MIHP Telehealth Questions & Answers for Providers
June 5, 2023

Responses to the questions regarding telehealth that have been submitted to the MIHP inbox are included below. The MIHP Operations Guide has also been updated as of June 2, 2023.

Update as of June 5, 2023: *MDHHS MIHP has added all remaining questions and answers that were received by May 31, 2023. These newly added questions begin on question #29.*

Update as of May 12, 2023: *MDHHS MIHP has obtained clarification regarding Place of Service (POS) guidance and such guidance has been reflected below (see updated response for question #12). MDHHS MIHP has also obtained guidance to clarify that the claim reporting updates are applicable for claims with dates of service on or after May 12, 2023 (see updated response for question #1). This document is anticipated to be updated again once clarification is obtained regarding codes such as H1000, H2000, etc.*

1. **Will the 60/40 include clients *enrolled* on or after 5/12/23? OR Will the 60/40 include any and all visits with families enrolled prior or after 5/12/23?**
    - It is the expectation that the required policy percentages are effective for all assessment and professional visits for new enrollees beginning May 12, 2023. The requirements do not apply to participants enrolled prior to May 12, 2023. The modifiers associated with the updated Medicaid Telehealth Policy must be documented for all claims with a date of service on and after May 12, 2023. For services rendered prior to 5/12/23, the previous guidance in effect for that date of service is to be followed. There will be no program extensions for the use of the GT modifier for dates of service on or after May 12, 2023.

2. **When you speak about provided up to 40 percent of all professional visits across the total agency caseload via telehealth. What do you consider total caseload?**
    - The 40/60 requirement applies to the assessment visit and professional visits conducted by an agency.
    - **Will Risk Screen Only Count?**
        - Yes, all enrolled participants will be counted in an agency caseload.

3. **At what time interval are the 60/40 in-person versus telehealth benchmarks measured? Monthly, quarterly, etc.?**
    - Agencies should monitor the in-person and telehealth claim percentages internally (e.g., billing audit). Beginning January 1, 2025 (Cycle 10), percentages will be reviewed as a part of the Quality Assessment process. MDHHS MIHP will be providing percentages based on the calendar year.

4. **When will these numbers be measured and what the time frames would look like.**
    - Agencies should monitor the in-person and telehealth claim percentages internally (e.g., billing audit). Beginning January 1, 2025 (Cycle 10), percentages will be discussed as a part of the Quality Assessment process.

5. **How do you manage the 60% with your total caseload as it changes daily due to discharges/enrollments.**
    - In-person and telehealth visit percentages can be assessed during quarterly billing audit process.

6. **Will this 60% take effect after 5/12/23? So, will it only count towards new enrollments after 5/12/23?**
    - Yes, it is the expectation that the required policy percentages are effective for all assessment and professional visits for new enrollees beginning May 12, 2023. The requirements do not apply to participants enrolled prior to May 12, 2023.

7. **What agency will be looking at this percentage and letting us know if we are out of compliance? OIG? MHPs? Are we at risk of not being reimbursed at some point for work we have done if we fall out of compliance with one of the MHPs?**
    - Adherence to the Medicaid policy requirement will be the sole responsibility of MDHHS MIHP.

8. **How will this new policy factor into certification and quality visits? What is the "consequence" for being out of compliance?**
    - Cycle 9 Certification review will include the indicator 6.10 for telehealth. Reviewers will evaluate the agency technology used for telehealth visits and assure that it matches the agency's approved telehealth protocol on file. The Cycle 10 Quality Assessment will include the agencies telehealth percentages and be included in the Quality Assessment Survey results for discussion.
    - Cycle 10 Certification Review Telehealth Indicator will include protocol adherence and compliance with required telehealth chart documentation.
    - Telehealth data will be included in the cycle 10 certification tool, however, as with Cycle 9 Certification, it is for the agency's information only. This data is not reflected in the certification results.
    - These results have no negative connotations for the Cycle 10 Certification Review.

9. **MMP23-17-we should use modifiers 95 and 93 (telephone-only, and only if visual portion is not possible). These modifiers would replace GT and FQ, correct?**
    - Yes, the modifiers 93 and 95 replace the GT modifiers.

