Macomb County Community Mental Health

Substance Use Services Department

(MCCMH-SUD)

Quality Assurance Guidelines

Updated June 2024

TABLE OF CONTENTS

I. OVERVIEW 4

A. Statement of Purpose 4
B. Statement of Scope 4
C. Administration and Coordination..5
D. Technical Assistance 5

II. GENERAL ADMISSION POLICY 5

A. Screening Requirement Guidelines 6
B. Income Eligibility Criteria..7
C. FOCUS Instructions 10
D. Admission Exclusion Policy for all Treatment Modality 13

III. ADMISSION PROTOCOLS...14

A. Managed Care Operations (MCO) 14
B. Opioid Health Homes..15
C. Recovery Homes 16
D. Significant Other Services..16
E. Relapse Prevention 16
F. Early Intervention..16
G. Peer Recovery Services 17

IV. CONTINUED STAY, DISCHARGE AND READMISSION 17

A. Re-Authorization for Continued Stay 18
B. Readmission Procedures..19
C. Intra-Agency Transfer Policy...19

V. CLINICAL DOCUMENTATION PROTOCOL...20

A. Clinical Assessments..21
B. Individualized Treatment Planning..22
C. Progress Notes 24
D. Aftercare 25
E. Discharge..25

VI. QUALITY ASSURANCE AUDIT AND RECORD REVIEW 27

A. Quality Assurance Audit Compliance Process 27
B. QA Audit Procedures for Outpatient Services 28
C. QA Audit Review procedures for Residential and IOP 29
D. Program Review Feedback Procedures 31

VII. MCCMH-SUD QA AUDIT, SERVICE VERIFICATION REVIEW, APPEALS…....... 32

VIII. GREIVANCE, LOCAL APPEAL AND FAIR HEARING 33

IX. COMMUNICABLE DISEASE POLICY AND GUIDELINES 33

A. Documentation Guidelines 34
B. Risk Screen Guidelines 35

X. Government Performance and Results Act (GPRA) 36

I. OVERVIEW

A. STATEMENT OF PURPOSE

The Quality Assurance (QA) Guidelines represent a compilation of acceptable treatment standards such as those described in the National Institute on Drug Abuse's Principles of Drug Addiction Treatment, December 2012, the American Society of Addiction Medicine Criteria, the Behavioral and Physical Health and Aging Services Administration Medicaid Manual, Policies and Technical Advisories, and adherence to guidelines set forth by the State and Federal requirements. This information is not all inclusive but highlights areas of focus.

B. STATEMENT OF SCOPE

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

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

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

C. ADMINISTRATION AND COORDINATION

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

are required to ensure compliance of these QA Guidelines by training staff in the use and any procedural updates. The QA Guidelines are located at www.mccmh.net. Comments or questions regarding the online QA Guidelines or website should be directed to mcosa@mccmh.net.

D. TECHNICAL ASSISTANCE

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

II. GENERAL ADMISSION POLICY

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

Children, adolescents and/or adults who are experiencing a recent (within six months of intake) relationship with a substance user (family member or co-habitant), referred here as "Significant Other", may be admitted into the treatment program if there is significant evidence that the issues to be addressed are clearly related to the substance using relationship and not an otherwise diagnosable behavioral health issue. It is required that the case record has documentation to show the impact of the Significant Other's substance use on the identified person served.

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

Individuals being released from jails or from Michigan Department of Corrections (MDOC) who meet ASAM criteria for substance use disorder treatment and have Medicaid or Healthy Michigan Plan coverage are eligible for MCCMH-SUD funded

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

All Assessments must utilize the current BPHASA approved assessment tool (ASAM Continuum, GAIN). A copy of the assessment summary must be contained in the client FOCUS record. Agencies making referrals to another provider should provide the next agency with a copy of the completed assessment for their review and records once a release of information is signed.

A. SCREENING DATA COLLECTION REQUIREMENT GUIDELINES

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

2. The screening form must include the following additional information

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

the number of dependent(s) on the household income, including the client.).

