



**AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)**

**Thursday, May 12, 2016**

**9:00 a.m. to 12:00 a.m.**

**Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1<sup>st</sup> 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](mailto:deb.a.sorg@healthpartners.com)
- **Membership request and/or updates:**  
Deb Sorg [deb.a.sorg@healthpartners.com](mailto:deb.a.sorg@healthpartners.com)

**2. Review of Antitrust Statement**

**3. Review of last meeting’s minutes – April 14, 2016**

**4. AUC Coding Recommendation Table Review**

2/11/16: No discussion of this agenda item due to time constraints	<b>OPEN</b>
2/23/16, 3/10/16 No discussion due to time constraints	<b>OPEN</b>
4/14/16: The table will be updated. Waiting for Ops approval.	<b>OPEN</b>

**5. 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.	<b>OPEN</b>
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.	<b>OPEN –</b> questions, suggestions scenarios are requested for review

<p>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.</p>	<p><b>OPEN</b></p>			
<p>12/10/15: Who bills: <b>The distant site (see diagram below) bills. They must use the dental codes in the SBAR (section R) and the U9 modifier.</b> (The distant site may or may not have a purchase of service agreement with the originating site, but that does not affect who bills.) For final version of SBAR response – define the terms “distant site” and “originating site” (see Medicare defines as example). Note that the recommendation will be to include the coding tele-dentistry coding requirements in the 837D companion guide – include a section re. tele-dentistry with the rule above in the companion guide. (Need clarification – need to ask DHS what happens if the originating site provider is different than the distant site provider.) Decision:</p> <table border="1" data-bbox="203 688 1045 814"> <tr> <td data-bbox="203 688 487 814"> <p>A. Distant site (billing clinic) – this is the site doing the diagnosing</p> </td> <td data-bbox="487 688 766 814"> <p style="text-align: center;">←————→ The originating site sends data back (live, or store and forward)</p> </td> <td data-bbox="766 688 1045 814"> <p>B. Originating site(nursing home, etc.) – where the patient is</p> </td> </tr> </table> <p>Question: When is a service teledentistry vs. referral?</p>	<p>A. Distant site (billing clinic) – this is the site doing the diagnosing</p>	<p style="text-align: center;">←————→ The originating site sends data back (live, or store and forward)</p>	<p>B. Originating site(nursing home, etc.) – where the patient is</p>	<p><b>OPEN</b></p>
<p>A. Distant site (billing clinic) – this is the site doing the diagnosing</p>	<p style="text-align: center;">←————→ The originating site sends data back (live, or store and forward)</p>	<p>B. Originating site(nursing home, etc.) – where the patient is</p>		
<p>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.</p>	<p><b>OPEN</b></p>			
<p>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, “<i>For MHCP recipient limitations refer to Department of Human Services MHCP Provider Manual.</i>” 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: <b>Q. When is a service teledentistry vs. referral?</b> A. <i>It is a referral when the distant site makes a referral.</i> <b>Q. Will completion of an attestation form be required for teledentistry as it is for telemedicine?</b> A. <i>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.</i> <b>Q. What happens if the originating site provider is different than the site provider?</b> 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.</p>	<p><b>OPEN</b> Verify effective date and applicability of teledentistry statutes for commercial health plans. Review and approval of the draft 837D companion guide.</p>			
<p>2/23/16 Judy reported that changes agreed upon at last meeting was incorporated into the draft and forwarded to the Minnesota Dental</p>	<p><b>OPEN</b></p>			

Association for their review and feedback. No further discussion due to time constraints	
3/10/16 No discussion due to time constraints.	OPEN
4/14/16: A summary of responses will be done.	OPEN

## 6. SBAR - CHW Universal Modifier - Will Wilson, DHS

4/14/16: CHW is a Community Health Worker. The request deals with identifying health equity for services rendered. A CHW is specifically trained to identify and deal with health equity. They provide outreach, education, care coordination, coaching, and referrals to needed services. Their services may be provided in the community, home or where employed. The scope is noted in legislation for MN Medical Assistance (MA). There are 650 CHW certified practitioners in MN. We are not capturing their involvement. There were about \$4000.00 in services billed to MA. Looking for a modifier for CHW services with the intent to measure their effectiveness. Because they are not acting as the primary provider but working under direction of primary provider a Category II code was identified. This request is identify the CHW involvement – not to bill a reimbursable service. In order to make this a uniquely identifiable service for reporting purposes, Kathy Sijan recommended code 4450F (Self-care education provided to patient (HF)) with the U7 modifier. MA will add a new definition to U7 specifically when used with 4450F. Proposed coding would be: 837I TOB-131; Revenue Code – 0969; HCPCS-4450F-U7 837P HCPCS-4450F-U7	OPEN
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## 7. Community Emergency Medical Technician Services – Shawnet Healy, DHS

4/14/16: Shawnet Healy presented information on an upcoming SBAR. She will build an SBAR for review. The legislated effective date is expected to be 1/1/2017. The service starts with a request from the primary practitioner to the EMT. The EMT visits the patient's home to check on/assess the patient including performing minor vitals. These services by the EMT has been shown to reduce patient readmissions. The billing would be done the same as the Community Paramedic; however, the EMT has a higher scope of practice. The anticipated code would be T1028.	OPEN
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## 8. 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
4/14/16: Judy Edwards if developing a template for responses. Judy will be identifying the outstanding SBARs.	OPEN

## 9. Additional Agenda Items/ Announcements

- Next regularly scheduled meeting: June 9, 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, April 14, 2016, 9:00 a.m. to 12:00 a.m.**  
**Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1<sup>st</sup> floor**

**Minutes By:** Judy Edwards and Faith Bauer

DRAFT

Agenda Item	Discussion	Action/Next Steps
<b>1. Welcome and Introduction</b> a. Attendance tracking: Deb Sorg <a href="mailto:deb.a.sorg@healthpartners.com">deb.a.sorg@healthpartners.com</a> b. Membership request and/or updates: Deb Sorg <a href="mailto:deb.a.sorg@healthpartners.com">deb.a.sorg@healthpartners.com</a>	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
<b>2. Review of Antitrust Statement</b>	Faith read anti-trust statement.	No discussion
<b>3. Review of last meeting's minutes – March 10, 2016</b>	Minutes approved with one correction. Page 3, #11, under Action/Next Steps, delete the comment "TAG members are to determine if their organization uses S9840 and for what services."	CLOSED
<b>4. Companion Guide Comment(s) Review</b>	Ten e-mail votes were received and all approved the 837P and 837I guides. A few minor corrections were noted and discussed at today's meeting.  Per DHS, the MAT tracking code will be taken out for now.  The guides are subject to Ops approval. Depending on approval date the guides may be published in the state register at the end of May with enforcement by the end of June.	CLOSED To Ops for approval
<b>5. SBAR – ADDENDUM – CFSS Community First Services and Supports - Increase – Kathy Sijan, DHS</b>	The SBAR will be pulled back at this time.	CLOSED
<b>6. AUC Coding Recommendation Table Review</b>	The table will be updated. Waiting for Ops approval.	OPEN
<b>7. Teledentistry – Kathy Sijan</b>	A summary of responses will be done.	OPEN
<b>8. SBAR - CHW Universal Modifier - Will Wilson, DHS</b>	CHW is a Community Health Worker. The request deals with identifying health equity for services rendered. A CHW is specifically trained to identify and deal with health equity. They provide outreach, education, care coordination, coaching, and referrals to needed services. Their services may be provided in the community, home or where employed. The scope is noted in legislation for MN Medical Assistance (MA).	OPEN

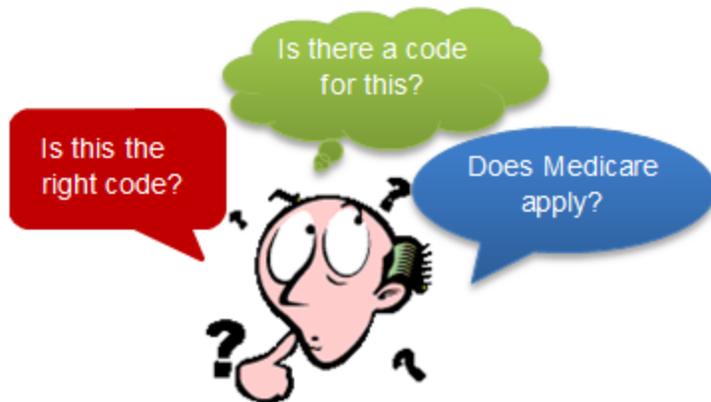
	<p>There are 650 CHW certified practitioners in MN.  We are not capturing their involvement. There were about \$4000.00 in services billed to MA.  Looking for a modifier for CHW services with the intent to measure their effectiveness.  Because they are not acting as the primary provider but working under direction of primary provider a Category II code was identified. This request is identify the CHW involvement – not to bill a reimbursable service.  In order to make this a uniquely identifiable service for reporting purposes, Kathy Sijan recommended code 4450F (Self-care education provided to patient (HF)) with the U7 modifier. MA will add a new definition to U7 specifically when used with 4450F. Proposed coding would be:  837I  TOB-131; Revenue Code – 0969; HCPCS-4450F-U7  837P  HCPCS-4450F-U7</p>	
<p><b>9. Community Emergency Medical Technician Services – Shawnet Healy, DHS</b></p>	<p>Shawnet Healy presented information on an upcoming SBAR. She will build an SBAR for review. The legislated effective date is expected to be 1/1/2017.  The service starts with a request from the primary practitioner to the EMT.  The EMT visits the patient’s home to check on/assess the patient including performing minor vitals.  These services by the EMT has been shown to reduce patient readmissions.  The billing would be done the same as the Community Paramedic; however, the EMT has a higher scope of practice. The anticipated code would be T1028.</p>	<p>OPEN</p>
<p><b>10. Miscellaneous - SBAR Review</b></p>	<p>Judy Edwards is developing a template for responses. Judy will be identifying the outstanding SBARs.</p>	<p>OPEN</p>
<p><b>11. Additional Agenda Items/ Announcements</b></p>	<ul style="list-style-type: none"> <li>• Next regularly scheduled meeting: May 12, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170</li> <li>• Carolyn Larson announced the state AAPC conference. The dates will be November 10 and 11 at the Ramada Plaza, 1330 Industrial Blvd NE, Minneapolis. Registration is \$250.00 by August 31. If five people register from the same establishment there is five for</li> </ul>	<p>CLOSED</p>

	<p>\$200.00 each participant.</p> <ul style="list-style-type: none"><li>• Kathy Sijan noted that there are two upcoming issues – children’s inpatient psych services and certified community behavioral health clinics.</li></ul>	
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**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<sup>1</sup> – 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

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<sup>1</sup> 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, 837 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			Coding topic	AUC Approval Date
Chapter No.	Chapter/Description Title	P	I	D		
12	Physician/Nonphysician Practitioner Billing				<a href="#">Alternate Care Site Billing</a>	April 1, 2013
12	Physician/Nonphysician Practitioner Billing	X			<a href="#">Autism Spectrum Disorder</a>	October 20, 2009
					<a href="#">Behavior Health Home</a>	TBD
12	Physician/Nonphysician Practitioner Billing				<a href="#">Code 69210 Bilateral Impacted Cerumen</a>	December 3, 2014
12	Physician/Nonphysician Practitioner Billing				<a href="#">Coding for SBIRT (Screening, Brief Intervention, and Referral to Treatment)</a>	May 9, 2013
12	Physician/Nonphysician Practitioner Billing	X			<a href="#">Consultation Services</a>	December 21, 2009
N/A	N/A	X	X		<a href="#">Dental Services Performed in OR</a>	February 8, 2010
N/A	N/A	X			<a href="#">Family Memory Care</a>	TBD
12	Physician/Nonphysician Practitioner Billing				<a href="#">Intensive Care Management of Obesity</a>	
12	Physician/Nonphysician Practitioner Billing				<a href="#">IONM Clarification</a>	
12	Physician/Nonphysician Practitioner Billing				<a href="#">Labor Epidural Billing</a>	May 9, 2013
12	Physician/Nonphysician Practitioner Billing				<a href="#">Modifier -25 on preventive medicine visits</a>	April 14, 2014
12	Physician/Nonphysician Practitioner Billing				<a href="#">Modifier 52</a>	
12	Physician/Nonphysician Practitioner Billing	X			<a href="#">Moving Home Minnesota – A Federal Demonstration Project</a>	June 13, 2013 July 18, 2014 December 3, 2014
12	Physician/Nonphysician Practitioner Billing				<a href="#">Partial Hospitalization POS</a>	
12	Physician/Nonphysician Practitioner Billing				<a href="#">Speech Language Pathologist VCD/PVFM</a>	
N/A	N/A			X	<a href="#">Teledentistry</a>	TBD

Table 2: Coding Recommendation Detail

<b>Alternate Site Billing</b>	
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	<u> X </u> Coding Recommendation Grid (Best practice, usage highly recommended) <u> </u> Companion Guide: <u> </u> 837 Professional <u> </u> 837 Institutional <u> </u> 837 Dental
Coding	71 Discharged/transferred to a Designated Disaster Alternative Care Site TOB 089X

<b>Autism Spectrum Disorder</b>	
MCT Minutes Reference	September 22, 2009
Background/Description	The AUC was asked how autism spectrum disorder services are to be reported.
Recommendation	
Disposition Status	<u> X </u> Coding Recommendation Grid (Best practice, usage highly recommended) <u> </u> Companion Guide: <u> </u> 837 Professional <u> </u> 837 Institutional <u> </u> 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	<p>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.</p> <p>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.</p> <p>BHH is a monthly service encompassing any or all of the following six services:</p> <ol style="list-style-type: none"> <li>1- Comprehensive Care Management</li> <li>2- Care Coordination</li> <li>3- Health Promotion Services</li> <li>4- Comprehensive Transitional Care</li> <li>5- Referral to Community and Social Support Services</li> <li>6- Individual and Family Support Services</li> </ol>
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	<p>___ Coding Recommendation Grid (Best practice, usage highly recommended)</p> <p><u> X </u> Companion Guide: <u> X </u> 837 Professional ___ 837 Institutional ___ 837 Dental</p> <p><b>Note: Recommend as proposed rule for inclusion in the 837P during next annual update of Minnesota uniform companion guides.</b></p>
Coding	<p>S0280 U5 Medical home program, comprehensive care coordination and planning, initial plan, BHH, monthly</p> <p>S0281 U5 Medical home program, comprehensive care coordination and planning, maintenance of plan, BHH, monthly</p>



**Title: Teledentistry Legislated Benefit 1-1-16**

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

Date Received: <b>April 1, 2016</b>		Log No.: <b>2016-08</b>	Date Closed
Status: Exec Review Date	Sent to TAG/WG <b>April 1, 2016</b>	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](mailto: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: <b>Teledentistry</b>	Date: <b>10-1-20154-1-16</b>
Contact Information for person completing this form: <b>Name: Katherine Sijan</b> <b>Title: HealthCare Coding Compliance Officer</b> <b>Email address: <a href="mailto:katherine.sijan@state.mn.us">katherine.sijan@state.mn.us</a></b> <b>Telephone: 651-431-5784</b>	Organization Information: <b>Name: MN Dept of Human Services</b> <b>Address: 540 Cedar St., 7<sup>th</sup> fl -0993</b> <b>St Paul, MN 55155</b>

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

**SBAR Issue Title:**

<b>S</b>	<b>SITUATION</b> – 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.

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<b>B</b>	<p><b>BACKGROUND</b> – Explain the pertinent history of the business practice (How does this work today):</p> <p>Currently Teledentistry is not part of the MA benefit today. refer to DHS Provider page: <a href="http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&amp;RevisionSelectionMethod=LatestReleased&amp;dDocName=ID_008953">http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&amp;RevisionSelectionMethod=LatestReleased&amp;dDocName=ID_008953</a></p>
<b>A</b>	<p><b>ASSESSMENT</b> – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain)</p> <p>See statute information on page 3-5</p>

# 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]

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=MNITS\\_040113](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=MNITS_040113)

This can be submitted via the MNITS interactive claim submission system:

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Procedure Code Modifier(s)  
(Loop: 2400, SV101-3, SV101-4, SV101-5, SV101-6)

This field is currently not required for the dental claim.

Description: Code (CDT modifier) that clarifies or further identifies the service indicated in the procedure code field.

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

Date [SBAR Response Approved by TAG]:  
Reviewed by [AUC TAG Name]:  
AUC Co-Chair(s):  
AUC Response:  
**Discussion/Summary:**

**Who bills:** The distant site (see diagram below) bills. They must use the dental codes in the SBAR (section R above) and the U9 modifier. (The distant site may or may not have a purchase of service agreement with the originating site, but that does not affect who bills.)

**For final version of SBAR response – define the terms “distant site” and “originating site” (see Medicare defns 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

B. Originating site (nursing home, etc.) – where the patient is

←

The originating site sends data back (live, or store and forward)

**Question: When is a service tele-dentistry vs. referral?**

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Minnesota Legislature recently expanded the coverage of Teledentistry to dental benefits effective January 1, 2016 and tasked DHS to establish a criteria for this benefit. Teledentistry, if successfully implemented in different oral health settings, has the potential to deliver improved health outcomes and positive health professional-patient experiences. This adds teledentistry to a list of specialty health care services for which face-to-face contact is not required for diagnostic services. Improved access to teledentistry may enhance early diagnosis, facilitate timely treatment of oral diseases, reduce isolation of practitioners through communication with peers and specialists, and improve access to specialist care. Teledentistry may also lead to a greater utilization of relatively low-cost preventive interventions and may result in future cost savings by avoiding more costly dental diseases and emergencies.

Clinical uses of teledentistry support a wide range of applications with benefits to patients and practitioners. A teledentistry consultation from a health professional to a dental specialist may improve diagnosis and support clinical treatment. Teledentistry may also reduce the number of inappropriate referrals by screening patients to ensure that only those who need to see a specialist are referred for the care they need. This ensures efficient use of scarce health resources, increasing access to care, improving productivity and supporting enhanced oral health across society.

To be eligible for reimbursement, providers must self-attest (form below) that they meet all of the conditions of the following MHCP teledentistry policy:

**1. Teledentistry originating site:**

- I. Healthcare facility,
- II. Long-term care facility,
- III. Public health agency or institution,
- IV. Public or private school authority,
- V. Private non-profit or charitable organizations,
- VI. Social services agency or program,
- VII. Residential setting in the presence of licensed healthcare providers.

