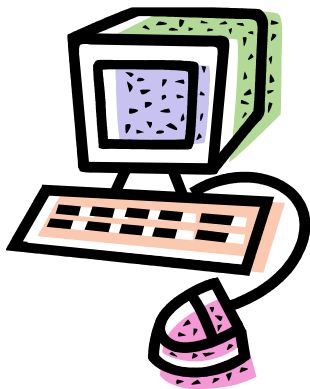


**NORTHCARE NETWORK
SUBSTANCE ABUSE
SERVICES**

PROVIDER MANUAL

2009-2010



NORTHCARE NETWORK SUBSTANCE ABUSE
PROVIDER MANUAL – 2009/2010

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GENERAL INFORMATION

Purpose of the Provider Manual

The purpose of this Provider Manual is to state general policies and procedures that apply to Block Grant funded agencies within the eight-county NorthCare Network Substance Abuse Services region as well as the Medicaid providers in the Upper Peninsula. While every attempt has been made to be as clear and accurate as possible, omissions, ambiguities, and other imperfections may exist. In the event an error is discovered or a policy changes, contracted providers will be notified in writing. This manual is meant to supplement the contract between NorthCare Network Substance Abuse Services and contracted providers. As updates, clarifications, and changes are made to our Master Contracts or the Medicaid Provider Manual, this Substance Abuse Provider Manual will also be updated. Providers will be notified when updates have occurred.

NORTHCARE NETWORK Substance Abuse Services **NORTHCARE/PATHWAYS** **Substance Abuse Coordinating Agency (CA)** **and Central Diagnostic & Referral (CDR)**

Main Office: 200 W. Spring Street, Marquette, MI 49855

Staff: GAIL HALL, Chief Executive Officer
CYNTHIA SHAFFER, Chief Operating Officer
DONNA KITRICK, Substance Abuse Director
JOE COOLS, M.D. Medical Director
MARY SWIFT, Recipient Rights Supervisor

CAROL EASTON, Assessment Specialist
JAN GRIM, Administrative Assistant
KATHRYN LYMAN, Access Specialist
[ROBERT MELLIN, Assessment Specialist](#)
JAN MCCOMBIE, Substance Abuse Data Coordinator

Numbers: Phone: (906) 225-7222
Toll-Free: (800) 305-6564
Fax: (906) 225-7224

Prevention/Finance/Accounting Office

Staff: JUDI BRUGMAN, Accountant – (906)225-7286
[MERRILEE KELLER](#), Prevention Coordinator – (906)226-0031
Fax Number: (906) 225-5149

Website: www.northcare-up.org/subA

Organizational Chart – State Level

Michigan Department of Community Health
Janet Olszewski, Director

BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES
Deb Hollis, Director

MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION
Mike Head, Director

CDR Mandate

The CDR is mandated and determined to be qualified by the State of Michigan to determine a level of care and to refer clients to an appropriate provider to receive those determined substance abuse services. It is the expectation of the CDR/CA that the chosen provider would accept the client into services at the LOC determined by the CDR. If, after receiving services, the provider has documented clinical basis for a LOC change, they should review this information with the client and the CDR. A release of information should be secured on the first visit or contact.

CDR Hours of Operation

Regular office hours are 8:00 A.M. until 5:00 P.M., EST, Monday through Friday. Voice mail is available to callers during non-business hours.

Callers will hear the following message during non-business hours:

“You have reached the NorthCare Network Substance Abuse Access Center. Our regular business hours are 8:00 A.M. until 5:00 P.M., EST, Monday through Friday. If you are in need of detox services, contact your local Emergency Department. If you are pregnant and concerned about your substance use or possible relapse, or are a current IV drug user (within the past 30 days), please contact Marquette General Hospital at 1-800-562-9753 and ask for substance abuse services on the 5th floor of the RCN building. The direct number is (906)225-3330. If you do not fit these circumstances, you can either leave a message for us to return your call – leaving your name and phone number where you can be reached or you can call back during regular business hours.”

TARGET POPULATION

While this varies somewhat according to funding source and priority status, the target population is generally comprised of low-income residents with a substance abuse/dependence disorder residing in Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee, and Schoolcraft counties and Medicaid recipients in the fifteen counties of the Upper Peninsula of Michigan.

Residency in Coordinating Agency (CA) Region

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

Use of Cell Phones

Legal Action Center Book - 2006 Edition

Mobile telephones present some new challenges to programs. Before the use of mobile telephones, conversations about confidential matters could take place in rooms or booths where some degree of privacy could be achieved. With mobile telephones, conversations about confidential matters can take place anywhere and be overheard by anyone. Although neither HIPAA nor 42 C.F.R. Part 2 specifically address the use of mobile telephones, a mixture of common sense and restraint will satisfy both laws. For instance, a staff member should not have a conversation about a patient in an area where there is an obvious risk of being overheard, like in a public gathering or aboard public transportation.

Some programs have also limited staff use of mobile telephones to discuss patients because there have been occasions where such conversations are inadvertently overheard on another mobile telephone. If this is a persistent problem in a particular area, limitations should be imposed.

List of Contract Providers

Refer to the NorthCare Network Customer Handbook for Substance Abuse for the most current listing of substance abuse providers – www.northcare-up.org/subA

FUNDING /ELIGIBILITY CRITERIA/CLINICAL NEED

12-Month Availability of Services

[Contracted Providers must maintain service availability throughout the fiscal year for persons who do not have the ability to pay.](#)

Treatment Services Must be Based on the Following:

[Medical Necessity Criteria For Substance Abuse Supports And Services](#)

[The CA must assure that treatment service authorization and reauthorization decisions are consistent with the following Medical Necessity Criteria. These](#)

criteria are substantively the same as the applicable criteria for substance abuse Medicaid services.

1.0 Medical Necessity Criteria

- 1.1 “Medically necessary” substance abuse services are supports, services, and treatment:
 - 1.1.1 Necessary for screening and assessing the presence of substance use disorder; and/or
 - 1.1.2 Required to identify and evaluate a substance use disorder; and/or
 - 1.1.3 Intended to treat, ameliorate, diminish or stabilize the symptoms of a substance use disorder; and/or
 - 1.1.4 Expected to arrest or delay the progression of a substance use disorder; and/or
 - 1.1.5 Designed to assist the individual to attain or maintain a sufficient level of functioning in order to achieve his/her goals of community inclusion and participation, independence, recovery or productivity.

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

- 1.3 Supports, services and treatment authorized by the CA must be:
 - 1.3.1 Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the individual; and
 - 1.3.2 Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
 - 1.3.3 Provided in the least restrictive, most integrated setting. Residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
 - 1.3.4 Delivered consistent with, where they exist, available research findings, health care practice guidelines and standards of practice issued by professionally recognized organizations or government agencies.

- 1.4 Using criteria for medical necessity, a CA may:
 - 1.4.1 Deny services a) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care; b) that are experimental or investigational in nature; or c) for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support, that otherwise satisfies the standards for medically-necessary services; and/or
 - 1.4.2 Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
 - 1.4.3 A CA may not deny services solely based on PRESET limits of the cost, amount, scope, and duration of services; but instead determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on industry standards and consistent with 1.3.4 above, and that are provisional and subject to modification based on individual clinical needs and clinical progress.

Clinical Eligibility: DSM IV-TR Diagnosis

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

- 303.90 Alcohol Dependence
- 305.00 Alcohol Abuse
- 303.00 Alcohol Intoxication
- 291.80 Alcohol Withdrawal
- 304.40 Amphetamine Dependence
- 305.70 Amphetamine Abuse
- 292.89 Amphetamine Intoxication
- 292.00 Amphetamine Withdrawal
- 304.30 Cannabis Dependence
- 305.20 Cannabis Abuse
- 292.89 Cannabis Intoxication
- 304.20 Cocaine Dependence
- 305.60 Cocaine Abuse
- 292.89 Cocaine Intoxication
- 292.00 Cocaine Withdrawal
- 304.50 Hallucinogen Dependence

305.30 Hallucinogen Abuse
292.89 Hallucinogen Intoxication
304.60 Inhalant Dependence
305.90 Inhalant Abuse
292.89 Inhalant Intoxication
304.00 Opioid Dependence
305.50 Opioid Abuse
292.89 Opioid Intoxication
292.00 Opioid Withdrawal
304.60 Phencyclidine Dependence
305.90 Phencyclidine Abuse
292.89 Phencyclidine Intoxication
304.10 Sedative, Hypnotic, or Anxiolytic Dependence
305.40 Sedative, Hypnotic, or Anxiolytic Abuse
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication
292.00 Sedative, Hypnotic, or Anxiolytic Withdrawal
304.90 Other (or Unknown) Substance Dependence
305.90 Other (or Unknown) Substance Abuse
292.89 Other (or Unknown) Substance Intoxication
292.00 Other (or Unknown) Substance Withdrawal

Individualized Treatment Planning

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

Treatment Plan:

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

Treatment Interventions:

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

Progress Notes:

- Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the treatment plan

- When progress notes are written, the note should reflect what goal(s) were addressed during a treatment episode
- The progress notes are also used to document any changes made to the treatment plan

Treatment Plan Reviews

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

Block Grant

To be eligible for Block Grant funding, a client must meet income, medical necessity criteria and residency requirements (per State contract) in Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee and Schoolcraft counties.

Access: Screening and Referral Services are Core Functions of the CDR: Services shall be provided in the amount and for the duration and with the scope that is appropriate to reasonably achieve the desired treatment outcomes and is the least restrictive. Level of care is determined using the following tools/clinical information: ASI Lite (Addiction Severity Index), ASAM placement criteria, DSM IV, substance abuse history, mental illness history, and motivation. [Access requirements apply to all funding sources.](#)

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

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

The sliding fee scale below became effective October 1, 2009 and was current at the time the Provider Manual was written. It is based on the Federal Poverty Guidelines, which are revised annually. The CA's sliding fee scale is subject to revision by the CA during the year. In the event that the scale is updated, providers will be notified in writing and given an effective date for applying the new revision.

Clients who meet the sliding fee scale and other requirements but are also covered by other insurance may be eligible for Block Grant funding in coordination with the other insurance plan. Block Grant funds must be the last source of funding either in conjunction with other insurance or funding, or, after other funding sources available to the consumer have been exhausted. See the Benefits Coordination example in the Provider Billing section. Contact Judi Brugman at 225-7286 or via email at jbrugman@up-pathways.org with questions.

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

PATHWAYS/NORTHCARE

Substance Abuse Services

FY 2009-2010
Sliding Fee Scale

Family Size (Based on # claimed on income tax return)	Income Level 1 225% of Poverty
1	\$0- 24,368
2	\$0-32,783
3	\$0-41,198
4	\$0-49,613
5	\$0-58,028
6	\$0-66,443
7	\$0-74,858
8	\$0-83,273
Pathways pays this percentage of the Contractual Rate	100%

Residency:

Priority clients will be placed according to State guidelines. The CA will exercise a priority admission system for non-priority clients. This procedure would give non-priority CA region residents the first opportunity to fill available treatment placements. All others would be considered for placement dependent on capacity of the programs funded.

Medical

Necessity:

Clients seeking **intensive levels** of care-other than sub-acute residential residential programming-must complete a CDR screening (i.e. a screening administered by CDR staff). Funds can only be accessed for intensive services if the CDR screening demonstrates a **medical necessity** for such services. Substance Abuse services will be provided in the least restrictive, most integrated setting.

