MID-STATE HEALTH NETWORK

SUBSTANCE USE DISORDER SERVICES PROVIDER MANUAL

Effective Date: October 1, 2016

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Date: February 1, 2017

MSHN
Mid-State Health Network

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PROVIDER MANUAL
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Welcome to the Mid-State Health Network (MSHN) substance use disorder (SUD) services provider manual. MSHN is pleased to be partnering with SUD prevention and treatment services providers that offer an array of services throughout MSHN's 21-county region. The purpose of this manual is to offer information and technical assistance regarding the requirements associated with provider contracted role(s). This manual is a referenced attachment to your contract for MSHN services and may be revised at any time.

MSHN utilizes the MDHHS-approved, 3-Year SUD Strategic Plan for Prevention, Treatment & Recovery, for FY 2015-2017. This plan identifies current priorities for SUD services within the region and may be found here: SUD Strategic Plan.

Governing Authorities and Prepaid Inpatient Health Plan (PIHP) Requirements

MSHN is under contract with the Michigan Department of Health and Human Services (MDHHS), with all the associated obligations and requirements for the use of public funds. As one of the 10 PIHPs in Michigan, MSHN has provider network management obligations including but not limited to, assurance of overall federal, state, and other compliance mandates, regional service array adequacy, and ensuring provider competency expectations are met in both professional enhancement and service delivery areas.
Key references for SUD services include:

- MSHN SUD Prevention Provider contract - Prevention Contract
- MSHN SUD Treatment Provider contract - Treatment Contract
- MSHN & MDHHS Contract FY 2017, SUD section, Attachment P.II.B.A., Substance Use Disorder Policy Manual - SUD Policy Manual
- MSHN Community Mental Health Service Programs (CMHSP)- Link to Region 5 CMHSPs
- MDHHS Office of Recovery Oriented Systems of Care (OROSC) policies & advisories - OROSC policies & advisories
- LARA - LARA Licensing, Certification, Training
- MDHHS, Medicaid Provider Manual, Chapter: Mental Health/Substance Abuse - Medicaid Provider Manual
- SAMHSA - SAMHSA mental and substance use disorders
- MDHHS Provider Qualifications Chart

Providers are expected adhere to all standards, requirements, and legal obligations contained in these referenced MDHHS guidance and requirement documents applicable to the specific services being purchased and provided. For efficiency, MSHN will highlight but will not duplicate, in entirety, the information found in the above-mentioned references. Providers are responsible for understanding, demonstrated through service delivery, the content pertinent to the scope of work identified in contract. MSHN will make every effort to inform SUD providers about policy, procedure, or other requirement change(s).

For convenience, MSHN has policies and procedures posted on the MSHN website here: MSHN policies & procedures. Applicable MSHN policies and procedures for SUD providers include, but are not limited to:

- Advance Directives
- Behavioral Health Recovery Oriented System of Care
- Compliance and Program Integrity
- Confidentiality and Notice of Privacy
- Conflict of Interest Policy
- Credentialing and Re-Credentialing
- Credentialing: Background Checks and Primary Source Verification
- Credentialing: Monitoring
- Credentialing: Suspension and Revocation
- Critical Incidents
- Cultural Competency
- Evidence-Based Practices
- Income Eligibility for MSHN Benefits (Policy & Procedure)
- Medicaid Beneficiary Appeals/Grievances
- Medicaid Information Management
- MSHN's Corporate Compliance Plan
- Monitoring and Oversight
- Provider Appeal Procedure for Substance Use Disorder (SUD) Providers
- Provider Network Management
- Quality Management
- Recipient Rights
- Record Retention
- Service Philosophy, Access System
- Service Provider Reciprocity
- SUD Services – Women's Specialty Services (Policy & Procedure)
- Use of Public Act 2 Dollars

MSHN's governing Board of Directors (BOD) includes representation from each of the 12 Community Mental Health Service Programs (CMHSP) in the region. The BOD has policy and fiduciary responsibilities for all contracts with MDHHS including SUD administration and services. Additionally, and as required by statute, the MSHN PIHP region has an SUD Oversight Policy Board (OPB), whose members represent each of the 21 counties in the region. The list of these board members can be found on the MSHN website, along with a calendar of regional meetings at MSHN OPB. The OPB is an advisory to the BOD and serves as the authority for approving use of Public Act 2 funds.

MSHN welcomes the opportunity to enhance SUD partnerships and appreciates feedback regarding SUD services. Please contact MSHN staff to share knowledge, concerns and/or expertise.

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MSHN Departments & Contact Information

Click here for Contact Information

CareNet Support:

- Incorrect admission, discharge, assessment dates were entered and need to be fixed/edited
- An incorrect client ID number was entered and needs to be fixed/edited
- A client record was entered into CareNet that should not be in CareNet
- Assistance with the demographic, payor or financial screens
- If during CareNet processes the user receives a message to "call the CA"
- Help generating a report

For these CareNet and other UM questions, please email UM@midstatehealthnetwork.org or call toll-free: **844-405-3095**
Please contact MSHN's Business Analyst for the following specific CareNet issues:

- User access, user deactivation, and user password reset
- A service was billed and the user cannot get the service added/accepted into CareNet
- To add clinicians to the CareNet Clinician list (for billing purposes)

For these and other CareNet IT questions, MSHN's business analyst can be reached at: linda.proper@midstatehealthnetwork.org

For additional details regarding utilization management, the **UM Provider Manual** is available in **Appendix A** of this manual.

Claims: Please contact the claims department for billing inquiries and for the submission of Explanation of Benefit forms at claims@midstatehealthnetwork.org. Please note for billing issues that require action to services submitted, providers should use the CareNet note system.

Customer Service and Recipient Rights: Customer Service staff operates as the front door of the Pre-Paid Inpatient Health Plan (PIHP) and are available to assist beneficiaries and stakeholders with their questions and concerns. This includes providing information regarding the services and benefits available including how to access services, handling individual complaints and grievances in an effective and efficient manner, and tracking and reporting patterns of problem areas for the organization.

The Customer Service Department is open Monday – Friday, 8:00 am to 5:00 pm to assist with any type of complaint/grievance, local appeal, Medicaid Fair Hearing, recipient rights, and compliance issues. Calls should be directed to the Customer Service & Rights Specialist at (517) 657-3011 or toll free at (844) 405-3094.

Finance: For finance matters not related to Claims Processing, please contact MSHN's Chief Finance Officer at Leslie.Thomas@midstatehealthnetwork.org or Financial Manager Amy.Keinath@midstatehealthnetwork.org. This may include items such as budgeting questions, payment frequency, and Financial Status Report (FSR) submission.

Prevention: MSHN's Prevention Specialists are available to assist with SUD Prevention Provider needs, including but not limited to: county prevention coalitions, prevention-initiatives, professional and other trainings, Michigan Prevention Data System, etc. The prevention specialists are specific to parts of the region: MSHN-South, MSHN-West, and MSHN-East. Please contact the prevention specialist in your part of the region to address any needs or concerns or call (517) 253-7552.

Provider Network: Please contact the Director of Provider Network Management Systems or the Contract Manager at 517.253.7525 for questions and feedback related to contract questions including amendments and service agreements; credentialing and re-credentialing processes; the network provider directory; provider communication systems; the provider appeal process; network expansion; the site review process. You may also find information related to provider qualifications and credentialing by visiting our credentialing webpage.

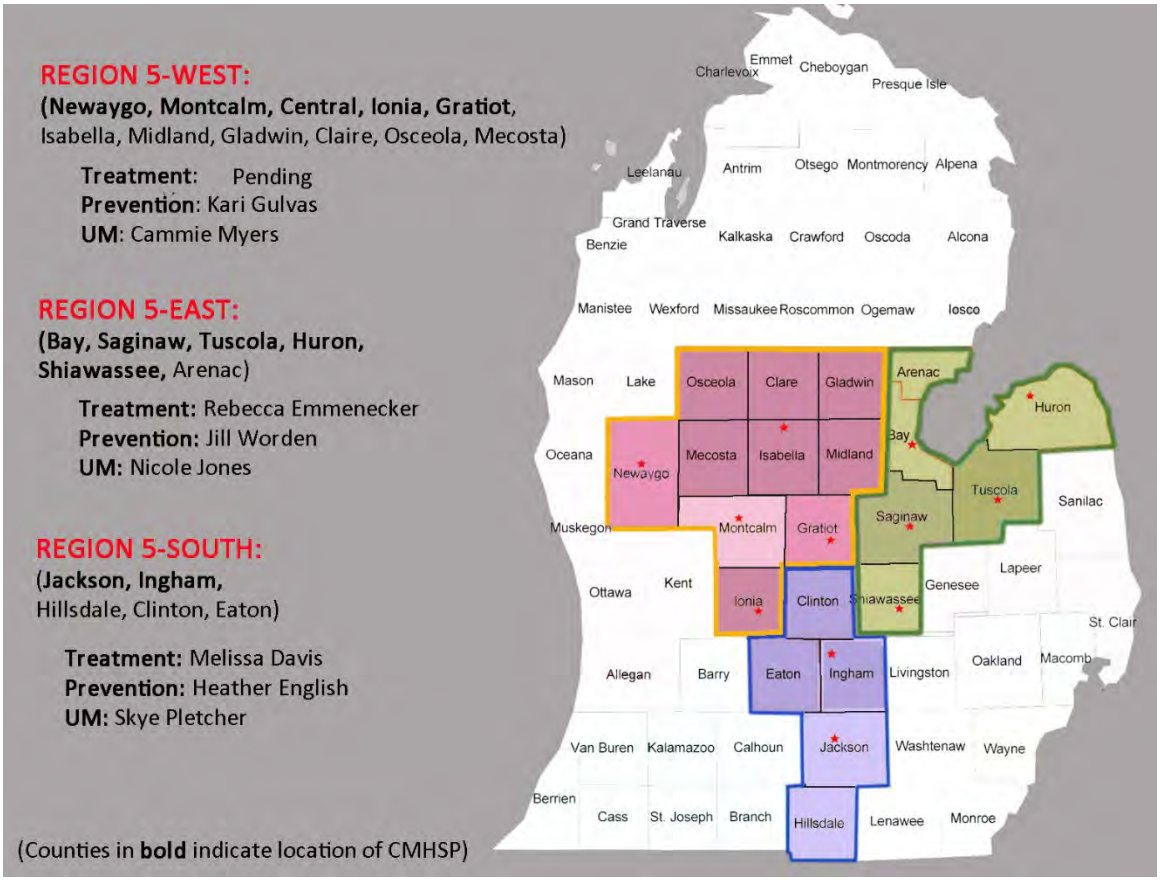
Reporting Requirements: The PIHP shall collect required reports as identified in provider contracts. Refer to the contract for a list of report due dates and point of contact. Reporting requirements are subject to changes based on state and federal requirements.

Treatment: MSHN's Treatment Specialists are available to assist treatment providers with questions pertaining to treatment programming, such as new program proposals, program enhancement, etc. Treatment Specialists also can assist with development of women's specialty services designation/enhancement, training needs related to treatment, community collaboration efforts. The treatment specialists are specific to parts of the region: MSHN-South, MSHN-West, and MSHN-East. Please contact the treatment specialist in your part of the region to address any needs or concerns or call (517) 253-7552.

Utilization Management: The Utilization Management (UM) team is dedicated to providing prompt, professional, and helpful support to the treatment provider network. UM has established consistent practices based on commonly accepted medical necessity criteria in alignment with the Office of Recovery-Oriented Systems of Care (OROSC) prevention and treatment policies, which are designed to benefit eligible consumers across the MSHN region. The UM specialists are available Monday through Friday from 8am-5pm via telephone and email. Each UM Specialist is assigned to specific counties located within the MSHN Region and can provide program-specific and location-specific support in addition to the areas of general assistance addressed above. The following is meant to give a general overview of common UM-related questions:

- Consumers seeking information about their SUD treatment benefits
- Consumers seeking access to SUD treatment
- Providers who need assistance referring a consumer to a different SUD provider
- Residential provider seeking information about outpatient treatment providers in a client's home community for purposes of discharge planning
- Questions or requests for assistance regarding CareNet authorizations
- Questions or requests for assistance regarding CareNet Admission or Discharge Records
- Questions related to the use of CPT and HCPCS codes

Map of MSHN's Regional Teams



Definitions

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.

AMS refers to the Access Management System which is required by the Michigan Department of Health and Human Services (MDHHS) to screen, authorize, refer and provide follow-up services.

ASAM refers to the American Society for Addiction Medicine. It is the medical association for Addictionologists. The members developed the patient placement criteria, the most recent of which is *The ASAM Patient Placement Criteria*, *3rd Edition*.

ASI refers to the Addiction Severity Index, a semi structured interview designed to address seven potential problem areas in clients with substance use disorders and to determine level of care.

Assessment includes those procedures by which a qualified clinician evaluates an individual's strengths, weaknesses, problems and needs including SUD diagnoses, and determines priorities so that a treatment plan can be developed.

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.

CareNet is the web-based data system used by MSHN for collection of state and federal data elements, PIHP performance indicators, utilization management (authorization of services), and reimbursement.

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 substance use disorder case management program offers these services through designated staff 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. MSHN has 12 CMHSP partners each of which has a role in being a potential door for clients to access SUD services.

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.

Continuum of Care refers to an integrated network of treatment services and modalities, designed so that an individual's changing needs will be met as that individual moves through the treatment and recovery process.

Co-Occurring Disorders are concurrent substance-related and mental disorders. Use of the term carries no implication as to which disorder is primary and which secondary, which disorder occurred first, or whether one disorder caused the other.

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 or 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 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.

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. (The ASAM Criteria, 3rd Edition Level .05 Early Intervention)

Encounter is used for billing purposes related to treatment services, recovery support, and early intervention services to indicate a measure of time spent providing a service with a consumer. A minimum of fifteen (15) minutes must be spent with a consumer in order to use this code for either recovery support or early intervention services. No more than one encounter may be billed per consumer within any twenty-four (24) hour time period.

Episode of Care is the period of service between the beginning of a treatment service for a drug or alcohol problem and the termination of services for the prescribed treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for termination. For reporting purposes, "completion of treatment" is defined as completion of all planned treatment for the current treatment episode.

Health Care Eligibility/Benefit Inquiry (270) is used to inquire about the health care eligibility and benefits associated with a subscriber or dependent.

Health Care Eligibility/Benefit Response (271) is used to respond to a request inquiry about the health care eligibility and benefits associated with a subscriber or dependent.

HMP refers to Healthy Michigan Plan, Michigan's Medicaid expansion program which became effective on April 1, 2014, to serve newly enrolled persons. HMP expanded the array of services available for persons with substance use disorders in need of treatment.

Individualized Treatment is treatment designed to meet a particular client's needs, guided by an individualized treatment plan that is informed by the individual client's assessment and his/her particular strengths, needs, and diagnostic areas.

Intensity of Service is the scope, type, and frequency of staff interventions and other services (such as consultation, referral or support services) provided during treatment at a particular level of care.

Interim Service 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 (i) injecting drug users who cannot be admitted to formal treatment within fourteen (14) days and (ii) pregnant women who cannot get into formal treatment immediately.

Length of Service is the number of days (for residential care) or units/visits/encounters (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.

Level of Care as used in *The ASAM Criteria, 3rd Edition*, refers to a discrete intensity of clinical and environmental support services bundled or linked together and available in a variety of settings.

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. The website is MAPS.

Matching is a process of selecting treatment resources to conform to an individual client's needs and preferences, based on careful assessment. Matching has been shown to increase treatment retention and thus to improve treatment outcome. It also improves resource allocation by directing clients to the most appropriate level of care and intensity of services.

MDHHS refers to the Michigan Department of Health and Human Services (MDHHS) which in 2015 was formed from the merger of the Michigan Department of Community Health (MDCH) with the Department of Human Services (DHS).

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 means 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.

Michigan Prevention Data System, or MPDS, is the State's web based data system that captures all direct funded prevention services and specific recovery based services and community out-reach services.

Non-urgent cases are those clients screened for substance use disorder services but who do not require urgent (immediate) services.

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

Program is a generalized term for an organized system of services designed to address the treatment needs of clients.

Readiness to Change refers to an individual's emotional and cognitive awareness of the need to change, coupled with a commitment to change. When applied to addiction treatment and particularly assessment Dimension 4, "Readiness to Change" describes the individual's degree of awareness of the relationship between his or her alcohol or other drug use or mental health problems, and the adverse consequences of such use, as well as the presence of specific readiness to change personal patterns of alcohol and other drug use.

Recognize, Understand, and Apply is the distinction that the criteria made between an individual's ability to *recognize* an addiction problem, *understand* the implications of alcohol and other drug use on the individual's life, and *apply* coping and other recovery skills in his/her life to limit or prevent further alcohol or other drug use. The distinction is in the difference between an intellectual awareness and more superficial acknowledgement of a problem (recognition) and a more productive awareness of the ramifications of the problems for one's life (understanding); and the ability to achieve behavior change through the integration of coping and other relapse prevention skills (application).

Recovery means a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. SAMHSA states Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.

RISC means Recovery and Integrated Services Collaborative, a regional effort to embed recovery-oriented systems of care (principles and practices) throughout the service providers network. Collaborative effort of substance use and mental health providers. Comprised of prevention providers, treatment providers, community members, and individuals in recovery.

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 builds over a period of months 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 stands for 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.
Stages of Change means assessing an individual's readiness to act on new healthier behavior while providing strategies or processes of change to guide the individual to action and maintenance. Stages of Change include:

- *Pre-contemplation*: "People are not intending to take action to change behaviors in the foreseeable future, are most likely unaware that their behavior is problematic, and are not considering change at this stage."
- *Contemplation*: "People have become aware that a problem exists, may be beginning to recognize that their behavior is problematic and that they should be concerned, start to look at the pros and cons of their continued actions, but are typically ambivalent about their use and changing their behavior."
- *Preparation*: "People understand the negative consequences of continued behavior outweigh any perceived benefits, are intending to take action in the immediate future, may begin specific planning for change, setting goals, and making a commitment to take small steps towards change."
- *Action*: "People have chosen a strategy for change and are actively pursuing it by making specific, overt, and drastic modifications in their life style (significant challenges for the person), and positive change has occurred."
- *Maintenance*: "People are working to sustain positive change, prevent relapse, become aware of situations that will trigger negative behavior, and actively avoid those when possible" a stage which can last indefinitely."

Support Services are those readily available to the program through affiliation, contract or because of their availability to the community at large (for example, 911 emergency response services). 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.
Transfer is the movement of the client from one level of service to another, within the continuum of care.
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.
Urgent cases are those clients screened for substance use disorder services (i.e. pregnant women) and must be offered treatment within 24 hours.

Access and Authorizations

Automated Request Processing (ARP)

MSHN may elect in some circumstances to use an automated request processing for service authorizations with providers. In these cases, an Initial and Re-authorization Request by a provider may be automatically approved unless one or more of the following exists:

- There are four or more outpatient treatment admissions within a year before the request begin date, across all Providers.
- The request contains services for Residential CPT codes: H0018 or H0019.
- The request contains more than one unit of CPT code H0001 or H0001 with the following modifiers: HA, HD, and HH.
- There is more than one unit of H0001, with or without modifiers, requested and/or paid and adjudicated for the client within the past 180 days across all providers.
- The Military Service field is marked 'yes' on client's most recent admission at the requesting Provider.
- The request is a 4th authorization request for detox services, and client has 3 admissions for detox services in the last 12 months.
- The request indicates that the client's income "exceeds eligibility guidelines."
- The request contains a combination of the following codes: H0010 (Medically Monitored Detox), H0012 (Clinically Managed Detox), H0018 (Residential Stabilization), H0019 (Long-term Residential) with or without modifiers.
- There are more than 180 days in the requested date range (outpatient).

If an Authorization Request fails to meet any one criterion from the list above, the request will not be automatically approved by the system, and will be sent to the Access Management Center for their review, in the same manner as if the Automated Request Processing (ARP) function was not in place.

If an Authorization request is automatically approved by CareNet, the system will insert a note into the Authorization record in the Authorization Comments section that reads, "System Message: Request was automatically approved". The date and time will display. In addition, a "stamp" will appear on the client's authorization history screen for that particular approved authorization which indicates "Auto-Approved" in the Status column.

Conversely, if an authorization request fails to meet any of the Automated Request Processing criteria and was not automatically approved, the system will insert a note into this record, in the "Request Comments" section, noting that the request was not automatically approved.

Capacity

The treatment provider will notify MSHN in the event there are any capacity limitations and/or any inability to accept new referrals. It is also the provider's responsibility to notify MSHN of any change in occupancy or service capacity relevant to their MSHN contract scope of work for SUD services. MSHN may elect to seek or add providers to the regional panel to meet existing or new needs of consumers at any time. All providers are required to submit the monthly Capacity Waitlist Report, regardless of the status.

Providers may be interested in MSHN's publication, *Assessment of Network Adequacy*, which is updated on an annual basis and is available on MSHN's website here: Network Adequacy Assessment.

CareNet "Notes"

CareNet has a tab where providers can document coordination of care that has taken place with other providers involved in that consumer's treatment (with appropriate release of information). Providers can also use this tab to record important clinical information about the consumer that may have changed since the last authorization and would be relevant for the UM team to know when reviewing future authorization requests.

Communicable Disease

MSHN adheres to requirements for communicable disease as described in the OROSC Prevention *Policy #2: Addressing Communicable Disease Issues in the Substance Abuse Service Network.*

All MSHN funded treatment programs must have a procedure in place for all clients entering their programs for treatment stating individuals will be appropriately screened for risk of Tuberculosis, Hepatitis B and C, Sexually Transmitted Infections (STIs and HIV). Minimally the procedure is to include:

- A high risk screening check list to be completed by the client and reviewed by appropriate staff to determine if a referral for testing in necessary based on risk exposure and to provide information regarding available resources if already infected.
- A protocol for accessing Hepatitis C testing for all clients with a history of IDU.
- A protocol for accessing STI (including Chlamydia) and HIV testing for all pregnant women presenting for treatment.
- A requirement for staff to follow-up to ensure that clients who are referred receive such services.
- For Residential Programs only**,** all clients entering residential treatment will be tested for Tuberculosis upon admission.

All funded programs will meet state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR Part 2 and Confidentiality of HIV/AIDS Information.

Health education and risk reduction education for at-risk clients must be provided at the treatment provider's site or referred to the local public health department. Follow-up must be monitored and documented in the client's record.

It is important for all staff working in a substance use disorder treatment program to have at least a minimum knowledge of communicable disease. Knowledge standards are expected to be consistent with the roles and responsibilities of program and clinical staff. Minimum standards are listed in the OROSC Policy under Minimum Knowledge Standards for Substance Abuse Professionals – Communicable Disease Related. Appropriate training for new staff is to be

completed within the first three (3) months of hire with updated training every two (2) years thereafter. Approved training can be located on the Improving MI Practices website at: Improving Practices. Documentation of completion of initial training is to be kept in each employee's record as well as documentation of updated training.

MSHN will monitor compliance with this requirement with review of contractor employee records during annual quality assurance site review and is subject to ad hoc review at any time.

Confidentiality & Privacy

MSHN contracted SUD treatment providers shall comply with the Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 – Privacy Standards (45 CFR Parts 160 and 164). MSHN requires provider compliance with all federal and state confidentiality and privacy laws.

42 CFR Part 2 – Federal Drug And Alcohol Confidentiality Law - 42 U.S.C. Section 290dd-3, 290ee-3 for Federal laws and 42 C.F.R. Part 2 for the Code of Federal Regulations is the law that protects client records and status within the context of SUD treatment. Generally, the program may not acknowledge to anyone outside the program that a client attends a program, or disclose any information identifying a client as an alcohol or drug abuser without a written signed release unless:

- The disclosure is allowed by a special court order; or
- The disclosure is made to medical personnel in a medical emergency;
- The disclosure is made to qualified personnel for research, audit, or program evaluation;

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. SUD Providers are mandated reporters of suspected child abuse or neglect and thus federal law and regulations do *not* protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. For additional information, see here: Mandated Reporting of Abuse/Neglect.

45 CFR Parts 160 and 164 – HIPAA Privacy - In conjunction with the protections under 42 U.S.C. and 42 CFR, all clients have all their personal health records protected under HIPAA, 45 CFR. The client record contains information that under HIPAA is called Protected Health Information or PHI.

The Privacy Rule defines PHI as individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity that is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse.
Some elements that are considered PHI include, but are not limited to: name, address (including street address, city, county, zip code and equivalent geocodes), name of relatives, name of employer, all dates (including birth, death, date of service, admission, discharge, etc.), telephone

numbers, fax number, social security number, health plan beneficiary number, account numbers, certificate/license number, any vehicle or other device serial number, web Universal Resource Locator (URL), Internet Protocol (IP) address number, finger or voice prints, and photographic images.

Continuing Education

MSHN providers are expected to maintain and stay up-to-date on all trainings required by their licensure and/or accreditation. All contracted/subcontracted providers are responsible to ensure that staff members involved in direct service delivery meet and maintain all continuing education requirements for needed credentials.

Cultural Competency

The Federal Register provides National Standards for Culturally and Linguistically Appropriate Services. It is critical that MSHN provider network members strive toward cultural competency for all persons from diverse cultural backgrounds in our communities who are in need of accessing SUD treatment and prevention services. Cultural response includes removing barriers and embracing differences, in order to offer safe and caring environments for all who are in need of services.

Cultural competency can be defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program, or among individuals which enables them to work effectively cross-culturally. Further, it refers to the ability to honor and respect the beliefs (including religious), 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, according to the National Center for Cultural Competency.

It is the expectation that each SUD prevention/treatment provider will have applicable policies and training of staff relative to cultural competency and available to MSHN for review, including governance and practitioners providing treatment. MSHN expects that providers will demonstrate training competencies to support a diverse population of clients served and seek to establish a diverse workforce to meet client needs. MSHN will endorse a variety of methods to help ensure cultural competency, including recognition in the regional strategic plan and other support as indicated.

Assessment tools and/or methods used must be culturally sensitive, reliable, and validated, whenever possible, for use with racial and ethnic minorities. Service/support/treatment plans and discharge plans must incorporate the natural supports and strengths specific to the racial and ethnic background of the client, family, community, faith-based, and self-help resources. Prevention, education and outreach efforts will include linkages with racial, ethnic, and cultural organizations throughout the community

Customer Service

MSHN is responsible to ensure appropriate customer services to meet client and provider needs, including but not limited to resource information and referrals. MSHN and providers will collaborate to meet any special needs of any client, including but not limited to those who have hearing or vision impairments, those who need written or oral interpreter services, those who have limited English language proficiency, or clients who need any other special accommodation to receive needed SUD treatment. Customer services is an important aspect of assuring that persons needing SUD treatment have information about how to access and/or be assessed for SUD treatment, as well as other relevant community resources to meet potential client and other community representatives or citizens' informational needs.

Documentation & Records

MSHN adheres to MDHHS's General Schedule #20 – Community Mental Health Services Programs' Record Retention and Disposal Schedule, located at: MDHHS Records Disposal. MSHN's policy regarding record retention is located at: MSHN Records Retention Policy.

