Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, April 14, 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** – March 10, 2016
4. **Companion Guide Comment(s) Review**

2/11/16: The TAG reviewed and discussed the following comments submitted for the proposed 837P and 837I companion guides during the public comment period (Jan 11-Feb 10): Request to revise Rounding rules in the 837P and 837I, Appendix A, Section A.3.4.2 – Units (basis for measurement) – TAG agreed that the rule is valid and will clarify language regarding round rules. Request to revise Early Intensive developmental and Behavioral Intervention (EIDBI) benefits, Appendix A, Table A.5.1 to add new service and code set. This comment applies to the 837P only. Request to revise ARMHS benefit in Table A.5.2 to include new services: **mental health service plan development** and **functional assessment**. The coding for functional assessment appears to be incomplete; a time based code is required. Discussion of this comment was postponed. Further research regarding omission of the UD modifier. Coding for the mental health service plan development and functional assessment as approved by CMS in August 2015. The coding for these services posted on DHS's website differs from the coding listed in the comments. Request to add new program to Table A.5.2: Behavior health home. The MCT approved the recommended coding presented in the Behavior Health Home SBAR; however, DHS will confirm CMS approval. Discussion postponed until February 23, 2016 meeting.	**OPEN** Each TAG member will draft and submit clarifying language for the rounding rules to MDH (Judy) for consolidation into a single document for review at 2/23/16 MCT meeting. Complete review and discussion of the public comment at next 2/23/16 meeting. A copy of the public comments is attached.
2/23/16 Four of the public comments submitted were discussed. The following recommendations in response to the comments were voted on and approved by TAG members as stated below. 1. **Appendix A, Section A.3.4.2 Units basis for measurement) – Public comments requested the AUC clarify the rounding rules as published in the proposed 837P and 837I companion guides.**	**OPEN** Carolyn will develop glossary (2017 adopted rule) Faith will update and post coding 101 Deb will prepare webinar

The TAG reviewed clarifying language submitted by one its members for the rounding rules. After a lengthy discussion of the clarifying language and HCPCS/CPT guidelines and a review of the rounding rules for time-based codes in the Medicare Claims Processing Manual, Chapter 5, the TAG maintained that the rule is valid and determined that it should be in Table A.5.1 "Minnesota Coding specifications, When to use codes different from Medicare" rather than the front matter. Changes to this section are as follows: Second sentence in second bullet point revised to read: *"Follow HCPCS/CPT for determining rounding time."* Deleted third bullet point statement: *Do not follow Medicare's round rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.* **Table A.5.1 Minnesota Coding Specifications: When to use codes different from Medicare** Revised Minnesota Rule to Medicare Claims Processing Guide Chapter 5 in to read: *"Follow HCPCS/CPT rounding guidelines."* **2. Tables A.5.3.c.i Substance Abuse Services: Outpatient Services – Claim Type 837I and A.5.3.c.ii Substance Abuse Services: Outpatient Services – Claim Type 837P - Public Comments requesting additional information and clarification regarding usage of HCPSC code 4306F for MAT Therapy and/or Counseling Services.** Usage of MAT Therapy and/or Counseling Services 4306F is required by new state and federal requirements. These new requirements are to prevent fraud and abuse in MAT programs. DHS provided written responses to address the questions submitted as part of the public comments. At this time, no changes are required for reporting these services because 4306F is a valid code that can be used to report these services. The TAG suggested the submitter discuss these issues further with DHS, specifically DHS deputy commissioner for OIG, The TAG also suggested the submitter request a specific code to identify these services from the HCPCS panel. **3. Table A.5.2. Behavior Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique to Minnesota Government Programs – Public Comment requesting that Peer Services remain in the 837P Companion Guide; it is a service for adults and is separate from the Certified Family Peer Specialist-DHS.** During the discussion of what differentiated these services, it was suggested that the description be appended to include "for adults" and the program name be changed to reflect what's posted on DHS website. A motion was moved and seconded to approve the recommended changes for this entry. The vote was unanimous to make the following change to the 837P: Change program name to "Certified Peer Specialist Services" and revise the description/definition to read: Non-clinical support counseling services for adults provided by certified peer specialist. **4. Changes to Table A.5.2.1 Mental Health-Related Modifiers Appearing in Table A.5.2 – Public comment to revise the table changing the description for Modifier UD and to add a new modifier U3 to the table for new services added to the Adult Rehabilitative Mental Health Services program in Table A.5.2.** The TAG agreed to make changes to guides as requested at DHS direction. **Changes to Table A.5.2 Behavioral Health Procedure Code/Modifier Combinations…Programs (same as above) – Adult Rehabilitative Mental Health Services (ARMHS) - Public comment regarding coding for Mental Health Service Plan Development.** DHS decided to roll the Mental Health Service Plan Development program into to the ARMHS program as additional services provided in ARMHS as opposed to a stand-alone benefit. Additionally, changes are to be made to some of the codes and code descriptions. Due to time constraints further discussion and recommendation of this public comment are postponed.	
3/10/16: Some TAG members stated that removing "Do not follow Medicare rounding rules" from Section A.3.4.2 in the front matter caused much confusion regarding Minnesota's rule regarding rounding time (units). Due to the many inquiries received, the TAG agreed to provide instructions in the front matter and made changes to the fourth bulleted paragraph in the front matter section, **A.3.4.2 Units (basis for measurement)** as follows: *"(See rounding rules instructions for OT/PT/SLP in Chapter 5 of Appendix A, Table A.5.1)"* after the second sentence. All public comments without final (completed) and approved SBARs will not be added to the guides. Consequently the TAG requested the recommendations reflect their decisions regarding all public comments, including those the TAG voted to not approve which are as follows and that their decisions be documented in today's minutes:	OPEN An email vote will be sent to members.

• Table A.5.2.1 - Mental Health-Related Modifiers Appearing in Table A.5.2: Request to revise U modifiers. TAG agreed not to accept these changes due to lack of approved SBAR. • Table A.5.2 – Behavioral Health Procedure Code/Modifier…: Request to add coding for MH Service Development Plan into to Adult Rehabilitative Mental Health Services (ARMHS) benefits. TAG agreed not to accept the requested changes due to lack of approved SBAR. The original MH Service Plan Development SBAR dated April 14, 2014 was closed. Subsequent SBARs submitted to the MCT had not been approved. • Table A.5.2 – (same as above): TAG rejected request to include MH Service Development Plan codes into ARMHS benefits. • Tables A.5.3.i and A.5.3.ii – Outpatient Services: Request for add J codes was rejected by the MCT. Previously submitted SBARs that have undergone changes, for example, title changes, recommended coding changes, and combined services will be closed and the SBAR originator will have to resubmit a new SBAR for the MCT consideration. DHS must submit a new SBAR for modifier change request to the mental health modifier table in Appendix A, table A.5.2.1 and to revise the ARMHS services and coding. Motion made and seconded to approve responses to comments as discussed and revised. Responses to public comments received on the 837P and 837I approved unanimously. Motion made to accept guide as revised based on recommendations approved as of today and forward to Ops for review and approval.	

5. SBAR – ADDENDUM – CFSS Community First Services and Supports - Increase – Kathy Sijan, DHS

2/11/16: No discussion of this agenda item due to time constraints	**OPEN**
2/23/16, 3/10/16 No discussion due to time constraints	**OPEN**

6. AUC Coding Recommendation Table Review

2/11/16: No discussion of this agenda item due to time constraints	**OPEN**
2/23/16, 3/10/16 No discussion due to time constraints	**OPEN**

7. 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. 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.	**OPEN**
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	**OPEN**

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?	
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**
2/11/16: TAG reviewed and discussed the draft 837 Dental companion guide, Appendix A, Section A.5 Teledentistry. After review of Minnesota Statutes 256B.0625, which was cited for the statutory requirement for teledentistry, the TAG agreed that revisions to the first paragraph would be needed because the cited statute specifically states telemedicine and not teledentistry. Teledentistry is a covered service under the telemedicine statutes. Changes made to the draft are as follows: 1. Removed coverage limitations from guide, except bullet #3. 2. Revised bullet # 3 so statement reads: Note: Non-billable services: • Sending materials • Originating site fee 3. Added statement, *"For MHCP recipient limitations refer to Department of Human Services MHCP Provider Manual."* Concern was expressed regarding some providers systems ability to file claims using the required modifier and whether or not the electronic dental claim could accommodate the required modifier. It was confirmed the modifiers could be billed on the electronic dental claim. For electronic claims, the X12 segment is SV3 – DENTAL SERVICE and the element details for procedure modifiers are SV301-3, SV301-4, SV301-5 and SV301-6. In addition to reviewing the 837D, the TAG also reviewed the Teledentistry SBAR and addressed questions regarding Teledentistry from the MCT's January 14 meeting: **Q. When is a service teledentistry vs. referral?** *A. It is a referral when the distant site makes a referral.* **Q. Will completion of an attestation form be required for teledentistry as it is for telemedicine?** *A. Completion of the attestation form will be required. DHS is in the process of developing a form for teledentistry. In the interim, the telemedicine form. It was confirmed that MCOs will also use the attestation form.* **Q. What happens if the originating site provider is different than the site provider?** A. After further discussion, it was agreed by the TAG any further revisions to the 837 Dental companion guide other than coding should be made by the Claims DD TAG. Kathy Sijan stated she would submit the Teledentistry SBAR to the Claims DD TAG for their review and further revision of the draft 837D companion guide. Judy stated that after the Medical Code TAG approved a final draft version of the 837D, MDH would forward it to the Claims DD TAG for their review and approval prior to submitting to Ops to approve before publishing as a proposed rule. Faith stated the Teledentistry SBAR will be closed after the TAG approves the draft of the revised, proposed 837D companion guide.	**OPEN** Verify effective date and applicability of teledentistry statutes for commercial health plans. Review and approval of the draft 837D companion guide.
2/23/16 Judy reported that changes agreed upon at last meeting was incorporated into the draft and forwarded to the Minnesota Dental Association for their review and feedback. No further discussion due to time constraints	**OPEN**
3/10/16 No discussion due to time constraints.	OPEN

8. SBAR - CHW Universal Modifier - Will Wilson, DHS

9. Community Emergency Medical Technician Services – Shawnet Healy, DHS

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**

2/11/16: No discussion of this agenda item due to time constraints	**OPEN**
2/23/16, 3/10/16 No discussion due to time constraints	**OPEN**

11. Additional Agenda Items/ Announcements

- Next regularly scheduled meeting: May 12, 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 - Tuesday, March 10, 2016, 2016, 9:00 a.m. to 12:00 a.m.
Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1st floor

Minutes By: Judy Edwards and Faith Bauer DRAFT

Agenda Item	Discussion	Action/Next Steps
1. Welcome and Introduction a. Attendance tracking: Deb Sorg deb.a.sorg@healthpartners.com b. Membership request and/or updates: Deb Sorg deb.a.sorg@healthpartners.com	Members were asked to introduce themselves and their organizations. Those attending via teleconference/WebEx were requested to send Deb attendance via email and include name and organization.	Completed
2. Review of Antitrust Statement	Faith read anti-trust statement.	No discussion
3. Review of last meeting's minutes – February 23, 2016	Minor corrections were made to Agenda Item #4 Companion Guide Comment(s) Review, noted below: • the word "of" was added to the paragraph after the #1 bullet; and • "to" was deleted in the first sentence of the third paragraph after bullet #4. A motion was made and seconded to approve minutes with corrections. TAG voted unanimously to approve.	CLOSED
4. **Companion Guide Comment(s) Review**	Some TAG members stated that removing "Do not follow Medicare rounding rules" from Section A.3.4.2 in the front matter caused much confusion regarding Minnesota's rule regarding rounding time (units). Due to the many inquiries received, the TAG agreed to provide instructions in the front matter and made changes to the fourth bulleted paragraph in the front matter section, **A.3.4.2 Units (basis for measurement)** as follows: *"(See rounding rules instructions for OT/PT/SLP in Chapter 5 of Appendix A, Table A.5.1)"* after the second sentence. All public comments without final (completed) and approved SBARs will not be added to the guides. Consequently the TAG requested the recommendations reflect their decisions regarding all public comments, including those the TAG voted to not approve which are as follows and that their decisions be documented in today's minutes: • Table A.5.2.1 - Mental Health-Related Modifiers Appearing in Table A.5.2: Request to revise U modifiers. TAG agreed	OPEN An email vote will be sent to members.

	not to accept these changes due to lack of approved SBAR. • Table A.5.2 – Behavioral Health Procedure Code/Modifier…: Request to add coding for MH Service Development Plan into to Adult Rehabilitative Mental Health Services (ARMHS) benefits. TAG agreed not to accept the requested changes due to lack of approved SBAR. The original MH Service Plan Development SBAR dated April 14, 2014 was closed. Subsequent SBARs submitted to the MCT had not been approved. • Table A.5.2 – (same as above): TAG rejected request to include MH Service Development Plan codes into ARMHS benefits. • Tables A.5.3.i and A.5.3.ii – Outpatient Services: Request for add J codes was rejected by the MCT. Previously submitted SBARs that have undergone changes, for example, title changes, recommended coding changes, and combined services will be closed and the SBAR originator will have to resubmit a new SBAR for the MCT consideration. DHS must submit a new SBAR for modifier change request to the mental health modifier table in Appendix A, table A.5.2.1 and to revise the ARMHS services and coding. Motion made and seconded to approve responses to comments as discussed and revised. Responses to public comments received on the 837P and 837I approved unanimously. Motion made to accept guide as revised based on recommendations approved as of today and forward to Ops for review and approval.	
5. SBAR - Mental Health Service Plan Development - REOPEN – Kathy Sijan, DHS	Closed – DHS will have to resubmit SBAR for ARMHS changes	CLOSED
6. SBAR – ADDENDUM – EIDBI/Autism Modifier 60 Day Temporary ABA/DBI Increase – Kathy Sijan, DHS	SBAR approved	CLOSED
7. SBAR – ADDENDUM – CFSS Community First Services and Supports - Increase – Kathy Sijan, DHS	No discussion due to time constraints	OPEN
8. AUC Coding Recommendation Table Review	No discussion due to time constraints	OPEN

9. Miscellaneous - SBAR Review	No discussion due to time constraints	OPEN
10. Teledentistry – Kathy Sijan	No discussion due to time constraints.	OPEN
11. SBAR - Intensive Outpatient Mental Health Program for Pregnant and Postpartum Women with Children ages 0-5 – Claire Persons, HCMC	DHS recognizes DBT IOPs but not non-DBTs IOPs Are payers willing to contract with HCMC for these services? HP uses S9480 for other services. Would need to be able to distinguish this program for something else. Code is currently being used to describe other services and would need something else to describe this program. Did DHS indicated they are interested? Yes, because postpartum and pre-natal are common. PrairieCare is using code with private payers as well as others. Questions addressed by Dr. Kim were: Will this be considered partial hospitalization? No, this is a step-down; two days as outpatient 3/hours a day. DHS is keeper of the U modifier. For other programs/who are they serving? BCBS S9480 behavioral health diagnosis only. Can be standard for intensive outpatient program. Not outpatient or day treatment. Is it psychiatric services? Would be difficult to track. Is this program just for pregnant and postpartum only? There is a modifier; What diagnosis would you be reporting for billing purposes? Major depression; bipolar, severe stress, etc. psychiatric program. Psychiatric service; will be charging per day. Intensive, psychiatric outpatient—how does it differ from other services? Because it is a per diem code; when other facilities use this code. The issue is that Medicare will probably never touch this; we don't discuss everything a payer would want to do that is contracting. If code fits service you're rendering. Is there any reason you would want to track for this? Is this a benefit for DHS? How do they regard PMAP people? Further discussion is postponed until DHS is in attendance Faith asked other payers to determine if their organizations use the S9480 code. Coding is appropriate for services being rendered. Recommend HCMC talk to payers to see if they would cover it? If DHS has to identify program, it will perhaps come back to the AUC. Mental health pregnancy code and postpartum code would be used. Are these moms that would be in the postpartum stage? If you want to distinguish it, you have to S code is charge code (CPT) and it goes on	CLOSED (Will place in FAQ) TAG members are to determine if their organization uses S9480 code and for what services.

	claim. In addition, a diagnosis code is required. Next layer of onion, unique pregnancy code and postpartum code. Payers' discussion should be recognition for these service codes. Diagnosis is important, payers make sure services are compatible with codes; apply right buckets of benefits, i.e., mental health or pregnancy in order to apply the correct contracting and subscriber.	
12. Miscellaneous - SBAR Review	No review or discussion of remaining SBARs due to time constraints.	OPEN
13. Additional Agenda Items/ Announcements	• March 22 meeting is cancelled. • Carolyn announced the MN AAPC conference has been scheduled. She will forward conference details to TAG members. • Next regularly scheduled meeting: April 14, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170	CLOSED

Summary of Changes to 837P & 837I from Public Comments
As of March 10, 2016

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Changes to Appendix A front matter		
Section A.3.4.2 **Units (basis for measurements)**	**Made revisions as noted below:** Revised second sentence in fourth bullet to read: *Follow HCPCS/CPT for determining rounding time.* Revised fifth bullet point statement: *Follow HCPCS/CPT for determining rounding time. (See round rule instructions for PT/OT/ST in Chapter 5 of Appendix A, Table A.5.1.)*	✓	✓
	Changes to Appendix A, Table A.5.1		
N/A **Early Intensive Developmental and Behavioral Intervention (EIDBI)**	**The TAG recommended changes to describe the TS modifier and made revisions to the EIDBI benefit are as follows:** Added an eighth service: 60-day temporary increase in ABA/DBI services Added coding description for this service and selected codes: UB H TF = 60-day temporary increase for ABA/DBI services Selected Codes ABA or DBI Intervention code: • 0364T UB H_ TF • 0365T UB H_ TF • 0366T UB H_ TF • 0367T UB H_ TF • 0368T UB H_ TF • 0369T UB H_ TF Request to add new table to EIDBI benefit section to include list of EIDBI modifiers.	✓	
N/A	**Add new program and Minnesota rule as follows:**	✓	

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
Family Caregiver Services	These services provide training, education, coaching and counseling services for family and informal caregivers who provide direct and ongoing services for recipients in the Elderly Waiver (EW) and Alternative Care (AC) Programs. Coding: S5115 - Home care training, nonfamily; per 15 minutes, Family Caregiver Training & Education S5115 TF - Home Care training, nonfamily; per 15 minutes, Family Counseling with Assessment S5115 TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care, Family Memory Care		
Chapter 5 Part B Outpatient Rehabilitation and CORF/OPT Services	**Revised Minnesota Rule to read as follows:** Follow HCPCS/CPT rounding guidelines.	✓	✓
	Changes to Appendix A, Table A.5.2.2		
List of Behavioral Health Programs	**Added link to the behavioral health programs listed in Table A.5.2** Peer Services	✓	
	Changes to Appendix A, Table A.5.2		
Behavioral Health Programs	Peer Services Added Peer Services benefit program and coding back into the 837 guide and made the following changes: • Program name from Peer Services to Certified Peer Specialist Services • Revised program description/definition to include "for adults": *Non-clinical support counseling services for adults provided by certified peer specialist*.	✓	

Section	Description of draft change	Applies to Professional (P) Guide	Applies to Institutional (I) Guide
	Adult Rehabilitative Mental Health Services (ARMHS) Added new services to the Adult Rehabilitative Mental Health Services (ARMHS) program as follows: ▪ 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		
	Changes to Appendix A, Table A.5.3.c.i and A.5.3.c.ii	√	√
Substance Abuse Services	Change MAT Therapy and/or Counseling Services to MAT Therapy Tracking		
	Changes to Appendix A, Table A.5.4.a	√	
Public health nurse clinic services	Patient Education only – if no other services (includes car seat education) Delete S9123 in Home or Place of Residence column Replace S9123 with the following codes: Individual S9945 Group S9446		

Minnesota Department of Health

DRAFT

Minnesota Department of Health (MDH) ~~Proposed~~ Rule

Title:	~~Proposed~~ Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X222A1 Health Care Claim: Professional (837) Version ~~1011~~12.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	~~This document was adopted into rule on June 1, 2015.~~ [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version ~~10~~11.0 (~~v10~~v11.0) of *the Minnesota Uniform Companion Guide (MUCG) for the* Implementation of the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*. It was announced as ~~an adopted~~a proposed rule in the Minnesota State Register, Volume ~~39~~40, Number ~~48~~, ~~June 1, 2015~~28, January 11, 2016 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version ~~8~~10.0 was the last version of this document to be adopted into rule ~~prior to this v10~~and remains in force until superseded by a subsequently adopted version. This document is available at no charge at MDH's "~~Minnesota Statutes, section 62J.536 Rules~~Health Care Administrative Simplification" webpage (http://www.health.state.mn.us/asa/~~rules.html~~).

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1. Overview

1.1. Statutory basis for this rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.1. Exceptions to applicability

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

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

accomplish the purpose of the transaction.

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

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

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

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

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1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

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

Version	Revision Date	Summary Changes
		10.0 supersedes all previous versions.
11.0	January 11, 2016	Proposed revisions to v10.0
12.0	TBD	Adopted into rule TBD. Version 12 incorporates changes proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.

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

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

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

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

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

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

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

- Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

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

Note regarding claims attachments for only workers compensation medical claims: Minnesota Statutes, Section 176.135 subd. 7a. (e) require that starting July 1, 2016

- "*Health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")*"; and
- *"Workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction."*

A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: https://www.revisor.mn.gov/statutes/?id=176.135.

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
	Provider Name	Referring Provider Secondary Identification	Reference Identification Qualifier	

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5. List of Appendices

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

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

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

Table A.5.4 -- Maternal and Child Health Billing Guide ~~F~~for Public Health Agencies

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

B. Appendix B: K3 Segment Usage Instructions

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

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

different from Medicare resulted because:

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

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

- Follow all related AMA guidelines in CPT[3] (e.g. “unit of service is the specimen” for pathology codes). Definition of “specimen”: "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow ~~general~~ HCPCS/CPT for determining rounding ~~rules~~time. ~~for reporting more than the code's time value~~. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- ~~Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.~~ Follow HCPCS/CPT for determining rounding time. (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for PT/OT/ST.)
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

[3] Current Procedural Terminology (CPT®), copyright 2013~~3~~4 American Medical Association

[4] Current Procedural Terminology (CPT®), copyright 2013~~3~~4 American Medical Association

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

- ASC X12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1 as “professional claim type” or “837P” or “Professional claim;”
- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.1 as “institutional claim type” or “837I” or “Institutional claim;”
- ASC X12/005010X224A2 Health Care Claim: Dental (837), referred to in Table A.5.1 as “837D.”

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

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

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

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

	12	Physicians/Nonphysician Practitioners	Interpreter services	To report interpreter services: Note: Rounding rules (see front matter section A.3.4.2) apply to all services below. A minimum of eight minutes must be spent in order to report one unit. • T1013 -- Face-to-face oral language interpreter services per 15 minutes • T1013 U3 -- Face-to-face sign language interpreter services per 15 minutes • T1013 GT -- Telemedicine interpreter services per 15 minutes • T1013 U4 -- Telephone interpreter services per 15 minutes • T1013 UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting • Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient • T1013 52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provided, report each on a separate line appended with the -59 modifier ▪ T1013 52 x 2 units (30 minutes of drive time) ▪ T1013 52 59 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013 52 may not be used for drive time if mileage is reported (see 99199) ~~is reported~~

			○ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service ○ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013 52) is reported ○ Report one unit per mile
12	Physicians/Nonphysician Practitioners	Collaborative psychiatric consultation (MN Statutes 256b.0625, subd. 48 – Psychiatric consultation to primary care practitioners)	Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care - 99499 HE AG U7 (by physician extender) • Primary Care - 99499 HE AG U4 U7 (non-face-to-face by physician extender) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face) • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face) • Consulting psychologist – 99499 HE AM • Consulting psychologist – 99499 HE AM U4 (non-face-to-face)
12	Physicians/Nonphysician Practitioners	Patient not in exam room	There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the

<table>
<tr><td></td><td></td><td></td><td>appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-~~9~~-CM code(s), based on date of service, for the diagnosis of the patient as the primary diagnosis or diagnoses. ~~Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.~~</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Health Care Homes</td><td>
The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:
Patient Complexity Level and Supplemental Factors
<table>
<tr><th>Patient Complexity Level</th><th>Complex-ity Modifiers</th><th>Non English Speak-ing Modifier</th><th>Active Mental Health Con-dition</th></tr>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>
Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level
o U2 – Care coordination, extended complexity level
o U3 – Care coordination, supplemental factor; Non-English language
o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition
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	12	Physicians/Nonphysician Practitioners	ImPACT testing	96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only
	12	Physicians/Nonphysician Practitioners	In-reach Community Based Coordination	Use HCPCS T1016 U2 or T1016 U2 TS. ▪ T1016 Case management, each 15 minutes ▪ U2 = In-reach, initial service ▪ U2 TS = In-reach, follow-up
	13	Radiology Services and Other Diagnostic Procedures	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components
	13	Radiology Services and Other Diagnostic Procedures	Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
	14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
	14	Ambulatory Surgical Centers	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
	14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
	15	Ambulance	General	Follow Medicare coding guidelines
	15	Ambulance	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: ▪ A0080 ▪ A0090 ▪ A0100 ▪ A0110

			▪ A0120 ▪ T2002 ▪ T2003 ▪ T2004
15	Ambulance	Community Paramedic	Community paramedic services are to be billed as follows: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – report the Medical director's NPI • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) — a minimum of 8 minutes of face to face time must be rendered in order to report one unit (see also section A.3.4.2 for units rounding rules) o T1016 Case management, each 15 minutes o U3 – service provided by certified community paramedic (EMT-CP) • Non-reportable services include: o ~~Incidental s~~Supplies (e.g., gloves, test strips, band aids, etc.); o Vaccines o Travel; o Mileage; o Medical record documentation. ~~Supplies and vaccines are reported by the ordering primary care physician only.~~
16	Laboratory Services	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.

16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
18	Preventive and Screening Services	New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.
18	Preventive and Screening Services	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-~~9~~ CM, , code set instructions based on date of service. All applicable diagnoses should be submitted.
18	Preventive and Screening Services	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers
18	Preventive and Screening Services	Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations

18	Preventive and Screening Services	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code
18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
~~**18**~~	~~Preventive and Screening Services~~	~~C&TC~~	~~S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed.~~ ~~▪ Maternal depression screening: 99420 UC~~ ~~▪ Developmental screening: 96110~~ ~~▪ Child Mental Health Screening: 96127.~~ ~~▪ Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately.~~ ~~▪ Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to:~~ ~~o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or~~

			~~$0.01 charge~~ ~~o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge~~ ~~o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier -52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible.~~ ~~▪ Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed.~~ ▪ ~~Use most appropriate diagnosis code based on patient age.~~
19	Indian Health Services	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.

21	Medicare Summary Notices		Not applicable to coding guidelines
22	Remittance Advice		Not applicable to coding guidelines
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations		Not applicable to coding guidelines

	and Decisions		
35	Independent Diagnostic Testing Facility (IDTF)		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines
See the following regarding ~~"Doula Services", "Home Infusion Therapy" and "Licensed Traditional Midwife Services (Not Certified Nurse Midwives)"~~ services that are not addressed in any chapter of the Medicare Claims Processing Manual: Doula Services; Home Infusion Therapy; Licensed Traditional Midwife Services (Not Certified Nurse Midwives); ~~,~~Child and Teen Checkups (C&TC); and Early Intensive Developmental and Behavioral Intervention (EIDBI).			
N/A	N/A	Doula Services MS 256B.0625, Subd. 28B Doula Services	Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to ~~six~~ seven sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the ~~six~~seven. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows: ▪ S9445 U4 – ante-partum and post – partum Doula services ▪ 99199 U4 – Doula attendance at labor and delivery
N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes).

			Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. <u>Place of Service:</u> 25 – Free-standing Birthing Center <u>HCPCS Code:</u> Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, free-standing birthing center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits. Fragmented services may be reported in certain circumstances: • If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes). • If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. • Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service). • Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal

			period. Urine dip sticks are considered part of the global package. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.
	N/A	N/A	Child and Teen Checkups (C&TC)	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. Refer to DHS for the C&TC Provider Guide Webpage for a complete list of reportable component codes. • 96110 – Developmental Screening • 96110 U1 – Autism Screening • 96127 – Social/Emotional or Mental Health Screening • Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed. • Use most appropriate diagnosis code based on patient age.

