Macomb County Community Mental Health

Substance Use Services Department

(MCCMH-SUD)

Quality Assurance Guidelines

Updated November 2026

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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 American Society of Addiction Medicine Criteria, the Michigan Department of Health and Human Services (MDHHS) Medicaid Manual, Policies and Technical Advisories, MCCMH-MCO Policies and Procedures and adherence to guidelines set forth by the State and Federal requirements. This information is not all inclusive but highlights areas of focus.

B. STATEMENT OF SCOPE

The QA Guidelines contained in this document describe parameters necessary to facilitate an efficient admission process, treatment planning, and maintaining the continued course of treatment for the individual served, funded by Macomb County MCCMH-SUD through Community Grant (Block Grant, PA2, Special Grant funds), Healthy Michigan Plan (HMP), and Medicaid.

Specifically, the guidelines address the general admission procedures for children, adolescents, and adults who are admitted into MCCMH-SUD 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.

The quality assurance record review guidelines provide an overview for monitoring case records and contract agency compliance. The process for appealing MCCMH-SUD 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 MCCMH-SUD with ongoing input/feedback from contract providers. MCCMH-SUD monitors compliance with the Guidelines through regularly scheduled audits. Contract providers are required to ensure compliance with these QA Guidelines by training staff in its content and any procedural updates. The QA Guidelines are located

at www.mccmh.net. Comments or questions regarding the online QA Guidelines or website should be directed to mcosa@mccmh.net.

D. TECHNICAL ASSISTANCE

The MCCMH-SUD Quality Assurance (QA) Coordinator provides technical/consultative assistance as needed. Technical/consultative assistance may be requested in 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 MCCMH-SUD's policy that individuals served with verified diagnoses of substance use disorder(s) will be admitted into an appropriate treatment program(s). The individual served must have a significant impairment in their functioning level in the areas of their occupational, educational, interpersonal, and/or medical status to warrant admission into the treatment program. Individuals served 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 served who have completed an intensive treatment program may be seen for aftercare treatment.

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), referred here as "Significant Other", 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 individual served.

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 MDHHS Technical Advisory T-TA-09, Early Intervention, issued November 30, 2011.

Individuals being released from jails or from the Michigan Department of Corrections (MDOC) who meet admission criteria and guidelines, must incorporate and comply with the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment, and have Medicaid or Healthy Michigan Plan coverage, are eligible for MCCMH-SUD-funded treatment. Those individuals seeking more intensive services (withdrawal management, residential, Medication

Assisted Treatment, intensive outpatient treatment) will be required to complete a screening with Managed Care Operations (MCO) to receive a referral. MCCMH's Priority Populations Care Coordinator will track all referrals received from MDOC and will provide updated information to the referring agent regarding any referrals made. Treatment providers will be responsible for requesting a signed release for MDOC and completion of monthly reports to the assigned agent.

All Assessments must utilize the current Michigan Department of Health and Human Services (MDHHS) approved assessment tool (ASAM Continuum or GAIN). A copy of the assessment summary must be contained in the individual served's FOCUS record. Agencies making referrals to another provider must provide the next agency with a copy of the completed assessment for their review and records once a release of information is signed.

A. SCREENING DATA COLLECTION REQUIREMENT GUIDELINES

1. MCCMH-SUD requires the use of a screening form as a means of gathering the initial information from an individual served. This form must include a summary of the individual served's demographic information, including residence, presenting substance use problem, current substance use, financial status, and insurance information, including whether the individual served is currently enrolled in Medicaid, HMP, or third-party insurance.

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

    a. Whether or not an individual served is pregnant.
    b. Whether an individual served is an injecting substance user (use of drugs by injection in the past thirty [30] days).
    c. Whether an individual served 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. Whether the individual served is referred to by the Michigan Department of Corrections (MDOC), a drug court, or is involved in the criminal justice system.
    e. The date the individual served first contacted the program for services, the intake appointment date that was first offered, the date accepted by the individual served, and the actual intake date; any additional appointments offered for the initial intake, including the related contact date, should also be documented.
    f. The individual served 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 individual served.)

3. The screening form must be filed as a part of the clinical record and made accessible for MCCMH-SUD 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.

5. Preference for access to services must be provided in the following order: Pregnant women, individuals served using drugs by injection, parents whose child/ren have been or are in danger of removal from the home as a result of protective services involvement, individuals served discharging from jails, as well as from the Michigan Department of Corrections.

Eligibility Guidelines for Medicaid Funded Services

1. Macomb County residents who have Medicaid eligibility must have this status verified upon admission into the program. The provider must utilize either the FOCUS system or CHAMPS to verify Medicaid status.

2. Providers must verify Medicaid status on the 1st day of every month that the individual served is in services.

B. INCOME ELIGIBILITY GUIDELINES

Community Grant (Block Grant or PA2) Funding

1. Individuals served with limited financial resources may qualify to have fees for substance use treatment subsidized. The individual served who may qualify are identified as follows:
   a. Individuals served who have no third-party substance use coverage and are low income, based on the current MCCMH-SUD Sliding Fee Scale.
   b. Individuals served who are low-income and unable to pay a substantial co-payment/deductible with their third-party substance use coverage.
   c. Individuals served who have exhausted their third-party substance use benefits and, due to limited financial resources, cannot pay the full fee established by the agency.

d. Those who qualify for Block Grant cannot be denied services due to their inability to pay any co-pays.

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

3. Individuals served eligibility for funding must be documented in the case record. The agency must complete the MCCMH-SUD Fee Agreement Form for each Community Grant individual served. The Fee Agreement Form must be signed by the contract agency and the individual served at the time of admission, for any subsequent change in insurance and/or co-pay amount and updated at least every 90 days. If an individual served moves from one level of care to another within the same provider agency, completion of a new Fee Agreement Form is not necessary. Verification of income or a signed and dated letter attesting to a lack of income must be in the case record. *(See attachments for MCCMH-SUD Fee Agreement Form and Instructions.)*

4. Early Intervention school-based activities that are determined to be a contracted service require a MCCMH-SUD 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 MCCMH-SUD FOCUS system.

5. 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, Michigan Medicaid Manual requirements, MCCMH MCO Policy 2-010, and MCCMH-SUD QA Guidelines, in order to be reimbursed.

   Reimbursable units of service are:
   a. Bed days for residential, withdrawal management, and recovery home service.
   b. Chair days for intensive outpatient service.
   c. Outpatient services include individual treatment, group treatment, didactic group presentations, SUDHH core services, case management, peer support services, psychiatric evaluation, medication review(s), and medication doses as specified by contract.