All services, such as, assessments, treatment planning, referrals, progress notes, discharge planning and all other content relative to service delivery must be properly documented in CareNet as well as the provider's SUD treatment/medical record by properly credentialed clinicians and linked to an individualized treatment plan. All progress notes must be signed and any clinicians under a professional development plan must have notes co-signed by a properly credentialed and authorized supervisor.

All records are subject to audit by MDHHS or MSHN, including event verification as required for federal Medicaid compliance. MSHN and providers could also be subject to federal audit relative to the use of Medicaid funds. Secure storing of records must meet requirements for privacy, security and retention, including any electronic records.

Destruction of records needs to follow the policy and retention and disposal schedule listed above. Disposal must be properly executed with cross-cut shredding or other such proper disposal under the supervision of an authorized person. Requests for client records from legal contacts or other entities as well as FOIAs should be coordinated with MSHN prior to release.

Discharge Planning

MSHN requires that effective discharge planning will be provided for clients, and that follow-up services meet contractual and regulatory requirements.

Discharge Planning is considered an integral part of SUD treatment. Consideration of the continuum of care and long term recovery needs of the client will be considered at every step of treatment planning. Discharge planning provides improvements to the quality of care and improves outcomes and controls cost, by assuring coordination and collaboration with mental health, SUD and other health providers to fully address the needs of the client. It is critical that all providers and organizations serving a client act together to develop an integrated health aftercare plan and then implement this ongoing aftercare plan in an environment that eliminates barriers and duplication of services.

Discharge Planning will occur according to best practices and the provider organizations' admission and discharge policies:

- A review of a client's discharge plan for all levels of care will be completed to ensure that appropriate follow-up care is arranged for those ending treatment.
- A written Discharge Plan will be prepared to ensure continuity of service and will be distributed to parties involved to carry out the plan.
- The MSHN contracted provider network will ensure that all clients are appropriately discharged from their care, including entering a discharge into CareNet.
- Aftercare services are incorporated into the treatment plan, and needs are identified and addressed in the discharge plan.
- Follow up SUD treatment services from a detox and or residential facility will be completed not more than seven (7) days after discharge.
- Consumer satisfaction surveys should be distributed to the clients at discharge.

Employee Confidentiality

MSHN will protect the confidentiality of the SUD treatment service clients and their records as provided by law. Every contracted/sub-contracted program staff member involved in MSHN funded work is expected to read and abide by the provisions of the MSHN standards of conduct for confidentiality and privacy. Contracted/Sub-Contracted Providers will utilize the standard form provided by MSHN.

- Every staff member will sign an employee confidentiality and/or privacy statement at time of employment;
- A signed copy of the statement will be placed in the staff personnel file;
- A review of the confidentiality policy will be provided annually to the staff; and,
- A new, signed confidentiality/privacy form will be obtained from each staff member annually.

General Business Requirements

Providers are responsible to ensure all provision of services are in compliance with local municipality and state and federal business requirements, including business records, reporting, and adherence to all relevant statutes. Providers must be in compliance with all applicable standards and expectations from the most current *MDHHS Substance Use Disorder Services (SUDS) Program Audit Guidelines,* which include single financial audit requirements for providers in receipt of federal funds above a $750,000 level in a fiscal year.

Healthy Michigan Plan (HMP)

The Healthy Michigan Plan (HMP) effective April 1, 2014 in Michigan has served to expand SUD services to newly enrolled persons, and has also expanded the array of services available under this new benefit for persons with substance use disorders in need of treatment. MSHN will be seeking to continue to expand defined services under this benefit to support clients (eligible enrollees/beneficiaries) with substance use disorders, according to published Medicaid Manual parameters.

Integrated Coordination of Care

MSHN expects providers will collaborate and coordinate services with other care providers as appropriate after completing a comprehensive assessment of needs. Individuals living with substance use disorders often have one or more physical health problems such as lung disease, hepatitis, HIV/AIDs, cardiovascular disease and cancer and mental health disorders such as depression, anxiety, bipolar disorder and schizophrenia. Research indicates that persons with substance abuse disorders have a:

- 9 times greater risk of congestive heart failure
- 12 times greater risk of liver cirrhosis
- 12 times the risk of developing pneumonia

Substance use disorders also complicate the management of other chronic disorders. Individuals with addictions and co-occurring physical illnesses may require health care that includes multiple healthcare providers, including SUD providers and primary care providers. The integration of primary and addiction care can help address the interrelated physical illnesses, improve health outcomes and improve coordination of care by reducing the back-and-forth referrals between behavioral health and primary care offices. Efficacy of new medications for the treatment of substance use disorders give providers new tools to fight addiction by expanding the range of treatment options for individuals with alcohol and drug addictions. By helping individuals achieve and sustain recovery, primary care providers can improve treatment for chronic conditions such as diabetes, asthma and hypertension and support the efforts of SUD treatment providers.

MSHN also expects SUD treatment providers to coordinate care with a consumer's previous and current behavioral health treatment providers. Coordination of care should include the consumer's primary care physician (PCP) and if the consumer does not have one, efforts should be made to link the consumer to a PCP wherever possible. Providers should maintain documentation of coordination of care between other behavioral health care providers and physical health care providers.

Coordination of care is expected to occur with every client and will be comprehensive and based on the client's individual needs. It may include, but is not limited to; legal, dental, transportation, education, employment, and any other areas of need.

Attributes of integrated care for addiction providers with primary care are:

- Self-management and recovery support: A person actively partners with their health care professional(s) to manage their health and recovery, working to maintain recovery and wellness by setting goals to change behaviors.
- Person-centeredness: A person's health care is self-directed and based on a partnership between the individual and a team of providers, and when appropriate, the individual's family. The provider works to ensure that treatment decisions respect the person's wants, needs and preferences. The person receives education and support in engaging in their care and making healthcare related decisions.

- Delivery system design: A team manages healthcare delivery that encompasses a collaborative approach with an expanded scope of provider types who have clearly defined roles.
- Clinical decision support: Treatment services and provider processes embrace evidence-based clinical guidelines.
- Clinical information systems: Information sharing systems identify relevant treatment options and other data on individuals and populations.
- Community resources: Relationships with other community resources (e.g. housing, employment) help support and meet individual's needs and preferences.

MSHN supports the promotion of the 8 dimensions of wellness from SAMHSA: emotional, financial, social, spiritual, occupational, physical, intellectual and environmental.

Medicaid Recipients with other Primary Insurance

MSHN will authorize Medicaid payment of services only after all other active insurances have been billed and/or denied. Medicaid recipients who have any other insurance code either listed on the Medicaid Card or, indicated through 270/271 information, or have coverage through Medicare Part B, Medicare is the primary insurance for SUD treatment and these clients must be transferred into a program that has an authorized Medicare provider.

For Medicaid recipients who have insurance other than those listed above, the primary insurance must be billed for SUD treatment coverage prior to billing Medicaid. These client services will not be authorized or paid by Medicaid funding until all other insurance coverage has been exhausted. Providers can contact Third Party Liability to notify MDHHS of any changes to third party insurance coverage here: Medicaid Coverage page.

Medicaid Verification/Reimbursement

The provider, upon admitting a client record into the CareNet system, must have the Medicaid card and perform a 270/271 eligibility check. Each month, while the client is in the program, the provider must check for a current Medicaid card and/or perform an eligibility check verifying coverage. If the copy or a 270/271 check has not been performed, reimbursement may be delayed and any re-authorization requests may be pended until the issue is resolved.

Providers are responsible to determine a client's Medicaid or HMP eligibility verification at the time of admission. Providers will perform monthly Medicaid or HMP eligibility verification checks and have the report placed in client's chart with a copy of the insurance card or perform a 270/271 eligibility check. It is the provider's responsibility to verify if there has been a change of coverage if the client has third party insurance coverage, Medicaid, or HMP eligibility prior to authorization.

Retrospectively, if it is determined that the client was NOT covered by Medicaid during the service period, the claim may be rejected and the provider notified. It is then the responsibility of the provider to notify the Access Management System and follow the established policy/procedure for obtaining payment under the Community Grant program (Block Grant).

Providers may be requested to assist clients or MSHN in submitting evidence of client disability and/or treatment provision or cost, in order to obtain and maintain benefit eligibility, including justification for ongoing Medicaid deductibles.

Since federal regulations are specific regarding billing for Medicaid, HMP, or a portion of federal community (block) grant funds, and eligibility requirements change from month to month, active eligibility in Medicaid, HMP, or other third party insurance plans must be verified on a monthly basis and filed in the consumer's chart or an eligibility check should be performed.

Notification of Closure

If a provider is ending its service contract with MSHN or is closing a program for any reason, the provider must notify MSHN and its clients of the intent to close no less than 30 days before the closure of the program. Each client, as coordinated with the responsible MSHN contact, will be notified in writing of:

- Date of closure.
- Directions regarding obtaining continued treatment.
- Where their records will be transferred.
- How to obtain information from their records.
- Procedure for transferring their records.
- The need for a signed release of information prior to the transfer of records.

The provider closing will notify MSHN of the client's needs and choices through weekly review and/or CareNet, and MSHN may ask the provider to assist the client with transfer to another treatment provider.

Providers who offer SUD services must have a mechanism to notify clients in a reasonable manner regarding unexpected program or site closure, such as due to inclement weather, building damage, etc.

Performance Indicators

MSHN Providers are responsible to meet the timeliness standards for Medicaid and Healthy Michigan Plan in accordance with the most current Michigan Mission-Based Performance Indicator System PIHP Reporting Codebook, in which there are three (3) timeliness performance indicators as listed below:

- Indicator 2: The percentage of new persons during the quarter receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service (by five sub-populations**:** MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95%
- Indicator 3: Percentage of new persons during the quarter starting any needed on-going service within 14 days of a non-emergent face-to-face assessment with a professional ((by five sub-populations**:** MI-adults, MI-children, DD-adults, DD-children, and persons with Substance Use Disorders). Standard = 95% within 14 days
- Indicator 4b: The percentage of discharges from a sub-acute Detox unit during the quarter that were seen for follow-up care within 7 days. Standard=95%.

Other treatment performance measures may be defined specific to the contractor. Prevention provider specific outcomes will be delineated in the contract as appropriate.

Provider Authorizations & Claims

All treatment providers contracted for MSHN SUD services must use the internet-based information system known as CareNet, a product of Net Smart Technologies. CareNet is the mechanism for the provider network members to request authorization for SUD services for clients who meet admission criteria. CareNet also serves as a central location for collecting and analyzing data. MSHN has established authorized provider access to CareNet and offer a common CareNet platform for provider use in the region.

For providers needing to activate or deactivate users in CareNet, the forms are located on MSHN's website at SUD Providers page under the *CareNet Access Request* heading.

Mid-State Health Network anticipates deactivation will occur immediately following the completion of employment for any staff utilizing CareNet.

In all cases the treatment provider is responsible for entering demographic, financial, insurance, admission and authorization data into the CareNet system. CareNet includes screening, assessment, treatment and demographic information for all clients served.

The provider is responsible for the hardware and software requirements of:

- Commercial Internet Service Provider
- Internet Explorer 9.0 or higher
- Internet browser
- Windows 7 or higher based on operating system

The provider shall electronically submit a claim utilizing CareNet to request reimbursement for authorized services once provided. The provider will submit all the necessary information and support for all billed services. MSHN is the payer of last resort and the provider must be knowledgeable about and seek other payment options wherever appropriate. Questions about payment source should be directed to MSHN whenever necessary to ensure funded services are provided. Claims must be submitted in a timely manner based on the published schedule which is generally the 10th day of the next month following the service month. Claims for unauthorized services will not be paid by MSHN. Any determination of inappropriate use of funding may result in provider repayment to MSHN.

Provider Compliance

Providers will be subject to contract compliance and performance improvement plans from MSHN when contract expectations are not met or maintained, including but not limited to corrective action plans, repayment of funds, suspension of referrals or contract termination. Providers will be offered opportunity to correct non-compliance wherever reasonable, and sanctions will be issued in writing, commensurate with the level of non-compliance.

In addition, providers are expected to communicate any issues regarding non-compliance in a timely manner so MSHN can assist with developing and/or supporting appropriate responses.

The Compliance Officer for MSHN is:
Kim Zimmerman
Customer Service & Rights Specialist
Mid-State Health Network
530 West Ionia Street, Suite F
Lansing, Michigan 48933
Office: 517-657-3018
Fax: 517-253-7552
kim.zimmerman@midstatehealthnetwork.org

Provider Qualifications and Supervision

Provider qualifications and supervision requirements are outlined in the Medicaid Managed Specialty Supports and Services Program Manual available here: SUD Policy Manual. SUD treatment and prevention provider staff cannot provide services if they are not certified or do not have a registered a development plan with MCBAP Treatment staff in this situation must complete a Temporary Privileging Form. Master's level interns will also need to complete a Temporary Privileging Form.

Reimbursable Diagnoses

Services for clients with substance use disorders will be provided only for applicable and appropriate substance use disorder diagnoses as included in the DSM-5 (effective October 1, 2015). The SUD diagnosis must be the primary diagnosis for SUD funds to be used for payment of services provided. SUD diagnoses applicable for reimbursement are delineated in the CareNet system.

Recipients Rights for Substance Use Disorder Services

MSHN adheres to the 1981 Administrative Rules for Substance Abuse Programs in Michigan, Section R325.14301 to R325.14306 on Recipient Rights. MSHN has a Recipient Rights Policy and Procedure for the purpose of protecting the rights of recipients (clients) receiving SUD services from MSHN providers to comply with the 1981 Administrative Rules for Substance Abuse Programs in Michigan regarding recipient rights. This applies to all services provided for clients receiving SUD treatment, prevention, and recovery support services within the provider network.

Clients have the right to know about the services they are receiving, to make a complaint about a possible violation to those rights, and expect a resolution. The recipient rights process establishes a method in which if a client believes his or her rights have been violated, there is a known procedure to follow. The first step in this process is that the program director will designate one staff member to function as the program rights advisor. The rights advisor shall:

- Attend all of the Substance Abuse Licensing training pertaining to recipient rights.

- Receive and investigate all recipient rights complaints independent of interference or reprisal from program administration.
- Communicate directly with the Coordinating Agency Rights Consultant when necessary.

Rights of recipients should be displayed in a public place on a poster to be provided by MDCH. Brochures, rights, and posters are available at Recipient Rights Brochure. The Recipient Rights poster will indicate the designated rights advisor's name and telephone number.

The Recipient Rights Consultant for MSHN is:
Jeanne Diver
Customer Service & Rights Specialist
Mid-State Health Network
530 West Ionia Street, Suite F
Lansing, Michigan 48933
Office: 517-657-3011
Fax: 517-253-7552
Jeanne.diver@midstatehealthnetwork.org

Service Codes & Rates

Fee for service payment rates, by each service code, are included in each SUD treatment provider's specific contract as Attachment B. MSHN seeks to have common regional rates and consistent payment methodologies for providers in the region. MSHN expects funds to be used in accordance with relevant guidelines and to include supporting documentation. Rates are based on best value, competitive and comparable market information. Unless otherwise referenced directly in the contract with providers with specific codes, the reference for service codes is the *PIHP/CMHSP Encounter Reporting, HCPCS and Revenue Codes, Reporting Cost per Code and Code Chart* published by MDHHS, the most current version, located at: Service & HCPCS Codes.

Veteran's Services

Please see **Appendix B**, Veteran's Eligibility Technical Requirement, for full documentation on determining service coordination options for Veterans. MSHN expects Veterans within our 21 counties to be able to access SUD services. Providers should note that a client's service in the military does not automatically mean they receive Veteran's Affairs (VA) benefits. Providers should, however, work with clients to ensure VA benefits are used as primary insurance, *if available*. Eligibility for VA benefits are determined by the VA upon review of a Veteran's discharge paper (known as the DD-214). The Veteran may also use the following site for obtaining their DD-214 if it has been misplaced: Michigan Department of Military and Veteran's Affairs A Veteran may begin applying for health benefits by completing the Department of Veteran's Affairs form 10-10EZ, located here: 10-10EZ Form. The basic requirements for eligibility include, but are not limited to:

- Honorable or General Discharge from service.
- Veterans who enlisted after September 1980 must have 24 months of continuous service.
- National Guard and Reservists may also qualify for VA benefits if they were called to active duty (other than for training) by Federal order.
- Eligibility determination is based on each individual's service.

Also, for county Veteran's Affairs departments, complete an internet search by entering the county name and "veteran affairs." For example, "Ingham county Veteran's Affairs, results in an option to go to http://va.ingham.org/. The contacts can change and this will provide the most up to date information needed to proceed. County Veteran's Affairs offices are a good place to start with assisting a Veteran with applying for disability (if appropriate), connecting to local transportation, and financial resources. If there are any questions or concerns about helping veterans access services, please contact the MSHN utilization management team or MDHHS Behavioral Health and Developmental Disabilities Administration (BHDDA)'s veteran liaison, Brian Webb, who may be able to assist with access issues for veterans. He can be reached at 517-373-8209.

TREATMENT SERVICES

General Expectations

Providers should refer to the Michigan Medicaid Manual for complete descriptions of treatment services along with all relevant MDHHS and MSHN policies and references noted in this manual. MDHHS/OROSC policies referenced in this manual are located here: OROSC policies & advisories.

Evidence-Based Practices: MSHN requires all SUD treatment providers to document and provide evidence-based programs for their services. Treatment providers must demonstrate knowledge and competencies in practice relevant to service provision. Each provider is monitored at least annually with regular site visits to verify that the evidence-based programs are being provided with fidelity to the model and that staff and clinicians have the requisite training and qualifications for the practices in which they are engaging clients. Core elements of evidence-base practice include motivational interviewing, trauma-informed care and positive behavioral supports. Recognizing the stages of change for persons recovering from SUDs is an important component of evidence-based service provision. Providers should take steps to ensure fidelity to evidence-practice models, including sustaining fidelity when valid models and/or program staffing changes occur, which may require new training or credentials in maintain integrity of clinical service provision. MSHN reserves the right to endorse evidence-based practices in use by funded provider programs.

Co-Occurring Mental Health and Substance Abuse Disorders: Providers are expected to screen, all consumers, for co-occurring mental health and substance use disorders, at the point of access and throughout treatment.

- MSHN will provide continuous, comprehensive and individualized services to individuals with substance use and psychiatric disorders in a coordinated or integrated manner.
- MSHN provider programs will demonstrate competency in the provision of services for those who have co-occurring conditions. Programs that address mental health and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning are defined as Co-occurring Capable Programs.
- Acknowledging the high rate of co-occurrence of mental health and SUD symptoms, MSHN providers are expected to be building co-occurring capacity. It is the expectation of MSHN that all providers will be moving towards becoming fully co-occurring capable by self-

scoring the Dual Diagnosis Capability in Addiction Treatment (DDCAT), providing documentation, and scheduling an on-site review of the DDCAT by MSHN staff. Those items that fall below a "3" will require annual provider goals to work toward achievement. Further information on the DDCAT process may be obtained from the MSHN Treatment Specialist team.

Trauma Informed Care: A trauma-informed approach to behavioral health care shifts away from the view of "What's wrong with this person?" to a more holistic view of "What *happened* to this person?" This becomes the foundation on which to begin a healing recovery process. Employing a trauma-informed approach creates a place of safety and mutual respect where a person's whole history can be considered. This enables trauma survivors and providers to work together to find the best avenues for healing and wellness. A program, organization, or system that is trauma-informed follows SAMHSA's four "Rs" by:

- *Realizing* the widespread impact of trauma and understands potential paths for recovery
- *Recognizing* the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- *Responding* with fully integrated knowledge about trauma into policies, procedures, and practices
- Resisting *re-traumatization*

Trauma-specific services refer to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including mental health concerns and substance use) that developed during or after trauma. SAMHSA's six principles of a trauma-informed approach and trauma-specific interventions are designed specifically to address the consequences of trauma and to facilitate healing. These principles include:

- *Safety*—Throughout the organization, staff and clients should feel physically and psychologically safe.
- *Trustworthiness and transparency*—Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members.
- *Peer support and mutual self-help*—Both are seen as integral to the organizational and service delivery approach and are understood as key vehicles for building trust, establishing safety, and empowerment.
- *Collaboration and mutuality*—There is true partnering between staff and clients and among organizational staff from direct care staff to administrators.
- *Empowerment, voice, and choice*—Throughout the organization, and among the clients served, individuals' strengths are recognized, built on, and validated, and new skills developed as necessary.
- *Cultural, historical, and gender issues*—The organization actively moves past cultural stereotypes and biases, considers language and cultural considerations in providing support, offers gender-responsive services, leverages the healing value of traditional cultural and peer connections, and recognizes and addresses historical trauma.

In addition to trauma-informed care, promoting recovery and resilience for those who have experienced traumatic events involves developing and implementing supports that specifically consider the event and trauma experienced. It also means examining ways to reduce re-

traumatization. Consistent with SAMHSA's working definition of recovery, trauma-informed services and supports build on consumer and family choice, empowerment, and collaboration.

Completion of Satisfaction Surveys**:** Completion of Short-term Outcome Evaluation identifying knowledge, attitude and behavior changes. For all programming outside of information dissemination, Providers must be able to demonstrate how they know the program was effective. (What were the goals of the program and were those goals obtained?). Development of a Performance Improvement plan, which incorporates evaluation outcomes, utilizing data to make program changes and identify how services impacted program goals and objectives.

Prohibition on Provision of Hypodermic Needles: Providers will assure that no federal, state or local public funds will be used to provide consumers with hypodermic needles or syringes enabling such consumers to use illegal drugs.

Case Management

MSHN adheres to requirements for case management as described in the OROSC *Treatment Policy #08: Substance Abuse Case Management Program Requirements*.

Case management services are those services which will assist clients in gaining access to needed medical, social, educational/vocational and other services, and can be an effective enhancement to intervention in the treatment of substance use disorders. This is especially true for clients with multiple disorders, who may not benefit from traditional substance use disorder treatment, who require multiple services over extended periods of time, and/or who face difficulty gaining access to those services. Case management can establish a stronger foundation for a client's recovery, reduce costs and enhance long term recovery for those who have addictive disorders, by assuring they have access to all needed services.

Core elements of case management include assessment, planning, linkage, coordination and monitoring to assist clients in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and supports developed through the individualized treatment planning process. Services are provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Case managers may follow clients as they progress through the continuum of care. Case management services may continue after discharge from treatment for up to six (6) months as stated in OROSC policy #8 and as authorized by MSHN. Case management services are not a case-finding activity as funded by MSHN but are supportive activities meant to enhance each client's long term recovery from an addictive disorder.

MSHN SUD treatment providers may determine the need for case management services during their assessment process or at any time during the treatment planning process. MSHN SUD treatment providers may determine and utilize a case management needs assessment of their own choosing as long as it meets the following guidelines: the assessment must be in a written format in the client record and must be incorporated into the client's treatment plan.

It is MSHN's expectation that **at a minimum, one (1) encounter per month is to be face-to-face** with the client. The frequency of case management encounters is to be determined by the individualized needs of the client based on the results of a needs assessment.

Case management services shall be available to *only* clients in MSHN funded SUD treatment system who are *not* eligible or served by case management through mental health, public health, or other community human service agencies.

Case management services shall be guided by each client's treatment plan which will incorporate case management goals and outcomes and is consistent with the individualized, coordinated, comprehensive treatment plan of service.

Case management service providers shall establish linkages with other agencies in the human services and community resources network for referral to ensure continued case management services beyond six (6) months after discharge, if necessary for the client.

The treatment record of clients receiving case management services must contain documentation for the determination of need for case management services, and case management activity notes indicating the following information:

- Date of contact and/or service;
- Duration of case management contact/services;
- Name of agency and/or person being contacted;
- Nature of case management services requested and extent of services requested; and/or
- Nature of case management services provided and extent of services provided;
- Place of service and/or referral.

Detoxification

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required.

Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and will not be meeting MSHN expectations for this service.

Expectations:
All clients entering residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.

Sub-acute detoxification is one component of a comprehensive SUD treatment strategy with detoxification as the beginning phase of SUD treatment.

- Sub-acute detoxification will be authorized as part of a planned SUD treatment episode, with the clinical pathway detailed in the authorization of services and explained to the client prior to admission into detoxification services.
- The sub-acute detoxification provider will facilitate and obtain follow up for the client's transfer to the next level of care.
- The sub-acute detoxification provider is to provide a safe withdrawal from the drug(s) of dependence and enable the client to become drug free.
- The sub-acute detoxification is to be provided in a supportive environment, with caring staff, sensitivity to cultural issues, confidentiality, and selection of appropriate detoxification medication (if needed) in order that the withdrawal is humane and protects the client's dignity.
- The sub-acute detoxification provider is to prepare the client for ongoing SUD treatment of his/her substance use disorder by emphasizing detoxification is the beginning phase of SUD treatment, not a treatment modality in itself. Detoxification is an opportunity to offer clients information and to motivate them for longer term treatment.

Clients in sub-acute detoxification may begin to attend treatment programming depending on their ability to participate. If the sub-acute detoxification provider will continue SUD treatment in either stabilization or long-term residential, full participation should begin *no later* than the third day of admission. If it is determined the client is not medically stable by the third day, the client is to follow the medical clinician's recommendation.

Pregnant Women in Detox:
Pregnant women (IDU or not) need to be offered admission into detoxification services within twenty-four (24) hours after the initial screening. It is **highly recommended** pregnant women whose primary drug(s) of choice are alcohol, benzodiazepines, and/or barbiturates (Sedatives-Hypnotics) be referred to an acute care medical hospital where the stress of detoxification on the pregnancy will be appropriately monitored until her need for detoxification or stabilization while pregnant is no longer needed, she can then be safely treated in a less intensive level of care.

Early Intervention - Treatment

MSHN adheres to the recommendations as described in the OROSC *Treatment Technical Advisory #09: Early Intervention.*

The ASAM Criteria; 3rd Edition defines Early Intervention as "an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and addiction behavior, and to help the individual recognize the harmful consequences of high risk substance use and/or addictive behavior."

Early Intervention is a new allowable service for SUD treatment providers whereas prevention providers have offered this level of service as Problem Identification and Referral (PIR) for many years. An important distinction is that in PIR with prevention providers, no SUD diagnosis is

made. For SUD treatment providers offering PIR, on the other hand, a diagnosis is required, even if only a provisional diagnosis.

SUD treatment providers may offer Early Intervention Services to clients who, for a known reason, may be *at risk for developing* a substance-related disorder as described in the DSM-5, even though there might not yet be sufficient information to document placement in the criteria for diagnosis.

Early Intervention Services are intended to be available to all individuals for whom the service is indicated as potentially beneficial, specifically those individuals determined to be in the early stages of alcohol/substance use and/or identified as being in the *early* stages of change (pre-contemplation, contemplation).

It is the intention of MSHN that Early Intervention Services in an SUD treatment setting be available to all eligible persons as clinically appropriate and as funding permits. Every Outpatient Services provider in the network is expected to either have a direct-operated Early Intervention component or a formal letter of agreement with a prevention provider or another outpatient services provider in the network to provide Early Intervention Services.