N/A	N/A	**Family Caregiver Services**	Family Caregiver Services provide training, education, coaching and counseling services for family and informal caregivers who provide direct and ongoing services for recipients in the Elderly Waiver (EW) and Alternative Care (AC) Programs. • S5115 - Home care training, nonfamily; per 15 minutes, Family Caregiver Training & Education • S5115 TF - Home Care training, nonfamily; per 15 minutes, Family Counseling with Assessment • S5115 TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care, Family Memory Care	

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

Note: This Early Intensive Development and Behavioral Intervention (EIDBI) table is part of ***Table A.5.1 Minnesota Coding Specifications: When to use code different from Medicare***. EIDBI is not applicable to any chapter or topic in the Medicare Claims Processing Manual. Due to the number of services and coding entries for the EIDBI benefit, it has been removed from Table A.5.1 and formatted differently to provide clarity and for ease of use.

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Both Department of Human Services (DHS) fee-for-service and managed care will need to provide coverage of the EIDBI benefit effective July 1, 2015. There are seven EIDBI benefit services:

1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI)
2. EIDBI Observation and Direction
3. Comprehensive Multi-Disciplinary Evaluation (CMDE)
4. Individual Treatment Plan Development and Monitoring
5. Family Caregiver Training and Counseling
6. Coordinated Care Conference
7. Travel Time
8. 60-day Temporary Increase for ABA/DBI services

1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Developmental and Behavioral Intervention (DBI)

Selected Codes
0364T, 0365T, 0366T, 0367T, 0368T, 0369T

HK – Qualified Supervising Professional [QSP]

HP – Doctorate /Mental Health Professional [MHP]

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

HO – Masters /Mental Health Professional [MHP]
HN – Bachelor's degree level I or II
HM – Less than bachelor degree level III
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Coding Individual	Coding Group
0368T UB HK –Qualified Supervising Professional, first 30 minutes	0366T UB HK –Qualified Supervising Professional, first 30 minutes
0369T UB HK –Qualified Supervising Professional, each additional 30 minutes	0367T UB HK –Qualified Supervising Professional, each additional 30 min
0368T UB HP – Doctorate /Mental Health Professional [MHP], first 30 minutes	0366T UB HP – Doctorate /Mental Health Professional [MHP], first 30 minutes
0369T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 minutes	0367T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 min
0368T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes	0366T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes
0369T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes	0367T UB HO – Masters /Mental Health Professional [MHP], each additional 30 min
0368T UB HN – Bachelor's degree level I, first 30 minutes	0366T UB HN – Bachelor's degree level I or II, first 30 minutes
0369T UB HN – Bachelor's degree level I, each additional 30 minutes	0367T UB HN – Bachelor's degree level I or II, each additional 30 min
0364T UB HN – Bachelor's degree level II, first 30 minutes	0366T UB HM –Less than bachelor's degree level III, first 30 min
0365T UB HN –Bachelor's degree level II, each additional 30 minutes	0367T UB HM – Less than bachelor degree level III, each additional 30 min
0364T UB HM –Less than bachelor's degree-level III, first 30 min	
0365T UB HM – Less than bachelor's degree level III, each additional 30 minutes	

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2. EIDBI Observation and Direction

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Selected Codes
0362T, 0363T
HP – Doctoral level
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT – via interactive audio and video telecommunications systems

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Coding	Telemedicine
0362T UB HN – Bachelor's degree level I or II, first 30 minutes	0362T UB HN GT- Bachelor's degree level I or II (telemedicine), first 30 minutes
0363T UB HN – Bachelor's degree level I or II, each additional 30 minutes	0363T UB HN GT– Bachelor's degree level I or II (telemedicine), each additional 30 minutes
0362T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes	0362T UB HO GT – Masters /Mental Health Professional [MHP] (telemedicine), first 30 minutes
0363T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes	0363T UB HO GT – Masters /Mental Health Professional [MHP] (telemedicine) each additional 30 minutes
0362T UB HP – Doctorate /Mental Health Professional [MHP] first 30 minutes	0362T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine), first 30 minutes
0363T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 minutes	0363T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine), each additional 30 minutes
0362T UB HK – Qualified Supervising Professional , first 30 minutes	0362T UB HK GT - Qualified Supervising Professional, first 30 minutes
0363T UB HK – Qualified Supervising Professional, each additional 30 minutes	0363T UB HK GT – Qualified Supervising Professional, each additional 30 minutes

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3. Comprehensive Multi-Disciplinary Evaluation (CMDE)

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Selected Code
0359T
AM – Psychiatrist [MD]/Physician
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
TG – Advanced Practice Registered Nurse (APRN)
GT– via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

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

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

[MHP] (telemedicine)
0359T UB HO – Masters /Mental Health Professional [MHP]
0359T UB HO-GT – Masters /Mental Health Professional [MHP] (telemedicine)

4. Individual Treatment Plan Development and Monitoring

Selected Codes
H0032 – Mental Health Service Plan Development by non-physician
UD – 15 minute unit
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
UB EIDBI [Early Intensive Developmental and Behavior Intervention]

Note:

This service is time based although H0032 by definition is not time based. The H0032 was approved for mental health service plan development with modifier UD to indicate a 15 minute time unit.

Coding
H0032 UB HK UD – Qualified Supervising Professional [QSP]
H0032 UB HP UD – Doctorate /Mental Health Professional [MHP]
H0032 UB HO UD – Masters /Mental Health Professional [MHP]
H0032 UB HN UD – Bachelor's degree level I or II

5. Family Caregiver Training and Counseling

Selected Codes
T1027
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or level II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT – via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Coding Individual	Coding Group
T1027 UB HK – Qualified Supervising Professional [QSP]	T1027 UB HK HQ – Qualified Supervising Professional [QSP], Group
T1027 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine)	T1027 UB HP HQ – Doctorate /Mental Health Prof [MHP], Group
T1027 UB HP – Doctorate /Mental Health Prof [MHP]	T1027 – UB HO HQ – Masters /Mental Health Prof [MHP], Group

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

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

6. Coordinated Care Conference

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Selected Codes Description
T1024
AM – Physician
HK – Qualified Supervising Professional (QSP)
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT – via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention
TG – Advanced Practice Registered Nurse (APRN)

Coding	Telemedicine Coding
T1024 UB AM –Physician	T1024 UB AM GT –Physician (telemedicine)
T1024 UB TG - APRN	T1024 UB TG GT– APRN (telemedicine)
T1024 UB HK – Qualified Supervising Professional [QSP]	T1024 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine]
T1024 UB HP – Doctorate /Mental Health Professional [MHP]	T1024 UB HP GT –Doctorate /Mental Health Professional [MHP] (telemedicine)
T1024 UB HO – Masters /Mental Health Professional[MHP]	T1024 UB HO GT – Masters /Mental Health Professional[MHP] (telemedicine)
T1024 UB HN – Bachelor's degree level I or II	T1024 UB HN GT – Bachelor's degree level I or II (telemedicine)

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7. Travel Time

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Selected Codes
H0046
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Notes:

One unit equals one minute.
Travel time is billed on the same claim as the provided service.

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

The actual number of minutes spent in transit is billed (no rounding up).

Coding
H0046 UB

8. 60-day temporary increase

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Selected Codes
ABA or DBI Intervention code:
0364T UB H_ TF
0365T UB H_ TF
0366T UB H_ TF
0367T UB H_ TF
0368T UB H_ TF
0369T UB H_ TF

TF – 60 Day Temporary Increase for ABA/DBI services

Modifier	Description
UB	EIDBI
UB AM	EIDBI, Physician or Psychiatrist
UB AM GT	EIDBI, Physician or Psychiatrist, Telemedicine
UB HK	EIDBI, Qualified Supervising Professional [QSP]
UB HK GT	EIDBI, Qualified Supervising Professional [QSP],Telemedicine
UB HK UD	EIDBI, [Qualified Supervising Professional [QSP],PER 15 MINUTES
UB HM	EIDBI, Level III, Support Specialist, less than Bachelor's
UB HN	EIDBI, Bachelor's level I or II
UB HN GT	EIDBI, Bachelor's level I or II, Telemedicine
UB HN HQ	EIDBI, Bachelor's Degree Level I or II, Group
UB HN UD	EIDBI, Bachelor's level I or II, PER 15 MINUTES
UB HO	EIDBI, Masters /Mental Health Professional [MHP]
UB HO GT	EIDBI, Masters /Mental Health Professional [MHP], Telemedicine
UB HO HQ	EIDBI, Masters/Mental Health Professional, Group
UB HO UD	EIDBI, Masters /Mental Health Professional [MHP], PER 15 MINUTES
UB HP	EIDBI Doctorate /Mental Health Professional [MHP]
UB HP GT	EIDBI, Doctorate /Mental Health Professional [MHP],Telemedicine
UB HP HQ	EIDBI, Doctorate/Mental Health Professional, Group
UB HP UD	EIDBI, Doctorate /Mental Health Professional [MHP],PER 15 MINUTES
UB TG	EIDBI, APRN
UB TG GT	EIDBI, APRN, Telemedicine
Note: TF is only used on ABA or DBI Interventions as a third modifier; with prior approval	
UB H TF	60-day temporary increase for ABA/DBI services

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

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

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

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

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

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

Assertive Community Treatment (ACT)

Adult Crisis Response Services

Children's Mental Health Crisis Response Services

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Children's Therapeutic Services and Supports (CTSS)

Adult Rehabilitative Mental Health Services (ARMHS)

~~Peer Services~~Certified Peer Specialist Services

Mental Health Certified Family Peer Specialist

Mental Health Diagnostic Assessment

Dialectical Behavior Therapy

Youth Assertive Community Treatment

Intensive Treatment in Foster Care

Mental Health Family Psychoeducation Services

Mental Health Clinical Care Consultation

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

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

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

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

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

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

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

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

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

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

Name of Program	Description/Definition	Coding
		CTSS ▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS ▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS *(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes ▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner

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

Name of Program	Description/Definition	Coding
		▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker ▪ 90882 - Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD - Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ 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] ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
Certified Peer Specialist Services Back to list of behavioral health programs	Non-clinical support counseling services for adults provided by certified peer specialist.	Codes: ▪ H0038 – Certified peer specialist services, per 15 minutes ▪ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes
Mental Health Diagnostic	A diagnostic assessment is a written report that documents the clinical and functional face-to-face	Codes: In order to report diagnostic assessments with

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

Name of Program	Description/Definition	Coding
Assessment Back to list of behavioral health programs	evaluation of a recipient's mental health and is necessary to determine a recipient's eligibility for mental health services.	levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee

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

Name of Program	Description/Definition	Coding
		▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (1) Psychotherapy provided by a mental health professional; (2) Crisis assistance provided according to standards for children's therapeutic services and supports; (3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee; (4) Clinical care consultation provided by a mental health professional or a clinical trainee; and (5) Service delivery payment	Codes: ▪ S5145 – Foster care, therapeutic, child; per diem ▪ HE – Mental health program Bill only one per diem code per day regardless of the number of services or who provides services.

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

Name of Program	Description/Definition	Coding
	requirements as provided under subdivision 4.	
Mental Health Family Psycho-education Services Back to list of behavioral health programs	• Family psycho-education services provided to a child up to age 21 with a diagnosed mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5 9505.0371, subpart 5, item C • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o understanding a child's symptoms of mental illness; o the impact on the child's development; o needed components of treatment; and o skill development.	Codes: ▪ H2027 - Individual ▪ H2027 HQ - Group (peer group) ▪ H2027 HR - Family with client present ▪ H2027 HS - Family without client present ▪ H2027 HQ HR - Multiple different families with clients present ▪ H2027 HQ HS - Multiple different families without clients present ▪ H2027 HN - Individual, clinical trainee ▪ H2027 HQ HN - Group (peer group), clinical trainee ▪ H2027 HR HN - Family with client present, clinical trainee ▪ H2027 HS HN - Family without client present, clinical trainee ▪ H2027 HQ HR HN - Multiple different families with clients present, clinical trainee ▪ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee
Mental Health Clinical Care Consultation Back to list of behavioral health programs	• MH clinical care consultation services provided to patients up to age 21 and provided by mental health professional or clinical trainee to other providers or educators not under their supervision. • Services may take place in, but are not limited to, school, community, office or clinic	Codes: ▪ 90899-U8 (5-10 minutes) ▪ 90899-U9 (11-20 minutes) ▪ 90899-UB (21-30 minutes) ▪ 90899-UC (31+ minutes) Additional modifiers could be appended, such as U4 for phone and/or HN for clinical trainee.
Certified Family Peer Specialist – DHS	• Services are for children under the following codes with the HA modifier. • For mental health services	Codes: • H0038 Certified peer specialist services, per 15 minutes

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

Name of Program	Description/Definition	Coding
Back to list of behavioral health programs	only; do not apply to substance abuse.	• H0038 U5 Advanced level certified peer specialist services, per 15 minutes • H0038 HQ Group setting, certified peer specialist services, per 15 minutes • H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes • H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes

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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

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

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

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

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

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

~~v10~~v11.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

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

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

inclusive: includes room and board and treatment.

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

v1~~1~~0.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

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

v1~~1~~0.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

Claim Type – 837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs **Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.**	Day	0944	H0047 U9	089x or 013x
MAT Therapy Tracking (See Note 2 below)	~~Day~~	~~0944~~	~~4306F~~	~~089x or 013x~~
Alcohol and/or drug assessment	Session /visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

Note 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.

Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing:

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

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

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

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
MAT Therapy Tracking (see Note 2 below)	Day	N/A	4306F	N/A
Note 1: -Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing: • 4306F – Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction.				
Alcohol and/or drug assessment	Session/visit	N/A	H0001	

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

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

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and miscellaneous

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

V1~~1~~0.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.4.a -- Public health nurse clinic services

Maternal And Child Health Billing Guide For Public Health Agencies

~~**Table A.5.4.a -- Public health nurse clinic services**~~

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Services Include: • Health Promotion & Counseling • Nursing Assessment & Diagnostic Testing • Medication Management • Nursing Treatment • Nursing Care, in the home, by RN (PHN & CPHN)	S9123	T1015
Home health aide or CNA, per visit	T1021	Individual S9445 Group S9446
Patient Education only - if no other services (includes car seat education)	Individual S9445 Group S9446~~S9123~~	Individual S9445 Group S9446

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

~~v10~~v11.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

Maternal And Child Health Billing Guide For Public Health Agencies

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

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

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Table A.5.4.c – OTHER SERVICES and MISCELLANEOUS

v110.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.4.c -- Other services

Maternal And Child Health Billing Guide For Public Health Agencies

~~**Table A.5.4.c -- Other services**~~

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **re-assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

~~V8~~V11.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.4.c -- Miscellaneous

Maternal And Child Health Billing Guide For Public Health Agencies

~~**Table A.5.4.c -- Miscellaneous**~~

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Maternal Depression Screening~~s~~	99420 UC	99420 UC
Child Developmental Screening~~s~~	96110	96110
Autism Screening	96110 U1	96110 U1
Child Social/Emotional or Mental Health Screening~~s~~	96127	96127
TB Case Management	T1016	T1016
TB Direct Observation Therapy	H0033	H0033

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B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

K3*LUMN~

Tooth Number/Oral Cavity

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

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

Report at 2400 Loop only.

K3*JP12~

K3*JP12 14~

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

Report at 2400 Loop only.

K3*JO10~

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

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

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C. Appendix C: Reporting MNCare Tax

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

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Minnesota Department of Health

Minnesota Department of Health (MDH) Proposed Rule

Title:	Proposed Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X222A1 Health Care Claim: Professional (837) Version 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:	[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 11.0 (v11.0) of *the Minnesota Uniform Companion Guide (MUCG) for the* Implementation of the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*. It was announced as a proposed rule in the Minnesota State Register, Volume 40, Number , 28, January 11, 2016 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version 10.0 was the last version of this document to be adopted into rule and remains in force until superseded by a subsequently adopted version. This document is available at no charge at MDH's "Health Care Administrative Simplification" webpage (http://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 rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.1. Exceptions to applicability

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

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

If group purchasers are exempt from one or more of the requirements, providers shall also be

exempt from exchanging those transactions with the group purchaser.

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

The AUC develops and publicizes best practices for the implementation of health care

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

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

1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v.8.0
10.0	June 1, 2015	Adopted into rule June 1, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.
11.0	January 11, 2016	Proposed revisions to v10.0

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

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

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

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

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

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

- Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

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

Note regarding claims attachments for only workers compensation medical claims: Minnesota Statutes, Section 176.135 subd. 7a. (e) require that starting July 1, 2016

- "*Health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")*"; and
- *"Workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction."*

A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: https://www.revisor.mn.gov/statutes/?id=176.135.

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
		Secondary Identification	Qualifier	

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5. List of Appendices

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

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

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

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

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

B. Appendix B: K3 Segment Usage Instructions

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

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

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

[3] Current Procedural Terminology (CPT®), copyright 2014 American Medical Association

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

- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow HCPCS/CPT for determining rounding time. . If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.

  Follow HCPCS/CPT for determining rounding time. (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for PT/OT/ST).

- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

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

- ASC X12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1 as “professional claim type” or “837P” or “Professional claim;”

[4] Current Procedural Terminology (CPT®), copyright 2014 American Medical Association

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

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

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

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

Commented [JE1]:

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

12	Physicians/Nonphysician Practitioners	Interpreter services	To report interpreter services: Note: Rounding rules (see front matter section A.3.4.2) apply to all services below. A minimum of eight minutes must be spent in order to report one unit. • T1013 -- Face-to-face oral language interpreter services per 15 minutes • T1013 U3 -- Face-to-face sign language interpreter services per 15 minutes • T1013 GT -- Telemedicine interpreter services per 15 minutes • T1013 U4 -- Telephone interpreter services per 15 minutes • T1013 UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting • Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient • T1013 52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provided, report each on a separate line appended with the -59 modifier ▪ T1013 52 x 2 units (30 minutes of drive time) ▪ T1013 52 59 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013 52 may not be used for drive time if mileage is reported (see 99199)

			○ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service ○ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013 52) is reported ○ Report one unit per mile
12	Physicians/Nonphysician Practitioners	Collaborative psychiatric consultation (MN Statutes 256b.0625, subd. 48 – Psychiatric consultation to primary care practitioners)	Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care - 99499 HE AG U7 (by physician extender) • Primary Care - 99499 HE AG U4 U7 (non-face-to-face by physician extender) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face) • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face) • Consulting psychologist – 99499 HE AM • Consulting psychologist – 99499 HE AM U4 (non-face-to-face)
12	Physicians/Nonphysician Practitioners	Patient not in exam room	There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and

<table>
<tr><td></td><td></td><td></td><td>management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-CM code(s), based on date of service, for the diagnosis of the patient as the primary diagnosis or diagnoses.</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Health Care Homes</td><td>The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:
Patient Complexity Level and Supplemental Factors
<table>
<tr><th>Patient Complexity Level</th><th>Complex-ity Modifiers</th><th>Non English Speak-ing Modifier</th><th>Active Mental Health Con-dition</th></tr>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>
Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level
o U2 – Care coordination, extended complexity level
o U3 – Care coordination, supplemental factor; Non-English language
o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>ImPACT testing</td><td>96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only</td></tr>
</table>

12	Physicians/Nonphysician Practitioners	In-reach Community Based Coordination	Use HCPCS T1016 U2 or T1016 U2 TS. ▪ T1016 Case management, each 15 minutes ▪ U2 = In-reach, initial service ▪ U2 TS = In-reach, follow-up
13	Radiology Services and Other Diagnostic Procedures	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components
13	Radiology Services and Other Diagnostic Procedures	Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
14	Ambulatory Surgical Centers	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance	General	Follow Medicare coding guidelines
15	Ambulance	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: ▪ A0080 ▪ A0090 ▪ A0100 ▪ A0110 ▪ A0120

			▪ T2002 ▪ T2003 ▪ T2004
15	Ambulance	Community Paramedic	Community paramedic services are to be billed as follows: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – report the Medical director's NPI • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) — a minimum of 8 minutes of face to face time must be rendered in order to report one unit (see also section A.3.4.2 for units rounding rules) o T1016 Case management, each 15 minutes o U3 – service provided by certified community paramedic (EMT-CP) • Non-reportable services include: o Supplies (e.g., gloves, test strips, band aids, etc.); o Vaccines o Travel; o Mileage; o Medical record documentation.
16	Laboratory Services	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.
16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code

			for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
18	Preventive and Screening Services	New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.
18	Preventive and Screening Services	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-CM, , code set instructions based on date of service. All applicable diagnoses should be submitted.
18	Preventive and Screening Services	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers
18	Preventive and Screening Services	Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
18	Preventive and Screening Services	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code

18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
			▪
19	Indian Health Services	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the

			upgraded and GK for the standard item.
21	Medicare Summary Notices		Not applicable to coding guidelines
22	Remittance Advice		Not applicable to coding guidelines
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A

33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines
35	Independent Diagnostic Testing Facility (IDTF)		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines
See the following regarding services that are not addressed in any chapter of the Medicare Claims Processing Manual: Doula Services; Home Infusion Therapy; Licensed Traditional Midwife Services (Not Certified Nurse Midwives); Child and Teen Checkups (C&TC); and Early Intensive Developmental and Behavioral Intervention (EIDBI).			
N/A	N/A	Doula Services MS 256B.0625, Subd. 28B Doula Services	Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to seven sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the seven. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows: ▪ S9445 U4 – ante-partum and post – partum Doula services ▪ 99199 U4 – Doula attendance at labor and delivery

N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes). Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. <u>Place of Service:</u> 25 – Free-standing Birthing Center <u>HCPCS Code:</u> Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, free-standing birthing center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits. Fragmented services may be reported in certain circumstances: • If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes). • If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. • Global services may be split when the patient's prenatal/antepartum

			services are less than four visits (use E/M service). • Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal period. Urine dip sticks are considered part of the global package. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.
N/A	N/A	Child and Teen Checkups (C&TC)	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. Refer to DHS for the C&TC Provider Guide Webpage for a complete list of reportable component codes. • 96110 – Developmental Screening • 96110 U1 – Autism Screening • 96127 – Social/Emotional or Mental Health Screening • Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the

			appropriate date the service was performed. • Use most appropriate diagnosis code based on patient age.
N/A	N/A	**Family Caregiver Services**	Family Caregiver Services provide training, education, coaching and counseling services for family and informal caregivers who provide direct and ongoing services for recipients in the Elderly Waiver (EW) and Alternative Care (AC) Programs. • S5115 - Home care training, nonfamily; per 15 minutes, Family Caregiver Training & Education • S5115 TF - Home Care training, nonfamily; per 15 minutes, Family Counseling with Assessment • S5115 TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care, Family Memory Care

Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

Note: This Early Intensive Development and Behavioral Intervention (EIDBI) table is part of ***Table A.5.1 Minnesota Coding Specifications: When to use code different from Medicare***. EIDBI is not applicable to any chapter or topic in the Medicare Claims Processing Manual. Due to the number of services and coding entries for the EIDBI benefit, it has been removed from Table A.5.1 and formatted differently to provide clarity and for ease of use.

Both Department of Human Services (DHS) fee-for-service and managed care will need to provide coverage of the EIDBI benefit effective July 1, 2015. There are seven EIDBI benefit services:

1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI)
2. EIDBI Observation and Direction
3. Comprehensive Multi-Disciplinary Evaluation (CMDE)
4. Individual Treatment Plan Development and Monitoring
5. Family Caregiver Training and Counseling
6. Coordinated Care Conference
7. Travel Time
8. 60-day Temporary Increase for ABA/DBI services

1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Developmental and Behavioral Intervention (DBI)

Selected Codes

Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

0364T, 0365T, 0366T, 0367T, 0368T, 0369T
HK – Qualified Supervising Professional [QSP]
HP – Doctorate /Mental Health Professional [MHP]
HO – Masters /Mental Health Professional [MHP]
HN – Bachelor's degree level I or II
HM – Less than bachelor degree level III
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Coding Individual	Coding Group
0368T UB HK –Qualified Supervising Professional, first 30 minutes	0366T UB HK –Qualified Supervising Professional, first 30 minutes
0369T UB HK –Qualified Supervising Professional, each additional 30 minutes	0367T UB HK –Qualified Supervising Professional, each additional 30 min
0368T UB HP – Doctorate /Mental Health Professional [MHP], first 30 minutes	0366T UB HP – Doctorate /Mental Health Professional [MHP], first 30 minutes
0369T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 minutes	0367T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 min
0368T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes	0366T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes
0369T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes	0367T UB HO – Masters /Mental Health Professional [MHP], each additional 30 min
0368T UB HN – Bachelor's degree level I, first 30 minutes	0366T UB HN – Bachelor's degree level I or II, first 30 minutes
0369T UB HN – Bachelor's degree level I, each additional 30 minutes	0367T UB HN – Bachelor's degree level I or II, each additional 30 min
0364T UB HN – Bachelor's degree level II, first 30 minutes	0366T UB HM –Less than bachelor's degree level III, first 30 min
0365T UB HN –Bachelor's degree level II, each additional 30 minutes	0367T UB HM – Less than bachelor degree level III, each additional 30 min
0364T UB HM –Less than bachelor's degree-level III, first 30 min	
0365T UB HM – Less than bachelor's degree level III, each additional 30 minutes	

2. EIDBI Observation and Direction

Selected Codes
0362T, 0363T
HP – Doctoral level
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]

Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

HP – Doctorate /Mental Health Professional [MHP]
GT – via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Coding	Telemedicine
0362T UB HN – Bachelor's degree level I or II, first 30 minutes 0363T UB HN – Bachelor's degree level I or II, each additional 30 minutes 0362T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes 0363T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes 0362T UB HP – Doctorate /Mental Health Professional [MHP] first 30 minutes 0363T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 minutes 0362T UB HK – Qualified Supervising Professional , first 30 minutes 0363T UB HK – Qualified Supervising Professional, each additional 30 minutes	0362T UB HN GT- Bachelor's degree level I or II (telemedicine), first 30 minutes 0363T UB HN GT– Bachelor's degree level I or II (telemedicine), each additional 30 minutes 0362T UB HO GT – Masters /Mental Health Professional [MHP] (telemedicine), first 30 minutes 0363T UB HO GT – Masters /Mental Health Professional [MHP] (telemedicine) each additional 30 minutes 0362T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine), first 30 minutes 0363T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine), each additional 30 minutes 0362T UB HK GT - Qualified Supervising Professional, first 30 minutes 0363T UB HK GT – Qualified Supervising Professional, each additional 30 minutes

3. Comprehensive Multi-Disciplinary Evaluation (CMDE)

Selected Code
0359T
AM – Psychiatrist [MD]/Physician
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
TG – Advanced Practice Registered Nurse (APRN)
GT– via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

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

0359T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine)
0359T UB HO – Masters /Mental Health Professional [MHP]
0359T UB HO-GT – Masters /Mental Health Professional [MHP] (telemedicine)

4. Individual Treatment Plan Development and Monitoring

Selected Codes
H0032 – Mental Health Service Plan Development by non-physician
UD – 15 minute unit
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
UB EIDBI [Early Intensive Developmental and Behavior Intervention]

Note:

This service is time based although H0032 by definition is not time based. The H0032 was approved for mental health service plan development with modifier UD to indicate a 15 minute time unit.

