MCCMH-SUD
New Provider Training

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Macomb County Community Mental Health's SUD Department receives federal, state and local funding.

Agenda

- Clinical Processes
  - Referrals
  - Intake
  - Authorizations
- Clinical Documentation
  - Assessment and ASAM Continuum
  - Treatment Planning
  - Changes to Level of Care and Recovery Housing
  - Discharge
- Administrative Requirements
  - Organization Registrations/Certifications
  - Staffing and Training
  - Required Reporting
- FOCUS EMR
  - Access and Functionality
  - Billing

Communications and Contacts

Communication

- SUD Updates – Monthly newsletter
- Network Provider Meetings – Quarterly, in Person
- Flash Updates – priority notifications distributed via email to subscribers of SUD Updates Newsletter

Contacts

- Nicole Gabriel – Director
  - Nicole.Gabriel@mccmh.net
  - Contracts
- Nicole Palazzolo – Coordinator
  - Nicole.Palazzolo@mccmh.net
  - Quality Assurance TA
  - Recipient Rights and Grievances
  - FOCUS removals
  - Incident/Death Reports
- Adam McHenry – Administrator
  - Adam.mchenry@mccmh.net
  - FOCUS errors/issues
  - SUDHH
  - Reports

Referral Processes

Outpatient Referral Process

- Providers may receive referrals from MCCMH-SUD contracted residential or detox providers, MCO (Managed Care Operations) or direct calls from the community.
- Intakes should be scheduled ASAP but no later than: 24 hours for priority populations; 7 days from discharge from detox/residential treatment; 14 days for all others.
- Refer back to MCO if there isn't an intake available within the required timeframes
- Phone screening log is required per client documenting:
  - Priority Population Status
  - Residence
  - Insurance
  - SUD treatment needs
  - First appointment offered date
  - Appointment accepted date
  - No show/reschedule appointment tracking.

Detox/Residential Referral Process

- Providers will receive referrals from MCCMH MCO.
- Staff will contact your agency along with the client via three-way call to facilitate the referral.
- Intakes should be scheduled ASAP but no later than: 24 hours for priority populations; 7 days from discharge from detox; 14 days for all others.
- If you cannot provide a timely appointment, the client may be offered a referral to another provider to ensure timely access to treatment.
- All providers are required to check for eligibility and medical necessity upon the clients' arrival to treatment. This includes checking for insurance/income status as well as ASAM criteria.

Intake Process

Intake Procedures

- At admission, complete a Release of Information (MDHHS 5515) and Fee Agreement Form with the client.
- Send a secure email with a copy of the MDHHS 5515 to sudadmissions@mccmh.net with a Request To Open Case form. (see next slides)
- MCO will then open the case in FOCUS and notify the provider via email.
- Provider then adds an Admission record, SUD Self-Pay Policy & insurance information form into FOCUS.
- Higher levels of care such as IOP, MAT, withdrawal management and residential treatment require prior authorization in FOCUS. Once the admission and other forms have been added, an authorization request can be submitted.
- Authorization requests must be submitted prior to the provision of the next service or within 72 hours for OP/IOP and within 72 hours for residential services.

MDHHS-5515, CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services (MDHHS)
(Revised 9-25)

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

If using this form for multiple party disclosures, all information identified will be shared with all parties identified on this form. If this is not the goal, use separate forms.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

To give consent, fill out Sections 1, and then fill out either section 2 Treatment, Payment, and Healthcare Operations (TPO) only, sections 3 and 4 only or sections 2, 3 and 4.

This consent will not be used for any civil, criminal, administrative, or legislative proceedings.

To take away consent, fill out Section 6.

Sign the completed form, then give it your health care provider. They can make a copy for you.

SECTION 1 - ABOUT YOU

Name (First, Middle Initial and Last)

Date of Birth

SECTION 2 - TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO)

Sharing information between individuals and organizations

Consent for All Future Uses for Treatment, Payment, and Health Care Operations

☐ Share all behavioral health and substance use disorder information with all my treating providers, health plans, third-party payers, and people helping to operate this program for treatment, payment, and health care operations.

