MEDICAID POLICY INFORMATION SHEET

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This policy outlines telemedicine allowances in effect post-federal Public Health Emergency, including discontinued and adapted temporary bulletins.

Reason for policy (problem being addressed):

To delineate telemedicine policy post-federal Public Health Emergency including discontinued and adapted bulletins.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

Yes, Claims

Does policy have operational implications on other departments?

Yes, general interest in services performed via telemedicine.

Summary of input:

☒ controversial Providers have been waiting for this policy to come out and may not agree with the discontinuation of some telemedicine services post-PHE.
☐ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2223-Telemedicine	**Date:** August 16, 2022

Comments Due: September 20, 2022
Proposed Effective Date: TBD
Direct Comments To: Laura Kilfoyle
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Policy Subject: Telemedicine Policy Post-COVID-19 Public Health Emergency

Affected Programs: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services, MIChild

Distribution: All Providers

Summary: This policy outlines telemedicine allowances in effect post-federal Public Health Emergency, including discontinued and adapted temporary bulletins.

Purpose: To delineate telemedicine policy post-federal Public Health Emergency including discontinued and adapted bulletins.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues:

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**

Tribal Notification: Yes ☒ **No** ☐ - **Date:** June 27, 2022

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: All Providers

Issued: TBD

Subject: Telemedicine Policy Post-COVID-19 Public Health Emergency

Effective: TBD

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Maternity Outpatient Medical Services, MIChild

The purpose of this bulletin is to update program coverage of telemedicine services after the conclusion of the federal COVID-19 Public Health Emergency (PHE) and to clarify which bulletins are now discontinued as of the date indicated. **NOTE:** MSA 20-09 and MSA 21-24 are permanent policy and remain in effect unless indicated per this policy. These two policies should be considered alongside this policy when considering MDHHS Post-PHE Telemedicine Policy as a whole.

I. General Telemedicine Policy Updates

Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid-enrolled health care professional in a different location. The Michigan Department of Health and Human Services (MDHHS) covers both synchronous (real-time interactions) and asynchronous (over separate periods of time) telemedicine services. MDHHS requires that all telemedicine policy provisions within this policy and other current policy are established and maintained within all telemedicine services.

Along with general telemedicine policy, specific program considerations (as listed within this policy) must be upheld during all telemedicine visits unless otherwise stated. The specific program section provides additional requirements and offers further clarification as needed. These should always be considered in combination with all general telemedicine policy.

Recognizing that telemedicine can never fully replace in-person care, MDHHS has established the following guiding principles to be used by MDHHS-enrolled providers during the provision of telemedicine services:

A. Effectual services – a service provided via telemedicine should be as effective as its in-person equivalent, ensuring convenient and high-quality care.

B. Improved and appropriate access – the right visit, for the right beneficiary, at the right time by minimizing the impact of barriers to care, such as transportation needs or availability of specialty providers in rural areas.

C. Appropriate beneficiary choice – the beneficiary is an active participant in the decision for telemedicine as a means for service delivery as appropriate (e.g., Does the beneficiary prefer telemedicine to an in-person visit? What is the optimal combination of ongoing service delivery for the individual? etc.).

D. Appropriate utilization – ensure providers are utilizing telemedicine appropriately and that items A-C above are taken into consideration when offering these services.

E. Value considerations – telemedicine visits should yield the desired outcomes and quality measures; health outcomes should be improving and remain consistent with in-person care at a minimum.

F. Privacy and security measures – providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy/security regulations as applicable.

II. Determination of Appropriateness/Documentation

Telemedicine must only be utilized when there is a clinical benefit to the beneficiary. Examples of clinical benefit include:

- Ability to diagnose a medical condition in a patient population without access to clinically-appropriate in-person diagnostic services.
- Treatment option for a patient population without access to clinically-appropriate in-person treatment options.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or another quantifiable symptom.

Furthermore, telemedicine must only be utilized when the beneficiary's goals for the visit can be adequately accomplished, there exists reasonable certainty of the beneficiary's ability to effectively utilize the technology, and the beneficiary's comfort with the nature of the visit is ensured. Telemedicine must be used as appropriate regarding the best interests/preferences of the beneficiary and not merely for provider ease. Appropriate guidance must be provided to the beneficiary to ensure they are prepared and understand all steps to effectively utilize the technology prior to the first visit. Beneficiary consent must be obtained prior to service provision (see policy for "Consent for Telemedicine Services" in MSA 20-09 for further information).