The focus of Early Intervention services in a SUD treatment setting is on stage-based, client-directed interventions to change risky behavior. Early Intervention treatment service functions include screening, individualized service planning, interventions, treatment, referring, and advocacy. *Treatment providers offering early intervention services must document the provisional diagnosis (at a minimum, Level 0.5 of The ASAM Criteria, 3rd Edition) for eligible clients in the CareNet system as part of the screening and authorization process.*

Early Intervention services should be time-limited and short-term and may be used as a stepping stone to the next level for those clients identified in an early stage of change. Early Intervention service providers must address the detection and prevention of communicable diseases, including hepatitis, tuberculosis, and HIV.

Early intervention services may be provided in individual or group modalities. It is expected that the majority of contacts between the service provider and the client will occur in the setting most conducive to treatment success. Such settings may include but are not limited to clients' home, school or other safe community settings or clinical settings such as an outpatient clinic, community centers, churches, etc. Service providers are required to document all services on the appropriate clinical form and made a part of the client's permanent record.

Jail Based Services

This section applies to providers whose service delivery extends to providing SUD treatment in a jail setting.

Jail-based SUD treatment can be an important aspect for an individual's rehabilitation process and with that in mind, MSHN will provide, when available, SUD treatment services to those who meet eligibility criteria.

However, providing SUD treatment services within the jail setting has barriers and complications relating specifically to it being provided in the jail. The provider has no control over client availability and knowledge of the actual release due to the jail's capacity. With MSHN's understanding of the barriers and complications involved, the following guidelines should be utilized when providing services to incarcerated clients:

- It is understood why treatment should begin as close to the scheduled release date as possible, usually within thirty (30) days; yet, this is not always feasible within the jail setting due to unscheduled early releases. The SUD treatment provider will assess the client when the client presents for services and begin the process of developing a treatment plan for post-jail. Jail-based services are not to be long-term in nature but considered a bridge between incarceration and return to the community.
- Each client will have an individual assessment, treatment plan and intake completed (there will be no "group intakes").
- Prior to the provision of services, clients will make a commitment to continuing in SUD treatment services once they are released from jail.
- All clients receiving services while incarcerated will have a referral made to an SUD provider in their respective county of residence, with an appointment date and time that is scheduled close to the next business day following their release date. Since there will be a possibility of clients being released early, clients are to have all the necessary referral information as soon as possible to be able to schedule an appointment themselves after early release.
- It is an expectation of MSHN if clients are released from jail early, every attempt will be made to contact the clients to help ensure a successful transition to their community SUD treatment provider is made. Documentation will be in the clients' file.
- The provider of jail-based services will secure a release to both the receiving provider and the client's home region, if not MSHN.
- All appointment dates and times will be documented in the CareNet system for each client in his/her discharge summary. A note will be made in the discharge note section of the discharge summary in CareNet stating if the client was released early.
- The provider of jail-based services will ensure that each client that receives any jail-based services will have documentation in CareNet for the services.

Medication Assisted Treatment

MSHN adheres to the requirements as described in OROSC's *Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery* and *OROSC'S Treatment and Recovery Policy #03: Buprenorphine.*

Medication Assisted Treatment (MAT) is a specialized SUD treatment service which is highly regulated on a state and federal level. There is considerable detail involved with the provision of MAT services; therefore MSHN has developed a separate MAT provider manual which describes how to meet the state and federal regulations and MSHN's expectations.

The MAT requirement is in Appendix C of this manual.

Outpatient Services

MSHN adheres to the requirements as described in OROSC's *Treatment Policy #09: Outpatient Treatment Continuum of Services.*

Outpatient SUD treatment services is an organized level of care which may be delivered in a wide variety of settings, in which addiction treatment staff provides professionally directed evaluation and treatment for substance-related disorders. In outpatient services, addiction, mental health treatment, or general health care personnel, including addiction-credentialed physicians, provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours for adults and fewer than six hours for adolescents. The services follow a defined set of policies and procedures or clinical protocols. Individual, couple, group and family therapy are common modalities appropriate for substance use disorder outpatient care. Outpatient treatment is the level of care with the least amount of restriction, so it is important that clients are able to maintain a degree of safety outside of session.

Co-Occurring Disorders

Clients are said to have co-occurring disorders when he or she have one or more substantiated mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

As per The ASAM Criteria, 3rd Edition, Co-Occurring substance use-related and mental disorders are appropriate at an Outpatient level if one of the two criteria below is met.

- The client's disorders are of *moderate severity* and have responded to more intensive treatment services. The mental disorders have resolved to an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.
- The client's disorders are of *high severity* and are chronic, but have stabilized to such an extent that integrated mental health and addiction treatment services are assessed as potentially beneficial. Clients who have severe and chronic mental health disorders may not have been able to achieve sobriety or maintain abstinence for significant period of time (months) in the past; nevertheless, they are appropriately placed in outpatient services because they need engagement strategies and intensive case management.

Peer Recovery/Recovery Supports

MSHN adheres to the recommendations described in OROSC's *Treatment Technical Advisory #7: Peer Recovery/Recovery Supports.*

Persons in treatment for substance use disorders experience better treatment outcomes and life experience improvements when their other problems, whether caused by the disorder or not, are addressed concurrently. Peer Recovery/Recovery Support services are intended to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary to enhance clients' recovery. These programs are designed and delivered primarily, but not exclusively, by individuals in recovery (peers) and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery. MSHN encourages the use of both peer and non-peer facilitated recovery support services.

Recovery support services will be available to all qualifying clients entering SUD treatment services. This does not necessarily mean every provider in the network has to have a direct-operated peer recovery/recovery support services component. Any provider choosing to not have a direct-operated peer recovery/recovery support services component must have a formal referral agreement with a provider located in the client's county of residence that offers peer recovery/recovery support services. Such referrals must be documented in the client's written record.

Peer recovery/recovery support services do not include therapy or other clinical services, ongoing transportation to regular appointments, and/or participation in activities that might jeopardize the coach's own recovery.

MSHN highly discourages agencies/organizations from hiring or assigning staff to dual roles – either therapists as recovery coaches or recovery coaches in a therapeutic role. This can be very confusing for both client and recovery coach and can diminish the role of peer recovery/recovery support services.

Individuals employed as recovery coaches are an integral part of the treatment recovery team that includes, but may not be limited to, Therapists and Counselors, Case Managers and Family and Friends. Cooperation and collaboration among treatment professionals are essential to ensure the success of recovery support services.

Persons employed to provide peer recovery/recovery support services must complete the MDHHS and MSHN approved Connecticut Community for Addiction Recovery (CCAR) model training curriculum. Other training curricula may be available, but must be approved by MDHHS as well as MSHN in order to be billable. This training should be completed prior to hire or as part of a new hire process (to be completed within an initial employment period). Appropriate continuing education in addiction and peer recovery/recovery supports is required. Peer recovery/recovery support staff should be considered part of the treatment team receiving all recommended agency training appropriate to the position (ethics, boundaries, confidentiality, etc.) to meet agency requirements.

Recovery Housing

Recovery housing is supportive, sober living settings for those in recovery from substance use disorders. Recovery housing is not a clinical treatment per se, but offers positive, safe and adjunctive living arrangements for the provision of outpatient or other evidence-based treatment services. MSHN may elect to fund recovery housing in certain communities based on need. Per the MDHHS TA 11, Recovery Housing, recovery housing providers must have a CAIT license. MDHHS TA 11 can be found at:
http://www.michigan.gov/documents/mdhhs/TA_T_11_Recovery_Housing_532174_7.pdf

MSHN's **Recovery Housing technical requirement** is available in **Appendix D** of this manual.

Residential Services

MSHN adheres to the requirements of OROSC's *Treatment Policy #10: Residential Treatment Continuum of Services*.

Residential SUD treatment services offer a planned and structured regimen of care in a 24-hour residential setting. Treatment services adhere to defined policies, procedures, and clinical protocols. They are housed in, or affiliated with, permanent facilities where clients can reside safely. They are staffed 24-hours a day.

As stated in OROSC's Treatment Policy #10, "Historically, residential services have been defined by length-of-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services: short-term residential: less than 30 days in a program, and long-term residential: 30 days or more in a program." Current CPT/HCPC coding continues this structure whereas The ASAM Criteria, 3rd Edition and OROSC's policy is based on a continuum ranging from least intensive residential to the most intensive medically monitored intensive inpatient services. The ASAM Criteria, 3rd Edition continues describing the "differences between Level 3 programs may be based partially on intensity (e.g., Level 3.1 requires a minimum of 5 hours of treatment per week compared to Level 3.5 which provides 24-hour services and supports). However, the defining differences between these levels of care are the functional limitations of the clients and the services provided to respond to those limitations. The goal is to provide a flexible system with overlapping levels of care making transition between levels of care as seamless as possible." OROSC's Treatment Policy #10: Residential Treatment Continuum of Care is based on this structure.

According to this policy, MSHN is expected to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM Levels 3.1, 3.3, and 3.5. The frequency and duration of residential treatment services are expected to be guided by The ASAM Patient Placement Criteria, 3rd Edition and described as follows:

> ASAM Level 3.1: Clinically Managed Low-Intensity Residential Services: These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focusing on improving the individual's functioning and coping skills in Dimension 5 and 6. The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.
>
> ASAM Level 3.3: Clinically Managed Medium-Intensity Residential Services: These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning. The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this level of care have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

ASAM Level 3.5: Clinically Managed High-Intensity Residential Services: These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment and/or criminal justice histories, limited work and educational experiences, and antisocial value systems. The length of treatment depends on the individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

In the event that a client is absent from treatment for more than 24 hours, a note needs to be generated in CareNet and a Utilization Management Specialist will need to be contacted.

Transportation

MSHN strives to reduce transportation barriers to accessing SUD treatment and recovery services, using the best quality, consumer-friendly, cost-efficient means possible. Transportation services are not a guaranteed benefit and are limited by the availability of Substance Abuse Block Grant funding during each fiscal year. Transportation needs must be identified during the screening and assessment process and clearly documented within the consumer's individualized treatment plan. If transportation needs arise during the course of a treatment episode, documentation of the need must be included in the consumer chart (i.e.: progress note, treatment plan review, etc.) and it must be included on an amended treatment plan. The treatment plan must include goals related to helping the consumer reduce barriers to transportation, and must promote consumer self-sufficiency and empowerment.

MSHN's **Transportation technical requirement** is available in **Appendix E** of this manual.

Women's Specialty Services

MSHN adheres to the requirements and recommendations made by OROSC in the following Treatment Policies and Treatment Technical Advisory: *Treatment Policy #11: Fetal Alcohol Spectrum Disorders; Treatment Policy #12: Women's Treatment Services; and, Technical Advisory #8: Enhanced Women's Services.*

Women's Specialty Services (WSS) may only be provided by providers that are designated as gender-responsive by MDHHS or as gender-competent by MSHN. Approved WSS providers must meet standard panel eligibility requirements in compliance with MDHHS Treatment Policy #12: Women's Treatment Services. Approved Enhanced WSS providers must meet standard panel eligibility requirements in compliance with MDHHS Technical Advisory #8: Enhanced Women's Services.

Providers must keep a list of didactic topics appropriate for WSS Services and be able to supply MSHN with this list, upon request. Providers are expected to use gender-specialty evidence-based programs and practices. Providers are expected to comply with educational requirements documented in MDHHS Treatment Policy #12 and/or MDHHS Technical Policy #8 and keep personnel logs of all relevant education and/or training. Education and/or Training must be approved by either the Michigan Department of Health & Human Services, Michigan Certification Board of Addiction Professionals (MCBAP) or MSHN.

Federal requirements are contained in 45 CFR (Part 96), section 96.124.

- Providers receiving funding from the Michigan Department of Health and Human Services (MDHHS)funds set aside for pregnant women and women with dependent children must provide or arrange for the following five types of services:
- Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care.
- Primary pediatric care for their children, including immunizations.
- Gender specific substance use disorder treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse and parenting.
- 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.
- Sufficient case management and transportation to ensure that women and their dependent children have access to the above mentioned services.

Additionally, WSS is to be gender competent which is defined as the "capacity to identify where difference on basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population."

Gender competence can be a characteristic of anything from individual knowledge and skills, to teaching, learning and practice environments, literature and policy. Wherever present, gender competence promotes equality in treatment and outcomes for men and women. Those treatment programs engaged in the practice of gender competence will be providing specialized programming. Focused services are not only substance use disorder related, but also include gender-specific issues such as: trauma, relationships, self-esteem, etc.

Providers must have policies/procedures in place that require additional training for communicable disease screening, referral and treatment.

Providers must have policies/procedures in place that require appropriate methods for neo-natal substance use exposure screening & referral.

Criteria to determine consumer WSS eligibility are as follows:

- Women who are pregnant.
- Women with dependent children.
- Men determined to be the sole party responsible for the care and well-being of dependent child(ren)

PREVENTION PROVIDERS

Contracted Prevention Providers must adhere to appropriate cultural competency, recipient rights, confidentiality, and privacy conditions in this manual, as well as any other policies of MSHN or the state, applicable to the provision of prevention services. Prevention contract arrangements funded by MSHN are based on identified local community needs and will vary from one community to another, including short-term projects, ongoing services, and collaborations with key community partners. Each contract for prevention services will include specific detail regarding scope of work, reporting and/or outcomes, as well as financial status reports (FSR) or claims submission for MSHN reimbursement.

Contracted Provider must notify and receive written permission to make changes to their submitted and approved prevention services plan.

Completion of Satisfaction Surveys

Completion of Short-term Outcome Evaluation identifying knowledge, attitude and behavior changes. For all programming outside of information dissemination, Providers must be able to demonstrate how they know the program was effective. (What were the goals of the program and were those goals obtained?)

Development of a Performance Improvement plan, which incorporates evaluation outcomes, utilizing data to make program changes and identify how services impacted program goals and objectives.

Coordination of Services

All Providers must be able to identify, at their site visit, how they coordinate services with other community agencies and coalitions. Coordination of Services should at a minimum include:

- Local Department of Health and Human Services
- Local Community Health Agency
- Local Schools
- Law Enforcement
- School Resource Officers (where applicable)
- Teen Health Centers (where applicable)
- Community Coalitions
- Local Health Departments and or Qualified Health Centers (where applicable)

Whenever possible, Providers are encouraged to enter into referral agreements with community agencies. MSHN will offer or support technical assistance for this as requested.

Designated Youth Tobacco Use Representation (DYTUR) Contracted Providers for DYTUR services will be responsible for:

a) Maintain and update the tobacco retailer list and information for represented county,

this includes at a minimum visiting or calling each vendor to verify information at least annually;

b) Responsible for Formal Synar civilian compliance check inspections and reporting, utilizing protocols identified by the State's Office of Recovery Oriented Service of Care;

c) Provide vendor education to at least 25% of county tobacco retailers with the Michigan Department of Community Health vendor education information and protocol, DYTUR contracted Providers should encourage all vendors to utilize the States Tobacco Education Program;

d) Conduct non-Synar compliance checks at a minimum of 25% of their responsible county's identified tobacco vendors. These checks can either be civilian checks or checks done in collaboration with local Law Enforcement. e) Provider will work in collaboration with local law enforcement, and whenever possible. Provider works whenever possible with the State Police Tobacco Tax Team. Contact information for the State Police Tobacco Tax Teams will be provided by your PIHP Prevention Specialist.

f) Provider staff funded by MSHN will be actively involved in local tobacco coalitions or other substance use disorder coalitions if no tobacco coalition is in place.

g) Provider provides education to local law enforcement, chamber of commerce, and other community groups on the SYNAR amendment.

h) Maintain records of any tobacco compliance checks being completed within the represented county, including compliance check of activity outside of MSHN funding;

i) Completion of the Youth Access to Tobacco Activity Report annually. Appropriate technical assistance, trainings, and protocol will be provided by MSHN.

DYTUR Meetings

Providers receiving funding for DYTUR services will have the opportunity to attend all State level meetings pertaining to the youth tobacco act. If DYTUR staff are not required by the State to attend, MSHN Prevention Coordinator(s) will attend and bring information back to DYTUR staff.

DYTUR Reporting

Providers receiving funding for DYTUR activities will submit the following reports to MSHN Prevention Coordinator(s) by the due dates provided in separate documentation.

a) Youth Access to Tobacco Activity Report –Format will be provided
b) Non-SYNAR and Vendor Education reports should be sent by the due date provided by the MSHN Prevention Coordinator(s). If no non-Synar checks have been completed in that quarter, Providers must send an email to the MSHN Prevention Coordinator(s) informing that no checks were completed and the DYTURs plan for completing the non Synar Checks.

c) Formal SYNAR Compliance Check forms – Due the fifth (5th) business day of month following SYNAR compliance check period.

d) Corrected Vendor List –Please note, that ALL vendors on the list must be verified either by a phone call or personal visit. Verification must include; Vendor name, address (including county) and phone number. DYTUR staff must also add any new vendors they have knowledge about in their counties.

e) All providers who are contracted for DYTUR services must enter Youth Tobacco Act activities (at a minimum this should include; Synar Compliance Checks, non-Synar compliance checks and tobacco vendor education visits) into the MPDS system. A guide will be provided by MSHN Prevention staff for the manner that these activities need to be entered into the system.

Please Note: SAPT Block Grant funds cannot be used for law enforcement; this includes Formal Synar and non-Synar activities

Early Intervention-Prevention

MSHN adheres to the recommendations described by OROSC *in Treatment Technical Advisory #9: Early Intervention*. As Early Intervention under SUD treatment services is described elsewhere in this manual, this section will focus on prevention's role in Early Intervention services. Prevention Early Intervention services typically exist within the community being served (e.g. schools, community centers, etc.). "Prevention" refers to this level of service under the federal strategy of Problem Identification and Referral (PIR), and defines it as "helping a person with an acute personal problem involving, or related to SUDs, to reduce the risk that the person might be required to enter the SUDs treatment system" (U.S. CFR, 1996).

PIR aims to identify those who have indulged in the illegal use of drugs in order to assess if their behavior can be reversed through education. PIR does not include any activity designed to determine if an individual is in need of treatment. Examples of methods used by Prevention Staff include driving while intoxicated education programs, employee assistance programs, and student assistance programs. (FY 2012-14 Action Plan Guidance)

PIR service activities are not required to occur in the context of an existing licensed SUD treatment program, however Providers of Prevention Early Intervention services must have appropriate Prevention licensure (CAIT).

PIR services must be delivered by individuals in provider organizations who have been credentialed as a Certified Prevention Specialist (CPS) or Certified Prevention Consultant (CPC) with appropriate documentation from the Michigan Certification Board for Addiction Professionals (MCBAP). Supervision of an identifiable PIR services program must be by an individual credentialed as a MCBAP prevention credentialed staff or an approved alternative certification.

Prevention Reporting

Providers need to be aware of and attempt whenever possible to collect data elements identified in the National Outcome Measures (i.e. past 30-day use, perceived risk).

Provider is responsible to provide MSHN an outcome report after the end of the fiscal year. This report should identify how activities were evaluated, outcome of those evaluations, and how the evaluations were utilized to improve programming.

To capture process data, all direct services must be accurately entered into the Michigan Prevention Data System (MPDS) as outlined in the MPDS Provider Manual. Activity data must be entered into the MPDS on a monthly basis. Failure to enter activity data by the 10th of the month following the month that the services were rendered may result in delayed payment by MSHN. Provider must have system in place to check accuracy of data entered.

If a Provider charges a fee for any prevention activity funded in part or entirety by MSHN, the provider must adhere to the following guidelines:
Provider must have a policy in place that is specific to charging for prevention services and the policy must identify how Provider will assure that services are not denied based on ability to pay. A copy of this policy is to be submitted to MSHN prior to the beginning of the contract period, and updated yearly.
Any prevention services that require payment must have a brochure or flyer that clearly states that scholarships are available. Provider must present these brochures or flyers when advertising or promoting the activity.
Provider must identify fees collected for prevention services as program income on their monthly FSRs.

Prevention Services

MSHN will elect to contract for appropriate prevention services based on local community needs in keeping with the *MSHN 3 Year SUD Strategic Plan for Prevention, Treatment and Recovery, FY 2015 – 2017.*

Prevention Providers and Youth Development Programs are required to verify in writing the use of evidence-based services at the time of contract initiation and/or renewal.

MSHN requires that all Contracted Prevention Providers adhere to the following MDHHS prevention guidelines (subject to revisions by MDHHS):
A Substance Abuse Prevention License is required for any organization offering, or purporting to offer prevention services. To meet this requirement, Contracted Prevention Providers must possess an active Community Change, Alternatives, Information, and Training (CAIT) License registered with the Michigan Department of Licensing and Regulatory Affairs (LARA).

- Contracted Prevention Provider Staff must possess an active Certified Prevention Specialist (CPS), or a Certified Prevention Consultant (CPC) certification through the Michigan Certification Board for Addiction Professionals (MCBAP). Staff may also be funded if they have a registered development plan through MCBAP, which is being actively pursued and properly supervised. In some cases, this certification requirement may be waived if prevention services are delivered by specifically-focused prevention staff. Specifically-focused staff are those that consistently provide a specific type of prevention service and do not have responsibilities for implementing a range of prevention plans, programs, or services. Specifically-focused prevention staff must have completed formal training for the

specific program they are conducting, demonstrable through certificates of completion or similar documentation.
- For each Contracted Prevention Provider Staff (1.0 FTE), a minimum of 700 hours of direct prevention services must be conducted annually. Prior to the beginning of the fiscal year, Contracted Prevention Providers must submit an annual prevention plan detailing the intended scope of work, evaluation method(s), responsible staff, and anticipated number of direct service hours.
- Direct services must be captured in the Michigan Prevention Data System (MPDS) as noted below. Trainings that Contracted Prevention Provider Staff attend also count as direct service hours, but are not captured in the MPDS.

All Contracted Prevention Provider Staff funded by MSHN must complete Level 1 Communicable Disease Training at least once every two years. Free Level 1 Communicable Disease Training is available online at: http://improvingmipractices.org.

- Prevention Activities must be focused on State and Regional priorities which include; 1) Reduction of Underage Drinking, 2) Reduction of Youth Tobacco Use, 3) Reduction of Prescription Drug and Over the Counter Medication misuse and abuse, and risk and protective factors associated with these problems. Whenever possible, providers should also address childhood obesity, infant mortality, and immunization.
- At a minimum, ninety-five percent (95%) of all services must be researched-based. Contracted Prevention Providers are to follow the guidelines outlined in the Guidance Document on Evidence-Based Programs developed by the State. The document can be found on the MDHHS website at: http://www.michigan.gov/documents/mdch/Mich_Guidance_Evidence-Based_Prvn_SUD_376550_7.pdf

Services should address both high-risk populations and the general community.

- No more than twenty-five (25%) of total direct services/units can be in the Federal Strategy of Information Dissemination and services under this category must tie into your agencies overall prevention plan. Contracted Prevention Providers must have a system in place to track total number of services/units delivered in each of the approved Federal Strategies.
- Services need to be based on identified, current community needs.
- Services are collaborative in nature representing coordination of resources and activities with other primary prevention providers – e.g. local health departments, community collaboratives and the Department of Human Services' prevention programs for women, children and families, and older adults.
- Services need to be supportive of local coalitions. New providers interested in providing prevention services should be a regular participant in county prevention coalition meetings to be considered for funding.
- Services must fall within one of the six federally defined strategies: information dissemination, education, problem identification and referral, alternatives, community based and environmental.
- Services must be provided in a culturally competent manner.
- All provider prevention literature must acknowledge funding source.

MSHN requires that all prevention services incorporate some method of evaluation. Contracted Providers must include all process evaluation data as outlined in Michigan Licensing rules. In addition, Providers need to incorporate the following processes:

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APPENDICES:

Appendix A: UM Manual

MSHN
Mid-State Health Network

MID-STATE HEALTH NETWORK

SUBSTANCE USE DISORDER UTILIZATION MANAGEMENT PROGRAM MANUAL

MSHN
Mid-State Health Network

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MID-STATE HEALTH NETWORK
UTILIZATION MANAGEMENT PROGRAM MANUAL

INTRODUCTION

The utilization management process consists of the authorization of treatment, concurrent reviews of treatment, retrospective reviews of identified cases, random samples, special studies, grievance and appeals, implementation and evaluation, and monitoring and assessment of operations and system trends. The protocol and guidelines adopted reflect the medical necessity and program contractual standards that comply with the Michigan Department of Health and Human Services (MDHHS) requirements and Center for Medicare and Medicaid Services federal regulations.

The MSHN Utilization Management (UM) team is dedicated to providing prompt, professional, and helpful support to its treatment provider network. MSHN has established consistent UM practices based on commonly accepted medical necessity criteria consistent with the Office of Recovery-Oriented Systems of Care (OROSC) prevention and treatment policies, as well as the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program contract, the Michigan Medicaid Manual and other accepted clinical sources (i.e. the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition), which are designed to benefit eligible consumers across the MSHN region.

The MSHN UM team has 3 full-time specialists who are available Monday through Friday from 8am-5pm via telephone and email. Each UM Specialist is assigned to specific counties located within the MSHN Region and provides program-specific and location-specific support in addition to areas of general assistance.

MSHN-South Region consists of: Hillsdale, Jackson, Clinton, Eaton, Ingham, Ionia, Gratiot
MSHN-East Region consists of: Arenac, Bay, Saginaw, Tuscola, Huron, Shiawassee
MSHN-West Region consists of: Montcalm, Newaygo, Mecosta, Isabella, Midland, Gladwin, Clare, Osceola

Skye Pletcher (MSHN-South): Skye.Pletcher@midstatehealthnetwork.org;
Nicole Jones (MSHN-East): Nicole.Jones@midstatehealthnetwork.org;
Cammie Myers (MSHN-West): Cammie.Myers@midstatehealthnetwork.org;

Additionally, the UM Department has a toll-free phone number which should be used to reach any available UM specialist, as well as a departmental email which is monitored daily:
Toll-Free Phone: **844-405-3095**
E-mail: **um@midstatehealthnetwork.org**

Access Management System/Service Access

MSHN adheres to requirements for access management as described in MDHHS Access Systems Standards. The link to the revised MDHHS Access Standards (Attachment P4.1.1.) is here: MDHHS Access System Standards. MA/PIHP Contract

MSHN is responsible for providing SUD treatment services to individuals if they have Medicaid insurance, Healthy Michigan Plan, or have no insurance and cannot pay for services. Under special situations, MSHN may serve some clients who have commercial or other insurance.

All clients residing or presenting in MSHN's 21-county region who request SUD treatment services must be assessed through a MSHN AMS. AMS consists of the administrative responsibilities associated with screening for eligibility, managing resources (including demand and access), ensuring compliance with various funding sources, meeting medical necessity, ensuring timely transfers from one provider to another for continuing care, and assuring quality of care. Activities to carry out these responsibilities may include referral to other community resources when these services are needed by the individual seeking substance use disorder (SUD) treatment services.

