Meeting Materials

Medical Code TAG Meeting Material

January 10, 2013

1. Agenda AUC Medical Code TAG Agenda 011013
2. AUC Medical Code TAG December Minutes
3. Proposed 837 Professional Guide
4. Changes to Proposed 837 Professional Guide (during 30-day comment period)
5. Proposed 837 Institutional Guide
6. Changes to Proposed 837 Professional Guide (during 30-day comment period)

Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, January 10, 2013
9 a.m. to 12 p.m.
Location: BCBSM, Yankee North, Minnehaha Park and Sky Hill Park conference rooms

Webex Information

Teleconference Information:

Call-in line: 1-605-475-5950

Participant Access Code: 337213#

Callers are responsible for any long distance charges.

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 Medical Code TAG"
4. Provide your name, email address, and the following password: Mct2010! (Note: the password must be typed in; it cannot be cut and pasted. The exclamation point is part of the password)
5. Click "Join now"

1. Welcome and Introductions

- **Attendance tracking: Deb Sorg**
  deb.a.sorg@healthpartners.com

2. Review of Antitrust Statement

3. Review of last meeting's minutes

4. Inreach Services – Barb Hollerung, DHS

3/22/12 Minutes: Inreach is a new community based service required by statute 256b.0625, subd. 56, effective 1/1/12. These are social worker services in the hospital emergency room department. They will be billed on an 837I. DHS is trying to find appropriate codes. 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. Suggested coding includes revenue code 0984 with T1016. Modifiers may be needed for initial and follow-up services. ACTION: Issue will be left open for additional discussion and coding review	OPEN
4/12/12 Minutes: DHS is proposing revenue code 0984 with T1016 with modifier U2 to identify the service as Inreach. Follow up visits provided by Inreach coordinator will be billed with the same revenue and HCPCS code with the U2 and TS modifiers. At this time there are three independent companies that can do follow-up (Touch Tone, Spectrum, and People, Inc.). The hospital could also provide these services (same coding). ACTION: Issue will be left open for additional discussion and coding review.	OPEN
5/10/12 Minutes: Note: corrected vendor name – Touch Stone (note TouchTone). Patient eligibility for Inreach based on frequent use of ER (more than 3 times in 4 months). There is no Medicare precedent – need to develop decision tree. These services can be done by any Inreach practitioner such as the hospital social worker or the independent company. Additionally, the hospital may contract with the independent practitioner to provide the services. Tree needs to reflect in-house Inreach, and outsourced. Initial claim is 837I (because initial encounter is in ER) using 0984 rev code, T1016 procedure code, U2 modifier (for Inreach). From there, can go two ways – in house, or refer to contracted vendor. If hospital continues to provide care, bill will be 873I, 0984, T1016 with U2 (Inreach) and TS (follow up modifier). Billing would be dictated by who is providing the service:	OPEN Barb H has article on Inreach to send out.

Hospital based/employed social worker	**Hospital contracts with independent Inreach coordinator**	**Independent Inreach vendor**

Hospital bills	Hospital bills	Vendor bills	
837I	837I	837P	
Revenue: 0984 HCPCS: T1016-U2TS	Revenue: 0984 HCPCS: T1016-U2TS	HCPCS: T1016-U2TS	
ACTION: Barb H. has article on Inreach to send out.			
7/12/12: Medicare is proposing new G code for primary care coordination after discharge from hospitals, SNFs, etc. The code would be for professional services, to be published in the Federal Register July 30. Reported narrative is "Post discharge transitional care management". This code may be useful for MN "inreach". No decision on existing SBAR pending review of federal rule. Effective date of state law was 1/1/12. Further information needed: Need to know whether federal G-code provides workable solution. ACTION: Barb is sending rule to Faith, Faith will distribute.			OPEN
8/9/12, 9/13/12, 10/11/12: Tentatively T1016-TS is being considered. Services must be reported in 15 minute increments. On hold under Medicare codes are released. ACTION: Barb Hollerung will complete the decision tree. Will discuss at the December meeting.			OPEN
12/13/12: Codes 99487-99489 have been identified. We will discuss in January.			OPEN Waiting

5. AAPC CEUs – De Krengel, Medica

5/10/12 Minutes: De inquired about the process to evaluate the possibility for AUC attendees to earn AAPC CEUs for attending the monthly 3 hour meetings. Below is the response from the CUE Vendor Dept Rep at AAPC. A few questions, first are you affiliated/employed with the MN-AUC? To clarify the reason for this question is that we cannot do an approval for a company/organization without their knowledge. Another question is are these meetings free to anyone, is it a membership organization, or is their a fee to attend? This question will assist us in explaining the application process due to any possible fees assessed. Once we have these questions answered I will be able to provide you with specific information about the approval process. You can also review our guidelines and FAQ page at this link: http://www.aapc.com/CEUVendors/guidelines-for-ceu-approval.aspx ACTION: De will work with Joann Wolf and Carolyn Larson. Our mission, agenda example, and additional information will be submitted to the AAPC.	OPEN
7/12/12: ACTION: Carolyn Larson and De Krengel will complete application to provide information that this activity is not a vendor activity.	OPEN
8/9/12, 9/13/12, 10/11/12, 12/13/12: Per Carolyn Larson, the AAPC is still pushing for vendor status. ACTION: Carolyn Larson will work with Dave to include additional information and resubmit the request.	OPEN

6. Community Paramedic Services – De Krengel, Medica

7/12/12: De Krengel raised issue of community paramedic services –how are services to be coded. Discussion – Does the paramedic have to be enrolled as a provider? Does ambulance service bill for paramedic services? Who is billing? What can be billed? No actual ambulance service is billed. Payers with public program members have to comply by 1/1/13. Do paramedics need taxonomy code? Medicare does not cover these services. Equivalent to home health type services. Try to fast track review of this issue due to 1/1/13 implementation date. De will send Faith link to legislative requirements, Faith will forward to MCT. DHS will provide more information. ACTION: De will write SBAR. The following information was submitted by Judy Edwards post-meeting: Attached is an SBAR we received from De Krengel and forwarded to the AUC Executive Committee for its review and recommendation. The committee has reviewed and approved the SBAR to the Medical Code TAG for its review for applicable coding guidelines. At Dave's request, I searched the Web to get some information about community paramedics and Minnesota's program and legislation. Below are some of the sites I visited that you may find of interest. In addition to the links included in the SBAR, these web sites may provide answers to some of the questions asked at the last TAG meeting during the brief discussion. https://www.revisor.mn.gov/statutes/?id=144E.28 (Minnesota's EMS statutes) https://www.revisor.mn.gov/statutes/?id=256B.0625 (DHS statutes cited in new law regarding billable services by community paramedics) http://communityparamedic.org/ (Minnesota's organization) http://www.emsworld.com/article/10318789/minnesota-gets-its-community-paramedics http://minnesota.publicradio.org/collections/special/columns/ground-level/archive/2011/04/paramedics-take-on-expanded-healthcare-role-in-rural-minnesota.shtml	OPEN

8/9/12: Discussion – Who is billing? The medical director from the ambulance service or eligible provider who performs the service will do the billing. What can be billed? No actual ambulance service is billed. Health assessment, chronic disease, vaccinations, collecting lab specimens, Do paramedics need taxonomy code? – Barb will check <u>Discussion of community paramedics</u> <u>What do we know:</u> Face to face element Professional claim only No travel/mileage No facility charges Will use code T1016 Who's the billing person? Ambulance medical director will determine scope of practice for each paramedic Each paramedic can have different scope of practice Community paramedics must be certified. There are three levels of expertise/certification Primary care provider consults with medical director to determine plan of care Has not been approved by Feds Effective date for community paramedic services is date approved by Feds (rather than July 1, 2012) Taxonomy will not be used **<u>What we don't know</u>**: Who is the referring provider, primary care provider or medical director? Who is billing? How will the provider be distinctly identified? Is code T1016 appropriate? Is a modifier needed to differentiate between In-reach services or other case management services for T1016? Is this just for DHS? What types of services? How will vaccines, drugs, and supplies be billed? Are there services and/or supplies that will be billed outside of T1016? Do we need extra modifiers? Is medical director only provider who determine community paramedics scope of practice? ACTION: Open for additional discussion and review. Send questions to Shawnet Healy.	OPEN
9/13/12: Shawnet Healy – Distributed handout with who can receive services, types of services, documentation required, according to statutes. Based on statutes, community paramedics need to be coordinated with local services public health agencies to determine duplication of services. Who is the referring provider, primary care provider or medical director? Primary care Who is billing? Ambulance Medical Director How will the provider be distinctly identified? NPI Is code T1016 appropriate? YES Is a modifier needed to differentiate between In-reach services or other case management services for T1016? YES, U3 is modifier Is this just for DHS? Yes What types of services? Covered services, see handout How will vaccines, drugs, and supplies be billed? SEPARATELY Are there services and/or supplies that will be billed outside of T1016? Yes, see prior question. Do we need extra modifiers? No Is medical director only provider who determine community paramedics scope of practice? Yes, per statute Place of service? 12 – home (Shawnet will verify POS) Claim format? 1500/837P Additional questions: How detailed do we anticipate supply coding or what is included? – Shawnet will check Verify place of service – Shawnet will research. Should this be included in companion guide and grid?	OPEN Shawnet will verify POS, supply coding and implementation date
10/11/12: Re. Taxonomy code: Additional training of paramedic changes the taxonomy code. Current levels: Basic, intermediate, EMT paramedic (EMT paramedic is 146L00000X but is not correct for community paramedic) But medical directors will be billing, so don't need to worry about EMT-CP because they are not billing. Ambulance medical director has to be enrolled as single and group provider (licensure requirement MS 144E.265: • Licensed physician) Issues recorded on white board during discussion. Short term: T1016 U3, place of service 12, no travel, no mileage: will require manual pending and processing as a medical benefit (because will have to allow home place of service and allow a non-ambulance svc to be billed on an ambulance claim) Long term: need procedure codes and provider specialty to identify Community Paramedic. Effective January 1, 2013 pending CMS review; CMS review requires 90 days from this point. Questions – how are vaccinations billed? Pharmacy will bill for Rx (e.g., flu shots) Will DHS consider enrolling Community Paramedics for ease of administrating benefit? Health Plans would need credentialing plan for enrolling Community Paramedics	OPEN Waiting for any updates

Are CPs eligible for an NPI Resolution at this time: Ambulance company bills T1016 U3, place of service 12. Floating for other services that might be allowed, included sutures, vaccines, etc. (depending on skill set of CP and authorization of medical director). The service should process as medical, no travel or mileage allowed.	
12/13/12: Community Paramedic services will be reported with code and modifier T1016-U3. This is reported per 15 minutes. Tentatively this is considered an all-inclusive service; however, there is still a question of what, if anything, can be reported in addition to T1016-U3, such as supplies or drugs. Should the supplies or drugs be supplied by the primary care provider? What is the effective date?	OPEN Waiting for any updates

7. MFP Demonstration Project – Barb Hollerung, DHS

DHS has a new 'Money Follows the Person' (MFP) demonstration project (Deficit Reduction Act and Affordable Care Act) that we are implementing. MFP promotes and enables the movement of Medicaid beneficiaries with disabling and chronic conditions from institutions into the community. The demonstration "reflects consensus that long-term supports must be transformed from being institutionally based and provider-driven to "person-centered" consumer directed and community-based." The services will be available via fee-for-service and managed care. We plan to use the U6 modifier to differentiate services related to the MFP demonstration from other waiver services. Some examples of the array of home and community based services

- Planning and coordination of community living arrangements – searching for and securing housing,
- moving,
- securing household goods – furniture, bedding, etc.,
- arranging for supportive housing, employment and environmental services.

9/13/12: John Anderson from DHS provided following information regarding the program. This is a federal Medicaid project that will include managed care. Looking for coding suggestions. The coding would identify services for federal funding. DHS has to submit and have the program approved through CMS. This is a five year demo project with 2,000 participants, with potential for 10-years. Most participants will be transitioning out a nursing home, ICF population and physically disabled. Need to identify eligible members. The coding recommendations will **not** be put in the guide but will be added to the coding recommendation grid. Who is the provider – transition coordinator (case managers) to begin with? Will they need to be credentialed? Will need an NPI to bill. Is DHS looking for payers to use their staff to provide case management? Billed on a professional claim. Some of the transitional services could be billed with others. Some are fragmented to account to reporting services. The U6 modifier will distinguish this program from others. Proposed coding below: • Transition Planning and Transition (90%) Coordination Services – T2038 with U6 modifier + UD Also used to purchase "stuff", for example, move; setup UD = transitioning to community/community living services • Comprehensive Community Support – home visits, wellness checks, assistance with budgeting, etc. Billed in 15 min. increments. H2015 with U6 modifier • Specialist services – additional clinical services to care coordination team for adult foster care. Billed hourly. T2013 with U6 modifier. • Supported employment – job coaching, work with employers to resolve problems—support employer o 15 minute code – T2019 o Per diem code T2018 • Self-help peer services – delivered by specialist with required training and certification; develop wellness and recovery plan for persons with mental illness. Code H0038 modifier U6, billed in 15 min. increments • Psycho-education Services – Code H2027, U6 modifier • Case consultation and collaboration – pay experts to participate in treatment planning process and to collaborate with provider – Need help in determining code • Therapeutic foster care – Code S5145 with U6 modifier. Paid per diem • Respite services – Codes o S5150 with U6 modifier In home 15 minutes o S5151 with U6 in home daily o S5150, U6+UB Out of home – 15 minutes o H0045, with U6 modifier out of home - daily DHS, John will clarify where out of home will take place • Text messaging – use technology to prompt certain behaviors for people with chemical dependency – Code H0047 (U6) - TAG felt	OPEN John Anderson and Barb Hollerung will forward additional information to Faith Faith will distribute upon receipt

