Northern Michigan Regional Entity

Substance Use Disorder Services

Provider Manual

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INTRODUCTION

Welcome to the Northern Michigan Regional Entity (NMRE) substance use disorder (SUD) services Provider Manual. The NMRE partners with SUD prevention, treatment, and recovery support services providers to offer an array of services throughout the NMRE's twenty-one (21) county region. The purpose of this Provider Manual is to offer information and technical assistance regarding the requirements associated with the roles and responsibilities of contracted Providers. This manual is a referenced attachment to the contract with the NMRE and may be revised in response to changes to contract requirements and/or NMRE Policies and Procedures. The most current version of the manual can be found on the NMRE website: www.nmre.org.

Mission, vision, and value statements may also be found on the NMRE website: www.nmre.org

Governing Authority

The counties of Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, and Wexford, through their designated Community Mental Health Service Program (CMHSP) Authorities or Organizations, created a Regional Entity known as the Northern Michigan Regional Entity (NMRE) pursuant to the authority granted under the Michigan Mental Health Code, MCL 330.1001 et seq., Section 1204b as amended, and, as applicable, the Michigan Public Health Code, MCL 333.1101, et seq., as amended.

The NMRE is under contract with the Michigan Department of Health and Human Services (MDHHS) and must comply with all the obligations and requirements associated with the use of public funds. As one of the ten Prepaid Inpatient Health Plans (PIHPs) in Michigan, NMRE has Provider Network management obligations including but not limited to, assurance of overall Federal, State, and other compliance mandates, regional service array adequacy, and ensuring provider competency expectations are met in both professional enhancement and service delivery areas.

Key references for SUD services are on the NMRE website www.nmre.org

- NMRE SUD Prevention Provider contract
- NMRE SUD Treatment Provider contract
- Opioid Health Home Provider contract
- NMRE & MDHHS Contract
- MDHHS Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Policies & Advisories
- LARA Licensing, Certification, Training
- Medicaid Provider Manual, Chapter: Mental Health/Substance Abuse
- SAMHSA Mental and Substance Use Disorders
- MDHHS Provider Qualifications Chart

- Medicaid Services Administration (MSA) Bulletins

Providers are expected to adhere to all standards, requirements, and legal obligations contained in these referenced MDHHS guidance and requirement documents applicable to the specific services being purchased and provided. For efficiency, NMRE will highlight but will not duplicate, in entirety, the information found in the above-mentioned references. Providers are responsible for understanding, demonstrated through service delivery, the content pertinent to the scope of work identified in the contract. NMRE will make every effort to inform Providers about policy, procedure, or other requirement changes.

Glossary of Terms/Definitions

Access Center – The NMRE Access Department responsible for benefit verification, authorization of services, and assisting access into treatment services.

AAAHC – Accreditation Association of Ambulatory Health Care

AAR – Access, assessment, and referral service within NMRE. This is also called the Access Center.

AOA – American Osteopathic Association.

ASAM Patient Placement Criteria – American Society for Addiction Medicine Patient Placement Criteria, second edition-revised. Standard criteria used to determine level of care and continuation in care.

ASAM Continuum – Assessment based on the American Society for Addiction Medicine Patient Placement Criteria, second edition-revised.

ASI-MV – Addiction Severity Index Multi-Media Version. Software used in the clinical assessment of adults.

BHDDA – Behavioral Health and Development Disability Administration, Currently the Bureau of Community Based Services

BSAAS – Bureau of Substance Abuse and Addiction Services

CARF - Commission on Accreditation of Rehabilitation Facilities

Comprehensive Health Assessment for Teens (CHAT) – Multi-media software used in the clinical assessment of adolescents

Clean Claim - A claim properly completed and containing all data elements necessary for processing in accordance with Data Clearing House (DCH) and NMRE policies and Federal 837 transaction requirements.

Member Handbook - A written and comprehensive document provided to Medicaid enrolled clients indicating the services covered under this plan, access to those services and any limitations to services that may apply.

COA – Council on Accreditation

Covered Provider or Provider – License substance use disorder treatment program or other health professional having a contractual agreement with NMRE to provide authorized treatment services to individuals residing in the NMRE's 21-county service area.

Covered Services - Medically necessary treatment services as amended from time to time (in accordance with the Provider Agreement), which Provider is qualified and responsible for administering to individuals eligible for services funded in whole or part by NMRE managed funds. Covered services must be delivered in accordance with NMRE Policies and Procedures, NMRE contract and Medicaid Manual as indicated in return for payments by NMRE under the Provider Agreement.

CMHSP - Community Mental Health Services Program

Client – Individual receiving covered treatment services funded in whole or part by NMRE managed funds (also Customer).

Customer – Individual receiving covered treatment services funded in whole or part by NMRE managed funds (also Client).

Dual diagnosis capable (DDC) - Those programs that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning."

Eligible Person - Individual who is eligible for Community Grant funding based on need as defined by the NMRE Fee Policy and NMRE Residency Determination Policy.

Expedited Review Situation - A situation where the standard time frame would seriously jeopardize the life, health or functioning of a Medicaid or HMP enrolled client.

Healthy Michigan Plan (HMP) – Provides low-cost health care benefits, including substance use disorder services to Michigan residents, who meet criteria and do not qualify for other assistance programs.

JCAHO – Joint Commission on Accreditation of Healthcare Organizations.

Local Appeal – Written request for remedy or reconsideration of a decision made by NMRE Access Center.

MDHHS – Michigan Department of Health and Human Services.

Medicaid Program or **Medicaid** - Medical assistance program established under Section 105 of Act No. 280 of the Public Acts of 1939, as amended, MCLA 400.105 Social Security Act, 42. U.S.C. 1396, et. seq.

Medicaid Deductible (formerly known as Medicaid Spend Down) - Individual meets eligibility criteria for Medicaid enrollment except for his/her income. Medicaid coverage each month is contingent upon meeting a deductible of medical expenses.

Member - Individual eligible for HMP, Medicaid or MIChild Benefits (also “enrollee” or “beneficiary”).

Medically Necessary Services - Services for the treatment of substance use disorders that are shown to be necessary to medically treat an individual’s substance use.

Medication Assisted Treatment – Refers to medication used in conjunction with counseling services for the treatment of a substance use disorder. Example – methadone maintenance services.

NCQA - National Committee for Quality Assurance

Northern Michigan Regional Entity (NMRE) – Prepaid Inpatient Health Plan (PIHP) that manages the funding and coordination of care for substance use disorder services for individuals residing within the 21 counties of northern Michigan who have Medicaid, the Healthy Michigan Plan, MIChild, or individuals who qualify for community grant funding based on their household income.

OROSC – Former Michigan Office of Recovery Oriented System of Care. Currently the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section

Prepaid Inpatient Health Plan (PIHP) – Entity that provides medical services to enrollees under contract with the State agency and responsible for the Michigan Medicaid and HMP behavioral health benefit carve-out including treatment for substance use disorders.

Provider Manual - Policies and procedures established by NMRE and titled "NMRE Substance Use Disorder Services Provider Manual" which provide guidance for the provision of services funded in whole or part by NMRE managed funds.

Administrative Manual – Policies and procedures established by the NMRE which govern the provision of services funded in whole or part by NMRE managed funds.

Rate Schedule - Schedule of charges for Covered Services including any amendments that appear in the Provider Agreement.

Recommended Level of Care - Level of care based on ASAM Patient Placement Criteria.

Medical Necessity - Means determination that a specific service is medically (clinically) appropriate, necessary to meet a person's treatment needs, consistent with the person's diagnosis, symptoms, and functional impairments, and consistent with clinical standards of care.

Unit - Terminology used to define quantity of service for billing purposes.

1 PROVIDER REQUIREMENTS

1.1 Credentialing and Recredentialing

REFERENCES:

- *NMRE Provider Contract: LICENSES/ACCREDITATION/CERTIFICATION/CREDENTIALING/PRIVILEGING, Credentialing/Privileges*
- *MDHHS/PIHP Master Contract Attachment P.7.1.1 "Credentialing and Re-credentialing Processes," (https://www.michigan.gov/documents/mdhhs/Credentialing_and_Recredentialing_Process_P-7-1-1_638453_7.pdf)*
- *NMRE Administrative Manual: Chapter 5*

The NMRE conducts an initial credentialing and the re-credentialing of organizations. The NMRE Policies and Procedures regarding Credentialing are available in the NMRE Administrative Manual. This can be found online at www.nmre.org under Resources, Administrative Manual, Chapter 5 (https://www.nmre.org/resources/administrative-manual/chapter-5-provider-network-contract-management/).

1.1.1 Credentialing Organizational Providers

For organizational providers included on the NMRE Provider Panel:

1. Current licensure by the Michigan Licensing and Regulatory Affairs (LARA) for substance use disorder services is required. If the services provided by the organization are not services currently covered by a license under LARA, a waiver may be made. This is required, as necessary, to operate in Michigan. The NMRE will validate and re-validate licensure at least every two years.
2. Provider must credential and re-credential direct-employed staff as well as any subcontracted direct service Providers in accordance with NMRE Policies and Procedures.
3. Federal requirements prohibit employment or contracts with Providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned Providers is available at http://exclusions.oig.hhs.gov. A complete list of sanctioned Providers is available on the Michigan Department of Health and Human Services website at www.michigan.gov/MDHHS. (click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers)
4. As necessary, designation by MDHHS for ASAM Level of Care is also required.

1.1.1.1 Deemed Status for Out of Region Providers

The NMRE will require an organization to submit all necessary documentation for initial organizational credentialing as well as re-credentialing. However, the NMRE will accept

certain items as deemed status from the provider's 'home' PIHP. Such as site visit results.

1.1.1.2 Notification of Adverse Credentialing Decision

An organizational Provider that is denied credentialing or re-credentialing by the NMRE will be informed of the reasons for the adverse credentialing decision in writing.

1.1.1.3 Appeal of Adverse Credentialing Decision

The NMRE has an appeal process that is available when credentialing or re-credentialing is denied, suspended, or terminated for any reason other than lack of need. The appeal process will be consistent with applicable Federal and State requirements.

1.1.1.4 Reporting Requirements

The NMRE is required to report known organizational Providers improperly credentialed that result in a suspension or termination from its Provider Network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.).

1.2 Provider Requirements for Credentialing and Re-credentialing Staff

REFERENCES:

- *NMRE SUD Contract: LICENSES/ACCREDITATION/CERTIFICATION/CREDENTIALING/PRIVILEGING, Credentialing/Privileges*
- *NMRE SUD Contract: General Responsibilities*

1.2.1 Excluded Provider Checks

It is the responsibility of Providers to check the following resource listings for ALL employees prior to hire:

- OIG (https://exclusions.oig.hhs.gov/)
- Michigan Excluded Provider (https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-16459--,00.html)

In addition, all practitioners listed below (per NMRE Credentialing Policy) need to be checked prior to hire on the National Practitioner Data Bank (https://www.npdb.hrsa.gov/). NMRE will also conduct a verification on these staff during annual Provider site reviews.

- Physicians (M.D. or D.O.)
- Physician Assistants
- Nurse Practitioners
- Psychologists
- Limited Licensed Psychologists
- Master's Social Workers
- Licensed Bachelor's Social Workers
- Limited Licensed Social Workers

- Registered Social Service Technicians
- Licensed Professional Counselors
- Limited Licensed Professional Counselors
- Registered Nurses
- Licensed Practical Nurses
- Occupational Therapists
- Occupational Therapy Assistants
- Physical Therapists
- Physical Therapy Assistants
- Speech Pathologists
- Dieticians
- Pharmacists
- Board Certified Behavioral Analysts

Per multiple requirements within the NMRE Provider Contract for Substance Use Disorder Services, the PIHP/MDHHS Master contract, and Code of Federal Regulations, employees and/or practitioners that meet excluded or sanctioned criteria as referenced in the resource lists above are not able to provide services to individuals receiving NMRE funding.

It is the responsibility of the provider to supply updated staff information to the NMRE for subsequent checks.

1.2.2 Provider Credentialing Individual Practitioners

Credentialing and re-credentialing must be conducted and documented for the following health care professionals, at a minimum:

- Physicians (M.D.s and D.O.s)
- Physician's Assistants
- Psychologists (Licensed, Limited License, and Temporary License)
- Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
- Licensed Professional Counselors
- Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
- Occupational Therapists and Occupational Therapist Assistants
- Physical Therapists and Therapist Assistants
- Speech Pathologists

1.2.2.1 Provider – Staff Initial Credentialing

At a minimum, providers should have policies and procedures for the initial credentialing of the individual practitioner that meet guidelines below. Providers must furnish documentation of completion prior to clinical staff providing services.

Provider Requirement	Documentation Required
Policies and procedures to check at the time of initial credentialing. Providers should have documentation prior to clinical staff providing services	1. A written application that is completed, signed, and dated by the practitioner Attestation of the practitioner of the following: a. Lack of present illegal drug use. b. Any history of loss of license and/or felony convictions. c. Any history of loss or limitation of privileges or disciplinary action. d. Attestation by the applicant of the correctness and completeness of the application. 2. An evaluation of the practitioner's work history for the prior five years. 3. Verification from primary sources of: a. Licensure or certification. b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training. c. Documentation of graduation from an accredited school. d. National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified: i. Minimum five-year history of professional liability claims resulting in a judgment or settlement; ii. Disciplinary status with regulatory board or agency; and iii. Medicare/Medicaid sanctions.

If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

1.2.2.2 Provider – Staff Temporary/Provisional Credentialing

REFERENCES:

- *NMRE SUD Contract: LICENSES/ACCREDITATION/CERTIFICATION/CREDENTIALING/PRIVILEGING, Credentialing/Privileges*
- *NMRE Policy for Temporary/Provisional Credentialing*

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of Providers in underserved areas, whether rural or urban. If a provider is requesting temporary or provisional credentialing of an individual practitioner for the purpose of payment of services by the NMRE, provider must make the request in writing to the NMRE. Request must contain a detailed explanation of the request, the timeline for when credentialing will be achieved and the practitioner's credentials. The NMRE has a policy and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that Providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing will not exceed 150 days.

The NMRE has up to 31 days from the receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

Provider Requirement	**Documentation Required**
Policies and procedures to check at the time of initial credentialing. Providers should have documentation prior to clinical staff providing services	For consideration of temporary or provisional credentialing, at a minimum a Provider must complete a signed application that must include the following items: 1. Lack of present illegal drug use. 2. History of loss of license, registration, or certification and/or felony convictions. 3. History of loss or limitation of privileges or disciplinary action. 4. A summary of the Provider's work history for the prior five years. 5. Attestation by the applicant of the correctness and completeness of the application.

	The NMRE will conduct primary source verification of the following: 1. Licensure or certification, 2. Board certification, if applicable, or the highest level of credential attained; and i. Medicare/Medicaid sanctions.

1.2.2.3 Provider – Staff Re-credentialing

At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following listed below.

Provider Requirement	**Documentation Required**
Policies and procedures for re-credentialing. A process for ongoing monitoring, and intervention if appropriate, of Provider sanctions, complaints and quality issues pertaining to the Provider, which must include items listed in documentation. Providers should complete the re-credentialing process at least every two years. This can be an update of information obtained during the initial credentialing.	• Documentation of re-credentialing completed at least every two years. • A process for ongoing monitoring, and intervention if appropriate, of Provider sanctions, complaints and quality issues pertaining to the Provider, which must include, at a minimum, review of: a. Medicare/Medicaid sanctions. b. State sanctions or limitations on licensure, registration, or certification. c. Member concerns which include grievances (complaints) and appeals information. d. PIHP Quality issues. The PIHP must conduct verification of the following annually: • Licensure or certification continuation; • Board certification, if applicable, continuation; and • Medicare/Medicaid sanctions.

1.2.2.4 Notification of Adverse Credentialing Decision

REFERENCES:

- *NMRE Credentialing Policy*

An individual practitioner that is denied for inclusion for reimbursement for services by the NMRE will be informed of the reasons for the adverse credentialing decision in writing.

1.2.2.5 Appeal of Adverse Credentialing Decision

REFERENCES:

- *NMRE Credentialing Policy*

An appeal process is available when inclusion for reimbursement is denied, suspended, or terminated for any reason other than lack of need. A provider wishing to appeal the adverse credentialing decision should make the request in writing and provide any additional documentation to support the request.

1.2.3 Provider Staff Credentials File

REFERENCES:

- *NMRE SUD Contract, General Responsibilities*

Providers are required to establish and maintain a credentials file on all employees or contractual staff providing clinical services.

Provider Requirement	**Documentation Required**

Credentials file on all employees or contractual staff providing clinical services that meets documentation requirements	• a written application that is completed, signed, and dated by the clinician that attests to:
	  ○ Lack of present illegal drug use
	  ○ History of loss of license and/or felony convictions
	  ○ History of loss or limitation of privileges or disciplinary action
	  ○ Five-year history of professional liability claims resulting in judgment or settlement and attestation by the applicant of the correctness of the findings.
	  ○ Completeness of the application.
	
	In addition, the credentials file must contain:
	• Academic history with proof of completion
	• Internship, practicum, and clinical experience that is supervised, with area

	of clinical practice, age group and/or specific skills learned • Employment experience in the form of a resume • Copies of professional licenses, certification, and registrations • Current list of "in-service" training completed, including other professional training experiences pertinent to clinical practice. • An evaluation of the clinician's work history for the prior five years.
Providers must ensure that criminal background checks are conducted as a condition of potential employment. This requirement is not intended to imply that a criminal record should necessarily bar employment.	• Documentation of a criminal background check conducted and the outcome
Providers must review the Medicaid Sanctioned Provider List, and the OIG office of Inspector General website http://exclusions.oig.hhs.gov annually to assure no staff in employment or contracting with the Provider is listed. Pursuant to Section 1128 and Section 1902(a)(39) of the Social Security Act, the Medicaid Program will not reimburse a Provider for any services rendered or that were ordered/prescribed by a sanctioned (e.g. suspended, terminated, excluded, etc.) Provider. The effect of the Provider's exclusion precludes them from furnishing, ordering, or prescribing items or services to any Medicaid member.	• Documentation of Sanctioned Provider List checked annually on all staff

The credentials file will serve as a support to clinical privileges practiced, which will be listed by date granted in the credentials file.

1.2.4 Training Requirements

REFERENCES:

- *NMRE SUD Contract, Staffing and Training Requirements*

Providers must assure that all clinical staff receive continuing education annually and the education is documented.

1.2.4.1 Compliance with the 2005 Deficit Reduction Act

REFERENCES:

- *PIHP-MDHHS Contract, Schedule A. Statement of Work, General Requirements, Program Integrity*

The Provider agrees to comply with language contained in the 2005 Deficit Reduction Act as indicated below.

Provider Requirement	**Documentation Required**
The Provider agrees to comply with language contained in the 2005 Deficit Reduction Act by minimally implementing employee, contractor and agent education containing "detailed" information about the Federal and State False Claims Acts, and any other administrative remedies for false claims and all whistleblowers' provisions. Provider also agrees that all new employees must be trained on the Deficit Reduction Act (including fraud and abuse and whistleblower protections) at the time they affiliate with the agency and existing employees should receive annual training on the Act.	• Documentation of annual staff training on the Deficit Reduction Act (including fraud and abuse and whistleblower protections)

1.2.4.2 Communicable Disease Training (Level I Training – Clinical & Non-Clinical Staff)

REFERENCES:

- *NMRE SUD Contract, MDHHS Service Requirements, Communicable Diseases*

All staff with client contact at a licensed treatment Provider are required to have at least a basic knowledge of HIV/AIDS, Hepatitis and STD, and the relationship to substance abuse by attending a Level 1 training. Staff members who have previously completed this training would not be required to complete it again.

Provider Requirement	**Documentation Required**
All staff with client contact at a licensed treatment Provider are required to have at least a basic knowledge of HIV/AIDS, Hepatitis and STD, and the relationship to substance abuse by attending a Level 1 training. Improving MI Practices has a web-based	• Documentation of online training for Communicable Disease are offered at the following website: www.improvingmipractices.org.

training that will cover minimal knowledge standards necessary to meet this Level 1 requirement.	

1.2.5 New Hire Notification Form

1.2.5.1 Clinical Staff

Prior to the delivery of services, it is the Provider's responsibility to submit a New Hire Notification Form for all staff with direct client contact. Completed New Hire Notification forms can be submitted by e-mail to providersupport@nmre.org. New Hire Notification forms will be reviewed, and must be approved, by NMRE prior to having any client contact.
Services rendered by clinical staff not approved by NMRE may not be reimbursed.

When clinical staff leave employment, NMRE requires notification of departure to ensure access to confidential information is not accessible. Providers should identify the last date of employment, to ensure accurate records, contact lists remain up to date and staff are deactivated from the RECON data system. Please send notice of any staff changes in location, position, or departure to providersupport@nmre.org.

1.2.5.2 Non-Credentialed Staff

Staff whose job responsibilities are paraprofessional or specifically focused, such as residential aides or generalist case managers, are not be required to obtain ICRC (International Certification & Reciprocity Consortium) certification, but must work under the supervision of certified staff. The Provider is required to conduct a criminal background check and assure that the non-clinical staff person is not listed on the Medicaid Sanctioned Providers list (https://exclusions.oig.hhs.gov/).

Provider Requirement	**Documentation Required**
Providers are to submit a New Hire Notification Form for staff	• New Hire Notification Form submission to the NMRE.

1.2.5.3 Non-Clinical Staff

Staff whose job responsibilities are non-clinical, are not be required to obtain ICRC (International Certification & Reciprocity Consortium) certification. The Provider is required to conduct a criminal background check and assure that the non-clinical staff person is not listed on the Medicaid Sanctioned Providers list (https://exclusions.oig.hhs.gov/).