**2. Affiliate practice or originator within MN Board of Dentistry defined scope of practice must be present at originating site:**

- I. Dentist,
- II. Advanced dental therapists,
- III. Dental therapists,
- IV. Dental hygienists,
- V. Licensed dental assistants,
- VI. Other licensed health care professionals.

**3. Considered Teledentistry technology equipment at sites may include:**

- I. A HIPAA compliant computer or tablet,
- II. Means of secure storage and transmission of patient data,

- III. Secure web-camera for video-conferencing,
- IV. Intraoral dental camera to capture images,
- V. Video-conferencing software (for example, Citrix GoToMeeting),
- VI. Sufficient bandwidth for real-time,
- VII. X-ray machine with digital sensors and digital radiograph software.

#### ***Two-way interactive video***

Involves a videoconferencing session that allows health professionals at distant locations to communicate with each other. A typical set-up involves high-definition webcams combined with hands-free microphone/speaker units so that the users can see and hear each other. For this type of consultation, both parties arrange a meeting time and information is exchanged in real-time between sites. This type requires sufficient bandwidth and HIPAA compliant software.

#### ***Store and forward***

Communication is asynchronous including - video clips, photographs and scans, storing them in a file and sent to the dentist. The dentist retrieves the file at a time of their convenience and examines the contents. Recommendations are provided to the oral health professional in the same manner, within 7 calendar days of the time of information gathering.

#### **Documentation requirements:**

1. The type of service provided by Teledentistry ,
  2. The time the service began and the time the service ended, including an a.m. and p.m. designation,
  3. The licensed healthcare provider's basis for determining that teledentistry is an appropriate and effective means for delivering services to the enrollee,
  4. The mode of transmission of the teledentistry service and records evidencing that a particular mode of transmission was utilized,
  5. The location of the distant site,
  6. If the claim for payment is based on a teledentistry consultation with a dentist, the written opinion from the consulting dentist providing the teledentistry consultation
  7. Compliance with the criteria attested to by the health care provider in accordance with statute,
  8. Dental provider must document verbal or written informed consent from the patient or patient's healthcare decision maker prior to delivery of care through teledentistry.
  9. All reports resulting from a teledentistry consultation are part of the patient's record.
4. **Reimbursement for teledentistry**- same rate as in person to a pay to provider
5. **Benefit sets:**  
Beginning January 1, 2016, MHCP will cover teledentistry claims for diagnostic services. The following CDT codes may be billed as part of teledentistry by enrolled MHCP providers. Coverage is limited to children, pregnant woman, and limited adult benefits as specified in [Minnesota Statutes 256B.0625](#), Subd. 9 (covered services). Teledentistry is limited to 3 services per recipient per week.

MCHP allows the following CDT codes for the following diagnostic services when performed via Teledentistry:

- D0120: Periodic oral evaluation — established patient
- 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

## Summary of Changes to Proposed 837D for AUC Ops Review and Vote

Section	Description of draft change
	<b>Changes to front matter – Section 3 How to use this document</b>
3.2.5 Claim Attachments and Notes	<p>Note regarding claims attachments for only workers’ compensation medical claims: Minnesota Statutes, Section 176.135 subd. 7a. (e) require that starting July 1, 2016</p> <ul style="list-style-type: none"> <li>• Health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge 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</li> <li>• 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 12 electronic acknowledgment for the attachment process.</li> </ul> <p>A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: <a href="https://www.revisor.mn.gov/statutes/?id=176.135">https://www.revisor.mn.gov/statutes/?id=176.135</a>.</p>
	<b>Changes to List of Appendices</b>
Section 5 List of Appendices	<p><b>Added new appendix and revised list as follows:</b></p> <ul style="list-style-type: none"> <li>• Added second sentence to Appendix A: It also provides information and instructions regarding teledentistry and eligible teledentistry codes.</li> <li>• Appendix B: Reporting MNCare Tax changed to Appendix C</li> <li>• Added new appendix “K3 Segment Usage Instructions” and description as Appendix B</li> </ul>
	<b>Changes to Appendix A: Code Set Supplemental Information for Minnesota Uniform Companion Guides</b>
Section A.1 Introduction	<p><b>Revised bullet lists in second paragraph:</b> Added third bullet: teledentistry</p>
Section A.5 Teledentistry	<p><b>Added new section titled “A.5 Teledentistry” that includes:</b></p> <ul style="list-style-type: none"> <li>• Cites Minnesota Statutes authorizing teledentistry, description of teledentistry and definitions</li> <li>• Includes a grid explaining Teledentistry Sites</li> </ul>
Section A.5.1 Minnesota Coding Specifications for Teledentistry Table	<p><b>Added new section and description for Teledentistry Table:</b> Table A.5.1 lists eligible dental codes and modifier combinations for identifying teledentistry services unique to Minnesota The table also</p>

Section	Description of draft change
	includes the definition of the U9 modifier and notes regarding non-billable services and a link to coverage limitations.
Table A.5.1	<p><b>Added new Table “A.5.1 Minnesota Coding Specifications for Teledentistry”</b></p> <ul style="list-style-type: none"> <li>• Created table of eligible ADA dental codes to be used for teledentistry services, including modifier and description for each code</li> <li>• Includes definition of the U9 modifier, note regarding non-billable services, and link to DHS website to learn about coverage limitations</li> </ul>

# AUC BUSINESS NEED EXPLANATION FORM (SBAR)

**TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH**

Date Received: <b>April 6, 2016</b>	Log No.: <b>2016-004</b>	Date Closed	
Status: Exec Review Date: <b>April 6, 2016</b>	Sent to TAG/WG: <b>April 6, 2016</b>	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](mailto: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: <b>Name: Will Wilson</b> <b>Title: Supervisor</b> <b>Email address: <a href="mailto:will.wilson@state.mn.us">will.wilson@state.mn.us</a></b> <b>Telephone: 651-201-3842</b>	Organization Information: <b>Name: MDH Office of Rural Health and Primary Care</b> <b>Address: PO Box 64882, St Paul, MN 55164-0882</b>

Complete for additional contact or Subject Matter Expert, as required:  
**Name: Joan Cleary**  
**Title: Executive Director, CHW Alliance**  
**Email address: [joanlcleary@gmail.com](mailto: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:**

<b>S</b>	<p><b>SITUATION:</b></p> <p>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.</p> <p>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.</p>
<b>B</b>	<p><b>BACKGROUND</b></p> <p>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.</p> <p>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.”</p>

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



**FIREFIGHTER HOME VISIT**



Date:	1 <sup>st</sup> Call:	Arrival:
Scheduled Time:	2 <sup>nd</sup> Call:	Clear Time:

**IF PATIENT DECLINES VISIT, NOTIFY: (952) 993-5421 OR [Tricia.Pettev@PARKNICOLLET.COM](mailto:Tricia.Pettev@PARKNICOLLET.COM)**

Name:	Address:		
Age:	Gender:	Phone:	Medical Record #:
Primary MD:	Clinic Location:		

**EVALUATION**

Temp:	BP:	HR:	RR:	SPO <sub>2</sub>	on RA
					on O <sub>2</sub>
<u>General Appearance</u>		<u>Pain</u>		<u>Respiratory</u>	
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:	<b>VISIT CHECKLIST</b>	
Department: <i>Eden Prairie Fire Department</i>	Who to call if they need assistance or clarification	
Phone:	Follow-up appointments were reviewed	
Signature:	Medications have been picked up / plan for keeping track	
Date:	Time:	Red flags have been addressed
		Smoke alarm present and working
		CO alarm present and working

<b>COMMENTS FOR TREATMENT TEAM (if needed)</b>
<i>"Medicines work best if taken while eating meals at regular times. Do you have food in your home for the next few days?"</i>
Complete this paperwork and fax back to Park Nicollet
If declined, email Tricia at <a href="mailto:Tricia.Pettev@parknicollet.com">Tricia.Pettev@parknicollet.com</a> 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:**

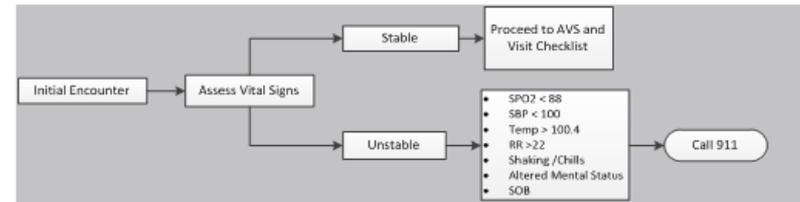
Pain If uncontrolled call Care Team

Functional status since home (bathroom, Dressing, 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
Electricity	2 Clutter (non-biodegradable items)	3 Lives alone	9 Possible (household items unsafe or improperly stored)
Running water (Potable water in home)	2 Small amounts of biodegradable waste	2 Verbal abuse / neglect	6 Probable
Temperature safe for proper health	2 Large amounts of biodegradable waste	1 Physical abuse / neglect	3 Certain
<b>Score (0-8):</b>	<b>Score (1-4):</b>	<b>Score (3-12):</b>	<b>Score (3-12):</b>



# 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

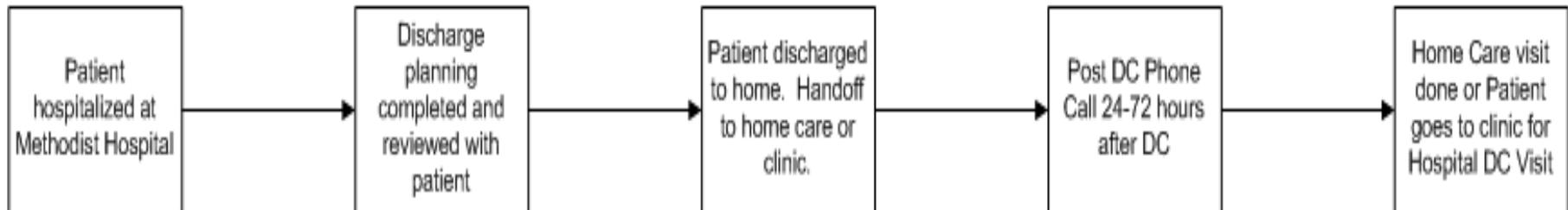
- The Changing Role of the Fire Department
  - Continued increased demand of fire resources for medical response
    - Calls could be preventable many times
  - Mandates of the Patient Protection Affordable Care Act on the roles of the fire department
  - Aligning the correct resource for the call type (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

Hospitalist, RN, SW team

Standard work for care integration team

Warm hand offs to next level of care

Post acute care partners

Medication safety  
MTM Pharmacists



Improved discharge instructions (After Visit Summary)

Post discharge phone calls

# Measuring Readmissions (a proxy for effective care coordination/transition to next level of care)

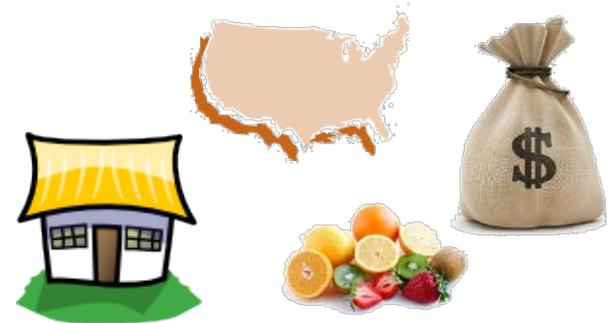
Out of the hospital's  
control:

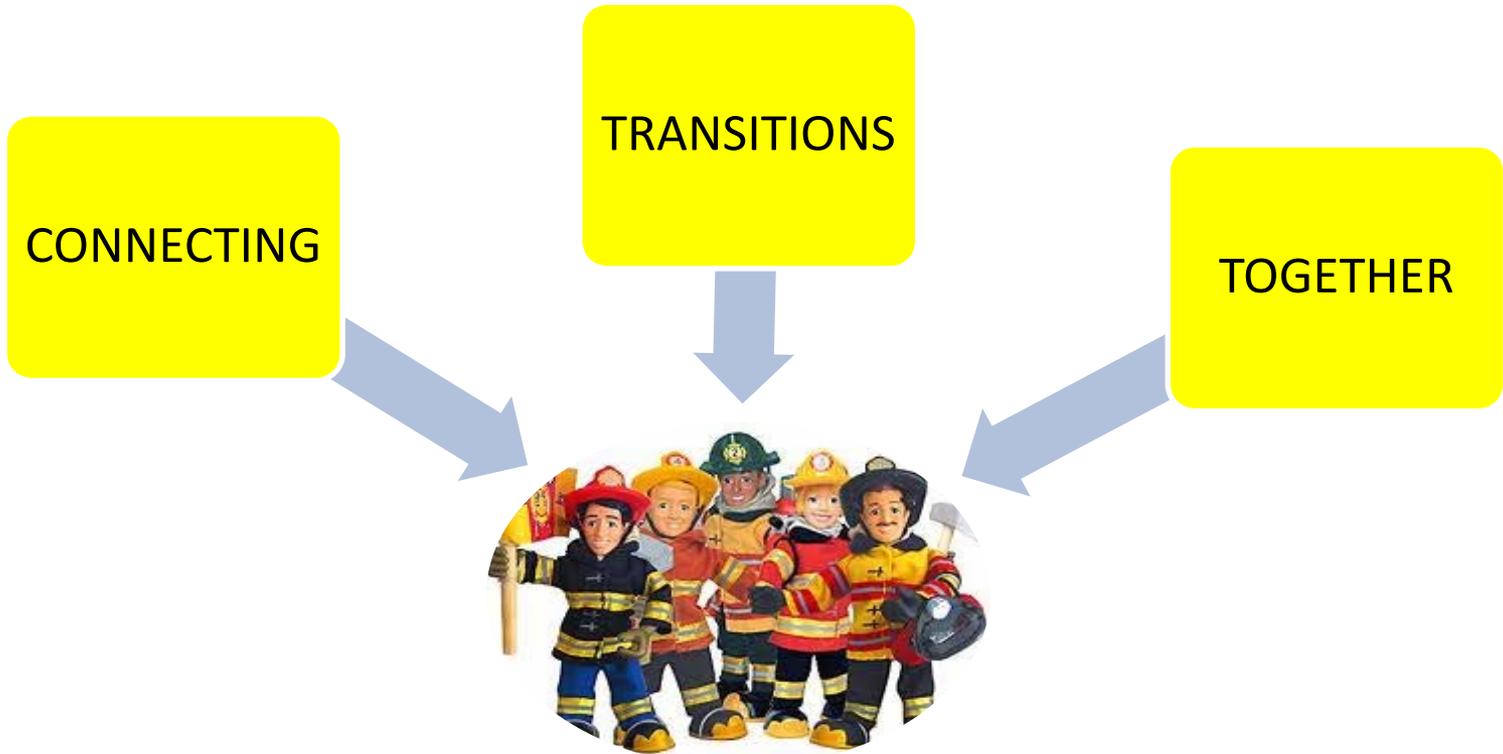
- *Patient level factors*
- *Community level factors*

CMS  
Adjusts for



—  
No  
Adjustment





Post Discharge Fire Fighter Visit

# Process Improvement Methodology Used: Kaizen

Workshop Project Form

Team # **1214** Project Name **Post Hospital Discharge Firefighter Visit** Date: **March 19, 18 and 20**  
 March 19- conduct first visits

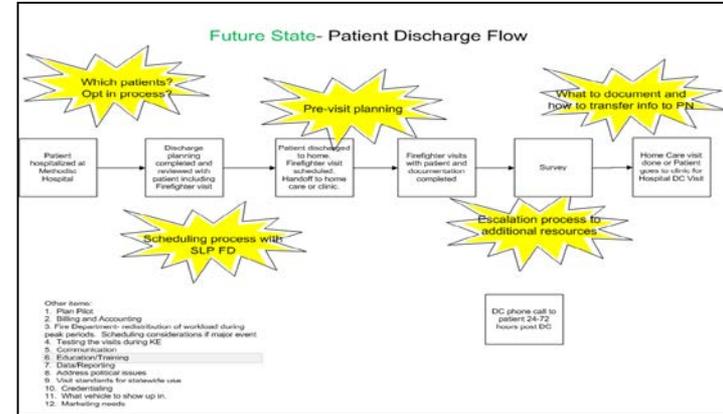
Project Description: **How do we improve the process of patient discharge planning and patient preparation for home care?**

Current Situation:

- Post Hospital has been part of the Pioneer ACO since 2011. For this, it accepted accountability for a population of Medicare Fee for Service patients. Our charge is to improve care based on the hope with quality care as a goal and positive patient experience.
- During this time, we also joined the RARE campaign. The state program's goal was to increase the number of nights that patients would be at home vs. the hospital as a result of better discharge planning and patient preparation.
- These readmission reduction programs led to a lot of changes in the way that we delivered care. Standardized care coordination/transition handoffs, Post DC phone calls 24-72 hours after DC, Senior Services after hours call program, Care team redesign, home care visits for patient who do not qualify for home care, medication reconciliation processes and goal, and an improved After Visit Summary.
- At a time in the patient process that continues to concern us is from the time that the patient is discharged to the time that home care starts or the patient comes in for a hospital discharge visit. This time has caused angst for home care as well as the clinic and decisions are made based on a gut feeling as to "is the patient be OK and ready?"
- The SLP Fire Department approached RN about becoming a community partner and using EMS to help decrease health care costs and improve the patient experience at the pre-311 timeframe, thus potentially decreasing 311 calls (a possible success measure).
- Patients call to 311 dispatch police, fire as well as the various other services and the ambulance service often times dispatching more than what the patient really needs.
- An opportunity exists to partner with the Fire Department around a Post Discharge Visit.
  - They are already seeing our patients in a crisis situation. They can already do a patient "check" by completing a planned visit within the first 24-72 hours post DC.
  - There is a high percentage of EMS in the area that know how to apply their skills to this type of patient encounter, usage up or down of resources with one phone call as they have systems in place.
  - Similar work has been done by other systems with success. North Memorial has reduced readmissions using Community Partners for

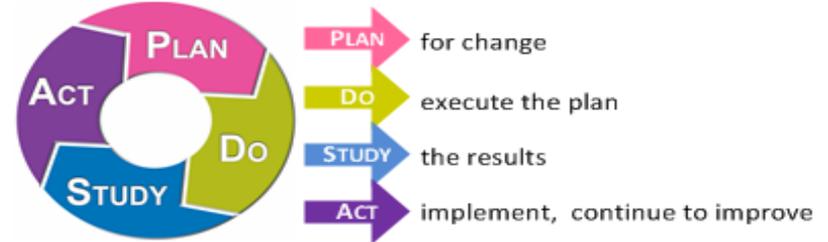
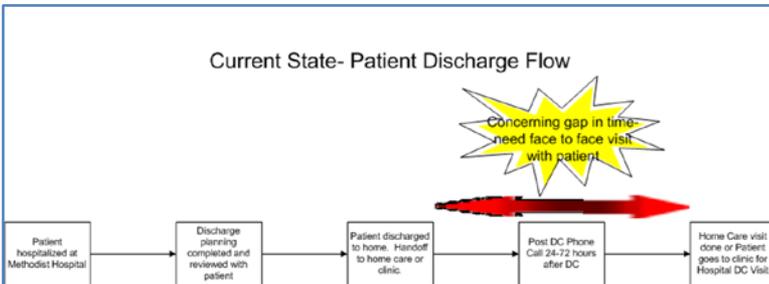
Other items:

- Plan Pilot
- Billing and Accounting
- Fire Department redistribution of workload during peak periods. Scheduling considerations if major event
- Testing the visit during RE
- Communication
- Education/Training
- Data/Reporting
- Address political issues
- Visit standards for statewide use
- Contracting
- What vehicle to show up in.
- Marketing needs.



