Minnesota Department of Health (MDH) Rule

Title:	**Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X224A2 Health Care Claim: Dental (837) Version 12**
Pursuant to Statute:	Minnesota Statutes 62J.536 and 62J.61
Applies to/interested parties:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536, and others
Description of this document:	This document was adopted into rule on August 14, 2017. [Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the ASC X12/005010X224A2 Health Care Claim: Dental (837) hereinafter referred to as 005010X224A2, by entities subject to Minnesota Statutes, section 62J.536; • 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 requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This is version 12.0 (v12.0) of the Minnesota Uniform Companion Guide (MUCG) for the Implementation of the ASC X12/005010X224A2 Health Care Claim:

Title:	**Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X224A2 Health Care Claim: Dental (837) Version 12**
	Dental (837). It was announced as an adopted rule in the Minnesota State Register, August 14, 2017 pursuant to Minnesota Statutes, section 62J.536 and 62J.61. Version 12.0 supersedes all previous versions of this MUCG. This document is available at no charge at MDH's "Minnesota Statutes, section 62J.536 Rules" webpage (htttp://www.health.state.mn.us/facilities/ehealth/asa/rules.html).

Table of Contents

1. Overview

1.1. Statutory basis for this rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2. Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program. The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year to year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

Minnesota Statutes, section 62J.03, Subd. 6 defines "group purchaser" as follows:

> "*Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.*

Minnesota Statutes, section 62J.03, Subd. 8 defines "provider or health care provider" as follows:

"*Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.*

Minnesota Statutes, section 62J.536, Subd. 3 defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Minnesota Statutes, section 62J.51, Subd. 11a defines "health care clearinghouse" as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions."

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1. Exceptions to applicability

Minnesota Statutes, section 62J.536, subd. 4 authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

ii. another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the rules for the eligibility inquiry and response transaction. This exception pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (ASC12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271), hereinafter 005010X279A1*)*. This exception shall be reviewed on an annual basis; the status of the exception can be found at: http://www.health.state.mn.us/facilities/ehealth/asa/implement.html

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction (*005010X279A1*) with group purchasers not covered by HIPAA.

1.3. About the Minnesota Department of Health (MDH)

1.3.1. MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: http://www.health.state.mn.us.Contact for further information on this document

Minnesota Department of
Health Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882St. Paul, Minnesota 55164-0882

1.4. Phone: (651) 201-3570Fax: (651) 201-5179Email: health.ASAguides@state.mn.usAbout the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the AUC website at: http://www.health.state.mn.us/facilities/ehealth/auc/index.html

1.5. Minnesota 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. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

1.6. Please visit the AUC website at

http://www.health.state.mn.us/facilities/ehealth/auc/index.html for more information about best practices for implementing electronic health care transactions in Minnesota.Document Changes

The content of this document is subject to change. The version, release and effective date of the document is included in the document, as well as a description of the process for future updates or changes.

1.6.1. Process for updating this document

The process for updating this document, including: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document is available from MDH's website at: http://www.health.state.mn.us/facilities/ehealth/asa/index.html

1.6.2. Document revision history

Version	Revision Date	Summary Changes
1.0	February 8, 2010	Version released for public comment
2.0	May 24, 2010	Adopted into rule. Final published version for implementation
3.0	February 22, 2011	Incorporated proposed technical changes and updates to v2.0
4.0	May 23, 2011	Adopted into rule. Incorporated all changes proposed in v3.0. Version 4.0 supersedes all previous versions.
5.0	November 13, 2012	Proposed revisions to v4.0
6.0	February 19, 2013	Adopted into rule. Incorporated revisions proposed in v5.0 and additional changes. Version 6.0 supersedes all previous versions.
7.0	September 23, 2013	Proposed revisions to v. 6.0

