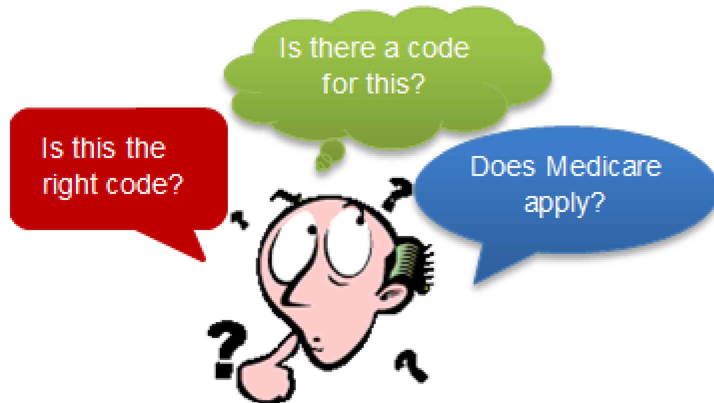
AUC CODING RESOURCE



Administrative Uniformity Committee (AUC) Coding Recommendations

PREPARED BY
AUC MEDICAL CODE TECHNICAL ADVISORY GROUP

Approved by AUC: July 14, 2016

Updated: September 22, 2016

AUC Coding Recommendations

Background

The Administrative Uniformity Committee (AUC) Medical Code Technical Advisory Group created the Minnesota AUC Coding Recommendations to track new or revised coding recommendations developed and approved between, and in anticipation of, the annual maintenance of the Minnesota Uniform Companion Guides (MUCGs) for the 837 Institutional, 837 Professional, and 837 Dental.

The coding recommendations are a coding resource for Minnesota payers and providers consisting of two tables that are updated at least semi-annually. Updates to the coding tables may stem from:

- Quarterly HCPCS coding changes;
- Medical coding in relation to Minnesota legislative changes;
- New or revised Medicare rules; and
- Other coding issues as identified

Further, the Coding Recommendations table:

1. Provides clarification and answers to frequently asked questions about recommended ways to code for health and medical services on the 837I and 837P electronic claim;
2. Is intended for use in conjunction with “Appendix A, Table A.5.1” of the “Minnesota Uniform Companion Guides (MUCGs) for the 837 Institutional (I) and 837 Professional (P) transactions;
3. Is not part of the MUCG rules and does not serve as a rule. Note: coding clarifications in this table may subsequently be incorporated into the MUCG rules.
4. Provides recommendations that may be transferred to the applicable MUCGs for the 837I and 837P as part of the annual maintenance;
5. Is a living document that is regularly updated with new coding recommendations; and
6. Is available online at: http://www.health.state.mn.us.auc/bp.htm.

Explanation of Tables

The coding recommendations are intended for use in conjunction with tables found in **Appendix A** of the Minnesota Uniform Companion Guides (MUCGs) for the 837 Professional, 837 Institutional, and 837 Dental transactions.

1. List of Coding Topics/Issues Tables

The table comprises a list of specific coding topics and their applicability to the Medicare Claims Processing Manual submitted to the Minnesota Administrative Uniformity Committee (AUC) for clarification of medical coding issues, new or revised Medicare rules, and for requests to establish new, uniform coding for newly legislated benefits.

These coding topics have been reviewed and discussed by the AUC Medical Code TAG (MCT). The recommendations and coding for each topic approved by MCT members are forwarded to the AUC for its review and determination of disposition. Each coding topic in this table includes a link to more detailed information (see Coding Recommendation Detail table below) about the coding topic or issue addressed by the Medical Code TAG's and the recommendation and coding approved by the AUC.

Table headings definitions:

Medicare Claims Processing Manual – A CMS publication consisting of 38 chapters which describe billing requirements, rules, and regulations that pertain to Medicare in all settings by each chapter number and chapter/description title. For example, Chapter No. 2 is Admission and Registration Requirements.

