

GENERAL MOTORS CORPORATION CARELINE
PROGRAM

AND

DELPHI CORPORATION MENTAL HEALTH &
SUBSTANCE ABUSE PROGRAM

CENTRAL DIAGNOSTIC & REFERRAL AGENCY

PROCEDURE MANUAL

Table of Contents

Section I Overview pages 4-18

- A. Introduction**
- B. Program Overview**
- C. Central Review Organization (CRO) Agency Overview**

Staff Description
Program Telephone Service Guidelines and Phone Numbers
CDR Contact Numbers
Program Telephone Service Guidelines
Program Telephone Services

- D. Central Diagnostic and Referral (CDR) Agency Overview**

Inter-CDR Case Transfer
Clinical Privileging of Staff
Appeal Procedure
Staff Description
CDR Responsibilities
Promotional Recommendations
Enrollee Assignment to CDR Agencies

- E. Provider Network Description**

SECTION II CDR Forms and Guidelines for Completing Forms pages 19 -35

- A. CDR FORM INTRODUCTION**

CDR Case Management Form 1

- B. CDR CASE MANAGEMENT FORM- GENERAL INFORMATION**

Purpose
Assessment
Detoxification
Inpatient/Residential and Halfway House Admissions
Outpatient and Partial Treatment

- C. GUIDELINES FOR COMPLETING FORM 1**

Demographics-First Section
Patient Information
Eligibility Clearance with the CRO
Case Open Date
Diagnostic Assessment Interview-Section A

Mid-Treatment Review -Section B
Completing Mid-Treatment Review
If Closing-Section D
Discharge Planning-Section C
Adjustment Counseling-Section E
Non-Reimbursable Interventions-Section F
Work/Family Representative Referrals-Section G
Client Release Form-Section H
Employee Sanction Form

D. CONTINUING CARE TREATMENT PLAN (FORM)

GENERAL INFORMATION

Continuing Care Treatment Plan Form 2

E. GUIDELINES FOR COMPLETING FORM 2

Demographics
Detoxification-Section A
Reimbursable Substance Abuse Interventions-Section B
Treatment Plan Revision
Clinical Information

SECTION III. Payment and Reporting **pages 36-38**

Provider Payment
CDR Payment
Case Closure
Activity Reports
Quality Assurance Reports
CDR Reporting
Inquires to CDR's Regarding Benefits Other Than Mental Health/Substance Abuse
CDR Catchment Areas

SECTION IV Appendices **pages 39-64**

Appendix A Work/Family Program Referrals
Appendix B Mental Health and Substance Abuse Diagnostic Code
Appendix C CDR Requirements
Appendix D Program Contract Language

Preamble

The following CDR Procedural Manual has been developed to aid in the successful implementation of General Motors and Delphi Corporation behavioral care benefits.

The only current CDR eligible participants are enrollees of the hourly UAW workers at General Motors or the Delphi Corporation. The Central Review Organization (CRO) for this population is ValueOptions. The CRO responsibilities are documented with the Procedural Manual.

CIGNA Behavioral Health (CBH) for the UAW enrollees has the Carrier duties as presented within the Procedural Manual.

To avoid confusion on eligibility for the UAW CDR benefit, please carefully follow the directions contained within to verify enrollee participation. Within the comprehensive General Motors and Delphi Corporation behavioral health benefit structure, General Motors and Delphi salaried employees and non-UAW organized members may utilize the provider panel and claims payment protocols similar to the UAW membership. For the General Motors salaried, Delphi salaried and non-UAW organized behavioral care participants CBH serves as their CRO. These participants are currently not eligible for the CDR Program.

April 1, 2006

The logo for ValueOptions features a stylized blue and green graphic on the left, resembling a checkmark or a bird in flight. The text "VALUEOPTIONS" is written in a large, light blue, sans-serif font. Below it, the tagline "Putting People First" is written in a smaller, green, sans-serif font.

VALUEOPTIONS
Putting People First

A. INTRODUCTION

Mental health and substance abuse treatment coverage for General Motors and Delphi Corporation-Traditional and Preferred Provider Organizations (PPO) option enrollees are to be provided through a managed care program. The program is designed to provide quality care in the most appropriate setting.

The program provides a comprehensive, managed care approach to the identification, diagnosis and treatment of problems related to mental health and/or substance abuse. It incorporates the internal Work/Family Program of General Motors or Delphi Corporation, a network of Central Diagnostic and Referral (CDR) agencies, ValueOptions as the Central Review Organization (CRO) for the UAW enrollees utilizing the CDR Program. Also, CIGNA Behavioral Health is the nationwide Carrier with primary responsibilities of provider network contracting and claims payment. These components, managed through this matrix of complementary units, comprise what will hereafter be referred to as the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program.

B. PROGRAM OVERVIEW

The General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse applicable provisions for UAW:

- a** Central Review Organizations (CRO)-ValueOptions is designated to: confirm the eligibility of the patient for coverage under the Program, authorize and approve all inpatient and outpatient behavioral care treatment, evaluate panel providers and give feedback to the carrier.
- b.** A network of Central Diagnostic and Referral Agencies (CDRs) located in most communities are responsible for making all the face-to-face assessments required under the Program for the development of substance abuse continuing care treatment plans. They make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment, make referrals to panel providers, and perform aftercare planning and follow-up. In addition, CDRs may provide short-term adjustment counseling (up to three visits) to employees (other enrollees excluded) needing assistance for personal problems.

The CDR will perform the compulsory assessment coordination for inpatient and halfway house substance abuse treatment and substance abuse continuing care treatment plans. It will be the voluntary but preferred access site to outpatient substance abuse treatment.

Further, CDR will communicate with Work/Family Program Representatives about assessment and referral activities relating to an employee, when appropriate and authorized by the employee.

- c. A nationwide limited network of inpatient and outpatient mental health and substance abuse professionals, including psychiatrists, Ph.D. psychologists, Masters Degree licensed social workers and professional counselors, hospitals, partial programs, halfway houses, and detoxification facilities.
- d. CIGNA Behavioral Health as the Carrier, has been designated to provide the following CDR functions:

Execute the CDR Services Agreement with qualified agencies and clinicians. Process CDR claims for service and make reimbursement for authorized services. Facilitate the overpayment/sanction program. Conduct on-site reviews with CDR Representatives to ensure delivery of quality services and performance of contracted obligations.

Coverage for the program includes:

- a. Up to 45 days for mental health and substance abuse inpatient care. These days (including detoxification) are renewable after 60 consecutive days of being "out-of-care." The 60 day renewal period includes all inpatient stays including medical admissions (non-psychiatric or substance abuse), psychiatric admissions, nursing home admissions and halfway house admissions, and applies whether or not benefits were available for the inpatient stay.
- b. Up to 35 fully paid visits per calendar year for outpatient substance abuse treatment. Outpatient mental health coverage provides up to 35 visits per calendar year, with visits 1-20 paid in full; and visits 21-35 paid at 75% of the panel reimbursement level, with a 25% co-pay to the insured.
- c. Up to 90 partial visits for mental health and/or substance abuse treatment. Each day of inpatient care for mental health or substance abuse treatment reduces by two the number of days of care available for mental health or substance abuse day or night treatment. Each two days of day or night treatment reduces by one the number of days of care available for inpatient care.
- d. Up to 90 days of mental health care in an approved skilled nursing facility. Each day of inpatient care for mental health treatment within the benefit period reduces by two the number of available days for skilled nursing facility care. Each two days of medical care for the treatment of mental disorders in a skilled

nursing facility reduces by one the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital.

- e. Up to a lifetime maximum of 90 days of care in a substance abuse halfway house treatment program.
- f. Outpatient psychological testing when authorized by the CRO.
- g. Inpatient psychological testing is included in all panel provider per diems.

The outpatient mental health and substance abuse provider is required to contact the CRO for initial and additional visits. Outpatient substance abuse cases with a Continuing Care Treatment Plan are managed by the CDR.

The following describes additional program features:

If mental health outpatient services are rendered by a non-panel physician, only the first visit will be covered at 100%. Any additional visits must be authorized by the CRO. Additional unauthorized visits performed by a non-panel physician will be paid at 50% of the amount that would have been paid to a panel provider. These payments will be made to the primary enrollee, not to the provider. Mental health services rendered by non-panel, non-physician providers, (psychologists, social workers, etc.) are not covered under the program.

Substance abuse services are not covered if rendered by a non-panel provider. The program is structured to provide easy access to the approved panel of substance abuse providers serving the enrollees. There are times when a waiver for non-network substance abuse treatment is appropriate and it must be pre-approved by the CDR Coordinator.

The focus of the substance abuse treatment coverage is to assist employees (and their dependents) in recovering. If an employee discontinues or fails to complete his/her treatment plan against the Assessment Coordinator's advice, the CDR will record such treatment discontinuation or failure in their medical record and on the CDR case activity form which is forwarded to the CRO for reporting.

Reports of all CDR record treatment discontinuation or non-completion against CDR advice will be forwarded to the Carrier on a regular basis. The member will be subsequently issued a warning for the first occurrence. For the second occurrence up to \$500 will be recovered from the employee as an overpayment. For a third occurrence up to \$750 will be recovered, and for a fourth and for each subsequent occurrence up to \$1000 will be recovered. Such overpayments will be recovered from the employee through cash payments or deduction from wages. (Refer to Program Contract Language, Appendix D).

When Medicare or another insurance is the primary payer of benefits, authorization through the CRO is not required. The CRO will provide the CDR agency and panel providers with this information. The CDR is asked to provide service to GM or Delphi enrollees who are enrolled in other primary insurance plans including Medicare. Providers who are not Medicare participants are required to submit the service claim to Medicare and Medicare will send the EOB (Explanation of Benefits) form to the enrollee. The enrollee must submit the EOB form to the provider, and the provider will forward the EOB and claim forms to CIGNA. CDRs that are involved with Medicare primary members are strongly encouraged to assure that any referrals offered are to Medicare participating providers.

Health Maintenance Organization (HMO) option enrollees are not included in the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse program. HMO option enrollees may be eligible for mental health and substance abuse services through their HMO.

For further information regarding definitions and descriptions of coverage see Program Contract Language, Appendix D



C. CENTRAL REVIEW ORGANIZATIONS (CRO) AGENCY OVERVIEW

ValueOptions, will serve the function of Central Review Organization (CRO) for the General Motors Careline Program UAW enrollees and Delphi Corporation Mental Health and Substance Abuse Program UAW enrollees. The CRO will case manage all levels of behavioral care provided to GM or Delphi UAW enrollees. The levels of care include inpatient treatment, partial hospital treatment, halfway house services, skilled nursing home and outpatient treatment.

Panel providers and CDR agencies must call the General Motors Careline Program or Delphi Corporation Mental Health and Substance Abuse Program to check benefit coverage eligibility. Services by non-panel providers may not be covered. The CRO submits all mental health and substance abuse benefit authorization information to CBH for claims payment purposes.

The CRO responsibilities shall include:

- Case management of all mental health
- Detoxification registration (authorization)
- Outpatient substance abuse cases, not involved with a CDR
- Checking coverage eligibility and benefit availability
- Assignment of CDR agency ID numbers for billing and reporting purposes
- Referring enrollees to designated CDRs and panel providers for assessment
- Coordinating treatment services on an as-needed basis with CDRs and Work/Family representatives
- Providing enrollee benefit utilization history to CDR agencies

1. STAFF DESCRIPTION-ValueOptions

The ValueOptions CRO staff is composed of clinical and support personnel. The Clinical Staff will perform the telephone based clinical case reviews. They are directly responsible for certifying payment of benefits for mental health inpatient treatment, skilled nursing facility, and partial and subsequent outpatient services and for monitoring treatment. The CRO clinical staff is board-certified psychiatrists, clinical psychologists, clinical social workers, and mental health nurse practitioners.

The CRO Support Staffs will service the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program calls, verify benefit eligibility and utilization for the certification of initial outpatient mental health and substance abuse benefits to panel providers only. The CRO support staff consists of Customer Service Representatives.

The ValueOptions CRO Provider Relations Staff will assist in inquiries regarding the credentialing process and participation on the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program panel, and conduct quality assurance reviews of panel

providers. The staff will schedule ongoing site visits to evaluate and conduct the Program's education.

The CRO CDR/WORK/FAMILY Coordinator Staff will work directly with the WORK/FAMILY representatives, benefit administrators and representatives to establish and maintain productive relationships. The CROs CDR/WORK/FAMILY LIFE Coordinators will assist in resolving enrollee case issues/concerns, out of state admissions, general inquiries, and provide ongoing information regarding program changes and revisions.

2. **STAFF DESCRIPTION-CBH**

The CBH staff is composed of clinical and support personnel. They are directly responsible for certifying payment of benefits for mental health inpatient treatment, skilled nursing facility, and partial and subsequent outpatient services and for monitoring all authorized treatment and providing a contracted network for the General Motors CareLine Program and Delphi Corporation Mental Health and Substance Abuse Program. The CBH clinical staff are board-certified psychiatrists, clinical psychologists, clinical social workers, and mental health nurse practitioners

The CBH support staff will service the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program calls, verify benefit eligibility and utilization for the certification of initial outpatient mental health and substance abuse benefits to panel providers and make claims payments for services rendered. The CBH support staff consists of Customer Service Representatives, Customer Service Consultants and Claims Processors.

3. **PROGRAM TELEPHONE SERVICE GUIDELINES AND PHONE NUMBERS.**

Providers calling the General Motors Careline Program or Delphi Corporation Mental Health and Substance Abuse Program are assisted by the CRO support and clinical staffs based on the type of treatment service requested. All calls are screened and referred to the appropriate CRO staff person for assistance.

CDR agencies should be familiar with the CRO telephone services and the numbers to reach the key components of the General Motors Careline program and Delphi Corporation Mental Health and Substance Abuse program. The table on page 6 of the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program Telephone Service Guidelines, illustrates the CRO procedure for assisting treatment providers based upon the type of service requested. A one-page summary of the Programs telephone numbers is included on page 7.

4. **CRO CONTACT NUMBERS**

The primary phone number for CDR related issues at the ValueOptions CRO is 248-208-5025. If that number is unavailable, call 248-208-5024. Both numbers may be reached through a toll-free telephone line for GM UAW eligible participants at 800-235-2302 or Delphi Corporation UAW eligible participants 877 786-4008 asking for CDR/WORK/FAMILY Coordinator. The ValueOptions CDR Coordinator is responsible for: out of state referrals; forms inquiries; referral coordination; CDR assessment coordinator credentialing; administrative issues and problems; complaints regarding providers; proposed referrals to non-panel providers and other general inquires.

The primary phone for CDR related issues for CBH is 248.226.9368. The CBH CDR Coordinator is responsible for assisting CDR with claims related issues, CDR contracting and assisting General Motors in the administration of the Overpayment (Sanction) Program.



**GENERAL MOTORS CARELINE PROGRAM AND DELPHI CORPORATION MENTAL HEALTH AND
SUBSTANCE ABUSE PROGRAM TELEPHONE SERVICE GUIDELINES**

Provider Initiated Calls

<u>Type of Telephone Call from Provider</u>	<u>Procedure</u>
Request for Inpatient or Partial Hospital Treatment	The clinical staff will check coverage eligibility, benefit availability, clinical information and provider status prior to admission. A provider requesting additional inpatient mental health benefits is referred to the assigned clinical staff person. Non-emergency admissions to non-panel providers are not authorized.
Request for Inpatient Mental Health Treatment	The clinical staff will determine the appropriateness of a distance waiver outside the state where the enrollee resides and authorize accordingly.
Request for Outpatient Mental Health Treatment	The customer service representative will check coverage eligibility, benefit availability, provider status, and will certify six (6) initial visits to a panel provider without a clinical review.
Request for Inpatient Substance or Halfway House Treatment	The call is registered and referred to the appropriate CDR for assessment. The CRO will check coverage eligibility, benefit availability and provider status.
Request for Detoxification Treatment	Coverage eligibility, benefit availability and provider status are checked. Three days are registered for detoxification and the case is referred to a CDR. Medical necessity must be established for further detoxification authorization.
Request for Inpatient Substance Abuse Treatment outside the state where the enrollee resides.	The CRO's WORK/ FAMILY CDR Coordinator Staff will assist in treatment outside out of state waivers should be made after an assessment and before a referral is made outside the state where the enrollee resides.
Request for Outpatient Substance Abuse Treatment	The customer service representative will check coverage eligibility, benefit availability, provider status and can certify six (6) outpatient visits without a clinical review. A case with a substance abuse history will be referred back to the CDR for authorization. The initial 6 visits can be certified for new cases and only to a panel provider. A provider requesting additional visits is referred to the clinical staff.
Request for Partial Hospital Substance Abuse Treatment	The clinical staff will check coverage eligibility benefit availability and provider status and ensure that no current Continuing Care Treatment Plan exists prior to initial benefit certification. A case with a current Continuing Care Treatment Plan will be referred back to the CDR for authorization. A provider requesting additional benefit certification will be referred to the assigned clinical staff person.
Please Note: coverage, eligibility verification and authorization of services does not guarantee payment for services. Payment depends on the enrollee's eligibility for coverage under the program and benefit plan limitations.	

General Motors Careline Program and Delphi Corporation
Mental Health and Substance Abuse Program
TELEPHONE SERVICES

The ValueOptions telephone services for General Motors Careline Program or Delphi Corporation Mental Health and Substance Abuse program may be used by Enrollees, WORK/FAMILY representatives, Providers and CDR staff and are available 24 hours a day, seven (7) days a week. Regular business hours are 8:30 a.m. to 5:00 p.m. ET, Monday through Friday. All calls after 5:00 p.m. ET, Monday through Friday and 24 hours on Saturday, Sunday and holidays are accepted by the Centralized Night Service Clinical Staffs. All after-hours non-emergency calls are registered and the Customer Service Representative (CSR) and/or Clinical Case Manager (CCM) will follow up the next business day.

