MINNESOTA
HEALTH CARE HOMES

Billing Minnesota Health Care Programs for HCH Care Coordination

Minnesota statutes 256B.0753 and 62U.03 directed the development of a system of per-person, risk-stratified care coordination payments to certified Health Care Homes (HCH). This payment methodology applies to the Minnesota Health Care Programs (MHCP) and other payers (including the state employee group insurance program and state-regulated private health plans).

For enrollees served under the MHCP fee-for-service system, refer to the Minnesota Department of Human Services (DHS) Provider Manual webpage for information on HCH reimbursement for the delivery of care coordination services by MHCP enrolled providers.

Other payers are required to develop payment terms and conditions "in a manner that is consistent with" this system. For recipients enrolled in a managed care organization (MCO), contact the MCO directly to understand the terms of payment and other contract details.

HCH certification and eligible HCH certified providers

MHCP enrolled providers that become HCH certified are eligible to receive reimbursement for the delivery of care coordination services to MHCP recipients who have complex and chronic medical conditions.

Be sure to continuously update MDH HCH when providers are added to prevent claims from being denied. MDH HCH will notify the Department of Human Services (DHS) when clinicians are updated. Clinics are responsible for notifying other payers.

A complexity tier level is needed for MHCP claims

Payments vary by thresholds of patient complexity. Clinical staff should complete the Care Coordination Tier Assignment Tool identifying patient conditions that are chronic, severe, and require a care team. Supplemental factors (language barrier or serious and persistent mental illness) are assigned a modifier. The clinical staff need to communicate the tier level and modifiers for each care coordinated patient to the billing staff.

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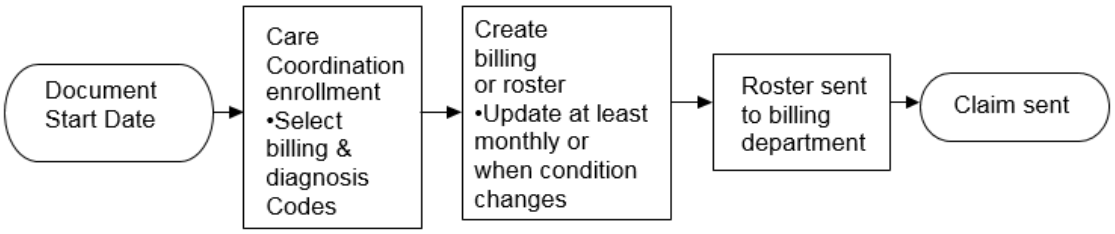
Coding for MHCP claims submission

Using these codes and modifiers, the HCH submits a claim for one unit per month per patient. The claim can be submitted to the payer at any time during the month for the full month's payment, and monthly payments will not be prorated by the number of days in the month. Care coordination services can be billed on a claim with other services. Billing is done based on the statewide claim transaction standards as defined by MN Statutes, 62J.536.

HCPCS Codes				
S0280	medical home program, comprehensive care coordination and planning, initial plan			
S0281	medical home program, comprehensive care coordination and planning, maintenance			
Modifiers				
Tier	Patient Complexity Level		Primary Language Non-English	Severe and Persistent Mental Illness
0	Low	**(no modifier)**	**U3**	**U4**
1	Basic	**U1**	**U3**	**U4**
2	Intermediate	**TF**	**U3**	**U4**
3	Extended	**U2**	**U3**	**U4**
4	Complex	**TG**	**U3**	**U4**

Billing Process



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Submitting a claim to MHCP

To claim care coordination payment from MHCP for covered recipients:

1. Document all care coordination services provided and justification for complexity tier assignment in the recipient's medical record (Clinical staff complete the Tier Assignment Tool).

2. Use the 837P electronic claim transaction to submit all claims.

3. A single date of service represents the entire month. Bill on one claim transaction, enter 1 unit of Initial Care Coordination planning code S0280 for the first month. Enter Maintenance Care Coordination Planning code S0281 for each additional month. Bill the procedure code once a month. If a patient is classified as being care coordinated, bill monthly until the patient is discharged from care coordination services. Care coordination is billed on a per member per month basis regardless if the patient has been seen or contacted each month.

Remittance process

To ensure accurate payment and to avoid claim denials, the HCH may develop and maintain a process for tracking ongoing care coordination as follows:

- The HCH should develop an internal process for communication between the clinical staff and the finance staff to stop the monthly claim process when the patient is no longer receiving care coordination services.
- The HCH should develop a remittance process for Claim Adjustment Reason Code (CARC) or Remittance Advice Remark Code (RARC).
- Prior to submitting a claim, verify that the provider is listed in MN-ITS as a health care home provider. MN-ITS is a function of DHS.
- When a claim is denied because another HCH is already providing care coordination services to a patient, the following remark codes should be used per Administrative Uniformity Committee (AUC) recommendations: B20 (CARC) or N472 (RARC).
- The HCH should establish a communication process whereby, in the case of a care coordination claim denial, billing staff notify clinical staff (such as the care coordinator) of the denial and a HCH team member discusses the issue with the patient.

General information on HCH

Please see the MDH HCH website.

Questions?

Provider Enrollment at DHS is responsible for MHCP billing questions related to Health Care Homes.
DHS Provider Enrollment contact information:

Phone: 651-431-2700 or 1-800-366-5411
Fax: 651-431-7462
Email: dhs.healthcare-providers@state.mn.us