

# SUD Services Policy Manual

# ATTACHMENT P.II.B

## Attachment A

# Substance Use Disorder (SUD) Policy Manual

Effective October 1, 2014,  
reference to Coordinating  
Agencies (CAs) throughout  
manual is applicable to  
Prepaid Inpatient Health  
Plans (PIHPs)

## SUD Services Policy Manual

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## **I. DATA REQUIREMENTS**

**Data Collection/Recording and Reporting Requirements –  
Revised July 2014**

**Encounter Reporting Via Health Insurance Portability and Accountability Act  
(HIPPA) 837 Standard Transactions—  
August 2011**

**Instructions for Treatment Episode Data Set (TEDS) Submission for  
Substance Abuse Services  
Revised July 2014**

**Michigan Prevention Data System (MPDS) Reference Manual –  
Effective October 1, 2007; Revised June 2, 2010**

**Substance Use Disorder Services Encounter Reporting; HCPCS and  
Revenue Codes—August 2007; Revised August 2011**

## SUD DATA COLLECTION/RECORDING AND REPORTING REQUIREMENTS

### Overview of Reporting Requirements

The reporting of substance abuse services data by the PIHP as described in this material meets several purposes at MDCH including:

- Federal data reporting for the SAPT Block Grant application and progress report, as well as for the treatment episode data set (TEDS) reported to the federal Office of Applied Studies, SAMHSA.
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- CMS Reporting
- Actuarial activities

Special reports or development of additional reporting requirements beyond the initial data and reports required by the Department may be requested within the established parameters of the contract. The PIHP will likely maintain, for management and local decision-making, additional information to that specified in the reporting requirements.

Standards for collecting and reporting data continue to evolve. Where standards and data definitions exist, it is expected that each PIHP will meet those standards and use the definitions in order to assure uniform reporting across the state. Likewise, it is imperative that the PIHP employs quality control measures to check the integrity of the data before it is submitted to MDCH. Error reports generated by MDCH will be available to the submitting PIHP the day following a DEG submission. MDCH's expectation is that the records that receive error IDs will be corrected and resubmitted as soon as possible. The records in the error file are cumulative and will remain errors until they have been corrected.

Individual services recipient data received at MDCH are kept confidential and are always reported out in aggregate. Only a limited number of MDCH staff can access the data that contains any possible individual client identifiers. (Social Security number, date of birth, diagnosis, etc.) All persons with such data access have signed assurances with MDCH indicating that they are knowledgeable about substance abuse services confidentiality regulations and agree to adhere to these and other departmental safeguards and protections for data.

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission with associated record tagging requirements at the PIHP level to assure data synchronization with MDCH data records, are in the *Instructions for Treatment Episode Data Set (TEDS) Submission for PIHPs*.

Reporting covered by these specifications includes the following:

**-TEDS Admission Records (due monthly)**

**-TEDS Discharge Records (due monthly)**

**A. Basis of Data Reporting**

The basis for data reporting policies for Michigan substance abuse services includes:

1. Federal funding awarded to Michigan through the Substance Abuse Prevention and Treatment (SAPT) federal block grant to share in support of substance abuse treatment and prevention requires submission of proposed budgets and plans. Resources and plans must be reviewed and considered by the State in light of statewide needs for substance abuse services.
2. Public Act 368 of 1978, as amended, requires that the department develop:

A comprehensive State plan through the use of federal, State, local, and private resources of adequate services and facilities for the prevention and control of substance abuse and diagnosis, treatment, and rehabilitation of individuals who are substance abusers.

In addition, the department shall:

Establish a statewide information system for the collection of statistics, management data, and other information required.

Collect, analyze and disseminate data concerning substance abuse treatment and rehabilitation services and prevention services.

Conduct and provide grant-in-aid funds to conduct research on the incidence, prevalence, causes, and treatment of substance abuse and disseminate this information to the public and to substance abuse services professionals.

3. Comprehensive planning requires statewide needs assessments to include identification of the extent and characteristics of both risks for development and current substance abuse problems for the citizens of Michigan.

**B. Policies and Requirements Regarding Data**

Treatment Data reporting will encompass Substance Abuse (SA) services provided to clients supported in whole or in part with state administered funds through funds for SA services to Medicaid recipients included in PIHP contracts.

**Definitions:**

State administered funds: Any state or federal funding provided by the MDCH/DSAGS/SA contract. Funds provided include federal SAPT Block Grant, state general funds, MICHild, and other categorical or special funds. Medicaid funds that are covered under the MDCH/PIHP contract are considered state administered funds.

Data: Client admission and discharge records (for treatment services), and client institutional and professional encounter records, and backup required to produce this information (e.g. billings from providers, services logs, etc.). Prevention services data are not addressed herein.

Services: Substance abuse treatment (residential, residential detox, intensive outpatient, outpatient, including pharmacological supports as part of above), substance abuse assessment (screening, assessment, referral and follow-up) provided by appropriately state licensed programs. Prevention services data are not addressed herein.

Supported in whole or in part: Describes those services for which the PIHP pays, inclusive of co-pays with other sources of funds (e.g. first party, third party insurance, and/or other funding sources).

**Policy:**

Reporting is required for all clients whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services. This includes both co-pay arrangements where public funds are applied from the starting date of admission to a service, as well as those where public funds are applied subsequent to the application of other funding or payments.

For purposes of MDCH reporting, an admission is defined as the formal acceptance of a client into substance abuse treatment. An admission has occurred if and only if the client begins treatment.

A client is defined as a person who has been admitted for treatment of his/her own drug problem. A co-dependent (a person with no alcohol or drug abuse problem who is seeking services because of problems arising from his or her relationship with an alcohol or drug user) who has been formally admitted to a treatment unit and who has his/her own client record also should be reported with the record indicating his/her co-dependency.

A client's episode of treatment is tracked by service category and by license number. The first event at a new provider or in a new service category is an admission and the last event is a discharge.

Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for discharge. For reporting purposes, "completion of treatment" is defined as the completion of ALL planned treatment for the current episode. Completion of treatment at one level of care or with one provider is not "completion of treatment" if there is additional treatment planned or expected as part of the current episode. The reason for discharge given in all instances where the treatment has not been terminated should be

06 (Transfer-Continuing in Treatment). The code of 06 will identify the fact that the client's treatment episode did not terminate on the date reported.

1. Data definitions, coding and instructions issued by MDCH apply as written. Where a conflict or difference exists between MDCH definitions and information developed by the PIHP or locally contracted data system consultants, the MDCH definitions are to be used.  
REVIEW AND APPROVE WORDS
2. All data collected and recorded on admission and discharge forms shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDCH at the program level (**along with the National Provider Identifier (NPI)**).
3. Combined reporting of client data in data uploads from more than one license site number is not acceptable or allowable, regardless of how a PIHP funds a provider organization.
4. Failure to assure initial set up and maintenance of the proper site license number and PIHP code will result in data that will be treated as errors by MDCH. Any data submitted to MDCH with improper license numbers will be rejected in full. The necessary corrections and data resubmissions will be the sole responsibility of the PIHP in cooperation with the involved service providers.
5. There must be a unique Substance Abuse client identifier assigned and reported. It can be up to 11 characters in length, all numeric. This same number is to be used to report data for all admissions and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.
6. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Failure to maintain corresponding data at the PIHP and program levels will result in data audit exceptions on discovery of discrepancies during an MDCH on-site data audit/review. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.
7. Providers of residential and/or detoxification services must maintain a daily client census log that contains a listing of each individual client in treatment. This listing can be made in client name or using the client identification number. Census must be taken at approximately the same time each day, such as when residents are expected to be in bed. MDCH or the PIHP will review the daily client census logs in data auditing site visits.

8. Providers of pharmacological support services (either methadone or buprenorphine) must maintain a log that contains a listing of each client in treatment, and their daily dosages of these medications provided by the program. MDCH or the PIHP will review these logs in data auditing site visits
9. Diagnosis coding on client data forms shall be consistent with the client's substance abuse treatment plan. If there is more than one substance abuse diagnosis determined, then the secondary diagnosis code should be reported accordingly. Diagnosis codes on the data records must be consistent with those listed on other client documentation (such as billing forms, etc.). Codes should be entered using only the proper DSM definitions for substance abuse and other related problems that are being treated.
10. The primary diagnosis should correspond to the primary substance of abuse reported at admission. The secondary diagnosis may or may not be consistent with the secondary substance of abuse if another diagnosis better reflects a more serious secondary problem than the secondary substance.
11. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDCH.
12. The PIHP is responsible for generating each month's data upload to MDCH consistent with established protocols and procedures. Monthly and quarterly data uploads must be received by MDCH via the DEG no later than the last day of the following month.
13. Treatment clients may be admitted to more than one program or one service category at the same time.
14. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.
15. Statements of MDCH policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.
16. Treatment clients who have not had any treatment activity in a 45-day period shall be considered inactive and their case discharged. A treatment discharge record should be completed and submitted; the effective date of discharge will be the last date of actual contact with the program. The record should be completed and submitted based on the client's status as of the last date of service; records with all data items marked as unknown or left blank are not acceptable.

**Encounter Reporting**  
**Via**  
**Health Insurance Portability and Accountability Act (HIPPA)**  
**837 Standard Transactions**

For the first quarter of FY 2012, the X12 version 40101A of the 837 Encounter will be accepted (as it has been for the last three years). However:

Effective January 1, 2012, must submit electronic healthcare transactions using the X12 version 5010. Those who do not convert to the version 5010 by the compliance date will have their encounters and other transactions rejected. Reimbursement delays and resubmission costs could occur.

Please reference this single web page for up-to-date instructions and guidance:

[http://www.michigan.gov/mdch/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42552\\_42696-256754--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42552_42696-256754--,00.html)

Relevant documents at this site are the following:

1. HIPPA 5010A1 EDI Companion Guide for ANSI ASC X12N 837P  
Professional Encounter  
Regional PIHPs
2. HIPPA 5010A1 EDI CDI Companion Guide for ANSI ASC X12N 837I  
Institutional Encounter  
Regional PIHPs
3. Michigan Department of Community Health Electronic Submission Manual  
March 18, 2011
4. HIPPA 5010A1EDI Companion Guide for ANSI ASC X12N 270/271  
Health Care Eligibility Benefit Inquiry and Response

## **MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

### **INSTRUCTIONS**

**For:**

**Treatment Episode Data Set  
(TEDS)  
DATA SUBMISSION  
FOR  
SUBSTANCE ABUSE**

**FY 2014**

## SUBSTANCE ABUSE TREATMENT EPISODE DATA SET (TEDS) FILE

### SA Admission File Format SA Admission Header Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4823 file.					
EDI TYPE	Text	4	1	4	“HDDR”
EDI APP	Text	2	5	6	“MA”
EDI USER					
EDI USER - prefix	Text	5	7	11	“DCH00” (DCH zero zero)
EDI USER - PIHP ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4823
EDI RUN TYPE	Text	1	39	39	“P” for production or “T” for test
EDI BATCH IDENTIFIER	Text	3	40	42	<u>Unique</u> batch identifier assigned by PIHP
FILLER	Text	146	43	188	

### SA Admission Input File Format

Field Name	Type	Size	Begin	End	Comments
Note: An Admission Record is stored using the following key values: PIHP Payer ID, Social Security Number, PIHP Client ID, Admission Date, Admission Time of Day, Admission Service Category.					
Each Admission Record must have the following unique key values: PIHP Payer ID, License Number, Social Security Number, PIHP Client ID, Admission Date, Admission Time of Day.					
Record Type	Text	1	1	1	A=Admission T=Transfer Y=Transition-in
Submission Type	Text	1	2	2	A=Add C=Change D=Delete E=Error

Field Name	Type	Size	Begin	End	Comments																																								
CA Payer ID	Text	9	3	11	<table border="1"> <thead> <tr> <th>CA Code</th><th>CA Name</th></tr> </thead> <tbody> <tr><td>001182841</td><td>Salvation Army-Harbor Light</td></tr> <tr><td>001183024</td><td>Riverhaven</td></tr> <tr><td>001182930</td><td>Kalamazoo</td></tr> <tr><td>001182903</td><td>Macomb</td></tr> <tr><td>001182850</td><td>Washtenaw</td></tr> <tr><td>001183123</td><td>Pathways</td></tr> <tr><td>001182832</td><td>Genesee</td></tr> <tr><td>001182878</td><td>Lakeshore</td></tr> <tr><td>001182967</td><td>CEI</td></tr> <tr><td>001183061</td><td>Network180</td></tr> <tr><td>001183104</td><td>Northern</td></tr> <tr><td>001182896</td><td>Oakland</td></tr> <tr><td>001182869</td><td>Saginaw</td></tr> <tr><td>001182976</td><td>SEMCA</td></tr> <tr><td>001183098</td><td>Muskegon CMH</td></tr> <tr><td>001182994</td><td>Western Upper Peninsula</td></tr> <tr><td>001183033</td><td>Detroit</td></tr> <tr><td>001182887</td><td>Thumb Alliance</td></tr> <tr><td>001183169</td><td>Venture</td></tr> </tbody> </table>	CA Code	CA Name	001182841	Salvation Army-Harbor Light	001183024	Riverhaven	001182930	Kalamazoo	001182903	Macomb	001182850	Washtenaw	001183123	Pathways	001182832	Genesee	001182878	Lakeshore	001182967	CEI	001183061	Network180	001183104	Northern	001182896	Oakland	001182869	Saginaw	001182976	SEMCA	001183098	Muskegon CMH	001182994	Western Upper Peninsula	001183033	Detroit	001182887	Thumb Alliance	001183169	Venture
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License Number	Text	6	12	17	LARA License Number																																								
Social Security Number	Text	9	18	26																																									
CA Client Identifier	Text	11	27	37																																									
Beneficiary Identifier	Text	10	38	47	Must be blank if not applicable																																								
Admission Type	Text	1	48	48	1 = first admission 2 = readmission																																								
Co-Dependent	Text	1	49	49	1 = yes 2 = no																																								
Date of Admission	Text	8	50	57	CCYYMMDD																																								
Service Category	Text	2	58	59	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>11</td><td>Outpatient</td></tr> <tr><td>21</td><td>Residential detoxification</td></tr> <tr><td>22</td><td>Residential - short-term (no more than 29 days)</td></tr> <tr><td>24</td><td>Residential - long-term (30 day or more)</td></tr> <tr><td>31</td><td>Intensive outpatient</td></tr> <tr><td>61</td><td>Case Management</td></tr> </tbody> </table>	Code	Description	11	Outpatient	21	Residential detoxification	22	Residential - short-term (no more than 29 days)	24	Residential - long-term (30 day or more)	31	Intensive outpatient	61	Case Management																										
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Number of Prior Treatments	Text	2	60	61	Number as reported																																								
Referral Source	Text	2	62	63	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>01</td><td>Outpatient</td></tr> <tr><td>05</td><td>Residential detoxification</td></tr> </tbody> </table>	Code	Description	01	Outpatient	05	Residential detoxification																																		
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					06	Residential																		
					09	Intensive outpatient																		
					10	Hospital: SA program																		
					13	AMS/AAR																		
					14	Other Access Center																		
					18	Prevention																		
					19	Student assistance program																		
					20	Drug Court - Adult																		
					21	Drug Court - Adolescent																		
					22	Community Corrections																		
					29	Other SA program																		
					30	Self																		
					31	Family Court																		
					32	Court																		
					33	Probation/Parole																		
					34	Police																		
					35	Secretary of State																		
					36	Lawyer																		
					37	Mental Health																		
					38	Dept. of Human Services																		
					39	Family/friend/relative																		
					40	Other human services																		
					41	Employer																		
					42	Union																		
					43	Clergy																		
					44	School																		
					45	Physician																		
					46	Hospital (non-substance abuse)																		
					47	Substance abuse client																		
					48	Alcoholics Anonymous																		
					49	Corrections																		
					90	Other																		
County of Residence	Text	2	64	65	Reference Appendix <b>SA County Codes</b> for a list of valid county codes.																			
Date of Birth	Text	8	66	73	CCYYMMDD																			
Sex	Text	1	74	74	1= Male 2 = Female																			
Race	Text	1	75	75	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr> <td>1</td><td>Native American</td></tr> <tr> <td>2</td><td>Asian or Pacific Islander</td></tr> <tr> <td>3</td><td>African American/Black</td></tr> <tr> <td>4</td><td>White</td></tr> <tr> <td>5</td><td>Hispanic</td></tr> <tr> <td>6</td><td>Multi-racial</td></tr> <tr> <td>8</td><td>Arab American</td></tr> <tr> <td>9</td><td>Refused to provide</td></tr> </tbody> </table>		Code	Description	1	Native American	2	Asian or Pacific Islander	3	African American/Black	4	White	5	Hispanic	6	Multi-racial	8	Arab American	9	Refused to provide
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Field Name	Type	Size	Begin	End	Comments															
					0	Unknown														
Ethnicity	Text	1	76	76	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>0</td><td>Not one of listed groups</td></tr> <tr><td>1</td><td>Puerto Rican</td></tr> <tr><td>2</td><td>Mexican</td></tr> <tr><td>3</td><td>Cuban</td></tr> <tr><td>4</td><td>Other Hispanic</td></tr> <tr><td>5</td><td>Arab Chaldean</td></tr> </tbody> </table>		Code	Description	0	Not one of listed groups	1	Puerto Rican	2	Mexican	3	Cuban	4	Other Hispanic	5	Arab Chaldean
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Marital Status	Text	1	77	77	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>1</td><td>Never Married</td></tr> <tr><td>2</td><td>Married/Cohabiting</td></tr> <tr><td>3</td><td>Widowed</td></tr> <tr><td>4</td><td>Divorced</td></tr> <tr><td>5</td><td>Separated</td></tr> </tbody> </table>		Code	Description	1	Never Married	2	Married/Cohabiting	3	Widowed	4	Divorced	5	Separated		
Code	Description																			
1	Never Married																			
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3	Widowed																			
4	Divorced																			
5	Separated																			
Military Status	Text	1	78	78	1 = yes 2 = no															
Education	Text	2	79	80	00 to 25 number of years of education (e.g., 4 years of college = 16)															
Currently in Training / Education	Text	1	81	81	4 = in training/education program 6 = in special education 7 = is attending college/university/community college 0 = not applicable															
Employment Status	Text	1	82	82	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>1</td><td>Employed, full time</td></tr> <tr><td>2</td><td>Employed, part time</td></tr> <tr><td>3</td><td>Unemployed - laid off, fired, seasonal, actively sought work in last 30 days</td></tr> <tr><td>4</td><td>Not in competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (includes nursing home)</td></tr> <tr><td></td><td></td></tr> <tr><td>8</td><td>Not applicable to the person (e.g., child under age 18)</td></tr> </tbody> </table>		Code	Description	1	Employed, full time	2	Employed, part time	3	Unemployed - laid off, fired, seasonal, actively sought work in last 30 days	4	Not in competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (includes nursing home)			8	Not applicable to the person (e.g., child under age 18)
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Primary Age at First Use	Text	2	86	87	2 character age 98 = not applicable (drug code was “none”)																																										
Primary Frequency of Use	Text	2	88	89	2 characters 00 = not used 02 = 1 or 2 times a month 06 = 1 or 2 times a week 18 = 3-6 times a week 30 = daily use 98 = not applicable (drug code was “none”)																																										
Primary Initial Prescription	Text	1	90	90	Initially a prescription 0 = not applicable (drug code was “none”) 1 = yes 2 = no																																										
Secondary Substance	Text	2	91	92	For list of values, reference Primary Substance																																										
Secondary Route	Text	1	93	93	For list of values, reference Primary Route																																										

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Secondary Age at First Use	Text	2	94	95	2 character age 98 = not applicable (drug code was "none")																				
Secondary Frequency of Use	Text	2	96	97	2 characters 00 = not used 02 = 1 or 2 times a month 06 = 1 or 2 times a week 18 = 3-6 times a week 30 = daily use 98 = not applicable (drug code was "none")																				
Secondary Initial Prescription	Text	1	98	98	Initially a prescription 0 = not applicable (drug code was "none") 1 = yes 2 = no																				
Tertiary Substance	Text	2	99	100	For list of values, reference Primary Substance																				
Tertiary Route	Text	1	101	101	For list of values, reference Primary Route																				
Tertiary Age at First Use	Text	2	102	103	2 character age 98 = not applicable (drug code was "none")																				
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Tertiary Initial Prescription	Text	1	106	106	Initially a prescription 0 = not applicable (drug code was "none") 1 = yes 2 = no																				
Total Annual Income	Number	6	107	112	6 characters, rounded to the nearest whole dollar; no decimal points or commas																				
Number of Dependents	Text	2	113	114	Number of dependents claimed in determining ability-to-pay																				
Correctional Status	Text	2	115	116	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr> <td>00</td><td>No status with corrections system</td></tr> <tr> <td>01</td><td>In prison</td></tr> <tr> <td>02</td><td>In jail</td></tr> <tr> <td>03</td><td>Paroled from prison</td></tr> <tr> <td>04</td><td>Probation from jail</td></tr> <tr> <td>05</td><td>Juvenile detention center</td></tr> <tr> <td>06</td><td>Court supervision (ie. tether)</td></tr> <tr> <td>08</td><td>Awaiting trial</td></tr> <tr> <td>09</td><td>Awaiting sentencing</td></tr> </tbody> </table>	Code	Description	00	No status with corrections system	01	In prison	02	In jail	03	Paroled from prison	04	Probation from jail	05	Juvenile detention center	06	Court supervision (ie. tether)	08	Awaiting trial	09	Awaiting sentencing
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					10	Refused to provide information																				
					98	Unknown																				
Recent Total Arrests – 30 days	Number	2	117	118	00 if no arrests																					
Recent Arrests - Possession/Sales --30 days	Number	2	119	120	00 if no arrests																					
Recent Arrests - DUI/DWI – 30 days	Number	2	121	122	00 if no arrests																					
Total Arrests - 5 years	Number	2	123	124	00 if no arrests																					
Arrests - Possession/Sales - 5 years	Number	2	125	126	00 if no arrests																					
Arrests - DUI/DWI - 5 years	Number	2	127	128	00 if no arrests																					
Living Arrangement	Text	1	129	129	1 = independent 2 = dependent 3 = homeless																					
Methadone Part of Treatment	Text	1	130	130	1 = yes (methadone) 2 = no 3 = buprenorphine																					
Primary Diagnosis	Text	6	131	136	Reference Appendix SA Diagnosis Codes for a list of the valid values																					
Secondary Diagnosis	Text	6	137	142	Secondary Diagnosis may not be the same as Primary Diagnosis																					
Pregnant	Text	1	143	143	1 = yes 2 = no																					
Other Factor 1	Text	1	144	144	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr> <td>0</td><td>None</td></tr> <tr> <td>2</td><td>Adult child</td></tr> <tr> <td>3</td><td>Significant other</td></tr> <tr> <td>4</td><td>Hearing impaired</td></tr> <tr> <td>5</td><td>Visually impaired</td></tr> <tr> <td>6</td><td>Head injury</td></tr> <tr> <td>7</td><td>Developmentally disabled</td></tr> <tr> <td>8</td><td>Mobility impaired</td></tr> <tr> <td>9</td><td>Gambling Addiction</td></tr> </tbody> </table>		Code	Description	0	None	2	Adult child	3	Significant other	4	Hearing impaired	5	Visually impaired	6	Head injury	7	Developmentally disabled	8	Mobility impaired	9	Gambling Addiction
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Other Factor 2	Text	1	145	145	For list of values, reference Other Factor 1																					
Other Factor 3	Text	1	146	146	For list of values, reference Other Factor 1																					
Time Waiting to Enter Treatment	Number	3	147	149	3 digit number of days																					
Primary Language Spoken	Alpha	3	150	152	For list of values, refer to <a href="http://lcweb.loc.gov/standards/iso639-2/langhome.html">http://lcweb.loc.gov/standards/iso639-2/langhome.html</a>																					

Field Name	Type	Size	Begin	End	Comments																		
MH Diagnostic Impression	Number	1	153	153	1 = yes 2 = no																		
Drug Court Client	Number	1	154	154	1 = yes 2 = no																		
Admission Time of Day	Number	4	155	158	24-hour HHMM																		
Detailed Not in Labor	Number	2	159	160	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr> <td>01</td><td>Homemaker</td></tr> <tr> <td>02</td><td>Student</td></tr> <tr> <td>03</td><td>Retired</td></tr> <tr> <td>04</td><td>Disabled</td></tr> <tr> <td>05</td><td>Inmate of Institution</td></tr> <tr> <td>06</td><td>Other</td></tr> <tr> <td>07</td><td>Not Actively Seeking Work</td></tr> <tr> <td>98</td><td>Not Applicable</td></tr> </tbody> </table>	Code	Description	01	Homemaker	02	Student	03	Retired	04	Disabled	05	Inmate of Institution	06	Other	07	Not Actively Seeking Work	98	Not Applicable
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Date of First Contact	Number	8	161	168	CCYYMMDD																		
Women's Specialty Program	Text	1	169	169	1= yes 2= no																		
Child Welfare Involvement	Text	1	170	170	1= yes 2= no																		
Attendance at Self-Help Programs	Text	2	171	172	2 characters 00 = none 02 = 1 or 2 times a month 06 = 1 or 2 times a week 18 = 3-6 times a week 30 = daily 98 = not applicable																		
Error ID	Number	8	173	180																			
Filler	Text	8	181	188																			

**SA Admission Trailer Format**

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4823 file.					
EDI TYPE	Text	4	1	4	“TRLR”
EDI APP	Text	2	5	6	“MA”
EDI USER					
EDI USER - prefix	Text	5	7	11	“DCH00” (DCH zero zero)
EDI USER - PIHP ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4823
EDI RUN TYPE	Text	1	39	39	“P” for production or “T” for test
EDI BATCH IDENTIFIER	Text	3	40	42	<u>Unique</u> batch identifier assigned by PIHP
EDI RECORD COUNT	Number	6	43	48	Number of records in a file including the header and trailer
FILLER	Text	140	49	188	

**SA Discharge File Format**  
**SA Discharge Header Format**

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4824 file.					
EDI TYPE	Text	4	1	4	“HDDR”
EDI APP	Text	2	5	6	“MA”
EDI USER					
EDI USER - prefix	Text	5	7	11	“DCH00” (DCH zero zero)
EDI USER - PIHP ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4824
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EDI BATCH IDENTIFIER	Text	3	40	42	<u>Unique</u> batch identifier assigned by PIHP
FILLER	Text	81	43	123	

**SA Discharge Input File Format**

Field Name	Type	Size	Begin	End	Comments
Note: A Discharge Record is stored using the following key values: PIHP Payer ID, License Number, Social Security Number, PIHP Client ID, Admission Date, Admission Time of Day, Discharge Service Category.					
Each Discharge Record must have the following unique key values: PIHP Payer ID, License Number, Social Security Number, PIHP Client ID, Admission Date, Admission Time of Day.					
Record Type	Text	1	1	1	D=Discharge X=Transition-out
Submission Type	Text	1	2	2	A=Add C=Change D=Delete E=Error

Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII B.A. Substance Abuse Disorder Policy Manual

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42	Crack Cocaine																																																													
43	Methamphetamines																																																													
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PSA Route Primary Route	Text	1	61	61	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>0</td><td>Not applicable (drug code was "none")</td></tr> <tr><td>1</td><td>Oral</td></tr> <tr><td>2</td><td>Smoking</td></tr> <tr><td>3</td><td>Inhalation/intranasal ("snorting")</td></tr> <tr><td>4</td><td>Injection</td></tr> <tr><td>5</td><td>Other</td></tr> </tbody> </table>		Code	Description	0	Not applicable (drug code was "none")	1	Oral	2	Smoking	3	Inhalation/intranasal ("snorting")	4	Injection	5	Other																																										
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PSA Frequency of Use	Text	2	62	63	Number of days drug used in last 30 days																																																									

Field Name	Type	Size	Begin	End	Comments																								
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SSA Code Secondary Substance	Text	2	64	65	For list of values, reference Primary Substance																								
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TSA Code Tertiary Substance	Text	2	69	70	For list of values, reference Primary Substance																								
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Correctional Status	Text	2	74	75	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr> <td>00</td><td>No status with corrections system</td></tr> <tr> <td>01</td><td>In prison</td></tr> <tr> <td>02</td><td>In jail</td></tr> <tr> <td>03</td><td>Paroled from prison</td></tr> <tr> <td>04</td><td>Probation from jail</td></tr> <tr> <td>05</td><td>Juvenile detention center</td></tr> <tr> <td>06</td><td>Court supervision (i.e. tether)</td></tr> <tr> <td>08</td><td>Awaiting trial</td></tr> <tr> <td>09</td><td>Awaiting sentencing</td></tr> <tr> <td>10</td><td>Refused to provide information</td></tr> <tr> <td>98</td><td>Unknown</td></tr> </tbody> </table>	Code	Description	00	No status with corrections system	01	In prison	02	In jail	03	Paroled from prison	04	Probation from jail	05	Juvenile detention center	06	Court supervision (i.e. tether)	08	Awaiting trial	09	Awaiting sentencing	10	Refused to provide information	98	Unknown
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Field Name	Type	Size	Begin	End	Comments																								
days																													
Recent Arrests - Possession/Sales --30 days	Number	2	78	79	00 if no arrests																								
Recent Arrests - DUI/DWI – 30 days	Number	2	80	81	00 if no arrests																								
Living Arrangement	Text	1	82	82	1 = independent 2 = dependent 3 = homeless																								
MH Diagnostic Symptoms	Text	1	83	83	1 = none 2 = mild/moderate 3 = severe																								
Date of Discharge	Text	8	84	91	CCYYMMDD																								
Discharge Reason	Text	2	92	93	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>01</td><td>Completed treatment</td></tr> <tr><td>02</td><td>Left against staff advice</td></tr> <tr><td>03</td><td>In jail</td></tr> <tr><td>04</td><td>Staff decision for rules violations</td></tr> <tr><td>05</td><td>Death</td></tr> <tr><td>06</td><td>Continuing in treatment - transfer</td></tr> <tr><td>07</td><td>Mutual staff/client decision</td></tr> <tr><td>08</td><td>Early jail release</td></tr> <tr><td>09</td><td>Client relocated</td></tr> <tr><td>10</td><td>Program closed/merged</td></tr> <tr><td>11</td><td>Other</td></tr> </tbody> </table>	Code	Description	01	Completed treatment	02	Left against staff advice	03	In jail	04	Staff decision for rules violations	05	Death	06	Continuing in treatment - transfer	07	Mutual staff/client decision	08	Early jail release	09	Client relocated	10	Program closed/merged	11	Other
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Admission Time of Day	Number	4	94	97	24-hour HHMM																								
Discharge Time of Day	Number	4	98	101	24-hour HHMM																								
Detailed Not in Labor	Number	2	102	103	<table border="1"> <thead> <tr> <th>Code</th><th>Description</th></tr> </thead> <tbody> <tr><td>01</td><td>Homemaker</td></tr> <tr><td>02</td><td>Student</td></tr> <tr><td>03</td><td>Retired</td></tr> <tr><td>04</td><td>Disabled</td></tr> <tr><td>05</td><td>Inmate of Institution</td></tr> <tr><td>06</td><td>Other</td></tr> <tr><td>07</td><td>Not Actively Seeking Work</td></tr> <tr><td>98</td><td>Not Applicable</td></tr> </tbody> </table>	Code	Description	01	Homemaker	02	Student	03	Retired	04	Disabled	05	Inmate of Institution	06	Other	07	Not Actively Seeking Work	98	Not Applicable						
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Women's Specialty Program	Text	1	104	104	1= yes 2= no																								
Child Welfare Involvement	Text	1	105	105	1= yes 2= no																								

Field Name	Type	Size	Begin	End	Comments
Attendance at Self-Help Programs	Text	2	106	107	2 characters 00 = none 02 = 1 or 2 times a month 06 = 1 or 2 times a week 18 = 3-6 times a week 30 = daily 98 = not applicable
Error ID	Number	8	108	115	
Filler	Text	8	116	123	

#### SA Discharge Trailer Format

Field Name	Type	Size	Begin	End	Comments
Note: Any errors on the HDDR or TRLR record will cause the entire file to reject and be returned to the appropriate submitter via the Data Exchange Gateway (DEG) via the 4824 file.					
EDI TYPE	Text	4	1	4	“TRLR”
EDI APP	Text	2	5	6	“MA”
EDI USER					
EDI USER - prefix	Text	5	7	11	“DCH00” (DCH zero zero)
EDI USER - PIHP ID	Text	2	12	13	Service Bureau ID
EDI USER - suffix	Text	1	14	14	Blank
EDI CREATION DATE	Text	8	15	22	YYYYMMDD
EDI TRANSFER DATE	Text	8	23	30	YYYYMMDD
EDI TRANSFER TIME	Text	4	31	34	HHMM
EDI FILE NAME	Text	4	35	38	4824
EDI RUN TYPE	Text	1	39	39	“P” for production or “T” for test
EDI BATCH IDENTIFIER	Text	3	40	42	<u>Unique</u> batch identifier assigned by PIHP
EDI RECORD COUNT	Number	6	43	48	Number of records in a file including the header and trailer
FILLER	Text	75	49	123	

### SA Diagnosis Codes

DRUG CODE	DRUG	DIAGNOSIS CODE	DIAGNOSIS
00	None	000.00	N/A
10	Alcohol	305.00 291.10 303.90 291.30 291.40 303.00 291.00 291.20 291.80	Alcohol abuse amnestic disorder dependence hallucinosis idiosyncratic intoxication intoxication withdrawal delirium Dementia associated with alcoholism Uncomplicated alcohol withdrawal
20 21 22	Heroin Methadone (non-Rx) Other opiates	305.50 304.00 292.00	Opioid abuse/intoxication dependence withdrawal
30 31 32 33 34	Barbiturates Other sedatives/hypnotics Other tranquilizers Benzodiazepine GHB, GBL	305.40 292.83 304.10 292.00	Sedative, hypnotic, or anxiolytic abuse/intoxication amnestic disorder dependence withdrawal delirium
41 42	Cocaine Crack Cocaine	305.60 292.81 292.11 304.20 292.00	Cocaine abuse/intoxication delirium delusional disorder dependence withdrawal
43 44 45	Methphetamines Phenethylamines Cathinone	305.70 292.11 292.81 304.40 292.00	Amphetamine or similarly acting sympathomimetic abuse/intoxication delusional disorder delirium dependence withdrawal
50	Hallucinogens	305.30 292.11 305.30 292.84 292.89	Hallucinogen abuse/hallucinosis delusional disorder dependence mood disorder Posthallucinogen perception disorder
51	PCP	305.90 292.81 292.11 304.50 292.84 292.90	Phencyclidine (PCP) or similarly acting arylcyclohexylamine: abuse/intoxication delirium delusional disorder dependence mood disorder organic mental disorder NOS

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<b>DRUG CODE</b>	<b>DRUG</b>	<b>DIAGNOSIS CODE</b>	<b>DIAGNOSIS</b>
53	Ecstasy	305.90	abuse/intoxication
54	Ketamine	292.81 292.11 304.50 292.84 292.90	delirium delusional disorder dependence mood disorder organic mental disorder NOS
52	Marijuana/hashish	305.20	Cannabis
55	Synthetic cannabimimetics	292.11 304.30	abuse/intoxication delusional disorder dependence
60	Inhalants	305.90 304.60	Inhalant abuse/intoxication dependence
61	Antidepressants	305.90 292.83 292.89 292.81 292.11 292.82 292.12 292.84 292.90 292.89 292.00 304.90	Other or unspecified psychoactive substance abuse/intoxication amnestic disorder anxiety disorder delirium delusional disorder dementia hallucinosis mood disorder organic mental disorder NOS personality disorder withdrawal Psychoactive substance dependence NOS
70	Over-the-Counter	305.90	Caffeine intoxication
72	Steroids	305.90 304.90	Other or unspecified psychoactive substance abuse/intoxication Psychoactive substance dependence NOS
81	Talwin and PBZ	305.50 304.00 292.00	Opioid abuse/intoxication dependence withdrawal
91	Other	305.10 292.00 305.90 292.83 292.89 292.81 292.11 292.82 292.12 292.84 292.90 292.89	Nicotine dependence withdrawal Other or unspecified psychoactive substance abuse/intoxication amnestic disorder anxiety disorder delirium delusional disorder dementia hallucinosis mood disorder organic mental disorder NOS personality disorder

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DRUG CODE	DRUG	DIAGNOSIS CODE	DIAGNOSIS
		292.00 304.90	withdrawal Psychoactive substance dependence NOS
<b>Polysubstance</b> (Must specify <u>at least</u> a primary and a secondary drug from list above)		304.80	Polysubstance dependence

### SA County Codes

<b>Code</b>	<b>County</b>
00	Out of State (Out of state other than those listed in codes 85-89)
01	Alcona
02	Alger
03	Allegan
04	Alpena
05	Antrim
06	Arenac
07	Baraga
08	Barry
09	Bay
10	Benzie
11	Berrien
12	Branch
13	Calhoun
14	Cass
15	Charlevoix
16	Cheboygan
17	Chippewa
18	Clare
19	Clinton
20	Crawford
21	Delta
22	Dickinson
23	Eaton
24	Emmet
25	Genesee
26	Gladwin
27	Gogebic
28	Grand Traverse
29	Gratiot
30	Hillsdale
31	Houghton

<b>Code</b>	<b>County</b>
46	Lenawee
47	Livingston
48	Luce
49	Mackinaw
50	Macomb
51	Manistee
52	Marquette
53	Mason
54	Mecosta
55	Menominee
56	Midland
57	Missaukee
58	Monroe
59	Montcalm
60	Montmorency
61	Muskegon
62	Newaygo
63	Oakland
64	Oceana
65	Ogemaw
66	Ontonagon
67	Osceola
68	Oscoda
69	Otsego
70	Ottawa
71	Presque Isle
72	Roscommon
73	Saginaw
74	St. Clair
75	St. Joseph
76	Sanilac
77	Schoolcraft
78	Shiawassee

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Code	County
32	Huron
33	Ingham
34	Ionia
35	Iosco
36	Iron
37	Isabella
38	Jackson
39	Kalamazoo
40	Kalkaska
41	Kent
42	Keweenaw
43	Lake
44	Lapeer
45	Leelanau

Code	County
79	Tuscola
80	Van Buren
81	Washtenaw
82	Wayne (excluding city of Detroit)
83	Wexford
84	City of Detroit
85	Wisconsin
86	Indiana
87	Ohio
88	Illinois
89	Canada
96	Homeless
97	Unknown

## Substance Abuse TEDS Edits

### SA Admission Data Element Edits

The following is the list of SA Admission data element edits listed in the order of the input file format.

Note: All Errors reported in this document will cause the record to be rejected. Every Data Element having a detectable error will produce a copy of the Record in error with appropriate error messages appended. Error records will be stored in the SA Error Master Tables on the Oracle Database. These errors will be returned to the submitter via the 4827 file on the Data Exchange Gateway (DEG).