The CBH telephone services for General Motors Careline Program or Delphi Corporation Mental Health and Substance Abuse Program enrollees, WORK/FAMILY representatives, providers and CDR staff operate. regular business hours are 8:30 a.m. to 5:00 p.m. ET, Monday through Friday. All calls after 5:00 p.m. ET, Monday through Friday and 24 hours on Saturday, Sunday and holidays are registered on voice mail and the Customer Service Representative (CSR) and/or CBH CDR Coordinator will follow up the next business day.

Although the 24-hour enrollee telephone numbers for both programs are accessible to CDRs, the preferred number for CDR inquiries is the one identified below. By utilizing this number, you will more directly access CRO staff the most familiar with CDR information. The CDR telephone number should be used if you wish the CRO to check coverage eligibility and benefit availability or have questions concerning the appropriate process and procedures to follow.

ValueOptions
General Motors UAW CareLine
800-235-2302
8:30 a.m. to 5 p.m. ET

ValueOptions
Delphi UAW Mental Health and Substance Abuse Program
877-786-4008
8:30 a.m. to 5 p.m. ET

Cigna Behavioral Health (CBH)
P.O. Box 5132
Southfield MI 48086
1-800-523-4626
248-226-9368

D. CENTRAL DIAGNOSTIC AND REFERRAL (CDR) AGENCY OVERVIEW

The CDR is responsible for conducting all the face-to-face assessments required under the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program for the development of substance abuse continuing care treatment plans. Determinations are made during the assessment process to determine if the enrollee's condition requires mental health and/or substance abuse treatment. CDRs are to utilize the guidelines provided in the ValueOptions manual for Clinical Protocols and Procedures and the ASAM criteria for substance abuse treatment. These protocols have been distributed by ValueOptions to each CDR administrator during the start up process. If additional copies are required contact **ASAM 301-656-3920 or 800-844-8948**.

UAW hourly workers are required to go through the CDR for an assessment prior to admission for substance abuse inpatient treatment, halfway house living arrangements or as a result of an admission to an inpatient facility for detoxification. Any inpatient residential or halfway house treatment will not be considered reimbursable if rendered prior to assessment and the development of a Continuing Care Treatment Plan {CCTP}.

Referrals to panel providers are made to the most appropriate level of care and in coordination with the CRO. In the case of a mental health referral, the CDR may refer directly to the provider and inform the CRO of the referral. Prior to referral, the CDR should call the CRO for coverage eligibility and benefit availability. The CRO is responsible for utilization review and working in coordination with the CDR for ongoing case management once the enrollee enters treatment.

The CDR performs the compulsory assessment for inpatient and halfway house substance abuse treatment and substance abuse Continuing Care Treatment Plans. {CCTP}. The CDR may authorize a detoxification extension beyond three days if certain medical criteria are met. The CDR has the responsibility of performing the mid-treatment review/interview and the discharge review/interview for all enrollees requiring inpatient substance abuse treatment.

In the case of some employees, short-term adjustment counseling may be provided for up to three visits. This component of the CDR function is designed to motivate, to explore alternatives, to identify and resolve problems and if the severity of illness indicates, to encourage the employee to seek further assistance. Short-term adjustment counseling is not available to retirees, surviving spouses or dependents, unless the spouse and/or dependent are a General Motors or Delphi Corporation employee.

1. INTER-CDR CASE TRANSFER

CDR staff may choose to refer enrollees with their consent to other CDR staff due to accessibility issues. In such cases, existing clinical records should be copied and transferred to the receiving agency after an appropriate release has been signed by the enrollee and/or his/her guardian. Prior to the transfer, the CRO should be informed of the transfer by the referring CDR and the receiving CDR should contact the CRO to check coverage eligibility and benefit availability.

2. CLINICAL PRIVILEGING OF STAFF

Prior to signing a contractual agreement with CBH, the CDR will have submitted the credentials of its designated assessment coordinator clinical staff and other pertinent information to ValueOptions for final review. At a minimum, clinical staff selected to function as a CDR Assessment Coordinator will have a license to practice independently in the state that they hold their license. In addition they will have a minimum of three years post-graduate training (Masters Degree or above) in a recognized mental health and substance abuse treatment track and significant training and post-graduate experience in the treatment of substance abuse disorders. During the course of the contract, the CDR is required to inform the ValueOptions and the CBH of any staff changes. New clinical staffs are required to submit their credentials for CRO approval and obtain an executed CDR contract from CBH prior to performing the function of an assessment coordinator.

3. Appeal Procedures

Denials & Appeals-CRO

Throughout the assessment, referral, and case management process the assessment coordinator is responsible for establishing medical necessity during treatment utilizing ASAM criteria. In the event that medical necessity can not be established the assessment coordinator will use the following procedure.

Review case with ValueOptions CDR Coordinator. If it is determined that the treatment doesn't meet medical necessity criteria, CDR Coordinator will send case for medical review and will communicate decision to local CDR Assessment coordinator. ValueOptions will be responsible for all written communication and the Assessment Coordinators will be responsible for all verbal notifications. The Assessment Coordinator will be involved in the initial denial, but all appeals will be handled by the CRO & Carrier. Below are the ERISA Guidelines that are required by law regarding denial of services.

Type of Review	Description	Time Frame for Decision	Time Frame for notification
Prospective	<p>Urgent (e.g., Emergency Services, Inpatient, Observation Holding Beds)</p> <p>Non-urgent (e.g., RTC, Partial Hospitalization and Outpatient)</p>	<p>As expeditiously as condition requires, but no later than 72 hours after receipt of request for services.</p> <p>Fifteen (15) calendar days after receipt of request for services.</p>	<p>Telephonic notification to provider on the same day the determination is made. Provider must agree to notify the member of the determination on the same day.</p> <p>Written notice issued to member, provider, and facility within the determination timeframe.</p>
Concurrent (Continued Stay)	<p>Urgent (e.g. Inpatient)</p> <p>Non-urgent (e.g. RTC, Partial Hospitalization and Outpatient)</p>	<p>1. As expeditiously as condition requires, but no later than 24 hours from receipt of the request for a utilization review determination received at least 24 hours before the expiration of the currently certified period or treatments.</p> <p>2. As expeditiously as condition requires, but no later than 72 hours from receipt of the request for a utilization review determination received less than 24 hours before the expiration of the currently certified period or treatments.</p> <p>1. As expeditiously as condition requires, but no later than 72 hours after receipt of request if the concurrent review request defaults to an urgent prospective review request.</p> <p>2. 15 calendar days after receipt of request (14 calendar days for CMS-governed contracts as applicable) if the concurrent review request defaults to a non-urgent prospective review request.</p>	<p>Telephonic notification to provider on the same day as the determination. Provider must agree to notify the member of the determination on the same day.</p> <p>Written notification to member, provider, and facility the determination timeframe, depending on the type of prospective review scenario of request.</p>
Retrospective	Non-urgent (all levels of care)	30 calendar days after receipt of request for retrospective review.	Written notice to member, provider, and facility within the determination timeframe.

CBH CDR Administrative Appeals-

You or your representative has the right to appeal administrative decisions. There are two internal appeal processes available to you through CBH. You can find out more about your appeal rights by calling the CBH CDR Coordinator at 1-800-523-4626. An appeal can be requested in one of the following ways: You can send a written request to CIGNA Behavioral Health at P.O. Box 5057, Southfield, MI 48034. You can send a fax to 1-248-6030. CBH will notify the requestor of the information we need to decide the appeal.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or your state insurance regulatory agency. You may also have the right to challenge this adverse benefit determination on review by bringing a civil action under the provisions of the Employee Retirement Income Security Act of 1074 (ERISA). This act governs some health benefits that are obtained through a non-government employer. To find out if this applies to your benefit plan or to find out how to call the agencies mentioned above, call CBH Customer Service at 1-800-523-4626.

4. STAFF DESCRIPTION

The CDR staff is composed of medical and clinical personnel consistent with the requirements and standards for CDR agencies. (See the Central Diagnostic and Referral Agency Requirements, Appendix C).

The CDR Assessment Coordinator will provide intake evaluation, triage assessment for mental health and substance abuse diagnostic determination, mid-treatment reviews/interviews, discharge reviews/interviews and employee adjustment counseling.

Each new Assessment Coordinator must be credentialed by ValueOptions prior to providing CDR services for the General Motors Careline UAW Program and Delphi Corporation Mental Health and Substance Abuse UAW Program and contracted for CDR services by CBH. When considering a new CDR Representative, please contact the CRO prior to a job offer so a complete reference check is possible.

5. CDR RESPONSIBILITIES

- a. Provide face-to-face assessments for the development of substance abuse Continuing Care Treatment Plans (CCTP) with panel providers for eligible enrollees entering detoxification, residential, or halfway house courses of treatment.
- b. Contact the CRO to check coverage eligibility and benefit availability and register all substance abuse admissions.
- c. Provide the following information to the CRO when checking coverage eligibility and benefit availability and registering a case:

- _ CDR Name & Identification Number
- _ Enrollee name

- Enrollee social security number/ National ID Number
- Client's full name (last, first and middle initial)
- Client's date of birth
- Client's sex

- d. Monitor substance abuse partial and/or outpatient courses of treatment when such services are obtained as the result of a Continuing Care Treatment Plan prescribed by the CDR.
- d. Coordinate with the CRO the treatment of those enrollees that require dual diagnosis treatment (both substance abuse and mental health services).
- f. Provide short-term adjustment counseling to employees.
- g. Authorize any detoxification days beyond 72 hours.
- h. Notify the CDR Coordinator of detoxification extensions, beyond the 5 extended days, by phone on the day the extension is authorized at 248 208-5025.

6. PROMOTIONAL RECOMMENDATIONS AND RESTRICTIONS

It is recommended that CDR Representatives refrain from promotional activities targeting General Motors or Delphi Corporation employees and/or enrollees. The present policies of the above companies regarding gifts and gratuities, prohibits any representative of the above companies or a member of his or her immediate family from accepting gifts, payments or accommodations from anyone with whom the Corporations do or are seeking to do business. It is important to avoid the appearance of any impropriety regardless of whether the representative believes an actual impropriety exists.

7. ENROLLEE ASSIGNMENT TO CDR AGENCIES

The principle of accessibility drives the assignment of all enrollees to the Central Diagnostic and Referral Agency (enrollees are defined as employees, retirees, surviving spouses and dependents enrolled in the Traditional and PPO options of the Informed Choice Plan). The two primary factors involved in accessibility are proximity to residence and proximity to location of employment. It is suggested that the CDR interface with the Work/Family representatives at least bi-monthly to discuss issues related to provision of service in that location.

a. CRO Triage: CDR Referral

In the event of either a requested or required CDR referral, the CRO will do the following:

- The CDR proximity to both residence of the enrollee and location of GM or Delphi employment (in the case of an employee) will be noted by the CRO.

The CRO will suggest a CDR appropriately matched to the enrollee's residence (zip code) and a CDR matched to location of GM or Delphi employment. The CRO will explain the need to choose a location convenient for the initial assessment and referral but also for continued care and follow-up. The employee

must return to the original CDR when the last episode of care has had a sanction due to a negative outcome.

In addition, the CDR Coordinator will recommend contact with the enrollee's WORK/FAMILY Representative at the employee's work location to assist in selecting the appropriate CDR.

- The enrollee's first CDR choice will result in an ongoing assignment until successful completion of the course of treatment, unless the enrollee moves to a residence in a different zip code or in the case of the employee, transfers to another General Motors or Delphi Corporation employment location.

b. WORK/FAMILY Representative Referral to the CDR

The principle of accessibility will be followed by WORK/FAMILY representatives when referring employees and/or enrollees to CDR. The WORK /FAMILY representative may refer to a CDR in close proximity to the location General Motors or Delphi location . If WORK/FAMILY representatives have questions regarding CDR choices, the CRO may be contacted to furnish more information.

The WORK/FAMILY Representative, the CDR Assessment Coordinator and the CRO are expected to explain the ongoing CDR assignment to the Enrollee prior to referral or during the intake process.

E. PROVIDER NETWORK DESCRIPTION

Providers who will administer high quality mental health and substance abuse care in a cost effective manner are chosen to participate in the General Motors Careline Program and Delphi Corporation — Mental Health and Substance Abuse Program. Such providers shall be contracted by CBH to perform services to the eligible enrollees. Program providers receive reimbursement for a full range of clinical services when all program requirements are met. This selective network consists of a limited number of the following types of providers:

- – Acute Care Hospitals
- – Mental Health Hospitals
- – Residential facility-24 hour nursing minimum criteria /inpatient quality standards
- – Partial Care Facilities
- – Outpatient Substance Abuse/Mental Health Facilities
- – Skilled Nursing Care Facilities
- – Halfway Houses
- – Psychiatrist (M.D./ D.O.)
- – Masters-level Social Worker and Professional Counselors
- – Ph.D. Psychologists
- – Selected Masters-level Psychiatric Clinical Nurse Specialists

The General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program require enrollees to utilize a Panel (Program) Provider. Providers can contact the CRO to register emergency detoxification admissions. Non-panel providers may be authorized when there is no available panel provider in the patient's geographic area (within a 25 mile radius) that can provide the required treatment.

For a complete listing of approved panel providers see the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program Provider Directory. Directories will be up-dated periodically by CBH and will be sent to the CDR. A provider directory can be obtained by calling the CBH CDR Coordinator at (248) 226-9368.



II. CDR FORMS AND GUIDELINES FOR COMPLETING FORMS


A. CDR FORM INTRODUCTION

This section presents the CDR forms that must be completed by the CDR Assessment Coordinator and provides guidelines for completing these forms.

The CDR agencies will record the services provided to enrollees on a designated CDR form for reimbursement of services. There are three (3) forms:

- Form 1 - CDR Case Management Form
- Form 2 – Continuing Care Treatment Plan
- Form 3 – Client Release Form.

Forms are completed by the Assessment Coordinator for both reimbursable and non-reimbursable services as provided by the CRO. The activity recorded on the forms will determine CDR reimbursement. It is important to fully complete all forms and indicate the agency ID number and mail to the CRO at the following addresses:



ValueOptions-UAW Participants
General Motors CareLine or Delphi Corporation
Mental Health and Substance Abuse Program
One Towne Square, Suite 300
Southfield, MI 48076

Putting People First

Forms that are not correct or are missing information cannot be processed for reimbursement and will be returned to the CDR for correction.

The CRO staff is available to answer questions regarding form completion.

Each CDR agency site will be assigned a CDR number by the CRO that should be written in the appropriate box.

CDR CASE MANAGEMENT FORM

CDR Case Management Form Revised 4/17/06 – Effective 4/17/06

Demographics		
CDR Number: _____ Assessment Coordinator Name: (please print name) _____		
Primary Enrollee Last Name: _____	First Name: _____	Contract Number: _____
Client Last Name: _____ First Name: _____ Date of Birth: _____		
Case Open Date: _____ Detox Related? YES / NO Extension Granted YES / NO Date of First Appt. Offered _____		

Section A – Diagnostic Assessment Interview		
Date of First Interview: _____ Did Client Show? YES / NO Date of Second Interview: _____ Did Client Show? YES / NO		
<input type="checkbox"/> 1 face to face CDR office (H0031) <input type="checkbox"/> 2 telephonic (H0031) <input type="checkbox"/> 3 face to face CDR office after hours (H2011) <input type="checkbox"/> 4 face to face @hospital (H0031) <input type="checkbox"/> 5 face to face hospital after hours (H2011) <input type="checkbox"/> 6 face to face @ OP provider (H0031) <input type="checkbox"/> 7 face to face OP provider after hours (H2011) <input type="checkbox"/> 8 face to face work/family rep office (H0031) <input type="checkbox"/> 9 face to face work/family rep office after hours (H2011) <input type="checkbox"/> 10 Assessment on a Holiday (H2011) <input type="checkbox"/> 11 Assessment on a Weekend (H2011) <input type="checkbox"/> 12 Second Diagnostic Interview (H0001) <input type="checkbox"/> 13 Detoxification Extension (H0009)		
Outcome of Assessment (please check <input checked="" type="checkbox"/> one)		
1. Reimbursable SA intervention accepted: _____ 2. Adjustment counseling referral: _____ 3. Closed (Complete Section D): _____		

Section B Mid-Treatment Review: YES / NO Closing Date _____ Date Client progressing satisfactorily? YES / NO _____ Date of Phone Review (H0047): _____ Or Date of Face-to-Face Interview (H0022): _____	Section C Discharge Planning: Yes / No Closing Date: _____ Date of Phone Review (H0046) : _____ or Date of Face-to-Face Interview (H0032): _____
--	---

Section D – Closing Reasons and/or Outcomes	
Diagnostic Assessment (please check <input checked="" type="checkbox"/> one) <input type="checkbox"/> 1. Client did not show or uncooperative, assessment completed <input type="checkbox"/> 2. Client did not accept recommendations <input type="checkbox"/> 3. Referral to Community Resource: (Complete Section F) <input type="checkbox"/> 4. Referral to mental health provider: Name: _____ Mid-treatment Review (please check <input checked="" type="checkbox"/> one) <input type="checkbox"/> 1. Client withdrew from service against CDR/medical advice <input type="checkbox"/> 2. Provider discharged client early, client did not cooperate <input type="checkbox"/> 3. Client needs more restrictive treatment <input type="checkbox"/> 4. Provider discharged client early, treatment satisfactory <input type="checkbox"/> 5. Other: _____	Adjustment Counseling (please check <input checked="" type="checkbox"/> one) <input type="checkbox"/> 1. Client did not show or uncooperative, assessment not completed <input type="checkbox"/> 2. Client did not accept recommendations <input type="checkbox"/> 3. Referral to Community Resource (Complete Section F) <input type="checkbox"/> 4. Referral to mental health or substance abuse provider <input type="checkbox"/> 5. Counseling completed no further treatment <input type="checkbox"/> 6. Case Reopened, additional sessions provided Name: _____ Discharge Planning (please check <input checked="" type="checkbox"/> one) <input type="checkbox"/> 1. Client withdrew from service against CDR/medical advice <input type="checkbox"/> 2. Provider discharged client early, client did not cooperate <input type="checkbox"/> 3. Client needs more restrictive treatment <input type="checkbox"/> 4. Provider discharged client early, treatment satisfactory <input type="checkbox"/> 5. Discharge planning process completed <input type="checkbox"/> Other: _____

Section E – Adjustment Counseling (H0025)		
Date of First Interview: _____ Date of Second Interview: _____ Date of Third Interview: _____		
Problem Description: (please check <input checked="" type="checkbox"/> at least one)		
<input type="checkbox"/> 1. Alcohol	<input type="checkbox"/> 2. Drug	<input type="checkbox"/> 3. Vocational/Occupational
<input type="checkbox"/> 4. Financial	<input type="checkbox"/> 5. Legal	
<input type="checkbox"/> 6. Emotional/Personal	<input type="checkbox"/> 7. Family/Marital	
<input type="checkbox"/> 8. Other (please describe) _____		

Section F – Non Reimbursable Intervention (check <input checked="" type="checkbox"/> all that apply)		
<input type="checkbox"/> 1. AA	<input type="checkbox"/> 2. CA	<input type="checkbox"/> 3. NA
<input type="checkbox"/> 4. COA/COA	<input type="checkbox"/> 5. Alanon / Alateen	<input type="checkbox"/> 6. Aftercare Group
<input type="checkbox"/> 7. Self Help	<input type="checkbox"/> 8. Other (please describe): _____	

Section G – Work/Family Representative or EAP Representative Referrals		
Was the client referred by the above representative? YES / NO Was referral made to the above representative? YES / NO		
Name: _____		

Section H – Authorization Signature		
Did client sign authorization consent form? YES / NO Date: _____		

Send completed forms to: ValueOptions, Attn: CareLine, One Towne Square, Suite. 300, Southfield, MI 48076 CDR FORM 4/17/06

B. CDR CASE MANAGEMENT FORM (FORM 1) GENERAL INFORMATION

1. PURPOSE

This form is necessary to record demographics, diagnostic assessment, mid-treatment, and discharge reviews, as well as detox extensions and adjustment counseling. This form provides information necessary for reimbursement of services as well as case outcome data.