Coding
H0032 UB HK UD – Qualified Supervising Professional [QSP]
H0032 UB HP UD – Doctorate /Mental Health Professional [MHP]
H0032 UB HO UD – Masters /Mental Health Professional [MHP]
H0032 UB HN UD – Bachelor's degree level I or II

5. Family Caregiver Training and Counseling

Selected Codes
T1027
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or level II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT – via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Coding Individual	Coding Group
T1027 UB HK – Qualified Supervising Professional [QSP]	T1027 UB HK HQ – Qualified Supervising Professional [QSP], Group
T1027 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine)	T1027 UB HP HQ – Doctorate /Mental Health Prof [MHP], Group
T1027 UB HP – Doctorate /Mental Health Prof	T1027 – UB HO HQ – Masters /Mental Health

Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

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

6. Coordinated Care Conference

Selected Codes Description
T1024
AM – Physician
HK – Qualified Supervising Professional (QSP)
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
GT – via interactive audio and video telecommunications systems
UB – EIDBI [Early Intensive Developmental and Behavior Intervention
TG – Advanced Practice Registered Nurse (APRN)

Coding	Telemedicine Coding
T1024 UB AM –Physician	T1024 UB AM GT –Physician (telemedicine)
T1024 UB TG - APRN	T1024 UB TG GT– APRN (telemedicine)
T1024 UB HK – Qualified Supervising Professional [QSP]	T1024 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine]
T1024 UB HP – Doctorate /Mental Health Professional [MHP]	T1024 UB HP GT –Doctorate /Mental Health Professional [MHP] (telemedicine)
T1024 UB HO – Masters /Mental Health Professional[MHP]	T1024 UB HO GT – Masters /Mental Health Professional[MHP] (telemedicine)
T1024 UB HN – Bachelor's degree level I or II	T1024 UB HN GT – Bachelor's degree level I or II (telemedicine)

7. Travel Time

Selected Codes
H0046
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Notes:

One unit equals one minute.
Travel time is billed on the same claim as the provided service.

Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

The actual number of minutes spent in transit is billed (no rounding up).

Coding
H0046 UB

8. 60-day temporary increase

Selected Codes
ABA or DBI Intervention code:
0364T UB H_ TF
0365T UB H_ TF
0366T UB H_ TF
0367T UB H_ TF
0368T UB H_ TF
0369T UB H_ TF

TF – 60 Day Temporary Increase for ABA/DBI services

Modifier	Description
UB	EIDBI
UB AM	EIDBI, Physician or Psychiatrist
UB AM GT	EIDBI, Physician or Psychiatrist, Telemedicine
UB HK	EIDBI, Qualified Supervising Professional [QSP]
UB HK GT	EIDBI, Qualified Supervising Professional [QSP],Telemedicine
UB HK UD	EIDBI, [Qualified Supervising Professional [QSP],PER 15 MINUTES
UB HM	EIDBI, Level III, Support Specialist, less than Bachelor's
UB HN	EIDBI, Bachelor's level I or II
UB HN GT	EIDBI, Bachelor's level I or II, Telemedicine
UB HN HQ	EIDBI, Bachelor's Degree Level I or II, Group
UB HN UD	EIDBI, Bachelor's level I or II, PER 15 MINUTES
UB HO	EIDBI, Masters /Mental Health Professional [MHP]
UB HO GT	EIDBI, Masters /Mental Health Professional [MHP], Telemedicine
UB HO HQ	EIDBI, Masters/Mental Health Professional, Group
UB HO UD	EIDBI, Masters /Mental Health Professional [MHP], PER 15 MINUTES
UB HP	EIDBI Doctorate /Mental Health Professional [MHP]
UB HP GT	EIDBI, Doctorate /Mental Health Professional [MHP],Telemedicine
UB HP HQ	EIDBI, Doctorate/Mental Health Professional, Group
UB HP UD	EIDBI, Doctorate /Mental Health Professional [MHP],PER 15 MINUTES
UB TG	EIDBI, APRN
UB TG GT	EIDBI, APRN, Telemedicine
Note: TF is only used on ABA or DBI Interventions as a third modifier; with prior approval	
UB H_ TF	60-day temporary increase for ABA/DBI services

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

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

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

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

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

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

Assertive Community Treatment (ACT)

Adult Crisis Response Services

Children's Mental Health Crisis Response Services

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Children's Therapeutic Services and Supports (CTSS)

Adult Rehabilitative Mental Health Services (ARMHS)

Certified Peer Specialist Services

Mental Health Certified Family Peer Specialist

Mental Health Diagnostic Assessment

Dialectical Behavior Therapy

Youth Assertive Community Treatment

Intensive Treatment in Foster Care

Mental Health Family Psychoeducation Services

Mental Health Clinical Care Consultation

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

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

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

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

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

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

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

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

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

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

Name of Program	Description/Definition	Coding
		▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS ▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS *(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes ▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner ▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker

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

Name of Program	Description/Definition	Coding
		▪ 90882 - Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD - Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ 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] ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
Certified Peer Specialist Services Back to list of behavioral health programs	Non-clinical support counseling services for adults provided by certified peer specialist.	Codes: ▪ H0038 – Certified peer specialist services, per 15 minutes ▪ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes
Mental Health Diagnostic Assessment Back to list of behavioral health programs	A diagnostic assessment is a written report that documents the clinical and functional face-to-face evaluation of a recipient's mental health and is necessary to determine a recipient's eligibility	Codes: In order to report diagnostic assessments with levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service

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

Name of Program	Description/Definition	Coding
	for mental health services.	▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee ▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee

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

Name of Program	Description/Definition	Coding
		▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (1) Psychotherapy provided by a mental health professional; (2) Crisis assistance provided according to standards for children's therapeutic services and supports; (3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee; (4) Clinical care consultation provided by a mental health professional or a clinical trainee; and (5) Service delivery payment requirements as provided under subdivision 4.	Codes: ▪ S5145 – Foster care, therapeutic, child; per diem ▪ HE – Mental health program Bill only one per diem code per day regardless of the number of services or who provides services.
Mental Health Family Psycho-	• Family psycho-education services provided to a child up to age 21 with a diagnosed	Codes: ▪ H2027 - Individual ▪ H2027 HQ - Group (peer group)

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

Name of Program	Description/Definition	Coding
education Services Back to list of behavioral health programs	mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5 9505.0371, subpart 5, item C • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o understanding a child's symptoms of mental illness; o the impact on the child's development; o needed components of treatment; and o skill development.	▪ H2027 HR - Family with client present ▪ H2027 HS - Family without client present ▪ H2027 HQ HR - Multiple different families with clients present ▪ H2027 HQ HS - Multiple different families without clients present ▪ H2027 HN - Individual, clinical trainee ▪ H2027 HQ HN - Group (peer group), clinical trainee ▪ H2027 HR HN - Family with client present, clinical trainee ▪ H2027 HS HN - Family without client present, clinical trainee ▪ H2027 HQ HR HN - Multiple different families with clients present, clinical trainee ▪ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee
Mental Health Clinical Care Consultation Back to list of behavioral health programs	• MH clinical care consultation services provided to patients up to age 21 and provided by mental health professional or clinical trainee to other providers or educators not under their supervision. • Services may take place in, but are not limited to, school, community, office or clinic	Codes: ▪ 90899-U8 (5-10 minutes) ▪ 90899-U9 (11-20 minutes) ▪ 90899-UB (21-30 minutes) ▪ 90899-UC (31+ minutes) Additional modifiers could be appended, such as U4 for phone and/or HN for clinical trainee.
Certified Family Peer Specialist – DHS Back to list of behavioral health programs	• Services are for children under the following codes with the HA modifier. • For mental health services only; do not apply to substance abuse.	Codes: • H0038 Certified peer specialist services, per 15 minutes • H0038 U5 Advanced level certified peer specialist services, per 15 minutes • H0038 HQ Group setting, certified peer specialist services, per 15 minutes • H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes

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

Name of Program	Description/Definition	Coding
		• H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes

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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

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

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

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

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

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Table A.5.3.a -- Substance Abuse Services: Hospital
(Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)

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

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

A.5.3.b – Substance Abuse Services: <u>All Other Residential</u>

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
Room and Board	Day	<u>1002</u>: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) <u>1003</u>: (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
Detox	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
Treatment program, treatment component	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
Treatment program, treatment component	Hour	0953	None	837I	086x – special facility, residential
Ancillary services	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

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

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

Claim Type – 837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs **Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.**	Day	0944	H0047 U9	089x or 013x
MAT Therapy Tracking (See Note 2 below)	Day	0944	4306F	089x or 013x
Alcohol and/or drug assessment	Session /visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

Note 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing:

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

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

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

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
MAT Therapy Tracking (see Note 2 below)	Day	N/A	4306F	N/A
Note 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing: • 4306F – Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction.				
Alcohol and/or drug assessment	Session/visit	N/A	H0001	

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

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

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and miscellaneous

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Table A.5.4.a -- Public health nurse clinic services

Maternal And Child Health Billing Guide For Public Health Agencies

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Services Include: • Health Promotion & Counseling • Nursing Assessment & Diagnostic Testing • Medication Management • Nursing Treatment • Nursing Care, in the home, by RN (PHN & CPHN)	S9123	T1015
Home health aide or CNA, per visit	T1021	Individual S9445 Group S9446
Patient Education only - if no other services (includes car seat education)	Individual S9445 Group S9446	Individual S9445 Group S9446

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

Maternal And Child Health Billing Guide For Public Health Agencies

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

Table A.5.4.c – OTHER SERVICES and MISCELLANEOUS

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Table A.5.4.c -- Other services

Maternal And Child Health Billing Guide For Public Health Agencies

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **re-assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

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Table A.5.4.c -- Miscellaneous

Maternal And Child Health Billing Guide For Public Health Agencies

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Maternal Depression Screening	99420 UC	99420 UC
Child Developmental Screening	96110	96110
Autism Screening	96110 U1	96110 U1
Child Social/Emotional or Mental Health Screening	96127	96127
TB Case Management	T1016	T1016
TB Direct Observation Therapy	H0033	H0033

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B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

K3*LUMN~

Tooth Number/Oral Cavity

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

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

Report at 2400 Loop only.

K3*JP12~

K3*JP12 14~

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

Report at 2400 Loop only.

K3*JO10~

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

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

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C. Appendix C: Reporting MNCare Tax

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

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Minnesota Department of Health

Minnesota Department of Health (MDH) ~~Proposed~~ Rule

Title:	~~Proposed~~Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X223A2 Health Care Claim: Institutional (837) Version ~~1011~~12.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	~~This document was adopted into rule June 1.2015.~~ [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X223A2 Health Care Claim: Institutional (837), hereinafter referred to as 005010X223A2, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version ~~10~~11.0 (~~v10~~v11.0) of the Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X223A2 Health Care Claim: Institutional (837). It was announced as ~~an adopted~~a proposed rule for public comment in the Minnesota State Register, Volume ~~39~~40, Number ~~48~~28, ~~June 1~~January 11, 201~~5~~6 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version ~~8~~10.0 was the last version of this document to be adopted into rule ~~prior to this v.10.0~~and remains in force until superseded by a subsequently adopted version. This document is available at no charge on MDH's "Health Care Administrative Simplification" webpage ~~"Minnesota Statutes, section 62J.536 Rules" webpage~~ (http://www.health.state.mn.us/asa/~~rules.html~~).

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1. Overview

1.1. Statutory basis for this rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.1. Exceptions to applicability

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

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

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

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-3830

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

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

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

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

Field Code Changed

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.~~ or revision date, and brief summary of changes from one version to the next of this document are provided section 1.6.1 below.

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. V8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v8.0.
10.0	June 1, 2015	Adopted into rule June 1, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.
11.0	January 11, 2015	Proposed changes to v10.0
12.0	TBD	Adopted into rule TBD. Version 12.0 incorporates changes

Version	Revision Date	Summary Changes
		proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.

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

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

Note: Use of this document does not mean that a claim will be paid and does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

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

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

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

Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

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

Note regarding claims attachments for only workers compensation medical claims: Minnesota Statutes, Section 176.135 subd. 7a. (e) require that starting July 1, 2016

- *"Health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")"*; and
- *"Workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction."*

A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: https://www.revisor.mn.gov/statutes/?id=176.135.

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

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

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Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element ~~(if applicable)~~	Value Definition and Notes
2010CA PATIENT NAME	DMG Patient Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient.
2300 CLAIM INFORMATION	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definition.
2300 CLAIM INFORMATION	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	PWK02 Attachment Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300 CLAIM INFORMATION	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300 CLAIM INFORMATION	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	NTE Billing Note	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage

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Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2320 OTHER SUBSCRIBER INFORMATION	SBR Other Subscriber Information	N/A	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2330B OTHER PAYER NAME	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV202-7 Description	See front matter section 3.2.5 of this document for additional instructions.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV204 Unit or Basis for Measurement Code	See Appendix A for coding measurements.

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Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element ~~(if applicable)~~	Value Definition and Notes
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV205 Quantity	Zero "0" is an acceptable value only if defined as appropriate pursuant to NUBC rules.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV207 Monetary Amount	This amount cannot exceed the service line charge amount.
2400 SERVICE LINE NUMBER	DTP Date – Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400 SERVICE LINE NUMBER	AMT Facility Tax Amount	N/A	See Appendix B for details on reporting MNCare.

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5. List of Appendices

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

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

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

B. Appendix B: K3 Segment Usage Instructions

Appendix B provides guidance for K3 SEGMENT USAGE INSTRUCTIONS

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

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

- "initial."

- Follow all related AMA guidelines in CPT[3] (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow ~~general rounding rules for reporting more than the code's time value~~HCPCS/CPT for determining rounding time. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- ~~Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.~~Follow HCPCS/CPT for determining rounding time. (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for PT/OT/ST.)
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

[3] Current Procedural Terminology (CPT®), copyright 20124 American Medical Association
[4] Current Procedural Terminology (CPT®), copyright 20124 American Medical Association

Medicare Claims Processing Manual.

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

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

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

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter- (Left blank if no specific topic)	
1	General Billing Requirements		Follow Medicare coding guidelines
2	Admission and Registration Requirements		Not applicable to coding guidelines
3	Inpatient Hospital Billing		Follow Medicare coding guidelines
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Observation	Any HCPCS Level I or II code can be submitted as appropriate for observation with revenue code 0762
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Partial Hospitalization	To report partial hospitalization, use revenue codes 0912 or 0913 and procedure code H0035. For child/adolescent program use H0035 with HA modifier
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Bilateral Radiology	Bilateral radiology services are reported as either: ▪ one line with a 50 modifier and one unit, **or** ▪ two separate lines, one with RT modifier and one with LT modifier.
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Outpatient Professional Services in Method II Critical Access Hospitals	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Interpreter Services	For interpreter services: ▪ Use Revenue code 0949 and appropriate HCPCS code(s) as follows.

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter- (Left blank if no specific topic)	
			Note: Rounding rules apply to all services below (See front matter section A.3.4.2). A minimum of eight minutes must be spent in order to report a unit. ▪ T1013 -- Face-to-face oral language interpreter services per 15 minutes ▪ T1013- U3 -- Face-to-face sign language interpreter services per 15 minutes ▪ T1013- GT -- Telemedicine interpreter services per 15 minutes ▪ T1013- U4 -- Telephone interpreter services per 15 minutes ▪ T1013- UN~~,~~ UP~~,~~ UQ~~,~~ UR~~,~~ US -- Interpreter services provided to multiple patients in a group setting ▪ Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient ▪ T1013- 52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provide, report each on a separate line appended with the -59 modifier o T1013- 52 x 2 units (30 minutes of drive time) o T1013- 5259 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line.

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter- (Left blank if no specific topic)	
			o Reporting drive time versus mileage is based on individual contract. T1013- 52 may not be used for drive time if mileage is reported (see 99199) ~~is reported~~. o A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation ▪ 99199 -- Mileage for interpreter service o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013- 52) is reported o Report one unit per mile
5	Part B Outpatient Rehabilitation and CORF/OPT Services		~~Do not follow Medicare's rounding rules for physical, occupational and speech therapies (See front matter section A.3.4.2). See general rules for reporting units at the front of this appendix.~~ Follow HCPCS/CPT rounding guidelines.
6	Inpatient Part A Billing and SNF Consolidated Billing	Room and Board	Room and Board is reported according to the level of nursing care provided using revenue codes 019X

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

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

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

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

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

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

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter- (Left blank if no specific topic)	
	Services	Screening	Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
18	Preventive and Screening Services	Colonoscopy	Coding of diagnosis for colonoscopy claims should follow the ICD-~~9~~CM code set instructions based on date of service for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.
18	Preventive and Screening Services	Vaccine Administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
18	Preventive and Screening Services	Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, group purchasers require the SL modifier be appended to the vaccine code

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~Assertive Community Treatment (ACT)~~

~~Adult Crisis Response Services~~

~~Children's Mental Health Crisis Response Services~~

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Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

~~Children's Therapeutic Services and Supports (CTSS)~~

~~Adult Rehabilitative Mental Health Services (ARMHS)~~

~~Peer Services~~

Mental Health Diagnostic Assessment

~~Dialectical Behavior Therapy~~

~~Youth Assertive Community Treatment~~

~~Intensive Treatment in Foster Care~~

~~Mental Health Family Psychoeducation Services~~

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

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

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

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

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

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

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

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

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

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

Name of Program	Description/Definition	Coding
		therapy incorporating biofeedback by any modality, with psychotherapy , 30 minutes, CTSS • 90876 UA Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 45 minutes, CTSS • H2014 UA - Skills training & development, individual, per 15 minutes, CTSS • H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS • H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS • H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS • H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS • H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS • H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS *(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: • H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes • H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes

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

Name of Program	Description/Definition	Coding
		• H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes • H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner • H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker • 90882 - Environmental/community intervention, mental health professional or practitioner • 90882 HM - Environmental/community intervention, mental health rehabilitation worker • 90882 UD - Environmental/community intervention; transition to community living intervention • 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker • H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
Peer Services Back to list of behavioral health programs	Non-clinical support counseling services provided by certified peer specialist.	Codes: • H0038 - Certified peer specialist services, per 15 minutes • H0038 U5 - Advanced level certified peer specialist services, per 15 minutes
Mental Health Diagnostic Assessment Back to list of behavioral health	A diagnostic assessment is a written report that documents the clinical and functional face-to-face evaluation of a recipient's mental health and is necessary to	Codes: In order to report diagnostic assessments with levels of complexity, report as follows:

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

Name of Program	Description/Definition	Coding
programs	determine a recipient's eligibility for mental health services.	▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
~~**Dialectical Behavior Therapy**~~ ~~Back to list of behavioral health programs~~	~~Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.~~	~~Codes:~~ ~~▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT~~ ~~▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee~~ ~~▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent~~ ~~▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee~~ ~~▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group~~

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

Name of Program	Description/Definition	Coding
		▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (1) Psychotherapy provided by a mental health professional; (2) Crisis assistance provided according to standards for children's therapeutic services and supports; (3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee; (4) Clinical care consultation provided by a mental health professional or a clinical trainee; and (5)(1) Service delivery payment requirements as provided	Codes: ▪ S5145 – Foster care, therapeutic, child, per diem ▪ HE – Mental health program Bill only one per diem code per day regardless of the number of services or who provides services.

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

Name of Program	Description/Definition	Coding
	under subdivision 4.	
Mental Health Family Psycho-education Services Back to list of behavioral health programs	• Family psycho-education services provided to a child up to age 21 with a diagnosed mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5-9505.0371, subpart 5, item C. • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o understanding a child's symptoms of mental illness; o the impact on the child's development; o needed components of treatment; and o skill development.	Codes: • H2027 - Individual • H2027 HQ - Group (peer group) • H2027 HR - Family with client present • H2027 HS - Family without client present • H2027 HQ HR - Multiple different families with clients present • H2027 HQ HS - Multiple different families without clients present • H2027 HN - Individual, clinical trainee • H2027 HQ HN - Group (peer group), clinical trainee • H2027 HR HN - Family with client present, clinical trainee • H2027 HS HN - Family without client present, clinical trainee • H2027 HQ HR HN - Multiple different families with clients present, clinical trainee ▪ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee

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A.5.3 Substance Abuse Services

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

a) Hospitals;
b) All other residential; and
c) Outpatient Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claim Type – 837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.	Day	0944	H0047 U9	089x or 013x
MAT Therapy Tracking (See Note 2 below)	~~Day~~	~~0944~~	~~4306F~~	~~089x or 013x~~
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

NOTE 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.

Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing:

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

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

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

Claim Type – 837P

Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
MAT Therapy Tracking (see Note 2 below)	~~Day~~	~~N/A~~	~~4306F~~	~~N/A~~
NOTE 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week- U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing: • 4306F – Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction.				N/A
Alcohol and/or drug assessment	Session/visit	N/A	H0001	N/A

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B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

K3*LUMN~

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C. Appendix C: Reporting MNCare Tax

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

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

MDH Minnesota Department *of* Health

DRAFT

Minnesota Department of Health (MDH) Rule

Title:	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X223A2 Health Care Claim: Institutional (837) Version 12.0**
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:	[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X223A2 Health Care Claim: Institutional (837), hereinafter referred to as 005010X223A2, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 11.0 (v11.0) of the Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X223A2 Health Care Claim: Institutional (837). It was announced as a proposed rule for public comment in the Minnesota State Register, Volume 40, Number 28, January 11, 2016 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version 10.0 was the last version of this document to be adopted into rule and remains in force until superseded by a subsequently adopted version. This document is available at no charge on MDH's "Health Care Administrative Simplification" webpage (http://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 rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.1. Exceptions to applicability

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

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

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

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-3830

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

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

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

Please visit the AUC best practice webpage at http://www.health.state.mn.us/auc/bp.htm 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 or revision date, and brief summary of changes from one version to the next of this document are provided section 1.6.1 below.

1.6.1. Process for updating this document

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

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v6.0
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. V8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v8.0.
10.0	June 1, 2015	Adopted into rule June 1, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.
11.0	January 11, 2015	Proposed changes to v10.0
12.0	TBD	Adopted into rule TBD. Version 12.0 incorporates changes proposed in v11.0 and additional changes. Version 12.0

Version	Revision Date	Summary Changes
		supersedes all previous versions.

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

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

  Note: Use of this document does not mean that a claim will be paid and does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

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

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

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

Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

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

Note regarding claims attachments for only workers compensation medical claims: Minnesota Statutes, Section 176.135 subd. 7a. (e) require that starting July 1, 2016

- "*Health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")*"; and
- *"Workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction."*

A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: https://www.revisor.mn.gov/statutes/?id=176.135.

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

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

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2010CA PATIENT NAME	DMG Patient Demographic Information	DMG02 Date Time Period	Services to unborn children should be billed under the mother as the patient.
2300 CLAIM INFORMATION	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definition.
2300 CLAIM INFORMATION	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	PWK Claim Supplemental Information	PWK02 Attachment Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300 CLAIM INFORMATION	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300 CLAIM INFORMATION	NTE Claim Note	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	NTE Billing Note	N/A	See front matter section 3.2.5 of this document for definition.
2300 CLAIM INFORMATION	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2310D RENDERING PROVIDER NAME	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
2310E SERVICE FACILITY LOCATION NAME	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	N/A	See front matter section 3.2.2 of this document for usage
2310F REFERRING PROVIDER NAME	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical provider.
2320 OTHER SUBSCRIBER INFORMATION	SBR Other Subscriber Information	N/A	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2330B OTHER PAYER NAME	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV202-7 Description	See front matter section 3.2.5 of this document for additional instructions.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV204 Unit or Basis for Measurement Code	See Appendix A for coding measurements.

Table 4.2 005010X223A2 (837) Institutional Transaction Specific Information

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

Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV205 Quantity	Zero “0" is an acceptable value only if defined as appropriate pursuant to NUBC rules.
2400 SERVICE LINE NUMBER	SV2 Institutional Service Line	SV207 Monetary Amount	This amount cannot exceed the service line charge amount.
2400 SERVICE LINE NUMBER	DTP Date – Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400 SERVICE LINE NUMBER	AMT Facility Tax Amount	N/A	See Appendix B for details on reporting MNCare.

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5. List of Appendices

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

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

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

B. Appendix B: K3 Segment Usage Instructions

Appendix B provides guidance for K3 SEGMENT USAGE INSTRUCTIONS

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

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

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

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

- “initial.”

- Follow all related AMA guidelines in CPT[3] (e.g. “unit of service is the specimen” for pathology codes). Definition of “specimen”: "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow HCPCS/CPT for determining rounding time. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Follow HCPCS/CPT for determining rounding time. (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for PT/OT/ST.) Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

[3] Current Procedural Terminology (CPT®), copyright 2014 American Medical Association
[4] Current Procedural Terminology (CPT®), copyright 2014 American Medical Association

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

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

V11.0 MUCG for the ASX X12N/005010X223A2 Health Care Claim: Institutional (837) **Table A.5.1**

Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
1	General Billing Requirements		Follow Medicare coding guidelines
2	Admission and Registration Requirements		Not applicable to coding guidelines
3	Inpatient Hospital Billing		Follow Medicare coding guidelines
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Observation	Any HCPCS Level I or II code can be submitted as appropriate for observation with revenue code 0762
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Partial Hospitalization	To report partial hospitalization, use revenue codes 0912 or 0913 and procedure code H0035. For child/adolescent program use H0035 with HA modifier
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Bilateral Radiology	Bilateral radiology services are reported as either: ▪ one line with a 50 modifier and one unit, **or** ▪ two separate lines, one with RT modifier and one with LT modifier.
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Outpatient Professional Services in Method II Critical Access Hospitals	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).
4	Part B Hospital (Including Inpatient Hospital Part B and OPPS)	Interpreter Services	For interpreter services: ▪ Use Revenue code 0949 and appropriate HCPCS code(s) as follows.

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			Note: Rounding rules apply to all services below (See front matter section A.3.4.2). A minimum of eight minutes must be spent in order to report a unit. ▪ T1013 -- Face-to-face oral language interpreter services per 15 minutes ▪ T1013 U3 -- Face-to-face sign language interpreter services per 15 minutes ▪ T1013 GT -- Telemedicine interpreter services per 15 minutes ▪ T1013 U4 -- Telephone interpreter services per 15 minutes ▪ T1013 UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting ▪ Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient ▪ T1013 52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provide, report each on a separate line appended with the -59 modifier o T1013 52 x 2 units (30 minutes of drive time) o T1013 5259 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line.

