Administrative Uniformity Committee

AGENDA – MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Thursday, December 1, 2016
9:30 a.m. to 12:30 p.m.
Location: HealthPartners, 8170 Building, Bloomington, Cedar – 2nd 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. **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** – October 13, 2016

4. **Telemedicine – JoAnne Wolf, Children's Health Network**

The expanded telemedicine benefit is a legislated benefit effective for state public programs 1/1/16 and then is effective for commercial plans on 1/1/17. I think we need to make sure we have some coding guidelines for this service or if using the telemedicine modifiers on an E/M would work. POS might be an issue though since the patient could be located anywhere (home, work, etc.) not just at a host facility.

9/8/16: Questions raised regarding newly legislated benefits expanded so that now patients can be anywhere and services performed will be HIPAA compliant. How to report services? What HCPCS or CPT codes are to be used? DHS requires attestation for all of its state public programs. Will attestation be implemented by all commercial plans by January 1, 2017? It was agreed that guidance is needed. Researched place of service for telehealth (POS); and found there is nothing available that addresses telehealth services being provided at a patient's home. POS for telehealth being proposed by CMS addresses typical telemedicine not Skype type visits or e-visits. Issue to be resolved is billing for online video consult. Need to define visit type – e-visit or video. Issues regarding privacy of Skype/electronically provided services. Issues – need to see CMS policy, to include POS to determine how it fits under Minnesota's telemedicine policy. AUC, what is Medicare policy; do we want a state policy different from Medicare benefit. How does MN differ from Medicare? Should there be a different MN rule. Also consider AMA website The TAG decided to consider the national guidelines being proposed by CMS and the AMA and then determine Minnesota's position, i.e., to follow Medicare or to develop a Minnesota rule. MCT will also review AMA's website to determine what information available regarding telemedicine/telehealth and include in discussion. The TAG will meet after the national guidelines have been published on Thursday, December 1, 2016 from 9:30 am to 11:30 a.m. 2nd Floor, Cedar Room.	OPEN – Pending info from CMS/AMA. SBAR may be needed.
10/1/16: Deb reported the AMA has added a new symbol, a star, which denotes all services that can be used for telemedicine services: mental health; E&M, including inpatient E&M; diagnostic service; nutrition; etc. AMA is also proposing a new modifier 95 for	OPEN

telehealth/telemedicine. MCT members attending the CPT symposium will provide update to TAG. Faith will allow extra time for the discussion.	

5. DHS and Companion Guide Maintenance – David Haugen, MDH

AUC Executive Committee discussed the increasing challenges of synchronizing DHS-specific information with the companion guide maintenance process, as evidenced by the lengthy maintenance process this year and the need to revote the guide as a result of the ARMHS changes. The Exec Committee agreed to include the issue on the agenda for the September Operations meeting for review and discussion.

9/8/16: This agenda item had been discussed previously by the MCT at its April 14th meeting. Due to the length of time to complete the 2015 annual maintenance of the 837P and 837I Minnesota Uniform Companion Guides, it was suggested that DHS programs be removed from the companion guide and replaced by a link to DHS website. The MCT maintains it position that DHS programs remain in the guide. Concerns were discussed and questions regarding the impact the removal of DHS programs would have on other payers. Options to consider if DHS programs were removed included the following: 1) If commercial plan and you plan on implementing some of DHS programs, you must follow coding on DHS MHCP provider manual at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000094 (2) It was also suggested that the list of programs remain in the guide and that the coding for each program be removed from the guide. Other questions raised were: How can we make exception to one payer if it is the law? What happens when coding differs from CMS or CMS does not address it? MCT would like for Dave to present a mockup of the guide to demonstrate what he is proposing or what the guide would look like.	OPEN
10/13/16: Dave did not attend today's meeting. However, Kathy Sijan reported she met internally with staff to discuss Dave Haugen's recommendation for removing DHS-only programs from the companion guides and having them maintained solely on DHS website. She stated DHS has several options under consideration of how to maintain the most appropriate information within the site. Kathy further stated that Pansi and Mike (DHS) are visiting today to hear input from the MCT. MCT members reiterated some of the same concerns voiced in previous meetings about removing the coding for DHS programs, i.e., directing commercial payers who may have contracted these services with their commercial clients as well as DHS; codes are constantly changing, four times a year CMS updates codes, the reason the recommendation table was created; and because Medicaid can also create a code and make it retroactive. Members also wanted to know if the decision to remove coding for DHS programs from the claims companion guides was final and if it was on the agenda as an FYI. They would like for Dave to participate in the discussion and answer questions.	OPEN

6. Decision Tree Creation Reminder– Judy Edwards, MDH

TAG members need to create a decision tree for SBARs and present for discussion and approval.