Project form:  
Defined targets and deliverables

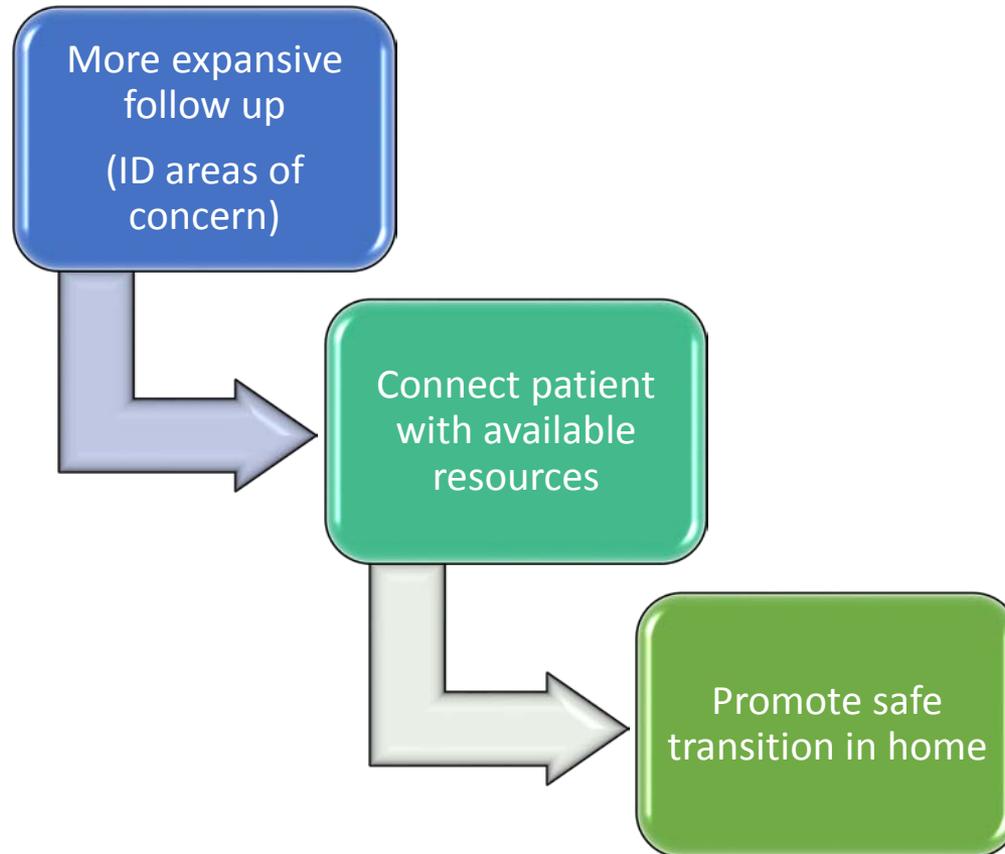
Agreeing to a future state process



Process flow or Value Stream Map:  
Understanding the current state process

PDCA Cycles: Trying something and making Changes as needed: "Fail forward quickly"

# OUR GOAL:



# 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

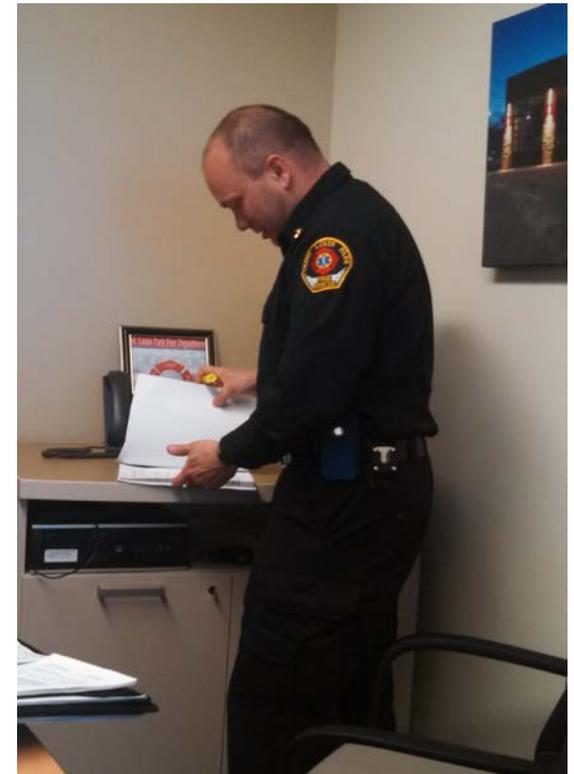
- Patient flyer
- Patient consent form
- Fax forms
- FF visit documentation form
- Patient survey
- And others

## Test Visits

- Three visits
- Made process and other changes

## Pilot Planning

- Three Departments
- Measures
- Training



# Our Process



# 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

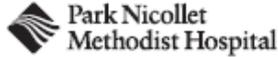
### How can I prepare for the visit?

- 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.

Our Patient Consent form- we must obtain consent as we share the patient's AVS (After Visit Summary) with the Fire Department



**Consent to Post-Hospital Discharge Visit by Emergency Medical Technician/Firefighter**



NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

MR#: \_\_\_\_\_ HCU#: \_\_\_\_\_

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



**Medications-** 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



## FIREFIGHTER HOME VISIT



Date:	1 <sup>st</sup> Call:	Arrival:
Scheduled Time:	2 <sup>nd</sup> Call:	Clear Time:

IF PATIENT DECLINES VISIT, NOTIFY: (952) 993-5421 OR [Tricia.Petty@PARKNICOLLET.COM](mailto:Tricia.Petty@PARKNICOLLET.COM)

Name:	Address:	
Age:	Phone:	Medical Record #:
Primary MD:	Clinic Location:	

### EVALUATION

Temp:	BP:	HR:	RR:	SPO <sub>2</sub>	on RA	
					on O <sub>2</sub>	
<u>General Appearance</u>		<u>Pain</u>		<u>Respiratory</u>		
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 <u>Appts.</u>
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)		
<input type="checkbox"/> Understood		
<input type="checkbox"/> Needed Clarification		
<input type="checkbox"/> Phone Call to Health Team Needed		

Your Name:	VISIT CHECKLIST	
Department: <i>Eden Prairie Fire Department</i>	Who to call if they need assistance or clarification	
Phone:	Follow-up appointments were reviewed	
Signature:	Medications have been picked up / plan for keeping track	
Date:	Time:	Red flags have been addressed
		Smoke alarm present and working

COMMENTS FOR TREATMENT TEAM (if needed)	CO alarm present and working
	"Medicinas 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 <a href="mailto:Tricia.Petty@parknicollet.com">Tricia.Petty@parknicollet.com</a> with "PFV 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:

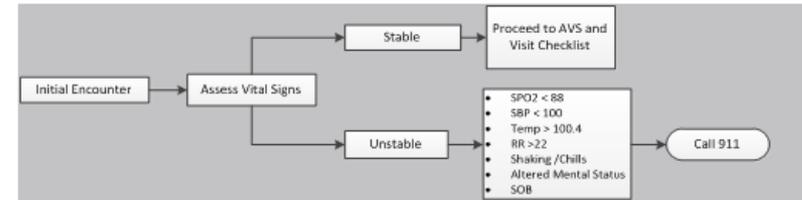
Pain If uncontrolled call Care Team

Functional status since home (bathroom, Dressing, 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
Electricity	2 Clutter (non-biodegradable items)	3 Lives alone	9 Possible (household items unsafe or improperly stored)
Running water (Potable water in home)	2 Small amounts of biodegradable waste	2 Verbal abuse / neglect	6 Probable
Temperature safe for proper health	2 Large amounts of biodegradable waste	1 Physical abuse / neglect	3 Certain
	Score (0-8):	Score (1-4):	Score (3-12):

# Current Program Components

## Departments:

St. Louis Park  
Minneapolis  
Minnetonka  
Hopkins  
Eden Prairie



**Visits:** Tuesday-Saturday  
Same day if needed

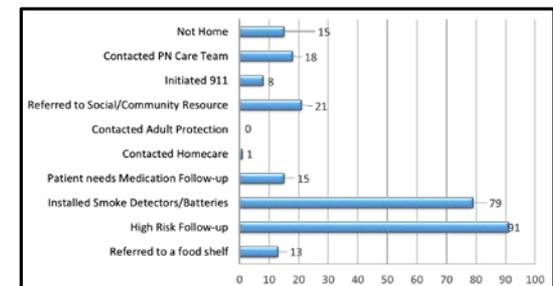
Weekly conference call with  
Core team



**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

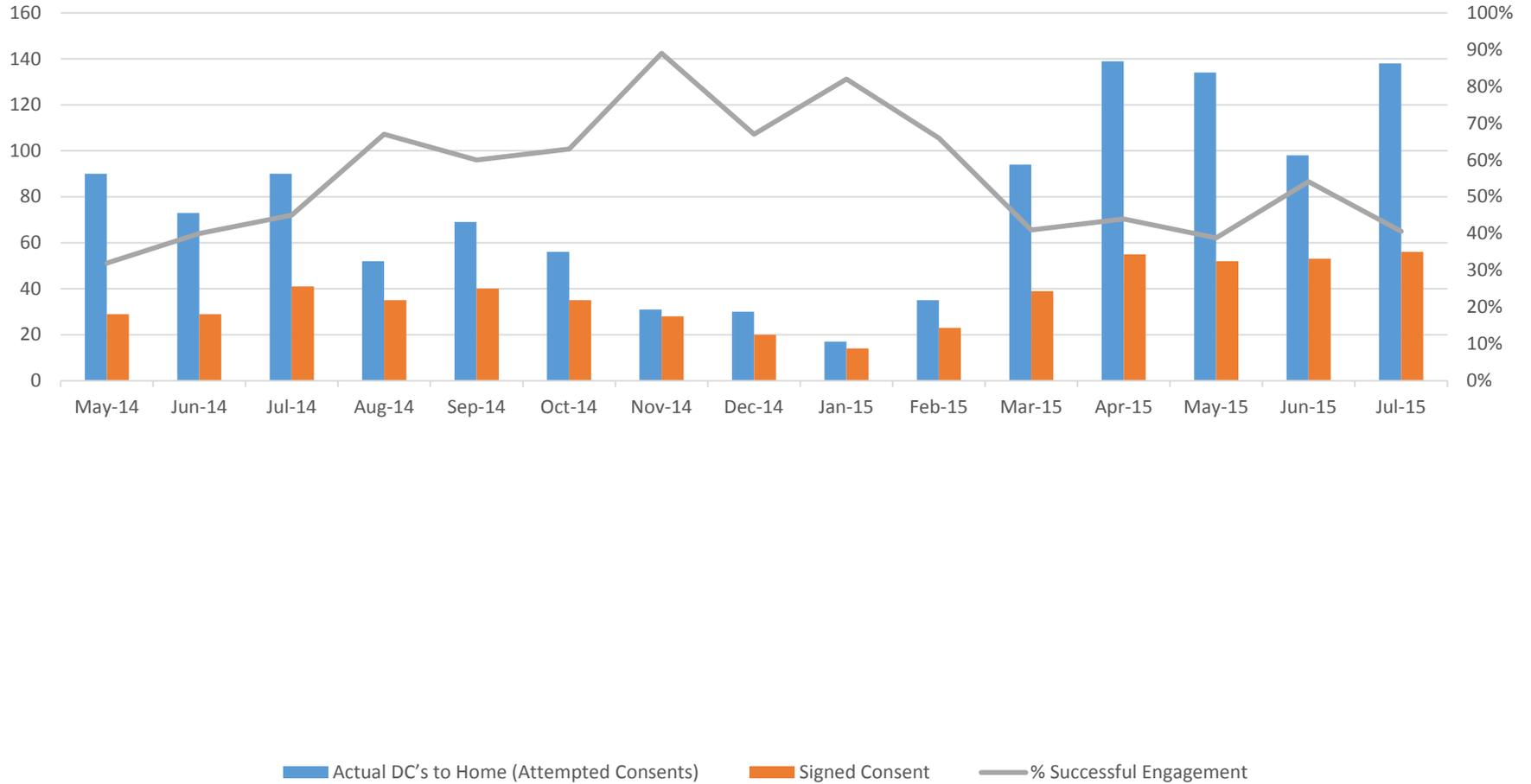
## Times

- Range 0900-2000
- Average time is 12:30

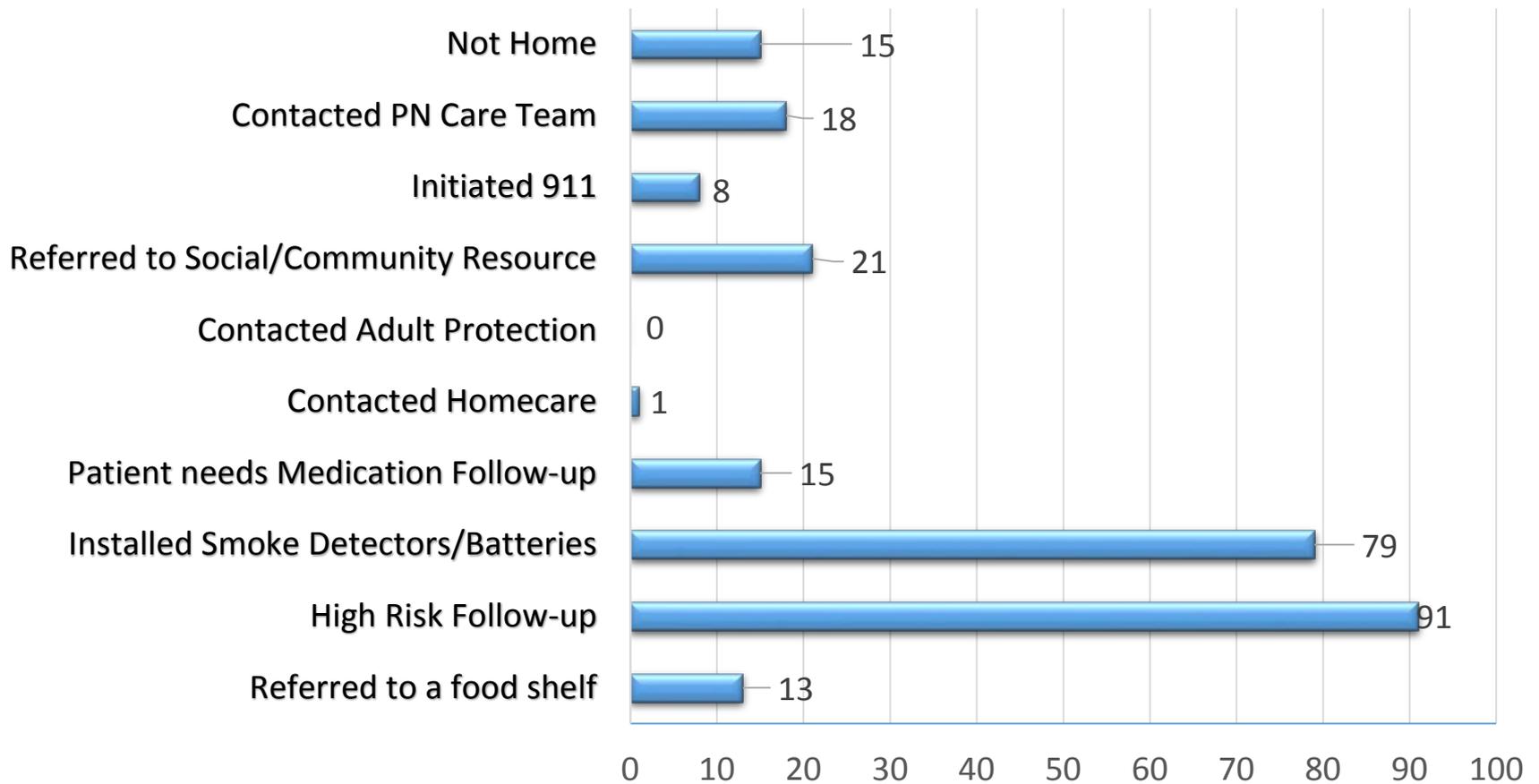
## PEAT Score

- Range: 22-38
- Average: 34

# Patient Engagement



# Visit Outcomes



# What our patients are saying about the visits:

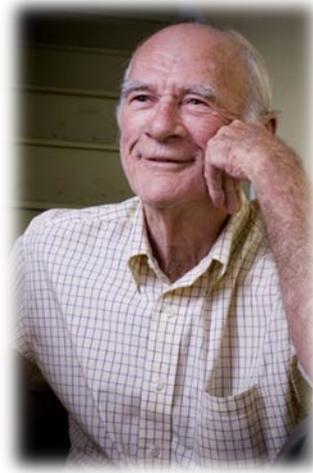
*MH staff informed me about the firefighter visit in a way that I could understand: **99% agree/strongly agree***



