Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, October 8, 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** – September 10, 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**
9/10/15: Discussion postponed.	**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**
9/10/15: Discussion postponed.	**OPEN**

6. 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**
9/10/15: The draft changes for both the 837P and I were reviewed and the separate guides will be updated. Email vote to review and approve will be sent to members.	**OPEN**

7. Methadone Therapy Tracking – Kathy Sijan, DHS – see SBAR

8. Additional Agenda Items/ Announcements

- Are you a member of the AAPC? Did you know that you could earn CEUs as an AUC MCT member?
- The next scheduled meeting is December 10, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – 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	For UCare for Seniors, a routine screening eye examination is identified by use of the V72.0 diagnosis code in the first position on the claim and the six benign refractive disorder ICD-9-CM codes in the second or subsequent position on the claim. ~~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.~~ Under the UCare for Seniors supplemental benefit, CPT code 92014 is reported for a comprehensive routine screening eye exam and CPT code 92015 is reported for refraction performed with the routine screening eye examination. Both CPT code 92014 AND 92015 reported with ICD-9-CM code V72.0 in the first position on the claim form (and any appropriate ICD-9-CM codes for benign refractive disorders in the second or subsequent position) must be reported in order to qualify for the supplemental benefit. CPT code 92014 typically represents comprehensive ophthalmological services for an established patient. UCare has requested that providers report this code (92014) regardless if the patient is new	**CLOSED**

Agenda Item	Discussion	Action/Follow-up:
	(which is identified by another code). It was noted that there is a defined code specifically for a routine or screening eye exam. This is an "S" code and Medicare will not allow submission of "S" codes. ~~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? 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. UCare stated that the request for providers to use CPT code 92014 to report a routine screening eye examination is only to identify the service as the supplemental benefit. Original Medicare does not cover routine screening eye examinations performed in the absence of eye disorders, disease or injury. The MCT cannot address this issue. All are asked to follow Medicare submission guides. Because this is a specific benefit for a Medicare Advantage Plan product, UCare may define the benefit. The MCT stated that use of CPT code 92014 for both new and established patients is not in line with State policy. AUC cannot dictate benefit. The code must represent the services provided. ~~thus payment, it is not in line with State policy. AUC cannot dictate benefit. The code must represent the services provided~~. The AUC recommended that UCare ~~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.	

Agenda Item	Discussion	Action/Follow-up:
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 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.	**CLOSED –** these corrections will be made in the 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	**CLOSED –** these corrections will be made in the 837P guide

Agenda Item	Discussion	Action/Follow-up:
	practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows: ☐S9445 U4– ante-partum and post –partum Doula services ☐99199 U4– Doula attendance at labor and delivery	
15. Next meeting	The next scheduled meeting is August 25, 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 – Tuesday, September 10, 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 – Ucare submitted comments and minutes have been corrected. A request for an email vote/approval will be done. Please see corrections to agenda item #10. 8/25/15 minutes reviewed and approved.	**OPEN** 8/13/15 minutes. Email vote to approve will be sent to members.
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	Kathy Sijan provided the 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	**CLOSED –** send final SBAR to Ops

Agenda Item	Discussion	Action/Follow-up:
	supervision and webinars, as available, as well as continuing education on dementia-related topics. FMCs are enrolled providers.	
7. Appendix A Review – Deb Sorg, HealthPartners	TAG reported updates and completed manual assignments.	**CLOSED**
8. C&TC Screenings and C&TC Update – Kathy Sijan, DHS	See revised and combined SBAR response.	**CLOSED –** send final SBAR to Ops
9. 2016 MN Uniform Companion Guide Review	The draft changes for both the 837P and I were reviewed and the separate guides will be updated.	**OPEN** Email vote to review and approve will be sent to members.
11. Additional Agenda Items/ Announcements	November meetings will be cancelled because of conflicts with the state AAPC conference and the AMA CPT Symposia. 2015 MN State AAPC Conference. Packed with CEU's and networking opportunities for only $275.00 Thursday, November 05, 2015 - Friday, November 06, 2015 Best Western Kelly Inn 320-253-0606 100 4th Ave S St Cloud, Minnesota 56301 United States	**CLOSED**
12. Next meeting	The next scheduled meeting is October 8, 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:

BHH – Behavioral Health Home

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

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

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

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

Definitions:

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

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

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

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

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

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

- Relocation Service Coordination

-Targeted Case Management for Vulnerable Adults and Developmental Disabilities

- Mental Health Targeted Case Management – Adult (Rule79)

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

- Assertive Community Treatment

- Health Care Home care coordination services

Summary of Public Comments to 837P & 837I for AUC Ops Review and Vote

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Changes to Appendix A front matter		
Section A.2 HIPAA Code Sets	**Revised first paragraph:** Added the following to first sentence: International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS);	✓	✓
Section A.3.2 Instructions for Using this Appendix and Its Accompanying Tables	**Revised footnote to include the following:** Added ICD-10-CM and ICD-10-PCS after ICD-9-CM in first sentence of first paragraph	✓	✓
	Changes to Appendix A, Table A.5.1		
Chapter 4 Part B Hospital (Including Inpatient Hospital Part B and OPPS) **Interpreter Services**	**Revised note section** Added link to rounding rules Section A.3.4.2 **Note**: Rounding rules (see front matter section A.3.4.2) apply to all services below. A minimum of eight minutes must be spent in order to report a unit. **Revised drive time versus mileage bullet statement (10th bullet)** Moved "is reported" from end of sentence: 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).		✓
Chapter 5 Part B Outpatient Rehabilitation and CORF/OPT Services	**Revised Minnesota Rule:** **Added link to rounding rules Section A.3.4.2** Do not follow Medicare's rounding rules (*see* A.4.3.2) for physical, occupational and speech therapies. **Deleted last sentence in paragraph** ~~See general rules for reporting units at the front of this appendix.~~		✓
Chapter 12 **Interpreter Services**	**Revised two statements regarding interpreter services as follows:** Inserted link to front matter in Note statement	✓	

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Note: Rounding rules (see front matter section A.3.4.2) apply to all services below. 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).		
Chapter 12 Physicians/NonPhysician Practitioners **Patient not in exam room**	**Revised first sentence in Minnesota Rule:** **Deleted** "*9*" from ICD-9-CM and **added** phrase "*based on date of service*" so that statement read "Report the appropriate ICD-CM code(s) based on date of service for the diagnosis of the patient as the primary diagnosis or diagnoses. **Deleted last sentence in paragraph:** ~~Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.~~	✓	
Chapter 15 Ambulance **Community Paramedic**	Revised Minnesota Rule entry: **Deleted last sentence and added "*vaccines*" to bulleted list**	✓	
Chapter 18 Preventive and Screening Services **Diagnosis coding for screening services**	**Revised the first sentence to read as follows:** Diagnosis coding for screening services must follow the ICD--CM, based on date of service, code set instructions. All applicable diagnoses should be submitted.	✓	
Chapter 18 Preventive and Screening Services **C&TC**	**Moved entry to end of table with other DHS-specific programs**		
Chapter 18 Preventive and Screening Services **Colonoscopy**	**Revised the first sentence to read as follows:** 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.		✓
Chapter 20	**Deleted statement from Minnesota Rule:** Not applicable to the Institutional guide		✓

