

**LAKESHORE REGIONAL ENTITY**  
**Substance Use Disorder Medication Assisted Treatment**

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

**1. Definition or Description of Service**

- a. Medication Assisted Treatment (MAT) and Opioid Treatment Services (OTS) are umbrella terms to define a set of organized and individualized treatment services for persons (a) diagnosed with an opioid use disorder and (b) with medical needs that include the use of an opioid agonist, partial agonist or full antagonist medications such as Methadone, Suboxone, and Naltrexone. Methadone and Suboxone are medications used to prevent withdrawal symptoms and opioid cravings while blocking the euphoric effects of opioid drugs while Naltrexone is a full opiate blocker. In doing so, these medications assist stabilizing the patient so that other components of evidence-based therapeutic services such as Cognitive Behavioral Therapy, Motivational Enhancement Therapy, Contingency Management, Trauma-Informed Care and care coordination can assist patients into recovery and increase their level of functioning.
- b. Agonist, partial agonist, or antagonist medications used in the treatment of opioid use disorders should be prescribed in the context of psychosocial supports and interventions to manage the patient's addiction.
- c. MAT should be considered a first line treatment for patients with opiate use disorders. Abstinence based treatment services, while not prohibited, should be considered after MAT has failed to assist the client. Addiction science shows that outcomes for patients with opiate use disorders who do not use MAT are significantly poorer and have much higher relapse and overdose rates.

**2. Practice Principles**

- a. The goal of MAT is to provide individuals with an opiate use disorder medication assisted treatment AND comprehensive medical, psychosocial, and addiction treatment that is co-occurring capable and staged-matched in a therapeutic environment that supports achievement of recovery. MAT programs will link and coordinate a patient's care and work with the patient to address all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. A patient's long term recovery may or may not include medication maintenance. Treatment is guided by what is achievable for the patient and results in a healthy lifestyle for him or her.
- b. The MAT program will assist in establishing physical and psychological stability in the individual's life. Opiate replacement medications will be dosed at a medically sound dosage. Once the individual has stabilized, the MAT treatment program may then work with the individual to stabilize their lives and develop recovery skills.
- c. All individuals enrolled in the MAT Program are expected to abstain from alcohol and other drugs. Continued use of alcohol and other drugs will result in assessing the individual's need for another level of care with or without MAT.
- d. Continued MAT participation will be determined by an evaluation of the individual's physical stability and progress attained on the individual's treatment plan assessed by Provider and the CMHSP.
- e. Individuals may be administratively detoxed from MAT if all other interventions have failed to assist the individual in their recovery program. The Medical Director decides upon an administrative detox and it is the Medical Director's responsibility to set the detoxification at a rapid, but medically sound rate. Administrative detox will be seen as a last resort for MAT individuals that are non-compliant with treatment expectations because MAT patients who are

administratively discharged have significantly worse outcomes than patients who remain in a MAT program.

