Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Tuesday, September 10, 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** – August 13, 2015 and August 25, 2015
4. **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:	**OPEN**

Richard Scherer was present to talk about his request. Club Recovery is a full service addiction clinic with a primary focus on pathological gambling and chemical abuse. A mental health component is included for those with co-addictions. The program is modelled after substance abuse programs. The primary focus is group treatment is group but individual treatment is also done. Treatment includes dealing with the family as well. DSM-5 reclassified gambling addiction under substance abuse disorders Current billing is done as a facility claim (837I) with the following codes: Revenue code: 0949 HCPCS codes: H2035-HQ H0031 H0001 H2020 Mental health services by an LICSW are billed on a professional claim using CPT BH codes and billed on a professional claim (837P). General discussion: The intent it establish uniform, consistent coding for gambling addiction. At this time payers differ. Some payers are using Rev code 0949 with H0001 for CD for assessment. H2020 was widely used (CMS stated H2020 was no longer an acceptable code and payers are moving away from this code). Some payers are requiring H2035 and H2020. Revenue codes 0944 – CD 0945 – alcohol and 0949 were also discussed. Also, the H codes noted basically deal with substance abuse. H2020 is per diem code. Services are being billed hourly. Need time code, such as H2019. We need to determine if this is a unique request or is applicable to other providers. What are best codes for reporting gambling services? Medica defines it as addictive behavior that substance abuse falls under; does not use standard SA codes for the gambling program. Is there a reason to not use H2035 since it falls in diagnostic are in addictive behavior? Initially under substance abuse. DHS gambling addiction is not being processed in their claim system. Distinct benefits for self-funded, commercial and Medicare. HCPCS code will distinguish services. Might be appropriate to go with CPT as one payer prefers the gambling addition services to be billed. CPT code would be hard to implement because of program type. Currently gambling addition is based on contracts. If providers can be identified to contact or the payers can determine. Gambling providers meet monthly.	MCT payers will discuss with their contract area. DHS will determine the policy. MDH will contact Ruth Moser (DHS) to schedule meeting with providers. MDH will forward meeting information to Faith for distribution to MCT. MCT payers will report their findings at December meeting
12/11/14: ~~Andrea Agerlie~~ 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**

8/13/15: The proposed coding grid was revised. It grid will be revised to include H2020 and its definition. This code is similar to the already listed code H2019. The difference is time – H2019 is "per 15 minutes". H2020 is "per diem". While a motion was made and approved the revised grid unanimously. We need to wait for the DHS decision about whether they will move forward with requiring billing on claims rather than invoice. This will ultimately affect how the recommendation is written and listed in the guides. Kathy Sijan will setup meeting with MDH, DHS and Faith	**OPEN**

5. 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). 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.	**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
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, 8/13/15: 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**

6. 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**
8/13/15: Family caregiver service already have coding in place on the DHS manual but memory care coding is being added for the professional guide (837P) in DHS only section. Family Memory Care – Family Memory Care [FMC] is a multi-component coaching and counselling intervention for supporting family and friend caregivers living with a person with dementia. Training and Education – S5115	**OPEN**

Assessment – S5115-TF Memory Care - S5115 – TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care [Family Caregiver Coaching and Counselling; Family Memory Care] Note: 1 unit = 15 minutes Effective date: 7/1/15 ACTION: Kathy Sijan will research the definition of caregiver and how the caregiver identification is billed.	

7. 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, 8/13/15, 8/25/15:: The table of Appendix A delegations was updated (see attached).	**OPEN**

8. 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 96127 ~~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**

9. 2016 MN Uniform Companion Guide Review

7/28/15, 8/13/15:, 8/25/15 The plan for completion of the 2016 Guide if targeted for fall, preferably September. The MCT will start working on revisions/updates.	**OPEN**

10. Additional Agenda Items/ Announcements

- The next scheduled meeting is October 8, 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 – Thursday, August 13, 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: Deb Sorg deb.a.sorg@healthpartners.com • Membership request and/or updates: Deb Sorg deb.a.sorg@healthpartners.com	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	8/13/15 minutes - Vote postponed – UCare has corrections to agenda item #10.	**OPEN** Paula will forward corrections to Faith. Faith will incorporate into minutes and forward to TAG for evote.
4. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	Discussion Postponed	**OPEN**
5. Behavior Health Home (BHH) – Kathy Sijan, DHS	Discussion Postponed	**OPEN**
6. Family Caregiver Coaching and Counseling: Family Memory Care – Kathy Sijan, DHS	Discussion Postponed	**OPEN**
7. Appendix A Review – Deb Sorg, HealthPartners	TAG reported update and completed manual assignments	**OPEN**
8. C&TC Screenings and C&TC Update – Kathy Sijan, DHS	Waiting for DHS policy department to update website. Kathy Sijan will confirm the effective date.	**OPEN**
9. 2016 MN Uniform Companion Guide Review	Comments for update: Chapter 12 – question re new POS 19 off-campus effective 1/2016 redefining POS 22 – MLN Matters MM7631. Has this been addressed by NUBC – nothing published. CMS stated applies to physician billing. Perhaps will be a reimbursement issue rather than a coding issue. MCT will not address at this point. Add section to guide for DHS specific programs (C&TC), Mental Health EIDBI ---move all DHS programs to end of guide. The following revisions were recommended for Appendix A of the 837I and 837P guides:	**OPEN**

Agenda Item	Discussion	Action/Follow-up:
	1. A.2 HIPPA Code Sets – Added red text to first sentence in first paragraph: "*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, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS);and Revenue codes."* 2. A.3.2 Instructions for Using…Tables – Added red text to first sentence: *CPT is a registered trademark of the American Medical Association (AMA); ICD-9-CM, ICD-10-CM and ICD-10-PCS are maintained and distributed by the… (NUBC)."* Table A.5.1 – Minnesota Coding Specifications: When to use Codes Different from Medicare 3. Chapter #4 (837I) Interpreter Services • under Note, convert Rounding Rules to hyperlink • add in parentheses "See section A.3.4.2" • move (see 99199) in second to last bullet to end of statement 4. Chapter #5 (837I) Part B Outpatient Rehabilitation and CORF/OPT Services • convert Rounding Rules to hyperlink • add in parentheses "See section A.3.4.2" • delete last sentence in entry under Minnesota Rule column 5. Chapter #6 (837I) Inpatient Part A Billing and SNF Consolidated Billing - delete entry for Long term care 6. Chapter #12 Physician/Nonphysician Practitioners - add new program: Early Intensive Developmental and Behavioral Intervention (EIDBI) (837P only) 7. Chapter #18 Preventive and Screening A. Services Diagnosis coding for screening services (837P) • Revised first sentence as follows: Diagnosis coding for screening services must follow the ICD-CM, based on date of service, code set instructions. B. C&TC (837P) • Added/revised coding as follows: o 96110 Social/Emotional (Developmental) Screening o 96110 U1 Autism Screening o 97127 Mental Health Screening	

Agenda Item	Discussion	Action/Follow-up:
	• Deleted statement: *"Report CPT codes99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately."* C. Colonoscopy (837I) • Revised first sentence - Coding of diagnosis for colonoscopy claims should follow the ICD-CM, based on date of service, code set instructions for coding for a screening visit where findings are noted.	
11. Additional Agenda Items/ Announcements	MCT members asked discussion of Chapter 18 Preventive and Screening Services if Minnesota Rules conflicted with Medicare/Medicaid/CPT. There was not consensus among members if Minnesota Rule was in conflict with CPT; however, all agreed that Medicare was not an issue because Medicare does not cover preventive and screening services. Further discussion was postponed and suggestion that SBAR be submitted for TAG's review at a future meeting. Co-chair stated that the purpose of this meeting was to review and update companion guide. Completion of an SBAR was suggested.	**CLOSED** pending SBAR
12. Next meeting	The next scheduled meeting is September 10, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.	**CLOSED**

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, August 13, 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: Deb Sorg deb.a.sorg@healthpartners.com • Membership request and/or updates: Deb Sorg deb.a.sorg@healthpartners.com	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 items 3 and 10. Review of last meeting's Minutes. Changes were made to last paragraph as follows. #3: 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 ~~in the~~ first position ~~position~~. Kathy responded that the U modifiers should always be reported in the first 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. #10: C&TC Screenings and C&TC Update - 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 96127 ~~96117~~ are effective 5/12/15.	Minutes will be posted on AUC MCT website
4. Mental Health Service Plan Development – DHS	Kathy Sijan noted that there is no update on federal approval. Kathy mentioned that there will be additional coding (modifiers) added to the program coding recommendation. ACTION: The SBAR will be withdrawn at this time and Kathy will work internally to develop and submit new SBAR to the AUC.	**CLOSED**
5. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	The proposed coding grid was revised. It grid will be revised to include H2020 and its definition. This code is similar to the already listed code H2019. The difference is time – H2019 is "per 15 minutes". H2020 is "per diem". While a motion was made and approved the revised grid unanimously. We need to wait for the DHS decision about whether they will move forward with requiring billing on claims rather than invoice. This will ultimately affect how the recommendation is written and listed in the guides. Kathy Sijan will setup meeting with MDH, DHS and Faith.	**OPEN**

Agenda Item	Discussion	Action/Follow-up:
6. Behavior Health Home (BHH) – Kathy Sijan, DHS	DHS will be submitting State plan to CMS. No updates at this time.	**OPEN**
7. Family Caregiver Coaching and Counseling: Family Memory Care – Kathy Sijan, DHS	Family caregiver service already have coding in place on the DHS manual but memory care coding is being added for the professional guide (837P) in DHS only section. Family Memory Care – Family Memory Care [FMC] is a multi-component coaching and counselling intervention for supporting family and friend caregivers living with a person with dementia. Training and Education – S5115 Assessment – S5115-TF Memory Care - S5115 – TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care [Family Caregiver Coaching and Counselling; Family Memory Care] Note: 1 unit = 15 minutes Effective date: 7/1/15 ACTION: Kathy Sijan will research the definition of caregiver and how the caregiver identification is billed.	**OPEN**
8. Appendix A Review – Deb Sorg, HealthPartners	TAG reported update and completed manual assignments	**OPEN**
9. C&TC Screenings and C&TC Update – Kathy Sijan, DHS	Waiting for DHS policy department to update website. Kathy Sijan will confirm the effective date.	**OPEN**
10. Eye codes 92014 & 92004 – Mary Cremers, Health Partners	Sue (UCare) reported that some confusion about what UCare covers and doesn't. If one member is seen by optometrist or ophthalmologist for medical eye condition, codes 92002, 92004, 92012, or 92014 would be accepted. What has created confusion is that the benefit is a routine, screening eye exams. Because this is Medicare advantage plan; to obtain approval UCare filed a supplemental benefits with CMS in order to offer the service to members. CMS approved the benefit. 92014 was chosen because it was most highly used code under eye exam. Allowed link to ICD-9 codes to ensure appropriate code was made. UCare also stated that this was supported by the MN Opthalmogical Association. This supplemental benefit applies to UCare for seniors Medicare Advantage products. UCare got approval to redefine the code narrative for their benefit. Under original routine screening Medicare done, in absence of disorder, does not have a specific CPT code. Routine screening is identified by use of the V72.0 diagnosis code in the first position and any benign refractive in any other subsequent claims and then are linked. CPT 92014 comprehensive exam with routine supplemental benefit (refractive and routine) 92014 is for established patient and providers are instructed to bill this code regardless if the patient is new (which is identified by another code). It was noted that there is a defined code specifically for a routine or screening eye exam, it is an "S" code and Medicare will not allow submission of "S" codes. Was it the intention of UCare to ask for this to be a standard coding in the MN guides?	**CLOSED**

Agenda Item	Discussion	Action/Follow-up:
	The intent for an AUC guide is to identify a coding standard when we differ from Medicare. The AUC will not support or put special coding in the guide for any one payer. There are no guides for eye exams, thus the state policy would fall to follow Medicare. According to AUC guideline you cannot use codes outside of the standard definition of the code. The services should be submitted as new or established based on the actual services performed and documented. Providers feel it is fraudulent 92012 or 92014 will they get fined if coding new patients as established. The MCT cannot address this issue. All are asked to follow Medicare submission guides. Because this is a specific benefit thus payment, it is not in line with State policy. AUC cannot dictate benefit. The code must represent the services provided. Recommendation to address this issue with national AAO for clarification. Decision: No action by the MCT. Nothing will be added to the recommendation grid or companion guides. Add the following to coding issues Q&A grid: Eye exams: report the appropriate HCPCS code (92002, 92004, 92012, 92014, S0620, S0621, 92002-92015) for the services performed and documented. The diagnosis supporting the service should be linked to the service.	
11. ICD-10 Grace Period – Carolyn Larson, PreferredOne	CMS - Coding to the highest specificity has always been the rule and that is still supported in the ICD-10 CMS Q&A. Follow Medicare guidelines re submission of ICD-10 codes to report diagnosis to their highest specificity. Additional info referencing benefit and payment policies are not applicable to MCD guides. The guides will need to be updated where ICD-9 is noted, for example, "ICD-CM diagnosis based on date of service."	**CLOSED**
12. 2016 MN Uniform Companion Guide Review	Being updated.	**OPEN**
13. Adult Day Care Corrections – 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 ARMHS-Adult Rehabilitative Mental Health Services Children's Crisis Response Services Children's Therapeutic Services and Supports -CTSS Dialectal Behavior Therapy - DBT Family Psychoeducation	**CLOSED –** these corrections will be made in the 837I guide

Agenda Item	Discussion	Action/Follow-up:
	Intensive Treatment in Foster Care Peer Services Youth Assertive Community Treatment Keep the following in the 837I guide: Adult Day Treatment Children's Day Treatment Therefore the following modifiers need to be removed from 837I 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 TAG voted revise services on 837I guide.	
14. Doula Correction – Shawnet Healy, DHS	The following will be revised on 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	**CLOSED –** these corrections will be made in the 837P guide
15. Next meeting	The next scheduled meeting is August 25, 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.

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

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

Medical Coding TAG Decision Tree Form

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

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

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

Section II

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

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

Section III

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

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

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

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

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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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Section I

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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:

Good Afternoon, here are definitions for "caregivers" and Family Memory Care consultants. Please note that Family Memory Care consultants have training in addition to the New York University Caregiver Intervention.

The term "caregiver" is a family or informal caregiver (e.g., a spouse/partner, adult child, other relative or friend) who provides direct and ongoing services for recipients enrolled in EW programs. A family caregiver is not paid and is not employed, or a volunteer through the organization that cares for the recipient. In most instances, the family caregiver does not need to be living in the same household as the care recipient to receive caregiver services, with the exception of Family Memory Care services. In terms of payment, EW family caregiver services are authorized by the care coordinator, entered into the community support plan and paid out of the recipients monthly case mix cap.

The Family Memory Care consultants, or FMCs, are trained professionals who specialize in dementia care. FMCs are generally health care professionals such as Master's level nurses or licensed clinical social workers who meet maintain all licenses, certifications or credentials specific to their profession. FMCs have at least a year of experience in family therapy or family-based interventions, at least one year of experience training and working with persons with Alzheimer's disease, have completed the New York University Caregiver Intervention Training, have completed the Minnesota Family Memory Care Training, and participate in clinical supervision and webinars, as available, as well as continuing education on dementia-related topics. FMCs are enrolled providers.

Sue Wenberg, Family Caregiver Program Consultant
Continuing Care for Older Adults
Minnesota Department of Human Services/MBA

From: Sijan, Katherine L (DHS)
Sent: Monday, August 24, 2015 10:26 AM
To: Rossett-Brown, Libby R (DHS) <libby.rossett-brown@state.mn.us>
Cc: Wenberg, Susan G (DHS) <sue.wenberg@state.mn.us>; faith.bauer@bluecrossmn.com
Subject: FW: AUC meeting -Family Memory Care
Importance: High

Libby/Sue,
See attached SBAR. This was the write up I gave to the AUC back in June explaining the new service you are adding 'Family Memory Care'.

The language was taken from the information you gave me, using the term 'caregiver', and 'FMC Consultants'.

Can you give me the definition of these terms?

Thanks,
Kathy

From: Sijan, Katherine L (DHS)
Sent: Wednesday, July 08, 2015 10:45 AM
To: Faith.Bauer@bluecrossmn.com
Cc: Agerlie, Andrea A (DHS) <andrea.agerlie@state.mn.us>; Edwards, Judy (MDH)

<judy.edwards@state.mn.us>
Subject: FW: AUC meeting -Family Memory Care

Faith,
This information that was sent on 6/25 for #9 on the agenda, for Family Memory Care, verifying these services [and all the other services] that are paid under managed care. This is a screen shot of a generic MCO contract table of contents.
You will also see in the attached email a link to DHS page sent by Sue Kvendru, of the contracting area.

Can you send out to AUC MCT TAG?

Kathy

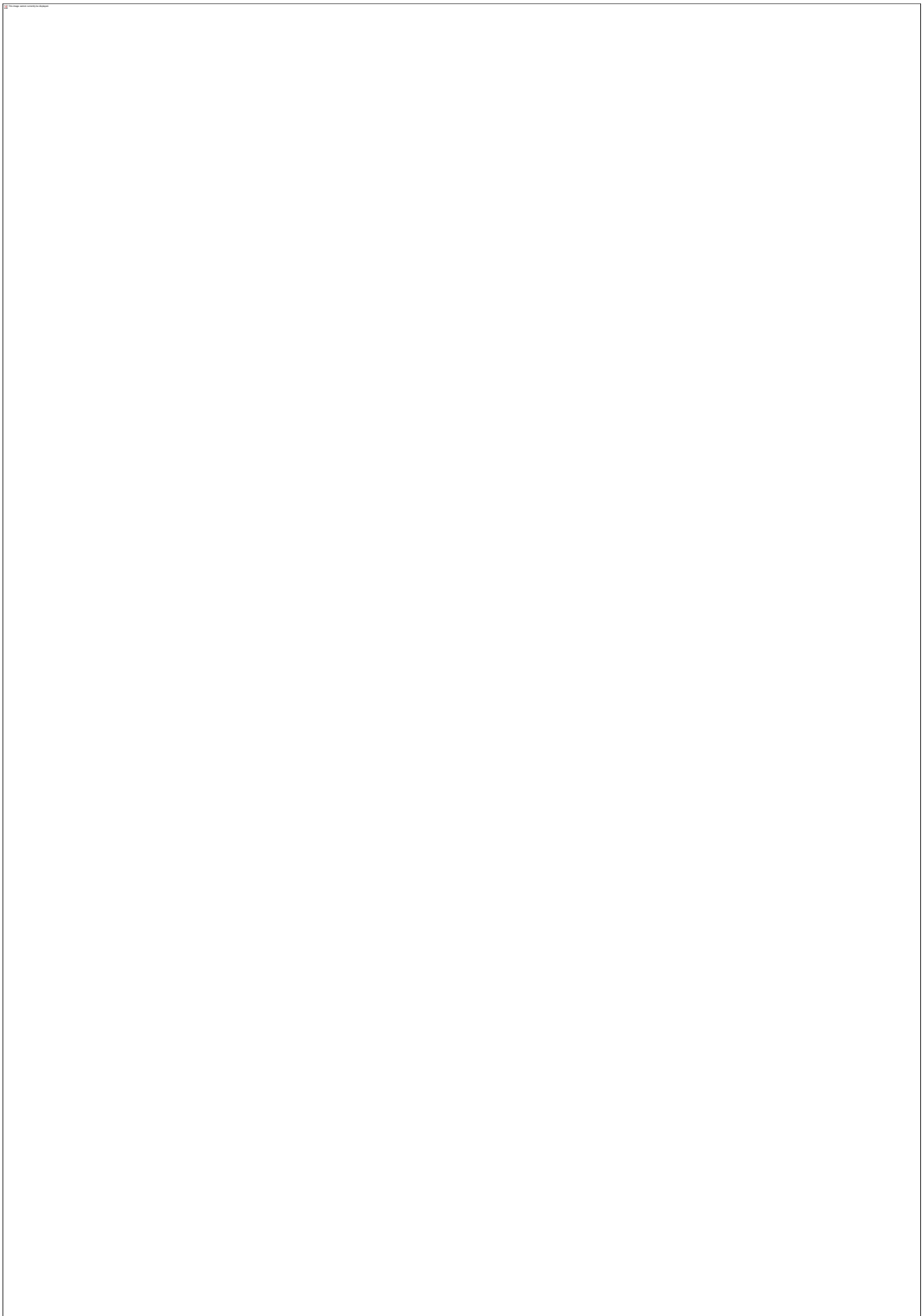
From: Sijan, Katherine L (DHS)
Sent: Thursday, June 25, 2015 11:38 AM
To: 'Bauer, Faith'
Cc: Rossett-Brown, Libby R (DHS)
Subject: FW: AUC meeting -Family Memory Care

Faith,

The attached information is for the follow up question to the SBAR for Family Memory Care. The main question at the meeting was:
Are these services paid by MCO's?

