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February 27, 2025

MEMORANDUM

MEMO NOS.
QI-2505 [Replaces QI-2323A]
CCS-2501 [Replaces CCS-2308A]

TO: QUEST Integration (QI) Health Plans
Community Care Services (CCS)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator JMP

SUBJECT: PLAN STAFF SERVICES REPORTING

This memorandum replaces QI-2323A and CCS-2308A which were issued on December 20, 2023.

The purpose of this memorandum is to provide coding guidance and timeframes for Health Plans to comply with contractual requirements to submit encounter data for "Plan Staff Services". Starting with services incurred in June 2025, plans must begin collecting data June 1, 2025, and begin submitting encounter data no later than July 31, 2025. These encounters will also be reported in the Health Coordination Services (HCS) Report that Health Plans submit to Med-QUEST (MQD) quarterly.

Background:
Plan Staff Services are services that Health Plan employees, or the Health Plan's contractors who perform services on behalf of the Health Plan using the Health Plan's system as if they were a staff extension of the Health Plan, or the Health Plan's contractors who perform services on behalf of the Health Plan using the Health Plan's system as if they were a staff extension of

the Health Plan, provide directly to members. Some examples of Plan Staff Services are care coordination, service coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities.

Currently, Health Plans submit spreadsheets with summarized data regarding these services to MQD, which are used when calculating capitation rates. However, this summarized data does not give MQD sufficient insight into the different services the Health Plans are rendering to our members. To increase transparency into these services rendered, MQD instituted a contractual requirement to submit Plan Staff Services to HPMMIS as encounters. These encounters should represent the services and quantity of services rendered by Health Plan staff to MQD members.

Contract Section 6, Part 6.4, Subpart A, Paragraph 7 (p.281) states:

(*7) The Health Plan shall create claims* and* ***submit encounter records*** *for direct services rendered to beneficiaries by the Health Plan personnel that may otherwise be delegable to providers in the community. Examples of such services include care coordination, service coordination, housing coordination, case management, outreach efforts, medication reconciliation, and quality improvement activities. These costs shall be captured by the Health Plan as part of its general ledger.*

***NOTE**: The requirement above was amended in the 23.1 revision to the Health Plan Manual Part II – Operational Guidance posted on the MQD Health Plan Resources website: https://medquest.hawaii.gov/en/plans-providers/health-plan-resources.html. Health Plans are not required to create a claim or run a claim through their claims processing but will be required to submit encounter records for direct services rendered to members.

Policy Action

Health Plans will begin reporting encounter data for services beginning June 1, 2025, by July 31, 2025.

NOTE: Health Plans will continue to submit the QI Reporting Package, the CCS Reporting Package, and the annual reports for the Milliman Actuaries.

Submission of encounters for Plan Staff Services must meet the Accuracy, Completeness, and Timeliness requirements for Encounter Data Submission. See – QI RFP Section 6.4.C Accuracy, Completeness, and Timeliness of Encounter Data Submission. Since this data may not go through the plans' claims processing process, encounter data for Plan Staff Services must be submitted to MQD monthly, no later than the end of the month following the month in which the service occurred.

If a Health Plan is unable to meet a reporting deadline, they must request a waiver of operational contract requirements from MQD ahead of time. See – QI RFP Section 14.23.G. Health Plan Request for Waiver of Contract Requirements.

The direction below specifies unique encounter guidance for Plan Staff Service encounters; overall Plan Staff Service encounters shall meet all requirements of the 837P HIPAA Standards set out in the ASC_X12 Guide, commonly known as the TR3, in conjunction with the Companion Guide, using the appropriate standard codes, dates, and values to describe the services rendered.

Plans will submit data for Plan Staff Services as follows:

Form Type: Use form type A (837P)

Diagnosis Codes: Health Plans must use diagnosis code Z91.89 - Other specified personal risk factors, not elsewhere classified when submitting Plan Staff Services. No decimal is allowed in the diagnosis code. Diagnosis code Z9189 must be submitted at the detail level to bypass editing. Health Plans may also include any additional diagnoses relevant to the plan staff services provided.

Procedure Codes: Health Plans will use procedure codes aligned to the service the encounter represents. Appendix A below indicates the activities that may be captured and the codes and modifiers that must be used. At this time, Health Plans shall not utilize codes that have not been included in this list.

