Minnesota Department of Health (MDH) Rule

Minnesota Uniform Companion Guide (MUCG) Version 16.0 for the Implementation of the X12/005010X222A1 Health Care Claim: Professional (837)

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Minnesota Uniform Companion Guide (MUCG) Version 16.0 for the Implementation of the X12/005010X222A1 Health Care Claim: Professional (837)

1 Introduction and Overview

This is version 16.0 of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the X12/005010X222A1 Health Care Claim: Professional (837). It was adopted into rule pursuant to Minnesota Statutes, section 62J.61 (https://www.revisor.mn.gov/statutes/cite/62J.61) and supersedes all previous versions. It remains in force unless suspended, revoked, or superseded by a subsequent version.

1.1 How to obtain a copy of this document

This document is available at no charge on the Minnesota Department of Health Minnesota Uniform Companion Guides webpage (https://www.health.state.mn.us/facilities/ehealth/auc/guides/index.html).

1.2 Applicable statutes and requirements

Minnesota Statutes, section 62J.536 (https://www.revisor.mn.gov/statutes/cite/62J.536) requires health care providers (https://www.revisor.mn.gov/statutes/cite/62J.03), group purchasers (payers) (https://www.revisor.mn.gov/statutes/cite/62J.03), and health care clearinghouses (https://www.revisor.mn.gov/statutes/cite/62J.51) to exchange certain health care business (administrative) transactions electronically. These exchanges must comply with the specifications of a single uniform “companion guide” adopted into rule by the Commissioner of Health in consultation with a large, voluntary external stakeholder advisory organization, the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html). The state’s companion guide rules are adopted pursuant to the process described in Minnesota Statutes, section 62J.61 (https://www.revisor.mn.gov/statutes/cite/62J.61). Other state statutes also reference MS §62J.536.

Note: Compliance with a companion guide rule adopted pursuant to MS §62J.536 does not mean that a health care claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

Additional information regarding Minnesota’s requirements for the standard, electronic exchange of health care administrative transactions, including relevant rules, examples of entities that are subject to MS §62J.536, Frequently Asked Questions (FAQs) and other information, is available on the MDH Administrative Simplification Act webpage (https://www.health.state.mn.us/facilities/ehealth/asa/index.html).

1.3 Further description and use of this document

This document:

- Describes the proposed data content and other transaction specific information to be used with the X12/005010X222A1 Health Care Claim: Professional (837), hereinafter referred to as 005010X222A1, by entities subject to Minnesota Statutes, section 62J.536.
- Supplements, but does not otherwise modify the 005010X222A1 in a manner that will make its implementation by users to be out of compliance.
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related X12N and retail pharmacy specifications (X12 and NCPDP implementation specifications).
- Was prepared by the Minnesota Department of Health (MDH) (https://www.health.state.mn.us) with the assistance of the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html).

1.4 Reference for this document

The X12 reference [(the X12 “Implementation Guide- Type 3 (TR3)” technical report] for this document is the X12/005010X222A1 Health Care Claim: Professional (837) (Copyright © 2008, Data Interchange Standards Association on behalf of X12. Format © 2008, X12. All Rights Reserved), hereinafter described below as 005010X221A1. Learn more about licensing X12’s work at https://x12.org/licensing.

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1.5 Best practices for the implementation of electronic health care transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. While use of the best practices is not required per statute, their use is strongly encouraged to aid in meeting the state’s health care administrative data exchange requirements, and to provide the greatest benefits of health care administrative simplification. Please visit the AUC best practices webpage (https://www.health.state.mn.us/facilities/ehealth/auc/bestpractices/index.html) for more information about best practices for implementing electronic health care administrative transactions in Minnesota.

1.6 Contact for further information

Minnesota Department of Health

Division of Health Policy

Center for Health Information Policy and Transformation

P.O. Box 64882

St. Paul, Minnesota 55164-0882

Phone: (651) 201-3570

Fax: (651) 201-3830

Email: health.ASAguides@state.mn.us

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2 Transaction specific instructions and information to be used with the 005010X222A1

The remainder of this document, including Appendices A-D, provides transaction-specific information to be used in conjunction with the 005010X222A1.

2.1 Business terminology and related instructions

For purposes of this document, the following terms have the meaning given to them in this section.