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

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

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

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

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

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

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

3. Client eligibility for funding must be documented in the case record. The agency must complete the MCCMH-SUD Fee Agreement Form

for each Community Grant, HMP, MI Health Link and Medicaid funded client. The Fee Agreement Form must be signed by the contract agency, as well as by the client, at the time of admission, for any subsequent change in insurance and/or co-pay amount and updated at least every 90 days. *(See attachments for MCOSA Fee Agreement Form and Instructions.)*

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

5. Reimbursement services must be documented within forty-eight (48) hours of rendering the service, in accordance with the Department of Licensing and Regulatory Affairs (LARA) licensing requirements and MCCMH-SUD QA Guidelines. Reimbursable units of service are:

   a. Bed days for residential, withdrawal management, and recovery home service.
   b. Chair days for intensive outpatient service.
   c. Outpatient services including individual treatment, group treatment, didactic group presentations, opioid health home core services, case management, peer support services, psychiatric evaluation, medication review(s), medication doses, and Medication Assisted Treatment laboratory/urinalysis services as specified by contract.

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

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

the individual must describe how they support themselves, including money from relatives, friends, etc.

8. Providers are required to verify eligibility for Macomb County HMP, Medicaid or MI Health Link funded services. Contract providers can verify coverage through the MCCMH-SUD data system or through the State's CHAMPS system. Clients are required to provide verification of their current Macomb County residence. If the address on HMP/Medicaid account is not a Macomb County address, the client should be assisted in contacting the PIHP that has financial responsibility. As a reminder, recovery housing cannot be used to establish residency. Agencies should be looking at the last independent address the client had. *(See MCOSA Data Instructions for additional information regarding verification of HMP/Medicaid/MI Health Link eligibility, including the requirement that all Community Grant funded recipients' eligibility be checked for HMP/Medicaid in the State's eligibility system prior to applying Community Grant funds).*

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

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

10. Block Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . .

requirements."); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana). Funds cannot be used to purchase needles for client use or pay for hospital-based treatment.

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

C. ELECTRONIC DATA SYSTEM: FOCUS

1. **MCCMH-SUD FOCUS USER POLICY**: Users of the Macomb County Community Mental Health (MCCMH) FOCUS Data System (FOCUS) must comply with the Focus User Agreement as presented when assigned an account.

   FOCUS is an extension of the client's clinical record. The system contains confidential client information that is protected by State and Federal regulations. It is the responsibility of the provider to establish and enforce written policies and procedures related to use of FOCUS. These policies and procedures must ensure access only by those individuals who are informed of, and agree to abide by, the confidentiality regulations, and have been authorized by MCCMH-SUD to access the system. The protections offered by State and Federal regulations cannot be guaranteed if the system is compromised by access from non-authorized individuals or accessed at locations that are not approved, supervised or controlled by the agency. Unauthorized attempts to access, obtain, alter, damage, or destroy information, or otherwise to interfere with the FOCUS system or its operation are prohibited by *MCCMH.* It is the *MCCMH* policy that staff may access 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 the staff's agency position may result in an appropriate disciplinary action.

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

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

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

2. **ADMISSION DUE DATES**: For the purposes of these instructions, days are considered in terms of calendar days. If the due date falls on a weekend or holiday, the due date is moved to the next business day.

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

   a. **Withdrawal Management, Residential & IOP** Admissions and related Demographic, Payer, Financial and Admission Appointment records must be entered into FOCUS within one business day. Eligibility must be run in the electronic FOCUS record.
   b. **Outpatient including Opioid Health Homes** Admissions and related Demographic, Payer, Financial and Admission Appointment records must be entered into FOCUS within seven days or prior to the next appointment after intake, whichever is sooner. Eligibility must be run in the electronic FOCUS record.

3. **DISCHARGE DUE DATES**: For the purposes of these instructions, days are considered in terms of calendar days. If the due date falls on a weekend or holiday, the due date is moved to the next business day.

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

   Any client not seen or heard from for a period of 30 calendar days is to be considered discharged, for purposes of FOCUS and MCCMH-SUD funding. A provider should complete the Discharge record using

the last date of face-to-face contact with the client as the Discharge date. Clients enrolled in Opioid Health Home programming that have not been seen nor heard from should only be discharged after completing three (3) outreach attempts over the course of three (3) consecutive months.

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

4. **INITIAL AUTHORIZATION REQUESTS**: Withdrawal Management, Residential and IOP must be entered within one day. Managed Care Operations will process these requests within one day of receipt and return them to the provider electronically as approved or denied. Opioid Health Home authorizations must be entered within seven (7) days, or by the next OHH encounter, whichever is sooner.

