




MCCMH-SUD New Provider Training

Presenters
Nicole Gabriel
Nicole Palazzolo
Adam McHenry

Presented on 6.21.24

1



Referral Processes

2



Outpatient Referral Process

- Providers may receive referrals from MCCMH-SUD contracted residential or detox providers, MCO (Managed Care Operations) or direct calls from clients.
- Intakes should be scheduled ASAP but no later than: 24 hours for priority populations; 7 days from discharge from detox/residential treatment; 14 days for all others.
- If you cannot provide a timely appointment, the client should be referred to MCO to find a provider that can provide a timely intake.
- All providers are required to keep a phone screening log. This screening should check for priority population status, residence, insurance and SUD treatment needs. The phone screen should also include an area to document: the appointment offered date, the appointment date accepted, any no shows and any rescheduled appointments.

3



Detox/Residential Referral Process

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

4



Intake Process

5



Intake Procedures

- At admission, complete a Release of Information and Fee Agreement Form with the client.
- Send a copy of the release to MCO with a Request To Open Case form. (see next slides)
- MCO will then open the case in FOCUS and notify provider via FOCUS.
- Provider then adds an Admission record, SUD Self-Pay Policy & insurance information form into FOCUS.
- Higher levels of care such as IOP, MAT, withdrawal management and residential treatment require prior authorization in FOCUS. Once the admission and other forms have been added, an authorization request can be submitted.
- Authorization requests must be submitted prior to the provision of the next service for IOP and within 24 hours for residential services.

6

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION
Michigan Department of Health and Human Services

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

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

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

Why This Form Is Needed

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

Instructions

- To give consent, fill out Sections 1, 2, 3, and 4.
- To take away consent, fill out Section 5.
- Sign the completed form, then give it to your healthcare provider. They can make a copy for you.

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations

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

1. Macomb County Community Mental Health	10. Elie & Willard St. Long	19. Peake Recovery
2. BioMed Behavioral Health	11. Hollywood Recovery Homes	20. Quality Behavioral Health
3. Personages Nursing Lighthouse	12. Kim & Just 4 Lodge State	21. Tanning Point Recovery
4. CARE of Southeastern Michigan	13. Live-Rite Properties	22. SHAR-Macomb
5. Meridian Health Services/CH	14. Macomb Family Services	23. Ascension Easternwood Clinics
6. Sacred Heart Rehabilitation Center	15. Clinton Counseling Center	24. Eastland Recovery House
7. Salvation Army Harbor Light	16. Holy Cross	25. Great Lakes Recovery Center
8. ACCESS	17. Judson Center	26. Easter Seals Michigan
9. Grace Recovery House	18. Clinton Counseling Center-Jail	

Section 2b: Sharing Information Electronically

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

Choose only one option:

Share my information through the organizations listed below. This information will be shared with individuals and organizations listed under section 2a.

Do not share my information through the organizations listed below.

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

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

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

Section 3: What Information You Want to Share

Choose one option:

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

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

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

Section 4: Your Consent and Signature

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

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information is also shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information they need to treat me.
- My records listed above in section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.
- My records may be shared with people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health

MDHHS-5515 (Rev. 10-19) Previous edition obsolete. 1

MDHHS-5515 (Rev. 10-19) Previous edition obsolete. 2

7

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.

- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for 1 year from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)
Date, event, or condition: **90 days post discharge**

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

Self

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

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

Self

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Applicable)	Date

Verbal Withdraw of Consent

The individual listed above in Section 1 has taken away his/her consent.

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

Individual listed above in Section 1.

Parent (Print Name) _____

Guardian (Print Name) _____

Authorized Representative (Print Name) _____

Signature of Person Who Received the Verbal Withdraw	Print Name	Date

Other Information for Health Care Providers and Health Plans

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

Additional Identifiers (Optional)

Medicaid _____ Last 4 of the Social Security Number _____

Form Copy (Optional, Choose One Option)

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

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

AUTHORITY: This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 268 of 1974 and MCL 330.1748 and PA 368 of 1978; MCL 333.1101 et seq. and PA 129 of 2014; MCL 330.1141a.

COMPLETION: Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MDHHS-5515 (Rev. 10-19) Previous edition obsolete. 3

MDHHS-5515 (Rev. 10-19) Previous edition obsolete. 4

8

Macomb County Community Mental Health
Office of Substance Abuse
SUD PROVIDER REQUEST TO OPEN CASE


Admission Date			
Requesting Agency		Site Location	
Person Making Request		Contact Number	

Consumer Demographic Information:			
First Name		Last Name	
Other Name Used		SSN	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Address		City	
State		Zip	
Home Phone		Alt. Phone	

Insurance Information: Check all that apply	
<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	Healthy Michigan Plan
<input type="checkbox"/>	MIChild
<input type="checkbox"/>	Block Grant/PA2
<input type="checkbox"/>	Women Specialty Funds
<input type="checkbox"/>	Other

Scan this form and consumer signed release to "SUD Release" in the Focus System Message
or
Fax this form and release to Access Center at 586-948-0223

9



Intake Procedures Continued

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

10

WHAT YOU CAN DO:

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

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

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

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

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

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

YOUR PROGRAM RIGHTS ADVISOR

Name _____

Phone _____


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

LARA
LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

LARA is an equal opportunity employer/program.
Revised 8/14

know
your
RIGHTS

11



Authorizations

- IOP, withdrawal management and residential auth should be submitted in FOCUS within one day. MCO cannot back date any authorizations.
- Authorization requests should align with the treatment plan and agreed upon treatment modality.
- If client is continuing in treatment beyond the time period of the first authorization, submit a reauthorization request to MCO. A treatment plan must be uploaded to the FOCUS system with any reauthorization request.
- Once MCO has responded to the authorization request, you will receive a message in the FOCUS system. Be sure to read all responses as an authorization may be "approved" but could be 'reduced'. Any denial will have a reason for denial and may have instructions on what needs to be completed prior to re-submitting the request.

12



Authorizations

Services Requiring Authorization FY24

Service Name	CPT Code
Withdrawal MGMT	H0010/H0012
Residential Lodging, Per Diem	S9976
Residential Treatment Per Diem	H0018/H0019
Recovery Housing	H2034
Intensive Outpatient	H0015
Opioid Health Homes	S0280

13

Clinical Documents

14



Clinical Assessment

- All MCCMH-SUD contracted providers must use the ASAM Continuum or GAIN assessment tools.
- New clients should receive an assessment at intake.
- If the GAIN or ASAM Continuum are started but cannot be completed at intake, they can be completed at the next appointment. The date the assessment was completed is the date the intake code would be billed.
- If the client has been in treatment with another provider within the last 45 days, your agency should obtain a copy of the ASAM Continuum completed with that agency and review/record updates with the client rather than completing a new ASAM Continuum.
- ASAM Continuum or GAIN Assessments must be completed annually. Once the annual assessment is completed a BH-TEDS update should be entered into FOCUS.
- All sections of the ASAM Continuum must be completed including any notation needed about level of care not matching the ASAM Continuum's recommendation.

15



Clinical Assessment Cont.

Assessments should also include an interpretive summary completed by the clinician. This summary should be clinical in nature rather than a historical retelling of biopsychosocial history and unique to the client served.

Example: New is a 39 year old, Caucasian, single female. She presents with a history of alcohol use. She reported periods of clean time in the past, the longest being two years after the birth of her son in 2012. Most recently, she has been drinking up to ten beers a few times per week. New recently lost her job due to absences. She has been living with her boyfriend for the last six months. New reports that he does drink on occasion but has never had any SUD treatment. New reported recent symptoms of anxiety including: excessive worry about the future, insomnia, fatigue, trouble concentrating, and trouble with decision making. New presents with diagnoses of Alcohol Use Disorder-Moderate and Generalized Anxiety Disorder. It is recommended that she attend monthly individual sessions and weekly group sessions to explore triggers for use, increase positive coping mechanisms, explore employment needs/opportunities, increase knowledge of addiction and post acute withdrawals and decrease symptoms of anxiety. New may benefit from a psychiatric evaluation to clarify mental health

16

Adding and ASAM Continuum

Please see instruction sheet for detailed instructions on adding an ASAM Continuum.

17



Other Required Documents

- Communicable disease risk screens must be completed for all clients. Any client identified as “high risk” must be provided with a referral for follow up care. (Referrals must be documented)
- All clients must have an initial fee agreement complete in full. These are then reviewed every 90 days or if there is a change in the clients' income.
- Any clients funded by Block Grant must have verification of income in the chart. This may be a bank statement, check stub or letter attesting to lack of income.
- All charts must include documentation of whether or not a client has a primary care physician and if so, coordination of care with that physician (with a release of information). Any client without a PCP should be assisted in obtaining a PCP or given a referral to a FQHC.
- The Communicable Disease Risk Screen and Fee Agreement Form can be located at our website: www.mccmh.net in the Substance Use Provider Manual

18

Fee Agreement Form

Admission Date: _____ Agency ID (optional): _____

**MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE (MCOSA)
VERIFICATION OF INCOME & FEE AGREEMENT FORM**

Name: _____
(Last) (First) (Middle)

Social Security Number (required): _____ Date of Birth: _____

Marital Status: Single Married/living with partner Divorced Separated Widowed

Current County of Residence: Macomb Other _____

Number of Dependents (include self): _____ Ages (include self): _____

I understand that a portion of the cost of my treatment may be subsidized by public funds. As required by eligibility guidelines, I hereby certify that my current yearly income is as follows:

Hourly Wage \$ _____ Hours worked in past two (2) weeks: _____

Annual Personal Income \$ _____ Annual Household Income \$ _____

Sources of Income: Employment Unemployment Disability
 Alimony/Child Support Parent (only if you are under 18)
 Spouse/partner Public Assistance Other (specify) _____

I understand that public funding should be the funding of last resort, and I certify that my current health insurance status is as follows:

Health Insurance/HMO/PPPO: Yes No If yes, Name of Insurer: _____
 VA Healthcare Benefits: Yes No
 Medicaid: Yes No
 Healthy Michigan Plan (HMP): Yes No
 Medicaid: Yes No
 Medicaid w/Deductible/Spend-Down: Yes No Deductible Amount (if known) \$ _____

Client to read and initial:

_____ I verify that the above statements are true, to the best of my knowledge. I understand that I will be required to provide verification of the above information for the purpose of substantiating eligibility for public funds and/or determining the fees to be charged for the services provided.

_____ I understand that if I am otherwise eligible for third-party insurance coverage, including Medicaid or Healthy Michigan Plan, and do not apply for, or decline to use my insurance, MCOSA is not obligated to supplement the cost of my treatment.

_____ I understand that I cannot be enrolled in more than one MCOSA-funded (Medicaid, Healthy Michigan, Block Grant) treatment program at the same time, and will inform my therapist if I am enrolled in any substance use treatment elsewhere. If I choose to remain at my other substance use treatment program, MCOSA will not fund my current request for substance use treatment and I will be responsible for any costs incurred.

1 MCOSA Fee Agreement Form Rev 6/17

COMPLETED BY PROVIDER:

Section 1 – Verification of Residency – Maintain proof of documentation in client file

Driver's License/State ID with Macomb County Address
 Mail addressed to client with Macomb County Address
 Other _____

Section 2 – Admission Category – Meets MCOSA Quality Assurance Guidelines, ASAM criteria and Medical Necessity criteria for admission to the following category below:

Detox/Residential – no copay
 Methadone Assisted Treatment
 IOP/Outpatient
 Outpatient Significant Other Admission (Maximum length of outpatient funding up to 12 sessions in 90 days; not eligible for reauthorization)
 Outpatient Release Prevention (Admission for an individual with a diagnosis of Substance Dependence in Sustained Full or Partial Remission, with the sole purpose of averting an impending relapse. Maximum length of outpatient funding up to 12 sessions in 90 days. If client experiences relapse during treatment, update admission category)
 Case Management – no copay
 Peer Recovery Coach – no copay
 Adolescent Outreach Program – no copay

Section 3 – Reimbursement Level Assignment

Type of Income Verification (attach proof to this Fee Agreement form):
 Medicaid/Healthy Michigan (verified in the MCOSA data system)
 Pay stub
 Income tax return
 Unemployment
 Receipt of application for Healthy Michigan Plan/Medicaid
 Other: _____

Check one:

Medicaid: No co-payment
 Healthy Michigan Plan: No co-payment
 Community Grant: Co-payment amount per service: \$ _____ Effective Date: _____

Explanation for exception, if applicable: _____

Client Acknowledgment & Acceptance of Fee	Agency Authorization
Signature: _____ Date: _____	Signature: _____ Date: _____

Note: There is a minimum fee for Community Grant (Block Grant/PAZ) clients. Those needing to have this fee waived must complete the "MCOSA Client Fee Waiver Request/Authorization" form, which must be forwarded to MCOSA for approval. See QA Guidelines in Chapter 3 of the MCOSA Provider Manual for instructions.

