Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, October 27, 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** – October 08, 2015
4. **Dental Therapist [DT] & Advanced Dental Therapist [ADT] – Kathy Sijan**

10/8/15: Kathy Sijan presented two dental related SBARs. After discussion, it was agreed that the SBARs should be included in a discussion of the 837D companion guide and possible updates to the guide. The TAG will meet on Oct. 27 to discuss the SBARs and to consider possible updates or revisions to the 837D guide.	**OPEN**

5. **Teledentistry – Kathy Sijan**

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

3/12/15: DHS Behavior Health Home policy staff, Jennifer Blanchard and Lisa Cariveau, attended the meeting to provide background and overview of the Behavior Health Home services described in the SBAR and to answer questions the MCT may have. Jennifer stated that the basis of BHH program is a result of the Affordable Care Act and that it is currently out for state public comments. It was noted that SAMSA approved the program. After approved, it will sent to CMS for federal approval. The anticipated start date is January 1, 2016. There are two services: • The first is the initial plan (S0280–U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH, monthly). This service is billed for the first six months. These services do not have to be consecutive.	**OPEN** DHS will send info to Faith re: State Plan language DHS will also make corrections to the SBAR and forward to

• 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.	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**
10/8/15: DHS submitted the BHH state plan amendment to CMS on October 12.	**OPEN**

7. Additional Agenda Items/ Announcements

- A special meeting will be held October 27, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. The purpose of the meeting will be to resolve two dental-related SBARs and to consider possible updates to the 837D companion guide.
- Next regularly scheduled meeting: December 10, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.

Administrative Uniformity Committee

AUC UPDATE

October 21, 2015 | Volume 3, Number 9

IN THIS EDITION

AUC NEWSLETTER SUBSCRIPTION

Interested in signing up to receive this newsletter and other AUC updates and information?

Please sign up using the Subscribe feature on the right hand side of the AUC homepage. (http://www.health.state.mn.us/auc/index.html) under the "Most Viewed" navigation frame.

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

New AUC "ACO Data Analytics TAG" to meet November 5

NEW TAG IS ACCEPTING MEMBERS

The AUC recently announced the formation of a new Technical Advisory Group (TAG), the "ACO Data Analytics TAG," as well as plans for a first meeting of the TAG on November 5, 2015.

The new TAG was requested by the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH), to recommend a more aligned way for sharing demographic and enrollment files with providers participating in accountable care arrangements. The files include data such as name, date of birth, address, beneficiary contact information and associated primary providers and payers for enrollees in accountable care arrangements.

The DHS/MDH request was presented and discussed at the last regular AUC quarterly meeting on September 8, 2015. The AUC learned that as part of Minnesota's continued payment and care delivery reform efforts, including a three year State Innovation Model (SIM) from the federal Centers for Medicare & Medicaid, a statewide goal has been established to increase the number of providers participating in accountable care arrangements as well as to increase the number of Minnesotan's receiving well-coordinated care.

Health care providers participating in accountable care models need a variety of demographic and other data (data analytics) to effectively coordinate care and to be responsible for a group of patients. However, at present the data needed by providers are exchanged in a variety of nonstandard formats, with varied field definitions, and across nonstandard timeframes. This is causing "costly challenges, potential errors and lack of understanding in interpreting and using information which diminishes the value and power of data analytics."

The new TAG will make recommendations for increased consistency in the format of the information shared between payers and providers in accountable care arrangements. This data standardization supports the state's health reform goals by allowing data from multiple payers to be used more meaningfully to improve patient care and outcomes.

The TAG is open to any interested parties. In keeping with AUC bylaws, only AUC members are eligible to vote if voting items are raised. All TAG meetings are open public meetings.

An organizational and working first TAG meeting has been scheduled for 8:30 am – 11:30 am, Thursday, November 5, 2015; place TBD. It is anticipated at this time that the TAG may meet approximately monthly from November, 2015 – February 2016.