In the attached email is the link to the legislative contract for MCO's and it contains all the services included in this contract; which include EW[Elderly Waiver] and AC [Alternative Care] Programs for all eligible persons who require the level of care provided in a nursing home, but choose to live in the community.

The Table of Contents:


This image cannot currently be displayed.

From: Kvendru, Sue R (DHS)
Sent: Wednesday, June 24, 2015 10:51 AM
To: Rossett-Brown, Libby R (DHS); Sijan, Katherine L (DHS); Wenberg, Susan G (DHS)
Cc: Agerlie, Andrea A (DHS)
Subject: RE: AUC meeting -Family Memory Care

As Libby indicates, the MCO's who provide MSHO/MSC+ cover all EW services so it would apply. In the past, the MCO staff attending the AUC are there representing all MCO products and they are not always well informed on public programs.

Here is a link to our model contract.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_174195

Section 6.1.13 shows that Elderly Waiver services are covered under the contract. The contract references Minnesota Statutes, § 256B.0915 which is the EW statute.

From: Rossett-Brown, Libby R (DHS)
Sent: Wednesday, June 24, 2015 10:37 AM
To: Sijan, Katherine L (DHS); Wenberg, Susan G (DHS); Kvendru, Sue R (DHS)
Cc: Agerlie, Andrea A (DHS)
Subject: RE: AUC meeting -Family Memory Care

You can point them to the MCO contracts with the state where they are required to deliver all EW services – there should be no question as under MSHO/MSC+ - MCO's deliver all EW services and they should not question when you bring them to the web page of EW services – Either the right people are not in the room or they need to ask their own right people concerning EW services that MCO's by contract provide

Sue – Can you please help with this situation (see below)– I am not understanding how they can think an EW service is not MCO related at the AUC and we are just trying to get a HCPC code for Family Memory Care – which will be new part of the EW service Caregiver Training and Education/Coaching and Counseling

From: Sijan, Katherine L (DHS)
Sent: Wednesday, June 24, 2015 9:22 AM
To: Wenberg, Susan G (DHS)
Cc: Agerlie, Andrea A (DHS); Rossett-Brown, Libby R (DHS)
Subject: RE: AUC meeting -Family Memory Care

Hello,

I apologize.

It was discussed, however there were more questions, therefore it is on hold until the next meet 7/28.

When I linked to the DHS webpage showing Family Caregiver, they weren't sure any of these were MCO related.
Can you point me to the statute language and also which services [or if all] are under managed care?

I went to this link and scrolled down to family caregiver, and clicked on that.

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

Thanks
Kathy

From: Wenberg, Susan G (DHS)
Sent: Wednesday, June 24, 2015 8:59 AM
To: Sijan, Katherine L (DHS)
Cc: Agerlie, Andrea A (DHS); Rossett-Brown, Libby R (DHS)
Subject: RE: AUC meeting -Family Memory Care

Good Morning Kathy, did the June 11th AUC meeting go well? Can we move ahead with the proposed modifier for Family Memory Care under EW and AC? It is S5115/TG.

Thanks for your work on this. Sue

Sue Wenberg, Family Caregiver Program Consultant
Continuing Care for Older Adults
Minnesota Department of Human Services/MBA

From: Sijan, Katherine L (DHS)
Sent: Monday, June 01, 2015 3:16 PM
To: Wenberg, Susan G (DHS); Rossett-Brown, Libby R (DHS)
Cc: Agerlie, Andrea A (DHS)
Subject: RE: AUC meeting -Family Memory Care
Importance: High

Hi Susan/Libby,

I am writing the SBAR for the AUC and I have a few questions please.

Q- Are these correct statements?

_____

FMC Consultants must meet professional standards and qualifications; participate in specialized training and clinical monitoring sessions. To participate in FMC, caregivers live with the person with dementia, are the primary caregiver, and at least one family member participates in each of the family meetings. The person with dementia has a GDS score of 4 or higher. Caregivers attend 4 to 6 meetings in a 90 day period, with a consultant, and a family member who participates in 2-4 meetings. Ad hoc support is included as part of this service.

S5115 – TG - Home care training, nonfamily; per 15 minutes, Family Caregiver Coaching and Counseling; Family Memory Care

1 unit = 15 minutes

QUESTIONS for either of you –

Question 1: Is there a time limit per day, or just the 90 day period?

Question 2: When provider bills, he/she will bill under recipient's name/id, for one person being trained, even if it is 2 or persons/ family members?

Question 3: Is the requested effective date still 7/1/15?

Question 4: Any updates regarding the SPA?

Question 5: I found this on your email: Ad hoc support is included as part of this service.. This sounds as if follow up could be via phone. Therefore this statement appears to include follow up questions by the trainees. Is that correct?

Question 6: What are the provider/provider types you are going to enroll to perform these services?

Thank you,
Kathy

From: Wenberg, Susan G (DHS)
Sent: Thursday, May 28, 2015 8:47 AM
To: Sijan, Katherine L (DHS); Rossett-Brown, Libby R (DHS)
Subject: RE: AUC meeting

Kathy, thanks for yesterday's meeting. I've attached the description of Family Memory Care and the Waiver Amendment. Let us know if you need anything else.

EW and AC Family Caregiver Services

Family Caregiver Training and Education	S5115
Family Caregiver Coaching and Counseling/Assessment	S5115/TF
Family Caregiver Coaching and Counseling/Family Memory Care	S5115/TG (requested)

Description:
Family Memory Care (FMC) is a multi-component coaching and counseling intervention for supporting family and friend caregivers living with a person with dementia. The FMC intervention includes assessment, education, plan development, coaching on strategies for coping with changes in personality and behavior, and finding resources. The protocol includes individual counseling sessions (2), family meetings (4) and ad hoc counseling, and optional support groups. FMC is based on the New York University Caregiver Intervention shown to prevent or delay nursing facility placement by 18 months, on average. FMC consultants must meet professional standards and qualifications, participate in specialized training and clinical monitoring sessions.

Waiver Amendment language for EW Family Caregiver Services (proposed changes in yellow):

Service Definition *(Scope):*
Family and caregiver training and education provide training, education, coaching, or counseling for caregivers who provide direct and on-going services to an enrollee. This may include a parent, spouse, children, relatives,

in-laws or other informal caregivers. This service does not provide training and counseling to people who are employed by or volunteer through an organization that is paid to care for the enrollee.

Training and education include instruction about treatment regimens, disease management, direct care skills, and the use of equipment and technology to maintain the health and safety of the enrollee. It may also include education about caregiver roles, family dynamics, self-care skills and dealing with difficult behaviors, and other areas as specified in the support plan to improve health and well-being of the caregiver and care provided for the enrollee. Training and education can include individual or group sessions.

Coaching and counseling include individualized support for caregivers of enrollees. Coaching or consulting includes an assessment of the caregiver's needs and strengths, development of a person-centered plan with goals, skills development (i.e., self-care skills, techniques for managing difficult behaviors), problem solving (i.e., family dynamics or family meetings, developing an informal support network), coaching, and ongoing support to reach established goals. Its goals are to improve caregiver health and well-being, and increase coping and self-efficacy skills to improve the quality of care provided for the enrollee. ~~Some~~ -Caregiver consultants ~~specialize~~ are trained in in memory care support. Counseling offers professional consultation to assist caregivers in making decisions and solving problems related to their caregiving role. It includes identification of needs and preferences, development of an individualized approach and plans, family counseling, conflict resolution, and problem solving or guidance directly related to providing care to the enrollee.

Family Memory Care (FMC) is a coaching counseling service for caregivers living with a family member or friend with dementia. FMC includes assessment, education, plan development, coaching on strategies for coping with changes in personality and behavior, and finding resources. To participate in FMC, caregivers live with the person with dementia, are the primary caregiver, and at least one family member/friend participates in each of the family meetings. The person with dementia has a GDS score of 4 or higher. Caregivers attend 4 to 6 meetings with a FMC consultant, and a family member/friend participates in 2 – 4 of the meetings. Ad hoc support is included as a part of this service.

Sue Wenberg, Family Caregiver Program Consultant
Continuing Care for Older Adults
Minnesota Department of Human Services/MBA

Medicare Claims Processing Manual		Volunteer
Chapter #	Title/Description	
1	General Billing Requirements	Deb Sorg – no changes
2	Admission and Registration Requirements	No changes
3	Inpatient Hospital Billing	Deb Sorg – no changes
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Deb Sorg – no changes
5	Part B Outpatient Rehabilitation and CORF/OPT Services	Faith Bauer – no changes
6	Inpatient Part A Billing and SNF Consolidated Billing	Faith Bauer – see changes in guide
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)	Mary Trethewey
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims	Sara Luther – no changes
9	Rural Health Clinics/Federal Qualified Health Centers	Kathy Sijan – no changes
10	Home Health Agency Billing	Mary Trethewey, Cindy Norling, Donna Lindberg – no changes
11	Processing Hospice Claims	Mary Trethewey
12	Physicians/Nonphysician Practitioners	Judith Blyth, Sheryl Theno – see changes in guide
13	Radiology Services and Other Diagnostic Procedures	De Krengel
14	Ambulatory Surgical Centers	Paula Walerius – no changes
15	Ambulance	Sara Luther – no changes
16	Laboratory Services	Carolyn Larson – no changes
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	No changes
22	Remittance Advice	No changes
23	Fee Schedule Administration and Coding Requirements	No changes
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims	No changes
25	Completing and Processing the Form CMS-1450 Data Set	No changes
26	Completing and Processing Form CMS-1500 Data Set	No changes
27	Contractor Instructions for CWF	No changes
28	Coordination with Medigap, Medicaid, and other Complementary Insurers	No changes
29	Appeals of Claims Decisions	De Krengel
30	Financial Liability Protections	No changes
31	ANSI X12N Formats Other than Claims or Remittance	No changes
32	Billing Requirements for Special Services	Faith Bauer
33	Miscellaneous Hold Harmless Provisions	No changes
34	Reopening and Revision of Claim Determinations and Decisions	No changes
35	Independent Diagnostic Testing Facility (IDTF)	Deb Sorg – no changes
36	Competitive Bidding	No changes
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project	No changes
38	Emergency Preparedness Fee for Service Guidelines	No changes

7/30/15

Yellow = review done; no change
Blue = revisions noted

SBAR – C & TC update

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.

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)

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

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:

FYI
Anne K's response.
K

From: Kollmeyer, Anne L (DHS)
Sent: Monday, August 24, 2015 10:47 AM
To: Sijan, Katherine L (DHS) <Katherine.Sijan@state.mn.us>
Cc: Yerke, Kimberly R (DHS) <kimberly.yerke@state.mn.us>
Subject: RE: question -verification of U1 modifier vote from Ops

Hi, Kathy:

I worked on final revisions to the entire Developmental and Social Emotional or Mental Health and Autism related sections last week. Several website links had to be changed due to some website changes.

I am working on adding an additional paragraph which our pediatric mental health staff person at DHS, Catherine Wright suggested today. The content will then be sent to our Communications staff for final review and preparation for posting.

Anne

From: Sijan, Katherine L (DHS)
Sent: Friday, August 07, 2015 9:34 AM
To: Kollmeyer, Anne L (DHS) <Anne.Kollmeyer@state.mn.us>; Yerke, Kimberly R (DHS) <kimberly.yerke@state.mn.us>
Cc: Agerlie, Andrea A (DHS) <andrea.agerlie@state.mn.us>; Averbeck, Kathleen A (DHS) <kathleen.averbeck@state.mn.us>
Subject: FW: question -verification of U1 modifier vote from Ops
Importance: High

Anne,
Have you submitted the update to the DHS provider manual for 'screening for Autism' changes that were approved by AUC Ops June 30th?
This needs to be changed ASAP as the next AUC meeting I will attend is next Thurs 8/13/15.

As you can see, this is the history of the coding changes in CT & C have been 'out of sync'.

96110 - developmental screening with a standardized instrument

96110-U1 – autism screening with a standardized instrument, 1 unit <<<<< effective 7/1/15, approved by AUC OPS 6/30.

96127 – social emotional <or> mental health <<< 1/1/15, DHS manual updated 5/12/15

Currently, the DHS site shows as noted below in the section; 'Autism in Toddlers', so it's very confusing for Providers to have only part of the page 'updated:

Would like to suggest the following language for the Screening for Autism in Toddlers section of the Provider Manual:

Screening for Autism in Children

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 billing for 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. Bill for the autism screening on the C&TC claim using CPT code 96110 and modifier U1.
- When an autism screening is completed in addition to another developmental screening using two separate standardized screening instruments, bill for the autism screening and the developmental screening on the C&TC claim using;
  CPT code 96110 (for the developmental screening)
  CPT code 96110 and modifier U1(for the autism screening)
- Required documentation must be maintained in the child's health record and at a minimum, must include the name of the screening instrument(s) used, the score(s) and the anticipatory guidance provided to the parent/caregiver related to the results.

From: Edwards, Judy (MDH)
Sent: Tuesday, July 07, 2015 4:37 PM
To: Sijan, Katherine L (DHS)
Cc: Haugen, David (MDH)
Subject: FW: question - need verification of U1 modifier vote from Ops
Importance: High

Hi Kathy:

Below is Dave's email he sent on June 30 confirming Ops had approved.

Judy

From: Haugen, David (MDH)
Sent: Tuesday, July 07, 2015 4:36 PM
To: Edwards, Judy (MDH)
Subject: FW: question - need verification of U1 modifier vote from Ops

Hi Judy –

Below is the email that I sent to Kathy confirming that the SBAR for the U1 modifier with 96110 for Autism Screening was approved by AUC Ops.

Dave Haugen

David K. Haugen
Director, Center for Health Care Purchasing Improvement
Minnesota Department of Health

From: Haugen, David (MDH)
Sent: Tuesday, June 30, 2015 4:16 PM
To: Sijan, Katherine L (DHS)
Subject: RE: question - need verification of U1 modifier vote from Ops

Hi Kathy –

Yes, the vote was to approve. Can you please remind me – if approved, is the change just going in the coding clarification grid (http://www.health.state.mn.us/auc/bestpractices/codinggridv4.pdf) and not the companion guide?

Dave Haugen

David K. Haugen
Director, Center for Health Care Purchasing Improvement
Minnesota Department of Health

From: Haugen, David (MDH)
Sent: Friday, June 26, 2015 1:39 PM
To: Sijan, Katherine L (DHS)
Subject: RE: question - need verification of U1 modifier vote from Ops

Hi Kathy –

Sorry for the continued delay on your question. The vote you are looking for was started May 20 and was extended June 4. The extension may have caused a little confusion in our record keeping, which I

working to resolve. I have seen a relatively small number of votes, all to approve, but I am trying to determine whether there may have been others, and if so, how they voted.

Dave Haugen

David K. Haugen
Director, Center for Health Care Purchasing Improvement
Minnesota Department of Health

From: Haugen, David (MDH)
Sent: Tuesday, June 23, 2015 5:34 PM
To: Sijan, Katherine L (DHS)
Cc: Edwards, Judy (MDH); Veness, Susie (MDH)
Subject: RE: question - need verification of U1 modifier vote from Ops

Hi Kathy –

The AUC was given additional time to vote on the SBAR (see email attached), and I am checking on the results of the email vote (I assume it passed, but I will get the confirmation and send it to you).

Thanks,

Dave Haugen

David K. Haugen
Director, Center for Health Care Purchasing Improvement
Minnesota Department of Health

From: Sijan, Katherine L (DHS)
Sent: Thursday, June 18, 2015 4:02 PM
To: Haugen, David (MDH)
Cc: Edwards, Judy (MDH)
Subject: question - need verification of U1 modifier vote from Ops
Importance: High

Hi,

I'm unable to locate where the U1 modifier with 96110 for Autism Screening was voted and approved by Ops?
This was presented at May meeting – see attached SBAR. Anne Kollmeyer wants verification this was approved
Before she will publish info on DHS site.

Thank you,
Kathy

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS);and Revenue codes.[2]

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

☐ valid on the date of service for medical code sets;

☐ valid at the time the transaction was created and submitted for non-medical code sets.

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

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

[2] CPT is a registered trademark of the American Medical Association (AMA); ICD-9-CM, ICD-10-CM and ICD-10-PCS are ~~is~~ maintained and distributed by the National Center for Health Statistics, U.S. Department of Health and Human Services (HHS); HCPCS are developed by the Centers for Medicare and Medicaid Services (CMS); Revenue codes are developed by the National Uniform Billing Committee (NUBC). Code set updates can be found at websites of the organizations named above.

A.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				

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

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.
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 (see section A.3.4.2) 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

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

					• ~~-~~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 T1013-52 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 is reported (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

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

					• 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 (see A.4.3.2) 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 • ~~-~~ 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		Not applicable to Professional claim		Follow Medicare coding guidelines

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

	Inpatient Part B and Outpatient Fee Schedule)				
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.		
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	For home care the industry standard defines "per diem" as all-inclusive services per patient encounter up to two hours.

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

				the same date of service	• To report extended continuous services beyond the encounter use the fifteen minute code(s). • To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.
10	Home Health Agency Billing			Approved HCPCS code set	Medicare's G codes are insufficient to describe the level of time codes that group purchasers require for proper case management. See Approved HCPCS Code Set below. Approved HCPCS code set: • Skilled Nursing Encounter: o RN: T1030 o LPN:T1031 • Home Health Aide Visit: T1021 • Home Health Aide (Extended: T1004 • PT Visit: S9131 o PT Asst. Visit: S9131 TF • OT Visit: S9129 o OT Asst. Visit: S9129 TF • RT Evaluation: S5180 • RT Visit: S5181 • Speech Visit: S9128 • MSW Visit: S9127 • RN: T1002 • RN Complex: T1002 TG • RN Shared 1:2 ratio T1002 TT • LPN: T1003 • LPN Complex: T1003 TG • LPN Shared 1:2 ratio T1003 TT • Postpartum home visit 99501 • Newborn care home visit 99502
11	Processing Hospice Claims		Not applicable to Professional claim		Follow Medicare coding guidelines
12	Physicians/	Allergy, clinical immunology	Medicare does not allow all allergy and clinical immunology codes, but group		

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	Nonphysician Practitioners		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 • 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 is reported (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 – Psychiatric consultation to primary care practitioners)	Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care 99499 HE AG U7 (by physician extender)		

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			• 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) based on date of service 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.~~		
12	Physicians/ Nonphysician Practitioners	Health Care Homes	The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with		

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

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>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 modifie</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>
Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level
o U2 – Care coordination, extended complexity level
o U3 – Care coordination, supplemental factor; Non-English language</td>
<td></td>
<td></td>
</tr>
</table>

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			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~~ MOVED	~~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 – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI) 2. EIDBI ~~Intervention Supervision~~ Observation 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 1~~a. The~~ EIDBI Intervention – Applied Behavioral Analysis (ABA) or Developmental and Behavioral Intervention (DBI) Selected Codes		Not applicable to the Institutional guide

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
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	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

			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	[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		

			minutes ~~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~~	~~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~~

			~~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-~~	~~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~~		

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

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

2. EIDBI ~~Intervention~~ Observation ~~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	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

			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	0362T- UB HO GT - Masters /Mental 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		

			<table><tr><td></td><td>additional 30 minutes</td></tr></table> 3. Comprehensive Multi-Disciplinary Evaluation (CMDE) <u>Selected Code</u> 0359T AM - Psychiatrist [MD]/Physician HO - Masters /Mental Health Professional [MHP] HP- Doctorate /Mental Health Professional [MHP] TG - Advanced Practice Registered Nurse (APRN) GT- via interactive audio and video telecommunications systems UB EIDBI [Early Intensive Developmental and Behavior Intervention] ~~(AUTISM)~~ <table><tr><td><u>Coding</u></td></tr><tr><td>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)</td></tr></table>		

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			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 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 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

			T1027 - UB HN GT - Bachelor's degree level I or II (telemedicine 6. Coordinated Care Conference Selected Codes Description T1024 AM – Physician 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)~~ TG - Advanced Practice Registered Nurse (APRN) Coding: T1024 – UB AM - Physician; T1024 – UB TG - APRN; T1024 – UB HK- Qualified Supervising Professional [QSP]; T1024 – UB HP- Doctorate /Mental Health Professional [MHP] Telemedicine Coding: 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		

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			T1024 – UB HO - Masters /Mental Health Professional[MHP] T1024 – UB HN - Bachelor's degree level I or II 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		
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.

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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) 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.

