AUC Medical Code Technical Advisory Group (MCT) Thursday,
Thursday, April 13, 2017
9:00 a.m. to 12:00 p.m.
HealthPartners, 8170 Building, Bloomington, St. Croix – 1st floor

AGENDA

WebEx Information
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!
5. Click “Join now”

Teleconference Information
Call-in line: 1-605-475-2874
Participant Access Code: 337213

** Callers are responsible for any long distance charges **

Visit our website at: http://www.health.state.mn.us/auc/index.html
AGENDA

1. Welcome and Introductions
   - Attendance tracking: Deb Sorg deb.a.sorg@healthpartners.com
   - Membership request and/or updates: Deb Sorg deb.a.sorg@healthpartners.com

2. Review of Antitrust Statement

3. Review of last meeting’s minutes – March 9, 2017

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 telehealth/telemedicine.

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

OPEN

12/1/16
After much discussions and review of Medicare guides, for Medicare, the new place of service 02 pulls a facility payment. The coding still includes reporting the originating site code Q3014 with the appropriate place of service; however, where the patient received services is reported with place of service 02 and the GT (or GQ) modifier. The intent of the new modifier 95 is the same as GT. Because these guides are accepted Medicare guides, nothing needs to be added to the Guides.

There is still question on other types of telemedicine and the need to develop a policy. Included would be reporting the place of service based on patient or provider location.

Kathy Sijan volunteered to obtain additional information from the AMA.

OPEN

2/9/17
Dave Haugen researched Medicare and state laws and put together a white paper. There are three sets of statutes. Most are the same with some differences. The need for a modifier is consistent; however, modifier may differ. There is no mention of place of service or practitioner in any policy. However, it is assumed that the 02 place of service is for distance site. Also an attestation is required for Medicaid claims.

Dave also put together a power point for a WEDI webinar and will share with the MCT.

Because these guides are accepted Medicare guides, nothing needs to be added to the Guides, JoAnne Wolf will present a policy to consider.

OPEN

3/9/17
Dave Haugen presented the power point developed for a WEDI webinar.

Items of not during discussion:

- Place of service (POS) 02 is used to indicate where the practitioner is.
- The originating site is billed with the actual POS, such as office (11).
- POS 02 is set up to generate a facility reimbursement.

Possible example 1: patient with practitioner’s office POS Bemidji but practitioner initiates telemedicine consult with a specialist in Minneapolis. Billing: two claims

- practitioner’s office POS Bemidji: POS 11; code Q3014
- specialist in Minneapolis: POS 02; code 99xxx

Possible example 2: patient is at home and initiates a telemedicine visit with a practitioner. One claim:

- patient at home: no bill in generated. This may be originating site, but the patient does not bill.
- practitioner in office: POS 02; code 99xxx
ACTION: Members are welcome to share examples of telemedicine scenarios.
ACTION: JoAnne Wolf will present a policy to consider.

OPEN

5. 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

12/1/16
Not discussed.

OPEN

2/9/17
The decision tree were intended as a tool to help with deciding the direction of a proposed SBAR (Medicare, DHS, Commercial impact, etc.); however, most decision trees are not completed.

Instead of a separate decision tree, can we enhance the SBAR will some of the information found on the decision tree? A mockup will be done.

OPEN

3/9/17
The revised SBAR forms were reviewed.

Comments included whether the completion of the decision tree should be done first to determine if the issue is a coding issue.
Dave reported that SBAR and decision tree review will go to the AUC Ops.

OPEN


The Medicare rounding rules once again need to be reviewed and clarified. An inquiry was received from a Medicare certified outpatient rehab agency regarding units reporting. The updated Uniform Companion Guide would have the provider follow Medicare rounding rules; however, MDH provider manual and BCBS provider policies specifies that we should NOT follow Medicare rounding rules.

7. **Psychiatric Residential Treatment Facility – Cher Vang, DHS**

Creating Psychiatric Residential Treatment Facilities is an important key to filling the gap of meeting the needs of children and youth with serious and complex mental health conditions.

8. **Certified Community Behavioral Health Clinics (CCBHC) – Cher Vang, DHS**

9. **Additional Agenda Items/Announcements**

   - Next scheduled meeting: May 11, 9:00-12:00, St. Croix – 1st floor, HealthPartners, 8170 Building, Bloomington.

   - Reminder: *AUC UPDATE* newsletter coding article volunteers needed.
AUC Medical Code Technical Advisory Group (MCT)

Thursday, March 9, 2017

MINUTES

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 – February 9, 2017

   Issue number 8, Recent DHS Changes – correct originator to Andrea Agerlie.

