Meeting Materials

Medical Code TAG Meeting

February 14, 2013

1. Agenda AUC Medical Code TAG 02-14-13
2. Minutes – AUC Medical Code TAG 01-10-13
3. AUC SBAR – InReach Services
4. AUC SBAR – Community Paramedics
5. AUC SBAR – Telephone and E-visits (CPT Physician Language Revision
6. AUC SBAR – Crisis Psychotherapy Codes
7. AUC SBAR – Newborn Screening
8. AUC SBAR – Billing Methodology for Labor Epidurals
9. AUC SBAR – E-visit Clarification
10. AUC SBAR – Methadone vs. all other drugs

Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, February 14, 2013
9 a.m. to 12 p.m.
Location: SOP, Minnesota conference room

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**

<table><tr><td>Hospital bills 837I Revenue: 0984 HCPCS: T1016-U2TS</td><td>Hospital bills 837I Revenue: 0984 HCPCS: T1016-U2TS</td><td>Vendor bills 837P HCPCS: T1016-U2TS</td></tr></table> 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 99495-99496 ~~99487-99489~~ have been identified. We will discuss in January.	OPEN Waiting
1/10/13: Concerns about feasibility of recommended codes. Barb Hollerung stated that DHS may be shifting to CPT codes. Codes 99495 and 99496 are clinic based, whereas Inreach is more hospital based. Codes 99488 and 99489 are more specific to Medical Home. The most appropriate code remains T1016. Additional qualifiers would be needed – modifier U2 to indicate Inreach and TS for follow-up services. Issue –Inreach not approved yet for state plan service by CMS? CMS approval determines effective date of use of T1016. ACTION: Barb H. to do decision tree on T1016. Put in coding rec grid until next guide maintenance.	OPEN

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
1/10/13: Carolyn Larson reported that we should know by next month whether we are getting "vendor status".	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	OPEN

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	
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 Discussion of community paramedics What do we know: 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 **What we don't know**: 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:	OPEN Waiting for any updates

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 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
1/10/13: Someone will come in next month to discuss services to be provided The agreed code is T1016-U3. Issue of billing of supplies and drugs still open. ACTION: Barb Hollerung will do the decision tree.	OPEN

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	OPEN John Anderson and Barb Hollerung will forward additional information to Faith Faith will distribute upon receipt

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 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.	OPEN John Anderson will forward any updates. Barb Hollerung will work on SBAR and decision tree.

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.	
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. 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.
1/10/13: MFP will use codes discussed previously. ACTION: Barb Hollerung will prepare SBAR and decision tree.	OPEN

8. 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.

1/10/13: Dave Haugen noted that there are two different lists. It is a condition of AUC membership that there are two TAG members representing their organization. Then each TAG has a list of members and contact. ACTION: Send AUC MCT list to Faith for list clean up.	OPEN

9. CPT Physician Language Revision – JoAnne Wolf

1/10/13: CPT changed language in E/M codes to delete "physician". Changes will be needed to the guide for 98960 and 99444. ACTION:SBAR will be written and submitted on this issue by Hennepin County.	OPEN See SBAR & issue 14

10. Partial Hospitalization Revision – HCMC

1/10/13: Partial hospitalization – inpatient codes for E/M prof services and psych have changed. ACTION: Pending SBAR	OPEN

11. Crisis Psych Codes – Claire Smith, HCMC

1/10/13: There are new psych codes for crisis. It was noted that DHS is not allowing the new codes. ACTION: Pending SBAR	OPEN See SBAR

12. Newborn Screening - Barb Hollerung, DHS

1/10/13: Newborn screening is usually in hospital. DHS has an add-on for newborn screening for hospitals, but currently not for birthing centers. Birthing centers are billing individual lab codes (incorrectly) rather than correct S3620 code. ACTION: Barb Hollerung will prepare SBAR.	OPEN See SBAR

13. Labor Epidural Billing – Gregory Maurer, Health Billing Systems – see SBAR

14. E-Visit Clarification – Robin Morphy, HCMC – see SBAR and issue 9

15. Coding for Intensive Management of Obesity – HealthPartners – see SBAR

16. MAT Billing – Methadone vs. Other – Barb Hollerung, DHS – see SBAR

17. Additional Agenda Items

- Next meeting scheduled for March 14, 2013.
- TREATS:
- Meeting rooms are needed past March.

