Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, June 9, 2016
9:00 a.m. to 12:00 a.m.
Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1st floor

Webex Information

Teleconference Information:

Call-in line: 1-712-832-8300

Participant Access Code: 337213#

Callers are responsible for any long distance charges.

1. To start the webex session, go to: https://health-state-mn-ustraining.webex.com.
2. Under "Attend a Session "click "Live Sessions"
3. Click on the session for "AUC Medical Code TAG"
4. Provide your name, email address, and the following password: Mct2010! (Note: the password must be typed in; it cannot be cut and pasted. The exclamation point is part of the password)
5. Click "Join now"

1. **Welcome and Introductions**
   - **Attendance tracking: Deb Sorg** deb.a.sorg@healthpartners.com
   - **Membership request and/or updates: Deb Sorg** deb.a.sorg@healthpartners.com
2. **Review of Antitrust Statement**
3. **Review of last meeting's minutes** – May 12, 2016
4. **AUC Coding Recommendation Table Review**

2/11/16: No discussion of this agenda item due to time constraints	**OPEN**
2/23/16, 3/10/16 No discussion due to time constraints	**OPEN**
4/14/16: The table will be updated. Waiting for Ops approval.	**OPEN**
5/12/16: The grid was reviewed. Judy Edwards will update the grid and send it out to members for review.	**OPEN**

5. **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	OPEN

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	
5/12/16: Waiting for SBAR.	OPEN

6. 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
5/12/16: Waiting for SBAR.	OPEN

7. 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, 5/12/16: Judy Edwards if developing a template for responses. Judy will be identifying the outstanding SBARs.	**OPEN**

8. Protected Transport - DHS

5/12/16: Waiting for SBAR.	OPEN

9. SBAR - Compulsive Gambling - Richard Scherer, Club Recovery, LLC

Per Judy Edwards, we need to talk about Richard Scherer's SBAR. As you may recall, we inadvertently closed Richard's SBAR instead of the SBAR DHS submitted. Richard has asked that the AUC considers his SBAR; he does not want to withdraw it. I've attached Richard's SBAR (Gambling Addiction) and the coding recommendation Kathy submitted with DHS's SBAR (Compulsive Gambling) for the TAG to consider. Not DHS SBAR but the coding worksheet (the SBAR is FYI).

10. Additional Agenda Items/ Announcements

- Next regularly scheduled meeting: July 14, 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, May 12, 2016, 2016, 9:00 a.m. to 12:00 a.m.
Location: HealthPartners, 8170 Building, Bloomington, St. Croix – 1st floor

Minutes By: Faith Bauer DRAFT

Agenda Item	Discussion	Action/Next Steps
1. Welcome and Introduction a. Attendance tracking: Deb Sorg deb.a.sorg@healthpartners.com b. Membership request and/or updates: Deb Sorg deb.a.sorg@healthpartners.com	Members were asked to introduce themselves and their organizations. Those attending via teleconference/WebEx were requested to send Deb attendance via email and include name and organization.	Completed
2. Review of Antitrust Statement	Faith read anti-trust statement.	No discussion
3. Review of last meeting's minutes – April 14 14, 2016	Minutes approved.	CLOSED
4. AUC Coding Recommendation Table Review	The grid was reviewed. Judy Edwards will update the grid and send it out to members for review.	OPEN
5. Teledentistry – Kathy Sijan	The 837D revisions were approved.	CLOSED
6. SBAR - CHW Universal Modifier - Will Wilson, DHS	Waiting for SBAR.	OPEN
7. Community Emergency Medical Technician Services – Shawnet Healy, DHS	Waiting for SBAR.	OPEN
8. Miscellaneous - SBAR Review	Judy Edwards if developing a template for responses. Judy will be identifying the outstanding SBARs.	OPEN
9. Protected Transport - DHS	Waiting for SBAR.	OPEN
10. SBAR - Intensive Outpatient Mental Health Program for Pregnant and Postpartum Women with Children ages 0-5 – Claire Persons, HCMC	This issue was closed in March. Deb Sorg recalled that HCMC should check with each payer regarding their policy, coverage or contract. It was indicated that there are inconsistent answers from payers. If HCMC still wants this addressed they will need to write a new SBAR.	CLOSED
11. Additional Agenda Items/ Announcements	• Next regularly scheduled meeting: June 9, 9:00-12:00, St. Croix Room – 1st floor, HealthPartners, 8170	CLOSED

Medical Code TAG (MCT) Decision Tree for Medical Coding Issues

Overview

This decision tree is a prototype decision tool to aid the AUC Medical Code TAG (MCT) in making decisions regarding medical coding issues and to assist SBAR submitters in documenting all relevant information related to the coding issue(s) to be addressed in their SBAR. The MCT Decision Tree consists of a series of three levels, as follows:

Level I. Prior to Medical Code TAG review

In Level 1 MDH staff collects MCT Decision Tree forms and SBARs or other inquiries regarding medical coding issues. The Decision Tree forms and SBARs are forwarded to both the MCT and to the AUC Executive Committee for their review. Decision Trees and SBARS are then added to the MCT project list to be addressed at future MCT meetings.

Level II. Determination as to whether Medicare applies

SBARs added to the MCT project list as stated in Level I above are reviewed by the MCT to determine whether Medicare coding instructions/requirements apply.

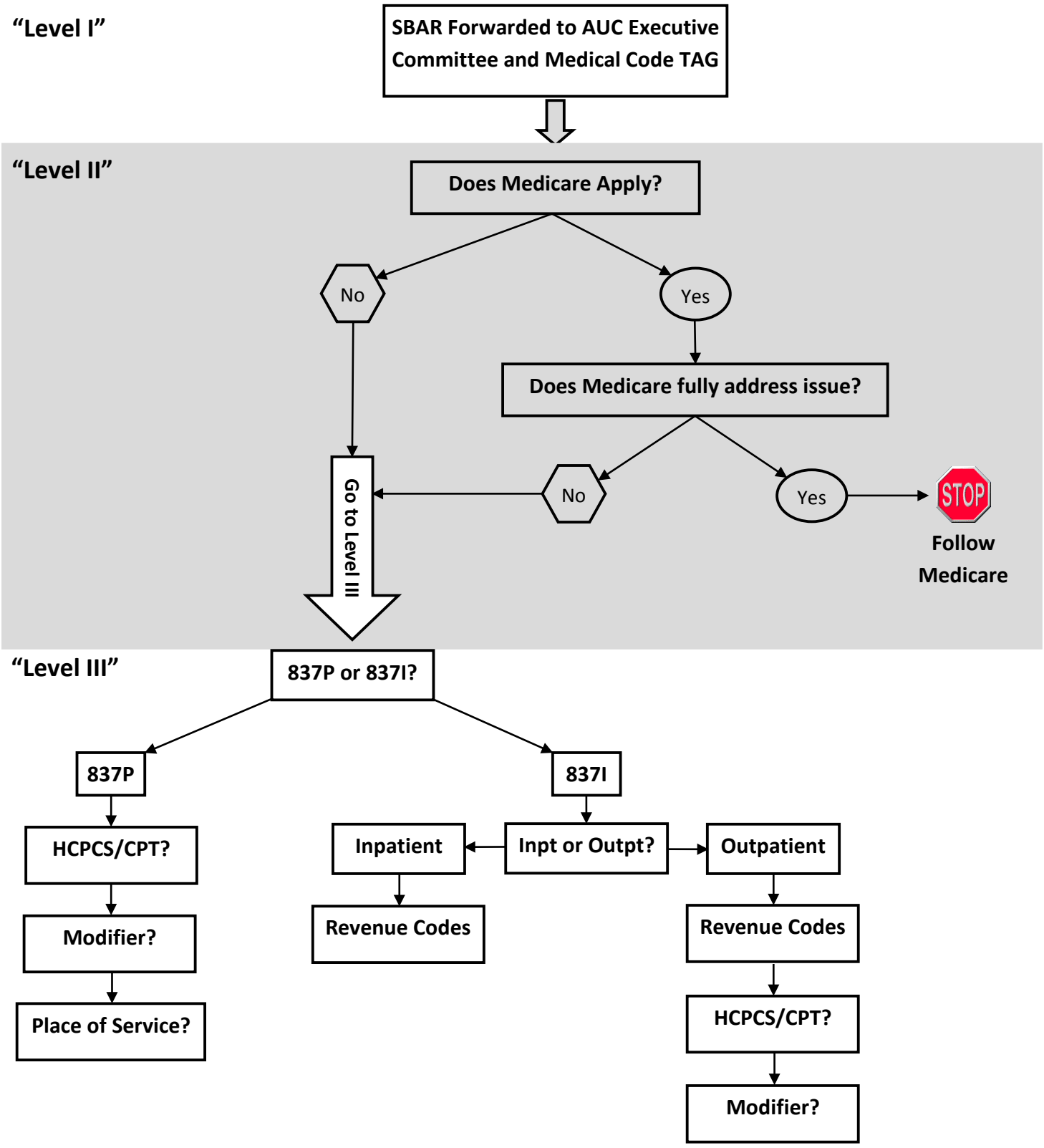
- If Medicare applies, and there are no other concerns or perceived problems with Medicare coding (e.g., vagueness or possible confusion in Medicare instructions, Medicare does not fully address the service in question), the MCT recommendation will be to "follow Medicare" and the issue will be considered closed.
- If Medicare does not apply, or if there are concerns or perceived problems regarding Medicare's applicability to the situation or its instructions/requirements, the issue continues through Level III below.

