Administrative Uniformity Committee

Streamlining Health Care Administrative Transactions in Minnesota

AUC EXECUTIVE COMMITTEE AGENDA
May 6, 2013 8:30 – 10:30 a.m.

Teleconference line: 1-605-475-5950
Participant passcode: 337213

WebEx instructions:

1. To start the WebEx session, go to: https://health-state-mn-ustraining.webex.com
2. Under "Attend a Session," click "Live Sessions"
3. Click on the session for "AUC Executive Committee"
4. Provide your name, email address, and the following password: Exc2010! (Note: The exclamation mark at the end is part of the password.)
5. Click "Join now"

The purpose of this meeting is to discuss follow-up task from AUC Ops March 12 meeting and to prepare Agenda for June 11, 2013 AUC Ops meeting.

Meeting Objectives:

- Develop June 11, 2013 Operations Committee agenda
- Review charge statement for HPID TAG and determine next steps
- Determine AUC TAGs for 2013 priorities
- Review SBAR process

Agenda items

1. Meeting to order – Keri Silvernagel
2. Anti-trust statement
3. Approve March 4, 2013 and April 1, 2013 meeting minutes – Keri Silvernagel

4. Acknowledgment PowerPoint Best Practice
5. Claims Best Practices Revisions
    a. Submission of Appeals Best Practice
    b. Replacement/Void Claims Best Practice
    c. Claims Attachments Best Practice
    d. Examples of NTE and PWK Usage
6. Follow-up from last AUC Exec meeting on April 1
7. SBAR status and update
8. Review of SBAR Responses
    a. Medical Code TAG
    b. Claims DD TAG
9. Brief update on any recent TAG activity and plans
10. Review of TAGs
11. Other Business

Next Meeting –
June 3, 2013
8:30-10:30 a.m.
Teleconference / WebEx only

Claim and Remittance

ACKNOWLEDGMENTS BEST PRACTICE

Prepared by the Minnesota Administrative Uniformity Committee (AUC)

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), Version 5010.

For more information, please see the AUC website, at:
www.health.state.mn.us/auc

Take aways

- Minnesota has requirements in law and rule for the standard, electronic exchange of several common health care administrative transactions
  - Includes acknowledgements
- This best practice is not required, but is highly encouraged to obtain the maximum value from acknowledgments
- This best practice:
  - Explains several important types of acknowledgments
  - Recommends how to use them in practice, according to a variety of scenarios
- Additional information is available at:
  - www.health.state.mn.us/auc
  - www.health.state.mn.us/asa

Contents

I. Best Practice Overview

Best Practices are …

- …Important to help reduce health care administrative burdens and costs.
  - This best practice is one of a series published as part of Minnesota's initiative to reduce health care administrative costs by bringing about more standard, more automated exchanges of common health care business ("administrative") transactions.
- …Used in conjunction with other standards and Minnesota and federal regulations.
  - Adherence to Minnesota's best practices is not required, but is strongly encouraged.

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Best Practices are …

- …. Developed as consensus recommendations by the Minnesota Administrative Uniformity Committee (AUC).
  - The AUC is a large, voluntary, multi-stakeholder organization comprised of providers, payers, associations, and state agencies working together to reduce health care administrative costs and burdens.

For more information, including applicable state statutes and rules, the AUC, and other information, see www.health.state.mn.us/auc and www.health.state.mn.us/asa.

Summary of this Best Practice

Title	Claim and Remittance Acknowledgments Best Practice
Applies to:	Health care providers, group purchasers (payers), clearinghouses and other interested parties
Topic and focus:	Minnesota has enacted requirements for the standard, electronic exchange of acknowledgments when receiving health care claims or remittance advices. This best practice recommends which acknowledgments to use in a variety of situations.
Description:	This best practice illustrates the recommended exchange of acknowledgment transactions through a number of scenarios. The scenarios are not exhaustive, but illustrate many of the most common situations to be addressed.

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.** For more information go to: www.health.state.mn.us/auc.

II. Minnesota Regulations

Minnesota Statutes, Section 62J.536

- Minnesota requires the standard, electronic exchange of several health care business transactions, pursuant to Minnesota Statutes, section 62J.356 and related rules.
  - For more information see www.health.state.mn.us/asa
  - For additional summary information regarding requirements specific to acknowledgments, see the following two slides.

Requirements to provide acknowledgments

Beginning January 1, 2012, all health care providers, health care clearinghouses, and group purchasers must provide an appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction.

Minnesota Session Laws 2012, Chapter 253, Article 1, section 2 (https://www.revisor.mn.gov/laws/?id=253&year=2012&type=0)

Requirements to provide acknowledgments (cont.)

The acknowledgment provided must be based on one or more of the following American National Standards Institute, Accredited Standards Committee X12 standard transactions or National Council for Prescription Drug Program (NCPDP) standards:

1) TA1;
2) 999; or
3) 277CA; or
4) the appropriate NCPDP response standard as the electronic acknowledgment. …

Minnesota Session Laws 2012, Chapter 253, Article 1, section 2 (https://www.revisor.mn.gov/laws/?id=253&year=2012&type=0)

Requirements for tracking mechanisms

Health care clearinghouses. (a) Beginning January 1, 2012, health care clearinghouses must use and make available suitable tracking mechanisms to allow health care providers and group purchasers to determine in a timely fashion that health care claims or equivalent encounter information transactions and health care payment and remittance advice transactions were delivered to their intended final destination. …

Minnesota Statutes, section 62J.536, Subd. 4
https://www.revisor.leg.state.mn.us/statutes/?id=62J.536

III. Acknowledgement Transactions

Sources

- The information in the following slides is based on ASC X12 TR3 Implementation Guides for Acknowledgments TA1, 999 and 277CA

Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.

Appendix B – “B.1.1.5.1 Interchange Acknowledgment, TA1” and

Appendix C – “TA1 – Interchange Acknowledgment”

Implementation Acknowledgment (999) 005010X231.

Washington Publishing Company, June 2007. <http://www.wpc-edi.com>.

Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.

“1.3.2 Other Usage Limitations”

Implementation Acknowledgement (999), 005010X231.

Washington Publishing Company, June 2007. <http://www.wpc-edi.com>.

Sources (cont.)

Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.

"IK5 – Transaction Set Response Trailer" and "AK9 – Functional Group Response Trailer"

Implementation Acknowledgement (999), 005010X231.

Washington Publishing Company, June 2007. <http://www.wpc-edi.com>.

Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N.

"1.4 Business Usage"

Health Care Claim Acknowledgement (227), 005010X214.

Washington Publishing Company, January 2007

<http://www.wpc-edi.com>.

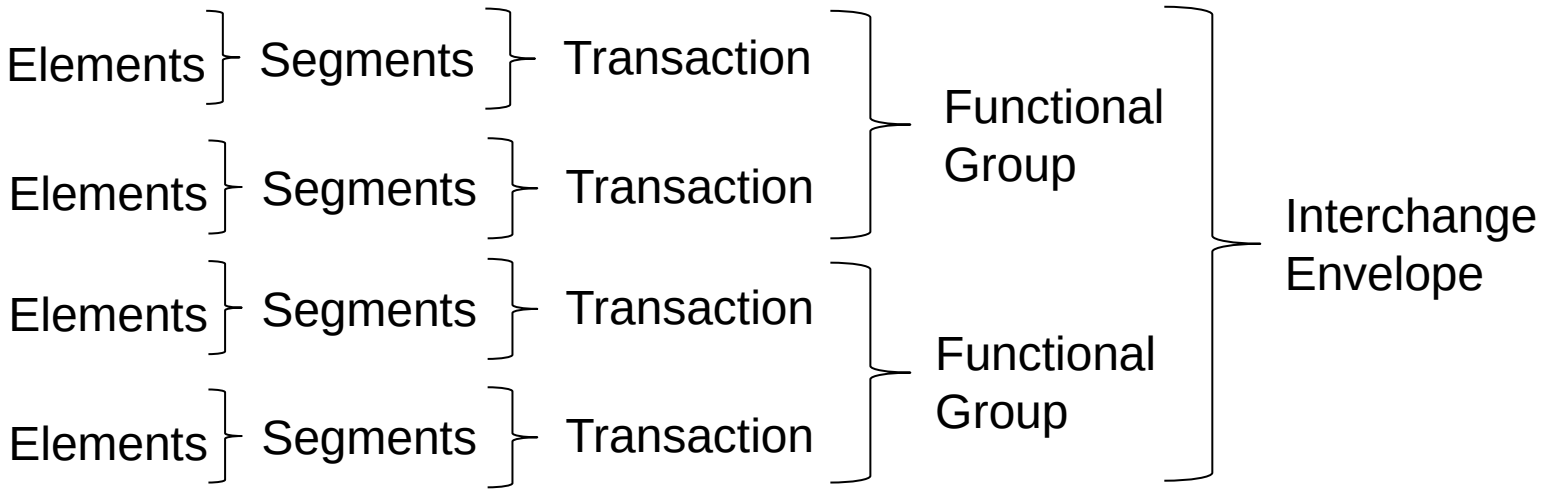
– This information is cited by using an abbreviated version of the information source(s) where applicable, and a list of the works cited in their complete, more detailed form at the end of this slide presentation.

Business Purpose

Acknowledgements are used in the exchange of transactions to:

- ❑Report Syntax Errors
- ❑Report HIPAA TR3 (Guide) Errors
- ❑Acknowledge Receipt
- ❑Accept or Reject

Reminder -- Nomenclature



Different acknowledgments are used to provide different levels of information.

Types of Acknowledgements per Minnesota requirements

Type	Name	Purpose
Delivery Acknowledgement	**TA1** (Interchange Acknowledgment)	• Explains Envelope Compliance and Acknowledgement Click TA1 details for TA1 description.
Syntax and HIPAA TR3 Response Acknowledgement	**999** (Implementation Acknowledgment)	• X12 Standard Compliance • Implementation Guide Compliance (HIPAA TR3) Click 999 details for 999 description.
Business Application Acknowledgement	**277CA** (Claims Acknowledgement)	• Pre-Adjudication Only Click 277CA details for 277CA description
This table was taken from		

TA1

Source: Slides 19 through 22 based on or adapted from 005010X231

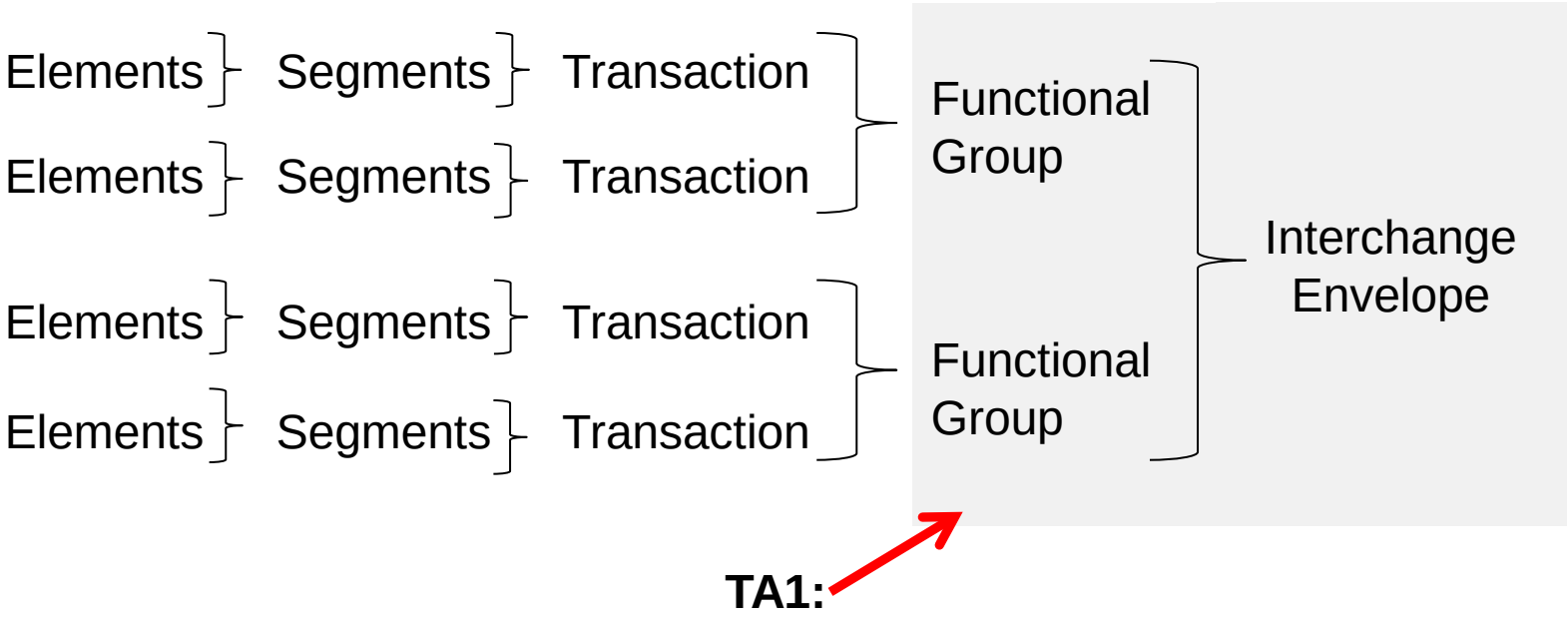
- *Interchange Business Purpose*
  - The TA1 verifies the envelopes only (whether the envelope was received).
    - The TA1 segment provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure.
    - The TA1 will be used to report the status of processing a received interchange header and trailer (ISA-IEA). It will either indicate that the interchange is accepted or rejected.
  - When a TA1 is received and it rejects:
    - You will need to correct and resubmit the entire ISA –IEA Interchange

TA1

- Interchange Business Purpose (cont.)
  - The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure.
  - A TA1 can be included in an interchange with other functional groups and transactions.
  - The X12 Implementation Guide (TR3) states that the TA1 is required to be sent when requested by the sender (as indicated in the ISA14 of the submitted interchange), or when an interchange is rejected.

Return to Table

TA1



- Indicates whether an envelope (functional group or interchange level) was received and any errors.
- Reports on whether envelope data such as the interchange control number, interchange date and time stamp, and other summary data are consistent and correct.
- Does not provide information at the transaction, segment, and element levels.

TA1

- Usage Recommendations:
  - This best practice recommends that the **receivers only send the TA1 when the interchange is noncompliant and is rejected**.
  - It is recommended that **senders of transactions set the ISA14 to zero** knowing that a TA1 will arrive if the Interchange is rejected.
    - When the Interchange is valid the sender will receive an appropriate acknowledgment (999 and/or 277CA) to verify receipt.

999

Source: Slides 23 through 27 based on or adapted from 005010X231 2

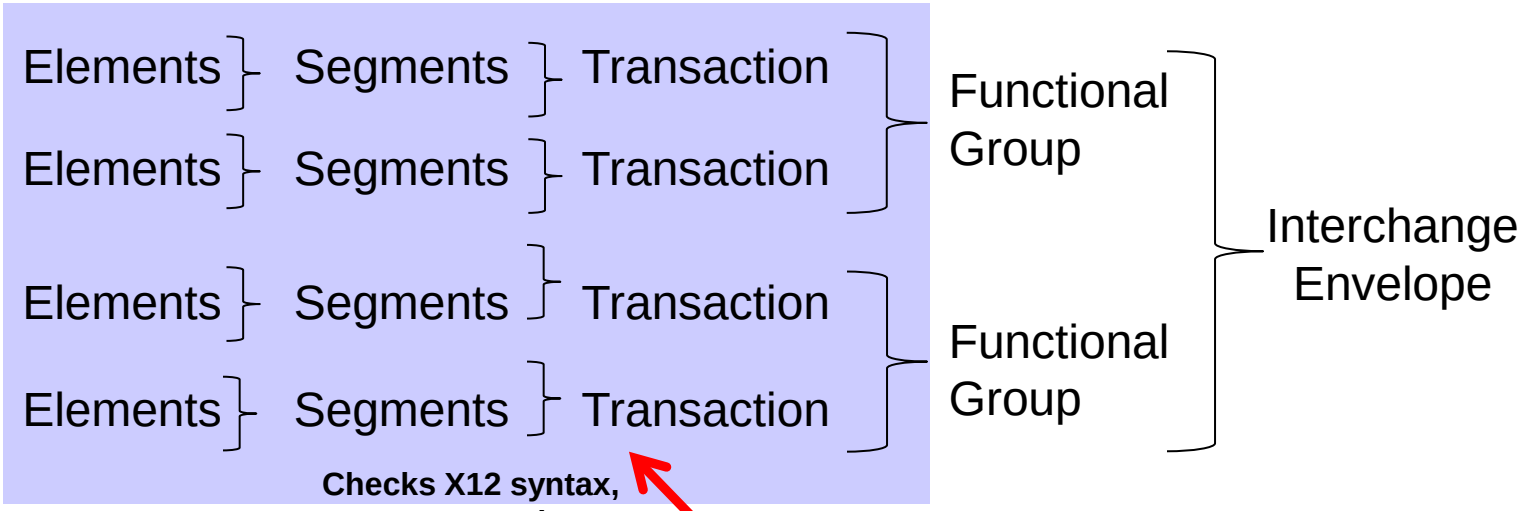
- Business Purpose
  - The 999 reports the results of the X12 syntactical analysis, plus the results of the HIPAA TR3 semantic analysis
  - The 999 replaces the 997 transaction.
    - It is not compliant to use a 997 to acknowledge HIPAA TR3s
      - See formal interpretation from X12 at: http://www.x12.org/subcommittees/x12rfi.cfm
    - Minnesota law requires use of the 999
      - Minnesota Session Laws 2012, Chapter 253, Article 1, section 2 (https://www.revisor.mn.gov/laws/?id=253&year=2012&type=0)

999

- Business Purpose (cont.)
  - This 999 implementation guide can NOT be used for any application level validations.
  - The ASC X12 999 transaction set is designed to respond to one and only one functional group (i.e. GS/GE), but will respond to all transaction sets (i.e. ST/SE) within that functional group.
  - When a 999 has a disposition of “accepted” this means the submitted file has completed syntactical and semantic edits only.
    - It does not mean that the file or units of work were accepted for processing.

Return to Table

999



999:

- Indicates whether information in an envelope meets the X12 Implementation Guide requirements (“syntax requirements”, “semantic requirements”)
- Checks for 13 types of errors at the segment level:
  - E.g., *“Required Segment Missing”; “Segment Not in Proper Sequence”; “Segment Has Data Element Errors”, and others*
- Checks for 18 types of errors at the data element level:
  - *E.g., “Required Data Element Missing”; “Invalid Character In Data Element”; “Too Many Data Elements”; and others*

999

Types of 999s	
A = Accepted	• This code value can only be used if there are no AK2 loops or all AK501 values = 'A'.
E = Accepted with Errors	• The transaction set is accepted but there are errors which are reported in the AK2 loop of the 999. – The AK2 loop will identify which transactions within a functional group contained errors, but were forwarded for further processing.
P = Partially accepted	• Partially accepted, at least one transaction set was rejected
R = Rejected	• The transaction set is not accepted and the errors will be reported in the AK2 loop of the 999. – This loop will identify which transactions within a functional group contained errors, and will NOT be forwarded for further processing. – Corrections will need to be made and the transaction resubmitted.

The table above presents 999 acknowledgment codes illustrating accept or reject conditions based on the syntax editing of the transaction set or functional group (005010X231).

999

- Usage Recommendations:
  - A 999 will be sent from a receiver to a sender only if the sender uses a v5010 X12 transaction format.
    - There is no way to send a 999 from a CH to a sender if the sender submits another format.