2 MCOSA Fee Agreement Form Rev 6/17

19

Client Name: _____ Agency ID (optional): _____

Fee Review

A review of assigned fees is required every 90 days, when submitting Outpatient (Drug-free and Methadone) re-authorization request, or when client financial situation changes, whichever comes first.

Fees Reviewed on (Date): _____	
Financial Situation Changed: <input type="checkbox"/> No (skip to signatures) <input type="checkbox"/> Yes	
If yes, current household income \$ _____ (attach verification to fee agreement)	Revised Fees Amount: \$ _____ New Amount Effective On (Date): _____
Explanation for exception, if applicable: _____	
Client Acknowledgment & Acceptance of Fees:	Agency Review:
Signature: _____ Date: _____	Signature: _____ Date: _____

Fees Reviewed on (Date): _____	
Financial Situation Changed: <input type="checkbox"/> No (skip to signatures) <input type="checkbox"/> Yes	
If yes, current household income \$ _____ (attach verification to fee agreement)	Revised Fees Amount: \$ _____ New Amount Effective On (Date): _____
Explanation for exception, if applicable: _____	
Client Acknowledgment & Acceptance of Fees:	Agency Review:
Signature: _____ Date: _____	Signature: _____ Date: _____

Fees Reviewed on (Date): _____	
Financial Situation Changed: <input type="checkbox"/> No (skip to signatures) <input type="checkbox"/> Yes	
If yes, current household income \$ _____ (attach verification to fee agreement)	Revised Fees Amount: \$ _____ New Amount Effective On (Date): _____
Explanation for exception, if applicable: _____	
Client Acknowledgment & Acceptance of Fees:	Agency Review:
Signature: _____ Date: _____	Signature: _____ Date: _____

(Attach additional pages of "Fee Reviews" to this fee agreement packet, if needed.)

3 MCOSA Fee Agreement Form Rev 6/17

Page 3 of the Fee Agreement is completed every 90 days or if there is a change in the clients' income. If there are changes to the clients' income, a new SUD self-pay policy should be added in FOCUS to reflect this.

20

**Macomb County Community Mental Health Services
Office of Substance Abuse
FY2024 Sliding Fee Scale - Effective 10/01/2023**

Step 1 - Determine Reimbursement Level

Find the client's family size in the left-most column of the chart below. Follow that line to the right until you reach the cell in which the client's household income falls. The Level number on the top of that column is the client's reimbursement level.

Family Size	Level 1 0-138% Poverty		Level 2 139-200% Poverty	
	Min. Income	Max Income	Min. Income	Max Income
1	\$0	\$20,120	\$20,121	\$29,160
2	0	27,214	27,215	39,440
3	0	34,307	34,308	49,720
4	0	41,400	41,401	60,000
5	0	48,493	48,494	70,280
6	0	55,586	55,587	80,560
7	0	62,680	62,681	90,840
8	0	69,773	69,774	101,120
9	0	76,866	76,867	111,400
10	0	83,959	83,960	121,680
11	0	91,052	91,053	131,960
12	0	98,146	98,147	142,240

Step 2 - Determine Fee Corresponding to Calculated Reimbursement Level

In the left-most column of the chart below, locate the reimbursement level determined above. Follow the line to the right until you reach the column that describes the service being provided. The fee (co-pay) is the dollar amount identified in that cell.

Level	Outpatient Session/IOP Chair Day	Methadone Dose
1		2.00
2	5.00	0.35

**Recovery Homes -
50% daily rate
copay applies after
60 days of service**

*Income Eligibility levels are based upon the 2023 U.S. Department of Health & Human Services (Federal) Poverty Guidelines.

21

SUBSTANCE ABUSE COMMUNICATION FORM
TO PRIMARY CARE PHYSICIAN

Date: _____

To: _____
Primary Care Physician
Address _____ City _____ State _____ Zip _____

From: _____
Treatment Agency
Therapist and Psychiatrist (if applicable)
Address _____ City _____ State _____ Zip _____
() Phone Number () Fax Number

Re: _____ Client Name _____ Date of Birth _____

The above client was admitted to _____ on _____
Level of care _____ Date _____

Treatment Plan: Type _____ Frequency _____ Est. length of Tx _____
Diagnosis: _____

Medication(s) Prescribed: _____

Comments: _____

Date of last session: _____ Treatment completed? Yes/No _____

We ask that the Primary Care Physician please send information related to relevant medical history, current medications prescribed and treatment to the above psychiatrist/therapist.

Thank you for your assistance.

Date sent: _____ Initials of sender _____ Method: Fax, Mail _____
cc: client chart

Example form that can be utilized for care coordination with primary care physicians.

22

MCOSA ASAM ASSESSMENT
ADULT SUBSTANCE ABUSE OUTPATIENT PLACEMENT
(Required for Direct Outpatient and IOP Admissions)

This ASAM-based placement tool is to be used as a guide to determine whether or not a consumer is appropriate for the ambulatory (outpatient/IOP) level of treatment. It is required to be placed in all MCOSA funded ambulatory treatment substance abuse records, but may be used for substance abuse treatment funded by other sources.

Consumer Name: _____ Identification No: _____

DIMENSION 1. WITHDRAWAL/DETOXIFICATION POTENTIAL

Intoxicated/high during assessment? No Yes
 Current withdrawal signs? No Yes
 If yes, specify: _____
 History of severe withdrawals? No Yes
 If yes, specify: _____
 History of medical problems, such as seizures, stroke, hypertension, etc., that would complicate outpatient detoxification? No Yes
 If yes, specify: _____

Is client appropriate for ambulatory level of treatment? No Yes*

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS (not related to withdrawal):

Current and/or chronic physical/medical illnesses that may complicate Tx? No Yes
 If yes, specify: _____
 Current prescribed medications that may interfere with abstinence? No Yes
 If yes, describe: _____

Is client appropriate for ambulatory level of treatment? No Yes*

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

Current and/or chronic co-occurring mood and/or thought disorder(s) or symptom(s) that needs to be addressed immediately or will interfere with treatment? No Yes
 If yes, specify: _____

Does consumer meet criteria for Serious and/or Persistent Mental Condition with co-occurring substance use disorder? No Yes
 Current psychiatric medication use? No Yes
 If yes, specify type/date of last use: _____

Is client appropriate for ambulatory level of treatment? No Yes*

*If answering "No," not appropriate for ambulatory treatment, to any of ASAM Dimensions 1, 2 or 3, consider phone contact with the AMS to screen for an alternate level of treatment. Individuals with acute Medical and/or Psychiatric problems should be directly referred to Medical or Psychiatric emergency/urgent services for stabilization prior to referral to CARE or admission to treatment.

ASAM - Page 1 of 2

DIMENSION 4. READINESS TO CHANGE

Lacks internal motivation for treatment? No Yes
 Refuses to accept other's perceptions that she has a substance use problem? No Yes
 Impulse control is poor, does not respond to negative consequences? No Yes

Is client appropriate for ambulatory level of treatment? No Yes**

DIMENSION 5. RELAPSE/CONTINUED USE POTENTIAL

Potential for continued or increased use is high? No Yes
 Lacks recovery skills to cope with addiction and avoid relapse? No Yes
 Lacks awareness of relapse triggers, urge management techniques? No Yes
 If abstinent, risk for using (including needle use) or imminent crisis is high? No Yes N/A

Is client appropriate for ambulatory level of treatment? No Yes**

DIMENSION 6. RECOVERY ENVIRONMENT

Family/living circumstances pose a threat to engaging or succeeding in Tx? No Yes
 Lacks sufficient drug free social outlets or friendships to support abstinence/recovery? No Yes
 Family/living environment limits access to substances and/or other using individuals? No Yes

Is client appropriate for ambulatory level of treatment? No Yes**

**If answering "No," not appropriate for ambulatory treatment, to two or more of ASAM Dimensions 4, 5 or 6, consider phone contact with the AMS to screen for referral to an alternate level of treatment.


Consumer is appropriate for the following level of care (check THE MOST acute problem area that applies):

Outpatient (Level I)	_____	(Direct admission, AMS screen not required)
Intensive Outpatient (Level II)	_____	(Direct admission, AMS screen not required)
Detox- Subacute (Level III.2/7 D)	_____	(Requires AMS Screen)
Residential (Level III.7)	_____	(Requires AMS Screen)
Detox- Acute Hospital Based	_____	(Not a MCOSA-funded service)
Inpatient Medical/Psych (Level IV)	_____	(Not a MCOSA-funded service)
Methadone (OMT)	_____	(Requires AMS screen)

ASSESSOR'S NAME: _____ DATE: _____

ASAM - Page 2 of 2

23



Treatment Plans/Progress Notes

- A valid treatment plan must be in place prior to the provision of ongoing services.
- Treatment Plans should include documentation of client involvement including client signature and use of clients' own words in the development of the plan. Treatment plans not signed by the client are not considered valid plans.
- Plans should identify goals with specific objectives, services, activities and time frames for completion. Objectives should be specific and measurable and match the time frames given.
- Progress notes must contain the file number, date/time of session, clinicians' signature and clinician credentials. They should also include documentation of progress toward goals/objectives.
- Group session notes must include the items listed above as well as the number of participants in the group.

24



Goal/Objective Samples

Example: Goal that is not specific or measurable

Goal: Abstinence.

Objectives:

- 1-Report no use of substances at each appointment.
- 2-Report less urges to use.

Example 2: Goal that is specific, measurable and shows what interventions will be provided

Goal: "I want to stay clean".

Objectives:

- 1-Client will participate in random UDS with no positives while in treatment.
- 2-Client will attend weekly groups and actively engage in sessions.
- 3- Client will develop a pros and cons lists of use.
- 4- Client will participate in individual sessions where the therapist will utilize Motivational Interviewing and Cognitive Behavioral Therapy to explore triggers for use and more positive coping techniques.

25



Change in Level of Care

- If a client presents with a need for a higher level of care or additional services such as recovery housing a change in level of care request should be submitted through FOCUS.
- In this form you must provide up to date information regarding the clients' current stage of change, current medications, current participation in treatment, what services are being requested and clinical justification for those requests.