Level III. Coding recommendation when Medicare does not apply or does not adequately address the issue

Level III is used for coding questions for which Medicare does not apply or does not adequately address the issue as described above. The MCT will then recommend coding to be used, based on a series of structured steps to determine the appropriate claim type(s), and possible HCPCS/CPT codes and modifiers, place of service, type of bill, revenue codes, and other coding characteristics as applicable and appropriate.

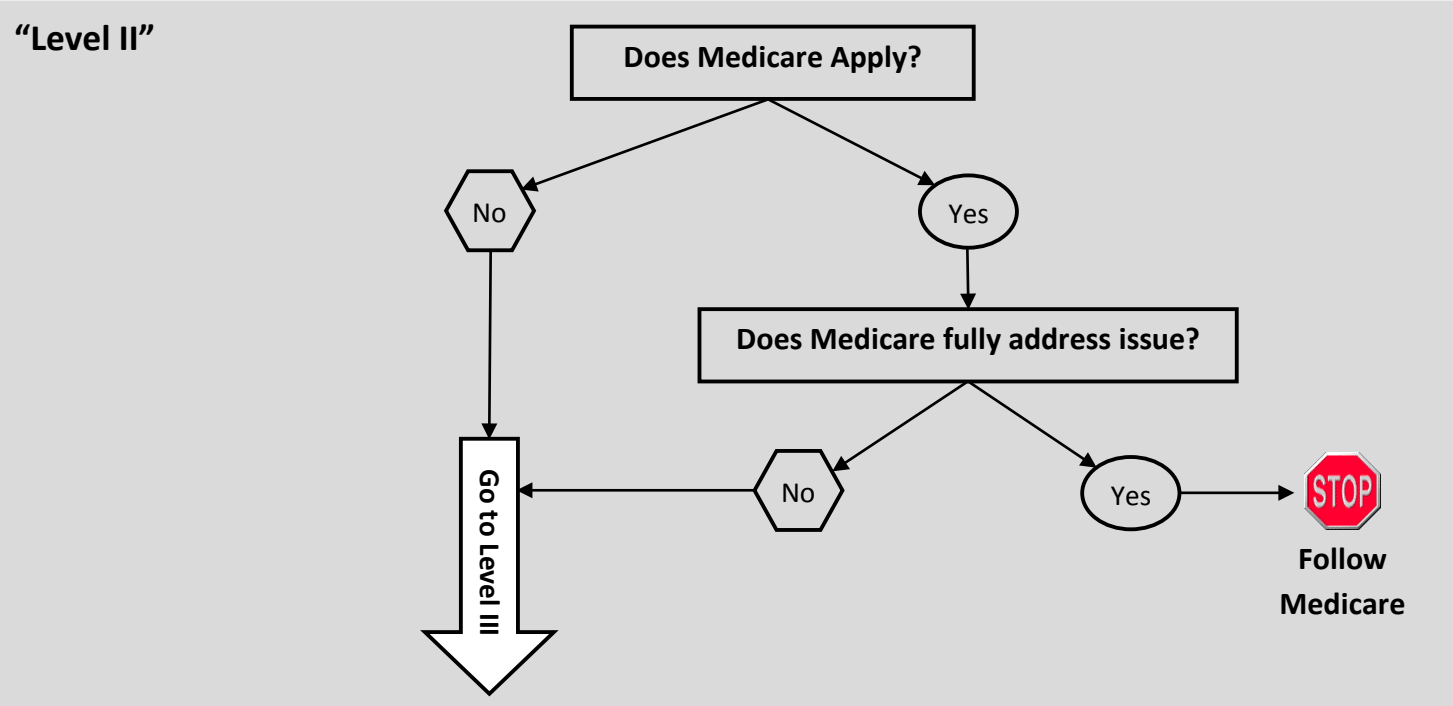
The MCT coding recommendation process above is presented schematically in the summary flow chart on the next page.

Illustrative Medical Code TAG (MCT) decision tree for medical coding issues



Note: Coding recommendations will include additional information as applicable regarding: who the decision applies to (who will provide the services); effective date(s); and appropriate references to federal authority. The MCT will coordinate with the Claims DD TAG on place of service issues. Final recommendations will also address revenue codes and type of bill for outpatient services, and type of bill for inpatient services.

Level II. Name/description of service/issue: _____



Decision Tree Questions for Level II:

1. Does Medicare have coding requirements/instructions for coding the medical service/procedure/etc. of interest?	
Yes ___	If "yes," please reference the source of the Medicare instructions and provide a link. Medicare source and link: Then go to question 2 below.
No ___	Go to Level III, beginning on page 4
2. Does Medicare's coding guidance fully address the issue?	
Yes ___	Done. STOP Follow Medicare as referenced at the link in question no. 1 above.
No ___	If "no," please check any of the concerns below that apply and provide examples, and then go to Level III, beginning on page 4. *a.* _____ More specific or appropriate codes are needed in order to reduce manual processing and administrative costs. *b.* _____ Duplicate codes exist and clarification of which code(s) to use is needed. Explain/provide examples: *c.* _____ Minnesota group purchasers accept and adjudicate codes for services above and beyond Medicare's coding guidelines based on their coverage policies and member benefits. *d.* _____ Other. Explain/provide examples: Go to Level III, beginning on page 4
Yes ___	Is this specific issue(s) applicable to more than one payer or provider?
No ___	If yes, state how many: _____
Yes ___	Have you consulted with payer or provider regarding this issue?
No ___	

Level III. Name/description of service/issue:

Decision Tree Questions for Level III: (MCT recommendations)

1. 837P or 837I?	
837P ___	If "837P," then go to question 2.
837I ___	If "837I," then go to question 5 below.
2. What are the HCPCS/CPT codes?	
HCPS:	Cite source and provide link: Go to question 3
3. Are modifiers needed/applicable	
Modifier:	Cite source and provide link: Go to question 4
4. What is the place of service (POS)?	
POS:	Cite source and provide link:

Level III. Name/description of service/issue:

Decision Tree Questions for Level III:

5. 837I Inpatient or 837I Outpatient?	
Inpatient ____	If "Inpatient," then go to question 6 below.
Outpatient ____	If "Outpatient," then go to question 7 below.
6. What are the correct Inpatient Revenue Codes?	
Revenue code:	Cite source and provide link:
7. What are the correct Outpatient Revenue Codes?	
Revenue code:	Cite source and provide link:
8. What are the correct Outpatient HCPCS/CPT codes?	
HCPCS/CPT:	Cite source and provide link: Go to question 9
9. Are modifiers needed/applicable?	
Modifier:	Cite source and provide link:

Summary of MCT findings and recommendations

Name/description of service/issue: _____

Level II findings

Is the finding to follow Medicare?