Provider Requirement	Documentation Required
Providers are to submit a partial New Hire Notification Form for staff only if RECON access is needed	• New Hire Notification Form submission to the NMRE.

2 CUSTOMER SERVICES AND RECIPIENT RIGHTS

2.1 Customer Services

The Northern Michigan Regional Entity is committed to fostering a recovery-oriented system of care. Substance use disorder treatment must be accessible, evidence based, and delivered by a coordinated system of professional organizations and staff that demonstrate the core belief of dignity and respect for all people.

2.2 Non-Discrimination

REFERENCES:

- *NMRE SUD Contract, Nondiscrimination*
- *Title VI of the Civil Rights Act of 1964*
- *28 C.F.R. Section 42.405(d)(1), Title VI*
- *The Americans with Disabilities Act*
- *Section 504 of the Rehabilitation Act of 1973*

Providers shall adhere to contractual, state, and federal requirements for non-discrimination.

Providers are not to render services for individuals with NMRE funding, in part or whole, in a different manner than those individuals not receiving public funding. Services are to be consistent with existing medical, ethical, and legal requirements for providing continuity of care to any client.

2.3 Confidentiality

REFERENCES:

- *Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2)*
- *Health Insurance Portability and Accountability Act of 1996-Privacy Standards (45 CFR Parts 160 and 164)*
- *NMRE SUD Contract, Compliance in General, Confidentiality*
- *NMRE SUD Contract, Definitions, Health Insurance Portability and Accountability Act of 1996*
- *NMRE SUD Contract, Customer Records/Establishment/ Retention/Access/Release/Confidentiality*

All Provider staff must comply with the Federal Drug and Alcohol Confidentiality Law (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996-Privacy Standards (45 CFR Parts 160 and 164).

Provider Requirement	Documentation Required
Providers are required to comply with HIPAA and 42 CFR, Part 2 requirements	• Release of information meeting all requirements, specifically the designated release of information, for any outgoing information releases

2.3.1 42 CFR Part 2-Federal Drug and Alcohol Confidentiality Law

Providers must review and provide a written summary of the confidentiality provisions at admission. Written acknowledgement of receipt shall be documented in the client file. In the event the client is not capable of rational communication at the time of admission as in the case of a sub-acute detoxification admission, the notice and summary should be provided as soon thereafter when the client is capable of rational communication.

All disclosures of information must be made consistent with the Federal Drug and Alcohol Confidentiality Law and the Health Insurance Portability and Accountability Act-Privacy Rules. Typically, communication will be made with the permission of the client as documented by a signed consent for the release of information that meets the requirements of 42 CFR Part 2.

Provider Requirement	Documentation Required
Providers are required to comply with HIPAA and 42 CFR, Part 2 requirements	• Release of information meeting all requirements, specifically the designated release of information, for any outgoing information releases

2.3.2 45 CFR Parts 160 and 164 - HIPAA Privacy

Providers must have a Notice of Privacy Practices including client rights under the Privacy Standards. The Notice of Privacy Practices must contain all elements required by 45 CFR Parts 160 and 164.

Provider Requirement	Documentation Required
The Privacy Notice must be provided to the client at the date of first service delivery. The Provider must have available a copy of the Notice for clients, and it must be posted in a clear and prominent location where it is reasonable to expect clients to be able to read it.	• The Provider must make a good faith effort to obtain the client's written acknowledgement of receipt of the notice. If acknowledgement is not obtained, the Provider must document its efforts and the reason it was not able to obtain the acknowledgement.

If the Provider maintains a website that provides information about its services or benefits, the Privacy Notice must be posted and made available electronically through the site in machine-readable format.	• Privacy Notice posted on the provider website and made available electronically through the site in machine-readable format.
The Provider must provide clients whose treatment is funded in whole or part by NMRE managed funds with a copy of the NMRE Privacy Notice.	• Documentation that the NMRE Privacy Notice was given to clients
Provider Policy for any unauthorized disclosures of information under 45 CFR Parts 160 and 164 consistent with HIPAA	• For any unauthorized disclosures, documentation that the Provider's HIPAA Privacy Policy was followed
The Provider shall appoint a Privacy Officer whose duties shall meet requirements as defined in 45 CFR Parts 160 and 164. All staff must receive and document training annually on HIPAA Privacy Standards/Rules.	• Identification of a Privacy Officer • Documentation of staff training annually on the HIPAA Privacy Standards/Rules

2.4 Limited English Proficiency Requirements

REFERENCES:

- *NMRE SUD Contract, MDHSS Service Requirements, Cultural Compliance*
- *Compliance in General, Laws, 4*

Providers receiving funding from NMRE are required to comply with Title VI of the Civil Rights Act of 1964, and Section 1557 of the Affordable Care Act (ACA). Office for Civil Rights (OCR) recent guidance clarifies Title VI obligations with respect to individuals who are Limited English Proficient (LEP). Ultimate responsibility for enforcing compliance with Title VI rests with the Office for Civil Rights, which investigates complaints and performs compliance reviews in entities covered by Title VI. Detailed information can be obtained from the United States Department of Health and Human Services website: http://www.hhs.gov

Provider Requirement	**Documentation Required**
Providers must have a Limited English Proficiency (LEP) policy in place and in practice. The LEP policies and procedures must include the following, as required by the Office for Civil Rights:	• LEP Policy and Procedures meeting the requirements

• Procedures for identifying and assessing the language needs of the community in the geographic area served. Needs must be based on current local and regional census data, as well as other State and Regional data. • Identified range of oral language assistance options appropriate to the Provider's service area. • Procedure for identifying the language needs of individuals requesting services. • Procedure for providing notice to individuals with LEP, in their primary language, of the right to free language assistance. • Process and procedures for staff training related to LEP policies and procedures. • Provisions for written materials of key documents in language other than English where a significant number or percentage of the affected population needs services or information in a language other than English, to communicate effectively. This must also include written information in other formats (large print, audio, electronic, etc.) Key documents include but are not limited to: enrollment applications, consent forms, letters containing important information regarding participation in the program, notices pertaining to the reduction, denial or termination of services or benefits, of the right to appeal such actions or that require a response from beneficiaries, and notices advising LEP persons of the availability of free language assistance. • Provisions for the procurement of qualified oral and sign language interpreters who are trained, competent, and accessible in a timely manner. • Statements explaining timely assistance. • Statements explaining there will be no charge to the LEP recipient for these services. • Statement regarding the exclusion of bilingual minors, adult family members, friends, and staff as medical interpreters according to Section 1557 of the ACA. Exceptions apply in emergency situations.	

2.4.1 Limited English Proficiency Assistance Services

Title VI provides that no person may be denied meaningful access to NMRE's managed benefits and services based on national origin. To comply with the Title VI requirement, NMRE and its Provider Network will ensure that Limited English Proficient persons have meaningful access to and can

understand information contained in program-related written documents. Thus, for language groups other than English or Spanish, NMRE will ensure such access by providing notice in writing, in the person's primary language, of the right to receive free language assistance in a language other than English or in an alternative format, including the right to competent oral translation of written materials, free of cost.

Providers will arrange for the provision of oral assistance in response to the needs of LEP clients, in both face-to face and telephone encounters. In addition, Providers must post and maintain "taglines" in regularly encountered languages other than English in waiting rooms, reception areas, and other initial points of entry informing clients of the right to free language assistance services and an invitation to self-identify as an individual in need of such services.

2.4.2 Vital Written Documents

Northern Michigan Regional Entity has the Recipient Rights Brochure and the NMRE HIPPA Privacy Notice as vital documents in Spanish available upon request.

NMRE will provide written materials in the prevalent non-English languages present in the Provider service area.

2.4.3 Interpreter Services

Interpreter services may be obtained by hiring qualified bilingual staff, contracting with an outside interpreter service, arranging for the services of qualified/certified voluntary community interpreters, or arranging/contracting for the use of a telephone language interpreter service that will meet the various language needs of the populations served.

NMRE will reimburse the Provider for language interpreter services for NMRE funded clients provided by a qualified interpreter service in the following instances: 1) outside contracted interpreter service or 2) telephone language interpreter service. NMRE will pay for these services for the initial contact with the Provider, assessment and ongoing treatment services funded in whole or part by NMRE managed funds. If the client does not keep the appointment for treatment and the Provider is billed by the interpreter service, then NMRE will pay the interpreter service fee associated with the missed appointment. NMRE will pay this missed appointment fee for no more than two sessions in a 30-day period. If the client continues to miss appointments on a regular basis, then reimbursement decisions will be made on a case-by-case basis. Clients cannot be charged for interpreter services. Note that Providers may not suggest that the client bring in his/her own interpreter or permit a minor or other client to interpret. This is in direct violation of Title VI.

Provider Requirement	Documentation Required
Providers must have procedures for obtaining the services of trained and competent interpreters in a timely manner.	• Reimbursement request for interpreter services should be made to the NMRE (submission of request and bill to providersupport@nmre.org)

2.5 Accommodation for Disabilities

REFERENCES:

- *The Rehabilitation Act of 1973*
- *The American with Disabilities Act of 1990 (ADA)*

2.5.1 The Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act makes it illegal for Providers to discriminate based on disability. Section 504 obligates Providers to ensure that persons with disabilities have equal access to any programs, services, or activities supported in whole or part by NMRE managed funds. Providers are also required to ensure that their employment practices do not discriminate based on disability.

2.5.2 The Americans with Disabilities Act of 1990 (ADA)

The ADA defines disability as a mental or physical impairment that substantially limits one or more major life activities. ADA protection extends not only to individuals who currently have a disability, but to those with a record of a mental or physical impairment that substantially limits one or more major life activities, or who are perceived or regarded as having a mental or physical impairment that substantially limits one or more major life activities.

2.5.3 Accommodations for Deaf and Hearing-Impaired Individuals

General

Accommodations to assist individuals who are deaf or hearing impaired include the use of qualified sign language and oral interpreters, note takers, computer-aided transcription services, written materials, telephone headset amplifiers, assistive listening systems, telephones compatible with hearing aids, open and closed captioning, videotext displays and teletypewriters (TTY/TDD).

Clients cannot be charged for or required to provide interpreter services.

Michigan Relay Center

The Michigan Relay Center will initiate a call to the Provider and indicate “Michigan Relay Center is calling." The Center is a communications system that allows hearing persons and hearing-impaired, hard-of hearing, or speech-impaired persons to communicate by telephone.

A person who is hearing-impaired, hard-of-hearing, or speech-impaired uses a keyboard device or Teletypewriter (TTY or TDD) to contact a Relay Representative.

The Relay Representative puts the TTY/TDD caller in touch with the Provider by giving the Provider the TTY/TDD message verbally. The representative literally "voices" the message verbatim and waits for your response. The Relay Representative then types your response back to the caller.

Hearing persons may also use the service. To communicate with someone who is hearing-impaired, hard-of-hearing, or speech-impaired, simply call the Michigan Relay Center at **711.** Tell the Relay Representative the name, area code and phone number of the person you would like to reach. You may also have to tell the Relay Representative the name of your long-distance company if it is a toll call so it can be properly billed. While you talk as though you were speaking directly to the TTY/TDD user, the Relay Representative is relaying your conversation via the TTY/TDD system.

Charges for calls through the Center, whether local or long distance, are charged the same as if the hearing or speech-impaired person had dialed the other person directly. The Relay Representative will provide information on a call's charges upon request.

Calls made through the Center are not edited by Relay Representatives. Relay Representatives are also forbidden to disclose any information from the calls and no records of conversations are kept.

Sign Language or Oral Interpreter Services

The NMRE will reimburse the Provider for oral or sign language interpreters.

Services must be provided by a qualified interpreter. The Americans with Disabilities Act (ADA) defines the term “qualified interpreter” in its Title III regulation to mean “an interpreter who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary.”

Provider Requirement	Documentation Required
Providers must have procedures for obtaining the services of trained and competent interpreters in a timely manner.	• Reimbursement request for interpreter services should be made to the NMRE (submission of request and bill to providersupport@nmre.org)

Michigan Coalition for Deaf, Deafblind, and Hard of Hearing People

Michigan specific web-based resource that provides information on interpreter services, links to online recovery groups, etc. Website link: http://www.michdhh.org

Provider Requirement	Documentation Required
Providers must have procedures for obtaining the services of trained and competent interpreters in a timely manner.	• Reimbursement request for interpreter services should be made to the NMRE (submission of request and bill to providersupport@nmre.org)

Residential Services for Deaf and Hard of Hearing People

The Michigan Department of Health and Human Services/Office of Drug Control Policy contracts directly with Salvation Army Harbor Light in Monroe, MI for residential services for individuals who are deaf and/or hard of hearing. If you need information on making a referral contact (734) 457-0661 (TTY) or (734) 457-4340 (Voice).

Provider Requirement	Documentation Required
Providers must have procedures for obtaining the services of trained and competent interpreters in a timely manner.	• Reimbursement request for interpreter services should be made to the NMRE (submission of request and bill to providersupport@nmre.org)

2.5.4 Physical Disabilities

Provider Requirement	Documentation Required
Providers must allow for accommodations for individuals with a physical disability in accordance with the Americans With Disabilities Act (ADA)	N/A

2.5.5 Service Animals

Provider Requirement	Documentation Required
Providers must allow for service animals in accordance with the Americans With Disabilities Act (ADA)	N/A

3 MEDICAID, HEALTHY MICHIGAN PLAN AND MICHILD SPECIFIC

3.1 Choice of Provider

REFERENCES:

- *42 CFR 438.6*
- *PIHP-MDHHS Contract, Schedule A. Statement of Work, 1. General Requirements, E. Access and Availability, 2. Network Requirements, 11. Choice*

3.1.1 Choice of Provider – Change in Level of Care

Clients must be given a choice of Provider for each level of care received. This must be documented in the client file and, at minimum, should include the client's signature as evidence that they have been given a choice of Providers.

3.1.2 Choice of Provider – Change in Level of Care

For clients changing levels of care, choice of provider must be given prior to discharging the client to the next level of care. This must be documented in the client file and at minimum, should include the client's signature as evidence that they have been given choice of Providers.

Provider Requirement	Documentation Required
Choice of Provider is to be given at the time of Admission and at any Change in Level of Care	• Documentation that choice was given

3.2 Member Handbook – Medicaid and HMP Only

Providers must offer clients from the NMRE region a copy of the PIHP Guide to Services. The Provider must obtain written acknowledgement of the offer and keep a copy of the signed and dated acknowledgement in the client's file.

Providers must have available copies of the PIHP Guide to Services. Copies may be obtained by contacting NMRE Customer Services Department. https://www.nmre.org/services/guide-to-services/

Provider Requirement	Documentation Required
• Clients are offered the NMRE Guide to Services upon entry to services and annually thereafter • Clients are provided the NMRE Guide to Services upon request.	• Client signature, dated, of the acknowledgement of the offer of the NMRE Guide to Services • If requested, documentation client received the copy

3.3 Grievance (Complaint)

REFERENCES:

- *NMRE-MDHHS Contract, Schedule A. Statement of Work, 1.General Requirements; L. Grievance and Appeals*
- *NMRE SUD Contract, Health and Safety of Customers/Enrollee Rights/Customer Grievance Procedures*

Providers must attempt to solve a complaint as good customer service, and if the client is not satisfied, they must be offered the ability to file a formal grievance with the provider or the NMRE.

3.3.1 Formal Grievance

REFERENCES:

- *NMRE SUD Contract, Health and Safety of Customers/Enrollee Rights/Customer Grievance Procedures*

Providers must follow the set NMRE process for the resolution of grievances from clients. However, a client may file a grievance on any aspect of service provided to him/her by NMRE, and/or a Provider. An important item to note is that there are no appeal rights on grievances unless the provider or NMRE fail to meet the 90-day deadline.

Process to file a formal grievance:

- Client completes the Grievance Form and submits to the Provider or directly to the NMRE. The provider must assist the client if necessary. Staffmay also take a verbal complaint over the phone.

1. Provider
    i. The complaint is logged on the required NMRE template
    ii. The Provider Customer Services Specialist will contact the client and work with them for any additional information as needed
    iii. The Provider Customer Services Specialist will work with the client and the provider to resolve the grievance.
    iv. Grievances filed by clients shall be acknowledged in writing by Provider within 10 business days of receipt of the grievance on the state-mandated 'Notice of Receipt of Grievance' form.

v. The Provider will work with the client to resolve the complaint and it will provide the client notice of the disposition of the grievance on the state-mandated 'Notice of Grievance Resolution' form within 90 calendar days from the date it receives the complaint.

2. NMRE
   i. The NMRE Customer Services Specialist will contact the client and work with them for any additional information as needed
   ii. The NMRE Customer Services Specialist will work with the client and the provider to resolve the grievance.
   iii. Grievances filed by clients shall be acknowledged in writing by NMRE within 10 business days of receipt of the grievance.
   iv. NMRE will work with the client and Provider to resolve the complaint and it will provide the client notice of the disposition of the grievance within 90 calendar days from the date it receives the complaint.

All grievances received by a Provider must be logged utilizing the template provided by the NMRE. These logs must be submitted to NMRE Customer Services QUARTERLY, no later than the following dates: January 15th, April 15th, July 15th, November 15th.

Provider Requirement	Documentation Required
If a grievance occurs, the provider is to follow the set process	• Required forms completed and submitted to the NMRE

3.3.2 Local Appeal

REFERENCES:

- *NMRE-MDHHS Contract, Schedule A. Statement of Work, 1. General Requirements, L. Grievance and Appeals Grievance and Appeal Technical requirements*

A client or his/her representative may submit a Local Appeal to an action that has resulted in an Adverse Benefit Determination (ABD). An ABD is a determination that an admission, availability of care, continued stay, or other service has been reviewed and based upon the information provided, does not meet the requirements for medical necessity, appropriateness, level of care or effectiveness, and the requested service or payment for it is therefore denied, reduced, or terminated. See Grievance and Appeal Tech requirement.

A clients' representative is defined as a person who has written authorization from the client to speak or act on their behalf. Consent must be obtained by completing a Release of Information form in order to share client information with the representative. Someone who assists but does not stand in for the client in the grievance or appeal process need not meet the above criteria.

Process to file an appeal:

- Client completes the Local Appeal Form and submits to the Provider or directly to the NMRE. The provider assist the client if necessary. . The Recipient Rights Advisors may also take a verbal request over the phone. However, an attempt to confirm the request in writing must be made unless the client requests expedited resolution.
    1. Provider

       The Local Appeal Form is submitted to the NMRE with a signed MDHHS-5515 consent to release confidential information.

    2. NMRE
        a. Upon receipt by NMRE of a completed Local Appeal Form and a signed consent for the release of information, NMRE will review the information.
        b. A determination will be made within 30 business days of receipt.
        c. When the appeal review process is completed, NMRE will inform the client of the decision in writing utilizing the state-mandated appeal notice.
        d. The client will also be notified at this time of their right to a Fair Hearing.
    3. Provider
       The provider shall enter the result of the Appeal into the client's record.

The Provider must be available to discuss the case with NMRE during this time period and provide necessary documentation.

No appeal will be considered after 60 calendar days from the date of the denial of authorization.

Provider Requirement	Documentation Required
If a local appeal occurs, the provider is to follow the set process	• Required forms completed and submitted to the NMRE

3.3.3 State Fair Hearing

The NMRE and its Provider Network must provide appropriate notice to Medicaid, Healthy Michigan, and MIChild clients regarding actions affecting benefits and the right to a State Fair Hearing. A State Fair Hearing is an impartial review of the client's case by a State Administrative Law Judge. Clients are given 120 days from the date of notice of Appeal Denial to file a request for a fair hearing.

Process to file an appeal:

- If a client requests a State Fair Hearing, the provider will direct the client to NMRE Customer Services.

A State Fair Hearing can only be requested after the client has completed the Local Appeal process. The Provider will direct the client to NMRE Customer Services if they would like assistance with this process.

Provider Requirement	Documentation Required
If a State Fair Hearing is requested, the provider will direct the client to NMRE Customer Services	• Submission of required documentation

3.4 Adverse Benefit Determination (ABD)

REFERENCES:

- *NMRE-MDHHS Contract, Schedule A. Statement of Work,1.General Requirements; L. Grievance and Appeals*
- *42 CFR 438.404*

The PIHP and contracted Providers are required by 42 CFR 438.404 to provide timely and adequate notice of any Adverse Benefit Determination. This includes denial of a requested service, denial for payment of a requested service, or reduction, suspension, or termination of an existing service.

Provider Requirement	Documentation Required
Provide timely and adequate notice of any Adverse Benefit determinations	• State-mandated Adverse Benefit Determination Notice
If the Provider suspends, reduces, or terminates authorized services, the provider must provide the ABD to the client at least 10 calendar days prior to the proposed effective date (Advance Notice)	• Documentation of ABD must be kept in the client's file
If the Provider removes a client from a program or otherwise reduces, suspends, or terminates authorized services "effective immediately," the client must be given the ABD at the time of the action (Adequate Notice)	• Documentation of ABD must be kept in the client's file

3.5 Advance Directive

REFERENCES:

- *NMRE SUD Contract, MDHHS Service Requirements, Advance Directives*

An Advance Directive is a legal document that provides written instruction, such as a Durable Power of Attorney for Health Care or a Do-Not-Resuscitate Order, for a medical or mental health provider in the event that the client is unable to make decisions for themselves.

Provider Requirement	Documentation Required
Providers are required at the time of intake into services to review with the client his/her right to an Advance Directive and to obtain signed acknowledgement of receipt of the information. Providers must ask if the client currently has an Advance Directive	• Documentation of the acknowledgement must be kept in the client's file • If the client has an Advance Directive, a copy must be requested and placed in the client's file in a location that is readily accessible. The file must be externally tagged or labeled so that it can be identified as containing an Advance Directive.