should not be billed separately, but with comprehensive services • Environmental modifications for safety and accessible not otherwise covered S5165 U6 modifier, per service Difference between transition and home modifications? TAG chance of double-dipping: Will services be itemized? Who will bill? Care coordinator • Personal emergence response system Code S5162 U6 for purchase Code S5161 U6 monthly • Tools, equipment and clothing necessary for employment - Code T1999 • Durable Medical equipment and assistive technology –cover items that waivers will not pay for Code E1399 • Non-medical transportation to find housing and employment – care coordinator will provide transportation o Code A0160 U6 – nonemergency transportation, per mile (Does it include miles case worker get to client or miles with client in vehicle—face-to-face time; what standards will be used? Might be based on federal standards for per mile.) o A0170 U6 – transportation ancillary; parking fees, tolls, other o A0180 U6 Non-emergency transportation: ancillary lodging recipient; o A0190 U6 Meals, recipient o A0210 U6 meals, escort • Membership fees for exercise classes or Y membership fees TAG members will review list of services and submit comments/suggestions/concerns to Judy at judy.edwards@state.mn.us by October 1. Judy will organize and collect to Faith. Contact John at 651-431-2240 and john.a.anderson@state.mn.us for additional info or questions. Dave Haugen forwarded the following links for more information: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_162194	
10/11/12: MFP part of MCO contract? -- most likely. Federally funded project to provide "gap" services (services missing from the current system). E.g., comprehensive supportive services to move individuals from institutional settings into the community. This is as demonstration project/grant. Still working on some aspects – e.g., text messaging: will be like a subscription service, paid monthly. Works like this: in the old days a client would call a therapist. Now you can make the connection more quickly via interactive texting. Focus at this time is on people with chemical dependency issues. One issue is coding (no HCPCS level 2 codes). Goal of MCT discussion? Not an item for the companion guide (doesn't relate to commercial business, relates to small DHS population at this time). Possible coding clarification grid item. Questions to determine MFP coding: **Is this 837P?** Yes (will never be 837I) **Billing provider?** Case mgr., transition coordinator. Will they be identified via NPI? (These are independent practitioners. They are not clinics. Most of the work to be done will be transition planning – "moving people". The target providers are those doing "case management" – e.g., employees of counties, tribes, health plans.) Need some way to identify practitioners. **Place of service?** Clients transitioning from institutional setting. Medicare place of service requirements come into play? John to get back to MCT re place of service. Need some way to identify place of service. Some codes still being decided. E.g. supported employment: • Supported employment – job coaching, work with employers to resolve problems—support employer o 15 minute code – T2019 o Per diem code T2018 DHS seeks input, including from MCT. Will finalize input at Dec. MCT meeting. MDH to develop/modify "decision tree" for helping determine coding issues. Process going forward on MFP coding: Can do interim processing of issues, questions, etc. via email, with "final" MCT review at Dec. MCT meeting. For more info see website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html Within next 3 weeks DHS will have a final list of MFP services and codes, will have info on case managers (who they are, how they are enrolled), place of service. Effective date January 1, 2013.	OPEN John Anderson will forward any updates. Barb Hollerung will work on SBAR and decision tree.
12/13/12: Barb Hollerung will work on the SBAR for the coding recommendation. Barb supplied a revised code list that will be sent to members. Additional discussion: This is a five year demonstration project (may be renewed for an additional five years). This is for a select Medicaid population. Requirements include patients who have been in a facility for 90 days or more (hospital, SNF, CFMR, IMD [Institution for Mental Disease]). Note that IMD patients have an age restriction of under age 21 or over 65. There is no age restriction for patients coming from other institutions.	OPEN Barb Hollerung will work on SBAR and decision

Commercial payers contracting with Medicaid will be responsible for administering/paying this service. MFP will coordinate/educate lead agencies (including MCO, Tribal and counties). This should be rolled out first quarter 2013, with an anticipated April implementation.	tree.

8. Substance Abuse Coding

Outpatient coding recommendations will be reviewed and revised as needed.

9. Coding for SBIRT – Deb Sorg, HealthPartners

SBIRT is an alcohol/substance abuse structured screening. We need to put something in the Coding Recommendations for coding consistency. Current reporting 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

10. AUC MCT Member List Clean-up – Deb Sorg, HealthPartners

A number of 'failed' email delivery responses for people previously on the AUC MCT email list have been received. We need to "clean-up" our membership to only include active members or participants.

11. Additional Agenda Items

- Next meeting scheduled for February 14, 2013.

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, December, 13 2012, 9 a.m. to 12 p.m.
Location of Meeting – SOP, Minnesota Room
Meeting Minutes

Minutes By: Faith Bauer

Agenda Item	Discussion	Action/Follow-up:
1. Welcome and Introductions • Attendance tracking	Introductions completed by members in attendance and those participants on the telephone. Deb Sorg tracks attendance. If calling into the meeting, please send an email to Deb Sorg @ deb.a.sorg@healthpartners.com . Include your name, organization and if you are calling in for another person within your organization	Completed.
2. Antitrust Statement	Reviewed – available on AUC website.	No discussion.
3. Review of last meeting's Minutes	Minutes were reviewed and approved.	Minutes will be sent to MDH for posting on AUC MCT website
4. Appendix A comment review	The earliest effective date for the guides would be eight to 10 weeks from today. Comments were reviewed (there were 10 identical comments relating to substance abuse changes). It was decided that the majority of outpatient substance abuse coding changes will be pulled for further review by DHS (with the exception individual versus group therapy coding). Substance abuse coding revisions will be added to the January agenda. The guides will be sent out for a member vote due no later than December 19. It was noted that if the content is not impacted by comments we will go ahead with the revisions noted.	CLOSED
5. Inreach service – DHS	Codes 99487-99489 have been identified. We will discuss in January.	OPEN Waiting
6.APC CEUs – De Krengel, Medica	Still reviewing the proposal	OPEN
7. Community Paramedic Services – De Krengel, Medica	Community Paramedic services will be reported with code and modifier T1016-U3. This is reported per 15 minutes. Tentatively this is considered an all-inclusive service; however, there is still a question of what, if anything, can be reported in addition to T1016-U3, such as supplies or drugs. Should the supplies or drugs be supplied by the primary care provider? What is the effective date?	OPEN Waiting for any updates

Agenda Item	Discussion	Action/Follow-up:
8. MFP Demonstration Project – Barb Hollerung, DHS	Barb Hollerung will work on the SBAR for the coding recommendation. Barb supplied a revised code list that will be sent to members. Additional discussion: • This is a five year demonstration project (may be renewed for an additional five years). • This is for a select Medicaid population. Requirements include patients who have been in a facility for 90 days or more (hospital, SNF, CFMR, IMD [Institution for Mental Disease]). Note that IMD patients have an age restriction of under age 21 or over 65. There is no age restriction for patients coming from other institutions. • Commercial payers contracting with Medicaid will be responsible for administering/paying this service. • MFP will coordinate/educate lead agencies (including MCO, Tribal and counties). • This should be rolled out first quarter 2013, with an anticipated April implementation.	OPEN Barb Hollerung will work on SBAR and decision tree.
9. C&TC Coding – JoAnne Wolf, Children's	Based on past review it was decided that it would be a benefit to providers and payers to add the following billing clarifications (noted in blue) in the guide: ▪ Maternal depression screening: 99420 UC ▪ Developmental screening: 96110 ▪ Child Mental Health Screening: 96110 UC ▪ Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately. ▪ Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. ▪ Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed. ▪ Use most appropriate diagnosis code based on patient age.	CLOSED

Agenda Item	Discussion	Action/Follow-up:
10. NUBC Request Updates – Faith Bauer, BCBSM	2 requests to NUBC. 1 revised, 1 delayed. ACS – 2 requests: type of bill, new discharge status code. NUBC -- No type of bill code granted (use 089X with DR code); granted patient discharge status code (69 - "Discharged/transferred to a Designated Disaster Alternative Care Site"). Combined drug and alcohol revenue code – NUBC November meeting (minutes not yet released) - new revenue code approved – 0953-Chemical Dependency. Effective date 10/1/13.	CLOSED
11. Additional Agenda Items Next Monthly meeting	Next regular monthly meeting scheduled for January 10, 2013 at BCBSM.	Closed. Informational only

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide for the ***ASC X12/005010X222A1 Health Care Claim: Professional (837)*** *Version 6.0.*
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)* hereinafter referred to as *005010X222A1,* by entities covered under Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This Version 6.0 Minnesota Uniform Companion Guide for the *ASC* X12/005010X222A1 Health Care Claim: Professional (837) supersedes *Version 5.0* and all previous versions. Version 5.0 was announced as a proposed rule for public comment in the *Minnesota State Register,* November 13, 2012, Volume 37, Number 20 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Public comments regarding Version 5.0 were accepted until December 12, 2012. The comments received were reviewed with the assistance of the AUC and changes were made to version 5.0 that were incorporated in version 6.0. An announcement of the adoption of this rule (Version 6.0) was published in the *Minnesota State Register*, Volume xx, Number xx, XXxx, 2013. This document is available at no charge at: www.health.state.mn.us/asa.

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1.0 Overview

1.1 Statutory basis for this proposed rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2 Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program. The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year to year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

Minnesota Statutes, section 62J.03, Subd. 6 defines "group purchaser" as follows:

> "*Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.*

Minnesota Statutes, section 62J.03, Subd. 8 defines "provider or health care provider" as follows:

> "*Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought*

reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Minnesota Statutes, section 62J.536, Subd. 3 defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Minnesota Statutes, section 62J.51, Subd. 11a defines "health care clearinghouse" as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1 Exceptions to applicability

Minnesota Statutes, section 62J.536, Subd. 4 authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (ASC12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)*, hereinafter 005010X279A1)*. This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html.

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction (*005010X279A1*) with group purchasers not covered by HIPAA.

1.3 About the Minnesota Department of Health (MDH)

MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: http://www.health.state.mn.us.

1.3.1 Contact for further information on this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Phone: (651) 201-3570
Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

1.4 About the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the AUC website at: http://www.health.state.mn.us/auc/index.html

1.5 Minnesota Best Practices for the Implementation of Electronic Health Care Transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

Please visit the AUC website at http://www.health.state.mn.us/auc/index.html for more information about best practices for implementing electronic health care transactions in Minnesota.

1.6 Document Changes

The content of this document is subject to change. The version, release and effective date of the document is included in the document, as well as a description of the process for future updates or changes.

1.6.1 Process for updating this document

The process for updating this document, including: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document is available from MDH's website at http://www.health.state.mn.us/asa/index.html.

1.6.2 Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Incorporated all changes proposed in v3.0
5.0	August 6, 2012	Proposed revisions to v4.0
6.0	[Date to be determined] 2012	This version will adopt v5.0 and incorporate any additional changes to v5.0

2.0 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document is the *ASC X12/005010X222A1 Health Care Claim: Professional (837)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, Washington Publishing Company. All Rights Reserved), hereinafter described below as *005010X222A1.* A copy of the full *005010X222A1* can be obtained from the Washington Publishing Company at: http://store.x12.org/store/.

2.1.1 Permission to use copyrighted information

[Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]

2.2 Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X222A1*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X222A1* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

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3.0 How to use this document

3.1 Classification and display of Minnesota-specific requirements

This document has been prepared for use by entities subject to Minnesota's requirements for the standard, electronic exchange of health care administrative transactions (Minnesota statutes, section 62J.536 and related rules) and other interested parties. It provides transaction specific information to be used in conjunction with the *005010X222A1* and other applicable information and specifications noted in section 2.0 above.

Table 4.2 of this document contains a row for each segment for which there is additional information over and above the information in the*005010X222A1*. The tables show the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

This document also contains the following four appendices:

- Appendix A includes a number of sections and provides additional instructions and specifications regarding the use of medical code sets and medical coding;
- Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction and tooth number/oral cavity;
- Appendix C provides brief instructions for reporting the MinnesotaCare (MNCare) Tax; and
- Appendix D includes examples for the v5010 reporting of data in the SV, LIN, or HI segments that was previously submitted in the NTE segment in v4010.

See also section 2.2 regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities covered by Minnesota Statutes, section 62J.536.

3.2 Information About the Health Care Claim: Professional (837) Transaction

3.2.1 Business Terminology

For purposes of this Companion Guide, the following terms have the meaning given to them in this section. Definitions used apply at both the claim and line level. For other definitions related to the Professional health care claim, please refer to section 1.5 of the *005010X222A1*.

3.2.1.1 Provider Definitions[1]

Billing Provider

[1] Sources: *005010X222A1*; National Uniform Billing Committee UB04 Manual. Placeholder -- Cited with permission.

The Billing Provider must be a health care or service provider. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop. Please refer to the *005010X222A1* for more billing provider and other types of provider requirements.

Billing Provider Name:

- Titles must not be used as part of the name as there is a separate field to report titles.
- If enrolled with the payer, the Billing Provider Name must match the enrollment with the payer.

Billing Provider Address: U.S. Postal Addressing Standards – the address must meet the U.S. Postal addressing standards.

Ordering Provider

This is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service. Loop 2310A should be used to report the ordering provider when applicable.

Pay-To Address

The Pay-To Address loop allows the billing provider to indicate a payment address that is different than the billing.

For providers who participate with the group purchaser health plan and are required to complete enrollment forms as part of the contracting process, the payment address submitted on the claim transaction may not be the address where payment is ultimately sent for the claim. The payer in this case may use the payment address from the enrollment form or within the contract rather than the address that is submitted in the 2010AB loop of an electronic claim. The contracted provider must request address changes to the payer records according to the instructions within the provider contract.

When a Pay-To Address loop is sent in addition to billing provider loop, it is the pay-to loop address where the payment should be sent, unless the payer utilizes an enrollment form or a contract.

3.2.1.2 Other Definitions

Factoring Agent

Business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name/address of Pay-To are different than Billing Provider. In order to use the *005010X222A1* for this business situation, the Accredited Standards Committee (ASC) X12 recommends that the Factoring

Agent entity name, address, and identification be submitted as the Pay-To Plan in loop 2010AC. The notes and guidelines should be followed as if the Pay-To Plan entity was performing post payment recovery as described.

Other Payer

The term "other payer" indicates any payer who is not the destination payer. The other payer may be the primary, secondary, tertiary, or even quaternary payer.

Patient

The term "patient" as used in this Companion Guide is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In that case, the patient is not the same person as the subscriber and cannot be uniquely identified separately from the subscriber. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 1.5 of the *005010X222A1* for further details.

