Michigan Department of Health & Human Services

Behavioral and Physical Health and Aging Services Administration

Encounter Data Integrity Team
Agenda

Date:	January 19, 2023	Location: Webex:	TEAMS Meeting Click here to join the meeting

Time:	10AM-12PM	Dial-in Number:	+1 248-509-0316 ID: 262 072 430#

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

X	Bruce Bridges

Prepaid Inpatient Health Plans

X	NCN: Joan Wallner
X	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: Deabra Hardrick-Crumps
X	DWIHN: Jeff White
X	OCHN: Jennifer Fallis
X	OCHN: Julia Emerzian
☐	MCCMH: Thomas Cole
X	MCCMH: Kristen DesJardins
X	Region 10: Laurie Story-Walker

MDHHS

X	Laura Kilfoyle
X	Kasi Hunziger
X	Kathy Haines
X	Belinda Hawks
X	Kim Batsche-McKenzie
X	Angie Smith-Butterwick
☐	Mary Ludtke
X	Brenda Stoneburner
X	Jackie Sproat
X	Phil Kurdunowicz
X	Lyndia Deromedi
X	Debi Andrews
☐	Mary Luchies
X	Lisa Collins
X	Nicole Roszkowski

Agenda Item	Presenter	Notes/Action Items
Welcome and Roll Call, membership updates	All	New MDHHS staff member: Nicole Roszkowski, CCBHC Analyst for Kathy Haines. Others in attendance not listed above: • Angela Zywicki • Beth Swetz • Krista Hausermann • Pam Werner • Joe Longcor • Tina Jones

		• Amy Kanouse
Review and approve prior meeting minutes (5 minutes)	Kasi	Minutes approved.
CLS and Music Therapy	Lyndia & Group	Feedback received from Oakland prior to today's meeting: CLS and music therapy. Unless something has changed this has historically always been billed at the same time for several reasons 1) It's a goal in the IPOS and staff can assist and learn so that they can carry it forward when the therapist is not there the rest of the week. 2) If the therapy is in the home the CLS staff would have to go on an unpaid break for each therapy provided to the child each week. They cannot do other things like make the child dinner as that is not considered to be an activity of daily living unless the child is participating. 3) CLS transportation to these therapies are allowed in the budget. We would be having CLS staff transport to a location and not pay them to wait. I think 2 and 3 would lead to staff retention issues as well as instances when the staff was late and never picked up from therapy or did not come back to the home in a timely manner and the therapist had already left. Lyndia – virtual – is this this also face-to-face or virtual aspect – question for Oakland. Jenny – will go back and ask clinical. Jeff White – the arguments in #2 and #3 are the same arguments made when transport to medical appts and that is not allowed to be billed while staff wait. Item #1 sounds more like staff training – is there another code to use for that? Lyndia – utilizing non-family training for #1 rather than a therapy code. Belinda – our policy states that the billing of two services, CLS and a clinical service, is not allowed to occur at the same time. The clinical service would be billed and not the CLS time. April 6, 2023, update – MDHHS was asked to clarify our statement regarding billing above. Community Living Support staff cannot report their time spent accompanying an individual/beneficiary to a therapeutic activity such as, Recreation, Music and Art Therapy. CLS staff should account for their time as indirect.

CLS and Other Services • Other therapeutic activities such as Recreation and Art Therapy • Primary doctor appointments • Psychiatric appointments • Urgent care appointments CLS would be allowed to be done concurrently only if the other services are done via telehealth.	Amy Keinath & Group	Angela Zywicki – when the clinical services are being provided via telemedicine the CLS staff are already in the home and cannot really leave. Is there a way for them to bill their time when the clinical services are being done virtual from the home? Laura – generally that would fall under the administrative cost of providing services under the provider, but this situation is a bit different with the population being served. Lyndia – urgent care visits seem to be a day of thing and not scheduled ahead of time. So, this could be more likely given the CLS worker could not leave the beneficiary alone for that visit. The primary doc and psych appts don't seem as likely as we would ask why the guardian isn't there with the beneficiary. The therapeutic activities may require additional conversation as what is the role of the CLS worker? Belinda – the CLS worker is still being paid as their time could still be reported under indirect time. Angela – our question would be for the 15-minute code – the H2015 specifically. Jeff White – likes the exceptions for the waiver populations. Belinda - at this point our policy states that this would not be allowed, the billing of both a CLS and a clinical service. We may consider a special exception for the waiver populations at some point but as of right our policy stands. April 6, 2023, update – MDHHS was asked to clarify our statement regarding billing above. Per the MMP 23-10: Telemedicine Policy Post-COVID-19 Public Health Emergency, "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." If Community Living Support (CLS) staff is providing this support, they should account for this time as indirect.
Housing Support Benefit / CCBHC	Lyndia Deromedi	Determined that it would be okay to do the housing service and have it be CCBHC. It's not the same service – this is a unique benefit under the 1915i. Joan has a question on CCBHC enrollment…. we have beneficiaries in our region that were previously enrolled in a CCBHC in another region…question on disenrollment of this for

