Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, January 14, 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** – December 10, 2015
4. **Teledentistry – 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**
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.	**OPEN –** questions, suggestions scenarios are requested for review
11/12/15: Does this apply to two dentists in the same practice – primary care dentist; specialty practitioner? Code list is not sufficient; additional information would be needed to fully understand what is considered a consultation for accurate coding. Discussion about whether the GT and GQ modifiers used for telemedicine could be used for tele-dentistry along with the recommended U9 modifier DHS is proposing. It was felt if possible, it would clearly distinguish tele-dentistry services. TAG member confirmed there is a place on electronic dental claim for modifier. 2012 Paper dental form 34a has space for diagnosis 9 vs. 10 indicator.	**OPEN**

ACTIONS: Kathy will develop grid along with additional scenarios – to include definition of location, providers, and services Services must be provided via video or stored forward Kathy will confirm billing site.	
12/10/15: Who bills: The distant site (see diagram below) bills. They must use the dental codes in the SBAR (section R) and the U9 modifier. (The distant site may or may not have a purchase of service agreement with the originating site, but that does not affect who bills.) For final version of SBAR response – define the terms "distant site" and "originating site" (see Medicare defines as example). Note that the recommendation will be to include the coding tele-dentistry coding requirements in the 837D companion guide – include a section re. tele-dentistry with the rule above in the companion guide. (Need clarification – need to ask DHS what happens if the originating site provider is different than the distant site provider.) Decision: A. Distant site (billing clinic) – this is the site doing the diagnosing → ← The originating site sends data back (live, or store and forward) → B. Originating site(nursing home,etc.) – where the patient is Question: When is a service teledentistry vs. referral?	**OPEN**

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

3/12/15: DHS Behavior Health Home policy staff, Jennifer Blanchard and Lisa Cariveau, attended the meeting to provide background and overview of the Behavior Health Home services described in the SBAR and to answer questions the MCT may have. Jennifer stated that the basis of BHH program is a result of the Affordable Care Act and that it is currently out for state public comments. It was noted that SAMSA approved the program. After approved, it will sent to CMS for federal approval. The anticipated start date is January 1, 2016. There are two services: • The first is the initial plan (S0280–U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH, monthly). This service is billed for the first six months. These services do not have to be consecutive. • The second is maintenance of plan (S0281–U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH, monthly). This service is billed after the six months initial plan billing. Maintenance is ongoing and does not have a maximum. A question was asked if 99490 was considered. Codes S0280 and S0281 are already used for Health Care Home (HCH) but with different modifiers. The codes were chosen but with the U5 modifier because of the similarity of the program, BHH does not need to rendered by a physician, this is not a timed procedure (99490 designates time, and DHS want to establish a model for future health models. Participation is voluntary but has requirements for the patient/participant to be actively involved with an engaged health plan. For DHS this is a per patient/per month straight payment methodology; not flexible. There are no levels of complexity for BHH (HCH has four levels of billing). DHS currently has a pilot program. 36 providers are interested in participating in BHH. Must be a Medicaid provider, MH practitioner or MH practitioner; MH provider and/or meet DHS standards and provide service. This is s professional only. The patient/participant cannot receive duplicative services in the same/month. For example, payment may only made for a BHH or HCH, not both. Suggested "Monthly" be added to the definition to clarify payment. Suggestion that providers track services and document in their notes. What if MH wants to become a BHH if they are HCH? The provider could because the goal is to establish a relationship with a primary care.	**OPEN** DHS will send info to Faith re: State Plan language DHS will also make corrections to the SBAR and forward to Faith for distribution and request for an e-vote by MCT to approve
4/9/15: Andrea Agerlie of DHS presented a summary of coding recommendations for Behavior Health Home (BHH). She clarified that the program will become effective January 1, 2017, and that the codes could be incorporated with the TAG's coding clarification grid. However, federal approval of the codes is needed the codes could be considered for inclusion in the claims companion guides.	**OPEN**
5/14/15: No discussion; waiting for CMS approval.	**OPEN**
6/11/15: The program was open for public comments. DHS reviewed responses and updated the plan based on feedback received during public comment period. State plan was resubmitted to federal.	**OPEN**
7/28/15, 8/13/15: BHH start date is 7/1/16 per legislative update. DHS is initiating informal conversations with CMS and will be submitting State Plan Amendment in the next few weeks.	**OPEN**
9/10/15: Discussion postponed.	**OPEN**

