Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, February 11, 2016
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** – January 14, 2016
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**
1/14/16: When is a service teledentistry vs. referral? If the distant site makes a referral. Questions raised regarding self-attestation. Provider assurance rate form for telemedicine. Faith asked TAG members to share changes to MN companion guide and best practices internally. Teledentistry – updated submitted to manual and will be updated soon. DHS has a telemedicine form; not sure if will be used for teledentistry. Kathy Sijan will check internally to determine/confirm if a form must be completed for attestation.	**OPEN**

5. **SBAR - Mental Health Service Plan Development - REOPEN – Kathy Sijan, DHS**
6. **SBAR – ADDENDUM – EIDBI/Autism Modifier 60 Day Temporary ABA/DBI Increase – Kathy Sijan, DHS**
7. **SBAR – ADDENDUM – CFSS Community First Services and Supports - Increase – Kathy Sijan, DHS**
8. **AUC Coding Recommendation Table Review**
9. **Companion Guide Comment(s) Review**
10. **Miscellaneous - SBAR Review**

1/14/16: Judy Edwards will send copy of MCT master list of issues to Faith Bauer, along with SBARs. Faith will send sign-up list along with SBARs to TAG members for review and update.	**OPEN**

11. **Additional Agenda Items/ Announcements**

- Next regularly scheduled meeting: February 23, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington.
- *AUC UPDATE* newsletter coding article volunteer.

Title of Meeting: AUC Medical Code TAG
Date and Time of Meeting – Thursday, January 14, 2016, 9 a.m. to 12 Noon
Location of Meeting – HealthPartners
Meeting Minutes

Minutes By: Judy Edwards 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 December meeting minutes	Minor corrections to minutes: #7 – removed "S" from AAPC #8 – corrected January meeting date to January Motion made and seconded. Minutes approved unanimously.	**CLOSED**
4. Teledentistry – Kathy Sijan	When is a service teledentistry vs. referral? If the distant site makes a referral. Questions raised regarding self-attestation. Provider assurance rate form for telemedicine. Faith asked TAG members to share changes to MN companion guide and best practices internally. Teledentistry – updated submitted to manual and will be updated soon. DHS has a telemedicine form; not sure if will be used for teledentistry.	**OPEN** Kathy Sijan will check internally to determine/confirm if a form must be completed for attestation.
5. Behavior Health Home (BHH) – Kathy Sijan, DHS	The SBAR was reviewed again. As this was a request to review and approve the recommended coding for federal approval, the issue can be closed. MCT approved coding recommendation and voted to close the SBAR. 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	**CLOSED**

	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 S0281–U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH, monthly	
6. SBAR - CHW Universal Modifier – Will Wilson, MDH Office of Rural Health and Primary Care	SBAR has been withdrawn	**CLOSED**
7. Miscellaneous	• Jo Anne reported that a new telemedicine service (in between telemedicine and e-visits) will become effective 1/1/17. The new service has been introduced to clinics and vendors are now offering telemedicine services to employees. The AUC will need to decide if coding for this new telemedicine service will be the same coding as traditional telemedicine. Currently being discussed internally at some of the AUC member organizations. • Judy will send copy of master list of issues to Faith, along with SBARs. Faith will send sign-up list along with SBARs to TAG members for review and update. • A coding article for monthly *AUC UPDATE* newsletter is being requested. We will ask for volunteers each meeting for an article for the next edition. Carolyn Larson volunteered for January. JoAnne Wolf volunteered for an article on developmental and other screenings. Articles are due February 15.	**OPEN – SBAR review**
8. Next regularly scheduled meeting:	February 11, 2016 and February 23 - 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170 Building, Bloomington. The need for the February 23 meeting will depend on number of comments received during the public.	**CLOSED**

Administrative Uniformity Committee

AUC UPDATE

February 2, 2016 | Volume 4, Number 1

IN THIS EDITION

Note: This issue combines the January and February 2016 issues, and starts a new publication schedule to make the newsletter available the first week of the month.

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.

Survey provides glimpse into Minnesota clinics' use of electronic transactions

Results of a recent survey show that most clinics in the state are consistently sending/receiving key administrative transactions electronically, including insurance eligibility inquiries, claims, remittance advices, and claims acknowledgments.

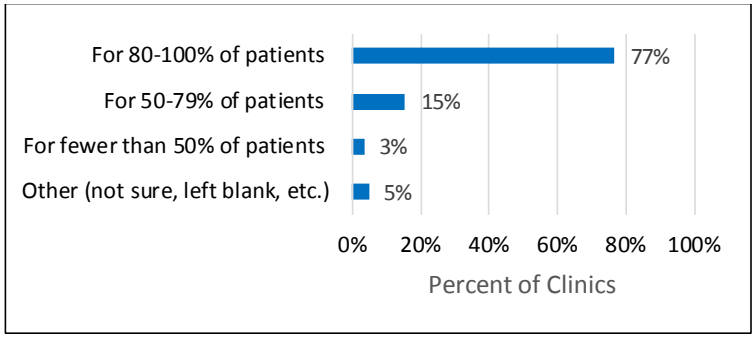
The survey, administered each year since 2010 by the Minnesota Department of Health's Office of Health Information Technology (OHIT), was conducted in the spring of 2015. Known as the 2015 Minnesota Health Information Technology (HIT) Ambulatory Clinics Survey, the study gathered information regarding implementation of "e-health," particularly the adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT). In addition, clinics were asked questions about their electronic exchange of four key administrative transactions as currently required under state law. Clinics could select from several categories to indicate how consistently they transmitted the transactions electronically.

All physician clinics in Minnesota were required to register and complete the survey under the Minnesota Statewide Quality Reporting and Measurement System (Minnesota Rules, Chapter 4654). The response rate was 80% with 1,181 of 1,473 Minnesota clinics responding.

Survey Results

Below are the relevant survey questions and a summary of responses. In the first example below, 77% of the clinics responding to the survey indicated that they routinely checked insurance eligibility electronically for at least 80% of their patients.

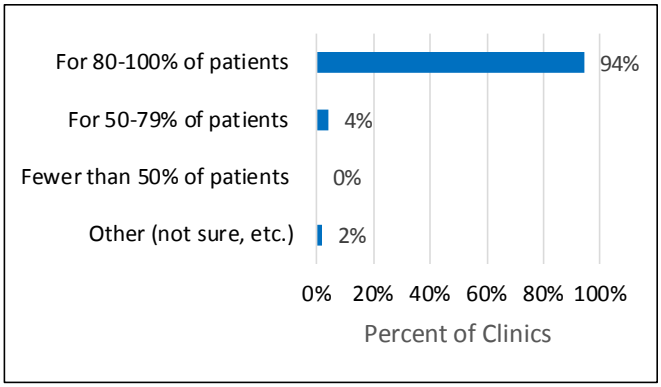
1. ***Does your clinic routinely check <u>insurance eligibility electronically</u>, either using the EHR or another electronic method?***



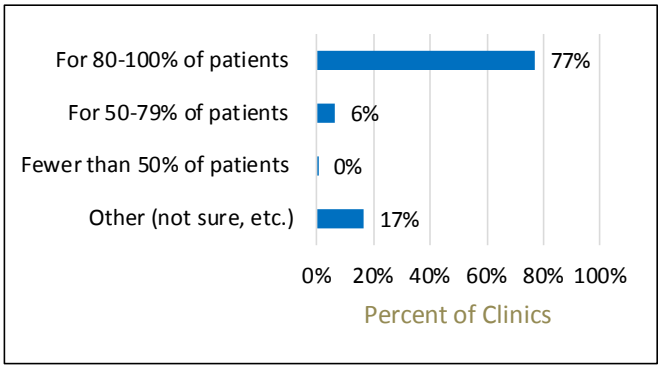
Article continued on page 2

Survey Results (continued)

