Macomb County Community Mental Health

Office of Substance Abuse (MCOSA)

Quality Assurance Guidelines

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I. OVERVIEW

A. STATEMENT OF PURPOSE

The Quality Assurance (QA) Guidelines represent a compilation of acceptable treatment standards such as those described in the National Institute on Drug Abuse's Principles of Drug Addiction Treatment, December 2012, the American Society of Addiction Medicine Criteria, the Michigan Department of Community Health Medicaid Manual and Office of Recovery Oriented System of Care Policies and Technical Advisories, and adherence to guidelines set forth by the State and Federal requirements.

B. STATEMENT OF SCOPE

The QA Guidelines contained in this document describe parameters necessary to facilitate an efficient admission process, treatment planning, and for maintaining the continued course of treatment for clients funded by Macomb County Office of Substance Abuse (MCOSA) through Community Grant (Block Grant, PA2), Healthy Michigan Plan (HMP), MI Health Link, and Medicaid.

Specifically, the guidelines address the general admission procedures for children, adolescents, and adults who are admitted into MCOSA funded contract agencies. The following procedures address the admission protocols including, but not limited to, screening, intake, assessment, treatment planning, and clinical documentation. Also, the reauthorization and readmission protocols are outlined for all treatment modalities.

Additionally, the quality assurance record review guidelines provide an overview for monitoring case records and contract agency compliance. The process for appealing MCOSA auditing decisions is also outlined. In addition, the local Community Grant Grievance process, Medicaid Local Grievance, Medicaid Local Appeal process, and the Michigan Department of Community Health's Administrative Fair Hearing procedures are briefly referenced.

C. ADMINISTRATION AND COORDINATION

The QA Guidelines are administered by MCOSA with ongoing input/feedback from contract providers. MCOSA monitors compliance with the Guidelines through regularly scheduled audits. Contract providers are

required to ensure compliance of these QA Guidelines by training staff in the use and any procedural updates. The QA Guidelines are located on the MCOSA website, www.mcosa.net, under Documents/Provider Manual/Chapter 3-tab). Comments or questions regarding the online QA Guidelines or website should be directed to mcosa@mccmh.net.

D. TECHNICAL ASSISTANCE

The MCOSA Quality Assurance (QA) Coordinator provides technical/consultative assistance as needed. Technical/consultative assistance may be requested on any area in the QA Guidelines. Appointments can be made with the QA Coordinator by the Program Director and/or Clinical Supervisor from any contracted site.

II. GENERAL ADMISSION POLICY

It is MCOSA's policy that individuals with verified diagnoses of substance use disorder(s) will be admitted into an appropriate treatment program(s). The individual with the substance use disorder must have significant impairment on their functioning level in the areas of their occupational, educational, interpersonal and/or medical status to warrant admission into the treatment program. Individuals with a diagnosed substance use disorder in full or partial remission may be admitted if relapse is imminent and can be averted with short-term therapeutic intervention. Individuals who have completed an intensive treatment program may be seen for aftercare treatment.

Block Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).
Children, adolescents and/or adults who are experiencing a recent (within six months of intake) relationship with a substance user (family member or co-habitant) may be admitted into the treatment program if there is significant evidence that the issues to be addressed are clearly related to the substance using relationship and not an otherwise diagnosable behavioral health issue. It is required that the case record has documentation to show the impact of the Significant Other's substance use on the identified client.

Children, adolescents, and adults who are at risk of developing a diagnosable substance use disorder may receive funded treatment under the Early Intervention service category, as outlined in the Technical Advisory T-TA-09, Early Intervention, issued November 30, 2011.

A. SCREENING DATA COLLECTION REQUIREMENT GUIDELINES

1. MCOSA requires the use of a screening form as a means of gathering the initial information from a client. This form must include a summary of the client's demographic information including residence, presenting substance use problem, financial status, and insurance information including whether or not the client is currently enrolled in Medicaid, HMP, MI Health Link, or 3rd party insurance.

2. The screening form must include the following additional information:

    a. Whether or not an individual is pregnant.
    b. Whether an individual is an injecting substance user (use of drugs by injection in the past thirty [30] days).
    c. Whether an individual is a parent whose child/ren have been removed or there is the threat of removal from the home as a result of protective services involvement.
    d. The date the client first contacted the program for services, the intake appointment date that was first offered, the date accepted by the client, and the actual intake date; any additional appointments offered for the initial intake, including the related contact date, should also be documented.
    e. The individual and household income, as well as the number of dependents, if any. (The number of dependents should be the number of dependent(s) on the household income, including the client.).

3. The screening form must be filed as a part of the clinical record and made accessible for MCOSA and/or other State or Federal auditors regarding compliance with Federal priority admissions and Medicaid admission requirements.

4. All questions on the screening form must be completed in full.

B. INCOME ELIGIBILITY GUIDELINES FOR COMMUNITY GRANT (BLOCK GRANT OR PA2) FUNDING

1. Clients with limited financial resources may qualify to have fees for substance use treatment subsidized. The clients who may qualify are identified as follows:

   a. Clients who have no third party substance use coverage and are low income, based on the current MCOSA Fee Scale.
   b. Clients who are low income and unable to pay a substantial co-payment with their third party substance use coverage.
   c. Clients who have exhausted their third party substance use benefits and due to limited financial resources, cannot pay the full fee established by the agency.

2. Preference for funding must be given to Macomb County residents. However, programs that are not maintaining a waiting list, and are not exceeding prior monthly billing allocations, may admit out-of-county residents unless otherwise stipulated in their contract.

3. Client eligibility for funding must be documented in the case record. The agency must complete the MCOSA Fee Agreement Form for each Community Grant, HMP, MI Health Links and Medicaid funded client. The Fee Agreement Form must be signed by the contract agency, as well as by the client, at the time of admission, for any subsequent change in insurance and/or co-pay amount, and updated at least every 90 days for individuals receiving community grant funding. *(See attachments for MCOSA Fee Agreement Form and Instructions.)*

4. Early Intervention school-based activities that are determined to be a contracted service require a MCOSA Fee Agreement Form to be completed including signatures from the agency and student. Additionally, the agency providing the school-based activities must complete all data screens in the MCOSA data system.

5. Reimbursement services must be documented within forty-eight (48) hours of rendering the service, in accordance with the Department of Licensing and Regulatory Affairs (LARA) licensing

requirements and MCOSA QA Guidelines. Reimbursable units of service are:

a. Bed days for residential, sub-acute detoxification, and recovery home service.
b. Chair days for intensive outpatient service.
c. Face-to-face contact for outpatient services including individual treatment, group treatment, didactic group presentations, case management, peer support services, psychiatric evaluation, medication review(s), medication doses, and Medication Assisted Treatment laboratory/urinalysis services as specified by contract.

6. MCOSA-funded intensive services, including sub-acute detoxification, residential treatment, Intensive Outpatient treatment and medication assisted treatment, as well as Recovery Home Services and Peer Recovery Coach Services, require an AMS screen or Change in Level of Treatment form to be completed, of which must be reviewed and authorized by the AMS.

7. Clients are required to provide verification of income to be eligible for Community Grant funding. Verification includes, but is not limited to: most recent Income Tax Returns, W-2 forms, 1099 forms, pay stubs, unemployment compensation forms, disability check stubs, or food stamp eligibility statements. Individuals who claim to be in the process of a divorce are required to have legal declarations of income available for verification. If there is no formal documentation, the individual must describe how they support themselves, including money from relatives, friends, etc.

8. Providers are required to verify eligibility for Macomb County HMP, Medicaid or MI Health Link funded services. Contract providers can verify coverage through the MCOSA data system or through the State's CHAMPS system. Clients are required to provide verification of their current Macomb County residence. If the address on HMP/Medicaid account is not a Macomb County address, the client is required to contact the DHHS office to update their residency. *(See MCOSA Data Instructions for additional information regarding verification of HMP/Medicaid/MI Health Link eligibility, including the requirement that all Community Grant funded recipients' eligibility be checked for HMP/Medicaid in the State's eligibility system prior to applying Community Grant funds).*

The AMS will provide a reimbursement level recommendation for clients screened; however, it is the contracted provider's responsibility to assign the correct reimbursement level based on proof provided by the client.

9. In order to obtain a fee exception for a lower reimbursement level, or to utilize Community Grant funding to assist in meeting a Medicaid or other third party deductible, the program is required to provide an explanation of the request for an exception on the Fee Agreement Form, along with the reimbursement level being requested. *(See Appendix for instructions on deductible co-pay assistance.)* Requests for a Fee Waiver should be made via the form with instructions listed in the Attachments. The Fee Waiver will not be considered without accompanying documentation of financial need or hardship.

C. FOCUS INSTRUCTIONS

1. **MCOSA FOCUS USER POLICY**: Users of the Macomb County Community Mental Health (MCCMH) FOCUS Data System (FOCUS) are authorized to access the system **<u>only from the licensed provider location</u>**. Users are not authorized, for any reason, to access the system from a location other than the licensed location. If another location is to be used, either on a routine or temporary basis, permission must be requested from MCOSA, in advance and in writing. Written approval by MCOSA must be received prior to implementing off-site access.