2. ASSESSMENT

The CDR will conduct the assessment and fill out the demographics and Section A on Form 1. All reimbursable interventions are recorded on Form 2. The treatment provider is not required to contact the CRO for authorization when the CDR completes Form 2. This form is the **CDR Assessment Coordinators bill** for services rendered and is to be submitted with a HCFA 1500 FORM to CBH Claims

3. DETOXIFICATION

A detoxification admission is viewed as a medically emergent condition. CDR Assessment Coordinators do not recommend or approve the first 72 hours of detoxification in order for benefits to be paid. The CRO will check eligibility and benefit availability and authorize up to 72 hours (3 days) of treatment. The treatment provider must register the admission within 24 hours of its occurrence with the CRO for reimbursement. The CRO will refer all detoxification admissions to the designated CDR for assessment and development of a CCTP.

Detoxification extensions should be approved only when additional time is needed to appropriately complete the medical detoxification process. Detoxification extensions beyond five days may be authorized by the CDR, but must be reported to the CRO on the date of authorization. The CDR must check benefit coverage available prior to authorizing a detoxification extension. When a provider calls the CRO for a detoxification extension during the first 72 hours, the CRO will re-contact the designated CDR.

Fill out the demographic section of Form 1 and record the detox extension on the CCTP-Form 2.

The following guidelines are intended to be helpful in discerning if a detoxification extension is warranted. This information should be solicited from the inpatient provider's medical personnel or the client's assigned therapist. Please use the ASAM criteria to determine dimension and level of treatment.

- a. Detoxification registration date. If the detoxification was not registered, inform the facility to contact the CRO, process detoxification extension and inform the CRO of the unregistered detoxification.
- b. ICD-9 diagnosis code/s assigned by facility.
- c. Substance(s) abused by individual.

- d. Results of any comprehensive drug screening (i.e., indicating if alcohol/drug usage is recent or in trace or significant amounts, and delineating all substances involved).
- e. Brief history of abuse including patterns of usage (i.e., continuous or episodic).
- f. Any current prescription medications being used.
- g. Any withdrawal symptoms, if noted.
- h. Description of any physical, medical or psychiatric problems noted (other complicating factors).
- i. Number of additional days the patient will require to successfully complete the detoxification process.
- j. Description of the detoxification regimen plan the facility will provide.
- k. Name of physician recommending detoxification extension.

4. **INPATIENT/RESIDENTIAL AND HALFWAY HOUSE ADMISSIONS**

This treatment **must** be authorized by the CDR. When the client has been admitted for detoxification or inpatient/residential treatment, the CRO will refer the provider to the designated CDR for authorization.

Record all reimbursable interventions on Form 2, the CCTP.

Authorization should be given in appropriate amounts to allow for continued clinical monitoring of medical necessity.

5. **OUTPATIENT AND PARTIAL TREATMENT**

This treatment must be authorized by the CDR. If the patient has been inpatient or has a prior substance abuse history; the CRO will refer cases to the CDR for authorization when necessary.

C. **GUIDELINES FOR COMPLETING FORM 1:**

Complete this form for each client receiving CDR assessment services and/or requiring detoxification extensions beyond the initial 72 hours, for each client who has a mid-treatment review; a discharge review; and/or adjustment counseling. A Continuing Care Treatment Plan (Form 2) should be developed to record all reimbursable authorizations.

1. DEMOGRAPHICS -1st Section

a. PATIENT INFORMATION

In this section, the information applies to the primary enrollee, i.e., the individual employee, retiree or surviving spouse eligible for benefits. It is critical to obtain the correct social security number and/or the (National ID Number), date of birth of the primary enrollee and to get clearance from the CRO for eligibility of the patient. This section also includes the CDR identifying information.

b. ELIGIBILITY CLEARANCE WITH CRO

Although there is no section to record the eligibility clearance on this form, make sure to document all clearance information in the patient's file.

c. CASE OPEN DATE

This is the date the CDR first had contact concerning this patient. Document detoxification information and the date you offered an initial appointment, even if that was not the date of the first interview. The case open date is carried forth on the CCTP related to the treatment episode. A case is defined as the episode of substance abuse treatment beginning with the first date of contact and ending on the date of closure.

2. Diagnostic Assessment Interview - Section A

- a. Indicate the date of either the first or second interview and indicate what type of interview by circling either face to face or telephone and the location of that interview
- b. Indicate the outcome of the first/second assessment by checking the appropriate box; reimbursable SA intervention accepted; adjustment counseling referral; closed in diagnostic assessment phase. If closing in the assessment phase, fill out Section D, document the reason for closing. (This includes mental health referrals.)

3. Mid-Treatment Review Section B

This documents the progress in substance abuse treatment by the client at the mid-point in his/her reimbursable services. The Assessment Coordinator is responsible for the scheduling of a face-to-face interview or telephone review.

Mid-Treatment Review is performed by the CDR Assessment Coordinator and with the treatment provider at the mid-point of reimbursable substance abuse treatment. This is to assess how treatment is progressing, and to determine if the Continuing Care Treatment Plan is appropriate and effectively relating to the client's specific problem. The mid-treatment review may be conducted by telephone or face-to-face with the client. The mid-treatment face-to-face interview must include the client, but may also include others, such as the provider, significant others and/or the WORK FAMILY Representative.

Please be aware that although only 1 mid-treatment review is reimbursable, updates and changes, (case management), to the CCTP will be required.

When completing the CDR Case Management form the following rules must be followed:

1. For the Mid-Treatment Review/ Section D Closing Reasons and/or Outcomes:

If a person needs more restrictive treatment #3, and this transfer to a more restrictive treatment setting is not considered a non-completion of a CCTP:

- Check the statement –client needs more restrictive treatment, **AND**
- On # 5-Other, write **NO SANCTION**

2. For the Discharge Planning/Section D Closing Reasons and/or Outcomes:

If a person needs more restrictive treatment #3, and this transfer to a more restrictive treatment setting is not considered a non-completion of a CCTP:

- Check the statement –client needs more restrictive treatment, **AND**
- On #6- Other, write **NO SANCTION**.

Also:

The only two acceptable situations where substance abuse service can overlap with another substance abuse service is as follows:

Halfway house can overlap service dates with Partial (treatment type 3 & 4)

And/or Halfway house can overlap service dates with outpatient (treatment type 3 & 8)

If a patient has had a closed case with a CDR in the last 6 months, the treatment plan and authorization **must** return to the same CDR. It does not matter if this treatment is **only OP SA sessions**. If a patient has had involvement with the CDR in the last 6 months this is a signal the patient should return to that CDR.

If a provider calls and wants OP SA or OP MH treatment for a patient and there is an open CDR case, the patient must be sent to the CDR for an assessment. The CDR screens must be checked to make sure there are no open cases for this patient with the CDR. **If the provider indicates any kind of SA history it is imperative that the CDR records are checked before any kind of authorization is done,**

a. Mid-Treatment Review - Section B

This section asks for information documenting dates of review, the closing date if appropriate, if the review was face-to-face or by telephone. If closing, be sure to fill out Section D, document the reason for closing.

b. If Closing - Section D

If the client withdrew or will not continue on with the recommended reimbursable services, the case is to be closed, and the reason checked. Check the most appropriate box for closing the case

and indicate the date of withdrawal or discharge from treatment. If a patient is admitted to a more “restrictive” level of care from a lower level of treatment and there is a determination made that this does not constitute a non-completion of a CCTP, then make sure that "No Sanction" is written on the blank space indicated by Other in the Mid –Treatment, Closing reason or Discharge Section, Closing reason.

4. **Discharge Planning –Section C**

a. The Discharge Review is performed near the completion of the reimbursable phase of treatment to determine whether an appropriate aftercare plan has been developed which relates to the client's problem. A face-to-face interview may be scheduled to review the aftercare plan with the client, the provider and others or the review may occur by phone with the client. The conditions surrounding reimbursement for the Discharge Review are the same as the Mid-Treatment Review.

In determining when a case should be closed, information should be obtained from the current provider, the WORK/FAMILY representative, if appropriate, and the patient. If the patient is not receptive to the current recommendations and/or revisions, the case should be closed.

In order to insure consistency in the case management process, it is important that the CDR provide on-going case management once a referral is made to the provider. The CDR should work in coordination with the Case Managers at the CRO, especially if the patient is dually diagnosed and has had extensive mental health and substance abuse treatment.

b. **If Closing, Section D Guidelines for Completing Discharge Review**

On both the Mid-Treatment Review and the Discharge Review form special attention must be given to Section D: "If Closing." The closing reasons are evaluated to determine whether the employee successfully completed the reimbursable recommendations of the CCTP. An employee who does not successfully complete the recommendations will be subject to the sanctioning process.

Please check yes or no, in Section C and the closing date. Indicate whether this was completed by face-to-face or telephone interview. Enter the discharge reason in Section D under Discharge Planning.

If a patient is admitted to a more “restrictive” level of care from a lesser level of treatment and there is a determination made that this does not constitute a failure to complete a CCTP, then make sure that "No Sanction" is written on the blank space indicated by Other in the Mid–Treatment, Closing Reasons or Discharge Section, Closing Reasons.

5. **Adjustment Counseling –Section E**

Indicate the date of the first, second and third interviews. Indicate all of the problem descriptions that apply. When closing an adjustment counseling phase of treatment, document, in Section D, the closing reasons and/or outcomes. Two more sessions can be activated, if necessary, by utilizing the 1st and 2nd diagnostic interviews.

This form records adjustment counseling services to employees only.

The adjustment counseling services are designed to motivate, to explore alternatives and to identify and resolve the problems of an employee. **Only employees can directly access this benefit.** However, other family members may attend the sessions if the employee is present in the sessions and the employee's presenting problem is the focus of the counseling.

6. Non-Reimbursable Interventions-Section F

Check to indicate which non-reimbursable interventions were recommended to the client. Check all that apply and specify "Others" where recommended. Some treatment facilities provide outpatient aftercare programs at no extra charge for patients who go through their inpatient programs. In a situation like this, the facility does not bill CBH separately for these services, the services are considered non-reimbursable and should be indicated in Section F. Please utilize the United Way, Community Chest or other organizations that have free classes or programs to enhance a patient's self-esteem and/or self-help groups.

7. WORK FAMILY Representative Referrals-Section- G

If the client is an employee, please document the client's referral to the WORK/FAMILY representative in this section of the form. List the name and telephone number of the WORK/FAMILY representative if a referral was made. Assessment Coordinators are strongly encouraged to recommend WORK/FAMILY representative involvement to clients who are active employees. If the client is an employee, and WORK/FAMILY representative involvement is recommended check yes for "Client Referred to WORK/FAMILY representative". The employee must sign a release of information in order for the CDR to contact and convey information to the WORK/FAMILY representative Team. This section must be filled out for reporting purposes.

The CRO strongly encourages the CDR's to work with the WORK/FAMILY representatives. These men and women are very helpful when the CDR needs support for treatment recommendations and historic information about the person going into treatment. It is essential to utilize the WORK/FAMILY representative's when job-jeopardy issues are involved. It can mean the difference between continued employment or potential loss of a job.

At the time of the first contact, you should encourage the employee to sign a release of information allowing you to communicate with the WORK/FAMILY representative. If an employee refuses to sign the release this must be documented.

When a release is signed:

- At a minimum, the WORK/FAMILY representative should get information from the CDR about the patient within 24 to 48 hours of the 1) diagnostic assessment, 2) the mid-treatment review and 3) the discharge interview.
- The information given to a WORK/FAMILY representative should be given based on the individual needs of the patient and if he/she is reluctant to sign a release assure him/her that information can be as simple as attendance and progress to date. (Personal Health Information based on HIPAA laws).
- This information should be transmitted by telephone and/or a written report so the WORK/FAMILY representative can be informed in a reasonable time once the treatment plans are made.

- The WORK/FAMILY representative is an excellent source of encouragement to urge the patient to comply with treatment or suggest consequences of non-compliance with the prescribed treatment.
- If there is disagreement between the CDR and the WORK/FAMILY representative, which cannot be resolved, the information can be discussed with the CDR Coordinator, who can facilitate a compromise.

8. CLIENT RELEASE FORM-SECTION H

The Client Release authorizes the Assessment Coordinator to release information to the CRO and/or Carrier to validate eligibility for services and benefits under the GM/Delphi Health Care Program. The release explains that all reimbursable treatment recommendations are subject to the limits of the Health Care Programs of General Motors or Delphi. In addition, the recommendations must commence within two weeks of their "to begin date" for each recommendation to be upheld.

Please take the time to explain each aspect of the release to clients before they sign.

When reimbursable substance abuse treatment is being authorized as a result of the diagnostic assessment, the mid-treatment and/or the discharge review, the CDR should attach the Continuing Care Treatment Plan Form 2 to the CDR Case Management Form -Form 1.

The form distribution is as follows **for form 2**:

- A. Make copies and send to the CRO, the provider, the work family representative and the patient as necessary.
- B. Make copies for the patient file.

Employee Overpayment/Sanction Information Form

I understand that all treatment must commence within two weeks of their specified "treatment to begin" date in order for each recommendation to be upheld.

I have been involved in the development of this treatment plan and agree to abide by the recommendations herewithin. If I am an active employee of, I understand that failure to abide by the requirements of this treatment plan may result in an overpayment of benefits. In such case, I authorize to collect any overpayments under the Continuing Care Treatment Plan which relate to me by making deductions from any wages or benefits payable to me, or which become payable to me by or on Corporation's behalf.

Employees and those on disability please note that if you enter treatment for detoxification, residential or halfway house treatment and do not complete portions of your treatment plan which are covered services (including outpatient and partial hospitalization program) as documented in this CCTP, it will result in the following actions: 1) a letter being sent notifying the employee and of failure to complete the treatment plan, 2) provisions of Article 1, section 9 of the Supplemental Agreement covering Health Care Programs will apply i.e. a warning letter for the first occurrence, an overpayment and recovery of \$500 for the second occurrence, \$750 for the third lifetime occurrence and \$1000 for the fourth and all subsequent lifetime occurrences.