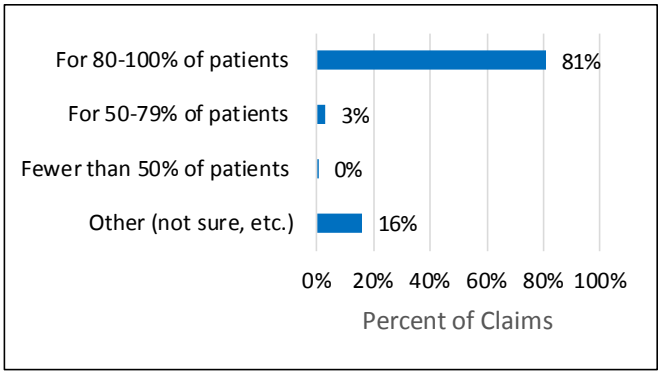
2. Does your clinic routinely file claims electronically for patients, either using the EHR or another electronic method?



3. Does your clinic receive electronic remittance advices (ERA)?



4. Does your clinic receive electronic acknowledgements of their claims submissions?



More information about the survey is available on the Minnesota e-Health website at http://www.health.state.mn.us/e-health/assessment.html#clinics.

Recent AUC voting results

Illustration from Retail-Awards.com

Single uniform home care prior authorization form approved and is now available

The AUC recently approved a single uniform home care prior authorization form developed and approved by the Home Health Prior Authorization (PA) Form TAG. The form is available for requesting PA for Home Health Services covered by a health plan or a county-based purchasing plan. It is not intended for Minnesota Department of Human Services (DHS) fee for service (FFS) Home Health Services or for personal care assistant (PCA) services. Use of the form is not mandatory but is highly encouraged.

The new form is posted on the forms page of the AUC website at http://www.health.state.mn.us/auc/forms.htm.

AUC "Customer Satisfaction" Survey

Each year MDH requests that AUC Operations Committee members complete a ten minute "customer satisfaction" survey to provide MDH with feedback about its staffing and support of the AUC. Operations members were emailed a link to the survey on January 27 and were asked to return it by February 3. All input and responses are very appreciated.

For questions, please contact david.haugen@state.mn.us or judy.edwards@state.mn.us.

Co-chairs Look Back – and Ahead

Note: Each year, AUC leadership changes. Below are letters to the AUC from the outgoing co-chairs, Ann Hale and Cherie Nauha, and from the new co-chair for 2016, Tony Rinkenberger.

Dear AUC –

Thank you for an outstanding and productive year. We completed many work products and activities in 2015, including companion guide rule updates, submissions of comments and requests to national standards setting and advisory groups, recommendations in new areas with the ACO Data Analytics TAG, and much more. We want to thank all of you and your organizations for the incredible work, passion, and support you continued to provide in 2015 to advance MN's administrative simplification goals through the AUC. We also want to thank Dave Haugen and Judy Edwards for all their hard work with the AUC.

Thank you for giving us the opportunity to chair.

Ann Hale and Cherie Nauha

Dear AUC –

Thank you very much for your contributions and accomplishments in 2015 and I look forward to working with you in 2016. We have a number of important goals and activities ahead of us, from continued improvements and refinements of companion guides, to helping improve the understanding and best use of standard business transactions, to responding to any new requests of us as we did with the formation of the recent ACO Data Analytics TAG. I hope you will join us at the next regularly scheduled quarterly AUC Operations meeting on March 8, to share updates of recent activities and developments, as well as to plan and guide work products and support used throughout the state and beyond.

Thank you all again for your help, and I look forward to a rewarding 2016 for the AUC.

Tony Rinkenberger, 2016 AUC co-chair

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.

ICD-10-CM Bilateral Codes

The first tip is an excerpt from the ICD-10 Manual with a clarification and example regarding ICD-10-CM Bilateral Codes, submitted by Carolyn Larson.

"When submitting clinic and outpatient service claims with bilateral surgical services, please report the bilateral ICD-10-CM code, i.e., bilateral knee injections without ultrasound guidance for osteoarthritis would be CPT® 20611-50 (Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting) with ICD-10-CM M17.0 (Bilateral primary osteoarthritis of knee). This would be a one line submission.

Reporting 20611-LT with M17.12 (Unilateral primary osteoarthritis, left knee) on one line and 20611-RT with M17.11 (Unilateral primary osteoarthritis, right knee) on a separate line is incorrect and may result in a claim denial."

The second tip focuses on ICD-10-CM codes that are causing claims to be rejected or denied for "invalid diagnosis code reported." The Category Heading codes below are incomplete, and therefore not valid reportable codes. Submitted by Carolyn Larson.

Category Heading codes that are incomplete and therefore not valid, reportable codes

ICD-10	CATEGORY HEADING	COMMENT
F10.1	Alcohol abuse	requires 5th or 6th digit
F11.1	Opioid abuse	requires 5th or 6th digit
F43.1	Post-traumatic stress disorder (PTSD)	requires 5th digit
F90	Attention-deficit hyperactivity disorders	requires 4th digit
G44.21	Episodic tension-type headache	requires 6th digit
H04.12	Dry eye syndrome	requires 6th digit
H52.1	Myopia	requires 5th digit
H52.20	Unspecified astigmatism	requires 6th digit
M25.57	Pain in ankle and joints of foot	requires 6th digit
M62.83	Muscle spasm	requires 6th digit
M75.1	Unspecified rotator cuff tear or rupture, not specified as traumatic	requires 6th digit
N39.49	Other specified urinary incontinence	requires 6th digit
Z00.0	Encounter for general adult medical examination	requires 5th digit

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.

Operations Committee

The Operations Committee met for its last regularly scheduled quarterly meeting of 2015 on December 8, 2015. The meeting was summarized in the December 2015 issue of this newsletter, which is available first on the on the home page of the AUC website, and then subsequently on the AUC archives webpage. The next regular quarterly meeting of the Operations Committee is scheduled for March 8, 2016.

Executive Committee

The Executive Committee met January 4 and discussed:

- recent TAG activity and votes;
- the status of companion guide annual maintenance;
- a planned meeting of the ACO Data Analytics TAG on January 14;
- results of a survey of over 1100 clinics statewide regarding their use of standard electronic administrative transactions (see related article, page 1); and
- an AUC "customer satisfaction survey" (see related article, page 2.

Medical Code TAG (MCT)

The Medical Code TAG met on January 14 and:

- Discussed billing and coding for teledentistry services, to be continued at the next meeting;
- Approved recommendations as part of a request ("SBAR") for coding recommendations regarding "behavioral health homes." The TAG's recommendations will be forwarded to the Operations Committee for review and vote;
- Discussed a preliminary working draft of possible revisions to the current Minnesota Uniform Companion Guide rule for the 837D (Dental) transaction, especially with updates regarding coding for teledentistry; and
- Discussed coding for new forms of telemedicine, to be continued at the next meeting.

The Medical Code TAG will meet next on February 11, 2016 to review comments received from a 30-day public comment period regarding proposed changes to the 837P and 837I Minnesota Uniform Companion Guide rules. A meeting is tentatively planned for February 23 if needed to complete any review of the public comments.

ACO Data Analytics TAG

The TAG also met on January 14 and approved recommendations for:

- The data content and format for standard electronic exchanges of ACO member files for members attributed to an ACO; and
- The file format to be used for exchanging the files.

