Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, January 8, 2015
8:00 a.m. to 12:00 a.m.
Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1st floor

Webex Information

Teleconference Information:

Call-in line: 9-1-857-232-0300

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
   - **Membership request and/or updates: Deb Sorg** deb.a.sorg@healthpartners.com
2. **Review of Antitrust Statement**
3. **Review of last meeting's minutes** – December 11, 2014
4. **Doulas – Shawnet Healy, DHS**
5. **MN Uniform Companion Guide Comment Reviews**
6. **Autism – Andrea Agerlie, DHS –** SBAR pending

08/26/14 Minutes: Autism – Isn't ready; last many changes regarding policy that affects coding. DHS working with internal staff to finalize.	**OPEN**
10/9/14 Minutes: Autism SBAR has been renamed – Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit. Autism coverage was new legislation in 2013 for children up to 18 years. CMS issued guidance that would fall under EPSDT and be available to patients up to 21 years of age. DHS met with CMS and other states to determine how to (originally submitted 1959 waiver). Cannot target autism population for the benefit. Coverage must be made available to individuals meeting the medical criteria who may not have autism. General discussion: There is insufficient knowledge to identify children early and what methodology to use- manifestation is unique and different for all children. Special education teachers are professionals more qualified to identify children. Legislation requires certification of professions to provide these services. Place of Service (POS) – looked at 11, 52, and 49. The POS is TBD. DHS modifiers will be developed to distinguish treatment and practitioners. What is the difference between a "professional' and a "practitioner"? Group – What if families have more than one child and services are provided in the home? Each child will have his/her own treatment plan. Will not fall under group	**OPEN** DHS will develop policy to be placed in MUCG and include definitions of service providers

Family caregiving training should be billed under child. CPT Codes 96150-96155 - Medica does not accept the recommended codes for physicians (see CPT page591). BCBSM – primary diagnosis for codes 96150-96155 have to be medical per CPT. These codes will be denied if the primary diagnosis is behavioral health. Same issue with UnitedHealth and PreferredOne. CPT changed definitions of physician and practitioner and used interchangeably. Two-way interactive video – Medicare allows for two charges (initiation and performing services; usually facility-based charge). Are two charges expected – initiates video and code for practitioner (for person performing service [-GT modifier - Via interactive audio and video telecommunication systems])? Q3014 is the Telehealth originating site facility fee. Multidisciplinary evaluation – If clinic offers ASD, evaluation from MD, psychological be appropriate. CMDE regardless if mental health prof, physician or APRN during initial assessment will all bill under these codes. DHS is developing a form that will determine medical necessity for services billed under these codes. Not billed during initial diagnoses. If prior assessments have been made a Psychologist (Pediatrics or MH) supervising an extensive evaluation may bill for supervision of that assessment Coordinator Care Conference team T1024 versus 99336. Codes 99336 is a bundled code. T1024 was the best fit to include all providers together to discuss coordinated services provided to the child. Are coding recommendations for all payers or government? Yes for government (managed care contracts); commercial payers will accept in system and determine coverage based on their benefits.	
12/11/14: • Andrea Agerlie reported that the recommendation will be revised. • Originally, DHS did not want to use the CPT Category III behavioural health because they appeared narrowly focused. Time designation is also an issue. DHS prefers 15 minute units. Andrea had a chance to talk to an AMA representative about DBT and emerging practices. The AMA indicated that the Category III codes should work for DHS' needs. • DHS is looking at the CPT Category III again. They may replace most of the codes on the prior recommendation. The use of these codes may reduce the number of modifiers needed to report the correct service. • An additional question/clarification would include defining the difference between service versus treatment plan. • Paula Decker recommended that Jennifer Garber attend at a future meeting from a clinician and payer perspective.	**OPEN**

7. Mental Health Service Plan Development – DHS

4/10/14 Minutes: See SBAR. Applies to children and adults, fee for service and public program plans. There are two services – service plan development and functional assessment. Can DHS develop a modifier to indicate units? TAG agreed that it might be the only option. DHS stated right thing to do is to request code from CMS; however, timing is the issue and getting buy-in from other states. Nine states cover these services using H00031 and H0032. Seven of those states use a 15 minute unit for the codes. DHS' concern is NCCI edits. CMS has recently begun looking at H codes for mental health. Are these codes being used by anyone? Not sure if used by health plans. Medica uses the H codes for autism and other assessments. Currently not being used by DHS for fee-for-service. What mental health providers are you using for these services? DHS' category of mental health professional. JoAnne Wolf feels that primary care provider will be involved and ask where they will fall into, medical homes. A DHS state that the service is mental health specific code only and is recognized by mental health professionals and practitioners. Services are authorized in statutes for CTSS only; children receiving CTSS services. Propose using it with UA code for CTSS. Adult Rehabilitative Mental Health Services (ARMHS) does not use modifier; UA modifier differentiate services for CTSS. Medica does not use modifier for Autism. TAG suggested creating a time modifier to use along with UA for ARMHS.	**OPEN** DHS will create a time modifier for time increment/units of time to use with modifier UA for ARMHS.
05/08/14 Minutes: The main issue is trying to find a code that represents the service and time. H0031 and H0032 fit the description of the service but are not time based. Nine states using H0031 and H0032; seven of the states are using the H codes, no modifiers, but instruct to use as 15-minute units. The reason modifiers are needed for MN is to indicate time variances because of the types of clients being served, for example adults, children, ESL clients. DHS will develop a new modifier(s). There may be other modifiers appended as needed such as UA or HN. DHS is waiting for federal approval before assigning modifiers.	**OPEN**
06/12/14 Minutes: No updates. DHS is still waiting for federal approval.	**OPEN**
06/24/14 Minutes: DHS reported the State Plan with the approved coding recommendations will be submitted 3rd quarter.	**OPEN**
07/22/14 Minutes: DHS reported request for approval from CMS will be submitted this quarter.	**OPEN**
08/14/14 Minutes: Action was deferred pending any additional comments.	**OPEN**
08/26/14, 10/9/14, 12/11/14 Minutes: Discussion of this item is postponed; waiting to hear from CMS	**OPEN**

8. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC: See SBAR

7/22/14 minutes: See SBAR. There is no current policy for gambling addiction. They currently use the substance abuse codes. DHS doesn't reimburse allowed services through the claims process/system. Richard Scherer states that gambling addiction services are entered on an excel document. Claims are electronically billed through state contract, then the spreadsheet is sent to show what services were done. Four codes are currently billed but for consistency we should determine which codes would be appropriate to report. For example, at this time individual therapy are being used to bill group sessions. Additionally, the claim format 837I versus 837P is inconsistent. DSM5 is guide for determining patient treatment but not diagnosis. Faith Bauer noted that although DSM5 is a guide to determine the patient's diagnosis and guide treatment, DSM5 codes are not HIPAA compliant and ICD-9-CM codes will need to be submitted. Additional information both from the program/provider as well as payers is required.	**OPEN** Commercial payers TAG members will research issue with their contracting division Richard will send additional information to Faith prior to next meeting
08/14/14 Minutes: Deferred pending Mr. Scherer's participation and discussion at the next meeting. Faith will contact to invite him to the next meeting.	**OPEN**
08/26/14 Minutes: Paula Decker's response and evaluation of gambling diagnosis and programs was reviewed. Gambling addiction is a separate issue and is not the same as substance abuse. Modalities may be the same but treatment strategies are not the same. Some may apply to both but are very different strategies. Codes are very specific to substance abuse. Leave open until SBAR originator is able to attend and address the issue.	**OPEN**
10/9/14 Minutes: Richard Scherer was present to talk about his request. Club Recovery is a full service addiction clinic with a primary focus on pathological gambling and chemical abuse. A mental health component is included for those with co-addictions. The program is modelled after substance abuse programs. The primary focus is group treatment is group but individual treatment is also done. Treatment includes dealing with the family as well. DSM-5 reclassified gambling addiction under substance abuse disorders Current billing is done as a facility claim (837I) with the following codes: Revenue code: 0949 HCPCS codes: H2035-HQ H0031 H0001 H2020 Mental health services by an LICSW are billed on a professional claim using CPT BH codes and billed on a professional claim (837P). General discussion: The intent it establish uniform, consistent coding for gambling addiction. At this time payers differ. Some payers are using Rev code 0949 with H0001 for CD for assessment. H2020 was widely used (CMS stated H2020 was no longer an acceptable code and payers are moving away from this code). Some payers are requiring H2035 and H2020. Revenue codes 0944 – CD 0945 – alcohol and 0949 were also discussed. Also, the H codes noted basically deal with substance abuse. H2020 is per diem code. Services are being billed hourly. Need time code, such as H2019. We need to determine if this is a unique request or is applicable to other providers. What are best codes for reporting gambling services? Medica defines it as addictive behavior that substance abuse falls under; does not use standard SA codes for the gambling program. Is there a reason to not use H2035 since it falls in diagnostic are in addictive behavior? Initially under substance abuse. DHS gambling addiction is not being processed in their claim system. Distinct benefits for self-funded, commercial and Medicare. HCPCS code will distinguish services. Might be appropriate to go with CPT as one payer prefers the gambling addition services to be billed. CPT code would be hard to implement because of program type. Currently gambling addition is based on contracts. If providers can be identified to contact or the payers can determine. Gambling providers meet monthly.	**OPEN** MCT payers will discuss with their contract area. DHS will determine the policy. MDH will contact Ruth Moser (DHS) to schedule meeting with providers. MDH will forward meeting information to Faith for distribution to MCT. MCT payers will report their findings at December meeting
12/11/14: Andrea Agerlie reported that Ruth Moser from DHS indicated that about 9-10 providers usually attend the monthly meeting. She was not sure if it would be helpful to include all providers in a discussion. Andrea will meet separately with Ruth to discuss coding.	**OPEN**

9. Health and Behavior Group Therapy by Mid-level Provider – Sara Luther, Mayo Clinic: See SBAR

08/14/14 Minutes: NGS article from this year says that CPT 96150-95154 is restricted to PhD. Andrea Agerlie – reviewed March 2002 "CPT Assistant" article that does not restrict to PhD.	**OPEN**

Payers to determine if they limit to PhDs only.	
08/26/14 Minutes: DHS PHD level, nor does PreferredOne, Medica, HealthPartners, PrimeWest or BCBS do not restrict. UCARE is still checking. Carolyn suggested that perhaps a new HCPCS code might be needed. Suggested medical directors involved and those from other providers that NGS directive is not correct and goes against CPT. NGS Has created a very burdensome situation for providers. Suggested some type communication with NGS to determine if they might withdraw. What is NGS reasoning for restricting…limited to PhDs. 96510-96514 series. Will leave open for UCare's response.	**OPEN**
10/9/14 minutes: Will leave open for UCare's response.	**OPEN**
12/11/14: UCare reported there is no provider restriction. PreferredOne will clarify with Sara Luther the intent of the program because it appears to be reported for the back care program.	**OPEN**

10. Concurrent Care Processing Change for E/M Services on the Same DOS – Judith Blyth, HCMC – see Medicare article

12/11/14: Waiting to discuss	**OPEN**

11. Speech Language Pathologists/VCD/PVFM – Gail Cain, Fairview – see SBAR

12/11/14: Judith Blyth noted the codes 92524, 31579, and 92507 as most appropriate. BCBSMN: no recommendation. DHS: recommended code 92700 with the GN modifier. PreferredOne: checking Medica: checking HealthPartners: checking	**OPEN**

12. IONM Clarification - Kandi Newton, Gillette Children's Specialty Healthcare – see SBAR

12/11/14: The codes 95940 and 95941 are not 26 or TC eligible. DHS indicated that this may be a unit issue. This will be left open for additional comments.	**OPEN**

13. Additional Agenda Items/ Announcements

- December meeting:
  - The next scheduled meeting is February 12, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.
- TREATS

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, December 11, 2014, 9 a.m. to 12 a.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	Faith called meeting to order. 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 at deb.a.sorg@healthpartners.com . Include your name, organization and if you are calling in for another person within your organization Members should provide Deb Sorg with email address changes and new members contact information. Also, let Deb Sorg know at least two days in advance if they plan to attend MCT meetings in person.	Completed.
2. Antitrust Statement	Reviewed – available on AUC website.	No discussion.
3. Review of last meeting's Minutes	• Correction to item 11, Moving Home Minnesota Changes. Kathy Sijan from DHS is new lead for this issue. • Gail Cain reported that the MN Universal Outpatient Mental Health/CD form is now available on the AUC website. The form is also available in a fillable format. Note: this was not on the agenda but was a previous issue that was finalized. • Motion made and seconded to approve minutes.	Minutes will be posted on AUC MCT website
4. MN Uniform Companion Guide Comment Reviews	• The companion guides were approved and will be listed in the state register December 22 for a 30 day comment period. • At the January 8, 2015 meeting we will submit our own comments as well as review any comments received. • We will schedule another January meeting if needed.	**OPEN**
5. Autism – Andrea Agerlie, DHS	• Andrea Agerlie reported that the recommendation will be revised. • Originally, DHS did not want to use the CPT Category III behavioural health because they appeared narrowly focused. Time designation is also an issue. DHS prefers 15 minute units. Andrea had a chance to talk to an AMA representative about DBT and emerging practices. The AMA indicated that the Category III codes should work for DHS' needs. • DHS is looking at the CPT Category III again. They may replace most of the codes on the prior recommendation. The use of these codes may reduce the number of modifiers needed to report the correct service. • An additional question/clarification would include defining the difference between service versus treatment plan. • Paula Decker recommended that Jennifer Garber attend at a future meeting from a clinician and payer perspective.	**OPEN**

Agenda Item	Discussion	Action/Follow-up:
6. Mental Health Service Plan Development – DHS	Discussion of this item is postponed; waiting to hear from CMS.	**OPEN**
7. Mental Health Clinical Care Consultation - DHS	• See MINNESOTA STATUTES 2013 256B.0625. Approved by CMS January 2015. The statute indicates these services are for patients up to age 21. • The approved coding is: 90899-U8 (5-10 minutes) 90899-U9 (11-20 minutes) 90899-UB (21-30 minutes) 90899-UC (31+ minutes) • Additional modifiers could be appended, such as U4 for phone and/or HN for clinical training. • This guide will be added to the MN Uniform Companion Guides during the comment period.	**CLOSED**
8. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	• Andrea Agerlie reported that Ruth Moser from DHS indicated that about 9-10 providers usually attend the monthly meeting. She was not sure if it would be helpful to include all providers in a discussion. • Andrea will meet separately with Ruth to discuss coding.	**OPEN**
9. Health and Behavior Group Therapy by Mid-level Provider – Sara Luther, Mayo Clinic	• UCare reported there is no provider restriction. • PreferredOne will clarify with Sara Luther the intent of the program because it appears to be reported for the back care program.	**OPEN**
10. Concurrent Care Processing Change for E/M Services on the Same DOS – Judith Blyth, HCMC	Waiting to discuss	**OPEN**
11. Speech Language Pathologists/VCD/PVFM – Gail Cain, Fairview	• Judith Blyth noted the codes 92524, 31579, and 92507 as most appropriate. • BCBSMN: no recommendation. • DHS: recommended code 92700 with the GN modifier. • PreferredOne: checking • Medica: checking • HealthPartners: checking	**OPEN**
12. IONM Clarification - Kandi Newton, Gillette Children's Specialty Healthcare	• The codes 95940 and 95941 are not 26 or TC eligible. • DHS indicated that this may be a unit issue. • This will be left open for additional comments.	**OPEN**
13. Next meeting	• The next Medical Code TAG meeting is scheduled for **January 8, 8:00-12:00**, St. Croix conference room, 1st floor, HealthPartners, 8170 Building, Bloomington	**CLOSED**

256B.0625 COVERED SERVICES.

Subdivision 1. **Inpatient hospital services.** Medical assistance covers inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.

Subd. 1a. **Services provided in a hospital emergency room.** Medical assistance does not cover visits to a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care, and does not pay for any services provided in a hospital emergency room that are not for emergency and emergency poststabilization care or urgent care.

Subd. 2. **Skilled and intermediate nursing care.** (a) Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

Subd. 2a. **Skilled nursing facility and hospice services for dual eligibles.** Medical assistance covers skilled nursing facility services for individuals eligible for both medical assistance and Medicare who have waived the Medicare skilled nursing facility room and board benefit and have enrolled in the Medicare hospice program. Medical assistance covers skilled nursing facility services regardless of whether an individual enrolled in the Medicare hospice program prior to, on, or after the date of the hospitalization that qualified the individual for Medicare skilled nursing facility services.

Subd. 3. **Physicians' services.** (a) Medical assistance covers physicians' services.

(b) Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of

calendar year set by legislature, "except that rates paid to physicians for the medical direction of a certified registered nurse anesthetist shall be the same as the rate paid to the certified registered nurse anesthetist under medical direction.

(c) Medical assistance does not cover physicians' services related to the provision of care related to a treatment reportable under section 144.7065, subdivision 2, clauses (1), (2), (3), and (5), and subdivision 7, clause (1).

(d) Medical assistance does not cover physicians' services related to the provision of care (1) for which hospital reimbursement is prohibited under section 256.969, subdivision 3b, paragraph (c), or (2) reportable under section 144.7065, subdivisions 2 to 7, if the physicians' services are billed by a physician who delivered care that contributed to or caused the adverse health care event or hospital-acquired condition.

(e) The payment limitations in this subdivision shall also apply to MinnesotaCare and general assistance medical care.

(f) A physician shall not bill a recipient of services for any payment disallowed under this subdivision.

Subd. 3a. **Sex reassignment surgery.** Sex reassignment surgery is not covered.

Subd. 3b. **Telemedicine consultations.** Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Subd. 3c. **Health Services Policy Committee.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 13-member Health Services Policy Committee, which consists of 12 voting members and one nonvoting member. The Health Services Policy Committee shall advise the commissioner regarding health services pertaining to the administration of health care benefits covered under the medical assistance, general assistance medical care, and MinnesotaCare programs. The Health Services Policy Committee shall meet at least quarterly. The Health Services Policy Committee shall annually elect a physician chair from among its members, who shall work directly with the commissioner's medical director, to establish the agenda for each meeting. The Health Services Policy Committee shall also recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental subcommittee to operate under the Health Services Policy Committee. The dental subcommittee consists of general dentists, dental specialists, safety net providers, dental hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental subcommittee shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance, MinnesotaCare, and general assistance medical care programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.

(d) The Health Services Policy Committee shall monitor and track the practice patterns of physicians providing services to medical assistance, MinnesotaCare, and general assistance medical care enrollees under fee-for-service, managed care, and county-based purchasing. The committee shall focus on services or specialties for which there is a high variation in utilization across physicians, or which are associated with high medical costs. The commissioner, based upon the findings of the committee, shall regularly notify physicians whose practice patterns indicate higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make this data available to the committee.

(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.

Subd. 3d. **Health Services Policy Committee members.** The Health Services Policy Committee consists of:

(1) seven voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness, and three of whom must represent health plans currently under contract to serve medical assistance recipients;

(2) two voting members who are physician specialists actively practicing their specialty in Minnesota;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;

(4) one consumer who shall serve as a voting member; and

(5) the commissioner's medical director who shall serve as a nonvoting member.

Members of the Health Services Policy Committee shall not be employed by the Department of Human Services, except for the medical director.

Subd. 3e. **Health Services Policy Committee terms and compensation.** Committee members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services Policy Committee meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each committee member in attendance except the medical director. The Health Services Policy Committee does not expire as provided in section 15.059, subdivision 6.

Subd. 3f. **Circumcision.** Circumcision is not covered, unless the procedure is medically necessary.

Subd. 3g. **Evidence-based childbirth program.** (a) The commissioner shall implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation. In this subdivision, the term "elective induction of labor" means the use of artificial means to stimulate labor in a woman without the presence of a medical condition affecting the woman or the child that makes the onset of labor a medical necessity. The program must promote the implementation of policies within hospitals providing services to recipients of medical assistance or MinnesotaCare that prohibit the use of elective inductions prior to 39 weeks' gestation, and adherence to such policies by the attending providers.

(b) For all births covered by medical assistance or MinnesotaCare on or after January 1, 2012, a payment for professional services associated with the delivery of a child in a hospital must not be made unless the provider has submitted information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth. The information must be on a form prescribed by the commissioner.

(c) The requirements in paragraph (b) must not apply to deliveries performed at a hospital that has policies and processes in place that have been approved by the commissioner which prohibit elective inductions prior to 39 weeks' gestation. A process for review of hospital induction policies must be established by the commissioner and review of policies must occur at the discretion of the commissioner. The commissioner's decision to approve or rescind approval must include verification and review of items including, but not limited to:

(1) policies that prohibit use of elective inductions for gestation less than 39 weeks;

(2) policies that encourage providers to document and communicate with patients a final expected date of delivery by 20 weeks' gestation that includes data from ultrasound measurements as applicable;

(3) policies that encourage patient education regarding elective inductions, and requires documentation of the processes used to educate patients;

(4) ongoing quality improvement review as determined by the commissioner; and

(5) any data that has been collected by the commissioner.

(d) All hospitals must report annually to the commissioner induction information for all births that were covered by medical assistance or MinnesotaCare in a format and manner to be established by the commissioner.

(e) The commissioner at any time may choose not to implement or may discontinue any or all aspects of the program if the commissioner is able to determine that hospitals representing

at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies in place.

(f) The commissioner of human services may discontinue the evidence-based childbirth program and shall discontinue all affiliated reporting requirements established under this subdivision once the commissioner determines that hospitals representing at least 90 percent of births covered by medical assistance or MinnesotaCare have approved policies and processes in place that prohibit elective inductions prior to 39 weeks' gestation.

Subd. 4. **Outpatient and physician-directed clinic services.** Medical assistance covers outpatient hospital or physician-directed clinic services. The physician-directed clinic staff shall include at least two physicians and all services shall be provided under the direct supervision of a physician. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section.

Subd. 4a. **Second medical opinion for surgery.** Certain surgeries require a second medical opinion to confirm the necessity of the procedure, in order for reimbursement to be made. The commissioner shall publish in the State Register a list of surgeries that require a second medical opinion and the criteria and standards for deciding whether a surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.01 to 14.69. The commissioner's decision about whether a second medical opinion is required, made according to rules governing that decision, is not subject to administrative appeal.

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board-certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0323, subpart 1, item F.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in section 245.481, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management. In addition, the provider must provide or be

capable of providing upon request of the local mental health authority day treatment services and professional home-based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional disturbance, and chemical dependency, and to individuals dually diagnosed with a mental illness or emotional disturbance and developmental disability.

(g) The provider must provide 24-hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24-hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Subd. 5a. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5b. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5c. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5d. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5e. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5f. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5g. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5h. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5i. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5j. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5k. [Repealed, 2007 c 147 art 5 s 41]

Subd. 5l. **Intensive mental health outpatient treatment.** Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Subd. 6. [Repealed, 1991 c 292 art 7 s 26]

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility,

unless the commissioner of human services has authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to sections 256B.0651 to 256B.0653.

Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home. To use private duty nursing services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in-home setting according to sections 256B.0651 and 256B.0654 to 256B.0656. All private duty nursing services must be provided according to the limits established under sections 256B.0651 and 256B.0653 to 256B.0656. Private duty nursing services may not be reimbursed if the nurse is the family foster care provider of a recipient who is under age 18, unless allowed under section 256B.0654, subdivision 4.

Subd. 8. **Physical therapy.** (a) Medical assistance covers physical therapy and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Subd. 8a. **Occupational therapy.** (a) Medical assistance covers occupational therapy and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

Subd. 8b. **Speech-language pathology and audiology services.** (a) Medical assistance covers speech-language pathology and related services. Specialized maintenance therapy is covered for recipients age 20 and under.

(b) Medical assistance covers audiology services and related services. Services provided by a person who has been issued a temporary registration under section 148.5161 shall be reimbursed

at the same rate as services performed by a speech-language pathologist or audiologist as long as the requirements of section 148.5161, subdivision 3, are met.

Subd. 8c. **Care management; rehabilitation services.** (a) A care management approach for authorization of rehabilitation services described in subdivisions 8, 8a, and 8b shall be instituted. The care management approach shall require the provider and the department rehabilitation reviewer to work together directly through written communication, or telephone communication when appropriate, to establish a medically necessary care management plan. Authorization for rehabilitation services shall include approval for up to six months of services at a time without additional documentation from the provider during the extended period, when the rehabilitation services are medically necessary due to an ongoing health condition.

(b) The commissioner shall implement an expedited five-day turnaround time to review authorization requests for recipients who need emergency rehabilitation services.

Subd. 8d. **Home infusion therapy services.** Home infusion therapy services provided by home infusion therapy pharmacies must be paid the lower of the submitted charge or the combined payment rates for component services typically provided.

Subd. 8e. **Chiropractic services.** Payment for chiropractic services is limited to one annual evaluation and 24 visits per year unless prior authorization of a greater number of visits is obtained.

Subd. 8f. **Acupuncture services.** Medical assistance covers acupuncture, as defined in section 147B.01, subdivision 3, only when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

Subd. 9a. **Volunteer dental services.** (a) A dentist not already enrolled as a medical assistance provider who is providing volunteer dental services for an enrolled medical assistance dental provider that is a nonprofit entity or government owned and not receiving payment for the services provided shall complete and submit a volunteer agreement form developed by the commissioner. The volunteer agreement shall be used to enroll the dentist in medical assistance only for the purpose of providing volunteer dental services. The volunteer agreement must specify that a volunteer dentist:

(1) will not be listed in the Minnesota health care programs provider directory;

(2) will not receive payment for the services the volunteer dentist provides to Minnesota health care program clients; and

(3) is not required to serve Minnesota health care program clients when providing nonvolunteer services in a private practice.

(b) A volunteer dentist enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from Minnesota health care programs as a fee-for-service provider.

(c) The volunteer dentist shall be notified by the dental provider for which they are providing services that medical assistance is being billed for the volunteer services provided.

Subd. 10. **Laboratory and x-ray services.** Medical assistance covers laboratory and x-ray services.

Subd. 11. **Nurse anesthetist services.** Medical assistance covers nurse anesthetist services. Rates paid for anesthesiology services provided by a certified registered nurse anesthetist under the direction of a physician shall be according to the formula utilized in the Medicare program and shall use the conversion factor that is used by the Medicare program. Rates paid for anesthesiology services provided by a certified registered nurse anesthetist who is not directed by a physician shall be the same rate as paid under subdivision 3, paragraph (b).

Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** Medical assistance covers eyeglasses, dentures, and prosthetic devices if prescribed by a licensed practitioner.

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in

consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; and (2) the number of dosage units required to complete the patient's course of therapy.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

Subd. 13a. [Repealed, 2007 c 133 art 2 s 13]

Subd. 13b. [Repealed, 1997 c 203 art 4 s 73]

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(5) drugs or active pharmaceutical ingredients for which medical value has not been established; and

(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum

allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of

care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking three or more prescriptions to treat or prevent one or more chronic medical conditions; a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

(2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the requirements may provide the services via two-way interactive video. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to the services provided. To qualify for reimbursement under this paragraph, the pharmacist providing the services must meet the requirements of paragraph (b), and must be located within an ambulatory care setting approved by the commissioner. The patient must also be located within an ambulatory care setting approved by the commissioner. Services provided under this paragraph may not be transmitted into the patient's residence.

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic

conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

Subd. 13i. **Drug Utilization Review Board; report.** (a) A nine-member Drug Utilization Review Board is established. The board must be comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative. The remainder must be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the board must be appointed by the commissioner, shall serve three-year terms, and may be reappointed by the commissioner. The board shall annually elect a chair from among its members.

(b) The board must be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board.

(c) The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r-8, subsection (g), paragraph (3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to:

(i) receive public comment regarding drug utilization review criteria and standards; and

(ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

(d) The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner

may enter into contracts for services to develop and implement a retrospective and prospective review program.

(e) The board shall report to the commissioner annually on the date the drug utilization review annual report is due to the Centers for Medicare and Medicaid Services. This report must cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $100 per meeting and reimbursement for mileage must be paid to each board member in attendance.

(f) This subdivision is exempt from the provisions of section 15.059. Notwithstanding section 15.059, subdivision 5, the board is permanent and does not expire.

Subd. 13j. **Antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications.** (a) The commissioner, in consultation with the Drug Utilization Review Board established in subdivision 13i and actively practicing pediatric mental health professionals, must:

(1) identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder based on available medical, clinical, and safety data and research. The commissioner shall periodically review the list of medications and pediatric dose ranges and update the medications and doses listed as needed after consultation with the Drug Utilization Review Board;

(2) identify situations where a collaborative psychiatric consultation and prior authorization should be required before the initiation or continuation of drug therapy in pediatric patients including, but not limited to, high-dose regimens, off-label use of prescription medication, a patient's young age, and lack of coordination among multiple prescribing providers; and

(3) track prescriptive practices and the use of psychotropic medications in children with the goal of reducing the use of medication, where appropriate.

(b) Effective July 1, 2011, the commissioner shall require prior authorization and a collaborative psychiatric consultation before an atypical antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medication meeting the criteria identified in paragraph (a), clause (2), is eligible for payment. A collaborative psychiatric consultation must be completed before the identified medications are eligible for payment unless:

(1) the patient has already been stabilized on the medication regimen; or

(2) the prescriber indicates that the child is in crisis.

If clause (1) or (2) applies, the collaborative psychiatric consultation must be completed within 90 days for payment to continue.

(c) For purposes of this subdivision, a collaborative psychiatric consultation must meet the criteria described in section 245.4862, subdivision 4.

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

(d) The commissioner shall encourage, at the time of the child and teen checkup or at an episodic care visit, the primary care health care provider to perform primary caries preventive services. Primary caries preventive services include, at a minimum:

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age one to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services. The provider must obtain parental or legal guardian consent before a fluoride varnish is applied to a minor child's teeth.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of one. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

Subd. 15. **Health plan premiums and co-payments.** (a) Medical assistance covers health care prepayment plan premiums, insurance premiums, and co-payments if determined to be cost-effective by the commissioner. For purposes of obtaining Medicare Part A and Part B, and co-payments, expenditures may be made even if federal funding is not available.

(b) Effective for all premiums due on or after June 30, 1997, medical assistance does not cover premiums that a recipient is required to pay under a qualified or Medicare supplement plan issued by the Minnesota Comprehensive Health Association. Medical assistance shall continue to cover premiums for recipients who are covered under a plan issued by the Minnesota Comprehensive Health Association on June 30, 1997, for a period of six months following receipt of the notice of termination or until December 31, 1997, whichever is later.

Subd. 16. **Abortion services.** Medical assistance covers abortion services, but only if one of the following conditions is met:

(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is

physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, clauses (c), (d), (e)(i), and (f), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion.

[See Note.]

Subd. 17. **Transportation costs.** (a) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) an ambulance, as defined in section 144E.001, subdivision 2;

(2) special transportation; or

(3) common carrier including, but not limited to, bus, taxicab, other commercial carrier, or private automobile.

(b) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile.

The commissioner may use an order by the recipient's attending physician to certify that the recipient requires special transportation services. Special transportation providers shall perform driver-assisted services for eligible individuals. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. Special transportation providers must obtain written documentation from the health care service provider who is serving the recipient being transported, identifying the time that the recipient arrived. Special transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Special transportation providers must take recipients to the health care provider, using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the recipient receives authorization from the local agency. The minimum medical assistance reimbursement rates for special transportation services are:

(1)(i) $17 for the base rate and $1.35 per mile for special transportation services to eligible persons who need a wheelchair-accessible van;

(ii) $11.50 for the base rate and $1.30 per mile for special transportation services to eligible persons who do not need a wheelchair-accessible van; and

(iii) $60 for the base rate and $2.40 per mile, and an attendant rate of $9 per trip, for special transportation services to eligible persons who need a stretcher-accessible vehicle;

(2) the base rates for special transportation services in areas defined under RUCA to be super rural shall be equal to the reimbursement rate established in clause (1) plus 11.3 percent; and

(3) for special transportation services in areas defined under RUCA to be rural or super rural areas:

(i) for a trip equal to 17 miles or less, mileage reimbursement shall be equal to 125 percent of the respective mileage rate in clause (1); and

(ii) for a trip between 18 and 50 miles, mileage reimbursement shall be equal to 112.5 percent of the respective mileage rate in clause (1).

(c) For purposes of reimbursement rates for special transportation services under paragraph (b), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies.

(d) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural.

(e) Effective for services provided on or after September 1, 2011, nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after September 1, 2011, ambulance services payment rates are reduced 4.5 percent. Payments made to managed care plans and county-based purchasing plans must be reduced for services provided on or after January 1, 2012, to reflect this reduction.

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers the most appropriate and cost-effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

(d) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an

enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

Subd. 18b. **Broker dispatching prohibition.** The commissioner shall not use a broker or coordinator for any purpose related to transportation services under subdivision 18.

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

(1) the development of, and periodic updates to, a policy manual for nonemergency medical transportation services;

(2) policies and a funding source for reimbursing no-load miles;

(3) policies to prevent waste, fraud, and abuse, and to improve the efficiency of the nonemergency medical transportation system;

(4) other issues identified in the 2011 evaluation report by the Office of the Legislative Auditor on medical nonemergency transportation; and

(5) other aspects of the nonemergency medical transportation system, as requested by the commissioner.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2014.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) two voting members who represent counties, at least one of whom must represent a county or counties other than Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright;

(2) four voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) four voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees; and

(7) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** (a) The commissioner shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning July 1, 2014. The single administrative structure and delivery system must:

(1) eliminate the distinction between access transportation services and special transportation services;

(2) enable all medical assistance recipients to follow the same process to obtain nonemergency medical transportation, regardless of their level of need;

(3) provide a single oversight framework for all providers of nonemergency medical transportation; and

(4) provide flexibility in service delivery, recognizing that clients fall along a continuum of needs and resources.

(b) The commissioner shall present to the legislature, by January 15, 2014, legislation necessary to implement the single administrative structure and delivery system for nonemergency medical transportation.

(c) In developing the single administrative structure and delivery system and the draft legislation, the commissioner shall consult with the Nonemergency Medical Transportation Advisory Committee.

Subd. 18f. **Enrollee assessment process.** (a) The commissioner shall require that the administrator of nonemergency medical transportation adhere to the assessment process recommended by the Nonemergency Medical Transportation Advisory Committee. The commissioner shall implement, by July 1, 2014, the comprehensive, statewide, standard assessment process for medical assistance enrollees seeking nonemergency medical transportation services recommended by the Nonemergency Medical Transportation Advisory Committee. The assessment process must identify a client's level of needs, abilities, and resources, and match the client with the mode of transportation in the client's service area that best meets those needs.

(b) The assessment process must:

(1) address mental health diagnoses when determining the most appropriate mode of transportation;

(2) base decisions on clearly defined criteria that are available to clients, providers, and counties;

(3) be standardized across the state and be aligned with other similar existing processes;

(4) allow for extended periods of eligibility for certain types of nonemergency transportation when a client's condition is unlikely to change; and

(5) increase the use of public transportation when appropriate and cost-effective, including offering monthly bus passes to clients.

Subd. 18g. **Use of standardized measures.** The commissioner, in consultation with the Nonemergency Medical Transportation Advisory Committee, shall establish performance measures to assess the cost-effectiveness and quality of nonemergency medical transportation. At a minimum, performance measures should include the number of unique participants served by type of transportation provider, number of trips provided by type of transportation provider, and cost per trip by type of transportation provider. The commissioner must also consider the measures identified in the January 2012 Department of Human Services report to the legislature on nonemergency medical transportation. Beginning in calendar year 2013, the commissioner shall collect, audit, and analyze performance data on nonemergency medical transportation annually and report this information on the agency's Web site. The commissioner shall periodically supplement this information with the results of consumer surveys of the quality of services, and shall make these survey findings available to the public on the agency Web site.

Subd. 19. [Repealed, 1991 c 292 art 7 s 26]

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0656. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0656. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not

less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Subd. 19b. **No automatic adjustment.** For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for home care services. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for home care services.

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b),

with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and the county pays no share.

(j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

(k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

(l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the

cost shall be provided by the state. Payments to county-contracted vendors shall include the federal earnings, the state share, and the county share.

(m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

(n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the lesser of:

(1) the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year; or

(2) the limits and conditions which apply to federal Medicaid funding for this service.

(o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

Subd. 20a. **Case management; developmental disabilities.** To the extent defined in the state Medicaid plan, case management service activities for persons with developmental disabilities as defined in section 256B.092, and rules promulgated thereunder, are covered services under medical assistance.

Subd. 21. [Repealed, 1989 c 282 art 3 s 98]

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made.

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943.

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

Subd. 25. **Prior authorization required.** (a) The commissioner shall publish in the Minnesota health care programs provider manual and on the department's Web site a list of health services that require prior authorization, the criteria and standards used to select health services on the list, and the criteria and standards used to determine whether certain providers must obtain prior authorization for their services. The list of services requiring prior authorization and the criteria and standards used to formulate the list of services or the selection of providers for whom prior authorization is required are not subject to the requirements of sections 14.001 to 14.69.

The commissioner's decision whether prior authorization is required for a health service or is required for a provider is not subject to administrative appeal. Use of criteria or standards to select providers for whom prior authorization is required shall not impede access to the service involved for any group of individuals with unique or special needs due to disability or functional condition.

(b) The commissioner shall implement a modernized electronic system for providers to request prior authorization. The modernized electronic system must include at least the following functionalities:

(1) authorizations are recipient-centric, not provider-centric;

(2) adequate flexibility to support authorizations for an episode of care, continuous drug therapy, or for individual onetime services and allows an ordering and a rendering provider to both submit information into one request;

(3) allows providers to review previous authorization requests and determine where a submitted request is within the authorization process;

(4) supports automated workflows that allow providers to securely submit medical information that can be accessed by medical and pharmacy review vendors as well as department staff; and

(5) supports development of automated clinical algorithms that can verify information and provide responses in real time.

(c) The system described in paragraph (b) shall be completed by March 1, 2012. All authorization requests submitted on and after March 1, 2012, or upon completion of the modernized authorization system, whichever is later, must be submitted electronically by providers, except requests for drugs dispensed by an outpatient pharmacy, services that are provided outside of the state and surrounding local trade area, and services included on a service agreement.

Subd. 25a. **Prior authorization of diagnostic imaging services.** (a) Effective January 1, 2010, the commissioner shall require prior authorization or decision support for the ordering providers at the time the service is ordered for the following outpatient diagnostic imaging services: computerized tomography (CT), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positive emission tomography (PET), cardiac imaging, and ultrasound diagnostic imaging.

(b) Prior authorization under this subdivision is not required for diagnostic imaging services performed as part of a hospital emergency room visit, inpatient hospitalization, or if concurrent with or on the same day as an urgent care facility visit.

(c) This subdivision does not apply to services provided to recipients who are enrolled in Medicare, the prepaid medical assistance program, the prepaid general assistance medical care program, or the MinnesotaCare program.

(d) The commissioner may contract with a private entity to provide the prior authorization or decision support required under this subdivision. The contracting entity must incorporate clinical guidelines that are based on evidence-based medical literature, if available. By January 1, 2012, the contracting entity shall report to the commissioner the results of prior authorization or decision support.

Subd. 25b. **Authorization with third-party liability.** (a) Except as otherwise allowed under this subdivision or required under federal or state regulations, the commissioner must not consider a request for authorization of a service when the recipient has coverage from a third-party payer

unless the provider requesting authorization has made a good faith effort to receive payment or authorization from the third-party payer. A good faith effort is established by supplying with the authorization request to the commissioner the following:

(1) a determination of payment for the service from the third-party payer, a determination of authorization for the service from the third-party payer, or a verification of noncoverage of the service by the third-party payer; and

(2) the information or records required by the department to document the reason for the determination or to validate noncoverage from the third-party payer.

(b) A provider requesting authorization for services covered by Medicare is not required to bill Medicare before requesting authorization from the commissioner if the provider has reason to believe that a service covered by Medicare is not eligible for payment. The provider must document that, because of recent claim experiences with Medicare or because of written communication from Medicare, coverage is not available for the service.

(c) Authorization is not required if a third-party payer has made payment that is equal to or greater than 60 percent of the maximum payment amount for the service allowed under medical assistance.

Subd. 26. **Special education services.** (a) Medical assistance covers medical services identified in a recipient's individualized education program and covered under the medical assistance state plan. Covered services include occupational therapy, physical therapy, speech-language therapy, clinical psychological services, nursing services, school psychological services, school social work services, personal care assistants serving as management aides, assistive technology devices, transportation services, health assessments, and other services covered under the medical assistance state plan. Mental health services eligible for medical assistance reimbursement must be provided or coordinated through a children's mental health collaborative where a collaborative exists if the child is included in the collaborative operational target population. The provision or coordination of services does not require that the individualized education program be developed by the collaborative.

The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. The nonfederal share of costs for services provided under this subdivision is the responsibility of the local school district as provided in section 125A.74. Services listed in a child's individualized education program are eligible for medical assistance reimbursement only if those services meet criteria for federal financial participation under the Medicaid program.

(b) Approval of health-related services for inclusion in the individualized education program does not require prior authorization for purposes of reimbursement under this chapter. The commissioner may require physician review and approval of the plan not more than once annually or upon any modification of the individualized education program that reflects a change in health-related services.

(c) Services of a speech-language pathologist provided under this section are covered notwithstanding Minnesota Rules, part 9505.0390, subpart 1, item L, if the person:

(1) holds a masters degree in speech-language pathology;

(2) is licensed by the Minnesota Board of Teaching as an educational speech-language pathologist; and

(3) either has a certificate of clinical competence from the American Speech and Hearing Association, has completed the equivalent educational requirements and work experience necessary for the certificate or has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(d) Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

(e) The commissioner shall develop and implement package rates, bundled rates, or per diem rates for special education services under which separately covered services are grouped together and billed as a unit in order to reduce administrative complexity.

(f) The commissioner shall develop a cost-based payment structure for payment of these services. Only costs reported through the designated Minnesota Department of Education data systems in distinct service categories qualify for inclusion in the cost-based payment structure. The commissioner shall reimburse claims submitted based on an interim rate, and shall settle at a final rate once the department has determined it. The commissioner shall notify the school district of the final rate. The school district has 60 days to appeal the final rate. To appeal the final rate, the school district shall file a written appeal request to the commissioner within 60 days of the date the final rate determination was mailed. The appeal request shall specify (1) the disputed items and (2) the name and address of the person to contact regarding the appeal.

(g) Effective July 1, 2000, medical assistance services provided under an individualized education program or an individual family service plan by local school districts shall not count against medical assistance authorization thresholds for that child.

(h) Nursing services as defined in section 148.171, subdivision 15, and provided as an individualized education program health-related service, are eligible for medical assistance payment if they are otherwise a covered service under the medical assistance program. Medical assistance covers the administration of prescription medications by a licensed nurse who is employed by or under contract with a school district when the administration of medications is identified in the child's individualized education program. The simple administration of medications alone is not covered under medical assistance when administered by a provider other than a school district or when it is not identified in the child's individualized education program.

Subd. 27. **Organ and tissue transplants.** All organ transplants must be performed at transplant centers meeting united network for organ sharing criteria or at Medicare-approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Subd. 28a. **Licensed physician assistant services.** (a) Medical assistance covers services performed by a licensed physician assistant if the service is otherwise covered under this chapter as a physician service and if the service is within the scope of practice of a licensed physician assistant as defined in section 147A.09.

(b) Licensed physician assistants, who are supervised by a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to medical assistance enrollees in inpatient hospital settings, consistent with their authorized scope of practice, as defined in section 147A.09, with the exception of performing psychotherapy or diagnostic assessments or providing clinical supervision.

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum.

[See Note.]

Subd. 29. **Public health nursing clinic services.** Medical assistance covers the services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health or registered nurse's license as a registered nurse, as defined in section 148.171.

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules

by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

Subd. 31a. **Augmentative and alternative communication systems.** (a) Medical assistance covers augmentative and alternative communication systems consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability.

(b) Augmentative and alternative communication systems must be paid the lower of the:

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

Subd. 31b. **Preferred diabetic testing supply program.** (a) The commissioner shall implement a point-of-sale preferred diabetic testing supply program by January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform to the limitations established under the program. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred diabetic testing supply list and supplemental rebate program.

The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall maintain an accurate and up-to-date list on the department's Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred diabetic testing supply program drug list after consulting with the Drug Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred diabetic testing supply program as part of the administration of the diabetic testing supply rebate program. Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply list may be subject to prior authorization.

(d) All claims for diabetic testing supplies in categories on the preferred diabetic testing supply list must be submitted by enrolled pharmacy providers using the most current National Council of Prescription Drug Plans electronic claims standard.

(e) For purposes of this subdivision, "preferred diabetic testing supply list" means a list of diabetic testing supplies selected by the commissioner, for which prior authorization is not required.

(f) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Subd. 32. **Nutritional products.** Medical assistance covers nutritional products needed for nutritional supplementation because solid food or nutrients thereof cannot be properly absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. Separate payment shall not be made for nutritional products for residents of long-term care facilities. Payment for dietary requirements is a component of the per diem rate paid to these facilities.

Subd. 33. **Child welfare targeted case management.** Medical assistance, subject to federal approval, covers child welfare targeted case management services as defined in section 256B.094 to children under age 21 who have been assessed and determined in accordance with section 256F.095 to be:

(1) at risk of placement or in placement as defined in section 260C.212, subdivision 1;

(2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or

(3) in need of protection or services as defined in section 260C.007, subdivision 6.

Subd. 34. **Indian health services facilities.** Medical assistance payments and MinnesotaCare payments to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, for enrollees who are eligible for federal financial participation, shall be at the option of the facility in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). General assistance medical care payments to facilities of the Indian health services and facilities operated by a tribe or tribal

organization for the provision of outpatient medical care services billed after June 30, 1990, must be in accordance with the general assistance medical care rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization. MinnesotaCare payments for enrollees who are not eligible for federal financial participation at facilities of the Indian health service and facilities operated by a tribe or tribal organization for the provision of outpatient medical services must be in accordance with the medical assistance rates paid for the same services when provided in a facility other than a facility of the Indian health service or a facility operated by a tribe or tribal organization.