9/8/16: Judy reminded the MCT that members were asked to come up with their version of a decision tree to be reviewed by the TAG at a future meeting. To date, Faith has not received any proposed decision trees from anyone. Medical Code TAG members are requested to submit their version of a decision tree to Judy and Faith prior to the October meeting so they can be incorporated into one document. The next meeting is October 13; decision tree forms are due to Faith and Judy by end of day on Thursday, October 6.	OPEN
10/13/16: Judy reported that two proposed decision trees had been submitted; recommendations that no changes in the current decision tree form was needed. The TAG edited one of the submitted drafts and asked that copies of the proposed decision trees be forwarded to them for their review prior to the next meeting. Judy will incorporate flip chart illustration to decision tree form and forward to TAG along with other drafts. Faith will send to TAG members.	OPEN

7. CEMT Provider Type Legislation – Shawnet Healy, DHS

Minnesota Statutes, section 256B.0625 was amended to authorize community emergency medical technician as a new provider type to provide services when ordered by a treating physician.

8. Additional Agenda Items/ Announcements

- Next scheduled meeting: December 7, 9:00-12:00, St. Croix – 1st floor, HealthPartners, 8170 Building, Bloomington.
- Reminder: *AUC UPDATE* newsletter coding article volunteers needed.

MEDICAL CODE TECHNICAL ADVISORY GROUP (MCT)
Meeting Minutes – Thursday October 13, 2016

Draft

Agenda Item	Discussion	Action Item
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	Faith called for introductions and reminded everyone to forward updates and membership requests to Deb Sorg. She also instructed those participating by phone to email their attendance to Deb.	Closed
2. Review of Antitrust Statement	Faith read AUC anti-trust statement.	Closed
3. Review of last meeting's minutes – September 8, 2016	The minutes were approved with the following revisions made to Agenda item No. 11: Corrected first bullet point by deleting "an audit" and replacing it with "phone calls." Fourth bullet point was expanded to indicate the reason for scheduling the December 1 meeting. It now states: "An additional meeting will be scheduled due to proposed coding changes by AMA and CMS; CMS has proposed place of service coding in their 2017 physician fee schedule interim rule."	Closed
4. Community Emergency Medical Technician Services – Shawnet Healy, DHS	Nursing home visits were combined with safe home check. Process in moving into section with hospital discharge. Language to Community Medical Response Community Emergency Technician Submitted to CMS and waiting for them to approve DHS would like to use T1016 rather than T1028. T1028 is not a timed code. It was determined that a new SBAR is required.	Closed – Shawnet will submit a new SBAR.
5. Telemedicine – JoAnne Wolf, Children's Health Network	Deb reported the AMA has added a new symbol, a star, which denotes all services that can be used for telemedicine services: mental health; E&M, including inpatient E&M; diagnostic service; nutrition; etc. AMA is also proposing a new modifier 95 for telehealth/telemedicine. MCT members attending the CPT symposium will provide update to TAG. Faith will allow extra time for the discussion.	OPEN
6. DHS and Companion Guide Maintenance – David Haugen, MDH	Dave did not attend today's meeting. However, Kathy Sijan reported she met internally with staff to discuss Dave Haugen's recommendation for removing DHS-only programs from the companion guides and having them maintained solely on DHS website. She stated DHS has several options under consideration of how to maintain the most appropriate information within the site. Kathy further stated	OPEN

	that Pansi and Mike (DHS) are visiting today to hear input from the MCT. MCT members reiterated some of the same concerns voiced in previous meetings about removing the coding for DHS programs, i.e., directing commercial payers who may have contracted these services with their commercial clients as well as DHS; codes are constantly changing, four times a year CMS updates codes, the reason the recommendation table was created; and because Medicaid can also create a code and make it retroactive. Members also wanted to know if the decision to remove coding for DHS programs from the claims companion guides was final and if it was on the agenda as an FYI. They would like for Dave to participate in the discussion and answer questions.	
7. Decision Tree Creation Reminder– Judy Edwards, MDH	Judy reported that two proposed decision trees had been submitted; recommendations that no changes in the current decision tree form was needed. The TAG edited one of the submitted drafts and asked that copies of the proposed decision trees be forwarded to them for their review prior to the next meeting. Judy will incorporate flip chart illustration to decision tree form and forward to TAG along with other drafts. Faith will send to TAG members.	OPEN
8. Additional Agenda Items/ Announcements	• Next scheduled meeting: December 1, 9:30-12:30, Cedar – 2nd floor, HealthPartners, 8170 Building, Bloomington • Reminder: *AUC UPDATE* newsletter coding article volunteers needed.	Closed

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: After completing sections I and II, 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. It is recommended that the Decision Tree form be completed first.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert). All fields must be completed. Incomplete forms will be returned to the submitter.

SBAR Short title (Required):	Version #:	Date submitted to AUC (Required):
Telemedicine / Telehealth		**11/16/16**

Contact Information for person completing this form (Required):	Organization Information (Required):
Name: JoAnne Wolf **Title: Coding Manager** **Email address: joanne.wolf@childrensmn.org** **Telephone: 612-813-5972**	**Name: Children's Health Network** **Address: 910 E. 26th St., Suite 330 Minneapolis, MN 55404**

SBAR presenter, if different from above:

Name:

Title:

Email address:

Phone number:

Please note: The SBAR presenter must be in attendance or available during the meeting(s) in order for the SBAR to be discussed. You will received notification from the TAG co-chair with the meeting date and time when the SBAR will be discussed.