2.1.1 Factoring Agent

Business models exist in the healthcare industry where services are performed by a provider, which are billed to an entity acting as a receivables Factoring Agent. The entity pays the provider directly. The Factoring Agent then bills the insurance company. In this case both the name/address of Pay-To are different than Billing Provider. In order to use the 005010X222A1 for this business situation, the Standards Development Organization X12 recommends that the Factoring Agent entity name, address, and identification be submitted as the Pay-To Plan in loop 2010AC. The notes and guidelines should be followed as if the Pay-To Plan entity was performing post payment recovery as described.

2.2 Provider Identifiers and National Provider Identifier (NPI) Assignments

If the provider is a health care provider as defined under federal standards, then the only identifier that is valid is the NPI with the exception of the billing loop. For the billing provider, a secondary identifier -- the Taxpayer Identification Number (TIN) -- is also required.

If the provider is not a health care provider as defined under federal standards the provider is known as an “atypical provider.” Atypical providers do meet the Minnesota statutory definition of health care provider and therefore are subject to the requirements of Minnesota statutes, section 62J.536 and related rules. For atypical providers, the primary identifier is the TIN and a secondary identifier is allowable. The qualifier for the secondary identifier is “G2.” The identifier associated with this qualifier is the specific payer assigned/required identifier.

2.3 Adjustments and Appeals

2.3.1 Definitions

- **Adjustment**

  Adjustment – Provider has additional data that should have been submitted on the original claim or has a need to correct data that was sent incorrectly on the original claim.

- **Appeal**

  Appeal – Provider is requesting a reconsideration of a previously adjudicated claim for which there is no additional data or corrected data to be submitted. Providers should contact the payer or the payer's website for further instructions regarding reconsiderations or appeals.

Examples of appeals include:

- Timely filing denial;
- Payer allowance;
- Incorrect benefit applied;
- Eligibility issues;
- Benefit Accumulation Errors; and
- Medical Policy/Medical Necessity.

2.3.2 Process for submission of adjustments and appeals

2.3.2.1 Adjustment

Adjustment – Provider should submit an adjustment electronically using the appropriate value in CLM05-3 to indicate that this is a replacement claim. If the payer has assigned a payer number to the claim, it must be submitted in loop 2300, REF02, using qualifier F8 in REF01 (Note: the original payer-assigned claim number is not the property and casualty number). If additional information is required to support the adjustment based on payer business rules, the SV101-7, NTE segment, PWK segment, or Condition Codes should be used. See section 2.5 below regarding these segments for appropriate instructions.

2.3.2.2 Appeal

Appeal – Follow payer standard processes for requesting an appeal to a previously adjudicated claim. If a paper appeal process is utilized, then a standard, Best Practice Minnesota appeal form is available at the AUC Forms webpage (https://www.health.state.mn.us/facilities/ehealth/auc/forms/index.html#31). Additional documentation should be sent as required by the payer to support the appeal consideration; this documentation does not include resubmission of the claim.

2.4 Claim Frequency Type Code (CFTC) Values

Claim/Bill submissions are often original, first time submissions with no follow-up submissions. In some cases, subsequent submissions directly related to a prior submission will be necessary. When subsequent submissions occur for legitimate business purposes, the normal processing flow may change.

Since a relationship between an original submission and subsequent submissions are necessary, the data requirements both for original and subsequent submissions must be specified.

For example, when a Replacement bill is submitted (CFTC 7), in order to meet the processing requirement to void the original and replace it with the re-submitted bill, common consistent data elements are required. To qualify as a Replacement, some data need to be different than the original.

If the bill is re-submitted with no changes from the original, and the claim was accepted by the payer, it would be considered a Duplicate instead of a Replacement.

If the bill is resubmitted with no changes from the original and the original was not accepted by the payer, the resubmitted bill will be considered an original claim. These distinctions are important to allow for proper handling of the submission.

Refer to the current National Uniform Billing Committee (NUBC) code list for allowed values and usage descriptions. Both the sender and receiver must understand how each code value should be interpreted and what processing requirements need to be applied.

In conjunction with the CFTC code values, Condition Codes may be submitted that will impact processing and handling requirements.

2.5 Claim Attachments and Notes

2.5.1 NTE segment

- Use the NTE segment at the claim or line level to provide free-form text with additional information.
  - The NTE segment must not be used to report data elements that are codified or may be codified within this transaction.
  - If reporting a simple description of the service is required, such as when a non-specific code is being reported, the SV101-7 in the 2400 loop must be used.
- Do not exceed the usage available in the 005010X222A1.
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.