The TAG's recommendations will next be reviewed by the AUC Executive Committee and then forwarded to the Operations Committee for a vote.

TAGs that did not meet in January 2016

The following TAGs did not meet in January:

- Eligibility;
- Claims DD;
- EOB/Remit;
- Home Health PA Form;
- Legislative.

National News

NUCC SURVEY SEEKS INPUT ON KEY DEFINITIONS

The Workgroup on Electronic Data Interchange (WEDI) recently requested that its members complete a special survey to provide input regarding definitions of four terms: "patient," "dependent," "subscriber," and "insured."

The survey was developed by the National Uniform Claim Committee (NUCC) in response to a request by the Accredited Standards Committee (ASC) X12 for standard definitions for the four terms above. The purpose of defining these terms is to standardize their meaning for use in various ASC X12 documents.

WEDI provided the following link for the survey: https://www.surveymonkey.com/r/XLT6SQP. The questions will take 5 to 10 minutes to complete. The survey will close at the end of the day on Friday February 26, 2016.

Please send any questions about the survey to nuccinfo@nucc.org.

AUC February - March 2016 Meeting Calendar

AUC meetings currently scheduled for February and March 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
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~~ Meeting canceled
~~**February 10**~~ ~~8:30am - 10:30am~~	~~**ACO Data Analytics TAG Meeting**~~ ~~ACO Data Analytics TAG Meeting Information~~	~~TBD~~ Meeting canceled
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 23 9:00am - 12:00pm (tentative)	**Medical Code TAG Meeting** Medical Code TAG Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - St. Croix Room
February 24 2:00pm - 4:00pm	**Eligibility TAG Meeting** Eligibility TAG Meeting Information	Teleconference & WebEx only
March 7 8:30am - 10:30am	**Executive Committee Meeting** Executive Committee Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - Walnut Room
March 8 2:00pm - 4:00pm	**Operations Committee Meeting** Operations Committee Meeting Information	TIES Event Center, Larpenteur Room, 1644 Larpenteur Avenue West, Falcon Heights, MN 55108
March 10 9:00am - 12:00pm	**Medical Code TAG Meeting** Medical Code TAG Meeting Information	HealthPartners-Bloomington 8170 Building, 1st Floor - St. Croix Room
March 21 1:00pm - 2:30pm	**EOB/Remit TAG Meeting** EOB/Remitt TAG Meeting Information	Teleconference & WebEx only
March 23 2:00pm - 4:00pm	**Eligibility TAG Meeting** Eligibility TAG Meeting Information	Teleconference & WebEx only

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):

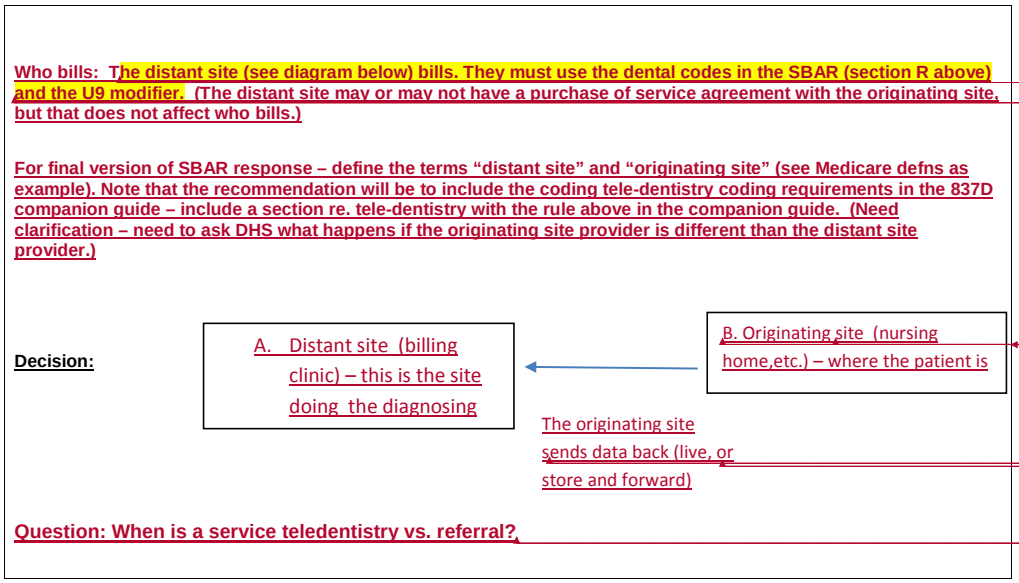
Date [SBAR Response Approved by TAG]:

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

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 ~~9~~11.0**
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 announced as a proposed revised rule for public comment on TBD. The public comment period is from *xx-yy, ~~2014~~ 2016 - xx-yy, ~~2014~~2016*. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the *ASC X12/005010X224A2 Health Care Claim: Dental (837)* hereinafter referred to as *005010X224A2*, by entities subject to Minnesota Statutes, section 62J.536; • 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 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. This document is available at no charge at: www.health.state.mn.us/asa

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Table of Contents

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1. Overview

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.

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

the provider's services would be reimbursed by *the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.*

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

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

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

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

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

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

1.2.1. Exceptions to applicability

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

i. a transaction is incapable of exchanging data that are currently being

exchanged on paper and is necessary to accomplish the purpose of the transaction; or

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

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

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (ASC12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271), *hereinafter 005010X279A1).* This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882
Phone: (651) 201-3570
Fax: (651) 201-5179
Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

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

1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

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

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

2.1. Reference for this document

The reference for this document is the *ASC X12/005010X224A2 Health Care Claim: Dental (837)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12.

Format © 2008,ASC X12. All Rights Reserved), hereinafter described below as *005010X224A2.* A copy of the full *005010X224A2* can be obtained from ASC X12 at: http://store.x12.org/store

2.1.1. Permission to use copyrighted information.

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

2.2. Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X224A2*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X224A2* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

Please note:

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

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

This document has been prepared for use by entities subject to Minnesota's requirements for the standard, electronic exchange of health care administrative transactions (Minnesota statutes, section 62J.536 and related rules) and other interested parties. It provides transaction specific information to be used in conjunction with the *005010X224A2* and other applicable information and specifications noted in section 2.0 above.

Table 4.2 of this document contains a row for each segment for which there is additional information over and above the information in the*005010X224A2*. The tables show the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

This document also contains the following 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.

3.2. Information about the Health Care Claim: Dental (837) Transaction

3.2.1. Business Terminology

The terms below were published with definitions and other information in the previous version of this companion guide to provide additional clarification and/or because of changes that occurred as a result of the adoption of version 5010.

Definitions of these terms are no longer being included in this companion guide. However, the terms are discussed and defined in the reference document to this companion guide (the 005010X224A2), which is available for purchase from ASCX12 at: http://store.x12.org/store

Terms previously defined in the companion guide but can now be referenced as noted above:

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

3.2.1.1. Other Definitions

Factoring Agent

Business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name/address of Pay-To are different than Billing Provider. In order to use the *005010X224A2* for this business situation, the Accredited Standards Committee (ASC) X12 recommends that the Factoring Agent entity name, address, and identification be submitted as the Pay-To Plan in loop 2010AC. The notes and guidelines should be followed as if the Pay-To Plan entity was performing post payment recovery as described.

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

Appeal – Provider is requesting a reconsideration of a previously adjudicated claim for which there is no additional data or corrected data to be submitted.

Providers should contact the payer or 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.