   FOCUS is an extension of the client's clinical record. The system contains confidential client information that is protected by State and Federal regulations. It is the responsibility of the provider to establish and enforce written policies and procedures related to FOCUS. These policies and procedures must ensure access only by those individuals who are informed of, and agree to abide by, the confidentiality regulations, and have been authorized by MCOSA to access the system. The protections offered by State and Federal regulations cannot be guaranteed if the system is compromised by access from non-authorized individuals or accessed at locations that are not approved, supervised or controlled by the agency.

As an extension of the client's clinical record, care should be taken to follow clinical record protocol in completing FOCUS screens. For example, correct capitalization, spelling, grammar and sentence structure must be used.

MCOSA reserves the right to deny access to FOCUS to any individual or agency in violation of this policy.

2. **ADMISSION DUE DATES**: For the purposes of these instructions, days are considered in terms of calendar days. If the due date falls on a weekend or holiday, the due date is moved to the next business day.
   Admissions and related Demographic, Payer, Financial and Assessment Appointment records must be entered/updated within one day.
   a. **Sub-Acute Detox, Residential & IOP** Admissions and related Demographic, Payer, Financial and Admission Appointment records must be entered into FOCUS within one day. Eligibility must be run in the electronic FOCUS record.
   b. **Outpatient** Admissions and related Demographic, Payer, Financial and Admission Appointment records must be entered into FOCUS within seven days or by the next appointment after intake, whichever is sooner. Eligibility must be run in the electronic FOCUS record.

3. **DISCHARGE DUE DATES**: For the purposes of these instructions, days are considered in terms of calendar days. If the due date falls on a weekend or holiday, the due date is moved to the next business day.
   Treatment Discharges must be entered into FOCUS within seven days of the client's discharge from the program. In accordance with MDCH requirements, FOCUS allows a client to have only one admission at any given time. Therefore, it is imperative that providers enter client discharges as quickly as possible, especially in the case of detox, residential and IOP programs. The aftercare provider will not be able to enter the client's admission into FOCUS until the detox/residential/IOP admission has been discharged.
   Any client not seen for a period of 30 calendar days is to be considered discharged, for purposes of FOCUS and MCOSA funding. A provider should complete the Discharge record using the

last date of face-to-face contact with the client as the Discharge date.

If a client returns to treatment within days of discharge, you may ask MCOSA to delete the discharge that was entered into FOCUS and request new authorizations starting at the original authorizations lapse date.

4. **INITIAL AUTHORIZATION REQUESTS**: **Sub-Acute Detox, Residential and IOP** must be entered within one day. The AMS will process these requests within one day of receipt and return them to the provider electronically as approved or denied.

   Outpatient Services must be entered within seven days or by the next appointment after intake, whichever is sooner. AMS will process these requests within three days of the receipt and return them to the provider electronically as approved or denied.

5. **DEVIATIONS FROM THE ADMISSION AND/OR AUTHORIZATION REQUEST SCHEDULE**: Deviations from the schedule are expected to be infrequent and allowable only under extenuating circumstances. Circumstances such as staff vacation or sick leave, losing track of the number of sessions for reauthorizations, part-time employment of the clinician and data-entry clerks not receiving FOCUS information from clinicians in a timely manner are NOT considered extenuating circumstances and will be approved with an effective date corresponding to the Request Date auto completed by FOCUS in the initial/reauthorization screen.

   NOTE: Clients are not to be held financially responsible for services omitted in the approved authorization period due to late submissions by the provider.

   Extenuating circumstances such as the provider's loss of Internet access, FOCUS problems or telephone/equipment failure, resulting in the delay of admission and/or authorization request entry must be conveyed to MCOSA's Director, or the Data & Finance Coordinator.

   Extenuating circumstances such as retroactive eligibility and delayed receipt of third-party liability documentation must be conveyed in the Comments box of the Authorization request, and admission, if applicable. Fax all related documentation (IE, third-party rejection notice) to MCOSA's Account Clerk IV Clerk.

   Programs wishing to appeal the decision by MCOSA/AAR to set the effective date to a date other than that requested by the provider

should submit a written Level One MCOSA Appeal to the Data and Finance Coordinator within five days of MCOSA/AAR's response to the authorization/reauthorization request.

D. ADMISSION EXCLUSION POLICY FOR ALL TREATMENT MODALITIES

1. Individuals with a primary psychiatric diagnosis **only** are not eligible for Community Grant, HMP or Medicaid funded substance use disorder services. Adults or adolescents who are at risk for developing a substance use disorder problem due to involvement with a using person or who are experiencing functional/social impairment as a result of use, but do not yet reach the threshold for Substance Use Disorder diagnoses, may be eligible for Early Intervention services.

2. Individuals referred for the sole purpose of receiving Drinking and Driving Education classes are not eligible for MCOSA funding.

3. Individuals who present only with Adult Children of Alcoholics (ACOA) issues, and who do not meet the criteria for a Significant Other or Early Intervention, do not qualify for MCOSA Community Grant, HMP, or Medicaid substance use disorder funding for psychotherapy.

4. Individuals who do not meet the MCOSA Admission Policy Guidelines and Medicaid Medical Necessity criteria (see Section VI, A-E, and MCOSA Provider Manual) are not eligible for MCOSA Community Grant, HMP, MI Health Link or Medicaid funded substance use disorder treatment.

III. ADMISSION PROTOCOLS FOR MCOSA COMMUNITY GRANT, HMP, MI Health Link, AND MEDICAID FUNDED SUBSTANCE USE DISORDER TREATMENT

The following criteria and guidelines are from the American Society of Addiction Medicine (ASAM) Criteria for the treatment of substance use disorders, the MDCH Medicaid Managed Care medical necessity criteria, and the MDCH Criteria for Opioid Dependent Substance Use Disorder Treatment with Methadone as an Adjunct.

The placement criteria is based on the principle of identifying the least restrictive environment necessary to meet the individual's treatment needs while offering choice and respecting the diversity of the individual. Individuals seeking substance use disorder treatment services must meet the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, diagnostic criteria for a substance use disorder(s), unless otherwise stated in these guidelines.

A. DETOXIFICATION CRITERIA

1. HOSPITAL-BASED OR ACUTE MEDICAL DETOXIFICATION - **Not covered under MCOSA Medicaid, HMP or Community Grant -** Hospital-based or acute medical detoxification with intensive medical supervision, _one or more_ of the following indicators below are evidenced:

   a. Individual reports to be at risk for severe withdrawal as evidenced by the presence of acute withdrawal symptoms and an acute or chronic medical condition that may complicate withdrawal (e.g., diabetes, hypertension);
   b. History of seizures, hallucinations, or delirium tremens when withdrawing from similar amounts of alcohol or sedative hypnotic drugs;
   c. History of life-threatening symptoms, such as convulsions, stupor, etc., related to excessive use of alcohol or other drugs;
   d. Individual is experiencing emotional/behavioral complications to the extent that they are in need of medical management of withdrawal (e.g. severe mental confusion and/or impaired judgment, imminent suicidal/homicidal/destructive behaviors);
   e. Individual meets the criteria included in the ASAM Criteria, or other standardized alcohol or drug withdrawal assessment tool criteria, i.e., the Clinical Opiate Withdrawal Scale (COWS) for identified risk of serious withdrawal from alcohol, drugs or both;
   f. MCOSA MI Health Link is the only fund utilized for a hospital-based detoxification. Screening by the AMS is required. Other individuals who require hospital-based acute medical detoxification should be referred to their Qualified

Health Plan, personal physician, or to the nearest hospital emergency room.

2. DETOXIFICATION IN A RESIDENTIAL SETTING (SUB-ACUTE) – Detoxification in a free-standing residential program with medical monitoring and is recommended if *one or more* of the indicators below are evidenced:

   a. Individual is showing signs of drug and/or alcohol intoxication with a history of withdrawal that is not life-threatening;
   b. Daily use of substance(s) known to have withdrawal symptoms (e.g. sedatives/hypnotics, opioids);
   c. Repeated use of high doses of stimulants daily, for at least several consecutive days, with a reported inability to break the use cycle and consequent inability to maintain activities of daily living;
   d. Individual displays marked lethargy or high levels of agitation with a high degree of expressed drug craving and consequent inability to maintain activities of daily living;
   e. Individual shows signs of physical addiction and/or withdrawal signs including high blood alcohol levels, incapacitation, or evidence that continued use may place the individual at risk for imminent medical complications.
   f. Screening by the AMS *is required for MCOSA funded sub-acute detoxification services*. Medicaid or Healthy Michigan funds may be used to pay for the treatment portion of service, but not room and board, within a sub-acute detoxification setting if authorized by the AMS. Aftercare services are required as part of the treatment episode of care.