2.5.2 PWK segment

If the number of characters for the NTE or SV101-7 will exceed available characters, or a hard copy document is sent, use only the PWK segment at the claim level.

When populating the PWK segment, the following guidelines must be followed:

- PWK01 - The qualifier value of 'OZ' should only be used if none of the other values apply. The most specific qualifier value must be utilized.
- PWK06 - Billing providers must use a unique number for this field for each individual attachment on the claim, as well as a unique number across all claims requiring attachments. This unique number identifies a specific attachment within the billing provider's system. This unique number is the key that associates the attachment to the claim. The number must be sent in PWK06 of the claim and with the attachment. The provider must not use the same number on any other claim in their system to identify different attachments.

2.5.3 Claim attachments for workers' compensation medical claims

NOTE: Regarding claim attachments for workers' compensation medical claims only -- Minnesota Statutes, section 176.135, Subd. 7a (https://www.revisor.mn.gov/statutes/cite/176.135) requires that:

"health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the ASC X12N 5010 version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter")," …; and

"workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the ASC X12N 5010 version of the ASC X12 electronic acknowledgment for the attachment transaction."

3 ASC X12N/005010X222A1 Health Care Claim: Professional (837) -- Transaction Specific Information

The table below summarizes transaction-specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 1.3. It includes a row for each segment for which there is additional information over and above the information in the 005010X222A1 and shows the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

Note: The designation "N/A" in Table 3.2 below means that the "Value Definition and Notes" applies to the segment rather than a particular data element. Please also see section 1.3 above.

Table 3.1 TRANSACTION-SPECIFIC INFORMATION TO BE USED IN CONJUNCTION WITH THE 005010X222A1

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2000B	Subscriber Hierarchical Level	SBR Subscriber Information	SBR01 Payer Responsibility Sequence Number Code	Do not send claims to secondary, tertiary, or any subsequent payer until previous payer(s) has(have) processed.
2010BA	Subscriber Name	NM1 Subscriber Name	NM103 Name Last or Organization Name	For Workers' Compensation this is the employer name. For Property & Casualty this may be a non-person.
2010BA	Subscriber Name	DMG Subscriber Demographic Information	DMG02 Subscriber Birth Date	Services to unborn children should be billed under the mother as the patient.
2010BB	Payer Name	REF Billing Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2010CA	Patient Name	DMG Patient Demographic Information	DMG02 Patient Birth Date	Services to unborn children should be billed under the mother as the patient.
2300	Claim Information	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 2.4 of this document for definitions.
2300	Claim Information	CLM Claim Information	CLM20 Delay Reason Code	If code 11 (Other) is used, additional documentation is required using NTE or PWK. Refer to section 2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300	Claim Information	PWK Claim Supplemental Information	N/A	See front matter section 2.5 of this document for definition.
2300	Claim Information	PWK Claim Supplemental Information	PWK02 Report Transmission Code	Use of AA value may result in a delay in claim payment. If an attachment is known to be needed by the payer it should be sent.
2300	Claim Information	AMT Patient Amount Paid	AMT02 Monetary Amount	Must not exceed total claim charge amount in CLM02.
2300	Claim Information	REF Payer Claim Control Number	N/A	If the original payer assigned claim number is obtained from the 835, it corresponds to CLP07.
2300	Claim Information	K3 File Information	N/A	See Appendix B of this document for usage instructions.

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2300	Claim Information	NTE Claim Note	N/A	See front matter section 2.5 of this document for definition.
2300	Claim Information	CRC EPSDT Referral	N/A	Required for Medicaid Programs when service is rendered under the Minnesota Child and Teen Checkup Programs.
2310A	Referring Provider Name	REF Referring Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage.
2310A	Referring Provider Name	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310B	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage.
2310B	Rendering Provider Name	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2310C	Service Facility Location Name	REF Service Facility Location Secondary Identification	N/A	See front matter section 2.2 of this document for usage.