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18	Preventive and Screening Services	New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.		
18	Preventive and Screening Services	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-~~9-CM~~/~~ICD-10-CM~~, based on date of service, 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	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.		with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
~~18~~	~~Preventive and Screening Services~~ MOVED	~~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. Refer to DHS for the C&TC Provider Guides for reportable component codes.~~ • ~~96110 Social/Emotional (Developmental) Screening~~ • ~~96110 U1 – Autism Screening~~ • ~~96127 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~~		

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			~~made to complete the service and rescheduling for a later date was not feasible.~~ ~~Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed.~~ • ~~Use most appropriate diagnosis code based on patient age.~~		
18	Preventive and Screening Services			Colonoscopy	Coding of diagnosis for colonoscopy claims should follow the ICD-~~9~~ CM~~/ICD-10-CM~~, based on date of service, 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		

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

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, Orthotics and Supplies				Not applicable to the Institutional guide
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

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

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
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		Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines

	for Service 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 seven ~~six~~ sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the seven ~~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.		

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

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

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					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. **Note**: Professional services related to the mother's and newborn's cares are reported on the 837P only.
N/A	**N/A**	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. Refer to DHS for the C&TC Provider Guides for reportable component codes. • 96110 Social/Emotional (Developmental) Screening • 96110 U1 – Autism Screening • 96127 ~~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. • Use most appropriate diagnosis code based on patient age.		
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	**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		H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes
N/A	TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs	~~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: 8. ~~The~~ EIDBI Intervention – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI) 9. EIDBI ~~Intervention~~ ~~Supervision~~ Observation and Direction 10. Comprehensive Multi-Disciplinary Evaluation (CMDE) 11. Individual Treatment Plan Development and Monitoring 12. Family Caregiver Training and Counseling 13. Coordinated Care Conference 14. Travel Time 1~~a. The~~ EIDBI Intervention – Applied Behavioral Analysis (ABA) or Developmental and Behavioral Intervention (DBI) <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		Not applicable to the Institutional guide

			and Behavior Intervention] ~~(AUTISM)~~ Coding Individual: 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 Coding Group: 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		

			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	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~~			

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

			~~[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 [MHP], each additional 30 minutes~~ ~~0368T-UB-HO - Masters /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 additional 30 min~~ ~~0366T-UB-HO - Masters /Mental Health Professional [MHP], first 30 minutes~~

			~~[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

			3. EIDBI ~~Intervention~~ Observation ~~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 [MHP], first 30 minutes 0363T-UB HO - Masters /Mental Health Professional [MHP], each	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 Health Professional [MHP] (telemedicine) , first 30 minutes 0363T-UB HO GT - Masters /Mental

			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) 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) <u>Selected Code</u> 0359T AM - Psychiatrist [MD]/Physician			

			HO - Masters /Mental Health Professional [MHP] HP- Doctorate /Mental Health Professional [MHP] TG - Advanced Practice Registered Nurse (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) 8. 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]		

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

			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 9. 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		

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<td>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 level I or II (telemedicine</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>
</table>

10. Coordinated Care Conference

Selected Codes Description</td>
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T1024
AM – Physician
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)~~
TG - Advanced Practice Registered Nurse (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]

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

			(telemedicine) T1024 – UB HN GT- Bachelor's degree level I or II (telemedicine) 11. 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		

837I:

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

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

~~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~~

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

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

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

~~Assertive Community Treatment (ACT)~~
~~Adult Crisis Response Services~~
~~Children's Mental Health Crisis Response Services~~
Mental Health Targeted Case Management (MH-TCM)
Children's Mental Health Residential Treatment Services
Intensive Residential Treatment Services (IRTS)
Adult Day Treatment
Children's Day Treatment
~~Children's Therapeutic Services and Supports (CTSS)~~
~~Adult Rehabilitative Mental Health Services (ARMHS)~~
~~Peer Services~~
Mental Health Diagnostic Assessment
~~Dialectical Behavior Therapy~~
~~Youth Assertive Community Treatment~~
~~Intensive Treatment in Foster Care~~
~~Mental Health Family Psychoeducation Services~~

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

		~~S9484 HN – Adult crisis assessment, intervention and stabilization, individual, by mental health practitioner~~ ~~S9484 HQ – Adult crisis stabilization, group~~ ~~H0018 – Adult crisis stabilization, residential~~ ~~90882 HK – Environmental intervention for medical management, community intervention~~ ~~90882 HK HM – Environmental intervention for medical management, community intervention, mental health rehabilitation worker~~
~~**Children's Mental Health Crisis Response Services**~~ ~~Back to list of behavioral health programs~~	~~Intensive face to face, short-term services initiated during a crisis; provided on-site by a mobile crisis response team.~~ ~~County or county contracted agency.~~	~~Codes:~~ ~~S9484 UA – Crisis intervention mental health services, per hour, Children's Crisis Response Services, mental health professional~~ ~~S9484 UA HN – Crisis intervention mental health services, per hour, Children's Crisis Response Services, bachelor's degree level mental health practitioner~~
~~**Children's Therapeutic Services and Supports (CTSS)**~~ ~~Back to list of behavioral health programs~~	~~Rehabilitative services that offer a broad range of medical and remedial services and skills to help restore individuals' self-sufficiency/functional abilities – a flexible package of mental health services for children.~~	~~Codes:~~ ~~90832 UA – Psychotherapy w/patient and/or family, 30 minutes, CTSS~~ ~~90833 UA – Psychotherapy w/patient and/or family, 30 minutes with an E/M*, CTSS~~ ~~90834 UA – Psychotherapy w/patient and/or family, 45 minutes, CTSS~~ ~~90836 UA – Psychotherapy w/patient and/or family, 45 minutes with an E/M*, CTSS~~ ~~90837 UA – Psychotherapy w/patient and/or family, 60 minutes, CTSS~~ ~~90837 UA plus 99354 Psychotherapy w/patient and/or family 60 minutes, CTSS~~ ~~90838 UA Psychotherapy w/patient and/or family, 60 minutes with E/M*, CTSS~~

		~~90839 UA - Psychotherapy for crisis, first 60 minutes, CTSS~~ ~~90840 UA Each additional 30 mins [add on to 90839], CTSS~~ ~~90846 UA- Family psychotherapy without patient, CTSS~~ ~~90847 UA- Family psychotherapy with patient, CTSS~~ ~~90849 UA- Multiple family group psychotherapy, CTSS~~ ~~90853 UA- Group psychotherapy, CTSS~~ ~~90875 UA- Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy , 30 minutes, CTSS~~ ~~90876 UA Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 45 minutes, CTSS~~ ~~H2014 UA- Skills training & development, individual, per 15 minutes, CTSS~~ ~~H2014 UA HQ- Skills training & development, group, per 15 minutes, CTSS~~ ~~H2014 UA HR- Skills training & development - family, per 15 minutes, CTSS~~ ~~H2015 UA- Comprehensive community support services - crisis assistance, 15 minutes, CTSS~~ ~~H2019 UA- Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS~~ ~~H2019 UA HM- Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS~~ ~~H2019 UA HE- Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS~~

		*(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: H2017- Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes H2017 HM- Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes H2017 HQ- Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes H2017 UD- Basic living and social skills, transitioning to community, mental health professional or practitioner H2017 UD HM- Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker 90882- Environmental/community intervention, mental health professional or practitioner 90882 HM- Environmental/community intervention, mental health rehabilitation worker 90882 UD- Environmental/community intervention; transition to community living intervention 90882 UD HM- Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker H0034- Medication education, individual: MD, RN, PA or Pharmacist

		☐ H0034 HQ - Medication education, group setting
Peer Services Back to list of behavioral health programs	Non-clinical support counseling services provided by certified peer specialist.	Codes: ☐ H0038 – Certified peer specialist services, per 15 minutes ☐ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ☐ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ☐ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ☐ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ☐ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ☐ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ☐ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ☐ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ☐ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	☐ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care)	Codes: ☐ S5145 – Foster care, therapeutic, child; per diem ☐ HE – Mental health program

	(1) Psychotherapy provided by a mental health professional; (2) Crisis assistance provided according to standards for children's therapeutic services and supports; (3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee; (4) Clinical care consultation provided by a mental health professional or a clinical trainee; and (5) Service delivery payment requirements as provided under subdivision 4.	Bill only one per diem code per day regardless of the number of services or who provides services.
Mental Health Family Psycho-education Services Back to list of behavioral health programs	☐ Family psycho-education services provided to a child up to age 21 with a diagnosed mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5 9505.0371, subpart 5, item C. ☐ Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o understanding a child's symptoms of mental illness; o the impact on the child's development; o needed components of treatment; and o skill development.	Codes: ☐ H2027 - Individual ☐ H2027 HQ - Group (peer group) ☐ H2027 HR - Family with client present ☐ H2027 HS - Family without client present ☐ H2027 HQ HR - Multiple different families with clients present ☐ H2027 HQ HS - Multiple different families without clients present ☐ H2027 HN - Individual, clinical trainee ☐ H2027 HQ HN - Group (peer group), clinical trainee ☐ H2027 HR HN - Family with client present, clinical trainee ☐ H2027 HS HN - Family without client present, clinical trainee ☐ H2027 HQ HR HN - Multiple different families with clients present, clinical trainee ☐ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee

FYI

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From: Harrington, Anne B (DHS)
Sent: Friday, August 28, 2015 9:26 AM
To: Sijan, Katherine L (DHS) <Katherine.Sijan@state.mn.us>
Subject: Response to Meeting with Anne, Eric, Nancy, Stacy at DHS on August 12th.

HI Kathy,
These are some of the issues that have been raised by stakeholders regarding our current CPT codes for EIDBI. This is what we need to discuss at the 9/1 meeting. I wanted to give you the heads up and also see if you had time to look at this and let me know what your thoughts are.

Best Regards,

Anne

Anne Harrington
Planning Director Autism Services
MN Department of Human Services
651-431-2119 (Phone)
651-431-7412 (Fax)

From: Deb Thomas [mailto:dthomas@pieofmn.com]
Sent: Thursday, August 27, 2015 5:03 PM
To: Deb Thomas <dthomas@pieofmn.com>; Jackie Vick <jvick@pieofmn.com>; Jim Erickson <jim.erickson@mac.com>; Melissa Haley <hlymlss@yahoo.com>; Jennifer VanDerHorst Larson <jlarson@vibrant.com>; Nancy Schussler PhD <nschussler@behavioraldimensions.com>; Dr. Eric Larsson <elarsson@lovaas.com>; Peggy Howell <peggy@lazarusprojectmn.org>; Craig Hunter <chunter@btsofmn.com>; Randy Bachman <rbachman@axishealth.com>; Jami Hughes <jhughes@alliantbehavioral.com>; Tara Bertone <tbertone@autismmatters.net>; Harrington, Anne B (DHS) <Anne.Harrington@state.mn.us>; Jim Abeler <jimabeler@hotmail.com>; Lisa Barsness <lbarsness@meapkids.org>
Subject: Fwd: Meeting with Anne, Eric, Nancy, Stacy at DHS on August 12th.

Hi All,

I wanted to provide a summary of a meeting that Eric Larsson, Nancy Schussler and I had with Anne Harrington from DHS on August 12th. Stacy Myhre joined us for a part of the meeting. She is a Legislative Liaison for DHS.

This meeting was requested by members of the ATAM group after a number of previous meetings between DHS staff and ATAM members in efforts to try to resolve a number of issues surrounding the Autism Benefit. This meeting on August 12th with Anne, Eric, Nancy and myself felt very productive and there are many things to report on.

Anne came prepared to say that the CMDE policy and the medical necessity policy has been updated and has been posted on the DHS website for everyone's review. These updates were the result of the previous meetings as DHS heard and responded to what the stakeholders were asking for. What I took away from this is that the treating provider will help set parent involvement, number of therapy hours, etc. as well as children under the age of 7 can have up to 40 hours without asking for an exception. In addition to these updates, I have discovered that the Coordinated Care Conference and the Service Authorization sections have also been updated in the on-line policy manual.

Anne also passed out a working document of stakeholder issues for us to review. This is in draft form, but it is a start and is attached here. After reviewing this document in detail, I can again see that they have heard and are responding to input from the ATAM group.

We spent a great deal of time talking about the billing issues. Anne requested that we send her any information regarding this as this area is the lightest for her. She would like information so she can get help from her associates on this in hopes to get some answers for us.

Billing Issues:

#1 One billing concern is that DHS wants us to use UMPI numbers for each individual staff. This would require us to have each staff sign the individual provider agreement and attach their training and certifications to each form. This creates problems as every time a staff changes in their training or certification, a new form must be filled out and submitted to DHS which can take 90 days or longer to process before that staff member can begin billing at the new level. I see 2 problems with this. The first being that when you hire a new staff they need to fill this out but are not billable until they are approved through DHS. Agencies can not hold billing for someone they are paying for this long. It is also unclear that if the staff quits prior to being accepted by DHS what happens in this case. It would provide some relief if the date on the individual

provider agreement would go back to the date that it was sent in to DHS. The second problem that I see is if you have an RBT (Level 3 ABA) that gets their BCBA (Level 1 ABA) you have to submit the new individual provider agreement to DHS for approval. This can take 90 days or longer. In the mean time you new BCBA staff member who would want a raise but the reimbursement for the Level 1 ABA is not in effect until approval is given. Then there is a bigger issue with the UMPI number and Individual provider agreements. DHS is requiring us to put the individual UMPI number on the insurance claim (1500 form) for every time that individual provider bills that day. This would require the billing staff to know everyones UMPI number to put this number on the claim matched with the units billed for that client on any given day. In a center base program we switch staff with the client every 1 1/2 hours so every day their will be 5-6 entries made on the claim for 1 code instead of billing 1 line item for a total number of units for 1 code all billed under the licensed professional or QSP. This also creates a problem from when the remits come in as each of the claims are looked at line by line to process the payment. This problem alone makes the Autism Benefit not obtainable. The costs to add staff in the billing department to manage such a large mass of data as well as the billing systems themselves are not set up this way and would cost too much money to have an IT department create this. When asked about why the UMPI number needing to be on the claim it was explained that DHS is following what they do for PCA services. In billing PCA services each PCA has their own number in which they bill for the time that they spend with an individual. DHS feels that this way of billing for the Autism Benefit services will help cut down on fraud. During this topic it was also brought up on who is requiring this to happen as there is a mixed message as to who is requiring this. Kim Anderson from DHS told us that OIG is requiring this and when Anne called them they said that they are not requiring this. Then Anne talked to another person and they thought it was a requirement by AUC. Anne is calling AUC and looking into this in more detail and will get back to us on this. A solution to this problem is to let the agency bill under the licensed professional/QSP like we do now in CTSS. Use a modifier for the code that we use based on the level of professional that is doing the service. This is how the Pre-Paid Medical Assistance plans are going to work and this is what our commercial plans are doing as well. Anne is aware of our problem and will check into this for us.

#2 DHS will be using the Adapted Behavior Codes that have been released by the AMA over a year ago. However, in doing so they have not approved using all of the codes such as the 0359T code. This is the code that is used for the initial assessment. Our commercial plans like Blue Cross, Cigna, Atena and others use this code for this purpose. Kim Anderson at DHS says that DHS will code this initial assessment with an H0031. Our commercial plans that are primary do not recognize H0031 other than UBH. This creates problems with our billing department when using primary insurance than going to secondary insurance as the codes do not match. DHS is payer of last resort and should be following

what the commercial plans are doing. The potential solution for this is for DHS to add all the adapted codes to their approved list as the commercial plans that are primary are already using these. I have attached a power point of a training that our staff attended to explain what these codes are and how they were introduced and what they can be used for. There are also other trainings on these codes out on the Internet for everyone to become familiar with.

#3 Prior Authorizations for services has become very complicated. Kim Anderson at DHS explained that only level 3 staff can bill out the 0364T and the 0365T code. The level 1 and 2 staff can only bill out the 0368T and 0369T codes. This is not in alignment with their SPA document and it is stated in the power point training that these codes can be used by anyone conducting the service. DHS should not be putting these restrictions on these codes. These codes have explanations as to what service is being provided and billing should use a modifier to indicate what level of staff is conducting the service. With Prior Authorizations this would mean that we would have to predict what level staff we would use for the six month treatment date span and get these codes prior authorized with DHS. The solution to this is to prior authorize codes that will be used during the 6 month treatment date span for services that we are intending to use no matter which staff provides the service. If DHS is not going to use these codes the way the commercial plans are then we are going to be consistently tracking and moving around units to meet this requirement which in the end could result in lost payment to the agency when they come up short with units for a particular staff level.

#4 When credentialling our staff, most if not all, of the ABA providers will need to credential under the DBI side as many of our MH Pract. would qualify under the DBI Level 1 requirements, using our own agencies training manual as the DHS approved training for ABA. The good part is that we can hire staff at the behavior aide level as the DBI Level 3 providers until they get their 2000 hours. This is when you would need to fill out a new Individual provider agreement and wait 90 days for approval from DHS.

Cultural Competency Training

In our meeting we expressed the concern about staff needing to go to DHS and get this training when we have been providers for so long and have our own training set up. We also explained that cultural training is more than language. It comes in the way of 2 moms, 2 dads, poverty, etc. and that each agency needs to tailor this training based on their clients and their workforce. Anne will do some checking on this.

When asked about the documentation process. Anne stated that the Autism Benefit will not require SDQ, CASII, ESCII, Skills Notes, DA's or monthly progress notes. The policy guide currently says that a 30 day progress note is

required, but that will be removed. The process is the CMDE document followed by a 6 month treatment plan.

In the meeting with Kim Anderson at DHS she said that providers that want to stay on CTSS follow the CTSS rules and the agencies that go to the Autism Benefit follows the Autism Benefit rules. If you are on both, you need to follow both. This was new information for me as I could not get my head around which polices and procedures I needed to keep and which ones are going to fall off when we let go of our CTSS agreement.

The CMDE document that was published is now under revision after changes have been made to the policy on CMDE. I did not see the CMDE document until the meeting as Nancy had a copy of this that I reviewed. I will be requesting a revised copy of the CMDE document from Anne.

The new codes have been published. I have not seen these either so I will be requesting these as well from Anne.

All in all, there has been progress made and I am thankful for that. There are many other things that still need to be worked out but I did feel that this was a step in the right direction.

During our discussion, it was also stated that John Z who was Anne's helper on the project has been re-assigned to a different project. Kim Anderson who was the project manager on this has also been re-assigned to a different project. Anne will also be resigning from her position on October 31st, 2015. It feels to me that upper management may feel that this Autism Benefit is implemented and therefore all the staff that have been working on it need to be done with it and re-allocated to other projects that DHS has going. Anne did say that she is available upon request to us until her last day. She asked if we could send in any ideas or thoughts we have regarding the manual to her so she can get answers for us prior to her leaving.

With that being said, I will be hosting a meeting at the Pointe in Prior Lake on Monday, August 31st starting at 11:30 until whenever to go through the policy manual line item by line item and identify what changes we would like to make. Everyone is invited and additional staff members from other departments are encouraged to come and give input. Please email me if you are planning on attending. Thank you.

Frequently Asked Questions on Applied Behavior Analysis Therapy Tracking Codes CPT 0359T-0374T

Who was on the American Medical Association CPT Workgroup that decided these codes?

We understand that the American Medical Association (AMA) for many years has received questions on how to report applied behavior analysis (ABA) services. AMA became aware of many inconsistencies in how providers of different specialties report and are paid for behavior analysis services. These codes resulted from a multi-specialty workgroup assigned by the AMA CPT Editorial Panel. ABAI was represented in this workgroup by Drs. Travis Thompson and Wayne Fisher. Several of the committee members were board certified behavior analysts and/or licensed-psychologist behavior analysts, but most were professionals from other interested disciplines. The workgroup consisted of members representing psychiatry, child psychiatry, psychology, speech-language and hearing, social work, neurology, occupational therapy, behavior analysis, pediatrics, and payers. Medicaid, Wellpoint, and TRICARE Military Health Systems medical directors also participated in this workgroup.

The workgroup collaborated in a collegial manner for over 3 years and concluded that ABA services for children with autism and related conditions have strong empirical support. These codes were not assigned to Category III as "experimental" treatments, but rather were assigned Category III status mainly due to the lack of data on the usage and costs of these services to assess their value relative to other Category I codes. ...Hide

Payment

What will the rates be for CPT® codes 0359T-0374T?

Specific dollar billing values are not set for these codes and ABAI cannot recommend rates. This is to avoid violating the federal Stark law—that is, of price fixing—by in any way implying that specific dollar billing values are already recommended for these codes.

ABA practitioners should not file reimbursement claims using these codes until they are assured that insurance companies with which they work have appropriate coverage in place for the codes. These are Temporary (5-year) CPT Category III codes and, as such, will have no nationally recognized values across all parts of the country until they are converted into permanent Category I CPT Codes. For the time being, each insurance company negotiates a reimbursement rate by geographic region.