_____ Yes (If yes, then stop. This is the finding/recommendation.)

_____ No (If no, go to phase III findings.)

Level III findings

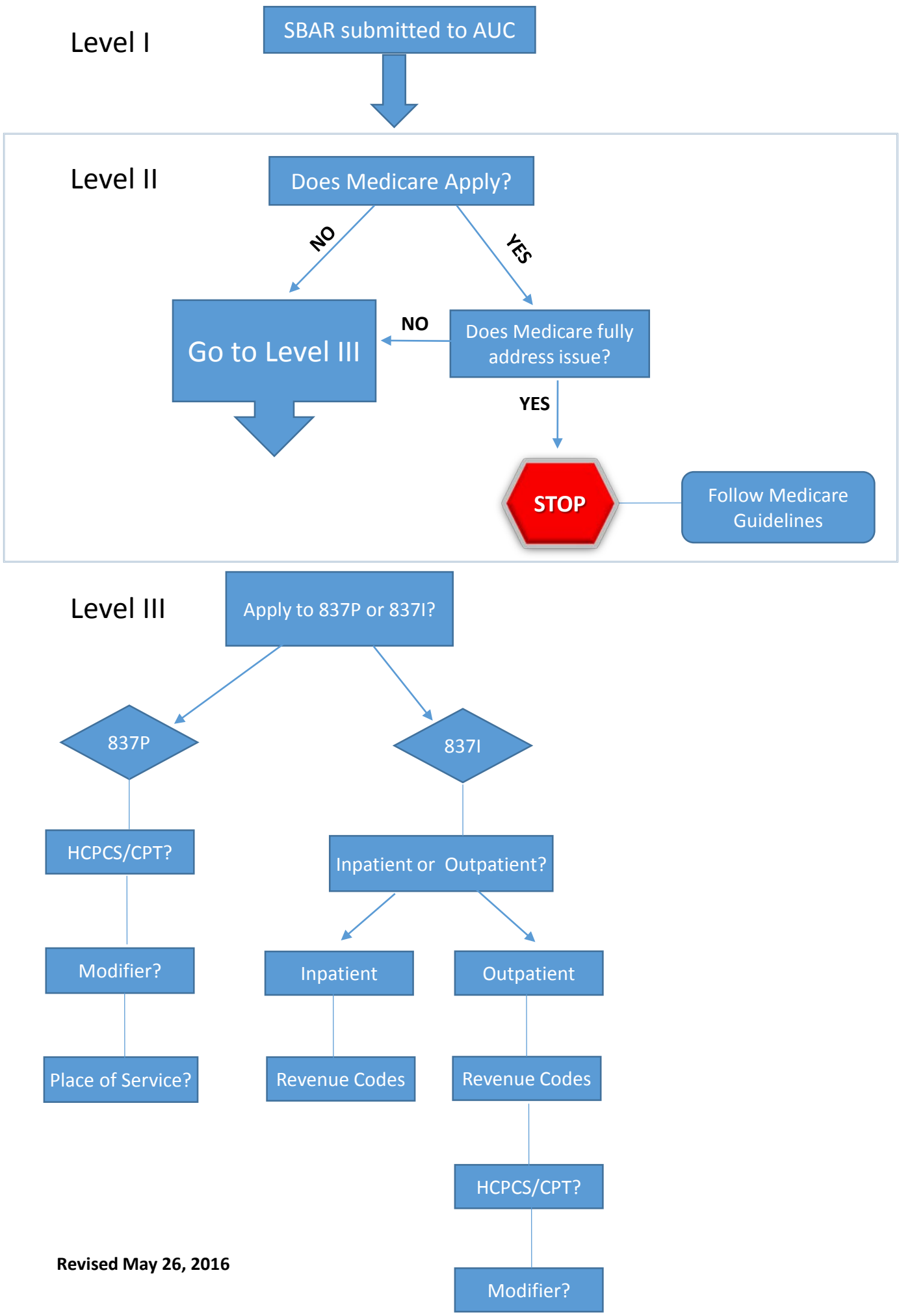
Use the table below:

- If 837P go to Column A
- If 837I to Column B
    - If 837I Inpatient, go to Column B1
    - If 837I Outpatient, go Column B2

Name/description of service/issue: _____

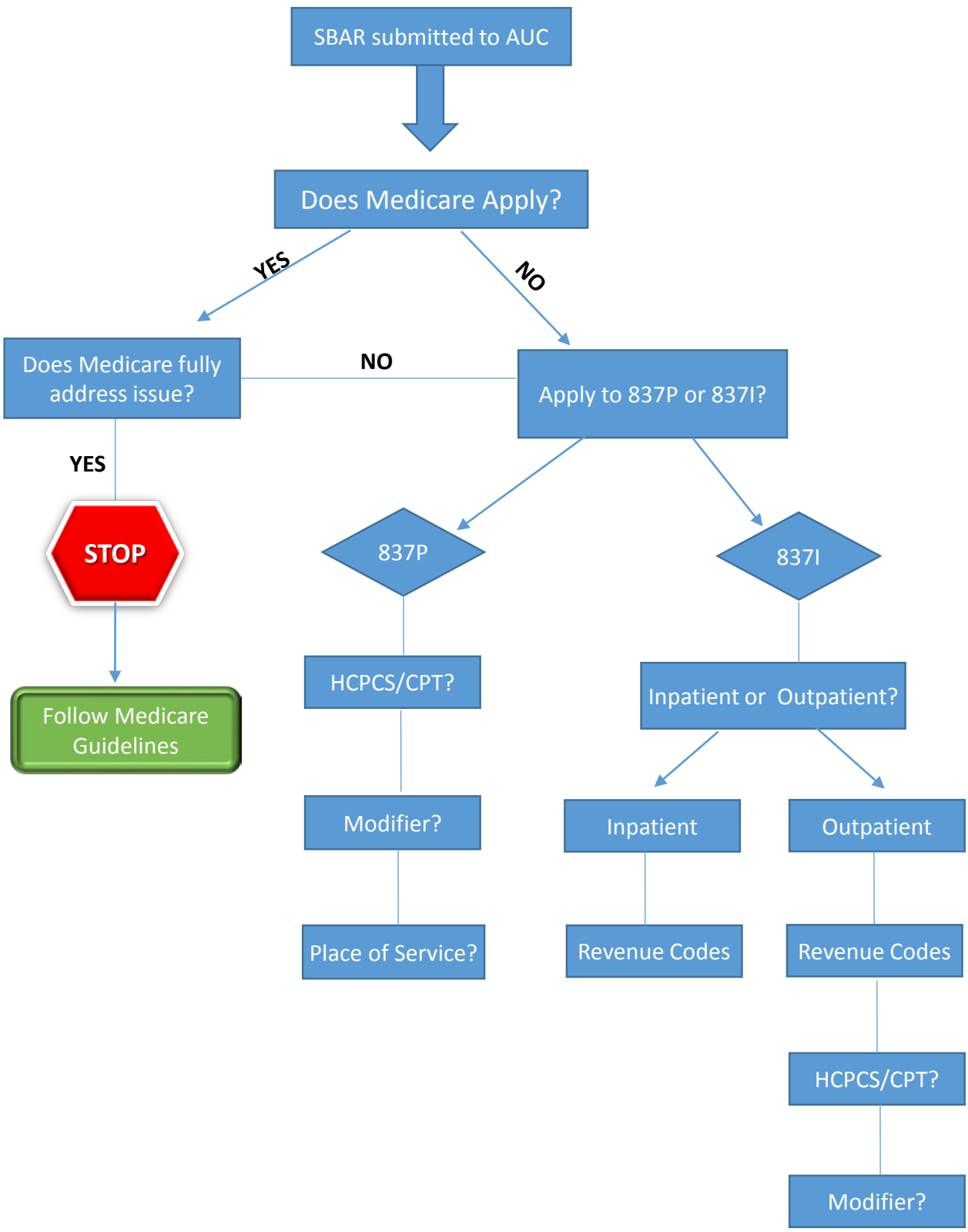
Coding Decision Recommendation (N/A = not applicable)	A 837P	B	
		B1 837I Inpatient	B2 837I Outpatient
HCPCS/CPT Source/Link			
Modifier Source/Link			
Place of Service Source/Link			
Revenue Code Source/Link			
Type of Bill Source/Link			
Decision applies to (who provides services)			
TAG Review Date			
Reference to state or federal authority			
Other notes, comments, instructions			