Vicky Swanson, Payer Relations and Network Consultant from Ridgeview Medical Center and Ridgeview Clinics, has volunteered to serve as a provider co-chair for this TAG. The AUC is seeking a payer co-chair for the TAG.

To sign up for the TAG, to volunteer for the payer co-chair position, or for more information, please email susie.veness@state.mn.us . Information about the ACO Data Analytics TAG and its planned meetings is also available on the TAG page of the AUC website.

New "Home Health Prior Authorization Form TAG" to meet October 23

The AUC has formed a new, temporary "Home Health Prior Authorization Form TAG" to review a proposed single, common home health prior authorization form that was presented to the AUC Operations Committee on September 8, 2015.

The TAG will hold its first meeting 9:30 am – 11:00 am, Friday, Oct. 23 at the Minnesota Council of Health Plans, Suite 255-South, Court International Building, 2550 University Avenue West, St. Paul. The meeting is an open, public meeting and any interested AUC members and interested parties are encouraged to attend. If the review is not completed at the Oct. 23 meeting, an additional meeting will be scheduled.

Kathryn Kmit, Minnesota Council of Health Plans, and Kathy Messerli, Minnesota HomeCare Association, will serve as co-chairs. Meeting materials are posted on the Home Health PA Form TAG webpage of the AUC website.

AUC welcomes two most recent members

The AUC extends a hearty welcome to its two newest members, South Country Health Alliance and Grand Itasca Clinic and Hospital. South Country is a county-based health plan serving 12 counties in Minnesota, headquartered in Owatonna, Minnesota. Its primary AUC representative is Joanne Retzer, and its secondary representative is Jim Barkhaus. Grand Itasca is a hospital and clinic operating out of Grand Rapids, Minnesota. Its primary AUC representative is Jennifer Notch, and its secondary representative is Ed Tusa.

For more information about AUC membership, please see the membership page (http://www.health.state.mn.us/auc/memborg.htm).

Coding Corner

We are starting a new column in this issue featuring updates, tips, and pointers regarding medical coding. The goal of the column is to help address common coding issues and to pass along coding news and updates suggested by the Medical Code TAG and other sources. We start the Corner with some reminders from the Medical Code TAG.

Annual 2015 Minnesota State AAPC Conference November 5-6

The annual Minnesota conference of the American Association of Professional Coders (AAPC) is taking place November 5-6, 2015 in St. Cloud, Minnesota. Attendees can earn up to 14 continuing education credits (CEUs), participate in a variety of sessions, discuss ICD-10 implementation, and network with other professionals.

In addition, two members of the AUC Medical Code TAG will be presenting at the conference. Carolyn Larson, PreferredOne, will be part of an ICD-10 panel, and Kathy Sijan, Minnesota Department of Human Services, will present on Autism Coding/Benefit.

For more information and/or registration go the registration website (https://www.regonline.com/builder/site/default.aspx?EventID=1704964).

Appropriate reporting of modifier 50 (Bilateral Procedure)

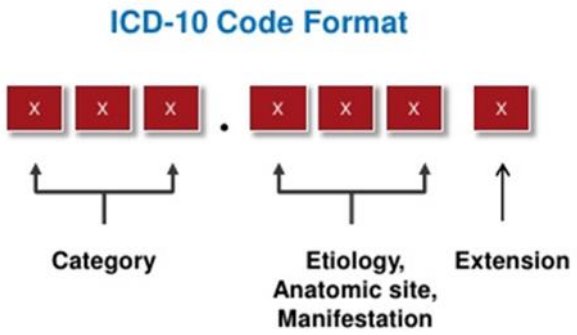
(from the Minnesota Uniform Companion Guides for the 837 Institutional and 837 Professional transactions)

Bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code. 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 (professional claims (837P)).

An exception to this is for Radiology Services. 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.

ICD-10 reminder: Use of 7th digit character



The national industry press and some local payers have reported challenges and problems stemming from incorrect coding and use of the ICD-10 seventh character (also known as seventh character extension). Below are some helpful reminders.