MQD has worked with Health Plans to identify the various services they provide to members. Health Plans have been provided with individual crosswalks between Health Plan activities and the category that they should be classified within. Plans will determine which activity code is most appropriate within the category. Health Plans may access previously distributed Health Plan-specific crosswalks that help Health Plans map their own care coordination systems to the proposed plan staff service categorizations by emailing the PCG MQD reporting inbox (mqdreporting@pcgus.com). Requests for activities not included in these crosswalks will be reviewed regularly for inclusion and the table below will be updated accordingly.

Appendix A lists each category and activity within that category as well as the codes and modifiers the Health Plans must use when reporting the services in encounter data and in reports to MQD. The list will be a “living” document that will be updated in the QI Health Plan Manual Part IV HPMMIS Technical Guide - Encounters as services are added or removed in the future.

Appendix B is a question-and-answer document containing Med-QUEST's responses to inquiries submitted by the Health Plans. Detailed answers can be found in the attachment. This is a 'living' document that will be updated as more frequently asked questions are addressed. Health Plans must submit additional questions to the PCG MQD reporting inbox (mqdreporting@pcgus.com).

Please note codes for CIS members in memo QI-2314 released as part of the QI reporting package are included in Appendix A and noted as CIS-only. These codes must only be used for CIS members. Alternate codes are provided for non-CIS members who receive similar services.

Submission timing: Health Plans are to submit at minimum one encounter per member receiving plan staff services each month, inclusive of all services provided to the member and the counts of services the member received; while a minimum of one all-inclusive encounter is required, Health Plans may submit as many encounters for plan staff services as necessary. Or in other words, Health Plans may choose to submit encounters as services are rendered, at any cadence that is more frequent than monthly.

Examples of monthly submissions:
If Health Plans use the option of submitting one encounter per member per month that contains all services provided to the member by the Health Plan staff during a calendar month, the following guidance is provided: for a particular service provided multiple times during the month on different dates, the service must be billed on separate lines according to the date on which the service was provided. Review the following table for examples.

Table 1: Example Service Codes Table for One Encounter Per Member Per Month

Monthly Submission Type	Encounter Number	Encounter Line Number	HAWI ID	Service Code	Date of Service (Loop 2400 DTP Segment)	Number of Units (Loop 2400 HCP Segment)	Note
Same Service on Different Days	1234567890	001	123456	H0043	10/24/2025	1	H0043 per diem code, only billable 1x day
	1234567890	002	123456	H0043	10/25/2025	1	
	1234567890	003	123456	H0043	10/26/2025	1	
Multiple Services on Same and Different Days	9876543210	001	123456	T2024	10/24/2025	1	
	9876543210	002	123456	T2022	10/24/2025	1	T2022 monthly code, only billable 1x month
	9876543210	003	123456	H0031	10/24/2025	1	
	9876543210	004	123456	T1016 UA	10/26/2025	4	T1016 UA 15 min incremental, bill to reach full time delivered
Same Service Multiple Times in a Day	5647382910	001	123456	S5130	10/24/2025	4	S5130 15 min incremental, bill to reach full time delivered

The number of units (quantity) must reflect multiples of the same timed service provided on the same day. I n our example, the service is specific to a 15-minute unit. If a member is seen for 1 hour the number of units billed would equal 4.

Therefore, billing the same timed service on a single detail line with the appropriate number of services for the same date of service would avoid duplicate edits, but other limitations may apply. For example, if a service code is limited to twice/day and the quantity submitted is 3, then the 3rd service may result in encounter rejection or pend.

Pricing: A Health Plan must price each service in such a way that the price represents the cost of the service rendered to the member as if the service was rendered by a contracted provider. Allowed amount shall reflect the cost of the service; paid amounts shall reflect the actual amounts the Health Plan paid for the services rendered. Since services are generally rendered by Health Plan staff, paid amount may often but, not necessarily, be $0.00. In these instances, the Health Plan shall populate the CN101 Contract Type Code in Loop 2300 or Loop 2400 with 05 (Capitated). (See Memo QI-2203/CCS-2202).

NOTE: These encounters will be used to clarify the bucketed costs Health Plans currently report in spreadsheets for rate setting and MQD will reconcile the encounter allowed and paid amounts against the bucketed costs. There will be no impact to capitation rate setting based on Health Plan Staff Service Encounters until CY2026 at the earliest.

Provider Information: For encounter submissions use Provider Type 99 and the appropriate HOKU Provider ID from the table below:

Table 2: Provider Information

Health Plan	Provider ID	Provider Name
Aloha Care	833493	ALOHACARE
HMSA	833500	HMSA
Kaiser	833518	KAISER PERMANENTE
Ohana	691156	OHANA HEALTH PLAN
United	691164	UNITED HEALTHCARE

Impact Summary

The immediate, intermediate, and future impacts are outlined below as a quick reference guide.

