Administrative Uniformity Committee

Meeting Materials

AUC Medical Code TAG Meeting

July 11, 2013

1. Agenda AUC Medical Code TAG 071113

2. May 9, 2013 Meeting Minutes

3. AUC Medical Code TAG Information Page

4. Minnesota Companion Guide Rulemaking Timeline

5. Draft Revisions to AUC 837 Professional Claims Guide

Administrative
Uniformity
Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, July 11, 2013
10:00 a.m. to 1:00 p.m.
Location: HealthPartners, 8170 Building, Bloomington, St. Croix room – 6 W Birch

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. 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
3/14/13: Deb Sorg has done some clean-up and is still working on the MCT member list. She will send email to individuals on distribution list to confirm their membership in TAG.	OPEN
5/9/13: BCBSMN, Minnehaha and Sky Hill Parks, Yankee N., 1750 Yankee Drive, Eagan	OPEN

5. MCT Information Page – Barb Hollerung, DHS

3/14/13, 5/9/13: Update AUC web page to provide instructions how to submit issue to AUC. Barb and Faith will draft language. Review goal and mission statement.	OPEN See copy of MCT home page

6. Annual Companion Guide Maintenance – Judy Edwards, MDH

The complete rulemaking process will take approximately 90 days to complete. However, if order to meet this timeframe we need your help and request that you submit any recommended changes to us within three weeks (i.e., no later than end of day July 23). If you cannot meet this deadline please let us know. We are asking if you do not have a scheduled TAG meeting soon that you:

- Send an email to your TAG members requesting they review the current companion guide and recommend updates to you within two weeks (July 16). Copies of the current CG can be downloaded from the AUC website at: http://www.health.state.mn.us/auc/guides.htm.
- You complete the review of recommendations you receive from TAG members and submit a list of the required CG updates one week later (July 23).

7. Tentative 2014 MCT Meetings Calendar – Susie Veness, MDH

Below is a tentative meeting schedule for 2014 Medical Code TAG Meetings. Please review and approve. A response by **Friday, August 9th** would be appreciated.

Date	Day	Start Time	AM/PM	End Time	Meeting	Location
1/9/14	Thurs	9:00	AM	12:00	Medical Code	TBD
2/13/14	Thurs	9:00	AM	12:00	Medical Code	TBD
3/13/14	Thurs	9:00	AM	12:00	Medical Code	TBD
4/10/14	Thurs	9:00	AM	12:00	Medical Code	TBD
5/8/14	Thurs	9:00	AM	12:00	Medical Code	TBD
6/12/14	Thurs	9:00	AM	12:00	Medical Code	TBD
7/10/14	Thurs	9:00	AM	12:00	Medical Code	TBD
8/14/14	Thurs	9:00	AM	12:00	Medical Code	TBD
9/11/14	Thurs	9:00	AM	12:00	Medical Code	TBD
10/9/14	Thurs	9:00	AM	12:00	Medical Code	TBD
11/13/14	Thurs	9:00	AM	12:00	Medical Code	TBD
12/11/14	Thurs	9:00	AM	12:00	Medical Code	TBD

8. Additional Agenda Items

- Next meeting scheduled for August 8, 2013, 9:00-12:00, HealthPartners, Lake of the Woods, HealthPartners, 8170 Building, Bloomington
- TREATS:
- Meeting rooms for remaining 2013:

Date	Time	Location
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, May 9, 2013, 9 a.m. to 12 p.m.
Location of Meeting – HealthPartners
Meeting Minutes