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2310C	Service Facility Location Name	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2320	Other Subscriber Information	SBR Other Subscriber Information	N/A	Do not send claim to secondary or any subsequent payer until previous payer has processed.
2330B	Other payer name	NM1 Other payer name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2330B loop must be unique within the claim.
2400	Service Line Number	SV1 Professional Service	SV101-7 Description	See front matter section 2.5 of this document for additional instructions.
2400	Service Line Number	SV1 Professional Service	SV103 Unit or Basis for Measurement Code	See Appendix A for coding units.
2400	Service Line Number	SV1 Professional Service	SV104 Quantity	Minnesota specific note: Zero “0” is not a valid value.
2400	Service Line Number	SV1 Professional Service	SV107-1 Diagnosis Code Pointer	Primary diagnosis code cannot point to an External Cause of Injury code.
2400	Service Line Number	DTP Date - Service Date	DTP03 Date Time Period	Must be greater than or equal to patient's date of birth. If DTP02 is RD8, then the 'to' date must be equal to or greater than the 'from' date.
2400	Service Line Number	AMT Sales Tax Amount	N/A	See Appendix C of this document for details on reporting MNCare Tax.

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2400	Service Line Number	K3 File Information	N/A	See Appendix B of this document for usage instructions.
2400	Service Line Number	NTE Line Note	N/A	See front matter section 2.5 of this document for definition and usage
2420A	Rendering Provider Name	REF Rendering Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage.
2420A	Rendering Provider Name	REF Rendering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420B	Purchased Service Provider Name	REF Purchased Service Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420C	Service Facility Location Name	REF Service Facility Location Secondary Identification	N/A	See front matter section 2.2 of this document for usage.
2420C	Service Facility Location Name	REF Service Facility Location Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.

Loop	Loop Name	Segment	Data Element (if applicable)	Value Definition and Notes
2420E	Ordering Provider Name	N3 Ordering Provider Address	N/A	This segment is recommended for use when the following N4 segment is used.
2420E	Ordering Provider Name	REF Ordering Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage.
2420E	Ordering Provider Name	REF Ordering Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.
2420F	Referring Provider Name	REF Referring Provider Secondary Identification	N/A	See front matter section 2.2 of this document for usage.
2420F	Referring Provider Name	REF Referring Provider Secondary Identification	REF01 Reference Identification Qualifier	Use G2 for atypical providers.

List of Appendices

- **Appendix A: Medical Code Set -- Supplemental Information for Minnesota Uniform Companion Guides**

  Appendix A lists instructions and related information for the selection and use of medical codes from HIPAA code sets. It includes a series of tables with specific coding requirements that have been organized according to several topic areas or themes.

- **Appendix B: K3 Segment Usage Instructions**

  Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction and tooth number/oral cavity.

- **Appendix C: Reporting MNCare Tax**

  Appendix C provides brief instructions for reporting the MinnesotaCare (MNCare) Tax

- **Appendix D: Required Reporting of National Drug Codes (NDC)**

  Appendix D provides instructions and examples for reporting National Drug Codes (NDC)

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Appendix A: Code Set Supplemental Information for Minnesota Uniform Companion Guides

A.1 Purpose and Scope

This Appendix provides coding information and instructions that must be followed to meet requirements for efficient, effective exchanges of the 837P transaction pursuant to Minnesota Statutes, Section 62J.536 (https://www.revisor.mn.gov/statutes/cite/62J.536) and this Minnesota Uniform Companion Guide (MUCG).

The appendix was developed in consultation with the Minnesota Administrative Uniformity Committee (AUC) (https://www.health.state.mn.us/facilities/ehealth/auc/index.html) and its Medical Code Technical Advisory Group (TAG) (https://www.health.state.mn.us/facilities/ehealth/auc/tags/mct/index.html) to address needs, priorities, and improvement opportunities identified by the AUC and the broader health care community.

A.1.1 Limits to scope

This appendix does not address or govern:

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

A.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[1] (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.

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

[1] 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.)

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

A.3 General coding instructions and information

A.3.1 Selection of codes

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

A.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 American Medical Association (AMA) guidelines in Current Procedural Terminology (CPT).[2]
  - For example, "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 physical, occupational, and speech language pathology services (PT/OT/SLP) follow HCPCS/CPT guidelines for determining rounding time.

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[2] Current Procedural Terminology (CPT®), copyright 2020 American Medical Association

- Anesthesia codes 00100-01999: 1 unit = 1 minute.
- 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.