A key difference between ICD-9 and ICD-10 is the use of the seventh digit coding character in ICD-10. According to the Centers for Medicare & Medicaid Services (CMS):

- "A 7th character is used in certain chapters, such as Musculoskeletal, Obstetrics, Injuries, and External Causes.
- Seventh characters are also used in a few other places outside of these particular chapters.
- The 7th character has a different meaning depending on the section where it is being used. It must always be used in the 7th character position, and when a 7th character applies, codes that are missing this character are considered invalid."

The take away?: *Please review the diagnosis(ses) on claims prior to submission to ensure the appropriate 7th character has been added.*

For more information, see resources such as:

- CMS ICD-10 Basics (http://www.roadto10.org/icd-10-basics/)
- ICD-10 monitor 1 (http://www.icd10monitor.com/coding/259-understanding-icd-10-cm-episode-of-care-seventh-character-extensions?showall=1&limitstart=)
- ICD-10 monitor 2 (http://www.icd10monitor.com/enews/item/1505-icd-10-is-up-and-running-but-much-anxiety-remains)
- CMS video transcript (https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-12-01-ICD-10-Video-Transcript.pdf)

Reminder: Reporting units

(from the Minnesota Uniform Companion Guides for the 837 Institutional and 837 Professional transactions)

"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 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.
- 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. 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."

TAG Updates

Information about AUC committees and Technical Advisory Groups (TAGs) and their activities, including meeting minutes, can be accessed from the AUC TAG page (http://www.health.state.mn.us/auc/activity.htm).

Meeting agendas and other materials are posted on the AUC website in advance of meetings. TAG meeting schedules and information are also available on the AUC calendar page (http://www.health.state.mn.us/auc/calendar.htm).

With the exception of the Medical Code TAG, TAG meetings are generally conducted via teleconference rather than in-person. All AUC meetings are open, public meetings.

Note: The AUC reviews Minnesota Uniform Companion Guides (MUCG) approximately annually for any revisions and updates to ensure that the guides remain up to date and accurate. The review and revisions occur generally during the second half of the calendar year. During the next several months then, it is anticipated that several TAGs will be assisting in the "annual maintenance" of the companion guides in addition to any other projects or tasks that they are completing.

Medical Code TAG (MCT)

The Medical Code TAG met on October 8 and completed recommendations in response to two coding requests (SBARs). The TAG also recommended changes as part of annual maintenance of the Minnesota Uniform Companion Guides (MUCGs) for the 837P and 837I transactions, and discussed plans for improved access to and search capabilities for the TAG pages on the AUC website.

The TAG next meets on October 27 to review possible changes and updates to the 837 Dental MUCG.

Claims DD TAG

The TAG met on September 16 and completed its reviews of the 837 Professional and 837 Institutional MUCGs as part of annual maintenance and updates of the Guides. The TAG next meets on December 9, 2015.

Eligibility TAG

The Eligibility TAG met September 23. It concluded that no changes were needed at this time to the Eligibility MUCG as part of the annual companion guide maintenance now underway. The TAG is next scheduled to meet October 28, to identify eligibility issues to be addressed through the development of best practices and other tools or resources.

National News

CMS Publishes New ICD-10 Resource Guide and Contact List

CMS has recently published a new ICD-10 Resource Guide and Contact List with phone numbers for Medicare Administrative Contractors (MACs) and email addresses for state Medicaid programs to contact in the event of ICD-10-related issues or questions.

CMS also suggests contact its ICD-10 Ombudsman regarding ICD-10 issues or questions.

CAQH CORE Announces New National Healthcare Operating Rules

The national Committee on Operating Rules for Information Exchange (CORE) announced on October 6 that it had adopted "phase IV" operating rules.