26

Change In Level Of Care

Request Date Requesting Therapist

As Current Date

Times Available

Diagnosis

SUD Diagnostic Code

MH Diagnostic Code 1

MH Diagnostic Code 2

MH Diagnostic Code 3

Diagnostic Formulation

characters left: 8000

Level Of Care Information

Current Level Of Treatment
Rehabilitation/Residential - Short-Term (30 days or fewer)

Additional Service Categories

Peer Recovery Coach
 Recovery Home
 Case Management

Request Change To

Detox IOP LT Residential OP Peer Recovery Coach Recovery Home Case Management ST Residential

SUD Substances (SA or MH/Integrated Tx episodes)

Substance Rank	Substance	Route of Administration	Frequency of Use	Age at First Use
Primary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Secondary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tertiary	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medication-Assisted Opioid Therapy Yes No Not Applicable

Attendance at Substance Use Self-Help Groups in past 30 Days

27

Results of Past 30 days drug screen (testing date, substance and result)

characters left: 8000

Opioid Use Only: Indicate type of Medication Assisted Treatment client is receiving

Methadone Suboxone Vivitrol None

Is Client Currently (check all that apply)

Injecting Drugs? Yes No

Pregnant? Yes No Not Applicable

On Rx Methadone? Yes No

A parent at risk of losing child(ren) due to substance use? Yes No

Eligible For Women's Specialty Funds? Yes No

ASAM Results

Dimension 1 <input type="text"/>	Dimension 4 <input type="text"/>
Dimension 2 <input type="text"/>	Dimension 5 <input type="text"/>
Dimension 3 <input type="text"/>	Dimension 6 <input type="text"/>

Level Of Care Comments

characters left: 8000

General Comments

characters left: 8000

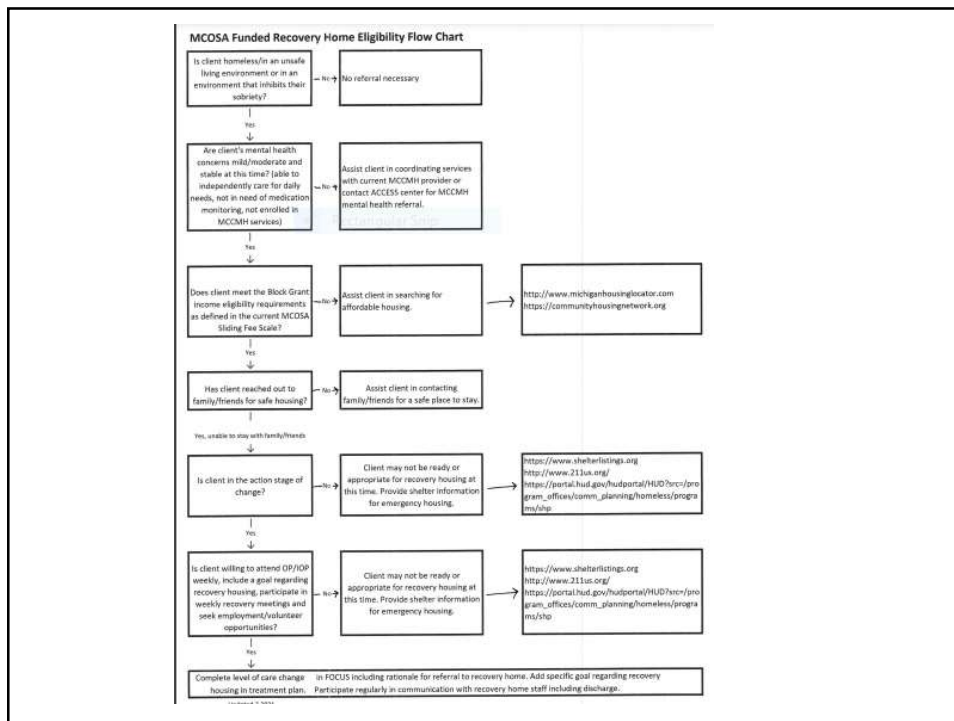
28



Recovery Home Referrals

- To ensure clients have safe, secure, sober housing to fully focus on treatment, MCCMH-SUD can provide short term funding for recovery housing with contracted recovery home providers.
- Individuals should only be referred to a MCCMH-SUD funded recovery home if they are highly motivated for recovery, in the action stage of change and willing to participate in regular treatment.
- Inappropriate referrals can threaten the integrity of the homes as well as the recovery of the other residents.
- MCCMH-SUD relies on clinicians' judgement to ensure appropriate referrals are made to the homes. Once at the home, any extension requests would come from the recovery home providers.
- MCCMH-SUD had created a flow-chart that staff can use to determine if a client is appropriate for funding.
- Clients can also be referred to recovery housing and self-pay if they are able.

29



30



Discharges

- Discharges should be entered into FOCUS within 30 days of the last session or sooner if the discharge is planned.
- Those clients who drop out of treatment should have outreach efforts documented in the chart (letters, phone calls, etc).
- If appropriate, after care referrals should be provided to all clients regardless of the nature of their discharge.
- All aftercare referrals should be documented in the FOCUS discharge.
- The discharge date is the last date a service was provided.
- Withdrawal Management, IOP and Residential treatment are not considered the last step in a treatment episode. Therefore any client discharging from one of these levels of care should be provided with an aftercare referral.

31



Administrative Requirements

32



Adding New Staff

- When a new staff member is hired to see MCCMH-SUD funded clients, the program must first ensure that they meet the credentialing requirements of the MCCMH-SUD contract.
- The supervisor would send a Directors Verification form to MCCMH-SUD for review/approval. These can be submitted to mcosa@mccmh.net
- Any staff requiring FOCUS access should have a request form completed and submitted by their supervisor. These can be submitted to mcosa@mccmh.net.
- Staff cannot provide services to MCCMH-SUD funded clients until they have an approved Director's Verification Form on file.
- Providers must complete an initial credentialing review and re-credential staff every two years.
- Staff must complete required training within 90 days of hire and every two years to align with re-credentialing.
- Staff must maintain any licenses/certifications required to provide services per MDHHS staff credentialing rules.

33



SUD Required Trainings

All MCCMH-SUD Required Trainings can be found at www.mccmh.net in the Substance Use Provider Manual

- Communicable Disease Level 1 (improving MI Practices)
- SUD Recipient Rights (Improving MI Practices)
- Corporate Compliance (internal to your agency)
- Cultural Diversity (Brainier)
- New Employee Orientation (internal to your agency)
- SUD Basics of Confidentiality (Improving MI Practices)
- Limited English Proficiency (Brainier)
- Integrated Primary and Behavioral Health (Brainier)
- Grievance and Appeals (Brainier)

34

**MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
DIRECTOR'S VERIFICATION OF STAFF CREDENTIALS**

Staff Name: _____ Title: _____
 Program Name: _____ Site: _____
 Requested Effective Date: _____

I. Substance Abuse Treatment Specialist - Check all that apply
 Has licensure in good standing in one of the following areas, is working within their licensure-specified scope of practice AND has SUD Certification or a Registered Development Plan and is timely in its implementation:

<p>Licensure</p> <ul style="list-style-type: none"> <input type="checkbox"/> Physician (MD/DO) <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Nurse Practitioner (NP) <input type="checkbox"/> Registered Nurse (RN) <input type="checkbox"/> Licensed Practical Nurse (LPN) <input type="checkbox"/> Licensed Psychologist (LP) <input type="checkbox"/> Limited Licensed Psychologist (LLP) <input type="checkbox"/> Temporary Limited Licensed Psychologist (TLTP) <input type="checkbox"/> Licensed Professional Counselor (LPC) <input type="checkbox"/> Limited Licensed Professional Counselor (LLPC) <input type="checkbox"/> Licensed Marriage and Family Therapist (LMFT) <input type="checkbox"/> Limited Licensed Marriage and Family Therapist (LLMFT) <input type="checkbox"/> Licensed Masters Social Worker (LMSW) <input type="checkbox"/> Limited Licensed Masters Social Worker (LLMSW) <input type="checkbox"/> Licensed Bachelor's Social Worker (LBSW) <input type="checkbox"/> Limited Licensed Bachelor's Social Worker (LLBSW) <input type="checkbox"/> EMT 	<p>Certification</p> <ul style="list-style-type: none"> <input type="checkbox"/> Certified Alcohol and Drug Counselor – Michigan (CADC-M) <input type="checkbox"/> Certified Alcohol and Drug Counselor – IC&RC (CADC-R) <input type="checkbox"/> Certified Advanced Alcohol and Drug Counselor – ICRC (CAADC) <input type="checkbox"/> Certified Co-Occurring Disorders Professional (CCDP) <input type="checkbox"/> Certified Co-Occurring Disorders Professional-Diplomat (CCDP-D) <input type="checkbox"/> Certified Criminal Justice Professional – IC&RC (CCJP-R) <input type="checkbox"/> State approved alternative credential (ASAM, CHES, APA Specialty in Addiction, UMICAD) <input type="checkbox"/> Registered Development Plan - Expiration date: _____
--	--

II. Substance Abuse Treatment Practitioner (not eligible for reimbursement of psychotherapy services)

- Has a Registered Development plan and is timely in its implementation
 Plan expiration date: _____

III. Clinical Supervisor

- Certified Clinical Supervisor – IC&RC (CCS-R)
- Certified Clinical Supervisor – Michigan (CCS-M)
- Clinical Supervisor Registered Development Plan – Plan expiration date: _____

Communicable Disease Training (Must be completed within 30 days of hire)

- Level I Communicable Disease Training Requirements Completed on _____ (attach verification), OR, Will be completed by _____

Application must be submitted and approved prior to the provision of direct service, or services may not be reimbursed. Documentation must be submitted for all items checked above. **ALSO INCLUDE A CURRENT RESUME.**

Documentation Attached:
 Resume
 License
 Certification
 Development Plan

Application Includes:
 Communicable Disease Training/Plan
 Required Signatures
 FOCUS Access Form

The undersigned attests to the personal possession of, and the authenticity and validity of the above described license, credential or equivalent and training.

Staff Member's Signature _____ Date _____

The undersigned attests that the above described license, credential or equivalent, and training, has been verified as being possessed and in good standing by the staff person named above. The program has/will complete all MCOSA Staff Qualification and Credentialing requirements and has this information available at MCOSA's request.

PRINT Program Director's Name _____
 Program Director's Signature _____ Date _____

MCOSA Use Only

Packet received on: _____
 Information Complete? Yes No
 If no, list missing information requested: _____
 Date additional information received: _____
 Additional follow up required: _____

Director's Verification: Approved Denied
 Authorization Effective Date: _____
 MCOSA Authorization _____ Signature Date _____

Response sent to provider on: _____

35

**MACOMB COUNTY COMMUNITY MENTAL HEALTH
FOCUS SOFTWARE SYSTEM
ACCESS REQUEST**

Enrollment Change Disenrollment

SYSTEM ACCESS REQUESTED FOR:
 Note: All requests for FOCUS Access must be submitted by an authorized supervisor

First Name: _____ Last Name: _____
 Email Address: _____ Phone: _____ Fax: _____
 Job Title: _____ Date of Hire: _____ Date of Termination: _____

Functions: Please place an "X" in one or more boxes as needed:
 Billing Clinical Clinical Clinical (without need for FOCUS user id) Supervisor

Agency Name & All Locations/Provider IDs

Clinical Staff ONLY:

License (required): _____ **Expiration Date (required): (month/date/year):** _____
 State of MI License(s) – name and number, issue date and expiration date(s): Clinical staff without a license must report years of post-degree experience _____

NPI number (if applicable): _____ **DEA number (physicians only)** _____

SUD Credential (required): _____ **Expiration Date (required): (month/date/year):** _____

The responsible supervisor MUST notify MCOSA immediately when a staff person's FOCUS profile needs updating. These updates include the following:

<p>Change in Employment Status:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Termination <input type="checkbox"/> Temporary leave <input type="checkbox"/> Change in duties <input type="checkbox"/> Transfer of Location 	<p>Contact Updates:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Change in phone number <input type="checkbox"/> Fax number <input type="checkbox"/> E-mail <input type="checkbox"/> License status change / Expiration <input type="checkbox"/> Name Change (include previous name)
---	---

Requesting Supervisor's Name: _____
 Title & Department: _____ Phone: _____ Fax: _____
 Supervisor Email Address: _____

My Signature attests that all information above is accurate and complete to the best of my knowledge.
 Supervisor Signature: _____ Date: _____

SUD: Please submit to mcosa@macomb.net or Fax at 586-469-5568. **ALL REQUESTS MUST BE IN WRITING!**

36



Required Reports

- Injecting Drug Users 90% Capacity Report-quarterly (Nicole G.)
- Priority Populations Waiting List Deficiencies Report-monthly (Nicole G.)
- Customer Satisfaction Survey Reports-quarterly (OP providers must include number of no shows) (Nicole P.)
- Death Reports should be submitted as soon as staff are notified but no later than the end of shift (Nicole P.)
- Incident Reports should be submitted within 24 hours (Nicole P.)
- WSS providers must complete a monthly report on WSS services and referrals (Nicole G.)
- WSS providers must submit the Child Referral Report bi-annually and the WSS Annual report (Nicole G.)