A.4 Specific coding instructions

This section includes tables with 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 tables list 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. The tables include coding instructions for services grouped according to the following general categories:

- A.4.1., Claim type;
- A.4.2., Modifier 50 and bilateral procedures;
- A.4.3., Services referencing Minnesota Department of Human Services (Medicaid) statutes and/or codes;
- A.4.4., Miscellaneous;
- A.4.5, Substance Abuse Services (divided into three parts):
    - A.4.5.a Hospital;
    - A.4.5.b All other residential;
    - A.4.5.c Outpatient;
- A.4.6 Maternal and Child Health Billing Guide for Public Health Agencies (divided into three parts):
    - A.4.6.a Public health nurse clinic services;
    - A.4.6.b Maternal & child health visits;
    - A.4.6.c Prenatal Nutrition Education, Medical Nutrition Therapy;
    - A.4.6.d Miscellaneous.

A.4.1 Claim Type

Ref. No. 1-4 below provide instructions for the type of claim to use for particular services in particular settings

Ref. No.	Topic/Issue	Setting/situation/ scenario	Instructions
1	Claim Type	Outpatient professional services provided by Critical Access Hospitals (CAH), Method II billing	Outpatient professional services provided by CAH electing Method II billing should be reported on the professional claim type (i.e. 837P).
2	Claim Type	Rural Health Clinics/Federal Qualified Health Centers	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.
3	Claim Type	Ambulatory Surgical Centers	Per trading partner agreement, either the 837P or the 837I claim type is allowed pending further guidance from CMS. Check with payer to determine the preferred billing method.
4	Claim Type	Indian Health Services	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.

A.4.2 Modifier 50 and bilateral procedures

Ref. nos. 5-9 provide instructions for the use of modifier 50 and bilateral procedures

Ref. No.	Topic/Issue	Setting/situation/ scenario	Instructions
5	Modifier 50	Modifier 50 – Physician services	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.
6	Bilateral Radiology	Bilateral radiology -- physician services	Bilateral radiology services are reported as either: ▪ one line with a 50 modifier and one unit, or ▪ two separate lines, one with RT modifier and one with LT modifier.
7	Bilateral Radiology	Bilateral radiology services -- radiology services and other diagnostic procedures	Bilateral radiology services are reported as either: ▪ one line with a 50 modifier and one unit, or ▪ two separate lines, one with RT modifier and one with LT modifier.
8	Modifier 50	Modifier 50 -- Ambulatory Surgical Centers	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.
9	Bilateral radiology	Bilateral radiology -- Ambulatory Surgical Centers	Professional bilateral radiology services are reported as two separate lines, one with RT modifier and one with LT modifier

A.4.3 Services referencing Minnesota Department of Human Services (Medicaid) statutes and/or codes

The Minnesota Department of Human Services (DHS) administers Minnesota Health Care Programs (MHCP), including perhaps most notably the state Medicaid program (known in Minnesota as Medical Assistance). Previous versions of this companion guide coding table included coding instructions for services listed below that are defined in state statute for the state Medicaid program and/or that require the use of "T" codes (national codes established for state Medicaid agencies). The reader is now directed via links to the appropriate DHS website for coding instructions for the services listed in reference numbers 10-24 below.

Ref No.	Topic/Issue with link to DHS coding information
10	Personal Care Assistance (PCA) Services
11	Homemaker services (as part of Elderly Waiver (EW) and Alternative Care (AC) Program)
12	Interpreter Services (part of Access Services)
13	Collaborative psychiatric consultation (Psychiatric Consultations to Primary Care Providers)
14	In-reach Community-Based Coordination (Hospital In-reach Service Coordination (IRSC))
15	Non-emergent, scheduled transport (Local County or Tribal Agency Nonemergency Medical Transportation (NEMT) Services)
16	Non-emergent, scheduled transport (as part of Day Training and Habilitation (DT&H) Day Services)
17	Community Paramedic Services
18	Doula Services (Per MS §256B.0625, Subd. 28B Doula Services)
19	Behavioral Health Home
20	Health Care Homes
21	Vaccines acquired through the Minnesota Vaccines For Children (MnVFC) program (Immunizations & Vaccinations)

TABLE A.4.4 MISCELLANEOUS

Ref No.	Topic/Issue with link to DHS coding information
22	Child and Teen Checkups (C&TC)
23	Family caregiver coaching and counseling with assessment – AC, ECS and EW; Family caregiver services – AC, ECS and EW
24	Community Emergency Medical Technician (CEMT) Services

A.4.4 Miscellaneous

Ref. Nos. 25-39 below address a number of topics/issues.

