Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, March 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: 1-712-832-8300

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** – February 12, 2015
4. **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.	**OPEN** DHS will develop policy to be placed in MUCG and include definitions of service providers

Two-way interactive video – Medicare allows for two charges (initiation and performing services; usually facility-based charge). Are two charges expected – initiates video and code for practitioner (for person performing service [-GT modifier - Via interactive audio and video telecommunication systems])? Q3014 is the Telehealth originating site facility fee. Multidisciplinary evaluation – If clinic offers ASD, evaluation from MD, psychological be appropriate. CMDE regardless if mental health prof, physician or APRN during initial assessment will all bill under these codes. DHS is developing a form that will determine medical necessity for services billed under these codes. Not billed during initial diagnoses. If prior assessments have been made a Psychologist (Pediatrics or MH) supervising an extensive evaluation may bill for supervision of that assessment Coordinator Care Conference team T1024 versus 99336. Codes 99336 is a bundled code. T1024 was the best fit to include all providers together to discuss coordinated services provided to the child. Are coding recommendations for all payers or government? Yes for government (managed care contracts); commercial payers will accept in system and determine coverage based on their benefits.	
12/11/14: • Andrea Agerlie reported that the recommendation will be revised. • Originally, DHS did not want to use the CPT Category III behavioral 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**
2/12/15: Ann Harrington, DHS, provided clarification regarding some of the changes to the Autism benefits. Ann has been working with the HPs and has received multiple-disciplinary evaluations and feedback from external and internal stakeholders. The CPT Category III were chosen based on information from the AMA and hope to reflect national coding consistency. . DHS is hoping to implement autism benefits prior to July 2015. May phase certain coverage. (There is also a research component to autism benefits that have not been completed at this time). DHS is developing manual for providers and the family care giver. All providers will be enrolled	**OPEN** Faith will send e-vote ballot to TAG, which will be due 2/24/15

5. Mental Health Service Plan Development – DHS

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

No updates. DHS is still waiting for federal approval.	
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**
2/12/15: DHS is Waiting for Feds to approve program and coding recommendations.	**OPEN**

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

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

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.	
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**
2/12/15: DHS met internally; they receive payment from lottery funds to provide compulsive gambling services. Assessment; active treatment and support services (H2019 TS) inpatient/outpatient; type of bill; revenue codes; Rule 82; court-orders, etc. Codes proposed on the SBAR are H2020; H0005 and H2035 are on original request. H2019 per 15 minute (treatment) H0031 (assessment) - No decision has been made by DHS on how to code at this time.	**OPEN** DHS will present in March

7. PH Nurse Updates – DHS

2/12/15: PH Nurse SBAR– two-part SBAR requesting: 1) change in coding in Table A.5.4.a for Home health aide, CNA, per visit and Patient education only and 2) additional column and coding for POS other than home or residence to be added to table. PH Nurses may provide services in shelter, college, and other facilities. Faith stated the coding for the tables were a collaboration of the MCT and the Public Health Nurse Association. Any potential changes must be discussed with them before changes are made to the table. No changes will be made to Table A.5.4.a or Table A.5.4.c in the guide. Postpone discussion. TAG will conduct research regarding coding per MCTs agreement with Public Health nurses.	**OPEN** Waiting for SBAR. Research needed.

8. Additional Agenda Items/ Announcements

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

Administrative Uniformity Committee

AUC UPDATE

February 27, 2015 | Volume 3, Number 2

INSIDE THIS ISSUE:

We want you – March Operations Meeting

Reminder -- The next regularly scheduled quarterly meeting of the AUC Operations Committee is 2:00 pm – 4:00 pm, March 10, 2015, at the TIES Conference Center, 1644 Larpenteur Avenue West, Falcon Heights, MN 55108. An agenda and meeting materials will follow in the near future. We look forward to seeing you at the meeting.

Please welcome Elise Westby as the new Eligibility TAG chair

Elise Westby has agreed to serve as the new AUC Eligibility TAG chair, filling a vacancy arising from the recent retirement of the previous chair, Ed Stroot. Elise is currently the Admitting/Registration Manager for Ridgeview Medical Center and Clinics and Two Twelve Emergency Center. She has worked in patient registration for over 13 years, with the last three years at Ridgeview Medical Center in Waconia.

When asked about her decision to serve as chair, Elise said, "I was interested in joining the AUC Eligibility committee because I thought it would be a new challenge in an area that I work in daily, but up until now, all of that work has always been in the Provider End User side of eligibility. I look forward to learning more and being part of this team."

Please welcome Elise to the AUC!

ICD-10 Updates

Minnesota Department of Human Services (DHS)

DHS continues to work on preparations for ICD-10 implementation and will provide opportunities coming up for providers to test system changes for ICD-10. DHS will update its ICD-10 web page with details as soon as testing opportunities are available.

CMS Reports Successful ICD-10 FFS End-to-End Testing

The federal Centers for Medicare and Medicaid Services (CMS) reported on February 25, 2015 that ICD-10 end-to-end testing conducted January 26 – February 3, 2015 was successful and that CMS systems are ready to accept ICD-10 claims. The testing included a sample of Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies representing a broad cross-section of provider, claim, and submitter types, who tested with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common

Electronic Data Interchange (CEDI) contractor.

In total, approximately 660 providers and billing companies submitted nearly 15,000 test claims during the week-long test period. Approximately 81% of the claims tested were accepted. The majority of claims rejected were for errors unrelated to ICD-9 or ICD-10, including for example: incorrect NPI, Health Insurance Claim Number, Submitter ID, dates of service outside the range valid for testing, invalid HCPCS codes, and invalid place of service.