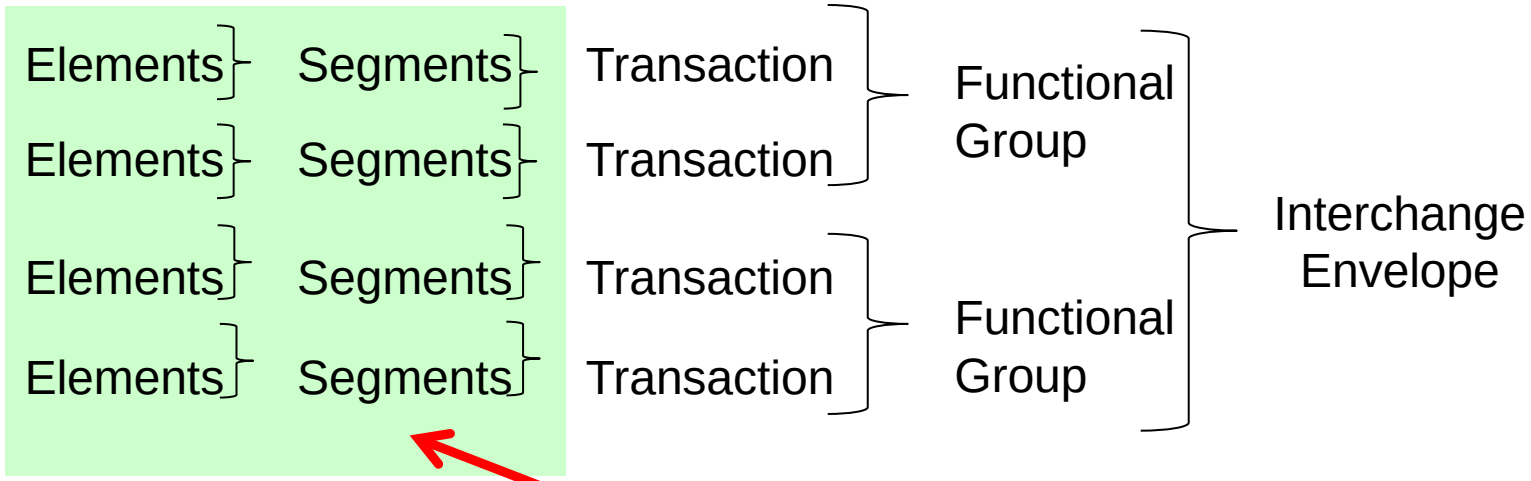
277CA

Source: Slides 28 through 30 based on or adapted from 005010X214 4

- Business Purpose
  - Acknowledges the validity and acceptability of claims at the pre-processing stage
  - Indicates Accepted or Rejected into the adjudication system (not pended)
  - This transaction is instrumental in tracking claim submissions through to payer adjudication.
  - The 277CA will be used to replace proprietary error reporting

Return to Table

277CA



277CA:

- Is the only notification of pre-adjudication claim status.
- Reports errors such as:
  - "missing the rendering provider number"; "source of payment (claim filing indicator) was not valid"; "date of service was either missing or invalid"; "claim was submitted to the wrong payer";
- Does not report final adjudication of claims.
  - Claims passing the pre-adjudication editing process are forwarded to the claims adjudication system and handled according to claims processing guidelines. Final adjudication of claims is reported in the 835.

277CA

- Business Usage
  - The 277CA should be created by the receiver of the 837 transaction set to acknowledge units of work.
  - Acknowledgment responses can be at the transaction set, provider, or claims/encounter, dependent upon whether or not it is accepted or rejected.

Addressing Problems/Errors – General Guidelines

Type of Problem/ Error	Acknowledgement to use	Follow-up/Action to be Taken
Technical Problems	Generally, **use the TA1 or 999 to reflect technical problems** that must be addressed by changes in the software used in preparing the EDI transmission.	• These problems will likely be addressed by technical resources to identify corrections needed before resubmission.
Data Problems	The **277CA reflects a data problem** that must generally be addressed by resources in the Provider office.	• Provider staff will likely need reports to be produced using the 277CA transaction in order to identify corrections before resubmission. • Clearinghouses and Vendors may consider offering a 277CA reporting capability.

Addressing Problems/Errors – **999**

Acknowledgment	Actions
When a 999R (Rejected) is received	• Recognize that syntax/guide errors occurred and begin a correct/resubmit action.
When a 999E (Accepted with Errors) is received	• While all transactions were accepted, recognize that there were errors and they should be corrected before your next submittal; • Watch for additional acknowledgment detail for claim submissions on the 277CA .
When a 999P (Partial) is received	• Correct the transaction in error and send back all data within the ST-SE that rejected.

Note: The receiver of a 999 does not respond with another 999 acknowledgement because the 999 does not require any additional acknowledgments.

Addressing Problems/Errors - **277CA**

Acknowledgment	Action
When a 277CA is received [with errors]	• Recognize that business rule errors occurred and begin a correct/resubmit action on specific units of work; • Recognize that each claim level (CLM) unit was either accepted or rejected; • You may receive a claim number (ICN) in the REF (1K) segment that is to be used in future claims inquiries.

Note: It is recommended that a receiver of a 277CA send a 999 to acknowledge receipt.

Quick recap – Recommended usage best practices

- Only send the TA1 when the interchange is noncompliant and is rejected
  - Senders of transactions set the ISA14 to zero
- When possible, when receiving a claims transaction, send both the 999 and the 277CA
- Also --
  - Acknowledge a 277CA with 999
  - Do not acknowledge a 999 with another 999 (to avoid endless looping of acknowledgments)
- See scenarios in the following section for examples

IV. Acknowledgement Scenarios

Introduction to Best Practice Scenarios

- The following scenarios do not depict all flows or acknowledgments that may occur in the exchange of transactions.
- The intent of the depicted flows is to provide a best practice model to be used when planning your acknowledgment process.

837 Claims Acknowledgement Scenarios

Acknowledgement Scenarios for Claims (837)

Scenario	Transaction	Claim Status
Scenario A (slide 38)	Provider to Payer (X12)	No Errors
Scenario B (slide 39)	Provider to CH (proprietary), CH to Payer (X12)	No Errors
Scenario C (slides 40-42)	Provider to CH (proprietary), CH to CH (X12), CH to Payer (X12)	No Errors
Scenario D (slide 43)	Provider to CH (proprietary), CH to Payer (X12)	Accepted with Errors

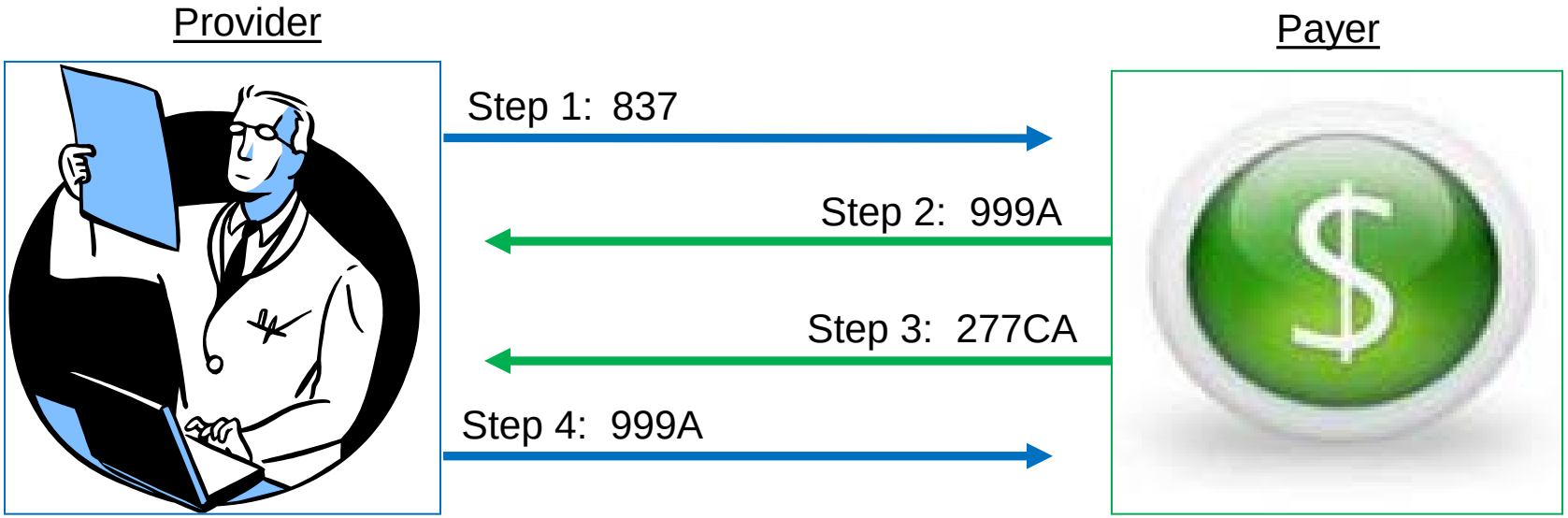
More to follow …

Table 1: Acknowledgement Scenarios for Claims (837)

Test Case	Transaction	Claim Status
Scenario E (slide 44)	Provider to Payer (X12)	Errors on First Transaction But Not Second Transaction
Scenario F (slide 45)	Provider to Payer (X12)	Errors on First and Second Transaction
Scenario G (slide 46)	Provider to CH, CH to Payer (X12)	With Errors

Scenario A:

Provider submits claim directly to Payer – No Errors



Step 1: Provider submits 837 claim directly to Payer, in compliant electronic format.

Step 2: Payer acknowledges transaction set has completed ST/SE edits and sends 999A to Provider. (As per slide 16 recommendation above, the TA1 should only be sent when the interchange is noncompliant and the transaction is rejected.)

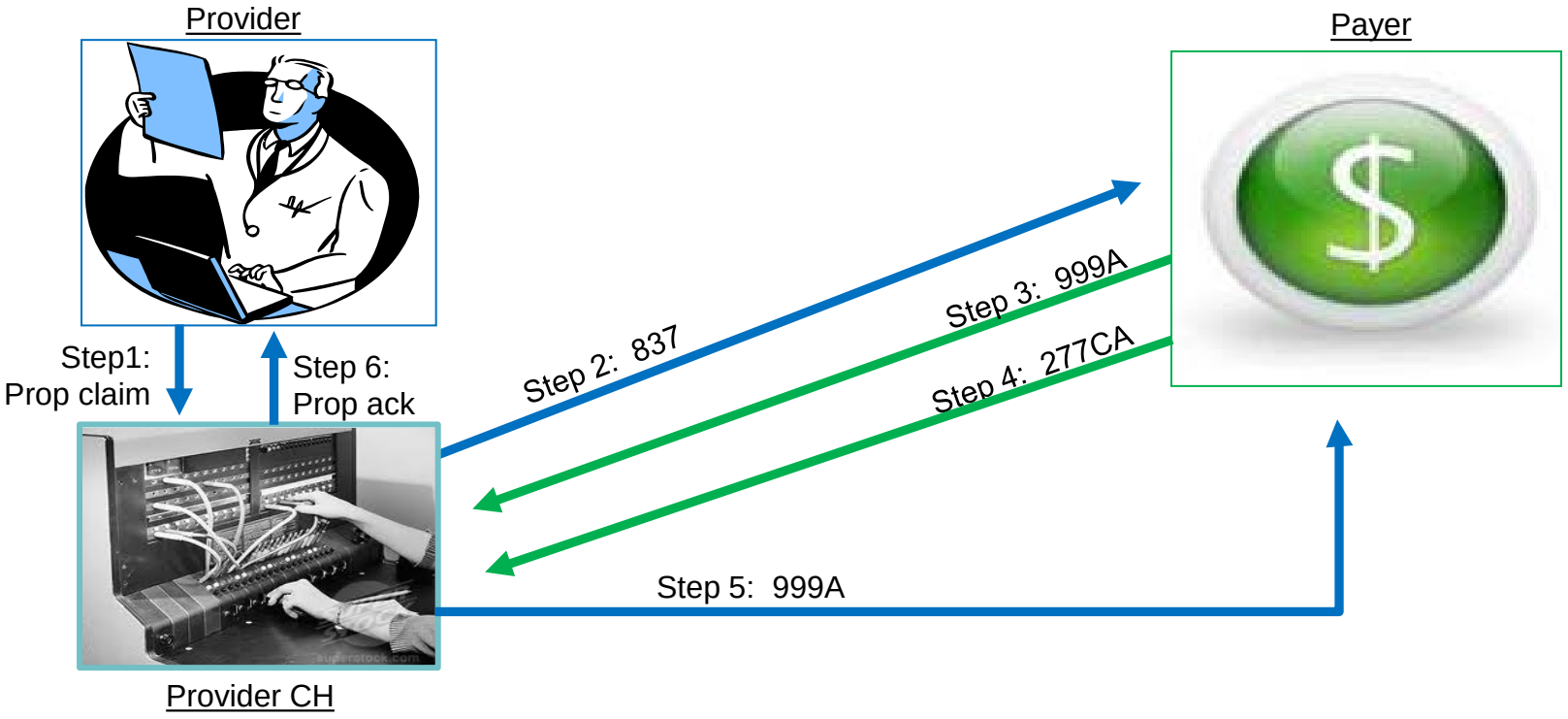
Step 3: Payer also sends Provider 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

Step 4: Provider acknowledges 277CA and sends 999A. (Per slide 26 above, it is recommended that a receiver of a 277CA send a 999.)

Return to Table 1

Scenario B:

Provider to CH (proprietary), CH to Payer (X12) – No Errors



Step 1: Provider submits proprietary claim format to its Clearinghouse.

Step 2: Provider's Clearinghouse creates compliant electronic 837 and sends to Payer.

Step 3: Payer acknowledges transaction set received and sends 999A to Provider's Clearinghouse.

Step 4: Payer also sends Provider's Clearinghouse 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

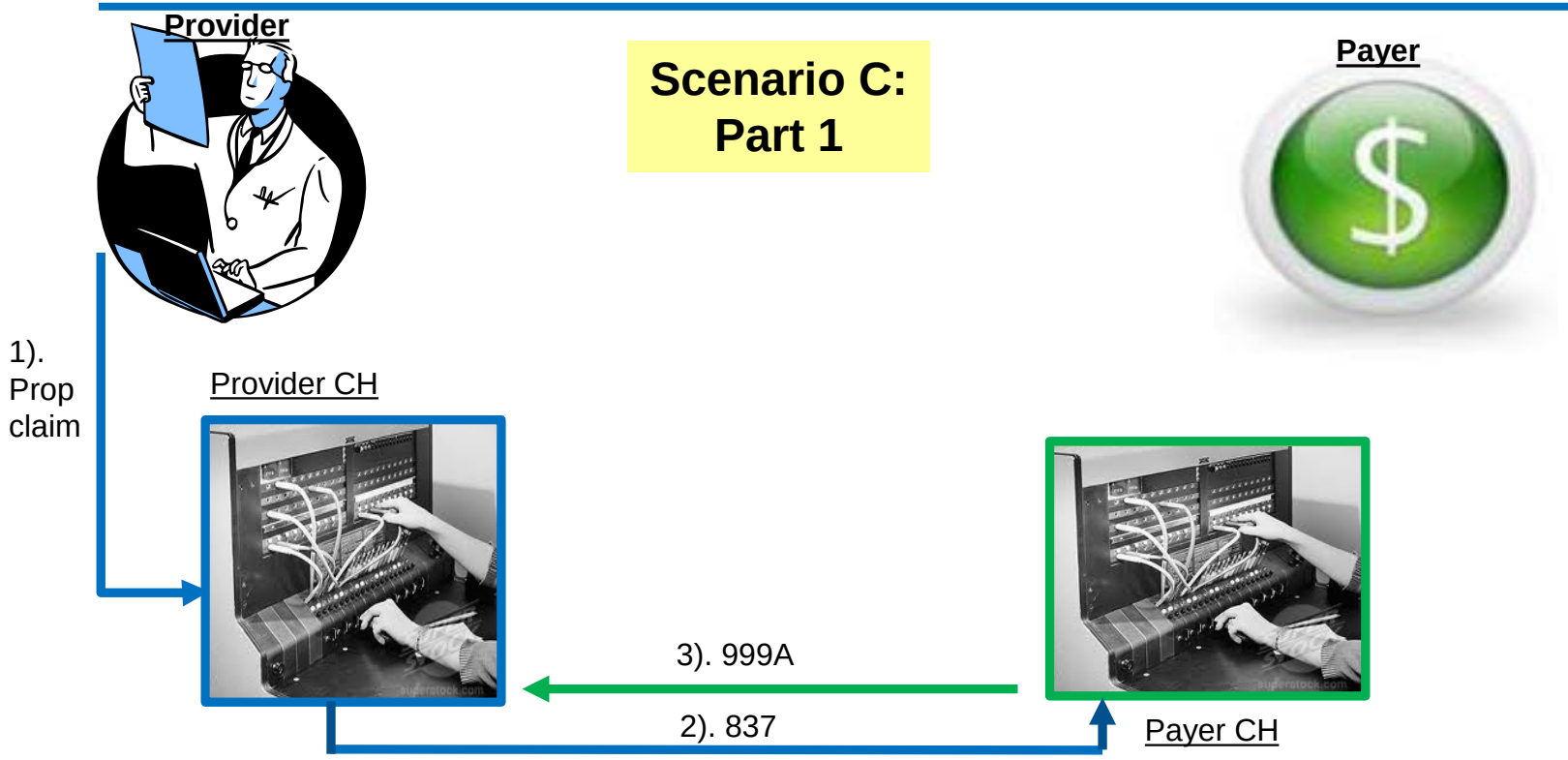
Step 5: Provider's Clearinghouse acknowledges 277CA and sends 999A to the Payer.

Step 6: Provider's Clearinghouse sends proprietary acknowledgment to Provider.

Return to Table 1

Scenario C: Provider to Provider CH, Provider CH to Payer CH, and Payer CH to Payer – No Errors

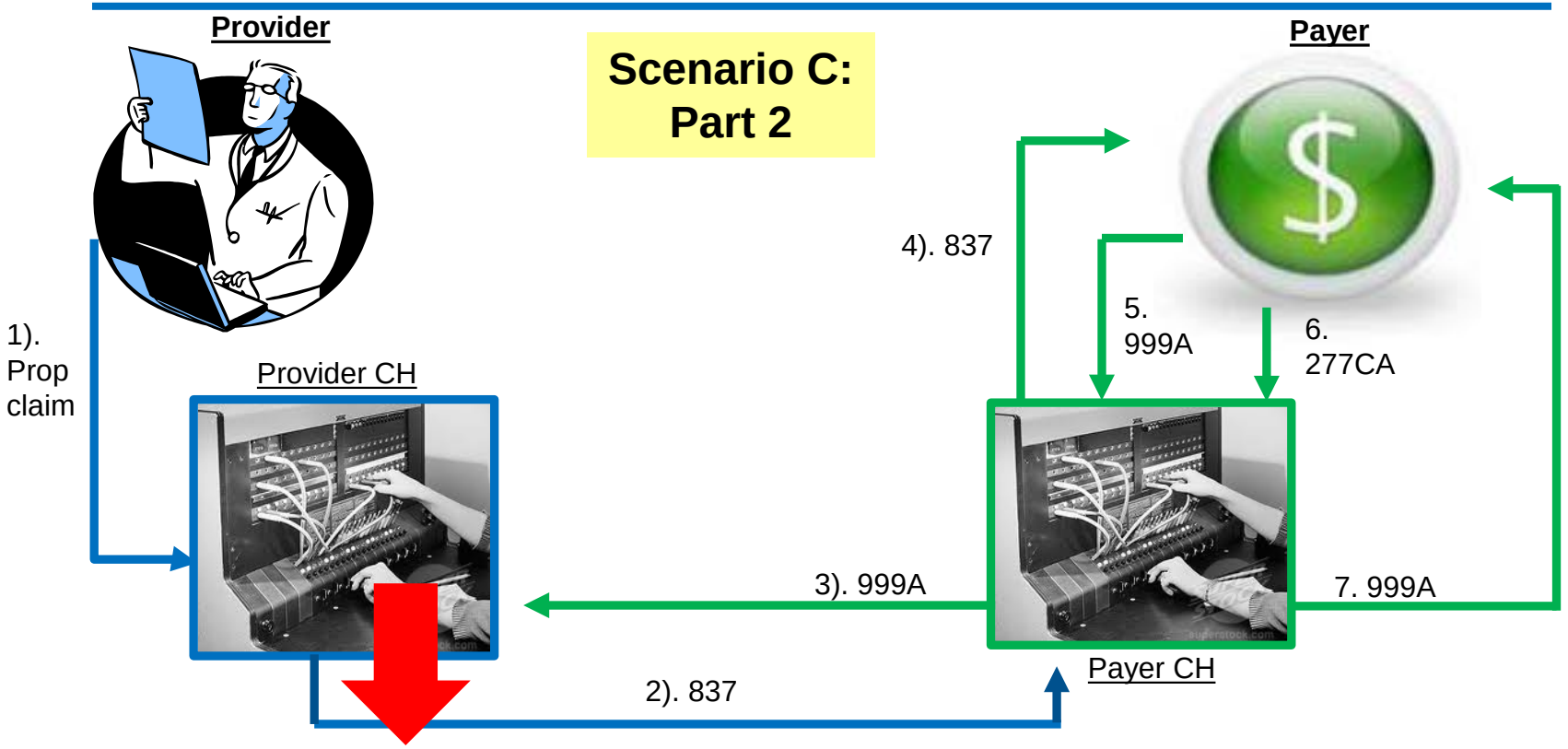
Note: This is a longer scenario, presented in 3 parts.