Ref. No.	Topic/Issue	Instructions
25	Rounding guidelines for Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation (CORF) Services	Follow HCPCS/CPT rounding guidelines.
26	Technical and professional component for Radiology services and other diagnostic procedures	If both technical and professional component are being billed by the same billing provider, same place of service, a global code must be used rather than TC/26 modifiers and separate components
27	Lab panels	Lab panels must be reported as 1 line item with 1 unit per panel. CPT defines panel components.
28	Newborn Screening	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. 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.
29	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 must 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.
30	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 must be submitted.

Ref. No.	Topic/Issue	Instructions
31	Roster billing	Roster billing is not applicable to Minnesota Group Purchasers.
32	Vaccine administration	**Initial Vaccine Administration Code Reporting** **Initial Administration Code Sets** There are three code sets that can be used to report initial vaccine administration codes: ▪ 90460 - Used for face-to-face counseling to the patient and/or family for patients younger than 19 years old ▪ 90471, 90473 - Used when there is no face-to-face counseling for patients of any age ▪ G0008 - G0010 - Used on a limited number of vaccines (usually Medicare beneficiaries) When more than one vaccine is given during the same visit, a decision as to which initial administration code to report must be made: ▪ Report only one initial administration code per claim. Additional initial administration code(s) will result in claim denial. ▪ Report counseling administration codes (90460 - 90461) before non-counseling administration codes (90471 - 90474). ▪ Report administration codes for injectable vaccines (90460 - 90461, 90470 - 90472) before oral or intranasal vaccines (90473 - 90474). **Units** Apply units to the subsequent administration code (90461, 90472, 90474) for every additional vaccine (two or more) of the same type (injectable or oral). **Vaccine Administration Codes** ▪ 90460 - Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

Ref. No.	Topic/Issue	Instructions
		▪ 90461 - Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure) ▪ 90471 - Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) ▪ 90472 - Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) ▪ 90473 - Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) ▪ 90474 - Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) ▪ G0008 - Administration of influenza virus vaccine ▪ G0009 - Administration of pneumococcal vaccine ▪ G0010 - Administration of hepatitis B vaccine
33	Vaccine administration with counseling for patients through 18 years of age	Vaccine administration with counseling for patients through 18 years of age: ▪ Vaccine administration with counseling must be reported in units with the accumulated total administrations representing initial and additional vaccine/toxoid components. ▪ Do not report separate administration lines for each administered vaccine. For example, DTaP-IPV/Hib 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.

Ref. No.	Topic/Issue	Instructions
34	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.
35	Modifiers to indicate rental or purchase	Appropriate modifiers are required to indicate rental or purchase of DME, e.g., NU, RR
36	Binaural hearing aids	Binaural hearing aids are reported as one line, with one unit
37	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.
38	Home Infusion	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.
39	Licensed Traditional Midwife Services (Not Certified Nurse Midwives)	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. Place of Service: 25 – Free-standing Birthing Center HCPCS Code: Appropriate delivery and/or other HCPCS code(s) describing the service(s) rendered. 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.

Ref. No.	Topic/Issue	Instructions
		Fragmented services may be reported in certain circumstances: If the patient is transferred to another facility for delivery, report only the portion of care provided (antepartum and/or postpartum HCPCS codes). If only antepartum and/or postpartum care are provided, report the appropriate antepartum and/or postpartum HCPCS code. Global services may be split when the patient's prenatal/antepartum services are less than four visits (use E/M service). 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. Facility (Birthing Center) services related to the delivery or observation are reported on the 837I only.

A.4.5 Substance Abuse Services

Tables 4.5.a-c are to be used for reporting substance abuse services by delivery setting category as follows:

A.4.5.a., Hospitals;

A.4.5.b, All other residential; and

A.4.5.c., Outpatient Services (further divided into (a)-Institutional vs. (b)-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:

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

A.4.5.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
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
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.