CMS also reported the results below for the following claim types:

- Professional and Supplier Claims: No issues identified and zero rejects due to front-end CMS systems issues.
- Institutional Claims: One issue identified related to system edits.
    - Home health claims with dates that spanned the October 1, 2015, implementation date were not processed correctly. These claims contained ICD-10 codes but were returned to the submitter. The problem impacted less than 10 test claims and will be resolved prior to the next testing week. Testers will have an opportunity to re-submit these claims.

In addition to acknowledgement testing, which may be completed at any time, two more end-to-end testing weeks will be held before the October 1, 2015, compliance date for ICD-10:

- April 27 through May 1: Volunteers have been selected
- July 20 through July 24: Volunteer forms will be available March 13 on the MAC and CEDI websites
- Testers who participated in the January testing are automatically eligible to test again in April and July

Tester education will be conducted to avoid non-ICD-10 related errors in preparation for the upcoming testing weeks. Testers who participated in the January testing are automatically eligible to test again in April and July, 2015.

For more information regarding CMS ICD-10 testing, see

- MLN Matters® Article #MM8867, "ICD-10 Limited End-to-End Testing with Submitters for 2015
- MLN Matters® Special Edition Article #SE1435, "FAQs – ICD-10 End-to-End Testing"
- MLN Matters® Special Edition Article #SE1409, "Medicare FFS ICD-10 Testing Approach"

TAG Updates

Executive Committee

The Executive Committee met February 2, 2015 and focused first on questions of reporting data to providers regarding the eligibility and enrollment of patients in publicly funded health care programs administered by the Department of Human Services (DHS). The AUC had previously addressed similar questions approximately two years ago. At that time, the AUC adopted a best practice for the eligibility inquiry and response transaction (270-271), and related requirements for the remittance advice transaction (835) companion guide, for transmitting information to providers concerning their patients' enrollment in publicly funded health care programs, such as MinnesotaCare or Medical Assistance (MA, often referred to as Medicaid). Providers sought the information to aid in receiving proper levels of federal "Disproportionate Share Hospital (DSH)" funding. DSH funding is intended to help level of the playing field between hospitals with disproportionate shares of public program patients and/or high uncompensated care levels, and other hospitals. The AUC's best practice and companion guide requirements were designed

to aid in reporting information known as "2 digit PMAP codes" to providers, to help in assigning patients to a public program category as part of the DSH payment calculation process.

In late 2014, the Executive Committee received questions about additional information that was desired to improve the DSH process, including whether perhaps the AUC's best practice and companion instructions should be modified to report the additional data. The Committee met February 2 to learn more about the issue. Representatives from DHS provided initial background and clarifications regarding public programs, DSH payments, and related information needs. They clarified that DSH is an issue particularly for hospitals, and also noted that there are inherent limitations in prospectively classifying patients for DSH purposes based on a patient's enrollment in a program at a point in time. Patients' circumstances often change frequently, and assignment to a particular public program that may have seemed correct at the time based on the information available may subsequently be determined to have been incorrect for DSH payment purposes. With this background and initial discussion, the Committee agreed to forward the issue to the appropriate TAGs, the Eligibility TAG and the EOB/Remit TAG respectively, for further review and consideration.

At the February 2 meeting, the Executive Committee also discussed:

- the status of companion guide maintenance. The 2014 guide maintenance will be concluded shortly with the publication into rule of guide revisions and updates discussed with the AUC;
- needs for an Eligibility TAG co-chair and possible recruiting options. Tony Rinkenberger volunteered to reach out Ridgeview Medical staff for possible interest. (Note: Elise Westby of Ridgeview subsequently volunteered to serve as the TAG co-chair for 2015.);
- the status of phase IV operating rules being developed as mandated per the ACA. The Exec Committee will continue to monitor operating rule development;
- the SBAR process for submitting questions and seeking information for correct medical coding. The SBAR process is used primarily by the Medical Code TAG to recommend correct coding and is an important resource. It is important that information needed by the TAG is submitted on the SBAR, and that responses are clear and detailed for Operations reviews and votes and for communicating recommendations; and
- preliminary plans for the next Operations meeting, scheduled for March 10. Preliminary agenda items include: status update and discussion of implementation of electronic prescription drug prior authorization by a statutory deadline of January 1, 2016; ICD-10 outreach and education; TAG updates; and follow-up to an industry-wide symposium held in November 2014 regarding workers compensation health care e-transactions.

CLAIMS DD TAG

The Claims DD TAG met February 4, 2015 and reviewed findings and updates from the November 2014 Workers' Compensation e-transactions symposium. The Minnesota Department of Labor and Industry (DLI) briefly summarized a draft legislative proposal it has been developing to address several key issues at the symposium, including: the need for standard claims attachments; ensuring that information and instructions needed by the parties to establish connectivity is shared and readily available; and assuring that "bulk" payments for many individual bills can be reconciled to the appropriate bill. The proposal was briefly discussed with no further actions or recommendations at this time.

MEDICAL CODE TAG

The Medical Code TAG met February 12 and reviewed and approved its final set of changes to the 837 companion guides as part of companion guide annual maintenance. In addition:

- An SBAR regarding coding for autism services was discussed and will be voted on via a TAG email vote;
- DHS provided an update on coding for the gambling addiction program and the item remains open for additional discussion at the next TAG meeting;
- A coding question regarding Health and Behavior Group Therapy by Mid-level Provider was resolved with recommendations to "follow CPT" and to place the recommendation on the TAG's "coding clarification grid."
- A question about the use of modifier 90 was resolved with the recommendation to note that the modifier may be used as appropriate for services paid for by other than DHS public programs ("Minnesota Health Care Programs"), in which case the instructions in MHCP Provider Update MHP-14-08 apply.