As standard practice, in-person visits are the preferred method of service delivery; however, in cases where this option is not available or in-person services are not ideal or are challenging for the beneficiary, telemedicine may be used as a complement to in-person services. Telemedicine services cannot be continued indefinitely for a given beneficiary without reasonably frequent and periodic in-person evaluations of the beneficiary by the provider to personally reassess and update the beneficiary's medical treatment/history, effectiveness of treatment modalities, and current medical/behavioral condition and/or treatment plan. Applicable beneficiary records must contain documentation regarding the reason for the use of telemedicine and the steps taken to ensure the beneficiary was provided utilization guidance in an appropriate manner.

In special situations, depending upon the needs of the beneficiary, providers may opt to deliver the majority of services via telemedicine. If this situation occurs, it must be documented in the beneficiary's record or in their individual plan of service (IPOS). This situation should be the exception, not the norm. (Refer to the program-specific subsections of this policy for specific guidance regarding this benefit.)

All services provided via telemedicine must meet all the quality and specifications as would be if performed in person. Furthermore, if while participating in the visit the desired goals of the beneficiary and/or the provider are not being accomplished, either party must be provided the opportunity to stop the visit and schedule an in-person visit instead (refer to the "Contingency Plan" section of MSA 20-09 for such instances). This follow-up visit must be provided within a reasonable time and be as easy as possible to schedule.

III. Prior Authorization Requirements

There are no prior authorization (PA) requirements when providing services via telemedicine for Fee-for-Service (FFS) beneficiaries or for those accessing Behavioral Health Services through Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) unless the equivalent in-person service requires PA. Authorization requirements for beneficiaries enrolled in Medicaid Health Plans (MHPs) may vary. Providers must refer to individual MHPs for any authorization or coverage requirements.

IV. 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.

This policy supersedes and discontinues MSA 20-09 (Facility Rate subsection) and MSA 20-42 (Telemedicine Reimbursement Rate Change section) per the date indicated.

V. Telemedicine Billing Requirements

All telemedicine visits are required to ascribe to correct coding requirements equivalent to in-person services, including ensuring that all aspects of the code billed are performed during the visit.

A. Allowable Services

Allowable telemedicine services for synchronous telemedicine are listed on the telemedicine fee schedule which can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Physicians/Practitioners/Medical Clinics >> Telemedicine Services.

Asynchronous telemedicine service codes are listed on the corresponding provider-specific fee schedules. Additional program-specific coverage will be represented on individual program fee schedules and will be indicated in the program-specific sections below as indicated.

Where face-to-face visits are required (such as End State Renal Disease [ESRD] and nursing facility-related services), the telemedicine service may be used in addition to the required face-to-face visit but cannot be used as a substitute. There must be at least one face-to-face hands-on visit (i.e., not via telemedicine) by a physician, physician's assistant or advanced practice registered nurse per month to examine the vascular site for ESRD services.

For PIHP/CMHSP service providers, refer to the MDHHS Bureau of Community-Based Services Telemedicine Database which can be accessed on the MDHHS website at www.michigan.gov/bhdda >> Reporting Requirements >> Bureau of Community Based Services Telemedicine Database for services allowed via telemedicine.

B. Place of Service (POS) and Modifier 95

All 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".

For services submitted on the Institutional invoice, the appropriate National Uniform Billing Committee (NUBC) revenue code, along with the appropriate telemedicine Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure code and modifier 95— "Synchronous Telemedicine Service", must be used.

Covered asynchronous telemedicine services (as defined above, represented on corresponding fee schedules, and outlined in MSA 21-24 – Asynchronous Telemedicine Services) should be billed with applicable POS and modifiers as standard practice.

Telemedicine claims without these indicators may be denied.

This policy supersedes and discontinues MSA 20-09 (Place of Service and GT Modifier subsection) and MSA 20-42 (Telemedicine Reimbursement Rate Change section), per the date indicated.

For PIHP/CMHSP service providers, refer to the Bureau of Community-Based Services Telemedicine Database, which can be accessed on the MDHHS website at www.michigan.gov/bhdda >> Reporting Requirements >> Bureau of Community Based Services Telemedicine Database for services allowed via telemedicine.

