NorthCare Network

Substance Use Disorder Services Operations Manual

Website: www.northcarenetwork.org

FY25: 10/1/2024 – 9/30/2025

10/1/2024 – 9/30/2025

NorthCare Network

NorthCare Network is the regional Prepaid Inpatient Health Plan (PIHP) for the Upper Peninsula of Michigan. Under contract with the Michigan Department of Health and Human Services (MDHHS) NorthCare Network operates at the Specialty Prepaid Inpatient Health Plan (PIHP) for persons enrolled in Medicaid living in any of the 15 counties in Michigan's Upper Peninsula. NorthCare partners with local Substance Use Disorder Providers, the five Community Mental Health Service providers (CMHSPs) to ensure the delivery of a comprehensive array of specialty mental health and substance use disorder services and supports for adults with serious mental illnesses (SMI), children and adolescents with serious emotional disturbances (SED), persons with intellectual/development disabilities (I/DD), and persons with substance use disorders (SUD). In addition, NorthCare manages the SUD Block Grants and PA2 Liquor Tax Funds for the region.

NorthCare's efforts are framed by the core values of providing services that foster consumer inclusion, trauma informed, recovery, independence, and freedom in the community. Care will be coordinated to include both physical health as well as behavioral health goals and consideration will be given to other social determinants of health. NorthCare will hold true to its mission to be accountable stewards of public funds.

Mission, Vision, and Values

Mission

NorthCare network ensures that every eligible recipient receives quality specialty mental health and substance use disorder services and support through the responsible management or regional resources.

Vision

NorthCare Network envisions a full range of accessible, efficient, effective, and integrated quality behavioral health services and community-based supports for residents of Michigan's Upper Peninsula.

Values

- We believe in respect, consumer empowerment, person centered care, self-determination, full community participation, recovery, and culture of gentleness.
- We also endorse effective, efficient community-based systems of care based on the ready availability of competent workforce and evidence-based practices.
- We believe in services that are accessible, accountable, value-based, and trauma informed.
- We support full compliance with state, federal and contract requirements, and responsible stewardship.
- The right care, at the right time, for the right cost, and with the right outcome.

Welcome

We are pleased to provide you with the NorthCare Network SUD Operations Manual. This manual, along with NorthCare Polices, Procedures, and Plans, contains core information necessary to fulfill obligations as a provider preventing substance use disorders, treating substance use disorders, or providing support to individuals in recovery with a substance use disorder for residents across the Upper Peninsula of Michigan. All Network Providers are required to review these at our website, www.northcarenetwork.org.

Purpose

The purpose of this Operations Manual is to outline the basic framework for the NorthCare Network Substance Use Disorder (SUD) service process. While every attempt has been made to be as clear and accurate as possible, omissions, ambiguities, and other imperfections may exist. In the event an error is discovered or a policy/procedure changes, contracted Providers will be notified in writing via email. The NorthCare Network Substance Use Disorder Services Operation Manual is incorporated by reference as part of the Provider Contract. As updates, clarifications, and changes are made to the MDHHS/PIHP Contracts or the Medicaid Provider Manual, this Substance use Disorder operations Manual will also be updated.

NorthCare Network Responsibilities

NorthCare Network is responsible for the operation of the 1115 Behavioral Health Demonstration Waiver, the healthy Michigan Plan, and SUD Community Grant Programs, and relevant approved Waivers within its designated service area and to ensure a comprehensive array of specialty mental health and substance abuse services and supports are available.

NorthCare Network is organized around the essential administrative functions of a PIHP. These functions support the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of the MDHHS/PIHP Contract. These seven functions are:

- Access Assurance
- Customer Services
- Financial Management
- Management Information Systems
- Organizational Structure
- Provider Network Services
- Quality Assessment & Performance Improvement
- Program Integrity
- Service & Utilization Management

NorthCare Network Hours of Operation

Regular office hours are 8:00 a.m. until 5:00 p.m., EST, Monday through Friday (holidays excluded). The NorthCare Substance Use Disorder (SUD) Access Center is available during this time.

The NorthCare Network after-hour answering service is "Protocall." Trained staff will answer the NorthCare SUD line and calls with be managed appropriately based on request and necessity.

NorthCare Network Organization

Refer to the NorthCare Network Organizational Chart for a complete list of staff. For assistance, email inquiries can be sent to pnm@northcarenetwork.org or by calling the SUD Access Center number at (800) 305-6564 or (906) 225-7222.

NorthCare Network Board Members

NorthCare Network's Governing Board and SUD Policy Board members and meeting information can be found on our website.

List of NorthCare Network Contracted Providers

Refer to the NorthCare Network website for the current listing of Providers. (Providers – northcarenetwork.org)

Notification of the NorthCare Network SUD Operations Manual Updates

Each Network Provider will be emailed with notification of any new or revised policy, procedure or plan and are responsible for informing appropriate staff within your organization. We ask that you update your contact information with NorthCare Network's Provider Network Specialist as needed, to ensure proper timely notice is received by your organization. By emailing pnm@northcarenetwork.org or phone (906) 205-2838.

General Information

Privacy

Protecting client health information is particularly important. The Federal Government has issued a set of regulations to guide the medical community in this area. Network Providers shall preserve the confidentiality of Protected Health Information (PHI). All information (oral, written, or electronic) in and regarding the clinical record or obtained in the course of providing services is confidential. In the used and disclosure of PHI, Network Providers are to comply with all legal, ethical, and applicable accreditation standards. PHI may be used or disclosed for treatment, payment and coordination of care activities per the Michigan Mental Health Code and NorthCare policy, unless it is protected under 42 CFR, Part 2 relative to substance abuse services, or HIPAA. Consumer identifying and confidential information shall not be released without an appropriately signed Consent to Share Behavioral Health Information or official judge's court order. Network Providers shall have written policies and procedures to comply with HIPAA, 42 CFR Part 2, the Michigan Mental Health Code and NorthCare Network Policies. Individuals needing access to an individual's medical record must do so only in the course of assigned duties and responsibilities. All individuals must follow the standards of "minimum necessary" and "need to know" for any and all access to protected health information.

Notice of Privacy Practice

The notice of privacy practices must be given to all NorthCare Network funded recipients of SUD treatment and recovery support services. The notice of privacy will describe the rights a client has about their medical record and services. The client has a right to inspect and copy their records; the right to request an amendment to their record; the right to a list of the disclosures and the right to inspect the information used or disclosed; and the right to request confidential communication with their health providers.

Consent

Confidentiality is expected to be maintained in accordance with Federal law and regulations (42 CFR Part 2). In keeping with this, appropriate written consent must be obtained from a client for NorthCare Network Substance use Disorder Services and Providers to share information.

MDHHS-5515 is used to begin the referral process in ELMER. Once the MDHHS-5515 form is properly completed and submitted via fax to NorthCare Network (248) 406-1286, a referral is generated to begin the Admission process.

The MDHHS-5515 consent is in effect, unless otherwise noted or revoked by the client, per the time indicated on the MDHHS-5515 (one-year from the client's signature unless otherwise documented on the consent). Exceptions permitting limited disclosures without written consent are as follows:

- Internal Communications

- De-identified disclosures
- Qualified Service Organization Agreements (QSOAs)
- Medical Emergency
- Research
- Audit & Evaluation
- Official Judge's Court Order
- Patient Threat/Crime on program premises or against program personnel
- Reporting Suspected Child Abuse and Neglect
- To public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule (45 CFR Section 164.514(a)).

Michigan Public Health Code, MCL 330.1265 Sec. 265 (1), indicates a program that is requested by a minor's parent or a person in loco parentis to a minor to perform substance use disorder treatment and rehabilitation services for the minor may perform those services for the minor without the minor's consent *if the minor is less than 14 years of age*, as verified by the minor's parents or person acting in loco parentis, and if request is made in writing.

The 42 CFR Part 2 final rule "requires that each disclosure made with patient consent include a copy of the consent or a clear explanation of the scope of the consent." Each disclosure for individuals receiving SUD services and made with the individual's consent must be accompanied by a re-disclosure statement that reads:

> "This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65."

Click here for the MDHHS-5515 form.

Americans with Disabilities Act

All contractors must comply with applicable provisions of the Americans with Disabilities Act (the ADA). Further information may be found at: *Nondiscrimination on the Basis of Disability in State and Local Government Services*: United States Code of Federal Regulation, Title 28, Part 35, Washington, D.C. (1991).

LEP – Limited English Proficient

Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited to English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type or service, benefit, or encounter. The following website may be helpful: www.LanguageLine.com.

Sign Language Interpreter

Signing Pros, LLC - Michigan's Premier American Sign Language Interpreting Agency (signingprosllc.com). To schedule a sign language interpreter service, click this link: Request Interpreters - Michigan. Appointments requested within 48 hours will be billed at the Emergency Rate. Try your best to schedule appointments well in advance.

Compliance and Ethics

NorthCare Network's Compliance Program is designed to further NorthCare's commitment to comply with applicable laws, promote quality performance throughout the NorthCare Network, and maintain a working environment that promotes honesty, integrity and high ethical standards. NorthCare's Compliance Program is an integral part of NorthCare's mission, and all NorthCare Personnel, Member CMHSPs, contracted Providers and subcontracted Providers are expected to comply with all regulations related to health care. These include but are not limited to; the Michigan Mental Health Code, Michigan Medicaid Provider Manual, BBA, the ADA, and civil rights laws and regulations, including limited English proficiency regulations, and applicable accreditation standards. It is up to the Provider to be aware of the laws and regulations governing health care services but may at any time contact the NorthCare Network Compliance Officer with any questions. Network Providers are expected to have policies and practices in place that will assist in the education and prevention of fraud, waste, and abuse of public resources. Policies and practices shall also promote an open-door policy for reporting suspected or known fraud, waste, or abuse as well as whistleblower provisions and non-retaliation protections when reporting in good faith.

Recipient Rights

Substance use disorder recipient rights complaints are handled by NorthCare Regional Recipient Rights Consultant who can be reached via the NorthCare Customer Service number (888) 333-8030 or (906) 225-7254.

Medicaid Administrative Hearing Process

Please note NorthCare Network's Customer Handbook is located on NorthCare's website for information on the Medicaid Administrative Hearing Process.

12-month availability of services

Contract Providers must maintain service availability throughout the fiscal year for people who do not have the ability to pay.

Access Management

Access Management consists of responsibilities associated with determining administrative and clinical eligibility, managing resources (including demand, capacity, and access), ensuring compliance with funding eligibility and service requirements, and assuring quality of care. Activities to carry out these responsibilities include appropriate referral and linkage to other community resources. Services shall be provided in the amount, duration, frequency, and within the scope that is appropriate to reasonably achieve the desired treatment outcomes in the least restrictive level of care. This determination will be made using the following tools/clinical information as appropriate: NorthCare Brief Screening Tool, Medicaid Provider Manual medical necessity criteria, ASAM placement criteria, and DSM-V. Access requirements apply to all funding sources through NorthCare Network**.**

Target Population

While this varies somewhat according to funding source and priority status, the target population is generally comprised of Medicaid beneficiaries or individuals who are uninsured or underinsured and who meet the NorthCare sliding fee scale guidelines.

Screening Services

Individuals seeking outpatient services (with the exception of those individuals being referred by the Michigan Department of Corrections) would contact the treatment provider directly as there is no prior authorization requirement. SUD Providers are to complete a screening to determine appropriateness for treatment and NorthCare funding.

Information captured during the initial call and screening must be documented and kept in the client chart. Minimum required data fields include:

- Demographics
- Initial Contact Date
- Screening Date
- Referral Date
- First Offered Date
- Anticipated Admission Date
- Priority Population Status
- Insurance

Individuals seeking Withdrawal Management services may contact the treatment provider directly as there is no prior authorization requirement. If an individual does contact the NorthCare Access Center, NorthCare will provide information regarding available Withdrawal Management providers to the individual so they may make an informed decision as to their choice of providers. If a referral to Residential SUD services is also requested, a brief screening will be completed by NorthCare. SUD Providers are to complete a screening to determine

appropriateness for treatment at their facility, level of care offered, and NorthCare funding. If an individual's need exceeds what can be safely managed by the SUD Withdrawal Management provider, the SUD Provider must notify Northcare and make an appropriate referral (such as the Emergency Department, the individual's primary care physician or a different Withdrawal Management provider). The NorthCare SUD Access Center is available to assist with referring the individual to another SUD provider.

Information captured during the initial call and screening must be documented and kept in the client chart. Minimum required data fields include:

- Demographics
- Initial Contact Date
- Screening Date
- Referral Date
- First Offered Date
- Anticipated Admission Date
- Priority Population Status
- Insurance

Individuals seeking residential services must first call NorthCare Network's SUD Access Center to complete a pre-screen where the following information will be obtained:

- Priority population status
- Potential funding source
- Other insurance or benefit that may cover Substance Use Disorder treatment (Coordination of Benefits)
- Annual household income
- Current Community Mental Health Client
- Type of service requesting
- Treatment History (current and/or historical)
- Name, Phone number, Social Security Number, Date of Birth
- County of residence

After the pre-screen is completed, a brief-screening will be conducted with the client to determine the appropriate level of care (LOC) applying ASAM criteria. At the screening's conclusion, the screener will offer to make a 3-way call to a contracted Provider of the client's choice to set up an admission date to enter the determined Level of Care. The client must give the screener permission to make the 3-way call and to disclose the level of care that was determined by the screening to the provider chosen by the client.

Once NorthCare obtains an appropriate release of information and a referral has been approved and 'sent' to the provider, if the provider was the original referral the brief screening will be available to the SUD Provider listed.

Non-Substance Use Referral

If a client is found to not need substance use disorder services, based on results of the screening, staff will make the appropriate community referrals based on client need. An Adverse Benefit Determination (ABD) notice must be sent to clients who do not meet the ASAM or medical necessity criteria for admission to services. ABDs are available to SUD Providers for all NorthCare Consumers (Medicaid and Block Grant recipients) through the ELMER system.

Outside Screenings

NorthCare will accept qualified screenings from Project Rehab Hispanic Program and Monroe Harbor Light Deaf/Hard of Hearing programs as part of determining an appropriate LOC.

Screenings for Inmates

To ensure a timely screening for individuals who are at substantial risk for relapses and overdose, individuals requesting SUD services from a county jail may be screened prior to release when assisted by a designated person from within the Criminal Justice system, such as a probation officer or the jail mental health professional (MHP) if one is available. The Consent to Share Behavioral Health Information form (MDHHS-5515) is required. Once received and it is verified that it is appropriately completed, a pre-screening phone interview will occur with either the client, if available, or the authorized person on the release of information. Insurance and income information will be requested. A phone screening will then be scheduled. The probation officer or MHP must be available to ensure that the incarcerated individual is available for the phone screening with NorthCare. Additionally, the probation officer, or MHP will be responsible for communication with the treatment Provider and for ensuring that the incarcerated individual has appropriate transportation to treatment when a treatment bed becomes available. Residential placement is not a guarantee, and Providers do not hold beds. The client must be available for treatment when the appropriate placement is determined.