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
Durable Medical Equipment, Prosthetics, Orthotics and Supplies **Oxygen Codes**	**Added new topic, "oxygen codes" and Minnesota Rule** Oxygen codes are used as defined. When appropriate to report contents, Minnesota providers may report E or S oxygen content codes as definition allows.		
N/A	**Moved all of the following DHS programs, including new programs not addressed in the Medicare Claims Processing Manual to end of table:** • Doula Services • Licensed Traditional Midwife… • Home Infusion Therapy • EIDBI • C & TC	✓	
N/A **EIDBI**	**Added:** New program name, link to Minnesota Statutes, and Minnesota Rule for Early Intensive Developmental and Behavioral Intervention (EIDBI) seven benefit programs: 1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI) 2. EIDBI 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	✓	
N/A **Doula Services**	**Revised statement**: Corrected doula sessions limit: from six to seven sessions	✓	
Chapter 18 Preventive Screening and Services **C&TC**	**Revised C &TC services and moved entry to list of N/A programs** Revised coding and description as follows: • 96110 – Developmental Screening • 96110 U1 – Autism Screening with a standardized instrument, 1 unit • 96127 – Social/Emotional or Mental Health Screening	✓	

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Added statement and link to DHS website		
N/A **Certified Family Peer Specialist**	**Added:** New program, description/definition and coding	✓	
	Changes to Appendix A, Table A.5.2.1		
These modifiers are used for coding mental health services that were removed from table A.5.2 listed below	**Delete the following modifiers:** • 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		✓
	Changes to Appendix A, Table A.5.2.2		
List of Behavioral Health Programs (Services pertain to professional only)	**Deleted links to the behavioral health programs listed in Table A.5.2** Assertive Community Treatment (ACT) Adult Crisis Response Services Children's Mental Health Crisis Response Services Children's Therapeutic Services and Supports (CTSS) Adult Rehabilitative Mental Health Services (ARMHS) Peer Services Dialectical Behavior Therapy Youth Assertive Community Treatment Intensive Treatment in Foster Care Mental Health Family Psychoeducation Services		✓
	Changes to Appendix A, Table A.5.2		
Behavioral Health Programs (see list in description column)	**Deleted the following programs:** Assertive Community Treatment (ACT) Adult Crisis Response Services Children's mental health Crisis Response Services Children's Therapeutic Services and Supports (CTSS) Adult Rehabilitative Mental Health Services (ARMHS)		✓

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Peer Services Dialectical Behavior Therapy Youth Assertive Community Treatment Intensive Treatment in Foster Care Mental health Family Psychoeducation Services		
	Changes to Table A.5.4.c – Miscellaneous		
Peer Services	**Deleted from table:** Peer Services program	✓	

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X223A2 Health Care Claim: Institutional (837) Version 10.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	This document was adopted into rule June 1, 2015. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X223A2 Health Care Claim: Institutional (837), hereinafter referred to as 005010X223A2, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 10.0 (v10.0) of the Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X223A2 Health Care Claim: Institutional (837). It was announced as an adopted rule in the Minnesota State Register, Volume 39, Number 48, June 1, 2015 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version 8.0 was the last version of this document to be adopted into rule prior to this v10.0. This document is available at no charge on MDH's "Minnesota Statutes, section 62J.536 Rules" webpage (http://www.health.state.mn.us/asa/rules.html).

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Table of Contents

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1. Overview

1.1. Statutory basis for this rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

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

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

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

1) *processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;*
2) *receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;*
3) *acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;*
4) *acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and*
5) *other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.*

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

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

1.2.1. Exceptions to applicability

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

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

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

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-3830

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as

part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

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

1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. V8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v8.0.
10.0	June 1, 2015	Adopted into rule June 1, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.

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

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X223A2*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X223A2* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.
- Use of this document does not mean that a claim will be paid and does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

- Appendix A provides additional information and instructions regarding the use of medical code sets and medical coding;
- Appendix B provides guidance for K3 Segment Usage Instructions;
- Appendix C provides instructions for reporting the MNCare Tax.

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

Appeal – Provider is requesting a reconsideration of a previously adjudicated claim for which there is no additional data or corrected data to be submitted. Providers should contact the payer or the payer's website for further instructions regarding reconsiderations or appeals.

Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional information.
    - The NTE segment must not be used to report data elements that are codified within this transaction.
    - If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV202-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X223A2*.
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.
- If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE or SV202-7 will exceed available characters, use only the PWK segment at the claim level.
- When populating the PWK segment, the following guidelines must be followed:
    - PWK01 - The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
    - PWK06 - Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

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

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5. List of Appendices

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

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

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

a) Hospital

b) All other residential

c) Outpatient

B. Appendix B: K3 Segment Usage Instructions

Appendix B provides guidance for K3 SEGMENT USAGE INSTRUCTIONS

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

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

A.2 HIPAA Code Sets

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

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

1. Select codes that most accurately identify the procedure/service/product provided. Codes with identical descriptions may be used interchangeably. If codes do not have identical description, then follow A.3.2 regarding use of the most appropriate code.

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

2. The medical record must always reflect the procedure/service/product provided.
3. Use instructions in this appendix and the accompanying tables A.5.1, A.5.2, and A.5.3, to select and use required codes.

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

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

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

- Report one unit for all services without a measure in the description.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
  - "per vertebral body;"
  - "each 30 minutes;"
  - "each specimen;"
  - "15 or more lesions;"

- o "initial."

- Follow all related AMA guidelines in CPT[3] (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow general rounding rules for reporting more than the code's time value. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

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

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

- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.1 as “institutional claim type” or “837I” or “Institutional claim;”
- ASCX12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1 as “professional claim type” or “837P” or “Professional claim”;
- ASC X12/005010X224A2 Health Care Claim: Dental (837), referred to in Table A.5.1 as “837D;”
- Pharmacy Claims Submission and Response and the Pharmacy Reversal Submission and Response Transactions per the NCPDP Telecommunication Standard Implementation Guide, Version D.Ø, referred to in Table A.5.1 as “NCPDP”.