6. MCCMH-SUD-funded intensive services, including withdrawal management, residential treatment, and medication-assisted treatment, Intensive Outpatient Treatment, and Recovery Home Services require a Managed Care Operations screen or Change in Level of Treatment form to be completed, which must be reviewed and authorized by the MCO.

7. Individuals served are required to provide verification of income, including but 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 served 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 served must describe how they support themselves, including money from relatives, friends, etc. Eligibility for Community Grant Funding requires verification of income to be documented in the record. Individuals served reporting zero income must complete a signed and dated letter attesting to their lack of income.

8. Providers are required to verify eligibility for Macomb County HMP, Medicaid-funded services monthly. Contract providers can verify coverage through the MCCMH-SUD FOCUS system or through the State's CHAMPS system. Individuals served are required to provide verification of their current Macomb County residence. If the individual served's address does not match the address listed in their HMP/Medicaid account, the individual served should be assisted in updating their account via MI Bridges. If the individual served is not a Macomb County resident, the individual served should be assisted in contacting the PIHP with financial responsibility. As a reminder, recovery housing cannot be used to establish residency. Agencies should be looking at the individual's last independent address.

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

9. 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 served 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). Funds cannot be used to purchase needles for use by the individuals served or pay for hospital-based treatment.

10. MCCMH-SUD funds may not be used to purchase needles or syringes that would allow the use of illegal drugs.

For Medicaid/HMP

1. The individual served's eligibility for funding must be documented in the case record. The agency must complete the MCCMH-SUD Fee Agreement Form for each Community Grant, HMP, and Medicaid-funded individual served. The Fee Agreement Form must be signed by the contract agency, as well as by the individual served, at the time of admission, for any subsequent change in insurance and/or co-pay amount and updated at least every 90 days. If an individual served moves from one level of care to another within the same provider agency and location, completion of a new Fee Agreement Form is not necessary. The new level of care will be required to complete the 90-day review based on the original fee agreement signature date. *(See attachments for MCCMH-SUD Fee Agreement Form and Instructions.)*

2. Early Intervention school-based activities that are determined to be a contracted service require a MCCMH-SUD 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 MCCMH-SUD FOCUS system.

3. Services must be documented within forty-eight (48) hours of rendering the service in order to be receive reimbursement, in accordance with the Department of Licensing and Regulatory Affairs (LARA) licensing requirements, Michigan Medicaid Manual requirements, MCCMH MCO Policy 2-010 and MCCMH-SUD QA Guidelines. Reimbursable units of service are:

    a. Bed days for residential, withdrawal management, and recovery home service.

b. Chair days for intensive outpatient service.
c. Outpatient services including individual treatment, group treatment, didactic group presentations, SUDHH core services, case management, peer support services, psychiatric evaluation, medication review(s) and medication doses as specified by contract.

4. MCCMH-SUD-funded intensive services, including withdrawal management, residential treatment, and medication assisted treatment, Intensive Outpatient Treatment, SUDHH services, and Recovery Home Services require an MCO screen or Change in Level of Treatment form to be completed, which must be reviewed and authorized by MCO.

5. Individuals served are required to provide verification of income that 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 served 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 served must describe how they support themselves, including money from relatives, friends, etc. Eligibility for Community Grant Funding requires verification of income to be documented in the record. Individuals served reporting zero income must complete a signed and dated letter attesting to their lack of income.

6. Providers are required to verify eligibility for Macomb County HMP, Medicaid-funded services monthly. Contract providers can verify coverage through the MCCMH-SUD FOCUS system or through the State’s CHAMPS system. Individuals served are required to provide verification of their current Macomb County residence. If the individual served's address does not match the address listed in their HMP/Medicaid account, the individual served should be assisted in updating their account via MI Bridges. If the individual served is not a Macomb County resident, the individual served should be assisted in contacting the PIHP with financial responsibility. As a reminder, recovery housing cannot be used to establish residency. Agencies should be looking at the individual's last independent address.

C. ELECTRONIC DATA SYSTEM: FOCUS

1. MCCMH-SUD FOCUS USER POLICY: Users of the MCCMH FOCUS Data System must comply with the FOCUS User Agreement as presented when assigned an account.

   FOCUS is an extension of the individual's served clinical record. The system contains confidential individual-served 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 the use of FOCUS. These policies and procedures must ensure access only by those individuals served who are informed of, and agree to abide by, the confidentiality regulations, and have been authorized by MCCMH-SUD 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 served or accessed at locations that are not approved, supervised or controlled by the agency. Unauthorized attempts to access, obtain, alter, damage, or destroy information, or otherwise to interfere with the FOCUS system or its operation are prohibited by *MCCMH.* It is the *MCCMH* policy that staff may access individual served Protected Health Information (PHI) only when access to that information is a necessary part of their job function. Accessing an individual served's PHI for purposes other than to perform functions of the staff's agency position may result in an appropriate disciplinary action.

   FOCUS user accounts are assigned to a single use and are not to be shared/used by anyone other than the assigned user.

   As an extension of the individuals served 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.

   MCCMH-SUD reserves the right to deny access to FOCUS to any person 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. A request to open a case form should be submitted within 48 hours of admission. The request to open must include the intake date and a valid release of information.

Admissions and related Demographic, Payer, Financial, and Assessment Appointment records entry time frames:

a. **Withdrawal Management, Residential & IOP** admissions and related demographic, payer, financial, and admission appointment records must be entered into FOCUS within 48 hours of the case being opened to you in FOCUS. Eligibility must be run in the electronic FOCUS record.
b. **Outpatient, OTP, including SUDHH** admissions and related demographic, payer, financial, and admission appointment records must be entered into FOCUS within seven days or prior to the next billed service, whichever is sooner. For SUDHH services, this information must be added within seven (7) days of the individual served signing the SUDHH consent form, or before the next SUDHH billed service, whichever is sooner. Eligibility must be run in the electronic FOCUS record.
c. The BH-Teds admission layer should reflect the treatment level you have started. The discharge layer should be the treatment level that the individual served is discharged from.

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 individuals served discharge from the program. In accordance with MDHHS requirements, FOCUS allows a individual served to have only one open treatment admission at any given time. Therefore, it is <u>imperative</u> that providers enter individual served discharges as <u>quickly as possible</u>, especially in the case of withdrawal management, residential, and IOP programs. The aftercare provider will not be able to enter the individuals served's admission into FOCUS until the withdrawal management/residential/IOP admission has been discharged.