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

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

Extenuating circumstances such as the provider's loss of Internet access, FOCUS problems or telephone/equipment failure, resulting in the delay of admission and/or authorization request entry must be conveyed to MCCMH-SUD's Director.
Extenuating circumstances such as retroactive eligibility and delayed receipt of third-party liability documentation must be conveyed in the Comments box of the Authorization request, and admission, if applicable. E-mail all related documentation (IE, third- ..party

rejection notice) to MCCMH-SUD's billing staff or to mcosa@mccmh.net.

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

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

D. ADMISSION EXCLUSION POLICY FOR ALL TREATMENT MODALITIES

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

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

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

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

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

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

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

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

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

SERVICES REQUIRING PRIOR AUTHORIZATION

MCCMH-SUD funded intensive services, including withdrawal management, residential treatment, Intensive Outpatient Treatment, Opioid Health Home services, and Recovery Home Services require prior authorization by Managed Care Operations (MCO).

SPECIALTY SERVICE CRITERIA

Managed Care Operations (MCO)

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

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

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

4. The AMS uses a standard screening tool which incorporates information to identify a diagnostic impression and current treatment needs. The MCCMH-SUD Quality Assurance Guidelines and the American Society of Addiction Medicine's Criteria, Medicaid Provider Manual and Medical Necessity Criteria are used to make a final determination regarding placement for individuals seeking prior authorization for funded intensive services.

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

Opioid Health Home (OHH) Services

OHH providers integrate comprehensive care management and coordination services to eligible beneficiaries with an opioid use disorder diagnosis. For enrolled beneficiaries, the OHH will function as the central point of contact for directing patient-centered care across the broader health care system. OHH providers must comply with requirements outlined in the MDHHS Opioid Health Home Handbook in addition to applicable standards for outpatient standards listed within the MCCMH – SUD provider handbook. Beneficiaries will work with an interdisciplinary team of providers to develop a person-centered health action plan to best manage their care. Participation is voluntary and enrolled beneficiaries may opt-out at any time. The OHH program will work to: 1) improve care management of beneficiaries with opioid use disorder; 2) improve care coordination between physical and behavioral health care services; and 3) improve care transitions between primary, specialty, and inpatient settings of care. Services will be provided in accordance with the Care Plan, but at least monthly. All new OHH enrollees are to receive at least three (3) OHH encounters within the first 30 days upon enrollment.

Recovery Home Services

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

1. Admission to a recovery house requires the individual has completed or does not need medical or Withdrawal Management, is currently enrolled in a MCCMH-SUD funded treatment service and is/will be participating in a MCCMH-SUD ambulatory treatment service while residing in the home. If the individual has a medical or psychiatric condition it will not interfere with the ability to function in a supervised supportive environment. The individual must be in the active stage of change, motivated for recovery, and willing to participate in weekly recovery meetings; and;

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

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

Significant Other Services

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

Relapse Prevention Services

To qualify for Relapse Prevention Services, there must be documentation of current environmental, social, familial, judicial, or other stressors that place the client at risk for relapse. Relapse prevention services will receive funding for a three (3) month period. The individual must not otherwise be eligible for mental health services or receiving treatment services elsewhere. Psychiatric evaluation and medication services are excluded from authorization.

Early Intervention Services

1. Referrals for at-risk youth are made from area middle and high school

districts to the Adolescent Outreach Program (AOP). AOP reduces barriers to access and provides services in the school setting to the highest risk youths.

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

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

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

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

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

Peer Recovery Services

Peer Recovery Services referrals can be made by Managed Care Operations at time of screening and/or by any contracted network provider throughout the episode of care. Contract providers complete a Peer Referral Request form and send it to CARE of Southeastern Michigan; documentation of the referral should be included in the clinical record. Clients can also self-refer by contacting CARE and requesting a peer recovery coach.

1. The Peer Recovery Program reviews each referral and assigns a Peer Recovery Coach to the individual based on the specific needs of the individual.

