I. Table of contents

(List of coding recommendations in this document, with hyperlinks to the coding recommendation)

MN Community Coding Practice/Recommendation Table (Informational Only)				
Medicare Claims Processing Manual		A) Subtopic (ST) B) Recommendation (Rec) C) AUC Medical Code TAG minutes reference D) AUC Operations Committee Approval date E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)		
Chapter No.	Chapter/Description Title	**P**	**I**	
12	Physician/Nonphysician	X		(A) ST: Autism Spectrum Disorder/Early Intensive Developmental and Behavioral Intervention

	Practitioner Billing			(EIDBI) 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 been named the Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit. On July 7, 2014, CMS submitted an information 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 and ASD diagnosis. (B) Rec: Both Department of Human Services (DHS) fee-for-service and managed care will need to provide coverage of the EIDBI benefit effective July 1, 2015. 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 1a. The EIDBI Intervention – Applied Behavioral Analysis ~~(Applied Behavioral Analysis and~~ <u>Selected Codes</u> 0364T, 0365T, 0366T, 0367T, 0368T, 0369T HK -Qualified Supervising Professional [QSP] HP Doctorate /Mental Health Professional [MHP] HO Masters /Mental Health Professional [MHP] HN Bachelor's degree level I or II HM Less than bachelor degree level III UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

<u>Coding Individual</u>	<u>Coding Group</u>
0368T-UB-HK–Qualified Supervising Professional, first 30 minutes	0366T-UB-HK-Qualified Supervising Professional, first 30 minutes
0369T-UB-HK–Qualified Supervising Professional, each additional 30 minutes	0367T-UB-HK-Qualified Supervising Professional, each additional 30 min
0368T- UB-HP - Doctorate /Mental Health	0366T-UB-HP - Doctorate /Mental Health

				Professional [MHP]]first 30 minutes 0369T-UB-HP- Doctorate /Mental Health Professional [MHP]] each additional 30 minutes 0368T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0369T-UB-HO - Masters /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HN- Bachelor's degree level I , first 30 minutes 0369T-UB-HN- Bachelor's degree level I , each additional 30 minutes 0364T-UB-HN- Bachelor's degree level II, first 30 minutes 0365T-UB-HN- Bachelor's degree level II, each additional 30 minutes 0364T-UB-HM -Less than bachelor's degree-level III, first 30 min 0365T-UB-HM- Less than bachelor's degree-level III, each additional 30 minutes	Professional [MHP]], first 30 minutes 0367T-UB -HP- Doctorate /Mental Health Professional [MHP]], each additional 30 min 0366T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0367T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 min 0366T-UB- HN- Bachelor's degree level I or II, first 30 minutes 0367T-UB -HN- Bachelor's degree level I or II, each additional 30 min 0366T-UB -HM -Less than bachelor's degree-level III, first 30 min 0367T-UB -HM- Less than bachelor degree-level III, each additional 30 min

1b. The EIDBI Intervention - ~~(~~Developmental and Behavioral Intervention~~)~~

Selected Code Descriptions
0364T, 0365T, 0366T, 0367T, 0368T, 0369T
HK - Qualified Supervising Professional
HM -Less than bachelor degree level III [QSP]
HN- Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP- Doctorate /Mental Health Professional [MHP]]
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding Individual	Coding Group
0368T-UB-HK–Qualified Supervising Professional, first 30 minutes 0369T-UB-HK–Qualified Supervising Professional, each additional 30 minutes 0368T-UB-HP - Doctorate /Mental Health	0366T-UB-HK-Qualified Supervising Professional, first 30 minutes 0367T-UB-HK-Qualified Supervising Professional, each additional 30 min 0366T-UB-HP - Doctorate /Mental Health

				Professional [MHP], first 30 minutes 0369T-UB-HP- Doctorate /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0369T-UB-HO - Masters /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HN- Bachelor's degree level I , first 30 minutes 0369T-UB-HN- Bachelor's degree level I , each additional 30 minutes 0364T-UB-HN- Bachelor's degree level II, first 30 minutes 0365T-UB-HN- Bachelor's degree level II, each additional 30 minutes 0364T-UB-HM -Less than bachelor's degree-level III, first 30 min 0365T-UB-HM- Less than bachelor's degree-level III, each additional 30 minutes	Professional [MHP], first 30 minutes 0367T-UB -HP- Doctorate /Mental Health Professional [MHP], each additional 30 min 0366T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0367T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 min 0366T-UB- HN- Bachelor's degree level I or II, first 30 minutes 0367T-UB -HN- Bachelor's degree level I or II, each additional 30 min 0366T-UB -HM -Less than bachelor's degree-level III, first 30 min 0367T-UB -HM- Less than bachelor degree-level III, each additional 30 min

2. EIDBI Intervention Supervision and Direction

<u>Selected Codes</u>
0362T, 0363T HP Doctoral level
HK -Qualified Supervising Professional [QSP]
HN- Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP- Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

<u>Coding</u>	<u>Telemedicine</u>
0362T-UB-HN - Bachelor's degree level I or II, first 30 minutes	0362T-UB-HN-GT- Bachelor's degree level I or II , (telemedicine, first 30 minutes
0363T-UB-HN- Bachelor's degree level I or II ,each additional 30 minutes	0363T-UB-HN-GT- Bachelor's degree level I or II , (telemedicine) each additional 30 minutes
0362T-UB-HO - Masters /Mental Health	0362T-UB-HO-GT - Masters /Mental Health

Professional [MHP], first 30 minutes 0363T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 minutes 0362T-UB-HP - Doctorate /Mental Health Professional [MHP] first 30 minutes 0363T-UB-HP - Doctorate /Mental Health Professional [MHP] each additional 30 minutes 0362T-UB-HK - Qualified Supervising Professional , first 30 minutes 0363T-UB-HK - Qualified Supervising Professional , each additional 30 minutes	Professional [MHP] (telemedicine) , first 30 minutes 0363T-UB-HO-GT - Masters /Mental Health Professional [MHP] (telemedicine) each additional 30 minutes 0362T-UB-HP-GT - Doctorate /Mental Health Professional [MHP] (telemedicine), first 30 minutes 0363T-UB-HP-GT - Doctorate /Mental Health Professional [MHP] (telemedicine), each additional 30 minutes 0362T-UB-HK-GT - Qualified Supervising Professional, first 30 minutes 0363T-UB-HK-GT - Qualified Supervising Professional , each additional 30 minutes

3. Comprehensive Multi-Disciplinary Evaluation (CMDE)

Selected Code
0359T
AM- Psychiatrist [MD]/Physician
HO - Masters /Mental Health Professional [MHP]
HP- Doctorate /Mental Health Professional [MHP]
TG- APRN
GT- via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding
0359T-UB-AM - Psychiatrist[MD]/Physician
0359T-UB-AM-GT- Psychiatrist[MD]/Physician (telemedicine)
0359T-UB-TG – APRN
0359T-UB-TG-GT- APRN (telemedicine)
0359T-UB –HP - Doctorate /Mental Health Professional [MHP]
0359T-UB -HP-GT – Doctorate /Mental Health Professional [MHP] (telemedicine)
0359T-UB –HO - Masters /Mental Health Professional [MHP]
0359T-UB -HO-GT - Masters /Mental Health Professional [MHP] (telemedicine)

4. Individual Treatment Plan Development and Monitoring

Selected Codes
H0032 Mental Health Service Plan Development by non-physician
UD 15 minute unit
HK - Qualified Supervising Professional [QSP]
HN -Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP - Doctorate /Mental Health Professional [MHP]
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)
Note:
This service is time based although H0032 by definition is not time based. The H0032 was approved for mental health service plan development with modifier UD to indicate a 15 minute time unit.

Coding
H0032-UB-HK-UD- Qualified Supervising Professional [QSP]
H0032-UB-HP-UD- Doctorate /Mental Health Professional [MHP]
H0032-UB-HO-UD- Masters /Mental Health Professional [MHP]
H0032-UB-HN-UD- Bachelor's degree level I or II

5. Family Caregiver Training and Counseling

Selected Codes
T1027
HK - Qualified Supervising Professional [QSP]
HN –Bachelor's degree level I or level II
HO - Masters /Mental Health Professional [MHP]
HP - Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding Individual	Coding Group
T1027-UB –HK – Qualified Supervising Professional [QSP]	T1027-UB-HK-HQ- Qualified Supervising Professional [QSP], Group
T1027-UB- HK-GT- Qualified Supervising Professional [QSP] (telemedicine)	T1027-UB-HP-HQ- Doctorate /Mental Health Prof [MHP], Group
T1027-UB -HP- Doctorate /Mental Health Prof [MHP]	T1027-UB-HO-HQ- Masters /Mental Health Prof [MHP], Group
T1027-UB -HP-GT - Doctorate /Mental Health	T1027-UB-HN-HQ- Bachelor's degree level I

				Prof [MHP] (telemedicine) T1027-UB -HO- Masters /Mental Health Prof [MHP] T1027-UB -HO-GT - Masters /Mental Health Prof [MHP] (telemedicine) T1027-UB–HN - Bachelor's degree level I or II T1027-UB -HN-GT- Bachelor's degree level I or II (telemedicine	or II, Group

6. Coordinated Care Conference

Selected Codes Description
T1024
AM – Physician
HK – QSP
HN - Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)
TG - APRN

Coding	Telemedicine Coding
T1024-UB-AM -Physician T1024-UB-TG - APRN T1024-UB-HK- Qualified Supervising Professional [QSP] T1024-UB-HP- Doctorate /Mental Health Professional [MHP] T1024-UB-HO- Masters /Mental Health Professional[MHP] T1024-UB-HN - Bachelor's degree level I or II	T1024-UB-AM-GT –Physician (telemedicine) T1024-UB-TG-GT- APRN (telemedicine) T1024-UB-HK-GT- Qualified Supervising Professional [QSP] (telemedicine] T1024-UB-HP-GT- Doctorate /Mental Health Professional [MHP] (telemedicine) T1024-UB-HO-GT- Masters /Mental Health Professional[MHP] (telemedicine) T1024-UB-HN-GT- Bachelor's degree level I or II (telemedicine)

7. Travel Time

Selected Codes
H0046
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

				Notes: 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). Coding • H0046/UB **(C)** MCT: 4/9/15 (D) AUC Operations approved (E) Proposed as an addition to next version of 837I and 837P companion guides
12	Physician/Nonphysician Practitioner Billing			A) ST: **Coding for SBIRT** SBIRT (Screening, Brief intervention, and Referral to Treatment) is an alcohol/substance abuse structured screening. Current reporting per SAMHSA (Substance Abuse and Mental Health Services Administration) is as follows: ▪ For commercial payers the codes are 99408 and 99409 ▪ For Medicare the codes are G0396 and G0397 ▪ For Medicaid the codes are H0049 and H0050 B) Rec: Do not follow SAMHSA coding recommendation. Use CPT or G codes, but not H codes. (Both codes are acceptable per Appendix A front matter in the current Claims companion guide.) C) 1/10/13 D) AUC Operations Committee E)
12	Physician/Nonphysician Practitioner Billing			A) Subtopic (ST) – **Consultation Services** B) Rec.: Per the Minnesota Uniform Companion Guide Section A.3.1, select codes that most accurately identify the service provided. Consultation codes most accurately identify the service provided for non- Medicare business. Group purchasers will continue to accept consultative service codes as defined by CPT for non-Medicare business. C) AUC Medical Code TAG minutes reference 11-24-09 D) AUC Operations Committee approved via email vote, 12-21-09. E)
12	Physician/Nonphysician	X		A) **Moving Home Minnesota – A Demonstration Project**

	Practitioner Billing			The federal Deficit Reduction and Affordable Care Act empowered states to develop demonstration projects that would promote and enable movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community. To provide community-based alternatives for persons of all ages and disability groups who reside in MA-funded institutional settings, the Moving Home Minnesota – a Demonstration Project which provides an array of home and community based services to include planning and coordination of community living arrangements, searching for and securing housing, moving, securing household goods, and arranging for supportive housing, employment and environmental services. B) Rec.: The following codes are recommended to report MHM activities:

HCPCS/ Modifiers	Description
A0160 U6	Non-Emergency transportation, case worker, per mile , MHM
A0170 U6	Transportation Ancillary: parking fees, tolls, other, MHM
A0180 U6	Non-emergency transportation: ancillary lodging, recipient, MHM
A0190 U6	Meals, recipient, MHM
A0200 U6	Lodging for caseworker, escort, parent, MHM
A0210 U6	Meals for caseworker, escort, parent, MHM
H0038 U5 U6	Self-help/Peer services – Level II Certified Peer Specialist, MHM
H0038 U6	Self-help/Peer services – Level I Certified Peer Specialist, MHM
H0038 U6 HQ	Self-help/Peer services – Certified Peer Specialist in a group setting, MHM
H0040 U6	Assertive Community Treatment, MHM
H0045 U6	Respite care services, not in home, MHM
H2000 U6	Pre-Discharge Case Consultation and Collaboration, MHM
H2015 U6	Comprehensive community support services, MHM
H2027 U6	Psychoeducational service, 15 minutes, MHM
S5111 U6	Home Care Training - Family, MHM
S5115 U6	Family Memory Care Intervention – 15 minutes, MHM
S5116 (U6)	Home Care Training – Non-Family, MHM
S5135 UA U6	Overnight Assistance, MHM
S5150 U6	Respite Care, in home, MHM
S5150 UB U6	Respite Care, out of home, MHM
S5151 U6	Respite Care in home, MHM
S5160 U6	Emergency response system installation and testing, MHM
S5161 U6	Emergency response system service fee per month, MHM
S5162 U6	Emergency response system purchase, MHM