Any individual served not seen or heard from for a period of 30 calendar days is to be considered discharged, for purposes of FOCUS and MCCMH-SUD funding. A provider should complete the Discharge record using the last date of face-to-face contact with the individual served as the Discharge date. Individuals served enrolled in SUDHH programming who have not been seen or heard from

should only be discharged after completing at least one (1) outreach attempt per month over the course of three (3) consecutive months.

If a individual served returns to treatment within thirty (30) days of discharge, you may ask MCCMH-SUD to delete the discharge that was entered into FOCUS and request new authorizations starting at the original authorizations lapse date.

4. INITIAL AUTHORIZATION REQUESTS: Withdrawal Management, Residential, IOP, and Outpatient Treatment authorizations must be entered within 72 hours of the case being opened to you in FOCUS. MCO will process these requests within 14 days of receipt and return them to the provider electronically as approved or denied. SUDHH authorizations must be entered within seven (7) days of the individual served signing the SUDHH Consent to Treat, or by the next SUDHH encounter, whichever is sooner.

5. REAUTHORIZATION FOR CONTINUED STAY: A reauthorization request must be submitted in the MCCMH-SUD FOCUS system, indicating the rationale for continued stay beyond the initially authorized request. Documentation to MCO must include documentation that the individual served still meets ASAM criteria for this level of care, documentation of goals to be addressed during the extension and why these goals cannot be addressed at a lower level of care.

   Requests for extension of services must be submitted on a Reauthorization Request form via the MCCMH-SUD FOCUS system in sufficient time for MCO to review and respond prior to the scheduled individual served discharge (three (3) business days).

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

   Continuation of Withdrawal Management: Initial authorizations for withdrawal management are three (3) days. An additional two (2) days of withdrawal management may be approved as medically necessary. Any authorization requests for more than three (3) days of withdrawal management must include documentation of medical necessity. 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. Utilization reviews by program medical and clinical staff are required for all cases where length of stay exceeds five (5) days.

6. 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: Individuals served 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 the MCCMH-SUD Director.

   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. Email all related documentation (IE, third-party rejection notice) to MCCMH-SUD's billing staff or to mcosa@mccmh.net.

   Programs wishing to appeal the decision by MCCMH-SUD/MCO to set the effective date to a date other than that requested by the provider should submit a written Level One MCCMH-SUD Appeal to the Quality Assurance Coordinator within five days of MCCMH-SUD/MCO's response to the authorization/reauthorization request.

   Any requests submitted over 30 days after the admission date will not be opened by MCO. Keep in mind that any services provided without a case being opened may result in denied claims.

D. ADMISSION EXCLUSION POLICY FOR ALL TREATMENT MODALITIES

1. Individuals served with a primary psychiatric diagnosis **only** are not eligible for substance use disorder funding. Adults or adolescents who are at risk for developing a substance use disorder problem due to involvement with a person using 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 served referred for the sole purpose of receiving Drinking and Driving Education classes are not eligible for MCCMH-SUD funding.

3. Individuals served referred for assessment only as a means to comply with parole/probation or other court order are not eligible for MCCMH-SUD funding.

4. Individuals served 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 MCCMH-SUD Community Grant, HMP, or Medicaid substance use disorder funding for psychotherapy.

5. Individuals served who do not meet the MCCMH-SUD Admission Policy Guidelines and Medicaid Medical Necessity criteria are not eligible for MCCMH-SUD Community Grant, HMP, or Medicaid-funded substance use disorder treatment.

6. Hospital-Based Acute Medical Detoxification and Inpatient SUD treatment are not funded by MCCMH-SUD.

III. ADMISSION PROTOCOLS FOR MCCMH-SUD COMMUNITY GRANT, HMP, AND MEDICAID FUNDED SUBSTANCE USE DISORDER TREATMENT

Admission criteria and guidelines must incorporate and comply with the ASAM Criteria for the treatment of substance use disorders, the MDHHS Medicaid Managed Care Policies, MDHHS SUDHH Handbook, MCCMH-SUD Medical Necessity Criteria, and the BPHASA Policies and Procedure criteria.

Placement criteria are based on the principle of identifying the least restrictive environment necessary to meet the treatment needs of the individuals served while offering choice and respecting the diversity of the individuals served. 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.

SERVICES REQUIRING PRIOR AUTHORIZATION

MCCMH-SUD funded services, including withdrawal management, residential treatment, IOP, SUDHH services, outpatient treatment, and Recovery Home Services require prior authorization by MCO.

SPECIALTY SERVICE CRITERIA

Managed Care Operations (MCO)

1. Individuals served 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 MCO.

2. Individuals served seeking publicly funded withdrawal management or intensive treatment (residential, IOP, MAT) are required to be pre-screened for eligibility for those services by MCO.

3. Individuals served seeking screening and referral services at MCO are not charged a fee for those services.

4. MCO uses a standard screening tool that incorporates information to identify diagnostic impressions and current treatment needs. The MCCMH-SUD Quality Assurance Guidelines, the ASAM Criteria, the Medicaid Provider Manual, and the Medical Necessity Criteria are used to make a final determination regarding placement for individuals served who are seeking prior authorization for funded intensive services.

5. MCO screening information is available in the FOCUS system to the provider once a valid release of information is received by MCO. The MCO 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.

Substance Use Disorder Health Home (SUDHH) Services

SUDHH providers integrate comprehensive care management and coordination services to eligible beneficiaries with an opioid use, alcohol use, or stimulant use disorder diagnosis. For enrolled beneficiaries, the SUDHH will function as the central point of contact for directing patient-centered care across the broader health care system. SUDHH providers must comply with requirements outlined in the MDHHS SUDHH Handbook in addition to applicable standards for outpatient standards listed within the MCCMH–SUD provider handbook. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. Participation is voluntary, and enrolled beneficiaries may opt out at any time.

The SUDHH program will work to 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care. Services will be provided in accordance with the Care Plan, but at least monthly. All new SUDHH enrollees are to receive at least three (3) SUDHH encounters within the first 30 days upon consenting to SUDHH services.