10. **Do we indicate whether or not the beneficiary is "at home" for the telehealth visit?**
    - No, that documentation is not required for program requirements.

11. **We no longer need to add the GT or GTFQ modifiers, right?**
    - Yes, that is accurate for dates of service on or after May 12, 2023.

12. **We were previously instructed to indicate place of service "office" for telehealth due to reimbursement rate. Can you provide guidance on when to use which place of service**

code? Can the 02 – Telehealth place of service code be used? It is helpful from an agency's perspective to have the correct place of services for internal reporting purposes.

- Telehealth – 02 place of service is no longer appropriate for dates of service on or after May 12, 2023. For place of service documentation, please see guidance in Medicaid Bulletin MMP 23-10, which indicates the following:
- 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".

13. **It would also be helpful if "telehealth" was an option for location on the risk identifier to accurately reflect its administration.**
    - Yes, these options will be available on the Health Assessment and a future version of the Professional Visit Progress Notes.

14. **MMP 23-10 section VII does not list H1000, H2000, or T1023 as acceptable codes for phone-only encounters. Will Risk Identifier visits be allowed via phone-only or will they be required to be in-person and video only?**
    - This code-specific information is pending per Medicaid. Once available, this will be updated.

15. **MMP 23-17 section about telephone-only states "Documentation in the beneficiary's chart must include the reason for a telephone-only visit." Where should this be documented? Options might include inside the PVPN and/or contact log.**
    - This will be a listed option on a future version of the Professional Visit Progress Note. Currently, rationale for telephone only professional visits must be documented in the "If telehealth or other, why?" section on the Professional Visit Progress Note.

16. **Is there a requirement to also document the reason for video visit or does this only apply to phone-only?**
    - This documentation requirement is for telephone only visits.

17. **If the reason for telehealth will be required in the "if other why" box on the PVPN, Patagonia users will not be able to comply for a while. The current algorithm is set up so**

that the "if other why" text box will not appear if Place of Service of Home or Office is selected. It will take some time to change that algorithm to make that text box available on all PVPNs.

- Providers must work with their EMR vendor to comply with documentation requirements. Please contact MDHHS MIHP if there are programming issues with EMR vendor.

18. **If a PVPN (99402) is completed via video while the beneficiary is at home and the visitor is in the office, we would bill a 99402 with modifier 95. However, I'm unclear if we would use Place of Service "11-office" or "12-home." So, is the Place of Service determined by the beneficiary or the visitor location?**
    - The place of service is reported as if the beneficiary were in-person for the visit.

19. **If a Maternal MRI is completed via video while the beneficiary is at home and the visitor is in the office, would we use code H1000 or H2000 (along with modifier 95) and would the Place of Service be 11 or 12? O again, is the billing code and Place of Service determined by the beneficiary or visitor location during the telehealth visit?**
    - Please see question #12 for Place of Service (POS) guidance. The code-specific information (re: H1000, etc.) is pending per Medicaid. Once available, this will be updated.
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20. **If an Infant IRI is completed via video while the infant was at home and the visitor was in the office, would we use code H2000 or T1023 (along with modifier 95) and would the Place of Service be 11 or 12? Again, this is a similar question about selecting the billing code and place of service – is it based on beneficiary location or visitor location?**
    - Please see question #12 for Place of Service (POS) guidance. The code-specific information (re: H2000, etc.) is pending per Medicaid. Once available, this will be updated.

21. **MMP 23-17 states "MIHP agencies will be allowed to provide up to 40 percent of all professional visits across the total agency caseload via telehealth." I am wondering how this is calculated (or what's the denominator in the equation?) Is it based on the number of services billed over a certain period of time or number of beneficiaries on the caseload over a period of time? And what's the period of time? For example, one month we may bill 200 encounters, have a caseload of 400, and 100 of those encounters may be telehealth. But the next month we may bill 300 encounters, have a caseload of 350, and 20 of those encounters may be telehealth. How would I calculate our percentage of telehealth?**
    - The calculation is based on the total assessment and professional visits conducted by a provider, this includes all paid claims and encounters. MDHHS MIHP will be providing percentages based on the calendar year.

