Michigan Department of Health & Human Services

Behavioral Health & Developmental Disabilities Administration Encounter Data Integrity Team Minutes

Date:	January 20, 2022	Location: Webex:	Click here to join the meeting

Time:	10AM-12PM	Dial-in Number:	+1 248-509-0316 ID: 136 063 925#

Community Mental Health Service Programs

X	Copper Country CMH: Susan Sarafini
X	Centra Wellness: Donna Nieman
X	Integrated Services of Kalamazoo: Ed Sova
X	Livingston County CMH: Kate Aulette
X	Newaygo CMH: Jeff Labun
X	Sanilac County CMHA: Beth Westover

Community Mental Health Association

☐	Maggie Beckmann
X	Bruce Bridges

Prepaid Inpatient Health Plans

X	NCN: Joan Wallner
X	NMRE: Brandon Rhue
X	LRE: Ione Myers
☐	LRE: Stacia Chick
X	SWMBH: Anne Wickham
X	MSHN: Amy Keinath
X	CMHPSN: Michelle Sucharski
X	DWIHN: ~~Tania Greason~~ Deabra Hardrick-Crump
X	DWIHN: Jeff White
X	OCHN: Jennifer Fallis
X	OCHN: Laura Aherns
☐	MCCMH: Bill Adragna
X	MCCMH: Amie Norman
X	Region 10: Laurie Story-Walker

MDHHS

X	Laura Kilfoyle
X	Kasi Hunziger
X	Kathy Haines
X	Belinda Hawks
X	Kim Batsche-McKenzie
☐	Angie Smith-Butterwick
☐	Mary Ludtke
X	Brenda Stoneburner
X	Jackie Sproat

Agenda Item	Presenter	Notes/Action Items
Welcome and Roll Call, membership updates (5 minutes)	All	Deabra Hardrick-Crump replaced Tania Greason for DWIHN. Other individuals present but not listed above: Phil Chvjoka (MDHHS), Barbara Culley (Milliman), Thomas Cole (Macomb), and Jill McKay (Newaygo)
Review and approve prior meeting minutes (5 minutes)	Kasi	Approved
EQI Update (10 minutes)	Kathy	Next meeting February 10th to design the EQI template for FY 22. The workgroup wanted experience with working on third period FY21 EQI which was released at the end of December.

		Laurie – Region 10 – FY21 encounter reporting at end of December issue with Place of Service. Is there a date that Milliman is pulling encounters? Kathy: Milliman receives extract every month and typically would use February extract. Laurie – will there be communication that goes out? Kathy – will communicate with Milliman regarding the December POS issue with the encounters and potential for having to use another month.
COB Subgroup (10-15 minutes)	Jackie/Kathy	Training tomorrow morning, January 21st. Intended audience is the CIOs from CMHSPs and PIHPs and their vendor staff. John Holland to walk through detailed example. New COB reporting requirements will be effective FY23.
Transportation Subgroup (5 minutes)	Kathy	On hold at the moment. Need to regroup and come up with some goals.
Code Chart Changes Subgroup (5 minutes)	Kasi	Completed our review of the SUD rows in November. The group did not meet in December. Group reconvened this month to start the review of the ABA rows.
Update on development of tiered rate for inpatient psychiatric services (5 minutes)	Jackie	Based on review of data with 3 hospitals and reps the group has decided basing rate tiers on violent behavior would be challenging to define and track. The last meeting of the full group agreed to base the inpatient tiered rates on staffing needs instead of violent behavior. Inpatient rates will be based on age and staffing needs. The workgroup members have said that this would be doable to use physician orders from the healthcare team for one-on-one care or some other heightened staffing need order. Staffing order is clear-cut. Inpatient group has been using a timeline – hasn't been sent out on beyond the group. The timeline can change. See attached MDHHS Inpatient Psych Rate Presentation – 20220106 for current status of timeline. Plan is for implementation for FY23. Amy – how would this be reported for higher level staffing – anything new on the encounter, such as revenue codes? Jackie – revenue code (0204) in legislative language – in early stages of looking at this. Henry Ford has been wanting to use this code and could already be.

