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CRSP PROVIDER MEETING
Monday, March 20, 2023
11:00 a.m. – 12:15 p.m.

Agenda

I. **Melissa Moody, VP of Clinical Operations**
   A. 1915(i) SPA
   B. Medicaid Re-determination
   C. Supports Intensity Scale

II. **Tiffany Karol, Utilization Management Manager**
   A. Habilitation Supports Waiver (HSW) Update

III. **Ebony Reynolds, Clinical Officer**
   A. DSM-V Conversion
   B. IPOS Train-the-Trainer Series

IV. **Marianne Lyons, Director of Adults Initiatives**
   A. Telemedicine Changes

V. **Kate Mancani, Residential Authorization Manager**
   A. Manual Authorization Update

VI. **Josephine Maples, Interim Residential Unit Manager**
   A. Home and Community Based Services (HCBS) Update

VII. **Jacquelyn Davis, Clinical Officer**
   *A. **Access Call Center Updates***
      1. New Managers – Clinical and Quality Coordinator
      2. Eligibility Screening Tools
      3. Disability Designation Changes

VIII. **Eric Doeh, President and CEO**
A. President/CEO Updates

CRSP PROVIDER MEETING RECAP
Monday, March 20, 2023
11:00 a.m. – 12:15 p.m.

1. **Will we get these slides (1915(i) SPA)?**

   Yes, they will be included with this meeting's recap.

2. **Since the SIS is not being used and the 1915(i) SPA Benefit Evaluation form has "Other" as a selection for I/DD population, please inform CRSP which supportive assessment is approved by MDHHS.**

   Providers can use the Integrated Biopsychosocial Assessment

3. **If there is more room for the trainings (IPOS Train-the-Trainer Series), are you able to let the biggest CRSPs know to add more people?**

   Yes, but space is limited so we are requesting that providers have staff be identified as Train-the-Trainers so the information can be brought back to the organization and have ongoing trainings internally.

4. **Was the IPOS Train-the-Trainer Memo sent out?**

   The IPOS Train-the-Trainer memo was sent out. Please reach out to Marianne Lyons at mlyons@dwihn.org or Ebony Reynolds at ereynolds@dwihn.org.

5. **DWIHN's Access Call Center's staff meetings are on the third Thursday of each month at 7:30 a.m. and 2:00 p.m. Please send an email to AccessCenter@dwihn.org if you would like your agency to be added to our agenda to give a presentation/overview about the programs and services your agency provides to our community and how to access those services.**

6. **Where is the Medicaid Re-Determination report located?**

   Medicaid Redetermination report is available Under Reports in PCE system. Please contact your PCE Project Manager to get a copy of the report turned on in your system.

CRSP Provider Meeting 3/20/23

1915iSPA

Medicaid Re-Determinations

Support Intensity Scale (SIS)

What is the 1915(i)SPA?

Following CMS requirements, Michigan is transitioning all specialty behavioral health services and supports currently covered under Medicaid (b3) authority to a 1915(i)SPA State plan benefit effective October 1, 2023.

Michigan developed the HCBS benefit to meet the specific needs of its behavioral health and developmental disabilities priority populations that were previously served through the Managed Specialty Services & Supports B3 Waiver authorities within Federal guidelines.

1915(i)SPA Services	CCBHC	Behavioral Health Covered EPSDT	Children's Waiver 1915C	SED Waiver 1915C	Habilitation Supports Waiver 1915C	1915(i)SPA
Community Living Supports		X	X	X	X	X
Enhanced Pharmacy					X	X
Environmental Modifications			X		X	X
Family Support & Training	X	X	X	X	X	X
Financial Management Services (FMS)/Fiscal Intermediary			X	X	X	X
Housing Assistance						X
Respite	X		X	X	X	X
Skill Building	X	X			**	X
Specialized Medical Equipment & Supplies (Assistive Tech)			X		X	X
Supported/Integrated Employment	X	X			X	X
Vehicle Modification (Assistive Tech)			*		*	X

* = This service may be covered under Specialized Medical Equipment & Suppplies. Please refer to the code chart for further details.

** = Skill Building (H2014) is not an HSW covered service; however Out-of-home non-voc (H2014WZ) is an HSW covered service. Please refer to code chart for further details.

X = This service is a covered service.

1915(i) Enrollment Process

- Each member's eligibility is evaluated annually to determine they meet the needs-based criteria for the 1915(i) benefit, which includes an array of services.

