



AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)

Thursday, November 12, 2015

9:00 a.m. to 11:00 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. 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 27, 2015

4. Teledentistry – Kathy Sijan

<p>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.</p>	<p>OPEN</p>
<p>10/27/15: Under traditional telemedicine/telehealth coding, and originating site (Q3014) must be reported separately and there is currently a standard modifier (GT) for professional for telemedicine or telehealth services. In many cases, the DT initiating teledentistry in a location other than the dental clinic is an employee of the clinic. Would this same policy apply to for originating site if it is the same dental clinic? Questions re new code set, would all be appropriate under teledentistry? For example, the comprehensive exam code D0150. The date of service for imaging services was questioned. Would it be the same as the professional service? Questions/suggestions regarding telemedicine. Julie will request scenarios from Appletree of what services are they billing, how often and other data they wish to share. Is there one bill they would submitted with GT? For example, house code when services provided in nursing facility, can you use Q code? Julie (DHS) Research what other states are doing with teledentistry and present at next meeting.</p>	<p>OPEN – questions, suggestions scenarios are requested for review</p>

5. SBAR - Public Health Response Condition Codes– Tess Konen, MDH – see SBAR

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

<p>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</p>	<p>OPEN DHS will send info to Faith</p>
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<p>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.</p> <p>There are two services:</p> <ul style="list-style-type: none"> • The first is the initial plan (S0280–U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH, monthly). This service is billed for the first six months. These services do not have to be consecutive. • The second is maintenance of plan (S0281–U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH, monthly). This service is billed after the six months initial plan billing. Maintenance is ongoing and does not have a maximum. <p>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 be rendered by a physician, this is not a timed procedure (99490 designates time, and DHS want to establish a model for future health models.</p> <p>Participation is voluntary but has requirements for the patient/participant to be actively involved with an engaged health plan.</p> <p>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).</p> <p>DHS currently has a pilot program. 36 providers are interested in participating in BHH.</p> <p>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.</p> <p>The patient/participant cannot receive duplicative services in the same/month. For example, payment may only made for a BHH or HCH, not both.</p> <p>Suggested “Monthly” be added to the definition to clarify payment.</p> <p>Suggestion that providers track services and document in their notes.</p> <p>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.</p>	<p>re: State Plan language DHS will also make corrections to the SBAR and forward to Faith for distribution and request for an e-vote by MCT to approve</p>
<p>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.</p>	<p>OPEN</p>
<p>5/14/15: No discussion; waiting for CMS approval.</p>	<p>OPEN</p>
<p>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.</p>	<p>OPEN</p>
<p>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.</p>	<p>OPEN</p>
<p>9/10/15: Discussion postponed.</p>	<p>OPEN</p>
<p>10/8/15, 10/27/15: DHS submitted the BHH state plan amendment to CMS on October 12.</p>	<p>OPEN</p>

7. Additional Agenda Items/ Announcements

- Next regularly scheduled meeting: December 10, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Tuesday, October 27, 2015, 9 a.m. to 12 Noon
Location of Meeting – HealthPartners
Meeting Minutes

