Behavioral Health & Developmental Disabilities Administration Encounter Data Integrity Team Minutes

Date:	October 21, 2021	Location: Webex:	Microsoft Teams Meeting
Time:	10AM-12PM	Dial-in Number:	+1 248-509-0316 ID: 317 253 342#

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
☐	Bruce Bridges

Prepaid Inpatient Health Plans

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

MDHHS

☐	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	Membership update: Stacia Chick from LRE has replaced Jane Shelton of West Michigan. Jackie announced the integration between the Adult and Aging Services Agency (AASA) and the Medical Services Administration to create the Health and Aging Services Administration.
Review and approve prior meeting minutes (5 minutes)	Kasi	One correction noted for the tiered rates stated starting FY22 and that should be FY23.
EQI Update (10 minutes)	Kathy	The EQI workgroup has initiated monthly meetings for FY22. The workgroup has developed an issues list that includes - decision on encounter reporting

		for MIHealth link PIHPs, state-wide use of Milliman's Drive tool, and populating the EQI using output from the standard cost allocation methodology. The draft 3rd Period 2021 EQI templates were sent out for review to the EQI workgroup with comments due to MDHHS Nov. 1st.
MI CCBHC Demonstration Update (15 minutes)	Jon Villasurda	The T1040 code created by CMS effective 10/1/21. Only pertinent to CMS CCBHC state-based demonstration sites. Not pertinent to SAMHSA CCBHC demonstration sites. Ed – is it meant to pair with every single service line or one per day? Jon - Only applicable to allowable CCBHC services in the manual. The reimbursement is reflective of one daily visit but regardless wants to see all service lines. Ed – is there harm in submitting with multiple T1040's a day? Jon – no, the system will be able to accommodate this. However, would it be better an idea to submit all services under the T1040. Ione Myers via chat - Follow-up thought on T1040 in encounters. Is the T1040 to be submitted as "single day per encounter line billing only"? Or can it be submitted as a "series billed" line? If submitted as "series billed", is the presumption that the number of units submitted represents the number of days on which services occurred? • The T1040 is should be submitted as a standalone, single-day encounter on one claim (plus the supporting qualifying CCBHC services for that day).
COB Subgroup (10-15 minutes)	Jackie/Kathy / John Holland	The COB workgroup has met every other week for several months. Our idea is to develop a process and implement 10/1/22. The COB workgroup decision was to work with EDIT to address different policy issues related to the COB process and wanted to share with EDIT to get input on a structure that John Holland developed and presented to the COB workgroup. John Holland – three documents shared with EDIT. Starting with summary document. Current method used to identify funding sources for encounters is limited. Claim code only has 3 usable values. Those choices don't cover enough grants and funding streams adequately.

		Technique called “shadow billing” uses additional Coordination of Benefit (COB) other payer loops to identify the MDHHS capitated benefit plans or other local funding sources that are involved in a claim and to allocate those dollars to each service. This pattern is similar in application to a Payer to Payer Coordination of Benefits model, where the additional payers involved are the various MDHHS benefit plans or other local funds. This technique allows for the CMHSP/PIHP to accurately communicate to MDHHS and Milliman the adjudication performed by the CMHSP/PIHP, following MDHHS, Medicaid, and Medicare claims billing rules. No impact to CHAMPS and or data warehouse. Amie Norman – finalization on this timeline incorporating on encounters on 10/1/22? Kathy – COB WG will develop proposals and decide on list of benefit plans to be reported. Then will bring to EDIT. For a joint cooperative. By December 2021 – EDIT will have final proposal from COB WG. Jennifer Fallis – is this doable by 10/1/22? Has this been discussed with IT vendors, such as PCE, to see if this would be doable? Kathy – John can you present your idea in detail to CIO’s and PCE and such. Amie – suggest and backs that idea of presenting. Ione – many encounters do change over time as COB comes available according to a timeline and presumptions. Recollection is not change these to overwhelm the system. Is this something being discussed? Bill Adragna via chat: So the finalization of the details of the encounter changes is a factor when discussing with PCE if they can meet the timeline. Until the encounter changes are finalized, meeting with PCE would likely be premature? So finalization of changes PCE won’t know what the volume would like. Joan – talking with PCE ahead of finalization is a good plan so they can give some input.

		Jennifer Fallis – how will it work in the future if we send something with Healthy Michigan and Milliman has Medicaid? Kathy – we have not discussed that aspect with Milliman yet. We don't know how this will work yet. John's proposal gives us that process for Milliman to look at to help with these discussions.
Transportation Subgroup (5 minutes)	Kathy	Meeting every other week. Revised timeline of pilot from Jan 1, 22 so we are in process of developing a different timeline and pushing to January 2023. The group is very knowledgeable of transportation questions. Macomb is very interested in pilot.
Code Chart Changes Subgroup (5 minutes)	Kasi	Started review of SUD service lines. Some key changes: Removed codes 99241-99255 SUD Physician Consults - Since inpatient services are not a covered SUD benefit (not an approved) ASAM level. Codes for inpatient services did not seem necessary. Its removal stemmed from the fact that it's almost never reported. Seems misguided to put a CPT code in the chart that nobody reports/utilizes. It was removed for disuse. Workgroup agreed that the regular outpatient E&M codes (99202-99215) would suffice. Renamed and changed formatting of the E&M Codes 99202-99215 to match national definition language: Evaluation and Management of New Patient & Evaluation and Management of Established Patient
Update on development of tiered rate for inpatient psychiatric services (5 minutes)	Jackie	The Section 1513 Inpatient Psychiatric Workgroup was established based on a legislative requirement to develop an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care. The workgroup began meeting in May of 2021. Membership includes reps from hospitals, PIHPs, MDHHS/Milliman, Blue Cross, and advocacy organizations-- CMHA, MAHP, MHA. EDIT members on the group include Jackie, Kathy, Belinda, and Jeff White.