Error #	Error Description	Field Name
A001	Invalid Admission Record Length - should be 188.	Input File
A100	Duplicate Admission record - Submission Type equals A and record already exists.	Admission Key CA Code, License Number, Social Security Number, PIHP Client ID, Admission Date, Admission Time of Day
A122	Admission Submission Type equals A and Date of Admission/Admission Time of Day is equal or prior to prior Discharge Date of Discharge/Discharge Time of Day - cannot add the Admission	
A118	Admission Submission Type equals A and client is already in Admitted Status – cannot add the Admission.	
A138	Admission Submission Type equals C and an Admission record not found - cannot process the change.	
A137	Admission Submission Type equals D and no Admission exits	
A124	Admission Submission Type equals D and Discharge exists with Date of Discharge/Discharge Time of Day greater than Admission Date of Admission/Admission Time of Day - cannot process delete.	
A002	Invalid Admission Record Type - should be A.	Record Type
A127	Transition-in window is not open – Admission record type is Y and transition-in transactions are not currently allowed.	
A128	Transition-in record exists – Regular admission record cannot modify transition-in record.	
A129	Admission record exists – Transition-in record cannot modify regular admission record.	
A130	Admission is not allowed after transition-out has occurred.	
A003	Invalid Admission Submission Type - should be A, C, D, E.	Submission Type
A139	Invalid Admission PIHP Code - not a valid PIHP Payer Identifier.	CA Code
A105	Admission PIHP Payer Identifier and Bureau ID do not match.	
A005	Invalid Admission License number - should be 6-digit.	License Number
A006	Invalid Admission Social Security Number - Should be 9-digit or blank.	Social Security Number
A140	Invalid Admission PIHP Client Identifier - not permitted to be spaces or null.	CA Client Identifier
A008	Invalid Admission Medicaid ID - should be 10-digit or blank.	Medicaid Identifier
A009	Invalid Admission Type - should be 1 or 2.	Admission Type
A010	Invalid Admission Co-Dependent Code - should be 1 or 2.	Co-Dependent

Error #	Error Description	Field Name
A011	Invalid Admission Date of Admission - should be valid date and less than current date.	Date of Admission
A069	Admission Admit Date less than Birth Date - Date of Admission date should be greater than birth date.	
A106	Admission Date of Admission is too old.	
A012	Invalid Admission Service Category - should be 11, 21, 22, 24, 31.	Service Category
A013	Invalid Admission Number of Prior Treatments - should be 00-96.	Number of Prior Treatments
A014	Invalid Admission Referral Source - should be valid code of 01, 05-06, 09-10, 13-14, 18, 29-49, 90.	Referral Source
A016	Invalid Admission County of Residence - should be 00-89, 96-97.	County of Residence
A017	Invalid Admission Date of Birth - should be valid date and less than current date.	Date of Birth
A018	Invalid Admission Sex - should be 1 or 2.	Sex
A019	Invalid Admission Race - should be 0-6, 8-9.	Race
A020	Invalid Admission Ethnicity - should be 0-5.	Ethnicity
A021	Invalid Admission Marital Status - should be 1-5.	Marital Status
A022	Invalid Admission Military Status - should be 1 or 2.	Military Status
A023	Invalid Admission Education - Should be 00-25.	Education
A024	Invalid Admission Currently in Training/Education - Should be 0, 4, 6-7.	Currently in Training/Education
A025	Invalid Admission Employment Status - should be 1-4, 6, 8.	Employment Status
A073	Admission Employed and Total Annual Income zero or blank - if Employment Status equals 1 or 2 then Total Annual Income is to be greater than 0.	
A015	Admission Primary Substance (PSA) and Other Factor do not match - if PSA equals 00 and Co-Dependent equals 2 (no), one of the Other Factors should be 2-3.	Primary Substance
A026	Invalid Admission Primary Substance (PSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	
A082	Admission Primary Substance of 10, 20, 41, 42, 45, 50-52 and Primary Initial Prescription equals 1 - Primary Substance can't be a prescription.	
A085	Admission Primary Substance and Secondary Substance are the same - PSA cannot be same as SSA.	
A088	All 3 Admission Substance values are the same - PSA, SSA, TSA cannot be the same.	
A107	Admission Primary Substance equals 00, Primary Route must be 0.	
A110	Admission Primary Substance equals 00 and Primary Age at First Use not equal 98.	
A027	Invalid Admission Primary Route - should be 0-5.	Primary Route
A028	Invalid Admission Primary Age at First Use - should be 00-98.	Primary Age at First Use
A067	Admission Primary Age at First Use greater than current age - Primary Age at First Use should be less than current age.	

Error #	Error Description	Field Name
A029	Invalid Admission Primary Frequency of Use - Should be 00 - 30 or 98.	Primary Frequency of Use
A093	Invalid Admission Primary Frequency of Use - if Primary Substance equals 00, Primary Frequency of Use must be 98.	
A030	Invalid Admission Primary Initial Prescription - should be 0 - 2.	Primary Initial Prescription
A031	Invalid Admission Secondary Substance (SSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	Secondary Substance
A083	Admission Secondary Substance of 10, 20, 41, 42, 45, 50-52 and Secondary Initial Prescription equals 1 - Secondary Substance can't be a prescription.	
A087	Admission Secondary and Tertiary Substance are the same - SSA cannot be the same as TSA.	
A091	Invalid Admission Secondary Substance - if PSA equals 00, SSA should be 00.	
A108	Admission Secondary Substance equals 00, Secondary Route must be 0.	
A111	Admission Secondary Substance equals 00, Secondary Age at First Use must be 98.	
A032	Invalid Admission Secondary Route - should be 0 - 5.	Secondary Route
A033	Invalid Admission Secondary Drug Age First Use - should be 00-98.	Secondary Age at First Use
A075	Admission Secondary Drug Age First Use greater than current age - Secondary Age at First Use should be less than current age.	
A034	Invalid Admission Secondary Frequency of Use - should be 00-30.	Secondary Frequency of Use
A094	Invalid Admission Secondary Frequency of Use - if Secondary Substance equals 00, Secondary Frequency of Use must be 98.	
A035	Invalid Admission Secondary Initial Prescription - should be 0-2.	Secondary Initial Prescription
A036	Invalid Admission Tertiary Substance (TSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	Tertiary Substance
A084	Admission Tertiary Substance of 10, 20, 41, 42, 45, 50-52 and Tertiary Initial Prescription equals 1 - Tertiary Substance can't be a prescription.	
A086	Admission Primary Substance and Tertiary Substance are the same - PSA cannot be same as TSA.	
A087	Admission Secondary Substance and Tertiary Substance are the same - SSA cannot be same as TSA.	
A092	Invalid Admission Tertiary Substance - if PSA or SSA equals 00, TSA should be 00.	
A109	Admission Tertiary Substance equals 00, Tertiary Route must be 0.	
A112	Admission Tertiary Substance equals 00, Tertiary Age at First Use must be 98.	
A037	Invalid Admission Tertiary Route - should be 0 - 5.	Tertiary Route
A038	Invalid Admission Tertiary Age at First Use - should be 00-98.	Tertiary Age at First Use
A089	Admission Tertiary Age at First Use greater than current age - Tertiary Age at First Use should be less than current age.	

Error #	Error Description	Field Name
A039	Invalid Admission Tertiary Frequency of Use - should be 00-30.	Tertiary Frequency of Use
A095	Invalid Admission Tertiary Frequency of Use, if Tertiary Substance equals 00, Tertiary Frequency of Use must be 98.	
A040	Invalid Admission Tertiary Drug Initial Prescription - should be 0-2.	Tertiary Initial Prescription
A041	Invalid Admission Total Annual Income - should be 000000-999999 or blank.	Total Annual Income
A042	Invalid Admission Number of Dependents - should be 00-99 or blank.	Number of Dependents
A043	Invalid Admission Program Eligibility - Able to pay - should be 1 or 2.	Program Eligibility: Able to pay
A044	Invalid Admission Program Eligibility: Commercial insurance - should be 1 or 2.	Program Eligibility: Commercial insurance
A045	Invalid Admission Program Eligibility: Services contract - should be 1 or 2.	Program Eligibility: Services contract
A046	Invalid Admission Program Eligibility: Medicare - should be 1 or 2.	Program Eligibility: Medicare
A047	Invalid Admission Program Eligibility: Medicaid - Should be 1 or 2.	Program Eligibility: Medicaid
A048	Invalid Admission Program Eligibility: Workers compensation - Should be 1 or 2.	Program Eligibility: Workers Compensation
A049	Invalid Admission Program Eligibility: Other public sources - Should be 1 or 2.	Program Eligibility: other public sources
A050	Invalid Admission Program Eligibility: PIHP resources - Should be 1 or 2.	Program Eligibility: PIHP Resources
A141	Invalid Admission Program Eligibility: State Medical Plan - should be 1 or 2.	Program Eligibility: State Medical Plan
A051	Invalid Admission Program Eligibility:- MI Child - should be 1 or 2.	Program Eligibility: MI Child
A052	Invalid Admission Program Eligibility: Medicaid Children's Waiver - should be 1 or 2.	Program Eligibility: Medicaid Children's Waiver
A053	Invalid Admission Program Eligibility:- Other Program Eligibility - should be 1 or 2.	Program Eligibility: Other Program Eligibility Not Listed Above
A054	Invalid Admission Correctional Status - should be 00-10, 98.	Correctional Status
A055	Invalid Admission Total Arrests – 30 days - should be 00-99.	Total Arrests – 30 days
A061	Invalid Admission Total Arrests – 30 days - should be equal or greater than Admission Arrests - Possession/Sales – 30 days plus Admission Arrests - DUI/DWI – 30 days.	
A056	Invalid Admission Arrests - Possession/Sales – 30 days - should be 00-99.	Arrests - Possession/Sales – 30 days
A057	Invalid Admission Arrests - DUI/DWI – 30 days - should be 00-99.	Arrests - DUI/DWI – 30 days
A058	Invalid Admission Total Arrests - 5 years - should be 00-99.	Total Arrests - 5 years
A062	Invalid Admission Total Arrests - 5 years - should be equal or greater than Admission Arrests - Possession/Sales - 5 years plus Admission Arrests - DUI/DWI - 5 years.	
A104	Invalid Admission Total Arrests - 5 years - should be equal or greater than Admission Total Arrests - 6 months.	

Error #	Error Description	Field Name
A059	Invalid Admission Arrests - Possession/Sales - 5 years should be 00-99.	Arrests - Possession/Sales - 5 years
A063	Invalid Admission Arrests - Possession/Sales - 5 years should be equal or greater than Admission Arrests - Possession/Sales - 6 months.	
A060	Invalid Admission Arrests - DUI/DWI - 5 years - should be 00-99.	Arrests - DUI/DWI - 5 years
A064	Invalid Admission Arrests - DUI/DWI s - 5 years - should be equal or greater than Admission Arrests - DUI/DWI - 6 months.	
A065	Invalid Admission Living Arrangement - should be 1-3	Living Arrangement
A074	Admission Living arrangement doesn't match County of Residence - if county is 96, then Living Arrangement must be 3 (homeless).	
A068	Invalid Admission Methadone Part of Treatment - should be 1 or 2.	Methadone Part of Treatment
A116	Invalid Admission Primary Diagnosis, must be a valid diagnosis code.	Primary Diagnosis
A097	Invalid Admission Primary Substance and Primary Diagnosis combination - Primary Diagnosis should match Primary Substance.	
A117	Invalid Admission Secondary Diagnosis format	Secondary Diagnosis
A066	Invalid Admission Pregnant value - Should be 1 or 2.	Pregnant
A070	If Admission pregnant equals 1, then sex must equal 2.	
A078	Invalid Admission Other Factor 1 - should be 0, 2-9, or blank.	Other Factor 1
A079	Admission Other Factor 1 equals Other Factor 2 - Other factor 1 and 2 cannot be the same.	
A080	Admission Other Factor 1 equals Other Factor 3 - Other factor 1 and 3 cannot be the same.	
A134	Invalid Admission Other Factor 2 - should be 0, 2-9 or blank.	Other Factor 2
A081	Admission Other Factor 2 equals Other Factor 3 - Other factor 2 and 3 cannot be the same.	
A076	Admission Other Factor 2 not blank or zero - if other factor 1 equals 0 or blank, Other Factor 2 should be zero or blank.	
A135	Invalid Admission Other Factor 3 - should be 0, 2-9 or blank	Other Factor 3
A077	Admission Other Factor 3 not blank or zero - If Other Factor 1 or Other Factor 2 equals 0 or blank, Other Factor 3 should be zero or blank.	
A096	Admission Time Waiting to Enter Treatment cannot be missing	Time Waiting to Enter Treatment
A136	Invalid Admission Primary Language Spoken.	Primary Language Spoken
A131	Invalid Admission Time of Day – should be valid time (24-hour)	Admission Time of Day
A151	Invalid Detailed Not in Labor – Should be a valid code of 01, 02, 03, 04, 05, 06, 07.	Detailed Not in Labor
A152	Invalid Detailed Not in Labor – Employment Status equals 04, Detailed Not in Labor should be a valid code of 01, 02, 03, 04, 05, 06, 07.	
A153	Invalid Admission Detailed Not in Labor Code - If Employment Status is not equal to 04 then Detailed Not in Labor Code must be 98.	

Error #	Error Description	Field Name
A098	Invalid Admission Error ID - should be 8-digit number or blank.	Error ID
A101	Invalid Admission Error ID - should be valid Error ID or blank.	
A154	Invalid Date of 1st Contact. Must be equal to or less than admission date.	Date of 1 <sup>st</sup> Contact
A157	<del>Days Waiting to Enter Treatment must equal Admission Date - Date of 1<sup>st</sup> Request</del>	
A155	Invalid Women's Specialty Program Code. Must be 1 or 2.	Women's Specialty Program Code
A156	Invalid Child Welfare Involvement. Must be 1 or 2.	Child Welfare Involvement
A158	Invalid Days of Social Support. Must be 00, 02, 06, 18, 30, or 98	Days of Social Support

### SA Discharge Data Element Edits

The following is the list of SA Discharge data element edits listed in the order of the input file format.

Note: All Errors reported in this document will cause the record to be rejected. Every Data Element having a detectable error will produce a copy of the Record in error with appropriate error messages appended. Error records will be stored in the SA Error Master Tables on the Oracle Database. These errors will be returned to the submitter via the 4827 file on the Data Exchange Gateway (DEG).

Error #	Error Description	Field Name
D001	Invalid Discharge Record Length - should be 123.	Input File
D098	No matching Discharge record - if Submission Type equals C or D, a matching record should exist.	
D099	Discharge Submission Type equals A and a Discharge already exists - cannot add the Discharge.	
D101	Discharge Submission Type equals A and an Admission record does not exist - a valid Admission record must exist.	
D113	Discharge Submission Type equals A and an Admission exists and Discharge Date of Discharge/Discharge Time of Day not greater than Admission Date of Admission/Admission Time of Day - cannot add the Discharge.	
D108	Discharge Submission Type equals C and Discharge Date of Discharge/Discharge Time of Day being changed to less than or equal Admission Date of Admission/Admission Time of Day on prior Admission or greater than or equal Admission Date of Admission/Admission Time of Day on subsequent Admission - cannot process the change.	
D120	Discharge Submission Type equals C and a Discharge record not found - cannot process the change.	
D106	Discharge Submission Type equals D and an Admission record exists with an Admission Date of Admission/Admission Time of Day greater than the Discharge Date of Discharge/Discharge Time of Day - delete of Discharge would create two consecutive Admissions.	
D118	Discharge Submission Type equals D and a Discharge record does not exist - cannot process the delete.	
D002	Invalid Discharge Record Type - should be D.	Record Type

Error #	Error Description	Field Name
D125	Transition-out window is not open – Discharge record type is X and transition-out transactions are not currently allowed.	
D126	Transition-out record exists – Regular discharge record cannot modify transition-out record.	
D127	Discharge record exists -- Transition-out record cannot modify regular discharge record.	
D003	Invalid Discharge Submission Type - should be A, C, D, E.	Submission Type
D102	Discharge PIHP Payer Identifier and Bureau ID do not match.	CA Code
D116	Invalid Discharge PIHP Code - not a valid PIHP Payer Identifier.	
D005	Invalid Discharge License Number - should be 6-digit.	License Number
D006	Invalid Discharge Social Security Number - should be 9-digits or blank.	Social Security Number
D117	Invalid Discharge PIHP Identifier - not permitted to be spaces or null.	CA Client Identifier
D008	Invalid Discharge Medicaid ID - should be 10-digit or blank.	Medicaid Identifier
D011	Invalid Discharge Date of Admission - should be valid date and less than current date.	Discharge Date of Admission
D069	Invalid Discharge Date of Admission/Admission Time of Day - should be less than Discharge Date of Discharge/Discharge Time of Day.	
D012	Invalid Discharge Service Category - should be 11, 21, 22, 24, 31.	Discharge Service Category
D122	Discharge service category does not match admission service category.	
D025	Invalid Discharge Employment Status - should be 1-4, 6, 8.	Employment Status
D026	Invalid Discharge Primary Substance (PSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91	PSA Code Primary Substance
D084	Discharge Primary Substance and Secondary Substance are the same - PSA cannot be same as SSA.	
D087	All 3 Discharge Substance values are the same - PSA, SSA, TSA cannot be the same.	
D103	Discharge Primary Substance equals 00, Primary Route must be 0.	
D027	Invalid Discharge Primary Route - should be 0-5.	PSA Route Primary Route
D029	Invalid Discharge Primary Frequency of Use - Should be 00 - 30 or 98 and equal or less than the number of days between admission and discharge.	PSA Frequency of Use Primary Frequency of Use
D092	Invalid Discharge Primary Frequency of Use - if Primary Substance equals 00, Primary Frequency of Use must be 98.	
D031	Invalid Discharge Secondary Substance (SSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81, 91.	SSA Code Secondary Substance
D090	Invalid Discharge Secondary Substance - if PSA equals 00, SSA should be 00.	
D104	Discharge Secondary Substance equals 00, Secondary Route must be 0.	

Error #	Error Description	Field Name
D032	Invalid Discharge Secondary Route - should be 0-5.	SSA Route Secondary Route
D034	Invalid Discharge Secondary Frequency of Use - should be 00-30 or 98 and equal or less than the number of days between admission and discharge.	SSA Frequency of Use Secondary Frequency of Use
D093	Invalid Discharge Secondary Frequency of Use - if Secondary Substance equals 00, Secondary Frequency of Use must be 98.	
D036	Invalid Discharge Tertiary Drug (TSA) - should be valid code of 00, 10, 20-22, 30-34, 41-45, 50-54, 60-61, 70, 72, 81,91.	TSA Code Tertiary Substance
D085	Discharge Primary Substance and Tertiary Substance are the same - PSA cannot be same as TSA.	
D086	Discharge Secondary Substance and Tertiary Substance are the same – SSA cannot be same as TSA.	
D091	Invalid Discharge Tertiary Substance - if PSA or SSA equals 00, TSA should be 00.	
D105	Discharge Tertiary Substance equals 00, Tertiary Route must be 0.	
D037	Invalid Discharge Tertiary Route - should be 0-5.	TSA Route Tertiary Route
D039	Invalid Discharge Tertiary Frequency of Use - should be 00-30 or 98 and equal or less than the number of days between admission and discharge.	TSA Frequency of Use Tertiary Frequency of Use
D094	Invalid Discharge Tertiary Frequency of Use, if Tertiary Substance equals 00, Tertiary Frequency of Use must be 98.	
D054	Invalid Discharge Correctional Status - Should be 00-10, 98	Correctional Status
D055	Invalid Discharge Total Arrests – 30 days – should be 00-99.	Total Arrests – 30 days
D061	Invalid Discharge Total Arrests – 30 days – should be equal or greater than Discharge Arrests -Possession/Sales – 30 days plus Discharge Arrests - DUI/DWI – 30 days.	
D056	Invalid Discharge Arrests - Possession/Sales – 30 days - should be 00-99.	Arrests - Possession/Sales – 30 days
D057	Invalid Discharge Arrests - DUI/DWI – 30 days - should be 00-99.	Arrests - DUI/DWI – 30 days
D065	Invalid Discharge Living Arrangement - should be 1-3.	Living Arrangement
D009	Invalid Discharge Date - Should be valid date and less than current date	Discharge Date of Discharge
D111	Discharge Date of Discharge is too old.	
D010	Invalid Discharge Reason - should be 01-11	Discharge Reason
D123	Invalid Admission Time of Day – should be valid time (24-hour)	Admission Time of Day
D124	Invalid Discharge Time of Day – should be valid time (24-hour)	Discharge Time of Day
D130	Invalid Detailed Not in Labor – Should be a valid code of 01, 02, 03, 04, 05, 06, 07.	Detailed Not in Labor
D131	Invalid Detailed Not in Labor – Employment Status equals 04, Detailed Not in Labor should be a valid code of 01, 02, 03, 04, 05, 06, 07.	
D132	Invalid Discharge Detailed Not in Labor Code - If Employment Status is not equal to 04 then Detailed Not in Labor Code must be 98.	

Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII B.A. Substance Abuse Disorder Policy Manual

Error #	Error Description	Field Name
D133	Invalid Women's Specialty Program Code. Must be 1 or 2.	Women's Specialty Program
D134	Invalid Child Welfare Involvement. Must be 1 or 2.	Child Welfare Involvement
D135	Invalid Days of Social Support. Must be 00, 02, 06, 18, 30, or 98	Days of Social Support
D097	Invalid Error ID - Should be 8-digit number or blank.	Error ID
D100	Invalid Discharge Error ID - should be valid Error ID or blank.	

## **II. METHADONE REQUIREMENTS**

Treatment Policy #03, Buprenorphine—  
Effective October 1, 2006

Treatment Policy #04, Off-site Dosing Requirements for  
Medication-Assisted Treatment—  
Effective December 1, 2006

Treatment Policy #05, Criteria for Using Methadone for  
Medication assisted Treatment and Recovery--  
Effective October 1, 2012



JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

## MEMORANDUM

**Date:** June 28, 2006

**To:** Regional Coordinating Agencies  
Opioid Treatment Programs

**From:** Doris Gellert, Director  
Bureau of Substance Abuse and Addiction Services  
Office of Drug Control Policy

**Subject:** Revised Treatment Policy # 03: *Buprenorphine*

Enclosed is Revised Treatment Policy # 03: *Buprenorphine*. This revised policy incorporates the Medicaid primary health care pharmacy benefit.

Policy compliance will be reviewed as part of program site visits. Please direct any questions to Marilyn Miller, Treatment Specialist, at 517-241-2608, via fax at 517-335-2121, or via email at [MillerMar@michigan.gov](mailto:MillerMar@michigan.gov).

DG/MM/mlf

Enclosure

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**TREATMENT POLICY # 03**

**SUBJECT:** Buprenorphine

**ISSUED:** August 2004, revised June 6, 2006

**EFFECTIVE:** September 1, 2004, revision effective October 1, 2006

**PURPOSE:**

This policy establishes standards for the use of buprenorphine when used as adjunct therapy in the treatment of opioid addiction for clients receiving substance abuse services administered through the Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP). Coordinating Agencies (CAs) are required to provide additional reports so the overall cost and experience gleaned from the use of buprenorphine as adjunct to treatment can be used to determine future planning and policy.

**SCOPE:**

CAs may choose to fund the cost of the buprenorphine/naloxone medication as adjunct therapy for opioid addiction in treatment services including residential, intensive outpatient, outpatient, and methadone programs. Allowable funding consists of federal block grant, state general funding, and local funding. Medicaid reinvestment savings may also be used if part of a Medicaid reinvestment plan submitted by the Pre-paid Inpatient Health Plan (PIHP) and approved by Centers for Medicare and Medicaid Services (CMS) and MDCH/ODCP. CAs may use Adult Benefit Waiver (ABW) funding for ABW clients on a discretionary basis after covered services have been paid.

Clients with Medicaid coverage may have access to the pharmacy benefit for buprenorphine/naloxone. It must be preauthorized through the Medicaid pharmacy plan.

Opioid Treatment Programs (OTPs) providing services must conform to the Federal opioid treatment standards set forth under 42 C.F.R. Part 8, including off-site dosing when dispensing buprenorphine/naloxone. There is no limit to the number of clients to whom buprenorphine can be dispensed from an OTP.

Private physicians who have the Substance Abuse and Mental Health Services Administration (SAMHSA) waiver for prescribing buprenorphine/naloxone are limited to managing 30 clients on buprenorphine at any one time. An OTP physician who has the SAMHSA waiver may prescribe the medication for off-site use as if the physician were in private practice. The maximum number of active clients would be 30 clients.

## TREATMENT POLICY – 03

EFFECTIVE: October 1, 2006

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### BACKGROUND:

The Food and Drug Administration (FDA) approved Buprenorphine hydrochloride (Subutex®) and buprenorphine hydrochloride/naloxone hydrochloride (Suboxone®) on October 8, 2002 for the treatment of opioid addiction. Both buprenorphine and buprenorphine/naloxone are administered in sublingual tablets (placed under the tongue) and gradually absorbed. Prior to their approval and subsequent scheduling as Schedule III medications, the only prescription medications approved for opioid substitution agents were methadone and LAAM, both Schedule II medications. Schedule II medications must be prescribed to patients enrolled in OTPs. Because of the numerous federal and state regulations with respect to OTPs, the addition of Schedule III medications as adjunctive treatment greatly increases access to services for potential opioid treatment clients because they can now receive medication for opioid addiction treatment through a qualified physician's office.

Buprenorphine has a ceiling effect for toxicity because of its antagonist properties. Once a certain dose or receptor occupancy level is reached, additional dosing does not produce further toxicity. Studies have shown that buprenorphine plateaus at the equivalent of 40 to 60 milligrams of methadone. Because of the maximum for toxicity, respiratory depression and/or death from overdose are less common than with opiate agonists, such as heroin, oxycodone, or methadone. Concurrent use of buprenorphine with alcohol, benzodiazepines, or other respiratory depressants can still result in overdose. Naloxone (Narcan) is added to buprenorphine by the manufacturer to prevent diversion because, although the naloxone will have no effect when absorbed under the tongue, crushing and injecting the medication will result in sudden and intense withdrawal symptoms. The ceiling effect also restricts the medication's effectiveness in treating patients who have a need for high levels of opioid replacement medication. Studies are currently being done to determine the safety of buprenorphine/naloxone in pregnancy as well as breastfeeding.

### REQUIREMENTS:

#### Program Requirements

1. The client must have a Diagnostic Statistical Manual (DSM) impression of opioid dependency as determined by the Access Management System (AMS). All six dimensions of the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria must be used. The client must meet medical necessity criteria as determined by a physician who has a SAMHSA waiver to prescribe or dispense buprenorphine.
2. Buprenorphine/naloxone must be used as adjunct to opioid treatment throughout the continuum of care (OP, IOP, Residential, sub-acute detoxification, and methadone adjunctive treatment as part of a detoxification regimen). It cannot be used without counseling.
3. Toxicology screens must be done at intake and then on a random, at least weekly, frequency until three (3) consecutive screens are negative. Thereafter, they must be done on a monthly,

**TREATMENT POLICY – 03**

**EFFECTIVE:** October 1, 2006

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random frequency. Screens must assay for opioids, cocaine, amphetamines, cannabinoids, benzodiazepines, and methadone metabolites. Screens must be random for days of the week and days since last screen was administered.

4. As an adjunctive medication for the treatment of opioid addiction, the CA cannot pay for the buprenorphine/naloxone alone. The medication must be used in conjunction with counseling at a substance abuse treatment program under contract with the CA. The CA must develop a plan in which the substance abuse treatment program, a qualified physician, and a pharmacy are involved.

**Reporting Requirements**

The data system has been modified to accommodate reporting for clients receiving buprenorphine/naloxone.

Data system:

- Admission and discharge Treatment Episode Data Set (TEDS) records must be submitted as is routine with other clients. In the client admission record, the field OPIOD TREATMENT PROGRAM (1= Methadone, 2= No, and 3= Buprenorphine) must be coded with “3” for all clients receiving buprenorphine/naloxone, regardless of service category.
- Buprenorphine/naloxone daily dosages and associated cost must be reported with HCPCS Code of H0033 as required in the 837 Professional Encounter record.

**PROCEDURE:**

**Prescribing Policy**

1. All physicians, including those at an OTP, must have a waiver from SAMHSA permitting them to prescribe or dispense buprenorphine/naloxone (e.g., Suboxone®).
2. Buprenorphine/naloxone (Suboxone®) must be used as an adjunctive treatment within an individualized treatment plan for opioid addiction. It is not appropriate as a stand-alone treatment procedure.
3. The target populations for buprenorphine/naloxone are the following:
  - Clients who are being transferred from methadone as part of a detoxification regimen;
  - Clients that have been opioid dependent less than one year, but for whom adjunctive therapy is deemed medically necessary; and

**TREATMENT POLICY – 03**

**EFFECTIVE:** October 1, 2006

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- Clients that are eligible for methadone adjunctive therapy within the 40-60 milligrams therapeutic range.
4. In accordance with FDA regulations, buprenorphine is not currently approved for pregnant women.
5. The combination medication buprenorphine/naloxone (Suboxone®) is the only medication approved for use under these guidelines. No “off-label” or experimental use of buprenorphine/naloxone is permitted under these policies.

**REFERENCES:**

American Psychiatric Association. (2000). *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, Washington, DC.

American Society of Addiction Medicine. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition-Revised, ASAM UPC-2R, Chevy Chase, Maryland.

*Certification of Opioid Treatment Programs:* United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (2003).

*Drug Addiction Treatment Act of 2000:* PL106-310, Section 3502, United States House, 105<sup>th</sup> Congress, Washington, DC. (October 17, 2000).

Food and Drug Administration. (October 8, 2002). *Subutex and Suboxone Approved to Treat Opiate Dependence*, FDA Talk Paper, Washington, DC.

*Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Addition of Buprenorphine and Buprenorphine Combination to List of Approved Opioid Treatment Medications:* Federal Register, Volume 68, Number 99, pp 27937-27939, Interim final rule, United States Superintendent of Documents. (May 22, 2003).

Schuster, C and Seine, S. (October 8, 2002). *Interview*. University Psychiatric Clinic, Wayne State University, Detroit Michigan.

**APPROVED BY:**

  
Donald L. Allen, Jr., Director  
Office of Drug Control Policy



STATE OF MICHIGAN

JENNIFER M. GRANHOLM  
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

**DATE:** November 30, 2006

**TO:** Regional Coordinating Agencies  
Opioid Treatment Programs

**FROM:** Doris Gellert, Director  
Bureau of Substance Abuse and Addiction Services  
Office of Drug Control Policy

**SUBJECT:** Revised Treatment Policy-04: Off-Site Dosing Requirements for Medication Assisted Treatment

Enclosed is the final version of the Michigan Department of Community Health/Office of Drug Control Policy (MDCH/ODCP) Treatment Policy #4 – Off-Site Dosing Requirements for Medication Assisted Treatment

There were no comments from the field. The following changes were made by MDCH/ODCP staff:

1. Labeling- page 5 – because Suboxone® is in tablet form rather than liquid like methadone, it can be dispensed for multiple days in the same bottle.
2. Out of Country Travel, page 9 – Center for Substance Abuse Treatment/Division of Pharmacologic Therapies (CSAT/DPT) approval is no longer necessary solely because the client wishes to travel outside the country. MDCH/ODCP approval is still required.

**Reminder: Extranet submissions are required.** The use of the Extranet, which is maintained by CSAT, will be the only manner in which exception requests will be accepted by MDCH/ODCP effective January 1, 2007. Call 1-866-687-2728 to sign up for the Extranet. For those OTPs that do not have Internet capability, a waiver of this requirement can be obtained by submitting a request, in writing, to ODCP. Fax the request to the attention of Marilyn Miller at 517-335-2121. This request should state the reasons why use of the Extranet cannot start on the effective date and the planned date for starting.

Should you have any questions or require further clarification of any issues in this policy, please contact Marilyn Miller at 517-241-2608, or by email at [millermar@michigan.gov](mailto:millermar@michigan.gov).

Enclosure

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**TREATMENT POLICY 04**

**SUBJECT:** Off-Site Dosing Requirements for Medication Assisted Treatment

**ISSUED:** September 1, 2004, revised March 1, 2006, revised November 13, 2006

**EFFECTIVE:** December 1, 2006

**PURPOSE:**

The purpose of this policy is to clarify the rules and procedures pertaining to off-site dosing of opioid treatment medication by clients in Opioid Treatment Programs (OTP).

**SCOPE:**

This policy pertains to off-site dosing for all clients who are receiving medication-assisted treatment as an adjunct in an OTP in Michigan, regardless of the funding source. Due to the complexities of off-site usage and the variety of rules and regulations involved, in situations where there is a conflict between state and federal rules not otherwise addressed in this policy, the most stringent rule applies. Off-site dosing is a privilege, not an entitlement, nor a right.

**BACKGROUND:**

The use of methadone and buprenorphine, through an OTP, as adjunct therapies in substance abuse treatment, is highly regulated. Clients must attend the OTP daily for on-site supervised dispensing of their medication until they have met certain specified criteria for the privilege of reduced attendance and dosing off site. Safety is the driving force behind the strict regulations for off site dosing with the goal of preventing diversion of the medication to the general public and the accidental ingestion of the medication by children.

Off-site dosing can be used on a temporary basis in cases when the clinic is closed for business, such as Sundays and holidays. On an individual basis, off-site dosing may be temporary or permanent. As specified in this policy, some off-site dosing may need approval from the Michigan Department of Community Health/Office of Drug Control Policy (MDCH/ODCP) and/or the Center for Substance Abuse Treatment/Division of Pharmacologic Therapies (CSAT/DPT).

**REQUIREMENTS:**

OTP program physicians and other designated OTP staff must ensure that clients are responsible for managing off-site dosing prior to granting the privilege. The amount of time in treatment, progress towards meeting the treatment goals, as well as exceptional circumstances or physical/medical issues are used to determine the number of doses of methadone allowed off site.

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Exceptions to these rules are allowed with approval from the State Methadone Authority (SMA) at MDCH/ODCP and, where federal law requires, CSAT/DPT approval.

**On-Site OTP Clinic Attendance Requirements**

A client in maintenance treatment must ingest the medication under observation, at the OTP clinic, for not less than six days a week for a minimum of the first 90 days in treatment (R 325.14417 Part 417[1]). If a client discontinues treatment and later returns, the time in treatment is restarted as if the client was newly admitted to treatment, unless there are extenuating circumstances.

When a client transfers from another OTP, the cumulative time in treatment must be used in calculating the client's time if the gap in treatment time is less than 90 days (R 325.14417 Part 417[4]).

After 90 days of treatment, a client may be allowed to reduce on-site dosing to three times weekly while receiving no more than two doses at one time for off-site dosing (R 325.14417 Part 417[2]).

After two years in treatment, a client may be allowed to reduce the on-site dosing to two times weekly while receiving no more than three doses at one time for off-site dosing (R 325.14417 Part 417[3]).

The inability of the client to qualify for off-site dosing or to maintain an off-site dosing schedule must be addressed as part of the client's individualized treatment plan. Dosage adjustments, establishment of compliance contracts, additional counseling sessions, specialized treatment groups, or assessment for another level of care must be considered. OTPs must coordinate sanctions with the prior authorization source such as an Access Management System (AMS) agency for funded clients or other involved third party as appropriate.

**Off-Site Dosing Requirements**

**Rules that Apply to All Off-Site Dosing:**

All clients who are dispensed medication for off-site dosing must be deemed responsible for handling the medication. This includes when the program is closed for business, such as Sundays and holiday observances as well as other qualified times. If the client is deemed not to be responsible for any of these times, other arrangements must be made for the client to be dosed on site at their current OTP or at another OTP. If a client needs to go to another program to be dosed, coordination between both programs is required to ensure the client is only dosing at one OTP for days when the client's OTP of record is closed.

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*Client Criteria:*

Medication for off-site dosing may only be given to a client who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication. Before reducing the frequency of on-site dosing, the rationale for this decision must be documented in the client's treatment record by a program physician or a designated staff. If a designated staff member records the rationale for the decision, a program physician must review, countersign, and date the client's record (R 325.14416 Part 416[1] and 42 CFR Part 8.12[I][3]). The client's off-site dosing schedule is to be reviewed every sixty days while the client receives doses for off-site use.

The program physician must utilize all of the following information in determining whether or not a client is responsible to handle opioid medication off site:

- Background and history of the client: the client is employed, actively seeking employment as evidenced by a sign-off sheet from potential employers, or disabled and unable to work as evidenced by a Social Security Income or Social Security Income Disability or Workmen's Compensation checks; and the client has appropriately handled off-site dosing in the past such as on Sundays and holidays or other off-site situations.
- General and specific characteristics of the client and the community in which the client resides (the client is working toward or maintaining treatment goals; the client has taken measures to ensure that third parties do not have access to the medication).
- An absence of current and/or recent abuse (within 90 days) of drugs, including alcohol on the basis of toxicology screens that must include opioids, methadone metabolites, barbiturates, amphetamines, cocaine, cannabinoids, benzodiazepines and any other drugs as appropriate for individual clients. Alcohol testing must be conducted by the use of a Breathalyzer or other standard testing means if alcohol is suspected at the time of dosing. (Clients who appear to be under the influence of any drug or alcohol will not be dosed until safe to do so. Clients should not be allowed to drive under this condition.) Any evidence of alcohol abuse in the client's chart within the past 90 days will be considered as positive for alcohol, as will any legal charges related to alcohol consumption. The need to verify toxicology tests or the need for more frequent toxicology tests must be components of the clinic rules. Legally prescribed drugs, including controlled substances, will not be considered as illicit substances, provided the OTP has verification the drug(s) were prescribed for the client. Such documentation must be included in the client's chart. Prescription documentation for all prescribed medication must be updated at least every 60 days until discontinued. Prescription medication documentation must be updated in the client's chart at the first opportunity – preferably at the next clinic visit – when the client is prescribed a medication or a medication is renewed. A copy of the prescription label, a printout from the pharmacy, or the information recorded in the chart from viewing

TREATMENT POLICY #4

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the patient's prescription bottle shall constitute documentation. All medications are to be considered within the context of coordinating care with other prescribing healthcare providers, and the safety considerations of granting off-site dosing privileges.

- Regularity of clinic attendance.  
including physician or a licensed physician assistant, nurse practitioner, or clinical social worker.
- Absence of serious behavioral problems in the clinic.
- Stability of the client's home environment and social relationships.
- Absence of recent known criminal activity.
- Length of time in opioid substance abuse treatment with medication as an adjunct.
- Assurance that medication can be safely stored off site, particularly with respect to prevention of accidental ingestion by children.
- The rehabilitative benefit to the client derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

R 325.14416 Part 416[3] and 42CFR Part 8.12 [I][2][i-viii]

Clients must receive a copy of the clinic's rules pertaining to responsible handling of off-site doses and the reasons for revoking them. Clinic rules must include a list of graduated sanctions such as decreasing and rescinding of all off-site dosing. A form signed by the client acknowledging receipt of this information must be included in the client file.

*Product Preparation:*

Methadone for off-site dosing must be dispensed in a liquid, oral form and formulated in such a way to minimize use by injection. The methadone must contain a preservative so refrigeration is not required.

Methadone must be dispensed in disposable, single use bottles, and must be packaged in childproof containers pursuant to section 3 of the Poison Prevention Packaging Act, 15 USC Part 1472. (R 325.14415 Part 415) In cases when clients take medication twice daily (split dosing), two separate childproof containers must be utilized. These efforts will help minimize the likelihood of accidental ingestion by children.

Buprenorphine/naloxone must be packaged in childproof containers and labeled similar to methadone. However, because buprenorphine/naloxone is in tablet form, a maximum of 30-days supply can be contained in the same bottle. The dose(s) dispensed for unsupervised off-site use must adhere to 42 CFR Part 8 unless an exception request has been approved. (MCL 333.17745)

*Labeling:*

Medication for off-site administration must be labeled as follows:

- The name of the medication
- The strength of the medication
- The quantity dispensed
- The OTP's name, address, and phone number
- Client's name or code number
- Medical director's/prescriber's name
- Directions for use
- The date dispensed and the date to be used
- A cautionary statement that the medication should be kept out of the reach of children
- Statement that this medication is only intended for the person to whom it was prescribed

R 325.14415 Part 415(2)  
MCL 333.17745(7)(a-h)

*Security:*

The client is expected to secure all take home medication in a locked box prior to leaving the OTP. It is expected that the client store this box in a manner that will prevent the key or combination from being readily available to children and/or others who could be harmed from accidental use and to prevent diversion to or by third parties. Clients should be able to explain the process that will be used to secure the medications that are taken home when asked by an OTP staff member. This process should be recorded in the client's record and updated when the client's take home status is reviewed every 60 days. Empty and unused bottles are to be returned to the OTP in the locked box for proper disposal. Failure to do so could result in revocation of take home privileges.

Temporary Off-Site Dosing:

Special circumstances such as a client's physical/medical needs or other exceptional circumstances, situations in which a program is closed such as Sundays and Holidays, or emergency situations may result in cases when the client is allowed to dose off site for a temporary time period.

*Physical/Medical Necessity:*

If a client's physician provides written documentation that reduced attendance at the clinic is necessary due to physical/medical necessity of the client and the OTP physician concurs, off-site dosing of up to 13 doses within a 14-day time frame is allowed without prior MDCH/ODCP approval unless the request exceeds the

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CSAT/DPT amounts allowed. (See Section entitled "CSAT/DPT Approval Required.")

The written documentation from the client's physician must include a medical diagnosis and whether the condition is permanent or temporary. If the condition is temporary, the date the client can return to his/her usual clinic attendance must be indicated. Whenever possible, the client's personal physician and the OTP physician should coordinate care including the prescribing of medication that interacts with methadone.

Temporary exceptions need to be reviewed and reissued if the exception is needed beyond the initial time frame. All exceptions must be reviewed during the usual 60-day OTP physician's review. All documentation must be maintained in the client's chart (R 325.14417 Part 417(5)). Requirements for counseling sessions and toxicology screens must be coordinated with CAs if the client is funded.

*Exceptional Circumstances:*

Medication for off-site dosing may only be given to a client who has an exceptional circumstance as indicated in this section and who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication. The exceptional circumstance must be clearly documented and any supportive documentation should be included in the client's chart.

Clients who have been in OTP treatment for at least 6 months and who are eligible for a 3-times a week schedule may be permitted up to three consecutive off-site doses within a specific 7-day period, depending on the situation, without prior approval from MDCH/ODCP, for the following exceptional circumstances:

- Employment schedule conflicts
- Educational training schedule conflicts
- Medical or mental health appointment conflicts
- Appointments with other agencies relative to the client's treatment goals

Clients who have been in OTP treatment for at least nine months may be permitted up to six off-site doses within a 7-day time period without prior approval from MDCH/ODCP for the following exceptional circumstance:

- Travel hardship (at least 60 miles or 60 minutes one way from an OTP). The actual mileage must be documented in the client's chart with the city of origin listed.