Minutes By: Judy Edwards and Faith Bauer

Agenda Item	Discussion	Action/Follow-up:															
1. Welcome and Introductions <ul style="list-style-type: none"> • 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	10/8/15 minutes reviewed and approved.	CLOSED															
4. Dental Therapist [DT] & Advanced Dental Therapist [ADT] – Kathy Sijan	DHS is not receiving data they need to provide report to legislature. DTs can get NPIs. Delta Dental does not enroll DTs; They subcontract with MCOs to provide dental services. DTs operate under general supervision and have scope of work identified in cooperative agreement. Preference would be to have NPI placed on claims since legislators are interested in knowing outcomes. Because of indirect services that the DTs can perform, should have their NPIs and should be identified as rendering provider when performed services. Dental Association does not credential DTs. Concern if dental practices will be able to populate modifiers. Where would the modifier be placed on dental form? Additionally, would the dental practice systems be able to accommodate this information? The electronic claim format does allow for modifier submission: Line Counter , LX 2400segment – elements: <table border="1" data-bbox="562 959 1041 1097" style="margin-left: 20px;"> <tbody> <tr> <td>267</td> <td>SV3</td> <td>012 – Procedure Code</td> </tr> <tr> <td>267</td> <td>SV3</td> <td>013 – Procedure Modifier</td> </tr> <tr> <td>267</td> <td>SV3</td> <td>014 – Procedure Modifier</td> </tr> <tr> <td>267</td> <td>SV3</td> <td>015 – Procedure Modifier</td> </tr> <tr> <td>267</td> <td>SV3</td> <td>016 – Procedure Modifier</td> </tr> </tbody> </table> DHS is withdrawing SBAR. Because M.S. 256B.0625 requires identification of services rendered by an ADT/DT, a consensus was reached that use of NPIs. An agreement was reached that the most appropriate course of action to ensure accurate reporting would be for DHS to require DTs/ADTs to obtain NPIs, according to MS Further discussion. Julie M. will solicit feedback from dental advisory group regarding DHS requiring dental therapists be enrolled.	267	SV3	012 – Procedure Code	267	SV3	013 – Procedure Modifier	267	SV3	014 – Procedure Modifier	267	SV3	015 – Procedure Modifier	267	SV3	016 – Procedure Modifier	CLOSED – SBAR withdrawn
267	SV3	012 – Procedure Code															
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	<p>The date of service for imaging services was questioned. Would it be the same as the professional service?</p> <p>Questions/suggestions regarding telemedicine. Julie will request scenarios from Appletree of what services are they billing, how often and other data they wish to share. Is there one bill they would submitted with GT?</p> <p>For example, house code when services provided in nursing facility, can you use Q code?</p> <p>Julie (DHS) Research what other states are doing with teledentistry and present at next meeting.</p>	
6. Behavior Health Home (BHH) – Kathy Sijan, DHS	DHS submitted the BHH state plan amendment to CMS on October 12.	OPEN
7. Next meeting	Next meeting: November 12, 9:00-11:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.	CLOSED

AUC BUSINESS NEED EXPLANATION FORM (SBAR) TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received		Log No.	Date Closed
Status: Exec Review Date	Sent to TAG/WG	TAG Recommendation: _____ Accept _____ Reject	Decision to Originator
REMINDER: Submit the completed SBAR and MCT Decision Tree form via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.			
Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert)			
SBAR Short title: Teledentistry		Date: 10-1-2015	
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	
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): <p>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.</p> <p>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.</p>		
B	BACKGROUND – Explain the pertinent history of the business practice (How does this work today): <p>Currently Teledentistry is not part of the MA benefit today.</p>		
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) <p>See statute information on page 3-5</p>		

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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 bandwidth 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
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- D0145: oral evaluation for a patient under 3 years of age

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- D0210: Intraoral — complete series of radiographic images
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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

