STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and Substance Abuse Coordinating Agencies (CAs)

FROM: Patrick Barrie, Deputy Director
Mental Health and Substance Abuse Administration

Donald Allen, Director
Office of Drug Control Policy

SUBJECT: Additional Information on Reporting Integrated Mental Health and Substance Abuse Services

This information is being provided in response to questions received on our February 16, 2007 memo regarding "Use of Encounter Code Modifiers for Integrated Mental Health and Substance Abuse Services."

General questions:

1. What date can we begin using the modifiers?

Use of the HH modifier was approved with the issuance of the memo on February 16, 2007. The HH TG modifier may be used after Michigan Department of Community Health (MDCH) approval of the Integrated Dual Diagnosis Treatment (IDDT) teams, as described in the memo.

2. Can MDCH clarify the proper assignment and funding for services provided to individuals who present with mild or moderate mental health conditions who are enrolled in a MHP, and have a co-occurring substance abuse condition?

Medicaid Health Plans are responsible for the Mental Health benefit of the Medicaid enrollees with a mild to moderate mental health condition, and the PIHP is responsible for the Medicaid Substance Abuse treatment.

3. How do PIHPs and CAs best serve people with co-occurring disorders who are eligible for care under the ABW and MIChild Programs?

Such individuals should be able to access care through both a Community Mental Health Services Program (CMHSP) and the Coordinating Agency (CA). Integrated care can be funded by either system or both systems when the individual meets CMHSP eligibility criteria for

mental health services and CA eligibility services for substance abuse services. When treating an Individual with co-occurring mental health and substance use disorders, both disorders are considered primary.

4. What demographic encounter data should CMHSPs and CAs use for persons who have co-occurring disorders and who have either ABW or MIChild insurance?

The local CMHSP and CA should have agreements on how to provide integrated care. The system that authorizes and pays for care is responsible for reporting. See the November 17, 2004 memo from Patrick Barrie on co-occurring disorder reporting and funding issues for more detail.

Questions applicable to services purchased with ODCP-administered funds:

5. When should the HH modifier be used in reporting Access Management System (AMS, formerly AAR) activities?

The HH modifier should only be used when reporting substance use disorder <u>treatment</u> services. The modifier should not be used for AMS activities such as screening and assessment. This is because ODCP requires that screening and assessment address substance use and mental health disorders.

6. Please clarify the conditions under which the HH modifier should be used for substance abuse treatment services.

We will state these conditions differently than in our February 16 memo in an attempt to clarify without changing the substance of the earlier memo. Here are the conditions that must be met to allow for the use of the HH modifier for substance abuse treatment encounters:

First, the provider must have an Integrated Treatment License. The provider must also meet any other standard criteria for being on a CA panel.

Second, it must be determined that the client has a substance use disorder and a mild or moderate mental health disorder. As always, the client must meet the CA's financial eligibility criteria.

And third, the services must be integrated: the treatment plan calls for integrated services, the services are provided within the same setting, etc. The services must be provided in a stage wise fashion.

7. Are CAs responsible for payment for any services provided in COD-IDDT programs?

No. These specialized services are designed for individuals with serious mental illness who also have substance use disorders and are expected to be provided in the mental health system.

Questions applicable to services purchased with public mental health funds:

8. Is it allowable to have a different group look at fidelity assessment other than the Michigan Fidelity Assessment Support Team (MIFAST), the state-approved fidelity assessment body?

It is the intent that all COD-IDDT fidelity reviews in Michigan be conducted by MiFAST. We will work with the two PIHPs that are presently using Wayne State University Project Care directly for these reviews to transition them to the use of MiFAST. Beginning October 1, 2007, it is expected that PIHPs utilize MiFAST for IDDT fidelity reviews.

9. Can MDCH clarify the criteria that must be met prior to our PIHP provider network using the HH TG modifier?

The "HH TG" modifier is intended for the SAMHSA-approved Evidence-Based Practice for Co-occurring Disorders: Integrated Dual Disorder Treatment only. Minimum criteria are listed in the February 16, 2007 memo on pages two and three. Department approval is required before the use of this modifier. Applications (attached) must be submitted to Tison Thomas at MDCH.