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: There does not appear to be a coding scenario to report telemedicine/telehealth services in which a HIPAA-compliant "skype" type of service is performed. In these situations, the patient is not at a host site, but could be anywhere (home, office, school, etc.). The traditional telemedicine services are reported by both the consultant and the host site. The coding rules around this type of telemedicine are published and clear. There are specific rules around coding (modifier use, place of service and CPT/HCPCS code(s) reported). Likewise there are published rules around other types of telemedicine such as telephone calls and e-visits. The previously published coding rules for these types of telemedicine do not seem to fit or seem adequate for the reporting of the new emerging types of telemedicine.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Telemedicine or telehealth encompasses several types of service including telephone calls, e-visits and traditional telemedicine (patient is at a host facility and consultant is at a distant site). However, there are other types of telemedicine that are emerging such as a HIPAA compliant "Skype" type of visit. The coding rules around the traditional telemedicine services do not fit for

	this service. Traditional telemedicine involves the billing of HCPCS code Q3014 by the host site and the consultant billing the CPT that would describe the service as if the consultant was with the patient. Example: If the patient was in a host site that was an outpatient hospital, the POS billed would be 22 (patient location) and the CPT code used would represent an outpatient E/M (eg, 99203) billed with modifier –GT or –GQ.
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): • Telemedicine services have a legislated mandated benefit beginning in 2017, which includes commercial plans • New types of telemedicine services are emerging including the HIPAA compliant "Skype" type of visits • Clinics and other organizations are beginning to utilize these alternative ways of delivering healthcare Other considerations: • New place of service code for telemedicine services (02) • New Appendix P and CPT codes with a start symbol in CPT 2017 indicating CPT codes that may be used for synchronous telemedicine services
R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: I recommend that the providers and health plans in the state of MN review the appropriate coding for emerging types of telemedicine (specifically the "Skype" type of visit) including appropriate CPT/HCPCS code, modifier and place of service.

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(s):

Disposition status *(e.g., Minnesota Uniform Companion Guide or Best practice)*:

Decision Summary:

AUC Response:

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

AUC Approval Date:

Medical Code TAG 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. It consists of a series of three levels, as follows:

Level I. Prior to Medical Code TAG review

In Level 1 MDH staff collects SBARs or other inquiries regarding medical coding issues. The SBARs are forwarded to both the MCT and to the AUC Executive Committee for their review. 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.

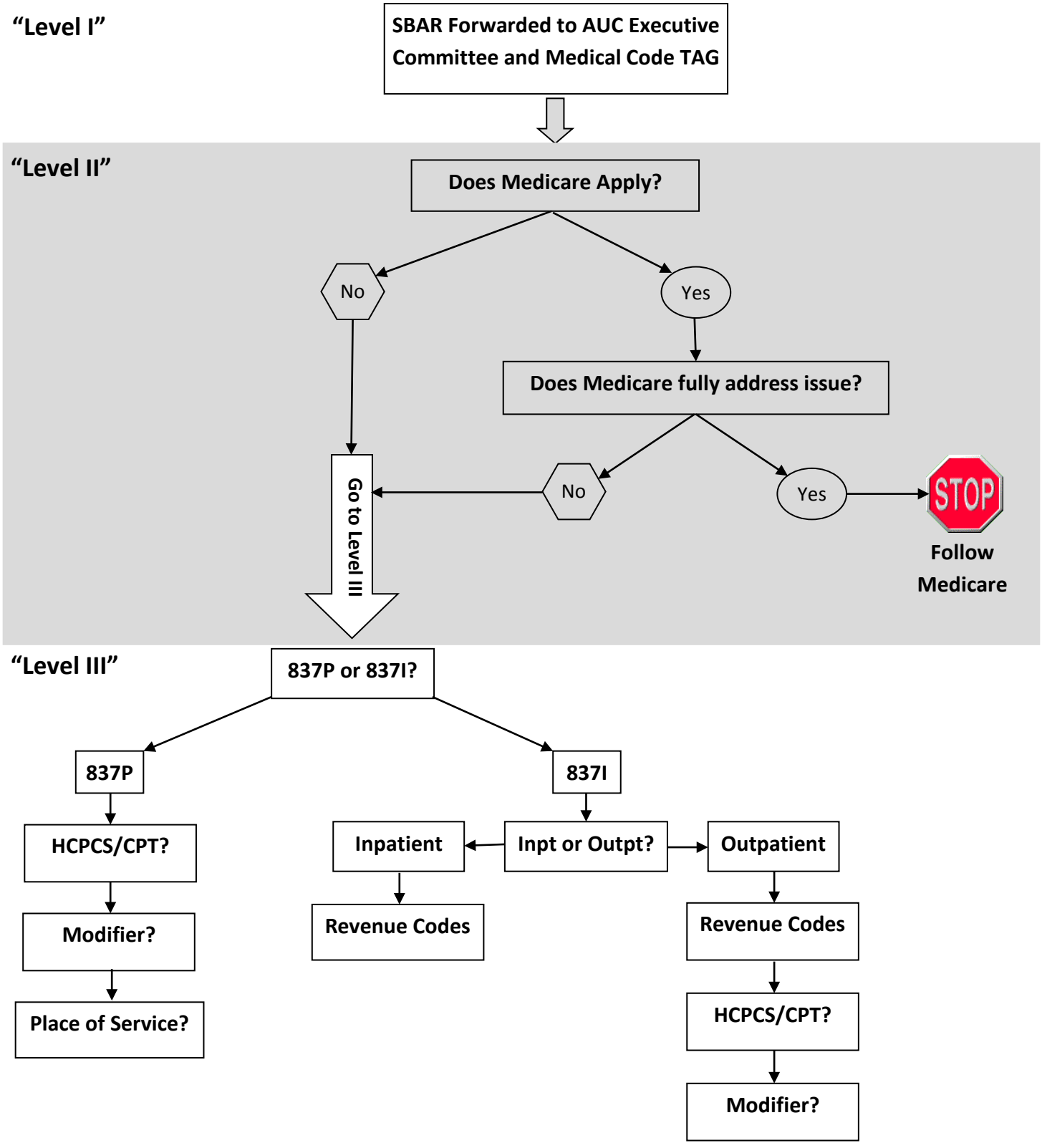
- If Medicare applies and there are no other concerns or perceived problems with Medicare coding (e.g., vagueness or possible confusion in Medicare instructions, Medicare does not fully address the service in question), the MCT recommendation will be to "follow Medicare" and the issue will be considered 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: provider type; effective date(s); and appropriate references to federal authority. The MCT will coordinate with the Claims DD TAG on place of service issues as needed. Final recommendations will also address revenue codes and type of bill for outpatient services, and type of bill for inpatient services.