Disposition Status – Determination of where the topics and recommendations will reside:

- MUCG[1] – Minnesota Uniform Companion Guide, version 5010 is a single, uniform companion guide to the Health Insurance Portability and Accountability Act (HIPAA) Implementation Guides mandated by Minnesota Statutes section 62J.536 and related rules. Health care providers that provide services for a fee in Minnesota, or who are otherwise eligible for reimbursement under the state's Medical Assistance program, as well as group purchasers (payers) and health care clearinghouses that are licensed or doing business in Minnesota must comply with the MUCG. The options below represent the specific 837 companion guide(s) that the recommendation applies to:
  - **837P** – Refers to the 837 Professional MUCG, i.e., Minnesota requirements for any claim submitted using HIPAA mandated Accredited Standards Committee X12 (ASC X12 or X12) 837 professional claim transaction
  - **837I** – Refers to the 837 Institutional MUCG, i.e., Minnesota requirements for any claim submitted using HIPAA mandated transaction X12 837 institutional claim transaction
  - **837D** – Refers to the 837 Dental MUCG, i.e. Minnesota requirements for any claim submitted using HIPAA mandated X12 837 dental claim transaction
- Grid – Usage of coding determined for the topic/issue has been approved by the AUC as a recommendation only; topic will reside in the Coding Recommendation Table

Specific Coding Topic – Coding issue(s), questions, or clarifications submitted on a completed AUC SBAR form for the AUC to consider

AUC Approval Date – Date the full AUC approved the Medical Code TAG's recommendations

2. Coding Recommendations Detail Table

The Coding Recommendations Detail is color-coded for ease of reference to determine if topic is a recommendation only or a Minnesota Rule, which is the rule of law. Each topic includes the detail information listed as described in the numbered items below.

[1] Minnesota Statutes section 62J.536 and related rules require the development and use of a single, uniform companion guide for the following transactions: eligibility; claims; payment/advice; acknowledgments and prescription drug prior authorization. Coding recommendations in this document is applicable to the 837 claims companion guides only.

The blue-highlight indicate coding topics that are recommendations only. These topics will remain in the coding recommendation table and their usage is highly encouraged. The green highlight indicate coding topics that are being proposed as Minnesota rules to be included in the designated companion guides during the next annual maintenance update of Minnesota Uniform Companion Guides for the 837 Professional, 873 Institutional, and the 837 Dental transactions.

1. Coding Topic – The medical service/health benefit or coding issue to be addressed and/or determined by the AUC
2. MCT Minutes Reference – Date of the Medical Code TAG's meeting minutes in which the coding issue(s) was closed and its recommendations approved by the TAG members
3. Background/Description – Summary of background information and brief description of the coding topic/issue to be resolved
4. Recommendation – The Medical Code TAG's recommendation to clarify or resolve the coding issue that is forwarded to the AUC for its review and final approval. The recommendations listed in this document have been reviewed and approved by the AUC for its inclusion in this table as a best practice or as a proposed rule of law. Topics designated as a proposed rule will be transferred from the recommendation table to the appropriate MUCG(s) during the annual maintenance update of the Minnesota Uniform Companion Guides to be ultimately adopted as rule of law.
5. Disposition Status – Identifies implementation status of the recommendation, i.e. place in one or more of the MUCGs or reside in the coding recommendation table:
   - Companion guide (Proposed rule providers and payers must comply when adopted as a Minnesota Rule (rule of law) for the designated claim transaction, e.g. 837P, 837I or 837D)
   - Coding Recommendation Table (recommendation is a best practice and highly recommended; optional to follow recommended usage)
6. Coding – Approved coding recommendations for the specific medical service/health benefit