Step 1: Provider submits proprietary claim format to its CH.
Step 2: Provider CH creates compliant electronic 837 and sends to Payer's CH.
Step 3: Payer's CH acknowledges transaction set has completed ST/SE edits and sends 999A to Provider's CH.

Scenario C: Provider to Provider CH, Provider CH to Payer CH, and Payer CH to Payer – No Errors

Note: This is a longer scenario, presented in 3 parts.



Step 1: Provider submits proprietary claim format to its CH.

Step 2: Provider CH creates compliant, electronic 837 and sends to Payer's CH.

Step 3: Payer's CH acknowledges transaction set has completed ST/SE edits and sends 999A to Provider's CH.

Step 4: After receiving electronic 837 from Provider's CH, Payer's CH sends 837 to Payer.

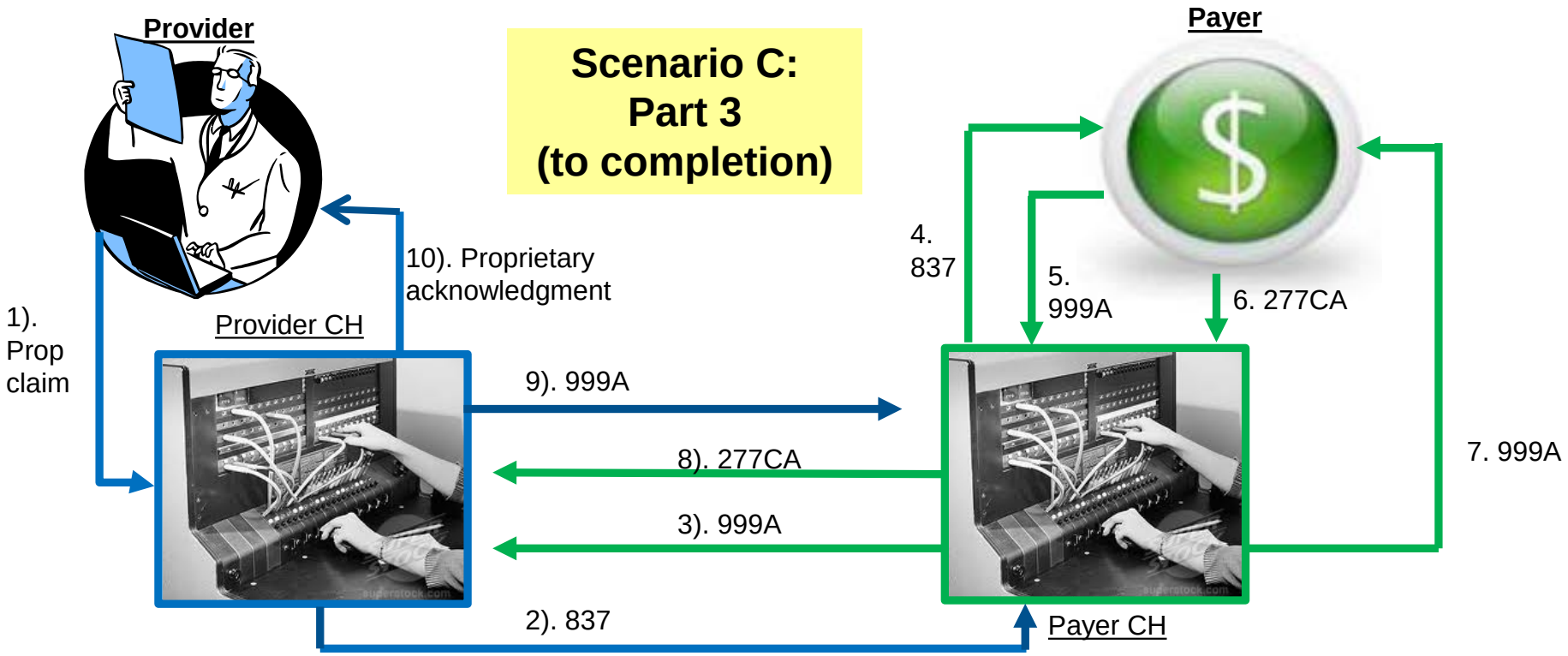
Step 5: Payer sends 999A to its CH acknowledging receipt of 837.

Step 6: Payer also sends 277CA to its CH.

Step 7: Payer's CH sends 999A to Payer. (General recommendation: send 999A in response to 277CA)

Scenario C: Provider to Provider CH, Provider CH to Payer CH, and Payer CH to Payer – No Errors

Note: This is a longer scenario, presented in 3 parts.



Step 1: Provider submits proprietary claim format to its CH.
Step 2: Provider CH creates compliant electronic 837 and sends to Payer's CH.
Step 3: Payer's CH acknowledges transaction set has completed ST/SE edits and sends 999A to Provider's CH.
Step 4: Payer's CH repackages claims that were accepted and forwards transaction to the Payer.
Step 5: Payer sends 999A to its CH acknowledging receipt of 837.
Step 6: Payer also sends 277CA to its CH.
Step 7: Payer's CH sends 999A to Payer.

Step 8:The CH repackages 277CA from the Payer to match original 277CA transactions for claims sent to Payer in step 1 and sends repackaged 277CA to the Provider.

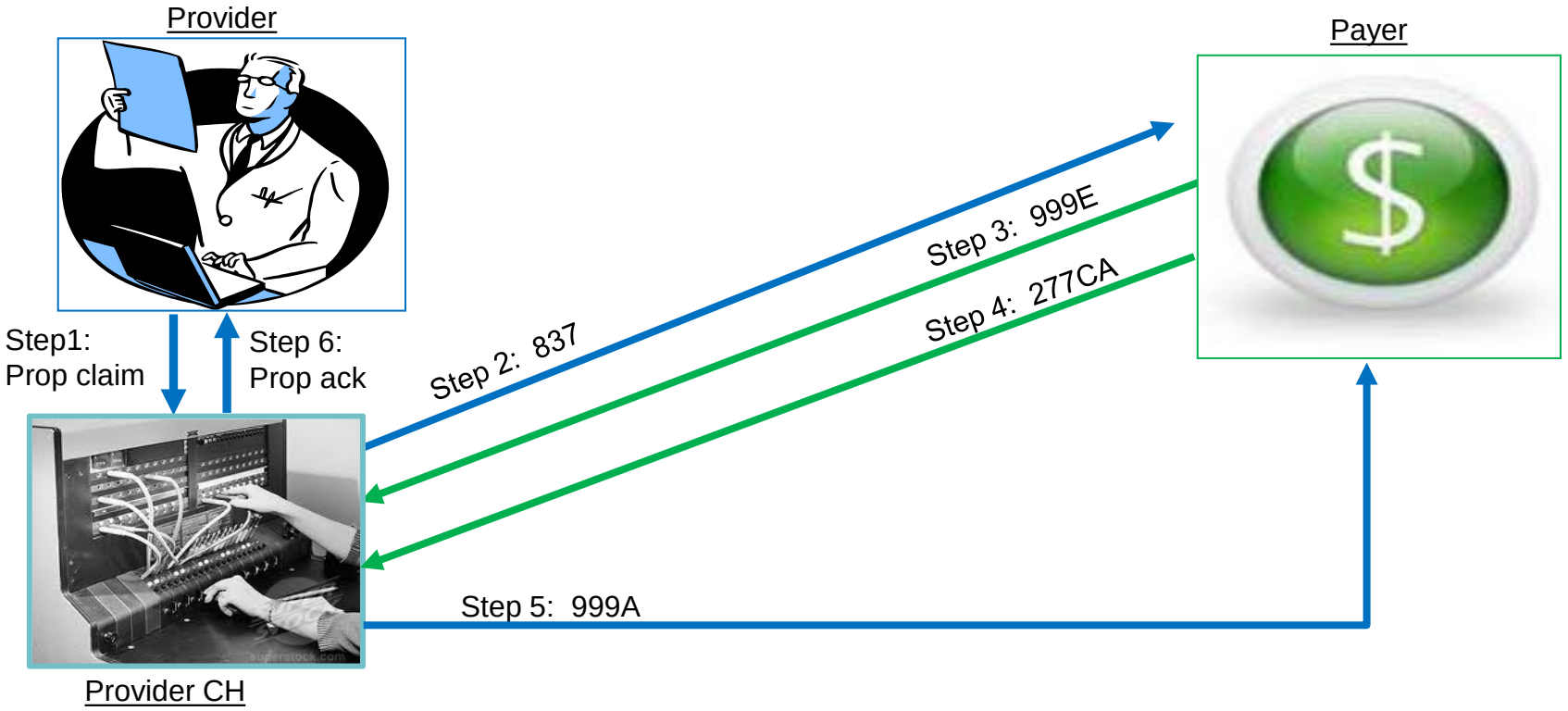
Step 9: Provider's CH responds with 999A to Payer's CH.

Step 10: Provider's CH sends proprietary acknowledgment to Provider.

Return to Table 1

Scenario D:

Provider to CH (proprietary), CH to Payer (X12) – Accepted with Errors

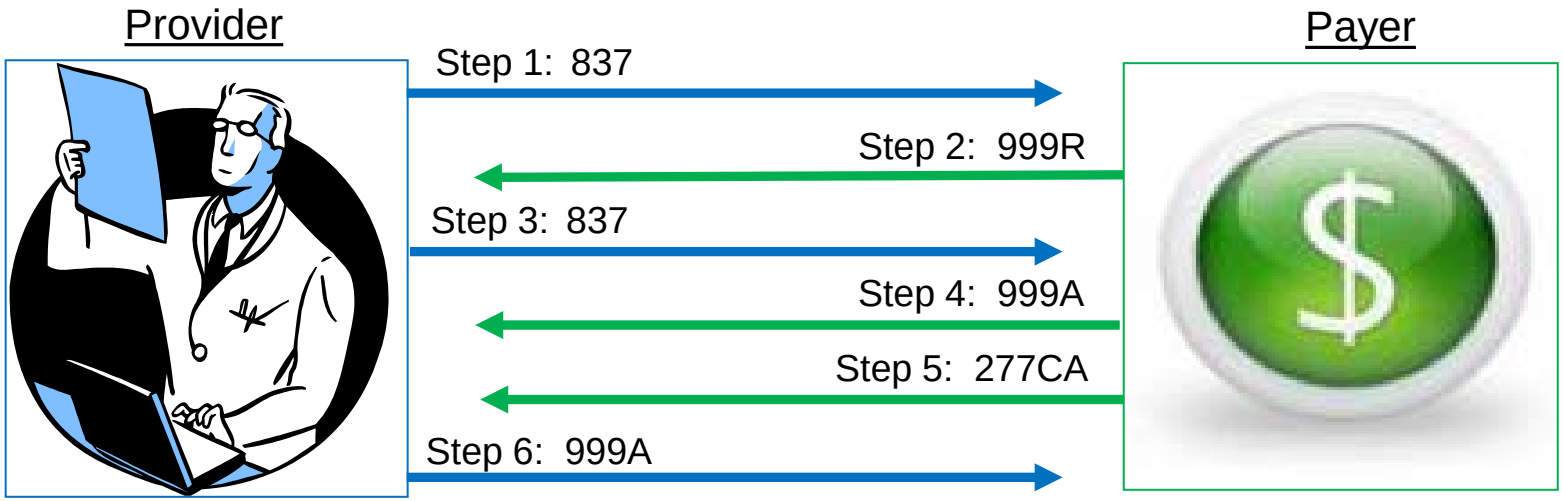


Step 1: Provider submits proprietary claim format to its Clearinghouse.
Step 2: Provider's Clearinghouse creates compliant electronic 837 and sends to Payer.
Step 3: Payer accepts transaction set with errors and sends 999E acknowledgement to Provider's Clearinghouse.
Step 4: Payer also sends Provider's Clearinghouse 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.
Step 5: Provider's Clearinghouse acknowledges 277CA and sends 999A to the Payer.
Step 6: Provider's Clearinghouse sends proprietary acknowledgment to Provider.

Return to Table 1

Scenario E:

Provider submits claim directly to Payer – Errors on First Transaction but Not Second Transaction



Step 1: Provider submits 837 claim directly to Payer, in compliant electronic format.

Step 2: Payer rejects transaction set and sends 999R to Provider.

Step 3: Provider corrects errors and resubmits the 837 claim transaction.

Step 4: Payer sends Provider 999A acknowledgment .

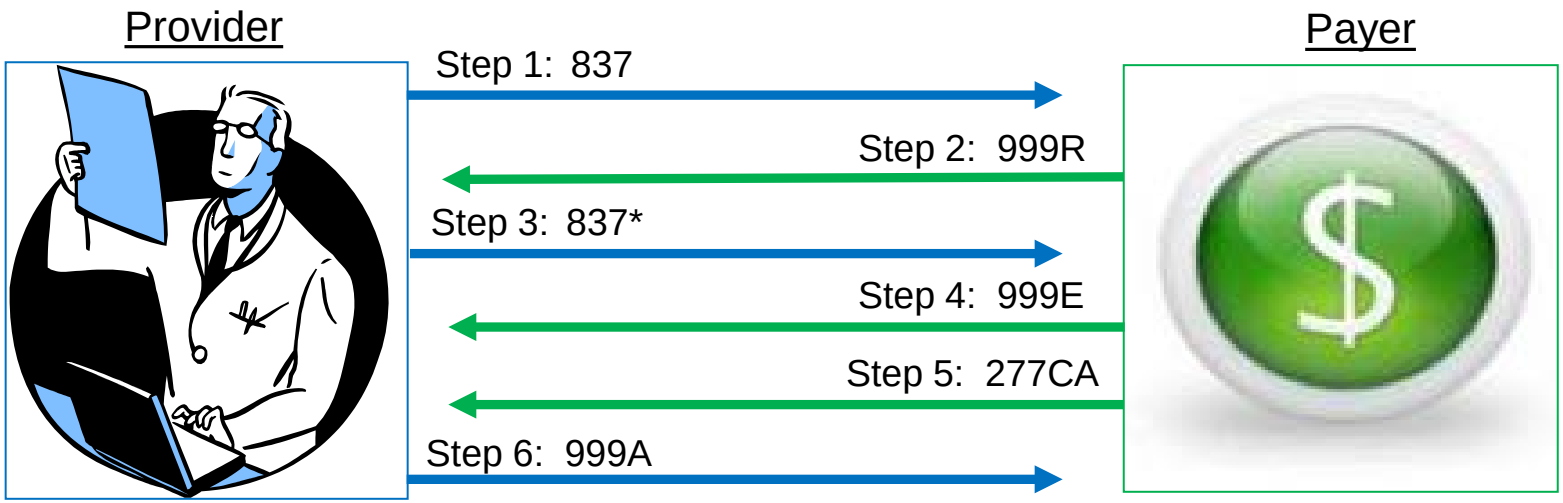
Step 5: Payer also sends Provider 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

Step 6: Provider acknowledges 277CA and sends 999A. (Per slide 26 above, it is recommended that a receiver of a 277CA send a 999.)

Return to Table 1

Scenario F:

Provider submits claim directly to Payer – Errors on First and Second Transactions



Step 1: Provider submits 837 claim directly to Payer, in compliant electronic format.

Step 2: Payer rejects transaction set and sends 999R to Provider.

Step 3: Provider corrects errors and resubmits 837 claims.

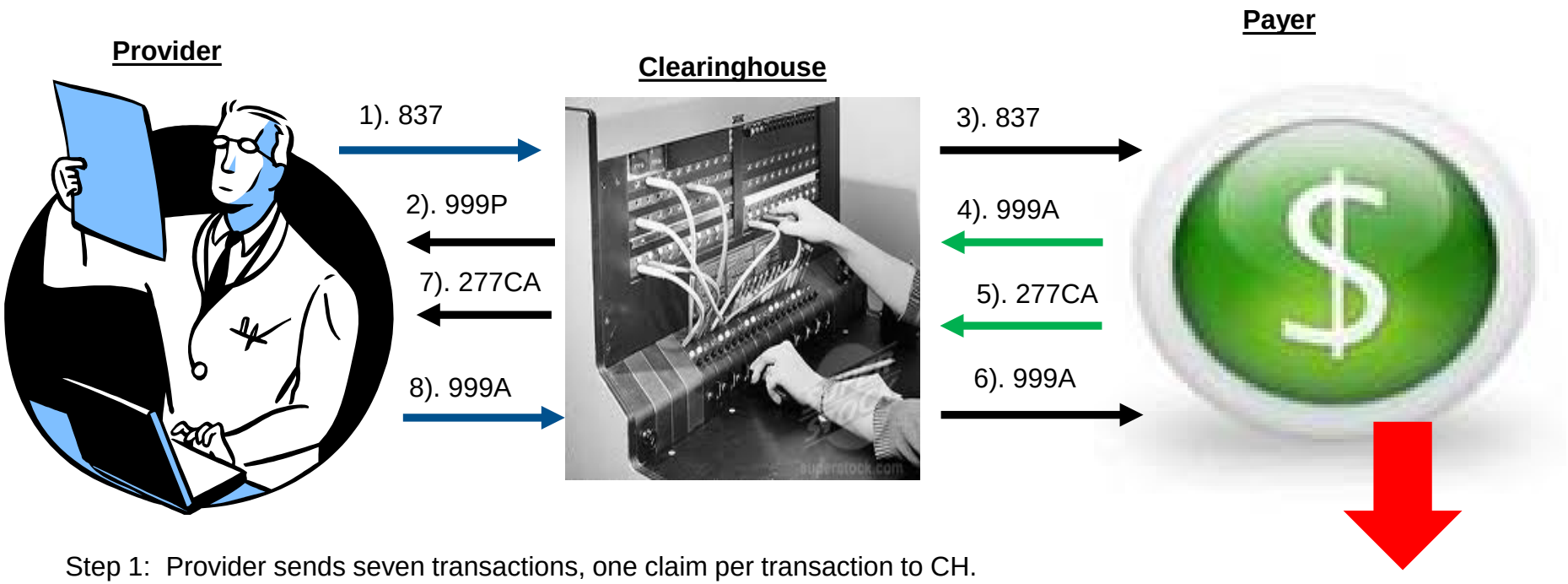
Step 4: Payer sends Provider 999E, acknowledging there are still errors on the second transaction set.

Step 5: Payer also sends Provider 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.

Step 6: Provider acknowledges 277CA and sends 999A. (Per slide 26 above, it is recommended that a receiver of a 277CA send a 999.)

Return to Table 1

Scenario G:
Provider to CH, CH to Payer – With Errors



Step 1: Provider sends seven transactions, one claim per transaction to CH.
Step 2: CH responds with 999P to indicate partial acceptance; in this scenario, it has accepted two of the Provider's seven claims and rejected five.
Step 3: CH repackages the two claims that were accepted and forwards them as one transaction to the Payer.
Step 4: Payer acknowledges transaction set has completed ST/SE edits and sends 999A to CH.
Step 5: Payer also sends CH a 277CA to acknowledge transaction set (837 claim) was accepted into adjudication system.
Step 6: The CH responds to the Payer's 277CA with a 999A to the Payer.
Step 7: The CH repackages 277CA from the Payer to match original 837 transactions for claims sent to Payer in step 1 and sends repackaged 277CA to the Provider.
Step 8: The Provider responds to the 277CA with a 999A to the CH.