2. The Peer Recovery Coach will contact the individual within one (1) business day of the receipt of the referral.

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

4. Peer Recovery Coach completes a Recovery Plan.

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

6. All clients will receive at least two (2) recovery services per month while enrolled in the PRC program.

7. If a client has not participated in peer recovery services in 30 days the case should be closed in FOCUS.

IV. CONTINUED STAY, DISCHARGE AND READMISSION

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

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

Children or adolescents admitted under the early intervention criteria, may have additional treatment authorized with documentation of the progress attained and rational for reauthorization beyond three months when extenuating circumstances exist (e.g., deterioration in home environment, return to past peer contacts) if still meeting ASAM Criteria for this level of care. Otherwise, clients needing a higher level of care, such as Outpatient treatment, should be referred to office/clinic based treatment provider.

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

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

REAUTHORIZATION FOR CONTINUED STAY

A reauthorization request must be submitted in the MCCMH-SUD data system indicating the rationale for continued stay beyond the initially authorized request (see MCOSA Data Instructions).

Requests for extension of services must be submitted on a Reauthorization Request form via the MCCMH-SUD data system in sufficient time for MCO to review and respond prior to the scheduled client discharge (three (3) business days). Reasons for extended length of stay must be clearly documented in the clinical record, including need and rationale for extension and documentation that the client meets ASAM Criteria for the requested level of care.

Continuation of Withdrawal Management: Average length of stay for Withdrawal Management is up to five (5) days. When detoxification cannot be completed within that time, the Medical Director must document a need for continued stay with rationale for each 24 hours beyond the 72-hour period. Utilization reviews by program medical and clinical staff are required for all cases where length of stay exceeds five (5) days.

READMISSION PROCEDURES

1. Each case of repeated admission (generally within the previous six-month period of time) to a contract program must include a readmission summary/admission update. The summary must include the following: analysis of previous goals and objectives, narrative explanation of the reasons for leaving previous treatment, the course and outcome of the previous treatment, and reason for seeking readmission. The summary may be included in a standard intake assessment procedure. A readmission summary/admission update cannot be completed on a previous readmission summary. In this instance, a complete assessment must be conducted.

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

3. This readmission policy does not apply to detoxification/withdrawal management services.

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

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

E. INTRA-AGENCY TRANSFER PROCEDURES

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

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

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

V. CLINICAL DOCUMENTATION PROTOCOL

A. CLINICAL ASSESSMENTS

All Assessments must utilize the current MDHHS approved assessment tool (ASAM Continuum, GAIN). A copy of the assessment summary must be contained in the client FOCUS record.

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

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

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

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

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

Dimension 5: Relapse/Continued Use Potential:

- Substance use assessment
- Recreational assessment
- Vocational assessment

Dimension 6: Recovery Environment:

- Substance use assessment
- Current family assessment
- Social assessment
- Cultural assessment
- Vocational/Educational assessment
- Recreational assessment
- Spiritual assessment; outside supports

1. The Intake Assessment Process

   a. The ASAM Continuum/GAIN Assessment must be placed in the client's file before treatment commences, or within three (3) working days of the intake date, whichever occurs first.
   b. During instances when a client transfers from one treatment provider to another without a treatment gap, the new treatment provider is required to obtain the most recent assessment tool, and complete an individual session to review the assessment, complete an interpretive summary, and document ASAM Dimensions and Level of Care. If previous ASAM Continuum/GAIN assessment is not provided by the previous provider before initiation of services, all efforts to obtain the previous ASAM Continuum/GAIN assessment must be documented in clinical record.
   c. A new ASAM Continuum/GAIN Assessment must be completed when a client has left all treatment for over forty-five (45) days and then returns to services.
   d. Should the client be unable to complete the ASAM Continuum due to withdrawal symptoms, clinical staff must document attempts to complete assessment and reason it could not be completed i.e. client's symptomology. Attempts must be made daily to complete the assessment. Assessment must be completed prior to discharge from this level of care.

3. Accompanying Intake Documents

   a. A consent for treatment for the providing agency must be included in the client chart with the client signature.

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

c. Each chart must include documentation regarding a clients' Primary Care Physician and care coordination activities.