Table 1: List of Coding Topics/Issues

Medicare Claims Processing Manual		Disposition Status			
Chapter No.	Chapter/Description Title	MUCG(s)	Grid	**Coding topic**	**AUC Approval Date**
			x	Alternate Care Site Billing	April 1, 2013
			x	Autism Spectrum Disorder	October 20, 2009
12	Physician/Nonphysician Practitioner Billing			Code 69210 Bilateral Impacted Cerumen	December 3, 2014
12	Physician/Nonphysician Practitioner Billing		**X**	Coding for SBIRT (Screening, Brief Intervention, and Referral to Treatment)	May 9, 2013
12	Physician/Nonphysician Practitioner Billing	**837P**		Consultation Services	December 21, 2009
			X	Dental Services Performed in OR	February 8, 2010
12	Physician/Nonphysician Practitioner Billing		**X**	IONM Clarification	
12	Physician/Nonphysician Practitioner Billing		**X**	Labor Epidural Billing	May 9, 2013
12	Physician/Nonphysician Practitioner Billing		**X**	Moving Home Minnesota – A Federal Demonstration Project	June 13, 2013 July 18, 2014 December 3, 2014 May 23, 2016
12	Physician/Nonphysician Practitioner Billing		**X**	Partial Hospitalization POS	June 17, 2013
12	Physician/Nonphysician Practitioner Billing	**837P, 837I**		Community Health Worker Modifier	July 14, 2016
12	Physician/Nonphysician Practitioner Billing	**837P, 837I**		Protected Transport	August 23, 2016

Table 2: Coding Recommendations Detail

Alternate Site Billing	
MCT Minutes Reference	February 1, 2013
Background/Description	Alternate Care Sites (ACS's) will provide austere (basic) patient care during a disaster response to a population that would otherwise be hospitalized or in a similar level of dependent care if those resources were available during the disaster. The opening of an ACS is a last resort when incident demands have overwhelmed the hospitals' surge capacity. The ACS's will be implemented in conjunction with local public health with the Regional Hospital Resource Center (RHRC) providing coordination on approval from the Minnesota Department of Health (MDH). This ACS plan is limited to the seven county area: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington and its jurisdictional public health entities. The primary site for the ACS is the Minneapolis Convention Center (MCC) and the secondary site is the River Centre in St. Paul.
Recommendation	A MCT subgroup was formed to discuss coding recommendations for services in an Alternate Care Site (ACS). From that group, requests were made to the National Uniform Billing Committee (NUBC) for a new Type of Bill (TOB) specifically for ACS and a unique new patient discharge status code indicating a transfer to an ACS. The NUBC did not approve the request for a TOB. They suggested using TOB 089x. The NUBC did approve a new patient discharge status code effective 10/1/13
Disposition Status	_**X**_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	71 Discharged/transferred to a Designated Disaster Alternative Care Site TOB 089X

Return to Topics List

Autism Spectrum Disorder	
MCT Minutes Reference	September 22, 2009
Background/Description	The AUC was asked how autism spectrum disorder services are to be reported.
Recommendation	
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter (may be reported on different days if multiple assessments are performed). Report as 1 unit per encounter. H2018 Psychosocial rehabilitation services, per diem. (Report modifier TF intermediate level, or TG complex level to differentiate between programs if necessary) H2020 Therapeutic behavioral services per diem (Report modifier TF intermediate

Autism Spectrum Disorder	
	level, or TG complex level to differentiate between programs if necessary.) H2014 Skills training and development, per 15 minutes H2017 Psychosocial rehabilitation services, per 15 minutes H2019 Therapeutic behavioral services, per 15 minutes G9012 Case Management Services

Return to Topics List

Code 69210 for Bilateral Impacted Cerumen	
MCT Minutes Reference	December 3, 2014
Background/Description	Request to approve standardized coding for 69210. The narrative for 69210 was revised in 2014 to a unilateral code. Thus is performed on both ears it would be appropriate to bill the code with a -50 modifier. However, CMS is not recognizing (denying) 69210 if billed with a modifier 50 (bilateral procedure). Medicare has instructed to use modifiers –RT and –LT instead.
Recommendation	Add coding recommendation to coding grid. MCT will determine at a later date if recommendation should be placed in companion guide.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	69210 Removal impacted cerumen requiring instrumentation, unilateral For bilateral procedure, Medicare guidelines for Medicare products: report 69210 one line one unit, no modifiers; and for Commercial and DHS report 69210 one line, one unit, 50 modifier