Table A.5.1

Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			○ Reporting drive time versus mileage is based on individual contract. T1013 52 may not be used for drive time if mileage is reported (see 99199). ○ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation ▪ 99199 -- Mileage for interpreter service ○ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013- 52) is reported ○ Report one unit per mile
5	Part B Outpatient Rehabilitation and CORF/OPT Services		Follow HCPCS/CPT rounding guidelines.
6	Inpatient Part A Billing and SNF Consolidated Billing	Room and Board	Room and Board is reported according to the level of nursing care provided using revenue codes 019X
6	Inpatient Part A Billing and SNF Consolidated Billing	Reporting private room and/or in lieu of day differentials	There are situations when skilled nursing and long term care facilities need to report private room and/or in lieu of day differentials separate from room and board charges. ▪ Private Room differential use 0229; 1 unit = 1 day ▪ In lieu of days differential use 0230; 1 unit = 1 hour
6	Inpatient Part A Billing and SNF Consolidated	Ancillaries	Ancillaries are reported separately as appropriate

V11.0 MUCG for the ASX X12N/005010X223A2 Health Care Claim: Institutional (837) **Table A.5.1**

Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
	Billing		
6	Inpatient Part A Billing and SNF Consolidated Billing	Long term care	Also applicable to Long Term Care
7	SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)		Follow Medicare coding guidelines
8	Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims		Follow Medicare coding guidelines
9	Rural Health Clinics/Federal Qualified Health Centers		Not applicable to the Institutional guide. Report on the claim type appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
10	Home Health Agency Billing	Home Health Services	Home Health Services are reported on the 837I using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P Revenue Codes 041X – 044X and 055x – 060x as appropriate

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
10	Home Health Agency Billing	Reporting continuous services beyond the encounter and multiple nurse encounters with the same date of service	For home care the industry standard defines "per diem" as all-inclusive services per patient encounter up to two hours. ▪ To report extended continuous services beyond the encounter use the fifteen minute code(s). ▪ To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.
10	Home Health Agency Billing	Approved HCPCS code set	Medicare's G codes are insufficient to describe the level of time codes that group purchasers require for proper case management. See Approved HCPCS Code Set below. Approved HCPCS code set: ▪ Skilled Nursing Encounter: o RN: T1030 o LPN:T1031 ▪ Home Health Aide Visit: T1021 ▪ Home Health Aide (Extended: T1004 ▪ PT Visit: S9131 o PT Asst. Visit: S9131 TF ▪ OT Visit: S9129 o OT Asst. Visit: S9129 TF ▪ RT Evaluation: S5180 ▪ RT Visit: S5181 ▪ Speech Visit: S9128 ▪ MSW Visit: S9127 ▪ RN: T1002 ▪ RN Complex: T1002 TG

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			▪ RN Shared 1:2 ratio T1002 TT ▪ LPN: T1003 ▪ LPN Complex: T1003 TG ▪ LPN Shared 1:2 ratio T1003 TT ▪ Postpartum home visit 99501 ▪ Newborn care home visit 99502
11	Processing Hospice Claims		Follow Medicare coding guidelines
12	Physicians/ Nonphysician Practitioners		Not applicable to Institutional claim
13	Radiology Services and Other Diagnostic Procedures	Bilateral Radiology	▪ Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
15	Ambulance		Follow Medicare coding guidelines
16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
18	Preventive and Screening Services	Colonoscopy	Coding of diagnosis for colonoscopy claims should follow the ICDCM code set instructions based on date of service for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.
18	Preventive and Screening Services	Vaccine Administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations
18	Preventive and Screening Services	Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, group purchasers require the SL modifier be appended to the vaccine code
18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. ▪ Do not report separate administration lines for each administered vaccine. For example,

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Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
			DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
19	Indian Health Services		Follow Medicare coding guidelines
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
21	Medicare Summary Notices		Not applicable to the Institutional guide
22	Remittance Advice		Not applicable to the Institutional guide
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to the Institutional guide

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Minnesota Coding Specifications: When to use codes different from Medicare

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to the Institutional guide
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to the Institutional guide
27	Contractor Instructions for CWF		Not applicable to the Institutional guide
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to the Institutional guide
29	Appeals of Claims Decisions		Not applicable to the Institutional guide
30	Financial Liability Protections		Not applicable to the Institutional guide
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to the Institutional guide
32	Billing Requirements for Special Services		Follow the code selection guidelines in the Appendix A front matter
33	Miscellaneous Hold Harmless Provisions		Not applicable to the Institutional guide

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

Medicare Claims Processing Manual			Minnesota Rule
Chapter Number	Title/Description	Specific coding topic within Manual chapter (Left blank if no specific topic)	
34	Reopening and Revision of Claim Determinations and Decisions		Not applicable to coding guidelines
35	Independent Diagnostic Testing Facility		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines

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

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

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

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

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

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

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

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

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Mental Health Diagnostic Assessment

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

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs		
Name of Program	**Description/Definition**	**Coding**
Mental Health Targeted Case Management (MH-TCM) Back to list of behavioral health programs	▪ Community support plan and functional assessment to help SPMI adults and SED children gain access to needed medical, social educational, vocational, financial services relative to mental health needs.	Codes: ▪ T2023 HE HA – Targeted case management; per month, mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years ▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older ▪ T2023 HE TF - Targeted case management intermediate level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental health program, face-to face contact between case manager and recipient 18 years or older ▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older ▪ T1017 HE – Targeted case management, per encounter (day), mental health program, adult, face-to-face contact between case manager and recipient age 18 or older, IHS/638 facilities and FQHCs ▪ T1017 HE HA – Targeted case management, per encounter (day), mental health program, child/adolescent program, face-to-face contact between case manager and recipient under 18 years, IHS/638 facilities and FQHCs
Children's Mental Health Residential Treatment Services Back to list of behavioral health	▪ 24-hour-a-day program under clinical supervision of a mental health professional, provided in a community setting.	PMAP/Commercial/County-based Purchasing (CBP): ▪ For room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items.

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs		
Name of Program	**Description/Definition**	**Coding**
programs		o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. Department of Human Services (DHS)/ Fee for Service: ▪ When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.
Intensive Residential Treatment Services (IRTS) Back to list of behavioral health programs	▪ Time-limited mental health services provided in a residential setting to recipients in need of more restrictive settings and at risk of significant functional deterioration. ▪ Develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.	PMAP/Commercial/County-based Purchasing (CBP): ▪ For room and board and/or treatment services, report on the 837I type of bill 86X, with the room and board and treatment services as separate line items. o Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X. Department of Human Services (DHS)/ Fee for Service: ▪ When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.
Adult Day Treatment Back to list of behavioral health programs	▪ A structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a recipient's mental health status, develop and improve independent living and socialization skills	Codes: ▪ H2012 - Behavioral health day treatment, per hour
Children's Day Treatment Back to list of behavioral health programs	▪ A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services provided by multidisciplinary team.	Codes: ▪ H2012 UA HK – Behavioral health day treatment, per hour, CTSS ▪ H2012 UA HK U6 – Behavioral health day treatment, per hour, CTSS interactive

TABLE A.5.2 -- Behavioral Health Procedure Code/Modifier Combinations: For Specific Benefit Packages Unique To Minnesota Government Programs		
Name of Program	**Description/Definition**	**Coding**
Mental Health Diagnostic Assessment Back to list of behavioral health programs	A diagnostic assessment is a written report that documents the clinical and functional face-to-face evaluation of a recipient's mental health and is necessary to determine a recipient's eligibility for mental health services.	Codes: In order to report diagnostic assessments with levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

c) Outpatient Services.

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

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

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

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

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

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

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

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

Table A.5.3.c.i – Substance Abuse Services: Outpatient Services – Claim Type 837I (Applicable to all providers and settings per applicable contract or established program standards)				
Claim Type – 837I				
Service Description	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.	Day	0944	H0047 U9	089x or 013x
MAT Therapy Tracking (See Note 2 below)	Day	0944	4306F	089x or 013x
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

NOTE 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.

Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing:

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

Table A.5.3.c.ii – Substance Abuse Services: Outpatient Services – Claim Type 837P (Applicable to all providers and settings per applicable contract or established program standards)				
Claim Type – 837P				
Service Descriptions	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
MAT Therapy Tracking (see Note 2 below)	Day	N/A	4306F	N/A
NOTE 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing: • 4306F – Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction.				N/A
Alcohol and/or drug assessment	Session/visit	N/A	H0001	N/A

B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

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C. Appendix C: Reporting MNCare Tax

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

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

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Minnesota Department of Health

DRAFT

Minnesota Department of Health (MDH) ~~Proposed~~ Rule

Title:	~~Proposed~~ Minnesota Uniform Companion Guide (MUCG) for the Implementation of the **ASC X12/005010X222A1 Health Care Claim: Professional (837) Version ~~1011~~12.0**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to /interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	~~This document was adopted into rule on June 1, 2015.~~ [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the data content and other transaction specific information to be used with the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536; • Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 Code of Federal Regulations (CFR) Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version ~~10~~11.0 (~~v10~~v11.0) of *the Minnesota Uniform Companion Guide (MUCG) for the* Implementation of the *ASC X12/005010X222A1 Health Care Claim: Professional (837)*. It was announced as ~~an adopted~~a proposed rule in the Minnesota State Register, Volume ~~39~~40, Number ~~48~~, ~~June 1, 2015~~28, January 11, 2016 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version ~~8~~10.0 was the last version of this document to be adopted into rule ~~prior to this v10~~and remains in force until superseded by a subsequently adopted version. This document is available at no charge at MDH's "~~Minnesota Statutes, section 62J.536 Rules~~Health Care Administrative Simplification" webpage (http://www.health.state.mn.us/asa/~~rules.html~~).

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Table of Contents

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1. Overview

1.1. Statutory basis for this rule

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

1.2. Applicability of state statute and related rules

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

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

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

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

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

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

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

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

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

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

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

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

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

1.2.1. Exceptions to applicability

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

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

accomplish the purpose of the transaction.

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

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

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

1.3. About the Minnesota Department of Health (MDH)

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

1.3.1. Contact for further information on this document

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

Phone: (651) 201-3570

Fax: (651) 201-5179

Email: health.ASAguides@state.mn.us

1.4. About the Minnesota Administrative Uniformity Committee

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

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

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

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

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1.6. Document Changes

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

1.6.1. Process for updating this document

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

1.6.2. Document revision history

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

Version	Revision Date	Summary Changes
11.0	January 11, 2016	Proposed revisions to v10.0
12.0	TBD	Adopted into rule TBD. Version 12 incorporates changes proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.

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

2.1. Reference for this document

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

2.1.1. Permission to use copyrighted information

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

2.2. Purpose and relationship

This document:

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

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

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following three appendices:

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

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

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

3.2.1. Business Terminology

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

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

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

- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

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

3.2.2. Provider Identifiers and NPI Assignments

Provider Identifiers

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

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

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action

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

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

3.2.3.2. Definitions

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

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

- Examples of appeals include:

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

3.2.3.3. Process for submission

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

3.2.4. Claim Frequency Type Code (CFTC) Values

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

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

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

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

3.2.5. Claim Attachments and Notes

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

Note regarding claims attachments for only workers compensation medical claims:
Minnesota Statutes, Section 176.135 subd. 7a. (e) require that starting July 1, 2016

- "*Health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")*"; and
- *"Workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction."*

A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: https://www.revisor.mn.gov/statutes/?id=176.135.

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

4.1. Introduction to Table

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

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

Please also see section 2.2 above.

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

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

Table 4.2 005010X22A1 Professional (837)
Transaction Specific Information

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

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
	Provider Name	Referring Provider Secondary Identification	Reference Identification Qualifier	

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5. List of Appendices

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

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

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

Table A.5.4 -- Maternal and Child Health Billing Guide ~~F~~for Public Health Agencies

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

B. Appendix B: K3 Segment Usage Instructions

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

C. Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction and Overview

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

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

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

NOTE-- As further described in the sections below:

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

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

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

A.2 HIPAA Code Sets

Code sets have been adopted under federal HIPAA rules (45 CFR § 162 Subpart J), including: Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS); International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); and Revenue codes.[2]

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

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

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

A.3 Code Selection and Use

A.3.1 General Rules

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

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

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

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

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

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

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

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

different from Medicare resulted because:

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

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

A.3.4 Additional Coding Specifications

A.3.4.1. Modifiers

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

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

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

A.3.4.2. Units (basis for measurement)

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

The following are clarifications/exceptions:

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

- Follow all related AMA guidelines in CPT[3] (e.g. “unit of service is the specimen” for pathology codes). Definition of “specimen”: "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."[4]
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow ~~general~~ HCPCS/CPT for determining rounding ~~rules~~time. ~~for reporting more than the code's time value~~. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- ~~Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.~~ Follow HCPCS/CPT for determining rounding time. (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for PT/OT/ST.)
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

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

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

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

A.5 Tables of Coding Requirements

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

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

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

[3] Current Procedural Terminology (CPT®), copyright 201~~3~~4 American Medical Association

[4] Current Procedural Terminology (CPT®), copyright 201~~3~~4 American Medical Association

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

- ASC X12/005010X222A1 Health Care Claim: Professional (837), referred to in Table A.5.1 as “professional claim type” or “837P” or “Professional claim;”
- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to in Table A.5.1 as “institutional claim type” or “837I” or “Institutional claim;”
- ASC X12/005010X224A2 Health Care Claim: Dental (837), referred to in Table A.5.1 as “837D.”

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

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

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

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

	12	Physicians/Nonphysician Practitioners	Interpreter services	To report interpreter services: Note: Rounding rules (see front matter section A.3.4.2) apply to all services below. A minimum of eight minutes must be spent in order to report one unit. • T1013 -- Face-to-face oral language interpreter services per 15 minutes • T1013 U3 -- Face-to-face sign language interpreter services per 15 minutes • T1013 GT -- Telemedicine interpreter services per 15 minutes • T1013 U4 -- Telephone interpreter services per 15 minutes • T1013 UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting • Report T1013 for each patient in the group setting o Append the modifier indicating how many patients in the group o Report one unit per 15 minutes per patient • T1013 52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes o Report one unit per 15 minutes per client o If more than one service is provided, report each on a separate line appended with the -59 modifier ▪ T1013 52 x 2 units (30 minutes of drive time) ▪ T1013 52 59 (12 minutes of wait time) o Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line. o Reporting drive time versus mileage is based on individual contract. T1013 52 may not be used for drive time if mileage is reported (see 99199) ~~is reported~~

			○ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation • 99199 -- Mileage for interpreter service ○ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013 52) is reported ○ Report one unit per mile
12	Physicians/Nonphysician Practitioners	Collaborative psychiatric consultation (MN Statutes 256b.0625, subd. 48 – Psychiatric consultation to primary care practitioners)	Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an opinion or advice regarding a patient should be reported using 99499 as follows: • Primary Care – 99499 HE AG • Primary Care – 99499 HE AG U4 (non-face-to-face) • Primary Care - 99499 HE AG U7 (by physician extender) • Primary Care - 99499 HE AG U4 U7 (non-face-to-face by physician extender) • Consulting Psychiatrist – 99499 HE AM • Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face) • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM • Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face) • Consulting psychologist – 99499 HE AM • Consulting psychologist – 99499 HE AM U4 (non-face-to-face)
12	Physicians/Nonphysician Practitioners	Patient not in exam room	There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient's condition. When a discussion between clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the

<table>
<tr><td></td><td></td><td></td><td>appropriate CPT code for evaluation and management services may be billed based on time to the patient's group purchaser. Report the appropriate ICD-~~9~~-CM code(s), based on date of service, for the diagnosis of the patient as the primary diagnosis or diagnoses. ~~Also ICD-9-CM code V65.19 Other person consulting on behalf of another person must be reported.~~</td></tr>
<tr><td>12</td><td>Physicians/Nonphysician Practitioners</td><td>Health Care Homes</td><td>The following instructions are for reporting health care home with patient complexity level and supplemental factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below:

Patient Complexity Level and Supplemental Factors
<table>
<tr><th>Patient Complexity Level</th><th>Complex-ity Modifiers</th><th>Non English Speak-ing Modifier</th><th>Active Mental Health Con-dition</th></tr>
<tr><td>Low (no major conditions)</td><td>No modifier</td><td>U3</td><td>U4</td></tr>
<tr><td>Basic</td><td>U1</td><td>U3</td><td>U4</td></tr>
<tr><td>Inter-mediate</td><td>TF</td><td>U3</td><td>U4</td></tr>
<tr><td>Extended</td><td>U2</td><td>U3</td><td>U4</td></tr>
<tr><td>Complex (most major conditions)</td><td>TG</td><td>U3</td><td>U4</td></tr>
</table>

Definitions of U modifiers with S0280 or S0281:
o U1 – Care coordination, basic complexity level
o U2 – Care coordination, extended complexity level
o U3 – Care coordination, supplemental factor; Non-English language
o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition</td></tr>
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	12	Physicians/Nonphysician Practitioners	ImPACT testing	96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only
	12	Physicians/Nonphysician Practitioners	In-reach Community Based Coordination	Use HCPCS T1016 U2 or T1016 U2 TS. ▪ T1016 Case management, each 15 minutes ▪ U2 = In-reach, initial service ▪ U2 TS = In-reach, follow-up
	13	Radiology Services and Other Diagnostic Procedures	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components
	13	Radiology Services and Other Diagnostic Procedures	Bilateral radiology	Bilateral radiology services are reported as either: o one line with a 50 modifier and one unit, or o two separate lines, one with RT modifier and one with LT modifier.
	14	Ambulatory Surgical Centers	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.
	14	Ambulatory Surgical Centers	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
	14	Ambulatory Surgical Centers	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
	15	Ambulance	General	Follow Medicare coding guidelines
	15	Ambulance	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: ▪ A0080 ▪ A0090 ▪ A0100 ▪ A0110

			▪ A0120 ▪ T2002 ▪ T2003 ▪ T2004
15	Ambulance	Community Paramedic	Community paramedic services are to be billed as follows: • Professional claims only – 837P • Place of services – 12 (home) • Individual provider number – report the Medical director's NPI • Code T1016 U3, 15 minutes increments (one billing, services all inclusive) — a minimum of 8 minutes of face to face time must be rendered in order to report one unit (see also section A.3.4.2 for units rounding rules) o T1016 Case management, each 15 minutes o U3 – service provided by certified community paramedic (EMT-CP) • Non-reportable services include: o ~~Incidental s~~Supplies (e.g., gloves, test strips, band aids, etc.); o Vaccines o Travel; o Mileage; o Medical record documentation. ~~Supplies and vaccines are reported by the ordering primary care physician only.~~
16	Laboratory Services	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.

16	Laboratory Services	Newborn Screening	When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card. For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.
17	Drugs and Biologicals		Follow Medicare coding guidelines
18	Preventive and Screening Services	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. "Welcome to Medicare") are only applicable to Medicare and Medicare replacement products.
18	Preventive and Screening Services	New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.
18	Preventive and Screening Services	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-~~9~~ CM, , code set instructions based on date of service. All applicable diagnoses should be submitted.
18	Preventive and Screening Services	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers
18	Preventive and Screening Services	Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations

18	Preventive and Screening Services	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code
18	Preventive and Screening Services	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.
~~**18**~~	~~Preventive and Screening Services~~	~~C&TC~~	~~S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed.~~ ~~▪ Maternal depression screening: 99420 UC~~ ~~▪ Developmental screening: 96110~~ ~~▪ Child Mental Health Screening: 96127.~~ ~~▪ Report CPT codes 99401-99404 if patient comes for counseling only. Preventive counseling is included in the preventive medicine evaluation and management service and should not be reported separately.~~ ~~▪ Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to:~~ ~~o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or~~

			~~$0.01 charge~~ ~~o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge~~ ~~o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier -52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible.~~ ~~▪ Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed.~~ ▪ ~~Use most appropriate diagnosis code based on patient age.~~
19	Indian Health Services	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit
20	Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.

21	Medicare Summary Notices		Not applicable to coding guidelines
22	Remittance Advice		Not applicable to coding guidelines
23	Fee Schedule Administration and Coding Requirements		Follow the code selection guidelines in the Appendix A front matter
24	General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims		Not applicable to coding guidelines
25	Completing and Processing the Form CMS-1450 Data Set		Not applicable to coding guidelines
26	Completing and Processing Form CMS-1500 Data Set		Not applicable to coding guidelines
27	Contractor Instructions for CWF		Not applicable to coding guidelines
28	Coordination with Medigap, Medicaid, and other Complementary Insurers		Not applicable to coding guidelines
29	Appeals of Claims Decisions		Not applicable to coding guidelines
30	Financial Liability Protections		Not applicable to coding guidelines
31	ANSI X12N Formats Other than Claims or Remittance		Not applicable to coding guidelines
32	Billing Requirements for Special Services		Follow the code selection guidelines in the front matter of Appendix A
33	Miscellaneous Hold Harmless Provisions		Not applicable to coding guidelines
34	Reopening and Revision of Claim Determinations		Not applicable to coding guidelines

	and Decisions		
35	Independent Diagnostic Testing Facility (IDTF)		Not applicable to coding guidelines
36	Competitive Bidding		Not applicable to coding guidelines
37	Department of Veteran Affairs (VA) Claims Adjudication Services Project		Not applicable to coding guidelines
38	Emergency Preparedness Fee for Service Guidelines		Not applicable to coding guidelines
See the following regarding ~~"Doula Services", "Home Infusion Therapy" and "Licensed Traditional Midwife Services (Not Certified Nurse Midwives)"~~ services that are not addressed in any chapter of the Medicare Claims Processing Manual: Doula Services; Home Infusion Therapy; Licensed Traditional Midwife Services (Not Certified Nurse Midwives); ~~-~~Child and Teen Checkups (C&TC); and Early Intensive Developmental and Behavioral Intervention (EIDBI).			
N/A	N/A	Doula Services MS 256B.0625, Subd. 28B Doula Services	Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to ~~six~~ seven sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the ~~six~~seven. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner's NPI. Coding and billing for these services on the 837P are as follows: ▪ S9445 U4 – ante-partum and post – partum Doula services ▪ 99199 U4 – Doula attendance at labor and delivery
N/A	N/A	Home Infusion	Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes).

			Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner's scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported. <u>Place of Service:</u> 25 – Free-standing Birthing Center <u>HCPCS Code:</u> Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, free-standing birthing center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits. Fragmented services may be reported in certain circumstances: • If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes). • If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. • Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service). • Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal

			period. Urine dip sticks are considered part of the global package. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.
	N/A	N/A	Child and Teen Checkups (C&TC)	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. Refer to DHS for the C&TC Provider Guide Webpage for a complete list of reportable component codes. • 96110 – Developmental Screening • 96110 U1 – Autism Screening • 96127 – Social/Emotional or Mental Health Screening • Visit can still be reported as a complete C&TC if documentation shows that a component could not be completed due to: o Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with $0.00 or $0.01 charge o Parent Refusal: Service may still be reported with $0.00 or $0.01 charge o Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible. Report all C&TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed. • Use most appropriate diagnosis code based on patient age.

N/A	N/A	**Family Caregiver Services**	Family Caregiver Services provide training, education, coaching and counseling services for family and informal caregivers who provide direct and ongoing services for recipients in the Elderly Waiver (EW) and Alternative Care (AC) Programs. • S5115 - Home care training, nonfamily; per 15 minutes, Family Caregiver Training & Education • S5115 TF - Home Care training, nonfamily; per 15 minutes, Family Counseling with Assessment • S5115 TG - Home care training, nonfamily; per 15 minutes, Complex/high level of care, Family Memory Care

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

Note: This Early Intensive Development and Behavioral Intervention (EIDBI) table is part of ***Table A.5.1 Minnesota Coding Specifications: When to use code different from Medicare***. EIDBI is not applicable to any chapter or topic in the Medicare Claims Processing Manual. Due to the number of services and coding entries for the EIDBI benefit, it has been removed from Table A.5.1 and formatted differently to provide clarity and for ease of use.

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Both Department of Human Services (DHS) fee-for-service and managed care will need to provide coverage of the EIDBI benefit effective July 1, 2015. There are seven EIDBI benefit services:

1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Development Behavioral Intervention (DBI)
2. EIDBI Observation and Direction
3. Comprehensive Multi-Disciplinary Evaluation (CMDE)
4. Individual Treatment Plan Development and Monitoring
5. Family Caregiver Training and Counseling
6. Coordinated Care Conference
7. Travel Time
8. 60-day Temporary Increase for ABA/DBI services

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

1. EIDBI Intervention – Applied Behavioral Analysis (ABA) or Developmental and Behavioral Intervention (DBI)

Selected Codes
0364T, 0365T, 0366T, 0367T, 0368T, 0369T

- HK – Qualified Supervising Professional [QSP]
- HM – Less than bachelor degree level III
- HN – Bachelor's degree level I or II
- HO – Masters /Mental Health Professional [MHP]
- HP – Doctorate /Mental Health Professional [MHP]
- UB – EIDBI [Early Intensive Developmental and Behavior Intervention]
- TF-60-day Temporary Increase for ABA/DBI services [ONLY APPLIES TO INTERVENTION]

~~HK – Qualified Supervising Professional [QSP]~~
~~HP – Doctorate /Mental Health Professional [MHP]~~
~~HO – Masters /Mental Health Professional [MHP]~~
~~HN – Bachelor's degree level I or II~~
~~HM – Less than bachelor degree level III~~
~~UB – EIDBI [Early Intensive Developmental and Behavior Intervention]~~

Coding Individual	Coding Group
0368T UB HK –Qualified Supervising Professional, first 30 minutes	0366T UB HK –Qualified Supervising Professional, first 30 minutes
0369T UB HK –Qualified Supervising Professional, each additional 30 minutes	0367T UB HK –Qualified Supervising Professional, each additional 30 min
0368T UB HP – Doctorate /Mental Health Professional [MHP], first 30 minutes	0366T UB HP – Doctorate /Mental Health Professional [MHP], first 30 minutes
0369T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 minutes	0367T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 min
0368T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes	0366T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes
0369T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes	0367T UB HO – Masters /Mental Health Professional [MHP], each additional 30 min
0368T UB HN – Bachelor's degree level I, first 30 minutes	0366T UB HN – Bachelor's degree level I or II, first 30 minutes
0369T UB HN – Bachelor's degree level I, each additional 30 minutes	0367T UB HN – Bachelor's degree level I or II, each additional 30 min
0364T UB HN – Bachelor's degree level II, first 30 minutes	0366T UB HM –Less than bachelor's degree level III, first 30 min
0365T UB HN –Bachelor's degree level II, each additional 30 minutes	0367T UB HM – Less than bachelor degree level III, each additional 30 min

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

0364T UB HM –Less than bachelor's degree-level III, first 30 min 0365T UB HM – Less than bachelor's degree level III, each additional 30 minutes	

2 EIDBI Observation and Direction

Selected Codes
0362T, 0363T

GT – via interactive audio and video telecommunications systems
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctoral level
HP – Doctorate /Mental Health Professional [MHP]
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

~~HP – Doctoral level~~
~~HK – Qualified Supervising Professional [QSP]~~
~~HN – Bachelor's degree level I or II~~
~~HO – Masters /Mental Health Professional [MHP]~~
~~HP – Doctorate /Mental Health Professional [MHP]~~
~~GT – via interactive audio and video telecommunications systems~~
~~UB – EIDBI [Early Intensive Developmental and Behavior Intervention]~~

Coding	Telemedicine
0362T UB HN – Bachelor's degree level I or II, first 30 minutes	0362T UB HN GT- Bachelor's degree level I or II (telemedicine), first 30 minutes
0363T UB HN – Bachelor's degree level I or II, each additional 30 minutes	0363T UB HN GT– Bachelor's degree level I or II (telemedicine), each additional 30 minutes
0362T UB HO – Masters /Mental Health Professional [MHP], first 30 minutes	0362T UB HO GT – Masters /Mental Health Professional [MHP] (telemedicine), first 30 minutes
0363T UB HO – Masters /Mental Health Professional [MHP], each additional 30 minutes	0363T UB HO GT – Masters /Mental Health Professional [MHP] (telemedicine) each additional 30 minutes
0362T UB HP – Doctorate /Mental Health Professional [MHP] first 30 minutes	0362T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine), first 30 minutes
0363T UB HP – Doctorate /Mental Health Professional [MHP], each additional 30 minutes	0363T UB HP GT – Doctorate /Mental Health Professional [MHP] (telemedicine), each additional 30 minutes
0362T UB HK – Qualified Supervising Professional , first 30 minutes	
0363T UB HK – Qualified Supervising Professional, each additional 30 minutes	

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

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

3. Comprehensive Multi-Disciplinary Evaluation (CMDE)

Selected Code
0359T
AM – Psychiatrist [MD]/Physician
GT– via interactive audio and video telecommunications systems
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
TG – Advanced Practice Registered Nurse (APRN)
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

~~AM – Psychiatrist [MD]/Physician~~
~~HO – Masters /Mental Health Professional [MHP]~~
~~HP – Doctorate /Mental Health Professional [MHP]~~
~~TG – Advanced Practice Registered Nurse (APRN)~~
~~GT – via interactive audio and video telecommunications systems~~
~~UB – EIDBI [Early Intensive Developmental and Behavior Intervention]~~

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

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

4 Individual Treatment Plan Development and Monitoring

Selected Codes
H0032 – Mental Health Service Plan Development by non-physician
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
UB EIDBI [Early Intensive Developmental and Behavior Intervention]
UD – 15 minute unit
~~UD – 15 minute unit~~
~~HK – Qualified Supervising Professional [QSP]~~
~~HN – Bachelor's degree level I or II~~
~~HO – Masters /Mental Health Professional [MHP]~~
~~HP – Doctorate /Mental Health Professional [MHP]~~
~~UB EIDBI [Early Intensive Developmental and Behavior Intervention]~~

Note:

This service is time based although H0032 by definition is not time based. The H0032 was approved for mental health service plan development with modifier UD to indicate a 15 minute time unit.