- Considered as Duplicate rather than a Replacement -- If the bill is re- submitted with no changes from the original, and the claim was accepted by the payer, this would be considered a Duplicate instead of a Replacement.

- Considered an Original Claim rather than a Replacement -- If the bill is resubmitted with no changes from the original and the original was not accepted by the payer, this will be considered an original claim. These distinctions are important to allow for proper handling of the submission.

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

In conjunction with the CFTC code values, Condition Codes may be submitted that will impact processing and handling requirements. For example, a Replacement bill (CFTC 7) may also contain a Condition Code 'D0' indicating service dates have been changed.

3.2.5. Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional information.
  - The NTE segment must not be used to report data elements that are codified within this transaction.
  - If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV301-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X224A2.*
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.
- If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE orSV301-7 will exceed available characters, use only the PWK segment at the claim level.
- When populating the PWK segment, the following guidelines must be followed:
  - PWK01 - The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
  - PWK06 - Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the

Commented [MN1]: Deleted to be consistent with v9 837I and 837P

Commented [MN2]: Deleted to be consistent with v9 837I and 837P

same number on any other claim in their system to identify different attachments.

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

4.1. Introduction to Table

The following table provides information needed to implement the *ASC X12/005010X224A2 Health Care Claim: Dental (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X224A2* and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

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

Please also see section 2.2 above.

4.2 005010X224A2 Dental (837) -- Transaction Table

MUCG for the Implementation of the ASC X12/005010X224A2 Health Care Claim: Dental (837)
Proposed Revised Version 9.0.

Table 4.2 005010X224A2 Dental (837) Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2000B Subscriber Hierarchical Level	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2010BA Subscriber Name	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
2300 Claim Information	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definitions.
2300 Claim Information	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.

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	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**
2300 Claim Information	PWK Claim Supplemental Information	PWK02 Report Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300 Claim Information	HI Health Care Diagnosis Code	N/A	If sending the claim to a medical or P&C carrier, this segment is recommended for use.
2320 Other Subscriber Information	SBR Other Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has/have processed.
2330B Other payer name	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2320 loops must be unique within the claim.
2400 Service Line Number	DTP Date – Prior Placement	N/A	If actual date not known, provide an estimate.
2400 Service Line Number	AMT Sales Tax Amount	N/A	See Appendix B of this document for details on reporting MNCare Tax

5. List of Appendices

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

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

B. Appendix B: Reporting MNCare Tax

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

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

A.1 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:
    - o valid on the date of service - for medical code sets (which include dental codes); and
    - o valid at the time the transaction was created and submitted – for non-medical code sets.

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

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

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

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

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. Minnesota Statute 256B.0625 requires commercial plans to comply by 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 American Dental Association (ADA) codes.

Dental 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 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 seven calendar days of the time of information gathering.

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

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
See the following regarding Teledentistry that is not addressed in any chapter of the Medicare Claims Processing Manual.			
N/A	N/A	Teledentistry	Eligible Teledentistry Codes: D0120 U9 - Periodic oral evaluation — established patient D0140 U9 - Limited oral exam D0150 U9 - Comprehensive oral evaluation – new or established patient D0210 U9 - Intraoral — complete series of radiographic images D0220 U9 - Intraoral — periapical first radiographic image D0230 U9 - Intraoral — periapical each additional radiographic image D0270 U9 - Bitewing — single radiographic image D0272 U9 - Bitewings — two radiographic images D0274 U9 - Bitewings — four radiographic images D0240 U9 – Intraoral – occlusal radiographic image D0330 U9 - Panoramic radiographic image D9310 U9 - Medical Dental Consultation Definition of U9 modifier: U9 – Service performed via Teledentistry 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. • Non-billable services: Sending materials; originating site fee.

			• Services are limited to children, pregnant women, and limited adult benefits as specified in Minnesota Statutes 256B.0625, Subd. 9

Please Note:

National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. Code sets referenced in this appendix were valid at the time of approval for publication. Code set changes may result in this appendix reflecting a deleted code or not reflecting a new code. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes.

Per HIPAA, "those that [send or] receive standard electronic administrative transactions must be able to [send], receive and process all standard codes irrespective of local policies regarding reimbursement for certain conditions or procedures, coverage policies, or need for certain types of information that are part of a standard transaction."

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

B. Appendix B: Reporting MNCare Tax

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

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

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

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

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

Medical Coding TAG Decision Tree Form

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

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

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

Section II

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

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

Section III

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

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

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

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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

Section I – SBAR Status/Disposition information (To be completed by the Minnesota Department of Health)

Date received:	Organization submitting:		
Short Title		Log No.	Date Closed
Status: Exec Review Date	Sent to TAG/WG	TAG Recommendation: _____ Accept _____ Reject	Decision to Originator

Section II – Contact information (Person submitting the SBAR and/or Subject Matter Expert)

Contact Information for person completing this form:

Name: ANDREA AGERLIE

Title: Health Care Coding Compliance Officer

Email address: andrea.agerlie@state.mn.us

Telephone: 651-263-6314

Organization Information:

Name: MINNESOTA DEPARTMENT OF HUMAN SERVICES

Address: 540 Cedar St. , St. Paul, MN 55164-0993

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

Name:

Title:

Email address:

Phone number:

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

SBAR Issue Title: MENTAL HEALTH SERVICE PLAN DEVELOPMENT

S

SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed):

The 2013 Minnesota Legislature modified 256B.0943 to add a new covered service under Children's Therapeutic Services and Supports (CTSS) called Mental Health Service Plan Development. The definition of Mental Health Service Plan Development in 256B.0943, Subd. 1(p) is as follows:

(1) The development, review, and revision of a child's individual treatment plan as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) Administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures as required by the commissioner.

In addition to CTSS, DHS has determined there is sufficient funding allocated to provision of Adult Rehabilitative Mental Health Services (ARMHS) to provide payment for similar services.

Mental Health Service Plan Development applies to both fee-for-service and managed care.

B

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

CTSS and ARMHS providers have clear requirements for completion of an individual treatment plan as well as timelines for review and revision of the plan. Legislation requires both CTSS and ARMHS providers to engage in Functional Assessment and related outcome measurement. Prior to the 2013 legislative changes, however, these time intensive activities were not reimbursed.

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):

Mental Health Service Plan Development will need to be split into two codes, one for the development, review and revision of the client's individual treatment plan (service plan development) and one for the administering of standard outcome measurements and reporting outcome measures (functional assessment). In addition, it is imperative the codes be defined with a time unit.

SERVICES TO BE CODED:

SERVICE PLAN DEVELOPMENT
CHILDREN:
* Treatment planning and review with family included
* Parent/legal guardian provides approval of individual treatment plan and any changes therein.

ADULTS:
* Treatment planning and review with or without family

FUNCTIONAL ASSESSMENT (AND OUTCOME MEASUREMENT)
CHILDREN:
* Strengths and Difficulty Questionnaire (SDQ)
* Child Adolescent Service Intensity Instrument (CASII) age 6-21 or Early Childhood Service Intensity Instrument (ECSII) under age 6
* Administration and reporting requirement at various intervals for the specified ages

ADULTS:
* Assessment covers 14 distinct domains of the clients functioning across different settings
* Assesses and identifies functional strengths and/or impairments.
* Clearly and concisely describes in narrative the individual's current status and level of functioning within each of 14 domains.
* Informs the Level of Care Utilization System (LOCUS) to help determine the resource intensity needs of individuals who receive adult mental health services.

For children, these services are completed by mental health professionals or clinical trainees. For adults, these services are completed by a practitioner, clinical trainee or mental health professional. Services can take place in a variety of settings, including but not limited to, clinic, school, home, community mental health center. Services are professional and will be billed on the 837p claim transaction.