Medical Code TAG Decision Tree - Illustrated



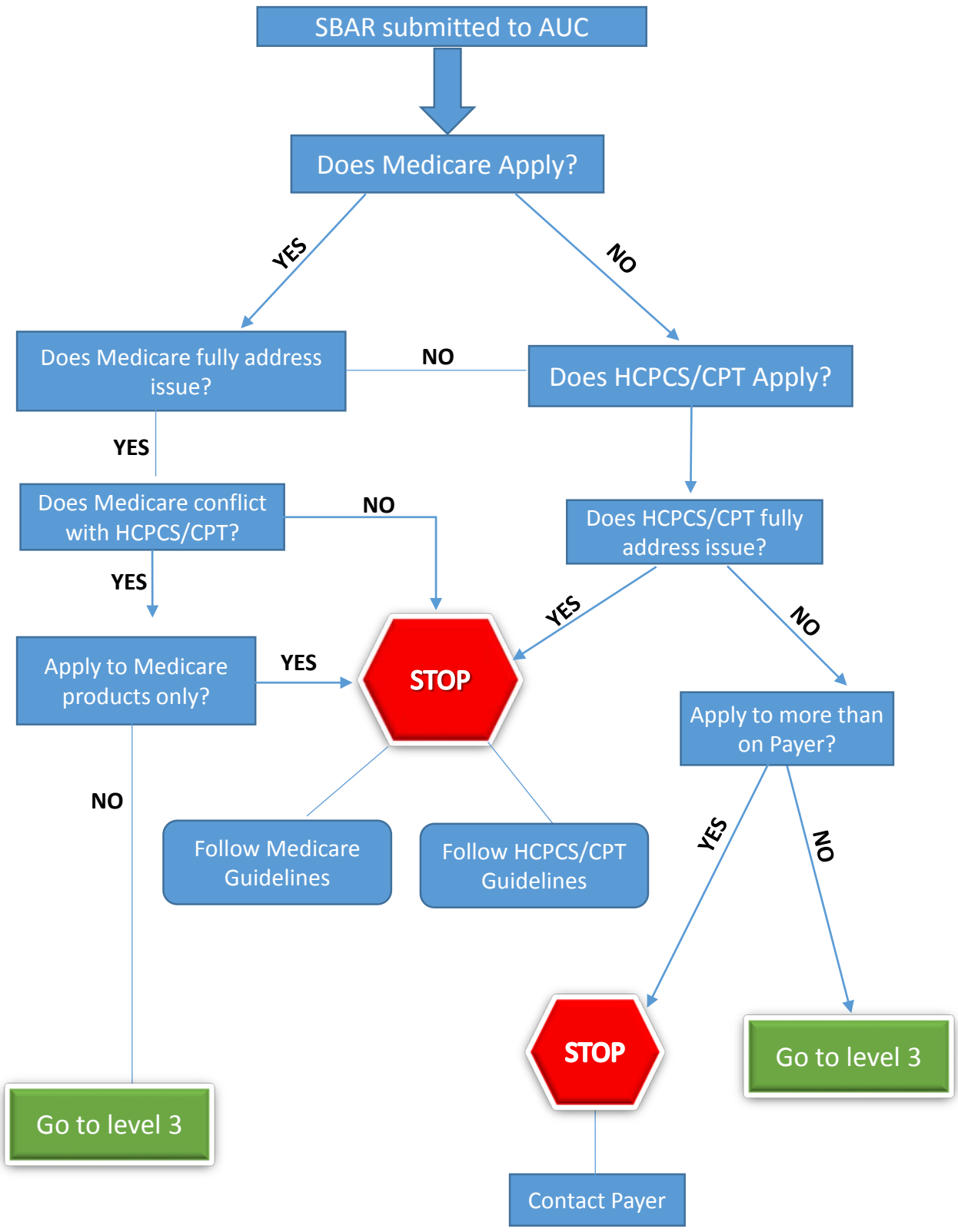
Revised May 26, 2016

Medical Code TAG Decision Tree - Illustrated



Revised May 26, 2016

Medical Code TAG Decision Tree - Illustrated



Revised June 2, 2016

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received:	**Log No.:**	**Date Closed:**	
Date Sent to AUC Executive Committee:	**Date Sent to AUC TAG Co-chair(s):**	**TAG Recommendation:** _____ Accept _____ Reject	**Date Decision Sent to Originator:**

REMINDER: Complete each section of this SBAR form and submit to the AUC inbox at health.AUC@state.mn.us. The Medical Code TAG Decision Tree form must be completed for medical coding issues and submitted with the SBAR.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert). Fully complete each block; additional contact and subject matter expert is optional.

SBAR Short title:	Version #:	Date:

Contact Information for person completing this form:	Organization Information:
Name: **Title:** **Email address:** **Telephone:**	**Name:** **Address:**

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

Name:
Title:
Email address:
Phone number:

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation). Each letter must be completed before the SBAR will receive consideration.

SBAR Issue Title:

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed:
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today):
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain):

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

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):

Discussion/Summary:

Key Findings and Recommendation:

Decision Summary:

Disposition status:

AUC Response:

The findings and recommendations above were also reviewed and _____ by the full AUC.

AUC Approval Date:

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received: April 6, 2016	**Log No.:** 2016-004	**Date Closed**	
Status: Exec Review Date: April 6, 2016	**Sent to TAG/WG:** April 6, 2016	**TAG Recommendation:** _____ Accept _____ Reject	**Decision to Originator**

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

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

SBAR Short title: CHW Universal Modifier	Date:
Contact Information for person completing this form: **Name: Will Wilson** **Title: Supervisor** **Email address: will.wilson@state.mn.us** **Telephone: 651-201-3842**	Organization Information: **Name: MDH Office of Rural Health and Primary Care** **Address: PO Box 64882, St Paul, MN 55164-0882**

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

Name: Joan Cleary
Title: Executive Director, CHW Alliance
Email address: joanlcleary@gmail.com
Phone number: 612-250-0902

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

SBAR Issue Title:

S

SITUATION:

Community Health Worker (CHW) services include a wide range of activities, such as education, navigation, advocacy, and care coordination. However, the only service covered (and only in MA) is "diagnosis-based health education," billable using codes 98960, 98961, and 98962. For a number of reasons, these codes are not billed frequently, and do not capture the range of activities CHW are currently performing. Also, different payers have used these codes for services provided by providers other than CHWs.

As a result, there is little or no data in the claim stream available to (1) understand the extent to which CHWs are involved in delivering patient services across our state providing services and (2) measure and evaluate the impact CHWs have on the care delivered to patients and clients.

B

BACKGROUND

MA coverage for CHW services was passed in 2007, as defined in MN Statute 256B.0625, Subd. 49. A State Plan Amendment was approved in 2008, and DHS established MA policy for the service soon after.

According to the Minnesota CHW Alliance, "Community Health Workers (CHWs) are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes. As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality, cultural competence and affordability; and empower individuals and communities for better health."

	Early adopters of CHW services have been, among other providers, integrated health systems, clinics, large hospitals, federally qualified health centers, community-based nonprofits, social services providers, faith-based organizations, and public health agencies. While payment has been established in fee-for-service MA, few claims are currently being submitted, in part due to the narrow nature of the covered service, as compared to the broad set of services CHWs actually provide. CHWs are uniquely positioned to address health disparities in underserved communities. Many have received training in a MnSCU-approved, competencies-based curriculum, and obtained a certificate, which is required to enroll with DHS as a non-billing provider, and be assigned an UMPI. Minnesota is the only state in the US with a statewide CHW curriculum and only one of a few states that are approved to cover specific CHW services under Medicaid. PMAP payment to date is minimal and commercial insurance coverage for CHW services is either minimal or non-existent. A recent survey by MDH showed there are over 650 certificate-holding CHWs in Minnesota. Due to the limited billable services and other issues, only a small percentage of these CHWs have enrolled with DHS. They are, however, providing services which are not being captured, and their impact on overall cost, health outcomes, and patient satisfaction is not being measured.
A	**ASSESSMENT** – A universal modifier creates the opportunity for administrative simplification by allowing a range of services from a uniquely flexible provider type to be reported, captured, and analyzed. Without a mechanism to capture CHW services on a claim, it is extremely difficult to measure and assess the impact CHWs have on the care received by their patients. One structural challenge is that no entity in Minnesota currently regulates CHWs as a profession. The term CHW is most understood to mean a person who has obtained a certificate from a school teaching the MNSCU-approved CHW curriculum, but the term may include similar practitioners who are trained by health systems or organizations to perform similar work. In approving a universal modifier for CHW services, the AUC could give guidance to payers in how the term CHW is defined. This could be exclusive to CHW certificate holders – which Medicaid requires for enrollment – or inclusive of a broader, as yet undefined set of workers who perform similar tasks. This modifier would not be tied to payment.
R	**RECOMMENDATION** – We recommend the creation of a universal modifier for Community Health Worker services, which can voluntarily be added to a claim for any service which involved the services a CHW. A CHW modifier would not be tied to payment. The intent is to create a mechanism within the claim stream to capture the broad set of services currently provided by CHWs, and ultimately, to measure the impact these services are having on the quality, cost, and patient satisfaction of care delivered in a wide range of settings. Use of the modifier will offer important information for several purposes. Data will facilitate understanding of the extent and scope of services which includes CHW engagement. It will allow payers to analyze which patients currently receive CHW services. It will also create the ability to compare outcomes for patients who receive care from a CHW vs those who do not, and to measure the effect CHWs have.

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

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision:

Administrative Uniformity Committee

SBAR New NEMT service: Protected Transport and other transportation changes

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

Date Received: May 12, 2016	Log No.: 2016-010	Date Closed	
Status: Exec Review Date: May 12, 2016	**Sent to TAG/WG:** May 12, 2016	**TAG Recommendation:** _____ Accept _____ Reject	**Decision to Originator**

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

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

SBAR Short title: Protected Transport	Date: 5-9-2016
Contact Information for person completing this form: **Name:** Katherine Sijan **Title:** HealthCare Coding Compliance Officer **Email address:** Katherine.sijan@state.mn.us **Telephone:** 651-431-5784	**Organization Information:** **Name:** MN Dept of Human Services **Address:** 540 Cedar St., 7th fl -0993 St Paul, MN 55155

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

SBAR Issue Title:

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: On 7-1-2016, the medical transportation services that DHS currently classifies as access transportation services (ATS) which is administered by the counties/tribes along with special transportation services (STS) administered by the state will change to add a new service, called protected transport.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Minnesota Statute 256B.0625, Subd. 17 thru 17b and 18 thru 18h, contains the full range of information related to this legislation that has changed to add 'protected transport. Subdivisions 17 thru 17b contain the real information related to the transports. Part of this change will require all NEMT providers to be STS certified by MnDOT unless they are a publically operated transit system, a volunteer driver, or "not for hire vehicle" (personal mileage). [Subd. 17, Item (c)]
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The change will include a change in transport service definitions and a new transportation type referenced as "protected transport".

