Administrative Uniformity Committee

Meeting Materials

Medical Code TAG Meeting

March 14, 2013

1. Agenda AUC Medical Code TAG 03-14-13
2. Minutes – AUC Medical Code TAG 02-04-13
3. Community Paramedics Decision Tree
4. In Reach Services Decision Tree
5. AUC SBAR – Telephone and E-visits (CPT Physician Language Revision
6. AUC SBAR – Crisis Psychotherapy Codes
7. AUC SBAR – E-visit Clarification
8. AUC SBAR – Coding for Extensive Management of Obesity
9. AUC SBAR – Health Care Homes

Administrative
Uniformity
Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, March 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. 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
2/14/13: Discussion postponed	OPEN

5. 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.	OPEN

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	
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)	OPEN Shawnet will verify POS, supply coding and implementation date

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?	
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 Are CPs eligible for an NPI <u>Resolution at this time:</u> 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.	OPEN Waiting for any updates
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
2/14/13: Guests included Ambulance Association Director, Buck Alpen (also representing North Memorial), provided an overview and description of the community paramedic services program and requirements for community paramedics. He and other guests in attendance responded to questions from TAG members to determine appropriate coding for community paramedic services and both DHS and North Memorial (Buck McAlpen) clarified the following: • Federal approval in the process of approving the waiver; • Ambulance charges and community paramedic charges are separate; • Community paramedics drive their individual vehicles and no mileage is billed; • If patient need medical care outside of scope of patient's care plan or emergency, community paramedics call 911 to dispatch ambulance service; • There will be no paperwork or form for services completed or submitted by paramedics; community paramedics will document services provided electronically into patient's medical record; • Place of service will be considered the patient's home, even when care is provided in a residential facility; • Primary care physician and Hospital Medical Director (aka Ambulance Director) will determine community paramedic's scope of practice – community paramedic must be listed in patient care plan in order to provide community paramedic services; • Hospital-based ambulance providers will be contracted separately as professional community paramedic providers; fire-based ambulance services will also provide community paramedics; • Medical supplies will be billed separately from ambulance services. Supplies will vary depending on care and will be supplied through the ambulance or primary care provider; • Actual vaccines and drug products will be billed separately and the professional services for administering vaccinations and immunizations included in T1016; • One bill submitted; • No prior authorization required; and • Typical length of time in patient's home varies from 15 minutes to two hours. TAG determined the following billing for community paramedics services: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – Medical director's • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) • Code supplies and vaccines as appropriate TAG agreed that coding for community paramedics services will be included in the coding recommendation grid with the intent of adding to the Guide during the next update.	OPEN Barb Hollerung developed a decision tree Issues to be resolved: Effective date of services and retro payment of community payment services – To be Determined by DHS

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

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. 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
2/14/13: DHS guest provided an overview of the Money Follows the Person (MFP) demo project and indicated that DHS will change the program's name and is currently considering a new name for the project. The project is pending federal approval. Effective date has not been finalized. Barb H. discussed the MFP SBAR and sought agreement from the TAG: • MFP will be professional claim only.	OPEN

• Code U6 will identify MFP
• Code T2038 transition
  o Community support services
  o Habilitation employment services
  o Supportive employment services
 	
TAG agreed that coding for MFP services will be included in the coding recommendation grid only because this is a demonstration project.
 	
Issues to be resolved:
1.Effective date of MFP
2.If additional modifiers for DME are needed
3.Transportation codes for recipient and social worker or escort
4.CMS need to approve MFP	

7. 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
2/14/13: Discussion postponed	OPEN

8. 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
2/14/13: Discussion postponed	OPEN See SBAR & E-Visit Clarification issue

9. Partial Hospitalization Revision – HCMC

1/10/13: Partial hospitalization – inpatient codes for E/M prof services and psych have changed. ACTION: Pending SBAR	OPEN
2/14/13: Discussion postponed	OPEN

10. 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
2/14/13: Discussion postponed	OPEN

11. E-Visit Clarification – Robin Morphy, HCMC – see SBAR and CPT Physician Language Revision issue

2/14/13: Discussion postponed	OPEN

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

2/14/13: Discussion postponed pending Executive Committee's review and response	OPEN