CHALLENGES (the need for a time based code):
The needs and time involved in performing the above activities with adults differ markedly from performing these activities with children and their families.

* In general, adult mental health clients are their own legal guardians and they bear the responsibility and right to approve their own treatment plan, whereas clients under age 18 cannot provide approval for their own services. Due to work schedules, family situations or different treatment and legal requirements, Service Plan Development activities for children are more complex than adults.

* Requirements for adult Functional Assessment are greater (and take much longer to complete) than the requirements for children. The Functional Assessment and level of care determination for adults are greater than the requirements for Functional Assessment (outcome measurement) for children and adolescents (CASII, ECSII and SDQ).

	* Treating children with different diagnostic profiles can vary substantially from child to child, requiring varying resources and activities necessary to complete their Service Plan Development. * Providers are continually challenged to meet the needs of emerging immigrant populations as a response to Minnesota's diversifying demographics. Services to culturally and linguistically diverse individuals can vary widely due to complexity of language and cultural differences. Additional time may be needed to engage and thoroughly understand the individual's service needs. * Single, session-based codes for services that vary widely case to case and provider to provider will over compensate many providers and under compensate many others. The likely outcome is poorer treatment planning and monitoring than is warranted by the treatment needs of the specific client. Mental Health Service Plan Development applies to DHS fee-for-service and managed care. Discussion is necessary to develop a uniform billing method.
R	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: Pending federal approval, the effective date for coverage of these services will be 7/1/14. H0031 Mental Health Assessment, by non-physician H0032 Mental Health Service Plan Development by non-physician Both of the above codes seem to be a good fit for the description of services provided, but they are not time based. We have not found time based codes that address these services. We have found 9 states that cover these services using the H0031 and H0032. Seven of the nine states use a 15 minute unit for the codes. We would like to temporarily use these codes with a 15 minute unit and pursue establishment of two new time based codes through the Pilot Medicaid HCPCS Code Modification Request. I have spoken with a CMS regarding this situation. This process does not guarantee approval of new codes and is dependent upon other state involvement. The process also takes time and if establishment of new codes does take place, they would not be effective until 2015 at the earliest. We need a method to bill Mental Health Service Plan Development beginning 7/1/14.

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide, HCPSC/CPT manuals, etc. reviewed and considered during the discussion.

Medical Code TAG should also include the disposition/status for coding decision in its response and effective dates, when required. (For example, inclusion of the clarification of a current practice or coding changes/additions in the MCT Coding Recommendation Grid and MN Uniform Companion Guide or inclusion in the MCT Coding Recommendation Grid only.) Additionally, information from the MCT Decision Tree summary and findings should be reflected in the response as applicable.

Date [SBAR Response Approved by TAG]:8/13/15

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

AUC Co-Chair(s): Faith Bauer

AUC Response: withdraw issue – no action

Tentatively, the coding as proposed by DHS was approved. Per the 5/8/14 AUC MCT minutes, H0031 and H0032 fit the description of the service but are not time based.

DHS indicated nine states using H0031 and H0032; seven of the states are using the H codes, no modifiers, but instruct to use as 15-minute units.

The reason modifiers are needed for MN is to indicate time variances because of the types of clients being served, for example adults, children, ESL clients.

DHS will develop a new modifier(s). There may be other modifiers appended as needed such as UA or HN. DHS subsequently sent the proposal to CMS for federal approval.

Because DHS is still waiting for federal approval and modifiers still need to be assigned the MCT agreed to withdraw this SBAR at this time. DHS will work internally to develop and submit new SBAR to the AUC.

SBAR Issue Title: MENTAL HEALTH SERVICE PLAN DEVELOPMENT

S

SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed):

The 2013 Minnesota Legislature modified 256B.0943 to add a new covered service under Children's Therapeutic Services and Supports (CTSS) called Mental Health Service Plan Development. The definition of Mental Health Service Plan Development in 256B.0943, Subd. 1(p) is as follows:

(1) The development, review, and revision of a child's individual treatment plan as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan; and

(2) Administering standardized outcome measurement instruments, determined and updated by the commissioner, as periodically needed to evaluate the effectiveness of treatment for children receiving clinical services and reporting outcome measures as required by the commissioner.

In addition to CTSS, DHS has determined there is sufficient funding allocated to provision of Adult Rehabilitative Mental Health Services (ARMHS) to provide payment for similar services.

Mental Health Service Plan Development applies to both fee-for-service and managed care.

*

July 2015 – see the RECOMMENDATION section below regarding the addition of 'Review or Update' services for both codes. This was part of the latest SPA revision sent to CMS. At this time, DHS is still waiting for CMS's response.

UPDATE OCT 2015- CMS approved August 1, 2015.

B

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

CTSS and ARMHS providers have clear requirements for completion of an individual treatment plan as well as timelines for review and revision of the plan. Legislation requires both CTSS and ARMHS providers to engage in Functional Assessment and related outcome measurement. Prior to the 2013 legislative changes, however, these time intensive activities were not reimbursed.

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):

Mental Health Service Plan Development will need to be split into two codes, one for the development, review and revision of the client's individual treatment plan (service plan development) and one for the administering of standard outcome measurements and reporting outcome measures (functional assessment). In

addition, it is imperative the codes be defined with a time unit.

SERVICES TO BE CODED:

SERVICE PLAN DEVELOPMENT
CHILDREN:
* Treatment planning and review with family included
* Parent/legal guardian provides approval of individual treatment plan and any changes therein.

ADULTS:
* Treatment planning and review with or without family

FUNCTIONAL ASSESSMENT (AND OUTCOME MEASUREMENT)
CHILDREN:
* Strengths and Difficulty Questionnaire (SDQ)
* Child Adolescent Service Intensity Instrument (CASII) age 6-21 or Early Childhood Service Intensity Instrument (ECSII) under age 6
* Administration and reporting requirement at various intervals for the specified ages

ADULTS:
* Assessment covers 14 distinct domains of the clients functioning across different settings
* Assesses and identifies functional strengths and/or impairments.
* Clearly and concisely describes in narrative the individual's current status and level of functioning within each of 14 domains.
* Informs the Level of Care Utilization System (LOCUS) to help determine the resource intensity needs of individuals who receive adult mental health services.

For children, these services are completed by mental health professionals or clinical trainees. For adults, these services are completed by a practitioner, clinical trainee or mental health professional. Services can take place in a variety of settings, including but not limited to, clinic, school, home, community mental health center. Services are professional and will be billed on the 837p claim transaction.

CHALLENGES (the need for a time based code):
The needs and time involved in performing the above activities with adults differ markedly from performing these activities with children and their families.

* In general, adult mental health clients are their own legal guardians and they bear the responsibility and right to approve their own treatment plan, whereas clients under age 18 cannot provide approval for their own services. Due to work schedules, family situations or different treatment and legal requirements, Service Plan Development activities for children are more complex than adults.

* Requirements for adult Functional Assessment are greater (and take much longer to complete) than the requirements for children. The Functional Assessment and level of care determination for adults are greater than the requirements for Functional Assessment (outcome measurement) for children and adolescents (CASII, ECSII and SDQ).

* Treating children with different diagnostic profiles can vary substantially from child to child, requiring varying resources and activities necessary to complete their Service Plan Development.