A.4.5.b., Substance Abuse Services: All Other Residential

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Claim Type	Type of Bill
Room and Board	Day	1002: (residentially licensed chemical dependency treatment provider, e.g., Rule 31 Licensed Facility, Children's Residential Facility with CD certification, Tribal CD licensed facility) 1003: (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
Detox	Day	0116, 0126, 0136, 0146, 0156	None	837I	086x – special facility, residential
Treatment program, treatment component	Day	Choose one per date of service: 0944 or 0945 or 0949	None	837I	086x – special facility, residential
Treatment program, treatment component	Hour	0953	None	837I	086x – special facility, residential
Ancillary services	Based on revenue code	As appropriate	None	837I	086x – special facility, residential

A.4.5.c.i Substance Abuse Services: Outpatient Services – Claim Type 837 Institutional

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

Service Description	Unit	Revenue Code	HCPCS Procedure Code	Type of Bill
Alcohol and/or drug assessment	Session/visit	0900	H0001	As appropriate
Outpatient program; Treatment only	Hour	0944 or 0945 or 0953	H2035 HQ (group) H2035 (individual)	089x or 013x
Medication Assisted Therapy (MAT)	Day	0944	H0020	089x or 013x
MAT – all other drugs Note: U9 – MAT, all other drugs, e.g. buprenorphine, naltrexone, Antabuse, etc.	Day	0944	H0047 U9	089x or 013x
Outpatient Ancillary Services	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.

A.4.5.c.ii Substance Abuse Services: Outpatient Services – Claim Type 837 Professional

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

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

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A.4.6 Maternal and Child Health Billing Guide for Public Health Agencies

Tables A.4.6.a – A.4.6.c are to be used for reporting Maternal and Child Health services for public health agencies as follows:

A.4.6.a, Public health nurse clinic services;

A.4.6.b, Maternal & child health visits;

A.4.6.c, Prenatal Nutrition Education, Medical Nutrition Therapy; and

A.4.6.d, Other services.

A.4.6.a Public health nurse clinic services

Services	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
Services Include: Health Promotion & Counseling Nursing Assessment & Diagnostic Testing Medication Management Nursing Treatment Nursing Care, in the home, by RN (PHN & CPHN)	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

A.4.6.b Maternal & child health visits

Services	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 - Mother	99501	N/A
Home Visit for Post-natal assessment & follow up care - Newborn	99502	N/A

Enhanced Services: for at-risk pregnancies as determined by the physician/nurse practitioner:

Services	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
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

A.4.6.c Prenatal Nutrition Education, Medical Nutrition Therapy

Services	Home or Place of Residence (Use appropriate POS)	Public Health Clinic (POS 71)
Prenatal Nutrition Education, Medical Nutrition Therapy; initial assessment and intervention, individual, face-to-face with patient, each 15 minutes	97802	97802
Prenatal Nutrition Education, Medical Nutrition Therapy; initial re-assessment and intervention, individual, face-to-face with patient, each 15 minutes	97803	97803

A.4.6.d Miscellaneous

Services	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

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Appendix B: K3 Segment Usage Instructions

The K3 segment in the 2300 and 2400 Loops is used to meet regulatory requirements when the X12N Committee has determined that there is no alternative solution within the current structure of the 005010X222A1. The situations noted here have been approved by the X12N Committee and will be considered as a business need in development of future versions of this transaction.

If multiple K3 needs exist on a single claim at the same loop level, it is recommended that separate K3 segments be sent.

B.1 State of Jurisdiction

In workers' compensation, insurance carriers have indicated a need to determine jurisdiction in certain situations. For this workers' compensation implementation, providers may populate this field with the appropriate state code.

LU is the qualifier to indicate this value and should be followed by the two-character state code.

Report at 2300 Loop only.

K3*LUMN~

B.2 Tooth Number/Oral Cavity

Oral surgeons and other non-dentist providers that supply oral cavity related procedures may have a need to report tooth number and/or oral cavity within the 005010X222A1 for proper benefit determination. To report the tooth number and/or oral cavity, the K3 segment should be used.

JP is the qualifier to indicate this value tooth number and should be followed by the actual tooth number value. Multiple tooth numbers may be reported in the same K3 segment with a space break between each number as indicated by the second example below.

Report at 2400 Loop only.

K3*JP12~

K3*JP12 14~

JO is the qualifier to indicate oral cavity and should be followed by the oral cavity value. Multiple oral cavities may be reported in the same K3 segment with a space break between each number.

Report at 2400 Loop only.

K3*JO10~

NOTE: Additional information can be found concerning the use of the K3 segment discussed here on the X12 Requests for Interpretation (RFI) website (http://rfi.x12.org/). Search for RFI numbers:

- 628 and 1399: State of Jurisdiction
- 638 and 1065: Send Tooth Information in K3.