3.6 Recipient Rights

REFERENCES:

- *NMRE SUD Contract, Health and Safety of Customers/Enrollee Rights/Customer Grievance Procedures, Recipient Rights*

All clients must be notified upon admission of their rights while receiving services under Michigan Public Act 368 and provided the brochure, "Know Your Rights". In addition, the client shall be given the name of the Provider's Rights Advisor and contact information as well as the name and contact information of the NMRE Rights Advisor (aka Customer Services Specialist).

If a client feels their rights have been violated, they can file a rights complaint with the program or the NMRE. If an NMRE client files a rights complaint with a contracted provider, the Provider must notify the NMRE Rights Advisor for documentation purposes. Copies of rights complaints must be uploaded to NMRE via the Share File system (see CONFIDENTIALITY). The state-mandated Rights forms (LARA) must be utilized.

All recipient rights complaints must be addressed and processed in compliance with Michigan Public Act 368, Administrative Rules for Substance Abuse Services Programs in Michigan. http://www.michigan.gov/mdch/0,1607,7-132-27417_27655_30419---,00.html

Provider Requirement	Documentation Required
If it is determined that the client is incapable of understanding his/her rights, this should be documented, and the Provider's Rights Advisor consulted. In the event the client's primary language is other than English and they do not speak English, the Limited English Proficiency procedures shall be followed. If the client is unable to read, information on his/her rights must be presented by the Provider's Rights	• Documentation to support the use of LEP procedures

Advisor or via an acceptable medium such as audiotape.	
Receipt and understanding of rights by the client should be acknowledged in writing and maintained in the client's file. If at any time during services the client needs to be reminded of his/her rights, it must be provided and documented in the client's file.	• Documentation of the client's receipt and understanding of rights should be acknowledged in writing and maintained in the client's file.
All clients must be notified upon admission of their rights while receiving services under Michigan Public Act 368 and provided the brochure, "Know Your Rights". In addition, the client shall be given the name of the Provider's Rights Advisor and contact information as well as the name and contact information of the NMRE Rights Advisor (aka Customer Services Specialist).	• Documentation of notification of rights (documentation that the brochure "Know Your Rights" was provided)

4 ACCESS TO CARE

4.1 Access Management

The Access Management System is described as a system, not a place, to assist individuals in needed and appropriate services.

4.2 Access to Care

REFERENCES:

- *NMRE SUD Contract, Service Access/Preauthorizations/Delivery/Utilization Management*

Access Management is a process of defining how access to care is performed in a region. In the NMRE region, access to care is a combined effort of NMRE and Provider working with a client to obtain appropriate services for individuals seeking treatment.

4.3 Accessing Care

Individuals seeking services may utilize the NMRE Access Center, Community Mental Health Service Providers, and Substance Use Disorder Service Providers as the initial point of contact.

1. The NMRE Access Center Care Managers are available Monday through Friday from 8:30am – 4:30pm.

2. After-hours and on weekends and holidays, the after-hours service will take the call. The calls are triaged based on the needs of the caller. If withdrawal management assistance is needed, a referral will be made directly to a contracted Provider for these services. For calls identified as screening appropriate, demographic information from the individual will be obtained for a call-back by NMRE staff person the next business day. If the client is a priority client and in need of screening, interim services will be provided. If the caller is in a crisis situation, the after-hours service will act and assist the individual.
   If an individual contacts a Provider directly, the Provider will follow the Access System Standards as described in the MDHHS/PIHP Contract.

Provider Requirement	Documentation Required
• Screen individuals calling in at initial contact to determine the potential need for an assessment	• Documentation of the screening and outcome must be kept in the client's file
• Screen individuals calling in at initial contact for priority populations, insurance verification and identifying issues of the individual	• Documentation of the screening and outcome for priority populations must be kept in the client's file
• If the individual has other insurance, insurance verification of benefits should be identified as the NMRE constitutes payor of last resort except in specific instances. If the Provider does not accept the client's insurance, the client must be referred to a provider that does take the insurance.	• Documentation of the screening and outcome for insurance must be kept in the client's file. If other insurance is identified and the Provider accepts the insurance, verification of benefits must be kept in the client's chart and provided at the time of authorization. If the Provider does not accept the other insurance, documentation of the referral to a Provider that does accept the other insurance must be kept in the client's file

4.4 When Admitted

Once an individual is admitted (assessment), intake paperwork is to be completed. This should include financial eligibility confirmation and documentation (Income Verification Form, proof of income, Medicaid Eligibility Verification via the 270/271 lookup in RECON).

Provider Requirement	Documentation Required
Financial Eligibility confirmation	Documentation showing financial eligibility
For Community Block Grant clients, the client's household income and family size must be verified	Income Verification Form

For clients receiving Community Block Grant funding (in whole or part), proof of the income noted on the Income Verification Form must be obtained. If proof is not possible, a signed client statement should be obtained describing the circumstance.	Proof of Income or Signed Client statement
Specific documentation must be obtained at the time of admission.	Information including: • Medical Information including 1. Primary Care Provider Name, Address, Telephone 2. Date of Last Physical 3. Relevant Medical Information • Mental Health background & present issues • SUD History – Use & Treatment • Legal background • Background and present issues • Emergency Contact
	Evidence of screening for: • Co-occurring disorder(s) • HIV/AIDS, STD/Is, TB, Hepatitis • Trauma • Women's Specialty Eligibility
	Evidence consumer has received information regarding: • General nature and objectives of the program • Grievance & Appeal (Medicaid Only) • Notice of Privacy • Consent to Treatment • Advanced Directives • 24/7/365 Access Information • Recipient Rights
	Consumer strengths are clearly documented. Examples of strengths: healthy support network, stable employment, stable housing, willingness to participate in treatment, etc.

	FASD (Fetal Alcohol Spectrum Disorder) Screening for children with which staff have contact with • FASD prevention and/or education efforts are documented in chart • FASD prescreen is complete • Referral, if applicable
	Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care-Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care

*Additional Information on Income Verification and Proof of Income is available in the Finance and Claims section

The table below documents how access to care is provided based on specific services:

Level of Care	**How to Access Services**	**Authorization**
Outpatient	Directly through a contracted provider.	Prior authorization is not required for assessment, treatment planning, transportation and/or crisis intervention services. Prior authorization is required for all services identified in the treatment plan
Intensive Outpatient	Directly through a contracted provider.	Prior authorization is not required for assessment, treatment planning, transportation and/or crisis intervention services. Prior authorization is required for all services identified in the treatment plan

Withdrawal Management	Directly through a contracted provider.	Prior authorization is not required
Residential	Clients seeking residential services are to contact the NMRE Access Center for a screening and referral to the appropriate level of care.	Prior authorization is required
Methadone Services	Clients seeking methadone services are to contact the NMRE Access Center for a screening and referral to the appropriate level of care.	Prior authorization is required

Provider Requirement	**Documentation Required**
Providers are to conduct an assessment to determine ASAM Level of Care, Medical Necessity and Diagnosis	Documentation of assessment, ASAM Level of Care determination, Medical Necessity and Diagnosis
Discrepancy for NMRE Access Center referral and identified ASAM Level of Care indicated on assessment	Documentation of the discrepancy should be submitted to the NMRE Access Center

4.5 Access Standards

REFERENCES:

- *PIHP-MDHHS Contract, Schedule A, Statement of Work, E. Access and Availability, 7. Access Standards*
- *NMRE SUD Contract, XII. Service Access/Preauthorizations/Delivery/Utilization Management*
- *MDHHS/PIHP Master Contract Attachment (**https://www.michigan.gov/documents/mdhhs/Access_Standards_702741_7.pdf**).*
- *CFR 96.121; CFR 96.131*
- *Tx Policy #04*
- *Michigan Public Health Code Section 6232*

The Provider must ensure timely access to supports and services in accordance with the Access Standards set forth by the Michigan Department of Health and Human Services. The Standards can be found in the MDHHS/PIHP Master Contract (https://www.michigan.gov/documents/mdhhs/Access_Standards_702741_7.pdf).

4.5.1 Medicaid/Healthy Michigan Access Standards

The Michigan Department of Health and Human Services sets Access Standards for clients with Medicaid and Healthy Michigan funding. The NMRE is required to submit Performance Indicator reports on a quarterly basis to MDHHS as part of its contractual requirements.

The current Access Standards for Medicaid/HMP may be found in the Medicaid Manual.

Provider Requirement	Documentation Required
Ensure clients receive a Treatment service within 14 calendar days of the First Request (Initial Contact)	• Documentation of the initial contact (first request), date offered, date accepted and date client came in for treatment services must be kept in the client's file • Documentation of individuals that called for treatment services were screened and found to be appropriate for services but did not come in to begin treatment services
Ensure clients are admitted for continuation of treatment within 7 calendar days of a discharge from Withdrawal Management	• Documentation of the discharge date, date offered, date accepted, and date client came in for treatment services must be kept in the client's file

4.5.2 Other Access Standards / Priority Populations

State and Federal priorities have been mandated for accessing substance abuse treatment as follows:

1. *Pregnant*

   The Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires that Providers ensure that each pregnant woman be screened and referred to treatment per the timelines in the MDHHS/PIHP Contract. These requirements are also included within the NMRE/Provider Contract. All females of childbearing age must be asked at initial contact whether she may be pregnant to determine if preference to treatment is indicated. Pregnant women determined to then need services, must be admitted to treatment within the timelines set by MDHHS.

   Pregnant women must be given preference for admission to treatment and if admission does not occur as noted above, interim services must be given. Women who are pregnant and are also injecting drugs must receive priority to services followed by women who are pregnant as noted in item 1 above.

   Interim services for pregnant women must include: referral for counseling and education about HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing in transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, and referral to HIV/AIDS and tuberculosis services if necessary, counseling on the effects of alcohol, tobacco and other drug use on the fetus, and referrals for prenatal care.

2. Injecting Drug Users

   The Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires that Providers ensure that clients who have injected drugs within their lifetime be

screened and referred to treatment per the timelines in the MDHHS/PIHP Contract. These requirements are also included within the NMRE/Provider Contract. All clients must be asked at initial contact if they have injected drugs to determine if preference to treatment is indicated. Clients indicating injecting drug use in their lifetime and determined to then need services, must be admitted to treatment within the timelines set by MDHHS.

Interim services minimally include: referral for counseling and education about; HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing, transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, and referral to HIV/AIDS and tuberculosis services if necessary.

3. *Parents with Children in Jeopardized Custody*

The Michigan Department of Health and Human Services has established as a priority for treatment admission, a parent whose child has been removed from the home under the Child Protection Laws or is in danger of being removed from the home under the Child Protection Laws because of the parent's substance use.

Screening must be conducted at initial contact to determine if preference to treatment is indicated due to the client having a child or children in jeopardy of being removed because of substance use.

A parent whose child has been removed from the home under the Child Protection Laws or is in danger of being removed from the home under the Child Protection Laws because of the parent's substance use must be screened and referred to treatment per the established timelines in the MDHHS/PIHP Contract and the PIHP/Provider Contract.

4. *MDOC*

An individual under supervision of the Michigan Department of Corrections (MDOC) and referred by MDOC or an individual being released directly from a MDOC facility without supervision and referred by MDOC. Excludes individuals referred by court and services through local community corrections systems.

5. *All Others*

The Michigan Department of Health and Human Services has established a requirement that all individuals not identified as a Federal or State priority population be screened and referred to treatment per the established timelines in the MDHHS/PIHP Contract and the PIHP/Provider Contract.

Provider Requirement	**Documentation Required**

Pregnant and Injecting Drug User • Providers ensure that each pregnant woman be screened and referred to treatment per the timelines specified above. All females of childbearing age must be asked at initial contact whether she may be pregnant to determine if priority to treatment is indicated. Pregnant women determined to need services, must be admitted to treatment within the timelines set by MDHHS. • Pregnant women must be given preference for admission to treatment and if admission does not occur as noted above, interim services must be given. Women who are pregnant and are also injecting drugs must receive first and highest priority to services followed by women who are pregnant. • Interim services for pregnant women must include; referral for counseling and education about HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing in transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, and referral to HIV/AIDS and tuberculosis services if necessary, counseling on the effects of alcohol, tobacco and other drug use on the fetus, and referrals for prenatal care.	• Documentation of the screening for pregnancy, and outcome, for all females of childbearing age at initial contact • Documentation of the screening for injecting drug use, and outcome, for all females of childbearing age at initial contact • If identified, documentation of initial contact, date offered, date accepted and date admitted • If services were not provided within the set guidelines, documentation of interim services provided

Pregnant Providers ensure that each pregnant woman be screened and referred to treatment per the timelines specified above. All females of childbearing age must be asked at initial contact if pregnant to determine if priority to treatment is indicated. Pregnant women determined to need services, must be admitted to treatment within the timelines set by MDHHS. Pregnant women must be given preference for admission to treatment and if admission does not occur as noted above, interim services must be given. Women who are pregnant and are also injecting drugs must receive priority to services followed by women who are pregnant as noted above. Interim services for pregnant women must include: referral for counseling and education about HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing in transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, and referral to HIV/AIDS and tuberculosis services if necessary, counseling on the effects of alcohol, tobacco and other drug use on the fetus, and referrals for prenatal care.	• Documentation of the screening for pregnancy, and outcome, for all females of childbearing age at initial contact • If identified, documentation of initial contact, date offered, date accepted and date admitted • If services were not provided within the set guidelines, documentation of interim services provided

Injecting Drug Users Providers ensure that clients who have injected drugs within their lifetime be screened and referred to treatment per the timelines above. All clients must be asked at initial contact if they have injected drugs to determine if preference to treatment is indicated. Clients indicating injecting drug use in their lifetime and determined to then need services, must be admitted to treatment within the timelines set by MDHHS. Interim services minimally include: referral for counseling and education about; HIV/AIDS, tuberculosis and hepatitis, the risk of needle sharing, transmission to sexual partners and children, steps that can be taken to ensure that HIV/AIDS transmission does not occur, and referral to HIV/AIDS and tuberculosis services if necessary.	• Documentation of the screening for lifetime injecting drug history, and outcome, at initial contact • If identified, documentation of initial contact, date offered, date accepted and date admitted • If services were not provided within the set guidelines, documentation of interim services provided
Parents with Children in Jeopardized Custody Providers are to screen at initial contact to deter if preference to treatment is indicated due to the client having a child or children in jeopardy of bei removed because of substance use. A parent whose child has been removed from the home under the Child Protection Laws or is in danger of being removed from the home under the Child Protection Laws because of the parent's substance use must be screened and referred to treatment per the established timelines.	• Documentation of the screening for jeopardized custody due to a parent's substance use, and outcome, at initial contact • If identified, documentation of initial contact, date offered, date accepted and date admitted • If services were not provided within the set guidelines, documentation of interim services provided
MDOC Providers are to screen at initial contact to determine if an individual is under supervision of MDOC and referred by MDOC **OR** if an individual is being released directly from an MDOC facility without supervision and referred by MDOC. Excludes individuals referred by court and services through local community corrections systems.	• Documentation of the screening for MDOC involvement, and outcome, at initial contact • If identified, documentation of initial contact, date offered, date accepted and date admitted • If services were not provided within the set guidelines, documentation of interim services provided

4.6 Client Eligibility

4.6.1 Clinical Eligibility

REFERENCES:

- *NMRE SUD Contract, Exhibit: Customer Population and Eligibility Criteria for SUD Services*

Clients must meet medical necessity to be eligible for funding through the NMRE and meet the ASAM criteria for the Level of Care they are receiving. Medical necessity criteria, as per the Medicaid Manual (https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html), are as follows:

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

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

Provider Requirement	**Documentation Required**
Ensure clients receiving substance use disorder services meet medical necessity	• Documentation in the client file
Ensure clients receiving substance use disorder services meet the criteria for the level of care set by the ASAM Patient Placement Criteria	• Documentation of ASAM in the client file
Ensure a client meets the diagnosis criteria for services. Diagnosis must be a covered diagnosis from the NMRE/Provider Contract	• Documentation of primary, secondary, etc. diagnosis in the client file

4.6.1.1 Residency Eligibility Determination

REFERENCES:

- *NMRE Block Grant Residency Policy*

Individuals meeting Clinical Eligibility and meeting Community Block Grant Financial Eligibility can be funded through Community Block Grant if they have resided within the

NMRE region for a minimum of 90 days prior to admission to treatment. If the client is part of a priority population or has other extenuating circumstances, funding may be available and is provided on a case-to-case basis if funding is available.

Provider Requirement	Documentation Required
Providers are to identify the length of time a client has resided in the NMRE region prior to seeking funding to ensure clients seeking treatment services through NMRE Community Block Grant funding have resided in the NMRE region for a minimum of 90 days prior to the request for NMRE funding.	• Documentation of time of residency in client file for any client receiving Community Block Grant funding
Requests for exceptions may be made. Consideration for an exception to policy will be made on a case-by-case basis.	• Requests for exceptions to the Community Block Grant Residency requirements may be made to the NMRE Access Center in writing.

4.6.2 Financial Eligibility Determination

REFERENCES:

- *NMRE Block Grant Residency Policy*
- *NMRE/Provider Contract*
- *NMRE SUD Contract, Exhibit: Customer Population and Eligibility Criteria for SUD Services*

Individuals seeking services utilizing funding available through the NMRE must meet specific financial eligibility requirements in addition to meeting Clinical Eligibility requirements.

Financial Eligibility Requirements include:

- Has active Medicaid coverage for the dates of service
- Has active Healthy Michigan Plan coverage for the dates of service
- Meets the household income guidelines for the number of individuals in the household per the NMRE/Provider contract.

4.6.2.1 Community Grant Funding

Individuals seeking Community Block Grant funding should obtain the total annualized income for all household family individuals. The annualized income is obtained by taking the current income and projecting forward for twelve months. Household includes all individuals who are part of a household. Examples include parent(s) living with adult children, a married couple, a non-married couple living together, etc. Examples of what household does not include would be two roommates who pay their own expenses, an individual who is 'couch surfing,' etc.

Individuals who are incarcerated within the NMRE region, and meet Block Grant requirements, may be served with Community Block Grant funding if their last known

residence is inside the NMRE region. NMRE Community Block Grant funds may not be used for individuals with a last known address outside of the NMRE region whose placement in the NMRE region is due to a boarding or bed purchase arrangement with a county entity located outside of the NMRE region.

Provider Requirement	**Documentation Required**
For Community Block Grant clients, the client's household income and household size must be verified Food stamps are not considered income but they can be recorded on the Income Verification Form, but no proof is required. The amount that is claimed on the Income Verification Form by the client must match the documentation. For example, if the client and the client's spouse both work and claim that they make $20,000 together, then the check stubs and/or other documentation must equal $20,000. If a client's household income changes while in treatment and they are receiving Community Block Grant funding, they need to fill out a new form and proof of income must be obtained to support the new form.	Income Verification Form signed by client
Also, if the client is in treatment for 12 months or more or the client's household income has changed, a new form must be completed and new documentation supporting the income on that form must be obtained.	New Income Verification Form
For clients receiving Community Block Grant funding (in whole or part), proof of the income noted on the Income Verification Form must be obtained. If proof is not possible, a signed client statement should be obtained describing the circumstance.	Proof of Income or Signed Client statement If proof of income does not exist, a statement handwritten and signed by the client documenting the reason proof is not available must be placed in the client file. Below are examples of acceptable documentation for income:

	• **If proof of income exists**, such as, if the client is receiving Social Security Income or Unemployment, the client may not have a check stub but they may have one of the following: a letter from the agency providing the income that states the amount they receive each month, an electronic report that can be obtained by the client logging into a system, or a bank statement showing a direct deposit. All of these are acceptable. • **If client receives cash** for work and there is no check stub, they should write a handwritten statement that they do not have proof of income because they are paid on a cash basis. • **If client's income is zero**, they still need to write a statement as to why they have no income, i.e. are unemployed and not receiving unemployment benefits.

4.6.2.2 Medicaid and Healthy Michigan Plan Funding

Individuals with Medicaid or Healthy Michigan Plan coverage must have a permanent residence in the NMRE region; this is what is indicated on the 270/271 under the address section. The address in the 270/271 is what MDHHS is reporting as the current address of the client. If an individual is seeking services with an address outside of the NMRE region, the provider should seek funding through the PIHP that covers the county of residence indicated on the 270/271. Please see Residency section below for information on how to process an address change for a client who has recently moved to the area.

Provider Requirement	**Documentation Required**
Check the 270/271 Medicaid Eligibility check in RECON to identify County of Residence	• If county of residence is within the NMRE region, nothing additional is required. • If county of residence is not within the NMRE region, the PIHP covering the county should be contacted.

Individuals with Medicaid or Healthy Michigan Plan funding who are also receiving services that are not covered by Medicaid or the Healthy Michigan Plan (covered by

Community Block Grant) do not need to meet Community Block Grant funding criteria. An example of this is for Room and Board or case management services. This does not include Medicaid spend down.

Provider Requirement	Documentation Required
Check the 270/271 Medicaid Eligibility check in RECON to identify Insurance, if any	• 270/271 in RECON
Ensure clients without Medicaid or Healthy Michigan Plan meet household income requirements.	• Documentation of Household Income projected and Family Member Size on Income Verification Form • Update income information every six months

4.6.2.3 Medicaid Spend Down

Individuals with a Medicaid Spend Down are eligible to receive Block Grant funding until the spenddown amount has been met; individuals must meet Block Grant eligibility.

4.6.2.4 Residency Changes

For individuals who have changed their county of residency during treatment, NMRE funding may be sought only for individuals who have planned, and made documented movement, of a permanent residence.

