Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, February 12, 2015
9:00 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** – January 8, 2015
4. **MN Uniform Companion Guide Comment Reviews**

1/8/15: Dave reported that the 837 proposed guides had been approved by AUC and is currently open for public comment period until January 22. TAG reviewed changes MDH made to the front matter of the 837 guides, which included technical nomenclature changes and updates describing the documents; other changes to the guides were formatting, grammar and punctuation corrections. Review of revisions made by TAG as agreed in previous MCT meetings were also reviewed and are as follows for the 837 P and 837 I: 1. Chapter 16 repeat lab services – Modifier 76 or 91 2. Free standing birth centers clarification 3. Midwife services – clarification 4. CTSS – reordered list entries for ease of use; no changes to coding or descriptions 5. Dialectical behavior therapy – correction: changed from DBP to DBT 6. Mental health changes 7. Substance abuse – added note to MAT to clarify coding for take-home doses (note added to both P and I) No questions regarding changes. Public comments for 837I and 837P discussed and submitted by MCT: 1. Replace Peer Services program with new program, Certified Family Peer Specialist – add three red bullets and revise description 2. Add new programs, descriptions, and coding to Behavior Health in Table A.5.2: a. Family Psycho-educational services – Table A.5.2 b. Intensive Treatment in Foster Care – add to companion guide c. Mental health clinical consultation are covered up to persons for …clinical trainee, description and coding	**OPEN** TAG review and approve by January 23; send to Ops. TAG review and send comments to Faith prior to January 22.

3. Doulas – add guides Note: usually use DHS effective date; has been approved by feds Add to recommendation grid Moving Home Minnesota – do not add to guide Autism services will not go into companion guide because DHS does not have approval from the feds.	

5. 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 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.	**OPEN** DHS will develop policy to be placed in MUCG and include definitions of service providers
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**
1/8/15: Kathy reported that no further updates were made to the Autism services at this time. Looking at new cat III codes; questions out to AMA and to colleagues. Connected before we left CPT symposium and he got us in contact with work group members. Some of the cat III codes are set for 30 minutes. DHS subject matter experts (Clinicians) stated 15 minutes were more appropriate due to attention span of children. Individual service plan versus treatment plan. One of the services billable that is not available. Kathy further stated to disregard document Andrea prepared; will be revised. The services described are the same but codes will be different. See AMA autism questions received from Andrea Agerlie.	**OPEN**

6. 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	**OPEN** DHS will create a time

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.	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**
1/8/15: Kathy stated the State plan has not been submitted to CMS as reported earlier. DHS will submit this quarter.	**OPEN**

7. 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	**OPEN** MCT payers will discuss with their contract area. DHS will determine the

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.	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**
1/8/15 Brief discussion whether to close SBAR. Decision to keep open until after internal DHS meeting with gambling addiction program managers and AUC MCT representatives (Andrea Agerlie and Kathy Sijan)	**OPEN**

8. 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. Payers to determine if they limit to PhDs only.	**OPEN**
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**
1/8/15: PreferredOne still researching – Carolyn Larson will contact Sara offline to discuss. Post-meeting, Carolyn sent the following: Sara and I have conversed re: 99499 claim submissions. Based on our conversation plus claims review for the description supplied for the unlisted code, the services being reported are for various pain rehab services including "stress group therapy" sessions. It is not for one specific (contracted) pain program. PreferredOne recommends these types of services be reported with the established CPT® codes 96150 – 96154 and not 99499 as required by Medicare.	**OPEN**

9. Modifier -90 Acceptance - Sue Lewis, UCare

Will the area health plans accept (or not) claims for lab services with the -90 modifier appended for their commercial products?

10. Additional Agenda Items/ Announcements

- March meeting:
  - The next scheduled meeting is March 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, January 8, 2015, 8 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	Minutes approved with following corrections: • #7 changed "training" to "trainee" • #8 changed "Andrea Agerlie" to "Judy Edwards"	Minutes will be posted on AUC MCT website
4. Doulas – Shawnet Healy, DHS	Shawnet reported that CMS had approved coding for Doula Services and that final coding recommendations are as follows: • S9445 U4 modifier for ante and post-delivery sessions • 99199 labor and delivery Doula services are limited to six sessions and prior authorization with medical necessity documentation is required for additional sessions to be approved by DHS. Doula services will also have the same 60-day post-partum limitation currently allowed. Lactation services may be provided by doulas. However lactation services will be paid to doulas or lactation specialist but not both; DHS will reimburse first approved submitted bill. Doula services must be provided under supervising practitioners and these practitioners must bill the doulas services under their NPI. (Note: Shawnet stated that the billing requirement has proven difficult for the doulas due to legal concerns for the supervising practitioners.)	**CLOSED** Suggestion that 60 days post-partum be included in provider guide Added to companion guide – Chapter 12 Shawnet will assist with any problems between practitioner and doulas Dave and Judy will send any comments received from non-MCT members
5. MN Uniform Companion Guide Comment Reviews	Dave reported that the 837 proposed guides had been approved by AUC and is currently open for public comment period until January 22. TAG reviewed changes MDH made to the front matter of the 837 guides, which included technical nomenclature changes and updates describing the documents; other changes to the guides were formatting, grammar and punctuation corrections. Review of revisions made by TAG as agreed in previous MCT meetings were also reviewed and are as follows for the 837 P and 837 I: 1. Chapter 16 repeat lab services – Modifier 76 or 91 2. Free standing birth centers clarification	**OPEN** TAG review and approve by January 23; send to Ops. TAG review and send comments to Faith prior to January 22.

Agenda Item	Discussion	Action/Follow-up:
	3. Midwife services – clarification 4. CTSS – reordered list entries for ease of use; no changes to coding or descriptions 5. Dialectical behavior therapy – correction: changed from DBP to DBT 6. Mental health changes 7. Substance abuse – added note to MAT to clarify coding for take-home doses (note added to both P and I) No questions regarding changes. Public comments for 837I and 837P discussed and submitted by MCT: 1. Replace Peer Services program with new program, Certified Family Peer Specialist – add three red bullets and revise description 2. Add new programs, descriptions, and coding to Behavior Health in Table A.5.2: a. Family Psycho-educational services – Table A.5.2 b. Intensive Treatment in Foster Care – add to companion guide c. Mental health clinical consultation are covered up to persons for …clinical trainee, description and coding 3. Doulas – add guides Note: usually use DHS effective date; has been approved by feds Add to recommendation grid Moving Home Minnesota – do not add to guide Autism services will not go into companion guide because DHS does not have approval from the feds.	
6. Autism – Andrea Agerlie, DHS	Kathy reported that no further updates were made to the Autism services at this time. Looking at new cat III codes; questions out to AMA and to colleagues. Connected before we left CPT symposium and he got us in contact with work group members. Some of the cat III codes are set for 30 minutes. DHS subject matter experts (Clinicians) stated 15 minutes were more appropriate due to attention span of children. Individual service plan versus treatment plan. One of the services billable that is not available. Kathy further stated to disregard document Andrea prepared; will be revised. The services described are the same but codes will be different. See AMA autism questions received from Andrea Agerlie.	**OPEN**
7. Mental Health Service Plan Development – DHS	Kathy stated the State plan has not been submitted to CMS as reported earlier. DHS will submit this quarter.	**OPEN**
8. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	Brief discussion whether to close SBAR. Decision to keep open until after internal DHS meeting with gambling addiction program managers and AUC MCT representatives (Andrea Agerlie and Kathy Sijan)	**OPEN**
9. Health and Behavior Group Therapy by Mid-level Provider – Sara Luther, Mayo Clinic	PreferredOne still researching – Carolyn Larson will contact Sara offline to discuss. Post-meeting, Carolyn sent the following: Sara and I have conversed re: 99499 claim submissions. Based on our conversation plus claims review for the description supplied for the unlisted code, the services being reported are for various pain rehab services including “stress group therapy” sessions. It is not for one specific (contracted) pain program.	**OPEN**

Agenda Item	Discussion	Action/Follow-up:
	PreferredOne recommends these types of services be reported with the established CPT® codes 96150 – 96154 and not 99499 as required by Medicare.	
10. Concurrent Care Processing Change for E/M Services on the Same DOS – Judith Blyth, HCMC	Article was submitted as an FYI to inform TAG about the reversal in denying E/M claims for services billed on same day by two different practitioners. Mary Tretheway sent additional information published by NGS that included the effective date of 8/26/14. TAG agreed to add Alert (article) to issue tracking table	**CLOSED** Add Alert (article) to issue tracking table
11. Speech Language Pathologists/VCD/PVFM – Gail Cain, Fairview	Waiting to hear back from payers. DHS prefers the 92700. Judith felt that 92700. PreferredOne – SLP does not agree with 92700 (what's currently being done). Medica – 92525 or; HealthPartners – no answer • 92507 and 92504 will be used Place in tracking grid because of low utilization.	**CLOSED** Place in tracking grid
12. IONM Clarification - Kandi Newton, Gillette Children's Specialty Healthcare	What's the average? Is it mostly brain surgery? DHS checked system and found that there was a number in for maximum number per day that was inaccurate. Agree that codes are incorrect. Coding in units. Do these codes require modifier 26 or should there be multiple lines with 59. No Add-on codes 95940 –each 15 minutes No to using code 26 Applicable documentation should support your unit bill. 59-modifier is not appropriate. MCT cannot address reimbursement. These are not TC or 26 eligible and cannot • Follow unit guidelines in a recommendation and follow CPT. Unit would be based one per line.	**CLOSED** Place in tracking grid
13. Next meeting	• Scheduled January 27 meeting for final review (if needed) and approval of public comments incorporated in the 837 I and 837P guides. Meeting from 9:00 a.m. to 12 noon. • The next scheduled meeting is February 12, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. • TREATS	**CLOSED**

Minnesota Department of Health (MDH) Proposed Rule for Public Comment

Title:	Proposed Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X222A1 Health Care Claim: Professional (837)** **Version 9.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	This document was announced as a proposed rule for public comment on December 22, 2014. The public comment period is from December 22, 2014 – January 22, 2015. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 9.0 of *the Minnesota Uniform Companion Guide (MUCG) for the* Implementation of the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*. It was announced as a proposed rule for public comment in the Minnesota State Register, Volume 39, Number 25, December 22, 2014 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. This document has not been adopted into rule. This document is available at no charge at: http://www.health.state.mn.us/asa.

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Table of Contents

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1. Overview

1.1. Statutory basis for this proposed rule

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

1.2. Applicability of state statute and related rules

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

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year-to-year exception for only group purchasers not subject to federal HIPAA transactions and code sets regulations from only the state's requirements for the standard, electronic exchange of the ASC X12N/00510X279A1 Health Care Eligibility Benefit Inquiry and Response transaction.

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

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

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

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

would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

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

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

> *"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:*
>
> *1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;*
>
> *2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;*
>
> *3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;*
>
> *4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and*
>
> *5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.*
>
> *A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.”*

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

1.2.1. Exceptions to applicability

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

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

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

If group purchasers are exempt from one or more of the requirements, providers shall also be

exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction described under Code of Federal Regulations, title 45, part 162, subpart L, and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the state's rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (the *ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)*, hereinafter *005010X279A1*). This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html.

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

Field Code Changed

1.4. About the Minnesota Administrative Uniformity Committee

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

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

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

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

1.6. Document Changes

The content of this document is subject to change. The version number, release date or revision date, and brief summary of changes from one version to the next of this document are provided section 1.6.1 below.

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v.8.0

2. Purpose of this document and its relationship with other applicable regulations

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

Note: Using this Companion guide does not mean that a claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following four appendices:

- Appendix A provides additional information and instructions regarding the use of medical code sets and medical coding;
- Appendix B provides instructions for use of the K3 segment;
- Appendix C provides instructions for reporting the MNCare Tax; and
- Appendix D provides examples for the v5010 reporting of data in the SV, LIN, or HI segments that was previously submitted in the NTE segment in v4010.

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

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

3.2.1. Business Terminology

The terms below were published with definitions and other information in the previous version of this companion guide to provide additional clarification and/or because of changes that occurred as a result of the adoption of version 5010. Definitions of these terms are no longer being included in this companion guide. However, the terms are discussed and defined in the reference document to this companion guide (the *005010X222A1*), which is available for purchase from ASCX12 at http://store.x12.org/store/.