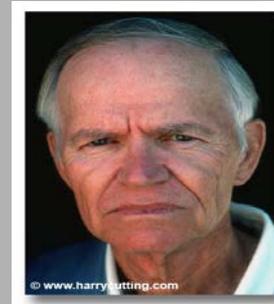
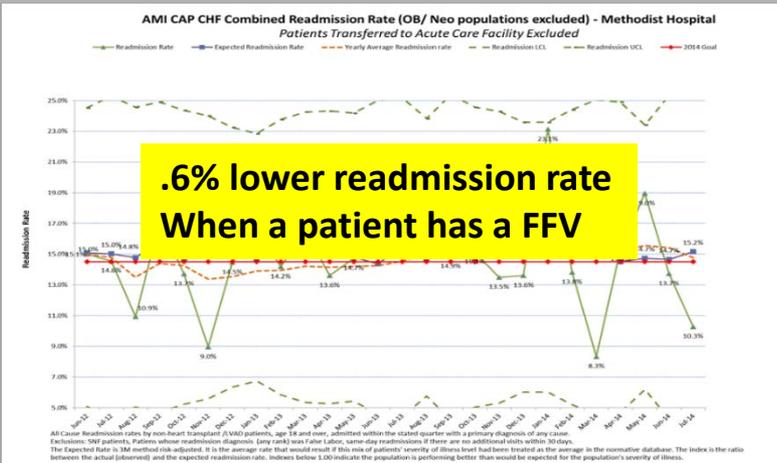
*Most important aspect of visit: **Safety Assessment***



*"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**



St. Louis Park	Minnetonka																																																
<table border="1"> <thead> <tr> <th>Total</th> <th>HRR</th> <th>Readmitted</th> <th>Rate</th> </tr> </thead> <tbody> <tr> <td>Visit</td> <td>83</td> <td>14</td> <td>21</td> <td>25.30%</td> </tr> <tr> <td>No Visit</td> <td>193</td> <td>64</td> <td>53</td> <td>27.50%</td> </tr> <tr> <td></td> <td></td> <td>276</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><b>2.2% lower</b></td> </tr> </tbody> </table>	Total	HRR	Readmitted	Rate	Visit	83	14	21	25.30%	No Visit	193	64	53	27.50%			276							<b>2.2% lower</b>	<table border="1"> <thead> <tr> <th>Total</th> <th>HRR</th> <th>Readmitted</th> <th>Rate</th> </tr> </thead> <tbody> <tr> <td>Visit</td> <td>148</td> <td>24</td> <td>31</td> <td>23.00%</td> </tr> <tr> <td>No Visit</td> <td>201</td> <td>38</td> <td>54</td> <td>26.90%</td> </tr> <tr> <td></td> <td></td> <td>349</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><b>3.3% lower</b></td> </tr> </tbody> </table>	Total	HRR	Readmitted	Rate	Visit	148	24	31	23.00%	No Visit	201	38	54	26.90%			349							<b>3.3% lower</b>
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**Drill down by Fire Department**

**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,

# 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, MS, MBA,  
Dr. Quality Improvement Specialist  
5/18/15

#### 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 gap between discharge time and follow up care.

#### 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 than 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

## MHA Innovation of the Year Award



## Community Paramedicine

Case Profiles of Successful Care Models

May 2015

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# 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

## **Triple Aim Summary**

## **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?





**Thank You!**





**DRAFT**

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## Minnesota Department of Health (MDH) Rule

<b>Title:</b>	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the <b>ASC X12/005010X223A2 Health Care Claim: Institutional (837) Version 4012.0</b>
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:	<p>This document was adopted into rule <del>June 1, 2015</del>TBD.</p> <p>[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.]</p> <p>This document:</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• 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);</li> <li>• Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).</li> </ul>
Status of this document:	<p>This is version 4012.0 (<del>v40v12.0</del>) of the Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X223A2 Health Care Claim: Institutional (837). It was announced as an adopted rule in the Minnesota State Register, Volume <del>39XX</del>, Number <del>48XX</del>, <del>June 1, 2015</del>TBD pursuant to Minnesota Statutes, section 62J.536 and 62J.61.</p> <p>Version <del>810.0</del> was the last version of this document to be adopted into rule prior to this <del>v40v12.0</del>.</p> <p>This document is available at no charge on MDH's "<del>Minnesota Statutes, section 62J.536 Rules</del>" <del>webpage</del>Health Care Administrative Simplification" <del>webpage</del> (<a href="http://www.health.state.mn.us/asa/rules.html">http://www.health.state.mn.us/asa/rules.html</a>).</p>

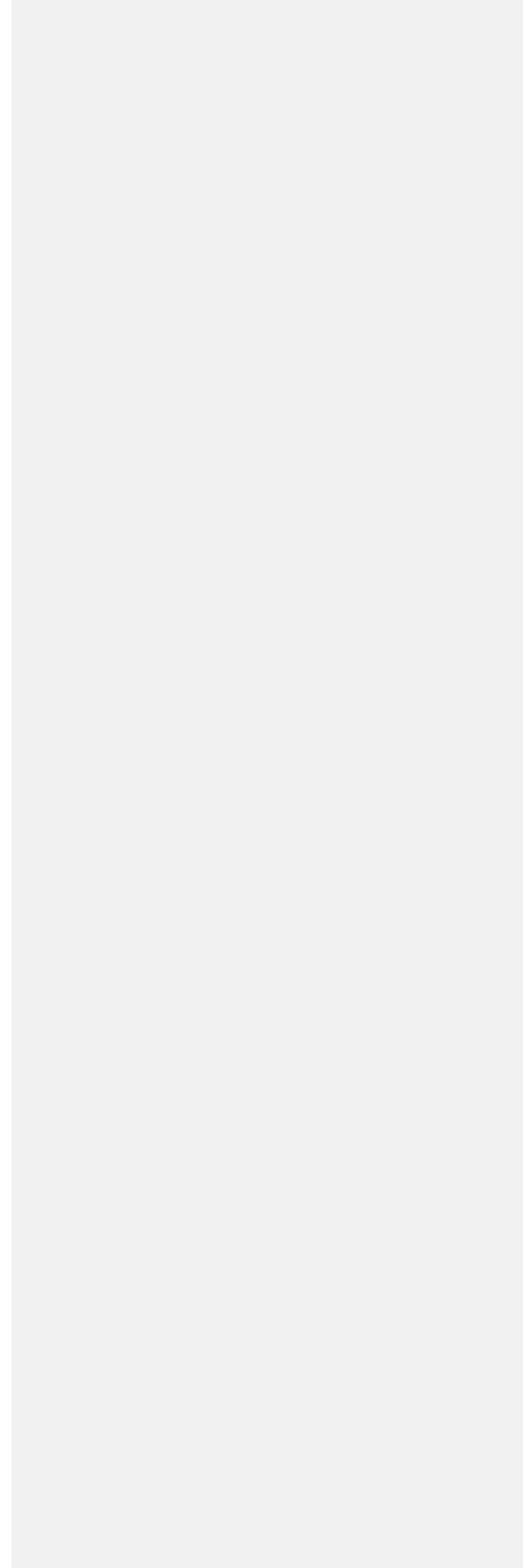
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# 1. Overview

## 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](#).

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## 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:

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*"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:

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*"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.

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[Minnesota Statutes, section 62J.51, Subd. 11a](#) defines "health care clearinghouse" as follows:

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*"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.*

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*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>.

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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>.

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#### 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](mailto:health.ASAguides@state.mn.us)

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### 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>.

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### 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](http://www.health.state.mn.us/auc/index.html) website at <http://www.health.state.mn.us/auc/index.html> <http://www.health.state.mn.us/auc/bp.htm> 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, 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>.

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### 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.

Version	Revision Date	Summary Changes
<a href="#">11.0</a>	<a href="#">January 11, 2016</a>	<a href="#">Proposed revisions to v10.0</a>
<a href="#">12.0</a>	<a href="#">TBD</a>	<a href="#">Adopted into rule TBD. Version 12.0 incorporates changes proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.</a>

## 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/>.

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#### 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.
- 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

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- 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 not 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](http://www.health.state.mn.us/auc/index.html) 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.

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### 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 only:  
Minnesota Statutes, Section 176.135 subd. 7.a (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>.

**Commented [DH1]:** Note: legislation is pending to change this date. The final published version should state the correct date

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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 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.
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
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	See front matter <a href="#">section 3.2.4</a> of this document for definition.

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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
		Claim Frequency Type Code	
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 <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.5</a> of this document for definition.
2300 CLAIM INFORMATION	NTE Billing Note	N/A	See front matter <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.2</a> of this document for usage
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	N/A	See front matter <a href="#">section 3.2.2</a> 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
	Secondary Identification		
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 <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.5</a> 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.
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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**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

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## 5. List of Appendices

### A. [Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides](#)

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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 [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

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### B. **Appendix B: K3 Segment Usage Instructions**

Appendix B provides guidance for K3 SEGMENT USAGE INSTRUCTIONS

### C. [Appendix C: Reporting MNCare Tax](#)

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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,<sup>1</sup> 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~~[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.

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<sup>1</sup> 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-910-CM); [International Classification of Diseases, Tenth Revision, Procedural coding system \(ICD-10-PCS\)](#) and Revenue codes.<sup>2</sup>

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.

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<sup>2</sup> CPT is a registered trademark of the American Medical Association (AMA); ICD-9-CM, [ICD-10-CM, is- 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.

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](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_167693).

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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;"

- o "initial."
- Follow all related AMA guidelines in CPT<sup>3</sup> (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."<sup>4</sup>
- In the case of time as part of the code definition, **follow HCPCS/CPT Time guidelines to determine the appropriate time to report. Per the guidelines, more than half the time of a time-based code must be spent performing the service in order to report that code. Follow general HCPCS/CPT guidelines for determining rounding rules for reporting more than the code's time value.** If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- ~~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.~~ **For therapy codes, follow HCPCS/CPT guidelines for determining rounding time (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for physical, occupational, and speech therapy services (PT/OT/SLP).**
- 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

<sup>3</sup> Current Procedural Terminology (CPT®), copyright 2012-2014 American Medical Association

<sup>4</sup> Current Procedural Terminology (CPT®), copyright 2012-2014 American Medical Association

Table A.5.1 below lists chapters from the [Medicare Claims Processing Manual](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html), 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 X12/005010X223A2 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.0, referred to in Table A.5.1 as “NCPDP”.

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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)	
1	<a href="#">General Billing Requirements</a>		Follow Medicare coding guidelines
2	<a href="#">Admission and Registration Requirements</a>		Not applicable to coding guidelines
3	<a href="#">Inpatient Hospital Billing</a>		Follow Medicare coding guidelines
4	<a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPSS)</a>	Observation	Any HCPCS Level I or II code can be submitted as appropriate for observation with revenue code 0762
4	<a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPSS)</a>	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	<a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPSS)</a>	Bilateral Radiology	Bilateral radiology services are reported as either: <ul style="list-style-type: none"> <li>▪ one line with a 50 modifier and one unit, <b>or</b></li> <li>▪ two separate lines, one with RT modifier and one with LT modifier.</li> </ul>
4	<a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPSS)</a>	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	<a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPSS)</a>	Interpreter Services	For interpreter services: <ul style="list-style-type: none"> <li>▪ Use Revenue code 0949 and appropriate HCPCS code(s) as follows.</li> </ul>

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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)	
			<p><b>Note:</b> Rounding rules apply to all services below. A minimum of eight minutes must be spent in order to report a unit.</p> <ul style="list-style-type: none"> <li>▪ <u>T1013</u> -- Face-to-face oral language interpreter services per 15 minutes</li> <li>▪ <u>T1013-U3</u> -- Face-to-face sign language interpreter services per 15 minutes</li> <li>▪ <u>T1013-GT</u> -- Telemedicine interpreter services per 15 minutes</li> <li>▪ <u>T1013-U4</u> -- Telephone interpreter services per 15 minutes</li> <li>▪ <u>T1013-UN, UP, UQ, UR, US</u> -- Interpreter services provided to multiple patients in a group setting</li> <li>▪ Report T1013 for each patient in the group setting                             <ul style="list-style-type: none"> <li>○ Append the modifier indicating how many patients in the group</li> <li>○ Report one unit per 15 minutes per patient</li> </ul> </li> <li>▪ <u>T1013-52</u> -- Interpreter drive time, wait time, no show/cancellation per 15 minutes                             <ul style="list-style-type: none"> <li>○ Report one unit per 15 minutes per client</li> <li>○ If more than one service is provide, report each on a separate line appended with the -59 modifier</li> <li>○ T1013-52 x 2 units (30 minutes of drive time)</li> <li>○ T1013-5259 (12 minutes of wait time)</li> <li>○ Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line.</li> </ul> </li> </ul>

**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)	
			<ul style="list-style-type: none"> <li>o Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage <u>is reported</u> (see 99199). <del>is reported</del></li> <li>o A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation</li> <li>▪ <u>99199</u> -- Mileage for interpreter service                             <ul style="list-style-type: none"> <li>o Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported</li> <li>o Report one unit per mile</li> </ul> </li> </ul>
5	<a href="#">Part B Outpatient Rehabilitation and CORF/OPT Services</a>		<del>Do not follow Medicare's rounding rules for physical, occupational and speech therapies. See general rules for reporting units at the front of this appendix. Follow HCPCS/CPT rounding guidelines</del>
6	<a href="#">Inpatient Part A Billing and SNF Consolidated Billing</a>	Room and Board	Room and Board is reported according to the level of nursing care provided using revenue codes 019X
6	<a href="#">Inpatient Part A Billing and SNF Consolidated Billing</a>	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.

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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)	
			<ul style="list-style-type: none"> <li>Private Room differential use 0229; 1 unit = 1 day</li> <li>In lieu of days differential use 0230; 1 unit = 1 hour</li> </ul>
6	<a href="#">Inpatient Part A Billing and SNF Consolidated Billing</a>	Ancillaries	Ancillaries are reported separately as appropriate
6	<a href="#">Inpatient Part A Billing and SNF Consolidated Billing</a>	Long term care	Also applicable to Long Term Care
7	<a href="#">SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)</a>		Follow Medicare coding guidelines
8	<a href="#">Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims</a>		Follow Medicare coding guidelines
9	<a href="#">Rural Health Clinics/Federal Qualified Health Centers</a>		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.

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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)	
10	<a href="#">Home Health Agency Billing</a>	Home Health Services	<p>Home Health Services are reported on the 8371 using the revenue code corresponding with the approved HCPCS code set with the exception of PCA services which are billed on the 837P</p> <p>Revenue Codes 041X – 044X and 055x – 060x as appropriate</p>
10	<a href="#">Home Health Agency Billing</a>	Reporting continuous services beyond the encounter and multiple nurse encounters with the same date of service	<p>For home care the industry standard defines "per diem" as all inclusive services per patient encounter up to two hours.</p> <ul style="list-style-type: none"> <li>▪ To report extended continuous services beyond the encounter use the fifteen minute code(s).</li> <li>▪ To report multiple nurse encounters within the same date of service use the appropriate encounter code with multiple units.</li> </ul>
10	<a href="#">Home Health Agency Billing</a>	Approved HCPCS code set	<p>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.</p> <p>Approved HCPCS code set:</p> <ul style="list-style-type: none"> <li>▪ Skilled Nursing Encounter: <ul style="list-style-type: none"> <li>○ RN: T1030</li> <li>○ LPN:T1031</li> </ul> </li> <li>▪ Home Health Aide Visit: T1021</li> <li>▪ Home Health Aide (Extended): T1004</li> <li>▪ PT Visit: S9131 <ul style="list-style-type: none"> <li>○ PT Asst. Visit: S9131 TF</li> </ul> </li> <li>▪ OT Visit: S9129 <ul style="list-style-type: none"> <li>○ OT Asst. Visit: S9129 TF</li> </ul> </li> </ul>

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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)	
			<ul style="list-style-type: none"> <li>▪ RT Evaluation: S5180</li> <li>▪ RT Visit: S5181</li> <li>▪ Speech Visit: S9128</li> <li>▪ MSW Visit: S9127</li> <li>▪ RN: T1002</li> <li>▪ RN Complex: T1002 TG</li> <li>▪ RN Shared 1:2 ratio: T1002 TT</li> <li>▪ LPN: T1003</li> <li>▪ LPN Complex: T1003 TG</li> <li>▪ LPN Shared 1:2 ratio: T1003 TT</li> <li>▪ Postpartum home visit: 99501</li> <li>▪ Newborn care home visit: 99502</li> </ul>
11	<a href="#">Processing Hospice Claims</a>		Follow Medicare coding guidelines
12	<a href="#">Physicians/ Nonphysicians Practitioners</a>		<a href="#">Not applicable to Institutional claim</a>
13	<a href="#">Radiology Services and Other Diagnostic Procedures</a>	Bilateral Radiology	<ul style="list-style-type: none"> <li>▪ Bilateral radiology services are reported as either:                             <ul style="list-style-type: none"> <li>○ one line with a 50 modifier and one unit, or</li> <li>○ two separate lines, one with RT modifier and one with LT modifier.</li> </ul> </li> </ul>
14	<a href="#">Ambulatory Surgical Centers</a>	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	<a href="#">Ambulance</a>		Follow Medicare coding guidelines

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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)	
16	<a href="#">Laboratory Services</a>	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	<a href="#">Drugs and Biologicals</a>		Follow Medicare coding guidelines
18	<a href="#">Preventive and Screening Services</a>	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	<a href="#">Preventive and Screening Services</a>	Colonoscopy	Coding of diagnosis for colonoscopy claims should follow the ICD-9 code set instructions for coding for a screening visit where findings are noted. All applicable diagnoses should be submitted.
18	<a href="#">Preventive and Screening Services</a>	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	<a href="#">Preventive and Screening Services</a>	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