- f. Co-occurring Disorders – In the MAT program co-occurring substance use and mental health disorders are the expectation and not the exception. The MAT provider will have therapists who are able to treat both disorders. The MAT provider will either provide psychiatric medication services or coordinate the patient’s psychiatric medication needs. Mental health therapeutic services must also be delivered and coordinated with the responsible payer.
- g. Motivating / Engagement with Patients – Services for MAT patients must be comprehensive and responsive to the needs of the patient. Services must be staged-matched and the use of motivational interviewing is a required competency for every therapist. Some of the most difficult MAT patients lack motivation to change, may have a co-occurring disorder and typically use other substances in addition to opiates. MAT services only relieves the withdrawal of opiates and does not provide any relief from the other substances the patient may be using. The MAT provider must address the other substance and work to motivate the patient to begin to reduce and end their use of other substances. In order to better engage with patients, services must match the patient’s needs and may be community-based, intensive in nature, and occur over time to gain the trust of the patient.
- h. Complex Care – Many patients who are appropriate for MAT treatment also have complex care needs with multiple chronic conditions both behavioral and physical. In order to best work with patients with multiple behavioral and physical health care needs the MAT provider must ensure that each patient has a primary care physician and that care is coordinated between physical health and behavioral health providers. For many patients there may be the need to work with the client for referral to physical health specialist to address ongoing pain issues, chronic headaches, and any other physical health issues that may affect the patient’s outcomes. Good coordination of care is vital to ensure that non-addictive medications are used, if possible, to address the patient behavioral and physical health needs.
- i. Discharge for Continued Substance Use – Patients should receive every chance to continue treatment and treatment should last as long as it is effective within MAT. Program effectiveness and progress may be determined by comparing a patient’s substance use and overall adjustment at admission with his or her current status. This means if a patient is reducing their use either by the amount of substance or the number of days used, they should remain in treatment because they are making gains. Progress should not be based only on drug tests and patients should understand that the ultimate goal is abstinence from illicit opiates and other illicit drug and alcohol.
- j. Overdose Protection – The risk for overdose for MAT patients is significant if the patient uses benzodiazepines, other opiates, or alcohol. The risk of overdose is greatly increased for patient who are being discharged from a correctional setting or are being discharged from the MAT program. To that end, for clients who enter MAT programs and/or are being discharge from MAT all patients must be provided with naloxone opiate overdose reversal kits.
- k. Provider/CMHSP/PIHP Partnership – The Provider will participate with the CMHSP and PIHP to work on emerging MAT treatment issues, treatment improvement initiatives, and keeping the CMHSP and PIHP aware of treatment issues as they occur.
- l. MAT providers must follow all of the below cited documents:
  - i. The Lakeshore Regional Entity (LRE) and its member CMHSPs support an approach to the treatment of opioid use disorders as described by the ASAM Public Policy Statement on Pharmacological Therapies for Opioid Use Disorder, included at the end of this document (retrieved 3/5/2015; available at: <http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2013/04/25/pharmacological-therapies-for-opioid-use-disorders>)
  - ii. statements/2013/04/25/pharmacological-therapies-for-opioid-use-disorders)
- m. The State of Michigan adopted the Medication Assisted Treatment Guidelines for Opioid Use Disorders in September 2014. The MAT services provided in the LRE (Region #3) will be expected to comply with the clinical parameters identified in those guidelines which have been

converted to the ACUITY and INTENSITY tables found on the last pages of this document. Original document available at: <http://www.lsre.org/>.

- n. Provision of Methadone and Suboxone Buprenorphine must comply with procedures and requirements as applicable in the following MDCH guidance documents (available at [http://www.michigan.gov/mdch/0,1607,7-132-2941\\_4871\\_4877-133156--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_4877-133156--,00.html)):
  - i. Treatment Recovery Policy #05, Criteria for Using Methadone for Medication-Assisted Treatment
  - ii. Recovery and Treatment Policy #04, Off-Site Dosing Requirements for Medication Assisted Treatment
  - iii. Technical Advisory #06, Counseling Requirement for Clients Receiving Methadone Treatment
  - iv. Treatment Policy #03, Buprenorphine
- o. Medicaid/Healthy Michigan Plans clients must use the Medicaid/Healthy Michigan Plans pharmacy benefit and procedures for the Suboxone® dose and the prescribing physician must be approved as a qualified prescriber. This benefit is not coordinated by the CMHSP.

### 3. Credentialing Requirements

- a. Provider facility must be a licensed Methadone substance abuse provider.
- b. Physicians must be federally licensed to dispense Methadone services. Ancillary staff need to possess addiction services certification. Physicians prescribing Buprenorphine must have a waiver from SAMHSA permitting them to prescribe or dispense.
- c. Professional staff must have a Master's degree in an approved field of behavioral health and meet the qualifications of a "Substance Abuse Treatment Practitioner" (SATS) per the "Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes" document available at [https://www.michigan.gov/documents/mdch/PIHP-MHSP\\_Provider\\_Qualifications\\_219874\\_7.pdf](https://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf).
- d. Master's level professional staff must also be credentialed by the [Michigan Certification Board for Addiction Professionals](#) as a CAADC, CADC, CCJP, or CCDP-D (or have a development plan for one of these credentials).
- e. Staff credentials are listed for each of the clinical functions below:
  - i. Clinical Interventions - For individual or group therapy not provided in the context of residential – Master's plus CAADC, CADC or CCS.
  - ii. Clinical Interventions - For clinical interventions provided in the context of residential – Bachelor's degree plus CAC: supervision by a Master's level clinician with 3 years' experience in direct treatment to the population.
  - iii. Didactic/Peer Support Interventions - CADC, CPS/CPC-R, Bachelor's with MAFE (Michigan Addiction Fundamentals Exam) or Recovery Coach and Master's level supervision.
  - iv. Case Management - Case Management services include linking, coordinating, monitoring, and follow-up of services – Recovery Coach, CADC and/or Bachelor's.
  - v. Care Coordination - Case Management extending beyond program services that includes individual therapy – Master's plus CAADC, CADC or CCS.
  - vi. Assessment and Diagnosis - Master's plus CADC, CAADC or CCS with Master's level supervision.
  - vii. Acupuncture may be performed by the following individuals: a) Medical Doctor, b) Doctor of Osteopathy, and 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 use disorder treatment.