Covered

Services: Refer to your contract

Medicaid

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

Income:

Financial eligibility for Medicaid is determined by Michigan's Department of Human Services (DHS). Clients apply at their local DHS office. A valid Medicaid card is documentation of income. Medicaid eligibility may also be checked through 271 on CareNet, Medifax or Web-Denis. Other options may be available for a fee.

It is essential that providers be vigilant about checking Medicaid eligibility, as clients may be eligible one month but not the next. Monthly documentation of **Medicaid eligibility must be maintained in client's charts or have been checked on the 271 eligibility screen on the MIS**. This documentation is subject to review during CA site visits.

Residency:

Each valid Medicaid card references the recipient's home county. In order to receive Medicaid-funded services in our region, a client's card must list one of the following counties: Alger, Baraga, Chippewa, Dickinson, Delta, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, or Schoolcraft. **NOTE: Be sure to verify that the county on the card is the county where the recipient has primary residency.** Medicaid recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate Coordinating Agency. Issues regarding county of financial responsibility should be referred to the CDR.

Medical

Necessity:

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

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

Covered

Services: Medicaid covered services include:
Initial Assessment, diagnostic evaluation, referral and patient placement;
Sub-acute Detox;
Residential Treatment;
Intensive Outpatient Treatment;
Outpatient Treatment; and
Methadone Treatment

Spend

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

For clients residing in the eastern 8 counties, the client would be set up in CareNet with Medicaid as the primary insurance. Services should also be billed as Medicaid. Use the notes section to track the dates of service where the deductible has/has not been met. It is possible that services could be paid for with block grant. Providers **must have documentation in the client record to support eligibility for block grant** in these situations. If the client is not block grant eligible, payment for services billed when the deductible has not been met will be denied.

If the client is not a resident covered by block grant with NorthCare (western 7 counties), the provider should secure other funding sources until the spend down (deductible) has been met. Once the deductible has been met, the Medicaid process would be followed.

Providers must ensure that Medicaid beneficiaries are not held liable when the PIHP does not pay the provider furnishing services under the contract. Beneficiaries are not to be held liable for payment of covered services furnished under the contract if those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the service directly.

***Adult Benefit Waiver**

Adult Benefit Waiver (ABW) is a limited benefit program that provides health insurance for eligible adults currently in need of insurance coverage.

Income: DHS determines eligibility for ABW. Clients eligible for ABW will be issued a Medicaid card stating this. **Providers must inquire if clients are eligible for ABW and document their eligibility.**

Residency: Services are available for ABW clients residing in Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee, and Schoolcraft counties.

Medical

Necessity: The same clinical need requirements apply as for Medicaid above.

Covered

Services: ABW covered services include:
Initial Assessment, diagnostic evaluation, referral, and patient placement;
Intensive Outpatient Treatment;
Outpatient Treatment; and
Methadone Treatment.

General

Information: ABW will be listed on CareNet's Admission and SARF screens as a Funding Source under Program Eligibility and must be checked if client has this coverage, whether or not ABW is paying for the particular service. ABW will also be listed as an option on CareNet's Insurance screen (primary and supplemental) and should be chosen accordingly. The number to call to order is: (517)373-7837 the fax number is: (517)335-4017. Providers can find more detailed information on ABW at the following website:
http://www.michigan.gov/documents/ABWII-AttachmentCw-FP_68140_7.pdf
http://www.michigan.gov/mdch/0,1607,7-132-2943_4853-66333--,00.html
http://www.michigan.gov/mdch/0,1607,7-132-2943_4853-70572--,00.html

MI-Child

MiChild is a health insurance program for uninsured children of Michigan working families. There are no co-pays or deductibles. A number of physical and behavioral health services are covered, including substance abuse services.

Income: Financial eligibility is determined by filing a brief application which is available through local Department of Human Services (DHS), health departments, and selected other human services agencies.

Residency: A minimal residency requirement applies. To qualify, children must be citizens of the U.S. (some legal immigrants qualify) and live in Michigan, even for a brief period of time.

Covered

Services: Outpatient treatment
Residential treatment
Inpatient treatment
Laboratory and pharmacy

Medical

Necessity: MiChild recipients seeking services can approach funded providers directly for outpatient services; the provider will file an authorization request that identifies the client as a MiChild covered life. Like those seeking Block Grant or Medicaid funding, children who wish to access intensive levels of service are required to complete a screening with the CDR to determine medical necessity. All services authorized must be medically necessary and be the most cost-effective option in the least restrictive environment.

State Disability Assistance (SDA)

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

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

Medical

Necessity: In order to receive SDA benefits, a client must be screened by the CDR as needing a residential level of care according to ASAM PPC-2R criteria and meeting medical necessity criteria.

LEVEL OF CARE

Individual Assessment

A face-to-face service for the purpose of identifying functional and treatment needs and a basis for formulating the Individualized Treatment Plan. An assessment-only option is for clients seeking to determine if substance use is a problem, but not necessarily seeking treatment. Outpatient providers on the panel provide an appropriate access point for this service.

Outpatient Treatment/Aftercare (Level 1.0) ABW, Block Grant, Medicaid & MI CHILD

Eligibility criteria for Outpatient care are as follows:

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

When a client is specifically seeking outpatient services and does not indicate a desire for intensive services, the appropriate point of entry is at the client's choice of contracted outpatient providers. Clinical staff will administer an assessment to determine appropriate services. If a potential client contacts the CDR first, they will be offered contact numbers to access outpatient services in their area.

Case Management (Level 1.0) Block Grant

Service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the individualized treatment planning process. Case Management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Case management services are generally provided in the client's community rather than an office building. The advantages to this are the ability to observe the client's behavior in their natural environments, provide recovery management skills in a real world setting, and increasing engagement through assertive outreach.

All intensive levels of service must be screened by the CDR and determined appropriate in order for funding to be considered.

Intensive Outpatient (Level 2.1) ABW, Block Grant, Medicaid

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

Services are provided over a period of weeks. Level II.I program provides essential education and treatment services while allowing the participant to apply their newly acquired skills in "real world environments". IOP can be provided in our region as 3 four hour days of treatment or 4 three hours days of treatment. The service array would include individual, group and family counseling as well as didactic elements regarding alcohol and drugs. Participants in this level of care would preferably leave the treatment facility after completing their daily treatment. The focus is to allow participants to implement the skills they have gained in the program by returning to their home communities. This level of service can be provided with a bed if the participant has transportation issues. In these cases, IOP would be provided over 3 consecutive days. The determining factor for this consideration is geographical and logistical which are evaluated with each individual with regards to distance from the provider. The CDR is responsible for granting authorization for **use of a bed** with IOP. Level of care is determined using the following tools/clinical information: ASI Lite (Addiction Severity Index), ASAM placement criteria, DSM IV, substance abuse history, mental illness history, and motivation.

Partial Hospitalization – (Level 2.5) Block Grant

Partial Hospitalization program offers more than 20 hours of clinically intensive programming per week, as well as daily or near daily contact, as specified in the participant's treatment plan. This level of care is hospital based which includes therapeutic interventions, medical, psychiatric access and laboratory services. A participant in this level of care would preferably leave the treatment facility for a few days after completing their treatment week of 20 plus hours. The focus is to allow participants the opportunity to implement the skills they have gained in the program by returning to their home communities. This level of service can be provided with a bed if the participant has transportation issues. In these cases, Partial Hospitalization would be

provided over 4 consecutive days. The determining factor for this consideration is geographical and logistical which will be evaluated on an individual basis with regards to distance from the provider. The CDR is responsible for granting authorization for **use of a bed** with PH. Level of care is determined using the following tools/clinical information: ASI Lite (Addiction Severity Index), ASAM placement criteria, DSM IV, substance abuse history, mental illness history, and motivation.

Residential Treatment – (Level 3.3) Block Grant, Medicaid & MI CHILD

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

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment. Level of care is determined using the following tools/clinical information: ASI Lite (Addiction Severity Index), ASAM placement criteria, DSM IV, substance abuse history, mental illness history, and motivation.

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

Residential Treatment – (Level 3.5) Block Grant, MI CHILD, MEDICAID

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

Residential Treatment - (Level 3.7) Block Grant & MI CHILD, MEDICAID

This is a 24/7 medically monitored service. Clients stay at the facility while receiving services. Persons admitted to the 24-hour a day services have serious medical and/or psychiatric issues that complicate recovery. Clients who begin at this level may step down in level of care as they are stabilized. Level of care is determined using the following tools: ASAM placement criteria, DSM IV, substance abuse history, mental illness history, and motivation.

Sub-Acute Detox – Residential Setting Block Grant, Medicaid & MI CHILD

The need for sub-acute detoxification is determined by qualified medical personnel. A qualification instrument such as the Clinical Institute Withdrawal Assessment (CIWA) may be used to rate the severity of symptoms related to withdrawal from alcohol and other physically addicting drugs. ~~Block grant~~ Funding may be available for this service in the form of a case rate.

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

counselor. Services must have arrangements for access to licensed medical personnel as needed.

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

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

Authorization Requirements – Sub-Acute Detox – Residential Setting:

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

Inpatient -- MI CHILD only

Inpatient (hospital-based) services are covered, but the CA is permitted to substitute less costly services outside the hospital if they meet the medical needs of the client. In the same way, the CA may substitute services for inpatient or residential services if they meet the client's needs and they are more cost effective.

Evaluation for Appropriateness of Methadone Therapy - ABW, Block Grant, Medicaid & MI CHILD

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

MANDATED ADMISSION PRIORITIES

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

Priority One

Pregnant, injecting drug users

Priority Two

Pregnant substance users

Priority Three

Injecting drug users (defined as anyone who has injected a drug during the past 30 days)

Priority Four

Parent at risk of losing their child(ren) due to Substance Abuse. ([Open CPS case](#))

Priority Five

All others

Access Timeliness Standards

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

Admission Priority Requirements

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1) Screened and referred within 24 hours 2) Detoxification, Methadone or Residential – Offer Admission within 24 business hours Other Levels or Care – Offer Admission within 48 Business hours	Begin within 48 hours: 1. Counseling and education on: a) HIV and TB b) Risks of needle sharing c) Risks of transmission to sexual partners and infants d) Effects of alcohol and drug use on the fetus 2. Referral for pre-natal care 3. <i>Early Intervention Clinical Services</i>	CFR 96.121; CFR 96.131; Treatment Policy #04 Recommended
Pregnant Substance Abuser	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. <i>Early Intervention Clinical Services</i>	CFR 96.121; CFR 96.131; Recommended
Injecting Drug User	Screened and referred within 24 hours; Offer Admission within 14 days	Begin within 48 hours – maximum waiting time 120 days 1. Counseling and education on: a) HIV and TB b) Risks of needle sharing c) Risks of transmission to sexual partners and infants 2. <i>Early Intervention Clinical Services</i>	CFR 96.121; CFR 96.126 Recommended
Parent at Risk of Losing Children (Open CPS case)	Screened and referred within seven calendar days 24 hours . Capacity to offer Admission within 14 days	Begin within 48 business hours <i>Early Intervention Clinical Services</i>	Michigan Public Health Code Section 6232 Recommended
All Others	Screened and referred within seven calendar days. Capacity to offer Admission within 14 days	Not Required	CFR 96.131(a) – sets the order of priority; ODCP MDCH and CA contract

MISCELLANEOUS

Provider Qualifications

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

Criminal Background Check

Criminal background checks must be conducted as a condition of employment for all network provider potential employees. Refer to the NorthCare Criminal Background Check policy on the NorthCare website (www.northcare-up.org) for complete details on the process that must be followed. **Providers must conduct criminal background checks on all active substance abuse employees periodically after the initial check.** All NorthCare policies referred to in this manual can be found at the NorthCare website – www.northcare-up.org

Cultural Competence

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

1. Identification and assessment of the cultural needs of potential and active clients based on population served.
2. Identification of how access to services is facilitated for persons with diverse cultural backgrounds and Limited English Proficiency (LEP.)
3. Identification standards for the recruitment and hiring of culturally competent staff members.
4. Identification of how ongoing staff training needs in cultural competency will be assessed and met and the evidence that staff members receive training.
5. Process for ensuring that panel providers comply with all applicable requirements concerning the provision of culturally competent services.
6. Process for annually assessing compliance with the cultural competence plan.