Subd. 35. [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 35a. **Children's mental health crisis response services.** Medical assistance covers children's mental health crisis response services according to section 256B.0944.

Subd. 35b. **Children's therapeutic services and supports.** Medical assistance covers children's therapeutic services and supports according to section 256B.0943.

Subd. 36. [Repealed, 1Sp2003 c 14 art 4 s 24]

Subd. 37. **Individualized rehabilitation services.** Medical assistance covers individualized rehabilitation services as defined in section 245.492, subdivision 23, that are provided by a collaborative, county, or an entity under contract with a county through an integrated service system, as described in section 245.4931, that is approved by the state coordinating council, subject to federal approval.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals shall be 80 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters-prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral-prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by physician assistants shall be 80.4 percent of the base rate paid to psychiatrists.

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Subd. 40. **Tuberculosis related services.** (a) For persons infected with tuberculosis, medical assistance covers case management services and direct observation of the intake of drugs prescribed to treat tuberculosis.

(b) "Case management services" means services furnished to assist persons infected with tuberculosis in gaining access to needed medical services. Case management services include at a minimum:

(1) assessing a person's need for medical services to treat tuberculosis;

(2) developing a care plan that addresses the needs identified in clause (1);

(3) assisting the person in accessing medical services identified in the care plan; and

(4) monitoring the person's compliance with the care plan to ensure completion of tuberculosis therapy. Medical assistance covers case management services under this subdivision only if the services are provided by a certified public health nurse who is employed by a community health board as defined in section 145A.02, subdivision 5.

(c) To be covered by medical assistance, direct observation of the intake of drugs prescribed to treat tuberculosis must be provided by a community outreach worker, licensed practical nurse, registered nurse who is trained and supervised by a public health nurse employed by a community health board as defined in section 145A.02, subdivision 5, or a public health nurse employed by a community health board.

Subd. 41. **Residential services for children with severe emotional disturbance.** Medical assistance covers rehabilitative services in accordance with section 256B.0945 that are provided by a county or an American Indian tribe through a residential facility, for children who have been diagnosed with severe emotional disturbance and have been determined to require the level of care provided in a residential facility.

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section 245.462, subdivision 18, clauses (1) to (6); or 245.4871, subdivision 27, clauses (1) to (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Subd. 43. **Mental health provider travel time.** Medical assistance covers provider travel time if a recipient's individual treatment plan requires the provision of mental health services outside of the provider's normal place of business. This does not include any travel time which is included in other billable services, and is only covered when the mental health service being provided to a recipient is covered under medical assistance.

Subd. 44. **Targeted case management services.** Medical assistance covers case management services for vulnerable adults and adults with developmental disabilities, as provided under section 256B.0924.

Subd. 45. **Subacute psychiatric care for persons under 21 years of age.** Medical assistance covers subacute psychiatric care for person under 21 years of age when:

(1) the services meet the requirements of Code of Federal Regulations, title 42, section 440.160;

(2) the facility is accredited as a psychiatric treatment facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation; and

(3) the facility is licensed by the commissioner of health under section 144.50.

Subd. 46. **Mental health telemedicine.** Effective January 1, 2006, and subject to federal approval, mental health services that are otherwise covered by medical assistance as direct face-to-face services may be provided via two-way interactive video. Use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement is at the same rates and under the same conditions that would otherwise apply to the service. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

Subd. 47. **Treatment foster care services.** Effective July 1, 2011, and subject to federal approval, medical assistance covers treatment foster care services according to section 256B.0946.

Subd. 48. **Psychiatric consultation to primary care practitioners.** Medical assistance covers consultation provided by a psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum; or

(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Subd. 50. **Self-directed supports option.** Upon federal approval, medical assistance covers the self-directed supports option as defined under section 256B.0657 and section 6087 of the Federal Deficit Reduction Act of 2005, Public Law 109-171.

[See Note.]

Subd. 51. **Provider-directed care coordination services.** The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. For purposes of this subdivision, a primary care clinic is a medical clinic designated as the patient's first point of contact for medical care, available 24 hours a day, seven days a week, that provides or arranges for the patient's comprehensive health care needs, and provides overall integration, coordination and continuity over time and referrals for specialty care.

Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after federal approval, whichever is later, medical assistance covers lead risk assessments provided by a lead risk assessor who is licensed by the commissioner of health under section 144.9505 and employed by an assessing agency as defined in section 144.9501. Medical assistance covers a onetime on-site investigation of a recipient's home or primary residence to determine the existence of lead so long as the recipient is under the age of 21 and has a venous blood lead level specified in section 144.9504, subdivision 2, paragraph (a).

(b) Medical assistance reimbursement covers the lead risk assessor's time to complete the following activities:

(1) gathering samples;

(2) interviewing family members;

(3) gathering data, including meter readings; and

(4) providing a report with the results of the investigation and options for reducing lead-based paint hazards.

Medical assistance coverage of lead risk assessment does not include testing of environmental substances such as water, paint, or soil or any other laboratory services. Medical assistance coverage of lead risk assessments is not included in the capitated services for children enrolled in health plans through the prepaid medical assistance program and the MinnesotaCare program.

(c) Payment for lead risk assessment must be cost-based and must meet the criteria for federal financial participation under the Medicaid program. The rate must be based on allowable expenditures from cost information gathered. Under section 144.9507, subdivision 5, federal medical assistance funds may not replace existing funding for lead-related activities. The nonfederal share of costs for services provided under this subdivision must be from state or local funds and is the responsibility of the agency providing the risk assessment. When the risk assessment is conducted by the commissioner of health, the state share must be from appropriations to the commissioner of health for this purpose. Eligible expenditures for the nonfederal share of costs may not be made from federal funds or funds used to match other federal funds. Any federal disallowances are the responsibility of the agency providing risk assessment services.

Subd. 53. **Centers of excellence.** For complex medical procedures with a high degree of variation in outcomes, for which the Medicare program requires facilities providing the services to meet certain criteria as a condition of coverage, the commissioner may develop centers of excellence facility criteria in consultation with the Health Services Policy Committee under subdivision 3c. The criteria must reflect facility traits that have been linked to superior patient safety and outcomes for the procedures in question, and must be based on the best available empirical evidence. For medical assistance recipients enrolled on a fee-for-service basis, the commissioner may make coverage for these procedures conditional upon the facility providing the services meeting the specified criteria. Only facilities meeting the criteria may be reimbursed for the procedures in question.

[See Note.]

Subd. 54. **Services provided in birth centers.** (a) Medical assistance covers services provided in a licensed birth center by a licensed health professional if the service would otherwise be covered if provided in a hospital.

(b) Facility services provided by a birth center shall be paid at the lower of billed charges or 70 percent of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available. If a recipient is transported from a birth center to a hospital prior to the delivery, the payment for facility services to the birth center shall be the lower of billed charges or 15 percent of the average facility payment made to a hospital for the services provided for an uncomplicated vaginal delivery as determined using the most recent calendar year for which complete claims data is available.

(c) Nursery care services provided by a birth center shall be paid the lower of billed charges or 70 percent of the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent calendar year for which complete claims data is available.

(d) Professional services provided by traditional midwives licensed under chapter 147D shall be paid at the lower of billed charges or 100 percent of the rate paid to a physician performing the same services. If a recipient is transported from a birth center to a hospital prior to the delivery, a licensed traditional midwife who does not perform the delivery may not bill for any delivery services. Services are not covered if provided by an unlicensed traditional midwife.

(e) The commissioner shall apply for any necessary waivers from the Centers for Medicare and Medicaid Services to allow birth centers and birth center providers to be reimbursed.

Subd. 55. **Payment for noncovered services.** (a) Except when specifically prohibited by the commissioner or federal law, a provider may seek payment from the recipient for services not eligible for payment under the medical assistance program when the provider, prior to delivering the service, reviews and considers all other available covered alternatives with the recipient and obtains a signed acknowledgment from the recipient of the potential of the recipient's liability. The signed acknowledgment must be in a form approved by the commissioner.

(b) Conditions under which a provider must not request payment from the recipient include, but are not limited to:

(1) a service that requires prior authorization, unless authorization has been denied as not medically necessary and all other therapeutic alternatives have been reviewed;

(2) a service for which payment has been denied for reasons relating to billing requirements;

(3) standard shipping or delivery and setup of medical equipment or medical supplies;

(4) services that are included in the recipient's long term care per diem;

(5) the recipient is enrolled in the Restricted Recipient Program and the provider is one of a provider type designated for the recipient's health care services; and

(6) the noncovered service is a prescription drug identified by the commissioner as having the potential for abuse and overuse, except where payment by the recipient is specifically approved by the commissioner on the date of service based upon compelling evidence supplied by the prescribing provider that establishes medical necessity for that particular drug.

(c) The payment requested from recipients for noncovered services under this subdivision must not exceed the provider's usual and customary charge for the actual service received by the recipient. A recipient must not be billed for the difference between what medical assistance paid for the service or would pay for a less costly alternative service.

Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state healthcare program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(2) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department or inpatient psychiatric unit for a child or young adult up to age 21 with a serious emotional disturbance who has frequented the hospital emergency room two or more times in the previous consecutive three months or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged to a shelter.

(b) Reimbursement must be made in 15-minute increments and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. For children and young adults with a serious emotional disturbance, in-reach community-based service coordination includes navigating and arranging for community-based services prior to discharge to address a client's mental health, chemical health, social, educational, family support and housing needs, or any other activity targeted at reducing multiple incidents of emergency room use, inpatient readmissions, and other nonmedically necessary health care utilization. In-reach services shall seek to connect them with existing covered services, including targeted case management, waiver case management, care coordination in a health care home, children's therapeutic services and supports, crisis services, and respite care. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) (1) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, education, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

(2) Hospitals utilizing in-reach service coordinators shall report annually to the commissioner on the number of adults, children, and adolescents served; the postdischarge services which they accessed; and emergency department/psychiatric hospitalization readmissions. The commissioner shall ensure that services and payments provided under in-reach care coordination do not duplicate services or payments provided under section 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

Subd. 57. **Payment for Part B Medicare crossover claims.** Effective for services provided on or after January 1, 2012, medical assistance payment for an enrollee's cost-sharing associated with Medicare Part B is limited to an amount up to the medical assistance total allowed, when the medical assistance rate exceeds the amount paid by Medicare. Excluded from this limitation are payments for mental health services and payments for dialysis services provided to end-stage renal disease patients. The exclusion for mental health services does not apply to payments for physician services provided by psychiatrists and advanced practice nurses with a specialty in mental health.

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for vaccines that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Subd. 59. **Services provided by advanced dental therapists and dental therapists.** Medical assistance covers services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in sections 150A.105 and 150A.106.

Subd. 60. **Community paramedic services.** (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b).

(b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility.

(c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies and that community paramedic services do not duplicate services already provided to the patient, including home health and waiver services. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director.

(d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services.

(e) The commissioner shall seek the necessary federal approval to implement this subdivision. ***[See Note.]***

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided

to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience.

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers or educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Subd. 63. **Payment for multiple services provided on the same day.** The commissioner shall not prohibit payment, including supplemental payments, for mental health services or dental services provided to a patient by a clinic or health care professional solely because the mental health or dental services were provided on the same day as other covered health services furnished by the same provider.

History: *Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 5 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1986 c 444; 1987 c 309 s 24; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 1987 c 403 art 2 s 73,74; art 5 s 16; 1988 c 689 art 2 s 141,268; 1989 c 282 art 3 s 54-58; 1990 c 422 s 10; 1990 c 568 art 3 s 43-50,104; 1991 c 199 art 2 s 1; 1991 c 292 art 4 s 41-49; art 6 s 45; art 7 s 5,9-11; 1992 c 391 s 1,2; 1992 c 513 art 7 s 43-49; art 9 s 25; 1993 c 246 s 1,2; 1993 c 247 art 4 s 11; 1993 c 345 art 13 s 1; 1Sp1993 c 1 art 3 s 23; art 5 s 36-49; art 7 s 41-44; art 9 s 71; 1Sp1993 c 6 s 10; 1994 c 465 art 3 s 52; 1994 c 625 art 8 s 72; 1995 c 178 art 2 s 26; 1995 c 207 art 6 s 38-51; art 8 s 33; 1995 c 234 art 6 s 38; 1995 c 263 s 10; 1996 c 451 art 2 s 20; art 5 s 15,16; 1997 c 203 art 2 s 25; art 4 s 25,26; 1997 c 225 art 4 s 3; art 6 s 5,8; 1998 c 398 art 2 s 46; 1998 c 407 art 4 s 20-28; 1999 c 86 art 2 s 4; 1999 c 139 art 4 s 2; 1999 c 245 art 4 s 37-49,121; art 5 s 20; art 8 s 5,87; art 10 s 10; 2000 c 298 s 3; 2000 c 347 s 1; 2000 c 474 s 6,7; 2000 c 488 art 9 s 16; 2001 c 178 art 1 s 44; 2001 c 203 s 9; 1Sp2001 c 9 art 2 s 30-38; art 3 s 16-19; art 9 s 41,42; 2002 c 220 art 15 s 13; 2002 c 277 s 12-14,32; 2002 c 294 s 6; 2002 c 375 art 2 s 13-16; 2002 c 379 art 1 s 113; 2003 c 112 art 2 s 50; 1Sp2003 c 14 art 3 s 25; art 4 s 4-7; art 11 s 11; art 12 s 33-36; 2004 c 288 art 5*

s 3; art 6 s 22; 2005 c 10 art 1 s 48; 2005 c 56 s 1; 2005 c 98 art 2 s 3,4; 2005 c 147 art 1 s 67; 2005 c 155 art 3 s 2-6; 1Sp2005 c 4 art 2 s 8-10; art 7 s 13,14; art 8 s 29-40; 2006 c 282 art 16 s 6; 2007 c 147 art 4 s 5-7; art 5 s 9; art 6 s 18; art 7 s 6,7; art 8 s 19-21; art 11 s 17; art 15 s 16; art 16 s 16; 2008 c 326 art 1 s 29-32; 2008 c 363 art 15 s 4; art 17 s 9; 2009 c 79 art 5 s 25-36; art 7 s 18,20; art 8 s 18-21; 2009 c 101 art 2 s 109; 2009 c 159 s 89; 2009 c 167 s 13; 2009 c 173 art 1 s 20,21,41; art 3 s 9,10; 2010 c 200 art 1 s 4,5; 2010 c 303 s 4; 2010 c 307 s 1; 2010 c 310 art 1 s 1; art 6 s 2; art 7 s 1; art 8 s 1; art 9 s 1; art 10 s 1; art 11 s 1; art 12 s 1,2; 2010 c 352 art 1 s 7; 1Sp2010 c 1 art 16 s 8-15; art 24 s 4; 2011 c 76 art 1 s 37; 2011 c 86 s 17,18; 1Sp2011 c 9 art 6 s 28-48; art 7 s 8; art 8 s 6; 1Sp2011 c 11 art 3 s 12; 2012 c 169 s 1; 2012 c 181 s 1; 2012 c 187 art 3 s 12; 2012 c 216 art 9 s 11; art 11 s 1; art 12 s 8; art 13 s 7-11; 2012 c 247 art 1 s 3-9,27; 2013 c 81 s 4-10; 2013 c 108 art 4 s 17-20; art 6 s 8-16; art 9 s 10; 2013 c 125 art 1 s 107

NOTE: Subdivision 16 was found unconstitutional with regard to public funding for medical services related to therapeutic abortions. Women of State of Minn. by Doe v. Gomez, 542 N.W.2d 17 (Minn. 1995).

NOTE: Subdivision 50 as added by Laws 2007, chapter 147, article 7, section 7, is effective upon federal approval of the state Medicaid plan amendment. Laws 2007, chapter 147, article 7, section 7, the effective date.

NOTE: Subdivision 53, as added by Laws 2009, chapter 173, article 3, section 10, is effective August 1, 2009, or upon federal approval, whichever is later. Laws 2009, chapter 173, article 3, section 10, the effective date.

NOTE: Subdivision 60, as added by Laws 2012, chapter 169, section 1, is effective July 1, 2012, or upon federal approval, whichever is later. Laws 2012, chapter 169, section 1, the effective date.

NOTE: Subdivision 28b, as added by Laws 2013, chapter 108, article 6, section 11, is effective July 1, 2014, or upon federal approval, whichever is later, and applies to services provided on or after the effective date. Laws 2013, chapter 108, article 6, section 11, the effective date.

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

Instructions: Do not combine issues in a single SBAR. Complete a separate SBAR form for each individual issue that needs to be addressed. The completion of the AUC Medical Code TAG (MCT) Decision Tree is highly recommended prior to completion of the SBAR form(s). If completed, please submit the MCT Decision Tree form along with your completed SBAR.

Complete Sections II and III of the SBAR. Section I is to be completed by MDH staff and Section IV is to be completed by the AUC.

Medical Coding TAG Decision Tree Form

In order to streamline and expedite the SBAR review process, the AUC Medical Code TAG utilizes the MCT Decision Tree in its decision-making process for consideration of SBARs under the TAG's review. The MCT has made the form available for use to ensure accurate and timely SBAR responses. The MCT Decision Tree form can be accessed from the AUC website at: http://www.health.state.mn.us/auc/forms.htm or by clicking on the link below in Step 1.

Step 1: Complete an MCT Decision Tree for each SBAR issue. Completing the MCT Decision Tree will enable a more thorough explanation of the SBAR issue(s) and prevent omission of critical or significant information.

Step 2: Fully complete Sections II and III. Incomplete or unclear analysis of the issue may cause unnecessary delay in the AUC response to the SBAR.

Section II

1. Provide contact information for person submitting the SBAR. Additional contact information may be required for the subject matter expert if different from the person completing the SBAR form.
2. The additional contact information may also be completed when the SBAR is being submitted on behalf of another individual who should also be notified of the AUC TAG meeting when the SBAR will be considered and who may or may not be a member of your organization.

   Please note: There may be a need to ask additional questions in order to clarify understanding of the issue as stated in the SBAR. The SBAR submitter and subject matter expert should be in attendance or available during the AUC TAG meeting and will be notified of meeting details at least one week prior to the SBARs' scheduled review date.

Section III

1. Provide an SBAR title for the issue you wish to have addressed.
2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

- **Situation**: Describe the type of problem or issue, e.g., coding or clarification/interpretation. What is the current business practice and why is it a problem or an issue? Would the continuance of the practice result in non-compliance of federal (e.g., CMS guidelines) and Minnesota administrative simplification rules and regulations?
- **Background**: In explaining the pertinent history of the business practice, state how it is used within your organization or within the industry today. What is the negative impact of the business practice if not addressed by the AUC?
- **Assessment**: Be specific and provide as much detail you feel is required to convey or explain why this issue should be addressed by the AUC. How would a change to this business practice benefit health care administrative simplification in Minnesota?
- **Recommendation**: What are you proposing as the solution to this issue that will benefit the health care administrative simplification in Minnesota or improve standardization of the administrative simplification process in Minnesota?

Step 3: Submit the completed SBAR(s) and MCT Decision Tree(s) to the AUC via email at: health.AUC@state.mn.us.

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

REMINDER: Submit the completed SBAR and MCT Decision Tree via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Status/Disposition information (To be completed by the Minnesota Department of Health)

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

Section II – Contact information (Person submitting the SBAR and/or Subject Matter Expert)

Contact Information for person completing this form:

Name: ANDREA AGERLIE
Title: Health Care Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Telephone: 651-431-3159

Organization Information:

Name: MINNESOTA DEPARTMENT OF HUMAN SERVICES
Address: 540 Cedar St., St. Paul, MN 55164-0993

Complete for additional contact or Subject Matter Expert, as required:

Name:
Title:
Email address:
Phone number:

Section III – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title: DOULA SERVICES

S

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

DHS, fee-for-service and managed care, requires a method for reporting a new service mandated in subdivision 28b of Section 11, Minnesota Statues 2012, section 256B.0625, described as Doula Services.

Subd. 28b Doula services, Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum.

The definition of a "certified doula" referenced in Section 148.995, subdivision 2 above, is:
"Certified doula" means an individual who has received a certification to perform doula services from the International Childbirth Education Association, the Doulas of North America (DONA), the Association of Labor Assistants and Childbirth Educators (ALACE), Birthworks, Childbirth and Postpartum Professional Association (CAPPA), Childbirth International, or International Center for Traditional Childbearing.

B

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

Doula services have not been covered in the past.

A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): Currently there are no codes specific to doula services. At this time, Oregon is the only state with federal approval for doula services and that is limited to labor/delivery only. Coverage of doula services applies to both DHS fee-for-service and managed care. Discussion is necessary to develop a uniform billing method for doula services. Additional information regarding doula services: -Doula services will be billed on the professional claim form -Doula services will be billed under the NPI of an enrolled provider -Doulas will not be enrolled providers -Place of service will be home, clinic, or hospital -Services are face-to-face on a per session basis -Services are provided antepartum, labor/delivery,and postpartum
R	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: DHS is seeking the recommendation of the Medical Code Tag for an appropriate, applicable code for doula services. Services would be billed with a state defined modifier to identify doula services. Minnesota statute indicates coverage of doula services is effective 7/1/2013, however, DHS must have federal approval first.

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide, HCPSC/CPT manuals, etc. reviewed and considered during the discussion.

Medical Code TAG should also include the disposition/status for coding decision in its response and effective dates, when required. (For example, inclusion of the clarification of a current practice or coding changes/additions in the MCT Coding Recommendation Grid and MN Uniform Companion Guide or inclusion in the MCT Coding Recommendation Grid only.) Additionally, information from the MCT Decision Tree summary and findings should be reflected in the response as applicable.

Date [SBAR Response Approved by TAG]: 4/10/14

Reviewed by: [AUC TAG Name]: Medical Code TAG

AUC Co-Chair(s):Faith Bauer

AUC Response: Coverage and coding of doula services is still under review at DHS. This SBAR is closed at this time pending clarification from DHS and federal approval.

MDH Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

MN Dept of Health (MDH) Proposes Updates to Health Care "e-billing" Rules and 30 Day Comment Period

The Minnesota Department of Health (MDH) administers a state law and related rules requiring the standard electronic exchange of health care administrative transactions. MDH has recently announced proposed updates to the three Minnesota Uniform Companion Guide (MUCG) rules below to ensure that the rules remain up to date and to correct minor grammatical and other errors. The updates were prepared in consultation with the Minnesota Administrative Uniformity Committee (AUC), a large voluntary stakeholder advisory committee.

MDH is seeking any comments regarding the proposed updates during a thirty day open public comment period December 22, 2014 – January 22, 2014. For further information regarding the proposed updates and the process for submitting comments, please see the announcement published in the Minnesota State Register, Monday December 15, 2014.

Updates are being proposed for the following MUCG rules below. For each rule, proposed changes are shown in underline-strikeout format. For more information regarding Minnesota's health care administrative simplification initiative, please see the MDH Administrative Simplification Act (ASA) website.