Immediate: Instructions for Plan Staff Services will be added to the HPMMIS Technical Guide for Encounters for Form A, and a link to the updated Guide will be provided by MQD to the Health Plans via email.

Intermediate: Beginning June 1, 2025, Health Plans must collect data about Plan Staff Services. Health Plans must submit this data as encounters to HPMMIS no later than July 31, 2025.

Future: MQD and its actuaries will reconcile encounters submitted to HPMMIS for Plan Staff Services to the summarized data shared in annual requests for capitation rate setting. There will not be an impact to rate setting based on Health Plan Staff Service Encounters until CY2026 at the earliest. When MQD transitions to using HPMMIS encounters for capitation rate setting, the Plan Staff Services submitted therein will be the source of truth for these costs.

Appendix A: Health Plan Staff Services Activity Codes

Category	Activity	HCPCS Code	Official Description	Modifier Information
Assessments	Assessment (General)	T2024	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	
Assessments	BH Assessment (Brief)	90791	Psychiatric diagnostic evaluation (with no medical services)	
Assessments	MH Assessment	H0031	Mental health assessment, by non-physician	
Assessments	Case Assessment (Behavioral Health Assessment)	H2015 U1	Comprehensive Community Support Service	
Assessments	Home Environment Assessment	T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs	
Assessments	Housing Assessment (CIS members only)	H0044	Supported housing, per month	
Assessments	Housing Assessment (non-CIS members only)	H0043	Supported housing, per diem	
Care Planning	Develop Care Plan	T2024 U1	Service assessment/plan of care development, waiver	
Care Planning	Care Plan Update	0580F	Multidisciplinary care plan developed or updated	

Referrals and Care Management	Care Coordination	T2022	Case management, per month	
Referrals and Care Management	Referrals	T2022 U1	Case management, per month	Modifier is required.
Referrals and Care Management	Psychiatric office visit with Member	99213	Psychiatric office visit with Member, 20-29 mins	
Referrals and Care Management	Psychiatric Diagnosis	90792	Psychiatric Diagnosis Interview Examination/Evaluation	
In Home and Community Services	Homemaker Services or Home Care not otherwise covered	S5130 S5131	S5130 - Homemaker services, nos; per 15 mins S5131 - Homemaker service, nos; per diem	
In Home and Community Services	Install Home Equipment	S5165	Home modifications, per service	
In Home and Community Services	DME Repair	K0739	Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes	NU - New equipment UE - Used durable medical equipment
Care Facilitation	Medication Adherence	S5185	Medication reminder service, non-face-to-face; per month	
Care Facilitation	Monitoring or Initiating delivery of medical supplies	T1505	Electronic medication compliance management device, includes all components and accessories, not otherwise classified	

Care Facilitation	Monitoring or Initiating delivery of durable medical equipment	T2029	Specialized medical equipment, not otherwise specified, waiver	
Care Facilitation	Appointment Reminders and Scheduling	T1016 UA	Case management, 15 mins	Modifier is required.
Care Facilitation	Translation and Interpretation Services	T1013	Sign language or oral interpretive services, per 15 minutes	
Care Facilitation	BH Facilitation	H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	
Care Facilitation	Home Modifications -- Vendor Provided, Health Plan Facilitated	S5165 U1	Home modifications, per service	Modifier is required.
Care Facilitation	Care Gaps	T1016 UC	Case management, 15 mins	Modifier is required.
Care Facilitation	Vehicle Modifications	T2039	Vehicle modifications waiver, per service	
Health Related Social Needs	Provision of medically tailored meals or home delivered meals	S5170	Home delivered meals, including preparation; per meal	
Health Related Social Needs	Non-Emergency Transportation - escort	T2001	Non-emergency transportation; patient attendant/escort	
Health Related Social Needs	Non-Emergency Transportation - trip	T2003	Non-emergency transportation; encounter/trip	
Health Related Social Needs	Non-Emergency Transportation - multi-pass	T2004	Non-emergency transportation; commercial carrier, multi-pass	
Health Related Social Needs	Non-Emergency Transportation - van	T2005	Non-emergency transportation; stretcher van	

Health Related Social Needs	Housing Transition Support Services (non-CIS, non-GHP members only)	T2038	Community transitions, waiver, per service	
Health Related Social Needs	Supplemental Services (clothing, rent, etc.) (GHP members only)	T2038 U1	Community transitions, waiver, per service	Modifier is required.
Health Related Social Needs	Housing Transition Support Services - pre-tenancy/tenancy support (CIS only)	H0044	Supported housing, per month	
Health Related Social Needs	Providing supplies	T2028	Specialized supply, not otherwise specified, waiver	
Health Related Social Needs	Form Assistance	T1017	Targeted case management, 15 mins	
Health Related Social Needs	Employment Assistance (non- CIS members only)	H2023	Supported employment, per 15 mins	
Outreach	Monthly Check-in Calls	T1023 U3	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Modifier is required. Additional modifier 52 must be used for unsuccessful attempts.

