MDHHS March 2021 H2015 TA Questions & Answers

Inquiry Date	Response Da	CMHSP Question/Comment	MDHHS Response Provided
2/22/21	3/8/21	Particularly challenging for providers serving multiple clients in a group living arrangement.	Providers/payors that are successfully using new modifiers should continue to do so. Those that are not able to can use TT until the end of FY21.
2/22/21	3/8/21	What can overlap with H2015? OT, PT, Dietician?	Questions about overlapping services have come up related to the COVID-19 emergency, and related to the change from H0043 to H2015. This response is intended to address the change from H0043 to H2015. The rules around this have not changed. CLS cannot overlap with any other services, except for case management monitoring as described in the BHDDA Code Chart appendix section titled Same Time Services Reporting numbers 11 and 12.
2/22/21	3/8/21	Is start and stop time documentation required?	Service Verification documentation requirements are determined by the payor. Generally, providers must ensure services are documented in formats that provide sufficient support to assure accurate submissions of claims/encounters.
2/22/21	3/12/21	Should all rates just be normalized for those sharing one residence and then units reported on preponderance time and the number per client/per day?	In situations where the same CLS worker provides services to more than one individual in a single residence during the same visit, and the service is not provided as a group service, it would be reasonable for a provider to track the number of units provided over the course of a visit, and then to assign (and report) those units based on the preponderance of time spent with each individual receiving the services. However, the provider must be able to demonstrate that an individual had at least 15 minutes of interaction with the CLS worker for every unit of service attributed to the individual. MDHHS does not establish rates at the service level for CLS, and rates would be negotiated between the CMHSP and providers. However, for service units provided to more than one individual simultaneously (i.e., as a group service), it would be reasonable adjust the rate to reflect the number of individuals simultaneously served. MDHHS is developing and plans to publish comparison rates that can be considered as part of such negotiations, and the published comparison rates for H2015 will be adjusted to reflect the service being provided to more than one individual simultaneously.
2/22/21	3/8/21	We have people who share a home where one person needs 24 hour care, the next may only have necessity for 16 hours. It's the same CLS worker in the home. Does the modifier change at the time the second person runs out of units for the day?	The consumer IPOS clarifies the extent that 1-1 dedicated or shared staffing is needed. It is expected that modifiers reported will align with the need for 1-1 or shared staffing outlined in the IPOS. To allow flexibility for sites with two or more consumers who may have 1-1 or shared staffing, a bundled authorization code could be used allowing H2015 or H2015xx.
2/23/21	3/11/21	Should the different modifiers have different rates? If the hourly cost of 1:1 and 1:2 is the same, is the expectation that the UN modifier (2 persons served) be reimbursed by half the rate?	MDHHS does not establish rates at the service level for CLS, and rates would be negotiated between the CMHSP and providers. However, for service units provided to more than one individual simultaneously (i.e., as a group service), it would be reasonable adjust the rate to reflect the number of individuals simultaneously served. MDHHS is developing and plans to publish comparison rates that can be considered as part of such negotiations, and the published comparison rates for H2015 will be adjusted to reflect the service being provided to more than one individual simultaneously.