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

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

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			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 ▪ T1013 GT -- Telemedicine interpreter services per 15 minutes ▪ T1013 U4 -- Telephone interpreter services per 15 minutes ▪ T1013 UN UP UQ UR US -- Interpreter services provided to multiple patients in a group setting ▪ Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient ▪ T1013 52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provide, report each on a separate line appended with the -59 modifier o T1013 52 x 2 units (30 minutes of drive time) o T1013 5259 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line.

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			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
5	Part B Outpatient Rehabilitation and CORF/OPT Services		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	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.

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			▪ Private Room differential use 0229; 1 unit = 1 day ▪ In lieu of days differential use 0230; 1 unit = 1 hour
6	Inpatient Part A Billing and SNF Consolidated Billing	Ancillaries	Ancillaries are reported separately as appropriate
6	Inpatient Part A Billing and SNF Consolidated Billing	Long term care	Also applicable to Long Term Care
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Follow Medicare coding guidelines
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers		Not applicable to the Institutional guide. Report on the claim type appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
10	Home Health Agency Billing	Home Health Services	Home Health Services are reported on the 837I using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P Revenue Codes 041X – 044X and 055x – 060x as appropriate
10	Home Health Agency Billing	Reporting continuous services beyond the encounter and multiple nurse encounters with the same date of service	For home care the industry standard defines "per diem" as all inclusive services per patient encounter up to two hours. ▪ To report extended continuous services beyond the encounter use the fifteen minute code(s). ▪ To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.
10	Home Health Agency Billing	Approved HCPCS code set	Medicare's G codes are insufficient to describe the level of time codes that group purchasers require for proper case management. See Approved HCPCS Code Set below. Approved HCPCS code set: ▪ Skilled Nursing Encounter: o RN: T1030 o LPN:T1031 ▪ Home Health Aide Visit: T1021 ▪ Home Health Aide (Extended: T1004 ▪ PT Visit: S9131 o PT Asst. Visit: S9131 TF ▪ OT Visit: S9129 o OT Asst. Visit: S9129 TF

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			▪ RT Evaluation: S5180 ▪ RT Visit: S5181 ▪ Speech Visit: S9128 ▪ MSW Visit: S9127 ▪ RN: T1002 ▪ RN Complex: T1002 TG ▪ RN Shared 1:2 ratio T1002 TT ▪ LPN: T1003 ▪ LPN Complex: T1003 TG ▪ LPN Shared 1:2 ratio T1003 TT ▪ Postpartum home visit 99501 ▪ Newborn care home visit 99502
11	Processing Hospice Claims		Follow Medicare coding guidelines
12	Physicians/ Nonphysician Practitioners		Not applicable to Institutional claim
13	Radiology Services and Other Diagnostic Procedures	Bilateral Radiology	▪ Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance		Follow Medicare coding guidelines
16	Laboratory	Newborn	When the specimen is taken for the Newborn

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
	Services	Screening	Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
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.
18	Preventive and Screening Services	Vaccine Administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
18	Preventive and Screening Services	Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, group purchasers require the SL modifier be appended to the vaccine code

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. ▪ Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
19	Indian Health Services		Follow Medicare coding guidelines
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	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. ~~Not applicable to the Institutional guide~~
21	Medicare Summary Notices		Not applicable to the Institutional guide
22	Remittance Advice		Not applicable to the Institutional guide
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims		Not applicable to the Institutional guide

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
	and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to the Institutional guide
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to the Institutional guide
27	Contractor Instructions for CWF		Not applicable to the Institutional guide
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to the Institutional guide
29	Appeals of Claims Decisions		Not applicable to the Institutional guide
30	Financial Liability Protections		Not applicable to the Institutional guide
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to the Institutional guide

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

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

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

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

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

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

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

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

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~~

Certified Family Peer Specialist – DHS

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

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

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

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

Name of Program	Description/Definition	Coding
~~Back to list of behavioral health programs~~	~~▪ County or county contracted agency.~~	~~▪ S9484 UA HN - Crisis intervention mental health services, per hour, Children's Crisis Response Services, bachelor's degree level mental health practitioner~~
Mental Health Targeted Case Management (MH-TCM) Back to list of behavioral health programs	▪ Community support plan and functional assessment to help SPMI adults and SED children gain access to needed medical, social educational, vocational, financial services relative to mental health needs.	Codes: ▪ T2023 HE HA – Targeted case management; per month, mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years ▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older ▪ T2023 HE TF - Targeted case management intermediate level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older ▪ T1017 HE – Targeted case management, per encounter (day), mental health program, adult, face-to-face contact between case manager and recipient age 18 or older, IHS/638 facilities and FQHCs ▪ T1017 HE HA – Targeted case management, per encounter (day), mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years, IHS/638 facilities and FQHCs
Children's Mental Health	▪ 24-hour-a-day program under clinical supervision of a mental	PMAP/Commercial/County-based Purchasing (CBP):

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

Name of Program	Description/Definition	Coding
Residential Treatment Services Back to list of behavioral health programs	health professional, provided in a community setting.	▪ For room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. Department of Human Services (DHS)/ Fee for Service: ▪ When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.
Intensive Residential Treatment Services (IRTS) Back to list of behavioral health programs	▪ Time-limited mental health services provided in a residential setting to recipients in need of more restrictive settings and at risk of significant functional deterioration. ▪ Develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.	PMAP/Commercial/County-based Purchasing (CBP): ▪ For room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. Department of Human Services (DHS)/ Fee for Service: ▪ When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.
Adult Day Treatment Back to list of behavioral health programs	▪ A structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a recipient's mental health status, develop and improve independent living and socialization skills	Codes: ▪ H2012 - Behavioral health day treatment, per hour

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

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

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

Name of Program	Description/Definition	Coding
		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

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

Name of Program	Description/Definition	Coding
		• 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
Mental Health Diagnostic Assessment Back to list of behavioral health	A diagnostic assessment is a written report that documents the clinical and functional face-to-face evaluation of a recipient's mental health and is necessary to	Codes: In order to report diagnostic assessments with levels of complexity, report as follows:

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

Name of Program	Description/Definition	Coding
programs	determine a recipient's eligibility for mental health services.	▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
~~**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~~

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

Name of Program	Description/Definition	Coding
		• 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) (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	Codes: • S5145 – Foster care, therapeutic, child; per diem • HE – Mental health program Bill only one per diem code per day regardless of the number of services or who provides services.

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

Name of Program	Description/Definition	Coding
	under subdivision 4.	
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
Certified Family Peer Specialist – DHS Back to list of behavioral health programs	• Services are for children under the following codes with the HA modifier. • For mental health services only; do not apply to substance abuse.	Codes: • H0038 Certified peer specialist services, per 15 minutes • H0038 U5 Advanced level certified peer specialist services, per 15 minutes • H0038 HQ Group setting, certified peer specialist services, per 15 minutes • H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes • H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes

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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

c) Outpatient Services.