22. **If MIHP Consent to Release and MIHP Consent to Participate are completed during a video admit visit, does that consent need to be done again at the first in-person visit or will that original verbal consent stand throughout course of care?**
    - Verbal consent must be documented, and written consent obtained at the next in-person visit. Verbal consents not able to be initialed, signed and dated by the beneficiary at the first in person visit, must have rationale of why this did not occur documented on the *Contact Log*.

23. **Does this mean that if we use an audio and video component when using telemedicine that we can bill the same rate as an in-person home visit?**
    - Yes.
24. **Is the new policy that ALL of our visits need to be 60/40 collectively - this would include intakes and revisits?**
    - The 40/60 requirement applies to the assessment visit and professional visits conducted by an agency.

25. **Is the policy saying the subset of intakes AND the subset of revisits have to be 60/40 each? For example, can an agency decide to do telehealth intakes with any new families or families who have not had maternal or infant services previously?**
    - The 40/60 requirement applies to the assessment visit and professional visits conducted by an agency.

26. **Will we receive guidance on documentation of the reason for telehealth visit?**
    - Please review the Medicaid telehealth policy for guidance on appropriateness of telehealth services.

27. **Will a face time audio visual call be considered Audio visual HIPAA compliant?**
    - MDHHS does not endorse any specific platforms and providers must adhere to the provisions of HIPAA according to federal policy. We are unable to interpret federal policy on behalf of providers.

28. **Currently our agency is writing in "Consent to Telehealth" under the "Others" section of the MIHP Consent to release PHI. All our telehealth visits have been phone but will be instituting Zoom visits as well. Will this current way be acceptable at the end of the Public Health Emergency or should something more be done.**
    - Beginning May 12, 2023, assessment visits conducted via telephone only, rationale must be documented on the *Contact Log.*

29. **I read the new guidance about telehealth and would like to make a suggestion for congruency. The guidance again states we only have to provide a reason for telephone only telehealth visits, but the professional visit note states "if telehealth or other, why?_____" which implies we need to have a reason any time it's telehealth. If the guidance is that we only need to give a reason for telephone only, would you please change the visit note to state, "If telephone only or other, why?____" - OR- if the**

requirement will be that we need to state a reason every time we have a telehealth visit, would you please update the guidance to reflect that?

- Thank you for your suggestion. This update to the PVPN has been discussed and is in process. Once an updated PVPN is available, all providers will be notified. Per the Medicaid policy, documentation must include the reason for a telephone-only visit, and the PVPN updates will capture this.

30. **For telehealth, when asked why do I need to answer for both audio and video or only audio?**
    - Per MMP 23-17, telephone-only visits must include documentation in the chart indicating the reason for a telephone-only visit.

31. **Is audio only paid at 66.79 and video at a higher rate? What rate is it 92.09?**
    - In accordance with the Medicaid program's overall telemedicine policy outlined in MMP 23-10, the following scenario will occur: 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" (page 8 of 14).
    - Services conducted via audio-only will be paid at the rate associated with the POS code reported on the claim. For example, If the POS is reported as "home" (POS 12), the rate of $92.09 will pay.

32. **I just wanted to follow up and receive clarification on the billing piece of our modifier discussion from the MIHP training. With the new modifiers in place for telehealth, we were wondering if the same place of service codes remain? I believe the place of service code for an office visit is 11. Just wanted to make sure for our billers.**
    - Yes, you are correct. The other place of service codes remain the same – typical POS codes for MIHP are 11 – Office and 12 – Home. For your reference, Place of Service Codes can be found at this CMS website.

33. **Please clarify the change to Section 6 under the Use of TH in MIHP section: *Any required hard-copy documentation normally provided at the Assessment Visit must be discussed during the telehealth visit and presented at the first in-person visit.* If we have a beneficiary who will not allow in home visits or if we want to get the hard copy information to the beneficiary before the first in home visit, can we continue to mail this information and document that? Currently, if we did a TH (prior to 5/13) assessment, we would mail the education/admit packet if client requested (we also sent it electronically) and documented it on the contact log. Is that sufficient, or should we wait until the first in person visit and give it then? My concern is that we might lose them and then they would not have any of the information hard copy if needed but I also do not want to mail it and then have to give them another whole packet on the face to face visit**.
    - Yes, mailing this information (or sending electronically) is acceptable.