Minutes By: Judy Edwards and 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 for March 14 meeting approved with the following corrections: • Agenda item #4 – change APC to AAPC • Two Agenda items are numbered 14; renumber 2nd. • Renumber the second Agenda item 14 Additional Agenda Items to 15 and delete last sentence. • Renumber Agenda item 15 to 16.	Minutes will be sent to MDH for posting on AUC MCT website
4. AAPC CEUs – De Krengel, Medica	Faith thanked Carolyn, De and Dave for their work in getting the AAPC CEUs approved for the Medical Code TAG meetings. Dave reported the AAPC accommodated the AUC MCT request and will award two CEUs for each meeting for one year (through April 2014). Dave took an applicable brief tour of AAPC website for members to view the CEU vendor information and schedule of MCT meetings and the Agenda template and the Certificate of Approval AAPC CEU – MDH will complete certificates and will need verification of attendance. David stated further awarding of the CEUs also meant adopting implementation of a structured process –submitted draft meeting agenda of the participation. Document everything well in the event of audit or verification. Since this is a new process, he and Faith will experiment to determine how best to proceed. The goal is to show AAPC or anyone else involved that we have a structured process. Dave presented overview of draft decision tree to TAG that he developed and shared with Faith and Barb Hollerung for feedback. Dave's illustration attempted to capture the decision making process for coding. He would like changes to draft and solicited TAG's suggestions/recommendations also. The goal is to have something to post on website that we can use to guide our work and SBAR originators will know how the TAG reaches its decision. – Judy B. questioned POS Claims DD and relation to coding MCT. Faith – Outpatient includes revenue code and type of bill. New decision branch. A Yes/No branch will be added.	CLOSED MDH will revise draft decision tree and get to Faith for distribution next week (5/18/13) An AAPC category will be added under each agenda item. Categories are: • New Code Updates (January, April, July, October) • CPT / HCPCS Coding Clarifications • DHS*-Specific Coding Requirements • Health Care Trends Instructions or for people wanting information on MCT website. Faith and Barb H. will update

Agenda Item	Discussion	Action/Follow-up:
	De recommended TAG use the agenda template and have it work in tandem with the decision tree. Deb will submit Excel spreadsheet of TAG members meeting attendance to MDH for issuance of CEUs certificates.	website.
5. MFP Demonstration Project – Barb Hollerung, DHS	DHS changed the MFP demo project's name. The new name is Moving Home Minnesota aka MFP – Faith reviewed the changes to the MFP decision tree recommended by Barb H.	CLOSED Faith will revise and forward to MDH
6. AUC MCT Member List Clean-up – Deb Sorg, HealthPartners	Deb has received some changes and is continuing to sanitize TAG distribution list.	OPEN
7. CPT Physician Language Revision – JoAnne Wolf	NOTE: See E-Visit Clarification SBAR DHS – recommendation – healthcare professionals –some who can report an E/M codes; not extender staff Lisa could not find any notes from the CPT symposium regarding these specific codes Follow CPT code There was discussion regarding the Chapter 12 – 98966 entry and who does not qualify as a qualified health care professional. For example, nurse practitioner services would be reported under the physician or other qualified healthcare practitioner language change. TAG's recommendation is to remove E-visits and Telephone services from the companion guide because providers should be to follow CPT and use appropriate codes. Adding to recommendation grid and note CPT language change. Dave will discuss with division director and legal counsel to indicate coding issue and see if MDH can post in bulletin. Companion guide update for next agenda	CLOSED The Coding Recommendation Grid will be updated
8. Partial Hospitalization Revision - HCMC	Barb H. sent the following DHS comments: "Was referred to DD TAG - place of service question. CPT notes are not new (1992). DHS definition of partial hospitalization refers to service "provided in an outpatient hospital facility or community mental health center;" our billing instructions state to use appropriate E/M code with place of service 22 or 53. MN Administrative Rule 9505.0372 Subd. 9 "partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization….." Any insight into why this is an issue now?" The DD TAG reviewed the SBAR and submitted its recommendation to MDH to forward to Executive Committee for review and delegation.	CLOSED Formal response will be forwarded to the SBAR originator once reviewed by AUC Ops.
9. E-Visit Clarification – Robin Morphy, HCMC	NOTE: See CPT Physician Revision Language SBAR for notes and actions	CLOSED The Coding Recommendation

Agenda Item	Discussion	Action/Follow-up:
		Grid will be updated
10. Coding Clarification Guide Update – Faith Bauer, BCBSMN	Faith will make recommended changes and distribute to TAG for their review and approval. TAG will have two days to review and provide comments. After TAG's approval, coding grid will be forwarded to MDH for Ops approval.	CLOSED
11. AUC MCT Webpage Update – Barb Hollerung	Barb and Faith will work on updates to the web page.	OPEN
12. Next Monthly meeting	Reschedule meetings – BCBS has space available on Tuesday, June 4, 2013. If any TAG member has availability on June 25 morning or afternoon let Faith know by end of this week. Otherwise, meeting will be June 4. Cancel November 14 meeting due to CPT symposium. TREATS: Lisa Kanivetsky	CLOSED