	Transport services as a whole will be referenced as "non-emergency medical transportation" or "NEMT". With that change in terminology, the current classification of "ATS" will change and be referenced as "**County/Tribal Administered NEMT**". Also, what is currently the "STS" transports will be referenced as "**State Administered NEMT**". Part of this change in terminology is based on statute and the common language used by the "Non-Emergency Medical Transportation Advisory Committee". These changes are effective on 7-1-2016.
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: **RE: Coding and billing; these changes will be as follows:** - The state modifiers that are currently used that **will continue to be used** for the County/Tribal NEMT transports for dates-of-service on/after 7-1-2016 are the following: o **UC** modifier will continue to be used with the A0090 (personal mileage) service code to indicate a higher mileage reimbursement rate licensed foster parents o **U2** modifier will continue to be used with the S0215 (ambulatory mileage) service code to indicate the mileage payment rate for county/tribal NEMT transports billed with the A0100 (taxi/dial-a-ride) county/tribal service code as part of "unassisted transport" o **U7** modifier will continue to be used with the A0110 (bus/light rail) county/tribal service code to indicate reimbursement for a "monthly" bus/light rail pass as part of the county/tribal NEMT transports included in the "unassisted transport" type - - The state **modifiers that will end with the last date-of-service 6-30-2016** for the county/tribal current ATS transports include: o **U4** modifier will no longer be needed for use with the A0100 transport county/tribal service code for "taxi/dial-a-ride, ambulatory, door-to-door" o **U5** modifier will no longer be needed for use with the A0100 transport county/tribal service code for "taxi/dial-a-ride, wheelchair, curb-to-curb" o **U6** modifier will no longer be needed for use with the A0100 transport county/tribal service code for "taxi/dial-a-ride, wheelchair, door-to-door" o **U2** modifier will no longer be needed for use with the S0209 mileage county/tribal service code for "taxi/dial-a-ride, wheelchair" **The following represents the new benefit for "protected transport"**, part of the State Administered NEMT services, and effective for dates-of-service on/after 7-1-2016. This is a new transport type for MHCP and there are no service (base/pickup) or mileage codes for this transport type. **The single modifier will be used with both the following codes for the base/pickup and mileage charges**: o **T2003 UA-** Nonemergency transportation; encounter/trip, Protected Transport -service code and state modifier will identify the transport base/pick-up billing for protected transport o **S0215 UA -**Nonemergency transportation; mileage, per mile, Protected Transport -service code and state modifier will identify the mileage billing for protected transport

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:**

Non Emergency Medical Transport [NEMT]

New Service: Protected Transport - effective 7-1-2016

Procedure Code / U MOD	HCPCS Description	DHS Description
T2003 UA	Nonemergency transportation; encounter/trip	Nonemergency transportation; encounter/trip, Protected Transport
S0215 UA	Nonemergency transportation; mileage, per mile	Nonemergency transportation; mileage, per mile, Protected Transport

Access Transportation Services [ATS}- Ending 6/30/16

Procedure Code / U MOD	HCPCS Description	DHS Description
A0100 U4	Nonemergency transportation; taxi	County/tribal service code for "taxi/dial-a-ride, ambulatory, door-to-door"
A0100 U5	Nonemergency transportation; taxi	County/tribal service code for "taxi/dial-a-ride, wheelchair, curb-to-curb"
A0100 U6	Nonemergency transportation; taxi	County/tribal service code for "taxi/dial-a-ride, wheelchair, door-to-door"
S0209 U2	Wheelchair van, mileage, per mile	Non-emergency transportation; wheelchair van, mileage per mile

No Change to any of the following services;
-County/Tribal Administered NEMT *[formerly known as ATS - Access Transportation Services thru 6-30-16*] and
-State Administered NEMT [*formerly known as STS - Special Transportation Services thru 6-30-16*]

Procedure Code / U MOD	HCPCS Description	DHS Description
A0080	Nonemergency transportation, per mile – volunteer driver	Volunteer driver mileage reimbursement
A0090 UC	Nonemergency transportation, per mile - Licensed foster parent - vehicle provided by individual licensed foster parent	Personal mileage reimbursement, licensed foster parent
A0100	Nonemergency transportation; taxi	Unassisted Transport Base/Pickup (Taxi/dial-a-ride for county/tribe Administered NEMT)
A0110	Nonemergency transportation and bus, intra- or interstate carrier	Bus/Light Rail

No Change to any of the following services; **-County/Tribal Administered NEMT** *[formerly known as ATS - Access Transportation Services thru 6-30-16*] and **-State Administered NEMT** [*formerly known as STS - Special Transportation Services thru 6-30-16*]		
A0110 U7	Nonemergency transportation and bus, intra- or interstate carrier	Bus/light rail monthly pass
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	ADA paratransit
A0130	Nonemergency transportation: wheelchair van	Ramp/lift Equipped Vehicle Base/Pickup (Wheelchair transport for State Administered NEMT)
A0140	Nonemergency transportation and air travel (private or commercial) intra- or interstate	Air travel
S0209	Wheelchair van, mileage, per mile	Mileage Ramp/Lift Equipped Vehicle
S0215	Nonemergency transportation, encounter/trip; mileage, per mile	Thru 6/30/16: STS ambulatory mileage Effective 7/1/16: State administered NEMT assisted transport mileage
S0215 U2	Nonemergency transportation; mileage, per mile	Mileage unassisted transport
T2001	Nonemergency transportation; patient attendant/escort	Extra Attendant – Stretcher
T2003	Nonemergency transportation, encounter/trip	Thru 6/30/16: STS ambulatory mileage Effective 7/1/16: State administered NEMT assisted transport mileage
T2005	Nonemergency transportation; stretcher van	Stretcher Transport Base/Pickup (State Administered NEMT)
T2049	Nonemergency transportation; stretcher van, mileage; per mile	Mileage Stretcher Transport

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

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

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

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

Medical Coding TAG Decision Tree Form

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

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

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

Section II

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

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

Section III

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

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

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

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

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

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

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

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

Contact Information for person completing this form:

Name:RICHARD SCHERER

Title:BUSINESS MANAGER

Email address:richard@clubrecoveryllc.com

Telephone: 952.926.2526

Organization Information:

Name:CLUB RECOVERY, LLC

Address: 6550 YORK AVE SOUTH
SUITE 620
EDINA, MN 55435

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

Name:

Title:

Email address:

Phone number:

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

SBAR Issue Title:

S	SITUATION Beginning January 1, 2014, one Minnesota health plan started to deny all claims submitted for their subscribers who were participating in our Gambling Addiction Program because they were under the impression that the AUC (or other govt agency) indicated beginning January 1, 2014 H2020 with the Rev Code 0949 was no longer applicable or acceptable. Up to January 1, 2014, we had been submitting claims using the coding nomenclature of H2020 with the Rev Code 0949 with no claim issues. Similarly, this coding structure has been used with all others payer up until the last year. That being said, another health plan changed their coding structure in July 2013 from H2020 0949 to H0005 0949. A third health plan continues using the billing structure of H2020 (however, it must be noted it has all claims submitted as "Professional" and are submitted using HCFA 1500 claim structure and therefore no rev code is associated . What I am trying to ascertain is how can billing for this level of care become more uniform across payers as well as be coded "appropriately"
B	BACKGROUND Aspects of the background of this issue is noted above. Currently there are 4 different coding structures utilized by most of the local payers: H2035 HQ 0949 (maybe???), H2020, H0005 0949, and H2020 0949.