	* Providers are continually challenged to meet the needs of emerging immigrant populations as a response to Minnesota's diversifying demographics. Services to culturally and linguistically diverse individuals can vary widely due to complexity of language and cultural differences. Additional time may be needed to engage and thoroughly understand the individual's service needs. * Single, session-based codes for services that vary widely case to case and provider to provider will over compensate many providers and under compensate many others. The likely outcome is poorer treatment planning and monitoring than is warranted by the treatment needs of the specific client. Mental Health Service Plan Development applies to DHS fee-for-service and managed care. Discussion is necessary to develop a uniform billing method.
R *	RECOMMENDATION – What are you recommending, including any known timing that needs to be considered: Adult Rehab Mental Health Services [ARMHS] Link to DHS: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_058153 Pending federal approval, the effective date for coverage of these services will be ~~7/1/14~~. 9-15-2015 H0031 Mental Health Assessment, by non-physician H0032 Mental Health Service Plan Development by non-physician H0031-TS Mental Health Assessment, by non-physician, Follow Up Service [Review or Update] H0032-TS Mental Health Service Plan Development by non-physician, Follow Up Services [Review or Update] Rate increase and new services On Aug. 11, 2015, CMS approved the rate increases and two new billable services for ARMHS. We updated the ARMHS section in the MHCP Provider Manual with new policy requirements to bill the MH functional assessment (FA) and individual treatment plan (ITP) service plan development. Refer to Billing in the ARMHS section for the modifiers and thresholds. [LINK ABOVE] Certified ARMHS provider organizations can register for training at ARMHS revisions: a seminar for certified provider organizations (MH131). Billing for FA and SPD is effective Sept. 15, 2015; however, the system is not yet programmed to accept billing for these services. We will notify providers when the system is updated to bill for the services. For the existing ARMHS services, DHS will do a mass adjustment to reimburse providers back to Jan. 1, 2015. We will post a new message when we do the mass adjustment.

	---------- Both of the above codes seem to be a good fit for the description of services provided, but they are not time based. We have not found time based codes that address these services. We have found 9 states that cover these services using the H0031 and H0032. Seven of the nine states use a 15 minute unit for the codes. We would like to temporarily use these codes with a 15 minute unit and pursue establishment of two new time based codes through the Pilot Medicaid HCPCS Code Modification Request. I have spoken with a CMS regarding this situation. This process does not guarantee approval of new codes and is dependent upon other state involvement. The process also takes time and if establishment of new codes does take place, they would not be effective until 2015 at the earliest. We need a method to bill Mental Health Service Plan Development beginning ~~7/1/14.~~ TBD

Section IV – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; state whether or not the SBAR originator's recommendation is accepted or rejected; substantiate in detail and specificity the basis or explanation for the TAG's response, citing or referencing as appropriate federal administrative simplification rules, Minnesota Uniform Companion Guide, HCPSC/CPT manuals, etc. reviewed and considered during the discussion.

Medical Code TAG should also include the disposition/status for coding decision in its response and effective dates, when required. (For example, inclusion of the clarification of a current practice or coding changes/additions in the MCT Coding Recommendation Grid and MN Uniform Companion Guide or inclusion in the MCT Coding Recommendation Grid only.) Additionally, information from the MCT Decision Tree summary and findings should be reflected in the response as applicable.

Administrative Uniformity Committee

Title: ADDENDUM - EIDBI / Autism modifier for 60 Day Temporary Increase

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:

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

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

Name:

Title:

Email address:

Phone number:

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

SBAR Issue: ADDENDUM - EIDBI / Autism modifier 60 Day Temporary ABA/DBI increase

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: There may be instances where a child/patient will need an increase in services over and above what was originally determined form the CMDE. This increase needs to be shown as a separate distinctive temporary increase.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work 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) The provider will complete a form requesting the temporary increase in hours and send to KePro or the MCO for approval/denial. This change will then be shown on the authorization as a temporary increase in hours. The child/patient's services will be tracked separately during the identified time period to determine if the increased intensive intervention helps the child make progress toward their goals and objectives. A determination of change in recommended

hours may be made based on the results of the temporary increase.

R

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

To distinguish services as 60 day Temporary Increase, add the TF modifier as the third modifier to the ABA or DBI (intervention) service:

TF – 60 Day Temporary Increase

		CPT	MOD	MOD
EIDBI Intervention: Individual	Qualified Supervising Professional (QSP)	0368T 0369T	UB	HK
EIDBI Intervention: Individual	Professional (Level I) - Doctorate	0368T 0369T	UB	HP
EIDBI Intervention: Individual	Professional (Level 1) - Masters	0368T 0369T	UB	HO
EIDBI Intervention: Individual	Professional (Level 1) - Bachelors	0368T 0369T	UB	HN
EIDBI Intervention: Individual	Practitioner (Level II) - Bachelors	0364T 0365T	UB	HN
EIDBI Intervention: Individual	Support Specialist (Level III) - less than Bachelor's	0364T 0365T	UB	HM
EIDBI Intervention: Group	Qualified Supervising Professional (QSP)	0366T 0367T	UB	HK
EIDBI Intervention: Group	Professional (Level I) - Doctorate	0366T 0367T	UB	HP
EIDBI Intervention: Group	Professional (Level 1) - Masters	0366T 0367T	UB	HO
EIDBI Intervention: Group	Professional (Level 1) - Bachelors	0366T 0367T	UB	HN
EIDBI Intervention: Group	Practitioner (Level II) - Bachelors	0366T 0367T	UB	HN
EIDBI Intervention: Group	Support Specialist (Level III) - less than Bachelor's	0366T 0367T	UB	HM

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

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision:

Administrative Uniformity Committee

ADDENDUM 2-4-2016: CFSS – Community First Services and Supports

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH

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

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

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

SBAR Short title:	Date:
CFSS – Community First Services and Supports	~~February 26, 2015~~ 2-2-2016
Contact Information for person completing this form: **Name:** Katherine Sijan **Title:** HealthCare Coding Compliance Officer **Email address:** katherine.sijan@state.mn.us **Telephone:** 651-431-5784	**Organization Information:** **Name:** MN Dept of Human Services **Address:** 540 Cedar St., 7th fl -0993 St Paul, MN 55155

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

SBAR Issue Title: CFSS – Community First Services and Supports

S

SITUATION – Describe the current business practice(Please describe the problem or issue to be addressed:

CFSS is a home and community based service that will take the place of the PCA program and the Consumer Support Grant."

CFSS services are available to an individual who qualifies for and receives at least one service under section 1915(c) waiver under the group at 1902(a)(1010(A)(ii)(VI) or is eligible as defined in the state plan approved in 2013: [[NOTE: takes approx. 3-4 mins to load]]

https://www.revisor.mn.gov/bills/text.php?number=HF1233&version=4&session=ls88&session_year=2013&session_number=0

2015 Language: https://www.revisor.leg.state.mn.us/statutes/?id=256B.85

Framework:

Participants may choose either: a traditional [1] Agency Model or a self-directed [2] Budget Model.

With either model, clients will have more choices over their own care. Participants will be able to purchase equipment or modifications that sustain or enhance their independence rather than being limited to purchasing the help of caregivers. Participants will receive the most appropriate service to meet their assessed needs, as they define their goals with a CFSS Coordinator. CFSS will allow more options that the current PCA program cannot.

NOTE: It is not related to Consumer Directed Community Supports (CDCS). CFSS does not include a hospital or nursing care facility.

B

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

CFSS will replace the current PCA program with more guidelines and requirements for becoming a PCA provider.