Client Signature _____

Date _____

CDR Assessment Coordinator Signature _____

CDR Form 3/25/03

Send completed forms to ValueOptions, attn: General Motors Careline or Delphi Corporation Mental Health and Substance Abuse Program, One Towne Square, Suite 300, Southfield MI 48076

*** The Overpayment/Sanction is only applicable to the GM/Delphi UAW employees**

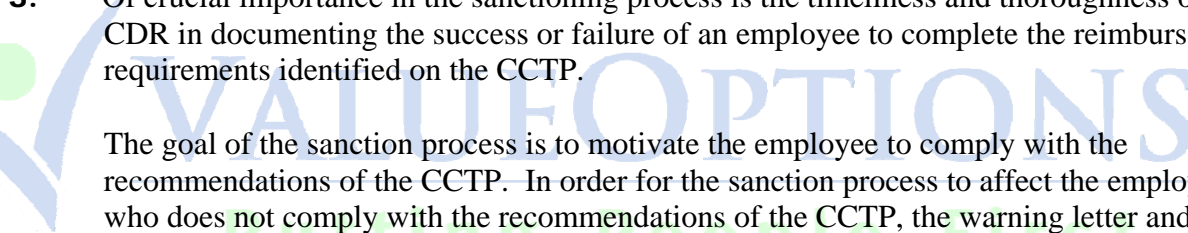
Continuing Care Treatment Plan Form

Demographics																															
CDR Number: _____ Revised? <input type="checkbox"/> YES <input type="checkbox"/> NO																															
Primary Enrollee Last Name: _____ First Name: _____	Contract Number: _____																														
Client Last Name: _____ First Name: _____ Date of Birth: ____/____/____																															
Case Open Date: ____/____/____ Primary Diagnosis: _____ Secondary Diagnosis: _____																															
Section A – Detoxification																															
Client admitted for detoxification? <input type="checkbox"/> YES <input type="checkbox"/> NO Was an extension beyond 72 hours requested and approved? <input type="checkbox"/> YES <input type="checkbox"/> NO																															
Section B - Reimbursable Substance Abuse Intervention (please <input checked="" type="checkbox"/> one only per section)																															
<table style="width: 100%; border: none;"> <tr> <td>01 <input type="checkbox"/> Detox</td> <td>02 <input type="checkbox"/> IP Residential</td> <td>03 <input type="checkbox"/> Halfway House</td> <td>04 <input type="checkbox"/> Partial Hospitalization</td> <td>05 <input type="checkbox"/> Initial OP Interview</td> </tr> <tr> <td>06 <input type="checkbox"/> IOP</td> <td>07 <input type="checkbox"/> THC</td> <td>08 <input type="checkbox"/> Full Ind. Therapy</td> <td>09 <input type="checkbox"/> 1/2 Ind. Therapy</td> <td></td> </tr> <tr> <td>10 <input type="checkbox"/> Family Therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 <input type="checkbox"/> Group Therapy</td> <td>12 <input type="checkbox"/> Med. Mgt.</td> <td>13 <input type="checkbox"/> 15 Min. Op Cons</td> <td>14 <input type="checkbox"/> 30 Min OP Cons</td> <td>15 <input type="checkbox"/> 40 Min OP Cons</td> </tr> <tr> <td>16 <input type="checkbox"/> 60 Min OP Cons</td> <td>17 <input type="checkbox"/> 80 Min OP Cons</td> <td>18 <input type="checkbox"/> Provider Denial</td> <td>19 <input type="checkbox"/> Emergency Room</td> <td>20 <input type="checkbox"/> 99221</td> </tr> <tr> <td>21 <input type="checkbox"/> 99222</td> <td>22 <input type="checkbox"/> 99223</td> <td>23 <input type="checkbox"/> 99231</td> <td>24 <input type="checkbox"/> 99232</td> <td>25 <input type="checkbox"/> 99233</td> </tr> </table>		01 <input type="checkbox"/> Detox	02 <input type="checkbox"/> IP Residential	03 <input type="checkbox"/> Halfway House	04 <input type="checkbox"/> Partial Hospitalization	05 <input type="checkbox"/> Initial OP Interview	06 <input type="checkbox"/> IOP	07 <input type="checkbox"/> THC	08 <input type="checkbox"/> Full Ind. Therapy	09 <input type="checkbox"/> 1/2 Ind. Therapy		10 <input type="checkbox"/> Family Therapy					11 <input type="checkbox"/> Group Therapy	12 <input type="checkbox"/> Med. Mgt.	13 <input type="checkbox"/> 15 Min. Op Cons	14 <input type="checkbox"/> 30 Min OP Cons	15 <input type="checkbox"/> 40 Min OP Cons	16 <input type="checkbox"/> 60 Min OP Cons	17 <input type="checkbox"/> 80 Min OP Cons	18 <input type="checkbox"/> Provider Denial	19 <input type="checkbox"/> Emergency Room	20 <input type="checkbox"/> 99221	21 <input type="checkbox"/> 99222	22 <input type="checkbox"/> 99223	23 <input type="checkbox"/> 99231	24 <input type="checkbox"/> 99232	25 <input type="checkbox"/> 99233
01 <input type="checkbox"/> Detox	02 <input type="checkbox"/> IP Residential	03 <input type="checkbox"/> Halfway House	04 <input type="checkbox"/> Partial Hospitalization	05 <input type="checkbox"/> Initial OP Interview																											
06 <input type="checkbox"/> IOP	07 <input type="checkbox"/> THC	08 <input type="checkbox"/> Full Ind. Therapy	09 <input type="checkbox"/> 1/2 Ind. Therapy																												
10 <input type="checkbox"/> Family Therapy																															
11 <input type="checkbox"/> Group Therapy	12 <input type="checkbox"/> Med. Mgt.	13 <input type="checkbox"/> 15 Min. Op Cons	14 <input type="checkbox"/> 30 Min OP Cons	15 <input type="checkbox"/> 40 Min OP Cons																											
16 <input type="checkbox"/> 60 Min OP Cons	17 <input type="checkbox"/> 80 Min OP Cons	18 <input type="checkbox"/> Provider Denial	19 <input type="checkbox"/> Emergency Room	20 <input type="checkbox"/> 99221																											
21 <input type="checkbox"/> 99222	22 <input type="checkbox"/> 99223	23 <input type="checkbox"/> 99231	24 <input type="checkbox"/> 99232	25 <input type="checkbox"/> 99233																											
Revised Date: ____/____/____ <input type="checkbox"/> Change of Units <input type="checkbox"/> Change in Provider <input type="checkbox"/> Added Modality <input type="checkbox"/> Change in Treatment Date																															
Treatment Begin Date: ____/____/____ Treatment End Date: ____/____/____																															
Provider Identification Number: _____ Provider Name: _____																															
Address: _____ City/State: _____																															
Recommended Duration _____ units/days Client agrees to follow recommendation? <input type="checkbox"/> YES <input type="checkbox"/> NO																															
<table style="width: 100%; border: none;"> <tr> <td>01 <input type="checkbox"/> Detox</td> <td>02 <input type="checkbox"/> IP Residential</td> <td>03 <input type="checkbox"/> Halfway House</td> <td>04 <input type="checkbox"/> Partial Hospitalization</td> <td>05 <input type="checkbox"/> Initial OP Interview</td> </tr> <tr> <td>06 <input type="checkbox"/> IOP</td> <td>07 <input type="checkbox"/> THC</td> <td>08 <input type="checkbox"/> Full Ind. Therapy</td> <td>09 <input type="checkbox"/> 1/2 Ind. Therapy</td> <td></td> </tr> <tr> <td>10 <input type="checkbox"/> Family Therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 <input type="checkbox"/> Group Therapy</td> <td>12 <input type="checkbox"/> Med. Mgt.</td> <td>13 <input type="checkbox"/> 15 Min. Op Cons</td> <td>14 <input type="checkbox"/> 30 Min OP Cons</td> <td>15 <input type="checkbox"/> 40 Min OP Cons</td> </tr> <tr> <td>16 <input type="checkbox"/> 60 Min OP Cons</td> <td>17 <input type="checkbox"/> 80 Min OP Cons</td> <td>18 <input type="checkbox"/> Provider Sanction</td> <td>19 <input type="checkbox"/> Emergency Room</td> <td>24 <input type="checkbox"/> 99232</td> </tr> <tr> <td>20 <input type="checkbox"/> 99221</td> <td>21 <input type="checkbox"/> 99222</td> <td>22 <input type="checkbox"/> 99223</td> <td>23 <input type="checkbox"/> 99231</td> <td>25 <input type="checkbox"/> 99233</td> </tr> </table>		01 <input type="checkbox"/> Detox	02 <input type="checkbox"/> IP Residential	03 <input type="checkbox"/> Halfway House	04 <input type="checkbox"/> Partial Hospitalization	05 <input type="checkbox"/> Initial OP Interview	06 <input type="checkbox"/> IOP	07 <input type="checkbox"/> THC	08 <input type="checkbox"/> Full Ind. Therapy	09 <input type="checkbox"/> 1/2 Ind. Therapy		10 <input type="checkbox"/> Family Therapy					11 <input type="checkbox"/> Group Therapy	12 <input type="checkbox"/> Med. Mgt.	13 <input type="checkbox"/> 15 Min. Op Cons	14 <input type="checkbox"/> 30 Min OP Cons	15 <input type="checkbox"/> 40 Min OP Cons	16 <input type="checkbox"/> 60 Min OP Cons	17 <input type="checkbox"/> 80 Min OP Cons	18 <input type="checkbox"/> Provider Sanction	19 <input type="checkbox"/> Emergency Room	24 <input type="checkbox"/> 99232	20 <input type="checkbox"/> 99221	21 <input type="checkbox"/> 99222	22 <input type="checkbox"/> 99223	23 <input type="checkbox"/> 99231	25 <input type="checkbox"/> 99233
01 <input type="checkbox"/> Detox	02 <input type="checkbox"/> IP Residential	03 <input type="checkbox"/> Halfway House	04 <input type="checkbox"/> Partial Hospitalization	05 <input type="checkbox"/> Initial OP Interview																											
06 <input type="checkbox"/> IOP	07 <input type="checkbox"/> THC	08 <input type="checkbox"/> Full Ind. Therapy	09 <input type="checkbox"/> 1/2 Ind. Therapy																												
10 <input type="checkbox"/> Family Therapy																															
11 <input type="checkbox"/> Group Therapy	12 <input type="checkbox"/> Med. Mgt.	13 <input type="checkbox"/> 15 Min. Op Cons	14 <input type="checkbox"/> 30 Min OP Cons	15 <input type="checkbox"/> 40 Min OP Cons																											
16 <input type="checkbox"/> 60 Min OP Cons	17 <input type="checkbox"/> 80 Min OP Cons	18 <input type="checkbox"/> Provider Sanction	19 <input type="checkbox"/> Emergency Room	24 <input type="checkbox"/> 99232																											
20 <input type="checkbox"/> 99221	21 <input type="checkbox"/> 99222	22 <input type="checkbox"/> 99223	23 <input type="checkbox"/> 99231	25 <input type="checkbox"/> 99233																											
Revised Date: ____/____/____ <input type="checkbox"/> Change of Units <input type="checkbox"/> Change in Provider <input type="checkbox"/> Added Modality <input type="checkbox"/> Change in Treatment Date																															
Treatment Begin Date: ____/____/____ Treatment End Date: ____/____/____																															
Provider Identification Number: _____ Provider Name: _____																															
Address: _____ City/State: _____																															
Recommended Duration _____ units/days Client agrees to follow recommendation? <input type="checkbox"/> YES <input type="checkbox"/> NO																															
<table style="width: 100%; border: none;"> <tr> <td>01 <input type="checkbox"/> Detox</td> <td>02 <input type="checkbox"/> IP Residential</td> <td>03 <input type="checkbox"/> Halfway House</td> <td>04 <input type="checkbox"/> Partial Hospitalization</td> <td>05 <input type="checkbox"/> Initial OP Interview</td> </tr> <tr> <td>06 <input type="checkbox"/> IOP</td> <td>07 <input type="checkbox"/> THC</td> <td>08 <input type="checkbox"/> Full Ind. Therapy</td> <td>09 <input type="checkbox"/> 1/2 Ind. Therapy</td> <td></td> </tr> <tr> <td>10 <input type="checkbox"/> Family Therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>11 <input type="checkbox"/> Group Therapy</td> <td>12 <input type="checkbox"/> Med. Mgt.</td> <td>13 <input type="checkbox"/> 15 Min. Op Cons</td> <td>14 <input type="checkbox"/> 30 Min OP Cons</td> <td>15 <input type="checkbox"/> 40 Min OP Cons</td> </tr> <tr> <td>16 <input type="checkbox"/> 60 Min OP Cons</td> <td>17 <input type="checkbox"/> 80 Min OP Cons</td> <td>18 <input type="checkbox"/> Provider Sanction</td> <td>19 <input type="checkbox"/> Emergency Room</td> <td>24 <input type="checkbox"/> 99232</td> </tr> <tr> <td>20 <input type="checkbox"/> 99221</td> <td>21 <input type="checkbox"/> 99222</td> <td>22 <input type="checkbox"/> 99223</td> <td>23 <input type="checkbox"/> 99231</td> <td>25 <input type="checkbox"/> 99233</td> </tr> </table>		01 <input type="checkbox"/> Detox	02 <input type="checkbox"/> IP Residential	03 <input type="checkbox"/> Halfway House	04 <input type="checkbox"/> Partial Hospitalization	05 <input type="checkbox"/> Initial OP Interview	06 <input type="checkbox"/> IOP	07 <input type="checkbox"/> THC	08 <input type="checkbox"/> Full Ind. Therapy	09 <input type="checkbox"/> 1/2 Ind. Therapy		10 <input type="checkbox"/> Family Therapy					11 <input type="checkbox"/> Group Therapy	12 <input type="checkbox"/> Med. Mgt.	13 <input type="checkbox"/> 15 Min. Op Cons	14 <input type="checkbox"/> 30 Min OP Cons	15 <input type="checkbox"/> 40 Min OP Cons	16 <input type="checkbox"/> 60 Min OP Cons	17 <input type="checkbox"/> 80 Min OP Cons	18 <input type="checkbox"/> Provider Sanction	19 <input type="checkbox"/> Emergency Room	24 <input type="checkbox"/> 99232	20 <input type="checkbox"/> 99221	21 <input type="checkbox"/> 99222	22 <input type="checkbox"/> 99223	23 <input type="checkbox"/> 99231	25 <input type="checkbox"/> 99233
01 <input type="checkbox"/> Detox	02 <input type="checkbox"/> IP Residential	03 <input type="checkbox"/> Halfway House	04 <input type="checkbox"/> Partial Hospitalization	05 <input type="checkbox"/> Initial OP Interview																											
06 <input type="checkbox"/> IOP	07 <input type="checkbox"/> THC	08 <input type="checkbox"/> Full Ind. Therapy	09 <input type="checkbox"/> 1/2 Ind. Therapy																												
10 <input type="checkbox"/> Family Therapy																															
11 <input type="checkbox"/> Group Therapy	12 <input type="checkbox"/> Med. Mgt.	13 <input type="checkbox"/> 15 Min. Op Cons	14 <input type="checkbox"/> 30 Min OP Cons	15 <input type="checkbox"/> 40 Min OP Cons																											
16 <input type="checkbox"/> 60 Min OP Cons	17 <input type="checkbox"/> 80 Min OP Cons	18 <input type="checkbox"/> Provider Sanction	19 <input type="checkbox"/> Emergency Room	24 <input type="checkbox"/> 99232																											
20 <input type="checkbox"/> 99221	21 <input type="checkbox"/> 99222	22 <input type="checkbox"/> 99223	23 <input type="checkbox"/> 99231	25 <input type="checkbox"/> 99233																											
Revised Date: ____/____/____ <input type="checkbox"/> Change of Units <input type="checkbox"/> Change in Provider <input type="checkbox"/> Added Modality <input type="checkbox"/> Change in Treatment Date																															
Treatment Begin Date: ____/____/____ Treatment End Date: ____/____/____																															
Provider Identification Number: _____ Provider Name: _____																															
Address: _____ City/State: _____																															
Recommended Duration _____ units/days Client agrees to follow recommendation? <input type="checkbox"/> YES <input type="checkbox"/> NO																															
<p><i>Notwithstanding CDR recommendations, benefits are payable subject to terms, conditions, provisions and limitations of the General Motors Health Care Plan. Any recommended reimbursable interventions not commencing within two weeks of the specified "Treatment Begin Date" are null and void. In this event, the CDR Assessment Coordinator must be contacted for a reassessment of treatment needs.</i></p>																															
Did client sign authorization consent form? <input type="checkbox"/> YES <input type="checkbox"/> NO Date: ____/____/____																															

D. CONTINUING CARE TREATMENT PLAN (FORM 2) GENERAL INFORMATION

1. The Assessment Coordinator is responsible for managing the care of the enrollee through a clinical assessment and the development of a CCTP that reflects the treatment needs of the enrollee and the available resources of the community.
2. Sanctions occur when an employee fails to comply with a CCTP or fails to obtain a CCTP after the first 3 days of detoxification. After the first occurrence, a warning letter is issued by the Carrier, CBH, to the employee and the employing unit's Medical Director. The second occurrence results in a notice from CBH of overpayment of benefits in the amount of up to \$500. Overpayment levels for the third occurrence are up to \$750. For the fourth or subsequent occurrence an overpayment of benefits of up to \$1000 may occur. Sanctions do not pertain to spouses, dependents or retirees. If an employee is on short or long-term disability and is going to return to work, sanctions for failure to comply with treatment can be imposed in this case.

If a patient is under 65 years old and retired, sanctions **cannot** be imposed because the patient will not be returning to work. The sanctions are imposed based on "return to work "guidelines.

3. Of crucial importance in the sanctioning process is the timeliness and thoroughness of the CDR in documenting the success or failure of an employee to complete the reimbursable requirements identified on the CCTP.


The goal of the sanction process is to motivate the employee to comply with the recommendations of the CCTP. In order for the sanction process to affect the employee who does not comply with the recommendations of the CCTP, the warning letter and subsequent penalty letters must be issued in a timely fashion. The CDR is the initial and most significant link in the process and must be attentive to the documentation and timing surrounding case closure and CCTP revisions.
4. This form records the diagnosis and recommended levels of treatment for substance abuse. The Assessment Coordinator completes this form based on the plans developed through the assessment and referral process. This form can be used to record initial treatment recommendations, detoxification beyond 72 hours, recommendations; and for reimbursable and non-reimbursable referrals.
Reminder, the CCTP is the authorization statement for providers of substance abuse services.
5. The form distribution is as follows:
 - a. Sent to the CRO
 - b. Make copies for the CDR files, and for the providers, WORK/FAMILY representatives, and the patient as necessary.

E. GUIDELINES FOR COMPLETING FORM 2:

Complete this form for each client requiring a Continuing Care Treatment Plan for substance abuse services, and when there is a change in the levels of reimbursable treatment and/or number of authorized days/visits.