Teledentistry Scenarios for Consideration

1. A consultation with a dentist who is at the distant site:
 - A primary care dentist at the originating site (could be a dental clinic, nursing facility, group home, or other facility) performs an oral exam (limited or comprehensive) and determines the need for a consult.
 - The consultant dentist may connect in real-time two way interactive video through the use of intra oral camera to perform an exam and provide information back to the patient and the primary care dentist.
 - Alternatively, the primary care dentist records images and documents their findings and sends all of that data to the consultant dentist via secure transmission (store and forward). The consultant dentist reviews at a later time (usually within 3 days) and provides information back to the primary care dentist.
 - The two dental providers may or may not work for the same clinic practice. Both providers may have performed an oral exam (limited or comprehensive).
2. The same situation as outlined in #1 may occur, except the dental provider at the originating site could be a hygienist (may be in collaborative practice) or a dental therapist (DT or ADT) who could perform services within their scopes of practice, but determines the need for consultation with a dentist.
 - The two dental providers may or may not work for the same clinic practice. Both providers may have performed services that can be billed by each of them.
 - It is also possible that no services are performed at the originating site and they are just facilitating the services of the distant site dental provider.
3. A consult could also be arranged by a medical professional at the originating site, if they determine, through the course of their evaluation, that there is a need for dental services.
 - The dental consultation could occur through two-way interactive video or through store and forward capabilities.
4. The date of service that is typically reported by the distant site dental provider when their service occurs using store and forward capabilities is the date that the distant site provider actually makes their diagnosis and records their findings. For example, if radiographs, images, and documentation is sent to a consultant dentist on 11/1 who then reviews that information and documents and sends their report back to the other dental provider on 11/2, the consultation service that was provided via teledentistry would be reported as being performed on 11/2.
5. Currently, there are not separate codes identifying the technical and professional components of imaging services rendered by dental providers. Likewise, dental providers do not use modifiers to separately report the two components when performed by different providers. However, it may be worth discussing whether such imaging codes could be modified by the use of the appropriate technical and professional modifiers to distinguish which providers did which component of the service.

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: <input type="checkbox"/> Accept <input type="checkbox"/> Reject	Decision to Originator

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

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

SBAR Short title: Public Health Identification of Cases for Public Health Response	Date: 10/29/2015
Contact Information for person completing this form: Name: Tess Konen Title: Environmental Epidemiologist Email address: Tess.Konen@state.mn.us Telephone: 651-201-5606	Organization Information: Name: Health Promotion and Chronic Disease Division, Minnesota Department of Health Address: 85 7th PI E, St Paul, MN 55101

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

Name: Jon Roesler
Title: Injury Epidemiologist
Email address: Jon.Roesler@state.mn.us
Phone number: 651-201-5487

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

SBAR Issue Title: Difficult for public health to determine if hospitalization cases are related to disasters or emerging opioid epidemics