- viii. Recovery Supports – The individual completed Recovery Coach Training in compliance with MDHHS requirements and is supervised by a Master’s prepared clinical supervisor.
  - ix. Clinical Supervision - Master’s plus CCS.
  - x. Master’s and Bachelor’s degrees must be behavioral health related.
- f. Provider is expected to have credentialing and supervision standards in place. Any requests for waiver will be submitted to the CMHSP which will review and respond to the request. As these standards are now being uniformly applied across the LRE region, providers with specific challenges in meeting these requirements with legacy staff should contact their contracting entity to discuss options for compliance.
- g. Interns may be involved in the treatment process, consistent with LRE standards.
- 4. Service Requirements** - Services provided to MAT program clients must comply with the provisions of Michigan’s Medicaid Manual, which incorporates the Healthy Michigan Plan and is available at <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>. The information contained in this description are drawn from the July 1, 2017 edition of the manual and are presented here for convenience. In all cases, the most current language of the Medicaid manual must be followed.

*[START OF MEDICAID MANUAL LANGUAGE]*

**12.2 TREATMENT (DPT/CSAT) APPROVED PHARMACOLOGICAL SUPPORTS**

**12.2.A. PROVISION OF SERVICES**

Opiate-dependent beneficiaries may be provided chemotherapy using methadone as an adjunct to a treatment service. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.
- 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;
  - certified by the Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT);
  - licensed by the Drug Enforcement Administration (DEA); and
  - accredited by a DPT/CSAT and state-approved accrediting organization (The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF)).
- Methadone must be administered by an appropriately-licensed MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist.

**12.2.B. COVERED SERVICES**

Covered services for Methadone and pharmacological supports and laboratory services, as required by DPT/CSAT regulations and the Administrative Rules for Substance Use Disorder Service Programs in Michigan, include:

- Methadone medication
- Nursing services

- Physical examination
- Physician encounters (monthly)
- Laboratory tests (including health screening tests as part of the initial physical exam, pregnancy test at admission, and required toxicology tests)
- TB skin test (as ordered by physician)

**12.2.C. ELIGIBILITY CRITERIA**

Medical necessity requirements shall be used to determine the need for methadone as an adjunct treatment and recovery service.

All six dimensions of the American Society of Addiction Medicine (ASAM) Criteria must be addressed:

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications.
- 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)
- Treatment acceptance/resistance
- Relapse/continued use potential
- Recovery/living environment

**12.2.D. 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 Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria.

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.

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 Treatment

**12.2.D.1. SPECIAL CIRCUMSTANCES FOR ADMISSIONS**

There are special circumstances for the admission of pregnant women, pregnant adolescents, and adolescents.

<p><b>Pregnant Women</b></p>	<ul style="list-style-type: none"> <li>• Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours.</li> <li>• Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an Opioid Treatment Program (OTP) provided the pregnancy is certified by the OTP physician and treatment is found to be justified.</li> <li>• For pregnant individuals, evidence of current physiological dependence is not necessary.</li> <li>• Pregnant opioid-dependent individuals must be referred for prenatal care and other</li> </ul>
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	<p>pregnancy-related services and supports, as necessary.</p> <ul style="list-style-type: none"> <li>• OTPs must obtain informed consent from pregnant women, and all women admitted to methadone treatment who may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice.</li> <li>• 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.</li> </ul>
<b>Pregnant Adolescents</b>	<ul style="list-style-type: none"> <li>• 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. (In Michigan, the relevant state authority is Children's Protective Services.) <ul style="list-style-type: none"> <li>○ A copy of this signed informed consent statement must be placed in the individual's medical record.</li> <li>○ 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.</li> </ul> </li> </ul>
<b>Non-Pregnant Adolescents</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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) consents, in writing, to such treatment.</li> <li>• Minors under 15 years of age must also have the permission of the State Opioid Treatment Authority and the Drug Enforcement Administration. (Refer to Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14409(5).) <ul style="list-style-type: none"> <li>○ A copy of this signed informed consent statement must be placed in the individual's medical record.</li> <li>○ 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. (Refer to 42CFR subpart 8.12(e)(2).)</li> </ul> </li> </ul>

### 12.2.E. MEDICAL MAINTENANCE PHASE

When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. The following criteria are to be considered 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 non-stabilized co-occurring disorders.