Outreach	Preventive Outreach Calls	T1023 U2	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Modifier is required. Additional modifier 52 must be used for unsuccessful attempts.
Outreach	General Outreach Calls (non-CIS members only)	T1023 U1	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Modifier is required. Additional modifier 52 must be used for unsuccessful attempts.
Outreach	General Outreach Calls (CIS members only)	T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Additional modifier 52 must be used for unsuccessful attempts.
Outreach	In Person Visit with Member	H2015	Comprehensive Community Support Service	
Care Transitions	Care Setting Change Facilitation	G9655	Case management, per month	
Care Transitions	Discharge Facilitation	1110F	Case management, per month	
Emergency and Disaster Support	Emergency Response System Installation and Testing	S5160	Emergency response system; installation and testing	
Emergency and Disaster Support	Emergency Response System Fee	S5161	Emergency response system, service fee per	

			month (excludes installation and testing)	
Emergency and Disaster Support	Emergency/Disaster Response	T1023 CR	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Modifier is required.
Disease Prevention and Management & Education	Nurse-line Calls	S0320	Telephone calls by a registered nurse to a disease management program member for monitoring purposes, per month	
Disease Prevention and Management & Education	Member Education	S9445	Patient education, not otherwise classified, non-physician provider, individual, per session	
Disease Prevention and Management & Education	Disease Management Program	S0317	Disease management program; per diem	
Disease Prevention and Management & Education	Disease Prevention	S0317	Disease management program; per diem	
Disease Prevention and Management & Education	Parenting Education and Support	S9444	Parenting classes, non-physician provider, per session	

Appendix B: Health Plan Staff Services (HPSS) Question and Answer Document

Question #1a: S5160, S5161 are provided by a vendor, not HP staff. Since this is submitted via claims, is MQD interested in Health Plans reporting the authorization of such services?

> **Answer #1a:** If services are submitted as claims, the Health Plan should not submit additional 'HPSS Encounters,' as this would lead to duplicate information. We expect the processed claim to be submitted into MQD's encounter system and request the Health Plan to confirm that this process is occurring as expected. The review and approval of a prior authorization request is not considered a health plan staff service; rather, this is a health plan administrative function.

Question #1b: If MCO has a sub-capitated third-party provider (paid PMPM) that does behavioral health assessments. The service is tracked in the same system (and will be in the upcoming new system) confirming that these should be included since they are not otherwise represented by encounter data today.

> **Answer #1b:** When a Health Plan subcontracts a Vendor to deliver services on the Health Plan's behalf and use the Health Plan's system to document these services—essentially acting as an extension of the Health Plan staff—it is both appropriate and necessary to report these services to MQD using the Health Plan's provider ID under HPSS. However, if the Vendor operates independently, such as by using its own system to provide services and submitting member data to the Health Plan, then the Vendor is considered a separate provider and must obtain its own Provider ID.

Question #2: There are services listed in Appendix A that are provided by a HOKU registered provider, not HP staff. Could you confirm that as long as we're submitting encounters for those services, no additional information is required?

> **Answer #2:** Yes, if a provider provides a particular service and submits claims to the Health Plan, MQD anticipates that the adjudicated claims will be submitted as encounter data. In these cases, submitting a second encounter for the same service under HPSS would be duplicative. It's also important to note that HPSS encounter guidance applies specifically to Health Plan-provided services that are not otherwise reported to MQD through encounters.

Question #3: Is the State willing to modify the submission date requirements to accommodate encounters that will flow through our Claims adjudication system? The date requirements in the memo states that services provided must be submitted no later than the month following the month that the services were rendered. I'm assuming that this variance from the standard

rule of submitted no later than the month following payment was to address these services not being adjudicated through a claims system. The MCO's implementation of this requirement is to utilize our claims system to consume and process the plan services. The claims adjudication system is configured to handle possible variables that could occur (ex. adjusting/reversing claims, duplicate editing, procedure/diagnosis code editing). Due to the nature of the adjudication system, the payment of a claim may take longer than expected and may not meet the timeliness requirements.

