



Tuesday, August 20, 2019

9:00 – 10:30 am

## AUC Medical Code TAG Meeting August 20, 2019

### AGENDA

1. Meeting to Order
2. Welcome & Introductions
3. Anti-trust Statement – <http://www.health.state.mn.us/auc/pdfs/antitrust.pdf>
4. Review/update MN Uniform Companion Guide (MUCG) for Claims – Appendix A
  - a) Review/discuss draft “straw man” appendix A
5. Other Business
6. Meeting Summary & Next Steps
7. Next Meeting – HealthPartners, Teleconference/WebEx OPTION (9am-12pm)  
9am – 12 pm, September 12, 2019

## Instructions for joining the Aug. 20, 2019 AUC Medical Code TAG meeting via Webex:

1. To start the WebEx session, go to: <https://health-state-mn-ustraining.webex.com/mw3200/mywebex/default.do?siteurl=health-state-mn-ustraining&service=7> (make sure you are in the Webex Training tab)
2. Find the date of the meeting you are looking for
3. Click on the session for “AUC Medical Code TAG”
4. Provide your name, email address, and the following password: **Mct2010!** (Note: The password is case sensitive and includes the exclamation mark at the end.)
5. Click “**Join now**”
6. Click “**Run**”
7. Under the “**Use Phone**” option, enter your phone number
8. When WebEx calls you at the indicated number, hit the number “**1**” to enter the meeting

**Note:** *If you have trouble with the WebEx “Call Back” feature described above, or if you would like to join by audio only, you may manually call into the meeting using the following:*

- Call-in number: 844-302-0362
- Participant Access Code: 797 063 749

Each meeting has a unique access code. The access code above is only for Aug. 20 MCT meeting. For the access code for other meetings, please see the TAG meeting information page at: <https://www.health.state.mn.us/facilities/auc/tags/elig/info.htm>.

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

### 1.1 Purpose and Scope

This Appendix provides coding information and instructions that must be followed to meet requirements for efficient, effective exchange of the 837P transaction pursuant to [Minnesota Statutes, Section 62J.536](#) and this Minnesota Uniform Companion Guide (MUCG).

The appendix was developed in consultation with the Minnesota Administrative Uniformity Committee (AUC) and its Medical Code Technical Advisory Group (TAG) to address needs, priorities, and improvement opportunities identified by the AUC and the broader health care community.

#### 1.1.1 Limits to scope

This appendix *does not address or govern*:

- a. the services or benefits that are eligible for payment under a contract, insurance policy, or law;
- b. payment for health care services under a contract, insurance policy, or law.

### 1.2 Relationship to state and federal requirements

MS §62J.536 requires that the MUCG must specify “uniform billing and coding standards.” The statute cites federal law, 45 CFR 162<sup>1</sup> (federal HIPAA Administrative Data Standards and Related Requirements), as well as the Medicare program as the sources for uniform billing and coding, and provides that the Commissioner of Health may adopt modifications from Medicare after consultation with the AUC.

---

<sup>1</sup> As noted in the body of this document, this MUCG (including all appendices) “*Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162 ....*”

As a result, it is important to note that “*Covered entities that create and process administrative transactions must implement the standard codes according to the implementation specifications adopted for each coding system and each transaction. Those that receive standard electronic administrative transactions must be able to receive and process all standard codes irrespective of local policies regarding reimbursement for certain conditions or procedures, coverage policies, or need for certain types of information that are part of a standard transaction.*” ([Health Insurance Reform: Standards for Electronic Transactions. Affected Entities. HHS/ASPE 2000.](#)

<https://aspe.hhs.gov/report/health-insurance-reform-standards-electronic-transactions/affected-entities>)

Consistent with the 45 CFR 162 HIPAA Requirements, all covered entities are required to submit or receive codes that are:

- valid on the date of service for medical code sets;
- valid at the time the transaction was created and submitted for non-medical code sets.

### **1.3 General coding instructions and information**

#### **1.3.1 Selection of codes**

- Select codes that most accurately identify the procedure/service/product provided.

#### **1.3.2 Units**

- The number of units is the number of services performed and reported per service line item as defined in the code description unless instructed differently in this appendix.
- The following are unit clarifications/exceptions:
  - Report one unit for all services without a measure in the description.
  - Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals:
    - “per vertebral body;”
    - “each 30 minutes;”
    - “each specimen;”
    - “15 or more lesions;”
    - “initial.”
- Follow all related AMA guidelines in CPT<sup>2</sup> (e.g. “unit of service is the specimen” for pathology codes). Definition of “specimen”: "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."
- In the case of time as part of the code definition, follow HCPCS/CPT guidelines to determine the appropriate unit(s) of time to report. Per the guidelines, more than half the time of a time-based code must be spent performing the service in order to report the code. If the time spent results in more than one and one half times the defined value of the code, and no additional time increment code exists, round up to the next whole number.
- For therapy codes, follow HCPCS/CPT guidelines for determining rounding time.
- Anesthesia codes 00100-01999: 1 unit = 1 minute

---

<sup>2</sup> Current Procedural Terminology (CPT®), copyright 2016 American Medical Association

- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

#### **1.4 Specific coding instructions**

This section lists coding instructions to be followed regarding particular priority topics and questions that have been reviewed and addressed by the AUC.