Return to Table 1

835 Remittance Advice Acknowledgement Scenarios

Table 2: Acknowledgement Scenarios for Remittance Advices (835)

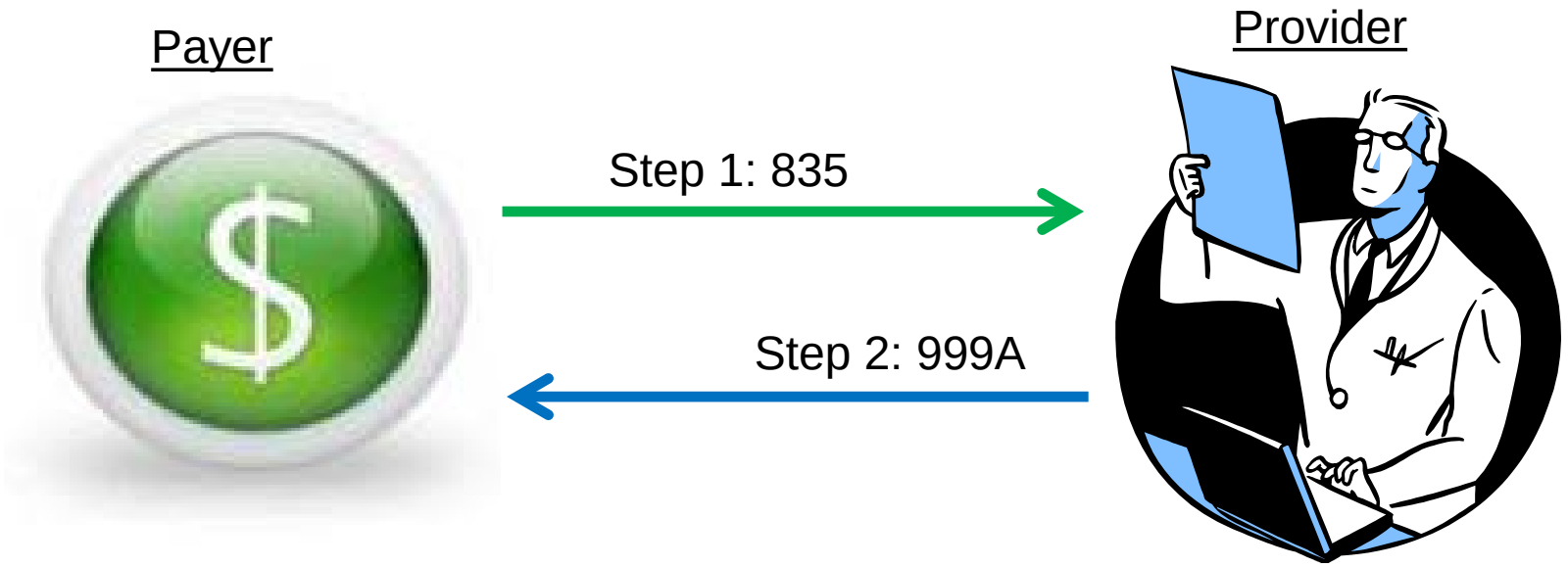
Scenario	Transaction	Claim Status
Scenario A (slide 50)	Payer to Provider	No Errors
Scenario B (slide 51)	Payer to Provider	Accepted with Errors
Scenario C (slide 52)	Payer to Provider	Reject Interchange
Scenario D (slide 53)	Payer to Provider	Reject Transaction

More to follow…

Acknowledgement Scenarios for Remittance Advices (835)

Test Case	Transaction	Claim Status
Scenario E (slide 54)	Payer to Payer CH to Provider	No Errors
Scenario F (slide 55)	Payer to Payer CH to Provider CH to Provider	No Errors
Scenario G (slide 56)	Payer to Provider CH to Provider	No Errors

Scenario A:
Remittance: Payer to Provider – No Errors

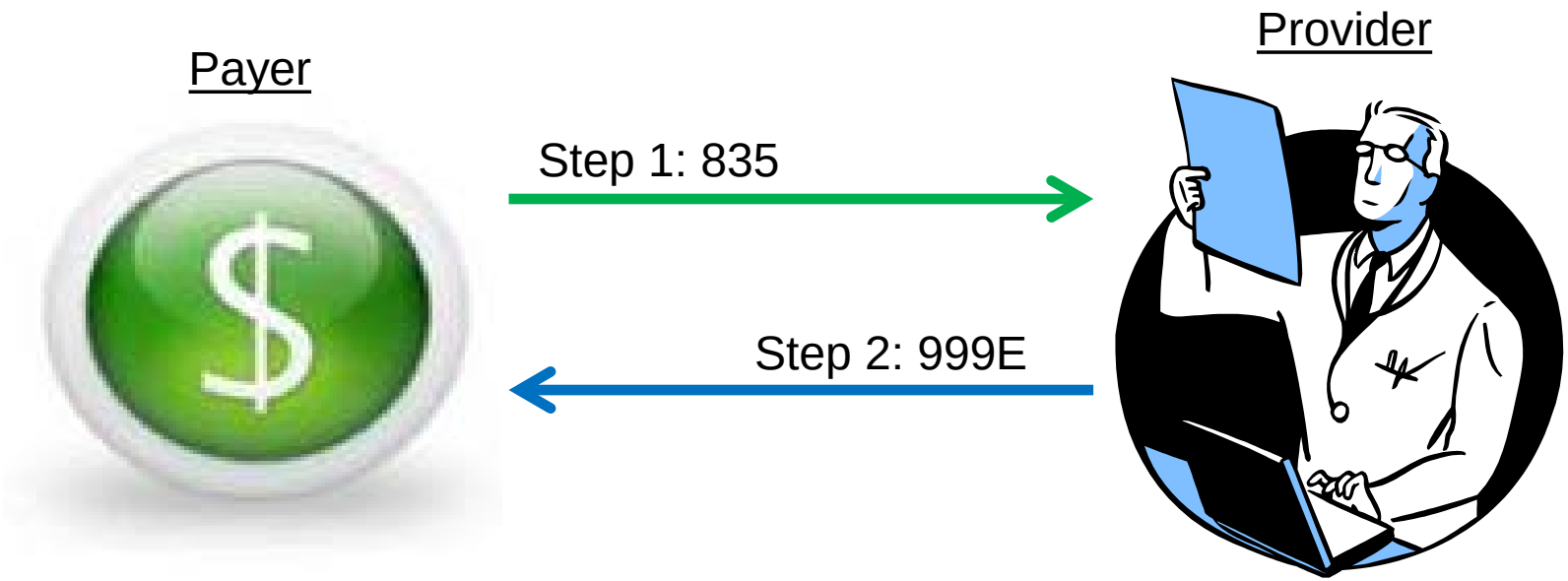


Step 1: Payer sends 835 remittance (transaction set) to Provider.

Step : Provider sends 999A to Payer to acknowledge file or transaction set has completed ST/SE edits.

Return to Table 2

Scenario B:
Remittance: Payer to Provider – Accepted with Errors

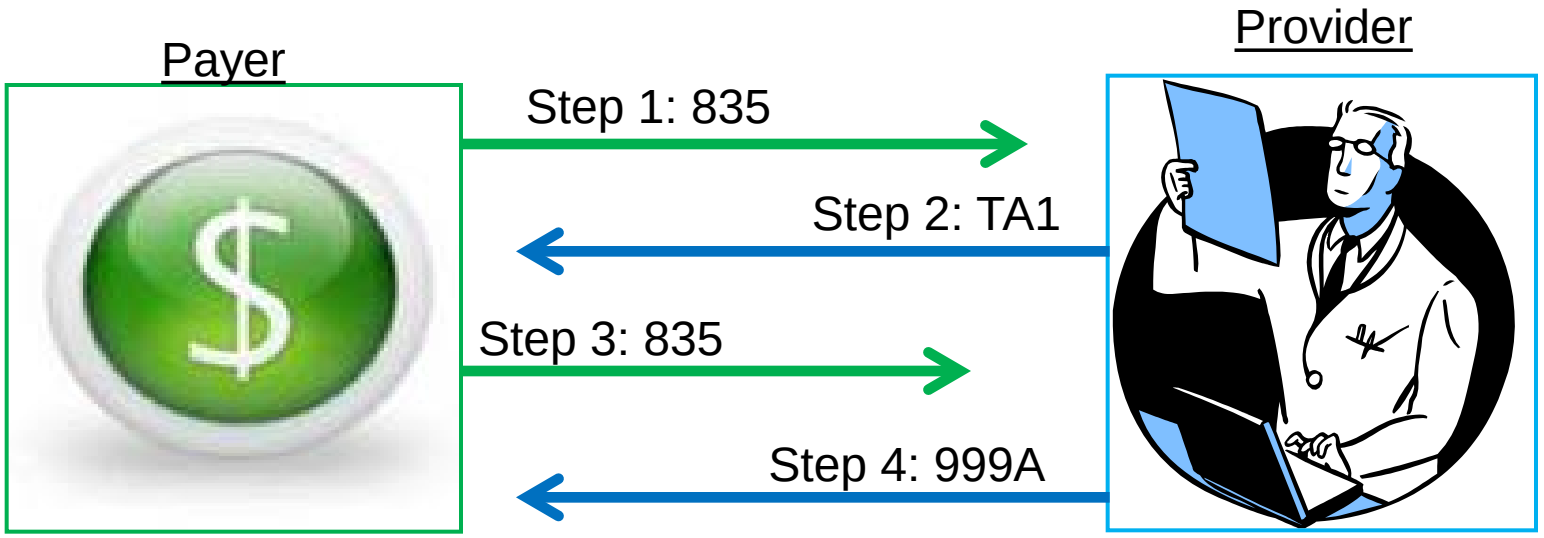


Step 1: Payer sends remittance to Provider in compliant formant.

Step 2: Provider 999E to acknowledge that the transaction set is accepted but there are errors which are reported in the AK2 loop of the 999.

Return to Table 2

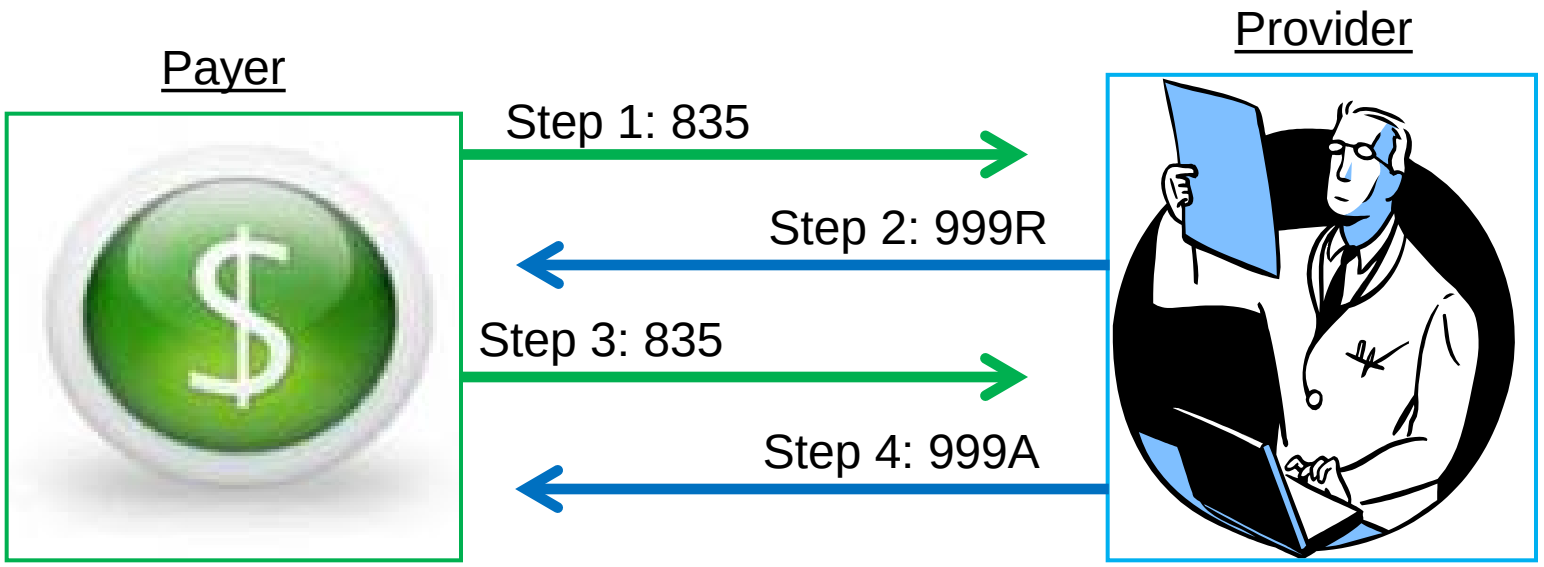
Scenario C:
Remittance: Payer to Provider – Reject Interchange



Step 1: Payer sends 835 remittance to Provider in compliant format.
Step 2: Provider reports a problem at the interchange and submits a TA1 report to Payer.
Step 3 Payer corrects the problem and resubmits the file to Provider.
Step 4: Provider accepts the file and sends 999A to Payer.

Return to Table 2

Scenario D:
Remittance: Payer to Provider – Reject Transaction



Step 1: Payer sends 835 remittance to Provider in compliant format.

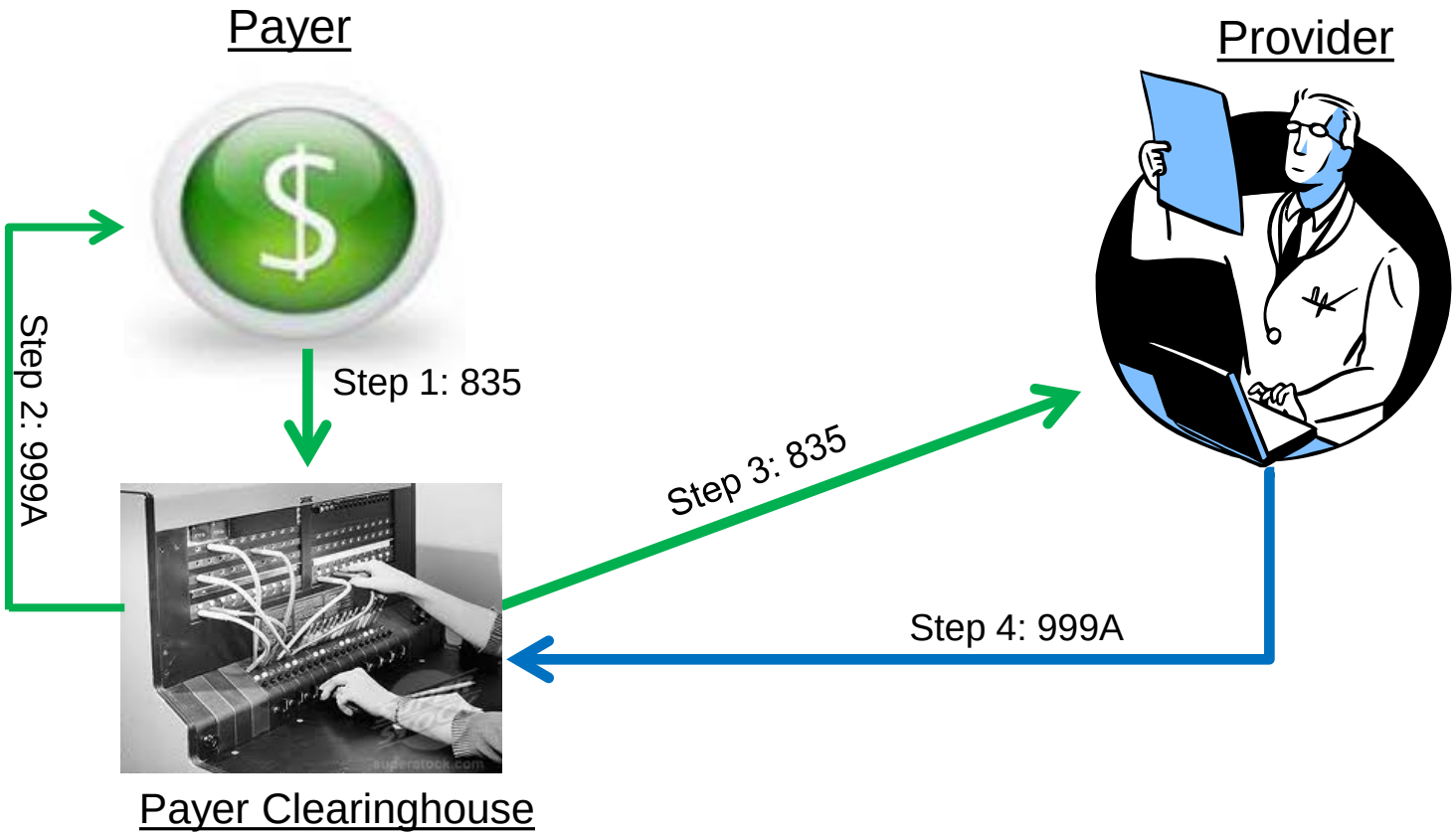
Step 2: Provider rejects the transaction and sends 999R acknowledgment to Payer.

Step 3: Payer corrects the problem and resubmits file to Provider.

Step 4: Provider accepts the file and sends 999A acknowledgment to Payer.

Return to Table 2

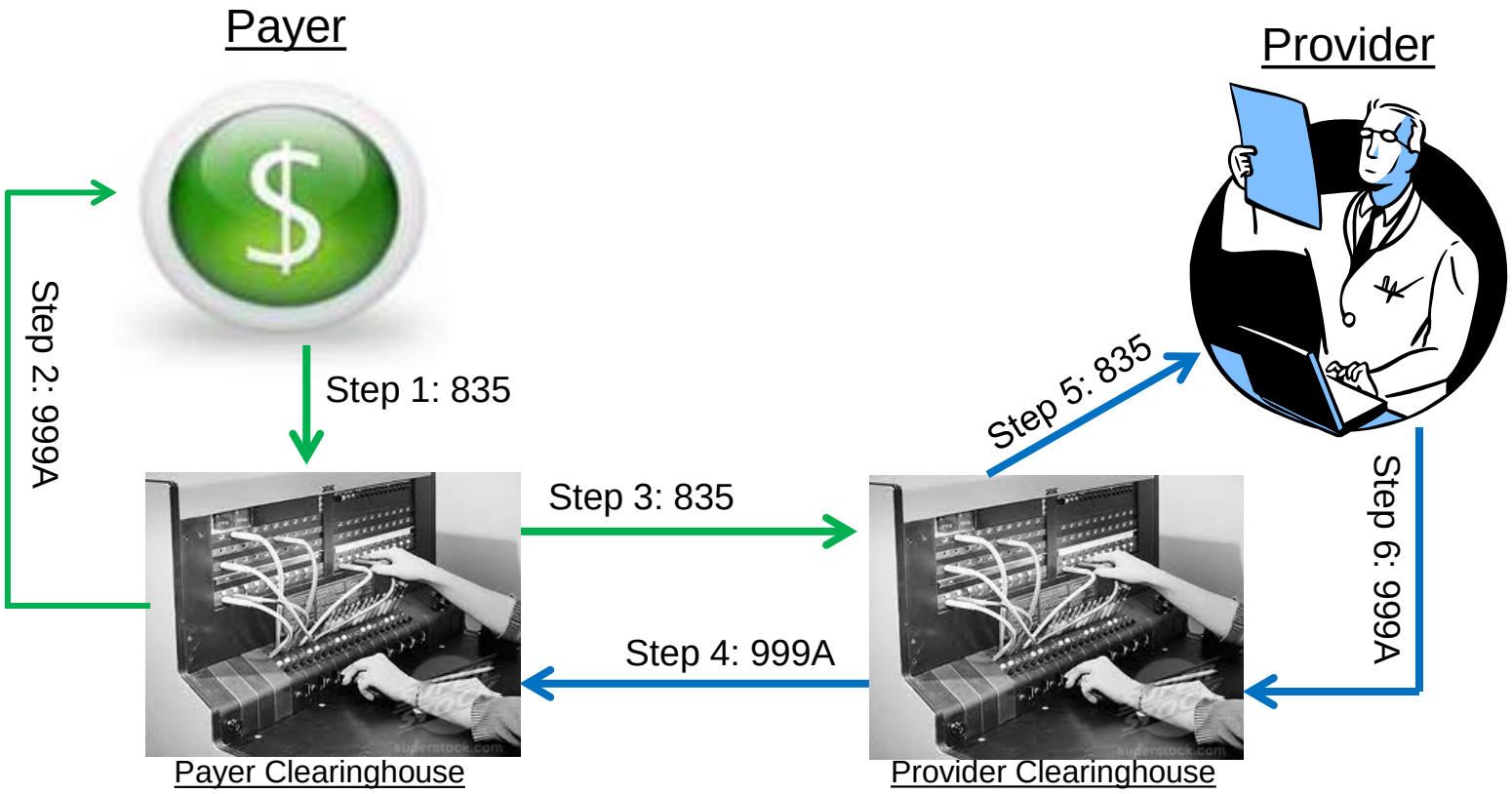
Scenario E:
Remittance: Payer to Payer CH to Provider – No Errors



Step 1: Payer sends 835 remittance to Payer CH in non-compliant format.
Step 2: Payer CH sends 999A acknowledgment to Payer.
Step 3: Payer CH re-envelopes the data it received from the Payer and sends to Provider.
Step 4: Provider sends 999A acknowledgment to Payer CH.