Version	Revision Date	Summary Changes
8.0	December 30, 2013	Adopted into rule December 30, 2013. Version 8.0 incorporates changes proposed in v7.0 and additional changes. Version 8.0 supersedes all previous versions.
9.0	December 22, 2014	Proposed revisions to v.8.0
10.0	June 1, 2015	Adopted into rule June 1, 2015. Version 10.0 incorporates changes proposed in v9.0 and additional changes. Version 10.0 supersedes all previous versions.
11.0	August 8, 2016	Proposed revisions to v10.0. Note: Following announcement of v11.0 as a proposed rule it was withdrawn from further consideration by the Minnesota Department of Health and was replaced by version 11.1 (see also the next entry below for v11.1).
11.1	May 15, 2017	Version 11.1 replaces v11.0. Version 11.1 was announced in the State Register as a proposed rule for public comment on May 15, 2017 with proposed revisions to v10.0.
12.0	August 14, 2017	Adopted into rule on August 14, 2017. Incorporates changes proposed in v11.1. Version 12.0 supersedes all previous versions.

2. Purpose of this document and its relationship with other applicable regulations

2.1. Reference for this document

The reference for this document is the *ASC X12N/005010X224A2 Health Care Claim: Dental (837)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, ASC X12. All Rights Reserved), hereinafter described below as *005010X224A2.* A copy of the full *005010X224A2* can be obtained from ASC X12 at: http://store.x12.org/store

2.1.1. Permission to use copyrighted information.

2.2. [Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X224A2*;
- 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 requirements for use of ICD-10) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X224A2* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

Please note:

Using this Companion guide does not mean that a claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

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3. How to use this document

3.1. Classification and display of Minnesota-specific requirements

This document has been prepared for use by entities subject to Minnesota's requirements for the standard, electronic exchange of health care administrative transactions (Minnesota statutes, section 62J.536 and related rules) and other interested parties. It provides transaction specific information to be used in conjunction with the *005010X224A2* and other applicable information and specifications noted in section 2.0 above.

Table 4.2 of this document contains a row for each segment for which there is additional information over and above the information in the*005010X224A2*. The tables show 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.

This document also contains the following three appendices:

- Appendix A consists of a number of sections and provides additional instructions and specifications regarding the use of medical code sets and medical coding,including information and coding instructions for teledentistry.
- Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction; and
- Appendix C provides instructions for reporting MNCare tax.

See also section 2.2 regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities covered by Minnesota Statutes, section 62J.536.

3.2. Information about the Health Care Claim: Dental (837) Transaction

3.2.1. Business Terminology

The terms below were published with definitions and other information in the previous version of this companion guide to provide additional clarification and/or because of changes that occurred as a result of the adoption of version

5010. Definitions of these terms are no longer being included in this companion guide. However, the terms are discussed and defined in the reference document to this companion guide (the 005010X224A2), which is available for purchase from ASCX12 at: http://store.x12.org/store

Terms previously defined in the companion guide but can now be referenced as noted above:

- Billing provider
- Billing provider name
- Billing provider address
- Pay-to address
- Other payer
- Patient
- Pay-to plan
- Subscriber

3.2.1.1. Other Definitions

Factoring Agent

3.2.2. 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 *005010X224A2* for this business situation, the Accredited Standards Committee (ASC) 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.Provider Identifiers and NPI Assignments

Provider Identifiers

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 of the TIN is also required.

If the provider is not a health care provider as defined under federal standards they are known as atypical providers. 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 for this qualifier would be the specific payer assigned/required identifier.

3.2.3. Handling Adjustments and Appeals

3.2.3.1. Determination of Action:

When determining whether to resubmit a claim as an original, request an adjustment or request an appeal, first determine whether the payer has accepted and adjudicated the original claim submission.

- If the original submission was not accepted into the payer adjudication system, resubmit the claim as an original. This is not considered to be an adjustment.
- If the original submission was accepted into the payer adjudication system, see definitions below to determine whether an adjustment or appeal should be requested.

3.2.3.2. Definitions:

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 – 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

3.2.3.3. Process for submission:

- 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 SV301-7, NTE segment, PWK segment, or Condition Codes should be used. See section 3.2.5 below regarding these segments for appropriate instructions.

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

3.2.4. 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.