				S5165 U6	Environmental accessibility adaptations, MHM
				S9970 U6 U5	Health club membership, monthly, MHM
				T1016 U6	Case management, MHM
				T1017 U6	Transition coordination, MHM
				T1028 U6	Adaptations – home assessment, MHM
				T1999 U6	Tools, clothing and equipment for employment, MHM
				T2018 U6	Supported Employment Benchmark Payment, daily, MHM
				T2019 U6	Supported Employment (15 minutes) , MHM
				T2029 U6 NU	Durable medical equipment, new, MHM
				T2029 U6 RB	Durable medical equipment, repair, MHM
				T2029 U6 RR	Durable medical equipment, rental, MHM
				T2038 U1 U6	Transitional services, furniture, MHM
				T2038 U2 U6	Transitional services, supplies, MHM
				T2038 U6	Transition plan development, MHM
				T2038 UA U6	Transitional services, housing deposit, MHM
				'U' Modifier definitions UA Night supervision (S3135)/Item, service or procedure furnished in conjunction with a demonstration project (T2038) UB – Out-of home UD – Transition to community living services U1 – Transitional services – furniture U2 – Transitional services- supplies U5 – Monthly U6 - Moving Home Minnesota C) MCT 2/14/13, 6/23/14 D) AUC Operations Committee approved E)	
12	Physician/Nonphysician Practitioner Billing			A (ST): **Labor Epidural Billing** The MCT responded to a request to approve standardized coding for "time present and immediately available" for billing of labor epidural anesthesia services, to be included in the relevant claims companion guides. B) Rec: The TAG agreed that there is no coding to identify specific standby services for anesthesia as requested and so no coding recommendation was possible. The TAG suggested that the SBAR submitter make a recommendation to CPT for national code(s) to	

				address labor epidural anesthesiology billing "time present and immediately available." C) MCT 2/14/13 D) AUC Operations Committee approval date E)
12	Physician/Nonphysician Practitioner Billing	**X**		A) ST: **Billing Requirements for CPT Code 69210** The MCT responded to a request to approve standardized coding for 69210. The narrative for 69210 was revised in 2014 to a unilateral code. Thus is performed on both ears it would be appropriate to bill the code with a -50 modifier. However, CMS is not recognizing (denying) 69210 if billed with a modifier 50 (bilateral procedure). Medicare has instructed to use modifiers –RT and –LT instead. B) REC: Medicare for Medicare products - report one line one unit, no modifiers. Commercial and DHS - report one line, one unit, 50 modifier. C) 6/12/14 D) AUC Operations approved E)
12	Physician/Nonphysician Practitioner Billing	**X**		**A)** ST: **Modifier -25 on preventive medicine visits (99381-99397)** The preventive exam denies against the immunization administration code. MN stated there is no need to add the -25 modifier but there are other health plans that require the modifier. Actions of the American Academy of Pediatrics last year caused the CCI policy to be temporary rescinded. However, the new effective date of the CCI policy is April 1, 2014. DHS must use the CCI edits. B) REC: All payers accept the -25 modifier so this is not a compliance issue, it is a payment issue. Need to work directly with payers she's having problem with. Reporting is uniform and MCT view as payment issue because it is a CCI edit. C) 4/14/14 D) AUC Operations approved E)
N/A	TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs	X	X	**A) Certified Family Peer Specialist – DHS** B) Rec: Peer specialist is different from the adult; for parents who have children who have gone through the system and can assist another parent; can be advocate for family going through the system. Used in other states for parents with children with mental illness; Concern that there be a training program and certification to ensure providing positive support. Certification standards will be adopted hopefully nationally (continuing education requirements). Services are for children under 21 with the HA modifier. TAG approved DHS recommended codes for these services and to place in coding recommendation grid, pending federal approval. New codes will also be placed in companion guide upon approval. For mental health services only and do not apply to substance abuse. H0038 Certified peer specialist services, per 15 minutes H0038 U5 Advanced level certified peer specialist services, per 15 minutes

				H0038 HQ Group setting, certified peer specialist services, per 15 minutes H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes C) MCT: 4/10/14 D) AUC Operations Committee E) Proposed as an addition to next version of 837P and the 837I companion guides.
N/A	**N/A**	**X**	**X**	A) ST: **Dental services performed in the operating room** B) Rec: 10-26-10 - For dental services not normally provided under general anesthesia…. Where dental HCPCS codes are the most specific, appropriate codes, they should be used to indicate dental procedures performed under general anesthesia in the operating room, on both the 837. Professional and 837 Institutional claims types. C) MCT: 01/14/2010 D) AUC Operations Committee approved 02/08/10 E)

I. Table of contents

(List of coding recommendations in this document, with hyperlinks to the coding recommendation)

MN Community Coding Practice/Recommendation Table (Informational Only)				
Medicare Claims Processing		A) Subtopic (ST) B) Recommendation (Rec) C) AUC Medical Code TAG minutes reference D) AUC Operations Committee Approval date E) Proposed as an addition to or deletion in the next version of companion guide (if blank, is not being proposed for next version of guide)		
Chapter No.	Chapter/Description Title	**P**	**I**	
~~**12**~~	~~Physician/Nonphysician Practitioner Billing~~	~~**X**~~		~~A) ST: **Autism Spectrum Disorder**~~ ~~Question: How are autism spectrum disorder services to be reported?~~ ~~B) Rec:~~ ~~T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter. (May be reported on different days if multiple assessments are performed) report as 1 unit per encounter.~~ ~~H2018 Psychosocial rehabilitation services, per diem. (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary)~~ ~~H2020 Therapeutic behavioral services per diem (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary.)~~ ~~H2014 Skills training and development, per 15 minutes. H2017 Psychosocial rehabilitation services, per 15 minutes. H2019 Therapeutic behavioral services, per 15 minutes.~~ ~~G9012 Case Management Services~~ ~~C) MCT: 9-22-09~~ ~~D) AUC Operations Committee approved via email vote, 10-20-09.~~ ~~E)~~
12	Physician/Nonphysician Practitioner Billing	X		(A) ST: Autism Spectrum Disorder/Early Intensive Developmental and Behavioral Intervention (EIDBI) 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 been named the Early Intensive Developmental and

				Behavioral Intervention (EIDBI) benefit. On July 7, 2014, CMS submitted an information 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 and ASD diagnosis. (B) Rec: Both Department of Human Services (DHS) fee-for-service and managed care will need to provide coverage of the EIDBI benefit effective July 1, 2015. 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 1a. The EIDBI Intervention – Applied Behavioral Analysis ~~(Applied Behavioral Analysis and Developmental and Behavioral Intervention)~~ ~~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 Codes 0364T, 0365T, 0366T, 0367T, 0368T, 0369T HK -Qualified Supervising Professional [QSP] HP Doctorate /Mental Health Professional [MHP] HO Masters /Mental Health Professional [MHP] HN Bachelor's degree level I or II HM Less than bachelor degree level III

UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding Individual	Coding Group
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0364T-UB-HN- Bachelor's degree level II, first 30 minutes 0365T-UB-HN- Bachelor's degree level II, each additional 30 minutes 0364T-UB-HM -Less than bachelor's degree- level III, first 30 min 0365T-UB-HM- Less than bachelor's degree- level III, each additional 30 minutes	

1b. The EIDBI Intervention - ~~(~~Developmental and Behavioral Intervention~~)~~

~~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, 0365T, 0366T, 0367T, 0368T, 0369T
HK - Qualified Supervising Professional
HM -Less than bachelor degree level III [QSP]
HN- Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
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UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding Individual	Coding Group
0368T-UB-HK–Qualified Supervising Professional, first 30 minutes 0369T-UB-HK–Qualified Supervising Professional, each additional 30 minutes 0368T-UB-HP - Doctorate /Mental Health Professional [MHP], first 30 minutes 0369T-UB-HP- Doctorate /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0369T-UB-HO - Masters /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HN- Bachelor's degree level I , first 30 minutes 0369T-UB-HN- Bachelor's degree level I , each additional 30 minutes	0366T-UB-HK-Qualified Supervising Professional, first 30 minutes 0367T-UB-HK-Qualified Supervising Professional, each additional 30 min 0366T-UB-HP - Doctorate /Mental Health Professional [MHP], first 30 minutes 0367T-UB -HP- Doctorate /Mental Health Professional [MHP], each additional 30 min 0366T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0367T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 min 0366T-UB- HN- Bachelor's degree level I or II, first 30 minutes 0367T-UB -HN- Bachelor's degree level I or II, each additional 30 min 0366T-UB -HM -Less than bachelor's degree- level III, first 30 min 0367T-UB -HM- Less than bachelor degree-level III, each additional 30 min
0364T-UB-HN- Bachelor's degree level II, first 30 minutes 0365T-UB-HN- Bachelor's degree level II, each additional 30 minutes 0364T-UB-HM -Less than bachelor's degree- level III, first 30 min 0365T-UB-HM- Less than bachelor's degree- level III, each additional 30 minutes	

2. EIDBI Intervention Supervision and Direction

~~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 Codes
0362T, 0363T HP Doctoral level
HK -Qualified Supervising Professional [QSP]
HN- Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP- Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding	Telemedicine
0362T-UB-HN - Bachelor's degree level I or II, first 30 minutes	0362T-UB-HN-GT- Bachelor's degree level I or II , (telemedicine, first 30 minutes
0363T-UB-HN- Bachelor's degree level I or II ,each additional 30 minutes	0363T-UB-HN-GT- Bachelor's degree level I or II , (telemedicine) each additional 30 minutes
0362T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes	0362T-UB-HO-GT - Masters /Mental Health Professional [MHP] (telemedicine) , first 30 minutes
0363T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 minutes	0363T-UB-HO-GT - Masters /Mental Health Professional [MHP] (telemedicine) each additional 30 minutes
0362T-UB-HP - Doctorate /Mental Health Professional [MHP] first 30 minutes	0362T-UB-HP-GT - Doctorate /Mental Health Professional [MHP] (telemedicine), first 30 minutes
0363T-UB-HP - Doctorate /Mental Health Professional [MHP] each additional 30 minutes	0363T-UB-HP-GT - Doctorate /Mental Health Professional [MHP] (telemedicine), each additional 30 minutes
0362T-UB-HK - Qualified Supervising Professional , first 30 minutes	0362T-UB-HK-GT - Qualified Supervising Professional, first 30 minutes
0363T-UB-HK - Qualified Supervising Professional , each additional 30 minutes	0363T-UB-HK-GT - Qualified Supervising Professional , each additional 30 minutes

				3. Comprehensive Multi-Disciplinary Evaluation (CMDE) ~~Who Can Provide Service?~~ ~~Licensed Mental Health Professional~~ ~~Psychiatrist~~ ~~APRN~~ ~~Doctorate /Mental Health Professional [MHP]~~ ~~Masters /Mental Health Professional [MHP]~~ ~~Where does Service Take Place?~~ ~~Center, clinic or office~~ Selected Code 0359T AM- Psychiatrist [MD]/Physician HO - Masters /Mental Health Professional [MHP] HP- Doctorate /Mental Health Professional [MHP] TG- APRN GT- via interactive audio and video telecommunications systems ~~GT via interactive audio and video telecommunications systems~~ UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM) Coding 0359T-UB-AM - Psychiatrist[MD]/Physician 0359T-UB-AM-GT- Psychiatrist[MD]/Physician (telemedicine) 0359T-UB-TG – APRN 0359T-UB-TG-GT- APRN (telemedicine) 0359T-UB –HP - Doctorate /Mental Health Professional [MHP] 0359T-UB -HP-GT – Doctorate /Mental Health Professional [MHP] (telemedicine) 0359T-UB –HO - Masters /Mental Health Professional [MHP] 0359T-UB -HO-GT - Masters /Mental Health Professional [MHP] (telemedicine) 4. Individual Treatment Plan Development and Monitoring ~~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 Codes
H0032 Mental Health Service Plan Development by non-physician
UD 15 minute unit
HK - Qualified Supervising Professional [QSP]
HN -Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP - Doctorate /Mental Health Professional [MHP]
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)
Note:
This service is time based although H0032 by definition is not time based. The H0032 was approved for mental health service plan development with modifier UD to indicate a 15 minute time unit.

Coding
H0032-UB-HK-UD- Qualified Supervising Professional [QSP]
H0032-UB-HP-UD- Doctorate /Mental Health Professional [MHP]
H0032-UB-HO-UD- Masters /Mental Health Professional [MHP]
H0032-UB-HN-UD- Bachelor's degree level I or II

5. Family Caregiver Training and Counseling
~~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 Codes
T1027
HK - Qualified Supervising Professional [QSP]
HN –Bachelor's degree level I or level II
HO - Masters /Mental Health Professional [MHP]
HP - Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding Individual	Coding Group
T1027-UB –HK – Qualified Supervising Professional [QSP]	T1027-UB-HK-HQ- Qualified Supervising Professional [QSP], Group

				T1027-UB- HK-GT- Qualified Supervising Professional [QSP] (telemedicine) T1027-UB -HP- Doctorate /Mental Health Prof [MHP] T1027-UB -HP-GT - Doctorate /Mental Health Prof [MHP] (telemedicine) T1027-UB -HO- Masters /Mental Health Prof [MHP] T1027-UB -HO-GT - Masters /Mental Health Prof [MHP] (telemedicine) T1027-UB–HN - Bachelor's degree level I or II T1027-UB -HN-GT- Bachelor's degree level I or II (telemedicine	T1027-UB-HP-HQ- Doctorate /Mental Health Prof [MHP], Group T1027-UB-HO-HQ- Masters /Mental Health Prof [MHP], Group T1027-UB-HN-HQ- Bachelor's degree level I or II, Group
				6. Coordinated Care Conference ~~Who Can Provide the Service?~~ ~~Physician~~ ~~APRN~~ ~~Qualified Supervising Professional~~ ~~Developmental/Behavioral Professional-Level I Provider~~ ~~Developmental/Behavioral Practitioner-Level II Provider~~ ~~Where Does It Take Place?~~ ~~Center or clinic~~ ~~Home~~ Selected Codes Description T1024 AM – Physician HK – QSP HN - Bachelor's degree level I or II HO - Masters /Mental Health Professional [MHP] HP – Doctorate /Mental Health Professional [MHP] GT via interactive audio and video telecommunications systems UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM) TG - APRN	
				Coding T1024-UB-AM -Physician	Telemedicine Coding T1024-UB-AM-GT –Physician