Return to Table 2

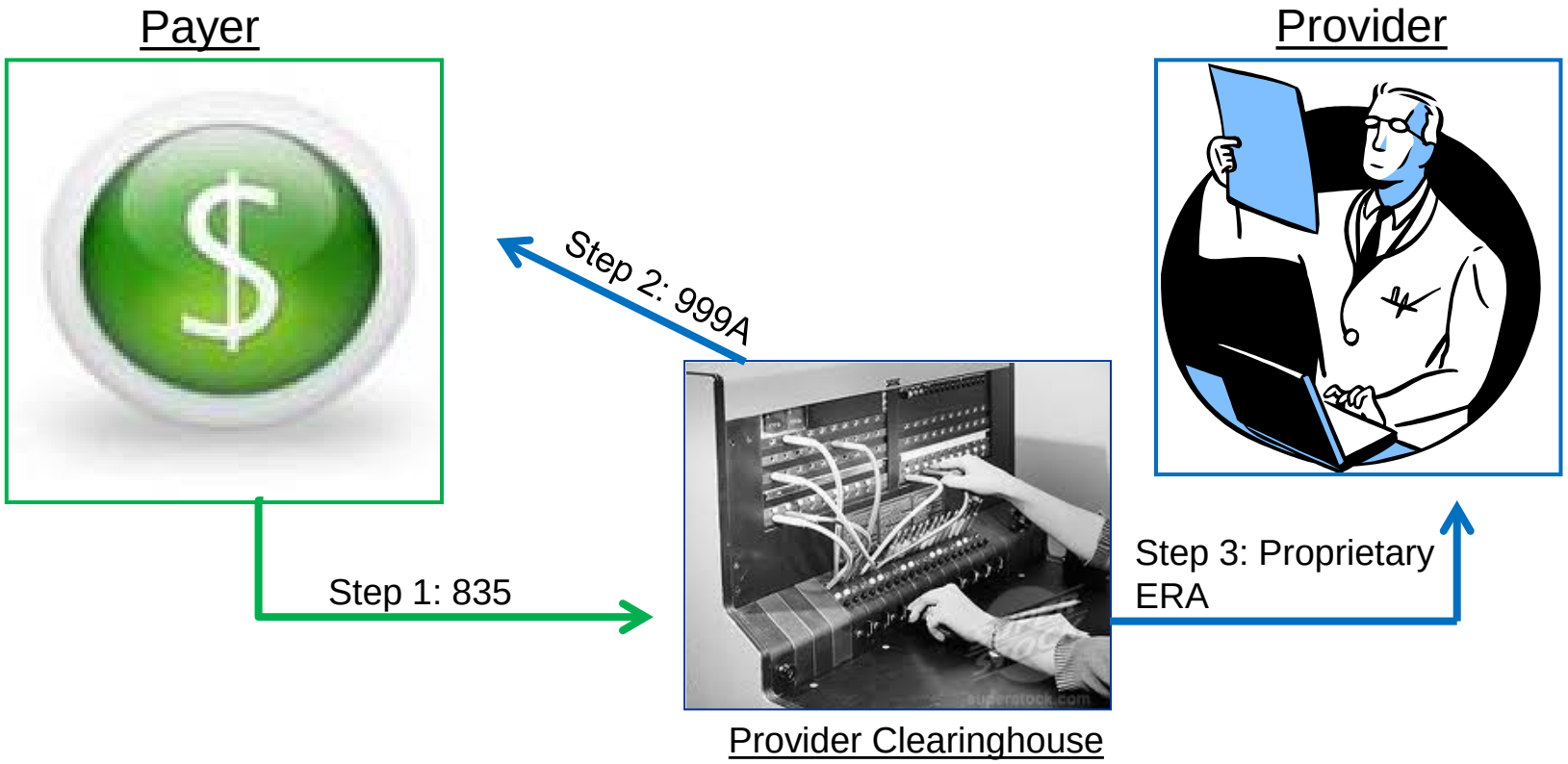
Scenario F:
Remittance: Payer to Payer CH to Provider CH to Provider – No Errors



Step 1: Payer sends 835 remittance to Payer CH in non-compliant format.
Step 2: Payer CH sends 999A acknowledgment to Payer.
Step 3: Payer CH re-envelopes the data it received from the Payer and sends 835 remittance to Provider CH.
Step 4: Provider CH sends 999A acknowledgment to Payer CH.
Step 5: Provider CH re-envelopes the data received from Payer CH and sends 835 remittance to Provider.
Step 6: Provider sends 999A acknowledgment to Provider CH.

Return to Table 2

Scenario G:
Remittance: Payer to Provider CH to Provider – No Errors



Step 1: Payer sends 835 remittance to Provider CH in compliant format.
Step 2: Provider CH sends 999A acknowledgment to Payer.
Step 3: Provider CH re-envelopes the data it received from the Payer and sends Proprietary ERA to Provider .

Return to Table 2

Cited Works

1. Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.
   Appendix B – “B.1.1.5.1 Interchange Acknowledgment, TA1” and
   Appendix C – “TA1 – Interchange Acknowledgment”
   Implementation Acknowledgment (999) 005010X231.
   Washington Publishing Company, June 2007
   <http://www.wpc-edi.com>. B.16; C10.

2. Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.
   “1.3.2 Other Usage Limitations”
   Implementation Acknowledgement (999), 005010X231.
   Washington Publishing Company, June 2007
   <http://www.wpc-edi.com>. 8.

Cited Works

3. Accredited Standards Committee X12, Communications and Control Subcommittee, ASC X12C.
   "IK5 – Transaction Set Response Trailer" and "AK9 – Functional Group Response Trailer"
   Implementation Acknowledgement (999), 005010X231.
   Washington Publishing Company, June 2007
   <http://www.wpc-edi.com>. 39, 42.

4. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N.
   "1.4 Business Usage"
   Health Care Claim Acknowledgement (227), 005010X214.
   Washington Publishing Company, January 2007
   <http://www.wpc-edi.com>. 8-9.

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010**

1. Title of best practice:

Claim and Remittance Acknowledgments Best Practice

2. Who does the best practice apply to:

Group Purchasers, Providers, Clearinghouses and other interested parties

3. Narrative description as to what is being addressed by this best practice:

This best practice recommends which acknowledgments to use in a variety of situations and includes illustrations of the exchange of acknowledgment transactions through a number of claim and remittance scenarios. The scenarios are not exhaustive and illustrate many of the most common situations to be addressed.

Further, this best practice provides information regarding Minnesota requirements in law and rule for the standard for the electronic exchange of several common health care administrative transactions, including acknowledgments. It also explains several important types of acknowledgments and recommends how to use them in practice.

Links to Minnesota regulations

Minnesota Statutes, section 62J.536 and related rules:
https://www.revisor.leg.state.mn.us/statutes/?id=62J.536

4. Describe how to do the best practice:

This best practice is a PowerPoint presentation. Click on this link to begin the best practice: [placeholder].

Use the mouse or the Enter key to advance the slides and to navigate through the PowerPoint.

This best practice PowerPoint presentation includes hyperlinks in the Table of Contents and many of the tables which allow navigation to and from selected slides with a simple click on the link.

This best practice is also available in Word format and can be accessed at: [placeholder]

5. Effective date: December 4, 2012

6. Last revision date: N/A

CHANGES MADE TO EOB/REMIT TAG AUC HOME PAGE - 4/15/13 TAG MEETING

Charge and mission statement of work

Create and maintain a common companion guide and best practices for the 835 transaction, covering topics such as:
1. Usage of situational data elements
2. Usage of CAS Segment – including business uses for the Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)
3. Usage of the PLB segment – including business uses of the PLB codes
4. Recommendations for: ~~Electronic Fund Transfer (EFT),~~
   - reversals,
   - reporting primary payer information on secondary claims and
   - overall balancing rules
5. Develop and propose best practices

6. Monitor and contribute to national level standards setting activities

Work plan and/or accomplishments (split into two sections)

1. ~~1.~~ Created uniform paper member EOB and provider Remittance guides.
2. Created 4010A1 Companion Guide and best practices.
3. Reviewed 5010 HIPAA Implementation Guide and document changes needed in the companion guide. Some issues will be documented as "parking lot" issues that require more input and discussion.
4. Resolve parking lot issues.
5. Ongoing review of External Codes Related to the 835 Transaction (Group Code, CARC and RARC) to determine appropriate business scenarios and recommended usage. Propose new codes to codes maintenance committees as needed.
6. Create front matter to address other Implementation Guide issues that need clarification.
7. Track developments related to HPID/OEID (including any errata to TR3s)

Work product to be developed by TAG

Annual update to ~~5010~~ common companion guide ~~to be developed~~, and any best practices.

Charge and mission statement of work

Create and maintain a common companion guide and best practices for t
835 transaction, covering topics such as:
1. Usage of situational data elements
2. Usage of CAS Segment – including business uses for the Group Cod
   Claim Adjustment Reason Codes (CARC) and Remittance Advice
   Remark Codes (RARC)
3. Usage of the PLB segment – including business uses of the PLB cod
4. Recommendations for:
   - reversals,
   - reporting primary payer information on secondary claims and
   - overall balancing rules

5. Develop and propose best practices
6. Monitor and contribute to national level standards setting activities

Accomplishments:

- Created uniform paper member EOB and provider Remittance guide
- Created 4010A1 Companion Guide and best practices.
- Reviewed 5010 HIPAA Implementation Guide and document chang
  needed in the companion guide.

Work plan

1. Ongoing review of External Codes Related to the 835 Transaction (Group Code, CARC and RARC) to determine appropriate business scenarios and recommended usage.
2. Propose new codes to codes maintenance committees as needed.
3. Create front matter to address other Implementation Guide issues tha need clarification.
4. Track developments related to HPID/OEID (including any errata to TR3s)

Work product to be developed by TAG

Annual update to common companion guide, and any best practices

CLAIMS DD TAG - REVISIONS MADE TO ATTACHMENT COVER SHEET INSTRUCTIONS
5/1/13 TAG MEETING

	INSTRUCTIONS

Attachment Control Number	• Create a unique Attachment Control Number of 50-characters or less
	• Enter that Attachment Control Number either:
	  • In the paperwork (PWK06) segment in Loop 2300 of the 837
	  • In the appropriate field on your claim if entered via a direct data entry (DDE) method, like MN–ITS Interactive or Orbit
	
	Refer to Minnesota Uniform Companion Guide for the 837, section ~~4.2.3~~

Billing Provider ID Number	Enter your NPI, UMPI, or payer assigned legacy ID number. ~~For Version 4010 Use:~~ ~~X12: Loop 2010AA, NM109 or 2010AA, REF02~~ For Version **5010** Use: X12: NPI: Loop 2010AA, NM109 Legacy ID (for atypical providers only): Loop 2010BB, REF02
Billing Provider Name	Enter your billing provider name. X12: Loop 2010AA, NM103, NM104 and NM105
Patient ID Number	Enter the patient's unique ID as assigned by the payer/group purchaser. ~~For Version 4010 Use:~~ ~~X12: Loop 2010CA, NM109 or Loop 2010BA, NM109. If both are populated within the claim, use Loop 2010CA, NM109.~~ For Version **5010** Use: X12: Loop 2010BA, NM109
Patient Name Last First Middle	Enter the patient's name as reported on the claim. ~~For Version 4010 Use:~~ ~~X12: Loop 2010CA, NM103, NM104, and NM105 or Loop 2010BA, NM103, NM104, and NM105. If both are populated within the claim, use Loop 2010CA, NM103, NM104, and NM105.~~ For Version **5010** Use: X12: Loop 2010CA, NM103, NM104, and NM105 or Loop 2010BA, NM1 NM104, and NM105. If both are populated within the claim, use Loop 2010CA, NM103, NM104, and NM105.
Property and Casualty Claim ID Number	This field is required only if services are related to a Property & Casualty claim. X12: Loop 2010CA, REF02 or Loop 2010BA, REF02.
Attachment Send Date	Enter the date you will send the attachment and this Cover Sheet in MMDDYY format.
Total Number of Pages	Enter the total number of pages of your attachment including the Attachm Cover Sheet
Contact Name / Phone Number	Enter the name and phone number of the individual or department in you organization for the payer/group purchaser to contact in case of fax transmission error

	INSTRUCTIONS

Attachment Control Number	• Create a unique Attachment Control Number of 50-characters or less
	• Enter that Attachment Control Number either:
	  • In the paperwork (PWK06) segment in Loop 2300 of the 837
	  • In the appropriate field on your claim if entered via a direct data entry (DDE) method, like MN–ITS Interactive or Orbit
	
	Refer to Minnesota Uniform Companion Guide for the 837, section 3.2.5

Billing Provider ID Number	Enter your NPI, UMPI, or payer assigned legacy ID number. For Version **5010** Use: X12: NPI: Loop 2010AA, NM109 Legacy ID (for atypical providers only): Loop 2010BB, REF02
Billing Provider Name	Enter your billing provider name. X12: Loop 2010AA, NM103, NM104 and NM105
Patient ID Number	Enter the patient's unique ID as assigned by the payer/group purchaser.. For Version **5010** Use: X12: Loop 2010BA, NM109
Patient Name Last First Middle	Enter the patient's name as reported on the claim.. For Version **5010** Use: X12: Loop 2010CA, NM103, NM104, and NM105 or Loop 2010BA, NM103 NM104, and NM105. If both are populated within the claim, use Loop 2010CA, NM103, NM104, and NM105.
Property and Casualty Claim ID Number	This field is required only if services are related to a Property & Casualty claim. X12: Loop 2010CA, REF02 or Loop 2010BA, REF02.
Attachment Send Date	Enter the date you will send the attachment and this Cover Sheet in MMDDYY format.
Total Number of Pages	Enter the total number of pages of your attachment including the Attachme Cover Sheet
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CLAIMS DD TAG - REVISIONS MADE TO APPEAL REQUEST INSTRUCTIONS
5/1/13 TAG MEETING

AUC Appeal Request Form Instructions

Please also refer to the Appeals Best Practice on the AUC website at http://www.health.state.mn.us/auc/index.html for additional information.

General Instructions:

Preferred method is to type the information within the fields provided. If completed by hand, the information must be clearly printed within the fields provided using blue or black ink.

All fields on this form are required unless otherwise noted below.

A copy of the Appeal Request Form and the attachment information should be retained for your records.

Field Instructions:

1. Payer Name: Include the name of the payer the appeal request is being made to.
2. Billing Provider Name: This must be the same name used in Loop 2010AA, NM103, NM104 and NM105.
3. Billing Provider ID: If eligible for a National Provider Identifier (NPI), you MUST use NPI in this field. This number must be the same as populated in Loop 2010AA, NM109. If you are ineligible for an NPI, then this number is your atypical billing provider ID utilized by the group purchaser. This number must be the same as populated in Loop 2010AA, REF02. For atypical providers, confirm the appropriate identifier with the group purchaser.
4. Patient Account Number: Use account number assigned by the provider for that claim. Loop 2300, CLM01.
5. Patient Name: Patient Name must be populated as reported on the claim. It is acceptable to use full middle name or initial but the value used should be the same as on the claim record sent to the group purchaser. Please refer to basic character set best practices on the AUC web site for information on punctuation.
6. Patient ID#: This is the patient's unique identifier as assigned by the group purchaser. This number must be the same as populated in Loop 2010CA, NM109 or Loop 2010BA, NM109. If both are populated within the claim, then the value in Loop 2010CA should be utilized.
7. Date(s) of Service: The date the service was provided.
8. Payer Claim Number: Identify the claim number that the payer assigned to the claim being appealed.
9. Property and Casualty or Workers Compensation Claim Number: This is also known as the event number. This field is only required for claims related to Property and Casualty or Workers Compensation.
10. Reason For Appeal Request: This is the reason the appeal is being requested.
11. Attachment(s): Check appropriate box.
12. Contact Information: Include the date the request is being completed, requester, contact phone number, contact email information and contact fax information. Include address where response should be sent.
13. Pages: Identify the total number of pages that are included. This number should include the cover sheet.

AUC Appeal Request Form Instructions

Please also refer to the Appeals Best Practice on the AUC website at:
http://www.health.state.mn.us/auc/index.html for additional information.

General Instructions:

The preferred method for completing this form is to type the information within the fields provided. If completed by hand, the information must be clearly printed within the fields provided using blue or black ink.

All fields on the AUC Appeal Request Form are required unless otherwise noted below.

A copy of the Appeal Request form and the attachment information should be retained for your records.

Fee-for-service Medicaid does not accept the appeals form that corresponds to this Best Practice due to regulatory requirements (citation: 42 CFR 447). In these cases, the provider must submit a new or replacement claim with the necessary documentation as an attachment.

Payer Name	Enter the name of the payer the appeal request is being made to.
Billing Provider Name	Enter your billing provider name. X12: Loop 2010AA, NM103, NM104 and NM105.
Billing Provider ID	Enter your NPI X12: NPI: Loop 2010AA, NM109. Atypical providers: Loop 2010BB, REF02.
Patient Account Number	Enter the patient's unique ID as assigned by the payer/group purchaser. For Version 5010 Use: Loop 2300, CLM01.
Patient Name	Enter the patient's name as reported on the claim. For Version **5010** Use: X12: Loop 2010CA, NM103, NM104, and NM105 or Loop 2010BA, NM103, NM104, and NM105. If both are populated within the claim, use Loop 2010CA, NM103, NM104, and NM105.
Patient ID#:	Enter the patient's unique identifier as assigned by the group purchaser. For Version 5010 Use: Loop 2010BA, NM109.
Date(s) of Service	Enter the date the service was provided in MMDDYY format.
Payer Claim Control Number	Use payer claim control number found in the 835 CLP07.
Property and Casualty or Workers Compensation Claim Number	This is also known as the event number. This field is only required for claims related to Property and Casualty or Workers Compensation.
Reason for Appeal Request	This is the reason the appeal is being requested.
Attachment(s)	Check appropriate box.
Contact Information	Enter the date the request is being completed, requester, contact phone number, contact email information and contact fax information. Include address where response should be sent.
Pages	Enter the total number of pages of your appeal information including the cover sheet.

CLAIMS DD TAG - REVISIONS MADE TO SUBMISSION OF APPEALS BEST PRACTICE
5/1/13 TAG MEETING

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. **Title of best practice:**

   Submission of Appeals

2. **Who does the best practice apply to:**

   Providers and Group Purchasers

3. **Narrative description as to what is being addressed by this best practice:**

   This document provides further instruction on how a provider should submit an appeal to a Minnesota group purchaser. It includes:

   - This general instruction document
   - The Common Appeal form
   - Instructions for completing the Common Appeal form

4. **The loops, segments and elements, etc. that the best practice applies to:**

   Not applicable.

5. **Describe how to do the best practice:**

   According to the Minnesota Common Companion Guides for professional, dental and institutional claims, section ~~4.2.3.1~~3.2.3, an appeal is defined as:

   Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.

   When a provider determines that an appeal needs to be sent, the provider should complete the Appeal Request Form using the instructions provided. Additional documentation should be sent as required by the group purchaser to support the appeal consideration; this documentation does not include resubmission of the claim. The Attachment Cover Sheet must not be sent with the Appeal Request Form.

Visit our website at: http://www.health.state.mn.us/auc/index.html

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. **Title of best practice:**

   Submission of Appeals

2. **Who does the best practice apply to:**

   Providers and Group Purchasers

3. **Narrative description as to what is being addressed by this best practice:**

   This document provides further instruction on how a provider should submit an appeal to a Minnesota group purchaser. It includes:

   - This general instruction document
   - The Common Appeal form
   - Instructions for completing the Common Appeal form

4. **The loops, segments and elements, etc. that the best practice applies to:**

   Not applicable.

5. **Describe how to do the best practice:**

   According to the Minnesota Common Companion Guides for professional, dental and institutional claims, section 3.2.3, an appeal is defined as:

   Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted.

   When a provider determines that an appeal needs to be sent, the provider should complete the Appeal Request Form using the instructions provided. Additional documentation should be sent as required by the group purchaser to support the appeal consideration; this documentation does not include resubmission of the claim. The Attachment Cover Sheet must not be sent with the Appeal Request Form.