> **Answer #3:** A waiver request should be submitted to MQD quoting the specific requirement the Health Plan is requesting an exception for. In general, for Health Plans who intend to process HPSS through their claims systems, standard encounter data submission guidelines described in the QI Contract will apply (see Section 6.4.A.11).

Question #4: Is MQD expecting a health plan to submit at least one encounter for each member enrolled in health plan for each calendar month which could include the activity of trying to contact a member who does not answer the outreach attempt?

> **Answer #4:** MQD expects the health plan to submit at least one encounter per member who received any type of HPSS in the calendar month (rather than one encounter per enrolled member, regardless of whether any HPSS were provided). Outreach activities are considered HPSS, and health plans should document the outreach attempt even if the member did not respond. Modifiers have been included in this memo to allow Health Plans to differentiate between attempted and successful outreach efforts.

Question #5: There doesn't seem to be a column to specify exactly which Lines of Business (QI-CCS) can be submitted for the Procedure codes allowed. Is that something you can possibly add or validate with us prior to us creating coding? Or can the codes be used interchangeably for both QI and CCS?

> **Answer #5:** Codes can be used interchangeably for both QI and CCS.

Question #6: Page 3 of the memo referenced a Health Plan crosswalk in August. We received a draft, however we did not receive a finalized one after submitting questions. Do we use the draft one or will there be a finalized one sent to us?

> **Answer #6:** A finalized version was provided to the Health Plans; please reach out to mqdreporting@pcgus.com if the Health Plan needs another copy. If Health Plans would like to add or report further health coordination activities, they should do their best to align new services to existing codes and categories. If the Health Plan believes they are offering a service that is not captured by the existing list, please contact mqdreporting@pcgus.com.

Question #7: For 90791 BH Assessment: Is this the PHQ-2 or PHQ-9?

Answer #7: This is intended to be a general code for any BH assessment, including those you have noted.

Question #8: For H0031 MH Assessment: Would this include the rHFA?

Answer #8: The rHFA is reassessment HFA. Health Plans are to classify this in the general assessment category. There is no need to differentiate reassessment from initial assessment.

Question #9: Please provide a definition for the time/duration elements listed below. *Per encounter, *Per month, *Per diem, *Per session. For ex S0317: Could MQD clarify per diem and how best to submit that service?

Answer #9: Per Encounter – each time the recipient is "encountered". A visit or a phone call could be an encounter.

Per Month – specific service covers the whole month. Units billed would be one (1), regardless of how many times during the month the recipient is seen. The payment covers the entire month.

Per Diem – means per day. Units billed would be one (1), regardless of how many times during the day the recipient is seen. The payment covers the entire day. For S0317, regardless of the time the recipient is seen, say 2 or 4 hours, S0317 would be billed with a quantity of 1 for the DOS.

Per Session – for example, a training session – could last 30 minutes or an hour. Regardless of the amount of time, the units billed would be one (1).

Question #10: T1023 U1 and T2024 have different activity descriptions but the same official description - could you confirm the difference. Is T1023 U1 screening for appropriateness vs T2024 is completing an assessment to determine appropriateness?

Answer #10: Screenings are a short questionnaire, used to quickly determine the need for further assessment (T1023 U1).
Assessments are longer surveys or forms which obtain a more comprehensive view of a member (T2024).
The difference is the Category under which each code falls.

T2024 is in the Assessment Category. This would be a face-to-face service.
T1023 U1 is in the Outreach Category. This is a General Outreach Call.

If any outreach call results in an assessment being conducted, then both procedure codes would be submitted in the encounter.

Question #11: T1023 U2 and T2024 have different activity descriptions but the same official description - T1023 U2 is outreach calls, T2024 is the assessment- could you clarify the distinction between the two?

Answer #11: The difference is the Category under which each code falls.

T2024 is in the Assessment Category.
T1023 U2 is a Preventive Outreach Calls.

The modifier is what makes the code mean General Outreach Call to the HPMMIS, as opposed to the U2 modifier which indicates Preventive Outreach Calls.
If an outreach call results in an assessment, both procedure codes would be billed.
Additionally, if outreach is required to complete an assessment, both procedure codes would be billed.

Question #12: For T2001, T2003, T2005 - these are currently codes that are sent via encounters today. In the activity description there is a parenthetical reference to LTSS members only. These codes are inclusive of LTSS and non-LTSS members today - how does MQD want us to send these services moving forward?