B. INDIVIDUALIZED TREATMENT PLANNING

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

1. Initial Treatment Plan

a. An Initial Treatment Plan including goals, objectives, and time frames must be in the client's file upon completion of the clinical assessment or within three (3) working days of the intake date, but prior to the beginning of treatment.

b. No treatment regimen may begin without at least an Initial Treatment Plan.

c. The Initial Treatment Plan is individualized and specifies needed services and/or referrals to ancillary services, as indicated in the initial assessment.

d. The client participates in the formulation of the Initial Treatment Plan, as indicated by a client signature demonstrating agreement with the written plan.

e. Each treatment plan has goals that are individualized and written in the language of the person served.

f. Each treatment goal has objectives that are measurable and contain specific intervention methods/techniques that include the date of expected achievement.

g. Each treatment goal has at least two (2) objectives.

2. Master Treatment Plan

a. The Master Treatment Plan including goals, objectives, and timeframes must be fully developed and in the clients file by the third (3rd) treatment session, or thirty (30) calendar days after intake, whichever comes first.

b. The Master Treatment Plan is individualized and specifies needed services and/or referrals as indicated in the initial and comprehensive assessments.

c. The client participates in the formulation of the Master Treatment Plan, as indicated by a client signature demonstrating agreement with the written plan.

d. Each treatment plan has goals that are individualized and written in the language of the person served.

e. Each treatment goal has objectives that are measurable and contain specific intervention methods/techniques that include the date of expected achievement.

f. Each treatment goal has at least two (2) objectives.

g. Should the client have a goal of abstinence, there must be an objective to measure abstinence included in the treatment plan.

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

3. Opioid Health Home Care Plan

a. Each individual enrolled in the Opioid Health Home program must have completed an OHH care plan within thirty (30) days of enrollment into the program.

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

c. The completed OHH care plan, or master treatment plan with incorporated OHH goals, must be uploaded to the Waiver Support Application (WSA) within 30 days of enrollment.

4. Treatment Plan and OHH Care Plan Update

a. The treatment plan must be formally evaluated as changes occur in the client’s condition, or at a minimum of every 90 calendar days.

b. The treatment plan update process identifies progress toward goals and objectives from the treatment plan. Identification of goals achieved, deferred, or continued, and

subsequent updating of the Master Treatment Plan is to be completed at this time.

c. The treatment plan update includes new goals and objectives, as appropriate.

d. The treatment plan update is reviewed and approved by a licensed or certified clinical professional as evidenced by a signature with the approved credentials.

e. The client participates in all treatment plan updates as evidenced by the client's input and signature.

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

C. PROGRESS NOTES

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

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

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

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

4. When substance use during treatment is addressed, quantitative documentation is required to be documented in the chart. For

example, the results of the urinalysis, breathalyzer, dates of last use/relapse, etc.

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

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

7. Group notes must include date, start/stop time, type of group, clinician signature with credentials, date signed, topic(s) covered, clients input during the group and number of clients who attended the group (therapeutic groups should have a maximum of 20 clients). Group notes must be placed in the client's file no later than forty-eight (48) hours after the end time of that treatment session.

D. AFTERCARE

1. An aftercare plan is developed with the input of the client to address continuing care needs with regards to transferring to another treatment program and/or providing medical, psychological, legal, and community support services. Aftercare planning should start at the beginning of the treatment episode for those in withdrawal management or residential treatment as there may be delays in making referrals or securing appointments.

2. The program, as part of case management activity, is required to follow-up with all referrals to other treatment programs to determine whether the client has contacted the new program. Additionally, the program is required to maintain compliance with 42 C.F.R. and 45

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

E. DISCHARGE

1. If there has been no client contact for thirty (30) days, despite outreach attempts (phone calls, letters sent, etc.), then the record is required to be discharged from the MCCMH-SUD system. Exceptions to this guideline would need to be clearly documented in the record, e.g., client called away on a family emergency.

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

3. The discharge summary includes the following elements:

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

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

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

VI. QUALITY ASSURANCE AUDIT AND RECORD REVIEW

A. QUALITY ASSURANCE (QA) AUDIT COMPLIANCE PROCESS

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

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

Authorization must be made by the Program Director, Clinical Director, or other approved designee. MCCMH-SUD cannot retroactively reimburse cases where a Fee Agreement is missing or is not authorized by the program, if identified on a QA Audit or Services Verification Review. All Medication Assisted Recovery clients must have documentation of medication reviews occurring within 30, 60 and 90 days of treatment and every 90 days thereafter. These reviews will include: a review of the recipient's service plan, a review of the counseling services progress notes and drug tests, a review of documentation of medical necessity for continued treatment in the program, and a review of any recommended adjustments to the service plan. All outpatient level treatment providers will utilize urine drug screens (UDS) as a therapeutic tool as indicated in the clients individualized treatment plan.

