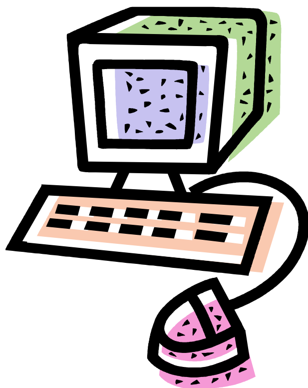
# NORTHCARE NETWORK SUBSTANCE ABUSE SERVICES

# PROVIDER MANUAL

## 2010-2011



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PROVIDER MANUAL – 2010/2011

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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 and MI CHILD funded agencies within the eight-county NorthCare Network Substance Abuse Services region as well as the Medicaid/ABW 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:
JOHN BASSE, Chief Executive Officer
BILL SLAVIN, Chief Operating Officer
**DONNA KITRICK, Substance Abuse Director**
**JUDI BRUGMAN, Supervisor**
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/Interim Prevention Coordinator
JAN MCCOMBIE, Substance Abuse Data Coordinator

Numbers:
Phone: (906) 225-7222
Toll-Free: (800) 305-6564
Fax: (906) 225-7224 (CDR)
Fax: (906) 226-0034 (Finance/Prevention)

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 a 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 regular 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."

**Holiday Telephone Message:**
The CDR will record an appropriate Holiday message for callers during State recognized Holidays.

## 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 use disorder residing in Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee, and Schoolcraft counties and Medicaid/ABW 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 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 is 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

## FUNDING SOURCES

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

**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),~~ NorthCare CDR Brief Screening Tool, 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, 2010 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 2010-2011
## 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/social detox 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;
Social 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 payor source. 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 all fifteen counties of the Upper Peninsula. ~~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 ~~(20 visit max for FY)~~
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 Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee, and Schoolcraft 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 is 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 is 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.

**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 clients attend a full spectrum of treatment programming but live at home or in special residences.

Services are provided over a period of weeks. Level 2.1(IOP) programming provides essential education and treatment services while allowing the participant to apply their newly acquired skills in "real world environments". 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 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)~~NorthCare CDR Brief Screening Tool, 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: NorthCare CDR Brief Screening Tool, 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, Medicaid, MI CHILD**
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, Medicaid, MI CHILD**
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. 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 & Social 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 user

**Priority Two**
Pregnant substance use disorders

**Priority Three**
Injecting drug user (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 Use. (Open CPS case)

**Priority Five**
All others

**Access Timeliness Standards**
The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are in italics: Screened and referred applies to intensive services and methadone. When a client calls an outpatient provider for services, the provider must follow the ADMISSION guidelines, not the screened and referred requirements. If a client calls 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<br>2) Detoxification, Methadone or Residential – Offer Admission within 24 business hours<br>Other Levels or Care – Offer Admission within 48 Business hours | **Begin within 48 hours:**<br>1. Counseling and education on:<br>a) HIV and TB<br>b) Risks of needle sharing<br>c) Risks of transmission to sexua l partners and infants<br>d) Effects of alcohol and drug use on the fetus<br>2. Referral for pre-natal care<br>3. *Early Intervention Clinical Services* | CFR 96.121;<br>CFR 96.131;<br>Treatment Policy #04<br><br>**Recommended** |
| | | | |
| ***Pregnant Substance* Use Disorders** | 1) Screened and referred within 24 hours<br>2) Detoxification, Methadone or Residential – Offer admission within 24 business hours<br>Other Levels of Care – Offer Admission within 48 Business hours | **Begin within 48 hours**<br>1. Counseling and education on:<br>a) HIV and TB<br>b) Risks of transmission to sexua l partners and infants<br>c) Effects of alcohol and drug use on the fetus<br>2. Referral for pre-natal care<br>3. *Early Intervention Clinical Services* | CFR 96.121;<br>CFR 96.131;<br><br>**Recommended** |
| | | | |
| ***Injecting Drug User*** | Screened and referred within 24 hours; Offer Admission within 14 days | **Begin within 48 hours – maximum waiting time 120 days**<br>1. Counseling and education on:<br>a) HIV and TB<br>b) Risks of needle sharing<br>c) Risks of transmission to sexual partners and infants<br>2. *Early Intervention Clinical Services* | CFR 96.121;<br>CFR 96.126<br><br>**Recommended** |
| | | | |
| **Parent at Risk of Losing Children(Open CPS case)** | Screened and referred within 24 hours. Capacity to offer Admission within 14 days | **Begin within 48 business hours**<br><br>*Early Intervention Clinical Services* | Michigan Public Health Code Section 6232<br><br>**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; 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 provider 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 and http://michigan.gov/healthlicense

## PRIMARY CARE COORDINATION

All appropriate steps must be taken to assure that substance use disorders 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.