The following terms that were previously defined in the Minnesota Uniform Companion Guide can be referenced as noted above:

- Billing provider
- Billing provider name
- Billing provider address
- Pay-to address
- Other payer

- Patient
- Pay-to plan
- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

Business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name/address of Pay-To are different than Billing Provider. In order to use the *005010X222A1* for this business situation, the Accredited Standards Committee (ASC) X12 recommends that the Factoring Agent entity name, address, and identification be submitted as the Pay-To Plan in loop 2010AC. The notes and guidelines should be followed as if the Pay-To Plan entity was performing post payment recovery as described.

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

If the provider is not a health care provider as defined under federal standards the provider is known as an atypical provider. Atypical providers do meet the Minnesota statutory definition of health care provider and therefore are subject to the requirements of Minnesota statutes, section 62J.536 and related rules. For atypical providers, the primary identifier is the TIN and a secondary identifier is allowable. The qualifier for the secondary identifier is "G2." The identifier for this qualifier would be the specific payer assigned/required identifier.

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

Adjustment – Provider has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.

Appeal – Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. Therefore the submission of the appeal is not

covered by this guide.

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

3.2.3.3. Process for submission

- Adjustment – Provider should submit an adjustment electronically using the appropriate value in CLM05-3 to indicate that this is a replacement claim. If the payer has assigned a payer number to the claim, it must be submitted in loop 2300, REF02, using qualifier F8 in REF01 (Note: the original payer- assigned claim number is not the property and casualty number). If additional information is required to support the adjustment based on payer business rules, the SV101-7, NTE segment, PWK segment, or Condition Codes should be used. See section 3.2.5 below regarding these segments for appropriate instructions.
- Appeal – Follow payer standard processes for requesting an appeal to a previously adjudicated claim. If paper appeal process is utilized, then a standard, Best Practice Minnesota appeal form is available at the AUC website at http://www.health.state.mn.us/auc/index.html. Additional documentation should be sent as required by the payer to support the appeal consideration; this documentation does not include resubmission of the claim.

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

In conjunction with the CFTC code values, Condition Codes may be submitted that will impact

processing and handling requirements.

3.2.5. Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional information.
    - The NTE segment must not be used to report data elements that are codified within this transaction.
    - If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV101-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X222A1*.
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.
- If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE or SV101-7 will exceed available characters, use only the PWK segment at the claim level.
- When populating the PWK segment, the following guidelines must be followed:
    - PWK01 - The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
    - PWK06 - Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

4. ASC X12N/005010X222A1 Health Care Claim: Professional (837) -- Transaction Specific Information

4.1. Introduction to Table

The following table provides information needed to implement the *ASC X12N/005010X222A1 Health Care Claim: Professional (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X222A1* and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

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

Please also see section 2.2 above.

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2000B	Subscriber Hierarchical Level	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has(have) processed.
2010BA	Subscriber Name	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
2010BA	Subscriber Name	DMG Subscriber Demographic Information	DMG02 Subscriber Birth Date	Services to unborn children should be billed under the mother as the patient.
2010BB	Payer Name	REF Billing Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2010CA	Patient Name	DMG Patient Demographic Information	DMG02 Patient Birth Date	Services to unborn children should be billed under the mother as the patient.
2300	Claim	CLM	CLM05-3	See front matter section 3.2.4 of this

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
	Information	Claim Information	Claim Frequency Type Code	document for definitions.
2300	Claim Information	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300	Claim Information	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
2300	Claim Information	PWK Claim Supplemental Information	PWK02 Report Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300	Claim Information	AMT Patient Amount Paid	AMT02 Monetary Amount	Must not exceed total claim charge amount in CLM02.
2300	Claim Information	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300	Claim Information	K3 File Information	N/A	See Appendix B of this document for usage instructions.
2300	Claim Information	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
2300	Claim Information	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310A	Referring Provider Name	REF Referring Provider	N/A	See front matter section 3.2.2 of this document for usage.

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
		Secondary Identification		
2310A	Referring Provider Name	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310B	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2310B	Rendering Provider Name	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310C	Service Facility Location Name	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2310C	Service Facility Location Name	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2320	Other Subscriber Information	SBR Other Subscriber Information	N/A	Do not send claim to secondary or any subsequent payer until previous payer has processed.
2330B	Other payer name	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400	Service Line	SV1	SV101-7	See front matter section 3.2.5 of this

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
	Number	Professional Service	Description	document for additional instructions.
2400	Service Line Number	SV1 Professional Service	SV103 Unit or Basis for Measurement Code	See Appendix A for coding units.
2400	Service Line Number	SV1 Professional Service	SV104 Quantity	Minnesota specific note: Zero “0” is not a valid value.
2400	Service Line Number	SV1 Professional Service	SV107-1 Diagnosis Code Pointer	Primary diagnosis code cannot point to an External Cause of Injury code.
2400	Service Line Number	DTP Date - Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400	Service Line Number	AMT Sales Tax Amount	N/A	See Appendix C of this document for details on reporting MNCare Tax
2400	Service Line Number	K3 File Information	N/A	See Appendix B of this document for usage instructions.
2400	Service Line Number	NTE Line Note	N/A	See front matter section 3.2.5 of this document for definition and usage
2420A	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2420A	Rendering Provider Name	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420B	Purchased Service Provider Name	REF Purchased Service	REF01 Reference Identification Qualifier	Use G2 for atypical providers.

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

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5. List of Appendices

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

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

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

Table A.5.4 -- Maternal and Child Health Billing Guide For Public Health Agencies

a) Public health nurse clinic services
b) Maternal & child health visits
c) Other services and Miscellaneous

B. Appendix B: K3 Segment Usage Instructions

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

C. Appendix C: Reporting MNCare Tax

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

A. Appendix A: Code Set Supplemental Information For Minnesota Uniform Companion Guides

A.1 Introduction and Overview

Minnesota Statutes, Section 62J.536 requires the standard, electronic exchange of health care claims using a single, uniform companion guide to HIPAA implementation guides,[1] including uniform billing and coding standards. The statute further requires the Commissioner of Health to base the transaction standards and billing and coding rules on federal HIPAA requirements and on the Medicare program, with modifications that the commissioner deems appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC).

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

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

NOTE-- As further described in the sections below:

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

1 Described in Code of Federal Regulations, title 45, part 162.

used interchangeably. If codes do not have an identical description then follow section A.3.2, "Instructions for Use", regarding use of the most appropriate code.

6. This appendix does not replace or substitute for standard, national coding resources for HIPAA-adopted code sets (including manuals, online resources, etc.). Consult coding resources for descriptions, definitions, and directions for code usage.
7. Medicare and national codes often change. National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes. (See also section A.4.)

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

1. For the state government behavioral health programs identified in Table A.5.2, use the codes referenced in the table.

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

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

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

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

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

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

1. Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits.

2. More specific or appropriate codes are needed in order to reduce manual processing and administrative costs.
3. Duplicate codes exist and clarification of which code(s) to use is needed.
4. Medicare does not have a guideline for coding a service or made no specific reference to a service but the AUC Medical Code Technical Advisory Group (TAG) had knowledge of differing submission requirements.

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

- Report one unit for all services without a measure in the description.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
  - "per vertebral body;"
  - "each 30 minutes;"
  - "each specimen;"
  - "15 or more lesions;"
  - "initial."
- Follow all related AMA guidelines in CPT[3] (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]

3 Current Procedural Terminology (CPT®), copyright 2013 American Medical Association
4 Current Procedural Terminology (CPT®), copyright 2013 American Medical Association

- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow general rounding rules for reporting more than the code's time value. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

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

- ASC X12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1 as "professional claim type" or "837P" or "Professional claim";
- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.1 as "institutional claim type" or "837I" or "Institutional claim";

- ASC X12/005010X224A2 Health Care Claim: Dental (837), referred to in Table A.5.1 as “837D”

Pharmacy Claims Submission and Response and the Pharmacy Reversal Submission and Response Transactions per the NCPDP Telecommunication Standard Implementation Guide, Version D.Ø, referred to in Table A.5.1 as “NCPDP”.

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

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
10	Home Health Agency Billing	PCA and Homemaking Services	PCA: T1019 PCA Shared 1:2: T1019-TT PCA Shared 1:3 or more: T1019-HQ PCA Temporary Service Increase: T1019-U6 PCA Notice of Reduction: T1019-U5 RN PCA Supervision: T1019-UA Homemaking: S5130, S5131 PCA services may not be billed with a span of dates; each date of service must be billed separately.
10	Home Health Agency Billing	Home Infusion	Home infusion is not addressed in this chapter. See instructions following this table.
11	Processing Hospice Claims		Not applicable to Professional claim
12	Physicians/Nonphysician Practitioners	Allergy, clinical immunology	Medicare does not allow all allergy and clinical immunology codes, but group purchasers accept all applicable codes. Follow the code selection guidelines in the front of Appendix A.
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~~Bilateral services are to be reported with the 50 modifier on one line with one unit.
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

Comment [MN1]: Comment received 1-9-15

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

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported o A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported o Report one unit per mile
12	Physicians/Nonphysician Practitioners	Collaborative psychiatric consultation MS 265B.0625, Subd. 48 Psychiatric consultation to primary care practitioners	Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist 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

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

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapter Number</th><th>Title/Description</th></tr>
<tr><td></td><td></td><td></td><td>U4 (non-face-to-face)
• Consulting APRN (certified in psychiatric mental health) – 99499 HE AM
• Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face)
• Consulting psychologist – 99499 HE AM
• Consulting psychologist – 99499 HE AM U4 (non-face-to-face)</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Patient not in exam room</td><td>There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-9-CM code(s) for the diagnosis of the patient as the primary diagnosis or diagnoses. Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Health Care Homes</td><td>The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:
Patient Complexity Level and Supplemental Factors
<table>
<tr><th>Patient Complexity Level</th><th>Complex-ity Modifiers</th><th>Non English Speak-ing Modifier</th><th>Active Mental Health Con-dition</th></tr>
</table>
</td></tr>
</table>

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

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapter Number</th><th>Title/Description</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>
Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level
o U2 – Care coordination, extended complexity level
o U3 – Care coordination, supplemental factor; Non-English language
o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition
</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>ImPACT testing</td><td>96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>In-reach Community Based Coordination</td><td>Use HCPCS T1016-U2 or T1016-U2 TS.
▪ T1016 Case management, each 15 minutes
▪ U2 = In-reach, initial service
▪ U2 TS = In-reach, follow-up</td></tr>
</table>

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
13	Radiology Services and Other Diagnostic Procedures	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components
13	Radiology Services and Other Diagnostic Procedures	Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	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.
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
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance	General	Follow Medicare coding guidelines
15	Ambulance	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: ▪ A0080 ▪ A0090 ▪ A0100 ▪ A0110 ▪ A0120

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			▪ T2002 ▪ T2003 ▪ T2004
15	Ambulance	Community Paramedic	Community paramedic services are to be billed as follows: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – report the Medical director's NPI • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) — a minimum of 8 minutes of face to face time must be rendered in order to report one unit (see also section A.3.4.2 for units rounding rules) o T1016 Case management, each 15 minutes o U3 – service provided by certified community paramedic (EMT-CP) • Non-reportable services include: o Incidental supplies (e.g., gloves, test strips, band aids, etc.); o Travel; o Mileage; o Medical record documentation. Supplies and vaccines are reported by the ordering primary care physician only.

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
16	Laboratory Services	Repeat services	Modifiers 76 (pathology only) or 91 (clinical diagnostic lab) are to be used for repeat services subsequent to the original service only. The number of units reported is the number of services performed as defined in the code description or relevant, current AMA guidelines in CPT
16	Laboratory Services	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.
16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.

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

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

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

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			$0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. ▪ Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed. ▪ Use most appropriate diagnosis code based on patient age.
19	Indian Health Services	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.
21	Medicare Summary Notices		Not applicable to coding guidelines
22	Remittance Advice		Not applicable to coding guidelines
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines
35	Independent Diagnostic Testing Facility (IDTF)		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines
See the following regarding “Doula Services”, “Home Infusion Therapy” and “Licensed Traditional Midwife Services (Not Certified Nurse Midwives)” that are not addressed in any chapter of the Medicare Claims Processing Manual.			

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
N/A	N/A	Doula Services MS 256B.0625, Subd. 28B Doula Services	Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to six sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the six. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows: ▪ S~~9~~9445 U4 – ante-partum and post – partum Doula services ▪ 99199 U4 – Doula attendance at labor and delivery
N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes). Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. Place of Service: 25 – Free-standing Birthing~~ing~~ Center

Field Code Changed

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			HCPCS Code: Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, free-standing birthing center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits. Fragmented services may be reported in certain circumstances: • If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes). • If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. • Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service). • Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal period. Urine dip sticks are considered part of the global package. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.