Answer #12: The distinction for LTSS and non-LTSS was removed.

Question #13: For T2004: Can you confirm what "multi-pass" means? Is this like a bus pass or Handivan vouchers?

Answer #13: Multi-pass refers to a multi-passenger vehicle, so a van or bus that picks up multiple recipients to transport to each one's appointment. A bus pass or Handivan voucher would count as a multi-pass.

Question #14: For T2004 do we need pick-up and drop-off location? i.e., Handivan. What about bus pass?

Answer #14: Please follow the requirements specified in QI-2117/CCS-2107.

Question #15: T2022 - Is this for CCMA monthly case management? Or a monthly encounter for HC case management of member?

> **Answer #15:** All procedure codes in the HPSS memo apply to services provided by Health Plan staff. Code T2022 falls under the 'Referrals and Care Management' category, with the activity type 'Care Coordination,' which includes any Health Plan-led or Health Plan-contracted case management on a monthly basis. Code T2022 U1 is also in the 'Referrals and Care Management' category, but it specifically pertains to the activity type 'Referrals'. Please review the response to question #1b for when Health plan contracted case management should be submitted as a HPSS.

Question #16: For T2024 Assessment (General): Would this be the Health and Functional Assessment (HFA)? Our screeners also do an assessment, would this be both? In other words, would this be any type of assessment that is done?

> **Answer #16:** T2024 covers any assessment not specifically listed elsewhere in the HPSS memo. It falls under the 'Assessments' category, with the activity type 'Assessment (general)' The HPSS memo outlines a total of six specific assessments. If none of these specific assessments are appropriate, the general assessment code T2024 should be used.

Question #17: How should welcome calls be coded? How about specific call campaigns like COVID/Flu Shot calls?

> **Answer #17:** Welcome calls: - T1023 U1, Special Projects: T1023 U2 Preventive Outreach Calls (for special call campaigns like COVID/flu shots).

Question #18: Are MCOs supposed to report all services the plan staff provided or map only services to the code based on the unit restrictions? Example: Our staff member provided a service mapped to H0044 (per month) on April 3, 2024. They also provided a service mapped to H0044 on April 16, 2024 for the same member. How should we treat the service provided on April 16, 2024?

> **Answer #18:** For codes with unit restrictions such as H0044, please follow the unit restrictions. In this example, please report this code just once per month per member who receives the services.

Question #19: If there are activities or multiple activities that map to a specific code that is defined as "Per Service", how does the time spent on the activity equate to the units of service on the encounter and how does the multiple activities that could occur on the same day impact the units.

Answer #19: MQD understands and appreciates that a procedure code that is labeled as "per service" indicates that all activities that fall under the description would be included and billed as a single unit of service. Multiples of the same code, that does not indicate per service, would be billed according to the number of minutes included in the total time. See example in the memo labeled "Same Service Multiple Times in a Day".

Question #20: For codes that are linked to assessments or activities that can potentially span over 1 DOS - does MQD want these submitted based on completion or as the activity occurred (i.e., HFA done over a period of time).

Answer #20: For codes that are linked to assessments or activities that can potentially span over 1 DOS, please use record this activity on the date the activity was completed. If an assessment is completed over 1 DOS, HPs may demonstrate this by accounting for 3 outreach attempts in addition to capturing the assessment completion.

Question #21: What encounter data quality measures will be implemented on the MQD side? Example, will MQD monitor the number of units being submitted?

Answer #21: MQD has no experience receiving detailed HPSS data, and at this time, the information will be used by MQD to learn about these services at a greater depth from Health Plans. As such, we will monitor the data, but do not have any pre-conceived notions as to what to expect. Our goal at this time is to establish accuracy in reporting.

Question #22: How are MCOs to develop a fee schedule?

Answer #22: The health plans should evaluate the cost of these services using methods available to the health plans.

Question #23: How do the services and units in this memo crosswalk to the following services in the HCS report: Face-to-face hours the member spent with anyone on the health coordination team, Telehealth video touchpoints the member had with anyone on the health coordination team, Telephone (no video) touchpoints the member had with anyone on the health coordination team, Comprehensive Care Management services, Care Coordination Services, Health Promotion Services, Comprehensive Transitional Care Service, Individual and Family Support Services, Referral to Community/Social Support Services.

Answer #23: The HPSS and HCS report are not directly correlated at this time as we have not cross walked the HCS report to these specific service categories.