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Outpatient Provider Meeting
Friday, June 2, 2023
Virtual Meeting
10:00 am –11:00 am
Agenda
Zoom Link: https://dwihn-org.zoom.us/j/93220807823

I. Welcome/Introductions
II. Telemedicine – Ebony Reynolds (pages 3-26)
III. Claims Department- Quinnetta Allen
- PIHP claims@dwihn.org – Billing Issues
- Residentialauthorizations@dwihn.org – Residential authorization questions/requests
- PIHP authorizations@dwihn.org – Outpatient Authorization issues/questions
- tomani@dwihn.org – Payment issues/questions
- Procedure.coding@dwihn.org – Coding, modifiers, rates, questions/issues
- MHWIN @dwihn.org – System issues, trouble tickets (page 27)

IV. Utilization Management – Leigh Wayna
- Urgent vs. Non- Urgent Authorization Requests (page 28-31)

V. Recipient Rights Department- Chad Witcher
- ORR Training
- Monitoring & Prevention PPT
- Consent to Release RR Info Form (pages 32-35)

VI. Credentialing – Ricarda Pope-King
- Credentialing Updates
- ORR Training (page 36-41)

VII. Quality Improvement – Tiffani Harris, Mark Matthews
- HCBS (page 42-47)

VIII. Administrative Updates – Eric Doeh, President and CEO

IX. Questions

X. Adjourn

March 14, 2023 --- Note these are selected areas of the Telemedicine Policy (other attachment). You'll find Behavioral Health language on this subject at the end of the Policy.

Issued: March 2, 2023
Subject: Telemedicine Policy Post-COVID-19 Public Health Emergency
Effective: May 12, 2023
Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services (MOMS), MIChild
The purpose of this bulletin is to update program coverage of telemedicine services after the conclusion of the federal COVID-19 Public Health Emergency (PHE) and to clarify which bulletins are now discontinued as of the date indicated. **NOTE:** MSA 20-09 and MSA 21-24 are permanent policy and remain in effect unless indicated per this policy. These two policies should be considered alongside this policy when considering MDHHS Post-PHE Telemedicine Policy as a whole.

I. General Telemedicine Policy Updates

Focus Points by Joe Longcor

Page 2:

- Recognizing that telemedicine can never fully replace in-person care, MDHHS has established the following principles
- A. Effectual services – a service provided via telemedicine should be as effective as its in-person equivalent, ensuring convenient and high-quality care.
- C. Appropriate beneficiary choice – the beneficiary is an active participant in the decision for telemedicine as a means for service delivery as appropriate
- E. Value considerations – telemedicine visits should yield the desired outcomes and quality measures; health outcomes should be improving and remain consistent with in-person care at a minimum.
- **Determination of Appropriateness/Documentation …** Telemedicine must only be utilized when there is a clinical benefit to the beneficiary.

Page 3:

- Furthermore, telemedicine must only be utilized when the beneficiary's goals for the visit can be adequately accomplished, there exists reasonable certainty of the beneficiary's ability to effectively utilize the technology, and the beneficiary's comfort with the nature of the visit is ensured. Telemedicine must be used as appropriate regarding the best interests/preferences of the beneficiary and not merely for provider ease. Appropriate guidance must be provided to the beneficiary to ensure they are prepared and understand all steps to effectively utilize the technology prior to the first visit. Beneficiary consent must be obtained prior to service provision (see policy for "Consent for Telemedicine Services" in MSA 20-09 for further information).
- As standard practice, in-person visits are the preferred method of service delivery; however, in cases where this option is not available or in-person services are not ideal or are challenging for the beneficiary, telemedicine may be used as a complement to in-person

services. Telemedicine services **cannot be continued indefinitely** for a given beneficiary **without reasonably frequent and periodic in-person evaluations** of the beneficiary by the provider to personally reassess and update the beneficiary's medical treatment/history, effectiveness of treatment modalities, and current medical/behavioral condition and/or treatment plan. Applicable beneficiary **records must contain documentation** regarding the reason for the use of telemedicine and the **steps taken to ensure** the beneficiary was provided utilization guidance in an appropriate manner.

- In special situations, depending upon the needs of the beneficiary, providers may opt to deliver the majority of services via telemedicine. If this situation occurs, it must be documented in the beneficiary's record or in their individual plan of service (IPOS). **This situation should be the exception, not the norm.**
- All services provided via telemedicine must meet all the quality and specifications as would be if performed in-person. Furthermore, if while participating in the visit the desired goals of the beneficiary and/or the provider are not being accomplished, either party must be provided the opportunity to stop the visit and schedule an in-person visit instead (refer to the "Contingency Plan" section of bulletin MSA 20-09 for such instances). This follow-up visit must be provided within a reasonable time and be as easy as possible to schedule.

Page 4:

- When providing services via telemedicine, sufficient privacy and security measures must be in place and documented to ensure confidentiality and integrity of beneficiary-identifiable information.

Page 8/9: All audio/visual telemedicine services, as allowable on the telemedicine fee schedule and submitted on the professional invoice, must be reported with the Place of Service (POS) code that would be reported as if the beneficiary were in-person for the visit MMP 23-10 Page 8 of 14

- along with modifier 95—"Synchronous Telemedicine Service rendered via a real-time interactive audio and video telecommunications system".

Behavioral Health

Page 9:

- In addition to the Determination of Appropriateness/Documentation section of this policy, the Bureau of Specialty Behavioral Health Services would like to reiterate that services delivered to the beneficiary via telemedicine be done at the convenience of the beneficiary, not the convenience of the provider. In addition, **these services must be a part of the person-centered plan of service and available as a choice**, not a requirement, to the beneficiary.
- The CMHSP/PIHP must guarantee the individual is not being influenced or prompted by others when utilizing telemedicine.
- Use of telemedicine should ensure and promote community integration and prevent isolation of the beneficiary. Evidence-based practice policies must be followed as

appropriate for all services. For services within the community, **in-person interactions must be prioritized.**

Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 23-10

Distribution: Practitioners, Hospitals, Nursing Facilities, Federally Qualified Health Centers (FQHC), Local Health Departments (LHD), Rural Health Clinics (RHC), Community Mental Health Services Programs (CMHSP), Prepaid Inpatient Health Plans (PIHP), Medicaid Health Plans (MHP), Indian Health Centers (IHC), School Services Program (SSP) Providers, Dentists, Dental Clinics, Dental Health Plans, Hearing Aid Dealers, Cochlear Implant Manufacturers, Audiologists/Hearing Centers, Vision Providers

Issued: March 2, 2023

Subject: Telemedicine Policy Post-COVID-19 Public Health Emergency

Effective: May 12, 2023

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services (MOMS), MIChild

The purpose of this bulletin is to update program coverage of telemedicine services after the conclusion of the federal COVID-19 Public Health Emergency (PHE) and to clarify which bulletins are now discontinued as of the date indicated. **NOTE:** MSA 20-09 and MSA 21-24 are permanent policy and remain in effect unless indicated per this policy. These two policies should be considered alongside this policy when considering MDHHS Post-PHE Telemedicine Policy as a whole.