B. RESIDENTIAL CRITERIA

1. INTENSIVE ADULT RESIDENTIAL ADMISSION - Intensive Adult Residential admissions are typically up to twenty-one (21) days in length of stay or less depending on the individual’s treatment needs. Intensive Residential treatment consists of planned didactic, group and individual rehabilitative treatment, which is highly structured, intensive, and includes 24-hour supervised care and meets the following guidelines:

a. Admission to an intensive residential program requires that the individual has completed, or is no longer in need of, medical or sub-acute detoxification; and if there is a medical or psychiatric condition it is not so severe as to warrant 24-hour medical management by a physician or skilled care nurse;

b. Screening by the AMS *<u>is required for MCOSA funded residential services</u>*. Medicaid or Healthy Michigan funds may be used to pay for the treatment portion of service, but not room and board, within a residential setting if authorized by the AMS. Aftercare treatment in an outpatient setting is the standard of care and it is expected that a referral be arranged prior to the client's residential discharge.

2. INTENSIVE ADOLESCENT RESIDENTIAL ADMISSIONS – Intensive Adolescent treatment admissions are typically 21 days duration or less consisting of planned didactic, group and individual rehabilitative treatment which is highly structured, intensive and includes 24-hour supervised care in a residential setting for adolescents who meet the diagnostic criteria for a substance use disorder (see Section VI for definitions) and meet the following guidelines:

a. Adolescent residential services must be provided by practitioners licensed, trained or otherwise privileged to work with adolescents with substance use disorder related problems;

b. Admission to an intensive residential program requires that the adolescent has completed, or is no longer in need of, medical or sub-acute detoxification; and if there is a medical or psychiatric condition it is not so severe as to warrant 24-hour medical management by a physician or skilled care nurse; the adolescent has a cognitive level of at least eleven;

c. Screening by the AMS *<u>is required for MCOSA funded Adolescent Residential services.</u>* Medicaid funds may be used to pay for the treatment portion of service, but not room and board, within a residential setting if authorized by the AMS;

d. Aftercare treatment in an outpatient setting is the standard of care and it is expected that a referral be arranged prior to the client's residential discharge.

3. THERAPEUTIC ADULT RESIDENTIAL ADMISSIONS – Therapeutic Residential treatment is typically more than 30 days duration, consisting of planned didactic, group and individual rehabilitative treatment, which is highly structured and includes 24-hour supervised care in a Residential setting for individuals who meet the diagnostic criteria for a substance use disorder (see Section VI for definitions) and meet the following guidelines:

   a. Admission to therapeutic Residential treatment requires the individual has completed, or is no longer in need of, medical or sub-acute detoxification; and if there is a medical or psychiatric condition it is no severe enough to interfere with treatment and can be managed in a non-intensive medical setting;
   b. Screening by the AMS *is required for MCOSA funded Residential services.* Medicaid or HMP funds may be used to pay for the treatment portion of service, but no room and board, within a long-term Residential setting if prior authorized by the AMS;
   c. Aftercare treatment in an outpatient setting is the standard of care and it is expected that a referral be arranged prior to the client's Residential discharge.

C. RECOVERY HOME ADMISSIONS

The goal of Recovery Housing services is to provide a supportive recovery environment to help reduce the incidence of drug and alcohol abuse and dependency, prevent relapse, and support individuals in their recovery efforts. Services include post therapeutic supervised support in a Residential setting for individuals who meet the diagnostic criteria for a substance use disorder (see Section VI for definitions) and meet the following guidelines:

1. Admission to a recovery house requires the individual has completed or does not need medical or sub-acute detoxification, is currently enrolled in a MCOSA funded treatment services and is/will be participating in a MCOSA ambulatory treatment service while residing in the home. If individual has a medical or psychiatric condition it will not interfere with the ability to function in a supervised supportive environment. And;

2. When *one or more* of the indicators below are evidenced:

a. the individual is in need of a highly structured and monitored living environment with strong recovery/12-step support available, with the goal of attaining independent living;
b. the individual has had past failed aftercare attempts which result in a return to chronic use;
c. there is significant negative factors in the family, social or work environment that place him/her at risk for relapse without ongoing structured support.

3. Prior authorization by the AMS is required.

D. INTENSIVE OUTPATIENT ADMISSIONS

1. INTENSIVE OUTPATIENT (IOP), ADULT – Adult IOP is a structured outpatient program of at least nine (9) hours of clinical intervention per week. IOP services are provided with the client continuing to reside in their home environment. Individuals attending MCOSA Community Grant, HMP or Medicaid-funded IOP must attend scheduled treatment sessions, provide evidence of abstinence via objective measures (e.g., urine screens, alco-strip), and provide verification of attendance at weekly 12-Step meeting, meet the diagnostic criteria for a substance use disorder (see above definitions), and meet the following guidelines:

a. Admission to IOP treatment requires that the individual does not need medical or sub-acute detoxification, or there is minimal risk for withdrawal, or the individual can be safely managed by a personal medical doctor's outpatient detoxification program;
   i. the individual does not have a biomedical condition or chronic mental disorder (e.g., uncontrolled bipolar disorder, active psychosis) which would *significantly interfere* with their ability to attend and participate in a structured outpatient setting; and
   ii. little or no risk for harm to self or others.

b. If a client is already admitted to another level of treatment and is in need for a higher level of care, the provider submits a Change in Level of Care form to the AMS. *See Change Level of Care tab in MCOSA Provider Manual, Data Instructions, for further information.* If a client presenting to for intake at an outpatient agency meets ASAM criteria for

IOP, ASAM criteria must be listed in the diagnostic formulation section of the FOCUS admission and clinical justification provided in the authorization request.

c. IOP is a Community Grant, HMP and Medicaid covered benefit. Aftercare treatment in an outpatient setting is the standard of care and it is expected that a referral be arranged prior to the client's IOP discharge.

2. INTENSIVE OUTPATIENT (IOP), ADOLESCENT – Adolescent IOP treatment is a structured outpatient program of at least nine (9) hours of clinical intervention per week, which includes individual and group treatment, recreational, didactic and family counseling, as well as adjunctive services such as case management. Adolescents must attend scheduled treatment sessions, have participation of a parent/surrogate supportive adult, provide verification of attendance at support group meetings, meet the diagnostic criteria for a substance use disorder, demonstrate a commitment to participate in all aspects of the program and be willing to attempt abstinence and meet the guidelines outlined below.

   a. Adolescent IOP services must be provided by practitioners licensed, trained or otherwise privileged to work with adolescents with substance use disorder related problems.
   b. Admission to the Adolescent IOP requires that the adolescent does not need medical or sub-acute detoxification, or there is minimal risk for withdrawal;
   c. The adolescent does not have a biomedical condition which would interfere with their ability to attend and participate in a structured outpatient setting, or if there is a biomedical condition, it can be monitored or managed within the IOP program or concurrently by arrangement with an appropriate treatment provider;
   d. History reflects cognitive development of at least 11 years of age and no history of a severe mental disorder (e.g., uncontrolled bipolar disorder, organic brain syndrome, active psychosis) which would significantly interfere with their ability to attend and participate in a structured outpatient setting. If there is a mental disorder, it can be monitored or managed within the IOP program or concurrently by arrangement with an appropriate treatment provider;

e. There is little or no risk for harm to self or others, but an inability to maintain behavioral stability for more than a 72-hour period; and,

f. Screening for Adolescent IOP services by the AMS ***is required***. Adolescent IOP is a Community Grant and Medicaid covered benefit.

E. OUTPATIENT ADMISSIONS

1. ADULT OUTPATIENT ADMISSION – Adult outpatient treatment consists of ongoing therapeutic intervention in an individual, family and/or group setting which occurs on a regular basis, usually weekly, with individuals who meet the diagnostic criteria for a substance use disorder (see above definitions) and meet the guidelines listed below:

a. In order to qualify for MCOSA funding, individuals receiving outpatient treatment attend scheduled treatment sessions in accordance with their Individualized Treatment Plan as formulated by the client and their therapist/provider team. Provider are required to document client progress towards meeting treatment goals and measure client abstinence through objective measures (e.g., urine screens, also-strip or breathalyzer tests, verification of 12-step attendance, monitored Antabuse use).

b. In order to qualify for MCOSA Community Grant funding, individuals who are receiving outpatient treatment as a "Significant Other", (see above definition) are expected to attend scheduled treatment sessions and comply with the established individualized treatment plan as formulated by the primary therapist and client. Significant Other cases receive funding are limited to 12 sessions, for up to a three (3) month period (see Section IV, Reauthorization of Services). Individual must not otherwise be eligible for mental health services or receiving treatment services elsewhere. Psychiatric evaluation and medication services are excluded from authorization.

c. In order to qualify for Relapse Prevention Services, there must be documentation of current environmental, social, familial, judicial or other stressors that place the client at risk

for relapse. Relapse prevention services will receive funding for a three (3) month period. Individual must not otherwise be eligible for mental health services or receiving treatment services elsewhere. Psychiatric evaluation and medication services are excluded from authorization.