MSHN is responsible for assuring the availability and operation of an efficient and effective AMS including assurance that staff performing these functions is skilled, trained, supervised and appropriately credentialed when carrying out clinical functions. MSHN expects providers to ensure that access to services for individuals seeking SUD treatment services is efficient, consumer-friendly, timely, and effective. Furthermore, there is an overarching goal that SUD treatment access be integrated with Community Mental Health Service Programs' (CMHSPs) 24/365 crisis and access services. To see what CMHSP covers your county, click here: Region 5 CMHSPs. For out of county persons, access will be coordinated with the appropriate CMHSP and/or PIHP access center.

Individuals seeking SUD treatment services may access SUD services at each of the funded providers listed in the *Customer Services Handbook* or they may also receive health information, referrals to community resources, and screening appointments through the access management system at any access point for MSHN, including any CMHSP. To receive services or information about services, individuals may call the site nearest to where they live.

Individuals who have Medicaid or Healthy Michigan Plan and are in need of medically necessary services receive their services as an enrollee benefit. For individuals who have no insurance, there is no guarantee of services if there is no funding available to provide those services. MSHN must provide services to as many individuals as possible within the financial resources that are available. Sometimes individuals may be placed on a waiting list if there is not enough funding to provide services immediately and the individuals do not qualify for Medicaid or Healthy Michigan Plan. Individuals may not be put on a waiting list if they have Medicaid or Healthy Michigan Plan.

In some circumstances MSHN may need to fund services from an agency that does not have a contract with the local region in order to meet a client's needs. If that is the case, the purchase of 'off panel' provider services should be facilitated by MSHN. MSHN utilization management staff as well as provider staff will coordinate to help make these arrangements for clients when necessary and appropriate.

The AMS must provide access, screening and referral 24/7days a week. For emergency services, this requires the capacity to make information available as to what other entity is providing the emergency service and how to access services. Pregnant women requesting or seeking treatment are considered urgent requests and must be screened and referred as soon as possible but no later than 24 hours upon contact. For routine service requests, the minimum timeliness standard for conducting individuals' screening, level of care determination, provider selection (placement activities) and admission to treatment is 14 calendar days from individuals' first contact with the AMS. These specified time frames do not apply to people while they are incarcerated.

The AMS must abide by the priority population according to the SAPT community (block) grant regulations at CFR 96.131. MDHHS has defined the following as priority populations for SUD treatment services and have admission preference in the order listed over any other client accessing the system: clients who are pregnant injecting drug users, pregnant users, injecting drug users, or parents of children who have been or are at risk of being removed from their home, in that order. Each MSHN contracted provider must meet the needs of individuals in these groups first. After that, MSHN may fund services for others who meet criteria for treatment.

If individuals in the priority population have to wait for services, they are to be offered interim services according to Section 96.121 of the SAPT Block Grant. Interim services must minimally include what is listed in the state policies, and provision of these services, or the refusal of such, will be documented in client files.

Clients should have freedom to choose their provider from the available options. If a provider is unable to offer treatment to a person seeking services, MSHN providers should offer a 'warm transfer' of individuals seeking treatment to an eligible and appropriate provider of the individual's choice by actively assisting individuals to find other agencies in the community best equipped to meet the client's needs.

Eligibility Determination

Residency Determination: Residency within the MSHN service region should always be determined by the service provider at the time of initial screening and admission into the program. In order to determine residency, the provider shall request any one of the following documents for verification (the document must include a current or updated regional address):

- State Driver's License
- State ID Card
- Voter Registration Card

- Utility bill in the consumer's name
- Medicaid County of Eligibility

If the consumer cannot produce any of these documents, or if the consumer has recently relocated to the MSHN region but their benefits have not yet been transferred from the previous county, the provider must have the consumer sign an attestation stating the consumer either is homeless or is living in MSHN region temporarily with a plan to move to the region permanently. The attestation can be an added sentence(s) in the case file on a form where the consumer(s) provide signature(s) or it can be a separate document. In cases where the consumer has Medicaid or Healthy Michigan Plan (HMP), the consumer must have their county status updated/changed within 30-60 days and/or verification in the client file of documented attempts to request the change from the local DHHS office. In cases where the consumer is eligible for block grant funding, the consumer must provide documentation that action has been taken to establish residency within 30-60 days. Documentation for these should also be included in the case file. Considerations for exceptions to this policy shall be reviewed on a case-by-case basis.

If a consumer enters a treatment program outside of the MSHN region, it is expected that the consumer shall retain their county of residence to which his or her Medicaid is attached. MSHN has established contracts with certain out of region (i.e. outside of the MSHN 21-county area) SUD treatment providers for residential and/or detoxification services. In other cases, MSHN will engage in "single-consumer" letters of agreement with providers not previously impaneled in the MSHN provider network to facilitate needed care.

It has been the historical practice of some SUD residential and/or detoxification treatment providers to contact local MDHHS eligibility personnel to transfer the consumer's Medicaid County of residence coverage to the county in which the treatment facility exists. Per the Medicaid Services Administration (MSA), there is no type of eligibility requirement dictating such a change in address when the consumer enters any treatment program. The unintended consequence of a provider switching a consumer's county of residence in their Medicaid is that the switch in counties results in the beneficiary being a part of a different Pre-Paid Inpatient Health Plan (PIHP) region. Also, when the person returns home, he or she will not get services in their home area until their information has been changed back. This increases the chance of reduced continuity of care, which is a key element in ensuring ongoing individual stability and treatment efficacy

Medical Necessity: In considering the appropriateness of **any** level of care, the four basic elements of Medical Necessity should be met:

- Client is experiencing a Substance Use Disorder reflected in a primary, validated, DSM5 or ICD-10 Diagnosis (not including V Codes) that is identified as eligible for services in the MSHN Provider Contract.
- A reasonable expectation that the client's presenting symptoms, condition, or level of functioning will improve through treatment.

- The treatment is safe and effective according to nationally accepted standard clinical evidence generally recognized by substance use disorder or mental health professionals.
- It is the most appropriate and cost-effective level of care that can safely be provided for the client's immediate condition based on The ASAM Patient Placement Criteria, 3rd Edition.

Block Grant Funding

A limited amount of Block Grant funding is available each fiscal year on a first-come, first-serve basis for those consumers residing within the MSHN service region who meet the established financial eligibility criteria. The purpose of the Block Grant funding is to facilitate entry into necessary Substance Use Disorder treatment for those persons who are uninsured or underinsured. Please see the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 17 and MSHN Policies and Procedures: Substance Use Disorder Income Eligibility & Fee Determination, for additional information regarding consumer eligibility around the use of Block Grant funding and applicable co-pays for which the consumer is responsible. It is the responsibility of the SUD provider to procure a completed and signed copy of the Income Verification and Fee Waiver form for all consumers accessing Block Grant funding. A signed copy of this form is required to be placed in the consumer record.

All consumers must submit proof of application for Medicaid/Healthy Michigan Plan insurance benefits within 30 days of admission to treatment under the Block Grant funding source. SUD providers should place documentation of the submitted application in the client file. MSHN reserves the right to discontinue Block Grant funding if consumers do not participate in the requested activities to secure health insurance benefits.

The Substance Abuse Block Grant (SABG) requirements indicate that clients who are pregnant or injecting drug users have admission preference over any other client accessing the system and are identified as a priority population. Priority population clients must be admitted to services as follows:

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours.	*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.

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

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

Medicaid/Healthy Michigan Plan Verification

The provider, upon admitting a client record into the CareNet system, must use the client's Medicaid ID card and perform a 270/271 eligibility check. Each month, while the client is in the program, the provider must check for a current Medicaid card and/or perform an eligibility check verifying coverage. If the copy

or a 270/271 check has not been performed, reimbursement may be held up and any re-authorization requests may be placed into pended status until the issue is resolved.

Providers are responsible to determine the client's Medicaid/HMP eligibility verification at the time of admission. Providers can confirm eligibility verification by calling Medicaid's Medifax line: 1-888-696-3510. Providers will perform monthly Medicaid or HMP, eligibility verification checks and have the report placed in client's chart with a copy of the insurance card- or perform a 270/271 eligibility check. It is the provider's responsibility to verify if there has been a change of coverage if the client has third party insurance coverage, Medicaid or HMP eligibility prior to authorization.

Retrospectively, if it is determined that the client was NOT covered by Medicaid during the service period, the claim may be rejected and the provider notified. It is then the responsibility of the provider to notify the MSHN UM Department and follow the established policy/procedure for obtaining payment under the Community Grant program (Block Grant).

Providers may be requested to assist clients or MSHN in submitting evidence of client disability and/or treatment provision or cost, in order to obtain and maintain benefit eligibility, including justification for ongoing Medicaid deductibles.

Since federal regulations are specific regarding billing for Medicaid, HMP, or federal portion of community (block) grant funds, and eligibility requirements change from month to month, active eligibility in Medicaid, HMP, or other third party insurance plans must be verified on a monthly basis and filed in the client's chart or an eligibility check performed. If the status of the client's insurance changes during a treatment episode, the provider must update the change on the Payer Screen in CareNet and notify the MSHN UM department of the change by phone or email so that corrective action can be taken, if needed, to amend any existing authorizations for service in the CareNet system.

Medicaid/HMP Recipients with other Primary Insurance

MSHN will authorize Medicaid payment of services only after all other active insurances have been billed and/or denied. If a Medicaid recipient has any other insurance code either listed on the Medicaid Card or, indicated through 270/271 information, the primary insurance must be billed for SUD treatment coverage prior to billing Medicaid. These client services will not be authorized or paid by Medicaid funding until all other insurance coverage has been exhausted.

Medicare and Third Party Liability (TPL) Coordination of Benefits: If a consumer has coverage through a Medicare plan or TPL, Medicare/TPL is the primary insurance for SUD treatment and these clients must be transferred into a program that has an authorized Medicare/TPL provider. The following exceptions apply:

Medicare/Third Party Liability (TPL) Primary For All Levels of Substance Use Disorder (SUD) Care	
What if Provider is not on the third party panel?	**Beneficiary must go to a Medicare or TPL Provider if the service is a covered benefit in the individual's insurance policy.** **Note: Healthcare Common Procedure Coding System (HCPCS) procedure codes are non-Medicare covered services, per the American Medical Association (AMA) 2016.**
Exceptions	• **The beneficiary has a primary SUD diagnosis for which SUD-specific treatment services are needed, meets medical necessity criteria, and the provider provides the necessary American Society of Addiction Medicine (ASAM) level of care necessary to meet the beneficiary's treatment needs.** • **For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence (i.e. there are no Medicare SUD-licensed programs or providers within these distances).** • **Must get pre-approval from MSHN Utilization Management (UM) department.** • **If MSHN UM Department approves exception for Medicare or TPL covered service, bill Block Grant only and include supporting notes.**
Who do I bill first?	• **Must bill covered services to third party insurance first, if paneled with the third party insurance.** • **Can only bill Medicaid or HMP if a denial with supporting Explanation of Benefits (EOB) is obtained from the primary insurance first. In cases where it is not possible to obtain a denial, Medicaid or HMP cannot be billed. The services can only be billed to Block Grant, provided the client meets the income eligibility guidelines for Block Grant and there is documentation in the client chart.** • **Note: Medicaid can be billed if the beneficiary has a tribal benefit.**
Denied Claims	• **If the provider is able to bill Medicare or TPL and obtains the denial with supporting EOB, then the provider can bill Medicaid or HMP, provided the previously noted guidelines are met.** • **Fax EOB to 517.574.4093, ATTN: Claims Department or email securely to claims@midstatehealthnetwork.org.** • **Place EOB in beneficiary's chart.** • **In cases where it is not possible to obtain a denial and supporting EOB for covered services from Medicare or TPL (i.e. not paneled and/or credentialed), Medicaid or HMP cannot be billed. The services can only be billed to Block Grant, provided the client meets the income eligibility guidelines for Block Grant and there is documentation in the client chart.** • **Note: HCPCS procedure codes are non-Medicare covered services. MSHN will pay with Medicaid or HMP, if beneficiary is eligible.**

Partial Payment	• **Bill beneficiary's secondary insurance up to third party insurance's allowable amount or MSHN's contracted rate, whichever is less, (minus first party co-pay for Block Grant funds).** • **Fax EOB to MSHN.** • **Place EOB in Beneficiary's chart.**
Deductible	• **Bill beneficiary's secondary insurance up to third party insurance's allowable amount or MSHN's contracted rate, whichever is less, (minus first party co-pay for Block Grant funds).** • **Fax EOB to MSHN.** • **Place EOB in Beneficiary's chart.**

Veteran's Coordination of Benefits: If a consumer is a veteran of the armed forces, they must attempt to access any treatment benefits for which they may be eligible through the Veteran's Administration or other approved provider relative to individual coverage. The use of Medicaid/HMP/Block Grant funding is allowable in assisting the veteran in being referred for the medically necessary SUD services, provided the veteran has Medicaid, HMP, and/or no other insurance coverage. The following exceptions may apply:

- There is not a VA provider within 40 miles of the client's home residence.
- The medically necessary level of care or type of service is not available to the veteran through the benefits provided by the VA.
- The consumer would have to wait more than 14 days for admission to a VA service provider.

Additionally, The Veterans Choice Program is a new temporary program established by the Veterans' Administration to improve Veterans' access to health care by allowing certain Veterans to elect to receive health care from eligible providers outside of VA. The program was established by section 101 of the *Veterans Access, Choice, and Accountability Act of 2014* (Choice Act). Veterans must call the Choice Program Call Center at (866) 606-8198 to verify eligibility and set up an appointment.

For a more in depth explanation of Veteran's access to MSHN SUD services, please refer to *Appendix E. MSHN Veteran's Eligibility Technical Requirement* in the MSHN SUD Provider Manual.

Out of Network Services

When extenuating circumstances prevent a consumer from otherwise obtaining services, MSHN provides a system of procedures for referral to other providers and access to non-network providers through its out-of-network panel policy. Providers may include: Accredited licensed Substance Use Disorder health facilities, other Substance Use Disorder licensed professionals and other health service providers that provide direct Substance Use Disorder health services. The purpose is to ensure that access objectives and standards are met.

When a consumer elects to self-refer to a non-network provider for services or when the MSHN Utilization Management department otherwise refers for a service that is not available in the MSHN Network, such organizations or professionals must contact MSHN for authorization. All out-of-network services should be pre-authorized.

A Letter of Agreement (LOA) with a negotiated rate may be assembled. If multiple services are anticipated, MSHN may choose to complete a formal contract via the credentialing process. If services have been rendered prior to contact with MSHN, MSHN will review on a case-by-case basis to determine what action/reimbursement will take place.

CareNet System

All treatment providers contracted for MSHN SUD services must use the internet-based information system called CareNet, a product of Net Smart Technologies. CareNet is the mechanism for the provider network members to request authorization for SUD services for clients who meet admission criteria. CareNet also serves as a central location for collecting demographics and analyzing utilization data. MSHN has established authorized provider access to a common CareNet platform for use in the region.

The MSHN SUDSP Manual provides general information related to the system requirements for CareNet, as well as the appropriate procedure for requesting new user accounts and deleting user accounts. The following pages in this manual will provide more detailed information about the various screens in CareNet, including required information to facilitate the authorization request and approval process.

Levels of Utilization Management

In order to fully implement all UM processes, MSHN shall also use data reports, CareNet information, and requested treatment provider documents to review care and adherence to all policies, rules, regulations, standards of care, and the like. When necessary, the MSHN UM Specialist staff may contact the provider via CareNet to request clarifications in treatment decisions/clinical practice and also to request copies of appropriate clinical and administrative documents in order to review medical necessity, amount, scope, and duration of treatment, as well as consistency with UM principles and standards of care, and all applicable contractual requirements, rules, regulations, and expectations with respect to provider treatment performance and outcomes.

A. Prospective Utilization Review (Pre-Authorization)

MSHN has a prospective utilization review process for non-emergent mental health and substance use disorder services, which will include the following components:

1. Service eligibility determination, through an access screening process
2. Verification of medical necessity, through a clinical assessment process (which may occur concurrently or sequentially with the access screening process)
3. Standardized assessments and/or level of care tools for certain clinical populations
4. Specialized testing/evaluations for certain services
5. Certification for certain enrollment based services
6. Pre-authorization (amount, scope and duration) for certain services

Service eligibility and medical necessity criteria for each clinical population are outlined in the MSHN Access System policy, including requirements for second opinions and advanced/adequate notice of denials.

1. Eligibility Determinations and Verification of Medical Necessity

Eligibility determinations and verification of medical necessity will be performed by CMHSP Participants for mental health services, and by SUD providers for substance use disorder services.

To ensure adequate integration, MSHN has established a coordinated service access process. CMHSPs and the SUD provider networks in their respective catchment areas will coordinate access processes, ensure there is 'no wrong door' for linking to services, and ensure there is a single point of contact for after-hours service inquiries from Medicaid enrollees and other individuals seeking mental health and SUD services. CMHSP Access Centers may assist with screening individuals seeking SUD services. Coordination of care will also occur with primary health care providers.

2. Monitoring Access Eligibility and Medical Necessity Determination

Each SUD Provider will monitor individual service eligibility and medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether the individual eligibility and medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to CMHSP Participants and SUD Providers. MSHN will also review individual SUD eligibility determinations through the CareNet record keeping system. The MSHN UM Committee in conjunction with MSHN UM staff will monitor regional compliance with the access eligibility and medical necessity criteria at the population level through the review of metrics. SUD Providers will offer second opinions and provide advanced/adequate notice of denials as outlined in the MSHN Access System policy.

B. Concurrent Utilization Review

Appropriate MSHN UM Specialist staff will perform concurrent SUD UM reviews. Each individual receiving services will have an individual plan of service which outlines the services to be received, including the amount, scope, and duration. The amount, scope and duration of each service, if not subject to the enrollment, authorization or other limitations described earlier in this plan, will be determined by the person who will be receiving the service and their SUD Provider or CMHSP, through a person centered and recovery oriented planning process.
Utilization decisions will not be made outside of the person centered planning process unless otherwise required by MDHHS. The individual plan of service for each person receiving services will specify the frequency of periodic (i.e., concurrent) review as determined in dialogue with the person receiving services.
SUD Providers will provide advanced/adequate notice of denials as outlined in the MSHN Access System policy for any service reduction resulting from loss of eligibility or lack of medical necessity. Unless MSHN service eligibility and medical necessity criteria are not being met, all utilization decisions will be made in the context of person centered planning activities.

Each SUD Provider will monitor individual continuing stay/eligibility/medical necessity determinations for consistency with local and regional policy. MSHN will monitor whether continuing stay/eligibility/medical necessity determinations that have been made are consistent with MSHN policies through record reviews during annual on-site visits to SUD Providers. MSHN will also review individual SUD determinations through the CareNet record keeping system as needed. The MSHN UM Committee in conjunction with MSHN UM staff will monitor regional compliance with continuing stay/eligibility/medical necessity criteria at the population level through the review of metrics.

C. Retrospective Utilization Review

Retrospective review will be performed by the MSHN UM Department for SUD services. The MSHN UM Committee in conjunction with MSHN staff will perform retrospective utilization review at the population level through the review of metrics.

Retrospective review will focus on the cost of care, service utilization, and clinical profiles. Analysis will consider encounter data in conjunction with other supplemental data as well as ASAM and other clinical need/outcomes data as available. BH-TEDS and Medicaid claims data will be incorporated as warranted.

The MSHN UM Department will review service utilization reports to identify potentially undesirable variance in service utilization at the population level. For purposes of ensuring effective management of Medicaid and Block Grant resources managed by the region, undesirable variance will be defined as:

1. Inconsistency with regional service eligibility and/or medical necessity criteria; and/or
2. Possible over and under-utilization of services when compared to the distribution of service encounters, associated measures of central tendency (i.e. mean, median, mode, standard deviation), and consumer clinical profiles (i.e., functional needs) across the region.

Based upon its findings, the MSHN UM Department will identify potential interventions for consideration. Interventions will vary, depending upon the nature of the variance and anticipated causal factors, but may include the following, presented in order of intensity, from least to highest:

1. Verify data
2. Request further analysis
3. Request change strategies from stakeholders
4. Provide regional training
5. Modify or clarify regional service eligibility and/or medical necessity criteria through proposed revisions to MSHN policy
6. Set utilization thresholds or limits
7. Address service configuration to affect utilization

Automatic Request Processing (Auto-Authorization)

CareNet has provided MSHN a mechanism that allows for automatic approval of non-complex outpatient service requests. Authorizations for outpatient services will be auto-approved unless one of the following items apply:

- The request is for a reauthorization that contains any services that are not an Outpatient Service Category CPT Code.
- The request contains requested services for Detox or Residential CPT Codes.
- The request contains more than 1 unit of CPT Code H0001.
- The 'Military Service' field is marked 'yes' on client's most recent admission at the requesting provider.
- The request is a fourth authorization request for detox services, and consumer has three admissions for detox services in the last 12 months.
- The request states that the consumer's income exceeds eligibility guidelines.
- The date range requested is longer than 180 days

If an authorization request meets any one of the criterion above, the request will be sent to the UM Department for manual review. The system will insert a note in the 'Request Comments' section, noting that the request was not automatically approved and list each criterion that was not met.

If the authorization request is automatically approved, the system will insert a note in the 'Authorization Comments' section, noting the approval along with the date and time of the approval.

Please note, the standards for clinical documentation in the CareNet system remain the same for auto-approved outpatient service requests as they do for all other types of service requests which are being manually reviewed by MSHN UM specialists. Further information regarding the clinical documentation standards for each section in CareNet is contained in the following pages of this manual. MSHN UM specialists will complete ongoing random reviews in CareNet for all agencies who have been given auto-authorization privileges. If it is found that a particular agency is not adhering to the established standards for documentation in CareNet, corrective action may be taken by MSHN up to and including removal of auto-authorization privileges.

Clinical Documentation Standards:

- Demographic- Completed for every consumer. Please note, a valid current address record must be entered for every client or the CareNet System will not allow you to create an admission record.

- Payors- Completed for every consumer; updated as needed. Please be sure to complete a 271 Eligibility look up for every consumer upon admission to the program, per MSHN SUDSP Manual and record each Payor source found in the 271 report on the Payors screen in CareNet. Continue to perform monthly 271 Eligibility look ups and update the Payor screen accordingly

- Financial - Completed for every consumer upon admission; updated every 90 days or more frequently as needed if client experiences a change in household financial status.

- Appointments - Completed for every consumer.

- Screening – Completed for every consumer with 1st request for treatment; if a consumer is transferred from a different treatment provider, the receiving provider does NOT need to complete a second screening in CareNet as the client has already been determined to be eligible for SUD services.

- Assessment - Completed for every consumer upon admission and once annually for clients who are continuously enrolled in treatment for longer than 12 months. If a consumer is transferred from a different treatment provider, the receiving provider does NOT need to complete the assessment screen in CareNet if they have received a copy of the biopsychosocial assessment completed by the referring provider and placed it in the consumer's chart.

- MSHN Toxicology - Only required for consumers who are receiving Medication-Assisted Treatment (Methadone or Suboxone)

- Admissions – Completed for every consumer; please note, the admission date is the date of first face-to-face treatment service provided to the consumer NOT the date the consumer first requests services. Refer to State Behavioral Health Treatment Episode Data Set (BH-TEDS) Admission/Discharge Coding Instructions at www.mi.gov/mdhhs.

  Please note, if you receive the error message "Please Contact the CA" when attempting to enter an admission record on CareNet, it most likely indicates the client is already admitted to a different

treatment provider agency in the CareNet system. Please use the following guide to determine the best course of action:

1. If <u>you know</u> where the client was recently receiving treatment and the client has given consent for coordination of care to occur, please contact the other treatment provider directly and request that the discharge summary be completed. Once the discharge summary has been completed, a new admission record can be created. Both providers should document that coordination of care took place regarding the transfer of the client. This documentation can be in the form of a general note kept in the client's file. *Please note, this is the preferred method, as it is most consistent with best care practices to ensure a smooth transfer experience for the client.* This type of coordination of care is not considered a billable service.

2. If it is not known where the client was recently receiving treatment or if the client did not give consent for coordination of care to occur, please call the MSHN UM department at 844-405-3095 and we will facilitate the discharge from the other treatment provider.

3. If it is known that the client is receiving services at a different treatment provider AND there is a plan in place for the client to receive services from both treatment providers at the same time (dual enrollment), please call the MSHN UM department at 844-405-3095 to review the clinical factors that warrant the dual enrollment and the plan for coordination of care to avoid duplication of services. Once this has occurred, an MSHN UM specialist will provide assistance to enter the new admission record into the CareNet system.

<u>A Note About Clinical Information When Providing Non-Clinical Services (e.g.: Recovery Supports)</u>

For agencies who provide recovery support services only, please be sure that you are not entering clinical information such as Substance Use or Mental Health Diagnoses into the admission record if the client has not received a clinical assessment by a qualified practitioner. If the client has received a clinical assessment by a qualified practitioner *and* your agency has obtained a copy of that assessment, you may enter any diagnoses that are indicated on the assessment into the admission record. A copy of the assessment must be kept in the client file.

If the client has not received a clinical assessment by a qualified practitioner, use of a provisional diagnosis or diagnostic impression is still necessary. The appropriate ICD-9-CM V code or Z code contained in the ICD-10-CM should be used to indicate factors associated with the predisposition toward a potential diagnosis that without proper intervention, will lead to a full diagnosis. Typically, a provisional diagnosis can be used when there is strong presumption that the criteria could or will be met, but not enough information exists to make the full diagnosis. Diagnosing can only be done by appropriate master's or greater-level clinicians. The application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions, and addictions is the purview of practice of social work at the master's level.

- <u>Authorizations</u>

    - Timeliness Standards: Authorizations requests should be completed for every consumer within 1 business day of admission to detox services or within 3 business days of admission to all other levels of care. Re-authorization requests are expected to be submitted within 3 business days of the expiration of the previous authorization. Incidents of repeated non-

adherence to these timeliness standards by a specific agency may result in denial of the late authorization request or approval for a reduced number of service units than requested. Authorization requests that are late may be denied. The MSHN UM Department should be contacted if the provider needs to discuss reasons for late authorization submission.

- Pended Authorization Requests: MSHN UM specialists may place an authorization request into pended status after reviewing it and request further information or corrections from the SUDSP. In these instances, the SUDSP is to respond within three (3) business days. MSHN UM specialists should then respond to pended responses within three (3) business days.

- Documentation Standards: When entering authorization requests, please adhere to the following clinical documentation standards:

- All areas of the authorization request need to be completed in their entirety to ensure that the MSHN UM Department has enough information to justify continued treatment.

- Please be sure that authorization date ranges are sequential and do not overlap. If the current authorization expires on 4/30/2016, please begin the re-authorization request on 5/1/2016.

- The treatment plan section must be completely filled out, identifying treatment goals and specific progress the client has made toward each goal.

- All reauthorizations must include a documented continuing care and/or discharge plan in order to be authorized. If a detailed plan has not yet been created, please give the estimated length of remaining treatment as well as natural and community supports that have been identified throughout the current treatment episode

- Reauthorization units will be determined on a case-by-case basis utilizing ASAM and medical necessity criteria.
- If you discover a mistake with an authorization request, please contact the MSHN UM department for assistance and do not simply enter another authorization request. The UM staff will advise you with regard to the best method for correcting the specific issue.