Date	Time	Location
April 11	9:00-12:00	6W Birch, HealthPartners, 8170 Building, Bloomington
May 9	9:00-12:00	St. Croix – 1st Floor, HealthPartners, 8170 Building, Bloomington
June 13	9:00-12:00	Minnehaha and Sky Hill Parks, BCBSMN, Yankee N., 1750 Yankee Drive, Eagan
July 11	10:00-1:00	6W Birch, HealthPartners, 8170 Building, Bloomington
August 8	9:00-12:00	Lake of the Woods, HealthPartners, 8170 Building, Bloomington
September 12	10:00-1:00	St. Croix – 1st Floor, HealthPartners, 8170 Building, Bloomington
October 10	9:00-12:00	6W Birch, HealthPartners, 8170 Building, Bloomington
November 14	9:00-12:00	Minnesota Room HealthPartners, 8170 Building, Bloomington
December 12	8:00-11:00	6W Sequoia, HealthPartners, 8170 Building, Bloomington

DRAFT

DRAFT

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, January 10, 2013, 9 a.m. to 12 p.m.
Location of Meeting – Blue Cross Blue Shield of MN
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. There was one correction to the Inreach Services issue – the correct codes are 99495-99496, not 99487-99489	Minutes will be sent to MDH for posting on AUC MCT website
4. Inreach service – DHS	Concerns about feasibility of recommended codes. Barb Hollerung stated that DHS may be shifting to CPT codes. Codes 99495 and 99496 are clinic based, whereas Inreach is more hospital based. Codes 99488 and 99489 are more specific to Medical Home. The most appropriate code remains T1016. Additional qualifiers would be needed – modifier U2 to indicate Inreach and TS for follow-up services. Issue –Inreach not approved yet for state plan service by CMS? CMS approval determines effective date of use of T1016. ACTION: Barb H. to do decision tree on T1016. Put in coding rec grid until next guide maintenance .	OPEN
5.APC CEUs – De Krengel, Medica	Carolyn Larson reported that we should know by next month whether we are getting "vendor status".	OPEN
6. Community Paramedic Services – De Krengel, Medica	Someone will come in next month to discuss services to be provided The agreed code is T1016-U3. Issue of billing of supplies and drugs still open. ACTION: Barb Hollerung will do the decision tree.	OPEN
7. MFP Demonstration Project – Barb Hollerung, DHS	MFP will use codes discussed previously. Barb Hollerung will prepare SBAR. ACTION: Barb Hollerung will prepare SBAR and decision tree.	OPEN

DRAFT DRAFT

Agenda Item	Discussion	Action/Follow-up:
8. Substance Abuse Coding	DHS needs to have outpatient therapies reported by hour. TAG voted to approve H2035 (group) and H2035-HQ (individual) outpatient therapy. DHS hopes to put into effect 3/1/13.	Closed
9. Coding for SBIRT – Deb Sorg, HealthPartners	Do not follow SAMHSA -- Use CPT or G codes, but not H codes. (Both codes are acceptable per appendix A front matter). Include in coding recommendation grid. HealthPartners will provide answer to person who asked.	Closed
10. AUC MCT Member List Clean-up – Deb Sorg, HealthPartners	Dave Haugen noted that there are two different lists. It is a condition of AUC membership that there are two TAG members representing their organization. Then each TAG has a list of members and contact. ACTION: Send AUC MCT list to Faith for list clean up.	OPEN
11. CPT Physician Language Revision – JoAnne Wolf	CPT changed language in E/M codes to delete "physician". Changes will be needed to the guide for 98960 and 99444. SBAR will be written and submitted on this issue by Hennepin County.	OPEN
12. Partial Hospitalization Revision - HCMC	Partial hospitalization – inpatient codes for E/M prof services and psych have changed. ACTION: Pending SBAR	OPEN
13. Crisis Psych Codes -	There are new psych codes for crisis. It was noted that DHS is not allowing the new codes. ACTION: Pending SBAR.	OPEN
14. Newborn Screening - Barb Hollerung, DHS	Newborn screening is usually in hospital. DHS has an add-on for newborn screening for hospitals, but currently not for birthing centers. Birthing centers are billing individual lab codes (incorrectly) rather than correct S3620 code. ACTION: Barb Hollerung will prepare SBAR.	OPEN
15. Additional Agenda Items Next Monthly meeting	Next regular monthly meeting scheduled for February 14, 2013 at SOP. TREATS: Lisa Kanivetsky volunteered. There was discussion about the need for meeting rooms past March. BCBSM has a room for June.	ACTION: All members are requested to check for possible meeting rooms.