Vacations are a special type of exceptional circumstance and shall be limited to six days within a 7-day period for clients who have been in treatment for at least nine months and 13 days within a 14-day period for clients who have been in treatment for one year or more without prior MDCH/ODCP approval. Sunday and holiday doses must be included in the specified off-site amounts (R 325.14416 Part 417[6]).

Documentation must be included in the chart verifying the client did travel to the planned destination(s) as indicated on the exception request.

**Allowable Program Closures:**

Medication for off-site dosing due to program closure may only be given to a client who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication.

*Sunday Dosing*

OTPs may be closed on Sundays without prior approval from MDCH/ODCP.

*Holiday Observances*

- ◆ OTPs may be closed for the following holidays without prior MDCH/ODCP approval:

New Year's Day	Labor Day
Martin Luther King, Jr. Birthday	Veterans' Day
Presidents' Day	Thanksgiving Day
Memorial Day	Christmas Day
Independence Day – July 4	

- ◆ Should the holiday fall on a Sunday, OTPs may be closed the following Monday without prior MDCH/ODCP approval.
- ◆ A day in which the OTP has abbreviated hours in which methadone will be dispensed will not be considered as a program closure.
- ◆ If the OTP wishes to close for more than two consecutive days (including Sundays and holidays), the SMA at MDCH/ODCP and CSAT/DPT must approve a plan. The plan must meet the following criteria:
  - The request must be for each circumstance. OTPs may request all holidays for the entire year at once. No approvals will be automatically approved from year to year.
  - The request must be submitted for each individual OTP.
  - The plan must be submitted to the SMA at MDCH/ODCP at least 10 working days prior to the first day the program wishes to close. MDCH/ODCP is not obligated to approve any plans submitted that do not meet the 10 day criteria. Fax the request to the current number for MDCH/ODCP – (517) 335-2121.
  - Be written on OTP letterhead.

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- Be signed by the OTP sponsor or administrator.
- Name holidays to be closed.
- List dates to be closed including the holiday as well as a Sunday, if applicable. 1 judgment of the program director
- Describe how clients who lack 90 days in treatment and those clients who do not meet the criteria for unsupervised dosing will be dosed face-to-face.

MDCH/ODCP will approve and forward the request to CSAT/DPT for their approval. Should MDCH/ODCP not approve the plan, the OTP will be notified. This notification will include the reason(s) for the denial.

### *Emergency Situations*

OTPs must have written plans and procedures which include how dosing clients on-site, as well as dispensing doses for off-site use, will be accomplished in emergency situations. Emergency situations include power failures, natural disasters, and other situations in which the OTP cannot operate as usual. This plan must also include how the security of the medication and client records will be maintained.

## **PROCEDURE:**

### MDCH/ODCP Approval Required:

MDCH/ODCP approval for off-site dosing is needed for clients who do not meet the criteria for approval at the OTP level and for all those cases where federal approval is needed. In addition, any client taking medication out of the country must have MDCH/ODCP approval. Note: medication transported out of the country is subject to that country's jurisdiction.

### CSAT/DPT Approval Required:

- CSAT/DPT approval is needed for clients not meeting the following federal off-site criteria for length of time in treatment:
  - Less than 90 days in treatment - 1 dose plus the Sunday dose
  - 90 to 180 days in treatment - 2 doses plus the Sunday dose
  - 180 to 270 days in treatment - 3 doses plus the Sunday dose

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- 270 to 360 days in treatment - 6 doses (includes the Sunday dose)
- One year in continuous treatment - 14 doses (includes the Sunday dose)

### Submission Of Exception Requests:

As the CSAT/DPT Extranet system is in place and functioning well, the hard copy and fax method may only be used when the Extranet system is temporarily unavailable. The Extranet system is more efficient and allows for faster responses by MDCH/ODCP and CSAT/DPT and provides better confidentiality and eliminates the chance of not being able to read a hand written request due to fax quality and/or legibility. Programs must not submit both hard copy and Extranet-based forms for the same exception request. Programs may request a short-term waiver from the use of the Extranet from the SMA at MDCH/ODCP. Each request will be considered on a case-by-case basis.

### *Extranet System:*

The CSAT/DPT Extranet System was designed to facilitate the processing of Exception and Record of Justification Forms nationwide. Instructions for using this system are the responsibility of CSAT/DPT. The Extranet form will be available as directed by CSAT/DPT on a Website designated by SAMHSA. OTPs must submit all exception requests using this method, even those that only require MDCH/ODCP approval. In those cases, CSAT/DPT will indicate, "Decision not required."

MDCH/ODCP requires that all exception requests be submitted by using the Extranet system. Faxed forms will only be accepted if the system is down or in special, pre-approved situations.

### *Extranet Downtime Procedure for Hard Copy Forms and Faxing:*

All downtime exceptions to the rules for off-site dosing must be submitted to MDCH/ODCP on the "MDCH/ODCP Methadone Exception Request and Record of Justification" form (Attachment A). **This is the only form that will be accepted by MDCH/ODCP.** In urgent situations, such as funerals, illness, immediate work and travel hardships, this form can be used but the OTP should call the SMA so this exception can be obtained quickly. The SMA reserves the right to determine if the situation is urgent enough to warrant not using the Extranet and may request it is made in that manner.

MDCH/ODCP will identify those exception requests that also need CSAT/DPT approval by marking the appropriate box on the form when it is sent back. It is the responsibility of the OTPs to complete the SMA-168 "Exception Request and Record of Justification" (Attachment D) – **this is not the same form that is sent to MDCH/ODCP** – and fax it to CSAT/DPT at their current fax number for exceptions. As indicated on this form, the current fax number is (240) 276-1630. A copy of the approved MDCH/ODCP Exception Request and Record of Justification Form must be submitted along with this form. Attachment D was included in this policy as a convenience to the OTPs. However, OTPs

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are responsible for using the most current CSAT/DPT form and fax number. This information can be located on the SAMHSA Website, [www.dpt.samhsa.gov](http://www.dpt.samhsa.gov).

Delivery of Methadone to a Client by a Third Party or to Another Facility

*Delivery of Methadone to a Client by a Third Party:*

Documentation must be kept in the client's file that the client meets the criteria for off-site dosing as indicated in R 325.14416 (3) (a)-(k) and 42CFR Part 8.12 (i)(2)(i-viii). In addition, a "MDCH/ODCP Delivery to a Client by a Third Party" form (Attachment B) must be completed and maintained at the program. A copy of the form signed by the person receiving the methadone must be returned to the program so that the chain of custody can be documented before another supply is issued. A maximum of 7 doses may be delivered to a client for self-administration. The methadone must be secured in a locked box before leaving the OTP. Empty and unused bottles must be returned to the OTP.

*Delivery of Methadone to Another Facility Form:*

A "MDCH/ODCP Delivery of Methadone to Another Facility Form" (Attachment C) must be completed and maintained at the program. A copy of the form signed by the person receiving the methadone must be returned to the program so that the chain of custody can be documented before another supply is issued. A staff member of the facility in which the client is housed may obtain a maximum of 14 doses. The facility will transport, secure, and administer the methadone, as well as dispose of empty and unused bottles, according to that facility's protocols for the use of medications that are controlled substances.

Exception Verification for Coordinating Agencies:

Funded OTPs must submit a copy of approved MDCH/ODCP Methadone Exception and Record of Justification Form to their respective CAs when requested to do so.

Monitoring For Compliance:

Site visits to OTPs by MDCH/ODCP will include a review of documentation verifying that clients meet the criteria for off-site dosing. Probation or rescinding of off-site dosing privileges, when the client has not followed the rules for off-site usage, will also be reviewed. This document must include the coordination of sanctions and any changes to the treatment plan or services authorized by the CA or AMS for funded clients. OTPs must have a system to readily identify those clients issued doses for off-site use.

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**REFERENCES:**

American Society of Addiction Medicine (for Buprenorphine information).

<http://www.asam.org/>

*Certification of Opioid Treatment Programs:* United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (s003) <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl>

Division of Pharmacologic Therapies. (2002). *Patient Exceptions SMA-168-Exception Request and Record of Justification under 42 CFR § 8.12.* Retrieved from the Substance Abuse and Mental Health Services Administration website at <http://dpt.samhsa.gov/webintro.htm>

*Drug Addiction Treatment Act of 2000:* Public Law 106-310, Section 3502, United States House, 106<sup>th</sup> Congress, Washington, DC. (October 17, 2000).

Labeling and Dispensing of Prescription Medication. *Public Health Code:* 1978 Public Act 369, as amended, Article 6. MCL 333.17745, Michigan Legislature, 1977-78 Legislative Session, Lansing, Michigan. (September 30, 1978).

<http://www.legislature.mi.gov/mileg.aspx?page=getObject&objectName=mcl-333-17745>

*Methadone Treatment and Other Chemotherapy:* Michigan Administrative Code, Rules 325.14401-325.14423, State Office of Administrative Hearings and Rules. Lansing, Michigan. (September 10, 1971).

[http://www.michigan.gov/documents/cis\\_bhs\\_fhs\\_sa\\_part4\\_37163\\_7.pdf](http://www.michigan.gov/documents/cis_bhs_fhs_sa_part4_37163_7.pdf)

*Poison Prevention Packaging Act of 1970:* Public Law 91-601, 84 Stat. 1670, as amended, 90<sup>th</sup> Congress, Washington, DC. (December 30, 1970).

<http://www.cpsc.gov/businfo/pppatext.html>

*Public Health Code:* 1978 Public Act 368, as amended, MCL 333.1100-333.25211, Michigan Legislature, 1977-1978 Legislative Session, Lansing, Michigan. (September 30, 1978).

<http://www.legislature.mi.gov/mileg.aspx?page=getobject&objectname=mcl-act-368-of-1978>

**APPROVED BY:**

 \_\_\_\_\_

Donald L. Allen, Jr., Director  
Office of Drug Control Policy

**ATTACHMENT A**

**MDCH/ODCP METHADONE EXCEPTION REQUEST AND RECORD OF JUSTIFICATION FORM**

**DIRECTIONS FOR COMPLETING THE FORM:**

**NOTE: This form is only to be used during Extranet downtime and may be used in rare urgent situations at the SMAs discretion.**

**Program ID:** Type the I-SATS Number.

**City:** Fill in the location of the program.

**Client ID:** Fill in the client's ID number.

**Program Telephone:** Type the program's phone number.

**E-mail Address:** Type the program's e-mail address if available.

**Name and Title of Requestor:** Type name and title of requestor.

**Client's admission date:** Fill in the patient's admission date to the program.

**If transfer from another program-original date:** If the client transferred from another OTP, use that program's admission date in addition to the admission date to your program if the gap between services is less than 90 days. If there has been a 90-day or more gap in treatment, leave this blank.

**Client's dosage level:** Fill in the patient's dosage level.

**Client's program attendance schedule per week:** Circle appropriate days.

**Client is:** employed, unemployed, student, other (specify): Circle appropriate category. If other, explain.

**Client is disabled (specify):** Specify and provide an explanation of the disability.

**Permanent Decrease in Attendance to:** Circle days.

**Temporary Change in Attendance:** Temporary Change in Attendance (please explain). Fill in the explanation.

**Justification for request:** Describe the justification for request. Be as specific as possible without providing any patient identifying information. Travel hardships must include the city and the roundtrip mileage. If visiting another city, indicate city and state and why guest dosing is not being done. Any criterion that is not in compliance must be explained. A positive toxicology screen for drugs other than methadone metabolites must be documented as having a prescription for that time period. Toxicology screens must be positive for methadone or methadone metabolites.

**DO NOT SUBMIT DOCUMENTATION TO MDCH/ODCP OR CSAT/DPT UNLESS IT IS SPECIFICALLY REQUESTED. ENSURE THAT ALL CLIENT IDENTIFYING INFORMATION IS REMOVED FROM THE DOCUMENTS.**

**Dates of Exception:** Fill in the date of the first and last off-site doses.

**Number of doses to be dispensed:** Fill in number of doses to be dispensed.

**Has the client been informed of the dangers of children ingesting methadone:** Circle the correct response.

**Does the client meet the criteria used to determine if the patient is responsible in handling methadone as outlined in MDCH/ODCP Policy-04, Administrative Rules of Substance Abuse Treatment Programs in Michigan – R 325.14416 Part 416(3)(a-k) and 42 CFR Part 8.12(i) (2) (i-viii):**  
Circle the correct response. If no, the explanation must be included under the justification.

**Name of Concurring Physician:** Type the name of the concurring physician and MD or DO.

**Signature of Physician:** Signature by physician along with MD or DO.

**DO NOT WRITE BELOW THIS LINE:** Leave Blank.

MDCH/ODCP will approve or deny the Exception Request. Denials will be explained.

This Exception Request Also Requires Federal Approval. MDCH/ODCP will identify those Exception Requests that also need CSAT/DPT approval. IT IS THE RESPONSIBILITY OF THE OTP TO COMPLETE FEDERAL FORM SMA-168 EXCEPTION REQUEST AND RECORD OF JUSTIFICATION AND FAX IT TO CSAT/DPT AT 240-276-1630 ALONG WITH A COPY OF THE SIGNED MDCH/ODCP FORM. SUBMIT ONLY THOSE REQUESTS THAT NEED CSAT/DPT APPROVAL.

**TO:** State Methadone Authority, MDCH/ODCP    **Fax:** 517-335-2121                      **DATE** \_\_\_\_\_

**FROM:** Program Name \_\_\_\_\_ **FAX** \_\_\_\_\_

## **MDCH/ODCP EXCEPTION REQUEST AND RECORD OF JUSTIFICATION**

**NOTE: This form is only to be used during Extranet downtime and may be used in rare urgent situations at the SMAs discretion.**

Program ID: \_\_\_\_\_ City: \_\_\_\_\_ Client ID: \_\_\_\_\_

Program Telephone: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Name & Title of requestor \_\_\_\_\_

Client's admission date \_\_\_\_\_ If transfer, original admission date \_\_\_\_\_ Client's dosage level \_\_\_\_\_  
Client's program attendance schedule per week S M T W T F S (circle days)

Client is: Employed    Unemployed    Student    Other (Circle) (specify)

**Client has a disability (please explain)**

Permanent Decrease in Attendance to  S  M  T  W  T  F  S (circle days)

**Temporary Change in Attendance (please explain)**

Justification for request:

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Digitized by srujanika@gmail.com

Dates of Exception   /  /   to   /  /   Number of doses to be dispensed \_\_\_\_\_

Has the client been informed of the dangers of children ingesting methadone? Yes No (circle)

Does the client meet the criteria used to determine if the client is responsible in handling methadone as outlined in MDCH/ODCP Policy-04, Administrative Rules of Substance Abuse Treatment Programs in Michigan – R 325.14416 part 416(3)(a-k) and 42 CFR § 8.12(i) (2) (i-viii)? Yes No (circle)

**Print Name of Concurring Physician**

Signature of Physician

**STATE USE ONLY**

Approved

Denied

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**State Methadone Authority or Designee  
ODCP (517) 373-4700**

Explain:  
The following diagram shows the relationship between the three types of energy systems in the body.

**This Exception Request Also Needs Federal Approval.** Complete Form SMA-168 for federal approval and fax Form SMA-168 and this state approved request to CSAT per Form SMA-168 instructions.  
State Comments:

Confidentiality Notice: "The documents contain information from the Michigan Department of Community Health/Office of Drug Control Policy (ODCP) which is confidential in nature. The information is for the sole use of the intended recipient(s) named on the coversheet. If you are not the intended recipient, you are hereby notified that any disclosure, distribution or copying, or the taking of any action in regard to the contents of this information is strictly prohibited. If you have received this fax in error, please telephone us immediately so that we can correct the error and arrange for destruction or return of the faxed document."

**ATTACHMENT B**

**DIRECTIONS FOR COMPLETING MDCH/ODCP DELIVERY TO A CLIENT BY A THIRD PARTY  
FORM**

**Date:** Fill in date methadone dispensed.

**Client#:** Fill in client's number.

**Program Treatment Name:** Fill in Treatment Programs Name

**Program ID:** Fill in Program's I-SATS Number

**Program Telephone:** Fill in Program's Phone Number

**Fax:** Fill in Program's Fax Number

**E-Mail:** Fill in Program's E-Mail Address

**Name of Dispensing Nurse:** Fill in Name of Dispensing Nurse

**Licensing Number of Dispensing Nurse:** Fill in Licensing Number

**Signature of Dispensing Nurse:** Dispensing Nurse's Signature

**Justification for why client is unable to pick up the methadone at the clinic:** Explain the reason, such as a disability; specify. A note from the client's physician or similar documentation from the OTP physician must be placed in the client's chart.

**Methadone is being transported to:** Fill in client at residence, relative's residence, not the specific address.

**Medication provided from \_\_\_\_\_ to \_\_\_\_\_:** List dates

**Number of Doses Dispensed at One Time \_\_\_\_\_:** List number of doses dispensed. Not to exceed 7 doses without MDCH/ODCP written permission.

**Person Delivering the Methadone:** List person's name that is delivering the methadone.

**Relationship to Client:** Indicate relationship to client, such as spouse, roommate, etc.

**Liability Statement:** Person delivering methadone should read and sign on the signature line.

**Signature of Person Delivering Methadone:** Deliverer signs.

**Witness:** Witness to the Deliverer's signature.

**Signature of Person Receiving Medication:** Signature of client who receives the methadone.

**THE FORM, SIGNED BY THE CLIENT, IS TO BE RETURNED TO THE CLINIC WITH THE EMPTY AND UNUSED BOTTLES.**

Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDCH/ODCP liable for any unauthorized use of the methadone.

**Distribution**

Original Copy to OTP: The original of the form is retained at the OTP.

Copy to Client: A copy of the form is to made and given to the client.

0. Treatment Manager Name \_\_\_\_\_



**MDCH/ODCP DELIVERY TO A CLIENT BY A THIRD PARTY FORM**

DATE: \_\_\_\_\_ Client #: \_\_\_\_\_

Program Treatment Name: \_\_\_\_\_ Program ID: \_\_\_\_\_

Program Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name Of Dispensing Nurse: \_\_\_\_\_ License#: \_\_\_\_\_

Signature of Dispensing Nurse: \_\_\_\_\_

Justification for why client is unable to pick up the methadone at the clinic:

\_\_\_\_\_

\_\_\_\_\_

(Documentation from the client's physician or OTP physician must be included in the client's chart)

Methadone is being Delivered to: \_\_\_\_\_

Methadone provided from: \_\_\_\_\_ to \_\_\_\_\_ Number of Doses Dispensed at One Time: \_\_\_\_\_  
(Date) (Date) (Not to exceed 7 doses)

Person Delivering Methadone : \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Due to the above named client's temporary inability to pick -up his/her methadone, the above named Opioid Treatment Program has permission from MDCH/ODCP to allow delivery of the methadone to the client. I understand that this arrangement is for a specific period of time only, and that when this time ends, I will either no longer be picking up the medication, or will have to complete another MDCH/ODCP DELIVERY TO A CLIENT BY A THIRD PARTY FORM. I further understand that methadone is a narcotic, to be ingested by the client only, and that harm, including death could come to anyone else ingesting it. When I pick -up this medication, I must present current government issued pictured identification (Driver's License, State Identification Card, Military Identification Card). I must also present any necessary documentation from the treating physician, so that the clinic is kept up -to-date on the current status of the client's medical condition. I am aware that the methadone must be transported in a locked box and kept in this manner. Empty and unused bottles must be returned in the locked box. I have been made aware that loitering within a one-block radius of the clinic is prohibited. Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDCH/ODCP liable for any unauthorized use of the methadone.

Signature of Person Delivering the Methadone

Signature of Person Receiving Methadone

Witness

**THE FORM, SIGNED BY THE BOTH THE PERSON DELIVERING AND THE PERSON RECEIVING THE METHADONE, IS TO BE RETURNED TO THE CLINIC WITH THE USED BOTTLES.**

**DISTRIBUTION:**      Original to OTP  
                          Copy to Client

**ATTACHMENT C**

**DIRECTIONS FOR COMPLETING MDCH/ODCP DELIVERY OF METHADONE TO ANOTHER FACILITY FORM**

Delivery to \_\_\_\_\_

**Date:** Fill in date methadone dispensed.

**Client#:** Fill in client's number.

**Program Treatment Name:** Fill in Treatment Programs Name

**Program ID:** Fill in Program's I-SATS Number

**Program Telephone:** Fill in Program's Phone Number

**Fax:** Fill in Program's Fax Number

**E-Mail:** Fill in Program's E-Mail Address

**Methadone Delivered to:** Facility Name, Phone Number: Fill in name of facility and phone number.

**Name of Dispensing Nurse:** Fill in Name of Dispensing Nurse

**Licensing Number of Dispensing Nurse:** Fill in Licensing Number

**Signature of Dispensing Nurse:** Dispensing Nurse's Signature

**Justification for why client is unable to pick up the methadone at the clinic:** Explain the reason such as incarceration, etc.

**Methadone is being transported to:** Facility's Name and Phone Number.

**Medication provided from \_\_\_\_\_ to \_\_\_\_\_:** List dates

**Number of Doses Dispensed at One Time \_\_\_\_\_:** List number of doses dispensed. Not to exceed 14 doses without MDCH/ODCP written permission.

**Liability Statement:** Person delivering the methadone should read and then sign.

**Person Delivering the Methadone:** Print the facility staff person's name.

**Witness:** Witness to the transporters signature. Print name and Sign.

**Name of Person Receiving the Methadone at the Facility:** Printed Name and Signature of facility staff who accepts delivery of the methadone.

Both the delivery person and the facility agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDCH/ODCP liable for any unauthorized use of the methadone.

**Distribution:** Original Copy to OTP: The original of the form is retained at the OTP.

Copy to Facility: A copy of the form is to be made and given to the facility.

## MDCH/ODCP DELIVERY OF METHADONE TO ANOTHER FACILITY FORM

DATE: \_\_\_\_\_ Client # \_\_\_\_\_

Program Treatment Name: \_\_\_\_\_ Program ID: \_\_\_\_\_

Program Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Methadone Delivered to: Facility Name \_\_\_\_\_ Phone \_\_\_\_\_

Name Of Dispensing Nurse: \_\_\_\_\_ License#: \_\_\_\_\_

Signature of Dispensing Nurse: \_\_\_\_\_

Justification for why client is unable to pick up the methadone at the clinic:

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Methadone provided from: \_\_\_\_\_ to \_\_\_\_\_ Number of Doses Dispensed at One Time: \_\_\_\_\_  
(Date) (Date) (Not to exceed 14 doses)

Due to the above named client's temporary inability to pick -up his/her methadone, the above named Opioid Treatment Program has permission from MDCH/ODCP to allow transportation of the methadone to the above named facility. I understand that this arrangement is for a specific period of time only, and that when this time ends, I will either no longer be picking up the methadone, or will have to complete another "MDCH/ODCP Delivery of Methadone to another Facility Form". I further understand that methadone is a narcotic, to be ingested by the client only, and that harm, including death could come to anyone else ingesting it. When I pick -up the methadone I must present current government issued pictured identification (Driver's License, State Identification Card, Military Identification Card). I must also present any necessary documentation from the treating physician, so that the clinic is kept up -to-date on the current status of the client's medical condition. I have been made aware that loitering within a one -block radius of the clinic is prohibited. I am aware that the methadone is a controlled substance and my institution's protocols will be observed. Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDCH/ODCP liable for any unauthorized use of the methadone.

Person Transporting Methadone \_\_\_\_\_ Title \_\_\_\_\_  
Print \_\_\_\_\_ Print \_\_\_\_\_

Signature \_\_\_\_\_

Facility Staff Receiving the Methadone \_\_\_\_\_  
Print \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_  
Print \_\_\_\_\_ Signature \_\_\_\_\_

**DISTRIBUTION:** Original to OTP  
Copy to Client

## ATTACHMENT D

### INSTRUCTIONS FOR EXCEPTION REQUEST AND RECORD OF JUSTIFICATION UNDER 42 CFR § 8.11(h) (FORM SMA-168)

**Purpose of Form:** The SMA-168 form was created to facilitate the submission and review of patient exceptions under 42 CFR § 8.11(h). SAMHSA will use the information provided to review "patient exception requests" and determine whether they should be approved or denied. A "patient exception request" is a request signed by the physician for approval to change the patient care regimen from the requirements specified in Federal regulation (42 CFR, Part 8). The physician makes this request when he/she seeks SAMHSA approval to make a patient treatment decision that differs from regulatory requirements.

This is a flexible, multi-purpose form on which various patient exception requests may be documented and approved or denied, along with an explanation for the action taken. It is most frequently used to request exceptions to the regulation on the number of take-home doses permitted for unsupervised use, such as during a family or health emergency. The form is also frequently used to request a change in patient protocol or for an exception to the detoxification standards outlined in the regulation.

#### GENERAL INSTRUCTIONS

Please complete **ALL** items on the form. As appropriate, there is space to indicate if an item does not apply.

The instructions below show the item from the form in **bold text**. In the column next to the bold text is a description of the information requested.

ITEM	INSTRUCTION
<b>BACKGROUND INFORMATION ON PROGRAM AND PATIENT</b>	
<b>Program OTP No</b>	Opioid Treatment Program (OTP) identification number—same as the old FDA number. Begins with 2 letters of your State abbreviation, followed by 5 numbers, then a letter. This number should fit into the format on the form.
<b>Patient ID No</b>	Confidential number you use to identify the patient. Please do not use the patient's name or other identifying information. Number of digits does <b>NOT</b> have to match number of boxes on the form.
<b>Program Name</b>	Name of opioid treatment program, clinic or hospital in which patient enrolled.
<b>Telephone</b>	Voice telephone number. <b>PLEASE INCLUDE YOUR AREA CODE.</b>
<b>Fax</b>	Facsimile (FAX) number. <b>PLEASE INCLUDE YOUR AREA CODE.</b>
<b>Email</b>	Indicate electronic mail (e-mail) address of the CONTACT person.
<b>Name &amp; Title of Requestor</b>	Name and title of physician or staff member authorized to submit this request.
<b>Patient's Admission Date</b>	Date patient enrolled at this facility.
<b>Patient's current dosage level</b>	Dosage patient receives <b>NOW</b> . Please indicate the dosage in milligrams (mg).
<b>Methadone/LAAM/Other</b>	Place an "X" on the line next to the medication the patient takes. If you check "Other," write in the name of the medication in the space provided.
<b>Patient's program attendance schedule per week</b>	Place an "X" on the line to the left of each day per week the patient <b>NOW</b> reports to the clinic for medication.
<b>*If current attendance is less than once per week, please enter the schedule</b>	If patient <b>NOW</b> reports to the clinic <b>LESS</b> than once a week, please indicate how often he/she reports.
<b>Patient status</b>	Place an "X" on the line to the left of the item that best describes the patient's <b>CURRENT</b> status. If the patient's status does not appear on the list on the form, please place an "X" on the line next to "Other" and write in the patient's <b>CURRENT</b> status.
<b>REQUEST FOR CHANGE</b>	
<b>Nature of request</b>	Please place an "X" on the line to the left of the description that <b>BEST</b> describes this request. If your request is not listed in this item on the form, place an "X" on the line to the left of "Other" and describe your request.
<b>Decrease regular attendance to</b>	Place an "X" on the line to the left of each day per week that the patient is to report for medication.
<b>Beginning date</b>	Enter the date that the exception is scheduled to begin.
<b>*If new attendance is less than once per week, please enter the schedule</b>	If you are asking to reduce the patient's attendance schedule to <b>LESS THAN</b> once per week, please indicate the schedule on the line provided.
<b>Dates of Exception</b>	Please indicate the dates that the exception will be effective.
<b># of doses needed</b>	Indicate how many doses will be dispensed during the exception period.
<b>Justification</b>	Please place an "X" on the line to the left of the best description of the reason for this request. If the reason

Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII B.A. Substance Abuse Disorder Policy Manual

ITEM	INSTRUCTION
	is not listed in this item, place an "X" on the line next to "Other" and write in the justification.
<b>REQUIREMENTS</b>	
<b>Regulation Requirements</b>	There are certain guidelines that programs must follow regarding take-home medication and detoxification admissions. Next to each of the 3 statements listed in this item, please indicate whether the OTP followed the stipulated requirements. For each statement that does not apply, place an "X" on the line to the left of "N/A" (not applicable).
<b>Submitted by:</b>	
<b>Printed Name of Physician</b>	Please PRINT the name of the physician making the request.
<b>Signature of Physician</b>	Once ALL the items above have been completed, the physician should SIGN here.
<b>Date</b>	Date the form is signed.

**APPROVAL**—This section will be completed by the appropriate authorities.

**State response to request** If this form must be reviewed or approved by your State, be sure that you forward this form to the proper authority, who will indicate approval or denial of your request in the space provided.

**Federal response to request** This is the place on the form where CSAT will indicate whether the request is accurate and approved. The form will be faxed or e-mailed back to you.

**Please submit to CSAT/OPAT—Fax: (301) 443-3994 or Email: otp@samhsa.gov** When you have completed the form, either fax or email it to CSAT at the numbers provided here.

**Effect:** This form was created to facilitate the submission and review of patient exceptions under 42 CFR § 8.11(h). This does not preclude other forms of notification.

**Paperwork Reduction Act Statement**

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer, Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx.

**SMA-168 INSTRUCTIONS (BACK)**

Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII B.A. Substance Abuse Disorder Policy Manual

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT  <b>Exception Request and Record of Justification</b> <b>Under 42 CFR § 8.11 (h)</b>	Form Approved: OMB Number 0930-0206 Expiration Date: 09 30 2003 See OMB Statement on Reverse  <b>DATE OF SUBMISSION</b> Date you submit form to CSAT.
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**BACKGROUND INFORMATION**

**Note:** This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42 CFR § 8.11 (h).  
**Detailed INSTRUCTIONS** are on the cover page of this form. PLEASE complete ALL applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

**BACKGROUND INFORMATION ON PROGRAM AND PATIENT**

Program OTP No:  -  -  -  | Patient ID No:  -  -  -  -  -

Program identification number—old FDA number. Begins with 2 letters of your State abbreviation, followed by 5 numbers, then a letter. Should fit into the format above.

Number you use to identify patient. Number of digits does NOT have to match number of boxes above. **DO NOT USE PATIENT'S NAME.**

Program Name: Name used to identify opioid treatment program, clinic, or hospital in which patient enrolled.

Telephone: Phone #, including area code. Fax: Fax #, including area code. E-mail: . . . of contact person.

Name & Title of Requestor: Name and title of physician or staff member authorized to submit request.

Patient's Admission Date: Date patient enrolled in this facility.	Patient's current dosage level: <input type="text"/> mg	<input type="checkbox"/> Methadone	<input type="checkbox"/> LAAM
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Dosage patient receives NOW.

Place an "X" on the line next to the medication the patient takes. If you check "Other," write in the name of the medication.

Patient's program attendance schedule per week  
(Place an "X" next to all days that the patient attends\*):

S  M  T  W  T  F  S

Place an "X" on the line to the left of each day per week the patient NOW reports to the clinic for medication.

\*If current attendance is less than once per week, please enter the schedule:

If patient NOW reports to the clinic LESS than once weekly, please indicate how often he/she reports.

Patient status: Employed <input type="checkbox"/>	Unemployed <input type="checkbox"/>	Homemaker <input type="checkbox"/>	Student <input type="checkbox"/>
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Other: \_\_\_\_\_

Place an "X" on the line next to the item that best describes the patient's CURRENT status. If that status does not appear on this list, please place an "X" on the line next to "Other" and write in the patient's CURRENT status.

**REQUEST FOR CHANGE**

**REQUEST FOR CHANGE REGARDING PATIENT TREATMENT**

Nature of request:

Temporary take-home medication  Temporary change in protocol  Detoxification exception  Other

Please place an "X" on the line next to the item above that BEST describes what this request is about. If your request is not listed above, place an "X" on the line next to "Other" and describe your request.

Decrease regular attendance to  
(Place an "X" next to appropriate days\*):

S  M  T  W  T  F  S

Beginning date: \_\_\_\_\_

Place an "X" on the line to the left of each day per week you want the patient to report for medication.

Date you want new attendance schedule to begin.

\*If new attendance is less than once per week, please enter the schedule:

If you are asking to reduce the number of days per week the patient reports to the program to LESS THAN once per week, please indicate the schedule on the line above.

Dates of Exception: From \_\_\_\_\_ to \_\_\_\_\_ # of doses needed: \_\_\_\_\_

Please indicate the dates that the exception you are requesting will be effective.

Indicate how many doses will be dispensed during the exception period.

Justification: _____	Family Emergency <input type="checkbox"/>	Incarceration <input type="checkbox"/>	Funeral <input type="checkbox"/>	Vacation <input type="checkbox"/>	Transportation Hardship <input type="checkbox"/>
_____	_____	_____	_____	_____	_____
_____	Step/Level Change <input type="checkbox"/>	Employment <input type="checkbox"/>	Medical <input type="checkbox"/>	Long Term Care Facility <input type="checkbox"/>	Other Residential Treatment <input type="checkbox"/>
_____	Homebound <input type="checkbox"/>	Split Dose <input type="checkbox"/>	Other <input type="checkbox"/>	_____	_____

Please place an "X" on the line to the left of the item above that best describes the reason for this request. If the reason is not listed above, place an "X" on the line next to "Other" and write in the justification.

## REQUIREMENTS

### REQUIREMENTS (GUIDELINES AND SIGNATURE)

#### Regulation Requirements:

- |    |   |     |        |     |
|----|---|-----|--------|-----|
| 1. | <b>For take-home medication:</b> Has the patient been informed of the dangers of children ingesting methadone or LAAM?  | Yes | No     | N/A |
| 2. | <b>For take-home medication:</b> Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR §8.12(i)(2)(i)-(viii)?    | Yes | No     | N/A |
| 3. | <b>For multiple detoxification admissions:</b> Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR §8.12(e)(4)? | Yes | N<br>o | N/A |

There are certain guidelines that programs must follow regarding take-home medication and detoxification admissions. Next to each item above, please indicate whether you followed the stipulated requirements. For each statement that does not apply to you, place an "X" on the line to the left of "N/A" (not applicable).

Submitted by:

Printed Name of Physician	Signature of Physician	Date
Please PRINT the name of the physician making the request.	Once ALL the items above have been completed, the physician should SIGN here.	Date form is signed.

### APPROVAL OF AUTHORITIES

#### APPROVAL

State response to request:

Approved       Denied

State Methadone Authority	Date
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Explanation:

If this form must be reviewed or approved by your State, be sure that you forward this form to the proper authority, who will indicate approval or denial of your request in the space above.

Federal response to request:

Approved       Denied

Public Health Advisor, Center for Substance Abuse Treatment	Date
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Explanation:

CSAT will indicate whether the request is accurate and approved or denied in this space. The form will be faxed or emailed back to you.

Please submit to CSAT/OPAT—Fax: (301) 443-3994; Email: [otp@samhsa.gov](mailto:otp@samhsa.gov)

*This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.*

FORM SMA-168 (FRONT)

**Purpose of Form:** This form was created to facilitate the submission and review of patient exceptions under 42 CFR § 8.11(h). This does not preclude other forms of notification.

#### Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.

FORM SMA-168 (BACK)

Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII B.A. Substance Abuse Disorder Policy Manual

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION  
CENTER FOR SUBSTANCE ABUSE TREATMENT  
**FORM SMA-168**  
**Exception Request and Record of Justification**  
**Under 42 CFR § 8.11 (h)**

Form Approved: OMB Number 0930 -0206  
Expiration Date: 09/30/2006  
See OMB Statement on Reverse

DATE OF SUBMISSION

Note: This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42-CFR § 8.11 (h).

Detailed INSTRUCTIONS are on the cover page of this form. PLEASE complete ALL applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

Program OTP No: [REDACTED] - [REDACTED] - [REDACTED] | Patient ID No: [REDACTED]

Program Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name & Title of Requestor: \_\_\_\_\_

Patient's Admission Date: \_\_\_\_\_ Patient's current dosage level: \_\_\_\_\_ mg Methadone LAAM  
Other: \_\_\_\_\_

Patient's program attendance schedule per week  
(Place an "X" next to all days that the patient attends\*): \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ T \_\_\_\_\_ F \_\_\_\_\_ S \_\_\_\_\_

\*If current attendance is less than once per week, please enter the schedule: \_\_\_\_\_

Patient status: \_\_\_\_\_ Employed \_\_\_\_\_ Unemployed \_\_\_\_\_ Homemaker \_\_\_\_\_ Student \_\_\_\_\_ Disabled  
Other: \_\_\_\_\_

Request Change  
Nature of request: \_\_\_\_\_  
Temporary take-home medication \_\_\_\_\_ Temporary change in protocol \_\_\_\_\_ Detoxification exception \_\_\_\_\_ Other \_\_\_\_\_

Decrease regular attendance to  
(Place an "X" next to appropriate days\*): \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ T \_\_\_\_\_ F \_\_\_\_\_ S \_\_\_\_\_ Beginning date: \_\_\_\_\_

\*If new attendance is less than once per week, please enter the schedule: \_\_\_\_\_

Dates of Exception: From \_\_\_\_\_ to \_\_\_\_\_ # of doses needed: \_\_\_\_\_  
Justification \_\_\_\_\_ Family Emergency \_\_\_\_\_ Incarceration \_\_\_\_\_ Funeral \_\_\_\_\_ Vacation \_\_\_\_\_ Transportation Hardship \_\_\_\_\_  
\_\_\_\_ Step/Level Change \_\_\_\_\_ Employment \_\_\_\_\_ Medical \_\_\_\_\_ Long Term Care Facility \_\_\_\_\_ Other Residential Treatment \_\_\_\_\_  
\_\_\_\_ Homebound \_\_\_\_\_ Split Dose \_\_\_\_\_ Other \_\_\_\_\_

- Regulation Requirements:
4. For take-home medication: Has the patient been informed of the dangers of children ingesting methadone or LAAM? Yes No N/A
  5. For take-home medication: Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR §8.12(i)(2)(i)-(viii)? Yes No N/A
  3. For multiple detoxification admissions: Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR §8.12(e)(4)? Yes No N/A

Submitted by: \_\_\_\_\_

Printed Name of Physician	Signature of Physician	Date
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State response to request: \_\_\_\_\_

Approved	Denied	State Methadone Authority	Date
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Explanation: \_\_\_\_\_

Federal response to request: \_\_\_\_\_

Approved	Denied	C. Todd Rosendale, Public Health Advisor Center for Substance Abuse Treatment	Date
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Explanation: \_\_\_\_\_

Please fax to CSAT/DPT, (240) 276-1630 or Email: otp@samhsa.gov

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.  
FORM SMA-168



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

JAMES K. HAVEMAN  
DIRECTOR

## MEMORANDUM

**DATE:** October 15, 2012

**TO:** Regional Substance Abuse Coordinating Agency Directors

**FROM:** Deborah J. Hollis, Director  
Bureau of Substance Abuse and Addiction Services

**SUBJECT:** Final Treatment Policy #5, Criteria for Using Methadone for Medication-Assisted Treatment and Recovery

On July 23, 2012, the Bureau of Substance Abuse and Addiction Services (BSAAS) sent a draft of the revised *Treatment Policy #5, Criteria for Using Methadone for Medication-Assisted Treatment and Recovery*, to all coordinating agencies for review and comment. Comments were due to BSAAS by August 23, 2012. No comments were received; therefore, this policy went into effect October 1, 2012 as revised.

As noted in the memo that accompanied the draft, changes were required to the portions of the policy and the consent form that addressed medication-assisted treatment for pregnant and non-pregnant adolescents. These revisions were on page six of the policy and page one of the consent form, and were made to clarify the previous policy as detailed in our April 20 memo (attached).

If you have any questions, please contact Lisa Miller at [millerL12@michigan.gov](mailto:millerL12@michigan.gov) or 517-241-1216.

Thank you.

Attachments

c: Felix Sharpe

**Michigan Department of Community Health, Behavioral Health and Developmental Disabilities Administration  
BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

**TREATMENT POLICY #05**

**SUBJECT:** Criteria for Using Methadone for Medication-Assisted Treatment and Recovery

**ISSUED:** September 1, 2003, revised August 5, 2005, October 3, 2007, July 31, 2011,  
October 1, 2011, and August 24, 2012

**EFFECTIVE:** October 1, 2012

**PURPOSE:**

The purpose of this policy is to clarify the process for the use of methadone in medication-assisted treatment and recovery for opioid dependence.

**SCOPE:**

This policy applies to all regional substance abuse coordinating agencies (CAs) and their provider network of opioid treatment programs (OTPs). Medicaid-specific services are also identified in this document. The state administrative rules and federal regulations are not replaced or reduced by these criteria.

**BACKGROUND:**

Methadone Use in Medication-Assisted Treatment and Recovery

Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for methadone as an adjunct treatment and recovery service. The Medicaid-covered substance use disorder benefit for methadone services includes the provision and administration of methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered tuberculosis (TB) skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.