37

Injecting Drug Users 90% Capacity Treatment Report				
Due dates: 1/31, 4/30, 7/31 and 10/31. Submit by the due date, to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov.				
Region - PHIP:				
Fiscal Year:				
Quarter:				
Date Submitted or Date				
Contact Person's Name,				
Title:				
Contact Person's Email:				
<p>If you have IDU providers who have reached 90% capacity during the quarter, complete the following table for each provider*. Insert rows if necessary. If you do not have IDU providers who reached 90% capacity during the quarter, you must type "NA" in Column A.</p> <p>*You must also report the 90% capacity event to MDHHS-BHDDA-Contracts-MGMT@michigan.gov by close of business the day after the provider notifies you and not to exceed seven days from the date that the provider reached capacity. MDHHS will compare your immediate notifications with this quarterly report to determine compliance with 45 CFR § 96.126.</p>				
Column A	Column B	Column C	Column D	Column E
Name of Providers (Serving Injecting Drug Users) at or Above 90% Capacity During the Quarter	Start Date of Being at 90% Capacity	End Date of Being at 90% Capacity	Provider's Michigan Licensing and Regulatory Affairs (LARA)	Provider's Federal Inventory of Behavioral Health Services (I-BHHS) Number

38

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

PRIORITY POPULATION WAITING LIST DEFICIENCIES REPORT

Submit this form on or before the last day of each month, following the month in which a deficiency occurred. Submit your completed report by email to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov. This report must be submitted even if there is no data to report. If there is no data to report, complete the top section (month, contact info) and enter "N/A" in the first row under "Program Name." If needed, there are additional reporting rows on page 3.

Fiscal Year: _____

Report Month: _____

PIHP Name: _____

Contact Person: _____

Email Address: _____

Clients not meeting the federal waiting list requirements:

Program Name	A Client Identifier Number	B Priority Code 1, 2, 3	C Service Request Date	D Date LOC Determined	E Days on Waiting List	F Service Requested	G Methadone: Drug-free	H Methadone: Refused Drug-free	I Interim Services Provided	J Interim Services Refused	K Type of Interim Services
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

39

MCOSA QUARTERLY CLIENT SATISFACTION SURVEY REPORT

Provider Name: _____ License #/Location: _____
Person completing form: _____

TIME PERIODS:		DUE DATES:	
<input type="checkbox"/>	1 st Quarter	January 15, 20__	
<input type="checkbox"/>	2 nd Quarter	April 15, 20__	
<input type="checkbox"/>	3 rd Quarter	July 15, 20__	
<input type="checkbox"/>	4 th Quarter	October 15, 20__	

1. Consumer Satisfaction with Funded Services (if you did not conduct any consumer satisfaction surveys during this quarter, report zero).

**Example: 15 clients surveyed, 10 clients responded to survey, of those 10 responders, 8 were satisfied*

Funded Substance Abuse Consumers	Number Surveyed	Number Responded to Survey	"NUMBER" of Responders Reporting Satisfied
<i>*Example:</i> 15	10	8	
Persons 18 years and older			
Persons under 18 years			

2. Recipient Rights Complaints from Funded Consumers:

Number of Recipient Rights Complaints Submitted this Quarter	Number of Recipient Rights Complaints Substantiated this Quarter

3. The Number of Funded Substance Abuse Consumers Discharged with Reason being Death this Quarter? _____

4. The number of Outpatient and IOP (Block Grant, PA2, Medicaid, HMP) clients who did not show for services this quarter:

Number of Outpatient clients	Number of IOP clients

Definitions:
Funded means the individual received substance abuse services reimbursed through your MCOSA contract agreement, including Medicaid.

40

**MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
REPORT OF DEATH FORM**

Provider Name: _____ Primary Therapist Name: _____
 Consumer Name: _____ DOB: _____
 Case # _____ SSN # _____
 Weight: _____ Height: _____ Marital Status: S / M / D Gender: M / F
 Level of Treatment: OP OMT IOP Detox Residential Admission Date: _____
 Total Number of Visits: _____ Last Treatment Contact Date: _____
 Status of Case at Time of Death: Open Closed. If Closed, Date of Discharge: _____

Clinical Progress: Prior to the report of death, consumer was: Abstinent/Compliant with Treatment
 Abstinent/Non-compliant Relapsed/Compliant Relapsed/Non-compliant Unknown
 Clinically/behaviorally how was consumer doing just prior to report of death, or if discharged, just prior to discharge?
 Greatly Improved Moderately Improved Slightly Improved Unchanged
 Regressed Unknown Explain: _____

Most Recent DSM-IV Diagnosis:
 Axis I (SA) _____
 Axis I (SA) _____
 Axis I (SMH) _____
 Axis II _____
 Axis III _____
 Axis IV Primary Supports Social Environment Educational
 Occupational Housing Economic
 Health Care Access Legal Other _____
 Axis V Most Recent GAF _____ Highest GAF Last Year _____

Medical: Primary Care Physician (PCP): _____
 Any hospitalizations: Y / N (if yes, when & why)
 Nicotine use Diabetes Hypertension
 Medications: Include all current prescribed or OTC medications used for medical or psychiatric treatment.
 (Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most recent Med Rev.)
 (Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most recent Med Rev.)
Use reverse side for additional medications.

Date of Death: _____ Age @ Time of Death: _____
 How and when (date) was program notified of death? _____
 Place and Circumstance of Death (Include whether or not substance use was involved): _____
Use reverse side for additional information.

Preliminary Cause of Death:
 Suicide Homicide Accident Overdose Natural Causes/Preexisting Illness
 Undetermined/Pending
 Other (Explain/Clarify): _____

Additional Comments/Relevant Information regarding Consumer Death:
Use reverse side for additional comments/information.

Secondary Cause of Death:
 Suicide Homicide Accident Overdose Natural Causes/Preexisting Illness
 Undetermined/Pending Other (Explain/Clarify): _____

Additional Comments/Relevant Information regarding Consumer Death:
Use reverse side for additional comments/information.

Actions taken by Program after Report of Death: (Check all that Apply)
 Incident Review Mortality Review
 Sentinel Event Review Root Cause Analysis Other: _____ (Describe)
 None: (if none explain) _____

Actions Taken as a Result of the Investigation of Consumer Death:

(Supervisory Staff Completing Report) (Date)

Additional Comments:

41

**MACOMB COUNTY COMMUNITY MENTAL HEALTH- SUD
CLIENT INCIDENT REPORT FORM**

TO BE COMPLETED BY MCCMH-SUD CONTRACTED AGENCY

AGENCY TYPE: Outpatient/IOP MAT/OHH Recovery Home Residential/Withdrawal Mgt

Program: License Number: _____ Facility: Name: _____
 Address: _____ Age: _____ Sex: M / F ()
 City: _____ State: _____ Zip: _____

Date of Incident: _____ Time: _____ Location of Incident: _____
 Witnesses* Staff: Y () N () Witnesses* Staff: Y () N ()
 Name or Focus # #: _____ Name or Focus # #: _____
 Contact Phone Number: _____ Contact Phone Number: _____

*Witnesses who are clients in treatment should be asked to sign release of information to MCCMH for possible future use in court, but are not required to do so.

CHECK TYPE OF INCIDENT:
 A. Death of Client
 B. Serious illness requiring admission to hospital
 C. Alleged cause of abuse or neglect
 D. Accident resulting in injury to client requiring emergency room visit or hospital admission
 E. Behavioral episode (with or without police contact)
 F. Client and/or car accident
 G. Vehicle or building issue

Explanation of What Happened (if agency is to include their own incident report, indicate here and attach completed report to this form):

Immediate Actions Taken (actions taken to protect, comfort and/or assure proper treatment of the client):

Actions Taken to Remedy and/or Prevent Recurrence of Incident:

Signature of Person Completing Form: _____ Date: _____

Send to:
 MCCMH-SUD, 19800 Hall Road, Clinton Township, MI 48038
 Secure email to: mccmh@mccmh.net, or Fax to: 588-469-5568

II. TO BE COMPLETED BY MCCMH-SUD

MCCMH-SUD Investigation Findings Check all that apply: <input type="checkbox"/> Death of Client <input type="checkbox"/> Physical Illness Requiring Admission to Hospital <input type="checkbox"/> Serious Challenging Behaviors	<input type="checkbox"/> Accident requiring ER visits and/or admission to hospital <input type="checkbox"/> Arrest/Conviction of Client <input type="checkbox"/> Medication Error
Determination: Check one: <input type="checkbox"/> Sentinel Event () <input type="checkbox"/> Non-Sentinel Event ()	
Check one: <input type="checkbox"/> MCCMH-SUD Plan of Action/Intervention () <input type="checkbox"/> Rationale For No Further Investigation () Provide a brief description: _____ _____	
MCCMH-SUD Signature: _____ Date: _____	

2

42

Monthly Women's Specialty Report
Macomb County Community Mental Health Substance Use Services

This report must be completed monthly and submitted to Nicole.gabriel@mccmh.net]

Agency submitting report: _____

Month reported: _____ Date submitted: _____

Total number of women who received WSS services during this reporting period.	
Number of pregnant women served during this reporting period.	
Number of women who delivered babies while in services during this reporting period.	
Number of children in service with mother.	
Percentage of women served who were able to identify a primary/prenatal care physician at admission or who were provided assistance in obtaining a PCP.	
Percentage of women served who were provided Gender Specific Treatment.	
Percentage of women served who had their transportation needs met.	
Percentage of women served who had their case management needs met.	
Number of children who received services with their parent.	
Number of children served who were provided referrals for primary care and/or immunization.	
Percentage of children in services with their parent who were provided with a referral for pediatric/immunization follow up.	
Number of children served who were provided EBP treatment services or were referred to EBP treatment services.	
Percentage of children who were eligible that received a referral for therapy.	
Number who refused services for their children.	
Number of children in residential treatment with current CPS or Foster Care involvement.	

43

Michigan Department of Health and Human Services
 Behavioral Health and Developmental Disabilities Administration

CHILD REFERRAL REPORT

This report must be submitted electronically each quarter by the due date to: EGRAMS. Submit to the SUGS Women's Specialty Services project. Due dates are: 1/31, 4/30, 7/31 and 10/31.

This report is to identify the number of children who "enter" services with their mother. Though the child might not be physically present, the clinician and case manager should ask about any concerns regarding the child/ren, and record and track all referrals made for services.

Region - PHP:

Fiscal Year:

Quarter:

DATE SUBMITTED OR DATE

CONTACT PERSON'S NAME, TITLE:

CONTACT PERSON'S EMAIL:

REPORTING TABLE	Prevention Services	Treatment Services	Mental Health Services	Other
1. Number of Children Referred				
2. Number of Children Who Accessed				
3. Number Who Refused Services				
4. Number of Children Entering Residential Treatment with their	N/A		N/A	N/A
5. Number of Children in Residential Treatment with Current CPS or	N/A		N/A	N/A

COMMENTS:

INSTRUCTIONS:

See complete instructions on next tab.

1. Indicate the total number of children referred for each service category listed across the top. There may be some "duplication" if a child is referred for more than one service.
2. Indicate the number of children (parents) who accessed the service they were referred to. This will require follow up with the family.
3. Indicate the number of children (parents) who refused the service they were referred to.

44

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Evidence-Based Programs/Practices (NREPP)

	Contact Person/Agency	Phone	Email
	Contact Person/Agency	Phone	Email
	Contact Person/Agency	Phone	Email

Promising Programs

	Contact Person/Agency	Phone	Email
	Contact Person/Agency	Phone	Email
	Contact Person/Agency	Phone	Email

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Enhanced Women's Services Information ONLY

Outcome Information

Provider	# of Total Women Participating	# of Pregnant Women Participating	# of Women Who Achieved Stable Employment or Income	# of Women Who Achieved Stable Housing	# of Women Actively Using Contraceptive Methods	# of Pregnant Women Who Consistently Participated in Prenatal Care	# of Non-Substance Exposed Births	# of Families Reunited

Children's Information

Number of Children	
Number of Children Up-to-Date on Immunizations	
Number of Children who Received Referrals for Services	

Indicate the most common referrals for mother (father) and children.

Indicate the number of women who were able to avoid incarceration, residential treatment, and out of home placement of the children. How were EWS helpful in this?

47

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

INSTRUCTIONS: WOMEN'S SPECIALTY SERVICES (WSS) ANNUAL REPORT

This form must be completed annually and submitted electronically, by November 30 (after the end of the project year), as an attachment report to the SWS WSS project in EGRAMS.

Incomplete reports will not be approved and will be returned for corrections in EGRAMS. Reports will not be considered submitted until corrections are completed and resubmitted.

Form Instructions
In the spaces provided at the top of the page, enter the PHP name and the fiscal year.