Coding
H0032 UB HK UD – Qualified Supervising Professional [QSP]
H0032 UB HP UD – Doctorate /Mental Health Professional [MHP]
H0032 UB HO UD – Masters /Mental Health Professional [MHP]
H0032 UB HN UD – Bachelor's degree level I or II

5 Family Caregiver Training and Counseling

Selected Codes
T1027
GT – via interactive audio and video telecommunications systems
HK – Qualified Supervising Professional [QSP]
HN – Bachelor's degree level I or level II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

~~HK – Qualified Supervising Professional [QSP]~~
~~HN – Bachelor's degree level I or level II~~
~~HO – Masters /Mental Health Professional [MHP]~~
~~HP – Doctorate /Mental Health Professional [MHP]~~
~~GT – via interactive audio and video telecommunications systems~~
~~UB – EIDBI [Early Intensive Developmental and Behavior Intervention]~~

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

Coding Individual	Coding Group
T1027 UB HK – Qualified Supervising Professional [QSP]	T1027 UB HK HQ – Qualified Supervising Professional [QSP], Group
T1027 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine)	T1027 UB HP HQ – Doctorate /Mental Health Prof [MHP], Group
T1027 UB HP – Doctorate /Mental Health Prof [MHP]	T1027 – UB HO HQ – Masters /Mental Health Prof [MHP], Group
T1027 UB HP GT – Doctorate /Mental Health Prof [MHP] (telemedicine)	T1027 UB HN HQ – Bachelor's degree level I or II, Group
T1027 UB HO – Masters /Mental Health Prof [MHP]	
T1027 UB HO GT – Masters /Mental Health Prof [MHP] (telemedicine)	
T1027 UB HN – Bachelor's degree level I or II	
T1027 UB HN GT – Bachelor's degree level I or II (telemedicine	

6 Coordinated Care Conference

Selected Codes Description
T1024
AM – Physician
GT – via interactive audio and video telecommunications systems
HK – Qualified Supervising Professional (QSP)
HN – Bachelor's degree level I or II
HO – Masters /Mental Health Professional [MHP]
HP – Doctorate /Mental Health Professional [MHP]
TG – Advanced Practice Registered Nurse (APRN)

UB – EIDBI [Early Intensive Developmental and Behavior Intervention
~~AM – Physician~~
~~HK – Qualified Supervising Professional (QSP)~~
~~HN – Bachelor's degree level I or II~~
~~HO – Masters /Mental Health Professional [MHP]~~
~~HP – Doctorate /Mental Health Professional [MHP]~~
~~GT – via interactive audio and video telecommunications systems~~
~~UB – EIDBI [Early Intensive Developmental and Behavior Intervention~~
~~TG – Advanced Practice Registered Nurse (APRN)~~

Coding	Telemedicine Coding
T1024 UB AM –Physician	T1024 UB AM GT –Physician (telemedicine)
T1024 UB TG - APRN	T1024 UB TG GT– APRN (telemedicine)
T1024 UB HK – Qualified Supervising Professional [QSP]	T1024 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine]
T1024 UB HP – Doctorate /Mental Health	T1024 UB HP GT –Doctorate /Mental Health

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

Professional [MHP] T1024 UB HO – Masters /Mental Health Professional[MHP] T1024 UB HN – Bachelor's degree level I or II	Professional [MHP] (telemedicine) T1024 UB HO GT – Masters /Mental Health Professional[MHP] (telemedicine) T1024 UB HN GT – Bachelor's degree level I or II (telemedicine)

7 Travel Time

Selected Codes
H0046
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Notes:

One unit equals one minute.
Travel time is billed on the same claim as the provided service.
The actual number of minutes spent in transit is billed (no rounding up).

Coding
H0046 UB

8 60-day temporary increase

Selected Codes
ABA or DBI Intervention codeS ONLY:
0364T UB H_ TF
0365T UB H_ TF
0366T UB H_ TF
0367T UB H_ TF
0368T UB H_ TF
0369T UB H_ TF

TF – 60 Day Temporary Increase for ABA/DBI services

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Table A.5.1.a Minnesota Coding Specifications for Early Intensive Development and Behavioral Intervention

TABLE

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Modifier	Description
UB	EIDBI
UB AM	EIDBI, Physician or Psychiatrist
UB AM GT	EIDBI, Physician or Psychiatrist, Telemedicine
UB HK	EIDBI, Qualified Supervising Professional [QSP]
UB HK GT	EIDBI, Qualified Supervising Professional [QSP],Telemedicine
UB HK UD	EIDBI, [Qualified Supervising Professional [QSP],PER 15 MINUTES
UB HM	EIDBI, Level III, Support Specialist, less than Bachelor's
UB HN	EIDBI, Bachelor's level I or II
UB HN GT	EIDBI, Bachelor's level I or II, Telemedicine
UB HN HQ	EIDBI, Bachelor's Degree Level I or II, Group
UB HN UD	EIDBI, Bachelor's level I or II, PER 15 MINUTES
UB HO	EIDBI, Masters /Mental Health Professional [MHP]
UB HO GT	EIDBI, Masters /Mental Health Professional [MHP], Telemedicine
UB HO HQ	EIDBI, Masters/Mental Health Professional, Group
UB HO UD	EIDBI, Masters /Mental Health Professional [MHP], PER 15 MINUTES
UB HP	EIDBI Doctorate /Mental Health Professional [MHP]
UB HP GT	EIDBI, Doctorate /Mental Health Professional [MHP],Telemedicine
UB HP HQ	EIDBI, Doctorate/Mental Health Professional, Group
UB HP UD	EIDBI, Doctorate /Mental Health Professional [MHP],PER 15 MINUTES
UB TG	EIDBI, APRN
UB TG GT	EIDBI, APRN, Telemedicine
Note: TF is only used on ABA or DBI Interventions as a third modifier; with prior approval	
UB H_ TF	60-day temporary increase for ABA/DBI services

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

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

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

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

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

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

Assertive Community Treatment (ACT)

Adult Crisis Response Services

Children's Mental Health Crisis Response Services

Mental Health Targeted Case Management (MH-TCM)

Children's Mental Health Residential Treatment Services

Intensive Residential Treatment Services (IRTS)

Adult Day Treatment

Children's Day Treatment

Children's Therapeutic Services and Supports (CTSS)

Adult Rehabilitative Mental Health Services (ARMHS)

~~Peer Services~~Certified Peer Specialist Services

Mental Health Certified Family Peer Specialist

Mental Health Diagnostic Assessment

Dialectical Behavior Therapy

Youth Assertive Community Treatment

Intensive Treatment in Foster Care

Mental Health Family Psychoeducation Services

Mental Health Clinical Care Consultation

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

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

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

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

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

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

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

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

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

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

Name of Program	Description/Definition	Coding
		CTSS ▪ H2014 UA - Skills training & development, individual, per 15 minutes, CTSS ▪ H2014 UA HQ - Skills training & development, group, per 15 minutes, CTSS ▪ H2014 UA HR - Skills training & development - family, per 15 minutes, CTSS ▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS ▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS ▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS ▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS *(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual) #(Use 90785-UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)
Adult Rehabilitative Mental Health Services (ARMHS) Back to list of behavioral health programs	Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.	Codes: ▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes ▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes ▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes ▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner

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

Name of Program	Description/Definition	Coding
		▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker ▪ 90882 - Environmental/community intervention, mental health professional or practitioner ▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker ▪ 90882 UD - Environmental/community intervention; transition to community living intervention ▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker ▪ 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] ▪ H0034 - Medication education, individual: MD, RN, PA or Pharmacist ▪ H0034 HQ - Medication education, group setting
Certified Peer Specialist Services Back to list of behavioral health programs	Non-clinical support counseling services for adults provided by certified peer specialist.	Codes: ▪ H0038 – Certified peer specialist services, per 15 minutes ▪ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes
Mental Health Diagnostic	A diagnostic assessment is a written report that documents the clinical and functional face-to-face	Codes: In order to report diagnostic assessments with

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

Name of Program	Description/Definition	Coding
Assessment Back to list of behavioral health programs	evaluation of a recipient's mental health and is necessary to determine a recipient's eligibility for mental health services.	levels of complexity, report as follows: ▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service ▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service
Dialectical Behavior Therapy Back to list of behavioral health programs	Dialectical behavior therapy (DBT) is a treatment approach provided in an intensive outpatient treatment program (IOP) using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT IOP program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.	Codes: ▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT ▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee ▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent ▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee

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

Name of Program	Description/Definition	Coding
		▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group ▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee ▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent ▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee
Youth Assertive Community Treatment Back to list of behavioral health programs	Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.	▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20
Intensive Treatment in Foster Care Back to list of behavioral health programs	Intensive treatment services to children with mental illness residing in foster family settings. (MS 256B.0946 Intensive Treatment in Foster Care) (1) Psychotherapy provided by a mental health professional; (2) Crisis assistance provided according to standards for children's therapeutic services and supports; (3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee; (4) Clinical care consultation provided by a mental health professional or a clinical trainee; and (5) Service delivery payment	Codes: ▪ S5145 – Foster care, therapeutic, child; per diem ▪ HE – Mental health program Bill only one per diem code per day regardless of the number of services or who provides services.

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

Name of Program	Description/Definition	Coding
	requirements as provided under subdivision 4.	
Mental Health Family Psycho-education Services Back to list of behavioral health programs	• Family psycho-education services provided to a child up to age 21 with a diagnosed mental health condition and provided by licensed mental health professional or a clinical trainee, as defined in Minnesota Rules, part 5 9505.0371, subpart 5, item C • Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in: o understanding a child's symptoms of mental illness; o the impact on the child's development; o needed components of treatment; and o skill development.	Codes: ▪ H2027 - Individual ▪ H2027 HQ - Group (peer group) ▪ H2027 HR - Family with client present ▪ H2027 HS - Family without client present ▪ H2027 HQ HR - Multiple different families with clients present ▪ H2027 HQ HS - Multiple different families without clients present ▪ H2027 HN - Individual, clinical trainee ▪ H2027 HQ HN - Group (peer group), clinical trainee ▪ H2027 HR HN - Family with client present, clinical trainee ▪ H2027 HS HN - Family without client present, clinical trainee ▪ H2027 HQ HR HN - Multiple different families with clients present, clinical trainee ▪ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee
Mental Health Clinical Care Consultation Back to list of behavioral health programs	• MH clinical care consultation services provided to patients up to age 21 and provided by mental health professional or clinical trainee to other providers or educators not under their supervision. • Services may take place in, but are not limited to, school, community, office or clinic	Codes: ▪ 90899-U8 (5-10 minutes) ▪ 90899-U9 (11-20 minutes) ▪ 90899-UB (21-30 minutes) ▪ 90899-UC (31+ minutes) Additional modifiers could be appended, such as U4 for phone and/or HN for clinical trainee.
Certified Family Peer Specialist – DHS	• Services are for children under the following codes with the HA modifier. • For mental health services	Codes: • H0038 Certified peer specialist services, per 15 minutes

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

Name of Program	Description/Definition	Coding
Back to list of behavioral health programs	only; do not apply to substance abuse.	• H0038 U5 Advanced level certified peer specialist services, per 15 minutes • H0038 HQ Group setting, certified peer specialist services, per 15 minutes • H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes • H0038 HA HQ Child/adolescent program, group setting, certified peer specialist services, per 15 minutes

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A.5.3 Substance Abuse Services

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

a) Hospitals;

b) All other residential; and

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

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

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

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

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

~~v10~~v11.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

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

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

inclusive: includes room and board and treatment.

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

v1~~1~~0.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

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

v1~~1~~0.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

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

Claim Type – 837I

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (*individual*)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs **Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.**	Day	0944	H0047 U9	089x or 013x
MAT Therapy Tracking (See Note 2 below)	~~Day~~	~~0944~~	~~4306F~~	~~089x or 013x~~
Alcohol and/or drug assessment	Session /visit	0900	H0001	As appropriate
Outpatient Ancillary Services	Based on revenue code	As appropriate		089x or 013x

Note 1: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.

Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing:

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

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

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

Claim Type – 837P				
Service Descriptions	**Unit**	**Revenue Code**	**HCPCS Procedure Code**	**Type of Bill**
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (*individual*)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
MAT Therapy Tracking (see Note 2 below)	Day	N/A	4306F	N/A
Note 1: -Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs Note 2: Append the following Category II code to the 837P or 837I claim as verification of services performed at the time of MAT dosing: • 4306F – Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction.				
Alcohol and/or drug assessment	Session/visit	N/A	H0001	

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

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

a) Public health nurse clinic services

b) Maternal & child health visits

c) Other services and miscellaneous

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

V1~~1~~0.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.4.a -- Public health nurse clinic services

Maternal And Child Health Billing Guide For Public Health Agencies

~~**Table A.5.4.a -- Public health nurse clinic services**~~

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Services Include: • Health Promotion & Counseling • Nursing Assessment & Diagnostic Testing • Medication Management • Nursing Treatment • Nursing Care, in the home, by RN (PHN & CPHN)	S9123	T1015
Home health aide or CNA, per visit	T1021	~~Individual S9445 Group S9446~~
Patient Education only - if no other services (includes car seat education)	**Individual S9445 Group S9446** ~~S9123~~	Individual S9445 Group S9446

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

~~v10~~v11.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

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

Maternal And Child Health Billing Guide For Public Health Agencies

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

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

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Table A.5.4.c – OTHER SERVICES and MISCELLANEOUS

v110.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.4.c -- Other services

Maternal And Child Health Billing Guide For Public Health Agencies

~~**Table A.5.4.c -- Other services**~~

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial **re-assessment** and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

~~V8~~V11.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)

Table A.5.4.c -- Miscellaneous

Maternal And Child Health Billing Guide For Public Health Agencies

~~**Table A.5.4.c -- Miscellaneous**~~

	Place of Service	
	Home or Place of Residence (Use appropriate POS)	**Public Health Clinic (POS 71)**
Maternal Depression Screening~~s~~	99420 UC	99420 UC
Child Developmental Screening~~s~~	96110	96110
Autism Screening	96110 U1	96110 U1
Child Social/Emotional or Mental Health Screening~~s~~	96127	96127
TB Case Management	T1016	T1016
TB Direct Observation Therapy	H0033	H0033

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B. Appendix B: K3 Segment Usage Instructions

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

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

State of Jurisdiction

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

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

Report at 2300 Loop only.

K3*LUMN~

Tooth Number/Oral Cavity

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

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

Report at 2400 Loop only.

K3*JP12~

K3*JP12 14~

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

Report at 2400 Loop only.

K3*JO10~

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

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

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C. Appendix C: Reporting MNCare Tax

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

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Administrative Uniformity Committee

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		

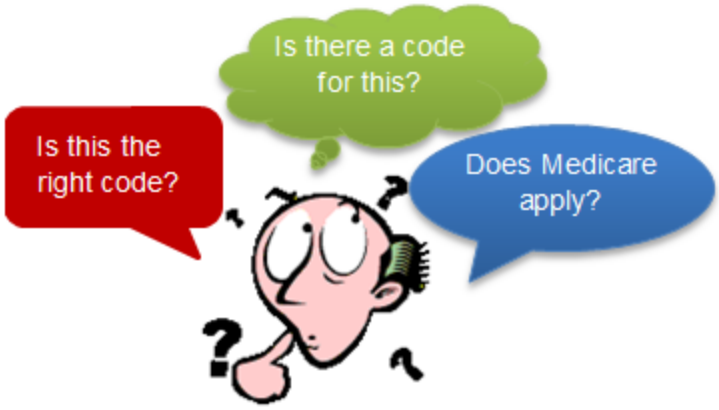
SERVICE	HCPCS	MOD	MOD	MOD	time	POS		COMMENTS
CFSS Agency Model - Shared Care (1:2)	T1019	U9	TT		15 min	12		the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by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

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):

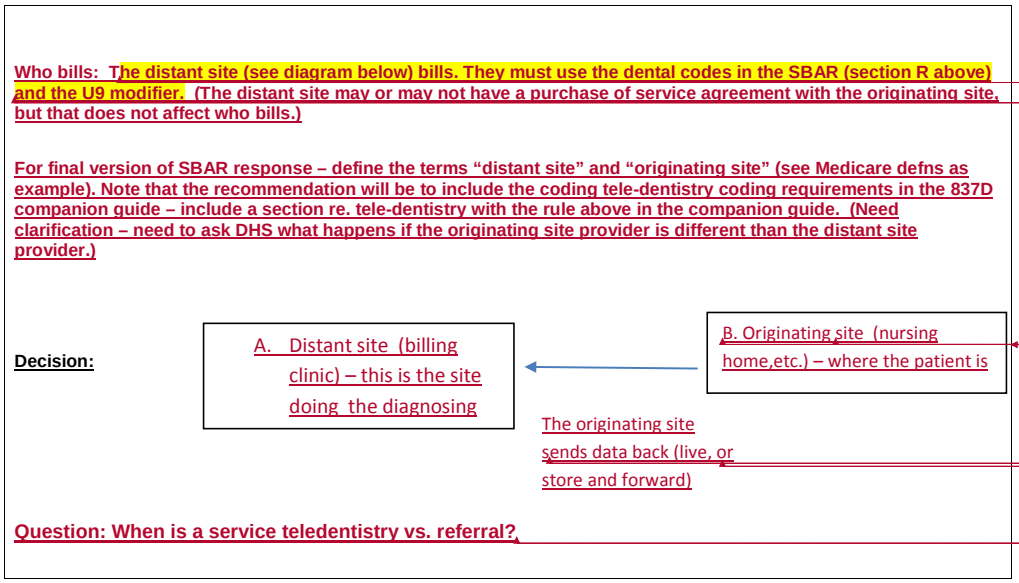
Date [SBAR Response Approved by TAG]:

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.

C. Appendix C: K3 Segment Usage Instructions

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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:
    - valid on the date of service - for medical code sets (which include dental codes); and
    - valid at the time the transaction was created and submitted – for non-medical code sets.

A.3 General Principles for Code Selection and Use in Minnesota

Code selection for claims submitted in Minnesota follows a hierarchy of preferred instructions.

1. Minnesota Statute 62J.536 requires all claims to be submitted according to the guidelines for Medicare that are issued by the Center for Medicare and Medicaid

[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.

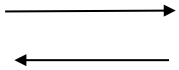
Dental services must be performed via Two-way interactive video or store and forward technology as defined below.

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~~bandwidth and HIPAA compliant software.

Store and forward

Communication is asynchronous including - video clips, photographs and scans, storing them in a file and sent to the dentist. The dentist retrieves the file at a time of their convenience and examines the contents. Recommendations are provided to the oral health professional in the same manner, within seven calendar days of the time of information gathering.

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

Formatted Table

Table A.5.1 Minnesota Coding Specifications:
When to use codes different from Medicare

Medicare Claims Processing Manual		Specific Coding Topic	Minnesota Rule
Chapter Number	Title/Description		
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 D0145 U9 - Oral evaluation for patient under 3 years of age~~-~~ 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 D0240 U9 - Intraoral – occlusal 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 Note: Non-billable services: Sending materials; originating site fee.

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			For MHCP recipient limitations refer to Department of Human Services MHCP Provider Manual. ÷ • ~~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~~ •

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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.

C. Appendix C: K3 Segment Usage Instructions

The K3 segment in the 2300 Loop is used to meet regulatory requirements when the X12N Committee has determined that there is no alternative solution within the current structure of the 005010X224A2. The situations noted here have been approved by the X12N Committee and will be considered as a business need in development of future versions of this transaction.

If multiple K3 needs exist on a single claim at the same loop level, it is recommended that separate K3 segments be sent.

State of Jurisdiction

In workers' compensation, insurance carriers have indicated a need to determine jurisdiction in certain situations. For this workers' compensation implementation, providers may populate this field with the appropriate state code.

LU is the qualifier to indicate this value and should be followed by the two-character state code.

Report at 2300 Loop only.

- K3*LUMN~

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Teledentistry services for Medicaid Recipients

ADA	MOD	ADA code description	U MOD description	Effective
D0120	*	Periodic Oral evaluation - esptablished patient	Teledentistry	1/1/2016
D0140	*	Limited oral exam	Teledentistry	1/1/2016
D0145	*	oral evaluation for a patient under 3 yrs of age	Teledentistry	1/1/2016
D0150	*	Comprehensive oral evaluation - new or established patient	Teledentistry	1/1/2016
D0210	*	Intraoral - complete series of radiographic images	Teledentistry	1/1/2016
D0220	*	Intraoral - periapical first radiographic image	Teledentistry	1/1/2016
D0230	*	Intraoral - periapical each additional radiographic image	Teledentistry	1/1/2016
D0240	*	Intraoral - occlusal radiographic image	Teledentistry	1/1/2016
D0270	*	Bitewing - single radiographic image	Teledentistry	1/1/2016
D0272	*	Bitewings- two radiographic images	Teledentistry	1/1/2016
D0274	*	Bitewings-four radiographic images	Teledentistry	1/1/2016
D0330	*	Panoramic radiographic images	Teledentistry	1/1/2016
D9310	*	Medical Dental Consultation	Teledentistry	1/1/2016

* = U9	Teledentistry	

DT and ADT services for Medicaid Recipients

ADA	MOD	ADA code description	U MOD description	Effective
D0120	*	Periodic Oral evaluation - esptablished patient	Dental Therapist or Advanced Therapist	1/1/2016
D0140	*	Limited oral exam	Dental Therapist or Advanced Therapist	1/1/2016
D0145	*	oral evaluation for a patient under 3 yrs of age	Dental Therapist or Advanced Therapist	1/1/2016
D0150	*	Comprehensive oral evaluation - new or established patient	Dental Therapist or Advanced Therapist	1/1/2016
D0210	*	Intraoral - complete series of radiographic images	Dental Therapist or Advanced Therapist	1/1/2016
D0220	*	Intraoral - periapical first radiographic image	Dental Therapist or Advanced Therapist	1/1/2016
D0230	*	Intraoral - periapical each additional radiographic image	Dental Therapist or Advanced Therapist	1/1/2016
D0240	*	Intraoral - occlusal radiographic image	Dental Therapist or Advanced Therapist	1/1/2016
D0270	*	Bitewing - single radiographic image	Dental Therapist or Advanced Therapist	1/1/2016
D0272	*	Bitewings- two radiographic images	Dental Therapist or Advanced Therapist	1/1/2016
D0274	*	Bitewings-four radiographic images	Dental Therapist or Advanced Therapist	1/1/2016
D0330	*	Panoramic radiographic images	Dental Therapist or Advanced Therapist	1/1/2016
D9310	*	Medical Dental Consultation	Dental Therapist or Advanced Therapist	1/1/2016

* = U9	Teledentistry	

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received: April 6, 2016	**Log No.:** 2016-004	**Date Closed**	
Status: Exec Review Date: April 6, 2016	**Sent to TAG/WG:** April 6, 2016	**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: CHW Universal Modifier	Date:
Contact Information for person completing this form: **Name: Will Wilson** **Title: Supervisor** **Email address: will.wilson@state.mn.us** **Telephone: 651-201-3842**	Organization Information: **Name: MDH Office of Rural Health and Primary Care** **Address: PO Box 64882, St Paul, MN 55164-0882**

Complete for additional contact or Subject Matter Expert, as required:

Name: Joan Cleary
Title: Executive Director, CHW Alliance
Email address: joanlcleary@gmail.com
Phone number: 612-250-0902

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:

Community Health Worker (CHW) services include a wide range of activities, such as education, navigation, advocacy, and care coordination. However, the only service covered (and only in MA) is "diagnosis-based health education," billable using codes 98960, 98961, and 98962. For a number of reasons, these codes are not billed frequently, and do not capture the range of activities CHW are currently performing. Also, different payers have used these codes for services provided by providers other than CHWs.

As a result, there is little or no data in the claim stream available to (1) understand the extent to which CHWs are involved in delivering patient services across our state providing services and (2) measure and evaluate the impact CHWs have on the care delivered to patients and clients.

B

BACKGROUND

MA coverage for CHW services was passed in 2007, as defined in MN Statute 256B.0625, Subd. 49. A State Plan Amendment was approved in 2008, and DHS established MA policy for the service soon after.

According to the Minnesota CHW Alliance, "Community Health Workers (CHWs) are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes. As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality, cultural competence and affordability; and empower individuals and communities for better health."

	Early adopters of CHW services have been, among other providers, integrated health systems, clinics, large hospitals, federally qualified health centers, community-based nonprofits, social services providers, faith-based organizations, and public health agencies. While payment has been established in fee-for-service MA, few claims are currently being submitted, in part due to the narrow nature of the covered service, as compared to the broad set of services CHWs actually provide. CHWs are uniquely positioned to address health disparities in underserved communities. Many have received training in a MnSCU-approved, competencies-based curriculum, and obtained a certificate, which is required to enroll with DHS as a non-billing provider, and be assigned an UMPI. Minnesota is the only state in the US with a statewide CHW curriculum and only one of a few states that are approved to cover specific CHW services under Medicaid. PMAP payment to date is minimal and commercial insurance coverage for CHW services is either minimal or non-existent. A recent survey by MDH showed there are over 650 certificate-holding CHWs in Minnesota. Due to the limited billable services and other issues, only a small percentage of these CHWs have enrolled with DHS. They are, however, providing services which are not being captured, and their impact on overall cost, health outcomes, and patient satisfaction is not being measured.
A	**ASSESSMENT** – A universal modifier creates the opportunity for administrative simplification by allowing a range of services from a uniquely flexible provider type to be reported, captured, and analyzed. Without a mechanism to capture CHW services on a claim, it is extremely difficult to measure and assess the impact CHWs have on the care received by their patients. One structural challenge is that no entity in Minnesota currently regulates CHWs as a profession. The term CHW is most understood to mean a person who has obtained a certificate from a school teaching the MNSCU-approved CHW curriculum, but the term may include similar practitioners who are trained by health systems or organizations to perform similar work. In approving a universal modifier for CHW services, the AUC could give guidance to payers in how the term CHW is defined. This could be exclusive to CHW certificate holders – which Medicaid requires for enrollment – or inclusive of a broader, as yet undefined set of workers who perform similar tasks. This modifier would not be tied to payment.
R	**RECOMMENDATION** – We recommend the creation of a universal modifier for Community Health Worker services, which can voluntarily be added to a claim for any service which involved the services a CHW. A CHW modifier would not be tied to payment. The intent is to create a mechanism within the claim stream to capture the broad set of services currently provided by CHWs, and ultimately, to measure the impact these services are having on the quality, cost, and patient satisfaction of care delivered in a wide range of settings. Use of the modifier will offer important information for several purposes. Data will facilitate understanding of the extent and scope of services which includes CHW engagement. It will allow payers to analyze which patients currently receive CHW services. It will also create the ability to compare outcomes for patients who receive care from a CHW vs those who do not, and to measure the effect CHWs have.

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:

Community Emergency Medical Technician Services

II. Legislation

Minnesota Session Laws 2015, Chapter 71, Article 9, **Sec. 18. COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.**

(a) The commissioner of human services, in consultation with representatives of emergency medical service providers, public health nurses, community health workers, the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters Association, the Minnesota State Firefighters Department Association, Minnesota Academy of Family Physicians, Minnesota Licensed Practical Nurses Association, Minnesota Nurses Association, and local public health agencies, shall determine specified services and payment rates for these services to be performed by community medical response emergency medical technicians certified under Minnesota Statutes, section 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes, section 256B.0625. Services must be in the CEMT skill set and may include interventions intended to prevent avoidable ambulance transportation or hospital emergency department use.

(b) In order to be eligible for payment, services provided by a community medical response emergency medical technician must be:

(1) ordered by a medical response unit medical director;

(2) part of a patient care plan that has been developed in coordination with the patient's primary physician, advanced practice registered nurse, and relevant local health care providers; and

(3) billed by an eligible medical assistance enrolled provider that employs or contracts with the community medical response emergency medical technician.

In determining the community medical response emergency medical technician services to include under medical assistance coverage, the commissioner of human services shall consider the potential of hospital admittance and emergency room utilization reductions as well as increased access to quality care in rural communities.

(c) The commissioner of human services shall submit the list of services to be covered by medical assistance to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and spending by February 15, 2016. These services shall not be covered by medical assistance until legislation providing coverage for the services is enacted in law.

I. DHS Advisory Board Executive Summary

This report provides a proposed list of Community Emergency Medical Technician (CEMT) services and payment rate to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and spending.

The CEMT Advisory Group created this proposed list of services. The group consisted of emergency medical service providers, healthcare providers, emergency response providers, and local public health personnel. The Department of Human Services (DHS) provided a proposed payment rate to the advisory group for their input.

The CEMT Advisory Group recommends the following CEMT services:

Post-Hospital Discharge Visit

The patient's physician (hospitalist or primary care) orders the post-hospital discharge visit. The visit is included in the patient's care plan.

Included components:

- Provide verbal or visual reminders of discharge orders
- Recording and reporting of vital signs to the patient's primary care provider
- Medication access confirmation
- Food access confirmation
- Identification of home hazards

Safety Evaluation Visit

Primary care would coordinate and be responsible for the treatment plan ordering the CEMT services.

- Circumstances that may trigger a safety evaluation visit:
    - Repeat ambulance calls due to falls
    - Nursing home discharges
    - Individuals identified by primary care as at risk for nursing home placement
- Included components:
    - Medication access confirmation
    - Food access confirmation
    - Identification of home hazards

The CEMT Advisory Group recommends a CEMT payment rate of $9.75 per 15 minutes.