1. SUDHH services are available to Macomb County residents with Medicaid or HMP eligibility.

2. SUDHH enrollment requires an individual served to have at least one qualifying diagnosis, as referenced in the MDHHS SUDHH Handbook and generally described below:
    a. Opioid Use Disorder
    b. Stimulant Use Disorder
    c. Alcohol Use Disorder

3. Individuals served must also either be at risk of developing, or have developed one of the following conditions:
    a. Asthma
    b. COPD
    c. Body Mass Index >25
    d. Heart Disease
    e. Any mental health condition

    Providers are required to recommend WSA enrollment for individuals served who meet eligibility criteria, have signed and dated the SUDHH Consent to Treat form, completed a social determinant of health (SDOH) screening, and completed a valid MDHHS-5515 Consent to Share

Behavioral Health Information form, within seven (7) days of completing these enrollment documents.

Medications for Opioid Use Disorders

The goal of Medications for Opioid Use Disorder (MOUD) is to utilize medications to help reduce illicit opioid use, retain individuals in treatment, reduce physiological symptoms associated with withdrawal, reduce cravings, and reduce opioid overdose. MCCMH-SUD requires that all individuals receiving MOUD treatment are also offered behavioral health treatment services including individual therapy and group therapy. Agencies may also provide peer recovery coaching, didactics, and SUDHH services as outlined in their MCCMH-SUD contract.

When the MOUD prescribed is methadone, MCCMH-SUD can be billed for all services associated with this treatment including the intake, medical evaluations, individual sessions, didactic sessions, group therapy and peer recovery coaching. The methadone can also be billed to MCCMH-SUD using the methadone dosing code, H0020. H0020 is a bundled code that includes the dosing, the medication and drug tests. Drug testing cannot be billed separately by an Opioid Treatment Provider.

When the MOUD prescribed is buprenorphine or naltrexone, MCCMH-SUD can be billed for treatment services including intake, medication evaluations, individual sessions, didactic sessions, group therapy and peer recovery coaching. **MCCMH-SUD is only able to reimburse for the cost of medications when the individual is eligible for Block Grant funding**. Buprenorphine can be billed using the H0033 medication administration code. However, the individual served must be present to receive this dose at the clinic in order to bill MCCMH-SUD for this code. Naltrexone injections can be billed using the J2315 code to reimburses for the established rate for the medication and the 96372 code can be billed for the administration of the injection. All individuals receiving services funded by MCCMH-SUD Block Grant funding must be assisted in applying for benefits through MDHHS's MI Bridges.

Any individual served receiving buprenorphine or naltrexone who is covered by Medicaid or Healthy Michigan Plan should have their medication reimbursed by their health plan. This may be accomplished by the individual taking their prescription to a pharmacy to be filled and the pharmacy billing the health plan. If your agency chooses to provide the medication directly, you must be paneled with the health plan in order to bill them for the medication. MCCMH-SUD cannot be billed for buprenorphine or naltrexone if the individual served has insurance coverage.

Recovery Home Services

The goal of Recovery Housing services is to provide a supportive recovery environment to help reduce the incidence of drug and alcohol use and dependency, prevent relapse, and support individuals served in their recovery efforts. Services include post-therapeutic supervised support in a Residential setting for individuals served 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 home requires that the individual served has completed or does not need medical oversight or Withdrawal Management, is currently enrolled in an MCCMH-SUD funded outpatient treatment service and is/will be participating in a MCCMH-SUD ambulatory treatment service while residing in the home. If the individual served has a medical or psychiatric condition, it will not interfere with the ability to function in a supervised, supportive environment. The individual served must be in the active stage of change, motivated for recovery, and willing to participate in weekly recovery meetings. And;

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

    a. the individual served 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 served has had past failed aftercare attempts which result in a return to chronic use;
    c. there are significant negative factors in the family, social, or work environment that place him/her at risk for relapse without ongoing structured support.
    d. the person meets eligibility requirements as outlined in the MCCMH-SUD Recovery Home Guidelines

Significant Other Services

To qualify for MCCMH-SUD Community Grant funding as a Significant Other, the individual served is expected to attend scheduled treatment sessions and comply with the established individualized treatment plan as formulated by the primary therapist and individual served. Significant Other cases receive funding are limited to 12 sessions, for up to a three (3) month period. (The individual served must not otherwise be eligible for mental health services or be receiving treatment services elsewhere. Psychiatric evaluation and medication services are excluded from authorization.

Relapse Prevention Services

To qualify for Relapse Prevention Services, there must be documentation of current environmental, social, familial, judicial, or other stressors that place the individual served at risk for relapse. The individual served must not otherwise be eligible for mental health services or be receiving treatment services elsewhere. Psychiatric evaluation and medication services are excluded from authorization.

Early Intervention Services

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.

1. Students can be self-referred to or referred to by school personnel.

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

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

4. School-based Early Intervention services are time-limited to an assessment and an average of eight (8) sessions.

5. Referrals are made for a higher level of care for individuals served in need of more intensive services.

Peer Recovery Services

MCCMH–SUD funded peer recovery services are offered through SUD Health Home providers and/or as a part of contracted outpatient treatment. Peer recovery services outside of SUD Health Homes are planned and agreed upon between the treatment team and individual served as evidenced by the consent to treat completed at admission. The focus, scope, and duration of peer recovery services are contained within the individualized treatment plan.

1. The individual served must be actively engaged in outpatient treatment at an MCCMH-SUD contracted agency.

2. There must be a goal related to peer recovery coaching in the treatment plan.

3. Peer recovery coaches must meet MCCMH-SUD credentialing guidelines and have an approved Director’s Verification form on file.

4. All peer recovery services must be documented in a progress note within 48 hours of the service in order to receive reimbursement.

5. Peer recovery coaching notes should include date and time of service, goals addressed, interventions provided and the signature of the peer providing the service.

6. The need for continued peer recovery coaching should be identified during treatment plan reviews and annual assessment updates.

Recovery Incentives Pilot

MCCMH-SUD funds the MDHHS contingency management (CM) program known as "Recovery Incentives (RI)." This program is delivered by contracted agencies who have completed the required readiness review and RI trainings. Individuals residing in Macomb County who are Medicaid Eligible with a stimulant and/or opioid use disorder and consent to the program complete urine drug tests (UDTs) over the course of 24 weeks. Upon completion of each test, a reward is provided via an automated contingency management platform. Negative UDTs results in higher rewards. The UDTs and related services are integrated into the treatment plan.

1. Eligible individuals are identified by the contracted RI treatment provider or self-refer to a contracted RI treatment provider.

2. The provider is responsible for verifying residency and Medicaid status, ensuring a qualified diagnosis is present, completing an RI orientation, signing the RI consent form, and enrollment into the contingency management platform (CHESS Health).