Medical Code Technical Advisory Group

Meeting Information

Policies

SBAR and work request forms

Chair

- Faith Bauer Faith_E_Bauer@bluecrossmn.com 651-662-8068

Charge and mission statement of work

For Minnesota Statutes 62J.536 project: Create common standards in cases where Medicare does not meet Minnesota needs and Minnesota commercial health plan group purchasers require providers to code medical services differently, depending upon the group purchaser.

An overarching principle of this work is the fact that, each MN group purchaser and provider will be required to make changes to procedures, policies and/or systems in some way, as a result of the work of the AUC and the Medical Code TAG.

Work plan and/or accomplishments

Determine scope and relevance to Medical Code TAG for Minnesota Statutes 62J.536 project:

1. In the Scope of the Medical Code TAG:
    - HCPCS Codes (CPT Codes)
    - Revenue Codes
    - Modifiers
    - Units – when not addressed in the Claims Data Definition ~~TAG and/or the MN 1500 Manual~~, e.g., bilateral procedures, anesthesia
    - ICD 9– Procedure Codes
2. Not in the Scope of the Medical Code TAG – such as, but not limited to:
    - Type of bill
    - Late charges
    - Adjustments
    - Timely filing
    - COB
    - Attachments

3. Items not within the above Scope of the Medical Code TAG will be forwarded on, via a spreadsheet, to the appropriate AUC TAG, e.g., Claims Data Definitions for resolution. The Medical Code TAG will bring any items with unknown ownership to the AUC Executive Committee.

Process for Minnesota Statutes 62J.536 project

1. For each coding topic the Medical Code TAG will first review the CMS Medicare Manual and if group purchasers/providers agree that Medicare is the preferred coding method then that item is considered to be - DONE.
2. If all group purchasers/providers do not agree to follow Medicare, then the Medical Code TAG will decide on ONE way to code for services for commercial business in MN. All participants should provide compelling business facts to support the preferred method.
    - If group purchasers/providers do not reach consensus on ONE method to code for services, then action items will be assigned to group purchasers/providers, with a deadline date to report back to the Medical Code TAG.
3. The Medical Code TAG will then review appropriate materials and determine the ONE way to code for services for commercial MN group purchasers for those items that are NOT in the CMS Medicare Manual, such as, EPSDT, maternity, pediatrics, etc.

Overarching considerations for this work are that the Medical Code TAG will need to continue to address new code standards using the above procedures.

Work product to be developed

Minnesota rules for medical codes when commercial health plan group purchasers use codes other than those in the CMS Medicare Manual. MN medical code rules will be in an appendix to the MN Institutional Claims (837I) Companion Guide, the MN Professional Claims (837P) Companion Guide, the MN Dental Claims (837D) Companion Guide, ~~and~~ the MN Pharmacy Claims (NCPDP 5.1) Companion Guide and the MN Community Coding Practice/Recommendation Table.

The MN Community Coding Practice/Recommendation Table:

☐Provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services on the 837I and 837P electronic claim;

☐Is intended for use in conjunction with "Appendix A, Table A.5.1" of the "Minnesota Uniform Companion Guides for the 837 Institutional (I) and 837 Professional (P) transactions;

- Is informational only – It is not part of the Minnesota Uniform Companion Guides and does not serve as a rule, but note that the recommendation may have been or will be added to the Compantion Guide;

☐Will be explained with header rows that will appear on every page of the table;