13. Health Care Home – Faith Bauer, BCBSMN – see SBAR

14. Additional Agenda Items

- Next meeting scheduled for April 11, 2013, 9:00-12:00, HealthPartners, 6W Birch, HealthPartners, 8170 Building, Bloomington
- TREATS:
- Meeting rooms for remaining 2013:

Date	Time	Location
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

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, February 14, 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.	Minutes will be sent to MDH for posting on AUC MCT website
4. Inreach service – DHS	Barb Hollerung reported that In-Reach Services applies to both 837I and 837P and U2 modifier = In-reach and U2 TS modifiers = In-reach, follow-up. Discussion regarding use of codes 9084 medical fees, local and 045x = emergency room.	CLOSED See decision tree
5.APC CEUs – De Krengel, Medica	Discussion postponed	OPEN
6. Community Paramedic Services – De Krengel, Medica	Guests included Ambulance Association Director, Buck Alpen (also representing North Memorial), provided an overview and description of the community paramedic services program and requirements for community paramedics. He and other guests in attendance responded to questions from TAG members to determine appropriate coding for community paramedic services and both DHS and North Memorial (Buck McAlpen) clarified the following: • Federal approval in the process of approving the waiver; • Ambulance charges and community paramedic charges are separate; • Community paramedics drive their individual vehicles and no mileage is billed; • If patient need medical care outside of scope of patient's care plan or emergency, community paramedics call 911 to dispatch ambulance service; • There will be no paperwork or form for services completed or submitted by paramedics; community paramedics will document services provided electronically into patient's medical record;	OPEN Barb Hollerung developed a decision tree Issues to be resolved: Effective date of services and retro payment of community payment services – To be Determined by DHS

Agenda Item	Discussion	Action/Follow-up:
	• Place of service will be considered the patient's home, even when care is provided in a residential facility; • Primary care physician and Hospital Medical Director (aka Ambulance Director) will determine community paramedic's scope of practice – community paramedic must be listed in patient care plan in order to provide community paramedic services; • Hospital-based ambulance providers will be contracted separately as professional community paramedic providers; fire-based ambulance services will also provide community paramedics; • Medical supplies will be billed separately from ambulance services. Supplies will vary depending on care and will be supplied through the ambulance or primary care provider; • Actual vaccines and drug products will be billed separately and the professional services for administering vaccinations and immunizations included in T1016; • One bill submitted; • No prior authorization required; and • Typical length of time in patient's home varies from 15 minutes to two hours. TAG determined the following billing for community paramedics services: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – Medical director's • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) • Code supplies and vaccines as appropriate TAG agreed that coding for community paramedics services will be included in the coding recommendation grid with the intent of adding to the Guide during the next update.	

7. MFP Demonstration Project – Barb Hollerung, DHS	DHS guest provided an overview of the Money Follows the Person (MFP) demo project and indicated that DHS will change the program's name and is currently considering a new name for the project. The project is pending federal approval. Effective date has not been finalized. Barb H. discussed the MFP SBAR and sought agreement from the TAG:
	• MFP will be professional claim only.
	• Code U6 will identify MFP
	• Code T2038 transition
	  o Community support services
	  o Habilitation employment services
	  o Supportive employment services
		OPEN
		Issues to be resolved:
		1. Effective date of MFP
		2. If additional modifiers for Durable medical equipment (DME) are needed
		3. Transportation codes for recipient and social worker or escort

Agenda Item	Discussion	Action/Follow-up:
	TAG agreed that coding for MFP services will be included in the coding recommendation grid only because this is a demonstration project.	**4.** Centers for Medicaid and Medical Services (CMS) need to approve MFP
8. AUC MCT Member List Clean-up – Deb Sorg, HealthPartners	Discussion Postponed	OPEN
9. CPT Physician Language Revision – JoAnne Wolf	Discussion Postponed	OPEN
10. Partial Hospitalization Revision - HCMC	Discussion Postponed	OPEN
11. Crisis Psych Codes -	Discussion Postponed	OPEN
12. Newborn Screening - Barb Hollerung, DHS	Guests Patti Constant and BethAnn Bloom of MDH and Suzanne Bruning attended to provide information re Newborn Screening and assist TAG in resolving newborn screening coding issues/concerns. Barb H. discussed the Newborn Screening SBAR. The state requires all babies be tested. The card is purchased form the state. A blood drop is placed on the card and sent to the state for testing. The dried blood is screened for 50 disorders. Each state defines what tests are included in S3620. There may be times when retesting is needed – problem with specimen itself, anemia, mail delivery, etc. TAG agreed on the following: • Inpatient services are billed on DRG payment methodology • Any newborn screening outside of inpatient (lab and birth centers) use code S3620 for initial screening and S3620-76 or -77 as needed, for retest newborn screening TAG approved Newborn Screening SBAR- Instructions to report newborn screening for lab and birth centers will be added to coding recommendation grid.	CLOSED Barb Hollerung developed decision tree
13. Labor Epidural Billing – Gregory Maurer, Health Billing Systems – see SBAR	Greg Maurer discussed the Labor epidural SBAR requesting coding for "time present and immediately available" of currently billing methodology for most payers be standardized coding in the Claims companion guides for anesthesia. TAG agreed that there is no coding to identify specific standby services for anesthesia but the SBAR is out of scope for the Medical Code TAG and suggested that ASA make	CLOSED – no action