3. During the initiation of RI, the treatment plan should be updated to include the intervention.

4. The provider must enter the weekly UDT schedule in the CM platform as outlined in the MDHHS RI handbook
    A) Weeks 1 – 12 required two weekly UDTs scheduled 72 hours apart
    B) Weeks 13 – 24 require one weekly UDT
    C) Each UDT result must be recorded in the chart, as well as the CM platform by the end of the RI session to ensure prompt payment of the reward.

D) All progress notes for RI must be signed, dated, credentialed, with start/stop times and otherwise completed in the record within 48 hours of the date of service.

E) Provider must complete and document outreach to the individual served for any missed scheduled RI UDTs.

IV. DISCHARGE AND READMISSION

Individuals served who are admitted with substance use disorder diagnoses who have not demonstrated progress towards treatment goals should be re-evaluated for changes to the Individualized Treatment Plan and/or referral to an alternate treatment modality/intensity based on ASAM Criteria. The Individualized Treatment Plan revisions should clearly identify areas of treatment that require specific focus in order for recovery goals to be achieved. Individuals served who have achieved treatment goals and meet ASAM Criteria for discharge should be provided with an aftercare plan.

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

Children or adolescents admitted under the early intervention criteria, may have additional treatment authorized with documentation of the progress attained and the 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, individuals served needing a higher level of care, such as Outpatient treatment, should be referred to an office/clinic-based treatment provider.

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

READMISSION PROCEDURES

1. Each case of repeated admission (generally within the previous six-month period) 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 re-admission. 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. Individuals served seeking readmission must meet the MCCMH-SUD 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/withdrawal management services.

4. Readmission to residential, MAT, and IOP requires screening by MCO.

5. Individuals served may be screened by MCO for referral to the extent that they continue to experience substance-use-related problems. MCO 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.

V. CLINICAL PROTOCOL

A. CLINICAL ASSESSMENTS

All treatment providers must utilize the current MDHHS-approved assessment tool (ASAM Continuum, GAIN). The assessment must be completed, in full, and signed by the clinician and present in the individual served FOCUS record. Treatment programs are required to utilize the ASAM Criteria for placement and treatment planning. The following tools are examples where information for the dimensions could be found:

Dimension 1: Intoxication, Withdrawal, and Addiction Medications:

- Substance use assessment (ASAM or GAIN)
- Medical assessment
- Nursing assessment

Dimension 2: Biomedical Conditions:

- Medical assessment
- Nursing assessment

Dimension 3: Psychiatric and Cognitive Conditions:

- Substance use assessment (ASAM or GAIN)
- PHQ-9

- Columbia Risk Screen
- Trauma History

Dimension 4: Substance Use Related Risk:
- Substance use assessment (ASAM or GAIN)

Dimension 5: Recovery Environment Interactions:
- Substance use assessment (ASAM or GAIN)
- Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool

Dimension 6: Person-Centered Considerations:
- Substance use assessment (ASAM or GAIN)
- Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool

1. The Intake Assessment Process

    a. The ASAM Continuum/GAIN Assessment must be completed at intake and placed in the individual's served file prior to the next billable service. The ASAM Continuum and GAIN are state-approved intake assessment tools and must be completed, in full, and signed prior to a treatment plan being developed.

    All sections of the ASAM Continuum need to be completed, including the level of care, the individuals served's impressions of the assessment, the interpretive summary, and the signature by the clinician. If the ASAM Continuum is completed by a SATP, the diagnoses and level-of-care recommendations must be reviewed and signed off by an SATS. This must be documented in the individuals served chart. (Please see MCCMH-SUD Staff Credentialing Requirements).

    b. During instances when an individual served transfers from one treatment provider to another without a treatment gap, the new treatment provider is required to obtain the most recent assessment tool, complete an individual session to review the assessment, complete an interpretive summary, and document ASAM Dimensions and Level of Care. If previous ASAM Continuum/GAIN assessment is not provided by the

previous provider before initiation of services, all efforts to obtain the previous ASAM Continuum/GAIN assessment must be documented in clinical record.

c. A new ASAM Continuum/GAIN Assessment must be completed when an individual served has left all treatment for six months or more and then returns to services.

d. A suicide risk screening should be completed at intake, such as the Columbia.

2. Outpatient ASAM Continuum Considerations.

a. The ASAM Continuum should be completed in the first session.

b. If there are circumstances that prevent the ASAM Continuum from being completed at the intake appointment, providers may bill the incomplete intake appointment with the H0004 CPT code. The provider must complete the ASAM Continuum during the following session and utilize the H0001 CPT code for billing purposes for that date of service. If the ASAM Continuum that was completed is reviewed by the previous provider, 90791 would be billed.

c. The assessment must be completed before a treatment plan can be created.

d. A re-assessment utilizing the ASAM Continuum or GAIN must be completed annually with each individual served, and an updated BH TEDS record must be added in the FOCUS EHR.

3. ASAM Continuum Considerations for Withdrawal Management

a. The approved assessment tool, as outlined above, is expected to be completed as part of the intake process on the first day of services.

b. If the assessment cannot be completed during the first day of services due to withdrawal symptoms, this must be documented in the clinical record.

c. Daily attempts must be made to complete the assessment, with each attempt documented in the record.

d. The assessment must be completed before the individual served leaves the withdrawal management level of care.

4. Accompanying Intake Documents

a. A consent for treatment for the providing agency must be included in the individual's served chart, with the individual's served signature.

b. Documentation must be included in the chart indicating the individual served was provided access to the Medicaid Help When You Need It Handbook, Privacy Notice, Recipient Rights information, and information regarding 42 CFR.

c. Documentation should include if the individual served was asked if they have an advanced directive and if they would like to receive information on completing one.

d. Each chart must include documentation regarding an individual's served Primary Care Physician or lack thereof, and evidence of care coordination activities.

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 individuals served functioning.