TREATMENT POLICY #05

EFFECTIVE: October 1, 2012

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The American Society of Addiction Medicine (ASAM) level of care (LOC) indicated for individuals receiving methadone is usually outpatient. The severity of the opioid dependency and the medical need for methadone should not be diminished because medication-assisted treatment has been classified as outpatient. Counseling services should be conducted by the OTP that is providing the methadone whenever possible and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record.

If methadone is to be self-administered off-site of the OTP, off-site dosing must be in compliance with the current Michigan Department of Community Health (MDCH) *Treatment Policy #4: Off-Site Dosing Requirements for Medication-Assisted Treatment*. This includes Sunday and holiday doses for those individuals not deemed to be responsible for managing take-home doses.

All six dimensions of the ASAM patient placement criteria must be addressed:

1. Acute intoxication and/or withdrawal potential.
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).
4. Treatment acceptance/resistance.
5. Relapse/continued use potential.
6. Recovery/living environment.

In using these dimensions, the strengths and supports, or recovery capital, of the individual will be a major factor in assisting with the design of the individualized treatment and recovery plan.

In many situations, case management or care coordination services may be needed by individuals to further support the recovery process. These services can link the individual to other recovery supports within the community such as medical care, mental health services, educational or vocational assistance, housing, food, parenting, legal assistance, and self-help groups. Documentation of such referrals and follow up must be in the treatment plan(s) and progress notes within the individual's chart. If it is determined that case management or care coordination is not appropriate for the individual, the rationale must be documented in the individual's chart. The acupuncture detoxification five-point protocol is suggested as a means of assisting the individual with symptom management of anxiety and restorative sleep.

Clarification of Substance-Dependence Treatment and Recovery with Methadone in Individuals with Prior or Existing Pain Issues

All persons assessed for a substance use disorder must be assessed using the ASAM patient placement criteria and the current Diagnostic and Statistical Manual of Mental Disorders (DSM). In the case of opioid addiction, pseudo-addiction must also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction. In some cases, primary care and other doctors may misunderstand the scope of the OTP and refer individuals to the OTP for pain control. The "Michigan Guidelines for the Use of

TREATMENT POLICY #05

EFFECTIVE: October 1, 2012

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Controlled Substances for the Treatment of Pain," should be consulted to assist in determining when substance use disorder treatment is appropriate, as well as the publication, *Responsible Opioid Prescribing: A Michigan Physician's Guide* by Scott M. Fishman, MD. This publication was distributed to all controlled substance prescribers in Michigan by the Michigan Department of Community Health, Bureau of Health Professions, in September of 2009. OTPs are not pain clinics, and cannot address the underlying medical condition causing the pain. The OTP and CA are encouraged to work with the local medical community to minimize inappropriate referrals to OTPs for pain.

Individuals receiving methadone as treatment for an opioid addiction may need pain medication in conjunction with this adjunct therapy. The use of non-opioid analgesics and other non-medication therapy is recommended whenever possible. Opioid analgesics as prescribed for pain by the individual's primary care physician (or dentist, podiatrist) can be used; they are not a reason to initiate detoxification to a drug-free state, nor does their use make the individual ineligible for using methadone for the treatment of opioid addiction. The methadone used in treating opioid addiction does not replace the need for pain medication. It is recommended that individuals inform their prescribing practitioners that they are on methadone, as well as any other medications. On-going coordination (or documentation of efforts if prescribing practitioners do not respond) between the OTP physician and the prescribing practitioner is required for continued services at the OTP and for any off-site dosing including Sunday and holidays.

**REQUIREMENTS:**

These codes, regulations, and manuals must be followed:

- *Methadone Treatment and Other Chemotherapy*, Michigan Administrative Code, Rule 325.14401-325.14423
- *Certification of Opioid Treatment Programs*, U.S. Code of Federal Regulations, 42 CFR Part 8
- *Michigan Medicaid Provider Manual*

An OTP using methadone for the treatment and recovery of opioid dependency must be:

1. Licensed by the state as a methadone provider.
2. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or The Joint Commission (TJC), formerly JCAHO.
3. Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.
4. Registered by the Drug Enforcement Administration (DEA).

TREATMENT POLICY #05

EFFECTIVE: October 1, 2012

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## PROCEDURE:

### Admission Criteria

Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Patient Placement Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria. It is important to note that each individual, as a whole, must be considered when determining LOC, as methadone maintenance therapy may not be the best answer for every individual. For exceptions, see "Special Circumstances for Pregnant Women and Adolescents" on page six (6). Consistent with the LOC determination, individuals requesting methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification.
- Sub-acute Detoxification.
- Residential Care.
- Buprenorphine/Naloxone.
- Non-Medication-Assisted Outpatient.

In addition to these levels of care, each CA is expected to have providers available that can also offer case management services, treatment for co-occurring disorders, early intervention, and peer recovery and recovery support services. Acupuncture detoxification may be used in all levels of care. These additional service options can be provided to opioid dependent individuals who do not meet the criteria for adjunct methadone treatment. Individuals should be encouraged to participate in treatment early in their addiction before methadone is necessary.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Individuals must be informed that all of the following are required:

1. Daily attendance at the clinic is necessary for dosing, including Sundays and holidays if criteria for take home medication are not met.
2. Compliance with the individualized treatment and recovery plan, which includes referrals and follow-up as needed.
3. Monthly random toxicology testing.
4. Coordination of care with all prescribing practitioners (physicians, dentists, and any other health care provider) over the past year.

It is the responsibility of the OTP, as part of the informed consent process, to ensure that individuals are aware of the benefits and hazards of methadone treatment. It is also the OTP's responsibility to obtain consent to contact other OTPs within 200 miles to monitor for enrollments in other programs (42 CFR §2.34).

OTPs must request that individuals provide a complete list of all prescribed medications. Legally

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prescribed medication, including controlled substances, must not be considered as illicit substances when the OTP has documentation that it was prescribed for the individual. Copies of the prescription label, pharmacy receipt, pharmacy print out, or a Michigan Automated Prescription System (MAPS) report must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.

Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law. For enrolled individuals, there must be a copy of the MDCH registration card for medical marijuana issued in the individual's name in the chart or the "prescribed medication log." Following these steps will help to ensure that an individual who is using medical marijuana per Michigan law will not be discriminated against in regards to program admission and exceptions for dosing.

If an individual is unwilling to provide prescription or medical marijuana information, the OTP must include a statement to this effect, signed by the individual, in the chart. These individuals will not be eligible for off-site dosing, including Sunday and holiday doses. OTPs must advise individuals to include methadone when providing a list of medications to their healthcare providers. The OTP physician may elect not to admit the individual for methadone treatment if the coordination of care with health care providers and/or prescribing physicians is not agreed to by the client.

Off-site dosing, including Sundays and holidays, is not allowed without coordination of care (or documentation of efforts made by the OTP for coordination) by the OTP physician, the prescriber of the identified controlled substance (opioids, benzodiazepines, muscle relaxants), and the physician who approved the use of medical marijuana. This coordination must be documented in either the nurse's or the doctor's notes. The documentation must be individualized, identifying the individual, the diagnosis, and the length of time the individual is expected to be on the medication. A MAPS report must be completed at admission. A MAPS report should be completed before off-site doses, including Sundays and holidays, are allowed and must be completed when coordination of care with other physicians could not be accomplished.

If respiratory depressants are prescribed for any medical condition, including a dental or podiatry condition, the prescribing practitioners should be encouraged to prescribe a medication which is the least likely to cause danger to the individual when used with methadone. Individuals who have coordinated care with prescribing practitioners, and are receiving medical care or mental health services, will be allowed dosing off site, if all other criteria are met. If the OTP is closed for dosing on Sundays or holidays, arrangements shall be made to dose the individual at another OTP if the individual is not deemed responsible for off-site dosing.

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Special Circumstance for Pregnant Women and Adolescents

*Pregnant women*

Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an OTP provided the pregnancy is certified by the OTP physician, and treatment is found to be justified. For pregnant individuals, evidence of current physiological dependence is not necessary. Pregnant opioid dependent individuals must be referred for prenatal care and other pregnancy-related services and supports, as necessary.

OTPs must obtain informed consent from pregnant women and all women admitted to methadone treatment that may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. Because methadone and opiate withdrawal are not recommended during pregnancy, due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.

*Pregnant adolescents*

For an individual under 18 years-of-age, a parent, legal guardian, or responsible adult designated by the relevant state authority, must provide consent for treatment in writing (Attachment A). In Michigan, the "relevant state authority" to provide consent is children's protective services (CPS) through the Department of Human Services [Public Act 238 722.621]. A copy of this signed, informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in the medical record.

*Non-Pregnant adolescents*

An individual under 18 years-of-age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual under 18 years-of-age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority/CPS consents, in writing, to such treatment (Attachment A). This is sufficient consent to allow for persons 16 and 17 years-of-age to enter methadone treatment [*Administrative Rules for Substance Abuse Services, Rule 325.14409(5)*]. However, persons 15 years-of-age and under must also have permission for admission by the state opioid treatment authority (SOTA), as well as the Drug Enforcement Administration (DEA). A copy of this signed informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in their medical record [42CFR Subpart 8.12 (e) (2)].

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Treatment and Continued Recovery Using Methadone

Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and treatment and recovery plans must be based on the needs and goals of the individual (*Treatment Policy #06: Individualized Treatment Planning*). Referrals for medical care, mental health issues, vocational and educational needs, spiritual guidance, and housing are required, as needed, based on the information gathered as part of the assessment and other documentation completed by the individual. The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible (*Treatment Policy #8: Substance Abuse Case Management Requirements*). Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Compliance with dosing requirements or attendance at counseling sessions alone is not sufficient to continue enrollment. Reviews to determine continued eligibility for methadone dosing and counseling services must occur at least every four months by the OTP physician during the first two years of service. An assessment of the ability to pay for services and a determination for Medicaid coverage must be conducted at that time, as well. If it is determined by the OTP physician that the individual requires methadone treatment beyond the first two years, the justification of the medical necessity for methadone only needs to occur annually. However, financial review and eligibility for Medicaid is required to continue at a minimum of every six months.

An individual may continue with services if all of the following criteria are present:

- a. Applicable ASAM criteria are met.
- b. The individual provides evidence of willingness to participate in treatment.
- c. There is evidence of progress.
- d. There is documentation of medical necessity.
- e. The need for continuation of services is documented in writing by the OTP physician.

Individuals, who continue to have a medical need for methadone, as documented in their medical record by the OTP physician, are not considered discharged from services; nor are individuals who have been tapered from methadone, but still need counseling services.

All substances of abuse, including alcohol, must be addressed in the treatment and recovery plan. Treatment and recovery plans and progress notes are expected to reflect the clinical status of the individual along with progress, or lack of progress in treatment. In addition, items such as the initiation of compliance contracts, extra counseling sessions, or specialized groups provided, and off-site dosing privileges that have been initiated, rescinded, or reduced should also be reflected in progress notes. Referrals and follow-up to those referrals must be documented. The funding authority may, at its discretion, require its approval of initial and/or continuing treatment and recovery plans.

For individuals who are struggling to meet the objectives in his/her individual treatment and recovery plans, OTP medical and clinical staff must review, with the individual, the course of treatment and recovery and make adjustments to the services being provided. Examples of such adjustments may be changing the methadone dosage (including split dosing), increasing the length

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or number of counseling sessions, incorporating specialized group sessions, using compliance contracts, initiating case management services, providing adjunctive acupuncture treatment, and referring the individual for screening to another LOC.

Medical Maintenance Phase of Treatment

As individuals progress through recovery, there may be a time when the maximum therapeutic benefit of counseling has been achieved. At this point, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. To assist the OTP in making this decision, *TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* offers the following criteria to consider when making the decision to move to medical maintenance:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system and absence of significant un-stabilized co-occurring disorders.

Discontinuation of Services

Individuals must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services. In addition, individuals may be terminated from services if there is clinical and/or behavioral non-compliance. If an individual is terminated, the OTP must attempt to make a referral for another LOC assessment or for placing the individual at another OTP, and must make an effort to ensure that the individual follows through with the referral. These efforts must be documented in the medical record. The OTP must follow the procedures of the funding authority in coordinating these referrals.

Any action to terminate treatment of a Medicaid recipient requires a notice of action be given to the individual. The individual has a right to appeal this decision; services must continue and dosage levels maintained while the appeal is in process.

The following are reasons for discontinuation/termination:

1. Completion of Treatment – The decision to discharge an individual must be made by the OTP's physician with input from clinical staff and the individual. Completion of treatment is determined when the individual has fully or substantially achieved the goals listed in his/her individualized treatment and recovery plan and when the individual no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state

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(tapering) should be implemented within safe and appropriate medical standards.

2. Administrative Discontinuation – The OTP must work with the individual to explore and implement methods to facilitate compliance. Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment.

The repeated or continued use of illicit opioids and non-opioid drugs, including alcohol, would be considered non-compliance. OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (*Administrative Rules of Substance Abuse Services Programs in Michigan*, R 325.14406). Individuals whose toxicology results do not indicate the presence of methadone metabolites must be considered noncompliant, with the same actions taken as if illicit drugs (including non-prescribed medication) were detected.

OTPs must test for alcohol use if: 1) prohibited under their individualized treatment and recovery plan; or 2) the individual appears to be using alcohol to a degree that would make dosing unsafe. The following actions are also considered to be non-compliant:

- Repeated failure<sup>1</sup> to submit to toxicology sampling as requested.
- Repeated failure<sup>1</sup> to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure<sup>1</sup> to follow through on other treatment and recovery plan related referrals.

<sup>1</sup> *Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist individuals to comply with activities.*

The commission of acts by the individual that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to the following:

- Possession of a weapon on OTP property.
- Assaultive behavior against staff and/or other individuals.
- Threats (verbal or physical) against staff and/or other individuals.
- Diversion of controlled substances, including methadone.
- Diversion and/or adulteration of toxicology samples.
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one block radius of the clinic.
- Sexual harassment of staff and/or other individuals.
- Loitering on the clinic property or within a one-block radius of the clinic.

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Administrative discontinuation of services can be carried out by two methods:

1. Immediate Termination – This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.
2. Enhanced Tapering Discontinuation – This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10% a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the individual.

It may be necessary for the OTP to refer individuals who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for noncompliance termination must be documented in the individual's chart.

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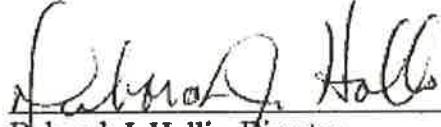
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APPROVED BY:   
Deborah J. Hollis, Director  
Bureau of Substance Abuse and Addiction Services

An electronic version of the *Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment* form (Attachment A) can be found on our website at [www.michigan.gov/mdch-bsaas](http://www.michigan.gov/mdch-bsaas), choose 'Treatment' and then 'BSAAS Policy and Technical Advisory Manual'.



STATE OF MICHIGAN

RICK SNYDER  
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

OLGA DAZZO  
DIRECTOR

## MEMORANDUM

**DATE:** April 20, 2012

**TO:** Substance Abuse Coordinating Agencies  
Opioid Treatment Program Sponsors

**FROM:** Deborah J. <sup>04/21</sup> Ellis, Director  
Bureau of Substance Abuse and Addiction Services

**SUBJECT:** Clarification Pertaining to Minors Accessing Methadone Services

This communication serves to clarify the current policy with regard to minors (persons under the age of 18) and the circumstances under which they can be admitted to methadone treatment services.

BSAAS Treatment Policy #5 *Criteria for Using Methadone for Medication-Assisted Treatment and Recovery*, indicates “no individual under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the state opioid treatment authority consents, in writing, to such treatment.” The State Opioid Treatment Authority (SOTA) cannot designate an individual to provide consent for a minor, the SOTA can only agree to an admission of a minor 15 years of age or younger.

This clarification is based on the *Federal Register dated Wednesday, January 17, 2001, Part II Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 21 CFR Part 91, 42 CFR Part 8, Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Final Rule – Section 8.1 (2)*

“Maintenance treatment for persons under age 18. ....No person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.”

In Michigan the “relevant state authority” to provide consent is children’s protective services (CPS) through the Department of Human Services. Public Act 238 722.621 et al referred to as the “Child Protection Law” establishes the authority for CPS to take action when parental consent cannot be secured. CPS must be contacted to initiate the process of determining a need for a guardian to provide consent for the minor.

COMMUNITY

The *Administrative Rules for Substance Abuse Services, Rule 409(5)* establishes the situation for the SOTA to provide admission approval for a minor 15 and younger and reads as follows:

“A person under 16 years of age is not eligible for methadone maintenance treatment without a prior approval of the State Methadone Authority (now referred to as the State Opioid Treatment Authority) and the Food and Drug Administration (now the Drug Enforcement Administration). This sub rule does not preclude a person who is under 16 years of age and is currently physiologically dependent on a narcotic from being detoxified with methadone if it is deemed medically appropriate by the program physician and is in accordance with the requirements for detoxification.”

In both situations, a minor must have two documented, unsuccessful detoxification attempts within a twelve month period to be eligible to participate in methadone treatment services. The detoxification criterion is not required for a minor that is pregnant but the appropriate consent for treatment must be obtained.

Revisions to the BSAAS Treatment Policy #5 are forthcoming. If you have questions with regard to this correspondence please contact Lisa Miller at (517) 241-1216.

c: Felix Sharpe

## Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment

Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ Patient's Age \_\_\_\_\_ Pregnant: Yes \_\_\_ No \_\_\_

Name of Parent or Legal Guardian \_\_\_\_\_

Name of Practitioner Explaining Procedures \_\_\_\_\_

Name of Program Medical Director \_\_\_\_\_

An individual under 18 years of age, who is not pregnant, is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment.

No individual 16 or 17 years-of-age may be admitted to maintenance treatment unless a parent or legal guardian consents, in writing, to such treatment. For persons 15 years-of-age and under, a parent or legal guardian consent is required, as well as permission for admission by the state opioid treatment authority (SOTA). A copy of the program's signed informed consent statement must be placed in the individual's clinical chart. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and shall be filed in their clinical charts.

The parent or legal guardian must sign a release of information for the Opioid Treatment Program (OTP) staff to verify the individual's admission and discharge dates and any other specific information requested by the OTP.

### Verification of Detoxification/Drug-Free Treatment Attempts (DOES NOT APPLY TO PREGNANT ADOLESCENTS)

Facility/Counselor Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Dates of Service: From (MM/DD/YY) \_\_\_\_\_

To (MM/DD/YY) \_\_\_\_\_

*Verified by:*

OTP Staff Person Name \_\_\_\_\_

Title \_\_\_\_\_

OTP Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

Facility/Counselor Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Dates of Service: From (MM/DD/YY) \_\_\_\_\_

To (MM/DD/YY) \_\_\_\_\_

*Verified by:*

OTP Staff Person Name \_\_\_\_\_

Title \_\_\_\_\_

OTP Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII.B.A Substance Abuse Disorder Policy Manual  
**Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment**  
– Page 2 –

**INFORMED CONSENT STATEMENT**

**FOR PARENT/GUARDIAN**

I hereby authorize and give voluntary consent to \_\_\_\_\_ Medication-Assisted Treatment Program and its medical personnel to dispense and administer opioid pharmacotherapy (includes methadone or buprenorphine) as part of the treatment of my child's addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve taking the prescribed opioid drug on the schedule determined by the program physician in accordance with federal and state regulations.

I further authorize provision of the following: diagnostic assessment, individual and group counseling, medication review and monitoring. My child's participation is voluntary. I understand that this program follows person-centered planning guidelines and that my child's treatment plan will be individualized to meet my child's needs and goals, and I will participate in the development of my child's treatment plan.

I understand that it is important for me to inform any medical provider, who may treat my child for any medical problem, that my child is enrolled in an opioid treatment program so that the provider is aware of all the medications my child is taking, can provide the best possible care, and can avoid prescribing medications that might affect the opioid pharmacotherapy or the chances of successful recovery from opioid addiction. If pregnant, my child will receive prenatal care and I will sign releases for coordination of care with that provider.

I understand that I may withdraw my child, from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand my child will be offered a medically supervised tapering process for discontinuation. Withdrawal is not recommended when the individual is pregnant.

**Parent/Guardian:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Witness:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**OTP Physician:**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**State Opioid Treatment Authority (Required for minors 15 years-of-age and younger.):**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

### **III. PREVENTION REQUIREMENTS**

**Prevention Policy #01, Synar—  
Effective October 1, 2006**

**Prevention Policy #02  
Addressing Communicable Disease Issues  
in the Substance Abuse Service Network—  
Effective January 1, 2012**

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**PREVENTION POLICY # 01**

**SUBJECT:** Synar

**ISSUED:** October 1, 2006

MDCH/ODCP

**EFFECTIVE:** October 1, 2006

**PURPOSE:**

The purpose of this policy is to specify Coordinating Agency (CA) requirements with regard to federal Substance Abuse Prevention and Treatment (SAPT) Block Grant Synar compliance.

**SCOPE:**

This policy applies to Regional Substance Abuse Coordinating Agencies (CAs) and their Synar-related provider network, including Designated Youth Tobacco Use Representatives (DYTUR), which are a part of substance abuse services administered through the Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP).

**BACKGROUND:**

States must show compliance with federal requirements to be considered eligible for the SAPT Block Grant. States are also required to submit an annual report and an implementation plan with regard to Synar related activities. These requirements are incorporated in the annual SAPT block grant application. The state may be penalized up to 40 percent of the State's federal (SAPT) Block Grant award for non-compliance.

The Synar Requirements are summarized as follows:

- 1) States must enact a youth access to tobacco law restricting the sale and distribution of tobacco products to minors. The Michigan Youth Tobacco Act (YTA) satisfies this requirement by restricting the sale and distribution of tobacco products to minors.
- 2) States must actively enforce their youth access to tobacco laws.
- 3) The State must conduct a formal Synar survey annually, to determine retailer compliance with the tobacco youth access law and to measure the effectiveness of the enforcement of the law.
- 4) The State must achieve and maintain a youth tobacco sales rate of 20 percent or less to underage youth during the formal Synar survey.

In addition, the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP) requires that an accurate listing of tobacco retail outlets be maintained, including periodic tobacco retail outlet coverage studies intended to confirm the accuracy of the list and establishes Synar sampling requirements.

## **PREVENTION POLICY # 01**

**EFFECTIVE:** October 1, 2006

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### **REQUIREMENTS:**

It is the responsibility of the CA to implement tobacco access prevention measures to achieve and maintain a youth tobacco sales rate of 20 percent or less within their region. In doing so, it is required that the CA will:

- 1) Use best practices relative to reducing access to tobacco products by underage youth;
- 2) Incorporate use of data specific to the CA region including youth sales data, analysis of the effectiveness of Synar related activities; and
- 3) Collaborate with local partners including law enforcement.

Activities associated with Synar best practices and other evidenced based prevention such as conducting inspections, and providing merchant or vendor education are defined as prevention services and must be carried out by a licensed substance abuse prevention program.

Specific responsibilities include the following:

- 1) Develop and implement a regional plan of Synar/tobacco prevention activity that will restrict youth access to tobacco and surpass the 80 percent non-sales rate.
- 2) Conduct activities necessary to ensure the Tobacco Retailer Master List is correct and participate in the Clarification and Improvement Initiative, as well as the CSAP Mandated Coverage Study. Submit to ODCP all information as required by the ODCP/CA contract agreement.
- 3) Annually conduct and complete the Formal Synar Survey to all outlets in the sample draw listing during the designated time period and utilize the official ODCP protocol. Additionally, edit the Survey Compliance Check forms and submit all required information to ODCP as required by the ODCP/CA contract agreement.
- 4) Contribute to enforcement of the Michigan YTA at tobacco outlets within the CA region by conducting non-Synar enforcement checks with law enforcement participation. When law enforcement involvement is not feasible, then by conducting non-Synar enforcement activity through civilian checks.

It is recommended that checks be carried out in no less than 10 percent of the outlets in the CA region with priority to vendors who have historically had a higher sell rate to minors, e.g., Gas Stations, Bar/Lounges, and Restaurants.

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For CAs with a 20 percent or higher “sell rate” in two or more of the last three Synar surveys, the requirement is that no less than 25 percent of the outlets within the CA region will each have at least one enforcement check activity during the fiscal year subsequent to the year in which the CA failed to meet this threshold.

**Note:** SAPT Block Grant funds can't be used for law enforcement, this includes Formal Synar and non-Synar activities.

- 5) Conduct Vendor Education activities, utilizing the ODCP approved vendor education protocol, with not less than 10 percent of the total outlets within the CA region.

For CAs with a 20 percent or higher sell rate in two or more of the last three Synar surveys, the requirement is that no less than 25 percent of the outlets within the CA region will each have at least one vendor education activity during the fiscal year subsequent to the year in which the CA failed to meet this threshold.

- 6) Develop relationships with stakeholders for the purposes of developing joint initiatives and/or for collaboration in changing community norms to impact sales trends to youth and by changing the community norms and conditions.
- 7) Identify a DYTUR agency to implement Synar-related activities. The agency identified as the DYTUR, and the individual identified as a DYTUR, must have knowledge in the area of youth tobacco access reduction and related Synar prevention initiatives.
- 8) Provide information to satisfy federal reporting requirements including information about law enforcement activities relative to violations of the YTA. Correspondingly, it is the responsibility of the CA to develop and implement a procedure for, or demonstrate a good faith effort to, obtaining and reporting this information. Documentation of good faith effort is required if the CA cannot provide the required information.

### **REPORTING REQUIREMENTS:**

See the MDCH/CA agreement and Action Plan Guidelines for CA reporting requirements.

### **PROCEDURE:**

Identification and implementation of activities, and local data collection and evaluation procedures, are left to the discretion of the CA with the exception of the Formal Synar Survey Protocol (to be used for all enforcement checks), the Vendor Education Protocol, the Synar Tobacco Retailer Master List Clarification, and Improvement/Coverage Study Procedures complete with methodology and practices requirements. All associated protocols are placed on the ODCP website, and updated as needed.

Technical assistance to CAs in development of local procedures is available through ODCP.

## **PREVENTION POLICY # 01**

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### **REFERENCES:**

Office of Drug Control Policy. (2006). *Formal Synar Survey Protocol*. Lansing, MI: Michigan Department of Community Health, ODCP. Can be found on website:  
<http://www.michigan.gov/odcp>

Office of Drug Control Policy. (2006). *Vendor Education Protocol*. Lansing, MI: Michigan Department of Community Health, ODCP. Can be found on website:  
<http://www.michigan.gov/odcp>

*Outlets* (for best practice on compliance checks). Retrieved 5/18/06 from Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Tobacco/SYNAR, Retail Outlet Guidance Documents website:  
<http://prevention.samhsa.gov/tobacco/guidance.aspx>

*State Law Regarding the Sales of Tobacco Products to Individuals Under Age of 18:* United States Code of Federal Regulations, Title 45, Part 96, §130, Washington, D.C. (1996). Can be found on website: <http://ecfr.gpoaccess.gov/cgi/t/text{text-idx?c=ecfr&sid=ef508eef1b9f10497f871661824881ee&rgn=div8&view=text&node=45:1.0.1.1.53.12.33.11&idno=45>

Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, Tobacco/SYNAR website: <http://prevention.samhsa.gov/tobacco/default.aspx>

*Tobacco and Nicotine Health and Safety Act of 1992:* PL102-321, Section 1926 State Law Regarding the Sales of Tobacco Products to Individuals Under Age of 18, United States Senate, 102<sup>nd</sup> Congress, Washington, DC. (July 10, 1992). Can be found on website:  
<http://www.brockport.edu/~govdoc/SocPol/pl1023c.pdf>

*Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants:* Federal Register, Volume 61, Number 13, pp 1491-1509, Final Rule, United States Superintendent of Documents. (January 19, 1996). Can be found on website:  
<http://www.gpoaccess.gov/fr/advanced.html> [Check: 1996 FR, Vol. 61, enter "page 1491-1509"]

*Youth Tobacco Act 31 of 1915*, MCL1915 PA31, Michigan Legislature, 1915-1916 Legislative Session, Lansing, MI. (Amended September 1, 2006). Can be found on website:  
[http://www.legislature.mi.gov/\(c32puon1tgtsa355dn3zqljp\)/mileg.aspx?page=MCLPASearch](http://www.legislature.mi.gov/(c32puon1tgtsa355dn3zqljp)/mileg.aspx?page=MCLPASearch)

**APPROVED BY:** Donald L. Allen

Donald L. Allen, Jr., Director  
Office of Drug Control Policy

## PREVENTION POLICY # 02

**SUBJECT:** Addressing Communicable Disease Issues in the Substance Abuse Service Network

**ISSUED:** October 1, 2006; Revised: April 1, 2011, and September 14, 2011

**EFFECTIVE:** January 1, 2012

### **PURPOSE:**

This policy revises regional substance abuse coordinating agency (CA) requirements with regard to addressing communicable disease. The primary charge of communicable disease efforts is to prevent the further spread of infection in the substance using population. The original policy, effective October 1, 2006, converted guidelines issued in the 2004 Action Plan Guidelines document, to a policy requirement. The policy was revised in April 2011 to re-affirm many of the original policy requirements, and implemented new requirements for targeting resources.

This revision eliminates most of the prior requirements that were put in place even though, for the past several years, Michigan has not been a designated state required to expend block grant funding on communicable disease (CD) services. When the results of CD services, such as outreach, counseling and testing services, performed over the years were examined, very low prevalence rates of new HIV infection and other CDs were found. Therefore, on the basis of a low prevalence rate of CDs, primarily new HIV infection rates, and reduced availability of funding for core substance use disorder (SUD) services, the requirement for designated communicable disease funding is repealed beginning in fiscal year 2012. However, in recognition of the linkage between CDs and SUD treatment, minimal requirements have been retained to assure needs are met for persons with, or at-risk for, HIV/AIDS or other communicable diseases, and are in treatment for substance abuse.

### **SCOPE:**

This policy applies to CAs and their provider network, which are a part of substance abuse services administered through the Michigan Department of Community Health (MDCH), Bureau of Substance Abuse and Addiction Services (BSAAS).

### **BACKGROUND:**

Given the causal relationship between HIV/AIDS, hepatitis, other CDs, substance abuse, and the importance of recognizing the role of CD assessment in the development of substance abuse treatment plans for clients, a comprehensive approach is the most effective strategy for preventing infections in the drug using population and their communities.

The CA must assure persons with SUDs who are at-risk for and/or living with HIV/AIDS, sexually transmitted diseases/infections (STD/Is), tuberculosis (TB), hepatitis C, and other CDs, have access to culturally sensitive and appropriate substance abuse prevention and treatment to address their multiple needs in a respectful and dignified manner.

## PREVENTION POLICY # 02

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### REQUIREMENTS:

#### Staffing

Each CA must assure staff knowledge and skills in the provider network are adequate and appropriate for addressing communicable disease related issues in the client population, as appropriate for each position within each provider, in accordance with the “Minimum Knowledge Standards” that follow:

##### *Minimum Knowledge Standards for Substance Abuse Professionals - Communicable Disease Related*

BSAAS mandates that all staff with client contact at a licensed treatment provider have at least a basic knowledge of HIV/AIDS, TB, Hepatitis, and STD, and the relationship to substance abuse. BSAAS provides a web-based training that will cover minimal knowledge standards necessary to meet this **Level 1** requirement. However, if a CA region desires to provide this training through other mechanisms, the following information must be included:

- HIV/AIDS, TB, Hepatitis (especially A, B, and C) and STD/Is, as they relate to the agency target population.
- Modes of transmission (risk factors, myths and facts, etc.).
- Linkage between substance abuse and these CDs.
- Overview of treatment possibilities.
- Local resources available for further information/screening.

CA regions are required to maintain a tracking mechanism to assure SUD provider staff completes Level 1 training.

#### Services

1. All persons receiving SUD services who are infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The CA's responsibility extends to ensuring that the agency, to which the client is referred to, has the capacity to provide these medical services, or to make these services available, based on the client's ability to pay. If no such agency can be identified locally (within reasonable distance), the CA must notify MDCH/BSAAS.
2. All clients entering residential treatment and residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.
3. All pregnant women presenting for treatment must have access to STD/Is and HIV testing.
4. Each CA is required to assure that all SUD clients entering treatment have been appropriately screened for risk of HIV/AIDS, STD/Is, TB, and hepatitis, and that they are provided basic information about risk.

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5. For those clients entering SUD treatment identified with high-risk behaviors, additional information about the resources available, and referral to testing and treatment must be made available.

**Financial and Reporting Requirements**

MDCH-Substance Abuse and Addiction Services

For the required services set forth in this policy, there are no separate financial or reporting requirements.

If a CA chooses to utilize state funds to provide communicable disease services beyond the scope of this policy:

1. The CA must ensure that recipients are persons with SUDs.
2. The Communicable Disease Provider Information Plan must be completed at the beginning of each fiscal year in conjunction with the CA Action Plan submission (Attachment A).
3. The Communicable Disease Provider Information Report must be completed within 60 days following the end of a fiscal year and submitted to [mdch-bsaas@michigan.gov](mailto:mdch-bsaas@michigan.gov) (Attachment A).
4. The CA must submit data to the HIV Event System [HES] for Health Education/Risk Reduction Informational Sessions and Single-Session Skills Building Workgroups, as well as HIV Counseling, Testing and Referral Services (CTRS), consistent with MDCH HIV/AIDS Prevention and Intervention Section (HAPIS) data collections methods.

**PROCEDURE:**

Procedures to meet these requirements are at the discretion of the CA.

**REFERENCES:**

Center for Substance Abuse Treatment. (Reprinted 2000). *Substance Abuse Treatment for Persons with HIV/AIDS*, Treatment Improvement Protocol (TIP) Series 37. U.S. Department of Health and Human Services, Substance Abuse, and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (Reprinted 1995). *Screening for Infectious Disease Among Substance Abusers*, Treatment Improvement Protocol (TIP) Series 6. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

APPROVED BY:



Deborah J. Hollis, Director  
Bureau of Substance Abuse and Addiction Services

<b>COMMUNICABLE DISEASE PROVIDER INFORMATION PLAN / REPORT</b>				
<b>CA:</b>	<b>Fiscal Year:</b>	<b>Date Submitted/ Revised:</b>		
<b>Name(s) of CD Providers under Contract with the CA:</b>				
<b>CA Contact Person and E-mail Address:</b>				
For each intervention listed below and provided in the CA's region, complete the following information:				
<b>INTERVENTION</b>	<b>PLAN</b>		<b>REPORT (Actual #'s)</b>	
	<input type="checkbox"/> Original	<input type="checkbox"/> Revised	Due Date: 60 days following the end of the fiscal year.	
<i>NOTE: Those items identified with an * are required to be reported in the HIV Event System (HES).</i>	<b>Estimated Number of Individuals to Receive Services</b>	<b>Estimated Number of Sessions to be Provided</b>	<b>Number of Individuals who Received Services</b>	<b>Number of Sessions that were Provided</b>
<i>Column A</i>	<i>Column B</i>	<i>Column C</i>	<i>Column D</i>	<i>Column E</i>
<b>* HE/RR HIV/AIDS Information Session</b>				
<b>* HE/RR Skills Building Workshops (single session)</b>				
<b>* HIV CTRS at SUD Treatment Provider</b> (include site type/site number on separate attachment)				
<b>* HIV CTRS at Other Locations</b> (include site type/site number on separate attachment)				
<b>* Other/Non-HIV CTRS Outreach Contacts</b> (include schedule of locations and times on separate attachment)				
<b>TOTALS</b>				

**Site Type/Site Numbers for locations where HIV CTRS will be provided:**

**Locations and Times where non-HIV CTRS Outreach will be provided:**

## **COMMUNICABLE DISEASE PROVIDER INFORMATION PLAN/REPORT**

### **INSTRUCTIONS**

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If a CA chooses to continue to fund CD services, the information on this form must be completed. The form lists various communicable disease (C-D) interventions/services that are eligible, although not required, to be funded through community grant dollars based on coordinating agency (CA) need and priority.

#### **I. Completing the Plan**

Columns B and C (Estimated Number of Individuals to Receive Services and Estimated Number of Sessions to be Provided) must be completed each fiscal year and is due to the Bureau of Substance Abuse and Addiction Services (BSAAS) with the CA's Action Plan submission.

Please use the check box provided to identify the CD Provider Information Plan as "Original" at the initial submission of the plan. If the CD Provider Information Plan data does change, please use the check box provided to identify that the plan was "Revised" as appropriate through the course of the fiscal year.

#### **II. Completing the Report**

For those services/events that an identified CD provider conducted for the CA, post the number of individuals who received the services and the number of sessions provided in Columns D and E.

*Report Due Date:* An annual report is required to be completed within sixty (60) days following the end of the fiscal year and submitted to [mdch-bsaas@michigan.gov](mailto:mdch-bsaas@michigan.gov).

#### **III. Questions**

For questions or assistance regarding this form, contact the BSAAS Communicable Disease Specialist, at [mdch-bsaas@michigan.gov](mailto:mdch-bsaas@michigan.gov) or 517-373-4700.

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Substance Abuse Disorder Policy Manual

## **IV. CREDENTIALING AND STAFF QUALIFICATION REQUIREMENTS**

**Michigan Department of Community Health**  
**Behavioral Health and Developmental Disabilities Administration**  
**Bureau of Hospitals and Administrative Operations**

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network**

This contract attachment outlines requirements for credentialing and staff qualifications throughout the substance abuse coordinating agency (CA) provider network. This document is organized as follows:

- I. CA Credentialing Requirements
- II. Provider Staff Certification Requirements
- III. Staff Qualifications for Substance Use Disorder Prevention Services
- IV. Staff Qualifications for Substance Use Disorder Treatment Services
- V. Other Staff-Related Definitions

**I. CA CREDENTIALING REQUIREMENTS**

In implementing staff qualifications requirements, the CA must:

- 1) Adopt and disseminate policy with respect to required professional qualifications for prevention and treatment direct service personnel in the CA network, applicable both to salaried and contractual personnel. In general, the requirements contained herein are expected to represent the minimum standards for substance use disorder (SUD) prevention and treatment services. However, it is recognized that specialized services may require enhanced staff qualifications.

When establishing requirements for qualifications or training, for staff that do not require certification, CAs are expected to:

- a) Recognize and utilize training and education that is specific or related to the needed knowledge and skills necessary to perform the required tasks.
  - b) Recognize in-service and provider new staff orientation.
  - c) Recognize and provide reciprocity for training provided through other CAs or PIHPs that address relevant topic and content areas.
- 2) Assure that staff qualifications are met throughout the provider panel through CA policy and procedures.  
CAs must consider the use of deemed status, reciprocity and delegation provisions when permissible, in order to establish a single credentialing and associated monitoring requirements for the provider, and reduce administrative burden on both the provider and the CA. Whenever possible, it is preferable that CAs permit deemed status or reciprocity, and that a single responsible CA be identified when multiple CAs contract with a single provider.
  - 3) Assure that criminal background checks are conducted as a condition of employment for its own potential employees and for network provider employees. Although criminal background checks are required, it is not intended to imply that a criminal record should necessarily bar employment. The verification of these

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

checks and a justification for the decisions that are made should be documented in the employee personnel or interview file. The decisions must be consistent with state and federal rules and regulations regarding individuals with a criminal history. CAs may also establish criteria for the frequency of criminal background checks for individuals during employment episodes. At a minimum, checks should take place every other year from when the initial check was made.

Criminal background checks must be completed by an organization, service, or agency that specializes in gathering the appropriate information to review the complete history of an individual. Use of the state of Michigan Offender Tracking Information System (OTIS) or a county level service that provides information on individuals involved with the court system are not appropriate resources to use for criminal background checks.

- 4) Recognize and comply with state health care licensing professional scope of practice and supervision requirements.

**Credentialing Responsibilities**

Primary responsibility for assurance that staff qualification requirements are met rests with the individual and the provider agency that directly employs or contracts with the individual to provide prevention or treatment services.

Responsibilities of the individual, provider agency and the CA are generally as follows:

- 1) The individual is responsible for achieving and maintaining his or her certification.
- 2) The provider agency that directly employs or contracts with the individual to provide prevention or treatment services is responsible for verifying the ongoing certification status of the employee. This includes verification of the credential(s), monitoring staff, development plans, and compliance with continuing education requirements.
- 3) The CA is responsible for establishing certification-related contractual obligations with their provider network consistent with these requirements. With the intended locus of responsibility resting with the individual and the provider agency, the CA has responsibility for provider agency performance monitoring to assure these obligations have been met.

Although it is not intended that CAs maintain primary source verification functions or individual certification or credentialing files on behalf of their provider network, it is recognized that this may represent a prudent or necessary business practice of the CA. CAs maintaining primary source verification files may be asked to provide their justification for doing so.