I. General Telemedicine Policy Updates

Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid-enrolled health care professional in a different location. The Michigan Department of Health and Human Services (MDHHS) covers both synchronous (real-time interactions) and asynchronous (over separate periods of time) telemedicine services. MDHHS requires that all telemedicine policy provisions within this policy and other current policy are established and maintained within all telemedicine services.

Along with general telemedicine policy, specific program considerations (as listed within this policy) must be upheld during all telemedicine visits unless otherwise stated. The specific program section provides additional requirements and offers further clarification as needed. These should always be considered in combination with all general telemedicine policy.

Recognizing that telemedicine can never fully replace in-person care, MDHHS has established the following principles to be used by MDHHS-enrolled providers during the provision of telemedicine services:

A. Effectual services – a service provided via telemedicine should be as effective as its in-person equivalent, ensuring convenient and high-quality care.

B. Improved and appropriate access – the right visit, for the right beneficiary, at the right time by minimizing the impact of barriers to care, such as transportation needs or availability of specialty providers in rural areas.

C. Appropriate beneficiary choice – the beneficiary is an active participant in the decision for telemedicine as a means for service delivery as appropriate (e.g., Does the beneficiary prefer telemedicine to an in-person visit? What is the optimal combination of ongoing service delivery for the individual? etc.).

D. Appropriate utilization – ensure providers are utilizing telemedicine appropriately and that items A-C above are taken into consideration when offering these services.

E. Value considerations – telemedicine visits should yield the desired outcomes and quality measures; health outcomes should be improving and remain consistent with in-person care at a minimum.

F. Privacy and security measures – providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy/security regulations as applicable.

II. Determination of Appropriateness/Documentation

Telemedicine must only be utilized when there is a clinical benefit to the beneficiary. Examples of clinical benefit include:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services.
- Treatment option for a beneficiary population without access to clinically appropriate in-person treatment options.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or another quantifiable symptom.

Furthermore, telemedicine must only be utilized when the beneficiary's goals for the visit can be adequately accomplished, there exists reasonable certainty of the beneficiary's ability to effectively utilize the technology, and the beneficiary's comfort with the nature of the visit is ensured. Telemedicine must be used as appropriate regarding the best interests/preferences of the beneficiary and not merely for provider ease. Appropriate guidance must be provided to the beneficiary to ensure they are prepared and understand all steps to effectively utilize the technology prior to the first visit. Beneficiary consent must be obtained prior to service provision (see policy for "Consent for Telemedicine Services" in MSA 20-09 for further information).

As standard practice, in-person visits are the preferred method of service delivery; however, in cases where this option is not available or in-person services are not ideal or are challenging for the beneficiary, telemedicine may be used as a complement to in-person services. Telemedicine services cannot be continued indefinitely for a given beneficiary without reasonably frequent and periodic in-person evaluations of the beneficiary by the provider to personally reassess and update the beneficiary's medical treatment/history, effectiveness of treatment modalities, and current medical/behavioral condition and/or treatment plan. Applicable beneficiary records must contain documentation regarding the reason for the use of telemedicine and the steps taken to ensure the beneficiary was provided utilization guidance in an appropriate manner.

In special situations, depending upon the needs of the beneficiary, providers may opt to deliver the majority of services via telemedicine. If this situation occurs, it must be documented in the beneficiary's record or in their individual plan of service (IPOS). This situation should be the exception, not the norm. (Refer to the program-specific subsections of this policy for specific guidance regarding this benefit.)

All services provided via telemedicine must meet all the quality and specifications as would be if performed in-person. Furthermore, if while participating in the visit the desired goals of the beneficiary and/or the provider are not being accomplished, either party must be provided the opportunity to stop the visit and schedule an in-person visit instead (refer to the "Contingency Plan" section of bulletin MSA 20-09 for such instances). This follow-up visit must be provided within a reasonable time and be as easy as possible to schedule.

III. Prior Authorization Requirements

There are no prior authorization (PA) requirements when providing services via telemedicine for Fee-for-Service (FFS) beneficiaries or for those accessing Behavioral Health Services through Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) unless the equivalent in-person service requires PA. Authorization requirements for beneficiaries enrolled in Medicaid Health Plans (MHPs) may vary. Providers must refer to individual MHPs for any authorization or coverage requirements.

IV. Face-to-Face Definition

When referenced within MDHHS Telemedicine Policy, face-to-face refers to either an in-person visit, or a visit performed via simultaneous audio/visual technology.

V. Privacy and Security Requirements

When providing services via telemedicine, sufficient privacy and security measures must be in place and documented to ensure confidentiality and integrity of beneficiary-identifiable information. This includes, but is not limited to, ensuring any tracking technologies used by websites, mobile applications, or any other technology used, comply with applicable law regarding use or disclosure of beneficiary-identifiable information. Transitions, including beneficiary email, prescriptions, and laboratory results, must be secure within existing technology (i.e., password protected, encrypted electronic prescriptions, or other reliable authentication, techniques). All beneficiary-physician email, as well as other beneficiary-related electronic communications, should be stored and filed in the beneficiary's medical record, consistent with transitional recordkeeping policies and procedures.

VI. Telemedicine Reimbursement Rate

Effective as indicated, the reimbursement rate for allowable telemedicine services will be the same (also known as "at parity") as in-person services. This means that all providers will be paid the equivalent amount, no matter the physical location of the beneficiary during the visit. To effectuate this policy, the provider must report the place of service as they would if they were providing the service in-person. See the "Telemedicine Billing Requirements" section of this policy for further details.

This policy supersedes and discontinues bulletin MSA 20-09 (Facility Rate subsection) and bulletin MSA 20-42 (Telemedicine Reimbursement Rate Change section) per the date indicated.

VII. Audio-Only Telemedicine Policy

MDHHS supports the use of simultaneous audio/visual telemedicine service delivery, as a primary method of telemedicine service, but in situations where the beneficiary cannot access services via a simultaneous audio/visual platform, either due to technology constraints or other concerns, MDHHS will allow the provision of audio-only services for a specific set of procedure codes.