1. Individualized Treatment Plan

a. An individualized treatment plan must be completed, signed and dated by the individual served prior to the next billable service.
   i. For outpatient services, this means before the next billable therapy sessions or group therapy session.
   ii. For withdrawal management/residential services, this means within 24 hours of the intake/admission.

iii. For MAT/MOUD outpatient services, this means before the next therapy service or methadone dosing service, whichever comes first.

b. Individualized treatment plans must show individual served involvement in the development of the plan by utilizing their own words.

c. Each treatment plan must include at least one goal with at least two objectives. Goals must be measurable, include specific time frames for completion and reference what treatment will be provided to address each goal. Goals must be individualized and address the unique needs of the individual served.

d. Treatment plans must include goals specific to their SUD and associated symptoms. Those individuals with co-occurring mental health and substance use concerns must have goals that address both their substance use and mental health diagnoses and associated symptoms.. If an individual's treatment goals are exclusively focused on mental health concerns and do not address a SUD diagnosis, the individual should be referred to appropriate behavioral health services to ensure their treatment needs are addressed in the most appropriate setting.

e. If the individual served has a goal of abstinence, there must be an objective to measure abstinence included in the treatment plan. Generally, this is either a urine drug screen, cheek swab, or alcohol breath test completed on-site by the treatment provider. The results of the screening are then discussed as a part of the therapeutic relationship.

f. All outpatient level treatment providers will utilize urine drug screens (UDS) as a therapeutic tool as indicated in the individuals served individualized treatment plan when abstinence is identified as a goal. Treatment providers must also have the ability to conduct urine drug screenings by way of an instant test to address any concerns in real time as a part of the assessment process or when an individual presents with symptoms that indicate they may be under the influence of a substance. If there is a dispute of the results of an instant test or the test results are inconclusive, samples

may be sent to a lab for further testing. Each provider must have procedures and a policy to complete these screens onsite.

g. Should the individual served 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.

h. Treatment plans must be signed and dated by both the individual served and the clinician. The treatment plan is considered completed when the individual served has signed and dated the plan.

i. The treatment plan must reflect the identified problem(s) being addressed, goals, objectives, interventions, staff responsible, and time frame for completion fur the current level of care.

j. When the individual served transitions from one level of care to another, a treatment plan update must be completed to reflect the services and goals associated with the new level of care. (Example: when an individual served moves from withdrawal management to residential, the treatment plan must be updated to show the new goals and services associated with that level of care).

2. SUDHH Care Plan

a. Each individual served enrolled in the SUDHH program must have a completed SUDHH care plan within thirty (30) days of the individual served consenting to the program.

b. The care plan follows the same guidelines found in the Individualized Treatment Plan section. The goals, objectives, and action steps for SUD Health Home programming can be incorporated in the individualized treatment plan.

c. The completed SUDHH care plan, or treatment plan with incorporated SUDHH goals, must be uploaded to the Waiver Support Application (WSA) within 30 days of the signed SUDHH Consent to Treat date.

d.. All SUDHH Care Plan/Individualized Treatment Plan with incorporated SUDHH goals/action steps, must contain the signatures of the Nurse Care Manager, Peer Recovery Coach, Behavioral Health Specialist, and individual served, along with a signature date.

3. Treatment Plan and SUDHH Care Plan Update

a. The treatment/care plan must be formally evaluated as changes occur in the individual's condition, a change in level of care, or at a minimum of every 90 calendar days from the completion of the initial treatment/care plan.

b. The treatment/care plan update must identify progress toward current goals and objectives from the treatment plan.

c. Identification of goals achieved, deferred, or continued, and subsequent updating of the Treatment Plan is to be completed at this time.

d. The treatment/care plan update can include new goals and objectives, as appropriate.

e. The treatment plan update is reviewed and approved by a licensed or certified clinical professional as evidenced by a signature with the approved credentials. SUDHH care plan review/updates must be signed by all SUDHH team members.

f. The individual served participates in all treatment/care plan updates as evidenced by the individual's input and signature, and date of signature.

g. The need for additional services is included in the treatment update, i.e., psychiatric consultation, medical services, housing services, etc.

h. SUDHH Care plan reviews/updates must be uploaded to the Waiver Support Application upon completion.

i. The SUDHH SDOH Screening form can be re-administered during the care plan update. The SDOH Screening must be re-administered at least annually.

j. As an individual served transitions between levels of care within the same organization, the treatment plan must be updated during the first treatment session for outpatient services (including MAT) or treatment day for residential services.

C. PROGRESS NOTES

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

   a. Focus, intervention, and individual served response segment.

   b. Date, start/stop time, and the type/modality of the intervention performed.

   c. Signature of the treatment practitioner complete with applicable credentials and date of signature; and
   d. Clear, concise language written in a legible fashion.

   e. SUDHH progress notes must identify which core services were rendered during the session.

2. A completed progress note meeting the above criteria must be placed in the individuals served 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 during a Quality Assurance Audit or Financial Review.

3. All individuals served-related activities/data must be documented in the record. This includes, but is not limited to, phone calls, correspondence, no-shows, cancellations, rescheduled appointments, 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 in 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 an 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.

7. Group Requirements:

    a. Group notes must include date, start/stop time, type of group, clinician signature with credentials, date signed, topic(s) covered, individuals served input during the group and number of individuals served who attended the group.

    b. Group notes must be placed in the individuals served file no later than forty-eight (48) hours after the end time of that treatment session.

    c. MCCMH SUD Group Size - a minimum of 3 individuals served is required for any type of group. Below are details related to the maximum group size based on type of group recommended to allow participants to engage, share common challenges and successes in their recovery journeys, and practice individualized skills.

        i. Therapeutic/Interpersonal (Core) Group Size: Average size limit of 8-10 participants (15 at max) for core/therapeutic/interpersonal process groups.
        ii. Psychoeducation/Didactic (Core) Group Size: Skills-building groups that hinge on participant engagement, sharing, and/or practice of skills Group size should be limited to 20 individuals served to allow participants

capacity to engage, interact, and practice individualized skills.

iii. Evidence-based Therapy (Core) Group Size: Group therapy with a particular curriculum, group structure and/or target population should follow the parameters of that program to fidelity, including group size recommendations, not to exceed 15 individuals served per therapist.

iv. Lecture (non-Core) Group Size (Residential Treatment only): Educational groups that are not contingent on participant engagement, sharing and/or practice of skills presented in a lecture format. Group size should accommodate the needs of individuals served. Lectures do not count towards “core” treatment services.

MAT Specific Documentation

1. All MAT providers must comply with MDHHS Treatment Policy #4, #5, and #6, as well as LARA Administrative Rules.

2. All Medication Assisted Recovery individuals served must have documentation of medication reviews occurring within 30, 60, and 90 days of treatment and every 90 days thereafter. These reviews will include: a review of the recipient's service plan; a review of the counseling services' progress notes and drug tests; a review of documentation of medical necessity for continued treatment in the program; and a review of any recommended adjustments to the service plan.

3. All MAT individuals served must have documentation of MAPS in their chart at intervals designed in MDHHS Treatment Policy #5.