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Documentation of Time

A number of the new CPT Category III (tracking) codes include times. I have not been in the habit of documenting times. Is this important to document?

Yes, time is important to document. Some of the assessment and treatment ABA codes have a stand-alone code for the first 30 minutes (i.e., 0360T, 0362T, 0364T, 0366T, 0368T) and an add-on code for each additional 30 minutes (i.e., 0361T, 0363T, 0365T, 0367T, 0369T and 0374T). No specific format exists for recording time, so ABA practitioners can decide the format that works best for them. Note that time is for one specific calendar day and is not additive over several days. The calendar day begins and ends at midnight. If a service is less than 30 minutes, do not report it.

Documentation of Time Example: The technician working directly with a child usually has an on-site (family home) therapy book into which they enter the start time (e.g., 8:17 am) and the stop time (e.g., 10:25 am). S/he calculates the nearest time in whatever unit the payer demands (e.g. 15 minutes) to currently report HCPCS codes H0004, H2014, H2019, S5108, or T1016. S/he enters 9 units (in this case, rounding up to the next whole 15-minute period) in a box.

Today, most providers electronically report times to the billing office. The biller may report total times per child daily, in some companies, or weekly/every other week in others. Nonetheless, it is important to document the total time within the patient/client record and not just let the insurer do the calculation, in order to become used to reporting codes for the first 30 minutes, and then each additional 30 minutes for the add-on codes.

Medical Necessity: Remember that documentation may be requested by a contractor to determine the medical necessity of the services provided. For example, if ABA therapy is provided for a patient/client and claims a diagnosis code not acceptable to the insurer, coverage will be denied.

Compliance Plan: It is advisable to have this list of Q&A's readily accessible. If you have developed a compliance plan in your practice, it is a good idea to keep copies of relevant information on the way the practice documents time on hand for easy access for providers and technicians.

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Under what code does one perform the task of graphing and analyzing baseline data, and graphing and analyzing session data? Additionally, what code is used for the task of writing programs and behavior plans?

It is assumed that this is performed with the patient not present. There are no CPT codes to separately report the tasks as described. When CPT I codes are valued, they include pre-service, intra-service, and post-service work. So the non-face-to-face time is included in the code.

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Behavior Identification Assessment (0359T)

How do the assessment codes relate to one another and which ones should be used when?

The 0359T is for the initial Behavior Identification assessment, which is essentially all initial intake assessments. This assessment is done by a qualified health care provider (QHCP) (usually a BCBA or a psychologist with expertise in behavior analysis). The visit is untimed and on average takes about 90 minutes, but it can be shorter or longer. The estimate of 90 minutes was based on practitioner input.

Based on the results of this assessment, the QHCP decides whether additional assessments are needed and plans accordingly. For example, the QHCP may proceed directly to treatment for uncomplicated problems (e.g., train the parent in 3-step guided compliance for a child whose only presenting problem is noncompliance). If the patient is a young child with autism who needs early intensive behavioral intervention, the 0359T may be followed by a 0360T procedure (first 30 minutes of each day of additional assessment) and several 0361T procedures (each additional 30 minutes in a day) of observational behavioral follow-up assessment implemented by a technician who is directed by a QHCP. The data collected during these follow-up sessions are interpreted and used by the QHCP as baseline data and to develop the specific behavioral goals for the treatment plan.

If the patient has severe destructive behavior, the 0359T may be followed by a 0362T procedure (first 30 minutes of each day of additional assessment) and several 0363T procedures (each additional 30 minutes in a day) of exposure behavioral follow-up assessment (i.e., a functional analysis conducted by technicians that are directed by a QHCP). These data are interpreted and used by the QHCP to identify the function of the patient's destructive behavior and to identify one or more potentially effective function-based interventions.

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The AMA description for 0359T says: *"Behavior identification assessment, by the physician or other qualified health care professional (QHCP), face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/ caregiver(s), and preparation of report."* The code is untimed; however accomplishing the above should take 10+ hours for the QHCP and should also include 1–2 hours that the QHCP will spend with the ABA Technician, the time for which will eventually need to be paid by the agency as well. Is it acceptable to claim 12–20 units of 0359T for an identification assessment and if so, how many per day?

No. Code 0359T is for the initial interview, reported once, and estimated at taking typically 90 minutes of QHCP time. The rest of the assessment is reported with the technician-administered codes (which also take into account QHCP time), 0360T Observational behavior follow-up assessment for the first 30 minutes of technician time, face-to-face with the patient, plus reporting 0361T for each additional 30 minutes (or 0362T for the first 30 minutes, plus 0363T times "x" numbers of 30 minutes for exposure assessment). We realize that the 90 minute time reported in the June 2014 issues of the AMA CPT Assistant is of concern to many ABA professionals.

CPT 0359T is not a timed code, not billed in increments. There is no minimum requirement at this point in time. You are thinking of timed codes, where for 30 minutes at least 16 minutes is required to report a 30 minute code. CPT 0359T is for the initial Behavior Identification assessment, which is performed by a qualified health care provider (QHCP). A QHCP is usually a BCBA or a licensed psychologist with expertise in behavior analysis. The initial assessment is untimed and on average takes about 90 minutes, but could be more or less time. The estimate of 90 minutes was based on practitioner input. Insurers usually plan coverage payments to the "typical" time rather than to outliers, the lowest or longest times for an assessment.

Based on the results of this assessment, the QHCP decides whether additional assessments are needed and plans accordingly. For example, the QHCP may proceed directly to treatment for uncomplicated problems (e.g., train the parent in 3-step guided compliance for a child whose only presenting problem is noncompliance).

If the patient is a young child with autism who needs early intensive behavioral intervention, the 0359T may be followed by a 0360T procedure (first 30 min of each day of additional assessment) and 0361T procedure (for each additional 30 min in a day) of observational behavioral follow-up assessment implemented by a technician who is directed by a QHCP. The data collected during these follow-up

sessions are interpreted and used by the QHCP as baseline data and to develop the specific behavioral goals for the treatment plan.

If the patient has severe destructive behaviors, the 0359T may be followed by a 0362T procedure (first 30 minutes of each day of additional assessment) and 0363T (for each additional 30 minutes in a day) of exposure behavioral follow-up assessment (i.e., a functional analysis conducted by technicians who are directed by a QHCP). These data are interpreted and used by the QHCP to identify the function of the patient's destructive behavior and to identify one or more potentially effective function-based interventions. It is important to note that a team of about three technicians work with the patient under the close direction of the QHCP, and thus the value of these follow-up assessment codes (0362T, 0363T) are expected to be greater that for the observation assessment codes (0360T, 0361T).

Also the June 2014 CPT Assistant provides the following coding tip: Reassessment may be reported with the assessment code 0359T. A reassessment is typically required after the success or failure of the current treatment plan necessitating new and/or revised treatment goal(s).

A behavior identification assessment (0359T) may be followed by an observational assessment of behavioral functioning (0360T, 0361T) or exposure behavioral follow-up assessment(s) (0362T, 0363T). Code 0359T may be reported for the assessment required for early intensive behavioral intervention (EIBI).

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It is my understanding that the initial assessment should be billed with code 0359T. Once that is done, is it mandatory to bill codes 0360T, 0361T, 0362T or 0363T for the follow up observation? Or can we go ahead and start billing for therapy using codes 0364T, 0365T, etc.?

In general, *all* clients will receive 0359T (an initial assessment) by the assigned BCBA (including intake, interview, direct observation, and development of assessment report and proposed treatment plan).

Then, once the initial assessment takes place and treatment plan is developed, *all* clients will receive *either* 0360T/0361T (for either an ABLLS, AFLS, or equivalent probe—1 BCaBA) *or* 0362T/0363T (to conduct a FBA if there is a serious behavioral concern—2 technicians, 1 BCBA, and 1 BCaBA). Then, once those follow-up assessments take place (0360T–0363T), the treatment plan is finalized and the direct

services begin (0364T–0370T and/or 0373T and 0374T for serious behavioral concerns). Then 0371T if the family joins a family training group, and/or 0372T if the client joins a social skills group.

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Which code is used for the 6-month re-assessment?

0359T.

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Observational Behavioral Follow-Up Assessment (0360T, 0361T)

Are the codes for observational behavioral follow-up assessment (0360T/0361T) used only once in the beginning of an authorization or can they be used again? If the latter, is it for ongoing updating of goals or anytime a reassessment is done?

Code 0360T—observational behavioral follow-up assessment— can only be reported once per day for the first 30 minutes of technician time, face-to-face with the patient. Code 0361T can be reported in multiple units, but the frequency that code can be reported might be capped by any insurer. Once you are instructed by an insurer to use these codes, monitor your explanation of benefits very carefully.

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Exposure Behavior Follow-Up Assessment (0362T, 0363T)

For codes 0362T and 0363T, can both the QHCP and the Technician bill for that time?

The exposure assessment codes, 0362T and 063T include both the QHCP's time and the time of multiple technicians. One code (0362T) is submitted for the entire behavioral team (QHCP and technicians) for the first 30 minutes and the other code is submitted for the entire behavioral team (QHCP and technicians) for each additional 30 minutes.

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Adaptive Behavior Treatment (0364T, 0365T)

In the past we have been informed that in order to avoid claims coming back as duplicates, all work done by multiple technicians on the same day for a specific client should be added up and submitted as total units performed under the BCBA. Now that the first 30 minutes of a session is billed as 0364T and

all subsequent 30 minutes of that session as 0365T, does the same apply? For example if one child has two 90-minute sessions in one day by two separate technicians, does it get submitted as a total of two units of 0364T and four units of 0365T, or can 0364T only be submitted once per day which results in one unit of 0364T and five units of 0365T for the same example?

0364T can only be reported once per day, which results in one unit of 0364T and five units of 0365T for the example given.

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Will the authorization for codes 0364T/0365T be given as one block or will it be necessary to request specific amount of 0364T units and 0365T units? The same question applies for codes 0368T/0369T.

The manner in which an authorization is given is likely to vary from one insurance provider to the next. Some insurers may employ frequency edits which would determine the maximum number of units they would accept. In this situation with tracking codes, once your insurer(s) want you to report these new codes, the practice should track them very closely.

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Adaptive Behavior Treatment with Protocol Modification (0368T, 0369T)

Which code provides for ongoing supervision?

The issue of supervision was a difficult one for the workgroup because BCBAs use the term "supervision" somewhat differently than other disciplines. The CPT Editorial Panel regards supervision as primarily a human resource function (e.g., providing performance feedback, resolving employee conflicts, approving vacation, annual evaluations). The CPT Editorial Panel regards these activities as part of one's practice expense, and as such, it does not publish codes that would allow professionals to bill for this activity as a separate and distinct health procedure.

We worked with the ABA workgroup to educate them on activities professional behavior analysts do when providing clinical supervision to ABA technicians that are well beyond human resource functions, such as procedural-integrity checks and modifying and modeling modifications to a treatment protocol that has not produced the desired outcomes. The committee agreed that these types of activities were separate from human-resource supervision and a code as created to cover these activities called Adaptive behavior treatment with protocol modification 0368T and 0369T. The 0368T code is billed for the first 30 minutes of an encounter and 0369T is billed for each additional 30 minutes.

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What code would be used for BCBA supervision of a technician?

When the QHCP is directing the activities of the technician in person (face-to-face contact with the patient) for purposes such as checking procedural integrity and problem solving and modifying a treatment protocol that is not effective, the QHCP would bill for this time using the adaptive behavior treatment with protocol modification code (0368T for the first 30 minutes and 0369T for each additional 30 minutes). The QHCP cannot submit this code and the code for the technician's time simultaneously (e.g., cannot submit a 0368T and a 0364T or 0365T for the same time period).

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Family Adaptive Behavior (0370T, 0371T)

Is there a code billable by both the BCBA and technician that accounts for presentation of the treatment plan by the BCBA to the parent/caregiver and the technicians without the patient present?

CPT 0370T: Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present).

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Will Codes 0370T, 0371T, and 0372T be used as a timed code in 30-minute increments? If not, can it be used once per day? And what is the minimum time necessary to bill the code? And how should authorizations for these codes be requested as far as units?

Family adaptive behavior treatment guidance (0370T) and multiple-family group adaptive treatment guidance (0371T) are not timed codes and able to be reported only once per day. Only timed codes have a minimum time requirement. Only one unit is reported per code. For 0371T and any other ABA group code, only groups no larger than 8 patients are able to be reported.

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Exposure Adaptive Behavior (0373T, 0374T)

There does not appear to be an option for the supervisor to observe a DI session. Would this be coded as 0373T/0374T, even if there isn't a serious behavioral concern?

The codes 0373T and 0374T are used to bill for a functional analysis of severe destructive behavior. For observing discrete trial training sessions and refining the protocol or correcting procedural integrity

errors, use the *adaptive behavior treatment with protocol modification 0368T and 0369T.* The 0368T code is billed for the first 30 minutes of an encounter and 0369T is billed for each additional 30 minutes.

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Documentation of Face-to-Face Time

When using the code 0359T or 0360T/0361T for the assessment, can the BCBA continue writing her findings after the patient has left or does it need to be completely face-to-face?

Documentation for face-to-face codes, in order to count as a component of total times, needs to be completed face-to-face with the patient present. Documentation completed after the visit is not included in a code.

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Most of the codes according to the AMA requires face-to-face with the patient and almost all of these codes requires lots and lots of documentation time. Is it OK to claim the documentation time using these codes even if the patient is no longer with them as long they started the services by treating the patient face-to-face? In other words, can a QHCP bill for time spent writing up the assessment while not on site? If so, what code would they use?

No. The QHCP cannot bill separately for time spent writing up the assessment. Rather, report writing and other indirect time should be captured in the assessment codes (i.e., billing for the assessment should include actual time spent with the patient and the indirect activities). The assessment is part of the work for the code. CPT codes include pre-service work, intra-service (face-to-face) time, and post-service work, which includes the write-up of the assessment. In summary, the code is measured based on face-to-face time, but the non-face-to-face time is considered part of the work of the code and the reimbursement. In other words, the face-to-face time is considered a more reliable measure, and is used as a proxy for the total time provided for the service. (One possible implication for ABA therapists is that more of the documentation will need to be done while the patient is present, as observed that most physicians document on their computers with the patient present.)

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Counting ABA Technician Time

When a patient gets direct care twice a day via different ABA technicians should each of them claim 0364T for their first 30 minutes of services, or should only one of them claim 0364T and the next ABA technician claim 0365T for their first 30 minutes?

The activity of the first technician should be reported with 0364T; technician activity for the rest of the day is reported with 0365T. If two technicians work with the same child on the same day, but at different times (e.g., one from 9:00 am to 11:30 am and the other from 1:00 pm to 3:30 pm), report the first 30 minutes of the first technicians time with the 0364T (1 unit of 0364T). Report each additional 30 minutes of each technician's time using the 0365T code (e.g., 9 units of 0365T). If two tecnicians are with one patient at the same time (e.g., both with the patient from 10:00 am to 12:00 pm), you report it the same as if just one technician were present (e.g., 1 unit of 0364T plus 3 units of 0365T).

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For exposure behavioral assessment codes 0362T and 0363T, can both the QHCP and the technician bill for that time?

The exposure assessment codes, 0362T and 0363T include both the QHCP's time and the time of multiple technicians. One code (0362T) is submitted for the entire behavioral team (QHCP and technicians) for the first 30 minutes and the other code is submitted for the entire behavioral team (QHCP and technicians) for each additional 30 minutes. In other words, technicians cannot bill insurers directly. Claims are submitted by the QHCP.

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ABA Supervision of Technicians

There is no code for supervision, but it is required (approximately 1 hour per 10 hours of direct care by the technician), so how will the QHCP get paid for it?

There is no separate code for supervision, but supervision is part of and considered an essential activity of all the technician codes. The bill for technician time is meant to include reimbursement for total time, including supervision, even though only the technician time is measured. (The codes should be selected, however, based strictly on face-to-face technician time.)

The issue of supervision was a difficult one for the ABA workgroup because BCBAs use the term "supervision" somewhat differently than other disciplines. The CPT Editorial Panel regards supervision as primarily a human resource function (e.g., providing performance feedback, resolving employee conflicts, approving vacation, annual evaluations).

The CPT Editorial Panel regards these activities as part of one's practice expense, and as such, it does not publish codes that would allow professionals to bill for this activity as a separate and distinct health procedure.

We worked with the ABA workgroup to educate them on activities professional behavior analysts do when providing clinical supervision to ABA technicians that are well beyond human resource functions, such as procedural-integrity checks and modifying and modeling modifications to a treatment protocol that has not produced the desired outcomes. The committee agreed that these types of activities were separate from human-resource supervision and a code was created to cover these activities called *adaptive behavior treatment with protocol modification 0368T and 0369T*. The 0368T code is billed for the first 30 minutes of an encounter and 0369T is billed for each additional 30 minutes. The QHCP must have face-to-face contact with the patient to bill using these codes.

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Adaptive Behavior Treatment With Protocol Modification (0368T, 0369T)

What code would be used for BCBA supervision of technician?

When the QHCP is directing the activities of the technician in person (face-to-face contact with the patient) for purposes such as checking procedural integrity and problem solving and modifying a treatment protocol that is not effective, the QHCP would bill for this time using the adaptive behavior treatment with protocol modification code (0368T for the first 30 minutes and 0369T for each additional 30 minutes). The QHCP cannot submit this code and the code for the technician's time simultaneously (e.g., cannot submit a 0368T and a 0364T or 0365T for the same time period). There is no separate code for BCBA supervision of a technician or technician(s) without the patient present. This type of supervision is included in the codes used to bill according to the technician's time, and is typically considered to be 10–15 minutes of the QHCP for each hour that the technician has face-to-face contact with the patient.

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Are the codes 0368T/0369T supposed to be used for supervision of a technician when the patient is present, and can the BCBA report these codes at the same time a technician is reporting 0364T/0365T? If not, is there another code set that accounts for supervision?

No provider is able to report multiple CPT codes accounting for the same time. This would be component coding, which is prohibited according to a long-time standing CPT convention.

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Team Meetings

There is no code for team meetings, but it is practically required, so how will the QHCP and ABA technicians get paid for it?

Team meetings (must include multiple disciplines, defined by CPT as an interdisciplinary team of health care professionals) are reported with the team meeting codes in the evaluation and management section of CPT 2014 (CPT 99366-99368). Meetings with just parents are reported with the parent guidance code, 0370T Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present).

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Miscellaneous

According to the AMA, observational behavioral follow-up assessments (0360T and 0361T) is to be done by an ABA technician, do you know if that is acceptable in New York in accordance to the rules imposed in Article 167?

Code 0359T is untimed (e.g. no units). How long can one spend on this? Horizon is providing a standard 8 hours for this code and it is unclear how Aetna or United are handling 0359T. Also, the code is described as "face-to-face," but office time is required to write the assessment report and the treatment plan. Is the BCBA allowed to bill under this code for the report writing and treatment planning, which are required of the initial assessment?

The CPT Editorial Panel prefers untimed codes whenever possible. The estimated length of time this assessment should take is approximately 90 minutes of face-to-face time with the professional behavior analyst (usually a BCBA or a licensed psychologist with expertise in behavior analysis). Some cases will require more time, some will require less. Office time for developing the treatment plan and writing the report should be included in the cost as a “practice expense.”

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Aetna will require billing with modifiers for each code (1 modifier for BCBA, 1 for BCaBA, and 1 for direct instructors), which brings the total number of possible code options to 48. Is there any way to streamline this moving forward?

The codes were developed such that all codes are billed under the professional behavior analyst. Each code specifies whether the face-to-face interaction with the patient is done by the professional behavior

analyst or by a technician. Even when the technician is delivering discrete trial training, it is billed under the professional behavior analyst. The technician's time is considered part of the professional behavior analysts: practice expenses." Thus, the modifiers required by Aetna are somewhat redundant (except, perhaps, for the distinction between a BCBA and a BCaBA).

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A big concern for insurance companies in states where insurance reimbursement is new (e.g., Arkansas) is that there is no longer a $50,000/year cap. Some groups are demanding that insurance companies reimburse at extreme rates. Is there a recommended value for rates in these instances?

Specific relative values that insurers use to convert to dollar amounts are not set for these tracking codes and ABAI cannot recommend rates. This is to avoid violating the Stark laws—that is, of price fixing—by in any way implying that specific dollar amounts are already recommended for these codes. ABA practitioners should not file reimbursement claims using these tracking codes until they are assured that insurance companies with which they work have appropriate coverage in place for the codes. These are temporary (up to 5 years) CPT Category III codes and, as such, will have no nationally recognized relative values across all parts of the country until they are converted into permanent CPT Category I codes. For the time being each insurance company negotiates a reimbursement rate by geographic region.