A	ASSESSMENT –One health plan reports they received a directive in changes to coding for Compulsive Gambling from the AUC and began rejecting claims submitted with the coding H2020 0949 January 1, 2014. Currently, we are attempting to rebill for all of those services with a new billing scheme of H2035 HQ 0949 yet the health plan also informed us that that coding structure would be rejected using the rev code 0949 and asked that we use 0944, 0945, or 0953. None of these rev codes would be appropriate and likely could be considered fraudulent coding by CMS (for any Medicaid (PMAP) or Medicare dollars used to make payment). Clearly, amongst the various payers it is apparent that there seems not to be a standardized coding structure to bill for Compulsive Gambling particularly in the group setting.
R	RECOMMENDATION – Similar to coding for chemical dependency, I ask if this committee can make recommendations that would identify a singular coding structure for billing Compulsive Gambling Disorder treatment. Please note, I would question if it is appropriate to use the HCPC code H2020 as an hourly code given it has been traditionally regarded as a per deim code. Therefore it may be necessary to be mindful of using these codes as globally defined. It may be the better part of valor to use H2035 HQ 0949 since it likely reflects more closely to changes in the DSM 5 as Compulsive Gambling is now defined under Addiction Disorders, similar to other substance abuse classifications in the DSM 5. That being said, H2035 is defined exclusively as a drug/alcohol treatment code. I am unaware of any issues of using the Rev Code 0949.

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

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

Date [SBAR Response Approved by TAG]:

Reviewed by: [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

SBAR Compulsive Gambling – DHS Proposal

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

Date Received	Log No.	Date Closed

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

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

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

SBAR Short title: SBAR Compulsive Gambling	Date: March 5, 2015
Contact Information for person completing this form: Name: Katherine Sijan Title: HealthCare Coding Compliance Officer Email address: katherine.sijan@state.mn.us Telephone: 651-431-5784	**Organization Information:** Name: MN Dept of Human Services Address: 540 Cedar St., 7th fl -0993 St Paul, MN 55155

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

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

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

SBAR Issue Title: Compulsive Gambling

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: DHS would like to move this service to be billed as a claim for processing through our claims system. Richard Scherer, Club Recovery LLC submitted an SBAR in Oct, asking for a consistent coding solution. The AUC MCT asked DHS to discuss and come up with proposed coding. The proposed coding is below.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Since 1999, treatment for compulsive gambling for DHS recipients has been a statewide program, mandated that the funds for the program must be administered on an individual client, fee for service basis. The eligible vendor would bill every 30 days [based on the beginning date of treatment]. This system is based on an invoice system, not through the claims system. DHS plans to eventually move this to billing to the claims system and approved codes for billing will be necessary.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): DHS currently covers these services as professional and facility based treatment services. Codes that indicated alcohol or drug abuse treatment are not appropriate to describe this treatment. In addition, gambling addiction treatment and CD treatment come from different funding sources at DHS. Gambling is funded through lottery funds. They must be kept separate.

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

Recommend the table attached be added to the coding recommendation table and eventually the MUCG professional and institutional companion guides.

Worksheet in H AUC SBAR Compulsive Gam

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: October 8, 2015:

Reviewed by Medical Code TAG

AUC Co-Chair(s): Faith Bauer

AUC Response: Issue withdrawn – no action

Discussion/Summary:

There was extensive discussion around this issue over a course of several meetings; however, Kathy Sijan of the Minnesota Department of Human Services (DHS) reported that DHS is examining next steps for the program and requested the item be removed from the standing agenda at this time.

Decision:

No further action or discussion at this time.

Gambling - Proposed Coding - FACILITY

	Service Description	Type of Bill	Procedure/Revenue Code	Mod	Mod	Mod	Unit
1	Assessment-Practitioner	89X	H0031	U8	HN	or H9	1/day
2	Assessment-Masters	89X	H0031	U8	HO	or H9	1/day
3	Assessment-Doctoral	89X	H0031	U8	HP	or H9	1/day
4	Individual-Practitioner	89X	H2019	U8	HN		15 mins
5	Individual-Masters	89X	H2019	U8	HO		15 mins
6	Individual-Doctoral	89X	H2019	U8	HP		15 mins
7	Family-Practitioner	89X	H2019	U8	HN	HR or HS	15 mins
8	Family-Masters	89X	H2019	U8	HO	HR or HS	15 mins
9	Family-Doctoral	89X	H2019	U8	HP	HR or HS	15 mins
10	Group	89X	H2019	U8	HQ		15 mins
11	*Group -Follow up	89X	H2019	U8	HQ	TS	15 mins
12	Residential -Treatment Services	86X	0900				day
13	Residential - Room and Board	86X	1001				day

Code	Description
H0031	Mental Health assessment, by nonphysician
H2019	Therapeutic behavioral services, per 15 minutes
0900	Behavioral Health Treatment Services/Gen Classification
1001	Behavioral Health Accomodations/Gen Classification
H9	Court Ordered
HN	Practitioner (MH Practitioner, 4 yr bachelor level, LADC)
HO	Master (LICSW, LMFT)
HP	Doctoral (PhD)
HQ	Group
HR	with client
HS	without client
TS	Follow up s *(recovery/continuing care[future])
U8	Compulsive Gambling Tx *(new U mod)*

Compulsive Gambling -
Proposed Coding -
PROFESSIONAL

	Service Description	POS	Procedure Code	Mod	Mod	Mod	Unit
1	Assessment-Practitioner	11,22,21	H0031	U8	HN	or H9	1/day
2	Assessment-Masters	11,22,21	H0031	U8	HO	or H9	1/day
3	Assessment-Doctoral	11,22,21	H0031	U8	HP	or H9	1/day
4	Individual-Practitioner	11,22	H2019	U8	HN		15 mins
5	Individual-Masters	11,22	H2019	U8	HO		15 mins
6	Individual-Doctoral	11,22	H2019	U8	HP		15 mins
7	Family-Practitioner	11,22	H2019	U8	HN	HR or HS	15 mins
8	Family-Masters	11,22	H2019	U8	HO	HR or HS	15 mins
9	Family-Doctoral	11,22	H2019	U8	HP	HR or HS	15 mins
10	Group	11,22	H2019	U8	HQ		15 mins
11	*Group -Follow up	11,22	H2019	U8	HQ	TS	15 mins

Code	Description
H0031	Mental Health assessment, by nonphysician
H2019	Therapeutic behavioral services, per 15 minutes
0900	Behavioral Health Treatment Services/Gen Classification
1001	Behavioral Health Accomodations/Gen Classification
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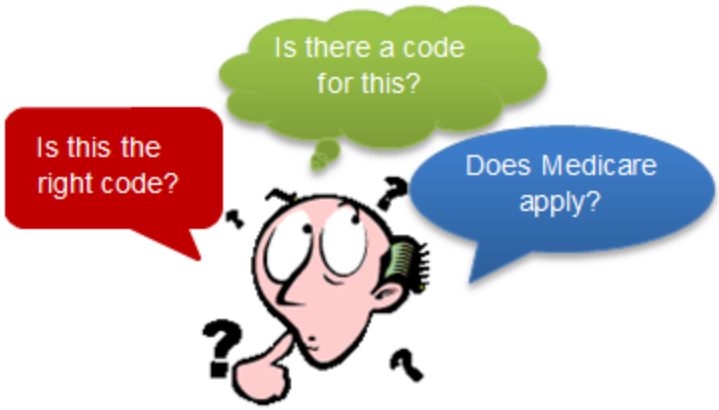
HP	Doctoral (PhD)
HQ	Group
HR	with client
HS	without client
TS	Follow up se *(recovery/continuing care[future])
U8	Compulsive Gambling Tx *(new U mod)*

Administrative Uniformity Committee

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 Recommendations 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 coding recommendations are a coding resource for Minnesota payers and providers consisting of two tables that are updated at least semi-annually. Updates to the coding tables 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 Coding Recommendations 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

The coding recommendations are intended for use in conjunction with tables found in **Appendix A** of the Minnesota Uniform Companion Guides (MUCGs) for the 837 Professional, 837 Institutional, and 837 Dental 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). The recommendations and coding for each topic approved by MCT members are forwarded to the AUC for its review and determination of disposition. 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.

Disposition Status – Determination of where the topics and recommendations will reside:

- MUCG[1] – Minnesota Uniform Companion Guide, version 5010 is a single, uniform companion guide to the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guides mandated by Minnesota Statutes section 62J.536 and related rules. Health care providers that provide services for a fee in Minnesota, or who are otherwise eligible for reimbursement under the state's Medical Assistance program, as well as group purchasers (payers) and health care clearinghouses that are licensed or doing business in Minnesota must comply with the MUCG. The options below represent the specific 837 companion guide(s) that the recommendation applies to:
  - **837P** – 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
  - **837I** – Refers to the 837 Institutional MUCG, i.e., Minnesota requirements for any claim submitted using HIPAA mandated transaction X12 837 institutional claim transaction
  - **837D** – Refers to the 837 Dental MUCG, i.e. Minnesota requirements for any claim submitted using HIPAA mandated X12 837 dental claim transaction

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

- ❑ Grid – Usage of coding determined for the topic/issue has been approved by the AUC as a recommendation only; topic will reside in the Coding Recommendation Table

Specific Coding Topic – Coding issue(s), questions, or clarifications submitted on a completed AUC SBAR form for the AUC to consider

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

Coding Recommendations Detail Table

The Coding Recommendations Detail is color-coded for ease of reference to determine if topic is a recommendation only or a Minnesota Rule, which is the rule of law. Each topic includes the detail information listed as described in the numbered items below.