Provider Requirement	Documentation Required
Ensure clients who have transferred from another PIHP Region is screened as to length of stay in the region	• Documentation to support permanent change in residency

4.6.2.5 SDA Eligibility

REFERENCES:

- *NMRE SUD Contract, State Disability Assistance (SDA) Requirements*

State Disability Assistance (SDA) funds are used to reimburse room and board costs while an individual is in residential treatment. SDA funds will not be used in conjunction with sub-acute detoxification services.

Provider Requirement	Documentation Required
<u>State Disability Assistance (SDA) Authorization for SDA Only</u> To be eligible for funding through SDA Room and Board Services for SDA Only, Providers must ensure clients meet criteria	• Documentation of: 1. Be determined through an initial screening by the residential Provider to be eligible;

	2. Be determined to be eligible for an incidental allowance through the Department of Human Services (DHS); 3. In residence in a residential treatment program each day that SDA payments are made
<u>State Disability Assistance (SDA) as a Supplemental Funding Source to Community Block Grant</u> To be eligible for SDA funding for Room and Board Services as a supplemental funding source to Community Block Grant, Providers must ensure clients meet criteria	• Documentation of: 1. Be at least 18 years of age; 2. Be determined through an initial screening by the residential Provider to be eligible; 3. Be determined to be eligible for an incidental allowance through the Department of Human Services (DHS); 4. Be eligible for Community Block Grant funding through NMRE; 5. In residence in a residential treatment program each day that SDA payments are made.

By using the SDA funding, the Provider will reduce the amount of Community Block Grant funding that is utilized during the fiscal year.

4.7 Welcoming

REFERENCES:

- *Michigan Department of Community Health, Office of Drug Control Policy, Treatment Technical Advisory #05: Welcoming.*

It is the policy of Northern Michigan Regional Entity to recognize and acknowledge the needs of clients with co-occurring addictive and mental health disorders. NMRE welcomes clients with co-occurring addictive and mental health disorders and will assist its Provider network in developing welcoming policies, procedures, and attitudes.

- **Access:** All persons seeking services shall be properly screened and further assessed as necessary in order to determine appropriate treatment needs.
- **Availability**: Treatment will be provided either directly or through appropriate referral regardless of where the client enters services.

- **Attitude**: Northern Michigan Regional Entity and its provider network shall treat all persons seeking services in a welcoming manner.

All services provided to clients funded in whole or part by NMRE funds must be delivered in accordance with the Michigan Department of Health and Human Services, Office of Drug Control Policy, Treatment Technical Advisory #05: Welcoming.

NMRE is committed to ensuring that substance use disorder treatment is delivered by a system of professional organizations and staff that demonstrates the core belief of dignity and respect for all people.

5 TREATMENT SERVICES

REFERENCES:

- *Michigan Medicaid Manual https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html*
- *Treatment Policies https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_45835_48569-133156--,00.html*
- *NMRE Administrative Manual*

The NMRE expects Providers to refer to the Michigan Medicaid Manual for complete descriptions of treatment services along with all relevant MDHHS and NMRE policies and references noted in this manual.

5.1 Individual Assessment

An Individual Assessment is a face-to-face service for the purpose of identifying functional and treatment needs; and, to formulate the basis for the Individualized Treatment/Recovery Plan to be implemented by the Provider.

Michigan's 1115 Demonstration Waiver for Substance Use Disorder Treatment Services requires the use of a standardized assessment. For adults, the standardized assessment is the American Society of Addiction Medicine (ASAM) Continuum. The ASAM Continuum is available through the NMRE's RECON system. For adolescents, the required assessment is the Global Appraisal of Individual Needs (GAIN).

Provider Requirement	Documentation Required
Completion of the state's designated standardized assessment	• ASAM Continuum for adults (individuals aged 18 and up) • GAIN for adolescents (individuals under the age of 18) – copy of the report is to be uploaded to the client chart in RECON

Level of Care	Required	Reimbursable Service
Outpatient	Yes	Yes
Intensive Outpatient	Yes	Yes
Residential	Yes	Included in Per Diem
Withdrawal Management	Yes	Included in Per Diem

5.2 Individualized Treatment Plans

REFERENCES:

- *NMRE SUD Contract, Exhibit: Customer Population and Eligibility Criteria for SUD Services*
- *Treatment Policies*
  https://www.michigan.gov/documents/mdch/Policy_Treatment_06_Invd_Tx_Planning_175180_7.pdf
- *NMRE SUD Contract, Exhibit: Customer Population and Eligibility Criteria for SUD Services*
- *NMRE SUD Contract, Exhibit: Performance Indicators and Objectives*

Individualized Treatment Planning is the process of developing an individual and meaningful treatment plan for a client. This involves active client involvement in identifying what areas they want to address and setting goals for treatment.

Provider Requirement	Documentation Required
Completion of an individualized treatment plan	• Completion of an individualized treatment plan • The Treatment Plan is to meet the following criteria: 1. Current and historical information 2. Identifies needs 3. Identifies strengths 4. Mutual setting of goals and objectives. 5. Goals must be stated in client's words. 6. Each goal must be directly tied to a need identified in the assessment and reflect the individual needs of the client. 7. Objectives must contain the steps that need to be taken to achieve the goals. 8. Objectives need to be measurable.

	9. Objectives must have target dates for completion. 10. Treatment plan must be signed and dated by both the client and clinician. 11. Treatment Interventions i. Determine the intervention(s) that will be used to assist the client in being able to accomplish the objective. ii. What action will the client take to achieve the goal; what action will the counselor take to assist the client in achieving the goal. iii. Interventions and methods must be mutually agreed upon. 12. Must contain amount, scope, duration, and the services the client will receive
Discharge Planning/ Aftercare Planning	• Documentation planning began at admission
Progress Note should link the service provided back to the Treatment Plan	• Documentation in the Progress Note of the Goal/Objective from the Treatment Plan
Treatment Plans are to be reviewed based on level of care requirements (see below).	• <u>Treatment Plan Reviews</u> must be documented in the case file. • Changes to the Treatment Plan should be completed and documented with client signature and date. • The reviews must include documentation of input from all clinicians/treatment Providers involved in the care of the client as well as any other individuals the client has involved in their treatment plan. • This review should document progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. • Treatment Plan Review should collect and document any feedback from the client on satisfaction with services.

Level of Care	Required	Reimbursable Service	Requirements Specific to Level of Care
Outpatient	Yes	Yes	Initial treatment plans are to be completed **prior to treatment** session with the client. Reviews: • Outpatient Treatment Plan reviews should be completed within the first 90 days of the Initial Treatment Plan and every 90 days thereafter, or sooner if there is a substantial change in condition or circumstance.
Intensive Outpatient	Yes	Yes	Initial treatment plans are to be completed **prior to treatment** session with the client. Reviews: • Completed within the first 90 days of the Initial Treatment Plan and every 90 days thereafter, or sooner if there is a substantial change in condition or circumstance.
Residential	Yes	Included in Per Diem	Initial treatment plans are due within three (3) calendar days of the initiation of treatment services. Reviews: • Completed every seven (7) calendar days
Withdrawal Management	Yes	Included in Per Diem	Initial treatment plans are due immediately upon initiation of treatment. Withdrawal Management treatment plans focus on the medical component of the sub-acute detoxification and required services to treat the detoxification.

5.3 Authorization

REFERENCES:

- *NMRE SUD Contract, Service Access/Preauthorizations/Delivery/Utilization Management*

All services must be authorized. Authorized services must meet medical necessity requirements, meet ASAM Level of Care requirements. Treatment services are required to be prior authorized with the exception of crisis intervention services and transportation.

Level of Care	Requirements
Outpatient – Assessment	Post Authorization One assessment per episode of care Four ASAM Continuum assessments are allowed per year The individual's assessment should move with the client as different levels of care are accessed Exclusions Assessments provided for the purpose of reinstatement of a driver's license by the Secretary of State will not be authorized nor will assessments be provided for the sole purpose of compliance with legal requirements.
Outpatient	Initial Authorization requests must be submitted after the assessment has been completed and/or the treatment plan. The authorization must occur prior to the first date of outpatient treatment. Additional service requests must also be prior authorized. The Initial Authorization request in RECON does not include ASAM which is required to provide treatment services. Therefore, if requesting treatment services in the Initial Authorization request, documentation of ASAM must also be submitted. There is no minimum or maximum number of units that may be requested if the documentation and information submitted with the authorization request justifies the request. Exceptions Providers may request an exception from the NMRE Access Center for services provided without a prior authorization. These will be reviewed on a case-by-case basis. Transportation and crisis intervention services do not fall under the prior authorization criteria.
Intensive Outpatient	Initial Authorization requests must be submitted after the assessment has been completed and/or the treatment plan. The authorization must occur prior to the first date of outpatient treatment. Additional service requests must also be prior authorized. The Initial Authorization request in RECON does not include ASAM which is required to provide treatment services. Therefore, if requesting treatment services in the Initial Authorization request, documentation of ASAM must also be submitted.

	There is no minimum or maximum number of units that may be requested if the documentation and information submitted with the authorization request justifies the request. Exceptions Providers may request an exception from the NMRE Access Center for services provided without a prior authorization. These will be reviewed on a case-by-case basis. Transportation and crisis intervention services do not fall under the prior authorization criteria.
Outpatient – Methadone	Services must be prior authorized by the NMRE Access Center. Individuals seeking this service must be screened to determine if medical necessity for the service has been met. The Initial Authorization should be requested by providers. The Initial Authorization should consist of the Assessment, the Treatment Plan, services to cover two weeks and dosing to cover two weeks. Additional service requests must also be prior authorized. There is no minimum or maximum number of units that may be requested if the documentation and information submitted with the authorization request justifies the request. Exceptions Transportation and crisis intervention services do not fall under the prior authorization criteria.
Residential	Services must be prior authorized by the NMRE Access Center. Individuals seeking this service must be screened to determine if medical necessity for Residential services has been met. The Initial Authorization for residential services consists of 14 days of treatment services and room and board services. Additional service requests must have prior authorization.. Initial Authorization requests must be submitted after the assessment has been completed and/or the treatment plan. The authorization must occur prior to the first date of outpatient treatment. Additional service requests must also be prior authorized. The Initial Authorization request in RECON does not include ASAM which is required to provide treatment services. Therefore, if requesting treatment services in the Initial Authorization request, documentation of ASAM must also be submitted.

	There is no minimum or maximum number of units that may be requested if the documentation and information submitted with the authorization request justifies the request. Exceptions Transportation services do not fall under the prior authorization criteria.
Withdrawal Management	Withdrawal Management services may be authorized after the service has been provided, with the assurance that medical necessity has been met.

5.3.1 Authorization Process

To request authorization (initial or continuation), the following process should be followed:

1. Client demographic data entry into the system if not already entered
2. Referral Form should be completed for the episode if a new provider
3. Completion of the Admission Form
4. Completion and Submission of the Authorization Request Form

Using criteria for medical necessity, NMRE may:

- Approve services that meet medical necessity and ASAM criteria for requested level of care
- Request additional information when documentation is insufficient to determine whether a service meets medical necessity
    - If a request is sent back to the Provider for additional information, the request is considered pending. This is not the same as denied. If an authorization request sent back to a Provider is not responded to within 14 days from the initial request, the request will be denied, and an Adverse Benefit Determination letter will be sent to the client indicating the reason for the denial.
- Deny services
    - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - which are experimental or investigation in nature, or
    - for which there exists an appropriate, efficacious, less restrictive and cost-effective alternative service, setting or support, that otherwise satisfies the standard for medically necessary services;
    - for which a request was made, returned to the provider, but not submitted with needed information within 14 days.

The NMRE will employ various methods to determine medical necessity, including prior authorization for certain services, concurrent utilization reviews, centralized assessment

and referral, gate keeping arrangements, protocols, and guidelines. NMRE will not deny covered services solely based on pre-set limits on the duration of services; instead, reviews of the continued need for services shall be conducted on an individual basis. All determinations regarding medically necessary services shall be made in a timely fashion, by appropriately trained substance use disorders treatment professionals with sufficient clinical experience.

Reauthorization or continued treatment should take place when it has been demonstrated that the client is benefiting from treatment, and additional covered services are needed for the client to be able to sustain recovery independently.

Reauthorization of services may be denied in situations where the client has:

- Not been actively involved in treatment, as evidenced by repeatedly missing appointments;
- Not been participating/refusing to participate in treatment activities;
- Continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the service

Clients may also be terminated from treatment services based on these violations.

If the provider would like continued consideration of the denied request the request may be sent to the Exception Que in RECON for additional review.

5.3.2 Criteria for Authorization

REFERENCES:

- *NMRE SUD Contract, Exhibit: Customer Population and Eligibility Criteria for SUD Services*

Provider Requirement	**Documentation Required**
Services are required to meet medical necessity. The determination of a medically necessary service must be based upon an individualized assessment of an individual's strengths, desires, needs and supports. *Criteria:* • Necessary for screening and assessing the presence of a substance use disorder, and/or are; • Required to identify and evaluate a substance use disorder that is inferred or suspected and/or are;	• Documentation showing medical necessity (as entered on the NMRE RECON Authorization Request Form – continuation of services) • If Community Block Grant funding, Income Verification Form needs to be uploaded to the client chart in RECON • If third party insurance, documentation of coverage should also be uploaded • If requesting treatment services in an Initial Authorization, ASAM criteria documentation must be included

• Intended to treat, ameliorate, diminish, or stabilize the symptoms of substance use disorder including impairment in functioning and/or are; • Expected to arrest or delay the progression of a substance use disorder and to forestall or delay relapse and/or are; • Designed to provide rehabilitation for the client to attain or maintain an adequate level of functioning.	
Services selected based upon medical necessity criteria should be: • Delivered in a timely manner; • Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; • Provided in the least restrictive appropriate setting; • Delivered consistent with national standards of practice, including standards of practice in community psychiatry, psychiatric rehabilitation and in substance use disorder treatment, as defined by standard clinical references, generally accepted professional practice or empirical professional experience; • Provided in sufficient amount, duration, and scope to reasonably achieve their purposes; • Cost effective.	• Documentation in the Client File to support services
Information to support the medical necessity and ASAM Level of Care should be made in the Authorization Request. If the request is sent back to the provider with the request of additional information, the information must be submitted within 14 days from the initial request.	• Provide additional information needed and submit the Authorization Request within 14 days of the initial request

5.4 Progress Note

Progress notes are the documentation necessary to provide proof a service took place.

Provider Requirement	Documentation Required
Progress Notes: Any Individual or group sessions that the client participates in must tie back to the goals and objectives identified in the individualized treatment plan.	• Goals and objectives from the treatment plan should be clearly identified in the progress note. ○ Progress notes must have a begin and end time. ○ All services must be documented by a progress note. ○ Progress notes are also used to document any changes made to the treatment plan ○ Discharge/aftercare/recovery planning begins at time of admission and must be documented in progress notes throughout the course of treatment. Lack of, or absence of appropriate discharge/aftercare/recovery planning may result in non-certification of reauthorization requests. ○ Progress Notes must be signedwith staff member's credentials listed as part of signature.

5.5 Discharge Planning

NMRE requires that effective discharge planning be provided for clients, and that follow-up services meet contractual and regulatory requirements.

Discharge Planning is considered an integral part of SUD treatment. Consideration of the continuum of care and long-term recovery needs of the client should be considered at every step of treatment planning. Discharge Planning provides improvements to the quality of care and improves outcomes and controls cost, by assuring coordination and collaboration with mental health, SUD, and other health providers to fully address the needs of the client. It is critical that all Providers and

organizations serving a client act together to develop an integrated health aftercare plan and then implement this ongoing aftercare plan in an environment that eliminates barriers and duplication of services.

Provider Requirement	Documentation Required
Discharge Planning will occur according to best practices and the Provider organizations' admission and discharge policies	• Documentation of a Discharge Plan noting appropriate follow-up care has arranged. • A written Discharge Plan will be prepared to ensure continuity of service and will be distributed to parties involved to carry out the plan. • Aftercare services are incorporated into the treatment plan, and needs are identified and addressed in the Discharge Plan.
The NMRE contracted Provider Network will ensure that all clients are appropriately discharged from their care, including entering a discharge into RECON.	• Documentation of a Discharge in RECON once client has been discharged from care
Clients following up from withdrawal management services will have a continuation of services (Admission) within seven (7) days from discharge of Withdrawal Management services.	• Documentation in client file (on Discharge Plan) of next provider and appointment information • Documentation in RECON

6 RECON

The NMRE utilizes PCE electronic health record nicknamed RECON. RECON is the system that collects information from individuals seeking and receiving funding through the NMRE for substance use disorder treatment services. Demographic information is collected through RECON as well as Behavioral Health Treatment Episode Data Set (BH-TEDS) and claims data. Providers may collect claims information from their own Electronic Medical Record and submit (upload) into RECON utilizing an appropriate 837 file. Additional information on RECON and the

requirements are located on the NMRE Knowledge Base (**https://support.nmre.org/helpdesk/KB**)

7 FINANCE AND CLAIMS

Prior to billing the NMRE for services rendered, client eligibility must be fully met. Providing services to individuals who do not meet eligibility requirements is prohibited.

Providers may request that Medicaid and HMP clients fill out the Income Verification Form and submit proof of income. This is helpful if a client suddenly loses their Medicaid/HMP eligibility. Treatment units for a Community Block Grant client should not be billed to NMRE unless the Income Verification Form is completed, signed by the client, and appropriate proof of income or signed client statement is obtained.

When calculating whether a client meets eligibility, please project the client's income from today forward. The current financial position of the client is how eligibility is determined. For example, if the check stub shows that the client earns $200 every week, then multiply this amount by 52 weeks to see what the estimated annual income would be at this rate of pay.

7.1 Provider Authorization and Claims

The NMRE requires that any substance use disorder treatment services be provided in accordance with the fee for service contract with its Providers. This includes submitting claims in an approved format and payment of the claims.

7.2 Claims Submission

REFERENCES:

- *NMRE SUD Contract, Billings/Payments, Clean Claims*

The NMRE manages substance use disorder treatment services on a fee for service basis. This is completed by providers submitting "clean claims" to request reimbursement for authorized services.

7.3 Entry of Claims

The NMRE requires claims to be entered directly into RECON or uploaded from a Provider's EMR in an 837 file (with specifications) into RECON.

7.3.1 Manual Entry of Claims

Providers may elect to enter claims data directly into the RECON system. Claims must be entered utilizing the Claims Submission section within RECON.

Provider Requirement	Documentation Required
If a provider submits claims manually via RECON, claims are to be submitted for services for which documentation exists meeting all rules and regulations.	• Claim information entered into RECON and data submitted

7.3.2 837 Submission

REFERENCES:

- *https://support.nmre.org/helpdesk/KB*

Providers may elect to submit an 837 file taken from claim information from the Provider EMR.

Provider Requirement	Documentation Required
If a provider submits claim information into the Provider EMR, file is to be uploaded into RECON for claims submitted in which documentation exists meeting all rules and regulations.	• 837 file uploaded into RECON and submitted

7.4 Other Insurance

REFERENCES:

- *NMRE SUD Contract, General Information, Other Insurance*

7.4.1 Coordination of Benefits

Funding through the NMRE including Community Block Grant, Medicaid or HMP is considered the payor of last resort. All other insurance a client may have must be billed prior to billing the NMRE. If a Provider does not take the insurance a client has then the client must be referred to a Provider that does, regardless of distance or hardship of the travel.

Provider Requirement	Documentation Required

First Party Fees The collection and reporting of first party fees will be the first source of funding for the eligible client. It will be the Provider's responsibility to develop and maintain policies and procedures regarding the collection and reporting of client fees and accounts receivable. The rates that the NMRE reimburses for Community Block Grant funding may be subject to a co-pay. All clients having insurance outside of the NMRE covered plans are required to utilize that insurance prior to utilizing the NMRE funding. If a Provider does not take the insurance an individual has then a referral must be made to a Provider who does take that insurance.	Explanation of Benefits should be kept in the client's file as well as uploaded to the client's file in RECON

Community Grant with Third Party Insurance When a client has active coverage by a third-party insurance, that insurance must be billed in conjunction with the submission of a claim to the NMRE. The client must also meet Community Block Grant requirements. If the third-party insurance denies the claim or makes a partial payment, Community Block Grant may be billed for the difference up to the contract rate for that service less the client co-pay. The total amount of insurance payments plus the client co-pay received for the service cannot exceed the NMRE contract rate for that service if the NMRE is billed for any part of that service. Therefore, the NMRE should only be billed when the third party either denies payment or pays an amount that is less than the contract rate for that service. If, after submitting a claim to the third-party insurance, the claim is denied or paid at a partial amount, Community Block Grant may be billed for the difference up to the contract rate for that service. The total amount of insurance payments received for the service cannot exceed the contract rate for that service if the NMRE is billed for any part of that service. If a Community Block Grant client has not met the plan's annual deductible amount, the full amount of the charge may be billed to Community Block Grant after the Provider has billed the insurance company and received a denial for payment due to 'deductible not met'. That denial must be available to NMRE, either physically or electronically, for audit purposes since the client's insurance status would show active at the time the treatment was delivered. If the client is receiving residential services and receives food stamps, this amount must be subtracted from the amount billed to NMRE each month and the food stamp approval letter should be placed in the client chart for documentation purposes.	Explanation of Benefits should be kept in the client's file as well as uploaded to the client's file in RECON If the claim is denied the denial must be uploaded to the client's file in RECON

Medicaid/HMP with Third Party Insurance If a client is covered under third-party insurance in addition to Medicaid, the third-party insurance must be billed first. If a third-party insurance is reported by a Medicaid eligibility tool, that insurance must be verified by calling the insurance company. The name of the insurance and the client's policy or contract number is usually given in order to make this verification. If the coverage is in effect, that insurance must be billed before submitting a claim to the NMRE. If the Provider does not participate with the other insurance, the client must be referred to a participating Provider unless that insurance does not provide benefit coverage for the level of care being provided. If, after submitting a claim to the third-party insurance, the claim is denied or paid at a partial amount, Medicaid may be billed for the difference up to the contract rate for Medicaid for that service. No fees of any kind may be collected from the client if Medicaid is billed. The total amount of insurance payments received for the service cannot exceed the Medicaid contract rate for that service if Medicaid is billed for any part of that service. If a Medicaid client has not met the plan's annual deductible amount, the full amount of the charge may be billed to Medicaid after the Provider has billed the insurance company and received a denial for payment due to 'deductible not met'. That denial must be available to NMRE, either physically or electronically, for audit purposes since the client's insurance status would show active at the time the treatment was delivered. If the client is receiving residential services and receives food stamps, this amount must be subtracted from the amount billed to NMRE each month and the food stamp approval letter should be placed in the client chart for documentation purposes.	Explanation of Benefits should be kept in the client's file as well as uploaded to the client's file in RECON If the claim is denied the denial must be uploaded to the client's file in RECON

Change of Coverage It is the Provider's responsibility to verify client's funding and eligibility for Community Block Grant funding, third party insurance coverage or enrollment in Medicaid or Healthy Michigan Plan (HMP) prior to admission and throughout the course of treatment. <u>Medicaid or Healthy Michigan Plan to Community Grant and Community Grant to Medicaid or Healthy Michigan</u> After the 5th of every month, the NMRE runs the Retro Funding Change Report. Clients who have changed funding, with claims within the effected month, will be properly adjusted to reflect the correct funding source. The adjustments can be found within the Provider's EOBs. The Provider will be responsible for refunding co-pays if a client becomes eligible for Medicaid or HMP services. Provider will be responsible for ensuring that clients who lose insurance eligibility meet income guidelines for Community Block Grant funding and collecting co-pays as appropriate.	Documentation of coverage or enrollment via the 270/271 lookup feature in RECON If a co-pay refund is necessary for the client due to funding change, documentation of the refund is required

Third-Party Liability, must include an accurate amount from the Third-Party Liability Insurance. The NMRE uses computer software referred to as RECON, a web-based data application system for manual claims entry or upload of 837 data.