Return to Topics List

Coding for SBIRT	
MCT Minutes Reference	January 10, 2013
Background/Description	SBIRT (Screening, Brief intervention, and Referral to Treatment) is an alcohol/substance abuse structured screening. Current reporting per SAMHSA (Substance Abuse and Mental Health Services Administration) is as follows: • For commercial payers the codes are 99408 and 99409 • For Medicare the codes are G0396 and G0397 • For Medicaid the codes are H0049 and H0050
Recommendation	Do not follow SAMHSA coding recommendation. Use CPT or G codes, but not H codes. (Both codes are acceptable per Appendix A front matter in the current Claims Companion Guide.)

Coding for SBIRT	
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	

Return to Topics List

Consultation Services	
MCT Minutes Reference	November 24, 2009
Background/Description	Explaining and following the documentation requirements specific to consultations has been problematic for years. CMS issued guidance in their 2010 fee schedule that all these services should be coded as office visits, hospital services, and nursing facility visits. Request AUC recommends a Minnesota Rule that allows services that meet the definition of consultations to be coded according to well established CPT guidelines because following Medicare will increase administrative burden in the form of resources for providers.
Recommendation	Per the Minnesota Uniform Companion Guide Section A.3.1, select codes that most accurately identify the service provided. Consultation codes most accurately identify the service provided for non-Medicare business. Group purchasers will continue to accept consultative service codes as defined by CPT for non-Medicare business.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	

Return to Topics List

Dental Services Performed in OR	
MCT Minutes Reference	January 14, 2010
Background/Description	There are no uniform billing with Minnesota group purchasers as related to dental procedures done in the operating. Some patients are unable to have dental work performed in a dental office due to their inability to cooperate; for example some patients have developmental delays, mental retardation, autism, or are too young to be in a dental chair for dental procedures. All group purchases do not accept the same codes; some require HCPCS and others CPT. Request AUC decide how hospital claims for dental procedures in OR can be billed with uniform coding.
Recommendation	For dental services not normally provided under general anesthesia…Where dental HCPCS codes are the most specific, appropriate codes, they should be used to indicate dental procedures performed under general anesthesia in the operating room, on both the 837 Professional and 837 Institutional claims types.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental

Dental Services Performed in OR	
Coding	

Return to Topics List

IONM Clarification	
MCT Minutes Reference	January 8, 2015
Background/Description	The industry is in need of a clarification regarding coding interpretation. Our business practice for procedure code 95940 is to bill units in 15 minute increments, as the CPT code description states, without a modifier and to bill procedure code 95941 in 1-hour increments without a modifier as CPT code description states. Payers are inconsistent in what they require in order to process procedure codes 95940 and 95941. Some payers require modifier 26, which is not indicated in the Medicare Correct Coding Guide, other payers will not pay more than one unit of each code, and some payers will pay with modifier 59 for anything over one unit. Request the AUC clarify billing of service of codes 94940 and 94941.
Recommendation	DHS checked system and found that there was a number in for maximum number per day that was inaccurate. The MCT agreed that use of code 26 or 59 to modifier for procedure codes 95940 and 95941 are incorrect. Coding in units. It was determined that codes 95940 and 95941 do not require Modifier 26 nor should there be multiple lines with Modifier 59. Add-on codes 95940 –each 15 minutes No to using code 26 Applicable documentation should support your unit bill. 59-modifier is not appropriate. MCT cannot address reimbursement. These are not TC and code 26 is not eligible.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	Follow unit guidelines and follow CPT. Unit would be based one per line.