Priority Populations Criteria and Requirements

In accordance with SAPT Federal Block Grant regulations at CFR 96.131 and Sec 6232 of Public Act 368 of 1978, as amended, and per Medicaid Manual Bulletin (04-03) admission priorities are delivered in accordance with Federal and State Standards.

Priority One – Pregnant, injecting drug user

Priority Two – Pregnant substance use disorders

Priority Three – Injecting drug user

Priority Four – Parent at risk of losing their child(ren) due to their Substance Use (Open CPS case)

Priority Five – Individual under supervision of the Michigan Department of Corrections (MDOC) and referred by MDOC OR an individual being released directly from a MDOC facility without supervision and referred by MDOC. Excludes individuals referred by court and services through local community corrections (PA 511 funded) systems.

Priority Six – all others

Access Timeliness Standards

The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are *italics.* Screened and referred applies to intensive services and methadone. When a client calls an outpatient Provider for services, the Provider must follow the admission guidelines, not the screened and referred requirements. If a client calls an outpatient provider and requests intensive services or methadone, they must then be referred to NorthCare for further services.

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1) Screened and referred within **24 hours**. 2) Detoxification, Methadone, or Residential – Offer admission within **24 business hours**. Other Levels or Care – Offer admission within **48 business hours**.	*Begin within **48 hours**:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for prenatal care. *3. Early intervention clinical services.*	CFR 96.121; CFR 96.131; Tx Policy #04 Recommended
Pregnant Substance User	1) Screened and referred within **24 hours**. 2) Detoxification, Methadone, or Residential – Offer admission within **24 business hours**. Other Levels or Care – Offer admission within **48 business hours**.	*Begin within **48 hours**:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for prenatal care. *3. Early intervention clinical services.*	CFR 96.121; CFR 96.131;

Population	Admission Requirement	Interim Service Requirement	Authority
			Recommended
Injecting Drug User	Screened and referred within **24 hours**. Offer admission within **14 days**.	*Begin within **48 hours** – maximum waiting time **120 days**:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. *2. Early intervention clinical services.*	CFR 96.121; CFR 96.126; Recommended
Parent at Risk of Losing Children	Screened and referred within **24 hours**. Offer admission within **14 days**.	*Begin within **48 business hours**:* *Early intervention clinical services.*	MI Public Health Code Sec. 6232 Recommended
Population	**Admission Requirement**	**Interim Service Requirement**	**Authority**
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from MDOC Without Super-vision and Referred by MDOC	Screened and referred **within 24 hours.** Offer admission within **14 days**.	*Not required* ~~*Begin within **48 business hours.***~~ ~~Recovery Coach Services~~ ~~*Early intervention clinical services.*~~	MDHHS & PIHP Contract Recommended
All Others	Screened and referred within **7 calendar days**. Capacity to offer admission within **14 days**.	Not required.	CFR 96.131(a) – sets the order of priority. MDHHS & PIHP contract

Eligibility Criteria

Treatment Services

Treatment services must meet Medical Necessity criteria including the following:

- American Society of Addiction Medicine (ASAM) Patient Placement Criteria
    - Clients Seeking services must meet the criteria of the level of care per the current version of the ASAM Patient Placement Criteria.
- DSM diagnostic criteria (DSM 5)
    - To be eligible for treatment services purchased in whole or part by state-administered funds, an individual must be found to meet the criteria for one or more selected substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). This requirement is not intended to prohibit the use of these funds for family therapy. It is recognized that people receiving family therapy do not necessarily have substance use disorders.
- NorthCare funding eligibility criteria., and
    - NorthCare Network manages two main funding streams for Substance Use Disorder service coverage. These include a Community Block Grant and Medicaid. Medicaid coverage is managed by the Michigan Department of Health and Human Services (MDHHS). Community Block Grant coverage is at the discretion of each PIHP.

      It is always the responsibility of the SUD provider to ensure that a client who is eligible for BG funding also completes and submits an application for Medicaid to the MDHHS. Insurance and income verification begins with the first contact a provider has with the client (this would generally be during the pre-screen process) and at every service contact with the client, thereafter.
- Medical Necessity criteria
    - Necessary for screening and assessing the presence of substance use disorder; and/or
    - Required to identify and evaluate a substance use disorder; and/or
    - Intended to treat, ameliorate, diminish, or stabilize the symptoms of a substance use disorder; and/or
    - Expected to arrest or delay the progression of a substance use disorder; and/or
    - Designed to assist the individual to attain or maintain a sufficient level of functioning to achieve his/her goals of community inclusion and participation, independence, recovery, or productivity.

Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the individual, individual's family, and/or other individuals (e.g., friends, personal assistants/aide) who know the individual; and
- Based on clinical information from the individual's primary care physician or clinicians with relevant qualifications who have evaluated the individual; and
- Based on individualized treatment planning; and
- Made appropriately trained substance use disorder professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and
- Document in the individual plan of service.

Supports, services and treatment authorized by NorthCare Network must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the individual.
- Responsive to the needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Provided in the least restrictive, most integrated setting. Residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistently with, where they exist, available research finding, health care practice guidelines and standards of practice issued by professionally recognized organizations or government agencies.

SUD Residential and/or Withdrawal Management Screening and Referral by Insurance:

The insurance table below is not an exhaustive list of insurance scenarios that may occur. Unique situations may arise which will require case by case consideration, as appropriate, and only in so far as beneficiary meets income guidelines for Block Grant, Block Grant funding is available, and all other available funding sources have been exhausted.

TABLE: SUBSTANCE USE DISORDER RESIDENTIAL SCREENING & REFERRAL BY INSURANCE

Insurance Benefit	**NorthCare SUD Screening for Residential and/or Withdrawal Management Services**	**NorthCare SUD Referral to Provider for Residential and/or Withdrawal Management Services**
Medicare + Medicaid	Yes	Yes, NorthCare will offer choice of provider and refer to one of our NorthCare paneled providers based on appropriate ASAM LOC.

Medicare only	No. The client will be directed to contact Medicare for further assistance, using the # on the back of their Medicare card.	No. The client will be directed to contact Medicare for further assistance, using the # on the back of their Medicare card.
MiHealth Link	Yes	Yes, refer as NorthCare normally does for MiHealth clients.
Medicare + Private Insurance *with* SUD treatment benefit OR Private insurance only *with* SUD treatment benefit	No. Refer client back to their insurance carrier.	No. Refer client back to their insurance carrier.
Private insurance only *without* SUD treatment benefit	No. Refer the client back to their insurance carrier.	No, unless contacted by the SUD treatment provider to arrange for a brief-screening, and only if written confirmation from the insurance carrier or other responsible party is received by NorthCare, verifying client does not have SUD treatment benefits and only if client meets the income guidelines for Block Grant coverage and Block Grant funding is available.
Private Insurance + Medicaid	The client will be directed to contact their insurance carrier for a provider that may accept their insurance. Once the client has been admitted for treatment, the provider will contact NorthCare to arrange for a brief-screening with the client so that the Medicaid benefit can be used as a secondary payor as appropriate.	No. The client will self-refer.

Incarcerated Medicaid	Yes	Yes, following guidelines outlined in NorthCare SOP for Jail Screening for Substance Use Disorder (SUD) Services, under Procedure heading and "If client is not eligible for DOC or OCC funding."
Medicare + Medicaid Spenddown, Not Met	Yes, as long as the client meets income guidelines for the use of Block Grant funding and so long as Block Grant funding is available.	Yes, as long as the client meets income guidelines for the use of Block Grant funding and so long as Block Grant funding is available.

Block Grant (BG)

To be eligible for Block Grant (BG) funding, a client must meet income, medical necessity criteria and residency requirements (per State Contract) in one of the fifteen counties in the Upper Peninsula of Michigan.

It is the responsibility of the SUD Provider to ensure that a client who is eligible for BG funding also completes and submits an application for Medicaid to MDHHS. SUD provider verification that an application was completed and when this occurred (date application was submitted) must be documented in the provider's records and indicated in the note section of the authorization request form. If a client has recently applied for Medicaid and been denied but still qualifies BG funding, the denial letter that the client received may be requested by NorthCare if there are no other means of verification available. NorthCare reserves the right to deny use of BG funding for clients who refuse to apply for Medicaid benefits.

Additionally, on the Provider Authorization Request form located in the ELMER system, NorthCare has added a BG verification checkbox the SUD provider must also complete, which indicates that BG eligibility has been verified.

> Providers can refer to the document "How to Use the SUD Authorization Bock Grant Verification Check Box" in ELMER, located in the Help menu.

Residency: for individuals who are uninsured and meet sliding fee scale requirements, the PIHP associated with the listed county of residence is considered the county of responsibility. Individuals meeting priority population federal and state criteria may be given access to treatment services regardless of county of residence based on individual need. NorthCare Network will give its regional residents priority in obtaining services when the actual demand

for services by those residents eligible for services exceeds the capacity of the programs. Providers are required to determine and document client's county of residence.

Income: financial eligibility is determined according to a sliding fee scale based on the national poverty index. Financial eligibility must be documented by the provider. Acceptable sources of documentation include pay stubs, unemployment check stubs, most recent income tax returns, or a letter from an employer attesting to an employee's income. Other reasonable forms of documentation will be considered; however, any other form must also be in the client chart. Under certain circumstances there may be conflicting income information. NorthCare reserves the right to request income documentation, prior to authorization consideration.

Generally, financial eligibility is determined by income over a 12-month period. Exception requests (for income consideration other than discussed above) must be put into writing and directed to NorthCare SUD Access.

Sliding Fee Scale Effective 10/1/2024

Family Size	Income Level
1	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680
8*	$105,440

*For each additional family member, add $10,760

The sliding fee scale is based on the Federal Poverty Guidelines, which are revised annually. The sliding fee scale is subject to revision by NorthCare Network during the year. If the scale is updated, providers will be notified in writing and given an effective date applying the new revision.

Clients who meet the sliding fee scale and other requirements but are also covered by other insurance may be eligible for Block Grant funding in coordination with the other insurance plan. Block Grant funds must be the last source of funding either in conjunction with other insurance funding, or after other funding sources available to the consumer have been exhausted.

Financial information needed to determine the ability to pay (financial responsibility) **must** be obtained at the time of admission, or anytime there is a change in an individual's financial status. SUD providers must "check in" with the client at **every** service contact to inquire if any changes have occurred, verify income, and electronically verify insurance.

Medicaid

To be eligible for Medicaid funding, a client must have Medicaid (as verified via the ELMER 270/271), meet medical necessity criteria and be a resident in one of the fifteen counties in the Upper Peninsula of Michigan.

It is essential that providers be vigilant about checking Medicaid eligibility, as clients may be eligible one month but not the next. Verification must continue monthly and/or before each service.

Residency: Medicaid recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate Regional Entity. Issues regarding the county of financial responsibility should be referred to NorthCare Network.

Deductible: Some consumers may have a monthly Medicaid Spend Down (deductible) requirement. Unless and until a consumer's Medicaid spenddown is met, they are not eligible for use of Medicaid funding. NorthCare Network is not responsible for those who have a deductible.

Health Michigan Plan (HMP)

Health care coverage for individuals who are age 19-64 years, have income at or below 133% of the federal poverty level under the modified adjusted gross income methodology, do not qualify for or are not enrolled in Medicare, do not qualify for, or are not enrolled in other Medicaid programs, are not pregnant at the time of application and are residents of the State of Michigan.

To be eligible for HMP funding, a client must have HMP (as verified via the ELMER 270/271), meet medical necessity criteria and be a resident in one of the fifteen counties in the Upper Peninsula of Michigan.

It is essential that providers be vigilant about checking HMP eligibility, as clients may be eligible one month but not the next. Verification must continue monthly and/or before each service.

Income: Financial eligibility for HMP is determined by the MDHHS.

Residency: HMP recipients whose County Code is not in the Upper Peninsula will be referred to the appropriate Regional Entity. Issues regarding the county of financial responsibility should be referred to NorthCare Network.

State Disability Assistance (SDA)

The SDA program provides case assistance to Michigan's eligible disabled, adults.

Income: Application is made through the Michigan Department of Health and Human Services (MDHHS). The case asset limit is $3,000.

Residency: Residency in Substance use Disorders residential treatment, Michigan residency and not receiving case assistance from another state. U.S. citizenship or have an acceptable alien status.

Welcoming

Welcoming/Customer Service

A welcoming philosophy is based on the core belief of dignity and respect for all people while in turn following good business practice. It is important for the system to understand and support the client in seeking treatment by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

Welcoming is conceptualized as an accepting attitude and understanding of how people "present" for treatment and a capacity on the part of the location to address their needs in a manner that accepts and fosters a service and treatment relationship that meets the needs and interests of the service recipient. Welcoming is also considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders.

General principles associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry, and on-going services
- Welcoming applies to all "clients" of an agency. Besides the individual seeking services and their family, a client also includes the public seeking services; other Providers seeking access for their clients; agency staff; and the community in which the service is located, and/or the community resides
- Welcoming is comprehensive and evidenced throughout all levels of care, all systems and service authorities
- A Welcoming system is "seamless." It enables service regardless of original entry point, Provider, and current services.
- In a Welcoming system, when resources are limited, or eligibility requirements are not met, the Provider ensures a connection is made to community support.
- A Welcoming system is culturally competent and able to provide access and services to all individuals seeking treatment

Welcoming – Service Recipient

- There is openness, acceptance and understanding of the presenting behaviors and characteristics of persons with substance use disorders
- And, for persons with co-occurring mental health problems, there is an openness, acceptance and understanding of their presenting behaviors and characteristics
- Welcoming is recipient based and incorporates meaningful client participation and "client satisfaction" that includes consideration to the family members/significant others
- Services are provided in a timely manner to meet the needs of the individual and/or their families
- Clients must be involved in the development of their treatment plans and goals.

Welcoming Organization

- The organization demonstrates an understanding and responsiveness to the variety of help-seeking behaviors related to various cultures and ages
- All staff within the organization incorporate and participates in the welcoming philosophy
- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the client repeat it at each Provider
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient
- Consideration is given to administrative details such as sharing paperwork across Providers, and ongoing reviews to streamline paperwork to essential and necessary information
- A welcoming system can provide follow-up and assistance to an individual as they navigate the Provider and the community network(s)
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a client receive training and develop skills that improve engagement in the treatment process
- All paperwork has purpose and represents added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient process, transmission, and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space and consideration to privacy, and/or other “amenities” to foster an accepting, comfortable environment.
- The service location is considered regarding public transportation and accessibility.
- Waiting areas include consideration for family members or others accompanying the individual seeking services

Clinical Services

Intake Paperwork

When an individual comes in for their initial visit, paperwork needed to meet regulatory requirements must be completed.