Publicizing Women's Specialty Services
In the table, enter any, and, all activities that the PHP and its WSS programs are engaged in, to promote women's services.

Unduplicated Treatment Services Provided
In the table, enter the name of the service provider, both designated women's providers and other providers considered to be gender competent, and then the corresponding information in each column. Include providers out of region also, unless they are statewide providers (Odyssey, Salvation Army). Do not leave any blanks in a row, if a column does not apply, indicate with a '0'.

Prepaid Inpatient Health Plan (PHIP) Specific Information
This information should be provided by the PHIP for their entire region, as well as those clients sent out of region. Include all referrals and services provided by all providers not just Designated Women's Providers (DWWPs).

Outcome Information
This information is for all programs that provide services to pregnant women. Indicate which programs are DWWPs by checking the box, and then provide the corresponding information for each column.

Michigan Department of Health and Human Services
Bureau of Specialty Behavioral Health Services

Program Information

This information is necessary if any programs changed treatment services/criteria during the fiscal year. Complete the requested information for each provider that changed. If no changes occurred in any programs, this can be left blank.

The remaining questions are related to expectations from Federal requirements and state site visits. If information or data is not available, indicate why and how this is going.

Evidence-Based Programs/Practices and Promising Practices
Indicate any evidence-based practices and programs that your providers are engaged in at the time of the report. Include a contact person and contact information for follow up questions. Provide the same information for promising practices in your region. Enhanced Women's Services (EWS) would be a good example of a promising practice.

Outcome Information Table
In the table, supply the name of the agency providing EWS. Complete each remaining section of the table. If there are no clients who meet the indicated criteria, enter '0'.

Stable employment is any employment considered to be non-seasonal, with consistent work hours across time.

Stable housing is any housing that is a fixed, regular, and adequate nighttime residence for the family.

Consistent participation in prenatal care means attending appointments regularly and participating in the medical care offered during such appointments.

Non-substance exposed births are those infants born without any exposure to alcohol or illicit substances while in utero.

Families reunited applies to those families involved with the child welfare system whose children are in out-of-home placement. Reunification refers to the time when the family is residing under the same roof again.

Children's Information:
Enter the total number of children involved with EWS through their mothers. Document any referral information given to mothers to access services for their children.

48



Helpful Links

Most required documents can be found on our website:

www.mccmh.net

Scroll to the bottom of the main page and you will find a link to the Substance Use Services Provider Manual

<https://www.mccmh.net/mcosa-provider-manual/>

MDHHS Required Reports:

[Fiscal Year 2024 SUD \(Non-Medicaid\) Reporting Instructions and Forms \(michigan.gov\)](#)

49



FOCUS EMR Overview

[Main \(pcesecure.com\)](http://pcesecure.com)

50

FOCUS Link

www.mccmh.net

Providers
Current Providers

The screenshot shows the MCOMH website header with navigation links like 'HOW WE HELP', 'COMMUNITY RESOURCES', 'MEMBERS', 'PROVIDERS', and 'ABOUT'. Below the header, there is a section titled 'To Our Providers' with a 'Focus Login' button highlighted by a red circle. The page also includes a 'FOCUS Login' button at the bottom of the main content area.

51

First Time FOCUS Login

Welcome to MCMH!

Access to this site is limited to authorized staff of Macomb County Community Mental Health users and authorized providers.

Please enter your Login ID and Password

Login ID:

Password:

[I forgot my password](#)

MCCMH monitors and logs the activities of this web site. By accessing this web site, you are expressly consenting to these monitoring activities. Unauthorized attempts to access, obtain, alter, damage, or destroy information, or otherwise to interfere with the system or its operation are prohibited and recorded by the MCCMH.

It is the MCCMH policy that staff may access consumer Protected Health Information (PHI) only when access to that information is a necessary part of their job function. Accessing consumer PHI for purposes other than to perform functions of your position may result in an appropriate disciplinary action.

ATTENTION

All information contained in this information system is private and confidential. This system is intended for professional use by the staff and contractors of Macomb County Community Mental Health and its affiliated organizations. Records contained herein should be accessed only by authorized staff from approved work stations. Information should be accessed on a need-to-know basis only.

By accepting these terms, you agree under penalty of law that you are an authorized agent using this system only for professional purposes.

For security and identification purposes, your IP address has been recorded.

Anyone accessing or using this system inappropriately will be prosecuted to the fullest extent of the law, as set forth in agency policies.

The confidentiality of this information is legally protected under the Michigan Mental Health Code (PA 258 of 1974, as amended) and the Health Insurance Portability and Accountability Act of 1996 (45 CFR, Parts 160 and 164). Additionally, some information may also be protected under the Confidentiality of Alcohol and Drug Abuse Patient Records: Final Rule (42 CFR, Part 2) and the Confidentiality of HIV/AIDS Information (MCL 333.5131; PA 488 of 1988, as amended).

FOCUS ALERT

To be in compliance with minimum necessary access rules of the Health Insurance Portability and Accountability Act (HIPAA), staff may access consumer Protected Health Information (PHI) only when access to that information is a necessary part of their job function.

Accessing consumer PHI for purposes other than to perform functions of your position may result in disciplinary action, up to and including termination.

This applies to paper records as well as the Electronic Medical Record (FOCUS).

52

FOCUS Passwords

Passwords must be 10 characters long and contain one of the following:

- At least one capital letter
- At least on lower case letter
- At least one special symbol
- At least one number

To reset your FOCUS Password contact MCOSA at mcosa@mccmh.net.

53

Security Questions and Password Reset

Your password has expired, or you were assigned a temporary password. Please enter a new password.

Change Password	
User ID:	suduser
Your Current or Temporary Password:	<input type="password"/>
New Password:	<input type="password"/>
Re-type New Password:	<input type="password"/>
Remember: passwords are case sensitive and are stored exactly as typed	
Security Questions	
Please answer the questions below. If you forget your password, these answers will be used to verify your identity and assign you a new password.	
What is your email address?	<input type="text"/>
What is the name of your favorite childhood friend?	<input type="text"/>
What was your favorite place to visit as a child?	<input type="text"/>
<input type="button" value="Save"/>	

54

Basic Navigation

55

Locating a Client

56



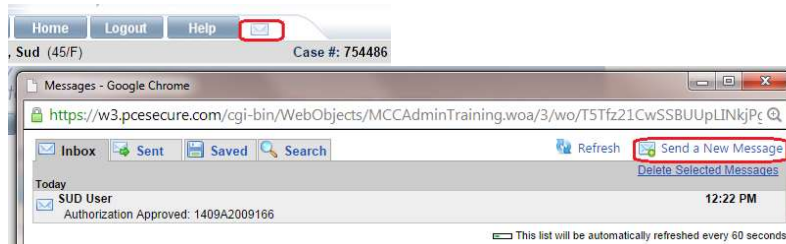
If your Client is not in FOCUS...

- Send the Release of Information Document to MCO
- Complete the 'SUD Provider Request To Open Case' form and send to MCO

57

Release of Information Process

- Scan and Save signed Release & Open Case Request form in your documents labeled with the clients name
- If you cannot scan a document fax it to **586-948-0223**
- In Focus click on the system messages envelope



58

Release of Information Process

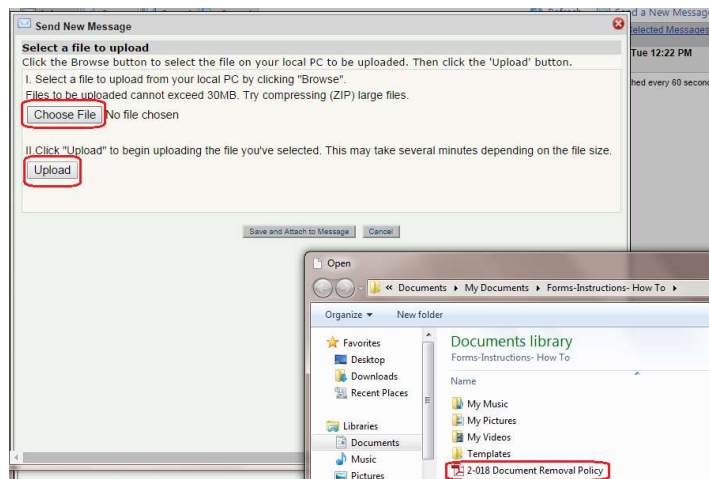
- Attach documents to system message (More details in the next slide)



- If faxing you must still send a message to SUD Release
- MCO will reply to your message once case is open/Referral is released.
- Contact MCO if you need assistance

59

Scanning and Uploading



60

Once in the Client Chart in FOCUS

Macomb County Community Mental Health SUD CA
 *** DEVELOPMENT MODE *** FOCUS
 SUD / CA (NEW)

Home Logout Help

Access Center
 Authorizations
 Claim Submission (AP)
 Consumers
 Financial Information
 Medicaid Lookup
 Provider Management
 Reports and Downloads
SUD / CA (NEW)
 Change Password

SUD Treatment Referrals, Admissions and Discharges
 SUD Treatment Referrals, Admissions and Discharges for a consumer [myPage](#)

Search SUD Referrals by Provider
 Search SUD Referrals by Provider [myPage](#)

Change In Level Of Care Forms
 Add, Change and View Change In Level Of Care Forms [myPage](#)

5 Treatment Referrals

Date	Provider	Referral Type	Admission Date	Discharge Date	Status	Add SUD Treatment Referral
10/20/2016	C.A.R.E. Peer Recovery	SUD			RELEASED BY: Tamara Pizzimenti on 10/20/2016	Change View Delete Print Twin 14 Forms
0 Admission / Discharge 0 Authorizations						
10/18/2016	Community Assessment Referral & Education	SUD Registry	10/18/2016	10/18/2016	RELEASED BY: Mike Gorvovskiy (PCE) on 10/18/2016	Print
2 Registries 0 Authorizations						
10/18/2016	Biomedical Behavioral Healthcare, Inc.	SUD Registry			RELEASED BY: Mike Gorvovskiy (PCE) on 10/18/2016	Print
0 Registries 0 Authorizations						

61

Macomb County Community Mental Health *** DEVELOPMENT MODE *** FOCUS
 Treatment Referral List

Back Home Logout Help

HEALTH AND SAFETY WARNING
 Show/Hide Details

Name: Consumer, Joe D (48/M) Case #: 999999 Case: MH: Open SUD: Open

Date of Birth: 05/01/1968 Home Phone: (586) 555-1212

Address: 1600 Pennsylvania Avenue MEMPHIS, MI 48041

Primary Program: MH : Arab American & Chaldean Council Outpatient SUD: CLINTON COUNSELING CENTER
 Case Holder: MH : Assma Khatib SUD: None
 Disability Designation: MI

Chart Documents
 Eligibility/Insurance
 Health/PHCP Info
 Clinical Guidelines
 Consumer Calendar
 No Alerts
 Diagnosis

OLD SUD ADMISSIONS (prior to 10/01/2015)
[Click to View Old SARF Referrals / Admissions / Discharges](#)
[Funding Sources and Insurance Policies](#)

Provider: [lookup](#) [clear](#) [SEARCH](#)

5 Treatment Referrals

Date	Provider	Referral Type	Admission Date	Discharge Date	Status	Add SUD Treatment Referral
10/20/2016	C.A.R.E. Peer Recovery	SUD			RELEASED BY: Tamara Pizzimenti on 10/20/2016	Change View Delete Print Twin 14 Forms
Admission / Discharge 0 Authorizations						
SUD Admission has not been completed for this referral Add SUD Admission						

62

FOCUS Admission a/k/a BH TEDS Admission

Index
 1. Admission Information
 2. Signatures

1. SUD Admission: Admission Information

Identifying Information

First Name: JFirst Middle Name: Last Name: CLast
 SSN: 111-88-4444 Date of Birth: 03/24/1984 Gender: Female Male
 Address: 150 Street Home Phone: () - x
 City: MEMPHIS State: MI Zip: 48041 Alternate Phone: () - x
 Medicaid ID #: 0000024635 MI Child ID #: Medicare ID: 123456789A County of Residence: Macomb