- Proposed revised Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X222A1 Health Care Claim: Professional (837) (PDF: 531KB/70 pgs), version 9.0 (changes shown in underline/strikeout)

- Proposed revised Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837) (PDF: 443KB/60 pgs), version 9.0 (changes shown in underline/strikeout)

- Proposed revised Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X224A2 Health Care Claim: Dental (837) (PDF: 215KB/25 pgs), version 9.0 (changes shown in underline/strikeout)

regarding Minnesota's requirements for the standard, electronic exchange of common health care administrative transactions please go to http://www.health.state.mn.us/asa/.

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Short Title		Log No.	Date Closed
Status: Exec Review Date	Sent to TAG/WG	TAG Recommendation: _____ Accept _____ Reject	Decision to Originator

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Contact Information for person completing this form:

Name: ANDREA AGERLIE
Title: Health Care Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Telephone: 651-431-3159

Organization Information:

Name: MINNESOTA DEPARTMENT OF HUMAN SERVICES
Address: 540 Cedar St., St. Paul, MN 55164-0993

Complete for additional contact or Subject Matter Expert, as required:

Name:
Title:
Email address:
Phone number:

Section III – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title: MENTAL HEALTH CLINICAL CARE CONSULTATION

S

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

The 2013 Minnesota Legislature passed legislation for coverage of Clinical Care Consultations. Minnesota Statute 256B.0625, Subd. 62 reads:

Mental Health Clinical Care Consultation. Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers and educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

The above legislation applies to DHS fee-for-service and managed care.

B

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

Mental Health Clinical Care Consultation is a new covered service.

A

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

Both DHS fee-for-service and managed care will need to cover Mental Health Clinical Care Consultations. Discussion is necessary to develop a uniform billing method for this service.
Service details are as follows:

- Consultation is provided by mental health professional or clinical trainee to other providers or educators not under their supervision.
- Mental Health Professionals include clinical social workers, psychologists, psychiatrists, marriage and family therapists, professional clinical counselors, tribally approved mental health care professionals, certified clinical nurse specialists or nurse practitioners (with appropriate credentials).
- The Mental Health Professional is communicating with other providers or educators such as teachers, pediatricians, case managers, probations officers, daycare providers, or other mental health professionals.
- Services may take place in, but are not limited to, school, community, office or clinic.
- Services may be over the phone or in person (client may or may not be present).
- Services would be billed on the professional claim.
- Service time can vary widely from a few minutes to a few hours, with shorter consultation times being most common.
- Time beginning with a 5 minute unit is preferable.
- Active consultation time is counted.
- We have not found any other states that cover a similar service.

It has been a challenge to come up with an appropriate, time based code. A time based code is necessary to accurately reflect the service and compensate providers correctly. Below are the codes we have reviewed and the challenges we found with each.

- 90899, 99499, H0046 all of which are unlisted and not linked to time.
- 99446-99449 all of which are codes for physicians consulting with other professionals.
- H0023 which is for a targeted population (e.g. homeless)
- T2025 and T2026 which are specific to a clinic setting.
- 99368 does not address time under 30 minutes and requires a minimum of three qualified health care professionals from different specialties or disciplines.

  Note: Non face-to-face services would be billed with the U4 modifier.

R

RECOMMENDATION – What are you recommending, including any known timing that needs to be considered:

DHS is seeking the recommendation of the Medical Code Tag for an appropriate, applicable code for Mental Health Clinical Care Consultation. Discussion is necessary to develop a uniform billing method for this service.
Minnesota Statute indicates coverage of Mental Health Clinical Care Consultations is effective 7/1/2013, however, DHS must have federal approval first.
After federal approval, coding guidance should be added to the MN Community Coding Practice/Recommendation Table and subsequently the Minnesota Companion Guide (837P).

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide,

HCPSC/CPT manuals, etc. reviewed and considered during the discussion.

Medical Code TAG should also include the disposition/status for coding decision in its response and effective dates, when required. (For example, inclusion of the clarification of a current practice or coding changes/additions in the MCT Coding Recommendation Grid and MN Uniform Companion Guide or inclusion in the MCT Coding Recommendation Grid only.) Additionally, information from the MCT Decision Tree summary and findings should be reflected in the response as applicable.

Date [SBAR Response Approved by TAG]: 12/11/14

Reviewed by: [AUC TAG Name]: Medical Code TAG

AUC Co-Chair(s): Faith Bauer

AUC Response:

- See MINNESOTA STATUTES 2013 256B.0625. Approved by CMS January 2015. The statute indicates these services are for patients up to age 21.
- The approved coding is:
  90899-U8 (5-10 minutes)

  90899-U9 (11-20 minutes)

  90899-UB (21-30 minutes)

  90899-UC (31+ minutes)

- Additional modifiers could be appended, such as U4 for phone and/or HN for clinical training.

This guide will be added to the MN Uniform Companion Guides during the comment period.

Collaborative psychiatric consultation issue (revisions in red):

Medicare Claims Processing Manual

Chapter No.	Chapter/Description Title	A) Subtopic (ST) B) Recommendation (Rec) C) AUC Medical Code TAG minutes reference D) AUC Operations Committee Approval date E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)
12	Physicians/Nonphysician Practitioners	A) Collaborative psychiatric consultation B) Revise Coding Recommendation Grid and MN Uniform Companion Guides entry Coding for a consultation initiated by the primary care provider (MD, DO, NPP, APRN or psychologist) 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) Consulting APRN (certified in psychiatric mental health) or psychologist – 99499 HE AM Consulting APRN (certified in psychiatric mental health) or psychologist – 99499 HE AM U4 (non-face-to-face) C) **4/10/14** D) **???** E) Proposed as a revision to next version of 837P and the 837I companion guides.

Mental Health Family Psychoeducation Services issue (new):

Medicare Claims Processing Manual

Chapter No.	Chapter/Description Title	A) Subtopic (ST) B) Recommendation (Rec) C) AUC Medical Code TAG minutes reference D) AUC Operations Committee Approval date

<table>
<tr><td></td><td></td><td>E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)</td></tr>
<tr><td>N/A</td><td>A.5.2.2. Behavioral Health Programs Listed in Table A.5.2</td><td>Add the following to the list showing code/modifier combinations for the programs listed that are administered by the Minnesota Department of Humans Services (DHS).

Mental Health Family Psychoeducation Services</td></tr>
<tr><td>N/A</td><td>TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs</td><td>A) Mental Health Family Psychoeducation Services
B) Add to the following policy to table A.5.2 Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to Minnesota Government Programs
<table>
<tr><th>Name of Program</th><th>Description/Definition</th><th>Coding</th></tr>
<tr><td>Mental Health Family Psychoeducation Services</td><td>• family psycho-education services provided to a child up to age 21 with a diagnosed MH condition and provided by licensed mental health professional
• information or demonstration provided to an individual or family as part of an individual, family multifamily group, or peer group session to:
o explain, educate, and support the child and family
o needed components of treatment
o skill development</td><td>• H2027 Individual
• H2027 HQ Group (peer group)
• H2027 HR Family with client present
• H2027 HS Family without client present
• H2027 HQ HR Multiple different families with clients present
• H2027 HQ HS Multiple different families without clients present
• H2027 HN Individual, clinical trainee
• H2027 HQ HN Group (peer group), clinical trainee
• H2027 HR HN Family with client present, clinical trainee
• H2027 HS HN Family without client present, clinical trainee
• H2027 HQ HR HN Multiple different families with clients present, clinical trainee
• H2027 HQ HS HN Multiple different families without clients present, clinical trainee</td></tr>
</table>
C) 4/10/14
D) ???
E) Proposed as an addition to next version of 837P and the 837I companion guides.</td></tr>
</table>

Certified Family Peer Specialist issue (revisions in red):

Medicare Claims Processing Manual

<table>
<tr><th>Chapter No.</th><th>Chapter/Description Title</th><th>A) Subtopic (ST)
B) Recommendation (Rec)
C) AUC Medical Code TAG minutes reference
D) AUC Operations Committee Approval date
E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)</th></tr>
<tr><td>N/A</td><td>A.5.2.2. Behavioral Health Programs Listed in Table A.5.2</td><td>Revise the entry on the following list showing code/modifier combinations for the programs listed that are administered by the Minnesota Department of Humans Services (DHS).

Certified Family Peer Specialist ~~Services~~</td></tr>
<tr><td>N/A</td><td>TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs</td><td>A) Certified Family Peer Specialist
B) Add to the following policy to table A.5.2 Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to Minnesota Government Programs
<table>
<tr><th>Name of Program</th><th>Description/Definition</th><th>Coding</th></tr>
<tr><td>Certified Family Peer Specialist ~~Services~~</td><td>Non-clinical support counseling services provided by certified peer specialist to adults or children.</td><td>Codes:
H0038 – Certified peer specialist services, per 15 minutes
H0038 U5 – Advanced level certified peer specialist services, per 15 minutes
H0038 HQ Group setting, certified peer specialist services, per 15 minutes
H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes
H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes</td></tr>
</table>
C) 4/10/14
D) ???
E) Proposed as a revision to next version of 837P and the 837I companion guides.</td></tr>
</table>

Intensive Treatment Foster Care (new)

Medicare Claims Processing Manual

Chapter No.	Chapter/Description Title	A) Subtopic (ST) B) Recommendation (Rec)

<table>
<tr><td></td><td></td><td>C) AUC Medical Code TAG minutes reference
D) AUC Operations Committee Approval date
E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)</td></tr>
<tr><td>N/A</td><td>A.5.2.2. Behavioral Health Programs Listed in Table A.5.2</td><td>Add the following to the list showing code/modifier combinations for the programs listed that are administered by the Minnesota Department of Humans Services (DHS).

Intensive Treatment Foster Care</td></tr>
<tr><td>N/A</td><td>TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs</td><td>A) Intensive Treatment Foster Care
B) Add to the following policy to table A.5.2 Behavioral Health Procedure Code/Modifier Combinations for Specific Benefit Packages Unique to Minnesota Government Programs
<table>
<tr><th>Name of Program</th><th>Description/Definition</th><th>Coding</th></tr>
<tr><td>Intensive Treatment Foster Care</td><td>Intensive treatment services to children with mental illness residing in foster family settings.
(1) psychotherapy provided by a mental health professional
(2) crisis assistance provided according to standards for children's therapeutic services and supports;
(3) individual, family, and group psychoeducation services by a mental health professional or a clinical trainee;
(4) clinical care consultation provided by a mental health professional or a clinical trainee; and
(5) service delivery payment requirements as provided under subdivision 4.</td><td>S5145 – Foster care, therapeutic, child; per diem
HE – Mental health program

Bill only one per diem code per day regardless of the number of services or who provides services.</td></tr>
</table>
C) 5/8/14
D) ???
E) Proposed as an addition to next version of 837P and the 837I companion guides.</td></tr>
</table>

POS codes for CCDTF claims issue (see proposed revisions in red and blue):

Medicare Claims Processing Manual

<table>
<tr><td>Chapter No.</td><td>Chapter/Description Title</td><td>A) Subtopic (ST)
B) Recommendation (Rec)
C) AUC Medical Code TAG minutes reference
D) AUC Operations Committee Approval date
E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)</td></tr>
<tr><td>N/A</td><td>A.5.3 Substance Abuse Services</td><td>
A) Substance Abuse Services
B) Recommendation (Rec)
Add column for POS (Place of Service) for 837P guide and instructions for selection of POS.

Alternative revision (in blue): add “POS” in the Type of Bill column

Claim Type – 837P
<table>
<tr><th>Service Descriptions</th><th>Unit</th><th>Revenue Code</th><th>HCPCS Procedure Code</th><th>Type of Bill/POS</th><th>Place of Service</th></tr>
<tr><td>Medication Assisted Therapy (MAT)</td><td>Day</td><td>N/A</td><td>H0020</td><td>TOB - N/A
POS - 22 or 12</td><td>22 or 12</td></tr>
<tr><td>MAT – all other drugs</td><td>Day</td><td>N/A</td><td>H0047 U9</td><td>TOB - N/A
POS - 22 or 12</td><td>22 or 12</td></tr>
<tr><td>MAT Plus</td><td>Day</td><td>N/A</td><td>H0020 UA</td><td>TOB - N/A
POS - 22 or 12</td><td>22 or 12</td></tr>
<tr><td>MAT Plus – all other drugs</td><td>Day</td><td>N/A</td><td>H0047 UB</td><td>TOB - N/A
POS - 22 or 12</td><td>22 or 12</td></tr>
</table>
Take-home doses place of service guide: The POS for directly observed administration would be 22. Additional days where the patient self-administers the doses should be reported with POS 12.

C) AUC Medical Code TAG minutes reference
D) AUC Operations Committee Approval date
E) Proposed as an addition to next version of 837P and the 837I companion guides.
</td></tr>
</table>

Bilateral Billing for Code 69210 (new)

Chapter No.	Chapter/Description Title	a) Subtopic (ST) b) Recommendation (Rec) c) AUC Medical Code TAG minutes reference d) AUC Operations Committee Approval date e) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)
12	Physicians/Nonphysician Practitioners	a) Bilateral Billing Requirements for CPT Code 69210 b) Submission of 69210 performed bilaterally Medicare for Medicare products - report one line one unit, no modifiers. Commercial and DHS - report one line, one unit, 50 modifier **c) 6/12/2014** **d) N/A** **e)**

Other general updates (i.e., typos):

Typo Correction for next update = 837P = pg 48 bottom

Dialectical Behavior	Dialectical behavior therapy ~~(DBP)~~ (DB**T**) is a treatment approach provided in an intensive outpatient	Codes: ▪ H2019 U1 – Therapeutic behavioral services,

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

Instructions: Do not combine issues in a single SBAR. Complete a separate SBAR form for each individual issue that needs to be addressed. The completion of the AUC Medical Code TAG (MCT) Decision Tree is highly recommended prior to completion of the SBAR form(s). If completed, please submit the MCT Decision Tree form along with your completed SBAR.

Complete Sections II and III of the SBAR. Section I is to be completed by MDH staff and Section IV is to be completed by the AUC.

Medical Coding TAG Decision Tree Form

In order to streamline and expedite the SBAR review process, the AUC Medical Code TAG utilizes the MCT Decision Tree in its decision-making process for consideration of SBARs under the TAG's review. The MCT has made the form available for use to ensure accurate and timely SBAR responses. The MCT Decision Tree form can be accessed from the AUC website at: http://www.health.state.mn.us/auc/forms.htm or by clicking on the link below in Step 1.

Step 1: Complete an MCT Decision Tree for each SBAR issue. Completing the MCT Decision Tree will enable a more thorough explanation of the SBAR issue(s) and prevent omission of critical or significant information.

Step 2: Fully complete Sections II and III. Incomplete or unclear analysis of the issue may cause unnecessary delay in the AUC response to the SBAR.

Section II

1. Provide contact information for person submitting the SBAR. Additional contact information may be required for the subject matter expert if different from the person completing the SBAR form.
2. The additional contact information may also be completed when the SBAR is being submitted on behalf of another individual who should also be notified of the AUC TAG meeting when the SBAR will be considered and who may or may not be a member of your organization.

   Please note: There may be a need to ask additional questions in order to clarify understanding of the issue as stated in the SBAR. The SBAR submitter and subject matter expert should be in attendance or available during the AUC TAG meeting and will be notified of meeting details at least one week prior to the SBARs' scheduled review date.

Section III

1. Provide an SBAR title for the issue you wish to have addressed.
2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

- **Situation**: Describe the type of problem or issue, e.g., coding or clarification/interpretation. What is the current business practice and why is it a problem or an issue? Would the continuance of the practice result in non-compliance of federal (e.g., CMS guidelines) and Minnesota administrative simplification rules and regulations?
- **Background**: In explaining the pertinent history of the business practice, state how it is used within your organization or within the industry today. What is the negative impact of the business practice if not addressed by the AUC?
- **Assessment**: Be specific and provide as much detail you feel is required to convey or explain why this issue should be addressed by the AUC. How would a change to this business practice benefit health care administrative simplification in Minnesota?
- **Recommendation**: What are you proposing as the solution to this issue that will benefit the health care administrative simplification in Minnesota or improve standardization of the administrative simplification process in Minnesota?

Step 3: Submit the completed SBAR(s) and MCT Decision Tree(s) to the AUC via email at: health.AUC@state.mn.us.

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

REMINDER: Submit the completed SBAR and MCT Decision Tree via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Status/Disposition information (To be completed by the Minnesota Department of Health)

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

Section II – Contact information (Person submitting the SBAR and/or Subject Matter Expert)

Contact Information for person completing this form:

Name: ANDREA AGERLIE
Title: Health Care Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Telephone: 651-431-3159

Organization Information:

Name: MINNESOTA DEPARTMENT OF HUMAN SERVICES
Address: 540 Cedar St., St. Paul, MN 55164-0993

Complete for additional contact or Subject Matter Expert, as required:

Name:
Title:
Email address:
Phone number:

Section III – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title: MENTAL HEALTH CLINICAL CARE CONSULTATION

S

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

The 2013 Minnesota Legislature passed legislation for coverage of Clinical Care Consultations. Minnesota Statute 256B.0625, Subd. 62 reads:

Mental Health Clinical Care Consultation. Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the purposes of this subdivision, "clinical care consultation" means communication from a treating mental health professional to other providers and educators not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

The above legislation applies to DHS fee-for-service and managed care.

B

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

Mental Health Clinical Care Consultation is a new covered service.

A

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

Both DHS fee-for-service and managed care will need to cover Mental Health Clinical Care Consultations. Discussion is necessary to develop a uniform billing method for this service.
Service details are as follows:

- Consultation is provided by mental health professional or clinical trainee to other providers or educators not under their supervision.
- Mental Health Professionals include clinical social workers, psychologists, psychiatrists, marriage and family therapists, professional clinical counselors, tribally approved mental health care professionals, certified clinical nurse specialists or nurse practitioners (with appropriate credentials).
- The Mental Health Professional is communicating with other providers or educators such as teachers, pediatricians, case managers, probations officers, daycare providers, or other mental health professionals.
- Services may take place in, but are not limited to, school, community, office or clinic.
- Services may be over the phone or in person (client may or may not be present).
- Services would be billed on the professional claim.
- Service time can vary widely from a few minutes to a few hours, with shorter consultation times being most common.
- Time beginning with a 5 minute unit is preferable.
- Active consultation time is counted.
- We have not found any other states that cover a similar service.

It has been a challenge to come up with an appropriate, time based code. A time based code is necessary to accurately reflect the service and compensate providers correctly. Below are the codes we have reviewed and the challenges we found with each.

- 90899, 99499, H0046 all of which are unlisted and not linked to time.
- 99446-99449 all of which are codes for physicians consulting with other professionals.
- H0023 which is for a targeted population (e.g. homeless)
- T2025 and T2026 which are specific to a clinic setting.
- 99368 does not address time under 30 minutes and requires a minimum of three qualified health care professionals from different specialties or disciplines.

  Note: Non face-to-face services would be billed with the U4 modifier.

R

RECOMMENDATION – What are you recommending, including any known timing that needs to be considered:

DHS is seeking the recommendation of the Medical Code Tag for an appropriate, applicable code for Mental Health Clinical Care Consultation. Discussion is necessary to develop a uniform billing method for this service.
Minnesota Statute indicates coverage of Mental Health Clinical Care Consultations is effective 7/1/2013, however, DHS must have federal approval first.
After federal approval, coding guidance should be added to the MN Community Coding Practice/Recommendation Table and subsequently the Minnesota Companion Guide (837P).

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide,

HCPSC/CPT manuals, etc. reviewed and considered during the discussion. **Medical Code TAG should also include the disposition/status for coding decision in its response and effective dates, when required. (For example, inclusion of the clarification of a current practice or coding changes/additions in the MCT Coding Recommendation Grid and MN Uniform Companion Guide or inclusion in the MCT Coding Recommendation Grid only.) Additionally, information from the MCT Decision Tree summary and findings should be reflected in the response as applicable.**
Date [SBAR Response Approved by TAG]: Reviewed by: [AUC TAG Name]: AUC Co-Chair(s): AUC Response:

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT

In 2013, the Minnesota Legislature enacted a statute (256B.0949) mandating an "autism early intensive intervention benefit" to children under age 18 with an autism spectrum disorder (ASD) diagnosis. This benefit has since been named the **Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit**. Minnesota's EIDBI benefit meets the Affordable Care Act (ACA) requirements and goes beyond the ACA in scope. While focused on early identification and early intervention, Minnesota's EIDBI benefit takes into account that many children are not identified until school age and later. Minnesota's EIDBI benefit expands the treatment modalities and recognizes the field of autism diagnostics and treatment is still emerging.

On July 7, 2014 CMS submitted an informational bulletin directing all states to provide medically necessary treatment for children with ASD consistent with provisions 1905 (a)(4)(B) for Early Periodic Screening Diagnosis and Treatment (EPSDT). This expands EIDBI service coverage to children up to 21 years of age and prevents targeting a specific population such as ASD. While most children receiving services in this benefit will have an ASD diagnosis, there are other children who may qualify for the benefit with a related condition, but won't have an ASD diagnosis.

Determination of medical necessity for the benefit will be made through a comprehensive multi-disciplinary evaluation (CMDE) and must include information from the child's primary physician. All treatment interventions will be authorized (via a service agreement).

The EIDBI benefit includes coverage with evidence development. DHS will collect and analyze individual outcome data to expand the evidence base leading to best practices and future policy development. Because of this, coding granularity is very important and the code/modifier combinations on the following pages were selected with that in mind. This is different than current coding where many services to children with ASD are billed under codes that do not provide this level of granularity (e.g. skills training). Code/modifier combinations must identify the exact service and who provided it. All providers will be enrolled.

Modifiers were chosen that will identify the service as EIDBI, identify the level of provider performing the service, and identify the type of treatment. The two types of treatment are Applied Behavioral Analysis (ABA) and Developmental and Behavioral Intervention (DBI).

Of note are the 7/1/14 CPT codes 0359T-0374T. These codes were not selected as they are specific to one type of treatment (ABA). The ABA community in Minnesota and nationally, currently has not supported the use of these codes. The codes are not reflective of the EIDBI benefit.

The following pages breakdown services for the EIDBI benefit into individual pages. Each of the 7 services has its own page.

1. Applied Behavioral Analysis (ABA) Intervention
2. Developmental and Behavioral (DBI) Intervention
3. Supervision of ABA or DBI Intervention
4. Comprehensive Multi-Disciplinary Evaluation (CMDE)
5. Individual Service Plan Development and Monitoring
6. Family Caregiver Training and Counseling
7. Coordinated Care Conference

APPLIED BEHAVIORAL ANALYSIS INTERVENTION

What is it?

ABA intervention is a structured program that includes incidental teaching techniques, environmental modifications and reinforcement techniques to produce socially significant improvement in behavior. ABA interventions increase positive behaviors and decrease negative or interfering behaviors to improve a variety of well-defined skills. ABA interventions tend to be skill based and data-driven with progress closely tracked and measured. ABA therapies include, but are not limited to, Lovaas, Discrete Trial Training, Verbal Behavior Intervention and Pivotal Response Training. This treatment may be individual or group.

Who Can Provide Service?