- The SUD provider will first complete the MDHHS-5515 Universal Consent form with the client and fax this to the NorthCare SUD fax queue at (248) 406-1286.
- Consent to treatment should be given and verified understanding by a client signature.
- Grievance and Appeal information should be given and verified understanding by a client signature.
- Notice of privacy practices should be given and verified by a client signature.
- Advanced Directives should be identified and obtained if the client has one
- All Clients must be offered the NorthCare Network Member Handbook verified by client signature.
- Clients should be given a choice of providers and verified by a client signature.
- If Block Grant is utilized, proof of income must be verified and a signed income verification form must be completed.

Assessment

A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the individualized Treatment Plan. The initial service may also be delivered in a non-face-to-face manner using the currently approved telehealth communications guidelines (simultaneous audio/visual). This flexibility will be effective with timelines cited in applicable state and federal policy.

There is also an assessment-only option available, initiated by individuals seeking to determine if their substance use is a problem, and who are willing to participate in the recommended treatment based on the assessment findings. Outpatient Providers on the panel provide an appropriate access point for this service.

If the individual shares information that would indicate risk (impaired driving, positive drug screen, etc.) and reports their willingness to follow through with treatment recommendations based on the assessment, this service is reimbursable by NorthCare via ELMER. For payment to occur, the SUD provider must obtain this information prior to an assessment being conducted, and this must be supported by the appropriate documentation.

It is the responsibility of the Provider to determine, at the time of scheduling, if the individual is being court ordered for assessment despite no evidence of a Substance Use Disorder, or if the individual is being court ordered for assessment but communicates, they are unwilling to consider treatment. NorthCare would not consider these for payment.

ASAM Continuum

The Bureau of Specialty Behavioral Health Services, Substance Use, Gambling and Epidemiology Section has approved the use of the American Society of Addiction Medicine (ASAM) Continuum as the standardized SUD assessment instrument to meet the criteria of the SUD 1115 Medicaid waiver.

- No more than four (4) Assessment (H0001) encounters, per individual, will be paid in a fiscal year
- An annual AC (using the H0001 billing code) must be completed for outpatient clients who have been receiving continuous outpatient services for over 1 year (for example, if an AC was completed on 4/1/23 and the client is still in service on 4/1/24, a new AC must be completed by 4/1/24 or shortly thereafter). If the NorthCare client is *only* receiving MAT services accompanied by the H0050 Brief Intervention service, and no additional treatment services, an initial AC must still be completed, however, an annual updated AC would not be required for MAT only + H0050 continuous OP services.

- An AC may be updated anytime there is a change in condition (for example, potentially a change in level of care needed). This may be accomplished one of two ways: using a progress note documenting the update, including the date the AC being updated was completed, and using the H0004 billing code; or completing a new AC, keeping in mind the MDHHS imposed limit of four (4) per fiscal year.
- All NorthCare clients approved for SUD treatment services or NorthCare clients who receive any SUD service that is reimbursed with Medicaid funds must be assessed using the AC.
- The AC will be accessed from within the ELMER system. If technical issues are encountered and the AC is not able to be accessed due to circumstances beyond the control of the Provider staff, depending on the nature of the problem, the NorthCare Clinical Director and/or NorthCare Systems Analyst should be notified immediately and upon resolution, the AC should be completed as soon as possible thereafter. The Continuum User Manual for Michigan Providers also provides additional options for tech support depending on the nature of the issue. (ContinuumSupport@FEIsystems.com).
- Additionally, the AC must be completed by an appropriately licensed and MCBAP certified clinician. Acceptable credentials include, but are not limited to, LLMSW, LMSW, with CAADC, CADC. If the clinician completing the AC does not have the appropriate licensure and MCBAP credential (e.g., clinician completing the assessment only has a MCBAP Development Plan) the AC must be reviewed, signed, and dated by a clinician that does have these credentials. The only exception to having a reviewer with a development plan is if the reviewer has a license to diagnose and a CCS-DP. The reviewed, signed, and dated document must be available in the client's chart within 5 days of completion of the assessment.
- NorthCare recommends that assessments be completed as soon as possible upon admission, but no later than three (3) days after admission (residential treatment).

- The use of the AC does not apply to adolescent population. MDHHS requires that the GAIN-I assessment tool be used for the SUD youth population.
- If an AC assessment has been initiated in ELMER, it must be completed, signed and synchronized in ELMER before authorizations are approved.
- If an AC assessment is initiated, but not able to be completed, the SUD provider must delete the incomplete AC from the ELMER system. NorthCare technical assistance is available if help is needed.
- An AC may be updated anytime there is a change in condition (for example, a change in the level of care is needed). This may be accomplished one of two ways: using a progress note documenting the update and using the H0004 billing code; or completing a new AC, keeping in mind the MDHHS imposed limit of four (4) per fiscal year.
- Appropriate steps must first be taken by NorthCare staff to ensure that any *non-contracted* provider who provides SUD services to a NorthCare referred client through Single Case Agreement (SCA) has or will have timely access to ELMER established to complete an AC. (Steps are outlined in the NorthCare SUD SCA Procedure under the ACCESS section. *This does not apply to non-contracted Border-State SUD providers, e.g., Willow Creek, Bellin Health who would only be providing sub-acute Withdrawal Management services not referred by NorthCare).*
- For any treatment service, the AC is required to be completed for payment of the treatment services. Payment is not able to be made for treatment services that were delivered by the SUD provider prior to the completion of an AC.
- For any peer support service, the AC is not required. However, an assessment identifying the needs of an individual is required.
- If clinically appropriate, an SUD outpatient provider may update an existing AC for a new or returning client using a progress note (H0004 code must be used for billing). For example, if a client completed an AC in January, left services in February, and the re-entered services in March, the AC completed in January could be used if clinically appropriate to do so. Reference must also be made to previous AC in the progress note. Providers are required to complete a new AC any time a client has been out of services longer than 60 days and/or when the previous AC was completed longer than 60 days before they returned. For example: an AC was completed on 12/1/24 and the client remained in services until 3/1/25. The client then returned to services on 4/1/25. Even though they have been out of service for under 60 days, a new AC should still be completed because the original AC is over 60 days old.

<u>Charitable Choice</u>

Treatment clients and prevention services recipients are required to be notified of their right to request alternative services if the Provider is faith-based. The faith-based Provider must provide notice. Notification must be in the form of a model notice contained in the final regulations. The model notice contained in the federal regulation is

"No Provider of substance use disorder services receiving Federal funds from the U.S. Substance use disorder and Mental Health services Administration, including this organization, may discriminate against you based on religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

If you object to the religious character of this organization, Federal law gives you the right to referral to another Provider of substance use disorder services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance use disorder services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization."

Providers and clients should contact NorthCare Network at 1-888-333-8030 with any questions, concerns or alternate referral related to Charitable Choice.

Primary Care Coordination

All appropriate steps must be taken to assure that substance use disorder treatment services are coordinated with other service Providers including primary health care. Treatment case files must include, at a minimum, the primary care physician's name and address, a signed waiver release of information for purposes of coordination, or a statement that the client has refused to sign the waiver.

Care coordination agreements or joint referral agreements, by themselves, are not coordination of care. Client case file documentation is also necessary.

Communicable Disease

- If an individual identifies as having high risk behaviors, a referral ~~process~~ for testing TB, Hepatitis, STD, and HIV should be made
- Any pregnant women presenting for treatment are offered referral for or provided STD and HIV testing.
- HIV/Health education for all clients
- Detox and Residential Only – all clients must have a TB test at admission. If a client does not have a valid test result available or a test has not yet been administered at time of admission, the test will be done on the first day of admission. Documentation that a TB test was administered along with the subsequent results must be in the client's chart.
- If suspicion of contagious diseases is evidenced upon client admission and prior to actual test being conducted the SUD provider must follow the appropriate agency protocols.

- Clients should be made aware of available resources if already infected with TB, Hepatitis, STD, or HIV
- Clinicians receive an expanded level of training relevant to their positions within six months of hire.

Fetal Alcohol Syndrome Disorder (FASD) Assessment

Substance use disorder treatment programs are in a unique position to have an impact on the FASD problem. It is required that all SUD programs include FASD prevention within the treatment regimen. All treatment programs that have contact with the children born to women who have used alcohol are required to screen these children for FASD and, if appropriate, refer for further diagnostic services. Additional information regarding FASD may be found at www.cdc.gov/ncbddd. Please reference the Michigan Department of Health and Human Services/Substance Use and Gambling Epidemiology/Treatment Policy #11 – Fetal Alcohol Spectrum Disorder for further information.

Documentation Standards and Supervision

- Progress notes, including individual notes and group notes, must be documented in the client file.
- All documentation must have an in/out time, be signed and dated by clinician
- Treatment plans must be signed and dated by the client and clinician. Documentation should include that client participated in the person centered treatment planning session.
- All service claims must be supported by progress note documentation, or in the case of an ASAM Continuum (H0001 claim), the assessment itself.
- Progress note documentation must identify the goal/objective being addressed and reflect individualized treatment.
- Discharge planning begins at admission and continues throughout the episode of care. This must be documented in the client chart and should include addressing social determinants and mental health needs. The lack, or absence of documented discharge planning, may result in denial of continued stay requests.
- Discharge summaries must also include aftercare plans/appointments. NorthCare recommends that discharge appointments include Primary Care Physician appointment. If there are no aftercare plans/appointments, the reason why must be documented.
- **Out of region SUD providers are required to notify NorthCare Clinical staff 1-2 weeks before a discharge so that discharge plans can be properly coordinated with the client prior to them returning to their home county.** Those clients that may choose to remain in an area outside of their region must be fully informed

of the options available to them for continuing care to avoid any interruption to care. NorthCare's SUD Managed Care Clinical Specialist or SUD Clinical Director may be reached at 906-225-7222 for assistance with this.

- All out of region SUD providers must fax the client's discharge summary to NorthCare (fax: 248-406-1286) at time of discharge or no later than fourteen (14) days post discharge.
- All residential SUD providers are responsible for notifying NorthCare when any client leaves services prior to completion of treatment plan goals and objectives. Client must be provided an ABD. Clients must be advised of their right to appeal the decision and in so doing they may choose to stay at the facility until the appeal is resolved. This is contingent upon the health and safety of the individual, other clients, and/or staff. Alternative arrangements, if possible, may need to be made to accommodate the circumstance. Notification to NorthCare can be accomplished through ELMER messaging or phone contact to the SUD Managed Care Access Clinician or SUD Clinical Director.
- If the client chooses to leave services prior to completion of treatment plan goals and objectives (i.e. Against Medical Advice), the ABD should include language to the effect that the client requested ceasing services.
- Residential and Outpatient providers are expected to coordinate discharges with MAT providers, for clients who are receiving MAT services. This would include ensuring that MAT aftercare appointments are made when the client leaves treatment and the discharge summary is sent to the MAT provider.
- Supervision of limited licensed staff should occur pursuant to the required standards set by LARA.
- The provider will provide at least monthly supervision for non-licensed staff (e.g., staff who have a MCBAP credential or Development Plan only). All clinical work including progress notes, treatment plans, use of the ASAM placement criteria, and assessments, must be reviewed by an appropriately licensed and credentialed supervisor with evidence available following agency protocol. (Example, supervision log or staff supervision records). Supervision records must be available upon request and will be reviewed during the annual site review process.

<u>Documentation for Access to Care</u>

NorthCare requires information prior to opening up a client record. This includes the NorthCare SUD Provider Referral Form, a copy of the MDHHS-5515, and ~~t~~he NorthCare Certificate of Eligibility.

To assist NorthCare in monitoring Block Grant funding and availability, NorthCare has included on the SUD Provider Referral Form an insurance section providers must complete.

Certificate of Eligibility

The Certificate of Eligibility form must be completed for all NorthCare clients who will be receiving Substance Use Disorder Services. For individuals receiving SUD Residential Services, or SUD Outpatient Services, the form must be faxed to NorthCare at 248-406-1286, along with the Consent to Share Behavioral health Information (MDHHS-5515) prior to an authorization request being considered. The form should be carefully reviewed with the client who is entering treatment, and all sections of this form requesting client input, client initials, or client signature must be completed.

Referral Form

The SUD Provider Referral Form must be completed for all NorthCare clients who will be receiving Substance Use Disorder Services. The form must be faxed to North Care at 248-406-1286, along with the Consent to Share Behavioral Health Information (MDHHS-5515) and the Certificate of Eligibility.

Data Entry Into ELMER

Assistance with ELMER can be found further in the Manual.

- Demographic data, financial information, and an Initial Authorization Request is entered into the appropriate online forms by the provider and electronically transmitted to NorthCare Network.
- In all cases, the provider is responsible for entering demographic, financial, insurance, admission, and authorization data into the ELMER system.

Cell Phone Usage

Mobile telephones present some challenges to programs as conversations about confidential matters can take place anywhere and be overheard by anyone. Although 42 CFR Part 2 does not specifically address the use of mobile telephones, common sense and restraint should prevail.

Telehealth

The use of Telemedicine presents challenges for maintaining confidentiality. Several providers may be involved, at different sites, with people listening to o~~u~~r viewing the Telemedicine session unbeknownst to the patient. In addition, communications could be intercepted or re-disclosed to unauthorized people.

The same confidentiality principles apply to Telemedicine as to in-person treatment. Moreover, if protected health information is being transmitted or stored electronically, then the HIPAA electronic security standards will need to be implemented. Particular care must be taken to ensure that records are available only to authorized personnel and those sessions (individual or group) with alcohol or drug patients are not witnessed by unauthorized persons. Most Telemedicine sessions that involve the disclosure of alcohol or drug information will require an

MDHHS-5515 consent form to be in place. The consent must list all parties participating in the Telemedicine conference, including technical support individuals operating video cameras or other equipment. Re-disclosures are prohibited without appropriate authorization.

This is a service that must be included in the Provider Contract and can only be billed using the appropriate Telemedicine place of service.

If Telemedicine/Telehealth services are being used, the SUD Provider is responsible for completing the NorthCare Informed Consent for Telehealth Services form with the client. The completed form must be available in the client's chart. The SUD Provider is also responsible for clearly documenting in the client chart/progress note that the service provided was conducted via Telehealth. Telehealth services must also be identified in the treatment plan as a possible method of service delivery. If the form template is needed, the NorthCare Clinical Director may be contacted for assistance, (906) 936-6847.

Levels of Care/ASAM Criteria

Outpatient Treatment/Aftercare (Level 1.0) Block Grant, Healthy Michigan Plan, Medicaid

Outpatient treatment is planned and organized non-residential treatment service in which SUD trained/educated clinicians provide several SUD treatment such as individual psychotherapy, group therapy, individual counseling, group counseling, peer recovery coach services. Outpatient treatment includes long term supports services.