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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)	
18	<a href="#">Preventive and Screening Services</a>	Vaccine administration with counseling for patients through 18 years of age	<p>Vaccine administration with counseling for patients through 18 years of age:</p> <ul style="list-style-type: none"> <li>Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components.</li> <li>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.</li> </ul>
19	<a href="#">Indian Health Services</a>		Follow Medicare coding guidelines
20	<a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	<a href="#">Oxygen codes</a>	<p>Not applicable to the Institutional guide</p> <p>Oxygen codes are used as defined. When appropriate to report contents, Minnesota providers may report E or S oxygen content codes as definition allows.</p>
21	<a href="#">Medicare Summary Notices</a>		Not applicable to the Institutional guide
22	<a href="#">Remittance Advice</a>		Not applicable to the Institutional guide
23	<a href="#">Fee Schedule Administration and Coding Requirements</a>		Follow the code selection guidelines in the Appendix A front matter
24	<a href="#">General EDI and EDI Support Requirements, Electronic Claims</a>		Not applicable to the Institutional guide

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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)	
	<a href="#">and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims</a>		
25	<a href="#">Completing and Processing the Form CMS-1450 Data Set</a>		Not applicable to the Institutional guide
26	<a href="#">Completing and Processing Form CMS-1500 Data Set</a>		Not applicable to the Institutional guide
27	<a href="#">Contractor Instructions for CWF</a>		Not applicable to the Institutional guide
28	<a href="#">Coordination with Medigap, Medicaid, and other Complementary Insurers</a>		Not applicable to the Institutional guide
29	<a href="#">Appeals of Claims Decisions</a>		Not applicable to the Institutional guide
30	<a href="#">Financial Liability Protections</a>		Not applicable to the Institutional guide
31	<a href="#">ANSI X12N Formats Other than Claims or Remittance</a>		Not applicable to the Institutional guide

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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)	
32	<a href="#">Billing Requirements for Special Services</a>		Follow the code selection guidelines in the Appendix A front matter
33	<a href="#">Miscellaneous Hold Harmless Provisions</a>		Not applicable to the Institutional guide
34	<a href="#">Reopening and Revision of Claim Determinations and Decisions</a>		Not applicable to coding guidelines
35	<a href="#">Independent Diagnostic Testing Facility</a>		Not applicable to coding guidelines
36	<a href="#">Competitive Bidding</a>		Not applicable to coding guidelines
37	<a href="#">Department of Veteran Affairs (VA) Claims Adjudication Services Project</a>		Not applicable to coding guidelines
38	<a href="#">Emergency Preparedness Fee for Service Guidelines</a>		Not applicable to coding guidelines

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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)	
N/A	N/A	Freestanding Birth Centers	<p><b>Licensed birthing centers</b> 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 <a href="#">144.615</a> and <a href="#">144.651</a> 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:</p> <ul style="list-style-type: none"> <li>• <b>Type of Bill:</b> 084x – Special Facility – Freestanding Birthing Center (NOTE: TOB 084x will be considered outpatient. HCPCS codes are required with submitted revenue codes.)</li> <li>• <b>Revenue Code:</b> 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.</li> <li>• <b>HCPCS Code:</b> Appropriate HCPCS code with revenue code 0724 for delivery, or S4005 when labor does not result in delivery.</li> </ul> <p><b>Note:</b> Professional services related to the mother’s and newborn’s cares are reported on the 837P only.</p>

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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
<del>UA</del>	<del>Children's Therapeutic Services and Supports (CTSS)</del>
<del>UD</del>	<del>Transition to community living (Adult Rehabilitation Mental Health Services (ARMHS))</del>
<del>U1</del>	<del>Dialectical Behavioral Therapy</del>
U4	Via other than face to face contact; e.g. telephone
<del>U5</del>	<del>Advanced level specialist</del>
U6	Interactive
U7	Physician extender (includes mental health practitioner as defined by MN Statute 245.4711, Subd. 17)
<b>NOTE: The U modifiers in this table are specific to Mental Health.</b>	

#### 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 \(ACT\)](#)

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[Adult Crisis Response Services](#)

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[Children's Mental Health Crisis Response Services](#)

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[Mental Health Targeted Case Management \(MH-TCM\)](#)

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[Children's Mental Health Residential Treatment Services](#)

Field Code Changed

[Intensive Residential Treatment Services \(IRTS\)](#)

Field Code Changed

[Adult Day Treatment](#)

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[Children's Day Treatment](#)

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[Children's Therapeutic Services and Supports \(CTSS\)](#)

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[Adult Rehabilitative Mental Health Services \(ARMHS\)](#)

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[Peer Services](#)

Field Code Changed

[Mental Health Diagnostic Assessment](#)

Field Code Changed

[Dialectical Behavior Therapy](#)

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[Youth Assertive Community Treatment](#)

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[Intensive Treatment in Foster Care](#)

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[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".

**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
<p><b>Assertive Community Treatment (ACT)</b> <a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>• <del>An intensive, comprehensive, non-residential rehabilitative mental health services (ARMHS) team model. Consistent with ARMHS multidisciplinary total team approach.</del></li> <li>• <del>Patients with serious mental illness who require intensive services; time unlimited basis, available 24/7/365.</del></li> <li>• <del>Face-to-face, all-inclusive daily rate.</del> <ul style="list-style-type: none"> <li>▪ <del>One provider per day</del></li> </ul> </li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>▪ <del>H0040— Assertive community treatment program, per diem</del></li> </ul>
<p><b>Adult Crisis Response Services</b> <a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>• <del>County or county contracted mental health professional, practitioner, or rehab worker, or crisis intervention team.</del></li> <li>• <del>Crisis assessment, intervention, stabilization, community intervention.</del></li> <li>• <del>Immediate, face-to-face evaluation, determine need for emergency services or referrals to other resources.</del></li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>• <del>S9484— Adult individual crisis assessment, intervention and stabilization, individual, by mental health professional or practitioner</del></li> <li>• <del>S9484 HM— Adult crisis assessment, intervention and stabilization, individual, by mental health rehabilitation worker</del></li> <li>• <del>S9484 HN— Adult crisis assessment, intervention and stabilization, individual, by mental health practitioner</del></li> <li>• <del>S9484 HQ— Adult crisis stabilization, group</del></li> <li>• <del>H0018— Adult crisis stabilization, residential</del></li> <li>• <del>90882 HK— Environmental intervention for medical management, community intervention</del> <ul style="list-style-type: none"> <li>▪ <del>90882 HK HM— Environmental intervention for medical management, community intervention, mental health rehabilitation worker</del></li> </ul> </li> </ul>
<p><b>Children's Mental Health Crisis Response Services</b></p>	<ul style="list-style-type: none"> <li>• <del>Intensive face-to-face, short-term services initiated during a crisis; provided on-site by a mobile crisis response team.</del></li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>• <del>S9484 UA— Crisis intervention mental health services, per hour, Children's Crisis Response Services, mental health professional</del></li> </ul>

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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
<a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li><del>County or county contracted agency.</del></li> </ul>	<ul style="list-style-type: none"> <li><del>S9484 UA HN – Crisis intervention mental health services, per hour, Children’s Crisis Response Services, bachelor’s degree-level mental health practitioner</del></li> </ul>
<p><b>Mental Health Targeted Case Management (MH-TCM)</b></p> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>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</li> <li>T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older</li> <li>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</li> <li>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</li> <li>T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older</li> <li>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</li> <li>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</li> </ul>
<p><b>Children’s Mental Health</b></p>	<ul style="list-style-type: none"> <li>24-hour-a-day program under clinical supervision of a mental</li> </ul>	PMAP/Commercial/County-based Purchasing (CBP):

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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
<p><b>Residential Treatment Services</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p>health professional, provided in a community setting.</p>	<ul style="list-style-type: none"> <li>▪ For room and board and/or treatment services, report on the 8371 type of bill 86X, with the room and board and treatment services as separate line items.                             <ul style="list-style-type: none"> <li>○ Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X.</li> </ul> </li> </ul> <p>Department of Human Services (DHS)/ Fee for Service:</p> <ul style="list-style-type: none"> <li>▪ When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.</li> </ul>
<p><b>Intensive Residential Treatment Services (IRTS)</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.</li> </ul>	<p>PMAP/Commercial/County-based Purchasing (CBP):</p> <ul style="list-style-type: none"> <li>▪ For room and board and/or treatment services, report on the 8371 type of bill 86X, with the room and board and treatment services as separate line items.                             <ul style="list-style-type: none"> <li>○ Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X.</li> </ul> </li> </ul> <p>Department of Human Services (DHS)/ Fee for Service:</p> <ul style="list-style-type: none"> <li>▪ When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019 and POS 99.</li> </ul>
<p><b>Adult Day Treatment</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>▪ <del>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</del></li> </ul>	<p><del>Codes:</del></p> <ul style="list-style-type: none"> <li>▪ <del>H2012 Behavioral health day treatment, per hour</del></li> </ul>

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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
<p><b>Children's Day Treatment</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services provided by multidisciplinary team.</li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>H2012 UA HK – Behavioral health day treatment, per hour, CTSS</li> <li><del>H2012 UA HK U6 – Behavioral health day treatment, per hour, CTSS interactive</del></li> </ul>
<p><b>Children's Therapeutic Services and Supports (CTSS)</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li><del>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.</del></li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li><del>90832 UA – Psychotherapy w/patient and/or family, 30 minutes, CTSS</del></li> <li><del>90833 UA – Psychotherapy w/patient and/or family, 30 minutes with an E/M*, CTSS</del></li> <li><del>90834 UA – Psychotherapy w/patient and/or family, 45 minutes, CTSS</del></li> <li><del>90836 UA – Psychotherapy w/patient and/or family, 45 minutes with an E/M*, CTSS</del></li> <li><del>90837 UA – Psychotherapy w/patient and/or family, 60 minutes, CTSS</del></li> <li><del>90837 UA plus 99354 Psychotherapy w/patient and/or family 60 minutes, CTSS</del></li> <li><del>90838 UA – Psychotherapy w/patient and/or family, 60 minutes with E/M*, CTSS</del></li> <li><del>90839 UA – Psychotherapy for crisis, first 60 minutes, CTSS</del></li> <li><del>90840 UA – Each additional 30 mins [add-on to 90839], CTSS</del></li> <li><del>90846 UA – Family psychotherapy without patient, CTSS</del></li> <li><del>90847 UA – Family psychotherapy with patient, CTSS</del></li> <li><del>90849 UA – Multiple family group psychotherapy, CTSS</del></li> <li><del>90853 UA – Group psychotherapy, CTSS</del></li> <li><del>90875 UA – Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 30 minutes,</del></li> </ul>

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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
		<p><del>CTSS</del></p> <ul style="list-style-type: none"> <li><del>* 90876 UA Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 45 minutes, CTSS</del></li> <li><del>* H2014 UA Skills training &amp; development, individual, per 15 minutes, CTSS</del></li> <li><del>* H2014 UA HQ Skills training &amp; development, group, per 15 minutes, CTSS</del></li> <li><del>* H2014 UA HR Skills training &amp; development family, per 15 minutes, CTSS</del></li> <li><del>* H2015 UA Comprehensive community support services— crisis assistance, 15 minutes, CTSS</del></li> <li><del>* H2019 UA Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS</del></li> <li><del>* H2019 UA HM Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS</del></li> <li><del>* H2019 UA HE Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS</del></li> </ul> <p><del>*(Use 90833 UA, 90836 UA or 90838 UA in conjunction with 99201-99255 where documentation supports per CPT manual)</del></p> <p><del>*(Use 90785 UA in conjunction with 90832-90838 when psychotherapy includes interactive complexity services)</del></p>
<p><del>Adult Rehabilitative Mental Health Services (ARMHS)</del></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p><del>Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.</del></p>	<p><del>Codes:</del></p> <ul style="list-style-type: none"> <li><del>* H2017 Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes</del></li> <li><del>* H2017 HM Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes</del></li> </ul>

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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
		<ul style="list-style-type: none"> <li>• <del>H2017 HQ – Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes</del></li> <li>• <del>H2017 UD – Basic living and social skills, transitioning to community, mental health professional or practitioner</del></li> <li>• <del>H2017 UD HM – Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker</del></li> <li>• <del>90882 – Environmental/community intervention, mental health professional or practitioner</del></li> <li>• <del>90882 HM – Environmental/community intervention, mental health rehabilitation worker</del></li> <li>• <del>90882 UD – Environmental/community intervention; transition to community living intervention</del></li> <li>• <del>90882 UD HM – Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker</del></li> <li>• <del>H0034 – Medication education, individual: MD, RN, PA or Pharmacist</del> <ul style="list-style-type: none"> <li>▪ <del>H0034 HQ – Medication education, group setting</del></li> </ul> </li> </ul>
<p><b>Peer Services</b> <a href="#">Back to list of behavioral health programs</a></p>	<p>Non-clinical support counseling services provided by certified peer specialist.</p>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>• <del>H0038 – Certified peer specialist services, per 15 minutes</del></li> <li>• <del>H0038 U5 – Advanced level certified peer specialist services, per 15 minutes</del></li> </ul>
<p><b>Mental Health Diagnostic Assessment</b> <a href="#">Back to list of behavioral health</a></p>	<p>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</p>	<p><u>Codes:</u></p> <p>In order to report diagnostic assessments with levels of complexity, report as follows:</p>

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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
<a href="#">programs</a>	determine a recipient's eligibility for mental health services.	<ul style="list-style-type: none"> <li>▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service</li> </ul>
<p><b>Dialectical Behavior Therapy</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p>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.</p>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>• <del>H2010 U1 – Therapeutic behavioral services, per 15 minutes, DBT</del></li> <li>• <del>H2010 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee</del></li> <li>• <del>H2010 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent</del></li> <li>• <del>H2010 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee</del></li> <li>• <del>H2010 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group</del></li> </ul>

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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
		<ul style="list-style-type: none"> <li>• <del>H2019 U1 HQ HN — Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee</del></li> <li>• <del>H2019 U1 HQ HA — Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent</del></li> <li>▪ <del>H2019 U1 HQ HA HN — Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee</del></li> </ul>
<p><b>Youth Assertive Community Treatment</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p>Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.</p>	<ul style="list-style-type: none"> <li>▪ H0040 HA — Assertive community child/adolescent treatment program per diem, ages 16 through 20</li> </ul>
<p><b>Intensive Treatment in Foster Care</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p>Intensive treatment services to children with mental illness residing in foster family settings. <del>(MS 256B.0946)</del></p> <p><b>Intensive Treatment in Foster Care)</b></p> <p>(1) Psychotherapy provided by a mental health professional;</p> <p>(2) Crisis assistance provided according to standards for children's therapeutic services and supports;</p> <p>(3) Individual, family, and group psychoeducation services by a mental health professional or a clinical trainee;</p> <p>(4) Clinical care consultation provided by a mental health professional or a clinical trainee; and</p> <p>(5) (1) Service delivery payment requirements as provided.</p>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>• <del>S5145 — Foster care, therapeutic, child, per diem</del></li> <li>• <del>HE — Mental health program</del></li> </ul> <p>Bill only one per diem code per day regardless of the number of services or who provides services.</p>

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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
<p><b>Mental Health-Family Psycho-education Services</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p><del>under subdivision 4.</del></p> <ul style="list-style-type: none"> <li>• 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 <a href="#">Minnesota Rules, part 5-9505.0371, subpart 5, item C.</a></li> <li>• Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in:                             <ul style="list-style-type: none"> <li>○ understanding a child's symptoms of mental illness;</li> <li>○ the impact on the child's development;</li> <li>○ needed components of treatment; and</li> <li>○ skill development.</li> </ul> </li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>• <del>H2027 – Individual</del></li> <li>• <del>H2027 HQ – Group (peer group)</del></li> <li>• <del>H2027 HR – Family with client present</del></li> <li>• <del>H2027 HS – Family without client present</del></li> <li>• <del>H2027 HQ HR – Multiple different families with clients present</del></li> <li>• <del>H2027 HQ HS – Multiple different families without clients present</del></li> <li>• <del>H2027 HN – Individual, clinical trainee</del></li> <li>• <del>H2027 HQ HN – Group (peer group), clinical trainee</del></li> <li>• <del>H2027 HR HN – Family with client present, clinical trainee</del></li> <li>• <del>H2027 HS HN – Family without client present, clinical trainee</del></li> <li>• <del>H2027 HQ HR HN – Multiple different families with clients present, clinical trainee</del></li> <li>▪ <del>H2027 HQ HS HN – Multiple different families without clients present, clinical trainee</del></li> </ul>

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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.

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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 MUCC 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.

**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)*

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

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
<b>Room and Board</b>	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
<b>Detox</b>	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
<b>Treatment program, treatment component</b>	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
<b>Treatment program, treatment component</b>	Hour	0953	None	837I	086x – special facility, residential
<b>Ancillary services</b>	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

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

*V10.0 MUGG 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**

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

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

**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**

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Service Descriptions	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Outpatient program; Treatment only	Hour	N/A	H2035 HQ (group) H2035 (individual)	N/A
Medication Assisted Therapy (MAT)	Day	N/A	H0020	N/A
MAT – all other drugs	Day	N/A	H0047 U9	N/A
MAT Plus	Day	N/A	H0020 UA	N/A
MAT Plus – all other drugs	Day	N/A	H0047 UB	N/A
NOTE: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12. MAT Plus – a licensed program providing at least 9 hours of treatment service per week U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc. UA – MAT Plus, methadone UB – MAT Plus, all other drugs				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.

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.

Filename: ~~v10 837I fnl for pstring - no us.docx~~v12 837I for Ops vote - us 4-27-16.docx

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## Minnesota Department of Health (MDH) Rule

<b>Title:</b>	Minnesota Uniform Companion Guide (MUCG) for the Implementation of the <b>ASC X12/005010X222A1 Health Care Claim: Professional (837) Version <del>40.012.0</del></b>
<b>Pursuant to Statute:</b>	Minnesota Statutes 62J.536 and 62J.61
<b>Applies to /interested parties:</b>	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
<b>Description of this document:</b>	<p>This document was adopted into rule on <del>June 1, 2015</del><u>TBD</u>.</p> <p>[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.]</p> <p>This document:</p> <ul style="list-style-type: none"> <li>• Describes the data content and other transaction specific information to be used with the <i>ASC X12/005010X222A1 Health Care Claim: Professional (837)</i>, hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536;</li> <li>• 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);</li> <li>• Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).</li> </ul>
<b>Status of this document:</b>	<p>This is version <del>4012.0</del> (<del>v40v12.0</del>) of the <i>Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X222A1 Health Care Claim: Professional (837)</i>. It was announced as an adopted rule in the Minnesota State Register, Volume <del>39XX</del>, Number <del>48XX</del>, <del>June 1, 2015</del>, <u>TBD</u> pursuant to Minnesota Statutes, section 62J.536 and 62J.61.</p> <p>Version <del>810.0</del> was the last version of this document to be adopted into rule prior to this <del>v40v12</del>.</p> <p>This document is available at no charge at MDH's "<a href="http://www.health.state.mn.us/asa/rules.html">Minnesota Statutes, section 62J.536 Rules Health Care Administrative Simplification</a>" webpage (<a href="http://www.health.state.mn.us/asa/rules.html">http://www.health.state.mn.us/asa/rules.html</a>).</p>

Minnesota Uniform Companion Guide for the Implementation of the ASC X12/005010X222A1 Health Care Claim: Professional (837). Version ~~4012.0~~. Adopted into rule on ~~June 1, 2015~~TBD.