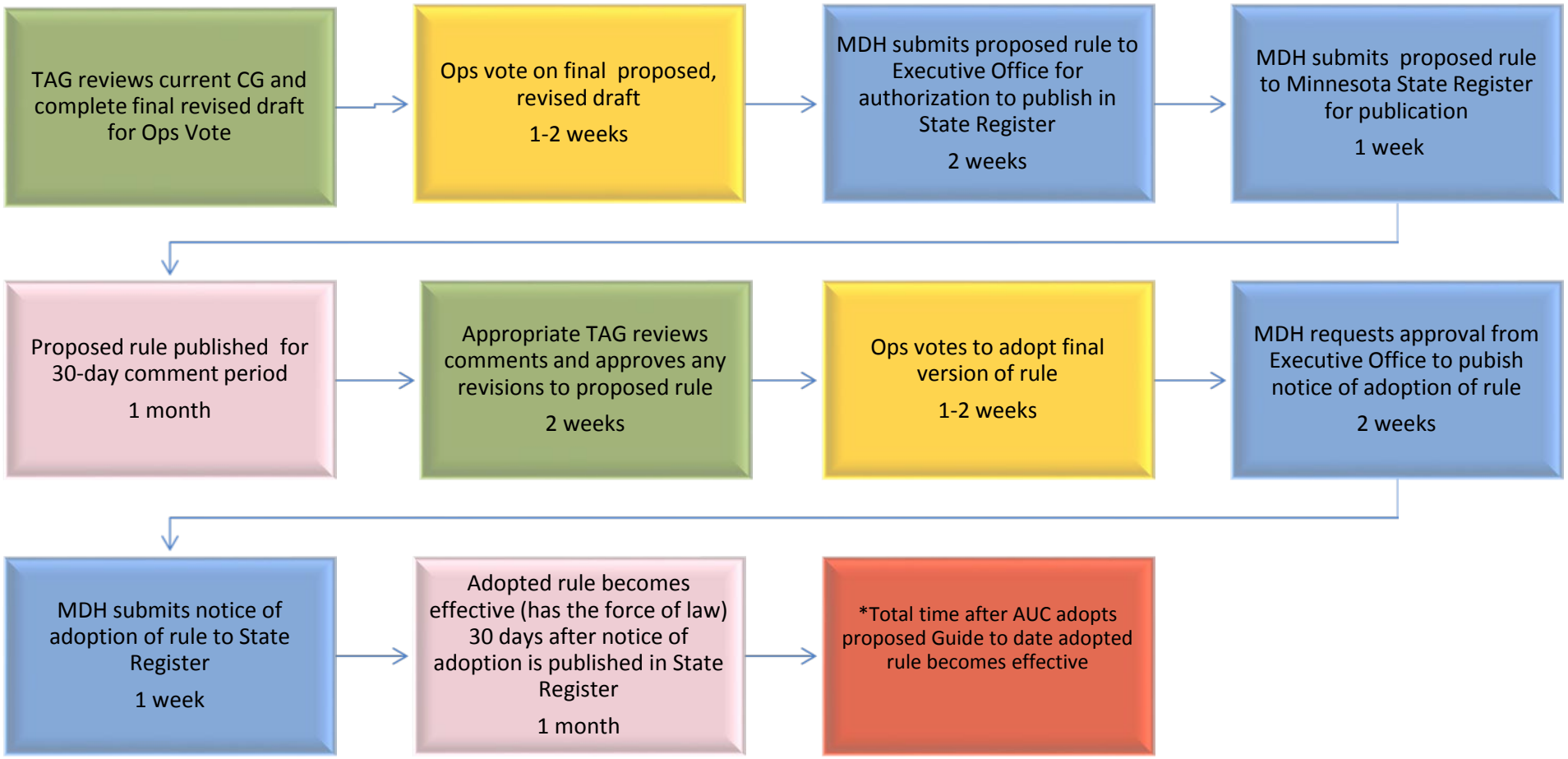
- Provides recommendations that may be transferred to the applicable Minnesota Uniform Companion Guides for the 837I and 837P as part of the annual maintenance;

- Is a living document that is regularly updated with new coding recommendations; and
- Was developed to track new or revised coding recommendations developed between, and in anticipation of, the annual companion guide update. Updates may stem from:
  - Quarterly HCPCS coding changes
  - Medical coding in relation to legislative changes
  - Reaction to new or revised Medicare rules
  - Other coding issues as identified

Activation or re-activation date: 01/01/2007 (Formerly State HCPCS Committee)