34. **I would like clarification regarding the documentation for Telehealth Visits. This is my understanding based on the questions answered document:**
    For AUDIOVISUAL telehealth visits- we only have to mark Telehealth on the PVPN- we no longer are required to document WHY.
    - Yes, this is correct.

    For PHONE ONLY telehealth visits- we have to mark Telehealth and in the WHY section document why we are doing it via telephone. (no smartphone, refused to do video call, etc.)
    - Yes, until the updated PVPN is available, this is correct. An updated PVPN will allow you to select "If telephone or other, why?"

    For PHONE ONLY admissions- we document the reason on the Contact Log.
    Is this correct? I felt like I was making it harder than it should be.
    - Yes, this is correct. Documentation must be indicated for phone-only and telehealth visits on the Contact Log until a new health assessment is available which will contain a specific checkbox for telehealth and telephone-only.

35. **So I need some clarification on RI documentation for Telehealth admissions. What location are we using now for that and are we using the 95 and 93 modifiers as well.**
    - Please see the response to question #12.

36. **Can you tell me if Google Meets is allowed for telehealth visits under the security requirements for the Medicaid Telehealth guidelines?**
    - MDHHS MIHP does not provide guidance on specific platforms such as this. As indicated in the Medicaid telemedicine policy MMP 23-10, MIHP Providers must ensure privacy of beneficiary and the security of any information shared via telemedicine in accordance with HIPAA.

37. **With the recent changes in regards to telehealth and billing, when it comes to the IRI/MRI, are we still to indicate "office" as our location if it was completed via telehealth? Because we are now able to bill using POS 12 for telehealth, are we also able to use "home" on the risk identifier if it was completed via telehealth?**
    - Place of Service documentation should reflect the location where the visit would typically occur. The previous guidance to use "office" when completing an IRI/MRI via telehealth is no longer in place. Instead, please select the location where the beneficiary would have been if the visit were in person.

38. **I wanted to circle back to your response to number 3 from my Questions from the Q&A document. I have spoken with other MIHPs and they have directed their staff to NOT allow for telephone assessment only' s. I was not under this impression as the Medicaid policy states it does allow phone only. Can you please advise?**
    - Telephone-only assessments are permitted. Please refer to the MMP 23-17 policy for appropriate use of telehealth and telephone-only visits.

39. **Please provided additional context to the question Number 14? "MMP 23-10 section VII does not list H1000, H2000, or T1023 as acceptable codes for phone-only encounters. Will Risk Identifier visits be allowed via phone-only or will they be required to be in-person and video only?**
    - Risk identifiers (initial assessments) are allowed via phone-only. Updates to the telephone-only codes are currently in process.

40. **How is telephone still pending per Medicaid? The Final Medicaid Bulletin MMP 23-17 stated that MIR and IRIs visits can be conducted via telephone-only are allowable when a beneficiary has a barrier to use audiovisual platform. Please explain what is pending.**
    - Updates to the telephone-only codes are currently in process.

41. **Will the OIG look at our claim's data/caseload ratio together or separate? Together in our MIHP Workflow when clients declined participation in MIHP but consent/agree to complete the Risk Screen these Risk Screen Only Clients never are added to our caseload as they decline MIHP Services, we complete the RI and discharge on the same day. Since this case are not on our caseload, do they not count for the telehealth percentage?**
    - Adherence to the Medicaid policy requirement will be the sole responsibility of MDHHS MIHP. All billed MIHP services are included in the allowable percentages. Any beneficiary who receives an MIHP service (even RI only) should be considered as part of your caseload. They are recorded as such in the data warehouse and State of MI documentation.

42. **Please provided additional context to the question Number 14? "*MMP 23-10 section VII does not list H1000, H2000, or T1023 as acceptable codes for phone-only encounters. Will Risk Identifier visits be allowed via phone-only or will they be required to be in-person and video only?*" How is telephone still pending per Medicaid? The Final Medicaid Bulletin MMP 23-17 stated that MIR and IRIs visits can be conducted via telephone-only are allowable when a beneficiary has a barrier to use audiovisual platform. Please explain what is pending.**
    - Updates to the telephone-only codes are currently in process. However, initial assessment visits are indeed allowable via phone if necessary.