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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](mailto: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](http://www.health.state.mn.us/auc/bp.htm) website at <http://www.health.state.mn.us/auc/index.html> <http://www.health.state.mn.us/auc/bp.htm> 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 10.0 supersedes all previous versions.
<u>11.0</u>	<u>January 11, 2016</u>	<u>Proposed revisions to v10.0</u>

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Version	Revision Date	Summary Changes
<u>12.0</u>	<u>TBD</u>	<u>Adopted into rule TBD. Version 12.0 incorporates changes proposed in v11.0 and additional changes. Version 12.0 supersedes all previous versions.</u>

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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 not 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](http://www.health.state.mn.us/auc/index.html) 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 workers' compensation medical claims only: Minnesota Statutes, sSection 176.135 subd. 7.a (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>.

Commented [DH1]: Note: legislation is pending to change this date. The final published version should state the correct date

## 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 005010X222A1 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 <a href="#">section 3.2.4</a> 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 <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.5</a> 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 <a href="#">section 3.2.5</a> of this document for definition and usage
2420A	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.2</a> 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 <a href="#">section 3.2.2</a> 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 ~~Fe~~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~~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,<sup>1</sup> 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");

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<sup>1</sup> 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, Ninth Revision, Clinical Modification ([ICD-910-CM](#)); [International Classification of Diseases, Tenth Revision, Procedural Coding System \(ICD-10-PCS\)](#); and Revenue codes.<sup>2</sup>

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.

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<sup>2</sup> 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](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<sup>3</sup> (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are)

<sup>3</sup> Current Procedural Terminology (CPT®), copyright 2013-2014 American Medical Association

submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."<sup>4</sup>

- In the case of time as part of the code definition, follow HCPCS/CPT Time guidelines to determine the appropriate time to report. Per the guidelines, more than half the time of a time-based code 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. 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.~~ For therapy codes, follow HCPCS/CPT guidelines for determining rounding time. (See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for physical, occupational, and speech therapy services [PT/OT/SLP].)
- 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](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html), 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.

<sup>4</sup> Current Procedural Terminology (CPT®), copyright 2013-2014 American Medical Association

**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.0, 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	<a href="#">General Billing Requirements</a>		Follow Medicare coding guidelines
2	<a href="#">Admission and Registration Requirements</a>		Not applicable to coding guidelines
3	<a href="#">Inpatient Hospital Billing</a>		Follow Medicare coding guidelines
4	<a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPPTS)</a>	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	<a href="#">Part B Outpatient Rehabilitation and CORF/OPT Services</a>		<del>Follow Medicare coding guidelines</del> Follow HCPCS/CPT rounding guidelines
6	<a href="#">Inpatient Part A Billing and SNF Consolidated Billing</a>		Not applicable to Professional claim
7	<a href="#">SNF Part B (Including Inpatient Part B and Outpatient Fee Schedule)</a>		Not applicable to Professional claim
8	<a href="#">Outpatient ESRD Hospital, Independent Facility and Physician/Supplier Claims</a>		Follow Medicare coding guidelines
9	<a href="#">Rural Health Clinics/Federal Qualified Health Centers</a>	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.

**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		
10	<a href="#">Home Health Agency Billing</a>	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	<a href="#">Home Health Agency Billing</a>	Home Infusion	Home infusion is not addressed in this chapter. See instructions following this table.
11	<a href="#">Processing Hospice Claims</a>		Not applicable to Professional claim
12	<a href="#">Physicians/Nonphysician Practitioners</a>	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	<a href="#">Physicians/Nonphysician Practitioners</a>	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	<a href="#">Physicians/Nonphysician Practitioners</a>	Bilateral Radiology	Bilateral radiology services are reported as either: <ul style="list-style-type: none"> <li>o one line with a 50 modifier and one unit, or</li> <li>o two separate lines, one with RT modifier and one with LT modifier.</li> </ul>

**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		
12	<a href="#">Physicians/Nonphysician Practitioners</a>	Interpreter services	<p>To report interpreter services: Note: Rounding rules (<a href="#">see front matter section A.3.4.2</a>) apply to all services below. A minimum of eight minutes must be spent in order to report one unit.</p> <ul style="list-style-type: none"> <li>• T1013 -- Face-to-face oral language interpreter services per 15 minutes</li> <li>• T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes</li> <li>• T1013-GT -- Telemedicine interpreter services per 15 minutes</li> <li>• T1013-U4 -- Telephone interpreter services per 15 minutes</li> <li>• T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting</li> <li>• Report T1013 for each patient in the group setting <ul style="list-style-type: none"> <li>○ Append the modifier indicating how many patients in the group</li> <li>○ Report one unit per 15 minutes per patient</li> </ul> </li> <li>• T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes <ul style="list-style-type: none"> <li>○ Report one unit per 15 minutes per client</li> <li>○ If more than one service is provided, report each on a separate line appended with the -59 modifier <ul style="list-style-type: none"> <li>▪ T1013-52 x 2 units (30 minutes of drive time)</li> <li>▪ T1013-52 59 (12 minutes of wait time)</li> </ul> </li> <li>○ Add narrative(s) in the NTE segment to report the service(s)</li> </ul> </li> </ul>

**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		
			<p>rendered. An NTE segment is required for each line.</p> <ul style="list-style-type: none"> <li>○ Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage <u>is reported</u> (see 99199) <del>is reported</del></li> <li>○ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation</li> </ul> <ul style="list-style-type: none"> <li>● 99199 -- Mileage for interpreter service                         <ul style="list-style-type: none"> <li>○ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported</li> <li>○ Report one unit per mile</li> </ul> </li> </ul>
12	<a href="#">Physicians/Nonphysician Practitioners</a>	<p>Collaborative psychiatric consultation (<a href="#">MN Statutes 256b.0625, subd. 48</a> – Psychiatric consultation to primary care practitioners)</p>	<p>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:</p> <ul style="list-style-type: none"> <li>● Primary Care – 99499 HE AG</li> <li>● Primary Care – 99499 HE AG U4 (non-face-to-face)</li> <li>● Primary Care – 99499 HE AG U7 (by physician extender)</li> <li>● Primary Care – 99499 HE AG U4 U7 (non-face-to-face by physician extender)</li> <li>● Consulting Psychiatrist – 99499 HE AM</li> <li>● Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face)</li> <li>● Consulting APRN (certified in psychiatric mental health) – 99499 HE AM</li> </ul>

**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		
			<ul style="list-style-type: none"> <li>Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face)</li> <li>Consulting psychologist – 99499 HE AM</li> <li>Consulting psychologist – 99499 HE AM U4 (non-face-to-face)</li> </ul>
12	<a href="#">Physicians/Nonphysician Practitioners</a>	Patient not in exam room	<p>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 management services may be billed based on time to the patient’s group purchaser. Report the appropriate ICD-9-CM code(s), <u>based on date of service</u>, for the diagnosis of the patient as the primary diagnosis or diagnoses. <del>Also ICD-9-CM code V65.19- Other person consulting on behalf of another person must be reported.</del></p>
<del>12</del>	<del><a href="#">Physicians/Nonphysician Practitioners</a></del>	<del>Behavior Health Home</del>	<p><b>Behavior Health Home (BHH) is a monthly service encompassing any or all of the following six services:</b></p> <ol style="list-style-type: none"> <li><b>1- Comprehensive Care Management</b></li> <li><b>2- Care Coordination</b></li> <li><b>3- Health Promotion Services</b></li> <li><b>4- Comprehensive Transitional Care</b></li> <li><b>5- Referral to Community and Social Support Services</b></li> <li><b>6- Individual and Family Support Services</b></li> </ol> <p><del>S0280 U5 – Medical home program, comprehensive care coordination and planning, initial planning</del></p> <p><del>S0281 U5 – Medical home program,</del></p>

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**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																										
			<p><u>comprehensive care coordination and planning, maintenance of plan</u></p> <p><u>Definitions:</u></p> <p><u>Care Engagement: The (initial) first six months of services [can be non-consecutive].</u></p> <p><u>Ongoing Standard Care: The ongoing care (maintenance) after the first six months of care engagement.</u></p> <p><u>U5 modifier: Behavior health home</u></p>																								
12	<u>Physicians/Nonphysician Practitioners</u>	Health Care Homes	<p>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:</p> <p>Patient Complexity Level and Supplemental Factors</p> <table border="1"> <thead> <tr> <th>Patient Complexity Level</th> <th>Complexity Modifiers</th> <th>Non English Speaking Modifier</th> <th>Active Mental Health Condition</th> </tr> </thead> <tbody> <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>Intermediate</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> </tbody> </table> <p>Definitions of U modifiers with S0280 or</p>	Patient Complexity Level	Complexity Modifiers	Non English Speaking Modifier	Active Mental Health Condition	Low (no major conditions)	No modifier	U3	U4	Basic	U1	U3	U4	Intermediate	TF	U3	U4	Extended	U2	U3	U4	Complex (most major conditions)	TG	U3	U4
Patient Complexity Level	Complexity Modifiers	Non English Speaking Modifier	Active Mental Health Condition																								
Low (no major conditions)	No modifier	U3	U4																								
Basic	U1	U3	U4																								
Intermediate	TF	U3	U4																								
Extended	U2	U3	U4																								
Complex (most major conditions)	TG	U3	U4																								

**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		
			S0281: <ul style="list-style-type: none"> <li>o U1 – Care coordination, basic complexity level</li> <li>o U2 – Care coordination, extended complexity level</li> <li>o U3 – Care coordination, supplemental factor; Non-English language</li> <li>o U4 – Care coordination, supplemental factor; Major Active Mental Health Condition</li> </ul>
12	<a href="#">Physicians/Nonphysician Practitioners</a>	ImPACT testing	96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only
12	<a href="#">Physicians/Nonphysician Practitioners</a>	In-reach Community Based Coordination	Use HCPCS T1016-U2 or T1016-U2 TS. <ul style="list-style-type: none"> <li>▪ T1016 Case management, each 15 minutes</li> <li>▪ U2 = In-reach, initial service</li> <li>▪ U2 TS = In-reach, follow-up</li> </ul>
13	<a href="#">Radiology Services and Other Diagnostic Procedures</a>	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	<a href="#">Radiology Services and Other Diagnostic Procedures</a>	Bilateral radiology	Bilateral radiology services are reported as either: <ul style="list-style-type: none"> <li>o one line with a 50 modifier and one unit, or</li> <li>o two separate lines, one with RT modifier and one with LT modifier.</li> </ul>
14	<a href="#">Ambulatory Surgical Centers</a>	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

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**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		
			one line with one unit.
14	<a href="#">Ambulatory Surgical Centers</a>	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier
14	<a href="#">Ambulatory Surgical Centers</a>	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	<a href="#">Ambulance</a>	General	Follow Medicare coding guidelines
15	<a href="#">Ambulance</a>	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: <ul style="list-style-type: none"> <li>▪ A0080</li> <li>▪ A0090</li> <li>▪ A0100</li> <li>▪ A0110</li> <li>▪ A0120</li> <li>▪ T2002</li> <li>▪ T2003</li> <li>▪ T2004</li> </ul>
15	<a href="#">Ambulance</a>	Community Paramedic	Community paramedic services are to be billed as follows: <ul style="list-style-type: none"> <li>• Professional claims only – 837P</li> <li>• Place of services – 12 (home)</li> <li>• Individual provider number – report the Medical director's NPI</li> <li>• 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 <a href="#">section A.3.4.2</a> for units rounding rules)</li> </ul>

**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		
			<ul style="list-style-type: none"> <li>o T1016 Case management, each 15 minutes</li> <li>o U3 – service provided by certified community paramedic (EMT-CP)</li> <li>• Non-reportable services include:                             <ul style="list-style-type: none"> <li>o <del>Incidental</del> Supplies (e.g., gloves, test strips, band aids, etc.);</li> <li>o <u>Vaccines</u>;</li> <li>o Travel;</li> <li>o Mileage;</li> <li>o Medical record documentation.</li> </ul> </li> </ul> <p><del>Supplies and vaccines are reported by the ordering primary care physician only.</del></p>
16	<a href="#">Laboratory Services</a>	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.
16	<a href="#">Laboratory Services</a>	Newborn Screening	<p>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.</p> <p>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.</p>
17	<a href="#">Drugs and Biologicals</a>		Follow Medicare coding guidelines
18	<a href="#">Preventive and Screening Services</a>	Preventive services and coding as	Preventive services and coding as defined by Medicare (i.e. “Welcome to Medicare”) are only applicable to Medicare and

**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		
		defined by Medicare	Medicare replacement products.
18	<a href="#">Preventive and Screening Services</a>	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	<a href="#">Preventive and Screening Services</a>	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-9-CM code set instructions <u>based on date of service</u> . All applicable diagnoses should be submitted.
18	<a href="#">Preventive and Screening Services</a>	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers
18	<a href="#">Preventive and Screening Services</a>	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	<a href="#">Preventive and Screening Services</a>	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

**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		
18	<a href="#">Preventive and Screening Services</a>	Vaccine administration with counseling for patients through 18 years of age	<p>Vaccine administration with counseling for patients through 18 years of age:</p> <ul style="list-style-type: none"> <li>▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components.</li> </ul> <p>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.</p>
N/A	N/A	(C&TC)	<p><del>S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&amp;TC) exam to indicate a complete C&amp;TC exam has been performed.</del></p> <ul style="list-style-type: none"> <li>• <del>Maternal depression screening— 99420-UC</del></li> <li>• <del>Developmental screening— 96110</del></li> <li>▪ <del>Child Mental Health Screening— 96127</del></li> <li>• <del>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.</del></li> <li>• <del>Visit can still be reported as a complete C&amp;TC if documentation shows that a component could not be completed due to:</del> <ul style="list-style-type: none"> <li>◦ <del>Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with \$0.00 or \$0.01 charge</del></li> </ul> </li> </ul>

**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		
			<ul style="list-style-type: none"> <li><del>○ Parent Refusal: Service may still be reported with \$0.00 or \$0.01 charge</del></li> <li><del>○ 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.</del></li> <li><del>▪ Report all C&amp;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.</del></li> <li><del>▪ Use most appropriate diagnosis code based on patient age.</del></li> </ul>
19	<a href="#">Indian Health Services</a>	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	<a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	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	<a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
20	<a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit

**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		
20	<a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	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	<a href="#">Medicare Summary Notices</a>		Not applicable to coding guidelines
22	<a href="#">Remittance Advice</a>		Not applicable to coding guidelines
23	<a href="#">Fee Schedule Administration and Coding Requirements</a>		Follow the code selection guidelines in the Appendix A front matter
24	<a href="#">General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims</a>		Not applicable to coding guidelines
25	<a href="#">Completing and Processing the Form CMS-1450 Data Set</a>		Not applicable to coding guidelines
26	<a href="#">Completing and Processing Form CMS-1500 Data Set</a>		Not applicable to coding guidelines
27	<a href="#">Contractor Instructions for CWF</a>		Not applicable to coding guidelines
28	<a href="#">Coordination with Medigap, Medicaid, and other Complementary Insurers</a>		Not applicable to coding guidelines
29	<a href="#">Appeals of Claims Decisions</a>		Not applicable to coding guidelines

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**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		
30	<a href="#">Financial Liability Protections</a>		Not applicable to coding guidelines
31	<a href="#">ANSI X12N Formats Other than Claims or Remittance</a>		Not applicable to coding guidelines
32	<a href="#">Billing Requirements for Special Services</a>		Follow the code selection guidelines in the front matter of Appendix A
33	<a href="#">Miscellaneous Hold Harmless Provisions</a>		Not applicable to coding guidelines
34	<a href="#">Reopening and Revision of Claim Determinations and Decisions</a>		Not applicable to coding guidelines
35	<a href="#">Independent Diagnostic Testing Facility (IDTF)</a>		Not applicable to coding guidelines
36	<a href="#">Competitive Bidding</a>		Not applicable to coding guidelines
37	<a href="#">Department of Veteran Affairs (VA) Claims Adjudication Services Project</a>		Not applicable to coding guidelines
38	<a href="#">Emergency Preparedness Fee for Service Guidelines</a>		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); Family Caregiver Services; and Early Intensive Developmental and Behavioral Intervention (EIDBI).~~

**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		
N/A	N/A	<p>Doula Services</p> <p><a href="#">MS 256B.0625, Subd. 28B Doula Services</a></p>	<p>Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to <del>six</del><u>seven</u> sessions. Prior authorization with medical necessity documentation is required for any additional sessions beyond the <del>six</del><u>seven</u>. 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 doula under the supervising practitioner's NPI.</p> <p>Coding and billing for these services on the 837P are as follows:</p> <ul style="list-style-type: none"> <li>▪ S9445 U4 – ante-partum and post – partum Doula services</li> <li>▪ 99199 U4 – Doula attendance at labor and delivery</li> </ul>
N/A	N/A	Home Infusion	<p>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.</p>
N/A	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	<p>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.</p> <p><u>Place of Service:</u></p> <p>25 – Free-standing Birthing Center</p>

**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		
			<p><u>HCPCS Code:</u></p> <p>Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered.</p> <p>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.</p> <p>Fragmented services may be reported in certain circumstances:</p> <ul style="list-style-type: none"> <li>• If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes).</li> <li>• If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code.</li> <li>• Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service).</li> <li>• 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.</li> </ul> <p>Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.</p>

