Behavioral Health & Developmental Disabilities Administration Encounter Data Integrity Team Minutes

Date: 4/16/2020	Webex: http://www.webmeeting.att.com
Time: 10AM-12PM	Dial-in Number: 877-336-1829,,8881705

Community Mental Health Service Programs

☒	Copper Country CMH: Susan Sarafini
☒	Centra Wellness: Donna Nieman
☒	West MI CMH: Jane Shelton
☒	Integrated Services of Kalamazoo: Ed Sova
☒	CEI CMH: Stacia Chick
☒	Livingston County CMH: Kate Aulette
☒	Sanilac County CMHA: Beth Westover

Community Mental Health Association

☒	Maggie Beckmann
☒	Bruce Bridges

Prepaid Inpatient Health Plans

☒	NCN: Joan Wallner
☐	NMRE: Brandon Rhue
☒	LRE: Ione Myers
☒	SWMBH: Anne Wickham
☒	MSHN: Amy Keinath
☒	CMHPSN: Michelle Sucharski
☒	DWIHN: Tania Greason
☒	DWIHN: Jeff White
☐	OCHN: Jennifer Fallis
☒	OCHN: Kim Avesian
☒	MCCMH: Bill Adragna
☒	MCCMH: Amie Norman
☒	Region 10: Pattie Hayes

MDHHS

☒	Laura Kilfoyle
☒	Kasi Hunziger
☒	Kathy Haines
☐	Belinda Hawks
☐	Kim Batsche-McKenzie
☐	Angie Smith-Butterwick
☐	Mary Ludtke
☐	Brenda Stoneburner
☐	Morgan VanDenBerg
☒	Jackie Sproat
☒	Phil Chvojka

Agenda Item	Presenter	Notes/Action Items
Welcome and Roll Call, membership updates (5 minutes)	All	
Review and approve prior meeting minutes (5 minutes)	Jackie	January 16, 2020, meeting minutes are approved
Community Living Support Coding with H2015 (5 minutes)	Jackie	**Seeking 1-2 CMH/PIHP volunteers to assist with development of Technical Assistance:** Community Living Support coding memo sent out March 23, 2020, from Jeff Wieferich. Questions have been coming in and BHDDA would like input from a small group of CMHSP/PIHPs that have dealt with these issues. These EDIT members expressed interest: Kate Aulette, Jeff White, Joan Wallner

		Anyone else interested should get back to Jackie by the end of next week. Questions that have come in so far are listed at the bottom of this document. Bruce is sure there are more. Guidance in June/July needed to have contract changes in place to start October 2020.
1. Code Chart and Provider Qualifications Chart updates 2. COVID-19 encounter code chart (15 minutes)	Kasi	**Code chart revisions** were posted 3/25 and 4/16. • New Infant and Early Childhood Mental Health Consultation, and Children's Friendship group service, pages 26, 28 and 42. Kim Batsche-McKenzie has more information. • Page 42, H0025 updated • Page 47, SUD laboratory test – note added for Methadone only and CANNOT be reported in conjunction with G bundle. • Page 49 to 50 – OTP G codes effective January 1, 2020 Question asked about S5116 Non-Family training: does beneficiary need to be present? No, service is face-to-face with CLS staff (with or without the beneficiary present). A **COVID-19 encounter code chart** is also posted on the website. This code chart provides information on which additional services can be provided via telemedicine during COVID-19 mitigation. Continues to be updated as services and codes become available and updated. Jeff Wieferich **Clarification of Rounding Rules memo** was sent on 4/8/2020. The intent was to "give credit" for brief contacts with consumers, for example a case manager calling to check-in on a client, therefore only applies to the first 15 minutes of codes with 15-minute units. Question was asked about 90832. CPT codes have mid-point rounding rules, therefore for a 30-minute code, need to get to at least 16 minutes to bill. Kathy will share the question about 30-minute therapy services with Jeff. Kasi said there are no updates at this time to the **Provider Qualifications** document, but expects to have changes to review at the next EDIT meeting
Outpatient partial hospitalization: telemedicine option during the COVID-19 State of Emergency?	Jackie	0912 and 0913 are not on the MDHHS MSA list of approved telemedicine codes. Jeff has been getting questions from providers asking for a telemedicine option. Is it an option to break down the 0912 and 0913 per diem rates to pull out specific services for billing and reporting? If so, how would remaining items be re-bundled for reporting with a rate that was adjusted down? Laura K. said there are no revenue codes currently approved for telemed. We would have to be careful about double billing, OAG has investigated partial hosp as