**Compatibility with PIHP Requirements**

CA policy and procedures with regard to credentialing should be compatible with PIHP credentialing and re-credentialing business processes. MDCH has issued a PIHP

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

credentialing policy entitled *Credentialing and Re-Credentialing Processes* (Attachment P.6.4.3.1 of the MDCH PIHP contract). This policy defines organizational providers as entities that directly employ and/or contract with individuals to provide health care services. These services include treatment of substance use disorders. In this regard, CAs are considered to be organizational providers.

The PIHP credentialing policy outlines two requirements associated with credentialing of organizational providers:

- 1) Each PIHP must validate, and re-validate at least every 2 years that the organizational provider is licensed or certified as necessary to operate in the state and has not been excluded from Medicaid or Medicare participation.
- 2) The PIHP must ensure that the contract between the PIHP and any organizational provider requires that the organizational provider credential and re-credential their directly employed and subcontracted direct service providers in accordance with the PIHP's policies and procedures (which must conform to MDCH's credentialing process).

***Added clarification for CAs that are not PIHPs:*** The intention of this policy is to assure that credentialing responsibilities are carried out, and associated records are maintained at the provider organization level. If a CA employs individual practitioners for the purposes of providing treatment or prevention services, the CA is an organizational provider. The CA is not required by the MDCH policy to perform the credentialing functions on behalf of its providers. When CAs contract with providers that meet the organizational provider definition, then the CA must:

- 1) Ensure that the contract between the CA and their organizational provider requires that the provider credential and re-credential their directly employed and subcontracted providers in accordance with the policy.
- 2) Ensure that the provider has not been excluded from Medicaid or Medicare participation.

## **II. PROVIDER STAFF CERTIFICATION REQUIREMENTS**

The following provides detailed information regarding the certification requirements for the CA provider network.

**General**

These certification requirements represent the standards for individual CA provider network requirements. Special consideration can be made for both special population needs (such as those of adolescents) and for specialty services (such as provision of methadone to women that are pregnant).

Also, it is expected that reimbursement rates reasonably acknowledge the cost implications of certification requirements and recognize workforce development

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

obligations already incorporated in provider accreditation requirements. CAs may consider rate incentives for enhanced staffing requirements for specialty services.

**Application**

Certification requirements apply to the entire CA provider network for services directed to the prevention and treatment of substance use disorders. This includes staff working for or within local governmental units such as intermediate school districts, local health departments, or community mental health service board programs when these are under contract to the CA as a provider and/or funded through the MDCH/CA master agreement, depending on the scope of their work, as described in this document.

Certification requirements do not apply to staff solely engaged in:

- 1) Synar tobacco compliance checks or vendor education.
- 2) Provision of communicable disease prevention and education services.

Refer to revised Prevention Policy #02-Addressing Communicable Disease Issues in the Substance Abuse Service Network for information about communicable disease staff training requirements.

Certification requirements apply on the basis of staff role and responsibility regardless of employment status or type. Examples of employment status include: direct employee, contractual, or volunteer. Examples of type include: full-time, part-time, intermittent, or seasonal.

An individual's certification requirements are determined on the basis of each of their job responsibilities. That is, situations in which an individual's responsibilities cross roles and responsibilities as outlined below, and each role category independently determines the associated certification requirement. For example, an individual functioning as a case manager (certification not required) and as a treatment clinician would be required to be certified even though their responsibilities include functions for which certification is not required. Unless an exception is specified below under the various staff types, individuals who are timely in the process of completing their registered development plan for the specified credential are considered to meet certification requirements. For example, a recent MSW graduate working in a position providing treatment to persons with substance use disorders with an approved development plan would be considered to meet certification requirements.

Development plans are required to include time frames, milestones, be date-specific and appropriate to the experience requirements associated with the certification credential. For example, a development plan must recognize hours of experience requirements in the context of the employee's status (full, part time). However, development plans must contain prompt and reasonable timeframes for completion. In general, a clinical staff person employed full-time will have up to a three-year development plan, and those working part-time will have up to a six-year plan. It is the responsibility of the individual to make the necessary changes to their plan, through

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

MCBAP, if there is a change in work status. A six-year plan for an individual working full-time would not be considered to have reasonable timeframes for completion.

Timely completion of a development plan refers to the completion of the plan in the established timeframe based on work status. Timely in the process of completion refers to the yearly progress being made with the goals of the plan. At minimum, this should reflect an appropriate proportion of the work being completed in each year of the plan. An individual who does no work on a three-year plan during years one and two and then seeks to complete everything during year three would not be seen as being timely in the process of completion and would not meet the credentialing requirements that have been established.

Since June 2007, the accepted equivalent credentials to the Michigan Certification Board for Addiction Professionals (MCBAP) certification are as follows:

- For prevention: Certified Health Education Specialist (CHES) through the *National Commission for Health Education Credentialing*
- For treatment: Certification through the *Upper Midwest Indian Council on Addiction Disorders (UMICAD)*
- For medical doctors: *American Society of Addiction Medicine (ASAM)* (Some physicians, depending on the scope of their work performed at the agency, will function in the category of "Specifically Focused Staff," as described in this document)
- For psychologists: *American Psychological Association (APA) specialty in addiction*

This listing will be updated, and CAs notified in writing, should additional equivalent credentials be identified.

Should a situation arise with an established provider where there are no longer employees available that meet the credentialing requirements, the provider and the CA are responsible for developing a "time-limited exception plan" appropriate to the situation to ensure that the established clients with the provider continue to receive services. An example of such a situation would be a provider that has one or more credentialed clinicians leave resulting in the remaining staff not being able to provide services to the clients. The CA and provider could then enter into an exception plan agreement where a qualified but non-credentialed person can provide services to those clients until credentialed staff are hired, return from leave, etc.

The length of the plan should be adequate to serve the immediate need of the affected clients but should not exceed 120 days in an initial agreement. For administrative efficiency, when providers participate in multiple CA provider panels, the affected CAs should jointly determine an appropriate exception plan. Once a plan is initiated, the CA must notify the department in writing specifying the situation and the action being taken to resolve it.

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

**MCBAP Staff Certification Requirements – By Staff Function**

Since October 1, 2008, all individuals performing staff functions outlined below must:

- 1) Be certified appropriate to their job responsibilities under one of the credentialing categories or an approved alternative credential; or
- 2) Have a registered development plan and be timely in its implementation; or
- 3) Be functioning under a time-limited exception plan approved by the CA as described earlier in this document.

Individuals under any of these three categories will be considered to meet MCBAP certification requirements. Note that a development plan is timely when there is evidence that steps or activities included in the development plan are being implemented and can be expected to be completed within a reasonable period of time. The supervisor of the individual is responsible for regularly monitoring the status of the development plan. MCBAP maintains a list of individuals who have active development plans and this can be accessed through their website at [mcbap.com](http://mcbap.com). All individuals who have an active development plan and are working toward completion are considered to meet the staff certification requirements for providing substance use disorder services in Michigan.

Staff functions for which these requirements apply are Prevention Professionals, Prevention Supervisors, Treatment Specialists, Treatment Practitioners, and Treatment Supervisors. The following chart outlines certification, supervision, and licensure requirements. It is intended to assist in the determination of MCBAP certification requirements in the provider network, licensing requirements may still apply depending on the nature of the work duties and scope of practice.

Job Function and Description	MCBAP Certification Required for the Job Function	Supervision Required for the Job Function
<b>Treatment Supervisors</b>  Commonly described as Supervisors, Managers, or Clinical Supervisors. This represents individuals directly supervising staff, including all levels (first, second line, etc) of clinical services.	<ul style="list-style-type: none"><li>• Certified Clinical Supervisor – Michigan (CCS-M)</li><li>• Certified Clinical Supervisor – IC&amp;RC (CCS)</li><li>• Development Plan – Supervisor (DP-S) – approved development plan in place</li></ul>	Professional licensure requirements may apply, depending on the nature of the work duties and scope of practice.

**Credentialing and Staff Qualification Requirements  
 for the Coordinating Agency Provider Network (Cont')**

Job Function and Description	MCBAP Certification Required for the Job Function	Supervision Required for the Job Function
<b>Treatment Specialists</b>  Commonly described as clinicians, therapists, or counselors. This represents direct clinical treatment service provider staff not identified as specifically focused.	<ul style="list-style-type: none"> <li>• Certified Alcohol and Drug Counselor – Michigan (CADC-M)</li> <li>• Certified Alcohol and Drug Counselor (CADC)</li> <li>• Certified Advanced Alcohol and Drug Counselor (CAADC)</li> <li>• Development Plan – Counselor (DP-C) – approved development plan in place</li> <li>• Certified Criminal Justice Professional – IC&amp;RC – (CCJP)</li> <li>• Certified Co-Occurring Disorders Professional – IC&amp;RC – (CCDP) – Bachelors level only</li> <li>• Certified Co-Occurring Disorders Professional Diplomat – IC&amp;RC – (CCDP-D) – Masters level only</li> </ul>	MCBAP supervisory credential – CCS-M or CCS, an approved alternative certification or a registered development plan to obtain the MCBAP credential.
<b>Treatment Practitioners</b>  Commonly described as treatment staff providing direct service to clients like education and support; or they may be new to the field.	<ul style="list-style-type: none"> <li>• A registered development plan that is timely in its implementation</li> <li>• Development Plan – Counselor (DP-C) – approved development plan in place</li> </ul>	MCBAP supervisory credential – CCS-M or CCS, an approved alternative certification or a registered development plan to obtain the MCBAP credential.
<b>Prevention Supervisors</b>  Commonly described as prevention program supervisors and represent individuals responsible for overseeing prevention staff and/or prevention services.	<ul style="list-style-type: none"> <li>• Certified Prevention Consultant – Michigan (CPC-M)</li> <li>• Certified Prevention Consultant – IC&amp;RC (CPC-R)</li> <li>• Certified Prevention Specialist – Michigan (CPS-M)</li> <li>• Certified Prevention Specialist – IC&amp;RC (CPS) – only if credential effective for three (3) years</li> </ul>	No state requirements specified.
<b>Prevention Professionals</b>  Commonly described as Program or Prevention Coordinator, Prevention Specialist or Consultant, or Community Organizer and have responsibility for implementing a range of prevention plans, programs, and services.	<ul style="list-style-type: none"> <li>• Certified Prevention Specialist – Michigan (CPS-M)</li> <li>• Certified Prevention Consultant – Michigan (CPC-M)</li> <li>• Certified Prevention Specialist – IC&amp;RC (CPS)</li> <li>• Certified Prevention Consultant – IC&amp;RC (CPC-R)</li> <li>• Development Plan – Prevention (DP-P) – approved development plan in place</li> </ul>	Supervision by MCBAP prevention credentialed staff or an approved alternative certification.

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

**Supervision Requirements for Non-Certified Staff**

Individuals with staff functions outlined below are not required to be MCBAP certified, but are required to be supervised by MCBAP certified staff. Individuals with a development plan for counseling (DP-C) or prevention (DP-P) cannot function in the role of supervisor for non-certified staff.

**Specifically Focused Treatment Staff**

This category includes Case Managers, Recovery Support Staff, as well as staff who provide ancillary health care services such as nurses, occupational therapists, psychiatrists, and children's services staff in women's specialty programs. Licensing requirements may apply depending on the nature of the work duties and scope of practice.

**Specifically Focused Prevention Staff**

Staff that consistently provide a specific type of prevention service. They do not have responsibilities for implementing a range of prevention plans, programs, or services.

**Treatment Adjunct Staff**

Commonly described as: Resident Aide, Pharmacy Techs or Child Care Aides or program aides/techs. Adjunct staff are involved with the client but not at a clinical treatment services level. It is recognized that some treatment adjunct staff provide didactic or skill development services. Licensing requirements may apply to adjunct staff depending on the nature of the work duties and scope of practice; they may also work under the direction of appropriately licensed and/or credentialed staff.

**Interns for the Provision of Services**

Interns are individuals who, as part of an educational curriculum while in the process of obtaining a degree related to the substance use disorder field, provide prevention or treatment services to clients. These services must be provided under the supervision of a MCBAP treatment credentialed staff (or an approved alternative certification) and any specific licensing requirements for the degree being sought. All services provided by interns may be allowable and billable as long as the intern is being appropriately supervised.

The MCBAP certification requirements do not replace or supersede state licensure scope of practice and supervision requirements for health care professionals such as social workers, counselors, or psychologists.

**Supervision Requirements for Clinical Staff**

**Individual/Clinical Supervision** – Refers to the intervention that is provided by a senior member of a profession to a junior member, or members, of the same profession.

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

This service is focused on enhancing the professional functioning of the junior member(s) and monitoring the quality of the professional services offered to clients by the junior member(s).

Supervision can be provided by a variety of methods like individual, group, live and recorded observation, and should include a review of documentation. Supervision activities are recorded outside of client records and are generally reflected in a log. Supervision activities that are recorded in client records involve the review and co-signing of progress notes, assessments, and treatment plans, only of those individuals who are providing clinical services as part of an internship placement through an institution of higher learning.

In Michigan, to provide supervision in the substance use disorder prevention and treatment fields, an individual must have one of the following MCBAP credentials or an established development plan leading to certification in one of the credentials:

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC-R)
- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years
- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)
- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS)
- Development Plan – Supervisor (DP-S) – approved development plan in place
- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*

Due to the variety of professional services that are provided within the substance use disorder treatment field, a clinical supervisor may in fact, not have what is viewed as a “clinical background” in terms of education and training. This could result in a situation where a CCS, with no formal education in clinical work, is supervising the work of clinical staff (Master’s prepared) providing psychotherapy. It is recommended that the supervisor have the appropriate education in the area where clinical supervision is being provided. In situations where this is not possible, due to staffing levels or the general staffing make up of an organization, the CA needs to approve the supervision process of the provider or enter into a plan with the provider that is outlined in the “Considerations Due To Availability of Certified Supervisory Staff” section below.

**Certification Requirements for Temporary or Supervisory Assignments**

Cross-over work assignments occur in those situations when an individual staff's roles and responsibilities have different MCBAP certification requirements on a temporary, time-limited basis (less than 120 days). Temporary work assignments include, for example, working out of class, temporary assignments to a higher or different position

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

during the time required to fill a vacancy, providing coverage for a staff person on leave status, or similar situations. Examples of temporary work assignments are: assignment of a treatment clinician to clinical supervisory responsibilities, or a prevention professional assigned to supervisory prevention activities due to a vacant position or employee leave of absence.

During the temporary work assignment period, the individual performing the duties of the absent/vacant staff position will not be required to meet the MCBAP certification requirement for that temporary position. However, the individual with the temporary work assignment must have the certification or development plan appropriate to their current roles and responsibilities. For example, an individual temporarily assigned to clinical supervision would be required to be treatment-certified and an individual assigned to prevention supervisory responsibilities would be expected to be prevention-certified.

When the provider does not have any suitable employee available, or does not have the capacity to meet these requirements, the provider and the CA are responsible for developing and implementing a "time-limited exception plan." The CA and provider should enter into an exception plan agreement where a qualified but non-credentialed person can provide adequate and appropriate supervision services to those credentialed staff currently providing services to clients. The length of the plan should be adequate to serve the immediate need of the provider and clients but should not exceed 120 days in an initial agreement.

Supervisory exception plans may include purchase of supervisory services on a short-term basis, cross-CA or provider staff support or other actions appropriate to the situation and health care professional licensure requirements. For administrative efficiency, when providers participate in multiple CA provider panels, the affected CAs should jointly determine an appropriate plan. Once a plan is initiated, the CA must notify the department in writing specifying the situation in detail and the action being taken to resolve it.

**Considerations Due To Availability of Certified Supervisory Staff**

It is expected that certified supervisory staff may not be available during the implementation period, or the size/scope of some providers (i.e. single provider in a rural setting) result in shared supervision of either prevention and treatment programs or other unique arrangements. In these situations, the responsible CA and provider must develop a plan that recognizes that general supervisory responsibilities (such as approval of time off, etc) are at the discretion of the provider. However, a plan addressing how "content specialty" and clinical supervision will be provided must be developed and implemented. The plan as feasible and appropriate to the situation may consider hiring qualifications for new staff, supervised practical training, use of mentors or consultants, use of regional/other resources, development of a regional cadre for the content area or continuing education. Once a plan is initiated, the CA must notify the

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

department in writing specifying the situation in detail and the action being taken to resolve it.

**Diversity and Workforce Development**

The development of a diverse pool of candidates and a workforce that is representative of the community and service population is valued and encouraged as is the development of career ladders that assist individuals in gaining the knowledge and skills that enable career advancement. The development of opportunities for peers as mentors and recovery specialists is also encouraged.

**III. STAFF QUALIFICATIONS FOR SUD PREVENTION SERVICES**

The staff qualifications that follow reflect changes that went into effect October 1, 2008.

**Definitions**

**Prevention Professional:**

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Specialist – IC&RC (CPS)
- Certified Prevention Consultant – IC&RC (CPC-R)

**OR** – An individual who has an approved alternative certification:

- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

**OR** – An individual who has a registered development plan for a prevention credential, and is timely in its implementation leading to certification. Individuals with a prevention development plan will utilize the following to identify their credential status:

- Development Plan – Prevention (DP-P)

**Prevention Supervisor:**

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC-R)
- Certified Prevention Specialist – Michigan (CPS-M)

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years

**OR – An individual who has an approved alternative certification:**

- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

Individuals must utilize the appropriate credential acronym designated in this document when applying signatures for any required billable services.

## **IV. STAFF QUALIFICATIONS FOR SUD TREATMENT SERVICES**

The staff qualifications that follow reflect changes that went into effect October 1, 2008.

### **Definitions**

#### **Substance Abuse Treatment Specialist (SATS):**

An individual who has licensure in one of the following areas, AND is working within his or her licensure-specified scope of practice:

Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Psychologist (LP), Limited Licensed Psychologist (LLP), Temporary Limited Licensed Psychologist (TLLP), Licensed Professional Counselor (LPC), Limited Licensed Counselor (LLC), Licensed Marriage and Family Therapist (LMFT), Limited Licensed Marriage and Family Therapist (LLMFT), Licensed Masters Social Worker (LMSW), Limited Licensed Masters Social Worker (LLMSW), Licensed Bachelor's Social Worker (LBSW), or Limited Licensed Bachelor's Social Worker (LLBSW);

AND they have a registered development plan and are timely in its implementation leading to certification. Individuals with a counselor development plan will utilize the following to identify their credential status:

- Development Plan – Counselor (DP-C)

**OR – they are functioning under a time limited exception plan approved by the CA, as detailed in this document.**

**OR – An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:**

- Certified Alcohol and Drug Counselor – Michigan (CADC-M)
- Certified Alcohol and Drug Counselor – IC&RC (CADC)
- Certified Advanced Alcohol and Drug Counselor – IC&RC (CAADC)
- Certified Criminal Justice Professional – IC&RC (CCJP)

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

- Certified Co-Occurring Disorders Professional – IC&RC (CCDP) – Bachelors level only
- Certified Co-Occurring Disorders Professional Diplomat – IC&RC (CCDP-D) – Masters level only

**OR – An individual who has an approved alternative certification:**

- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*
- Certification through the *Upper Midwest Indian Council on Addiction Disorders (UMICAD)*

A Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is not providing treatment services to clients beyond the scope of practice of their licensure are considered to be Specifically Focused Treatment Staff and are not required to obtain the MCBAP credentials. If one of these individuals wants to provide substance use disorder treatment services to clients, outside the scope of their licensure, then the MCBAP certification requirements apply.

**Substance Abuse Treatment Practitioner (SATP):**

An individual who has a registered MCBAP certification development plan that is timely in its implementation AND is supervised by an individual with a CCS-M, CCS, or a DP-S. Individuals with a counselor development plan will utilize the following to identify their credential status:

- Development Plan – Counselor (DP-C)

**Treatment Supervisor:**

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS)

**OR – An individual who has an approved alternative certification:**

- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*

**OR – An individual who has a registered development plan, for the supervisory credential and is timely in its implementation leading to certification. Individuals with a supervisor development plan will utilize the following to identify their credential status:**

- Development Plan – Supervisor (DP-S)

**Credentialing and Staff Qualification Requirements  
for the Coordinating Agency Provider Network (Cont')**

Individuals must utilize the appropriate credentials acronym designated in this document when applying signatures for any required billable services.

## **V. Other Staff-Related Definitions**

**Individual Licensure Requirements** – Refers to the requirements set forth in the public health code for each category of licensed professions. The licensed individual is responsible for ensuring that he/she is functioning within the designated scopes of service and is involved in the appropriate supervision as designated by the licensing rules of his/her profession.

**Clinical Addiction Services** – The services in substance use disorder treatment that involve individual or group interventions, that focus on providing education, assisting with developing insight into behaviors and teaching skills to understanding and change those behaviors.

**Individual Therapy** – The actions involved in assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems; and may include the involvement of the intra-psychic, intra-personal, or psychosocial dynamics of individuals. This requires specially trained and educated clinicians to perform these functions.

**Other Services** – Those services in substance use disorder treatment that involve directing, assisting, and teaching client skills necessary for recovery from substance use disorders. Specially focused staff or recovery coaches generally provide these services.

**Program Supervision** – An administrative function that ensures agency compliance with laws, rules, regulations, policies, and procedures that have been established for the provision of substance use disorder prevention and treatment services.

### **Treatment Billing Codes Based on Qualifications**

All services provided by a SATS or SATP must be performed under appropriate supervision for billing to occur. Prevention billing is maintained by a statewide agreement and data system.

Billing Code	Code Description	Substance Abuse Treatment Specialist (SATS)	Substance Abuse Treatment Practitioner (SATP)
H0001	Alcohol and/or drug assessment face-to-face service for the purpose of identifying functional and treatment needs and to formulate the basis for the Individualized Treatment Plan	X	X
H0004	Behavioral health counseling and therapy, per 15 minutes	X	X

**Credentialing and Staff Qualification Requirements  
 for the Coordinating Agency Provider Network (Cont')**

Billing Code	Code Description	Substance Abuse Treatment Specialist (SATS)	Substance Abuse Treatment Practitioner (SATP)
H0005	Alcohol and/or drug services; group counseling by a clinician	X	X
H0010	Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox (ASAM Level III.7-D)	X	X
H0012	Alcohol and/or drug services; sub-acute detoxification; clinically monitored residential detox; non-medical or social detox setting (ASAM Level III.2-D)	X	X
H0014	Alcohol and/or drug services; ambulatory detoxification without extended on-site monitoring (ASAM Level I-D)	X	X
H0015	Alcohol and/or drug services; intensive outpatient (from 9 to 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education	X	X
H0018	Alcohol and/or drug services; short term residential (non-hospital residential treatment program)	X	X
H0019	Alcohol and/or drug services; long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days)	X	X
H0022	Early Intervention	X	X
H2035	Substance abuse treatment services, per hour	X	X
H2036	Substance abuse treatment services, per diem	X	X
T1012	Peer recovery and recovery support *	X	X
90804 - 90815	Psychotherapy (individual) **	X	
90826	Interactive individual psychotherapy **	X	
90847	Family psychotherapy **	X	
90853	Group psychotherapy **	X	
90857	Interactive group psychotherapy **	X	
0906	Intensive Outpatient Services – Chemical dependency	X	X

\* Specially focused treatment staff may also provide and bill for this service.

\*\* Appropriate licensure may still apply.

## V. TECHNICAL ADVISORIES

Contract Technical Advisory #01  
Local Advisory Council Guidelines—  
Issued August 9, 1990; Reissued September 18, 2006

Treatment Technical Advisory #01  
Suboxone® Use in an Opioid Treatment Program—  
Issued December 1, 2005

Treatment Technical Advisory #05  
Welcoming—  
Issued October 1, 2006

Treatment Technical Advisory #06  
Counseling Requirements for Clients  
Receiving Methadone Treatment—  
Issued August 10, 2007

Treatment Technical Advisory #07  
Peer Recovery/Recovery Support—  
Issued March 17, 2008

Treatment Technical Advisory #08  
Enhanced Women's Services—  
Issued January 31, 2012

Treatment Technical Advisory #09  
Early Intervention—  
Issued November 30, 2011

Treatment Technical Advisory #10  
Residential Treatment Continuum of Services—  
Issued September 15, 2010



STATE OF MICHIGAN

JENNIFER M. GRANHOLM  
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

## MEMORANDUM

**Date:** September 18, 2006

**To:** Regional Coordinating Agencies

**From:** Donald L. Allen, Jr., Director *(DA)*  
Office of Drug Control Policy

**Subject:** Technical Advisory (TA)

Attached is the finalized document: *Contract Technical Advisory #01 – Local Advisory Council Guidelines*. This is an update to the 1990 document currently required by contract and will go into effect on October 1, 2006.

This advisory was distributed to the field for comments on 7/13/06. Comments from Northern and Pathways were received during the review period, ending 9/11/06, and were considered in this final document.

If you have any questions or need further clarification on any issue in this advisory, please contact Mark Steinberg at (517) 335-0180 or [SteinbergM@michigan.gov](mailto:SteinbergM@michigan.gov).

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**CONTRACT TECHNICAL ADVISORY # 01**

**SUBJECT:** Local Advisory Council Guidelines

**ISSUED:** August 9, 1990, revised October 1, 2006

**PURPOSE:**

To provide guidelines regarding the structure and membership of the Local Advisory Council.

**SCOPE:**

This advisory applies to Substance Abuse Regional Coordinating Agencies (CAs).

**BACKGROUND:**

Section 6226 (3) of Public Act 368 of 1978 states that a "coordinating agency shall have a local advisory council consisting of representatives of public and private treatment and prevention programs and private citizens in accordance with the guidelines established by the Administrator".

**RECOMMENDATIONS:**

Purpose of the Council

Each local advisory council should:

- a. Seek to ensure the quality of services;
- b. Seek to ensure that the services made available through the CA are accessible and responsive to their community's needs, that services are available to all segments of the community, and that the services are comprehensive and delivered in a culturally competent manner;
- c. Provide a mechanism for efforts to expand and coordinate resources and activities with other agencies, community organizations and individuals to support the mission of the CA;
- d. Provide opportunity for public comment on matters relevant to substance abuse prevention and treatment within the community; and
- e. Provide their community a forum to discuss substance abuse services and problems throughout the service area.

## CONTRACT TECHNICAL ADVISORY # 01

ISSUED: revision October 1, 2006

Page 2 of 3

Each local advisory council may:

- a. Comment on the application and issuance and renewal of substance abuse services licenses, opportunities for comment may include web based means; and
- b. Review and comment not less than biannually on the progress and effectiveness of services in the region and resource development partnerships.

### Structure of the Council

The Advisory Council membership should include representation from the following sectors (not in any priority order):

- a. Public and private substance abuse prevention, treatment or recovery providers including representation from the CA provider panel;
- b. Individuals who are or have been directly served by substance abuse prevention, treatment, and recovery programs;
- c. Local agencies or other stakeholders such as law enforcement, education, related services agencies such as housing, employment assistance or other health and social services agencies including local foundations, United Way as well as advocacy-oriented agencies and organizations; and
- d. The general public, including civic organizations and the business community representing an interest in and willingness to advocate for prevention and treatment services for persons with, or at risk of substance use disorders.

### Administration of the Council

Membership is required to be representative of the diversity of the CA catchment area. CAs must seek to include representation from underserved populations.

Note: the CA governing board may also function as the Advisory Council so long as the duties and membership guidelines are met.

Information regarding the Advisory Council must initially be submitted with the CA's designation material to the Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP) and must be resubmitted as changes occur. The information submitted must include:

- a. Exact title of the council;

## CONTRACT TECHNICAL ADVISORY # 01

ISSUED: revision October 1, 2006

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- b. Membership roster including expiration dates of terms, place of residence, professional position and/or other pertinent information to reflect the groups represented;
- c. Method of selecting membership, including opportunities for new council members and average term duration not to exceed six years, unless an exception is approved by the state substance abuse authority (ODCP); and
- d. Council by-laws or charter.

The council by-laws or charter is expected to be approved by the Governing Board of the CA, and provide a process by which to reconcile differences between council and governing board in a manner reflective of the best interests of the community being served.

Alternative Method. In recognition that some CAs may satisfy the recommendations contained in this advisory through an alternative arrangement, the CA may request a waiver. A waiver request must provide sufficient information to demonstrate that the purpose of the Advisory Council will be met, that representation through alternative means satisfies the content of this guideline and that their governing board has approved the alternative method. Waiver approval of the alternative method by the state substance abuse authority (ODCP) is required.

### Advisory Council Costs

Reasonable costs associated with the Advisory Council, or an approved alternative method that meets the intent and purpose of this advisory, will be considered eligible for MDCH/ODCP funding as contained in the annual allocation consistent with applicable Federal Office of Management and Budget (OMB) Circulars and general contract requirements. Members may be reimbursed for reasonable costs associated with meeting participation such as for example, mileage or meals when these are consistent with the policies of the CA with regard to reimbursement standards. State administered funds may not be used to reimburse employees of governmental or other agencies to the extent they receive reimbursement for the same expenses from their employers. State administered funds may not be used for payment of per diems for Advisory Council members. For these purposes, a per diem means a payment for meeting attendance.

### **REFERENCES:**

*Public Health Code*, MCL 1978 PA368, Article 6, Part 62, Section 333.6226, Michigan Legislature, 1977-1978 Legislative Session, Lansing, MI. (September 30, 1978)

APPROVED BY: Donald Allen

Donald L. Allen, Jr., Director  
Office of Drug Control Policy



JENNIFER M. GRANHOLM  
GOVERNOR  
*One Michigan*

STATE OF MICHIGAN  
OFFICE OF DRUG CONTROL POLICY  
Department of Community Health

JANET OLSZEWSKI  
DIRECTOR  
Department of Community Health

**DATE:** November 21, 2005

**TO:** Opioid Treatment Programs  
Regional Coordinating Agencies

**FROM:** Doris Gellert, Director  
Bureau of Substance Abuse and Addiction Services

**SUBJECT:** Suboxone® Use in an Opioid Treatment Program

Attached is “Treatment Advisory 1: Suboxone® Use in an Opioid Treatment Program.” This advisory addresses questions from Opioid Treatment Programs (OTPs) and regional coordinating agencies (CAs) regarding limits for prescribing or dispensing Suboxone®.

Contact Marilyn Miller, Treatment Specialist at 517-241-2608, 517-335-2121 fax, or email [millermar@michigan.gov](mailto:millermar@michigan.gov) if you have any questions or concerns.

cc: Irene Kazieczko

## MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

### Substance Abuse Technical Advisory 1: Suboxone® Use in an Opioid Treatment Program

**Issue Date:** December 1, 2005

#### Purpose

This advisory is to clarify the issue of the maximum number of patients for prescribing or dispensing Suboxone® at an Opioid Treatment Program (OTP).

#### Scope

Suboxone® may be obtained by clients in two ways through an OTP.

- 1) The OTP physician can write a prescription for the client to fill at a pharmacy, or
- 2) the medication may be dispensed from an OTP, like methadone.

OTP physicians and programs must consider the best interest of the client and safety to the public when determining by which method a client should receive Suboxone®.

Counseling requirements are the same for clients receiving physician prescribed Suboxone® as they are for those receiving Suboxone® from an OTP. Administrative Rules of Substance Abuse Service Programs in Michigan state:

R325.14419(2): “A client record shall contain, at a minimum, all of the following information . . . (g) twice monthly progress reports by the counselor, signed and dated . . .”

#### Prescribing for External Fill at a Pharmacy-30 Patient Maximum Per Physician

Prescribing Suboxone® is limited to physicians who have obtained the waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) for prescribing buprenorphine-containing products and who have a Drug Enforcement Administration (DEA) registration. When prescribing Suboxone® to be filled at a pharmacy, the physician is limited to a maximum of 30 active clients at a time. The 30 maximum number of clients includes the total number of clients from all locations in which the physician works (OTP, private office, clinic, etc.). Requirements for prescribing buprenorphine-containing products are listed in the Drug Addiction Treatment Act of 2000 (PL 106-310), Section 3502. Clients are automatically approved for off-site dosing. Physicians should select clients for Suboxone® for external fill at a pharmacy based on stability of the client for off-site dosing rather than the chronological order in which the clients were admitted to treatment.

### Dispensing from an OTP

When a client will be obtaining Suboxone® through an OTP, a physician's order for dispensing the medication at the OTP will be necessary. There is no limit to the number of clients that can be dispensed Suboxone® through an OTP, however the regulations regarding how the client receives this medication are more stringent than those who have obtained a prescription for external fill at a pharmacy. Suboxone® dispensed from an OTP must adhere to 42 CFR, Part 8.12 of the federal regulations as well as MDCH "Treatment Policy #4-Revised: Off-Site Dosing of Opioid Treatment Medication-Methadone." However, because Suboxone® is a Class III Controlled Substance and methadone is a Class II Controlled Substance, an accelerated reduced attendance schedule can be requested using the SAMHSA Exception Request and Record of Justification Form (SMA 168). Weekly attendance after one week in treatment would be considered reasonable. Suboxone® should be specified in the "Other" category on the exception request. This request needs both MDCH and CSAT/DPT approval.



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JENNIFER M. GRANHOLM  
GOVERNOR

JANET OESZEWSKI  
DIRECTOR

**DATE:** September 20, 2006

**TO:** Regional Coordinating Agencies

**FROM:** Donald L. Allen, Jr., Director  
Office of Drug Control Policy

**SUBJECT:** Welcoming Technical Advisory

Attached is Technical Advisory #5 – Welcoming that will go into effect October 1, 2006.

This technical advisory (TA) was submitted to coordinating agencies for comment and none were presented by the due date. The attached is the final version of this TA.

Should you have any questions or need further clarification of this advisory, please contact Joyce Washburn at (517) 335-5247 or by email at [washburnjoy@michigan.gov](mailto:washburnjoy@michigan.gov).

Attachment

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

DRAFT DRAFT

**TREATMENT TECHNICAL ADVISORY # 05**

**SUBJECT:** Welcoming

**ISSUED:** October 1, 2006

October

**PURPOSE:**

The purpose of this technical advisory is to establish expectations for the implementation of a welcoming philosophy.

**SCOPE:**

This technical advisory applies to the Regional Substance Abuse Coordinating Agencies (CAs) and their provider network, as administered through the Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP).

It is expected that all CA and provider network staff involved in the provision of substance abuse services understand and take action to operate within these welcoming principles. These actions consist of reviewing business practices, identifying areas in need of improvement, and implementing identified changes.

**BACKGROUND:**

A welcoming philosophy is based on the core belief of dignity and respect for all people, while, in turn, following good business practice. The concept of welcoming became popular in the 1990s, when there was an increased emphasis on co-occurring disorder treatment. In this context welcoming was determined to be an important factor in contributing to successful client outcomes.

The goal of addiction treatment is to move individuals along the path of recovery. There are two main features of the recovery perspective. It acknowledges that recovery is a long-term process of internal change and it recognizes that these internal changes proceed through various stages. As addiction is a chronic disease, it is characterized by acute episodes or events that precipitate a heightened need for an individual to change their behavior. It is important for the system to understand and support the treatment-seeking client by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

The Network for the Improvement of Addiction Treatment (NIATx) has expanded the application of welcoming principles to include all customers of an agency (agency staff, referral sources, client families). This technical advisory concurs with this expanded perspective. The NIATx "Key Paths to Recovery" goals of reduced waiting, reduced no shows, increased admissions, and increased continuation in treatment, incorporate an expectation for a welcoming philosophy.

## TREATMENT TECHNICAL ADVISORY # 05

ISSUED: October 1, 2006

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MMSS Policy Manual

### **RECOMMENDATIONS:**

Welcoming is conceptualized as an accepting attitude and understanding of how people ‘present’ for treatment. It also reflects a capacity on the part of the provider to address the client’s needs in a manner that accepts and fosters a service and treatment relationship. Welcoming is also considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders.

The following principles list the characteristics/attitudes/beliefs that can be found at a program or agency that is fostering a welcoming environment:

#### **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. Beside 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 supports.
- 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.
- For persons with co-occurring mental health problems, there is 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 individuals 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.

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- All staff within the agency integrates 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, ongoing review to streamline paperwork to essential and necessary information.
- A welcoming system is capable of providing 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 represent added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient processing, transmission, and storage.

### Welcoming – Environmental and Other Considerations

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

### Staff Competency Principles

- Skills and knowledge appropriate to staff and their roles throughout the system (reception, clinical, treatment support, administrative).
- Staff should have the knowledge and skill to be able to differentiate between the person and their behaviors.
- Staff should be respectful of client boundaries in regards to personal questions and personal space.
- Staff uses attentive behavior, listening with empathy not sympathy.

### Performance Indicators

CAs are expected to include a provision in their provider network contracts requiring welcoming principles be implemented and maintained.

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Client satisfaction surveys are expected to incorporate questions that address the ‘welcoming’ nature of the agency and its services.

CAs include consideration to welcoming principles in their provider network site visit protocols. MDCH/ODCP may review these provider network protocols during their visits to the CA.

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**APPROVED BY:**



Donald L. Allen, Jr., Director  
Office of Drug Control Policy



JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

**DATE:** August 10, 2007

**TO:** Regional Coordinating Agencies  
Opioid Treatment Programs

**FROM:** Donald L. Allen, Jr., Director  
Office of Drug Control Policy

**SUBJECT:** Technical Advisory – 06, Counseling Requirement for Clients Receiving Methadone Treatment

Attached is Technical Advisory #6 – Counseling Requirements for Clients Receiving Methadone Treatment that becomes effective August 10, 2007. The draft policy was submitted to coordinating agencies and opioid treatment programs on March 6, 2007, with a 60-day comment period. Comments from the Michigan Association of Substance Abuse Coordinating Agencies, Clinton-Eaton-Ingham Substance Abuse Services Program and Project Rehab-Life Guidance Services were received and taken into consideration for the final document.

If you have any questions, please contact Marilyn Miller, State Methadone Authority, at [millermar@michigan.gov](mailto:millermar@michigan.gov) or by phone at 517-241-2608.

Attachment

cc: Division of Licensing and Certification

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**TREATMENT TECHNICAL ADVISORY # 06**

**SUBJECT:** Counseling Requirement for Clients Receiving Methadone Treatment

**ISSUED:** August 10, 2007

**PURPOSE:**

The purpose of this technical advisory is to clarify the substance abuse administrative rule specific to the counseling requirements for clients receiving methadone as part of their substance abuse treatment.

**SCOPE:**

This technical advisory provides direction to all Opioid Treatment Programs (OTPs) in Michigan that receive public funds and can be utilized by non-funded programs for guidance, as well.

**BACKGROUND:**

Effective July 5, 2006, The Michigan Department of Community Health Administrative Rules for Substance Abuse Service Programs was revised in several areas for the first time since their inception in 1981. One of the rule changes involved the requirements for counseling services for clients receiving treatment through a methadone program. The new language for counseling requirements is as follows:

Per R325.14419 (2) (g), if the client's treatment plan identifies a need for counseling services and includes the provision of these services, then signed and dated progress reports by the counselor must be included in the clinical record.

The previous rule language for this section read as follows:

"Twice monthly progress reports by the counselor, signed and dated."

The change in this rule was meant to emphasize the importance of individualized care for clients receiving medication-assisted treatment in an OTP and that duration and frequency of counseling must be based on medical necessity. The previous language established universal counseling criteria for all clients without consideration of individual needs. As a result, clients could receive counseling services that were not needed or could have been inadequate to meet the needs of the clients based on the interpretation of this rule.

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**RECOMMENDATIONS:**

The following recommendations are being made to assist programs in making the adjustment to this rule change and offer direction on how to provide needed services to clients. These recommendations seek to emphasize individualized treatment and the need for counseling services to be based on medical necessity. Further, these recommendations will also provide guidance for programs on how client recovery can be supported in ways other than individual counseling. The justification for the counseling services must be in the treatment plan with specific goals and objectives indicating why the services are being provided and what is going to be accomplished. The recommendations and guidance are as follows:

1. The amount and duration of counseling for the client should be determined based on medical necessity as well as the individual needs of the client and not on arbitrary criteria such as predetermined time, funding source, philosophy of the program staff, or payment limits. Decisions on counseling should be determined in collaboration with the client, the program physician, the client's primary counselor and the clinical supervisor. This decision-making process should be documented in the clinical record and the treatment plan should reflect the decisions that are made.
2. Counseling services must be included in the treatment plan. The treatment plan and the treatment plan reviews not only serve as tools in guiding treatment, they help in the administrative function of service authorizations. Decisions concerning the duration of stay, intensity of counseling, transfer, discharge, referrals, and authorizations are based on individualized determination of need and on progress toward treatment goals and objectives. The client's need for counseling, in terms of quantity and duration, must be reflected in the treatment plan and the need that is being addressed in the counseling must be identified by a comprehensive biopsychosocial assessment. The Michigan Department of Community Health/Office of Drug Control Policy Treatment Policy #6-Individualized Treatment Planning can be used as a guide to assist with this process.
3. As client needs change throughout treatment, adding counseling services or increasing the frequency of contacts is not always the right answer. Many times support services can be added or modified as necessary to assist the client in meeting his/her goals without having to immediately depend on individual counseling services. These modifications may be the addition of specialized treatment groups or community support services. Attendance at community support groups should be incorporated into the client's treatment plan. This will enhance the formal counseling, if it is being provided, and help the client develop on-going support as they complete counseling. Peer recovery support should also be included when necessary and available. Case management and referrals for medical and dental care, housing, vocational education and employment, resolutions of legal issues, parenting classes, family reunification, etc. should be incorporated into the treatment plan when the client is at an appropriate stage of change and is ready to address these needs. Special needs of clients can be coordinated with another licensed substance abuse treatment provider. These services may include residential care and specialized prenatal care or specialized women's services, depending on the need of the

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client. Assisting the client in maintaining recovery goes beyond counseling services and ensuring that all other needs are appropriately met is an important component of success.