As noted above, this MUCG’s uniform billing and coding instructions are based on federal HIPAA requirements and the guidelines of the federal Medicare program, with possible modifications by the MDH commissioner after consulting the AUC.

In some cases however, general instructions to “follow Medicare coding guidelines” (as described in the Medicare online claims processing manual, Pub. 100-04, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html>) may be subject to inherent limitations and therefore may be inadequate or confusing. For example, this is especially the case in billing and coding for services not covered by Medicare.

The following table lists a number of priority coding instructions, especially to clarify or provide additional information for situations in which “following Medicare” may be otherwise inadequate or difficult to interpret and apply in practice.

**TABLE 1.4 Specific coding instructions**

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
1	4 <a href="#">Part B Hospital (Including Inpatient Hospital Part B and OPPTS)</a>	Outpatient professional services provided by CAH, Method II billing	Outpatient professional services provided by Critical Access Hospitals electing Method II billing should be reported on the professional claim type (i.e. 837P).	DH – we have a few similar entries about type of claim to use. Should they be organized together? (Should they be in the body of the guide, or this coding appendix)
2	5 <a href="#">Part B Outpatient Rehabilitation and CORF/OPT Services</a>		Follow HCPCS/CPT rounding guidelines	
3	9 <a href="#">Rural Health Clinics/Federal Qualified Health Centers</a>	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.	DH – See note re. Ref No. 1
4	10 <a href="#">Home Health Agency Billing</a>	PCA and Homemaking Services	PCA: T1019 PCA Shared 1:2: T1019-TT PCA Shared 1:3 or more: T1019-HQ PCA Temporary Service Increase: T1019-U6 PCA Notice of Reduction: T1019-U5 RN PCA Supervision: T1019-UA Homemaking: S5130, S5131 PCA services may not be billed with a span of dates; each date of service must be billed separately.	DH – T codes are Medicaid. Should the reader be redirected to the DHS website for this coding info? CL = T codes are NOT restricted to Medicaid only. Commercial may use dependent on employer group request.
5	10 <a href="#">Home Health Agency Billing</a>	Home Infusion	Home infusion is not addressed in this chapter. See instructions following this table.	DH – We can probably remove this entry as it comes up later. CL – reference here since the chapter is Home Health Agency

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
				Billing. Prefer to leave it since reference is made to other area of this table.
6	12 <a href="#">Physicians/Nonphysician Practitioners</a>	Allergy, clinical immunology	Medicare does not allow all allergy and clinical immunology codes, but group purchasers accept all applicable codes. Follow the code selection guidelines in the front of Appendix A.	DH – Clarify or remove second sentence of instructions
7	12 <a href="#">Physicians/Nonphysician Practitioners</a>	Modifier 50	Modifier 50 should only be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. Bilateral services are to be reported with the 50 modifier on one line with one unit.	
8	12 <a href="#">Physicians/Nonphysician Practitioners</a>	Bilateral Radiology	Bilateral radiology services are reported as either: <ul style="list-style-type: none"> <li>▪ one line with a 50 modifier and one unit, or</li> <li>▪ two separate lines, one with RT modifier and one with LT modifier.</li> </ul>	
9	12 <a href="#">Physicians/Nonphysician Practitioners</a>	Interpreter services	To report interpreter services: Note: Rounding rules (see front matter section A.3.4.2) apply to all services below. A minimum of eight minutes must be spent in order to report one unit. <ul style="list-style-type: none"> <li>• T1013 -- Face-to-face oral language interpreter services per 15 minutes</li> <li>• T1013-U3 -- Face-to-face sign language interpreter services per 15 minutes</li> <li>• T1013-GT -- Telemedicine interpreter services per 15 minutes</li> <li>• T1013-U4 -- Telephone interpreter services per 15 minutes</li> </ul>	DH – T codes – refer reader to DHS site? CL = T codes are NOT restricted to Medicaid only. Commercial may use dependent on employer group request.