The TAG discussed additional possible changes to the 837 companion guides to revise tables for "Maternal and Child Health Billing Guide For Public Health Agencies." However, no action was taken pending additional possible discussion with public health nurses.

Eligibility TAG

The Eligibility TAG met February 25 with Elise Westby serving as the new chair. As reported in the summary for the February 2, 2015 Executive Committee meeting above, the TAG received a request from the Committee to discuss issues related to reporting of "2-digit PMAP codes." The TAG discussed the issues with representatives in attendance from DHS and is taking no further action at this time, pending more discussion between DHS and hospitals submitting information for DSH payments.

The TAG also discussed priorities and plans for the year. In addition to completing the annual companion guide maintenance for the Eligibility (270-271) transaction, the TAG will be seeking input on challenges and obstacles to using the transaction as fully and correctly as possible, and will be developing best practices and other resources to address them.

Minnesota Uniform Companion Guide – Annual Maintenance Update

The Minnesota Department of Health (MDH) plans to publish an announcement in the State Register on March 9, 2015 of the adoption into rule of revised, updated versions (v10.0) of the Minnesota Uniform Companion Guides (MUCGs) for the Eligibility (270/271) and Remittance Advice (835) transactions. The primary changes from the previously adopted versions of the MUCGs (v8.0) include:

- For the 835 MUCG: addition of three Remittance Advice Remark Codes (RARC) available to be used for the "Scenario: Additional Information Required – Missing/Invalid/Incomplete Information from the Patient" in Appendix A; and correction of a number of claim adjustment reason codes (CARCs) to replace deleted codes with appropriate new codes in Appendix B.
- For the 270-271 MUCG: correction of segment names in section 5.

In addition, annual final updates and revisions to the MUCGs for the claims transactions (837P, 837I, and 837D) were recently submitted to AUC Operations for a vote. Following the vote, they will also be announced as final rules as described above.

On behalf of MDH, we wish to thank the AUC for its assistance with the annual companion guide maintenance.

AUC Newsletter Subscription

Interested in signing up to receive this newsletter and other AUC updates and information? Please sign up using the Subscribe feature on the right hand side of the

AUC homepage (http://www.health.state.mn.us/auc/index.html) under the "Most Viewed" navigation frame.

Comments or questions about this newsletter? Please contact us at: health.auc@state.mn.us.

AUC Calendar

Date/Time	Event
March 2	Executive Committee Meeting
March 10	Operations Committee Meeting
March 12	Medical Code TAG Meeting
March 16	EOB Remit TAG Meeting
March 25	Eligibility TAG Meeting

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, February 12, 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. Deb reminded members to notify her in advance if bringing guests to meeting and she no longer need to be notified when only the member is attending. AUC co-chair Ann Hale was in attendance at today's meeting. Ann stated since her office is in the building and she wanted to take advantage of the MCT. Ann announced she is the 2015 chair and wanted to personally thank the TAG for all of their hard work with the coding issues submitted to the AUC.	Completed.
2. Antitrust Statement	Reviewed – available on AUC website.	No discussion.
3. Review of last meeting's Minutes	Minutes approved with one correction: Agenda item #4. Modifier U4 was added to Doulas code 99199. The correct code for Doula services at labor and deliver is 99199 U4.	Minutes will be posted on AUC MCT website
4. MN Uniform Companion Guide Comment Reviews	Revisions noted: Add place of service headings for Table A.5.4.c. DHS provided explanation of the code change for Child MH screening – 96110 UC is replaced with 96127 because the UC is no longer needed. The 96127 is valid code and describes the child mental health screening service. DHS stated that having "pathology" in parentheses after modifier 76 was confusing and suggested that pathology be removed as part of the description. Request for changes to repeat services modifier was not made in guides – Discussion postponed. Motion was made and seconded to approve the changes to the 837P & 837I guides. Motion passed	**CLOSED** MDH will make final changes to the 837I and 837P and forward to AUC Ops for voted to adopt final guides as rules DHS will complete SBAR for Repeat Services under Laboratory Services
5. Autism – Andrea Agerlie, DHS	Ann Harrington, DHS, provided clarification regarding some of the changes to the Autism benefits. Ann has been working with the HPs and has received multiple-disciplinary evaluations and feedback from external and internal stakeholders.	**OPEN** Faith will send e-vote ballot to TAG, which will be due 2/24/15

Agenda Item	Discussion	Action/Follow-up:
	The CPT Category III were chosen based on information from the AMA and hope to reflect national coding consistency. . DHS is hoping to implement autism benefits prior to July 2015. May phase certain coverage. (There is also a research component to autism benefits that have not been completed at this time). DHS is developing manual for providers and the family care giver. All providers will be enrolled.	
6. Mental Health Service Plan Development – DHS	DHS is Waiting for Feds to approve program and coding recommendations.	**OPEN**
7. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	DHS met internally; they receive payment from lottery funds to provide compulsive gambling services. Assessment; active treatment and support services (H2019 TS) inpatient/outpatient; type of bill; revenue codes; Rule 82; court-orders, etc. Codes proposed on the SBAR are H2020; H0005 and H2035 are on original request. H2019 per 15 minute (treatment) H0031 (assessment) - No decision has been made by DHS on how to code at this time.	**OPEN** DHS will present in March
8. Health and Behavior Group Therapy by Mid-level Provider – Sara Luther, Mayo Clinic	Recommendation is to follow CPT; CPT states physician or qualified practitioner. Clarification will be placed coding question index/question grid	**CLOSED**
9. Modifier -90 Acceptance - Sue Lewis, UCare	Modifier 90 for adjudication is accepted modifier for commercial. Different for DHS. Refer to DHS Provider Update MHP-14-08, effective 1/1/15 – (see DHS website)	**CLOSED**
10.PH Nurse Updates - DHS	PH Nurse SBAR– two-part SBAR requesting: 1) change in coding in Table A.5.4.a for Home health aide, CNA, per visit and Patient education only and 2) additional column and coding for POS other than home or residence to be added to table. PH Nurses may provide services in shelter, college, and other facilities. Faith stated the coding for the tables were a collaboration of the MCT and the Public Health Nurse Association. Any potential changes must be discussed with them before changes are made to the table. No changes will be made to Table A.5.4.a or Table A.5.4.c in the guide. Postpone discussion. TAG will conduct research regarding coding per MCTs agreement with Public Health nurses.	**OPEN** Waiting for SBAR. Research needed
11. Next meeting	• The next scheduled meeting is March 12, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. • TREATS - Kelly Carrier will bring treats.	**CLOSED**