   The minutes were approved.

   CLOSED

4. Telemedicine – JoAnne Wolf, Children’s Health Network

   Dave Haugen presented the power point developed for a WEDI webinar.
   Items of not during discussion:
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- practitioner’s office POS Bemidji: POS 11; code Q3014
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ACTION: Members are welcome to share examples of telemedicine scenarios.
ACTION: JoAnne Wolf will present a policy to consider.

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The revised SBAR forms were reviewed.

Comments included whether the completion of the decision tree should be done first to determine if the issue is a coding issue.

Dave reported that SBAR and decision tree review will go to the AUC Ops.

OPEN

6. CEMT Provider Type Legislation – Shawnet Healy

Andrea Agerlie reported that Shawnet did the language update.

There are two services legislated are:

- Post-hospitalization visit
- Home safety evaluation

DHS is developing a new provider type.

SBAR approved – send to AUC Ops

CLOSED

7. Additional Agenda Items/Announcements

- AUC Operations is meeting on Tuesday, April 14, 2017, 2:00-4:00.
- Next scheduled meeting: April 13, 2017, 9:00-12:00, St. Croix – 1st floor, HealthPartners, 8170 Building, Bloomington
- Reminder: AUC UPDATE newsletter coding article volunteers needed.

CLOSED
<table>
<thead>
<tr>
<th><strong>Scenario</strong></th>
<th><strong>Originating Site - Site A</strong></th>
<th><strong>Distant Site - Site B</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandria Clinic (A) contacts Mpls Clinic of Neurology (B) for discussion on seizure medications due to patient drug sensitivities, while the patient is still in their exam room.</td>
<td>Claim form type: 837P CPT/HCPCS code: Q3014 Modifier: GT POS: 11</td>
<td>Claim form type: 837P CPT/HCPCS code: E/M (99201) Modifier: 95 POS: 02</td>
</tr>
<tr>
<td>St Mary’s, Duluth ER (A) contacts Mayo Clinic (B), during the day, for advice on concussion protocol following a skiing incident on one of their patients.</td>
<td>Claim form type: 837I Rev Code: 0780 Type of Bill (TOB) code: 013x CPT/HCPCS code: Q3014 Modifier: GT POS: None</td>
<td>Claim form type: 837P CPT/HCPCS code: E/M (99201) Modifier: 95 POS: 02</td>
</tr>
<tr>
<td>FV Maple Grove ER (A) contacts a UMP hospital based clinic provider (B)</td>
<td>Claim form type: 837I Rev Code: 0780 Type of Bill (TOB) code: 013x CPT/HCPCS code: Q3014 Modifier: GT POS: None</td>
<td>Claim form type: 837P CPT/HCPCS code: E/M (99201) Modifier: 95 POS: 02</td>
</tr>
<tr>
<td>Hennepin County hospital based clinic provider (A) contacts Mayo clinic provider (B)</td>
<td>Claim form type: 837P CPT/HCPCS code: Q3014 Modifier: GT POS: 22</td>
<td>Claim form type: 837P CPT/HCPCS code: E/M (99201) Modifier: 95 POS: 02</td>
</tr>
</tbody>
</table>
| Mayo clinic based provider (B) contacted by Healtheast provider (A) to review diagnostics and E/Ms on a patient that is not currently in the clinic or facility. | Claim form type: 837P CPT/HCPCS code: Q3014 Modifier: GQ POS: 11 (Asynchronous) | Claim form type: 837P CPT/HCPCS code: E/M (99201) Modifier: GQ POS: 02 May need to match up to originating site claim in order to verify it was asynchronous as site B may report modifier 95 in error.
A.3.4.2. Units (basis for measurement)

For therapy codes, follow HCPCS/CPT guidelines for determining rounding time. [See rounding rule instructions in Chapter 5 of Appendix A, Table A.5.1 for physical, occupational, and speech language pathology services (PT/OT/SLP)]

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

<table>
<thead>
<tr>
<th></th>
<th>Part B Outpatient Rehabilitation and CORF/OPT Services</th>
<th>Follow HCPCS/CPT rounding guidelines</th>
</tr>
</thead>
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<tr>
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<td></td>
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Psychiatric Residential Treatment Facility

A new level of care

Minnesota does not have the capacity to meet the needs of children and youth with serious and complex mental health conditions. Creating psychiatric residential treatment facilities (PRTF) is an important part of filling this gap.

PRTFs will provide services to children and youth with complex mental health conditions. PRTFs will be more intensive than other services currently available in the state, such as residential treatment or day treatment, but less medically intensive than a psychiatric hospital or a psychiatric unit of a general hospital.