		high priority in the past. Laura and Jackie to follow up after the meeting.
Telemedicine and recent MSA policies (10 minutes)	Laura	**MSA 20-09** is a permanent policy, continues after COVID-19 emergency ends. This policy did not increase the number of codes approved for telemedicine (see Telemedicine Services database on MDHHS website). Consumer consent for telemed is needed. Originating site is up to provider discretion, can be home or car. Facility fee clarification on "Neither the originating site or the distant site is permitted to bill both the telehealth facility fee and the code for the professional service for the same beneficiary at the same time"-- if CMH psychiatrist works at a different location (not the CMH office), the facility fee Q code cannot be billed. Definition of telemedicine: will audio only be allowed after COVID-19 emergency is over? As of now, audio-visual only will return when COVID-19 emergency is over. Laura said MSA is looking into options. Consent for SUD services is currently a challenge. **MSA 20-13** is temporary policy specific to COVID-19. (Any that are COVID-19 specific will show COVID-19 Response in the subject.) Allows services by telephone only, until 30 days past the emergency order or following month, whichever is later. Watch for additional policies coming from MSA. Transitioning data systems from the COVID-19 temporary rules back to "normal" will take time. Suggestion for MDHHS to share timeline information as much as possible.
OTP Medicare Duals EDIT Subgroup Guidance (20 minutes)	Laura	**EDIT Review and approve guidance developed by subgroup.** OTP guidance was approved with this clarification added to the RECOMMENDATIONS section: *The May 1, 2020 deadline applies to Medicare/Medicaid dual eligible. MDHHS would like to gradually transition services for beneficiaries with primary Medicaid or block grant funding to the G codes, ideally as of the start of FY21.* G codes need to be used for dual Medicare/Medicaid beneficiaries as of 5/1. EDIT members asked for clarification that the G codes don't need to be used for beneficiaries with primary Medicaid or block grant funding as of 5/1. Kathy said that Phil Chvojka said the goal is not to force folks to use one code structure but to have choice.

		Milliman has recommended discontinuing use of H0020 as of FY21, to gradually move to using G codes for all beneficiaries. MIHealthLink regions need to take dual eligibles into consideration who are not MIHealthLink enrolled. Jeff Wieferich would like feedback on retiring the H0020 code. Decision needs to be made soon to get contracts set up for FY21. EDIT members requested 1) to have a final version of the guidance sent out ASAP, and 2) final decision prior to next EDIT meeting on whether H0020 is ok to use after 9/30/20.
Encounter Quality Initiative (20 minutes)	Kathy	Jeremy Cunningham walked through the three templates: Regional PIHP template, CMHSP templates, Dual CMHSP/PIHP template. **Regional PIHP template**: the CMH column should align with each CMH template. Includes rows for each CMHSP in the regional as well as rows for services contracted through the PIHP. Make sure to filter it correctly. Collects utilization and cost information for each service for the Medicaid-enrolled populations – DAB/TANF, HMP, and Mi Health Link mild to moderate. Also, for c - waiver services information is collected for HSW, SED, and CWP populations. SUD grant funding wasn't previously included in the template but based on user feedback was added for every service. **CMHSP template**: For collecting total cost information. Collects utilization and cost information for all populations - DAB/TANF, HMP, General Fund, Grants, MiHealth Link mild to moderate, HSW, SED, CWP. **Dual CMHSP/PIHP:** consistent with CMHSP templates but includes regional PIHP Capitation Payments, Retroactive Eligibility and Capitation Revenue (excluding IRA and HRA). Attestation tab has a dropdown for each CMH. Select your CMH. Reporting Basis dropdown used to select net or gross expenditure. Entities have the option to report net expenditures for the first EQI reporting period. BHDDA expects subsequent EQI reporting to be based on gross expenditures. Kathy said the templates will be posted on the BHDDA website soon. Reports from PIHPs are due to MDHHS on June 30, deadline was postponed due to COVID-19 emergency.
Wrap-Up and Next Steps (5 minutes)	Jackie	

Action Items	Person Responsible	Status
EDIT members send Jackie volunteers by 4/24 from CMHs to assist with developing H2015 technical assistance.	EDIT members	**Volunteers as of 4/17:** Kate Aulette, Jeff White, Joan Wallner
Send final OTP Medicare Duals EDIT Subgroup Guidance to PIHP and CMHSP CEOs.	Jackie	
EDIT members send feedback to Jackie by 4/30 on retiring the H0020 code as of 10/1/20.	EDIT members	
Follow up meeting on partial hospitalization and telehealth, as well as consent	Laura & Jackie	

Next Meeting: 7/16/2020

CLS H2015 Example Questions

1. Scenario with 2 people receiving services---share a staff. One individual is out of home in AM (working, whatever) other is out of home in evening (job, community). So, the provider would have to bill 15-minute units for CLS H2015:TT for some hours of the day, H2015 other hours and then overnight monitoring. It's the switching up of these codes and rates for each day that presents a challenge. And how do you ever auth the 15-minutes unit for each individual---knowing the split between 1:1 and 1:2 (TT) will vary every day?
2. Will there be a cap on the number of H2015 units in a SIP each day? If there isn't a cap, can we justify staffing during sleep time in a service plan given the HSW sleep time code?
3. Do we separately code H2015 services to people who leave their SIP home during the day to shop, work, go to appointments or day programs or socialize with staff being needed for assistance if those staff are employed by the same "in home" employer as a separate location?
4. There are situations where there typically is only a once a day "eyes on" contact or med drop and the H2015 code 15 minute doesn't fit where the H0043 did. Is there a potential to use another code to accommodate the cost of this effort?
5. The other hard part of this code switch is rate setting. The daily rate accommodated fluctuations in daily service units and established more of an "average" cost for the day. I see that 15-minute rates would have to be varied and how does that get programmed into the billing system – even if a different rate is set for each individual, the individual could have several rates based on what level of CLS the person is getting throughout the day? Also, this leads to there not being a standard 15-minute H2015 or H2015-TT rate across all consumers. I'm not sure this meets Medicaid rate-setting standards?