Administrative
Uniformity
Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed): DHS, fee-for-service and managed care, requires a method for reporting a new service mandated in 256B.0625, Subd. 56 described as "in-reach community-based service coordination" where a social worker or other qualified person works closely with frequent emergency department users to provide better service and more appropriate community-based care at a lesser cost
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): 256B.0625 Subd. 56.Medical service coordination. (a) Medical assistance covers in-reach community-based service coordination that is performed in a hospital emergency department as an eligible procedure under a state healthcare program or private insurance for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization. (b) Reimbursement must be made in 15-minute increments under current Medicaid mental health social work reimbursement methodology and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. A frequent user who is participating in care coordination within a health care home framework is ineligible for reimbursement under this subdivision. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision. (c) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The major consideration is that the code for reporting be in 15 minute increments, and be distinctly recognizable as "in-reach" 837I – provided by hospital staff Revenue Code 0984 Medical social services – professional service provided in a facility – I assume no technical/facility fee Considered the following HCPCS codes for reporting with revenue code 0984: Coordinated Care – allows for initial but not 15 minute codes G9001 Coordinated care fee, initial rate G9002 Coordinated care fee, maintenance rate G9012 Other specified case management service not elsewhere classified (used to report clozaril management) Case Management T1016 Case management, each 15 minutes T1017 Targeted case management, each 15 minutes H2015 Comprehensive community support services, per 15 minutes H2021 Community-based wrap-around services, per 15 minutes S0315 – disease management program; initial assessment and initiation of the program (not 15 minute unit value) S0316 – disease management program, follow-up, reassessment (not 15 minute unit value) TS Follow-up services State defined U modifier to identify the service as "in-reach"
R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered: The department proposed using G9012 because it has limited conflict with other services but recognizes the code's lack of a specified time value severely limits its use. After preliminary discussion at AUC the Medical Code TAG recommends T1016 (case management, each 15 minutes) with to-be-defined 'U' modifier for "in-reach" and TS used for follow-up services.

	CONTACT INFORMATION – This form was completed by: Name: Barb Hollerung Title: Coding Compliance Officer Email address: barb.hollerung@state.mn.us Phone number: 651-431-3180 Organization: DHS Address: PO Box 64987, 540 Cedar St St. Paul, MN 55164-0987

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AUC Response

Administrative Uniformity Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed): To ensure administrative uniformity, there is a need for consistent coding for eligible services provided by Community Paramedics to MHCP enrollees, for those covered by fee-for-service MA and MNCare and those enrolled in health plans.
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): In 2011, the Legislature passed and Governor Dayton signed SF 119, creating a new certification for Community Paramedics. The law included language directing the Department of Human Services to create this report. In a Health Services Medical Management Legislative Report dated January, 2012, it was introduced that there was a goal to apply and expand the skills learned by Paramedics into the domain of preventative, primary care medicine, creating the Community Paramedic practice model. In a newsletter from MHCP to enrollees, an announcement was made that Community Paramedics may provide some services to MHCP enrollees. These services must: - be part of a coordinated care plan ordered by a primary health care provider, - be billed by an eligible, enrolled provider who employs or contracts with the community paramedic, - are approved by the medical director of an ambulance service Services may include: Health assessments Chronic disease monitoring and evaluation Help with taking medications Immunizations and vaccines Collecting lab specimens Follow-up care after being treated at a hospital Other minor medical procedures As published in a recent news article, there was a graduating class of Community Paramedics from Eden Prairie Hennepin Technical College ready to perform eligible medical services to those individuals who meet the requirements.
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): Eligibility of these services provided by community paramedics to MHCP enrollees presents the need for uniform billing among payers that enroll those eligible for these services, to achieve administrative simplification. Reimbursement methods will require standard billing codes, considering the impact of uniform billing requirements set forth by the AUC MCT.