**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		
N/A	N/A	Child and Teen Checkups (C&TC)	<p><u>S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&amp;TC) exam to indicate a complete C&amp;TC exam has been performed. Refer to DHS for the C&amp;TC Provider Guide webpage for a complete list of reportable component codes.</u></p> <ul style="list-style-type: none"> <li>▪ <u>96110 – Developmental screening</u></li> <li>▪ <u>96110 U1 – Autism Screening</u></li> <li>▪ <u>96127 – Social/Emotional or Mental Health Screening</u></li> <li>▪ <u>Visit can still be reported as a complete C&amp;TC if documentation shows that a component could not be completed due to:</u> <ul style="list-style-type: none"> <li>○ <u>Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with \$0.00 or \$0.01 charge</u></li> <li>○ <u>Parent Refusal: Service may still be reported with \$0.00 or \$0.01 charge</u></li> <li>○ <u>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.</u></li> </ul> </li> <li>▪ <u>Report all C&amp;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.</u></li> </ul>

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**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		
			<ul style="list-style-type: none"> <li>▪ <u>Use most appropriate diagnosis code based on patient age.</u></li> </ul>
<u>N/A</u>	<u>N/A</u>	<u>Family Caregiver Services</u>	<p><u>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.</u></p> <ul style="list-style-type: none"> <li>• <u>S5115 – Home care training, nonfamily; per 15 minutes, Family Caregiver Training and Education</u></li> <li>• <u>S5115 TF – Home care training, nonfamily; per 15 minutes, Family Counseling and Assessment</u></li> <li>• <u>S5115 TG – Home care training, nonfamily; per 15 minutes; Complex/high level of care, Family Memory Care</u></li> </ul>

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**Table A.5.1 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, the table has been formatted differently for greater 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

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

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]

HO – Masters /Mental Health Professional [MHP]

HN – Bachelor’s degree level I or II

HM – Less than bachelor degree level III

TF – 60-day temporary increase for ABA/DBI services

UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

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

2. EIDBI Observation and Direction

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

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  
UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

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

**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]

<u>Coding</u>
<u>0359T UB AM –Psychiatrist[MD]/Physician</u>

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

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**

T1027 UB HK – Qualified Supervising Professional [QSP]

**Coding Group**

T1027 UB HK HQ – Qualified Supervising Professional [QSP], Group

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

<u>T1027 UB HK GT– Qualified Supervising Professional [QSP] (telemedicine)</u>	<u>T1027 UB HP HQ – Doctorate /Mental Health Prof [MHP], Group</u>
<u>T1027 UB HP – Doctorate /Mental Health Prof [MHP]</u>	<u>T1027 – UB HO HQ – Masters /Mental Health Prof [MHP], Group</u>
<u>T1027 UB HP GT – Doctorate /Mental Health Prof [MHP] (telemedicine)</u>	<u>T1027 UB HN HQ – Bachelor’s degree level I or II, Group</u>
<u>T1027 UB HO – Masters /Mental Health Prof [MHP]</u>	
<u>T1027 UB HO GT – Masters /Mental Health Prof [MHP] (telemedicine)</u>	
<u>T1027 UB HN – Bachelor’s degree level I or II</u>	
<u>T1027 UB HN GT – Bachelor’s degree level I or II (telemedicine)</u>	

**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)

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

**7. Travel Time**

Selected Codes

H0046

UB – EIDBI [Early Intensive Developmental and Behavior Intervention]

Notes:

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

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 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**

<b>Modifier</b>	<b>Description</b>
<u>UB</u>	<u>EIDBI</u>
<u>UB AM</u>	<u>EIDBI, Physician or Psychiatrist</u>
<u>UB AM GT</u>	<u>EIDBI, Physician or Psychiatrist, Telemedicine</u>
<u>UB HK</u>	<u>EIDBI, Qualified Supervising Professional [QSP]</u>
<u>UB HK GT</u>	<u>EIDBI, Qualified Supervising Professional [QSP], Telemedicine</u>
<u>UB HK UD</u>	<u>EIDBI, Qualified Supervising Professional [QSP], PER 15 MINUTES</u>
<u>UB HM</u>	<u>EIDBI, Level III, Support Specialist, less than Bachelor's</u>
<u>UB HN</u>	<u>EIDBI, Bachelor's level I or II</u>
<u>UB HN GT</u>	<u>EIDBI, Bachelor's level I or II, Telemedicine</u>
<u>UB HN HQ</u>	<u>EIDBI, Bachelor's Degree Level I or II, Group</u>
<u>UB HN UD</u>	<u>EIDBI, Bachelor's level I or II, PER 15 MINUTES</u>
<u>UB HO</u>	<u>EIDBI, Masters /Mental Health Professional [MHP]</u>
<u>UB HO GT</u>	<u>EIDBI, Masters /Mental Health Professional [MHP], Telemedicine</u>
<u>UB HO HQ</u>	<u>EIDBI, Masters/Mental Health Professional, Group</u>
<u>UB HO UD</u>	<u>EIDBI, Masters /Mental Health Professional [MHP], PER 15 MINUTES</u>
<u>UB HP</u>	<u>EIDBI, Doctorate /Mental Health Professional [MHP]</u>
<u>UB HP GT</u>	<u>EIDBI, Doctorate /Mental Health Professional [MHP], Telemedicine</u>
<u>UB HP HQ</u>	<u>EIDBI, Doctorate/Mental Health Professional, Group</u>
<u>UB HP UD</u>	<u>EIDBI, Doctorate /Mental Health Professional [MHP], PER 15 MINUTES</u>
<u>UB TG</u>	<u>EIDBI, APRN</u>
<u>UB TG GT</u>	<u>EIDBI, APRN, Telemedicine</u>

**Note: TF is only used on ABA or DBI Interventions as a third modifier; with prior approval**

<u>UB H TF</u>	<u>60-day temporary increase for ABA/DBI services</u>
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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)
<b>NOTE: The U modifiers in this table are specific to Mental Health.</b>	

#### 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 Diagnostic Assessment](#)

[Dialectical Behavior Therapy](#)

[Youth Assertive Community Treatment](#)

[Intensive Treatment in Foster Care](#)

[Mental Health Family Psychoeducation Services](#)

[Mental Health Clinical Care Consultation](#)

[Certified Family Peer Specialist Services](#)

[Behavior Health Home](#)

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
<b>Assertive Community Treatment (ACT)</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>▪ An intensive, comprehensive, non-residential rehabilitative mental health services (ARMHS) team model. Consistent with ARMHS - multidisciplinary total team approach.</li> <li>▪ Patients with serious mental illness who require intensive services; time unlimited basis, available 24/7/365.</li> <li>▪ Face-to-face, all-inclusive daily rate.</li> <li>▪ One provider per day</li> </ul>	<u>Codes:</u> <ul style="list-style-type: none"> <li>▪ H0040 - Assertive community treatment program, per diem</li> </ul>
<b>Adult Crisis Response Services</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>▪ County or county-contracted mental health professional, practitioner, or rehab worker; or crisis intervention team.</li> <li>▪ Crisis assessment, intervention, stabilization, community intervention.</li> <li>▪ Immediate, face-to-face evaluation, determine need for emergency services or referrals to other resources.</li> </ul>	<u>Codes:</u> <ul style="list-style-type: none"> <li>▪ S9484 – Adult individual crisis assessment, intervention and stabilization, individual, by mental health professional or practitioner</li> <li>▪ S9484 HM – Adult crisis assessment, intervention and stabilization, individual, by mental health rehabilitation worker</li> <li>▪ S9484 HN – Adult crisis assessment, intervention and stabilization, individual, by mental health practitioner</li> <li>▪ S9484 HQ – Adult crisis stabilization, group</li> <li>▪ H0018 – Adult crisis stabilization, residential</li> <li>▪ 90882 HK – Environmental intervention for medical management, community intervention</li> <li>▪ 90882 HK HM – Environmental intervention for medical management, community intervention, mental health rehabilitation worker</li> </ul>
<b><u>Behavior Health Homes</u></b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>▪ <u>Behavior Health Home (BHH) is a monthly service encompassing any or all of the following six services:</u> <ol style="list-style-type: none"> <li><u>1. Comprehensive Care Management</u></li> <li><u>2. Care Coordination</u></li> </ol> </li> </ul>	<u>Coding:</u> <p><u>S0280 U5 – Medical home program, comprehensive care coordination and planning, initial planning</u></p> <p><u>S0281 U5 – Medical home program, comprehensive care coordination and planning,</u></p>

**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
	<p><u>3. Health Promotion Services</u>  <u>4. Comprehensive Transitional Care</u>  <u>5. Referral to Community and Social Support Services</u>  <u>6. Individual and Family Support Services</u></p> <ul style="list-style-type: none"> <li>▪ <u>Definitions:</u> <ul style="list-style-type: none"> <li>○ <u>Care Engagement: The (initial) first six months of services [can be non-consecutive].</u></li> <li>○ <u>Ongoing Standard Care: The ongoing care (maintenance) after the first six months of care engagement.</u></li> </ul> </li> </ul>	<p><u>maintenance of plan</u></p>
<p><b>Children's Mental Health Crisis Response Services</b>  <a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>▪ Intensive face-to-face, short-term services initiated during a crisis; provided on-site by a mobile crisis response team.</li> <li>▪ County or county contracted agency.</li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>▪ S9484 UA - Crisis intervention mental health services, per hour, Children's Crisis Response Services, mental health professional</li> <li>▪ S9484 UA HN - Crisis intervention mental health services, per hour, Children's Crisis Response Services, bachelor's degree level mental health practitioner</li> </ul>
<p><b>Mental Health Targeted Case Management (MH-TCM)</b>  <a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ T2023 HE – Targeted case management; per month, mental health program, face-to-face contact between case manager and recipient 18 years or older</li> <li>▪ 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</li> <li>▪ T2023 HE TG - Targeted case management complex/high level of care; per month, mental</li> </ul>

**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
		<p>health program, face-to face contact between case manager and recipient 18 years or older</p> <ul style="list-style-type: none"> <li>▪ T2023 HE U4 – Targeted case management, per month, mental health program, telephone contact between case manager and recipient 18 years or older</li> <li>▪ 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</li> <li>▪ 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</li> </ul>
<p><b>Children's Mental Health Residential Treatment Services</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>▪ 24-hour-a-day program under clinical supervision of a mental health professional, provided in a community setting.</li> </ul>	<p>PMAP/Commercial/County-based Purchasing (CBP):</p> <p>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.</p> <ul style="list-style-type: none"> <li>○ Submit the room and board charges under revenue code 1001 and the treatment services under revenue codes 090X or 091X.</li> </ul> <p>Department of Human Services (DHS)/ Fee for Service:</p> <p>When room and board with treatment is billed, services are reported on the 837P, with HCPCS Code H0019, and POS 99.</p>
<p><b>Intensive Residential Treatment Services (IRTS)</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Develop and enhance psychiatric stability, personal</li> </ul>	<p>PMAP/Commercial/County-based Purchasing (CBP):</p> <p>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.</p> <ul style="list-style-type: none"> <li>○ Submit the room and board charges under revenue code 1001 and the</li> </ul>

**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
	and emotional adjustment, self-sufficiency and skills to live in a more independent setting.	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.
<b>Adult Day Treatment</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>▪ 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</li> </ul>	<u>Codes:</u> <ul style="list-style-type: none"> <li>▪ H2012 - Behavioral health day treatment, per hour</li> </ul>
<b>Children's Day Treatment</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>▪ A structured MH treatment program consisting of group psychotherapy and other intensive therapeutic services provided by multidisciplinary team.</li> </ul>	<u>Codes:</u> <ul style="list-style-type: none"> <li>▪ H2012 UA HK – Behavioral health day treatment, per hour, CTSS</li> <li>▪ H2012 UA HK U6 – Behavioral health day treatment, per hour, CTSS interactive</li> </ul>
<b>Children's Therapeutic Services and Supports (CTSS)</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>	<u>Codes:</u> <ul style="list-style-type: none"> <li>▪ 90832 UA – Psychotherapy w/patient and/or family, 30 minutes, CTSS</li> <li>▪ 90833 UA – Psychotherapy w/patient and/or family, 30 minutes with an E/M*, CTSS</li> <li>▪ 90834 UA - Psychotherapy w/patient and/or family, 45 minutes, CTSS</li> <li>▪ 90836 UA - Psychotherapy w/patient and/or family, 45 minutes with an E/M*, CTSS</li> <li>▪ 90837 UA - Psychotherapy w/patient and/or family, 60 minutes, CTSS</li> <li>▪ 90837 UA plus 99354 Psychotherapy w/patient and/or family 60 minutes, CTSS</li> <li>▪ 90838 UA- Psychotherapy w/patient and/or family, 60 minutes with E/M*, CTSS</li> <li>▪ 90839 UA –Psychotherapy for crisis, first 60</li> </ul>

**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
		<p>minutes, CTSS</p> <ul style="list-style-type: none"> <li>▪ 90840 UA- Each additional 30 mins [add on to 90839], CTSS</li> <li>▪ 90846 UA - Family psychotherapy without patient, CTSS</li> <li>▪ 90847 UA - Family psychotherapy with patient, CTSS</li> <li>▪ 90849 UA - Multiple family group psychotherapy, CTSS</li> <li>▪ 90853 UA - Group psychotherapy, CTSS</li> <li>▪ 90875 UA - Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy , 30 minutes, CTSS</li> <li>▪ 90876 UA Individual psychophysiological therapy incorporating biofeedback by any modality, with psychotherapy, 45 minutes, CTSS</li> <li>▪ H2014 UA - Skills training &amp; development, individual, per 15 minutes, CTSS</li> <li>▪ H2014 UA HQ - Skills training &amp; development, group, per 15 minutes, CTSS</li> <li>▪ H2014 UA HR - Skills training &amp; development - family, per 15 minutes, CTSS</li> <li>▪ H2015 UA - Comprehensive community support services - crisis assistance, 15 minutes, CTSS</li> <li>▪ H2019 UA - Therapeutic behavioral services, Level I Mental Health Behavioral Aide (MHBA), 15 minutes, CTSS</li> <li>▪ H2019 UA HM - Therapeutic behavioral services, Level II MHBA, 15 minutes, CTSS</li> <li>▪ H2019 UA HE - Therapeutic behavioral services direction of MHBA, 15 minutes, CTSS</li> </ul> <p>*(Use 90833-UA, 90836-UA or 90838-UA in conjunction with 99201-99255 where documentation supports per CPT manual)</p> <p>*(Use 90785-UA in conjunction with 90832-90838</p>

**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
<p><b>Adult Rehabilitative Mental Health Services (ARMHS)</b> <a href="#">Back to list of behavioral health programs</a></p>	<p>Develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills.</p>	<p>when psychotherapy includes interactive complexity services)</p> <p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>▪ H2017 - Basic living and social skills, individual; mental health professional or practitioner, per 15 minutes</li> <li>▪ H2017 HM - Basic living and social skills, individual; mental health rehabilitation worker, per 15 minutes</li> <li>▪ H2017 HQ - Basic living and social skills, group; mental health professional, practitioner, or rehabilitation worker, per 15 minutes</li> <li>▪ H2017 UD - Basic living and social skills, transitioning to community, mental health professional or practitioner</li> <li>▪ H2017 UD HM - Basic skills, transitioning to community, less than bachelor's degree level, mental health rehabilitation worker</li> <li>▪ <u>H0031 - Mental health assessment, by non-physician</u></li> <li>▪ <u>H0032 - Mental health service plan development by non-physician</u></li> <li>▪ <u>H0031 TS - Mental health assessment, by physician, Follow up service [Review or update]</u></li> <li>▪ <u>H0032 TS - Mental health service plan development by non-physician, Follow up services [Review or update]</u></li> <li>▪ <b>H0034 - Medication education, individual: MD, RN, PA or Pharmacist</b></li> <li>▪ <b>H0034 HQ - Medication education, group setting</b></li> <li>▪ 90882 - Environmental/community intervention, mental health professional or practitioner</li> <li>▪ 90882 HM - Environmental/community intervention, mental health rehabilitation worker</li> </ul>

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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
		<ul style="list-style-type: none"> <li>▪ 90882 UD - Environmental/community intervention; transition to community living intervention</li> <li>▪ 90882 UD HM - Environmental/community intervention; transition to community living intervention, less than bachelor's degree level, mental health rehabilitation worker</li> </ul>
<p><b>Certified Peer Specialist Services</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p>Non-clinical support counseling services <u>for adults</u> provided by certified peer specialist.</p>	<p><b>Codes:</b></p> <ul style="list-style-type: none"> <li>▪ H0038 – Certified peer specialist services, per 15 minutes</li> <li>▪ H0038 U5 – Advanced level certified peer specialist services, per 15 minutes</li> </ul>
<p><b>Mental Health Diagnostic Assessment</b></p> <p><a href="#">Back to list of behavioral health programs</a></p>	<p>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.</p>	<p><b>Codes:</b></p> <p>In order to report diagnostic assessments with levels of complexity, report as follows:</p> <ul style="list-style-type: none"> <li>▪ 90791/90792 – Standard diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 plus 90785 – Interactive standard diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 52 – Brief diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 52 plus 90785 – Interactive brief diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TS – Adult update diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TS plus 90785 – Interactive adult update diagnostic assessment, without medical service/with medical service</li> <li>▪ 90791/90792 TG – Extended diagnostic assessment, without medical service/with medical service</li> </ul>

**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
		<ul style="list-style-type: none"> <li>▪ 90791/90792 TG plus 90785 – Interactive extended diagnostic assessment, without medical service/with medical service</li> </ul>
<p><b>Dialectical Behavior Therapy</b> <a href="#">Back to list of behavioral health programs</a></p>	<p>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.</p>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>▪ H2019 U1 – Therapeutic behavioral services, per 15 minutes, DBT</li> <li>▪ H2019 U1 HN – Therapeutic behavioral services, per 15 minutes, DBT, by qualified trainee</li> <li>▪ H2019 U1 HA – Therapeutic behavioral services, per 15 minutes, DBT, adolescent</li> <li>▪ H2019 U1 HA HN – Therapeutic behavioral services, per 15 minutes, DBT, adolescent, by qualified trainee</li> <li>▪ H2019 U1 HQ – Therapeutic behavioral services, per 15 minutes, DBT, group</li> <li>▪ H2019 U1 HQ HN – Therapeutic behavioral services, per 15 minutes, DBT, group, by qualified trainee</li> <li>▪ H2019 U1 HQ HA – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent</li> <li>▪ H2019 U1 HQ HA HN – Therapeutic behavioral services, per 15 minutes, DBT, group, adolescent, by qualified trainee</li> </ul>
<p><b>Youth Assertive Community Treatment</b> <a href="#">Back to list of behavioral health programs</a></p>	<p>Intensive nonresidential rehabilitative mental health services as adapted for youth ages 16 to 21.</p>	<ul style="list-style-type: none"> <li>▪ H0040 HA – Assertive community child/adolescent treatment program per diem, ages 16 through 20</li> </ul>
<p><b>Intensive Treatment in Foster Care</b> <a href="#">Back to list of behavioral health programs</a></p>	<p>Intensive treatment services to children with mental illness residing in foster family settings. (<a href="#">MS 256B.0946 Intensive Treatment in Foster Care</a>) (1) Psychotherapy provided by a</p>	<p><u>Codes:</u></p> <ul style="list-style-type: none"> <li>▪ S5145 – Foster care, therapeutic, child; per diem</li> <li>▪ HE – Mental health program</li> </ul> <p>Bill only one per diem code per day regardless of the number of services or who provides services.</p>