Provider Requirement	**Documentation Required**
Providers shall electronically submit a "clean claim" to request reimbursement for authorized services. Claims must have accurate data and be without error to be considered a clean claim. This includes: Date of Service, Procedure Code, Time of Service, an appropriate primary SUD diagnosis code for the level of care being claimed as well as any supporting diagnosis needed for the use of additional	Submission of a "clean claim" that meets all the Michigan fee for service encounter criteria

modifiers such as a MH diagnosis if using the HH modifier.	

7.5 Retrospective Review

If a client obtains funding the NMRE covers at a later date. The provider may request a retrospective review.

Provider Requirement	Documentation Required
Retrospective reviews may be completed on: a. Cases that had an appeal or grievance filed; b. Cases where an inquiry has been made regarding provided services; c. Cases identified by NMRE or Network Provider staff as being problematic; d. Cases involving lengths of stay that exceed selected statistical levels (outliers) for that age, sex, and diagnosis group; e. A percentage of a Network Provider's open and closed cases selected randomly; f. Cases where the insurance eligibility has changed.	Client file including, but not limited to: • Assessment • Treatment Plan • Progress Notes • Treatment Plan Reviews • Any EOBs

7.6 Claims Denial – Provider Appeal Process

REFERENCES:

- *NMRE Provider Appeal Process*

Should the NMRE fail to pay or adequately provide for such payment to Provider within 30 days following receipt of notification from Provider, the Provider shall have the right and process of appeal.

Provider Requirement	Documentation Required
If the NMRE denies the Provider any compensation to which Provider believes it is entitled, Provider may request an appeal. Providers are encouraged to contact Northern Michigan Regional Entity or the Access Center prior to submitting an appeal for the purpose of reaching a satisfactory resolution in the most expedient manner possible. Authorization and payment decisions are based on the information presented.	Provider shall notify the NMRE in writing within 30 days of the date of notification of denial and state the grounds upon which it bases its claim for such compensation. All appeals must be in writing and include the action being appealed, resolution requested, and supporting rationale for requested change in decision. Providers should submit the appeal with supporting documentation to the attention of the NMRE Access Center either by US Post

No appeal will be considered after 60 calendar days from the date of the decision appealed. Once the appeal is received by the NMRE, staff will review the appeal and mail a written response to the Provider within 14 calendar days of receipt of the appeal.	(1999 Walden Drive – Gaylord, MI 49735) or by secure email to providersupport@nmre.org.

Note that the Provider Appeal process is distinct from the Grievance and Appeal Process available to clients enrolled in Medicaid or Healthy Michigan Plan.

8 QUALITY IMPROVEMENT

REFERENCES:

- *PIHP-MDHHS Contract, Schedule A, Statement of Work, 1.General Requirements; K, Quality Improvement*
- *Exhibit: Performance Indicators and Objectives*

8.1 QAPIP

The NMRE's Quality Assessment and Performance Improvement Program (QAPIP) is structured to facilitate and ensure an objective and systematic performance improvement program that monitors and evaluates the quality of care provided to clients identified to have any one or more of the following: mental illness, developmental disabilities, or substance use disorder. The QAPIP is responsible for conducting annual Quality Assurance reviews for activities related to provider compliance monitoring and ensuring successful monitoring processes are in place as well as continued monitoring of corrective action plan implementation. Reviews include site and desk reviews for the purposes of evaluating Providers in areas of administration, clinical performance, and compliance. NMRE supports reciprocity, and where appropriate, may accept the results of an audit conducted by another PIHP. The QAPIP emphasizes the use of client and other stakeholder involvement to improve services. Quality management stresses a partner relationship between the NMRE, CMHSPs, Substance Use Disorder Providers, advocacy groups and other human service agencies.

The QAPIP is reviewed and approved on an annual basis by the NMRE Board of Directors. Through this process, the governing board gives authority for implementation of the plan and all its components. This authority is essential to the effective execution of the plan.

The NMRE Governing Board authorizes the NMRE's Chief Executive Officer (CEO) with the day-to-day implementation of the NMRE QAPIP. IN turn, the CEO discharges this authority through the Chief Compliance Officer with the support and assistance of the NMRE Operations Committee. The Regional Quality Oversight and Compliance Committee (QOC) has the

responsibility for ensuring that Network Providers have appropriate quality improvement structures and activities necessary to meet Federal and State requirements. This group provides the primary link between the quality improvement structures of Network Providers and the NMRE. To create this link, the CEO of each Member CMHSP appoints one representative to serve as a Member of the QOC. Additional membership may include:

- Primary or secondary services beneficiaries from appropriate service populations, including persons with developmental disabilities, adults with mental illness, children with severe emotional disturbances, and persons with substance use disorders
- NMRE Managing Director of SUD Services
- NMRE Provider Network Manager
- NMRE Chief Compliance Officer (Chair)

Each SUD Provider is strongly encouraged to implement an Assessment and Performance Improvement Program within its Provider organization that addresses:

- Structure and accountability for the Quality Improvement Program
- Active participation by stakeholders
- Components and activities
- Processes for the review and follow-up of sentinel events
- Evaluation of client's experiences with services
- Practice guidelines
- Qualifications for scope of practice (credentialing and privileging)
- Verification of service delivery
- Utilization Management activities
- Procedures for adopting and communicating process and outcome improvements

8.2 Contractual Compliance Reviews

REFERENCES:

- *NMRE SUD Contract, Record Access/Investigation/Reviews, E. Site Reviews*

8.2.1 Site Visits and Desk Audits

Annual site visits will be conducted using an overall quality management plan. The site visit areas of review will include, but are not limited to:

- Organizational policies and contractual requirements
- Claims management
- Client chart review
- Data collection
- Performance indicator timeliness
- Reporting

- Licensing and accreditation
- Staff credentials and professional training
- Exclusion checks
- Clinical practices
- Recipient rights

All requirements along with the site visit date will be sent to the Providers in advance.

Portions of the annual Site Visits will be conducted via Desk Audit. This is meant to reduce the time spent at each Provider site and allows provider staff flexible time to submit contractual requirements. Desk audits are considered part of the annual site review for each Provider. An email will be sent to Program Directors/Supervisors requesting various contractual agency information, along with a date stating when the information must be returned to the NMRE. Desk Audit data must be submitted to the PIHP prior to the on-site review.

8.2.2 Special Site Visits

The NMRE periodically conducts unannounced site visits for the purpose of assuring compliance in areas considered high risk for compliance.

8.2.3 Electronic Client Chart or File Review

The NMRE periodically audits client charts or files electronically. The Provider is notified in advance of the day the audit will occur and asked to have staff available to pull requested documents. The documents will then be uploaded via ShareFile to NMRE or NMRE may retrieve then onsite. Client files or charts identified for the audit must be made available to NMRE in a timely manner. No changes to client files or charts may be made upon notification that the files will be reviewed.

8.3 Satisfaction Surveys

REFERENCES:

- *NMRE SUD Contract, MDHHS Service Requirements, Satisfaction Surveys*

All in-region (within NMRE's 21-counties) Providers are required to participate in the NMRE client satisfaction survey process. This process surveys the Provider's clients, funded in whole or part by NMRE managed funds, for each level of care for which the Provider is contracted.

Surveys are divided into categories: Residential, Methadone, Outpatient, and Withdrawal Management/Detox. Each survey will be conducted over a one-month period. Each client funded in whole or in part by NMRE managed funds must be offered an opportunity to take the survey. A link and instructions will be sent to each Provider one week prior to the start of the survey.

Provider Requirement	Documentation Required
Provision of NMRE client satisfaction surveys per the designated process	• N/A

Process:

- Clients will be offered the client satisfaction survey and informed of the benefits of completing the survey, and that responses are confidential.
- Clients should receive instruction for completing the online or paper survey and should be allowed to complete the survey on their own unless assistance is required due to limited English proficiency or other accessibility barrier.
- It is the client's right to decline the survey, and their wishes must be respected. Do not pressure the client.
- Thank the client for their participation.

8.3.1 NMRE iPads:

Select providers may be given the opportunity to utilize equipment provided by the NMRE to facilitate the survey process. This equipment is the property of the NMRE and must be returned in working order upon completion of the survey. A signature will be required upon receipt of the equipment; the signer claims responsibility for safe return of the equipment.

8.3.2 Survey Results

Survey results are 100% confidential. Once the client completes the survey, it is automatically uploaded electronically and only accessible by NMRE staff.

The NMRE will provide a summary, not individual responses, of the survey results to the Provider. In the event satisfaction for an item on the survey falls below 80% satisfaction, the Provider will be requested to review the item through its quality improvement program and as indicated, provide a corrective action plan for improvement.

The results of each survey period will be reviewed by the NMRE Quality Oversight and Compliance Committee and NMRE Substance Use Disorder Policy Oversight Board. As indicated, recommendations may be developed to improve satisfaction within the region.

Response rates will be determined by the number of surveys received compared to the number of clients whose services were reimbursed by the NMRE managed funds during the survey period. Response rates will be monitored by the NMRE Quality Oversight and Compliance Committee to assure participation and compliance at the Provider level.

8.4 Sentinel Events

REFERENCES:

- *NMRE SUD Contract, Health and Safety of Customers/Enrollee Rights/Customer Grievance Procedures, Sentinel Events*

A Sentinel Event is an "unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious physical injury specifically includes loss of limb or function. The phrase, 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." (JCAHO, 1998)

All treatment Providers, regardless of level of care, are required to report Sentinel Events to NMRE. All incidents occurring while an individual is an active client must be reviewed to determine if a Sentinel Event has occurred. If it is found that an incident is a Sentinel Event, the NMRE must be notified immediately (within 24 hours) and the Provider must conduct a Root Cause Analysis and provide feedback to the NMRE within 30 days, as described below.

NMRE has established specific requirements for the review and reporting of Sentinel Events to initiate corrective action, make systematic changes, and to improve the quality of substance use disorders treatment services.

8.4.1 Root Cause Analysis (RCA)

A root cause is defined as a factor that caused a nonconformance and should be permanently eliminated through process improvement. The root cause is the core issue—the highest-level cause—that sets in motion the entire cause-and-effect reaction that ultimately leads to the problem(s).

Root cause analysis is part of a more general problem-solving process and an integral part of continuous improvement. Because of this, root cause analysis is one of the core building blocks in an organization's continuous improvement efforts. It is important to note that root cause analysis will not produce any results; it must be made part of a larger problem-solving effort for quality improvement.

Root cause analysis (RCA) is defined as a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems. Some RCA approaches are geared more toward identifying true root causes than others, some are more general problem-solving techniques, and others simply offer support for the core activity of root cause analysis.

There are many methodologies, approaches, and techniques for conducting root cause analysis, including:

1. **Events and Causal Factor Analysis:** Widely used for major, single-event problems, such as a refinery explosion, this process uses evidence gathered quickly and methodically to

establish a timeline for the activities leading up to the accident. Once the timeline has been established, the causal and contributing factors can be identified.

2. **Change Analysis:** This approach is applicable to situations where a system's performance has shifted significantly. It explores changes made in people, equipment, information, and more that may have contributed to the change in performance.
3. **Barrier Analysis:** This technique focuses on what controls are in place in the process to either prevent or detect a problem, and which might have failed.
4. **Management Oversight and Risk Tree Analysis:** One aspect of this approach is the use of a tree diagram to look at what occurred and why it might have occurred.
5. **Kepner-Tregoe Problem Solving and Decision Making:** This model provides four distinct phases for resolving problems:
   - Situation analysis
   - Problem analysis
   - Solution analysis
   - Potential problem analysis

8.4.2 Reporting Requirements and Procedures

The Provider is required to review any incidents to determine if they meet the criteria for a Sentinel Event and whether the incident is related to the practice of care. The outcome of this review is a classification of the incident as either a Sentinel Event or Non-Sentinel Event.

The Provider must document the review consistent with its Sentinel Event, Incident and/or Adverse Outcome policy as required by its accrediting body. The Provider must respond appropriately to a Sentinel Event by conducting a thorough and credible root cause analysis, implementing improvement to reduce risk, and monitoring the effectiveness of the improvements. (JCAHO, 1998).

Following the completion of a root cause analysis or investigation, the Provider must implement either:

- A plan of action or intervention to prevent further occurrence of the Sentinel Event. This must identify who will implement and when, and how implementation will be monitored or evaluated, **or**
- Provide a presentation of a rationale for not pursuing an intervention.

Provider Requirement	**Documentation Required**

Reporting of Sentinel Events to NMRE within 24 hours of the determination that an incident is a Sentinel Event.	• Communication in writing indicating that there was a Sentinel Event including the following:
	  ○ Nature of the Sentinel Event,
	  ○ Assurance that prompt and proper care of client affected has been accomplished

	○ Assurance that immediate action needed has been taken to assure client safety
Within 30 days, a provider must submit the Sentinel Events Data report	• Submission of the NMRE Sentinel Events Data report
If an incident is determined to be a Sentinel Event, a Root Cause Analysis must be conducted	• Documentation of Root Cause Analysis kept at the provider

9 UTILIZATION MANAGEMENT

REFERENCES:

- *XII. Service Access/Preauthorizations/Delivery/Utilization Management*
- *Exhibit: Service Access/Preauthorizations/Delivery/Utilization Management Procedures*

Utilization Management is a set of functions and activities focused on ensuring that clients receive services with the appropriate frequency and duration and that they are delivered according to practice guidelines for obtaining the best possible outcomes

Please refer to the NMRE website (www.nmre.org) for the complete Utilization Management Plan. Although the NMRE is responsible for authorizing services, Providers are required to review the effectiveness of interventions and adjust accordingly. This includes, but is not limited to, the following standards:

1. To assure an accessible and appropriate set of services for plan members.
2. To maximize cost-effectiveness.
3. To ensure Uniform Benefit. Clients with similar needs will receive similar services regardless of where they obtain services within the catchment area.
4. Medicaid services must comply with the standards within the current MDHHS Medicaid Provider Manual.
5. Substance Use Disorder services must utilize DSM-V for diagnosis and ASAM criteria for level of care (placement/admission, continued stay and discharge/transfer.
6. Performance measures are expected to meet or exceed industry standards.

Provider Requirement	**Documentation Required**
Providers should review the effectiveness of interventions and adjust services accordingly	• Documentation of the adjustment of services

10 REPORTING

10.1 Provider Reporting

Provider Reporting Requirements is included in the NMRE/Provider Contract. The NMRE only requests information not available elsewhere.

Report	Timeframe
90% Capacity Management Report The 90% Capacity Management Report includes reporting the data a provider which serves individuals with IV Drug use reaches 90% capacity. The date the provider no longer is at 90% capacity is also reported in this report.	As reach 90% capacity and as no longer at 90% capacity
Children's Referral Report The Children's Referral Report identifies referrals for Women's Specialty Services client's children.	Monthly
Residential Sentinel Events Summary Report The residential Sentinel Events Summary is a report for all residential clients, regardless of funding source or region. The total number of residential clients for a provider as well as the number of Sentinel Events is reported.	October – March April - September
Women's Specialty Services Report The Women's Specialty Services report gathers information that the NMRE does not have access to. This information is provided to legislatures.	Annual
Performance Indicator Report The number of individuals who have requested services but have not obtained treatment services is not information the NMRE has access to without obtaining it from providers.	Quarterly
Grievances Although the NMRE does not require providers to submit grievances at the time of occurrence as required by Recipient Rights Complaints, grievance reports are required to be submitted monthly.	Monthly

RESOURCE DOCUMENTS

Code Chart – link (https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf)

Staff Qualifications – link (https://www.michigan.gov/documents/mdhhs/PIHP-MHSP_Provider_Qualifications_530980_7.pdf)

Medicaid Manual – link (https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html)

Managed Care Rules – link (https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rule/index.html)

MDHHS/PIHP Contract – link (www.nmre.org under Resources)

ATTACHMENTS

Attachment 1: Priority Populations Details / Requirements

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User ***Any female who is currently pregnant and is injecting drugs***	Screened & referred w/in 24 hrs. Detox, Methadone or Residential – Offer Admission w/in 24 business hours Other Levels of Care – Offer Admission w/in 48 Business hours	**Begin w/in 48 hrs.:** Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants Effects of alcohol & drug use on the fetus Referral for pre-natal care *Early Intervention Clinical Svc*
Pregnant Substance User ***Any female who is currently pregnant***	Screened & referred w/in 24 hours Detox, Methadone or Residential Offer admission w/in 24 business hours Other Levels of Care – Offer Admission w/in 48 Business hours	**Begin w/in 48 hrs.** 1. Counseling & education on: A. HIV & TB B. Risks of transmission to sexual partners & infants C. Effects of alcohol & drug use on the fetus 2. Referral for pre-natal care 3. *Early Intervention Clinical Svc*
Injecting Drug User ***Any individual who is injecting drugs***	Screened & Referred w/in 24 hours; Offer Admission w/in 14 days	**Begin w/in 48 hrs. – maximum waiting time 120 days** 1. Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants 2. *Early Intervention Clinical Svc*

Population	Admission Requirement	Interim Service Requirement
Parent at Risk of Losing Children ***Any parent who has Child Protective Services involvement and is at risk of losing custody of their children due to their substance use***	Screened & referred w/in 24 hours Offer Admission w/in 14 days	**Begin w/in 48 business hrs.** *Early Intervention Clinical Services*
MDOC Involvement ***Individual Under Supervision of MDOC and referred by MDOC or Individual Being Releases Directly From and MDOC Without Supervision and Referred by MDOC***	*Screened & referred w/in 24 hours* *Offer Admission w/in 14 days*	***Begin w/in 48 business hrs.*** *Early Intervention Clinical Services* *Recovery Coach Services*
All Others	Screened & referred w/in seven (7) calendar days. Capacity to offer Admission w/in 14 days	**Not Required**

Attachment 2: Block Grant Funding - Household Income Sliding Fee Scale

Sliding Fee Scale:

REFERENCE:

- *Most recent contract*

Northern Michigan Regional Entity

FY 2022 Income Eligibility

Minimum Family Size	Maximum Family Size	Minimum Income	Maximum Income
1	1	$0	$25,760
1	2	$0	$34,840
1	3	$0	$43,920
1	4	$0	$53,000
1	5	$0	$62,080
1	6	$0	$71,160
1	7	$0	$80,240
1	8*	$0	$89,320

*For each additional family member, add $4,540

Sliding fee scale based upon 2021 poverty guidelines Effective: 1/13/2021

Services are subject to applicable co-payment benefit limitations for Community Block Grant funding and other contractual requirements. Medicaid, Healthy Michigan and MIChild funding are not subject to co-payment benefit limitations and may not include any form of client payment.

Attachment 3: Practice Guidelines – SUD Specific

Early Intervention *(ASAM Level 0.5)*

The NMRE adheres to the recommendations as described in the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Technical Advisory #09: Early Intervention. Licensure as an Early Intervention program is required as well as a State determination of appropriate ASAM Level(s).

The ASAM Criteria; 3rd Edition defines Early Intervention as "an organized service that may be delivered in a wide variety of settings. Early Intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and addiction behavior, and to help the individual recognize the harmful consequences of high risk substance use and/or addictive behavior."

Early Intervention services should be short-term and may indicate a need for the individual to enter a new level of care. Early Intervention services may be provided in individual or group modalities and may be office or community based.

Early Intervention services may be provided as prevention services to prevent a substance use disorder by NMRE contracted prevention providers or as treatment services for individuals meeting ASAM Level 0.5 by NMRE Contracted treatment providers.

Population to be Served

Prevention: Individuals identified and assessed as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs that do not meet the threshold for ASAM Level 0.5.