R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered: Since these services were to be eligible for reimbursement for MA fee-for-service on 7/1/2012 and will be eligible on 1/1/2013 for those enrolled in a health plan, there is a need to develop standard billing in a timely manner. Consider reviewing DHS billing requirements for the Community Health Worker to determine if this practice could serve as a model for billing eligible services provided by Community Paramedics.
	CONTACT INFORMATION – This form was completed by: Name: De Krengel Title: Payment Intent Administrator Email address: deidre.krengel@medica.com Phone number: 952-992-3476 Organization: Medica Address: 401 Carlson Parkway Minnetonka, MN 55305

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AUC Response

Administrative Uniformity Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed): In 2013, the AMA revised CPT codes 99441-99443 for telephone E/M services, 99444 Online E/M service, 98966-98968 for telephone assessment and 98969 for online assessment. The revised language now states that codes 99441-99443 and 99444 should be used by a "qualified health care professional who may report evaluation and management services". A nurse practitioner (NP), physician assistant (PA) or a clinical nurse specialist (CNS) would meet this definition. However, in the 837P Minnesota Uniform Companion Guide, providers are instructed to use 99441-99443 and 99444 for MD/DO/DC only. NP, PA and CNS providers are instructed in the guide to use the codes in the Medicine section of the CPT manual (98966-98968 and 98969).
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): NP, PA and CNS providers are currently instructed to report telephone and online visits with codes 98966-98968 and 98969.
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The language in the Companion Guide directly contradicts the language in the CPT manual.
R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered: This affects dates of service beginning 1/1/2013. I recommend that the language be changed in the companion guide or the language is removed altogether from the guide.
	CONTACT INFORMATION – This form was completed by: Name: JoAnne Wolf, RHIT, CPC, CEMC Title: Coding Manager Email address: joanne.wolf@childrensmn.org Phone number: 612-813-5972 Organization: Children's Physician Network Address: 910 E. 26th St., Suite 330, Minneapolis, MN 55404

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AUC Response

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AUC BUSINESS NEED EXPLANATION

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

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

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

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AUC BUSINESS NEED EXPLANATION

S	SITUATION –: It has come to our attention that the NEWBORN SCREENING required for all births (except parental opt-out) by MN Statute 144.125 may result in erroneous billing to payers. http://www.health.state.mn.us/newbornscreening
B	BACKGROUND – Birth institutions, nurse midwife or midwife in attendance at the birth are required to "arrange to have administered to every infant or child in its care tests for heritable and congenital disorders...the commissioner (of health) shall charge a fee so that the total of fees collected shall approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders." When the baby is 24-48 hours old, a blood specimen is taken to fill five spots on the Newborn Screening Card provided by MDH. The commissioner of health determines the tests to be included in the NEWBORN SCREEN - MDH tests for over 50 conditions and recently added SCID. The fee is $106 per specimen payable to the Treasurer, State of Minnesota. For DHS the NEWBORN SCREENING is incorporated in the DRG paid to the birth facility; no additional charges are incurred for the initial screening.
A	ASSESSMENT – There seems to be a general misunderstanding from birth centers about NEWBORN SCREENING and whether they're allowed to report the tests separately. The issue has correct coding merit that may be dependent on the reimbursement methodology of the payer - if the birth DRG includes the screen or not. There are conditions that may prevent the initial specimen to be collected by the birth facility however payment has already been made.
R	RECOMMENDATION – We propose that a coding recommendation be developed to describe the methods for reporting initial and subsequent specimen collection for NEWBORN SCREENING.
	CONTACT INFORMATION – This form was completed by: Name: Barb Hollerung Title: Coding Compliance Email address: barb.hollerung@state.mn.us Phone number: 651-431-3180 Organization: DHS Address: 540 Cedar St St. Paul, MN 55155