Return to Topics List

Labor Epidural Billing	
MCT Minutes Reference	February 14, 2013
Background/Description	According to the 2013 Relative Value Guide from the American Society of Anesthesiologists (ASA), "Unlike operative anesthesia services, there is no single, widely accepted method for accounting for time for neuraxial labor anesthesia services. Request clarification of the rule in the MUCG as it relates specifically to neuraxial anesthesia management time (code 01967) or establish code for "time present and immediately available" of currently billing methodology for most payers be standardized coding in the Claims companion guides for anesthesia
Recommendation	The Medical Code TAG agreed there is no coding to identify specific standby services for anesthesia and suggested that the ASA make recommendation to CPT for national code(s) to address labor epidural anesthesiology billing for "time present and immediately available." Out of scope for AUC. No action taken.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	N/A

Return to Topics List

Moving Home Minnesota – A Federal Demonstration Project	
MCT Minutes Reference	February 14, 2013 original; June 23, 2014 revised
Background/Description	The federal Deficit Reduction and Affordable Care Act empowered states to develop demonstration projects that would promote and enable movement of Medicaid beneficiaries with disabling and chronic conditions from institutions to the community. To provide community-based alternatives for persons of all ages and disability groups who reside in Minnesota Assistance-funded institutional settings, the Moving Home Minnesota (MHM) -a Demonstration Project provides an array of home and community based services to include planning and coordination of community living arrangements, searching for and securing housing, moving, securing household goods, and arranging for supportive housing, employment and environmental services.
Recommendation	The coding listed below are recommended to report Moving Home Minnesota activities.
Disposition Status	_X_ Coding Recommendation Grid (recommendations only; usage is optional) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	A0160 U6 Non-emergency transportation, case worker, per mile, MHM A0170 U6 Transportation Ancillary: parking fees, tolls, other, MHM A0180 U6 Non-emergency transportation: ancillary lodging, recipient, MHM A0190 U6 Meals, recipient, MNM A0200 U6 Lodging for caseworker, escort, parent, MNM

Moving Home Minnesota – A Federal Demonstration Project		
	A0210 U6	Meals for caseworker, escort, parent, MNM
	H0038 U5 U6	Self-help/Peer services- Level II Certified Peer Specialist, MHM
	H0038 U6	Self-help/Peer services- Level II Certified Peer Specialist, MHM
	H0038 U5 U6	Self-help/Peer services- Level I Certified Peer Specialist, MHM
	H0038 U6 HQ	Self-help/Peer services- Certified Peer Specialist in a group setting, MHM
	H0040 U6	Assertive Community Treatment, MHM
	H0045 U6	Respite Care Services, not in home, MHM
	H2000 U6	Pre-discharge Case Consultation and Collaboration, MHM
	H2015 U6	Comprehensive Community Support Services, MHM
	H2027 U6	Psychoeducational Service, 15 minutes, MHM
	S5111 U6	Home Care Training – Family, MHM
	S5115 U6	Family Memory Care Intervention, 15 minutes, MHM
	S5116 U6	Home Care Training – Non-Family, MHM
	S5135 UA U6	Overnight Assistance, MHM
	S5150 U6	Respite Care, in home, MHM
	S5150 UB U6	Respite Care, out of home, MHM
	S5151 U6	Respite Care, in home, MHM
	S5160 U6	Emergency response system installation and testing, MHM
	S5161 U6	Emergency response system service fee per month, MHM
	S5162 U6	Emergency response system purchase, MHM
	S1565 U6	Environmental accessibility adaptation, MHM
	S9970 U5 U6	Health club membership, monthly, MHM
	T1016 U6	Case Management, MHM
	T1017 U6	Transition Coordination, MHM
	T1028 U6	Adaptations – home assessment, MHM
	T1999 U6	Tools, clothing and equipment for employment, MHM
	T2018 U6	Supported employment benchmark payment, daily, MHM
	T2019 U6	Supported employment, 15 minutes, MHM
	T2029 U6 NU	Durable medical equipment, new, MHM
	T2029 U6 RB	Durable medical equipment, repair, MHM
	T2029 U6 RR	Durable medical equipment, rental, MHM