43. Place of Service. The OB Office in which our program is connected to no longer request an in-office visit for the initial visits, so those patients are in their home, when we complete our MRI along side of this appointment what is the place of services? Is this consider a home place of services?

- The new policy directs agencies to use the place of service that would be used for the specific service if telehealth was not an option. If the visit would typically occur in the office—use 11. If you would typically conduct the RI in the home—use 12. If you would conduct the visit in the community –use 15. For your reference, Place of Service Codes can be found at this CMS website.

44. During the coordinators meeting we were told we would receive update information regarding the new billing requirements. Is that now available? How should we proceed?

- This document provides updated information regarding the new billing requirements. In addition, updates to the Medicaid telephone-only codes are currently in process.

45. In stating that the 60% only counts for those enrolled beginning 5/12/2023, does that also include the guideline for Audio visual telehealth vs audio only?

- MIHP agencies will be allowed to provide up to 40 percent of all professional visits across the total agency caseload via telehealth. This 40% includes visits conducted via the audiovisual format as well as via telephone-only.
- At least 60 percent of all professional visits across the total agency caseload must be provided in person.

46. I have a question about the MIHP telehealth bulleting MMP 23-17. It indicates that for Telehealth visits, to use the "place of service code that would typically be used if the beneficiary were in person for the visit (eg: home or office)". I guess I'm not sure how to know if this would be home or office. Or does it not matter? I understand the modifier of 95 or 93 will also be added, but I'm not sure whether to use POS 11-office or 12-home for the telehealth visits. Can you please clarify this for me?

- Place of service codes should reflect where the visit would typically occur, per agency practices. Please see additional information in the response to question #41.

47. If someone is completing a visit in their car (not ideal, but it happens), would this be considered a community visit?

- This can be considered a “home” visit if the visit would have typically occurred in the home. Place of service codes should reflect where the visit would typically occur, per agency practices.

48. Even after pulling the information on telehealth, I have some questions and wonder if I can schedule with a consultant to discuss?

- Yes, you may request a consultation via this link: https://www.surveymonkey.com/r/ProviderConsultationSurvey

49. **I feel like it would still be best practice to include & have the client initial permission for "Telehealth Consent Obtained "on the maternal and infant consent to release protected health information forms during in person enrollment visits in case there needs to be a future telehealth appt…what are thoughts on this?**
    - It is not required to obtain consent specific to conducting telehealth visits. Telehealth is an acceptable service delivery option in MIHP.

50. **If we complete a video enrollment, would the location be home, office or community? Is that also based on where the client is?**
    - Place of service codes should reflect where the visit would typically occur, per agency practices. Additional information is available in question #12.

51. **Please clarify, do office visits count as home visits for the 60/40 rule? Is the office in-person and counted as the 60 of the 60/40 rule? Prior to covid office was not an in-person visit." Our biller is saying it's considered as part of the 60 percent rule, and considered part of the in-person (home visit). Also, she is saying the clients prior are now also part of the 60/40 rule. It was under our interpretation on Tuesday that prior clients were not part of the 60/40 rule. Can you please clarify this for me?**
    - Yes, office visits count in the 60/40 percentiles. The 60% refers to in person visits.
    - It is the expectation that the required policy percentages are effective for all assessment and professional visits for new enrollees beginning May 12, 2023. The requirements do not apply to participants enrolled prior to May 12, 2023.