These procedure codes include the telephone only CPT/HCPCS codes (99441-99443 and 98955-98968) along with the following codes:

1. Physical Health/Mild-to-Moderate Behavioral Health:
    a. Psychotherapy services for adult or child (up to 45 minutes) (90832, 90834, 90839, 90840 and 90785)

b. Genetic and preventative counseling services (96040)
c. Risk Assessments (96160 and 96161)
d. Office visits for established patients up to 19 minutes (99212)
e. Preventative counseling (99401, 99402, 99403 and 99404), Behavioral Change Counseling for smoking (99406, 99407) and diabetes management (G0108)
f. Screening Brief Intervention and Referral to Treatment Services (SBIRT) (99408 and 99409)
g. Transitional Care Management Services (99495, 99496)
h. Inpatient Follow-up Services (G0406, G0407 and G0408)

2. Specialty Behavioral Health Services:
   a. Psychotherapy services for adult or child (up to 45 minutes) (90832, 90834, 90839, 90840 and 90785)
   b. Assertive Community Treatment (ACT) (psychiatric services only) (H0039)
   c. Crisis Intervention (H2011) Note: does not include H2011 ICSS for Children
   d. Office visits for established patients up to 19 minutes (Psychiatrist) (99212)
   e. Assessments—Interpretation or explanation of results (90887)
   f. Substance Use Disorder Individual Assessment (H0001)
   g. Substance Use Disorder Outpatient Treatment (H0004)
   h. Substance Use Disorder Early Intervention (H0022)
   i. Substance Abuse—Outpatient Care-Recovery Supports (T1012)
   j. Supportive Employment Services for Individuals (including job coaching) (H2023 and H2025)
   k. Clubhouse Psychosocial Rehabilitation Programs (H2030)

NOTE: Current Procedural Terminology (CPT) coding changes occur frequently. Providers should consult with MDHHS fee schedules for current allowable codes which can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information. The Medicaid Code and Rate Reference Tool, located via the External Links menu in CHAMPS, may also be used to determine eligible reimbursement codes.

Additional guidelines for audio-only service include:

1. Visits that include an assessment tool—the tool must be made available to the beneficiary and the provider must ensure the beneficiary can access the tool.
2. When a treatment technique or evidence-based practice requires visualization of the beneficiary, it must be performed via simultaneous audio/visual technology.
3. Audio-only must be performed at the preference of the beneficiary, not the provider's convenience.
4. Privacy and security of beneficiary information must always be established and maintained during an audio-only visit.

To effectuate this in perpetuity, MDHHS will publish audio-only databases that will include all codes MDHHS is permitting via audio-only. These databases will be created for both

FFS/MHP providers and for those providers within the PIHP/CMHSP system and will be maintained on the MDHHS website. MDHHS will, on a regular and ongoing basis, assess the audio-only databases and will add/remove codes as needed. Some of the criteria used to determine addition/removal from the audio-only database include provider/stakeholder feedback, new coding guidelines, utilization data and quality reports.

Based upon this updated policy, bulletin MSA 20-13 – COVID-19 Response: Telemedicine Policy Expansion; Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) Implications, allowing the provision of audio-only services for the codes listed on the telemedicine database, is discontinued per the date indicated.

Since MDHHS is discontinuing the provision of audio-only telemedicine services indicated in bulletin MSA 20-13, and replacing this with an audio-only database, this policy philosophy applies to the provision of services within the School Services Program (SSP) as well. These programs also have the allowance to provide the audio-only codes as described above. As such, bulletin MSA 20-15 - COVID-19 Response: Behavioral Health Telepractice; Telephone (Audio Only) Services, Telephone (Audio Only) Services section is discontinued with the enactment of this policy per the date indicated.

Additionally, MDHHS is continuing bulletin MSA 20-34 - COVID-19 Response: Telemedicine Reimbursement for Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers, in that it allows identified audio-only services (those represented on the audio-only fee schedule and that are identified as qualifying visits) to generate the Prospective Payment System/All-Inclusive Rate (PPS/AIR) for applicable clinics. Clinics will be permitted to submit for reimbursement allowable audio-only service codes, as indicated above, if appropriate for the interaction with the beneficiary. Medicaid clinic billing and reimbursement requirements apply. The provider must be employed by or contracted with the FQHC, RHC, or THC and the procedure code billed must appear on the clinic qualifying visit list located on the MDHHS website at www.micigan.gov/medicaidproviders >>Provider Specific Information.

The allowance for payment of the AIR for Indian Health Centers is contingent upon successful approval from the Centers for Medicare and Medicaid Services (CMS). The provision of bulletin MSA 20-34 which allows providers to work from home, is also allowable per bulletin MSA 20-09, which defines the parameters for the distant site to include “the provider’s office, or any established site considered appropriate by the provider, so long as the privacy of the beneficiary and security of the information shared during the telemedicine visit are maintained”.

Clinics are also permitted to submit for reimbursement telemedicine services (using simultaneous audio/visual technologies) per bulletin MSA 20-09 if all other provisions of telemedicine policy are maintained. Simultaneous audio/visual telemedicine services, as indicated by CPT/HCPCS codes listed on the telemedicine fee schedule and considered qualifying visits, will also be considered face-to-face and will trigger the PPS/AIR if the service billed is listed as a qualifying visit.

MDHHS will be discontinuing audio-only allowances across dental providers, as stated in bulletin MSA 20-21 - COVID-19 Response: Limited Oral Evaluation via Telemedicine, which will be discontinued with the enactment of this policy per the date indicated. MDHHS will continue other telemedicine dental services (see below for further details).

VIII. Telemedicine Billing Requirements

All telemedicine visits are required to ascribe to correct coding requirements equivalent to in-person services, including ensuring that all aspects of the code billed are performed during the visit.

A. Allowable Services

Allowable telemedicine services for synchronous telemedicine are listed on the telemedicine fee schedules which can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Asynchronous telemedicine service codes are listed on the corresponding provider-specific fee schedules. Additional program-specific coverage will be represented on individual program fee schedules and will be indicated in the program-specific sections below as indicated.

Where in-person visits are required (such as End Stage Renal Disease [ESRD] and nursing facility-related services), the telemedicine service may be used in addition to the required in-person visit but cannot be used as a substitute. There must be at least one in-person hands-on visit (i.e., not via telemedicine) by a physician, physician's assistant, or advanced practice registered nurse per month to examine the vascular site for ESRD services.

For PIHP/CMHSP service providers, where in-person visits are required, the telemedicine service may be used in addition to the required in-person visit but cannot be used as a substitute. Refer to the MDHHS Bureau of Specialty Behavioral Health Services Telemedicine Database which can be accessed on the MDHHS website at www.michigan.gov/bhdda >> Reporting Requirements >> Bureau of Specialty Behavioral Health Services Telemedicine Database for services allowed via telemedicine.

B. Place of Service (POS), Modifier 95 and Modifier 93

All audio/visual telemedicine services, as allowable on the telemedicine fee schedule and submitted on the professional invoice, must be reported with the Place of Service (POS) code that would be reported as if the beneficiary were in-person for the visit

along with modifier 95—"Synchronous Telemedicine Service rendered via a real-time interactive audio and video telecommunications system".