### 12.2.F. DISCONTINUATION/TERMINATION CRITERIA

Discontinuation/termination from methadone treatment refers to the following situations:

- Beneficiaries must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services.
- Beneficiaries may be terminated from services if there is clinical and/or behavioral noncompliance.
- If a beneficiary is terminated,
  - The OTP must attempt to make a referral for another LOC assessment or for placing the beneficiary at another OTP.
  - The OTP must make an effort to ensure that the beneficiary 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 beneficiary requires a "notice of action" be given to the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation.

Services are discontinued/terminated either by Completion of Treatment or through Administrative Discontinuation. Refer to the following subsections for additional information.

#### **12.2.F.1. COMPLETION OF TREATMENT**

The decision to discharge a beneficiary must be made by the OTP's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

#### **12.2.F.2. ADMINISTRATIVE DISCONTINUATION**

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 OTP must work with the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) to explore and implement methods to facilitate compliance.

Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to:

- The repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).
- Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected.)

In both of the aforementioned circumstances, OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14406).

OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe.

- Repeated failure to submit to toxicology sampling as requested.
- Repeated failure 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 use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.)

The commission of acts by the beneficiary 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

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

- **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.
- **Enhanced Tapering Discontinuation** - This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10 percent 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 beneficiary.

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

***[END OF MEDICAID MANUAL LANGUAGE]***

Service Requirements in Addition to Medicaid

- a. Medication Detoxification: A client may receive methadone for the purposes of medication detoxification or maintenance, defined as the dispensing of drugs in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug. It is also used as a method of bringing the individual to a narcotic-free state within a specified period. There are two types of medication detoxification: 1) short-term detoxification is for less than thirty (30) days; and 2) long-term detoxification is for between 30 and 180 days
- b. Broad/Contextual
  - i. Provide co-occurring capable services in a welcoming environment.
  - ii. Focus treatment to include elimination of illicit opiate and other alcohol or drug use and stabilizing the individual's life.
  - iii. Linkage with the full continuum of substance use disorder treatment services that promote ongoing recovery from addiction.
  - iv. This benefit is not intended for clients with physical dependency to prescribed pain medications, or with short, infrequent, or low level opiate use histories.

- v. Hospital inpatient services cannot be purchased using MDHHS funding.
  - i. A client may be authorized to receive additional therapeutic services at another provider when appropriate based on ASAM criteria. Additional therapeutic services may be requested up to the amount allowable under the appropriate level of care. The client may receive therapeutic services at another provider when necessary. Coordination of Care will be required if multiple providers are serving a client.
- c. Clinical
- i. Provide integrated screening, data collection/reporting, assessment, and treatment planning.
  - ii. Possess the capability to for meeting the needs of individuals with co-occurring mental health and substance use disorder conditions. Provider must screen for the presence of mental health and substance use disorders, and provide an integrated assessment for all outpatient individuals.
  - iii. The ability to admit pregnant women who are eligible for the program within 24 hours.
  - iv. Individualized psychosocial treatment/services and/or interventions that are stage-matched with ongoing evaluation to meet changing needs and abilities, including referrals to alternative services as needed.
  - v. Each therapeutic episode must be documented in the individual's chart.
  - vi. Individuals in the MAT program will be expected to participate concurrently in another substance use disorder treatment as needed. This service must be provided by a licensed substance use disorder treatment provider.
  - vii. Provide and/or link vocational and educational services.
- d. Medical
- i. The program physician must evaluate an individual's mental and physical status every 60 days.
  - ii. Provider will maintain a log that contains a listing of each individual in treatment and the dosages of the medications provided to each individual by the program. This log will be reviewed in site visits.
  - iii. Daily medication visits within a structured program.
  - iv. Detoxification/taper treatment services.
  - v. Linkage with or provision of psychological, medical, and psychiatric consultation.
  - vi. Linkage with or provision to emergency medical and psychiatric affiliations with more intensive levels of care, as needed.
  - vii. Linkage with or provision of evaluation and ongoing primary medical care.
  - viii. Coordinate treatment with the primary health care provider and other community resources.
  - ix. Conduct or arrange for appropriate laboratory and toxicology tests.
  - x. Physicians to evaluate, prescribe, and monitor use of Methadone, Suboxone, or naltrexone, and nurses and pharmacies to dispense and administer Methadone, Suboxone, or naltrexone.
  - xi. Licensed medical, nursing or pharmacy staff are available to administer medications in accordance with the physician's prescriptions or orders.
  - xii. Intensity of nursing care is appropriate to the services provided by an outpatient treatment program that uses Methadone.
  - xiii. Physician available during medication dispensing and clinic operating hours, either in person or by telephone.
- e. Financial
- i. Treat individuals with Medicare.
  - ii. At least every 6 months the program must reassess the financial status of individuals and adjust the sliding fee scale if necessary. CMHSP should be informed of any change in an individual's financial status.