Please refer to *FY17 Substance Use Disorder (SUD) Master CPT & HCPCS Code Grid* for additional information regarding the length of authorization requests and standard numbers of service units which can be requested for each Level of Care

- 271 Eligibility – Monthly eligibility checks are required to be performed for each client enrolled in services. Any changes to insurance benefits must be documented on the Payer screen in CareNet.

- Notes - When using the "Notes" section in CareNet please be sure to begin your correspondence with ATTN: and the name of the department/person you are seeking assistance from (i.e.: UM, Claims, Technical Assistance, etc.). This helps to ensure that your correspondence is directed to the correct MSHN staff person in a timely manner.

Modifier Codes:

The Michigan Department of Health and Human Services (MDHHS) has developed a set of modifiers (listed in the table below) which are attached to service billing codes for the purpose of tracking service provision to certain specialty populations. Please note, these modifiers are assigned to each SUDSP on an individual basis according to established licensing and credentialing criteria so these modifiers will not be available in CareNet to every treatment agency. Treatment agencies who wish to have access to specific modifiers will need to work with their designated MSHN Treatment or Prevention Specialist to submit documentation of appropriate credentialing/licensing in order to have the requested modifier made available in CareNet.

Transfer Between Providers: If a client is transferring from one provider to a different provider OR if a provider has more than one (1) license and the consumer is changing levels of care to a different license number, then please complete a discharge summary and choose "transfer" as the reason for discharge. In the comments section please note which provider or level of care the client is transferring to, and date of first appointment with that provider.

Level of Care Changes Within the Same Provider: If a client is transferring from one level of care to a different level of care within the same provider, and both levels of care have the same license number, a discharge summary is not required until the client has completely finished the treatment episode and is being discharged from all services.

Dual Program Enrollment: At times it may become necessary for one client to be enrolled in treatment services with more than one SUDSP at the same time. MSHN has established the following guidelines to prevent duplication of services and facilitate best client care:

- The programs must each be providing different services to the consumer that are not available at the same provider
- There is clinical justification for medical necessity of all services being provided, established by an assessment
- There is coordination between all programs involved in the client's care, (with appropriate client release of information), which is documented in the client's clinical chart as well as in CareNet authorization requests.
- The MSHN UM department must be contacted prior to dual enrollment

Case Managed Function: Both the Assessment page and Demographic page in CareNet include a check box at the top of the page that can be selected to designate "Yes, this client is case managed." Please DO NOT check these boxes, as this feature is reserved for MSHN staff use for the purpose of tracking specific client cases that may warrant additional attention and care coordination among providers (in accordance with MDHHS Treatment Policy #8 regarding the role of care management by the coordinating agency). This is a special feature in CareNet which will place a red bar across the top of the page of the client's record which states "CASE MANAGED." If you encounter a "CASE MANAGED" client in CareNet, please contact the MSHN UM department prior to admitting the client to services as this is an indication that MSHN is providing specialized care coordination due to extenuating circumstances with the client case.

Discharge Summary: A treatment episode is assumed to have ended at the time the consumer has not been seen for five (5) days for residential treatment and sixty (60) days in the case of outpatient care. Consumers not seen in these timeframes shall be discharged from the CareNet system. (See State Treatment Episode Data Set (BH-TEDS) Admission/Discharge Coding Instructions at www.mi.gov/mdhhs). Please note, the discharge date recorded on the CareNet system should be the last date the client received a billable treatment service from the provider.

For Medicaid/Healthy Michigan Plan Clients: If a client has not participated in scheduled services, please send the required Medicaid Advance Action notice to the client and allow them at least 12 days to respond. Once that time period has passed then proceed to enter the discharge summary on CareNet, however on the discharge form the date of discharge will be recorded as the date the client was last seen for services. That date is still considered the date the client effectively disengaged from services, but they are then given the required 12-day response time to have the opportunity to re-engage in services. If the client re-engages in services within that timeframe, the discharge does not occur.

MSHN places a high level of importance on discharge/continued care planning. Please review the expectations related to Discharge Planning beginning on page 24 of the MSHN SUDSP Manual. Additionally, it is the expectation of MSHN that all discharge summaries are completed in a timely manner. For a planned discharge (i.e.: the client is referred to a different provider, the client successfully completed treatment, etc.), the expectation is that the discharge summary is completed in 24 hours for Detox service providers and 3 business days for all other levels of care. In the event of an unplanned discharge, (i.e.: client has stopped attending scheduled treatment), please follow Medicaid Notice of Action guidelines by providing the client (or mailing to client's last known address) a written Advance Action Notice to close the client's case. Once the window of response time has lapsed, please complete the discharge from CareNet within 3 business days. The MSHN UM department may require providers to complete a monthly discharge report to ensure they are adhering to these established timeliness standards.

Outpatient

Outpatient treatment is organized and delivered in a variety of settings, in which addiction treatment staff provides professionally directed evaluation and treatment for substance-related disorders. Individual, couple, group and family therapy are common modalities appropriate for substance use disorder outpatient care.

This level of care typically consists of less than 9 hours of service per week for adults, or less than 6 hours per week for adolescents for recovery or motivational enhancement therapies and strategies. (ASAM Criteria)

Outpatient treatment is the level of care with the least amount of restriction, so it is important that clients' clinical presentation for the service matches medical necessity criteria.

Eligibility Criteria for Outpatient Treatment:

1. The client is experiencing a Substance Use Disorder reflected in a primary, validated DSM-V^{TR} or ICD-10 Diagnosis (not including V codes) that is identified as eligible for services in the MSHN SUDSP provider contract and the following (A or B, and C and D) manifestations is present:

a. The client reports or expresses a subjective level of distress and/or psychosocial problems and has been unable to maintain abstinence.

Or

b. The client's alcohol and/or drug abuse/dependence has resulted in significant consequences and social/family impairment but not to the degree that higher levels of care are not needed to provide additional structure, nor are any life-threatening withdrawal symptoms present.

And

c. The client is motivated for, or amenable to, treatment and has the skills to obtain a primary support system and a good recovery environment to aid in his or her recovery.

And

d. While various combinations of modalities may be employed an intensive approach is not necessary to either motivate the client or to achieve the treatment objectives, nor is a multidisciplinary treatment staff required.

And

2. A reasonable expectation that the client's presenting symptoms, conditions, or level of functioning will improve through treatment.

And

3. The treatment is safe and effective according to nationally accepted standards generally recognized by substance use disorder and mental health professionals.

And

4. It is the most appropriate and cost-effective level of care that can be safely provided for the client's immediate condition based on the ASAM PPC-2R.

Detoxification Services

Individuals in need of sub-acute detoxification services may access services directly from the provider. The provider will be responsible for securing a clinical assessment as part of detox services to ensure that the consumer meets ASAM and medical necessity criteria related to this level of care. Please note, symptom alleviation alone is not sufficient justification for authorization of detox services. Please meet the following guidelines related to requests for detox services:

Detoxification Expectations:

1. The initial drug and alcohol assessment (H0001) may not be billed. This activity will be reimbursed as part of the daily reimbursement rate of detox service (H0010 or H0012).

2. The individual must be experiencing physical symptoms of withdrawal from one of the following substances in order for the detox admission to be considered medically necessary: Alcohol, Opioids, and/or Benzodiazepines. According to *The ASAM Criteria 3rd Edition,* detoxification services are not usually medically necessary to manage the withdrawal effects from Cocaine, Marijuana, Hallucinogens, or Amphetamines. Exceptions to this need to be discussed with MSHN UM department prior to admission to a detoxification program.

3. An initial authorization request must be submitted on CareNet within 24 hours, or 1 business day in the case of weekend/holiday admissions. An initial authorization request can include up to 5 days of detox services for clients with a diagnosis of Opioid Use Disorder, and up to 3 days of

detox services for clients with primary SUD diagnoses other than Opioid Use Disorder. Re-authorization requests should be submitted on a daily basis thereafter, with documentation of continued medical necessity *and* ASAM criteria for the additional days being requested.

4. Services will not be authorized unless discharge planning is clearly identified. The provider shall coordinate the transfer to aftercare services and document in CareNet.

Clients in need of acute detox should go to their local emergency room. This service is limited to stabilization of the medical effects of the withdrawal and referral to ongoing treatment services. Symptom alleviation is not sufficient for purposes of admission to this level of care, given its emergent nature. Acute detoxification in a medical facility is a benefit of the Medicaid Health Plan and is not covered by MSHN.

For non-Medicaid consumers, MSHN will not reimburse more than three (3) episodes of detox in a twelve-month period.

(H0010) Medically-Monitored and (H0012) Clinically-Managed

Medically-Monitored detox (H0010) must be staffed twenty-four (24) hours per day, seven (7) days per week, by a licensed physician or by the designated representative of a licensed physician. Clinically-Managed detox (H0012) can be non-medical setting but must be provided under the supervision of a certified addictions counselor. The services must have arrangements for access to medical personnel as needed and consistent with MDHHS Substance Licensing Rules. Sub-acute detoxification services are defined as "supervised care provided in a sub-acute residential setting for the purpose of managing the effects of withdrawal from alcohol and/or other drugs." Services typically last three (3) to five (5) days.

Residential Treatment (Including Women's Specialty and Adolescent Residential)

MSHN adheres to the requirements of OROSC's *Treatment Policy #10: Residential Treatment Continuum of Services*.

Residential SUD treatment services offer a planned and structured regimen of care in a 24-hour staffed residential setting. Treatment services adhere to defined policies, procedures, and clinical protocols. They are housed in, or affiliated with, permanent facilities where clients can reside safely. They are staffed 24-hours a day.

OROSC's Treatment Policy #10 notes, "Historically, residential services have been defined by length-0f-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services: short-term residential: less than 30 days in a program, and long-term residential: 30 days or more in a program." Current CPT/HCPC coding continues this structure whereas The ASAM Criteria, 3rd Edition and OROSC's policy is based on a continuum ranging from least intensive residential to the most intensive medically monitored intensive inpatient services. The ASAM Criteria, 3rd Edition continues describing the differences between Level 3 programs, "may be based partially on intensity (e.g., Level 3.1 requires a minimum of 5 hours of treatment per week compared to Level 3.5 which provides 24-hour services and supports). However, the defining differences between these levels of care are the functional limitations of the clients and the services provided to respond to those limitations. The goal is to provide a flexible system with overlapping levels of care making transition between levels of care as seamless as possible." OROSC's Treatment Policy #10: Residential Treatment Continuum of Care is based on this structure.

According to this policy, MSHN is expected to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM Levels 3.1, 3.3, and 3.5. The frequency and duration of residential treatment services are expected to be guided by The ASAM Criteria, 3rd Edition and described as follows:

ASAM Level 3.1: Low-Intensity Residential Services (H0018): These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focusing on improving the individual's functioning and coping skills in Dimension 5 and 6. The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

ASAM Level 3.3: Medium-Intensity Residential Services (H0019): These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning. The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this level of care have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

ASAM Level 3.5: High-Intensity Residential Services (H0019): These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment and/or criminal justice histories, limited work and educational experiences, and antisocial value systems. The length of treatment depends on the individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

Service Requirements for Residential Programs

**From OROSC Treatment Policy #10- Residential Treatment Continuum of Services*

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM 3.1 (Low Intensity) Clients with lower impairment or lower complexity of needs.	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM 3.3 (Medium Intensity) Clients with moderate to high impairment or moderate to high complexity of needs.	Not less than 13 hours per week	Not less than 13 hours per week
ASAM 3.5 (High Intensity) Clients with a significant level of impairment or very complex needs.	Not less than 20 hours per week	Not less than 20 hours per week

Residential Treatment Expectations:

1. Prior to admission, alternative, less restrictive levels of care should be considered and attempted as appropriate. A more restrictive level of care should not be considered solely on a "convenience" basis or automatically considered when presented as an alternative to incarceration or when ordered by the court system. The client still must meet medical necessity criteria for the residential level of care as determined by ASAM placement.

2. All clients entering residential treatment must be tested for tuberculosis (TB) upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.

3. The initial drug and alcohol assessment (H0001) may not be billed. This activity will be reimbursed as part of the daily rate for residential service (H0018 or H0019).

4. An initial authorization request must be submitted on CareNet within 3 business days of admission. Requests for H0018 Low Intensity Residential Treatment will be reviewed in increments of 10 days (Initial authorization requests and re-authorization requests). Requests for H0019 Medium Intensity Residential Treatment or High Intensity Residential Treatment will be reviewed in increments of 21 days (Initial authorization requests and re-authorization requests).

5. For adolescents, face-to-face family meetings are a critical part of the treatment plan. The frequency of these meetings is to be determined from the clinical presentation of a given case but not less than once per week. (Multi-family therapy does not take the place of individual family therapy.)

6. In the event that a client is absent from treatment for more than 24 hours, a note needs to be generated in CareNet and a Utilization Management Specialist will need to be contacted.

Continuing Care Following Detox or Residential Treatment

Providers are responsible for setting up continuing care appointments and facilitating a smooth transition to continuing care following a residential treatment episode. It is critical that the receiving provider obtain clinical information prior to the first continuing care appointment. The following procedure should be followed to facilitate this process:

1. Complete all appropriate releases, especially to MSHN UM Department and the new provider.

2. Aid consumer in choosing appropriate MSHN contracted Provider and document consumer's choice.

3. Facilitate a consumer call to the new provider to set the first continuing care appointment.

4. Fax a Release of Information and all printed CareNet screens and other pertinent information to the new provider prior to first appointment.

5. Describe continuing care and/or discharge plan in discharge notes section of CareNet Discharge screen (Information must include, at a minimum date, time and location of continuing care appointment).

Medication-Assisted Treatment (MAT)

Due to the specialized nature of medication-assisted treatment (MAT) and the intensive monitoring requirements established at the Federal and State level, MSHN has developed a separate attachment to the MSHN SUD Provider Manual for MAT providers. Please reference the MSHN Medication-Assisted Treatment (MAT) Guidelines further guidance and information.

Provider Appeal Process

Mid-State Health Network (MSHN) has established a process for providers for the resolution of appeals of MSHN denials of service. This process is for when the provider has already provided the service, the consumer is no longer receiving services at the agency, the authorization request was subsequently submitted and reviewed, and was denied by MSHN. A provider may file an initial appeal to the MSHN Customer Service Department regarding service authorization decisions. Providers are encouraged to contact the MSHN Utilization Management (UM) Department prior to submitting an appeal for the purpose of reaching a satisfactory resolution in the most expedient manner possible.

If MSHN should deny the provider compensation to which the provider believes it is entitled, the provider shall notify MSHN Customer Services in writing within thirty (30) days of the date of notification of denial, stating the grounds upon which it bases its claim. MSHN shall then have thirty (30) days to review and provide final determination of the appeal.

Services shall not be delayed or denied as a result of the dispute or potential dispute of payment responsibility, however at the time of delivery, each service must meet medical necessity criteria and be documented to accepted standards of care. All services provided must be clearly specified and relate to scope, amount, and duration in the approved plan of service.

When the treatment service has already been provided to the consumer and where the MSHN UM Department has denied the service authorization request, an adequate action letter (see attachment A) (including the Request for Hearing Form and envelope) shall be mailed to the consumer and a copy of the letter will also go to the provider. The consumer shall also receive a phone call and be informed as to why the adequate action letter was sent. The consumer shall be informed of the formality of the requirement, including that as a Medicaid or Health Michigan Plan beneficiary, he or she is not liable to pay for the service and does not need to do anything with the Request for Hearing Form. The consumer shall not be billed by the provider. The letter also explains that the consumer may also contact MSHN should he or she receive a bill from the provider, or if there should be any other concerns or questions about the letter or any part of the process.

Appeal Process

1. All appeals must be in writing and include the date of the appeal, decision grieved, resolution requested, and supporting rationale for requested change in decision and indicate if issue warrants an "Expedited Review Situation."

2. All appeals must be in writing and include the date of the appeal, decision grieved, resolution requested, and supporting rationale for requested change in decision and indicate if issue warrants an "Expedited Review Situation."

3. An Expedited Review Situation is an expedited review of a service authorization denial, requested by the provider. When the provider requests the expedited review, MSHN shall determine, if the request is warranted and shall inform the provider as to the status of the decision.

4. No appeal will be considered after sixty (60) calendar days from the date of the action being grieved.

5. The appeal can be made directly to the Utilization Management Department for decisions made regarding the authorization or determination of the service(s).

6. As appropriate, the MSHN UM Department will include input from the appropriate MSHN position/function, including:

    a. Director of Provider Network Management Systems;
    b. Contract Manager;
    c. Utilization Management Specialist;
    d. Claims Specialist;
    e. Director of Utilization Management and Waivers;
    f. Chief Clinical Officer;
    g. Medical Director

7. The Utilization Management Department will communicate the decision to the provider within seven (7) calendar days of receipt of the appeal. If the appeal is an Expedited Review Request, the Utilization Management Department will render a decision within three (3) business days of receipt of the appeal.

8. Mid-State Health Network (MSHN) is obliged to offer contracted providers with an appropriate mechanism to dispute contract concerns, payment performance review findings, contract monitoring and oversight, or adverse credentialing decisions. The Provider Appeal Procedure for Substance Use Disorder (SUD) Providers procedure is intended to assure that a uniform process for appeal is used in the region.
9.
10. Any appeals that pertain to requests for provider expansion of use of treatment/service codes or additional treatment/service codes requested for authorization shall be referred to the MSHN Director of Provider Network Management Systems and the MSHN Contract Manager for review.

Appendix A
Adequate Action Notice

[Name] [Date]
[Address]
[City, State, Zip]

RE: Beneficiary's Name: [_____]
Beneficiary's Medicaid ID Number: [_____]

Dear [_____]:

On **DATE(S)** you received **SERVICE(S)** from **TREATMENT PROVIDER. TREATMENT PROVIDER** has submitted a request for authorization of payment for these services to Mid-State Health Network (MSHN). Following a review of the authorization request by a MSHN utilization management specialist, it has been determined that the authorization for payment for these services will be denied to **TREATMENT PROVIDER** for the following reason(s): **list clinical reasons and relevant policy/codes.** The legal basis for this decision is **[enter relevant Medicaid Provider Manual sections]** and 42C.F.R. 440.230(d).

This letter is to inform you that authorization for payment for services has been denied to **TREATMENT PROVIDER** and to also inform you that *as a Medicaid or Healthy Michigan Plan beneficiary you are not responsible for any costs associated with the services you received*. If you would happen to receive a bill for any portion of these services, please contact the MSHN customer service and rights specialist for assistance:

Jeanne L. Diver, MPA, Customer Service & Rights Specialist
Mid-State Health Network (MSHN)
530 W. Ionia St., Suite F, Lansing, MI 48933
Phone: (517) 657-3011; Toll Free Phone (844) 405-3094
Fax: (517) 574-4093

Sincerely,

CC: **TREATMENT PROVIDER**

Appendix B: FY17 SUBSTANCE USE DISORDER (SUD) MASTER CPT & HCPCS CODE GRID

OUTPATIENT	DESCRIPTION (HCPCS/CPT)	BILLING PARAMETERS	STANDARD AUTHORIZATION PATTERN	REAUTHORIZATION PATTERN	PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)
Criteria/ASAM Parameters: Dimensions 1, 2, and 3 are minimal to stable. At least one of Dimensions 4,5, or 6 meets ASAM Level I criteria; if multiple Dimensions meet criteria for Levels II through IV, outpatient services may not be sufficient to address the needs of the individual and a higher level of care (LOC) should be considered					
90832 (Psychotherapy Individual)	Psychotherapy, 30 minutes with individual and/or family member	Encounter	Up to 20 units (combination of 90832, 90834, 90837, 90846, 90847, 90853) per 6-month period.	Re-Auth up to 20 sessions (combination of 90832, 90834, 90837, 90846, 90847, 90853). ASAM and clinical rationale need to be provided in the MSHN electronic health management system.	For psychotherapy (908xx series codes): Substance Abuse Treatment Specialist (SATS), Only Master's prepared with appropriate licensure and working under appropriate supervision may provide services.
90834 (Psychotherapy Individual)	Psychotherapy, 45 minutes with individual and/or family member	Encounter	Up to 20 units (combination of 90832, 90834, 90837, 90846, 90847, 90853) per 6-month period.	Re-Auth up to 20 sessions (combination of 90832, 90834, 90837, 90846, 90847, 90853). ASAM and clinical rationale need to be provided in the MSHN electronic health management system.	Same as above
90837 (Psychotherapy Individual)	Psychotherapy, 60 minutes with individual and/or family member	Encounter	Up to 20 units (combination of 90832, 90834, 90837, 90846, 90847, 90853) per 6-month period.	Re-Auth up to 20 sessions (combination of 90832, 90834, 90837, 90846, 90847, 90853). ASAM and clinical rationale need to be provided in the MSHN electronic health management system.	Same as above
90846 (Family Psychotherapy without consumer present)	Psychotherapy, 60 minutes with family member(s), without client present	Encounter	Up to 20 units (combination of 90832, 90834, 90837, 90846, 90847, 90853) per 6-month period.	Re-Auth up to 20 sessions (combination of 90832, 90834, 90837, 90846, 90847, 90853). ASAM and clinical rationale need to be provided in the MSHN electronic health management system.	Same as above
90847 (Family Psychotherapy with consumer present)	Psychotherapy, 60 minutes with family member(s), with client present	Encounter	Up to 20 units (combination of 90832, 90834, 90837,	Re-Auth up to 20 sessions (combination of 90832, 90834, 90837, 90846,	Same as above

			90846, 90847, 90853) per 6-month period.	90847, 90853). ASAM and clinical rationale need to be provided in the MSHN electronic health management system.	
OUTPATIENT	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD AUTHORIZATION PATTERN**	**REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
90853 (Psychotherapy Group)	Group Psychotherapy, may be provided in units of 60 minutes, 90 minutes, or 120 minutes	Encounter (If billing more than 1 unit per day, services must be provided at different times and recorded as 2 separate services in the medical record)	Up to 20 units (combination of 90832, 90834, 90837, 90846, 90847, 90853) per 6-month period.	Re-Auth up to 20 sessions (combination of 90832, 90834, 90837, 90846, 90847, 90853). ASAM and clinical rationale need to be provided in the MSHN electronic health management system.	Same as above
90791 (Psychiatric Diagnostic Evaluation, No Medical Services)	Integrated biopsychosocial assessment, including history, mental status and recommendations	Encounter	One unit per episode of care	NA	Psychiatrist or Psychiatric Mental Health Nurse Practitioner
97810/97811 (Acupuncture 1 or more needles, Initial; Acupuncture 1 or more needles, Subsequent)	97810- Initial 15-minute contact 97811- Subsequent; each additional 15- minute contact within the same session	Only one initial (97810) code per day. 97811 must be billed in conjunction with 97810. NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO BLOCK GRANT ONLY			Approved via LARA certified diplomate of the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Acupuncture or Oriental Medicine
99202-New Patient Medication Review **99213-Established Patient Medication Review**	Brief, 20-minute encounter, may be face to face or telemedicine, patient evaluation and medication management	Encounter	Varies by provider. Currently methadone, Suboxone and for co-occurring if psychiatrist is on site.		Physician (MD or DO), licensed physician's assistant, or nurse practitioner under their scope of practice and under the supervision and delegation of a physician
H0001 (Individual Assessment)	Alcohol and/or drug assessment face-to-face service for the purpose of identifying functional and	Encounter	Must be completed annually when a continuous treatment episode lasts more than 12 months. 1 unit per treatment		Provider agency licensed and accredited as substance abuse treatment program. Service

	treatment needs and to formulate the basis for the Individualized Treatment Plan (Minimum 60 minutes)	Not billable with H0010, H0012, H0018, or H0019	provider, per episode of care for episodes of care lasting less than 12 months.		provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.
OUTPATIENT	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD AUTHORIZATION PATTERN**	**REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
H0002 (Brief Screen, SBIRT; Face-to-Face)	Brief Screen	Encounter	Available to select providers only using the SBIRT model; 1 unit per treatment provider, per episode of care	Not Applicable	
H0003 (Laboratory Analysis of Drug Screening)	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs	Encounter NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO BLOCK GRANT ONLY	2 per month		N/A
H0004 (Behavioral Health Counseling)	Behavioral health individual counseling. Includes: SUD/MH, Community-Based, Women's Specialty, and Adolescent.	15 Minute Increment (maximum 6/Day)	Up to 40 units per 6-month period. (May allow up to 80 units if requesting individual only, with no groups (per 12 month period).		Provider agency licensed and accredited as substance abuse treatment program For all "H" and "T" HCPCS Codes: Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.
H0005 (Group Counseling by a Clinician)	Alcohol and/or drug services; group counseling by a clinician; 90 minutes	Encounter (If billing more than 1 unit per day, services must be provided at different times and recorded as 2 separate services)	Up to 20 units per 6-month period. (May allow up to 80 units if requesting group services only, with no individual).		Please see above for "H" and "T" codes

OUTPATIENT	DESCRIPTION (HCPCS/CPT)	BILLING PARAMETERS	STANDARD AUTHORIZATION PATTERN	REAUTHORIZATION PATTERN	PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)
H0006 (Case Management Services)	Alcohol and/or drug services; case management services provided to link, refer and coordinate clients to other essential medical, educational, social and/or other services	15 Minute Increment No limit on number of units billed in one day, however must be documented accurately in client record with start/stop times NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO BLOCK GRANT ONLY	Up to 48 units (combination of H0048 and/or H0006) per authorization request		Provider agency licensed and accredited as substance abuse treatment program with case management license
H0020 (Methadone Administration Daily Dose)	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program); Per Day	Encounter (Daily Dosing)	Must complete annual assessment Includes Initial Lab/Drug Testing and Dosing Initial Authorization: 90 Days	Re-Authorization: Up to 120 Days for clients in phases 2-6 of program	Provider agency licensed and accredited as methadone clinic. Supervision by licensed physician. Administration of methadone by an MD, DO, licensed physician's assistant, RN, LPN or pharmacist.
H0022 (Alcohol and/or Drug Intervention)	Alcohol and/or drug intervention service (planned facilitation); May be individual or group	Encounter	Up to 10 units of individual or 20 of group in an initial authorization		Provider agency licensed and accredited as substance abuse treatment program. Service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.
H0048 (Instant Drug Testing Collection & Handling Only)	Alcohol and/or drug screening; **instant only** analysis of specimens for	Encounter	2 per month		

	presence of alcohol and/or drugs.				
OUTPATIENT	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD AUTHORIZATION PATTERN**	**REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
H0050 (Brief Intervention/Care Coordination)	Alcohol and/or drug services; brief intervention/Care Coordination	15 Minute Increment	Up to 48 units (combination of H0048 and/or H0006) per authorization request		Provider agency licensed and accredited as substance abuse treatment program For all "H" and "T" HCPCS Codes: Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.
H2027 (Psychoeducation Services)	Psychoeducational Service; Didactic/Educational Group	15 Minute Increment No limit on number of units billed in one day, however must be documented accurately in client record with start/stop times	Up to 100 units per authorization period		Please see above for "H" and "T" codes
T1012 (Recovery Support Services)	Individual Recovery Support; Non-clinical services that assist individuals and families to recover from alcohol and/or drug problems.	Encounter	Up to 20 individual encounters per authorization		A recovery coach or SUD peer specialist must be certified through an MDHHS-approved training program.
H0038 (Recovery Support-Group)	Group Recovery Support	15 Minute Increment	Up to 50 group units per authorization		A qualified SUD peer specialist must be certified through an MDHHS-approved training program.