10/8/15, 10/27/15, 11/12/15, 12/10/15: DHS submitted the BHH state plan amendment to CMS on October 12.	**OPEN**

6. SBAR - CHW Universal Modifier – Will Wilson, MDH Office of Rural Health and Primary Care

7. Additional Agenda Items/ Announcements

- Next regularly scheduled meeting: January 14, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, December 10, 2015, 9 a.m. to 12 Noon
Location of Meeting – HealthPartners
Meeting Minutes

Minutes By: Dave Haugen and Faith Bauer

1. Welcome and Introductions a. Attendance tracking: Deb Sorg deb.a.sorg@healthpartners.com b. Membership request and/or updates: Deb Sorg deb.a.sorg@healthpartners.com	Faith convened meeting. Requested those on phones email their attendance to Deb Sorg.	Completed.
2. Review of Antitrust Statement	Faith read anti-trust statement	No discussion.
3. Review of October and November meeting minutes – October 27, 2015 November 12, 2015	Corrected October minutes and November minutes approved.	**CLOSED**
4. Teledentistry – Kathy Sijan	Who bills: The distant site (see diagram below) bills. They must use the dental codes in the SBAR (section R) and the U9 modifier. (The distant site may or may not have a purchase of service agreement with the originating site, but that does not affect who bills.) For final version of SBAR response – define the terms "distant site" and "originating site" (see Medicare defines as example). Note that the recommendation will be to include the coding tele-dentistry coding requirements in the 837D companion guide – include a section re. tele-dentistry with the rule above in the companion guide. (Need clarification – need to ask DHS what happens if the originating site provider is different than the distant site provider.) Decision: A. Distant site (billing clinic) – this is the site doing the diagnosing → ← The originating site sends data back (live, or store and forward) → B. Originating site(nursing home,etc.) – where the patient is	**OPEN**

	Question: When is a service teledentistry vs. referral?	
5. Behavior Health Home (BHH) – Kathy Sijan, DHS	The state plan amendment was submitted on October 12th, and we are currently in the review process with CMS.	**OPEN**
6. MCT Article for Monthly AUC Update – Dave Haugen, MDH	The AUC would like to work with the TAG for regular contributions to a coding section in each month's AUC Update (newsletter). Members will be asked to volunteer for a coding article each month.	**CLOSED**
7. Miscellaneous	Carolyn Larson contributed the following information: • Ruby Woodward announced that the AAPCS is looking at developing a test to confirm participation in a phone conference eligible for CEUs. • Joanne Wolf will be available at the January meeting to discuss children and telehealth services. • There will be a national telehealth conference summer 2016 in Minneapolis.	**CLOSED**
8. Next regularly scheduled meeting:	January 16, 2016, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. Treats – Carolyn Larson	**CLOSED**

Administrative Uniformity Committee

AUC UPDATE

December 23, 2015 | Volume 3, Number 11

Congratulations AUC on a great 2015!

By the numbers:

AUC 2015

4 National Submissions

- Response to HHS request for information (RFI) regarding Health Plan ID
- Comments to NCVHS ACA Review Committee
- Proposed new business scenario to CORE
- Preliminary adoption of AUC change request to X12 (CR 1359-continue AMT segment MinnesotaCareTax reporting capability in v7030)

50 meetings of AUC TAGs and groups

ICD-**10** collaboration

9 rule changes

- 4 companion guide revisions adopted
- 5 companion guide revisions proposed

5 Best practices reviewed, revised

2 new TAGS:

- ACO Data Analytics
- Home Health PA form

Congratulations AUC on a great 2015!