The blue-highlight indicate coding topics that are recommendations only. These topics will remain in the coding recommendation table and their usage is highly encouraged. The green highlight indicate coding topics that are being proposed as Minnesota rules to be included in the designated companion guides during the next annual maintenance update of Minnesota Uniform Companion Guides for the 837 Professional, 873 Institutional, and the 837 Dental transactions.

1. Coding Topic – The medical service/health benefit or coding issue to be addressed and/or determined 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 – Summary of background information and brief description of the coding topic/issue to be resolved
4. Recommendation – The Medical Code TAG's recommendation to clarify 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 of law. Topics designated as a proposed rule will be transferred from the recommendation table to the appropriate MUCG(s) during the annual maintenance update of the Minnesota Uniform Companion Guides to be ultimately adopted as rule of law.
5. Disposition Status – Identifies implementation status of the recommendation, i.e. place in one or more of the MUCGs or reside in the coding recommendation table:
    - Companion guide (Proposed rule providers and payers must comply when adopted as a Minnesota Rule (rule of law) for the designated claim transaction, e.g. 837P, 837I or 837D)
    - Coding Recommendation Table (recommendation is a best practice and highly recommended; optional to follow recommended usage)
6. Coding – Approved coding recommendations for the specific medical service/health benefit

Table 1: List of Coding Topics/Issues

Medicare Claims Processing Manual		Disposition Status			
Chapter No.	Chapter/Description Title	MUCG(s)	Grid	Coding topic	AUC Approval Date
			x	Alternate Care Site Billing	April 1, 2013
			x	Autism Spectrum Disorder	October 20, 2009
12	Physician/Nonphysician Practitioner Billing			Code 69210 Bilateral Impacted Cerumen	December 3, 2014
12	Physician/Nonphysician Practitioner Billing		X	Coding for SBIRT (Screening, Brief Intervention, and Referral to Treatment)	May 9, 2013
12	Physician/Nonphysician Practitioner Billing	837P		Consultation Services	December 21, 2009
			X	Dental Services Performed in OR	February 8, 2010
12	Physician/Nonphysician Practitioner Billing		X	IONM Clarification	
12	Physician/Nonphysician Practitioner Billing		X	Labor Epidural Billing	May 9, 2013
12	Physician/Nonphysician Practitioner Billing		X	Modifier -25 on preventive medicine visits	April 14, 2014
12	Physician/Nonphysician Practitioner Billing		X	Moving Home Minnesota – A Federal Demonstration Project	June 13, 2013 July 18, 2014 December 3, 2014 May 23, 2016
12	Physician/Nonphysician Practitioner Billing		X	Partial Hospitalization POS	

Table 2: Coding Recommendations Detail

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

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

Autism Spectrum Disorder	
	H2020 Therapeutic behavioral services per diem (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary.) 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

Code 69210 for Bilateral Impacted Cerumen	
MCT Minutes Reference	December 3, 2014
Background/Description	Request to approve standardized coding for 69210. The narrative for 69210 was revised in 2014 to a unilateral code. Thus is performed on both ears it would be appropriate to bill the code with a -50 modifier. However, CMS is not recognizing (denying) 69210 if billed with a modifier 50 (bilateral procedure). Medicare has instructed to use modifiers –RT and –LT instead.
Recommendation	Add coding recommendation to coding grid. MCT will determine at a later date if recommendation should be placed in companion guide.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	69210 Removal impacted cerumen requiring instrumentation, unilateral For bilateral procedure, Medicare for Medicare products report 69210 one line one unit, no modifiers for; and for Commercial and DHS report 69210 one line, one unit, 50 modifier

Coding for SBIRT	
MCT Minutes Reference	January 10, 2013
Background/Description	SBIRT (Screening, Brief intervention, and Referral to Treatment) is an alcohol/substance abuse structured screening. Current reporting per SAMHSA (Substance Abuse and Mental Health Services Administration) is as follows: • For commercial payers the codes are 99408 and 99409 • For Medicare the codes are G0396 and G0397 • For Medicaid the codes are H0049 and H0050
Recommendation	Do not follow SAMHSA coding recommendation. Use CPT or G codes, but not H codes. (Both codes are acceptable per Appendix A front matter in the current Claims companion guide.)
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended)

Coding for SBIRT	
	___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	

Consultation Services	
MCT Minutes Reference	November 24, 2009
Background/Description	Explaining and following the documentation requirements specific to consultations has been problematic for years. CMS issued guidance in their 2010 fee schedule that all these services should be coded as office visits, hospital services, and nursing facility visits. Request AUC recommends a Minnesota Rule that allows services that meet the definition of consultations to be coded according to well established CPT guidelines because following Medicare will increase administrative burden in the form of resources for providers.
Recommendation	Per the Minnesota Uniform Companion Guide Section A.3.1, select codes that most accurately identify the service provided. Consultation codes most accurately identify the service provided for non-Medicare business. Group purchasers will continue to accept consultative service codes as defined by CPT for non-Medicare business.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	

Dental Services Performed in OR	
MCT Minutes Reference	January 14, 2010
Background/Description	There are no uniform billing with Minnesota group purchasers as related to dental procedures done in the operating. Some patients are unable to have dental work performed in a dental office due to their inability to cooperate; for example some patients have developmental delays, mental retardation, autism, or are too young to be in a dental chair for dental procedures. All group purchases do not accept the same codes; some require HCPCS and others CPT. Request AUC decide how hospital claims for dental procedures in OR can be billed with uniform coding.
Recommendation	For dental services not normally provided under general anesthesia…Where dental HCPCS codes are the most specific, appropriate codes, they should be used to indicate dental procedures performed under general anesthesia in the operating room, on both the 837 Professional and 837 Institutional claims types.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	

IONM Clarification	
MCT Minutes Reference	January 8, 2015
Background/Description	The industry is in need of a clarification regarding coding interpretation. Our business practice for procedure code 95940 is to bill units in 15 minute increments, as the CPT code description states, without a modifier and to bill procedure code 95941 in 1-hour increments without a modifier as CPT code description states. Payers are inconsistent in what they require in order to process procedure codes 95940 and 95941. Some payers require modifier 26, which is not indicated in the Medicare Correct Coding Guide, other payers will not pay more than one unit of each code, and some payers will pay with modifier 59 for anything over one unit. Request the AUC clarify billing of service of codes 94940 and 94941.
Recommendation	DHS checked system and found that there was a number in for maximum number per day that was inaccurate. Agree that codes are incorrect. Coding in units. Do these codes require modifier 26 or should there be multiple lines with 59. No Add-on codes 95940 –each 15 minutes No to using code 26 Applicable documentation should support your unit bill. 59-modifier is not appropriate. MCT cannot address reimbursement. These are not TC or 26 eligible and cannot
Disposition Status	**_X_** Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	Follow unit guidelines in a recommendation and follow CPT. Unit would be based one per line.

Labor Epidural Billing	
MCT Minutes Reference	February 14, 2013
Background/Description	According to the 2013 Relative Value Guide from the American Society of Anesthesiologists (ASA), "Unlike operative anesthesia services, there is no single, widely accepted method for accounting for time for neuraxial labor anesthesia services. Request clarification of the rule in the MUCG as it relates specifically to neuraxial anesthesia management time (code 01967) or establish code for "time present and immediately available" of currently billing methodology for most payers be standardized coding in the Claims companion guides for anesthesia
Recommendation	The Medical Code TAG agreed there is no coding to identify specific standby services for anesthesia and suggested that the ASA make recommendation to CPT for national code(s) to address labor epidural anesthesiology billing for "time present and immediately available." Out of scope for AUC. No action taken.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	N/A

Modifier 25 on Preventive Medicine Visits	
MCT Minutes Reference	April 14, 2014, Updated September 8, 2014
Background/Description	A Minnesota payer has communicated effective February 15, 2014, they plan to require modifier -25 on preventive medicine visits when a vaccine administration service is also performed at the same visit and billed with the same date of service. The definition of the preventive medicine visit indicates that an age and gender appropriate history and exam (of a comprehensive nature) are included as well as counseling, anticipatory guidance and risk factor reduction interventions. This definition already indicates that these services are considered significant and separately identifiable from the service of administering a vaccine, making the application of modifier -25 unnecessary. Implementation of this policy conflicts with the AUC's mission, vision, values and strategy of simplifying health care administrative processes and requiring submission of the claims differently than other payers will cause an administrative burden on providers.
Recommendation	The preventive exam denies against the immunization administration code. MN stated there is no need to add the -25 modifier but there are other health plans that require the modifier. Actions of the American Academy of Pediatrics last year caused the CCI policy to be temporary rescinded. However, the new effective date of the CCI policy is April 1, 2014. DHS must use the CCI edits. All payers accept the -25 modifier so this is not a compliance issue, it is a payment issue. Need to work directly with payers she's having problem with. Reporting is uniform and MCT view as payment issue because it is a CCI edit.
Disposition Status	**_X_** Coding Recommendation Grid (Best practice, usage is optional) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	N/A