- f. Regulatory
  - i. Adhere to all applicable regulations and requirements set forth in the Medicaid Provider Manual.
  - ii. Provide services in a licensed setting by an individual credentialed in accordance to state law and regulation and federal regulations FDA 21 CFR Part 291.
  - iii. Adherence to all State and Federal laws and guidelines as they pertain to MAT treatment including but not limited to the following:
    - (1) United States Code, (2001) CFR 21, Part 291, Section 510-505, Drugs Used for Treatment of Narcotic Addicts, Washington D.C.
    - (2) United States Code, (2001) CFR 42, Part 8, (2001) Section 8.1-8.34, Certification of Opioid Treatment Programs, Washington D.C.
    - (3) Methadone Treatment and other Chemotherapy, Michigan Administrative Code, Rule 325.14401-325.14423
- g. Communicable Disease - Screening and Testing:
  - i. All individuals must be screened at assessment for risk of TB, STD, HIV, and Hepatitis in a manner that is consistent with the MDHHS Best Practice.
  - ii. If the screen identifies high-risk behavior, the individual must be referred for testing.
  - iii. Referral for testing is required for the following populations:
    - (1) Hepatitis C for all individuals with history of IDU.
    - (2) STD and HIV testing for all pregnant women.
  - iv. Mandatory TB testing for all individuals entering residential treatment within 48 hours of admission.
  - v. Referral agreements with Communicable Disease testing sites.
  - vi. Method for ensuring that the agency to which the individual has been referred has the capacity to accept the referral.
  - vii. Protocol for linking infected individuals with appropriate treatment/support resources.
  - viii. Protocol for recording the screening, referral, and linking activities in the individual's file.
  - ix. Completion of the Communicable Disease reporting requirements as specified by the MDHHS.
- h. Health Education and Risk Reduction:
  - i. All individuals who are identified as having high risk behaviors must receive Health Education and Risk Reduction services delivered by a qualified provider.
  - ii. Health Education and Risk Reduction services must be documented in the individual's file.
- i. Staff Capability:
  - i. A Training Plan to provide program staff with Level I Training, delivered by a qualified provider.
  - ii. A Training Plan to provide treatment staff with Level II Training, delivered by a qualified provider.
  - iii. Documented evidence of the implementation of the Training Plan.
- j. Fetal Alcohol Spectrum Disorder (FASD):
  - i. FASD prevention information must be provided to men and women in all substance use disorder treatment programs.
  - ii. For any treatment program that serves individuals with children, it is required that the program complete the FASD Pre-Screen for children they interact with during the treatment episode. In the event a child has a positive pre-screen, a referral must be made to a Fetal Alcohol Diagnostic Clinic.
- k. Michigan Mission-Based Performance Indicator System Access Requirements:
  - i. Persons requesting a screening for eligibility must be seen within 14 days from the request for service.

- ii. Persons determined to be eligible for CMHSP ongoing services must be seen within 14 days of the date of determination.
  - iii. Persons discharged from detoxification services must be seen within 7 days for follow-up.
  - iv. Persons discharged from psychiatric inpatient services must be seen within 7 days for follow-up.
- l. Treatment Guidelines Grid – The grid found at the end of this service description is derived from the State of Michigan’s MAT Guidelines. Services for MAT must be provided according to this grid; providers must ensure that both group and individual services are provided.

**5. Training Requirements**

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the individual’s plan of services prior to delivery of service.