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): CFSS is available to a person who meets **one** of the following criteria: ☐ is a recipient of Medical Assistance (MA) ☐ is a recipient of the alternative care program ☐ is a MA waiver recipient (elderly waiver, developmental disabilities waiver, brain injury waiver, community alternative care waiver, or community alternatives for disabled individuals waiver) ☐ has medical services identified in a participant's individualized education program and is eligible for MA special education services In addition to meeting the eligibility criteria above, a person must also: ☐ require assistance and be determined dependent in one activity of daily living (ADL) or Level I behavior based on an assessment; ☐ not be a family support grant recipient; and ☐ live in the person's own apartment or home (not a hospital or institutional setting).	
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: See attached grid with coding recommendations. ~~FEB 2015~~  CFSS Community First Services and Sup **FEB 2016:**  AUC SBAR 2-4-2016 ADDENDUM-CFSS Co	
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:	

CFSS Community First Services and Supports

SERVICE	HCPCS	MOD	MOD	MOD	time	POS		COMMENTS
CFSS Services - Agency Model	T1019	U9			15 min	12		A method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.
CFSS Services - Budget Model	T1019	UB			15 min	12		A service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.
CFSS Agency Model - Temporary Reduction	T1019	**U9**	**U5**		15 min	12		
CFSS Budget Model -Temporary Reduction	T1019	**UB**	**U5**		15 min	12		
CFSS Agency Model -Temporary Increase	T1019	U9	U6		15 min	12		
CFSS Budget Model -Temporary increase	T1019	UB	U6		15 min	12		
CFSS Agency Model - Extended Services	T1019	U9	UC		15 min	12		services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.
CFSS Budget Model - Extended Services	T1019	UB	UC		15 min	12		services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.
CFSS 45 Agency Model - Day Temporary Start	T1019	U9	SE					Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this paragraph shall have no bearing on a future authorization. Participants approved for a temporary authorization shall access the consultation service to complete their orientation and selection of a service model.Agency ONLY

SERVICE	HCPCS	MOD	MOD	MOD	time	POS		COMMENTS
Consultation	S9445				Per Session	in the community or remotely		POLICY: Per session is per person per encounter. Limit is one per day
Budget Model -Financial Management Service Fee	99199	UB			Financial Mgmt Serv fee - per month			12/30/15 Will use the 99199 and push on CMS for a more accurate code (for FUTURE updates) with the CMS request. Kathy will look up sched and assist with document.
Agency Model - Goods (includes fee for FMS)	T5999	U9			1 per day			a description of the item must be included on claim line for billing
Budget Model - Goods	T5999	UB			1 per day			a description of the item must be included on claim line for billing
Agency Model - Worker Training & Development	S5115	U9			15 min	At the business site or in the community		services provided for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.
Agency Model - Worker Training & Development	S5116	U9			per session	At the business site or in the community		
Budget Model - Worker Training & Development	S5116	UB			per session	At the business site or in the community		

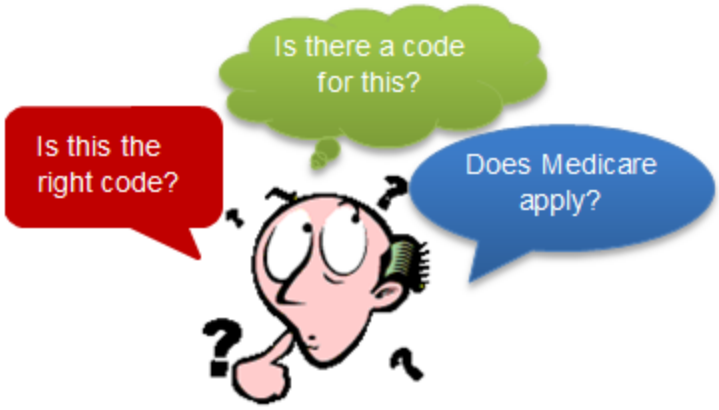
SERVICE	HCPCS	MOD	MOD	MOD	time	POS		COMMENTS
CFSS Agency Model - Shared Care (1:2)	T1019	U9	TT		15 min	12		the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same employer.
CFSS Budget Model - Shared Care (1:2)	T1019	UB	TT		15 min	12		
CFSS Agency Model - Shared Care (1:3)	T1019	U9	HQ		15 min	12		
CFSS Budget Model - Shared Care (1:3)	T1019	UB	HQ		15 min	12		
CFSS Agency Model - Shared Care (1:2), Extended	T1019	U9	TT	UC	15 min	12		
CFSS Budget Model - Shared Care (1:2), Extended	T1019	UB	TT	UC	15 min	12		
CFSS Agency Model - Shared Care (1:3), Extended	T1019	U9	HQ	UC	15 min	12		
CFSS Budget Model - Shared Care (1:3), Extended	T1019	UB	HQ	UC	15 min	12		

LEGEND	
HQ	Group setting
SE	State and/or federally-funded programs/services
TT	Individualized service provided to more than one patient in same setting
U5	Temporary Reduction
U6	Temporary Increase
U9	Agency Model
UB	Budget Model
UC	Extended Services
S5115	Home care training, nonfamily; per 15 minutes
S5116	Home care training, nonfamily; per session
S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
T5999	Supply, not otherwise specified
99199	Special Service

Administrative Uniformity Committee

DRAFT -- DRAFT

AUC CODING RESOURCE



Administrative Uniformity Committee (AUC) Coding Recommendations

PREPARED BY

AUC MEDICAL CODE TECHNICAL ADVISORY GROUP

Approved by AUC: [Date]

AUC Coding Recommendations

Background

The Administrative Uniformity Committee (AUC) Medical Code Technical Advisory Group created the Minnesota AUC Coding Recommendation Table to track new or revised coding recommendations developed and approved between, and in anticipation of, the annual maintenance of the Minnesota Uniform Companion Guides (MUCGs) for the 837 Institutional, 837 Professional, and 837 Dental.

The table is a coding resource for Minnesota payers and providers and is updated at least semi-annually. Updates to the table may stem from:

- Quarterly HCPCS coding changes;
- Medical coding in relation to Minnesota legislative changes;
- New or revised Medicare rules; and
- Other coding issues as identified

Further, the table:

1. Provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services on the 837I and 837P electronic claim;
2. Is intended for use in conjunction with "Appendix A, Table A.5.1" of the "Minnesota Uniform Companion Guides (MUCGs) for the 837 Institutional (I) and 837 Professional (P) transactions;
3. Is not part of the MUCG rules and does not serve as a rule. Note: coding clarifications in this table may subsequently be incorporated into the MUCG rules.
4. Provides recommendations that may be transferred to the applicable MUCGs for the 837I and 837P as part of the annual maintenance;
5. Is a living document that is regularly updated with new coding recommendations; and
6. Is available online at: http://www.health.state.mn.us.auc/bp.htm.

Explanation of Tables

This coding recommendations document consists of two tables and is intended for use in conjunction with the tables found in **Appendix A** of the Minnesota Uniform Companion Guides (MUCGs) for the 837 Professional, 837 Institutional, and 837 Dental claim transactions.

List of Coding Topics/Issues Tables

The table comprises a list of specific coding topics and their applicability to the Medicare Claims Processing Manual submitted to the Minnesota Administrative Uniformity Committee (AUC) for clarification of medical coding issues, new or revised Medicare rules, and for requests to establish new, uniform coding for newly legislated benefits.

These coding topics have been reviewed and discussed by the AUC Medical Code TAG (MCT) with. The recommendations for each topic approved by MCT members are forwarded to the AUC for its review and approval. Each coding topic in this table includes a link to more detailed information (see Coding Recommendation Detail table below) about the coding topic or issue addressed by the Medical Code TAG's and the recommendation and coding approved by the AUC.