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These adaptive behavior codes are Category III. What is the difference between Category III and Category I codes?

CPT Category III codes are temporary (up to 5 years) tracking codes and used to track claims processed looking for widespread usage. The AMA CPT Guide states: The use of these codes "allow physicians and other qualified health care professionals, insurers, health services researchers and health policy experts to identify emerging technology, services and procedures for clinical efficacy, utilization and outcomes." CPT Category III codes replace using CPT Category I unlisted codes. CPT Category I codes require that the service/procedure be performed by many health care professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received.

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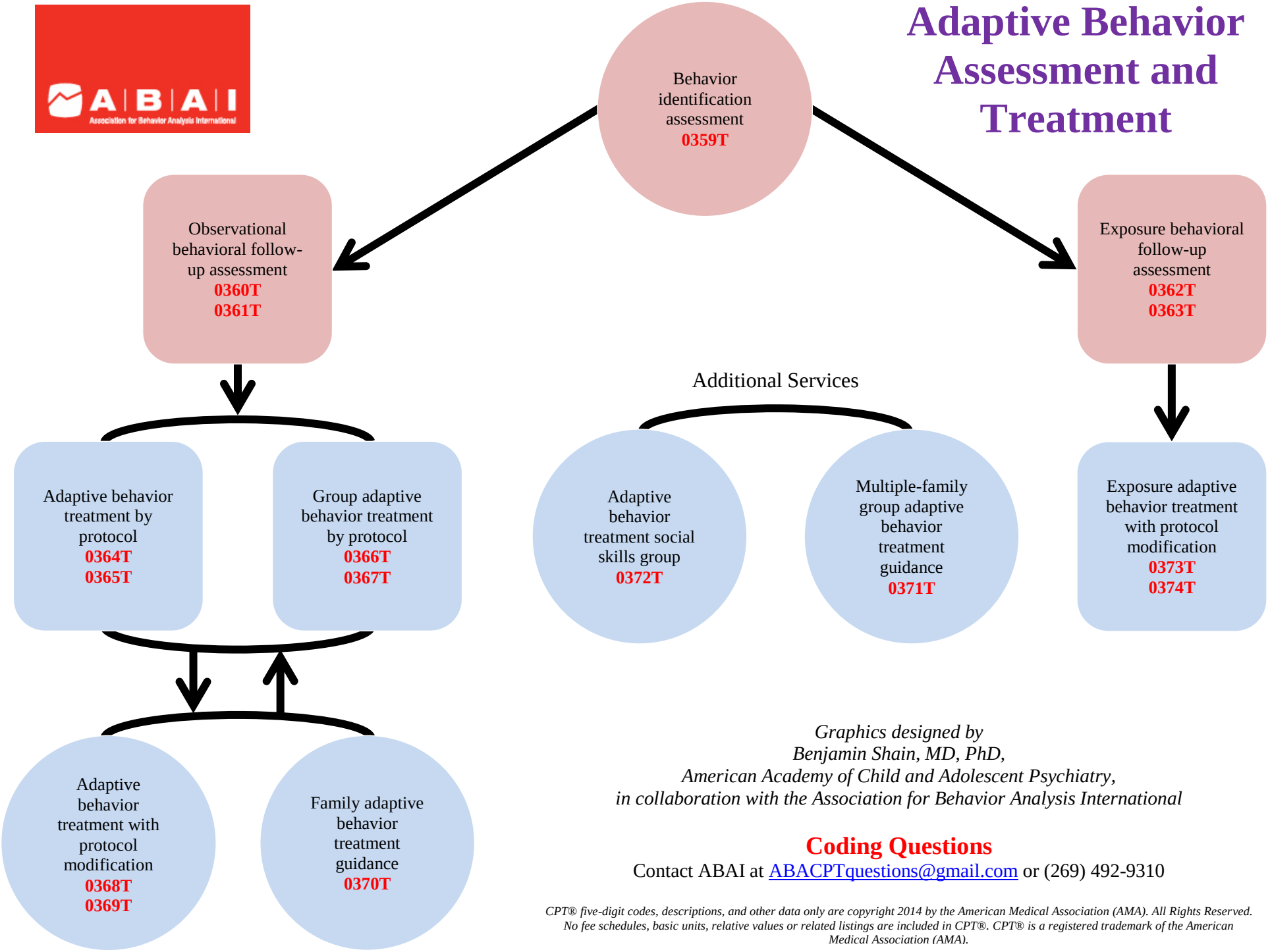
How should intensive treatment provided and supervised by Early Start Denver Model (ESDM) certified professionals be handled under the new codes?

The workgroup that developed the newly approved codes looked at around twenty controlled studies (5-6 were random assignment) that were based substantially on ABA principles. One of these random assignment studies was a longitudinal ESDM study: Pivotal response training was combined with Rogers' original Denver Early Start developmental techniques, yielding significant improvements. To the extent that effective behavioral intervention strategies are reliably combined with developmental approaches and are delivered at sufficient intensity, there is no reason it should not be considered an approved therapy. As with all practices, ongoing outcome monitoring should continue to demonstrate not only changes in norm referenced test scores, but functional social and communication skills required for the child's everyday life.

Adaptive Behavior Assessment and Treatment



Graphics designed by
Benjamin Shain, MD, PhD,
American Academy of Child and Adolescent Psychiatry,
in collaboration with the Association for Behavior Analysis International

Coding Questions

Contact ABAI at ABACPTquestions@gmail.com or (269) 492-9310

A | B | A | I

Association for Behavior Analysis International

Behavior Analysis CPT Code Workshop

Travis Thompson, PhD, LP
ABAI Council of Representatives

Success in Proposing New Codes Requires

- Understand the process
- Know what you're talking about
- Every seat at the table has a vested interest, mostly not supporting your proposed code
- Lining up supporters outside your field
- Persistence and more persistence…***and more persistence***.

"If you can't describe what you're doing as a process, then you don't know what you're doing."

W. Edwards Demming

What is CPT?

- **CPT= Current Procedural Terminology**

- The Health Care Finance Administration (now CMS) chose the **Current Procedural Terminology (CPT)** codes that had been developed by CPT Editorial Board of the American Medical Association for billing by ALL medical practitioners and health care providers… ***ALL***

Standard Medical Billing Mechanism

- Prior to use of CPT Codes there was no standard method of medical billing
- CPT Codes provided that mechanism mandated by Congress
- Its not just about money for practitioners

- ***NO CPT CODE MEANS A GIVEN SERVICE IS NOT LIKELY TO BE AVAILABLE TO PATIENTS (CLIENTS)***

What Does a CPT Code Accor

- American Medical Association recognizes the procedure is supported by scientific evidence.
- A mechanism by which practitioners who use that procedure can get paid for their service

- It *DOES NOT* guarantee insurers will pay for the service, but it guarantees that if they deny payment they must have a strong rationale. Denying payment invites law suits.

Types of CPT Codes

- I. Standard, established widely recognized medical procedures are usually be reimbursed, though some insurers will not pay for all procedures

- II. Codes that are mainly for epidemiological record keeping and are not reimbursed.

- III. New codes which are a step away from becoming Type I Codes. Reimbursement must be negotiated with payers. There are no common national rates.

New ABA CPT Codes…

- To be Are Type III Codes, that will become Type I codes within five years (*or eliminated*)

- Will allow for collecting data on how widely each code is used and used to establish the likely projected long term reimbursement rates

How Much Reimbursement?

- **Reimbursement values for each CPT code**, are assigned based on interpretation of Congressional mandates. Congress authorized development of **The Resource-based Relative-value Scale (RBRVS)** (Hsiao, 1987). (*We will Discuss Later*)

How New CPT Codes Are Created

- **Three step process:**
  - A **Work Group** representing various professional societies interested in the area in question propose codes for services not previously covered. Some new codes are initiative by individual practitioner groups.
  - The **CPT Editorial Panel** Reviews the recommendations and approves, disapproves or delays action
  - The **Relative Value Scale Update Committee (RUC)** recommends relative reimbursement rates, which are then assigned by the Center for Medicaid Services *[This only occurs when new codes become Level I codes]*

Thanks to…

Support from the American Academy of Child and Adolescent Psychiatry

In particular Dr. Ben Shain (Chicago) and Dr. David Berland (St.Louis), the ABAI garnered the essential support necessary to move forward with the proposed codes.

Work Group Process

- Met by phone conference call every 3 weeks for 2 hours each for 18 months

- Held 4 face to face meetings twice per year to recommend:
  - Should new codes be created?
  - What should be covered?
  - Service delivered by whom?
  - Precise wording of each recommended code.

OUTCOME

- **Three Assessment CPT Codes** were recommended and approved

- **Seven Treatment CPT Codes** were recommended and approved

CPT Ground Rules

- Within the language of the codes, **they cannot** specify a specific degree, certificate, license or training required to use a code (i.e. MD, PhD, BCBA or LP)

- Codes specify that a **Qualified Health Care Professional** in a given state may employ the code… it is usually up to states to define a QHCP in each jurisdiction.

Codes ***CANNOT…***

- Specify the discipline that can use a procedure, e.g. behavior analysts vs. occupational therapists vs licensed psychologists. That means some unqualified people are likely to claim to be able to use “our” codes. Have to work with insurers to stop this.

- Specify a given diagnosis for which that procedure is appropriate… e.g. only autism, not ADHD

No Jargon

- As much as possible, **technical jargon used by specific disciplines may not be used**, unless it is broadly accepted by the medical community

- As a result, none of the standard behavior analysis terminology will be found in of the approved codes (e.g. reinforcement schedule, extinction, fading, etc).

ABAI
Association for Behavior Analysis International

APPROVED

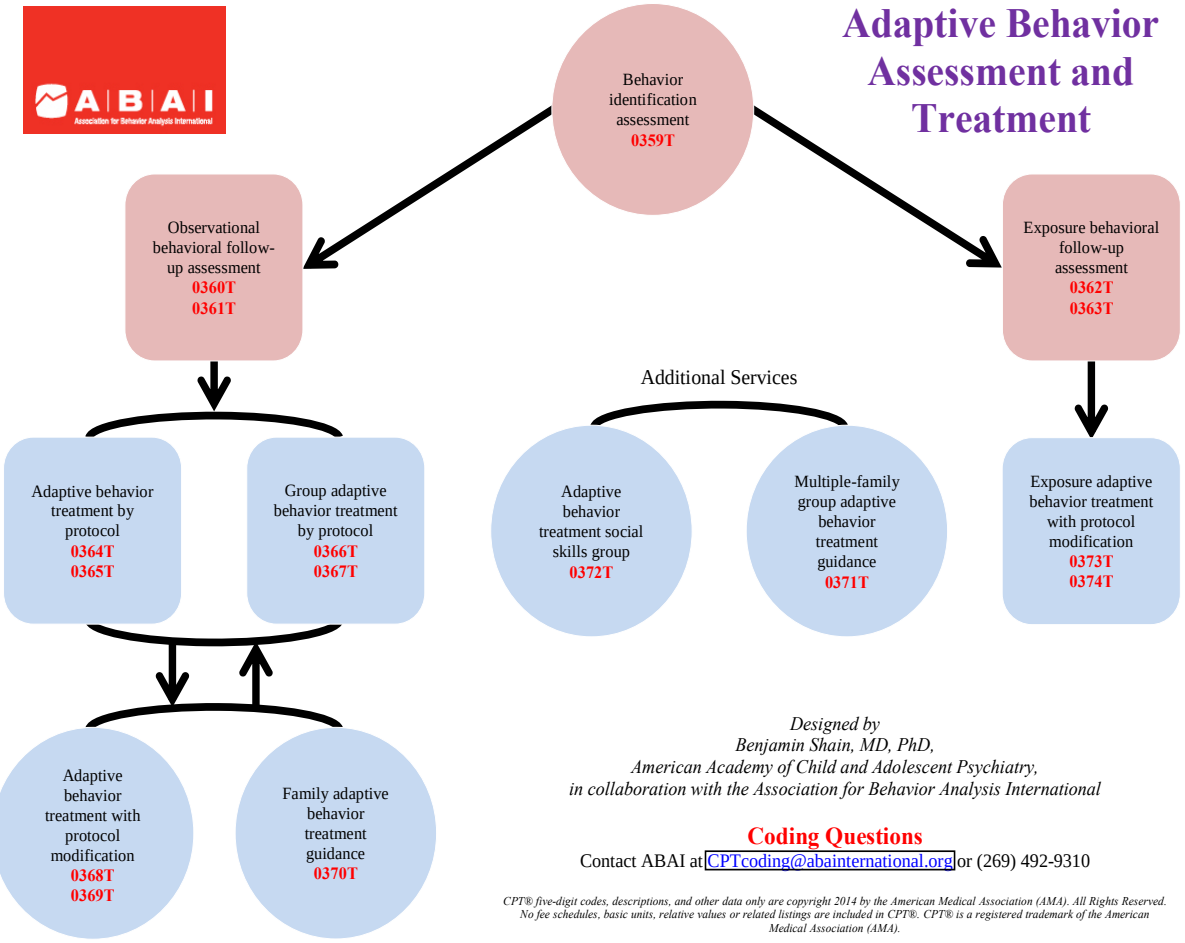
Behavior Analysis Adaptive Behaivor Assessment and Treatment CPT Codes

From the CPT Assistant Manual

- "**Billing Professional (QHCP):** Any physician or other qualified health care professional (QHCP) with expertise in adaptive behavior treatment, typically a behavior analyst or licensed psychologist."

- "**Assistant ("technician"):** An assistant behavior analyst or trained technician who delivers services under the direction of the QHCP. **The technician does not bill services**"

Adaptive Behavior Codes: Assessment & Treatment



ABA Assessment & Treatment Codes

- **Adaptive Behavior Codes**
  - Comprehensive Early Behavioral Intervention
  - Individualized Interventions for less severe Challenging Behavior in Natural Environments that incorporate promoting adaptive skills
- **Exposure Codes**
  - Clinical Functional Behavior Analysis Interventions (Iwata, Wacker) in an isolated setting such as an enclosed protective treatment room within a clinic or hospital
  - Functional Behavioral Analysis Interventions (Iwata, Wacker) but in a less controlled non-clinical setting such as a licensed day program or residential center.
  -

Assessment Codes

Code	Service	Administers
0359T	Behavior identification assessment	QHCP
0360T 0361T	Observational behavioral follow-up assessment	Technician
0362T 0363T	Exposure behavioral follow-up assessment	Technicians

Treatment Codes

0364T **0365T**	Adaptive behavior treatment by protocol	Technician
0366T **0367T**	Group adaptive behavior treatment by protocol	Technician
0368T **0369T**	Adaptive behavior treatment with protocol modification	QHCP
0370T	Family adaptive behavior treatment guidance	QHCP
0371T	Multiple-family group adaptive behavior treatment guidance	QHCP
0372T	Adaptive behavior treatment social skills group	QHCP
0373T **0374T**	Exposure adaptive behavior treatment with protocol modification	Technicians

Who Submits Reimbursement Requests

- **QHCP submits all reimbursement requests** on behalf of:
  - Her or himself…i.e. their own professional time
  - Technician…i.e. the time the Technician spends face to face working with patient/client

In CPT terminology…

Reporting means submitting a CPT code representing a specific procedure completed, to the payer for reimbursement

Codes may be ***Untimed*** (no specific amount of time involved) or ***Timed*** **(in minutes)**

Examples of Untimed Codes

- **0359T: Behavior Identification Assessment**, QHCP conducts intake review of documents, interview with parents (e.g. history, current status) and initial child observation (e.g. in a clinic)
- **0372T: Family Adaptive Behavior Guidance**: QHCP discusses with parents face to face how an intervention is to be implemented

Examples of timed Codes

- **0360T: Observational Behavioral Followup Assesment**: Technician obtains real-time observation samples of child behavior in natural environment
- **0364T: Adaptive Behavior Treatment by Protocol:** Technician implements behavioral intervention plan developed by QHCP in consultation with family

CPT Code Time Reporting

to assist in code selection.

Codes 0360T-0367T

Face-to-Face Technician Time	Report
Less than 16 min	Not reportable
16-45 min	0360T
	0362T
	0364T
	0366T
46-75 min	0360T and 0361T x 1
	0362T and 0363T x 1
	0364T and 0365T x 1
	0366T and 0367T x 1
76-105 min	0360T and 0361T x 2
	0362T and 0363T x 2
	0364T and 0365T x 2

Directions

1. Select the service (see American Medical Association CPT code descriptions)
2. Report an untimed service (codes 0359T, 0370T-0372T) with 1 code regardless of the duration of the service
3. Report a timed service (codes 0360T-0369T, 0373T, 0374T) based on face-to-face time on the date of service (see charts on this page)
4. The timed codes are all paired, with the first 30 (16-45) or 60 (31-75) minutes of service reported with the first code and successive 30 minute increments on the same date reported with the second code

Example

Adaptive behavior treatment by protocol (codes

See Your Handouts

CPT Code Time Reporting

Assessment	0359T	assessment	QHCP	Untimed; typically 90		guardian(s)/ caregiver(s)	0360T, 0361T or 0362T, 0363T
	0360T 0361T	Observational behavioral follow-up assessment	Technician	First 30: Each additional 30:	0360T 0361T	Patient	
	0362T 0363T	Exposure behavioral follow-up assessment	Technician	First 30: Each additional 30:	0362T 0363T	Patient	QHCP onsite direction
Treatment	0364T 0365T	Adaptive behavior treatment by protocol	Technician	First 30: Each additional 30:	0364T 0365T	Patient	
	0366T 0367T	Group adaptive behavior treatment by protocol	Technician	First 30: Each additional 30:	0366T 0367T	Patients	Maximum 8 patients
	0368T 0369T	Adaptive behavior treatment with protocol modification	QHCP	First 30: Each additional 30:	0368T 0369T	Patient	May include protocol demonstration to technician(s), guardian(s), caregiver(s) with patient present
	0370T	Family adaptive behavior treatment guidance	QHCP	Untimed; typically 60-75		Guardian(s)/ caregiver(s)	Patient not present
	0371T	Multiple-family group adaptive behavior treatment guidance	QHCP	Untimed; typically 90-105		Guardians/ caregivers	Guardians/caregivers of maximum 8 patients; patients not present
	0372T	Adaptive behavior treatment social skills group	QHCP	Untimed; typically 90-105		Patients	Maximum 8 patients
	0373T	Exposure adaptive behavior		First 60:	0373T		QHCP onsite

Case Example and Discussion of Code Assignments

Early Intensive Behavioral Intervention Client/Patient

- 3 yr old female previously diagnosed with Autism by LP using ADOS and valid intellectual, speech and ability assessments

QHCP Evaluation

0359T Behavior identification assessment (Face to Face QHCP)

[untimed]

- Review psych testing and pediatrics report
- Interview mother, get history, and current complaints
- Observe child to validate DSM diagnosis
- Complete Functional Assessment Checklist
- Discuss the nature of EIBI intervention with mother and answer questions
- Establish tentative therapy schedule and set up first home appointment.

Technician Observational Assessment

- **0360T Observational behavioral follow-up assessment. Session1 (Face to Face Technician)**

[*Time 30 minutes Plus 0362T for each additional 30 minues*]

- Observation with mother & child in their home
- Establish Rapport with Child
- Discuss ABLLS with mother
- Observe child with probe ABLLS items

Technician Observational Assessment

- **0360T Observational behavioral follow-up assessment. Sessions 2 & 3 (Face to Face Technician)**
- ***[Timed first 30 minutes* plus 0361T**

  for each additional 30 minutes]

- Conduct ABLLS assessment (Sessions 2 & 3 Scales A-F)
- (Sessions 4 & 5 Scales G-L)

- **0364T & 0365T Adaptive behavior treatment by protocol**.
- [Face to Face Technician 106-135 minutes]
- 1 unit of 0364T and 3 units of 0365T.

- Conduct individual 1 to 1 therapy with the child beginning with basic skills and building more complex skills according to data. Summarize data at the end of each session and record progress notes.

Case Example 2 and Discussion of Code Assignments

Example 2: Focused intervention for Mild/Moderate challenging behavior

- 9 year old male with ADHD and high functioning autism. Presenting with periodic impulsive aggressive outbursts. Referred for ***Functional Assessment Based Treatment.***

QHCP Evaluation

0359T Behavior identification assessment (Face to Face QHCP)

[untimed]

- Review psych testing and pediatrics report
- Interview mother, get history, and current complaints
- Observe child to validate DSM diagnosis
- Complete Functional Behvioral Assessment Checklist
- Discuss initial impression of the nature of the behavior challenge
- Establish tentative therapy schedule and set up first home appointment.