All audio-only telemedicine services, as represented on the audio-only telemedicine fee schedule and submitted on the professional invoice, must be reported with the Place of Service (POS) code that would be reported as if the beneficiary were in-person for the visit along with modifier 93 - "Synchronous Telemedicine Service rendered via telephone or other real-time interactive audio-only telecommunications system".

For services submitted on the Institutional invoice, the appropriate National Uniform Billing Committee (NUBC) revenue code, along with the appropriate telemedicine Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure code and modifier 95 or Modifier 93, must be used.

PIHP/CMHSP providers must submit encounters for audio/visual telemedicine with POS 02 or 10 (as applicable) and for audio-only POS 02 or 10 (as applicable) and Modifier 93.

Covered asynchronous telemedicine services (as defined above, represented on corresponding fee schedules, and outlined in bulletin MSA 21-24 – Asynchronous Telemedicine Services) should be billed with applicable POS and modifiers as standard practice.

Telemedicine claims without these indicators may be denied.

This policy supersedes and discontinues bulletin MSA 20-09 (Place of Service and GT Modifier subsection), bulletin MSA 20-42 (Telemedicine Reimbursement Rate Change section) and bulletin HASA 22-03 (Telemedicine Coding Changes section), per the date indicated.

For PIHP/CMHSP service providers, refer to the Bureau of Specialty Behavioral Health Services Telemedicine Database and Audio-Only Telemedicine Database, which can be accessed on the MDHHS website at www.michigan.gov/bhdda >> Reporting Requirements >> Bureau of Specialty Behavioral Health Services Telemedicine Database for services allowed via both audio/visual and audio-only telemedicine.

This information should be used in conjunction with the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters of the MDHHS Medicaid Provider Manual, as well as the Medicaid Code and Rate Reference tool and other related procedure databases/fee schedules located on the MDHHS website.

IX. Specific Program/Service Site Considerations

A. Outpatient Hospital

When the outpatient facility provides administrative support for a telemedicine service, the outpatient hospital facility may bill the hospital outpatient clinic visit on the institutional claim with modifier 95 or modifier 93 and the appropriate revenue code.

B. Behavioral Health

i. PIHP/CMHSP

The MDHHS Bureau of Specialty Behavioral Health Services requires all the requirements of Telemedicine policy are attained and maintained during all beneficiary visits. In addition to the Determination of Appropriateness/Documentation section of this policy, the Bureau of Specialty Behavioral Health Services would like to reiterate that services delivered to the beneficiary via telemedicine be done at the convenience of the beneficiary, not the convenience of the provider. In addition, these services must be a part of the person-centered plan of service and available as a choice, not a requirement, to the beneficiary.

If the individual (beneficiary) is not able to communicate effectively or independently they must be provided appropriate on-site support from natural supports or staff. This includes the appropriate support necessary to participate in assessments, services, and treatment.

The CMHSP/PIHP must guarantee the individual is not being influenced or prompted by others when utilizing telemedicine.

Use of telemedicine should ensure and promote community integration and prevent isolation of the beneficiary. Evidence-based practice policies must be followed as appropriate for all services. For services within the community, in-person interactions must be prioritized.

Requirements for Visit:

Telemedicine is allowed for all services indicated in the Bureau of Specialty Behavioral Health Services Telemedicine Database. The features of what will be counted as a telemedicine visit need to align with the same standards of an in-person visit. Any phone call or web platform used to schedule, obtain basic information or miscellaneous work that would have been billed as a non-face-to-face and therefore non-billable contact, will remain non-billable. Telemedicine visits must include service provision as indicated in the IPOS and should reflect work towards or review of goals and objectives indicated forthwith.

Populations:

This policy applies to all populations served within PIHPs/CMHSPs and does not supersede any federal regulations that must be followed for SUD treatment.

ii. Outpatient Mental Health Services Providers

Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs may receive outpatient mental health services through Medicaid Fee-for-Service (FFS) or Medicaid Health Plans as applicable. These FFS/MHP enrolled non-physician behavioral health services may be provided via telemedicine when performed by Medicaid-enrolled psychologists, social workers, counselors, and marriage and family therapists. Services are covered when performed in a non-facility setting or outpatient hospital clinic. All applicable services are listed in the telemedicine audio/visual and audio-only databases.

C. Physical Therapy, Occupational Therapy and Speech Therapy Services

MDHHS will allow select therapy services to be provided via telemedicine when performed by Medicaid-enrolled private practice and outpatient hospital physical therapy (PT), occupational therapy (OT) and speech therapy (ST) providers. PT, OT and ST services allowed via telemedicine will be represented by applicable CPT/HCPCS codes on the telemedicine fee schedule. Therapy services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate for the individual beneficiary

Documentation re-evaluation, performance, and treatment elements that typically require hands-on contact for measurement or assessment must include a thorough description of how the assessment or performance findings were established via telemedicine. This includes, but is not limited to, such elements as standardized tests, strength, range of motion, and muscle tone.

Initial physical therapy and occupational therapy evaluations and oral motor/swallowing services are not allowed telemedicine and should be provided in-person.

Services that require utilization of equipment during treatment and/or physical hands-on interaction with the beneficiary cannot be provided via telemedicine.

Therapy re-evaluations performed via telemedicine must be provided by a therapist whose facility/clinic has previously evaluated and/or treated the beneficiary in-person.

Durable Medical Equipment (DME) re-assessments performed via telemedicine must be provided by a therapist who has previously evaluated and/or treated the beneficiary in-person, otherwise an in-person visit is required.

This policy supplements existing PT, OT, and ST services policy. All current therapy referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. All telemedicine therapy services will count toward the beneficiary's therapy service limits. (Refer to the Therapy Services chapter of the MDHHS Medicaid Provider Manual for complete information.)

i. Billing Considerations

Modifier 95 should be used in addition to the required modifiers for therapy services as outlined in therapy policy.

ii. Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)/Tribal Health Center (THC)/ Tribal Federally Qualified Health Centers (Tribal FQHC) Considerations

PT, OT and ST, when provided in accordance with this policy using both audio/visual modalities, will be considered face-to-face and will trigger the PPS AIR if the service billed is listed as a qualifying visit.

For FQHCs, RHCs, THCs and Tribal FQHCs, the appropriate CPT/HCPCS code, PPS/AIR payment code (if the service generates a Qualifying Visit), and modifier 95 – synchronous telemedicine must be used. Refer to www.michigan.gov/medicaidproviders >> Provider Specific Information for additional information.

iii. School Services Program Considerations

School Services Program (SSP) PT and OT services, as outlined in this policy, will also be allowed via telemedicine. These services must meet all other telemedicine policies as outlined.

This policy ends bulletin MSA 20-22 - COVID-19 Response: Telemedicine Policy Changes, Updates to Coverage for Physical Therapy, Occupational Therapy and Speech Therapy per the date indicated, but continues some of the allowances permanently with the changes indicated.