1. Demographics

Complete all demographic information. Record the CDR agency number. The case open date should correspond to the date of the first contact of each case. Indicate the date the treatment recommendations were revised. All Continuing Care Treatment Plans with recommendations for reimbursable interventions must include an appropriate ICD-9 substance abuse diagnosis.

2. Detoxification - Section A

When recommending a detoxification extension, list the days recommended for detoxification excluding the initial three days approved when registered with the CRO.

3. Reimbursable Substance Abuse Interventions-Section B

Recommendations listed here must be for reimbursable treatment services. Referrals must be made to a panel provider that is approved for the treatment modality recommended. Access to care is a core issue, and if there are no panel providers in your locality please contact the CRO.

Providers must be listed according to provider id #, name, city and state indicated on the current approved provider list. This is important since a provider with multiple locations may be approved in one location and not approved in others. The type of treatment modality recommended must be indicated.

All recommendations listed in the Reimbursable Intervention(s), Section B, must be within the known limits of benefits available to the client. Always list detoxification, inpatient and residential treatment as separate recommendations even if in the same facility. The Recommended Duration (days) apply to any detoxification, inpatient, partial and halfway house treatment and units to outpatient visits recommended.

If more than one reimbursable recommendation is made, show each in proper time order according to their recommended use. List the date treatment is recommended to begin. This date must never be prior to the date of first contact listed on the Diagnostic Assessment Form and should be on or after the date of the first assessment interview. (Continuing Care Treatment Plans may not be backdated unless it approved by the CDR Coordinator).

The treatment end date specifies the length of time within which the authorized treatment should occur.

Drugs (i.e., Methadone, Antabuse, Naltrexone) administered on an outpatient basis are not reimbursable under the program unless they are dispensed by a facility in connection with reimbursable substance abuse treatment received at the facility on the same day.

Because the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program emphasizes community based treatment, all referrals made to treatment providers outside your state must receive prior approval from the CRO.

4. Treatment Plan Revision

Any recommended change in treatment, after the Continuing Care Treatment Plan, must be listed as a revision and indicated in a new box. If this is not the first treatment plan submitted for this period of service (case) the appropriate reason for treatment plan revision must be indicated in this section. Treatment recommendations may change at several points in the process of the client's reimbursable substance abuse care. The treatment plan can be revised as many times as the CDR Assessment Coordinator deems appropriate and at any juncture within the assessment process.

If a revision is made, the new treatment plan must include all previous unchanged recommendations made, including ones already completed, plus all revised or new recommendations. As an example, the original treatment plan recommends fourteen (14) inpatient days followed by ten (10) outpatient contacts. After two inpatient days a decision is made to transfer the client to a different facility for the duration originally recommended. The revised treatment plan should be recorded on the form indicating Facility A, inpatient 3 days, followed by Facility B, inpatient 11 days, followed by the outpatient recommendations showing 10 contacts.

A copy of all revised treatment plans must be sent to the CRO promptly and a copy should be made available to the client and/or treatment provider. The CRO will consider the latest treatment plan in their possession as the authorized treatment.

We have updated the CDR form i.e., the CCTP for the General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program to accurately record the specific treatment modality you, as the CDR, are certifying as medically necessary. (Please be sure to throw away any CDR forms that are dated before 2/1/2005.)

Please note that the CDR enhancement applies to the authorizations for outpatient treatment and the MD charges for inpatient rehab and partial hospitalization. The authorizations that you have been recording for the other levels of care i.e. detox, inpatient rehab, halfway house, partial hospitalization and ordering specialized lab tests for marijuana all remain the same. Please review the 23 choices that can be made in each bucket (box) on the Continuing Care Treatment Plan.

Levels of treatment numbered 1-7 have been used before and are self-explanatory.

Levels of treatment numbered 8-12 deal with the type of outpatient treatment to be done and the time frame for individual sessions i.e. individual therapy-half session or whole, family therapy, group therapy and medication management. Please note that the selection of medication management as well as all of the other treatment selections is to be done **only when the primary diagnosis is substance abuse**. If the primary diagnosis is mental health, the CRO needs to be contacted and a care manager needs to be involved in the management of the case. The CDR should stay in touch with the case manager and work in conjunction with him/her especially patients with extensive mental health and substance abuse history.

Levels of treatment numbered 13-17 occur if an outpatient psychiatric/psychological consult is necessary. The difference in each level of treatment is based solely on the time spent for the evaluations i.e. time ranges from 15 to 80 minutes. These are used rarely.

Selection number 18 addresses the administrative denial of the provider. There are times when network providers do not follow the protocols written in their contract pertaining to obtaining an authorization prior to delivering a service (other than the initial visit/session). If a network provider contacts you to obtain authorization for substance abuse treatment after treatment has started, you are to comply with the following procedure. After you complete your assessment of the patient and develop a CCTP, you are to record a denial for the network provider for all dates of service prior to the date the CCTP was developed. When you check number 18 you need to record the date range during which time the provider is denied (denial needs to be discussed with the CDR Coordinator at the CRO to ensure the denial is appropriate and appeal procedures can be followed). (Provider is not reimbursed for services provided and the provider is not able to bill the patient for these services). All medically necessary treatment that occurs after the denial period is to be recorded in the next bucket.(box)

Please note that the sanction process for the **patient** is different from the denial process for the provider. The **employee** sanction is still recorded on the CDR Case Management form.

Selection 19 is used if the CDR is aware that the patient has been admitted to an emergency room. The CDR needs to do an authorization and CBH will pay all bills meeting the “prudent lay-person” standard.

Selections 20-25 are used for MD charges while the patient is inpatient or in partial hospitalization at a facility, if it is not all-inclusive. Specifically, selection 20 is an **initial** authorization for a 30- minute visit, selection 21 is an **initial** authorization for a 50 minute visit and selection 22 is an **initial** authorization for a 70 minute visit. Selection 23 is a **subsequent** authorization for a 15 minute visit, selection 24 is a **subsequent** authorization for a 25 minute visit and selection 25 is a **subsequent** authorization for a 35 minute visit by an MD.

The following is an example of how to enter an authorization:

A patient has been sent for outpatient treatment. He will have 20 sessions from 1/2/2000-6/30/2000.

The sessions need to be broken down like this:

1	initial OP interview (bucket 1-Item #5 is checked)	1/2/2000-1/2/2000	If appropriate
9	full ind. therapy (bucket 2-Item #8 is checked)	1/3/2000-6/30/2000	
8	group therapy (bucket3-Item #11 is checked)	1/3/2000-6/30/2000	
2	family therapy (bucket 4-Item #10 is checked)	1/3/2000-6/30/2000	

Each one of these treatment types must be put in a different bucket (box) on the form.

Reminder: #'s 13-17 are for outpatient consults, typically psychiatric or psychological in nature that can't be handled within regular outpatient sessions.

SUGGESTED METHADONE PROGRAM GUIDELINES

The current guidelines for methadone maintenance make the assumption that an individual who is involved in a methadone program is an individual who has a long-term addiction and who may require long-term maintenance in a methadone program.

The current literature recommends for methadone maintenance, a daily dose of 80-120 mg is appropriate. Individuals who have daily doses in the range of 50-60 mg are reported in the literature to be highly vulnerable to relapse. Some individuals who are on lower maintenance doses i.e. 30-50 mg can report complaints that the dose “doesn’t cover” the discomfort of withdrawal. If the individual is involved in a good group program this can be enough support to assist the individual to remain on this lower maintenance dose.

The symptoms of methadone withdrawal may be more severely experienced by an individual than the withdrawal symptoms from heroin.

An individual is considered a candidate for methadone withdrawal if:

- 1) They are actively involved in the treatment program provided
- 2) They have had a significant period of time where their random urinalyses did not come up positive for opiates or other drugs.
- 3) The individual expresses a desire to detox from methadone
- 4) The therapist concurs that detox is in the best interest of the patient

A withdrawal dose schedule of up to 5 mg per day is clinically feasible, though in reality outpatient methadone withdrawal is a slow process, with reductions in dose of 1 mg per week being more of the norm.

An individual in a methadone maintenance program must also be in therapy in order to receive a benefit per the GM or DELPHI benefit plan design. The preferred treatment modality is weekly group therapy with a maximum of 6 members in the group. Occasionally individual therapy may be appropriate to address pertinent individuals not able to be addressed in a group setting. It can occur occasionally and minimally in addition to the weekly group therapy, which is the preferred therapeutic modality.

MARIJUANA TESTING

As of 1998, the UAW and General Motors have requested drugs screens for marijuana use for employees. When an employee is on a substance abuse related sick leave a drug screen for marijuana is to be completed while the patient is in treatment. This test must be obtained from a Department of Health and Human Services (DHHS) approved laboratory using the gas chromatography (GC)/ mass spectrometry (MS) technology, and specifying the urine creatinine concentration in ng/dl. The purpose of this test, if completed according to these guidelines is to be available to be used as a baseline test for applying the falling rate theory for marijuana in determining whether or not an employee tests positive for marijuana upon return from a substance abuse sick leave.

All CDR assessment coordinators, when developing a continuing care treatment plan (CCTP) for an employee, and if inpatient, partial, or IOP levels of treatment are recommended, that you contact the treating facility and inform them of this requirement. **Include # 7 on the CCTP so that a drug screen for marijuana can be completed. This drug screen is covered under the current benefit.**

Guidelines for re-certification of outpatient substance abuse treatment

There are 35 outpatient substance abuse sessions per **calendar** year. When outpatient treatment is going to continue from 1 year to the next, the authorization needs to be divided into 2 separate buckets on the CCTP.

For example, 2004 authorizations should be in Section B bucket 1. 2005 authorizations should be in Section B bucket 2 on the CCTP form.

The benefit starts again at the beginning of the New Year. The patient may not need another assessment so the overlapping treatment from 1 year to another needs to be handled in the manner described above.

For inpatient and/or partial treatment, the authorization is continuous. Authorization is based on 45 days inpatient or partial hospitalization, and 60 days out of any inpatient facility, halfway house, nursing home, etc.

Enrollee Input on the CCTP

Assessment Coordinators are encouraged to seek enrollee input when developing a CCTP. However, if after discussions are held, the Assessment Coordinator's recommendation is not in harmony with the enrollee's desires, the Assessment Coordinator has **full authority to maintain his or her clinical position** stated on the CCTP. It is not necessary to reach a compromise or to allow the enrollee to choose treatment options unless the options have the potential for equal efficacy. However, the enrollee does retain the right of appeal with the process noted within this manual.

If the enrollee refuses to accept the CCTP recommendations, the Assessment Coordinator should note the refusal on the CCTP and notify the WORK/FAMILY representative if a confidentiality release has been signed.

Treatment of Dual Diagnosed Patients

Significant problems in the management of dually diagnosed patients arise primarily when an Axis I psychiatric disorder co-exists with active substance abuse/dependence. To be admitted to a dual diagnosis unit, the patient must meet Clinical Criteria codes for both psychiatric and substance abuse treatment. Given the problems that chemical dependency may cause in cognitive functioning, the chemical dependence diagnosis should be the primary diagnostic focus of treatment unless the severity of psychiatric condition poses an immediate risk to the patient. Identification of a significant Axis II disorder such as borderline or antisocial personality is important in targeting plans for continuing care.

Some psychiatric symptoms are artifacts of substance abuse. Untreated psychiatric illness contributes to relapse. While medication therapy is not always the answer, appropriate use of psychotropic medication is not incompatible with abstinence. Where psychiatric disorders exist, an appropriate treatment plan must be developed.

RELAPSE

Much effort is focused on breaking patterns of denial and enabling behaviors that have permitted the individual and family to avoid dealing with the impact of the substance abuse.

Relapse is an issue that will be monitored comprehensively with the Delphi Corporation and General Motors as a major piece of the year end reports for both organizations.

A medically necessary program for relapse is customized (in duration and in targeted interventions) to the needs of the recovering individual.

F. GUIDELINES FOR INTENSIVE OUTPATIENT PROGRAMS (IOP)

An IOP benefit was added to the General Motors Careline Program and the Delphi Corporation Mental Health and Substance Abuse Program provider contract, as of 1997. This is not a new benefit.

It will draw off of the 35 outpatient visits per calendar year. However, IOP does require separate authorization. Please note that a new modality line has been added to the Continuing Care Treatment Plan to be checked when authorizing for IOP.

IOP programs are indicated for patients who require structured, multi-modal treatment. This enables patients to maintain residence in the community and continue their work, attend school, and be part of family life. An ideal IOP program has variable lengths of stay and reduces each participant's frequency of attendance as recovery becomes reliably established and the individual can resume more of his/her usual life obligations.

The following is a list of criteria to use to determine if the program is standard outpatient, IOP, or partial treatment. Once you have determined which course of treatment is to be authorized, be sure you clearly communicate this information to the facility. If their billing does not match the authorization the bills will be denied.

1. Treatment must be more than two hours a day but may not be more than four hours per day.
2. Treatment must occur two to three times per week.
3. The program must be in a paneled clinic/facility not in an individual provider's office.
4. The program consists of multiple treatment modalities (i.e.: individual/didactic/group.)

Over four hours a day, more than 3 times a week must be authorized as partial treatment. One to two hours per day, once a week must be authorized as standard outpatient.

Please note if you authorize for an IOP program or a partial program for a period of time, that authorization applies to the patient regardless of whether he attends.

III. PAYMENT AND REPORTING

A. PROVIDER PAYMENT

The CRO benefit authorization data for mental health and substance abuse services is submitted to CBH for payment of services. CBH will match the authorized data with the provider claims and pay accordingly. It is the responsibility of providers to submit claims to CBH at the following address:

**CIGNA Behavioral Health
P.O. Box 5132
Southfield, MI 48086**

It should be noted that although coverage eligibility and available benefits are checked when a provider contacts the General Motors Careline Program or the Delphi Corporation Mental Health and Substance Abuse Program, this does not guarantee reimbursement for services. Payment depends on several factors including: eligibility, program limitations and coordination of benefits with other plans.

B. CDR PAYMENT

Mutually agreed upon rates have been established for all CDR agencies. Payment will come from CBH by sending a HCFA 1500 which should match the dates on the CDR Case Management form exactly. The payment is according to the contracted rate per service (see definition of reimbursable services, Section IV, appendix C). The agency should fax the CDR Case Management forms to the CRO as soon as possible after the initial assessment.

The CDR should mail the HCFA 1500 forms to:

**CIGNA Behavioral Health
P.O. Box 5132
Southfield, MI 48086**

C. CASE CLOSURE

In order to maintain accurate data, cases should be reviewed at the assessment, mid-treatment, discharge review and employee adjustment counseling phases to determine the appropriate status of a case. Follow up should occur on cases without contact for 30 days, to ensure timely closure.

D. ACTIVITY REPORTS

Quarterly and annual Program Activity Reports for all CDR activity may be submitted to General Motors and Delphi. Each CDR Agency Administrator may receive requests to complete a Program Activity Report.

The reports will summarize the total number of assessment sessions, treatment plans, mid-term treatment reviews, discharge plans, adjustment counseling sessions and referrals to out of network providers.

E. QUALITY ASSURANCE REPORTS

Using the CDR quality assurance indicators, reports will be submitted and utilized to improve the quality of service provided to enrollees.

Here are some of the quality assurance guidelines:

1. Implementation of the ASAM Criteria for Substance Abuse Treatment
2. Appropriate use of CROW Clinical Criteria for Mental Health Assessments
3. Appropriate assessment of contributing physical problems of the patient
4. Compliance with and appropriate application of the sanction process.
5. Consistent application of the sanction process for chronic patients (more than three distinct) lifetime inpatient treatment episodes - rehab or detox) who, while in outpatient, partial care “relapse” and require treatment at either the inpatient or detox level of care.
6. Compliance with an appeals process.
7. Timeliness of paperwork flow to ValueOptions/General Motors Careline and Delphi Corporation Mental Health and Substance Abuse Programs account for provider payment. This is defined as postmarked or faxed within two business days after the date of the initial assessment, treatment updates or mid treatment review, or the due date of the discharge report.
8. Case management of inpatient substance abuse, that provides for re-assessment of continuing inpatient days, a maximum of every 7 days.
9. Clear documentation of the rationale for inpatient rehabilitation for chronic substance abusers (more than 3 lifetime inpatient rehabilitation treatments)
10. Compliance with General Motors Careline Program and Delphi Corporation Mental Health and Substance Abuse Program protocols for all detox episodes of care
11. Discharge plans information, which specifically includes outcomes and aftercare suggestions.

F. CDR REPORTING

To assist in prevention of problems in areas where CDR reside, CDR Administrators are asked to review their network of CDR representatives monthly. The review should focus on potential problems with policy enforcement or procedures, WORK/FAMILY communication, provider quality or access issues. In addition, previously identified issues may be given status updates.

A brief monthly narrative summary of potential problems, recommendations for problem resolution, and problems solved is due by the 15th of the month. This report will assist CBH, ValueOptions, WORK/FAMILY representatives, and CDR Coordinators in identifying problems and solutions for the benefit of the CDR network. Please note: only one report should be sent for CDR vendor network, not one reports for each CDR location.

G. INQUIRIES TO CDR REGARDING BENEFITS OTHER THAN MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

From time to time inquiries are received by CDR regarding general health care coverage eligibility. Even though the CDR may be knowledgeable about a particular coverage, such inquiries for General Motors or Delphi employees should be referred to the respective program's eligibility vendor contacts at the following numbers:

General Motors Hourly active & retirees: 1-800-235-2302

Delphi Corporation Hourly active & retirees 1-877-786-4008

The UAW benefit representatives and the WORK/FAMILY Representatives at each plant can be helpful also.