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

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

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

HA	Child/adolescent program
HE	Mental health program
HK	Specialized mental health programs for high-risk populations
HM	Less than bachelor's degree
HN	Bachelor's degree level
HQ	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
HW	Funded by state mental health agency (service provided by state staff person)
TF	Intermediate level of care
TG	Complex/high tech level of care
TS	Follow up service
UA	Children's Therapeutic Services and Supports (CTSS)
UD	Transition to community living (Adult Rehabilitation Mental Health Services (ARMHS))
U1	Dialectical Behavioral Therapy
U4	Via other than face to face contact; e.g. telephone
U5	Advanced level specialist
U6	Interactive
U7	Physician extender (includes mental health practitioner as defined by MN Statute 245.4711, Subd. 17)
NOTE: The U modifiers in this table are specific to Mental Health.	

~~**NOTE: The U modifiers in this table are specific to Mental Health**~~

A.5.2.2. Behavioral Health Programs Listed in Table A.5.2

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

Assertive Community Treatment (ACT)

Adult Crisis Response Services

Children's Mental Health Crisis Response Services

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Children's Therapeutic Services and Supports (CTSS)

Adult Rehabilitative Mental Health Services (ARMHS)

~~Certified Family Peer Specialist~~

Peer Services

Mental Health Diagnostic Assessment

Dialectical Behavior Therapy

Youth Assertive Community Treatment

Intensive Treatment in Foster Care

Mental Health Family Psychoeducation Services

Mental Health Clinical Care Consultation

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

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

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

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

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

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

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

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

Name of Program	Description/Definition	Coding
behavioral health programs	intensive therapeutic services provided by multidisciplinary team.	treatment, per hour, CTSS ▪ H2012 UA HK U6 – Behavioral health day treatment, per hour, CTSS interactive
Children's Therapeutic Services and Supports (CTSS) Back to list of behavioral health programs	▪ Rehabilitative services that offer a broad range of medical and remedial services and skills to help restore individuals' self-sufficiency/functional abilities - a flexible package of mental health services for children.	▪ Codes: ▪ 90832 UA – Psychotherapy w/patient and/or family, 30 minutes, CTSS ▪ 90833 UA – Psychotherapy w/patient and/or family, 30 minutes with an E/M*, CTSS ▪ 90834 UA - Psychotherapy w/patient and/or family, 45 minutes, CTSS ▪ 90836 UA - Psychotherapy w/patient and/or family, 45 minutes with an E/M*, CTSS ▪ 90837 UA - Psychotherapy w/patient and/or family, 60 minutes, CTSS ▪ 90837 UA plus 99354 Psychotherapy w/patient and/or family 60 minutes, CTSS ▪ 90838 UA- Psychotherapy w/patient and/or family, 60 minutes with E/M*, CTSS ▪ 90839 UA –Psychotherapy for crisis, first 60 minutes, CTSS ▪ 90840 UA- Each additional 30 mins [add on to 90839], CTSS ▪ 90846 UA - Family psychotherapy without patient, CTSS ▪ 90847 UA - Family psychotherapy with patient, CTSS ▪ 90849 UA - Multiple family group psychotherapy, CTSS ▪ 90853 UA - Group psychotherapy, CTSS ▪ 90875 UA - Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy , 30 minutes, CTSS ▪ 90876 UA Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 45 minutes,

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

Name of Program	Description/Definition	Coding
Children's Therapeutic Services and Supports (CTSS) (continued) Back to list of behavioral health programs		CTSS ▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS ▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS *(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes ▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills,

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

Name of Program	Description/Definition	Coding
		transitioning to community, mental health professional or practitioner ▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker ▪ 90882 - Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD - Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
~~Certified Family Peer Specialist~~ **Peer Services** Back to list of behavioral health programs	Non-clinical support counseling services provided by certified peer specialist ~~to adults or children.~~	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~~
Mental Health Diagnostic Assessment Back to list of	A diagnostic assessment is a written report that documents the clinical and functional face-to-face evaluation of a	Codes: In order to report diagnostic assessments with levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic

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

Name of Program	Description/Definition	Coding
behavioral health programs	recipient's mental health and is necessary to determine a recipient's eligibility for mental health services.	assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by

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

Name of Program	Description/Definition	Coding
		qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (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.	Codes: ▪ 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.
Mental Health	• Family psycho-education	Codes:

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

Name of Program	Description/Definition	Coding
Family Psychoeducation Sservices Back to list of behavioral health programs	services provided to a child up to age 21 with a diagnosed ~~MH~~ mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5 9505.0371, subpart 5, item C • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o ~~Explain, educate, and support the child and family~~understanding a child's symptoms of mental illness; o the impact on the child's development; o n~~N~~eeded components of treatment; and o s~~S~~kill development	▪ 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
Mental Health Clinical Care Consultation Back to list of behavioral health programs	• MH clinical care consultation services provided to patients up to age 21 and provided by mental health professional or clinical trainee to other providers or educators not under their supervision • Services may take place in, but are not limited to, school, community, office or clinic	Codes: ▪ 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 trainee.

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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

c) Outpatient Services (further divided into Institutional vs. Professional claim type).

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

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

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

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

v9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.3.a -- Substance Abuse Services: Hospital
(Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)

Service Description	Option 1 or 2 *	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
Room and Board	1	Day	0118, 0128, 0138, 0148, 0158	N/A	837I	011x-hospital inpatient
Detox	1	Day	0116, 0126, 0136, 0146, 0156	N/A	837I	011x-hospital inpatient
Treatment component	1	Day	Choose one per date of service: 0944 or 0945 or 0949	N/A	837I	011x-hospital inpatient
Ancillary	1	Based on Revenue Code	As appropriate	N/A	837I	011x-hospital inpatient
All-inclusive Room and Board	2	Day	0101	N/A	837I	011x-hospital inpatient
Detox	2	Day	0116, 0126, 0136, 0146, 0156	N/A	837I	011x-hospital inpatient
Ancillary Services	2	Based on Revenue Code	as appropriate	N/A	837I	011x-hospital inpatient

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

inclusive: includes room and board and treatment.

Table A.5.3.b Substance Abuse Services: <u>All Other Residential</u>

v9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)					
A.5.3.b – Substance Abuse Services: <u>All Other Residential</u>					
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	Day	<u>1002</u>: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) <u>1003</u>: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
Treatment program, treatment component	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
Treatment program, treatment component	Hour	0953	None	837I	086x – special facility, residential
Ancillary services	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

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

v9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.3.c.i – Substance Abuse Services: Outpatient Services – Claim Type 837I

(Applicable to all providers and settings per applicable contract or established program standards)

Claim Type – 837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs **Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.**	Day	0944	H0047 U9	089x or 013x
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

Note: Take-home doses place of service 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.

Table A.5.3.c.ii – Substance Abuse Services: Outpatient Services – Claim Type 837P

(Applicable to all providers and settings per applicable contract or established program standards)

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A

Note: Take-home doses place of service 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.

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

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

UA – MAT Plus, methadone
UB – MAT Plus, all other drugs

Alcohol and/or drug assessment	Session/visit	N/A	H0001	

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

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

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and miscellaneous

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

v9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.a -- Public health nurse clinic services**		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Services Include: • Health Promotion & Counseling • Nursing Assessment & Diagnostic Testing • Medication Management • Nursing Treatment • Nursing Care, in the home, by RN (PHN & CPHN)	S9123	T1015
Home health aide or CNA, per visit	T1021	Individual S9445 Group S9446
Patient Education only - if no other services (includes car seat education)	S9123	Individual S9445 Group S9446

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

v9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.b -- Maternal & child health visits**		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Birthing Classes	N/A	S9442
Home Visit for Postnatal assessment & follow up care - **Mother**	99501	N/A
Home Visit for Post-natal assessment & follow up care - **Newborn**	99502	N/A
Enhanced Services - for at-risk pregnancies as determined by the physician/nurse practitioner		
At-Risk Antepartum Management	H1001	H1001
At-Risk Care Coordination	H1002	H1002
At-Risk Prenatal Health Education	H1003	H1003
At-Risk Prenatal Health Education I	H1003	H1003
At-Risk Prenatal Health Education II	H1003	H1003
At-Risk Enhanced Service; Follow-up Home Visit	H1004	N/A
At-Risk Enhanced Service Package	H1005	H1005

Table A.5.4.c – OTHER SERVICES and MISCELLANEOUS

v9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.c -- Other services**	
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97802 ~~97802~~ ~~97803~~ ~~97803~~
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **re-assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97803

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~~V8~~V9.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.c -- Miscellaneous**	
Maternal Depression Screenings	99420 UC~~99420 UC~~
Child Developmental Screenings	96110~~96110~~
Child Mental Health Screenings	96127~~96110 UC~~
TB Case Management	T1016~~T1016~~
TB Direct Observation Therapy	H0033~~H0033~~

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B. Appendix B: K3 Segment Usage Instructions

The K3 segment in the 2300 and 2400 Loops is used to meet regulatory requirements when the X12N Committee has determined that there is no alternative solution within the current structure of the 005010X222A1. The situations noted here have been approved by the X12N Committee and will be considered as a business need in development of future versions of this transaction.

If multiple K3 needs exist on a single claim at the same loop level, it is recommended that separate K3 segments be sent.

State of Jurisdiction

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

LU is the qualifier to indicate this value and should be followed by the two-character state code.

Report at 2300 Loop only.

K3*LUMN~

Tooth Number/Oral Cavity

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

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

Report at 2400 Loop only.

K3*JP12~

K3*JP12 14~

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

Report at 2400 Loop only.

K3*JO10~

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

- 628 and 1399: State of Jurisdiction
- 638 and 1065: Send Tooth Information in K3.

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C. Appendix C: Reporting MNCare Tax

NOTE: Instructions for MNCare Tax billing only apply if the provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document DOES NOT require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT.MNCare Tax must be reported as part of the line item charge and reported in the corresponding AMT tax segment on the lines.

Minnesota Department of Health (MDH) Proposed Rule for Public Comment

Title:	Proposed Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837) Version 9.0
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	This document was announced as a proposed rule for public comment on December 22, 2014. The public comment period is from December 22, 2014 – January 22, 2015. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X223A2 Health Care Claim: Institutional (837), hereinafter referred to as 005010X223A2, by entities subject to Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 9.0 of the Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X223A2 Health Care Claim: Institutional (837). It was announced as a proposed rule for public comment in the Minnesota State Register, Volume 39, Number 25, December 22, 2014 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. This document has not been adopted into rule. This document is available at no charge on the MDH Health Care Administrative Simplification website (http://www.health.state.mn.us/asa).

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Table of Contents

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1. Overview

1.1. Statutory basis for this proposed rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

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

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

> *"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:*
>
> 1) *processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;*
> 2) *receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;*
> 3) *acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;*
> 4) *acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and*
> 5) *other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.*
>
> *A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.*

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

1.2.1. Exceptions to applicability

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

i. *a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or*
ii. *another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.*

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

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction described under Code of Federal Regulations, title 45, part 162, subpart L, and that group purchasers not covered by HIPAA, including workers’ compensation, auto, and property and casualty insurance carriers, are not required to comply with the state’s rules for the eligibility inquiry and response transaction. This exception pertains only to

those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (the *ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)*, hereinafter *005010X279A1*). This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html.

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-3830

Email: health.ASAguides@state.mn.us

Field Code Changed

1.4. About the Minnesota Administrative Uniformity Committee

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

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

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

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

1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. V8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v8.0

2. Purpose of this document and its relationship with other applicable regulations

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following four appendices:

- Appendix A provides additional information and instructions regarding the use of medical code sets and medical coding;
- Appendix B provides guidance for K3 SEGMENT USAGE INSTRUCTIONS
- Appendix C provides instructions for reporting the MNCare Tax;

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

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

3.2.1. Business Terminology

The terms below were published with definitions and other information in the previous version of this companion guide to provide additional clarification and/or because of changes that occurred as a result of the adoption of version 5010. Definitions of these terms are no longer being included in this companion guide. However, the terms are discussed and defined in the reference document to this companion guide (the *005010X223A2*), which is available for purchase from ASCX12 at http://store.x12.org/store/.