We start this month's AUC update with a cover showing some of the highlight's of this year's AUC work, with contributions to the maintenance of the state's uniform companion guide rules, submissions to national level health care administrative simplification, two new Technical Advisory Groups (TAGs) involved in two new areas, and collaboration to implement the ICD-10 coding system. The AUC's 2015 activities and accomplishments were discussed at the final AUC Operations meeting on December 8, 2015 (see related meeting summary in the TAG updates section.).

Recent AUC voting results

Illustration from Retail-Awards.com

The AUC Operations Committee recently concluded an email vote to unanimously approve the items below. For additional background regarding the items put to a vote, please see the November issue of the AUC Update.

Recent AUC voting results:

- The September 2015 AUC Operations Committee meeting minutes were approved;
- Dave Andersen was approved as co-chair elect in 2016. He will be joined on the 2016 AUC Executive Committee by Tony Rinkenberger, who will replace Ann Hale as 2016 co-chair, while Ann will replace Bob Aliperto as immediate past chair. A recognition of the AUC leadership contributions and transitions is planned as part of the AUC's next regular quarterly meeting, March 8; 2016;
- The AUC approved a limited, annually-renewable, statutorily-permitted exception to the state's requirements for only the standard, electronic exchanges of health care benefit eligibility inquiries and responses (270-271). The exception applies only to the exchange of 270-271 transaction with payers not subject to federal HIPAA regulations;
- An AUC statement in support of the rulemaking procedure used in adopting the Minnesota Uniform Companion Guides was approved and submitted to the Minnesota Department of Health (MDH) as part of public comments about the process being collected by MDH.

In a separate TAG vote, the Home Health Prior Authorization (PA) Form TAG approved a single, uniform home health PA form. The form will be emailed to the AUC Operations committee in the near future for a vote.

Coding Corner

The Coding Corner is a collection of updates, tips, and pointers intended to help address common medical coding issues and to pass along coding news and updates suggested by the AUC's Medical Code TAG and other sources.

Note for the following Coding Corner article: ICD-9-CM's condition coding instructions included one form of an "excludes" note that could be interpreted and applied two different ways, and was therefore subject to some confusion. ICD-10-CM addressed the issue by creating two different excludes notes—Excludes1

and Excludes2—to distinguish between the two possible situations or interpretations. The Excludes1 note is "used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition." The Excludes 2 note "indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time." In late October 2015, the federal Centers for Disease Control (CDC) identified circumstances where some conditions included in Excludes1 notes should be allowed to both be coded, and thus might be more appropriate for an Excludes2 note. Additional information and clarification from CDC regarding this issue is provided below.

Coding Corner –

CDC Provides Guidance for ICD-10 Excludes1 Notes

(*Submitted by Medical Code TAG member*, Cindy Norling, CCS-P, COC)

The Centers for Disease Control and Prevention (CDC) have corroborated circumstances identified where some conditions included in Excludes1 notes should be allowed to both be coded and thus might be more appropriate for an Excludes2 note. Responding to several questions regarding the interpretation of Excludes1 notes, the CDC issued guidance to allow conditions currently subject to an Excludes1 note to be reported together when appropriate as shown in the two examples below because no changes to Excludes notes or revisions to the official guidelines can be made until October 1, 2016.

Example 1:

If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note. For example, the Excludes1 note at code range R40-R46, states that symptoms and signs constituting part of a pattern of mental disorder (F01-F99) cannot be assigned with the R40-R46 codes. However, if dizziness (R42) is not a component of the mental health condition (e.g., dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and the mental health condition.

Example 2:

Code range I60-I69 (Cerebrovascular Diseases) has an Excludes1 note for traumatic intracranial hemorrhage (S06.-). Codes in I60-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage. However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, then it would be appropriate to assign both a code from S06- and I69-.

The guidance above was originally posted on October 19, 2015 and was updated on October 26 to include the following statement: "This coding advice has been approved by the four Cooperating Parties—the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS). This advice will also be published in the 4th Quarter 2015 issue of Coding Clinic for ICD-10-CM and ICD-10-PCS."

You may view the full CDC October 26, 2015 Excludes1 Notes Update at the CDC website (http://www.cdc.gov/nchs/data/icd/Interim_advice_updated_final.pdf).