When a client is specifically seeking outpatient services and does not indicate a desire for more intensive services, the appropriate point of entry is at the client's choice of contracted outpatient providers. The provider's clinical staff will administer an assessment to determine appropriate services. If a potential client contacts NorthCare first, they will be offered a warm transfer to access outpatient services in their area. The only exception to this is for MDOC referred clients who are screened for all Levels of Care, including Outpatient. If a SUD provider receives a request for services directly from an MDOC referred individual, if possible and appropriate, they should warm transfer the MDOC client back to NorthCare to complete a brief screening and referral to the appropriate LOC.

Individuals receiving Recovery Residence services must also be active in Outpatient services. The level of outpatient care would need to be indicated in the treatment plan.

Intensive Outpatient (Level 2.1), Block Grant, Healthy Michigan Plan, Medicaid

Intensive Outpatient (IOP) treatment is a planned and organized non-residential treatment service in which SUD trained/educated clinicians provide several SUD treatment service components to beneficiaries. Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in special residences.

Services are provided over a period of weeks. Level 2.1 (IOP) programming provides essential education and treatment services while allowing the participant to apply their newly acquired skills in "real world environments". The service array would include individual, group, and family counseling as well as didactic elements regarding alcohol and drugs. Participants in this level of care would leave the treatment facility after completing their daily treatment. The focus is to allow participants to implement the skills they have gained in the program by returning to their home communities.

Low-Intensity Residential (Level 3.1), Block Grant, Healthy Michigan Plan, Medicaid

Low-intensity (3.1) treatment is a clinically managed, low-intensity residential 24-hour structure with available trained personnel. This setting must at least 5 hours of core clinical services per week, such as individual and/or group therapy, and at least 5 hours per week of Life Skills/Selfcare (LS/SC), such as social activities that promote healthy community

integration/reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education. Services in a 3.1 setting must occur daily and must be documented in the client's chart for Medicaid or Block Grant funding to be used. When documenting Life Skills/Selfcare, if time in/out is not specified, length of time participating in Life Skills/Selfcare must be specified.

Documentation must, include date, activity/service with client response (for example, client was encouraged by staff to complete assigned chores; client was observed completing chores without additional assistance from staff; client participated in a house meeting today which lasted 60 minutes and interacted appropriately with others, offered suggestions to the group, and displayed positive attitude; or client was observed in the milieu for two hours today, engaging and interacting appropriately with other residents). Staff signature and date. Where possible the duration of the activity/service should be documented, such as the length of the house meeting or self-help meeting.

One option for the daily documentation of LS/SC may be summarization at the end of the day/shift, which combines all services provided to the client throughout the day, related to the required elements noted above.

If the client is attending a house meeting for the daily LS/SC service, a sign in/out sheet is not sufficient documentation and must be accompanied by a progress note in the client's chart.

Codes H0018, H0019, S9976 should be used under the following circumstances:

- H0018 should be used for individuals anticipated to have a short-term stay in residential services at the time of admission (less than 30 days)
- H0019 should be used for individuals anticipated to have a long term stay in residential services at the time of admission (more than 30 days)
- S9976 may be requested in addition to the H0018 or H0019 codes for room and board
- Modifier: W1

<u>Residential Treatment/Continued Care – (Level 3.3) Block Grant, Healthy Michigan, Medicaid</u>

Residential treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative, or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance use disorder specialists. Residential treatment must be staffed 24 hours per day.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Codes H0018, H0019, S9976 should be used under the following circumstances:

- H0018 should be used for individuals anticipated to have a short-term stay in residential services at the time of admission (less than 30 days)
- H0019 should be used for individuals anticipated to have a long term stay in residential services at the time of admission (more than 30 days)
- S9976 may be requested in addition to the H0018 or H0019 codes for room and board
- Modifier: W3

Residential Treatment – (Level 3.5) Block Grant, Healthy Michigan Plan, Medicaid

This is a 24/7 clinically monitored level of care. Clients stay at the facility while receiving services. Clients admitted to this level of care have significant social and/or psychological problems but can benefit from high-intensity treatment services.

Codes H0018, H0019, S9976 should be used under the following circumstances:

- H0018 should be used for individuals anticipated to have a short-term stay in residential services at the time of admission (less than 30 days)
- H0019 should be used for individuals anticipated to have a long term stay in residential services at the time of admission (more than 30 days)
- S9976 may be requested in addition to the H0018 or H0019 codes for room and board
- Modifier: W5

RESIDENTIAL SERVICE REQUIREMENTS

Level of Care	**Minimum Weekly Core Services**	**Minimum Weekly Life Skills/Self Care**
ASAM 3.1 Clients with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM 3.3 Clients with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
ASAM 3.5 Clients with a significant level of impairment or very complex need	Not less than 20 hours per week	Not less than 20 hours per week
ASAM 3.7 Clients with a significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week

RESIDENTIAL COVERED SERVICES

TYPE	RESIDENTIAL SERVICES DESCRIPTION
Basic Care	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery oriented.
Treatment Basics Core Service	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions Core Service	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice
Interactive Education /Counseling Core Service	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/ reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.
Medical Services Core Service	Physician monitoring, nursing care, and observation are available. Medical specialty consultation, psychological, laboratory and

	toxicology services available. Psychiatric services available on-site

Clinically Managed Residential Withdrawal Management (Level 3.2 WD) – Non-Medical or Social Detoxification Setting

The need for withdrawal management is determined by qualified medical personnel. A qualification instrument such as the Clinical Institute Withdrawal Assessment (CIWA) may be used to rate the severity of symptoms related to withdrawal from alcohol and other physically addicting drugs.

Emphasizes peer and social support for clients who warrant 24-hour support (ASAM Level 3.2 – WM). These services must be provided under the supervision of a certified addictions counselor. Services must have arrangements for access to licensed medical personnel as needed.

Code H0012 should be used

Medically Managed Residential Withdrawal Management (Level 3.7WD) – Freestanding Detoxification Center

These services must be staffed 24 hours per day by a licensed physician (ASAM Level 3.7 WM). This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting. Appropriate program licensure is required.

Code H0010 should be used

Authorization Requirements – Withdrawal Management (Detox Programming) Residential setting

- Symptom alleviation is insufficient for purposes of admission, NorthCare will not pay for Residential detox programming for a person who reports suicidal ideation and needs to become sober for a psychological evaluation to take place; in acute psychological distress; and/or needing a bed until sober.
- The client must be willing to participate in a planned sequence of addiction treatment and there must be documentation of current client status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- The provider must notify NorthCare of a client admission to a detox program by the next business day.
- Medical necessity and ASAM criteria for LOC will determine eligibility for admission to Withdrawal management services.
- For authorization purposes one unit equals 24 hours. The timeline must:

- Clearly indicate the time of admission and discharge or transfer to another unit.
- If medical clearance is necessary, the "clock" does not start until a client has returned from the medical provider and receives their initial withdrawal assessment.
- ASAM guidelines will be followed for "detox" scoring purposes and determining when a client is ready to transition from WM to another level of care.

Code H0012 should be used

Methadone Therapy: Block Grant, Healthy Michigan Plan, and Medicaid

NorthCare does not perform the eligibility screening for Methadone therapy, but rather funds an assessment performed by an addictionologist/physician, a behavioral health professional, and other medical staff. Clients may access the service by contacting NorthCare, which will then determine program availability. Clients who are determined to be appropriate for Methadone treatment by a qualified provider will be assisted in gaining entry to a qualified Methadone program which is mutually agreed to by NorthCare and the client.

Code H0020 should be used for the methadone dosing. Additional codes include evaluation and management codes and any outpatient treatment codes.

Co-Occurring referrals for Intensive Levels of Care

For co-occurring residential requests:

- CMHSP consumer contacts NorthCare SUD Access to request screening and potential placement
- Pre-screen will be completed, and the consumer will be offered a brief screen
- Once the brief screen has been completed and a clinical decision has been made, the NorthCare SUD screener will proceed with the referral process, as appropriate, and will also attempt a 3-way call with the client and their CMH worker, if the client is agreeable, for coordination of care purposes.

Co-occurring Services

Screening/Assessments for co-occurring disorders should be completed by the SUD Provider on all NorthCare clients being admitted for services. This screening should be part of the routine intake or assessment process for new clients.

The co-occurring screening should include:

- A diagnostic interview to determine which, if any, DSM 5 mental disorder diagnoses is met by the client.
- A treatment history assessing the outcome of previous treatment experiences and barriers to effective treatment

- An assessment of the impact of mental disorders on the substance disorder from a longitudinal perspective
- An assessment of the consumer's awareness of the problem and stage of motivation to change

Coordination of Care for Co-occurring clients:

- The CMHSP and SUD provider should collaborate throughout the course of treatment to provide efficient, medically necessary care. MDHHS 5515 Consent form is required for the coordination between providers. The SUD provider will obtain this at the time of admission and should encourage the individual to include the CMHSP, NorthCare Network, SUD Provider and any other Providers as appropriate. At a minimum, there must be a release obtained at the time of admission for NorthCare and the SUD Provider. All releases should be faxed to NorthCare (fax number: 248-406-1286).
- The CMHSP and the SUD Provider are responsible for appropriately coordinating services and for co-occurring clients. **Please note, having two therapists is not recommended as best practice and should be time limited if utilized.**
- To continue therapy with the CMHSP Provider while the client is in SUD residential treatment, for example, the following criteria must be met:
    - If a CMHSP client in residential SUD treatment has been receiving individual therapy at the CMSHP, and
    - Their therapy needs exceed what the SUD provider is able to provide, and
    - The CMHSP therapy does not include SUD counseling, and
    - If after care coordination between the CMHSP Provider and the SUD Provider takes place, and
    - It is clinically appropriate for the therapy to continue with the CMHSP Provider, and
    - The client is in agreement.
- For co-occurring clients
    - Services must not be duplicated (example: the client may not receive Case Management services at both agencies at he same time; or both agencies providing SUD counseling at the same time)
    - The CMHSP services must take place at the CMHSP designated site, and the SUD services must take place at the SUD designated site
    - NorthCare Network SUD Clinical Director should be notified by the agency requesting services outside of their scope that care coordination is taking place (example: if the SUD Provider is requesting that the client continue in individual therapy while in residential treatment)
    - In summary: in situations where it is determined that the client's needs cannot be met, authorization for concurrent enrollment can be provided by NorthCare

Network on a case-by-case basis. In the situations, there must be coordination with the other program to ensure that specific services are not duplicated.

- Further details may be found in the NorthCare Coordinating Co-occurring Services Procedure. Please contact the NorthCare SUD Clinical Director at 906-936-6847 to request a copy of this process.

Out of Network Services

If a medically necessary service covered under the contract is unavailable within the network, NorthCare Network will adequately and timely cover the service out of network using a Single Case Agreement for as long as the current network is unable to provide the care required.

NorthCare Network requires out-of-network providers to coordinate with NorthCare regarding payment and ensures that any cost to the beneficiary is no greater than it would be if the services were furnished within the network.

Treatment Planning

Treatment planning takes the area of need identified in the assessment and creates a plan on how and what to address in treatment. Treatment plans are meant to change throughout the course of treatment and as new areas to address are identified. A treatment plan is to be developed in coordination with the client and whomever they wish to be included. No treatment services are to be conducted without a treatment plan in place.

Treatment plans are meant to change as the needs of an individual changes.

Code T1007 – HCPCS – Alcohol and/or substance abuse services, treatment plan development and/or modification should be used under the following circumstances:

- Initial treatment plan development (one encounter)
- A scheduled treatment plan review (for example, the required outpatient 90-day review).
- When there is a significant change in conditions for the client.
- For co-occurring population and WSS treatment planning and treatment planning modification, use the appropriate modifier as you normally would for those designated populations/programs.
- Treatment plans
    - As treatment plan goals/objectives are routinely reviewed during the course of a scheduled SUD counseling or SUD therapy session, T1007 would not be used and the encounter with the client would continue to be coded as H0004 or 9083x, (as you normally would), as that is the primary service being provided.
    - When requesting the T1007 for authorization, under amount, NorthCare recommends that SUD providers request two encounters for a six-month

review. After the first 6 months you would request reauthorization for two encounters to correspond with the number of treatment plan reviews scheduled.

- An additional “How To Guide” is available under the ELMER Help Guide tab.

Authorization Process

All services must be authorized. Withdrawal Management and initial treatment service sessions (assessment, treatment planning, and one individual session as needed) may be authorized after the service has been provided. A current release must be on file with NorthCare Network prior to the client being "referred" to a specific SUD provider. A current release is one that covers the current authorization period being requested. An authorization becomes invalid once it is connected with an admission that has been or should be discharged. The release must be in the ELMER system.

Once the release is in the ELMER system the authorization request can be completed. It represents a snapshot of the client, so it is important to fully complete the form including an individualized treatment plan. NorthCare will approve units of service based on medical necessity, ASAM LOC criteria, DSM-5 and treatment plan.

Clinical authorization does not guarantee payment. The authorization is considered a part of the whole billing process. A final payment decision is made at the time of payment.

If you have questions on authorization the preferred method of contact is using the ELMER messaging system. The second method would be to contact a NorthCare SUD Managed Care Clinical Specialist at 906-936-6851.

Authorization Requirements:

- The requested treatment/service meets medical necessity criteria as established by the Michigan Medicaid Provider Manual.
- The current edition of the DSM-5 is used to determine an initial diagnostic impression.
- The request treatment/service is based on individualized determination of need.
- The treatment/service requested is the most appropriate, efficacious, least restrictive service, setting, or support that otherwise satisfies the standards for medically necessary services.
- Amount, scope, duration and frequency is identified and appropriate for the request.
- ASAM Criteria is met for the level of care requested.

Initial Authorizations:

Initial authorization requests:

- Residential: initial authorization requests must be submitted as soon as possible after admission, not to exceed 10 calendar days of the client's date of admission. Initial requests will include up to 14 units.
- Outpatient: initial authorization request may include assessment code, treatment planning code, and one session and should be submitted as soon as possible after admission, not to exceed 10 calendar days of the client's date of admission. Outpatient initial authorization requests are not required to be prior authorized. However, services

are required to be billed no more than 60 days after the date of service and an authorization must be in place to bill.

- Methadone: initial authorization request may include assessment code, treatment planning code, one session, and dosing. Outpatient initial authorization requests are not required to be prior authorized. However, services are required to be billed no more than 60 days after the date of service and an authorization must be in place to bill.
- Peer Recovery Coach Services: initial authorization request may include coaching service codes. Services are to be prior authorized.
- If an authorization request is not submitted within the required timeframe, a request may still be submitted. However, the authorization may only be approved for the request date forward. The provider is responsible for communicating to NorthCare if extenuating circumstances exist.