Expiration for TPO consent: Unless otherwise specified below, this consent does not expire.

☐ This consent expires (optional)

When providing a consent for treatment, payment, and health care operations there is the potential for the records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 CFR Part 2.

If you do not consent to sharing for treatment, payment, and health care operations the consequences, if any; are

SECTION 3 - WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

A. Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

☐ Health Plan -	☐ Pre-paid Inpatient Health Plan (PIHP) -
1.	2.
3.	4.
5.	6.

B. Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically, This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

☐ Share my information through the organizations listed below. This information will be shared (not shared) with the individuals and organizations listed under Section 3a.

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only.
List all health information exchanges or networks:

1.	2.
3.	4.
5.	6.

SECTION 4 - WHAT INFORMATION YOU WANT TO SHARE

Choose one option:

☐ Share all my behavioral health and substance use disorder records. This does not include "psychotherapy notes and/or substance use disorder counseling notes."

☐ Share only the types of behavioral health and/or substance use disorder records listed above. For example, what I am being treated for, my medications, lab results, etc.

Types of Records

1.	2.
3.	4.
5.	6.

The expiration date, event, or condition for Sections 3 and 4:
This signature is good for one year from the date signed. I can choose an earlier date to terminate this consent or have it end after the event or condition listed below.

Date, event, or condition

SECTION 5 - YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and/or substance use disorder records. This includes referrals and services for alcohol and substance use disorders and/or other information may also be shared.
- My records may be shared with the people or organizations as described above.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes and/or with substance use disorder counseling notes."
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.

State your relationship to the person giving consent then sign and date.

☐ Self

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Signature →	Date

SECTION 6 - TAKE AWAY YOUR CONSENT, WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed above. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date.

☐ Self

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Signature →	Date

SECTION 7 - FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

List the individual who requested the withdrawal below, then sign and date.

☐ The individual listed in Section 1.

☐ Parent (print name)

☐ Guardian (print name)

☐ Authorized Representative (print name)

Print name of person who received the verbal withdrawal

Signature →	Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information for any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at www.michigan.gov/bhconsent.

Additional Identifiers (optional)

Medicaid ID Number	Last four digits of Social Security Number

Form Copy (choose one option)

☐ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: This form is acceptable to MDHHS as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION: Voluntary but required of disclosure is requested.

Macomb County Community Mental Health
Substance Use Services

SUD PROVIDER REQUEST TO OPEN CASE

Admission Date	
Requesting Agency	Site Location
Person Making Request	Contact Number
Contact Email	

Consumer Demographic Information:	
First Name	Last Name
Other Name Used	SSN
Gender ☐ Male ☐ Female ☐ Other _____	Date of Birth
Address	City
State	Zip
Home Phone	Alt. Phone

Insurance Information: Check all that apply
☐ Medicaid
☐ Healthy Michigan Plan
☐ MiChild
☐ Block Grant/PA2
☐ Women Specialty Funds
☐ Other _____

- *Scan this form and the consumer signed release, attach it to an **encrypted email** and send it to sudadmissions@mccmh.net. No PHI can be in the attachment name or subject line of the email.*
- ***If encrypted email is unavailable**, then scan this form and consumer signed release to "SUD Release" in the Focus Message System.*

Intake Procedures Continued

- At intake, each client must be provided with a copy or access to the “Help When You Need It” booklet, Privacy Notice, MCCMH Notice of Privacy Practices, Confidentiality information, information on Advanced Directives and information regarding Recipient Rights. Documentation that each client was provided these documents must be included in the client chart.
- This is often documented in a consent for treatment form signed by the client.
- The "Help When You Need It" Handbook, "Know Your Rights" booklet and Privacy Notices can be found on our website: www.mccmh.net under chapter four.