				T1024-UB-TG - APRN T1024-UB-HK- Qualified Supervising Professional [QSP] T1024-UB-HP- Doctorate /Mental Health Professional [MHP] T1024-UB-HO- Masters /Mental Health Professional[MHP] T1024-UB-HN - Bachelor's degree level I or II (telemedicine) T1024-UB-TG-GT- APRN (telemedicine) T1024-UB-HK-GT- Qualified Supervising Professional [QSP] (telemedicine] T1024-UB-HP-GT- Doctorate /Mental Health Professional [MHP] (telemedicine) T1024-UB-HO-GT- Masters /Mental Health Professional[MHP] (telemedicine) T1024-UB-HN-GT- Bachelor's degree level I or II (telemedicine) 7. Travel Time ~~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 Codes H0046 UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM) Notes: 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). Coding • H0046/UB **(C)** MCT: 4/9/15 (D) AUC Operations approved (E) Proposed as an addition to next version of 837I and 837P companion guides
12	Physician/Nonphysician Practitioner Billing			A) ST: **Coding for SBIRT** SBIRT (Screening, Brief intervention, and Referral to Treatment) is an alcohol/substance abuse structured screening. Current reporting per SAMHSA (Substance Abuse and

<table>
<tr><td></td><td></td><td></td><td></td><td>Mental Health Services Administration) is as follows:
For commercial payers the codes are 99408 and 99409
For Medicare the codes are G0396 and G0397
For Medicaid the codes are H0049 and H0050
B) Rec: Do not follow SAMHSA coding recommendation. Use CPT or G codes, but not H codes. (Both codes are acceptable per Appendix A front matter in the current Claims companion guide.)
C) 1/10/13
D) AUC Operations Committee
E)</td></tr>
<tr><td>12</td><td>Physician/Nonphysician Practitioner Billing</td><td></td><td></td><td>A) Subtopic (ST) – Consultation Services
B) Rec.: Per the Minnesota Uniform Companion Guide Section A.3.1, select codes that most accurately identify the service provided. Consultation codes most accurately identify the service provided for non- Medicare business. Group purchasers will continue to accept consultative service codes as defined by CPT for non-Medicare business.
C) AUC Medical Code TAG minutes reference 11-24-09
D) AUC Operations Committee approved via email vote, 12-21-09.
E)</td></tr>
<tr><td>12</td><td>Physician/Nonphysician Practitioner Billing</td><td>X</td><td>X</td><td>A) ST – In-reach Community Based Coordination
In-reach is a community based service required by statute 256b.0625, subd. 56, effective 1/1/12. These are case management type services primarily for patients coming to the ED multiple times. The social worker provides management to help direct the patient to appropriate care and services. The services are billable in 15 minute increments. Practitioners approved to render these services are social worker (BA), Public Health nurse or corrections practitioner.
B) Rec: In-Reach Services applies to both 837I and 837P:
<table><tr><td></td><td>837I</td><td>837P</td></tr><tr><td>TOB</td><td>013x</td><td>N/A</td></tr><tr><td>Revenue Code</td><td>0984</td><td>N/A</td></tr><tr><td>HCPCS</td><td>T1016-U2 T1016-U2 TS</td><td>T1016-U2 T1016-U2 TS</td></tr></table>T1016 Case management, each 15 minutes
U2 = In-reach, initial service
U2 TS = In-reach, follow-up</td></tr>
</table>

				~~C) MCT – 2/14/13~~ ~~D)AUC Operations Committee approved~~ ~~E) Proposed as an addition to next version of 837I and 837P companion guides~~
12	Physician/Nonphysician Practitioner Billing	X		A) **Moving Home Minnesota – A ~~Money Follows the Person~~ Demonstration Project ~~(a.k.a. MFP Demonstration Project)~~** The federal Deficit Reduction and Affordable Care Act empowered states to develop demonstration projects that would promote and enable movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community. To provide community-based alternatives for persons of all ages and disability groups who reside in MA-funded institutional settings, the Moving Home Minnesota – ~~A Money Follows the Person (MFP)~~ a Demonstration Project which provides an array of home and community based services to include planning and coordination of community living arrangements, searching for and securing housing, moving, securing household goods, and arranging for supportive housing, employment and environmental services. B) Rec.: The following codes are recommended to report MHM ~~MFP~~ activities:

HCPCS/ Modifiers	Description
A0160 U6	Non-Emergency transportation, case worker, per mile , MHM
A0170 U6	Transportation Ancillary: parking fees, tolls, other, MHM
A0180 U6	Non-emergency transportation: ancillary lodging, recipient, MHM
A0190 U6	Meals, recipient, MHM
A0200 U6	Lodging for caseworker, escort, parent, MHM
A0210 U6	Meals for caseworker, escort, parent, MHM
H0038 U5 U6	Self-help/Peer services – Level II Certified Peer Specialist, MHM
H0038 U6	Self-help/Peer services – Level I Certified Peer Specialist, MHM
H0038 U6 HQ	Self-help/Peer services – Certified Peer Specialist in a group setting, MHM
H0040 U6	Assertive Community Treatment, MHM
H0045 U6	Respite care services, not in home, MHM
H2000 U6	Pre-Discharge Case Consultation and Collaboration, MHM
H2015 U6	Comprehensive community support services, MHM
H2027 U6	Psychoeducational service, 15 minutes, MHM
S5111 U6	Home Care Training - Family, MHM
S5115 U6	Family Memory Care Intervention – 15 minutes, MHM

S5116 (U6)	Home Care Training – Non-Family, MHM
S5135 UA U6	Overnight Assistance, MHM
S5150 U6	Respite Care, in home, MHM
S5150 UB U6	Respite Care, out of home, MHM
S5151 U6	Respite Care in home, MHM
S5160 U6	Emergency response system installation and testing, MHM
S5161 U6	Emergency response system service fee per month, MHM
S5162 U6	Emergency response system purchase, MHM
S5165 U6	Environmental accessibility adaptations, MHM
S9970 U6 U5	Health club membership, monthly, MHM
T1016 U6	Case management, MHM
T1017 U6	Transition coordination, MHM
T1028 U6	Adaptations – home assessment, MHM
T1999 U6	Tools, clothing and equipment for employment, MHM
T2018 U6	Supported Employment Benchmark Payment, daily, MHM
T2019 U6	Supported Employment (15 minutes) , MHM
T2029 U6 NU	Durable medical equipment, new, MHM
T2029 U6 RB	Durable medical equipment, repair, MHM
T2029 U6 RR	Durable medical equipment, rental, MHM
T2038 U1 U6	Transitional services, furniture, MHM
T2038 U2 U6	Transitional services, supplies, MHM
T2038 U6	Transition plan development, MHM
T2038 UA U6	Transitional services, housing deposit, MHM

~~HCPCS Modifier(s) Description~~

~~T2038 U6 Community transition, MFP *(plan development)*~~
~~T2038 U6 UD Community transition, MFP *(coordination)*~~
~~T2038 U6 U1 Community transition, MFP, furniture~~
~~T2038 U6 U2 Community transition, MFP, supplies~~
~~T2038 U6 UA Community transition, MFP, deposits associated with securing housing~~
~~T2015 U6 Comprehensive community support services, per 15 minutes, MFP~~

				~~T1016 U6 Case management, each 15 minutes, MFP~~ ~~T2019 U6 Habilitation, supported employment, per 15 minutes, MFP~~ ~~H0038 U6 Self-help/peer services, per 15 minutes, MFP~~ ~~H2027 U6 Psychoeducational service, per 15 minutes, MFP~~ ~~S5115 U6 Home care training, nonfamily, per 15 minutes, MFP *(caregiver education)*~~ ~~H2000 U6 Comprehensive multidisciplinary evaluation, MFP *(in the development of a transition or service plan)*~~ ~~T2013 U6 Habilitation, educational, per hour, MFP *(intervention provided to support placement in the community)*~~ ~~S5150 U6 Unskilled respite care, per 15 minutes, MFP *(in home)*~~ ~~S5151 U6 Unskilled respite care, per diem, MFP *(in home)*~~ ~~S5150 U6 UB Unskilled respite care, per 15 minutes, MFP, out of home~~ ~~H0045 U6 Respite care services, not in the home, per diem, MFP~~ ~~S5165 U6 Home modifications; per service, MFP~~ ~~S5162 U6 Emergency response system; purchase only, MFP~~ ~~S5161 U6 Emergency response system; service fee, per month, MFP~~ ~~T1999 U6 Miscellaneous therapeutic items and supplies, retail purchases, NOC, MFP~~ ~~E1399 U6 (NU, RR or RB) Durable medical equipment, MFP (include modifier for purchase, rental or repair~~ ~~S5135 U6 UA Companion care, adult; per 15 minutes, MFP, night supervision~~ ~~A0160 U6 Nonemergency transportation; per mile – caseworker or social, MFP~~ ~~A0170 U6 Transportation ancillary: parking fees, tolls, other, MFP~~

				~~A0180 U6 Nonemergency transportation: ancillary; lodging-recipient, MFP~~ ~~A0190 U6 Nonemergency transportation: ancillary; meals, recipient, MFP~~ ~~A0200 U6 Nonemergency transportation: ancillary; lodging, escort, MFP~~ ~~A0210 U6 Nonemergency transportation: ancillary; meals, escort, MFP~~ ~~S9970 U6 U5 Health club membership, monthly annual, MFP~~ 'U' Modifier definitions ~~U6 Money follows the person demonstration (Moving Home Minnesota)~~ UA Night supervision (S3135)/Item, service or procedure furnished in conjunction with a demonstration project (T2038) UB – Out-of home UD – Transition to community living services U1 – Transitional services – furniture U2 – Transitional services- supplies U5 – Monthly U6 - Moving Home Minnesota C) MCT 2/14/13, 6/23/14 D) AUC Operations Committee approved E)
12	Physician/Nonphysician Practitioner Billing			A (ST): **Labor Epidural Billing** The MCT responded to a request to approve standardized coding for "time present and immediately available" for billing of labor epidural anesthesia services, to be included in the relevant claims companion guides. B) Rec: The TAG agreed that there is no coding to identify specific standby services for anesthesia as requested and so no coding recommendation was possible. The TAG suggested that the SBAR submitter make a recommendation to CPT for national code(s) to address labor epidural anesthesiology billing "time present and immediately available." C) MCT 2/14/13 D) AUC Operations Committee approval date E)
12	Physician/Nonphysician Practitioner Billing	**X**		A) ST: Billing Requirements for CPT Code 69210 The MCT responded to a request to approve standardized coding for 69210. The narrative for 69210 was revised in 2014 to a unilateral code. Thus is performed on both ears it

				would be appropriate to bill the code with a -50 modifier. However, CMS is not recognizing (denying) 69210 if billed with a modifier 50 (bilateral procedure). Medicare has instructed to use modifiers –RT and –LT instead. B) REC: Medicare for Medicare products - report one line one unit, no modifiers. Commercial and DHS - report one line, one unit, 50 modifier. C) 6/12/14 D) AUC Operations approved E)
12	Physician/Nonphysician Practitioner Billing	**X**		A) ST: Modifier -25 on preventive medicine visits (99381-99397) The preventive exam denies against the immunization administration code. MN stated there is no need to add the -25 modifier but there are other health plans that require the modifier. Actions of the American Academy of Pediatrics last year caused the CCI policy to be temporary rescinded. However, the new effective date of the CCI policy is April 1, 2014. DHS must use the CCI edits. B) REC: All payers accept the -25 modifier so this is not a compliance issue, it is a payment issue. Need to work directly with payers she's having problem with. Reporting is uniform and MCT view as payment issue because it is a CCI edit. C) 4/14/14 D) AUC Operations approved E)
~~**12**~~	~~Physician/Nonphysician Practitioner Billing~~	~~**X**~~		~~**A) E-visits**~~ ~~For 2013, changes were made throughout the CPT code set to expand references to "physician" to include any "qualified health care professional" and generally to remove references to the provider from the code descriptors if at all possible. As described in the introduction to the codebook, "A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service."~~ ~~B) Rec.: Based on the definition change, the MCT agreed that the current MUCG coding instructions for E-visits should be removed. Providers should submit codes based on the new CPT definition.~~ ~~C) MCT 5/9/13~~ ~~D)~~ ~~E) Remove the following entry from next version of the companion guide:~~ ~~"For E-visits, use 99444 for MD/DO/DC; use 98969 for non-physician healthcare professionals (e.g. Nurse Practitioner, Physician Assistant, and Clinical Nurse Specialist)."~~
~~**12**~~	~~Physician/Nonphysician~~	~~**X**~~		~~**A) Telephone services**~~

	Practitioner Billing			For 2013, changes were made throughout the CPT code set to expand references to "physician" to include any "qualified health care professional" and generally to remove references to the provider from the code descriptors if at all possible. As is described in the introduction to the codebook, "A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." B) Rec.: Based on the definition change, the MCT agreed that the current MUCG coding instructions for Telephone services should be removed. Providers should submit codes based on the new CPT definition. C) MCT 5/9/13 D) E) Remove the following entry from next version of the companion guide: "For telephone services, use 99441-99443 for MD/DO/DC; use 98966-98968 for non-physician healthcare professionals (e.g. Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist)."
15	Ambulance	**X**		A) ST: **Community Paramedics** MN Statute 256B.0625, subd. 60 requires Medical Assistance cover services provided by community paramedics certified under section 144R.28, subd. 9 B) Rec: Community paramedic services should be billed as followed: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – report the Medical director's NPI • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) o T1016 Case management, each 15 minutes o U3 – service provided by certified community paramedic (EMT-CP) • Supplies and vaccines may be reported as needed with the appropriate HCPCS codes C) MCT 2/14/13 D) AUC Operations Committee approved Proposed as an addition to next version of 837P companion guide.
16	Laboratory Services	**X**	**X**	A) **Reporting Newborn Screening** MN Statute 144.125 requires all infants be screened for heritable and congenital disorders using a Newborn Screening Card purchased from the Minnesota Department of Health. Generally, the cost of the screen is incorporated in the birthing facility fees; however, in some circumstances, the specimen is taken after discharge. Rec.: When the specimen is taken for the Newborn Screening Card purchased from Minnesota

				~~Department of Health after the birth discharge, the newborn screen should be reported using S3620.~~ ~~This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.~~ ~~S3620 Newborn metabolic screening panel, includes test kit, postage and the laboratory tests specified by the state for inclusion in this panel (e.g., galactose; hemoglobin, electrophoresis; hydroxyprogesterone, 17-d; phenylanine (PKU); and thyroxine, total)~~ ~~76, 77 – repeat service~~ ~~C) MCT 2/14/13~~ ~~D) AUC Operations Committee approved~~ ~~Proposed as an addition to next version of 837P and 837I companion guides.~~
N/A	TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs	X	X	A) Certified Family Peer Specialist – DHS B) Rec: Peer specialist is different from the adult; for parents who have children who have gone through the system and can assist another parent; can be advocate for family going through the system. Used in other states for parents with children with mental illness; Concern that there be a training program and certification to ensure providing positive support. Certification standards will be adopted hopefully nationally (continuing education requirements). Services are for children under 21. The HA modifier. TAG approved DHS recommended codes for these services and to place in coding recommendation grid, pending federal approval. New codes will also be placed in companion guide upon approval. For mental health services only and do not apply to substance abuse. H0038 Certified peer specialist services, per 15 minutes H0038 U5 Advanced level certified peer specialist services, per 15 minutes H0038 HQ Group setting, certified peer specialist services, per 15 minutes H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes C) MCT: 4/10/14 D) AUC Operations Committee E) Proposed as an addition to next version of 837P and the 837I companion guides.
N/A	**N/A**	**X**	**X**	A) ST: **Dental services performed in the operating room** B) Rec: 10-26-10 - For dental services not normally provided under general anesthesia…. Where dental HCPCS codes are the most specific, appropriate codes, they should be used to indicate dental procedures performed under general anesthesia in the operating room, on both the 837.