Example: Submission of a Replacement Bill (CFTC 7)

Note: the following distinctions are important to ensure proper handling of the submission.

- 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.
  - Replacement -- To qualify as a Replacement, some data need to be different than the original.
  - Considered as Duplicate rather than a Replacement -- If the bill is re-submitted with no changes from the original, and the claim was accepted by the payer, this would be considered a Duplicate instead of a

Replacement.

- Considered an Original Claim rather than a Replacement -- If the bill is resubmitted with no changes from the original and the original was not accepted by the payer, this 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. For example, a Replacement bill (CFTC 7) may also contain a Condition Code 'D0' indicating service dates have been changed.

3.2.5. Claim Attachments and Notes

- Use the NTE segment at the claim or line level to provide free-form text of additional information.
  - The NTE segment must not be used to report data elements that are 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 SV301-7 in the 2400 loop must be used.
- Do not exceed the usage available in the *005010X224A2.*
- Be succinct and abbreviate when possible. Do not repeat code descriptions or unnecessary information.
- If the NTE segment must be exceeded, or a hard copy document sent, use the PWK segment at the claim level. If the number of characters for the NTE orSV301-7 will exceed available characters, 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.

NOTE: Regarding claim attachments for workers' compensation medical claims only, Minnesota Statutes, section 176.135, Subd. 7a requires that starting January 1, 2017:

- "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."

A copy of the above statute is available for review and reference at website of the Minnesota Office of the Revisor of Statutes at: https://www.revisor.leg.state.mn.us/statutes/?id=176.135.

4. ASC X12N/005010X224A2 Health Care Claim Dental (837) – Transaction Specific Information

4.1. Introduction to Table

The following table provides information needed to implement the *ASC X12/005010X224A2 Health Care Claim: Dental (837)* Transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X224A2* 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 4.2 below means that the "Value Definition and Notes" applies to the segment rather than a particular data element.

Please also see section 2.2 above.

4.2. 005010X224A2 Dental (837) -- Transaction Table

Table 4.2 005010X224A2 Dental (837) Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X224A2 and any other applicable information and specifications noted in section 2.2.

Loop	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 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.
2300 Claim Information	CLM Claim Information	CLM05-3 Claim Frequency Type Code	See front matter section 3.2.4 of this document for definitions.

Table 4.2 005010X224A2 Dental (837) Transaction Specific Information This table summarizes transaction specific information to be used in conjunction with the 005010X224A2 and any other applicable information and specifications noted in section 2.2.			
Loop	Segment	Data Element (if applicable)	Value Definition and Notes
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 3.2.5 of this document for usage. If CLM20 value of 11 is used, PWK02 must not be a value of AA.
2300 Claim Information	DN2 Tooth Status	N/A	Required when the tooth status codes in DN202 apply to the claim.
2300 Claim Information	PWK Claim Supplemental Information	N/A	See front matter section 3.2.5 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	HI Health Care Diagnosis Code	N/A	If sending the claim to a medical or P&C carrier, this segment is recommended for use.
2320 Other Subscriber Information	SBR Other 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.
2330B Other payer name	NM1 Other Payer Name	NM109 Identification Code	If multiple other insureds, the payer ID values contained in the 2320 loops must be unique within the claim.
2400	DTP	N/A	If actual date not known, provide an estimate.

Table 4.2 005010X224A2 Dental (837) Transaction Specific Information This table summarizes transaction specific information to be used in conjunction with the 005010X224A2 and any other applicable information and specifications noted in section 2.2.			
Loop	Segment	Data Element (if applicable)	Value Definition and Notes
Service Line Number	Date – Prior Placement		
2400 Service Line Number	AMT Sales Tax Amount	N/A	See Appendix B of this document for details on reporting MNCare Tax
2400 Service Line Number	SV3 Dental Service	N/A	See Appendix A of this document for details on reporting Teledentistry services

5. List of Appendices

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

Appendix A provides additional information and instructions regarding the use of medical code sets and medical coding.