Re-Authorization Requirements:

Re-authorization requests may be approved when authorization requirements continue to be met. The request must:

- Be prior authorized
- Document evidence of progress in achieving treatment goals
- Document continued medical necessity
- Document any cognitive and behavioral impairments which are impacting the clients progress towards achieving treatment goals
- Document discharge/aftercare/recovery plans, beginning at the time of admission and continuing throughout the entire treatment episode
- Have documentation that includes DSM 5 diagnoses
- Have an updated ASAM Criteria LOC

Re-authorization requests must meet treatment criteria.

Clients who transition from social detox into residential treatment at the same facility will be admitted into social detox and discharged from residential treatment. A separate referral from social detox into residential treatment is not necessary.

Returned Authorizations:

NorthCare responsibilities:

- The reason that NorthCare is returning the authorization request will be outlined in the Authorizing Agent section of the Authorization Request form that was submitted in ELMER. For timely processing, provider response should be submitted within five business days, however, providers may take up to ten calendar days from the date the initial authorization request was submitted to respond.
- On day eleven, if no response is received from the provider, NorthCare will begin the process of issuing an Adverse Benefit Determination (ABD) notice to the client with a

copy to provider of denial due to not meeting medical necessity criteria. This is pursuant to the requirement that an ABD must be completed and mailed no later than fourteen days from the date the authorization was first requested if there has been no response from the provider.

SUD Provider Responsibilities:

- Provide a response to NorthCare within five business days, but no later than ten calendar days from the date of the initial request. Response is defined as: returning authorization to NorthCare, accompanied by the requested information.
- If denied due to medical necessity, the provider will need to submit a new authorization request if the service is still needed, along with the previously requested information and any additional clinical criteria.
- If the provider determines that the initial request will not be re-submitted, the provider will be responsible for issuing an ABD to the client, including the reason for the action. Providers must complete and mail this within fourteen days from the day the authorization request was first submitted.

A provider may request an extension when unique circumstances exist. NorthCare may also determine that an extension is in the best interest of the client. If an extension is appropriate NorthCare will give the client a written notice of delay including the reason for the decision to extend the time and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. Extensions will not exceed more than twenty-eight days from the date the authorization was first requested. The client also has the right to appeal a denial by following the process explained in the ABD that they receive.

***Please note that in 2026, the fourteen-day rule will be shortened to seven days and there will not be time to return and review authorizations. Staff should begin to provide all required documentation/information as standard practice. Required documentation/information includes: § 438.404 Timely and adequate notice of adverse benefit determination; 42 CFR 438.210 ©*

Provider Appeal

Once a case has been reviewed by the SUD Utilization Management Team and a determination has been made that the client no longer meets medical necessity/ASAM criteria for continued stay, an Adverse Benefit Determination Notice (ABD) will be sent to the client, and a copy will be given to the Provider. Depending on the funding source the client will be sent the corresponding notice which outlines their perspective rights. The ABD will include the rationale for the clinical decision and outline the client's rights, which include the right to a local appeal if applicable, again, depending on the funding source.

Adverse Benefit Determination Notice

Adverse Benefit Determinations (ABD's) are for Adverse (negative) service or payment decisions.

- Service decisions are based on consumers meeting medical necessity and ASAM criteria for SUD programs or services within a program.
- Payment decisions are based on consumers meeting medical necessity and ASAM criteria for eligibility for specific programs/services already provided. NorthCare, as the Medicaid payor, would create the ABD for any payment denials.
- A Notice for an ABD is required any time a new adverse service decision is made, or denial of payment decision is made.
- Decisions may include:
    - Denying a request for a new service
    - Denying an increase in service (e.g., amount, scope, or duration)
    - Delaying the start of a particular service
    - Reducing, suspending, or terminating existing services
    - Denial of payment for a claim in whole or in part
- SUD Providers must use the ABD form available in ELMER and provide this written notice to the client following the guidelines in the NorthCare Adverse Benefit Determinations for SUD Providers training. This is located in the ELMER Help guide, along with a guide for ABD SUD frequently asked questions (FAQ) available to all NorthCare paneled SUD providers.

Specialty Programs

All clients are screened for specialty programs and if they are applicable, clients are offered specialty programs based on client's choice and need. NorthCare will refer and coordinate services for clients based on specialty qualifications.

In cases where clients do not meet criteria for SUD treatment services, referrals to other types of services are offered, as appropriate.

Women's Specialty Services (WSS)

Providers must screen and/or assess pregnant women, women with dependent children, and women attempting to regain custody of their children, to determine whether these individuals or their children could benefit from the defined federal services listed below. If found appropriate, the individual should be referred to a program designated to deliver the specialty services listed below:

Designated treatment programs receiving funding for pregnant women and women with dependent children must provide or arrange for the following:

- Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment – childcare.
- Primary pediatric care for their children, including immunizations.
- Gender specific substance use disorder treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare while the women are receiving these services.
- Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect.
- Sufficient case management and transportation to ensure that women and their dependent children have access to the above-mentioned services. Women with dependent children are defined to include women in treatment who are attempting to regain custody of their children.

The above five types of services, especially primary medical care, can only be covered when no other source of support is available and when no other source is financially responsible.

The same population must be screened by all Providers for ancillary services (childcare and transportation assistance) and pre-screened for Fetal Alcohol Syndrome Disorder (FASD). Ancillary services can be accessed through NorthCare Network, and children found to need further FASD services need to be referred to UP Health System Marquette Specialty clinic in Marquette, 906-449-4424, located at 850 W Baraga Avenue Suite 31.

Training Requirements for designated Women's Specialty Programs

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, gender specific substance use disorder training or 2080 hours of supervision gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirement must be supervised by another individual working within the program and be working towards meeting the requirement. Documentation is required to be kept in personnel files. Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Bureau of Substance Abuse and Addiction Services (BSAAS)Women's Treatment Coordinator. Pregnant women are given preference in admission to treatment facilities.

Philosophy

Women's services are developed around a relational model which recognizes that the self is organized and developed in the context of important relationships. A model of empowerment and collaboration are essential treatment components. Treatment is specifically designed to be gender competent to address the specific needs of the family.

Access to WSS Treatment

Eligible women are defined as "pregnant women and women with dependent children, including women who are attempting to regain custody of their children. Michigan law extends priority population status to men whose children have been removed from the home or are in danger of being removed from the home under the child protection laws. Men who are shown to be the primary caregivers for their children are eligible to access ancillary services such as childcare, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care." When completing an admission in ELMER, enroll the consumer in the Women's Specialty Program.

Assessment

Upon determining that an individual is eligible for WSS, the designated provider sites will complete a Women and Families assessment that will be the basis for a collaborative treatment plan that includes the needs of children and family. The Referral Checklist for each child should be completed and a referral made and documented for each identified need; if FASD screening is indicated, the referral for this should be documented; the

Women's Referral Checklist should be completed, and referrals documented for each identified need; and the Women's Specialty Assessment must be completed before the delivery of an ancillary HD service. The WSS assessment requires staff signature and date. Providers may bill for the agency's ASAM Continuum assessment in addition to the WSS assessment. Since there is an extensive amount of information required, continued assessment over time will lend more information as the family and clinician gain trust. It is the expectation that each child in the family system will be assessed, and appropriate referrals made. The clinician should be asking about each child's needs regardless of whether the child is physically present and addressing the health care needs of both the mother and child(ren). H0001 HD is the authorization code for a WSS assessment. When requesting authorization, you will be asked to enter the number of children's referrals made. For the initial authorization, put "zero" in the appropriate boxes and for each subsequent authorization, record the number of referrals made for children.

Treatment Planning

Individual plans of service (IPOS) will be family centered, strength based, culturally competent and collaborative across systems with a culture of unconditional care. Plans should include an emphasis on safety, self-sufficiency and be outcome oriented. Consumers should be offered care coordination and access to a Recovery Coach where available. A will conducted assessment will also identify barriers and needs. Childcare, transportation and referrals for women and children's services will be addressed through an appropriate goal and objective in the IPOS. Women's health and reproductive needs should be explored and addressed. Parenting issues, employment, and children's mental and physical health needs will be addressed with appropriate services and referrals provided. The intensity of service will vary according to the IPOS and needs of the client and family.

Services

Once it is determined that the individual qualifies for WSS, the HD modifier will be used for authorization of services. Non-gender specific services identified in the IPOS but not provided by a WSS Specialist, may be coded with the HD modifier. These services should be reviewed with the primary counselor to assure they are appropriate. For example, a woman may choose to attend a co-occurring, co-ed, non-gender specific group as part of her treatment plan

Care Coordination

At times, the clinician can perform the function of both the care coordinator and counselor. Care coordination can be provided by paraprofessionals and interns. Care coordination contacts (15-minute units) should be scheduled to benefit the client and may vary in length depending on the IPOS and needs of the client. Recovery Coaches can be used to support the plan. Care Coordination conducted by phone may be billed but

should not be used as a substitute for face-to-face. Authorization code: H0050 HD Brief Intervention/Care Coordination (15-munite unit). WSS Care Coordination claims must be supported by appropriate, corresponding documentation (progress note) which matches the authorized service.

Transportation

All Women's Specialty Services will provide access to transportation for women, children, and eligible men. This can be in the form of bus tickets, transport by a Recovery Coach, gas cards, etc. Use the T2003 HD in the ELMER system when gas cards are being provided. When requesting authorization for transportation, request one unit per day for the date that transportation (most often gas card) will be used. For example, a client comes weekly for 3 months (12 sessions) and has a treatment plan that has the stated goal need for transportation. Request authorization for 12 (T2003 HD) units. If a client is given $10 in gas cards per one counseling session, bill 1 unit of T2003 for that date, then bill the amount ($10). (T2003 can only be billed once per day.) Maximum of 1 unit/$40 per day. Use S2015 when requesting mileage – typically to reimburse a provider for transporting a client out of region, etc.

Childcare

Funds are available to pay for licensed and kin care. All WSS programs are encouraged to provide on-site childcare whenever possible. When childcare is provided on-site, it is not necessary that the site be licensed as a day care provider. Besides removing a significant barrier for the family, onsite childcare allows the clinician to evaluate the child(ren) for health and safety needs as well as mental health issues. To request reimbursement for childcare, complete the WSS Ancillary Services request form and submit for payment as instructed on the form.

Additional information regarding WSS may be found in the Michigan Department of Health and Human Services/Substance Use Gambling and Epidemiology/Treatment Policy #12.

Substance Use Disorder Health Home – SUDHH

The SUDHH will provide comprehensive care management and coordination services to Medicaid beneficiaries with Opioid, Stimulant, Alcohol use disorder. For enrolled beneficiaries, the SUDHH functions as the central point of contact for directing patient centered care. Participation is voluntary and enrollees can opt-out at any time.

SUDHH has 5 goals:

1. Improve care management of beneficiaries including MOUD and medications for alcohol use disorder
2. Improve care coordination between physical and behavioral health care services

3. Improve care transitions between primary, specialty, and inpatient settings of care
4. Improve coordination with dental care
5. Educate on fetal alcohol spectrum disorders

Providers are required to follow the SUDHH Handbook found in the provider section of the State of Michigan's website: Substance Use Disorder Health Home.

SUDHH services are provided by an interdisciplinary care team that addresses the individual's unique needs. To complete this, SUDHH providers are required to have a specific number of full-time employees. Any team member may be assigned "lead" for any of the beneficiaries. Services are paid on a Per Member Per Month basis. Any allowable service, per the SUDHH Handbook, is billed using the S0280.

Recovery Housing

The goal of providing recovery housing services is to provide a supportive recovery environment to help reduce the incidence of drug and alcohol abuse and dependency, prevent relapse, and support individuals in their recovery. Houses must have the Michigan Association of Recovery Residences (MARR) certification.

Substance Abuse Block Grant (SABG) and other grant funds may be used to fund room and board in conjunction with treatment admission to the extent it is integral to the treatment process. Up to sixty days will be funded for individuals meeting Recovery Residence requirements. This includes participating in outpatient programming as evidenced by authorizations.

Eligibility screening requirements.

- Individual meets the criteria for NorthCare funding (Medicaid insurance from one of the fifteen counties in the UP, HMP insurance with a county of residence from one of the fifteen counties in the UP, or meets BH eligibility, residency, and substance use disorder diagnosis)
- Individuals are actively engaged in outpatient services. If not currently active in outpatient services (due to being recently discharged from residential services for example), it is acceptable for the outpatient services to begin shortly after a client enters Recovery Housing. The provider must have this documented as well as the dates for admission or services.
- Individual requires a highly structured and monitored living environment where recovery support is available
- Individuals have significant negative factors in the areas of family, social, work, or environment that places him/her at-risk for relapse

Admission Requirements

- Individuals have completed or does not need medical or sub-acute detoxification

- Individuals do not present with severe medical or psychiatric conditions that would interfere in his/her ability to function in a supervised supportive living environment
- Individual adheres to the requirement of attending an appropriate funded treatment service while residing in the recovery home which will be documented in the client's file
- An admission would be entered into ELMER utilizing the Second Admission feature with an authorization request of up to 30 days. Two authorizations of up to 30 days will be authorized if the client continues meeting requirements for recovery Housing
- When requesting authorization for Recovery Housing, the SUD provider's authorization request should include the following documents be faxed to the NorthCare SUD Access:
    - SUD Provider Referral Form fully completed
    - Certificate of Eligibility fully completed
    - MDHHS-5515 form with NorthCare, the Recovery House, the Outpatient service provider, and the name of the Recovery House provider (if different than the Outpatient provider) should be included in Section 2a
- One Recovery Housing stay is permitted per Episode of Care. NorthCare may fund up to 60 days of Recovery Housing during an episode of care. NorthCare may also fund a second episode of care for Recovery Housing as long as there is a minimum 60 days between episodes. If more than one Recovery Housing stay is requested per FY, the NorthCare SUD Access should be contacted and the SUD provider must develop a plan for success. A maximum of 2 Recovery Housing stays may be funded by NorthCare per FY.

Code H2034 should be used.

<u>Peer Recovery Coach Services</u>

Peer Recovery Coach Services are a valued and important part in treatment services. NorthCare supports the move to ensure all Recovery Coaches have the MDHHS required training necessary to provide Medicaid services. The different kinds of activities have been divided into four service categories: emotional support, information support, instrumental support, and affiliation support (SAMHSA, 2009a).

Additional information may be found in the Michigan Health and Human Services/Substance Use Gambling and Epidemiology/Treatment Technical Advisory #7.

<u>Program Discharge Policy</u>

All programs must have a policy that details their Client Discharge policy. Clients must be given this information upon admission and must sign a document showing they received and understand the Discharge policy. The use of behavioral contracts related to client relapse and continued use during treatment is not clinically appropriate. This practice is not supported by research and fails to comply with the Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines.