Visit our website at: http://www.health.state.mn.us/auc/index.html

CLAIMS DD TAG – REVISIONS TO REPLACEMENT/VOID CLAIMS BEST PRACTICE
5/1/13 TAG MEETING

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

---

1. **Title of best practice:**

Replacement/Void Claims

2. **Who does the best practice apply to:**

Both providers and group purchasers

3. **Narrative description as to what is being addressed by this best practice:**

This best practice document clarifies definitions, identification and handling of replacement and void claim types.

Replacement claim may also be referred to as corrected claim; void claim may also be referred to as a cancel claim.

4. **The loops, segments and elements, etc. that the best practice applies to:**

Includes 837 professional, institutional and dental claim formats.

Loop 2300, CLM05-3
Loop 2300, REF02 where REF01 value is "F8"

5. **Describe how to do the best practice:**

This best practice must be used per definitions of replacement and void submissions in section ~~4.2.3.2~~3.2.3 ~~and section 4.2.3.3~~ of the Minnesota Uniform Companion Guides.

Replacement and Void:

The bill frequency in CLM05-3 indicates the claim is an original, replacement or a void. For example, a value of "7" represents a replacement claim and value "8" represents a void claim. For a complete list of values, see code source 235.

Visit our website at: http://www.health.state.mn.us/auc/index.html

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

---

1. **Title of best practice:**

Replacement/Void Claims

2. **Who does the best practice apply to:**

Both providers and group purchasers

3. **Narrative description as to what is being addressed by this best practice:**

This best practice document clarifies definitions, identification and handling of replacement and void claim types.

Replacement claim may also be referred to as corrected claim; void claim may also be referred to as a cancel claim.

4. **The loops, segments and elements, etc. that the best practice applies to:**

Includes 837 professional, institutional and dental claim formats.

Loop 2300, CLM05-3
Loop 2300, REF02 where REF01 value is "F8"

5. **Describe how to do the best practice:**

This best practice must be used per definitions of replacement and void submissions in section 3.2.3 of the Minnesota Uniform Companion Guides.

Replacement and Void:

The bill frequency in CLM05-3 indicates the claim is an original, replacement or a void. For example, a value of "7" represents a replacement claim and value "8" represents a void claim. For a complete list of values, see code source 235.

Visit our website at: http://www.health.state.mn.us/auc/index.html

CLAIMS DD TAG – REVISIONS TO EXAMPLES OF NTE AND PWK USAGE BEST PRACTICE
5/1/13 TAG MEETING

	Minnesota Licensed Payer					
Examples	**BCBS MN**	**DHS**	**HealthPartners Insurance**	**Medica**	**UCare**	**5010 Usage**
22 modifier - requires submission of an operative report, narrative and/or other relevant documentation that adequately describes what care/service was greater than usually required	X		X	X	X	NTE ~~and/or attachment~~ and/or PWK
62 Modifier (two surgeons) - documentation to support need for two primary surgeons (all surgeons must submit their individual dictatus of op report)	X		X		x	PWK
66 Modifier - Team Surgeons. Services Per CPT, team surgeons are described as three or more surgeons (with different or same specialties) working together during an operative session in the management of a specific surgical procedure. -Modifier 66 id	X		X	X	X	PWK
Air ambulance - need ambulance run report including origin and destination	X				X	PWK
Claim is over one year old (provider error does not qualify)/past timely filing limit	X	X	X		X	PWK
Dental services were started but not completed		X			X	PWK
Hearing aid repair for non-contracted hearing aid/shells; re-casing; miscellaneous hearing aid services -- provider sends invoice		X			X	PWK
Hearing aid repairs require a note sent with expiration date of the warranty and type of hearing aid		X			X	NTE or PWK
DT&H services approved after graduation and before 21st birthday		X			X	PWK
Individualized Education Program (IEP) provider billing assistive technology device(s) -- provider to send MSRP and IEP		X			X	PWK
Medical necessity - need medical records, rational for service	X		X		X	PWK
Medicare Part A benefits are exhausted --		X			X	PWK

CLAIMS DD TAG – REVISIONS TO CLAIMS ATTHACMENT BEST PRACTICE – pg 1
Approved via TAG E-vote 1/13/13

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. **Title of best practice:**

Claims Attachments

2. **Who does the best practice apply to:**

Providers and Group Purchasers

3. **Narrative description as to what is being addressed by this best practice:**

This best practice provides guidance on how to complete and send an attachment that is related to a submitted claim. It includes:

- Method to send the attachment
- Timeframe for sending the attachment to avoid a claim denial for missing information
- The cover sheet
- Instructions for completing the required cover sheet

Important Note: Non-FAX/non-electronic attachments may only be sent if their size, quality or type is not conducive to an electronic means (such as a photo image).

4. **The loops, segments and elements, etc. that the best practice applies to:**

Loop 2300, Segment PWK

There are references to other loops, segments and elements in the Attachment Sheet Instructions for proper population of the Attachment Cover Sheet.

5. **Describe how to do the best practice:**

Submission Guidelines:

For claims requiring an attachment, the claim must be sent electronically with the paperwork (PWK) segment in the claim populated in Loop 2300.

Administrative Uniformity Committee

This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010.**

1. **Title of best practice:**

Claims Attachments

2. **Who does the best practice apply to:**

Providers and Group Purchasers

3. **Narrative description as to what is being addressed by this best practice:**

This best practice provides guidance on how to complete and send an attachment that is related to a submitted claim. It includes:

- Method to send the attachment
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4. **The loops, segments and elements, etc. that the best practice applies to:**

Loop 2300, Segment PWK

There are references to other loops, segments and elements in the Attachment Sheet Instructions for proper population of the Attachment Cover Sheet.

5. **Describe how to do the best practice:**

Submission Guidelines:

For claims requiring an attachment, the claim must be sent electronically with the paperwork (PWK) segment in the claim populated in Loop 2300.

CLAIMS DD TAG – REVISIONS TO CLAIMS ATTHACMENT BEST PRACTICE – pg 2
Approved by TAG E-vote 1/13/13

The AUC specific cover sheet must be sent with each attachment to ensure a proper match to the submitted claim.

The ~~preferred~~ minimum method for submission of the attachment and cover sheet is facsimile (FAX). Other electronic means for submission are acceptable and encouraged if agreed upon by trading partners. ~~Non-FAX/non-electronic attachments may only be sent if their size, quality or type is not conducive to an electronic means (such as a photo image).~~ For a partial listing of group purchaser FAX numbers, please refer to the AUC website.

Providers must send the attachment by end of next business day after submitting the electronic claim.

Group purchasers must not deny the claim for lack of an attachment, if the electronic method was indicated, until 3 business days after their receipt of the claim. Claims where the method of transmission is non-electronic may be denied if not received by the group purchaser within 10 business days of receipt of claim.

If the group purchaser receives an attachment but does not receive a claim, the group purchaser must not purge the attachment information from their retrieval system until a time period equal to the group purchaser's timely filing requirements.

General Guidelines:

Maximum number of characters allowed in the PWK06 (attachment control number) is 50 to align with the 5010 version of the Implementation Guides.

Attachment control numbers must be unique for a particular attachment within a billing provider.

Use of different qualifiers for multiple types of attachments would dictate sending separate cover sheets/attachment control numbers. Each PWK within a claim should use a different cover sheet and have unique attachment control numbers.

Providers should refer to the Minnesota Common Companion Guides on the AUC website for additional instructions regarding how to use the Attachment Control Number (section ~~4.2.3.4~~3.2.5).

If there are multiple attachments within the same transmission, the provider must pair each attachment with its cover sheet and send the documents in that order (i.e. cover sheet #1, attachment #1, cover sheet #2, attachment #2). A copy of the cover sheet and the attachment information should be retained by the provider for their records. Providers should verify internally that the attachment was sent successfully prior to

The AUC specific cover sheet must be sent with each attachment to ensure a proper match to the submitted claim.

The minimum method for submission of the attachment and cover sheet is facsimile (FAX). Other electronic means for submission are acceptable and encouraged if agreed upon by trading partners. For a partial listing of group purchaser FAX numbers, please refer to the AUC website.

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Attachment control numbers must be unique for a particular attachment within a billing provider.

Use of different qualifiers for multiple types of attachments would dictate sending separate cover sheets/attachment control numbers. Each PWK within a claim should use a different cover sheet and have unique attachment control numbers.

Providers should refer to the Minnesota Common Companion Guides on the AUC website for additional instructions regarding how to use the Attachment Control Number (section 3.2.5).

If there are multiple attachments within the same transmission, the provider must pair each attachment with its cover sheet and send the documents in that order (i.e. cover sheet #1, attachment #1, cover sheet #2, attachment #2). A copy of the cover sheet and the attachment information should be retained by the provider for their records. Providers should verify internally that the attachment was sent successfully prior to attempting to re-send the claim attachment.

Administrative
Uniformity
Committee

Medical Code Technical Advisory Group (TAG) "MN Community Coding Practice/Recommendation Table":

I. Background: Medical Code TAG "MN Community Coding Practice/Recommendation Table"

The AUC Medical Code TAG has created a "MN Community Coding Practice/Recommendation Table" The Table:

- Provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services on the 837I and 837P electronic claim;
- Is intended for use in conjunction with "Appendix A, Table A.5.1" of the "Minnesota Uniform Companion Guides for the 837 Institutional (I) and 837 Professional (P) transactions;
- Is informational only – It is not part of the Minnesota Uniform Companion Guides and does not serve as a rule, but note that the recommendation may have been or will be added to the Compantion Guide;
- Will be explained with header rows that will appear on every page of the table;
- Provides recommendations that may be transferred to the applicable Minnesota Uniform Companion Guides for the 837I and 837P as part of the annual maintenance;
- Is a living document that is regularly updated with new coding recommendations; and
- Was developed to track new or revised coding recommendations developed between, and in anticipation of, the annual companion guide update. Updates may stem from:
  - Quarterly HCPCS coding changes
  - Medical coding in relation to legislative changes
  - Reaction to new or revised Medicare rules
  - Other coding issues as identified

II. Table Explanation

Each row in the table displays a particular question/answer or clarification related to an issue associated with a chapter of the Medicare Claims Processing Manual. The designations P and I indicate the Companion Guides (837 Professional or Institutional) to which the clarification applies. The "A)" through "D)" listing in the right column identifies the specific topic as well as the TAG's recommended clarification/answer, the TAG discussion date, and an AUC Operations Committee approval date.

TABLE HEADER

MN Community Coding Practice/Recommendation Table (Informational Only) **The table below is intended for use in conjunction with "Appendix A, Table A.5.1" of the "Minnesota Uniform Companion Guides" for the 837 Institutional (I) and 837 Professional (P) transactions. It is informational only and has not been adopted as part of the Minnesota Uniform Companion Guides. It provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services on the 837I and 837P electronic claim. The table below was developed by the Minnesota Administrative Uniformity Committee (AUC) Medical Code Technical Advisory Group (TAG) and was posted following review and approval by the AUC.**	
Medicare Claims Processing Manual Chapter No. / Chapter/Description Title	MN Community Coding Practice/Recommendation Table A) Subtopic (ST) – *this is the topic title and the associated question or request* B) Recommendation (Rec) – *this is the recommended action, addition or revision from the MCT* C) AUC Medical Code TAG (MCT) minutes reference – *this is the date of the latest MCT minutes where further discussion can be found; more than one date may be noted as appropriate* D) AUC Operations Committee (AUC Ops) Approval date – *this is the effective date of the addition, revision or deletion, unless other noted* E) Proposed as an addition to next version of companion guide (if blank, is not being proposed for next version of guide) – *this is the companion guide version and/or effective date. If blank, the issue is a clarification only and will not be added to the companion guide.*

III. MN Community Coding Practice/Recommendation Table

MN Community Coding Practice/Recommendation Table (Informational Only)

The table below is intended for use in conjunction with "Appendix A, Table A.5.1" of the "Minnesota Uniform Companion Guides" for the 837 Institutional (I) and 837 Professional (P) transactions. It is informational only and has not been adopted as part of the Minnesota Uniform Companion Guides. It provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services on the 837I and 837P electronic claim. The table below was developed by the Minnesota Administrative Uniformity Committee (AUC) Medical Code Technical Advisory Group (TAG) and was posted following review and approval by the AUC.

Medicare Claims Processing Manual		MN Community Coding Practice/Recommendation Table A) Subtopic (ST) B) Recommendation (Rec) C) AUC Medical Code TAG minutes reference D) AUC Ops Approval date E) Proposed as an addition to next version of companion guide (if blank, is not being proposed for next version of guide)		
Chapter No.	Chapter/Description Title	**P**	**I**	
12	Physician/Nonphysician Practitioner Billing	**X**		A) ST: **Autism Spectrum Disorder** Question: How are autism spectrum disorder services to be reported? B): Rec: T10 23 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. (May be reported on different days if multiple assessments are performed) report as 1 unit per encounter. H2018 Psychosocial rehabilitation services, per diem. (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary) H2020 Therapeutic behavioral services per diem (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary.) H2014 Skills training and development, per 15 minutes. H2017 Psychosocial rehabilitation services, per 15 minutes. H2019 Therapeutic behavioral services, per 15 minutes.

MN Community Coding Practice/Recommendation Table (Informational Only)

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Chapter No.	Chapter/Description Title	**P**	**I**	
				<u>G9012</u> Case Management Services C) MCT: 9-22-09 D) AUC Operations Committee approved via email vote, 10-20-09. E)

MN Community Coding Practice/Recommendation Table (Informational Only)

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Medicare Claims Processing Manual		MN Community Coding Practice/Recommendation Table		
Chapter No.	Chapter/Description Title	A) Subtopic (ST) B) Recommendation (Rec) C) AUC Medical Code TAG minutes reference D) AUC Ops Approval date E) Proposed as an addition to next version of companion guide (if blank, is not being proposed for next version of guide)		
		P	**I**	
12	Physician/Nonphysician Practitioner Billing			**A)** ST: **Coding for SBIRT** SBIRT (Screening, Brief intervention, and Referral to Treatment) is an alcohol/substance abuse structured screening. Should we put something in the Coding Recommendations for coding consistency? Current reporting per SAMHSA (Substance Abuse and Mental Health Services Administration) is as follows: For commercial payers the codes are 99408 and 99409 For Medicare the codes are G0396 and G0397 For Medicaid the codes are H0049 and H0050 B) Rec: Do not follow SAMHSA coding recommendation -- Use CPT or G codes, but not H codes. (Both codes are acceptable per Appendix A front matter) C) 1/10/13 D) AUC Operations Committee E)

MN Community Coding Practice/Recommendation Table (Informational Only)

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Chapter No.	Chapter/Description Title	**P**	**I**	
12	Physician/Nonphysician Practitioner Billing	**X**		A) Subtopic (ST) – **Consultation Services** B) Recommendation (Rec) Per the Minnesota Uniform Companion Guide Section A.3.1, select codes that most accurately identify the service provided. Consultation codes most accurately identify the service provided for non-Medicare business. Group purchasers will continue to accept consultative service codes as defined by CPT for non-Medicare business C) AUC Medical Code TAG minutes reference 11-24-09 D) AUC Operations Committee approved via email vote, 12-21-09. E)

MN Community Coding Practice/Recommendation Table (Informational Only)

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		P	**I**	
12	Physician/Nonphysician Practitioner Billing	X	X	**A)** ST – **In-reach Community Based Coordination** In-reach is a community based service required by statute 256b.0625, subd. 56, effective 1/1/12. These are case management type services primarily for patients coming to the ED multiple times. The social worker provides management to drive the patient to appropriate care and services. The service is billable in 15 minute increments. Practitioners approved to render these services are social worker (BA), Public Health nurse or corrections practitioner. B) REC: In-Reach Services applies to both 837I and 837P.

	837I	837P
TOB	013x	N/A
Revenue Code	0984	N/A
HCPCS	T1016-U2 T1016-U2 TS	T1016-U2 T1016-U2 TS

T1016 Case management, each 15 minutes
U2 = In-reach, initial service
U2 TS = In-reach, follow-up

C)MCT – 2/14/13

D) AUC Ops approval date

E) Proposed as an addition to next version of 837I and 837P companion guides.

MN Community Coding Practice/Recommendation Table (Informational Only)

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		P	**I**	

12	Physician/Nonphysician Practitioner Billing			A) **MFP Demonstration Project** The Deficit Reduction and Affordable Care Act empowered states to develop demonstration projects that would promote and enable movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community. To provide community-based alternatives for persons of all ages and disability groups who reside in MA-funded institutional settings. Money Follows the Person (MFP) provides an array of home and community based services to include planning and coordination of community living arrangements, searching for and securing housing, moving, securing household goods, and arranging for supportive housing, employment and environmental services. B)The following codes are recommended to report Money Follows the Person activities: HCPCS Modifier(s) Description T2038 U6 Community transition, MFP *(plan development)* T2038 U6 UD Community transition, MFP *(coordination)* T2038 U6 U1 Community transition, MFP, furniture T2038 U6 U2 Community transition, MFP, supplies T2038 U6 UA Community transition, MFP, deposits associated with securing housing T2015 U6 Comprehensive community support services, per 15 minutes, MFP T1016 U6 Case management, each 15 minutes, MFP T2019 U6 Habilitation, supported employment, per 15 minutes, MFP H0038 U6 Self-help/peer services, per 15 minutes, MFP H2027 U6 Psychoeducational service, per 15 minutes, MFP S5115 U6 Home care training, nonfamily, per 15 minutes, MFP *(caregiver education)*

				H2000 U6 Comprehensive multidisciplinary evaluation, MFP *(in the development of a transition or service plan)* T2013 U6 Habilitation, educational, per hour, MFP *(intervention provided to support placement in the community)* S5150 U6 Unskilled respite care, per 15 minutes, MFP *(in home)* S5151 U6 Unskilled respite care, per diem, MFP *(in home)* S5150 U6 UB Unskilled respite care, per 15 minutes, MFP, out of home H0045 U6 Respite care services, not in the home, per diem, MFP S5165 U6 Home modifications; per service, MFP S5162 U6 Emergency response system; purchase only, MFP S5161 U6 Emergency response system; service fee, per month, MFP T1999 U6 Miscellaneous therapeutic items and supplies, retail purchases, NOC, MFP E1399 U6 (NU, RR or RB Durable medical equipment, MFP (include modifier for purchase, rental or repair S5135 U6 UA Companion care, adult; per 15 minutes, MFP, night supervision A0160 U6 Nonemergency transportation; per mile – caseworker or social, MFP A0170 U6 Transportation ancillary: parking fees, tolls, other, MFP A0180 U6 Nonemergency transportation: ancillary; lodging-recipient, MFP A0190 U6 Nonemergency transportation: ancillary; meals, recipient, MFP A0200 U6 Nonemergency transportation: ancillary; lodging, escort, MFP A0210 U6 Nonemergency transportation: ancillary; meals, escort, MFP S9970 U6 Health club membership, annual, MFP 'U' Modifier definitions for this purpose: U6 - Money Follows the Person demonstration (Moving Home Minnesota) UA - Night supervision (S5135)/Item, service, or procedure furnished in conjunction with a demonstration project (T2038) UB – Out-of-home UD – Transition to community living services U1 – Transitional services – furniture U2 – Transitional services- supplies C)MCT 2/14/13 D) AUC Ops approval date E)

MN Community Coding Practice/Recommendation Table (Informational Only)

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Chapter No.	Chapter/Description Title	**P**	**I**	
12	Physician/Nonphysician Practitioner Billing			A) ST: Labor Epidural Billing Request to approved coding for "time present and immediately available" of currently billing methodology for most payers be standardized coding in the Claims companion guides for anesthesia. B) REC: No action. TAG agreed that there is no coding to identify specific standby services for anesthesia but the SBAR is out of scope for the Medical Code TAG and suggested that ASA make recommendation to CPT for national code(s) to address labor epidural anesthesiology billing "time present and immediately available." C)MCT 2/14/13 D) AUC Ops approval date E)

MN Community Coding Practice/Recommendation Table (Informational Only)

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		P	**I**	
15	Ambulance	**X**		A) ST: **Community Paramedics** MN Statute 256B.0625, subd. 60 requires Medical Assistance cover services provided by community paramedics certified under section 144R.28, subd. 9 B) Rec: Community paramedic services should be billed as followed: Professional claims only – 837P Place of services – 12 (home) Individual provider number – report the Medical director's NPI Code T1016 U3, 15 minutes increments (one billing, services all inclusive) Code supplies and vaccines may be reported as needed with the appropriate HCPCS codes T1016 Case management, each 15 minutes U3 – service provided by certified community paramedic (EMT-CP) C) MCT 2/14/13 D) AUC Ops approval date 2/14/13 E) Proposed as an addition to next version of 837P companion guide.