d. Admission to outpatient treatment requires that an individual does not require medical or sub-acute detoxification, there is minimal risk of withdrawal, and the individual does not have a biomedical condition severe or unstable enough to interfere with outpatient treatment;

e. If a mental disorder exists, it appears to be related to the substance use rather than an ongoing, debilitating or chronic major mental disorder, which requires long-term psychiatric intervention and monitoring once the substance use disorder treatment is concluded. There is little or no risk of harm to self or others;

f. If *one or more* of the following are evidenced;
   i. the individual meets the DSM criteria for substance use disorder that is significantly effecting current level of functioning.
   ii. the individual meets the MCOSA definition of a Significant Other (see Section VI for definition), and the case record clearly and consistently documents the effects of the substance use disorder behaviors on the Significant Other.
   iii. the individual has completed an intensive treatment program and requires aftercare services on an outpatient basis.

g. The individual is able to achieve or maintain abstinence without a structured therapeutic program, and has a sufficiently stable home environment, or has a level of motivation and willingness to create a stable home environment that can support abstinence and the ongoing recovery process.

h. Screening by the AMS for outpatient treatment *is not required*. The program may provide an assessment session without authorization; however, an Initial Authorization Request for outpatient treatment must be submitted to the AMS via the MCOSA data system prior to the initiation of treatment, usually prior to second session. See MCOSA data instructions for additional data entry requirements.

2. OUTPATIENT, CHILD AND ADOLESCENT – Child and Adolescent outpatient treatment consists of ongoing therapeutic intervention in an individual, family and/or group setting which occurs on a regular basis, usually weekly, with individuals who meet the diagnostic criteria for a substance use disorder (see Section VI for definitions) and/or those determined to be at risk for developing a substance use disorder, or who are a Significant Other. Children or adolescents receiving outpatient treatment attend scheduled treatment and didactic sessions, provide evidence of abstinence through objective measures (e.g., urine screens, alco-strip testing, parental verification), and comply with the established individualized treatment plan as formulated by the primary therapist, client, and if necessary, parent or guardian.

   Individuals who are receiving outpatient treatment as a Significant Other, are expected to attend scheduled treatment and didactic sessions and comply with the established individualized treatment plan as formulated by the primary therapist, client, and if necessary, parent or guardian. The clinical record must include in the treatment plan goals and objectives regarding the direct effect of substance use disorders behavior on the client, and steps taken to provide Prevention services.

   a. Outpatient services for children and adolescents must be provided by practitioners licensed, trained or otherwise privileged to work with children and adolescents with substance use related problems.
   b. Admission to child or adolescent drug-free outpatient treatment requires that the child/adolescent does not need detoxification, or there is minimal risk or withdrawal.
   c. The child/adolescent does not have a biomedical condition severe or unstable enough to interfere with outpatient treatment.
   d. The child/adolescent does not have a chronic mental disorder and there is little or no risk of harm to self or others.
   e. The child/adolescent has a sufficiently stable home environment to allow for family therapy as a primary treatment intervention tool whenever possible.
   f. Screening by the AMS for Community Grant or Medicaid funded outpatient drug-free treatment *is not required.* Individuals meeting the above medical necessity and ASAM

criteria are authorized for drug-free outpatient services by the AMS via the MCOSA data system.

3. OPIOID MEDICATION ASSISTED TREATMENT (MAT) ADMISSION

A. Short-term and Long-term Opioid Detoxification:

i. Opioid dependent individuals requesting Medication Assisted Treatment detoxification are admitted into a detoxification track only upon the recommendation of the MAT physician. If the AMS authorized Community Grant, HMP, MI Health Link, or Medicaid funded recipients for short or long-term detoxification, the AMS clinician will discuss the referral with the program physician, who must then recommend short or long-term detoxification, prior to the recipient initiating detoxification services.

ii. Individuals who request a short-term Medication Assisted Treatment detoxification may not be admitted into the long-term detoxification track without medical approval, and should display considerable motivation to become narcotic free, including a supportive network of family and/or friends.

iii. Individuals admitted into the Medication Assisted Treatment detoxification track must engage in counseling (individual, group, didactic) based on the individual plan of service.

iv. Each individual admitted to a Medication Assisted Treatment detoxification program is required to submit to a urinalysis schedule as prescribed under state and federal guidelines.

v. Individuals dependent upon substances in addition to opioids are eligible for admission. The cross-addiction must be addressed in treatment with appropriate goals and objectives placed into the individualized treatment plan.

vi. Each Community Grant funded client is provided with the Letter of Agreement regarding the MCOSA funding guidelines and criteria for discontinuation of MCOSA funding. The client must read, sign and date the Letter of Agreement, a copy of which must be

placed in the client case record, in order to be eligible for Community Grant funding.

vii. Screening by the AMS for short or long-term Medication Assisted Treatment detoxification ***is required*** for Community Grant, HMP and Medicaid funded clients.

B. Medication Assisted Treatment (MAT) Maintenance

i. An individual is eligible for admission to a medication assisted treatment program (MAT) based on ASAM criteria and level of opioid use disorder. Methadone assisted treatment required the individual to have one year or longer history of severe opioid use disorder, meet the MDCH criteria for methadone as an adjunct or meet the 42-CFR, Part 8, Certification of Opioid Treatment Program's exception criteria, such as pregnancy, and is deemed appropriate by the programs physician.

ii. Individuals authorized for MAT must attend scheduled treatment and didactic sessions, as indicated in the individualized Master Treatment Plan. Less intensive clinical services are provided during the maintenance phase of treatment, as clinical need reduces.

iii. Clients with no previous MAT experience admitted into the methadone maintenance tract must complete a methadone didactic series within 60 days from admission. The didactic series includes information on methadone, HIV/AIDS, Hepatitis C and other communicable disease risk reduction and other addiction and recovery related topics relevant to the individual client's needs.

iv. Each individual admitted to a Medication Assisted Treatment is required to submit to a urinalysis schedule as prescribed under state and federal guidelines, including opioids, methadone, methadone metabolites, amphetamines, cocaine, cannabinoids and benzodiazepines.

v. Individuals also diagnosed with other substance use disorders in addition to opioid disorder are eligible for admission if the amount and frequency of use are not so severe as to warrant detoxification prior to initiating

methadone treatment. The cross addictions must be addressed in treatment with appropriate goals and objectives placed in the individualized treatment plan. Individuals misusing drugs other than opioids must provide evidence of abstinence through objective measures (e.g., urine screens, alco-strip or breathalyzer tests, verification of 12-step attendance, monitored Antabuse use), and comply with the established individualized treatment plan as formulated by the primary therapist, client, and MAT physician.

vi. Clients stabilized on methadone dosing who are in need of sub-acute detoxification from other drugs of abuse may be referred to Sacred Heart Rehabilitation Center where they can be maintained on methadone while being treated for the other drug or alcohol addiction when approved by the Access Management system.

vii. Screening for MAT by the AMS *is required.* In order to be admitted to treatment and/or placed on the waiting list for funding, if there is one, a screening must be conducted by the AMS.

F. EARLY INTERVENTION

1. Referrals for at-risk youth are made from area middle and high school districts to the Adolescent Outreach Program (AOP). AOP reduces barriers to access, and provides services in the school setting to the highest risk youths.

2. Students can be self-referred or referred by school personnel.

3. At-risk adolescents are identified by school personnel due to their poor school performance, poor school attendance, disruptive behavior, and substance use.

4. Priorities for school-based services include involving the family in treatment.

5. School-based Early Intervention services are time-limited to an average of six (6) sessions.

6. Referrals are made for higher level of care for clients in need of more intensive services.

G. SPECIALIZED CASE MANAGEMENT SERVICES

1. Specialized case management services criteria includes:

    a. Client must be a Macomb County resident
    b. Client must be receiving MCOSA funded SUD services
    c. Client must be active with a Macomb County contracted treatment facility
    d. Client must be willing to commit to case management services
    e. Client needs must meet at least two (2) of the following designated areas of need:
        i. Multiple treatment episodes/relapses
        ii. First time in treatment and lacks a primary support system
        iii. Pregnant substance user
        iv. Open Child Protective Services and/or Foster Care Case
        v. Economic challenges (i.e. food, shelter, clothing, etc.)
        vi. Unstable living arrangement (i.e. living with family member/significant other/friend who uses substances)
        vii. Untreated mental health concerns

2. AMS will screen individuals for the Women's and Families or Medication Assisted Treatment case management services and make a referral based on need.

3. Provider may request a Women's and Families or Medication Assisted Treatment case manager by completing the Level of Care change form located in the FOCUS system.