D. AFTERCARE

All individuals served must be offered aftercare and assisted in setting up aftercare appointments as needed prior to the completion of the current treatment episode regardless of discharge reason. An aftercare plan is developed with the input of the individual served to address continuing care needs with regard to transferring to another treatment program and/or providing medical, psychological, legal, and community support services. Aftercare planning should start at the beginning of the treatment episode for

those in withdrawal management or residential treatment, as there may be delays in making referrals or securing appointments.

E. DISCHARGE

1. When an individual served has successfully completed all treatment goals included in their plan, has a planned transition to another level of care, has decided to leave treatment, or has not participated in treatment in over 30 days, a discharge must be entered into the FOCUS system.

2. If there has been no individual served contact for fourteen (14) days, staff must complete outreach attempts (phone calls, letters sent, etc.) in an effort to re-engage the individual served. If the individual served does not re-engage in treatment within thirty (30 days) then the record is required to be discharged from the MCCMH-SUD system. Exceptions to this guideline would need to be clearly documented in the record, e.g., individual served called away in a family emergency.

   SUD Health Homes – Individuals served can only be discharged from SUDHH services due to unresponsiveness/no contact if the provider completes at least three outreach attempts over three consecutive months. Each outreach attempt must be documented, and the outreach attempts must be documented in the WSA discharge section.

3. <u>BH TEDS/Registry Discharge Date</u> – A BH TEDS discharge or Registry discharge date is the date that MCCMH-SUD funding ceases, either due to a denial of funding, the individual served being discharged or the individual served having exhausted available funding. The discharge date entered in FOCUS should be the date of the last billable service provided. For withdrawal management, residential treatment or recovery housing, this is the last date the individual served stayed overnight at the facility.

4. A discharge summary must be placed into the individual's served 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 contact with the individual served for thirty (30) days, and the individual served is discharged. Attempts to contact the individual served to return to treatment, by mail or by phone, should be documented in the clinical record prior to actual discharge.

5. The discharge summary includes the following elements:

   a. Diagnoses at time of discharge.

   b. Progress toward the goals and objectives contained in the individual's treatment plan.

   c. Recommendations and arrangements for further treatment, name of referring agency, address, date and time of follow-up appointment.

   d. Referrals for additional services needed such as housing, medical, psychiatric appointment, etc.

6. Individuals served may be discharged for documented noncompliance with the program's written rules. The individual served 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 the treatment provider to facilitate contact with MCO for assistance in determining the need for an alternative level of care, identification of barriers to treatment and/or other case management assistance. Any individual served being terminated by treatment agency must have an explanation of the reason for termination and aftercare information provided included in the notes section of the BH TEDS discharge in FOCUS.

7. Medicaid recipients who discontinue services prior to the end of their authorization must be provided with an Advanced or Adequate Notice of the termination of services letter. This letter should include the reason for their case being closed as well as instructions on how to resume treatment services and instructions on how to file an appeal if desired. Refer to MCO Policy 4-020.

F. TELEHEALTH SERVICES

1. As standard practice, in-person visits are the preferred method of delivery service. However, in cases where this option is not available or in-person services are not ideal or are challenging for the beneficiary, telemedicine may be used as a complement to in-person services.

2. Documentation that the individual requested services to be provided via telehealth must be documented in the chart prior to the provision of telehealth services.

3. Regular treatment plan reviews (every 90 days or when there is a change in individual served status) must take place in person to offer in-person services and, if the individual served continues to request telehealth, document this request.

4. Treatment providers utilizing telehealth services must comply with all applicable state and federal guidelines regarding telehealth services for Medicare/Medicaid/HMP/Block Grant funding.

VI. QUALITY ASSURANCE AUDIT AND RECORD REVIEW

A. QUALITY ASSURANCE (QA) AUDIT COMPLIANCE PROCESS

All MCCMH-SUD Community Grant, HMP, 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. Discussing the merits or specifics of a particular QA standard is outside the scope of the audit and must be done outside of the scheduled audit. A review of a program's documentation practices and procedures can be conducted through a meeting with the MCCMH-SUD Quality Coordinator. The results of the QA Audits are also used by MCCMH-SUD as part of the Annual Contract Compliance Audit, as well as determinations for re-contracting.

2. Quality Assurance Audit Compliance

   a. Quality Assurance audit compliance is defined as the percentage of the applicable standards that have been met on each of the cases sampled for the review. (See Audit Tools in the MCCMH-SUD Provider Manual.)

   b. An audit item that scores less than 80% will require a corrective action plan.

   c. Only documentation that is provided and, in the record, available on the day of the audit, will be considered during the audit.

d. A record selected for full review that is found not to meet the MCCMH-SUD criteria for admission (refer to QA Guidelines, Section II), 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 because of incomplete or insufficient documentation, or based on audit findings, the program is held financially responsible for all services rendered and not MCCMH-SUD nor the individual served. Once the documentation is corrected, MCCMH-SUD may consider resuming funding from the date on which it was corrected (refer to the QA Audit Appeals section).

B. QA AUDIT PROCEDURES

MCCMH-SUD 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, MCCMH-SUD 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 MCCMH-SUD from those entered in the MCCMH-SUD FOCUS 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 based on the total number of individuals served. If a pattern is identified during the audit which suggests noncompliance with the QA Guidelines or MCCMH-SUD contract, MCCMH-SUD has the option of scheduling a return visit to explore these areas further.

3. For each case reviewed for compliance with the QA Guidelines, an MCCMH-SUD Audit tool (see MCCMH-SUD Provider Manual for the most up to date version) is completed, which includes the auditor's comments and recommendations, and the QA Quality Score.

4. MCCMH-SUD will only consider documentation that is presented on the day of the QA audit to determine compliance with these quality assurance standards. Additional documentation provided after the

completion of the audit will not be considered in calculating the overall compliance score.

5. The MCCMH-SUD Fee Agreement should be maintained in the individual served record. The Fee Agreement must be filed in a standard manner and easily accessible to the auditor.

6. MCCMH-SUD cannot reimburse for any services provided without a valid treatment plan signed by the individual served and the treating clinician.

7. MCCMH-SUD cannot reimburse any Block Grant-funded individual served without verification of income included in the chart. Treatment providers must have documentation that the individual served meets Block Grant eligibility guidelines as outlined in the Sliding Fee Schedule.

8. If an individual served moves from one level of care to another within the same provider agency, completion of a new Fee Agreement Form is not necessary.

9. For those cases selected for full review, the MCCMH-SUD Audit tool is completed, which includes the auditor's findings and any comments or recommendations, and a Quality Score.