RESIDENTIAL	DESCRIPTION (HCPCS/CPT)	BILLING PARAMETERS	STANDARD INITIAL AUTHORIZATION PATTERN	STANDARD REAUTHORIZATION PATTERN	PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)
Criteria/ASAM Parameters: ASAM 3.1 (Low Intensity) Clients with lower impairment or lower complexity of needs. ASAM 3.3 (Medium Intensity) Clients with moderate to high impairment or moderate to high complexity of needs. ASAM 3.5 (High Intensity) Clients with a significant level of impairment or very complex needs.					
H0018 (Clinically Managed Low-Intensity Residential Services)	Alcohol and/or drug services; Low Intensity residential (non-hospital residential treatment program); directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. **ASAM 3.1**	Per Diem Cannot bill H0001 in conjunction with H0018	Authorized in up to 21 day increments with a recommendation of an initial authorization of 10 days. 2 episodes of care within 12-month period.	Reauthorized in up to 10 day increments, as medically necessary. ASAM and clinical rationale need to be provided in the managed care information system.	Provider agency licensed and accredited as substance abuse treatment program. The clinical program must be provided under the supervision of a SATS with licensure as a psychologist, master's social worker, licensed or limited-licensed professional counselor, physician, or licensed marriage and family therapist. Please see MSHN SUD Provider Manual for additional requirements pertaining to hours of service provision per week.
H0019 (Clinically Managed Medium-Intensity Residential Services)	Alcohol and/or drug services; Medium Intensity residential (non-medical, non-acute care in residential treatment program); structured recovery environment in combination with medium-intensity clinical services to support recovery. **ASAM 3.3**	Per Diem Cannot bill H0001 in conjunction with H0019	Authorized in up to 21 day increments. 2 episodes of care within 12-month period.	Reauthorized in up to 21 day increments, as medically necessary. ASAM and clinical rationale need to be provided in the managed care information system.	Provider agency licensed and accredited as substance abuse treatment program. The clinical program must be provided under the supervision of a SATS with licensure as a psychologist, master's social worker, licensed or

					limited-licensed professional counselor, physician, or licensed marriage and family therapist. Please see MSHN SUD Provider Manual for additional requirements pertaining to hours of service provision per week.
RESIDENTIAL	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD INITIAL AUTHORIZATION PATTERN**	**STANDARD REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
Criteria/ASAM Parameters: ASAM 3.1 (Low Intensity) Clients with lower impairment or lower complexity of needs. ASAM 3.3 (Medium Intensity) Clients with moderate to high impairment or moderate to high complexity of needs. ASAM 3.5 (High Intensity) Clients with a significant level of impairment or very complex needs.	Per Diem	May not exceed more than one per day. NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO BLOCK GRANT ONLY	Up to 90 days with documentation of concurrent enrollment in outpatient therapy	Up to 180 day total benefit with documentation of concurrent enrollment in outpatient therapy during each month recovery housing is funding.	
S9976 (Residential room and board)	Per Diem	May not exceed more than one per day. Cannot be billed with H0010 or H0012 Detox Services NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO BLOCK GRANT ONLY	Authorized in conjunction with H0018 or H0019; Authorized in same number of day increments as the H0018 and H0019.		N/A

RESIDENTIAL	DESCRIPTION (HCPCS/CPT)	BILLING PARAMETERS	STANDARD INITIAL AUTHORIZATION PATTERN	STANDARD REAUTHORIZATION PATTERN	PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)
S9976:SD (Residential room and board – State Disability Assistance)	Per Diem	May not exceed more than one per day Cannot be billed with H0010 or H0012 Detox Services NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO STATE DISABILITY ASSISTANCE ONLY	The PIHP may employ either of two methods for determining whether an individual meets MDHHS eligibility criteria: The PIHP may refer the individual to the local MDHHS human services office. This method must be employed when there is a desire to qualify the individual for an incidental allowance under the SDA program. Or, The PIHP may make its own determination of eligibility by applying the essential MDHHS eligibility criteria. Regardless of the method used, the PIHP must retain documentation sufficient to justify determinations of eligibility. The PIHP must have a written agreement with a provider in order to provide SDA funds.		N/A
DETOXIFICATION	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD INITIAL AUTHORIZATION PATTERN**	**STANDARD REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
Criteria/ASAM Parameters: Sub-Acute Detox: Meets criteria for level of care in Dimension 1 and does not indicate the need for a more intensive level of treatment. Note: Pregnant clients who are opiate dependent and not recommended for detoxification services. Pregnant clients can be referred to Opioid Maintenance Treatment (OMT)					
H0010 (Medically Monitored Residential Detox)	Alcohol and/or drug services; sub-acute detoxification; ASAM Level 3.7-D	Cannot bill H0001 or S9976 in conjunction with H0012	3 episodes of care within twelve-month period 5 Day Initial Authorization with Opioid Use Disorder Primary Diagnosis; Re-		For residential settings (H0010 and H0012): provider agency licensed and accredited as substance abuse residential detoxification

			Authorization requests are reviewed for medical necessity for each subsequent day 3 Day Initial Authorization with Alcohol Use Disorder or Benzodiazepine Use Disorder Diagnosis; Re-Authorization requests are reviewed for medical necessity for each subsequent day		program. Supervision by licensed physician. Staffed 24-hours-per-day, 7-days-per-week by licensed physician or by the designated representative of a licensed physician.
DETOXIFICATION	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD INITIAL AUTHORIZATION PATTERN**	**STANDARD REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
H0012 (Clinically Managed Residential Detox)	Alcohol and/or drug services; sub-acute detoxification; ASAM Level 3.2-D	Cannot bill H0001 or S9976 in conjunction with H0012	3 episodes of care within twelve-month period 5 Day Initial Authorization with Opioid Use Disorder Primary Diagnosis; Re-Authorization requests are reviewed for medical necessity for each subsequent day 3 Day Initial Authorization with Alcohol Use Disorder or Benzodiazepine Use Disorder Diagnosis; Re-Authorization requests are reviewed for medical necessity for each subsequent day		For residential settings (H0010 and H0012): provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by licensed physician. Provided under the supervision of a Substance Abuse Treatment Specialist. Must have arrangements for access to licensed medical personnel as needed.

ADDITIONAL SERVICES	DESCRIPTION (HCPCS/CPT)	BILLING PARAMETERS	STANDARD AUTHORIZATION PATTERN	STANDARD REAUTHORIZATION PATTERN	PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)
A0110 (Non-Emergency Transportation & Bus Token)	Non-Emergency transportation service	Up to 10 units maximum per day BILLABLE TO HMP AND BLOCK GRANT ONLY	Please see MSHN Transportation technical advisory for limitations regarding utilization of this code Pre-Authorization Required through MSHN UM department: 1-844-405-3095		
S0215 (Non-Emergency Transportation per mile)	Non-Emergency transportation services	Per Mile. IRS rate is the maximum allowable.	Please see MSHN Transportation technical advisory for limitations regarding utilization of this code Pre-Authorization Required through MSHN UM department: 1-844-405-3095		State Plan and "b3" Services: Aide with valid Michigan driver's license appropriate to the vehicle being driven.
T2003 (Non-Emergency Gas Card)	Non-Emergency transportation service	BILLABLE TO BLOCK GRANT ONLY	Please see MSHN Transportation technical advisory for limitations regarding utilization of this code Pre-Authorization Required through MSHN UM department: 1-844-405-3095		
H2011 (Crisis Intervention)	Crisis intervention service	15-minute unit, face to face. May use up to four 15-minute units (equaling 60 minutes); Only used in situations where a client arrives for group but is in a crisis best handled in a one-on-one, face-to-face setting. The group code can then be	Do NOT request this code in an authorization for services request, as this is an exchange allowed only code. This code is NOT to be used if a client calls in a crisis situation and talks with a PROVIDER on the phone and/or an individual session is then scheduled.		Provider agency licensed and accredited as substance abuse treatment program For all "H" and "T" HCPCS Codes: Clinical service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when

		exchanged for the crisis intervention code.			working under the supervision of a SATS.
ADDITIONAL SERVICES	**DESCRIPTION (HCPCS/CPT)**	**BILLING PARAMETERS**	**STANDARD AUTHORIZATION PATTERN**	**STANDARD REAUTHORIZATION PATTERN**	**PROVIDER/STAFF QUALIFICATIONS (Per MDHHS)**
T1009 (Care of Child(ren) of the Individual Receiving Outpatient SUD Services; Care of Child(ren) of the Individual Receiving Residential SUD Services)	Child Sitting services for children of the individual receiving outpatient alcohol and/or substance abuse services (Per hour/Per child) -OR- Child Sitting services for children of the individual receiving residential alcohol and/or substance abuse services (Per Diem)	Must be Women's Specialty (HD Modifier) NOT BILLABLE TO MEDICAID/HMP; BILLABLE TO BLOCK GRANT ONLY	In Outpatient Treatment Settings: T1009 Child Care units are authorized in conjunction with the number of treatment service units being authorized for the parent In Residential Treatment Settings: Per Diem, per child		Provider agency licensed and accredited as substance abuse treatment program and also has "Women's Specialty Services" Designation

Modifiers for Substance Abuse HCPCS & CPT Codes

Modifier	Description
GT	**Telemedicine**: the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real-time interactive audio and video telecommunications system. The beneficiary must be able to see and interact with the off-site practitioner at the time services are provided via telemedicine.
HA	**Child-Adolescent Program**: services designed for persons under the age of 18.
HD	**Women's Specialty Services: Pregnant/Parenting Women Program**: services provided in a program that treats pregnant or women with dependent children. **HD is required for all qualified Women's Specialty Services.**
HF	**Substance Abuse Program**: to be used with those codes shared between Mental Health and SUD. The modifier is to differentiate between SUD and Mental Health for billing purposes.
HH	**Integrated Substance Abuse/Mental Health Program**: program specifically designed to provide integrated services to persons who need both substance abuse and mental health services, as planned in an integrated, individualized treatment plan. **HH modifier is required for qualifying Integrated Substance Abuse/Mental Health services.** Providers will be assigned the use of HH modifiers with submission of documentation of licensure for Integrated Substance Abuse & Mental Health Services. All subsequent services delivered to meet the goals of the integrated plan are to be reported with an 'HH'.
HH TG	**SAMHSA – Approved Evidence Based Practice for Co-Occurring Disorders: Integrated Dual Disorder Treatment is provided.**
SD	**State Disability assistance**

References

OROSC Treatment Policy #7 Access Management System

OROSC Treatment Policy #10 Residential Treatment Continuum of Services

MSHN CMHSP Responsibilities for 24/7/365 Access for Individuals with Primary Substance Use Disorders

MDCH Technical Treatment Advisory #6 Counseling Requirements for Clients Receiving Methadone Treatment

MDCH Technical Treatment Advisory #7 Recovery Support Services

MDCH Technical Treatment Advisory #5 Welcoming

Michigan Compiled Laws-MCL Section 333.18501

Michigan Department of Health and Human Services "Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes", January 2016

Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY17

Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, Section 2-Program Requirements, 2.3 Location of Service

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM-5, American Psychiatric Association

Appendix B: Technical Requirements for Veterans

Technical Requirement

Veteran's Access to MSHN Substance Use Disorder Treatment

I. Summary

Veterans who request services from the Mid-State Health Network's (MSHN) provider system may require additional assistance through coordination of benefits to ensure that the proper referral is made in a timely fashion. The following technical requirement has been established to further supplement MSHN's Technical Requirement, *CMHSP Responsibilities for 24/7/365 Access for Individuals with Primary Substance Use Disorders*.

II. Purpose

These requirements exist to establish MSHN Utilization Management (UM) guidelines for Veteran's access to the MSHN substance use disorder (SUD) treatment system of care and/or referral to the appropriate Veteran's Affairs (VA) provider, where applicable.

III. Procedure

A. Veteran's Affairs (VA) Benefits

If the individual served in the active military, naval, or air service and are separated under any condition other than dishonorable, they may qualify for VA health care benefits. Staff will seek out insight as to whether the Veteran is covered by any/some of them. These benefits include:

1) Tricare

Tricare, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the United States Department of Defense Military Health System. Tricare provides civilian health benefits for U.S Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve Component.

2) CHAMPVA

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a health benefits program in which the Department of Veterans Affairs (VA) shares the cost of certain health care services and supplies with eligible beneficiaries. In general, the CHAMPVA program covers most health care services and supplies that are medically and psychologically necessary.

3) Veteran's Choice Program

To improve access to and quality of care for veterans, the Veterans Access, Choice, and Accountability Act (VACAA) of 2014 requires that the VA offer an authorization to receive non-VA care to any veteran who is enrolled in the VA health care system as of August 1,

2014, or who is a newly discharged combat veteran if such veteran is unable to secure an appointment at a VA medical facility within 30 days (or within 30 days that he or she wishes to be seen) or resides more than 40 miles from the nearest VA medical facility. The VACAA requires the VA to provide a Veterans Choice Card to eligible veterans to facilitate care provided by non-VA providers. Veterans Choice Program (VCP) provides primary care, inpatient and outpatient specialty care, and mental health care for eligible Veterans when the local U.S. Department of Veterans Affairs (VA) health care facility cannot provide the services. To verify eligibility, Veterans must call the Choice Program call center at: 866-606-8198

B. Verification and Coordination of Benefits

MSHN shall screen any Veteran to determine whether the individual has active VA benefits, other third-party liability coverage (TPL), is covered by Medicaid or Health Michigan Plan (HMP), or has no coverage. The MSHN UM Specialists shall verify the coverage of the Veteran, including the following details:

1) Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort.

2) Information about a beneficiary's other insurance is available through the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from the CHAMPS 270/271 transaction.

3) Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage.

4) If a Medicaid beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed (Michigan Medicaid Provider Manual, 2016, p. 129).

5) Verification of Medicaid or HMP eligibility at the time the screening is performed. If the Veteran has Medicaid or HMP, the MSHN UM Specialist will proceed with authorizing services as with any other caller who possesses the same coverage.

6) Verification of Medicaid or HMP eligibility before action is taken on provider's request for authorization or reauthorization for treatment services (i.e. the Veteran has already started service with the SUD treatment provider). If the request for authorization or re-authorization is made, it shall include the details necessary to assist the MSHN UM Specialist in determining eligibility for coverage.

7) If the Veteran has active VA insurance, a warm transfer to the appropriate VA facility should be initiated.

8) If the Veteran is uninsured (i.e. does not have Medicaid or HMP), a warm transfer to the VA should be made to determine the Veteran's VA eligibility and/or level of care.

9) If the uninsured Veteran is ineligible for VA services, then the MSHN UM Specialist should ensure there are no other funding options present for the Veteran before assigning Block Grant funds.

10) The VCP benefit may be limited in the service area, including access to specialty care (i.e. case management, recovery support, and concurrent psychiatric care), and MSHN UM Specialists should authorize SUD services consistent with medical necessity criteria and VA benefit limitations in order to close service gaps and enhance care access and delivery.

11) If the Veteran has no third-party coverage and has Medicaid or HMP, then MSHN is the primary authorizer of substance use disorder (SUD) services.

The MSHN-contracted SUD treatment provider shall also verify the coverage of the Veteran, including the following:

1) Responsibility for Veteran's Medicaid or HMP eligibility verification, regardless of whether confirmed by the Veteran or UM Specialist at time of the Veteran's admission.

2) Provider will also perform monthly Medicaid or HMP eligibility verification and maintain evidence of having done so.

C. Veteran Service Access

Providers should note that a client's service in the military does not automatically mean they receive Veteran's Affairs (VA) benefits. Providers should, however, work with clients to ensure VA benefits are used as primary insurance, *if available*. Eligibility for VA benefits are determined by the VA upon review of a Veteran's discharge paper (known as the DD-214). The Veteran may also use the following site for obtaining their DD-214 if it has been misplaced: Michigan Department of Military and Veteran's Affairs A Veteran may begin applying for health benefits by completing the Department of Veteran's Affairs form 10-10EZ, located here: 10-10EZ Form. The basic requirements for VA health care eligibility include, but are not limited to:

1. Honorable or General Discharge from service.
2. Veterans who enlisted after September 1980 must have 24 months of continuous service.
3. National Guard and Reservists may also qualify for VA benefits if they were called to active duty (other than for training) by Federal order.
4. Eligibility determination is based on each individual's service.

Also, for county Veteran's Affairs departments, complete an internet search by entering the county name and "veteran affairs." For example, "Ingham county Veteran's Affairs, results in an option to go to http://va.ingham.org/. The contacts can change and this will provide the most up to date information needed to proceed. County Veteran's Affairs offices are a good place to start with assisting a Veteran with applying for disability (if appropriate), connecting to local transportation, and financial resources. Please note that Veteran's access to healthcare and to disability benefits are different. Generally, the Veteran will find out if he or she is eligible for healthcare benefits rather quickly. Veterans are encouraged to complete the 10-10EZ form with the assistance of the Enrollment

Coordinator at their local VA health care facility, mailing the form in is not encouraged due to the delay it will cause.

The VA has Relapse Prevention and Intensive Outpatient (IOP) services available to eligible Veterans. Veterans who are eligible. The VA also has Veteran's Justice Outreach (VJO). The VJO is designed to collaborate with the local justice system partners to identify Veterans that enter the criminal justice system and are in need of treatment services rather than incarceration. Both can be referred to the VA provider.

Residential/Detox: requests for eligible Veterans should be sent to the VA. If the Veteran is not eligible, treat them as any other client. MSHN may pay for detox if the VA does not. The Veteran should have no other funding options.

Methadone Services: If a Veteran is uninsured, the VA can contract with the Victory Clinic, depending on the county they reside in.

SUD Outpatient Care (OP): The VA also has a contract for those who are uninsured and are in need of SUD OP services. The VA contact person should be contacted to determine whether the Veteran is eligible for coverage.

Other Related Materials

MSHN Utilization Management Manual

References/Legal Authority

Department of Veteran's Affairs

Michigan Medicaid Provider Manual, 2016

Veterans Access, Choice, and Accountability Act of 2014 (VACAA): Veteran's Choice Program

Appendix C: MSHN MAT Guidelines

INSTRUCTIONS AND PROTOCOLS FOR THE IMPLEMENTATION OF MEDICATION-ASSISTED TREATMENT (MAT)

Note: This document was written and reviewed by Mid-State Health Network's (MSHN) Clinical and Utilization Management staff as well as reviewed by MSHN's SUD Medical Director, Dr. Bruce Springer

and the MSHN Medication Assisted Treatment (MAT) workgroup. While a primary focus is MAT for Opioid Use Disorder (OUD), additional sections address MAT's applications to other addictive disorders as well. Should you have any questions, please contact MSHN at 517-253-7525 or email to: *todd.lewicki@midstatehealthnetwork.org*

INSTRUCTIONS AND PROTOCOLS FOR THE IMPLEMENTATION OF MEDICATION-ASSISTED TREATMENT (MAT)

This document establishes technical and service requirements that must be incorporated into the design and delivery of all medication-assisted treatment (MAT) services funded through Mid-State Health Network (MSHN). MAT service providers are required to adopt these protocol guidelines in their entirety, as well as incorporate the requirements of the Michigan Department of Health and Human Services, Behavioral Health and Development Disabilities Administration's (MDHHS-BHDDA) policies and advisories, and the Michigan Medicaid Provider Manual.

INTRODUCTION:

For several decades, addiction to drugs and alcohol was viewed as a character flaw, a sign of moral weakness. Treatment and recovery were almost exclusively abstinence-based, rooted in the 12-step model, and often utilized 30-90 day inpatient stays. This paradigm worked for some patients, particularly those who developed their addictions in adulthood and had networks of support for their recovery.

With the evolution of Methadone Maintenance Treatment in 1968 (and FDA approval in 1972), a reliable and effective treatment for chronic, long-term opioid users became available. In the mid-1980's, buprenorphine (*Suboxone and others*) was introduced as an effective detoxification medication for Opioid Use Disorder (OUD). The Drug Abuse Treatment Act of 2000 enabled specially trained physicians to prescribe approved forms of buprenorphine for the detoxification and/or treatment of OUD. These medical and statutory developments were reinforced by recent research into the neurochemistry of addiction—the role of dopamine in particular--leading to a more robust understanding of addiction as a chronic often lifelong brain disease which, like other diseases, may require medications as a component of treatment.

MAT, therefore, broadly refers to the use of medication in treating addiction to a variety of substances: opioids (prescription analgesics and heroin), alcohol, cocaine, benzodiazepines, and marijuana. It is worth noting, however, that MAT has been a standard medical practice in medicine for many decades in both physical and behavioral domains, insulin for diabetes, for example, or Prozac for depression.

Opioid addiction, however, has received most attention due to what is now viewed as a national public health crisis. In the United States, 2.1 million people were estimated in 2012 to be suffering from substance use disorders related to prescription opioid pain relievers and another 467,000 were addicted to heroin. Among the factors contributing to the severity of the current opioid drug abuse problem are a four-fold rise in the number of opioid prescriptions from 1999 to 2010. The United States is the world's primary consumer of opioids, accounting for 99 percent of the global consumption of hydrocodone
(Vicodin) and 81 percent for oxycodone (Percocet, Oxycontin and others). Nationally, the Midwest is second only to the South in terms of opioid prescriptions. Michigan, in particular, falls in the top 10 states with 107 opioid prescriptions per 100 people. Over time, opioid-addicted individuals develop an increasing tolerance requiring more and more of the pharmaceutical drugs to achieve the desired effect. Many opiate-addicted individuals are unable to afford costly prescription medications and "graduate" to heroin, which is cheaper and more accessible. Hence the boom in prescription painkiller abuse and a growing heroin epidemic are inextricably linked.

Consistent with Medicaid rules, MSHN's policy is that *clients should have a full service array of treatment options available*. This should include MAT for all persons who have met clinical eligibility for MAT via appropriate screening and assessment, and medical necessity criteria. Since not all individuals are appropriate for MAT (even when they may meet clinical criteria), MSHN expects providers to assess and stage every client to determine the client's readiness for change as a means of ensuring that the provision of MAT services will best meet the individual needs of the client.

MEDICATION-ASSISTED TREATMENT
&
OPIOID USE DISORDER

Medication-Assisted Treatment (MAT) is intended to stabilize the client and to foster readiness for making continued treatment decisions. An individual currently abusing opioids and seeking treatment services may not be initially capable of making decisions regarding their continuing treatment needs.

It is the expectation that clients seeking opioids for chronic pain issues will be referred to a primary care physician. MSHN does not fund the use of methadone or buprenorphine/naloxone for pain management. A clear diagnosis of Opioid Use Disorder must be present prior to any MSHN funds being utilized for clients with chronic pain.

Although MSHN realizes that Opioid Use Disorder is a chronic, relapsing brain disease that can last a lifetime, it is not the intention of MSHN to provide funding for Medication-Assisted Treatment indefinitely. It is the goal of MSHN to provide intensive medication-assisted treatment to those clients with Opioid Use Disorder in order to enable them to acquire/reacquire the life skills as well as the degree of recovery to assume the financial responsibility for their own treatment. Reviews to determine continued eligibility for methadone dosing and counseling services must occur at least every four months by the OTP physician during the first two years of service. An assessment of the ability to pay for services and a determination for Medicaid coverage must be conducted at that time, as well.

If it is determined by the OTP physician that the individual requires methadone treatment beyond the first two years, the justification of the medical necessity for methadone only needs to occur annually. However, financial review and eligibility for Medicaid is required to continue at a minimum of every six months (Treatment Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery, 2012. MSHN requires that the *Justification for Continuation of Medication-Assisted Treatment Form* (Appendix B) be completed in detail once a client is determined to have medical necessity and financial inability to pay for continued services (and annually thereafter).

Please send the completed form via confidential fax to:

Mid-State Health Network
Attn: UM Department
Fax: (517) 253-7552

SERVICE DEFINITION:

According to the Treatment Improvement Protocol #43, as published by the U.S. Department of Health and Human Services (USDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA),

Center for Substance Abuse Treatment (CSAT), the definition of Medication-Assisted Treatment for Opioid Use Disorder is:

Any treatment for Opioid/Opiate addiction that includes a medication (e.g. methadone, buprenorphine, naltrexone) approved by the U.S. Food and Drug Administration (FDA) for Opioid/Opiate addiction detoxification or maintenance treatment.

"A patient's daily pattern of opioid abuse should be determined. Regular and frequent use to offset withdrawal is a clear indicator of physiological dependence. In addition, people who are opioid addicted spend increasing amounts of time and energy obtaining, using, and responding to the effects of these drugs" (p. 48).

MAT may be provided at a licensed and state-regulated opioid treatment provider (OTP), or for buprenorphine/naloxone, a physician's office or other healthcare setting, including an OTP. Comprehensive maintenance, medical maintenance, interim maintenance, detoxification, and medically supervised withdrawal are types of MAT services.

- **Comprehensive Maintenance Treatment**: combines pharmacotherapy with a full program of assessment, psychosocial intervention and support services; it is the approach with the greatest likelihood of long-term success for many clients. Maintenance treatment is typically indicated for the first two years of a methadone program.
- **Medical Maintenance Treatment**: is provided to stabilize clients and may include long-term provision of methadone, buprenorphine or naltrexone with a reduction in clinic attendance and other services. A client may receive medical maintenance at an OTP after he or she is stabilized fully. A key feature of medical maintenance treatment is a reduction in clinic attendance as the client receives fewer ancillary treatment services including monthly random, mandatory toxicology screening once stabilized on medication. Medical maintenance treatment is typically indicated subsequent to the first two years of a methadone program.

Medication-Assisted Treatment is part of a broader continuum of care for substance use disorders that may include recovery supports, case management and outpatient therapy. The minimum required services for MAT are outlined in Federal regulations (42 Code of Federal Regulations [CFR], Part 8). The MDHHS-BHDDA has published Treatment Policies for both methadone and buprenorphine/naloxone. These treatment policies are identified in the reference section of this document and are available on the MDHHS website.

Medication-Assisted Treatment providers must inform clients of daily attendance requirements, mandatory counseling requirements, toxicology testing requirements and other program participation requirements outlined in this protocol document both at admission and throughout the course of treatment as applicable.

ELIGIBILITY CRITERIA

To be eligible for methadone-assisted treatment services funded through MSHN, the intended recipient must meet the level of care (LOC) determination using the most current edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC-2R) and the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Medical necessity requirements shall be used to determine the need for methadone as an adjunct treatment and recovery service (Medicaid Provider Manual). Further, the intended recipient should be assessed for the ability to benefit from methadone-assisted treatment services, including the stage of change in which the client is presenting. Individuals are afforded a choice of provider upon determination of appropriate level of care.