				Professional and 837 Institutional claims types. C) MCT: 01/14/2010 D) AUC Operations Committee approved 02/08/10 E)
~~N/A~~	~~N/A~~	~~X~~	~~X~~	~~A) ST: **MAT (Medication Assisted Treatment) Billing – Methadone vs. Other**~~ ~~To meet CMS and legislative requirements, DHS must revise coding for MAT services:~~ ~~1. to establish a code to distinguish methadone from all other drugs for MAT and~~ ~~2. to identify MAT intensive (plus)services for~~ ~~a. methadone and~~ ~~b. all other drugs~~ ~~B) Rec: Revise MUCG Table A.5.3.c – Substance Abuse Services: Outpatient Services as follows:~~ ~~**837I:**~~ ~~Service description Unit Revenue Code HCPCS Procedure Code TOB~~ ~~MAT Day 0944 H0020 089x or 013x~~ ~~MAT – all other drugs Day 0944 H0047 U9 089x or 013x~~ ~~**837P:**~~ ~~Service description Unit Revenue Code HCPCS Procedure Code TOB~~ ~~MAT Day 0944 H0020 089x or 013x N/A~~ ~~MAT – all other drugs Day 0944 H0047 UA N/A~~ ~~MAT Plus Day N/A N/A H0020 N/A~~ ~~MAT Plus – all other drugs Day N/A N/A H0047 UB N/A~~ ~~MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.~~ ~~UA – MAT Plus, methadone UB – MAT Plus, all other drugs~~ ~~C) MCT 2/14/13~~ ~~D) AUC Operations Committee approved~~

				~~E)~~ ~~Proposed as an addition to next version of 837P and the 837I companion guides.~~

Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday 13, 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** – July 28, 2015
4. **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.	**OPEN**

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.	
06/12/14 Minutes: No updates. DHS is still waiting for federal approval.	**OPEN**
06/24/14 Minutes: DHS reported the State Plan with the approved coding recommendations will be submitted 3rd quarter.	**OPEN**
07/22/14 Minutes: DHS reported request for approval from CMS will be submitted this quarter.	**OPEN**
08/14/14 Minutes: Action was deferred pending any additional comments.	**OPEN**
08/26/14, 10/9/14, 12/11/14 Minutes: Discussion of this item is postponed; waiting to hear from CMS	**OPEN**
1/8/15: Kathy stated the State plan has not been submitted to CMS as reported earlier. DHS will submit this quarter.	**OPEN**
2/12/15, 3/12/15, 4/9/15, 5/14/15, 6/11/15, 7/28/15: DHS is Waiting for Feds to approve program and coding recommendations.	**OPEN**

5. 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.	**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

DHS gambling addiction is not being processed in their claim system. Distinct benefits for self-funded, commercial and Medicare. HCPCS code will distinguish services. Might be appropriate to go with CPT as one payer prefers the gambling addition services to be billed. CPT code would be hard to implement because of program type. Currently gambling addition is based on contracts. If providers can be identified to contact or the payers can determine. Gambling providers meet monthly.	
12/11/14: ~~Andrea Agerlie~~ Judy Edwards 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~~ Judy Edwards 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
3/12/15: DHS still reviewing coding; not considering chemical or substance abuse codes. Met with policy staff and will review coding. DHS is currently invoicing services and is now reviewing to send through claim system.	**OPEN**
4/9/15: DHS presented a worksheet with proposed gambling addiction treatment coding. 'Since 1999, treatment for compulsive gambling for DHS recipients has been a statewide program, mandated that the funds for the program must be administered on an individual client, fee for service basis. The eligible vendor would bill every 30 days [based on the beginning date of treatment]. This currently is based on an invoice system, not a health care claim transaction. DHS currently covers these services as professional and facility based treatment services. Codes that indicate alcohol or drug abuse treatment are not appropriate to describe this treatment. In addition, gambling addiction treatment is funded by the state lottery and CD treatment is funded by CCDTF. DHS plans to move this type of service to be billed as a claim for processing through the claims system and approved codes for billing will be necessary. Richard Scherer, Club Recovery LLC submitted an SBAR in Oct, asking for a consistent coding solution. There are three parts to this proposal: assessment, treatment and ongoing treatment." See proposed coding is on the Worksheet in - Compulsive Gambling - DHS Proposal worksheet. In addition, DHS has prepared a gambling addiction treatment handbook with additional more detailed information that will be forwarded to the TAG. In discussion, concerns were raised about possible double billing for both professional and facility services. It was agreed to continue discussion of the proposed coding at a subsequent TAG meeting, and to request that DHS program staff (Helen Ghere) and Mr. Scherer attend the meeting.	**OPEN** All payers are asked to review proposed coding
5/14/15, 6/11/15, 7/28/15: DHS is meeting internally to discuss issue. The issue remains open.	**OPEN**

6. Behavior Health Home (BHH) – Kathy Sijan, DHS

3/12/15: DHS Behavior Health Home policy staff, Jennifer Blanchard and Lisa Cariveau, attended the meeting to provide background and overview of the Behavior Health Home services described in the SBAR and to answer questions the MCT may have. Jennifer stated that the basis of BHH program is a result of the Affordable Care Act and that it is currently out for state public comments. It was noted that SAMSA approved the program. After approved, it will sent to CMS for federal approval. The anticipated start date is January 1, 2016. There are two services: • The first is the initial plan (S0280–U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH, monthly). This service is billed for the first six months. These services do not have to be consecutive. • The second is maintenance of plan (S0281–U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH, monthly). This service is billed after the six months initial plan billing. Maintenance is ongoing and does not have a maximum. A question was asked if 99490 was considered. Codes S0280 and S0281 are already used for Health Care Home (HCH) but with different modifiers. The codes were chosen but with the U5 modifier because of the similarity of the program, BHH does not need to rendered by a physician, this is not a timed procedure (99490 designates time, and DHS want to establish a model for future health models. Participation is voluntary but has requirements for the patient/participant to be actively involved with an engaged health plan. For DHS this is a per patient/per month straight payment methodology; not flexible. There are no levels of complexity for BHH (HCH has four levels of billing).	**OPEN** DHS will send info to Faith re: State Plan language DHS will also make corrections to the SBAR and forward to Faith for distribution and request for an e-vote by MCT to approve

DHS currently has a pilot program. 36 providers are interested in participating in BHH. Must be a Medicaid provider, MH practitioner or MH practitioner; MH provider and/or meet DHS standards and provide service. This is s professional only. The patient/participant cannot receive duplicative services in the same/month. For example, payment may only made for a BHH or HCH, not both. Suggested "Monthly" be added to the definition to clarify payment. Suggestion that providers track services and document in their notes. What if MH wants to become a BHH if they are HCH? The provider could because the goal is to establish a relationship with a primary care.	
4/9/15: Andrea Agerlie of DHS presented a summary of coding recommendations for Behavior Health Home (BHH). She clarified that the program will become effective January 1, 2017, and that the codes could be incorporated with the TAG's coding clarification grid. However, federal approval of the codes is needed the codes could be considered for inclusion in the claims companion guides.	**OPEN**
5/14/15: No discussion; waiting for CMS approval.	**OPEN**
6/11/15: The program was open for public comments. DHS reviewed responses and updated the plan based on feedback received during public comment period. State plan was resubmitted to federal.	**OPEN**
7/28/15: BHH start date is 7/1/16 per legislative update. DHS is initiating informal conversations with CMS and will be submitting State Plan Amendment in the next few weeks.	**OPEN**

7. Family Caregiver Coaching and Counseling: Family Memory Care – Kathy Sijan, DHS

6/11/15: Memory Care SBAR – Kathy will research to determine if services fall under managed care. Are there any managed care services that do not have coding? TAG will review SBAR prior to July TAG meeting.	**OPEN**
7/28/15: All MCOs should have the service in their contracts. (The service does fall under MCO managed care.)	**OPEN**

8. Appendix A Review – Deb Sorg, HealthPartners

6/11/15: Deb Sorg reported that it is time to review Medicare manual to assure our MN rules are correct or if any new guides need to be developed. Need to address issue of A9270 for take home drugs for Medicare members. Deb volunteered to review Chapter 4/inpatient/outpatient hospital (A9270). Volunteers will be recruited to review a specific chapter(s) in the Medicare Claims Processing Manual.	**OPEN – Medicare chapters will be reviewed; a sign-up sheet will be routed**
7/28/15: The table of Appendix A delegations was updated (see attached).	**OPEN**

9. C&TC Screenings and C&TC Update – Kathy Sijan, DHS

7/28/15: See SBARs. Items 12 and 13 were combined. Kathy will provide a grid clarifying three services and appropriate coding. The revised coding/guides for 96110 are effective 7/1/15. The revised coding/guides for 96117 are effective 5/12/15. . 96110 is for social/emotional (developmental) screening 96127 is for mental health screening 96110-U1 is for autism screening	**OPEN**

10. Eye codes 92014 & 92004 – Mary Cremers, Health Partners

7/28/15: The group discussed an SBAR regarding coding of eye exams. The TAG consensus was that the correct codes should be used, and requested that UCare be available to discuss its coding requirements for the eye exams at the next TAG meeting.	**OPEN**

11. ICD-10 Grace Period – Carolyn Larson, PreferredOne

7/28/15: The TAG also reviewed recent guidance and clarifications from the CMS/AMA regarding a grace period for ICD-10. The TAG will consider whether to include links to CMS and other ICD-10 resources as part of the MN Community Coding Practice/Recommendation Table.	**OPEN**

12. 2016 MN Uniform Companion Guide Review

7/28/15: The plan for completion of the 2016 Guide if targeted for fall, preferably September.	**OPEN**

The MCT will start working on revisions/updates.	

13. Adult Day Care Correction– Kathy Sijan, DHS

Upon further review with the child [John Kowalczyk] and adult [Deidre Jackson] Mental Health policy managers, it was noted that the following services should not be listed in the 837I. These services should only be listed in the 837P. Please remove the following from the MN AUC Companion Guide 837I, section A.5.2.2:

ACT Assertive Community Treatment
Adult Crisis Response Services
~~Adult Day Treatment~~
ARMHS-Adult Rehabilitative Mental Health Services
Children's Crisis Response Services
~~Children's Day Treatment~~
Children's Therapeutic Services and Supports -CTSS
Dialectal Behavior Therapy - DBT
Family Psychoeducation
Intensive Treatment in Foster Care
Peer Services
Youth Assertive Community Treatment

Therefore the following modifiers need to be removed from Table A.5.2.1 as well:

UA - Children's Therapeutic Services and Supports (CTSS)
UD - Transition to community living (Adult Rehabilitation Mental Health Services (ARMHS))
U1 - Dialectical Behavioral Therapy
U5 - Advanced level specialist

14. Doula Correction – Shawnet Healy, DHS

Page 39 of the 837P Companion Guide:
Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to seven sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the seven. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI.
Coding and billing for these services on the 837P are as follows:
☐S9445 U4– ante-partum and post –partum Doula services
☐99199 U4– Doula attendance at labor and delivery

15. Additional Agenda Items/ Announcements

- The next scheduled meeting is September 10, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Tuesday, July 28, 2015, 9 a.m. to 12 Noon
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.	Completed.
2. Antitrust Statement	Reviewed – available on AUC website.	No discussion.
3. Review of last meeting's Minutes	Minutes approved with corrections to Agenda item #3 Review of last meeting's Minutes. Changes were made to last paragraph as follows. Since a large number of modifiers are part of the Autism EIDBI benefits coding, members wanted to know the order of which modifiers should be reported ~~in the~~ first ~~position~~. Kathy responded that the U modifiers should always be reported in the first ~~or second~~ position because they describe the program; she also stated that the coding listed in the Autism EIDBI benefits table ~~is~~were in ~~code~~code order.	Minutes will be posted on AUC MCT website
4. Mental Health Service Plan Development – DHS	Kathy Sijan reported DHS is still waiting for approval from CMS.	**OPEN**
5. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	DHS is following up with hiring resource person and other follow up	**OPEN** All payers are asked to review proposed coding
6. Behavior Health Home (BHH) – Kathy Sijan, DHS	BHH start date is 7/1/16 per legislative update. DHS is initiating informal conversations with CMS and will be submitting State Plan Amendment in the next few weeks.	**OPEN**
7. MN Community Coding Practice/Recommendation Table	The coding grid was reviewed with a few minor changes (see version attached). The TAG discussed including a link to the DHS website for autism services but voted against because links and their content change over time. The TAG approved the revised coding practice/recommendation table via a unanimous voice vote. The revised table will be submitted to Ops for its review and a vote.	**CLOSED**
8. Family Caregiver Coaching and Counseling: Family Memory Care – Kathy Sijan, DHS	All MCOs should have the service in their contracts. (The service does fall under MCO managed care.)	**OPEN**
9. Appendix A Review – Deb Sorg, HealthPartners	The table of Appendix A delegations was updated (see attached).	**OPEN – Medicare chapters will be reviewed; a sign-up sheet will be routed**

Agenda Item	Discussion	Action/Follow-up:
10. C&TC Screenings and C&TC Update – Kathy Sijan, DHS	See SBARs. Items 12 and 13 were combined. Kathy will provide a grid clarifying three services and appropriate coding. The revised coding/guides for 96110 are effective 7/1/15. The revised coding/guides for 96117 are effective 5/12/15. . 96110 is for social/emotional (developmental) screening 96127 is for mental health screening 96110-U1 is for autism screening	**OPEN**
11. Eye codes 92014 & 92004 – Mary Cremers, Health Partners	The group discussed an SBAR regarding coding of eye exams. The TAG consensus was that the correct codes should be used, and requested that UCare be available to discuss its coding requirements for the eye exams at the next TAG meeting. .	**OPEN**
12. ICD-10 Grace Period – Carolyn Larson, PreferredOne	The TAG also reviewed recent guidance and clarifications from the CMS/AMA regarding a grace period for ICD-10. The TAG will consider whether to include links to CMS and other ICD-10 resources as part of the MN Community Coding Practice/Recommendation Table.	**OPEN**
13. 2016 MN Uniform Companion Guide Review	The plan for completion of the 2016 Guide if targeted for fall, preferably September. The MCT will start working on revisions/updates.	**OPEN**
14. Next meeting	The next scheduled meeting is August 13, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.	**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.