- The enrollment process includes:
  1. Evaluation completed by the clinical staff
  2. Services requested are included in the IPOS/Addendum
  3. 1915(i)SPA Lead enters the information into the Waiver Support Application (WSA)
  4. DWIHN is notified that there is an application to review
  5. DWIHN processes the application and sends to MDHHS for final review
  6. Provider is notified directly via e-mail of application status

Current Status

- **DWIHN has received 648 applications in the WSA (should be minimum- 4,000 enrollees. Est.):**
  - **Immediately focus on entering all members into the WSA that had an IPOS completed between 10/1/2022 to 3/19/23 asap**
  - **All those with IPOS's expiring from 3/20/23 to 9/30/23 need to have the 1915iSPA evaluation and WSA completed at the same time as the IPOS.**

Training:

- **3/23/23 9am- Children Providers**
- **3/24/23 9am- Adult Providers**

Medicaid Re-Determination:
Ending of Public Health Emergency

- Michigan's Medicaid caseload grew by more than 700,000 people during the Public Health Emergency.
- More than three million persons benefited from keeping Medicaid coverage without redeterminations during the COVID-19 pandemic. This includes pending deductibles.
- Renewals for traditional Medicaid & Healthy Michigan Plan take place monthly starting June 2023. Monthly renewal notices will be sent three months prior to renewal date.
  - Members need to:
    - Make sure their address, phone number and email address are up to date at Michigan.gov/MIBridges. Can also call local MDHHS office.
    - Report any changes of household or income. You can report changes at Michigan.gov/MIBridges or by calling your local MDHHS office.
    - Fill out renewal packet, sign the forms and return it by the due date with any proof needed. NOTE: If you do not complete and return the renewal, you may lose Medicaid coverage.

Supports Intensity Scale

- MDHHS has discontinued use of Supports Intensity Scale for I/DD population in March 2023
- MDHHS has requested feedback on alternative assessment tools
- MDHHS will determine if, and when, an alternative will be implemented
- DWIHN is currently evaluating UM Standard Utilization Guidelines (SUGs) relative to the discontinuation of the SIS (currently defaults to lowest level when SIS is not completed)
- DWIHN will be communicating with the provider network on next steps in regard to SUG's utilized within the I/DD population

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March 13, 2023

To: DWIHN- Clinically Responsible Service Providers (CRSP)
From: Marianne Lyons-Director of Adult Initiatives
Cc; Melissa Moody-VP of Clinical Operations, Ebony Reynolds-Clinical Officer, Leigh Wayna-Director of Utilization Management, Cassandra Phipps-Director of Childrens Initiatives, Shirley Hirsh-Director of Residential Services, Judy Davis-Director of Substance Use Disorder
RE: CRSP IPOS Train the Trainer Series

DWIHN is excited to announce a training initiative to support best practices on Person-Centered Planning guidelines in development of the Individualized Plan of Service, (IPOS). This training will provide instruction on the core principles of Person-Centered Planning, facilitating appropriate goals, objectives and interventions. This course will assist with developing a Train the Trainer model and allow for on-going training and skill development within your agency to be facilitated by your clinical leads.

The goal of this initiative is to train clinical leads at each organization so they can support their clinicians in understanding how to develop the IPOS based on medical necessity criteria and to reduce the amount of returned authorizations by DWIHN Utilization Management department. DWIHN does not want to delay approval of service authorizations due to IPOS's that are not written with the appropriate clinical justification for the service request. Therefore, DWIHN has collaborated with several internal departments to develop this training.

DWIHN is offering three opportunities for the Train the Trainer series scheduled on the following dates;

April 5, 2023 at Lincoln Behavioral Services
July 20, 2023 at The Guidance Center
October 4, 2023 TBD

All trainings are scheduled from **9:00AM-12:00PM** and participation is expected. Please add these dates to your calendar to ensure availability and participation in one or more of these trainings.

Please use the following link to register, https://forms.office.com/g/b1KA3whd2C
Each training session will be limited to 50 individuals max, so please register soon to guarantee your spot.

If you have questions, please contact ereynolds@dwihn.org, or mlyons@dwihn.org.

We appreciate your support in this matter.
Thank you

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

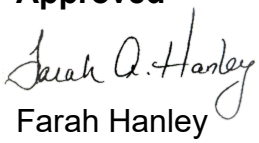
Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

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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