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

~~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 that 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 use disorder services funding. If the youth is currently attending substance use disorder 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 use disorder 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;
- 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 is met by the client.

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

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

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

Please refer to the NorthCare Website at www.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, 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

1. Clients seeking outpatient services would contact the treatment provider directly
2. Client seeking intensive levels of care would contact, or be referred to the CDR for a screening to determine level of care
3. The following information must be obtained via a pre-screening in order to determine client’s priority status:

- **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? If so, where?** | Yes/No | | |
| **Is client in danger of losing children because of use** | Yes/No | | |
| **Level and Options Given After Screening:** | Yes | **Level Recommended:** | 2.1 |
| | | **Initials:** | KL |
| **Did Client Attend Tx?:** | Yes | | |
| **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 |

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 use disorder treatment must be based on medical necessity. Demographic data, financial information, and an Initial Authorization Request is entered into the appropriate online forms and electronically transmitted to the 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 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 CareNet 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 may 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 have followed through with a planned sequence of addiction treatment following previous sub-acute/social 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 7/3/10 – 10/3/10 or 7/3/10 to unknown. The HIPAA attorney hired by MASACA made this a marked issue – the 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, 12/31/10, 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 faxed 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).**
- o To facilitate the assessment process and the provision of appropriate treatment services.
- o To provide information necessary for authorizing reimbursement under the Pathways Block Grant
- o Funding Assistance, Medicaid, State Disability Assistance (SDA), MI-Child and/or other appropriate sources of public funding.
- o To monitor client treatment progress and provide assistance in discharge planning.
- o To verify service delivery.
- o To provide information necessary for the CDR to conduct follow-up.
- o Determination of benefits.
- o 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

### *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 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 is 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, username and passwords must be assigned. Contact NorthCare Substance Abuse Services (Jan Grim 225-4404) to have username and passwords established or reset. Employees must not share their username or passwords. Off-site accessing of the CareNet system is strictly **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 Substance Abuse Services **immediately** to have a username disabled when an employee leaves your Agency. This should be done **without delay** so that continued access is not possible.

# 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 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. 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 CareNet system upon discharge from the program. Providers may be asked to discharge clients sooner by the CDR even though 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 CareNet 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 an individualized treatment plan. The main components include basic identification for the client, name of appointed clinician, presenting problem, multi-axial DSM-IV diagnosis, a 30-day history of alcohol and drug use, 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 determination 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

**Re-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 due to cognitive and behavioral impairments ~~which prevent the client from benefitting from less intensive treatment.~~

## Providers

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

- The provider who disagrees with a 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 CareNet system must be filed and approved within 14 days of a client's admission.

Click the "submit" button only ONCE - repeatedly clicking that button may 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 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 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 Substance Abuse Provider Manual. Provider acknowledges that the failure to follow the terms of NorthCare policies and procedures may result in a reduction in the amount of payments to Provider.

## 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
- Auto Process Report
- Billed Treatment Report
- Daily Admissions, Discharge, SARF
- Financial Report
- Financial Report (NEW)
- Most Expensive Client
- Open Client Summary
- Re-Authorization Due Report
- Unanswered Notes from Provider
- Unanswered Notes to Provider
- 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~~ finance department.

# CUSTOMER SERVICE

**The following are on our Substance Abuse Website:**

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

NorthCare Customer Services Complaints/Grievance Tracking Form for SA

# 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 (PA), nurse practitioner (NP), registered nurse (RN) or licensed practical nurse (LPN) who is not providing treatment services to clients beyond the scope of practice of their licensure are considered to be Specifically Focused Treatment Staff and are 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.

**<u>Substance Abuse Treatment Practitioner</u>**

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 .

**<u>Treatment Supervisor</u>**

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 of 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 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~~ within 2 weeks of hire. This notification will ensure the clinician is properly credentialed to provide substance abuse services to NorthCare funded clients. 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 by 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 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 data provider manual.) Be sure the payor 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 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 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 screen before entering treatment details. The dates of eligibility for primary, secondary, or tertiary, payors 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)226-0034.

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 Reporting and Data Provider Manual under "Provider Manual" on Substance Abuse website: www.northcare-up.org/subA

### MEDICAID ADMINISTRATIVE HEARING PROCESS

See NorthCare Website

## 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 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 – staff must review this training annually. Document must kept in employee file including the date review completed.
- 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 that 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

See NorthCare Substance Abuse Website