A final caution and reminder below regarding the excludes1 and excludes2 notes, as well as the "Holiday Song Quiz," were also submitted as part of this month's Coding Corner feature.

Reminder: Closely monitor for internal system edits as well as claims edits from the payors or your clearinghouse. Before appealing on the basis of the CDC October communication, review the documentation to verify that it clearly supports that the two conditions affected by the Excludes 1 note are not related (different areas, conditions, unrelated sign and symptom).

Watch for further guidance in the AHA Coding Clinics and with the October 2016 updates.

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 the "annual maintenance" of the companion guides in addition to any other projects or tasks that they are completing.

Operations Committee

The Operations Committee met for its last regularly scheduled quarterly meeting of the year on December 8, 2015. The Committee reviewed and discussed a number of items also reported on in the November Update, and reviewed the accomplishments shown on the cover of this issue. The Minnesota Department of Health (MDH) thanked the Committee for its contributions to the maintenance of the Minnesota Uniform Companion Guide rules, its support of ICD-10 implementation, including participation of several members as resources at a two-day ICD-10 clinic associated with this year's annual Rural Health Conference in Duluth, Minnesota, and for other activities, including formation of the Data Analytics TAG to help recommend more standard ACO member files. As follow-up to the meeting discussion, the Committee also subsequently completed several related email votes (see related story on page 2).

Home Health Prior Authorization Form TAG

The Home Health Prior Authorization Form TAG completed and approved recommendations for a single, common form for home health prior authorizations. The form will be emailed to the AUC Operations Committee for further review and a vote in the near future. No further meetings of the TAG are scheduled at this time.

Executive Committee

The Executive Committee met December 7 for a series of updates and to make final plans and preparations for the December 8 Operations Committee meeting.

Medical Code TAG (MCT)

The Medical Code TAG met on December 10 and reviewed a coding request regarding tele-

dentistry services. MDH also requested the TAG's assistance in providing coding information as part of this newsletter (see related "Coding Corner" article, page 3) and other related outreach, education, and technical assistance materials.

ACO Data Analytics TAG

The TAG met on December 16 to review responses to requests for examples of ACO member file data dictionaries and record layouts from TAG members. During the review and discussion of the responses at the meeting, the TAG agreed to use HIPAA standard transaction formats for exchanging key demographic variables of interest, as well as a single common file layout based on a pipe-delimited text file. MDH agreed to provide additional information and examples regarding the HIPAA standard formats and how they would be applied in exchanging the data of interest. MDH recently completed the analysis and examples and forwarded them to the TAG for review. A follow-up TAG email vote to approve these products is pending the TAG's current review. If approved by the TAG, the materials will be forwarded to AUC Operations for review and an email vote.

The TAG is next scheduled to meet on January 14, 2016. However, if the TAG completes its work via email and email voting prior to the meeting date, the meeting will likely be canceled. As with all TAGs, meeting information for the ACO Data Analytics TAG will be posted on the AUC Calendar.

TAGs that did not meeting December 2016

The following TAGs did not meet in December:

- Eligibility
- Claims DD
- EOB/Remit
- Acknowledgment
- Legislative.

National News

CAQH CORE Rejects AUC proposed Operating Rule Business Scenario

As previously reported in the January 2015 and November 2015 AUC Updates, the AUC submitted a proposed change in early 2015 to federally mandated operating rules via the national authoring organization for the rules, CAQH CORE. The proposal was to adopt a new additional business scenario describing remittance advice coding for situations in which claim adjudication cannot be completed because information needed from the patient is missing, invalid, or incomplete.

The AUC's proposal was reviewed and voted by the delegated CORE group, the CORE Code Combinations Task Group, earlier this month. The proposal garnered only 30% support from the Task Group and will therefore not be recommended for further consideration. In a meeting held December 15 to discuss its decisions, the Task Group noted that:

- Whereas the AUC's proposal recommended a single Claim Adjustment Reason Code (CARC) update, and several related Remittance Advice Remark Codes (RARC), several CORE Task Force members felt that, to be valid, CORE-defined Business Scenarios should include multiple associated CARCs;

- One respondent felt that the situation described in the AUC proposal could be addressed through an already existing CORE operating rule business scenario ("Scenario #3");
- One respondent did note that advising the provider what information is needed from the patient in a consistent way may expedite the process, or enable the provider to assist in obtaining information.