Qualified Supervising Professional (physician, mental health professional or APRN)
Developmental/Behavioral Professional (Board Certified Behavior Analyst or BCBA)
Developmental/Behavioral Practitioner (Board Certified Behavior Analyst Assistant or BCaBA)
Developmental/Behavioral Support Specialist (Registered Behavior Technician or RBT)

Where does Service Take Place

Home or Center-individual ABA intervention
Center-group ABA intervention

Selected Code Descriptions

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
HM Less than bachelor degree level

Coding Individual	Coding Group
96152/new ABA modifier- physician or APRN	96153/new ABA modifier-Physician or APRN
96152/new ABA modifier/HP-Doctoral level	96153/new ABA modifier/HP-Doctoral level
96152/new ABA modifier/HO- Master's degree level	96153/new ABA modifier/HO-Master's degree level
96152/new ABA modifier/HN-Bachelor's degree level	96153/new ABA modifier/HN-Bachelor's degree level
96152/new ABA modifier/HM-Less than bachelor degree level	96153/new ABA modifier/HM-Less than bachelor degree level

Notes:

This service requires a time based code. Treatment time can vary greatly. This is not a mental health service and therefore code selection was done with this in mind. We looked at CPT Assistant for background on the codes.

Per the March 2004 CPT Assistant, "From a CPT coding perspective, codes 96150-96155 are reported to describe those services performed to address difficulties associated with an acute or chronic illness, prevention of a physical illness or disability, and maintenance of health that do not meet criteria for a psychiatric diagnosis. Use of the health and behavior assessment codes eliminates inappropriate labeling of the patient as having a mental health disorder when the problem is actually a physical illness. It is important to note that the focus of these services is not on mental health but rather on the bio-psychosocial factors affecting physical health problems and treatments."

The above codes were chosen because CPT guidelines indicate they relate to the prevention, treatment, or management of physical health problems. Autism spectrum disorder (ASD) arises from a neurobiological condition. Per the Center for Medicaid and CHIP Services Informational Bulletin dated 07/07/14, "Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges". The majority of children served under this benefit will have ASD.

Other codes considered were: H2019 (description of services was not a good fit), H2027 (indicates mental illness), H2033 (description is confining and indicates juvenile), H2017 (description indicates mental illness and only part of description fits)

DEVELOPMENTAL AND BEHAVIORAL INTERVENTION

What is it?

Developmental and behavioral interventions are individualized treatment approaches based in developmental theory and behavioral science. DBI's are socially directed, highly engaging and capitalize on natural motivators to strengthen primary relationships and support child development. The interventions focus on joint attention, social engagement and reciprocity, social communication, behavioral regulation, cognition and play, to address the core deficits of ASD. Many current ASD treatment methods pull from a mixture of developmental and behavioral science, child development, psychology, speech pathology and occupational therapy and are not strictly "behavioral' or "developmental".

DBI therapies include:

* Developmental Individualized Relationship-based (D.I.R./Floortime)
* Relationship Development Interaction (R.D.I.)
* Early Start Denver Model (ESDM)
* Social Skills Interventions
* Play Based Interventions
* Parent Implemented Intervention (e.g. P.L.A.Y Project)

Who Can Provide Service?

Qualified Supervising Professional (physician, mental health professional or APRN)
Developmental/Behavioral Professional
Developmental/Behavioral Practitioner
Developmental/Behavioral Support Specialist

Where does Service Take Place

Home or Center-individual DBI
Center-group DBI

Selected Code Descriptions

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
HM Less than Bachelor degree level

Coding Individual:	Coding Group:
96152/new DBI modifier-Physician or APRN	96153/new DBI modifier-Physician or APRN
96152/new DBI modifier/HP -Doctoral level	96153/new DBI modifier/HP- Doctoral level
96152/new DBI modifier/HO -Master's degree level	96153/new DBI modifier/HO -Master's degree level
96152/new DBI modifier/HN -Bachelor's degree level	96153/new DBI modifier/HN -Bachelor's degree level
96152/new DBI modifier/HM -Less than bachelor degree level	96153/new DBI modifier/HM- Less than bachelor degree level

Coding Notes:

This service requires a time based code. Treatment time can vary greatly. This is not a mental health service and therefore code selection was done with this in mind. We looked at CPT Assistant for background on the codes.

Per the March 2004 CPT Assistant, "From a CPT coding perspective, codes 96150-96155 are reported to describe those services performed to address difficulties associated with an acute or chronic illness, prevention of a physical illness or disability, and maintenance of health that do not meet criteria for a psychiatric diagnosis. Use of the health and behavior assessment codes eliminates inappropriate labeling of the patient as having a mental health disorder when the problem is actually a physical illness. It is important to note that the focus of these services is not on mental health but rather on the bio-psychosocial factors affecting physical health problems and treatments."

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Other codes considered were: H2019 (description of services was not a good fit), H2027 (indicates mental illness), H2033 (description is confining and indicates juvenile), H2017 (description indicates mental illness and only part of description fits).

SUPERVISION OF ABA OR DBI INTERVENTION

What is it?

Supervision is the clinical direction and oversight by a qualified professional to a lower level provider based on the licensing or certification requirements regarding provision of EIDBI services to a child. Services that are otherwise covered as direct face-to-face may be provided via **two-way interactive video** if medically appropriate to the condition and needs of the recipient.

The supervising provider:

* Assumes professional responsibility for services provided, provides an integral portion of the services directly and is in compliance with the scope of practice that is applicable to their license or certification.
* Provides observation and supervision regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors and generalization of acquired skills for each child.
* Evaluates reviews and revises the child's individual treatment plan.

Who Can Provide Service?

Qualified Supervising Professional (physician, mental health professional or APRN)
Developmental/Behavioral Professional
Developmental/Behavioral Practitioner

Where does Service Take Place?

Home or Center-individual supervision
Center-group supervision

Selected Code Descriptions

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
GT via interactive audio and video telecommunications systems

Coding Individual	Coding Group
96152/new EIDBI mod/supervision mod-Physician or APRN	96153/new EIDBI mod/supervision mod-Physician or APRN
96152/new EIDBI mod/supervision mod/GT-Physician or APRN (telemedicine)	96153/new EIDBI mod/supervision mod/GT-Physician or APRN (telemedicine)
96152/new EIDBI mod/supervision mod/HP-Doctoral level	96153/new EIDBI mod/supervision mod/HP-Doctoral level
96152/new EIDBI mod/supervision mod/HP/GT-Doctoral level (telemedicine)	96153/new EIDBI mod/supervision mod/HP/GT-Doctoral level (telemedicine)
96152/new EIDBI mod/supervision mod/HO-Master's degree level	96153/new EIDBI mod/supervision mod/HO-Master's degree level
96152/new EIDBI mod/supervision mod/HO/GT-Master's degree level (telemedicine)	96153/new EIDBI mod/supervision mod/HO/GT-Master's degree (telemedicine)
96152/new EIDBI mod/supervision mod/HN-Bachelor's degree level	96153/new EIDBI mod/supervision mod/HN-Bachelor's degree level
96152/new EIDBI mod/supervision mod/HN/GT-Bachelor's degree level (telemedicine)	96153/new EIDBI mod/supervision mod/HN/GT-Bachelor's degree (telemedicine)

Coding Notes

This service requires a time based code. We had difficulty finding a code for supervision and had hoped not to use the above codes again, however, we couldn't find more suitable coding that described the service. The UA modifier is already defined for supervision, however, it is used in CTSS to indicate the CTSS benefit and this could be confusing. A modifier will need to be chosen for supervision.

COMPREHENSIVE MULTI-DISCIPLINARY EVALUATION (CMDE)

What is it?

This service determines medical necessity for the EIDBI benefit. Service could be done via **two way interactive video** if medically appropriate to the condition and needs of the recipient.

* Assessment of the child's degree of severity of core features of ASD as well as functional, cognitive, learning and play, social interactive, communication, adaptive, self-help, behavioral, motor skills and sensory regulatory needs and capacities.
* Review and incorporation of the autism diagnosis and other related assessment information from other qualified professionals.
* Assessment of type and level of parent/caregiver training preferred.
* Assessment of type and level of parent/caregiver involvement in treatment.
* Identification of current services the child is receiving and other needed services.
* Recommendation of treatment options, intensity, frequency and duration.
* Determination of how frequently to monitor the child's progress if monitoring is required more frequently than every 6 months.

Who Can Provide Service?

Mental Health Professional
Physician
APRN

Where does Service Take Place?

Center, clinic or office

Selected Code Descriptions

H2000 Comprehensive Multidisciplinary Evaluation
HP Doctorate Level
HO Master's Degree Level
GT via interactive audio and video telecommunications systems

Coding

H2000/new EIDBI modifier-Physician or APRN
H2000/new EIDBI modifier/GT-Physician or APRN (telemedicine)
H2000/new EIDBI modifier/HP-Doctorate level
H2000/new EIDBI modifier/HP/GT –Doctorate level (telemedicine)
H2000/new EIDBI modifier/HO- Master's degree level
H2000/new EIDBI modifier/HO/GT-Master's degree level (telemedicine)

INDIVIDUAL SERVICE PLAN DEVELOPMENT AND MONITORING

What is it?

A care consultant coordinates and integrates information from the CMDE process and develops the person and family-centered service plan.
The service plan will:

- Identify the level and type of parent involvement in child's treatment.
- Document treatment scope, modality, intensity, frequency and duration based on the CMDE recommendation.
- Integrate care and services across service providers to ensure access to appropriate and necessary care including medically necessary speech therapy, occupational therapy, mental health or special education service.
- Coordinate care conference including the initial CMDE medical necessity conference, re-evaluation, treatment modification and progress monitoring.

Who Can Provide the Service?

Qualified Care Consultant (e.g. case manager)
Qualified Supervising Professional (mental health professional or APRN)

Where Does the Service Take Place?

Center, clinic or office

Selected Code Descriptions

H0032 Mental Health Service Plan Development by non-physician
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level

Coding

H0032/new EIDBI modifier/new time based modifier/HP-Doctoral level
H0032/new EIDBI modifier/new time based modifier/HO-Master's degree level
H0032/new EIDBI modifier/new time based modifier/HN-Bachelor's degree level

Notes

This service needs to be time based. The code is not time based. The H0032 would be set on a 15 minute unit with a state defined U modifier (MCT approved a time based modifier for the H0032 earlier in the year for CTSS and ARMHS).

Qualified Supervising Professional above is different than Qualified Supervising Professional on other pages of this document. This service would not be performed by a physician, so "physician" was removed.

FAMILY/CAREGIVER TRAINING AND COUNSELING

What is it?

Family/caregiver training and counseling is specialized training and education provided to a family/caregiver. This training and counseling assists with a child's needs and development while educating and supporting families. Service could be done via **two-way interactive video** telecommunications if medically appropriate to the condition and needs of the recipient and family.

Who Can Provide the Service?

Qualified Supervising Professional (physician, mental health professional or APRN)
Developmental/Behavioral Professional
Developmental/Behavioral Practitioner

Where Does It Take Place?

Home or center-individual training and counseling
Center-group training and counseling

Selected Code Descriptions

T1027 Family training and counseling for child development, per 15 minutes
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
HQ Group setting
GT via interactive audio and video telecommunications systems

Coding Individual	Coding Group
T1027/new EIDBI modifier-Physician or APRN	T1027/new EIDBI modifier/HQ-physician or APRN
T1027/new EIDBI modifier/GT-Physician or APRN (telemedicine)	T1027/new EIDBI modifier/HQ/HP-doctoral level
T1027/new EIDBI modifier/HP-Doctoral level	T1027/new EIDBI modifier/HQ/HO-Master's degree level
T1027/new EIDBI modifier/HP/GT-Doctoral level (telemedicine)	T1027/new EIDBI modifier/HQ/HN-Bachelor's degree level
T1027/new EIDBI modifier/HO-Master's degree level	
T1027/new EIDBI modifier/HO/GT-Master's degree level (telemedicine)	
T1027/new EIDBI modifier/HN-Bachelor's degree level	
T1027/new EIDBI modifier/HN/GT-Bachelor's degree level (telemedicine)	

COORDINATED CARE CONFERENCE

What is it?

The coordinated care conference brings together the team of professionals that work with the child and family to develop and monitor the individual service plan. It assures that services are coordinated and integrated across providers and service delivery systems. Service could be done via **two way interactive video** telecommunications if medically appropriate to the condition and needs of the recipient.

Participants in the conference:

* Review the child's progress towards goals with the child's family.
* Describe treatment expectations across service settings.
* Direct and coordinate services provided to the child and family.

Who Can Provide the Service?

Qualified Supervising Professional (physician, mental health professional or APRN)
Developmental/Behavioral Professional
Developmental/Behavioral Practitioner
Qualified Care Consultant (e.g. case manager)

Where Does It Take Place?

Center, clinic or office

Selected Code Description

T1024 Evaluation and Treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter
HP doctoral level
HO Master's degree level
HN Bachelor's degree level
GT via interactive audio and video telecommunications systems

Coding

T1024/new EIDBI modifier-Physician or APRN
T1024/new EIDBI modifier/GT-Physician or APRN (telemedicine)
T1024/new EIDBI modifier/HP-Doctoral level
T1024/new EIDBI modifier/HP/GT-Doctoral level (telemedicine)
T1024/new EIDBI modifier/HO-Master's degree level
T1024/new EIDBI modifier/HO/GT- Master's degree level (telemedicine)
T1024/new EIDBI modifier/HN-Bachelor's degree level
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AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

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Section III

1. Provide an SBAR title for the issue you wish to have addressed.
2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

- **Situation**: Describe the type of problem or issue, e.g., coding or clarification/interpretation. What is the current business practice and why is it a problem or an issue? Would the continuance of the practice result in non-compliance of federal (e.g., CMS guidelines) and Minnesota administrative simplification rules and regulations?
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Step 3: Submit the completed SBAR(s) and MCT Decision Tree(s) to the AUC via email at: health.AUC@state.mn.us.

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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Section I – SBAR Status/Disposition information (To be completed by the Minnesota Department of Health)

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

Section II – Contact information (Person submitting the SBAR and/or Subject Matter Expert)

Contact Information for person completing this form:

Name: ANDREA AGERLIE
Title: Health Care Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Telephone: 651-263-6314

Organization Information:

Name: MINNESOTA DEPARTMENT OF HUMAN SERVICES
Address: 540 Cedar St. , St. Paul, MN 55164-0993

Complete for additional contact or Subject Matter Expert, as required:

Name:
Title:
Email address:
Phone number:

Section III – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title: MENTAL HEALTH SERVICE PLAN DEVELOPMENT

S

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

The 2013 Minnesota Legislature modified 256B.0943 to add a new covered service under Children's Therapeutic Services and Supports (CTSS) called Mental Health Service Plan Development. The definition of Mental Health Service Plan Development in 256B.0943, Subd. 1(p) is as follows:

(1) The development, review, and revision of a child's individual treatment plan as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and
(2) Administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures as required by the commissioner.

In addition to CTSS, DHS has determined there is sufficient funding allocated to provision of Adult Rehabilitative Mental Health Services (ARMHS) to provide payment for similar services.

Mental Health Service Plan Development applies to both fee-for-service and managed care.

B

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

CTSS and ARMHS providers have clear requirements for completion of an individual treatment plan as well as timelines for review and revision of the plan. Legislation requires both CTSS and ARMHS providers to engage in Functional Assessment and related outcome measurement. Prior to the 2013 legislative changes, however, these time intensive activities were not reimbursed.

A

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

Mental Health Service Plan Development will need to be split into two codes, one for the development, review and revision of the client's individual treatment plan (service plan development) and one for the administering of standard outcome measurements and reporting outcome measures (functional assessment). In addition, it is imperative the codes be defined with a time unit.

SERVICES TO BE CODED:

SERVICE PLAN DEVELOPMENT
CHILDREN:
* Treatment planning and review with family included
* Parent/legal guardian provides approval of individual treatment plan and any changes therein.

ADULTS:
* Treatment planning and review with or without family

FUNCTIONAL ASSESSMENT (AND OUTCOME MEASUREMENT)
CHILDREN:
* Strengths and Difficulty Questionnaire (SDQ)
* Child Adolescent Service Intensity Instrument (CASII) age 6-21 or Early Childhood Service Intensity Instrument (ECSII) under age 6
* Administration and reporting requirement at various intervals for the specified ages

ADULTS:
* Assessment covers 14 distinct domains of the clients functioning across different settings
* Assesses and identifies functional strengths and/or impairments.
* Clearly and concisely describes in narrative the individual's current status and level of functioning within each of 14 domains.
* Informs the Level of Care Utilization System (LOCUS) to help determine the resource intensity needs of individuals who receive adult mental health services.

For children, these services are completed by mental health professionals or clinical trainees. For adults, these services are completed by a practitioner, clinical trainee or mental health professional. Services can take place in a variety of settings, including but not limited to, clinic, school, home, community mental health center. Services are professional and will be billed on the 837p claim transaction.

CHALLENGES (the need for a time based code):
The needs and time involved in performing the above activities with adults differ markedly from performing these activities with children and their families.

* In general, adult mental health clients are their own legal guardians and they bear the responsibility and right to approve their own treatment plan, whereas clients under age 18 cannot provide approval for their own services. Due to work schedules, family situations or different treatment and legal requirements, Service Plan Development activities for children are more complex than adults.

* Requirements for adult Functional Assessment are greater (and take much longer to complete) than the requirements for children. The Functional Assessment and level of care determination for adults are greater than the requirements for Functional Assessment (outcome measurement) for children and adolescents (CASII, ECSII and SDQ).

	* Treating children with different diagnostic profiles can vary substantially from child to child, requiring varying resources and activities necessary to complete their Service Plan Development. * Providers are continually challenged to meet the needs of emerging immigrant populations as a response to Minnesota's diversifying demographics. Services to culturally and linguistically diverse individuals can vary widely due to complexity of language and cultural differences. Additional time may be needed to engage and thoroughly understand the individual's service needs. * Single, session-based codes for services that vary widely case to case and provider to provider will over compensate many providers and under compensate many others. The likely outcome is poorer treatment planning and monitoring than is warranted by the treatment needs of the specific client. Mental Health Service Plan Development applies to DHS fee-for-service and managed care. Discussion is necessary to develop a uniform billing method.
R	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: Pending federal approval, the effective date for coverage of these services will be 7/1/14. H0031 Mental Health Assessment, by non-physician H0032 Mental Health Service Plan Development by non-physician Both of the above codes seem to be a good fit for the description of services provided, but they are not time based. We have not found time based codes that address these services. We have found 9 states that cover these services using the H0031 and H0032. Seven of the nine states use a 15 minute unit for the codes. We would like to temporarily use these codes with a 15 minute unit and pursue establishment of two new time based codes through the Pilot Medicaid HCPCS Code Modification Request. I have spoken with a CMS regarding this situation. This process does not guarantee approval of new codes and is dependent upon other state involvement. The process also takes time and if establishment of new codes does take place, they would not be effective until 2015 at the earliest. We need a method to bill Mental Health Service Plan Development beginning 7/1/14.

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide, HCPSC/CPT manuals, etc. reviewed and considered during the discussion.

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Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

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SBAR ISSUE: Gambling Addiction Program

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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Short Title		Log No.	Date Closed
Status: Exec Review Date	Sent to TAG/WG	TAG Recommendation: _____ Accept _____ Reject	Decision to Originator

Section II – Contact information (Person submitting the SBAR and/or Subject Matter Expert)

Contact Information for person completing this form:

Name:RICHARD SCHERER

Title:BUSINESS MANAGER

Email address:richard@clubrecoveryllc.com

Telephone: 952.926.2526

Organization Information:

Name:CLUB RECOVERY, LLC

Address: 6550 YORK AVE SOUTH
SUITE 620
EDINA, MN 55435

Complete for additional contact or Subject Matter Expert, as required:

Name:

Title:

Email address:

Phone number:

Section III – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title:

S	SITUATION Beginning January 1, 2014, one Minnesota health plan started to deny all claims submitted for their subscribers who were participating in our Gambling Addiction Program because they were under the impression that the AUC (or other govt agency) indicated beginning January 1, 2014 H2020 with the Rev Code 0949 was no longer applicable or acceptable. Up to January 1, 2014, we had been submitting claims using the coding nomenclature of H2020 with the Rev Code 0949 with no claim issues. Similarly, this coding structure has been used with all others payer up until the last year. That being said, another health plan changed their coding structure in July 2013 from H2020 0949 to H0005 0949. A third health plan continues using the billing structure of H2020 (however, it must be noted it has all claims submitted as "Professional" and are submitted using HCFA 1500 claim structure and therefore no rev code is associated . What I am trying to ascertain is how can billing for this level of care become more uniform across payers as well as be coded "appropriately"
B	BACKGROUND Aspects of the background of this issue is noted above. Currently there are 4 different coding structures utilized by most of the local payers: H2035 HQ 0949 (maybe???), H2020, H0005 0949, and H2020 0949.

A	ASSESSMENT –One health plan reports they received a directive in changes to coding for Compulsive Gambling from the AUC and began rejecting claims submitted with the coding H2020 0949 January 1, 2014. Currently, we are attempting to rebill for all of those services with a new billing scheme of H2035 HQ 0949 yet the health plan also informed us that that coding structure would be rejected using the rev code 0949 and asked that we use 0944, 0945, or 0953. None of these rev codes would be appropriate and likely could be considered fraudulent coding by CMS (for any Medicaid (PMAP) or Medicare dollars used to make payment). Clearly, amongst the various payers it is apparent that there seems not to be a standardized coding structure to bill for Compulsive Gambling particularly in the group setting.
R	RECOMMENDATION – Similar to coding for chemical dependency, I ask if this committee can make recommendations that would identify a singular coding structure for billing Compulsive Gambling Disorder treatment. Please note, I would question if it is appropriate to use the HCPC code H2020 as an hourly code given it has been traditionally regarded as a per deim code. Therefore it may be necessary to be mindful of using these codes as globally defined. It may be the better part of valor to use H2035 HQ 0949 since it likely reflects more closely to changes in the DSM 5 as Compulsive Gambling is now defined under Addiction Disorders, similar to other substance abuse classifications in the DSM 5. That being said, H2035 is defined exclusively as a drug/alcohol treatment code. I am unaware of any issues of using the Rev Code 0949.

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Short Title		Log No.	Date Closed
Status: Exec Review Date	Sent to TAG/WG	TAG Recommendation: _____ Accept _____ Reject	Decision to Originator

Section II – Contact information (Person submitting the SBAR and/or Subject Matter Expert)

Contact Information for person completing this form:

Name: Sara Luther
Title: Regulatory and Reimbursement Manager
Email address: luther.sara@mayo.edu
Telephone: 507-284-5216

Organization Information:

Name: Mayo Clinic
Address: 200 First Street SW
Rochester, MN 55905

Complete for additional contact or Subject Matter Expert, as required:

Name: Kevin Meincke
Title: Revenue Analyst
Email address: Meincke.kevin@mayo.edu
Phone number: 507-284-1967

Section III – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title:

S	SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed): We are receiving conflicting information from payers on how to code for group therapy provided by a Certified Nurse Specialist (CNS).
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): Prior to January 2014 we had billed Health and Behavior codes for services by providers other than a Ph.D. Specifically CPT 96153 was billed for group therapy provided by a mid-level provider. After receiving guidance from CPT and Medicare our billing practices changed to bill 99499 for group therapy. This has resulted in payers indicating that the CPT is not specific enough and that they expect to see 96153 when group therapy is performed by a non-Ph.D.
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): CPT indicates that health and behavior assessment and/or intervention performed by a physician or other qualified

	health care professional who can report evaluation and management services should use E&M codes. Additionally, Medicare Contractor guidance states that Health and Behavior codes (CPT 96150-95154) can only be performed by a Clinical Psychologist. There is not a specific E&M code for groups. Therefore, 99499 has been utilized although payers are indicating that CPT 96153 should be used.
R	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: Consensus among payers to either allow Health and Behavior codes (96150-96155) to be utilized for group therapy by a mid-level provider (which is in conflict with CPT and the local Medicare Contractor) or a suggestion of another code, other than 99499, that will be accepted by payers within the state of MN for this service.