PRTFs provide treatment seven days per week to residents and their families under the direction of a physician, and may include individual, family and group therapy. PRTFs will be:

• **Person-centered**, supporting individuals’ ability to express preference, choice, control, and direction in all aspects of services.
• **Family-centered**, ensuring inclusion of families as partners in all aspects of mental health care and treatment, including access to family services evenings and weekends.
• **Culturally responsive**, recognizing the cultural needs of individuals and their families and engaging their culture as a resource to meet the person’s needs.
• **Trauma-informed**, understanding the impact of trauma on residents, their families, and staff to ensure a safe and therapeutic environment.

In addition to treatment, PRTFs will offer:

• Educational services in collaboration with the local school district and school district of residence.
• Recreational programming and access to exercise facilities to maintain healthy physical activity.
• Access to other therapies such as occupational therapy, recreational therapy, physical therapy, speech therapy, or other therapeutic services.
• Health care services, nursing services, dietary services, emergency physician services, and medication monitoring.
Who will benefit

PRTF services will be funded by Minnesota Health Care Programs, which includes Medical Assistance and MinnesotaCare for eligible recipients. This new level of care will support individuals under the age of 21:

- Who have serious and complex mental health needs.
- For whom other community based mental health services have been exhausted and/or cannot provide the level of care needed.
- Where psychiatric residential treatment is required to improve the individual’s condition or prevent further regression.

Referral for PRTF

Referrals to PRTF may be made by a credentialed mental health professional from the community or acute care settings, along with the parent or legal guardian. Other members of a recipient’s treatment team, such as case managers and other providers, may also have a role in facilitating the referral. Referrals will be submitted to the state’s medical review agent to determine medical necessity.

The need

Past reports illustrate the need for PRTFs. In 2014, the Minnesota Association of County Social Services Administrators participated in a survey on how many children and youth within the previous two years who fit the profile for PRTF. From the 53 counties (out of 87) who responded:

- 339 children and youth in 2012
- 385 children and youth in 2013

In August 2015, Wilder Research published a Services Gaps Analysis. Key findings suggested a lack of access to psychiatric services, as well as residential and residential treatment services for youth with complex mental health conditions. Counties, in their role of lead agencies, rated residential child and youth psychiatry beds, psychiatric prescribers, and residential placements for children and youth with aggressive behaviors (particularly for youth under age 13) as the largest or most significant gaps.

Psychiatric Residential Treatment Facilities are intended to provide active treatment and comprehensive discharge planning for individuals to successfully transition to home, school and community.

Mental Health at DHS

The Department of Human Services is dedicated to supporting adults, children and youth with a mental illness in their personal journey toward recovery, as well as preventing mental illness whenever possible.

For more information, visit http://mn.gov/dhs
Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHC) are community clinics that offer mental health and substance use disorder services as well as a range of other services. CCBHC will provide outreach, increase access, improve services, and serve as a “one-stop-shop” to those who are currently underserved.

About CCBHC

Navigating mental health and substance use disorder systems can be difficult. Typically, a person with a mental illness will need to contact several different agencies to obtain a different level of care, and rarely can someone obtain both mental health and substance use disorder treatment through the same agency.

CCBHC will improve the way Minnesotans access mental health and addiction treatment by creating a model of community clinics providing comprehensive, coordinated and integrated care to children and adults with complex mental and chemical health conditions.

This high level of care coordination and partnerships between providers, social services agencies, counties and other key stakeholders should increase the likelihood that care will be received before a person enters into crisis, lessening the burden on emergency rooms, law enforcement and families.

Integrated care

People who use CCBHCs may receive:

- Outpatient mental health and substance use services
- Primary care screening and monitoring
- Screening, assessment and diagnosis, including risk management
- Psychiatric rehabilitation services
- Crisis mental health services, including 24-mobile crisis teams, emergency crisis intervention services and crisis stabilization
- Patient-centered treatment planning
- Targeted case management
- Peer and family support
- Services for members of the armed forces and veterans
- Connections with other providers and systems
Demonstration program

In 2014, the U.S. Congress enacted the Excellence in Mental Health Act, which established an eight-state demonstration project to test CCBHCs. The 2015 Minnesota legislature provided funding to support planning. In December 2016, Minnesota was chosen to be one of eight states to pilot CCBHC.

In Minnesota, six clinics were chosen to be the first CCBHCs.

Clinics will begin providing services by July 2017. During the demonstration period, states will receive an enhanced Federal match on Medicaid for the services provided by CCBHCs. The pilot is scheduled to run until June 30, 2019.