Treatment: Individuals meeting Level 0.5 who are experiencing some problems and/or consequences associated with their substance use.

Program Requirements

Licensed by the Michigan Department of Licensing and Regulations to provide Outpatient/Early Intervention Services or be a governmental entity and in good standing as a provider on the NMRE Treatment Provider Panel. Services must be provided with fidelity to the model.

Clinician Requirements

In order to facilitate the early intervention program, a clinician must successfully complete the training for that program and have documentation to support this. The clinician must also be in good standing as a clinician on the NMRE Treatment Provider Panel including being current on certification requirements to provide substance use disorder treatment. PRI (Prevention Research Institute)

Group Size

No maximum size of the group has been established.

Each program (12 hour service) must have a minimum of five (5) or more people enrolled for the first session.

Documentation Requirements

Early Intervention services are licensed under an outpatient license and therefore documentation requirements of an outpatient license apply. See Administrative Rules for Substance Abuse Service Programs in Michigan including but not limited to a treatment plan, progress note and discharge plan/summary.

Reimbursement

NMRE will reimburse for these services through the RECON system.

Consistent with the agreement signed by the Provider and the trained clinician at the time of the PRIME for Life training, this service shall be provided at no cost. The program and/or the clinician cannot provide PRIME for Life and charge participants.

Outpatient Services *(ASAM Levels 1 and 2)*

NMRE adheres to the requirements as described in the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Policy #09: Outpatient Treatment Continuum of Services. Licensure as an outpatient program is required as well as a State determination of appropriate ASAM Level(s).

Outpatient and Intensive Outpatient SUD treatment services are organized levels of care which may be delivered in a wide variety of settings where addiction treatment staff provide professionally directed screening, evaluation, treatment, and ongoing recovery and disease management services.

Such services are provided in regularly scheduled sessions of:

- Outpatient: Fewer than nine contact hours per week of structured programming for adults, and fewer than six hours per week for adolescents.
- Intensive Outpatient: Nine to nineteen hours of structured programming for adults, and six to nineteen hours for adolescents.

The services follow a defined set of policies and procedures or clinical protocols. Individual, couple, group, and family therapy are common modalities appropriate for SUD outpatient care. Outpatient treatment is the level of care with the least amount of restriction, so it is important that clients can maintain a degree of safety outside of services.

Residential *(ASAM Level 3)*

NMRE adheres to the requirements of the Bureau of Community Based Services. Treatment Policy #10: Residential Treatment Continuum of Services. (https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_45835_48569-133156--,00.html) Licensure as a residential program is required as well as a State determination of appropriate ASAM Level(s).

Residential services are delineated between "short-term" (30 days or less) and "long-term" (more than 30 days), and reflect the current ASAM Levels of 3.1 Clinically Managed Low Intensity Residential Services, 3.3 Clinically Managed Population-Specific Residential Services, 3.5 Clinically Managed High Intensity Residential Services, and 3.7 Medically Monitored High-Intensity Inpatient Services using modifiers or no modifiers as described below:

ASAM Level	Description	HCPCS	Modifier
3.1	Clinically Managed Low Intensity	H0018, H0019	W1
3.3	Clinically Managed Population-Specific	H0018, H0019	W3
3.5	Clinically Managed High Intensity	H0018, H0019	W5
3.7	Medically Monitored Intensive	H0018, H0019	W7

Each Provider contracted with the NMRE to provide residential services is expected to have a specific designation for one (or more) of these levels from the Michigan Bureau of Community Based Services. NMRE is expected to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM Levels 3.1, 3.3, 3.5, and 3.7.

In addition to the requirements of the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Policy #10: Residential Treatment Continuum of Services NMRE maintains the following expectations of its contracted residential treatment providers:

- Providers are expected to offer treatment that is flexibly staged with variable lengths of stay. Length of stay should always be determined by individual client need, medical necessity, and ASAM criteria, not pre-determined time frames ("21-Day program", "30-Day program", "Long-term" treatment, etc.). Flexibly staged treatment adapts with the changing needs of the client such as increasing/decreasing the number of treatment hours per week and matching treatment modalities to the client's unique needs. Flexibly staged treatment is client care driven as opposed to process driven.
- Additionally, length of stay should not be driven by funding expectations. NMRE uses concurrent and retrospective utilization practices for residential treatment services; residential services are not pre-authorized. Treatment Providers should not discharge clients in the event a re-authorization request has not been reviewed or approved by

NMRE. Providers should ensure that their own prospective (i.e. eligibility) practices are sound in determining appropriate level of care to ensure that authorization requests are reviewed without any problems.

- Residential treatment Providers should actively assist clients with continuing care planning and are expected to coordinate care with the continuing care provider. This includes but is not limited to: assisting the client with scheduling the first appointment following discharge from residential treatment and securing a signed release of information and sending the residential discharge summary to the identified continuing care provider.
- If a client is absent from treatment for more than 24 hours, a note needs to be placed within the client's chart.
- Staff providing direct clinical services within a residential program need to be appropriately credentialed and licensed based on the services they provide.

Tuberculosis (TB) Testing Requirement

All clients entering residential and/or withdrawal management must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.

Recovery Support

NMRE adheres to the recommendations described in the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Technical Advisory #7: Peer Recovery/Recovery Supports and MSA (Medicaid Services Administration) Bulletin 17-45 (https://www.michigan.gov/documents/mdhhs/MSA_17-45_607335_7.pdf). Licensure as an Outpatient program is required with a Peer Recovery designation.

Recovery support services will be available to all qualifying clients entering SUD treatment services. This does not necessarily mean every Provider in the network has to have a direct operated peer recovery/recovery support services component.

Peer recovery/recovery support services do not include therapy or other clinical services, ongoing transportation to regular appointments, and/or participation in activities that might jeopardize the coach's own recovery.

Persons employed to provide peer recovery/recovery support services as a Qualified Peer Specialist must meet requirements as outlined in the Medical Services Bulletin MSA 17-45, effective January 1, 2018, in order to bill under Medicaid and/or Healthy Michigan. .

Note: NMRE highly discourages organizations from hiring or assigning staff to dual roles – either therapists as recovery coaches or recovery coaches in a therapeutic role. This can be very confusing for both client and recovery coach and can diminish the role of peer recovery/recovery support services.

Recovery Housing

Per the MDHHS Technical Advisory 11: Recovery Housing, recovery housing provides a location where individuals in early recovery from a behavioral health disorder are given the time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program.

Recovery housing providers are also expected to follow the standards outlined in the National Alliance for Recovery Residences (NARR) – Domains, Core Principles, and Standards (available on the NARR website https://narronline.org/). NMRE also requires Providers to obtain and maintain certification from Michigan Association of Recovery Residences (MARR).

PURPOSE

Service Description

Service Purpose

The purpose of this protocol is to establish the requirements for Recovery Residence services for the Northern Michigan Regional Entity Substance Use Disorder Services Provider Panel.

SERVICE Services Definition

Please refer to the individual rule/code/policy/etc. for the most current information. Information that has been updated in the individual rule/code/policy/etc. supersedes what is included in this guideline.

Administrative Rule

Mental Health Code

Public Health Code

LARA

Treatment Policies

Treatment Technical Advisory 11

Recovery housing provides a location where individuals in early recovery from a behavioral health disorder are given the time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program.

NMRE/PIHP Contract

MDHHS/PIHP Contract

Medicaid Manual

Medicaid Code Description

State Measures

Michigan Association of Recovery Residences

National Measures

National Association of Recovery Residences

PROTOCOLS

Service Description

Recovery Housing allows beneficiaries to gain a safe environment while the individual is in early recovery. There are certain aspects of establishing and maintaining recovery residences that are necessary for success. All Recovery Residences should adhere to the National Association of Recovery Residences (NARR) Guidelines. Only those residences meeting the residence criteria will be approved to provide services with funding through the NMRE.

Aspects of Recovery Housing Necessary for Success as defined by the Technical Advisory #11:

a) Maintain an alcohol and illicit drug free environment

b) Maintain a safe, structured and supportive environment

c) Set clear rules, policies, and procedures for the house and participating residents

d) Establish an application and screening process for potential residents

e) Endeavor to be good neighbors and get residents involved in their community

Service Requirements

Recovery Housing must, as defined by the Technical Advisory #11:

f) Identify clearly the responsible person(s) in charge of the recovery residence to all residents

g) Collect and report an accurate process and outcome data for continuous quality improvement

h) Maintain an accounting system that fully documents all resident's financial transactions, such as fees, payments, and deposits

i) Use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery

j) Foster mutually supportive and recovery-oriented relationships between residents and staff through peer-based interactions, house meetings, community gatherings, recreational events and other social activities

k) Encourage each resident to develop and participate in his/her own personalized recovery plan

l) Provide non-clinical recovery support and related services

m) Encourage residents to attend mutually supportive, self-help groups and/or outside professional services

n) Maintain the interior and exterior of the property in a functional, safe and clean manner that is compatible with the neighborhood

o) Provide rules that are responsive to a neighbor's reasonable complaints regarding noise, smoking, loitering, and parking

NARR Standards:

I. Administrative and Operational

a. Principle: Operate with Integrity

i. Are guided by a mission with integrity (Levels I, II, III and IV)

1. Has a written statement that corresponds with NARR's core principles

2. Has a vision statement that corresponds with NARR's core principles

ii. Adheres to legal and ethical codes (Levels I, II, III and IV)

1. Has an affidavit that attests to complying with non-discriminatory state and federal

requirements
2. Any marketing materials, claims and advertising must be honest and substantiated
3. Prior to approval to complete services, the operator must inform all applicants of all fees and charges for which the beneficiary will be, or could potentially be, responsible. This information must be in writing and signed by the applicant.
4. The operator must maintain accurate and complete records of all resident charges, payments, and deposits. A resident must be provided with a statement of his/her personal charge and payment history upon request.
5. The operator must disclose refund policies to applicants in advance of acceptance into the home and before accepting any applicant fees.
6. Staff must never become involved in a resident's personal financial affairs, including lending or borrowing money, or other transactions involving property or services, except that the operator may make agreements with residents with respect to payment of fees.
7. Must have a policy and procedure in place that ensures refunds consistent with the terms of a resident agreement are provided within 10 business days and preferably upon departure from the home.
iii. Are financially honest and forthright (Levels I, II, III and IV)
1. Can identify and demonstrate the type of accounting system used and its capability to fully document all resident financial transactions, such as fees, payments, and deposits
2. Has a policy and procedure for disclosing to potential residents their financial obligations, including costs for which they might become liable, such as forfeiture of any deposits and fees as a result of prematurely leaving the home
3. Policies about the timing of and requirements for the return of deposits if financial deposits are required
4. The ability to produce clear statements of a resident's financial dealings with the operator
5. Policies and procedures that ensure the following conditions are met if the residence provider or staff member employs, contracts with, or enters into a paid work agreement with residents:
• Paid work arrangements are completely voluntary.
• Paid work for the operator or staff does not impair participating residents' progress towards their recovery goals.
• The paid work is treated the same as any other employment situation.
• Wages are commensurate with marketplace value, and at least minimum wage. The arrangements are viewed by a majority of the residents as fair.
• Paid work does not confer special privileges on residents doing the work. Work relationships do not negatively affect the recovery environment or morale of the home. Unsatisfactory work relationships are terminated without recriminations that can impair recovery.
iv. Collect data for continuous quality improvement (Levels I, II, III and IV)
1. Procedures that collect residents' demographic information
2. Procedures that collect, evaluate, and report accurate process and outcomes data for continuous quality improvement (Levels III, IV)
v. Operate with prudence (Levels I, II, III and IV)
1. Legal business entity documentation e.g. incorporation, LLC documents or business license
2. Documentation that the owner/operator has current liability coverage and other insurance

appropriate to their level of support
3. Written permission from the owner of record to operate a recovery residence on the property
4. Policies and procedures that ensure that background checks are conducted on all staff, including volunteers that have direct and regular interaction with residents
b. Principle: Uphold Resident Rights
i. Communicate rights and requirements before agreements are signed (Levels I, II, III and IV)
1. A process that ensures residents receive an orientation on agreements, policies, and procedures prior to committing to terms.
2. Written resident's rights and requirements (e.g. House Rules and grievance process) posted in common areas
3. Written resident agreement that includes:
a. Services provided
b. Recovery plan including a move-in (i.e. goals and objectives) and move-out (i.e. contingency) plan
4. Resident documents that fully disclose policies regarding possessions (personal property) left in a home
ii. Promote self and peer advocacy (Levels I, II, III and IV)
1. Grievance policy and procedures, including the right to take unresolved grievances to the operator's oversight organization
2. Policy and procedure for identifying the responsible person(s) in charge to all residents
iii. Support Housing Choice (Levels I, II, III and IV)
1. Applicant screening policies and procedures provide current residents a voice in the acceptance of new members.
2. Policies and procedures that promote resident-driven length of stay (Levels I, II and III)
3. Policies and procedures that defend resident's fair housing rights
iv. Protect privacy (Levels I, II, III and IV)
1. Policies and procedures that keep resident's records secure, with access limited to authorized staff only
2. Policies and procedures that comply with applicable confidentiality laws
c. Principle: Are Recovery-Oriented
i. View recovery as person driven, holistic, and lifelong process (Levels I, II, III and IV)
1. Documentation that residents participate in the development of their recovery plan including an exit plan and/or lifelong plan
2. Documentation that the operator cultivates alumni participation
ii. Culturally responsive and competent (Levels I, II, III and IV)
1. Policies and procedures that identify the priority population, which at a minimum includes persons in recovery from a substance use disorder but may also include other demographic criterion
2. A staffing or leadership plan that reflects the priority population's needs
3. Documented cultural responsiveness and competence trainings that are relevant to the priority population (Levels III and IV)
d. Principle: Are Peer Staffed and Governed
i. Involve peers in governance in meaningful ways (Levels I, II, III and IV)

1. Some rules are both made and enforced by the residents rather than staff
2. A resident council or process is in place that ensures resident's voices can be heard
3. The resident council has a voice in the governance of the home
ii. Use peer staff and leaders in meaningful ways (Levels I, II, III and IV)
1. Residents' responsibilities increase with their length of stay or progress in their recovery
2. Staffing or leadership plan that formally includes a peer component
3. Written job description and/or contracts for peer staff and leaders
iii. Maintain resident and staff leadership based on recovery principles (Levels I, II, III and IV)
1. A home staffing or leadership plan that includes current residents and, where possible, former residents that model recovery principles
2. Leader and/or staff job descriptions and selections are based in part on modeling recovery principles
iv. Create and sustain an atmosphere of recovery support (Levels I, II, III and IV)
1. Integrated recovery support in the daily activity schedule
2. The schedule includes formal and informal opportunities for staff and resident interaction in support of recovery
v. Ensure staff are trained or credentialed appropriate to their level (Levels III and IV)
1. Written staffing or workforce development plan
2. Certification and verification policies and procedures
vi. Provide supportive staff supervision (Levels III and IV)
1. Policies and procedures for supervision of staff (Levels III and IV)
2. Ongoing skills development, oversight, and support policies and procedures appropriate to staff roles and level of support
II. Recovery Support
a. Principle: Promote Health
i. Encourage residents to 'own their recovery' (Levels I, II, III and IV)
1. Policies and procedures that encourage each resident to develop and participate in their own personalized recovery plan
2. Policies and procedures that encourage residents to make their own outside appointments
ii. Inform and encourage residents to participate in a range of community-based supports (Levels I, II, III and IV)
1. Staff and/or resident leaders that are knowledgeable about local community-based resources
2. Resource directories or similar resources are readily available to residents
iii. Offer recovery support in informal social settings (Levels I, II, III and IV)
1. Staffing plan that corresponds with the delivery of this service
2. Traditions, policies, or procedures that foster mutually supportive and recovery-oriented relationships between residents and/or staff through peer-based interactions
iv. Offers recovery support services in formal settings (Levels III and IV)
1. Weekly schedule of recovery support services recognized by the respective NARR Affiliate organization
2. Weekly schedule of recovery-oriented presentations, group exercises and activities
3. Staffing plan that corresponds with the delivery of this service
v. Offering life skills development services in a formal setting (Levels III and IV)

1. Weekly schedule of formal life skills development services or classes
2. Staffing plan that corresponds with the delivery of this service
vi. Offer clinical services in accordance with State law (Level IV)
1. Weekly schedule of clinical services available to residents across all phases if multiple phases are used
2. Staffing plan that corresponds with the delivery of this service
b. Principle: Provide a Home
i. Provide a physically and emotionally safe and respectful environment (Levels I, II, III and IV)
1. Policies and procedures, such as applicant screenings, that establish the home's priority population and cultivate physically and emotionally safe environments for discussing needs and feelings as well as maintaining recovery-supported connections
2. Policies that promote resident-determined lengths of stay that support health and safety of the household/community
ii. Provide an alcohol and illicit drug-free environment (Levels I, II, III and IV)
1. Written and enforced policies and procedures that address:
a. Alcohol and/or other prohibited drug-seeking or use;
b. Possession of hazardous or other prohibited items and associated searches;
c. Drug screening and or toxicology protocols; and/or
d. Prescription and non-prescription medication usage and storage consistent with the level of support and relevant state law
iii. Are cultivated through structure and accountability (Levels I, II, III and IV)
1. Written resident rights, requirements, agreements, social covenants, and/or "House Rules"
2. Requirements and protocols for peer leadership and/or mentoring policies that foster individual and community accountability
c. Principle: Inspire Purpose
i. Promote meaningful daily activities (Levels I, II, III and IV)
1. A weekly schedule of the typical resident's activities
2. Residents are encouraged to (at least one of the following):
a. Work, go to school, or volunteer outside of the residence community (Levels I, II and some III)
b. Participate in mutual aid or caregiving (All Levels)
c. Participate in social, physical, or creative activities (All Levels)
d. Attend daily or weekly programming (All Levels)
3. Person-driven recovery planning and peer governance
d. Principle: Cultivate Community
As evidenced by meeting at least fifty percent (50%) of the following:
i. Create a "functionally equivalent family" within the household (Levels I, II, III and IV)
1. Residents are involved in food preparation
2. Residents decide with whom they live
3. Residents help maintain and clean the home (i.e. chores)
4. Residents share in household expenses
5. Family or house meetings are held at least once a week
6. Residents have access to the common areas of the home
ii. Foster ethical, peer-based, mutually supportive relationships between residents and/or

staff (Levels I, II, III and IV)
1. Policies and procedures that encourage residents to engage one another in informal activities and conversation
2. Policies and procedures that encourage staff to engage residents in informal activities and conversations
3. Policies and procedures that coordinate community gatherings, recreational events, and/or other social activities amongst residents and/or staff
iii. Connect residents to the local (greater) recovery community (Levels I, II, III and IV)
As evidenced by at least fifty percent (50%) of the following for Levels II through IV and at least one for Levels I:
1. Residents are informed of or linked to mutual aid, recovery community centers, recovery ministries, recovery-focused leisure activities, and recovery advocacy opportunities
2. Mutual aid meetings are hosted on-site and there are typically attendees from the greater recovery community
3. The recovery residence helps participants find a recovery mentor or mutual aid sponsor if they are having difficulty finding one
4. Participants are encourages to find a recovery mentor or mutual aid sponsor before leaving the recovery residence
5. Residents are formally linked with the community resources such as job search, education, family services, health, and/or housing programs
6. Residents engage in community relations and interactions to promote kinship with other recovery communities and goodwill for recovery services
7. Sober social events are regularly scheduled (each participant can attend at least one)
III. Property and Architecture
a. Principle: Promote Recovery
i. Create a home-like environment (Levels I, II, III and IV)
1. Furnishings are typical of those found in single family homes or apartments as opposed to institutional settings
2. Entrances and exits that are home-like (vs institutional or clinical)
3. Fifty or more square feet per bed per sleeping room
4. One sink, toilet, and shower per six residents
5. Each resident has personal item storage
6. Each resident has food storage space
7. Laundry services are accessible to all residents
8. Working appliances
9. A staffing plan that provides for addressing repairs and maintenance in a timely fashion
ii. Promote community (Levels I, II, III and IV)
1. Community room (space) large enough to accommodate community living and meetings
2. A comfortable group area or living room with seating for participants to informally socialize
3. A kitchen and dining area(s) that encourages residents to share meals together
4. Entertainment or recreational areas and/or furnishings that promote social engagement
5. Furniture that is in good condition
b. Principle: Promote Health and Safety
i. Create a home safety (Levels I, II, III and IV)

1. Affidavit from the owner or operator attesting that the residence meets nondiscriminatory local health and safety codes or document from government agency or credentialed inspector attesting to the property meeting health and safety standards
2. Signed and dated safety self-assessment checklist which includes:
a. Functioning smoke detectors in the sleeping rooms
b. Functioning carbon monoxide detectors if there are gas appliances
c. Functioning fire extinguishers in plain sight and/or clearly marked locations
d. Interior and exterior of the property is in a functional, safe, and clean condition and free of fire hazards
e. Smoke-free living environment policy and/or designated smoking area outside of the residence
ii. Have an emergency plan (Levels I, II, III and IV)
1. Post emergency numbers, procedures, and evacuation maps in conspicuous locations
2. Collect emergency contact information from residents and orient them to emergency procedures
IV. Good Neighbor
a. Principle: Are Good Neighbors
i. Are compatible with the neighborhood (Levels I, II, III and IV)
1. If recovery residence is in a residential neighborhood, there are no external indications that the property is anything other than a single family household typical of its neighborhood
2. The property and its structures are consistently maintained
ii. Are responsive to neighbor concerns (Levels I, II, III and IV)
1. Policies and procedures that provide neighbors with the responsible person(s) contact information upon request
2. Policies and procedures that require the responsible person(s) to respond to neighbors' concerns, even if it is not possible to resolve the issue
3. New resident orientation includes how residents and staff are to greet and interact with neighbors and/or concerned parties
iii. Have courtesy rules (Levels I, II, III and IV)
1. Policies that are responsive or preemptive to neighbor's reasonable complaints regarding:
a. Smoking
b. Loitering
c. Parking
d. Noise
e. Lewd or offensive language
f. Cleanliness of public space around the property
2. Parking courtesy rules where street parking is scarce

Administrative Functions

Provider Requirements

To receive approval for the recovery housing service, providers must obtain approval of the house. Each house must be approved separately based on the standards in section 1.1. A formal request including a budget to support the services with a rate must be sent to the NMRE and approved prior to seeking reimbursement for the services.