Appendix C: Reporting MNCare Tax

NOTE: Instructions for MNCare Tax billing only apply if the provider bills the group purchaser for MNCare Tax. Some providers do not bill the group purchaser for MNCare Tax. This document DOES NOT require them to do so but if they do identify the tax it must be done as follows. Some group purchasers may not reimburse MNCare Tax unless it is identified in the AMT. MNCare Tax must be reported as part of the line item charge and reported in the corresponding AMT tax segment on the lines.

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Appendix D: Required Reporting of National Drug Codes (NDC)

- Bill physician-administered drugs to a patient as part of a clinic or other outpatient visit using the appropriate HCPCS code(s). **Note: This NDC reporting requirement does not apply to inpatient claims.**
- This Minnesota Uniform Companion Guide requires the reporting of National Drug Codes (NDC) when reporting the non-vaccine HCPCS codes listed at the Minnesota Department of Human Services "HCPCS Codes Requiring NDC" webpage, (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147971.)
- For injections that involve multiple national drug codes (NDCs), bill the initial line with the HCPC code, units and NDC with modifier KP (first drug of a multiple drug unit dose formulation). Bill the second, and any subsequent line item(s) of the same HCPC code with modifier KQ (second or subsequent drug of a multiple drug unit dose formulation). If billing the same HCPC code on more than two lines, the KQ modifier and an additional modifier are needed on each subsequent line.
- Multiple service lines are necessary to report a compound drug. One NDC is allowed per line. Report the HCPC code as a separate line for each associated NDC.

D.1 Additional Information and Examples

The following information and examples below are excerpted from the Workgroup on Electronic Data Interchange (WEDI) "NDC Reporting White Paper" (https://www.wedi.org/2014/10/28/ndc-reporting-requirements-in-health-care-claims/).

D.1.1 NDC Format

NDCs must be reported using the "5-4-2 format" shown below. If a drug's NDC does not follow this format, then a zero must be inserted at the beginning of the appropriate section of the number, as shown in the table below, in order to create the 5-4-2 format. The following table shows where to insert the zeros. Note: NDCs are reported in the 837 transaction without the hyphens shown below.

NDC	11 digits ("5-4-2" format)	Examples
4-4-2 XXXX-XXXX-XX	**0**XXXX-XXXX-XX	1234-5678-91 = **0**1234-5678-91
5-3-2 XXXXX-XXX-XX	XXXXX-**0**XXX-XX	12345-678-91 = 12345-**0**678-91
5-4-1 XXXXX-XXXX-X	XXXXX-XXXX-**0**X	12345-6789-1 = 12345-6789-**0**1

D.1.2 Reporting NDC in Professional Claims

D.1.2.1 Data Requirements

SV1 is where the drug procedure code is reported. Qualifier "HC" in SV101-1 indicates that the procedure code is a HCPCS or Current Procedural Terminology (CPT®) code. The actual procedure code is reported in SV101-2. SV103 is the qualifier for the procedure units and SV104 is where the procedure units are reported. All of the SV1 data elements for reporting drug procedure code information are required.

The Drug Information (LIN) segment is situational and is required to be reported when federal or state regulations mandate that the drugs or biologics be reported with NDC. Providers or submitters may also report NDC when it is known to support the claim and facilitate the adjudication. LIN02 is the qualifier for reporting the NDC number, which is code value N4. LIN03 is where the NDC number is reported. Both of these data elements are required when reporting the segment.

The CTP segment is required to be reported when reporting the NDC in the LIN segment. Both CTP04 (NDC unit count) and CTP05 (unit of measure) are required.

D.1.2.2 Example 1

A patient is given an injection in the physician's office of 500 mg Ampicillin sodium, which is reconstituted from a 500 mg vial of powder.

Therefore:

- HCPCS: J0290 (Injection, Ampicillin sodium, 500 mg)
- NDC: 00781-9407-78
- HCPCS unit: 1
- NDC quantity: 1
- Unit of measure: UN

See additional details in the following table.

Loop	Segment	Data Element	Data Reported
2400	SV1	SV101-1	HC
		SV101-2	J0290
		SV103	UN
		SV104	1
2410	LIN	LIN02	N4
		LIN03	00781940778
2410	CTP	CTP04	1
		CTP05-1	UN

See WEDI "NDC Reporting White Paper" (https://www.wedi.org/2014/10/28/ndc-reporting-requirements-in-health-care-claims/) for more examples.