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

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

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

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

V10.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)

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

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

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

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

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

V10.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)					
A.5.3.b – Substance Abuse Services: All Other Residential					
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	Day	1002: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) 1003: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
Treatment program, treatment component	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
Treatment program, treatment component	Hour	0953	None	837I	086x – special facility, residential
Ancillary services	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

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

V10.0 MUCG for the Implementation of the ASC X12/005010X223A2 Health Care Claim: Institutional (837)

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

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

Claim Type – 837I

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

NOTE: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.

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

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

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
NOTE: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs				N/A
Alcohol and/or drug assessment	Session/visit	N/A	H0001	N/A

B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

K3*LUMN~

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C. Appendix C: Reporting MNCare Tax

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

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

Filename: v10 837I fnl for psting - no us.docx

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X222A1 Health Care Claim: Professional (837) Version 10.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	This document was adopted into rule on June 1, 2015. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 10.0 (v10.0) of *the Minnesota Uniform Companion Guide (MUCG) for the* Implementation of the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*. It was announced as an adopted rule in the Minnesota State Register, Volume 39, Number 48, June 1, 2015 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version 8.0 was the last version of this document to be adopted into rule prior to this v10. This document is available at no charge at MDH's "Minnesota Statutes, section 62J.536 Rules" webpage (http://www.health.state.mn.us/asa/rules.html).

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Table of Contents

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1. Overview

1.1. Statutory basis for this rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

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

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

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

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

1.2.1. Exceptions to applicability

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

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

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

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

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as

part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

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

1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v.8.0
10.0	June 1, 2015	Adopted into rule June 1, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.

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

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X222A1*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X222A1* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

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

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

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

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

Appeal – Provider is requesting a reconsideration of a previously adjudicated claim for which there is no additional data or corrected data to be submitted. Providers should contact the payer or the payer's website for further instructions regarding reconsiderations or appeals.

- Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

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

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2010CA	Patient Name	DMG Patient Demographic Information	DMG02 Patient Birth Date	Services to unborn children should be billed under the mother as the patient.
2300	Claim Information	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definitions.
2300	Claim Information	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300	Claim Information	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
2300	Claim Information	PWK Claim Supplemental Information	PWK02 Report Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300	Claim Information	AMT Patient Amount Paid	AMT02 Monetary Amount	Must not exceed total claim charge amount in CLM02.
2300	Claim Information	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300	Claim Information	K3 File Information	N/A	See Appendix B of this document for usage instructions.
2300	Claim Information	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
2300	Claim	CRC	N/A	Required for Medicaid Programs when service is rendered under the

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
	Information	EPSDT Referral		Minnesota Child and Teen Checkup Programs.
2310A	Referring Provider Name	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2310A	Referring Provider Name	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310B	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2310B	Rendering Provider Name	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310C	Service Facility Location Name	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2310C	Service Facility Location Name	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2320	Other Subscriber	SBR Other Subscriber	N/A	Do not send claim to secondary or any subsequent payer until previous payer

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
	Information	Information		has processed.
2330B	Other payer name	NM1 Other payer name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400	Service Line Number	SV1 Professional Service	SV101-7 Description	See front matter section 3.2.5 of this document for additional instructions.
2400	Service Line Number	SV1 Professional Service	SV103 Unit or Basis for Measurement Code	See Appendix A for coding units.
2400	Service Line Number	SV1 Professional Service	SV104 Quantity	Minnesota specific note: Zero “0” is not a valid value.
2400	Service Line Number	SV1 Professional Service	SV107-1 Diagnosis Code Pointer	Primary diagnosis code cannot point to an External Cause of Injury code.
2400	Service Line Number	DTP Date - Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400	Service Line Number	AMT Sales Tax Amount	N/A	See Appendix C of this document for details on reporting MNCare Tax
2400	Service Line Number	K3 File Information	N/A	See Appendix B of this document for usage instructions.
2400	Service Line Number	NTE Line Note	N/A	See front matter section 3.2.5 of this document for definition and usage
2420A	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage.
2420A	Rendering	REF	REF01	Use G2 for atypical providers.

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837) Transaction Specific Information This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2.				
Loop	**Loop Name**	**Segment**	**Data Element (if applicable)**	**Value Definition and Notes**
		Secondary Identification	Qualifier	

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5. List of Appendices

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

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

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

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

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

B. Appendix B: K3 Segment Usage Instructions

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

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

A.2 HIPAA Code Sets

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

A.3.1 General Rules

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

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.3.2 Instructions for Using This Appendix and Its Accompanying Tables

1. For the state government behavioral health programs identified in Table A.5.2, use the codes referenced in the table.
2. For substance abuse services, use the codes listed in Table A.5.3.
3. For Maternal and Child Health Billing Guide for Public Health Agencies use the codes listed in Table A.5.4.
4. For all other procedures/services/products, use Table A.5.1 as follows:
    a) Step 1. Find the appropriate row ("Medicare Claims Processing Manual Chapter") in Table A.5.1 for the type of procedure/service/product provided.
    b) Step 2. If the "Minnesota Rule" column in Table A.5.1 states "Follow Medicare Coding Guidelines," then select and use codes consistent with the claims submission coding instructions and requirements maintained by or on behalf of the Centers for Medicare and Medicaid Service (CMS) (e.g., Medicare Claims Processing Manual and communications from or on behalf of CMS).
        1. Note: Exception to the "Follow Medicare Coding Guidelines" statement above. If either of the following applies:
            - The procedure/service/product is listed in a Medicare coding resource but is limited by Medicare coverage; OR
            - The procedure/service/product is not listed in a Medicare coding resource;

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

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

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

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

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

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

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

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

A.5 Tables of Coding Requirements

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

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

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

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

- ASC X12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1

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

as “professional claim type” or “837P” or “Professional claim;”

- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.1 as “institutional claim type” or “837I” or “Institutional claim;”
- ASC X12/005010X224A2 Health Care Claim: Dental (837), referred to in Table A.5.1 as “837D.”