The SUD Provider's Discharge policy must include the following components:

- A recipient shall be informed if a program has a policy for discharging recipients who fail to comply with program rules and shall receive, at admission and thereafter upon request, a notification form that includes written procedures which explain all the following:
    - The types of infractions that can lead to discharge
    - Who has the authority to discharge recipients
    - How and in what situations prior notification is to be given to the recipient who is being considered for discharge
    - The mechanism for review or appeal of a discharge decision
    - A copy of the notification form signed by the recipient shall be maintained in the recipient's case file
    - If the client is being discharged prior to the expiration of their current authorization for a program violation, the provider is responsible for giving the client appropriate written notice (ABD)

Provider Staff Requirements

Any New or renewals to certifications or licenses will be requested along with the development plans for counselors and supervisors with MCBAP. Individual credentialing paperwork can be obtained from NorthCare Network Provider Network Specialist, Karena Grasso, 906-205-2838, or via email kgrasso@northcarenetwork.org.

Staff Qualifications and Professional Development

Refer to your provider contract.

MCBAP Development plan requirements

Development Plan must be completed and submitted to MCBAP within 30 business days of beginning employment. It is the responsibility of the Provider/staff to meet requirements.

NorthCare Network Credentialing policy

Refer to NorthCare Network website: www.northcarenetwork.org for all policies. Information for credentialing will be found in NorthCare Network Credentialing Privileging Policy and NorthCare Network Credentialing Program Policy. More information can also be found in the Medicaid Manual and Provider contracts.

Providers must have a written system in place for credentialing and re-credentialing individual practitioners included in their Provider network. Appropriate and timely credentialing is the provider's responsibility.

Clinician's Development Plan must be valid and on file at MCBAP prior to consideration to be added as a qualified clinician to the NorthCare Provider panel.

IC&RC Exam

Completion 6 months before applying for certification is highly recommended. If you fail the exam, you must wait 60 days before taking it again.

Expiration of Licenses

Any provider who has not renewed their license or certification prior to its expiration will be immediately suspended/terminated from the provider network. Services are not reimbursed during periods of lapsed license/certification. This can be monitored on the License And Regulatory Affairs (LARA) website.

Upper Midwest Indian Council on Addictive Disorders (UMICAD)

Tribal providers get their certification from UMICAD, they have 3 levels of certification: ADC I, ADC II, ADC III. The IC&RC has a residency rule called "the 51% rule" on where a person can apply to take the ADC written exam and/or certification.

Peer Recovery Coaches

To be a Peer Recovery Coach, individuals will need to complete the current designated training approved by MDHHS and meet all current requirements. To complete the entire scope of necessary elements, an average training course would encompass approximately 40 hours.

Additional information can be found at this link: Peer Recovery Information (Michigan.gov) and in MSA 17-45 (003) Recovery Coach Provider Description.

Following certification, a minimum of 20 hours of continuing education, with at least 10 hours being SUD specific, and 6 hours in ethics is required over a two-year-period. For additional information on Recovery Coach certification, contact the NorthCare Network SUD Services Director 906-936-6844.

Recovery Coach Support Services (RCSS)

Within RCSS it is recognized that individuals in recovery, their families, and their community allies are critical resources that can effectively extend, enhance, and improve formal treatment services. RCSS are designed to assist individuals in achieving personally identified goals for their recovery by selecting and focusing on specific services, resources, and supports. These services are available within most communities employing a peer-driven, strength-based, and wellness-oriented approach that is grounded in the culture(s) of recovery and utilizes existing community resources. RCSS emphasizes strength, wellness, community-based delivery, and the provision of services by peers rather than SUD service professionals. As such, these services can be viewed as promoting self-efficacy, community connectedness, and quality of life, which are key factors to sustained recovery.

> Codes H0038 should be used with modifiers WR for Certified Peer Recovery Coaches (MDHHS Trained), HM for coaches trained but pending MDHHS Peer certification, and no modifier for coach with CCAR training or MCBAP peer mentor credential.

Credentialing Updates

Programs are required to notify NorthCare of any updates/changes to any existing clinician's credentials when the information is available to the clinician and/or program. All newly hired (or transferred between internal programs) clinician's credentialing information, along with hire date, must be submitted to NorthCare *within 2 weeks of hire* (or transfer). This notification will ensure the clinician is properly credentialed to provide substance use disorder service to NorthCare funded clients. *Termination dates* of all clinicians and ELMER users must be submitted *immediately* to NorthCare Network Provider Network Specialist, Karena Grasso via email kgrasso@northcarenetwork.org so that they can be removed from the ELMER system.

License Exclusion Check

The following website can be used to check any exclusions for licensed Providers. NorthCare Network will check all contracted Providers and clinicians through this website regularly:

- Department of Health & Human Services sanctioned Provider information is available on the following website: http://exclusions.oig.hhs.gov.
- MDHHS licensing sanctions for health facilities and professionals are available at http://michigan.gov/healthlicense.

Provider Qualifications

Funded programs must be nationally accredited, and State licensed per contract. If a provider loses accreditation or licensure, the agency must notify NorthCare Network within two business days. Provider Credentialing paperwork can be obtained from NorthCare Network's Provider Network Specialist, Karena Grasso, 906-205-2838, or via email kgrasso@northcarenetwork.org.

Accessibility & Accommodation Policy

Substance use disorder Providers must have an accommodation policy - refer to "Accessibility & Accommodation Policy" on the NorthCare website.

- Access and accommodation of persons with the limited English proficiency
- Sensitivity and accommodation of diverse ethnic and cultural backgrounds (example, Native Americans)
- Accommodations for those with visual impairments (including persons who do not use verbal language to communicate or who use alternative forms of communicating)
- Staff education on the importance of each individual's diverse needs and the necessity to utilize person-centered thinking to create individual plans of service and actions to meet those needs. This training will recognize the disabilities affecting members may not be visible to the naked eye and may require accommodation in areas such as recognizing the effects of medications, adjusting meeting schedules and the length of meetings.
- A commitment to remove any barrier that may not be currently addressed. This may be accomplished by a variety of means: e.g., focus groups, consumer complaints, and consumer surveys.

Providers will be monitored for appropriate compliance during annual site reviews.

Background Check

It is the policy of NorthCare Network that appropriate background and exclusion checks be completed on all potential employees, students, interns, volunteers, contractors, and board members as part of their screening process. Criminal background checks are required prior to

hire and every other year after the initial check. Refer to the NorthCare Network Background and Exclusion Check policy for complete details on the process that must be followed.

Compliance/Program Integrity

All providers are expected to have written policies and follow principles that promote ethical health care and uphold the integrity of ethical business practice. Failure to do so will result in remediation efforts and/or contract action, if needed. NorthCare has the responsibility of regulating, overseeing, and monitoring the Medicaid processes of business conducted throughout its service area and to support business practices conducted with integrity and in compliance with the requirements of applicable laws and sound business practices. The NorthCare Compliance Plan, standards, and policies referenced herein are not exhaustive or all inclusive. All Network Providers are required to comply with all applicable laws, rules and regulations and policies including those that are not specifically addressed in the Compliance Plan. NorthCare will monitor compliance efforts of Network Providers during annual site reviews, at minimum.

The provider must report to NorthCare Network within 30 calendar days when it has identified payments more than the amounts specific in the contract. Recoveries of over payments due to fraud, waste, or abuse shall be reported by the Provider to NorthCare Network.

The provider will provide prompt notification to NorthCare Network when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including, changes in the enrollee's residence and the death of an enrollee.

Quality Management

Quality Improvement

NorthCare's Quality Assessment and Performance Improvement Program (QAPIP) is structured to facilitate and ensure an objective and systematic performance improvement program that monitors and evaluates the quality of care provided to clients identified to have any one or more of the following: mental illness, developmental disabilities, or substance use disorder. QAPIP emphasizes the use of consumer and other stakeholder involvement to improve services. Quality management stresses the self-worth of employees; cooperation between employees; team building; and a partner relationship between NorthCare, CMHSP's, and advocacy groups and other human service agencies. Quality management is that it is less expensive overall to build quality into an organization's services (prevention) than it is to expend additional resources on rework and dissatisfied customers (remediation).

Each substance use disorder provider is strongly encouraged to implement a Quality Assessment and Performance improvement Program within their provider organization that addresses:

- Structure and Accountability for the QI Program
- Active participation by stakeholders
- Components and activities
- Process for review and follow-up of Sentinel Events
- Evaluation of members' experiences with Services
- Practice Guidelines
- Qualifications for Scope of Practice (Credentialing and Privileging)
- Verification of service delivery
- Utilization Management activities
- Procedure for Adopting & Communication Process & Outcome Improvements

Training

Provider Staff training

NorthCare Network Substance Use Disorder Providers can utilize Improving MI Practices for contractual training requirements listed below to be completed within 30 days of hire and annually thereafter.

- Communicable Diseases
- Confidentiality/Consent
- Corporate Compliance/Deficit Reduction Act (DRA)
- Cultural Competency
- HIPAA/Security
- Recipient Rights
- Trauma Informed/Responsive Systems of Care

The training site will provide a certificate of completion for the training and NorthCare will monitor this at time of site review in the employee human resources file. NorthCare strongly encourages providers to have a tracking system in place to ensure that all staff have the required training.

Communicable Disease

- Provider policy for referral process for testing – TB, Hepatitis, STD, & HIV when appropriate
- Provider policy assuring all pregnant women presenting for treatment are offered referral for or provided STD and HIV testing
- Protocol for residents and staff if suspicion of contagious diseases is evidenced upon client admission and prior to actual test being conducted
- Provider policy/protocol for making clients aware of available resources if already infected with TB, Hepatitis, STD, or HIV
- Utilization of state funds is prohibited for the distribution of sterile needles for injection of any illegal drugs
- Provider policy – ALL staff (including clerical, janitorial, etc.) must have minimal knowledge of HIV/AIDS, TB – training logs documentation
- All new hires into the system must receive a minimum of 3 hours training on communicable disease within 6 months of hire
- Clinicians receive an expanded level of training relevant to their positions within 6 months of hire
- Updates are provided at least every two years
- Screening tool to identify high risk clients

Definition for 13 Training

Level 1 – Minimal standards for ALL employees:

- HIV/AIDS, TB, Hepatitis (especially A, B, & C) and STDs as they relate to the agency target population
- Modes of transmission (risk factors, myths, and facts, etc.)
- Linkage between substance use disorder and these communicable diseases
- Overview of treatment possibilities
- Local resources available for further information/screening
- Universal precautions procedures – basic knowledge of universal precautions for blood borne and body fluids transmission of pathogens

It is anticipated that the above could be adequately covered in a two-hour session, with update trainings every year, and may be provided by agency staff that have completed Level 2 training.

Deficit Reduction Act (DRA)

The provider must educate all staff on the DRA and provide up-to-date information to staff on a regular basis.

Cultural Competence

All providers must have a written cultural competency plan implemented at their agency. The plan must include:

- Identification on assessment of the cultural needs of potential and active clients based on population served
- Identification of how ongoing staff training needs in Cultural Competency will be assessed and met the evidence that staff members receive training
- Process for ensuring the panel providers comply with all applicable requirements concerning the provision of culturally competent services
- Process for annually assessing compliance with the cultural competence plan

Using the ELMER system

System Authentication/Data Encryption

The ELMER system requires user authentication. Base credentials are a username and password. All user passwords must be changed at least every 90 days and are required to be at least 12 characters and should contain a combination of letters and numbers. All data transmitted over the internet is SSL encrypted. To access the ELMER system, the username and passwords must be assigned. To request access to ELMER contact NorthCare's Provider Network Specialist, Karena Grasso, 906-205-2838, or via email at kgrasso@northcarenetwork.org.

Usernames/passwords will be given via confidential email or over the telephone only. Sharing username/passwords is strictly prohibited. Off-site access to the ELMER system is also prohibited. Access to Electronic Health Systems (including ELMER) is permitted only from NorthCare Network managed equipment or Business Associate managed equipment. No personal equipment shall be used to gain access to Electronic Health Systems. Notify NorthCare Network immediately to have a username disabled when an employee leaves your agency. This should be done without delay, so that continued access is not possible. Any issues with the ELMER system should be reported to NorthCare's Provider Network Specialist at pnm@northcarenetwork.org.

Data Entry

Refer to the "Help" section of ELMER to view referral guides.

Outpatient Treatment Discharge

Discharge date extensions: Discharge data must be submitted when no treatment services have been provided to the client in the last 60 days. Discharge date is the date of the last billable treatment service.

Residential Treatment "Reason for Discharge"

Do not use "Completed Treatment" for Residential Treatment Discharge reason when additional treatment is planned or expected as part of the current treatment episode. In the Episode of Care model Residential SUD Treatment is not considered to be the ideal "end" of treatment. While a client at discharge from residential treatment may have "*successfully completed the level of care*," it is generally expected the client will be stepped down, or referred to a lower level of care, i.e., outpatient SUD treatment, for follow-up care. Therefore, the guideline is to reserve "Completed Treatment" for an Outpatient SUD Discharge reason.

Importance of Discharge Data and Keeping Discharges "up to date"

SUD Treatment discharge data is used to measure outcomes of Treatment, from each admission to the corresponding discharge. Outcomes, in turn, help determine State and Federal funding. NOMS (National Outcome Measures) specifically look at changes in frequency of use, employment status and housing status, as well as "how many days did it take client to access treatment" and "how long did client engage in outpatient treatment."

If a client in outpatient treatment needs to enter detox for example, the outpatient Provider must discharge the clint before the detox provider can admit him/her. Although the client may be returning to the outpatient program following a two-day detox stay, courtesy discharge, followed by a new admission is required.

A discharge, from ANY level of care, may be requested of the appropriate provider staff by NorthCare for administrative purposes. This will be done in writing via secure email, or ELMER messaging. The format used will be client initials and MCO ID. This discharge is expected to be completed within 2 business days.

<u>For detox discharges, only use the "reason for delay" if there is a delay or exception related to follow up treatment</u>

Document the Treatment Referral Plan to follow Detox Discharge. In the Discharge Notes box, include the Name of Follow-up Treatment Provider client is being referred to after Detox and the Date planned for follow-up Treatment Admission. IF clients will not meet the 7-day timeliness standard (from Detox to Treatment). List appointment dates offered, refused, accepted and check reason for Delay following Detox Discharge.

BH-TEDS Admission Update & Discharge Coding Structure

State Behavioral Health Treatment Episode Data Set (BH-TEDS) collects information at the time of Admission, Update, and at time of discharge and should reflect the current status of the client. Reference the BH-TEDS Coding Instructions in the ELMER Help section – SUD How-To-Guides. Review this guide for all instructions as this guide is updated as changes occur.

If an individual gets a new Medicaid ID number during the course of treatment, like in the case of adoption, submit an updated record with the date of the Medicaid ID change.

