Residential Provider Meeting Q&A

Friday, March 10, 2023

Virtual Meeting

11:30am –12:30pm

1. Thank you DWIHN for the retro rate increase back to 10/01/23.
   As of today, the rate changes, i.e., for $1.00 /hr. increase, for some persons in I/DD Licensed settings have not increased.
   All persons with L5 modifier for H2016 and T1020 have not received rate updates / increases. That means we are missing rate increases for (21) persons with a H2016 authorization, and (49) persons with a T1020 authorization.
   Some persons have both L5 status for H2016 and T1020

   Would this lack of change affect the recent retro payment received too?
   A. Good afternoon, we are working with our PCE and Finance department on updating the L5 issues. Could you please send a direct email to residentialauthorizations@dwihn.org with the member IDs and Home Names?

2. Do providers still need to have a separate line for Covid hazard pay for payroll or is it all just in dcw's pay? And what is the minimum that dcws should be making hourly?
   A. MDHHS no longer requires a separate line for hazard pay thus the $2.35/hr. should be included in the base rate. Per MDHHS guidance, providers should be able to demonstrate they did increase the base for the hazard pay. There is no minimum amount a DCW should make per hour. DWIHN is not the employer of record and cannot establish a minimum rate.

3. The 2023 site review tool om DWIHN website has some type of type over issue on the report and unable to read some area. Please it be corrected and updated
   A. We will review the 2023 Environmental/Safety Site Review Assessment and make sure it is legible.

4. Do we register for these trainings or you tell us when?
   A. Which trainings are you referring to?

   Q. you spoke of meetings/trainings you had to review the RR policies and procedures with providers.
   A. If this question is in reference to the ORR presentation, Providers will be informed by the ORR when the review will occur.

5. The $1.00 retro dcw wage increase from 10/1/22 can be used by providers for other costs (overtime, mileage, etc.) correct? It is no longer mandated as a hourly increase to the staff?
    A. Yes. That is correct.

6. Could you please give an over view of Pathway#3 and 4
    A. The HCBS Statewide Transition Plan had several stages to roll-out and respond to the HCBS Survey Process which started in 2018. The first stage was the Non-Responder Providers List Transition. This is where the Members who live in what is termed Non-Responder List Providers were to be provided Person Centered Planning to discuss Transition Pathways to address the Non-Compliant Providers

    Pathway #4 was the plan where Members would move to new provider homes and be able to continue receiving HCBS Services, Supports and Funding. This was facilitated by the CRSPs and the DWIHN Residential Department to support choice and provide a warm hand off to the new provider

    Pathway #3 was the plan where the Members chose to remain with their current Non-Responder List Provider and the provider agreed to allow them to remain. The Member chooses to suspend their HCBS Services, Supports and Funding until their current provider is reinstated by CMS and MDHHS to provide HCBS Services and Supports. The expectation to support the Member without their HCBS Funding was where the Provider agreed to continue providing CLS Supports and Personal Care Assistance without Medicaid Funding until their reinstatement. The CRSP are to provide enhanced supports and contacts to continue to assess the Members needs and observe whether the Member needs further resources or a new placement referral. The CRSP were to make sure all services remain in place during this “suspension” of funding time frame

7. Thank you for working with the CRISP for the IPOS. It is still a challenge for some thereby denying billing for some consumers.
    A. You are welcome, DWIHN is planning some future IPOS trainings with the CRSP to continue the efforts and hopefully limiting the denying of billing.

8. Can someone speak more on the Salary and Wage survey Excel-based survey that has to be completed by March 24? I did ask our provider specialist but it's still unclear to me
    A. Please direct specific questions to Dhannetta Brown dbrown@dwihn.org

9. CLS, Inc. has recently stated via Annette Downey that they are not responsible to provide training on assessment or plans contained in the IPOS. Is this correct? Where is training supposed to come from? I thought the author or the plan or program or treatment was responsible to train the staff implementing it?
    A. Support coordinators should be training on their IPOS. I am not sure what has been shared with you. Please send me email with specifics. Thanks Manny Singla

B. not sure of the details here, but I do know that they stated that in regards to Clinical assessments and plans attached to the IPOS like Eating guidelines, behavior plans, etc.

   The problem is getting those in-services from the clinicians and especially the requirement that they personally in-service each staff and not train the trainer is almost impossible and is not being done by those clinical providers

10. From the first Quality Dept/HCBS monthly meeting, can we get a transcript/minutes of the meeting
    A. The transcript is being reviewed and upon approval it will be posted. It should be posted in by 3/27/2023.

11. Who do we contact if we have expenses from having to move people due to power outages and what expenses can be submitted?
    A. Please contact residential team and share those expenses along with any necessary details.

12. Persons living in Licensed Homes with L5 modifiers have not received rate increases for H2016 nor T1020 authorizations services - for recent $1.00 an hour increase. Whom do providers contact about this? Will this affect the retro amounts going back to 10/01/2022?
    A. Please contact the residential team for those updates so the authorizations can correct as appropriately.

13. Is DWIHN aware some providers already paid the $1 raise because they were following the memo and it was almost 2 weeks later before it was taken back
    A. DWIHN paid out the $1.00/hr. retroactive payment and it hit providers bank accounts on Monday. Providers that paid out the $1.00/hr. received the funds and are therefore not harmed.

14. Are you aware that some providers did not receive the updated increase in MHWIN?
    A. Please send an email to the Residential Authorization team at residentialauthorizations@dwihn.org with the member ID and home name

15. What can you do about CRISP copying and pasting IPOS, that are not specific to the c Is it the providers choice to continue with separate checks? Regular pay and Hazard pay specifically to consumers?
    A. We want to use our upcoming meetings with the CRSPs and the Providers to discuss issues like this to make sure the IPOSs meet the needs of our Members.

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

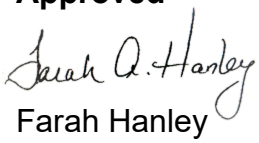
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

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



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