Pay-To Plan

In addition to the definition in the *005010X222A1*, business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name and address of Pay-To are different than the Billing Provider. The Factoring Agent name will be placed in the Pay-To Plan loop.

Subscriber

The subscriber is the person or entity whose name is listed on the insurance policy. Other synonymous terms include "member" and/or "insured." In some cases the subscriber is the same person as the patient. See the definition of patient, and see Section 1.5 of the *005010X222A1* for further details.

3.2.2 Provider Identifiers and NPI Assignments

Provider Identifiers

If the provider is a health care provider as defined under federal standards, then the only identifier that is valid is the NPI with the exception of the billing loop. For the billing provider, a secondary identifier of the TIN is also required.

If the provider is not a health care provider as defined under federal standards they are known as atypical providers. Atypical providers do meet the Minnesota statutory definition of health care provider and therefore are required to utilize the electronic administrative transactions for eligibility, claims and remittance advices. For atypical providers, the primary identifier is the TIN and a secondary identifier is allowable. The qualifier for the secondary identifier is 'G2'. The identifier for this qualifier would be the specific payer assigned/required identifier.

3.2.3 Minnesota Requirements for Compliance

This section contains general Minnesota requirements for compliance applicable to this transaction.

Handling Adjustments and Appeals

Determination of Action:

When determining whether to resubmit a claim as an original, request an adjustment or request an appeal, first determine whether the payer has accepted and adjudicated the original claim submission.

- If the original submission was not accepted into the payer adjudication system, resubmit the claim as an original. This is not considered to be an adjustment.
- If the original submission was accepted into the payer adjudication system, see definitions below to determine whether an adjustment or appeal should be requested.

Definitions:

- Adjustment – Provider has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.
- Appeal – Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. Therefore the submission of the appeal is not covered by this guide.

Examples of Appeals include:

- Timely filing denial;
- Payer allowance;
- Incorrect benefit applied;
- Eligibility issues;
- Benefit Accumulation Errors; and
- Medical Policy/Medical Necessity

Process for Submission:

- Adjustment – Provider should submit an adjustment electronically using the appropriate value in CLM05-3 to indicate that this is a replacement claim. If the payer has assigned a payer number to the claim, it must be submitted in loop 2300, REF02, using qualifier F8 in REF01 (Note: the original payer-assigned claim number is not the property and casualty number). If additional information is required to support the adjustment based on payer business rules, the SV101-7, NTE segment, PWK segment, or Condition Codes should be used. See section 3.2.5 below regarding these segments for appropriate instructions.
- Appeal – Follow payer standard processes for requesting an appeal to a previously adjudicated claim. If paper appeal process is utilized, then a

standard, Best Practice Minnesota appeal form is available at the AUC website at http://www.health.state.mn.us/auc/index.html. Additional documentation should be sent as required by the payer to support the appeal consideration; this documentation does not include resubmission of the claim.

3.2.4 Claim Frequency Type Code (CFTC) Values

Claim/Bill submissions are often original, first time submissions with no follow-up submissions. In some cases, subsequent submissions directly related to a prior submission will be necessary. When subsequent submissions occur, for legitimate business purposes, the normal processing flow may change.

Since a relationship between an original submission and subsequent submissions are necessary, the data requirements both for original and subsequent submissions must be specified. For example, when a Replacement bill is submitted (CFTC 7), in order to meet the processing requirement to void the original and replace it with the re-submitted bill, common consistent data elements would be required. To qualify as a Replacement, some data would need to be different than the original. If the bill is re-submitted with no changes from the original, and the claim was accepted by the payer, this would be considered a Duplicate instead of a Replacement. If the bill is resubmitted with no changes from the original and the original was not accepted by the payer, this will be considered an original claim. These distinctions are important to allow for proper handling of the submission.

Refer to the current National Uniform Billing Committee (NUBC) code list for allowed values and usage descriptions. Both the sender and receiver must understand how each code value should be interpreted and what processing requirements need to be applied.

In conjunction with the CFTC code values, Condition Codes may be submitted that will impact processing and handling requirements.

3.2.5 Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional information. The NTE segment must not be used to report data elements that are codified within this transaction. If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV101-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X222A1.*
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.
- If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE or SV101-7 will exceed available characters, use only the PWK segment at the claim level.
- When populating the PWK segment, the following guidelines must be followed:

- PWK01 - Attachment Report Type Code is a required element: The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
- PWK06 - Attachment Control Number is a situational element that is required if the transmission type is anything other than 'available upon request'. This value is used to identify the attachment. Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

4.0 ASC X12/005010X222A1 Health Care Claim: Professional (837) -- Transaction Specific Information

4.1 Introduction to Table

The following table provides information needed to implement the *ASC X12/005010X222A1 Health Care Claim: Professional (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X222A1* and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

Note: The designation "N/A" in Table 4.2 below means that the "Value Definition and Notes" applies to the segment rather than a particular data element.

Please also see section 2.2 above.

4.2 *005010X222A1* Professional (837) -- Transaction Table

Table 4.2 005010X22A1 **Professional (837)**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2010AA Billing Provider Name	NM1 Pay-to Address Name	N/A	See front matter section 3.2.1.1 of this document for definition and usage of pay-to information.
2010AB Pay-To Address Name	NM1 Pay-to Address Name	N/A	See front matter section 3.2.1.1 of this document for definition and usage of pay-to information
2010AC Pay-To Plan Name	NM1 Pay-To Plan Name	N/A	See front matter section 3.2.1.2 of this document for definition and usage of pay-to information.
2000B Subscriber Hierarchical Level	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.

Table 4.2 005010X22A1 **Professional (837)**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
		Code	
2010BA Subscriber Name	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
	DMG Subscriber Demographic Information	DMG02 Subscriber Birth Date	Services to unborn children should be billed under the mother as the patient.
2010BB Payer Name	REF Billing Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2010CA Patient Name	DMG Patient Demographic Information	DMG02 Patient Birth Date	Services to unborn children should be billed under the mother as the patient.
2300 Claim Information	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definitions.
		CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
		PWK02	Use of AA value may result in a

Table 4.2 005010X22A1 **Professional (837)**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
		Report Transmission Code	delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
	AMT Patient Amount Paid	AMT02 Monetary Amount	Must not exceed total claim charge amount in CLM02.
	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
	K3 File Information	N/A	See Appendix B of this document for usage instructions.
	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310A Referring Provider Name	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310B Rendering Provider Name	REF Rendering Provider	N/A	See front matter section 3.2.2 of this document for usage.

Table 4.2 005010X22A1 **Professional (837)**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
	Secondary Identification		
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310C Service Facility Location Name	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2320 Other Subscriber Information	SBR Other Subscriber Information	N/A	Do not send claim to secondary or any subsequent payer until previous payer has processed.
2330B Other payer name	NM109 Identification Code	N/A	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400 Service Line Number	SV1 Professional Service	SV101-7 Description	See front matter section 3.2.5 of this document for additional instructions.
		SV103 Unit or Basis for Measurement Code	See Appendix A for coding units.
		SV104 Quantity	Zero “0” is not a valid value.
		SV107-1 Diagnosis Code Pointer	Primary diagnosis code cannot point to an External Cause of Injury code.

Table 4.2 005010X22A1 **Professional (837)**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
	DTP Date - Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
	AMT Sales Tax Amount	N/A	See Appendix C of this document for details on reporting MNCare Tax
	K3 File Information	N/A	See Appendix B of this document for usage instructions.
	NTE Line Note	N/A	See front matter section 3.2.5 of this document for definition and usage
2420A Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420B Purchased Service Provider Name	REF Purchased Service Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420C Service Facility	REF Service Facility	N/A	See front matter section 3.2.2 of this document for usage.

Table 4.2 005010X22A1 **Professional (837)**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
Location Name	Location Secondary Identification		
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420E Ordering Provider Name	NM1 Ordering Provider Name	N/A	See front matter section 3.2.1.1 of this document for definition.
	N3 Ordering Provider Address	N/A	This segment is recommended for use when the following N4 segment is used.
	REF Ordering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420F Referring Provider Name	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
		REF01 Reference Identification Qualifier	Use G2 for atypical providers.

5.0 List of Appendices

Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides

Appendix A lists rules and related information for the selection and use of medical codes from HIPAA code sets. The appendix includes the following four tables with specific coding requirements and examples:

- Table A.5.1 -- Minnesota Coding Specifications: When to use codes different from Medicare
- Table A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs
- Table A.5.3 -- Substance Abuse Services
  a) Hospital
  b) All other residential
  c) Outpatient
- Table A.5.4 -- Maternal And Child Health Billing Guide For Public Health Agencies
  a) Public health nurse clinic services
  b) Maternal & child health visits
  c) Other services and Miscellaneous

Appendix B: K3 Segment Usage Instructions

Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction and tooth number/oral cavity.

Appendix C: Reporting MNCare Tax

Appendix C provides brief instructions for reporting the MinnesotaCare (MNCare) Tax

Appendix D: Examples – Data Previously Submitted in the NTE Segment Now Submitted in the SV, LIN, or HI segments

Appendix D includes examples for the v5010 reporting of data in the SV, LIN, or HI segments that was previously submitted in the NTE segment in v4010.

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Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides

A.1 Introduction and Overview

Minnesota Statutes, Section 62J.536 requires the standard, electronic exchange of health care claims using a single, uniform companion guide to HIPAA implementation guides,[2] including uniform billing and coding standards. The statute further requires the Commissioner of Health to base the transaction standards and billing and coding rules on federal HIPAA requirements and on the Medicare program, with modifications that the commissioner deems appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC).

This appendix, including the accompanying tables, presents rules for the selection and use of medical codes from the HIPAA code sets that are associated with the 005010X22A1 Professional (837) transaction.

The appendix was developed in consultation with the AUC and its Medical Code Technical Advisory Group (TAG).

NOTE-- As further described in the sections below:

1. All codes must be compliant with federal HIPAA requirements.
2. This appendix **does not** address or govern:
    a. the services or benefits that are eligible for payment under a contract, insurance policy, or law;
    b. payment for health care services under a contract, insurance policy, or law.
3. This appendix includes the following four tables which must also be consulted when selecting and using medical codes:
    a. Table A.5.1: Minnesota Coding Specifications: When to Use Codes Different From Medicare;
    b. Table A.5.2: Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique to State Government Programs;
    c. Table A.5.3: Substance Abuse Services.
    d. Table A.5.4: Maternal And Child Health Billing Guide For Public Health Agencies
4. This Appendix and its accompanying tables establish requirements for the selection and use of medical codes. The coding requirements vary as indicated by the type of service/procedure/product being provided. Depending on the service/procedure/product provided, the requirement in this appendix will be to select codes in the following order:

[2] Described in Code of Federal Regulations, title 45, part 162.

a. The subset of HIPAA codes based on specific Minnesota coding requirements in Tables A.5.1, A.5.2, A.5.3, or A.5.4.

b. If the tables above do not apply, or if the table states "follow Medicare guidelines", use HIPAA codes for the federal Medicare program ("Follow Medicare Coding Guidelines");

5. If a. or b. above does not apply, use the HIPAA-compliant codes that most appropriately describe the service/procedure/product provided. Codes with identical descriptions may be used interchangeably. If codes do not have an identical description then follow section A.3.2, "Instructions for Use", regarding use of the most appropriate code.
6. This appendix does not replace or substitute for standard, national coding resources for HIPAA-adopted code sets (including manuals, online resources, etc.). Consult coding resources for descriptions, definitions, and directions for code usage.
7. Medicare and national codes often change. National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes. (See also section A.4.)

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes. [3]

Consistent with the HIPAA electronic Transactions and Code Sets regulations, all covered entities are required to submit or receive codes that are:

- valid on the date of service for medical code sets;
- valid at the time the transaction was created and submitted for non-medical code sets.

This Appendix includes requirements and information related to the HIPAA code sets, as well as: modifiers found in the CPT and HCPCS Level II including those established for definition by State Medicaid; revenue codes – a data element of the institutional claim; units of service (basis for measurement).

A.3 Code Selection and Use

A.3.1 General Rules

[3] CPT is a registered trademark of the American Medical Association (AMA); ICD-9-CM is maintained and distributed by the National Center for Health Statistics, U.S. Department of Health and Human Services (HHS); HCPCS are developed by the Centers for Medicare and Medicaid Services (CMS); Revenue codes are developed by the National Uniform Billing Committee (NUBC). Code set updates[3] can be found at websites of the organizations named above.

1. Select codes that most accurately identify the procedure/service/product provided. Codes with identical descriptions may be used interchangeably. If codes do not have identical description, then follow A.3.2 regarding use of the most appropriate code.
2. The medical record must always reflect the procedure/service/product provided.
3. Use instructions in this appendix and the accompanying tables A.5.1, A.5.2, A.5.3, and A.5.4 to select and use required codes.

A.3.2 Instructions for Using This Appendix and Its Accompanying Tables

1. For the state government behavioral health programs identified in Table A.5.2, use the codes referenced in the table.
2. For substance abuse services, use the codes listed in Table A.5.3.
3. For Maternal and Child Health Billing Guide for Public Health Agencies use the codes listed in Table A.5.4.
4. For all other procedures/services/products, use Table A.5.1 as follows:
   a) Step 1. Find the appropriate row ("Medicare Claims Processing Manual Chapter") in Table A.5.1 for the type of procedure/service/product provided.
   b) Step 2. If the "Minnesota Rule" column in Table A.5.1 states "Follow Medicare Coding Guidelines", then select and use codes consistent with the claims submission coding instructions and requirements maintained by or on behalf of the Centers for Medicare and Medicaid Service (CMS) (e.g., Medicare Claims Processing Manual and communications from or on behalf of CMS).
      1. Note: Exception to the "Follow Medicare Coding Guidelines" statement above. If either of the following applies:
         - The procedure/service/product is listed in a Medicare coding resource but is limited by Medicare coverage; OR
         - The procedure/service/product is not listed in a Medicare coding resource;

         THEN**:** select the code(s) that most accurately identify the procedure/service/product provided. CPT codes are preferred, but HCPCS Level II codes can be used if they describe the service more completely (e.g. H, S, T codes). Codes with identical descriptions may be used interchangeably.
   c) Step 3. If the "Minnesota Rule" column for the row describing the type of procedure/service/product being provided states other than "Follow Medicare Coding Guidelines", then use the specific code(s) and/or instructions listed.
5. For procedures/services/products not found in Tables A.5.1, A.5.2, A.5.3, or A.5.4, select the code(s) that most accurately identify the procedure/service/product provided. CPT codes are preferred, but HCPCS Level II codes can be used if they describe the service more completely (e.g. H, S, T codes). Codes with identical descriptions may be used interchangeably.