Medicare beneficiary Identification (MBI)

MBI is made up of eleven randomly generated numbers and upper-case letters all in a specific format and no special characters are used. If an individual obtains Medicare during an episode of treatment, a separate S record is not required to be submitted. Simply enter the new Medicare ID number on all records submitted after the number has been received.

BH-TEDs validate against the Medicare ID number format. If this field is not blank and any field position contains an invalid value, the record will generate an error.

Date of request/First contact with treatment provider (Performance Indicator Reporting)

ELMER uses the date of the first contact to calculate time to treatment. This date is when the client OR NorthCare SUD Services screener and the client contact the admitting treatment provider to request this treatment admission.

Gender Identity

Gender Identity is a person's internal understanding and experience of their gender. It is separate from sex assigned at birth.

Type of Treatment Service setting at Admission, Update and Discharge:

02 – Residential Detox – Substance Use services in 24-hour, free-standing residential setting that provides for safe withdrawal and transition to ongoing Substance Use treatment. Includes ASAM Levels WM-3.2 and WM 3.7.

04 – Residential Rehab – Substance Use services in non-acute 245-hour settings that typically provide 30 or less days of Substance Use treatment. Typically includes ASAM Levels 3.3, 3.5, and 3.7.

05 – Residential Rehab – Substance Use services in non-acute residential settings that typically provide more than 30 days of Substance Use treatment. Typically includes ASAM Levels 3.3 and 3.1 and may include transitional living arrangements such as half-way houses.

06 – Ambulatory Intensive Outpatient – (IOP Treatment) Substance Use ambulatory IOP in a non-acute care setting. Similar to ASAM Level 2.1 with nine (9) or more hours per week and Level 2.5 with 20 or more hours per week.

07 – Ambulatory Outpatient – Substance Use ambulatory non-intensive services in outpatient settings which include individual, family, group, case management, and/or pharmacological therapies. Similar to ASAM Level 1.0, outpatient treatment, non-intensive with less than nine hours per week.

Prior Treatment Episodes

Indicates an attempt to answer the question: ow many times have you tried to address this problem at any treatment provider?"

0 – 0 previous episodes

1 – 1 previous episodes

2 – 2 previous episodes

3 – 3 previous episodes

4 – 4 previous episodes

5 – 5 or more previous episodes

7 – Unknown

Codependent/Collateral Person Served

A Codependent/collateral individual is a person with no alcohol or drug problem but is formally receiving substance use treatment to address problems arising from his/her relationship with an alcohol or drug user.

Designations

I/DD Designation

Intellectual/Developmental Disability

1 – Yes

2 – No

3 – Not Evaluated (Is not allowed on the Update or Discharge records. When it is unclear if the individual meets the Michigan Mental Health Code Definition of I/DD, select No)

SMI or SED Designation

Serious Mental illness or Severe Emotional Disturbance

1 – Yes

2 – No

3 – Not Evaluated (Is not allowed on the Update or Discharge records. When it is unclear if the individual meets the Michigan Mental Health Code Definition of I/DD, select No).

Detailed SMI or SED Status

Serious Mental Illness or Severe Emotional Disturbance

1 – SMI

2 – SED

3 – Neither SMI nor SED

4 – Not Evaluated or N/A (Is not allowed on the Update or Discharge records. When it is unclear if the individual meets the Michigan Mental Health Code Definition of I/DD, select No)

Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment

1 – Integrated Treatment - Yes, client with co-occurring SUD and MH problems is being treated with an integrated treatment plan by an integrated team

2 – No, client does NOT have a co-occurring SUD and MH problem

3 – Co-occurring, Not Integrated - Client with co-occurring SUD and MH problems is NOT currently receiving integrated treatment

Currently in Mainstream Special Education

Identifies whether the individual is currently in mainstream education with Special Education Status

1 – Yes

2 – No

6 – Not Applicable – Individual is not school age

School Attendance Status

Only applies to school-age (3-17 years old) or, individuals in Special Education (0-26 years old). *Always choose 6 – Not applicable for a person who is older than 26 years old.*

1 – Yes

2 – No

6 – Not applicable

Living Arrangements

Identifies whether an individual is homeless or describes the individual's current residential situation or arrangement.

1 – Homeless – Individual having no fixed address and includes homeless shelters

2 – Dependent Living – Individual living in a supervised setting such as a residential institution, halfway house, transitional housing, recovery housing, a group home, OR children (under age 18) living with parents, relatives or guardians, OR SUD individuals in foster care

3 – Independent Living – Individual with a fixed address living alone or with others in a private residence independently. Includes adult children (18 and older) living with parents and adolescents living independently. Also includes individuals living independently with case management or supported housing support.

Employment Financial

Employment status – Describes the individual's current employment status.

1 – Individual working 35 hours or more per week, with or without supports, in a typical workplace setting, where the majority of persons employed are not persons with disabilities, earning wages consistent with those paid workers without disabilities in the community performing the same or similar work. The individual earns at least minimum wage. May include self-employment and active-duty members of the uniformed services.

2 – Individual working less than 35 hours per week, with or without supports, in a typical workplace setting, where the majority of persons employed are not persons with disabilities, earning wages consistent with those paid workers without disabilities in the community performing the same or similar work. The individual earns at least minimum wage. May include self-employment.

3 – Unemployed – Individual who has actively looked for work during the past 30 days or on a layoff from a job

4 – Not in competitive, Integrated Labor Force An individual: a.) who has not looked for work in the past 30 days; b.) whose current disability symptoms prevent him/her from competitively or non-competitively working; c.) who is primarily a student, homemaker, retired, inmate of an institution; or d.) who works in a non-competitive or non-integrated environment. Individuals in this category are further described in "Detailed Not in Labor Force.

98 – Not applicable – Individual is under 16 years of age; always use 98

Total Annual Income – Specifies the individuals' current annualized income utilized in calculating his/her ability to pay.

Number of Dependents – Number of dependents utilized in calculating ATP.

Enrolled in State Disability Income (SDA,) Supplemental Security Income (SSI,) or Social Security Disability Income (SSDI) – Identifies whether the individual is enrolled in SDA, SSI, and/or SSDI or if an individual who *otherwise qualifies for SDA is having his/her room and board at a substance use facility being paid by SDA funds*.

Veteran Military Information – Fields must be completed to sign document. When Veteran Status is Veteran, the following question – Would you like to be referred to the Veteran Navigator? It is required to be answered. All Veterans wishing to speak to the Veteran Navigator will be contacted by the Veteran Navigator directly.

Substance Use Problem

The following coding applies to Primary, Secondary and Tertiary Substances. The same drug cannot be used for more than one category. If Primary Substance – 00 at Admission, client must have Co-Dependent – "Yes" and/or 2, 3, or 9 must be coded in other factors.

01 – None – If none, all related fields (route of administering, frequency of use, and age of first use) must be N/A

02 – Alcohol

03 – Cocaine/Crack

04 – Marijuana/Hashish – Includes THC and any other cannabis sativa preparations

05 – Heroin

06 – Non-prescription Methadone (illicit use)

07 – Synthetic Opiates & Other Opiates – includes buprenorphine, butorphanol, codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and other narcotic analgesics, opiates, or synthetics

08 – PCP – phencyclidine

09 – Hallucinogens – Includes LSD, DMT, mescaline, peyote, psilocybin, STD, and other hallucinogens

10 – Methamphetamine/Speed

11 – Other Amphetamines – Includes amphetamines, MDMA, 'bath salts', phenmetrazine, and other amines and related drugs

12 – Other Stimulants – Includes methylphenidate and any other stimulants

13 – Benzodiazepines – Includes alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, flurazepam, halazepam, lorazepam, oxazepam, prazepam, temazepam, triazolam, and other benzodiazepines

14 – Other Tranquilizers – Includes meprobamate, and other non-benzodiazepine tranquilizers

15 – Barbiturates – Includes amobarbital, pentobarbital, phenobarbital, secobarbital, etc.

16 – Other Sedatives or Hypnotics – Includes chloral hydrate, ethchlorvynol, glutethimide, methaqualone, and other non-barbiturate sedatives and hypnotics

17 - Inhalants – Includes aerosols, chloroform, ether, nitrous oxide and other anesthetics, gasoline, glue, nitrites, paint thinner and other solvents, and other inappropriately inhaled products

18 – Over-the-counter medications – includes aspirin, dextromethorphan and other cough syrups, diphenhydramine, and other antihistamines, ephedrine, sleep aids, and any other legally obtained, non-prescription medication

20 – Other drugs – includes diphenylhydantoin/phenytoin, GHB/GBL, ketamine, "spice," carisoprodol, and other drugs

Medication-Assisted Opioid Therapy

Identify whether the use of opioid medications such as methadone, buprenorphine, vivitrol, suboxone, or naltrexone will be part of the individual's treatment plan.

1 – Yes

2 – No

6 – N/A used if the individual is not in treatment for an opioid problem.

Attendance at Substance Use or Co-dependent Self-help Groups in the Past 30 days

Indicates the frequency of attendance at a self-help group in the past 30 days or since Service Start/Most recent Update, whichever is sooner.

01 – No Attendance

02 – less than once a week (1-3 times in the past 30 days)

03 – About once a week (4-7 times in the past 30 days)

04 – 2 to 3 times per week (8-15 times in the past 30 days)

05 – At least 4 times per week (16-30 or more times in the past 30 days)

Discharge Date

The date of *last treatment service* client received and usually matches last billable treatment. Unless Service End is due to death, then Date of Death is the Discharge (service end date)

Reason for Service Update/End

Identifies the records as Update/End or indicates the outcome of a treatment episode or reason for transfer/discontinuance. Most significant reason for client's discharge:

01 – Treatment completed – Substantially all parts of the Treatment plan or program are completed, and the individual is not transferring on to another LOC or treatment provider

02 – Dropped Out of Treatment – Individual chose not to complete treatment program. Includes individuals who drop out of treatment for unknown reasons, individuals with whom contact has been lost, individuals who fail to return from leave (i.e., AWOL), and individuals who have not attended for some time as identified by state guidelines.

03 – Terminated by Facility – Generally because of non-compliance with treatment or violation of rules, laws, policies, or procedures

04 – Transferring to another program or Facility/Completed Level of Care – Individual will transfer to another level of care, program, Provider, or facility

05 – Incarcerated or Released by Courts – Individual's treatment is terminated because s/he has been subject to jail, prison, or house confinement or s/he has been released by or to the courts

06 – Death – the death of the individual receiving SUD services

07 – Other – Individual transferred or discontinued treatment because of change in life circumstances, like extended illness, hospitalization, or change or residence out of NorthCare Network's SUD treatment region.

Diagnosis – Must have at least one SUD Diagnosis, if co-occurring treatment is provided must also have a secondary diagnosis for the Mental Health Problem

<u>Note – Outpatient Discharges</u>

Discharge must be submitted when no treatment services have been provided to the client in the last *60 days* and/or Previous authorization has expired. Discharge Date is the date of the last billable service.

<u>Note – Detox Discharges</u>

Document the Treatment referral plan to follow detox discharge. In the discharge notes box include the name of follow-up treatment Provider client is being referred to after Detox and the date planned for follow-up treatment admission. If client will not make the *7-day* timeliness standard (from detox discharge to follow-up treatment), list appointment dates offered, refused, accepted and check reason for delay following detox discharge.

Provider Billing

General Information

Treatment Providers will bill for services via the NorthCare ELMER system. To accomplish billing, all services must be prior-authorized.

Treatment services should be billed to NorthCare Network on a monthly basis. Providers are encouraged to bill for services by the 10th of the month following the month treatment was provided.

ALL services must be billed within 60 days of treatment. An exception will be automatic for those clients with 3rd party insurance. This will allow the treatment Provider the opportunity to bill the 3rd party insurance prior to billing NorthCare. Once third-party payment has been received, the amount paid can be included when the treatment is entered into the ELMER system.

DO NOT combine fiscal years in a batch.

Example: September 2024 dates of service should not be processed in the same batch as November 2024 dates of service. Create and submit a separate batch.

Providers can expect reimbursement from NorthCare Network within 45 days for clean claims submitted for payment. Processed claims can be viewed and printed by the provider.

Claims Processing

Refer to the How to Guides in ELMER – click on “Help” at the top of the ELMER Provider page.

- SUD Provider Claims Entry Quick Reference
- SUD Provider Claims Submission User Manual

Reporting

State-Required Reporting

The Michigan Department of Health and Human Services (MDHHS) requires periodic reporting by NorthCare Network SUD Services of information specific to the regional panel of Treatment Providers and clients they serve. For NorthCare Network SUD Services to compile accurate regional data, it is essential that reliable information from individual Providers be submitted on a timely basis. In addition to the data entered in ELMER, Providers are required to submit the following report forms.

Monthly Provider Report – 90% Capacity Management report

The purpose of this report is to show which SUD Treatment Providers reach 90% capacity during the reported month. It provides another way to look at our region's capacity to serve Federal Priority Populations: IV Drug Users and Pregnant Women. Whereas many Residential SUD Treatment Providers reach 90% capacity in a specific month, Outpatient SUD Treatment Providers, according to the State, seldom hit 90% full capacity on any given day. Please refer to "How to Complete Monthly Capacity Management Report" for Outpatient and Residential Methods for calculating 90% capacity. Submit this report by the 15th of the month following the reported month.

Monthly Provider Report – Federal Priority Populations Waiting List Exception Report

This monthly report is used for NorthCare Network SUD Services certification that federal block grant priority clients (pregnant drug users and/or IV drug users) are served according to timeliness guidelines specified in Public Law 102-321. The monthly Federal Priority Populations Waiting List Exception Report form was designed for electronic submission via email or faxing of this information to the NorthCare SUD Services 1-248-406-1286. NorthCare staff will compile the majority of this report from data submitted through admissions. However, for individuals contacting providers directly and do not get admitted, additional information is needed.

Report is due within 15 days of the end of every report month. Electronic submission (email completed form) is preferred. The following are definitions and timeliness guidelines to be used for this report:

Federal Priority Codes

1 – Pregnant injecting drug user

2 – Pregnant non-injecting drug user

3 – injecting drug user

Child Referral Report

The Quarterly Children's referral report is used to capture the number of children who enter residential services with their parent and who are referred, access, or refuse prevention services, treatment services, and mental health services. The report also captures the number of children in residential treatment who have current CPS or Foster Care involvement.

Michigan Department of Corrections (MDOC) Monthly Reviews

Monthly, NorthCare staff will randomly select a sample of clients in which MDOC involvement was indicated on either the admission form or the Brief Screen. Staff will request documentation of communication with MDOC Supervising Agents by contract.

Client BH-TEDS Data Uploads (Admissions and Discharges) – generated from ELMER data

The NorthCare Network SUD Services submits batches of regional client SA Treatment admissions and discharges to the State, monthly. These files are used by MDHHS for the Federal BH-TEDS. Admission and Discharge information is used for Performance Indicators and NOMS (National Outcome Measures), as well. This data is used to help determine treatment funding needs. It is essential that Providers enter this information into the ELMER website in a timely, accurate manner so that the NorthCare Network SUD Services can submit reliable data to the State. Providers are asked to regularly check the accuracy of data and run the ELMER Open Client Summary to keep the discharge up to date. This information forms the basis for statistics related to our region and reflects trends in Michigan.