CEMT Advisory Group

The following organizations staffed the CEMT Advisory Group:

- Minnesota State Fire Chiefs Association
- Minnesota Professional Firefighters Association
- Minnesota State Firefighters Department Association
- Minnesota Academy of Family Physicians
- Minnesota Licensed Practical Nurse Association
- Minnesota Nurses Association
- Carlton-Cook-Lake-St. Louis Community Health Board
- North Country Community Health Services
- Stearns County Human Services - Public Health
- Southwest Health & Human Services Public Health
- Le Sueur-Waseca Community Health Board
- St. Paul-Ramsey County Public Health
- Hennepin County Public Health

Park Nicollet

FIREFIGTHER HOME VISIT

Date:		1st Call:		Arrival:	
Scheduled Time:		2nd Call:		Clear Time:	

IF PATIENT DECLINES VISIT, NOTIFY: (952) 993-5421 OR Tricia.Pettey@PARKNICOLLET.COM

Name:			Address:		
Age:		Gender:	Phone:	Medical Record #:	
Primary MD:			Clinic Location:		

EVALUATION

Temp:		BP:		HR:		RR:		SPO_2 on RA / on O_2

General Appearance		Pain		Respiratory	
Comfortable	Uncomfortable	Controlled	Uncontrolled	Labored	Unlabored

PEAT Assessment Score:		7-16 Consider notifying Hennepin county Adult Protection: (612)348-8526 17-22 Consider notifying local Health Department

VISIT	ACTION *(if needed)*	REASON *(if needed)*
☐ Visit Complete	☐ Contacted PN Care Team	☐ Medication Concerns
☐ Patient Declined Visit (Notify PN)	☐ Contacted Adult Protection	☐ Pain Management
☐ Attempted Visit Became Welfare Check	☐ Contacted Home Care	☐ Clarification on Follow-up Appts.
☐ Not Home	☐ Referred to Social or Community Resource	☐ Vulnerability
☐ Initiated 9-1-1	☐ Installed Smoke &/or CO Alarm(s)	☐ Food Shelf
☐ Patient was Readmitted Prior to Visit		☐ Other:
☐ Patient is a "High Risk" Follow-up		
☐ Patient has Home Care Scheduled		
Patient understood AVS *(select one below)*		
☐ *Understood*		
☐ *Needed Clarification*		
☐ *Phone Call to Health Team Needed*		

Your Name:	
Department:	*Eden Prairie Fire Department*
Phone:	
Signature:	
Date:	Time:

COMMENTS FOR TREATMENT TEAM *(if needed)*

VISIT CHECKLIST	
☐	Who to call if they need assistance or clarification
☐	Follow-up appointments were reviewed
☐	Medications have been picked up / plan for keeping track
☐	Red flags have been addressed
☐	Smoke alarm present and working
☐	CO alarm present and working
☐	*"Medicines work best if taken while eating meals at regular times. Do you have food in your home for the next few days?"*
☐	Complete this paperwork and fax back to Park Nicollet
☐	If declined, email Tricia at Tricia.Pettey@parknicollet.com with "FFV Declined" in subject line and patient name in the body of the email or call (952) 993-5421.

Form faxed on Date: Time: by Name:

DISCHARGE SPECIFIC DIAGNOSIS

Asthma / COPD/ Pneumonia:

☐ Inhaler questions If yes, medication follow up.

☐ Asthma Action Plan

CHF:

☐ Weight Log

☐ CHF: If / Then from AVS

☐ Weight gain

Diabetes:

☐ Hyperglycemia (increased thirst & urination, ABD pain) If yes, call Care Team.

☐ Hypoglycemia: (shaking, sweating,) If yes, check blood sugar and call Care Team.

☐ Blood Sugar Log

Post Surgical:

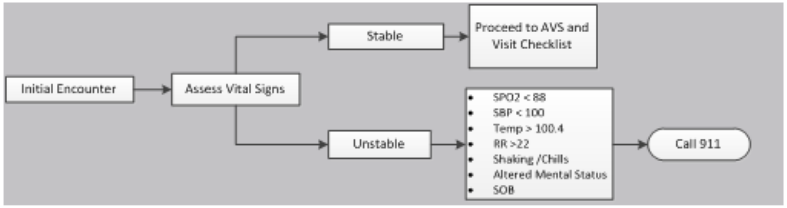
☐ Pain If uncontrolled call Care Team

☐ Functional status since home (bathroom, Ddessing, questions) If yes, contact Home Care

If additional concerns call PN Care Team: (952) 993-9555 (after 5 pm, weekends, holidays (952) 993-3123)

HealthPartners West General: (952) 541-2500; HealthPartners Brooklyn Center RN Hotline: (763) 503-4477

· When calling PN or HP Care Team state: *Hello, My name is _____ with the _____ Fire Department. I am with a patient at a home visit. Please put me through to the _____ (primary care provider location) emergency line. Thank you*



Physical Environment Assessment Tool (P.E.A.T. Scale)

DWELLING *(Select all that apply)*		CLEANLINESS *(Select one)*		SOCIAL STRUCTURE *(Select one)*		HAZARDS *(Select one)*	
Enclosed shelter	2	Immaculate (no clutter)	4	Lives with other(s)	12	None	12
Electricity	2	Clutter *(non-biodegradable items)*	3	Lives alone	9	Possible *(household items unsafe or improperly stored)*	9
Running water *(Potable water in home)*	2	Small amounts of biodegradable waste	2	Verbal abuse / neglect	6	Probable	6
Temperature safe for proper health	2	Large amounts of biodegrable waste	1	Physical abuse / neglect	3	Certain	3
Score (0-8):		**Score (1-4):**		**Score (3-12):**		**Score (3-12):**	

Strengthening Community Partnerships:

The Post Discharge Fire Fighter Visit

Partnership of Park Nicollet and Fire Departments in St. Louis Park, Minneapolis, Minnetonka and St. Louis Park , Hopkins, Eden Prairie

Post Discharge Fire Fighter Visit Program

Background and methodology of how the Post Discharge Fire Fighter visit got developed

Processes and content of the visit: a focus on enhancing patient safety in the home

Data and outcomes from the visits

How the fire fighter visit addresses the triple aim and enhances patient and community resilience

Background of the Fire Fighter Visit

January 6, 2014: first meeting between SLP FD and PN to discuss possible partnership

Current State:
Fire Department

SLP Fire Department: **70%** of their calls are now medical– with many of those calls involving patients that are recently discharged

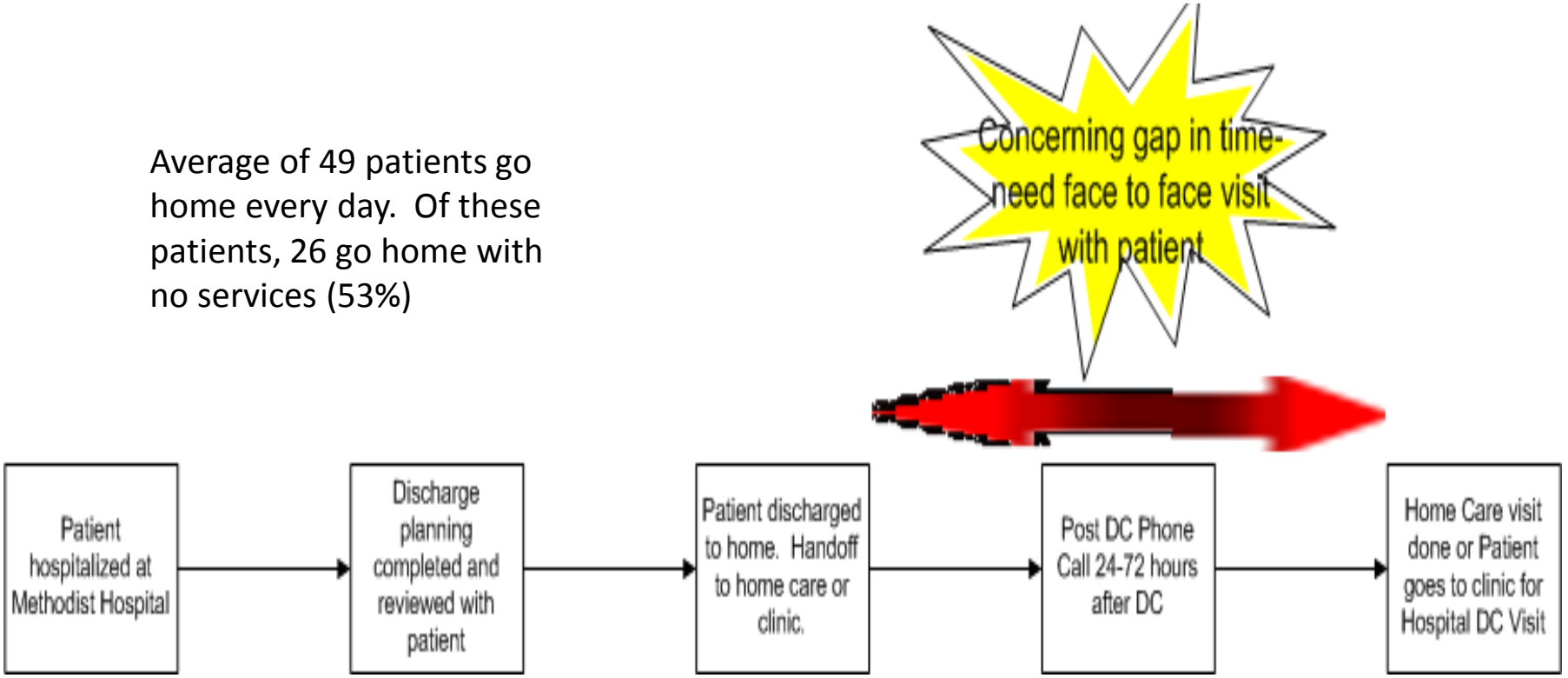
Background of the Fire Fighter Visit

- The Changing Role of the Fire Department
  - Continued increased demand of fire resources for medical response
    - Calls could be preventable many times
  - Mandates of the Patient Protection Affordable Care Act on the roles of the fire department
  - Aligning the correct resource for the call type (both vehicle and staff)
  - Need to create a revenue stream to sustain service levels

Background of the Fire Fighter Visit

Current State:
Methodist Hospital

Average of 49 patients go home every day. Of these patients, 26 go home with no services (53%)



Readmission Interventions

Risk Stratification Tool to identify high risk for readmission patients

Medication safety
MTM Pharmacists

Hospitalist, RN, SW team

Standard work for care integration team

Warm hand offs to next level of care

Improved discharge instructions (After Visit Summary)

Post acute care partners

Post discharge phone calls

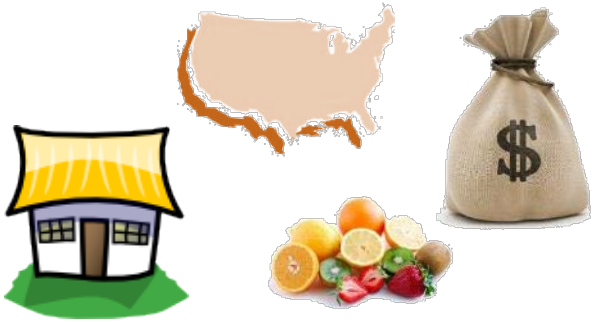
Measuring Readmissions
(a proxy for effective care coordination/transition to next level of care)

Out of the hospital's control:

- *Patient level factors*
- *Community level factors*

CMS Adjusts for

No Adjustment



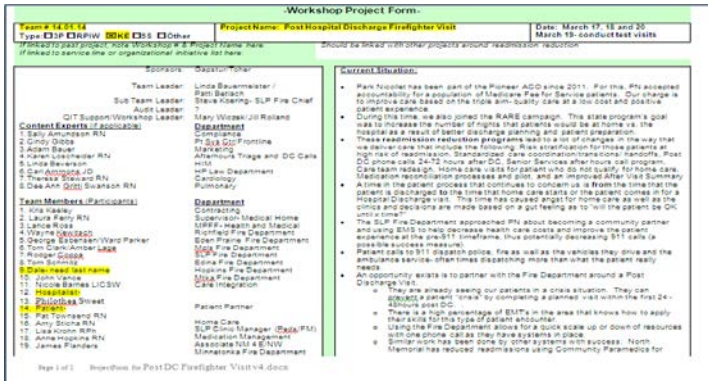
CONNECTING

TRANSITIONS

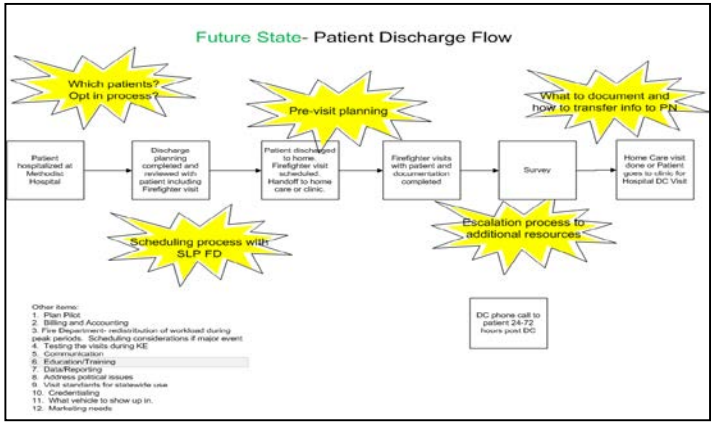
TOGETHER

Post Discharge Fire Fighter Visit

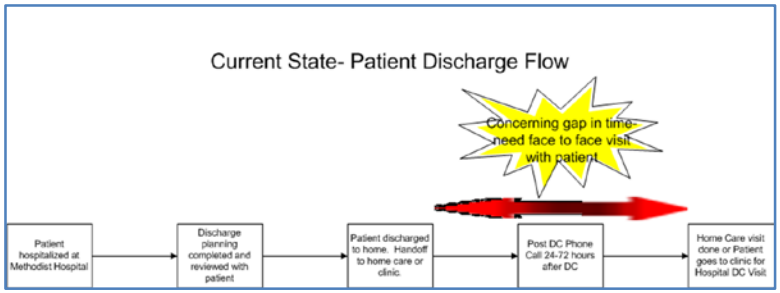
Process Improvement Methodology Used: Kaizen



Project form:
Defined targets and deliverables



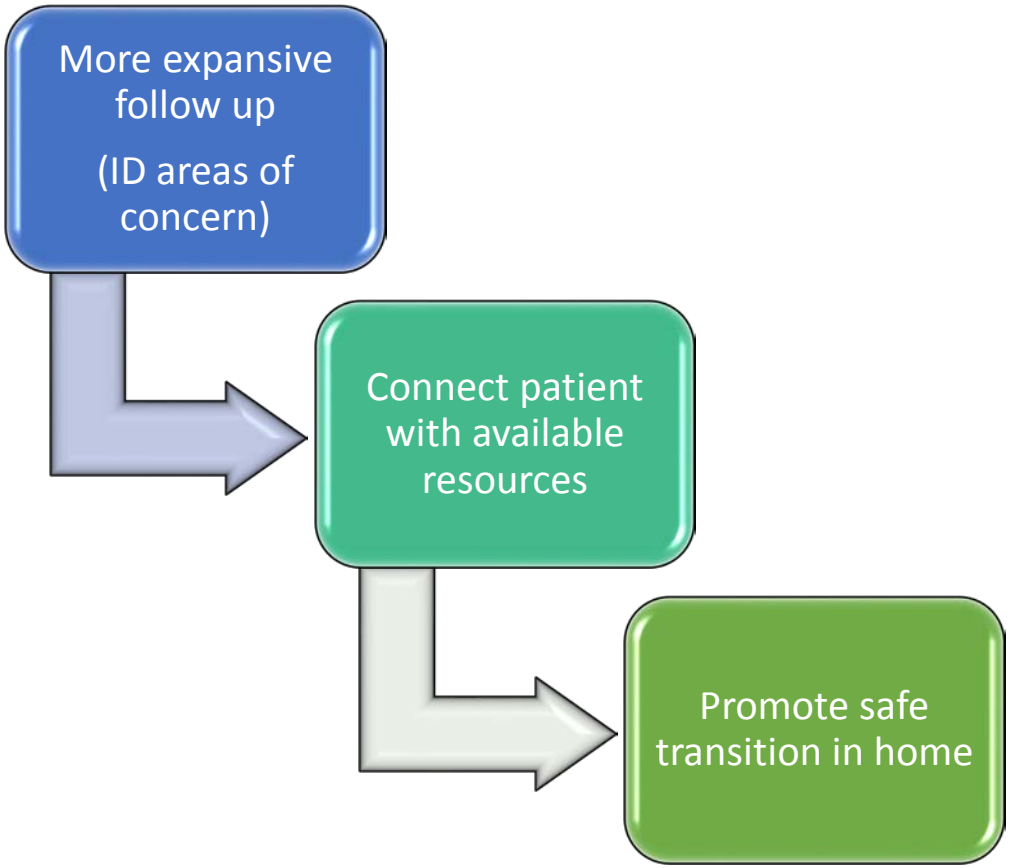
Agreeing to a future state process



Process flow or Value Stream Map:
Understanding the current state process

PDSA Cycles: Trying something and making Changes as needed: "Fail forward quickly"

OUR GOAL:


More expansive follow up
(ID areas of concern)
Connect patient with available resources
Promote safe transition in home

Post Discharge Fire Fighter Visit Kaizen Event Deliverables

Process

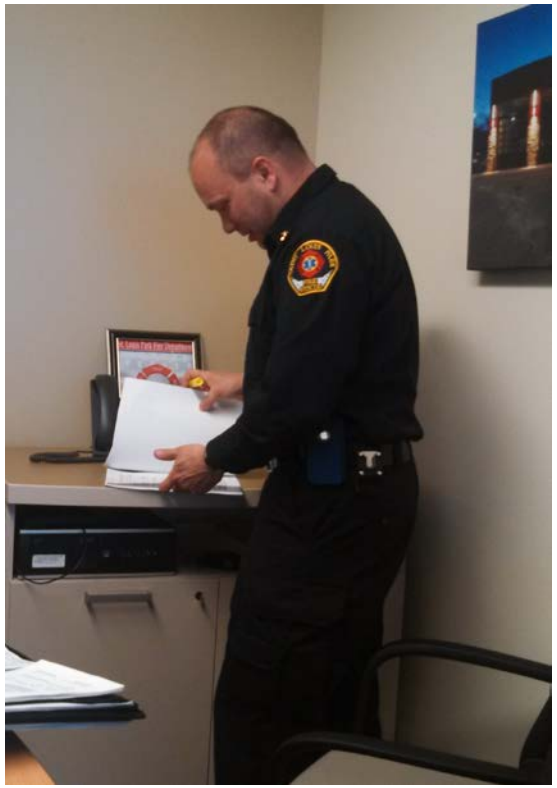
- Patient ID and consent process
- Dispatch process
- Fire Department receipt of information process
- Fire Department scheduling/pre-visit/visit process

Visit Components

- Medications
- Red flags
- Who to call
- Follow up visit
- PEAT

Tools

- Patient flyer
- Patient consent form
- Fax forms
- FF visit documentation form
- Patient survey
- And others



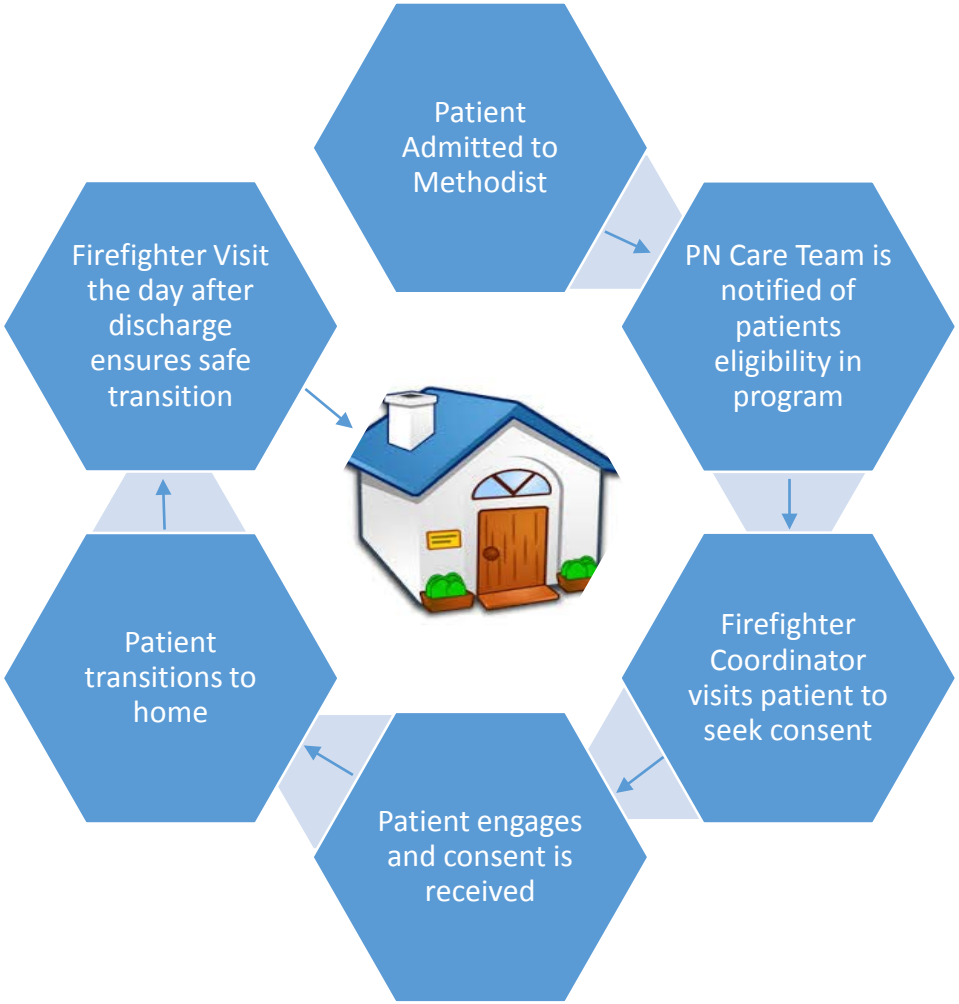
Test Visits

- Three visits
- Made process and other changes

Pilot Planning

- Three Departments
- Measures
- Training

Our Process


Patient Admitted to Methodist
PN Care Team is notified of patients eligibility in program
Firefighter Coordinator visits patient to seek consent
Patient engages and consent is received
Patient transitions to home
Firefighter Visit the day after discharge ensures safe transition

Our Patient Flyer

We also have a patient education video

Post-Discharge Firefighter Visit

Transitioning safely to home after leaving the hospital

Why is a post-discharge firefighter visit important?

Park Nicollet Methodist Hospital and local fire departments are partnering to help you transition safely to home after you leave the hospital. Even though you may be excited to leave the hospital, going home can be overwhelming. You may be experiencing pain or taking certain medications that make remembering everything you need to know to take care of yourself difficult. We want to review your discharge information in the comfort of your own home.

A firefighter will schedule a time to come to your home the day after you are discharged. The firefighter will make sure you have the information and resources you need to safely transition to your home environment.

How do I sign up for a firefighter visit?

A member of your care team will talk to you about scheduling the visit. You will need to sign a consent form. Your care team will send your information to the fire department when you leave the hospital.

You will receive a call from a firefighter to schedule a time for the visit the morning after you leave the hospital. Usually, the firefighter will try to call between 8:30 a.m. and 10:30 a.m.

What does the visit cost?

There is no charge to you or your health insurance for the visit.

What happens during the visit?

During the visit, the firefighter will:

- Review your discharge instructions
- Check your medications and review how to take them

- Check your home for safety, including smoke detector installation if needed
- Connect you with community resources if needed

How can I prepare for the visit?

- If possible, ask a family member or friend to join the visit. Your family member or friend can help take notes during your discussion with the firefighter or write down questions and concerns you have about caring for yourself at home. The firefighter can connect you with your care team if needed.
- Put your pets in a kennel or a separate room.

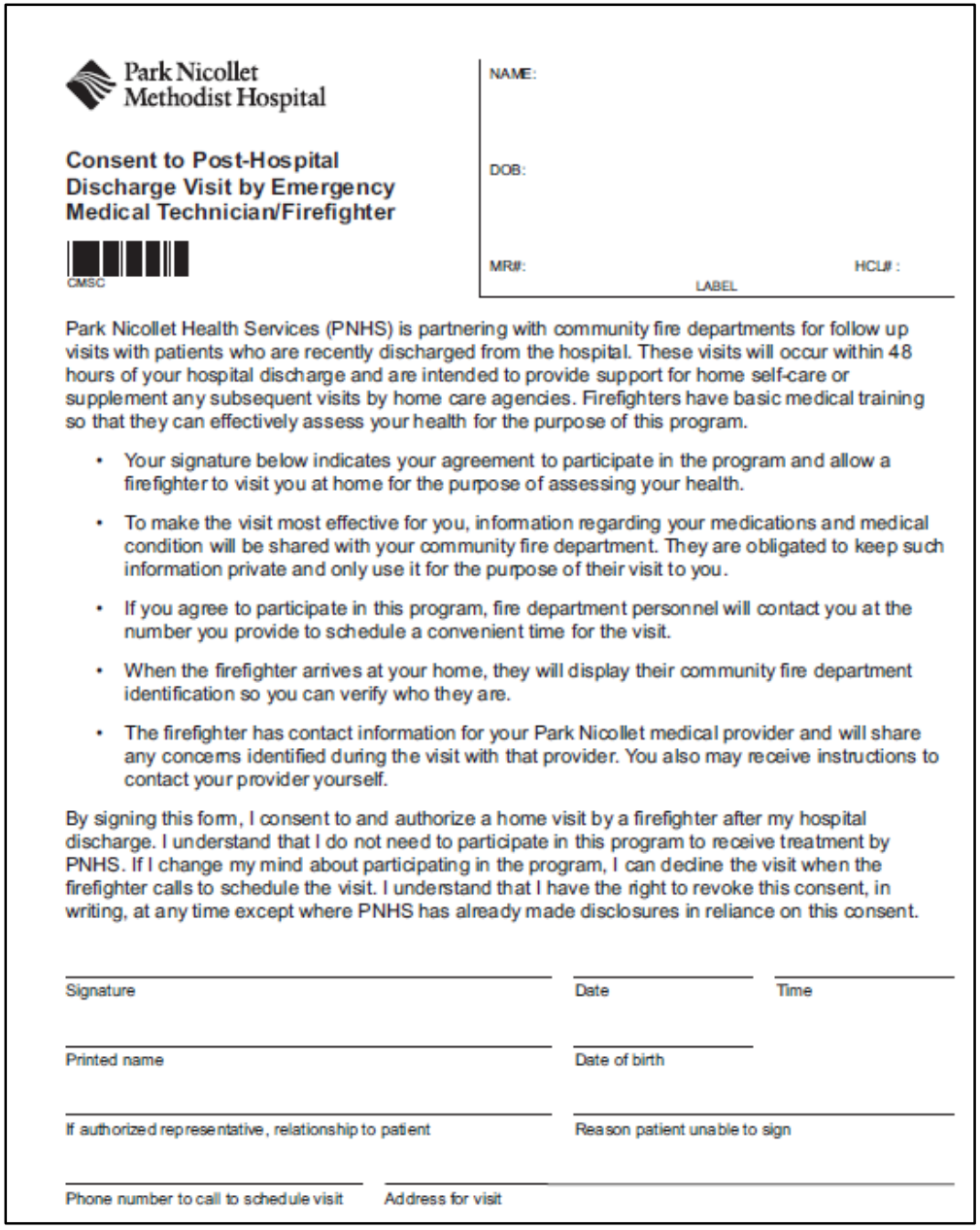
Who can I call if I have questions?

- If you have any medical questions before your firefighter visit, call your primary care clinic before the visit.
- If you have a medical emergency, call 911.

Park Nicollet® Methodist Hospital
HealthPartners®

21043 (6/2015)

Our Patient Consent form- we must obtain consent as we share the patient's AVS (After Visit Summary) with the Fire Department



Park Nicollet Methodist Hospital

Consent to Post-Hospital Discharge Visit by Emergency Medical Technician/Firefighter

CMSC

NAME:

DOB:

MR#: HCL#:

LABEL

Park Nicollet Health Services (PNHS) is partnering with community fire departments for follow up visits with patients who are recently discharged from the hospital. These visits will occur within 48 hours of your hospital discharge and are intended to provide support for home self-care or supplement any subsequent visits by home care agencies. Firefighters have basic medical training so that they can effectively assess your health for the purpose of this program.