D. Audiology Services

MDHHS will allow speech therapy, auditory rehabilitation, select hearing device adjustments, programming, device performance evaluations, and education or counseling to be performed via telemedicine (simultaneous audio/visual). Remote device programming must be provided in compliance with current U.S. Food and Drug Administration (FDA) guidelines. Auditory brainstem response **(**ABR) and auditory

evoked potential (AEP) testing may also be conducted via telemedicine when performed using remote technology located at a coordinating clinical site with appropriately trained staff (i.e., mobile unit, office/clinic, or hospital).

Reimbursable procedure codes are limited to the specific set of audiology codes listed in the telemedicine fee schedule. Audiology services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate.

Audiological diagnostic tests (other than those mentioned above), hearing aid examinations, surgical device candidacy evaluations, and other audiology and hearing aid services conducted via telemedicine are not reimbursable by Michigan Medicaid and should be provided in-person.

This policy supplements the existing audiology, hearing aid dealer and speech therapy services policies. All current referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. Providers should refer to the Hearing Services chapter in the MDHHS Medicaid Provider Manual for complete information.

This policy ends bulletin MSA 20-53 - COVID-19 Response: Telemedicine Policy Changes for Audiology Services per the date indicated but continues the allowance permanently with the changes outlined within this section.

E. Dentistry

MDHHS will allow dentists to provide the limited oral evaluation (Current Dental Terminology [CDT] code D0140) via telemedicine (simultaneous audio/visual) technology so long as all other telemedicine policy is followed. D9995 teledentistry-synchronous; real-time encounter, must be reported in addition to the applicable CDT code.

All requirements of the general telemedicine policy described in bulletin MSA 20-09 and the MDHHS Medicaid Provider Manual must be followed when providing the limited oral evaluation via telemedicine, including scope of practice requirements, contingency plan, and the use of both audio/visual service delivery unless otherwise indicated by federal guidance.

Services delivered to the beneficiary via telemedicine must be done for the convenience of the beneficiary, not the convenience of the provider. Services must be performed using simultaneous audio/visual capabilities. All services using telemedicine must be documented in the beneficiary's record, including the date, time, and duration of the encounter, and any pertinent clinical documentation required per CDT code description. The provider is responsible for ensuring the safety and quality of services provided with telemedicine technologies.

Billing instructions depend upon the claim format used:

- American Dental Association (ADA) Claim Format: Use POS 02 or POS 10; report D9995 with the procedure code.
- Institutional Claim Format: POS 02 and POS 10 are not required; Use modifier 95; report D9995 with the procedure code.

This policy ends bulletin MSA 20-21 - COVID-19 Response: Limited Oral Evaluation via Telemedicine per the date indicated but continues other telemedicine dental services as outlined within this section.

F. Vision

Telemedicine vision services can be provided through a Medicaid-enrolled physician or other qualified health care professional who can report evaluation and management (E/M) services as listed in the telemedicine fee schedules.

An intermediate ophthalmological exam can be provided via telemedicine for an established patient with a known diagnosis. The provider must have a previous in-person encounter with the beneficiary to ensure the provider is knowledgeable of the beneficiary's current medical history and condition. For cases in which the provider must refer the beneficiary to another provider, a consulting provider is not required to have a pre-existing provider-patient relationship if the referring provider shares medical history, past eye examinations, and any related beneficiary diagnosis with the consulting provider. Intermediate ophthalmological exam codes should not be used to diagnose eye health conditions (an initial diagnosis). When medically necessary, providers must refer beneficiaries for an in-person encounter to receive a diagnosis and/or care. Telemedicine cannot act as a replacement for recommended in-person interactions.

G. School Services Program

Because of the unique circumstances regarding the delivery of services within the School Services Program, telemedicine may be the primary delivery modality for some beneficiaries; however, the decision to use telemedicine should be based on the needs or convenience of the beneficiary, and not those of the provider.

In cases where the beneficiary is unable to use telemedicine equipment without assistance, an attendant must be provided by the provider. The attendant must be trained in the use of the telemedicine equipment to the point where they can provide adequate assistance. The attendant must also be available for the entire telemedicine session; however, they should also ensure the beneficiary's privacy to the greatest extent possible. When the originating site for the service is the student's home, any cost for an attendant is not reimbursable.

Billing and reimbursement for telemedicine services are accomplished using the same methodology as other services; however, the service must be billed using POS 03—school and modifier 95 or modifier 93. Telemedicine claims for the School Services Program are paid according to the Centers for Medicare & Medicaid Services (CMS) approved cost-based methodology used for other services provided within the program and not the information provided previously in this policy. School Services Program providers are not eligible for the facility fee as the facility is an integral part of the service provided and is covered under the service claim. A database of allowable telemedicine services for SSP can be found on the SSP website.

This policy ends bulletin MSA 20-15 - COVID-19 Response: Behavioral Health Telepractice; Telephone (Audio Only) Services per the date indicated but continues telemedicine SSP services as indicated.

H. Durable Medical Equipment (DME) Providers

All DME Providers must reference the DME chapter of the MDHHS Medicaid Provider Manual for specific requirements in the provision of services via telemedicine.

Manual Maintenance

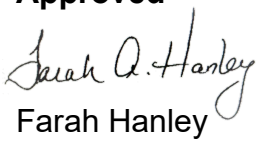
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



Farah Hanley
Chief Deputy Director for Health

Bureau of Specialty Behavioral Health Services

Telemedicine Database

Effective: May 12, 2023

Please refer to MMP 23-10 for policy requirements and standards of appropriate use of telemedicine within the Michigan Medicaid Program.