52. **Our agency uses Patagonia Health EMR. Our POC1 and PVPN are programmed to allow us to enter both the Service Code (H1000/H2000, 99402, etc.) and Place of Service (11-Office, 12-Home, etc.). The notes are directly tied to billing. Our plan, post-PHE, is that for any telehealth visits, the provider will utilize a built-in "pop-up note" which is sent to our billing department, to indicate if the telehealth visit was synchronous or audio-only. Upon receipt of the electronic super bill and pop-up note (if applicable), billing will add the appropriate 95 or 93 modifier. Our understanding, which was reiterated to us in both the Q&A, as well as during the Detroit Coordinator Meeting, is that the Telehealth Place of Service code is defunct as of 5/12/23 and not to be used. Therefore, the only relevant Place of Service codes would be Office, Home, or Community, and are to be determined based on the location of the client during the visit. If we were to indicate "Telehealth" on our Patagonia notes, this would cause us to be using the now-obsolete Place of Service code. The Q&A, the email sent on 5/10/23, and the update provided at the Coordinator meeting do not make it clear how to proceed with documenting if a visit is conducted via Telehealth for those of us using an EMR. Would it be acceptable to:**
    - **On PVPN, document the Place of Service, according to the Medicaid updates (Home, Office, Community) and to add a note in the "Other Visit Information" that the visit was Telehealth? Or…**
        - Yes, this is approved for Patagonia users until the system is updated with the new PVPN.

- **Create a Contact Log note when a visit or enrollment is done via Telehealth and indicate audiovisual or audio-only?**
  - Patagonia users are expected to note if the visit is provided via telehealth in the "Other Visit Information" section of the PVPN until the system is updated with the new PVPN.
- **If these are not permissible - are you able to clarify for us how we are to document a Telehealth visit on our EMR notes?**
  - Not applicable; please see above guidance.

53. Billing and Reimbursement Considerations

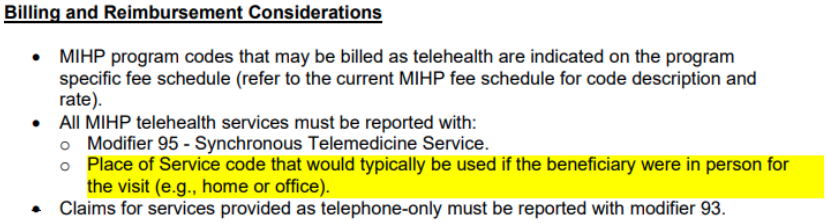
MIHP program codes that may be billed as telehealth are indicated on the program specific fee schedule (refer to the current MIHP fee schedule for code description and rate). All MIHP telehealth services must be reported with: Modifier 95 - Synchronous Telemedicine Service. Place of Service code that would typically be used if the beneficiary were in person for the visit (e.g., home or office). Claims for services provided as telephone-only must be reported with modifier 93. For further program-based telehealth requirements, refer to the MIHP Operations Guide.

- **If they are reimbursing the same as a home visit and the modifiers 93 and 95 will specify what type of telehealth visit was done, is it safe to assume that we use the following codes for billing again:**
  - **H2000 for all intakes and 99402 for all professional visits as indicated on the MIHP Fee Schedule?**
    - Place of service codes should reflect where the visit would typically occur, per agency practices.
  - **The other codes listed would be if the visit were actually performed in an office setting (H1000, T1023). I know they used these for TH during the COVID pandemic.**
    - Place of service codes should reflect where the visit would typically occur, per agency practices.
  - **If the beneficiary is at HOME during a Telehealth intake assessment, we mark it as home going forward, NOT office as we have been doing during the pandemic, correct?**
    - Place of service codes should reflect where the visit would typically occur, per agency practices.

54. After reviewing the guidance, I didn't see anything regarding the current Infant Office visit policy, can that be disregarded now?

- The new policy supersedes previous requirements regarding format of infant visits.

55. I have a question regarding Bulletin MMP 23-17 and I'm hoping you can help me out. The highlighted statement below regarding the place of service code is confusing. In the past, our agency has billed telehealth visits with a place of service '02'. This statement indicates the place of service would be home (12) or office (11)? Can you clarify what place of service code should be used for telehealth visits effective 5/12/2023?



Billing and Reimbursement Considerations

- MIHP program codes that may be billed as telehealth are indicated on the program specific fee schedule (refer to the current MIHP fee schedule for code description and rate).
- All MIHP telehealth services must be reported with:
  - Modifier 95 - Synchronous Telemedicine Service.
  - Place of Service code that would typically be used if the beneficiary were in person for the visit (e.g., home or office).
- Claims for services provided as telephone-only must be reported with modifier 93.

- The information that you've highlighted above is correct with regard to Place of Service code documentation.