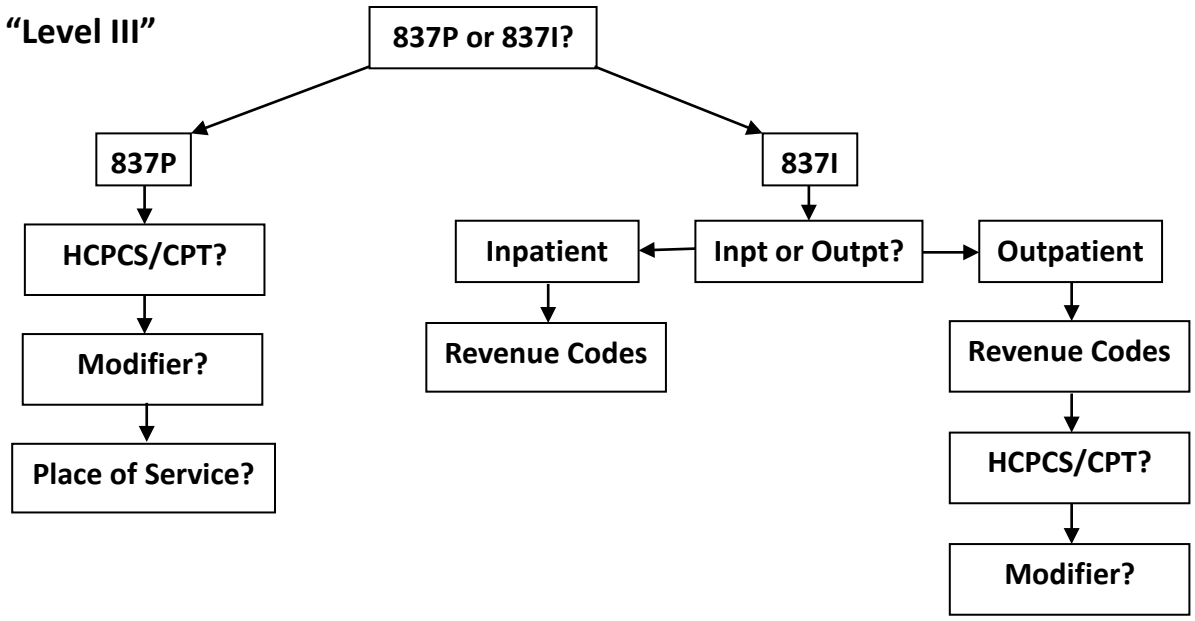
Level II. Name/description of service/issue:

Decision Tree Questions for Level II:

1. Does Medicare have coding requirements/instructions for coding the medical service/procedure/etc. of interest? If "yes," please reference the source of the Medicare instructions and provide a link. Then go to question 2 below.	
Yes _X_	
No ___	Proceed to Question #3
2. Does Medicare's coding guidance fully address the issue?	
Yes ___	 Follow Medicare as referenced at the link in question no. 1 above.
No _X__	If "no," please check any of the concerns below that apply and provide examples and complete questions 3-5. *a.* __X___ 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:
3. Is the service related to a statute or rule? If yes, please list and provide a link.	
Yes _X_	Legislated telemedicine benefit for MN
No ___	
4. Include all health care professional types who may provide or bill for this service?	
Clinics and providers (MD, NP, PA, etc.) would report as a professional service.	
5. Is the service billed on an 837 Professional or 837 Institutional transaction? Check all that apply.	
837P___	
837I_X_	
6. Does the code(s) need to be time-based? If yes, please indicate billing increments.	
Yes ___	
No ___	
7. What HCPCS/CPT code(s) and modifiers are you recommending for the following? Cite source and provide link	
HCPCS/CPT	?
Modifier(s)	-GT or -GQ
Place of Service	New POS code 02?

Application of MCT Decision Tree -- Level III – **TO BE COMPLETED BY MEDICAL CODE TAG**

Level III. Name/description of service/issue:



Decision Tree Questions for Level III: TO BE COMPLETED BY MEDICAL CODE TAG

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?	
HCPCS:	Cite source and provide link: Go to question 3
3. Are modifiers needed or applicable? Yes_____ No_____	
Modifier:	Cite source and provide link: Go to question 4
4. What is the place of service (POS)?	
POS:	Cite source and provide link:

Application of MCT Decision Tree -- Level III: **TO BE COMPLETED BY MEDICAL CODE TAG**

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.
Not Applicable ____	
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 or applicable? Yes _____ No _____	
Modifier:	Cite source and provide link:

Summary of MCT findings and recommendations

Name/description of service/issue: _____

Level III 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.)

_____ Other (Please see below)

Level III findings

Use the table below:

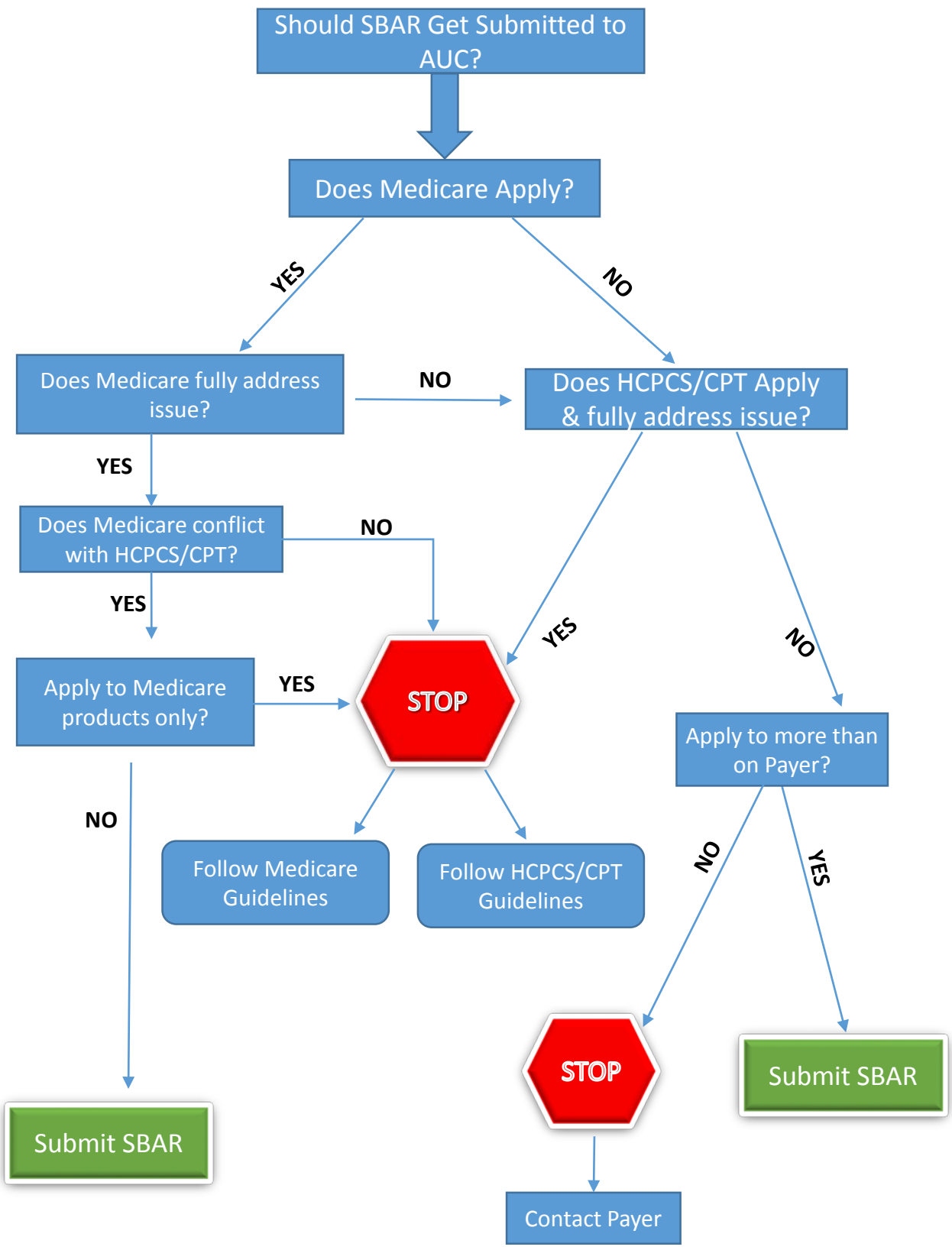
- If 837P go to Column A
- If 837I to Column B
    - If 837I Inpatient, go to Column B1
    - If 837I Outpatient, go Column B2