H. CDR CATCHMENT AREAS

The CDR will be responsible for enrollees living within a 40- mile radius of the CDR agency location unless such boundaries intersect with other CDR agency catchment areas.

In areas where more than one CDR is within a 40- mile radius, the boundaries of responsibility will be defined by zip code. All areas outside the CDR 40 mile radius will be considered remote and the responsibility of the CRO to determine appropriate care of the enrollee.

1. Phone Interviews

The CRO may contact the CDR closest to the enrollee's residence to help coordinate care and may request assessment and other CDR services be done by the CDR either by phone or face-to-face. All phone interviews are to be authorized by the CRO if outside the 40 mile catchment area radius. The CDR must report all phone interviews to the CRO.

IV. APPENDICES

A. EMPLOYEE ASSISTANCE PROGRAM (WORK/ FAMILY) REFERRALS

WORK/FAMILY representatives will be referring employees and enrollees to the CDR for a variety of reasons. It is important to remember that the WORK/FAMILY representative plays an integral role in the early identification of employees with problems and in follow-up and support.

WORK/FAMILY representatives often know the employees with substance abuse problems including treatment history, job performance, level of motivation, and have knowledge of the plant community overall. Consultation with the WORK/FAMILY representative is valuable in making accurate assessments and appropriate referrals. The employee prior to consultation with the WORK/FAMILY Representative must sign a valid release of information. The employee should be encouraged to sign a release of information for WORK/FAMILY representative. Both the WORK/FAMILY representative and the CDR agency have a common goal of helping the employee deal with a problem through appropriate assistance and normal differences of opinion should be resolved within the context of this common goal.

The WORK/FAMILY Representative may refer an employee if the employee has a substance abuse problem, a mental health problem, a life situation problem that could respond to adjustment counseling, or if the WORK/FAMILY Representative is uncertain as to the nature of the employee's problem. Regardless of the reason for referral, the eligible employee should be scheduled for an assessment interview.

In addition, there is a category of referral that deserves special mention:

1. **Drug Testing Policy Referral**. Some General Motors or Delphi Automotive Systems, employees returning to work from substance abuse related sick leave might be tested for drug/alcohol use as a part of the return to work physical. Employees testing positive will have their return to work deferred for up to two weeks and may be referred to the CDR. These employees will be tested again, approximately two weeks from the date of the original drug/alcohol test. Therefore, it is important to maintain close contact with the WORK/ FAMILY Representative concerning the assessment and treatment planning in order to effectively coordinate referrals and for case management. As in all other cases, CDR contact with the WORK/FAMILY Representative regarding clients must be authorized by a valid release of information.

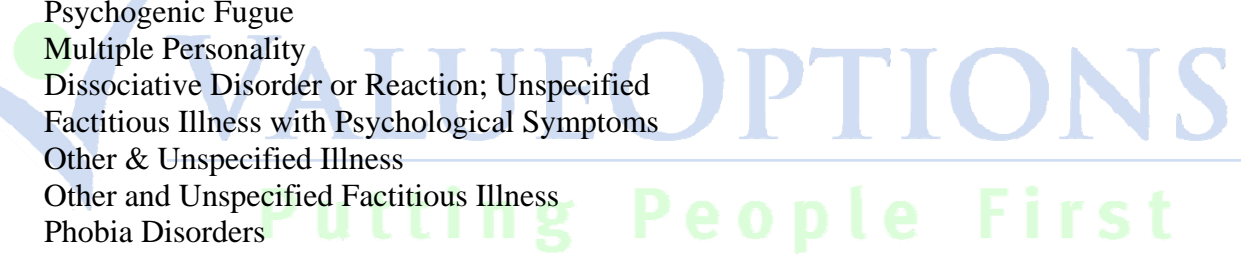
The following diagnostic codes information identifies the internal classification of mental health and substance abuse diseases by diagnostic code according to the International Classification of Diseases Ninth Revision ICD-9-CM, 1989, U.S. Department of Health and Human Services.

These diagnostic codes may be reimbursable for diagnostic evaluation and treatment under the General Motors Careline and Delphi Corporation Mental Health and Substance Abuse program.

MENTAL HEALTH CODES

<u>DX Code</u>	<u>Description</u>
290.00	Senile Dementia Uncomplicated
290.10	Presenile Dementia, Uncomplicated
290.20	Senile Dementia with Delusional Features
290.21	Senile Dementia with Depressive Features
290.30	Senile Dementia with Delirium
290.40	Arteriosclerotic Dementia
290.80	Other Specified Senile Psychotic Conditions
290.90	Unspecified Senile Psychotic Condition
293.00	Acute Delirium
293.81	Organic Delusional Syndrome
293.82	Organic Hallucinosi s Syndrome
293.83	Organic Affective Syndrome
294.00	Amnes tic Syndrome
294.10	Dementia in Conditions Classified Elsewhere
294.80	Other Unspecified Organic Brain Syndromes (Chronic)
295.00	Schizophrenia, Simple Type
295.10	Schizophrenia, Disorganized Type
295.20	Schizophrenia, Catatonic Type
295.30	Schizophrenia, Paranoid Type
295.40	Acute Schizophrenic Episode
295.50	Latent Schizophrenic
295.60	Residual Schizophrenia
295.70	Schizo-Affective Type
295.80	Other Specified Types of Schizophrenia
295.90	Unspecified Schizophrenia
296.00	Manic Disorder; Single Episode
296.10	Manic Disorder; Recurrent Episode
296.20	Major Depressive Disorder; Single Episode
296.30	Major Depressive Disorder; Recurrent Episode
296.40	Bipolar Affective Disorder; Manic
296.50	Bipolar Affective Disorder; Depressed
296.60	Bipolar Affective Disorder; Mixed
296.70	Bipolar Affective Disorder; Unspecified
296.80	Manic-Depressive Psychoses; Other and Unspecified
296.90	Other and Unspecified Affective Psychoses
297	Paranoid States

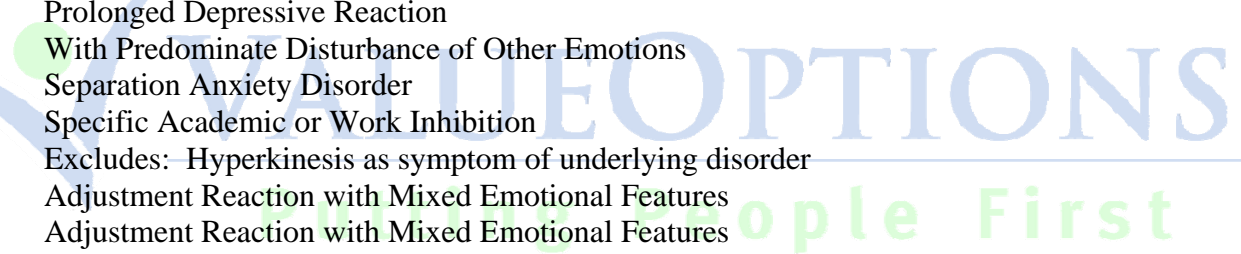
297.10 Paranoia
 297.30 Shared Paranoid Disorder
 297.90 Unspecified Paranoid State
 298 Other Nonorganic Psychoses
 298.20 Reactive Confusion
 298.3 Acute Paranoid Reaction
 298.4 Psychogenic Paranoid Psychosis
 298.8 Other and Unspecified Reactive Psychosis
 298.9 Unspecified Psychosis
 299 Psychoses with Origin Specific to Childhood
 299.1 Disintegrative Psychosis
 299.8 Other Unspecified Early Childhood Psychoses
 299.9 Unspecified
 300.00 Anxiety States; Unspecified
 300.0 Anxiety States
 300.01 Panic Disorder
 300.02 Generalized Anxiety Disorder
 300.09 Other
 300.1 Hysteria
 300.10 Hysteria; Unspecified
 300.11 Conversion Disorder
 300.12 Psychogenic Amnesia
 300.13 Psychogenic Fugue
 300.14 Multiple Personality
 300.15 Dissociative Disorder or Reaction; Unspecified
 300.16 Factitious Illness with Psychological Symptoms
 300.19 Other & Unspecified Illness
 300.19 Other and Unspecified Factitious Illness
 300.2 Phobia Disorders
 300.20 Phobia Unspecified
 300.21 Agoraphobia with Panic Attacks
 300.22 Agoraphobia without Panic Attacks
 300.23 Social Phobia
 300.29 Other Isolated or Simple Phobias
 300.3 Obsessive-Compulsive Disorders
 300.4 Neurotic Depression
 300.4 Neurotic Depression
 300.5 Neurasthenia
 300.6 Depersonalization Syndrome
 300.7 Hypochondriasis
 300.8 Other Neurotic Disorders
 300.9 Unspecified Neurotic Disorders
 301 Personality Disorders, Includes Character Neurosis
 301.0 Paranoid Personality Disorder
 301.1 Affective Personality Disorder
 301.10 Affective Personality Disorder, Unspecified
 301.11 Chronic Hypomanic Personality Disorder
 301.12 Chronic Depressive Personality Disorder
 301.13 Cyclothymic Disorder
 301.2 Schizoid Personality Disorder



301.20 Schizoid Personality Disorder, Unspecified
 301.21 Introverted Personality
 301.22 Schizotypal Personality
 301.3 Explosive Personality Disorder
 301.4 Compulsive Personality Disorder
 301.5 Histrionic Personality Disorder
 301.50 Histrionic Personality Disorder, Unspecified
 301.51 Chronic Factitious Illness with Physical Symptoms
 301.51 Chronic Factitious Illness with Physical Symptoms
 301.59 Other Histrionic Personality Disorder
 301.6 Dependent Personality Disorder
 301.8 Other Personality Disorders
 301.81 Narcissistic Personality
 301.82 Avoidant Personality
 301.83 Borderline Personality
 301.84 Passive-Aggressive Personality
 301.89 Other
 301.9 Unspecified Personality Disorder
 302 Sexual Deviations and Disorders
 302.1 Zoophilia
 302.2 Pedophilia
 302.3 Transvestism
 302.4 Exhibitionism
 302.5 Trans-sexualism
 302.50 Trans-sexualism With Unspecified Sexual History
 302.51 Trans-sexualism With Asexual History
 302.52 Trans-sexualism With Homosexual History
 302.53 Trans-sexualism With Heterosexual History
 302.6 Disorders of Psychosexual Identity
 302.7 Psychosexual Dysfunction
 302.70 Psychosexual Dysfunction, Unspecified
 302.71 With Inhibited Sexual Desire
 302.72 With Inhibited Sexual Excitement
 302.73 With Inhibited Female Orgasm
 302.74 With Inhibited Male Orgasm
 302.75 With Premature Ejaculation
 302.76 With Functional Dyspareunia
 302.79 With Other Specified Psychosexual Dysfunctions
 302.8 Other Specified Psychosexual Disorders
 302.81 Fetishism
 302.82 Voyeurism
 302.83 Sexual Masochism
 302.83 Sexual Masochism
 302.84 Sexual Sadism
 302.84 Sexual Sadism
 302.85 Gender Identity Disorder of Adolescent or Adult Life
 302.89 Other
 302.9 Unspecified Psychosexual Disorder
 307.1 Anorexia Nervosa
 307.20 Tic Disorder, Unspecified



- 307.21 Transient Tic Disorder of Childhood
- 307.22 Chronic Motor Tic Disorder
- 307.23 Gilles de la Tourette's Disorder
- 307.40 Nonorganic Sleep Disorder, Unspecified
- 307.42 Persistent Disorder of Initiating or Maintaining Sleep
- 307.44 Persistent Disorder of Initiating or Maintaining Wakefulness
- 307.45 Phase-shift Disruption of 24-hour Sleep-wake Cycle
- 307.46 Somnambulism or Night Terrors
- 307.47 Other Dysfunctions of Sleep Stages or Arousal From Sleep
- 307.51 Bulimia
- 307.52 Pica
- 307.6 Enuresis
- 307.7 Encopresis
- 307.80 Psychogenic Pain, Site Unspecified
- 308 Acute Reaction to Stress
- 308.0 Predominate Disturbance of Emotions
- 308.1 Predominate Disturbance of Consciousness
- 308.2 Predominate Psychomotor Disturbance
- 308.3 Other Acute Reactions to Stress
- 308.4 Mixed Disorders as Reactions to Stress
- 308.9 Unspecified Reactions to Stress
- 309.0 Brief Depressive Reaction
- 309.1 Prolonged Depressive Reaction
- 309.2 With Predominate Disturbance of Other Emotions
- 309.21 Separation Anxiety Disorder
- 309.23 Specific Academic or Work Inhibition
- Excludes: Hyperkinesia as symptom of underlying disorder
- 309.24 Adjustment Reaction with Mixed Emotional Features
- 309.28 Adjustment Reaction with Mixed Emotional Features
- 309.3 With Predominate Disturbance of Conduct
- 309.4 With Mixed Disturbance of Emotions and Conduct
- 309.8 Other Specified Adjustment Reaction
- 309.81 Prolonged Post traumatic Stress Disorder
- 309.82 Adjustment Reaction with Physical Symptoms
- 309.83 Adjustment Reaction with Withdrawal
- 309.9 Unspecified Adjustment Reaction
- 310.1 Organic Personality Syndrome
- 311 Depressive Disorder; Not Elsewhere Classified
- 311 Depressive Disorder; Not Elsewhere Classified
- 312 Disturbance of Conduct; Not Elsewhere Classified
- 312.0 Undersocialized Conduct Disorder; Aggressive Type
- 312.2 Socialized Conduct Disorder
- 312.3 Disorders of Impulse Control; Not Elsewhere Classified
- 312.31 Pathological Gambling
- 312.32 Kleptomania
- 312.33 Pyromania
- 312.33 Pyromania
- 312.34 Intermittent Explosive Disorder
- 312.34 Intermittent Explosive Disorder
- 312.35 Isolated Explosive Disorder



- 312.39 Other
- 312.39 Other Disorders of Impulse Control NEC
- 312.4 Mixed Disturbance of Conduct and Emotions
- 312.8 Other Classified Disturbances of Conduct; Not Elsewhere Classified
- 312.8 Other Specified Disturbances of Conduct; Not Elsewhere Classified
- 313.0 Overanxious Disorder
- 313.1 Misery and Unhappiness Disorder
- 313.2 Sensitivity, Shyness, and Social Withdrawal
- 313.21 Shyness Disorder of Childhood
- 313.21 Shyness Disorder of Childhood
- 313.22 Introverted Disorder of Childhood
- 313.3 Relationship Problems
- 313.8 Other or Mixed Emotional Disturbances of Childhood or Adolescent
- 313.81 Oppositional Disorder
- 314 Hyperkinetic Syndrome of Childhood
- 314.0 Attention Deficit Disorder
- 314.00 Without Mention of Hyperactivity
- 314.1 Hyperkinesis With Developmental Delay
- 314.2 Hyperkinetic Disorder
- 314.9 Unspecified Hyperkinetic Disorder
- 316 Psychic Factors Associated with Diseases Classified Elsewhere
- 317.00 Mild Mental Retardation
- 318.00 Moderate Mental Retardation



SUBSTANCE ABUSE CODES

291	Alcoholic Psychoses
291.0	Alcohol Withdrawal Delirium
291.1	Alcohol Amnestic Syndrome
291.2	Other Alcoholic Dementia
291.3	Alcohol Withdrawal Hallucinosi
291.4	Idiosyncratic Alcohol Intoxication
291.5	Alcoholic Jealousy
291.8	Other Specified Alcoholic Psychosis
291.9	Unspecified Alcoholic Psychosis
292	Drug Psychosis
292.0	Drug Withdrawal Syndrome
292.1	Paranoid and/or Hallucinatory States Induced by Drugs
292.11	Drug-induced Organic Delusional Syndrome
292.12	Drug-induced Hallucinosi
292.2	Pathological Drug Intoxication
292.8	Other Specified Drug-induced mental disorders
292.81	Drug-induced Delirium
292.89	Other
292.9	Unspecified Drug-induced Mental Disorder
303	Alcohol Dependence Syndrome
303.0	Acute Alcoholic Intoxication
303.9	Other and Unspecified Alcohol Dependence
304	Drug Dependence
304.0	Opioid Type Dependence
304.1	Barbiturate and Similarly Active or Hypnotic Dependence
304.2	Cocaine Dependence
304.3	Cannabis Dependence
304.4	Amphetamine and Other Psychostimulant Dependence
304.5	Hallucinogen Dependence
304.6	Other Specified Drug Dependence
304.7	Combination of Opioid Type Drug with Any Other
304.8	Combinations of Drug Dependence Excluding Opioid Type Drug
304.9	Unspecified Drug Dependence
305.0	Alcohol Abuse
305.2	Cannabis Abuse
305.3	Hallucinogen Abuse
305.4	Barbiturate and Similarly Acting Sedative or Hypnotic
305.5	Opioid Abuse
305.6	Cocaine Abuse
305.7	Amphetamine or Related Acting Sympathomimetic Abuse
305.8	Antidepressant Type Abuse

CENTRAL DIAGNOSTIC AND REFERRAL AGENCY REQUIREMENTS

STANDARDS FOR CENTRAL DIAGNOSTIC AND REFERRAL AGENCY

1. The Corporate-Union Committee on Health Care Benefits (CUCHCB) will establish standards to impanel and monitor a program of "central diagnostic and referral agencies" or "CDR". This refers to a national network of local agencies which employs assessment coordinators designated to:
 - 1) make all contractually mandated face-to-face assessments for the development of substance abuse continuing care treatment plans;
 - 2) make determinations as to whether the patient's condition requires mental health or substance abuse treatment;
 - 3) make referrals to panel providers;
 - 4) perform after-care planning and follow-up as indicated;
 - 5) provide short- term adjustment counseling for employees.