S	<p>SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed:</p> <p>Currently, there is no method for identifying emergency department and inpatient hospitalization cases that are related to disasters. Following a disaster, it is important for public health to be able to identify and quantify the resulting cases for public health response and assessment.</p> <p>A typical method that public health uses to estimate cases, when there is no specific code available, is to create a case definition from multiple external cause codes. However, for the purpose of identifying disaster cases, we did not find this process effective. We evaluated using external cause codes for two possible disaster scenarios. Using a train derailment scenario, we found that the external cause codes were too disparate (i.e., there was not a unique code), such that several external cause codes might be needed to code a single patient in the case of a train derailment disaster like the 2013 Lac-Mégantic rail disaster in Quebec. For a radiation release from a nuclear plant, we found the external cause code (W88 code, “Exposure to ionizing radiation”) was not specific enough. Additionally, we would not be able to differentiate disaster-related cases from baseline poisonings, injuries, and etcetera.</p> <p>This same issue also applies to emerging opioid epidemics. When an outbreak of bath salt use occurred in Duluth, one hospital flagged these cases in their own internal EMR. Public health intended to use the diagnoses from these identified opioid cases to create a case definition for finding other cases. However, there was no consistency in the symptoms of the flagged cases,</p>
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<p>B</p>	<p>making it impossible to create a case definition to identify new opioid cases. As a result, public health had to rely on that single hospital's own internal flagging system. As in the disaster-related cases, external cause codes were insufficient for identifying these cases of interest.</p> <p>BACKGROUND – Explain the pertinent history of the business practice (How does this work today):</p> <p>In the early 1990s, an epidemic of violence, especially associated with firearm injury, was experienced by cities in the U.S. and even in Minnesota (“Murderapolis”). Within our state there were several agencies, organizations, and individuals that worked together to enable the systematic description and analyses of all injury (not just firearm injury) in Minnesota from hospital discharge data:</p> <ul style="list-style-type: none"> • Minnesota Department of Health (MDH), • Minnesota Hospital Association (MHA; formerly MHHP), • Minnesota Health Care Coalition on Violence (HCCV; dissolved in 2001: http://www.mnhealthplans.org/collateral/responce_violence.pdf), and • U.S. Centers for Disease Control and Prevention (CDC). <p>Minnesota hospitals regularly submit a copy of their claims data (after removing patient identifiers) on the universal billing form (UB) to the MHA, which is a trade association representing Minnesota's acute care hospitals. In the past, the claims data included little (if any) information about the external cause of injury. One could ascertain, for example, that a 27-year-old male from Hennepin County was treated for a skull fracture on March 13. Only when an external cause code (then known as an “E-code”) is added can one attribute that injury to a motor vehicle crash. <u>The UB at that time already had one field dedicated for reporting the external cause code.</u> However, because of strictures put in place by third-party payers, hospitals did not report this code.</p> <p>In January 1996, the Governor’s Task Force on Violence as a Public Health Problem recommended that Minnesota health care organizations move toward standardized use of E-codes with hospital UB data to improve injury data. The HCCV delineated how Minnesota’s hospitals should use E-codes to record data on the causes of injuries, and report this information to the MHA. Due to its experience in public health surveillance and injury prevention and control, the MDH became a partner with MHA in the public health surveillance of hospitalized and ED-treated injuries. The CDC provided funding and technical assistance.</p> <p>Beginning in 1997, third-party payers agreed not to reject UB claims with external cause codes and hospitals in the Minneapolis and St. Paul area voluntarily included E-codes on appropriate inpatient claims. In 1998, hospitals statewide began including E-codes on both inpatient and outpatient claims data provided to MHHP, making 1998 the first year that cause of injury was consistently reported statewide. This reporting system continues today, with aggregate data available through the online MIDAS query system: www.health.state.mn.us/injury/midas</p> <p>Use of the existing UB has facilitated a system for hospitals to operationalize reporting requirements for firearm injury (M.S. 625.52), burns (to State Fire Marshalls Office via MDH; M.S. 625.53), and some traumatic brain and spinal cord injury (M.S. 144.661-665). Because this system also captures ATV and snowmobile injury, the Minnesota Department of Natural Resources did not go forward with its own hospital reporting requirement; instead, relying on data from MDH. Using and “tweaking” an existing data system greatly reduced costs and facilitated reporting.</p> <p><u>A similar situation and opportunity exists today.</u> As the MDH explores and considers moving towards creating a data system to identify and describe health events associated with natural or man-made disasters, we are looking towards <u>using existing fields on the current UB</u> to identify cases. Specifically, we are looking at the “Condition Codes” (Form Locator 18-28) on the UB-04, to allow hospitals to flag disaster-related cases with the “DR” (Disaster Related) code, or with one of the “P” codes reserved for PUBLIC HEALTH DATA REPORTING (P0, P2-PZ).</p> <p>At this time it is not clear who has the authority to designate/authorize the use of the DR, P0, and P2-PZ occurrence codes by hospitals on the UB-04; it is also not clear to us if use of these codes might jeopardize reimbursement by third-party payers.</p>
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	<p>We are requesting assistance in establishing procedures and protocols for how these codes might be used in the event of a disaster in Minnesota, or in the treatment of disaster-related cases who are transferred to or show up at Minnesota hospitals.</p> <p>We became aware of the potential for the use of the occurrence codes when investigating the outbreak of adverse health events associated with synthetic drug use in the Duluth community (http://www.minnesotamedicine.com/Portals/mnmed/February%202014/Clinical_Dugan_0214.pdf). One hospital was internally flagging in their EMR system those patients who reported or were identified as having their hospital treatment associated with their synthetic drug use. As we explored how this information might be conveyed to MDH via the UB-04, we became aware of the P0, P2-PZ occurrence codes. Then, as now, it was not clear to us who could designate and authorize the use of those codes.</p>
<p>A</p>	<p>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):</p> <p>While hospital discharge data is first and foremost for billing purposes, we must acknowledge that this is also a tool used by public health to assess the population. By using PD (public health disaster) or PI (public health incident) condition codes, the medical community can communicate to public health more efficiently, so we can better serve the community.</p> <p>These condition codes already exist and are available for use. There is no need to create or alter existing codes. We are not aware of how the public health condition codes are currently used or to what extent they are used. To utilize these codes for public health awareness might require some training or education for medical coders. Following a disaster we would send out a Health Alert Network (HAN alert) informing physicians to document if a case is disaster-related and to have the medical coders use the public health disaster condition code.</p> <p>In the past health insurance companies rejected records that were using external cause codes, but as they became more common and the utility of external cause codes were acknowledged, insurers began to accept them. A similar process might occur with health insurers accepting the use of condition codes.</p> <p>Utilizing these condition codes would improve communication from the medical community to public health, reduce time and resources spent on medical record abstraction, and improve the accuracy of identifying cases of interest for use in public health assessment and response. This would allow us to provide more accurate information to the public on the disaster impact and possible prevention steps to reduce future cases. This would be a standardized method for the medical community to inform us of the impact of the disaster through the use of codes in the hospital data; this is an area that many states are now exploring with their hospital association to facilitate better communication and information pertaining to disasters.</p> <p>This system would also allow a possible opportunity to do longitudinal investigation, and may not require using a roster created at the time of the disaster.</p>
<p>R</p>	<p>RECOMMENDATION – What are you recommending, including any known timing that needs to be considered:</p> <p>We find external cause codes to be insufficient for the purpose of identifying disaster-related cases and novel emerging opioid poisoning epidemics. Alternatively, we suggest utilizing existing PD (public health disaster) or PI (public health incident) condition codes.</p> <p>We recommend investigating the current use of these condition codes and the exploration of utilizing them for public health benefit. Hospital billing software would have to be assessed to determine if they include condition code fields and ensure that medical coders have access to these fields and are aware of them. It would be necessary to work with the health insurers to petition that they accept billing records that included these condition codes.</p>