**6. Eligibility Criteria**

- a. Individuals served must have an opiate dependence, reflected in a primary, validated, DSM V diagnosis.
- b. Individuals served must meet ASAM Criteria for this service.
- c. Individuals served must have been continuously dependent for at least one (1) year before admission or enrollment. Note: The DSMV distinguishes substance related disorders from non-pathological substance use and from use of medications for appropriate medical purposes. The CMHSP will respond to requests from individuals requesting MAT services for pain management by corresponding with the individual’s primary care physician for the prescription of the necessary pain medications and recommend other treatment options available within the LRP region substance abuse treatment continuum. Individuals seeking Methadone for the expressed purpose of pain control and not for substance abuse treatment for addiction to opioid drugs should not be referred into a MAT program.
- d. Individuals served must meet MDHHS Treatment Policy #05 Criteria for Using Methadone for Medication-Assisted Treatment and Recovery. Although clients who have been addicted to opioid drugs for one year or more may be eligible for substance use disorder treatment using MAT as an adjunct, it is not mandated that they be placed in such a program. All substance use disorder treatment levels of care are to be considered based on ASAM criteria.
- e. A client who is between 16 and 18 years of age is required to have had two documented unsuccessful attempts at short-term detoxification or drug free treatment within a 12-month period to be eligible for Methadone maintenance treatment.
- f. Individuals with a co-occurring Mental Illness and Substance Use Disorder are eligible and welcomed in this service.
- g. The individual served within the MAT program must, through assessment, meet the diagnostic criteria for Opioid Use Disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or other standardized and widely accepted criteria, aside from those exceptions listed in the Federal Register of the Department of Health and Human Services, Food and Drug Administration, 21 CFR Part 291.
- h. In instances where the presenting alcohol/other drug history is inadequate to substantiate such a diagnosis, but there is a high degree of probability of a diagnosis, Provider may consider material submitted by other health care professionals, programs, collaterals (such as family members, legal guardians, etc.) and may conduct further evaluation.
- i. Individuals admitted to treatment with Methadone must demonstrate specific objective and subjective signs of opiate dependence, as defined in FDA 21 CFR Part 291.

## 7. Access Requirements

- a. Priority Populations – Provider will prioritize services for the following populations (below). Admission time line standards will be met as stated in the contract. For pregnant women, if Provider cannot provide services within 24 hours, the individual will be referred back to the CMHSP and then referred to an alternative service provider.
  - i. Pregnant Women-Injecting Drug Users – if the opiate use is significant, please refer to MAT services. If opiate use is not significant, detox can be commenced.
  - ii. Pregnant Women
  - iii. Injecting Drug Users who have injected drugs in the past 30 days
  - iv. Parents whose children have been removed from the home under the Child Protection Laws of this State or are in danger of being removed from the home because of the parents' substance abuse
  - v. All others

## 8. Authorization Procedures

- a. For authorization of MAT Services, eligible individuals will receive a screening by CMHSP staff. If the ASAM criteria for MAT Services is met, a referral is made to the attending physician at the provider site, for the completion of the medical assessment. Once the physician completes the medical assessment and believes MAT Services are appropriate, CMHSP staff will authorize this service.
- b. All individuals referred from the CMHSP will participate in the process of determining goals and outcomes that are expected from the treatment. The CMHSP clinician will determine the appropriate type/number of services authorized.
- c. Provider will use CMHSP-approved criteria to obtain access for services.
- d. Provider will provide the CMHSP the following material within two business days of the start of service:
  - i. Patient registration form
  - ii. Signed physician's documentation of addiction
  - iii. State admission form
  - iv. Behavioral Health TEDS data
- e. Provider will use CMHSP-approved criteria to determine if the individual needs other additional services authorized.
- f. MAT provider must notify the CMHSP of any client discharge.
- g. Individuals who have not had any treatment activity in a 30-day period shall be considered inactive and their case discharged. A substance use disorder discharge treatment form should be completed and submitted; the effective date of discharge would be the last date of actual contact with the program. The record should be completed and submitted based on the individual's status as of the last contact. If the individual's case is to remain open and they have not been seen within 30 days, there must be a documented clinical rationale in the individual's chart to support this decision.
- h. All CMHSP-sponsored review and funding authorizations will follow the current MDHHS Enrollment Criteria for Methadone Maintenance and Detoxification Program and MDHHS Technical Advisory: Counseling Requirement for Clients receiving Methadone guidelines, in addition to ASAM DSM-V assessment and diagnosis criteria.
- i. Meeting admission criteria does not ensure funding approval. The CMHSP will determine eligibility based on likelihood of successfully meeting the criteria and no other complicating factors that would indicate the need for a more intensive level of treatment.
- j. Prior authorization is required for medication supported services with the exception of pregnant clients presenting for MAT.
- k. When pregnant clients present for MAT an authorization request must be submitted within twenty-four (24) hours of admission to ensure eligibility and provide retroactive authorization for

that first day and any subsequent days. Proof of pregnancy must be collected by the Provider prior to admission and documentation placed in the client's records.

- I. CMHSP shall pay for MAT services when the individual is served and authorized accordingly:
  - i. Provider will fill out the Client Admission form and submit to CMHSP.
  - ii. Provider will notify CMHSP when an individual has been discharged from the program.
  - iii. Outpatient therapy provided by a licensed substance abuse outpatient provider will follow the authorization for this level of care.
  - iv. At the time of authorization and any reauthorization Provider will verify and document in the individual's file the individual's eligibility for CMHSP services and the individual's financial status which includes Medicare and/or Medicaid status, commercial insurance/Medicaid status, and the individual's ability to pay.
  - v. Services will be authorized initially on a 90-day basis. If the client is stable as evidenced by the patient's attendance in treatment and clean urine screens services may be authorized for up to 180 days.
  - vi. Reauthorization decisions will be based on ASAM and best practice standards. If approved, the authorization will begin on the date the request was received by CMHSP.

**9. Relevant Forms**

- a. Michigan's Medicaid Manual, which incorporates the Healthy Michigan Plan (<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>)
- b. Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes ([https://www.michigan.gov/documents/mdch/PIHP-MHSP\\_Provider\\_Qualifications\\_219874\\_7.pdf](https://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf))
- c. ASAM Public Policy Statement on Pharmacological Therapies for Opioid Use Disorder, Adopted April 24, 2013, <http://www.asam.org/docs/default-source/public-policy-statements/pharmacological-therapies-for-opioid-use-disorder-2013-04-24.pdf?sfvrsn=4>.

Level of Care will be matched to the acuity of symptoms and severity of disease (adapted from p. 33 of the MAT Guidelines):

ACUITY TABLE				
Acuity of Illness	DSMV Criteria for Opioid Use Disorder	Treatment Setting	Behavioral Service Content and Intensity	Medication Guidelines
Mild	2 to 3	Outpatient	<ul style="list-style-type: none"> <li>Weekly for 4 weeks then bi-weekly for 2 months then monthly for 12 months</li> <li>Contingency Management, CBT</li> <li>Self-Help/12-step (weekly for 6 months)</li> </ul>	<b>Buprenorphine</b> or <b>Naltrexone</b> <ul style="list-style-type: none"> <li>&lt;300 morphine equivalents</li> <li>Oral or intranasal abuse</li> <li>Start 4 to 8 mg daily</li> </ul> <ul style="list-style-type: none"> <li>&lt;300 morphine equivalents</li> <li>Oral intranasal abuse</li> <li>Start 50mg daily</li> </ul>
Moderate	4 to 5 (or 2 to 3 with COD)	Outpatient	<ul style="list-style-type: none"> <li>Intensive outpatient (IOP) or</li> <li>Weekly for 4 weeks then bi-weekly for 12 months</li> <li>Contingency Management, CBT</li> <li>Self-Help/12-step (weekly for 6 months)</li> <li>Sobriety coach / mentor / CHW</li> </ul>	<b>Buprenorphine</b> or <b>Naltrexone</b> <ul style="list-style-type: none"> <li>&lt;300 morphine equivalents</li> <li>Oral, intranasal or IV abuse</li> <li>Start 8 to 16 mg daily</li> </ul> <ul style="list-style-type: none"> <li>Oral, intranasal or IV abuse</li> <li>Start 50mg daily</li> </ul>
Severe	6 or more (or 4 to 5 with COD)	Outpatient/Inpatient	<ul style="list-style-type: none"> <li>Intensive outpatient (IOP) or</li> <li>Weekly for 8 weeks then every 2 weeks for 4 months then monthly for 18 months</li> <li>Contingency Management, CBT, DBT skills</li> <li>Self-Help/12-step</li> <li>Sobriety coach/mentor/CHW</li> </ul>	<b>Methadone</b> or <b>Buprenorphine</b> or <b>Depo-Naltrexone</b> <ul style="list-style-type: none"> <li>Start 20-40mg per day based on daily use</li> <li>Titrate to level that stabilizes craving and withdrawal (80-120mg)</li> </ul> <ul style="list-style-type: none"> <li>&lt;300 morphine equivalents</li> <li>Oral, intranasal or IV abuse</li> <li>Start 8 to 16 mg daily</li> </ul> <ul style="list-style-type: none"> <li>Detox prior</li> <li>Oral, intranasal or IV abuse</li> <li>Start 380 IM monthly</li> </ul>

**Intensity of Service will be matched to the phase of treatment, including track considerations (adapted from p34 of the MAT Guidelines):**

**Note:** Relapse at any point should begin a reassessment and placement back in Rehabilitative phase or Acute phase if relapse is extensive. Additional outreach services should also be considered for additional support