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<ul style="list-style-type: none"> <li>• T1013-UN, UP, UQ, UR, US -- Interpreter services provided to multiple patients in a group setting</li> <li>• Report T1013 for each patient in the group setting               <ul style="list-style-type: none"> <li>○ 10Append the modifier indicating how many patients in the group</li> <li>○ Report one unit per 15 minutes per patient</li> </ul> </li> <li>• T1013-52 -- Interpreter drive time, wait time, no show/cancellation per 15 minutes               <ul style="list-style-type: none"> <li>○ Report one unit per 15 minutes per client</li> <li>○ If more than one service is provided, report each on a separate line appended with the -59 modifier                   <ul style="list-style-type: none"> <li>▪ T1013-52 x 2 units (30 minutes of drive time)</li> <li>▪ T1013-52 59 (12 minutes of wait time)</li> </ul> </li> <li>○ 11Add narrative(s) in the NTE segment to report the service(s) rendered. An NTE segment is required for each line.</li> <li>○ Reporting drive time versus mileage is based on individual contract. T1013-52 may not be used for drive time if mileage is reported (see 99199)</li> <li>○ A canceled service may only be reported if the interpreter has already arrived for the appointment prior to the cancellation.</li> </ul> </li> <li>• 99199 -- Mileage for interpreter service</li> </ul>	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<ul style="list-style-type: none"> <li>○ Reporting mileage versus drive time is based on individual contract. 99199 may not be used if drive time (T1013-52) is reported.</li> <li>○ Report one unit per mile.</li> </ul>	
10	<p style="text-align: center;"><b>12</b>  <a href="#">Physicians/Nonphysician Practitioners</a></p>	<p style="text-align: center;">Collaborative psychiatric consultation                      (MN Statutes <a href="#">256b.0625, subd. 48</a> –                      Psychiatric consultation to primary care practitioners)</p>	<p>Coding for a consultation initiated by the primary care practitioner/provider to psychiatrist, APRN (certified in psychiatric mental health) or psychologist for an opinion or advice regarding a patient should be reported using 99499 as follows:</p> <ul style="list-style-type: none"> <li>● Primary Care – 99499 HE AG</li> <li>● Primary Care – 99499 HE AG U4 (non-face-to-face)</li> <li>● Primary Care – 99499 HE AG U7 (by physician extender)</li> <li>● Primary Care – 99499 HE AG U4 U7 (non-face-to-face by physician extender)</li> <li>● Consulting Psychiatrist – 99499 HE AM</li> <li>● Consulting Psychiatrist – 99499 HE AM U4 (non-face-to-face)</li> <li>● Consulting APRN (certified in psychiatric mental health) – 99499 HE AM</li> <li>● Consulting APRN (certified in psychiatric mental health) – 99499 HE AM U4 (non-face-to-face)</li> <li>● Consulting psychologist – 99499 HE AM</li> <li>● Consulting psychologist – 99499 HE AM U4 (non-face-to-face)</li> </ul>	<p>DH – Mentions services specific to DHS statute. Direct reader to DHS site?</p> <p>CL = Commercial also follows, especially when MA is 2ndry.</p>
11	<p style="text-align: center;"><b>12</b>  <a href="#">Physicians/Nonphysician Practitioners</a></p>	<p style="text-align: center;">Patient not in exam room</p>	<p>There are circumstances when it is inappropriate to have the patient in the exam room with the physician or nurse practitioner due to extenuating circumstances regarding the patient’s condition. When a discussion between</p>	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<p>clinician and caregiver is vital for the health of the patient and necessary for the patient to be properly cared for, the appropriate CPT code for evaluation and management services may be billed based on time to the patient’s group purchaser. Report the appropriate ICD-CM code(s), based on date of service, for the diagnosis of the patient as the primary diagnosis or diagnoses.</p>	
12	<p style="text-align: center;"><b>12</b> Physicians/Nonphysician Practitioners</p>	Behavioral Health Home	<p>Behavioral Health Home (BHH) is a monthly service encompassing any or all of the following six services:</p> <ul style="list-style-type: none"> <li>1- Comprehensive Care Management</li> <li>2- Care Coordination</li> <li>3- Health Promotion Services</li> <li>4- Comprehensive Transitional Care</li> <li>5- Referral to Community and Social Support Services</li> <li>6- Individual and Family Support Services</li> </ul> <p>S0280 U5 – Medical home program, comprehensive care coordination and planning, initial planning S0281 U5 – Medical home program, comprehensive care coordination and planning, maintenance of plan</p> <p><u>Definitions:</u> Care Engagement: The (initial) first six months of services [can be non-consecutive]. Ongoing Standard Care: The ongoing care (maintenance) after the first six months of care engagement. U5 modifier: Behavioral health home</p>	
13	<p style="text-align: center;"><b>12</b> <a href="#">Physicians/Nonphysician Practitioners</a></p>	Health Care Homes	<p>The following instructions are for reporting health care home with patient complexity level and supplemental</p>	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments																								
			<p>factor modifiers. Use U modifiers in conjunction with medical home codes S0280 or S0281 as shown below: Patient Complexity Level and Supplemental Factors</p> <table border="1" data-bbox="884 418 1467 1045"> <thead> <tr> <th data-bbox="884 418 1052 607">Patient Complexity Level</th> <th data-bbox="1052 418 1205 607">Complexity Modifiers</th> <th data-bbox="1205 418 1339 607">Non English Speaking Modifier</th> <th data-bbox="1339 418 1467 607">Active Mental Health Condition</th> </tr> </thead> <tbody> <tr> <td data-bbox="884 607 1052 721">Low (no major conditions)</td> <td data-bbox="1052 607 1205 721">No modifier</td> <td data-bbox="1205 607 1339 721">U3</td> <td data-bbox="1339 607 1467 721">U4</td> </tr> <tr> <td data-bbox="884 721 1052 769">Basic</td> <td data-bbox="1052 721 1205 769">U1</td> <td data-bbox="1205 721 1339 769">U3</td> <td data-bbox="1339 721 1467 769">U4</td> </tr> <tr> <td data-bbox="884 769 1052 850">Intermediate</td> <td data-bbox="1052 769 1205 850">TF</td> <td data-bbox="1205 769 1339 850">U3</td> <td data-bbox="1339 769 1467 850">U4</td> </tr> <tr> <td data-bbox="884 850 1052 899">Extended</td> <td data-bbox="1052 850 1205 899">U2</td> <td data-bbox="1205 850 1339 899">U3</td> <td data-bbox="1339 850 1467 899">U4</td> </tr> <tr> <td data-bbox="884 899 1052 1045">Complex (most major conditions)</td> <td data-bbox="1052 899 1205 1045">TG</td> <td data-bbox="1205 899 1339 1045">U3</td> <td data-bbox="1339 899 1467 1045">U4</td> </tr> </tbody> </table> <p>Definitions of U modifiers with S0280 or S0281:</p> <ul style="list-style-type: none"> <li>○ U1 – Care coordination, basic complexity level</li> <li>○ U2 – Care coordination, extended complexity level</li> <li>○ U3 – Care coordination, supplemental factor; Non-English language</li> <li>○ U4 – Care coordination, supplemental factor; Major Active Mental Health Condition</li> </ul>	Patient Complexity Level	Complexity Modifiers	Non English Speaking Modifier	Active Mental Health Condition	Low (no major conditions)	No modifier	U3	U4	Basic	U1	U3	U4	Intermediate	TF	U3	U4	Extended	U2	U3	U4	Complex (most major conditions)	TG	U3	U4	
Patient Complexity Level	Complexity Modifiers	Non English Speaking Modifier	Active Mental Health Condition																									
Low (no major conditions)	No modifier	U3	U4																									
Basic	U1	U3	U4																									
Intermediate	TF	U3	U4																									
Extended	U2	U3	U4																									
Complex (most major conditions)	TG	U3	U4																									
14	12	ImPACT testing	96120 U2 – Post injury, neuro-cognitive testing (e.g., ImPACT), professional service only																									