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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.

Medical Coding TAG Decision Tree Form

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

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

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

Section II

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

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

Section III

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

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

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

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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

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

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

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

Contact Information for person completing this form:

Name: ANDREA AGERLIE

Title: Health Care Coding Compliance Officer

Email address: andrea.agerlie@state.mn.us

Telephone: 651-263-6314

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.

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

Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

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

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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

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

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

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

Contact Information for person completing this form:

Name: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.

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

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

Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

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.

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

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

Section I

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

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

Section II

1. Provide an SBAR short title for your issue.

2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

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

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

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. This is only a professional service.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): 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 coding details and outline of program. DHS anticipates that this program will be effective January 1, 2016, pending Federal Approval. AUC Approval is needed now to begin internal work for these services.  BHH Behavioral Home - Coding.docx **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:

AUC BUSINESS NEED EXPLANATION FORM
(AUC SBAR)

Instructions for Completing the AUC SBAR

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

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

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

Medical Coding TAG Decision Tree Form

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

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

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

Section I

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

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

Section II

1. Provide an SBAR short title for your issue.

2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

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

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

Administrative Uniformity Committee

Family Caregiver Coaching and Counseling: Family Memory Care

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

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

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

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

SBAR Short title:	Date:
Family Caregiver Coaching and Counseling: Family Memory Care	June 1, 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)

Title: Family Caregiver Coaching and Counseling: Family Memory Care

S

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

DHS Link: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056766

Elderly Waiver (EW) and Alternative Care (AC) programs fund home and community-based services (HCBS) for people age 65 and older who require the level of care provided in a nursing home, but choose to live in the community. These programs provide services and supports for people to live in their homes or a community setting, and may delay or prevent nursing facility (NF) care. The purpose of these programs is to promote community living and independence with services and

	supports designed to address each person's individual needs and choices. In the case of EW, the additional services go beyond what is otherwise available through Medical Assistance (MA). **Family Caregiver** This service provides training, education, coaching and counseling services for family and informal caregivers who provide direct and ongoing services for recipients enrolled in EW and AC programs. Elderly Waiver (EW) and Alternative Care (AC) Program currently includes the following Family Caregiver Services: 1- Training and Education – S5115 2- Assessment - S5115-TF
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): See Below
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): EW and AC would like to add a new service called **Family Memory Care.** Family Memory Care [FMC] is a multi-component coaching and counseling intervention for supporting family and friend caregivers living with a person with dementia. Family Memory Care is a new service is based on the *New York University Caregiver Intervention program, which has been shown to prevent or delay nursing facility placement by 18 months on average. Family Memory Care includes: -Assessment -Education -Plan development -Coaching on strategies for coping FMC Consultants must meet professional standards and qualifications; participate in specialized training and clinical monitoring sessions. Caregiver consultants are trained in in memory care support. Caregivers live with the person with dementia where they are the primary caregiver. Caregivers attend 4 to 6 meetings in a 90 day period, with a consultant, and a family member who participates in 2-4 meetings. The person with dementia must have a GDS score of 4 or higher. The limit of total billable hours is up to 20 over a 365 day period for this intervention. Family caregiver services are a part of the care recipient's support plan and billed under the recipient's name and ID. The FMC targets the primary caregivers but other family members participate in the meetings. [Regardless the billable amount is up to 20 hours every 365 days.] Ad hoc support - family caregivers often need follow up information and advice from the family memory care consultant which can be provided in-person or over the phone. The ad hoc support has been a most helpful component of this intervention to families and is included in memory care training.\ NOTE: Per the program policy person, the waiver amendment has been submitted to federal gov't. _____ * http://nrepp.samhsa.gov/ViewIntervention.aspx?id=74

R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: Recommend to add the following service to EW/AC Family Caregiver Services: S5115 – TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care [Family Caregiver Coaching and Counseling; Family Memory Care] Note: 1 unit = 15 minutes Effective date: 7/1/15

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:

From Kathy Sijan

Faith –

96110 – is related to the attached SBAR. This was reviewed back in March or April to remove the UC modifier and use 96127.

Then = the policy manager [not me] wanted 96110 to have the U1 Modifier for Autism screening for toddlers.

Memory Care – whole different thing. See that SBAR attached reviewed in June for adding to EW/AC Family Caregiver Services.
This SBAR was pending for more information that this is something the MCO's do pay for. I sent that information [the listing of what is included in MCO contracts] to you after the June Meeting. If you need me to resend the information, let me know.

K

From: Bauer, Faith [mailto:Faith.Bauer@bluecrossmn.com]
Sent: Wednesday, July 15, 2015 11:06 AM
To: Haugen, David (MDH); Edwards, Judy (MDH); Sijan, Katherine L (DHS)
Subject: RE: Memory Care SBAR status

We do have 96110 in the guide already under preventive and screening services (Developmental screening: 96110) so I'm kinda lost on this one.

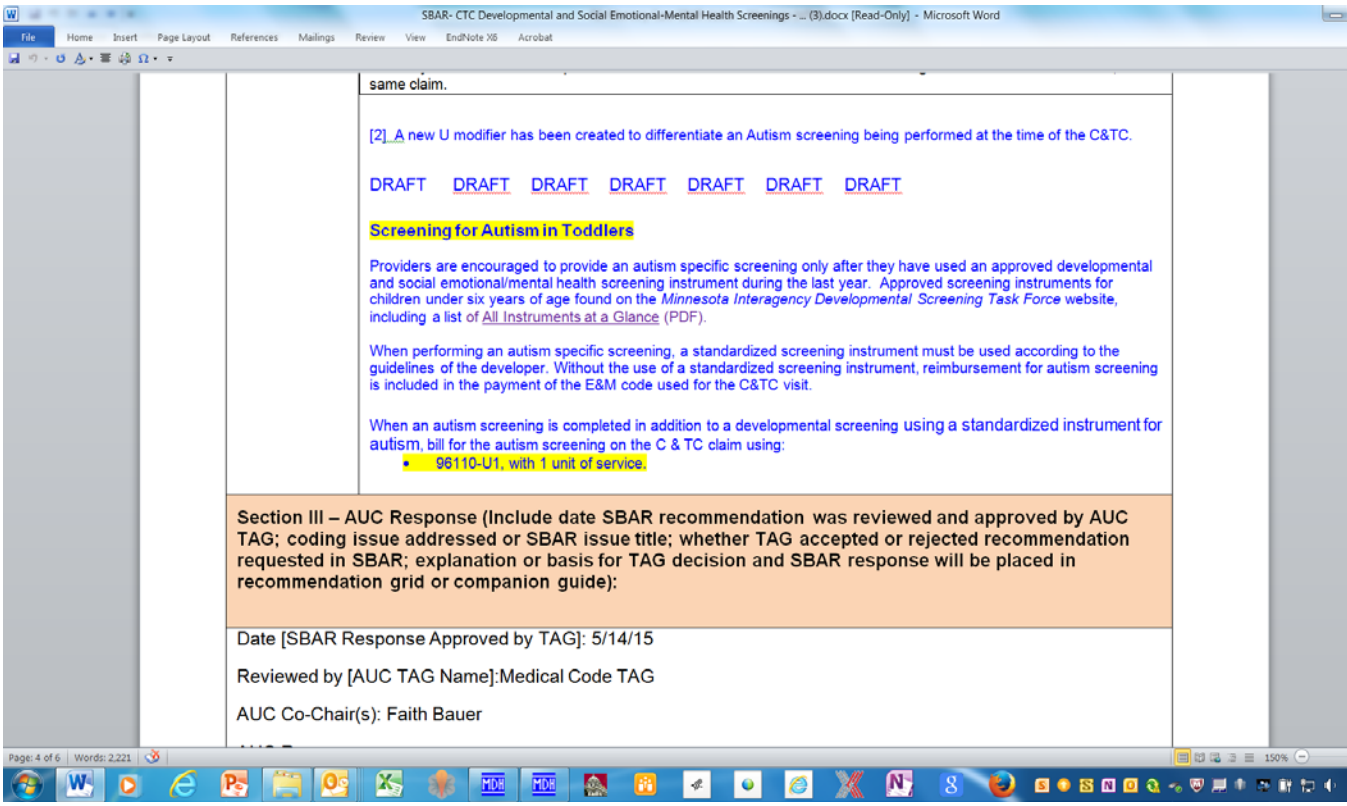
Faith E. Bauer, CPC, CPC-H, CPC-P
Principal Healthcare Coding Analyst
Blue Cross Blue Shield of Minnesota
3400 Yankee Drive, R317
Eagan, MN 55121-1627
Tele: 651-662-8068

From: Haugen, David (MDH) [mailto:david.haugen@state.mn.us]
Sent: Friday, July 10, 2015 2:49 PM
To: Bauer, Faith; Edwards, Judy (MDH); Sijan, Katherine L (DHS)
Subject: RE: Memory Care SBAR status

Faith –

As I understand it, the issue of the SBAR in question was the agreement on the 96110-U for screening for autism for toddlers. Please see the screen shot below from the SBAR, which also shows that the TAG approved it on 5/14/15.

Dave Haugen



David K. Haugen

From: Bauer, Faith [mailto:Faith.Bauer@bluecrossmn.com]
Sent: Friday, July 10, 2015 2:43 PM
To: Haugen, David (MDH); Edwards, Judy (MDH); Sijan, Katherine L (DHS)
Subject: RE: Memory Care SBAR status

Sorry, I'm confused. We already added/corrected the 96127 for C&TC.

18	Preventive and Screening Services	C&TC	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. ▪ Child Mental Health Screening: 96127.

Is this a new issue?

Faith E. Bauer, CPC, CPC-H, CPC-P

From: Haugen, David (MDH) [mailto:david.haugen@state.mn.us]
Sent: Friday, July 10, 2015 2:26 PM
To: Bauer, Faith; Edwards, Judy (MDH); Sijan, Katherine L (DHS)
Subject: RE: Memory Care SBAR status

Faith –

Sorry about any possible miscommunication. We submitted a request to Ops on May 21 to complete an email vote on 4 items. The four items included the SBAR entitled "*CTC Development and Social Emotional-Mental Health Screenings*" (see attached). My understanding is that the SBAR had had been approved by MCT. Ops also subsequently approved the SBAR.

As I understand it, the SBAR still to be addressed by MCT is the *Memory Care* SBAR, not the SBAR regarding *CTC Development and Social Emotional-Mental Health Screening.*

Hope that helps. Please contact me if you have questions or if anything does not seem correct.

Thanks,

Dave Haugen

From: Bauer, Faith [mailto:Faith.Bauer@bluecrossmn.com]
Sent: Friday, July 10, 2015 1:41 PM
To: Edwards, Judy (MDH); Sijan, Katherine L (DHS)
Cc: Haugen, David (MDH)
Subject: RE: Memory Care SBAR status

How did this happen? We never completed a recommendation from the MCT.

Faith E. Bauer, CPC, CPC-H, CPC-P

From: Edwards, Judy (MDH) [mailto:judy.edwards@state.mn.us]
Sent: Tuesday, July 07, 2015 4:26 PM
To: Sijan, Katherine L (DHS)
Cc: Bauer, Faith; Haugen, David (MDH)
Subject: RE: Memory Care SBAR status

Kathy,
That SBAR has been approved by Ops. Dave responded to you last week.
J

From: Sijan, Katherine L (DHS)
Sent: Tuesday, July 07, 2015 4:24 PM
To: Edwards, Judy (MDH)
Cc: Faith.Bauer@bluecrossmn.com; Haugen, David (MDH)
Subject: RE: Memory Care SBAR status

That's correct. I'll look for the email I sent to you and Faith a few weeks ago.

The only SBAR that needs a vote is an email vote for the C & TC Autism Screening.
See attached.
K

From: Edwards, Judy (MDH)
Sent: Tuesday, July 07, 2015 4:01 PM
To: Sijan, Katherine L (DHS)
Cc: Faith.Bauer@bluecrossmn.com; Haugen, David (MDH)
Subject: Memory Care SBAR status

Hi Kathy:

The MCT did not vote on the Memory Care SBAR recommendations at its June meeting. According to my draft meeting notes (see excerpt below) you were going to find out if memory care fell under managed care services. The TAG were to review the SBAR and be prepared to discuss at the July 28 meeting.