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: 2-12-15	**Organization submitting:** Department of Human Services		
Short Title: Autism		**Log No.** 3	**Date Closed:** 2-12-15
Status: Exec Review Date	**Sent to TAG/WG** 2-12-15* *Update to SBAR sent 10-9-14	**TAG Recommendation:** ___X____ 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:	Organization Information:
Name: ANDREA AGERLIE **Title: Health Care Coding Compliance Officer** **Email address: andrea.agerlie@state.mn.us** **Telephone: 651-431-3159**	**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: KATHY SIJAN
Title: Health Care Coding Compliance Officer
Email address: Katherine.Sijan@state.mn.us
Phone number: 651-431-5784

SBAR Issue Title: EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION (EIDBI) BENEFIT

S

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

The 2013 Minnesota Legislature passed legislation for an "autism early intensive intervention benefit". Minnesota Statute 256B.0949 describes this benefit. Subdivisions 1 and 3 (below) describe purpose and initial eligibility:

> Subdivision 1. Purpose. This section creates a new benefit to provide early intensive intervention to a child with an autism spectrum disorder diagnosis. This benefit must provide coverage for diagnosis, multidisciplinary assessment, ongoing progress evaluation, and medically necessary treatment of autism spectrum disorder.
>
> Subdivision 3. Initial eligibility. This benefit is available to a child enrolled in medical assistance who:
>
> 1. Has an autism spectrum disorder diagnosis;
> 2. Has had a diagnostic assessment described in subdivision 5, which recommends early intensive intervention services; and
> 3. Meets the criteria for medically necessary autism early intensive intervention services.

The 2014 Minnesota Legislature made changes to the 2013 statute. See Chapter 312, Article 27, section 52, 53.

On July 7, 2014 CMS submitted an informational bulletin directing all states to provide medically necessary treatment for children with ASD consistent with provisions at 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.
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): The EIDBI benefit is a new covered benefit for children with autism spectrum disorder (ASD) or a related condition. Currently, some children with ASD receive services that are billed under the Children's Therapeutic Services and Support (CTSS) benefit. CTSS is a mental health benefit. The current codes billed under the CTSS benefit are in the 837P and 837I Minnesota Uniform Companion Guides (table A.5.2). The EIDBI benefit will need new codes. A comprehensive multi-disciplinary evaluation determines medical necessity for the EIDBI benefit. Children may receive services under both benefit sets, but not duplicative services.
A	ASSESSMENT – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): Challenges include: • ASD diagnosis and treatment is an emerging field of practice. There is emerging recognition of a range of developmental and behavioral treatment modalities. • Organizations that are impacted by these challenges are treatment providers who represent various modalities of treatment. Both DHS fee-for-service and managed care will need to provide coverage of the EIDBI benefit. Discussion is necessary to develop a uniform billing method for these services. See attached coding document.
R	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: DHS is seeking review of the proposed codes on the attached coding document. Discussion is necessary to develop a uniform billing method for the services. DHS must have federal approval of the services under the EIDBI benefit. After federal approval, coding guidance should be added to the MN Community Coding Practice/Recommendation Table and possibly added to the Minnesota Uniform Companion Guide (837P). DHS is targeting a 7/1/15 implementation date.

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

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

Date [SBAR Response Approved by TAG]: 12/24/15

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

AUC Co-Chair(s): Faith Bauer

AUC Response: NOTE: revisions in red.

There are seven EIDBI benefit services:

1. The 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

Each service and related coding are listed separately. The MCT is proposing adding the seven benefit services and coding in the MN Companion Guide (in the interim this will be added to the Recommendation Grid). Additional and detailed program information will available in a policy manual being developed by DHS.

1. The EIDBI Intervention

(Applied Behavioral Analysis)

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

(Developmental and Behavioral Intervention)

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

2. EIDBI Intervention Supervision and Direction

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

3. Comprehensive Multi-Disciplinary Evaluation (CMDE)

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)

4. Individual Treatment Plan Development and Monitoring

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

5. Family Caregiver Training and Counseling

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/GT/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)	

6. Coordinated Care Conference

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)