Administrative
Uniformity
Committee

AUC BUSINESS NEED EXPLANATION

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed): Confusion exists as to the appropriate units billing for neuraxial anesthesia management time (code 01967). This code is used for maternity claims only. This code includes the needle placement, drug injection and necessary replacement of an epidural catheter during labor as well as the monitoring of the patient for the duration of the delivery.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): According to the 2013 Relative Value Guide(RVG) from the American Society of Anesthesiologists (ASA), "Unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor anesthesia services. Professional charges and payment policies should reasonably reflect the costs of providing labor anesthesia services as well as the intensity and time involved in performing and monitoring any neuraxial labor anesthesia service. Methods to determine professional charges consistent with these principles include: - Base units plus time units (insertion through delivery)subject to a reasonable cap - Base units plus one unit per hour for neuraxial anesthesia service management plus direct patient contact time. - Incremental time based fees - Single fee" According to the MN Uniform Companion Guide for Professional Claims, May 2011, Appendix A, page 37, Anesthesia codes 00100-01999: 1 unit = 1 minute. The 2013 ASA RVG defines time as is customary in the local area The local standard is based on 15 minutes per unit of time. The CMS 1500 Claim Form box 24G reports minutes for anesthesia. Based on the Medicare Claims Processing Manual as of 10/26/2012, Chapter 26, Section 10.9.1, Methodology for Coding Number of Services, is "For claims reporting anesthesia time in 15 minute periods or fractions of 15 minute periods, the following example should be used to code the line item: The anesthesiologist attended the patient for 35 minutes. Number of services: 1 MTUS (time units) 23(one decimal point implied)* MTUS indicator 2 *Two 15 minute periods + 1/3 of a 15 minute period = 2.3 The CMS Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), Version 005010A1, Companion Guide Version Number:2.0, June 10,2011, which is used to define the fields on the CMS 1500

	claim form for electronic submission, references on page 15, SV104, Service Unit Count, Codes MJ, "Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)." It is now mandated that the "5010" rules be applied to all claim forms submitted to all payers by professionals. Therefore minutes for all procedures are billed on the CMS 1500 claim form, Box 24G.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): We established in the late 1990's with most commercial payers that a fair methodology for billing the 01967 was to include the base units of 5 plus insertion time plus any bolus time plus 4 units of time (1 hour) for the time that the anesthesiologist was immediately available to respond to the obstetric need. This meant that the anesthesiologist was in-house as long as the labor epidural was in place which generally averages 4 to 6 hours. This was a modification of the "Base units plus one unit per hour for neuraxial anesthesia service management plus direct patient contact time." as noted in the ASA methods. As a result of the coding options available for 01967, providers may bill using different calculation of units depending on the payer. It is our desire to have a single, uniform coding rule related to these services that align with the national recommendations from the American Society of Anesthesiologists to ease the burden on providers and utilize the national guideline.
R	**RECOMMENDATION** – What are you recommending including any known timing that needs to be considered: Clarify the rule in the MN Uniform Companion Guide as it relates specifically to neuraxial anesthesia management time (code 01967). The methodology recommended is base units of 5 plus insertion time plus any bolus time plus 4 units of time (1 hour) for the time that the anesthesiologist was immediately available to respond to the obstetric need. We recommend that this policy be implemented April 1, 2013.

	CONTACT INFORMATION – This form was completed by: Name: Gregory Maurer Title: Operations Director Email address: gmaurer@healthbilling.net Phone number: 763-852-0409 Organization: Health Billing Systems, Inc. Address: 14700 28th Ave. No., #20 Plymouth, MN 55125

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AUC Response

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 in the Minnesota HCPCS manual located on the AUC website. Minnesota group purchasers accept all modifiers including DHS defined modifiers. This appendix includes a list of required modifiers for Minnesota Department of Human Services (DHS) behavioral health 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[2] (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." [3]

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

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

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

- 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.
Per the HIPAA Transactions and Code Set Rule, "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."

Code set updates[4] can be found at websites of the following organizations:

- Centers for Medicare and Medicaid Services (CMS)
- American Medical Association (AMA)
- National Center for Health Statistics (NCHS)
- National Uniform Billing Committee (NUBC)

A.5 Tables of Coding Requirements

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".

[4] 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).