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
	<a href="#">Physicians/Nonphysician Practitioners</a>			
15	12 <a href="#">Physicians/Nonphysician Practitioners</a>	In-reach Community Based Coordination	Use HCPCS T1016-U2 or T1016-U2 TS. <ul style="list-style-type: none"> <li>▪ T1016 Case management, each 15 minutes</li> <li>▪ U2 = In-reach, initial service</li> <li>▪ U2 TS = In-reach, follow-up</li> </ul>	DH – T codes for Medicaid – Direct reader to DHS site? CL = T codes are NOT restricted to Medicaid only. Commercial may use dependent on employer group request.
16	13 <a href="#">Radiology Services and Other Diagnostic Procedures</a>	Technical and professional component	If both technical and professional component are being billed by the same billing provider, same place of service, a global code should be used rather than TC/26 modifiers and separate components	
17	13 <a href="#">Radiology Services and Other Diagnostic Procedures</a>	Bilateral radiology	Bilateral radiology services are reported as either: <ul style="list-style-type: none"> <li>▪ one line with a 50 modifier and one unit, or</li> <li>▪ two separate lines, one with RT modifier and one with LT modifier.</li> </ul>	DH – several different entries for bilateral and modifier 50 – group together? CL = different type of services, radiology vs physician vs ASC, thus different chapters.
18	14 <a href="#">Ambulatory Surgical Centers</a>	Modifier 50	Modifier 50 should be used on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.	
19	14 <a href="#">Ambulatory Surgical Centers</a>	Bilateral radiology	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier	
20	14	Claim Type	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS.	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
	<a href="#">Ambulatory Surgical Centers</a>		Check with payer to determine the preferred billing method.	
21	15 <a href="#">Ambulance</a>	Non-emergent, scheduled transport	For non-emergent, scheduled transportation by non-ambulance providers: <ul style="list-style-type: none"> <li>▪ A0080</li> <li>▪ A0090</li> <li>▪ A0100</li> <li>▪ A0110</li> <li>▪ A0120</li> <li>▪ T2002</li> <li>▪ T2003</li> <li>▪ T2004</li> </ul>	
22	15 <a href="#">Ambulance</a>	Community Paramedic	Community paramedic services are to be billed as follows: <ul style="list-style-type: none"> <li>• Professional claims only – 837P</li> <li>• Place of services – 12 (home)</li> <li>• Individual provider number – report the Medical director’s NPI</li> <li>• Code T1016 U3, 15 minutes increments (one billing, services all inclusive) — a minimum of 8 minutes of face to face time must be rendered in order to report one unit (see also section A.3.4.2 for units rounding rules)                             <ul style="list-style-type: none"> <li>○ T1016 Case management, each 15 minutes</li> <li>○ U3 – service provided by certified community paramedic (EMT-CP)</li> </ul> </li> <li>• Non-reportable services include:</li> </ul>	DH – T codes for Medicaid – refer reader to DHS site CL = T codes are NOT restricted to Medicaid only. Commercial may use dependent on employer group request.