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

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

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

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

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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
12	Physicians/Nonphysician Practitioners	Interpreter services	To report interpreter services: 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 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)

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			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) • 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

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

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapter Number</th><th>Title/Description</th></tr>
<tr><td></td><td></td><td></td><td>• Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face)
• Consulting psychologist – 99499 HE AM
• Consulting psychologist – 99499 HE AM U4 (non-face-to-face)</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Patient not in exam room</td><td>There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD~~-9~~-CM code(s) 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.~~</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Health Care Homes</td><td>The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:
Patient Complexity Level and Supplemental Factors
<table>
<tr><th>Patient Complexity Level</th><th>Complex-ity Modifiers</th><th>Non English Speak-ing Modifier</th><th>Active Mental Health Con-dition</th></tr>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
</table></td></tr>
</table>

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			<table><tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr><tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr><tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr><tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr></table> Definitions of U modifiers with S0280 or S0281: o U1 – Care coordination, basic complexity level o U2 – Care coordination, extended complexity level o U3 – Care coordination, supplemental factor; Non-English language o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition
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
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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
13	Radiology Services and Other Diagnostic Procedures	Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
14	Ambulatory Surgical Centers	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance	General	Follow Medicare coding guidelines
15	Ambulance	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: ▪ A0080 ▪ A0090 ▪ A0100 ▪ A0110 ▪ A0120 ▪ T2002 ▪ T2003 ▪ T2004
15	Ambulance	Community Paramedic	Community paramedic services are to be billed as follows:

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			• 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~~ ~~s~~Supplies (e.g., gloves, test strips, band aids, etc.); o Vaccines; 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.

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
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 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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
18	Preventive and Screening Services	Vaccine administration	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
18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
~~**18**~~	~~Preventive and Screening Services~~	~~C&TC~~	~~S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed.~~ ~~▪ Maternal depression screening: 99420 UC~~ ~~▪ Developmental screening: 96110~~ ~~▪ Child Mental Health Screening: 96127.~~ ~~▪ Report CPT codes 99401-99404 if~~

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			~~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.~~
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.

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.
21	Medicare Summary Notices		Not applicable to coding guidelines
22	Remittance Advice		Not applicable to coding guidelines
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines
35	Independent Diagnostic Testing Facility (IDTF)		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines
See the following regarding "Doula Services", "Home Infusion Therapy" and "Licensed Traditional Midwife Services (Not Certified Nurse Midwives)" that are not addressed in any chapter of the Medicare Claims Processing Manual.			
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.

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
N/A	N/A	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. <u>Place of Service:</u> 25 – Free-standing Birthing Center <u>HCPCS Code:</u> 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

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
			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**	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 a complete list of reportable component codes. • 96110 – Developmental Screening • 96110 U1 – Autism Screening with a standardized instrument, 1 unit • 96127 – Social/Emotional or Mental Health Screening • 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.

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

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapter Number</th><th>Title/Description</th></tr>
<tr><td>N/A</td><td>N/A</td><td>Early Intensive Developmental and Behavioral Intervention (EIDBI)</td><td>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. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI)
2. EIDBI 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. 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 and Behavior Intervention]

<table><tr><th><u>Coding Individual</u></th><th><u>Coding Group</u></th></tr><tr><td>0368T UB HK – Qualified Supervising Professional, first 30 minutes
0369T UB HK – Qualified Supervising Professional, each additional 30 minutes
0368T UB HP – Doctorate /Mental Health Professional [MHP]]first 30 minutes</td><td>0366T UB HK –Qualified Supervising Professional, first 30 minutes
0367T UB HK –Qualified Supervising Professional, each additional 30 min
0366T UB HP – Doctorate /Mental Health Professional [MHP]], first 30 minutes
0367T UB HP – Doctorate /Mental Health Professional</td></tr></table></td></tr>
</table>

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule	
Chapter Number	Title/Description			
			0369T UB HP – Doctorate /Mental Health Professional [MHP]] each additional 30 minutes 0368T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes 0369T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes 0368T UB HN – Bachelor's degree level I , first 30 minutes 0369T UB HN – Bachelor's degree level I , each additional 30 minutes 0364T UB HN – Bachelor's degree level II, first 30 minutes 0365T UB HN – Bachelor's degree level II, each additional 30 minutes 0364T UB HM –Less than bachelor's degree- level III, first 30 min 0365T UB HM – Less than bachelor's degree- level III, each additional 30 minutes	[MHP]], each additional 30 min 0366T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes 0367T UB HO – Masters /Mental Health Professional [MHP], each additional 30 min 0366T UB HN – Bachelor's degree level I or II, first 30 minutes 0367T UB HN – Bachelor's degree level I or II, each additional 30 min 0366T UB HM –Less than bachelor's degree- level III, first 30 min 0367T UB HM – Less than bachelor degree - level III, each additional 30 min
			2. EIDBI Observation and Direction Selected Codes 0362T, 0363T	

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

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapter Number</th><th>Title/Description</th></tr>
<tr><td></td><td></td><td></td><td>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]

<table><tr><th>Coding</th><th>Telemedicine</th></tr><tr><td>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 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</td><td>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 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</td></tr></table></td></tr>
</table>

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		

	additional 30 minutes 0362T UB HK GT - Qualified Supervising Professional, first 30 minutes 0363T UB HK GT – Qualified Supervising Professional , each additional 30 minutes

3. Comprehensive Multi-Disciplinary Evaluation (CMDE)

Selected Code

0359T

AM – Psychiatrist [MD]/Physician

HO – Masters /Mental Health Professional [MHP]

HP – Doctorate /Mental Health Professional [MHP]

TG – Advanced Practice Registered Nurse (APRN)

GT– via interactive audio and video telecommunications systems

UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

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

4. Individual Treatment Plan Development and Monitoring

Selected Codes

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

<table>
<tr><th colspan="2">Medicare Claims Processing Manual</th><th rowspan="2">Specific Coding Topic</th><th rowspan="2">Minnesota Rule</th></tr>
<tr><th>Chapter Number</th><th>Title/Description</th></tr>
<tr><td></td><td></td><td></td><td>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]
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.

<table><tr><th>Coding</th></tr><tr><td>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</td></tr></table>
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]

<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</td><td>T1027 UB HK HQ – Qualified Supervising Professional [QSP], Group
T1027 UB HP HQ – Doctorate /Mental</td></tr></table></td></tr>
</table>

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		

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

Health Prof [MHP], Group
T1027 – UB HO HQ – Masters /Mental Health Prof [MHP], Group
T1027 UB HN HQ – Bachelor's degree level I or II, Group

6. Coordinated Care Conference

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
TG – Advanced Practice Registered Nurse (APRN)

Coding	Telemedicine Coding
T1024 UB AM – Physician T1024 UB TG - APRN	T1024 UB AM GT – Physician (telemedicine) T1024 UB TG GT– APRN (telemedicine)

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		

			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 HK GT– Qualified Supervising Professional [QSP] (telemedicine] T1024 UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine) T1024 UB HO GT – Masters /Mental Health Professional[MHP] (telemedicine) T1024 UB HN GT – Bachelor's degree level I or II (telemedicine) 7. Travel Time Selected Codes H0046 UB – EIDBI [Early Intensive Developmental and Behavior Intervention] 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

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

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

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

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

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

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

Assertive Community Treatment (ACT)