Medicare Claims Processing Manual

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

Table of Contents

(Rev. 2571, 10-26-12)

Transmittals for Chapter 26

Code	Non-physician Practitioner/Supplier/Provider Specialty
B4	Rehabilitation Agency
B5	Ocularist

NOTE: Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use type of supplier code "69".

10.9 - Miles/Times/Units/Services (MTUS)

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-2010, Implementation: 10-04-10)

Miles/Times/Units/Services (MTUS) count and MTUS indicator fields are on Part B Physician/Supplier Claims. These fields are documented in the CMS National Claims History Data Dictionary.

Standard systems are to put MTUS count and MTUS indicators on all claims at the line item level.

The purpose of the MTUS Count Field on the line item is to document additional information reflecting certain volumes related to indicators. In most cases, the value in this field will be the same as in the Service Count Field on the line item; however, for services such as anesthesia the field values will differ. In this case, the service count field will likely contain a value of 1 for the occurrence of the surgery while the MTUS Count Field will contain the actual time units that the anesthesiologist spent with the patient in 15 minute increments or a fraction thereof.

The purpose of the MTUS Indicator Field is to indicate what the value entered into the MTUS Count Field means. There are 6 indicator values, as follows:

0 - No allowed services
1 - Ambulance transportation miles
2 - Anesthesia Time Units
3 - Services
4 - Oxygen units
5 - Units of Blood

Examples of how to code these fields are specified in §10.10.1 below.

10.9.1 - Methodology for Coding Number of Services, MTUS Count and MTUS Indicator Fields

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-2010, Implementation: 10-04-10)

The following instructions should be used as a guide for coding the number of services, MTUS Count and MTUS Indicator fields on the Part B Physician/Supplier Claim. These fields are documented in the CMS National Claims History Data Dictionary as CWFB_SRVC_CNT, CWFB_MTUS_CNT, and CWFB_MTUS_IND_CD, respectively. Services not falling into examples B, C, E, or F should be coded as shown in example D (services/pricing units).

A. No Allowed Services – (CWFB_MTUS_IND_CD = 0)

For claims reporting no allowed services, the following example should be used to code the line item:

A total of 2 visits was reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient. Both services were denied.

Number of services:	2 (furnished)
MTUS (services):	0 (allowed)
MTUS indicator:	0

B. Ambulance Miles - (CWFB_MTUS_IND_CD = 1)

For claims reporting ambulance miles, the following example should be used to code the line item:

Mileage Reporting: A total of 10 miles (1 trip) was reported for HCPCS code A0425: Ground mileage, per statute mile.

Number of services:	10
MTUS (miles):	10
MTUS indicator:	1

C. Anesthesia Time Units - (CWFB_MTUS_IND_CD = 2)

For claims reporting anesthesia time units in 15-minute periods or fractions of 15-minute periods, the following example should be used to code the line item:

A total of 1 allowed service is reported for HCPCS code 00142: Anesthesia for procedures on eye; lens surgery. The anesthesiologist attended the patient for 35 minutes.

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

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

D. Services/Pricing Units - (CWFB_MTUS_IND_CD = 3)

CMS

Standard Companion Guide Transaction Information

Instructions related to the 837 Health Care Claim: Professionals based on ASC X12 Technical Report Type 3 (TR3), version 005010A1

Companion Guide Version Number: 2.0
June 10, 2011

Loop ID	Reference	Name	Codes	Notes/Comments	Category
2400	SV102	Line Item Charge Amount		SV102 must equal the sum of all payer amounts paid found in 2430 SVD02 and the sum of all line adjustments found in 2430 CAS Adjustment Amounts.	9
2400	SV103	Unit or Basis for Measurement Code	MJ, UN	SV103 must be "MJ" when SV101-3, SV101-4, SV101-5, or SV101-6 is an anesthesia modifier (AA, AD, QK, QS, QX, QY or QZ). Otherwise, must be "UN".	6
2400	SV104	Service Unit Count	MJ	Anesthesia claims must be submitted with minutes (qualifier MJ). Claims for anesthesia services that do not contain minutes will be rejected. (SV104)	6
2400	SV104	Service Unit Count		The max value for anesthesia minutes (qualifier MJ) cannot exceed 4 bytes numeric. Claims for anesthesia services that exceed this value will be rejected. (SV104)	2
2400	SV104	Service Unit Count		The max value for units (qualifier UN) cannot exceed 4 bytes numeric and one decimal place. Claims for medical services that exceed this value will be rejected. (SV104)	2
2400	SV104	Service Unit Count		SV104 (Service unit counts) (units or minutes) cannot exceed 9999.9.	2
2400	PWK – Segment Rule	DURABLE MEDICAL EQUIPMENT CERTIFICATE OF MEDICAL NECESSITY INDICATOR		Must not be present. Submission of this segment for Part B will cause your claim to reject.	4