The following terms that were previously defined in the Minnesota Uniform Companion Guide can be referenced as noted above:

- Billing provider
- Billing provider name
- Billing provider address
- Pay-to address
- Other payer
- Patient
- Pay-to plan
- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

If the provider is not a health care provider as defined under federal standards they are known as atypical providers. Atypical providers do meet the Minnesota statutory definition of health care provider and therefore are subject to the requirements of Minnesota statutes, section 62J.536 and related rules. For atypical providers, the primary identifier is the TIN and a secondary identifier is allowable. The qualifier for the secondary identifier is 'G2'. The identifier for this qualifier would be the specific payer assigned/required identifier.

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

Adjustment – Provider has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.

Appeal – Provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. Therefore the submission of the appeal is not covered by this guide.

Examples of appeals include:

- Timely filing denial;
- Payer allowance;

- Incorrect benefit applied;
- Eligibility issues;
- Benefit Accumulation Errors; and
- Medical Policy/Medical Necessity

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional

information.

  - The NTE segment must not be used to report data elements that are codified within this transaction.
  - If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV202-7 in the 2400 loop must be used.

- Do not exceed the usage available in the *005010X223A2*.
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.
- If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE or SV202-7 will exceed available characters, use only the PWK segment at the claim level.
- When populating the PWK segment, the following guidelines must be followed:
  - PWK01 - The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
  - PWK06 - Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

4. ASC X12N/005010X223A2 Health Care Claim: Institutional (837) -- Transaction Specific Information

4.1. Introduction to Table

The following table provides information needed to implement the *ASC X12N/005010X223A2 Health Care Claim: Institutional (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X223A2* and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

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

Please also see section 2.2 above.

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2000B SUBSCRIBER HIERARCHICAL LEVEL	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2010BA SUBSCRIBER NAME	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
2010BA SUBSCRIBER NAME	DMG Subscriber Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient
2010BB PAYER NAME	REF Billing Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers
2010CA PATIENT NAME	DMG Patient Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient.
2300 CLAIM INFORMATION	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definition.

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2300 CLAIM INFORMATION	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	PWK02 Attachment Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300 CLAIM INFORMATION	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300 CLAIM INFORMATION	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	NTE Billing Note	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2320 OTHER SUBSCRIBER INFORMATION	SBR Other Subscriber Information	N/A	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2330B OTHER PAYER NAME	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV202-7 Description	See front matter section 3.2.5 of this document for additional instructions.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV204 Unit or Basis for Measurement Code	See Appendix A for coding measurements.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV205 Quantity	Zero “0" is an acceptable value only if defined as appropriate pursuant to NUBC rules.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV207 Monetary Amount	This amount cannot exceed the service line charge amount.
2400 SERVICE LINE NUMBER	DTP Date – Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400 SERVICE LINE NUMBER	AMT Facility Tax Amount	N/A	See Appendix B for details on reporting MNCare.

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5. List of Appendices

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

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

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

a) Hospital

b) All other residential

c) Outpatient

B. Appendix B: K3 SEGMENT USAGE INSTRUCTIONS

Appendix B provides guidance for K3 SEGMENT USAGE INSTRUCTIONS

C. Appendix C: Reporting MNCare Tax;

Appendix C provides instructions for reporting the MNCare Tax.

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A. Appendix A: Code Set Supplemental Information For Minnesota Uniform Companion Guides

A.1 Introduction and Overview

Minnesota Statutes, Section 62J.536 requires the standard, electronic exchange of health care claims using a single, uniform companion guide to HIPAA implementation guides,[1] including uniform billing and coding standards. The statute further requires the Commissioner of Health to base the transaction standards and billing and coding rules on federal HIPAA requirements and on the Medicare program, with modifications that the commissioner deems appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC).

This appendix, including the accompanying tables, presents rules for the selection and use of medical codes from the HIPAA code sets that are associated with the 005010X223A2 Institutional (837) transaction.

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

NOTE--As further described in the sections below:

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

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

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

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

- Report one unit for all services without a measure in the description.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
  - "per vertebral body;"
  - "each 30 minutes;"
  - "each specimen;"
  - "15 or more lesions;"
  - "initial."
- Follow all related AMA guidelines in CPT[3] (e.g. "unit of service is the specimen" for pathology

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

codes). Definition of “specimen”: "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]

- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow general rounding rules for reporting more than the code’s time value. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Do not follow Medicare’s rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

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

- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.1 as “institutional claim type” or “837I” or “Institutional claim”;

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

- ASCX12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1 as “professional claim type” or 837P or “Professional claim”;
- ASC X12/005010X224A2 Health Care Claim: Dental (837), referred to in Table A.5.1 as “837D”;
- Pharmacy Claims Submission and Response and the Pharmacy Reversal Submission and Response Transactions per the NCPDP Telecommunication Standard Implementation Guide, Version D.Ø, referred to in Table A.5.1 as “NCPDP”.

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

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

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Interpreter Services	For interpreter services: ▪ Use Revenue code 0949 and appropriate HCPCS code(s) as follows. Note: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report a unit. o T1013 -- Face-to-face oral language interpreter services per 15 minutes o T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes o T1013-GT -- Telemedicine interpreter services per 15 minutes o T1013-U4 -- Telephone interpreter services per 15 minutes o T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting o Report T1013 for each patient in the group setting ▪ Append the modifier indicating how many patients in the group ▪ Report one unit per 15 minutes per patient o T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes ▪ Report one unit per 15 minutes per client ▪ If more than one service is provide, report each on a separate line appended with the -59 modifier ▪ T1013-52 x 2 units (30 minutes of drive time)

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			▪ T1013-5259 (12 minutes of wait time) ▪ Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. ▪ Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported ▪ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation o 99199 -- Mileage for interpreter service ▪ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported ▪ Report one unit per mile
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Modifiers 76 or 91	Modifiers 76 (pathology only) or 91 (clinical diagnostic lab) are to be used for repeat services subsequent to the original service only. The number of units reported is the number of services performed as defined in the code description or relevant current AMA guidelines in CPT.
5	Part B Outpatient Rehabilitation and CORF/OPT Services		Do not follow Medicare's rounding rules for physical, occupational and speech therapies. See general rules for reporting units at the front of this appendix.
6	Inpatient Part A Billing and SNF Consolidated Billing	Room and Board	Room and Board is reported according to the level of nursing care provided using revenue codes 019X

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
6	Inpatient Part A Billing and SNF Consolidated Billing	Reporting private room and/or in lieu of day differentials	There are situations when skilled nursing and long term care facilities need to report private room and/or in lieu of day differentials separate from room and board charges. ▪ Private Room differential use 0229; 1 unit = 1 day ▪ In lieu of days differential use 0230; 1 unit = 1 hour
6	Inpatient Part A Billing and SNF Consolidated Billing	Ancillaries	Ancillaries are reported separately as appropriate
6	Inpatient Part A Billing and SNF Consolidated Billing	Long term care	Also applicable to Long Term Care
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Follow Medicare coding guidelines
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers		Not applicable to the Institutional guide. Report on the claim type appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
10	Home Health Agency Billing	Home Health Services	Home Health Services are reported on the 837I using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P Revenue Codes 041X – 044X and 055x – 060x as appropriate

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
10	Home Health Agency Billing	Reporting continuous services beyond the encounter and multiple nurse encounters with the same date of service	For home care the industry standard defines "per diem" as all inclusive services per patient encounter up to two hours. ▪ To report extended continuous services beyond the encounter use the fifteen minute code(s). ▪ To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.
10	Home Health Agency Billing	Approved HCPCS code set	Medicare's G codes are insufficient to describe the level of time codes that group purchasers require for proper case management. See Approved HCPCS Code Set below. Approved HCPCS code set: ▪ Skilled Nursing Encounter: o RN: T1030 o LPN:T1031 ▪ Home Health Aide Visit: T1021 ▪ Home Health Aide (Extended: T1004 ▪ PT Visit: S9131 o PT Asst. Visit: S9131 TF ▪ OT Visit: S9129 o OT Asst. Visit: S9129 TF ▪ RT Evaluation: S5180 ▪ RT Visit: S5181 ▪ Speech Visit: S9128 ▪ MSW Visit: S9127 ▪ RN: T1002 ▪ RN Complex: T1002 TG ▪ RN Shared 1:2 ratio T1002 TT ▪ LPN: T1003 ▪ LPN Complex: T1003 TG ▪ LPN Shared 1:2 ratio T1003 TT ▪ Postpartum home visit 99501 ▪ Newborn care home visit 99502
11	Processing Hospice Claims		Follow Medicare coding guidelines

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
~~12~~	~~Physicians/ Nonphysician Practitioners~~	~~In-reach Community Based Coordination~~	~~Report under TOB 013x and revenue code 0984. Use HCPCS T1016-U2 or T1016-U2-TS.~~ ~~▪ T1016 Case management, each 15 minutes~~ ~~▪ U2 = In-reach, initial service~~ ~~▪ U2-TS = In-reach, follow-up~~
13	Radiology Services and Other Diagnostic Procedures	Bilateral Radiology	▪ Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance		Follow Medicare coding guidelines
16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. “Welcome to Medicare”) are only applicable to Medicare and Medicare replacement products

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

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

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
22	Remittance Advice		Not applicable to the Institutional guide
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to the Institutional guide
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to the Institutional guide
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to the Institutional guide
27	Contractor Instructions for CWF		Not applicable to the Institutional guide
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to the Institutional guide
29	Appeals of Claims Decisions		Not applicable to the Institutional guide

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
30	Financial Liability Protections		Not applicable to the Institutional guide
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to the Institutional guide
32	Billing Requirements for Special Services		Follow the code selection guidelines in the Appendix A front matter
33	Miscellaneous Hold Harmless Provisions		Not applicable to the Institutional guide
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines
35	Independent Diagnostic Testing Facility		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines
See the following for Freestanding Birth Centers (Not addressed in the Medicare Claims Processing Manual)			

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

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

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			newborn's cares are reported on the 837P only.

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

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

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

HA	Child/adolescent program
HE	Mental health program
HK	Specialized mental health programs for high-risk populations
HM	Less than bachelor's degree
HN	Bachelor's degree level
HQ	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
HW	Funded by state mental health agency (service provided by state staff person)
TF	Intermediate level of care
TG	Complex/high tech level of care
TS	Follow up service
UA	Children's Therapeutic Services and Supports (CTSS)
UD	Transition to community living (Adult Rehabilitation Mental Health Services (ARMHS))
U1	Dialectical Behavioral Therapy
U4	Via other than face to face contact; e.g. telephone
U5	Advanced level specialist
U6	Interactive
U7	Physician extender (includes mental health practitioner as defined by MN Statute 245.4711, Subd. 17)

NOTE: The U modifiers in this table are specific to Mental Health

A.5.2.2. Behavioral Health Programs Listed in Table A.5.2

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

Assertive Community Treatment (ACT)

Adult Crisis Response Services

Children's Mental Health Crisis Response Services

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Children's Therapeutic Services and Supports (CTSS)

Adult Rehabilitative Mental Health Services (ARMHS)

~~Certified Family Peer Specialist~~Peer Services

Mental Health Diagnostic Assessment

Dialectical Behavior Therapy

Youth Assertive Community Treatment

Intensive Treatment in Foster Care

Mental health Family Psychoeducation Services

Mental Health Clinical Care Consultation

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

V9.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)

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

Name of Program	Description/Definition	Coding

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

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

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

Name of Program	Description/Definition	Coding
Children's Mental Health Crisis Response Services Back to list of behavioral health programs	▪ Intensive face-to-face, short-term services initiated during a crisis; provided on-site by a mobile crisis response team. ▪ County or county contracted agency.	Codes: ▪ S9484 UA - Crisis intervention mental health services, per hour, Children's Crisis Response Services, mental health professional ▪ S9484 UA HN - Crisis intervention mental health services, per hour, Children's Crisis Response Services, bachelor's degree level mental health practitioner

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

Name of Program	Description/Definition	Coding
Mental Health Targeted Case Management (MH-TCM) Back to list of behavioral health programs	▪ Community support plan and functional assessment to help SPMI adults and SED children gain access to needed medical, social educational, vocational, financial services relative to mental health needs.	Codes: ▪ T2023 HE HA – Targeted case management; per month, mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years ▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older ▪ T2023 HE TF - Targeted case management intermediate level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older ▪ T1017 HE – Targeted case management, per encounter (day), mental health program, adult, face-to-face contact between case manager and recipient age 18 or older, IHS/638 facilities and FQHCs ▪ T1017 HE HA – Targeted case management, per encounter (day), mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years, IHS/638 facilities and FQHCs

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

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

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

Name of Program	Description/Definition	Coding
Children's Day Treatment Back to list of behavioral health programs	▪ A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services provided by multidisciplinary team.	Codes: ▪ H2012 UA HK – Behavioral health day treatment, per hour, CTSS ▪ H2012 UA HK U6 – Behavioral health day treatment, per hour, CTSS interactive