4. As a client progresses through treatment, there may be a time when the maximum therapeutic benefit of counseling has been achieved. At this point, the client may be appropriate to enter the methadone only (medical maintenance) phase of treatment if it has been determined that ongoing use of the medication is medically necessary and appropriate for the client. To assist the OTP in making this decision, TIP 43 "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" offers the following criteria to consider when making the decision to move to medical maintenance:
  - a. Absence of a significant, unstable co-occurring disorder.
  - b. Abstinence from all illicit drugs and from abuse of prescription drugs for a period of at least six months prior to entry into methadone only status.
  - c. No alcohol use problem.
  - d. Ability to maintain stability in their current living environment.
  - e. Stable and legal source of income.
  - f. Involvement in productive activities as defined in their individual plan of service; e.g., employment, school, volunteering.
  - g. No new criminal or legal involvement for one year prior to the methadone only phase.
  - h. Adequate social support system, including but not limited to, self-help groups and sponsorship.

These guidelines are not inclusive of all of the areas to be considered when making this decision. It is important to review each client on an individual basis when making this decision and document in the medical record how the decision was made to move to medical maintenance.

5. If a client has received counseling and successfully completed it, the client may receive counseling again as long as it is based on the needs of the client and it is determined to be medically necessary. Being involved in medical maintenance does not preclude the client from again receiving or starting counseling services.

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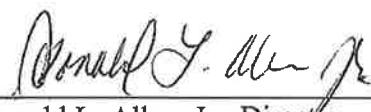
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**APPROVED BY:**

  
Donald L. Allen, Jr., Director  
Office of Drug Control Policy



STATE OF MICHIGAN

JENNIFER M. GRANHOLM  
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

**DATE:** March 12, 2008

**TO:** Regional Coordinating Agencies

**FROM:** Donald L. Allen, Jr., Director  
Office of Drug Control Policy

**SUBJECT:** Peer Recovery/Recovery Support Technical Advisory

Attached is Technical Advisory #7 – Peer Recovery/Recovery Support Services that will go into effect March 17, 2008.

The draft technical advisory (TA) was submitted to coordinating agencies on November 16, 2007, for comment, giving a 60-day reply period. Comments were received from Northern Michigan Substance Abuse Services and incorporated in this final document.

Should you have any questions or need further clarification on any issues in this advisory, please contact Joyce Washburn at (517) 335-5247 or by email at [washburnjoy@michigan.gov](mailto:washburnjoy@michigan.gov).

Attachment

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**OFFICE OF DRUG CONTROL POLICY**  
**TREATMENT TECHNICAL ADVISORY # 7**

**SUBJECT:** Peer Recovery/Recovery Support Services

**ISSUED:** March 17, 2008

**PURPOSE:**

The purpose of this technical advisory (TA) is to issue guidance to the publicly funded substance abuse system regarding the development of peer recovery/recovery support services.

**SCOPE:**

This TA impacts coordinating agencies (CAs) and the provider network that is funded by Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP).

**BACKGROUND:**

The Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP) formed a workgroup in January 2007, for the purpose of developing standards and implementation guidelines for the new licensing category: Peer Recovery/Recovery Support Services. The administrative rules for substance abuse programs were revised July 2006, to recognize peer recovery and recovery support as an expansion of the existing licensing categories that cover treatment and prevention services in Michigan. This program category was intended to recognize and thereby permit recovery support programs for persons with substance use disorders in Michigan. This licensing category was developed to allow programs to provide services to assist individuals in the process of recovery through program models such as using peers and other professionals in a community setting and providing a location or other supports for activities of the recovering community. Peer recovery and recovery support programs, are designed to include prevention strategies and support services to attain and maintain recovery and prevent relapse.

As defined in the administrative rules:

Peer recovery and recovery support means recovery support programs that are designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery.

Peer recovery programs must be licensed under the appropriate treatment setting for this service category. This activity must occur in the context of an existing licensed substance abuse program and does not require distinct licensure. The service category licensure threshold is:

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- 1) Must meet the threshold of a ‘program’;
- 2) Must be identifiable and distinct within the agency’s service configuration; and
- 3) The agency offers or purports to offer the service (program) category as a distinct service.

It should be noted that recovery support services might be provided in other programs as part of a treatment plan. In this situation, separate category licensure is not required as this is considered an activity within the program and not a separate service. A clinician or substance abuse treatment specialist provides the recovery support services. The use of a recovery coach to provide the services is not required.

The workgroup began by reviewing the values that the Substance Abuse and Mental Health Services Administration (SAMHSA) had developed for their Recovery Community Services Program. The group revised the SAMHSA-developed values for use in Michigan as the guiding principles for developing, implementing and providing recovery support services. These values are as follows:

- **Recovery** – The goal of recovery support services is to help individuals reclaim a healthy level of life functioning across a variety of areas: self, family and community.
- **Inclusion** – Recovery support services are for all individuals with a substance use disorder at any stage of recovery.
- **Authenticity** – Recovery support services need to be defined by those who are in recovery.
- **Culture** – Recovery support services must be provided in a culturally appropriate and welcoming environment.

This advisory describes two distinct modalities of peer recovery support services that can be developed or utilized within a region. One method is not preferred over the other and allows for decisions at the local level to determine what modality will be most beneficial in each region. ODCP recognizes that there may be other models that better meet the needs of the local community, this advisory does not limit the CAs ability to implement such a model so long as alternative models reflect national best practice and/or are monitored and evaluated to determine their effectiveness.

### Definitions

**Peer** – An individual who has shared similar experiences of addiction and recovery.

**Peer-to-peer services** – Recovery support services that are provided when a relationship is formed between two individuals that prevent relapse and promote recovery. Generally, peers have a shared challenge and/or intention (addiction and recovery) and shared similar experiences that foster mutual support.

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**Recovery center** – Location in which recovery programming is designed and delivered, primarily by individuals in recovery, and house services that offer social, emotional and/or educational support to help prevent relapse and promote recovery.

**Recovery support services** – Services designed to promote recovery and prevent relapse by providing knowledge and assisting in the individual's development of skills necessary for an individual's recovery.

**Recovery** – A voluntarily maintained lifestyle comprised of sobriety, personal health and socially responsible living.

**Recovery coach** – The position title given to a peer that provides recovery support services to individuals in formal treatment or during the post-treatment period. (*This position has also been referred to as a Peer Support Specialist.*)

**Recovery expertise** – Knowledge and awareness of recovery and the recovery process gained through personal life experience, allowing for expertise of these matters not held by someone who has not shared similar experiences.

**Recovery services plan** – This plan specifies the actions to be taken to address and overcome identified problems in preventing relapse and maintaining recovery by building on the individual's strengths and addressing any deficits.

**Relapse prevention** – A systematic method of teaching recovering individuals to recognize and manage relapse-warning signs. Relapse prevention includes teaching the individual about the relapse process and how to manage it, as well as identifying the problems and situations that may cause a relapse (triggers).

**Stable recovery** – An individual in stable recovery has little or no involvement with a treatment professional but may still be involved in community support services.

### RECOMMENDATIONS:

A recovery model of addiction treatment shifts the focus of care from professional-centered episodes of acute symptom stabilization provided in formal treatment settings toward the client-directed management of long-term recovery provided in less formal community settings. The recovery model looks at a continuum of services that covers the whole formal treatment process and extends into the post treatment period.

Interventions in a recovery model may include services during any of the three stages of recovery: pre-treatment, in-treatment and post-treatment. The services during each stage are expected to target the needs of the individual with the goal of attaining and maintaining a state of recovery.

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Pre-treatment support services enhance readiness for treatment and recovery. During this stage, services center on motivation for change and increasing the individual's readiness for treatment services. These services help with engaging the individual in treatment. Outreach is one example of pre-treatment activities.

In-treatment recovery support services help to remove obstacles to recovery and shift focus of treatment from acute stabilization to support for long-term recovery maintenance. Examples of these services are transportation and assistance with obtaining basic needs.

Post-treatment recovery support services enhance the quality of recovery, through emotional support, informational support, instrumental support and affiliation support. (A description of these services is in the recovery center model below.)

With the limited resources available for substance abuse treatment, it is good business practice to provide services to individuals during treatment that strengthen the likelihood of attaining long-term stable recovery. The goal is for individuals to develop skills for recovery and, if necessary, to seek services earlier, with a lower intensity level if recovery is jeopardized or relapse occurs.

### Recovery Coach

The role of a recovery coach is to support individuals working on recovery both in the treatment center and in their natural environments. This includes providing services that remove the barriers and support a recovery lifestyle in the home and social networks of the person. They focus on helping the individual develop a life of self-sustained recovery within their family and community. Recovery coaches can work with an individual one-on-one or in groups providing education or other types of group support (e.g., after-care support groups).

Services that recovery coaches provide are designed to support the clinical work that is being done or has been done with a client. Recovery coaches do not diagnose or provide clinical treatment. However, they may work closely with the clinician to link the individual with community resources. In some ways, recovery coaches may act in a similar capacity as a case manager by assisting the individual in obtaining housing, employment or child care issues, as well as providing transportation to appointments, supervising visitation with children in out-of-home placement or introducing the individual to the recovery community. In situations where a client has significant functional deficits and requires close monitoring to ensure follow-through, case management services would initially be more appropriate to ensure success and maintain the close link with clinical services.

Recovery coaches are not voluntary service providers such as those affiliated with twelve-step programs. They do not sponsor the individual or advocate for that individual to participate in a specific recovery program, rather they assist the individual with resolving issues that impede the recovery process and look at client specific needs that will support recovery. Recovery coaches must be employed by a substance abuse program that has a license for peer recovery/recovery support services.

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### Staff qualifications

A recovery coach must meet the following minimum requirements:

- Must be a peer in recovery.
- High school diploma or equivalent recommended.
- Stable recovery.
  - Each program must have written policies and procedures defining stable recovery.
  - Must be actively working in a recovery program (e.g., twelve-step, church/spiritual, other recovery support group).
- Interpersonal skills.
  - Communication skills.
  - Listening skills.
  - Recovery expertise.
  - Organizational skills.
- Ability to adapt to changing circumstances and situations.
- There is no requirement for IC&RC certification of a recovery coach. MDCH/ODCP currently considers these positions as specially focused staff that are to be supervised by an individual with the appropriate credentials.

### Training requirements

Although there is no certification required, the following list of training subjects are required for a coach to have basic knowledge of addiction and addiction services. These trainings should be completed as part of a new hire process. Appropriate continuing education in addiction and recovery supports is required. CAs are responsible for assuring that training is conducted for coaches within their region that addresses the following topics:

- Fundamentals of addiction and recovery.
- Personal safety.
- Ethics.
- Confidentiality.
- Maintaining appropriate relationships (boundary setting).
- CPR/first aid/universal precautions (recommended).
- Individualized treatment and recovery planning.
- Role as a member of a recovery team.
- Cultural competence.
- Recipient rights.
- Communicable disease per MDCH/ODCP policy.

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### Services provided by recovery coaches

Services provided by recovery coaches are based on the individual need(s) of the client and are documented in the treatment plan or in a recovery services plan. The goal of recovery support services is for the individual to establish self-sustaining recovery. With such a goal in mind, services are expected to phase out as the individual gains confidence and the self-assurance to successfully navigate life domains. This progression continues until the individual no longer requires support by the coach.

The following is a list of general services that may be provided by a recovery coach. It is not meant to be all inclusive or meant that all services must be provided. It is meant to provide general descriptions of various services that a coach may help the recovering individual address or get involved in, if the individual's needs require it. These services seek to identify and strengthen existing natural supports for the client and assist the client in developing the skills for sustained recovery:

1. Recovery Planning provides both the recovery coach and the individual an opportunity to jointly assess what services are needed and develop a recovery plan that will be the basis for services provided. The plan will be based on needs identified during the treatment episode, from the relapse prevention plan completed during treatment and by an assessment of needs completed jointly by the recovery coach and individual. This plan will be reviewed and updated as goals are met and new goals are added.
2. Relationships are often lost or severely damaged when the individual has a history of, or is actively using, alcohol or other drugs. The recovery coach may provide services that facilitate working on the relationship between the individual and their support network. If the situation is irreparable the coach and client may instead work on developing a new support network within the recovering community. The goal for these services is to develop social skills needed to maintain relationships.
3. Leisure activities are behaviors or activities from the individual's using past that must be replaced with new activities or behaviors that support their recovery. Many individuals need help to develop a new way of life that does not center on their past addictive behaviors. Examples of services in this area that the coach can assist the client with are working on time management, identifying new leisure and fun activities, assistance in connecting to social activities/hobbies, supporting use of or rehearsing social skills and coaching/helping the person in social situations.
4. Substance use behaviors will always be of concern to an individual who has been through treatment and is working on attaining or maintaining their recovery. The reality is that addiction is a chronic relapsing illness and therefore it can be expected that an individual may relapse and need treatment services. The recovery coach must be educated in relapse prevention and in identifying relapse indicators, so that if needed they can help to make revisions in the relapse prevention plan or address a relapse before it becomes

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severe. The recovery coach must know how to link the individual for re-entry into addiction treatment services.

In the process of assisting the client in the above areas, the recovery coach may also need to provide some basic referral information to the client due to changes the person is making as a result of recovery or as a result of consequences from previous use or abuse of substances. This area seeks to help the client utilize the organizational supports available in the community and requires little involvement from the coach once referral or contact information is identified or provided to the client. As a result, the coach should have some direct awareness of how a client can access a variety of services within their community but does not have to provide support in the areas beyond assistance in identifying or contacting a resource or obtaining a referral, as the client would be expected to be able to follow through with the service. These services may include:

- Transportation – how to access and use public transportation
- Housing – where to go to explore housing resources
- Basic needs – where to go to get help with food or clothing
- Health issues – location of public health offices, free clinics or community mental health offices
- Legal problems – how to access legal aid services
- Employment – location of local employment assistance or training programs
- Education – location of educational resources for completion or continuation of degrees or training

### Recovery Centers

Recovery Centers are facilities that are used as a substance-free location where individuals in recovery can meet and obtain support to maintain their recovery. The recovery center is similar in nature to a drop-in center in the mental health system. It is expected that both recovery center staff and clients abide by confidentiality regulations.

Staffing of a recovery center will vary from setting to setting. All recovery centers must have the services of at least one credentialed substance abuse professional staff to help those individuals who may have clinical needs by arranging access to appropriate clinical services. Other non-clinical staff members may be paid or volunteers. Many recovery centers use individuals who are in recovery and want to give back to the recovery community as volunteers. They provide a wide variety of services depending on their background and experience. These volunteers can work as secretaries, computer programmers, and teachers or in a variety of other functions depending on the needs of the center and the recovery community, and the experiences and resources of the volunteer.

The recovery center seeks to create a community environment for people in recovery. The center provides a place where individuals in recovery can connect to others who are also in recovery. Community agencies may use the center as a place where they can provide services to community members. Social events and self-help meetings are often held at

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recovery centers or are sponsored by the center. The recovery center is a location for activities and services. Individuals who have become more stable and self-sufficient would be most appropriate for services at a recovery center.

Services that may be provided at recovery centers include:

- Emotional support – refers to services that provide empathy, caring and concern to bolster a person's self-esteem and confidence.
  - o Peer-lead support groups
    - Twelve step meetings
    - Non-12 step meetings
    - Support groups for specific populations
- Informational support – refers to the sharing of knowledge and information or providing training. It is expected that recovery centers house services provided by other agencies and community partners.
  - o Space for community resource representatives to meet with people in recovery
    - Medical clinic
    - Legal services
    - Human services
      - Public assistance
      - Emergency assistance
      - Benefits and entitlements
    - Housing referrals
    - Educational applications and financial aid
    - Vocational rehabilitation
  - o Educational
    - GED
    - High School completion
  - o Life skills training
    - Job seeking skills
    - Budgeting
    - Parenting
    - Nutrition
    - Relationship skills
- Direct Support - Services provided by the center either through the use of volunteers, donations or CA funding when no other source is available.
  - o Child care
  - o Transportation
  - o Clothing bank
  - o Food bank

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- o Washer/dryer
- o Donation center for households items
- Social/Recreational Support
  - o Drop in center
  - o Space for meetings and activities
  - o Sober socialization
  - o Networking
  - o Picnics
  - o Meetings

### Technical Requirements

#### Eligibility for services

In addition to determination of treatment services, a determination must be made in regards to whether or not the client is eligible to receive recovery support services. Of the five eligibility criteria listed below, the first and at least one other must be present in addition to the client's agreement to participate in services.

1. Client is not meeting recovery support needs through services from another eligible service or program (mental health, child welfare, justice system etc.) and needs are or could be met through another service for which the client is eligible, AND
2. Client has a documented need in at least one domain involving community living skills, health care, housing, employment/financial, education or another functional area in that person's life, OR
3. Client has a demonstrated history of recovery failure with or without recovery support services, OR
4. Client has a substance use disorder involving a primary drug of choice that will require longer term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants), OR
5. The chronicity and severity of the client's disorder is such that ongoing support is needed to increase the probability of recovery (such as years of use and first involvement with treatment, or co-occurring mental health disorder is present with substance use disorder).

Services can be provided as an adjunct or in addition to another treatment service or level of care, as a step-down from an intensive level of treatment, or as a stand-alone service if eligibility requirements are met. Services are designed to provide the client with the support to maintain recovery during the transition from the intensive, formal services of treatment to self-sustained recovery, but are expected to assist in providing additional support while the client is receiving services in the initial period of treatment.

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### Funding mechanisms

MDCH/ODCP will support the use of state agreement funds for peer recovery/recovery support services through the use of recovery coaches and/or development of recovery centers. Funding for recovery support services is based on local decisions; however other community funding streams must be utilized before MDCH/ODCP can be used.

**Recovery coach** services can be reimbursed by paying for a staff position with a performance-based contract or by units in a fee for service contract.

**Recovery centers** can be reimbursed through an expense based staffing grant, individual vouchers for hours of service, performance based contracting or fee for service. CAs can reimburse agencies for the costs of the facility, costs associated with staffing a center or a combination of both. It is important to remember that MDCH/ODCP funds are to be used only when no other means of support is available. Programs must look to other sources; donations, fund raising and community resources before MDCH/ODCP funds are applied.

### Data and Encounter Reporting

**Recovery coaches** are expected to report encounters for services provided. Admissions and discharges to recovery support services must also be completed for each client entering this service category.

The following encounter codes are applicable for recovery coaches:

Recovery Support Services	T1012 - Alcohol and/or drug services; Recovery Support and Skills Development. Activities to develop client community integration and recovery support	Encounter	Line	Institutional or Professional (depends on other payers)
Self-help/peer services	H0038 – Self-help/peer services per 15 minutes			Recovery coach

**Recovery centers** will not be required to submit TEDS data or encounter reporting, unless the services provided within the center are funded through the CA and have a data reporting requirement attached to them. (Example: recovery coach)

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**APPROVED BY:**

  
\_\_\_\_\_  
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Office of Drug Control Policy



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

OLGA DAZZO  
DIRECTOR

## MEMORANDUM

**DATE:** January 20, 2012

**TO:** Regional Substance Abuse Coordinating Agency Directors  
Michigan Association of Substance Abuse Coordinating Agencies President  
Association of Licensed Substance Abuse Organizations President  
Salvation Army Harbor Light Director

**FROM:** Deborah ~~DJH~~, Director  
Bureau of Substance Abuse and Addiction Services

**SUBJECT:** Technical Advisory for Enhanced Women's Services Expectations

Attached is the final version of Technical Advisory #08 – Enhanced Women's Services, which will go into effect on January 31, 2012.

A draft of this technical advisory (TA) was submitted to the coordinating agencies, Michigan Association for Substance Abuse Coordinating Agencies, Association of Licensed Substance Abuse Organizations, and Salvation Army Harbor Light on October 11, 2011, for a 30-day response period. Comments were received from network180, Lakeshore Coordinating Council and Kalamazoo Community Mental Health and Substance Abuse Services, and incorporated into the final document.

This TA focuses on establishing guidelines for enhanced women's services, as an adjunct to designated women's programs. Also attached are the reporting requirements for Enhanced Women's Services programming and instructions for the report. The report is in addition to current reporting requirements for designated women's programs. Because this is a new service opportunity, special care was taken to ensure that enhanced women's services operate the same across the state.

Should you have any questions or need further clarification on any issues in this advisory, please contact Angie Smith-Butterwick at [smitha8@michigan.gov](mailto:smitha8@michigan.gov), or (517) 373-7898.

Attachments

DJH:ssb

c: Felix Sharpe

**Michigan Department of Community Health, Mental Health and Developmental Disabilities Administration**  
**BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

**TREATMENT TECHNICAL ADVISORY #08**

**SUBJECT:** Enhanced Women's Services

**ISSUED:** January 31, 2012

**PURPOSE:**

The purpose of this advisory is to provide guidance to the field on developing an intensive case management program for coordinating agencies (CA) and their designated women's programs. It is designed to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

**SCOPE:**

This advisory impacts the CA and its designated women's programs provider network.

**BACKGROUND:**

In 2008, the Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (MDCH/BSAAS) was awarded a four-year grant from the Center for Substance Abuse Prevention (CSAP) to implement the Parent-Child Assistance Program (PCAP), an evidence-based program developed at the University of Washington. PCAP is a three year case management/advocacy program targeted at high-risk mothers, who abuse alcohol and drugs during pregnancy, and their children. The eligibility criteria for PCAP participation is women who are pregnant or up to six-months postpartum, have abused alcohol and/or drugs during the pregnancy, and are ineffectively engaged with community service providers.

Traditional case management services offered through designated women's programs tend to be for the duration of the woman's treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician, and involve linking and referring the client to the next level of care or other supportive services that are needed. Enhanced Women's Services are designed to encourage providers to take case management to the next level for designated women's providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The PCAP model shares the same theoretical basis, relational theory, as women's specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women's growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important

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aspect of PCAP. The PCAP model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

In September 2009, BSAAS embarked on a recovery oriented system of care (ROSC) transformational change initiative. This initiative changes the values and philosophy of the existing service delivery system from an acute crisis orientation to a long term stable recovery orientation. As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The PCAP model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives clients a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. PCAP also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the PCAP model, and in response to interest in the program by current non-PCAP funded coordinating agencies, this technical advisory has been developed to provide guidance on implementing enhanced women's services in the state. This technical advisory identifies core components of PCAP needed for implementation of enhanced women's services, and should be considered as a supplement to the BSAAS Women's Treatment Policy (BSAAS Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

### **Definitions**

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

**Community Based** – the provision of services outside of an office setting. Typically these services are provided in a client's home or in other venues, including while providing transportation to and from other appointments.

**Core Components** – those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.

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**Crisis Intervention** – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

**Face-to-Face** – this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and providers, as long as this service is provided within the established confidentiality standards for substance use disorder services.

**Fetal Alcohol Spectrum Disorders (FASD)** – an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND), and alcohol-related birth defects (ARBD).

**Individual Assessment** – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

**Individual Treatment Planning** – direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

**Peer** – an individual who has shared similar experiences of parenthood, addiction, or recovery.

**Peer Advocate (for Enhanced Women's Services)** – an individual with similar life experience who provides support to a client in accessing services in a community.

**Peer Support** – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

**Recovery** – a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being.

**Recovery Planning** – process that highlights and organizes a person's goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to help people achieve their goals. This should include an asset and strength-based assessment of the client.

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**Substance Use Disorder** – a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

**RECOMMENDATIONS:**

Components Required for Enhanced Women's Services Programming

1. Any Designated Women's Program is eligible to offer Enhanced Women's Services to the target population. Programs choosing to develop an Enhanced Women's Services program will be required to follow the guidelines of the Women's Treatment Policy (BSAAS Treatment Policy #12), as well as those outlined in this technical advisory.
2. The Enhanced Women's Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug-exposed births:
  - The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women's Services are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.
  - The second is to promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.
  - The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.
3. Peer advocates in Enhanced Women's Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.
4. One of the core components of Enhanced Women's Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled clients to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.
5. A second core component is the persistence with which the peer advocates stay in touch with their clients. A woman is not discharged from Enhanced Women's Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer

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advocate will actively look for clients when they have unexpectedly moved, and will utilize emergency contacts provided by the client to re-engage her in services.

Enrollment Criteria

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women's Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women's Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women's specialty services.

As identified in the Individualized Treatment Policy (BSAAS Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. As a client's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

Service Requirements

In addition to the services provided through Women's Specialty Services, the following are requirements of Enhanced Women's Services:

1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.
4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage clients who are "lost" or drop out of the program, and efforts made to re-engage the client in services.
6. Coordinate service plan with extended family and other providers in the client's life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help clients define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer clients to appropriate community services for clients and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation

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challenges. Peer advocates' billable time for transporting clients to and from relevant appointments is allowable and encouraged.

14. Develop referral agreement with community agency to provide family planning options and instruction.
15. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (BSAAS Treatment Policy #11).
16. Identify clients in Enhanced Women's Services programming with the "HD" modifier.

Education/Training of Peer Advocates:

Individuals working and providing direct services for Enhanced Women's Services must complete training on the following topics within three months of hire:

- Fundamentals of Addiction and Recovery\*
- Ethics (6 hours)
- Motivational Interviewing (6 hours)
- Individualized Treatment and Recovery Planning (6 hours)
- Personal Safety, including home visitor training (4 hours)
- Client Safety, including domestic violence (2 hours)
- Advocacy, including working effectively with the legal system (2 hours)
- Maintaining Appropriate Relationships (2 hours)
- Confidentiality (2 hours)
- Recipient Rights (2 hours, available online)

\*Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:

- Relational Treatment Model (6 hours)
- Cultural Competence (2 hours)
- Women and Addiction (3 hours)
- FASD (including adult FASD) (6 hours)
- Trauma and Trauma Informed Services (6 hours)
- Gender Specific Services (3 hours)
- Child Development (3 hours)
- Parenting (3 hours)
- Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one-year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another individual who meets the training requirements and is working within the program.

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Documentation is required and must be kept in personnel files. Other arrangements can be approved by the BSAAS Women's Treatment Coordinator. These hours are an approximation only, and based on P-CAP requirements and consideration of the needs of Michigan's population.

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Bureau of Substance Abuse and Addiction Services



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

OLGA DAZZO  
DIRECTOR

## MEMORANDUM

**DATE:** November 23, 2011

**TO:** Regional Substance Abuse Coordinating Agency Directors  
Michigan Association of Substance Abuse Coordinating Agencies President  
Association of Licensed Substance Abuse Organizations President  
Salvation Army Harbor Light Director

**FROM:** Deborah J. ~~Hollis~~, Director  
Bureau of Substance Abuse and Addiction Services

**SUBJECT:** Technical Advisory for Early Intervention Expectations

Attached is the final version of Technical Advisory #09 – *Early Intervention*, which will go into effect on November 30, 2011.

The draft technical advisory (TA) #09 was submitted to the coordinating agencies (CAs), Michigan Association for Substance Abuse Coordinating Agencies, Association of Licensed Substance Abuse Organizations, residential providers, and the Salvation Army Harbor Light on April 13, 2011, for a 90-day response period. Comments were received from Macomb County Community Mental Health, and Oakland Substance Abuse Services, and incorporated into the final document.

This TA focuses on establishing minimal guidelines for early intervention treatment services, while keeping traditional prevention services intact. Because this is a new service category, special care was taken to allow enough variability so that CAs could tailor their early intervention programming to best meet the needs of their region.

Should you have any questions or need further clarification on any issues in this advisory, please contact Angie Smith-Butterwick at [smitha8@michigan.gov](mailto:smitha8@michigan.gov), or (517) 373-7898.

Attachment

DJH:ssb

c: Felix Sharpe

**Michigan Department of Community Health, Mental Health and Developmental Disabilities Administration**  
**BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

**TREATMENT TECHNICAL ADVISORY #09**

**SUBJECT:** Early Intervention

**ISSUED:** November 30, 2011

**PURPOSE:**

The purpose of this advisory is to establish the processes and expectations for Level 0.5 of the *American Society of Addiction Medicine's Patient Placement Criteria, 2<sup>nd</sup> Edition-Revised (ASAM PPC-2R)* in substance use disorder treatment.

**SCOPE:**

This advisory impacts all substance abuse coordinating agencies (CAs) and their providers who offer substance use disorder (SUD) services.

**BACKGROUND:**

Substance abuse treatment early intervention programs are effective with clients who are considered risky users, those experiencing mild or moderate problems, as well as those who are experiencing some of the symptoms of abuse or dependence (DHHS CSAP, 2002). Early intervention services would also be appropriate for those individuals who are considered to be in the pre-contemplative stage of change.

Treatment and prevention service providers may offer early intervention services to clients who, for a known reason, are at risk for developing alcohol or other drug abuse or dependence, but for whom there is not yet sufficient information to document alcohol or other drug abuse or dependence. Those staff providing early intervention services must be supervised by appropriately credentialed staff. The goals of early intervention include:

- Increasing protective factors that promote a reduction in substance use.
- Improving a client's readiness to change.
- Preparing clients for the next level of treatment.
- Integrating new skills into clients' lives on a daily basis.

The Center for Substance Abuse Treatment's (CSAT) *Treatment Improvement Protocol (TIP) 35* (DHHS CSAT, 1999b), indicate providers can be helpful at any time in the change process by accurately assessing the client's readiness to change by utilizing the appropriate motivational strategies to assist their move to the next level. Clients already engaged in more intensive services (outpatient [OP], intensive outpatient [IOP], residential) should not receive early intervention services. However, clients who are at the level of contemplation that makes them appropriate for treatment may receive early intervention services as an interim service.

A workgroup was convened to determine standards for early intervention treatment. The workgroup was comprised of representatives from CAs, providers and the Bureau of Substance Abuse and Addiction Services. Revisions to the *Substance Abuse Administrative Rules* have designated early intervention as a "substance abuse treatment service category." The Michigan Administrative Code, R325.14102(a)(1), defines early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a

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screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

ASAM PPC-2R defines early intervention as "services that explore and address any problems or risk factors that appear to be related to the use of alcohol and other drugs and that help the individual to recognize the harmful consequences of inappropriate use. Such individuals may not appear to meet the diagnostic criteria for a substance use disorder, but require early intervention for education and further assessment," (Mee-Lee et. al., 2001). Ideally, early intervention services in Michigan will follow ASAM PPC-2R criteria while staying within the guidelines of the administrative rules.

It is important to note that, while this is a new service category for the treatment field, the prevention field has been providing this type of service for sometime. "Prevention" refers to this level of service as Problem Identification and Referral (PIR), and defines it as "helping a person with an acute personal problem involving, or related to SUDs, to reduce the risk that the person might be required to enter the SUDs treatment system" (U.S. CFR, 1996). Individuals eligible for PIR services are identified as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs. These individuals are screened to determine if their behavior can be reversed through education. Designed to increase and enhance protective factors that reduce and prevent SUDs, the assessment for, and the implementation of PIR services, may be population-based or focused on the individual. These potential participants of PIR services do not meet the threshold for substance abuse or dependence, and no diagnosis is made. PIR services include, but are not limited to, interventions such as, employee assistance programs, and student assistance and education programs targeting persons charged with driving under the influence (DUI), or driving while intoxicated. The Institute of Medicine's "Continuum of Care" model (Institutes of Medicine, 1994), classifies prevention interventions based on their target populations. For example, PIR interventions targeting individuals using substances, but not diagnosed with a substance use disorder, would be classified as "case identification" services, also described as "early intervention."

Early intervention as a treatment service provides an intervention that is appropriate for the individual and their stage of change, as well as access to clinical services. Clients are screened on an individual level only, and a diagnosis is required, at least on a provisional basis. Intervention plans, or at minimum a participation goal, are developed for this level of service. Participants are not required to meet abuse or dependence thresholds for early intervention services.

### DEFINITIONS:

- **Community Group Activist/Recovery or Other Volunteer:** Not recognized as a credential category; responsibilities determine credentialing requirement.
- **Intervention Plan:** A minimal plan that sets forth the goals, expectations, and implementation procedures for an intervention. Specific activities that intend to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals.
- **Prevention Professional:** An individual who has licensure as identified in the *Credentialing and Staff Qualifications* portion of the Michigan Department of Community Health (MDCH) CA contract, AND is working within his or her licensure-specific scope of practice, or an individual who has an approved certification. These individuals have responsibility for implementing a range of prevention plans, programs and services.
- **Specially Focused Staff:** Individuals responsible for carrying out specific activities relative to treatment programs and are not responsible for clinical activities. May include case managers or

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AMS staff. Staff works under the direction of specialists or supervisors. Certification is not required, although appropriate licensure may be required depending on the scope of practice.

• **Stages of Change:**

- **Pre-contemplation:** clients are not considering change at this stage, and do not intend to change behaviors in the foreseeable future.
- **Contemplation:** clients have become aware that a problem exists, may recognize that they should be concerned about their behavior, but are typically ambivalent about their use, and changing their behavior.
- **Preparation:** clients understand that the negative consequences of continued substance use outweigh any perceived benefits and begin specific planning for change. They may begin to set goals for themselves, and make a commitment to stop using.
- **Action:** clients choose a strategy for change and actively pursue it. This may involve drastic lifestyle changes and significant challenges for the client.
- **Maintenance:** clients work to sustain sobriety and prevent relapse. They become aware of situations that will trigger their use of substances and actively avoid those when possible.

• **Substance Abuse Treatment Specialist (SATS):** An individual who has licensure as identified in the *Credentialing and Staff Qualifications* portion of the MDCH CA contract, AND is working within his or her licensure-specific scope of practice, **OR** an individual who has an approved certification. These are clinical staff providing substance use disorder treatment and counseling, and are responsible for the provision of treatment programs and services.\*

• **Substance Abuse Treatment Practitioner (SATP):** An individual who has a registered Michigan Certification Board for Addiction Professionals (MCBAP) certification development plan, that is timely in its implementation, AND is supervised by an individual with a Certified Clinical Supervisor credential through MCBAP or a registered development plan to obtain the supervisory credential, while completing the requirements of the plan (6000 hours).\*

\* *The above definitions can be found in the SUD Services Policy Manual included in the MDCH CA contract agreement. Please refer to the contract agreement for a full description of the credentialing requirements.*

**RECOMMENDATIONS:**

Clients who are appropriate for this level of treatment, at the very least, shall meet the criteria in the current edition of the ASAM PPC-2R, for level 0.5 or its equivalent. The criteria are as follows:

- The individual who is appropriate for level 0.5 services shows evidence of problems and risk factors that appear to be related to substance use, but do not meet the diagnostic criteria for a Substance-Related Disorder, as defined in the current Diagnostic and Statistical Manual (DSM).
- Dimensions 1, 2, and 3: concerns are stable or being addressed through appropriate services.
- Dimensions 4, 5, and 6: one of the following specifications in these dimensions must be met.
  - Dimension 4: the individual expresses a willingness to gain an understanding of how his/her current alcohol or drug use may be harmful or impair the ability to meet responsibilities and achieve goals.

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- Dimension 5: the individual does not understand the need to alter his/her current pattern of use, or the individual needs to acquire the specific skills needed to change his/her current pattern of use.
- Dimension 6: the individual's social support system consists of others whose substance use patterns prevent them from meeting responsibilities or achieving goals, or the individual's family members are abusing substances which increases the individual's risk for a substance use disorder, or the individual's significant other holds values regarding substance use that create a conflict for the individual, or the individual's significant other condones or encourages inappropriate use of substances.

Services should be focused on meeting the client where they are within the stages of change. Some clients may be appropriate for a higher level of care, but uncomfortable engaging in formal treatment, or at a stage of change that may not significantly benefit from formal treatment services. In this instance, early intervention services would be allowable. Clients may be screened through the local Access Management System (AMS) and, if appropriate, referred for early intervention services at the provider of their choice. However, clients may also be screened through the early intervention program, as determined by the appropriate coordinating agency. Treatment providers will perform, at minimum, a screening to determine appropriate services for the client, as well as to measure future progress. The treatment provider and the client will then establish goals to achieve during the course of treatment/intervention. Clients may then be offered an appropriate intervention, based on their established goals. Some clients will require referral for further assessment or to another level of treatment due to emerging concerns.

Early intervention services should be time-limited and short-term, and may be used as a stepping-stone to the next level for those clients who need it. Early intervention may also be used as an interim service, while an individual waits for their assessed level of care to become available.

Allowable Services in Early Intervention

- **Group:** Prevention and/or treatment occurring in a setting of multiple persons with similar concerns/situations gathered together with an appropriately credentialed staff that is intended to produce prevention of, healing or recovery from, substance abuse and misuse. Group models used in early intervention prevention and treatment are not intended to be psychotherapeutic or limited, and may include:
  - **Educational groups**, which educate clients about substance abuse.
  - **Skill development groups**, which teach skills needed to attain and sustain recovery, for example: relapse triggers and tools to sustain recovery.
  - **Support groups**, which support members and provide a forum to share information about engaging in treatment, maintaining abstinence and managing recovery. These may be managed by peers or credentialed staff.
  - **Interpersonal process groups**, which look at major developmental issues that contribute to addiction or interfere with recovery.
- **Individual:** One-on-one education and/or counseling between a provider and the client.
- **Alcohol and Drug Education:** May occur in a group setting as outlined above (educational groups), or may be used as independent study, with the provider giving "assignments" to be discussed at the next session.

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- **Referral/Linking/Coordination of Services:** Office-based service activity performed by the primary service provider to address needs identified, and/or to ensure follow-through with outside services/community resources, and/or to establish the client with other substance use disorder services.

Please note that the above services are offered in many treatment settings, and may be utilized for those clients seeking early intervention services. However, in order to be billed as an early intervention service, a program must have a license for early intervention.

Clients may engage in more than one of the above interventions at a time, based upon individual need. If it becomes evident that a client is in need of a higher level of care, arrangements should be made to transfer that client into the appropriate level of service. Also to be taken into consideration at that point, is the client's readiness to change and willingness to engage in treatment.

The transferring of clients between treatment providers and counselors often results in client dropout. Thus, what is frequently termed a "warm hand-off," connecting the client with the new provider/therapist directly by way of a three-way call or other appropriate communication, is preferred when transitioning clients.

#### Eligibility

**Prevention:** Persons identified and assessed as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs that do not meet the threshold for substance abuse or dependence, and for whom no diagnosis is made; i.e., college or military substance abuse; alcohol, tobacco, and illicit drug-impaired driving; children of alcoholics; children of substance abusing parents; Fetal Alcohol Spectrum Disorder; and HIV/AIDs.

**Treatment:** As previously noted, clients seeking this level of care, must meet, at a minimum, Level 0.5 of the ASAM PPC-2R, and be experiencing some problems and/or consequences associated with their substance use. For example, those who are seeking services related to a first time DUI charge would not be eligible without also meeting ASAM criteria. Clients already engaged in more intensive services, or at a level of contemplation that makes them appropriate for treatment, should not receive early intervention services. However, those clients waiting for treatment services may access early intervention as an interim service.

#### Funding

Funding for early intervention services comes from treatment and prevention. However, early intervention services performed or provided within a prevention program shall not be funded with Community Grant dollars. The Healthcare Common Procedure Coding System for early intervention services provided with treatment funding is H0022, which encompasses many of the allowable services. The Medicaid Provider Manual lists early intervention as an allowable service (12.1.B, 2011).

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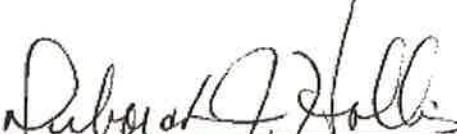
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**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**Bureau of Substance Abuse and Addiction Services**

**TREATMENT TECHNICAL ADVISORY # 10**

**SUBJECT:** Residential Treatment Continuum of Services

**ISSUED:** September 15, 2010

**EFFECTIVE:** October 1, 2010

**PURPOSE**

The purpose of this advisory is to establish the requirements for residential services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age and gender appropriateness.

**SCOPE**

This advisory impacts the coordinating agency (CA) and its adult residential level of care service provider network.

**BACKGROUND**

Residential treatment includes a wide variety of covered services with the provision that these services are expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They indicate ten hours of scheduled activities, with two of those hours being formalized counseling, which must take place during each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Patient Placement Criteria and the stages-of-change models that have been developed have essentially left the administrative rules obsolete in the area of recommended services. This advisory is seeking to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM, and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential services.