Staff Requirements

Provider staff must be in supervision of the house and inhabitants

Client Requirements

A client must be receiving outpatient substance use disorder treatment services to be eligible for reimbursement for recovery residence stays. Clients must also meet the Northern Michigan Regional Entity eligibility criteria for treatment services (i.e. documented substance use disorder diagnosis as defined by the DSM-V/ICD-10 and meet funding requirements)

Expected Outcomes

Minimum Service Expectations

Recovery residence services will be reimbursed for each day of stay if the criteria listed in this protocol and procedures are met. Client must be in residence for each day billed. One unit of service is equal to one night stay at the residence. Services will be authorized one month at a time for up to three months. Additional units will be evaluated on a case-by-case basis.

PROCEDURE

ADMISSION CRITERIA

Admission Criteria

The client must have an outpatient admission and be attending outpatient sessions routinely

SERVICE AUTHORIZATIONS

Prior Authorization Required?

Yes - prior authorization is required

Unit or Encounter

Encounter 1 Unit = 1 Day = 1 Encounter

Code (s)

H0034

SERVICE AUTHORIZATION MATRIX

Initial Authorization:

30

Re-Authorization:

30

SERVICE DELIVERY

Service Requirements

The delivery of recovery residence services shall be completed on an individual needs basis, but shall be subject to the following:

a) Client meets criteria for any NMRE funding (Medicaid, Healthy Michigan Plan or Block Grant)

b) Client is not able to meet the financial requirements to stay at the recovery residence

c) Client adheres to residence rules and requirements

Documentation Requirements

d) The treatment record of clients receiving recovery residence services must contain documentation indicating the following information:

§ Date of residential stay;

§ Documentation client was in-residence;

§ Documentation of activities; and

§ Staff sign off

BILLING

Billing Description

H0034

CONTINUED SERVICE CRITERIA

Continued Service Criteria

As medically necessary

DISCHARGE CRITERIA

Discharge Requirements

When treatment plan needs for recovery housing are met

Withdrawal Management (ASAM Level 3.2-WM and 3.7-WM)

NMRE adheres to the recommendations described in the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Policy #13: Withdrawal Management Continuum of Services. Licensure as a withdrawal management program is required.

Sub-acute withdrawal management is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The withdrawal management process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A withdrawal management process that does not incorporate all three components is considered incomplete and does not meet NMRE's expectations for this service.

- Sub-acute withdrawal management is part of a SUD treatment episode, with the clinical pathway detailed in the authorization of services and explained to the client prior to admission into detoxification services.
- The sub-acute withdrawal management Provider will facilitate and obtain follow up for the client's transfer to the next level of care.
    - Follow up involves the communication between the sub-acute withdrawal management Provider and the Provider receiving the individual to ensure the individual is admitted in a timely manner to their referral destination. Timely is defined according to the MDHHS requirement whereby the individual is admitted to the provider receiving the individual post discharge from a sub-acute withdrawal management provider within the required seven calendar days.
- The sub-acute withdrawal management provider is to provide a safe withdrawal from the drug(s) of dependence.
    - The sub-acute withdrawal management is to be provided in a supportive environment, with caring staff, sensitivity to cultural issues, confidentiality, and selection of appropriate withdrawal management medication (if needed) in order to be sure that the withdrawal is humane and protects the client's dignity.
    - The sub-acute withdrawal management Provider is to prepare the client for ongoing treatment of their substance use disorder by emphasizing withdrawal management as one phase of SUD treatment, not a treatment modality by itself. Withdrawal management is an opportunity to offer clients information and to motivate them for longer term treatment.
- Sub-Acute Detoxification services will be provided via ASAM Level of Care 3.7WD. This is a medical services with medical staff on-site 24 hours a day. LARA licensure is specific to Sub-Acute Detoxification services.

- Withdrawal Management services will be provided via ASAM Level of care 3.2WD. These services are a clinical based services with medical staff available as needed. LARA licensure required is for residential.

Pregnant Women in Detox

Pregnant women (IDU (Injecting Drug Users) or not) need to be offered admission into withdrawal management services within twenty-four (24) hours after the initial screening. It is highly recommended that pregnant women whose primary drug(s) of choice are alcohol, benzodiazepines, and/or barbiturates (Sedatives-Hypnotics) be referred to an acute care medical hospital where the stress of withdrawal on the pregnancy will be appropriately monitored until her need for withdrawal management while pregnant is no longer needed.

Tuberculosis (TB) Testing Requirement

All clients entering residential and/or withdrawal management must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.

Medication Assisted Treatment (MAT)

NMRE adheres to requirements described in all Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section policies related to MAT. -Licensure as an Outpatient-Methadone program is required as well as a State determination of appropriate ASAM Level(s).

Medication Assisted Treatment (MAT) is a standard of care that is broadly recognized as an essential service in any comprehensive approach to the national opioid addiction and overdose epidemic. NMRE seeks to ensure that no consumer is denied access to or pressured to reject the full-service array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that client.

NMRE supports a MAT-inclusive treatment philosophy in which:

- the Provider demonstrates willingness to serve all eligible treatment seeking individuals, including those who are using MAT as part of their individual recovery plan at any stage of treatment or level of care, and without precondition or pressure to adopt an accelerated tapering schedule and/or a mandated period of abstinence, and
- the Provider develops policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain.

NMRE supports the MDHHS Medication Assisted Treatment Guidelines for Opioid Use Disorders.
https://www.michigan.gov/documents/mdhhs/MAT_Guidelines_for_Opioid_Use_Disorders_524339_7.pdf.

Abstinence-Based (AB) Providers

In the interest of consumer choice, NMRE will contract with Abstinence-Based providers who offer written policies and procedures stating the following:

- If a prospective client, at the point of access, expresses his/her preference for an abstinence-based treatment approach, the access worker will obtain a signed MDHHS 5515 form (https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686--,00.html) that attests that the client was informed in an objective and non-judgmental way about other treatment options including MAT, and attest that the client is choosing an abstinence-based Provider from an informed perspective.
- When a client already on MAT (or considering MAT) is seeking treatment services (counseling, case management, recovery supports, and/or transitional housing) at the point of access to an AB facility, access staff
    - will be accepting and non-judgmental towards MAT as a choice,
    - will not pressure the client to make a different choice, and
    - will work with that client to do a "warm handoff" to another Provider who can provide those ancillary services while the client pursues his or her chosen recovery pathway that includes MAT.
- Providers' policies will include language that prohibits delegitimizing, and/or stigmatizing of MAT (e.g. using either oral or written language that frames MAT as "substituting one addiction for another") either verbally with individual clients, in written materials for clients or for public consumption, or in the public domain.

A consensus statement in support of inclusion was endorsed by all ten PIHP's on November 1, 2017.

Ancillary Services

Case Management (CM)

NMRE adheres to the requirements as described in the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Policy #08: Substance Abuse Case Management Program Requirements (https://www.michigan.gov/documents/mdch/P-T-08_Case_Management_218836_7.pdf).

Case Management (CM) services are those services which assist clients in gaining access to needed medical, social, educational/vocational, and other services. CM services can help establish a stronger foundation for a client's long-term recovery for those who have addictive disorders by assuring they have access to all needed services.

PURPOSE

Service Description

Service Purpose

The purpose of this protocol is to establish the requirements for Case Management (CM) services for the Northern Michigan Regional Entity Substance Use Disorder Treatment Services Provider Panel.

Service Definition

Please refer to the individual rule/code/policy/etc. for the most current information. Information that has been updated in the individual rule/code/policy/etc. supersedes what is included in this guideline.

Administrative Rule

Administrative Rule 325.14101(g)

Case Management means a substance use disorder case management program that coordinates, plans, provides, evaluates, and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

Mental Health Code

Public Health Code

LARA

Treatment Policies

Treatment Policy 8

The case management program must be identifiable and distinct within the agency's service configuration, and the agency must offer the case management services (CMS) as a separate and distinct program among any other program services that may be offered.

NMRE/PIHP Contract

MDHHS/PIHP Contract

Medicaid Manual

Medicaid Code Description

State Measures

National Measures

PROTOCOLS

Service Description

Case management (CM) is an activity that assists beneficiaries to gain access to necessary care: medical, behavioral, social, and other services appropriate to their needs. Case management should be individualized, person-centered, empowering, comprehensive, strengths-based, and outcome-focused.

Service Requirements

The Case Management program must:

a) Be identifiable and distinct within the agency's service configuration.

b) Offer or purport to offer the case management services as a separate and distinct program.

c) Be available when involved with any level of care.

d) Be provided in a responsive, client-centric, coordinated, effective and efficient manner focusing on goals, progress, and outcomes.

e) Meet a minimum requirement of one (1) face-to-face encounter per month

f) Guided by a client's case management goals and objectives and be consistent with the rest of the client's individualized, coordinated, comprehensive treatment plan of service, as applicable.

g) Make outreach efforts to engage clients who are not consistently attending treatment services, or drop out of the program and try to re-engage the client in services or discharge from services.

h) Follow-up on clients when they have unexpectedly moved, or end treatment services without completing all treatment goals, and will utilize emergency contacts provided by the client to re-engage them in services.

i) Continue despite service setbacks and referred to the Northern Michigan Regional Entity access Center if more intensive services are indicated.

j) Be provided in a community-based setting when office-based services pose a barrier to client engagement and participation. At a minimum, the provider must have the ability to see clients in their community with capability for face-to-face client interaction outside of the office setting.

k) Be able to serve as an advocate to assist and/or represent the client and his/her needs with other agencies or service providers. This may include but is not limited to serving as the "voice" of the client in situations where the client is unable to effectively represent themselves, such as accompanying clients to appointments, assisting with completion of forms or meeting other requirements the client may have to secure support/services, making appointments for clients, or ensuring compliance/follow-through of appointments.

The Case Management services may:

l) Be provided as a step-down from a more intensive level of treatment and/or can be provided as a stand-alone service if eligibility requirements are met.

m) Follow clients as they progress through the continuum/levels of care.

n) Continue for up to six (6) months or one hundred eighty (180) days, post discharge from

treatment services.

The clinical functions of Case Management include (but are not limited to):
§ Development of a Case Management Plan based on assessment with periodic treatment plan review including client feedback
§ Linkage and Referral
§ Monitoring and Follow-Up and
§ Advocacy and Empowerment
a) Assessment
The ASAM Continuum will be utilized when identifying areas of need. If Case Management services would be beneficial as an adjunct to traditional treatment services, the need must be indicated within the Treatment Plan.
b) Case Management Plan
The broad goal of the Case Management Plan is to assist the client to obtain the outcomes, skills, and symptom reduction that they desire. The plan must include goals to increase domain deficit areas and support recovery. The Case Management Plan may be revised as the client's needs, preferences, and/or goals change.
c) Linkage and Referral
Linkage and Referral activities connect a client with medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the Case Management Plan.
Referral and linkage activities include:
§ Coordinating the delivery of services to reduce fragmentation of care;
§ Facilitating access to and connecting the client to services and supports identified in the Case Management Plan. This includes preparing the client for attendance at any set appointments;
§ Making referrals to providers for needed services and scheduling appointments with the client;
§ Assisting the client as he or she transitions through levels of care; and
§ Assisting a pregnant client in establishing obstetrician and prenatal care as necessary.

d) Monitoring and Follow-Up
Monitoring and follow up includes activities and contacts that are necessary to ensure that the Case Management Plan is effectively implemented and adequately addresses the needs of the client. Monitoring activities may involve the client, his or her supports, providers, and/or others involved in care delivery.
Monitoring activities helps determine whether:
§ Services are being provided in accordance with the client's Case Management Plan;
§ Services in the plan are adequate and effective;
§ There are changes in the needs or status of the client; and
§ The client is making progress toward his or her goals.

e) Advocacy

Advocacy on behalf of a specific client for the purpose of accessing needed services is considered a case management service. Activities may include making and receiving phone calls, coordination of services and the completion of applications or forms with the client to access identified services that are needed.

Administrative Functions

The administrative functions of Case Management include (but are not limited to):

f) Documentation

The client's record must contain sufficient information to document the provision of case management, including the nature of the service, the goal for which the service is indicated, the date, time/duration, and the location/type of contacts between the case manager and the client, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the client's needs, and guided by the Case Management Plan.

The case manager must review services at intervals defined in the Case Management Plan. The Case Management Plan shall be kept current and modified when indicated (reflecting the intensity of the client's health and welfare needs). A client or his/her guardian or authorized representative may request and review the Case Management Plan at any time. A periodic review of the Case Management Plan shall not occur less often than every three months, or ninety (90) days, to review progress toward goals and objectives and to assess client satisfaction.

g) Monitoring

The case manager must determine, on an ongoing basis, if the supports and services have been delivered and if they are adequate to meet the needs/wants of the client. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the client's health and welfare needs identified in the Case Management Plan. Case management shall not include direct delivery of ongoing day-to-day supports and/or training or provision of Medicaid services. Case managers are prohibited from exercising the funding agency's authority to authorize or deny the provision of services. Case management shall not duplicate services that are the responsibility of another program or service provider(s).

h) Expected Outcomes

The client receiving Case Management services:

§ has a comprehensive Case Management Plan that addresses all service and support needs;

§ is linked to natural supports;

§ has reduced episodes requiring intervention through the Emergency Department (ED), Mobile Crisis, Facility Based Crisis, hospitalization, or detoxification within the most recent past three to six-month period; and

§ becomes increasingly independent in managing his/her own care (e.g., making treatment appointments, attending treatment, taking medications as prescribed, etc.) as appropriate.

The parent or pregnant client receiving Case Management services:

§ is linked to a primary care physician or obstetrician and gynecologist (OBGYN);

§ is receiving appropriate and timely medical assessment or intervention including OBGYN care and other prenatal care as necessary.
§ as indicated, assists in the linking of pediatrician services for children
§ as indicated, assists in the linking of counseling services for children
§ becomes increasingly independent in managing his/her own care (e.g., making treatment appointments, attending treatment or prenatal appointments, taking medications as prescribed, etc.).

Provider Requirements

A provider must be licensed for case management services through the Department of Licensing and Regulatory Affairs (LARA) if services are received through Outpatient services. Otherwise, a Residential or Sub-Acute Detoxification licensure is required. Case Managers must provide clinical applications and be approved to provide services through the Northern Michigan Regional Entity. Case Managers must comply with all contractual staffing requirements including Communicable Disease training as well as continuing education. In addition:
§ Providers must demonstrate the capacity to provide all core requirements specified below and have enough staff to meet the needs of the target population.
§ Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.
§ Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the PCP/treatment plan developed through the person-centered planning process.

Staff Requirements

Client Requirements

Clients with a documented substance use disorder diagnosis as defined by the DSM V/ICD-10 and meet criteria for funding through the NMRE are eligible to have CM services reimbursed by the NMRE.

In addition, at least one of the following criteria must be for a client to be eligible for CM services:

a) Client must have a documented need in at least one domain involving community living skills, health care, housing, employment, financial, education or other functional area in that person's life. Which may include, but is not limited to, the following:

§ There are chronic physical conditions that affect treatment and will likely affect recovery. (e.g., chronic pain with narcotic analgesics)

§ Client is pregnant/parent of dependent children, or is at risk of losing custody of children.

§ Client has documented involvement with multiple systems such as Department of Human Services/Protective Services or Foster Care, Probation, Drug/Sobriety Substance Use Disorder (SUD) Treatment Courts, etc.

§ Client has a history of recidivism, and/or a treatment history involving multiple treatment attempts/episodes of care.

b) Client has a demonstrated history of unsuccessful recovery attempts.

c) Client has a substance use disorder involving a primary drug of choice and history of use that will require longer-term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants).

d) The chronicity and severity of the client's disorder is such that ongoing support is necessary to increase the probability of recovery (such as years of use and first involvement with treatment).

A client who is receiving case management services from another service provider or program (mental health, child welfare, justice system etc.) is not eligible for substance use disorder case management services regardless of whether the client meets criteria as detailed above.

Expected Outcomes

Minimum Service Expectations

PROCEDURE

ADMISSION CRITERIA

Admission Criteria

a) SUD treatment providers may determine the need for case management services during their assessment process or at any time during the treatment planning process.
b) Case Management services may be provided while the client is not receiving other SUD services.
c) Case Management services may be provided while the client is receiving any level of care through the Northern Michigan Regional Entity Substance Use Disorder Provider Panel.

Admission into Case Management services requires the following:
a) Completion of the ASAM Continuum or GAIN indicating a deficit in any one of the domains.
b) A clinical determination that Case Management services would benefit the clients recovery
c) Once the clinical determination is made for Case Management services, the client will meet with a case manager to review any areas of need noted in the assessmentand determine appropriateness for service.
d) Once appropriate areas of need are identified a Case Management Plan will be created.

SERVICE AUTHORIZATIONS

Prior Authorization Required?

Yes - prior authorization is required

Unit or Encounter

Unit

Code (s)

H0006

SERVICE AUTHORIZATION MATRIX

Initial Authorization:

as needed

Re-Authorization:

as needed

SERVICE DELIVERY

Service Requirements

As outlined in the Michigan Department of Health and Human Services (MDHHS) the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section Treatment Policy #08, the following functions for a case management program represent the minimum expectations:
a) The ability to link and/or refer clients to support services depending on the needs and functioning level of clients.
b) The provider must be able to serve as an advocate to assist and/or represent the client and his/her needs with other agencies or service providers. This may include but is not limited to serving as the "voice" of the client in situations where the client is unable to effectively represent himself/herself, accompanying clients to appointments, assisting with completion of forms or meeting other requirements the client may have to secure support/services, making appointments for clients, or ensuring follow-through of appointments. The level and intensity of involvement should be dependent on the individual client.
c) Ability to see clients in their community or the capability for face-to-face client interaction outside of the office setting.
d) The Case Management provider must be able to monitor and continually assess the changing functional and social needs of clients as they progress through recovery and document this information as required.
e) The Case Management programs must be able to work with a treatment team if needed.
f) Case management services must be based on an individualized treatment or recovery plan and have the ability to provide, or refer for, crisis intervention.

1.3.1 MINIMUM CODE EXPECTATIONS – H0006
a) Linking and/or referring clients to other services, areas, etc. as identified areas of need in the assessment.
b) A minimum of fifteen (15) minutes of direct or indirect care within one day.
c) Documentation as required in Protocols.
d) Staff meet the set requirements of the code (SATS or SATP)

All case management services must be preauthorized and submitted for reimbursement via the designated NMRE system.
a) Case Management services billable to Block Grant (H0006) for a minimum of 15 minutes would include:
§ telephone contact with the client
§ collateral family contact (collateral family contact is defined as any contact that are not direct treatment services) and
§ collateral professional contact

Documentation Requirements

Identified need in assessment; Included on treatment plan; Documentation to support individual service including client name, location of service, date, time in, time out, goal from treatment plan, response to treatment, signature with credentials and date of signature

BILLING

Billing Description

Request for authorization of case management services shall be submitted via the set electronic system. Case Management services must be prior authorized.
Case Management services are authorized (by the PIHP) based on the number of hours/encounters and/or intensity of services that are deemed clinically/medically necessary. Services must be based on the individual needs of the client and individually tailored to those needs identified.
Case Management authorization units are encounter based, and issued/billed as follows:
1 (Case Management Authorization) Unit = 1 Case Management Encounter
Case Management authorizations shall be issued to SUD treatment providers according to the PIHP SUD Service Authorization Matrix.
As per the NMRE Authorization Matrix, re-authorization of Case Management service units may be requested if the services are documented in the Case Management Plan and are medically necessary.

CONTINUED SERVICE CRITERIA

Continued Service Criteria

The delivery of Case Management services shall be completed on an individual needs basis, but shall be subject to the following:
a) Case management services are not a case-finding activity, but rather supportive activities to enhance each client's long term recovery.
b) It is expected that at a minimum, one (1) encounter per month is to be face-to-face with the client. The frequency of case management encounters is to be determined by the individualized need(s) of the client, based on the results of a needs assessment.
c) Case management services shall be guided by each client's treatment plan which indicates the need for Case Management services.
d) Case managers may follow clients as they progress through a continuum of care. Case management services may continue after discharge from treatment for up to six (6) months, or one hundred eighty (180) days, as stated in Currently the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section policy #8, and as authorized by the NMRE.
e) Case management service providers shall establish linkages with other agencies in the human services and community resources network for referral to ensure continued case management services beyond six (6) months after discharge, if necessary and indicated for the client.
f) The treatment record of clients receiving case management services must contain documentation for the determination of need for case management services, and case management activity notes indicating the following information:
§ Date of contact and/or service;
§ Duration of case management contact/services;
§ Goal on the Case Management Plan;
§ Name of agency, provider, and/or person being contacted;
§ Nature of case management services requested and extent of services requested; and/or

§ Nature of case management services provided and extent of services provided;
§ Place of service, referral, and/or any follow-up plans.