Note: Table A.5.1 lists chapter headings from the “Medicare Claims Processing Manual”. Each chapter entry has an associated “Minnesota Rule” (e.g., “Follow Medicare Coding Guidelines” or other, more specific instructions). For some chapters (e.g., “Chapter 21 – Medicare Summary Notices”, “Chapter 22 – Remittance Notice to Providers”, and others), the requirement is stated as "Not applicable to coding guidelines". These chapters are relevant to Medicare business processes but do not pertain to coding requirements of this Appendix and may be disregarded.

A.3.3 When Instructions Differ From “Follow Medicare Coding Guidelines”

In some instances shown in the accompanying tables, requirements are to code differently than Medicare with the code(s) and/or instructions stated. Coding that is different from Medicare resulted because:

1. Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare’s coding guidelines based on their coverage policies and member benefits.
2. More specific or appropriate codes are needed in order to reduce manual processing and administrative costs.
3. Duplicate codes exist and clarification of which code(s) to use is needed.
4. Medicare does not have a guideline for coding a service or made no specific reference to a service but the AUC Medical Code Technical Advisory Group (TAG) had knowledge of differing submission requirements.

Specific coding instructions that are listed in Tables A.5.1, A.5.2, A.5.3, and A.5.4 as other than “Follow Medicare Coding Guidelines” apply only to a limited subset of particular codes or a category of codes selected on the basis of the criteria above.

A.3.4 Additional Coding Specifications

A.3.4.1 Modifiers

Modifiers are found in the CPT and HCPCS Level II including those allowed by CMS to be defined by State Medicaid agencies.

The Minnesota Department of Human Services (DHS) has specifically defined select “U” modifiers to help identify and administer their legislatively required programs. These definitions can be found on the DHS website at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_167693.

Minnesota group purchasers accept all modifiers including DHS defined modifiers. This appendix includes a list of required program-specific modifiers for some Minnesota Department of Human Services (DHS) programs.

A.3.4.2 Units (basis for measurement)

The number of units is the number of services performed and reported per service line item as defined in the code description unless instructed differently in this appendix.

The following are clarifications/exceptions:

- Report one unit for all services without a measure in the description.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
  - "per vertebral body"
  - "each 30 minutes"
  - "each specimen"
  - "15 or more lesions"
  - "initial".
- Follow all related AMA guidelines in CPT[4] (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis." [5]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow general rounding rules for reporting more than the code's time value. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

A.4 Submitters and Receivers Are Responsible for Selecting And Using The Correct, Appropriate Medical Codes

Codes used in this appendix were valid at the time of approval for publication of this companion guide. Code set changes may result in this appendix reflecting a deleted code or not reflecting a new code. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes.

[4] Current Procedural Terminology (CPT®), copyright 2012 American Medical Association
[5] Current Procedural Terminology (CPT®), copyright 2012 American Medical Association

Per the HIPAA Transactions and Code Set Rule [Code of Federal Regulations, title 45, part 162], *"those that [send or] receive standard electronic administrative transactions must be able to [send], receive and process all standard codes irrespective of local policies regarding reimbursement for certain conditions or procedures, coverage policies, or need for certain types of information that are part of a standard transaction."*

A.5 Tables of Coding Requirements

A.5.1 Minnesota Coding Specifications: When to Use Codes Different From Medicare

Table A.5.1 below lists chapters from the Medicare Claims Processing Manual, which can be accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html. In addition, in the electronic version of this document each of the chapter titles below is also provided as a link to the corresponding chapter of the Medicare Claims Processing Manual.

For Instructions on the use of Table A.5.1 see Section A.3.2.

Please note: Table A.5.1 below references several standard health care claims transactions as follows:

- *ASC X12/005010X222A1 Health Care Claim: Professional (837),* referred to in Table A.5.1 as "professional claim type" or "837P" or "Professional claim"
- *ASC X12/005010X224A2 Health Care Claim: Dental (837)*, referred to in Table A.5.1 as "837D"
- *Pharmacy Claims Submission and Response and the Pharmacy Reversal Submission and Response Transactions per the NCPDP Telecommunication Standard Implementation Guide, Version D.Ø*, referred to in Table A.5.1 as "NCPDP".

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
1	General Billing Requirements		Follow Medicare coding guidelines
2	Admission and Registration Requirements		Not applicable to coding guidelines
3	Inpatient Hospital Billing		Follow Medicare coding guidelines
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Outpatient professional services provided by CAH, Method II billing	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).
5	Part B Outpatient Rehabilitation and CORF/OPT Services		Follow Medicare coding guidelines
6	Inpatient Part A Billing and SNF Consolidated Billing		Not applicable to Professional claim
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Not applicable to Professional claim
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
10	Home Health Agency Billing	PCA and Homemaking Services	PCA: T1019 PCA Shared 1:2: T1019-TT PCA Shared 1:3 or more: T1019-HQ PCA Temporary Service Increase: T1019-U6 PCA Notice of Reduction: T1019-U5 RN PCA Supervision: T1019-UA Homemaking: S5130, S5131 PCA services may not be billed with a span of dates; each date of service must be billed separately.
		Home Infusion	Home infusion is not addressed in this chapter. See instructions following this table.
11	Processing Hospice Claims		Not applicable to Professional claim
12	Physicians/Nonphysician Practitioners	Allergy, clinical immunology	Medicare does not allow all allergy and clinical immunology codes, but group purchasers accept all applicable codes. Follow the code selection guidelines in the front of Appendix A.
		Modifier 50	Modifier 50 should only be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
		Bilateral Radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
		E-visits	For E-visits, use 99444 for MD/DO/DC; use 98969 for nonphysician healthcare professionals (e.g. Nurse Practitioner, Physician Assistant, and Clinical Nurse Specialist).
		Telephone services	For telephone services, use 99441-99443 for MD/DO/DC; use 98966-98968 for nonphysician healthcare professionals (e.g. Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist).

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
		Interpreter services	To report interpreter services: Note: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report one unit. • T1013 -- Face-to-face oral language interpreter services per 15 minutes • T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes • T1013-GT -- Telemedicine interpreter services per 15 minutes • T1013-U4 -- Telephone interpreter services per 15 minutes • T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting • Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient • T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provided, report each on a separate line appended with the -59 modifier ▪ T1013-52 x 2 units (30 minutes of drive time) ▪ T1013-52 59 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported o A canceled service may only be reported if the interpreter has already arrived for the

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
			appointment prior to the cancellation • 99199 -- Mileage for interpreter service o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported o Report one unit per mile
		Collaborative psychiatric consultation	Coding for a consultation initiated by the primary care provider (MD, DO, NPP) to psychiatrist for an opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care 99499 HE AG U7 (by physician extender) • Primary Care 99499 HE AG U4 U7 (non-face-to-face by physician extender) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face)
		Patient not in exam room	There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-9-CM code(s) for the diagnosis of the patient as the primary diagnosis or diagnoses. Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapt. No.</th><th>Title/Description</th></tr>
<tr><td></td><td></td><td>Health Care Homes</td><td>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
<table>
<tr><th>Patient Complexity Level</th><th>Complexity Modifiers</th><th>Non English Speaking Modifier</th><th>Active Mental Health Condition</th></tr>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Intermediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>
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</td></tr>
<tr><td></td><td></td><td>ImPACT testing</td><td>96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only</td></tr>
<tr><td>13</td><td>Radiology Services and Other Diagnostic Procedures</td><td>Technical and professional component</td><td>If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components</td></tr>
</table>

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
		Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
		Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
		Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method
15	Ambulance	General	Follow Medicare coding guidelines
		Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: o A0080 o A0090 o A0100 o A0110 o A0120 o T2002 o T2003 o T2004

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
16	Laboratory Services	Repeat services	Modifiers 76 or 91 are to be used for repeat services subsequent to the original service only. The number of units reported is the number of services performed as defined in the code description or relevant AMA guidelines in CPT[6]
		Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
		New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.
		Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-9 code set instructions. All applicable diagnoses should be submitted.
		Roster billing	Roster billing is not applicable to Minnesota Group Purchasers
		Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations

[6] Current Procedural Terminology (CPT®), copyright 2012 American Medical Association

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
18	Preventive and Screening Services (continued)	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code
		Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
		C&TC	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. ▪ Maternal depression screening: 99420 UC ▪ Developmental screening: 96110 ▪ Child Mental Health Screening: 96110 UC ▪ Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately. ▪ Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
			reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. ▪ Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed. ▪ Use most appropriate diagnosis code based on patient age.
19	Indian Health Services	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
		Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
		Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit
		Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.
21	Medicare Summary Notices		Not applicable to coding guidelines
22	Remittance Advice		Not applicable to coding guidelines

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
See the following regarding "Home Infusion Therapy" and "Licensed Traditional Midwife Services (Not Certified Nurse Midwives)" that are not addressed in any chapter of the Medicare Claims Processing Manual.			
N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes). Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. <u>Place of Service:</u> 25 – Birthing Center <u>HCPCS Code:</u> Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, office/center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits. Fragmented services may be reported in certain circumstances: • If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes). • If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. • Global services may be split when the

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapt. No.	Title/Description		
			patient's prenatal/antepartum services are less than four visits (use E/M service). • Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal period. Urine dip sticks are considered part of the global package. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.

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A.5.2 Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to Minnesota Government Programs

Table A.5.2 lists behavioral health procedure code and modifier combinations for identifying specific benefit packages unique to Minnesota government programs. The behavioral health modifiers displayed in Table A.5.2 are listed and defined below.

A.5.2.1 Mental Health-Related Modifiers Appearing in Table A.5.2

HA	Child/adolescent program
HE	Mental health program
HK	Specialized mental health programs for high-risk populations
HM	Less than bachelor's degree
HN	Bachelor's degree
HQ	Group setting
HR	Family/couple with client present
HW	Funded by state mental health agency (service provided by state staff person)
UA	Children's Therapeutic Services and Supports (CTSS)
UD	Transition to community living (Adult Rehabilitation Mental Health Services (ARMHS))
U1	Dialectical Behavioral Therapy
U4	Via other than face to face contact; e.g. telephone
U5	Advanced level
U6	Interactive
U7	Physician extender (includes mental health practitioner as defined by MN Statute 245.4711, Subd. 17)

A.5.2.2 Table A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Table A.5.2 shows code/modifier combinations for the programs listed below that are administered by the Minnesota Department of Humans Services (DHS). In the electronic version of this document, clicking on the program from the list below will take the reader to the program listing in Table A.5.2.

Behavioral Health Programs listed in Table A.5.2
Assertive Community Treatment (ACT)
Adult Crisis Response Services
Children's Mental Health Crisis Response Services

Behavioral Health Programs listed in Table A.5.2
Mental Health Targeted Case Management (MH-TCM)
Children's Mental Health Residential Treatment Services
Intensive Residential Treatment Services (IRTS)
Adult Day Treatment
Children's Day Treatment
Children's Therapeutic Services and Supports (CTSS)
Adult Rehabilitative Mental Health Services (ARMHS)
Peer Services
Mental Health Diagnostic Assessment
Dialectical Behavior Therapy
Youth Assertive Community Treatment

Please note: Table A.5. 2 below references standard health care claims transactions as follows: ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.2 as “837I”.

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Assertive Community Treatment (ACT) Back to list of behavioral health programs	▪ An intensive, comprehensive, non-residential rehabilitative mental health services (ARMHS) team model. Consistent with ARMHS - multidisciplinary total team approach. ▪ Patients with serious mental illness who require intensive services; time unlimited basis, available 24/7/365. ▪ Face-to-face, all-inclusive daily rate. ▪ One provider per day	Codes: ▪ H0040 - Assertive community treatment program, per diem
Adult Crisis Response Services Back to list of behavioral health programs	▪ County or county-contracted mental health professional, practitioner, or rehab worker; or crisis intervention team. ▪ Crisis assessment, intervention, stabilization, community intervention. ▪ Immediate, face-to-face evaluation, determine need for emergency services or referrals to other resources.	Codes: ▪ S9484 – Adult individual crisis assessment, intervention and stabilization, individual, by mental health professional or practitioner ▪ S9484 HM – Adult crisis assessment, intervention and stabilization, individual, by mental health rehabilitation worker ▪ S9484 HN – Adult crisis assessment, intervention and stabilization, individual, by mental health practitioner ▪ S9484 HQ – Adult crisis stabilization, group ▪ H0018 – Adult crisis stabilization, residential ▪ 90882 HK – Environmental intervention for medical management, community intervention ▪ 90882 HK HM – Environmental intervention for medical management, community intervention, mental health rehabilitation worker

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Children's Mental Health Crisis Response Services Back to list of behavioral health programs	▪ Intensive face-to-face, short-term services initiated during a crisis; provided on-site by a mobile crisis response team. ▪ County or county contracted agency.	Codes: ▪ S9484 UA - Crisis intervention mental health services, per hour, Children's Crisis Response Services, mental health professional ▪ S9484 UA HN - Crisis intervention mental health services, per hour, Children's Crisis Response Services, bachelor's degree level mental health practitioner
Mental Health Targeted Case Management (MH-TCM) Back to list of behavioral health programs	▪ Community support plan and functional assessment to help SPMI adults and SED children gain access to needed medical, social educational, vocational, financial services relative to mental health needs.	Codes: ▪ T2023 HE HA – Targeted case management; per month, mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years ▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older ▪ T2023 HE TF - Targeted case management intermediate level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older ▪ T1017 HE – Targeted case management, per encounter (day), mental health program, adult, face-to-face contact between case manager and recipient age 18 or older, IHS/638 facilities and FQHCs