In addition, the CDR will communicate with WORK/FAMILY Program Representatives and Benefit Representatives about assessment and referral activities relating to an employee, where appropriate and when authorized by the employee. The CDR will supply necessary information to the Central Review Organization (CRO) and CBH about provider performance, selection and other utilization data and statistics as required, including evaluations using appropriate performance data of panel providers.

2. The standards and criteria set forth in this document will address the licensure, credentialing, privileging, scope of service, access, availability of care, and geographic distribution of the CDR as they will interact within a national network of local agencies.
3. The Corporation-Union Committee on Health Care Benefits (CUCHCB) will arrange for quality, cost-effective central diagnostic and referral services in required locations nationwide. The number and location of necessary sites will be established to provide adequate access and availability of services to all Traditional and PPO option enrollees in the General Motors and Delphi Corporation Mental Health and Substance Abuse Program. To assure consistency from location to location, requirements will be established for vendors of CDR services.

MISSION/GOAL

1. Each contracted CDR agency must agree to, and maintain, a treatment philosophy consistent with the objectives of the managed mental health and substance abuse program. Our objective is to create an environment in which all enrollees and their eligible dependents may receive psychiatric care and substance abuse treatment from quality providers that is most appropriate to their condition. In addition, short-term adjustment counseling will be available from the CDR for employees.
2. The goal of the program is to assure the provision of quality and appropriate mental health and substance abuse services and to provide access to care for all enrollees. The CDR shall play a pivotal role in the triage of patients from Work/Family Program Representatives and must be able to recognize the most appropriate course of treatment or assistance that will be most cost-effective in the longer term and consistent with the least restrictive and least debilitating

treatment environment and refer accordingly. The CDR will be one major component of an organized managed mental health and substance abuse care delivery program. It will interface appropriately with WORK/FAMILY Program Representatives, the Central Review Organization (CRO) and CBH, a closed panel of substance abuse and mental health providers, including both individual providers and institutions. The CDR, most importantly, will effectively interact with employees in need of mental health or substance abuse care to assure access to this managed care system.

3. The CDR is to be an independent, non-affiliated triage, assessment, referral and short-term adjustment counseling agency. In order to meet these requirements, certain professional standards must be met. The corporation Union Committee on Health Care Benefits oversight group will assure that each of the local agencies making up this national network can perform the necessary diagnostic, evaluative and triage functions up to a standard of care that is essential to our enrollee population.

SITE AND ORGANIZATION

1. Each CDR local agency:
 - ✦ Must have and maintain all requisite state licenses and/or accreditation to provide the required CDR services.
 - ✦ Must avoid any actual or potential conflict of interest with any health care provider.
 - ✦ Should not share physical facilities with an impaneled health care provider of the General Motors Careline and Delphi Corporation Mental Health and Substance Abuse program provider panel network.
 - ✦ Should be organizationally free-standing and not affiliated with any mental health or substance abuse inpatient or outpatient facility.
 - ✦ Must agree to hold GM or DELPHI or any union harmless from any liability claims or suits arising out of or in connection with the vendor's delivery of CDR services.
2. In each case, the CDR will be selected with the joint input of the plant Benefit Representative and the WORK/FAMILY Representative.
3. The ultimate responsibility for selecting and contracting with CDR providers is with the Corporation-Union Committee on Health Care Benefits through the designated agent, CBH.
4. In each particular geographical area, an agency, or a number of individual freestanding agencies, may be chosen to provide the CDR function. In a case such as this, a requirement of these agencies will be to form working groups for purposes of this CDR contract.

STAFFING

1. Consistent with the requirement of high quality diagnostic and referral function, it is essential that each CDR local agency be staffed with appropriate numbers of qualified mental health and substance abuse professionals.
2. "Assessment Coordinator" means a qualified employee of a CDR that has been selected and approved to provide assessment services.

3. Each assessment coordinator who provides intake evaluation and triage assessment must have demonstrated competence through degree and experience to make diagnostic determinations as to the type and scope of the illness, whether it be a mental health or substance abuse condition, and adequate experience and knowledge of the local closed panel of providers to make an appropriate referral.
4. All mental health and substance abuse assessment coordinators must have at a minimum a Master's Degree in clinical or counseling psychology, social work, or psychiatric clinical nurse specialties, with a minimum of 3-5 years of post-master's clinical experience, as well as being professionally certified or licensed by the state at the highest independent practice level for that license or certification.
5. ALL staff members who function as a CDR shall have specific training, expertise, and experience in substance abuse treatment is required and should be credentialed with substance abuse counseling certification such as National Certified Addiction Counselor (NCAC) or National Certified Alcohol and Drug Counselor Certification (NCADC).
6. There must be an adequate number of Ph.D. degree clinical psychologists available.
7. Each CDR local agency must have a consulting psychiatrist available for supervision and consultation on all cases.
8. It is essential that the CDR be able to make diagnostic determinations of the most appropriate level of care and be able to facilitate in a humane manner the access of this care to the affected enrollee. All CDR assessment coordinators are expected to follow medical necessity criteria in making treatment recommendations. CDR staff will be provided criteria for mental health diagnoses. For Substance abuse diagnoses CDR assessment coordinators are to follow ASAM criteria and include referrals to panel providers (hospitals, residential care facilities, and professional outpatient providers), interactions with state community mental health agencies, the court systems, as well as appropriate community or public agencies.
9. Each local agency must have a documented procedure to arrange psychiatric evaluation or second level consultation on any case where there are significant concerns over the validity of the initial triage evaluation.
10. Each agency will provide access to handicapped enrollees and other special assistance as required.

SERVICES

1. The CDR will provide to enrollees the following services: assessment, differential diagnosis, treatment plan development, short-term adjustment counseling for employees, referral, consensus with client and provider on the treatment plan, and follow-up to support a continuum of care. The CDR will be the compulsory assessment coordination site for inpatient substance abuse treatment and substance abuse continuing care treatment plans. It will be the voluntary but preferred access site to outpatient substance abuse treatment and the full range of mental health providers. Each local agency must:
 - _ Provide a direct scheduling of appointments not limited to traditional working hours.

- _ Provide the initial appointments for enrollees within 24 hours of the initial inquiry.
- _ Provide assessment service, including comprehensive history and differential diagnosis as per The Diagnostic and Statistical Manual IV- Revised (DSM-IV-R) or the International Classification of Diseases-9th Revision (ICD-9).
- _ Make arrangements and refer enrollees for appropriate treatment based upon the completed differential diagnosis.
- _ Provide knowledge of a wide range of community resources for treatment or specialized assistance.
- _ Provide a working knowledge of the General Motors and Delphi Corporation Mental Health and Substance Abuse Program benefit coverage for services by the various treatment and referral sources.
- _ Refer enrollees to panel providers.
- _ The CDR also will be responsible for continuing care treatment plans, aftercare planning, follow-up assessment, and documentation consistent with the contractual provisions which support enrollees to complete their substance abuse continuing care treatment plans. In addition, the CDR will communicate such information to the WORK/FAMILY representative when authorized and where appropriate.
- _ The CDR will provide an assessment and a preliminary diagnosis, and develop an initial treatment plan within two (2) visits and/or, in the case of certain employees, provide short-term adjustment counseling for up to three (3) additional visits.
- _ The CDR will refer the patient to a panel provider if treatment is necessary and notify the CRO of the referral. This will be the case for an individual patient who requires mental health or outpatient substance abuse treatment. If an enrollee requires inpatient substance abuse treatment, he CDR will have responsibility of performing the initial assessment, the mid-course evaluation, discharge planning, and will have the responsibility for making the referral to the appropriate panel provider. The CDR will accept referrals from the WORK/FAMILY Program Representative. The CDR will provide crisis intervention, informational counseling, assessment and referral and short-term adjustment counseling for employees who are referred. This component of the CDR function is aimed particularly at early identification of substance abuse problems and strongly encouraging the enrollees to seek the appropriate professional assistance.
- _ The CDR is responsible for monitoring substance abuse outpatient and/or partial courses of treatment when such services are obtained as the result of a continuing care treatment plan prescribed by the CDR and follows either a detoxification and/or residential course of treatment.
- _ With the appropriate release of information, the CDR should communicate back to the WORK/FAMILY Program representative who referred the patient. to the action taken by the CDR in the client's behalf.

- A 24-hour intake hotline should be available in each geographic area. Depending upon the size and complexity of the employee/patient population, this may be handled by the CDR or as a delegated responsibility to the national CRO 1-800 number for down-linkage to 24-hour CDR coverage.
2. Each agency must respond to all emergencies and report them to the CRO.

MANAGEMENT INFORMATION REQUIREMENTS

1. Each CDR local agency through the appropriate channels must promptly submit MIS data to the CRO and/or CBH that will include but not be limited to diagnostic and therapeutic information on clients seen, demographic data on each client, copies of client's treatment plans and quality assurance information as described below.
2. Although the nature and depth of information will depend on the recommended course of action, certain key demographic information will be necessary for all cases:
- CDR identification information: name, city, state, and identification number, staff member responsible for client.
 - Enrollee identification information: name, social security number and/or national ID number, status, and CISCO code.
 - Client identification information: name, relationship to employee, date of birth, location, diagnoses codes (primary, and secondary).
 - Triage and Administrative Process:
 - Reason for contacting CDR (voluntary, mandatory benefit requirement, mandatory attendance procedure related)
 - WORK/FAMILY representative information: client referred to WORK/FAMILY representative, release information authorized, WORK/FAMILY representative contacted.
3. Reports of services provided:
- Substance abuse treatment referral (acute detoxification, inpatient, residential, halfway house): type of review (initial, mid-course, discharge); name of provider and location; type of treatment authorized, units of service authorized.
 - Mental health panel referral: recommended level of treatment; how referral was made (telephone, correspondence, escorted, directed); date of referral, provider name and location. This information will be treated as a triage and a case will be opened by the CRO on its data base.
 - Community resources referral: identification of community resource and date of referral;
 - Short-term adjustment counseling referral: type of counseling provided, dates of service, total sessions provided, additional referrals, name of therapist.

QUALITY ASSURANCE

1. Continuous Monitoring Requirements:

- A document outlining essential quality assurance monitoring indices will be provided and compliance will be agreed to by each CDR as a contractual requirement. This quality assurance documentation will include but not be limited to consideration of a complete bio-psychosocial history assessment including:
 - – treatment justification,
 - – alternative level of care consideration,
 - – history of previous treatment,
 - – physical problems,
 - – treatment plan development,
 - – treatment plan evaluation,
 - – discharge plan,
 - – careful documentation of the continuing care treatment plans.

2. Periodic and Focused Audits:

Periodic audits and assessments will be carried out to ensure continuing compliance with the quality assurance standards outlined above. These audits also will evaluate inter-rater reliability between the various CDR staff and the adherence to established criteria for the required treatment.

3. The CROW protocols for diagnostic categories are to be used as the standardized severity of illness and intensity of service criteria for purposes of this program.
4. Documentation of consistency of standards between the CDR staff and the CRO and consistency with the understanding of the carrier as to the intensity of service referral will be periodically assessed and be considered for the CDR evaluation and decisions resulting in retention of the contract.
5. Selected CDR staff will work with the panel of mental health and substance abuse inpatient and outpatient providers to establish a free-flow of information and an effective arrangement for appropriate and timely referrals to treatment for all employees.

DEFINITIONS OF REIMBURSABLE SERVICES

1. Diagnostic Assessment:

Determination by an assessment coordinator of the nature of the enrollee's condition (mental health and/or substance abuse), the need for treatment, the type of treatment required and referral to the most appropriate level of care; and, for the substance abuse patient, the development of a continuing care treatment plan by the enrollee, the assessment coordinator and, where appropriate, the attending physician.

The Continuing Care Treatment Plan means a document completed for substance abuse patients by an assessment coordinator at the conclusion of the assessment process. The continuing care treatment plan includes the recommended provider(s), and the type(s) and duration of treatment, and may be modified by the provider and the assessment coordinator in consultation during the course of treatment.

2. Detoxification extension:

The assessment process includes processing detoxification extensions when so indicated while the enrollee is in a treatment program for undergoing acute withdrawal from an intoxicating substance.

3. Mid-Treatment Review:

Performed by the Assessment Coordinator of the CDR in conjunction with the treatment provider at the mid-point of reimbursable substance abuse treatment to assess how treatment is progressing and to determine if the Continuing Care Treatment Plan is appropriate and effectively relating to the client's specific problem. An interview may be scheduled with the client and/or the panel provider to discuss problems revealed during the Mid-Treatment Review or to assess the need for further treatment.

4. Short-term Adjustment Counseling:

Services provided by the Assessment Coordinator of the CDR following a diagnostic assessment of the employee designed to motivate, to explore alternatives, to identify and resolve problems and if the severity of illness indicates, to encourage the employee to seek further assistance. (Not to exceed three counseling sessions.)

5. Discharge Planning:

The determination by the Assessment Coordinator of the CDR as to whether an appropriate aftercare plan has been developed which relates to the client's problem and which shows promise of providing a therapeutically sound approach to further resolving the substance abuse problem. This review constitutes an analysis of the treatment that has occurred, and the formulated aftercare plan. It is done at, or very near, the completion of the reimbursable phase of treatment. The Discharge Planning phase can be by phone or by face-to-face interview and concludes the substance abuse case management process by the CDR.

**SUPPLEMENTAL AGREEMENT COVERING
HEALTH CARE PROGRAM
EXHIBIT C
TO
THE COLLECTIVE BARGAINING AGREEMENT
2003**

The provisions of this Appendix B apply to enrollees of the Traditional and Preferred Provider Organization options of the Informed Choice Plan.

I. Definitions

To the extent they are not in conflict with the following, definitions in Appendix A are incorporated herein by reference. For purposes of this Appendix:

- A. "approved mental health or substance abuse treatment program and/or provider"** means an inpatient or outpatient program and/or provider which/who provides medical and other services to enrollees for a mental health or substance abuse condition, meets all state licensure and approval requirements, and has entered into an agreement with the coverage carrier to provide services as specified in this Appendix;
- B. "assessment"** means
1. determination by an assessment coordinator of the nature of the enrollee's condition (mental health and/or substance abuse), the need for treatment, the type of treatment required and referral to the most appropriate level of care; and,
 2. for the substance abuse patient, the development of a continuing care treatment plan by the enrollee, the assessment coordinator, and the attending physician, if appropriate;
- C. "assessment coordinator"** means a qualified employee of a central diagnostic and referral agency (CDR) which has been selected and approved to provide assessment services. Assessment coordinators must meet Program standards for selection.
- D. "central diagnostic and referral agency" or "CDR"** means an approved agency which employs assessment coordinators designated to: make all contractually-mandated face-to-face assessments for the development of substance abuse continuing care treatment plans; make determinations regarding whether the patient's condition requires mental health and/or substance abuse treatment; make referrals to panel providers; provide short-term counseling (up to 2 visits) and perform aftercare planning and follow-up. In addition the CDR may provide up to 3 short-term counseling sessions for employees, and communicate with Employee Assistance Program representatives about assessment and referral activities relating to an employee. The CDR will supply necessary information to the Carrier about panel provider performance and selection and other utilization data and

statistics as required, including evaluation using designated performance date of panel providers with whom the Carrier contracts;

- E. "central review organization" or "CRO"** means a national organization which has been designated to provide the following functions: confirm eligibility of the patient for mental health and/or substance abuse coverage under the Program; authorize and approve inpatient and outpatient mental health treatment, outpatient substance abuse treatment and outpatient psychological testing; exercise managed care protocols, with CDR assistance when appropriate, for those enrollees who require both mental health and substance abuse outpatient visits; and evaluate panel providers and give input to the Carrier, using designated performance standards;
- F. "clinical nurse specialist"** means a person who meets all the following criteria: possesses a Master of Arts (MA), Master of Science (MS) or Master of Science in Nursing (MSN) degree from an accredited school of nursing; the Master's degree must be in psychiatric nursing or the individual must have 2,000 hours of clinical supervision post-Master's degree; must have a minimum of five years post-Master's degree clinical experience in the field of psychiatric mental health nursing at least 2 years of which were supervised by a Masters level psychiatric nurse (or the equivalent); possesses a license as a registered nurse in the jurisdiction in which the practice is to occur; be eligible for listing in an American Nursing Association Register of Certified Nurses in Advanced Practice as a clinical specialist in adult psychiatric mental health nursing or child/adolescent psychiatric nursing; and participates as a panel provider.
- G. "continuing care treatment plan"** means a document completed for substance abuse patients by an assessment coordinator at the conclusion of the assessment process. The continuing care treatment plan includes the recommended provider(s), and the type(s) and duration of treatment, and may be modified by the provider and the assessment coordinator in consultation during the course of treatment.
- H. "partial hospitalization treatment"** means a semi-residential level of care for patients with mental health or substance abuse disorders who require coordinated, intensive, comprehensive and multidisciplinary treatment in a structured setting, but less than full-time hospitalization. The patient undergoes therapy for more than four (4) hours a day, and may receive additional services (e.g., meals, bed, recreation);
- I. "detoxification"** means treatment for the physiologic stabilization of an enrollee who is undergoing acute withdrawal from an intoxicating substance. To be covered under this Program, such treatment must be provided by, or under the supervision of, a physician and through a facility approved to provide such care.
- J. "detoxification facility"** means a hospital or residential treatment facility which is a provider of detoxification services. Such facilities may offer substance abuse rehabilitation treatment subsequent to detoxifying an enrollee.
- K. "halfway house treatment"** means treatment provided under a semi-residential living arrangement to a substance abuse patient who requires a more structured living environment than outpatient treatment or day or night treatment would provide, but who

does not require full-time residential treatment and care. It provides a controlled environment during the hours of the day the enrollee is not undergoing treatment or is not engaged in specific constructive activity (e.g., working, attending school).