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

11. For specialty, out-of-county, and non-panel Medicaid providers, MCCMH-SUD selects a sampling of admission cases based on utilization of services.

C. PROGRAM REVIEW FEEDBACK PROCEDURES

The 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 is included for each case reviewed during the audit period. Cases requiring financial adjustments are noted on the individual audit tool, on a separate Financial Adjustment Form, and on the QA Audit Report.

2. Appeal Process – All cases where a financial take-back is initiated can be appealed 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.

3. When a Corrective Action Plan is requested, MCCMH-SUD will provide a due date for the plan. The provider agency must develop a written Corrective Action Plan and submit it to the MCCMH-SUD auditor on or prior to the due date for review. The audit process is completed when a Corrective Action Plan has been approved by MCCMH-SUD. MCCMH-SUD may request documentation that the Corrective Action Plan has been implemented.

VII. MCCMH-SUD AUDIT APPEAL PROCESS

A. Only cases where a financial takeback is initiated can be appealed by the agency within five (5) working days of receipt of the narrative review report. The appeal process is for cases in which new or additional documentation is available that was not presented at the time of the audit. Any appeal submitted without new/additional documentation can be denied. Once MCCMH issues a response for the appeal, that response cannot be changed, and the provider must submit the next level of appeal for further consideration. Once the provider has exhausted all three levels of appeal, or if the next level of appeal was not provided within the required timeframe, MCCMH will initiate the financial takeback.

B. Appeals Process – Three Levels

1. The first level requires the submission of an appeal by the agency to the MCCMH-SUD Coordinator or Auditing designee. Appeals must contain justification for the appeal request, as well as include all documentation related to the initial decision, as well as any additional evidence to support the reason for appeal.

The Level One Appeal is completed on the MCCMH-SUD Level One Appeal Form (see the MCCMH-SUD Provider Manual 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 MCCMH-SUD Coordinator responds in writing on the Level One Appeal Response Form within five (5) business days of receipt by MCCMH-SUD.

2. The second level involves an appeal to the MCCMH-SUD Administrator or Finance Administrator. The second level appeal occurs when the agency disagrees with the first level appeal decision made by the MCCMH-SUD Coordinator or the Auditing designee. A Level 2 Appeal must contain new evidence/support that was not available/submitted during the Level 1 Appeal. It must also include all original documentation. If no new additional evidence is provided with the Level 2 Appeal, it may be denied.

   The program may submit a Level Two Appeal Form to the MCCMH-SUD Administrator within five (5) working days of the receipt of the Level One appeal Response Form from MCCMH-SUD. 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 MCCMH-SUD Administrator within five (5) working days after receipt of the Level Two Appeal from the program.

3. The third level appeal is made to the MCCMH-SUD Director, whose decision is final, when the agency disagrees with the decision of the SUD Administrator. The Level 3 Appeal must include new evidence that was not present in the Level 1 or Level 2 Appeals, along with the original documentation pertaining to the financial recoupment. Failure to provide additional evidence may result in denial.

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

C. Appeal cases to be presented to the MCCMH-SUD reviewer at the next scheduled audit do not appear on the Audit Report and will not be requested by MCCMH-SUD 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

MDHHS requires that MCCMH-SUD provide information to recipients of funded substance use disorder services regarding individual served complaints, grievances, or Local Appeals, and for Medicaid/Healthy Michigan Plan recipients, the Administrative Fair Hearing process. Information on the appeal process is included in Notice of Adverse Benefit Determination letters provided by individual treatment agencies and/or MCCMH Managed Care. (See the MCCMH-SUD Provider Manual for further information regarding individual served complaints and grievances) (See MCO Policy for further information on 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 individuals served.

IX. COMMUNICABLE DISEASE POLICY AND GUIDELINES

It is the policy of MCCMH-SUD that contract agencies complete a Communicable Diseases Risk Screen on each admitted individual served 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. If an individual answered "yes" to any question, they should be considered high risk and offered referral for follow-up testing and care. (See MCCMH-SUD Provider Manual for the Communicable Diseases Risk Screen Form.)

It is required by MDHHS that individuals served contracted by MCCMH-SUD provide substance use disorder services, either prevention or treatment, and demonstrate the minimum knowledge requirements related to HIV/AIDS and Substance Use Disorder. All provider agency staff are required to complete the approved Communicable Disease training within 90 days of hire. (Refer to the SUD Training Grid in the MCCMH-SUD Provider Manual).

<u>Documentation</u>

1. Identification of an individual served 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 served 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 individual served about the transmission of HIV/AIDS, STDs, Hepatitis, or TB.

4. If the individual served is deemed to be at risk for Hepatitis, HIV/AIDS, STDs, or TB, the agency includes documentation in the individuals served case record that a referral was made for a health screen through either the individuals served 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 outcome of the referral must be documented within 90 days of the completion of the communicable disease risk screen. If a individual served does not follow through with the referral, the provider is required to offer additional assistance with the referral. The additional assistance must be documented in the record. 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 individual served to seek appropriate care.

6. All pregnant women should be provided a referral for STI screening.

X. SUPRT DATA COLLECTION AND REPORTING REQUIREMENTS

Contracted providers receiving SOR funds for treatment and/or recovery services are required to complete and administer the SAMHSA's Unified Performance Reporting Tool (SUPRT). The SUPRT consists of two components: Administrative (A) and Client (C).

1. SUPRT–A (Administrative)

   Required to be completed by the service provider (e.g., clinician, peer recovery coach, support staff, etc.).
   - Baseline: Within 24 hours of the client's first date of service
   - 6-Month Reassessment: At six months of service
   - Annual: At one year of service
   - Closeout: Upon client discharge from services

2. SUPRT–C (Client)

   Voluntary completion by the client. SUPRT–C must be offered to all clients receiving services and should correspond with the SUPRT–A timeline.
   - Baseline
   - 6-Month Reassessment
   - Annual
   - *A closeout survey is not required for SUPRT–C.*

3. Early Termination of Services

   If services end before the six-month assessment, no further SUPRT surveys are required.

4. Re-engagement with Services

   A new SUPRT series must begin each time a client re-engages in services. Service providers are required to use the same Client ID for returning clients.

5. Submission and Record Retention Requirements

   All SUPRT data (A and C) must be submitted through Qualtrics within 48 hours of completion. Providers must retain a copy of both the Administrative and Client surveys (including client refusals) for auditing purposes. Providers are required to submit a monthly SUPRT tracking form to the MCCMH–SUD SOR Coordinator.