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<ul style="list-style-type: none"> <li>○ Supplies (e.g., gloves, test strips, band aids, etc.);</li> <li>○ Vaccines;</li> <li>○ Travel;</li> <li>○ Mileage;</li> <li>○ Medical record documentation.</li> </ul>	
23	<p style="text-align: center;"><b>16</b> <a href="#">Laboratory Services</a></p>	Lab panels	Lab panels should be reported as 1 line item with 1 unit per panel. CPT defines panel components.	
24	<p style="text-align: center;"><b>16</b> <a href="#">Laboratory Services</a></p>	Newborn Screening	<p>When the specimen is taken for the Newborn Screening Card purchased from Minnesota Department of Health after the birth discharge, the newborn screen is reported using S3620. This covers the cost incurred for the screening card.</p> <p>For repeat screens, report S3620 with the appropriate modifier (76, 77) for repeat services. Diagnostic testing should be reported with the appropriate HCPCS code for the test being performed.</p>	
25	<p style="text-align: center;"><b>18</b> <a href="#">Preventive and Screening Services</a></p>	Preventive services and coding as defined by Medicare	Preventive services and coding as defined by Medicare (i.e. “Welcome to Medicare”) are only applicable to Medicare and Medicare replacement products.	<p>DH – this is Medicare only – our guides do not apply to Medicare (delete?)</p> <p>CL - ?? initially as providers were also reporting to commercial when no Medicare component applied. Sort of recall this being a clinic’s inquiry.</p>

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
26	18 <u>Preventive and Screening Services</u>	New patient receives preventive care and an illness-related E/M service at the same visit	In instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately-identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem oriented E/M code.	
27	18 <u>Preventive and Screening Services</u>	Diagnosis coding for screening services	Diagnosis coding for screening services must follow the ICD-CM code set instructions based on date of service. All applicable diagnoses should be submitted.	
28	18 <u>Preventive and Screening Services</u>	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers	
29	18 <u>Preventive and Screening Services</u>	Vaccine administration	Either G codes or CPT codes may be reported as needed for vaccine administration. If using G codes for covered Medicare vaccines, use CPT for subsequent administration of additional immunizations	
30	18 <u>Preventive and Screening Services</u>	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program	When vaccines are acquired through the Minnesota Vaccines For Children (MnVFC) program, Group purchasers require the SL modifier be appended to the vaccine code	
31	18 <u>Preventive and Screening Services</u>	Vaccine administration with counseling for patients through 18 years of age	<p>Vaccine administration with counseling for patients through 18 years of age:</p> <ul style="list-style-type: none"> <li>▪ Vaccine administration with counseling should be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components.</li> </ul> <p>Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib</p>	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			would be reported with 1 unit of initial vaccine/toxoid component administration with counseling and 4 units of additional vaccine/toxoid component administration with counseling.	
32	19 <a href="#">Indian Health Services</a>	Claim type	Report on the claim type with procedure codes appropriate to the services provided, e.g., physician/clinic services on the 837P, dental services on the 837D, pharmacy on NCPDP.	
33	20 <a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	Oxygen codes	Oxygen codes are used as defined. When appropriate to report contents, MN providers may report E or S oxygen content codes as definition allows.	
34	20 <a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR	
35	20 <a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit	
36	20 <a href="#">Durable Medical Equipment, Prosthetics, Orthotics and Supplies</a>	Upgrades	Upgrades – if a patient prefers an item with features or upgrades that are not medically necessary and has elected responsibility, the items are billed as two lines using the same code on both lines, if no upgrade code is available. Use the GA modifier for the upgraded and GK for the standard item.	
37	N/A	Doula Services <a href="#">MS 256B.0625, Subd. 28B Doula Services</a>	Coverage of Doula services applies to both DHS fee-for-service and managed care. Doula services are limited to seven sessions. Prior authorization with medical necessity	DH – Refers to services under DHS statute. Refer reader to information on DHS website?