7. Travel Time

Coding
H0046/new EIDBI modifier

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT

(Draft for AUC MCT 02/12/15)-revised
Andrea Agerlie

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 1 patient, 1st 30 minutes of technician time.
0365T Adaptive behavior treatment by protocol, administered by technician, face-to-face with 1 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 1st 30 minutes
0369T/new EIDBI modifier - physician or APRN each additional 30 minutes	0367T/new EIDBI modifier -Physician or APRN each additional 30 min
0368T/HP/new EIDBI modifier -Doctoral level 1st 30 minutes	0366T/HP/new EIDBI modifier -Doctoral level 1st 30 minutes
0369T/HP/new EIDBI modifier - Doctoral level each additional 30 minutes	0367T/HP/new EIDBI modifier Doctoral level each additional 30 min
0368T/HO/new EIDBI modifier -Master's degree level 1st 30 minutes	0366T/HO/new EIDBI modifier -Master's degree level 1st 30 minutes
0369T/HO/new EIDBI modifier -Master's degree level each addl 30 minutes	0367T/HO/new EIDBI modifier -Master's degree level each addl 30 min
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 1 patient, 1st 30 minutes of technician time.
0365T Adaptive behavior treatment by protocol, administered by technician, face-to-face with 1 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 1st 30 minutes
0369T/new EIDBI modifier- physician or APRN each additional 30 min	0367T/new EIDBI modifier -Physician or APRN each additional 30 min
0368T/HP/new EIDBI modifier-Doctoral level 1st 30 minutes	0366T/HP/new EIDBI modifier -Doctoral level 1st 30 minutes
0369T/HP/new EIDBI modifier- Doctoral level each additional 30 min	0367T/HP/new EIDBI modifier Doctoral level each additional 30 min
0368T/HO/new EIDBI modifier-Master's degree level 1st 30 minutes	0366T/HO/new EIDBI modifier -Master's degree level 1st 30 minutes
0369T/HO/new EIDBI modifier-Master's degree level each addl 30 min	0367T/HO/new EIDBI modifier -Master's degree level each addl 30 min
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 min	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

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, includes physician or other qualified health care professional (QHCP) direction with interpretation and report administered by physician or other QHCP with the assistance of one or more technicians; 1st 30 minutes of technician(s) time, face-to-face with the patient
0363T Exposure Behavioral Follow-up Assessment, includes physician or other qualified health care professional (QHCP) direction with interpretation and report administered by physician or other QHCP with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient

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 Doctoral 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-Doctoral level
0359T-HP/GT/new EIDBI modifier –Doctoral 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
HQ Group setting

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/GT/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

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

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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.

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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.

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

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

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

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

Contact Information for person completing this form:

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

Organization Information:

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

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

Name:
Title:
Email address:
Phone number:

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

SBAR Issue Title: MENTAL HEALTH SERVICE PLAN DEVELOPMENT

S

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

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

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

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

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

B

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

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

A

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

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

SERVICES TO BE CODED:

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

ADULTS:
* Treatment planning and review with or without family

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

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

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

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

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

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

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

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

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Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

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SBAR ISSUE: Gambling Addiction Program

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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

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

Contact Information for person completing this form:

Name:RICHARD SCHERER

Title:BUSINESS MANAGER

Email address:richard@clubrecoveryllc.com

Telephone: 952.926.2526

Organization Information:

Name:CLUB RECOVERY, LLC

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

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

Name:

Title:

Email address:

Phone number:

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

SBAR Issue Title:

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

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

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Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

SBAR: Behavioral Health Home

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

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

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

Medical Coding TAG Decision Tree Form

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

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   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.

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1. Provide an SBAR short title for your issue.

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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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   - **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.

SBAR: BHH – Behavioral Health Home

AUC BUSINESS NEED EXPLANATION FORM (SBAR)
TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH

Date Received	Log No.	Date Closed

Status: Exec Review Date	Sent to TAG/WG	TAG Recommendation:	Decision to Originator
		_____ Accept _____ Reject	

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

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

SBAR Short title: BHH – Behavioral Health Home	Date: March 2, 2015
Contact Information for person completing this form: **Name: Katherine Sijan** **Title: HealthCare Coding Compliance Officer** **Email address: katherine.sijan@state.mn.us** **Telephone: 651-431-5784**	**Organization Information:** **Name: MN Dept of Human Services** **Address: 540 Cedar St., 7th fl -0993** **St Paul, MN 55155**

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

Name: Andrea Agerlie
Title: HealthCare Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Phone number: 651-431-3159

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

SBAR Issue Title: BHH – Behavioral Health Home

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: The Chemical and Mental Health Services and the Health Care Administrations have designed the Behavioral Health Home (BHH) model to provide access to coordinated delivery of primary care and behavioral health services for children and youth with serious emotional disorders (SED) and adults with serious mental illness (SMI) or serious and persistent mental illness (SPMI). To receive BHH services, a person must be eligible for Medical Assistance (MA) and have a current diagnostic assessment indicating that the individual meets the criteria for SMI, SPMI, or SED. BHH services cannot duplicate any other case management service including waivers and the patient cannot be on both BHH and HCH at the same time. The BHH model differs from the Health Care Home (HCH) model in that HCH is an all payer model, whereas BHH is limited to only Medical Assistance (MA) recipients. BHH provides integrated primary and behavioral health services with the goal of developing the consumer's ability to manage his/her chronic behavioral health condition and HCH does not.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): There currently is no other service like this at this time.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The monthly service will include any or all six services provided for each month the recipient is eligible. This is not a mental health treatment or service. The first six months of BHH are called 'care engagement'. After the first six months of care engagement [can be non-consecutive], an individual will receive 'ongoing standard care'. NOTE: If the recipient is eligible and receives BHH care engagement services in January (month 1) and February (month

	2), then chooses not to receive BHH services or loses MA eligibility until May, then May will be 'month 3', and so on until six months of 'Care Engagement' have been completed. Then the client will receive 'Ongoing Standard' care for each subsequent month.
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: See embedded document for details. DHS anticipates that this program will be effective July 2017. Approval is needed now to begin internal work for these services.  BHH Program_3_9_2015.dc **Statute:** MN Statute: 256B.0747 Section 12 **http://www.senate.leg.state.mn.us/departments/scr/billsumm/summary_display_from_db.php?ls=89&id=2655**

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

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision:

BHH – Behavioral Health Home

BHH is a monthly service encompassing any or all of the following six services:

1- Comprehensive Care Management
2- Care Coordination
3- Health Promotion Services
4- Comprehensive Transitional Care
5- Referral to Community and Social Support Services
6- Individual and Family Support Services

S0280-U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH

S0281-U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH

Definitions:

Care Engagement: The first six months of services [can be non-consecutive].