4. Women's and Families case management services are extended to substance abusing pregnant women, particularly if using drugs by injection, and women with dependent children.

    a. The Women and Families Case Manager will coordinate substance use disorder services, ensure timely access to treatment as appropriate to meet the woman's needs and within the federal priority guidelines, ensure that all recommended services are followed and provide community

based specialized intensive case management services to promote treatment success and recovery.

b. The case manager will also coordinate services needs identified for the woman's dependent children to ensure needs are met according to federal guidelines.

c. The case manager will work with treatment programs to coordinate ancillary service needs for the identified population and assist in identifying and removing barriers to treatment.

5. Medication Assisted Treatment case management services are provided to clients authorized and receiving medication assisted treatment services and/or waiting for funding for Medication Assisted Treatment services.

   a. The Medication Assisted Treatment case manager will provide outreach weekly at the Medication Assisted Treatment agencies to assist any funded client with ancillary service referrals.

   b. The case manager will also coordinate services needs identified for the woman's dependent children to ensure needs are met according to federal guidelines.

   c. The case manager will work with treatment programs to coordinate ancillary service needs for the identified population and assist in identifying and removing barriers to treatment.

H. PEER RECOVERY SERVICES

1. Peer Recovery Services can be accessed at the time the AMS screen is conducted and/or by any contracted network provider throughout the episode of care.

2. Referrals to Peer Recovery Services – AMS
   AMS will screen for Peer Recovery Services and make referrals based on need.

3. Referrals to Peer Recovery Services – Contract Providers

a. Contract providers complete a Change in Level of Care form and submit the form and approved consent form in the MCOSA data system. AMS will approve all appropriate requests and send confirmation to the provider via the data system and contact the Peer Recovery Service provider.

b. Therapists are required to document in the clinical record that the individual has been referred to Peer Recovery Services.

4. Peer Recovery Program Supervisor reviews each referral and assigns a Peer Recovery Coach to the individual based on the specific needs to the individual.

5. Peer Recovery Coach contacts the individual within one (1) business day of the receipt of the referral.

6. Peer Recovery Coach meets with the individual face-to-face within one (1) week of the initial contact to provide an orientation with the client and complete all the required paperwork in order to begin services.

7. Peer Recovery Coach completes a Recovery Plan and administers the Self-Sufficiency Matrix by the second visit.

8. All contact with the individual via phone or face-to-face is documented in contract provider record.

I. ACCESS MANAGEMENT SYSTEM (AMS)

1. Individuals in Macomb County, who are affected by substance use disorder, either directly or indirectly, as a Significant Other/Co-dependent, may access referral services through the AMS.

2. Individuals seeking publicly funded sub-acute detoxification or intensive treatment (residential and medication assisted treatment) are required to be pre-screened for eligibility for those services by the AMS.

3. Adults seeking screening and referral services at the AMS are not charged a fee for those services.

4. The AMS, as required by the Department, uses a standard screening tool which incorporates parts of the Addiction Severity Index for adult screening, the ADAD for adolescents and a comprehensive substance use disorder history. This information and the American Society of Addiction Medicine's Criteria are used to make a final determination regarding placement for individuals seeking prior authorization for funded intensive services.

5. The AMS utilizes, in addition to guideline 4 above, the MCOSA QA Guidelines in making placement decisions for individuals seeking non-intensive services or placement in service categories not covered by the ASAM Criteria. Readmission to intensive treatment also requires meeting MCOSA readmission criteria as well as a review of previous intensive treatment episodes,

6. AMS screening information is available in the data system to the provider once a valid release of information is received at the AMS. The AMS screen provides the treatment agency with the results of the level of care determination via the ASAM Criteria, diagnostic impression of the latest version of the DSM and the number of days of services recommended for intensive service levels.

IV. REAUTHORIZATION AND READMISSION

A. PROTOCOL FOR THE CONTINUATION OF OUTPATIENT TREATMENT

1. An individual who has been approved for MCOSA Community Grant, HMP, MI Health Link, or Medicaid funded outpatient substance use disorder treatment, are eligible for additional services as requested on a Reauthorization Request form submitted via the MCOSA data system, based on medical necessity and ASAM criteria. See MCOSA data instructions for specific information on submission time frames and requirements. This data review determines whether an individual qualifies for reauthorization of funding for outpatient treatment services, and if not, transfer to a more appropriate level of care or discharge. Note: Programs should refer to the ASAM Criteria for a comprehensive discussion of rationale for continued stay for substance use disorder treatment across levels of care.

2. The MCOSA Reauthorization Request should be completed based on documentation in the progress notes, treatment plan updates, additional treatment plan goals and objectives, etc.

3. Each Reauthorization Request form submitted via the MCOSA data system must clearly indicate the length of abstinence, date(s) of last use/relapse, rationale for reauthorization as indicated by progress towards accomplishing treatment plan goals, and estimated length of stay (see MCOSA data instructions). The reauthorization request must reflect documentation in the clinical record of the need for continued treatment. The current treatment plan must accompany the request for services.

4. Individuals admitted with a substance use disorder diagnoses who have not demonstrated progress towards treatment goals, should be re-evaluated for referral to an alternate treatment modality/intensity based on ASAM Criteria; or the request should clearly state revisions to the treatment plan that support currently level of care. The Individualized Treatment Plan revisions should clearly identify areas of their treatment that requires specific focus in order for recovery goals to be achieved. Individuals who have achieved treatment goals and meet ASAM Criteria for discharge would not require further services or authorization.

5. Individuals admitted with diagnoses of substance use disorder who are making demonstrated progress towards goals and objectives established in the treatment plan, are eligible for additional MCOSA funded treatment as clinically appropriate. The reauthorization request should reflect the amount of time requested by the primary therapist to allow for the completion of the treatment plan goals. This time is often used for the consolidation of treatment gains and to focus on the prevention of relapse.

6. Individuals admitted under the Significant Other criteria are not eligible for Community Grant funding beyond 12 sessions within a three month period of time.

7. Children or adolescents admitted under the early intervention criteria, may have additional treatment authorized with documentation of the progress attained and rational for reauthorization beyond three months when extenuating circumstances exist (e.g., deterioration in home environment, return

to past peer contacts) if still meeting ASAM Criteria for this level of care. Otherwise, clients needing a higher level of care, such as Outpatient treatment, should be referred to office/clinic based treatment provider.

8. Individuals admitted for Relapse Prevention are not eligible for reauthorization. The maximum length of funding for Relapse Prevention is three (3) months.

9. Individuals admitted for aftercare from a more intensive level of treatment are eligible for reauthorization based on medical necessity and ASAM criteria. Additional funds approval is based on continued medical necessity and meeting ASAM Criteria.

10. Individuals who have completed the identified treatment plan goals and objectives, according to the information submitted by the program in the MCOSA Reauthorization Request and/or client record, will not be approved for continuing services as medical necessity would not be met.

B. PROTOCOL FOR THE CONTINUATION OF MAT

The Michigan Department of Community Health's Criteria for Opioid Dependent Substance Use Disorder Treatment with Methadone as an Adjunct contains a description of continued stay requirements, incorporating the ASAM Continued Stay Criteria for MAT, federal certification and state licensing regulations. MCOSA contracted MAT providers should utilize these criteria when looking to continue care. Additionally, MCOSA has established guidelines for waiting list management and discontinuation of funding for non-compliance

1. A request for reauthorization of MAT services should be based on documentation in the record including: progress notes, treatment plan updates, medical and nursing notes, additional treatment plan goals and objectives, attendance, motivation, drug screen results, etc., and is submitted via the MCOSA data system as described above and include the current treatment plan.

2. The Reauthorization Request form must clearly indicate the length of abstinence from illicit opioids as well as other drugs of abuse, the date(s) of last use/relapse, rationale for reauthorization as indicated by progress towards treatment plan goals and estimated length of

stay. (*See the MCOSA Data Instructions for Reauthorization Request information specific to MAT.)*

3. Individuals who are not making progress in treatment despite revisions to the treatment and team consultation may not be appropriate for an outpatient level of treatment. The provider should work with AMS and the client to determine the most appropriate level of care or additional services for the client (i.e, case management, peer recovery coach services, etc.). Serious violations of MAT program policy, in accordance with OROSC policies, may result in transfer of the client to administrative detoxification and/or referral to an alternative treatment modality. The program is responsible for coordinating this with the AMS.

4. Clients found in violation of rules that result in immediate discharge (e.g., violence, diversion of medication, buying or dealing drugs should be immediately referred to the AMS for further assistance.

5. Clients whose funding is discontinued for any reason are to be given a referral to an alternative treatment program via the AMS or assisted by the agency in establishing alternative funding sources for treatment.

6. Per the Administrative Rules for Substance Use Disorder Programs in Michigan, Federal requirements and the Department's criteria, the program is required to document that an MAT client continues to meet the medical necessity criteria and the ASAM criteria for MAT for services beyond the initial 24 months, and then annually thereafter. The program completes the 24 month evaluation based on the medical and clinical judgment of the program's physician, and documents results in the clinical record.