The Phase IV rules address infrastructure requirements for four healthcare business transactions: healthcare claims; prior authorization; employee premium payment; and enrollment and disenrollment in a health plan. Examples of these infrastructure requirements include:

- Offering at least one common method of connectivity (i.e., a "safe harbor") among entities transmitting data electronically.
- A minimal amount of time that systems must be available to receive and send data.
- An acknowledgement to ensure the transaction has been received, has not been lost between entities, and will be addressed.
- Required response times for acknowledgement and processing for both real-time and large record "batch" submissions.
- A common format that entities must use when providing information about their proprietary data exchange systems via "companion guides."

Rules regarding data content for the transactions may be added later if deemed appropriate by industry stakeholders.

The Phase IV operating rules are part of a series of operating rules that have been developed as mandated by the Accountable Care Act (ACA). As noted by CORE, the federal Department of Health and Human Services (HHS) "will determine if the Phase IV Operating Rules will be included in any regulatory mandates….The Phase I, II and III CAQH CORE Operating Rules became federally mandated for HIPAA-covered entities after HHS designated CAQH CORE as the authoring entity of those operating rules."

AUC October-November 2015 Meeting Calendar

AUC meetings currently scheduled for October – November 2015 are listed below. For more information, please see the AUC calendar page (http://www.health.state.mn.us/auc/calendar.htm).

October 2015	
Date/Time	**Event**
October 23 9:30 - 11:00am	**Home Health Prior Authorization Form TAG Meeting**
October 27 9:00am - 12:00pm	**Medical Code TAG Meeting**
October 28 2:00pm - 4:00pm	**Eligibility TAG Meeting**

November 2015	
Date/Time	**Event**
November 2 8:30am - 10:30am	**Executive Committee Meeting**
November 5 8:30am - 11:30am	**ACO Data Analytics TAG**
November 12 9:00am - 12:00pm	**Medical Code TAG Meeting**
November 16 1:00pm - 2:30pm	**EOB/Remit TAG Meeting**
November 25 2:00pm - 4:00pm	**Eligibility TAG Meeting**

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Tuesday, October 8, 2015, 9 a.m. to 12 Noon
Location of Meeting – HealthPartners
Meeting Minutes

Minutes By: Dave Haugen 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 minute revisions and 9/10/15 minutes reviewed and approved.	**CLOSED**
4. Gambling Addiction Program - Richard Scherer, Club Recovery, LLC	Kathy Sijan of the Minnesota Department of Human Services (DHS) reported that DHS is examining next steps for the program and requested that the item be removed from the standing agenda at this time.	**CLOSED**
5. Behavior Health Home (BHH) – Kathy Sijan, DHS	DHS submitted the BHH state plan amendment to CMS on October 12.	**OPEN**
6. 2016 MN Uniform Companion Guide Review	In discussion, clarifying changes were approved by the TAG for both the 837I and 837P companion guides, to: 1. remove a heading that was no longer needed from tables A.5.3.a, A.5.3.b, A.5.3.c.i, A.5.3.c.ii, A.5.4.a, A.5.4.b, A.5.4.c, and 2. add a "service description" for "counseling" and a related note in table A.5.3.c.ii In addition, Kathy Sijan presented an update regarding an SBAR for "Mental Health Service Plan Development." Following discussion, it was agreed to approve the SBAR and to add the following recommended codes to the 837I and 837P in Table A.5.2: • H0031 Mental Health Assessment, by non-physician • H0032 Mental Health Service Plan Development by non-physician • H0031-TS Mental Health Assessment, by non-physician, Follow Up Service [Review or Update] • H0032-TS Mental Health Service Plan Development by non-physician, Follow Up Services [Review or Update] Note: The location of the four codes above Table A.5.2 is pending additional DHS consideration, and particularly a DHS decision about whether the codes are to be included as part of the existing Adult Rehabilitative Mental Health Services (ARMHS) category, or in a different category. The TAG agreed to approve all the changes described in number 1 and 2 above, and the Mental Health Service Development Codes, and to forward them to Operations for a vote as soon as a decision was reached by DHS about where to put the Mental Health Service Development Codes.	**CLOSED –** send final guides to Ops
7. Methadone Therapy Tracking – Kathy Sijan, DHS	Discussion included the need to report the Level II reporting CPT code because there it is implied that documentation is always needed to justify the service. However, as a DHS requirement, the coding information will be added to the guides.	**CLOSED** send final SBAR to Ops