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
		▪ T1017 HE HA – Targeted case management, per encounter (day), mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years, IHS/638 facilities and FQHCs
Children's Mental Health Residential Treatment Services Back to list of behavioral health programs	▪ 24-hour-a-day program under clinical supervision of a mental health professional, provided in a community setting.	▪ When reporting room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. ▪ When room and board and treatment are billed to separate entities, treatment is reported on the 837P, with HCPCS Code H0019.
Intensive Residential Treatment Services (IRTS) Back to list of behavioral health programs	▪ Time-limited mental health services provided in a residential setting to recipients in need of more restrictive settings and at risk of significant functional deterioration. ▪ Develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.	▪ When reporting room and board and treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. ▪ When room and board and treatment are billed to separate entities, treatment is reported on the 837P, with HCPCS Code H0019.
Adult Day Treatment Back to list of behavioral health	▪ A structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a recipient's mental health status, develop	Codes: ▪ H2012 - Behavioral health day treatment, per hour

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
programs	and improve independent living and socialization skills	
Children's Day Treatment Back to list of behavioral health programs	▪ A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services provided by multidisciplinary team.	Codes: ▪ H2012 UA HK – Behavioral health day treatment, per hour, CTSS ▪ H2012 UA HK U6 – Behavioral health day treatment, per hour, CTSS interactive
Children's Therapeutic Services and Supports (CTSS) Back to list of behavioral health programs	▪ Rehabilitative services that offer a broad range of medical and remedial services and skills to help restore individuals' self-sufficiency/functional abilities - a flexible package of mental health services for children.	Codes: ▪ 90832 UA - Individual psychotherapy, 30 minutes, CTSS ▪ Appropriate E/M UA plus 90833 UA – Individual psychotherapy 30 minutes with E/M, CTSS ▪ 90834 UA - Individual psychotherapy, 45 minutes, CTSS ▪ Appropriate E/M UA plus 90836 UA - Individual psychotherapy 45 minutes with E/M, CTSS ▪ 90837 UA - Individual psychotherapy, 60 minutes, CTSS ▪ Appropriate E/M UA plus 90809 UA -Individual psychotherapy 60 minutes with E/M, CTSS ▪ 90875 UA - Biofeedback training, CTSS ▪ 90846 UA - Family psychotherapy without patient, CTSS ▪ 90847 UA - Family psychotherapy with patient, CTSS ▪ 90849 UA - Multiple family group psychotherapy, CTSS ▪ 90832 UA plus 90785 UA - Interactive

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Children's Therapeutic Services and Supports (CTSS) **(continued)** Back to list of behavioral health programs		individual psychotherapy 30 minutes, CTSS ▪ Appropriate E/M UA plus 90833 UA plus 90785 UA - Interactive individual psychotherapy 30 minutes with E/M, CTSS ▪ 90834 UA plus 90785 UA - Interactive individual psychotherapy 45 minutes, CTSS ▪ Appropriate E/M UA plus 90836 UA plus 90785 UA - Interactive individual psychotherapy 45 minutes with E/M, CTSS ▪ 90837 UA plus 90785 UA - Interactive individual psychotherapy 60 minutes, CTSS ▪ 90853 UA - Group psychotherapy, CTSS ▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS ▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2012 UA - Behavioral health day treatment, per hour, therapeutic components of preschool program, 60 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS
Adult Rehabilitative Mental Health Services	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes ▪ H2017 HM - Basic living and social skills,

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
(ARMHS) Back to list of behavioral health programs **Adult Rehabilitative Mental Health Services (ARMHS)** **(continued)** Back to list of behavioral health programs	and community skills.	individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner ▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker ▪ 90882 - Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD - Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
Peer Services Back to list of behavioral health programs	Non-clinical support counseling services provided by certified peer specialist.	Codes: ▪ H0038 – Certified peer specialist services, per 15 minutes ▪ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes
Mental Health		Codes:

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Diagnostic Assessment Back to list of behavioral health programs		In order to report diagnostic assessments with levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health programs		Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ U2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
		▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20

A.5.3 Substance Abuse Services

Table A.5.3 is to be used for reporting substance abuse services by delivery setting category. The table has been divided into three parts based on the delivery setting, as follows:

a) Hospitals;

b) All other residential; and

c) Outpatient Services.

The tables incorporate both institutional and professional claim types for ease of reference.

Please note: Table A.3 below references standard health care claims transactions as follows:

- *ASC X12/005010X222A1 Health Care Claim: Professional (837),* referred to in Table A.5.3 as "Professional" or "837P".
- *ASC X12/005010X223A2 Health Care Claim: Institutional (837),* referred to in Table A.5.3 as "Institutional" or "837I"

Table A.5.3.a - Substance Abuse Services: Hospital

Table A.5.3.a -- Substance Abuse Services: Hospital (Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)						
Service Description	**Option 1 or 2 ***	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board		Day	0118, 0128, 0138, 0148, 0158	N/A	837I	011x-hospital inpatient
Detox			0116, 0126, 0136, 0146, 0156			
Treatment component			Choose one per date of service: 0944 or 0945 or 0949			
Ancillary		Based on Revenue Code	As appropriate			
All-inclusive Room and Board	2	Day	0101			
Detox			0116, 0126, 0136, 0146, 0156			
Ancillary Services		Based on Revenue Code	as appropriate			

***Note:** "Option 1" treatment is reported separately from room and board. "Option 2" is all-inclusive: includes room and board and treatment.

Table A.5.3.b Substance Abuse Services: All Other Residential

A.5.3.b – Substance Abuse Services: All Other Residential					
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	Day	1002: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) 1003: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox		0116, 0126, 0136, 0146, 0156			
Treatment program, treatment component		Choose one per date of service: 0944 or 0945 or 0949			
Ancillary services	Based on revenue code	As appropriate			

Table A.5.3.c – Substance Abuse Services: Outpatient Services

Table A.5.3.c – Substance Abuse Services: Outpatient Services (Applicable to all providers and settings per applicable contract or established program standards)				
Claim Type – 837I				
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	0944 or 0945	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Treatment(MAT) – methadone, buprenorphine, naltrexone, antabuse (LIN segment to identify drug)	Day	0944	H0020	
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x
Claim Type – 837P				
Service Descriptions	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Treatment (MAT) – methadone, buprenorphine, naltrexone, antabuse (LIN segment to identify drug)	Day		H0020	
Alcohol and/or drug assessment	Session/visit		H0001	

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A.5.4 Maternal And Child Health Billing Guide For Public Health Agencies

Table A.5.4 is to be used for reporting Maternal and Child Health services for public health agencies. The table has been divided into three parts as follows:

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and Miscellaneous

Table A.5.4.a -- PUBLIC HEALTH NURSE CLINIC SERVICES

Maternal And Child Health Billing Guide For Public Health Agencies Table A.5.4.a -- Public health nurse clinic services		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Services Include: • Health Promotion & Counseling • Nursing Assessment & Diagnostic Testing • Medication Management • Nursing Treatment • Nursing Care, in the home, by RN (PHN & CPHN)	**S9123**	**T1015**
Home health aide or CNA, per visit	**T1021**	**Individual S9445** **Group S9446**
Patient Education only - if no other services (includes car seat education)	**S9123**	

Table A.5.4.b -- MATERNAL & CHILD HEALTH VISITS

Maternal And Child Health Billing Guide For Public Health Agencies Table A.5.4.b -- Maternal & child health visits		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Birthing Classes		**S9442**
Home Visit for Postnatal assessment & follow up care - **Mother**	**99501**	N/A
Home Visit for Post-natal assessment & follow up care - **Newborn**	**99502**	N/A
Enhanced Services - for at-risk pregnancies as determined by the physician/nurse practitioner		
At-Risk Antepartum Management	**H1001**	**H1001**
At-Risk Care Coordination	**H1002**	**H1002**
At-Risk Prenatal Health Education	**H1003**	**H1003**
At-Risk Prenatal Health Education I	**H1003**	**H1003**
At-Risk Prenatal Health Education II	**H1003**	**H1003**
At-Risk Enhanced Service; Follow-up Home Visit	**H1004**	N/A
At-Risk Enhanced Service Package	**H1005**	**H1005**

Table A.5.4.c – Other services and Miscellaneous

Maternal And Child Health Billing Guide For Public Health Agencies Table A.5.4.c -- Other services		
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **assessment** and intervention, individual, face-to-face with patient, each 15 minutes	**97802**	**97802**
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **re-assessment** and intervention, individual, face-to-face with patient, each 15 minutes	**97803**	**97803**

Maternal And Child Health Billing Guide For Public Health Agencies Table A.5.4.c -- Miscellaneous		
Maternal Depression Screenings	**99420 UC**	**99420 UC**
Child Developmental Screenings	**96110**	**96110**
Child Mental Health Screenings	**96110 UC**	**96110 UC**
TB Case Management	**T1016**	**T1016**
TB Direct Observation Therapy	**H0033**	**H0033**

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Appendix B: K3 Segment Usage Instructions

The K3 segment in the 2300 and 2400 Loops is used to meet regulatory requirements when the X12N Committee has determined that there is no alternative solution within the current structure of the *005010X222A1*. The situations noted here have been approved by the X12N Committee and will be considered as a business need in development of future versions of this transaction. If multiple K3 needs exist on a single claim at the same loop level, it is recommended that separate K3 segments be sent.

State of Jurisdiction

In workers' compensation, insurance carriers have indicated a need to determine jurisdiction in certain situations. For this workers' compensation implementation, providers may populate this field with the appropriate state code.

LU is the qualifier to indicate this value and should be followed by the two-character state code.
Report at 2300 Loop only.

K3*LUMN~

Tooth Number/Oral Cavity

Oral surgeons and other non-dentist providers that supply oral cavity related procedures may have a need to report tooth number and/or oral cavity within the *005010X222A1* for proper benefit determination. To report the tooth number and/or oral cavity, the K3 segment should be used.

JP is the qualifier to indicate this value tooth number and should be followed by the actual tooth number value. Multiple tooth numbers may be reported in the same K3 segment with a space break between each number as indicated by the second example below.
Report at 2400 Loop only.

K3*JP12~
K3*JP12 14~

JO is the qualifier to indicate oral cavity and should be followed by the oral cavity value. Multiple oral cavities may be reported in the same K3 segment with a space break between each number.
Report at 2400 Loop only.

K3*JO10~

NOTE: Additional information can be found concerning the use of the K3 segment discussed here on the ASC X12N Interpretations Portal: http://www.x12n.org/portal. Search for HIR numbers:

- 628: State of Jurisdiction
- 638: Send Tooth Information in K3

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Appendix C: Reporting MNCare Tax

NOTE: Instructions for MNCare Tax billing only apply if the provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document **DOES NOT** require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT.

- MNCare Tax must be reported as part of the line item charge and reported in the corresponding AMT tax segment on the lines.

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Appendix D: Examples – Data Previously Submitted in the NTE Segment Now Submitted in the SV, LIN, or HI Segments

The 5010 version of the 837 (ASC/X12 005010X222A1 Health Care Claim: Professional (837)) requires that certain information previously submitted in the NTE segment now be submitted in the SV, LIN, or HI segments. The table below is not an all-inclusive list but provides examples of scenarios in which data reporting has changed.

Table D1. Example data previously provided in NTE in version 4010 with current 5010 usage

Examples	Data provided in NTE in 4010	5010 Usage
Dental Policy	Dental policy to include the diagnosis if the treatment is accident related, for cleft lip/palate or TMJ diagnosis	HI
Hearing Aids	Hearing Aids: Purchase requires the model number from the hearing aid contract.	SV
Medical Supplies/Enteral Products	Medical Supplies/ Enteral Products: Description of supply for auto pricing	SV
Modifiers	Modifiers: 5 + modifiers; use 99 in the fourth modifier position and list the additional modifiers	SV
NDC for certain drugs	E.g., unlisted drug codes, compounded drugs, physician administered drugs	LIN
Unlisted codes	NOC HCPCS/CPT code, regardless of charge, needs a narrative description submitted. Miscellaneous CPT/CDT Codes require a description of service to determine if covered.	SV

Key changes in the proposed revised 005010X222A1 837P (Professional) Minnesota Uniform Companion Guide (MUCG)

The table below describes changes made during the 30-day comment period from the version currently proposed at the AUC website at: http://www.health.state.mn.us/auc/guides.htm

Changes from current 005010X222A1 837P (Professional) to proposed new version	Page no. (proposed version)	Page no. (revised proposed new version)
1. ***Appendix A:*** The Appendix A (*Medical Code Set – Supplemental Information for Minnesota Uniform Companion Guides*) has been revised and updated with additional information, including:		
a. Table A.5.2, "*Behavioral Health Procedure Code/ Modifier Combinations: For Specific Benefit Packages Unique to State Government Programs*" changes include:		
i. Addition of definition of new listing for "Youth Assertive Community Treatment" (intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21)	49	49
b. Table A.5.3.c "*Substance Abuse Services: Outpatient Services*", lists describing modifiers and combination codes (combinations of modifiers) used in Substance Abuse Services table were removed (entire page deleted).	52	Removed
c. Table A.5.3.c "*Substance Abuse Services: Outpatient Services* (Applicable…standards)," was modified:		
i. The section of the table for "Outpatient services – Outpatient program; Treatment only, HCPCS procedure codes (modifiers and combination codes descriptors in deleted lists) were removed and changes to code H2035 were made by DHS in both 873I and 837P Claim Types. 1. Added H2035 (group) 2. Added H2035 (*individual*) 3. The Unit "Session" and its codes (H0005) were deleted from the table.	53	Page 52
ii. The section of the table for "Outpatient services – Outpatient program; treatment only" "All other medication therapy assisted (MAT) drugs" was also deleted from the table.	53	52

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide for the **ASC X12/005010X223A2 Health Care Claim: Institutional (837)** *Version 6.0.*
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the *ASC X12/005010X223A2 Health Care Claim: Institutional (837)* hereinafter referred to as *005010X223A2,* by entities covered under Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This Version 6.0 Minnesota Uniform Companion Guide for the *ASC* X12/005010X223A2 Health Care Claim Institutional (837) supersedes *Version 5.0* and all previous versions. Version 5.0 was announced as a proposed rule for public comment in the *Minnesota State Register,* November 13, 2012, Volume 37, Number 20 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Public comments regarding Version 5.0 were accepted until December 12, 2012. The comments received were reviewed with the assistance of the AUC and changes were made to version 5.0 that were incorporated in version 6.0. An announcement of the adoption of this rule (Version 6.0) was published in the *Minnesota State Register*, Volume *xx*, Number *xx*, *XXxx*, 2013. This document is available at no charge at: www.health.state.mn.us/asa.