Client Satisfaction Surveys

Providers are required, on an ongoing basis, to survey anonymously their open and/or closed client satisfaction.

Treatment Providers distribute their own Client Satisfaction Surveys, which must include one "Over-All Satisfaction" question. The Provider must be able to interpret the answer to this "Over-All Satisfaction" question as either "Satisfied" or "Not Satisfied," over-all, with the Treatment Provider's Program. Another way to ask this question is, "Would client refer family or friends for Treatment with this Treatment Provider?" The Treatment Provider should *survey* an individual client only once in a fiscal year to avoid duplication of respondents in summary to NorthCare SUD Services.

Immediate Provider Report – EVENT Notification

MDHHS requires immediate reporting of an "unexpected occurrence" involving a person receiving services involving unexpected death, homicide, or action by the person receiving services that requires immediate notification to MDHHS to allow MDHHS to address any required immediate follow-up actions including statements to the media, or removal of others from a group setting. This report shall be submitted to NorthCare within 24 hours of learning of the event. NorthCare will then submit a report of the event to MDHHS, via the CRM, within 48 hours. This includes:

- Any death that occurs because of suspected staff member action or inaction or any death that is the subject of a recipient rights, licensing, or police investigation.

NorthCare SUD Treatment Providers are required to report Event Types #2, #3, and #4, listed below, when SUD clients are involved or affected. Providers must fax the NorthCare SUD Event Notification Report form (an updated reporting form has been distributed to SUD providers for use beginning in FY23), via confidential fax 1-248-406-1286, to the NorthCare Clinical Director, *within two business days of the Event's occurrence*. NorthCare then reports these events electronically to MDHHS, via the Incident Report Module:

- #2 Relocation of consumer placement due to licensing issues
- #3 An occurrence that requires the relocation of any PIHP Regional Entity or Provider Panel service site, governance, or administrative operation for more than 24 hours
- #4 The conviction of a PIHP Regional Entity, or Provider Panel Staff member for any offense related to the performance of their job duties or responsibilities.

Residential Provider Required Event Reporting

Residential SUD Treatment Providers are to report within three business days any critical incident via the NorthCare SUD Event Notification Report form. NorthCare requires a complete Root Cause Analysis report in the event that a critical incident is determined to be a Sentinel Event, except for most arrests and/or convictions. Within three days of a critical incident, the provider reporting organization must determine if the event meets the sentinel event standards. If it does meet that standard the provider reporting organization has two days from the date of that determination to start the root cause analysis of the incident. Refer to the NorthCare website for the entire Incident, Event, & Death Reporting, Monitoring & Oversight policy.

The following are examples of Critical Incidents, which may be determined to be Sentinel Events:

- Death of a recipient
- Serious illness requiring admission to hospital.
- Alleged cause of abuse or neglect
- Accident resulting in injury to recipient requiring emergency room visit and/or admission to hospital.
- Behavioral episode
- Arrest and/or conviction (Note: always count each as a Sentinel Event, but typically not required to do Root Cause Analysis)
- Medication error

Any Critical Incident falling into the categories listed above should be thoroughly reviewed to determine whether it meets the criteria for Sentinel Event (defined below) and if it is also related to practice of care.

Grievance and Appeal Reporting

Individuals receiving substance use disorder services have the right to a fair and efficient process for resolving disagreements regarding their services and support. Providers shall educate beneficiaries and staff on the beneficiary's right to file a grievance or appeal and the process to do so. Beneficiaries wanting to file a grievance or appeal are to be referred directly to NorthCare. Providers shall provide contact information for NorthCare and assist individuals in reaching the appropriate contact at NorthCare as needed. If an individual makes a complaint that is not related to services or supports and the individual prefers immediate resolution by the Provider, the Provider may address the complaint and log it for review by NorthCare upon request or at time of site review. *The client must still be given an opportunity to file the complaint with NorthCare if they so desire.* Please see Regional SUD Reporting Requirement Chart below for details.

Other Reporting

On occasion, the NorthCare Network SUD Services may survey its Providers on substance abuse related issues or request specialized information. Providers' cooperation in these instances is essential to ensure quality programming that is responsive to clients.

Please note that the inadvertent omission of a required report in this Provider Manual does not relieve Providers of the responsibility for completing requirements previously, or subsequently, requested by the NorthCare Network SUD Services.

REGIONAL SUD REPORTING REQUIREMENT CHART

NorthCare Network Substance Use Disorder Services

1230 Wilson Street, Marquette MI 49855

Phone: (906) 225-7222 Toll Free: (800) 305-6564 Fax: (248) 406-1286

Report and Frequency	*Annual: Report* Month and Due Date											
	1st 6 Months						*2nd 6 Months*					
	1st Qtr.			*2nd Qtr.*			*3rd Qtr.*			*4th Qtr.*		
	Oct due Nov 15	Nov due Dec 15	Dec due Jan 15	Jan due Feb 15	Feb due Mar 15	Mar due Apr 15	Apr due May 15	May due June 15	June due July15	July due Aug 15	Aug due Sept15	Sept due Oct 15
Immediate: Please report immediately to NorthCare Network any of these 2 events:	Immediate reporting to NorthCare Network is required for the following: *1.* Immediate (24 business hours) Notification Report for Sentinel Event or Critical Incident: *Residential Providers, only* 2. Immediate Event Notification (e.g., a "newsworthy" Event) involving a NorthCare client.											
Monthly: *1. "Federal Priority Pops Waiting List Exception Report"* *2. "90% Capacity Mgt. Rpt."*	√	√	√	√	√	√	√	√	√	√	√	√

OUT OF REGION SUD REPORTING REQUIREMENT CHART

NorthCare Network Substance Use Disorder Services

1230 Wilson Street, Marquette MI 49855

Phone: (906) 225-7222 Toll Free: (800) 305-6564 Fax: (248) 406-1286

Report and Frequency	*Annual: Report* Month and Due Date											
	1st 6 Months						*2nd 6 Months*					
	1st Qtr.			*2nd Qtr.*			*3rd Qtr.*			*4th Qtr.*		
	Oct due Nov 15	Nov due Dec 15	Dec due Jan 15	Jan due Feb 15	Feb Due Mar 15	Mar due Apr 15	Apr due May 15	May due June15	June due July15	July due Aug. 15	Aug due Sept 15	Sept due Oct 15
Immediate:	Immediate reporting to NorthCare Network is required for the following: 1. Immediate (24 business hours) Notification Report for Sentinel Event or Critical Incident. *Residential Providers, only.* 2. Immediate Event Notification (NorthCare "newsworthy" Event) Please report immediately to NorthCare Network any of these 2 events: Call 1-800-305-6564 and ask for the SUD Clinical Director											

Definitions

Access system – Provides prompt, responsive, timely and easy access to specialty services and support for all beneficiaries. The access system functions as the front door for obtaining behavioral health services and they provide an opportunity for callers with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood, and provided with options including treatment and Provider options. The access system is available, accessible, and welcoming to all individuals on a telephone and walk-in basis.

Admission – is that point in an individual's relationship with an organized treatment service when the intake process has been completed, and the individual is determined eligible to receive services of the treatment program.

ASAM – refers to the American Society for Addiction Medicine.

ASAM Continuum – exclusive assessment tool required by MDHHS.

Care Coordination – is the deliberate organization of client care activities between two or more Providers/agencies/participants involved in a client's care to collaboratively facilitate the appropriate delivery of clinically necessary services.

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

CMHSP – stands for Community Mental Health Services Program. There are five CMHPS in the Upper Peninsula; Copper Country Community Mental Health, Gogebic County Community Mental Health, Hiawatha Behavioral Health, Northpointe Behavioral Health System, and Pathways Community Mental Health.

Continued Service Criteria – is when, in the process of client assessment, certain problems and priorities are identified as justifying admission to a level of care. Continued Service Criteria describe the degree of resolution of those problems and priorities and indicate the intensity of services needed. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for continued service.

Co-Occurring – Individuals who have at least one mental disorder as well as an alcohol or drug use disorder (SAMSHA). Use of the term carries no implication as to which disorder is primary and which is secondary, which disorder occurred first, or whether one disorder caused the other.

Critical Incident – Examples to be reported by residential Providers; death of a recipient, injury requiring emergency room visit and/or admission to hospital, serious illness requiring admission to hospital, alleged case of abuse or neglect, serious challenging behavior, arrest and/or conviction, and medication error. (MDHHS)

Cultural Competency – is defined as a set of values, behaviors, attitudes, and practices within a system, organization, and program or among individuals and which enables them to work effectively cross culturally. It refers to the ability to honor respect the beliefs (religious or otherwise), language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Discharge Summary – is the written summary of the client's treatment episode. The elements of a discharge summary include description of the treatment received, its duration, a rating scale of the clinician's perception of investment by the client, a client self-rating score, description of the treatment and non-treatment goals attained while the client was in treatment, and detail those goals not accomplished with a brief statement as to why. Formal discharge summary must be in the client's chart within fourteen-days of discharge.

Discharge/Transfer Criteria – is when, in the process of client assessment, certain problems and priorities are identified as justifying treatment in a level of care. Discharge/Transfer Criteria describe the degree of resolution of those problems and priorities and thus are used to determine when a client can be treated at a different level of care or discharged from treatment. Also, the appearance of new problems may require services that can be provided effectively only at a more or less intensive level of care. The level of function and clinical severity of a client's status in each of the six assessment dimensions is considered in determining the need for a discharge or transfer.

DSM-V – refers to the Diagnostic and Statistical Manual of Mental Disorders (5th Edition), developed by the American Psychiatric Association (APA). It is the standard classification of mental health disorders used by mental health professionals in the United States. It is intended to be used in clinical settings by clinicians for determining behavioral health diagnosis that are part of the assessment and inform development of an individualized treatment plan with the medically necessary level of care.

DRA – Deficit Reduction Act established the Medicaid Integrity Program under Section 6034 of the Social Security Act, signed into law February 8, 2006. (cms.gov)

Early Intervention – is a specifically focused treatment program including stage – based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence.

ELMER – Electronic Medical Record System that NorthCare Network utilizes across the region.

FASDs – "Fetal Alcohol Spectrum Disorders" is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental behavioral, and/or learning disabilities with possible lifelong implications (SAMHSA).

HMP – Healthy Michigan Plan – health care coverage for individuals who; are age 19-64 years, have income at or below 133% of the federal poverty level under the modified adjusted gross income methodology, do not qualify for or are not enrolled in Medicare, do not qualify for, or are not enrolled other Medicaid programs, are not pregnant at the time of application, are resident of the State of Michigan.

Interim Service Requirements – Services the Providers must supply in lieu of recipient admitted within the admission priority requirements (MDHHS). Is a provisional service(s) provided while a client is waiting for an appropriate level of care. Interim services must begin within forty-eight (48) hours for (1) injecting drug users who cannot be admitted to formal treatment within fourteen (14) days and (2) pregnant women who cannot get into formal treatment immediately.

Length of service – is the number of days (for residential care) or units/visits/encounter (for outpatient care) of service provided to a client, from admission to discharge, at a particular level of care.

Level of Function – is an individual's relative degree of health and freedom from specific signs and symptoms of a mental or substance-related disorder, which determine whether the individual requires treatment.

Level of Service – as used in ASAM Criteria, 3rd Edition, this term refers to broad categories of patient placement, which encompass a range of clinical services such as early intervention, detoxification, or opioid maintenance therapy services and levels of care such as intensive outpatient treatment or clinically managed medium-intensity residential treatment.

MAPS – stands for Michigan's Automated Prescription Service. It is a web-based service to monitor prescriptions for individuals in Michigan.

MDHHS – stands for Michigan Department of Health and Human Services.

Medicaid Health Plans, or MHPs – are insurance companies who contract with the State to provide coverage for the physical health care and mild-moderate behavioral health care benefits of Medicaid enrollees.

Medical Necessity – is determination that a specific service is medically (clinically) appropriate and necessary to meet a client's treatment needs, consistent with the client's diagnosis, symptoms, and functional impairments and consistent with clinical Standards of Care.

Non-urgent cases – are those clients screened for substance use disorder services but who do not require urgent (immediate) services.

OUD – Opioid Use Disorder

Peer Recovery Associate – the name given to individuals who assist the peer recovery coach by engaging in designated peer support activities. These persons have been provided an orientation and brief training in the functional aspect of their role by the entity that will utilize them to provide supports. These individuals are not trained to the same degree as a peer recovery coach.

Peer Recovery Coach – the name given to peers who have been specifically trained to provide advanced peer recovery support services in Michigan. A peer recovery coach works with individuals during their recovery journey by linking them to the community and its resources. They serve as personal guide or mentor, helping the individual overcome personal and environmental obstacles.

PIHP – Prepaid Inpatient Health Plan. NorthCare Network is the PIHP for Region 1, which is made up of the 15 counties in the Upper Peninsula of Michigan.

Primary Care Coordination – substance use disorder treatment services must be coordinated with primary health care. (MDHHS)

Recipient – individual receiving services

Re-disclosure – additional disclosure of information is prohibited unless further disclosure is expressly permitted by the written consent of the person to whom is pertains or as otherwise permitted by 42 C.F.R. Part 2 (Federal Regulation 42 C.F.R. Part 2).

Recovery – a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA).

RCSS **–** stands for Recovery Coach Support Services. A recovery coach support is an individual who has lived experience in receiving services and/or supports for a substance use condition. They service as a guide to initiate, achieve, and sustain long-term recovery from addiction including medication assisted, faith based, 12-step and other pathways to recovery. Recovery coaches provide connections in navigating recovery supportive systems and resources including professional and non-professional services.

ROSC – stands for Recovery Oriented System of Care, which describes a paradigm shift from an acute model of treatment to a care model that views SUD as a chronic illness. A ROSC is a coordinated network of community-based services and supports that is person-centered and build over a period of months and/or years on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

SAMHSA – stands for Substance Abuse and Mental Health Services Administration. It is the federal agency which oversees the funding to the states for substance use disorder and mental health services. It is a department within the U.S. Department of Health and Human Services.

SAPT – stands for Substance Abuse, Prevention, and Treatment grant sometimes called a “block” grant. It is the community grant funding from SAMHSA for substance use disorder treatment and prevention services in the 50 states.

Sentinel Event – is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase, ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a

serious adverse outcome. (TJC, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Support Services – are those readily available to program through affiliation, contract or because of their availability to community at large. They are used to provide services beyond the capacity of the staff of the program on a routine basis or to augment the services provided by the staff.

Treatment – is the application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.