MN Community Coding Practice/Recommendation Table (Informational Only)

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Chapter No.	Chapter/Description Title	**P**	**I**	
16	Laboratory Services	X	X	A) Reporting Newborn Screening MN Statute 144.125 requires all infants be screened for heritable and congenital disorders using a Newborn Screening Card purchased from the Minnesota Department of Health. Generally, the cost of the screen is incorporated in the birthing facility fees; however, in some circumstances, the specimen is taken after discharge. B) When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen should be reported using S3620, this covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed. S3620 Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-d; phenylanine (PKU); and thyroxine, total) 76, 77 – repeat service C) MCT 2/14/13 D) AUC Ops approval date 2/14/13 E) Proposed as an addition to next version of 837P and 837I companion guides.

MN Community Coding Practice/Recommendation Table (Informational Only)

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		P	**I**	
N/A	**N/A**	**X**	**X**	A) ST: **Dental services performed in the operating room** B) Rec: 10-26-10 - For dental services not normally provided under general anesthesia…. Where dental HCPCS codes are the most specific, appropriate codes, they should be used to indicate dental procedures performed under general anesthesia in the operating room, on both the 837 Professional and 837 Institutional claims types. C) MCT: 01/14/2010 D) AUC Operations Committee approved 02/08/10 E)

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		P	**I**	

N/A	N/A	X	X	**A)** ST: **MAT (Medication Assisted Treatment) Billing – Methadone vs. Other** To meet CMS and legislative requirements, DHS needs to revise coding for MAT services: 1. to establish a code to distinguish methadone from all other drugs for MAT and 2. to identify MAT intensive (plus)services for a. methadone and b. all other drugs B) Rec: Revise Table A.5.3.c – Substance Abuse Services: Outpatient Services as follows: 837I:

Service description	Unit	Revenue Code	HCPCS Procedure Code	TOB
MAT	Day	0944	H0020	089x or 013x
MAT – all other drugs	Day	0944	H0047 U9	089x or 013x

837P

Service description	Unit	Revenue Code	HCPCS Procedure Code	TOB
MAT	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A

MAT Plus – a licensed program providing at least 9 hours of treatment service per week
U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.
UA – MAT Plus, methadone
UB – MAT Plus, all other drugs

C) MCT 2/14/13

D) AUC Ops approval date 2/14/13

E) Proposed as an addition to next version of 837P and the 837I companion guides.

AUC BUSINESS NEED EPXLANATION FORM
(aka AUC SBAR)

Instructions for Completing the AUC SBAR

Purpose: To provide a formal communication method by which member organizations or non-member interested parties may request the AUC to consider working on a particular issue related to administrative simplification or to request clarification of Minnesota rules and regulations related to administrative simplification.

Instructions: Complete each section of the SBAR form, using descriptive and concise language and/or examples. Do not combine issues in a single SBAR. Complete a separate SBAR for each individual issue that needs to be addressed.

Please note: Incomplete or unclear analysis of the issue may cause unnecessary delay in the AUC response to the SBAR.

Situation: Describe the type of problem or issue, e.g., coding or clarification/interpretation. What is the current business practice and why is it a problem or an issue? Would the continuance of the practice result in non-compliance of federal and Minnesota administrative simplification rules and regulations?

Background: In explaining the pertinent history of the business practice, state how it is used within your organization or within the industry today. What is the negative impact of the business practice if not addressed by the AUC?

Assessment: Be specific and provide as much detail you feel is required to convey or explain why this issue should be addressed by the AUC. How would a change to this business practice benefit health care administrative simplification in Minnesota?

Recommendation: What are you proposing as the solution to this issue that will benefit the health care administrative simplification in Minnesota or improve standardization of the administrative simplification process in Minnesota?

Contact Information: Please provide all of the contact information requested. If the person completing the SBAR is not the subject matter expert(s), include the subject matter expert's name(s) and contact information also.

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

This section to be completed by the Minnesota Department of Health

Date received:	**Organization submitting:**		
Short Title		**Log No.**	**Date Closed**
Status: Exec Review Date	**Sent to TAG/WG**	**TAG Recommendation**	**Decision to Originator**

S	SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed):
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today):
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain):
R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered:
	CONTACT INFORMATION – This form was completed by: Name: Title: Email address: Phone number: Organization: Address:
	AUC RESPONSE:

AUC BUSINES NEED EXPLANATION FORM
(aka the SBAR)

Purpose and Process

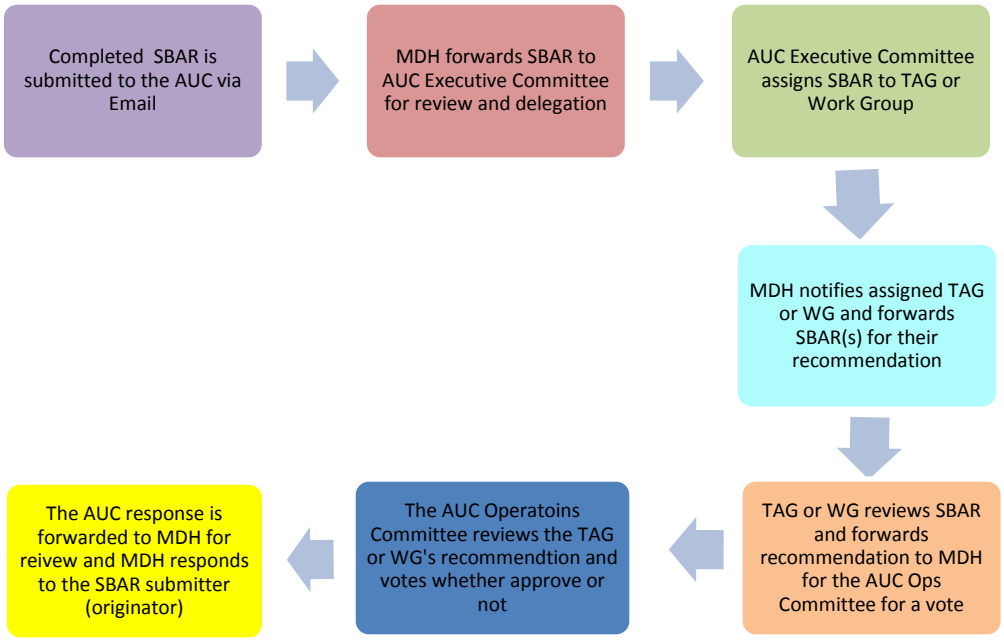
Purpose

The purpose of the SBAR form is to provide a formal communication method by which member organizations or non-member interested parties may request the AUC to consider working on a particular issue related to administrative simplification or to request clarification of Minnesota rules and regulations related to administrative simplification.

Summary of the SBAR Process (see also "Step-by-Step SBAR process" on the next page)

An organization or interested party completes the SBAR form and submits it to the AUC mailbox at: health.AUC@state.mn.us. The SBAR is logged and forwarded to the AUC Executive Committee for review and delegation to an AUC Technical Advisory Group (TAG) or Work Group (WG). If the SBAR falls within the scope of AUC and does not violate antitrust laws, the Executive Committee assigns the SBAR to a specific TAG(s) or Work Group for a review and recommendation. The TAG or Work Group forwards its recommendation to the AUC Operations Committee for review and approval.

The SBAR Process



Step-by-Step SBAR Process

1. An AUC member organization or non-member interested party completes the SBAR and submits it to: health.AUC@state.mn.us.
    - Organizations submitting an SBAR are expected to assist to the AUC Technical Advisory Group or Work Groups created or assigned the SBAR.
    - For example, the submitter may be requested to conduct internet searches and contact other organizations or states as part of required work for the SBAR.
2. MDH staff acknowledges receipt of all SBARS received in the AUC Email "Inbox" within 24-48 hours.
3. MDH logs and forwards the SBAR(s) to the AUC Executive Committee (AUC Exec) for its review and delegation to the appropriate TAG or WG:
    1. If the AUC Exec determines the SBAR falls within scope of the AUC and does not violate the AUC anti-trust statement, the SBAR is delegated to the appropriate Technical Advisory Group (TAG) or Work Group for review and recommendation.
        - The SBAR originator and/or subject matter expert will be notified of the TAG or Work Group assigned the SBAR; a link to the AUC calendar page will be included in the notification.
        - The SBAR submitter or the subject matter expert will be notified and should be in attendance or available at the AUC TAG meeting when the SBAR will be reviewed. There may be a need to ask additional questions in order to clarify understanding of the issue as stated in the SBAR.
    2. If the AUC Exec determines the SBAR is not within the purview of the AUC or may possibly violate the AUC anti-trust statement, the SBAR is not assigned to an AUC TAG or Work Group.
        - The SBAR originator and/or subject matter expert will be notified in writing when AUC Exec determines the SBAR is out of scope for the AUC.
    3. If no appropriate TAG or Work Group exists, AUC Exec forwards the SBAR to the AUC Operations Committee and requests they consider the creation of a TAG or Work Group to assign this work.
4. MDH notifies the TAG(s) or WG co-chairs, along with a copy of the SBAR(s) that the AUC Exec assigned the SBAR to the TAG for resolution if the SBAR is within AUC's scope and does not violate AUC anti-trust statement.
5. The assigned TAG(s) or Work Group reviews the SBAR and forms a recommendation.
6. MDH staff notifies the Exec of the TAG or Work Group's recommendation and forwards a copy of the TAG or WG's recommendation to the Operations Committee o the AUC Operations Committee for its review and approval.
7. The AUC Operations Committee votes to approve the recommendation. If the Ops Committee does not vote to approve the TAG or WG's recommendation, it will send the SBAR back to the TAG or WG for further review and recommendation.
8. Once the SBAR is approved by Ops, the response is forwarded to the Minnesota Department of Health (MDH) for review and MDH responds to the SBAR originator and/or subject matter expert.

Administrative Uniformity Committee

FOR SUBMISSION TO AUC MEDICAL CODE TAG - JANUARY 12, 2012

AUC BUSINESS NEED EXPLANATION

S	SITUATION – Describe the current business practice: HCMC has been involved in All Hazards Planning. The scope of work included in this document is for Alternate Care Site (ACS) field operations for all hazards, not just pandemic planning.
B	BACKGROUND – Explain the pertinent history of the business practice: Alternate Care Sites (ACS's) will provide austere (basic) patient care during a disaster response to a population that would otherwise be hospitalized or in a similar level of dependent care if those resources were available during the disaster. The opening of an ACS is a last resort when incident demands have overwhelmed the hospitals' surge capacity. The ACS's will be implemented in conjunction with local public health with the Regional Hospital Resource Center (RHRC) providing coordination on approval from the Minnesota Department of Health (MDH). This ASC plan is limited to the seven county area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington) and its jurisdictional public health entities. The primary site for the ACS is the Minneapolis Convention Center (MCC) and the secondary site is the River Centre in St. Paul. The standard of care will be determined by the disaster situation and the resources available, and is likely to change over time in response to resources becoming available. Patients will be assessed on a routine basis and transported to higher levels of care when indicated and possible.
A	ASSESSMENT – Summarize your analysis of this issue considering key stakeholder perspective and the AUC mission, vision, values and strategy: Alternate Care Site Admission Criteria: 1. Patients who have been decontaminated (as needed), triaged and screened for admission by an existing healthcare facility, clinic, or ACS personnel and are accepted for admission by the ACS admissions/triage unit leader. 2. Patients requiring peripheral IV therapy for drug administration, rehydration, and/or

	palliative care – no IV pumps are planned for the site. 3. Patients requiring stable oxygen therapy delivered by nasal cannula, mask, or trach collar only (assuming O2 delivery is possible). 4. Patients with communicable diseases who are able to cohort 5. The types of patients admitted to the ACS will be event dependent, but often will be patients such as with isolated orthopedic injury, those requiring intravenous rehydration or ongoing scheduled intravenous medications. Medications will need to be those listed on the ACS formulary. 6. Patients who are have or require the following ARE NOT ELIGIBLE for admission to the ACS: a. Requiring mechanical ventilation, continuous ECG monitoring, vasopressors, or other intensive interventions for unstable clinical states unless being treated with palliative care only b. Active labor c. Existing diseases (cardiovascular disease, diabetes, cancer, etc) who are experiencing exacerbations of these diseases concomitant with injury or infection. d. Frequent and/or complex diagnostic testing (e.g., Radiology, Lab Services, etc.) e. Blood transfusions f. Hemodialysis g. Restraint use or sedation for behavioral issues including psychiatric, chemical dependency, dementia, or delirium-related agitation or confusion h. Complex or frequent medications. Services provided at the Alternate Care Site(s): 1. Multidisciplinary admission assessment, plan of care, and discharge plan 2. Basic peripheral IV therapy 3. Oxygen therapy delivered by cannula, face mask, or trach collar (assuming O2 available)

	4. Palliative care 5. Counseling 6. Medication administration (oral and scheduled intravenous drip) a. An RN, LPN, pharmacist, physician, or paramedic may administer medications within the parameters of their licensure and in conjunction with appropriate orders and administration policies. b. Medications will be documented on the medication administration record. c. The patient and/or family member may administer medications brought from home as previously prescribed if there is a current order from the ACS physician. The ACS physician must write orders to use medications from home. Staffing at the Alternate Care Site(s): 1. Physician (licensed in Minnesota) should be available for medical treatment and consultation. 2. Registered nurse (licensed in Minnesota) 3. Respiratory Therapist is a person familiar with the provision of oxygen therapy and will be under the supervision of a physician. RTs will be used if oxygen or other respiratory therapies are provided on-site that require their presence. 4. Medical Support Personnel may assist in providing care under the supervision of a registered nurse and they will include LPNs, certified nursing assistants, personal care assistants, home health aides, physical and occupational therapists, medical and nursing and dental students. 5. Volunteers will assist with non-clinical tasks in the ACS and be supervised by staff when providing patient assistance (feeding, bathing, etc). Staffing from all job categories will work 12 hour shifts with a 30 minute briefing period between shifts. ACS staffing needs for each 50 patient pod: a. 1 physician

	b. 1 PA/NP or 2nd physician c. 5 nurses and/or LPNs, paramedics (at least 3 RNs) d. 5 nursing assistants/EMT-B personnel e. 1 social worker/case manager f. 1 environmental services worker Additional support personnel: a. 1 charge RN/250 patients b. 1 - 2 unit secretaries/100 patients c. 1 respiratory therapist/100 patients d. 1 patient admissions clerk/100 patients e. 1 chaplain/100 patients f. 1 pharmacist (from hospital >200 beds) Alternate Care Site(s) Supplies & Materials: 1. Supplies and equipment will be based on a 50 patient pod and will be coordinated through the RHRC (either acquired from storage supplies or from metro hospitals). Lists are available in Appendix A. a. Cots, IV poles, lamps, clipboards, linen, plastic bins, masks, gloves, bad bug kits, facial shields/goggles, body bags/morgue kits and megaphones will need to be moved from designated storage sites. This will be coordinated by the logistics chief. b. A list of supplies per 50 bed/cots has been developed. A list of pharmaceuticals & their security needs have been developed.
R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered: Condition Code - To report nursing care provided in the Alternate Care Site(s) during an all hazards disaster,

	the proposal is to use Condition Code DR. DR condition code is defined as Disaster Related. This code is reported to identify a claim that is or may be impacted by specific payer or health plan policies related to a national or regional disaster (e.g., Medicare policies in effect for Hurricane Katrina related claims). Revenue Code - The proposal is to consider one or more of the following sets of Revenue Codes: 1. 067X Outpatient Special Residence Charges: 067X is defined as outpatient special residence charges to indicate residence arrangements for patients requiring continuous outpatient care. This revenue code may not be billable to Medicare at this time. Noridian was unable to verify correct use (inpatient vs. outpatient) for these revenue codes at this time. 0671 Hospital owned 0672 Contracted 0679 Other Special Residence Charge 2. 076X Specialty Services 076X is defined as specialty services to indicate charges for the use of a specialty room such as a treatment room or observation room. The observation services are provided by a hospital or on the hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for possible admission to the hospital as an inpatient. According to Noridian, these revenue codes can be used for both inpatient and outpatient. 0762 - Observation Hours 0769 - Other Specialty Services - (THIS IS THE SUGGESTED REVENUE CODE)

	Place of Service (POS) - Recommend the use of '16' as place of service. 16 is defined a short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
	CONTACT INFORMATION – This form was completed by: Name: Mary Myslajek, Sheryl Theno, and Pat Hadfield Title: Regulatory Review and Analysis Manager, Regulatory Review Analyst, Clinical Care Supervisor Email address: Mary.Myslajek@hcmed.org, SherylTheno@hcmed.org, Pat.Hadfield@hcmed.org Phone numbers: 612-873-3320, 612-873-2514, 612-873-2668 Organization: Hennepin County Medical Center Address: 701 Park Avenue, Minneapolis, Minnesota, 55435
	Reference Documents: Field Guide Operations Guide for Alternative Care Site, Updated 2/19/2010 CMS Fact Sheet- Hospital Alternative Care Sites during H1N1 Public Health Emergency CMS.Gov - Place of Service Codes for Professional Claims

INSTRUCTIONS: This form is to be completed by organizations desiring the AUC to consider working on a particular issue related to administrative simplification that would benefit Minnesota. Organizations submitting an SBAR are

expected to provide resource(s) to the TAG or work group created or assigned to this work. Please note, additional information may be requested if form is not complete. Additional questions may be asked in order to clarify understanding of the issue.

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AUC Response

MCT response:

A subgroup was formed to discuss coding recommendations for services in an Alternative Care Site (ACS). From that group, requests were made to the National Uniform Billing Committee (NUBC) for a new Type of Bill (TOB) specifically for ACS and a unique new patient discharge status code indicating a transfer to an ACS.

The NUBC did not approve the request for a TOB. They suggested using TOB 089x.

The NUBC did approve a new patient discharge status code effective 10/1/13:

71 Discharged/transferred to a Designated Disaster Alternative Care Site

Administrative
Uniformity
Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – 2013 CPT code changes included the new Crisis Psychotherapy services reported by the following CPTs: - 90839 Psychotherapy for crisis, first 60 minutes - 90840 each additional 30 minutes. (List separately in addition to code for primary service.) We at HCMC found these codes appropriate for the crisis services we provide within our clinical areas and acute psychiatric ED. There is not another code available and more pertinent for the psychologists and social workers to report for their professional crisis services from a clinic and ED. Are the other payers going to accept these new crisis psychotherapy codes? Would they require a prior authorization or other criteria to report these codes?
B	BACKGROUND – HCMC - we have set up these codes (90839, 90840) in anticipation of reporting the crisis psychotherapy services to the payers per the 2013 CPT information, and the CPT/AMA education provided at the Chicago symposium. Crisis services occur within our clinical and ED locations of our HCMC system. Providers spend their efforts and time with patients who experience a mental health crisis during office visits. There are not sufficient codes to report this extra work effort and time for psychologists as they do not report evaluation and management codes. In addition, we do not meet the criteria for the MN DHS Adult Crisis Response Services. This criterion is restrictive to providers in a clinical setting with regular business hours. Per MN DHS, the criteria is the crisis intervention must be mobile, available 24 hours per day 7 days a week, 365 days per year, provided by a mobile team in a community setting and provided promptly.
A	ASSESSMENT – These 2013 crisis psychotherapy codes meet a specific need by our Psychology Department and Social Work Department to report crisis services separately from a regular assessment or psychotherapy session. There is more work involved, the patient could be at risk to themselves or others, and could potentially be admitted to inpatient status.
R	RECOMMENDATION – My recommendation is that the Crisis Psychotherapy codes be deemed appropriate for reporting crisis psychotherapy services in Minnesota by Mental Health professionals.

	I would like to know what the MN AUC recommends for reporting crisis psychotherapy services for freestanding, hospital outpatient clinic and emergency department settings. Thank you.
	CONTACT INFORMATION – This form was completed by: Name: Claire Smith, RHIA Title: Revenue Cycle Analyst Email address: claire.smith@hcmed.org Phone number: 612.873.7606 Organization: Hennepin County Medical Center Address: 701 Park Avenue, Minneapolis, MN 55415

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If the issue is determined to be in scope, the form will be forwarded to the AUC Operations Committee and/or the appropriate Technical Advisory Group (TAG) for discussion and consideration. The submitter will be notified when this meeting will occur and will be asked to attend. A reply will be made to the submitter following the discussion at an AUC Operations Committee and/or TAG meeting.