Service / Treatment Information

Date of First Request / Contact: 09/22/2016 Admission Date: 9/23/2016 Admission Time: 1000 AM
 Type of Treatment Service Setting: Ambulatory - Intensive Outpatient
 Time to Treatment: 1 Days Prior Treatment Episodes: 2 previous episodes
 Codependent/Collateral Person Served: Client Codependent/collateral individual
 Referral Source: Court/criminal justice referral/DUI/DWI
 Detailed Criminal Justice Referral: *Select
 Race / Ethnic Origin 2: Native Hawaiian or other Pacific
 Hispanic or Latino Ethnicity: Not of Hispanic or Latino origin

63

Admission continued

Race / Ethnic Origin 1: Alaskan native (Aleut, Eskimo)
Race / Ethnic Origin 2: Native Hawaiian or other Pacific
Race / Ethnic Origin 3: *Select Race / Ethnic Origin 3
Hispanic or Latino Ethnicity: Not of Hispanic or Latino origin

Designations

ID/DD Designation: Yes No Not Evaluated
 MI/SED Designation: Yes No Not Evaluated
 Integrated Substance Use and Mental Health Treatment: Yes No
Integrated Substance Use and Mental Health Treatment
 - Diagnosis must include both MH & SUD and
 - Treatment plan must be integrated, including both MH & SUD goals and
 - Clinical encounters occur at a single facility

Education History

Education Level:
 Currently in Mainstream Special Education: No School Attendance Status:
Residential Living Arrangement

Living Arrangements: Homeless

Employment / Financial

Employment Status: Full-time competitive, integrated employment
 Minimum Wage: Individual is currently earning minimum wage or more
 Total Annual Income: 150 Number of Dependents: 1 Enrolled in SDA, SSI or SSDI: Yes No
 Not collected at this co-located service Not collected at this co-located service Not collected for this crisis-only service Not collected for this crisis-only service

Corrections / Legal Status

Corrections Related Status: Probation Arrests in Past 30 Days:
 Not collected at this co-located service Not collected for this crisis-only service

64

Other Demographics Information

Marital Status: Married / Cohabiting | Maiden Name: | Veteran Status: Not a veteran

Pregnancy

Pregnant on Service Start Date: N/A - male adult or prepubescent child | Due Date:

Women's Specialty Program

Yes No

Has Dependent Children? Yes No | Number Of Children: | Trying to Regain Custody of Children? Yes No

SUD Substances (SA or MH/Integrated Tx episodes)

Substance Rank	Substance	Route of Administration	Frequency of Use	Age at First Use
Primary	Alcohol	Oral	3-6 days in the past week	16
Secondary				
Tertiary				

Medication-Assisted Opioid Therapy Yes No Not Applicable

Attendance at Substance Use Self-Help Groups in past 30 Days

Medication-Assisted Opioid Therapy

Yes - Opioid medications such as methadone, buprenorphine vivotrol, suboxone, or naltrexone will be part of the individual's treatment plan.

No - Opioid medications such as methadone, buprenorphine vivotrol, suboxone, or naltrexone will NOT be part of the individual's treatment plan.

Not Applicable - Used if the individual is not in treatment for an opioid problem.

Diagnosis

SUD Diagnostic Code: [lookup](#)
F10.10 Alcohol abuse

65

65

Diagnosis

SUD Diagnostic Code: [lookup](#)
F10.129 Alcohol abuse with intoxication, unspecified

MH Diagnostic Code 1: [lookup](#) [clear](#)

MH Diagnostic Code 2: [lookup](#) [clear](#)

MH Diagnostic Code 3: [lookup](#) [clear](#)

Diagnostic Formulation

characters left: 8000

66

66

Adding a Diagnosis

Case: Open

Select Diagnosis Code

Description: alco

Diagnosis Code:

SEARCH CANCEL

Search Full Catalog

71 Diagnosis Code Crosswalks <PREVIOUS Page 1 of 8 NEXT>

ICD-9	Description	Mappings	
291.0	Alcohol intoxication/withdrawal delirium ICD-10: Alcohol abuse with intoxication delirium ICD-9: ALCOHOL WITHDRAWAL DELIRIUM	ICD-10: F10.121	Select
291.0	Alcohol intoxication/withdrawal delirium ICD-10: Alcohol dependence with intoxication delirium ICD-9: ALCOHOL WITHDRAWAL DELIRIUM	ICD-10: F10.221	Select

DIAGNOSIS

ICD-9	ICD-10	Description	Status Date	Status
Pri 291.0	F10.121	Alcohol intoxication/withdrawal delirium	08/27/2014	Active
Sec 291.0	F10.221	Alcohol intoxication/withdrawal delirium	09/09/2014 Use Current Date	Active

Diagnostic Formulation

characters left: 4096

67

Indication of Mental Health Issues

Yes No

Injecting Drug Use In Past 30 Days?

Yes No

Drug Court

Drug Court Client

Yes No

If Yes

16th Circuit Drug Court

Other Drug Court:

Notes

characters left: 8000

68

On-going Services Appointment

Check here if consumer refused ongoing services

On-going Services Provider **lookup** **clear**
191847 BioMedical Behavioral Healthcare, Inc

Other Location

Appointment Offered Date: 10/02/2015
Appointment Offered Time: 11:00 AM

Appointment Accepted Date: 10/02/2015
Appointment Accepted Time: 11:00 AM

Consumer requested an appointment outside of 14 days of admission date:

Reason

characters left: 128

Status: Changes in Progress
Submission Status: Pending Submission (Add)
✓ Spell Check

Record Added: tpizziment 10/01/2015 08:22:53 AM
Record Changed: tpizziment 10/01/2015 08:22:53 AM
Record ID: 4634944

Save and Continue to Signatures Save Cancel

69

Signatures

Index

- 1. Discharge Information
- 2. Signatures**

2. SUD Discharge: Signatures

TEDS

Type / Status	Event
SA Discharge / Service End	Discharge Date: 10/13/2015 Discharge Time: 8:00 AM Use Current Time
Pending Signature	Episode to Discharge Episode 19: 10/01/2015 / Outpatient / BioMedical Behavioral Healthcare, Inc Type Of Treatment Service Setting: Outpatient Reason for Discharge / Service End: Treatment completed

Electronic Signatures

Instructions
When the form/document is completed, type in your password and click 'Sign and Save'. By entering your password you are electronically signing this form/document. Your signature represents your acceptance and approval of the records. Once signed, any future changes must be made via the 'Change Signed Document' option.

Staff Signature Required By **lookup**
5947 Tamara Pizzimenti

Enter your password to sign
[Password Field] Sign and Save

Record Added: tpizziment 10/13/2015 10:32:19 AM
Record Changed: tpizziment 10/13/2015 10:32:19 AM
Record ID: 4641845

Save Cancel

70

FOCUS Discharges

HEALTH AND SAFETY WARNING
Show/Hide Details

Name: Consumer, Joe (23/M) **Case #:** 999999 **Case:** MH: Open SUD: Open

Date of Birth: 05/31/2001 **Home Phone:** (586) 876-2752

Address: 12345 Treasure Hunt Rd
Warren, MI 48093

Primary Program: MH : None
SUD: CARE of Southeastern Michigan

Case Holder: MH : None
SUD: None

Disability Designation: MI DD

Consumer is currently under the following Court Orders:
1 Year Continuing AOT NGR1 Order Date: 09/29/2023 Expiration Date: 09/27/2024

OLD SUD ADMISSIONS (prior to 10/01/2015)

[Click to View Old SARF Referrals / Admissions / Discharges Funding Sources and Insurance Policies](#)

Provider: 10113 Ascension Eastwood Clinics - Residential [lookup](#) [clear](#) [SEARCH](#)

1 Treatment Referral

Date	Provider	Referral Type	Admission Date	Discharge Date	Status	Actions
09/15/2021	Ascension Eastwood Clinics - Residential	SUD Residential Short-Term	11/01/2022		RELEASED BY: Allen Iatepho on 10/14/2021	Add SUD Treatment Referral Add SUD Registry Referral Add SUD OHR Registry Referral Add SUD Engagement Center Registry Referral Change View Delete Print Twin 14 Forms

Type	Date	Type of Treatment	TEDS Submission Status	Status	Actions
Admission / Update / Discharge	11/01/2022	Detoxification	Pending Submission (Add)	SIGNED BY: NICOLE GABRIEL	Add SUD Discharge (circled) Change Signatures View Details Print Document History

71

FOCUS Discharges

Address: 12345 Treasure Hunt Rd
Warren, MI 48093

Case Holder: SUD: CARE of Southeastern Michigan
MH : None
SUD: None
Disability Designation: MI DD

Consumer is currently under the following Court Orders:
1 Year Continuing AOT NGR1 Order Date: 09/29/2023 Expiration Date: 09/27/2024

1. SUD Discharge: Discharge Information

Identifying Information

First Name: Joe **Middle Name:** **Last Name:** Consumer **SSN:** 999-99-9998

Gender Identity: Man/Cisgender Man

Address: 12345 Treasure Hunt Rd **Home Phone:** (586) 876-2752

City: Warren **State:** MI **Zip:** 48093 **Alternate Phone:**

Medicaid ID #: 000111111 **MI Child ID #:** **Medicare ID:** **County of Residence:** Macomb

Admission Date: 11/01/2022 **Provider / License Title:** Ascension Eastwood Clinics - Residential (License # 630311)

Discharge Date: **Discharge Time:** 1:00 AM

Provider / Responsible CMISP: Ascension Eastwood Clinics - Residential

Reason for Discharge / Service End: * Select Reason for Discharge / Service End

*** Select Reason for Discharge / Service End**

- Treatment plan and program were substantially completed
- Dropped out of treatment
- Terminated by agency
- Transferring to another level of care, program or facility outside of MCCMH
- Incarcerated
- Death
- Other

MI or SED Designation: Yes No Not Evaluated

Detailed SMI or SED Status: SMI SED Not Evaluated

72

FOCUS Discharge

Designations

IDD Designation
 Yes No Not Evaluated

Detailed SMI or SED Status
 SMI SED Neither SMI nor SED Not Evaluated

Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment ⓘ
 Yes, client with co-occurring SU and MH problems is being treated with an integrated Tx plan by an integrated team
 No, client does NOT have a co-occurring SU and MH problem
 Client with co-occurring SU and MH problems is NOT currently receiving integrated treatment
 Not collected (crisis only, unknown, other exception, etc.)

MI or SED Designation
 Yes No Not Evaluated

Education

Education Level ⓘ
 * Select Education Level ▼

Currently in Mainstream Special Education
 * Select Mainstream Special Education ▼

School Attendance Status
 * Select School Attendance Status ▼

Residential Living Arrangement

Living Arrangements ⓘ
 * Select Living Arrangements ▼

Employment / Financial

Employment Status
 * Select Employment Status ▼

Minimum Wage
 Individual is currently earning minimum wage or more ▼

Total Annual Income ⓘ **Number Of Dependents** ⓘ **Enrolled in SDA, SSI or SSDI**
 \$ Yes No Not collected (crisis only, unknown, other exception, etc.)

Not collected (crisis only, unknown, other exception, etc.) Not collected (crisis only, unknown, other exception, etc.)

73

FOCUS Discharge

Corrections / Legal Status

Legal Related Status
 * Select Corrections Related Status ▼ **Arrests in Past 30 Days**

Juvenile Justice Involvement at Update or Discharge
 N/A ▼

Youth Prior Law Enforcement History **Youth Prior Juvenile Justice History**
 N/A ▼ N/A ▼

SUD Substances (SA or MH/Integrated Tx episodes)

Substance Rank	Substance	Route of Administration	Frequency of Use	Age at First Use
Primary	Alcohol ▼	Oral ▼	<input type="text"/> ▼	Age: <input type="text"/> 13 ▼
Secondary	<input type="text"/> ▼	<input type="text"/> ▼	<input type="text"/> ▼	Age: <input type="text"/> ▼
Tertiary	<input type="text"/> ▼	<input type="text"/> ▼	<input type="text"/> ▼	Age: <input type="text"/> ▼

Medication-Assisted Opioid Therapy
 Yes No Not Applicable Not collected (crisis only, other exception, etc.)

