



## AUC Best Practices

**The following list is intended as a quick reference guide for all existing AUC Best Practices.**

The [Minnesota Uniform Companion Guides](#) are rules for the exchange of standard, electronic health care administrative transactions. Health care providers providing health care services for a fee in the state of Minnesota and group purchasers (i.e. “payers,” “HMOs,” “carriers,” “TPAs,” etc.) licensed or doing business in Minnesota [must comply with these rules](#). The Minnesota Department of Health ([MDH](#)) has consulted with the Minnesota Administrative Uniformity Committee ([AUC](#)) to develop these rules in accordance with [Minnesota Statutes, section 62J.536](#).

Best Practices documents are consensus recommendations of the AUC to further standardize and harmonize health care administrative transactions for the providers and group purchasers for which the rules apply. While adoption or adherence to the Best Practices is voluntary, it is strongly encouraged to further reduce health care administrative burdens and costs. The Minnesota Uniform Companion Guides and corresponding AUC Best Practices can be found [online](#).

Please note: In 2009, Minnesota implemented v4010 Uniform Companion Guides for the Eligibility Inquiry and Response (270/271), Health Care Claim (837P, 837I, 837D), and Claim Payment/Remittance Advice (835) transactions. The Best Practices denoted as “v4010” in this table should be used with the corresponding v4010 Minnesota Uniform Companion Guide. In 2010, Minnesota will publish updated v5010 Uniform Companion Guides related to the same transactions noted here. At that time, this Grid will be updated with any corresponding Best Practices. **Users should not assume that the v4010 AUC Best Practices listed here will apply to v5010 MN Uniform Companion Guides.**

### Transactions:

- **270/271:** [Eligibility Inquiry and Response](#)
- **837P:** [Health Care Claim, Professional](#)
- **837I:** [Health Care Claim, Institutional](#)
- **837D:** [Health Care Claim, Dental](#)
- **835:** [Claim Payment/Remittance Advice](#)

### Other:

- Dataset to be provided for Skilled Nursing Facility admissions decisions

AUC Best Practice	Transaction	Summary/Purpose	V4010	V5010
<b><u>270/271 Eligibility Inquiry and Response Best Practices</u></b>				
<a href="#">Verifying Eligibility</a>	270	<ul style="list-style-type: none"> <li>Provides recommendations for providers to facilitate verifying a patient's eligibility with a group purchaser.</li> </ul>	X	
<a href="#">Reporting Patient Financial Responsibility</a>	271	<ul style="list-style-type: none"> <li>Outlines how to report known patient financial responsibility in the 271 Eligibility Response.</li> </ul>	X	
<a href="#">Timely Enrollment Reporting Requirements</a>	270/271 reporting	<ul style="list-style-type: none"> <li>Provides guidance for group purchasers and clearinghouse users regarding how and when patient enrollment updates should be implemented.</li> </ul>	X	
<b><u>837 Health Care Claim: Professional, Institutional, and Dental Best Practices</u></b>				
<a href="#">MN Community Coding Recommendation Grid</a>	837P, 837I	<ul style="list-style-type: none"> <li>The MN Community Coding Grid consists of medical coding recommendations. It is updated on a regular basis as needed, and the recommendations in the grid are approved and used in the same manner as Best Practices.</li> </ul>	X	
<a href="#">Provider COB Claims Data Population</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>Provides assistance to providers and group purchasers for payer to payer COB transactions.</li> <li>NOTE: <a href="#">MS 62J.536</a> does <b>not</b> apply to payer to payer coordination of benefits (COB).</li> </ul>	X	
<a href="#">Format of Claim Submitter's Identifier</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>Outlines for providers how to best format and submit patient control/account numbers in the claims transaction.</li> </ul>	X	
<a href="#">Utilization of the Basic Character Set Values</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>Explains best use of the basic character values in the claims transaction.</li> </ul>	X	

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<a href="#">Reporting Services and Charges Related to Adverse Health Events</a>	837I	<ul style="list-style-type: none"> <li>▪ Provides additional guidance to providers submitting a claim that contains both services that are related to an Adverse Health Event and those that are not.</li> </ul>	X	
<a href="#">Taxonomy Submission Requirements</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Indicates situations where taxonomy code(s) should be included in the claim record as it will impact the adjudication of the claim.</li> </ul>	X	
<a href="#">Claims Attachments</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Provides guidance on how to complete and send an attachment that is related to a submitted claim.</li> <li>▪ <a href="#">Attachment Cover Sheet Instructions</a></li> <li>▪ Attachment Cover Sheet (<a href="#">MS Word</a>), (<a href="#">PDF</a>)</li> <li>▪ <a href="#">AUC Member Contact Information</a></li> <li>▪ NOTE: Claims Attachment Cover Sheets should be sent to the appropriate group purchaser and not the MN Department of Health or the AUC.</li> </ul>	X	
<a href="#">Hearing Aid Model Numbers in NTE Segment</a>	837P	<ul style="list-style-type: none"> <li>▪ Outlines how to submit hearing aid model numbers as part of a claim, avoiding the need to submit the numbers as a claims attachment.</li> </ul>	X	
<a href="#">Miscellaneous Supply/Product Numbers in NTE Segment</a>	837P, 837I	<ul style="list-style-type: none"> <li>▪ Provides guidance for submitting codes for miscellaneous supplies/products as part of a claim, avoiding the need to submit the codes as claims attachments.</li> <li>▪ NOTE: This best practice does not apply to institutional inpatient claims.</li> </ul>	X	