- **0360T Observational behavioral follow-up assessment. Session1 (Face to Face Technician)**

[***Timed 45 minutes***]

- Observational interview with mother & child in treatment center
- Establish Rapport with Child
- Review Child Interests
- Complete Reinforcer Checklist
- Instruct caregiver on Touchette Scatter Plot to complete
- Discuss priorities with parent

Example 2: Focused behavioral challenge in natural setting

- **0360T Observational behavioral follow-up assessment. Session1 (Face to Face Technician)**

[*Timed 45 minutes*]

THIS IS ACTUALLY QHCP WORK

- Review Scatter plot data, identify problem areas
- Explain and instruct parent how to complete ABC assessment form
- Begin working with child on goal setting
- Progress notes

Focused Behavioral Challenge

- 0370T Family Adaptive Behavior Guidance [QHCP child not present]

- Review and interpret all assessment findings
- Establish intervention protocol; specific activities and times daily
- Review intervention materials with caregiver
- Review forms for progress tracking

Case Example 3 and Discussion of Code Assignments

Severe Self Injury: Exposure Assessment and Treatment

- 19 year old male with severe Autism and severe intellectual disability and extreme self injury. Previously evaluated by pediatric neurologist and LP.

QHCP Evaluation

0359T Behavior identification assessment (Face to Face QHCP)

[untimed]

- Review psych and neurology testing and pediatrics report
- Interview mother, get history, and current complaints
- Observe youth to validate DSM diagnosis
- Complete Functional Behavioral Assessment Checklist
- Discuss initial impression of the nature of the behavior challenge
- Establish daily Exposure Assessment Schedule

- 0362T & 0363T Exposure Behavior Follow Up Assessment
- Billed as Technician Time but supervised directly by QHCP

- Patient (client) is seen in an enclosed room, padded with minimum of two technicians.
- Clinical Functional Behavioral Analysis conducted systematically to assess functions of self-injurious behavior and probable alternative adaptive replacement behavior.

Severe Self Injurious Behavior

- 0373T and 0374T Exposure adaptive behavior with protocol modification
- Billed as Technician Time in 60 minute; 0374T in subsequent intervals

- QHCP reviews data after each FBA assessment and determines probable functions of SIB and likely alterantive behavior;
- QHCP directs Technicians in implementing function-based behavioral interventions including replacing SIB with alternative behavior serving the same function.

Other Adaptive Behavior Treatments

- 0371T Multiple-family group adaptive behavior treatment guidance
- QHCP Time

- QHCP reviews weekly child progress with parents and has parents identify ways of working on same problems at home; QHCP guides problem solving and trouble shooting common problems across families

Other Adaptive Behavior Treatments:

- 0372T Adaptive behavior social skills group
- QHCP led

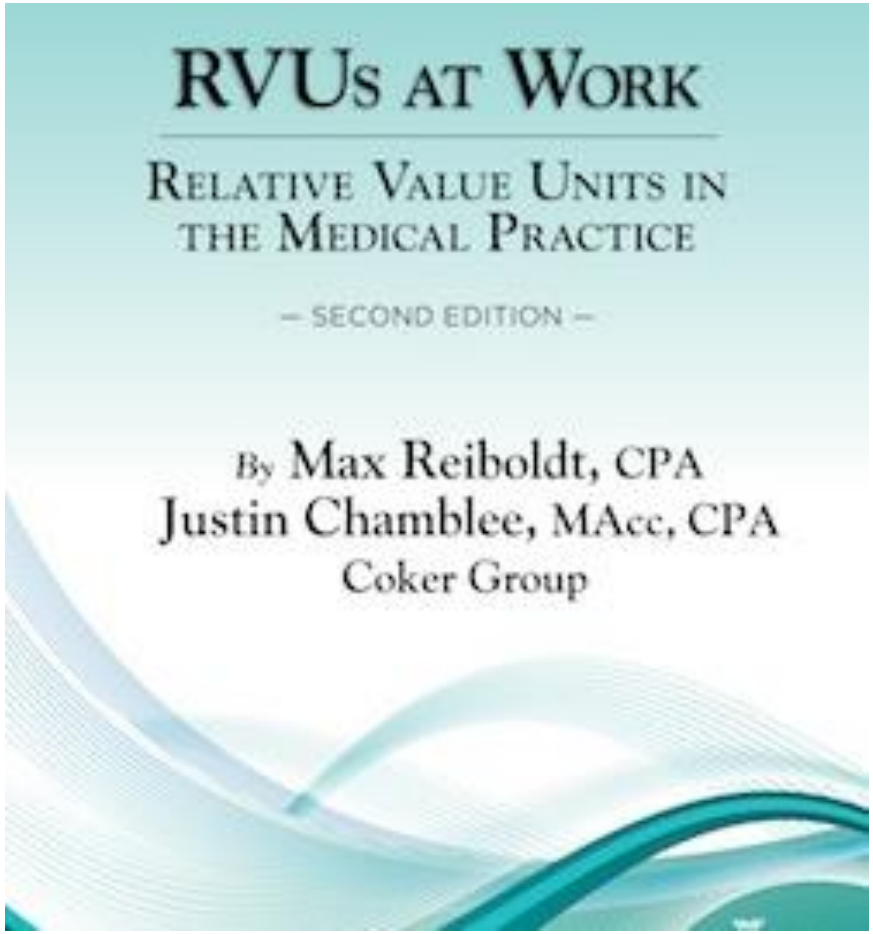
- QHCP works with a group of children either in a center based program or at a clinic
- Focus on teaching communication and social skills for children needing such assistance

How Much Reimbursement?

- At present reimbursement rates must continue to be negotiated with individual payers…
- Over the next three years we will apply to convert these codes into Level I codes which will involve a survey of utilitization patterns and costs.

Reimbursement Rates…

At that point, Relative Value Amounts will be established for Each ABA Code



Special Thanks to….

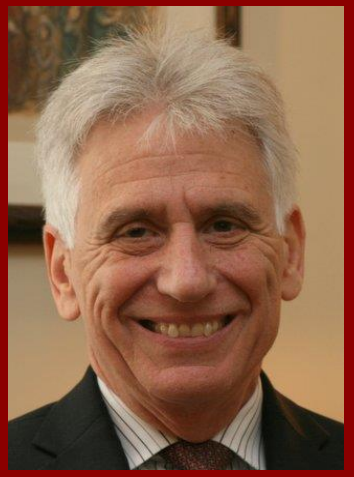
Benjamin Shain, MD, PhD

with the support of

David Berland, MD

American Academy of
Child & Adolescent Psychiatry

B. Shain



D. Berland

Thanks as well to…

The Assn for Behavior Analysis International Executive Council and

Dr. Maria Malott, CEO, ABAI

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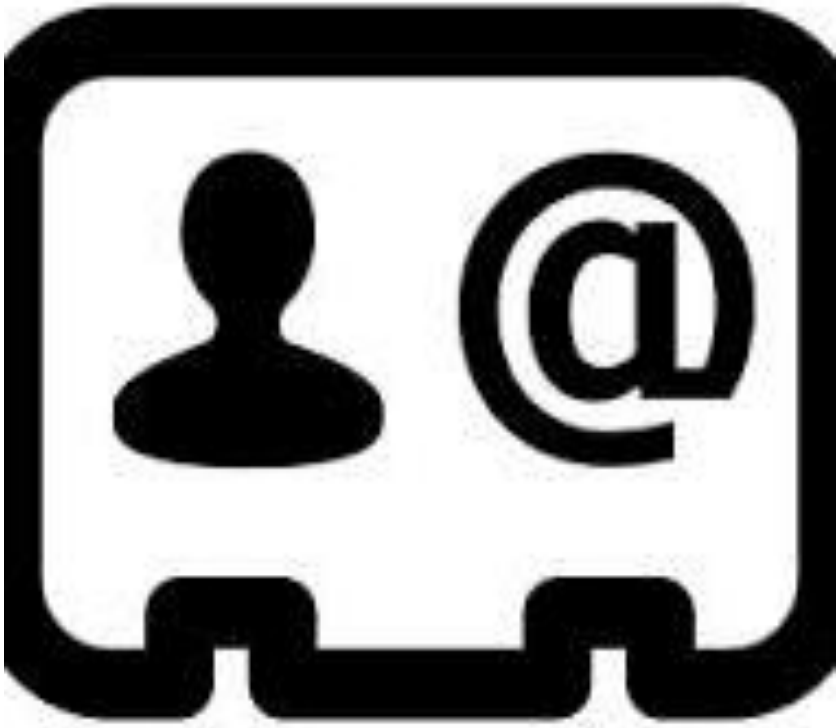


A | B | A | I

Association for Behavior Analysis International

Behavior Analysis CPT Code Workshop

Wayne Fisher, Ph.D., BCBA-D
ABAI Practice Board

QHCP Evaluation

0359T Behavior identification assessment (Face to Face QHCP)

[untimed]

- Review psych testing and pediatrics report
- Interview mother, get history, and current complaints
- Observe child to validate DSM diagnosis
- Complete Functional Assessment Checklist
- Discuss the nature of EIBI intervention with mother and answer questions
- Establish tentative therapy schedule and set up first home appointment.

0359T: Components of a Behavior Identification Assessment

- Imitation skills
- Listener or receptive skills
- Language production or expressive skills
- Compliance
- Nonverbal communication (e.g.,eye-contact, joint attention)
- Play (e.g., functional, imaginative)
- Social skills

Structure Observations

Imitation			
Object			
Task objective	**Administration**	**Probes (Appendix 11)**	**Criteria**
D1: Upon request, student will imitate a motor activity with an object	Randomly select 5 probes for pre-test and 5 different probes for post-test	Randomly select 5 for pre-test and 5 for post-test Tap drum with a stick Rub stick on table Wave stick up and down Wave stick side-to-side Stack a block on another block Tap block on a table Push block with a finger Put a block in a cup Place block on a book Draw a line with a pencil Roll the pencil Put pencil in cup Roll the pencil Draw a line with a pencil	Raw Score % Correct

0359T: Components of a Behavior Identification Assessment (cont.)

- Repetitive behavior
- Insistence on sameness
- Unusual reactions to sensory input
- Feeding difficulties
- Sleep difficulties
- Aggression, elopement, property destruction, self-injury, pica

0359T: Disposition of a Behavior Identification Assessment (cont.)

- Appropriate type of service-observation assessment, exposure assessment, begin focused treatment or parent training
- Appropriate level or intensity of service-EIBI, outpatient, intensive outpatient, day treatment, inpatient

- 0362T & 0363T Exposure Behavior Follow Up Assessment
- Billed as Technician Time but supervised directly by QHCP

- Patient (client) is seen in an enclosed room, padded with minimum of two technicians.
- Clinical Functional Behavioral Analysis conducted systematically to assess functions of self-injurious behavior and probable alternative adaptive replacement behavior.

Severe Self Injurious Behavior

- 0373T and 0374T Exposure adaptive behavior with protocol modification
- Billed as Technician Time in 60 minute; 0374T in subsequent intervals

- QHCP reviews data after each FBA assessment and determines probable functions of SIB and likely alterantive behavior;
- QHCP directs Technicians in implementing function-based behavioral interventions including replacing SIB with alternative behavior serving the same function.

Budget Planning (Costs)

Severe Behavior Day Treatment Costs		W/O Medical
Team of 2.5 Bachelor's/Master's Therapists	$84.85	$84.85
Ph.D. Supervisor (25%)	$20.61	$20.61
Postdoctoral Fellow (25%)	$9.70	$9.70
Developmental Pediatrician (5%)	$6.79	
Nursing (10%)	$3.79	
Receptionist (12.5%)	$4.24	$4.24
Insurance Authorization Liaison (25%)	$9.70	$9.70
Supplies	$13.00	$13.00
Total Directs	$152.66	$142.09
Overhead	$30.53	$28.42
Total Hourly Costs	$183.20	$170.51
Total Daily Costs @ 6 hours/day	$1,099.18	$1,023.03

Specialized Space

(a)

(b)

(c)

Problem behavior is quantified and measured precisely

It is Important to Hire Employees Who are Good Actors and Love Their Work

ABAI
Association for Behavior Analysis International

Getting authorization for Exposure Assessment and/or Tx

- Verify insurance benefits for recommended service (e.g., day Tx)
- Obtain letter of support from referring physician indicating medical necessity
- Rule-out alternative, in-network providers
- Keep family informed and have them request a case manager and then work with that individual

Getting authorization for Exposure Assessment and/or Tx (cont.)

- Review evaluation and medical history
- Document previous services that have not been effective
- Document all contacts with the family, the insurance company, and other providers
- Prepare and submit a pre-determination letter

Pre-Determination Letter

- Requesting ad-hoc in-network approval – due to unique nature of the program it should be covered in-network
- Always include codes in header request
- Include brief description of program
- Include the letter of support documenting medical necessity from the referring M.D.
- Call case manager after a few days to verify that the letter was received

Pre-Determination (Continued)

- Call case manager or customer service at least weekly to check status
- Be prepared to verify fax, resend entire request, and be on hold for long periods of time
- Be polite, pleasant, but determined (don't let your frustration show through)

Status

- Denied - Start appeal process
  - Get in Writing (reason for denial)
  - Never take “No” for an answer
- Authorized – Initiate “Letter of Agreement”
- Notify family
- Remember – Nothing set in stone until we receive written authorization

Approval

- Never begin an admission on a verbal approval
- Verbal approval is ½ the battle – Notify family and feeding team of status
- Determine what is approved: What CPT code, what billing code, how many days, and was it approved in-network
- Notify insurance that you would like work out a rate agreement

Rate Negotiation

- Day Treatment Per Diem $1400.00 (per day)
- Insurance Liaison Supervisor can authorize discounts up to 20% ($1,120)
- Fees are always billed at the $1400.00 rate but the LOA is attached so the bill can be processed correctly

Predetermination Letter

- Attn: Predetermination/Claims
- Re: Fredrick B. Skinner
- DOB: 2/7/4
- Policy #: W111111112
- Diagnoses:
  - 312.34 Intermittent Explosive Disorder with severe aggression
  - 307.30 Stereotypic movement disorder with severe self-injury

Predetermination Letter (cont.)

- Request: Ad hoc in network approval for F.B. Skinner to receive services through the Severe Behavior Program.
- Rationale:There are no in-network programs or facilities that can offer this level of care for him. We would like to begin intensive treatment as soon as possible.
- CPT Codes: 0362T, 0363T, 0373T, 0374T
- GAF = 50

Predetermination Letter (cont.)

- Dear Reviewer:
- Summary of activities that led to this request
- Clinical information
- Psychosocial Impact of the Behavior Disorder
- Our approach to severe behavior disorders
  - 90% or greater reduction in severe behavior in 84% of cases
  - Behavior therapy team consisting of a Ph.D. psychologist and board certified behavior analyst who oversees a highly trained team of master's- and bachelor- level therapists

Other Adaptive Behavior Treatments

- 0371T Multiple-family group adaptive behavior treatment guidance
- QHCP Time

- QHCP reviews weekly child progress with parents and has parents identify ways of working on same problems at home; QHCP guides problem solving and trouble shooting common problems across families

Other Adaptive Behavior Treatments:

- 0372T Adaptive behavior social skills group
- QHCP led

- QHCP works with a group of children either in a center based program or at a clinic
- Focus on teaching communication and social skills for children needing such assistance

Adaptive Behavior Assessments and Treatment Descriptors for July 1, 2014 Reporting

Current Procedural Terminology (CPT®) Category III Adaptive Behavior Assessment and Treatment codes and guidelines were published on the AMA CPT Web site at www.ama-assn.org/go/cpt (see Related Link-Category III codes) in January and March 2014, for implementation on July 1, 2014, and for inclusion in the CPT® 2015 code set. The Category III codes are a set of temporary codes that provide a uniform mechanism for reporting emerging technology services and procedures and facilitate data tracking and utilization.

The Category III codes for adaptive behavior assessment and treatment are applicable to patients of any age with autism spectrum disorders (ASDs) or other diagnoses or conditions (eg, developmental disabilities, head trauma) associated with deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication, destructive behaviors, or additional functional limitations secondary to maladaptive behaviors). These codes were developed by a CPT Editorial Panel workgroup consisting of members representing psychiatry, psychology, speech-language and hearing, clinical social workers, neurology, occupational therapy, behavioral analysts, pediatrics, and payers.

While the adaptive behavior assessment and treatment Category III codes may be used by any physician or other qualified health care professional (licensed and/or credentialed professional), the majority of these services will be delivered by a behavior analyst (advanced degree professional) or licensed psychologist who designs and directs treatment protocols delivered by an assistant behavior analyst or technician(s). Some states require that behavior analysts be certified by the Behavior Analyst Certification Board® (BACB). State laws and government and private health plans determine coverage for these services and who may report and receive these services.

Legislation requiring coverage of autism treatment including applied behavior analysis (ABA) services has been considered or already enacted by most, if not all, states. A uniform mechanism was not available for reporting ABA services as states and insurance companies adopted the use of different codes.-Some states adopted Level II Healthcare Common Procedure Coding System (HCPCS) codes (eg, H2001, H2010, H2011, H2012, H2013, H2014, H2019, H2020), while others allowed the use of Level 1 HCPCS codes (CPT Category I codes) that do not accurately describe behavior analysis treatment services and are not appropriate to report for these services. Examples of such CPT codes are individual psychotherapy [90834]; group psychotherapy [90853]; psychological testing [96101]; development screening [96110]; neurobehavioral status exam [96116]; neuropsychological testing [96118]; health and behavior intervention [96152]; group speech therapy [92508]; and occupational therapy evaluation [97003]. These codes are outside the scope of practice for most of the professionals (eg, behavior analysts) who typically provide ABA services and typically, the elements of these codes are not met when ABA services are rendered. CPT Category I codes should not be used to report adaptive behavior assessment and treatments. However, it is not uncommon for other professionals (eg, psychologists) to use behavior-analytic principles and procedures as components of their overall clinical assessments and interventions, and in such cases, CPT Category I codes may be appropriate.

Occupational therapists (OT); speech language pathologists (SLP); licensed clinical social workers (LCSWs); physical therapists (PTs); psychiatrists; psychologists; and clinical neurologists also provide services to patients with ASD. However, their services are considered separate and distinct from ABA and should be reported separately, as instructed in the exclusionary parentheticals in the new Category III adaptive behavior assessment and treatment codes:

(For psychiatric diagnostic evaluation, see 90791, 90792)

(For speech evaluations, see 92521, 92522, 92523, 92524)

(For occupational therapy evaluation, see 97003, 97004)

(For medical team conference, see 99366, 99367, 99368)

(For health and behavior assessment/intervention, see 96150, 96151, 96152, 96153, 96154, 96155)

(For neurobehavioral status exam, use 96116)

(For neuropsychological testing, use 96118)

Workgroup's Guiding Principles for Code Development

The CPT Editorial Panel ABA workgroup applied a list of guiding principles to their development of the assessment and treatment codes, specifically that the codes should (1) not be limited to a specific diagnosis; (2) focus on behavior therapy and not educational services (exception: family and multiple family–group codes [0370T, 0371T] incorporate educational components, and treatment requiring

modified protocols codes [0368T, 0369T, 0373T, 0374T] incorporate demonstration/training of behavior analysis team or caregivers); (3) not be site-specific (the services may be provided in various settings, including home, school, community, clinic, outpatient and inpatient hospital settings); (4) not be age-specific (codes are for both children and adults); (5) differentiate between direction provided on-site (direct) or off-site (indirect); (6) distinguish between activities of the physician and/or qualified health care professional and those of the technician and/or assistant; (7) avoid unnecessary layers of complexity (eg, comprehensive, initial, reassessment); (8) avoid terms that are open to interpretation or defined differently by different specialty groups (eg, functional, probing, in-vivo); (9) avoid overlap with existing codes that have in the past or are presently being inappropriately reported; (10) provide exclusionary cross-references denoting codes used by other professionals who treat the same type of patients (eg, speech language hearing and occupational therapy services); (11) designate codes to be reported by a single provider (although behavior analysis services are often provided by more than one individual [eg, behavioral analyst and technicians], only the physician or other qualified health care professional [eg, behavioral analyst] bills for these services); and (12) adhere to the time concepts already established in the CPT code set (see guidelines on page xv, *CPT 2014 Professional Edition*).