- Your signature below indicates your agreement to participate in the program and allow a firefighter to visit you at home for the purpose of assessing your health.
- To make the visit most effective for you, information regarding your medications and medical condition will be shared with your community fire department. They are obligated to keep such information private and only use it for the purpose of their visit to you.
- If you agree to participate in this program, fire department personnel will contact you at the number you provide to schedule a convenient time for the visit.
- When the firefighter arrives at your home, they will display their community fire department identification so you can verify who they are.
- The firefighter has contact information for your Park Nicollet medical provider and will share any concerns identified during the visit with that provider. You also may receive instructions to contact your provider yourself.

By signing this form, I consent to and authorize a home visit by a firefighter after my hospital discharge. I understand that I do not need to participate in this program to receive treatment by PNHS. If I change my mind about participating in the program, I can decline the visit when the firefighter calls to schedule the visit. I understand that I have the right to revoke this consent, in writing, at any time except where PNHS has already made disclosures in reliance on this consent.

Signature _____ Date _____ Time _____

Printed name _____ Date of birth _____

If authorized representative, relationship to patient _____ Reason patient unable to sign _____

Phone number to call to schedule visit _____ Address for visit _____

Post Discharge Fire Fighter Visit Components- based on the elements known to ensure a safe transition

- **Medication**s- does the patient understand what medications to take?
- **Follow up visit-** does the patient have a follow up visit scheduled with her doctor?
- **Symptoms**- does the patient know what symptoms to be aware of and who to call if she experiences the symptom?
- **Food**- does the patient have enough food in the house to get through the next few days?
- **Home safety**- are there hazards in the house? Is the smoke/CO2 alarm working? (PEAT Assessment)

The Visit Form

Park Nicollet

FIREFIGTHER HOME VISIT

Date:		1st Call:		Arrival:	
Scheduled Time:		2nd Call:		Clear Time:	

IF PATIENT DECLINES VISIT, NOTIFY: (952) 993-5421 OR Tricia.Pettey@PARKNICOLLET.COM

Name:			Address:		
Age:		Gender:	Phone:	Medical Record #:	
Primary MD:			Clinic Location:		

EVALUATION

Temp:		BP:		HR:		RR:		
						SPO_2	on RA	
							on O_2	

General Appearance		Pain		Respiratory	
Comfortable	Uncomfortable	Controlled	Uncontrolled	Labored	Unlabored

PEAT Assessment Score:	

7-16 Consider notifying Hennepin county Adult Protection: (612)348-8526
17-22 Consider notifying local Health Department

VISIT	ACTION *(if needed)*	REASON *(if needed)*
☐ Visit Complete	☐ Contacted PN Care Team	☐ Medication Concerns
☐ Patient Declined Visit (Notify PN)	☐ Contacted Adult Protection	☐ Pain Management
☐ Attempted Visit Became Welfare Check	☐ Contacted Home Care	☐ Clarification on Follow-up Appts.
☐ Not Home	☐ Referred to Social or Community Resource	☐ Vulnerability
☐ Initiated 9-1-1	☐ Installed Smoke &/or CO Alarm(s)	☐ Food Shelf
☐ Patient was Readmitted Prior to Visit		☐ Other:
☐ Patient is a "High Risk" Follow-up		
☐ Patient has Home Care Scheduled		
Patient understood AVS *(select one below)*		
☐ *Understood*		
☐ *Needed Clarification*		
☐ *Phone Call to Health Team Needed*		

Your Name:	
Department:	*Eden Prairie Fire Department*
Phone:	
Signature:	
Date:	Time:

VISIT CHECKLIST
☐ Who to call if they need assistance or clarification
☐ Follow-up appointments were reviewed
☐ Medications have been picked up / plan for keeping track
☐ Red flags have been addressed
☐ Smoke alarm present and working
☐ CO alarm present and working
☐ *"Medicines work best if taken while eating meals at regular times. Do you have food in your home for the next few days?"*
☐ Complete this paperwork and fax back to Park Nicollet
☐ If declined, email Tricia at Tricia.Pettey@parknicollet.com with "FFV Declined" in subject line and patient name in the body of the email or call (952) 993-5421.

COMMENTS FOR TREATMENT TEAM *(if needed)*

Form faxed on Date: Time: by Name:

DISCHARGE SPECIFIC DIAGNOSIS

Asthma / COPD/ Pneumonia:

☐ Inhaler questions If yes, medication follow up.

☐ Asthma Action Plan

CHF:

☐ Weight Log

☐ CHF: If / Then from AVS

☐ Weight gain

Diabetes:

☐ Hyperglycemia (increased thirst & urination, ABD pain) If yes, call Care Team.

☐ Hypoglycemia: (shaking, sweating,) If yes, check blood sugar and call Care Team.

☐ Blood Sugar Log

Post Surgical:

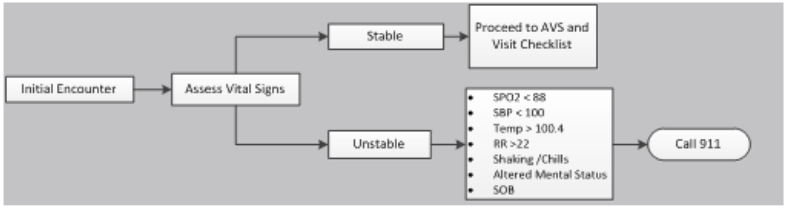
☐ Pain If uncontrolled call Care Team

☐ Functional status since home (bathroom, Ddessing, questions) If yes, contact Home Care

If additional concerns call PN Care Team: (952) 993-9555 (after 5 pm, weekends, holidays (952) 993-3123)

HealthPartners West General: (952) 541-2500; HealthPartners Brooklyn Center RN Hotline: (763) 503-4477

· When calling PN or HP Care Team state: *Hello, My name is _____ with the _____ Fire Department. I am with a patient at a home visit. Please put me through to the _____ (primary care provider location) emergency line. Thank you*



Physical Environment Assessment Tool (P.E.A.T. Scale)

DWELLING *(Select all that apply)*		CLEANLINESS *(Select one)*		SOCIAL STRUCTURE *(Select one)*		HAZARDS *(Select one)*	
Enclosed shelter	2	Immaculate (no clutter)	4	Lives with other(s)	12	None	12
Electricity	2	Clutter *(non-biodegradable items)*	3	Lives alone	9	Possible *(household items unsafe or improperly stored)*	9
Running water *(Potable water in home)*	2	Small amounts of biodegradable waste	2	Verbal abuse / neglect	6	Probable	6
Temperature safe for proper health	2	Large amounts of biodegrable waste	1	Physical abuse / neglect	3	Certain	3
Score (0-8):		**Score (1-4):**		**Score (3-12):**		**Score (3-12):**	

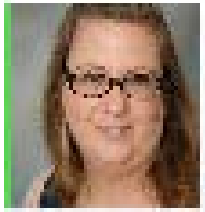
Current Program Components

Departments:
St. Louis Park
Minneapolis
Minnetonka
Hopkins
Eden Prairie

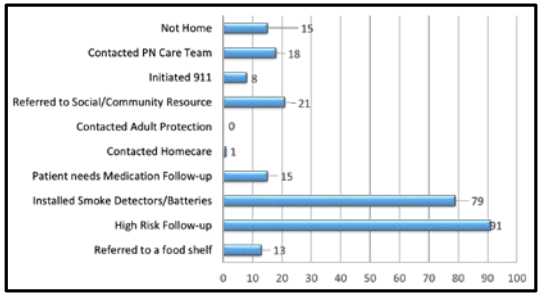
Visits: Tuesday-Saturday
Same day if needed

Weekly conference call with Core team

Data Collected from Start of pilot



Part Time **Project Coordinator**



Who are the patients?

Age

Youngest: 7 months

Oldest: 102

Average: 65

Gender

41% males

59% females

Totals

HRR patients:

91

TOTAL VISITS: 448

Fire Fighter Visit Data

Averages

- Number of calls to schedule= 1.3
- Cycle time of visit= 23 Minutes

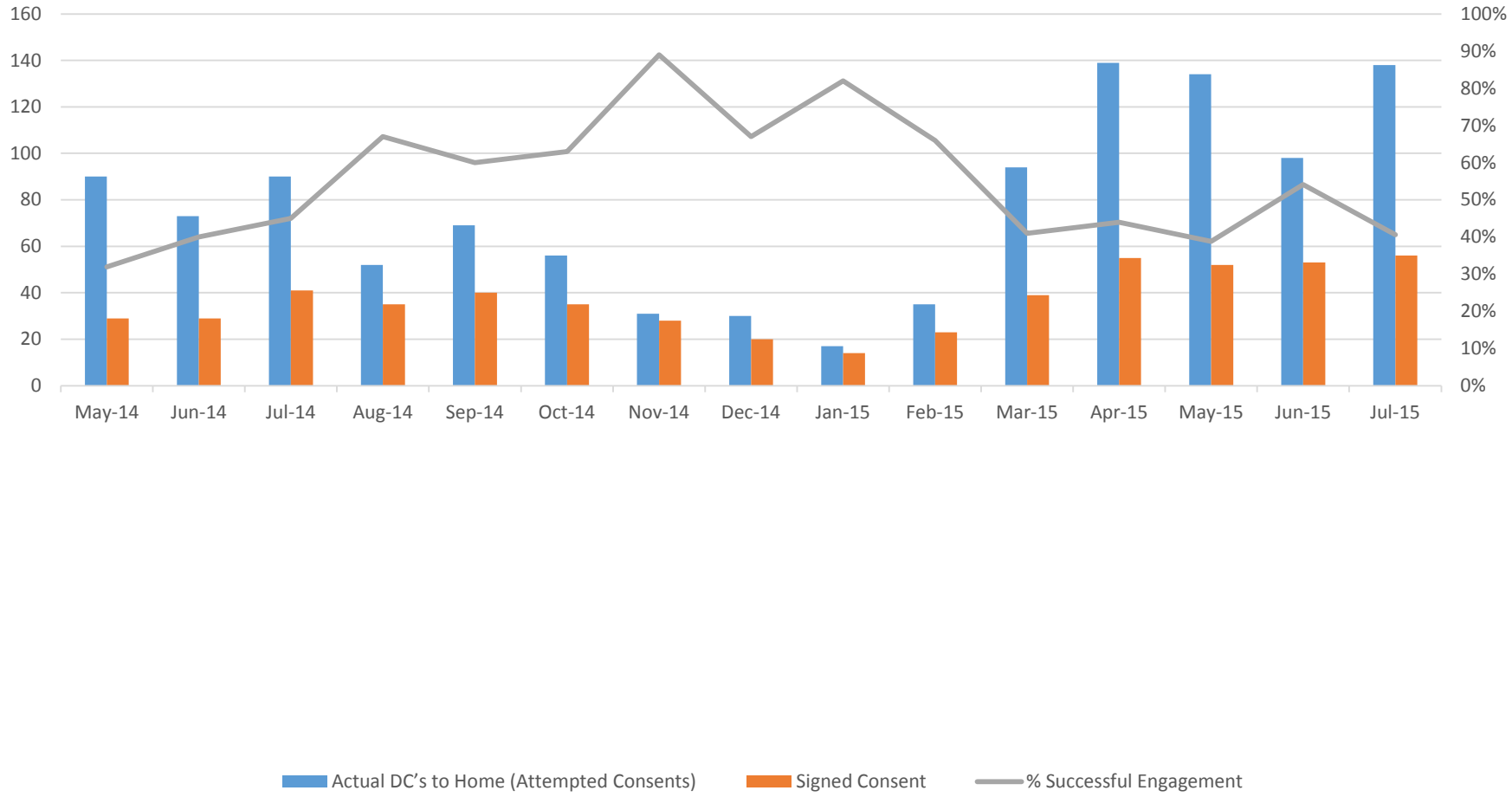
Times

- Range 0900-2000
- Average time is 12:30

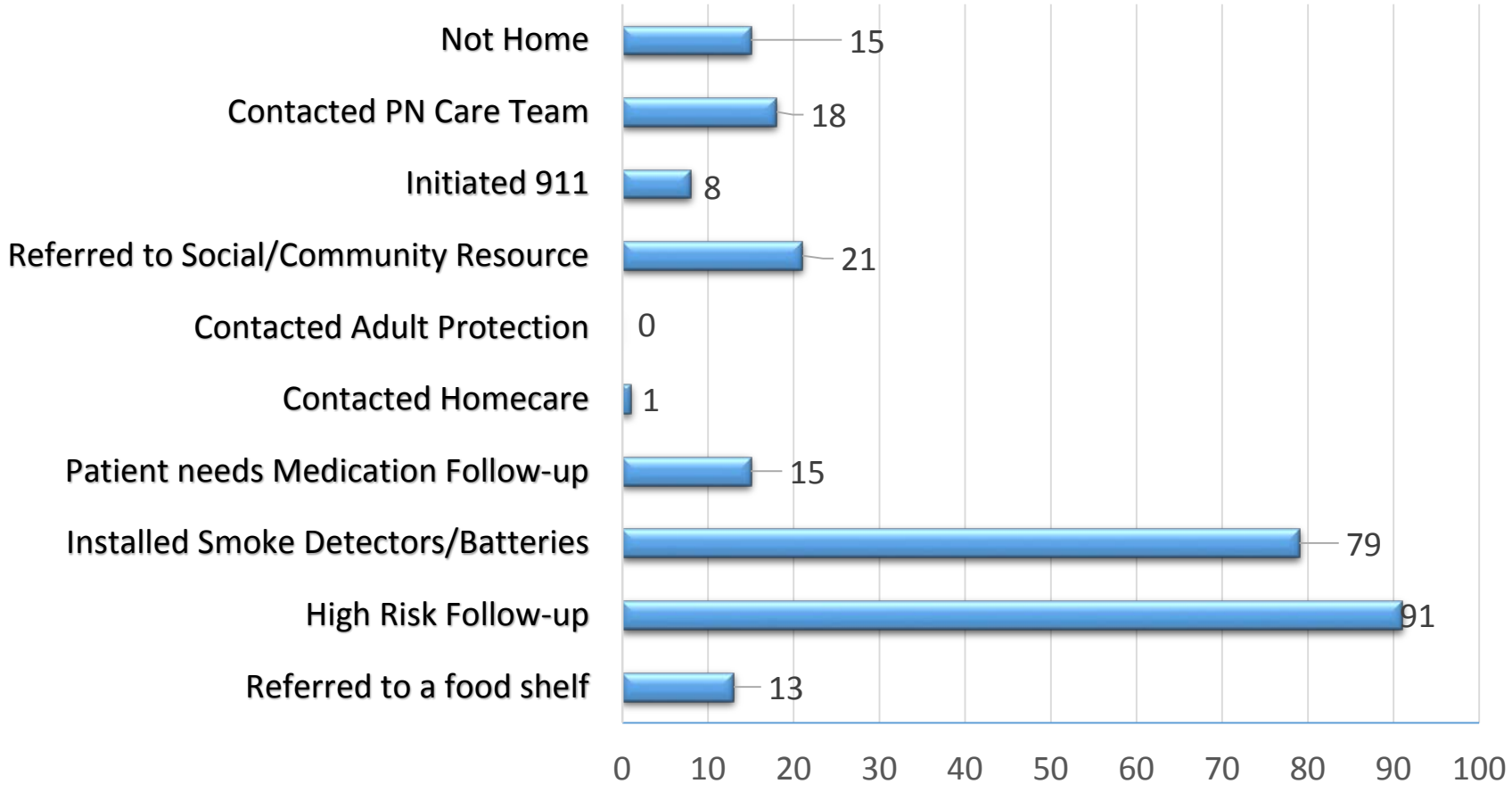
PEAT Score

- Range: 22-38
- Average: 34

Patient Engagement



Visit Outcomes

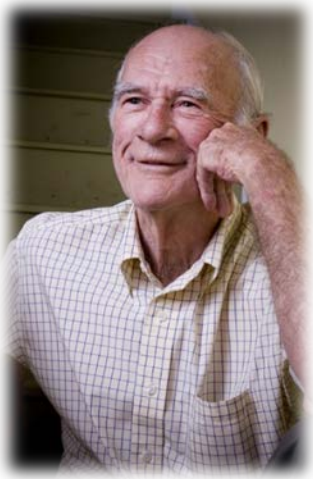


What our patients are saying about the visits:

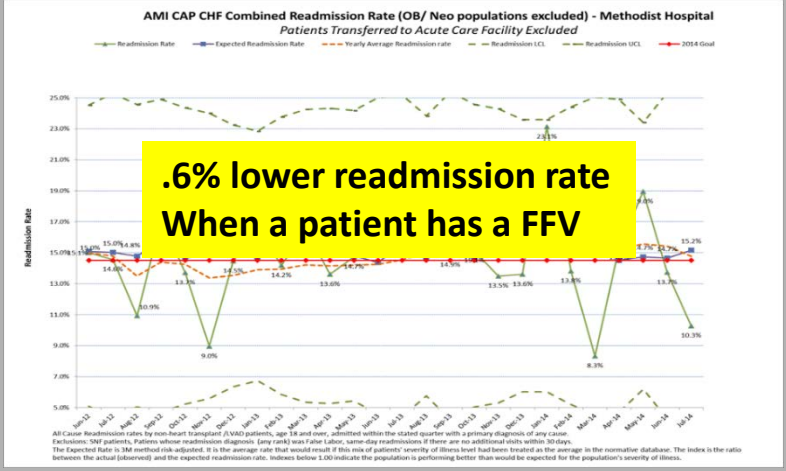
MH staff informed me about the firefighter visit in a way that I could understand: ***99% agree/strongly agree***

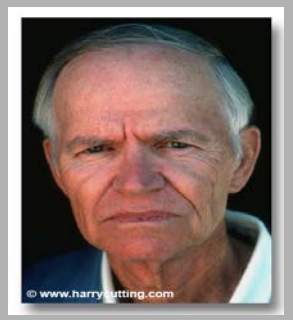
Most important aspect of visit: ***Safety Assessment***

"I would recommend a firefighter visit to my family and friends": ***99% agree/strongly agree***



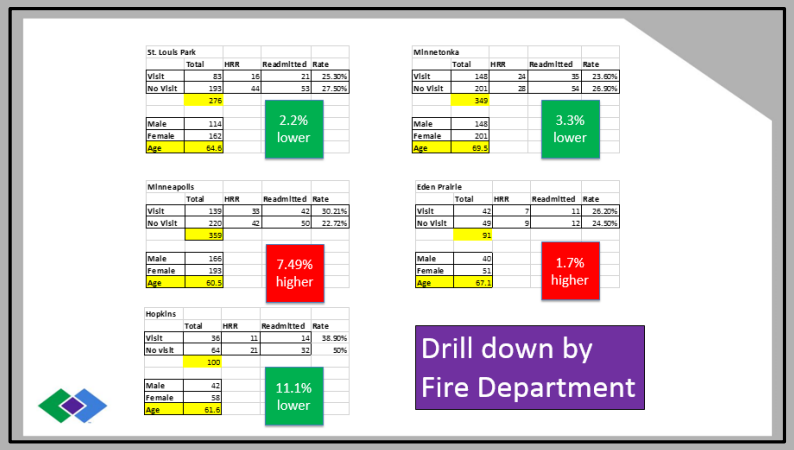
Fire Fighter Visit Impact on Readmissions





For males, the readmission rate was 2.9% lower

For females, the readmission rate was 1.9% higher



3/5 Fire Departments had lower readmission rates than overall population

Successes

MHA Innovation of the Year Award, in Patient Care

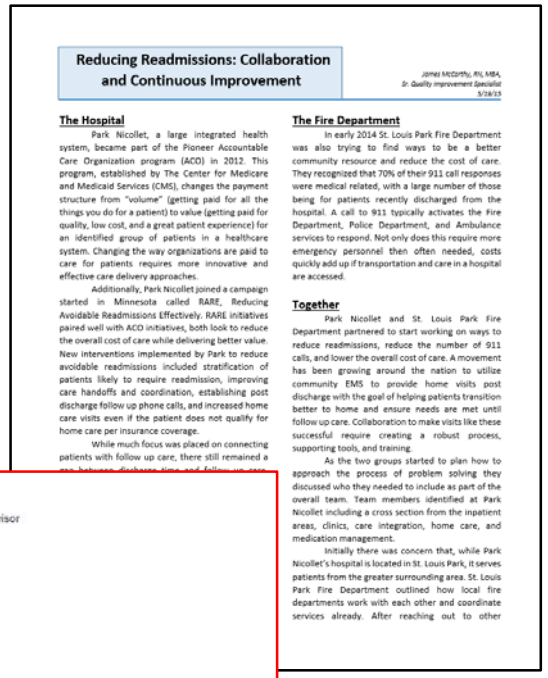
Park Nicollet Methodist Hospital, Saint Louis Park

2015

Large hospital category. As an Accountable Care Organization, Park Nicollet has been working on an infrastructure to ensure safe patient transitions. One transition of key importance is the transition from hospital to home. Although the hospital has made great improvements, there continued to be a gap in time between the patient discharge and arrival of the home care nurse or the timing of the follow up visit. This caused great concern and could result in an unsafe situation or readmission for the patient. In January 2014, the St. Louis Park Fire Department approached Park Nicollet to discuss how they could partner around patient safety/transitions. The hospital learned that several of the fire department's emergency medical calls were occurring after hospital discharges. In March of 2014, Park Nicollet and five community fire departments joined together to create a Post Discharge Firefighter visit. This structured, one time visit is a face-to-face meeting with a recently discharged patient to ensure that the patient has safely transitioned to home and understands the next steps in his/her care. The visit includes: medication review, follow up visit(s), signs and symptoms, who to call with questions, and a home safety assessment. Patients are referred to resources as needed. For example, in June, a food insecurity question was added to the visit and connections were made with local food shelves so that if a patient identifies a need for food, delivery can happen that same day. As of February, 227 visits have taken place and 99 percent of patients who had a visit would recommend one to a family member or friend. Partnering with local fire departments has created a unique partnership that benefits the patient, care system,

MHA Innovation of the Year Award

Highlighted in The Advisory Board Community Paramedicine Best Practices Research and Case Study for Project Management Course on improvements



Reducing Readmissions: Collaboration and Continuous Improvement

James McCarthy, RN, MBA, Sr. Quality Improvement Specialist 5/28/15

The Hospital

Park Nicollet, a large integrated health system, became part of the Pioneer Accountable Care Organization program (ACO) in 2012. This program, established by The Center for Medicare and Medicaid Services (CMS), changes the payment structure from "volume" (getting paid for all the things you do for a patient) to value (getting paid for quality, low cost, and a great patient experience) for an identified group of patients in a healthcare system. Changing the way organizations are paid to care for patients requires more innovative and effective care delivery approaches.

Additionally, Park Nicollet joined a campaign started in Minnesota called RARE, Reducing Avoidable Readmissions Effectively. RARE initiatives paired well with ACO initiatives, both look to reduce the overall cost of care while delivering better value. New interventions implemented by Park to reduce avoidable readmissions included stratification of patients likely to require readmission, improving care handoffs and coordination, establishing post discharge follow up phone calls, and increased home care visits even if the patient does not qualify for home care per insurance coverage.

While much focus was placed on connecting patients with follow up care, there still remained a

The Fire Department

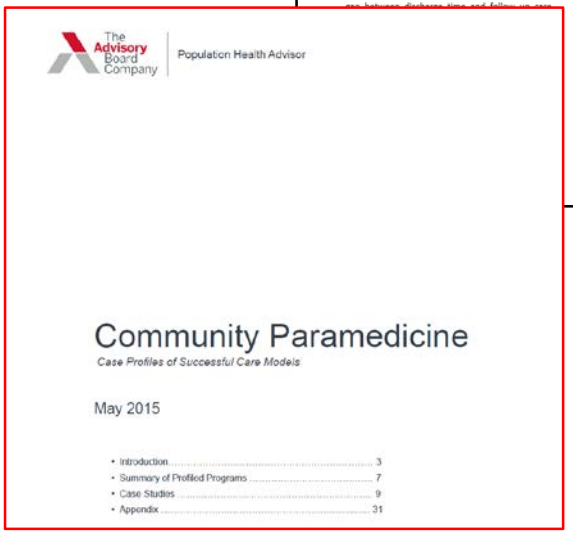
In early 2014 St. Louis Park Fire Department was also trying to find ways to be a better community resource and reduce the cost of care. They recognized that 70% of their 911 call responses were medical related, with a large number of those being for patients recently discharged from the hospital. A call to 911 typically activates the Fire Department, Police Department, and Ambulance services to respond. Not only does this require more emergency personnel then often needed, costs quickly add up if transportation and care in a hospital are accessed.

Together

Park Nicollet and St. Louis Park Fire Department partnered to start working on ways to reduce readmissions, reduce the number of 911 calls, and lower the overall cost of care. A movement has been growing around the nation to utilize community EMS to provide home visits post discharge with the goal of helping patients transition better to home and ensure needs are met until follow up care. Collaboration to make visits like these successful require creating a robust process, supporting tools, and training.

As the two groups started to plan how to approach the process of problem solving they discussed who they needed to include as part of the overall team. Team members identified at Park Nicollet including a cross section from the inpatient areas, clinics, care integration, home care, and medication management.

Initially there was concern that, while Park Nicollet's hospital is located in St. Louis Park, it serves patients from the greater surrounding area. St. Louis Park Fire Department outlined how local fire departments work with each other and coordinate services already. After reaching out to other



The Advisory Board Company | Population Health Advisor

Community Paramedicine

Case Profiles of Successful Care Models

May 2015

Patient Story

Post Discharge Fire Fighter Visit

Health

- Patients have what they need to care for themselves at home and understand what community resources to use if something changes

Experience

- Safe and successful integration back into their home/community
- Consistent and repeated key messages from PN team and fire fighter colleagues

Affordability

- Decrease readmissions
- Appropriate use of healthcare resources and decrease unnecessary 911 calls

Community Integration in Patient Transition Processes Require New Drivers for Success

Relationship Management-
Fire Department and HC Provider

Expectation Management-
City Management/Elected Officials/HC Provider/Community

Resource Management for Visits-
Recommend resource increases or realignment

Financial Management-
Responsible for viability and sustainability of program to tax payers

Questions?

Park Nicollet Methodist Hospital
HealthPartners

Thank You!