Attendance at Substance Use Self-Help Groups in past 30 Days
 * Select ▼

Diagnosis

SUD Diagnostic Code [lookup](#)
 F10.10 Alcohol use disorder: Mild

MH Diagnostic Code 1 [lookup](#) | [clear](#)

MH Diagnostic Code 2 [lookup](#) | [clear](#)

MH Diagnostic Code 3 [lookup](#) | [clear](#)

Mental Health Issues Identified during Treatment
 None Severe Mild/Moderate

Women's Specialty Program
 Yes No

74

FOCUS Discharge

Aftercare/Continuation

Check here if consumer refused followup care

Aftercare Provider [lookup](#) [clear](#)

Other Location

Appointment Offered Date Appointment Offered Time

AM ▼

Appointment Accepted Date Appointment Accepted Time

AM ▼

Consumer requested an appointment outside of 7 days of Discharge

Reason

characters left: 128

Notes

characters left: 8000

[✓ Spell Check](#)

Record Added
mchenrya 06/20/2024 02:02:30 PM

Record Changed
mchenrya 06/20/2024 02:02:30 PM

Record ID: 15521018

[Save and Continue to Signatures](#) [Save](#) [Cancel](#)

75

76 **SUD Treatment Referral/Admission Form Changes**

- Make sure the text in the “Reason for Change” text field is detailed.

10/01/2015	BioMedical Behavioral Healthcare, Inc	SUD	10/01/2015	RELEASED BY: Tamara Pizzimenti on 10/01/2015	
Admission / Discharge					
Type	Date	Type of Treatment	TEDS Submission Status	Status	Add SUD Discharge
Admission	10/01/2015	Outpatient	Pending Submission (Add)	SIGNED BY: Tamara Pizzimenti	Change Signed Document View Delete Print Document History
Authorizations					
Authorization #	Provider	Effective Dates	Status	Request SUD Authorization Request SUD Re-Authorization	
1510A2122879	BioMedical Behavioral Healthcare, Inc	10/02/2015 - 12/02/2015	Approved	Change View Delete Print Early Terminate Void	
Authorized Service Description	Units Authorized	Units Claimed to Date	Units Paid to Date	Units Available	
90834 HG	12 Per Auth	0	0	12	

76

Client Demographics

Macomb County
Community Mental Health

*** TRAINING MODE *** FOCUS

Back Home Logout Help

Access Center
Assessments & Screenings
Authorizations
Claim Submission (AP)
Consumers
Financial Information
Insurance Billing
Medicaid Lookup
SID / CA

Consumer Chart
Go to Consumer Chart, consisting of all documents related to a Consumer. This includes a page of links that makes it easier to move from one form to another within a consumer's chart.

Macomb County
Community Mental Health

*** TRAINING MODE *** FOCUS

Back Home Logout Help

Consumer Chart

Name: Test, Sud (45/F) Case #: 754486 Case: Open

Date of Birth: 08/27/1969 Home Phone: (586) 555-1212

Address: 22550 Hall Rd
CLINTON TOWNSHIP, MI 48036

Current Admission

Primary County: Unassigned
Primary Program: Unassigned
Case Holder: Unassigned
Disability Designation:

Chart Documents
Eligibility/Insurance
Health/PHCP Info
Consumer Calendar

No Alerts
Diagnosis

Chart Links

Demographics

[Change Demographics](#)
[View Demographics](#)
[View Consumer Address Changes History](#)

77

77

WARNING!!

FOCUS will time out after 59 minutes on the same page. Save your work often to avoid it getting lost.

SUD User

TIME-OUT IN: 57 Minutes, 56 Seconds

Record Added
tpizziment 08/27/2014 14:31:32

SAVE CANCEL

Back Home

Tuesday, September 09, 2014 11:30 AM Eastern

78

Funding Sources & Insurance Policies

Macomb County Community Mental Health
 *** DEVELOPMENT MODE *** FOCUS
 Treatment Referral List

HEALTH AND SAFETY WARNING
 Close/Print/Details

Name: Consumer, Joe D (31/M) Case #: 999999 Case: MH: Open SUD: Open
 Consumer is deceased

Date of Birth: 03/24/1984 Home Phone: (248) 634-8299
 Address: 1500 Pennsylvania Avenue MEMPHIS, MI 48041

Current Admission:
 Primary Program: MH : First Resources North SUD: CLINTON COUNSELING CENTER
 Case Holder: MH : Jessica Youhanna SUD: None
 Disability Designation: MI

OLD SUD ADMISSIONS (prior to 10/01/2015)
[Click to View Old SARF Referrals / Admissions / Discharges](#)
[Funding Sources and Insurance Policies](#)

Provider:

4 Treatment Referrals

Date	Provider	Referral Type	Admission Date	Discharge Date	Status	Add SUD Treatment Referral
10/02/2015	CLINTON COUNSELING CENTER	SUD	10/13/2015		RELEASED BY: Tamara Pizzimenti on 10/02/2015	View Delete Print 1 x in 14 Forms

Admission / Discharge

79

79

Funding Sources and Insurance Policies

Macomb County Community Mental Health
 FOCUS
 Insurance Policy List

Name: Mcosa, New (44F) Case #: 768078 Case: MH: Closed SUD: Open

Date of Birth: 01/01/1980 Home Phone: (555) 555-5555
 Address: 2 Hall Road Clinton Twp, MI 48036

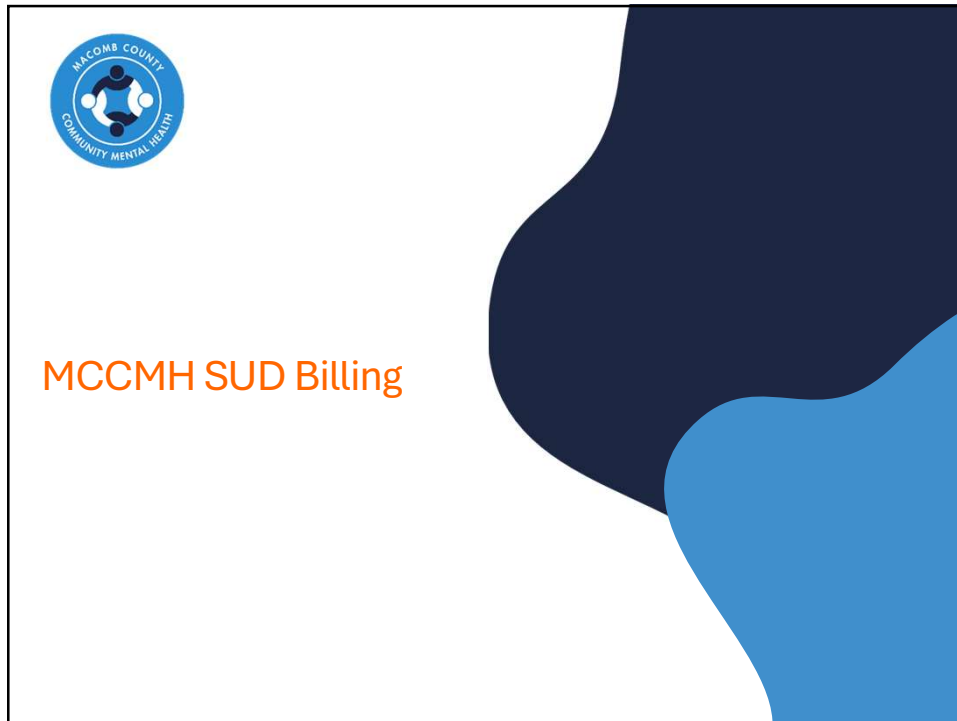
Current Admission:
 Primary Program: MH : None SUD: SELF HELP ADDICTION
 Case Holder: MH : None SUD: None
 Disability Designation:

[Click here to add Self-Pay Policy/Fee Determination](#)
[Click here to add Medicaid Deductible](#)
[Click here to add Children's or SED Waiver](#)
[Click here to add Autism Policy](#)
[Click here to add SDA](#)
[Click here to add CCBHC Policy](#)
[Click here to add COVID Supplemental Policy](#)

[Click here to add 3rd Party Insurance](#)
[Click here to add Medicare Part A/B](#)
[Click here to add Medicare Part D](#)
[Click here to add Advantage Part C](#)
[Click here to add SUD Self Pay](#)
[Click here to add Women's Specialty Services](#)
[Click here to add 16th Drug Court Policy](#)
[Click here to add Opioid Health Home \(OHH\) Policy](#)
[Click here to add SOR Grant Policy](#)
[Click here to add ARPA Policy](#)

- 1.) All Clients are required to have a SUD Self-Pay Policy entered upon admission into services
 - 2.) Women's Specialty Services Policy required for WSS providers rendering WSS services
- For any Policy, click the link and complete data entry for each line -

80



81

General Billing Guidelines

<u>Definitions</u>	<u>Batch Guidelines</u>
<p>Claim – one bundle of services for a single client being billed</p> <p>Batch – all monthly agency claims bundled together</p>	<p>Standalone Batches</p> <ol style="list-style-type: none"> 1.) 3rd party Insurance 2.) MiHealth Link 3.) Methadone Dosing (H0020)

All batches are due by the 10th of the following month.
For example – all June batches are due by July 10th

82

Billing Process

Macomb County
Community Mental Health

SUD CA

Claim Submission (AP) FOCUS

Home Logout Help

24-Hour Crisis Center
Access Center
Admissions and Assignments
Assessments & Screenings
Authorizations
Calendar
Case Load
Certificates of Need
Claim Management (AP)
Claim Submission (AP)

Step (1)-Enter New Claims
View authorized service and enter claims. [+ myPage](#)

Step (2)-Review and Send Batch of Entered Claims to CMH for Payment
View a list of claim batches that have been entered. You can review the claims in each batch and send batches to CMH to request payments. [+ myPage](#)

Step (3)-View Checks and Print EOB
View claim payments by check number and print explanation of benefits. [+ myPage](#)

View all Batches and Claims
View a list of all batches regardless of current status. This option can be useful for looking up historical claims. [+ myPage](#)

83

Billing Process Continued

Home Logout Help

24-Hour Crisis Center
Access Center
Admissions and Assignments
Assessments & Screenings
Authorizations
Calendar
Case Load
Certificates of Need
Claim Management (AP)
Claim Submission (AP)
Consumers
Court Orders
Dashboard
Data Transfers
Financial Information
Help Desk
Insurance Billing
MDCH / ICO Reporting
Medicaid Lookup
Medical - Health Services
Person Centered Plans
Progress Notes
Provider Management
Records

Step (1)-Enter New Claims
View authorized service and enter claims. [+ myPage](#)

Step (2)-Review and Send Batch of Entered Claims to CMH for Payment
View a list of claim batches that have been entered. You can review the claims in each batch and send batches to CMH to request payments. [+ myPage](#)

Step (3)-View Checks and Print EOB
View claim payments by check number and print explanation of benefits. [+ myPage](#)

View all Batches and Claims
View a list of all batches regardless of current status. This option can be useful for looking up historical claims. [+ myPage](#)

View and Upload EDI 837 Claim Files
Upload new EDI 837 Claim Files and view 837 Files that have been uploaded to FOCUS for processing. [+ myPage](#)

View Provider Claims by Consumer
View a list of provider claims for consumers that are authorized to receive services from logged in provider. Only the claims made by this provider will be displayed. [+ myPage](#)


Print Provider Authorization Verification Report
Print Provider Authorization Verification Report. [+ myPage](#)

List of Place Of Service Codes
View list of valid Place Of Service Codes used for HCFA-1500 Claim Entry. [+ myPage](#)

General Claim Search
Search for AP and EDI claims by payer, client or claim number. Allows for basic claim options such as viewing, voiding, transfer balances and more. [+ myPage](#)

84

Billing Process Continued


SUD CA

Back Home Logout Help
Claim Entry
FOCUS

Provider Beaumont Family Medicine (192623) Phone	Location Type SUD Treatment Agency Fax	Address 44250 Dequindre Road Sterling Heights, MI 48314-1002
--	--	--

Case #: Last Name:

Authorization Number:

Check this box to show all authorizations
If not checked, only authorizations that expired less than a year ago will be shown.

Provider: lookup clear SEARCH


To enter a claim, find the approved authorization you wish to base the claim on in the list below and click **Enter HCFA-1500** or **Enter UB-04**.
If you cannot find the Authorization in the list or if there are no more available units for you to claim on an authorization, contact your CMH Support Coordinator to issue an Authorization.