CORE seeks and reviews recommendations for additional operating rule business scenarios annually. For more information about the process, please visit the CORE website.

CMS Updates "ICD-10 Wheel"

The Centers for Medicare & Medicaid Services (CMS) recently released an updated ICD-10 Website Wheel for Medicare Fee-for-Service (FFS) providers. The Website Wheel provides easy access to official resources on CMS ICD-10 web pages including:

- ICD-10-CM/PCS Frequently Asked Questions
- Medicare Learning Network® (MLN) Products
- Medicare FFS Provider Resources
- CMS Industry Resources
- Statute and Regulations

Walter G. Suarez, MD, MPH Receives WEDI's 2015 Sullivan Award

Walter G. Suarez, MD, MPH, Executive Director of Health IT Strategy and Policy of Kaiser Permanente received the national Workgroup for Electronic Data Interchange (WEDI) 2015 Sullivan Award on October 28, 2015. The award is named in honor of former HHS Secretary, Louis W. Sullivan, MD who created WEDI in 1991 and recognizes individuals who have distinguished themselves through their leadership, vision and achievements in advancing the overall quality and efficiency of healthcare.

Dr. Suarez has served a variety of health care leadership roles, and in 2015 he was appointed the Chair of the National Committee on Vital and Health Statistics (NCVHS). He is familiar to many AUC members as he previously served as President and CEO of the Institute for HIPAA/HIT Education and Research, CEO of the Midwest Center for HIPAA Education, Executive Director and CEO of the Minnesota Health Data Institute, and in various senior policy positions in the Minnesota Department of Health.

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.

AUC January – February 2016 Meeting Calendar

AUC meetings currently scheduled for January and February 2016 are listed below. For more information, please see the AUC calendar page (http://www.health.state.mn.us/auc/calendar.htm)

Date/Time	Event	Location
January 4 8:30am - 10:30am	**Executive Committee Meeting** Executive Committee Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - Walnut Room
January 14 8:30am - 10:30am	**ACO Data Analytics TAG Meeting** ACO Data Analytics TAG Meeting Information	TBD
January 14 9:00am - 12:00pm	**Medical Code TAG Meeting** Medical Code TAG Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - St. Croix Room
January 19 1:00pm - 2:30pm	**EOB/Remit TAG Meeting** EOB/Remitt TAG Meeting Information	Teleconference & WebEx only
January 27 2:00pm - 4:00pm	**Eligibility TAG Meeting** Eligibility TAG Meeting Information	Teleconference & WebEx only
February 1 8:30am - 10:30am	**Executive Committee Meeting** Executive Committee Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - Walnut Room
February 3 9:00am - 10:30am	**Claims DD TAG Meeting** Claims DD TAG Meeting Information	Teleconference & WebEx only
February 10 8:30am - 10:30am	**ACO Data Analytics TAG Meeting** ACO Data Analytics TAG Meeting Information	TBD
February 11 9:00am - 12:00pm	**Medical Code TAG Meeting** Medical Code TAG Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - St. Croix Room
February 16 1:00pm - 2:30pm	**EOB/Remit TAG Meeting** EOB/Remit TAG Meeting Information	Teleconference & WebEx only
February 24 2:00pm - 4:00pm	**Eligibility TAG Meeting** Eligibility TAG Meeting Information	Teleconference & WebEx only

Season's Greetings!