Adult Crisis Response Services

Children's Mental Health Crisis Response Services

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Children's Therapeutic Services and Supports (CTSS)

Adult Rehabilitative Mental Health Services (ARMHS)

Peer Services

Mental Health Diagnostic Assessment

Dialectical Behavior Therapy

Youth Assertive Community Treatment

Intensive Treatment in Foster Care

Mental Health Family Psychoeducation Services

Mental Health Clinical Care Consultation

Certified Family Peer Specialist – DHS

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

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

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

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

Name of Program	Description/Definition	Coding
programs		Response Services, bachelor's degree level mental health practitioner
Mental Health Targeted Case Management (MH-TCM) Back to list of behavioral health programs	▪ Community support plan and functional assessment to help SPMI adults and SED children gain access to needed medical, social educational, vocational, financial services relative to mental health needs.	Codes: ▪ T2023 HE HA – Targeted case management; per month, mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years ▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older ▪ T2023 HE TF - Targeted case management intermediate level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older ▪ T1017 HE – Targeted case management, per encounter (day), mental health program, adult, face-to-face contact between case manager and recipient age 18 or older, IHS/638 facilities and FQHCs ▪ T1017 HE HA – Targeted case management, per encounter (day), mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years, IHS/638 facilities and FQHCs
Children's Mental Health Residential Treatment Services	▪ 24-hour-a-day program under clinical supervision of a mental health professional, provided in a community setting.	PMAP/Commercial/County-based Purchasing (CBP): For room and board and/or treatment services, report on the 837I type of bill 86X, with the

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

Name of Program	Description/Definition	Coding
Back to list of behavioral health programs		room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. Department of Human Services (DHS)/ Fee for Service: When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019, and POS 99.
Intensive Residential Treatment Services (IRTS) Back to list of behavioral health programs	▪ Time-limited mental health services provided in a residential setting to recipients in need of more restrictive settings and at risk of significant functional deterioration. ▪ Develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.	PMAP/Commerical/County-based Purchasing (CBP): For room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. Department of Human Services (DHS)/ Fee for Service: When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.
Adult Day Treatment Back to list of behavioral health programs	▪ A structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a recipient's mental health status, develop and improve independent living and socialization skills	Codes: ▪ H2012 - Behavioral health day treatment, per hour
Children's Day Treatment Back to list of behavioral health	▪ A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services	Codes: ▪ H2012 UA HK – Behavioral health day treatment, per hour, CTSS

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

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

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

Name of Program	Description/Definition	Coding
		▪ H2014 UA - 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

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

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

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

Name of Program	Description/Definition	Coding
		▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by 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	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20

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

Name of Program	Description/Definition	Coding
Back to list of behavioral health programs		
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (1) Psychotherapy provided by a mental health professional; (2) Crisis assistance provided according to standards for children's therapeutic services and supports; (3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee; (4) Clinical care consultation provided by a mental health professional or a clinical trainee; and (5) Service delivery payment requirements as provided under subdivision 4.	Codes: ▪ S5145 – Foster care, therapeutic, child; per diem ▪ HE – Mental health program Bill only one per diem code per day regardless of the number of services or who provides services.
Mental Health Family Psycho-education 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	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,

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

Name of Program	Description/Definition	Coding
	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.	clinical trainee ▪ H2027 HS HN - Family without client present, clinical trainee ▪ H2027 HQ HR HN - Multiple different families with clients present, clinical trainee ▪ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee
Mental Health Clinical Care Consultation Back to list of behavioral health programs	• MH clinical care consultation services provided to patients up to age 21 and provided by mental health professional or clinical trainee to other providers or educators not under their supervision. • Services may take place in, but are not limited to, school, community, office or clinic	Codes: ▪ 90899-U8 (5-10 minutes) ▪ 90899-U9 (11-20 minutes) ▪ 90899-UB (21-30 minutes) ▪ 90899-UC (31+ minutes) Additional modifiers could be appended, such as U4 for phone and/or HN for clinical trainee.
Certified Family Peer Specialist – DHS Back to list of behavioral health programs	• Services are for children under the following codes with the HA modifier. • For mental health services only; do not apply to substance abuse.	Codes: • H0038 Certified peer specialist services, per 15 minutes • H0038 U5 Advanced level certified peer specialist services, per 15 minutes • H0038 HQ Group setting, certified peer specialist services, per 15 minutes • H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes • H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes

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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

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

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

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

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

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

v10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

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

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

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

v10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) **A.5.3.b – Substance Abuse Services: All Other Residential**					
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Claim Type**	**Type of Bill**
Room and Board	Day	1002: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) 1003: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
Treatment program, treatment component	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
Treatment program, treatment component	Hour	0953	None	837I	086x – special facility, residential
Ancillary services	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

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

v10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

Claim Type – 837I

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

Note: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.

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

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

Claim Type – 837P				
Service Descriptions	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
Note: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs				
Alcohol and/or drug assessment	Session/visit	N/A	H0001	

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

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

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and miscellaneous

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

V10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.a -- Public health nurse clinic services**		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Services Include: • Health Promotion & Counseling • Nursing Assessment & Diagnostic Testing • Medication Management • Nursing Treatment • Nursing Care, in the home, by RN (PHN & CPHN)	S9123	T1015
Home health aide or CNA, per visit	T1021	Individual S9445 Group S9446
Patient Education only - if no other services (includes car seat education)	S9123	Individual S9445 Group S9446

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

v10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Maternal And Child Health Billing Guide For Public Health Agencies

Table A.5.4.b -- Maternal & child health visits

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Birthing Classes	N/A	S9442
Home Visit for Postnatal assessment & follow up care - **Mother**	99501	N/A
Home Visit for Post-natal assessment & follow up care - **Newborn**	99502	N/A
Enhanced Services - for at-risk pregnancies as determined by the physician/nurse practitioner		
At-Risk Antepartum Management	H1001	H1001
At-Risk Care Coordination	H1002	H1002
At-Risk Prenatal Health Education	H1003	H1003
At-Risk Prenatal Health Education I	H1003	H1003
At-Risk Prenatal Health Education II	H1003	H1003
At-Risk Enhanced Service; Follow-up Home Visit	H1004	N/A
At-Risk Enhanced Service Package	H1005	H1005

Table A.5.4.c – OTHER SERVICES and MISCELLANEOUS

v10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.c -- Other services**		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **re-assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

V8.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837) Maternal And Child Health Billing Guide For Public Health Agencies **Table A.5.4.c -- Miscellaneous**		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Maternal Depression Screenings	99420 UC	99420 UC
Child Developmental Screenings	96110	96110
Child Mental Health Screenings	96127	96127
TB Case Management	T1016	T1016
TB Direct Observation Therapy	H0033	H0033

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B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

K3*LUMN~

Tooth Number/Oral Cavity

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

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

Report at 2400 Loop only.