1 Authorizations

Authorization #	Provider Name	Consumer Name	Authorization Effective			
2107A3212539	Beaumont Family Medicine	Joe B. Consumer (999999)	07/30/21 - 07/29/22			View Authorization Enter HCFA-1500 (ICD10)
Authorized Service Description	Units Authorized	Units Claimed	Units Paid	Units Available		
S0280 HG Opioid Medical Home	60 Per Auth Total 60	2	0	60	07/30/21-07/29/22	
S0280 HG TS Opioid Medical Home	60 Per Auth Total 60	2	0	60	07/30/21-07/29/22	

85

Entering a Claim


SUD CA

Back Home Logout Help
Claim Entry
FOCUS

Provider Beaumont Family Medicine (192623) Phone	Location Type SUD Treatment Agency Fax	Address 44250 Dequindre Road Sterling Heights, MI 48314-1002
--	--	--

Case #: Last Name:

Authorization Number:

Check this box to show all authorizations
If not checked, only authorizations that expired less than a year ago will be shown.

Provider: lookup clear SEARCH

To enter a claim, find the approved authorization you wish to base the claim on in the list below and click **Enter HCFA-1500** or **Enter UB-04**.
If you cannot find the Authorization in the list or if there are no more available units for you to claim on an authorization, contact your CMH Support Coordinator to issue an Authorization.

1 Authorizations

Authorization #	Provider Name	Consumer Name	Authorization Effective			
2107A3212539	Beaumont Family Medicine	Joe B. Consumer (999999)	07/30/21 - 07/29/22			View Authorization Enter HCFA-1500 (ICD10)
Authorized Service Description	Units Authorized	Units Claimed	Units Paid	Units Available		
S0280 HG Opioid Medical Home	60 Per Auth Total 60	2	0	60	07/30/21-07/29/22	
S0280 HG TS Opioid Medical Home	60 Per Auth Total 60	2	0	60	07/30/21-07/29/22	

Back Home

86

Adding Claim Details

Health Insurance Claim Form
Claim Batch: 200595

Patient's Name: 999999 CONSUMER JOE B
 Patient's Address: 111 TRAINER
 City: CLINTON TOWNSHIP State: MI Zip Code: 48035 Telephone: 5553351225

Patient's Birthdate: 09/01/1986 Sex: Male
 Insured's Name: CONSUMER JOE B
 Insured's Address: 111 TRAINER
 City: CLINTON TOWNSHIP State: MI Zip Code: 48035 Telephone: 5553351225

17. Ordering/Referring Provider: [Link]
 21. Diagnosis Codes: 1) F11.20 2) 3) 4) [Link]
 Add More Detail Lines Expand All Contract All

	A Dates of Service		B Time of Service		C POS	D TOR	E Procedure/Service		F CPT/HCPCS	G Mod	H Dx	I Charges	J Units	K Plan	L ERG	M COB	N Local Use
	From	To	From	To													
+	08/02/2021	08/02/2021	AM	AM	11	50280	MG										

Allowed Amount: 290.45
 Paid Amount: 0.00
 Adjustment Reason Code: []

Staff: [Link] [Link]
 Check to specify Rendering Provider not in the system

Notes: Profile COVID-19 Telehealth Note codes or Audio-Only

87

Submitting Completed Claims

	Code	From	To	AM	AM	11	50280	MG		1	.00	0	0				Pay: 290.45	Override		
Service Line Allowed/Paid: 290.45 / 290.45																				
08/02/2021 Duplicate and/or overlapping service already claimed on this date. See claim # 12283938 and Contact SUD Division. Alw: .00 Pay: .00																				
Service Line Allowed/Paid: 00 / 00																				
Total Billed: 580.90													4							
Total Allowed/Paid: 580.90 / 580.90													3							

26. Patient Account No. 099999
 Rendering Provider (Claim Level) [Link]
 Internal ID: [] Primary ID: [] Secondary ID: []
 Check to specify Rendering Provider not in the system

27. Accept Assignment? YES NO
 Facility Name and Address: BEAUMONT FAMILY MEDICINE 44250 DEQUINDRE ROAD STERLING HEIGHTS MI 48314-1002
 Internal ID: 192623 Primary ID: 1003820441 Secondary ID: 192623

28. Total Charge 580.90
 Billing Name and Address: WILLIAM BEAUMONT HOSPITAL 44201 DEQUINDRE ROAD TROY MI 48065
 Internal ID: 192624 Primary ID: 1003820441 Secondary ID: 383593303

29. Prior Paid Amount 00
 30. Balance Due 580.90

Comments: TEST Claim for Beaumont Training
 characters left 992

Record Added: mchenrya 08/02/2021 11:31:19 Record Changed: mchenrya 08/02/2021 11:35:08
 Claim ID: 12283938

[SAVE] [CANCEL]

88

Checking Claim Integrity

Mocomb County Community Mental Health | Claim Submission (AP) | FOCUS

Home | Logout | Help

24-Hour Crisis Center
Access Center
Admissions and Assignments
Assessments & Screenings
Authorizations
Calendar
Case Load
Certificates of Need
Claim Management (AP)
Claim Submission (AP)
Consumers
Court Orders
Dashboard
Data Transfers
Financial Information
Help Desk
Insurance Billing
MCH / FCO Reporting
Medical Lookup
Medical - Health Services
Person Centered Plans
Progress Notes
Provider Management
Records

Step (1)-Enter New Claims
View authorized service and enter claims. [View](#)

Step (2)-Review and Send Batch of Entered Claims to CMH for Payment
View a list of claim batches that have been entered. You can review the claims in each batch and send batches to CMH to request payments. [View](#)

Step (3)-View Checks and Print EOB
View claim payments by check number and print explanation of benefits. [View](#)

View all Batches and Claims
View a list of all batches regardless of current status. This option can be useful for looking up historical claims. [View](#)

View and Upload EDI 837 Claim Files
Upload new EDI 837 Claim Files and view 837 Files that have been uploaded to FOCUS for processing. [View](#)

View Provider Claims by Consumer
View a list of provider claims for consumers that are authorized to receive services from logged in provider. Only the claims made by this provider will be displayed. [View](#)

Print Provider Authorization Verification Report
Print Provider Authorization Verification Report. [View](#)

List of Place Of Service Codes
View list of valid Place Of Service Codes used for HCFA-1500 Claim Entry. [View](#)

General Claim Search
Search for AP and EDI claims by payer, client or claim number. Allows for basic claim options such as viewing, voiding, transfer balances and more. [View](#)

89

Checking Batch Integrity

Claim Batch List | FOCUS

Back | Home | Logout | Help

Provider: 192623 Beaumont Family Medicine [lookup](#) [clear](#)

For Batch Dates: 07/02/2021 thru 08/02/2021

Batch Number:

1 Claim Batch(es) - Ready

Batch Number	Billing Provider	Batch Date	Claims	Total Billed/ Payable	
200595 Regular	William Beaumont Hospital (192624) - mchenrya	08/02/2021	1	290.45 0.00	View Claims in Batch Adjudication Report Submit Claims to CMH View Batch Info View Attachments

90

Running Reports to Check for Errors

[Back](#) [Home](#) [Logout](#) [Help](#)

Provider: 192624 William Beaumont Hospital [lookup](#) [clear](#)
 For Batch Dates: 07/02/2021 thru 08/02/2021 [SEARCH](#)
 Batch Number:


Claim Batch(es) - Ready

Batch Number	Billing Provider	Batch Date	Claims	Total Billed/ Payable	
200595 Regular	William Beaumont Hospital (192624) - mchenrya	08/02/2021	1	580 580	View Claims Editor Adjudication Report View Batch Info View Attachments

[Back](#) [Home](#)

91

Adjudication Report Sample


Macomb County Community Mental Health
 Batch Edit Report for Batch 200595

FOCUS

CLM#	BILLING PROVIDER	SERVICE PROVIDER	CONSUMER	ADJUDICATOR
12283938	William Beaumont Hospital	Beaumont Family Medicine	990999 - Joe Consumer	2107A3212039
	Procedure/Revenue	Claimed	Allowed	Payable
		Units	Amount	Amount
07/02/2021 - 07/02/2021	000000 142	1	\$290.45	\$290.45
07/02/2021 - 07/02/2021	000000 142	1	\$0.00	\$0.00
07/02/2021 - 07/02/2021	000000 142	1	\$290.45	\$290.45
08/02/2021 - 08/02/2021	000000 142	0	\$0.00	\$0.00
08/02/2021 - 08/02/2021	000000 142	0	\$0.00	\$0.00
08/02/2021 - 08/02/2021	000000 142	0	\$0.00	\$0.00
08/02/2021 - 08/02/2021	000000 142	0	\$0.00	\$0.00
Adjudicated Service Date Processing Notes 08/02/2021 - 08/02/2021 Duplicate and/or overlapping service already claimed on this date. See claim # 12283938 and Conrad BMD 08/02/2021 - 08/02/2021				
Claim Totals:		4	\$580.90	\$580.90
Batch Totals:			\$580.90	# of Claims: 1

NOTES
 TES1 Claim for Beaumont Training

Page 1 of 1 Printed: 08/02/2021 11:41:12 am

92

Sending Batches to MCCMH SUD Division

Batch Number	Billing Provider	Batch Date	Claims	Total Billed/ Payable	Actions
200595 Regular	William Beaumont Hospital (192624) - mchenrya	08/02/2021	1	580.90 580.90	View Claims in Batch Adjudication Report Submit Claims to CMH ← View Batch Info View Attachments

93



Required Modifiers for Billing (staff credentials)

Modifier	Description
AF	Specialty physician
AG	Physician
AH	Clinical psychologist
HN	the rendering provider has a highest educational attainment of a bachelor's degree
HO	the rendering provider has a highest educational attainment of a master's degree
HP	the rendering provider has a highest educational attainment of a doctoral degree
TD	RN
TE	LPN/LVN

Staffing Modifiers

94



Required Modifiers for Billing (treatment type/group size)

Modifier	Description
HH	Integrated Mental Health/Substance Abuse Program
HD	Women's Specialty Service
HG	Opioid addiction treatment program

Modifier	Description
UP	Three total patients served
UQ	Four total patients served
UR	Five total patients served
US	Six or more total patients served

95



Frequently Asked Questions

- Q: What do I do if the client is being discharged from residential and already completed and ASAM Continuum there?
- A: If a consumer is discharging from residential to your facility, the ASAM continuum should be requested when the consumer calls to schedule the appointment.
- Q: How do I know if they already completed an ASAM Continuum within the last 45 days?
- A: When clients call to schedule an appointment, they should be asked if they have received treatment from any other provider in the last 45 days. If they have, they can request to have their assessment sent to you by their previous provider.
- Q: What do I do once I receive the ASAM from another provider?
- A: Review the ASAM Continuum to note any changes and add a progress note noting any changes and including updated level of care determination

96



Frequently Asked Questions, cont.

- Q: What do I do if a client says that they are at a recovery home and need a referral for their housing to be funded?
- A: Use the flowchart to determine if the client is appropriate for funding, ensure that the home they are residing at is contracted with MCCMH-SUD, submit a change in level of care request. If these items are not met, other housing options should be explored with the client
- Q: What do I do if the client refuses aftercare when leaving a higher level of care?
- A: Check the box at the bottom of the FOCUS discharge indicating that the client refused aftercare and provide them with the contact information for MCO if they want treatment in the future.


97



MCCMH-SUD Contacts

- FOCUS Password resets: mcosa@mccmh.net
- FOCUS removal requests, quality concerns, audits, grievances, appeals or recipient rights concerns: nicole.palazzolo@mccmh.net
- FOCUS issues, contract questions, reports : nicole.gabriel@mccmh.net
- Billing questions: donna.fisher@mccmh.net or tykeisha.hudson@mccmh.net
- OHH/SUD Health Home questions: adam.mchenry@mccmh.net
- Prevention questions: ricki.torsch@mccmh.net
- Billing verification audits: heather.gilbert@mcch.net
- Priority Populations or grants: teresa.crosby@mccmh.net

98



Questions?

(586) 469-5278 www.mccmh.net

The slide features a white background with a dark blue and light blue abstract graphic on the right side. The logo in the top left corner is circular with the text 'NACOMB COUNTY' at the top and 'COMMUNITY MENTAL HEALTH' at the bottom, surrounding a central icon of three stylized figures holding hands.