<table>
<tr><th>Agenda Item</th><th>Discussion</th><th>Action/Follow-up:</th></tr>
<tr><td></td><td>Kathy Sijan reviewed a Methadone Therapy Tracking SBAR. Recommendations submitted on the SBAR were approved, and were incorporated in the 837I and 837P companion guide updates as referenced in the agenda item above regarding addition of a new service category for counseling and a related note in table A.5.3.c. ii.
837P:
<table>
<tr><th>Service Descriptions</th><th>Unit</th><th>Revenue Code</th><th>HCPCS Procedure Code</th><th>Type of Bill</th></tr>
<tr><td>MAT Therapy and/or counseling services</td><td>Day</td><td>N/A</td><td>4306F Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction</td><td>N/A</td></tr>
</table>
837I:
<table>
<tr><th>Service Descriptions</th><th>Unit</th><th>Revenue Code</th><th>HCPCS Procedure Code</th><th>Type of Bill</th></tr>
<tr><td>MAT Therapy and/or counseling services</td><td>Day</td><td>0944</td><td>4306F Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction</td><td>089x or 013x</td></tr>
</table></td><td></td></tr>
<tr><td>8. Dental Therapist [DT] & Advanced Dental Therapist [ADT] – Kathy Sijan</td><td>Kathy Sijan presented two dental related SBARs. After discussion, it was agreed that the SBARs should be included in a discussion of the 837D companion guide and possible updates to the guide. The TAG will meet on Oct. 27 to discuss the SBARs and to consider possible updates or revisions to the 837D guide.</td><td>OPEN</td></tr>
<tr><td>9. Teledentistry – Kathy Sijan</td><td>Kathy Sijan presented two dental related SBARs. After discussion, it was agreed that the SBARs should be included in a discussion of the 837D companion guide and possible updates to the guide. The TAG will meet on Oct. 27 to discuss the SBARs and to consider possible updates or revisions to the 837D guide.</td><td>OPEN</td></tr>
<tr><td>10. Additional Agenda Items/ Announcements</td><td>Dave Haugen of the Minnesota Department of Health (MDH) thanked the Medical Code TAG for its work and noted that he Judy Edwards of MDH have been reviewing MDH’s support of the TAG and had several suggestions for discussion and feedback from the TAG.
Dave noted that:
MDH will be placing a new page on the AUC website to consolidate information about SBARs, the SBAR process, and status of SBARs. In discussion it was noted that in reporting the status of the SBARs, it will be important to differentiate between SBARs that have been completed and approved, and those that are still pending and have not been completed.
An index concept of interest to the TAG is difficult to develop and maintain and demonstrated some Google search techniques to find information of interest on the AUC website. MDH will be posting search tips on the AUC website.</td><td>CLOSED</td></tr>
</table>

Agenda Item	Discussion	Action/Follow-up:
	• He and Judy felt that it would be important to include a coding feature in each edition of the AUC monthly newsletter. The next edition of the newsletter is due to go out next week. The TAG will submit at least one article for the edition next week, regarding the upcoming AAPC statewide meeting in November, and will be considering other possible article topics. • MDH is examining its role and responsibilities in administering CEU credits for those attending TAG meetings, and will be seeking to promote as much participation and involvement of TAG members in the TAG activities as possible. A range of options will be considered to meet this goal, including rotating roles and assignments, writing articles for the AUC monthly newsletter, taking on particular research issues, and others. The TAG agreed to also request that if members do not participate in a full TAG meeting that they inform the TAG member who is tracking attendance for CEU purposes. • MDH is interested in further exploring questions of the criteria that should help be used to set priorities, and to determine where work products appear (e.g., in companion guides, in the coding clarification grid, etc.). Examples of the types of criteria to consider might include: potential for impact on patients and patient care; legal and statutory requirements; extent to which the issue impacts administrative costs and burdens; and others. The item remains opens for additional discussion.	
12. Next meeting	A special meeting will be held October 27, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. The purpose of the meeting will be to resolve two dental-related SBARs and to consider possible updates to the 837D companion guide. Next regularly scheduled meeting: December 10, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.	**CLOSED**