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

Name of Program	Description/Definition	Coding
Children's Therapeutic Services and Supports (CTSS) Back to list of behavioral health programs	▪ Rehabilitative services that offer a broad range of medical and remedial services and skills to help restore individuals' self-sufficiency/functional abilities - a flexible package of mental health services for children.	Codes: ▪ 90832 UA – Psychotherapy w/patient and/or family, 30 minutes, CTSS ▪ 90833 UA – Psychotherapy w/patient and/or family, 30 minutes with an E/M*, CTSS ▪ 90834 UA - Psychotherapy w/patient and/or family, 45 minutes, CTSS ▪ 90836 UA - Psychotherapy w/patient and/or family, 45 minutes with an E/M*, CTSS ▪ 90837 UA - Psychotherapy w/patient and/or family, 60 minutes, CTSS ▪ 90837 UA plus 99354 Psychotherapy w/patient and/or family 60 minutes, CTSS ▪ 90838 UA- Psychotherapy w/patient and/or family, 60 minutes with E/M*, CTSS ▪ 90839 UA –Psychotherapy for crisis, first 60 minutes, CTSS ▪ 90840 UA- Each additional 30 mins [add on to 90839], CTSS ▪ 90846 UA - Family psychotherapy without patient, CTSS ▪ 90847 UA - Family psychotherapy with patient, CTSS ▪ 90849 UA - Multiple family group psychotherapy, CTSS ▪ 90853 UA - Group psychotherapy, CTSS ▪ 90875 UA - Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy , 30 minutes, CTSS ▪ 90876 UA Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 45 minutes, CTSS ▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS

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

Name of Program	Description/Definition	Coding
		▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS *(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)

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

Name of Program	Description/Definition	Coding
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes ▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner ▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker ▪ 90882 - Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD - Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting

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

Name of Program	Description/Definition	Coding
~~Certified Family Peer Specialist~~ Peer Services Back to list of behavioral health programs	Non-clinical support counseling services provided by certified peer specialist ~~to adults or children~~	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 HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes~~

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

Name of Program	Description/Definition	Coding
Mental Health Diagnostic Assessment Back to list of behavioral health programs	A diagnostic assessment is a written report that documents the clinical and functional face-to-face evaluation of a recipient's mental health and is necessary to determine a recipient's eligibility for mental health services.	Codes: In order to report diagnostic assessments with levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service

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

Name of Program	Description/Definition	Coding
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20

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

Name of Program	Description/Definition	Coding
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (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.	Codes: ▪ 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.

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

Name of Program	Description/Definition	Coding
Mental Health Family Psychoeducation services Back to list of behavioral health programs	• Family psycho-education services provided to a child up to age 21 with a diagnosed ~~MH~~ mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5 9505.0371, subpart 5, item C • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o ~~Explain, educate, and support the child and family~~understanding a child's symptoms of mental illness o The impact on the child's development; o ~~Needed~~ needed components of treatment; and o ~~Skill~~ skill development	Codes: ▪ 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
~~**Mental Health Clinical Care Consultation**~~ ~~Back to list of behavioral health programs~~	~~• MH clinical care consultation services provided to patients up to age 21 and provided by mental health professional or clinical trainee to other providers or educators not under their supervision~~ ~~• Services may take place in, but are not limited to, school, community, office or clinic~~	~~Codes:~~ ~~▪ 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 trainee.~~

A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

c) Outpatient Services.

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

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

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

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

V9.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)

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

(Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)

Service Description	Option 1 or 2 *	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
Room and Board	1	Day	0118, 0128, 0138, 0148, 0158	N/A	837I	011x-hospital inpatient
Detox	1	Day	0116, 0126, 0136, 0146, 0156	N/A	837I	011x-hospital inpatient
Treatment component	1	Day	Choose one per date of service: 0944 or 0945 or 0949	N/A	837I	011x-hospital inpatient
Ancillary	1	Based on Revenue Code	As appropriate	N/A	837I	011x-hospital inpatient
All-inclusive Room and Board	2	Day	0101	N/A	837I	011x-hospital inpatient
Detox	2	Day	0116, 0126, 0136, 0146, 0156	N/A	837I	011x-hospital inpatient

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

(Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)

Service Description	Option 1 or 2 *	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
Ancillary Services	2	Based on Revenue Code	as appropriate	N/A	837I	011x-hospital inpatient

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

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

V8.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)					
A.5.3.b – Substance Abuse Services: All Other Residential					
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	Day	1002: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) 1003: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
Treatment program, treatment component	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
Treatment program, treatment component	Hour	0953	None	837I	086x – special facility, residential
Ancillary services	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

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

V8.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)

Table A.5.3.c.i – Substance Abuse Services: Outpatient Services – Claim Type 837I

(Applicable to all providers and settings per applicable contract or established program standards)

Claim Type – 837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.	Day	0944	H0047 U9	089x or 013x
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

NOTE: Take-home doses place of service 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.

Table A.5.3.c.ii – Substance Abuse Services: Outpatient Services – Claim Type 837P

(Applicable to all providers and settings per applicable contract or established program standards)

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
Note: MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs				N/A
Alcohol and/or drug assessment	Session/visit	N/A	H0001	N/A

Note: Take-home doses place of service 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.

B. APPENDIX B: K3 Segment Usage Instructions

The K3 segment in the 2300 Loop is used to meet regulatory requirements when the X12N Committee has determined that there is no alternative solution within the current structure of the 005010X223A2. The situations noted here have been approved by the X12N Committee and will be considered as a business need in development of future versions of this transaction.

If multiple K3 needs exist on a single claim at the same loop level, it is recommended that separate K3 segments be sent.

State of Jurisdiction

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

LU is the qualifier to indicate this value and should be followed by the two-character state code.

Report at 2300 Loop only.

K3*LUMN~

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C. Appendix C: Reporting MNCare Tax

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

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

Summary of Public Comments to 837P & 837I for AUC MCT Final Review and Vote
Rev 2-9-15

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Changes to Appendix A, Table A.5.1		
N/A – Doula Services P37 or (41 of 67)	Added: Program name, link to MS, and Minnesota Rule for Doula Services* **S9445 U4** – ante-partum and post-partum Doula services 99199 U4 – Doula attendance at labor and delivery *Included "Doula Services" in current note above new entry, "See the following…that are not addressed…Medicare Claims…"	✓	
N/A – Licensed Traditional Midwife…	Revised Free-standing Birth to Free-standing **Birthing** Center	✓	
Table A.5.1 Chapter 12 Physician/Nonphysician Practitioners Modifier 50	Revised statement to read: *Modifier 50 should only be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. Bilateral services are to be reported with the 50 modifier on one line with one unit. (**Public Comment submitted 1-9-15**)*	✓	
Table A.5.1 Freestanding Birth Centers	Correction to entries for **Freestanding Birth Centers** Replaced Birth with Birthing Revise entry to mirror billing information posted on DHS website for Freestanding birth center services as follows (**changes not made**): • Bill professional CNM & CPM charges on the 837P • If a recipient is transferred to the hospital before delivery, professionals may bill an Evaluation and Management (E/M) visit and appropriate prolonged care codes. Only one 99355 may be billed per recipient transfer, up to six units (three hours max)		✓

Comment [MN1]: Faith, we discuss the midwives in the 837P, including transferred patient. Are any changes required?

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	• Bill facility charges on the Outpatient 837I, as follows: • Type of bill is 084x (0840 through 0848) • Revenue code is 0724 • Use CPT code 59400 for before birth (antepartum), labor and delivery, and postpartum care • Use HCPCS code S4005 for transfers		
Chapter 12 – Physician/Nonphysician Practitioner	Deleted program entry from guide (now in 837 only): ~~In-reach Community Based Coordination~~		✓
	Changes to Appendix A, Table A.5.2.1 (Modifiers found in Table A.5.2)		
Mental Health-Related Modifiers	Correction to modifier U5: Added "specialist" to read Advanced level specialist Moved note into modifier table Note: The U modifiers in this table are specific to Mental Health.	✓	✓
	Changes to Appendix A, Table A.5.2.2 (List of programs found in Table A.5.2)		
List of links to programs in Table A.5.2	Deleted link: ~~Certified Family Peer Specialist~~ Added link: Peer Services	✓	✓
List of links to programs in Table A.5.2	Deleted link: ~~Mental Health Clinical Care Consultation~~		✓
	Changes to Appendix A, Table A.5.2		
Certified Family Peer Specialist	D~~eleted program entry from list~~ (Removed per DHS request and replaced previous Peer Services program in v8.0; program has not been approved by CMS)	✓	✓
Peer Services	Added new: Peer Services Non-clinical support counseling services provided by certified peer specialist ▪ H0038 – Certified peer services, per 15 minutes	✓	✓

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	▪ H0038 U5 – Advanced level certified peer services, per 15 minutes		
Mental Health Family Psychoeducation Services	Description/definition was incomplete. Revised bullets to read as follows: • Family psycho-education services provided to a child up to age 21 with a diagnosed mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5, 9505.0371, subpart 5, item C • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o understanding a child's symptoms of mental illness; o the impact on the child's development; o needed components of treatment; and o skill development	✓	✓
	Changes to Table A.5.4.c – Other Services		
Maternal and Child Health Billing Guide for Public Health Agencies	Deleted duplicate Code column	✓	
	Changes to Table A.5.4.c – Miscellaneous		
Maternal and Child Health Billing Guide for Public Health Agencies	Deleted duplicate Code column Replaced Child Mental Health Screenings code 96110 UC with 96127	✓	

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

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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.

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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?
- **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?

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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]: 1/8/15

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

AUC Co-Chair(s):Faith Bauer

AUC Response:

CMS had approved coding for Doula Services and that final coding recommendations are as follows:

- S9445 U4 modifier for ante and post-delivery sessions
- 99199 labor and delivery

Doula services are limited to six sessions and prior authorization with medical necessity documentation is required for additional sessions to be approved by DHS. Doula services will also have the same 60-day post-partum limitation currently allowed. Lactation services may be provided by doulas. However lactation services will be paid to doulas or lactation specialist but not both; DHS will reimburse first approved submitted bill.

Doula services must be provided under supervising practitioners and these practitioners must bill the doulas services under their NPI.

Guide will be added to the 2015 MN Uniform Companion Guides.

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- **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?
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AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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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 CERTIFIED FAMILY PEER SPECIALIST

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 Mental Health Certified Family Peer Specialist for children. Minnesota Statute 256B.061, subd. 1 reads:

Medical assistance covers mental health certified family peer specialist services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a certified family peer specialist who has completed the training under subdivision 5. A family peer specialist cannot provide services to the peer specialist's family.

Coverage for Mental Health Certified Family Peer Specialist services for children applies to DHS fee-for-service and managed care.

B

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

Currently, adult mental health uses the H0038 (with and without modifiers) for certified peer specialist services. "Peer Services" with HCPCS code H0038 is in table A.5.2 in the Companion Guide for the 837P.

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): Coverage of Mental Health Certified Family Peer Specialist for children applies to DHS fee-for-service and managed care. "Peer Services" already exists in the Minnesota Uniform Companion Guide (837P), table A.5.2. We will need to update the table.
R	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: After federal approval, the following should be added to the MN Community Coding Practice/Recommendation Table and subsequently the Minnesota Companion Guide (837P), table A.5.2. Also, currently the guide does not list modifier HQ for group services and it is billable. Since we would be updating the guide for children, it would be good to add the HQ modifier as well. The guide would be updated to read (new in red): 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

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]:NCT

AUC Co-Chair(s):Faith Bauer

AUC Response:

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

CLOSED

Add to Coding Recommendation Grid and MN Uniform Companion Guides when updated

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.

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- 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 trainee
- This guide will be added to the 2015 MN Uniform Companion Guides during the comment period.

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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 FAMILY PSYCHOEDUCATION SERVICES

S

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

The 2013 Minnesota Legislature passed legislation for Family Psychoeducation Services. The following is from 256B.0625, Subd. 61:

Family Psychoeducation Services. Effective July 1, 2013 or upon federal approval, whichever is later, medical assistance covers family psycho-education services provider 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 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.

Coverage of Mental Health Family Psychoeducation 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 Family Psychoeducation is a new covered service for persons 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).

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):

Family psychoeducation explains, educates, and supports 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. This is done so the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and to achieve optimal mental health and long-term resilience.