Summary of MCT findings and recommendations – Level III: **TO BE COMPLETED BY MEDICAL CODE TAG**

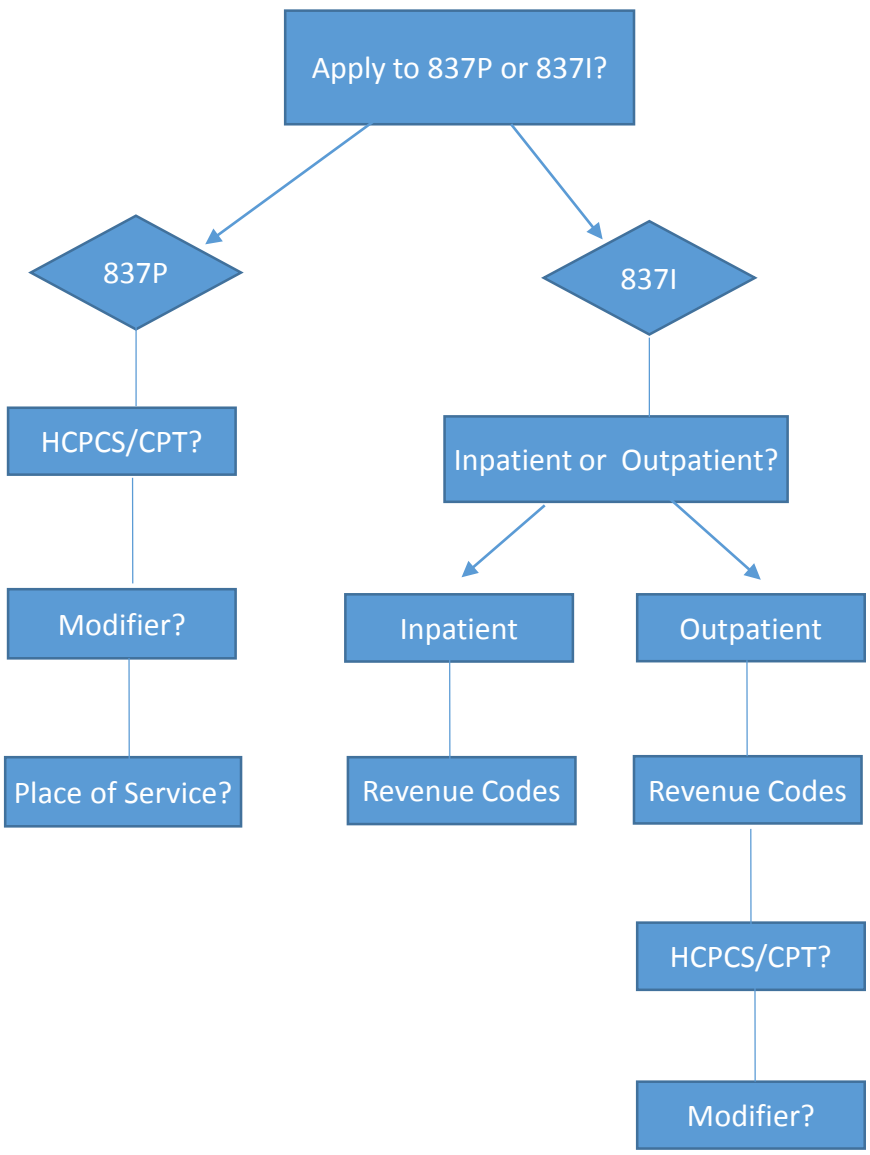
Name/description of service/issue: _____

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 (recommendation statement, including issue being addressed)			

Medical Code TAG SBAR Decision Tree - Illustrated



Medical Code TAG Decision Tree - Illustrated



Revised September 19, 2016

Administrative Uniformity Committee

Medical Code Technical Advisory Group [MCT TAG] Decision Tree Form for Medical Coding Issues

Overview

This decision tree is a tool to aid the AUC Medical Code TAG (MCT) in making decisions regarding medical coding issues. It consists of a series of three levels, as follows:

Level I. Prior to Medical Code TAG review

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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.