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<p>documentation is required for any additional sessions beyond the seven. Doula services must be provided under a supervising practitioner (must be a physician, nurse practitioner, or certified nurse midwife) and billed on behalf of the doulas under the supervising practitioner’s NPI.</p> <p>Coding and billing for these services on the 837P are as follows:</p> <ul style="list-style-type: none"> <li>▪ S9445 U4 – ante-partum and post –partum Doula services</li> <li>▪ 99199 U4 – Doula attendance at labor and delivery</li> </ul>	<p>CL = providers are also billing these codes to commercial, whether a covered benefit or not. They’re being compliant with “bill all payers the same”.</p>
38	N/A	Home Infusion	<p>Medicare has limited coverage for home infusion services. Home Infusion services must be reported on the 837P transaction using applicable home infusion HCPCS codes (per diem S codes, CPT home infusion nurse visit codes, and drug codes). Providers must perform/provide all services as defined in order to report the S code(s). Related NDC codes for compounded products are itemized using the LIN and CTP segments.</p>	
39	N/A	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	<p>Minnesota group purchasers require that professional services by licensed traditional midwives be reported on an 837P transaction. Services rendered must be within the practitioner’s scope of practice and are reported using the appropriate valid HCPCS code. The following place of service must be reported.</p> <p><u>Place of Service:</u></p> <p>25 – Free-standing Birthing Center</p> <p><u>HCPCS Code:</u></p>	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<p>Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered.</p> <p>Global services (antepartum, delivery and postpartum) should not be fragmented. This includes but is not limited to, free-standing birthing center or home visits for pre- or post- natal care, stand by services, and post-delivery home visits.</p> <p>Fragmented services may be reported in certain circumstances:</p> <ul style="list-style-type: none"> <li>• If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes).</li> <li>• If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code.</li> <li>• Global services may be split when the patient’s prenatal/antepartum services are less than four visits (use E/M service).</li> <li>• Routine lab test and ultrasounds may be reported in addition to the global package during the prenatal period. Urine dip sticks are considered part of the global package.</li> </ul> <p>Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.</p>	
40	N/A	Child and Teen Checkups (C&TC)	S0302 is reported in addition to all of the age appropriate components of a Child and Teen Checkups (C&TC) exam to indicate a complete C&TC exam has been performed. Refer to DHS for the <a href="#">C&amp;TC Provider Guide webpage</a>	

[Ref. No.]	[Medicare claims processing chapt. no.]	Topic	Instructions	Notes/comments
			<p>(<a href="https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4212-ENG">https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4212-ENG</a>) for a complete list of reportable component codes.</p> <ul style="list-style-type: none"> <li>▪ 96110 – Developmental screening</li> <li>▪ 96110 U1 – Autism Screening</li> <li>▪ 96127 – Social/Emotional or Mental Health Screening</li> <li>▪ Visit can still be reported as a complete C&amp;TC if documentation shows that a component could not be completed due to:                             <ul style="list-style-type: none"> <li>○ Contraindication (medical reasons, service recently performed elsewhere): Service may still be reported with \$0.00 or \$0.01 charge</li> <li>○ Parent Refusal: Service may still be reported with \$0.00 or \$0.01 charge</li> <li>○ Unsuccessful Attempt (child uncooperative): Service may be reported with modifier –52 with usual charge if documentation shows that a valid attempt was made to complete the service and rescheduling for a later date was not feasible.</li> </ul> </li> <li>▪ Report all C&amp;TC services together on the same claim even if components were performed on different dates of service. Each line of the claim should indicate the appropriate date the service was performed.</li> <li>▪ Use most appropriate diagnosis code based on patient age.</li> </ul>	
41	N/A	Family Caregiver Services	Family Caregiver Services provide training, education, coaching and counseling services for family and informal caregivers who provide direct and ongoing services for	