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):

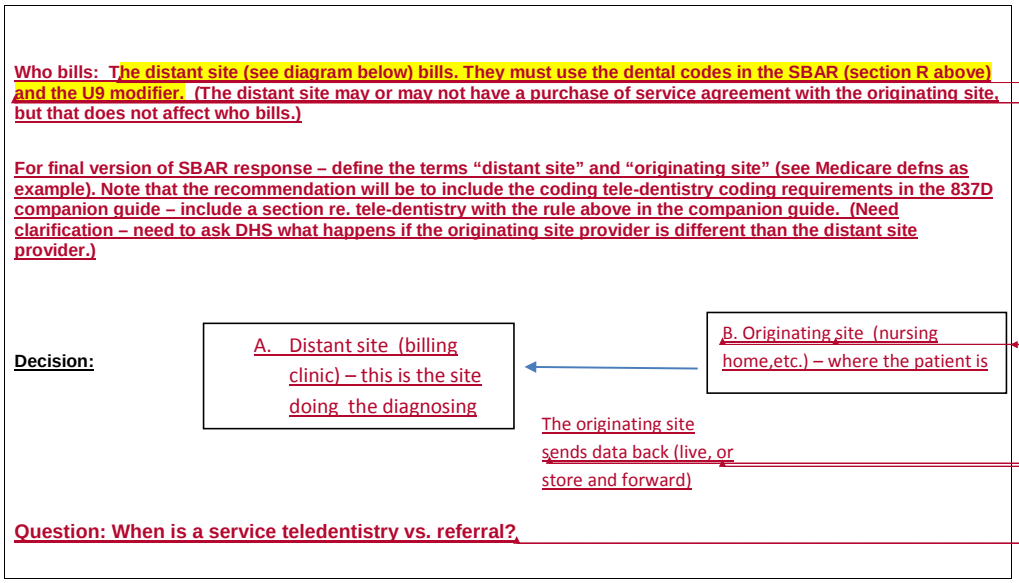
Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:



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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

DELTA DENTAL OF MINNESOTA – NOTES ON TELEDENTISTRY
December 9, 2015

Background Information:
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. The new benefit is limited to 12 ADA codes.

Definition: The use of information technology and telecommunications for dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine. *Teledentistry in and of itself is not a service. It is a method by which services are delivered.*

Description: Teledentistry can take a number of forms including:

1. Live video: Two-way interaction between a patient and dentist using audiovisual technology.
2. Store and forward: Recorded health information — such as radiographs, photos, video, digital impressions or photomicrographs — is transmitted through a secure electronic communications system to a practitioner. The practitioner then uses the information to evaluate the patient's condition or render a service outside of a real-time or live interaction.
3. Remote patient monitoring: Personal health and medical information is collected from an individual in one location then transmitted electronically to a provider in a different location for use in care. This could be used in a nursing home setting or in an educational program.
4. Mobile health: Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers or personal digital assistants. This could include apps that monitor patient brushing or other home care.

Teledentistry is an expansion of the traditional dental practice, where patients can have a virtual dental home instead of a physical one. It provides easier access to dental care to patients in nursing homes or those who live in rural areas without a dentist. It also allows for dentists in remote areas to communicate with specialists or medical colleagues.

Note: The Minnesota Legislature approved Options #1 and #2

Current Events:

- HCMC is launching a pilot with the U of MN to utilize teledentistry.
- The ADA House of Delegates passed Resolution 45H-2015, Comprehensive ADA Policy Statement on Teledentistry, in November at ADA 2015 – America's Dental Meeting.

Delta Dental of Minnesota's Role:

- Ensures both the originating provider and the distant provider are credentialed with DDMN
- Once the providers are credentialed, claims are filed according to existing CDT codes and per the contract limitations. There is no dual coverage for the same service.
- Manages claims according to DHS limitations
- DDMN credentials dentists; dental hygienists, dental therapists and advanced dental therapist are not credentialed as providers.

Scenario 1 Outcome: Per the legislation, only the distant site services will be considered for benefits.

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.
o 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.
o 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.
o 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).

Originating Site	POS	DOS	CODE	MOD	MOD	Description	Distant Site*	POS	DOS	CODE	MOD	MOD	Description
Jones Dental-DDS	14	9/1	D0120	GT	U9	Oral Exam	Green Dental-DDS	11	9/1	D0120	GT	U9	Oral Exam
Jones Dental-DDS	14	9/1	Q3014			Telehealth, originating site fee	Green Dental-DDS	11	9/1	D0270	GT	U9	Single xray

Scenario 2

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.