Once it's determined that the condition codes can be used for public health, then there would need to be some training and education for medical coders and physicians on how to use the condition codes. On the public health side, there would have to be some consensus on the definition of disaster and when the codes would be used. There may need to be constraints to limit overutilization of these condition codes.

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:

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

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

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

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

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

SBAR Short title: Dental Therapist [DT] & Advanced Dental Therapist [ADT]	Date: 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	<p>SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed:</p> <p>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.</p> <p>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.</p>
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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:

<u>Provider type</u>	<u>U Modifier</u>
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Advanced Dental Therapist – UA	
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Dental Therapist -	UD
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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]:10/27/15

Reviewed by [AUC TAG Name]:Medical Code TAG

AUC Co-Chair(s):Faith Bauer

AUC Response:

Discussion/Summary:

DHS is not receiving data they need to provide report to legislature.

DTs can get NPIs.

Delta Dental does not enroll DTs; They subcontract with MCOs to provide dental services. DTs operate under general supervision and have scope of work identified in cooperative agreement. Preference would be to have NPI placed on claims since legislators are interested in knowing outcomes. Because of indirect services that the DTs can perform, should have their NPIs and should be identified as rendering provider when performed services. Dental Association does not credential DTs.

Concern if dental practices will be able to populate modifiers. Where would the modifier be placed on dental form? Additionally, would the dental practice systems be able to accommodate this information? The electronic claim format does allow for modifier submission.

Because M.S. 256B.0625 requires identification of services rendered by an ADT/DT, a consensus was reached that use of NPIs would be the best action to take.

Decision:

DHS is withdrawing SBAR. Because M.S. 256B.0625 requires identification of services rendered by an ADT/DT, a consensus was reached that use of NPIs. An agreement was reached that the most appropriate course of action to ensure accurate reporting would be for DHS to require DTs/ADTs to obtain NPIs, according to MS Further discussion.