1. Case Record Audit Compliance

   a. Case record audit compliance is defined as the percentage of the applicable standards that have been met on each of the cases sampled for the review. (Refer to attachments for MCCMH-SUD QA Evaluation Form.)
   b. A case record with a quality score of below 90% may result in comments and/or specific recommendations by MCCMH-SUD on the Evaluation Form and/or in the narrative report.
   c. A case record with a quality score of 75% or lower may result in denial of funding for the entire case in question.
   d. A record selected for full review that is found not to meet the MCCMH-SUD criteria for admission (refer to QA Guidelines, Section VI), is ineligible and automatically denied funding. These cases are excluded from further review. Another case may be selected for full review as a replacement.
   e. When funding is denied as a result of incomplete or insufficient documentation or based on audit findings, the program is held financially responsible for all services rendered and not MCCMH-SUD nor the client. Once the documentation is corrected, MCCMH-SUD may consider resuming funding from the date on which it was corrected (refer to the QA Audit Appeals section).
   f. Under circumstances in which a case qualifies for funding but is denied due to deficiencies in the documentation and a Service End Date/Lapse Date has been set, the program retains the responsibility for providing treatment to the individual as clinically indicated. A Service End Date/Lapse Date is the day on which MCCMH-SUD funding ceases and is not to be construed as the date the client must be discharged from the program (refer to section VIII-D, regarding Discharge Procedures).

2. Agency Audit Compliance

   The Quality scores for the individual case records reviewed are averaged to provide the agency's Audit Compliance Quality Score.
   a. An average compliance rate of 85% or higher is expected for each contract program.
   b. An overall quality score of below 90% may result in comments and/or specific recommendations by MCCMH-SUD on the Evaluation Form and/or in the narrative report.

c. A noncompliance Quality Audit Score of 80% or below will result in one of the following:
   i. Submission of a Corrective Action Plan, and/or;
   ii. Financial payback.

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

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

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

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

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

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

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

6. MCCMH-SUD cannot reimburse for any Block Grant funded client without verification of income included in the chart. Treatment

providers must have documentation that the client meets Block Grant eligibility guidelines as outlined in the Sliding Fee Schedule.

C. QA AUDIT REVIEW PROCEDURES FOR RESIDENTIAL AND INTENSIVE OUTPATIENT

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

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

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

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

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

6. MCCMH-SUD cannot reimburse for any Block Grant funded client without verification of income included in the chart. Treatment

providers must have documentation that the client meets Block Grant eligibility guidelines as outlined in the Sliding Fee Schedule.

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

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

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

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

D. PROGRAM REVIEW FEEDBACK PROCEDURES

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

1. Approval and Denial Parameters for Treatment Cases – The QA Audit report includes a narrative summary of the audit results, including areas of improvement and/or areas found not to be in

compliance with QA or contract requirements. A copy of the Evaluation Form is included for each case reviewed during the audit period. Cases requiring financial adjustments are noted on the individual Evaluation Forms, on a separate Financial Adjustment Form, and on the QA Audit Report.

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

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

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

VII. MCCMH-SUD QA AUDIT AND SERVICES VERIFICATION REVIEW APPEAL PROCESS

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

B. Appeals may be submitted from the annual Financial Service Verification Review of the records which compares documentation in the record against billings submitted for a particular audit period. A separate

narrative report and review form is forwarded to the program identifying the percentage of errors and/or irregularities, if any are noted.

C. Appeals Process – Three Levels

1. The first level requires the submission of an appeal by the agency to the MCCMH-SUD QA Coordinator or Medicaid Verification Audit Reviewer.
2. The second level involves an appeal to the MCCMH-SUD Administrator or Finance Administrator. The second level appeal occurs when the agency disagrees with the first level appeal decision made by the QA Coordinator or Medicaid Verification Audit Reviewer.
3. The third level appeal is made to the MCCMH-SUD Director, whose decision is final, when the agency disagrees with the decision of the SUD Administrator.