		CHAMPS. Follow-up post meeting from Amy Kanouse: *Unlike most benefit plans, the CCBHC benefit plan just indicates that the beneficiary is eligible for CCBHC – at some point in the last 18 months, that individual had an encounter with a behavioral health diagnosis on it. PIHPs get a prospective payment for individuals in their region with the benefit plan, but the payment is intended to give PIHPs more cash on hand and is reconciled at the end of the year if not used. PIHPs that aren't participating in the demonstration- Regions 1 and 2- do not get that payment (most of the time, sometimes there are errors), but the benefit plan will hang on until CHAMPS catches up. If the CCBHC knows that a beneficiary left the region, they can disenroll them in the WSA, at which point the disenrollment is sent to Champs and they end-date the benefit plan.* *The important take away for the field is that "Benefit Plan = Eligible for CCBHC services", and doesn't mean that person is receiving CCBHC services or even in a CCBHC region.* Questions related to the CCBHC should be sent to the dedicated mailbox: MDHHS-CCBHC@michigan.gov
Consideration for the allowance of biofeedback/neurofeedback as an allowable modality for therapy.	Kasi & Group	Findings on if 90901, 90875, and 90876 could potentially be covered. These services would require amendments to the waivers and that would take a considerable amount of time not to mention the cost considerations that would need to be made when approving the service and who could provide the service, etc. Therefore, we will not be adding these codes at this time.
Independent Facilitation and Wraparound	Lyndia & Group	The Department will send a request for feedback e-mail to the EDIT group. Feedback will be sent to Kasi Hunziger, and she will forward on to appropriate staff.
Telemedicine Update (5 minutes)	Laura	Federal PHE extended through April 11, 2023. Final policy is close to being released. It will go into effect one day after the end of the federal PHE. We are not holding this policy and will release for prep time.
EQI Update (10 minutes)	Kathy	The EQI workgroup met last Thursday. The EQI template for FY22 period 3 is due Feb 28th. That was sent out at the end of December to the PIHPs, and we also have posted to the reporting requirements webpage too. At the last meeting there was a discussion of measuring mild to

		moderate for CCBHC – where that information should be and how it should be collected.
COB Subgroup (10 minutes)	Jackie/Kathy	The workgroup met last Friday; we reiterated the goal is to collect third party information payment for PIHP/CMHSP services. Current requirement for FY23 third party is to be reported if there is an FFS arrangement between PIHP/CMHSP and network provider. The workgroup stated that there is a hurdle to reporting direct run. Next meeting is Feb 9th, and we can talk through this issue.
Update on status of tiered rate for licensed residential services (5 minutes)	Belinda	The workgroup continues to meet monthly, next meeting January 25th at 9am. We are preparing for the pilot in Q 3 of FY 24 by getting feedback on the needs assessment and the comparison rates factors for these residential settings. I will continue to bring updates to this group as available.
Code Chart Changes Subgroup (5 minutes)	Kasi	We are continuing to work our way through the code chart. There was a break in December but have picked it back up again. Code Chart Appendix group is set to begin meeting in early February to start their review of the language in the appendix.
Code Chart and Provider Qualifications Chart updates (10 minutes)	Kasi	• Separated the H2014 & H2014-WZ into two lines • Removed "Out of Home" as part of the description for T2015 • Added U modifiers for Family Training (S5110) • Added MH Service line for S0215 Transportation code • Added Qualifications for BHH/OHH code S0280 • Updated the SFY23 Provider/Staff Qualifications to 'Other Bachelor's and 'Other Master's' for Wraparound H2021. • Correct the HM modifiers on S5111, Family Training, to be less than bachelor's level • Removed the UJ modifier from the H2015-SEDW/CWP line. T2027 would be used for overnight health and safety. • 97153 & 97154 - Removed the following language from the reporting and costing considerations column: "Encounter needs to be reported under the BCBA and not the BT. Need to use the NPI of the BCBA." • 92526 had the incorrect description listed