Agenda Item	Discussion	Action/Follow-up:
	recommendation to CPT for national code(s) to address labor epidural anesthesiology billing "time present and immediately available."	
14. E-Visit Clarification – Robin Morphy, HCMC – see SBAR and issue 9	Discussion Postponed	OPEN
15. Coding for Intensive Management of Obesity – HealthPartners – see SBAR	Discussion Postponed pending Executive Committee's review and response	OPEN
16. MAT Billing – Methadone vs. Other – Barb Hollerung, DHS – see SBAR	Barb H reported the need to identify Methadone and other drugs: Responding to TAG questions Barb stated: • MAT billing would include therapy. • Coding for other drugs plus = UB and is effective March 1. • Modifiers will be required on all claims. TAG approved MAT billing SBAR for coding recommendation grid	CLOSED See decision tree
17. Additional Agenda Items Next Monthly meeting	Next regular monthly meeting scheduled for March 14, 2013 at SOP. TREATS: De Krengel volunteered.	CLOSED

Decision Tree for Medical Coding Decisions Based on Medicare
Community Paramedic

Step No.	Instructions	Information/Steps to follow	
	MN Uniform Claims Companion Guide(s) to which this issue may apply: **Medical service/procedure/etc. of interest or at issue:** (Fill in column to the right)	837P __X____ 837I _____ 837D _____ MN Statute 256B.0625, subd. 60 requires Medical Assistance cover services provided by community paramedics certified under section 144R.28, subd. 9	
1	**Does Medicare have coding requirements/instructions for coding medical service/procedure/etc. named above**? (Check appropriate answer to right)	Yes _____ Go to 2	No __X____ Go to 8
2	**Source(s) of Medicare instructions:** (Clearly cite source, including, date, other identifying information to right. If available online, also provide any online link(s)	When complete, go to 3.	
3	**Summary of Medicare instructions:** (Summarize what the Medicare instructions say to do in the column to the right)	When complete, go to 4.	
4	**Medicare instructions are clear and unambiguous:**	Yes _____ Go to 5	No _____ Go to 6
5	**Medicare has coding requirements/instructions that are clear and unambiguous. Are there any issues/concerns/problems with following Medicare requirements/instructions?**	Yes _____ Go to 6	No _____ If "No" is checked, **STOP. Use Medicare coding requirements/instructions**

Step No.	Instructions	Information/Steps to follow
		described in 2 and 3 above.
6	**Check any issues/concerns/problems below that apply if Medicare requirements/instructions are followed. Explain and provide examples of any checked items.**	
	_____a) **More specific or appropriate codes are needed in order to reduce manual processing and administrative costs.** Explain/provide examples:	
	_____ b) **Duplicate codes exist and clarification of which code(s) to use is needed.** Explain/provide examples:	
	_____ c) **Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits** Explain/provide examples:	
	_____d) **Other** Explain/provide examples:	
	Go to 7	
7	**Provide any suggested coding options to address problems in #6 above, with rationale:**	
8	**Medicare does not have a guideline for coding a service or made no specific reference to a service. Please suggest any possible coding options and rationale:** **Community Paramedic** Community paramedic services should be billed in 15 minute increments with **T1016 U3.** Supplies may be billed separately with appropriate HCPCS codes.	