Throughout the current residential level of services, assessment, treatment planning, and recovery support preparations are required; and must be included in the authorized treatment services. Historically, residential services have been defined by length of stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services:

- Short-term residential: less than 30 days in a program

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- Long-term residential: 30 days or more in a program

This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

### **Definitions**

**Toxicology Screening** – screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis)

**Core Services** – Treatment Basics, Therapeutic Interventions and Interactive Education/Counseling. See the chart in the “Covered Services” section for further information.

**Counseling** – an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

**Crisis Intervention** – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

**Detoxification/Withdrawal Monitoring** – monitoring for the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

**Face-to-Face** – this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

**Facilitates Transportation** – assist the client, or potential client, or referral source in arranging transportation to and from treatment.

**Family Counseling** – face-to-face intervention with the client and the significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

**Family Psychotherapy** – face-to-face, insight-oriented interventions with the client and the significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

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**Group Counseling** – face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

**Group Psychotherapy** – face-to-face, insight-oriented interventions with three or more clients.

**Individual Assessment** – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

**Individual Counseling** – face-to-face intervention for the purpose of goal setting and achievement, and skill building.

**Individual Psychotherapy** – face-to-face, insight-oriented interventions with the client.

**Individual Treatment Planning** – direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

**Interactive Education** – services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as didactic education.

**Interactive Education Groups** – activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

**Medical Necessity** – treatment which is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

**Peer Support** – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

**Psychotherapy** – an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (from Social Work Administrative Rules).

**Recovery** – a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to

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such problems, and develop a healthy, productive, and meaningful life. (White, Journal of Substance Abuse Treatment, 2007).

**Recovery Planning** – process that highlight's and organize a person's goals, strengths and capacities and to determine what barriers need to be removed or problems resolved to help people achieve their goals. This should include an asset and strength based assessment of the client.

**Recovery Support and Preparation** – services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

**Referral/Linking/Coordination of Services** – office-based service activity performed by a primary clinician or other assigned staff to address needs identified through the assessment, and/or of ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

**Substance Use Disorder** – a term inclusive of substance abuse and dependence that also encompasses problematic use of substances.

## **RECOMMENDATIONS**

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short- and long-term descriptors will no longer be used to describe residential services. Coordinating agencies will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels III.1, III.3, and III.5. ASAM level III.7 is not a requirement, but was included for those regions that have this service available. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

### **ASAM Level III.1 – Clinically Managed Low-Intensity Residential Services**

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual in the worlds of work, education and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility or lack of connection to employment, education or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

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### **ASAM Level III.3 – Clinically Managed Medium-Intensity Residential Services**

These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have more intensive needs and therefore, to effectively benefit from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for any benefit to be received.

### **ASAM Level III.5 – Clinically Managed High-Intensity Residential Services**

These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus, addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The services offered to clients in this modality tend to be of the longest duration among the four levels of care. As impairment is considered to be significant at this level, services must be provided over a longer time frame in order for any benefit to be received. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being centered on habilitation and development, or re-development of life skills.

### **ASAM Level III.7 – Medically Monitored Intensive Inpatient Treatment**

These programs provide 24-hour medical monitoring, evaluation, observation and addiction treatment in an inpatient setting. "They are appropriate for patients whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment," (Mee-Lee, Shulman, Fishman, Gastfriend & Griffith, 2001). Treatment is provided by an interdisciplinary staff of appropriately credentialed treatment professionals, and is specific to substance use disorders. The treatment team can also accommodate clients with detoxification, medical, emotional, behavioral and cognitive conditions. Clients at this level will have functional deficits in Dimensions 1, 2 and/or 3.

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The length of service will vary, based on the severity of a client's illness and their response to treatment. In addition, clients with a high severity of illness in Dimension 1, 2 or 3 require more intensive support services, as well as staff monitoring the program.

ASAM levels of care describe the need for treatment from the perspective of the level of impairment of the client; with the higher level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment.

### Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity;
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis) – the diagnostic impression must include all five axes:
  - 1) Axis I Clinical Disorders
  - 2) Axis II Personality Disorders, Mental Impairment
  - 3) Axis III General Medical Conditions
  - 4) Axis IV Psychosocial and Environmental Problems
  - 5) Global Assessment of Functioning
- Individualized determination of need; and
- Use of ASAM Patient Placement Criteria (PPC) to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the current ASAM PPC below:
  - 1) Withdrawal potential.
  - 2) Medical conditions and complications.
  - 3) Emotional, behavioral or cognitive conditions and complications.
  - 4) Readiness to change – as determined by the Stages-of-change Model.
  - 5) Relapse, continued use or continued problem potential.
  - 6) Recovery/living environment.

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Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. Authorization decisions on length of stay (including continued stay), change in level of care, and discharge, must be based on the ASAM PPC. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

### Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the four levels of care. Alternative forms of therapy such as art, music, etc., should be reflected in the client's treatment plan and follow the documentation requirements. Documentation of all required services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

Level of Care	Minimum Daily Core Services	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
<b>ASAM III.1</b> Clients with lower impairment or lower complexity of needs	n/a	At least 5 hours of clinical services per week.	At least 5 hours per week.
<b>ASAM III.3</b> Clients with moderate to high impairment or moderate to high complexity of needs	6 days per week; not less than 3 hours per day. 7 <sup>th</sup> Day; not less than 2 hours. Core services not under 2 hours in any day.	Not less than 20 hours per week.	Not less than 13 hours per week.
<b>ASAM III.5</b> Clients with a significant level of impairment or very complex needs	6 days per week; not less than 2 hours per day. 7 <sup>th</sup> Day; not less than 1 hour. Core services not under 1 hour in any day.	Not less than 13 hours per week.	Not less than 20 hours per week.
<b>ASAM III.7</b> High Dimension 1, 2 and 3 needs	Due to the intensive medical needs and components of the programming, we are not identifying specific service requirements for this level of care. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures and clinical protocols.		

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### Covered Services

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
<b>Basic Care</b>	Room, board, supervision, monitoring self administration of medications, toxicology screening, facilitates transportation to and from treatment, treatment environment: structured, safe, and recovery oriented.
<b>Treatment Basics</b> <b>Core Service</b>	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.'
<b>Therapeutic Interventions</b> <b>Core Service</b>	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.
<b>Interactive Education /Counseling</b> <b>Core Service</b>	Interaction and teaching with client(s) and staff that 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. Ex: disease of addiction, mental health & substance use disorder.
<b>Life Skills/Self-Care</b>	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.
<b>Milieu/Environment (building recovery capital)</b>	Peer support; recreation/exercise; leisure activities; family visits; coordination with treatment, support groups; maintaining a drug/alcohol free campus.

### Treatment Planning/Recovery Planning

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment

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**EFFECTIVE: October 1, 2010**

continuum, it is expected that the provider, as part of treatment planning, begin the process of preparing the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next service, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next level of care, the residential care provider may assist the client in: choosing an appropriate service based on needs and location, scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided as examples of activities that could take place if it were determined that doing so would benefit the client. There could potentially be many other activities or arrangements that may be needed or the client may require very little assistance. To the best of their ability, it is expected that the residential provider provide any needed assistance to ensure a seamless transfer to the next level of care.

**Continuing Stay Criteria**

Re-authorization or continued treatment should be based on ASAM PPC continued service criteria, medical necessity, and when there is a reasonable expectation of benefit from continued care.

Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.

## TREATMENT TECHNICAL ADVISORY #10

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The ASAM Assessment Dimensions must be used to assist in the determination of the level of care needed by a client:

<b>Level of Care</b>	<b>Level III.1</b>	<b>Level III.3</b>	<b>Level III.5</b>
<b>Dimension 1</b> Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; Concurrently receiving Level I-D or Level II-D	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D	At minimal risk of severe withdrawal at Levels III.3 or III.5. If withdrawal is present, it meets Level III.2-D criteria
<b>Dimension 2</b> Medical conditions & complications	None or very stable, or receiving concurrent medical monitoring	None or stable or receiving concurrent medical monitoring	None or stable or receiving concurrent medical monitoring
<b>Dimension 3</b> Emotional, behavioral, or cognitive conditions and complications	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits	Demonstrates repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client
<b>Dimension 4</b> Readiness to change	Open to recovery but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level III.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)	Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)
<b>Dimension 5</b> Relapse, continued use or continued problem potential	Understands relapse but needs structure to maintain therapeutic gains	Has little awareness and needs intervention only available at Level III.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction	Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences
<b>Dimension 6</b> Recovery/living environment	Environment is dangerous, but recovery achievable if Level III.1 24-hour structure is available	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting

**TREATMENT TECHNICAL ADVISORY #10**

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**EFFECTIVE: October 1, 2010**

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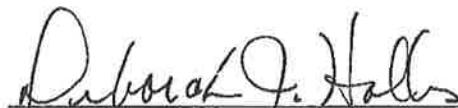
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APPROVED BY:



Deborah J. Hollis, Director  
Bureau of Substance Abuse and Addiction Services

## **VI. TREATMENT REQUIREMENTS**

Treatment Policy #02  
Acupuncture—  
Effective May 1, 1994; Reissued March 2007

Treatment Policy #06  
Individualized Treatment and Recovery Planning—  
Effective April 2, 2012

Treatment Policy #07  
Access Management System—  
Effective November 1, 2006

Treatment Policy #08  
Substance Abuse Case Management Program Requirements—  
Effective January 1, 2008

Treatment Policy #09  
Outpatient Treatment Continuum of Services—  
Effective June 20, 2008

Treatment Policy #10  
Residential Treatment Continuum of Services—  
Effective October 1, 2010

Treatment Policy #12  
Women's Treatment Services—  
Effective October 1, 2010

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**TREATMENT POLICY – 02**

**SUBJECT:** Acupuncture

**ISSUED:** May 1, 1994, revised June 2001, March 2007

**EFFECTIVE:** May 1, 1994

**PURPOSE:**

To establish the standards for the use of acupuncture when it is used as adjunct therapy in substance abuse treatment.

**SCOPE:**

The Michigan Department of Community Health/Office of Drug Control Policy will allow community grant expenditures for acupuncture as adjunct therapy in any substance abuse treatment setting: residential, intensive outpatient, individual or group outpatient. Acupuncture may be used either in drug-free or medication-assisted treatment.

**BACKGROUND:**

In 1972, the use of auricular acupuncture for acute drug withdrawal was developed in Hong Kong. Shortly thereafter, Michael Smith, M.D., a psychiatrist at Lincoln Hospital in the South Bronx, New York City, started using it extensively. Dr. Smith developed a five-point auricular protocol, which has been adopted by the National Acupuncture Detoxification Association. The following ear points are used in the protocol: liver, kidney, lung, sympathetic nervous system, and shen men (spirit gate). Stimulation of these ear points reduces stress and anxiety, which allows the patient to be more receptive to counseling. It also lessens depression and insomnia. It alleviates the craving for substances, thus aiding in recovery. It should be noted that the term “detoxification” is used in an eastern concept and is meant to be used throughout the treatment continuum and to prevent relapse rather than the initial stage of treatment.

Auricular acupuncture offers a low-cost way to enhance outcomes and lower the total cost of substance abuse treatment. It has been shown to be effective in relieving the symptoms of withdrawal from alcohol, heroin, and crack cocaine; making patients more receptive to treatment; reducing or eliminating the need for medication-assisted treatment; and lessening the chances of relapse. Auricular acupuncture has been used successfully in treating pregnant substance abusing women and drug-exposed infants who are going through withdrawal.

Non-auricular acupuncture points can also be used as part of an individualized acupuncture treatment plan when performed by a registered acupuncturist.

## TREATMENT POLICY #02

EFFECTIVE: May 1, 1994

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Acupuncture may be done as adjunct therapy to any treatment modality in any setting. Counseling, 12-step programs, relapse prevention, referral for supportive services, and life skills training are all components of a comprehensive program that can include acupuncture. Auricular acupuncture for substance abuse treatment appears to work best in a group setting. In keeping with the philosophy of Chinese medicine, the patient is encouraged to be actively involved in his/her own treatment and to see his/her substance abuse as part of his/her total emotional, physical, and spiritual health and its relationship to other people and the environment.

### REQUIREMENTS:

#### Michigan Law

Acupuncture may be performed by the following individuals: a) Medical Doctor, b) Doctor of Osteopathy, c) Registered Acupuncturist. An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by the National Acupuncture Detoxification Association (NADA) and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for substance abuse treatment. The supervising physician need not be trained in acupuncture nor present when the procedure is performed.

Disposable sterile needles must be used for all acupuncture treatments.

Michigan Compiled Laws, from the Public Health Code, pertaining to acupuncture:

- 333.16215 Supervision of Acupuncture
- 333.16501 Definition of Acupuncturist
- 333.16511 Exemption from Registration

### PROCEDURE:

The recommended procedure for the use of acupuncture as a substance abuse treatment support is the protocol developed by the National Acupuncture Detoxification Association (NADA). This five point auricular protocol is the only procedure allowed to be done by the NADA trained and certified ADS. Registered Acupuncturists and physicians may use their professional judgment and expertise in determining the acupuncture points to be used.

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Acupuncture and Oriental Medicine Alliance. <http://www.acuall.org>

**TREATMENT POLICY #02**

**EFFECTIVE:** May 1, 1994

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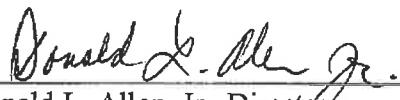
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Smith, M. and Khan, I. (1993). *Acupuncture helps programs more than patients*. Unpublished manuscript presented at the May 1993 National Acupuncture Detoxification Association Conference.

**APPROVED BY:**

  
\_\_\_\_\_  
Donald L. Allen, Jr., Director  
Office of Drug Control Policy



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

OLGA DAZZO  
DIRECTOR

## MEMORANDUM

DATE: April 26, 2012

TO: Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hobbs, Director  
Bureau of Substance Abuse and Addiction Services

SUBJECT: Treatment Policy #6: *Individualized Treatment and Recovery Planning*

Attached is the final version of Treatment Policy #6: *Individualized Treatment and Recovery Planning*. This policy became effective April 2, 2012.

A draft of this policy was sent to all substance abuse coordinating agencies for review in December 2011. Comments and feedback were received from the Detroit Bureau of Substance Abuse Prevention, Treatment and Recovery, Mid-South Substance Abuse Commission, and Genesee County Community Mental Health, which were utilized to finalize this policy. Some of the feedback received indicated that there was a preference for separate treatment and recovery planning. BSAAS believes that it is important that these activities take place simultaneously to ensure client input and the viability of recovery planning. Concerns were expressed that treatment goals and objectives that completely reflect the client's words are not always measurable. Adjustments were made to the policy to correct this issue. The policy also provides clarification regarding required signatures on treatment plans and updates.

If you have any questions or need further clarification, please contact Angie Smith-Butterwick, at [smitha8@michigan.gov](mailto:smitha8@michigan.gov) or 517-373-7898.

DJH:ssb

Attachment

c: Felix Sharpe  
Jeff Wieferich

**Michigan Department of Community Health, Behavioral Health and Developmental Disabilities Administration**  
**BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

**TREATMENT POLICY # 06**

**SUBJECT:** Individualized Treatment and Recovery Planning

**ISSUED:** September 22, 2006, revised February 29, 2012

**EFFECTIVE:** April 2, 2012

**PURPOSE**

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. Treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment. By participating in the development of their recovery plan, clients can identify resources they may already be familiar with in their community and begin to learn about additional available services. Treatment and recovery planning requires an understanding that each client is unique and each plan must be developed based on the individual needs, goals, desires and strengths of each client.

The planning process can be limited by the information that is gathered in the assessment or by actual planning forms. All planning forms should be reviewed on at least an annual basis to ensure that the information being gathered, or the manner in which it is recorded, continues to support the individualized treatment and recovery planning process.

**SCOPE**

This policy impacts the coordinating agency (CA) and its provider network of substance use disorder services.

**BACKGROUND**

Expectations for individualized treatment planning had been advisory requirements in the contract with the CAs from 2004 through 2006. This policy formalizes those expectations and introduces the need for recovery planning as an essential part of this process.

**REQUIREMENTS**

The Administrative Rules for Substance Abuse Programs in Michigan promulgated under PA 368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

**TREATMENT POLICY # 06**

EFFECTIVE: April 2, 2012

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All CA providers must also be accredited by one of the approved national accreditation bodies. Accreditation standards also require evidence of client participation in the treatment planning process. Evidence of client participation includes goals and objectives in the client's own words, goals and objectives based on needs the client identified in the assessment, and evidence the client was in attendance when the plan was developed.

**PROCEDURE**

Treatment and recovery planning begins at the time the client enters treatment – either directly or based on a referral from an access system – and ends when the client completes or leaves formal treatment services. Planning is a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the client's needs change, the plan must be revised to meet the new needs of the client.

Recovery planning is undertaken as a component of the treatment plan and should progress as the client moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the client and, upon the end of formal treatment services, he/she is able to continue along his/her recovery path with guidance from his/her plan. It is not acceptable that the recovery plan be developed the day before a client's planned completion of treatment services.

The treatment and recovery plans are not limited to just the client and the counselor. The client may request any family members, friends or significant others be involved in the process. Once each plan is developed, the client, counselor, and other involved individuals, such as significant others, family and mental health providers, must sign the form indicating understanding of the plan and the expectations.

**Establishing Goals and Objectives**

The initial step in developing an individualized treatment and recovery plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals based on the client's individual needs. Examples of strengths might be a healthy support network, stable employment, stable housing, a willingness to participate in counseling, etc. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment, assist in identifying the most appropriate modality of treatment (individual, group, etc.), and may take the focus off any negative situations that surround the client getting involved in treatment, i.e., legal problems, work problems, relationship problems, etc.

TREATMENT POLICY # 06

EFFECTIVE: April 2, 2012

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Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the planning document utilized by the provider. Goals must be stated in the client's words or based on the client's reported concerns. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, then the objectives – the activities the client needs to perform to achieve the goal – are recorded. The objectives must be developed with the client but do not have to be recorded in the client's exact words. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a targeted completion date. The completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objectives. In other words – what action will the client take to achieve a goal, and what action will the counselor take to assist the client in achieving the goal. This should be specific, not just generalized statements of individual or group therapy. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which services should be provided. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the plan. When progress notes are written, they reflect what goal(s)/objective(s) were addressed during a treatment session. The progress notes recorded by the clinician, should document progress or lack of progress and any adjustments/changes to the treatment and recovery plan. Once a change is decided on, it should then be added to the plan in the format described above and initialed by the client or with documentation of client approval.

Treatment and Recovery Plan Progress Reviews

Plans must be reviewed and documentation of such must be placed in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90, 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8, 10, 12 episodes). The reviews must include input from all clinicians/treatment/recovery providers involved in the care of the client, as well as any other individuals the client has involved in his/her plan. This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. As with the initial plan, the client, clinician, and other relevant

TREATMENT POLICY # 06

EFFECTIVE: April 2, 2012

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individuals should sign this review. If individual signatures are unable to be obtained, documentation explaining why must be provided.

The plan and plan reviews not only serve as tools to provide care to the client, they help in the administrative function of service authorization. Decisions concerning, but not limited to, length of stay, transfer, discharge, continuing care, and authorizations by CAs must be based on individualized determinations of need and on progress toward treatment and recovery goals and objectives. Such decisions must not be based on arbitrary criteria, such as pre-determined time or payment limits.

Policy Monitoring and Review

The CA will monitor compliance with individualized treatment and recovery planning and these reviews will be made available to the Bureau of Substance Abuse and Addiction Services (BSAAS) during site visits. BSAAS will also review for individualized treatment and recovery planning during provider site visits. Reviews of plans will occur in the following manner:

- A review of the biopsychosocial assessment to determine where and how the needs and strengths were identified.
- A review of the plan to check for:
  1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan.
  2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients.
  3. Measurable objectives – The ability to determine if and when an objective will be completed.
  4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan.
  5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
  6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.
  7. Recovery planning activities are taking place during the treatment episode.
- A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

TREATMENT POLICY # 06

EFFECTIVE: April 2, 2012

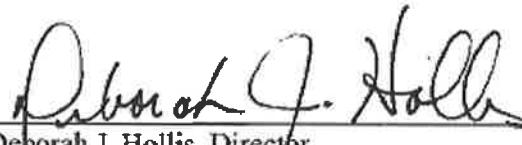
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- An audit of the treatment and recovery plan progress review to check for:
  1. Progress note information matching what is in review.
  2. Rationale for continuation/discontinuation of goals/objectives.
  3. New goals and objectives developed with client input.
  4. Client participation/feedback present in the review.
  5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

## REFERENCES

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APPROVED BY:

  
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Deborah J. Hollis, Director  
Bureau of Substance Abuse and Addiction Services



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

OLGA DAZZO  
DIRECTOR

**MEMORANDUM**

**DATE:** November 30, 2011

**TO:** Regional Substance Abuse Coordinating Agency Directors  
Michigan Association of Substance Abuse Coordinating Agencies President  
Association of Licensed Substance Abuse Organizations President  
Salvation Army Harbor Light Director

**FROM:** Deborah J. Hall, Director  
Bureau of Substance Abuse and Addiction Services

**SUBJECT:** Treatment Policy #07: *Access Management System*

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Enclosed is the final version of Treatment Policy #07: *Access Management System*, which takes effect on November 30, 2011. The purpose of this policy is to establish the requirements of an access management system. The expectations have been updated, based on changes in practice and policy since this policy was issued on November 1, 2006.

On June 24, 2011, a draft of this policy was sent to all coordinating agencies and opioid treatment programs for a 60-day review period. Mid-South Substance Abuse Coordinating Agency, the City of Grandville, and the Muskegon County Criminal Justice System submitted comments that were used to complete the final version of this policy.

Should you have any questions or need further clarification, please contact Jeff Wieferich, at [wieferichj@michigan.gov](mailto:wieferichj@michigan.gov) or 517-335-0499.

DJH:ssb

Enclosure

c: Felix Sharpe

Michigan Department of Community Health, Mental Health and Developmental Disabilities Administration

**BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

**TREATMENT POLICY #07\***

**SUBJECT:** Access Management System

**ISSUED:** November 1, 2006, revised September 30, 2011

**EFFECTIVE:** November 30, 2011

**PURPOSE:**

The purpose of this policy is to establish the requirements for the access management system (AMS).

**SCOPE:**

This policy applies to the substance abuse coordinating agencies (CAs) and their provider networks.

**DEFINITIONS:**

**Access Management** – As outlined in the procedures section of this policy, access management consists of those responsibilities, associated with determining administrative and clinical eligibility, managing resources (including demand, capacity, and access), ensuring compliance with various funding eligibility and service requirements, and assuring associated quality of care. Activities to carry out these responsibilities include appropriate referral and linkage to other community resources.

**Access Management System** – AMS as a system refers to the manner in which the CA carries out access management functions. Since AMS is administrative in nature, the CA can directly operate the AMS and/or these activities can be assigned to various providers. The AMS is a “system” not a “place.”

**Administrative Eligibility Determination and Enrollment** – Administrative eligibility determination and enrollment is the process by which the client requesting treatment is determined to be eligible for services and enrolled as a client of the CA. Enrollment includes determination of financial responsibility, notice of recipient rights, confidentiality, and release of information documents, as required by law or funding source.

**Assessment** – An assessment is used to collect information in a manner that will enable the provider to establish (or rule out) the presence of a substance use disorder. It is also used to determine the client’s readiness for change, identify client strengths or problem areas that may affect the processes of treatment and recovery, and engage the client in the development of a treatment relationship. The assessment serves as the initial basis for the treatment and recovery plan. Assessment is included in the service delivery process and is therefore outside of

## TREATMENT POLICY 07

EFFECTIVE: November 30, 2011

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(excluded from) the AMS. In contrast, an initial screening is a formal, brief process that occurs as the client requests or presents for services to determine the likelihood of a substance use disorder and a preliminary identification of other needs. The screening process results in the determination of eligibility for assessment at an initial level of care and an initial service authorization.

**Capacity Management** – Capacity management is the ability of an AMS to track and manage service availability. Capacity management includes assuring year-long access is available for all services, maintaining waiting list information, assuring access for priority populations, and monitoring the provision of interim services as necessary.

**Clinical Eligibility Determination** – Clinical eligibility determination includes triage (assessment of risk), determination of medical necessity (the presence or a likelihood of a substance use disorder), a determination of the initial level of care (LOC) (based on the American Society of Addiction Medicine Patient Placement Criteria 2R (ASAM), and a provisional diagnostic impression that must include appropriate referral(s) for services.

**Crisis Situation** – A situation in which a client seeking access is experiencing a medical or psychiatric emergency or who is suicidal or homicidal, thereby requiring an immediate referral/intervention to a provider specializing in the service most appropriate to the client's situation and needs.

**Customer Services** – Customer services are non-treatment and support services provided to clients and other consumers that are directed at the entire population of the CA catchment area and consist of information services, coordination of client participation in managed care activities, community benefit, and complaint, grievance, and appeals processes.

**Demographic Data** – Demographic data is the client identifying information needed to open a case file. It includes, but is not limited to, name, address, city, state, zip, telephone, date of birth, income, sex, marital status, and race/ethnicity.

**Quality Assurance Monitoring** – Quality assurance monitoring is the review and monitoring of the provider network to determine an appropriate application of service guidelines and criteria.

**Routine** – a request for service that is a non-urgent or non-crisis situation from a potential client or referral source.

**Service Driven** – A system is service driven when it is responsive to the needs of the client, service providers, and referral sources.

**Utilization Review** – Utilization review is the review of individual client records specific to system practices and trends. In the AMS, utilization review includes but is not limited to assuring that the initial level of care determination is appropriate.

## TREATMENT POLICY 07

EFFECTIVE: November 30, 2011

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**Urgent Situation** – A situation in which an individual is determined to be at-risk of experiencing a substance use disorder or mental health crisis in the near future, without the intervention of care, treatment, or support services. Note: Any priority population clients seeking substance use disorder services that meet the level of care criteria for admission to detoxification or residential services are an urgent situation.

**Welcoming** – Welcoming is conceptualized as an accepting attitude and understanding of how clients ‘present’ for treatment, and an ability on the part of the provider to address client needs in a manner that accepts and fosters a relationship that meets the needs, cultural expectations, and interests of the individual.

### **BACKGROUND:**

The requirement for a statewide system of Central Diagnostic and Referral (CDR) services became a substance abuse treatment system mandate for Michigan in the early 1990s. Accurate, unbiased, and comprehensive assessment of treatment needs and assurance that clients received the needed level of care (treatment) were the goals of the CDR system. During the 1990s, the CDR system evolved to include the use of ASAM Patient Placement Criteria, a requirement for a diagnostic impression based on Diagnostic and Statistical Manual (DSM) criteria, and the use of medical necessity criteria.

In fiscal year 2002, the CDRs were renamed the Access, Assessment, and Referral (AAR) services. The name change was made to emphasize access to treatment at the provider level. The need for further change became evident in 2004 due to conflicts between administrative and treatment responsibilities, the need to reduce duplication of services, and the desire to adopt best practices relative to client engagement and retention.

In late 2004, a draft policy was issued on access management. A workgroup began meeting in January 2006 to review the draft policy and develop a final AMS policy. This document incorporates the discussion and input from that workgroup. It moves toward using a brief screening for service authorization purposes and “moving” the biopsychosocial assessment to the treatment provider while fostering the welcoming concept. In July 2006, the administrative rules for substance abuse were revised to define access management as an administrative function.  
*Note: As of September 30, 2008, an assessment is no longer a covered service if it takes place at a centralized CA access management setting, or one that does not also provide licensed treatment services.*

### **REQUIREMENTS:**

Administrative Rules for Substance Abuse Service Programs, promulgated pursuant to Section 6231(1) of Michigan Public Act 368 of 1978, as amended.

42 United States Code (U.S.C.) 290dd-2; 42 C.F.R. Part 2 (Confidentiality).

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Public Act 368 of 1978, as amended, Article 6, Part 62, Section 6228, (Coordinating Agency Required Functions).

Requirements as stated in the Michigan Department of Community Health (MDCH) contract with the coordinating agencies.

### **PROCEDURE:**

The following core values were established by the workgroup and are incorporated in this policy. These are considered essential to best practice.

- ◆ Access management is a “system” not a “place.”
- ◆ An AMS is welcoming. Welcoming is intended to facilitate building the relationship between the provider and the client from the initial service contact.
- ◆ An AMS must be service-driven to meet the needs of clients, service providers, and referral sources.
- ◆ An AMS must be client-centered and foster engagement, and support recovery.
- ◆ An AMS must be administratively and clinically effective as well as efficient.

This policy recognizes the importance of the biopsychosocial assessment as the first step in the development of an individualized treatment/recovery plan. In doing so, the need for assessment from the provider who will be treating the individual is emphasized. This procedure supports a welcoming framework that minimizes the client having to repeat information, and facilitates the development of a relationship between the provider and the client, as the counselor will be able to work with the client from the initial treatment contact.

One of the goals of the AMS is to provide easy access for clients seeking services in an efficient and cost-effective manner. CAs are responsible for assuring the availability and operation of an efficient and effective access management system, including the assurance that staff performing these functions are skilled, trained, and appropriately supervised in the functioning of the AMS. Further, the CA needs to ensure that access for clients seeking substance use disorder services is streamlined, client-friendly, culturally appropriate, and effective in making accurate referrals.

The responsibility rests with the CA to ensure an AMS meeting these standards is in place and operational. The selection of the procedures, programs, or methods by which this is accomplished is at the discretion of the CA. CAs must meet the following requirements when developing and implementing their regional system:

#### Availability

The AMS must be available to triage clients seeking services 24-hours-a-day, seven-days-a-week. This requirement does not demand 24/7 staffing, unless volume/demand is sufficient

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to support such a capacity. Triage can be completed in various ways, such as an on-call person available by telephone (voice mail is not adequate), an answering service utilizing trained staff, a contracted 24/7 crisis center or a detoxification provider open 24/7. Clients, who are identified as needing urgent help or have been determined to currently be in a crisis situation, must be screened and referred to the appropriate services. A crisis situation requires an immediate referral to the appropriate provider to assist the individual. If the client does not meet the criteria for an urgent or a crisis situation, a referral for screening by the AMS on the next business day is required.

The AMS may offer services in a face-to-face manner, by telephone or electronically when geographic or other barriers make it more efficient or accessible. In situations where a method other than face-to-face is used, the CA must have protocols in place to ensure that there is documentation of the client receiving information regarding recipient rights and that the confidentiality requirements have been met.

For routine service requests, the minimum timeline standard for conducting a client's screening, level-of-care (LOC) determination, provider selection (placement activities), and admission to treatment is fourteen days from the first contact with the AMS.

Requirements at Initial Contact with Clients

*Administrative Functions*

- Administrative eligibility – Enough information should be gathered during the first contact to make a provisional eligibility determination. Further verification efforts can take place during the assessment process. The CA needs to ensure that the access management system is designed to gather the following information:
  - Verification of county of residence.
  - Verification of income and sliding fee scale application.
  - Verification of need for the coordination of benefits by:
    - Determining the existence of third party insurance.
    - Determining the existence of a responsible relative that has income or insurance.
    - Determining the priority population status; is the client:
      - Pregnant.
      - Pregnant injecting drug user.
      - Injecting drug user.
      - Parents of children who have been or are at-risk of being removed from their home.
  - Provide information regarding confidentiality to all clients.
  - Provide information regarding recipient rights to all clients.
  - Obtain/ensure completion of a signed release of information based on individual client circumstance(s).
- Enrollment.
  - Collection of identifying information and essential demographic data.

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- Initial authorization or denial of service.
  - Authorization to receive an assessment/service at the determined LOC and at the provider chosen by the client.
  - If the client is not eligible or does not require services, referral and/or linkage to an appropriate service/provider to meet identified needs.
  - Notification of rights to grievance and appeal.

### *Clinical Functions*

There are four components to the clinical requirements when a client presents for service: triage, screening, LOC determination, and referral for services.

1. Triage.
  - Risk assessment.
  - Determination of situation as crisis, urgent or routine.
2. Screening for substance use disorders, mental health problems, and co-occurring disorders.
3. Level of care determination.
  - Determination of medical necessity.
  - Provisional diagnostic impression using all five axes of the current version of the DSM of Mental Disorders.
  - LOC determination using ASAM PPC - 2<sup>nd</sup> Edition, Revised (ASAM PPC-2R).
    - Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
    - Dimension 2 – Biomedical Conditions and Complications.
    - Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
    - Dimension 4 – Readiness to Change.
    - Dimension 5 – Relapse, Continued Use or Continued Problem Potential.
    - Dimension 6 – Recovery Environment.
4. Service referral.
  - Provide information on available programs to assist the client with an informed choice.
  - Referral to the selected service or program.
  - Linkage to other needs that may be identified during the screening process, such as physical and primary health care, housing, food, vocational/academic, self-help groups, childcare, child welfare, mental health, legal, employment, transportation, and communicable disease.

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### *Ongoing Administrative Functions*

The AMS has the responsibility to perform and maintain documentation of the following ongoing administrative functions relative to access management:

- Capacity management – It must assure all services are available for the full 12 months of the fiscal year; monitor provider capacity to accept new clients; and adjust the service mix consistent with demand and funding.
- Service authorization/reauthorization based on ASAM PPC-2R.
  - Initial service authorization.
  - Continuing stay reviews.
  - Notification of rights to grievance and appeal procedures.
- Utilization review – assuring that level of care determinations are accurate and making necessary recommendations for change.
- Quality assurance monitoring – can involve the review of services being received by clients at various levels of care to determine effectiveness and make necessary recommendations for change.
- Administrative oversight to timeliness, access, tracking clients between levels of care and follow-up to collect post-discharge information for outcome studies.
- Identify community-based service providers; develop referral or working relationships for the purpose of ensuring that a variety of client needs can be addressed.
- Care management for the efficient and effective use of resources.
- Public information regarding access to prevention, treatment, and recovery services.
- Ensure access to culturally competent/sensitive services.
- Ensure data related to the AMS function is accurate, timely, and complete. This includes quality improvement and/or other performance indicator data that must be collected and transmitted as required by MDCH/CA agreement.
- Provide customer service information.

### Waiting List and Priority Population Management

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements indicate that clients who are pregnant or injecting drug users have admission preference over any other client accessing the system and are identified as a priority population. Priority population clients must be admitted to services as follows:

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<b>Population</b>	<b>Admission Requirement</b>	<b>Interim Service Requirement</b>
Pregnant Injecting Drug User	<ul style="list-style-type: none"> <li>1) Screened and referred within 24 hours.</li> <li>2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.</li> </ul>	<p><i>Begin within 48 hours:</i></p> <ol style="list-style-type: none"> <li>1. Counseling and education on:                             <ul style="list-style-type: none"> <li>a) HIV and TB.</li> <li>b) Risks of needle sharing.</li> <li>c) Risks of transmission to sexual partners and infants.</li> <li>d) Effects of alcohol and drug use on the fetus.</li> </ul> </li> <li>2. Referral for pre-natal care.</li> <li>3. Early intervention clinical services.</li> </ol>
Pregnant Substance Use Disorders	<ul style="list-style-type: none"> <li>1) Screened and referred within 24 hours.</li> <li>2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.</li> </ul>	<p><i>Begin within 48 hours:</i></p> <ol style="list-style-type: none"> <li>1. Counseling and education on:                             <ul style="list-style-type: none"> <li>a) HIV and TB.</li> <li>b) Risks of transmission to sexual partners and infants.</li> <li>c) Effects of alcohol and drug use on the fetus.</li> </ul> </li> <li>2. Referral for pre-natal care.</li> <li>3. Early intervention clinical services.</li> </ol>
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	<p><i>Begin within 48 hours – maximum waiting time 120 days:</i></p> <ol style="list-style-type: none"> <li>1. Counseling and education on:                             <ul style="list-style-type: none"> <li>a) HIV and TB.</li> <li>b) Risks of needle sharing.</li> <li>c) Risks of transmission to sexual partners and infants.</li> </ul> </li> <li>2. Early intervention clinical services.</li> </ol>
Parent At-Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	<p><i>Begin within 48 business hours:</i></p> <ol style="list-style-type: none"> <li>1. Early intervention clinical services.</li> </ol>
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

It is the expectation that the CA provide services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity.

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The AMS is responsible for maintaining a waiting list by contacting clients who are placed on it every 30 days to check their status/well-being and continued interest in services until they are linked with the appropriate level of care. Attempts and contacts shall be documented to ensure that the list is properly maintained. Those clients who are not able to be contacted, or who do not respond after 90 days, may be removed.

Priority population clients placed on a waiting list are required to be offered interim services (see section 96.121 of the SAPT Block Grant). Interim services must minimally include:

- ◆ Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB).
- ◆ The risks of needle sharing.
- ◆ The risks of transmission to sexual partners, infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
- ◆ HIV or TB treatment service referrals.
- ◆ Counseling on the effects of alcohol and drug use on a fetus and referral for prenatal care are required for pregnant women.

Provision of these services, or the refusal of such, must also be documented for every priority client.

Coordination of Care with the Court System

The AMS must be able to utilize the substance use disorder screening information and treatment needs provided by district court probation officer assessments when the probation officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP). A release of information form must accompany the district court probation officer referral. The information provided by the probation officer should supply enough information to the AMS to apply ASAM PPC to determine LOC and referral for placement. In situations where information is not adequate, the release of information will allow the AMS to contact the district court probation officer to obtain other needed information. The AMS must be able to authorize these services based on medical necessity, so CA funds can be used to pay for treatment.

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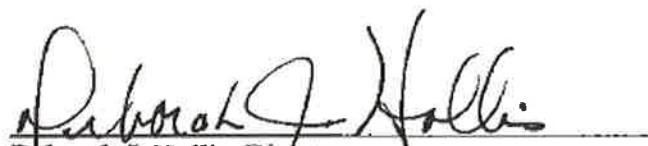
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**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**TREATMENT POLICY # 08**

**SUBJECT: SUBSTANCE ABUSE CASE MANAGEMENT PROGRAM REQUIREMENTS**

**ISSUED:** January 1, 2008

**EFFECTIVE DATE:** January 1, 2008

**PURPOSE:**

The purpose of this policy is to establish requirements for Case Management (CSM) programs.

**SCOPE:**

Coordinating Agency (CA) substance abuse provider network.

**BACKGROUND:**

The substance abuse administrative rules were changed July 5, 2006. These changes resulted in case management becoming a licensable program category. In October 2006, Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP) provided the field with a technical advisory on the different types of case management models to assist programs in making a decision on the type of CSM programs that can be utilized based on the needs of the population within their region.

**REQUIREMENTS:**

The definition of case management contained in Administrative Rule 325.14101(g) is as follows:

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

The action plan guideline (APG) has established the requirement of having a CSM program available in each CA region by September 30, 2009. To ensure that each CA and their providers develop an identifiable case management program and satisfy APG requirements, the following must be incorporated in the development of CSM services process:

1. The program must be identifiable and distinct within the agency's service configuration.

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2. The agency must offer or purport to offer the case management services as a separate and distinct program among any other program services that may be offered.

### Eligibility

In addition to the client agreeing to participate in CSM services, at least one of following criteria must be present in order for the client to be eligible for CSM services:

1. Client has a documented need in at least one domain involving community living skills, health care, housing, employment/financial, education or another functional area in that person's life.
2. Client has a demonstrated history of recovery failure with or without recovery support services.
3. Client has a substance use disorder involving a primary drug of choice that will require longer-term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants).
4. The chronicity and severity of the client's disorder is such that ongoing support is needed to increase the probability of recovery (such as years of use and first involvement with treatment, or a co-occurring mental health disorder is present with substance use disorder).

A client who is receiving CSM services from another CSM service or program (mental health, child welfare, justice system etc.) is not eligible for substance use disorder CSM services regardless of the criteria met above. Also, a client who has needs that could be met through another CSM service, for which the client qualifies, is not eligible for substance use disorder CSM services. In situations where it is determined that the client's needs cannot be met, authorization for concurrent enrollment can be provided by the CA on a case-by-case basis. In these situations, there must be coordination with the other program to ensure that specific services are not duplicated.

Clients can receive CSM services when they are involved in other levels of care if it is determined to be a necessary adjunct to the current services. CSM services can also be provided as a step-down from a more intensive level of treatment and can be provided as a stand-alone service if eligibility requirements are met. CSM services are designed to provide the client with support to maintain recovery during the transition from formal treatment services to self-sustained recovery, but are also designed to assist in providing additional support while the client is receiving services in the initial period of treatment.