This information should be used in conjunction with the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters of the MDHHS Medicaid Provider Manual, as well as the Medicaid Code and Rate Reference tool and other related procedure databases/fee schedules located on the MDHHS website.

VI. Audio Only Telemedicine Policy

MDHHS supports the use of simultaneous audio/visual telemedicine service delivery in all situations and, as such, MSA 20-13 – COVID-19 Response: Telemedicine Policy Expansion; Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) Implications, allowing the provision of audio only services for the codes listed on the telemedicine fee schedule, is discontinued with the enactment of this policy per the date indicated.

However, to ensure some audio only services in situations where a beneficiary does not have access to audio/visual capabilities, MDHHS will permit the use of certain telephone (audio) only CPT/HCPCS codes. For example, these codes are currently represented as 99441-99443 and 98966-98968 and are listed on applicable provider fee schedules. Since audio codes are required to utilize audio only capabilities, they do not require an audio only modifier and should be reported with the most applicable POS code.

Since MDHHS is discontinuing the provision of telephone (audio) only telemedicine services indicated in MSA 20-13, this policy philosophy applies to the provision of services within the School Services Program (SSP) as well. These programs also have the allowance to provide the telephone (audio) only codes as described above. As such, MSA 20-15 - COVID-19 Response: Behavioral Health Telepractice; Telephone (Audio Only) Services, Telephone (Audio Only) Services section is discontinued with the enactment of this policy per the date indicated.

Additionally, since MDHHS is discontinuing the provision of telephone (audio) only telemedicine services (as indicated in MSA 20-13) across all programming, MDHHS is also discontinuing MSA 20-34 - COVID-19 Response: Telemedicine Reimbursement for Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers, which allows audio only interactions to generate the Prospective Payment System/All-Inclusive Rate (PPS/AIR) for applicable clinics, with the enactment of this policy per the date

indicated. Clinics will be permitted to bill for the audio only codes, as indicated above, if appropriate for the interaction with the beneficiary; however, these codes do not generate the PPS/AIR. Clinics are permitted to bill for telemedicine services (using simultaneous audio/visual technologies) per MSA 20-09 if all other provisions of telemedicine policy are maintained. Simultaneous audio/visual telemedicine services, as indicated by CPT/HCPCS codes listed on the telemedicine fee schedule and considered qualifying visits, will be considered face-to-face and will trigger the PPS/AIR if the service billed is listed as a qualifying visit.

MDHHS will also be aligning audio only policy across dental providers; therefore, audio only for dental providers, as stated in MSA 20-21 - COVID-19 Response: Limited Oral Evaluation via Telemedicine, will be discontinued with the enactment of this policy per the date indicated. MDHHS will continue other telemedicine dental services (see below for further details).

VII. Specific Program/Service Site Considerations

A. Hospitals

Hospitals may utilize telemedicine services as appropriate within telemedicine policy guidelines. Medicare guidelines are the basis for MDHHS hospital and Outpatient Prospective Payment System (OPPS) coverage and payment structures. Providers should refer to the Hospital and the Billing & Reimbursement for Institutional Providers chapters of the MDHHS Medicaid Provider Manual for information on billing and when MDHHS varies from Medicare billing. Telemedicine information for hospitals is covered in these chapters with the following coverage and billing guidelines.

- MDHHS varies from Medicare telehealth billing by requiring the POS to be reported as the same as if the beneficiary was in person (not using POS 02 or 10) but aligns in the use of modifier 95. (Refer to the Telemedicine Billing Requirements section of this policy.)
- When the facility provides administrative support for a telemedicine service, the hospital may bill the originating site facility fee on the institutional claim with modifier 95 and the appropriate revenue code. If also submitting a professional claim for telemedicine services provided on the same day, only the telemedicine service with modifier 95 is allowed. (Refer to MSA 20-09 for further details on the use of the Telehealth Facility Fee.)
- Outpatient hospital facilities should not bill the outpatient clinic visit on the same day as the originating site facility fee. (Refer to MSA 20-09 for further details on the use of the Telehealth Facility Fee.)
- Approved professional telehealth services provided by a hospital, such as an evaluation and management (E/M), therapy code, counseling code, etc. should be billed using modifier 95 to identify the service as telemedicine. When provided by telemedicine, the hospital would not use the code for the originating site facility fee when billing for these services. (Refer to MSA 20-09 for further details on the use of the Telehealth Facility Fee.)