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide, HCPSC/CPT manuals, etc. reviewed and considered during the discussion.

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Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

National Government Services
Part B Provider
NGSMedicare News

Concurrent Care Processing Change for Evaluation & Management Services on the Same Date of Service

We have been working with several Jurisdiction 6 Part B providers to find a way to alter the initial processing of concurrent care evaluation & management (E&M) services that are done on the same day. Specifically, due to a change in the way healthcare is administered, several providers have asked if we can establish a method to initially identify and accept claims in which a non-physician practitioner (NPP) has performed an E&M service on the same day as an E&M service by a different physician in the same group.

We have researched this issue thoroughly and believe we have found a solution that will allow us to process NPP claims for E&M services when a physician from the same group has submitted an E&M on the same day. At this time, there will be no additional indication needed from the provider when submitting the E&M service that was performed by an NPP. This new process will begin Tuesday, 08/26/14. Any claims that have been processed prior to this date that you believe were not adjudicated properly will need to be appealed with the proper documentation.

This change does not override any duplicate logic that applies in the claims processing system. If a claim is submitted that contains the same current procedural terminology (CPT), date of service, group, and diagnoses-then the claim may still be subject to duplicate processing guidelines.

While we are changing the way the claims processing system will look at these claims on initial processing, the concurrent care guidelines do still apply. As such, please make sure your documentation in the patient's medical record supports that policy. If not, auditors may determine that the payment was not correct and request the claim be processed for a refund.

Concurrent care guidelines still apply and are listed below for reference:

- According to Medicare regulations, only one E&M service may be billed per day, per patient (The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 30.6, "Evaluation and Management Service Codes - General" [1 MB]).
- In some instances, physicians may see a patient multiple times on a given day, or in multiple settings. Except in rare circumstances outlined in the above manual section, only the highest level of E&M service

rendered on that date should be billed. For example, if a patient is examined in the office and later examined and admitted into the hospital, the physician would report the hospital admission as the E&M service rendered for that day.

- In the case of group practices, Medicare pays for one E&M visit in a day provided to a patient by the same physician or a member of the same group with the same specialty. If multiple visits are provided, the group should select a level of service representative of the combined visits and submit the appropriate code for that level. This does not apply to physicians who are in different groups or physicians in the same group with different specialties.
- A "different recognized specialty" refers to a subspecialty for which the physician has received formal additional training in a recognized program and for which there is generally separate board recognition rather than just additional experience in management/treatment of a particular condition or entity. For additional information on reporting and documenting E&M services, please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html.

Please also reference CMS IOM 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 30 (1 MB) which contains the Medical Policy for Concurrent Care services. For more information, please visit the Policy Education section of our website by clicking on Education & Training > Policy Education > Evaluation and Management.

Administrative Uniformity Committee

Speech Language Pathologists/VCD/PVFM

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH

Date Received	**Log No.**	**Date Closed**	
Status: Exec Review Date	**Sent to TAG/WG**	**TAG Recommendation:**	**Decision to Originator**
		_____ Accept	
		_____ Reject	

REMINDER: Submit the completed SBAR and MCT Decision Tree form via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert)
SBAR Short title:

Speech Language Pathologists/VCD/PVFM **Date:** 9/30/2014

Contact Information for person completing this form:
Name: Gail Cain
Title: Coding & Doc Auditor
Email address: gcain1@fairview.org
Telephone: 612-672-6696

Organization Information:
Name: Fairview Health Services
Address: 400 Stinson Blvd
Mpls., MN 55413

Complete for additional contact or Subject Matter Expert, as required:

Name: n/a
Title:
Email address:
Phone number:

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title: **Speech Language Pathologists/VCD/PVFM**

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

Speech Language Pathologists (SLP) are treating patients for Vocal Cord Dysfunction (VCD)/ Paradoxical Vocal Fold Movement (PVFM) by therapy. Below is a sample of the services being provided.

- We were able to change some breathing behaviors while she was attempting to become symptomatic; as inhalation was never problematic and she moved air freely whenever she stopped, it seemed apparent that there is no upper airway obstruction
- Techniques for abdominal relaxation during inhalation, to allow for maximum diaphragmatic descent
- Techniques for improved contraction of the external intercostals during inhalation, to allow for improved ribcage expansion.

  During this process, patient learned:

- To use abdominal relaxation and contraction of the external intercostals during inhalation, to allow for maximum diaphragmatic descent; I placed my hands on his abdominal area and lower ribcage to provide manual feedback for correct inhalation technique; she recognized that this was different
- To inhale on the contraction of a push-up, and on the relaxation of a sit-up, but to avoid holding his breath by initiating a strong Valsalva maneuver; I explained the anatomical/physiologic basis for this, which he found to be quite helpful; I also provided considerable manual feedback

  During this process, patient learned:

- To use abdominal relaxation and contraction of the external intercostals during inhalation, to allow for maximum diaphragmatic descent; I placed my hands on her abdominal area and lower ribcage to provide manual feedback for correct inhalation technique; she found this to be very helpful, and I taught her mother to provide the same manual feedback
- To maintain a high chest posture without shoulder or clavicular elevation during inhalation; she became aware of her propensity to use clavicular muscles, which increases the propensity for paradoxical vocal fold motion; she was able to reduce this propensity with practice today
- Moderate cues were provided to help relax her shoulders, while maintaining a high chest posture.
- To use oral configurations to improve the sensation of an open airway
- To concentrate on respiratory timing to ensure adequate inhalation and exhalation
- To use a mental checklist for self-monitoring her posture, muscle use, and breathing technique
- We completed her session by developing a written plan of care to facilitate practice at home.

I am unable to find corresponding HCPCS codes that describe this service provided by the SLPs. The service is hands on so it feels like physical therapy but it is being performed by SLPs.

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

Today the service is being coded using HCPCS 92524-GN *Behavioral and Qualitative Analysis of Voice and Resonance* for the evaluation and HCPCS 92507-GN *Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder, individual* for the therapy.
GN: Services delivered under an outpatient speech language pathology plan of care.

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

Challenges include the inability to find HCPCS codes that correspond to the service provided. I am not aware of any community standards.

R **RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered:

Recommendation for evaluation/therapy is unlisted code 92700 *Unlisted Otorhinolaryngological service or procedure.*

Speech Language Pathologists/VCD/PVFM

Medical Code TAG Decision Tree for Medical Coding Issues

Overview

This decision tree is a prototype decision tool to aid the AUC Medical Code TAG (MCT) in making decisions regarding medical coding issues. It consists of a series of three levels, as follows:

Level I. Prior to Medical Code TAG review

In Level 1 MDH staff collects SBARs or other inquiries regarding medical coding issues. The SBARs are forwarded to both the MCT and to the AUC Executive Committee for their review. SBARS are then added to the MCT project list to be addressed at future MCT meetings.

Level II. Determination as to whether Medicare applies

SBARs added to the MCT project list as stated in Level I above are reviewed by the MCT to determine whether Medicare coding instructions/requirements apply.

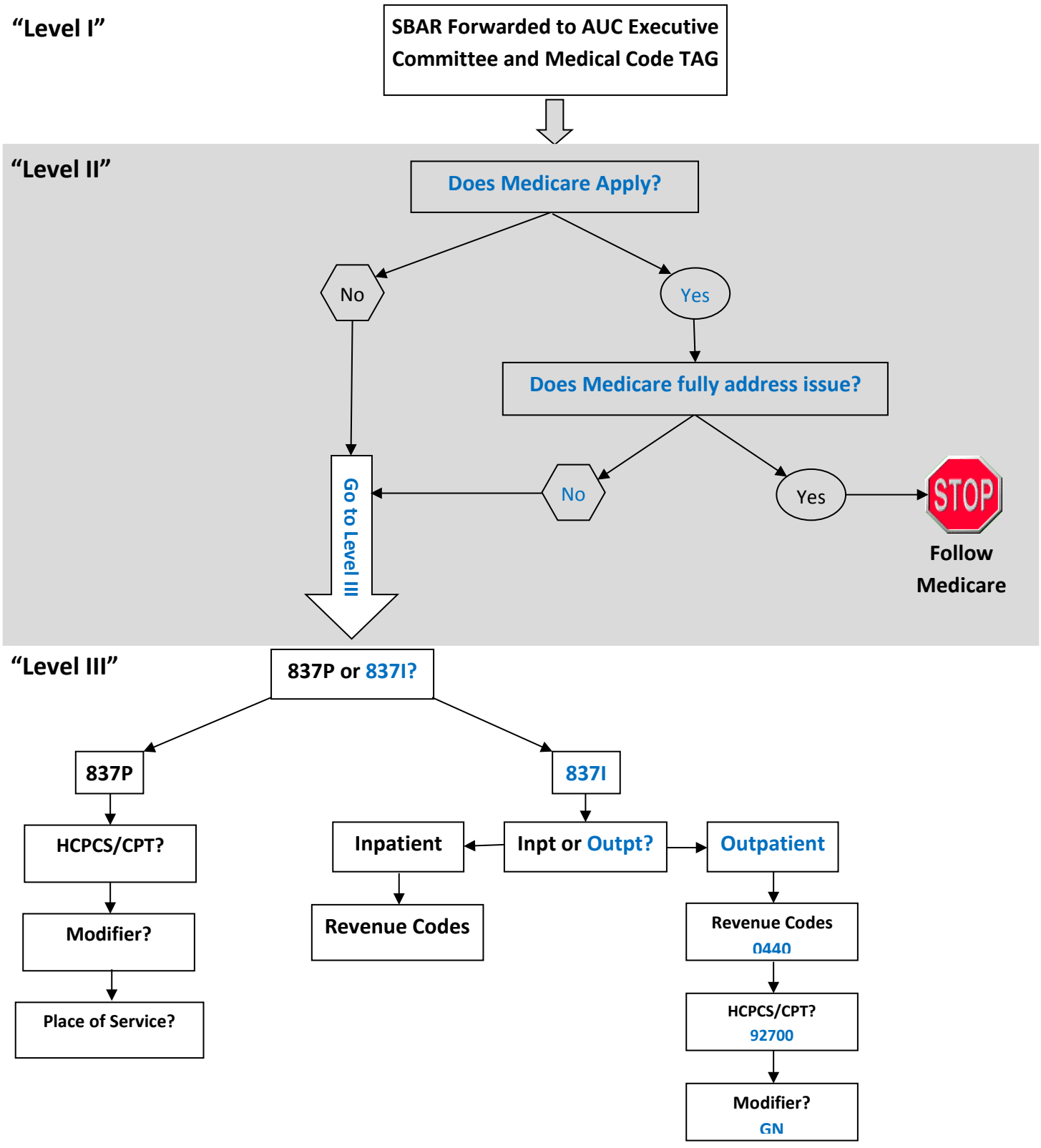
- If Medicare applies and there are no other concerns or perceived problems with Medicare coding (e.g., vagueness or possible confusion in Medicare instructions, Medicare does not fully address the service in question), the MCT recommendation will be to "follow Medicare" and the issue will be considered closed.
- If Medicare does not apply, or if there are concerns or perceived problems regarding Medicare's applicability to the situation or its instructions/requirements, the issue continues through Level III below.

Level III. Coding recommendation when Medicare does not apply or does not adequately address the issue

Level III is used for coding questions for which Medicare does not apply or does not adequately address the issue as described above. The MCT will then recommend coding to be used, based on a series of structured steps to determine the appropriate claim type(s), and possible HCPCS/CPT codes and modifiers, place of service, type of bill, revenue codes, and other coding characteristics as applicable and appropriate.

The MCT coding recommendation process above is presented schematically in the summary flow chart on the next page.

Illustrative Medical Code TAG (MCT) decision tree for medical coding issues



Note: Coding recommendations will include additional information as applicable regarding: provider type; effective date(s); and appropriate references to federal authority. The MCT will coordinate with the Claims DD TAG on place of service issues as needed. Final recommendations will also address revenue codes and type of bill for outpatient services, and type of bill for inpatient services.

Level II. Name/description of service/issue: Speech Language Pathologists/VCD/PVFM

Decision Tree Questions for Level II:

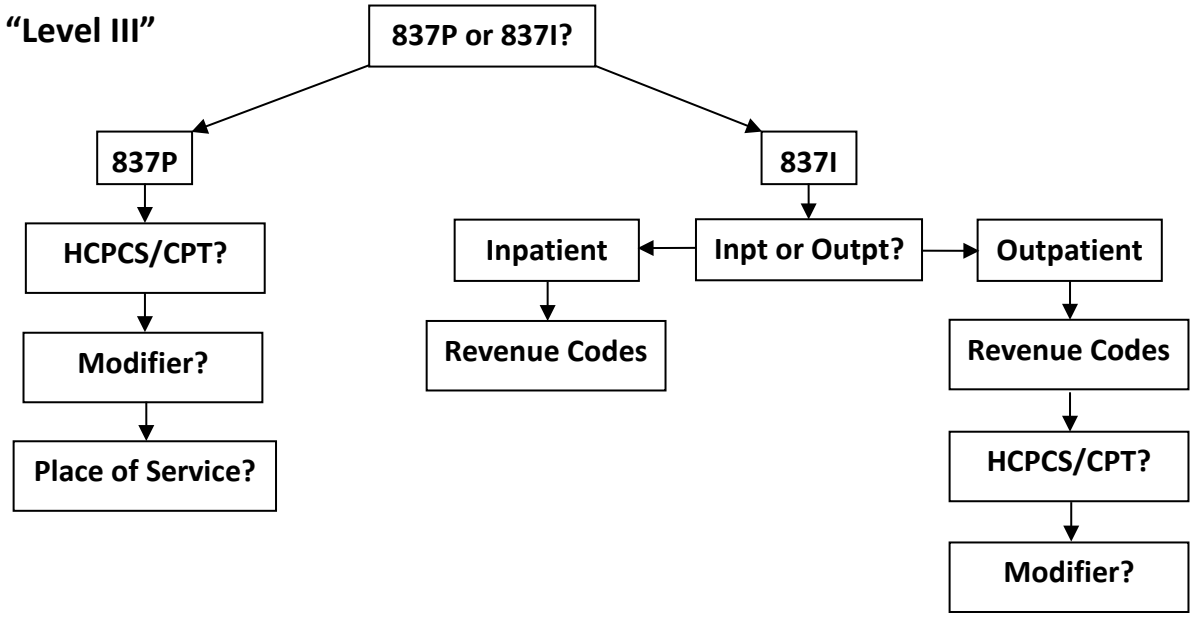
1. Does Medicare have coding requirements/instructions for coding the medical service/procedure/etc. of interest? If "yes," please reference the source of the Medicare instructions and provide a link. Then go to question 2 below.	
Yes ___	
No X__	Proceed to Question #3
2. Does Medicare's coding guidance fully address the issue?	
Yes ___	 Follow Medicare as referenced at the link in question no. 1 above.
No ____	If "no," please check any of the concerns below that apply and provide examples and complete questions 3-5. *a.* _____ More specific or appropriate codes are needed in order to reduce manual processing and administrative costs. *b.* _____ Duplicate codes exist and clarification of which code(s) to use is needed. Explain/provide examples: *c.* _____ Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits. *d.* _____ Other Explain/provide examples:
3. Is the service related to a statute or rule? If yes, please list and provide a link.	
Yes ___	
No _X__	
4. Include all health care professional types who may provide or bill for this service?	
Speech Language Pathologists	
5. Is the service billed on an 837 Professional or 837 Institutional transaction? Check all that apply.	
837P___	
837I_X_	
6. Does the code(s) need to be time-based? If yes, please indicate billing increments.	

Yes ___	
No _X__	
7. What HCPCS/CPT code(s) and modifiers are you recommending for the following? Cite source and provide link	
HCPCS/CPT	92700
Modifier(s)	GN
Place of Service	22

Speech Language Pathologists/VCD/PVFM

Application of MCT Decision Tree -- Level III – **TO BE COMPLETED BY MEDICAL CODE TAG**

Level III. Name/description of service/issue: Speech Language Pathologists/VCD/PVFM



Decision Tree Questions for Level III: TO BE COMPLETED BY MEDICAL CODE TAG

Speech Language Pathologists/VCD/PVFM

1. 837P or 837I?	
837P ___	If "837P," then go to question 2.
837I ___	If "837I," then go to question 5 below.
2. What are the HCPCS/CPT codes?	
HCPCS:	Cite source and provide link: Go to question 3
3. Are modifiers needed or applicable? Yes_____ No_____	
Modifier:	Cite source and provide link: Go to question 4
4. What is the place of service (POS)?	
POS:	Cite source and provide link:

Application of MCT Decision Tree -- Level III: **TO BE COMPLETED BY MEDICAL CODE TAG**

Level III. Name/description of service/issue: Speech Language Pathologists/VCD/PVFM

Decision Tree Questions for Level III:

5. 837I Inpatient or 837I Outpatient?	
Inpatient ____	If "Inpatient," then go to question 6 below.
Outpatient ____	If "Outpatient," then go to question 7 below.
Not Applicable ____	
6. What are the correct Inpatient Revenue Codes?	
Revenue code:	Cite source and provide link:
7. What are the correct Outpatient Revenue Codes?	
Revenue code:	Cite source and provide link:
8. What are the correct Outpatient HCPCS/CPT codes?	
HCPCS/CPT:	Cite source and provide link:
	Go to question 9
9. Are modifiers needed or applicable? Yes _____ No _____	
Modifier:	Cite source and provide link:

Summary of MCT findings and recommendations

Name/description of service/issue: Speech Language Pathologists/VCD/PVFM

Level III findings

Is the finding to follow Medicare?

_____ Yes (If yes, then stop. This is the finding/recommendation.)

_____ No (If no, go to phase III findings.)

_____ Other (Please see below)

Level III findings

Use the table below:

- If 837P go to Column A
- If 837I to Column B
    - If 837I Inpatient, go to Column B1
    - If 837I Outpatient, go Column B2

Summary of MCT findings and recommendations – Level III: **TO BE COMPLETED BY MEDICAL CODE TAG**

Name/description of service/issue: Speech Language Pathologists/VCD/PVFM

Coding Decision Recommendation (N/A = not applicable)	**A** **837P**	**B**	
		B1 **837I Inpatient**	**B2** **837I Outpatient**
HCPCS/CPT Source/Link			
Modifier Source/Link			
Place of Service Source/Link			
Revenue Code Source/Link			
Type of Bill Source/Link			
Decision applies to (who provides services)			
TAG Review Date			
Reference to state or federal authority			
Other notes, comments, instructions (recommendation statement, including issue being addressed)			

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

Instructions: Do not combine issues in a single SBAR. Complete a separate SBAR form for each individual issue that needs to be addressed. The completion of the AUC Medical Code TAG (MCT) Decision Tree is highly recommended prior to completion of the SBAR form(s). If completed, please submit the MCT Decision Tree form along with your completed SBAR.

Complete Sections II and III of the SBAR. Section I is to be completed by MDH staff and Section IV is to be completed by the AUC.

Medical Coding TAG Decision Tree Form

In order to streamline and expedite the SBAR review process, the AUC Medical Code TAG utilizes the MCT Decision Tree in its decision-making process for consideration of SBARs under the TAG's review. The MCT also requires SBAR submitters to use the form to ensure accurate and timely SBAR responses. The MCT Decision Tree form can be accessed from the AUC website at: http://www.health.state.mn.us/auc/forms.htm or by clicking on the link below in Step 1 below.

Step 1: Complete an MCT Decision Tree for each SBAR issue. Completing the MCT Decision Tree will enable a more thorough explanation of the SBAR issue(s) and prevent omission of critical or significant information.

Step 2: Fully complete Sections I and II. Incomplete or unclear analysis of the issue may cause unnecessary delay in the AUC response to the SBAR.

Section I

1. Provide contact information for person submitting the SBAR. Additional contact information may be required for the subject matter expert if different from the person completing the SBAR form.
2. The additional contact information is completed when the SBAR is being submitted on behalf of another individual who should also be notified of the AUC TAG meeting when the SBAR will be considered and who may or may not be a member of your organization.

   Please note: There may be a need to ask additional questions in order to clarify understanding of the issue as stated in the SBAR. The SBAR submitter and subject matter expert should be in attendance or available during the AUC TAG meeting and will be notified of meeting details at least one week prior to the SBARs' scheduled review date.

Section II

1. Provide an SBAR short title for your issue.
2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

   - **Situation**: Describe the type of problem or issue, e.g., coding or clarification/interpretation. What is the current business practice and why is it a problem or an issue? Would the continuance of the

practice result in non-compliance of federal (e.g., CMS guidelines) and Minnesota administrative simplification rules and regulations?

- **Background**: In explaining the pertinent history of the business practice, state how it is used within your organization or within the industry today. What is the negative impact of the business practice if not addressed by the AUC?
- **Assessment**: Be specific and provide as much detail you feel is required to convey or explain why this issue should be addressed by the AUC. How would a change to this business practice benefit health care administrative simplification in Minnesota?
- **Recommendation**: What are you proposing as the solution to this issue that will benefit the health care administrative simplification in Minnesota or improve standardization of the administrative simplification process in Minnesota?

Step 3: Submit the completed SBAR(s) and MCT Decision Tree(s) to the AUC via email at: health.AUC@state.mn.us.

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received	**Log No.**	**Date Closed**	
Status: Exec Review Date	**Sent to TAG/WG**	**TAG Recommendation:** **_____ Accept** **_____ Reject**	**Decision to Originator**

REMINDER: Submit the completed SBAR and MCT Decision Tree form via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert)

SBAR Short title: **IONM Clarification**	**Date:** **10/23/14**
Contact Information for person completing this form: **Name: Kandi Newton** **Title: Patient Account Rep – Physician Billing** **Email address: KandiNewton@gillettechildrens.com** **Telephone: 651-325-2115**	**Organization Information:** **Name: Gillette Children's Specialty Healthcare** **Address: 200 University Ave E, St Paul MN 55101**

Complete for additional contact or Subject Matter Expert, as required:

Name: Rochelle Hernandez
Title: Coder – Physician Billing
Email address: RochelleRHernandez@gillettechildrens.com
Phone number: 651-325-2196

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title: IONM Clarification

S	**SITUATION** – The industry is in need of a clarification regarding coding interpretation. Our business practice for procedure code 95940 is to bill units in 15 minute increments, as the CPT code description states, without a modifier. Our business practice for procedure code 95941 is to bill units in 1hr increments, as the CPT code description states, without a modifier. The problem we are having is that payers are inconsistent in what they require in order to process procedure codes 95940 and 95941. Some payers require modifier 26, which is not indicated in the Medicare Correct Coding Guide, other payers will not pay more than one unit of each code, and some payers will pay with modifier 59 for anything over one unit. It appears that payers requiring a modifier or that will not pay the billed units are non-compliant with CMS or standard coding rules.
B	**BACKGROUND** – Currently, when the monitoring of a patient is done in a one to one setting and the health care professional is in the operating room with the patient, we will bill service code 95940 (without a modifier) at a rate of one unit for every 15 minutes as long as there is one to one monitoring in the operating room. We will bill service code 95941 (without a modifier) when the health care professional is monitoring the operating room patient from outside the operating room. We bill at a rate of one unit for every hour as long as the patient is being monitored. Currently, when these claims are processed by the payer, there are inconsistencies regarding the required information needed to process the claims. If the AUC does not address this issue, the negative impact will be out of compliance payers and providers spending unnecessary resources to resolve claims with these codes. This could also encourage some providers to bill out of CMS compliance in an effort to receive claims payments.