Originating Site	POS	DOS	CODE	MOD	MOD	Description	Distant Site*	POS	DOS	CODE	MOD	MOD	Description
Jones Dental-ADT	14	10/1	Q3014	GT	U9	Telehealth, originating site fee	Green Dental-DDS	11	10/1	D9310	GT	U9	Medical Dental Consult

Scenario 3

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.

Originating Site	POS	DOS	CODE	MOD	MOD	Description	Distant Site*	POS	DOS	CODE	MOD	MOD	Description
Jones Dental-ADT	31	10/4	D9310	GT	U9	Medical Dental Consult	Green Dental-DDS	11	10/4	D9310	GT	U9	Medical Dental Consult
Jones Dental-ADT	31	10/4	Q3014			Telehealth, originating site fee							

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.

Scenario 4

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.

Originating Site	POS	DOS	CODE	MOD	MOD	Description	Distant Site*	POS	DOS	CODE	MOD	MOD	Description
Jones Dental-DT	34	11/1	Q3014			Telehealth, originating site fee	Green Dental-DDS	11	11/2	D9310	U9		Medical Dental Consult

Scenario 5

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.

Originating Site	POS	DOS	CODE	MOD	MOD	Description	Distant Site*	POS	DOS	CODE	MOD	MOD	Description

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

A technical correction: both sites could technically submit a claim (the originating site could potentially try to bill for the originating site fee), but under current law, MA only covers the services performed at the distant site. As Faith noted at the last TAG meeting, Medicare does cover an originating site fee, so I believe her thought was that the AUC should have a uniform standard to bill the service, but whether any payer in the state covers it would be up to each payer. If other services are performed at the originating site, they can certainly bill for any of those services that they rendered face to face with the patient, of course

Legend	U9-Teledentistry		POS
	GT-Via interactive audio and video telecommunication systems		11 - Office 14 - Group Home
	Q3014- Telehealth originating site facility fee		31- skilled nursing facility 34-Hospice

SBAR: Behavioral Health Home

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

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

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

Medical Coding TAG Decision Tree Form

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

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

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

Section I

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

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

Section II

1. Provide an SBAR short title for your issue.

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

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

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

SBAR: BHH – Behavioral Health Home

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

Date Received	Log No.	Date Closed

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

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

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

SBAR Short title: BHH – Behavioral Health Home	Date: March 2, 2015
Contact Information for person completing this form: **Name:** Katherine Sijan **Title:** HealthCare Coding Compliance Officer **Email address:** katherine.sijan@state.mn.us **Telephone:** 651-431-5784	**Organization Information:** **Name:** MN Dept of Human Services **Address:** 540 Cedar St., 7th fl -0993 St Paul, MN 55155

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

Name: Andrea Agerlie
Title: HealthCare Coding Compliance Officer
Email address: andrea.agerlie@state.mn.us
Phone number: 651-431-3159

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

SBAR Issue Title: BHH – Behavioral Health Home

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: The Chemical and Mental Health Services and the Health Care Administrations have designed the Behavioral Health Home (BHH) model to provide access to coordinated delivery of primary care and behavioral health services for children and youth with serious emotional disorders (SED) and adults with serious mental illness (SMI) or serious and persistent mental illness (SPMI). To receive BHH services, a person must be eligible for Medical Assistance (MA) and have a current diagnostic assessment indicating that the individual meets the criteria for SMI, SPMI, or SED. BHH services cannot duplicate any other case management service including waivers and the patient cannot be on both BHH and HCH at the same time. The BHH model differs from the Health Care Home (HCH) model in that HCH is an all payer model, whereas BHH is limited to only Medical Assistance (MA) recipients. BHH provides integrated primary and behavioral health services with the goal of developing the consumer's ability to manage his/her chronic behavioral health condition and HCH does not.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): There currently is no other service like this at this time. This is only a professional service.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The monthly service will include any or all six services provided for each month the recipient is eligible. This is not a mental health treatment or service. The first six months of BHH are called 'care engagement'. After the first six months of care engagement [can be non-consecutive], an individual will receive 'ongoing standard care'.