Moving Home Minnesota – A Federal Demonstration Project	
MCT Minutes Reference	February 14, 2013 original; June 23, 2014 revised
Background/Description	The federal Deficit Reduction and Affordable Care Act empowered states to develop demonstration projects that would promote and enable movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community. To provide community-based alternatives for persons of all ages and disability groups who reside in Minnesota Assistance-funded institutional settings, the Moving Home Minnesota (MHM) -a Demonstration Project provides an array of home and community based services to include planning and coordination of community living arrangements, searching for and securing housing, moving, securing household goods, and arranging for supportive housing, employment and environmental services.
Recommendation	The coding listed below are recommended to report Moving Home Minnesota

Moving Home Minnesota – A Federal Demonstration Project		
	activities.	
Disposition Status	_**X**_ Coding Recommendation Grid (recommendations only; usage is optional) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental	
Coding	A0160 U6	Non-emergency transportation, case worker, per mile, MHM
	A0170 U6	Transportation Ancillary: parking fees, tolls, other, MHM
	A0180 U6	Non-emergency transportation: ancillary lodging, recipient, MHM
	A0190 U6	Meals, recipient, MNM
	A0200 U6	Lodging for caseworker, escort, parent, MNM
	A0210 U6	Meals for caseworker, escort, parent, MNM
	H0038 U5 U6	Self-help/Peer services- Level II Certified Peer Specialist, MHM
	H0038 U6	Self-help/Peer services- Level II Certified Peer Specialist, MHM
	H0038 U5 U6	Self-help/Peer services- Level I Certified Peer Specialist, MHM
	H0038 U6 HQ	Self-help/Peer services- Certified Peer Specialist in a group setting, MHM
	H0040 U6	Assertive Community Treatment, MHM
	H0045 U6	Respite Care Services, not in home, MHM
	H2000 U6	Pre-discharge Case Consultation and Collaboration, MHM
	H2015 U6	Comprehensive Community Support Services, MHM
	H2027 U6	Psychoeducational Service, 15 minutes, MHM
	S5111 U6	Home Care Training – Family, MHM
	S5115 U6	Family Memory Care Intervention, 15 minutes, MHM
	S5116 U6	Home Care Training – Non-Family, MHM
	S5135 UA U6	Overnight Assistance, MHM
	S5150 U6	Respite Care, in home, MHM
	S5150 UB U6	Respite Care, out of home, MHM
	S5151 U6	Respite Care, in home, MHM
	S5160 U6	Emergency response system installation and testing, MHM
	S5161 U6	Emergency response system service fee per month, MHM
	S5162 U6	Emergency response system purchase, MHM
	S1565 U6	Environmental accessibility adaptation, MHM
	S9970 U5 U6	Health club membership, monthly, MHM
	T1016 U6	Case Management, MHM
	T1017 U6	Transition Coordination, MHM

Moving Home Minnesota – A Federal Demonstration Project	
	T1028 U6 Adaptations – home assessment, MHM T1999 U6 Tools, clothing and equipment for employment, MHM T2018 U6 Supported employment benchmark payment, daily, MHM T2019 U6 Supported employment, 15 minutes, MHM T2029 U6 NU Durable medical equipment, new, MHM T2029 U6 RB Durable medical equipment, repair, MHM T2029 U6 RR Durable medical equipment, rental, MHM T2038 U1 U6 Transitional services, furniture, MHM T2038 U2 U6 Transitional services, supplies, MHM T2038 U6 Transition plan development, MHM T2038 UA U6 Transitional services, housing deposit, MHM <u>U Modifier definitions</u>: UA- Night supervision (WS3135)/item, service or procedure furnished in conjunction with a demonstration project (T2038) UB- Out of home UD- Transition to community living services U1- Transitional services, furniture U2- Transitional services, supplies U5- Monthly U6- Moving Home Minnesota (MHM)

Partial Hospitalization Place of Service (POS)	
MCT Minutes Reference	May 1, 2013
Background/Description	A new requirement from CPT/AMA states in the 2013 CPT book that inpatient evaluation and management (E/M) codes (99221-99233) be reported for hospital care for partial hospitalization, see page 483. This E/M requirement for the psychiatric medical professionals to report inpatient hospital codes for partial hospital services creates an inconsistent reporting dilemma between the CPT code and the place of service code.
Recommendation	The correct code to use is Code 52 for psychiatric partial hospitalization. Code 21 is inappropriate. Clarify: DHS does not require 22 for place of service for partial hospitalization as stated in the SBAR and suggests use of Code 22 for appropriate E-M services. DHS will add Code 52 POS for partial hospitalization to match CPT to eliminate the confusion.
Disposition Status	**_X_** Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	52 Psychiatric Facility-Partial Hospitalization

Speech Language Pathologist VCD/PVFM	
MCT Minutes Reference	January 8, 2015
Background/Description	Speech Language Pathologists (SLP) are treating patients for Vocal Cord Dysfunction (VCD)/ Paradoxical Vocal Fold Movement (PVFM) by therapy. Unable to find corresponding HCPCS codes that describe this service provided by the SLPs, which is hands on so it feels like physical therapy but it is being performed by SLPs. Today the service is being coded using HCPCS 92524-GN ***Behavioral and Qualitative Analysis of Voice and Resonance*** for the evaluation and HCPCS 92507-GN *Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder, individual* for the therapy. GN: Services delivered under an outpatient speech language pathology plan of care. Requests the AUC determine appropriate codes for services performed by Speech Language Pathologists who are treating patients for VCD/PVFM by therapy.
Recommendation	Polling of AUC payers indicate the following: DHS prefers the 92700. Judith (HCMC) felt that 92700. PreferredOne – SLP does not agree with 92700 (what's currently being done). Medica – 92525 or; HealthPartners – no answer. Recommend using CPT 92507 and 92524
Disposition Status	**_X_** Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	92507 Treatment of speech, language, voice communication and/or auditory processing disorder, individual 92524 Behavioral and qualitative analysis of voice and resonance

Coding

The **AUC** Medical Code **Technical Advisory Group (**TAG) provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services and also addresses new code standards pertaining to administrative simplification uniformity in Minnesota.

This work is accomplished formally through the AUC SBAR Process, which includes review of **the** completed **AUC** SBAR form and the Medical Code TAG (MCT) Decision Tree form **submitted by AUC member organizations and other interested parties requesting AUC address administrative simplification medical coding issues pertinent to Minnesota.**

SBAR coding decisions recommended by the MCT and approved by the AUC may be recorded in the Minnesota Community Coding Practice/Recommendation Table described below.

Minnesota Community Coding Practice/Recommendation Table v4.0 (PDF: 725KB/12pgs) (Updated 06/17/13)

The Minnesota Community Coding Practice/Recommendation Table **(aka Recommendation Grid) is a living document that** is intended for use in conjunction with Appendix A of the Minnesota Uniform Companion Guides (MUCGs) for the 837 professional, dental, and institutional transactions.

The Recommendation Grid is regularly updated with new coding recommendations or clarifications and answers to SBARs with coding issues. Coding clarifications in this table may be transferred to the applicable 837P, 837D and 837I MUCGs as part of the annual companion guides maintenance.

Updates in the table may stem from quarterly HCPCS coding changes, medical coding in relation to legislative changes; new or revised Medicare rules; and other coding issues as identified.

AUC SBAR Process

States the purpose of the SBAR form and provides a summary and illustration of the AUC SBAR process as well as a step-by-step description of the process.

AUC SBAR Form
The AUC SBAR form is completed to formally request the AUC to consider working on medical coding issues related to administrative simplification or to request clarification of Minnesota rules and regulations related to medical coding issues. Included with the form are instructions for its proper completion.

MCT Decision Tree Form
The **AUC Medical Code TAG (MCT)** utilizes the MCT Decision Tree form to aid in its decision-making process when reviewing SBARs submitted to the **MCT**.

Archived Minnesota Community Coding Practice/Recommendation Tables

Version	Dates
Version 3.0 (PDF: 227KB/30pgs)	02/16/12
Version 2.0 (PDF: 187KB/23pgs)	01/06/12

Version 1.0 (PDF: 189KB/23pgs)	10/20/2009-12/31/2011