- Family Psychoeducation can be provided to an individual child or adolescent alone, to an individual and their family alone, to a group of multiple different families, or to a group of individuals who would benefit from psychoeducation in a peer group.
- Family Psychoeducation is provided by a licensed mental health professional or clinical trainee.
- A licensed mental health professional includes 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).
- Family Psychoeducation is provided when a mental health professional has determined that it is medically necessary to involve family member in the child or adolescent's care.
- Family Psychoeducation services may take place in, but are not limited to, school, community, office or clinic
- Family Psychoeducation is billed in 15 minute increments and is a professional service that would be billed on the 837P claim transaction.

Coverage of Mental Health Family Psychoeducation applies to DHS fee-for-service and managed care.

R

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

H2027 Psychoeducational service, per 15 minutes.
HN Bachelor's degree level
HQ Group setting
HR Family/couple with client present
HS Family/couple without client present

Coverage of Mental Health Family Psychoeducation is effective 07/01/13, however, DHS must have federal approval first. After federal approval, the following should be added to the MN Community Coding Practice/Recommendation Table and subsequently the Minnesota Companion Guide.

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

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]: 4/10/14

Reviewed by: [AUC TAG Name]: MCT

AUC Co-Chair(s): Faith Bauer

AUC Response:

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

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."

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).

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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- **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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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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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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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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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: 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.

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:

Medical Code TAG (MCT) 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.

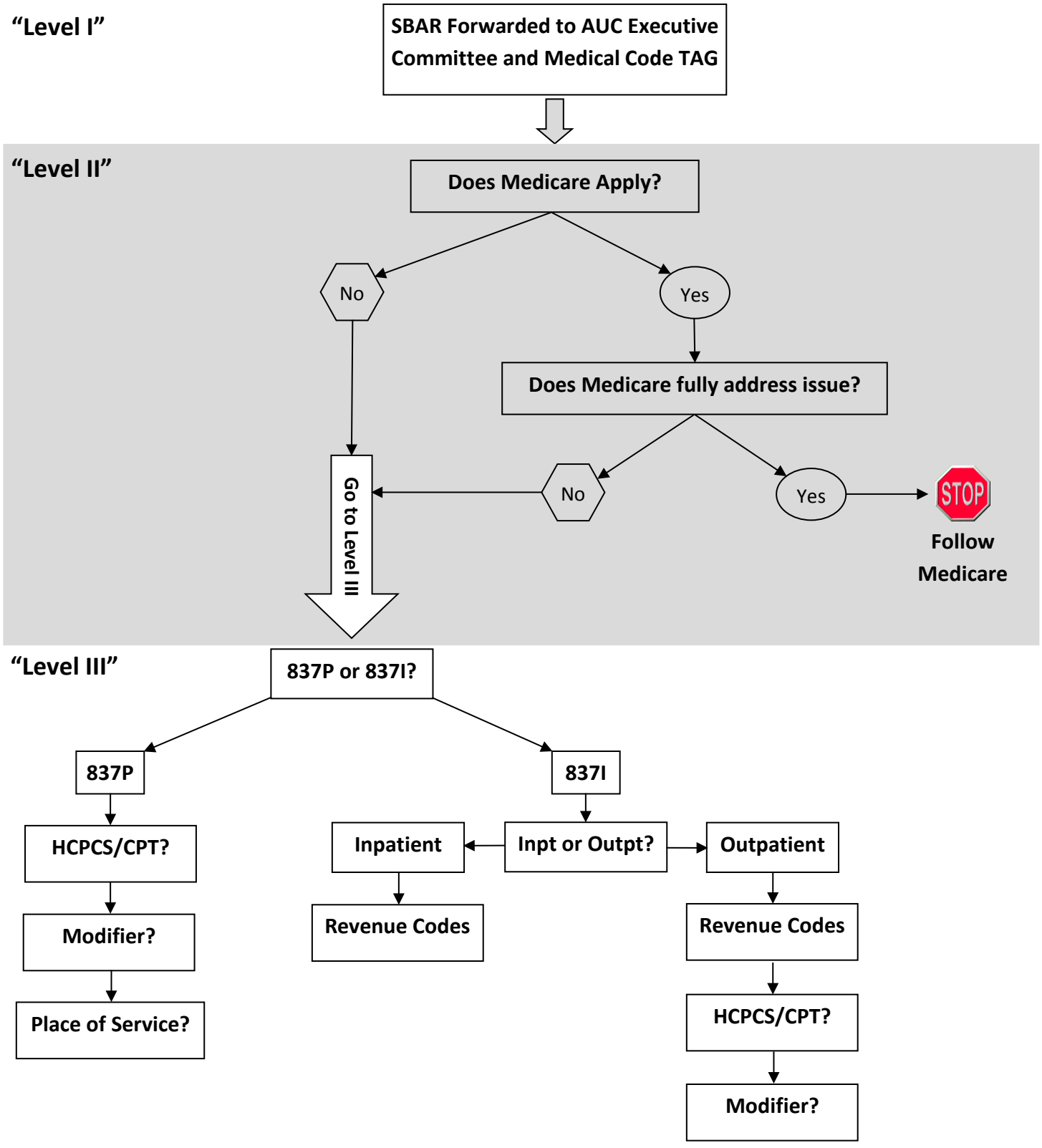
- If Medicare applies, and there are no other concerns or perceived problems with Medicare coding (e.g., vagueness or possible confusion in Medicare instructions, Medicare does not fully address the service in question), the MCT recommendation will be to "follow Medicare" and the issue will be considered 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.

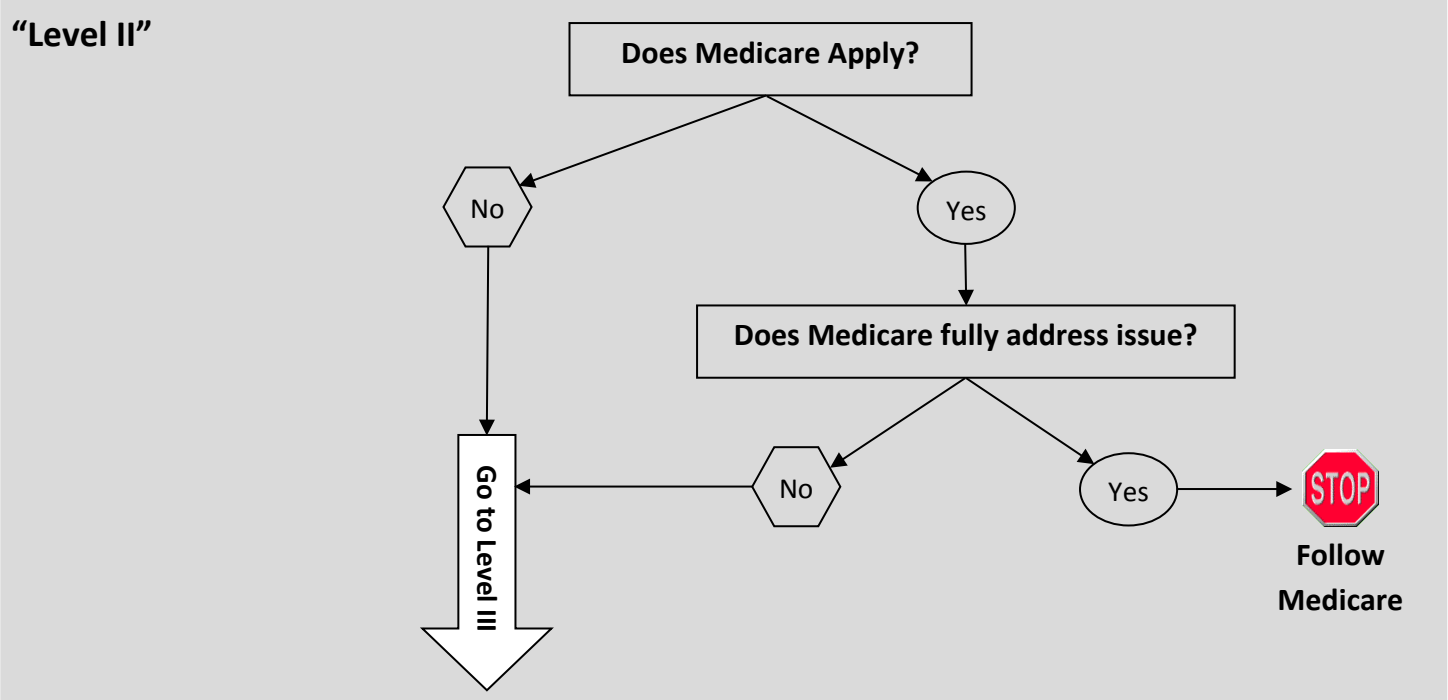
The MCT coding recommendation process above is presented schematically in the summary flow chart on the next page.

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



Note: Coding recommendations will include additional information as applicable regarding: who the decision applies to (who will provide the services); effective date(s); and appropriate references to federal authority. The MCT will coordinate with the Claims DD TAG on place of service issues. 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:

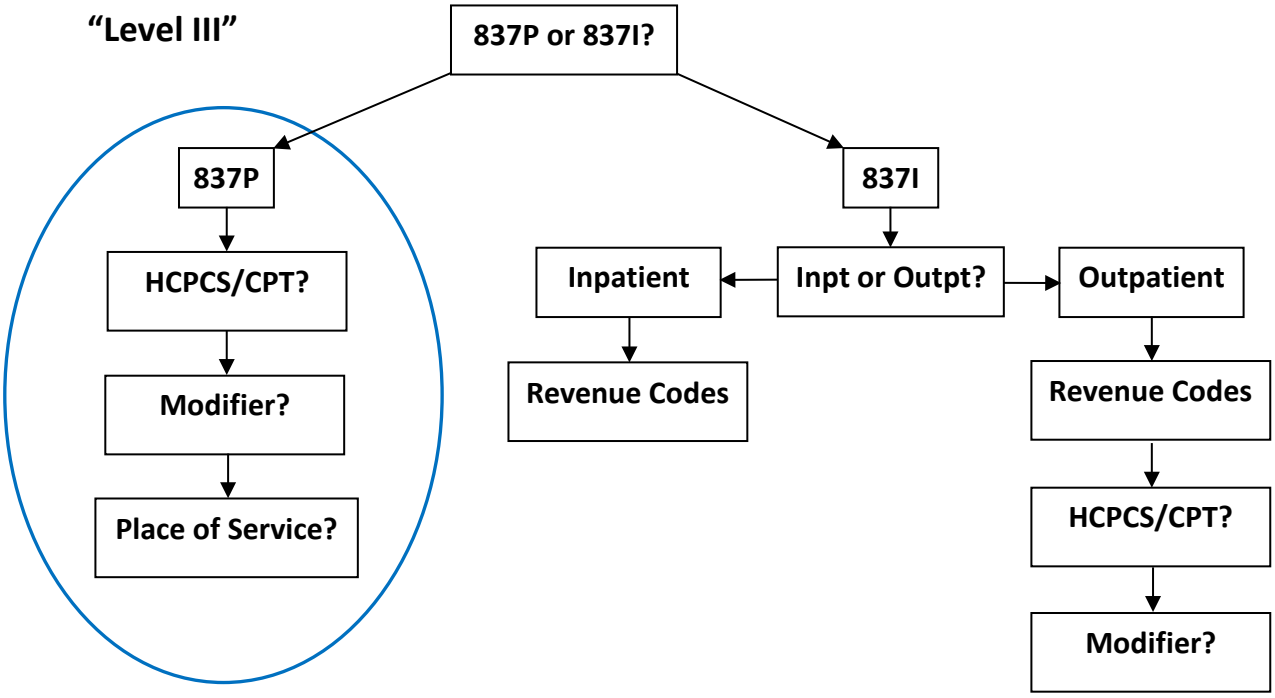


Decision Tree Questions for Level II:

1. Does Medicare have coding requirements/instructions for coding the medical service/procedure/etc. of interest?	
Yes _X_	If "yes," please reference the source of the Medicare instructions and provide a link. Medicare source and link: NGS Article for Health and Behavior Assessment/Intervention Medical Policy Article (A48209) http://www.ngsmedicare.com/ngs/portal/ngsmedicare/a48209/!ut/p/a1/tVPBcoIwFPwVLx6dvBIicKTWOrairYyjcOnE8MBUDIoZp_37JmqnXkQvzeltsps32X0hKVmQVPGDLLiWleKlxWn3A8b0KXxmLkDMGAz7MPWi2HPAfTCExBJe4t6JEAUAw7AbPw8GQCdj1qifsFt65079lRVCo96nZE5Sku75AUVVrSVaJErk9R-c9gfDyfh4oPRWr0iiiv0GMyl4bVRKo9JtuNhrg6gOWPMCWxlqrDdSHe1sw4lRtrZVKcV3Sxgl1m3gru9AYDtsjSjDvSzUEQmZkcRxkdIlgMswCLwuXWY-LjOaB9TLGIrcMkeTR5K88Vq3Hn8duf7kG4nGqE6u3Mi1meD8EhqSuZVNYl7iXSW8OiS2d8x70cf7rD817IscDbrM0cBzjqa6dOt-m1_u-Aryc7dLQzMpdiy-NFn806iYVk4d9aLCjoxedaTKK7I4H84bbXO7JAUy58L2OTl4rpO99WtFtpvZbLaeDvxPXLK8L4cdnoShT1l5GOWlTH4AGzRrng!!/dl5/d5/L3dHQSEvUUtRZy9nQSEh/?clearcookie=&savecookie=&REGION=&LOB=Part%20B# Then go to question 2 below.
No ___	Go to Level III, beginning on page 4
2. Does Medicare's coding guidance fully address the issue?	
Yes ___	Done. STOP Follow Medicare as referenced at the link in question no. 1 above.
No _X_	If "no," please check any of the concerns below that apply and provide examples, and then go to Level III, beginning on page 4. *a.* _X___ 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: Go to Level III, beginning on page 4

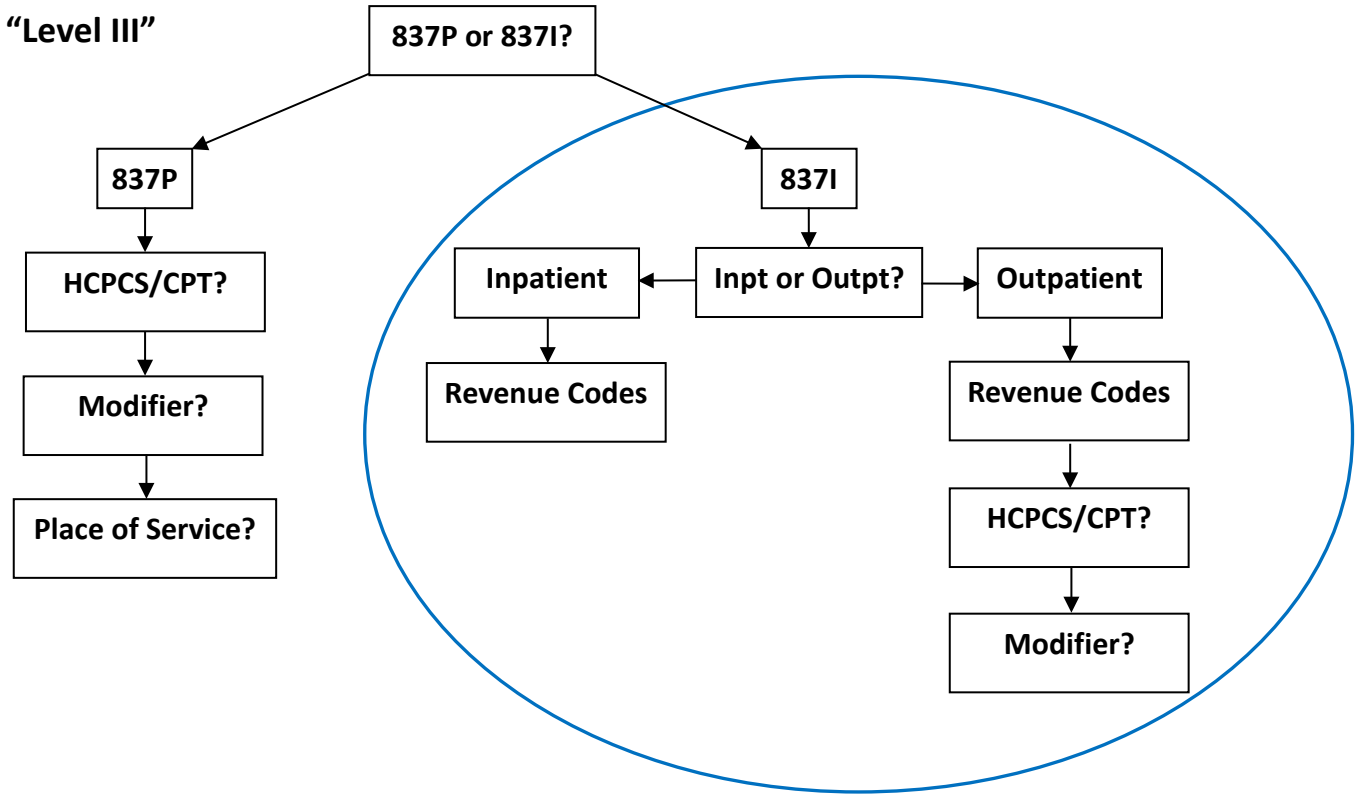
Level III. Name/description of service/issue:



Decision Tree Questions for Level III: (MCT recommendations)

1. 837P or 837I?	
837P _X_	If "837P," then go to question 2.
837I ___	If "837I," then go to question 5 below.
2. What are the HCPCS/CPT codes?	
HCPS: 96150-96155	Cite source and provide link: Go to question 3
3. Are modifiers needed/applicable	
Modifier: n/a	Cite source and provide link: Go to question 4
4. What is the place of service (POS)?	
POS: Clinic	Cite source and provide link:

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.
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/applicable?	
Modifier:	Cite source and provide link:

Summary of MCT findings and recommendations

Name/description of service/issue: _____

Level II 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.)

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

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			

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT

(Draft for AUC MCT 02/12/15)

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 and identify the level of provider performing the service. The two types of treatment are Applied Behavioral Analysis (ABA) and Developmental and Behavioral Intervention (DBI).

Of note are the 7/1/14 CPT Category III codes 0359T-0374T. These codes initially were not selected because they appeared to be specific to one form of treatment. In November 2014, the AMA CPT Symposium presented these codes with a great deal of information. As a result, we have replaced many of our previous choices with the Category III codes. The following pages breakdown services for the EIDBI benefit into individual pages. Each of the 7 services has its own page.

1. EIDBI Intervention
2. EIDBI Intervention Supervision and Direction
3. Comprehensive Multi-Disciplinary Evaluation (CMDE)
4. Individual Treatment Plan Development and Monitoring
5. Family Caregiver Training and Counseling
6. Coordinated Care Conference
7. Travel Time

EIDBI INTERVENTION
(APPLIED BEHAVIORAL ANALYSIS)

What is it?

Applied Behavioral Analysis (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. DHS recognized ABA therapies may include, but are not limited to, Discrete Trial Training, Verbal Behavior Intervention and Pivotal Response Training. This treatment may be individual or group.

Who Can Provide ABA Services?

Qualified Supervising Professional
Developmental/Behavioral Professional (Board Certified Behavior Analyst or BCBA)-Level I Provider
Developmental/Behavioral Practitioner (Board Certified Behavior Analyst Assistant or BCaBA)-Level II Provider
Developmental/Behavioral Support Specialist (Registered Behavior Technician or RBT)-Level III Provider

Where does Service Take Place

Home or Center-individual intervention
Center-group intervention

Selected Code Descriptions

0364T Adaptive behavior treatment by protocol, administered by technician, face-to-face with patient, 1st 30 minutes of technician time.
0365T Adaptive behavior treatment by protocol, administered by technician, face-to-face with patient, each additional 30 minutes of technician time
0366T Group adaptive behavior treatment by protocol, admin by technician, face-to-face with 2 or more patients; first 30 minutes of tech time.
0367T Group adaptive behavior treatment by protocol, admin by technician, face-to-face with 2 or more patients; each additional 30 minutes of tech time.
0368T Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with 1 patient, first 30 minutes of patient face-to-face time.
0369T Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with 1 patient, each additional 30 minutes of patient face-to-face time.
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
HM Less than bachelor degree level

Coding Individual	Coding Group
0368T/new EIDBI modifier -physician or APRN 1st 30 minutes	0366T/new EIDBI modifier-Physician or APRN
0369T/new EIDBI modifier - physician or APRN each additional 30 minutes	0367T/new EIDBI modifier -Physician or APRN
0368T/HP/new EIDBI modifier -Doctoral level 1st 30 minutes	0366T/HP/new EIDBI modifier -Doctoral level
0369T/HP/new EIDBI modifier - Doctoral level each additional 30 minutes	0367T/HP/new EIDBI modifier Doctoral level
0368T/HO/new EIDBI modifier -Master's degree level 1st 30 minutes	0366T/HO/new EIDBI modifier -Master's degree level
0369T/HO/new EIDBI modifier -Master's degree level each addl 30 minutes	0367T/HO/new EIDBI modifier -Master's degree level
0364T/HN/new EIDBI modifier Bachelor's degree level 1st 30 minutes	0366T/HN/new EIDBI modifier - Bachelor's degree level 1st 30 minutes
0365T/HN/new EIDBI modifier Bachelor's degree level each addl 30 minutes	0367T/HN/new EIDBI modifier -Bachelor's degree level each addl 30 min
0364T/HM/new EIDBI modifier Less than bachelor degree level 1st 30 min	0366T/HM/ new EIDBI modifier -Less than bachelor's degree level 1st 30 min
0365T/HM/new EIDBI modifier Less than bachelor degree level each addl 30 min	0367T/HM/new EIDBI modifier -Less than bachelor degree level each addl 30 min

Notes:

This service requires a time based code. Treatment time can vary greatly based on individual child needs. We contacted a member of the CPT Editorial Panel to suggest a 15 minute unit on several codes (these codes included), however, no changes will be made. The codes will remain with a 30 minute unit.

EIDBI INTERVENTION
(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".

DHS recognized DBI therapies may include but are not limited to:

* 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
Developmental/Behavioral Professional-Level I Provider
Developmental/Behavioral Practitioner-Level II Provider
Developmental/Behavioral Support Specialist-Level III Provider

Where does Service Take Place

Home or Center-individual DBI
Center-group DBI

Selected Code Descriptions

0364T Adaptive behavior treatment by protocol, administered by technician, face-to-face with patient, 1st 30 minutes of technician time.
0365T Adaptive behavior treatment by protocol, administered by technician, face-to-face with patient, each additional 30 minutes of technician time
0366T Group adaptive behavior treatment by protocol, admin by technician, face-to-face with 2 or more patients; first 30 minutes of tech time.
0367T Group adaptive behavior treatment by protocol, admin by technician, face-to-face with 2 or more patients; each additional 30 minutes of tech time.
0368T Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with 1 patient, first 30 minutes of patient face-to-face time.
0369T Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with 1 patient, each additional 30 minutes of patient face-to-face time.
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
HM Less than bachelor degree level

Coding Individual	Coding Group
0368T-physician or APRN 1st 30 minutes	0366T/new EIDBI modifier-Physician or APRN
0369T- physician or APRN each additional 30 minutes	0367T/new EIDBI modifier -Physician or APRN
0368T/HP-Doctoral level 1st 30 minutes	0366T/HP/new EIDBI modifier -Doctoral level
0369T/HP- Doctoral level each additional 30 minutes	0367T/HP/new EIDBI modifier Doctoral level
0368T/HO-Master's degree level 1st 30 minutes	0366T/HO/new EIDBI modifier -Master's degree level
0369T/HO-Master's degree level each additional 30 minutes	0367T/HO/new EIDBI modifier -Master's degree level
0364T/HN Bachelor's degree level 1st 30 minutes	0366T/HN/new EIDBI modifier - Bachelor's degree level 1st 30 minutes
0365T/HN Bachelor's degree level each additional 30 minutes	0367T/HN/new EIDBI modifier -Bachelor's degree level each addl 30 min
0364T/HM Less than bachelor degree level 1st 30 minutes	0366T/HM/ new EIDBI modifier -Less than bachelor's degree level 1st 30 min
0365T/HM Less than bachelor degree level each additional 30 minutes	0367T/HM/new EIDBI modifier -Less than bachelor degree level each addl 30 min

Coding Notes:

This service requires a time based code. Treatment time can vary greatly based on individual child needs. We contacted a member of the CPT Editorial Panel to suggest a 15 minute unit on several codes (these codes included), however, no changes will be made. The codes will remain with a 30 minute unit.

EIDBI INTERVENTION SUPERVISION and DIRECTION

What is it?