Appendix B: K3 Segment Usage Instructions

Appendix B provides instructions for the use of the K3 segment for reporting state of jurisdiction.

Appendix C: Reporting MNCare Tax

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

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

A.1 Introduction

The purpose of this Appendix is to provide guidance to Minnesota submitters and receivers of dental electronic health care claims on requirements, selection and use of specific code sets that are associated with these transactions.

The Appendix covers:

- general background information about code sets, and
- a series of principles to guide the selection and use of codes in connection with Minnesota electronic health care claim transactions; and
- teledentistry.

In preparing this Guide, the official guidelines for code selection documented in code resources were followed, unless otherwise explicitly noted. Consult official coding resources for descriptions, definitions and directions for code usage. This material is not intended to be a substitute for coding manuals or official guidelines. All codes are expected to be used in a manner consistent with their descriptors, instructions, and correct coding principles.

Group purchasers (payers) will continue to administer applicable coverage policies and member benefits.

A.2 Basic Concepts on HIPAA Code Sets

- Code sets are described in the front matter of this Companion Guide.
- The dental codes are a separate category of national codes. The Department of Health and Human Services has an agreement with the American Dental Association (ADA) to include Current Dental Terminology (CDT)[1] as a set of HCPCS Level II codes for use in billing for dental services.
- Consistent with the HIPAA Electronic Transactions and Code Sets regulations, all covered entities are required to submit or receive codes that are:
    - valid on the date of service - for medical code sets (which include dental codes);

[1] CDT is a registered trademark of the American Dental Association (ADA)

and

- valid at the time the transaction was created and submitted – for non-medical code sets.

A.3 General Principles for Code Selection and Use in Minnesota

Code selection for claims submitted in Minnesota follows a hierarchy of preferred instructions.

1. Minnesota Statute 62J.536 requires all claims to be submitted according to the guidelines for Medicare that are issued by the Center for Medicare and Medicaid Services (CMS) whenever possible.
2. It is understood that Medicare excludes from coverage, items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth.
3. Select codes that accurately identify the procedure or service provided.
4. All nationally-developed codes are accepted by all group purchasers even when Medicare coding and coverage limitations may not allow reporting of a code.
5. Acceptance of a code does not imply any health insurance coverage or reimbursement policy.
6. The dental/medical record must always reflect the service provided.

A.4 Units (basis for measurement)

- Units are reported according to the code description.

A.5 Teledentistry

Minnesota law requires that the state's Medical Assistance (Medicaid) program administered by the Minnesota Department of Human Services (DHS) cover services delivered via telemedicine, subject to provisions in law. Effective January 1, 2017, Minnesota law also requires health carriers (insurers) to cover "telemedicine benefits" subject to additional provisions in statute.

Starting January 1, 2017, when reporting teledentistry services, use the appropriate procedure code from the Code on Dental Procedures and Nomenclature (CDT Code) with

the Place of Service (POS) code “02” which denotes “The location where health services and health related services are provided or received, through a telecommunication system.”

Please Note:

National organizations are responsible for maintenance of medical codes and periodically add, delete, or make other changes to these codes. Code sets referenced in this appendix were valid at the time of approval for publication. Code set changes may result in this appendix reflecting a deleted code or not reflecting a new code. This Guide and Appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes. Submitters of health care claims are responsible for selecting and using the correct, appropriate codes.

Per HIPAA, “those that [send or] receive standard electronic administrative transactions must be able to [send], 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.”

CDT codes are evaluated and updated annually by the Code maintenance Committee of the ADA. For questions on codes contact the ADA at 1-800-621-8099 or dentalcode@ada.org. For information on the HCPCS annual release of alpha-numeric medical codes visit www.cms.gov or email hcpcs@cms.hhs.gov.

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B. 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 005010X224A2. 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.

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~

NOTE: Additional information can be found concerning the use of the K3 segment discussed here on the ASC X12N Request for Interpretations (RFI) Portal: http://www.x12n.org/portal. Search for RFI numbers:

- 628 and 1399: State of Jurisdiction.

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C. 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.