Behavior Identification Assessment (0359T)

Code 0359T is used to report identification of deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication deficits, destructive behaviors, and additional functional limitations secondary to maladaptive behaviors) and development of plan of care. This service includes the following elements (not necessarily in this order), and may be reported only once within a defined period of time (typically, a six-month to one-year interval):

- Conducting a face-to-face observation of patient (patient must be present)
- Obtaining a history of current and past behavioral functioning
- Reviewing previous assessments and health records
- Conducting interviews with guardian/caregiver to further identify and define deficient adaptive or maladaptive behaviors
- Administering standardized and non-standardized tests (eg, Assessment of Basic Language and Learning Skills (ABLLS)
- Interpreting test results
- Determining areas that need to be addressed including development of plan of care, and when warranted, design of instructions for technician(s) to conduct follow-up observation or exposure assessments to study specific adaptive skills and problem behaviors (these assessments are reported separately with codes 0360T, 0361T, 0362T, 0363T)
- Discussing findings and recommendations with the primary guardian(s)/caregiver(s)
- Preparing report

Code 0359T is an untimed code, although the typical face-to-face time with the patient and guardian(s)/caregiver(s) is approximately 90 minutes, and code 0359T is considered a single unit of service regardless of the number of hours or days required to complete the assessment. Code 0359T is reported by a single physician or other qualified health care professional.

●**0359T** Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report

Coding Tip

Reassessment may be reported with the assessment code 0359T. A reassessment is typically required after the success or failure of the current treatment plan necessitating new and/or revised treatment goal(s).

A behavior identification assessment (0359T) may be followed by an observational assessment of behavioral functioning (0360T, 0361T) or exposure behavioral follow-up assessment(s) (0362T, 0363T). Code 0359T may be reported for the assessment required for early intensive behavioral intervention (EIBI).

Behavioral Follow-up Assessments

One of two different types of behavioral follow-up assessments (0360T, 0361T, 0362T, 0363T) may be required to enable the physician or other qualified health care professional to finalize or fine-tune the baseline results and plan of care that were initiated in the behavior identification assessment (0359T).

Codes 0360T and 0361T are used to report follow-up assessments that require patient observation and the presence of one technician directed by physician and/or other qualified health care professional, who may be off-site. Codes 0362T and 0363T are used to report follow-up assessments that are less frequently performed and require manipulation of the patient's environment. Codes 0362T and 0363T are provided by a team of technicians and require direct (on-site) direction by a physician or other qualified health care professional due to the high intensity of the patient's severe destructive behavior(s).

The behavioral follow-up assessment codes (0360T, 0361T, 0362T, 0363T) are structured to enable the face-to-face time of the technician(s) to serve as a proxy for capturing the work of the physician or other qualified health care professional, who provides either off-site direction (0360T, 0361T) or on-site direction (0362T, 0363T). The time that the patient is face-to-face with the technician(s) correlates with the physician's or other qualified health care professional's work, which includes: technician direction; analysis of results of testing and data collection; preparation of report and plan of care; and discussion of findings and recommendations with the primary guardian(s)/caregiver(s). This is similar to the methodology used in valuing the complex chronic care coordination service codes (99487-99489).

The follow-up assessments are services administered on a single calendar day based on 30-minute increments of technician time face-to-face with the patient. Often these assessments must be repeated over multiple days, usually less than one month. See Table 1 for assistance in selecting the appropriate follow-up assessment codes based on the time concepts established in the CPT code set (see guidelines on page xv, *CPT 2014 Professional Edition*).

Table 1. CPT Time–Rule for Face-to-Face Technician Time

Time	CPT code(s)
Less than 16 min	Not reportable
16-45 min	0360T or 0362T
46-75 min	0360T and 0361T or 0362T and 0363T
Each additional increment up to 30 min	Additional 0361T or 0363T

Coding Tip

When more than one technician is present with the patient, codes 0360T, 0361T, 0362T, and 0363T are based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians.

Observational Behavioral Follow-Up Assessment

The observational behavioral follow-up assessment (0360T, 0361T) is designed by the physician or other qualified health care professional to identify and evaluate factors that may impede the expression of adaptive behavior. This assessment utilizes structured observation and/or standardized and nonstandardized tests to determine the levels of adaptive behavior. It also enables the technician to evaluate a patient's social behavior to determine if the patient has a particular set of social skills, as well as the contexts in which social responses are either likely or unlikely to occur, and the qualitative and quantitative parameters of the reinforcers that maintain the responses. Areas assessed may include cooperation, motivation, visual understanding, receptive and expressive language, imitation, requests, labeling, play and leisure, and social interactions. Typical patients are young children with severe problems in communication, social relatedness, and/or repetitive behaviors, such as echolalia, lack of pragmatic language, lack of empathy, lack of social reciprocity, little or no functional play skills, repetitive and ritualistic behavior, and self-injurious behavior (eg, head hitting and finger biting). Assessments are typically completed over multiple days and less than one month after the behavior identification assessment–results are provided (0359T).

●0360T Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient

+●0361T each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)

▶(Use 0361T in conjunction with 0360T)◀

Coding Tip

If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code.

Exposure Behavioral Follow-Up Assessment

The exposure behavioral follow-up assessment (0362T, 0363T), which is less frequently performed, is designed by the physician or other qualified health care professional to manipulate or stage environmental or social contexts in order to examine triggers, events, cues, responses, and consequences associated with maladaptive destructive behavior(s) (eg, self-injurious behavior, aggression, property destruction, pica, or incessant screaming). This service requires the physician or other qualified health care professional to provide on-site direction to a team of technicians. Typically, two to three technicians are required for this service but additional technicians may be needed for exceptionally strong, combative, or dangerous patients.

Exposure behavioral follow-up assessment often requires the use of protective gear and/or a padded room to avoid injuries to patient (eg, hitting head against objects, hitting head with hands, forcefully throwing body, self-biting to hands and arms) and others (eg, hitting, biting, kicking, spitting).

●0362T Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient

+●0363T each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)

▶(Use 0363T in conjunction with 0362T)◀

▶(0362T, 0363T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians)◀

Coding Tip

In reporting codes 0362T and 0363T, only the face-to-face time spent by any one technician during a single session of sequential time may be counted.

Adaptive Behavior Treatment

The adaptive behavior treatment codes (0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0373T, 0374T) are used to report services for patients diagnosed with ASD or other diagnoses or conditions (eg, developmental disabilities, head trauma) associated with deficient adaptive or maladaptive behaviors (eg, impaired social skills and communication, destructive behaviors, or additional functional limitations secondary to maladaptive behaviors). These services are face-to-face with a patient or patient's family alone or in a group. The majority of these services are provided by technician(s) under the direction of a behavior analyst.

Adaptive behavior treatment addresses the patient's specific target problems and treatment goals as defined in previous assessments (see 0359T-0363T). Adaptive behavior treatment is based on principles including analysis and alteration of contextual events and motivating factors, stimulus-consequence strategies and replacement behavior, and monitoring of outcome metrics.

Goals of adaptive behavior treatment may include reduction of repetitive and aberrant behavior, and improved communication and social functioning. Adaptive behavior skill tasks are often broken down into small, measurable units, and each skill is practiced repeatedly until the patient masters it.

Adaptive behavior treatment may take place in multiple sites and social settings (eg, controlled treatment programs with the patient alone or in a group setting, home or other natural environment).

The treatment codes are based on daily units of service in 30-minute increments. The frequencies with which the services are provided vary depending on the number of target problems and treatment goals. The typical EIBI patient initially has 15 or more treatment targets and requires 25 hours of treatment per week during a defined treatment period. Older patients typically have fewer targets and require considerably fewer treatment units per week. State mandates and payer policies regulate the frequency in which these services are compensated.

Coding Tip

The same time rules applied to the assessment codes (see Table 1) also apply to the codes for adaptive behavior treatment by protocol (0364T, 0365T), group adaptive behavior treatment by protocol (0366T, 0367T), and adaptive behavior treatment with protocol modification (0368T, 0369T). For example, the timed-treatment codes may be reported when the midpoint is reached (eg, 16 minutes for the 30-minute codes 0364T, 0366T, 0368T). Add-on codes 0365T, 0367T, 0369T may be reported for 16 minutes or more of treatment beyond the first 30 minutes of treatment up to a total of 75 minutes. An additional unit of 0365T, 0367T, or 0369T may be reported for each additional increment of up to 30 minutes of face-to-face technician time (0365T, 0367T) or other qualified health care professional time (0369T).

Adaptive Behavior Treatment by Protocol

Adaptive behavior treatment by protocol (0364T, 0365T, 0366T, 0367T) is administered by a single technician under the direction (on-site or off-site) of the physician or other qualified health care professional by adhering to the protocols that have been designed by the physician or other qualified health care professional. This treatment is delivered to a patient alone (0364T, 0365T) or while attending a group session (0366T, 0367T).

Codes 0364T, 0365T include skill training delivered to a patient who, for example, has poor emotional responses (eg, rage with foul language and screaming) to deviation in rigid routines. The technician introduces small, incremental changes to the patient's expected routine along one or more stimulus dimension(s), and a reinforcer is delivered each time the patient appropriately tolerates a given stimulus change. Gradually, more intrusive changes in routines are faded into preferred daily activities until the patient appropriately tolerates typical variations in daily activities without poor emotional response. The physician or other qualified health care professional directs the treatment by designing the overall sequence of stimulus and response fading procedures, analyzing the technician-recorded progress data to assist the technician in adhering to the protocol and judges whether the use of the protocol is producing adequate progress.

●0364T Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time

+●0365T each additional 30 minutes of technician time (List separately in addition to code for primary procedure)

▶(Use 0365T in conjunction with 0364T)◀

Codes 0366T and 0367T include skill training delivered to a patient, with ASD or another condition, who could benefit from skill training in a group of peers, typically with similar issues. For example, the technician assists the patient in playing a game that requires group interaction by simple turn taking. The amount of time and complexity of turn taking of each participant is gradually increased (which the patient is more reluctant to interrupt). The technician administers reinforcers, error-correction procedures, or other consequences based on the patients' level of participation. The physician or other qualified health care professional has analyzed each of the social tasks required for the turn-taking exercise before the group begins and has designed graded levels of social participation, such that the patient is able to succeed in their turn at the appropriate time and allow others to take turns at other times. The other qualified health care professional analyzes technician-recorded progress data to assist the technician in adhering to the protocol and judges whether the use of the protocol is producing adequate progress.

●0366T Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time

+●0367T each additional 30 minutes of technician time (List separately in addition to code for primary procedure)

▶(Use 0367T in conjunction with 0366T)◀

Coding Tip

Do not report codes 0366T and 0367T for patients in groups larger than 8 patients.

Report group adaptive behavior treatment by protocol (0366T, 0367T) only for patients who are participating in the interaction in order to meet their own individual treatment goals.

Adaptive Behavior Treatment by Protocol Modification

Unlike the adaptive behavior treatment by protocol, adaptive behavior treatment with protocol modification (0368T, 0369T) is not administered by a technician, but rather the physician or other qualified health care professional, who is face-to-face with a single patient, delivers the service. The service may include demonstration of the new or modified protocol to a technician, guardian(s) and/or caregiver(s). For example, codes 0368T and 0369T will include treatment services provided to a teenager who is recently placed with a foster family for the first time and is experiencing a regression of the behavioral targets which were successfully met in the group-home setting related to the patient's atyp-

ical sleeping patterns. The clinical social worker modifies the past protocol targeted for desired results to incorporate changes in the context and environment. A modified-treatment protocol is administered by the qualified health care professional to demonstrate to the new caregiver how to apply the protocol(s) to facilitate the desired sleeping patterns to prevent sleep deprivation.

●0368T Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time

+●0369T each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)

▶(Use 0369T in conjunction with 0368T)◀

Coding Tip

When the physician or other qualified health care professional instructs the technician about the treatment protocol without the patient present, the service is not reported separately.

Family and Multiple-Family Group Adaptive Behavior Treatment Guidance

It is important that family members or guardians learn to apply the same treatment protocols to reduce maladaptive behaviors and reinforce appropriate behavior. Family adaptive behavior treatment guidance and multiple-family group adaptive behavior treatment guidance (0370T, 0371T) are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s), without the presence of a patient, and involve identifying problem behaviors and deficits, and teaching guardian(s)/caregiver(s) of one patient (0370T) or multiple patients (0371T) to utilize treatment protocols designed to reduce maladaptive behaviors and/or skill deficits.

●0370T Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

●0371T Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

Coding Tip

Do not report codes 0370T and 0371T if the group includes guardian(s)/caregiver(s) of more than 8 patients.

Adaptive Behavior Treatment Social Skills Group

Adaptive behavior treatment social skills group (0372T) is administered by a physician or other qualified health care professional to patients in a social skills group. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the therapeutic techniques in real-time to address targeted social deficits and problem behaviors utilizing various techniques (eg, modeling, rehearsing, corrective feedback). For example, code 0372T includes the treatment of an adult patient with Savant syndrome who works for a community agency that employs special needs individuals. This patient annoys his co-workers because he tells the same joke over and over, and talks incessantly about comic-book heroes. The qualified health care professional begins the group session by asking each group member to briefly discuss two social encounters with the Savant syndrome patient that occurred since the last session, one that went well and one that did not. The qualified health care professional uses this information to then develop a group activity in which each patient will have the opportunity to practice the activities from the encounters that went well and to problem solve the activities that did not go well. Each participant is given specific measurable goals to contribute to the success of their social relationships at work. The qualified health care professional adjusts the level of assistance (eg, prompts) and feedback given to each member based on their skill level and ongoing progress in the group. The qualified health care professional ends the group session by summarizing the behavioral treatment principles that were addressed, answering questions, and giving each member of the group an individualized homework assignment to practice a particular social skill.

●0372T Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients

Coding Tip

Do not report code 0372T if the group is larger than 8 patients.

Report adaptive behavior treatment social skills group (0372T) only for patients who are participating in the interaction in order to meet their own individual treatment goals.

Exposure Adaptive Behavior Treatment

An exposure adaptive behavior treatment (0373T, 0374T) is required when environmental conditions need to be staged to train appropriate alternative responses under the environmental contexts that typically evoke problem behavior. Exposure adaptive behavior treatment addresses one or more specific severe destructive behaviors (eg, self-injurious behavior [SIB], aggression, property destruction). These services are provided to patients under the onsite direction of the physician or other qualified health care professional and require multiple technicians. For example, three technicians work with a patient who uses violent behavior to avoid non-preferred tasks; the first technician collects continuous real-time data on the patient's SIB, aggression, and communication responses, a second technician stands closely behind the patient and blocks the patient's attempts at SIB, while the third technician uses modeling and differential reinforcement to teach the patient to request attention using a short phrase ("Pay please"). The physician or other qualified health care professional directs the sequence of events utilizing, for example, real-time observation (eg, from behind a one-way mirror) and two-way radio. The physician or other qualified health care professional reviews and analyzes data and refines the therapy using single-case designs; ineffective components are modified or replaced until discharge goals are achieved (eg, reducing destructive behavior by at least 90%, generalizing the treatment effects across caregivers and settings, or maintaining the treatment effects over time). Often, these services are provided in intensive outpatient, day treatment, or inpatient facilities, depending on the dangerousness of the behavior.

●**0373T** Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient

+●**0374T** each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)

►(Use 0374T in conjunction with 0373T)◄

►(0373T, 0374T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians)◄

Coding Tip

Exposure adaptive behavior treatment is typically provided in a structured, safe environment (eg, padded room), and protective gear is utilized as needed to protect the patient and the technicians and other qualified health care professional.

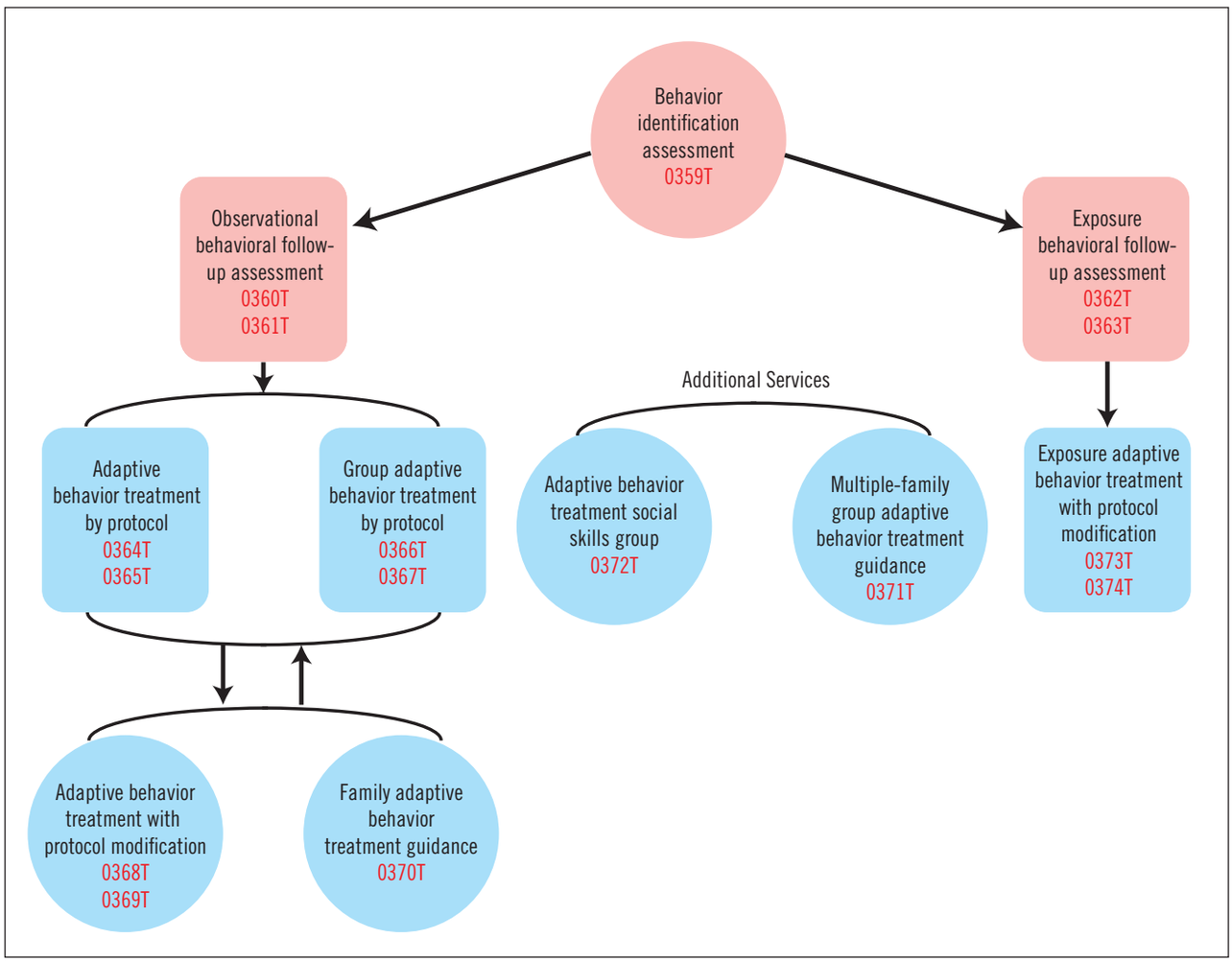
In reporting codes 0373T, 0374T, only the face-to-face time spent by one technician during a single session of sequential time may be counted. Although the physician or other qualified health care professional is on-site, he or she may be directing 5-10 other similar treatments simultaneously.

The complexity of the exposure adaptive behavior treatment codes (0373T, 0374T) is addressed by the increased time designation (60 minutes) and the usage of multiple technicians. Exposure adaptive behavior treatment services that extend beyond the initial hour may be reported with code 0373T when the face-to-face technician time extends 15 minutes beyond the first 60 minutes. The add-on code 0374T may be reported for 16 minutes or more of treatment beyond the first 60 minutes of treatment, up to a total of 105 minutes. An additional unit of code 0374T may be reported for each additional increment of face-to-face (multiple) technician time up to 30 minutes. Time does not need to be sequential, as the patient may require frequent breaks in treatment.

For an overview of the adaptive behavior algorithm and the appropriate CPT codes to report, see Figure 1.