		Beyond that there is a possibility of a modifier to indicate higher level staffing on a particular day. Donna – different rate each day based on staffing levels required? Jackie – yes that could be. Ione – if that follows through – the encounter reporting methodology would have to change – an entire stay would not be reported on one encounter line and instead separate encounter lines. Jackie – Yes. Days with same rate would be on the same line. Determination of level of staffing would come through pre-screen as well as the on-going back and forth communication during hospital stay. Jeff White – local modifier used for rates on their hospital stays. Hospital requests authorization for higher rate. 3 days for higher rate and 7 days for standard rate.
Update on status of tiered rate for licensed residential services (5 minutes)	Belinda	The workgroup is meeting tomorrow and revisiting the assessment tool based on the population served in the setting. Looking at how we want to modify tier assignment approach. Timeline to speak to next steps to identify payment tier. Brandon – struggle with figuring out how to pass the dollars through to the CMHs. We prefer to use the state approach but the more complicated the rate sets are without communication and direction the more complicated on paying the CMHs in the region. Timeline – no timeline established yet.
Does Milliman want to know level of licensure or highest level of education the individual has regarding the provider level modifiers?	Milliman	Action item from our October 21, 2021, meeting. If a code requires a Master level – you would report that if appropriate. If person has a masters of fine arts but code requires MSW but has a BA that is appropriate then report the BA. Milliman doesn't want to know the highest level of education – they want to know the highest level for the code. Joan – it is problematic – our staff records include credentials of providers – supported employment – staff is LMSW – mapping this credential – if this person provides SE but SE only goes up to Bachelor's level and now have to go into the staff record to add a bachelor's level.

		Jeff – has same problem as Joan. Also, Region10 has same issue. Anne W. agrees with Joan – in billing you bill licensure of the provider not the maximum for the code. Jeff – we should have minimum level such as bachelors or higher. We need the state to accept any minimum or higher. So if a code only lists up to a Master's – the state should accept the Ph.D. modifier if that person is a Ph.D.
Code Chart and Provider Qualifications Chart updates (15 minutes)	Kasi	BHDDA will only make changes to the code chart workbook on a quarterly basis unless there are errors and/or urgent problems that need to be addressed immediately. Most recent changes: • Added the following SEDW and/or Child Waiver services that were missing. 90863, 92626, 92627, 92630, 92633, 97761, and K0739. • H2000 - added the LBA and BCBA as allowable providers along with their provider modifier. • T2038 - removed the SEDW/CWP line as it is only covered under the 1115(i)SPA. • H2021 – removed the SEDW/CWP line as it is not covered under the SEDW. • T2038 – removed the language that it is not a staff covered service. Added provider level modifiers. • H2023 – Drop-In Centers – removed provider level modifiers. • Added ALBA (Assistant Licensed Behavior Assistant) to the job-title crosswalk under the HN. • H2000 TS – added this as a new row with provider level modifiers. • 97151 – opened for everyone – must add the U5 to Autism beneficiaries effective 1/1/22. • H2011 – use this code for all Intensive Crisis Stabilization for children 0-21. Next update will be on: **April 1, 2022,** and will include changes from the code chart changes subgroup as well as any other updates needed.

		Any substantial changes will be given lead time such as making effective a couple months out so systems can be changed.
Telemedicine Update	Kasi/Laura	On January 16th the Federal PHE was extended for another 90 days. COVID-19 policies still in play and operating. The new 90 day extension expires on April 16th. Will provide guidance on when we will end these policies if this is not extended again. We are negotiating post-PHE policies. Will give as much advance notice as possible. Senior leadership is looking at post-PHE policy.
Place of Service Update for Telemedicine	Laura	As of January 1, 2022, CMS has changed their definition of POS 02 from “telehealth” to “telehealth provided other than the patent’s home” and they are adding Place of Service 10—"telehealth provided in patient’s home”. HASA has decided **NOT TO USE POS 10** and to continue with POS 02. So, all claims and encounters should continue to come in with POS 02, even if the service is provided in the patient’s home. We are requesting that the provider “if they are able” include “patient’s home” in the comments on the claim/encounter so we will be able to see if the service is provided in the home. Amie – doesn’t make sense to not use POS like Medicare, etc. Laura – systems edits need lead time. Don’t want to burden making multiple changes if we made the change now and have to change it again 6 months later.
Modifier FQ	Laura/Kasi	“FQ” was created to distinguish services provided with only an audio component. As you know, per MSA 20-13 (COVID temporary policy) we are requiring providers report services provided via audio only with POS 02, the GT modifier and with “services provided via telephone” in the comments section. Thoughts on adding this modifier during the PHE from EDIT? Will this be an issue with only allowing four modifier slots? Should we continue to just use the comments section to track this?