		Meetings held during FY21 focused on reviewing reimbursement models and identification of factors most important for use in determining rates. The group recommends creating a tiered rate structure with higher rates paid for pediatric patients, patients with potential for violent behavior and patients that require one-on-one care. Defining rate tier logic and determining payment amounts will be a focus for the workgroup in FY22, with a planned implementation of tiered rates 10/1/22. EDIT assistance/recommendations requested to meet these project milestones: By 1/31/22: PIHPs establish process for reporting violent behavior and provision of one-on-one care. (Based on data reported by hospitals.) By 7/1/22: PIHP encounters include reporting violent behavior and provision of one-on-one care. EDIT comments/suggestions: • Need specific definitions of 1) patients with potential for violent behavior and 2) patients that require one-on-one care. • one on one is a patient that has behaviors whereby they cannot be left alone (e.g., someone with an eating disorder), it's not just about violent behavior. • would UB-04 support use of a modifier that would indicate one on one care? • if the hospital bills a higher daily rate, would that be sufficient indication of violent behavior? • Use one or more diagnoses codes to indicate violent behavior. Would need to ensure UB-04 can be used to report them and clearly define the code(s). • could the "involved physicians" for the day indicate one on one staffing if the actual staff are behavioral health techs, not professional staff? • could a "high intensity" add on code indicate one on one staffing? Jackie to schedule a meeting with interested EDIT members to further discuss, participants: Amie Norman, Joan Wallner.
Update on status of tiered rate for licensed residential services (5 minutes)	Belinda	We met on the 15th of this month and scheduled more meetings starting in January and will be quarterly in 2022. Purpose of this work is to

		determine an assessment instrument across residential populations to support what is in the plan for primary engagement hours. To better understand if there is a way to look at the IPOS to better assess rate to establish tiers. Look at assessments already have data on such as SIS and encounter data. Belinda will continue to bring these updates to EDIT to work together to establish these rates. This was moved to implement in FY23 but to be a monitoring year and not set rates for that year just to look at the data. Joan – having the availability to go into homes to understand how tools are being used is an awesome thing because we have struggled with that for years.
Code Chart and Provider Qualifications Chart updates (30 minutes)	Kasi	SFY 2022 Behavioral Health Code Charts and Provider Qualifications – review the update log. Updates 17 through 105 made since last EDIT meeting. Doctor of Occupational Therapy is not there. Shouldn't it be since Doctor of PT is. Not common. Typically, the standard is Master's of OT whereas PT requires a doctorate when going into the profession. Joan SEDW Only language on H2021 needs to be removed as that is not SEDW only code. Introduce adding the WX to H0036 and T1023 as well as other changes since start of Fiscal Year. Joan pointed out one of the updates (group therapy) are not group codes and those U modifiers should be deleted. I will update the chart and take the U modifiers back off 90832-90837. Jeff – the inconsistency of the modifiers is hard. One example is the doctoral level versus clinical psychologist. PCE spits out one modifier and it may not be on that service line. Providers yelling because HO and HP are allowable but doesn't list AH. Claims stacking because they are being rejected. Mapping modifiers is extremely tedious and can cause errors. Many struggling. PCE says it is not

		their determination. Does Milliman want to know level of licensure or highest level of education the individual has? Belinda – we can take this back and discuss with Milliman. Laurie – not prepared to submit October encounters. Macomb too. Can the Department make an exception to the contract requirement of monthly for October. It is pointed out that October encounters are not due until November 30th. H0031 – dual enrolled Medicaid/Medicare – Joan's Medicare's inability to pay twice by same provider/entity. This person is in our care and required to have plan of action and follow that plan if medically necessary to provide 90791 that when in with LMSW NPI and 8 weeks later and Psych Eval and then the NPI is Psychologist then on 2nd rejection – not writing off as General Fund as medially necessary so then it goes to Medicaid. Joan would like confirmation that is is an acceptable practice. Question/comment from chat from Ed Sova: That EQI codeset workbook - there are 90 permutations of 9034 on the Full Code-Modifier List, but only 40 when it comes to the EQI. 90834:AH and 90934:HO are mutually exclusive on both tabs (EQI Code List & Full Code-Modifier List)
S5116	Ione	Can S5116 be funded with 1115ispa dollars? Currently there are individuals placed residentially with behavior plans that are not on a waiver. As part of stabilizing staffing in residential homes we are looking to provide more support implementing the plans with the use of Behavior Techs. Also, the credentials for the code S5111 can QIDP staff utilize this code? The answer is no. Must make an amendment to the waiver to allow for non-family training/home care training for the non-HSW population. Network180 has a proposal. Ione will send this to Belinda.
Wrap-Up and Next Steps (5 minutes)	Kasi	

Action Items	Person Responsible	Status
Does Milliman want to know level of licensure or highest level of education the individual has in regard to the provider level modifiers?	MDHHS/Milliman	

Next Meeting: January 20, 2022