HCPCS/ CPT Code	Description	Simultaneous Audio/Visual Must Include: POS 02 or POS 10 No Modifier Required	Audio Only Allowed Must Include: Modifier 93 & POS 02 or POS 10
0362T	ABA Behavioral Follow-up Assessment (reporting units of per 15 minutes effective 1/1/19)	Yes	No
90785	Interactive Complexity - This code is reported in addition to the code for a primary psychiatric service. It is reported when the patient being treated has certain factors that increase the complexity of treatment rendered. These factors are limited to the following: the need to manage disruptive communication that complicates the delivery of treatment; complications involving the implementation of a treatment plan due to caregiver behavioral or emotional interference; evidence of a sentinel event with subsequent disclosure to a third party and discussion and/or reporting to the patient(s); or use of play equipment or translator to enable communication when a barrier exists.	Yes	Yes
90791	Psychiatric diagnostic evaluation (no medical services)	Yes	No
90792	Psychiatric diagnostic evaluation with medical services	Yes	No
90832	Individual therapy, adult or child, 30 minutes of psychotherapy	Yes	Yes
90833	Psychotherapy with evaluation and management (30 min); add-on codes only	Yes	No
90834	Mental Health Outpatient Care & SUD Outpatient Care - Individual therapy, adult or child, 45 minutes	Yes	Yes
90836	Psychotherapy with evaluation and management (45 min); add-on codes only	Yes	No
90837	Mental Health Outpatient Care & SUD Outpatient Care - Psychotherapy, 60 minutes with individual and/or family member	Yes	No
90838	Psychotherapy with evaluation and management (60 min)	Yes	No
90839	Psychotherapy for Crisis First 60 Minutes	Yes	Yes
90840	Psychotherapy for Crisis Each Additional 30 Minutes	Yes	Yes
90846	Therapy-Group Therapy & SUD Outpatient Treatment & PMTO - Family psychotherapy (without patient present), 50 minutes	Yes	No
90847	Therapy-Group Therapy & SUD Outpatient Treatment & PMTO - Family psychotherapy (conjoint psychotherapy) (with patient present)	Yes	No
90849	Therapy-Group Therapy & SUD Outpatient Treatment & PMTO	Yes	No
90853	Therapy-Group Therapy & SUD Outpatient Treatment - Group therapy, adult or child, per session Includes MOM Power	Yes	No
90887	Assessments-Other	Yes	Yes
96105	Assessments-Other - Other assessments, tests (includes inpatient initial review and re-certifications, vocational assessments, interpretations of tests to family, etc.) Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report	Yes	
96110	Assessments-Other - Other assessments, tests (includes inpatient initial review and re-certifications, vocational assessments, interpretations of tests to family, etc.) Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	Yes	
96112	Assessments - Testing - Other assessments, tests (includes inpatient initial review and re-certifications, vocational assessments, interpretations of tests to family, etc.) Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report For reporting BHT/ABA eligibility assessments and re-evaluation assessments related to Autism by a Qualified Licensed Practitioner, working within their scope of practice with training, experience, and expertise in ASD	Yes	

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96113	Assessments - Testing - Other assessments, tests (includes inpatient initial review and re-certifications, vocational assessments, interpretations of tests to family, etc.) Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure) For reporting BHT/ABA eligibility assessments and re-evaluation assessments related to Autism by a Qualified Licensed Practitioner, working within their scope of practice with training, experience, and expertise in ASD	Yes	
96116	Neurobehavioral Status Exam - Psychological testing Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; For reporting BHT/ABA eligibility assessments and re-evaluation assessments related to Autism by a Qualified Licensed Practitioner, working within their scope of practice with training, experience, and expertise in ASD	Yes	
96121	Assessments - Testing - Psychological testing Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report	Yes	
96127	Assessments-Other - Other assessments, tests (includes inpatient initial review and re-certifications, vocational assessments, interpretations of tests to family, etc.) Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	Yes	
96130	Assessments - Testing -Psychological testing Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed;	Yes	
96131	Assessments - Testing - Psychological testing Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure	Yes	
96132	Assessments - Testing - Psychological testing Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed;	Yes	
96133	Assessments - Testing - Psychological testing Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)	Yes	
96136	Assessments - Testing -Psychological testing Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method	Yes	

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96137	Assessments - Testing - Psychological testing Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	Yes	
96138	Assessments - Testing - Psychological testing Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method;	Yes	
96139	Assessments - Testing - Psychological testing Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)	Yes	
96146	Assessments - Testing - Psychological testing Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	Yes	
97151	ABA Behavior Identification Assessment - Behavior identification assessment by a qualified provider face to face with the individual and caregiver (s); includes interpretation of results and development of the behavioral plan of care.	Yes	
97153	ABA Group Adaptive Behavior Treatment - Adaptive behavior treatment by protocol administered by technician, face to face with one individual	Yes	
97154	ABA Group Adaptive Behavior Treatment - Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more individuals.	Yes	
97155	ABA Clinical Observation and Direction of Adaptive Behavior Treatment - Clinical observation & direction of adaptive behavior treatment with protocol modification administered by qualified professional, face- to- face with one individual	Yes	
97156	ABA Family Behavior Treatment Guidance - Family behavior treatment guidance administered by qualified professional.	Yes	
97157	ABA Family Behavior Treatment Guidance - Multiple family behavior treatment guidance administered by qualified professional.	Yes	
97158	ABA Adaptive Behavior Treatment Social Skills Group	Yes	
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion		Yes, report POS only, no audio-only modifier
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion		Yes, report POS only, no audio-only modifier
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion		Yes, report POS only, no audio-only modifier
99202	New Patient Evaluation and Management & SUD New Patient E&M - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Yes	
99203	New Patient Evaluation and Management & SUD New Patient E&M - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Yes	

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99204	New Patient Evaluation and Management & SUD New Patient E&M - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Yes	
99205	New Patient Evaluation and Management & SUD New Patient E&M - Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	Yes	
99211	Established Patient Evaluation and Management & SUD Established E&M - Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	Yes	
99212	Established Patient Evaluation and Management & SUD Established E&M - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Yes	Yes
99213	Established Patient Evaluation and Management & SUD Established E&M - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Yes	
99214	Established Patient Evaluation and Management & SUD Established E&M - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Yes	
99215	Established Patient Evaluation and Management & SUD Established E&M - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Yes	
99231	Additional Codes-Physician Services - Subsequent Hospital Care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the	Yes	
99232	Additional Codes-Physician Services - Subsequent Hospital Care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the	Yes	
99233	Additional Codes-Physician Services - Subsequent Hospital Care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	Yes	
99307	Nursing Facility Services evaluation and management - Subsequent Nursing Facility Care - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	Yes	
99308	Nursing Facility Services evaluation and management - Subsequent Nursing Facility Care - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.	Yes	

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HCPCS/ CPT Code	Description	Simultaneous Audio/Visual Must Include: POS 02 or POS 10 No Modifier Required	Audio Only Allowed Must Include: Modifier 93 & POS 02 or POS 10
99309	Nursing Facility Services evaluation and management - Subsequent Nursing Facility Care - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	Yes	
99310	Nursing Facility Services evaluation and management - Subsequent Nursing Facility Care - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	Yes	
99441	Telephone Calls for Patient Management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion		Yes, report POS only, no audio-only modifier
99442	Telephone Calls for Patient Management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion		Yes, report POS only, no audio-only modifier
99443	Telephone Calls for Patient Management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion		Yes, report POS only, no audio-only modifier
G0176	Activity Therapy (Children's Waiver & SEDW) - Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	Yes	
G0177	Family Training/Support EBP only - Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)	Yes	
G0409	Substance Use Disorder Recovery Support Services - Social work and psychological services, directly relating to and/or furthering the patient's rehabilitation goals, each 15 minutes, face-to-face; individual (services provided by a CORF qualified social worker or psychologist in a CORF)	Yes	
G2067	Substance Use Disorder MAT - Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled opioid treatment program)	Yes	
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion	Yes	Yes, report POS only, no audio-only modifier
H0001	Substance Use Disorder Individual Assessment - Alcohol and/or drug assessment	Yes	Yes
H0004	Substance Use Disorder Outpatient Treatment - Behavioral health counseling and therapy, per 15 minutes	Yes	Yes
H0005	Substance Use Disorder Outpatient Treatment - Alcohol and/or drug services; group counseling by a clinician	Yes	