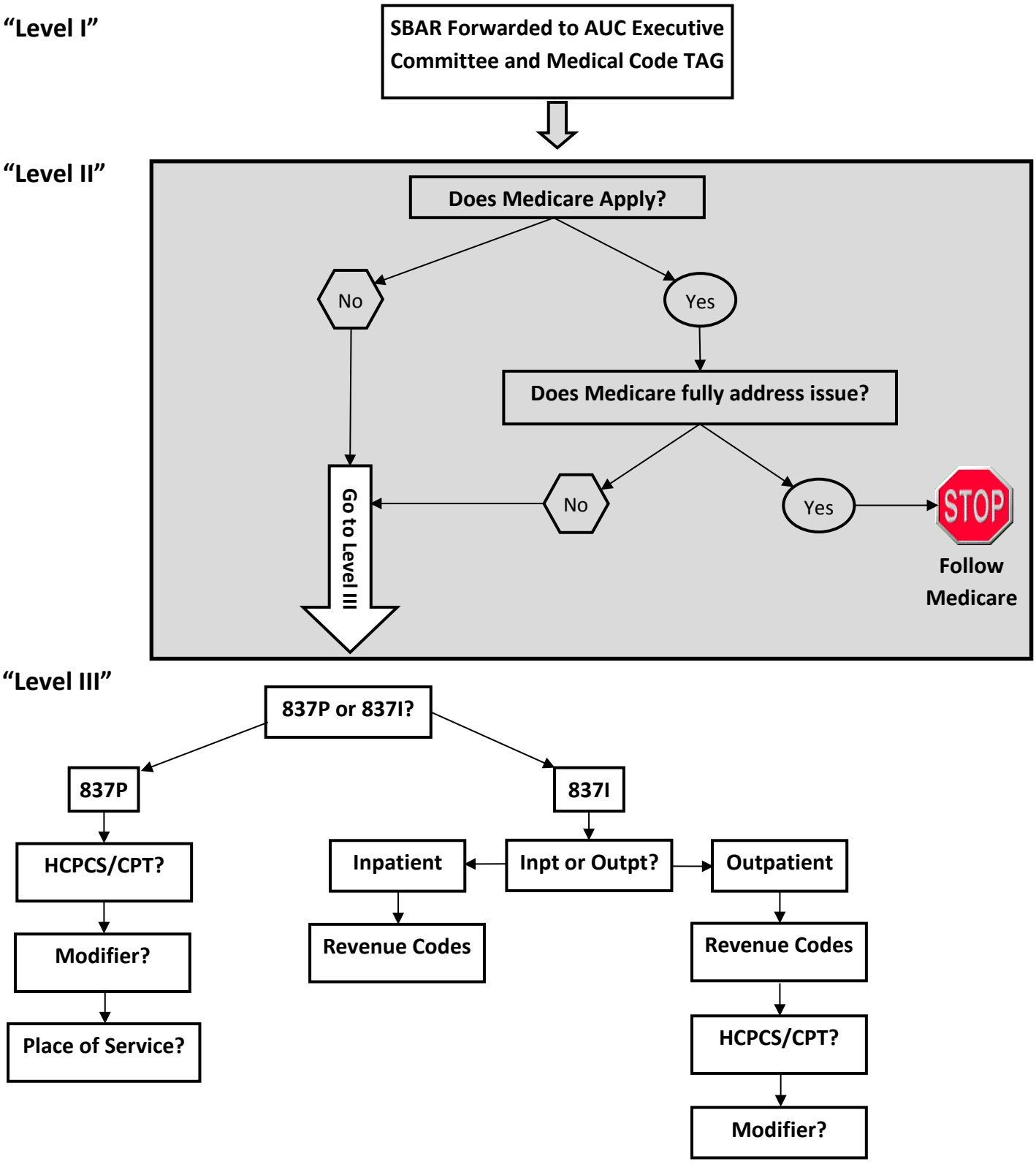
Level III. Coding recommendation when Medicare does not apply or does not adequately address the issue

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 review and 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 in the summary flow chart on the next page.

PLEASE CONTINUE AND FILL OUT THE BLUE SECTIONS UNDER LEVEL II ON PAGE 3

Illustrative Medical Code TAG (MCT) work flow for medical coding issues



Note: Coding recommendations will include additional information as applicable regarding: provider type; effective date(s); and appropriate references to federal authority. The MCT will coordinate with the Claims DD TAG on place of service issues as needed. 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? If "yes," please reference the source of the Medicare instructions and provide a link. Then go to question 2 below.	
Yes ___	
No ___	Proceed to Question #3
2. Does Medicare's coding guidance fully address the issue?	
Yes ___	 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 complete questions 3-5. *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:
3. Is the service related to a statute or rule? If yes, please list and provide a link.	
Yes ___	
No ___	
4. Include all health care professional types who may provide or bill for this service?	
5. Is the service billed on an 837 Professional or 837 Institutional transaction? Check all that apply.	
837P___	
837I___	
6. Does the code(s) need to be time-based? If yes, please indicate billing increments.	
Yes ___	
No ___	