Persons presenting for treatment are admitted to treatment in the following order:

1. Pregnant injecting drug users;
2. Pregnant substance abusers;
3. Injecting drug users;
4. Parents whose children have been removed from the home or are in danger of being removed from the home due to the parents' substance abuse; and
5. All others.

Admission procedures for MAT require a physical examination. This examination must include a medical assessment to confirm the current Diagnostic and Statistical Manual (DSM) diagnosis of Opioid Use Disorder, as identified in the screening process. In the case of opioid addiction, pseudo-addiction must also be ruled out (Treatment Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery, 2012). The physician may refer the client to other care providers (dentists, PCP, or other health care providers) for further medical assessment as indicated.

GENERAL EXPECTATIONS:

Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and treatment and recovery plans must be based on the needs and goals of the individual (Treatment Policy #06: Individualized Treatment Planning, 2012). Collaborative care ideally includes: "multiple professional, individual patients, family members, and to assist patients as they maneuver through often complex multi-component systems of care," (Waller, 2014, p.14). The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible (Treatment Policy #08: Substance Abuse Case Management Requirements, 2008). Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Counseling services should be conducted by the opioid treatment program (OTP) that is providing the methadone whenever possible and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record. (Treatment Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery, 2012). These exceptions must be approved by the MSHN Utilization Management (UM) Department prior to admission into another treatment program.

Comprehensive Recovery Planning:

MSHN expects the provider to begin working on a comprehensive recovery plan with EVERY client immediately upon admission and be able to show documentation of assisting the client with developing a comprehensive recovery plan, which includes but should not be limited to: building a recovery support network, developing a relapse prevention plan, achieving a stable living environment, securing stable employment (when appropriate), and improving overall wellness and quality of life.

Progress will be measured by the documentation of active participation in treatment as evidenced by: quantifiable evidence of progress toward goals and objectives on a collaborative recovery plan designed to address treatment, promote recovery and self-sufficiency; reduction in problem severity, and negative toxicology screens or evidence of engagement in strategies to address recovery.

According to the Medication-Assisted Treatment Guidelines for Opioid Use Disorder (Waller, 2014), if there is evidence that progress is not being made toward agreed-upon goals, the diagnosis, treatment modalities, treatment intensity, and treatment goals will be reassessed in order to revise the treatment plan rather than introduce a premature termination from treatment.

All agencies that provide methadone assisted treatment will be responsible for completing the annual assessment to determine if the client will continue in treatment and to update assessment information. An annual assessment, post the initial two-year review, is required in order to ensure that clients continue to qualify for MSHN-funded substance use disorder treatment services. At this time, and throughout treatment, the client should also be evaluated and educated on the possibility of tapering off their medication. Tapering should be done with significant client input due to increased relapse potential. Throughout the course of medication-assisted treatment, specific documentation must be included in the client file which evidences attempts at decreasing the dosage tapering off of the medication, decreasing problem severity, and provider assisting the client in achieving employment and other recovery goals that promotes self-sufficiency. Without such documentation medication-assisted treatment services may cease to be funded.

Clients funded through Medicaid for buprenorphine/naloxone or methadone may continue treatment according to their specific Medicaid benefit as long as medically necessary and clinically appropriate. Justification for this continued treatment must be documented in the client file and in the CareNet system, including treatment attendance, medical necessity, and ASAM Patient Placement Criteria.

Regulatory Compliance/Coordination of Care:

All MAT providers must obtain client consent to contact other MAT providers within a 200 mile range to have the ability to regularly monitor for enrollment in other medication-assisted treatment programs.

Legally prescribed medication including controlled substances must be presented to the physician, who will decide whether these prescriptions are appropriate for the patient who is taking methadone. **Coordination of care with the prescribing physician is required.** Upon admission (within five business days), a release of information and a letter explaining client's involvement in MAT will be faxed to the prescribing physician, with a copy being placed in the client file. A response from the prescribing physician is expected. If the MAT provider is unable to elicit a response within the first 90 days from the prescribing physician, the provider is to contact the MSHN UM Department for assistance. Updates to the prescribing physician regarding client's progress in MAT will be completed during each re-authorization period. These updates need to be included in the client file as well as documented in the CareNet system.

All MAT providers will require that clients provide a complete list of all prescribed medications. Legally prescribed medication, including controlled substances, must not be considered as illicit substances when the provider has documentation that it was prescribed for the client. Legally prescribed medications that are not being used as prescribed will be treated as illicit substances and must be documented in the client file. Approved examples of such documentation include copies of the prescription label, pharmacy receipt, or pharmacy printout.

A Michigan Automated Prescription System (MAPS) report must be completed at admission into the program ("Treatment Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery," 2012). For clients receiving methadone, a MAPS report must be completed prior to initial dosing and prior to off-site dosing being approved. Off-site dosing is not allowed without documented coordination of care by the MAT provider's physician and the prescriber of identified controlled substances, which include, but may not be limited to: Opioid/Opiates, benzodiazepines, muscle relaxants. This

coordination must be documented in the doctor's notes. Documentation must be individualized, identifying the client, the diagnosis, and the length of time the client is expected to be on the prescribed medication.

A MAPS report must be run prior to all reauthorization requests for individuals that are receiving MAT with either methadone or buprenorphine/naloxone. If a MAPS report shows prescriptions of controlled substances, this will be addressed on the client's individualized treatment plan.

According to Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery (2012, p. 5), "Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law. For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the [client] chart or the 'prescribed medication log'." A copy of the client's ***registration card*** must be included in the client chart and documented in CareNet.

Nine percent of people exposed to Cannabis develop Cannabis use disorder. MSHN strongly agrees that Cannabis is a gateway drug to other substances and to relapse. There is real concern that marijuana negatively alters the pleasure center of the brain and may pave the way for psychotic illness in vulnerable individuals. MSHN asks that all of its providers continue to work with their clients to encourage abstinence from marijuana while undergoing MAT for opiate/opioid use disorders. Evidence of continued use of Cannabis will be sought during site reviews and will remain a subject of ongoing discussion with MSHN contracted providers.

METHADONE ASSISTED TREATMENT:

Methadone Assisted Treatment Expectations:

Upon assessment, every individual wishing to enter or re-enter methadone assisted treatment will be provided with *Methadone Assisted Treatment Expectations* form (Appendix A). Upon admission to the methadone assisted treatment provider, the individual will sign the *Methadone Assisted Treatment Expectations* form assuring his/her understanding of the expectations, which include the following and will be reviewed annually or as necessary by the outpatient treatment provider (if applicable) and methadone assisted treatment provider:

- Discontinuation of the use of all illicit and non-prescribed drugs and alcohol;
- Regular attendance at the MAT provider for dosing (daily, with the possible exception of Sundays and holidays, until such time that the individual meets criteria for take-home dosages in the case of methadone, and as clinically and medically appropriate for buprenorphine);
- Submit to toxicology sampling as requested;
- Attendance and active participation at all group, individual treatment sessions, and/or other clinical activities;
- Comply with the individualized treatment and recovery plan, inclusive of following through on other treatment and recovery plan related referrals. Repeated failure should be considered on an individual basis and only after the MAT provider and outpatient treatment provider (if applicable) have taken steps to assist the individual to comply with activities;
- Adherence to all program rules and policies;
- Manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual;

- Provide the names, addresses, and phone numbers of all medical, dental, and pharmacy providers;
- Sign Authorizations to Release Information with medical, dental and pharmacy providers in order to better coordinate treatment. If an individual refuses to meet these expectations, it could negatively impact the individual's success with treatment;
- Produce valid prescription or medication bottles with the physician's name on the label for all controlled substances within one week of admission. If the individual tests positive for a controlled substance that he/she has not previously provided a valid prescription for, the individual agrees to present a valid prescription or current medication bottle(s) with the physician's name on the label for the controlled substance before the individual receives his/her next regular or full methadone dose. Coordination should occur with prescribing doctor if that this the case. If illicit use is determined, the illicit source should be discontinued;
- Prescribed medications may have to be changed in order to better coordinate treatment;
- Enrollment in one MAT provider only (methadone and/or buprenorphine). If an individual is enrolled in more than one (1) medication-assisted treatment Provider at a time (methadone and/or buprenorphine), the individual may be administratively discharged from the methadone program;
- Evidence of continued work toward goals outlined in treatment plan; and,
- No altered urine screens or non-compliance with drug testing.

General eligibility guidelines to consider when authorizing treatment for methadone-assisted treatment services:

- Client meets criteria for a diagnosis of Opioid Use Disorder;
- Client has been opioid dependent for a minimum of one year;
- Is 18 years of age or older. A client under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment with the exception of a pregnant woman for which detoxification is not recommended;
- There must be no acute, serious, and unmanaged medical problems. This would require hospitalization and stabilization of the medical issue prior to assisting the client with substance use disorder treatment;
- Other drug/alcohol use will be considered. Other drug use is not necessarily a reason to deny methadone-assisted treatment. If clinically appropriate (alcohol and benzodiazepines), send client to detox before admission to MAT;
- Concurrent illnesses can be stabilized and maintained on an outpatient basis;
- No psychiatric illnesses that need to be addressed that could complicate treatment; (Untreated, un-medicated, unmanaged psychiatric issues or psychiatric issues that the Methadone-assisted treatment facility is not equipped to handle);
- Client is in immediate danger of continued using behavior without the treatment;
- Sufficient, safe, and supportive living environment (or client agrees to work toward obtaining);
- Client exhibits moderate to severe withdrawal or potential moderate to severe withdrawal;
- Client is pregnant and has a documented Opioid/Opiate dependency in the past and may continue to engage in active use during the pregnancy;
- Client is not seeking Methadone dosing for pain management (for pain management, refer to PCP or pain clinic, etc.);
- Provider will communicate to the client the importance of full participation in coordination of care efforts with the primary care physician(s); and,
- Client must have access to transportation (as they will be required to present at the facility on a daily basis).

General minimum service requirements for authorizing methadone assisted treatment services:

- Comprehensive biopsychosocial assessment with an initial diagnosis of Opioid Use Disorder of at least one-year duration;
- Coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers;
- Physical examination upon admission and as appropriate during the course of treatment;
- Mandatory 90-day review for initial requests and the first re-authorization request followed; by 120-day reviews to determine continued eligibility;
- Daily attendance requirements for medication dispensing;
- Must be used as an adjunct to Opioid Use Disorder treatment which must include a counseling component;
- Mandatory toxicology screening at intake and randomly thereafter, to be conducted at a rate of no less than two per month; toxicology screening must assay for Opioid/Opiates, cocaine, amphetamines, cannabinoids, benzodiazepines and methadone metabolites;
- Identification, treatment, or referral for treatment of co-occurring disorders and neuropsychological problems;
- Counseling to assist in discontinuation of substance abuse and manage drug cravings and urges;
- Evaluation of and interventions to address family problems;
- HIV and Hepatitis C Virus (HCV) education, counseling, and referral for testing and/or care; and,
- Referral for additional services as needed.

Behavioral Contracts:

It is MSHN's expectation that all clients will be compliant with the rules of the methadone assisted treatment provider. Clients that are non-compliant will be subject to placement on behavioral contracts according to the below stipulations:

180-Day Induction

Upon admission, clients are expected to begin to eliminate the use of other drugs (non-prescribed) or alcohol. Following the initial 180-day induction period, clients who fail to eliminate the use of other drugs (non-prescribed) or alcohol will be placed on a 90-day behavioral contract and treatment plan will be revised. Clients showing little or no progress during the 90-day Behavioral Contract will begin a 90-day rapid tapering of methadone, known as an administrative discharge. If at any time during the 90-day administrative discharge period the client begins to show progress, by achieving a non-positive urine drug screen, the client may be placed on a new 90-day behavioral contract, at the discretion of the methadone-assisted treatment provider. Clients continuing to produce positive urine drug screens during this second 60-day Behavioral Contract will begin a 90-day rapid tapering of methadone and be administratively discharged from the program. Documentation of the Behavioral Contract, client response, and detailed discharge reason will be included in the client's file and in the client's CareNet record.

Post 180-Day Induction

At any time following the 180 day induction into treatment, clients who produce three consecutive positive drug screens (including any substances of abuse and misuse of prescription medication) will be placed on a 90-day Behavioral Contract. During this 90-day period, it is recommended that the client participate in weekly drug screens. Clients showing little or no progress during the 90-day Behavioral Contract will begin a 90-day tapering of methadone, known as an administrative discharge.

If at any time during the 90 day administrative discharge period the client begins to show progress by achieving a non-positive drug screen, the client may be placed on a new 90-day behavioral contract, at the discretion of the methadone assisted treatment provider. Clients continuing to produce positive urine drug screens during this second 90-day Behavioral Contract will begin a 90-day tapering of methadone and be administratively discharged from the program. Documentation of the Behavioral Contract, client response, and detailed discharge reason will be included in the client's file and in the client's CareNet record.

Clients being administratively discharged will not be allowed back into methadone assisted treatment until re-evaluated. This action should be carefully considered and appropriate steps should be taken to match the client to the appropriate level of care based on the re-evaluation results, including client stage of change and level of motivation. The client wishing to re-enter methadone assisted treatment may contact the MAT provider or MSHN UM Department. The MAT provider and the MSHN UM Department will determine eligibility for re-admission into methadone assisted treatment. Additionally, in order to be re-admitted into methadone assisted treatment, a client must sign the *Methadone Assisted Treatment Expectations* form (Appendix A) and will be immediately placed on a probationary period of not less than 90-days.

Block Grant Wait-list for Methadone Assisted Treatment:

At times, the demand for an individual funded through Block Grant and seeking methadone services may exceed capacity. When this occurs, the MSHN UM Department will place the individual on a waiting list. Census of the Block Grant funded individual must remain static. As such, methadone assisted treatment providers may admit an individual approved by the MSHN Utilization Management Department, *only when a treatment slot becomes available*. Such admission slots become available only when an existing individual funded through Block Grant is discharged from treatment services; whether due to program non-compliance, transfer to self-pay status, obtaining Medicaid, or successful program completion.

The individual funded through Block Grant and placed on the waiting list should 1) be encouraged to go to local Outpatient treatment services while on the waiting list, 2) be encouraged to apply for Medicaid or Healthy Michigan Plan, and 3) be told to contact the MSHN UM Department if he/she obtains Medicaid or Healthy Michigan Plan and is still interested in receiving methadone assisted treatment services. An individual on the Block Grant waiting list will be admitted to methadone assisted treatment services according to his/her current priority status on the waiting list.

When an admission slot becomes available, the MSHN UM Department will make three attempts to contact the next client on the Block Grant waiting list (according to priority status) via telephone. If unable to make contact with client via telephone, the MSHN UM Department will move to the next client according to priority status and repeat the above process until a client is successfully contacted.

Clients so contacted, will be warm transferred to a methadone assisted treatment provider of their choice to arrange for an admission appointment. Clients contacted will have 14 calendar days from the date of initial contact to be admitted into methadone-assisted treatment services. After 14 calendar days have lapsed, the methadone assisted treatment provider will contact MSHN UM Department indicating whether the client failed to present for admission.

If the client fails to present at the methadone assisted treatment provider within 14 calendar days of initial contact by MSHN UM Department, the provider will inform MSHN UM Department. MSHN UM Department will then review the waiting list to determine the next client to be admitted to methadone-assisted treatment services according to their current priority status.

If the client does present at the methadone assisted treatment provider within 14 calendar days, the provider will inform MSHN UM Department of the client's admission date.

Block Grant-funded clients meeting criteria for urgent priority population (pregnant injecting drug users and pregnant substance abusers) will be allowed direct admission into methadone assisted treatment, if appropriate and will not be placed on the Block Grant waiting list.

Individuals funded through Medicaid or Healthy Michigan Plan will not be placed on the Block Grant or any other waiting list. Clients determined to meet eligibility criteria for this level of care will be directed to the provider of their choice.

For buprenorphine/naloxone assisted services: clients receiving buprenorphine/naloxone assisted services will not be placed on a waiting list. Buprenorphine/naloxone assisted services are NOT an alternative to methadone assisted treatment services. Therefore, if a client is assessed as needing methadone assisted treatment services, they would not be placed in treatment with buprenorphine/naloxone. Clients cannot receive buprenorphine/naloxone while on the waiting list for methadone-assisted treatment services.

BUPRENORPHINE/NALOXONE ASSISTED TREATMENT:

General eligibility guidelines to consider when authorizing treatment for buprenorphine/naloxone services:

- Client meets criteria for a diagnosis of Opioid Use Disorder.
- Is 18 years of age or older.
- No acute (serious, unmanaged) medical problems.
- Other drug/alcohol use will be considered. Other drug use is not necessarily a reason to deny buprenorphine/naloxone-assisted treatment. If clinically appropriate (alcohol and benzodiazepines), send client to detox before admission to MAT.
- Concurrent illnesses can be stabilized and maintained on an outpatient basis.
- No psychiatric illnesses that need to be addressed that could complicate treatment. (Untreated, un-medicated, unmanaged psychiatric issues or psychiatric issues that the Medication-Assisted Treatment facility is not equipped to handle).
- Client must agree to and fully participate in Coordination of Care efforts with primary care physicians.
- Client is in immediate danger of continued using behavior without the treatment.
- Sufficient, safe, and supportive living environment (or client agrees to work toward obtaining).
- Client exhibits moderate to severe withdrawal or potential moderate to severe withdrawal.
- Client must have access to transportation.

General minimum service requirements for authorizing buprenorphine/naloxone assisted treatment services:

- Comprehensive psychosocial assessment with an initial diagnosis of Opioid Use Disorder
- Coordination of care with all prescribing physicians, treating physicians, dentists and other health care providers
- Used as an adjunct to Opioid Use Disorder treatment which must include a counseling component
- Physical examination upon admission

- Mandatory 90-day review for initial requests followed by 120-day reviews to determine continued eligibility
- Mandatory toxicology testing at intake and every week (until 3 consecutive negative screens are achieved) and randomly on a monthly basis thereafter; toxicology screening must assay for Opioid/Opiates, cocaine, amphetamines, cannabinoids, benzodiazepines and methadone metabolites.
- Identification, treatment or referral to treatment of co-occurring disorders and neuropsychological problems
- Counseling to assist in discontinuation of substance abuse and manage drug cravings and urges
- Evaluation of and interventions to address family problems
- HIV and hepatitis C virus (HCV) education, counseling, and referral for testing and/or care
- Referral for additional services as needed.

Special Notes regarding the use of buprenorphine/naloxone as part of medication-assisted treatment for Opioid Use Disorder:

- All physicians prescribing buprenorphine/naloxone must have a waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) permitting them to prescribe buprenorphine/naloxone.
- Buprenorphine/naloxone medication is a medical benefit administered through the client's qualified medical health plan and not funded through MSHN.

Medically Supervised Withdrawal Treatment using buprenorphine/naloxone (Suboxone):

It is required of all contracted methadone providers with MSHN that they will offer many various services such as; individual and group therapy, recovery support, case management. MSHN believes that there is great therapeutic value to the client to be included in group sessions with other clients. MSHN promotes the use of group therapy in Medication Assisted Treatment. All services provided must be documented clearly in the record of the person served.

Note: A client entering an outpatient program with buprenorphine/naloxone will usually not require sub-acute detoxification services prior to admission to the outpatient program. It is expected that the majority of clients will enter directly into buprenorphine/naloxone-assisted treatment at the outpatient level without first receiving services through sub-acute detoxification. Special exceptions should be referred to MSHN UM Department at 1-844-405-3095.

According to the Treatment Improvement Protocol #40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (McNicholas, 2004, p. 48), as published by the U.S. Department of Health and Human Services (USDHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT):

"The literature suggests that the use of buprenorphine for gradual detoxification over long periods is probably more effective than its use for rapid detoxification over short or moderate periods. Patients who are unwilling or unable to engage actively in rehabilitation services without agonist support may not be appropriate candidates for short-term detoxification, however such patients may benefit from long-term detoxification (or even more so, from maintenance treatment)."

DISCONTINUATION/TERMINATION/READMISSION:

According to the Michigan Medicaid Provider Manual (methadone-assisted treatment Provider is referred to as an Opioid Treatment Provider (OTP)), 12.2.F. Discontinuation/Termination Criteria, and applicable for all individuals, discontinuation/termination from methadone treatment refers to the following situations:

- Beneficiaries may be terminated from services if there is clinical and/or behavioral noncompliance.

- If a beneficiary is terminated:

  - The OTP must attempt to make a referral for another LOC assessment or for placing the beneficiary at another OTP.
  - The OTP must make an effort to ensure that the beneficiary follows through with the referral.
  - These efforts must be documented in the medical record.
  - The OTP must follow the procedures of the funding authority in coordinating these referrals.

- Any action to terminate treatment of a Medicaid beneficiary requires a "notice of action" be given to the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation. Services are discontinued/terminated either by Completion of Treatment or through Administrative Discontinuation. Refer to the following subsections for additional information.

12.2.F.1. COMPLETION OF TREATMENT

- The decision to discharge a beneficiary must be made by the OTP's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.
-

12.2.F.2. ADMINISTRATIVE DISCONTINUATION

- Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The OTP must work with the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) to explore and implement methods to facilitate compliance.

- Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to:

1) The repeated or continued use of illicit opioids and non-opioid substances (including cannabinoids, benzodiazepines, cocaine, amphetamines, barbiturates, and alcohol).
2) Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected).

In both of the aforementioned circumstances, OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14406).

OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe.

- Repeated failure to submit to toxicology sampling as requested.
- Repeated failure to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.)

The commission of acts by the beneficiary that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge from MAT services, but is also relevant and applicable for beneficiary of any provider service. Such acts include, but are not limited to, the following:

- Possession of a weapon on OTP property.
- Assaultive behavior against staff and/or other individuals.
- Threats (verbal or physical) against staff and/or other individuals.
- Diversion of controlled substances, including methadone.
- Diversion and/or adulteration of toxicology samples.
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one-block radius of the clinic.
- Sexual harassment of staff and/or other individuals.
- Loitering on the clinic property or within a one-block radius of the clinic.

Administrative discontinuation of services can be carried out by two methods:

1) **Immediate Termination -** This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.
2) **Enhanced Tapering Discontinuation -** This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10 percent a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the beneficiary.

It may be necessary for the OTP to refer beneficiaries who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for non-compliance termination must be documented in the beneficiary's chart.

PROVIDER REQUIREMENTS

Medication-Assisted Treatment Providers must have an appropriate license issued by the State of Michigan and a contract with MSHN in order to be reimbursed for medication-assisted treatment and outpatient treatment through MSHN.

The Michigan Department of Health and Human Services (MDHHS) states:

1) The program must be identifiable and distinct with the agency's service configuration; and
2) The agency must offer or purport to offer MAT services as a separate and distinct program among any other program services that may be offered.

Providers must base their program of services on the principles detailed in Treatment Improvement Protocol (TIP) #43, "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" and Treatment Improvement Protocol (TIP) #40, "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid/Opiate Addiction."

Individuals employed by provider organizations must be appropriately credentialed to provide the services described in this document (see "Staff Credential Requirements" below).

STAFF CREDENTIALS AND PROGRAM SUPERVISION REQUIREMENTS

Medication-Assisted Treatment for Opioid/Opiate Addiction services must be delivered by individuals in provider organizations who have been credentialed as a Certified Addictions Counselor or Certified Advanced Addictions Counselor, or an individual who has a registered Development Plan with the Michigan Certification Board for Addiction Professionals.

Supervision of an identifiable MAT program within a licensed provider organization must be by an individual credentialed as a Certified Clinical Supervisor, or an individual who has a registered Development Plan for Certification as a Clinical Supervisor with the Michigan Certification Board for Addiction Professionals.

MAT services must be provided under the supervision of a physician licensed to practice medicine in Michigan. The physician must be licensed to prescribe controlled substances. Within a methadone program, the physician must be specifically licensed to work at a methadone program. Methadone must be administered by an MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist. A physician prescribing buprenorphine/naloxone must have completed all certification requirements mandated by the State of Michigan. All MAT providers must follow the State of Michigan Licensing and Regulatory Affairs (LARA) Administrative Rules (R 325.14403 Medical staffing patterns. Rule 403) in regards to appropriate staffing.

INCLUDED SERVICES

Medication-Assisted Treatment in an outpatient setting is intended for the purpose of 1) managing the effects of withdrawal from opioids (prescription painkillers and heroin) and/or alcohol; 2) stabilizing the client and 3) providing maintenance treatment. Ancillary services such as individual therapy, group therapy, Recovery Supports, acupuncture, and/or Case Management will be available during a client's episode of care.

Covered services for methadone and pharmacological supports and laboratory services, as required by Federal regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include:

- Methadone medication
- Nursing services
- Physical examination

- Physician encounters (monthly)
- Laboratory tests
- TB skin test (as ordered by physician)

Clients diagnosed with Opioid Use Disorder may be provided Medication-Assisted treatment using methadone as an adjunct to therapy. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.
- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be licensed as such by the state and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration (DEA).
- Methadone must be administered by an MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist.

Service providers are required to document all services on the appropriate clinical form (i.e., Assessments on Assessment Forms, Individualized Treatment Plans on an appropriate form, contacts on progress note forms, etc.). All documents will be made a part of the permanent clinical record.

As each client is unique and presents with individual concerns, MSHN encourages contact to discuss exceptions on a case-by-case basis.

AUTHORIZATION PARAMETERS

Please see the MSHN Utilization Management Program Manual, Appendix B: *FY17 SUBSTANCE USE DISORDER (SUD) MASTER CPT & HCPCS CODE GRID (Outpatient)* for authorization parameters for a complete list of codes, descriptions, billing parameters, standard authorization patterns, provider/staff qualifications, and MSHN contract rates.

Please note the following:

1) A reauthorization will not be approved unless the provider has entered ***every*** toxicology report for the client into CareNet prior to the reauthorization request.
2) Providers will be required to complete an annual re-assessment for continuing care and will enter re-assessment information into CareNet.
3) Additional services such as medication reviews, drug screens, and actual dosing may vary depending on the service provider.

MAT GUEST DOSING

Guest Dosing is allowable between different locations of the same MAT provider. Pre-authorization must occur prior to the dosing. The MAT provider that has an approved authorization in CareNet will call MSHN UM Department to discuss the client and circumstances of the guest dosing to get a pre-authorization. The two locations are to have an internal policy for documentation and payment. Situations where guest dosing is to occur between different providers will be reviewed on a case by case basis by the MSHN UM Department.

MEDICAL MARIJUANA CARD: EXPECTATION OF PROVIDERS

When a client presents for medication-assisted treatment and also possesses a valid medical marijuana card, the following issues should be carefully addressed by the MAT provider as an integral part of the individualized treatment plan:

Verification of Medical Marijuana Card: According to Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery (2012, p. 5), "Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana.

- For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the [client] chart or the "prescribed medication log"." A copy of the client's *registration card* must be included in the client chart. *MSHN expects verification will be made for any consumer with a MM card, not just consumers on methadone.*
- Diagnosis for which the client is receiving treatment and the length of time the individual is expected to be on the medication (including the diagnosis for which the client was certified to use medical marijuana) should be documented in the client's chart.