C. PROTOCOL FOR CONTINUATION OF FUNDED TREATMENT FOR OTHER MODALITIES

1. Continuation of Sub-acute Detoxification:

   a. Normal length of stay for sub-acute detoxification is up to five (5) days. When detoxification cannot be completed within that time, the Medical Director must document a need for continued stay with rationale for each 24 hours beyond the 72-hour period. A reauthorization request must be

submitted in the MCOSA data system indicating the rationale for continued stay beyond the initially authorized request (see MCOSA Data Instructions).

b. Utilization reviews by program medical and clinical staff are required for all cases where length of stay exceeds five (5) days.

2. Continuation of Residential Treatment:

a. Requests for extension of residential services must be submitted on a Reauthorization Request form via the MCOSA data system. Since the turnaround time is very short, the program must submit a reauthorization request in sufficient time for the AMS to review and respond prior to the scheduled client discharge (three (3) business days).

b. Reasons for extended length of stay must be clearly documented in the clinical record, including need and rationale for extension and documentation that the client meets ASAM Criteria for the requested level of care.

3. Continuation of Intensive Outpatient (IOP):

a. Standard length of stay for IOP is stipulated in the individual contractual agreement. Requests for additional IOP sessions need to be support by ASAM criteria and progress towards treatment plan goals. After completion of the IOP, the agency should initiate an intra-agency transfer to aftercare treatment.

b. Request for extension of IOP services must be submitted on a Reauthorization Request form via the MCOSA data system. Since the turnaround time for such requests is short, it must be submitted in sufficient time for the AMS to review and respond prior to the client's scheduled discharge (three (3) business days).

D. READMISSION PROCEDURES

1. Each case of repeated admission (generally within the previous six month period of time) to a contract program must include a

readmission summary/admission update. The summary must include the following: analysis of previous goals and objectives, narrative explanation of the reasons for leaving previous treatment, the course and outcome of the previous treatment, and reason for seeking readmission. The summary may be included in a standard intake assessment procedure. A readmission summary/admission update cannot be completed on a previous readmission summary. In this instance, a complete assessment must be conducted.

2. Clients seeking readmission must meet the MCOSA guidelines for admission to the appropriate service element, demonstrate medical necessity and meet the ASAM Criteria for admission to the requested level of care.

3. This readmission policy does not apply to detoxification clients.

4. Readmission to residential and MAT requires screening by the AMS.

5. Individuals may be screened by the AMS for referral to the extent that they continue to experience substance use related problems. The AMS monitors substance use referrals to outpatient and intensive services for excessive utilization, dual enrollments, and multiple requests for services and follow-up for aftercare compliance.

E. INTRA-AGENCY TRANSFER PROCEDURES

1. A comprehensive assessment update must be completed within five (5) days of the date of transfer to the new level of care and within 30 days of discharge from the previous service category.

2. A treatment plan update identifying needed goals and objectives related to the transfer or issues identified in the Comprehensive Assessment Update, must be placed into the treatment record before treatment in the new level of care begins.

3. This policy does not include changes from detoxification into a more restrictive service.

V. CLINICAL DOCUMENTATION PROTOCOL

A. CLINICAL ASSESSMENTS

Treatment programs are required to utilize the ASAM Criteria for placement and treatment planning.

Dimension 1: Withdrawal/Detoxification Potential:
- Substance use assessment
- Medical assessment

Dimension 2: Biomedical Conditions and Complications:
- Medical assessment
- Nutritional assessment

Dimension 3: Emotional/Behavioral/Cognitive Conditions & Complications:
- Emotional assessment and status
- Behavioral/Psychological/Cognitive assessment
- Family or Origin assessment
- Current family

Dimension 4: Readiness to Change:
- Substance use assessment
- Legal assessment, internal versus external motivation
- Identification of the Stage of Change for primary and secondary issues

Dimension 5: Relapse/Continued Use Potential:
- Substance use assessment
- Recreational assessment
- Vocational assessment

Dimension 6: Recovery Environment:
- Substance use assessment
- Current family assessment
- Social assessment
- Cultural assessment
- Vocational/Educational assessment
- Recreational assessment
- Spiritual assessment; outside supports

1. Initial Assessment Process

    a. An initial assessment must be placed into the case record before treatment commences or within three (3) working days of the intake date.
    b. The initial assessment must include a complete presenting problem statement.
    c. The initial assessment includes major factors in the following areas as they impact directly on the presenting problem; only

the relevant data need be included, unless no other assessment is to be completed. In that case, the initial assessment must address all six ASAM Dimensions listed above.

d. The initial assessment determines whether a physical examination is required. This assessment is based on the client's report of medical problems, medication prescribed and taken, and/or the date of the most recent physical examination.

e. The initial assessment determines whether a psychiatric and/or psychological evaluation is needed for diagnostic clarification or treatment purposes.

2. The Comprehensive Assessment Process

a. A Comprehensive Assessment must be placed in the client's file by the third treatment session or 30 calendar days after intake, whichever occurs first.

b. A Comprehensive Assessment includes a detailed analysis and formulation for all areas listed in Section VIII, A-1 (Initial Assessment) above, including the need for a medical or psychiatric consult.

c. A Clinical Assessment Summary outlines the salient aspects of the client's history as applied to the presenting problems toward the goal of creating a treatment plan.

d. A diagnosis (or diagnoses) is/are determined on the basis of the data contained in the Initial and Comprehensive assessments. The diagnosis/diagnoses conform(s) to the criterion set out in the latest version of the DSM and ICD manuals.

e. The Comprehensive assessment may include a summary of the above required elements contained within the six ASAM dimensions.

B. INDIVIDUALIZED TREATMENT PLANNING

Individualized treatment planning is an integral process that directs, guides, and determines the nature and type of intervention to be delivered. This process is dynamic and should be updated as changes occur in the client's functioning.

1. Initial Treatment Plan

a. An Initial Treatment Plan including goals, objectives, and time frames must be in the client's file upon completion of the clinical assessment or within three (3) working days of the intake date, but prior to the beginning of treatment.
b. No treatment regimen may begin without at least an Initial Treatment Plan.
c. The Initial Treatment Plan is individualized and specifies needed services and/or referrals to ancillary services, as indicated in the initial assessment.
d. The client participates in the formulation of the Initial Treatment Plan, as indicated by a client signature demonstrating agreement with the written plan.
e. Each treatment plan has goals that are individualized and written in the language of the person served.
f. Each treatment goal has objectives that are measurable and contain specific intervention methods/techniques that include the date of expected achievement.
g. Each treatment goal has at least two (2) objectives.

2. Master Treatment Plan

a. The Master Treatment Plan including goals, objectives, and time-frames must be fully developed and in the clients file by the third (3rd) treatment session, or thirty (30) calendar days after intake, whichever comes first.
b. The Master Treatment Plan is individualized and specifies needed services and/or referrals as indicated in the initial and comprehensive assessments.
c. The client participates in the formulation of the Initial Treatment Plan, as indicated by a client signature demonstrating agreement with the written plan.
d. Each treatment plan has goals that are individualized and written in the language of the person served.
e. Each treatment goal has objectives that are measurable and contain specific intervention methods/techniques that include the date of expected achievement.
f. Each treatment goal has at least two (2) objectives.
g. Should the client have a goal of abstinence, there must be an objective to measure abstinence included in the treatment plan.

h. Should the client have previously been prescribed medical marijuana to treat a mental health or substance use disorder, there must be a goal in the treatment plan to address working toward an evidence-based alternative to treat that disorder.

3. Treatment Plan Update

a. The treatment plan must be formally evaluated as changes occur in the client's condition, or at a minimum of every 90 calendar days.
b. The treatment plan update process identifies progress toward goals and objectives from the treatment plan. Identification of goals achieved, deferred or continued, and subsequent updating of the Master Treatment Plan is to be completed at this time.
c. The treatment plan update includes new goals and objectives, as appropriate.
d. The treatment plan update is reviewed and approved by a licensed or certified clinical professional as evidenced by a signature with the approved credentials.
e. The client participates in all treatment plan updates as evidenced by the client's input and signature.
f. The need for additional services is included in the treatment update, i.e., psychiatric consultation, medical services, housing services, etc.

C. PROGRESS NOTES

1. Each session must have an accompanying progress note. Each progress note must reflect a specific treatment plan goal. The stage change throughout the treatment episode is also documented in the progress note. Each progress note must contain the following:

a. Focus, intervention, and client response segment;
b. Date, clock-time, and the type/modality of the intervention performed;
c. Signature of the treatment practitioner complete with applicable credentials; and
d. Clear, concise language written in a legible fashion.

2. Progress notes must be placed in the client's file no later than forty-eight (48) hours after the end time of that treatment session. Failure to complete a progress note within this time frame may result in financial consequences to the program if identified on a Quality Assurance Audit or Financial Review.

3. All client-related activities/data must be recorded in the record. This includes, but is not limited to, phone calls, correspondence, no-shows, etc.

4. When substance use during treatment is addressed, quantitative documentation is required to be documented in the chart. For example, the results of the urinalysis, breathalyzer, dates of last use/relapse, etc.