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1.0 Overview

1.1 Statutory basis for this proposed rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2 Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program. The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year to year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

Minnesota Statutes, section 62J.03, Subd. 6 defines "group purchaser" as follows:

> "*Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.*

Minnesota Statutes, section 62J.03, Subd. 8 defines "provider or health care provider" as follows:

> "*Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought*

reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Minnesota Statutes, section 62J.536, Subd. 3 defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Minnesota Statutes, section 62J.51, Subd. 11a defines "health care clearinghouse" as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1 Exceptions to applicability

Minnesota Statutes, section 62J.536, subd. 4 authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (ASC12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)*, hereinafter 005010X279A1)*. This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html.

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction (*005010X279A1*) with group purchasers not covered by HIPAA.

1.3 About the Minnesota Department of Health (MDH)

MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: http://www.health.state.mn.us.

1.3.1 Contact for further information on this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Phone: (651) 201-3570
Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

1.4 About the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the AUC website at: http://www.health.state.mn.us/auc/index.html

1.5 Minnesota Best Practices for the Implementation of Electronic Health Care Transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

Please visit the AUC website at http://www.health.state.mn.us/auc/index.html for more information about best practices for implementing electronic health care transactions in Minnesota.

1.6 Document Changes

The content of this document is subject to change. The version, release and effective date of the document is included in the document, as well as a description of the process for future updates or changes.

1.6.1 Process for updating this document

The process for updating this document, including: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document is available from MDH's website at http://www.health.state.mn.us/asa/index.html.

1.6.2 Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Incorporated all changes proposed in v3.0
5.0	August 6, 2012	Proposed revisions to v4.0
6.0	[Date to be determined] 2012	This version will adopt v5.0 and incorporate any additional changes to v5.0

2.0 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document is the *ASC X12/005010X223A2 Health Care Claim: Institutional (837)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, Washington Publishing Company. All Rights Reserved), hereinafter described below as *005010X223A2.* A copy of the full *005010X223A2* can be obtained from the Washington Publishing Company at: http://store.x12.org/store/.

2.1.1 Permission to use copyrighted information

[Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]

2.2 Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X223A2*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X223A2* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

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3.0 How to use this document

3.1 Classification and display of Minnesota-specific requirements

This document has been prepared for use by entities subject to Minnesota's requirements for the standard, electronic exchange of health care administrative transactions (Minnesota statutes, section 62J.536 and related rules) and other interested parties. It provides transaction specific information to be used in conjunction with the *005010X223A2* and other applicable information and specifications noted in section 2.0 above.

Table 4.2 of this document contains a row for each segment for which there is additional information over and above the information in the*005010X223A2*. The tables show the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

This document also contains the following two appendices:

- Appendix A includes a number of sections and provides additional instructions and specifications regarding the use of medical code sets and medical coding;
- Appendix B provides brief instructions for reporting the MinnesotaCare (MNCare) Tax.

See also section 2.2 regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities covered by Minnesota Statutes, section 62J.536.

3.2 Information About the Health Care Claim: Institutional (837) Transaction

3.2.1 Business Terminology

For purposes of this Companion Guide, the following terms have the meaning given to them in this section. Definitions used apply at both the claim and line level. For other definitions related to the Institutional health care claim, please refer to section 1.5 of the *005010X223A2*.

3.2.1.1 Provider Definitions[1]

Billing Provider

The Billing Provider must be a health care or service provider. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop. Please refer to the *005010X223A2* for more billing provider and other types of provider requirements.

Billing Provider Name:

[1] Sources: *005010X223A2*; National Uniform Billing Committee UB04 Manual. Placeholder -- Cited with permission.

- If enrolled with the payer, the Billing Provider Name must match the enrollment with the payer.

Billing Provider Address:

- U.S. Postal Addressing Standards – the address must meet the U.S. Postal addressing standards.

Pay-To Address

The Pay-To Address loop allows the billing provider to indicate a payment address that is different than the billing.

For providers who participate with the group purchaser health plan and are required to complete enrollment forms as part of the contracting process, the payment address submitted on the claim transaction may not be the address where payment is ultimately sent for the claim. The payer in this case may use the payment address from the enrollment form or within the contract rather than the address that is submitted in the 2010AB loop of an electronic claim. The contracted provider must request address changes to the payer records according to the instructions within the provider contract.

When a Pay-To Address loop is sent in addition to billing provider loop, it is the pay-to loop address where the payment should be sent, unless the payer utilizes an enrollment form or a contract.

3.2.1.2 Other Definitions

Factoring Agent

Business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name/address of Pay-To are different than Billing Provider. In order to use the *005010X223A2* for this business situation, the Accredited Standards Committee (ASC) X12 recommends that the Factoring Agent entity name, address, and identification be submitted as the Pay-To Plan in loop 2010AC. The notes and guidelines should be followed as if the Pay-To Plan entity was performing post payment recovery as described.

Other Payer

The term “other payer” indicates any payer who is not the destination payer. The other payer may be the primary, secondary, tertiary, or even quaternary payer.

Patient

The term “patient” as used in this Companion Guide is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In that case, the patient is not the same person as the subscriber and cannot be uniquely identified separately from the subscriber. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 1.5 of the *005010X223A2* for further details.

Pay-To Plan

In addition to the definition in the *005010X223A2*, business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name and address of Pay-To are different than the Billing Provider. The Factoring Agent name will be placed in the Pay-To Plan loop.

Subscriber

The subscriber is the person or entity whose name is listed on the insurance policy. Other synonymous terms include "member" and/or "insured." In some cases the subscriber is the same person as the patient. See the definition of patient, and see Section 1.5 of the *005010X223A2* for further details.

3.2.2 Provider Identifiers and NPI Assignments

Provider Identifiers

If the provider is a health care provider as defined under federal standards, then the only identifier that is valid is the NPI with the exception of the billing loop. For the billing provider, a secondary identifier of the TIN is also required.

If the provider is not a health care provider as defined under federal standards they are known as atypical providers. Atypical providers do meet the Minnesota statutory definition of health care provider and therefore are required to utilize the electronic administrative transactions for eligibility, claims and remittance advices. For atypical providers, the primary identifier is the TIN and a secondary identifier is allowable. The qualifier for the secondary identifier is 'G2'. The identifier for this qualifier would be the specific payer assigned/required identifier.

3.2.3 Minnesota Requirements for Compliance

This section contains general Minnesota requirements for compliance applicable to this transaction.

Handling Adjustments and Appeals

Determination of Action:

When determining whether to resubmit a claim as an original, request an adjustment or request an appeal, first determine whether the payer has accepted and adjudicated the original claim submission.

- If the original submission was not accepted into the payer adjudication system, resubmit the claim as an original. This is not considered to be an adjustment.
- If the original submission was accepted into the payer adjudication system, see definitions below to determine whether an adjustment or appeal should be requested.

Definitions:

- Adjustment – Provider has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.
- Appeal – Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. Therefore the submission of the appeal is not covered by this guide.

Examples of Appeals include:

- Timely filing denial;
- Payer allowance;
- Incorrect benefit applied;
- Eligibility issues;
- Benefit Accumulation Errors; and
- Medical Policy / Medical Necessity

Process for submission:

- Adjustment – Provider should submit an adjustment electronically using the appropriate value in CLM05-3 to indicate that this is a replacement claim. If the payer has assigned a payer number to the claim, it must be submitted in loop 2300, REF02, using qualifier F8 in REF01 (Note: the original payer-assigned claim number is not the property and casualty number). If additional information is required to support the adjustment based on payer business rules, the SV202-7, NTE segment, PWK segment, or Condition Codes should be used. See section 3.2.5 below regarding these segments for appropriate instructions.
- Appeal – Follow payer standard processes for requesting an appeal to a previously adjudicated claim. If paper appeal process is utilized, then a standard, Best Practice Minnesota appeal form is available at the AUC website at http://www.health.state.mn.us/auc/index.html. Additional documentation should be sent as required by the payer to support the appeal consideration; this documentation does not include resubmission of the claim.

3.2.4 Claim Frequency Type Code (CFTC) Values

Claim/Bill submissions are often original, first time submissions with no follow-up submissions. In some cases, subsequent submissions directly related to a prior submission will be necessary. When subsequent submissions occur, for legitimate business purposes, the normal processing flow may change.

Since a relationship between an original submission and subsequent submissions are necessary, the data requirements both for original and subsequent submissions must be specified. For example, when a Replacement bill is submitted (CFTC 7), in order to meet the processing requirement to void the original and replace it with the re-submitted bill, common consistent data elements would be required. To qualify as a Replacement, some data would need to be different than the original. If the bill

is re-submitted with no changes from the original, and the claim was accepted by the payer, this would be considered a Duplicate instead of a Replacement. If the bill is resubmitted with no changes from the original and the original was not accepted by the payer, this will be considered an original claim. These distinctions are important to allow for proper handling of the submission.

Refer to the current National Uniform Billing Committee (NUBC) code list for allowed values and usage descriptions. Late charge billings (xx5) are not considered for processing in Minnesota; replacement (xx7) must be utilized. Should a covered provider submit a late charge bill using (xx5), the adjudication rules of the payer may result in denial of the claim as it should not have been sent. Both the sender and receiver must understand how each code value should be interpreted and what processing requirements need to be applied.

In conjunction with the CFTC code values, Condition Codes may be submitted that will impact processing and handling requirements.

3.2.5 Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional information. The NTE segment must not be used to report data elements that are codified within this transaction. If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV202-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X223A2.*
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.

If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE or SV202-7 will exceed available characters, use only the PWK segment at the claim level.

- When populating the PWK segment, the following guidelines must be followed:
    - PWK01 - Attachment Report Type Code is a required element: The qualifier value of ‘OZ’ should only be used if none of the other values apply. The most specific qualifier value must be utilized.
    - PWK06 - Attachment Control Number is a situational element that is required if the transmission type is anything other than “available upon request.” This value is used to identify the attachment. Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider’s system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

4.0 ASC X12/005010X223A2 Health Care Claim: Institutional (837) -- Transaction Specific Information

4.1 Introduction to Table

The following table provides information needed to implement the *ASC X12/005010X223A2 Health Care Claim: Institutional (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X223A2* and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

Note: The designation "N/A" in Table 4.2 below means that the "Value Definition and Notes" applies to the segment rather than a particular data element.

Please also see section 2.2 above.

4.2 *005010X223A2* Institutional (837) -- Transaction Table

Table 4.2 005010X223A2 (837) **Institutional**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X223A2 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2010AA BILLING PROVIDER NAME	NM1 Billing Provider Name	N/A	See front matter section 3.2.1.1 of this document for definition and usage of billing information
2010AB PAY-TO ADDRESS NAME	NM1 Pay-To Address Name	N/A	See front matter section 3.2.1.1 of this document for definition and usage of Pay-To information.
2010AC PAY-TO PLAN NAME	NM1 Pay-To Plan Name	N/A	See front matter section 3.2.1.2 of this document for definition and usage of Pay-To Plan information.
2000B SUBSCRIBER HIERARCHICAL EVEL	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2010BA SUBSCRIBER NAME	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.

Table 4.2 005010X223A2 (837) **Institutional**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X223A2 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
	DMG Subscriber Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient
2010BB PAYER NAME	REF Billing Provider Secondary Identification	N/A	Use G2 for atypical providers
2010CA PATIENT NAME	DMG Patient Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient.
2300 CLAIM INFORMATION	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definition.
		CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
		PWK02 Attachment Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
	NTE Billing Note	N/A	See front matter section 3.2.5 of this document for definition.
	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the

Table 4.2 005010X223A2 (837) **Institutional**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X223A2 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
			Minnesota Child and Teen Checkup Programs.
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
		REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
		REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
		REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2320 OTHER SUBSCRIBER INFORMATION	SBR Other Subscriber Information	N/A	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2330B OTHER PAYER NAME	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV202-7 Description	See front matter section 3.2.5 of this document for additional instructions.
		SV204 Unit or Basis for Measurement Code	See Appendix A for coding measurements.
		SV205	Zero “0" is an acceptable value only

Table 4.2 005010X223A2 (837) **Institutional**
Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X223A2 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
		Quantity	if defined as appropriate pursuant to NUBC rules.
		SV207 Monetary Amount	This amount cannot exceed the service line charge amount.
	DTP Date – Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
	AMT Facility Tax Amount	N/A	See Appendix B for details on reporting MNCare.

5.0 List of Appendices

Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides

Appendix A lists rules and related information for the selection and use of medical codes from HIPAA code sets. The appendix includes the following three tables with specific coding requirements and examples:

- Table A.5.1 -- Minnesota Coding Specifications: When to use codes different from Medicare
- Table A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs
- Table A.5.3 -- Substance Abuse Services
  a) Hospital
  b) All other residential
  c) Outpatient

Appendix B: Reporting MNCare Tax

Appendix B provides brief instructions for reporting the MinnesotaCare (MNCare) Tax

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Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides

A.1 Introduction and Overview

Minnesota Statutes, Section 62J.536 requires the standard, electronic exchange of health care claims using a single, uniform companion guide to HIPAA implementation guides,[2] including uniform billing and coding standards. The statute further requires the Commissioner of Health to base the transaction standards and billing and coding rules on federal HIPAA requirements and on the Medicare program, with modifications that the commissioner deems appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC).

This appendix, including the accompanying tables, presents rules for the selection and use of medical codes from the HIPAA code sets that are associated with the 005010X22A1 Institutional (837) transaction.