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<a href="#">COB Claims When Primary Payer is not a MN Group Purchaser</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Gives instructions for submission of a secondary claim when the primary claim is submitted to a payer who is not a group purchaser covered under Minnesota Statutes, section 62J.536.</li> </ul>	X	
<a href="#">Claim Service Dates Restricted to Same Calendar Month</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Most patient eligibility changes occur at the beginning/end of a calendar month. Some systems require claims contain only services that are associated with a particular eligibility period, and current practice is to split these claims. The purpose of this Best Practice is to provide guidance in order to avoid split claims and rejections.</li> </ul>	X	
<a href="#">Product and Supply Description in NTE Segment</a>	837P, 837I	<ul style="list-style-type: none"> <li>▪ Provides guidance for submitting descriptions of a product or supply as part of a claim, avoiding the need to submit the codes as claims attachments.</li> </ul>	X	
<a href="#">Replacement/Void Claims</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Clarifies definitions, identification and handling of replacement and void claim types.</li> <li>▪ NOTE: Replacement claims may also be referred to as “corrected claims”; void claims may also be referred to as “cancel claims”.</li> </ul>	X	

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<a href="#">Submission of Appeals</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Provides instruction for submitting an appeal by a provider to a Minnesota group purchaser</li> <li>▪ <a href="#">Instructions for Completion of Appeal Request Form</a></li> <li>▪ Appeal Request Form (<a href="#">MS Word</a>), (<a href="#">PDF</a>)</li> <li>▪ <a href="#">AUC Member Contact Information</a></li> <li>▪ NOTE: Claims Appeal Request Forms should be sent to the appropriate group purchaser and <b>not</b> the MN Department of Health or the AUC. The Attachment Cover Sheet must <b>not</b> be sent with the Appeal Request Form.</li> </ul>	X	
<a href="#">Coordination of Benefits/Non-Assignment of Primary Payer Benefits</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Provides guidance on how the secondary or tertiary group purchaser can determine whether they need to request the payment information from the patient rather than the provider, or adjust as patient liability, in situations in which the patient initially received the EOB/Payment.</li> </ul>	X	
<a href="#">Coding for Preventative Medicine Visit with a Separately-Identifiable, Problem-Oriented Service During the Same Encounter</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ This Best Practice states that the comprehensive work required to establish a patient/physician relationship is completed when a Preventive Medicine Service is provided.</li> <li>▪ Therefore, an established patient E/M code should be used to report a separately-identifiable problem-oriented E/M service in addition to a Preventive Medicine Service on the same date.</li> </ul>	X	

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<a href="#">Billing for Postage Services</a>	837P, 837I, 837D	<ul style="list-style-type: none"> <li>▪ Provides instructions for postage billing, which only apply if the provider bills the group purchaser for postage. Some providers do not bill the group purchaser for postage and some contracts exclude coverage for postage.</li> <li>▪ Providers are <b>not</b> required to bill for postage nor are group purchaser required to reimburse for postage.</li> </ul>	X	
<a href="#">Reporting of admission, principal and other procedure, and statement dates</a>	837I	<ul style="list-style-type: none"> <li>▪ This best practice is a revision to current billing requirements of the Minnesota Uniform Companion Guide For the Implementation of the Health Care Claim - Institutional Electronic Transaction (ANSI ASC X12 837I). It explains reporting of admission, principal and other procedure, and statement dates.</li> <li>▪ This best practice is intended for use 10/1/11 – 12/31/11.</li> </ul>		
<b><a href="#">835 Claim Payment/Remittance Advice Best Practices</a></b>				
<a href="#">Electronic Funds Transfer (EFT)</a>	835	<ul style="list-style-type: none"> <li>▪ Outlines standard EFT processes for providers, group purchasers, and financial institutions wishing to implement this process.</li> <li>▪ NOTE: <a href="#">MS 62J.536</a> does <b>not</b> require that providers and group purchasers use electronic funds transfer (EFT) as a component of the claim payment/remittance advice transaction.</li> </ul>	X	

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<a href="#">Acknowledge Receipt of Manual Full Refund</a>	835	<ul style="list-style-type: none"> <li>Provides guidance for group purchasers acknowledging the receipt of a manual refund check in the 835 transaction.</li> <li>NOTE: Group purchasers need <b>not</b> acknowledge receipt of a manual refund check in the 835 transaction.</li> </ul>	X	
<a href="#">Balance Forward Processing</a>	835	<ul style="list-style-type: none"> <li>Indicates preferred method to report group purchaser recoveries in excess of payments within the 835 transaction.</li> </ul>	X	
<b>Other</b>				
<a href="#">Dataset to be provided for Skilled Nursing Facility admissions decisions</a>	N/A	<ul style="list-style-type: none"> <li>The dataset described in this best practice is an inventory of the information needed by SNFs to decide whether they can adequately care for a resident and to prepare for providing that care.</li> </ul>	X	