5. All progress notes from individual or group (process/didactic) therapy sessions that are placed into the clinical record are required to be the original and not photocopies.

6. Progress notes must not be altered with correction fluid, correction tape or similar agents. Errors must be crossed out with a single line, dated and initialed, and the correction written next to the error. Corrections to a typed or word processed document should be the same as with a written document. Scribbling over, writing or otherwise altering a record is not acceptable documentation procedure. Progress notes should be written in permanent blue or black ink, and should never be written in pencil or other nonpermanent means. Progress notes that are typed must contain an original signature. All progress notes need to be free of typographical errors and should be reviewed and corrected prior to entering them in the clinical record.

D. AFTERCARE

1. Aftercare plan is developed with the input of the client to address continuing care needs with regards to transferring to another treatment program and/or providing medical, psychological, legal, and community support services.
2. The program, as part of case management activity, is required to follow-up with all referrals to other treatment programs to determine whether the client has contacted the new program. Additionally, the program is required to maintain compliance with 42 C.F.R. and

45 C.F. R. Parts 160 & 164 regarding confidentiality of substance abuse records.

E. DISCHARGE

1. If there has been no client contact for thirty (30) days, then the record is required to be discharged from the MCOSA system. Exceptions to this guideline would need to be clearly documented in the record, e.g., client called away on a family emergency.

2. A discharge summary must be placed into the client's file within ten (10) working days from the date of the last scheduled treatment session; or, ten (10) working days following documentation that there has been no client contact for thirty (30) days and the client is discharged. Attempts to contact the client to return to treatment, by mail or by phone, should be documented in the clinical record prior to actual discharge.

3. The discharge summary includes the following elements:

   a. A summary of the presenting problem and initial diagnosis.
   b. The progress toward the goals and objectives contained in the client's treatment plan.
   c. The significant cumulative treatment findings.
   d. A final assessment that conveys an understanding of the client's initial condition, treatment, and discharge status.
   e. Recommendations and arrangements for further treatment, name of referring agency, address, date and time of follow-up appointment.
   f. Referrals for additional services needed such as housing, medical, psychiatric appointment, etc.
   g. The final primary and secondary diagnoses.

4. Individuals may be discharged for documented noncompliance with the program's written rules. The client must be given an explanation as to the nature and justification for discharge from the program. For Medicaid recipients, discharge for any other reason than a mutually agreed upon termination decision, requires contact with the access center for assistance in determining the need for an alternative level of care, identification of barriers to treatment and/or other case management assistance.

5. For Medicaid recipients, any premature discontinuation of authorized treatment must be coordinated by the Access Center, per the Medicaid Administrative Fair Hearing requirements. (See the MCOSA Provider Manual for a description of the Medicaid Fair Hearing procedures and for issuance of Advanced or Adequate Notice of the termination of services and local appeal and grievance procedures.) Note, that if the client and therapist mutually agree to discontinue authorized treatment services, and that statement is documented in writing and placed in the record, no notice is required.

VI. QUALITY ASSURANCE AUDIT AND RECORD REVIEW

A. QUALITY ASSURANCE (QA) AUDIT COMPLIANCE PROCESS

All MCOSA Community Grant, HMP, MI Health Link, and Medicaid funded cases may be included in the audit process. The purpose of the audit is to provide feedback to contract providers regarding compliance with the QA Guidelines and to assist contract agencies in providing quality services which are consistent with the expectations of the contract. The results of the QA Audits are also used by MCOSA as part of the Annual Fund Application review process related to meeting quality assurance standards and continuous quality improvement efforts.

All clinical records must have a MCOSA Fee Agreement Form, completed in full, reviewed and signed by the agency representative at the time of admission.

Authorization must be made by the Program Director, Clinical Director or other approved designee. MCOSA cannot retroactively reimburse cases where a Fee Agreement is missing or is not authorized by the program, if identified on a QA Audit or Services Verification Review.

1. Case Record Audit Compliance

   a. Case record audit compliance is defined as the percentage of the applicable standards that have been met on each of

the cases sampled for the review. (Refer to attachments for MCOSA QA Evaluation Form.)

b. A case record with a quality score of below 90% may result in comments and/or specific recommendations by MCOSA on the Evaluation Form and/or in the narrative report.

c. A case record with a quality score of 75% or lower may result in denial of funding for the entire case in question.

d. A record selected for full review that is found not to meet the MCOSA criteria for admission (refer to QA Guidelines, Section VI), is ineligible and automatically denied funding. These cases are excluded from further review. Another case may be selected for full review as a replacement.

e. When funding is denied as a result of incomplete or insufficient documentation or based on audit findings, the program is held financially responsible for all services rendered and not MCOSA nor the client. Once the documentation is corrected, MCOSA may consider resuming funding from the date on which it was corrected (refer to the QA Audit Appeals section).

f. Under circumstances in which a case qualifies for funding, but is denied due to deficiencies in the documentation and a Service End Date/Lapse Date has been set, the program retains the responsibility for providing treatment to the individual as clinically indicated. A Service End Date/Lapse Date is the day on which MCOSA funding ceases, and is not to be construed as the date the client must be discharged from the program (refer to section VIII-D, regarding Discharge Procedures).

2. Agency Audit Compliance

The Quality scores for the individual case records reviewed are averaged to provide the agency's Audit Compliance Quality Score.

a. An average compliance rate of 85% or higher is expected for each contract program.

b. An overall quality score of below 90% may result in comments and/or specific recommendations by MCOSA on the Evaluation Form and/or in the narrative report.

c. A noncompliance Quality Audit Score of 80% or below will result in one of the following:

    i. Submission of a Corrective Action Plan, and/or;

ii. Financial payback.

B. QA AUDIT PROCEDURES FOR OUTPATIENT SERVICES (INCLUDING MAT)

MCOSA selects a sampling of Admission cases on a regularly scheduled basis, depending on the average Quality Score from the previous audit. Agencies with an average Quality Score below 80% for two consecutive audits may be reviewed more frequently until the overall Quality Score reaches 80% or above. If there are issues that persist across audits, MCOSA reserves the right to audit more frequently despite a score that reaches 80%.

1. A list of new admission and continuation cases will be generated by MCOSA from those entered in the MCOSA data system and forwarded to the program approximately one (1) week prior to a Quality Assurance Audit.

2. On average, ten (10) cases are reviewed for compliance with the QA Guidelines. If a pattern is identified during the audit which suggests noncompliance with the QA Guidelines or MCOSA contract, MCOSA has the option of scheduling a return visit to explore these areas further.

3. For each case reviewed for compliance with the QA Guidelines, a MCOSA Evaluation Form (see Appendix for the most up to date version) is completed, which includes the auditor's comments, recommendations, reauthorization review dates, Service End Dates/Lapse Dates, comments, and the QA Quality Score.

C. QA AUDIT REVIEW PROCEDURES FOR RESIDENTIAL AND INTENSIVE OUTPATIENT

1. MCOSA selects a sampling of Admission cases on a regularly scheduled basis, depending on the average Quality Score from the previous audit. Agencies with an average Quality Score below 80% for two consecutive audits may be reviewed more frequently until the overall Quality Score reaches 80% or above. If there are issues that persist across audits, MCOSA reserves the right to audit more frequently despite a score that reaches 80%.

2. A list of randomly selected new admission cases and open cases will be generated by MCOSA from those entered in the MCOSA data system and forwarded to the program approximately one week prior to a QA Audit. Transfers from Intensive Outpatient to aftercare may be reviewed as new admissions or as part of the Reauthorization Review process.

3. On average, ten (10) cases are reviewed for compliance with the QA Guidelines. If a pattern is identified during the audit which suggests noncompliance with the QA Guidelines or MCOSA contract, MCOSA has the option of scheduling a return visit to explore these areas further. If more than one service category is reviewed, a selection of cases from each category will be identified. The sample will not be expanded during the scheduled audit. If a pattern is identified during the audit which suggests noncompliance with the QA Guidelines or MCOSA contracts, MCOSA has the option of scheduling a return visit to explore these areas further.

4. The MCOSA Fee Agreement should be maintained in the client record. The Fee Agreement must be filed in a standard manner and easily accessible to the auditor.

5. For Intensive Outpatient cases that have been transferred to Outpatient services within the same agency, and Outpatient cases that have transferred to Intensive Outpatient services within the same agency, the MCOSA data Discharge and Admission Forms should be completed. However, completion of a new Fee Agreement Form is not necessary. Per the Fee Agreement Instructions, reassessment of the client's ability to pay may be re-determined at the time of transfer, and should be updated in the MCOSA data Financial Screen and on the Fee Agreement Form under Revised Reimbursement Level, as necessary. For each subsequent change in reimbursement Level, the Director, Clinical Supervisor, clinician or designee should review the change, sign and date the Fee Agreement, then have the client review and initial the change.

6. For those cases selected for full review, the MCOSA Evaluation Form is completed, which includes the auditor's findings and any comments or recommendations, and a Quality Score.