The appendix was developed in consultation with the AUC and its Medical Code Technical Advisory Group (TAG).

NOTE-- As further described in the sections below:

1. All codes must be compliant with federal HIPAA requirements.
2. This appendix **does not** address or govern:
    a. the services or benefits that are eligible for payment under a contract, insurance policy, or law;
    b. payment for health care services under a contract, insurance policy, or law.
3. This appendix includes the following four tables which must also be consulted when selecting and using medical codes:
    a. Table A.5.1: Minnesota Coding Specifications: When to Use Codes Different From Medicare;
    b. Table A.5.2: Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique to State Government Programs;
    c. Table A.5.3: Substance Abuse Services.
    d. Table A.5.4: Maternal And Child Health Billing Guide For Public Health Agencies
4. This Appendix and its accompanying tables establish requirements for the selection and use of medical codes. The coding requirements vary as indicated by the type of service/procedure/product being provided. Depending on the service/procedure/product provided, the requirement in this appendix will be to select codes in the following order:

[2] Described in Code of Federal Regulations, title 45, part 162.

a. The subset of HIPAA codes based on specific Minnesota coding requirements in Tables A.5.1, A.5.2, A.5.3, or A.5.4.

b. If the tables above do not apply, or if the table states "follow Medicare guidelines", use HIPAA codes for the federal Medicare program ("Follow Medicare coding guidelines");

5. If a. or b. above does not apply, use the HIPAA-compliant codes that most appropriately describe the service/procedure/product provided. Codes with identical descriptions may be used interchangeably. If codes do not have an identical description then follow section A.3.2, "Instructions for Use", regarding use of the most appropriate code.
6. This appendix does not replace or substitute for standard, national coding resources for HIPAA-adopted code sets (including manuals, online resources, etc.). Consult coding resources for descriptions, definitions, and directions for code usage.
7. Medicare and national codes often change. National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes. (See also section A.4.)

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes.[3]

Consistent with the HIPAA electronic Transactions and Code Sets regulations, all covered entities are required to submit or receive codes that are:

- valid on the date of service for medical code sets;
- valid at the time the transaction was created and submitted for non-medical code sets.

This Appendix includes requirements and information related to the HIPAA code sets, as well as: modifiers found in the CPT and HCPCS Level II including those established for definition by State Medicaid; revenue codes – a data element of the institutional claim; units of service (basis for measurement).

A.3 Code Selection and Use

A.3.1 General Rules

[3] CPT is a registered trademark of the American Medical Association (AMA); ICD-9-CM is maintained and distributed by the National Center for Health Statistics, U.S. Department of Health and Human Services (HHS); HCPCS are developed by the Centers for Medicare and Medicaid Services (CMS); Revenue codes are developed by the National Uniform Billing Committee (NUBC). Code set updates[3] can be found at websites of the organizations named above.

1. Select codes that most accurately identify the procedure/service/product provided. Codes with identical descriptions may be used interchangeably. If codes do not have identical description, then follow A.3.2 regarding use of the most appropriate code.
2. The medical record must always reflect the procedure/service/product provided.
3. Use instructions in this appendix and the accompanying tables A.5.1, A.5.2, A.5.3, and A.5.4 to select and use required codes.

A.3.2 Instructions for Using This Appendix and Its Accompanying Tables

1. For the state government behavioral health programs identified in Table A.5.2, use the codes referenced in the table.
2. For substance abuse services, use the codes listed in Table A.5.3.
3. For Maternal and Child Health Billing Guide for Public Health Agencies use the codes listed in Table A.5.4.
4. For all other procedures/services/products, use Table A.5.1 as follows:
   a) Step 1. Find the appropriate row ("Medicare Claims Processing Manual Chapter") in Table A.5.1 for the type of procedure/service/product provided.
   b) Step 2. If the "Minnesota Rule" column in Table A.5.1 states "Follow Medicare Coding Guidelines", then select and use codes consistent with the claims submission coding instructions and requirements maintained by or on behalf of the Centers for Medicare and Medicaid Service (CMS) (e.g., Medicare Claims Processing Manual and communications from or on behalf of CMS).
      1. Note: Exception to the "Follow Medicare Coding Guidelines" statement above. If either of the following applies:
         - The procedure/service/product is listed in a Medicare coding resource but is limited by Medicare coverage; OR
         - The procedure/service/product is not listed in a Medicare coding resource;

         THEN**:** select the code(s) that most accurately identify the procedure/service/product provided. CPT codes are preferred, but HCPCS Level II codes can be used if they describe the service more completely (e.g. H, S, T codes). Codes with identical descriptions may be used interchangeably.
   c) Step 3. If the "Minnesota Rule" column for the row describing the type of procedure/service/product provided states other than "Follow Medicare Coding Guidelines", then use the specific code(s) and/or instructions listed.
5. For procedures/services/products not found in Tables A.5.1, A.5.2, A.5.3, or A.5.4, select the code(s) that most accurately identify the procedure/service/product provided. CPT codes are preferred, but HCPCS Level II codes can be used if they describe the service more completely (e.g. H, S, T codes). Codes with identical descriptions may be used interchangeably.

Note: Table A.5.1 lists chapter headings from the "Medicare Claims Processing Manual". Each chapter entry has an associated "Minnesota Rule" (e.g., "Follow Medicare Coding Guidelines" or other, more specific instructions). For some chapters (e.g., "Chapter 21 – Medicare Summary Notices", "Chapter 22 – Remittance Notice to Providers", and others), the requirement is stated as "Not applicable to coding guidelines". These chapters are relevant to Medicare business processes but do not pertain to coding requirements of this Appendix and may be disregarded.

A.3.3 When Instructions Differ From "Follow Medicare Coding Guidelines"

In some instances shown in the accompanying tables, requirements are to code differently than Medicare with the code(s) and/or instructions stated. Coding that is different from Medicare resulted because:

1. Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits.
2. More specific or appropriate codes are needed in order to reduce manual processing and administrative costs.
3. Duplicate codes exist and clarification of which code(s) to use is needed.
4. Medicare does not have a guideline for coding a service or made no specific reference to a service but the AUC Medical Code Technical Advisory Group (TAG) had knowledge of differing submission requirements.

Specific coding instructions that are listed in Tables A.5.1, A.5.2, A.5.3, and A.5.4 as other than "Follow Medicare Coding Guidelines" apply only to a limited subset of particular codes or a category of codes selected on the basis of the criteria above.

A.3.4 Additional Coding Specifications

A.3.4.1 Modifiers

Modifiers are found in the CPT and HCPCS Level II including those allowed by CMS to be defined by State Medicaid agencies.

The Minnesota Department of Human Services (DHS) has specifically defined select "U" modifiers to help identify and administer their legislatively required programs. These definitions can be found on the DHS website at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_167693.

Minnesota group purchasers accept all modifiers including DHS defined modifiers. This appendix includes a list of required program-specific modifiers for some Minnesota Department of Human Services (DHS) programs.

A.3.4.2 Units (basis for measurement)

The number of units is the number of services performed and reported per service line item as defined in the code description unless instructed differently in this appendix.

The following are clarifications/exceptions:

- Report one unit for all services without a measure in the description.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
  - "per vertebral body"
  - "each 30 minutes"
  - "each specimen"
  - "15 or more lesions"
  - "initial".
- Follow all related AMA guidelines in CPT[4] (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis." [5]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow general rounding rules for reporting more than the code's time value. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

A.4 Submitters and Receivers are Responsible for Selecting and Using the Correct, Appropriate Medical Codes

Codes used in this appendix were valid at the time of approval for publication of this companion guide. Code set changes may result in this appendix reflecting a deleted code or not reflecting a new code. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes.

[4] Current Procedural Terminology (CPT®), copyright 2012 American Medical Association
[5] Current Procedural Terminology (CPT®), copyright 2012 American Medical Association

Per the HIPAA Transactions and Code Set Rule [Code of Federal Regulations, title 45, part 162], *"those that [send or] receive standard electronic administrative transactions must be able to [send], receive and process all standard codes irrespective of local policies regarding reimbursement for certain conditions or procedures, coverage policies, or need for certain types of information that are part of a standard transaction."*

A.5 Tables of Coding Requirements

A.5.1 Minnesota Coding Specifications: When to Use Codes Different from Medicare

Table A.5.1 below lists chapters from the Medicare Claims Processing Manual, which can be accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html. In addition, in the electronic version of this document each of the chapter titles below is also provided as a link to the corresponding chapter of the Medicare Claims Processing Manual.

For Instructions on the use of Table A.5.1 see Section A.3.2.

Please note: Table A.5.1 below references several standard health care claims transactions as follows:

- *ASC X12/005010X222A1 Health Care Claim: Professional (837),* referred to in Table A.5.1 as "professional claim type" or "837P" or "Professional claim"
- *ASC X12/005010X224A2 Health Care Claim: Dental (837)*, referred to in Table A.5.1 as "837D"
- *Pharmacy Claims Submission and Response and the Pharmacy Reversal Submission and Response Transactions per the NCPDP Telecommunication Standard Implementation Guide, Version D.Ø*, referred to in Table A.5.1 as "NCPDP".

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
1	General Billing Requirements		Follow Medicare coding guidelines
2	Admission and Registration Requirements		Not applicable to coding guidelines
3	Inpatient Hospital Billing		Follow Medicare coding guidelines
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Observation	Any HCPCS Level I or II code can be submitted as appropriate for observation with revenue code 0762
		Partial Hospitalization	To report partial hospitalization, use revenue codes 0912 or 0913 and procedure code H0035. For child/adolescent program use H0035 with HA modifier
		Bilateral Radiology	Bilateral radiology services are reported as either: ▪ one line with a 50 modifier and one unit, **or** ▪ two separate lines, one with RT modifier and one with LT modifier.
		Outpatient Professional Services in Method II Critical Access Hospitals	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).
		Interpreter Services	For interpreter services: ▪ Use Revenue code 0949 and appropriate HCPCS code(s) as follows. Note: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report a unit. o T1013 -- Face-to-face oral language

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS) (continued)		interpreter services per 15 minutes o T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes o T1013-GT -- Telemedicine interpreter services per 15 minutes o T1013-U4 -- Telephone interpreter services per 15 minutes o T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting o T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes ▪ Report one unit per 15 minutes per client ▪ If more than one service is provide, report each on a separate line appended with the -59 modifier ▪ T1013-52 x 2 units (30 minutes of drive time) ▪ T1013-5259 (12 minutes of wait time) ▪ Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. ▪ Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported ▪ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS) (continued)		o 99199 -- Mileage for interpreter service ▪ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported ▪ Report one unit per mile
		Modifiers 76 or 91	Modifiers 76 or 91 are to be used for repeat services subsequent to the original service only. The number of units reported is the number of services performed as defined in the code description or relevant AMA guidelines in CPT[6].
5	Part B Outpatient Rehabilitation and CORF/OPT Services		Do not follow Medicare's rounding rules for physical, occupational and speech therapies. See general rules for reporting units at the front of this appendix.
6	Inpatient Part A Billing and SNF Consolidated Billing	Room and Board	Room and Board is reported according to the level of nursing care provided using revenue codes 019X
		Reporting private room and/or in lieu of day differentials	There are situations when skilled nursing and long term care facilities need to report private room and/or in lieu of day differentials separate from room and board charges. o Private Room differential use 0229; 1 unit = 1 day o In lieu of days differential use 0230; 1 unit = 1 hour
		Ancillaries	Ancillaries are reported separately as appropriate
		Long term care	Also applicable to Long Term Care

[6] Current Procedural Terminology (CPT®), copyright 2010 American Medical Association

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Follow Medicare coding guidelines
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers		Not applicable to the Institutional guide. Report on the claim type appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
10	Home Health Agency Billing	Home Health Services	Home Health Services are reported on the 837I using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P Revenue Codes 041X – 044X and 055x – 060x as appropriate
		Reporting continuous services beyond the encounter and multiple nurse encounters with the same date of service	For home care the industry standard defines "per diem" as all inclusive services per patient encounter up to two hours. ▪ To report extended continuous services beyond the encounter use the fifteen minute code(s). ▪ To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.
		Approved HCPCS code set	Medicare's G codes are insufficient to describe the level of time codes that group purchasers require for proper case management. See Approved HCPCS Code Set below. Approved HCPCS code set: ▪ Skilled Nursing Encounter: o RN: T1030 o LPN:T1031

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
10	Home Health Agency Billing (continued)	Approved HCPCS code set (continued)	▪ Home Health Aide Visit: T1021 ▪ Home Health Aide (Extended: T1004 ▪ PT Visit: S9131 o PT Asst. Visit: S9131 TF ▪ OT Visit: S9129 o OT Asst. Visit: S9129 TF ▪ RT Evaluation: S5180 ▪ RT Visit: S5181 ▪ Speech Visit: S9128 ▪ MSW Visit: S9127 ▪ RN: T1002 ▪ RN Complex: T1002 TG ▪ RN Shared 1:2 ratio T1002 TT ▪ LPN: T1003 ▪ LPN Complex: T1003 TG ▪ LPN Shared 1:2 ratio T1003 TT ▪ Post partum home visit 99501 ▪ Newborn care home visit 99502
11	Processing Hospice Claims		Follow Medicare coding guidelines
12	Physicians/Nonphysician Practitioners		Not applicable to the Institutional guide
13	Radiology Services and Other Diagnostic Procedures	Bilateral Radiology	▪ Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers		Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance		Follow Medicare coding guidelines
16	Laboratory Services		Not applicable to the Institutional guide.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and	Preventive services and coding as defined by Medicare (i.e. “Welcome to Medicare”) are only

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
		coding as defined by Medicare	applicable to Medicare and Medicare replacement products
		Colonoscopy	Coding of diagnosis for colonoscopy claims should follow the ICD-9 code set instructions for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.
		Vaccine Administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
		Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, group purchasers require the SL modifier be appended to the vaccine code
		Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. ▪ Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
19	Indian Health Services		Follow Medicare coding guidelines
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies		Not applicable to the Institutional guide
21	Medicare Summary Notices		Not applicable to the Institutional guide
22	Remittance Advice		Not applicable to the Institutional guide

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to the Institutional guide
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to the Institutional guide
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to the Institutional guide
27	Contractor Instructions for CWF		Not applicable to the Institutional guide
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to the Institutional guide
29	Appeals of Claims Decisions		Not applicable to the Institutional guide
30	Financial Liability Protections		Not applicable to the Institutional guide
31	ANSI X12N Formats		Not applicable to the Institutional guide
32	Billing Requirements for Special Services		Follow the code selection guidelines in the Appendix A front matter
33	Miscellaneous Hold Harmless Provisions		Not applicable to the Institutional guide
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
See the following for Freestanding Birth Centers (Not addressed in the Medicare Claims Processing Manual)			
N/A	N/A	Freestanding Birth Centers	**Licensed birthing centers** Medicare publishes limited billing information for free-standing birthing centers. "Birth center" means a facility licensed for the primary purpose of performing low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy. See Minnesota Statutes, Sections 144.615 and 144.651 for more information. Low-risk deliveries, and services related to the delivery, performed in a free-standing birthing center should be reported on an 837I transaction including the following data: • Type of Bill: 084x – Special Facility – Freestanding Birthing Center (NOTE: TOB 084x will be considered outpatient. HCPCS codes are required with submitted revenue codes.) • Revenue Code: 0724 – Birthing Center Note: Ancillary services and/or items relating to delivery or labor 0724 are included under this revenue code and should not be reported separately. • HCPCS Code: Appropriate HCPCS code with revenue code 0724 for delivery, or S4005 when labor does not result in delivery. Note: Professional services related to the mother's and newborn's cares are reported on the 837P only.