.→Other·Business¤	Kathy·reported·that·Certified·Family·Peer·Specialist·SBAR·has·been·approved·by·CMS;·DHS·

Visit·our·website·at:·http://www.health.state.mn.us/auc/index.html¶

DRAFT →

Agenda·Item¤	Discussion·¤
	working·to·implement.·Effective·date·is·undetermined·at·this·point.¶ Primary·Care·Consult·Track·one·is·completed·and·currently·in·companion·guide.·Track·two·is·in·the·works·at·DHS.¶ MHCP·guide·needs·to·be·updated·to·reflect·Track·two.¶ Memory·Care·SBAR – Kathy·will·research·to·determine·if·services·fall·under·managed·care.·Are·there·any·managed·care·services·that·do·not·have·coding?·TAG·will·review·SBAR·prior·to·July·TAG·meeting.¶ Deb·reported·time·to·review·Medicare·manual.·Need·to·address·issue·of·A9270·for·take·home·drugs·for·Medicare·members.·Deb·volunteered·to·review·Chapter·4/inpatient/outpatient·hospital·(A9270);·Judith.¶ ¤

Judy W. Edwards

Medicare Claims Processing Manual		Volunteer
Chapter Number	Title/ Description	
1	General Billing Requirements	Deb Sorg – no changes
2	Admission and Registration Requirements	No changes
3	Inpatient Hospital Billing	Deb Sorg
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Deb Sorg
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	
5	Part B Outpatient Rehabilitation and CORF/OPT Services	
6	Inpatient Part A Billing and SNF Consolidated Billing	
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)	Mary Trethewey
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims	
9	Rural Health Clinics/Federal Qualified Health Centers	Kathy Sijan – no changes
10	Home Health Agency Billing	Mary Trethewey, Cindy Norling, Donna Lindberg
11	Processing Hospice Claims	Mary Trethewey
12	Physicians/Nonphysician Practitioners	Judith Blyth, Sheryl Theno
13	Radiology Services and Other Diagnostic Procedures	De Krengel
14	Ambulatory Surgical Centers	Paula Walerius
15	Ambulance	
16	Laboratory Services	Carolyn Larson
17	Drugs and Biologicals	No changes
18	Preventive and Screening Services	Christy May and Gail Cain P15 – change to ICD9/ICD10 P16 – 96127 – social, emotional, mental health screening Remove reference to CPT codes (remove complete para) P17 – ICD9 reference (change to ICD10) in 837I
19	Indian Health Services	Kathy Sijan – no changes
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Carolyn Larson
21	Medicare Summary Notices	
22	Remittance Advice	
23	Fee Schedule Administration and Coding Requirements	
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims	
25	Completing and Processing the Form CMS-1450 Data Set	
26	Completing and Processing Form CMS-1500 Data Set	
27	Contractor Instructions for CWF	
28	Coordination with Medigap, Medicaid, and other Complementary Insurers	
29	Appeals of Claims Decisions	De Krengel
30	Financial Liability Protections	
31	ANSI X12N Formats Other than Claims or Remittance	
32	Billing Requirements for Special Services	
33	Miscellaneous Hold Harmless Provisions	
34	Reopening and Revision of Claim Determinations and Decisions	
35	Independent Diagnostic Testing Facility (IDTF)	Deb Sorg – no changes
36	Competitive Bidding	
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project	
38	Emergency Preparedness Fee for Service Guidelines	

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.

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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.

Medical Coding TAG Decision Tree Form

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

Section I

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Section II

1. Provide an SBAR short title for your issue.

2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

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

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

Administrative Uniformity Committee

C&TC Developmental and Social, Emotional/Mental Health, and Autism Screenings

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:	Date
C&TC Screenings	May 6, 2015

Contact Information for person completing this form:	Organization Information:
Name: Katherine Sijan Title: HealthCare Coding Compliance Officer Email address: katherine.sijan@state.mn.us Telephone: 651-431-5784	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: C&TC Developmental and Social Emotional/Mental Health Screenings

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: A Developmental and social screening, as well as an emotional/mental health screening are C&TC screening components. DHS requires providers to use a standardized screening instrument for the developmental/social screen as well as the emotional/mental health screening. A new U modifier has been developed to differentiate billing for an autism screening. See below.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): See below for outline of proposed coding and U modifiers to differentiate these C&TC services.
A	**ASSESSMENT** – See below for outline of proposed coding and U modifiers to differentiate these C&TC services.

R

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

C&TC instructions will be updated with the following information with an effective date of: 7-1-2015, pending AUC approval.

Child and Teen Checkups (C&TC)

[1] Recently, AUC voted to change 96110-UC to 96127 for the following;

Bill the developmental and/or mental health screening on the same claim as other C&TC services. Use:

- CPT code 96110 for a developmental screening with a standardized instrument
- CPT code 96127 for an emotional/mental health screening with a standardized instrument

You may bill for both a developmental and a social emotional/mental health screening on the same date of service, on the same claim.

[2] A new U modifier has been created to differentiate an Autism screening being performed at the time of the C&TC.

DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT

Screening for Autism in Toddlers

Providers are encouraged to provide an autism specific screening only after they have used an approved developmental and social emotional/mental health screening instrument during the last year. Approved screening instruments for children under six years of age found on the *Minnesota Interagency Developmental Screening Task Force* website, including a list of All Instruments at a Glance (PDF).

When performing an autism specific screening, a standardized screening instrument must be used according to the guidelines of the developer. Without the use of a standardized screening instrument, reimbursement for autism screening is included in the payment of the E&M code used for the C&TC visit.

When an autism screening is completed in addition to a developmental screening using a standardized instrument for autism, bill for the autism screening on the C & TC claim using:

- 96110-U1, with 1 unit of service.

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:

SBAR – C & TC update

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

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AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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

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

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

SBAR Short title:	**Date:**
C&T C update	February 6, 2015
Contact Information for person completing this form:	**Organization Information:**
Name: Katherine Sijan Title: HealthCare Coding Compliance Officer Email address: katherine.sijan@state.mn.us Telephone: 651-431-5784	Name: Minnesota Dept of Human Services Address: 540 Cedar St 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: **SBAR – C & TC update**

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: There has been a coding update relating to the following code. See recommendation below. 96110-UC
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): See below.
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): See below.
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: Per the CT&C Policy manager, DHS is making the following updates: 96110 was revised as of 1/1/2015 to be only developmental screening and a new code was released for mental health screening. DHS would like to change 96110-UC (mental health screening) to 96127 effective 1-1-2015. **Code verbiage as of 1/1/2015;** **96110**- Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument **96127**-Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

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:

18	Preventive and Screening Services	C&TC	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. ▪ Maternal depression screening: 99420 UC ▪ Developmental screening: 96110 ▪ Child Mental Health Screening: 96110 UC ▪ Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately. ▪ Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or

35

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

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Section II

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

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

SBAR Short title:	**Date:**
Eye codes 92014 & 92004	**July 24, 2015**
Contact Information for person completing this form: **Name: Mary Cremers CPC, ICDCT-CM** Õ¿Õ¬ **Title: Eye Care Revenue Cycle Specialist** **Email address: mary.b.cremers@healthpartners.com** **Telephone: 651-265-0434**	**Organization Information:** **Name: HealthPartners** **Address: 180 E 5th Office Bldg, St. Paul, 55101**

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

Name: same as above
Title:
Email address:
Phone number:

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

SBAR Issue Title: Eye codes 92014 & 92004

S

SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed:
Ucare only accepts 92014 for annual eye exam without any medical condition(s) regardless of the patients' status of new or established.

Ucare only accepts 92004 for new patients with medical conditions.

CPT description:
92014 eye code is for routine annual eye exams for established patients
92004 eye code is for routine/annual eye exam for new patients

CPT specially indicates 92014 is for established patient visits and 92004 is for new patient visits
Reference CPT expert pg. 558 or CPT Professional pg. 564 & 565
Reference CMS IOM -Chapter 12, Section 30.6.7(A) Definition of a New Patient
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

- According to CPT- It is incorrect coding to change the codes to payers preference in order to receive payment.

	Due to Ucare only accepting 92014 for new patient annual exams, there has been an increase in denials.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Effective 1/1/2015 - UCare has a new Routine/Screening Eye Exam benefit for its UCare for Seniors members December 12, 2014 Bulletin https://www.ucare.org/providers/Documents/Dec_2014_BULLETIN_EyesEarsUpdates.pdf April 16, 2015 Bulletin https://www.ucare.org/providers/Documents/April_2015_Bulletin_Vision_Clarification.pdf May 11, 2015 Bulletin https://www.ucare.org/providers/Documents/May_2015_Bulletin_Vision_Benefit_RoutineScreening%20Eye%20Examinations.pdf June 2015 Bulletin https://www.ucare.org/providers/Documents/June_2015_providerFAQ_UFS.Vision.pdf
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): Incorrect coding Costly and unnecessary denials are created
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: We would like to see a consistent and correct coding guidelines applied for these services across all payers.

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:

Q & A from CMS on ICD-10 ‘flexibilities’

https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf

CMS Corrects Recent ICD-10 Guidance for Physicians

CMS and AMA recently developed guidance on new ICD-10 flexibility for physicians during the first year of compliance. Now, at the request of stakeholders who found errors, CMS has substantially changed the guidance in Questions 3 and 5.

Below is background on policy changes that necessitated the guidance.

Under pressure from the AMA and other provider organizations, CMS agreed to:

* Not deny claims solely based on the specificity of diagnosis codes as long as they are in the appropriate family of codes, so physicians won’t be penalized because of a coding error;

* Not audit Medicare claims in the first year of ICD-10 based on specificity of diagnosis codes if in the appropriate family of codes;

* Authorize advance payments if Medicare contractors cannot process physician claims coded with ICD-10;

* Not penalize physicians via reduced reimbursements for errors in selecting and calculating quality codes for the EHR meaningful use, PQRS and Value-based Modifier reporting programs as long as they use codes within the appropriate family of codes. Penalties also will not be applied if CMS has difficulty calculating quality scores during the ICD-10 transition; and

* CMS will establish an ICD-10 Ombudsman office to help physicians resolve problems during the transition.

Now, the agreement is significantly clarified with 13 specific questions and answers, including the changed guidance for Questions 3 and 5.

Question 1: When will the ICD-10 Ombudsman be in place?

Answer 1: The Ombudsman will be in place by October 1, 2015.

Question 2: Does the Guidance mean there is a delay in ICD-10 implementation?

Answer 2: No. The CMS/AMA Guidance does not mean there is a delay in the implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

Question 3: What is a valid ICD-10 code? (Revised 7/31/15)

Answer 3: All claims with dates of service of October 1, 2015 or later must be submitted with a valid ICD-10 code; ICD-9 codes will no longer be accepted for these dates of service. ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, if a valid ICD-10 code from the right family (see question 5) is submitted, Medicare will process and not audit valid ICD-10 codes unless such codes fall into the circumstances described in more detail in Questions 6 & 7.

An example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain 5 characters, such as:

C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site

C81.03 Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes

C81.10 Nodular sclerosis classical Hodgkin lymphoma, unspecified site

C81.90 Hodgkin lymphoma, unspecified, unspecified site

During the 12 months after ICD-10 implementation, using any one of the valid codes for Hodgkin's lymphoma (C81.00, C81.03, C81.10 or C81.90) would not be cause for an audit under the recently announced flexibilities.

In another example, a patient has a diagnosis of G43.711 (Chronic migraine without aura, intractable, with status migrainosus). Use of the valid codes G43.701 (Chronic migraine without aura) or G43.719 (Chronic migraine without aura, intractable without status migrainosus) instead of the correct code, G43.711, would not be cause for an audit under the audit flexibilities occurring for 12 months after ICD-10 implementation, since they are all in the same family of codes.

Many people use the terms "billable codes" and "valid codes" interchangeably. A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure as to whether an additional 4th, 5th, 6th or 7th character is needed. Using this free list of valid codes is straightforward. Providers can practice identifying and using valid codes as part of acknowledgement testing with Medicare, available through September 30, 2015. For more information about acknowledgement testing, contact your Medicare Administrative Contractor, and review the Medicare Learning Network articles on testing, such as SE1501.

Question 4: What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?

Answer 4: Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

Question 5: What is meant by a family of codes? (Revised 7/31/15)

Answer 5: "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Another example, K50 (Crohn's disease) has codes within the category that require varying numbers of characters to be valid. The ICD-10-CM code book clearly provides information on valid codes within this, and other categories. And if in doubt, providers can check the list of valid 2016 ICD-10-CM codes to determine if all characters have been selected and reported. Examples of valid codes within category K50 include:

K50.00 Crohn's disease of small intestine without complications

K50.012 Crohn's disease of small intestine with intestinal obstruction

K50.90 Crohn's disease, unspecified, without complications

To include the Crohn's disease diagnosis on the claim, a valid code must be selected. If the paid claim were to be selected later for audit, the Guidance makes it clear that the claim would not be denied simply because the wrong code was included, so long as the code was in the same family. As long as the selected code was within the K50 family, then the audit flexibility applies.

Question 6: Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

Answer 6: In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.
In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is

not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

Question 7: National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) often indicate specific diagnosis codes are required. Does the recent Guidance mean the published NCDs and LCDs will be changed to include families of codes rather than specific codes?

Answer 7: No. As stated in the CMS' Guidance, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes. The Medicare review contractors include the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.
As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side, or bilateral do not allow for unspecified side. The NCDs and LCDs are publicly available and can be found at http://www.cms.gov/medicare-coverage-database/.

Question 8: Are technical component (TC) only and global claims included in this same CMS/AMA guidance because they are paid under the Part B physician fee schedule?

Answer 8: Yes, all services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the guidance.

Question 9: Do the ICD-10 audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

Answer 9: No, the audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests.

Question 10: If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim?

Answer 10: State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after October 1 in a timely manner. Claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, Medicaid can deny claims based on system edits that indicate that a diagnosis code is not valid.

Question 11: Does this added ICD-10 flexibility regarding audits only apply to Medicare?

Answer 11: The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. This Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

Question 12: Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?