A	**ASSESSMENT** – The challenges we face are inconsistent claims payment and denials due to the inconsistent interpretation of these procedure codes at the payer level. Any provider that monitors a patient in the operating room is impacted by these challenges. The health plans are also impacted as they are receiving claims and are not able to process them consistently, thus increasing inquiries. If the AUC clarifies the coding interpretation of these two codes, there will be increased efficiencies at the provider level and at the payer level. The provider would have the ability better utilize their resources and decrease the amount of time spent monitoring and following up on claims with these codes. It would also be beneficial to the payers as it would ensure compliance with CMS.
R	**RECOMMENDATION** – I am proposing a clarification for the billing of service codes 95940 and 95941. Specifically, answering the questions: 1. Do these codes require a 26 modifier? 2. When billing units are all units billed on one line or are there multiple lines with one unit each and a 59 modifier to indicate multiple units. By clarifying the coding interpretation of these two service codes, it will bring payers and providers in compliance with CMS and allow providers to better utilize their resources.

Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision:

Medical Code TAG Decision Tree for Medical Coding Issues

Overview

This decision tree is a prototype decision tool to aid the AUC Medical Code TAG (MCT) in making decisions regarding medical coding issues. It consists of a series of three levels, as follows:

Level I. Prior to Medical Code TAG review

In Level 1 MDH staff collects SBARs or other inquiries regarding medical coding issues. The SBARs are forwarded to both the MCT and to the AUC Executive Committee for their review. SBARS are then added to the MCT project list to be addressed at future MCT meetings.

Level II. Determination as to whether Medicare applies

SBARs added to the MCT project list as stated in Level I above are reviewed by the MCT to determine whether Medicare coding instructions/requirements apply.

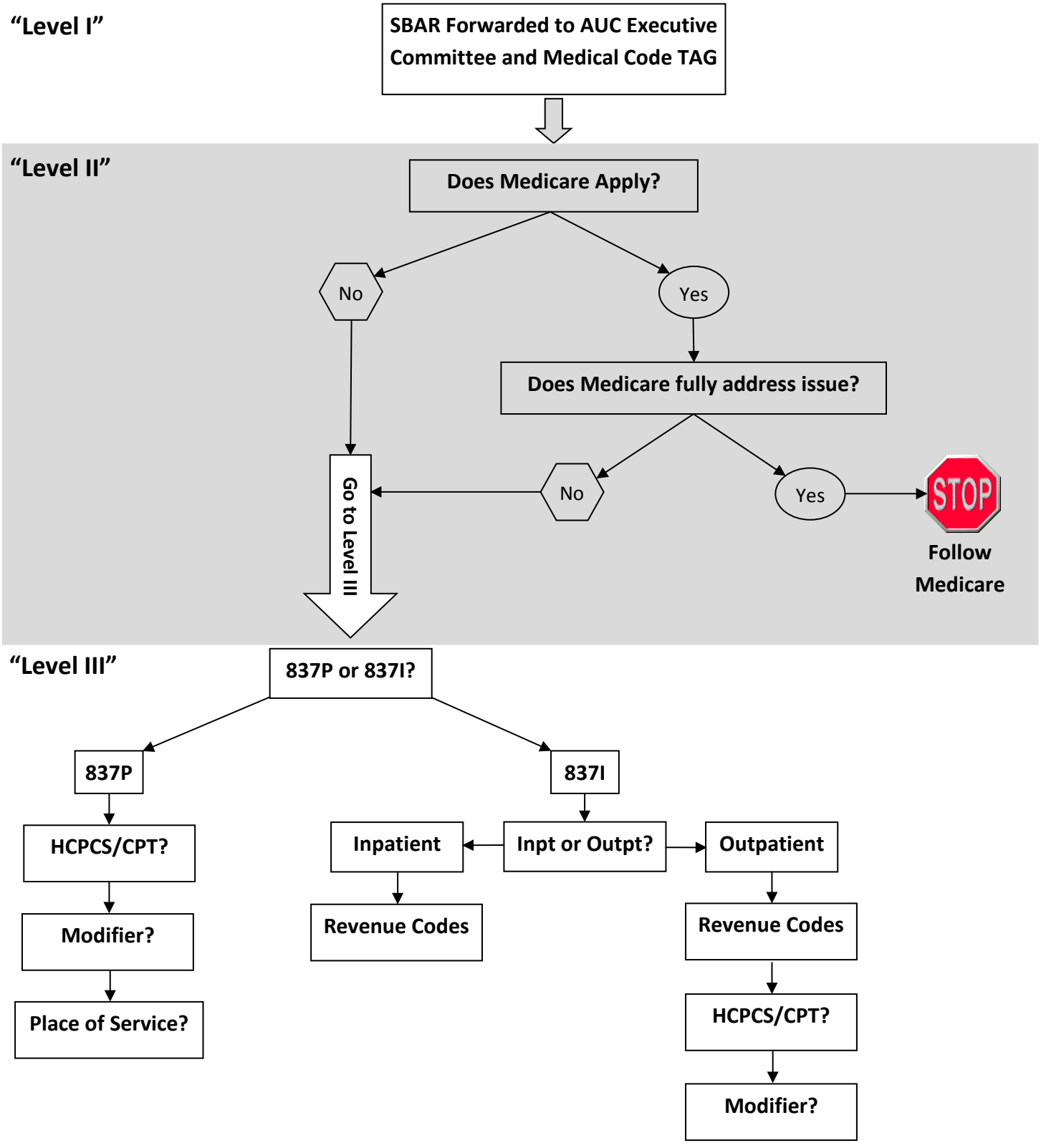
- If Medicare applies and there are no other concerns or perceived problems with Medicare coding (e.g., vagueness or possible confusion in Medicare instructions, Medicare does not fully address the service in question), the MCT recommendation will be to "follow Medicare" and the issue will be considered closed.
- If Medicare does not apply, or if there are concerns or perceived problems regarding Medicare's applicability to the situation or its instructions/requirements, the issue continues through Level III below.

Level III. Coding recommendation when Medicare does not apply or does not adequately address the issue

Level III is used for coding questions for which Medicare does not apply or does not adequately address the issue as described above. The MCT will then recommend coding to be used, based on a series of structured steps to determine the appropriate claim type(s), and possible HCPCS/CPT codes and modifiers, place of service, type of bill, revenue codes, and other coding characteristics as applicable and appropriate.

The MCT coding recommendation process above is presented schematically in the summary flow chart on the next page.

Illustrative Medical Code TAG (MCT) decision tree for medical coding issues



Note: Coding recommendations will include additional information as applicable regarding: provider type; effective date(s); and appropriate references to federal authority. The MCT will coordinate with the Claims DD TAG on place of service issues as needed. Final recommendations will also address revenue codes and type of bill for outpatient services, and type of bill for inpatient services.

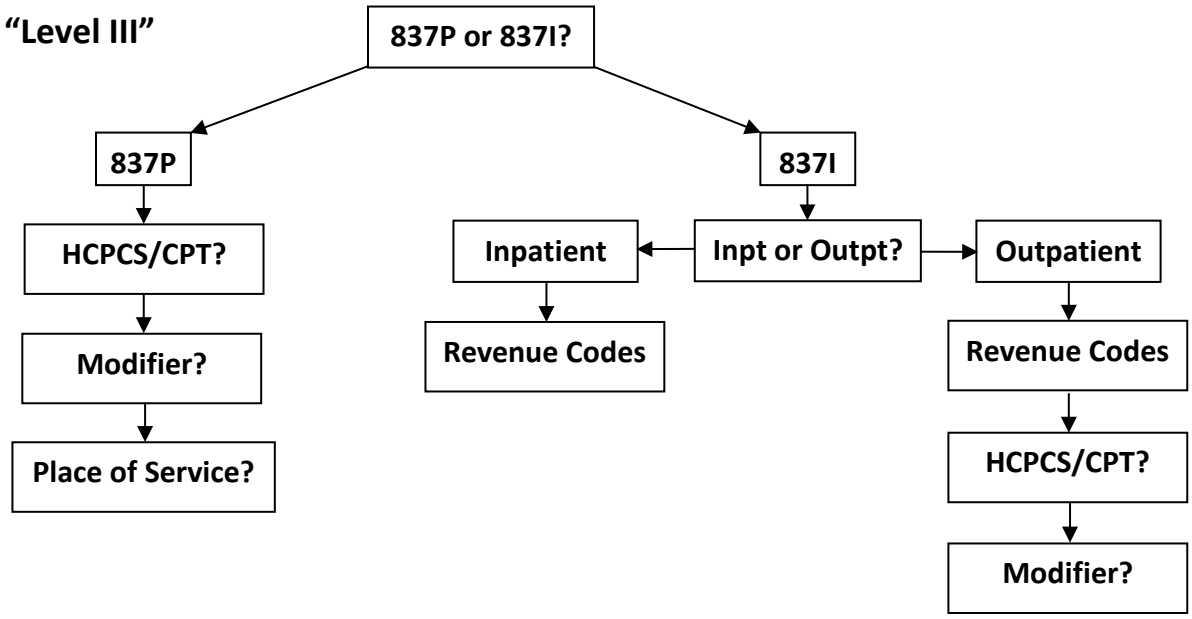
Level II. Name/description of service/issue: IONM 95940 and 95941

Decision Tree Questions for Level II:

1. Does Medicare have coding requirements/instructions for coding the medical service/procedure/etc. of interest? If "yes," please reference the source of the Medicare instructions and provide a link. Then go to question 2 below.	
Yes ___	
No _X__	Proceed to Question #3
2. Does Medicare's coding guidance fully address the issue?	
Yes ___	 Follow Medicare as referenced at the link in question no. 1 above.
No ____	If "no," please check any of the concerns below that apply and provide examples and complete questions 3-5. *a.* _____ More specific or appropriate codes are needed in order to reduce manual processing and administrative costs. *b.* _____ Duplicate codes exist and clarification of which code(s) to use is needed. Explain/provide examples: *c.* _____ Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits. *d.* _____ Other Explain/provide examples:
3. Is the service related to a statute or rule? If yes, please list and provide a link.	
Yes ___	
No _X__	
4. Include all health care professional types who may provide or bill for this service?	
Any provider that monitors a patient in the operating room	
5. Is the service billed on an 837 Professional or 837 Institutional transaction? Check all that apply.	
837P_X__	
837I___	
6. Does the code(s) need to be time-based? If yes, please indicate billing increments.	
Yes _X__	95940 is billed in 15 minute increments 95941 is billed in 1 hour increments
No ___	
7. What HCPCS/CPT code(s) and modifiers are you recommending for the following? Cite source and provide link	
HCPCS/CPT	95940 and 95941
Modifier(s)	We are not recommending any modifiers. The use of modifiers is not compliant with CMS or standard coding rules.
Place of Service	22

Application of MCT Decision Tree -- Level III – **TO BE COMPLETED BY MEDICAL CODE TAG**

Level III. Name/description of service/issue:



Decision Tree Questions for Level III: TO BE COMPLETED BY MEDICAL CODE TAG

1. 837P or 837I?	
837P ___	If "837P," then go to question 2.
837I ___	If "837I," then go to question 5 below.
2. What are the HCPCS/CPT codes?	
HCPCS:	Cite source and provide link: Go to question 3
3. Are modifiers needed or applicable? Yes_____ No_____	
Modifier:	Cite source and provide link: Go to question 4
4. What is the place of service (POS)?	
POS:	Cite source and provide link:

Application of MCT Decision Tree -- Level III: **TO BE COMPLETED BY MEDICAL CODE TAG**

Level III. Name/description of service/issue:

Decision Tree Questions for Level III:

5. 837I Inpatient or 837I Outpatient?	
Inpatient ____	If "Inpatient," then go to question 6 below.
Outpatient ____	If "Outpatient," then go to question 7 below.
Not Applicable ____	
6. What are the correct Inpatient Revenue Codes?	
Revenue code:	Cite source and provide link:
7. What are the correct Outpatient Revenue Codes?	
Revenue code:	Cite source and provide link:
8. What are the correct Outpatient HCPCS/CPT codes?	
HCPCS/CPT:	Cite source and provide link: Go to question 9
9. Are modifiers needed or applicable? Yes _____ No _____	
Modifier:	Cite source and provide link:

Summary of MCT findings and recommendations

Name/description of service/issue: _____

Level III findings

Is the finding to follow Medicare?

_____ Yes (If yes, then stop. This is the finding/recommendation.)

_____ No (If no, go to phase III findings.)

_____ Other (Please see below)

Level III findings

Use the table below:

- If 837P go to Column A
- If 837I to Column B
    - If 837I Inpatient, go to Column B1
    - If 837I Outpatient, go Column B2

Summary of MCT findings and recommendations – Level III: **TO BE COMPLETED BY MEDICAL CODE TAG**

Name/description of service/issue: _____

Coding Decision Recommendation (N/A = not applicable)	**A** **837P**	**B**	
		B1 **837I Inpatient**	**B2** **837I Outpatient**
HCPCS/CPT Source/Link			
Modifier Source/Link			
Place of Service Source/Link			
Revenue Code Source/Link			
Type of Bill Source/Link			
Decision applies to (who provides services)			
TAG Review Date			
Reference to state or federal authority			
Other notes, comments, instructions (recommendation statement, including issue being addressed)			

Volume 2 Number 11

AUC Update

December 23, 2014

The AUC Update is published monthly and provides news and updates regarding the Minnesota Administrative Uniformity Committee (AUC) and Minnesota's health care administrative simplification initiative pursuant to Minnesota Statutes, section 62J.536 and related federal and state regulations. The Minnesota Department of Health (MDH) administers MS §62J.536 and publishes this newsletter in association with the AUC.

More information about the AUC is available at: AUC home page.

Inside this issue:

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Comings …

Welcome Tony Rinkenberger as New AUC Provider Co-Chair

Congratulations and welcome to Tony Rinkenberger, who was elected as AUC Operations Committee Provider Co-chair for 2015 via a recent email vote.

Tony is currently the Director, Revenue Cycle Services for Ridgeview Medical Center, Waconia, MN. He has over twenty years of health care revenue cycle management experience, and is a speaker and author for organizations such as American Association of Healthcare Administrative Management (AAHAM), Minnesota HFMA, and Northwest Dentistry.

The AUC's committee of the whole, the Operations Committee, develops strategies and priorities, new administrative uniformity opportunities, and makes recommendations. The Committee is led by co-chairs, which alternate annually between provider and payer organizations. Tony's duties will include serving on the AUC Executive Committee starting in 2015, and as the Operations Committee "co-chair in waiting" to assume the co-chair role in 2016.

For more information about the co-chair elect position, please see the "Minnesota Administrative Uniformity Committee (AUC) Mission Statement, History and Governing Principles" and/or contact the current Executive Committee members or MDH staff. A new "AUC Handbook" is now also available with a brief introduction and background on the AUC. (The handbook can be found in the "About" section of the AUC homepage.)

And Goings ….

Long time AUC member and TAG Chair Ed Stroot Announces His Retirement

At the conclusion of the December 9, 2014 AUC Operations meeting Ed Stroot, co-chair of the Eligibility TAG, announced that he is retiring in January and that the December meeting was his last as an AUC member. Ann Hale, AUC Co-chair, noted that Ed has been a key player in administrative simplification in and outside of the AUC, and has played several roles, including Operations Chair, TAG chair, and key contributor. Ann thanked Ed for his participation, and noted that AUC will miss him for his humor, expert knowledge, and valuable contributions.

Ed's humor was evident in a follow up email to several other long time AUC members in which he wrote:

"…Here is an abbreviated transaction that explains my announcement:

ST*834*0001~
INS*Y*18*024*04*A***RT~
DTP*286*D8*20150115~
NM1*IL*1*STROOT*EDWARD~
SE*5*0001~

Ed supplied a translation for message above, which is that he is retiring next month and that his last day with his employer, PreferredOne, will be January 15, 2015.

Ed also wrote: "The past 19 years of working towards administrative simplification has been exciting and excruciating; and we have made tremendous progress (remember the NSF format?). It has been a privilege to work with all of you and I wish you continued success."

Limited Exception for Non-HIPAA Payers from Electronic Exchange of Eligibility Transactions (270-271) is Continued For 2015

Each year MDH consults with the Eligibility TAG and the AUC Operations Committee regarding continuation of a current very narrow exception from state requirements to exchange the 270-271 eligibility inquiry and response transaction that was granted per state statute to payers not subject to federal HIPAA regulations.

The TAG examined the issue and recommended continuation of the current targeted exception because the version of the 270-271 adopted pursuant to the federal Health Insurance Protection and Portability Act (HIPAA) does not fully meet the business needs of non-HIPAA covered entities.

The AUC Operations Committee reviewed the TAG's recommendation and also voted recently to continue the exception. MDH considered the AUC's recommendations and announced on December 15 that the exception will be continued.

The exception for 2015 applies only to exchanges of the ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270-271) with health care group purchasers not subject to federal HIPAA transactions regulations. All other requirements of MS §62J.536 remain in force.

MDH's announcement will also be published in the State Register on December 29, 2014. The next annual review of this exception to rules adopted pursuant to Minnesota Statutes, section 62J.536 is scheduled for October 2015.

Update: Minnesota Uniform Companion Guide Annual Maintenance

Each year the AUC and MDH review Minnesota Uniform Companion Guide (MUCG) rules for any changes or updates needed to ensure that the Guides remain accurate and relevant. Below is a table summarizing the current status of the annual Guide maintenance.

Companion Guide(s): 270/271 and 835

Maintenance Status: *Final Rules for Most Recent Changes Being Developed*

The Eligibility and EOB/Remit TAGs completed their annual reviews of the 270/271 and 835 MUCGs respectively earlier this fall and suggested revisions to correct previous errors and to ensure that the guides remained current. An announcement of proposed updates and corrections for each of the companion guides and the start of a 30-day public comment period regarding the proposed changes was published in the November 10, 2014 State Register. Following the conclusion of the public comment period, the comments received were reviewed for any further possible changes to the guides. Final changes (a final rule) will be submitted in the near future to AUC Operations for a vote and then published in the State Register.

Companion Guide(s): 837I, 837P, 837D

Maintenance Status: *Proposed Changes Now in 30-Day Public Comment Period*

The Claims DD and Medical Code TAGs reviewed the 837 claims MUCGs earlier this fall as well, and suggested revisions to correct previous errors and to ensure that the guides remained current. The TAG's recommendations were approved via an email vote by AUC Operations. MDH reviewed the AUC's findings and recommendations, and published a notice in the State Register on December 15, 2014 of the proposed changes. The notice also announced the start of a public comment period ending January 22, 2015.

AUC Technical Advisory Group (TAG) Updates

Information about AUC committees and TAGs and their activities can be accessed from the AUC TAG page and by clicking on the TAG or committee name in the following article(s).

With the exception of the Medical Code TAG, all TAG meetings are generally conducted via teleconference rather than in-person. All AUC meetings are open, public meetings. Meeting agendas and other materials are posted on the AUC website in advance of meetings. TAG meeting schedules and information are also available on the AUC calendar page http://www.health.state.mn.us/auc/calendar.htm).

Operations Committee

The AUC's committee of the whole, the Operations Committee, met December 9, 2014 at its regularly scheduled quarterly meeting to briefly review the past year, wrap up several issues, and to set the stage for additional discussions for 2015 goals and priorities.

Highlights of the meeting included:

- MDH's brief review of 2014, which noted despite the uncertainties of "on again, off again" delays in implementing the ICD-10 coding system and federal enforcement of rules regarding Health Plan Identifier (HPID), the AUC accomplished a number of important goals, including: its annual reviews and updates of Minnesota Uniform Companion Guides; and adoption of best practices to meet federal regulations that providers be informed of patients who had missed payments of their subsidized Health Insurance Exchange coverage premiums, and who were receiving a special 90 day grace period to make the missed premium payments.
- A brief report on an item brought to the AUC Executive Committee, seeking a venue for broader discussion of the need for standard data analytics from health care payers to providers operating under Accountable Care

Organization (ACO) models. After discussion with MDH and the Minnesota Department of Human Services (DHS), it was agreed that the most appropriate venue for the discussion at this time is another existing health care advisory group, the Data Analytic Subgroup. The Subgroup was convened as part of Minnesota's State Innovation Model (SIM) grant, a $45 million, three-year federal grant to test new ways of delivering and paying for care based on the Minnesota Accountable Health Model Framework (ACO model). The AUC will continue to monitor the ACO data analytics issue in 2015.

- A brief report and update regarding steps that will be taken to submit an AUC response to a national Committee on Operating Rules for Information Exchange (CORE) solicitation for changes or additions to "business scenarios" adopted as part of federal operating rules for the health care claim/payment advice (remittance advice, 835) transaction. In particular, the AUC EOB/Remit TAG will be preparing a submission to CORE recommending that a part of the 835 MUCG – specifically the CARC/RARC usage for "Table A-1" -- be adopted by CORE as an additional business scenario.
- A brief summary of an industry-wide symposium hosted jointly by the MDH and the Department of Labor and Industry (DLI) on November 5. The purpose of the symposium was to identify challenges and obstacles to health care business "e-transactions" for workers' compensation, and to begin exploring possible solutions. The symposium was well received and led to three recent presentations with national audiences regarding the symposium findings. MDH and DLI are reviewing the symposium discussions and presentations to the national groups above in planning possible follow-up and next steps.

A detailed summary of the meeting will be available at the Operations Committee meeting information page.

Executive Committee

The Executive Committee met December 1 and discussed:

- Status updates regarding annual maintenance of Minnesota Uniform Companion Guides;
- The ACO data analytics discussion issue noted in the Operations Committee meeting summary above
- Preliminary planning for the Operations meeting December 9, including: recruiting nominations for a provider co-chair; AUC Wrap up and Review of 2014 and AUC accomplishments; status of implementation of HIX grace period notification; ACO data analytics update; Worker's Comp e-transaction symposium update and next steps; remittance advice business scenario and related CARC/RARC codes submission to CORE; and 2015 planning.

Medical Code TAG

The Medical Code TAG met December 11. The TAG:

- Agreed to research any further possible proposed changes to the claims (837I, P, and D) companion guides for submission during the public comment period December 22, 2014 – January 22, 2015;
- Discussed coding for autism services and plans for follow-up to obtain additional information and clarifications as needed;
- Received an update regarding additional coding specificity for "Mental Health Clinical Care Consultation" services;
- Received other coding updates and briefly discussed several other coding issues.