[Ref. No.]	[Medicare claims processing chapt. no.]	<b>Topic</b>	<b>Instructions</b>	Notes/comments
			recipients in the Elderly Waiver (EW) and Alternative Care (AC) Programs. <ul style="list-style-type: none"> <li>• S5115 – Home care training, nonfamily; per 15 minutes, Family Caregiver Training and Education</li> <li>• S5115 TF – Home care training, nonfamily; per 15 minutes, Family Counseling and Assessment</li> <li>• S5115 TG – Home care training, nonfamily; per 15 minutes; Complex/high level of care, Family Memory Care</li> </ul>	

### 1.5 Substance Abuse Services

Table 1.5.1 is to be used for reporting substance abuse services by delivery setting category. The table has been divided into three parts based on the delivery setting, as follows:

- a) [Hospitals](#);
- b) [All other residential](#); and
- c) [Outpatient Services](#) (further divided into Institutional vs. Professional claim type).

The tables incorporate both institutional and professional claim types for ease of reference.

**Please note:** The table below references standard health care claims transactions as follows:

- ASC X12/005010X222A1 Health Care Claim: Professional (837), referred to as “Professional” or “837P”.
- ASC X12/005010X223A2 Health Care Claim: Institutional (837), referred to as “Institutional” or “837I”.

Table 1.5.1.a -- Substance Abuse Services: <u>Hospital</u> (Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)						
Service Description	Option 1 or 2 *	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
Room and Board	1	Day	0118, 0128, 0138, 0148, 0158	N/A	837I	011x- hospital inpatient
Detox	1	Day	0116, 0126, 0136, 0146, 0156	N/A	837I	011x- hospital inpatient
Treatment component	1	Day	Choose one per date of service: 0944 or 0945 or 0949	N/A	837I	011x- hospital inpatient
Ancillary	1	Based on Revenue Code	As appropriate	N/A	837I	011x- hospital inpatient

Table 1.5.1.a -- Substance Abuse Services: Hospital  
 (Facility licensed as a hospital under Minnesota statutes, section 144.50 to 144.56)

Service Description	Option 1 or 2 *	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
All-inclusive Room and Board	2	Day	0101	N/A	837I	011x- hospital inpatient
Detox	2	Day	0116, 0126, 0136, 0146, 0156	N/A	837I	011x- hospital inpatient
Ancillary Services	2	Based on Revenue Code	as appropriate	N/A	837I	011x- hospital inpatient

**\*Note:** "Option 1" treatment is reported separately from room and board. "Option 2" is all-inclusive: includes room and board and treatment.

<b>1.5.1.b – Substance Abuse Services: <u>All Other Residential</u></b>					
<b>Service Description</b>	<b>Unit</b>	<b>Revenue Code</b>	<b>HCPCS Procedure Code</b>	<b>Claim Type</b>	<b>Type of Bill</b>
<b>Room and Board</b>	Day	<u>1002</u> : (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children’s Residential Facility with CD certification, Tribal CD licensed facility) <u>1003</u> : (facilities licensed to provide room and board services only, e.g., board and lodge, supervised living facility, foster care)	None	837I	086x – special facility, residential
<b>Detox</b>	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
<b>Treatment program, treatment component</b>	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
<b>Treatment program, treatment component</b>	Hour	0953	None	837I	086x – special facility, residential

<b>1.5.1.b – Substance Abuse Services: <u>All Other Residential</u></b>					
<b>Service Description</b>	<b>Unit</b>	<b>Revenue Code</b>	<b>HCPCS Procedure Code</b>	<b>Claim Type</b>	<b>Type of Bill</b>
<b>Ancillary services</b>	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

<b>Table 1.5.1.c.i – Substance Abuse Services: <u>Outpatient Services – Claim Type 837I</u></b> (Applicable to all providers and settings per applicable contract or established program standards)				
<b>Claim Type – 837I</b>				
<b>Service Description</b>	<b>Unit</b>	<b>Revenue Code</b>	<b>HCPCS Procedure Code</b>	<b>Type of Bill</b>
<b>Alcohol and/or drug assessment</b>	Session/visit	0900	H0001	As appropriate
<b>Outpatient program; Treatment only</b>	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 ( <i>individual</i> )	089x or 013x
<b>Medication Assisted Therapy (MAT)</b>	Day	0944	H0020	089x or 013x
<b>MAT – all other drugs</b> <b>Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.</b>	Day	0944	H0047 U9	089x or 013x
<b>Outpatient Ancillary Services</b>	Based on revenue code	As appropriate		089x or 013x

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

**Table 1.5.1.c.ii – Substance Abuse Services: Outpatient Services – Claim Type 837P**

(Applicable to all providers and settings per applicable contract or established program standards)