		for the code. This has been updated to read: Treatment of swallowing dysfunction and/or oral function for feeding. • 90833 - added the following provider level modifiers as this is an add-on for E&M codes and these are allowable providers: Physician, LPA, NP, and CNS. • S5140 & S5145 MH lines had the incorrect age group listed. They have been labeled as which is adult and which is child. • Codes 99324-99328 retired on 12/31/22. Will need to use 99341, 99342, 99344, and 99345. • Codes 99334-99337 retired on 12/31/22. Will need to use 99347-99350. • Code 99343 retired on 12/31/22. • Language for 99341-99342 and 99344-99350 updated and may include unit updates too. • Codes 99354 & 99355 retired on 12/31/22. Will need to use 99417. • Updated language for 99417. Upcoming changes for April update: • Remove Provider Modifiers for G2067, G2068, G2073, and G2074. These are weekly bundle codes, and the provider level modifiers are not needed.
Supported Employment / "Applicable Experience" concern from NorthCare	Joe Longcor/ Joan Wallner	Question: Could the requirement of 1-year applicable experience be verified? What is considered to be applicable experience? Joan – column F – H2023 has 1 yr applicable experience – what is considered to be experience? Who makes the call on this? Some guidelines seem to be needed. Joe – nothing formal – I have given examples in the past as questions have come up. If someone doesn't have degree but have volunteered and can prove they were good at it is one example. Joe to meet with Brenda to see if he can put something together. *2/1/23 follow-up and proposal from Joe Longcor:* *Propose we change the wording to:* - *Associates Degree preferred; at least one-year relevant experience with proven success*

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<tr><td></td><td></td><td>acceptable in areas such as, but not limited to: job development/placement/supports, community development, sales, successful volunteer experience, breadth of employer work experiences/connections. Individuals with accepting personalities such as but not limited to being curious, outcome-driven, problem solvers, team focused, partnership builders, skilled at motivational listening, and other relevant qualities to champion individual competitive integrated employment in the local community.
Will add this to the April 20th meeting agenda to discuss.</td></tr>
<tr><td>Peer Services and Modifiers</td><td>Ione Myers</td><td>Ione – we feel that we need more input from subject-matter expertise (clinicians) and need to be notified sooner of these major changes to the code chart. Can these changes be vetted through this group or another subgroup earlier because of enormous amount of work it takes when these changes are being made? How can we reach more of the right people in the field.

Pam Werner: MDHHS staff are subject matter experts. We develop the policies with public input and work together on coding. Additionally, clinicians would not be the subject-matter experts on Peer codes. Peers are the subject-matter experts over Peer work and not clinicians.

Questions from Peer Modifiers document that Ione sent:
1) Update log – Modifiers – 11/15/2021: This was just language clarification and not process change right. Yes – it clarified on the modifiers tab. In the earlier FY22 workbook on the modifiers tab it listed the two modifiers as:
<table>
<tr><td>WR</td><td>Peer Recovery Coach</td></tr>
<tr><td>WS</td><td>Certified Peer Specialist provided or assisted with covered service</td></tr>
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The update on 11/15/21:
<table>
<tr><td>WR</td><td>Peer Recovery Coach - not MDHHS certified (MCBAP or C-CAR)</td></tr>
<tr><td>WS</td><td>Certified Peer Specialist/Peer Recovery Coach - MH/SUD - provided or assisted with covered service</td></tr>
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2) FY22 code chart on the MDHHS website as of 1/3/2023: (looks aligned with change log</td></tr>
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<td>note from 11/15/21) Correct, that language clarification was made in FY22.
3) Regarding MSA 22-01 memo, can someone please confirm whether the effective date of that change [for encounter reporting purposes] is in effect retroactively, or only from 4/1/2022 forward? - Started on 4/1/22 per Pam. No retro needed – as it was issued on 4/1/22.

FY23 Peer changes:

<table><tr><td>WR</td><td>Certified Peer Recovery Coach</td></tr><tr><td>WS</td><td>Certified Peer Support Specialist</td></tr></table>
4) CMH asks: Are the details of changes such as these being fully discussed and vetted within the MDHHS EDIT group, and if not, then can they be going forwards? It would be very helpful.
The changes made for FY23 came after several questions/concerns were sent to MDHHS staff regarding the Peer modifiers and how much confusion there was amongst the PIHPs as to proper and consistent reporting. A number of MDHHS staff met internally to discuss the best possible solution for addressing the concerns and confusion.

5) Need to know: Do they need to go back and update their Oct-Dec 2022 peer encounters to put them into alignment with the FY23 code chart requirements? They have 8 peer staff, and they do a lot of peer services, so it is a large number of transactions for them to modify. Take into consideration time for changes. Retro changes are very burdensome. Per the Department, retro is changes is not needed. Is Jan 1, 2023, reasonable? Yes. Will have to let Milliman know that Q1 may not include these Peer changes. Kasi Hunziger e-mailed Milliman after the meeting to let them know of this decision.</td>
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<td>Wrap-Up and Next Steps (5 minutes)</td>
<td>Kasi</td>
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Action Items	Person Responsible	Status
Discussion about the H0018 & H0019 codes and clarification on included costs	Richard Carpenter	Discussion at April 20, 2023, meeting

Next Meeting: April 20, 2023