7. Intensive outpatient and Residential (short-term, long-term and sub-acute detoxification) cases must have a valid Initial Authorization/Reauthorization in the data system. The program should review the AMS screen, which contains the level of care decision and additional clinical data, once it is released to the program.

8. For specialty, out-of-county and non-panel Medicaid providers, MCOSA selects a sampling of admission cases based depending on utilization of services.

D. PROGRAM REVIEW FEEDBACK PROCEDURES

A QA Audit report will be provided to the program within ten (10) business days of the QA Audit date. Holidays and furlough days will not be counted in the ten (10) business days.

1. Approval and Denial Parameters for Treatment Cases – The QA Audit report includes a narrative summary of the audit results, including areas of improvement and/or areas found not to be in compliance with QA or contract requirements. A copy of the Evaluation Form in included for each case reviewed during the audit period. Cases requiring financial adjustments are noted on the individual Evaluation Forms, on a separate Financial Adjustment Form, and on the QA Audit Report.

2. Outpatient Reauthorization Approval and Denial Procedure – The QA Audit Narrative Report also includes a summary of Reauthorization Review cases seen for full review. Eligible reauthorization cases for Outpatient programs are reviewed via the MCOSA data system at ninety (90) days or when authorized services are due to be used completely. MCOSA reviews the request against the documentation in the record for accuracy, clinical relevance and timeliness.

3. Services End Dates/Lapse Dates – A Services End Date/Lapse Date is the date that MCOSA funding ceases on a case, either due to a denial of funding, the client being discharged or the client having exhausted available funding. The Services End Date may also represent the Lapse Date on an Initial Authorization or Reauthorization Response Form. If a Service End Date for

funding is set, MCOSA sets the Authorization Lapse Date in the MCOSA data system to reflect the Service End Date.

4. Appeal Process – All cases where funding has been denied or a Service End Date has been set, are subject to appeal by the agency within five (5) working days from the receipt of the narrative review report. All appeals must follow the formal appeal process as specified in Section VII.C.

VII. MCOSA QA AUDIT AND SERVICES VERIFICATION REVIEW APPEAL PROCESS

A. Appeals may be submitted when the contract agency does not agree with the results of the QA Audit, which may require a Corrective Action Plan and/or financial payback. A financial payback may be requested on an individual case record review that did not achieve a quality score of at least 80%.

B. Appeals may be submitted from the annual Financial Service Verification Review of the records which compares documentation in the record against billings submitted for a particular audit period. A separate narrative report and review form is forwarded to the program identifying the percentage of errors and/or irregularities, if any are noted.

C. Appeals Process – Three Levels

1. The first level requires the submission of an appeal by the agency to the MCOSA QA Coordinator.
2. The second level involves an appeal to the MCOSA Assistant Director. The second level appeal occurs when the agency disagrees with the first level appeal decision made by the QA Coordinator.
3. The third level appeal is made to the Appeals Committee, whose decision is final, when the agency disagrees with the decision of the Assistant Director.

D. The Contract Program Director or Clinical Supervisor has five (5) working days after receipt of the QA Audit Report to submit a MCOSA Level One written appeal to the MCOSA QA Coordinator.

E. The Contract Program Director or Clinical Supervisor has five (5) working days after receipt of the Service Verification Review report to submit a

MCOSA Level One written appeal to the MCOSA Data and Finance Coordinator.

F. The Level One Appeal is completed on the MCOSA Level One Appeal Form (see attachments for Appeal and Response Forms). One form must be completed for each case to be appealed, and the appeal must be approved by the Contract Program Director or Clinical Supervisor. The MCOSA QA Coordinator responds in writing on the Level One Appeal Response Form, within five (5) business days of the date received by MCOSA.

G. The program may submit a Level Two Appeal Form to the MCOSA Assistant Director within five (5) working days of the receipt of the Level One appeal Response Form from MCOSA. The Level Two Appeal must be completed on the Level Two Appeal Form. One form should be completed for each case to be appealed. The Level Two Appeal Response Form will be returned from the MCOSA Assistant Director within five (5) working days after receipt of the Level Two Appeal from the program.

H. The program may submit a Level Three Appeal Form to the Appeals Committee within fifteen (15) business days of receipt of Level Two Appeal decision. The Appeals Committee submits a final decision to the contract agency within fifteen (15) business days from submission.

I. Appeal cases to be presented to the MCOSA reviewer at the next scheduled audit, do not appear on the Audit Report and will not be requested by MCOSA at the time of the audit. It remains the program's responsibility to ensure that the appeal case is presented at the next scheduled QA Audit. Failure to present the record may result in a financial adjustment for the record in question and a forfeiture of the appeal.

VIII. GRIEVANCE, LOCAL APPEAL AND FAIR HEARING PROCEDURES

The Michigan Department of Community Health (MDCH) requires that MCOSA provide information to recipients of funded substance use disorder services regarding consumer complaints or grievances and for Medicaid/Healthy Michigan Plan recipients, the Local Appeal and Administrative Fair Hearing process. MCOSA developed a "Dear Consumer" letter to be presented to each Medicaid/HMP recipient upon admission to the treatment provider. A "Dear Consumer" letter for Reauthorization of services is provided to each recipient when the program receives the Reauthorization Response via the MCOSA data

system. (See the MCOSA Provider Manual for further information regarding consumer complaints and grievances, Local Appeals and Administrative Fair Hearings.)

The local complaint process (grievance for Medicaid recipients), a Medicaid Local Appeal, as well as the Administrative Fair Hearings for Medicaid recipients, may be pursued in place of, in addition to, or simultaneous to the State's Recipient Rights for Substance Use Disorder Services clients.

IX. COMMUNICABLE DISEASE POLICY AND GUIDELINES

It is the policy of MCOSA that contract agencies complete a Communicable Diseases Risk Screen on each admitted client toward the identification of high-risk behaviors/events for HIV, Hepatitis, sexually transmitted diseases (STDs), and Tuberculosis (TB), promote knowledge of high-risk behaviors and effect voluntary referrals for health screening where applicable, and provide case management and follow-up on referrals. (See attachments for the Communicable Diseases Risk Screen Form and Instructions.)

It is required by the Department that individuals contracted by MCOSA to provide substance use disorder services, either prevention or treatment, demonstrate the minimum knowledge requirements related to HIV/AIDS and Substance Use Disorder. If unable to demonstrate the minimum knowledge requirement, they must do so within six months of hire or of agency approval to provide substance use disorder treatment within the organization (e.g., via Staff Credentialing or Professional Service Agreements).

A. DOCUMENTATION

1. Identification of a client's HIV/AIDS status in the case record must comply with the MDCH Public Health Guidelines and 42 CFR and 45 CFR, Parts 160 and 164.
2. The information regarding an individual's risk status for communicable diseases is documented in the case record on a Communicable Diseases Risk Screen.
3. The agency documents on the Communicable Disease Risk Screen any written and/or verbal instructions that have been provided to the client about the transmission of HIV/AIDS, STDs, Hepatitis, or TB.

4. If the client is deemed to be at risk for Hepatitis, HIV/AIDS, STDs, or TB, the agency includes documentation in the individual's case record that a referral was made for a health screen through either the client's personal physician, the public Health Department, or other appropriate agency.

5. If a referral has been made based on risk for communicable disease, the record must contain information relating to the outcome of that referral. The provider does not need to document the results of the referral, only if and when it was completed and if not, any further steps that are taken to encourage the client to seek appropriate care.

B. RISK SCREEN GUIDELINES

1. An individual is determined to be at high risk for HIV/AIDS, STDs or Hepatitis when one or more of the following apply:

    a. The individual engages in unprotected sexual interaction with a partner or partners where the health status is unknown.
    b. The individual engages in unprotected sexual interaction with a partner or partners where the HIV/AIDS, STD or Hepatitis status is known to be positive.
    c. The individual has used needles or shared injecting needles.
    d. The individual has experienced blood-to-blood or body fluid contact, i.e., blood transfusions, hemophilia treatments, employment in the medical field, etc.
    e. The individual is a child whose mother was known to have been an HIV high-risk candidate and in which exposure could have occurred in utero, during delivery, or as a product of breast feeding.

2. An individual is determined to be at high-risk for TB when one or more of the following apply:

    a. The individual is currently or has recently lived in a substance use disorder residential treatment facility, half-way house, homeless shelter, drug house, jail/prison, mental hospital, or in close quarters with persons of unknown health status, such as migrant housing.

b. Was born in or recently traveled to a region with a high rate of TB, e.g., Asia, Latin America, Africa, and India.
c. Has recently had close contact with someone diagnosed as having TB.
d. The individual has a chronic cough and one or more of the following symptoms: weight loss, fever for three days or longer, night sweats, or coughs up blood.
e. The individual has tested positive for HIV or has been diagnosed with AIDS.

3. All pregnant women need to be provided with a referral for HIV/AIDS, Hepatitis, TB, and other STD screening.