B. Behavioral Health

i. PIHP/CMHSP

The MDHHS Bureau of Community Based Services requires all the requirements of Telemedicine policy are attained and maintained during all beneficiary visits. In addition to the Determination of Appropriateness/Documentation section of this policy, the Bureau of Community Based Services would like to reiterate that services delivered to the beneficiary via telemedicine be done at the convenience of the beneficiary, not the convenience of the provider. In addition, these services must be a part of the person-centered plan of service and available as a choice, not a requirement, to the beneficiary.

Populations:

This policy applies to all populations served within PIHPs/CMHSPs, including Adults with Mental Illness (MI), Individuals with Intellectual/Developmental Disabilities (I/DD), Children with Serious Emotional Disturbance (SED), and individuals with a Substance Use Disorder (SUD). This policy does not supersede any federal regulations that must be followed for SUD treatment.

ii. Outpatient Mental Health Services Providers

Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs may receive outpatient mental health services through Medicaid Fee-for-Service (FFS) or Medicaid Health Plans as applicable. These non-physician behavioral health services may be provided via telemedicine when performed by Medicaid-enrolled psychologists, social workers, counselors, and marriage and family therapists. Services are covered when performed in a non-facility setting or outpatient hospital clinic. All applicable services are listed in the telemedicine fee schedule.

C. Physical Therapy, Occupational Therapy and Speech Therapy Services

MDHHS will allow select therapy services to be provided via telemedicine when performed by Medicaid-enrolled private practice and outpatient hospital physical therapy (PT), occupational therapy (OT) and speech therapy (ST) providers. PT, OT and ST services allowed via telemedicine will be represented by applicable CPT/HCPCS codes on the telemedicine fee schedule. Therapy services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate.

Therapy re-evaluations and Durable Medical Equipment (DME) re-assessments performed via telemedicine must be provided by a therapist who has previously evaluated the beneficiary in-person.

Documentation re-evaluation, performance, and treatment elements that typically require hands-on contact for measurement or assessment must include a thorough description of how the assessment or performance findings were established via telemedicine. This includes, but is not limited to, such elements as standardized tests, strength, range of motion, and muscle tone.

Initial evaluations will not be allowed via telemedicine and should be provided in-person. Additionally, services that require utilization of equipment during treatment and/or physical hands-on interaction with the beneficiary may not be provided via telemedicine.

This policy supplements existing PT, OT and ST services policy. All current therapy referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. All telemedicine therapy services will count toward the beneficiary's therapy service limits. (Refer to the Therapy Services chapter of the MDHHS Medicaid Provider Manual for complete information.)

i. Billing Considerations

Modifier 95 should be used in addition to the required modifiers for therapy services as outlined in therapy policy.

ii. Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)/Tribal Health Center (THC)/ Tribal Federally Qualified Health Centers (Tribal FQHC) Considerations

PT, OT and ST, when provided in accordance with this policy using both audio/visual modalities, will be considered face-to-face and will trigger the PPS AIR if the service billed is listed as a qualifying visit.

For FQHCs, RHCs, THCs and Tribal FQHCs, the appropriate CPT/HCPCS code, PPS/AIR payment code (if the service generates a Qualifying Visit), and modifier 95 – synchronous telemedicine must be used. Refer to www.michigan.gov/medicaidproviders >> Provider Specific Information for additional information.

iii. School Services Program Considerations

School Services Program (SSP) PT and OT services, as outlined in this policy, will also be allowed via telemedicine. These services must meet all other telemedicine policies as outlined.

This policy ends MSA 20-22 - COVID-19 Response: Telemedicine Policy Changes, Updates to Coverage for Physical Therapy, Occupational Therapy and Speech Therapy per the date indicated, but continues some of the allowances permanently with the changes indicated.

D. Audiology Services

MDHHS will allow ST, auditory rehabilitation, select hearing device adjustments, programming, performance evaluations, and education or counseling to be performed via telemedicine (simultaneous audio/visual). Reimbursable procedure codes are limited to the specific set of audiology codes listed in the telemedicine fee schedule. Audiology services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate.