Claims DD TAG

The Claims DD TAG met December 3. After canceling several meetings in 2014 due to limited agenda and participation, the TAG discussed whether to continue as a standing TAG, and if so, to develop a tentative meeting schedule and topics for 2015.

The TAG felt that it was important to continue meeting as a standing TAG, and it set the following initial priorities for 2015:

- Help address challenges to workers' compensation e-transactions that were identified at a recent symposium on the same topic;
- Undertake annual companion guide maintenance during an earlier timeframe;
- Be ready to assist on ICD-10 questions and implementation as needed;
- Consider reviewing a new bill type frequency code for the institutional claim and other issues as needed.

The TAG also set 3 tentative meeting dates: February 4, April 8, and June 10.

Upcoming TAG meetings January – February 2015

(For additional information, see the AUC Calendar)

Date/Time	Event
January 5	Executive Committee Meeting
January 8	Medical Code TAG Meeting
January 20	EOB/Remit TAG Meeting
February 2	Executive Committee Meeting
February 4	Claims DD TAG Meeting
February 12	Medical Code TAG Meeting
February 17	EOB/Remit TAG Meeting

12/11/14 minutes:

7. Mental Health Clinical Care Consultation - DHS	• See MINNESOTA STATUTES 2013 256B.0625. Approved by CMS January 2015. The statute indicates these services are for patients up to age 21. • The approved coding is: 90899-U8 (5-10 minutes) 90899-U9 (11-20 minutes) 90899-UB (21-30 minutes) 90899-UC (31+ minutes) • Additional modifiers could be appended, such as U4 for phone and/or HN for clinical training. • This guide will be added to the MN Uniform Companion Guides during the comment period.	**CLOSED**

8/26/14 Minutes:

7. MN Uniform Companion Guide Updates	Changes to the 837P and 837I were recommended as follows: 1. <u>CTSS table revisions in 837P and 837I:</u> ▪ Delete: H2012 UA – Behavioral health day treatment, per hour, therapeutic components of preschool program, 60 minutes, CTSS ▪ Add: 99354 UA – Prolonged service code for psychotherapy services (add-on to 90837); 90839 UA - Psychotherapy for crisis; 90840 UA ▪ Format CTSS table to mirror DHS website listing for CTSS billing 2. Delete repeat services code Modifier 77 in 837P and 837I MCT completed revisions of Appendix A in the 837P and 837I companion guides. MDH stated the goal is to have guides approved by TAGs in time for Ops vote at their next meeting, which will be held September 16, 2014 meeting. Would like to have members at least a week to review the updated guides prior to requesting their vote.	MDH will format CTSS table in companion guide to mirror DHS website. **OPEN for final review and vote.**

Comment [MN1]: Did not complete the descriptions for these new codes because decision was made to mirror DHS website

Comment [MN2]: Faith, Andrea is confirming these new codes; they are not posted on DHS website or in their provider manual. They were listed in a rates documents; so, not sure how they should be documented in minutes since the minutes are incomplete…

10.Health Care Home Guide Clarification – Gail Cain, Fairview	Healthcare Home guide clarification – Community work group got together and determined coding and it is the codes that are in the companion guide. CMS healthcare homes direct use policy POS 99. The companion guide does not mention a required POS. Close issue. Deb will forward document.	**CLOSED**

8/14/14 Minutes:

7. MN Uniform Companion Guide Updates	Changes to 837P: • *Table A.5.1, Chapter 16, Laboratory services, repeat services:* After discussion it was agreed not to add modifier 77. The words "pathology only" were added in parentheses after "Modifiers 76." The words "clinical diagnostic lab" were added in parentheses after "or 91." Changes to 837I: • *Table A.5.1, Chapter 4, Part B Hospital (Including Inpatient Hospital Part B and OPPS, Modifiers 76 or 91:* The title was changed to include "77." The rule was also changed to add "77." [Note: Following discussion regarding modifier 59, Deb Sorg will further research the 837I issue of repeat services modifiers.] • A footnote referencing CPT on page 25 was removed. DHS will review the mental health sections of the 837I and 837P for any possible changes, including whether H2012 UA is still being used for CTSS. Any changes will apply to 837P and 837I Guides (Andrea, Kathy and Cindy will work on this) In conjunction with reviewing the companion guides, the MCT also reviewed the coding clarification grid and made the following changes: • *Chapter 12, Physician/Non-physician Practitioner Billing, Autism Spectrum Disorder:* Code "G2012" was corrected to "H2012" • *Chapter 12, Physician/Non-physician Practitioner Billing, In-reach Community Based Coordination:* Deleted from grid (it is now in the companion guides) • *Chapter 12, Physician/Non-physician Practitioner Billing, Collaborative Psychiatric Consultation:* To be deleted when latest revisions of companion guides are approved (this entry will be included in the companion guides)	**OPEN**

	• *Chapter 15, Ambulance, Community Paramedics:* Deleted from grid (it is now in the companion guides) • *Chapter 16, Laboratory Services, Reporting Newborn Screening:* Deleted from grid (it is now in the companion guides) • *Chapter N/A, A.5.3 Substance Abuse Services, Substance Abuse Services:* To be deleted when latest revisions of companion guides are approved (this entry will be included in the companion guides) • *Chapter N/A, N/A, MAT (Medicated Assisted Treatment) Billing – Methadone vs. Other*: Deleted from grid (it is now in the companion guides.)	

10.Health Care Home Guide Clarification – Gail Cain, Fairview	Deb Sorg will pull documents from previous work on health care homes to see if there was a recommendation for POS. There was a brief discussion regarding the significance of the companion guides being silent on an issue. Generally, unless the guides state otherwise, the default is to "follow Medicare" as well as to follow HIPAA coding.	**OPEN**

7/22/14 Minutes:

8. MN Uniform Companion Guide Updates	Ops is meeting September 16. Materials for discussion need to be sent to Ops one –two weeks prior to the meeting. So we need to finish and send our guides to Ops by the end of August. DHS mental health and foster care changes will not be published until approved by CMS. **Page 32**: Chapter 16 Laboratory Services – Repeat Services. Questions regarding billing for repeat lab services due to bills being denied. Should a modifier 77 be used (should 77 be added to guide)? Is 77 an appropriate code? For lab services, is code 76 or 91 okay for repeat services? Separate lab tests performed in ER on same day patient came from different facility (e.g. clinic or urgent care) Mary Kay Edwards reported that if a patient comes to Children's from another facility	**OPEN** TAG members will check to see if modifier 77 is being accepted for professional and institutional claims – Report at next meeting

	(such as clinic or urgent care) they use 77 for the repeated lab test (the initial test was done at the other facility). The 91 is used for repeats within same facility. Tentatively, modifier 77 will be added but all members are asked to review their policies. Change to guide: Delete footnote 5 and add "current" to second sentence: *The number of units reported is the number of services performed as defined in the code description or relevant, **current** AMA guidelines in CPT*. **Page 28**: Chapter 12 – Physicians/Non-physician Practitioners – Collaborative Psychiatric Consultation – Divided APRN or consulting psychologist into four separate entries, illustrating coding for the APRN and Psychologist	

6/24/14 Minutes:

9. MN Uniform Companion Guide Updates	The MCT began its first review of the proposed revised Coding Recommendation Grid (grid) and the annual maintenance of the current 837P and 837I companion guides (Appendix A) to determine required changes to both documents. The MCT discussed and agreed upon the following recommended changes: **Grid revisions**: Chapter 12 Physicians/Non-physician Practitioners 1. Moving Home Minnesota – • Revise table and put in alpha order by code and by U modifier. • Update the health club membership with the U5 modifier and new description for the entry to read: S9970 U6 U5 health club membership, monthly, MFP • Add "U5" to list of U modifier definitions • Update MCT approval date in C : 6/23/14 2. Collaborative psychiatric consultation • Revise line item A to include ~~d~~ (Minnesota Statutes 256b.0265, subd. 48 – Psychiatric consultation to primary care practitioners) • Revise line item B instructions to code 99499 for specific consultations; add new non-physician practitioners:	**OPEN**

	• Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist (APRN or psychologist) for an opinion or advice regarding a patient should be reported using 99499 as follows: • *Consulting APRN (certified in psychiatric mental health) or psychologist – 99499 HE AM* • *Consulting APRN (certified in psychiatric mental health) or psychologist – 99499 HE AM U4 (non-face-to-face)* 3. Add new subtopic entry: Bilateral billing requirements for CPT Code 69210 4. A.5.3. Substance Abuse Services • Revised line item B: *Replaced Claim Type 837P grid with sentence: MAT take home doses place of service (POS) guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.* • Added line item E: *Proposed as an addition to next version of 837P and 837I companion guides* 5. Add new subtopic entry: Birth Centers **837P companion guide**: 1. P. 28 – Collaborative psychiatric consultation: Transferred coding description and new non-physician practitioners' codes as outlined in coding recommendation grid above. 2. P. 38 – Licensed Traditional Midwife Services (Not Certified Nurse Midwives): • Under Place of Service, second paragraph, second sentence: replace "office" with "birth center". **837I companion guide**: P. 31 – Freestanding Birth Centers: Added additional sentence in the Notes section to clarify Revenue Code 0724 Birthing Centers, "*There is no room and board charge for the mother and/or the baby*."	

6/12/14 Minutes:

3. Review of last meeting's Minutes	Minutes were approved with the changes to the following Agenda items: #7- Changes to second paragraph -Corrected modifiers description from U4 for phone to U4 for non-face-to-face	Minutes will be sent to MDH for posting on AUC MCT website

	HN for clinical training to HN for clinical trainee #9- Changes to third paragraph – Deleted 55 and replaced it with "22 (for a hospital-based outpatient MAT clinic)"; fifth paragraph – Deleted "they" and replaced it with "who"; seventh paragraph – Revised the first sentence to read: "Members discussed whether a POS 22 should be added to the recommendation table, the issues tracking grid and/or the companion guide."	

9. Billing Requirements for CPT Code 69210 – Gail Cain, Fairview Health Services	Discussion: • Gail – change 69210 from lateral to bilateral Medicare states to override MUE Correct way to code 50 LT and RT • Judith – AMA updated 69210 - CMS clarified that bilateral indicator of two (2) will be maintained for this CPT code. • Andrea – DHS follows AMA/CPT bilateral, one unit 69210 – with 50 modifier The RT or LT will work on ASCs but not on APC • HealthPartners – same as DHS • UCare will deny claims with modifier 50 - one line with one unit and RT and LT for Medicare • Medica will allow 50 modifier The TAG's approved recommendation is to add the following to recommendation grid and include in tracking issues grid. Will determine at later date if placed in companion guide. Medicare for Medicare products - report one line one unit, no modifiers. Commercial and DHS - report one line, one unit, 50 modifier.	**CLOSED** Add to recommendation grid and tracking issues grid

5/8/14 Minutes:

8. Intensive Treatment in Foster Care – DHS	DHS is seeking the approval of the MCT of S5145-HE for coding. S5145 - Foster care, therapeutic, child; per diem HE – Mental health program DHS confirmed that there would only be one per diem per day regardless of the number of services or who provides services. MCT approved code and modifier recommended by DHS. Will place in coding recommendation grid. Will include in companion guide pending approval by feds. Code and modifier is to be used for the Intensive Treatment in Foster Care in a mental health program only.	**CLOSED** Add to Recommendation grid with intent to move to MN Companion Guides

9. POS Codes for CCDTF Claims – HCMC	See SBAR DHS is requiring place of service 12 be reported for home administered MAT services. The intent of the request is to clarify the definition of "Home" for clients that have take home privileges to self-administer their drugs dispensed by the methadone clinic. 12 – Home: Location, other than a hospital or other facility, where the patient receives care in a private residence. An example of a situation is where the patient presents to the facility weekly for a directly observed dose and receives take home doses for the remaining days of the week. The POS for directly observed administration would be ~~55~~ 22 (for a hospital-based outpatient MAT clinic) but the additional days where the patient self-administers the doses should be reported with POS 12. The patient's home; however, may not a private residence as defined by POS 12. The request is to consider POS 12 the patient's home regardless if the "home" is a private residence or another "home" such as a group home. It was reported that it would require additional work and cost for billing vendors to identify and accommodate the specific national living arrangement POS, such as 04 for homeless shelter or 14 group home. The DHS instruction arose from a billing issue that was OIG identified regarding improper billing by transportation providers billing for certain patients who ~~they~~ were not transported	**CLOSED** Add to Recommendation grid

	because they self-administered at home. Providers should bill on professional claim for non-residential services. Members discussed whether a POS 22 ~~(22 versus 12)~~ should be added to the recommendation table, the issues tracking grid and/or the companion guide. TAG voted to place clarification in coding recommendation grid regarding POS for CCDTF claims. If added to the Companion Guide, the table would need to be revised. At this time the same grid is present in both the 837I and 837P guide. This change would be applicable only to the 837P guide. Possible future changes would require retitling the last column to POS instead of TOB.	

11. Newborn Facility Service Fee – Paula Bernini Feigal, Morning Star	Newborn facility is not what the statutes say; it states nursery care services. • Shawnet Healy supplied the following information: • Per Minnesota Statute 256.0625, subdivision 54, section b, "facility services provided by a birth center shall be paid at the lower of billed charges or 70% of the statewide average for a facility payment rate made to a hospital for an uncomplicated vaginal birth as determined using the most recent calendar year for which complete claims data is available". It goes on to describe payment if a recipient is transported from a birth center to a hospital prior to the delivery. This section is the facility fee for the delivery. • Per Minnesota Statute 256.0625, subdivision 54, section c, nursery care services provided by a birth center shall be paid the lower of billed charges or 70% of the statewide average for a payment rate paid to a hospital for nursery care as determined by using the most recent complete claims date is available. This section does not indicate a nursery facility fee. It states *nursery care services*. Professional services to the newborn, which are *care services*, are billed on the professional claim form. • The birth center does not have a separate and established newborn nursery as seen in a hospital. The baby stays with the mother and is discharged a few hours after birth. • There is no billable *facility* fee service. Companion guides can be clarified for the 724 revenue code.	**CLOSED** Clarification to current guides – 837P; "office" reference will be struck from the guide and add "newborn care services"

13. Billing Requirements for CPT Code 69210 – Gail Cain, Fairview Health Services	The narrative for 69210 was revised in 2014 to a unilateral code. Thus is performed on both ears it would be appropriate to bill the code with a -50 modifier. However, CMS is not recognizing (denying) 69210 if billed with a modifier 50 (bilateral procedure). Medicare has instructed to use modifiers –RT and –LT instead. Kathy Sijan supplied the following information: Federal Register info: http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/html/2013-28696.htm "14) Cerumen Removal (CPT Code 69210) This code was reviewed as a potentially misvalued code pursuant to the CMS high expenditure screen. The CPT Editorial Panel changed the code descriptor for removal of impacted cerumen from ``1 or both ears'' to ``unilateral,'' effective January 1, 2014. The AMA RUC recommended a work RVU for this code of 0.58. In its recommendation to the AMA RUC, the specialty society stated that there was no information to determine how often the service was performed unilaterally but asserted, and the AMA RUC agreed, that the service was performed bilaterally 10 percent of the time. In determining its recommendation, the AMA RUC applied work neutrality to the current work RVU of 0.61 to arrive at the recommended work RVU of 0.58 based upon the assertion that the code that was previously only reported once if furnished bilaterally, would now be reported for two units, due the descriptor change. We disagree with the assumption by the AMA RUC that the procedure will be furnished in both ears only 10 percent of the time as the physiologic processes that create cerumen impaction likely would affect both ears. Given this, we will continue to allow only one unit of CPT 69210 to be billed when furnished bilaterally. We do not believe the AMA RUC's recommended value reflects this and therefore, we will maintain the CY 2013 work value of 0.61 for CPT code 69210 when the service is furnished."	**OPEN**

	The current guides in the 837P Companion guide referencing the -50 modifier are: Chapter 12, Physicians/Nonphysician Practitioners, 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. Chapter 12, Physicians/Nonphysician Practitioners, 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 Chapter 13, Radiology Services and Other Diagnostic Procedures, Bilateral Radiology Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT Chapter 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. Chapter 14, Ambulatory Surgical Centers, Bilateral radiology Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier Members will review.	

4/10/14 Minutes:

5. Modifier -25 on preventive medicine visits (99381-99397) -	JoAnne Wolf stated that this is affecting Children's Physician claims – most based on CCI edits for Medicaid. The preventive exam denies against the immunization administration	**OPEN** Faith Bauer will draft

JoAnne Wolf, Children's Physician Network	code. MN stated there is no need to add the -25 modifier but there are other health plans that require the modifier. DHS will also implement the edit. The hope is to have the same guide for all. Members agree to add the guide in the recommendation grid; however, we do not want to add it to the companion guide or grid.	proposed Q&A

9. Family Psycho-education Services – DHS	See SBAR. TAG agreed to codes recommended by DHS. Will place in Coding Recommendation Grid, pending federal approval. • H2027 Individual • H2027 HQ Group (peer group) • H2027 HR Family with client present • H2027 HS Family without client present • H2027 HQ HR Multiple different families with clients present • H2027 HQ HS Multiple different families without clients present • H2027 HN Individual, clinical trainee • H2027 HQ HN Group (peer group), clinical trainee • H2027 HR HN Family with client present, clinical trainee • H2027 HS HN Family without client present, clinical trainee • H2027 HQ HR HN Multiple different families with clients present, clinical trainee • H2027 HQ HS HN Multiple different families without clients present, clinical trainee	**CLOSED** Add to Coding Recommendation Grid and MN Uniform Companion Guides when updated

10. Certified Family Peer Specialist – DHS	Peer specialist is different from the adult; for parents who have children who have gone through the system and can assist another parent; can be advocate for family going through the system.	**CLOSED** Add to Coding Recommendation Grid and MN Uniform Companion

	Used in other states for parents with children with mental illness; Concern that there be a training program and certification to ensure providing positive support. Certification standards will be adopted hopefully nationally (continuing education requirements). Services are for children under 21. The HA modifier. TAG approved DHS recommended codes for these services and to place in coding recommendation grid, pending federal approval. New codes will also be placed in companion guide upon approval. For mental health services only and do not apply to substance abuse. H0038 Certified peer specialist services, per 15 minutes H0038 U5 Advanced level certified peer specialist services, per 15 minutes H0038 HQ Group setting, certified peer specialist services, per 15 minutes H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes	Guides when updated

3/13/14 Minutes:

4. Collaborative psychiatric consultation – Faith Bauer, BCBSMN	Andrea reported that DHS reviewed 99499—on two tracks as 99446-99449 are for consulting physicians only. (See MN statutes.) Track 1, for 99499, need to include two additional providers in the guides – Psychologist or Advance Practice Registered Nurse (APRN) certified in psychiatric mental health. This	**CLOSED**

	change can be done now with an effective date of 7/1/13. Track 2, DHS will have to change state plan coding for consulting psychiatrists and submit to federal for approval. State plan has 99499, with payment rates. Codes are not just for mental health services but also other services. After approval from feds, will change 99446-99449. Will also look at primary care. Recommendation: Add the following to the Coding Recommendation Grid with the intent to revise the MN Companion Guide in the next yearly update. Changes to the current guide in red. Effective 7/1/14. Chapter 12, Physician/Nonphysician Practitioners, Collaborative psychiatric consultation Coding for a consultation initiated by the primary care provider (MD, DO, NPP~~, Psychologist, APRN~~) to psychiatrist, psychologist, or APRN 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 Psychologist or Advanced Practice Registered Nurse (APRN) certified in psychiatric mental health – 99499 HE • Consulting Psychologist or Advanced Practice Registered Nurse (APRN) certified in psychiatric mental health – 99499 HE U4 (non-face-to-face) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face)	

6. Modifier -25 on preventive medicine visits (99381-99397) - JoAnne Wolf, Children's Physician Network	Carolyn Larson noted that actions of the American Academy of Pediatrics last year caused the CCI policy to be temporary rescinded. However, the new effective date of the CCI policy is April 1, 2014. DHS must use the CCI edits. There is no current policy in the Companion Guide. Modifier-25 not addressed in companion guide. All payers accept the -25 modifier so this is not a compliance issue, it is a payment issue. Need to work directly with payers she's having problem with. Reporting is uniform and MCT view as payment issue because it is a CCI edit.	**OPEN** Leave open for JoAnne's comments.

9. Family Planning Services – Paula Bernini Feigal, Morning Star	Services are being denied for family planning services performed by qualified MHCP - MA patients seen by certified midwives. If listed as free-standing birth center per MHCP guideline the birth center is POS 25. ~~In order to be enrolled as an 11, must have a physician on record). Clinic services POS 11 is restricted to physician on record.~~ POS 25 is the most appropriate code for place of service. Can bill professional services under POS 25 in companion guide? Based on guidelines 11 will not be appropriate. This is a payment and contract issue. Recommendation: Companion guide – performing services under free-standing birth centers. Who's rendering the service? Because of the licensure of the facility (POS), the midwife cannot be paid for family planning services performed in a birthing center. (Tentative) POS 25 is correct based on MHCP requirements.	**OPEN** Leave open for comments.

10. Newborn Facility Service Fee – Paula Bernini Feigal, Morning Star	Services provided in birth center. The codes recommended are room and board and is not allowed in a freestanding birthing center. The AUC did not determine that the revenue code. National standards (NUBC) that this type of bill is outpatient. Room and board (the nursery revenue code) is inpatient only. HCPCS codes are required with revenue code. This is noted in the Companion Guide and is part of the NUBC standards. Newborn care is specified in MN statutes (256D.0625 subd. 54. Recommendation: Add the following to the Coding Recommendation Grid with the intent to revise the 837I MN Companion Guide in the next yearly update. Changes to the current guide in red. Effective ?. Freestanding Birth Centers (Not addressed in the Medicare Claims Processing Manual) **Licensed birthing centers** Medicare publishes limited billing information for free-standing birthing centers. "Birth center" means a facility licensed for the primary purpose of performing low-risk deliveries that is not a hospital or licensed as part of a hospital and where births are planned to occur away from the mother's usual residence following a low-risk pregnancy. See Minnesota Statutes, Sections 144.615 and 144.651 for more information. Low-risk deliveries, and services related to the delivery, performed in a free-standing birthing center should be reported on an 837I transaction including the following data: • Type of Bill: 084x – Special Facility – Freestanding Birthing Center (NOTE: TOB 084x will be considered outpatient. HCPCS codes are required with submitted revenue codes.) • Revenue Code: 0724 – Birthing Center Note: Ancillary services and/or items relating to delivery or labor 0724 are included under this	**OPEN** Leave open for comments.

	revenue code and should not be reported separately. • HCPCS Code: • Appropriate HCPCS code with revenue code 0724 for delivery, or ~~S4005 when labor does not result in delivery.~~ • HCPCS S4005 code with revenue code 0724 when labor does not result in delivery • Appropriate HCPCS code with revenue code 0724 for newborn specific services Note: Professional services related to the mother's and newborn's cares are reported on the 837P only.	