### Minimum Service Expectations

There are many functions and/or activities that a case management program can be engaged in to provide services to clients. Although many of the functions of case management programs will be established at the local level, the following functions for a case management program are being established as the minimum expectations:

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1. The ability to link and/or refer clients to support services depending on the needs and functioning level of clients.
2. The provider must be able to serve as an advocate to assist and/or represent the client and his/her needs with other agencies or service providers. This may include but is not limited to serving as the “voice” of the client in situations where the client is unable to effectively represent himself/herself, accompanying clients to appointments, assisting with completion of forms or meeting other requirements the client may have to secure support/services, making appointments for clients, or ensuring follow-through of appointments. The level and intensity of involvement should be dependent on the individual client.
3. Ability to see clients in their community or the capability for face-to-face client interaction outside of the office setting.
4. The CSM provider must be able to monitor and continually assess the changing functional and social needs of clients as they progress through recovery and document this information as required.
5. The CSM programs must be able to work with a treatment team if needed.
6. Case management services must be based on an individualized treatment or recovery plan and have the ability to provide, or refer for, crisis intervention.

It is not permissible for CSM providers to incorporate both service provision and service authorization/re-authorization responsibility for their own clients. Authorizations must be distinct from CSM functions and should be completed through a separate process that is independent of providing case management services to the client.

### CSM Program Categories

Treatment Technical Advisory (TA) #03: *Implementing Case Management Services* identified four types of case management models that have been shown to be effective in helping clients with recovery from substance use disorders. In the TA, licensing requirements were not established for each model. To further clarify the requirements and expectations for CAs and providers developing a case management program funded through the MDCH-CA contract agreement, the models are reviewed below and licensing requirements for the CA provider network CSM programs have been established for each model:

1. **The Broker/Generalist:** This model identifies clients' needs and assists clients to access resources. Service planning or areas of needed assistance may be limited to contacts with the case manager and would not require development of an intensive long-term relationship. Clients who receive this type of CSM service typically do not have multiple needs and are able to access and utilize other resources more independently than clients who receive case management services under the other models. The case manager advocacy role is less intensive than other CSM service models. Essentially, the case manager provides the client with the information and provides assistance with access to other services and supports, and the client is

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responsible for follow through. The case manager assesses and monitors follow-through, but less intensive support is needed by the client.

The ability for the case manager to be able to work with the client outside the office and in the client's environment is required but interventions within the office are appropriate given the higher functioning level of the clients. Therapeutic services, beyond resource acquisition, are not provided under this model and, if needed, the client is referred to an appropriate source for the service or referred back to the primary treatment provider if these services are being provided as an adjunct to another level of care. Crisis intervention services are limited to providing assistance with acquiring resources. Any clinical or mental health crisis interventions are provided by previously identified providers in the community. The development of social support networks for the client, a function of the other models of CSM, is not a part of this model.

- Possession of a Screening, Assessment, Referral and Follow-up (SARF) only license is permitted for programs that will be strictly providing this model only. A treatment license is not required as long as services meet the CSM Administrative Rule definitions. A service category license for case management programs for persons with substance use disorders is required.
- 2. **Strengths-Based Perspective:** The two principles of this model are 1) providing clients support for asserting direct control over the search for resources; and 2) assisting clients in examining their own strengths and assets as the vehicle for resource acquisition. This model encourages the use of informal helping networks, promotes the importance of the client-case manager relationship, and provides an active, aggressive form of outreach. This model has been used with the substance abuse population because of 1) the usefulness of helping the client access resources for recovery; 2) the strong advocacy component; and 3) the emphasis on helping clients identify their strengths, assets, and abilities.

Services in this model include therapeutic interventions like therapy or skills teaching for clients and/or their significant others, when these are needed to assist with the recovery process. Crisis intervention services are provided as a part of this model as well. In keeping with the concept of building the client-case manager relationship, services in this model generally take place in the community or the client's environment in contrast to an office based setting.

- A treatment license is required in addition to the case management service category license to provide this type of program.
- 3. **Assertive Community Treatment:** Utilizes a team model to provide services to clients. This model also provides services in the community and clients are sought out by the team for contact. The chronic nature of substance abuse is acknowledged with the purpose of modifying the course of the condition and alleviating suffering.

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Abstinence is not an expectation of participation. Typically, this model is set up for relatively long-term involvement with clients due to the chronic nature of the population served and maintains ongoing contact with the client to assist with recovery. This model is fundamentally similar to the mental health Assertive Community Treatment (ACT) program and services design except for the composition of the team and the type of credentialed staff providing the service. The team composition is at local discretion.

- A treatment license is required in addition to the case management service category license to provide this type of program.
- 4. **Clinical/Rehabilitation:** This model involves combining therapy and case management services. In this way, all of the client needs are addressed through a single program. This can be described as having a single clinician serve as a therapist and as the case manager. This model serves clients that have been identified as having many needs and functional impairments but are not so severe that an ACT program is required. These clients have the ability to make many decisions for themselves in regards to treatment issues as well as the level of CSM intervention and advocacy needed.

Whereas in the previous models, getting the clients involved in services and programs to meet identified needs is the main focus, there is equal focus on the therapeutic interventions and activities that are provided in this model. Services are provided in the community in the client's environment and this is the distinguishing factor between this service and standard outpatient care that takes place in an office setting.

The following conditions must be in place in order for this type of program to meet the established CSM requirements:

1. The program must have a distinct component of integrated CSM and clinical services
  2. Distinct eligibility criteria must be in place regarding client qualifications for the program
  3. The program must meet the minimum service expectations of a CSM program
  4. Clients are able to continue in the program even after the therapeutic needs are addressed but functional needs remain.
- A treatment license is required in addition to the case management service category license to provide this type of program.

### Care Management/Care Coordination

This service is designed to support CA resource allocation as well as service utilization. Agencies engaged in care coordination monitor and/or assist with referrals and assess associated barriers to service utilization by the client. Care Management/Care Coordination is considered to represent treatment episode management. Care management or care

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coordination, an allowable administrative expenditure service under Medicaid, is an administrative function performed at the CA or through the access system. Care management recognizes that some clients represent such service or financial risk to the organization that closer monitoring of the individual case is warranted. Involvement in care management services does not preclude the client from being involved in CSM services as the two programs have separate and distinct functions. However, services must be coordinated, collaborative and unduplicated.

The CA or access system provider may implement care management at any time.

**Women's Specialty Services**

Women's specialty services, required as part of the Federal Substance Abuse Prevention and Treatment block grant, are commonly referred to as "case management" services. However, the requirements of 1) providing or arranging primary medical care for women, including prenatal care, and child care while women are receiving such services; 2) providing or arranging primary pediatric care and immunizations for the children of women in treatment; and 3) providing sufficient transportation to ensure that women and their dependent children have access to the previously mentioned services, do not meet the expectations that ODCP has established for case management services as defined in the administrative rules. The services under the women's specialty requirements are considered care coordination but can be provided as part of a case management program.

**REQUIRED REPORTS:**

None unless otherwise specified in the MDCH-CA agreement.

**PROCEDURE:**

None specified for establishing a CSM program.

**REFERENCES:**

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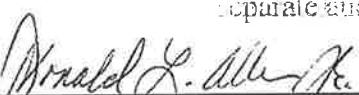
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*Treatment Policy #3: Buprenorphine. Michigan Department of Community Health, Office of Drug Control Policy, 2006.*

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Separate and distinct jurisdictions. How

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Medicaid Managed Specialty Supports and Services Program FY 15  
Attachment PII B.A. Substance Abuse Disorder Policy Manual



STATE OF MICHIGAN

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**DATE:** June 20, 2008

**TO:** Regional Coordinating Agencies  
Outpatient Treatment Continuum of Services Workgroup

**FROM:** Donald L. Allen, Jr., Director  
Office of Drug Control Policy

**SUBJECT:** Treatment Policy #09: *Outpatient Treatment Continuum of Services*

Attached is the final version of the Michigan Department of Community Health (MDCH), Office of Drug Control Policy (ODCP) Treatment Policy #09: *Outpatient Treatment Continuum of Services*. This policy was sent to all coordinating agencies and the Outpatient Treatment Continuum of Services Workgroup on February 28, 2008 with a review period of 60 days. St. Clair County Community Mental Health, Mid-South Substance Abuse Commission, Riverhaven Coordinating Agency, Southeast Michigan Community Alliance (SEMCA) and Lakeshore Coordinating Council submitted comments that were utilized in the finalization of the policy.

This policy is effective immediately and full cooperation is expected.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
OFFICE OF DRUG CONTROL POLICY**

**TREATMENT POLICY #09**

**SUBJECT:** Outpatient Treatment Continuum of Services

**ISSUED:** February 20, 2008

**EFFECTIVE:** June 20, 2008

**PURPOSE**

The purpose of this policy is to establish the requirements for outpatient services that endorse use of American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria and to ensure that services are individualized and culturally, age and gender appropriate.

**SCOPE**

This policy impacts the coordinating agency (CA) and its outpatient LOC service provider network.

**BACKGROUND**

Outpatient treatment includes a wide variety of covered services with the expectation that authorizations for these services are individualized to the needs of the client. Throughout the outpatient LOC, assessment, treatment plan and recovery support preparations are required as they must be included in the authorized treatment services. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. The ASAM levels correspond with planned hours of services, in a group and/or individual setting during a week and as scheduled with the client.

Historically, services have been described as follows:

- Outpatient – treatment that may be offered in a variety of settings, but often takes place in an office-type setting. Can include group and/or individual therapy services.
- Intensive Outpatient – treatment that often takes place in an office-type setting, but can be offered in other settings, and consists of a minimum of nine hours, maximum of 19 hours of services per week. Services include individual, group and interactive education-(didactic) type services.
- Enhanced Outpatient – similar to intensive outpatient service because it also offers expanded hours per week, but with a greater emphasis on individualized treatment to meet the client's needs.

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- Ambulatory Detoxification – detoxification that does not take place in a continuously monitored program/setting.

The frequency and duration of outpatient treatment services are expected to be guided by the ASAM LOC and are referred to as follows:

**ASAM Level 0.5 Early Intervention** – These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the client's motivation to change and other risk factors that may be present.

**ASAM Level I.0 Outpatient** – Services are less than nine hours during a week.

**ASAM Level I-D Ambulatory Detoxification Without Extended On-Site Monitoring** – Services are not established by hours but are set up to effectively monitor/educate an individual going through the detoxification process. Medical monitoring is at a minimum.

**ASAM Level II.1 Intensive Outpatient** – Services 9-19 hours in a week. The services are provided at least three days a week to fulfill the minimum nine-hour commitment.

**ASAM Level II-D Ambulatory Detoxification With Extended On-Site Monitoring** – Services are not established by hours but must be sufficient to effectively monitor/educate an individual going through the detoxification process. Medical monitoring is more routine to determine impact of withdrawal.

**ASAM Level II.5 Partial Hospitalization** – Services that are provided 20 or more hours in a week. (Hospitalization is used as a descriptor by ASAM. It is not meant to indicate that the service must take place in a hospital setting.)

ASAM levels of care describe the need for treatment from the perspective of weekly service intensity based on the needs of the client. The identification of these needs is intended to drive service selection and authorization for care. The determination of service intensity, within outpatient services, is based on the client's ASAM LOC determination; not the designation of the provider program as being early intervention, outpatient, intensive outpatient, or partial hospitalization. For purposes of treatment episode data set (TEDS) admission reporting, LOC may be established on the basis of the authorization for service rather than service participation.

Definitions

**Bundled Services** – Are an approach to treatment that ties multiple covered services together and provides them in a single treatment setting. Specific activities are not differentiated in billing or reimbursement.

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**Counseling** – An interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

**Interactive Education (didactic)** – Refers to services that are designed or intended to teach information about addiction and/or recovery skills.

**Medical Necessity** – Treatment that is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

**Psychotherapy (therapy)** – The assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (from Social Work Administrative Rules).

**Recovery** – A voluntarily maintained lifestyle comprised of sobriety, personal health and socially responsible living.

**Substance Use Disorder** – A term inclusive of substance abuse and dependence that also encompasses problematic use of substances that does not meet the criteria for substance abuse or dependence.

**Unbundled Services** – An approach to treatment that seeks to provide the appropriate service or combination of specific services to match the needs of a client. Billing and reimbursement is specific to the service provided.

## **REQUIREMENTS**

CAs must have the capacity to provide an outpatient continuum that will meet the needs of clients at all ASAM levels of intensity. Outpatient care is defined as treatment services that are provided in a setting that does not require the client to have an overnight stay at a facility as part of the treatment service but involves regularly scheduled sessions. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week, but when medically necessary can total over 20 hours in a week. The combination of days and hours and nature of services is based on the client's needs. A program director is responsible for the overall management of the clinical program and appropriate, credentialed and certified staff members provide treatment.

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Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include age, gender, culture and development. Authorization decisions regarding length of stay (including continued stay), change in LOC and discharge, must be based on the ASAM patient placement criteria. Client participation in referral and continuing care planning must occur prior to transfer or discharge.

continuing care

Outpatient care may be provided only when the service meets all of the following criteria:

- Medical necessity;
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders is used to determine an initial diagnostic impression of a substance use disorder, abuse or dependence (also known as provisional diagnosis) – the diagnostic impression must include all five axes;
- Is based on individualized determination of need; and,
- ASAM Patient Placement Criteria are used to determine substance use disorder treatment placement/admission and/or continued stay needs and are based on a LOC determination using the six assessment dimensions of the current ASAM Patient Placement Criteria below:
  - 1) Withdrawal potential.
  - 2) Medical conditions and complications.
  - 3) Emotional, behavioral or cognitive conditions and complications.
  - 4) Readiness to change.
  - 5) Relapse, continued use or continued problem potential.
  - 6) Recovery/living environment.

Outpatient treatment services are appropriate for those clients with minimal or manageable medical conditions; minimal or manageable withdrawal risks; emotional, behavioral and cognitive conditions that will not prevent the client from benefiting from this level of care; services must address treatment readiness; minimal or manageable relapse potential; and, a minimally to fully supportive recovery environment. Clients who continue to demonstrate a lack of benefit from outpatient services, whether they are actively or sporadically involved in their treatment, may be referred to the Access Management System (AMS) for another level of care determination and discharged if the client is unwilling to accept other services appropriate to their level of care determination. Relapse alone is not sufficient justification to discharge a client from treatment but it does indicate that a change in treatment services may be needed.

**Covered Services**

The following services can be provided in the outpatient setting:

**Individual Assessment** – A face-to-face service for the purpose of identifying functional and treatment needs; and, to formulate the basis for the Individualized Treatment Plan to be implemented by the provider. *Note: By September 30, 2008, assessment will no longer be a*

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*covered service if it takes place at a centralized CA Access Management setting or one that does not also provide licensed treatment services. Time limited waivers to this requirement may be requested of the Office of Drug Control Policy (ODCP).*

**Individual Treatment Planning** Refers to the direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

**Individual Therapy** – Face-to-face interventions with the client.

**Group Therapy** – Face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling.

**Counseling** – Face-to-face intervention (by non-professional staff) with a client, for the purpose of goal setting and achievement and skill building.

**Interactive Education (didactic) Groups** – Activities that center on teaching skills to clients and are necessary to support recovery. These groups can be lead by non-masters prepared staff.

**Family Therapy** – Face-to-face interventions with the client and significant other and/or traditional or non-traditional family members. *Note: In these situations, the identified client need not be present for the intervention.*

**Crisis Intervention** – A service for the purpose of addressing problems/issues that may arise during treatment, which could result in the client requiring a higher LOC if intervention is not provided.

**Referral/Linking/Coordinating of Services** – Office-based service activity performed by the primary clinician to address needs identified through the assessment, and/or ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

**Recovery Support and Preparation** – Services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

**Compliance Monitoring** – For the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program (i.e., onsite testing such as pbt's or non-laboratory urinalysis).

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**Early Intervention** – Treatment services for individuals with substance use disorders and/or individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use. Services may be initiated at any stage of change but are expected to be stage-based.

**Detoxification/Withdrawal Monitoring** – For the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

**Substance Abuse Outpatient Program** – Programs that are individualized and include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation and treatment based on medical necessity. These may include individual, group and family treatment. These services are billed under the “H” code sequence.

*Note: The Substance Abuse Outpatient Program is the ‘bundled’ outpatient category while the above are various optional services within outpatient programs.*

## PROCEDURE

### Admission Criteria

Outpatient services must be authorized based on the number of hours and/or types of services that are medically necessary. Re-authorization or continued treatment must take place when it has been demonstrated that the client is benefiting from treatment but additional covered services are needed for the client to be able to sustain recovery independently.

Re-authorization of services can be denied in situations where the client has not been actively involved in their treatment or engaging in behavior that is deemed to violate the rules and regulations of the program providing services. This is evidenced as repeatedly missing appointments, not participating/refusing to participate in treatment activities, patients present a risk of harm to self or others, or a demonstrated lack of benefit from treatment. Progress notes must support lack of benefit and that other, appropriate services have been offered.

The services provided in the outpatient setting can be provided through a bundled substance abuse outpatient program or in an unbundled manner. The CA may decide if services in their region will be bundled or unbundled. Regardless of how services are purchased by the CA, services must be based on the individual needs of the client and services must be individually tailored to the client’s needs.

### Additional Programs Within the Outpatient Category

The 2006 Administrative Rule Revisions add new program categories of Early Intervention, Peer Recovery/Recovery Support Services, and Case Management for persons with substance use disorders and Integrated Treatment for persons with substance use disorders

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and mental health disorders. Services provided in this program setting must be licensed under the appropriate treatment setting for the specific category and when the following conditions are met:

- Must meet the threshold of a 'program.'
- Must be identifiable and distinct within the agency's service configuration.
- The agency must offer or purport to offer the service (program) category as a distinct service. That is, a client may be admitted only to the program category without additional outpatient services in place (i.e., case management, peer recovery).

Outpatient programs may incorporate services such as recovery support, early intervention, information and referral/linking/coordinating if these are offered in the context of the program and do not meet the three conditions outlined above.

In the outpatient LOC, clients may benefit from additional supportive services and may participate in case management, integrated treatment or recovery support services concurrently. However, concurrent participation in early intervention services is not allowed.

Caseload requirements and staffing ratios must be within the established licensing criteria [Part 7, R 325.14701, 701(1)]; however, these decisions must also be made with consideration to the needs and characteristics of the clients being served.

**Medication Assisted Treatment**

Covered services for methadone and pharmacological supports and laboratory services, as required by Office of Pharmacological Alternative Treatment/Center for Substance Abuse Treatment (OPAT/CSAT) regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include:

- Methadone medication.
- Suboxone.
- Nursing services.
- Physical examination.
- Physician encounters.
- Laboratory tests.
- TB skin test (as ordered by physician).

Opiate-dependent patients may be provided chemotherapy using medication as an adjunct to therapy. This service takes place in an outpatient capacity and provisions of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in the state of Michigan.

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- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be licensed as such by the state and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration of a program.
- An MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist must administer methadone.
- Michigan Department of Community Health (MDCH)/Office of Drug Control Policy (ODCP) Treatment Policy #05 - *Enrollment Criteria for Methadone Maintenance and Detoxification Program* (attached to the MDCH/prepaid inpatient health plan (PIHP) contract) must be followed.

### Early Intervention

A specifically focused treatment program including stage-based intervention for individuals with substance use disorders or, problems related to substance use, as identified through a screening or assessment process. These individuals may or may not meet the threshold of a diagnosis of abuse or dependence of a substance.

To meet medical necessity criteria, an early intervention program must:

- 1) Screen and assess for the presence of a substance use disorder.
- 2) Be required to identify or evaluate a substance use disorder.
- 3) Be intended to treat, diminish or stabilize the symptoms of a substance use disorder.
- 4) Be expected to arrest or delay the progression of a substance use disorder.
- 5) Be designed to assist the client to attain or maintain a sufficient level of functioning in order to achieve the goal of recovery.

Early intervention treatment must be based on individualized treatment planning, provided by an appropriately credentialed substance abuse professional, and sufficient to assist the client in their recovery. This does not prohibit or restrict prevention programs from providing services within the Problem Identification and Referral strategy and/or through the allocation for prevention services.

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To distinguish between problem identification and referral offered by prevention programs and early intervention treatment programs, see below:

<b>Prevention–Problem Identification and Referral</b>	<b>Treatment- Early Intervention</b>
Screening for substance use disorders may be <b>population based or individual</b> .	Screening for substance use disorders at <b>individual level</b> .
No diagnosis is made.	<b>Assessment required</b> ; diagnosis may be provisional.
Program may include substance use interventions in addition to or in context of other services.	Individual treatment plan; a goal for recipient program participation is minimal requirement.
Participants not <b>determined</b> to meet substance abuse or dependence thresholds.	Participants not <b>required</b> to meet substance abuse or dependence thresholds.
Purpose of service may be larger and/or <b>designed to increase protective and/or decrease risk factors</b> .	Purpose of program is to provide <b>clinical intervention</b> appropriate to the individual and their stage of change.

Peer Recovery/Recovery Support Services

Recovery support programs that are designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery. These services are provided on an individual basis (through recovery coaches) or through a centralized location where services can be accessed by clients (through recovery centers):

**Recovery coach** – The position title given to a peer that provides recovery support services to individuals in formal treatment or during the post-treatment period.

**Recovery center** – Location in which recovery programming is designed and delivered, primarily by individuals in recovery, and house services that offer social, emotional and/or educational support to help prevent relapse and promote recovery.

Minimum Requirements for Peer Recovery and Recovery Support Programs are:

- Programs must promote and support the recovery of the participant
- Services must be included in the individual's recovery plan
- Ethics and confidentiality training for program leadership is required
- The CA must assure appropriate training of staff and peer leaders, and must assure program oversight based on guidelines established for developing this service (Treatment Technical Advisory #07)

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- Community grant agreement funds cannot be used for services and costs that are not otherwise allowable under federal and state guidelines
- Community grant agreement funds cannot be used for recreational events

### Case Management Services

A substance use disorder case management program 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. It offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

### Integrated Treatment Services

These services are accommodated by a program design that offers and provides both substance use disorder and mental health treatment in an integrated manner as evidenced by staffing, services and program content. The program is designed for individuals determined through an assessment process to have both distinct substance use and mental health disorders. Services must be provided through one service setting and through a single treatment plan and represent appropriate clinical standards including stage-based interventions.

Programs that focus primarily on one disorder but are able to address the interaction between the disorders and/or coordinate services with other providers do not require a service category license as an integrated treatment program and are not viewed as providing integrated treatment services.

### REFERENCES

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**APPROVED BY:**

  
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**Michigan Department of Community Health, Behavioral Health and Developmental Disabilities Administration**  
**BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

**TREATMENT POLICY #10**

**SUBJECT:** Residential Treatment Continuum of Services

**ISSUED:** May 3, 2013

**EFFECTIVE:** May 3, 2013

**PURPOSE:**

The purpose of this policy is to establish the requirements for residential services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

**SCOPE:**

This policy impacts the coordinating agency (CA) and its adult residential LOC service provider network.

**BACKGROUND:**

Residential treatment includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They do indicate, however, that ten hours of scheduled activities, with two of those hours being formalized counseling, must take place each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Patient Placement Criteria Second Edition – Revised (ASAM PPC-2R), and the stages-of-change models that have been developed. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM, and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential care.

Throughout the current residential level of services assessment, treatment planning, and recovery support preparations are required, and must be included in the authorized treatment services. Historically, residential services have been defined by length-of-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services:

- Short-term residential: less than 30 days in a program
- Long-term residential: 30 days or more in a program

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This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

### Definitions

**Toxicology Screening** - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

**Core Services** - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the “Covered Services” section for further information.

**Counseling** - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

**Crisis Intervention** - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

**Detoxification/Withdrawal Monitoring** - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

**Face-to-Face** - this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

**Facilitates Transportation** - assist the client, potential client, or referral source in arranging transportation to and from treatment.

**Family Counseling** - face-to-face intervention with the client and their significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

**Family Psychotherapy** - face-to-face, insight-oriented interventions with the client and their significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

**Group Counseling** - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

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**Group Psychotherapy** - face-to-face, insight-oriented interventions with three or more clients.

**Individual Assessment** - face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

**Individual Counseling** - face-to-face intervention for the purpose of goal setting and achievement, and skill building.

**Individual Psychotherapy** - face-to-face, insight-oriented interventions with the client.

**Individual Treatment Planning** - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

**Interactive Education** - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

**Interactive Education Groups** - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

**Medical Necessity** - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

**Peer Support** - individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another in a treatment setting.

**Psychotherapy** - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other biopsychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (MDLARA, Michigan Administrative Code, Social Work General Rules).

**Recovery** - a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, 2007).

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**Recovery Planning** - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

**Recovery Support and Preparation** - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

**Referral/Linking/Coordination of Services** - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

**Substance Use Disorder** - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

**REQUIREMENTS:**

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short and long-term descriptors will no longer be used to describe residential services. Coordinating agencies will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels III.1, III.3, and III.5. The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

**ASAM Level III.1 – Clinically Managed Low-Intensity Residential Services**

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

**ASAM Level III.3 – Clinically Managed Medium-Intensity Residential Services**

These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly,

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cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

**ASAM Level III.5 – Clinically Managed High-Intensity Residential Services**

These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily rehabilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

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<b>Level of Care</b>	<b>Level III.1</b>	<b>Level III.3</b>	<b>Level III.5</b>
<b>Dimension 1</b> Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level I-D or Level II-D	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D	At minimal risk of severe withdrawal at Levels III.3 or III.5. If withdrawal is present, it meets Level III.2-D criteria
<b>Dimension 2</b> Medical conditions and complications	None or very stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring
<b>Dimension 3</b> Emotional, behavioral, or cognitive conditions and complications	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits	Demonstrates repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client
<b>Dimension 4</b> Readiness to change	Open to recovery but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level III.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)	Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)
<b>Dimension 5</b> Relapse, continued use, or continued problem potential	Understands relapse but needs structure to maintain therapeutic gains	Has little awareness and needs intervention only available at Level III.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction	Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences
<b>Dimension 6</b> Recovery/living environment	Environment is dangerous, but recovery achievable if Level III.1 24-hour structure is available	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting

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### PROCEDURE:

#### Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis) – the diagnostic impression must include all five axes. The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM PPC-2R is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the current ASAM PPC-2R below:
  - 1) Withdrawal potential.
  - 2) Medical conditions and complications.
  - 3) Emotional, behavioral, or cognitive conditions and complications.
  - 4) Readiness to change – as determined by the Stages of Change Model.
  - 5) Relapse, continued use or continued problem potential.
  - 6) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM PPC-2R. As a client's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

#### Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

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<b>Level of Care</b>	<b>Minimum Weekly Core Services</b>	<b>Minimum Weekly Life Skills/Self Care</b>
<b>ASAM III.1</b> Clients with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
<b>ASAM III.3</b> 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
<b>ASAM III.5</b> 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

### Covered Services

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

<b>Type</b>	<b>Residential Services Description</b>
<b>Basic Care</b>	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.
<b>Treatment Basics</b>  <u>Core Service</u>	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'.
<b>Therapeutic Interventions</b>  <u>Core Service</u>	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.
<b>Interactive Education /Counseling</b>  <u>Core Service</u>	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.
<b>Life Skills/Self-Care (building recovery capital)</b>	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.
<b>Milieu/Environment (building recovery capital)</b>	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.

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### **Treatment Planning/Recovery Planning**

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

### **Continuing Stay Criteria**

Re-authorization or continued treatment should be based on ASAM PPC-2R Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.

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APPROVED BY:

  
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Michigan Department of Community Health, Mental Health & Substance Abuse Administration  
**BUREAU OF SUBSTANCE ABUSE & ADDICTION SERVICES**

**SUBSTANCE ABUSE TREATMENT POLICY # 12**

**SUBJECT:** Women's Treatment Services

**ISSUED:** September 30, 2010

**EFFECTIVE:** October 1, 2010

**PURPOSE:**

The purpose of this policy is to establish the philosophy and requirements for women's treatment services (designated women's programs and gender competent programs).

**SCOPE**

This policy impacts the coordinating agency (CA), its designated women's programs, and gender competent service provider network.

**BACKGROUND**

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment and ancillary services for eligible women. Eligible women have been defined as, "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." (42 U.S.C. 96.124 [e])

Pregnant women are identified as a priority population under the SAPT Block Grant regulations. Michigan Public Act 368 of 1978, part 62, section 333.6232, identifies "a parent whose child has been removed from the home under the child protection laws of this state or is in danger of being removed from the home under the child protection laws of this state because of the parent's substance abuse," as a priority population for substance use disorder services above others with substantially similar clinical conditions.

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

In August 2008, the National Association of State Alcohol and Drug Abuse Directors and the Women's Services Network (WSN), comprised of representatives from all 50 states, produced a document for the field entitled, *Guidance to States: Treatment Standards for Women with Substance Use Disorders*. This document is based on the knowledge and experience of the WSN

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members. Its purpose is to improve substance use disorder treatment services to women through the establishment of standards that build on the capabilities, strengths and creativity of state systems and provider networks.

To be able to offer services that are gender and culturally competent, it is important to understand the client and their environment, and embrace values that promote the best services possible to the population. Successful recovery for women requires that the service delivery system integrates substance use disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery.

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes a woman's development in terms of the range of relationships in which a woman can engage. This is very different from the theories of emotional growth, which have been the basis of substance use disorder treatment, and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

### Vision

To implement a change in the practice of women's substance use disorder treatment providers and system transformation in Michigan. This will be accomplished by having a strength-based coordinated system of care, driven by a shared set of core values that is reflected and measured in the way we interact with, and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

### Core Values

- ♦ Family-Centered: A family centered approach means that the focus is on the family, as defined by the client themselves. Families are responsible for their children and are respected and listened to as we support them in working toward meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single

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client represented in a system, to a focus on the functioning, safety and well being of the family as a whole.

- ♦ Family Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions made about their service plans. It is important to recognize that a woman defines her own family and that this definition may not be traditional.
- ♦ Build on Natural and Community Supports: Recognize and utilize all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the family's relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- ♦ Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the family's needs. Strengths should also be found in the family's environment through their informal support networks, as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge, with strategies discussed and implemented.
- ♦ Unconditional Care: Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family – not of the family to adapt to the needs of a program. If difficulties arise, the individualized services and supports change to meet the family's needs.
- ♦ Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance use disorder, mental health, child welfare and other identified systems collaborate and coordinate a single system of care for families involved within their services.
- ♦ Team Approach Across Agencies: Planning, decision-making and strategies rely on the strengths, skills, mutual respect, and creative and flexible resources of a diversified, committed team. Team member strengths, skills, experience and resources are utilized to select strategies that will support the family in meeting their needs. Team members may include representatives from the multiple agencies a family is involved in, as well as any who offer support and resources to families. All family, formal and informal team

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members share responsibility, accountability, and authority; while understanding and respecting each other's strengths, roles and limitations.

- ◆ Ensuring Safety: When Children's Protective Services, foster care agencies, or domestic violence shelters are involved, the team will maintain a focus on family and child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible and whether the safety services in place are effectively controlling those threats. In situations involving domestic violence, the team will need to work with the family to develop and maintain a viable safety plan.
- ◆ Gender/Age/Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity and sexual orientation, and also reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- ◆ Self-sufficiency: Families will be supported, resources shared and team members held responsible for achieving self-sufficiency in essential life domains (including, but not limited to safety, housing, employment, financial, educational, psychological, emotional and spiritual).
- ◆ Education and Work Focus: Dedication to positive, immediate and consistent education, employment and or employment-related activities that result in resiliency and self-sufficiency, improved quality of life for self, family and the community.
- ◆ Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.
- ◆ Outcome Oriented: From the onset of family team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports, are discussed, agreed upon and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety and other applicable mandates are considered in developing outcomes. Progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable and based on the life of the family and its individual members.

## DEFINITIONS

Care Management/Care Coordination: An administrative function performed at the CA or through the access system, allowable under Medicaid, which manages an episode of care.

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

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

Gender Competent: Capacity to identify where difference on the basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender-Responsiveness (Designated Women's Program): Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women and girls, and that addresses and responds to their strengths and challenges. (Bloom and Covington, 2000)

## REQUIREMENTS AND PROCEDURE

The Michigan Department of Community Health (MDCH) is dedicated to the following fundamental principles as the foundation for integrating women-specific substance use disorder treatment services and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

### Developing a Philosophy of Working with Women who have Substance Use Disorders

#### Program Structure:

1. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.
  - ◆ Gender-responsive programs are not simply “female only” programs that were designed for males.
  - ◆ A woman’s sense of self develops differently in women-specific groups as opposed to co-ed groups.
  - ◆ Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman’s identity.
  - ◆ Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.

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- ◆ The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
  - ◆ Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.
2. A relational model, based on the psychological growth of women shall be the foundation for recovery (e.g., the Self-in-Relation model). The recognition that, for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. (Surrey, 1985)
- ◆ A model that emphasizes the importance of relationships in a woman's life, and attempts to address the strengths as well as the problems arising for women from a relational orientation.
3. A collaborative philosophy, driven by the woman and her family, shall be used.
- ◆ Utilizing cross-systems collaboration and the involvement of informal supports to promote a woman's recovery.
  - ◆ A client-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
    1. assessing needs, resources and priorities,
    2. planning for how the needs can be met,
    3. establishing linkages to enhance a woman's access to services to meet those identified needs,
    4. coordinating and monitoring service provision through active cross-system communication and coordinated treatment/service plans, and
    5. removing barriers to treatment and advocating for services.
  - ◆ A woman's needs determine the connections with agencies and systems that impact her life or her family's life, despite the number of agencies or systems involved.
  - ◆ Ideally, each woman will have a single, collaborative treatment plan or service plan used across systems. When this is not possible, coordination of as many systems as possible will lessen the confusion and stress this creates in a woman's life.
  - ◆ Care coordination and case management are the key to a woman's progress in recovery.
4. A model of empowerment is utilized in treatment and recovery planning.
- ◆ The client is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
  - ◆ This process is woven into recovery, and could be taught by a recovery coach or case manager.
  - ◆ The ultimate goal for the service system is to weave the woman so well into the informal support systems that the role of formal services is very small or not needed at all.

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5. Employment is recommended as an important component in recovery and serves as an important therapeutic tool.
  - ◆ The structure of work is a benefit to recovery, and treatment providers need to be aware of the work requirements of Temporary Assistance for Needy Families/Work First. Historically, treatment providers have been reluctant to encourage clients to return to work or engage in work related activities during the early stages of recovery. However, waiting to address employment concerns may create further challenges for the client facing Work First requirements.
6. A multi-system approach that is culturally aware shall be employed in the recovery process.
  - ◆ Gender specificity and cultural competence go hand-in-hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable people of and from the community.

Education/Training of Staff:

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, of gender specific substance use disorder training or 2080 hours of supervised gender specific substance use disorder training/work experience within a designated women's program. 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.

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.

Appropriate topics for gender specific substance use disorder training include, but are not limited to:

- ◆ Women's studies
- ◆ Trauma
- ◆ Grief
- ◆ Relationships
- ◆ Parenting
- ◆ Child Development
- ◆ Self-esteem/empowerment
- ◆ Relational treatment model
- ◆ Women in the criminal justice system
- ◆ Women and addiction

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Admissions:

Coordinating agencies and treatment providers must follow the priority population guidelines identified in the MDCH/BSAAS contract with coordinating agencies, listed below, for

admitting women to treatment:

Population	Admission Requirement	Interim Service Requirement
<u>Pregnant Injecting Drug User</u>	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	<b>Begin within 48 hours:</b> 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 pre-natal care. 3. Early Intervention Clinical Services.
<u>Pregnant with Substance Use Disorder</u>	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	<b>Begin within 48 hours:</b> 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 pre-natal care. 3. Early Intervention Clinical Services.
<u>Injecting Drug User</u>	Screened and referred within 24 hours. Offer admission within 14 days.	<b>Begin within 48 hours – maximum waiting time 120 days:</b> 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.
<u>Parent at Risk of Losing Children</u>	Screened and referred within 24 hours. Offer admission within 14 days.	<b>Begin within 48 business hours:</b> Early Intervention Clinical Services.
<u>All Others</u>	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	<b>Not Required.</b>

\* The full table can be found in the MDCH/BSAAS contract with coordinating agencies.

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The admission standards listed above should be considered minimum standards. Those CAs and programs interested in providing the best possible treatment to families should be meeting a higher standard for admission and interim service provision.

**Treatment:**

Programs that are designed to meet women's needs tend to be more successful in retaining women clients. For a provider to be able to offer women-specific treatment, its programs shall include the following criteria:

**1. Accessibility**

CAs and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.

- ◆ There are many barriers that may critically inhibit attendance and follow-through for women with children. They may include child care, transportation, hours of operation and mental health concerns.

**2. Assessment**

Assessment shall be a continuous process that evaluates the client's psychosocial needs and strengths within the family context, and through which progress is measured in terms of increased stabilization/functionality of the individual/family. In addition, all assessments shall be strength-based.

- ◆ Women with children need to be assessed and treated as a unit. Women often both enter and leave treatment because of their children's needs. By assessing the family and addressing areas that need strengthening, providers give women a better chance at becoming stable in their recovery.

**3. Psychological Development**

Providers shall demonstrate an understanding of the specific stages of psychological development and modify therapeutic techniques according to client needs, especially to promote autonomy.

- ◆ Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness and "learned helplessness," particularly as they operate in relationships with their children and significant others.

**4. Abuse/Violence/Trauma**

Providers must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed setting and provide safety from abuse, stalking by partners, family, other participants, visitors and staff.

- ◆ A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent women. A provider who does not take this history into consideration when treating the woman is not fully addressing the addiction or resulting behaviors.

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5. Family Orientation

Providers must identify and address the needs of family members through direct service, referral or other processes. Families are a family of choice defined by the clients themselves. Agencies will include informal supports in the treatment process when it is in the best interest of the client.

- ◆ Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and developmental problems. Early identification and intervention for the children's problems is essential.

6. Mental Health Issues

Providers must demonstrate the ability to identify concurrent mental health disorders, and develop a process to have the treatment for these disorders take place, in an integrated fashion, with substance use disorder treatment and other health care. It is important to note that treatment for both mental health issues and substance use disorders may lead to the use of medication as an adjunct to treatment.

- ◆ Women with substance abuse problems often present with concurrent mood disorders and other mental health problems.

7. Physical Health Issues

Providers shall:

- ◆ inquire about health care needs of the client and her children, including completing the Fetal Alcohol Syndrome Disorder screening as appropriate (MDCH/BSAAS Treatment Policy #11, 2009),
- ◆ make appropriate referrals, and
- ◆ document client and family health needs, referrals, and outcomes.
  - Women with a substance use disorder and their children are at high risk for significant health problems. They are at a greater risk for communicable diseases such as HIV, TB, hepatitis and sexually transmitted diseases. Prenatal care for women using/abusing substances is especially important, as their babies are at risk for serious physical, neurological and behavioral problems. Early identification and intervention for children's physical and emotional growth and development, and for other health issues in a family is essential.

8. Legal Issues

Providers shall document each client's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will individualize treatment in such a way as to help a client manage compliance with legal authorities.

- ◆ Women entering treatment may be experiencing legal problems including custody issues, civil actions, criminal charges, probation and parole. This adds another facet to the treatment and recovery planning process and reinforces the need for case management associated with women's services. By helping a woman identify her legal issues, steps that need to be taken, and how to incorporate this information into goals for her

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individualized treatment plan, a provider can greatly reduce stress on the client and make this type of challenge seem more manageable.

### 9. Sexuality/Intimacy/Exploitation

Providers shall:

- ◆ conduct an assessment that is sensitive to sexual abuse issues,
- ◆ demonstrate competence to address these issues,
- ◆ make appropriate referrals,
- ◆ acknowledge and incorporate these issues in the recovery plan, and
- ◆ assure that the client will not be exposed to exploitative situations that continue abuse patterns within the treatment process (co-ed groups are not recommended early in treatment, physical separation of sexes is recommended in residential treatment settings).
  - A high rate of treatment non-compliance among females with substance use disorders, with a history of sexual abuse, has been documented. The frequent incidence of sexual abuse among women with substance use disorders necessitates the inclusion of questions specifically related to the topic during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

### 10. Survival Skills

Providers must identify and address the client's needs in the following areas, including but not limited to:

- ◆ Education and literacy.
- ◆ Job readiness and job search.
- ◆ Parenting skills.
- ◆ Family planning.
- ◆ Housing.
- ◆ Language and cultural concerns.
- ◆ Basic living skills/self care.

The provider shall refer the client to appropriate services and document both the referrals and outcomes.

- ◆ Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process. Many of these problems may be addressed in the community, utilizing community resources, which will in turn help the client build a supportive relationship with the community.

### 11. Continuing Care/Recovery Support

Providers shall:

- ◆ develop a recovery/continuing care plan with the client to address and plan for the client's continuing care needs,
- ◆ make and document appropriate referrals as part of the continuing care/recovery plan, and

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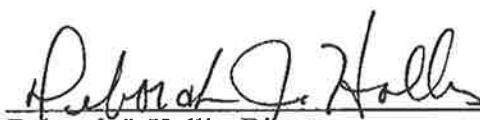
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- ◆ remain available to the client as a resource for support and encouragement for at least one year following discharge.
  - In order for a woman to maintain recovery after treatment, she needs to be able to retain a connection to treatment staff or case managers, and receive support from appropriate services in the community.

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