Modifier 93		Jenny – Oakland – temp policy could eliminate audio only. Should poll providers – many set-up to do comments already. This would be changes to the system. Jeff – given all the changes making right now – we should leave this alone. Livingston agrees. Also, Ione. Oakland too. Mid-State agrees as well. A question was submitted asking if we will be using the new 93 - "Audio Only" modifier. HASA and BHDDA will not be implementing this modifier. Comment: Using CPT or HCPCS codes in the future would be better than modifiers.
Audio Only Codes	Kasi/Laura	98966-98968 nonphysician codes, 99441-99443 physician codes, and G2251 brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services. Anne – MIHealthLink has added these already. Some concern the CMHSPs are allowed to report these MIHealthLink their portion to MDHHS. The codes need to be added. Caution people that the requirement for the service has to be initiated by beneficiary and not the provider. Providers were billing inappropriately and had to re-coup. Amy – support adding these codes as it will be make it easier for MIHealthLink and Medicare. Many providers have asked for them. Also, suggestion prolonged E&M service codes like is covered under MIHealthLink.
What codes should be used for a Crisis Intervention Contact Note and Inpatient Screening. The obvious first thought was that a Crisis Intervention Contact Note would be a H2011 and an Inpatient Screening would be a T1023. However, we also remember there has been previous discussions about H0036, H0038, H0039, T1017, and possibly other codes being used because they are either bundled services or should be used instead of the H2011 and T1023. It would be nice to make this less confusing and always just report the Crisis	Group	Jenny – Oakland – crisis center use H2011 and T1023. ACT providers would use the H0039 with the pre-screen modifier. Don't use any of the other codes. Same for Livingston and Central Wellness. Use the bundled code for those bundled service beneficiaries and use the H2011/T1023 for all others.

Intervention Contact Note as a H2011 and an Inpatient Screening as a T1023, but we want to be consistent with the rest of the CMHs and MDHHS.		
West Michigan has a consumer who we are administering vivitrol injections to, which is a medication assisted treatment under SUD. 96372 Medication Administration is not listed as a reportable SUD service. We would like to request 96372 be added to the SUD service array for that reason.	Phil/Group	The H0033 is being used by some agencies for this; however, its official definition is "oral" not injection. So, adding the 96372 and having it be allowable for both naltrexone (Vivitrol) or buprenorphine (Suboxone) could eliminate the need for H0033. Phil – volume is low, not seen often, otherwise we see H0033 even if injection – it's the cost of admin not the cost of the medication. Thoughts on adding the 96372 SUD to the chart – Jeff White: uses this code currently and uses other funding. Very appropriate code to use. Anne – already uses it as well. Livingston as well. Consensus to add 96372 SUD to code chart for the injectables and keep H0033 as is for the oral meds.
Need to be able to differentiate between Block Grant and COVID Block Grant funds for both dollars and people for Block Grant reporting.	Phil	Under the block grant there is a separate funding for COVID-19 block grant dollars, and we need to separate this out for the block grant reporting. What's the best way to do that? Oakland – putting it on the encounters would be difficult – could it be on financial reporting? Would be difficult to get these from the providers as they wouldn't know that necessarily. Phil – we could add a flag to BH Teds too as that could be a way to get to the demographics for them. Brandon – the number of modifiers is an issue – having to weight them as there are only four slots. Is there another method to collect this that would be best because of the potential for dropping modifiers? When the funds dry up then this won't be necessary down the road. A flag on the encounter and the person (BH Teds) would provide all of the information needed for the report. Amie – can discuss with SUD team at Macomb – has concerns with adding modifiers. Can this be reported in the FSR or other financial report? Could we potentially with efforts of finance group report through finance group? Phil – if that is easiest for everyone. Anne – will have to go back to finance group to figure it out. Will have to see if serving people with the funds or if it is provider stability use. Ione – SUD Director – when gathering

		numbers for FY21. Some of the funding used for things not for reportable encounters. The COVID money did not fund the service but the mechanism to get the person to treatment. Brandon mentioned looking at 2300 loop in 837s which could be used for funding source and have other with supplemental codes. Could be an option to not report the people and just the dollars on the tables. Consensus to NOT add this to the encounter and find another way to capture this information.
Wrap-Up and Next Steps (5 minutes)	Kasi	

Action Items	**Person Responsible**	**Status**
West Michigan has requested the following services be added to the code chart as well as the CCBHC allowable codes: 96158, 96159, and 99409.	Group – Save for April 21 meeting.	

Next Meeting: April 21, 2022