	NOTE: If the recipient is eligible and receives BHH care engagement services in January (month 1) and February (month 2), then chooses not to receive BHH services or loses MA eligibility until May, then May will be 'month 3', and so on until six months of 'Care Engagement' have been completed. Then the client will receive 'Ongoing Standard' care for each subsequent month.
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: See embedded document for coding details and outline of program. DHS anticipates that this program will be effective January 1, 2016, pending Federal Approval. AUC Approval is needed now to begin internal work for these services.  BHH Behavioral Home - Coding.docx **Statute:** MN Statute: 256B.0747 Section 12 http://www.senate.leg.state.mn.us/departments/scr/billsumm/summary_display_from_db.php?ls=89&id=2655

Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision:

BHH – Behavioral Health Home

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

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

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

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

Definitions:

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

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

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

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

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

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

- Relocation Service Coordination

-Targeted Case Management for Vulnerable Adults and Developmental Disabilities

- Mental Health Targeted Case Management – Adult (Rule79)

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

- Assertive Community Treatment

- Health Care Home care coordination services

Minnesota Department of Health (MDH) Proposed Rule for Public Comment

Title:	Proposed Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X224A2 Health Care Claim: Dental (837)** **Version ~~8~~9.0**
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 December 30, 2013~~was announced as a proposed revised rule for public comment on TBD. The public comment period is from *xx-yy, 2014 - xx-yy, 2014*. [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 ~~covered under~~subject to Minnesota Statutes, section 62J.536; • Is intended to 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 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 ~~8~~9.0 of the *Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X224A2 Health Care Claim: Dental (837)*. It was announced as a proposed rule for public comment in the Minnesota State Register, pursuant to Minnesota Statutes, section 62J.536 and 62J.61 on [TBD]. This document has not been adopted into rule. ~~It was announced as an adopted rule in the *Minnesota State Register*, Volume 38, Number 27, December 30, 2013 pursuant to Minnesota Statutes,~~

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~~2.~~1. Overview

~~2.1.~~1.1. Statutory basis for this proposed 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.

~~2.2.~~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.

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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;

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(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."

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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~~)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.

~~2.3.~~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

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~~2.4.~~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

~~2.5.~~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.

~~2.6.~~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	TBD	Proposed revisions to v8.0

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~~5.~~2. Purpose of this document and its relationship with other applicable regulations

~~5.1.~~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 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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~~6.~~3. How to use this document

~~6.1.~~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 four 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.

~~6.2.~~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~~as noted~~:

- 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 ~~but~~ for which there is no additional data or corrected data to be submitted.

~~Therefore the submission of the appeal is not covered by this guide.~~Providers should contact the payer or payer 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.
- ~~o~~ 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~~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 - ~~Attachment Report Type Code is a required element:~~ 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 - ~~Attachment Control Number is a situational element that is required if the transmission type is anything other than "available upon request." This value is used to identify the~~ attachment. 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

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with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

9.4. ASC X12N/005010X224A2 Health Care Claim Dental (837) – Transaction Specific Information

9.1.4.1. 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)
Proposed Revised Version 89.0.

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.

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.

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 Information	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
	~~Information~~		
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.

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2400 Service Line Number	DTP Date – Prior	N/A	If actual date not known, provide an estimate.
2400 Service Line Number	AMT Sales Tax		See Appendix B of this document for details on reporting MNCare Tax

~~12.~~5. List of Appendices

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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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~~C.~~A. Appendix A: Code Set Supplemental Information for Minnesota Uniform Companion Guides

~~C.1~~A.1 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

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

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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.
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.

A.5

Teledentistry

The Minnesota Legislature (https://www.revisor.mn.gov/statutes/?id=256B.0625) 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 the following ADA codes.

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 as defined below.

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

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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.

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

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U9 –Service via Teledentistry

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

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.

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. ~~Contact the ADA for official code set update information. The HCPCS annual release of alpha- numeric codes can be found on the CMS website.~~

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~~F.~~B. Appendix B: Reporting MNCare Tax

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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.