Moving Home Minnesota – A Federal Demonstration Project	
	T2038 U1 U6 Transitional services, furniture, MHM T2038 U2 U6 Transitional services, supplies, MHM T2038 U6 Transition plan development, MHM T2038 UA U6 Transitional services, housing deposit, MHM U Modifier definitions: UA- Night supervision (WS3135)/item, service or procedure furnished in conjunction with a demonstration project (T2038) UB- Out of home UD- Transition to community living services U1- Transitional services, furniture U2- Transitional services, supplies U5- Monthly U6- Moving Home Minnesota (MHM)

Return to Topics List

Partial Hospitalization Place of Service (POS)	
MCT Minutes Reference	May 1, 2013
Background/Description	A new requirement from CPT/AMA states in the 2013 CPT book that inpatient evaluation and management (E/M) codes (99221-99233) be reported for hospital care for partial hospitalization, see page 483. This E/M requirement for the psychiatric medical professionals to report inpatient hospital codes for partial hospital services creates an inconsistent reporting dilemma between the CPT code and the place of service code.
Recommendation	The correct code to use is Code 52 for psychiatric partial hospitalization. Code 21 is inappropriate. Clarify: DHS does not require 22 for place of service for partial hospitalization as stated in the SBAR and suggests use of Code 22 for appropriate E-M services. DHS will add Code 52 POS for partial hospitalization to match CPT to eliminate the confusion.
Disposition Status	_X_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	52 Psychiatric Facility-Partial Hospitalization

Return to Topics List

Speech Language Pathologist VCD/PVFM	
MCT Minutes Reference	January 8, 2015
Background/Description	Speech Language Pathologists (SLP) are treating patients for Vocal Cord Dysfunction (VCD)/ Paradoxical Vocal Fold Movement (PVFM) by therapy. Unable to find corresponding HCPCS codes that describe this service provided by the SLPs, which is hands on so it feels like physical therapy but it is being performed by SLPs. Today the service is being coded using HCPCS 92524-GN ***Behavioral and Qualitative Analysis of Voice and Resonance*** for the evaluation and HCPCS 92507-GN *Treatment of Speech, Language, Voice, Communication, and/or Auditory Processing Disorder, individual* for the therapy. GN: Services delivered under an outpatient speech language pathology plan of care. Requests the AUC determine appropriate codes for services performed by Speech Language Pathologists who are treating patients for VCD/PVFM by therapy.
Recommendation	Polling of AUC payers indicate the following: DHS prefers the 92700. Judith (HCMC) felt that 92700. PreferredOne – SLP does not agree with 92700 (what's currently being done). Medica – 92525 or; HealthPartners – no answer. Recommend using CPT 92507 and 92524
Disposition Status	_**X**_ Coding Recommendation Grid (Best practice, usage highly recommended) ___ Companion Guide: ____837 Professional ____837 Institutional ____837 Dental
Coding	92507 Treatment of speech, language, voice communication and/or auditory processing disorder, individual 92524 Behavioral and qualitative analysis of voice and resonance

Return to Topics List

Community Health Worker Modifier	
MCT Minutes Reference	June 9, 2016
Background/Description	Community Health Worker (CHW) services include a wide range of activities, such as education, navigation, advocacy, and care coordination. However, the only service covered (and only in MA) is "diagnosis-based health education," billable using codes 98960, 98961, and 98962. As a result, there is little or no data in the claim stream available to (1) understand the extent to which CHWs are involved in delivering patient services across our state providing services and (2) measure and evaluate the impact CHWs have on the care delivered to patients and clients. A universal modifier for Community Health Work services is needed within the claim stream to capture the broad set of services currently provided by CHWs, and ultimately, to measure the impact these services are having on the quality, cost, and patient satisfaction of care delivered in a wide range of settings. The CHW modifier would not be tied to payment; it is for tracking purposes only.
Recommendation	The Medical Code TAG recommends the use of 4450F [Self-care education provided to patient (HF)] with the U7 modifier for coding to track services provided by Community Health Workers. Medical Assistance will add a new definition for U7 to