2/23/21	3/11/21	Discussion on how to handle transfer between providers and the issue of concurrent services? If one provider says they dropped a client off at 9:03 and the other begins service at 9:00 (both legitimate if they are helping with a transfer between 9:00 and 9:03) one provider loses a unit of reimbursement.	According to the BHDDA Code Chart, outside temporary COVID rules, a minimum of 15 minutes is required to bill one unit of face-to-face time.	
2/24/21	3/10/21	It would be a great help, if there could be a more clear definition of the Preponderance Rule and how that can be applied in practice.	U modifiers do not need to indicate the number of consumers served at each 15-minute increment but instead can be reported based on the number of consumers who are generally expected to be in the home. See 2.10.2021 H2015 memo from Jeff Wieferich.	
2/24/21	2/24/21	Regarding overnight Health and Safety for non-HSW beneficiaries in an Unlicensed Setting (H2015:UJ), Case Managers have no idea of the number of units to authorize for the year for overnight. Some people may go to bed at 8pm and others may not go to bed until midnight.	Regardless of how much sleeping the person actually does between the hours of 8pm and 8am, when there is a plan for overnight health and safety can it be determined to begin at 8pm and end at 8am. This would allow the case manager to authorize 48 units per day.	
2/26/21	3/10/21	Implementing the H0043 to H2015 transition would be more doable for the provider if providers could go back to using the TT modifier for more than one consumer. Can providers continue to use TT modifier for FY21?	It should be noted that MDHHS will be publishing comparison rates for H2015 that will be adjusted for instances where more than one individual is served at the same time. These rates, which will be defined by the use of modifiers, will reflect instances where 2, 3, 4, 5 or 6+ individuals share in the same service. MDHHS may also publish an H2015 service based on the TT modifier, which will be reflective of an average number of individuals served when the services is provided as a group or shared service.	
3/3/21	3/8/21	The issue is that staff are supposed to be awake for T2027. Currently all of the supported living arrangements have sleeping overnight staff. Do you think we can use the H2015 UJ for our HAB Waiver individuals instead of T2027, because the staff is asleep and not awake? The staff is available to assist HAB Waiver individuals with their health and safety during their typical sleeping hours.	There should not be sleeping staff at any time for any service on any waiver, state plan, or 1915 (i). No matter the code/modifier (H2015 or T2027) you cannot report it when the staff are asleep. They need to be awake in order to bill for this service.	
3/3/21	3/8/21	Also, there are individuals we serve in this setting that are non-waiver and HAB Waiver residing in the same home. Is it okay to use H2015 UJ for all individuals served in the same residence?	T2027 must be used for HAB Waiver consumers.	
Residents live in an apartment complex where there are many apartments leased through a Provider to our consumer and many apartments that are leased from the apartment complex to the general public. Residents have been assessed for their needs for 1:1 and 1: multiple CLS services. The provider has regular staffing on site which can vary some based on the needs of the individuals who are part of the “mix” of the campus. Multiple groups are offered (on the campus but not in the consumer apartments) on various CLS topics at different times throughout the day. In addition to the DCW staffing the groups, there are other DCW’s providing 1:1 F2F support for other individuals in their apartments throughout the complex. Individuals may “decline” their in-home 1:1 CLS some days and although individuals are scheduled for group services, they may or may not show up.				
3/18/21	3/19/21	a) Under the preponderance rule, could the Provider bill for the “regularly scheduled” hours of CLS services for every individual even if they did not attend their 1:1 session and/or group sessions?	No, services can be billed for F2F services provided.	

3/18/21	3/19/21	b) If an individual leaves the apartment for an "outing" that is not a billable service and therefore is not available for their 1:1 15 minute service, but will be back on campus later, under the preponderance rule, can all individuals still be billed their regularly scheduled 1:1?	No, services can be billed for F2F services provided.	
3/18/21	3/19/21	c) If an individual leaves the apartment for an "outing" to visit relatives or a short vacation, can all residents be billed their regularly scheduled services, including the resident who is gone?	No, services can be billed for F2F services provided.	
3/18/21	3/19/21	d) Does "preponderance rule" permit billing for no-show services (when the indirect prep time has already been expended) for all residents who were scheduled to attend the group?	No, services can be billed for F2F services provided.	
3/18/21	4/14/21	Residents live in apartment building modeled under the old Supportive Housing model. The Provider has staff available on site at apartment complex however typically little support needed by residents. Since the staff typically assist with med administration, we have estimated one 15 minute per day. Does this unit need to be at least 15 minutes long before it can be billed?	Yes, with exceptions as applicable during the COVID-19 State of Emergency.	
3/18/21	5/11/21	Residents live in apartment building modeled under the old Supportive Housing model. The Provider has staff available on site at apartment complex however typically little support needed by residents. Is there a Medicaid billable "supportive housing" type code that could be used to support these arrangements? We would need to cover minimal staffing and/or possibly staff on-call services.	Medicaid Provider Manual rules must be adhered to. We are not aware of a code that is currently available.	
3/19/21	5/7/21	Any examples of multiple apartments within an apartment complex where staff provider periodic and unpredictable direct CLS to individuals living in those apartments? is there any guidance on the preponderance rule or documentation for staff? For example, I anticipate that 15 minutes of intermittent support will be quite difficult to accurately document, and yet is exactly the need for someone to be successful in their own home. Preponderance rule is confusing and seems to be contrary to the 15 minute reporting and documentation.	If no U modifier is used, the preponderance rule does not apply. In an apartment complex where consumers live alone, the preponderance rule would not apply unless there was a group service offered (for example, smoking cessation group in a common area).	