7. What HCPCS/CPT code(s) and modifiers are you recommending for the following? Cite source and provide link	
HCPCS/CPT	
Modifier(s)	
Place of Service	

->TO BE COMPLETED BY MEDICAL CODE TAG<-

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

Decision Tree Questions:

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?	
HCPCS:	Cite source and provide link: Go to question 3
3. Are modifiers needed or applicable? Yes_____ No_____	
Modifier:	Cite source and provide link: Go to question 4
4. What is the place of service (POS)?	
POS:	Cite source and provide link:
5. 837I Inpatient or 837I Outpatient?	
Inpatient ____	If "Inpatient," then go to question 6 below.
Outpatient ____	If "Outpatient," then go to question 7 below.
Not Applicable ____	
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 or applicable? Yes _____ No _____	
Modifier:	Cite source and provide link:

Summary of MCT findings and recommendations

TO BE COMPLETED BY MEDICAL CODE TAG

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 Level III findings.)
_____ Other (Please see below)

Level III findings

Use the table below:

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

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 (recommendation statement, including issue being addressed)			

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received: July 15, 2016	**Log No.:** 082	**Date Closed:**	
Date Sent to AUC Executive Committee: July 21, 2016	**Date Sent to AUC TAG Co-chair(s):** July 21, 2016	**TAG Recommendation:** _____ Accept _____ Reject	**Date Decision Sent to Originator:**

REMINDER: After completing sections I and II, 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. It is recommended that the Decision Tree form be completed first.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert). All fields must be completed. Incomplete forms will be returned to the submitter.

SBAR Short title (Required): CEMT provider type legislation 256B.0625, sec. 13, subd. 60a	Version #: 4	Date submitted to AUC (Required): 11-1-16
Contact Information for person completing this form (Required): Name: Shawnet Healy Title: MN DHS Benefit Policy Specialist Email address: Shawnet.healy@state.mn.us Telephone: 651.431.3721	**Organization Information (Required):** Name: MN DHS – Andersen Bldg. Address: 540 Cedar St. St. Paul, MN 55101	

SBAR presenter, if different from above:

Name: Shawnet Healy
Title: Benefit Policy Specialist
Email address: Shawnet.healy@state.mn.us
Phone number: 651.431.3721

Please note: The SBAR presenter must be in attendance or available during the meeting(s) in order for the SBAR to be discussed. You will received notification from the TAG co-chair with the meeting date and time when the SBAR will be discussed.

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: Community Emergency Medical Technicians (CEMTs) as new provider type in MN

S	**SITUATION** – Minnesota Statutes, section 256B.0625 was amended to authorize community emergency medical technician as a new provider type to provide services when ordered by a treating physician ; 1) post-hospital discharge visits 2) safety evaluation visits - These are to an individual who has repeat ambulance calls due to falls, has been discharged from a nursing home, or has been identified by the individual's primary care provider as at risk for nursing home placement when ordered by a primary care provider and documented in the individual's care plan. These services are provided to patients covered by medical assistance.
B	**BACKGROUND** – 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.

CEMTs provide services to hospital discharge patients, nursing home discharges or repeated ambulance calls.

- **For hospital discharges:**

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

- **For nursing home discharges or repeated fall calls-**

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

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.**
Minnesota Statutes 256B.0625 subd 60a Community Emergency Medical Technician Services
Minnesota Statutes 144E.275 subd. 7 Medical Response Unit Registration

Minnesota Statutes 144E.001 subd. 5h, Definitions

A

ASSESSMENT –

Currently there is no provider type to do these home visits post hospital discharge, or when someone is returning home from a nursing home, or when someone has had repeated home calls by paramedics/ambulance services for falls and a 'safe home' check is needed. Pilot program in St. Louis Park that included 4 other communities was very successful in reducing readmits.

This provider type is to assist in reducing readmission and it is working.

	This is addressing the first 24-48 hours post discharge to go over the discharge orders from the primary provider, confirm the recipient has the necessary meds, their food supply is checked and the home is safe. This will be billed by the medical director for the ambulance service in units of 15 minutes. A CEMT must use at least eight minutes of a unit in order to bill it.
R	**RECOMMENDATION** – DHS is recommending **T1016**, with two specific modifiers to denote; 1] a CEMT post hospital visit or 2] a safety evaluation visit. These visits are usually completed within a 30 minute visit and are billed in units of 15 minutes. To qualify for 15 minutes, the visit must be documented that eight or more minutes was performed. The effective date is 1.1.17 or upon federal approval, whichever is later. Recommending this be in the MUCG, 837P **CODE | Mod1** T1016 U4 - case management, per 15 minutes, CEMT post-hospital discharge visit T1016 U5 – case management, per 15 minutes, CEMT safety evaluation visit

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(s):

Disposition status *(e.g., Minnesota Uniform Companion Guide or Best practice)*:

Decision Summary:

AUC Response:

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

AUC Approval Date: