respect the beliefs (religious or otherwise), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such

services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Discharge summary – is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why.

Discharge/Transfer Criteria – is when, in the process of client assessment, certain problems and priorities are identified as justifying treatment in a particular level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and thus are used to determine when a client can be treated at a different level of care of discharged from treatment. Also, the appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for a discharge or transfer.

DSM-V – refers to the Diagnostic and Statistical Manual of Mental Disorders (5th Edition), developed by the American Psychiatric Association (APA). It is the standard classification of mental health disorders used by mental health professionals in the United States. It is intended to be used in SUD clinical settings by clinicians for determining behavioral health diagnoses that are part of the assessment and inform development of an individualized treatment plan with the medically necessary level of care.

DRA-Deficit Reduction Act established the Medicaid Integrity Program under Section 6034 of the Social Security Act, signed into law February 8, 2006. (CMS.gov)

Early Intervention – is a specifically focused treatment program including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence.

FASD- "Fetal alcohol spectrum disorders" (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drink alcohol during pregnancy. These effects may include physical, mental behavioral, and/or learning disabilities with possible lifelong implications (SAMHSA)

GAIN – The GAIN-I Core will be the exclusive assessment tool required by MDHHS as of 10/1/2019. Transition to this assessment tool is in process.

HMP-Healthy Michigan Plan – health care coverage for individuals who: are age 19-64 years, have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology, do not qualify for or are not enrolled in Medicare, do not qualify for or are not enrolled other Medicaid programs, are not pregnant at the time of application are resident of the State of Michigan (State of MI)

Interim Service Requirements-Services the Providers must supply in lieu of recipient admitted within the Admission Priority Requirements (MDHHS). Is a provisional service(s) provided while client is waiting for an appropriate level of care. Interim services must begin within forty-eight (48) hours for (1) injecting drug users who cannot

be admitted to formal treatment within fourteen (14) days and (2) pregnant women who cannot get into formal treatment immediately.
Length of service – is the number of days (for residential care) or units/visits/encounter (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.
Level of Function – is an individual's relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.
Level of Service – as used in ASAM Criteria, 3rd Edition, this term refers to board categories of patient placement, which encompass a range of clinical services such as early intervention, detoxification, or opioid maintenance therapy services and levels of care such as intensive outpatient treatment or clinically managed medium-intensity residential treatment.
MAPS – STANDS FOR Michigan's Automated Prescription Service. It is a web-based service to monitor prescriptions for individuals in Michigan.
MDHHS – Michigan Department of Health and Human Services
Medicaid Health Plans, or MHP's – are insurance companies who contract with the State to provide coverage for the physical health care and mild-moderate behavioral health care benefits of Medicaid enrollees
Medical Necessity – is the determination that a specific service is medically (clinically) appropriate and necessary to meet a client's treatment needs, consistent with the client's diagnosis, symptoms and functional impairments and consistent with clinical Standards of Care.
Non-urgent cases – are those clients screened for substance use disorder services but who do not require urgent (immediate) services.
Peer Recovery Associate-The name given to individuals who assist the peer recovery coach by engaging in designated peer support activities. These persons have been provided an orientation and brief training in the functional aspect of their role by the entity that will utilize them to provide supports. These individuals are not trained to the same degree as peer recovery coach.
Peer Recovery Coach-The name given to peers who have been specifically trained to provide advanced peer recovery support services in Michigan. A peer recovery coach works with individuals during their recovery journey by linking them to the community and its resources. They serve as a personal guide or mentor, helping the individual overcome personal and environmental obstacles.
Primary Care Coordination-Substance use disorder treatment services must be coordinated with primary health care (MDHHS)
Recipient-Individual receiving services
Re-disclosure-Additional disclosure of information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom is pertains or as otherwise permitted by 42 C.F.R. Part 2 (Federal Regulation 42 C.F.R. Part 2)
Recovery- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA)
ROSC – refers to Recovery Oriented System of Care which describes a paradigm shift from an acute model of treatment to a care model that views SUD as a chronic illness. A

ROSC is a coordinated network of community-based services and supports that is person-centered and build over a period of month and/or years on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.
SAMHSA – stands for Substance Abuse and Mental Health Services Administration. It is the federal agency which oversees the funding to the states for substance use disorder and mental health services. It is a department within the U.S. Department of Health and Human Services.
SAPT – Substance Abuse, Prevention, and Treatment grant sometimes called a “block” grant. It is the community grant funding from SAMHSA for substance use disorder treatment and prevention services in the 50 states.
Support Services – are those readily available to the program through affiliation, contract or because of their availability to the community at large. They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.
Treatment – is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.