**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 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.	
<b>Mental Health Family Psycho-education Services</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>• 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 <a href="#">Minnesota Rules, part 5.9505.0371, subpart 5, item C</a></li> <li>• Information or demonstration provided to an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in:                             <ul style="list-style-type: none"> <li>○ understanding a child's symptoms of mental illness;</li> <li>○ the impact on the child's development;</li> <li>○ needed components of treatment; and</li> <li>○ skill development.</li> </ul> </li> </ul>	<b>Codes:</b> <ul style="list-style-type: none"> <li>▪ H2027 - Individual</li> <li>▪ H2027 HQ - Group (peer group)</li> <li>▪ H2027 HR - Family with client present</li> <li>▪ H2027 HS - Family without client present</li> <li>▪ H2027 HQ HR - Multiple different families with clients present</li> <li>▪ H2027 HQ HS - Multiple different families without clients present</li> <li>▪ H2027 HN - Individual, clinical trainee</li> <li>▪ H2027 HQ HN - Group (peer group), clinical trainee</li> <li>▪ H2027 HR HN - Family with client present, clinical trainee</li> <li>▪ H2027 HS HN - Family without client present, clinical trainee</li> <li>▪ H2027 HQ HR HN - Multiple different families with clients present, clinical trainee</li> <li>▪ H2027 HQ HS HN - Multiple different families without clients present, clinical trainee</li> </ul>
<b>Mental Health Clinical Care</b>	<ul style="list-style-type: none"> <li>• MH clinical care consultation</li> </ul>	<b>Codes:</b>

**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
<b>Consultation</b> <a href="#">Back to list of behavioral health programs</a>	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. <ul style="list-style-type: none"> <li>Services may take place in, but are not limited to, school, community, office or clinic</li> </ul>	<ul style="list-style-type: none"> <li>90899-U8 (5-10 minutes)</li> <li>90899-U9 (11-20 minutes)</li> <li>90899-UB (21-30 minutes)</li> <li>90899-UC (31+ minutes)</li> </ul> Additional modifiers could be appended, such as U4 for phone and/or HN for clinical trainee.
<b>Certified Family Peer Specialist – DHS</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>Services are for children with the HA modifier</li> <li>For mental health services only; do not apply to substance abuse</li> </ul>	Codes: <ul style="list-style-type: none"> <li>H0038 Certified -peer specialist services, per 15 minutes</li> <li>H0038 U5 Advanced level certified peer specialist services, per 15 minutes</li> <li>H0038 HQ Group setting, certified peer specialist services, per 15 minutes</li> <li>H0038 HA Child/adolescent program, certified peer specialist services, per 15 minutes</li> <li>H0038 HA HQ Child/adolescent program, group setting, per 15 minutes</li> </ul>
<b>Behavior Health Home</b> <a href="#">Back to list of behavioral health programs</a>	<ul style="list-style-type: none"> <li>Behavior Health Home (BHH) is a monthly service encompassing any or all of the following six services:                             <ol style="list-style-type: none"> <li>Comprehensive Care Management</li> <li>Care Coordination</li> <li>Health Promotion Services</li> <li>Comprehensive Transitional Care</li> <li>Referral to Community and Social Support Services</li> <li>Individual and Family Support Services</li> </ol> </li> <li>Definitions:                             <ul style="list-style-type: none"> <li>Care Engagement: The (initial) first six months of</li> </ul> </li> </ul>	S0280 U5 – Medical home program, comprehensive care coordination and planning, initial planning  S0281 U5 – Medical home program, comprehensive care coordination and planning, maintenance of plan

**Commented [JE2]:** Kathy is the HA modifier for children under a certain age. Please note I made a change to the original bullet: deleted “under the following codes”

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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
	<p>services [can be non-consecutive].</p> <ul style="list-style-type: none"> <li>o Ongoing Standard Care: The ongoing care (maintenance) after the first six months of care engagement.</li> <li>o U5 modifier: Behavior health home</li> </ul>	

**Commented [JE3]:** Kathy you might want to say something about this U5 modifier because it is defined in this table as being "advanced level specialist". Perhaps something similar like we have for health care homes, i.e., when used with these CPT codes...

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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**

*v10.0 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

**\*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**

*v10.0 MUJG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)*

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

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Service Description	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
<b>Room and Board</b>	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
<b>Detox</b>	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
<b>Treatment program, treatment component</b>	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
<b>Treatment program, treatment component</b>	Hour	0953	None	837I	086x – special facility, residential
<b>Ancillary services</b>	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 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)

<b>Claim Type – 837I</b>				
<b>Service Description</b>	<b>Unit</b>	<b>Revenue Code</b>	<b>HCPCS Procedure Code</b>	<b>Type of Bill</b>
<b>Outpatient program; Treatment only</b>	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 ( <i>individual</i> )	089x or 013x
<b>Medication Assisted Therapy (MAT)</b>	Day	0944	H0020	089x or 013x
<b>MAT – all other drugs</b> <b>Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.</b>	Day	0944	H0047 U9	089x or 013x
<b>Alcohol and/or drug assessment</b>	Session/visit	0900	H0001	As appropriate
<b>Outpatient Ancillary Services</b>	Based on revenue code	As appropriate		089x or 013x

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

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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
<b>Outpatient program; Treatment only</b>	Hour	N/A	H2035 HQ (group) H2035 ( <i>individual</i> )	N/A
<b>Medication Assisted Therapy (MAT)</b>	Day	N/A	H0020	N/A
<b>MAT – all other drugs</b>	Day	N/A	H0047 U9	N/A
<b>MAT Plus</b>	Day	N/A	H0020 UA	N/A
<b>MAT Plus – all other drugs</b>	Day	N/A	H0047 UB	N/A
<p>Note: Take-home doses place of service guide: The POS for directly observed administration would be 11 or 22. Additional days where the patient self-administers the doses should be reported with POS 12.                      MAT Plus – a licensed program providing at least 9 hours of treatment service per week                      U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.                      UA – MAT Plus, methadone                      UB – MAT Plus, all other drugs</p>				
<b>Alcohol and/or drug assessment</b>	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](#)

**Table A.5.4.a – PUBLIC HEALTH NURSE CLINIC SERVICES**

<i>V10.0-MUCG for the ASC X12N/005010X222A1 Health Care Claim- Professional (837)</i>		
Maternal And Child Health Billing Guide For Public Health Agencies		
<b>Table A.5.4.a -- <u>Public health nurse clinic services</u></b>		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
Services Include: <ul style="list-style-type: none"> <li>• Health Promotion &amp; Counseling</li> <li>• Nursing Assessment &amp; Diagnostic Testing</li> <li>• Medication Management</li> <li>• Nursing Treatment</li> <li>• Nursing Care, in the home, by RN (PHN &amp; CPHN)</li> </ul>	S9123	T1015
Home health aide or CNA, per visit	T1021	<del>Individual S9445- Group S9446</del> T1021
Patient Education only - if no other services (includes car seat education)	<del>S9123-Individual S9445 Group S9446</del>	Individual S9445 Group S9446

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

*v10.0 MUCC for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)*

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 - <b>Mother</b>	99501	N/A
Home Visit for Post-natal assessment & follow up care - <b>Newborn</b>	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**

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

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 <b>assessment</b> and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial <b>re-assessment</b> and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

*v8.0 MUCG for the ASC X12N/005010X222A1 Health Care Claim: Professional (837)*

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 Screenings	99420 UC	99420 UC
Child Developmental Screenings	96110	96110
<u>Autism Screening</u>	<u>96110 U1</u>	<u>96110 U1</u>
Child <u>Social/Emotional or</u> Mental Health Screenings	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 (MDH) Proposed Rule for Public Comment

<b>Title:</b>	<b><u>Proposed</u> Minnesota Uniform Companion Guide (MUCG) -for the <u>Implementation of the</u> ASC X12/005010X224A2 Health Care Claim: Dental (837) -Version 10.0</b>
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:	<p>This document was <del>adopted into rule on June 1, 2015</del> announced as a <u>proposed revised rule for public comment on [TBD]. The public comment period is from [TBD].</u></p> <p>[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.]</p> <p>This document:</p> <ul style="list-style-type: none"> <li>• 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;</li> <li>• 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);</li> <li>• Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).</li> </ul>
Status of this document:	<p>This is version <del>10.0 (v10.0)</del> <u>11.0 (v11.0)</u> of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X224A2 Health Care Claim: Dental (837). It was announced as <del>an adopted a proposed</del> rule in the Minnesota State Register, <del>Volume 39, Number 48, June 1, 2015</del> pursuant to Minnesota Statutes, section 62J.536 and 62J.61 <u>on [TBD]. This document has not been adopted into rule.</u></p> <p><del>Version 8.0 was the last version of this document to be adopted into rule prior to this v10.</del></p> <p>This document is available at no charge at MDH's "<a href="http://www.health.state.mn.us/asa/rules.html">Administrative Simplification</a> webpage <del>-(http://www.health.state.mn.us/asa/rules.html).</del></p>



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# 1. Overview

## 1.1. Statutory basis for this rule

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

## 1.2. Applicability of state statute and related rules

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

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

[Minnesota Statutes, section 62J.03, Subd. 6](#) defines "group purchaser" as follows:

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

[Minnesota Statutes, section 62J.03, Subd. 8](#) defines "provider or health care provider" as follows:

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

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

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

[Minnesota Statutes, section 62J.51, Subd. 11a](#) defines "health care clearinghouse" as follows:

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

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

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

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

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

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

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

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

### **1.2.1. Exceptions to applicability**

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

- i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

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

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

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

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

### **1.3. About the Minnesota Department of Health (MDH)**

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

#### **1.3.1. Contact for further information on this document**

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

Version	Revision Date	Summary Changes
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.
<u>11.0</u>	<u>TBD</u>	<u>Proposed revisions to v10.0</u>

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

#### 2.1.1. Permission to use copyrighted information.

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

### 2.2. Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X224A2*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules and requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X224A2* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

#### Please note:

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

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## 3. How to use this document

### 3.1. Classification and display of Minnesota-specific requirements

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

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

This document also contains the following two appendices:

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

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

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

#### 3.2.1. Business Terminology

The terms below were published with definitions and other information in the previous version of this companion guide to provide additional clarification and/or because of changes that occurred as a result of the adoption of version 5010. Definitions of these terms are no longer being included in this companion guide. However, the terms are discussed and defined in the reference document to this companion guide (the 005010X224A2), which is available for purchase from ASCX12 at: <http://store.x12.org/store>

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

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

### 3.2.1.1. Other Definitions

#### Factoring Agent

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

### 3.2.2. Provider Identifiers and NPI Assignments

#### Provider Identifiers

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

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

### 3.2.3. Handling Adjustments and Appeals

#### 3.2.3.1. Determination of Action:

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

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

#### 3.2.3.2. Definitions:

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

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

reconsiderations or appeals.

Examples of appeals include:

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

### 3.2.3.3. Process for submission:

- Adjustment – Provider should submit an adjustment electronically using the appropriate value in CLM05-3 to indicate that this is a replacement claim.

If the payer has assigned a payer number to the claim, it must be submitted in loop 2300, REF02, using qualifier F8 in REF01 (Note: the original payer- assigned claim number is not the property and casualty number). If additional information is required to support the adjustment based on payer business rules, the SV301-7, NTE segment, PWK segment, or Condition Codes should be used. See section 3.2.5 below regarding these segments for appropriate instructions.

- Appeal – Follow payer standard processes for requesting an appeal to a previously adjudicated claim. If paper appeal process is utilized, then a standard, Best Practice Minnesota appeal form is available at the [AUC website](http://www.health.state.mn.us/auc/index.html) 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 or SV301-7 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 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 12 electronic acknowledgment for the attachment process.

• 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/005010X224A2 Health Care Claim Dental (837) – Transaction Specific Information

### 4.1. Introduction to Table

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

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

Please also see section 2.2 above.

### 4.2. 005010X224A2 Dental(837) -- Transaction Table

MUCG for the Implementation of the ASC X12/005010X224A2 Health Care Claim: Dental (837) Version 10.0.			
Table 4.2 005010X224A2 Dental (837) Transaction Specific Information			
This table summarizes transaction specific information to be used in conjunction with the 005010X224A2 and any other applicable information and specifications noted in section 2.2.			
Loop	Segment	Data Element (if applicable)	Value Definition and Notes
2000B Subscriber Hierarchical Level	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has processed.
2010BA Subscriber Name	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
2300 Claim Information	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter <a href="#">section 3.2.4</a> 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 <a href="#">section 3.2.5</a> of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300 Claim Information	DN2 Tooth Status	N/A	Required when the tooth status codes in DN202 apply to the claim.

**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
2300 Claim Information	PWK Claim Supplemental Information	N/A	See front matter <a href="#">section 3.2.5</a> 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	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
<u>2400 Service Line Number</u>	<u>SV3 Dental Service</u>	<u>N/A</u>	<u>See Appendix A of this document for details on reporting Teledentistry services</u>

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## 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. It also provides information and instructions regarding teledentistry and eligible teledentistry codes.

### 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.

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### ~~B-C.~~ Appendix BC: Reporting MNCare Tax

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

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

### A.1 A. Introduction

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

The Appendix covers:

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

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)<sup>1</sup> 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

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<sup>1</sup> CDT is a registered trademark of the American Dental Association (ADA)

Medicaid Services (CMS) whenever possible.

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

#### **A.4 Units (basis for measurement)**

- Units are reported according to the code description.

#### **A.5 Teledentistry**

Minnesota Statutes 256B.0625 expanded telemedicine to include dental benefits (teledentistry) under Medical Assistance and MinnesotaCare, effective January 1, 2016. Minnesota Statutes, section 62A.672 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.

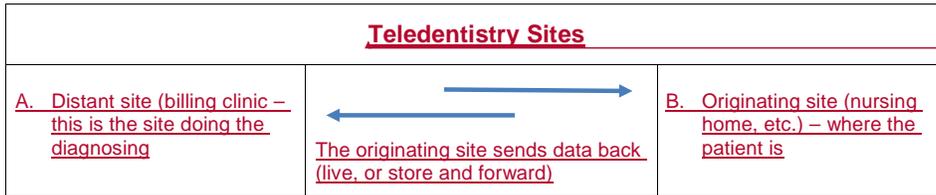
Dental services must be performed via real-time two-way, interactive video or store and forward technology as defined below.

##### **Real-time two-way interactive video**

Involves a videoconferencing session that allows health professionals at distant locations to communicate with each other. A typical set-up involves high-definition webcams combined with hands-free microphone/speaker units so that the users can see and hear each other. For this type of consultation, both parties arrange a meeting time and information is exchanged in real-time between sites. This type requires sufficient bandwidth and HIPAA compliant software.

##### **Store and forward technology**

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.



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### A.5.1 Minnesota Coding Specifications for Teledentistry Table

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Table A.5.1 lists eligible dental codes and modifier combinations for identifying teledentistry services unique to Minnesota. The table also includes the definition of the U9 modifier and notes regarding non-billable services and coverage limitations.

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<b>Table A.5.1 Minnesota Coding Specifications for Teledentistry</b>		
<u>Eligible teledentistry codes are listed below:</u>		
<u>Code</u>	<u>Modifier</u>	<u>Description</u>
<u>D0120</u>	<u>U9</u>	<u>Periodic oral evaluation - established patient</u>
<u>D0140</u>	<u>U9</u>	<u>Limited oral exam</u>
<u>D0145</u>	<u>U9</u>	<u>Oral evaluation for a patient under 3 years of age</u>
<u>D0150</u>	<u>U9</u>	<u>Comprehensive oral evaluation, new or established patient</u>
<u>D0210</u>	<u>U9</u>	<u>Intraoral – complete series of radiographic images</u>
<u>D0220</u>	<u>U9</u>	<u>Intraoral – periapical first radiographic image</u>
<u>D0230</u>	<u>U9</u>	<u>Intraoral – periapical each additional radiographic image</u>
<u>D0240</u>	<u>U9</u>	<u>Intraoral – occlusal radiographic image</u>
<u>D0270</u>	<u>U9</u>	<u>Bitewing – single radiographic image</u>
<u>D0272</u>	<u>U9</u>	<u>Bitewings – two radiographic images</u>
<u>D0274</u>	<u>U9</u>	<u>Bitewings – four radiographic images</u>
<u>D0330</u>	<u>U9</u>	<u>Panoramic radiographic image</u>
<u>D9310</u>	<u>U9</u>	<u>Medical Dental Consultation</u>
		<ul style="list-style-type: none"> <li>• <u>Definition of U9 modifier:</u> <ul style="list-style-type: none"> <li>○ <u>U9 – Service performed via Teledentistry</u></li> </ul> </li> <li>• <u>Note: Non-billable services:</u> <ul style="list-style-type: none"> <li>○ <u>Sending materials;</u></li> <li>○ <u>Originating site fee.</u></li> </ul> </li> <li>• <u>For MHCP recipient limitations refer to the Minnesota Department of Human Services MHCP Provider Manual.</u></li> </ul>

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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](mailto:dentalcode@ada.org). For information on the HCPCS annual release of alpha-numeric medical codes visit [www.cms.gov](http://www.cms.gov) or email [hcpcs@cms.hhs.gov](mailto:hcpcs@cms.hhs.gov).

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

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

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

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## 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.

2

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

## 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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