Ongoing Standard Care: The ongoing care after the first six months of care engagement.

Providers: A BHH care team consists of the following team members: Team Leader, Integration Specialist, Systems Navigator, Qualified Health Home Specialist. The following team members may be listed as the "pay-to" provider: physician, psychiatrist, nurse practitioner, clinical nurse specialist, licensed independent social worker, licensed marriage and family therapist, licensed professional clinical counselor and psychologist.

A BHH provider may be a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity or provider that is determined by the Department of Human Services to be qualified to be a health home for eligible individuals. This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the Department of Human Services.

The eligible client must not receive any of the following services in the same calendar month:

- Home and Community Based Services (HCBS) waiver services (BI,DD,EW,CADI,CAC)

- Relocation Service Coordination

-Targeted Case Management for Vulnerable Adults and Developmental Disabilities

- Mental Health Targeted Case Management – Adult (Rule79)

- Mental Health Targeted Case Management – Children (Rule 79)

- Assertive Community Treatment

- Health Care Home care coordination services

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 and to assist SBAR submitters in documenting all relevant information related to the coding issue(s) to be addressed in their SBAR. The MCT Decision Tree consists of a series of three levels, as follows:

Level I. Prior to Medical Code TAG review

In Level 1 MDH staff collects MCT Decision Tree forms and SBARs or other inquiries regarding medical coding issues. The Decision Tree forms and SBARs are forwarded to both the MCT and to the AUC Executive Committee for their review. Decision Trees and 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.

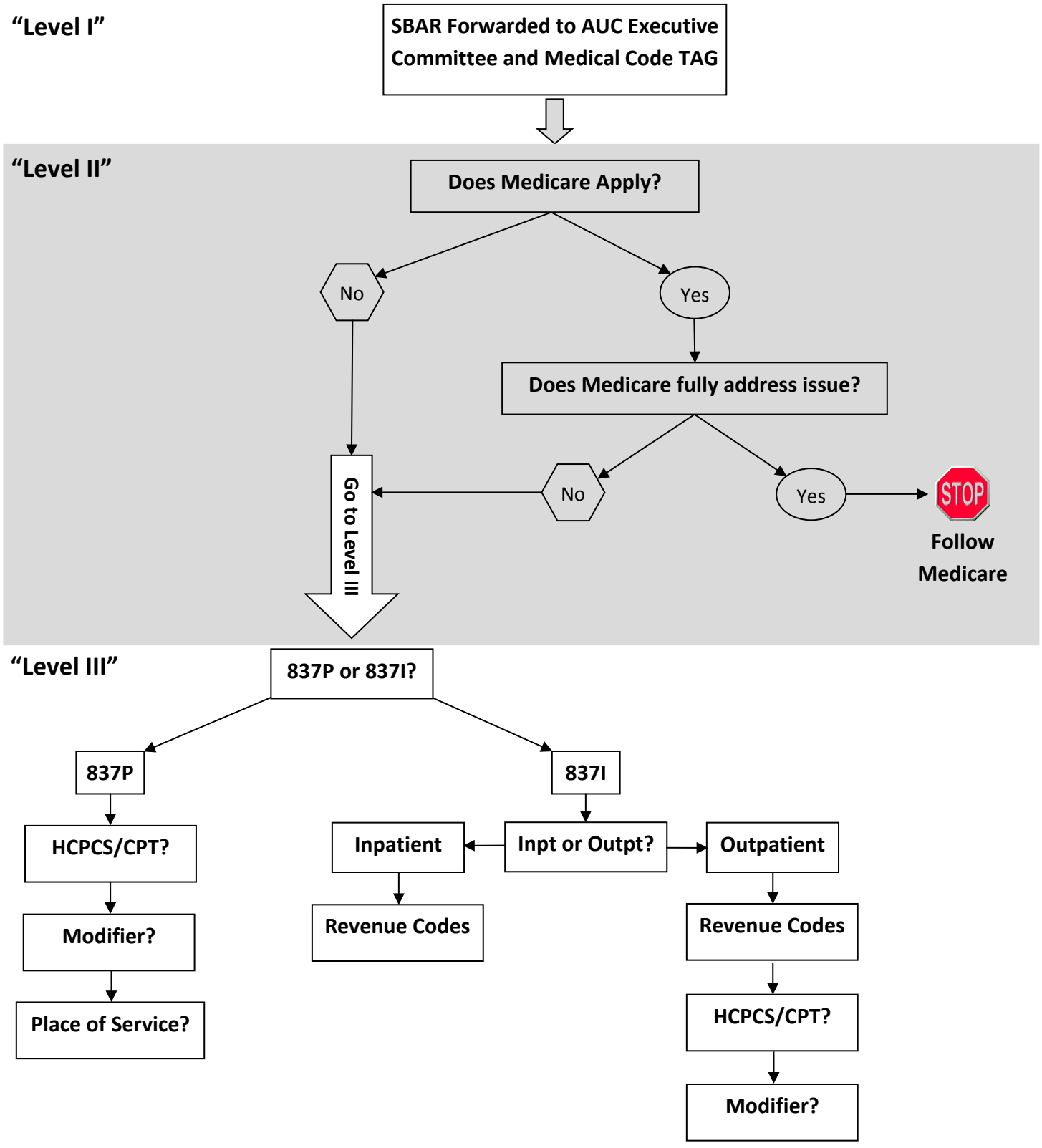
- If Medicare applies, and there are no other concerns or perceived problems with Medicare coding (e.g., vagueness or possible confusion in Medicare instructions, Medicare does not fully address the service in question), the MCT recommendation will be to "follow Medicare" and the issue will be considered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