EIDBI services must be provided under the supervision of, and billed by, a qualified supervising professional who assumes professional responsibility for the services provided and is a mental health professional or a physician. Intervention Supervision and direction is the clinical direction and oversight by a qualified EIDBI provider to a lower level provider based on the required provider standards and qualifications regarding provision of EIDBI services to a child. The qualified provider delivers face-to-face observation and directions to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each 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.

Who Can Provide Service?

Qualified Supervising Professional
Developmental/Behavioral Professional-Level I Provider
Developmental/Behavioral Practitioner-Level II Provider

Where does Service Take Place?

Home or Center-individual supervision
Center-group supervision

Selected Code Descriptions

0362T Exposure Behavioral Follow-up Assessment
0363T Exposure Behavioral Follow-up Assessment each additional 30 minutes of technician(s) time

HP Doctoral level
HO Master's degree level
HN Bachelor's degree level
GT via interactive audio and video telecommunications systems

Coding

0362T/new EIDBI modifier-Physician or APRN 1st 30 minutes
0363T/new EIDBI modifier-Physician or APRN each additional 30 minutes
0362T/GT/new EIDBI modifier Physician or APRN (telemedicine) 1st 30 minutes
0363T/GT/new EIDBI modifier -Physician or APRN (telemedicine) each additional 30 minutes
0362T/HP/new EIDBI modifier - Doctoral level 1st 30 minutes
0363T/HP/new EIDBI modifier - Doctoral level each additional 30 minutes
0362T/HP/GT/ new EIDBI modifier - Doctoral level (telemedicine) 1st 30 minutes
0363T/HP/GT/ new EIDBI modifier - Doctoral level (telemedicine) each additional 30 minutes
0362T/HO/new EIDBI modifier-Master's degree level 1st 30 minutes
0363T/HO/new EIDBI modifier-Master's degree level each additional 30 minutes
0362T/HO/GT/new EIDBI modifier-Master's degree level (telemedicine) 1st 30 minutes
0363T/HO/GT/new EIDBI modifier/GT-Master's degree level (telemedicine) each additional 30 minutes
0362T/HN/new EIDBI modifier-Bachelor's degree level 1st 30 minutes
0363T/HN/new EIDBI modifier-Bachelor's degree level each additional 30 minutes
0362T/HN/GT/new EIDBI modifier- Bachelor's degree level (telemedicine) 1st 30 minutes
0363T/HN/GT/new EIDBI modifier- Bachelor's degree level (telemedicine) each additional 30 minutes

Coding Notes:

These codes do not state "supervision", however, we believe they are 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. The CMDE must include:

- Assessment of the child's degree of severity of core features of ASD or related condition 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 including information gathered from family members, child care providers as well as any medical or assessment information from other licensed professionals working with the child.
- 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 referral for 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.
- Medical information from a licensed physician or advanced practice registered nurse.

Who Can Provide Service?

Licensed Mental Health Professional
Psychiatrist

Where does Service Take Place?

Center, clinic or office

Selected Code Descriptions

0359T Behavioral Identification Assessment
HP Doctorate Level
HO Master's Degree Level
GT via interactive audio and video telecommunications systems

Coding

0359T-new EIDBI modifier-Physician or APRN
0359T-GT/new EIDBI modifier-Physician or APRN (telemedicine)
0359T-HP/new EIDBI modifier-Doctorate level
0359T-HP/GT/new EIDBI modifier –Doctorate level (telemedicine)
0359T-HO/new EIDBI modifier- Master's degree level
0359T-HO/GT/new EIDBI modifier-Master's degree level (telemedicine)

Notes:

We contacted a member of the CPT Editorial Panel who created the new Category III codes. The panel member suggested this service could fit into a Category I code. The only category I code(s) that seem to fit are 96150 and 96151 which are part of the Health and Behavioral Assessment/Intervention code group. We were concerned about other payers and codes in this group. Based on feedback we heard regarding other codes in this range, we thought the 0359T may work best for all payers.

INDIVIDUAL TREATMENT PLAN DEVELOPMENT AND MONITORING

What is it?

Development and monitoring by the qualified supervising professional or Level I ABA or DBI Professional who coordinates and integrates information from the CMDE process to develop the Individual Treatment Plan. The Individual Treatment Plan specifies the:

* child's functional goals which are developmentally appropriate, and work toward generalization across people and environments;
* treatment modality or modalities
* treatment intensity, frequency and duration
* setting
* discharge criteria
* treatment outcomes and the methods to be implemented to support the accomplishment of outcomes, including the amount of time needed for each level of provider to deliver child treatment and parent training

The Individual Treatment Plan reflects the values, goals, preferences, culture and language of the child's family.

Who Can Provide the Service?

Qualified Supervising Professional
Developmental/Behavioral Professional-Level I Provider
Developmental/Behavioral Practitioner-Level II Provider

Where Does the Service Take Place?

Center, clinic or office

Selected Code Descriptions

H0032 Mental Health Service Plan Development by non-physician
UD 15 minute unit
HP Doctoral level
HO Master's degree level
HN Bachelor's degree level

Coding

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

Notes

This service needs to be time based. The H0032 by definition is not time based. The H0032 was approved for mental health service plan development with time and we would suggest using it here as time based too (UD modifier). We contacted a member of the CPT Editorial Panel and suggested a new Category III code be created for this service. It was recommended that we submit a request.

FAMILY/CAREGIVER TRAINING AND COUNSELING

What is it?

Specialized training and education provided to a family/caregiver to assist with a child's needs and development while educating and supporting families. The provider will observe, instruct and train the family/caregivers on the child's development status, and techniques and strategies to promote the child's development. 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-Level I Provider
Developmental/Behavioral Practitioner-Level II Provider

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
GT via interactive audio and video telecommunications systems

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

Coding Notes:

The variability with which parents may choose to participate in this service will be great making the need for a timed code. Time will allow for individualization based on parent/caregiver preferences and needs. The T1027 describes the service and is based on a 15 minute unit which is good. An alternative code Category III coding solution, the 0370T and 0371T, was also considered:

0370T Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (w/o patient)
0371T Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (w/o patient)

The 0370T and 0371T are not time based and represent a less desirable coding solution.

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 coordinate the implementation of the individual treatment 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 will:

* Coordinate and integrate information from the CMDE process
* Describe intensive treatment options and expectations across service settings
* Document intensive treatment scope, modality, intensity, frequency and duration based on the CMDE recommendations and family choice.
* Review the child's progress towards goals with the child's family.
* Coordinate services provided to the child and family
* Identify the level and type of parent involvement in the child's intensive treatment.
* Integrate care and services across service providers to ensure access to appropriate and necessary care including medically necessary speech therapy, occupational therapy, mental health, human services or special education.

Who Can Provide the Service?

Qualified Supervising Professional
Qualified CMDE Provider
Developmental/Behavioral Professional-Level I Provider
Developmental/Behavioral Practitioner-Level II Provider

Where Does It Take Place?

Center or clinic
Home

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/GT/new EIDBI modifier-Physician or APRN (telemedicine)
T1024/HP/new EIDBI modifier-Doctoral level
T1024/HP/GT/new EIDBI modifier-Doctoral level (telemedicine)
T1024 HO/ new EIDBI modifier-Master's degree level
T1024 HO/GT/new EIDBI modifier- Master's degree level (telemedicine)
T1024 HN/new EIDBI modifier-Bachelor's degree level
T1024 HN/GT/new EIDBI modifier-Bachelor's degree level (telemedicine)

TRAVEL TIME

What is It?
Provider travel time allows providers to bill for traveling to the recipient's home to provide covered face-to-face EIDBI services. Recipients must have an individual treatment plan specifying why the provider must travel to the recipient's home. Travel time covers only the time the provider is in transit to and from the recipient. Travel time only applies to the following services: EIDBI Intervention, EIDBI Intervention Supervision and Family Caregiver Training and Counseling.

Who Can Provide the Service?
EIDBI providers traveling to provide EIDBI Intervention, EIDBI Intervention Supervision or Family Caregiver Training and Counseling.

Where does the service take place?
99- Other Place of Service

Selected Code Description
H0046 Provider Travel Time

Coding
H0046/new EIDBI modifier

Coding Notes
The H0046 is currently used for provider travel time for mental health services on a per minute basis.
One unit equals one minute.
Travel time is billed on the same claim as the provided service.
The actual number of minutes spent in transit is billed (no rounding up).

PROVIDERS

Licensed Mental Health Professional :

- Licensed psychologist;
- Licensed psychological practitioner;
  Licensed independent clinical social worker;
- An advanced practice registered nurse who is licensed and is certified as a clinical nurse specialist in mental health, or is certified as a nurse practitioner in pediatric or family or adult mental health nursing by a national nurse certification organization;
- Licensed marriage and family therapists with at least two years of post-master's supervised experience. Covered Medicaid mental health services do not include marriage counseling; and
- Effective January 1, 2010, licensed professional clinical counselor with at least 4,000 hours of post-master's supervised experience.

To qualify as a CMDE provider the licensed mental health professional or psychiatrist must:

- Have at least 2,000 hours of clinical experience in the evaluation and treatment of children with ASD, or equivalent documented course-work at the graduate level by an accredited university in the following content areas: ASD diagnosis, ASD treatment strategies, child development;
- Be able to diagnose and/or provide treatment
- Work within their scope of practice and professional license; and
- Not be the same professional who delivers or supervises the child's direct treatment. In geographic areas with a provider shortage, as determined by the Department, the same professional may perform the CMDE and deliver or supervise the child's direct treatment.

Qualified Supervising Professional:

EIDBI services must be provided under the supervision of, and billed by, a qualified supervising professional who assumes professional responsibility for the services provided and is a:

- Mental health professional
- Physician; or
- Advanced practice registered nurse.

Qualified supervising professionals must work within their licensed scope of practice, and have at least 2,000 hours of experience and/or training in the examination and/or treatment of children with ASD or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development.

ABA and DBI Developmental/Behavioral Professional (Level I provider):

All Level I ABA and DBI providers must:
Work under the supervision of a qualified supervising professional, and
Have at least 2,000 hours of clinical experience and/or training in the examination and/or treatment of children with ASD or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development **.**

Additionally, all Level I ABA treatment providers must have a:

- Master's degree in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university, and
- Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst – Doctoral (BCBA-D) certification from the National Behavior Analyst Certification Board.

Additionally, all Level I DBI treatment providers must have a:

- Master's degree in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university, or
- Bachelor's degree in one of the behavioral health, child development or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university and certification in one of the DHS recognized treatment modalities.

ABA and DBI Developmental/Behavioral Practitioner (Level II provider):

All Level II ABA and DBI providers must:
Have at least 2,000 hours of clinical experience and/or training in the examination and/or treatment of children with ASD or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies and typical child development, or
Be fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, meet the Department's ASD specific training requirements, and receive supervision from a qualified supervising professional or qualified Level I ABA or DBI Developmental/Behavioral Professional at least once a week until the requirement of 2,000 hours of supervised experience is met.

Additionally, all Level II ABA treatment providers receive supervision from a qualified supervising professional (QSP), or Level I ABA professional, and must have a:

- Bachelor's degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university; and
- Board Certified Assistant Behavior Analyst (BCaBA) certification from the National Behavior Analyst Certification Board;

Additionally, all Level II DBI treatment providers receive supervision from a QSP or qualified Level I ABA or DBI professional, and must have a:

- Bachelor's degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university; or
- Associate degree in one of the behavioral or child development sciences or allied fields (such as, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy) from an accredited college or university and at least 4,000 hours of supervised clinical experience in the delivery of treatment to children with ASD. Hours worked as a Behavioral Aide or Developmental/Behavioral Support Specialist may be included in the required hours of experience; or
- At least 6,000 hours of supervised clinical experience in the delivery of treatment to children with ASD. Hours worked as a Behavioral Aide or Developmental/Behavioral Support Specialist may be included in the required hours of experience; or
- Is a graduate student in one of the behavioral sciences, child development sciences, or allied fields and is formally assigned by an accredited college or university to an agency or facility for clinical training with children with ASD.

ABA and DBI Developmental/Behavioral Support Specialist (Level III provider):

All Level III ABA and DBI providers must:

Work under the supervision of a qualified supervising professional, or a Level I or II ABA or DBI provider.

Have the following experience and or training:

Be at least 18 years old;

Meet the Department's ASD specific training requirements; and

Have a high school diploma or general equivalency diploma (GED) or:

- Be fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong; or
- Have two years of experience as a primary caregiver to a child with autism spectrum disorder within the previous five years; or
- Be a Registered Behavior Technician (RBT) as defined by the Behavior Analyst Certification Board