56. I have a general question regarding the telehealth bulletin that was released on April 10, 2023. I am wondering at what time interval are the 60/40 in-person versus telehealth benchmarks measured? Monthly, quarterly, etc.? We monitor our ratios through monthly reports, and have noticed that, historically, there does seem to be some fluctuation in the percentages. This raised the question of when these numbers would be measured and what the time frames would look like.

- Agencies should monitor the in-person and telehealth claim percentages internally (e.g., billing audit). Beginning January 1, 2025 (Cycle 10), percentages will be reviewed as a part of the Quality Assessment process. MDHHS MIHP will provide information based on the calendar year.

57. How do you manage the 60% with your total caseload as it changes daily due to discharges/enrollments?

- Please see question #56. The 40/60 requirement applies to the assessment visit and professional visits conducted by an agency. All enrolled participants will be counted in an agency caseload.

58. Will this 60% take effect after 5/12/23? So, will it only count towards new enrollments after 5/12/23?

- It is the expectation that the required policy percentages are effective for all assessment and professional visits for new enrollees beginning May 12, 2023. The requirements do not apply to participants enrolled prior to May 12, 2023

59. If I read MMP23-17 correctly, we should use modifiers 95 and 93 (telephone-only, and only if visual portion is not possible). These modifiers would replace GT and FQ, correct?

- Yes, this is correct for service dates on or after May 12, 2023.

60. What is the frequency of measurement for the 40% / 60%? Will this be a monthly aggregate total? Quarterly? Annual? (Calendar Year vs. Fiscal Year?) I would like an idea of the frequency of measurement so I can better create a tracking process to ensure we comply with the ratios.

- Agencies should monitor the in-person and telehealth claim percentages internally (e.g., billing audit). Beginning January 1, 2025 (Cycle 10), percentages will be reviewed as a part of the Quality Assessment process. MDHHS MIHP will provide information based on the calendar year.

61. Do we indicate whether or not the beneficiary is "at home" for the telehealth visit?

- No, this is not necessary. However, Place of Service documentation should reflect where the visit would typically take place.

62. We no longer need to add the GT or GTFQ modifiers, right?

- Yes, this is correct for dates of service on or after May 12, 2023. The Medicaid policy indicates the following for modifiers to be used for dates of service on or after May 12, 2023: 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".

63. We were previously instructed to indicate place of service "office" for telehealth due to reimbursement rate. Can you provide guidance on when to use which place of service code? Can the 02 – Telehealth place of service code be used? It is helpful from an agency's perspective to have the correct place of services for internal reporting purposes.

- Place of service documentation should reflect where the visit would typically take place. The 02-telehealth code should not be used for any claims on or after May 12, 2023.

64. It would also be helpful if "telehealth" was an option for location on the risk identifier to accurately reflect it's administration.

- Thank you. The updated health assessment will include this option.

65. **MMP 23-10 section VII does not list H1000, H2000, or T1023 as acceptable codes for phone-only encounters. Will Risk Identifier visits be allowed via phone-only or will they be required to be in-person and video only?**
    - The updates to the Medicaid telephone-only codes are currently in process. However, risk identifiers (initial assessments) are allowable via phone-only.

66. **MMP 23-17 section about telephone-only states "Documentation in the beneficiary's chart must include the reason for a telephone-only visit."**
    - **Where should this be documented? Options might include inside the PVPN and/or contact log**.
        - Please refer to question #15 and #34.
    - **Is there a requirement to also document the reason for video visit or does this only apply to phone-only?**
        - Please refer to question #34.
    - **If the reason for telehealth will be required in the "if other why" box on the PVPN, Patagonia users will not be able to comply for a while. The current algorithm is set up so that the "if other why" text box will not appear if Place of Service of Home or Office is selected. It will take some time to change that algorithm to make that text box available on all PVPNs.**
        - Please refer to question #52 for Patagonia-specific guidance.

67. **If a PVPN (99402) is completed via video while the beneficiary is at home and the visitor is in the office we would bill a 99402 with modifier 95. However, I'm unclear if we would use Place of Service "11-office" or "12-home." So is the Place of Service determined by the beneficiary or the visitor location?**
    - Place of service documentation should reflect where the visit would typically take place.

68. **If a Maternal MRI is completed via video while the beneficiary is at home and the visitor is in the office, would we use code H1000 or H2000 (along with modifier 95) and would the Place of Service be 11 or 12? O again, is the billing code and Place of Service determined by the beneficiary or visitor location during the telehealth visit?**
    - Place of service documentation should reflect where the visit would typically take place.

69. **If an Infant IRI is completed via video while the infant was at home and the visitor was in the office, would we use code H2000 or T1023 (along with modifier 95) and would the Place of Service be 11 or 12? Again this is a similar question about selecting the billing code and place of service – is it based on beneficiary location or visitor location?**
    - Place of service documentation should reflect where the visit would typically take place.

70. **MMP 23-17 states "MIHP agencies will be allowed to provide up to 40 percent of all professional visits across the total agency caseload via telehealth." I am wondering how this is calculated (or what's the denominator in the equation?) Is it based on the number of services billed over a certain period of time or number of beneficiaries on the caseload over a period of time? And what's the period of time? For example, one month we may bill 200 encounters, have a caseload of 400, and 100 of those encounters may be telehealth. But the next month we may bill 300 encounters, have a caseload of 350, and 20 of those encounters may be telehealth. How would I calculate our percentage of telehealth?**
    - Please refer to question #56. With regard to caseloads, the 40/60 requirement applies to the assessment visit and professional visits conducted by an agency. All enrolled participants will be counted in an agency caseload.

71. **If MIHP Consent to Release and MIHP Consent to Participate are completed during a video admit visit, does that consent need to be done again at the first in-person visit or will that original verbal consent stand throughout course of care?**
    - Please refer to the MIHP Operations Guide, page 21 for telehealth specific documentation, including consent forms.

72. **On Bulletin Number: MMP 23-10, this document does not mention anything specifically about MIHP. However on the alert you all sent out, it says to reference this bulletin for more information.**
    - MIHP providers must comply with the MIHP-specific telehealth policy MMP 23-17 as well as the broad Medicaid telemedicine policy, MMP 23-10.

73. **Based on the two bullet point items, VI, and VII on the bulletin listed above. Does this mean that if we use an audio and video component when using telemedicine that we can bill the same rate as an in person home visit?**
    - ***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.***
    - ***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.***
        - Yes, please refer to question #12 and document place of service in accordance with where the visit would typically occur.

74. According to MIHP cycle 9 requirements, do the HMHB visits count as part of the 60/40% home and virtual visits.

- Please refer to the program guidance document available here: Program-Guidance-Document-HMHB_Version-11.pdf (michigan.gov)

75. Could you clarify the following:

- **When we conduct; an Audio Only telephone telehealth visit what POS code do we use?**
  - Place of service documentation should reflect where the visit would typically take place. Please see additional information in question #12. For your reference, Place of Service Codes can be found at this CMS website.
- **When we conduct; a Visual-Audio (video) telehealth visit what POS code do we use?**
  - Place of service documentation should reflect where the visit would typically take place. Please see additional information in question #12. For your reference, Place of Service Codes can be found at this CMS website.

76. I see 99402 listed on the Medicaid bulletin but I do not see T1023 or H1000. Will we still use the T1023 and the H1000 procedure codes? If not will you list the new procedure codes?

- Updates to the telephone-only codes are currently in process.

77. I understand we use the 93 modifier for audio-only and 95 modifier for audio-visual (video) telehealth visits; just need clarification on the Place of Service codes.

- Please refer to questions #12 and #41. For your reference, Place of Service Codes can be found at this CMS website.

78. When providing a telehealth appt, does the language of:

- **Examples of when telehealth is an appropriate option may include, but are not limited to, "circumstances such as when a beneficiary: • Refuses an in-person visit and would benefit from receiving MIHP services, • Has an illness in their household, or • Needs to share sensitive information that cannot be discussed in the home environment and a transportation barrier exists for an office visit. " Belong in the spot on the PVPN under Why? For example, instead of Covid-19 , we may be writing: Refuses an in-person visit and would benefit from receiving MIHP services.**
  - Rationale must be included for telephone-only visits but is not required for telehealth visits. The PVPN will be updated to reflect this. However, you are correct that when rationale is necessary, it should be documented on the PVPN in the section "If telehealth or other, why?"