Table headings definitions:

Medicare Claims Processing Manual – A CMS publication consisting of 38 chapters which describe billing requirements, rules, and regulations that pertain to Medicare in all settings by each chapter number and chapter/description title. For example, Chapter No. 2 is Admission and Registration Requirements.

MUCG[1] – Minnesota Uniform Companion Guide, version 5010 is a single, uniform companion guide to the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guides mandated by Minnesota Statutes section 62J.536 and related rules. Health care providers that provide services for a fee in Minnesota, or who are otherwise eligible for reimbursement under the state's Medical Assistance program, as well as group purchasers (payers) and health care clearinghouses that are licensed or doing business in Minnesota must comply with the MUCG. The options below represent the claims companion guide that the recommendation applies to:

- **P** – Refers to the 837 Professional MUCG, i.e., Minnesota requirements for any claim submitted using HIPAA mandated Accredited Standards Committee X12 (ASC X12 or X12) 837 professional claim transaction
- **I** – Refers to the 837 Institutional MUCG, i.e., Minnesota requirements for any claim submitted using HIPAA mandated transaction X12 837 institutional claim transaction
- **D** – Refers to the 837 Dental MUCG, i.e. Minnesota requirements for any claim submitted using HIPAA mandated X12 837 dental claim transaction

Specific Coding Topic – Coding issue(s), questions, or clarifications submitted for the AUC to address

AUC Approval Date – Date the full AUC approved the Medical Code TAG's recommendations

[1] Minnesota Statutes section 62J.536 and related rules require the development and use of a single, uniform companion guide for the following transactions: eligibility; claims; payment/advice; acknowledgments and prescription drug prior authorization. Coding recommendations in this document is applicable to the 837 claims companion guides only.

Coding Recommendations Detail Table

The Coding Recommendations Detail is color-coded and includes the information listed below. The blue-highlight indicate coding topics that are recommendations only. Their usage is highly encouraged. The green highlight indicate coding topics that are being proposed as Minnesota rules to be included in the designated companion guides during the next annual maintenance update of Minnesota Uniform Companion Guides for the 837 Professional, 873 Institutional and the 837 Dental transactions.

1. Coding Topic – The medical service/health benefit or coding issue to be addressed and/or resolved by the AUC
2. MCT Minutes Reference – Date of the Medical Code TAG's meeting minutes in which the coding issue(s) was closed and its recommendations approved by the TAG members.
3. Background/Description – Background information and description of the coding topic/issue to be resolved
4. Recommendation – The Medical Code TAG's response to address or resolve the coding issue that is forwarded to the AUC for its review and final approval. The recommendations listed in this document have been reviewed and approved by the AUC for its inclusion in this table as a best practice or as a proposed rule to be included during the annual maintenance of the Minnesota Uniform Companion Guides for the 837P, 837I or 837D.
5. Disposition Status – Identifies implementation status of the recommendation:
    - Coding Recommendation Table (best practice and highly recommended; optional to follow)
    - Companion guide (Proposed rule providers and payers must comply if adopted as rule of law for the designated claim transaction, e.g. 837P, 837I or 837D)
6. Coding – Approved coding recommendations for the specific medical service/health benefit

Table 1: List of Coding Topics/Issues

Medicare Claims Processing Manual		MUCG				
Chapter No.	Chapter/Description Title	P	I	D	Coding topic	AUC Approval Date
12	Physician/Nonphysician Practitioner Billing				Alternate Care Site Billing	April 1, 2013
12	Physician/Nonphysician Practitioner Billing	**X**			Autism Spectrum Disorder	October 20, 2009
					Behavior Health Home	TBD
12	Physician/Nonphysician Practitioner Billing				Code 69210 Bilateral Impacted Cerumen	December 3, 2014
12	Physician/Nonphysician Practitioner Billing				Coding for SBIRT (Screening, Brief Intervention, and Referral to Treatment)	May 9, 2013
12	Physician/Nonphysician Practitioner Billing	**X**			Consultation Services	December 21, 2009
N/A	N/A	**X**	**X**		Dental Services Performed in OR	February 8, 2010
N/A	N/A	**X**			Family Memory Care	TBD
12	Physician/Nonphysician Practitioner Billing				Intensive Care Management of Obesity	
12	Physician/Nonphysician Practitioner Billing				IONM Clarification	
12	Physician/Nonphysician Practitioner Billing				Labor Epidural Billing	May 9, 2013
12	Physician/Nonphysician Practitioner Billing				Modifier -25 on preventive medicine visits	April 14, 2014
12	Physician/Nonphysician Practitioner Billing				Modifier 52	
12	Physician/Nonphysician Practitioner Billing	**X**			Moving Home Minnesota – A Federal Demonstration Project	June 13, 2013 July 18, 2014 December 3, 2014
12	Physician/Nonphysician Practitioner Billing				Partial Hospitalization POS	
12	Physician/Nonphysician Practitioner Billing				Speech Language Pathologist VCD/PVFM	
N/A	N/A			X	Teledentistry	TBD

Table 2: Coding Recommendation Detail

Alternate Site Billing	
MCT Minutes Reference	February 1, 2013
Background/Description	Alternate Care Sites (ACS's) will provide austere (basic) patient care during a disaster response to a population that would otherwise be hospitalized or in a similar level of dependent care if those resources were available during the disaster. The opening of an ACS is a last resort when incident demands have overwhelmed the hospitals' surge capacity. The ACS's will be implemented in conjunction with local public health with the Regional Hospital Resource Center (RHRC) providing coordination on approval from the Minnesota Department of Health (MDH). This ACS plan is limited to the seven county area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington and its jurisdictional public health entities. The primary site for the ACS is the Minneapolis Convention Center (MCC) and the secondary site is the River Centre in St. Paul.
Recommendation	A MCT subgroup was formed to discuss coding recommendations for services in an Alternate Care Site (ACS). From that group, requests were made to the National Uniform Billing Committee (NUBC) for a new Type of Bill (TOB) specifically for ACS and a unique new patient discharge status code indicating a transfer to an ACS. The NUBC did not approve the request for a TOB. They suggested using TOB 089x. The NUBC did approve a new patient discharge status code effective 10/1/13
Disposition Status	**_X_** Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	71 Discharged/transferred to a Designated Disaster Alternative Care Site TOB 089X

Autism Spectrum Disorder	
MCT Minutes Reference	September 22, 2009
Background/Description	The AUC was asked how autism spectrum disorder services are to be reported.
Recommendation	
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter (may be reported on different days if multiple assessments are performed). Report as 1 unit per encounter. H2018 Psychosocial rehabilitation services, per diem. (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary) H2020 Therapeutic behavioral services per diem (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary.)

Autism Spectrum Disorder		
	H2014	Skills training and development, per 15 minutes
	H2017	Psychosocial rehabilitation services, per 15 minutes
	H2019	Therapeutic behavioral services, per 15 minutes
	G9012	Case Management Services

Behavior Health Home	
MCT Minutes Reference	January 8, 2016
Background/Description	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). There currently is no other service like this at this 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. 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
Recommendation	Approve the recommended coding and place in coding recommendation grid and move to the 837 Professional Minnesota Uniform Companion Guide during the next annual update/maintenance.
Disposition Status	___ Coding Recommendation Grid (Best practice, usage highly recommended) _X_ Companion Guide: _X__837 Professional ____837 Institutional ____837 Dental **Note: Recommend as proposed rule for inclusion in the 837P during next annual update of Minnesota uniform companion guides.**
Coding	S0280 U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH, monthly S0281 U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH, monthly