Inactivation date: N/A

Minnesota Rulemaking Process for Minnesota
Uniform Companion Guides
Suggested Timeline for 2013 Maintenance



Minnesota Department of Health (MDH) DRAFT Rule

Title:	Draft Minnesota Uniform Companion Guide for the ***ASC X12/005010X222A1 Health Care Claim: Professional (837)*** *Version 7.0.*
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description and status of this document:	This document is a draft version *7.0 Minnesota Uniform Companion Guide for the ASC X12/005010X222A1 Health Care Claim: Professional (837)*. It was prepared by the Minnesota Department of Health (MDH) in its role in implementing requirements for the standard, electronic exchange of health care administrative transactions pursuant to Minnesota Statutes, section 62J.536, with the assistance of the Minnesota Administrative Uniformity Committee (AUC). It is being submitted to the AUC Medical Code TAG for its review and consideration to supersede the version currently in force, version 6.0, and all previous versions. This document has not yet been approved by the AUC and has not been adopted into rule. [Placeholder for the following statement to be added later: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)* hereinafter referred to as *005010X222A1,* by entities subject to Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536; and • Includes information and instructions in a series of appendices. This document is available at no charge at: www.health.state.mn.us/asa.

This page was left blank.

TABLE OF CONTENTS

1.0 OVERVIEW 1

1.1 Statutory basis for this proposed rule 1

1.2 Applicability of state statute and related rules 1

1.3 About the Minnesota Department of Health (MDH) 3

1.4 About the Minnesota Administrative Uniformity Committee 3

1.5 Minnesota Best Practices for the Implementation of Electronic Health Care Transactions 3

1.6 Document Changes 4

2.0 PURPOSE OF THIS DOCUMENT AND ITS RELATIONSHIP WITH OTHER APPLICABLE REGULATIONS 5

2.1 Reference for this document 5

2.2 Purpose and relationship 5

3.0 HOW TO USE THIS DOCUMENT 7

3.1 Classification and display of Minnesota-specific requirements 7

3.2 Information About the Health Care Claim: Professional (837) Transaction 7

4.0 ASC X12/005010X222A1 HEALTH CARE CLAIM: PROFESSIONAL (837) -- TRANSACTION SPECIFIC INFORMATION 13

4.1 Introduction to Table 13

4.2 *005010X222A1* Professional (837) -- Transaction Table 13

5.0 LIST OF APPENDICES 19

APPENDIX A: MEDICAL CODE SET -- SUPPLEMENTAL INFORMATION FOR MINNESOTA UNIFORM COMPANION GUIDES 21

APPENDIX B: K3 SEGMENT USAGE INSTRUCTIONS 44

APPENDIX C: REPORTING MNCARE TAX 47

APPENDIX D: EXAMPLES – DATA PREVIOUSLY SUBMITTED IN THE NTE SEGMENT NOW SUBMITTED IN THE SV, LIN, OR HI SEGMENTS 49

This page was left blank.

1.0 Overview

1.1 Statutory basis for this proposed rule

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

1.2 Applicability of state statute and related rules

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.1 Exceptions to applicability

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

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

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

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

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

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

1.3 About the Minnesota Department of Health (MDH)

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

1.3.1 Contact for further information on this document

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

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

Email: health.ASAguides@state.mn.us

1.4 About the Minnesota Administrative Uniformity Committee

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

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

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

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

1.6 Document Changes

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

1.6.1 Process for updating this document

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

1.6.2 Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	[placeholder]	[placeholder: Proposed revisions to v6.0]

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

2.1 Reference for this document

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

2.1.1 Permission to use copyrighted information

Express permission to use ASC X12 copyrighted materials within this document has been granted.

2.2 Purpose and relationship

This document:

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

This page was left blank.