DISCHARGE CRITERIA

Discharge Requirements

Once the client meets on or more of the following criteria, the client may be discharged from the CM program:

a) The client has met the goals outlined in the PCP/treatment plan that require case management functions; or

b) The client no longer meets continued service criteria; or

c) The client or his legally responsible guardian no longer wishes to receive case management services.

d) Advance Notice of discharge from services have been completed and documented.

Transportation

NMRE strives to reduce transportation barriers throughout the 21-county region to assist clients with accessing SUD treatment and recovery services. Transportation services are not a guaranteed benefit and are limited by the availability of Community Block Grant funding during each fiscal year. To qualify for transportation reimbursement, transportation needs must be identified during the screening and assessment process and clearly documented within the consumer's individualized treatment plan. **Documentation identifying all potential transportation options and estimated expense is required prior to utilization of NMRE transportation reimbursement.** If transportation needs arise during the course of a treatment episode, documentation of the need must be included in the consumer chart (i.e.: progress note, treatment plan review, recovery, etc.) and it must be included on an amended treatment or recovery plan. The treatment or recovery plan must include goals related to helping the consumer reduce barriers to transportation, and must promote consumer self-sufficiency and empowerment.

PURPOSE

Service Description

Provide for the transportation of clients to and from treatment appointments. This service is allowable only when Block Grant funding is in excess for the NMRE region. Transportation reimbursement may be allowed or disallowed by the NMRE with little to no notice as funding trends change.

Service Purpose

Support an individual in their recovery efforts by providing transportation when no other option is available to the individual so that attendance at treatment appointments occurs.

SERVICE Services Definition

Please refer to the individual rule/code/policy/etc. for the most current information. Information that has been updated in the individual rule/code/policy/etc. supersedes what is included in this guideline.

Administrative Rule

Mental Health Code

Public Health Code

LARA

Treatment Policies

Treatment Technical Advisory #8 - Enhanced Women's Services
Definition of Community Based includes transportation to and from appointments; One of the core components of Enhanced Women's Services is transportation.

Treatment Policy #8 - Substance Use Disorder Case Management Program Requirements
Under Women's Specialty Services, a requirement is to provide "sufficient transportation to ensure that women and their dependent children have access" to needed services

Treatment Policy #10 - Residential Treatment Continuum of Services
Under Covered Services for Basic Care, facilitation of transportation to and from treatment is one of the items noted. In addition, one of the Life Skills is how to use public transportation as well as a part of treatment/recovery planning.

Treatment Policy #12 - Womens' Treatment Services
One of the federal requirements, defined by 45 CFR Part 96, is to access transportation.

Treatment Policy #13 - Withdrawal Management Continuum of Services
For Ambulatory Withdrawal Management (ASAM Level 1 and 2), the ability to provide or assist in accessing transportation services for individuals who lack safe transportation is required. This is also included as a requirement under basic care - facilitating transportation to and from treatment.

NMRE/PIHP Contract

MDHHS/PIHP Contract

Section 25.0 Women's Specialty Services
Federal requirements include sufficient transportation to ensure that women and their dependent children have access to primary medical care, primary pediatric care, treatment services for the woman and therapeutic interventions for the children. This includes men who are primary caregivers.

Attachment PII.B.A.
If a client receives methadone from an Opioid Treatment Program, permission may be given by MDHHS to allow for the transportation of the methadone to a separate facility. Clients may also request a change in daily dosing due to transportation hardship.

Medicaid Manual

Medicaid Code Description

State Measures

National Measures

PROTOCOLS

Service Description

Provision of transportation services.

Service Requirements

Transportation to and from treatment appointments.

For Women's Specialty Service clients, transportation is allowed for treatment, children's therapeutic appointments, medical care appointments, children's medical care appointments. If other areas where transportation is needed, providers should contact the PIHP's Women's Specialist to discuss additional options.

Administrative Functions

Provide coordination of the transportation services in addition to payment for transportation services until such time that reimbursement is obtained.

Provider Requirements

In the NMRE SUD Provider Panel

Staff Requirements

N/A

Client Requirements

Be active in treatment while receiving funding through the NMRE.

Expected Outcomes

Expected outcomes include an increase in attendance in treatment services as well as recovery support services.

Minimum Service Expectations

Active in treatment services. Should be used to assist in transitional care.

PROCEDURE

ADMISSION CRITERIA

Admission Criteria

Must have an active admission in place

SERVICE AUTHORIZATIONS

Prior Authorization Required?

No (can authorize prior to service or after service is delivered)

Unit or Encounter

Encounter ($1=1 unit/encounter - cost of bus pass, LYFT, Uber, etc. or $.20/mile rate, rounded, if driving)

Code (s)

T2003

SERVICE AUTHORIZATION MATRIX

Initial Authorization:

Authorization is given based on documented need. The T2003 code may be requested as an add on once the need is identified. Services do not need prior authorization.

Re-Authorization:

Authorization is given based on documented need. The T2003 code may be requested as an add on once the need is identified or requested in the authorization of services. Services do not need prior authorization.

SERVICE DELIVERY

Service Requirements

Transportation assistance may be provided to clients in need of services. Assistance may not be cash provided to the client or other type that may be used to purchase anything other than transportation (gas, bus pass, etc.). Documented attempts of coordination for transportation (for example, with DHHS) is required.

Documentation Requirements

Documented need of transportation assistance noted in client chart. Documentation should include client name, date assistance was provided, type of assistance provided (bus pass, Uber cost, taxi cost, gas card, etc.), amount of assistance and who distributed the type of assistance. Assistance may not be cash provided to the client or other type that may be used to purchase anything other than transportation (gas, bus pass, etc.). Documented attempts of coordination for transportation (for example, with DHHS) is required.

BILLING

Billing Description

Billing should be completed in RECON utilizing the T2003 code.

CONTINUED SERVICE CRITERIA

Continued Service Criteria

Transportation services may continue if the client is active in treatment services and the need is still identified.

DISCHARGE CRITERIA

Discharge Requirements

Discontinuation of transportation services should be completed at the time when treatment services are no longer being provided.

Acupuncture

Acupuncture can be used as a low-cost way to enhance the outcomes of substance abuse treatment. Auricular acupuncture has been shown to be effective in relieving the symptoms of withdrawal from alcohol, heroin, and crack cocaine; making patients more receptive to treatment; reducing or eliminating the need for MAT; and lessening the chances of relapse.

Acupuncture may be performed as an adjunct therapy to any treatment modality in any setting. Counseling, 12-step programs, relapse prevention, referral for supportive services, and life skills training are all components of a comprehensive program that can include acupuncture. Auricular acupuncture for substance use disorder treatment appears to work best in a group setting. The patient is encouraged to be actively involved in their own treatment and to see substance abuse holistically, as part of total emotion, physical, and spiritual health, and to recognize the relationship their disorder has to other people and the environment.

Acupuncture may be performed by the following individuals:

- Medical Doctor
- Doctor of Osteopathy
- Registered Acupuncturist

An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by NADA and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for SUD treatment. The supervising physician needs not be trained in acupuncture nor be present when the procedure is performed.

Clients with a documented substance use disorder diagnosis as defined by the DSM V/ICD-10 and meet criteria for funding through the NMRE are eligible to have acupuncture services reimbursed by the NMRE. *NMRE's Acupuncture Protocol is available as an* Attachment to this Provider Manual.

PURPOSE

Service Description

Auricular acupuncture for the prevention, correction, or assistance with substance use disorders.

Service Purpose

The purpose of this protocol is to establish the requirements for Acupuncture services for the Northern Michigan Regional Entity Substance Use Disorder Treatment Services Provider Panel.

Services Definition

Please refer to the individual rule/code/policy/etc. for the most current information. Information that has been updated in the individual rule/code/policy/etc. supersedes what is included in this guideline.

Administrative Rule

Mental Health Code

Public Health Code

Public Health Code 333.16501

"Acupuncture" means the insertion and manipulation of needles through the surface of the human body at specific locations on the human body for the prevention or correction of disease, injury, pain, or other condition.

LARA

Treatment Policies

NMRE/PIHP Contract

MDHHS/PIHP Contract

Medicaid Manual

Medicaid Code Description

State Measures

National Measures

PROTOCOLS

Service Description

Acupuncture can be used as a low-cost way to enhance the outcomes of substance abuse treatment. Auricular acupuncture has been shown to be effective in relieving the symptoms of withdrawal from alcohol, heroin, and crack cocaine; making patients more receptive to treatment; reducing or eliminating the need for MAT; and lessening the chances of relapse.

Service Requirements

Acupuncture may be performed as an adjunct therapy to any treatment modality in any setting. Counseling, 12-step programs, relapse prevention, referral for supportive services, and life skills training are all components of a comprehensive program that can include acupuncture. Auricular acupuncture for substance use disorder treatment appears to work best in a group setting. The patient is encouraged to be actively involved in his/her own treatment and to see substance abuse holistically, as part of total emotion, physical, and spiritual health, and to recognize the relationship his/her disorder has to other people and the environment.

Administrative Functions

Provider Requirements

Staff Requirements

Acupuncture may be performed by the following individuals:

a) Medical Doctor
b) Doctor of Osteopathy
c) Registered Acupuncturist

An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by NADA and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for substance use disorder treatment. The supervising physician needs not be trained in acupuncture nor be present when the procedure is performed.

Client Requirements

Clients with a documented substance use disorder diagnosis as defined by the DSM V/ICD-10 and meet criteria for funding through the NMRE are eligible to have acupuncture services reimbursed by the NMRE.

Expected Outcomes

Minimum Service Expectations

PROCEDURE

ADMISSION CRITERIA

Admission Criteria

SERVICE AUTHORIZATIONS

Prior Authorization Required?

Yes - prior authorization needed

Unit or Encounter

Unit, 15 minutes

Code (s)

97810 for the first 15 minutes, 97811 for subsequent 15-minute increments

SERVICE AUTHORIZATION MATRIX

Initial Authorization:

as needed

Re-Authorization:

as needed

SERVICE DELIVERY

Service Requirements

Substance abuse covered Acupuncture services are to be provided at state licensed sites.

Documentation Requirements

Documentation to support individual service including client name, location of service, date, time in, time out, goal from treatment plan, response to treatment, signature with credentials and date of signature

BILLING

Billing Description

97810 for the first 15 minutes, 97811 for subsequent 15-minute increments; a substance use disorder diagnosis is required

CONTINUED SERVICE CRITERIA

Continued Service Criteria

As medically necessary

DISCHARGE CRITERIA

Discharge Requirements

Once treatment plan goals for acupuncture have been met

Specialty Services

Women's Specialty Services (WSS)

NMRE adheres to the requirements and recommendations made by the Bureau of Community Based Services, Division of Adult Home and Community-Based Services, Substance Use Disorder Treatment Section in the following Treatment Policies and Treatment Technical Advisories related to Women's Specialty Services:

- Treatment Policy #11: Fetal Alcohol Spectrum Disorders (https://www.michigan.gov/documents/mdch/TX_Policy_11_FASD_295506_7.pdf
- Treatment Policy #12: Women's Treatment Services (link https://www.michigan.gov/documents/mdch/P-T-12_Women_Srv_eff_100110_338279_7.pdf
- Technical Advisory #8: Enhanced Women's Services (only State Certified Enhanced Women's Programs) (link https://www.michigan.gov/documents/mdch/TA-T-08_Enhanced_Women_Serv_375874_7.pdf)

Women's Specialty Services (WSS) may only be provided by Providers that are designated as gender-responsive by MDHHS or as gender-competent by NMRE. Approved WSS providers must meet standard panel eligibility requirements in compliance with MDHHS Treatment Policy #12: Women's Treatment Services (link above). Approved Enhanced WSS Providers must meet standard panel eligibility requirements in compliance with MDHHS Technical Advisory #8: Enhanced Women's Services (link above).

Federal requirements are contained in 45 CFR (Part 96), section 96.124, and may be summarized as: Providers receiving funding from the state-administered funds set aside for WSS consumers must provide or arrange for the 5 types of services, as noted below.
Use of state administered funds to purchase primary medical care and primary pediatric care must be approved, in writing, in advance, by the Department contract manager.

Eligible:

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children and/or women whose children are at-risk of out-of-home placement due to substance abuse
- Men who are the primary caregivers of dependent children
- Men, established as primary caregiver, attempting to regain custody of their children and/or men, established as primary caregiver, whose children are at-risk of out-of-home placement due to substance abuse

For eligible clients, the following Federal services must be made available:

1. Primary medical care for women receiving SUD treatment.

2. Primary pediatric care for their children, including immunizations.
3. Gender specific SUD treatment and therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, and parenting.
4. Childcare while women are receiving these services, therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect.
5. Sufficient case management and transportation services to ensure that women and children have access to the services provided in the first 4 requirements.

The above five types of services may be provided through the MDHHS/PIHP agreement only when no other source of support is available and when no other source is financially responsible.

All women and family's needs must be addressed within a client's Treatment Plan if identified during the assessment process. If the needs are being addressed with a separate agency or have stabilized, a note indicating this must be included in the client's chart.

If women and family services are indicated and included on the Treatment Plan, services should be included to address the client's mental health needs. Progress Notes should include documentation of the work being conducted during treatment services.

During billing, the HD modifier should be utilized to identify the specialty services that the client received.

Telemedicine Services

Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. MDHHS requires a real time interactive system at both the originating and distant site, allowing instantaneous interaction between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Providers must have a contract with or be authorized by NMRE in order to provide allowable services via telemedicine. Refer to Section 17 of the Medicaid Provider Manual for more information on telemedicine (https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html) . Refer to the PIHP/CMHSP Encounter Reporting document for a list of allowable telemedicine services codes and modifier requirements.

Veteran Services

NMRE has a Veteran Navigator whose role is to facilitate access to services for incoming clients who currently or in the past served in one of the branches of the U.S. Military. Upon identification of a client who is serving or has served in the U.S. Armed Forces, the client should be given contact information of how to reach the Veteran Navigator:

Brian Martinus, Veterans Navigator
bmartinus@nmre.org
(Office: 231.383.6388 / Cell: 231.330.6486)

Attachment 9: Evidence Based Practices

Evidence Based Practices

Evidence Based Practice (EBP) was originally developed in medicine and was gradually adopted by other health disciplines such as; dentistry, nursing, psychology, occupational therapy, education, etc. Evidence based practice advocates that treatment decisions should be based on and supported by scientific research and not just on different philosophies of treatment. The American Psychological Association and the Association of Behavioral and Cognitive Therapies also support evidence-based practice.

NMRE requires all SUD treatment Providers to document and provide evidence-based programs for their services. Treatment Providers must demonstrate knowledge and competencies in practice relevant to service provision. Each Provider is monitored at least annually with regular site visits to verify that the evidence-based programs are being provided and may verify that staff and clinicians have the requisite training and qualifications for the practices in which they are engaging clients. Evidence-based practices may include motivational interviewing, trauma informed care and positive behavioral supports. Recognizing the stages of change for persons recovering from SUD is a critical component of evidence-based service provision. Providers should take steps to ensure fidelity to evidence-practice models, including sustaining fidelity when valid models and/or program staffing changes occur, which may require new training or credentials in maintaining integrity of clinical service provision. NMRE reserves the right to endorse evidence-based practices in use by funded Provider programs.

Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is the most commonly used evidence-based practice treatment approach for a wide range of psychological problems in children, adolescents, and adults.

CBT focuses on the interaction between thoughts, behavior, and emotions, the settings they occur in, and their consequences. Cognitive Behavioral Therapy focuses on decreasing maladaptive emotions, behaviors and thoughts and increasing adaptive ones through goal-oriented therapeutic interventions. CBT is evidence based, meaning research supports its effectiveness. It focuses on what maintains the behavior, thoughts, and emotions and how to change them.

A systems approach is most effective when working with people suffering from emotional, behavioral, developmental, head injuries, chronic pain, and related problems. This means working with all aspects of the person's environment impacting his/her behavior. When appropriate, therapy is conducted in the natural setting. This enables the development of coordinated behavior plans in the setting where the

problems exist. Homework is often given to help the patient learn how to change problematic thoughts, behaviors, and emotions in their natural settings.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) treatment is a type of psychotherapy — or talk therapy — that utilizes a cognitive-behavioral approach. DBT emphasizes the *psychosocial* aspects of treatment.

The theory behind the approach is that some people are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations, primarily those found in romantic, family and friend relationships. DBT theory suggests that some people's arousal levels in such situations can increase far more quickly than the average person's, attain a higher level of emotional stimulation, and take a significant amount of time to return to baseline arousal levels. DBT is a method for teaching skills that will help in this task.

Components of DBT:

- Support-oriented**:** It helps a person identify their strengths and builds on them so that the person can feel better about him/herself and their life.
- Cognitive-based**:** DBT helps identify thoughts, beliefs, and assumptions that make life harder: "I have to be perfect at everything." "If I get angry, I'm a terrible person" and helps people to learn different ways of thinking that will make life more bearable: "I don't need to be perfect at things for people to care about me," "Everyone gets angry, it's a normal emotion.
- Collaborative**:** It requires constant attention to relationships between clients and staff. In DBT people are encouraged to work out problems in their relationships with their therapist and the therapists to do the same with them. DBT asks people to complete homework assignments, to role-play new ways of interacting with others, and to practice skills such as soothing yourself when upset. These skills, a crucial part of DBT, are taught in weekly lectures, reviewed in weekly homework groups, and referred to in nearly every group. The individual therapist helps the person to learn, apply and master the DBT skills.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. Repeated studies show that by using EMDR therapy people can experience the benefits of psychotherapy that once took years to make a difference. It is widely assumed that severe emotional pain requires a long time to heal. EMDR therapy shows that the mind can in fact heal from psychological trauma much as the body recovers from physical trauma. When you cut your hand, your body works to close the wound. If a foreign object or repeated injury irritates the wound, it

festers and causes pain. Once the block is removed, healing resumes. EMDR therapy demonstrates that a similar sequence of events occurs with mental processes. The brain's information processing system naturally moves toward mental health. If the system is blocked or imbalanced by the impact of a disturbing event, the emotional wound festers and can cause intense suffering. Once the block is removed, healing resumes. Using the detailed protocols and procedures learned in EMDR therapy training sessions, clinicians help clients activate their natural healing processes.

EMDR Treatment Description

EMDR therapy combines different elements to maximize treatment effects. A full description of the theory, sequence of treatment, and research on protocols and active mechanisms can be found in F. Shapiro (2001) Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures (2nd edition) New York: Guilford Press.

EMDR therapy involves attention to three time periods: the past, present, and future. Focus is given to past disturbing memories and related events. Also, it is given to current situations that cause distress, and to developing the skills and attitudes needed for positive future actions. With EMDR therapy, these items are addressed using an eight-phase treatment approach.

- **Phase 1**: The first phase is a history-taking session(s). The therapist assesses the client's readiness and develops a treatment plan. Client and therapist identify possible targets for EMDR processing. These include distressing memories and current situations that cause emotional distress. Other targets may include related incidents in the past. Emphasis is placed on the development of specific skills and behaviors that will be needed by the client in future situations.

  Initial EMDR processing may be directed to childhood events rather than to adult onset stressors or the identified critical incident if the client had a problematic childhood. Clients generally gain insight on their situation, the emotional distress resolves and they start to change their behaviors. The length of treatment depends upon the number of traumas and the age of PTSD (posttraumatic stress disorder) onset. Generally, those with single event adult onset trauma can be successfully treated in under 5 hours. Multiple trauma victims may require a longer treatment time.
- **Phase 2:** During the second phase of treatment, the therapist ensures that the client has several different ways of handling emotional distress. The therapist may teach the client a variety of imagery and stress reduction techniques the client can use during and between sessions. A goal of EMDR therapy is to produce rapid and effective change while the client maintains equilibrium during and between sessions.
- **Phases 3-6:** In phases three to six, a target is identified and processed using EMDR therapy procedures. These involve the client identifying three things:
  1. The vivid visual image related to the memory
  2. A negative belief about self
  3. Related emotions and body sensations

  In addition, the client identifies a positive belief. The therapist helps the client rate the positive belief as well as the intensity of the negative emotions. After this, the client is

instructed to focus on the image, negative thought, and body sensations while simultaneously engaging in EMDR processing using sets of bilateral stimulation. These sets may include eye movements, taps, or tones. The type and length of these sets is different for each client. At this point, the EMDR client is instructed to just notice whatever spontaneously happens.

After each set of stimulation, the clinician instructs the client to let their mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. Depending upon the client's report, the clinician will choose the next focus of attention. These repeated sets with directed focused attention occur numerous times throughout the session. If the client becomes distressed or has difficulty in progressing, the therapist follows established procedures to help the client get back on track.

When the client reports no distress related to the targeted memory, they are asked to think of the preferred positive belief that was identified at the beginning of the session. At this time, the client may adjust the positive belief if necessary, and then focus on it during the next set of distressing events.

- **Phase 7:** In phase seven, closure, the therapist asks the client to keep a log during the week. The log should document any related material that may arise. It serves to remind the client of the self-calming activities that were mastered in phase two.
- **Phase 8:** The next session begins with phase eight. Phase eight consists of examining the progress made thus far. The EMDR treatment processes all related historical events, current incidents that elicit distress, and future events that will require different responses

Trauma Informed Care

A trauma-informed approach to behavioral health care shifts away from the view of "What's wrong with this person?" to a more holistic view of "What happened to this person?" This becomes the foundation on which to begin a healing recovery process. Employing a trauma informed approach creates a place of safety and mutual respect where a person's whole history can be considered. This enables trauma survivors and providers to work together to find the best avenues for healing and wellness. A program, organization, or system that is trauma informed follows SAMHSA's four "Rs" by:

- *Realizing* the widespread impact of trauma and understanding potential paths for recovery
- *Recognizing* the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- *Responding* with fully integrated knowledge about trauma into policies, procedures, and practices
- *Resisting* re - traumatization