<b>INTENSITY TABLE</b>				
<b>PHASE</b>	<b>Goals</b>	<b>Clinical Activities</b>	<b>Criteria for Movement to Next Phase</b>	<b>Intensification Options</b>
<b>Acute</b>	<ul style="list-style-type: none"> <li>• Achieve withdrawal from all substances</li> <li>• Reduce/manage craving</li> <li>• Eliminate/reduce ongoing illicit drug use</li> <li>• Establish treatment plan</li> <li>• Meet basic needs</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral and Medication services as described in the Acuity table.</li> <li>• Complete comprehensive biopsychosocial assessment</li> <li>• Physical evaluation (including pain)</li> <li>• Initiate Methadone, Buprenorphine or Naltrexone</li> <li>• Develop comprehensive COD-capable treatment plan</li> <li>• Home visit</li> <li>• Referral for any medical needs</li> <li>• Case management to address basic needs</li> <li>• Initiate SUD treatment at least 1-2 times per week (individual/group therapy, motivational interviewing)</li> <li>• Coordinate care with all relevant providers (including corrections)</li> </ul>	<ul style="list-style-type: none"> <li>• No longer in withdrawal</li> <li>• Reduced/manageable craving</li> <li>• Elimination/reduction in other drug use</li> <li>• Treatment plan developed</li> <li>• Basic needs satisfactorily met</li> </ul>	<p><b>Individualized intensification of behavioral services described in the Acuity table.</b></p> <p><b>Assertive Community Treatment:</b> SUD outreach based treatment for patients who continue to use illicit drugs/stop showing up for dosing. Can begin at any point of the process. Can also be when client relapse/taper off. Service generally for non-adherence</p>
<b>Rehabilitative</b>	<ul style="list-style-type: none"> <li>• Discontinue drug and alcohol use</li> <li>• Initiate services in specialty track if indicated               <ul style="list-style-type: none"> <li>○ Co-Occurring</li> <li>○ Pregnant</li> <li>○ Emotive Regulation – DBT Skills</li> <li>○ Corrections</li> </ul> </li> <li>• Stabilize medical issues</li> <li>• Stabilize mental health issues</li> <li>• Stabilize source of legal income</li> <li>• Stabilize family issues</li> <li>• Stabilize legal issues</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral and Medication services as described in the Acuity table.</li> </ul>	<ul style="list-style-type: none"> <li>• Drug and alcohol use discontinued</li> <li>• Specialty track services established</li> <li>• Medical issues stable</li> <li>• Mental health issues stable</li> <li>• Legal income source established</li> <li>• Family issues stabilized</li> <li>• Legal issues stabilized</li> </ul>	<ul style="list-style-type: none"> <li>• Assertive Community Treatment: SUD outreach based treatment for patients who continue to use illicit drugs/stop showing up for dosing.</li> <li>• Can begin at any point of the process.</li> <li>• Can also be when client relapse/taper off.</li> <li>• Service generally for non-adherence</li> <li>• Reassessment and placement back in Acute phase (if relapse is extensive). Additional outreach services should also be considered for additional support</li> </ul>

INTENSITY TABLE				
PHASE	Goals	Clinical Activities	Criteria for Movement to Next Phase	Intensification Options
<b>Supportive</b>	<ul style="list-style-type: none"> <li>Client assumes primary responsibility for his/her life.</li> <li>Treatment continues at reduced intensity.</li> <li>Client begins to shift or augment program support to support groups, social supports, community, faith based groups, healthy friends, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Behavioral and Medication services as described in the Acuity table.</li> <li>Ongoing Case Management: Using a mixture of office-based and outreach-based linking, coordinating, referring (no time limit)</li> </ul>	<p>If to Maintenance Phase:</p> <ul style="list-style-type: none"> <li>2 years' stability with alcohol and drug use</li> <li>All other treatment plan issues are stable</li> <li>Relapse prevention check-ups set up quarterly</li> <li>Taper not successful or patient not ready</li> <li>Maintenance clients may request to Taper if fully stable if the client has an interest but must be fully stable</li> </ul> <p>If to Tapering Phase: (MW – unless administratively triggered, conversation about tapering should not initiated by the MAT provider)</p> <ul style="list-style-type: none"> <li>All treatment issues stable and client/program agree taper or discontinue MAT</li> <li>Taper plan completed with client and medical/clinical</li> <li>Treatment/outreach intensified during end of taper and 90 days post discontinuation of MAT</li> <li>If disease worsens and is not stabilized by behavioral interventions, then restart MAT</li> </ul>	<ul style="list-style-type: none"> <li>Reassessment and placement back in Rehabilitative Phase (or Acute if relapse is extensive).</li> <li>Additional outreach services should also be considered for additional support Rehabilitative phase</li> </ul>