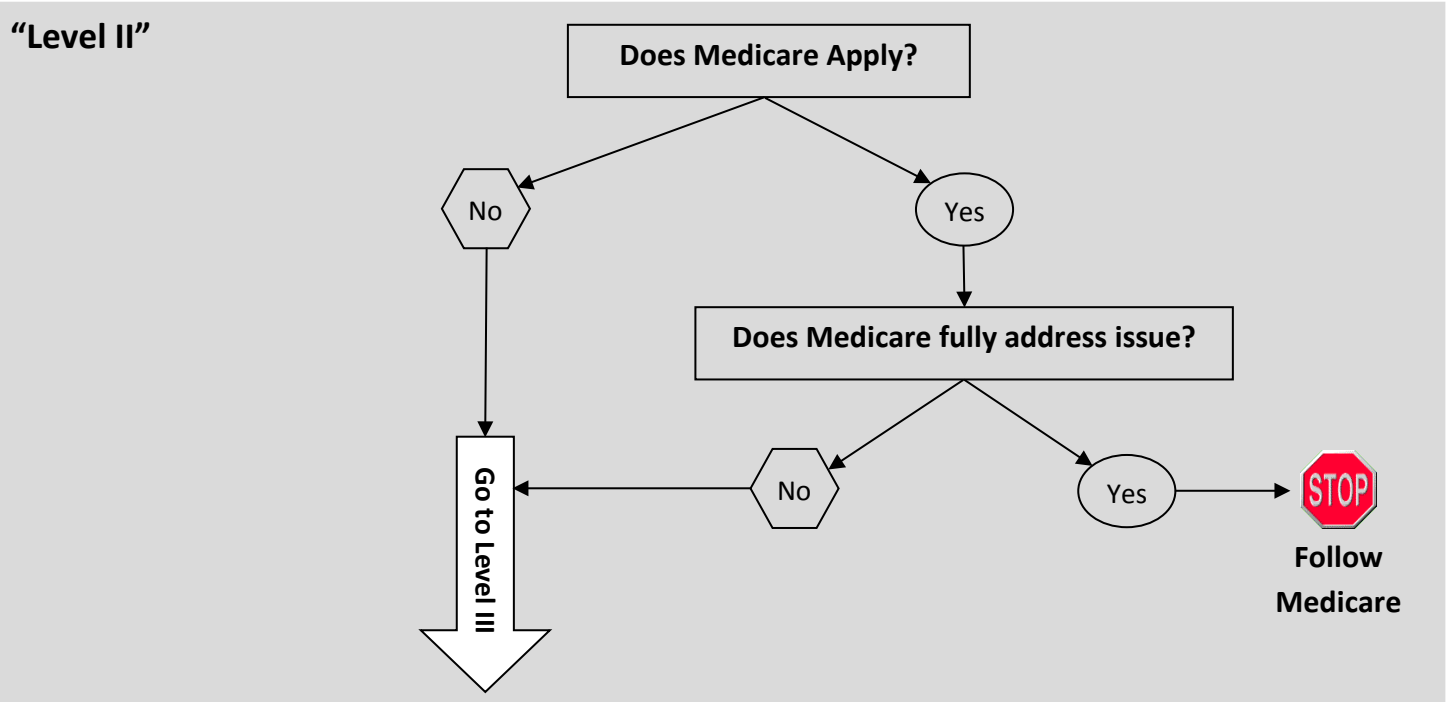
The MCT coding recommendation process above is presented schematically in the summary flow chart on the next page.

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.

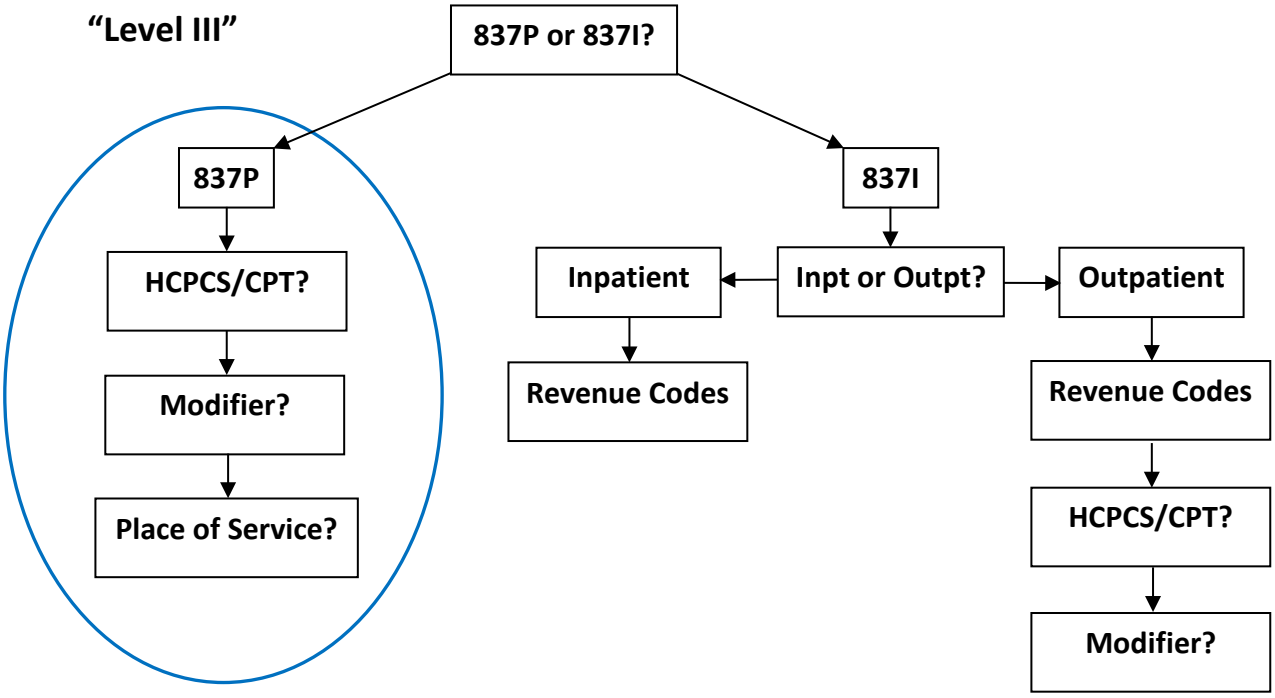
Level II. Name/description of service/issue: _____