Answer 12: Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

Question 13: Will the commercial payers observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?

Answer 13: The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities.

Yellow = no action or changes as noted; changes in red

A.5 Tables of Coding Requirements

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

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

Medicare Claims Processing Manual		**Specific Coding Topic 837P**	**Minnesota Rule 837P**	**Specific Coding Topic 837I**	**Minnesota Rule 837I**
Chapter Number	Title/ Description				
1	General Billing Requirements		Follow Medicare coding guidelines		Follow Medicare coding guidelines
2	Admission and Registration Requirements		Not applicable to coding guidelines		Not applicable to coding guidelines
3	Inpatient Hospital Billing		Follow Medicare coding guidelines		Follow Medicare coding guidelines
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Outpatient professional services provided by CAH, Method II billing	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).	Outpatient professional services provided by CAH, Method II billing	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)			Observation	Any HCPCS Level I or II code can be submitted as appropriate for observation with revenue code 0762
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)			Partial Hospitalization	To report partial hospitalization, use revenue codes 0912 or 0913 and procedure code H0035. For child/adolescent program use H0035 with HA modifier
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)			Bilateral Radiology	Bilateral radiology services are reported as either: • one line with a 50 modifier and one unit, **or** • two separate lines, one with RT modifier and one with LT modifier.

Yellow = no action or changes as noted; changes in red

4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)			Interpreter Services	For interpreter services: ☐Use Revenue code 0949 and appropriate HCPCS code(s) as follows. **Note**: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report a unit. • ☐T1013 -- Face-to-face oral language interpreter services per 15 minutes • ☐T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes • ☐T1013-GT -- Telemedicine interpreter services per 15 minutes • ☐T1013-U4 -- Telephone interpreter services per 15 minutes • ☐T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting • Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient • T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provide, report each on a separate line appended with the -59 modifier o T1013-52 x 2 units (30 minutes of drive time) o T1013-5259 (12 minutes of wait time)

Yellow = no action or changes as noted; changes in red

					o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported o A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported o Report one unit per mile
5	Part B Outpatient Rehabilitation and CORF/OPT Services		Follow Medicare coding guidelines		Do not follow Medicare's rounding rules for physical, occupational and speech therapies. See general rules for reporting units at the front of this appendix.
6	Inpatient Part A Billing and SNF Consolidated Billing		Not applicable to Professional claim		
6	Inpatient Part A Billing and SNF Consolidated Billing			Room and Board	Room and Board is reported according to the level of nursing care provided using revenue codes 019X
6	Inpatient Part A Billing and SNF Consolidated Billing			Reporting private room and/or in lieu of day differentials	There are situations when skilled nursing and long term care facilities need to report private room and/or in lieu of day differentials separate from room and board charges. • ☐Private Room differential use 0229; 1 unit = 1 day

Yellow = no action or changes as noted; changes in red

					• In lieu of days differential use 0230; 1 unit = 1 hour
6	Inpatient Part A Billing and SNF Consolidated Billing			Ancillaries	Ancillaries are reported separately as appropriate
6	Inpatient Part A Billing and SNF Consolidated Billing			Long term care	Also applicable to Long Term Care
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Not applicable to Professional claim		Follow Medicare coding guidelines
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.		Not applicable to the Institutional guide. Report on the claim type appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
10	Home Health Agency Billing	PCA and Homemaking Services	PCA: T1019 PCA Shared 1:2: T1019-TT PCA Shared 1:3 or more: T1019-HQ PCA Temporary Service Increase: T1019-U6 PCA Notice of Reduction: T1019-U5 RN PCA Supervision: T1019-UA Homemaking: S5130, S5131 PCA services may not be billed with a span of dates; each date of service must be billed separately.		
10	Home Health Agency Billing	Home Infusion	Home infusion is not addressed in this chapter. See instructions following this table.		

Yellow = no action or changes as noted; changes in red

10	Home Health Agency Billing			Home Health Services	Home Health Services are reported on the 837I using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P Revenue Codes 041X – 044X and 055x – 060x as appropriate
10	Home Health Agency Billing			Reporting continuous services beyond the encounter and multiple nurse encounters with the same date of service	For home care the industry standard defines "per diem" as all-inclusive services per patient encounter up to two hours. • To report extended continuous services beyond the encounter use the fifteen minute code(s). • To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.
10	Home Health Agency Billing			Approved HCPCS code set	Medicare's G codes are insufficient to describe the level of time codes that group purchasers require for proper case management. See Approved HCPCS Code Set below. Approved HCPCS code set: • Skilled Nursing Encounter: o RN: T1030 o LPN:T1031 • Home Health Aide Visit: T1021 • Home Health Aide (Extended: T1004 • PT Visit: S9131 o PT Asst. Visit: S9131 TF • OT Visit: S9129 o OT Asst. Visit: S9129 TF • RT Evaluation: S5180 • RT Visit: S5181 • Speech Visit: S9128 • MSW Visit: S9127 • RN: T1002 • RN Complex: T1002 TG • RN Shared 1:2 ratio T1002 TT

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					• LPN: T1003 • LPN Complex: T1003 TG • LPN Shared 1:2 ratio T1003 TT • Postpartum home visit 99501 • Newborn care home visit 99502
11	Processing Hospice Claims		Not applicable to Professional claim		Follow Medicare coding guidelines
12	Physicians/ Nonphysician Practitioners	Allergy, clinical immunology	Medicare does not allow all allergy and clinical immunology codes, but group purchasers accept all applicable codes. Follow the code selection guidelines in the front of Appendix A.		
12	Physicians/ Nonphysician Practitioners	Modifier 50	Modifier 50 should only be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. Bilateral services are to be reported with the 50 modifier on one line with one unit.		
12	Physicians/ Nonphysician Practitioners	Bilateral Radiology	Bilateral radiology services are reported as either: • one line with a 50 modifier and one unit, or • two separate lines, one with RT modifier and one with LT modifier.		
12	Physicians/ Nonphysician Practitioners	Interpreter services	To report interpreter services: Note: Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report one unit. • T1013 -- Face-to-face oral language interpreter services per 15 minutes • T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes • T1013-GT -- Telemedicine interpreter services per 15 minutes • T1013-U4 -- Telephone interpreter services per 15 minutes • T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting		

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			• Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient • T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provided, report each on a separate line appended with the -59 modifier • T1013-52 x 2 units (30 minutes of drive time) • T1013-52 59 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage (see 99199) is reported o A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported o Report one unit per mile		
12	Physicians/ Nonphysician Practitioners	Collaborative psychiatric consultation (MN Statutes 256b.0625, subd. 48 –	Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an		

		Psychiatric consultation to primary care practitioners)	opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care 99499 HE AG U7 (by physician extender) • Primary Care 99499 HE AG U4 U7 (non-face-to-face by physician extender) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face) • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face) • Consulting psychologist – 99499 HE AM • Consulting psychologist – 99499 HE AM U4 (non-face-to-face)		
12	Physicians/ Nonphysician Practitioners	Patient not in exam room	There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-9-CM code(s) for the diagnosis of the patient as the primary diagnosis or diagnoses. Also ICD-9-CM code V65.19 Other person consulting		

<table>
<tr><td></td><td></td><td></td><td>on behalf of another person must be reported.</td><td></td><td></td></tr>
<tr><td>12</td><td>Physicians/ Nonphysician Practitioners</td><td>Health Care Homes</td><td>The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:
Patient Complexity Level and Supplemental Factors
<table>
<tr><th>Patient Complexity Level</th><th>Complex-ity Modifiers</th><th>Non English Speak-ing Modifier</th><th>Active Mental Health Con-dition</th></tr>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>
Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level</td><td></td><td></td></tr>
</table>

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			o U2 – Care coordination, extended complexity level o U3 – Care coordination, supplemental factor; Non-English language o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition		
12	Physicians/ Nonphysician Practitioners	ImPACT testing	96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only		
12	Physicians/ Nonphysician Practitioners	In-reach Community Based Coordination	Use HCPCS T1016-U2 or T1016-U2 TS. • T1016 Case management, each 15 minutes • U2 = In-reach, initial service • U2 TS = In-reach, follow-up		
12	Physicians/ Nonphysician Practitioners				Not applicable to Institutional claim
12	Physicians/ Nonphysician Practitioners	Autism Spectrum Disorder/Early Intensive Developmental and Behavioral Intervention (EIDBI)	Both Department of Human Services (DHS) fee-for-service and managed care will need to provide coverage of the EIDBI benefit effective July 1, 2015. 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 1a. The EIDBI Intervention – Applied Behavioral Analysis Selected Codes 0364T, 0365T, 0366T, 0367T, 0368T, 0369T HK -Qualified Supervising Professional		Not applicable to the Institutional guide

Yellow = no action or changes as noted; changes in red

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<td>[QSP]
HP Doctorate /Mental Health Professional [MHP]
HO Masters /Mental Health Professional [MHP]
HN Bachelor's degree level I or II
HM Less than bachelor degree level III
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)
<table>
<tr><th>Coding Individual</th><th>Coding Group</th></tr>
<tr>
<td>0368T-UB-HK– Qualified Supervising Professional, first 30 minutes
0369T-UB-HK– Qualified Supervising Professional, each additional 30 minutes
0368T- UB-HP - Doctorate /Mental Health Professional [MHP]]first 30 minutes
0369T-UB-HP- Doctorate /Mental Health Professional [MHP]] each additional 30 minutes
0368T-UB-HO - Masters /Mental Health Professional</td>
<td>0366T-UB-HK- Qualified Supervising Professional, first 30 minutes
0367T-UB-HK- Qualified Supervising Professional, each additional 30 min
0366T-UB-HP - Doctorate /Mental Health Professional [MHP]], first 30 minutes
0367T-UB -HP- Doctorate /Mental Health Professional [MHP]], each additional 30 min
0366T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes</td>
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			[MHP], first 30 minutes 0369T-UB-HO - Masters /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HN- Bachelor's degree level I , first 30 minutes 0369T-UB-HN- Bachelor's degree level I , each additional 30 minutes 0364T-UB-HN- Bachelor's degree level II, first 30 minutes 0365T-UB-HN- Bachelor's degree level II, each additional 30 minutes 0364T-UB-HM - Less than bachelor's degree- level III, first 30 min 0365T-UB-HM- Less than bachelor's degree- level III, each additional 30 minutes	0367T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 min 0366T-UB- HN- Bachelor's degree level I or II, first 30 minutes 0367T-UB -HN- Bachelor's degree level I or II, each additional 30 min 0366T-UB -HM - Less than bachelor's degree- level III, first 30 min 0367T-UB -HM- Less than bachelor degree- level III, each additional 30 min		

Yellow = no action or changes as noted; changes in red

			1b. The EIDBI Intervention - ~~(~~Developmental and Behavioral Intervention~~)~~ Selected Code Descriptions 0364T, 0365T, 0366T, 0367T, 0368T, 0369T HK - Qualified Supervising Professional HM -Less than bachelor degree level III [QSP] HN- Bachelor's degree level I or II HO - Masters /Mental Health Professional [MHP] HP- Doctorate /Mental Health Professional [MHP]] UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)		

Coding Individual	Coding Group
0368T-UB-HK– Qualified Supervising Professional, first 30 minutes 0369T-UB-HK– Qualified Supervising Professional, each additional 30 minutes 0368T-UB-HP - Doctorate /Mental Health Professional [MHP], first 30 minutes 0369T-UB-HP- Doctorate /Mental Health Professional	0366T-UB-HK- Qualified Supervising Professional, first 30 minutes 0367T-UB-HK- Qualified Supervising Professional, each additional 30 min 0366T-UB-HP - Doctorate /Mental Health Professional [MHP], first 30 minutes 0367T-UB -HP- Doctorate /Mental Health Professional [MHP], each

			[MHP], each additional 30 minutes 0368T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0369T-UB-HO - Masters /Mental Health Professional [MHP], each additional 30 minutes 0368T-UB-HN- Bachelor's degree level I , first 30 minutes 0369T-UB-HN- Bachelor's degree level I , each additional 30 minutes 0364T-UB-HN- Bachelor's degree level II, first 30 minutes 0365T-UB-HN- Bachelor's degree level II, each additional 30 minutes 0364T-UB-HM - Less than bachelor's degree- level III, first 30 min	additional 30 min 0366T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes 0367T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 min 0366T-UB- HN- Bachelor's degree level I or II, first 30 minutes 0367T-UB -HN- Bachelor's degree level I or II, each additional 30 min 0366T-UB -HM - Less than bachelor's degree- level III, first 30 min 0367T-UB -HM- Less than bachelor degree- level III, each additional 30 min		

			0365T-UB-HM- Less than bachelor's degree- level III, each additional 30 minutes		

2. EIDBI Intervention Supervision and Direction

Selected Codes
0362T, 0363T HP Doctoral level
HK -Qualified Supervising Professional [QSP]
HN- Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP- Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

Coding	Telemedicine
0362T-UB-HN - Bachelor's degree level I or II, first 30 minutes 0363T-UB-HN- Bachelor's degree level I or II ,each additional 30 minutes 0362T-UB-HO - Masters /Mental Health Professional	0362T-UB-HN-GT- Bachelor's degree level I or II , (telemedicine, first 30 minutes 0363T-UB-HN-GT- Bachelor's degree level I or II , (telemedicine) each additional 30 minutes 0362T-UB-HO-GT - Masters /Mental

			[MHP], first 30 minutes 0363T-UB-HO- Masters /Mental Health Professional [MHP], each additional 30 minutes 0362T-UB-HP - Doctorate /Mental Health Professional [MHP] first 30 minutes 0363T-UB-HP - Doctorate /Mental Health Professional [MHP] each additional 30 minutes 0362T-UB-HK - Qualified Supervising Professional , first 30 minutes 0363T-UB-HK - Qualified Supervising Professional , each additional 30 minutes	Health Professional [MHP] (telemedicine) , first 30 minutes 0363T-UB-HO-GT - Masters /Mental Health Professional [MHP] (telemedicine) each additional 30 minutes 0362T-UB-HP-GT - Doctorate /Mental Health Professional [MHP] (telemedicine), first 30 minutes 0363T-UB-HP-GT - Doctorate /Mental Health Professional [MHP] (telemedicine), each additional 30 minutes 0362T-UB-HK-GT - Qualified Supervising Professional, first 30 minutes 0363T-UB-HK-GT - Qualified Supervising Professional , each additional 30 minutes		