10. Will these code modifiers be separated in the MUNC, Sub-element, and SA Block Grant reports?

This has not been determined and is being referred to the EDIT group for consideration.

11. Related to screening, what does "formal process of testing" mean?

For a screening service to be reported with an HH modifier, it must include questions that are used with an individual to illicit any indication of possible substance use or mental health disorders.

12. How do we meet the requirement to show that an individual has a substance use disorder when reporting integrated services for that individual?

Before reporting integrated treatment services with an HH or HH TG modifier for an individual, the plan to address both disorders with one or more integrated services must be documented in the individual plan of service through the person-centered planning process The individual's QI record must be updated to reflect both mental health and substance use disorders within the time frame specified in the contract.

13. What does "ONE SETTING" mean? Does one setting mean the CMHSP and any of their sites, or does it literally mean a single setting like one office building? For instance, could an ACT consumer have an encounter coded with HH if they attended a group at the clinic center when the ACT office was located elsewhere in the community?

Developing integrated treatment capacity means that the system develops co-occurring disorder capability at a minimum. For the individual who enters the mental health system or substance abuse system, the services must appear seamless. We recognize that there are different funding streams, eligibility, and medical necessity requirements in CAs, CMHSPs and PIHPs. For example, an individual with a co-occurring disorder admitted to a substance abuse treatment program may not meet the CMH eligibility standard and vice versa. We are not mandating new eligibility to either the mental health or substance abuse system. Thus "ONE SETTING" implies one clinician or a team of clinicians who address both mental health and substance use conditions. An encounter may be coded "HH" only if that particular encounter is a service which is part of providing integrated treatment.

14. On page 4, the first bullet talks about the integrated assessment. If the substance use assessment done after the initial assessment for mental health disorders revealed the need for

a full assessment of substance use and the service is being done by the ongoing case manager as part of their bundled service, would the clinician code a T1016HH or T1017HH depending on whether the consumer was receiving Targeted Case Management or Supports Coordination?

If a bundled service includes integrated treatment, the HH modifier can be used for the entire service. MDCH may consider unbundling these services in the future.

15. On page 4, the second and third bullets refer to there being ONE integrated service plan for all the services being received. If there is a single plan, should every service being provided to that consumer have the HH modifier? Or would the HH modifier only be attached to a specific service focused on a goal around the co-occurring disorders? It seems obvious that a co-occurring group would have an HH modifier but if on the same integrated plan a consumer were also receiving community supports to go grocery shopping, would the CLS have an HH modifier as well?

It is desirable for individuals who have integrated service plans to have their primary services be integrated. It is possible that the service array may include services that are not intended to address both disorders. Such services are not to be reported with the HH modifier. An encounter may be coded "HH" only if that particular encounter is a service which is part of providing integrated treatment.

PB:DA:tj

Attachment

PIHP application for approval to use "HH TG" for reporting Evidence-Based Integrated Dual Disorder Treatment (IDDT) team

1. Name of the PIHP:	**2.** Contact person, address, email and phone number:

3. Name of the provider/program:	**4.** IDDT team start date:

5. Name of the team members, credentials and role on the team:

Team Leader _____

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

6. Please describe how you provide IDDT services. (ACT, Case Management, OP, etc.)

7. Trainings/consultations for the team to date:

8. On-site MiFAST review date and MiFAST team leader:	**9.** Any other fidelity reviews/self assessments dates/Assessors:

10. Integrated treatment license date: _____

If pending, date of application _____

PIHP Clinical Director Signature _____ Date _____

Submit the application to: **Tison Thomas, Service Innovation & Consultation Section, Division of Program Development Consultation & Contracts, Michigan Department of Community Health, 5th Floor Lewis Cass Bldg, 320 South Walnut Street, Lansing, Michigan 48913.**
email: thomasti@michigan.gov Phone: (517) 241-2616