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:	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:
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

Minnesota Department of Health (MDH) Rule

Title:	**Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X224A2 Health Care Claim: Dental (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 proposed data content and other transaction specific information to be used with the ASC X12/005010X224A2 Health Care Claim: Dental (837) hereinafter referred to as 005010X224A2, by entities subject to Minnesota Statutes, section 62J.536; • 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); • 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 X12/005010X224A2 Health Care Claim: Dental (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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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 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 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 (ASC12/005010X279A1 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 covered by 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, 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 v. 6.0
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

Version	Revision Date	Summary Changes
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 X12/005010X224A2 Health Care Claim: Dental (837)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008,ASC X12. All Rights Reserved), hereinafter described below as *005010X224A2.* A copy of the full *005010X224A2* 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 *005010X224A2*;
- 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 *005010X224A2* 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.

Please 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 *005010X224A2* 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*005010X224A2*. 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 two appendices:

- Appendix A includes a number of sections and provides additional instructions and specifications regarding the use of medical code sets and medical coding;
- Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction and tooth number/oral cavity.

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: Dental (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 005010X224A2), which is available for purchase from ASCX12 at: http://store.x12.org/store

Terms previously defined in the companion guide but can now 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 *005010X224A2* 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 SV301-7, 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

Example: Submission of a Replacement Bill (CFTC 7)

Note: the following distinctions are important to ensure proper handling of the submission.

- In order to meet the processing requirement to void the original and replace it with the re-submitted bill, common consistent data elements are required.
  - Replacement -- To qualify as a Replacement, some data need to be different than the original.
  - Considered as Duplicate rather than a Replacement -- 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.

- Considered an Original Claim rather than 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. For example, a Replacement bill (CFTC 7) may also contain a Condition Code 'D0' indicating service dates have been changed.

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 SV301-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X224A2.*
- 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 orSV301-7 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/005010X224A2 Health Care Claim Dental (837) – Transaction Specific Information

4.1. Introduction to Table

The following table provides information needed to implement the *ASC X12/005010X224A2 Health Care Claim: Dental (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X224A2* 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. 005010X224A2 Dental(837) -- Transaction Table

MUCG for the Implementation of the ASC X12/005010X224A2 Health Care Claim: Dental (837) Version 10.0.

Table 4.2 005010X224A2 Dental (837) Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X224A2 and any other applicable information and specifications noted in section 2.2.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2000B Subscriber Hierarchical Level	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2010BA Subscriber Name	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
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	DN2 Tooth Status	N/A	Required when the tooth status codes in DN202 apply to the claim.
2300 Claim	PWK	N/A	See front matter section 3.2.5 of this

Table 4.2 005010X224A2 Dental (837) Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X224A2 and any other applicable information and specifications noted in section 2.2.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
Information	Claim Supplemental Information		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	HI Health Care Diagnosis Code	N/A	If sending the claim to a medical or P&C carrier, this segment is recommended for use.
2320 Other Subscriber Information	SBR Other 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.
2330B Other payer name	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2320 loops must be unique within the claim.
2400 Service Line Number	DTP Date – Prior Placement	N/A	If actual date not known, provide an estimate.
2400 Service Line Number	AMT Sales Tax Amount	N/A	See Appendix B of this document for details on reporting MNCare Tax

5. List of Appendices

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

Appendix A provides additional information and instructions regarding the use of medical code sets and medical coding.