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
Transportation Services					
343800000X	Transportations Services	Secured Medical Transport (VAN)		Z753	Unavailability and inaccessibility of health-care facilities
343900000X	Transportations Services	Non-emergency Medical Transport (VAN)		Z418	Encounter for other procedures for purposes other than remedying health state
344600000X	Transportations Services	Taxi		Z029	Encounter for administrative examinations, unspecified
344800000X	Transportations Services	Air Carrier			
347B00000X	Transportations Services	Bus			
347C00000X	Transportations Services	Private Vehicle			
347D00000X	Transportations Services	Train			
347E00000X	Transportations Services	Transportation Broker			
172A00000X	Other Service Providers	Driver			
Transportation Services [Ambulance]					
341600000X	Transportation Services	Ambulance		R69	Illness, unspecified
3416A0800X	Transportation Services	Ambulance	Air Transport	T148	Other injury of unspecified body region
3416L0300X	Transportation Services	Ambulance	Land Transport	T1490	Injury, unspecified
3416S0300X	Transportation Services	Ambulance	Water Transport	Z029	Encounter for administrative examinations, unspecified
341800000X	Transportation Services	Military/U.S. Coast Guard Transport		Z418	Encounter for other procedures for purposes other than remedying health state
3418M1110X	Transportation Services	Military/U.S. Coast Guard Transport	Military or U.S. Coast Guard Ambulance, Ground Transport	Z753	Unavailability and inaccessibility of health-care facilities
3418M1120X	Transportation Services	Military/U.S. Coast Guard Transport	Military or U.S. Coast Guard Ambulance, Air Transport	R402111	Coma scale, eyes open, never, in the field [EMT or ambulance]
3418M1130X	Transportation Services	Military/U.S. Coast Guard Transport	Military or U.S. Coast Guard Ambulance, Water Transport	R402121	Coma scale, eyes open, to pain, in the field [EMT or ambulance]
				R402131	Coma scale, eyes open, to sound, in the field [EMT or ambulance]
				R402141	Coma scale, eyes open, spontaneous, in the field [EMT or ambulance]
				R402211	Coma scale, best verbal response, none, in the field [EMT or ambulance]
				R402221	Coma scale, best verbal response, incomprehensible words, in the field [EMT or
				R402231	Coma scale, best verbal response, inappropriate words, in the field [EMT or ambulance]
				R402241	Coma scale, best verbal response, confused conversation, in the field [EMT or ambulance]
				R402251	Coma scale, best verbal response, oriented, in the field [EMT or ambulance]
				R402311	Coma scale, best motor response, none, in the field [EMT or ambulance]
				R402321	Coma scale, best motor response, extension, in the field [EMT or ambulance]
				R402331	Coma scale, best motor response, abnormal, in the field [EMT or ambulance]
				R402341	Coma scale, best motor response, flexion withdrawal, in the field [EMT or ambulance]
				R402351	Coma scale, best motor response, localizes pain, in the field [EMT or ambulance]
				R402361	Coma scale, best motor response, obeys commands, in the field [EMT or ambulance]

Taxonomy Codes	Provider Type	Classification	Specialty	*ICD-10*	*Code Description*

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
Emergency Response Systems (Lifeline)					
333300000X	Suppliers	Emergency Response System Companies		*Z743*	*Need for continuous supervision*
				R69	*Illness, unspecified*
				Z029	*Encounter for administrative examinations, unspecified*
				Z753	*Unavailability and inaccessibility of health-care facilities*
				Z754	*Unavailability and inaccessibility of other helping agencies*
				Z742	*Need for assistance at home and no other household member able to render care*
				Z748	*Other problems related to care provider dependency*
				Z418	*Encounter for other procedures for purposes other than remedying health state*
Residential Support					
177F00000X	Other Service Providers	Lodging		*Z7401*	*Bed confinement status*
320600000X	Residential Treatment Facilities	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities		*Z7409*	*Other reduced mobility*
320700000X	Residential Treatment Facilities	Residential Treatment Facility, Physical Disabilities		*Z741*	*Need for assistance with personal care*
320800000X	Residential Treatment Facilities	Community Based Residential Treatment Facility, Mental Illness		*Z742*	*Need for assistance at home and no other household member able to render care*
320900000X	Residential Treatment Facilities	Community Based Residential Treatment, Mental Retardation and/or Developmental Disabilities		*Z743*	*Need for continuous supervision*
322D00000X	Residential Treatment Facilities	Residential Treatment Facility, Emotionally Disturbed Children		*Z755*	*Holiday relief care*
323P00000X	Residential Treatment Facilities	Psychiatric Residential Treatment Facility		*Z742*	*Need for assistance at home and no other household member able to render care*
324500000X	Residential Treatment Facilities	Substance Abuse Rehabilitation Facility		*Z748*	*Other problems related to care provider dependency*
3245S0500X	Residential Treatment Facilities	Substance Abuse Rehabilitation Facility		*Z749*	*Problem related to care provider dependency, unspecified*
385H00000X	Respite Care Facility	Respite Care		*Z753*	*Unavailability and inaccessibility of health-care facilities*
385HR2050X	Respite Care Facility	Respite Care	Respite Care Camp	*Z590*	*Homelessness*
385HR2055X	Respite Care Facility	Respite Care	Respite Care, Mental Illness, Child	*Z591*	*Inadequate housing*
385HR2060X	Respite Care Facility	Respite Care	Respite Care, Mental Retardation and/or Developmental Disabilities, Child	*Z592*	*Discord with neighbors, lodgers and landlord*
385HR2065X	Respite Care Facility	Respite Care	Respite Care, Physical Disabilities, Child	*Z593*	*Problems related to living in residential institution*
253Z00000X	Agencies	In Home Supportive Care		*Z594*	*Lack of adequate food and safe drinking water*
				Z595	*Extreme poverty*
				Z596	*Low income*
				Z597	*Insufficient social insurance and welfare support*
				Z598	*Other problems related to housing and economic circumstances*

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
				Z599	Problem related to housing and economic circumstances, unspecified
				Z029	Encounter for administrative examinations, unspecified
				Z750	Medical services not available in home
				Z751	Person awaiting admission to adequate facility elsewhere
				Z752	Other waiting period for investigation and treatment
				Z753	Unavailability and inaccessibility of health-care facilities
				Z754	Unavailability and inaccessibility of other helping agencies
				Z758	Other problems related to medical facilities and other health care
				Z759	Unspecified problem related to medical facilities and other health care
Counselor					
101Y00000X	Behavioral Health & Social Service Providers	Counselor		Z550	Illiteracy and low-level literacy
101YM0800X	Behavioral Health & Social Service Providers	Counselor	Mental Health	Z551	Schooling unavailable and unattainable
101YP2500X	Behavioral Health & Social Service Providers	Counselor	Professional	Z552	Failed school examinations
101YS0200X	Behavioral Health & Social Service Providers	Counselor	School	Z553	Underachievement in school
				Z554	Educational maladjustment and discord with teachers and classmates
				Z558	Other problems related to education and literacy
				Z559	Problems related to education and literacy, unspecified
				Z593	Problems related to living in residential institution
				Z597	Insufficient social insurance and welfare support
				Z600	Problems of adjustment to life-cycle transitions
				Z602	Problems related to living alone
				Z603	Acculturation difficulty
				Z604	Social exclusion and rejection
				Z605	Target of (perceived) adverse discrimination and persecution
				Z608	Other problems related to social environment
				Z609	Problem related to social environment, unspecified
				Z640	Problems related to unwanted pregnancy
				Z641	Problems related to multiparity
				Z644	Discord with counselors
				Z652	Problems related to release from prison
				Z653	Problems related to other legal circumstances
				Z654	Victim of crime and terrorism
				Z655	Exposure to disaster, war and other hostilities
				Z658	Other specified problems related to psychosocial circumstances
				Z659	Problem related to unspecified psychosocial circumstances
				Z029	Encounter for administrative examinations, unspecified
				Z730	Burn-out
				Z7289	Other problems related to lifestyle
				Z731	Type A behavior pattern
				Z732	Lack of relaxation and leisure
				Z733	Stress, not elsewhere classified

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
				Z734	Inadequate social skills, not elsewhere classified
				Z735	Social role conflict, not elsewhere classified
				Z736	Limitation of activities due to disability
				Z7389	Other problems related to life management difficulty
				Z739	Problem related to life management difficulty, unspecified
				Z710	Person encountering health services to consult on behalf of another person
				Z711	Person with feared health complaint in whom no diagnosis is made
				Z712	Person consulting for explanation of examination or test findings
				Z7141	Alcohol abuse counseling and surveillance of alcoholic
				Z7142	Counseling for family member of alcoholic
				Z7151	Drug abuse counseling and surveillance of drug abuser
				Z7152	Counseling for family member of drug abuser
				Z716	Tobacco abuse counseling
				Z717	Human immunodeficiency virus [HIV] counseling
				Z7189	Other specified counseling
				Z719	Counseling, unspecified
				F819	Developmental disorder of scholastic skills, unspecified
				F89	Unspecified disorder of psychological development
Counselor [Pastoral]					
101YP1600X	Behavioral Health & Social Service Providers	Counselor	Pastoral	Z7181	Spiritual or religious counseling
Counselor [Marriage]					
106H00000X	Behavioral Health & Social Service Providers	Marriage & Family Therapist		F910	Conduct disorder confined to family context
				Y07499	Other family member, perpetrator of maltreatment and neglect
				Z6331	Absence of family member due to military deployment
				Z6332	Other absence of family member
				Z634	Disappearance and death of family member
				Z635	Disruption of family by separation and divorce
				Z6379	Other stressful life events affecting family and household
				Z029	Encounter for administrative examinations, unspecified
				Z7142	Counseling for family member of alcoholic
				Z7152	Counseling for family member of drug abuser
Social Worker					
104100000X	Behavioral Health & Social Service Providers	Social Worker		Z750	Medical services not available in home
1041C0700X	Behavioral Health & Social Service Providers	Social Worker	Clinical	Z751	Person awaiting admission to adequate facility elsewhere

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
1041S0200X	Behavioral Health & Social Service Provider	Social Worker	School	Z752	*Other waiting period for investigation and treatment*
				Z753	*Unavailability and inaccessibility of health-care facilities*
				Z754	*Unavailability and inaccessibility of other helping agencies*
				Z758	*Other problems related to medical facilities and other health care*
				Z759	*Unspecified problem related to medical facilities and other health care*
				Z602	*Problems related to living alone*
				Z608	*Other problems related to social environment*
				Z609	*Problem related to social environment, unspecified*
				Z029	*Encounter for administrative examinations, unspecified*
				Z736	*Limitation of activities due to disability*
				Z7389	*Other problems related to life management difficulty*
				Z739	*Problem related to life management difficulty, unspecified*
				Z651	*Imprisonment and other incarceration*
				Z652	*Problems related to release from prison*
				Z653	*Problems related to other legal circumstances*
				Z7289	*Other problems related to lifestyle*
Other Behavioral Health Support					
103K00000X	Behavioral Health & Social Service Providers	Behavioral Analyst		Z558	*Other problems related to education and literacy*
251S00000X	Agencies	Community/Behavioral Health		Z559	*Problems related to education and literacy, unspecified*
				Z593	*Problems related to living in residential institution*
				Z600	*Problems of adjustment to life-cycle transitions*
				Z603	*Acculturation difficulty*
				Z604	*Social exclusion and rejection*
				Z605	*Target of (perceived) adverse discrimination and persecution*
				Z640	*Problems related to unwanted pregnancy*
				Z644	*Discord with counselors*
				Z650	*Conviction in civil and criminal proceedings without imprisonment*
				Z651	*Imprisonment and other incarceration*
				Z652	*Problems related to release from prison*
				Z653	*Problems related to other legal circumstances*
				Z654	*Victim of crime and terrorism*
				Z655	*Exposure to disaster, war and other hostilities*
				Z69010	*Encounter for mental health services for victim of parental child abuse*
				Z69011	*Encounter for mental health services for perpetrator of parental child abuse*
				Z69020	*Encounter for mental health services for victim of non-parental child abuse*
				Z69021	*Encounter for mental health services for perpetrator of non-parental child abuse*
				Z6911	*Encounter for mental health services for victim of spousal or partner abuse*
				Z6912	*Encounter for mental health services for perpetrator of spousal or partner abuse*

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
				Z6981	Encounter for mental health services for victim of other abuse
				Z6982	Encounter for mental health services for perpetrator of other abuse
				Z029	Encounter for administrative examinations, unspecified
				Z730	Burn-out
				Z72810	Child and adolescent antisocial behavior
				Z72811	Adult antisocial behavior
				Z7289	Other problems related to lifestyle
				Z731	Type A behavior pattern
				Z732	Lack of relaxation and leisure
				Z733	Stress, not elsewhere classified
				Z734	Inadequate social skills, not elsewhere classified
				F819	Developmental disorder of scholastic skills, unspecified
				F89	Unspecified disorder of psychological development
Community Health Worker					
172V00000X	Other Service Providers	Community Health Worker		Z418	Encounter for other procedures for purposes other than remedying health state
				R69	Illness, unspecified
				Z558	Other problems related to education and literacy
				Z559	Problems related to education and literacy, unspecified
				F819	Developmental disorder of scholastic skills, unspecified
				F89	Unspecified disorder of psychological development
Health Educator					
174H00000X	Other Service Providers	Health Educator		Z418	Encounter for other procedures for purposes other than remedying health state
				R69	Illness, unspecified
				Z029	Encounter for administrative examinations, unspecified
				Z558	Other problems related to education and literacy
				Z559	Problems related to education and literacy, unspecified
				F819	Developmental disorder of scholastic skills, unspecified
				F89	Unspecified disorder of psychological development
Care Coordination					
171M00000X	Other Service Providers	Case Manager/Care Coordinator		Z741	Need for assistance with personal care
				Z742	Need for assistance at home and no other household member able to render care
				R6889	Other general symptoms and signs
				R69	Illness, unspecified
				Z418	Encounter for other procedures for purposes other than remedying health state
				T148	Other injury of unspecified body region

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
				T1490	Injury, unspecified
				Z029	Encounter for administrative examinations, unspecified
				Z753	Unavailability and inaccessibility of health-care facilities
Interpreter					
171R00000X	Other Service Providers	Interpreter		Z418	Encounter for other procedures for purposes other than remedying health state
				Z029	Encounter for administrative examinations, unspecified

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
Other Therapists					
102X00000X	Behavioral Health & Social Service Providers	Poetry Therapist		Z732	*Lack of relaxation and leisure*
221700000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Art Therapist		Z733	*Stress, not elsewhere classified*
222Q00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Developmental Therapist		Z730	*Burn-out*
225600000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Dance Therapist		F819	*Developmental disorder of scholastic skills, unspecified*
225700000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Massage Therapist		F89	*Unspecified disorder of psychological development*
225800000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Recreation Therapist			
225A00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Music Therapist			
Contractor					
171W00000X	Other Service Providers	Contractor		Z591	*Inadequate housing*
171WH0202X	Other Service Providers	Contractor	Home Modifications	Z9989	*Dependence on other enabling machines and devices*
171WV0202X	Other Service Providers	Contractor	Vehicle Modifications	Z993	*Dependence on wheelchair*
				Z736	*Limitation of activities due to disability*
				Z7401	*Bed confinement status*
				Z7409	*Other reduced mobility*
				Z418	*Encounter for other procedures for purposes other than remedying health state*
				Z590	*Homelessness*
				Z992	*Dependence on renal dialysis*
				Z9981	*Dependence on supplemental oxygen*

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
Rehabilitation Support					
225C00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Rehabilitation Counselor		*Z7409*	*Other reduced mobility*
225CA2400X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Rehabilitation Counselor	Assistive Technology Practitioner	*Z741*	*Need for assistance with personal care*
225CA2500X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Rehabilitation Counselor	Assistive Technology Supplier	*Z736*	*Limitation of activities due to disability*
225CX0006X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Rehabilitation Counselor	Orientation and Mobility Training Provider	*Y701*	*Therapeutic (nonsurgical) and rehabilitative anesthesiology devices associated with adverse incidents*
				Y711	*Therapeutic (nonsurgical) and rehabilitative cardiovascular devices associated with adverse incidents*
				Y721	*Therapeutic (nonsurgical) and rehabilitative otorhinolaryngological devices associated with adverse incidents*
				Y731	*Therapeutic (nonsurgical) and rehabilitative gastroenterology and urology devices associated with adverse incidents*
				Y741	*Therapeutic (nonsurgical) and rehabilitative general hospital and personal-use devices associated with adverse incidents*
				Y751	*Therapeutic (nonsurgical) and rehabilitative neurological devices associated with adverse incidents*
				Y761	*Therapeutic (nonsurgical) and rehabilitative obstetric and gynecological devices associated with adverse incidents*
				Y771	*Therapeutic (nonsurgical) and rehabilitative ophthalmic devices associated with adverse incidents*
				Y781	*Therapeutic (nonsurgical) and rehabilitative radiological devices associated with adverse incidents*
				Y791	*Therapeutic (nonsurgical) and rehabilitative orthopedic devices associated with adverse incidents*
				Y801	*Therapeutic (nonsurgical) and rehabilitative physical medicine devices associated with adverse incidents*
				Y811	*Therapeutic (nonsurgical) and rehabilitative general- and plastic-surgery devices associated with adverse incidents*
				Z742	*Need for assistance at home and no other household member able to render care*
				Z753	*Unavailability and inaccessibility of health-care facilities*
				Z754	*Unavailability and inaccessibility of other helping agencies*
				F819	*Developmental disorder of scholastic skills, unspecified*
				F89	*Unspecified disorder of psychological development*
Orthotics and Prosthetics					
222Z00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Orthotist		*Z44001*	*Encounter for fitting and adjustment of unspecified right artificial arm*

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
224P00000X	Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Prosthetist		Z44002	Encounter for fitting and adjustment of unspecified left artificial arm
				Z44009	Encounter for fitting and adjustment of unspecified artificial arm, unspecified arm
				Z44011	Encounter for fitting and adjustment of complete right artificial arm
				Z44012	Encounter for fitting and adjustment of complete left artificial arm
				Z44019	Encounter for fitting and adjustment of complete artificial arm, unspecified arm
				Z44021	Encounter for fitting and adjustment of partial artificial right arm
				Z44022	Encounter for fitting and adjustment of partial artificial left arm
				Z44029	Encounter for fitting and adjustment of partial artificial arm, unspecified arm
				Z44101	Encounter for fitting and adjustment of unspecified right artificial leg
				Z44102	Encounter for fitting and adjustment of unspecified left artificial leg
				Z44109	Encounter for fitting and adjustment of unspecified artificial leg, unspecified leg
				Z44111	Encounter for fitting and adjustment of complete right artificial leg
				Z44112	Encounter for fitting and adjustment of complete left artificial leg
				Z44119	Encounter for fitting and adjustment of complete artificial leg, unspecified leg
				Z44121	Encounter for fitting and adjustment of partial artificial right leg
				Z44122	Encounter for fitting and adjustment of partial artificial left leg
				Z44129	Encounter for fitting and adjustment of partial artificial leg, unspecified leg
				Z448	Encounter for fitting and adjustment of other external prosthetic devices
				Z449	Encounter for fitting and adjustment of unspecified external prosthetic device
Ostomy Care					
163WX1500X	Nursing Service Providers	Registered Nurse	Ostomy Care	Z430	Encounter for attention to tracheostomy
				Z431	Encounter for attention to gastrostomy
				Z432	Encounter for attention to ileostomy
				Z433	Encounter for attention to colostomy
				Z434	Encounter for attention to other artificial openings of digestive tract
				Z435	Encounter for attention to cystostomy
				Z436	Encounter for attention to other artificial openings of urinary tract
				Z437	Encounter for attention to artificial vagina
				Z438	Encounter for attention to other artificial openings
				Z439	Encounter for attention to unspecified artificial opening
Speech and Hearing Support					
231H00000X	Speech, Language and Hearing Service Providers	Audiologist		F804	Speech and language development delay due to hearing loss

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
231HA2400X	Speech, Language and Hearing Service Providers	Audiologist	Assistive Technology Practitioner	F8089	Other developmental disorders of speech and language
231HA2500X	Speech, Language and Hearing Service Providers	Audiologist	Assistive Technology Supplier	F809	Developmental disorder of speech and language, unspecified
235500000X	Speech, Language and Hearing Service Providers	Specialist/Technologist		H900	Conductive hearing loss, bilateral
2355A2700X	Speech, Language and Hearing Service Providers	Specialist/Technologist	Audiology Assistant	H9011	Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
2355S0801X	Speech, Language and Hearing Service Providers	Specialist/Technologist	Speech-Language Assistant	H9012	Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
235Z00000X	Speech, Language and Hearing Service Providers	Speech-Language Pathologist		H902	Conductive hearing loss, unspecified
237600000X	Speech, Language and Hearing Service Providers	Audiologist-Hearing Aid Fitter		H903	Sensorineural hearing loss, bilateral
237700000X	Speech, Language and Hearing Service Providers	Hearing Instrument Specialist		H9041	Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
332S00000X	Suppliers	Hearing Aid Equipment		H9042	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
				H905	Unspecified sensorineural hearing loss
				H906	Mixed conductive and sensorineural hearing loss, bilateral
				H9071	Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
				H9072	Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
				H908	Mixed conductive and sensorineural hearing loss, unspecified
				H9101	Ototoxic hearing loss, right ear
				H9102	Ototoxic hearing loss, left ear
				H9103	Ototoxic hearing loss, bilateral
				H9109	Ototoxic hearing loss, unspecified ear
				H9120	Sudden idiopathic hearing loss, unspecified ear
				H9121	Sudden idiopathic hearing loss, right ear
				H9122	Sudden idiopathic hearing loss, left ear
				H9123	Sudden idiopathic hearing loss, bilateral
				H918X1	Other specified hearing loss, right ear
				H918X2	Other specified hearing loss, left ear
				H918X3	Other specified hearing loss, bilateral
				H918X9	Other specified hearing loss, unspecified ear
				H9190	Unspecified hearing loss, unspecified ear
				H9191	Unspecified hearing loss, right ear
				H9192	Unspecified hearing loss, left ear
				H9193	Unspecified hearing loss, bilateral
				I69028	Other speech and language deficits following nontraumatic subarachnoid hemorrhage

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
				I69128	Other speech and language deficits following nontraumatic intracerebral hemorrhage
				I69228	Other speech and language deficits following other nontraumatic intracranial hemorrhage
				I69328	Other speech and language deficits following cerebral infarction
				I69828	Other speech and language deficits following other cerebrovascular disease
				I69928	Other speech and language deficits following unspecified cerebrovascular disease
				Q169	Congenital malformation of ear causing impairment of hearing, unspecified
				R4781	Slurred speech
				R4789	Other speech disturbances
				R479	Unspecified speech disturbances
				Z0110	Encounter for examination of ears and hearing without abnormal findings
				Z01110	Encounter for hearing examination following failed hearing screening
				Z01118	Encounter for examination of ears and hearing with other abnormal findings
				Z0112	Encounter for hearing conservation and treatment
				Z45328	Encounter for adjustment and management of other implanted hearing device
				Z461	Encounter for fitting and adjustment of hearing aid
				Z9620	Presence of otological and audiological implant, unspecified
				Z9629	Presence of other otological and audiological implants
				Z822	Family history of deafness and hearing loss
				Z974	Presence of external hearing-aid
				F819	Developmental disorder of scholastic skills, unspecified
				F89	Unspecified disorder of psychological development
Dietary					
132700000X	Dietary & Nutritional Service Providers	Dietary Manager		D513	Other dietary vitamin B12 deficiency anemia
133N00000X	Dietary & Nutritional Service Providers	Nutritionist		D520	Dietary folate deficiency anemia
133NN1002X	Dietary & Nutritional Service Providers	Nutritionist	Nutrition, Education	D538	Other specified nutritional anemias
133V00000X	Dietary & Nutritional Service Providers	Dietitian, Registered		D539	Nutritional anemia, unspecified
133VN1004X	Dietary & Nutritional Service Providers	Dietitian, Registered	Nutrition, Pediatric	E41	Nutritional marasmus
133VN1005X	Dietary & Nutritional Service Providers	Dietitian, Registered	Nutrition, Renal	E43	Unspecified severe protein-calorie malnutrition
133VN1006X	Dietary & Nutritional Service Providers	Dietitian, Registered	Nutrition, Metabolic	E440	Moderate protein-calorie malnutrition
136A00000X	Dietary & Nutritional Service Providers	Dietetic Technician, Registered		E441	Mild protein-calorie malnutrition
				E45	Retarded development following protein-calorie malnutrition
				E46	Unspecified protein-calorie malnutrition
				E58	Dietary calcium deficiency
				E59	Dietary selenium deficiency
				E60	Dietary zinc deficiency
				E638	Other specified nutritional deficiencies
				E639	Nutritional deficiency, unspecified

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
				E640	Sequelae of protein-calorie malnutrition
				E648	Sequelae of other nutritional deficiencies
				E649	Sequelae of unspecified nutritional deficiency
				F5002	Anorexia nervosa, binge eating/purging type
				F508	Other eating disorders
				F509	Eating disorder, unspecified
				J305	Allergic rhinitis due to food
				K522	Allergic and dietetic gastroenteritis and colitis
				L236	Allergic contact dermatitis due to food in contact with the skin
				L237	Allergic contact dermatitis due to plants, except food
				M833	Adult osteomalacia due to malnutrition
				O2510	Malnutrition in pregnancy, unspecified trimester
				O2511	Malnutrition in pregnancy, first trimester
				O2512	Malnutrition in pregnancy, second trimester
				O2513	Malnutrition in pregnancy, third trimester
				O252	Malnutrition in childbirth
				O253	Malnutrition in the puerperium
				R638	Other symptoms and signs concerning food and fluid intake
				Z713	Dietary counseling and surveillance
				Z1321	Encounter for screening for nutritional disorder
				Z724	Inappropriate diet and eating habits
				Z91013	Allergy to seafood
				Z91018	Allergy to other foods
				Z9102	Food additives allergy status
				Z8349	Family history of other endocrine, nutritional and metabolic diseases
				Z8639	Personal history of other endocrine, nutritional and metabolic disease
				Z9111	Patient's noncompliance with dietary regimen
				Z736	Limitation of activities due to disability
Home Health Support					
372500000X	Nursing Service Related Providers	Chore Provider		Z755	Holiday relief care
372600000X	Nursing Service Related Providers	Adult Companion		Z741	Need for assistance with personal care
373H00000X	Nursing Service Related Providers	Day Training/Habilitation Specialist		Z7401	Bed confinement status
374700000X	Nursing Service Related Providers	Technician		Z7409	Other reduced mobility
3747A0650X	Nursing Service Related Providers	Technician	Attendant Care Provider	Z742	Need for assistance at home and no other household member able to render care
3747P1801X	Nursing Service Related Providers	Technician	Personal Care Attendant	Z743	Need for continuous supervision
374J00000X	Nursing Service Related Providers	Doula		Z748	Other problems related to care provider dependency
374K00000X	Nursing Service Related Providers	Religious Nonmedical Practitioner		Z749	Problem related to care provider dependency, unspecified
374T00000X	Nursing Service Related Providers	Religious Nonmedical Nursing Personnel		Z753	Unavailability and inaccessibility of health-care facilities
374U00000X	Nursing Service Related Providers	Home Health Aide		Z590	Homelessness
376G00000X	Nursing Service Related Providers	Nursing Home Administrator		Z591	Inadequate housing

Taxonomy Codes	Provider Type	Classification	Specialty	ICD-10	Code Description
376J00000X	Nursing Service Related Providers	Homemaker		Z750	Medical services not available in home
376K00000X	Nursing Service Related Providers	Nurse's Aide		Z751	Person awaiting admission to adequate facility elsewhere
332U00000X	Suppliers	Home Delivered Meals		Z752	Other waiting period for investigation and treatment
				Z753	Unavailability and inaccessibility of health-care facilities
				Z754	Unavailability and inaccessibility of other helping agencies
				Z758	Other problems related to medical facilities and other health care
				Z759	Unspecified problem related to medical facilities and other health care
Home Health Support					
173F00000X	Other Service Providers	Sleep Specialist, PhD		F5112	Insufficient sleep syndrome
				F513	Sleepwalking [somnambulism]
				F514	Sleep terrors [night terrors]
				F518	Other sleep disorders not due to a substance or known physiological condition
				F519	Sleep disorder not due to a substance or known physiological condition, unspecified
				G4711	Idiopathic hypersomnia with long sleep time
				G4712	Idiopathic hypersomnia without long sleep time
				G4720	Circadian rhythm sleep disorder, unspecified type
				G4721	Circadian rhythm sleep disorder, delayed sleep phase type
				G4722	Circadian rhythm sleep disorder, advanced sleep phase type
				G4723	Circadian rhythm sleep disorder, irregular sleep wake type
				G4724	Circadian rhythm sleep disorder, free running type
				G4725	Circadian rhythm sleep disorder, jet lag type
				G4726	Circadian rhythm sleep disorder, shift work type
				G4727	Circadian rhythm sleep disorder in conditions classified elsewhere
				G4729	Other circadian rhythm sleep disorder
				G4730	Sleep apnea, unspecified
				G4731	Primary central sleep apnea
				G4733	Obstructive sleep apnea (adult) (pediatric)
				G4734	Idiopathic sleep related nonobstructive alveolar hypoventilation
				G4736	Sleep related hypoventilation in conditions classified elsewhere
				G4737	Central sleep apnea in conditions classified elsewhere
				G4739	Other sleep apnea
				G4752	REM sleep behavior disorder
				G4753	Recurrent isolated sleep paralysis
				G4762	Sleep related leg cramps
				G4763	Sleep related bruxism
				G4769	Other sleep related movement disorders
				G478	Other sleep disorders
				G479	Sleep disorder, unspecified
				P283	Primary sleep apnea of newborn
				Z72820	Sleep deprivation

Taxonomy Codes	Provider Type	Classification	Specialty	*ICD-10*	*Code Description*
				Z72821	*Inadequate sleep hygiene*
				Z73810	*Behavioral insomnia of childhood, sleep-onset association type*