	identify Community Health Worker when used with 4450F.
Disposition Status	___ Coding Recommendation Grid (recommendations only; usage is optional) ___ Companion Guide: __X_837 Professional __X_837 Institutional ____837 Dental
Coding	Coding for 837I: • 131 Type of bill (TOB) • 0969 Revenue Code • 4450F U7 Community Health Worker Coding for 837P: • 4450F U7 Community Health Worker

Return to Topics List

Protected Transport

MCT Minutes Reference	July 14, 2016
Background/Description	DHS currently classifies Medical Transportation Services administered by the counties/tribes as access transportation services (ATS) and those administered by the State as special transportation services (STS). Effective July 1, 2016, changes to legislation in Minnesota Statutes 256B.0265, Subd. 17 thru 17b and 18 thru 18H these services will add a new service called protected transport, which will be referenced as non-emergency transportation services (NEMT). The new legislation also authorized changes in defining transport services.
Recommendation	The Medical Code TAG approved the coding recommendations as stated in the SBAR.
Disposition Status	___ Coding Recommendation Grid (recommendations only; usage is optional) ___ Companion Guide: __X_837 Professional __X_837 Institutional ____837 Dental
Coding	(see table below)

Procedure Code/U MOD	HCPCS Description	DHS Description
S0215 UA	Nonemergency transportation; mileage, per mile	Nonemergency transportation; mileage, per mile, Protected Transport
T2003 UA	Nonemergency transportation; encounter/trip	Nonemergency transportation; encounter/trip, Protected Transport
A0080	Nonemergency transportation, per mile – volunteer driver	Volunteer driver mileage reimbursement
A0090	Nonemergency transportation, per mile - vehicle provided by individual	Personal mileage reimbursement, individual
A0090 UC	Nonemergency transportation, per mile - Licensed foster parent -	Personal mileage reimbursement, licensed foster parent

		vehicle provided by individual licensed foster parent	
	A0100	Nonemergency transportation; taxi	Unassisted Transport Base/Pickup Taxi (dial-a-ride for county/tribe Administered NEMT)
	A0110	Nonemergency transportation and bus, intra- or interstate carrier	Bus/Light Rail
	A0110 U7	Nonemergency transportation and bus, intra- or interstate carrier	Bus/light rail monthly pass
	A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	ADA paratransit
	A0130	Nonemergency transportation: wheelchair van	Ramp/lift Equipped Vehicle Base/Pickup (Wheelchair transport for State Administered NEMT)
	A0140	Nonemergency transportation and air travel (private or commercial) intra- or interstate	Air travel
	S0209	Wheelchair van, mileage, per mile	Mileage Ramp/Lift Equipped Vehicle
	S0215	Nonemergency transportation; taxi mileage	Unassisted Transport Mileage Taxi (dial-a-ride for county/tribe Administered NEMT)
	S0215	Nonemergency transportation; Assisted Transport, mileage	Nonemergency transportation; mileage, per mile
	S0215 UA	Nonemergency transportation; mileage, per mile	Nonemergency transportation: mileage,, Protected Transport
	T2001	Nonemergency transportation; patient attendant/escort	Extra Attendant – Stretcher
	T2003	Nonemergency transportation; Assisted Transport	Nonemergency transportation; encounter/trip
	T2003 UA	Nonemergency transportation; encounter/trip	Nonemergency transportation; encounter/trip, Protected Transport

	Code	Description	Recommendation
	T2005	Nonemergency transportation; stretcher van	Stretcher Transport Base/Pickup (State Administered NEMT)
	T2049	Nonemergency transportation; stretcher van, mileage; per mile	Mileage Stretcher Transport

Return to Topics List