- L. "inpatient care"** means treatment in:
1. a hospital;
 2. a detoxification facility; and
 3. a residential care facility.
- M. "mental disorder"** means any mental, emotional, or personality disorder classified as a mental disorder in the most recent edition of the "International Classification of Diseases, 9th Revision, Clinical Modification", including classification 305.1, but excluding alcohol and drug abuse as classified in categories 303.0 through 305.8;
- N. "outpatient facility"** means an administratively distinct governmental, other public, private, or independent unit or part of such unit that provides outpatient mental health or substance abuse services. The term includes centers for the care of adults or children such as hospitals, clinics, and day or night treatment centers. For mental health services, the definition includes Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963, as amended;
- O. "outpatient treatment" or "visit"** means a therapy session provided in an outpatient mental health or substance abuse treatment facility or by an individual mental health or substance abuse provider. All sessions between an individual patient and a provider in a single day, with a total duration of four (4) hours or less, are considered to be a single treatment or visit. If outpatient sessions with all providers in a given day total more than four (4) hours, such treatment shall be considered day or night treatment.
- P. "panel provider"** means a mental health or substance abuse provider who has been selected and has agreed to provide services in accordance with the terms of participation established by the Program and has executed an agreement with the carrier.
- Q. "psychiatrist"** means a physician who is board eligible or board certified in psychiatry and licensed to practice medicine at the time and place services are rendered or performed.
- R. "psychologist"** means a person who possesses a doctor of philosophy (Ph.D.), doctor of education (Ed.D.), doctor of mental health (DMH.), or doctor of psychology (PsyD.) degree from a regionally accredited university, has a minimum of five years of post-doctoral clinical experience (at least two of which were supervised by a licensed clinical psychologist or by a board-qualified psychiatrist), possesses a valid license for the independent practice of psychology at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Register of Health Care Providers in Psychology, and participates as a panel provider.

- S. "registration"** means contact by the provider with the CRO to inform the agency that the enrollee is commencing a course of mental health or substance abuse treatment, to confirm eligibility under the Program, and to obtain any necessary approvals or authorizations.
- T. "residential care facility"** means an approved inpatient facility which operates twenty-four (24) hours a day, seven (7) days a week for the provision of residential mental health and/or substance abuse treatment.
- U. "social worker"** means a person who possesses a master in social work (MSW), master of science in social work (MSSW), or doctor of social work (DSW) from a graduate school of social work accredited by the Council on Social Work Education, has a minimum of five years of post-masters or post-doctoral degree clinical social work experience (at least two of which were supervised by a licensed clinical social worker), possesses a valid license or certificate for the independent practice of social work at the highest level recognized by the state in which practice is to occur, is eligible for listing in the National Association of Social Work Register of Clinical Social Workers and/or the National Register of Mental Health Care Providers in Social Work, and participates as a panel provider; and
- V. "substance abuse"** means alcohol or drug dependence as classified in categories 303.0 through 305.8 (except 305.1) of the most current edition of the "International Classification of Diseases, 9th Revision, Clinical Modification."

II. Terms and Conditions of Coverage

A. Conditions of Benefit Payment

An enrollee is eligible for benefits for covered expenses incurred during an approved course of treatment only if the following conditions are met:

1. Services must be provided, or admissions must commence, on or after the enrollee's effective date of coverage under the Program and this Appendix.
2. Benefits must be available within the benefit period (see II.B., below).
3.
 - a. In order to be covered in full under the Program, all covered services rendered in the care and treatment of mental health and substance abuse related disorders must be delivered by panel providers, except in the case of emergency which is subject to the provisions of Section IV.B.1. of this Appendix. The panel may be comprised of the following types of facilities and providers:
 - (1) Hospitals
 - (2) Outpatient facilities
 - (3) Detoxification facilities

- (4) Residential care facilities
- (5) Partial Hospitalization facilities
- (6) Halfway houses
- (7) Skilled nursing facilities
- (8) Psychiatrists
- (9) Psychologists
- (10) Social workers

- b.** In addition, if due to the unavailability of specialized services, the enrollee needs referral to a non-panel provider, then, in such cases only, non-panel providers will be covered in full subject to App. B, II.B.4.a. and b., provided the enrollee is referred by a panel provider and the services are authorized, in advance, by the CRO.
 - c.** Services provided in accordance with App. B.IV.B.3. are covered in full.

- 4.** Benefits for outpatient treatment rendered by a social worker or psychologist as an independent practitioner are available only if such practitioner participates as a panel provider.
- 5.** In order to be eligible for benefits for residential and/or halfway house substance abuse treatment, the enrollee must be assessed by an assessment coordinator from a designated CDR. Expenses for days of treatment during an admission to a residential treatment facility or halfway house program will not be covered prior to the time assessment and a treatment plan are obtained from a substance abuse assessment coordinator. If such coordinator makes a determination of substance abuse and the assessment specifies a level of care which includes residential or halfway house treatment, such treatment will be covered subject to other Program provisions.
- 6.** Detoxification admissions must be reported to the CRO within twenty-four (24) hours of admission. In such cases, the CRO will notify the CDR assigned to that location. The CDR's assessment coordinator will contact the enrollee during or after the detoxification and develop a plan for treatment subsequent to detoxification (continuing care treatment plan). Detoxification confinements longer than three (3) days must be approved by the CDR or CRO.
- 7.** Mental health inpatient services and admissions must be authorized by the CRO within 24 hours of admission.
- 8.** Day or night treatment and outpatient mental health and substance abuse treatment must be registered with the CRO. This procedure does not apply to outpatient treatment services rendered as part of an authorized substance abuse continuing care treatment plan.

9. Admission to a skilled nursing facility must be for the treatment of a mental health condition, must be authorized by the CRO and must immediately follow a confinement for the same condition.
10. Benefits are payable subject to the provisions and limitations of the Program, regardless of the treatment plan developed through assessment.
11. Benefits payable under this Appendix for an enrollee eligible for Medicare shall be paid in accordance with the terms and conditions pertaining to Medicare as specified in Appendix A, Section II.E.

B. Benefit Period

1. An enrollee is eligible for a maximum of forty-five (45) days of covered inpatient mental health care within the benefit period set forth in Appendix A, II.B.1.

An enrollee is eligible for a maximum of forty-five (45) days of covered inpatient substance abuse care including detoxification within the benefit period set forth in Appendix A, II. B.1.

Each day of care utilized for inpatient substance abuse treatment is charged against the unused portion of the 45-day inpatient mental health benefit period. Likewise, each day of inpatient mental health care is charged against the unused portion of the forty-five (45) day inpatient substance abuse treatment period.

2. An enrollee is eligible for a maximum of ninety (90) days of care in a day or night treatment facility within the benefit period set forth in Appendix A, II.B.1.

Each day of inpatient care for mental health or substance abuse treatment reduces by two (2) the number of days of care available for mental health or substance abuse day or night treatment. Each two (2) days of day or night treatment reduces by one (1) the number of days of care available for inpatient care.

3. An enrollee is eligible for a maximum of ninety (90) days of mental health care in an approved skilled nursing facility within the benefit period set forth in Appendix A, II.B.1.

Each day of inpatient care for mental health treatment within the benefit period reduces by two (2) the number of available days for skilled nursing facility care. Each two (2) days of medical care for the treatment of mental disorders in a skilled nursing facility reduces by one (1) the number of days of inpatient medical care available for the treatment of mental health related disorders in a hospital.

4. An enrollee is eligible for twenty (20) outpatient mental health visits at 100% coverage and an additional fifteen (15) visits at 75% coverage for outpatient mental health treatment for both facility and professional services per calendar year.

An enrollee is eligible for 35 outpatient substance abuse visits at 100% coverage for both

facility and professional services per calendar year.

When an enrollee requires mental health and/or substance abuse outpatient treatment, the CRO and/or CDR (where appropriate) shall exercise managed care protocols after a total of six (6) outpatient visits and shall monitor the treatment plan(s) to assure appropriate coordinated care.

Anorexia Nervosa, Bulimia and other conditions covered by App. B. which are appropriate for case management, may be case managed by the CRO utilizing the case management procedures described in Appendix A, III. K. with any alternative benefit plan being limited to the dollar pool created using the 45-day inpatient benefit described in this section.

Outpatient psychological testing is not considered "treatment" and is not charged against the outpatient visit maximum.

Each visit by one or more members of an enrollee's family for family counseling counts as one (1) visit applicable to the enrollee's annual outpatient treatment maximum.

5. An enrollee shall be eligible for a lifetime maximum of ninety (90) days of substance abuse treatment in a panel halfway house.
6. A new benefit period begins only when the enrollee has been out of care (as described below) for a continuous period of sixty (60) days. Accordingly, there must be a lapse of at least sixty (60) consecutive days between the date of the enrollee's last discharge from any hospital, skilled nursing facility, residential care facility or any other facility to which the 60-day benefit renewal period of this Appendix and Appendix A apply (see Appendix A, II.B.4. for example), and the date of the next admission, irrespective of the reason for the last admission and irrespective of whether or not benefits are paid as a consequence of such admission. Further, if subsequent to such discharge, the enrollee is a patient in a psychiatric or substance abuse day or night care program, a substance abuse halfway house, a hospice program or is receiving home health care visits, the 60-day renewal period is broken, whether or not benefits are paid as a result of receipt of such services.

C. Non-Completion of the Substance Abuse Treatment Plan by an Employee

Employees entering detoxification, residential or halfway house treatment facilities are required to receive a continuing care treatment plan from the assessment coordinator as part of the assessment process. Non-completion of the portions of such treatment plan which are covered services (including outpatient and day or night programs), will result in the following actions being taken:

1. The Carrier will send a letter to the employee and to the appropriate GM or DELPHI Medical Director notifying them of the failure to complete the treatment plan.
2. The letter will notify the employee that if a second continuing care treatment plan is established and not completed, a maximum of up to a \$500 overpayment will have occurred as a result of medical expenses incurred on the employee's behalf.

3. If the employee fails to complete a second continuing care treatment plan, the carrier will notify the employee and the GM or DELPHI Medical Director of such failure and of any overpayment. The provisions of Article I, Section 9, of the Program will apply. However, if the employee establishes to the satisfaction of the GM or DELPHI Medical Director that such employee is motivated towards recovery and that the treatment plan was discontinued for a satisfactory reason, then such overpayment will not have occurred.
4. For each subsequent non-completion of a treatment plan, the maximum overpayment amount will increase in increments of \$250, up to a maximum overpayment amount of \$1,000 for each occurrence.

III. Coverages (Mental Health and Substance Abuse)

A. Inpatient Coverage

1. Inpatient mental health and substance abuse care is subject to the benefit period set forth in App.B, II.B.1.
2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.
3. Coverage includes the following inpatient services when provided and billed by the facility:
 - a. semiprivate room, including general nursing services, meals and special diets;
 - b. laboratory and pathology examinations related to the treatment received in the facility;
 - c. drugs, biologicals, solutions and supplies related to the treatment received and used while the enrollee is in the facility;
 - d. supplies and use of equipment required in the care and treatment of the enrollee's condition;
 - e. professional and ancillary services, including those of other trained staff, necessary for patient care and treatment, including diagnostic examinations;
 - f. individual and group therapy;
 - g. counseling for family members;
 - h. electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock

therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy;

- i. supplies and use of equipment required for detoxification or rehabilitation of substance abuse patients; and
- j. psychological testing administered by a panel psychologist when medically indicated and when directly related to the organic medical or functional condition or when it has an integral role in rehabilitative or psychiatric treatment programs.

- 4. Coverage for medical care for the treatment of mental disorders is limited to (i) individual psychotherapeutic treatment, (ii) family counseling for the enrollee's family, (iii) group psychotherapeutic treatment, (IV) psychological testing when prescribed or performed by a physician, and (v) electroshock therapy and anesthesia for electroshock therapy.

B. Skilled Nursing Facility Care (Mental Health Only)

- 1. Mental health care in a skilled nursing facility is subject to the benefit period set forth in App. B, II.B.3.
- 2. Coverage includes services as described in A.3., above, and medical care. Medical care in a skilled nursing facility is limited to a maximum of two (2) physician visits per week.

C. Halfway House Care (Substance Abuse Only)

- 1. Substance abuse care in a halfway house is subject to the benefit period set forth in App. B, II.B.5.
- 2. Coverage includes the following halfway house services when provided and billed by the facility:
 - a. bed and board;
 - b. intake evaluation;
 - c. up to one (1) routine drug screen per week;
 - d. individual and group therapy or counseling; and
 - e. counseling for family members.

D. Partial Hospitalization (Mental Health and Substance Abuse)

1. Mental health and substance abuse care in day or night care treatment facilities is subject to the benefit period set forth in App. B, II.B.2.
2. Inpatient services by non-panel providers are subject to the provisions of Sections IV.B.2. (for mental health treatment) and IV.B.4. (for substance abuse treatment) of this Appendix.
3. Coverage for treatment in a day or night care treatment facility includes the following services when, provided and billed by the facility:
 - a. laboratory examinations related to the treatment received in the facility;
 - b. prescribed drugs, biologicals, solutions and supplies related to the treatment received, including, for substance abuse, drugs to be taken home;
 - c. supplies and use of equipment required in the care of the enrollee's condition;
 - d. professional and ancillary services including those of other trained staff, necessary for the treatment of ambulatory enrollees, including diagnostic examinations;
 - e. individual and group therapy;
 - f. psychological testing;
 - g. counseling for family members;
 - h. electroshock therapy for a mental health patient when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy; and
 - i. an enrollee admitted to night care treatment also is entitled to a semiprivate room, general nursing services, meals and special diets.

E. Outpatient Care (Mental Health and Substance Abuse)

1. Outpatient mental health and substance abuse treatment is subject to the benefit periods set forth in App. B, II. B. 4.a. and b.
2. Covered outpatient mental health and substance abuse treatment includes the following:
 - a. Services provided and billed by facilities
 - (1) professional and other staff and ancillary services made available by facilities to ambulatory patients;

- (2) prescribed drugs and medications dispensed by a facility in connection with treatment received at the facility; and
- (3) electroshock therapy for a mental health patient, when administered by, or under the supervision of, a physician and anesthesia for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy.

b. Services provided and billed by facilities or professional providers

- (1) Individual psychotherapeutic treatments of less than twenty (20) minutes when provided in an outpatient mental health facility approved by the carrier.
- (2) Individual psychotherapeutic treatments of a duration of twenty (20) minutes or more (all sessions with a given provider on a single day, with a total duration of four (4) hours or less, shall constitute a single "visit" and be reimbursed as a single unit of service).

(a) Benefits will be paid as set forth in App. B, II. B. 4.a. for outpatient mental health services at 100% of the panel reimbursement amount for the first twenty (20) outpatient mental health treatments and 75% for the next fifteen (15) treatments per calendar year when provided by panel providers. Services rendered by non-panel providers as provided in App. B, II.A.3.b. and in App. B, IV.B.3. shall be covered in full. Otherwise, when outpatient mental health services are received from a non-panel provider without referral, such services must be rendered by physicians, and will be reimbursed at 50% of the amount payable to panel providers for comparable services. Such reimbursement will be made only to the primary enrollee.

(b) Benefits will be paid as set forth in App. B, II.B.4.b. for individual outpatient substance abuse treatment at 100% of the panel reimbursement amount for 35 visits per calendar year when provided by panel providers. No benefits are payable for treatment by non-panel providers, except when services are rendered by non-panel providers as provided in App. B, II.A.3.b. in which case such treatment shall be covered in full.

- (3) Group mental health and substance abuse treatment is covered subject to the payment provisions in subsections (a) or (b) above.
 - (4) Family counseling to members of the patient's family is covered subject to the payment provisions in subsections (a) or (b) above.
3. Outpatient psychological testing is covered only when preauthorized by the CRO and performed by a panel provider. Such testing is not considered treatment and therefore is not subject to the benefit period maximum.

4. Arrangements with the CDR's;
 - a. For inpatient substance abuse care, assessments, referrals, and continuing care treatment follow-up are mandatory and do not reduce the enrollee's outpatient visit entitlement; and
 - b. Voluntary utilization of the CDR for outpatient mental health or substance abuse assessment and referral, does not count as an outpatient visit.

IV. Limitations and Exclusions

- A. Panel providers are required to contact the CRO to verify eligibility and receive prior authorization of non-emergency inpatient and outpatient mental health and substance abuse services.
- B. Coverage will be limited to the following when rendered by or through non-panel providers:
 1. Emergency services. Providers must contact the CRO within 24 hours of the inpatient admission or outpatient treatment for authorization of such services.
 2. Non-emergency services. Benefits for mental health services provided by non-panel providers without referral by a panel provider are limited to 50% of the panel reimbursement amount. The carrier will make payment to the primary enrollee. Payment to the provider, including any balance, is the responsibility of the enrollee.
 3. Outpatient services. Services provided by non-panel physician (e.g., internists or general practitioners) must be registered with the CRO after the first visit and are limited to a maximum of one (1) visit.
 4. Substance abuse treatment. Coverage for substance abuse treatment does not include services provided by non-panel providers except for emergency detoxification.
- C. Coverage is not available for services for treatment of mental disorders which, according to generally accepted medical standards, are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.
- D. Coverage for substance abuse treatment does not include professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling or psychological testing are provided on the same day.
- E. Coverage does not include family counseling which is rendered by a provider other than the provider for the family member in the course of treatment. Furthermore,

reimbursement will be provided only for services rendered to enrollees covered under the General Motors Health Care Program.

- F.** Coverage does not include diversional therapy.
- G.** Coverage does not include psychological testing if used as part of, or in connection with, vocational guidance, training or counseling.
- H.** General Limitations and Exclusions under Section IV. and subsections II.C., E., G., and H. of the Terms and Conditions of Appendix A are equally applicable under this Appendix.