WHAT YOU CAN DO:

Talk to your program rights advisor. Maybe together you can find a simple solution to your complaint.

If that doesn't work, you can fill out a formal complaint. Your rights advisor has complaint forms.

After you give your complaint to your rights advisor, the complaint will be investigated. You will get a written answer to your complaint within 30 working days.

If you don't accept the written answer to your complaint, you have 15 working days to file an appeal to the regional rights consultant. Your rights advisor will provide you with appeal forms or you can send for one by writing to the address on the back of this brochure.

Within 30 working days, the regional rights consultant will give you a written answer to your appeal.

If you don't agree with the written answer to your appeal, you can file another appeal to the state rights coordinator.

YOUR PROGRAM RIGHTS ADVISOR

Name _____

Phone _____

For additional information or to obtain forms to initiate a complaint, contact your local Substance Abuse Coordinating Agency at:

LARA
LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

LARA is an equal opportunity employer/program.

Revised 8/14

know your RIGHTS

YOUR RIGHTS

We are dedicated to providing you with quality services. We also believe that as someone who is receiving services from our program, you should know your rights. You should know how to make a complaint if you believe any of your rights have been violated.

YOU HAVE THE RIGHT TO KNOW:

- How much our services cost, and how much you must pay
- When violation of program rules could lead to your discharge
- All about any drugs that are used in your treatment
- If you, or information about you, will be used in any research or experiments.

YOU HAVE THE RIGHT TO:

- All civil rights guaranteed by state and federal law
- Suggest changes in our services
- Expect us to look into your complaints
- Help make up your own treatment plan
- Refuse our services and be told what will happen if you do
- Talk with your own doctor or lawyer
- Obtain a copy or summary of your client record unless the program director recommends otherwise

YOU HAVE THE RIGHT TO EXPECT THAT PROGRAM STAFF WILL NOT:

- Abuse and neglect you
- Give out information about you without your permission
- Require you to be part of any research if you don't want to

AND:

If you are in a hospital, halfway house, or other live-in setting, you have some additional rights.

All of these rights have some special limits. Check with your program rights advisor for further details. These additional rights include the right to:

- Know all the rules about having visitors
- Not be restrained – physically or by drugs, unless authorized by a physician
- Refuse to do work for us unless the work is part of your treatment plan
- Have space to put your personal belongings
- Keep your own money

If you want to know more about your rights, please read the recipient rights poster in the lobby or ask the program rights advisor for a more complete list of your rights.

YOUR RESPONSIBILITIES:

- You are responsible for payment of your bill
- You are responsible for knowing if your insurance company will pay for part or all of your bill
- You are responsible for providing clear and accurate information about yourself
- You are responsible for following rules of our program
- You are responsible for being considerate of the rights of others who are recipients of services or our staff

YOU AND YOUR RIGHTS ADVISOR

If you think your rights have been violated at our program, please talk to your rights advisor. This person is interested in listening to your complaint and helping you find a solution.

Your rights advisor's name and phone number are on the back of this brochure. Please contact your rights advisor if you believe your rights have been violated.

Authorizations

- MCO cannot backdate any authorizations.
- Authorization requests should align with the treatment plan and the agreed upon treatment modality.
- If the client is continuing in treatment beyond the time period of the first authorization, submit a reauthorization request to MCO. A treatment plan must be uploaded to the FOCUS system with any reauthorization request.
- Once MCO has responded to the authorization request, you will receive a message in the FOCUS system. Be sure to read all responses as an authorization may be “approved” but could be ‘reduced’. Any denial will have a reason for denial and may have instructions on what needs to be completed prior to resubmitting the request.

Authorizations

Services Requiring Authorization FY26

Service Name	CPT Code
Intensive Outpatient	H0015
Partial	H2036
SUD Health Homes	S0280
Withdrawal Management	H0010/H0012
Residential	H0018/H0019
Recovery Housing	H2034