Refer to NorthCare Cultural Competence Policy – www.northcare-up.org

LEP – Limited English Proficient

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled language assistance with respect to a particular type or service, benefit, or encounter. The following website may be helpful: www.LanguageLine.com. Refer to the NorthCare website for the entire LEP policy.

All providers must have documentation that a current LEP policy is in place and in practice. The policy must be in compliance with related Federal and State requirements. LEP policies and procedures must include the following, as required by the Office of Civil Rights.

1. Procedures for identifying and assessing the language needs of the CA, individual provider and the geographic area served. Needs must be based on current local and regional census data, as well as other state and regional data.
2. Identified range of oral language assistance options appropriate to the CAs circumstances.
3. How the CA provides notice to LEP persons, in their primary language, or the right to free language assistance.
4. What staff training and program monitoring is performed related to LEP policies and procedures.
5. Provisions for written materials in language other than English where a significant number or percentage of the affected population needs services or information in a language other than English, to communicate effectively.
6. Provisions for language interpreters who are trained and competent.

7. Statements explaining timely assistance.
8. Statements explaining there will be no charge to the LEP recipient for these services.
9. Provisions regarding use of family member and/or friend as a language interpreter must not be required. Should the consumer choose to use family or friend as an interpreter, both the offering of other resources, and the consumer's choice, must be documented in writing. Availability of consumer family and friends as translator/interpreter will not waive other LEP requirements herein described.

Charitable Choice

Treatment clients and prevention service recipients are required to be notified of their right to request alternative services. Notice may be provided by the CDR or by the providers that are faith-based. Notification must be in the form of a model notice contained in the final regulations. The model notice contained in the federal regulations is:

“No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.”

Americans with Disabilities Act

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

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

Compliance

Local functions of regulatory management/compliance are required for organizations that pay out or received at least \$5 million in Medicaid. Activities shall include, but not be limited to:

1. To have an operational regulatory management/compliance program in place that is tightly integrated with Quality Management efforts. This program shall provide the framework to ensure that:
 - ✓ a Compliance Officer is identified,
 - ✓ ethical business practices are implemented and followed,
 - ✓ applicable regulations required by oversight agencies, state and/or federal laws are complied with,
 - ✓ staff and contract providers are educated regarding regulatory management/compliance efforts, ethical expectations, The Deficit Reduction Act, False Claims Act, and Whistleblowers' Act, and their obligation regarding same,

- ✓ written policies include detailed provisions regarding procedures for detecting and/or preventing fraud, abuse and waste within the organization,
- ✓ any employee handbook (or policy if no handbook) includes, specific information regarding Federal and state False Claims Act, the whistleblower provisions and rights,
- ✓ and the organization's policies and procedures for detecting and/or preventing fraud, abuse and waste in the federal healthcare programs.
- ✓ identify and address areas that are at high risk for non-compliance.

2. Organizations that do not meet the above stated threshold amount are strongly encouraged to implement regulatory/compliance management practices of their own.

- [MDCH licensing sanctions for health facilities and professionals are available at http://michigan.gov/bhs](http://michigan.gov/bhs) and <http://michigan.gov/healthlicense>

PRIMARY CARE COORDINATION

All appropriate steps must be taken to assure that substance abuse treatment services are coordinated with primary health care.

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

1. Treatment plan should state Primary Care Physician as a community support when needed.
2. Release should be specific to Primary Care Physician by Name or Agency (however stated in Assessment.) However, there are times when someone doesn't have a specific Primary Care Physician but rather goes to "Doctors Park" for example. Whatever is in the assessment should match what is on the Release of Information.
3. Date Release expires should be on Release itself. Make sure that the date the Release of Information expires is clearly stated on the release. If the release is good one year from the date it is signed, that must be clearly stated "from the date signed" on the expiration line.

YOUTH PROTOCOL

Youth must call to schedule a screening from the CDR if they are requesting intensive substance abuse services funding. If the youth is currently attending substance abuse services at the outpatient level, they will be asked to contact that clinician to call us with collaborating information. The same would be asked if the youth were involved in legal or DHS services.

In the case of youth who are receiving services through their local community mental health agency, the decision to refer the client for a CDR screening must come through the community mental health medical director and clinical director.

NON-SUBSTANCE USE REFERRAL

If a client is found to not need substance abuse services, based on [results of](#) CDR screening, staff will make appropriate referrals based on client need. Examples are as follows: LSS Homeless program, Local DHS, Local Police Departments, Local Emergency Departments.

OUTSIDE SCREENINGS

The CDR will accept qualified screenings from certified District Court Probation Officers, as well as other CDRs as part of determining an appropriate LOC.

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

HYPODERMIC NEEDLES

Funds shall not be used to provide individuals with hypodermic needles or syringes.

INCARCERATED PERSONS

Clients who are incarcerated will be screened **after** they are released from jail/prison. **Clients must be available for all levels of care.** CDR staff will advise the client/PO/attorney, etc. that the client must call back to schedule a screening when release from jail/prison has occurred. Level of care determinations will be made by the CDR staff once the screening has been completed.

INFORMATIONAL FACT SHEETS

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

NOTICE OF PRIVACY PRACTICE

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

MAILING

There is a section on the demographic page where the CDR tracks whether a client agrees to have information mailed to the primary residence or not. This is documented by two boxes "yes" and "no". Providers also have this documentation method available to them. Clients must be asked how they would like to receive information – funding, recipient rights, notice of privacy practices, etc. The CDR will need to be notified via the notes section of the authorization

request if an alternate method has been chosen by the client to receive information other than mailing to their primary residence.

FUNDED SERVICES

Funded services include those that are aimed at achieving permanent changes in an individual's behavior with respect to harmful alcohol or other drug use. It is anticipated that this will include lifestyle, attitude, and behavioral changes that enhance an individual's ability to achieve his or her treatment goals and abstain from non-healthy use of substances.

Descriptions of levels of care and treatment services are paraphrased, based on the ASAM Patient Placement Criteria, Second Edition (Revised). While these have been briefly summarized below, it is the intent that the actual PPC-2R be consulted in cases where greater detail is necessary. With the exception of the initial screening, all levels of treatment require a diagnosis of substance abuse or substance dependence in order to be reimbursable.

Services shall be provided in the amount, scope and duration that are appropriate to reasonably achieve the desired treatment objectives, in the least restrictive environment for the individual client.

The services below are limited to those who will benefit from treatment and have been determined to have:

- An acceptable readiness to change level;
- Minimal or manageable medical conditions;
- Minimal or manageable withdrawal risks;
- Emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care;
- Minimal or manageable relapse potential; and
- A minimally to fully supportive recovery environment

Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following services can be provided in the outpatient setting:

Assessment - ABW, Block Grant, Medicaid & MI CHILD

Assessment is the process of gathering sufficient information to determine whether a client has an alcohol or other drug problem, and if so, what areas of their lives have been affected. A standardized assessment instrument with a biopsychosocial orientation and application of DSM-IV criteria for substance dependence and substance abuse determine a need for intervention. ASAM PPC-2R is used to determine level of care when treatment is warranted.

Screening/Assessments for Co-occurring Disorders

Screening for co-occurring disorders should be completed on all clients being admitted to the NorthCare network. This screening should be part of the routine intake or assessment processes on new clients. A regional mental health form is being used by all contracted Providers – source: J.F.X. Carroll, Ph.D., and John J. McGinley, Ph.D; Project Return Foundation, Inc., 2000

The Co-occurring Screening Should Include

1. A diagnostic interview to determine which, if any, DSM mental disorder diagnoses are met by the client.
2. A treatment history assessing the outcome of previous treatment experiences and barriers to effective treatment.
3. An assessment of the impact of the mental disorders on the substance disorder from a longitudinal perspective.
4. An assessment of the consumer's awareness of the problem and stage of motivation to change.

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

Not all components used in an assessment must be completed by the same agency or the same clinician but all information should have been collected within the past year. Clinicians completing the assessment shall be trained and privileged by their agency to complete a co-occurring assessment. All access sites will have professional staff cross-trained and privileged to complete assessments for co-occurring disorders.

Co-occurring Services – Per Dr. Cools, NorthCare Medical Director:

If a co-occurring client is receiving services at a Community Mental Health Center and meets clinical criteria for Priority Population the best practice of integrated care within the CMH system would be implemented. The CMH would utilize clinical services to meet the needs of the individual as stated in the Person Centered Plan with appropriate amount, scope, and duration.

If after completing an integrated co-occurring assessment and implementing an integrated plan of service, the clinician determines that separate Substance Abuse services are necessary – then the following procedure would be followed:

1. The CMH clinician would share the information with the clinical director and then CMH Medical Director.
2. If all parties agree that separate Substance Abuse services are necessary, the CMH Clinician would contact the NorthCare SA Access Center and forward the clinical documentation. The clinician would assist in arranging a screening with the client and the NorthCare SA Services Access Center.
3. The NorthCare SA screening would determine the level of care and facilitate coordination of care. The consumer may invite the CMH clinician to participate in the screening.
4. If SA services are authorized, the CMH clinician will generate an addendum to the consumer's IPOS. The IPOS will identify the scope, amount and duration of the SA services. The CMH clinician remains the primary clinician.
5. The primary CMH clinician is responsible for completing all necessary releases of information to coordinate the care between the CMH and the SA provider.
6. The CMH Medical Director involved in the case will present the case at the next regional Medical Directors meeting to establish consistency in clinical practice across the region.

If a client at a Community Mental Health Center does not meet Priority Population criteria and is receiving clinical services for mild to moderate mental health issues (this would be a client with ABW or MICHild benefits) and is also in need of substance abuse treatment, then the CMH clinician would coordinate a referral to the NorthCare SA Access Center for a screening. The referral would include the assessment and IPOS. The NorthCare SA Access Center would determine level of care based on a screening and the clinical documents provided by the CMH clinician. Both systems would strive to coordinate care for this consumer.