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H0015	Substance Use Disorder Intensive Outpatient Care - Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	Yes	
H0022	Substance Use Disorder Early Intervention - Alcohol and/or drug intervention service (planned facilitation)	Yes	Yes
H0025	Prevention Services - Direct Model - Prevention-direct service models are programs using individual, family and group interventions designed to reduce the incidence of behavioral, social, emotional or cognitive dysfunction and increase the beneficiary's behavioral functionality, resilience and optimal mental health, thus reducing the need for individuals to seek treatment through the public mental health system	Yes	
H0031	Assessment & Support Intensity Scale (SIS)	Yes	
H0032	Treatment Planning & Monitoring of Treatment - Clinician - Mental health service plan development by nonphysician	Yes	
H0036	Home Based Services - Community psychiatric supportive treatment, face-to-face, per 15 minutes	Yes	
H0039	Assertive Community Treatment (ACT) - Psychiatric Services Only	Yes	Yes
H2011	Crisis Intervention - *Note: does not include H2011 ICSS for children*	Yes	Yes
H2011-HT	Mobile Crisis	Yes	
H2014	Skill-Building - **this cannot be provided in the beneficiary home**	Yes	
H2014-WZ	Out of Home Non Vocational Habilitation - **this cannot be provided in the beneficiary home**	Yes	
H2015	Community Living Supports (15 Minutes)	Yes	
H2021	Wraparound - **providers may only use telemedicine for wraparound activities as permissible under Medicaid policy**	Yes	
H2022	Wraparound for SEDW - **providers may only use telemedicine for wraparound activities as permissible under Medicaid policy**	Yes	
H2023	Supported Employment Services	Yes	Yes - for individual only. Not allowed for groups.
H2025	Supported Employment - Job Coaching	Yes	Yes - for individual only. Not allowed for groups.
H2027	Mental Health Therapy - Psychoeducational service, per 15 minutes	Yes	
H2030	Clubhouse Psychosocial Rehabilitation Programs	Yes	Yes
H2033	Home Based Services - Multisystemic therapy for juveniles, per 15 minutes	Yes	
Q3014	Telemedicine Facility Fee	Yes	
S5111	Family Training	Yes	
S5116	Home Care Training, Non-Family (Children's Waiver)	Yes	
S9482	Prevention Services - Direct Model	Yes	
S9484	Intensive Crisis Stabilization-Enrolled Program (for adults)	Yes	
T1012	Substance Abuse - Outpatient Care - Recovery Supports	Yes	Yes
T1015	Family Psycho-Education - EBP	Yes	
T1017	Targeted Case Management	Yes	

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T1023	Assessments - Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Yes	
T2015	Prevocational Service	Yes	

Claims Reminders

PIHPclaims@dwihn.org -- Billing Issues

Residentialauthorizations@dwihn.org – Residential authorization questions/requests

PIHPauthorizations@dwihn.org – Outpatient Authorization issues/questions

tomani@dwihn.org – Payment issues/questions

Procedure.coding@dwihn.org -- Coding, modifiers, rates questions/issues

MHWIN@dwihn.org – System issues, trouble tickets,

Claims have not been submitted if status indicated "Claim Data Entry" and can be edited/modified prior to submission.

Claim status can be reviewed via MHWIN. "View All Batches"

PRIOR AUTHORIZATION REQUESTS

Urgent vs. Non-Urgent Requests

WHEN: On 6/15/23 at 1:00pm

WHAT: The DWIHN Utilization Management Department will be hosting a brief training regarding a change in the way authorizations are entered/requested.

WHERE: Zoom

https://us05web.zoom.us/j/89413046836?pwd=R2xqdk5sZnp4cUhPRVZjR0xmL1NiQT09

Meeting ID: 894 1304 6836 -- Passcode: Kqvk4Y

PRE-SERVICE REQUEST DEFINITIONS

Urgent Pre-Service - A request for coverage of care or services where ***absent a disposition within 72 hours***, application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life, health or safety of the enrollee/member or others, due to the enrollee/member's psychological state or, in the opinion of the practitioner, would subject the enrollee/member to adverse health consequences without the care or treatment. **If the request meets this criteria**, a disposition will be provided within 72 hours.

Non-Urgent Pre-Service - A request for care or services for which application of the time periods for decision making *does not* jeopardize the life or health of the enrollee/member, or the enrollee/member's ability to regain maximum function, and *would not* subject the member to severe pain. If the request does not meet the criteria for Urgent Pre-Service Request, the disposition will be provided within 14 days.

QUESTIONS?

ORR New Hire Recipient Rights Training

Updates

- ORR Training- preparation for MDHHS Triennial Assessment in Oct. 2023 continues.
- If Providers have registered a staff for NHRRT but then need to cancel/reschedule, notify ORR Trainers at orr.training@dwihn.org, and they'll be happy to assist you.
- **MHWIN Staff Record-Provider to ensure the record is filled in, completely.** Register your staff for NHRRT training during the **onboarding/orientation** process.
- NHRRT provided on Monday-Wednesday each week from 10am-12pm. **Evening NHRRT offered once per month on the 2nd Tuesday of the month from 4pm-6pm. Check MHWIN for available training dates.**
- If your staff fails to receive the NHRRT email by **8:30 am for morning classes (2:30 pm for evening classes),** check email address is correct in MHWIN & have staff check their spam folder. Otherwise, you may contact us via email at orr.training@dwihn.org no later than **9:30 am for morning classes (3pm for evening classes)** for assistance.
- Participants must be present **online**, with working cameras, and remain **visible** and available to communicate with us **throughout** the course.
- If your staff are OBSERVED OTHERWISE NOT ENGAGED DURING THE TRAINING, they will be removed from the training
- Please review the DWIHN website and/or MHWIN newsflash for updates regarding NHRRT.
- **NHRRT must be completed w/i 30 doh for new staff**
- **Comments Section for Staff Records-located on registration page in mhwin-ORR staff only**

OFFICE OF RECIPIENT RIGHTS: MONITORING (SITE REVIEWS)

Updates:

- ORR Monitoring dept. continues to prepare for the upcoming MDHHS Triennial Assessment-10/16-10/20/23
- Assessment will focus on Rights Protection for DWIHN members including: complaint investigations, monitoring, training, death reporting, appeals, RRAC, prevention efforts
- Increase in staff not attending NHRRT with site reviews and complaints-adhere to the requirement of the MMHC mandate that all new employees required to receive NHRRT w/i 30 doh

Site Review Process:

- ORR Site Visit conducted onsite (in person). Covid 19 Questionnaire-If +exposure, an alternative will be arranged
- Any new staff hired since the previous site review-NHRRT completed w/I 30 doh
- NHRRT obtained from different county, pls provide evidence
- ORR Reviewer looks for: required postings, confidential items stored, health/safety violations, interior/exterior of facility, interviews staff & members re: rights
- Any violation(s) found requires a Corrective Action Plan. Provider has 10-business days from the date of the site visit to remedy violation
- Site Rep required to sign & date page #4 of site review tool

Important Reminders:

- Provider contact info and staff records should be kept current, as required in MHWIN
- **NHRRT vs. ARRT**

ORR Prevents Rights Violations

Revised Recipient Rights Background Checks

- Obtain an updated consent form by visiting our website at https://www.dwihn.org/ORR_forms_consent_background.pdf or by emailing ORR Administrative Support staff (see contact information below).
- Submit updated, completed consent form via fax to ORR at **313-833-7066.**
- You should receive your consent form via fax or email (based on a preference you have previously specified), within 5 business days.
- Consent forms are completed by ORR daily. Although it does not take 5 days to complete your consent form, if you do not receive it back within 5 days, please reach out to our Administrative Support staff (Vanique Houser) via email and/or phone at vhouser@dwihn.org., 313-344-9099 ext. 3831 (please leave a voicemail and your call will be returned.) You may also reach out to our Clerical Support staff (Whitley Kidd-King) via email at wkiddking@dwihn.org.
- Reasons for delays in processing consents:

  · Sent to the wrong fax number (313-833-2043)

  · The top portion is blank and we do not know who to send the form to.

  · Staff/applicant name is not printed clearly and we cannot read it.

  · Staff/Applicant and other signatures are not present on the form.

CONSENT TO RELEASE OF RECIPIENT RIGHTS INFORMATION

Send to: DWIHN-ORR
707 W. Milwaukee Street, 2nd floor
Detroit, MI 48202-2943
Phone: (888) 339-5595
Fax: (313) 833-7066 - Attn: DWIHN ORR

I, _____, hereby authorize Detroit Wayne Integrated Health Network (DWIHN), Office of Recipient Rights (DWIHN ORR) to release to:

Company/Name:
Address:
City, Zip
Phone:
Fax:

any and all written reports and records, including the outcome(s) of any investigation(s) of allegation(s) of abuse or neglect that the Recipient Rights Office has conducted involving me. By signing this Consent, I hereby release, waive and relinquish any and all claims against DWIHN, arising from the disclosure of information covered by this Consent to the third-party named above. I absolve DWIHN of any and all liability for the use of the information contained in any disclosed written reports and/or records. I fully understand and accept that the information contained in documents disclosed pursuant to this Consent may preclude my employment with third-party entities.

_____ _____
Name [please print] Maiden or Other name used [please print]

Last 4 digits of SSN: _____ Date of Birth: _____

Applicant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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To Be Completed by Above Named Corporation:

I verify that the above named individual has been given a conditional offer of employment with the listed company and that the identifying information listed above matches the information provided in the application of employment completed by this individual, that the Recipient Rights information requested from DWIHN ORR pertains only to the time period specified below and that DWIHN ORR makes no representation as to whether the Recipient Rights information disclosed includes every Recipient Rights violation substantiated against the above named individual.

Signature of Executive Director/Designee_____ Date: _____

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To Be Completed by DWIHN ORR:

Upon review of our records for the period from _____ to _____, the following was discovered. For the above named individual:

☐ Was identified as violating a recipient's Michigan Mental Health Code protected right(s)

- Date(s) of report(s): _____
- Violation(s): _____

☐ Was not identified as violating a recipient's Michigan Mental Health Code protected right(s)

Signature for DWIHN ORR: _____ Date: _____

CREDENTIALING

Anytime you make any changes to your Microsite and Provider Source application you must re-attest and upload that document. If you do not re-attest Medversant will not see the document and continue to do outreach for what is missing in your file.

- Providers and practitioners are notified 6 months prior to the expiration of the initial or re-credentialing date. If you do not meet the re-credentialing date your file will be treated as a credentialing file.

PRACTITIONER RIGHTS

1. Review information submitted to support their credentialing application.
2. Correct erroneous information.
3. Receive the status of their credentialing or re-credentialing application, upon request.
4. Right to Appeal:
   - If you receive an adverse credentialing decision you have the right to appeal.
   - The letter that you received of the adverse decision has an appeal document attached that must be returned within 30 calendar days of the decision in order to get a review by the Appeals Committee.
   - The applicant will receive a decision within 7 business days of the final disposition.
   - Failure to send a valid request for appeal within 30 calendar days allotted shall constitute waiver by the practitioner of any right to appeal.

PRACTITIONER RIGHTS

- If you receive an adverse credentialing decision you have the right to appeal.
- The letter that you received of the adverse decision has an appeal document attached that must be returned within 30 calendar days of the decision in order to get a review by the Appeals Committee.
- The applicant will receive a decision within 7 business days of the final disposition.
- Failure to send a valid request for appeal within 30 calendar days allotted shall constitute waiver by the practitioner of any right to appeal.

EVERY PROVIDER MUST BE CREDENTIALED. IF YOU HAVE NOT STARTED THE PROCESS IMMEDIATELY CONTACT THE CREDENTIALING UNIT AT PIHPCREDENTIALING@DWIHN.ORG OR YOUR PROVIDER NETWORK MANAGER AT PIHPPROVIDERNETWORK@DWIHN.ORG

Home and Community Based Services Updates

Quality Residential and HCBS Team

6/02/2023

Residential Settings on Heightened Scrutiny

Current Process:

- Complete remediation if needed
- collect evidence of HCBS remediation / HCBS readiness
- Complete attestation of HCBS remediation / HCBS readiness
- Schedule virtual review with MDHHS representative
- Participate in virtual review with MDHHS HCBS Team.

Non-responders on Heightened Scrutiny

All Virtual Reviews with MDHHS Rep. must be scheduled by **June 12, 2023.**

All Virtual Reviews with MDHHS Rep. must be completed by **June 23, 2023**

Observations from Process

Areas for Continued Improvement:

- Modify IPOS language to represent HCBS approved approaches reflecting member choice, autonomy, and participation to include wants, desires and needs.

Improvement Noted:

- Observed improvements addressing environmental safety and as well as improvement in documentation processes. This allows the IPOS to be the roadmap for the services and execute successful HCBS approved approaches.

Observations from Process

General observations

- Observed the bond between residential providers and members. Members/guardians chose to remain in their home, and residential providers advocate for members to remain (often times members remained in house without funding, with the goal of having funding returned and retro pay to May 1st.)

DWIHN Goals

Network and Community Goal is to support residential providers as an ally, to provide the transfer of knowledge, skills and the tools for HCBS Sustainability.

The goal of the HS Consultation is the returning the Members to full funding and maintaining the spirit of HCBS principles going forward.