Step No.	Instructions	Information/Steps to follow
	U3 – service provided by certified community paramedic (EMT-CP)	

Decision Tree for Medical Coding Decisions Based on Medicare
MEDICAID Money Follows the Person Demonstration Project

Step No.	Instructions	Information/Steps to follow	
	MN Uniform Claims Companion Guide(s) to which this issue may apply: **Medical service/procedure/etc. of interest or at issue:** (Fill in column to the right)	837P ___X___ 837I _____ 837D _____ The Deficit Reduction and Affordable Care Acts empowered states to develop demonstration projects that would promote and enable movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community. To provide community-based alternatives for persons of all ages and disability groups who reside in MA-funded institutional settings.	
1	**Does Medicare have coding requirements/instructions for coding medical service/procedure/etc. named above**? (Check appropriate answer to right)	Yes _____ Go to 2	No _X_____ Go to 8
2	**Source(s) of Medicare instructions:** (Clearly cite source, including, date, other identifying information to right. If available online, also provide any online link(s)	When complete, go to 3.	
3	**Summary of Medicare instructions:** (Summarize what the Medicare instructions say to do in the column to the right)	When complete, go to 4.	
4	**Medicare instructions are clear and unambiguous:**	Yes _____ Go to 5	No _____ Go to 6

Step No.	Instructions	Information/Steps to follow	
5	**Medicare has coding requirements/instructions that are clear and unambiguous. Are there any issues/concerns/problems with following Medicare requirements/instructions?**	Yes _____ Go to 6	No _____ If "No" is checked, **STOP. Use Medicare coding requirements/instructions described in 2 and 3 above.**
6	**Check any issues/concerns/problems below that apply if Medicare requirements/instructions are followed. Explain and provide examples of any checked items.**		
	____a) **More specific or appropriate codes are needed in order to reduce manual processing and administrative costs.** Explain/provide examples:		
	____ b) **Duplicate codes exist and clarification of which code(s) to use is needed.** Explain/provide examples:		
	____ c) **Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits** Explain/provide examples:		
	_____d) **Other** Explain/provide examples:		
	Go to 7		
7	**Provide any suggested coding options to address problems in #6 above, with rationale:**		
8	**Medicare does not have a guideline for coding a service or made no specific reference to a service. Please suggest any**		

Step No.	Instructions	Information/Steps to follow

possible coding options and rationale:
Money Follows the Person provides an array of home and community based services to include planning and coordination of community living arrangements, searching for and securing housing, moving, securing household goods, and arranging for supportive housing, employment and environmental services. The following codes are recommended to report Money Follows the Person activities:

Money Follows the Person

HCPCS code	Modifier(s)	Description
T2038	U6	Community transition, MFP *(plan development)*
T2038	U6 UD	Community transition, MFP (*coordination)*
T2038	U6 U1	Community transition, MFP, furniture
T2038	U6 U2	Community transition, MFP, supplies
H2015	U6	Comprehensive community support services, per 15 minutes, MFP
T2019	U6	Habilitation, supported employment, per 15 minutes, MFP
H0038	U6	Self-help/peer services, per 15 minutes, MFP
H2027	U6	Psychoeducational service, per 15 minutes, MFP
S5115	U6	Home care training, nonfamily, per 15 minutes *(caregiver education)*
H2000	U6	Comprehensive multidisciplinary evaluation, MHP *(in the development of a transition or service plan)*
T2012	U6	Habilitation, educational, per diem, MHP *(intervention provided to support placement in the community)*
S5150	U6	Unskilled respite care, per 15 minutes, MFP *(in home)*
S5151	U6	Unskilled respite care, per diem, MFP *(in home)*
S5150	U6 UB	Unskilled respite care, per 15 minutes, MFP, out of home
H0045	U6	Respite care services, not in the home, per diem, MFP
S5165	U6	Home modifications; per service, MFP
S5162	U6	Emergency response system; purchase only, MFP
S5161	U6	Emergency response system; service fee, per month, MFP
T1999	U6	Miscellaneous therapeutic items and supplies, retail purchases, NOC, MFP
E1399	U6 (NU,	Durable medical equipment (include modifier for purchase,