Remote device programming must be provided in compliance with current U.S. Food and Drug Administration (FDA) guidelines.

Audiological diagnostic testing, surgical device candidacy evaluations, and other audiology and hearing aid services are not appropriate for telemedicine and should be provided in-person.

This policy supplements the existing audiology services and hearing aid dealer policy. All current referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. Providers should refer to the Hearing Services chapter in the MDHHS Medicaid Provider Manual for complete information.

This policy ends MSA 20-53 - COVID-19 Response: Telemedicine Policy Changes for Audiology Services per the date indicated but continues the allowance permanently with the changes outlined within this section.

E. Dentistry

MDHHS will allow dentists to provide the limited oral evaluation (Current Dental Terminology [CDT] code D0140) via telemedicine (simultaneous audio/visual) technology so long as all other telemedicine policy is followed. D9995 teledentistry-synchronous; real-time encounter, must be reported in addition to the applicable CDT code.

All requirements of the general telemedicine policy described in Bulletin MSA 20-09 and the MDHHS Medicaid Provider Manual must be followed when providing the limited oral evaluation via telemedicine, including scope of practice requirements, contingency plan, and the use of both audio/visual service delivery unless otherwise indicated by federal guidance.

Services delivered to the beneficiary via telemedicine must be done for the convenience of the beneficiary, not the convenience of the provider. Services must be performed using simultaneous audio/visual capabilities. All services using telemedicine must be documented in the beneficiary's record, including the date, time, and duration of the encounter, and any pertinent clinical documentation required per CDT code description. The provider is responsible for ensuring the safety and quality of services provided with telemedicine technologies.

Billing instructions depend upon the claim format used:

- American Dental Association (ADA) Claim Format: Use POS 02 or POS 10; report D9995 with the procedure code.
- Institutional Claim Format: POS 02 and POS 10 are not required; Use modifier 95; report D9995 with the procedure code.

This policy ends MSA 20-21 - COVID-19 Response: Limited Oral Evaluation via Telemedicine per the date indicated but continues other telemedicine dental services as outlined within this section.

F. Vision

Telemedicine vision services can be provided through a Medicaid-enrolled physician or other qualified health care professional who can report evaluation and management (E/M) services as listed in the telemedicine fee schedule.

A routine eye exam (currently CPT 92012) can be provided via telemedicine for an established patient with a known diagnosis that requires intermediate examination and evaluation. The provider must have a previous face-to-face encounter with the beneficiary to ensure the provider is knowledgeable of the beneficiary's current medical history and condition. For cases in which the provider must refer the beneficiary to another provider, a consulting provider is not required to have a pre-existing provider-patient relationship if the referring provider shares medical history, past eye examinations, and any related beneficiary diagnosis with the consulting provider. CPT 92012 should not be used to diagnose eye health conditions (an initial diagnosis). When medically necessary, providers must refer beneficiaries for an in-person encounter to receive a diagnosis and/or care. Telemedicine cannot act as a replacement for recommended face-to-face interactions.

G. School Services Program

Because of the unique circumstances regarding the delivery of services within the School Services Program, telemedicine may be the primary delivery modality for some beneficiaries; however, the decision to use telemedicine should be based on the needs or convenience of the beneficiary, and not those of the provider.

In cases where the beneficiary is unable to use telemedicine equipment without assistance, an attendant must be provided by the provider. The attendant must be trained in the use of the telemedicine equipment to the point where they can provide adequate assistance. The attendant must also be available for the entire telemedicine session; however, they should also ensure the beneficiary's privacy to the greatest extent possible. When the originating site for the service is the student's home, any cost for an attendant is not reimbursable.

Billing and reimbursement for telemedicine services are accomplished using the same methodology as other services; however, the service must be billed using POS 03—school and modifier 95. Telemedicine claims for the School Services Program are paid according to the Centers for Medicare & Medicaid Services (CMS) approved cost-based methodology used for other services provided within the program and not the information provided previously in this policy. School Services Program providers are not eligible for the facility fee as the facility is an integral part of the service provided and is covered under the service claim. A database of allowable telemedicine services for SSP can be found on the SSP website.

This policy ends MSA 20-15 - COVID-19 Response: Behavioral Health Telepractice; Telephone (Audio Only) Services per the date indicated but continues telemedicine SSP services as indicated.