Note: The Category III behavior assessment and treatment codes are scheduled to sunset (archive) in January, 2020. For more information on conversion from Category III to Category I code status (maintenance process), download the "CPT® Category III Codes: The First Ten Years" from Category III Codes in the **Related Links** navigation–panel at www.ama-assn.org/go/CPT. ◆

Figure 1. Adaptive Behavior Assessment and Treatment



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EIDBI Stakeholder Issues
Working Document
July 21, 2015

Issue	Discussion	Recommendation	Short-Term Options	Long-Term Options
Provider Requirements Does DHS have authority over the EIDBI provider requirements to implement a transitional process to eventually achieve the desired requirements?	ATAM: EIDBI ABA provider requirements as written in the SPA include the BACB standard licensing requirements. While this is something to work toward this precludes many current ABA providers from being eligible to provide the benefit. DHS generally agrees with the EIDBI provider qualification recommendations for each level of provider below. However the current requirements are written into the State Plan Amendment (SPA).	DHS will need a change of language in the SPA. DHS is looking into possible options for a work around for this initial phase of the benefit until the changes can be made in the SPA.	To the extent that the concerns relate specifically to EIDBI/ABA standards but not DBI standards, consider ways in which ABA could be placed under DBI: • The claims system will not record the service as either ABA or DBI • Develop policies that indicate that unless a provider specifically attests to meeting Minnesota EIDBI- ABA/BACB standards as defined in the SPA, DHS will consider the provider for meeting DBI qualifications. • Clarify that where certification is required for DBI, ABA certification is one of the state-approved modalities for DBI and therefore could qualify as a DBI provider • If providers do not meet current EIDBI-ABA standards but the treatment that they provide is generally viewed as ABA philosophically, they should inform the family before service begins what their primary treatment modality is and whether the service they provide meets BACB standards or EIDBI/DBI standards.	Amend the state plan to provide the recommended changes in provider requirements. This process would likely be at least a 5 month process. The SPA currently has identified ABA as a distinct treatment modality with distinct requirements that match the BACB standards. The current SPA language does not allow for a way to phase in the ABA standards.
Qualified Supervising Professional (QSP)	Simply collapse the qualifications into a single track, allowing the same entry qualifications for each track.	See Above	See Above	See Above

	• Licensed MH Professional **and** • 2000 hours of ASD experience/training **or** • Graduate ASD coursework **or** Certification as BCBA-D or BCBA			
Developmental/ Behavioral Professional (Level I Provider)	Simply collapse the qualifications into a single track, allowing the same entry qualifications for each track. • Master's degree in behavioral health fields **or** • Certification as BCBA-D or BCBA **or** • Certification in a DHS-approved treatment modality **or** • Bachelor's degree **and** • 2000 hours of experience/training/coursework in ASD	See Above	See Above	See Above
Developmental/ Behavioral Practitioner (Level II Provider)	Simply collapse the qualifications into a single track, allowing the same entry qualifications for each track. Eliminate the unnecessary restriction of 2,000 hours and graduate coursework for Bachelor's practitioners, according to the evidence-based staff development system in which all practitioners require weekly supervision for the first 2,000 hours. • Bachelor's degree **or** • Certification as BCaBA **or** • Associate degree plus 2000 hours of experience in the program **or**	See Above	See Above	See Above

	• 4000 hours of experience in the program **or** • In a graduate internship program **or** • Fluency in child's home language			
Developmental/ Behavioral Support Specialist services (Level III Provider)	Simply collapse the qualifications into a single track, allowing the same entry qualifications for each track. • Have a high school or equivalent diploma **or** • In an undergraduate practicum program **or** • Fluency in child's home language (if other than English) **or** • 2 years of experience as the primary PCA-level provider to a child with ASD **or** • RBT: Registered Behavior Technician	See Above	See Above	See Above
Provider Shortage	ATAM: No amendment here, but DHS and providers will need to monitor the shortage declaration to ensure that provider practices are valid.	DHS will be meeting with providers and other stakeholders during the next year to establish the criteria for determining when the provider shortage declaration can be lifted in a particular geographic area.	DHS plans to develop and facilitate a small stakeholder **EIDBI Advisory Council** to provide experience-based, effective and efficient input into on-going operations and policy recommendations for EIDBI operations and policies including the provider shortage criteria. Implement by 10/15/15.	7/1/16
Agency Policies and Standards Providers need time to develop and implement EIDBI policy standards such as facility standards	ATAM: Develop a transition plan for EIDBI providers to accomplish the policy provisions in the provider manual.	DHS recommends using these policies and procedures as the basis for an eventual EIDBI agency licensing legislative proposal for the 2016 session.	Clarify which of the EIDBI polices and standards such as the facility, environment, and health and safety standards are viewed as standards to be ***working toward*** and can be done over time and possibly until agency	Consider legislative proposal for EIDBI agency licensing or certification in the future.

and health and safety requirements in a gradual and meaningful manner.	DHS: These policies and procedures were developed with the Provider Standards work group where we were initially focused toward EIDBI agency licensing standards. They were derived from existing standards for child care licensing standards and 245D requirements and combined with stakeholder input specifically for EIDBI centers. The policies regarding facility, space and health and safety standards were developed to ensure well-being of children who attend EIDBI center-based treatment programs for more than two hours/day. The Client Rights section of the EIDBI Policy Manual and Guide is best practice for home-based or center-based EIDBI services	By providing these EIDBI policies and procedures from initial implementation, we are giving providers time to prepare and ***start*** addressing these issues before they become law. DHS does not view the facility and health and safety standards as necessary to have in place in order to become an enrolled EIDBI provider during this initial phase of implementation.	licensing or other standards can be passed through legislation. Identify those requirements such as Client Rights that must be provided upon implementation. Clarify this by 8/30/15	
Medical Necessity Determination and Treatment Guidelines The limits of intensity contained in the CMDE guidelines and provider manual prevent children from getting individualized, medically necessary treatment early and effectively. The current CMDE assessment form includes a cap on	ATAM: Following the EIDBI statute and the concept of "coverage with evidence development" implement a flexible planning process that enables treating providers to clinically evaluate response to treatment based on each provider's service model including the ability to use clinical evaluation of response to treatment, treatment intensity, duration, age at intake and family capacity.	There are no caps on EIDBI services. DHS developed treatment guidelines that take into consideration the child's age, developmental level and severity of ASD core deficits. The medical necessity determination criteria outlines exceptions to the guidelines when recommended intensity goes beyond that in the guidelines, in order to individualize treatment based on the child's needs.	DHS will review and change as determined appropriate the medical necessity determination criteria and treatment guidelines. DHS will pull together a sub-group of the EIDBI Clinical Consultant work group including diagnosticians and treating providers to receive further stakeholder input into these guidelines before the CMDE/ITP policies are finalized and trainings occur.	The treatment guidelines should be brought to the Learning Collaborative for review and discussion once the Learning Collaborative is established and for on-going input as the research component for EIDBI is developed.

services of 25 hours per week and EPSDT rules prohibit such caps.	ATAM: Evaluation research on results of these services should be completed and distributed to providers for peer review before DHS should enforce any strict guidelines on intensity determination.	DHS also recognizes that the current guidelines may inadvertently be viewed as caps. DHS is open to considering whether the current guidelines may be too restrictive to provide the range of treatment options that DHS intends to study.	Clinical Work Group input received 8/5/15. Finalize by 9-15-15	
CMDE Timelines Provider shortages make the current timelines unrealistic and inadvertently prevent access to the EIDBI benefit.	ATAM and U of M: Remove all CMDE timelines and limits.	DHS developed timelines for some of the medical necessity determination processes to ensure that children receive timely access to services.	DHS will remove CMDE provider timeline requirements from policy guide due to the current provider shortage. Removed from policy guide 8/1/15.	Develop best practices for CMDE and treatment time-lines once the provider shortage is no longer a factor. DHS plans to develop and facilitate a small stakeholder EIDBI Advisory Council to provide experience-based, effective and efficient input into on-going operations and policy recommendations for EIDBI operations and policies including the timelines. This could also be an issue for the Learning Collaborative to provide input as well.
CMDE Determination of Treatment Recommendations	U of M: Recommendations for treatment intensity, frequency and duration as well as options for modality may be beyond the scope of the CMDE provider and are better address by the EIDBI provider with the family.	DHS developed the CMDE process and qualifications of the CMDE provider to help in evaluating the medical necessity for EIDBI and to include the amount and type of intensive intervention to be provided. The intent was that this be done by a qualified but independent person from the	DHS has postponed the previously scheduled CMDE/ITP trainings in order to review and change as determined appropriate the medical necessity determination criteria and treatment recommendation guidelines.	The treatment guidelines should be brought to the Learning Collaborative for review and discussion once the Learning Collaborative is established and for on-going input as the research

		treating provider, to remove the potential for conflict of interest. Due to the provider shortage the separation of CMDE provider and treating provider has been temporarily waived. DHS discussed that this determination could be made as a recommendation for treatment intensity based on the CMDE providers' clinical judgement for a particular child's "minimum amount" recommended initially. That would allow an initial opportunity to evaluate the child's response to treatment. The need for increases could be made subsequent to this by the treating provider at the Progress Review or earlier if adequate progress was not being made. DHS is also open to considering a broader range for intensity guidelines and recommendations. (such as providing a recommendation for intensity that falls within a range of minimum to maximum)	DHS will pull together a sub-group of the EIDBI Clinical Consultant work group including diagnosticians and treating providers to receive further stakeholder input into these guidelines before the CMDE/ITP trainings occur. Clinical Work Group input received; 8/5/15. Finalize by 9/15/15	component for EIDBI is developed.
CMDE Billing	ATAM: Given the many required components of the CMDE, it is unlikely that the evaluation can be completed within 2.5 hours, as the rate implies.	The rate for the CMDE is based on a **daily encounter** rather than hourly rate. The CMDE can be billed for **up to two full days** (encounters) by two different providers if necessary.	Clarification provided. No action needed.	

		Extended diagnostic assessments are only billed as one encounter regardless of how long it takes to complete.		
CMDE When the CMDE fails to include required components, this should not prevent the family and child from accessing or continuing timely early intervention services.	DHS: • For children who are not already receiving CTSS services during the time of their CMDE the family can access the 200 hours of pre-authorization treatment through CTSS while they are completing the CMDE. • The required components of the CMDE are the recommendations provided by the qualified CMDE provider (mental health professional) after gathering, administering and/or reviewing the diagnostic, developmental and medical information. Any other relevant developmental or assessment information is helpful but not required to complete the CMDE. • If the diagnostic assessments necessary to make an ASD or related conditions diagnosis have been performed by a qualified mental health professional and include a parent interview, developmental history, face-to-face observation of the child and information from the child's	Kepro has a 5 day timeline for review of the CMDE and notifying the CMDE provider of missing information to ensure timely access.	Clarification provided. No action needed. DHS has postponed the previously scheduled CMDE/ITP trainings in order to review and change as determined appropriate the medical necessity determination criteria and treatment recommendation guidelines. DHS will pull together a sub-group of the EIDBI Clinical Consultant work group including diagnosticians and treating providers to receive further stakeholder input into these guidelines before the CMDE/ITP trainings occur. Clinical Work Group input received; 8/5/15. Finalize by 9/15/15	

	medical provider, the CMDE should be able to be completed and recommendations for treatment provided. • ITP development can also begin while the required components of the CMDE are completed.			
Coordinated Care Conference CCC should not be required as part of the CMDE.	U of M: Make coordinated care conference optional per parent request.	DHS covers the Coordinated Care Conference as part of EIDBI and views it as best practice for these complex children who are accessing multiple services. It is important to bring the team of providers together initially and annually to review progress, discuss the child's and family's needs and make recommendations whenever possible. DHS expects the CMDE provider to review the summary results of the evaluation including the treatment options and recommendations with the parent, in some manner. The parent needs to sign off on the CMDE to attest that they understand and agree with the findings and recommendations.	DHS will **remove the requirement** for the coordinated care conference and make it optional, **per parent request** in the policy guide. DHS will remove these from policy guide by 8/30/15. DHS will pull together a sub-group of the EIDBI Clinical Consultant work group including diagnosticians and treating providers to receive further stakeholder input into these guidelines before the CMDE/ITP trainings occur. Clinical Work Group input received; 8/5/15. Finalize by 9/15/15	Review this with the Learning Collaborative. Possibly develop a study outcome to determine if there is an impact of having or not having a Coordinated Care Conference on child or family outcomes.
Provider Enrollment	ATAM: Remove requirement that all staff need to be enrolled individually.	DHS currently does not have the legal authority to license agencies and therefore must enroll individual EIDBI providers per OIG.	DHS is pursuing other possible options.	DHS has drafted legislation to address licensing EIDBI provider agency sometime in the future. DHS has begun the process to develop and facilitate a small

EIDBI Stakeholder Issues
Working Document
July 21, 2015

		This is to ensure that client rights and needs are being met and to ensure the safety of recipients and their families.		stakeholder EIDBI Advisory Council to provide experience-based, effective and efficient input into on-going operations and policy recommendations for EIDBI operations including the provider enrollment criteria. Implement by 10/15/15
Provider Enrollment 60-90 days to become an enrolled and approved EIDBI agency and provider	ATAM: 1. If provider hires new employees, they need to float the cost of the employee with admin dollars until they become an enrolled provider and can bill MA. Does it take 90 days to enroll providers, even the level III? 2. Will DHS approve enrollment effective the date the application and provider assurance was received?	DHS: 1. Enrollment for new agencies can take 60 days due to the enrollment site visit requirement. The EIDBI agency must be enrolled first before the individual provider within the agency can be enrolled in order to create the affiliation between the enrollment records. Once an agency is enrolled, the enrollment of individual providers can take 30 days. 2. No, this is not an option. The EIDBI provider must be actively enrolled on the date of service for the provider to be paid.	DHS has met with SIRS and they are working to expedite the site visits for existing CTSS providers and new EIDBI applicant agencies. DHS enrollment is monitoring EIDBI enrollment closely and will expedite this process as much as feasible. 30 working or calendar days?	
EIDBI Billing Need a more individualized, flexible and practical way of billing and authorizing services. Requiring undue detail in paperwork reduces	ATAM: Have providers bill only under the QSP as CTSS does and not billed per individual staff UMPI numbers.	The MMIS system is already set up to include the QSP, Treating Provider and Pay-To Provider on the claim.	These questions will be addressed in the provider Billing Trainings. DHS will pull together a sub-group of the EIDBI Clinical Consultant work group including diagnosticians and treating providers to receive further stakeholder	

provider treatment capacity and ability to timely and responsive to changes in service needs.			input into these guidelines before the CMDE/ITP trainings occur. Clinical Work Group input received; 8/5/15. Finalize by 9/15/15	
EIDBI Billing It would be simpler to program and manage billing systems if the same units were used throughout.		DHS agrees, however the new CPT III codes from the AMA dictated the 30 minute units while other services dictate use of other units (15 minutes etc.)		DHS would like to work with a group of coding specialists, providers and with other states to work nationally on more descriptive and consistent coding standards.
EIDBI Billing Excessive fraud prevention, over-regulation and micromanagement for an "untested system".	ATAM: Implement a process of gradually increasing controls in response to evaluating provider practices. Seek agreed upon fixes now that can be implemented without legislation and work on a set of needed amendments to current statute for a bill in 2016 session.	This is a somewhat general recommendation and DHS is not sure what is being referred to here.	DHS plans to develop and facilitate a small stakeholder **EIDBI Advisory Council** to provide experience-based, effective and efficient input into on-going operations and policy recommendations for EIDBI operations and policies. Implement by 10/15/15	
Simultaneous billing	ATAM: Clarifies again that more than one practitioner may be necessary to ensure the safest and cost-effective service, as evidence-based practices have demonstrated.	DHS recognized the need for more than one practitioner when medically necessary, and this is allowed as defined in the medical necessity determination criteria.		Continue to evaluate through the Learning Collaborative and the EIDBI Operations and Policy Advisory whether this addresses the unique circumstances that arise for individual children.
Service Authorization Process Flexibility in use of level of providers across service authorization by procedure code	ATAM: Overall hours of EIDBI treatment intervention should be able to be used interchangeably by direct service staff.	Some EIDBI procedure codes are defined by the level of professional that can provide the service. Service authorization must include the appropriate services, codes and units of service requested over the 6 month authorization period.	This issue was addressed with the clinical work group meeting and changes will be included in the policy guide by 8/30/15	DHS plans to develop and facilitate a small stakeholder **EIDBI Advisory Council** to provide experience-based, effective and efficient input into on-going operations and policy recommendations for

EIDBI Stakeholder Issues
Working Document
July 21, 2015

				EIDBI operations and policies. Projected implement by 10/15/15
Covered Services Intervention Supervision and Direction	ATAM: Clarifies that the medically necessary individualized training is in the form of "Clinical Direction" and it is expected that two practitioners will each be billing for their service at the same time. It is also expected that two practitioners at the same level may bill for this service. This is the evidence-based system.	The issue of "Supervision" versus "Observation and Direction" vs "Clinical Direction" was a major sticking point with CMS and held up their approval of our SPA. We were finally able to receive approval by separating out "Supervision" from "Intervention Observation and Direction". That is how we were allowed to bill for the "Intervention Observation and Direction" for EIDBI. EIDBI Intervention Observation and Direction allows a higher level provider to bill for Observation and Direction at the same time the lower level provider is billing for intervention.	Want 068 069 Cont use Cont 062 063	DHS plans to develop and facilitate a small stakeholder **EIDBI Advisory Council** to provide experience-based, effective and efficient input into on-going operations and policy recommendations for EIDBI operations and policies. Projected implement by 10/15/15
Family/ Caregiver Training and Counseling	Clarifies that it is expected that two practitioners will occasionally be billing for their service at the same time when it is medically necessary. It is also expected that two practitioners at the same level may bill for this service.	DHS recognized the need for more than one practitioner when medically necessary, and this is allowed as defined in the medical necessity determination criteria.		
Individual Service/ Treatment Plan	Clarifies that this service includes the evidence-based direct observation, assessment, and analysis of the child's behavior and skills with or without other providers being present, separately or in groups.	ITP development assumes that direct observation, assessment and analysis of the child's behavior and skills with or without other providers being present has occurred.		

	It is not noted here, but assumed that this process can be conducted without the child or parent's presence.	Portions of ITP development can be conducted without the child or parent present but must include direct parent input and reflect parent goals, preferences and values with signature of understanding and agreement by the parent.		
Telemedicine services	In this home-based service, many disadvantaged and rural families do not have adequate Wi-Fi to support video conferencing. Telephone service eliminates this unfair restriction on those families.	Telemedicine is a relatively new service to be covered under medical treatment. It was specifically included as a covered service for EIDBI to provide other means to access diagnostic assessments, provide parent training and counseling or intervention observation and direction for families living in parts of the state where providers are often lacking and they must drive for miles or hours to access these services or where for other reasons in-person access is prohibitive. Telemedicine as currently defined does not allow this to be done via telephone. There are many ways to assist families who lack the technology in their home to access this service in other ways, for example, through their local community school or child's medical clinic.		
EIDBI Evaluation	ATAM: Per the EIDBI statute, develop written plan in concert with all providers that empirically evaluates response to treatment based on aspects of each provider's service models (must include evaluation of	ATAM: DHS must hire nationally recognized researchers in ABA and DBI to design state evaluation plan. Research must be completed and distributed to providers for peer review before the state may enforce strict guidelines on service intensity.	DHS is in the process of hiring a Research/Evaluation Coordinator. This individual will oversee the research and evaluation advisory groups as well as the learning collaborative.	Study of the EIDBI benefit is viewed as a long-term project. DHS hopes to learn from and with other states as we all

	hours of treatment, treatment intensity, length of treatment, age at intake). Providers must be able to individually agree to evaluation methods.	DHS developed a charter for the research and learning collaborative and has begun some outreach to national experts.	DHS has also been collaborating with professionals from the U of M and reaching out to other states to pursue grants for national collaborative research efforts. The EIDBI research, advisory groups and learning collaborative will be made up of external experts in the field including providers and parents. Projected implementation of these groups 10/30/15	move forward implementing autism treatment benefits.
CTSS/EIDBI Coordination ATAM: What process will be used to determine whether a child is being served under the SPA versus the current CTSS provisions?	DHS: MN Law expanded the umbrella under which ASD is viewed for early intensive intervention. CMS guidance received in July, 2014 and CMS approval of the new EIDBI SPA also identifies ASD as a developmental disability which requires a more comprehensive approach to ASD and medical necessity determination. All of these state and federal changes have taken ASD out of the mental health services framework that up until now has been the only way that these services could be provided in MN. Medical necessity for EIDBI for individuals with ASD and related conditions must be distinctly different from that for individuals who need mental health services.	ATAM: Revise language in both the CTSS and EIDBI provider manuals that allow a provider to bill EITHER service for medically necessary services for children with autism and other mental health disorders. Language in each provider manual should be identical with regards to medical necessity. DHS recognizes the continued need for, regular, close collaboration with current CTSS providers and families receiving these services. DHS CTSS and EIDBI staff has been and will continue to develop the transition process as the new EIDBI benefit is implemented.	DHS plans to develop and facilitate a small stakeholder **EIDBI Advisory Council** to provide experience-based, effective and efficient input into on-going operations and policy recommendations for EIDBI operations and policies. Projected implementation by 10/15/15	

	There are some individuals who have ASD and may need both EIDBI as well as other mental health services. There also may be individuals with ASD who only need EIDBI or only need mental health services. Which services a child needs and in what doses needs to be determined through the integrated medical review process for medical necessity determination based on the individual client needs.			
Other Related Issues	Language interpretation should have a clearly specified billing rate.	Language interpreter services are billed under MA, not EIDBI.		