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A.5.2 Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to Minnesota Government Programs

Table A.5.2 lists behavioral health procedure code and modifier combinations for identifying specific benefit packages unique to Minnesota government programs. The behavioral health modifiers displayed in Table A.5.2 are listed and defined below.

A.5.2.1 Mental Health-Related Modifiers Appearing in Table A.5.2

HA	Child/adolescent program
HE	Mental health program
HK	Specialized mental health programs for high-risk populations
HM	Less than bachelor's degree
HN	Bachelor's degree
HQ	Group setting
HR	Family/couple with client present
HW	Funded by state mental health agency (service provided by state staff person)
UA	Children's Therapeutic Services and Supports (CTSS)
UD	Transition to community living (Adult Rehabilitation Mental Health Services (ARMHS))
U1	Dialectical Behavioral Therapy
U4	Via other than face to face contact; e.g. telephone
U5	Advanced level
U6	Interactive
U7	Physician extender (includes mental health practitioner as defined by MN Statute 245.4711, Subd. 17)

A.5.2.2 Table A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Table A.5.2 shows code/modifier combinations for the programs listed below that are administered by the Minnesota Department of Humans Services (DHS). In the electronic version of this document, clicking on the program from the list below will take the reader to the program listing in Table A.5.2.

Behavioral Health Programs listed in Table A.5.2
Assertive Community Treatment (ACT)
Adult Crisis Response Services
Children's Mental Health Crisis Response Services

Behavioral Health Programs listed in Table A.5.2
Mental Health Targeted Case Management (MH-TCM)
Children's Mental Health Residential Treatment Services
Intensive Residential Treatment Services (IRTS)
Adult Day Treatment
Children's Day Treatment
Children's Therapeutic Services and Supports (CTSS)
Adult Rehabilitative Mental Health Services (ARMHS)
Peer Services
Mental Health Diagnostic Assessment
Dialectical Behavior Therapy
Youth Assertive Community Treatment

Please note: Table A.5. 2 below references standard health care claims transactions as follows: ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.2 as “837I”.

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Assertive Community Treatment (ACT) Back to list of behavioral health programs	▪ An intensive, comprehensive, non-residential rehabilitative mental health services (ARMHS) team model. Consistent with ARMHS - multidisciplinary total team approach. ▪ Patients with serious mental illness who require intensive services; time unlimited basis, available 24/7/365. ▪ Face-to-face, all-inclusive daily rate. ▪ One provider per day	Codes: ▪ H0040 - Assertive community treatment program, per diem
Adult Crisis Response Services Back to list of behavioral health programs	▪ County or county-contracted mental health professional, practitioner, or rehab worker; or crisis intervention team. ▪ Crisis assessment, intervention, stabilization, community intervention. ▪ Immediate, face-to-face evaluation, determine need for emergency services or referrals to other resources.	Codes: ▪ S9484 – Adult individual crisis assessment, intervention and stabilization, individual, by mental health professional or practitioner ▪ S9484 HM – Adult crisis assessment, intervention and stabilization, individual, by mental health rehabilitation worker ▪ S9484 HN – Adult crisis assessment, intervention and stabilization, individual, by mental health practitioner ▪ S9484 HQ – Adult crisis stabilization, group ▪ H0018 – Adult crisis stabilization, residential ▪ 90882 HK – Environmental intervention for medical management, community intervention ▪ 90882 HK HM – Environmental intervention for medical management, community intervention, mental health rehabilitation worker

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Children's Mental Health Crisis Response Services Back to list of behavioral health programs	▪ Intensive face-to-face, short-term services initiated during a crisis; provided on-site by a mobile crisis response team. ▪ County or county contracted agency.	Codes: ▪ S9484 UA - Crisis intervention mental health services, per hour, Children's Crisis Response Services, mental health professional ▪ S9484 UA HN - Crisis intervention mental health services, per hour, Children's Crisis Response Services, bachelor's degree level mental health practitioner
Mental Health Targeted Case Management (MH-TCM) Back to list of behavioral health programs	▪ Community support plan and functional assessment to help SPMI adults and SED children gain access to needed medical, social educational, vocational, financial services relative to mental health needs.	Codes: ▪ T2023 HE HA – Targeted case management; per month, mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years ▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older ▪ T2023 HE TF - Targeted case management intermediate level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older ▪ T1017 HE – Targeted case management, per encounter (day), mental health program, adult, face-to-face contact between case manager

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
		and recipient age 18 or older, IHS/638 facilities and FQHCs ▪ T1017 HE HA – Targeted case management, per encounter (day), mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years, IHS/638 facilities and FQHCs
Children's Mental Health Residential Treatment Services Back to list of behavioral health programs	▪ 24-hour-a-day program under clinical supervision of a mental health professional, provided in a community setting.	▪ When reporting room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. ▪ When room and board and treatment are billed to separate entities, treatment is reported on the 837P, with HCPCS Code H0019.
Intensive Residential Treatment Services (IRTS) Back to list of behavioral health programs	▪ Time-limited mental health services provided in a residential setting to recipients in need of more restrictive settings and at risk of significant functional deterioration. ▪ Develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.	▪ When reporting room and board and treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. ▪ When room and board and treatment are billed to separate entities, treatment is reported on the 837P, with HCPCS Code H0019.
Adult Day Treatment Back to list of behavioral health programs	▪ A structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a recipient's mental health status, develop and improve independent living and socialization skills	Codes: ▪ H2012 - Behavioral health day treatment, per hour

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Children's Day Treatment Back to list of behavioral health programs	▪ A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services provided by multidisciplinary team.	Codes: ▪ ▪ H2012 UA HK – behavioral health day treatment, per hour, CTSS ▪ H2012 UA HK U6 – behavioral health day treatment, per hour, CTSS interactive
Children's Therapeutic Services and Supports (CTSS) Back to list of behavioral health programs	▪ Rehabilitative services that offer a broad range of medical and remedial services and skills to help restore individuals' self-sufficiency/functional abilities - a flexible package of mental health services for children.	Codes: ▪ 90832 UA - Individual psychotherapy, 30 minutes, CTSS ▪ Appropriate E/M UA plus 90833 UA – Individual psychotherapy 30 minutes with E/M, CTSS ▪ 90834UA - Individual psychotherapy 45 minutes, CTSS ▪ Appropriate E/M UA plus 90836 UA – Individual psychotherapy 45 minutes with E/M, CTSS ▪ 90837 UA - Individual psychotherapy, 60 minutes, CTSS ▪ Appropriate E/M UA plus 90809 UA – Individual psychotherapy 60 minutes with E/M, CTSS ▪ 90875 UA - Biofeedback training, CTSS ▪ 90846 UA - Family psychotherapy without patient, CTSS ▪ 90847 UA - Family psychotherapy with patient, CTSS ▪ 90849 UA - Multiple family group psychotherapy, CTSS ▪ 90832 UA plus 90785 UA - Interactive individual psychotherapy 30 minutes, CTSS ▪ Appropriate E/M UA plus 90833 UA plus 90785 UA - Interactive individual psychotherapy 30 minutes with E/M, CTSS ▪ 90834 UA plus 90785 UA - Interactive individual psychotherapy 45 minutes,

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Children's Therapeutic Services and Supports (CTSS) (continued) Back to list of behavioral health programs		CTSS ▪ Appropriate E/M UA plus 90836 UA plus 90785 UA - Interactive individual psychotherapy 45 minutes with E/M, CTSS ▪ 90837 UA plus 90785 UA - Interactive individual psychotherapy 60 minutes, CTSS ▪ 90853 UA - Group psychotherapy, CTSS ▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS ▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2012 UA - Behavioral health day treatment, per hour, therapeutic components of preschool program, 60 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS
Adult Rehabilitative Mental Health Services	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
(ARMHS) Back to list of behavioral health programs **Adult Rehabilitative Mental Health Services (ARMHS) (continued)** Back to list of behavioral health programs		▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner ▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker ▪ 90882 – Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM – Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD – Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM – Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
Peer Services Back to list of behavioral health programs	Non-clinical support counseling services provided by certified peer specialist.	Codes: ▪ H0038 – Certified peer specialist services, per 15 minutes ▪ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
Mental Health Diagnostic Assessment Back to list of behavioral health programs3		Codes: In order to report diagnostic assessments with levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health		Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ U2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs

Name of Program	Description/Definition	Coding
programs		▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20

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A.5.3 Substance Abuse Services

Table A.5.3 is to be used for reporting substance abuse services by delivery setting category. The table has been divided into three parts based on the delivery setting, as follows:

a) Hospitals;

b) All other residential; and

c) Outpatient Services.

The tables incorporate both institutional and professional claim types for ease of reference.

Please note: Table A.3 below references standard health care claims transactions as follows:

- *ASC X12/005010X222A1 Health Care Claim: Professional (837),* referred to in Table A.5.3 as "Professional" or "837P".
- *ASC X12/005010X223A2 Health Care Claim: Institutional (837),* referred to in Table A.5.3 as "Institutional" or "837I"

Table A.5.3.a Substance Abuse Services: Hospital

Table A.5.3.a -- Substance Abuse Services: Hospital (Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)						
Service Description	**Option 1 or 2 ***	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	1	Day	0118, 0128, 0138, 0148, 0158	N/A	837I	011x-hospital inpatient
Detox			0116, 0126, 0136, 0146, 0156			
Treatment component			Choose one per date of service: 0944 or 0945 or 0949			
Ancillary		Based on Revenue Code	As appropriate			
All-inclusive Room and Board	2	Day	0101			
Detox			0116, 0126, 0136, 0146, 0156			
Ancillary Services		Based on Revenue Code	As appropriate			

***Note:** "Option 1" treatment is reported separately from room and board. "Option 2" is all-inclusive: includes room and board and treatment.

Table A.5.3.b Substance Abuse Services: All Other Residential

A.5.3.b – Substance Abuse Services: All Other Residential					
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	Day	1002: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) 1003: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox		0116, 0126, 0136, 0146, 0156			
Treatment program, treatment component		Choose one per date of service: 0944 or 0945 or 0949			
Ancillary services	Based on revenue code	As appropriate			

Table A.5.3.c – Substance Abuse Services: Outpatient Services

Table A.5.3.c – Substance Abuse Services: Outpatient Services (Applicable to all providers and settings per applicable contract or established program standards)				
Claim Type – 837I				
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	0944 or 0945	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT) – methadone, buprenorphine, naltrexone, antabuse (LIN segment to identify drug)	Day	0944	H0020	
Alcohol and/or drug assessment	Session/ visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x
Claim Type – 837P				
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT) – methadone, buprenorphine, naltrexone, antabuse (LIN segment to identify drug)	Day		H0020	
Alcohol and/or drug assessment	Session/ visit		H0001	

Appendix B: Reporting MNCare Tax

NOTE: Instructions for MNCare Tax billing only apply if the provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document **DOES NOT** require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT.

- MNCare Tax must be reported as part of the line item charge and reported in the corresponding AMT tax segment on the lines.

Key changes in the proposed revised 005010X222A2 837I (Institutional) Minnesota Uniform Companion Guide (MUCG)

The table below describes proposed changes during the 30-day comment period from the version currently posted at the AUC website at: http://www.health.state.mn.us/auc/guides.htm

Changes from current 005010X222A1 837P (Professional) to proposed new version	Page no. (proposed version)	Page no. (revised proposed new version)
1. ***Appendix A:*** The Appendix A (*Medical Code Set – Supplemental Information for Minnesota Uniform Companion Guides*) has been revised and updated with additional information, including:		
a. Table A.5.2, "*Behavioral Health Procedure Code/ Modifier Combinations: For Specific Benefit Packages Unique to State Government Programs*" changes include:		
i. Addition of definition of new listing for "Youth Assertive Community Treatment" (intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21)	48	48
b. Table A.5.3.c "*Substance Abuse Services: Outpatient Services*", lists describing modifiers and combination codes (combinations of modifiers) used in Substance Abuse Services table were removed (entire page deleted).	52	Removed
c. Table A.5.3.c "*Substance Abuse Services: Outpatient Services* (Applicable…standards)," was modified:		
i. The section of the table for "Outpatient services – Outpatient program; Treatment only, HCPCS procedure codes (modifiers and combination codes descriptors in deleted lists) were removed and changes to code H2035 were made by DHS in both 873I and 837P Claim Types. 1. Added H2035 (group) 2. Added H2035 (*individual*) 3. The Unit "Session" and its codes (H0005) were deleted from the table.	53	Page 52
ii. The section of the table for "Outpatient services – Outpatient program; treatment only" "All other medication therapy assisted (MAT) drugs" was also deleted from the table.	53	Removed