K3*JP12~

K3*JP12 14~

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

Report at 2400 Loop only.

K3*JO10~

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

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

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C. Appendix C: Reporting MNCare Tax

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

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Administrative Uniformity Committee

Title: Methadone Therapy Tracking

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: Methadone Therapy Tracking	Date: Oct 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:

Title:

Email address:

Phone number:

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

SBAR Issue Title: Methadone Therapy Tracking

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: Per the Deputy Inspector General Vicki Kunerth, MAT Therapy and/or counseling must be provided on the day when MAT dosing is dispensed. Due to 2015 Legislative changes, in order to verify therapy and/or counseling was performed, as per the statute, DHS will require Category II code 4306F to be included on the claim with the methadone dispensing services billed under H0047-U9 – MAT-all other drugs.

B

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

Per the AMA, Category II codes are 'supplemental tracking codes that can also describe results from clinical laboratory tests or other procedures, as well as identify processed intended to address patient safety practices, or services reflecting compliance with state or federal law'.

Statute/2015 Legislation:

https://www.revisor.mn.gov/laws/?id=71&doctype=Chapter&year=2015&type=0#laws.2.20.0

EFFECTIVE DATE.

This section is effective January 1, 2016, with hearings starting no later than February 1, 2016.

Sec. 20. Minnesota Statutes 2014, section 254B.05, subdivision 5, as amended by Laws 2015, chapter 21, article 1, section 52, is amended to read:

Subd. 5. **Rate requirements.**

(a) The commissioner shall establish rates for chemical dependency services and service enhancements funded under this chapter.

(b) Eligible chemical dependency treatment services include:

(1) outpatient treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license;

(2) medication-assisted therapy services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6500, or applicable tribal license;

(3) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (2) and provide nine hours of clinical services each week;

(4) high, medium, and low intensity residential treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505, or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(5) hospital-based treatment services that are licensed according to Minnesota Rules, parts 9530.6405 to 9530.6480, or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(6) adolescent treatment programs that are licensed as outpatient treatment programs according to

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)

In order to verify therapy and/or counseling was performed, as per the statute*, DHS will require Category II code 4306F to be included with their claim for dispensing methadone. This will hold the provider accountable to attest to the services performed.

R

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

DHS will require providers performing MAT Therapy and/or counseling services, to append the following Category II code to their 837P or 837I claim as verification of services performed at the time of MAT dosing.

4306F – Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction

v10.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
Note: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs				
Alcohol and/or drug assessment	Session/visit	N/A	H0001	

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:**

Administrative Uniformity Committee

Title: Dental Therapist [DT] & Advanced Dental Therapist [ADT]

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:
Dental Therapist [DT] & Advanced Dental Therapist [ADT]	10-06-2015
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

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

SBAR Issue Title: Dental Therapist [DT] & Advanced Dental Therapist [ADT]

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: 2011 Legislation requires coverage of services provided by DT's and ADT's and allows MHCP to enroll DT's and ADT's to provide oral health services to MHCP recipients. DT's and ADT's primarily provide services to low-income, uninsured and underserved recipients, or in dental care shortage areas. Although DT's and ADT's are enrolled, and ADT's have an NPI, there is a need to identify the services rendered with a state U modifier for MHCP recipients for MCO reporting to DHS as well as DHS reporting to the state.

	150A.105 DENTAL THERAPIST. Subdivision 1.**General.** A dental therapist licensed under this chapter shall practice under the supervision of a Minnesota-licensed dentist and under the requirements of this chapter. Subd. 2.**Limited practice settings.** A dental therapist licensed under this chapter is limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area. Subd. 3.**Collaborative management agreement.** (a) Prior to performing any of the services authorized under this chapter, a dental therapist must enter into a written collaborative management agreement with a Minnesota-licensed dentist. A collaborating dentist is limited to entering into a collaborative agreement with no more than five **dental therapists or advanced dental therapists** at any one time.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Link to statute: https://www.revisor.mn.gov/statutes/?id=150A.105 Link to DHS Manual: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166913
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) DHS proposes that ADT's are reported as the treating provider with their NPI on claims. DHS proposes to identify the services rendered by a DT's with a U modifier. This will ensure that the service is clearly identified as being rendered by a DT or ADT, and not the dentist. Reporting the services back to the state will be uniform and consistent across all fee for service and managed care claims data. Recent studies show services are being reported as being done by the dentist, which does not allow for appropriate program integrity oversight, and analysis of the impact of these professionals..

R

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

Although DT's and ADT's are enrolled, and ADT's have an NPI, there is a need to identify the services rendered by ADT's as the treating provider on the claim and by DT's with a state U modifier for MHCP recipients for MCO reporting to DHS as well as DHS reporting to the state.

Legislation:

- A DT certified by the Minnesota Board of Dentistry may perform the services and procedures within their scope of practice as identified in MS 150A.105 Subd. 4c &d and as specified in their written CMA.

An ADT certified by the Minnesota Board of Dentistry may perform the following services and procedures within their scope of practice as identified in their written CMA under general supervision.

- • Oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan authorized by the collaborative dentist
- • All DT procedures listed in MS 150A.105, Subd. 4 c & d
- • Nonsurgical extractions of periodontally diseased permanent teeth with tooth mobility of +3 to +4 under general supervision if authorized in advance by the collaborating dentist
- • May provide, dispense, and administer the following medications with the authorization of the collaborating dentist:
- • Analgesics
- • Anti-inflammatories
- • Antibiotics

DHS proposes the following modifiers to report on services rendered by the provider type:

Provider type	**U Modifier**
Advanced Dental Therapist –	UA
Dental Therapist -	UD

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:

Administrative Uniformity Committee

Title: Teledentistry Legislated Benefit 1-1-16

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:
Teledentistry	10-1-2015

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

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

SBAR Issue Title:

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: The Minnesota Legislature recently expanded coverage of Teledentistry to dental benefits under Medical Assistance and MinnesotaCare effective January 1, 2016. Coverage under commercial plans is effective January 1, 2017. Teledentistry will help with improved access which may increase early diagnosis, facilitate timely treatment, reduce isolation of practitioners through communication with peers and specialists, and improve access to care. This new benefit is limited to 12 ADA codes.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Currently Teledentistry is not part of the MA benefit today.
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 statute information on page 3-5

R

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

As stated in statute: https://www.revisor.mn.gov/statutes/?id=256B.0625

SYNOPSIS OF STATUTE:

-Providers must self-attest that they meet all of the conditions of the following MHCP Teledentistry policy. Dental and medical services must be performed via Two-way interactive video or store and forward technology. Documentation requirements are also outlined in the attached policy.