AUC Response
MCT response: Discussion focused on whether or not the Crisis Psych SBAR was related to

coverage and and/or scope of practice and also whether or not the SBAR was related to the CPT physician language SBAR. TAG's response to questions in SBAR:

Are the other payers going to accept the new 2013 CPT crisis psychotherapy codes 90839 and 90840? They are valid CPT codes and use when appropriate.

Would they require a prior authorization or other criteria to report these codes? Beyond AUC's purview. Decision individual payer will make.

As a result of the brief discussion about notifying authors of the SBARs of decisions made by the TAG, MDH will work with Executive Committee to formalize SBAR process to include notification to individuals who submit SBARs for consideration.

Administrative
Uniformity
Committee

AUC BUSINESS NEED EXPLANATION

S

SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed):

The MN Uniform Companion Guide contains the following coding guides for Health Care Homes:

Health Care Homes
The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:
Patient Complexity Level and Supplemental Factors

Patient Complexity Level	Complexity Modifiers	Non English Speaking Modifier	Active Mental Health Condition
Low (no major conditions)	No modifier	U3	U4
Basic	U1	U3	U4
Intermediate	TF	U3	U4
Extended	U2	U3	U4
Complex (most major conditions)	TG	U3	U4

Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level
o U2 – Care coordination, extended complexity level
o U3 – Care coordination, supplemental factor; Non-English language
o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition

B

BACKGROUND – Explain the pertinent history of the business practice (How does this work today):

Three new HCPCS codes were developed January 2013 for "medical home" services.

G9148 National Committee for Quality Assurance-Level 1 medical home
G9149 National Committee for Quality Assurance-Level 2 medical home
G9150 National Committee for Quality Assurance-Level 3 medical home

A

ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain):

The Medical Code TAG should review the new codes in relation to the policy to determine if the coding recommendation/guide

	should change for Health Care Homes.
R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered: Update the MN Uniform Companion Guide as appropriate.
	CONTACT INFORMATION – This form was completed by: Name: Faith Bauer Title: Principal Healthcare Coding Analyst Email address: faith_e_bauer@bluecrossmn.com Phone number: 651-662-8068 Organization: Blue Cross Blue Shield of MN Address: 3400 Yankee Dr., R3-17, Eagan, MN 55121

INSTRUCTIONS: This form is to be completed by organizations desiring the AUC to consider working on a particular issue related to administrative simplification that would benefit Minnesota. Organizations submitting an SBAR are expected to provide resource(s) to the TAG or work group created or assigned to this work. Please note, additional information may be requested if form is not complete. Additional questions may be asked in order to clarify understanding of the issue.

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AUC Response

MCT response:

Barb Hollerung reported that NCQHS classifies the G9148-G9150 as levels 1, 2, and 3 medical homes codes based on providers meeting certain elements. Code S0281 and modifier is specific to the patient and their needs.

Recommendation –the new G codes developed for medical homes will not be a substitute for the current health care home guide. S0281 is classified on the medical care and not the provider. No change to the current guide.

AUC BUSINESS NEED EXPLANATION

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed): Confusion exists as to the appropriate units billing for neuraxial anesthesia management time (code 01967). This code is used for maternity claims only. This code includes the needle placement, drug injection and necessary replacement of an epidural catheter during labor as well as the monitoring of the patient for the duration of the delivery.

B

BACKGROUND – Explain the pertinent history of the business practice (How does this work today):

According to the 2013 Relative Value Guide(RVG) from the American Society of Anesthesiologists (ASA), "Unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor anesthesia services. Professional charges and payment policies should reasonably reflect the costs of providing labor anesthesia services as well as the intensity and time involved in performing and monitoring any neuraxial labor anesthesia service. Methods to determine professional charges consistent with these principles include:
- Base units plus time units (insertion through delivery)subject to a reasonable cap
- Base units plus one unit per hour for neuraxial anesthesia service management plus direct patient contact time.
- Incremental time based fees
- Single fee"
According to the MN Uniform Companion Guide for Professional Claims, May 2011, Appendix A, page 37,
Anesthesia codes 00100-01999: 1 unit = 1 minute.

The 2013 ASA RVG defines time as is customary in the local area The local standard is based on 15 minutes per unit of time.

The CMS 1500 Claim Form box 24G reports minutes for anesthesia. Based on the Medicare Claims Processing Manual as of 10/26/2012, Chapter 26, Section 10.9.1, Methodology for Coding Number of Services, is
"For claims reporting anesthesia time in 15 minute periods or fractions of 15 minute periods, the following example should be used to code the line item: The anesthesiologist attended the patient for 35 minutes.

Number of services:	1
MTUS (time units)	23(one decimal point implied)*
MTUS indicator	2

*Two 15 minute periods + 1/3 of a 15 minute period = 2.3

The CMS Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), Version 005010A1, Companion Guide Version Number:2.0, June 10,2011, which is used to define the fields on the CMS 1500

	claim form for electronic submission, references on page 15, SV104, Service Unit Count, Codes MJ, "Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)." It is now mandated that the "5010" rules be applied to all claim forms submitted to all payers by professionals. Therefore minutes for all procedures are billed on the CMS 1500 claim form, Box 24G.

A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): We established in the late 1990's with most commercial payers that a fair methodology for billing the 01967 was to include the base units of 5 plus insertion time plus any bolus time plus 4 units of time (1 hour) for the time that the anesthesiologist was immediately available to respond to the obstetric need. This meant that the anesthesiologist was in-house as long as the labor epidural was in place which generally averages 4 to 6 hours. This was a modification of the "Base units plus one unit per hour for neuraxial anesthesia service management plus direct patient contact time." as noted in the ASA methods. As a result of the coding options available for 01967, providers may bill using different calculation of units depending on the payer. It is our desire to have a single, uniform coding rule related to these services that align with the national recommendations from the American Society of Anesthesiologists to ease the burden on providers and utilize the national guideline.

R	**RECOMMENDATION** – What are you recommending including any known timing that needs to be considered: Clarify the rule in the MN Uniform Companion Guide as it relates specifically to neuraxial anesthesia management time (code 01967). The methodology recommended is base units of 5 plus insertion time plus any bolus time plus 4 units of time (1 hour) for the time that the anesthesiologist was immediately available to respond to the obstetric need. We recommend that this policy be implemented April 1, 2013.
	CONTACT INFORMATION – This form was completed by: Name: JoAnne Wolf, RHIT, CPC, CEMC Title: Coding Manager Email address: joanne.wolf@childrensmn.org Phone number: 612-813-5972 Organization: Children's Physician Network Address: 910 E. 26th St., Suite 330, Minneapolis, MN 55404

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AUC Response

The Medical Code TAG reviewed this issue on February 14, 2014. The MCT does not support the request. Below are the minutes from the meeting.

Greg Maurer discussed the Labor epidural SBAR requesting coding for “time present and immediately available” of currently billing methodology for most payers be standardized coding in the Claims companion guides for anesthesia.

TAG agreed that there is no coding to identify specific standby services for anesthesia but the SBAR is out of scope for the Medical Code TAG and suggested that ASA make recommendation to CPT for national code(s) to address labor epidural anesthesiology billing “time present and immediately available.”

CLOSED - no action

Administrative
Uniformity
Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – A new requirement from CPT/AMA states in the 2013 CPT book that inpatient evaluation and management (E/M) codes (99221-99233) be reported for hospital care for partial hospitalization, see page 483. This E/M requirement for the psychiatric medical professionals to report inpatient hospital codes for partial hospital services creates an inconsistent reporting dilemma between the CPT code and the place of service code. For example, inpatient E/M codes (99221-99233) should be reported with a place of service 21 Inpatient hospital. Yet, in 2012 payer requirements for the partial place of service were found to be 22 Hospital Outpatient
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): Through 2012, the Hennepin County Medical Center's professional medical partial hospitalization services have been reported with mental health codes with a place of service 22 for MN Medicaid and commercial plans, and a place of service code 52 for Medicare per requirements. For example, MN DHS requires a place of service 22 on the professional partial hospitalization claims per their on-line manual for Partial Hospitalization services.
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): This coding change impacts the place of service we should report on the 1500 claim form for professional partial hospitalization services. I think this change impacts all Partial Hospital professional providers reporting to all health plans. Challenges we face are denials because of the place of service. This is a correct coding issue.
R	RECOMMENDATION – I recommend that the place of service for professional medical partial hospitalization service be consistent with the E/M codes reported, for example, inpatient E/Ms with place of service 21.
	CONTACT INFORMATION – This form was completed by: Name: Claire Smith, RHIA Title: Revenue Cycle Analyst Email address: claire.smith@hcmed.org Phone number: 612-873-7606 Organization: Hennepin County Medical Center Address: 701 Park Avenue, Minneapolis, MN 55415

	Claims DD TAG response: 21 is inappropriate Use 52 for psych/partial hosp Can't use 22 Clarify: DHS does not require 22 on the services listed (use 22 for appropriate E-M services; DHS happy to add 52 to partial hosp to match CPT)

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AUC Response

SBAR/Work Request Status Update

Below is a list of SBARs/Work Requests that have not been completely closed out, and require possible staff, Exec, and/or TAG action.

SBARs/Work Requests **Requiring Exec Committee Review and/or Delegation**				
	Date received	Title, brief description, excerpts from SBAR	Updates/Notes	Next Steps Needed
2	1-11-13	Alternate Care Site Billing The SBAR requests codes for field operations patient care during a disaster response to a population that would otherwise be hospitalized or in a similar level of dependent care if those resources were available during the disaster. **AUC Medical Code TAG Response: 2-1-13** A subgroup was formed to discuss coding recommendations for services in Alternative Care Site (ACS). From that group, requests were made to the National Uniform Billing Committee (NUBC) for a new Type of Bill (TOB) specifically for ACS and a unique new patient discharge status code indicating a transfer to an ACS. The NUBC did not approve the request for a TOB. They suggested using TOB 089x. The NUBC did approve a new patient discharge status code effective 10/1/13: 71 Discharged/transferred to a Designated Disaster Alternative Care Site	**This SBAR was forwarded to MCT TAG co-chair on 1-29-13 to determine if it was closed and was not included in the first SBAR status report presented to Exec Committee.** **MDH received response from MCT TAG co-chair on 2-5-13**	Exec review and approval of TAG response Respond to SBAR originator Add **Code TOB 089x** to coding recommendations grid

SBARs/Work Requests **Requiring Exec Committee Review and/or Delegation**				
	Date received	Title, brief description, excerpts from SBAR	Updates/Notes	Next Steps Needed
3	1-2-13	Billing Methodology for Labor Epidurals Clarify the rule in the MN Uniform Companion guide as it relates specifically to neuraxial anesthesia management time (code 01967). As a result of the coding options available for 01967, providers may bill using different calculation of units depending on the payer. Have a single, uniform coding rule related to these services that align with the ASA recommendations of 15 minutes per unit of time as opposed to the 1 unit = 1 minute currently in the MNUCG 837P **AUC Medical Code TAG Response: 3-7-13** The Medical Code TAG reviewed this issue on February 14, 2014. The MCT does not support the request. Below are the minutes from the meeting. Greg Maurer discussed the Labor epidural SBAR requesting coding for "time present and immediately available" of currently billing methodology for most payers be standardized coding in the Claims companion guides for anesthesia. TAG agreed that there is no coding to identify specific standby services for anesthesia but the SBAR is out of scope for the Medical Code TAG and suggested that ASA make recommendation to CPT for national code(s) to address labor epidural anesthesiology billing "time present and immediately available." **CLOSED - no action**	Sent to Exec on 1-3-13 Discussed at MCT 2-14-13 meeting. **DENIED.** SBAR not in scope with AUC. MCT recommended SBAR originator request code directly from CPT. **CLOSED**	Exec delegate to MCT? Units of service – MCT needs to coordinate with DD TAG None—per MCT recommendation at 2-14-13 TAG meeting • Exec review and recommendations • Response to SBAR originator
4	1-11-13	HCMC asks to bill Crisis Psychotherapy Services based on 2013 CPT codes 90839 and 90840. HCMC would like to know what the MN AUC recommends for reporting crisis psychotherapy services for freestanding, hospital outpatient clinic and emergency department settings. **AUC Medical Code TAG Response: 3-22-13** Discussion focused on whether or not the Crisis Psych SBAR was related to coverage and and/or scope of practice and also	Not discussed at MCT 2-14-13 meeting; discussion postponed **CLOSED – MCT determined that codes are valid and should be used as appropriate**	Exec delegate to MCT? Review and approval by MCT at 3-14-13 TAG meeting • Exec review and recommendations • Response to SBAR originator

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		whether or not the SBAR was related to the CPT physician language SBAR. TAG's response to questions in SBAR: Are the other payers going to accept the new 2013 CPT crisis psychotherapy codes 90839 and 90840? They are valid CPT codes and use when appropriate. Would they require a prior authorization or other criteria to report these codes? Beyond AUC's purview. Decision individual payer will make.		
5	2-7-13	<u>SBAR Coding for Intensive Management of Obesity</u> Under federal health care reform, health plans are required to cover all U.S. Preventive Services Task Force (USPSTF) recommendations Grade A or B at the preventive benefit level (100% coverage). The USPSTF recommended with a B rating that physicians screen patients for obesity and provide or refer to intensive, multi-component intervention for obese adult patients with a BMI or 30 or more. SBAR recommended codes would identify patients obtaining intensive obesity counseling vs. health education and indicate counseling done by physician and non-physician providers. **AUC Medical Code TAG Response: 3-22-13** Medicare does not address, there are specific codes as noted in the SBAR. They will be appropriate; note other policies may be payer specific. Codes are very specific; S9449 may be an issue. G0447 – Face-to-face behavioral counseling for obesity, 15 minutes S9449 – Weight management classes, non-physician provider, per session Valid codes and TAG does not recommend be placed in coding recommendation grid coverage and scope not in AUC purview. How to differentiate G0447 from 97802? Refer to Appendix A	MDH forwarded to Exec Committee 2-14-17 MCT discussed 3-14-13 meeting; no action taken because scope not in purview of AUC. Valid codes exist currently and should be used. Coding for this SBAR not recommended for AUC coding recommendation grid; refer to Appendix A for coding instructions	Assign to MCT **CLOSED. Add language in coding recommendations grid to refer to Appendix A in claims guide for coding instructions** • Exec review and recommendation • Response to SBAR originator
		<u>Health Care Home</u> – the SBAR requests codes for reporting health	MCT discussed at 3-14-13	Julie Schulte, Children's, will

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		care home with patient complexity level and supplemental factor modifiers be added to the coding recommendation grid/guide. **AUC Medical Code TAG Response: 3-22-13** Barb Hollerung reported that NCQHS classifies the G9148-G9150 as levels 1, 2, and 3 medical homes codes based on providers meeting certain elements. Code S0281 and modifier is specific to the patient and their needs. Recommendation –the new G codes developed for medical homes will not be a substitute for the current health care home guide. S0281 is classified on the medical care and not the provider. No change to the current guide.	meeting. Barb H (DHS) explained that DHS codes are based on the level of the patient and Medicare codes are based on medical home level. **CLOSED**	write SBAR for complex chronic care CPT codes and how they related to the current health care codes. • Exec review and recommendation • Response to SBAR originator
6	1-11-13	Partial hospitalization place of service According to HCMC: "…the place of service for professional medical partial hospitalization service [should] be consistent with the E/M codes reported, for example, inpatient E/Ms with place of service 21 (inpatient hospital)." However, "MN DHS requires a place of service 22 on the professional partial hospitalization claims per their on-line manual for Partial Hospitalization services." **AUC Claims DD TAG response: 5-1-13** The correct code to use is Code 52 for psychiatric partial hospitalization. Code 21 is inappropriate. Clarify: DHS does not require 22 for place of service for partial hospitalization as stated in the SBAR and suggests use of Code 22 for appropriate E-M services. DHS will add Code 52 to partial hospitalization to match CPT to eliminate the confusion.	Not discussed at MCT 2-14-13 meeting; discussion postponed MDH met with DHS 3-11-13 to discuss. Refer this issue to the Medical Code TAG to help clarify the concept that "the most appropriate codes should be used," regardless of payment considerations Forwarded to Claims DD for review and recommendation **Claims DD TAG prepared response during its 5-1-13 meeting**	Is more discussion (with DHS) needed for next steps? If referred, go to DD TAG Closed: TAG's response to: • Exec for review and recommendation • Response to SBAR originator **Forward response to Ops for review and approval (perhaps E-vote?)**

SBARs/Work Requests **APPROVED BY MCT TAG - ADD TO THE MCT CODING RECOMMENDATION GRID**				
	Date	Title, brief description, excerpts from SBAR	Updates/Notes	Next Steps Needed

1	1-25-13	Newborn Screening There seems to be a general misunderstanding from birth centers about NEWBORN SCREENING and whether they're allowed to report the tests separately. Some payers, e.g. DHS, reimburse births on a DRG basis that includes the testing. DHS proposes that a coding recommendation be developed to describe the methods for reporting initial and subsequent specimen collection for NEWBORN SCREENING.	Sent to Exec 1-25-13 Sent to MCT 2-6-13 **APPROVED by MCT 2-14-13**	Exec review Add methods to report initial and subsequent specimen collection for Newborn Screening to coding recommendations grid
2	2-7-13	SBAR Methadone vs. all other Drugs To meet CMS and legislative requirements, DHS needs to reinstate the proposals 1. to establish a code to distinguish methadone from all other drugs for Medication Assisted Treatment (MAT)and 2. to identify MAT intensive (plus)services for a. methadone and b. all other drugs In the absence of Appendix A coding instructions to distinguish these services, DHS strongly encourages the use of the following codes: H0047 U9 all other medication assisted treatment (MAT) drugs H0020 UA methadone MAT plus H0047 UB all other drugs MAT plus	MDH forwarded to Executive Committee and DHS sent directly to MCT co-chair **APPROVED by MCT 2-14-13 meeting**	Exec Review Add to coding recommendations grid
3		SBAR Community Paramedics Service – Paramedics who have received certification as a community paramedic will provide home health care services to MHCP enrollees as part of a coordinate care plan ordered by a primary health care provider and approved by the medical director of an ambulance service. Reimbursement for eligible services performed by the Community Paramedics requires uniform billing among payers that enroll those eligible for these services. Reimbursement methods need standard billing codes. DHS seeks assistance from AUC in determining the appropriate codes for the community paramedics based on DHS billing requirements for the Community Health Worker.	**APPROVED** by MCT 2-14-13 TAG meeting	Exec review Add to coding recommendations grid
4	3-27-12 Rev. 8-6-12	SBAR In-reach Services - In-reach is a community-based medical service coordination program performed in a hospital emergency department as an eligible procedure under a state health care program or private insurance for a frequent user. In-reach Services Coordination is a state mandated program. DHS needs a method for reporting this new service and has requested that the MCT code assist with determining appropriate code to distinguish this service.	Discussed at 2-14-13 MCT meeting; however, was not approved. DHS had incorrect revenue code. **APPROVED** recommendations, noted in 2-14-13 minutes	Exec Review Add to coding recommendations grid

SBARs/Work Requests **Requiring Other Review and Action**				
	Date received	Title, brief description, excerpts from SBAR	Updates/Notes	Next Steps Needed
1	2-5-13	Minnesota's Universal Outpatient Mental Health/Chemical Health Authorization Form SBAR states the MN OP authorization form was created by the AUC Mental Health TAG and that the CPT codes listed on the form need to be updated. The codes listed were deleted effective 1/1/13. If the form remains valid it must reflect valid HIPPA codes. SBAR requests that the form be placed on the Forms link on the AUC website for easy accessibility.	Sent to Exec **On-hold** Exec review postponed until further notice Delegate to MCT	Determine if form should be updated and made available on AUC web site • Is it currently being used and if so, by whom • Has the form been replaced MCT to update MDH announce and post revised form to AUC website
2	1-15-13	E-visit Clarification Due to new language added to CPT regarding other qualified health care (QHC) professional for e-visits, need clarification which provider type would be qualified to utilize 98969?	Not discussed at MCT 2-14-13 meeting; discussion postponed **OPEN –MCT 3-14-13 pending research**	Exec delegate to MCT?
3		Split claims with ICD-9 and ICD-10	MDH forwarded to MCT and Claims DD 2/24/12	Status??

SBARs/Work Requests **Referred to DHS**				
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