B. Appendix B: Reporting MNCare Tax

Appendix B 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 A. Introduction

The purpose of this Appendix is to provide guidance to Minnesota submitters and receivers of dental electronic health care claims on requirements, selection and use of specific code sets that are associated with these transactions.

The Appendix covers:

- general background information about code sets, and
- a series of principles to guide the selection and use of codes in connection with Minnesota electronic health care claim transactions.

In preparing this Guide, the official guidelines for code selection documented in code resources were followed, unless otherwise explicitly noted. Consult official coding resources for descriptions, definitions and directions for code usage. This material is not intended to be a substitute for coding manuals or official guidelines. All codes are expected to be used in a manner consistent with their descriptors, instructions, and correct coding principles.

Group purchasers (payers) will continue to administer applicable coverage policies and member benefits.

A.2 Basic Concepts on HIPAA Code Sets

- Code sets are described in the front matter of this Companion Guide.
- The dental codes are a separate category of national codes. The Department of Health and Human Services has an agreement with the American Dental Association (ADA) to include Current Dental Terminology (CDT)[1] as a set of HCPCS Level II codes for use in billing for dental services.
- 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 (which include dental codes); and
  - valid at the time the transaction was created and submitted – for non-medical code sets.

A.3 General Principles for Code Selection and Use in Minnesota

Code selection for claims submitted in Minnesota follows a hierarchy of preferred instructions.

1. Minnesota Statute 62J.536 requires all claims to be submitted according to the guidelines for Medicare that are issued by the Center for Medicare and Medicaid Services (CMS) whenever possible.

[1] CDT is a registered trademark of the American Dental Association (ADA)

2. It is understood that Medicare excludes from coverage, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.
3. Select codes that accurately identify the procedure or service provided.
4. All nationally-developed codes are accepted by all group purchasers even when Medicare coding and coverage limitations may not allow reporting of a code.
5. Acceptance of a code does not imply any health insurance coverage or reimbursement policy.
6. The dental/medical record must always reflect the service provided.

A.4 Units (basis for measurement)

- Units are reported according to the code description.

Please Note:

National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. Code sets referenced in this appendix were valid at the time of approval for publication. 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. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes.

Per HIPAA, "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."

CDT codes are evaluated and updated annually by the Code maintenance Committee of the ADA. For questions on codes contact the ADA at 1-800-621-8099 or dentalcode@ada.org. For information on the HCPCS annual release of alpha-numeric medical codes visit www.cms.gov or email hcpcs@cms.hhs.gov.

B. Appendix B: 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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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:

SBAR ISSUE: Gambling Addiction Program

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AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

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

Medical Coding TAG Decision Tree Form

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

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

Section II

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

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

Section III

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

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

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

SBAR ISSUE: Gambling Addiction Program

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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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:	Organization Information:
Name:RICHARD SCHERER Title:BUSINESS MANAGER Email address:richard@clubrecoveryllc.com Telephone: 952.926.2526	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]:10/8/15

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

AUC Co-Chair(s):Faith Bauer

AUC Response: There was extensive discussion around this issue; however, Kathy Sijan of the Minnesota Department of Human Services (DHS) reported that DHS is examining next steps for the program and requested that the item be removed from the standing agenda at this time.

No further action or discussion at this time.

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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):

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
MAT Therapy and/or counseling services	Day	N/A	**4306F** Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction	N/A

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

MAT Therapy and/or counseling services	Day	0944	**4306F** Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction	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

Date [SBAR Response Approved by TAG]:10/8/15

Reviewed by [AUC TAG Name]:Medical Code TAG

AUC Co-Chair(s):Faith Bauer

AUC Response:

Discussion/Summary: discussion included the need to report the Level II reporting CPT code because there it is implied that documentation is always needed to justify the service. As a DHS requirement, the coding information will be added to the guides.

Decision: Add requested category II code with explanation to 837P and 837I Guides Add coding to the Table A.d.3.c Substance Abuse Services – Outpatient Services, Claim Type 837P entries in both the 837P and 837I guides. See revisions above.