-Coverage is limited to children, pregnant woman, and limited adult benefits as specified in Minnesota Statutes 256B.0625, Subd. 9 (covered services). Teledentistry is limited to 3 services per week.

-MCHP allows the following CDT codes for the following diagnostic services when performed via Teledentistry:

D0120: Periodic oral evaluation — established patient
D0140: Limited oral exam
D0150: Comprehensive oral evaluation – new or established patient
D0210: Intraoral — complete series of radiographic images
D0220: Intraoral — periapical first radiographic image
D0230: Intraoral — periapical each additional radiographic image
D0270: Bitewing — single radiographic image
D0272: Bitewings — two radiographic images
D0274: Bitewings — four radiographic images
D0240: intraoral---- occlusal radiographic image
D0330: Panoramic radiographic image
D9310: Medical Dental Consultation

Providers may bill for Teledentistry on the same claim form as other types of procedure codes and the above diagnostic services are based on the current MHCP coverage for Children and adults.

Coverage Limitations

- Teledentistry services are limited to three per week per recipient
- Only one reading or interpretation of diagnostic tests such as x-rays, lab tests, and diagnostic assessment.

Not covered: Sending materials; originating site fee

DHS proposes identifying these services with U modifier to denote DHS/Medicaid service:

U9 –Service via Teledentistry

Add **U9** modifier to service performed via Teledentistry [only those listed above]

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:

DHS Teledentistry Policy

Minnesota Legislature recently expanded the coverage of Teledentistry to dental benefits effective January 1, 2016 and tasked DHS to establish a criteria for this benefit. Teledentistry, if successfully implemented in different oral health settings, has the potential to deliver improved health outcomes and positive health professional-patient experiences. This adds teledentistry to a list of specialty health care services for which face-to-face contact is not required for diagnostic services. Improved access to teledentistry may enhance early diagnosis, facilitate timely treatment of oral diseases, reduce isolation of practitioners through communication with peers and specialists, and improve access to specialist care. Teledentistry may also lead to a greater utilization of relatively low-cost preventive interventions and may result in future cost savings by avoiding more costly dental diseases and emergencies.

Clinical uses of teledentistry support a wide range of applications with benefits to patients and practitioners. A teledentistry consultation from a health professional to a dental specialist may improve diagnosis and support clinical treatment. Teledentistry may also reduce the number of inappropriate referrals by screening patients to ensure that only those who need to see a specialist are referred for the care they need. This ensures efficient use of scarce health resources, increasing access to care, improving productivity and supporting enhanced oral health across society.

To be eligible for reimbursement, providers must self-attest (form below) that they meet all of the conditions of the following MHCP teledentistry policy:

1. **Teledentistry originating site:**
   - I. Healthcare facility,
   - II. Long-term care facility,
   - III. Public health agency or institution,
   - IV. Public or private school authority,
   - V. Private non-profit or charitable organizations,
   - VI. Social services agency or program,
   - VII. Residential setting in the presence of licensed healthcare providers.

2. **Affiliate practice or originator within MN Board of Dentistry defined scope of practice must be present at originating site:**
   - I. Dentist,
   - II. Advanced dental therapists,
   - III. Dental therapists,
   - IV. Dental hygienists,
   - V. Licensed dental assistants,
   - VI. Other licensed health care professionals.

3. **Considered Teledentistry technology equipment at sites may include:**
   - I. A HIPAA compliant computer or tablet,
   - II. Means of secure storage and transmission of patient data,
   - III. Secure web-camera for video-conferencing,

IV. Intraoral dental camera to capture images,
V. Video-conferencing software (for example, Citrix GoToMeeting),
VI. Sufficient bandwidth for real-time,
VII. X-ray machine with digital sensors and digital radiograph software.

Two-way interactive video

Involves a videoconferencing session that allows health professionals at distant locations to communicate with each other. A typical set-up involves high-definition webcams combined with hands-free microphone/speaker units so that the users can see and hear each other. For this type of consultation, both parties arrange a meeting time and information is exchanged in real-time between sites. This type requires sufficient bandwith and HIPAA compliant software.

Store and forward

Communication is asynchronous including - video clips, photographs and scans, storing them in a file and sent to the dentist. The dentist retrieves the file at a time of their convenience and examines the contents. Recommendations are provided to the oral health professional in the same manner, within 7 calendar days of the time of information gathering.

Documentation requirements:

1. The type of service provided by Teledentistry ,
2. The time the service began and the time the service ended, including an a.m. and p.m. designation,
3. The licensed healthcare provider's basis for determining that teledentistry is an appropriate and effective means for delivering services to the enrollee,
4. The mode of transmission of the teledentistry service and records evidencing that a particular mode of transmission was utilized,
5. The location of the distant site,
6. If the claim for payment is based on a teledentistry consultation with a dentist, the written opinion from the consulting dentist providing the teledentistry consultation
7. Compliance with the criteria attested to by the health care provider in accordance with statute,
8. Dental provider must document verbal or written informed consent from the patient or patient's healthcare decision maker prior to delivery of care through teledentistry.
9. All reports resulting from a teledentistry consultation are part of the patient's record.

4. **Reimbursement for teledentistry**- same rate as in person to a pay to provider

5. **Benefit sets:**

Beginning January 1, 2016, MHCP will cover teledentistry claims for diagnostic services. The following CDT codes may be billed as part of teledentistry by enrolled MHCP providers. Coverage is limited to children, pregnant woman, and limited adult benefits as specified in Minnesota Statutes 256B.0625, Subd. 9 (covered services). Teledentistry is limited to 3 services per recipient per week.

MCHP allows the following CDT codes for the following diagnostic services when performed via Teledentistry:

- D0120: Periodic oral evaluation — established patient
- D0140: Limited oral exam
- D0145: oral evaluation for a patient under 3 years of age

- D0150: Comprehensive oral evaluation – new or established patient
- D0210: Intraoral — complete series of radiographic images
- D0220: Intraoral — periapical first radiographic image
- D0230: Intraoral — periapical each additional radiographic image
- D0270: Bitewing — single radiographic image
- D0272: Bitewings — two radiographic images
- D0274: Bitewings — four radiographic images
- D0240: intraoral---- occlusal radiographic image
- D0330: Panoramic radiographic image
- D9310: Medical Dental Consultation

Providers may bill for teledentistry on the same claim form as other types of procedure codes and the above diagnostic services are based on the current MHCP coverage for Children and adults.

Coverage Limitations

- Payment for telemedicine services is limited to three per week per recipient
- Payment will be made for only one reading or interpretation of diagnostic tests such as x-rays, lab tests, and diagnostic assessment.
- Payment is not available to providers for sending materials