Administrative Uniformity Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed): Can you please clarify due to the new language added to CPT regarding other qualified health care (QHC) professional for e-visits who should be utilizing 99444? 1) MD, 2) Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist With that being said there is a parenthetical in CPT which states other QHC professional use 98969. What provider type would be qualified to utilize 98969? ??????????
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): Minnesota Community Coding Practice/Recommendation Table v3.0 form updated on 2/16/12 - 1 - under general states: A) ST: E-visits -- Question: What is proper code for E-visits by 1) physicians and 2) non-physicians? B) Rec.: CPT has specific E-visit codes for physicians and nonphysicians as follows. For E-visits, Use 99444 for MDs/DO/DCs; use 98969 for nonphysician healthcare professionals (e.g.. Nurse Practitioners, Physician Assistants, Clinical Nurse Specialist). C) MCT: Discussed 9-22-09; discussed at Ops 10/12/09, referred back to MCT for additional review and changes to add "DCs" and change "i.e" to "e.g." Change approved by MCT 10-27-09. Sent to Ops 11-4-09 for a vote at 11-10-09 Ops meeting.
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): Due to the language added to 99444 physician and other QHC, who may report E/M services then MD, DO, DC, NP, PA, CNS should be able to utilize this code for E-Visits. As those providers may report E/M services. Need a recommendation on who would qualify for 98969?
R	RECOMMENDATION – What are you recommending including any known timing that needs to be considered: MD, DO, DC, NP, PA, CNS should be able to utilize CPT code 99444 for E-Visits. As those providers may report E/M services. Need a recommendation on who would qualify for 98969?

	CONTACT INFORMATION – This form was completed by: Name: Robin L. Morphy Title: Revenue Integrity Analyst Email address: Robin.Morphy@hcmed.org Phone number: 612.873.6585 Organization: Hennepin County Medical Center Address:

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

Send this completed form to the AUC e-mail box at Health.auc@state.mn.us. You will be notified when it is received and provided a link to the AUC Executive Committee calendar to determine the date/time the AUC Executive Committee will evaluate your SBAR. The meeting date will be the next AUC Executive Committee meeting following receipt of the SBAR submission The AUC Executive Committee will determine if it falls within scope of the AUC and does not violate the AUC anti-trust statement.

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

AUC Response

Administrative
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Committee

AUC BUSINESS NEED EXPLANATION

S	SITUATION – To meet CMS and legislative requirements, DHS needs to reinstate the proposals 1. to establish a code to distinguish methadone from all other drugs for Medication Assisted Treatment (MAT)and 2. to identify MAT intensive (plus)services for a. methadone and b. all other drugs
B	BACKGROUND – Codes were proposed for the latest revision to the Companion Guides but rescinded due to additional anticipated changes.
A	ASSESSMENT – Additional changes have been put on hold so we need to proceed with the original recommendation.
R	RECOMMENDATION – In the absence of Appendix A coding instructions to distinguish these services, DHS strongly encourages the use of the following codes: H0047 U9 all other medication assisted treatment (MAT) drugs H0020 UA methadone MAT plus H0047 UB all other drugs MAT plus
	CONTACT INFORMATION – This form was completed by: Name: Barb Hollerung Title: Coding Compliance Email address: barb.hollerung@state.mn.us Phone number: 651-431-3180 Organization: DHS Address: 540 Cedar St, St Paul MN 55155
	Modifier definitions: UA = Mat Plus, methadone UB = MAT Plus, all other drugs U9 = MAT, all other drugs

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AUC Response