3.0 How to use this document

3.1 Classification and display of Minnesota-specific requirements

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

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

This document also contains the following four appendices:

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

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

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

3.2.1 Business Terminology

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

3.2.1.1 Provider Definitions[1]

Billing Provider

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

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

Billing Provider Name:

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

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

Ordering Provider

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

Pay-To Address

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

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

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

3.2.1.2 Other Definitions

Factoring Agent

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

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

Other Payer

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

Patient

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

Pay-To Plan

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

Subscriber

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

3.2.2 Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3 Minnesota Requirements for Compliance

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

Handling Adjustments and Appeals

Determination of Action:

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

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

Definitions:

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

Examples of Appeals include:

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

Process for Submission:

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

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

3.2.4 Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5 Claim Attachments and Notes

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

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

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

4.1 Introduction to Table

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

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

Please also see section 2.2 above.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.0 List of Appendices

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

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

- Table A.5.1 -- Minnesota Coding Specifications: When to use codes different from Medicare
- Table A.5.2 – Hyperlink to information and instructions for *Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to State Government Programs*
- Table A.5.3 -- Hyperlink to information and instructions for *Substance Abuse Services*

  Note: The information and instructions in the links in tables A.5.2 and A.5.3 above are incorporated by reference as part of this Minnesota Uniform Companion Guide.

- Table A.5.4 -- Maternal And Child Health Billing Guide For Public Health Agencies
  a) Public health nurse clinic services
  b) Maternal & child health visits
  c) Other services and Miscellaneous

Appendix B: K3 Segment Usage Instructions

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

Appendix C: Reporting MNCare Tax

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

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

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

This page was left blank.

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

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

5. If a. or b. above does not apply, use the HIPAA-compliant codes that most appropriately describe the service/procedure/product provided. Codes with identical descriptions may be used interchangeably. If codes do not have an identical description then follow section A.3.2, "Instructions for Use", regarding use of the most appropriate code.

6. This appendix does not replace or substitute for standard, national coding resources for HIPAA-adopted code sets (including manuals, online resources, etc.). Consult coding resources for descriptions, definitions, and directions for code usage.

7. Medicare and national codes often change. National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes. (See also section A.4.)

A.2 HIPAA Code Sets

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

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1 Modifiers

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

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

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

A.3.4.2 Units (basis for measurement)

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

The following are clarifications/exceptions:

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

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

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

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

incorporates by reference the information and instructions found at the hyperlinks in tables A.5.2 and A.5.3.

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

A.5 Tables of Coding Requirements

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

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

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

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

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
1	General Billing Requirements		Follow Medicare coding guidelines
2	Admission and Registration Requirements		Not applicable to coding guidelines
3	Inpatient Hospital Billing		Follow Medicare coding guidelines
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Outpatient professional services provided by CAH, Method II billing	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).
5	Part B Outpatient Rehabilitation and CORF/OPT Services		Follow Medicare coding guidelines
6	Inpatient Part A Billing and SNF Consolidated Billing		Not applicable to Professional claim
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Not applicable to Professional claim
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
10	Home Health Agency Billing	PCA and Homemaking Services	PCA: T1019 PCA Shared 1:2: T1019-TT PCA Shared 1:3 or more: T1019-HQ PCA Temporary Service Increase: T1019-U6 PCA Notice of Reduction: T1019-U5 RN PCA Supervision: T1019-UA Homemaking: S5130, S5131 PCA services may not be billed with a span of dates; each date of service must be billed separately.
		Home Infusion	Home infusion is not addressed in this chapter. See instructions following this table.
11	Processing Hospice Claims		Not applicable to Professional claim
12	Physicians/Nonphysician Practitioners	Allergy, clinical immunology	Medicare does not allow all allergy and clinical immunology codes, but group purchasers accept all applicable codes. Follow the code selection guidelines in the front of Appendix A.
		Modifier 50	Modifier 50 should only be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
		Bilateral Radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
		Note: Entries for Chapt. 12 for "e-visits" and "telephone services" were removed from this version	