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

E. The Contract Program Director or Clinical Supervisor has five (5) working days after receipt of the Service Verification Review report to submit a MCCMH-SUD Level One written appeal to the MCCMH-SUD Finance Team.

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

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

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

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

VIII. GRIEVANCE, LOCAL APPEAL AND FAIR HEARING PROCEDURES

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

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

IX. COMMUNICABLE DISEASE POLICY AND GUIDELINES

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

It is required by the Department that individuals contracted by MCCMH-SUD to provide substance use disorder services, either prevention or treatment, demonstrate the minimum knowledge requirements related to HIV/AIDS and

Substance Use Disorder. If unable to demonstrate the minimum knowledge requirement, they must do so within six months of hire or of agency approval to provide substance use disorder treatment within the organization (e.g., via Staff Credentialing or Professional Service Agreements).

A. DOCUMENTATION

1. Identification of a client's HIV/AIDS status in the case record must comply with the MDCH Public Health Guidelines and 42 CFR and 45 CFR, Parts 160 and 164.

2. The information regarding an individual's risk status for communicable diseases is documented in the case record on a Communicable Diseases Risk Screen.

3. The agency documents on the Communicable Disease Risk Screen any written and/or verbal instructions that have been provided to the client about the transmission of HIV/AIDS, STDs, Hepatitis, or TB.

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

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

B. RISK SCREEN GUIDELINES

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

    a. The individual engages in unprotected sexual interaction with a partner or partners where the health status is unknown.
    b. The individual engages in unprotected sexual interaction with a partner or partners where the HIV/AIDS, STD or Hepatitis status is known to be positive.
    c. The individual has used needles or shared injecting needles.

d. The individual has experienced blood-to-blood or body fluid contact, i.e., blood transfusions, hemophilia treatments, employment in the medical field, etc.

e. The individual is a child whose mother was known to have been an HIV high-risk candidate and in which exposure could have occurred in utero, during delivery, or as a product of breast feeding.

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

   a. The individual is currently or has recently lived in a substance use disorder residential treatment facility, half-way house, homeless shelter, drug house, jail/prison, mental hospital, or in close quarters with persons of unknown health status, such as migrant housing.
   b. Was born in or recently traveled to a region with a high rate of TB, e.g., Asia, Latin America, Africa, and India.
   c. Has recently had close contact with someone diagnosed as having TB.
   d. The individual has a chronic cough and one or more of the following symptoms: weight loss, fever for three days or longer, night sweats, or coughs up blood.
   e. The individual has tested positive for HIV or has been diagnosed with AIDS.

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

X. GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)

It is the policy of MCCMH-SUD that contract agencies receiving payments from federal grant funding comply with any and all GPRA requirements. This includes completing intake, discharge and six-month follow-up interviews with all clients receiving services funded with federal grant monies.

A. DOCUMENTATION

1. Clients receiving services funded by federal grants must have documentation in their chart identifying that they are grant funded and have the appropriate insurance policy entered into FOCUS at the time of admission.

2. Clients must have documentation in their chart that the intake and discharge GPRA were completed.

B. PROCEDURES

1. The Agency must collect multiple forms of contact from each client including alternate phone numbers, emergency contacts, etc. to assist with completion of six-month follow-up GPRA.
2. The Agency will utilize the updated BPHASA 5515 release of information form that extends the validity of the release to nine months post discharge.

3. The Agency must utilize a tracking system to ensure timely completion of the six-month follow-up GPRA as well as their outreach efforts to get the six-month follow-up GPRA completed.

4. Outreach should continue over the entire window of eligibility for the six-month follow-up GPRA.

5. The Agency will submit billing to MCCMH-SUD upon the completion of GPRA interviews only. Reimbursement is not provided for outreach attempts. GPRA billing forms along with the completed GPRA should be e-mailed to MCOSAgrants@mccmh.net.

6. Gift cards in the amount of $30 must be purchased and offered as an incentive to clients for participating in the six-month follow-up GPRA interview. Reimbursement for gift cards should also be billed to MCCMH-SUD.

7. The Agency must ensure that at least one staff member is trained on GPRA requirements, interviews, documentation, and reporting received by Wayne State University.

8. Prior to entering any six-month follow-up GPRA as anything other than “complete”, the AGENCY will contact the SOR Coordinator to plan for outreach efforts.