Assessment for Overuse/Misuse of Prescription: Clinicians should carefully assess for the possibility of overuse/misuse of any controlled substance prescription medications (including medical marijuana). Misrepresentation of medical symptoms in order to obtain prescription medication is often a primary function of substance use disorder and *must also be ruled out for medical marijuana* use. A detailed medical history should be obtained as part of the assessment process, including other forms of treatment the client has attempted in order to manage the chronic medical condition prior to obtaining medical marijuana certification. Onset age of the use of marijuana should also be considered in relation to the onset of the medical condition for which the client is certified to use medical marijuana. Whenever possible, exploration of other treatment modalities with the potential to adequately address the client's medical condition(s) without the use of controlled substance prescription medications.

Coordination of Care with Other Treating Physicians: Coordination of care should occur between the MAT program physician, the client's primary care physician, and any other prescribing physicians including the physician who certified the use of medical marijuana. This coordination of care should occur upon admission to the MAT program and address the following which must be clearly documented in the client chart and individualized to the client (i.e. a "form letter" sent to the physician's office is not sufficient).

Nine percent of people exposed to Cannabis develop Cannabis use disorder. MSHN strongly agrees that Cannabis is a gateway drug to other substances and to relapse. There is real concern that Marijuana negatively alters the pleasure center of the brain and may pave the way for psychotic illness in vulnerable individuals. MSHN asks that all of its providers continue to work with their clients to encourage abstinence from marijuana while undergoing MAT for opiate and alcohol use disorders. Evidence of continued use of Cannabis will be sought during site reviews and will remain a subject of ongoing discussion with our providers.

NOTE**: If the consumer does not consent to coordination of care with all prescribing physicians, including the physician who certified the use of medical marijuana, off-site dosing will not be permitted in accordance with Treatment and Recovery Policy #05: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery (2012, p. 5).**

**ALCOHOL USE DISORDER &
MEDICATION-ASSISTED TREATMENT**

Medication-Assisted Treatment (MAT) for alcohol use disorder includes three FDA approved oral medications that help reduce cravings for alcohol and can be a component of MAT in working with clients struggling with alcohol use disorder. The MSHN expectation is that medication will be an adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity.

1. ***Disulfiram*** *(*Brand name**:** *Antabuse)* – This medication blocks an enzyme that is involved in metabolizing alcohol. Disulfiram produces unpleasant side effects when combined with alcohol in the body. *Antabuse* is used in certain people with chronic alcoholism. This medicine can help keep the client from drinking because of the unpleasant side effects that will occur if consuming alcohol while taking *Antabuse*. *Antabuse* is used together with behavior modification, psychotherapy, and counseling support to help stop drinking.

2. ***Acamprosate Calcium (****Brand name**:** Campral)* – This medication helps promote abstinence from alcohol in patients with alcohol dependence *who are abstinent at treatment initiation*. Treatment with Acamprosate should be part of a comprehensive management program that includes psychosocial support. The efficacy of Acamprosate in promoting abstinence has not been demonstrated in subjects who have not undergone detoxification and not achieved alcohol abstinence prior to beginning Campral treatment. The efficacy of Campral in promoting abstinence from alcohol in polysubstance abusers has not been adequately assessed.

3. ***Naltrexone HCL (****Brand name**:** ReVia, Vivatrol)* This medication, (an opiate antagonist that works in the brain to prevent feelings of well-being, paint relief, etc.) is used to treat alcohol abuse by reducing cravings. It can help clients drink less alcohol or stop drinking altogether. It also decreases the desire to drink alcohol when used with a treatment program that includes counseling, support, and lifestyle changes.

PLEASE NOTE: *The medications referenced in this section are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.*

**BENZODIAZAPINE USE DISORDER &
MEDICATION-ASSISTED TREATMENT**

Medication-Assisted Treatment (MAT) for Benzodiazepine Use Disorder includes the anticonvulsant medication *Neurontin*. The MSHN expectation is that medication will be adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity.

Gabapentin *(Brand name: Neurontin)* – The anticonvulsant Neurontin has demonstrated a positive impact on reducing cravings for benzodiazepines as well as offering a reduction in the severity of withdrawal effects like seizures.

PLEASE NOTE*: The medications referenced above are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case*

management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.

ATTENTION: Please note that use of gabapentin (Neurontin) to reduce cravings and/or to reduce the severity of withdrawal symptoms is not FDA-approved. There is evidence of its effectiveness for this use, however. Any decision regarding use of this medication for MAT purposes should only take place after a transparent and clear conversation between doctor and patient regarding benefits and risks and notification of its FDA status.

COCAINE USE DISORDER &
MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT) for cocaine use disorder includes two oral medications that help reduce cravings. The MSHN expectation is that medication will be adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity. These medications include:

1. ***Citalopram Hydrobromide*** *(Brand name: Celexa*) – Celexa is most commonly used for depression, but has been shown to help reduce cravings for cocaine.

2. ***Buproprion HCL*** *(Brand name: Wellbutrin)* - Wellbutrin is most commonly used for depression but has been shown to help reduce cravings for cocaine.

PLEASE NOTE: *The medications referenced above are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.*

ATTENTION: Please note that use of Citalopram Hydrobromide (Celexa) and Buproprion HCL (Wellbutrin) to reduce cravings is not FDA-approved. There is evidence of its effectiveness for this use, however. Any decision regarding use of this medication for MAT purposes should only take place after a transparent and clear conversation between doctor and patient regarding benefits and risks and notification of its FDA status.

MARIJUANA USE DISORDER &
MEDICATION-ASSISTED TREATMENT

Medication-Assisted Treatment (MAT) includes two medications that have been effective as one component of working with clients who have marijuana use disorder. The MSHN expectation is that medication will be adjunct to other services like outpatient individual and group therapy, case management and peer recovery supports as dictated by ASAM and medical necessity.

1. ***Gabapentin*** *(Brand name: Neurontin)* – The anticonvulsant Neurontin, used primarily to treat seizures, has demonstrated a positive impact on reducing cravings for marijuana as well as a reduction in the severity of withdrawal effects.

2. **Acetylcysteine** (*(Brand name: Mucomyst)* – This medication, when inhaled, helps open the airways due to lung diseases such as emphysema, bronchitis, cystic fibrosis and pneumonia. When taken orally,

Acetylcysteine helps prevent liver damage caused by an overdose of acetaminophen (Tylenol). For use with clients abusing marijuana, this medication can help reduce cravings.

PLEASE NOTE: *The medications referenced above are not funded through MSHN. However, MSHN will fund medically appropriate ancillary services that accompany medication like outpatient therapy, case management and peer recovery supports for clients receiving these medications as part of their substance abuse treatment.*

ATTENTION: Please note that use of gabapentin (Neurontin) to reduce cravings and/or to reduce seizures associated with withdrawal from marijuana use is not FDA-approved. There is evidence of its effectiveness for this use, however. Any decision regarding use of this medication for MAT purposes should only take place after a transparent and clear conversation between doctor and patient regarding benefits and risks and notification of its FDA status.

REFERENCES AND IMPLEMENTATION GUIDANCE

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, has issued treatment improvement protocols (TIPs) to assist with the implementation of these services.

Treatment Improvement Protocol #43 (TIP-43), "Medication-Assisted Treatment for Opioid/Opiate Addiction in Opioid/Opiate Treatment Programs ", Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (http://www.atforum.com/SiteRoot/pages/addiction_resources/MAT-TIP_43-MMT_Guidelines2005.pdf)

Treatment Improvement Protocol #40 (TIP-40), "Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid/Opiate Addiction", Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (available from http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf)

Substance Abuse Treatment/Recovery Policy # (TP-5), "Criteria for Using Methadone for Medication - Assisted Treatment/Recovery", Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (available from http://www.michigan.gov/documents/Treatment_Policy_05_Enrollment_Criteria_for_Methadone_145925_7.pdf)

Substance Abuse Treatment/Recovery Policy # (TP-3), "Buprenorphine", Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (available from http://www.michigan.gov/documents/Treatment_Policy_03_Buprenorphine_145923_7.pdf)

"Medication for the Treatment of Alcohol Use Disorder: A Brief Guide," Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (available from http://store.samhsa.gov/shin/content//SMA15-4907/SMA15-4907.pdf)

Additional resources used in the development of this treatment protocol include:

Michigan Medicaid Provider Manual (available from http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf)

American Society of Addiction Medicine Patient Placement Criteria-3rd Edition (available from http://www.asam.org/publications/patient-placement-criteria)

Waller, R.C., MD, MS. "Medication-Assisted Treatment Guidelines for Opioid Use Disorders", (available from https://macmhb.org/sites/default/files/attachments/files/Waller%20-%20Opioid%20Tx%20Guidelines.pdf).

Appendix A

Methadone Assisted Treatment Expectations

I, _____ understand that my funding through Mid-State Health Network is contingent upon my following the expectations listed below.

- Discontinuation of the use of all illicit and non-prescribed drugs and alcohol.
- Regular attendance at the methadone-assisted treatment provider for dosing (daily, until such time that the individual meets criteria for take-home dosages in the case of methadone, and as clinically and medically appropriate for buprenorphine) dosing (with the possible exception of Sundays and holidays.
- Submit to toxicology sampling as requested.
- Attendance and active participation at all group and/or individual treatment sessions or other clinical activities.
- Comply with the individualized treatment and recovery plan, inclusive of following through on other treatment and recovery plan related referrals. Repeated failure should be considered on an individual basis and only after the methadone-assisted treatment Provider and outpatient treatment Provider (if applicable) have taken steps to assist the individual to comply with activities.
- Adherence to all program rules and policies.
- Manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Provide the names, addresses, and phone numbers of all medical, dental, and pharmacy providers.
- Produce valid prescription or medication bottles with the physician's name on the label for all controlled substances within one week of admission. If the individual tests positive for a controlled substance that he/she has not previously provided a valid prescription for, the individual agrees to present a valid prescription or current medication bottle(s) with the physician's name on the label for the controlled substance before the individual may receive his/her next regular or full methadone dose.
- Prescribed medications may have to be changed in order to better coordinate treatment.
- Sign Authorizations to Release Information with medical, dental and pharmacy providers in order to better coordinate treatment. If an individual refuses to meet these expectations, it could negatively impact the individual's success with treatment.
- Enrollment in one medication-assisted treatment Provider only (methadone and/or buprenorphine). If an individual is enrolled in more than one (1) medication-assisted treatment Provider at a time (methadone and/or buprenorphine), the individual may be administratively discharged from the methadone or buprenorphine program.
- Evidence of continued work toward goals outlined in treatment plan.
- No altered urine screens or non-compliance with drug testing.

The above expectations were reviewed and explained by the methadone assisted treatment provider. I have read and understand the expectations and agree to adhere to these expectations.

Client	Signature	Date
MAT Provider Staff Member	Signature	Date

Appendix B

JUSTIFICATION FOR CONTINUATION OF MEDICATION-ASSISTED TREATMENT FORM

( ) TWO YEAR JUSTIFICATION ( ) ANNUAL

CLIENT: _____ CLINIC: _____

TODAY'S DATE: _____ ADMISSION DATE: _____

DSM-V DIAGNOSIS (Current):

Current Medication and Dosage:

Current Treatment Services (Including Frequency):

To determine whether a client should continue in medication-assisted treatment, the program physician in cooperation with the clinical staff must use the following ASAM Patient Placement criteria in evaluating the client.
It is appropriate to retain the client at the present level of care if (Please CIRCLE any that apply):

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

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1. Acute dependence and/or withdrawal (check at least one):

____ Continued medication-assisted treatment is required to prevent relapse to substance use.
____ The client needs ongoing medical monitoring and access to medical management.
____ The client is pregnant and detoxification would endanger the client and the pregnancy.

Clinical Impressions:

2. Biomedical Conditions and Complications (check at least one):

____ There is a current or chronic illness and substance dependence problem that requires medical monitoring and management.

____ The client has biomedical problems that can be managed on an outpatient basis, such as liver disease or problems with potential hepatic decompensation, pancreatitis, gastrointestinal problems, cardiovascular disorders, HIV and AIDS, sexually transmitted diseases and tuberculosis.

____ The client has a concurrent biomedical illness or pregnancy which can be treated on an outpatient basis with minimal daily medical monitoring.

Clinical Impressions:

3. Emotional/Behavioral or Cognitive Conditions and Complications (check at least one):

____ Client's emotional/behavioral functioning may be jeopardized by discontinuation of methadone maintenance treatment.

____ Client demonstrates the ability to benefit from methadone treatment but may not have achieved significant life changes.

____ Client is making progress toward resolution of an emotional/behavioral problem, but has not sufficiently resolved problems to benefit from a transfer from methadone maintenance to a less intensive level of care.

____ Client's emotional/behavioral disorder continues to distract the client from focusing on treatment goals, however, the client is responding to treatment and it is anticipated that with additional intervention the client will meet treatment objectives.

____ Client continues to exhibit risk behaviors endangering self or others but the situation is improving.

____ Client is being detained pending transfer to a more intensive treatment service.

____ Client has a diagnosed but stable emotional/behavioral or neurological disorder which requires monitoring, management, and/or psychotropic medication due to the client's history of being distracted from recovery and/or treatment.

Clinical Impressions:

4. Readiness to change (check at least one):

____ Client recognizes the severity of the drug problem, however, the client exhibits little understanding of the detrimental effects of drug use, including alcohol, yet the client is progressing in treatment.

____ Client recognizes the severity of the addiction and exhibits an understanding of his/her relationship with narcotics, however, the client does not demonstrate behaviors that indicate the client has assumed responsibility necessary to cope with the situation.

____ Client is becoming aware of responsibility for addressing the narcotic addiction, but still requires current level of treatment and psychotherapy to sustain person responsibility in treatment.

____ Client has accepted responsibility for addiction and has determined that ongoing methadone treatment is the best strategy for preventing relapse to narcotics dependence.

Clinical Impressions:

5. Relapse, Continued Use or Continued Problem Potential (check at least one):

____ Due to continued relapse attributable to physiological cravings, the client requires structured outpatient psychotherapy with methadone to promote continued progress and recovery.

____ Client recognized relapse cures, but has not developed or exhibited coping skills to interrupt, postpone or neutralize gratification or to change impulse control behavior.

____ Narcotic symptoms are stabilized, but have not been reduced to support successful functioning without structured outpatient treatment.

____ Pharmacotherapy (methadone) has been effective as an adjunct to psychotherapy and as a strategy used to prevent relapse, however, withdrawal from methadone is likely to lead to recurrence of addiction symptoms and, possibly relapse.

Clinical Impressions:

6. Recovery Environment (check at least one):

____ Client has not integrated and exhibited coping skills sufficient to survive stressful situations in the work environment, or has not developed vocational alternatives.

____ Client has not developed coping skills sufficient to successfully deal with a non-supportive family and social support environment or has not developed alternative living support systems.

____ Client has not integrated and exhibited the socialization skills essential to establishing a supportive family and social support environment.

____ Client has responded to treatment of psychosocial problems affecting client's social and interpersonal life, however, the client's ability to cope with psychosocial problems would be limited if the client is transferred to a less intensive level of treatment.

____ Client's social and interpersonal life has not changed or deteriorated, however, the client needs additional treatment to cope with his/her social and interpersonal life or to take steps to secure an alternative environment.

____ Emotional and behavioral complications of addiction are present, however, the behavioral complications are manageable in a structured outpatient program. The behaviors include, 1) criminal activity involving illicit drugs, 2) victim of abuse or domestic violence, 3) inability to maintain a stable household, including the provision of food, shelter, supervision of children and health care, and 4) inability to secure or retain employment.

Clinical Impressions:

Has the client been consistent with clean urine drug screens? Yes No

If NO, Explain reason and plan:

Has the client been consistent with attending treatment sessions? Yes No

If NO, Explain reason and plan:

Does the client have any medical conditions that are currently being treated? Yes No
If YES, Explain:

Does the client have ongoing psychiatric conditions that are currently being treated? Yes No
If YES, Explain:

Is the client currently being treated with any prescription medications that are classified as controlled substances and/or respiratory depressants (including medical marijuana)? Yes No
If YES, please list each medication, the prescribing physician, and document coordination of care efforts:

Titration Plan: (To be completed by PHYSICIAN only) Please provide information regarding any attempts that have been made to titrate client's current dose of medication. Please provide information related to the anticipated length of continued treatment:

Clinical and Medical Recommendations: (Include any client information that is not covered in this review that must be considered for re-evaluation of medical necessity for continuing methadone dosing.)

Print Therapist Name **Signature**
Date

Print Physician Name **Signature** **Date**

Appendix D:

Technical Requirement for Recovery Housing

Purpose

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the implementation of recovery housing.

Policy

It is the expectation of Mid-State Health Network (MSHN) that recovery housing be provided to aid clients in recovery in accordance with standards identified by the National Alliance of Recovery Residences (NARR). MSHN supports the recommendations of the Office of Recovery Oriented Systems of Care as stated in Treatment Technical Advisory #11. Recovery housing is expected to be a safe, structured, and substance free environment. *Clients residing in recovery housing must be actively engaged in formal outpatient treatment*. Recovery housing must be identified as medically necessary in the client's treatment plan and a copy of the treatment plan must be present in the client's recovery housing file. Transportation may be a component of recovery housing in a limited capacity on a case by case basis as authorized by MSHN. If transportation is being provided, it must also be addressed in the client's treatment plan.

MSHN also expects recovery housing providers to employ recovery coaches to enhance a client's recovery experience. If the provider cannot offer this service, they must coordinate care with another local provider of recovery coaching services while the recovery residence actively seeks to hire a trained recovery coach. MSHN expects that providers have trained recovery coaches *on-site* at all recovery residences.

The provider of the recovery residence will maintain a file on each client admitted into recovery housing. The outpatient services that the client is receiving should be formal, documented, and part of a treatment/recovery plan including clearly written recovery goals and objectives.

The recovery residence file should include but not be limited to:

- Basic demographic information
- Releases of information are required in client file for the following: primary care physician, outpatient provider, MSHN, emergency contact
- Application and screen
- Signed client acknowledgement of discussion and receipt of recovery housing rules and expectations
- Treatment plan from treatment provider
- Recovery Plan developed with the client and recovery residence staff
- Evidence of regular care coordination with service providers
- Evidence of regular drug screening
- Evidence of weekly house meetings run by trained recovery coaches
- Recovery coaching progress notes in recovery coaching is being provided on location

Out of County consumers
Consumers from outside on of MSHN's 21 county region may come into our region for SUD services including recovery housing. Most of these consumers return to their home upon completion of treatment. MSHN's expectation is that providers will engage the sending PIHP in a single-case agreement for that consumer to obtain reimbursement for that consumer's services. In most cases, switching the consumer's Medicaid from their originating county to the host county of the provider impacts the PIHP that is responsible for payment of the service. However, switching the consumer's Medicaid coverage can result in the consumer being assigned to a different PIHP region, meaning that the newly assigned PIHP is not obligated to cover the service, since the placement occurred previous to the onset of service and is not the consumer's address of record at time of admission. The logistical challenge (for individual consumers) of making that change often results in consumers falling off of Medicaid coverage.

Cap on Treatment Length
MSHN will fund up to 90 days of transitional housing based upon determination of medical necessity. Providers are expected to add progress notes in CareNet a minimum of every 30 days. Providers should work with each consumer and the consumer's outpatient treatment provider to develop an individualized plan identifying either alternative housing to which consumer will go after discharge or alternative sources of funding to pay for the consumer's continued stay in transitional housing.

Levels of Recovery Housing
The four levels of recovery housing are as follows:

- **Level I** - Peer Run- This level of housing is democratically run with clear policies and procedures. Staff positions are not paid. *Mid State does not reimburse for this level of Recovery Housing.*
- **Level II** - Monitored- This level of housing maintains structure and a minimal level of structure. There is at least one paid staff position.
- **Level III** - Supervised-This level of housing has administrative oversight and provides more structure. Paid staff positions include a facility manager and certified staff or case managers.
- **Level IV** - Service Provider- This level of housing is highly structured and employees administrative and credentialed clinical staff.

Funding
Clarification regarding using *Substance Abuse Block Grant (SABG)* funds for recovery housing was sought from the *Center for Substance Abuse Treatment*. *SABG* funds may not be used to fund an individual's lodging in recovery housing. **However, *SABG* funding can be used in conjunction with a treatment service category to provide room and board for any individual, to the extent that it is integral to the treatment process.** In addition, the *SABG* set aside for pregnant and parenting women does allow payment to provide housing eligible women. Recovery Housing for the pregnant and parenting population will ideally be offered

through a designated program to ensure that all of their needs are met. Reimbursement structures are based upon individual programming and recovery house needs. When Block Grant funding is utilized, the S9976 code will be used to bill for services. All programs interested in developing recovery housing will need to meet individually with MSHN finance/clinical staff to discuss reimbursement rates.

Monitoring

Mid State Health Network expects providers of recovery housing to comply with NARR standards. Recovery housing programs will be monitored regularly by on-site visits and/or desk audits by Mid State Health Network staff using NARR standards. For more information on NARR satndards and Treatment Technical Advisory #11 (Office of Recovery Oriented Systems of Care, Effective October 1, 2015).

Definitions

Recovery housing is defined by OROSC as "providing a location where individuals in early recovery from a behavioral health disorder are given time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program."

References/Legal Authority

Treatment Technical Advisory #11
National Alliance of Recovery Residences (http://narronline.org)

Appendix E:

Technical requirement for SUD Transportation Services

MSHN strives to reduce transportation barriers to accessing SUD treatment and recovery services, using the best quality, consumer-friendly, cost-efficient means possible. Transportation services are not a guaranteed benefit and are limited by the availability of Substance Abuse Block Grant funding during each fiscal year. Transportation needs must be identified during the screening and assessment process and clearly documented within the consumer's individualized treatment plan. If transportation needs arise during the course of a treatment episode, documentation of the need must be included in the consumer chart (i.e.: progress note, treatment plan review, etc.) and it must be included on an amended treatment plan. The treatment plan must include goals related to helping the consumer reduce barriers to transportation, and must promote consumer self-sufficiency and empowerment.

Transportation services authorized by the PIHP are available only after all other transportation options have been exhausted. These options include but are not limited to: natural/community supports and Medicaid Health Plans (MHPs). Efforts to obtain other available and appropriate means of transportation must be documented in the consumer chart and shall be subject to MSHN confirmation. For consumers using transportation services, a transportation log must be included in the consumer chart. Transportation logs must include the following: date of service, signature/initials of consumer and program staff person(s), purpose of transportation and destination(s) with total mileage or number of bus tickets or gas cards issued.

***All transportation CPT/HCPCS service codes shall be pre-authorized. Providers should contact the MSHN Utilization Management department directly at 1-844-405-3095.** A utilization management specialist will work with the requesting provider agency to review the specific transportation needs of the individual client and determine the appropriate form of transportation (if any). The utilization management specialist will create an authorization for the transportation services and release it to the provider agency via the CareNet system. The MSHN Utilization Management department will monitor the utilization of transportation codes region-wide and will work closely with the MSHN Finance department to monitor availability of block grant funding for transportation assistance. Eligibility for transportation services is determined using the following criteria:

I. LEVEL OF CARE

A. **Detoxification & Residential Treatment**

Transportation services are available to all consumers who meet medical necessity criteria for these levels of care. The detoxification or residential service provider is responsible for determining the consumer's transportation needs during the course of the screening process. The following parameters apply to transportation services for these levels of care:

1. Least costly method of transportation must be used; starting travel begins at the consumer's home and/or point of pick up (i.e. bus station) and destination is complete when consumer reaches the designated treatment center.

2. Return transportation assistance from detox/residential treatment to the consumer's home will not be funded if the consumer leaves treatment against medical advice or due to program rules violation. Exceptions to this policy may be authorized on an individual case basis with supporting clinical documentation. The treatment provider requesting the exception must contact the MSHN Utilization Management department for authorization.

3. Routine transportation provided to the consumer during the course of the residential treatment episode is considered intrinsic in the residential service delivery and is factored into the per diem reimbursement rate for residential treatment services (H0018/H0019). Additional mileage reimbursement may be authorized for excessive, non-routine transportation that is provided to the consumer during the course of the residential treatment episode. Authorization requests for excessive, non-routine transportation must be submitted to the MSHN Utilization Management department via CareNet for review.
    - **Examples of *routine transportation* during the course of the residential treatment episode include but are not limited to: transporting the consumer to local stores for the purpose of obtaining necessary personal items; transporting the client to local recovery-support meetings; and transporting the consumer for medical services such as methadone treatment and physician visits in close proximity to the residential treatment center.**
    - Examples of *excessive, non-routine transportation* include, but are not limited to: transporting the client to his/her home community to participate in required court proceedings, Department of Health and Human Services (DHHS) case conferences, or visitations with children in foster care; Transporting the client to his/her home community to receive specialty medical or behavioral health treatment from a provider with whom the client has an established treatment history or for the purpose of establishing aftercare.
4. Available Transportation Codes
    - A0110 Long Distance Bus Transportation- $15 per unit, maximum 10 units billed at one time; supporting documentation (i.e.: receipt for Greyhound bus ticket, etc.) must be submitted to MSHN claims department.
    - S0215 Non-Emergency Transportation (per mile)- IRS mileage reimbursement rate; May be used by treatment center to bill for transportation expense in cases where treatment center staff members provide transportation to the client. This service code may only be used when long-distance bus transportation is not available or if this is the least costly means of transportation; May be used in combination with long-distance bus transportation to transport client from the bus station to the treatment center; May also be used when treatment center staff provide transportation to clients throughout the duration of the residential treatment episode for excessive, non-routine transportation as outlined above.

B. Outpatient

Transportation assistance is available for outpatient SUD services with the following priority status:

1. Women's Specialty Consumers and dependent children;
2. Consumers residing in rural settings (defined as 15 or more miles from the nearest outpatient service provider);
3. All other consumers if SUD Block Grant funding permits.

Public transportation (bus tokens) should be the first method of transportation used, whenever possible. Justification for using a form of transportation assistance other than public transportation (bus tokens) must be documented in the consumer chart. Examples of justification for using other forms of transportation include but are not limited to: the consumer does not reside on a public transportation route; the consumer has a specific physical or emotional disability which would make utilizing public transportation a hardship for that consumer; or the impairment caused by the

consumer's substance use disorder poses safety concerns or high risk of relapse when using the public transportation system.

1. **Available Transportation Codes**
   - A0110 Bus Tokens- $1.50 per unit; consumers may be given the amount of tokens necessary for one round trip between their home and the recovery treatment provider for each day they attend treatment. The same limitation applies, per day, for each dependent child accompanying a consumer to Women's Specialty treatment services.
   - T2003 Gas Card- $5.00 per unit; this code is available only for consumers who do not reside on a public transportation route. The maximum units permitted depends on individual consumer needs and must be clearly documented in the consumer chart. The provider is responsible for evaluating individual need and assisting consumers with planning.
   - S0215 Mileage – IRS mileage reimbursement rate; May be used in addition to A110 if/when consumer requires transportation from public transportation point to treatment facility; May also be used to assist consumers with recovery-oriented service access outside of the treatment center. Mileage is to be utilized using least costly methods and only when required to assist consumers with treatment plan goals.

References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY16 - Medicaid Services Verification-Technical Requirements