Step No.	Instructions	Information/Steps to follow

	RR or RB)	rental or repair)
S5135	U6 UA	Companion care, adult; per 15 minutes, MFP, night supervision
A0160	U6	Nonemergency transportation: per mile – caseworker or social worker, MFP
A0170	U6	Transportation ancillary: parking fees, tolls, other, MFP
A0180	U6	Nonemergency transportation: ancillary; lodging-recipient, MFP
A0190	U6	Nonemergency transportation: ancillary; meals, recipient, MFP
A0200	U6	Nonemergency transportation: ancillary; lodging, escort, MFP
A0210	U6	Nonemergency transportation: ancillary; meals, escort, MFP
S9970	U6	Health club membership, annual, MFP

'U' Modifier definitions for this purpose:
U6 - Money Follows the Person demonstration
UA - Night supervision
UB – Out-of-home
UD – Transition to community living services
U1 – Transitional services – furniture
U2 – Transitional services- supplies

Administrative
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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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Committee

AUC BUSINESS NEED EXPLANATION

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

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

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AUC Response

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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:

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AUC Response

S-B-A-R SITUATIONAL BRIEFING MODEL

AGENDA ITEM: CODING FOR INTENSIVE MANAGEMENT OF OBESITY
DISCUSSION LEADER:

SITUATION: *BRIEFLY DESCRIBE THE CURRENT SITUTATION. GIVE A CLEAR VIEW OF CURRENT ISSUES*

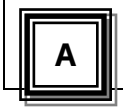
The U.S. Preventive Services Task Force (USPSTF) recommended, with a "B" rating, that physicians:

- Screen patients for "obesity" (body mass index (BMI) of 30 or more);
- For adult patients with a BMI of 30 or more provide or refer to an intensive, multi-component intervention that include:
  - ✓ Behavioral management activities such as setting weight loss goals
  - ✓ Improving diet/nutrition and increasing physical activity
  - ✓ Addressing barriers to change
  - ✓ Self-monitoring
  - ✓ Strategizing how to maintain lifestyle changes

BACKGROUND: *BRIEFLY TELL HOW WE GOT TO THIS POINT; ANY PERTINENT HISTORY.*

HealthPartners intent is to comply with the USPSTF requirement to cover intensive obesity counseling.

1. Under federal health care reform, health plans are required to cover all USPSTF recommendations Grade A or B at the preventive benefit level (100% coverage)
2. Plans have one year from the date the recommendation is released to add the benefit to their plans. This recommendation was released in June 2012. Plans will implement the new benefit effective July 1, 2013 as groups renew.



ASSESSMENT: *SUMMARY OF YOUR VIEW OF TOPIC; LIST KEY QUESTIONS.*

HealthPartners would like to establish a consistent and unique way for our community to code these services. This will enable plans to identify which of our members are obtaining intensive obesity counseling vs. health education which is already a covered benefit. It will also enable us to differentiate intensive obesity counseling from eating disorder programs.

RECOMMENDATION: *WHAT ACTIONS YOU ARE ASKING FOR.*

Based on our understanding of the codes currently being used in the community, we recommend the following be used for this new, required benefit.

G0447 – Face-to-face behavioral counseling for obesity, 15 minutes
S9449 – Weight management classes, non-physician provider, per session

These codes reflect that counseling may be done by physician and non-physician providers and may take place in an individual or group sessing. These codes are more appropriate than 97802 – 97804 (medical nutrition therapy) because the scope of this benefit is broader than nutrition. We also believe these codes are more appropriate than 99401 – 99404 (preventive medicine counseling) because they are more specific to obesity and weigh management.

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AUC BUSINESS NEED EXPLANATION

S

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

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

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

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

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

B

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

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

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

A

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

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

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

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AUC Response

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

837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Medication Assisted Treatment (MAT) – methadone (report LIN segment to identify drug)	Day	0944	H0020	089x or 013x
Medication Assisted Treatment (MAT) – all other drugs (report LIN segment to identify drug)			H0047 U9	
MAT Plus – methadone (report LIN segment to identify drug)	Day	0944	H0020 UA	089x or 013x
MAT Plus – all other drugs (report LIN segment to identify drug)			H0047 UB	
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

837P

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Medication Assisted Treatment (MAT) – methadone	Day	N/A	H0020	N/A
Medication Assisted Treatment (MAT) – all other drugs			H0047 U9	
MAT Plus – methadone	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs			H0047 UB	
Alcohol and/or drug assessment	Session/visit		H0001	

MAT Plus – a licensed program providing at least 9 hours of treatment service per week

U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.

UA – MAT Plus, methadone

UB – MAT Plus, all other drugs