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		

		Interpreter services	To report interpreter services:
			Note: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report one unit.
			• T1013 -- Face-to-face oral language interpreter services per 15 minutes
			• T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes
			• T1013-GT -- Telemedicine interpreter services per 15 minutes
			• T1013-U4 -- Telephone interpreter services per 15 minutes
			• T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting
			• Report T1013 for each patient in the group setting
			  o Append the modifier indicating how many patients in the group
			  o Report one unit per 15 minutes per patient
			• T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes
			  o Report one unit per 15 minutes per client
			  o If more than one service is provided, report each on a separate line appended with the -59 modifier
			  ▪ T1013-52 x 2 units (30 minutes of drive time)
			  ▪ T1013-52 59 (12 minutes of wait time)
			  o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported o A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported o Report one unit per mile
		Collaborative psychiatric consultation	Coding for a consultation initiated by the primary care provider (MD, DO, NPP) to psychiatrist for an opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care 99499 HE AG U7 (by physician extender) • Primary Care 99499 HE AG U4 U7 (non-face-to-face by physician extender) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face)
		Patient not in exam room	There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			may be billed based on time to the patient's group purchaser. Report the appropriate ICD-9-CM code(s) for the diagnosis of the patient as the primary diagnosis or diagnoses. Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.
		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:

- U1 – Care coordination, basic complexity level
- U2 – Care coordination, extended complexity level
- U3 – Care coordination, supplemental factor; Non-English language
- U4 – Care coordination, supplemental factor; Major Active Mental Health Condition

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
		ImPACT testing	96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only
13	Radiology Services and Other Diagnostic Procedures	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components
		Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
		Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
		Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance	General	Follow Medicare coding guidelines

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
		Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: o A0080 o A0090 o A0100 o A0110 o A0120 o T2002 o T2003 o T2004
16	Laboratory Services	Repeat services	Modifiers 76 or 91 are to be used for repeat services subsequent to the original service only. The number of units reported is the number of services performed as defined in the code description or relevant AMA guidelines in CPT[6]
		Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.
17	Drugs and Biologicals		Follow Medicare coding guidelines
		Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
18	Preventive and Screening Services	New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.
		Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-9 code set instructions. All applicable diagnoses should be submitted.
		Roster billing	Roster billing is not applicable to Minnesota Group Purchasers
		Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
		Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
18	Preventive and Screening Services (continued)	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
		C&TC	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. ▪ Maternal depression screening: 99420 UC ▪ Developmental screening: 96110 ▪ Child Mental Health Screening: 96110 UC ▪ Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately. ▪ Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt

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

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare			
Medicare Claims Processing Manual		**Specific Coding Topic**	**Minnesota Rule**
Chapter Number	Title/Description		
See the following regarding "Home Infusion Therapy" and "Licensed Traditional Midwife Services (Not Certified Nurse Midwives)" that are not addressed in any chapter of the Medicare Claims Processing Manual.			
N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes). Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. <u>Place of Service:</u> 25 – Birthing Center <u>HCPCS Code:</u> Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, office/center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits. Fragmented services may be reported in certain circumstances: • If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes).

Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare			
Medicare Claims Processing Manual		**Specific Coding Topic**	**Minnesota Rule**
Chapter Number	Title/Description		
			• If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. • Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service). • Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal period. Urine dip sticks are considered part of the global package. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.

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

Table A.5.2 provides a hyperlink to a Minnesota Department of Human Services (DHS) website with behavioral health procedure code and modifier combinations for identifying specific benefit packages unique to Minnesota government programs. The information and instructions at the link are incorporated in this companion guide by reference. The information at the link below is maintained by DHS and is subject to change. Follow the link in Table A.5.2 for the most current version now in use.

Table A.5.2.

A.5.2 Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to Minnesota Government Programs	**[Placeholder for applicable DHS URL/link]**

A.5.3 Substance Abuse Services

Table A.5.3 provides a hyperlink to a Minnesota Department of Human Services (DHS) website with procedure code and modifier combinations for identifying substance abuse services. The information and instructions at the link are incorporated in this companion guide by reference. The information at the link below is maintained by DHS and is subject to change. Follow the link in Table A.5.2 for the most current version now in use.

Table A.5.3.

A.5.3 Substance Abuse Services	**[Placeholder for URL/link]**

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

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

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and Miscellaneous

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

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

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

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

Table A.5.4.c – Other services and Miscellaneous

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

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

This page was left blank.

Appendix B: K3 Segment Usage Instructions

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

State of Jurisdiction

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

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

K3*LUMN~

Tooth Number/Oral Cavity

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

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

K3*JP12~
K3*JP12 14~

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

K3*JO10~

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

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

This page was left blank.

Appendix C: Reporting MNCare Tax

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

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

This page was left blank.

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

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

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

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