Yellow = no action or changes as noted; changes in red

			3. Comprehensive Multi-Disciplinary Evaluation (CMDE) Selected Code 0359T AM- Psychiatrist [MD]/Physician HO - Masters /Mental Health Professional [MHP] HP- Doctorate /Mental Health Professional [MHP] TG- APRN GT- via interactive audio and video telecommunications systems UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM) Coding 0359T-UB-AM - Psychiatrist[MD]/Physician 0359T-UB-AM-GT- Psychiatrist[MD]/Physician (telemedicine) 0359T-UB-TG – APRN 0359T-UB-TG-GT- APRN (telemedicine) 0359T-UB –HP - Doctorate /Mental Health Professional [MHP] 0359T-UB -HP-GT – Doctorate /Mental Health Professional [MHP] (telemedicine) 0359T-UB –HO - Masters /Mental Health Professional [MHP] 0359T-UB -HO-GT - Masters /Mental Health Professional [MHP] (telemedicine) 4. Individual Treatment Plan Development and Monitoring		

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			Selected Codes H0032 Mental Health Service Plan Development by non-physician UD 15 minute unit HK - Qualified Supervising Professional [QSP] HN -Bachelor's degree level I or II HO - Masters /Mental Health Professional [MHP] HP - Doctorate /Mental Health Professional [MHP] UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM) Note: This service is time based although H0032 by definition is not time based. The H0032 was approved for mental health service plan development with modifier UD to indicate a 15 minute time unit. Coding H0032-UB-HK-UD- Qualified Supervising Professional [QSP] H0032-UB-HP-UD- Doctorate /Mental Health Professional [MHP] H0032-UB-HO-UD- Masters /Mental Health Professional [MHP] H0032-UB-HN-UD- Bachelor's degree level I or II 5. Family Caregiver Training and Counseling Selected Codes T1027 HK - Qualified Supervising Professional [QSP] HN –Bachelor's degree level I or level II HO - Masters /Mental Health Professional		

Yellow = no action or changes as noted; changes in red

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<td>[MHP]
HP - Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)

<table>
<tr><th>Coding Individual</th><th>Coding Group</th></tr>
<tr><td>T1027-UB –HK – Qualified Supervising Professional [QSP]
T1027-UB- HK-GT- Qualified Supervising Professional [QSP] (telemedicine)
T1027-UB -HP- Doctorate /Mental Health Prof [MHP]
T1027-UB -HP-GT - Doctorate /Mental Health Prof [MHP] (telemedicine)
T1027-UB -HO- Masters /Mental Health Prof [MHP]
T1027-UB -HO-GT - Masters /Mental Health Prof [MHP] (telemedicine)
T1027-UB–HN - Bachelor’s degree level I or II
T1027-UB -HN-GT- Bachelor’s degree</td><td>T1027-UB-HK-HQ- Qualified Supervising Professional [QSP], Group
T1027-UB-HP-HQ- Doctorate /Mental Health Prof [MHP], Group
T1027-UB-HO-HQ- Masters /Mental Health Prof [MHP], Group
T1027-UB-HN-HQ- Bachelor’s degree level I or II, Group</td></tr>
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			level I or II (telemedicine		

6. Coordinated Care Conference

Selected Codes Description
T1024
AM – Physician
HK – QSP
HN - Bachelor's degree level I or II
HO - Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT via interactive audio and video telecommunications systems
UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM)
TG - APRN

Coding	Telemedicine Coding
T1024-UB-AM - Physician T1024-UB-TG - APRN T1024-UB-HK- Qualified Supervising Professional [QSP] T1024-UB-HP- Doctorate /Mental Health Professional [MHP] T1024-UB-HO- Masters /Mental Health Professional[MHP]	T1024-UB-AM-GT –Physician (telemedicine) T1024-UB-TG-GT- APRN (telemedicine) T1024-UB-HK-GT- Qualified Supervising Professional [QSP] (telemedicine] T1024-UB-HP-GT- Doctorate /Mental Health Professional [MHP] (telemedicine)

Yellow = no action or changes as noted; changes in red

			T1024-UB-HN - Bachelor's degree level I or II T1024-UB-HO-GT- Masters /Mental Health Professional[MHP] (telemedicine) T1024-UB-HN-GT- Bachelor's degree level I or II (telemedicine) 7. Travel Time Selected Codes H0046 UB EIDBI [Early Intensive Developmental and Behavior Intervention] (AUTISM) Notes: 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) Coding H0046/UB		
13	Radiology Services and Other Diagnostic Procedures	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components		
13	Radiology Services and Other Diagnostic Procedures	Bilateral radiology	Bilateral radiology services are reported as either: • one line with a 50 modifier and one unit, or • two separate lines, one with RT modifier and one with LT modifier.	Bilateral radiology	Bilateral radiology services are reported as either: • one line with a 50 modifier and one unit, or • two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the		

			service appended with the 50 modifier on one line with one unit.		
14	Ambulatory Surgical Centers	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier		
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance	General	Follow Medicare coding guidelines		Follow Medicare coding guidelines
15	Ambulance	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: • A0080 • A0090 • A0100 • A0110 • A0120 • T2002 • T2003 • T2004		
15	Ambulance	Community Paramedic	Community paramedic services are to be billed as follows: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – report the Medical director's NPI • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) — a minimum of 8 minutes of face to face time must be rendered in order to report one unit (see also section A.3.4.2 for units rounding rules)		

Yellow = no action or changes as noted; changes in red

			o T1016 Case management, each 15 minutes o U3 – service provided by certified community paramedic (EMT-CP) • Non-reportable services include: o Incidental supplies (e.g., gloves, test strips, band aids, etc.); o Travel; o Mileage; o Medical record documentation. Supplies and vaccines are reported by the ordering primary care physician only.		
16	Laboratory Services	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.		
16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. “Welcome to Medicare”) are only applicable to Medicare and Medicare replacement products.	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. “Welcome to Medicare”) are only applicable to Medicare and Medicare replacement products.
18	Preventive and Screening Services	New patient receives preventive care and an	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established		

		illness-related E/M service at the same visit	patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.		
18	Preventive and Screening Services	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-9-CM/ICD-10-CM code set instructions. All applicable diagnoses should be submitted.		
18	Preventive and Screening Services	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers		
18	Preventive and Screening Services	Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations	Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
18	Preventive and Screening Services	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code	Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, group purchasers require the SL modifier be appended to the vaccine code
18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ☐☑Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ☐☑Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.

Yellow = no action or changes as noted; changes in red

18	Preventive and Screening Services	C&TC	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. • Social/Emotional or ~~Child~~ Mental Health Screening: 96127. • ~~Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately.~~ • Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed.		

Yellow = no action or changes as noted; changes in red

			• Use most appropriate diagnosis code based on patient age.		
18	Preventive and Screening Services			Colonoscopy	Coding of diagnosis for colonoscopy claims should follow the ICD-9-CM/ICD-10-CM code set instructions for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.
19	Indian Health Services	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.		Follow Medicare coding guidelines
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.		
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR		
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit		
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.		
20	Durable Medical Equipment, Prosthetics,				Not applicable to the Institutional guide

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	Orthotics and Supplies				
21	Medicare Summary Notices		Not applicable to coding guidelines		Not applicable to the Institutional guide
22	Remittance Advice		Not applicable to coding guidelines		Not applicable to the Institutional guide
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines		Not applicable to the Institutional guide
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines		Not applicable to the Institutional guide
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines		Not applicable to the Institutional guide
27	Contractor Instructions for CWF		Not applicable to coding guidelines		Not applicable to the Institutional guide
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines		Not applicable to the Institutional guide
29	Appeals of Claims Decisions		Not applicable to coding guidelines		Not applicable to the Institutional guide

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30	Financial Liability Protections		Not applicable to coding guidelines		Not applicable to the Institutional guide
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to coding guidelines		Not applicable to the Institutional guide
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines		Not applicable to the Institutional guide
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines		Not applicable to coding guidelines
35	Independent Diagnostic Testing Facility (IDTF)		Not applicable to coding guidelines		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines

N/A	N/A	Doula Services MS 256B.0625, Subd. 28B Doula Services	Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to six sessions. Prior authorization with medical necessity documentation is required for any additional sessions		

			beyond the six. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows: ▪ S9445 U4 – ante-partum and post – partum Doula services ▪ 99199 U4 – Doula attendance at labor and delivery		
N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes). Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.		
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. Place of Service:		

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

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

Yellow = no action or changes as noted; changes in red

					Note: Professional services related to the mother's and newborn's cares are reported on the 837P only.
N/A	TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs	**Certified Family Peer Specialist – DHS**	Services are for children under the following codes with the HA modifier. For mental health services only; do not apply to substance abuse. H0038 Certified peer specialist services, per 15 minutes H0038 U5 Advanced level certified peer specialist services, per 15 minutes H0038 HQ Group setting, certified peer specialist services, per 15 minutes H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes	**Certified Family Peer Specialist – DHS**	Services are for children under the following codes with the HA modifier. For mental health services only; do not apply to substance abuse. H0038 Certified peer specialist services, per 15 minutes H0038 U5 Advanced level certified peer specialist services, per 15 minutes H0038 HQ Group setting, certified peer specialist services, per 15 minutes H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes

Today at MCT it was pointed out that the 837I and 837P reference ICD-9 and that the references need to be updated to ICD-10. Although we have been successful in adhering to a policy of only changing the guides once a year during annual maintenance, we may have to make an exception to correct the ICD-9 issue prior to October 1.

Below are where the ICD-9 references occur in the companion guides and some initial thoughts about some possible edits to make the references ICD-10 appropriate.

If we correct the references to ICD-9, do you have any suggestions for the items below? We would also need to move the changes through the MCT and Ops very quickly.

Thanks,

Dave Haugen

1. The following statement is in both the 837I and 837P:

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

- It looks like we would need to change the statement above to read something like:

> Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)for dates of service on or after October 1, 2015); and Revenue codes.

2. The ICD-9 reference also appears in **the 837P** Table A.1.5 as shown below:

12 Physicians/Nonphysician Practitioners Patient not in exam room
There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-9-CM code(s) for the diagnosis of the patient as the primary diagnosis or diagnoses. Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.

18 Preventive and Screening Services Diagnosis coding for screening services
Diagnosis coding for screening services must follow the ICD-9 code set instructions. All applicable diagnoses should be submitted.

- It looks like we would need to change the above to something like:

  12 Physicians/Nonphysician Practitioners Patient not in exam room
  There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD code(s) for the diagnosis of the patient as the primary diagnosis or diagnoses. Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.[*Is this last sentence still needed? If so, what does it need to say?]*

18 Preventive and Screening Services Diagnosis coding for screening services
Diagnosis coding for screening services must follow the appropriate ICD code set instructions. All applicable diagnoses should be submitted.

3. The ICD-9 reference also appears in the **837I** Table A.1.5 as shown below:

  18 Preventive and Screening Services Colonoscopy
  Coding of diagnosis for colonoscopy claims should follow the ICD-9 code set instructions for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.

- It looks like we would need to change the above to something like:

  18 Preventive and Screening Services Colonoscopy
  Coding of diagnosis for colonoscopy claims should follow the appropriate ICD code set instructions for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.

Companion Guide updates from Cindy Norling:

I wanted to let you know that Mary, Donna, and I agree that no changes needed for both Companion Guides needed for Chapter 10.

Chapter 10 has added wording for clarification in 10.1.17 (see below in previous email).

In Chapter 10, 40.1 has added clarification wording on the revenue code. In the Institutional Companion Guide we list the following.

10	Home Health Agency Billing	Home Health Services	Home Health Services are reported on the 837I using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P Revenue Codes 041X – 044X and 055x – 060x as appropriate

The additional wording in Chapter 10 clarifies on the Revenue code that already was in the chapter. The 837I Companion Guide already reads to use the appropriate Revenue Code for the corresponding HCPCS code.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

Optional - If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Service Date

Required - *For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.*

Medicare Claims Processing Manual Chapter 10 Home Health Care Agency billing:

Page 20 & 21/22:

10.1.17 - Adjustments of Episode Payment - Low Utilization Payment Adjustments (LUPAs)

(Rev. 3176, Issued: 01-30-15, Effective: 07-01-15 - From claims received on or after this date, Implementation: 07-06-15)

If the LUPA episode is the first episode in a sequence of adjacent episodes or is the only episode of care the beneficiary received, Medicare will make an additional add-on payment. For LUPA episodes ending on or after January 1, 2014, Medicare will add to these claims an amount calculated from a factor established in regulation. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit for skilled nursing, physical therapy or speech-language pathology.

One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim "From" Date. HHAs should take care to ensure that they submit accurate admission dates, especially if episodes are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated episode in the same sequence of adjacent episodes.

Additionally, Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

10.1.18 - Adjustments of Episode Payment - Special Submission Case: "No-RAP" LUPAs

(Rev. 1, 10-01-03)
HH-467.26, A3-3639.26

Page 49/53 & page 69:

40.1 - Request for Anticipated Payment (RAP)

(Rev. 3176, Issued: 01-30-15, Effective: 07-01-15 - From claims received on or after this date, Implementation: 07-06-15)

The following data elements are required to submit a RAP under HH PPS. Home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit a RAP using the coding described below.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

Optional - If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

Service Date

Required - *For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.*

Page 69:

Q5009: Hospice or home health care provided in place not otherwise specified

The location where services were provided must always be reported along with the first visit reported on the claim. In addition to reporting a visit line using the G codes as described above, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit and a nominal covered charge (e.g., a penny). If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Service Date

Required - *For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.*

Page 39 of the 837P Companion Guide:

Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to ~~six~~ seven sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the ~~six~~seven. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows:

- S9445 U4 – ante-partum and post –partum Doula services
- 99199 U4 – Doula attendance at labor and delivery

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