SPECIALITY PROGRAMS

All clients are screened for specialty programs and if they are applicable, the clients are offered specialty programs based on client's choice. The CDR will refer and coordinate services for clients based on specialty qualifications. Some of the more common specialty programs are: The Salvation Army Harbor Light – Deaf/Hard of Hearing Substance Abuse Program, Closed Head Injury – Personal Therapists, Inc., Project Rehab Hispanic Program, New Hope – Women's Residential – Women and Families Program and Great Lakes Recovery Center – Adolescent Services. Please refer to the NorthCare Policy titled "Service Authorization Policy" found at the NorthCare website: www.northcare-up.org

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

Women's Services

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

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

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

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

This same population must be screened by all Providers for ancillary services (child care and transportation assistance) and pre-screened for **Fetal Alcohol Syndrome**. Ancillary services can be accessed through the CA and children found to be in need of further FAS services need to be referred to: (906)225-4777 for an FAS diagnostic evaluation. (FAS pre-screen form can be found on the NorthCare Network Substance Abuse Services website under "Screening Forms.")

Counselor Requirements serving this population must have at a minimum, documented education or work and volunteer experience with female clients. Minimum standards are 15 semester hours, or the equivalent, in women's specific issues which include 2080 hours of paid or volunteer direct service experience with a human service provider which serve women. The education or experience, or both, must include training in women's specific issues. The CDR will continue to monitor the activities of programs that provide services to women and their dependent children. Sites will be reviewed annually utilizing the State Evaluation format for Women and Families Specialty Services Programs. Questions regarding all five of the federally mandated criteria will be asked and reviewed. **Pregnant women are given preference in admission to treatment facilities.**

Out-of-Network Services

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

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

Using a Sign Language Interpreter

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

By James Tresh, MA, MS CSC, LMHC

Founder, President and CEO of National Deaf Academy, an exclusively Deaf residential facility located on twenty acres in Florida, serving the mental health needs of Deaf and Hard of Hearing children, adolescents and adults. For more information, please call: 353-735-9500 V/TTY or 352-735-9570 TTY

POINTS OF ENTRY FOR FUNDED SERVICES

Welcoming/Customer Service – Training Component on Website:

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

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

General Principles Associated with Welcoming

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

Welcoming – Service Recipient

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

Welcoming – Organization

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

Welcoming – Environmental and Other Considerations

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

APPLICATION PROCESS

Outpatient clients begin the application process of being authorized for funding by contacting the approved outpatient provider of their choice. Clients seeking intensive levels of service should contact the CDR; clients who present at a provider will need to be directed to schedule a screening with the CDR prior to beginning intensive services. If clients are currently in outpatient substance abuse services with a provider in the NorthCare Network and is seeking a higher level of care, they must be referred to the CDR by their current counselor to be considered for that change in service. Non-urgent Medicaid consumers must receive a screening/assessment within 5 days of contacting the CDR/Treatment provider and must enter treatment within 7 days of the screening/assessment. Urgent consumers must receive a screening/assessment within 24 hours of contacting CDR/Treatment provider and must enter treatment within 24 hours of screening/assessment. A pre-screening must be conducted when a client calls for an appointment. The following information should be collected at that time:

- **Admission Priority – Pregnant/Injecting Drug User, Pregnant Substance Abuser, Injecting Drug User, Parent at Risk of Losing Children and All Others**
- **Potential Funding Source – This should be verified and documented using the CareNet 271 system or Provider contracted source**
- **Other Insurance or benefit that may cover Substance Abuse treatment (Coordination of Benefits)**
- **Annual household income**
- **Current Community Mental Health client**
- **Type of service requesting**
- **Treatment History**
- **Name, Phone number, Social Security #, DOB**
- **County of Residence**

Screening Form NorthCare Substance Abuse CDR

12/29/2004 09:26 AM

Client First Name:	John	Client Last Name:	Doe
SSN:	111-11-1111	Date of Birth:	05/26/1965
Phone:	222-2222	42CFR2 Administered?:	Yes
County of Residency:	Marquette	How Long?:	6 years
Household Income:	\$5,000	Sliding Fee Eligible?:	Yes
Medicaid Eligible:	No	Medicaid #:	
Other Insurance:	No	Medicare Eligible:	No
Pregnant-Urgent:	No	IDU-Last 30 Days-Urgent:	No
Seeking Intensive Tx:	Yes	Prior Treatment:	Yes
Lite ASI:	Yes	CDR Assessment:	Yes
Appointment Type:	1. Adult	Appointment Status:	5. Scheduled
Funding Source/Insurance:	1. Block Grant		
Community MH Client?	Yes/No		
If so, where?			
Is client in danger of losing children because of use	Yes/No		
Level and Options Given After Screening:	Yes	Level Recommended:	2.1
Did Client Attend Tx?:	Yes	Initials:	KL
Agency:	Test TA	Date Admitted:	01/05/2005
Was Admission Timely:	No	Provider:	Test TC
Comments:			
Created by:	Kathryn Lyman/ADMIN/AMCMHC	Reservation Link:	
		Appointment Date:	01/03/2005
Appointment with:	Carol Easton/Assessment/Marquette CDR	Time:	10:30:00 AM
Days from Screening to Assessment:	6	Days from Assessment to Admission:	2

As noted earlier in this point of entry section, clients seeking traditional outpatient services schedule an appointment directly with the outpatient provider of their choice. A substance abuse clinician from the provider agency conducts a comprehensive assessment which includes biopsychosocial elements, diagnostic impression, and application of the ASAM PPC-2R criteria. [Substance abuse treatment must be based on medical necessity.](#) Demographic data, financial information, and an Initial Authorization Request is entered into the appropriate online forms and electronically transmitted to the CDR.

Clients seeking intensive services must complete a **screening** with a CDR assessor. Whenever [other](#) providers offer the level of care for which the client qualifies, the client **is must be given a choice of provider.** [This choice must be documented on a "choice of provider" form](#)

and kept in the client's file. The client must sign-off that they received the "choice of provider" form – this is required for all levels of care. Once the CDR obtains an appropriate release of information; the screening is "released" within the CareNet system so the SA provider listed can access that information.

Providers

In all cases, the provider is responsible for entering demographic, financial, insurance and admission data into the CARE NET MIS, along with an authorization request that provides information such as presenting problem, applicable DSM-IV diagnoses, ASAM admission level, treatment plan, additional comments when relevant, and a request for a specific number of treatment units.

Providers are encouraged to enter this information into the CARENET system as soon as possible and **ONLY** from the provider site. The following rules apply:

- ✓ Initial authorization requests must be submitted and **approved** within 14 days of the client's admission or the entire request may be denied. If you miss submitting within the 14 day window, you can still file a request; however, you can only backdate 14 days. For example, John Doe presents for OP treatment at the provider agency. The provider submits an initial authorization request to the CDR on June 21st. If the authorization is requested to begin on June 8th, it may be authorized (**if the request is properly completed.**) If the authorization is requested to begin on June 1st, the entire request will be denied. Remember, requests can be backdated a maximum of 14 days.
- ✓ *Problems (pended authorization requests) that are not resolved within 14 days from the date of **admission** will result in a denial. Following a denial, you are eligible to resubmit an authorization request. Remember though, that filing a whole new request means typing in all the information over again and adhering to the above 14 day administrative rule. In other words, read **all** the comments the CDR reviewer is making and address **all the errors at once** - not one at a time.
- ✓ Outpatient Reauthorization requests must be filed 14 days prior to the begin date. Residential Reauthorization requests must be filed 48 business hours prior to the begin date. If this procedure is not followed, there is the possibility that the begin date will be adjusted to the date CDR staff are able to review and approve the request. Motivation for treatment will be reviewed at this time.
- ✓ **Discharge planning, including housing and mental health issues must be addressed at admission**, and included in the treatment plan and progress noted in the progress notes.
- ✓ Utilization Management staff will review cases for clients who repeatedly are accessing treatment without showing significant improvement.

For clients receiving sub-acute residential programming and social detox, the discharge screen in the CARENET system **must document referral to Substance Abuse treatment in the comment section**. In order to be considered for approval of subsequent detox services, a client must followed through a with planned sequence of addiction treatment following previous sub-acute detoxification services.

Health Information Release Authorization

Providers need to make sure each section on the Health Information Release Authorization form is completed properly. Failure to do so will result in **delayed approval** of authorization requests.

- A. Client's name, address, birthday, telephone number and social security number.
 1. Client's name must be **printed clearly**.
 2. The receiver of information – name, address, telephone number and fax number needs to be **printed clearly**.
 3. Dates of Service need to be specified in this section. For example, dates could be from 7/3/03 – 10/3/03 or 7/3/03 to unknown. The HIPAA attorney hired by MASACA made this a marked issue – her opinion was, based on her interpretation of the HIPAA requirements, that the client needs to have control over what time period information would be released.
 4. Purpose and need for disclosure needs to be checked.
 5. Expiration of Authorization must have an event, condition or date specified. An example would be: upon discharge, 12/31/03, one year past discharge.
 6. Signature and date must be completed in this section by the client regardless of age. Documentation of guardianship (**legal paperwork – court order**) must be on file at provider agency if a guardian signs for the SA client.
 7. Discharge of an admission for a client results in completing all new required paperwork in order for that client to be considered for a future authorization request. (We consider that a discharge negates an otherwise current release of information).

The release must be faxed to the CDR prior to authorization consideration. **If any section is not completed properly, the authorization will be sent back for the client to complete and may result in a delay of receiving an approved authorization request.**
Copy of form:

NORTHCARE NETWORK SUBSTANCE ABUSE SERVICES
200 W. Spring Street, Marquette, MI 49855
Phone: (906) 225-7222 Toll-Free: (800) 305-6564 Fax: (906) 225-7224

HEALTH INFORMATION RELEASE AUTHORIZATION

 (PRINT NAME) (ADDRESS)

 (BIRTHDATE) (TELEPHONE NUMBER) (SOCIAL SECURITY No)

1. _____ authorize **NorthCare Network Substance Abuse Services** to use and disclose information contained in the substance abuse records of the client identified above in accordance with Federal Regulations (45 CFR Part 164, 42 CFR Part 2 and Public Act 258). The information may be released to the following:

2. **Receiver of Information – Name, address, phone/fax number**

3. **Specific type of information to be disclosed – Include dates of service:**
 Funding Eligibility _____ Recommendations _____
 Demographic information _____ Substance Abuse Treatment History _____
 Screening _____ **Dates of Participation** _____ to _____

4. **Purpose and need for such disclosure: (Please Check all the appropriate).**
- To facilitate the assessment process and the provision of appropriate treatment services.
 - To provide information necessary for authorizing reimbursement under the Pathways Block Grant
 - Funding Assistance, Medicaid, State Disability Assistance (SDA), MI-Child and/or other appropriate sources of public funding.
 - To monitor client treatment progress and provide assistance in discharge planning.
 - To verify service delivery.
 - To provide information necessary for the CDR to conduct follow-up.
 - Determination of benefits.
 - Upon request of client.

5. I understand that I have a right to revoke this authorization at any time except as noted below. I understand that the revocation will not apply to information that has already been released in response to this authorization or where North Care Network Substance Abuse Services has acted in reliance upon this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked**, this authorization will expire upon the occurrence of the **following event, condition or date:** _____

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization; however, by refusing to authorize disclosure I may be unable to obtain treatment or may not be eligible for benefits under Pathway's block grant, Medicaid, SDA, MI-Child or other funding source. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal and state confidentiality rules.

 Signature of Client Date

 Signature of Personal Representative Date

Certification of Eligibility

This form must be completed for all clients to be put through the NorthCare Network Substance Abuse Services. For **Intensive services** the form must be faxed to the CDR along with the Release prior to an authorization request being considered. Outpatient services must have the form completed by the client and kept in the client chart. Below is a copy of the form:

NorthCare Network Substance Abuse Services
200 W. Spring Street, Marquette, MI 49855
Phone: (906) 225-7222 Toll-Free: (800) 305-6564 Fax: (906) 225-7224

Certification of Eligibility/Notification of Rights

GENERAL STATEMENT OF ELIGIBILITY

I understand that residency and income eligibility requirements must be met in order to receive funding assistance for treatment. Proof of income and residency must be provided to the treatment provider or CDR. A valid Medicaid card is documentation of residency and income.

CERTIFICATION OF RESIDENCY

My permanent county of residency is: _____ (SPECIFY)

I have been a resident of the above county for _____ years or _____ months.

CERTIFICATION OF INCOME (check applicable option(s) below)

My total household income for the past 12 months is \$ _____ with a family size of _____, which means I am eligible for funding. Generally, financial eligibility is determined by income over a 12-month period of time. Yearly income can be based on the following alternative method for a valid reason such as recent unemployment.

The formula is: Last 3 months of income X 4 (quarters in a year) = \$(Projected 12 month income).

I have a valid Medicaid card. My recipient ID # is: _____.

I have Adult Benefit Waiver. My recipient ID # is: _____.

I meet eligibility criteria for State Disability Assistance through FIA. My case number : _____.

I am enrolled in the MI-Child program.

NOTIFICATION OF RECIPIENT RIGHTS; CONFIDENTIALITY; HIV/AIDS, TB & Hepatitis C INFORMATION

I affirm that I have received the "Client Notice of Confidentiality" and the brochure entitled "Know Your Rights," along with pamphlets concerning HIV/AIDS, TB and Hepatitis C. This information has been explained to me, and I was given an opportunity to ask questions about this information. I understand that additional information about my rights are available from the Program Rights Advisor.

NOTIFICATION OF MEDICAID GRIEVANCE PROCEDURE (Medicaid recipients only)

I acknowledge having been provided with notification of my right to file a request for an administrative hearing if a benefit is denied, terminated, suspended, or reduced.

Client Signature: _____

CLIENT CERTIFICATION

I have read this agreement or have had this agreement read to me by treatment program/CDR staff. By signing, I certify that all information reported on this application is correct. If changes occur while I am receiving services under this project, I will report them immediately. If information in this application is found to be untrue or if proof of income and residency are not provided, benefits may be forfeited. I understand that only direct substance abuse services are covered and **that I am responsible for paying any services that are not covered under this program.**

Client Signature

Date

Client Name Clearly Printed

Social Security Number

Staff Certification- I have attempted to obtain proof of residency and income for this client and have documented my efforts in his/her chart.

Staff Signature

Date

Treatment Program

USING THE CARENET SYSTEM

System Authentication/Data Encryption

Since no public access web systems are hosted in our data center, all CareNet systems require user authentication. Base credentials are a username and password. All user passwords must be changed every 90 days and are required to be at least 6 characters. All data transmitted over the internet is SSL encrypted. All system login logs are maintained for two years. In order to access the CareNet system, usernames and passwords must be assigned. Contact NorthCare Network Substance Abuse Services to have usernames and passwords established. Employees must not share their usernames or passwords. Off-site accessing of the CareNet system is **prohibited**. You may only access the CareNet system from the approved, licensed Provider site – this practice allows the system to be HIPAA and 42 C.F. R. Part 2 compliant. Notify NorthCare Network Substance Abuse Services to have a username disabled when an employee leaves your Agency. This should be done as soon as possible so that continued access is not possible.

Data Entry

The CARENET website is mouse driven, with clickable colored links that allow movement between forms. A menu appears on the left-hand side of the screen. *It is important to use the provided links to move within the system, rather than the back button on your browser, as the latter can cause errors.*

Another tip for successfully using the system is to be sure you will be able to enter all the information for a particular form within the limited time frame. Because it is an Internet-based, “real time” system, it is not possible to save a partially completed form and finish it later. If you stop multiple times while entering information - you may have the unpleasant experience of getting “timed out.” For those who have not experienced this, all the information entered disappears and must all be retyped. So, we suggest you choose a time to enter data when you will be able to complete the entire form with a minimum of interruptions.

The State requires that clients must be discharged if no service/activity has occurred for 45 days.

Discharges must be kept up-to-date. Clients who complete services should be discharged promptly from the system upon discharge from the program. Providers may be asked to discharge clients sooner by the CDR. There may be time and/or units left on an authorization. In these instances, the provider has a maximum of two business days to comply. The CDR reserves the right to discharge clients.

State regulations do not allow clients to be open in more than one service category at a time. If a client in outpatient treatment needs to enter detox, for example, the outpatient provider must discharge the client before the detox provider can admit him/her. Although the client may be returning to the outpatient program following a two-day detox stay, a courtesy discharge, followed by a new admission, is required.

AUTHORIZATION PROCESS

In order to submit an authorization request, it is necessary to complete several electronic forms. These are listed along the left-hand frame of your screen and include Demographics, Financial, Insurance, and Admission options. **A Notes section has been added for your convenience – it is not a required screen.**

While obtaining a copy of a client's Medicaid card is good practice, **monthly** documentation in the client file must reflect that funding eligibility was checked using the 271 system within CareNet, Medifax, Netwerkes, or Web Denis. If the 271 system is used, it would not be necessary to keep hard copies in the client file. Information needed to obtain the access number and codes for each provider is available through Medicaid licensing. Since other forms of documentation are options, late submissions (beyond the 14-day window – the first day counted is the day the authorization is to begin) cannot be accepted due to inability to get a copy of a client's Medicaid card.

The next step is to fill out the authorization request itself. It represents a snapshot of the client, so it is important to fully complete the form including ~~the~~ **an individualized** treatment plan. There are spaces for basic identification about the client, as well as recording the name of the clinician responsible for supplying the data. The main components include presenting problem, multi-axial DSM-IV diagnosis, a 30-day history of alcohol and drug use, a treatment plan and the ASAM level the client meets based on evaluation of the client's functioning on six dimensions, and a grid to request units of treatment. The CDR will approve units of service based on medical necessity, ASAM, DSM-IV and treatment plan.

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

A current release must be on file with the CDR prior to submitting an authorization request. A current release is one that covers the current authorization period being requested. An authorization becomes invalid once it is connected with an admission that has been or should be discharged.

Authorization Requirements – Outpatient:

- A service meets medical necessity criteria
- The current edition of the Diagnostic and Statistic Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression. The diagnostic impression must include all five axes.
- The service is based on individualized termination of need.
- The service is cost effective
- The American Society of Addiction Medicine (ASAM) Patient Placement Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs.
- The service is based on a level of care determination using the six assessment dimensions of the current ASAM Patient Placement Criteria:

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

Authorization Requirements – Residential:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment.
- Admissions to Residential Treatment must be based on:
 - ✓ Medical necessity criteria
 - ✓ Level of Care determination based on an evaluation of the six assessment dimensions of the current ASAM Patient Placement Criteria
- Reauthorizations may be approved when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the client from benefiting from less intensive treatment.

Providers

Providers may appeal an adverse determination that concerns utilization and/or quality management issues. These may include medical necessity determination, level of care authorized, number of units approved, etc.

- The provider who disagrees with a CDR decision **must** first discuss the situation with the CDR staff person who made the adverse determination. The discussion between provider and staff person must occur within five business days of the disputed action.

While prior authorization is not required for detox clients, an authorization request via the CARE NET system must be filed and approved within 14 days of a client's admission.

Never use the “back” button when entering information into the CareNet system – particularly when doing authorization requests. Multiple requests and other data errors occur. Also, please click the “submit” button only ONCE. Repeatedly clicking that button will also result in multiple submissions.

Access

Provider agrees to fully cooperate with NorthCare by: (a) securing prior payment authorization for all treatment rendered with the exception of situations as described in the NorthCare Network Substance Abuse Provider Manual (b) accepting screenings, concurrent reviews and retrospective review findings by the CDR to determine Medical Necessity for payment of benefits subject to the applicable appeal procedures as described in the NorthCare Network Substance Abuse Provider Manual and (c) following the procedures outlined for the filing of an appeal or grievance related to the determination of Medical Necessity for payment of benefits as described in the NorthCare Network Substance Abuse Provider Manual. Provider acknowledges that the failure to follow these terms of NorthCare policies and procedures may result in a reduction in the amount of payments to Provider.

Viewing Reports

At the present time, providers are able to click on “Reporting” on the main menu. From there – Reporting Options are: Adolescent Admissions Report; Billed Treatment Report; Daily Admission; Discharge; SARF; Financial Report; Most Expensive Client; Open Client Summary; Re-Authorization Due Report; Unanswered Notes; and Unbilled Treatment Report.

CARE NET Related Questions/Issues

~~Although both treatment and prevention data are recorded using CareNet, these are two distinctly different systems.~~ Authorization questions should be directed to CDR staff. Billing is most appropriately dealt with by contacting the CA’s accountant.

NorthCare Customer Services Complaint/Grievance Tracking Form Instructions for Substance Abuse

When completing the form with a consumer over the phone, explain to the consumer that you are completing a form and if there is a pause – you are simply writing in the information they are giving you.

Name of Caller: Simply who you are receiving the complaint/grievance from.

Phone #: Again, the phone number of the person you are talking to (or receiving the complaint/grievance from).

Relationship/Organization: Provide the relationship to the consumer that this complaint/grievance is regarding. It may be a family member or it could be a staff member from an agency.

Consumer: Name of the consumer the complaint/grievance is regarding.

Consumer Phone #: This number is collected in case the consumer needs to be called.

Date of Birth (DOB): Please provide the DOB for the consumer this complaint is regarding. If the DOB is not available, use today’s date.

Medicaid: Indicate if the consumer is Medicaid or not. If the consumer has Medicaid, this form must be completed and sent to Sally Olson, Member Services at NorthCare. If the consumer does not have Medicaid, please track in your own QI/Customer Service system – submit to Jan Grim at Pathways/NorthCare CDR.

Medicaid #: The Medicaid number is needed for tracking. This is to ensure “unduplicated” numbers.

Board: Name of the Community Mental Health Agency or Substance Abuse Agency receiving the complaint.

Site/Program: Name and site of the program that the complaint/grievance is pertinent to. (Many of the CMHSPs and SA agencies have numerous sites in different counties.)

County: Indicate which county the complaint/grievance is about.

Population: Please check the correct box.

Received Information Via: How was the complaint received? Over the phone, through email, or face-to-face.

Staff Receiving Complaint: The person receiving the complaint & filling out the form.

Date of Complaint Received: Date complaint received. If a Medicaid recipient, fax (225-5149) to Sally Olson at NorthCare Network within 24 hours of receiving. This is important due to timeliness guidelines requiring the complaint/grievance be resolved within 60 days.

Time: What time was the complaint/grievance received.

Reference #: Only use if the consumer does not have Medicaid. It is recommended that you use the following to create a reference number: Year (05), Month (9), day (29), two digit code for program (SA) (Note: All substance abuse providers should use SA.) and consumer initials (SO). 05929SASO

Nature of the Inquiry/Complaint: Please choose one. The definitions are included on the form.

Specific Concern: Write in what the issue is. Be as specific as possible.

Date Issue Occurred: This may be different than the date you receive the complaint. For example: A concern brought up about the crisis line. The date and time of the call you allow an individual to pull up the actual notes from that call.)

Time: Time the issue/concern occurred.

Address of Consumer or Guardian: This must be completed if it is a Medicaid consumer.

The BBA mandates that a written letter is sent with the resolution of the complaint/grievance to the Medicaid consumer.

NorthCare Customer Services Complaints/Grievance Tracking Form for SA

Name of Caller _____ Phone #: _____
Relationship/Organization _____
Consumer _____
Consumer Phone # _____
DOB: _____ Medicaid ____ Yes ____ No
Medicaid #: _____
Board: _____ Site/Program: _____
County: _____
Source/Complainant: Consumer Family/Guardian Provider
 Community Member Other Staff

Population: SMI SED DDA DDC SA Other
Received Information Via: Phone, Face-to-Face, Written, Other
Staff Receiving Complaint: _____
Date of Complaint Received: _____ Time _____ am/pm
Reference # _____ Year/month/day/NP/consumer initials) Reference # **ONLY**
needed if **NOT** a Medicaid Recipient

NATURE OF THE INQUIRY/COMPLAINT:

- Access Issue:** Anything that prevents access. Ex: parking, timeliness of appointment, transportation, barriers to the building, stigma, concerns about quality of care, not knowing who to call, etc.
- Financial Issue:** Billing concerns, budget issues, determination of ability to pay, insurance concerns and more.
- Respect Issue:** Anything that is not a rights issue that concerns equality, fairness, and being courteous
- Treatment Issue:** Any non-rights issue that someone has about their treatment. Ex: lack of a male or female therapist.
- Suggestion Issue:** Solution oriented comments or positive suggestions.

Specific Concern: (Use back of form if needed.) _____

Date Issue Occurred: _____
Time: _____ a.m./p.m.
Address of Consumer or Guardian: (MUST FILL IN IF MEDICAID)

RESOLUTION PROCESS

IF MEDICAID recipient, fax (906) 225-5149 to Sally Olson within 24 hours of receiving complaint. If not, fax (906)225-7224 to Jan Grim within 24 hours of receiving complaint.

IF Referred to Recipient Rights (Tracking will be the responsibility of the Recipient Rights Department)

Date Forwarded _____ Forwarded By _____

IF Non-Medicaid Recipient: Substance Abuse Agency Internal Resolution Process:

Parties involved in resolution:

Name	Title
_____	_____

Date of FINAL resolution: _____

Date of disposition mailed _____

Summary of Resolution: _____

INDIVIDUAL - CERTIFICATION REQUIREMENTS

Definitions

Substance Abuse Treatment Specialist:

An individual who has licensure in one of the following areas, and is working within their scope of practice:

- Physician (MD/DO)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Licensed Psychologist (LP)
- Limited Licensed Psychologist (LLP)
- Temporary Limited Licensed Psychologist (TLLP)
- Licensed Professional Counselor (LPC)
- Limited Licensed Professional Counselor (LLPC)
- Licensed Marriage and Family Therapist (LMFT)
- Limited Licensed Marriage and Family Therapist (LLMFT)
- Licensed Master's Social Worker (LMSW)
- Limited Licensed Master's Social Worker (LLMSW)
- Licensed Bachelor's Social Worker (LBSW)
- Limited Licensed Bachelor's Social Worker (LLBSW)

AND who has a registered development plan leading to certification and is timely in its implementation; or who is functioning under a time-limited exception plan approved by the substance abuse coordinating agency; **OR**

An individual who has one of the following Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC&RC) credentials:

- Certified Addictions Counselor – Michigan (CAC-M)
- Certified Addictions Counselor – IC & RC – Reciprocal (CAC-R)
- Certified Addictions Counselor – IC&RC (CAAC)
- Certified Criminal Justice Professional – IC&RC (CCJP-R)
- Certified Co-Occurring Disorders Professional – IC&RC(CCDP) – Bachelors level only
- Certified Co-Occurring Disorders Professional Diplomat – IC&RC (CCDP-D) – Masters level only; **OR**

An individual who has one of the following approved alternative certifications:

- For medical doctors: American Society of Addiction Medicine (ASAM)
- For psychologists: American Psychological Association (APA)
- Certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD)

A physician (MD,DO), physician assistant, nurse practitioner, registered nurse or licensed practical nurse who provides substance use disorder treatment services within the scope of their practice is considered to be specifically-focused treatment staff and is not required to obtain MCBAP credentials. If one of these professionals provides substance use disorder treatment services outside their scope of practice, the MCBAP applies.

Substance Abuse Treatment Practitioner

An individual who has a registered MCBAP certification development plan, is timely in its implementation, and is supervised by a Certified Clinical Supervisor – Michigan (CCS-M) or Certified Clinical Supervisor – IC & RC – Reciprocal (CCS-R); or who has a registered development plan to obtain the supervisory credential while completing the requirements .

Treatment Supervisor

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS-R)

OR an individual who has an approved Alternative Certification:

- For medical doctors: [American Society of Addiction Medicine \(ASAM\)](#)
- For psychologists: [American Psychological Association \(APA\)](#)

OR an individual who has a registered development plan, for the supervisory credential and is timely in its implementation leading to certification.

NorthCare Network Credentialing Policy - Overview

Initial Credentialing

Policies and procedures for the initial credentialing of individual practitioners must require:

1. A written application that is completed, signed and dated by the provider and attests to the following elements:
 - a) Lack of present illegal drug use.
 - b) Any history of loss of license and/or felony convictions
 - c) Attestation by the applicant of the correctness and completeness of the application.
2. An evaluation of the practitioner's work history for the prior five years.
3. Verification from primary sources of:
 - a) Licensure of certification
 - b) Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
 - c) Documentation of graduation from an accredited school.
 - d) National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
 - i. Minimum of five-year history of professional liability claims resulting in a judgment or settlement

- ii. Disciplinary status with regulatory board or agency; and
 - iii. Medicare/Medicaid sanctions.
- e) If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association may be used to satisfy the primary source of requirements of (a), (b), and (c) above.

Re-credentialing Individual Practitioners

Re-credentialing policies must identify procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two years.
2. An update of information obtained during the initial credentialing
3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
 - a) Medicare/Medicaid sanctions
 - b) State sanctions or limitations on licensure, registration or certification.
 - c) Member/client concerns which include grievances (complaints) and appeals information.
 - d) Organizational Provider Quality issues.

Refer to NorthCare Network Credentialing Policy on NorthCare website.

Credential Files

All treatment providers are required to maintain a credential file on all clinical staff that is providing clinical services which include the following:

- **The Provider shall assure that all individuals, whether employed or contracted by the Provider to provide clinical or medical services, will be properly credentialed.**
 - ✓ **Credentials shall be verified, by primary source, prior to employment.**
 - ✓ **Academic history with proof of completion; internship, practicum and clinical experience that is supervised, with area of clinical practice, age group and/or special skills learned and experience in the form of resume.**
 - ✓ **Verification shall occur at time of renewal and, at minimum, every two years (re-credentialing process).**
 - ✓ **Copies of all licenses, registrations, and/or certifications shall be kept in the employees' or contractors' files.**
 - ✓ **Prior to employment, the Provider shall verify that the individual is not included in any excluded or sanctioned provider lists that apply. This verification process shall also occur at the time of re-credentialing or contract renewal.**
 - ✓ **Conduct criminal background checks.**
 - ✓ **Current list of "in-service" training completed, including other professional training experiences pertinent to clinical practice.**
- **All clinicians and physicians, whether employed or contracted by the Provider, will be privileged for each specific function to be performed.**

- ✓ **Clinical privileging is to be done, minimally, at time of hire or contract and when duties/responsibilities change in terms of primary eligibility group a person is working with and/or scope of work.**

Re-Credentialing Procedure

- Re-credentialing will be completed every two years
- Questionnaire will be sent to Supervisors requesting individual provider update of information obtained during the initial credentialing and progress on development plans
- Review of Medicare/Medicaid sanctions will be completed
- Review of State sanctions or limitations on licensure, registration of certification will be completed
- By contract, providers must continue report any grievances and appeals to CA
- Clinical quality will be reviewed via CareNet treatment plan review and annual site visit review

Credentialing Updates

Programs are required to notify the CDR of any updates/changes to any existing clinician's credentials as soon as the information is available to the clinician and/or program. All newly hired clinicians' credentialing information, along with hire date, must be submitted to the CDR as soon as possible in order to enter them into the MIS. Termination dates of all clinicians and CareNet users must be submitted immediately to the CDR so that they can be removed from the MIS.

License Exclusion Check

The following website can be used to check any exclusions for licensed providers. The CDR will check all contracted providers and clinicians through this website **every two years**:

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

PROVIDER BILLING

General Information

Treatment providers will bill for services via the CareNet system. In order to accomplish billing, all services must be prior authorized.

Treatment services should be billed to NorthCare Network Substance Abuse Services on a monthly basis. Providers are encouraged to bill for services the 10th of the month following the month treatment was provided. **All services must be billed within 60 days of treatment.**

Exceptions to the 60-day billing requirement must be approved by the Substance Abuse Division Finance Manager. Contact [Judi Brugman](#) the Finance Manager if unable to bill for services within 60 days of treatment. An exception will be automatic for those clients with 3rd party insurance. This will allow the treatment provider the opportunity bill the 3rd party insurance prior to billing Pathways. Once 3rd party payment has been received, the amount paid can be included when the treatment is entered into the CareNet system.

Providers can expect reimbursement from NorthCare Network Substance Abuse Services within 45 days for claims received by the 10th of each month. Bills processed can be viewed and printed at the provider level. A remittance summary is also created for each bill processed. Payments from NorthCare Network Substance Abuse Services will reference the bill date(s). Sample billing pages can be found in the provider manual on the CareNet site.

Entering Treatment

Treatment is entered into the CareNet system by individual client record. (Sample pages of data screens are included in provider manual.) Be sure the [payor insurance](#) and finance screens are up-to-date. From the main menu, select [Lookup/Edit Client](#). Select Client by entering Name or Client ID. Once client has been selected, from options on left-hand side of screen, click on [Treatment](#). The next screen will be the Client Treatment History for that client. Click on the "Add New Treatment Service(s)" box. The Add Treatment Setup Screen will appear. The appropriate CPT code (Treatment type) and the # of Units must be entered. Then enter the date(s) of service. There are three options for dates of service. Select from an individual date, a range of dates, or multiple dates. For the range of dates and multiple date options; if an authorization/reauthorization period ends during the range of service being billed for, you will need to enter separate sets of dates for each period. After the correct information has been entered, click on the "Set Treatment Date" box. (Note: A history of authorized units of service exists for each client at the bottom of the Add Treatment Setup screen. This can be a very helpful tool.) The next screen will be Add Treatment-Details. This screen will list treatment details. Also, if there is a 3rd party payment received the amount should be entered as a 3rd party payment on this screen. If there is a co-pay involved, it will be calculated based on the sliding fee scale and listed on this screen. If the information is correct, click "Add Treatment(s)". Any services entered will appear on the client history as unbilled.

Billing

Once individual treatment has been entered for all clients, billing can be accomplished. From the main menu, select [Billing](#). From the Treatment billing screen, select the appropriate fiscal year to bill for, as well as the funding source. Click the "Generate New Bill" box. A Generate Bill – Summary screen will appear with any unbilled services listed. If all information is correct, click the "View Bill Summary" box. This will generate a bill to NorthCare Network Substance Abuse Services. If any information is incorrect, or for any reason, you do not wish to generate the bill at this time, click the "Cancel/Delete Bill" box. Selecting "Save But Not Submit" will save the bill details for submission at a later date. The bill cannot be altered at this point. Generally, if you are not ready to submit a bill, you will want to select the "Cancel/Delete Bill" option. This does not delete the services, only the group of services at that time. The individual client services will remain in the system as unbilled.

You may choose not to bill for a client. On the Treatment – billing screen select the appropriate client ID> At the Treatment Billing – View Clients, click off the check () box for the services you are not ready to bill for.

Bills received by the 10th of the month will be adjudicated by NorthCare Network Substance Abuse Services staff for payment within 45 days. Once the bill has been adjudicated, the program can view both a billing summary and a remittance advice as well as look at individual client history for payment details. The billing summary will reflect what was billed, what is pending, paid, denied, or if an adjustment has been made. The billing summary will also provide a breakdown of funding source, and the CPT code. The remittance advice will list each service by client and date. I will include the agency client number if one was entered by the program. If an adjustment has been made, a notes option will appear for that client on the View Bill – Client Details screen. For the details of the adjustment, click on the word *View*.

It is important to have the correct information when billing. Providers are able to edit services prior to billing. Once treatment has been billed, corrections can only be made by the Finance Manager thru editing future bills. Contact the Finance Manager for assistance with corrections. Other billing questions should also be directed to the Finance Manager.

Coordination of Benefits

NorthCare Network Substance Abuse Services Benefits Coordination Example

Coordination of benefits will vary depending on other contractual relationships providers maintain with other payors. The example is based on the assumption that the NorthCare Network Substance Abuse Services rate is the lowest rate accepted by the provider.

- Annual Income = \$25,000
- Family Size = 3
- Other insurance coverage = 50% of allowable charge
- Provider charge = \$93.00
- Allowable charge = \$90.00
- Other insurance payment = \$45.00
- NorthCare Network SA Services rate = \$74.00

Provider bills NorthCare Network Substance Abuse Services:

\$74.00 Pathways/NorthCare rate

\$45.00 Amount paid by primary insurance

\$29.00 Amount paid by NorthCare Network SA Services

Contact Judi Brugman at (906) 225-7286 for information regarding situations differing from the example.

Outpatient Providers

Outpatient providers are encouraged to enter treatment services on a weekly basis. Services should be billed at least monthly. Remember to contact the **Finance Manager** if unable to bill services within 60 days of treatment.

To avoid billing problems:

- Be sure all treatment has been prior authorized
- Verify the client has an open admission for date of service being billed.
- Verify that the **payor insurance** page is accurate. This includes listing 3rd party insurance as a funding source.
- The financial page must also be kept current. Any change in income must be entered on this screen.
- Multiple units of service provided on the same date may be entered at one time by entering the number of units on the Add Treatment Setup Screen. It is not possible to enter additional units of service type for a specific date after any amount of that service has been entered. (Example, if a client had two separate group sessions with different counselors on the same day, they have to be entered at one time – not as two separate entries.)

Residential Providers

- Residential providers are required to enter treatment for all clients at least monthly. Treatment may be entered more frequently, but bill only once per month. Be sure to list SDA as secondary funding on the **payor insurance** screen if the client is eligible for SDA. Remember to include the amount of food stamps received for clients as a 3rd party payment when billing. Select food stamps as a 3rd party payment option on the **payor insurance** screen before entering treatment details. The dates of eligibility for primary, secondary, or tertiary, **payors funding** must correspond with the dates of service being billed for.
- Contact NorthCare Network Substance Abuse Services Division Finance Manager with billing questions or problems.

Billing Corrections

If a provider discovers that an error has been made after a bill has been adjudicated by NorthCare Network Substance Abuse Services, the correction can be made on a future bill. The following information should be faxed to Judi Brugman at the Coordinating Agency fax (906)225-5149.

1. Provider name and treatment location
2. Client ID
3. Funding source
4. Date of service
5. Description of what needs to be corrected

Corrections to funding or treatment type can be accomplished. Changes in dates require that the original date be denied. The correct date can then be billed by the provider. Call Judi with questions at (906) 225-7286.

State Required Reporting and Data

See separate Reporting and Data Provider Manual under “Provider Manual” on Substance Abuse website: www.northcare-up.org/subA

MEDICAID ADMINISTRATIVE HEARING PROCESS See Attachment A

RECIPIENT RIGHTS

Substance Abuse recipient rights complaints are handled at the provider level by the recipient rights officer at that agency. Substance Abuse Recipient Rights data is reported to Mary Swift (mswift@up-pathways.org) quarterly.

CONFIDENTIALITY/CONSENT

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

- Providers are encouraged to use the Health Information Release Authorization form supplied by NorthCare Network SA Services, or their own, as long as it meets Federal guidelines AND specifically refers to NorthCare Network Substance Abuse Services. Because the mental health side of Pathways follows mental health confidentiality regulations rather than the stricter substance abuse regulations, information cannot **automatically** be shared between these two divisions within Pathways.
- *RELEASES* are good for the time period noted on the Health Information Release Authorization form – with some exceptions. Exceptions permitting limited disclosures without written consent are as follows:
 1. Internal Communications
 2. Anonymous Disclosures
 3. Qualified Service Organization Agreements (QSOAs)
 4. Medical Emergency
 5. Research
 6. Audit & Evaluation
 7. Authorizing Court Order
 8. Patient Threat/Crime on program premises or against program personnel
 9. Reporting Suspected Child Abuse and Neglect
- There is no age limit for consent. Children and adolescents receiving treatment services must sign any release they choose to give; parental signatures are **NOT** acceptable.

QUALITY MANAGEMENT

Quality Improvement

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

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

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

Utilization Management

Utilization management is a set of functions and activities focused on ensuring that clients receive services with the appropriate frequency and duration which are delivered according to practice guidelines for obtaining the best possible outcomes. Refer to NorthCare website: www.northcare-up.org for the complete Utilization Management policy.

Site Visits

Annual site reviews will be conducted with each provider in the overall quality management plan. The Site Visit Protocol areas of review will include but not be limited to: organizational and contractual issues; financial management; client chart review; data collection; performance indicator timeliness, recording, reporting; licensing and accreditation; staff credentials and professional training; and recipient rights. All requirements along with the site visit date will be sent to the Providers in advance of the proposed date.

NORTHCARE WEBSITE

NorthCare Network Substance Abuse Services website address is: www.northcare-up.org/subA. Included in this website is a Training Center that includes the following training components:

DRA
HIPAA
Customer Service (Welcoming)
Communicable Disease
Recipient Rights
Confidentiality

COMMUNICABLE DISEASE – Included in Website Training Center

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

DEFINITION – for Communicable Disease Training

Level 1 – Minimal standards for ALL employees:

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

- Overview of treatment possibilities
- Local resources available for further information/screening
- Universal precaution procedures-basic knowledge of universal precautions for blood borne and body fluids transmission of pathogens

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

Level 2 – In addition to level 1, clinicians serving clients in a treatment setting are required to have an expanded level of training on HIV/AIDS, TB, Hepatitis and STD. This expanded Level 2 training is to include:

- Statistics (statewide and local geographic area, modes of transmission, how to interpret)
- HIV/AIDS, TB and Hepatitis C (what they are, cause, definition, types)
- Stages/Phases of HIV/AIDS and Hepatitis infection (immune response and viral load, impact on other body organs, co-factors, signs and symptoms of related disease, including those specific to women and children, related infections and cancers)
- Factors for assessing risk and willingness and/or ability for client behavior change (ways to eliminate/reduce risk; infection control)
- Treatment options/possibilities (antiretrovirals, prophylaxis, anti-infectives, immune-modulators, clinical trials, nutrition, complementary/alternative treatments, impact of substance use on medication/treatment effectiveness)
- Testing – HIV Antibody testing (philosophy, goals, legal requirements, benefits/risks, types (i.e. serum, OraSure), laboratory test, used, limitations, overview of testing processes), Hepatitis testing and vaccines, TB testing and treatment, Options for STD screening/testing
- Overview of psychosocial Issues – Psychosocial framework (issues for people with HIV/AIDS), Overview of Psychological issues (social isolation, alteration in quality of life, self esteem, intensity of emotion, control, denial, financial and employment issues)
- Professional challenges (discussion on what some key issues may be for clinicians in a substance abuse treatment program, conceptions, attitudes/values, etc)
- Confidentiality, especially for HIV/AIDS (felony, partner notification, testing, reporting, ADA, HIPAA)
- Resources (local, state, federal)

It is anticipated the above could be adequately covered in a three-hour session, with two-hour update trainings every two years. This level of training would require a more advance level of expertise for the trainer, which could be achieved through the MDCH/HAPIS HIV Specialist training certification process. [A recorded version of the Level II Communicable Disease Training will be available to providers who have staff unable to attend training in person or via video conferencing. This requirement too must be completed within 60 days of hire for appropriate staff.](#)

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

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

The Compliance Office for NorthCare emailed a training packet to all Substance Abuse Program Directors on 12/15/2006 to be appropriately distributed to all staff.

DRA – Program Activities:

- Reviewing the actions of Medicaid providers under any type of payment system to determine if their actions have produced fraud, abuse or waste, are likely to, or may potentially result in unintended expenditures on the part of the Medicaid program.
- Auditing of claims for payment of Medicaid services, items, or administrative services rendered including cost reporting, consulting contracts, and various risk contracts.
- Identification of overpayments to individuals or entities receiving Medicaid Federal funds.
- Education of providers, managed care companies, beneficiaries, and others with respect to payment integrity and quality of care.

NorthCare Policies – Specifically Pertaining To Substance Abuse

Access Policy & Overview of Access Process
Accessibility & Accommodation Policy & Procedures
Coordination of Care/Collaboration
Criminal Background Checks
Credentialing Policy
Cultural Competency Policy
Customer Grievance & Appeal Process
Enrollee Rights and Protections
Notice of Privacy Practices
Privileging Policy
Procurement Process
Provider Network Selection, Management and Appeal Mechanisms
Quality Improvement Plan
Quality Management
Utilization Management Plan
Recipient Rights for Substance Abuse
Sanction Policy
Sentinel Events
Staff Competencies/Staff Education

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

Methadone Providers in Michigan

Genesee County

Recovery Unlimited Treatment Center
G-3169 W. Pierson Road
Flint, MI 48504

Phone 810-785-4930 Fax 810-785-4931

Ingham County

Clinton, Eaton, Ingham Community Mental
Health Substance Abuse Program
812 E. Jolly Road, G14
Lansing, MI 48910
Phone 517-346-8270 Fax 517-346-8290

Ingham County

Treatment Works
3401 E. Saginaw, Suite 106
Lansing, MI 48912
Phone 517-332-9000 Fax 517-332-7225

Jackson County

Victory Clinical Services III
1949 Lansing Ave., Suite B
Jackson, MI 49202
Phone 517-784-2929 Fax 517-784-3030

Washington Way
(Detox from Meth) Co Occurring
2424 W. Washington St.
Jackson, MI 49203
Phone 517-782-4001 Fax 517-783+4992

Kalamazoo County

Victory Clinical Services
1020 South Westnedge
Kalamazoo, MI 49008
Phone 269-344-4458 Fax 269-344-4459

Kent County

Eastern Clinic
1555 Eastern St. SE
Grand Rapids, MI 49507
Phone 616-243-6262 Fax 269-344-4459

Project Rehab
822 Cherry Street
Grand Rapids, MI 49506

Phone 616-458-8521 Fax 616-776-9906

Macomb County

Bio Med Behavioral Health Care
22900 E. Remick, Suite B
Clinton Township, MI 48036
Phone 586-783-4800 Fax 586-783-4805

Millennium Treatment
23700 VanDyke Avenue
Warren, MI 48089
Phone 586-758-6670 Fax 586-758-0243

Parkview Counseling Centers
27115 Gratiot Avenue
Roseville, MI 48066
Phone 586-776-7000 Fax 586-532-8073

Sacred Heart
400 Stoddard Road
P.O. Box 41038
Memphis, MI 48041-1038
Phone 810-392-2167 Fax 810-392-2057

Muskegon County

Eastside Substance Abuse Clinic
445 E. Sherman Blvd.
Muskegon Heights, MI 49444
Phone 231-739-4359 Fax 231-733-6151

Oakland County

Metropolitan Rehabilitation
21700 Greenfield, Suite 130
Oak Park, MI 48237
Phone 248-976-4310 Fax 248-967-4301

Millennium Treatment Services
1400 E. Twelve Mile Road
Madison Heights, MI 48071
Phone 248-547-2223 Fax 248-547-2226

Parkview Counseling Centers
989 University Drive

Pontiac, MI 48342
Hone 248-370-0010 Fax 313-532-8073

Washtenaw County

Help Source/ClearHouse/Clear Day
3879 Packard Road
Ann Arbor, MI 48108
Phone 734-973-1900 Fax 734-973-2445

Wayne County – City of Detroit

Comprehensive Services
4630 Oakman Blvd.
Detroit, MI 48204
Phone 313-934-8400
Fax 313-934-7920

City of Detroit/Dept. of
Human Services
8809 John C. Lodge
Building #5
Detroit, MI 48202
Phone 313-876-4227
Fax 313-876-0532

Detroit Health Department
Gratiot Clinic
3506 Gratiot
Detroit, MI 48207
Phone 313-852-4840
Fax 313-852-4847

John D. Dingell VA
Medical Hospital(vets only)
4646 John R. Street, Rm B136
Detroit, MI 48201
Phone 313-576-1000
Fax 313-576-1025

Detroit Health Department
Northwest Clinic/Greenfield
14602 Greenfield Road
Detroit, MI 48227
Phone 313-852-4573
Fax 313-852-4483

Eleanor Hutzel Recovery
(Pregnant Women)
301 E. Hancock
Detroit, MI 48201
Phone 313-745-7411
Fax 313-745-0556

Metro E. Drug Treatment Corp.
13627 Gratiot P.O. Box 13408
Harper Station
Detroit, MI 48205
Phone 313-571-9763

Metro E. Drug Treatment
8061 Harper
Detroit, MI 48213
Phone 313-371-7770
Fax 313-371-1409

Fax 313-371-1409

Metro E. Drug Treatment Corp.
Chalmers
13929 Harper Avenue
Detroit, MI 48213
Phone 313-834-5930
Fax 313-834-4541

Nardin Park Recovery Ctr.
9605 Grand River Ave
Detroit, MI 48204
Phone 313-371-0055
Fax 313-371-1409

New Light Recovery Ctr.
300 W. McNichols
Detroit, MI 48203
Phone 313-867-8015
Fax 313-867-8040

Parkview Counseling Ctrs.
18609 W. Seven Mile Rd.
Detroit, MI 48219
Phone 313-532-8015
Fax 313-532-8073

STAR Center, Inc.
13575 Lesure
Detroit, MI 48227
Phone 313-493-4410
Fax 313-493-4415

University Psychiatric Ctr.
Jefferson Ave. Research
Clinic
2761 E. Jefferson Ave.
Phone 313-993-3964
Fax 313-993-6372

Wayne County – Out Wayne County

M.Y. Miracle Rehab. Ctr.
3001 Caniff
Hamtramk, MI 48212
Phone 313-368-5160
Fax 313-368-3771

Parkview Counseling Ctrs.
25639 Ford Road
Dearborn Hts ,MI 48127
Phone 313-227-3293
Fax 313-532-8073

Parkview Counseling Ctrs.
15135 Hamilton
Highland Park, MI 48203
Phone 313-883-1400
Fax 313-532-8073

Rainbow Center of MI
12501 Hamilton
Highland Park, MI 48203
Phone 313-532-8073
Fax 313-865-1582

Update 12/28/2007

Attachment 1

Grievance and Appeals Resolution Processes

**GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT
PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES**

July 2004

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I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part II, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Community Health (DCH). These requirements are applicable to all PIHPs, affiliate Community Mental Health Services Programs (CMHSPs), Substance Abuse Coordinating Agencies (CAs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term “Grievance system,” as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal**. Any other type of complaint is considered a **grievance**.

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive “due process” whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the “Code”) Chapters 7, 7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Action: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as "**B3**" waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested**. Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided / mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an "action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP must grant the request.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action**. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action**.

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process: Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Disposition: Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

III. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an “action” taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an “action”.
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an “action”.
- The right to **concurrently** file a PIHP level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP level appeal of an “action”.
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP **must provide** the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

Standard Authorization: Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service.

If the beneficiary or provider requests an extension **OR** if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the **14 calendar** day time period by up to **14 additional calendar days**.

Expedited authorization: In cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days**

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an **"action"** by authorizing a service in amount, duration or scope less than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

PIHP Notice of Action requirements include:

- The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.

- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

- **If** the utilization review function is not performed within part of an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, **and requires** a written notice of action.

The notice of action must be either Adequate or Advance:

• **Adequate notice:** is a written notice provided to the beneficiary **at the time of EACH** action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.

• **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

- What action the PIHP has taken or intends to take,
- The reason(s) for the action
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instruction for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman,

The content of an advance notice must also include an explanation of:

- The circumstances under which services will be continued pending resolution of the appeal,
- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

NOTE: Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

There are limited exceptions to the advance notice requirement. The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP has factual information confirming the death of the beneficiary.
- The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.

- The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.
- The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days**.

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days**.

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending **if**:

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar** days pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary.
- The time period or service limits of the previously authorized service has been met.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days**. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See section VI above for notice information.)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate.
- Expedited hearings are available.

Detailed information and instructions for the Fair Hearing process can be found in the DCH Administrative Tribunal Policy and Procedures Manual online at:

www.michigan.gov/documents/Manual_9658_7.pdf

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
- The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

When a beneficiary requests a local appeal, the PIHP is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
- Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program.
- Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues
- Provide the beneficiary, or representative with:
 - Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
 - Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
 - Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
 - Information regarding the right to a fair hearing and the process to be used to request

the hearing.

Notice of Disposition requirements:

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution.
- The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
 - The right to request a state fair hearing, and how to do so;
 - The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
 - That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.
- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working** days after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

- If the PIHP denies a request for expedited resolution of an appeal, it must:
 - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;
 - Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
 - Give the beneficiary follow up **written notice** within **two (2) calendar days**.

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions"**.

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process **unless**, the PIHP fails to respond to the grievance **within 60 calendar days**. This constitutes an "action", and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:

- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
 - Involves clinical issues, or
 - Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP received the grievance/complaint. The content of the Notice of disposition must include:
 - The results of the grievance process
 - The date the grievance process was concluded.
 - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
 - How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers
- The volume of denied claims for services in the most recent year.

Amendment #2 - Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: Attachment P6.3.2.1

MEDICAID ADEQUATE NOTICE OF ACTION FOR SUBSTANCE ABUSE SERVICES

Name: _____ Date: _____

Address: _____ City, State, and Zip: _____

RE: Beneficiary's Medicaid / Adult Benefit Waiver ID Number: _____

Following a review of the **SUBSTANCE ABUSE** services that you are requesting or receiving, this is your Adequate Notice regarding:

_____ Treatment Plan Service(s)	_____ Denial of funding for requested services Units	Effective Date(s)
_____	_____	_____
_____	_____	_____

The reason for this action is:

The legal basis for this decision is 42 CFR Part 2

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person. At a fair hearing you may represent yourself or use a lawyer, relative, friend, or other spokesperson.

To request a fair hearing, contact the Administrative Tribunal at the address below:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
1033 Washington
P.O. BOX 30763
LANSING, MI 48909
Fax: (517) 334-9505

You have the right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 1-877-833-0870.

If you do not agree with this action, **you may also request a local appeal.** To make this request contact the NorthCare CDR listed below. File the appeal within 45 days of the date of this notice. The request may be oral or written.

CDR Recipient Rights Office
200 West Spring Street
Marquette, MI 49855
(906) 225-7254 or 1-888-333-8030
Fax # (906) 225-5149
TDD # 1-800-649-3777

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call Mary Swift @ (906) 225-7254 or 1-888-333-8030.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or NorthCare @ 225-7254 or 1-888-333-8030 if you have further questions.

Notice has been faxed/mailed/given to _____ Date ___/___/_____

MEDICAID ADVANCE NOTICE OF ACTION FOR SUBSTANCE ABUSE SERVICES

Name: _____ Date: _____

Address: _____ City, State, and Zip: _____

Beneficiary's Medicaid ID Number: _____

Following a review of the **SUBSTANCE ABUSE** services that you are requesting/receiving, this is your **Advance Notice of Action re:** _____ Reduction of service

_____ Suspension of service

_____ Termination of service

Service(s)	Effective Date
_____	_____
_____	_____

The reason for this action is: _____

The legal basis for this decision is 42 CFR Part 2

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form, and return it in the enclosed pre-addressed envelope or fax or mail to:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
1033 Washington
P.O. BOX 30763
LANSING, MI 48909
Fax: 517-334-9505

You have the right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call toll-free, 877-833-0870.

If you do not agree with this action, **you may also request a local appeal.** To make this request contact the Recipient Rights Office listed below. File the appeal within 45 days of the date of this notice. The request may be oral or written.

CDR Recipient Rights Office
200 West Spring Street
Marquette, MI 49855
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You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call Mary Swift @ (906) 225-7254 or 1-888-333-8030.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or NorthCare @ (906) 225-7254 or 1-888-333-8030 if you have further questions.

You will continue to receive the affected services until the hearing decision is rendered if your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

Notice has been mailed to: _____ on _____

Enclosures: Hearing Request Form
Return Envelope

ATTACHMENT 2

Michigan Medicaid Provider Manual, Chapter on Mental Health/ Substance Abuse Services, Section 2.5 Medical Necessity Criteria

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

2.5.C. Supports, Services and Treatment Authorized by the PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is

- accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

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

2.5.D. PIHP Decisions

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
 - Deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
 - Experimental or investigational in nature; or
 - For which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individual basis.