**Claim Type – 837P**

<b>Service Descriptions</b>	<b>Unit</b>	<b>Revenue Code</b>	<b>HCPCS Procedure Code</b>	<b>Type of Bill</b>
<b>Alcohol and/or drug assessment</b>	Session/visit	N/A	H0001	
<b>Outpatient program; Treatment only</b>	Hour	N/A	H2035 HQ (group) H2035 ( <i>individual</i> )	N/A
<b>Medication Assisted Therapy (MAT)</b>	Day	N/A	H0020	N/A
<b>MAT – all other drugs</b>	Day	N/A	H0047 U9	N/A
<b>MAT Plus</b>	Day	N/A	H0020 UA	N/A
<b>MAT Plus – all other drugs</b>	Day	N/A	H0047 UB	N/A

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

MAT Plus – a licensed program providing at least 9 hours of treatment service per week

U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.

UA – MAT Plus, methadone

UB – MAT Plus, all other drugs

## 1.6 Maternal and Child Health Billing Guide For Public Health Agencies

Table 1.6.1 is to be used for reporting Maternal and Child Health services for public health agencies. The table has been divided into three parts as follows:

- a) [Public health nurse clinic services](#)
- b) [Maternal & child health visits](#)
- c) [Other services and miscellaneous](#)

Maternal And Child Health Billing Guide For Public Health Agencies		
<b>Table 1.6.1.a -- <u>Public health nurse clinic services</u></b>		
	<b>Place of Service</b>	
	<b>Home or Place of Residence (Use appropriate POS)</b>	<b>Public Health Clinic (POS 71)</b>
Services Include: <ul style="list-style-type: none"> <li>• Health Promotion &amp; Counseling</li> <li>• Nursing Assessment &amp; Diagnostic Testing</li> <li>• Medication Management</li> <li>• Nursing Treatment</li> <li>• Nursing Care, in the home, by RN (PHN &amp; CPHN)</li> </ul>	S9123  For Evidence-Based Public Health Home Nurse Visits pursuant to Minnesota Statutes, section 256B.7635, use S9123 with the U8 modifier (S9123 U8)	T1015
Home health aide or CNA, per visit	T1021	T1021
Patient Education only - if no other services (includes car seat education)	Individual S9445 Group S9446	Individual S9445 Group S9446

Maternal And Child Health Billing Guide For Public Health Agencies		
<b>Table 1.6.1.b -- Maternal &amp; child health visits</b>		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
Birthing Classes	N/A	S9442
Home Visit for Postnatal assessment & follow up care - <b>Mother</b>	99501	N/A
Home Visit for Post-natal assessment & follow up care - <b>Newborn</b>	99502	N/A
Enhanced Services - for at-risk pregnancies as determined by the physician/nurse practitioner		
At-Risk Antepartum Management	H1001	H1001
At-Risk Care Coordination	H1002	H1002
At-Risk Prenatal Health Education	H1003	H1003
At-Risk Prenatal Health Education I	H1003	H1003
At-Risk Prenatal Health Education II	H1003	H1003
At-Risk Enhanced Service; Follow-up Home Visit	H1004	N/A
At-Risk Enhanced Service Package	H1005	H1005

Maternal And Child Health Billing Guide For Public Health Agencies		
Table 1.6.1.c -- <u>Other services</u>		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
Prenatal Nutrition Education, Medical Nutrition Therapy; initial <b>assessment</b> and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial <b>re-assessment</b> and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

Maternal And Child Health Billing Guide For Public Health Agencies		
Table 1.6.1.c -- <u>Miscellaneous</u>		
	Place of Service	
	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
Maternal Depression Screenings	96161	96161
Child Developmental Screenings	96110	96110
Autism Screening	96110 U1	96110 U1

Child Social/Emotional or Mental Health Screenings	96127	96127
TB Case Management	T1016	T1016
TB Direct Observation Therapy	H0033	H0033

**Additional information/comments regarding  
the straw man example that were received from AUC small group**

1. The Minnesota Department of Human Services (DHS) created a special “landing page” on its website for coding information regarding DHS-specific behavioral health services that were previously published in Appendix A of the 837P and 837I MN Uniform Companion Guides. In recent small group discussion, a question was asked regarding how many “hits” DHS was receiving on its “AUC Landing Page” described above. DHS researched the issue and the answer was: 360 hits in one year.
2. Please note the following comment submitted by one of the small group members in response to the straw man example above:

“We feel the straw man supports the claims processing aspect about 80% and the coding and documentation of about 20%. Medical groups therefore are not unified in their coding and documentation practices and the community is at risk for losing significant health care dollars.

With the removal of the Medicare Claims Processing reference on the straw man, may we ask to have a “contracting and administrative documentation coding TAG” to address our questions that remain unanswered? Our request of a different TAG will help us submit accurate and unified codes for the medical services that we provide and document.”