3/19/21	5/7/21	The MDDHS memo dated 2/10/21 notes, “Reporting of the U modifier should reflect the number of consumers who are regularly expected to be in the home (given work, school, regular weekend visits with family, etc. daytime schedules) as opposed to the number of consumers in the home every 15-minute increment.” The problem is that the PIHPs have done their rate setting based on which modifiers are reported per 15 minutes (including which U modifier is utilized). This leads to an inherent conflict when applying the preponderance methodology.	The preponderance rule is not required to be used, if the staff are not responsible for the resident. The U modifiers are for shared staffing requirements. For example, in a four resident home where one resident is outside in the yard for 30 minutes, if staff are responsible for the resident, the preponderance rule does apply.	
3/19/21	5/7/21	Preponderance rule, if applied for setting of 3, would not provide the funding needed to cover the staff time when one client leaves and the same staff time is now spread across only two clients - leaving 1/3 of the staff time unpaid. (Sheehan)	In this situation where one client leaves and is no longer receiving services, you would change the modifier reported for the remaining residents who continue to receive services.	
3/19/21	5/7/21	Can you address the conflict between allowing a total of 15 min over a longer period of time and the Medicaid requirement of actual start and stop times?	A service must be 15 minutes of face-to-face and passive monitoring for health and safety in order to bill one unit.	
3/19/21	5/7/21	So cannot be provided during the actual face to face time with the doctor, but could bill 1 unit for 5 min of face to face before the appt and 10 mins after?	Rolling up minutes, or intermittent time being added together to total 15 minutes is not allowed.	
3/19/21	5/7/21	Just to be clear, if the CLS worker is helping the consumer on a hour long med review appt, the CLS worker can bill for the entire hour as long as they are having at least 15 minutes of interaction with the consumer during that time?	Per Medicaid Policy, CLS cannot be billed at any time during another service. The CLS worker is already getting paid their hourly rate. The time spent logging a beneficiary into a telemedicine visit is part of the administrative cost the physician/provider is billing for. The one exception is case management monitoring as described in the BHDDA Code Chart appendix section titled Same Time Services Reporting, numbers 11 and 12.	
3/19/21	5/7/21	How did you factor in the units you could no longer bill due other services occurring during that time that required provider staff to be present to help the person implement, yet the provider cannot bill for staffing supports during that time due to the specialty services occurring	CLS cannot overlap with any other services, except for case management monitoring as described in the BHDDA Code Chart appendix section titled Same Time Services Reporting numbers 11 and 12.	

3/19/21	5/7/21	Can we please discuss start/stop times? Per the spreadsheet that was sent out, MDHHS states "Service Verification documentation requirements are determined by the payor. Generally, providers must ensure services are documented in formats that provide sufficient support to assure accurate submissions of claims/encounters." HOWEVER, the Medicaid Provider Manual states "For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin and end time of the particular service." These two statements seem contradictory.	Medicaid Provider Manual rules must be adhered to. State rules supersede local CMHSP/PIHP rules.	
3/19/21	5/7/21	From a compliance and Medicaid encounter verification perspective what documentation is to be expected for each 15-minute unit and each of the potential 15-minute modifiers. Also has the idea of using the preponderance rule been vetted through the OIG and Medicaid as a viable option and could we get a formal response from those agencies as to what they expect to see. As it stands right now, the OIG could get a referral and pull these units and will expect specific documentation for each of these 15-minute units. I believe there are numerous implications from a compliance perspective that need to be looked at as we move forward.	MDHHS works in partnership with the Michigan Office of the Inspector General (OIG) in ensuring compliance with all Medicaid behavioral health service rules and regulations.	
Revised: 5/11/21				