Decision Tree Questions for Level II:

1. Does Medicare have coding requirements/instructions for coding the medical service/procedure/etc. of interest?	
Yes ___	If "yes," please reference the source of the Medicare instructions and provide a link. Medicare source and link: 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 ___	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.* _____ 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
Yes ___ **No ___**	Is this specific issue(s) applicable to more than one payer or provider? If yes, state how many: _____
Yes ___ **No ___**	Have you consulted with payer or provider regarding this issue?

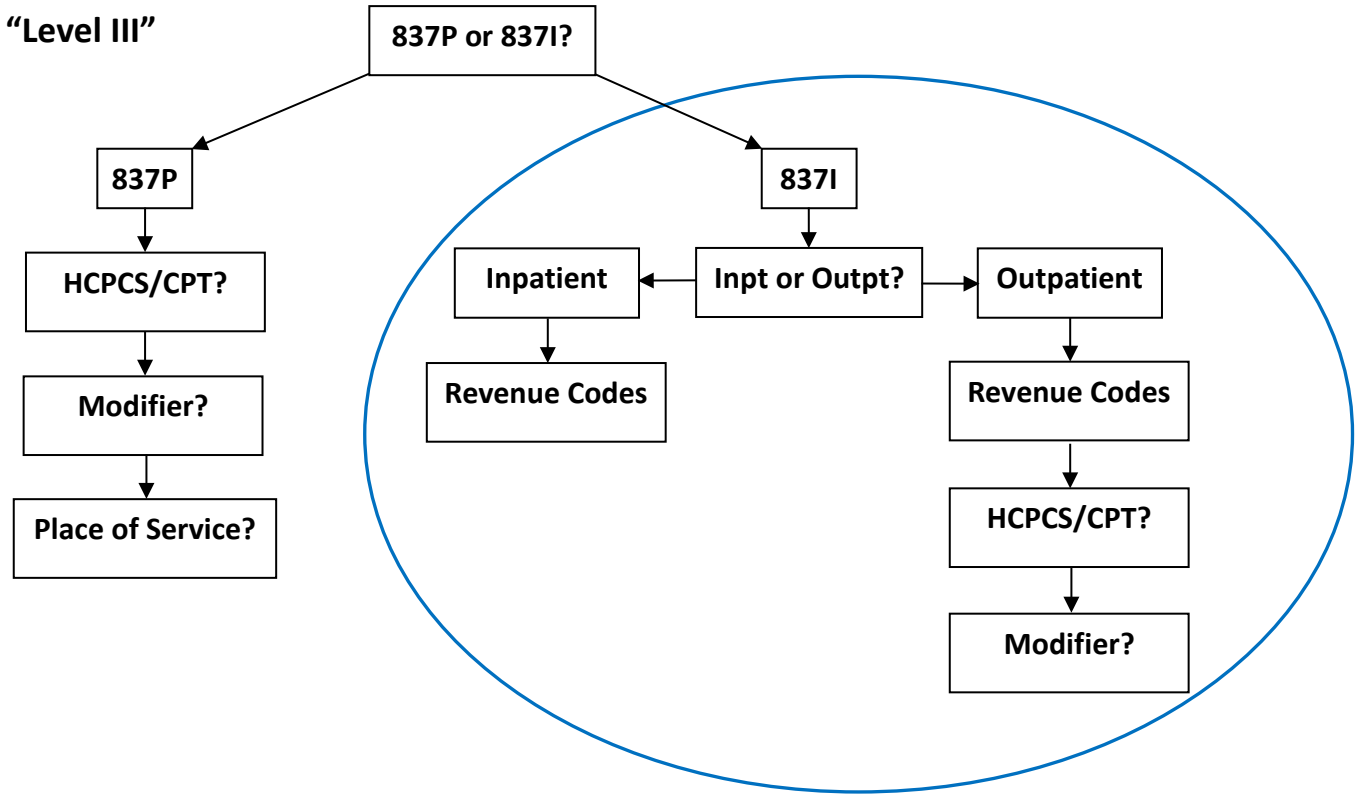
Level III. Name/description of service/issue:



Decision Tree Questions for Level III: (MCT recommendations)

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

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

Name: Andrea Agerlie
Title: HealthCare Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Phone number: 651-431-3159

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Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision: