MHCP provider news and updates
July 9 – 22, 2019

Systems announcements

Watch this space for information about MN–ITS availability, technical information and other systems notifications.

Legislative changes to the Medical Assistance reimbursement rate for outpatient drugs

Important changes were made to state law regarding the reimbursement rate for outpatient drugs covered by the fee-for-service (FFS) Medical Assistance (MA) program during the 2019 legislative session. See the Office of the Revisor Statutes SF 12 Bill Text Versions webpage for statutory references. Effective for claims with a date of service on or after July 1, 2019, the following changes will be incorporated into the MA reimbursement for outpatient drugs:

Drug reimbursement (ingredient cost, for example)
- The reimbursement rate for drugs is the same for all pharmacies. The differential rate paid to rural independently owned pharmacies was eliminated.
- The reimbursement rate for drugs is the lesser of the National Average Drug Acquisition Cost (brand or generic), the state maximum allowable cost or specialty maximum allowable cost, or the usual and customary charge submitted. If a drug does not have a National Average Drug Acquisition Cost, state maximum allowable cost and specialty maximum allowable cost, then the reimbursement rate is the lesser of the wholesale acquisition cost minus 2 percent or the usual and customary charge submitted.

Dispensing fee
- The dispensing fee for “covered outpatient drugs”, as defined by federal law, will be increased to $10.48 from $3.65.
- The dispensing fee for covered drugs that don’t meet the federal definition of a “covered outpatient drug” will remain $3.65. An example of a covered drug that doesn’t meet the definition of a “covered outpatient drug” is a covered over-the-counter (OTC) multivitamin.
- The dispensing fee for all compounded intravenous solutions was changed to $10.48 per bag. All other dispensing fees for compounded intravenous products were eliminated.
- The dispensing fee for covered OTC drugs will be prorated if a claim is for less than the manufacturer’s original package size.
- The retrospective billing pharmacy OTC drug dispensing fee was eliminated.
- The Long-term care blister card system dispensing fee was eliminated.

340B reimbursement
- The reimbursement rate for outpatient drugs dispensed by a 340B covered entity is the lesser of the 340B Drug Pricing Program ceiling price, the National Average Drug Acquisition Cost (brand or generic), or the usual and customary charge submitted. If a drug does not have a 340B Drug Pricing Program ceiling price and National Average Drug Acquisition Cost, then the reimbursement rate is the lesser of the wholesale acquisition cost minus 2 percent or the usual and customary charge submitted.
- The reimbursement rate for drugs administered to FFS members by 340B covered entities will be discounted by 28.6 percent. Before July 1, 2019, these claims were discounted by 20 percent.
- All outpatient pharmacy claims dispensed to FFS members must be submitted with a submission clarification code of ‘20’. All medical claims for 340B drugs administered to FFS members must be submitted with the ‘UD’ modifier. Minnesota Department of Human Services will use the submission clarification code and modifiers to exclude claims from the Medicaid drug rebate program.
Over-the-counter (OTC) drugs
- Covered OTC drugs prescribed to FFS members are no longer required to be dispensed in the manufacturer’s original package. Claims for partial packages of OTC drugs will be reimbursed at the sum of the ingredient cost plus a prorated dispensing fee.

MinnesotaCare tax
- Subject to federal approval, the drug reimbursement (ingredient cost) will be increased by 1.8 percent to account for the MinnesotaCare tax applied to wholesale drug distributors.

Additional Changes
- The definition of a provider’s usual and customary price was revised to clarify that it includes prices that are offered as part of a discount program offered by the pharmacy.
  …“The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain.”
- Minnesota Health Care Programs (MHCP) will conduct a Cost of Dispensing Survey every three years. All pharmacies enrolled with MHCP must participate in the survey and may face sanctions if they do not participate. We will provide additional information regarding the survey and survey process in the future.

All changes were moved to production as of July 19, 2019. We will reprocess those claims for dates of service from July 1, 2019 – July 18, 2019 on Aug. 29, 2019, and they will appear on your Sept. 17, 2019, remittance advice. Pharmacies may reverse and resubmit their own claims. (pub. 7/19/19)

Early Intensive Development and Behavioral Intervention (EIDBI) state plan amendment approved

Minnesota Department of Human Services revised the state plan to amend observation and direction services criteria under the EIDBI Benefit beginning June 10, 2019. The change allows a Level 1 or Level 2 provider to provide observation and direction with providers of the same or lower level. Please see the state plan amendment (PDF) for more information. (pub. 7/19/19)

Minnesota Family Planning Program (MFPP) Provider Training Guide updates

We made updates to income information in the MFPP Training Guide. The updates include:
- Question 2b: Household size and income information - Removed alimony income because federal tax requirements around alimony have changed.
- Questions 7-9: Household income information
  o Removed the explanation of zero income because it is no longer required.
  o Removed explanation of proof of stopping work because it is no longer a requirement.
- Family size and income limits chart - Made annual changes to income limits effective July 1, 2019 – June 30, 2020.

The training guide is intended for Minnesota Health Care Programs (MHCP) enrolled providers who are certified or want to become certified, to determine presumptive eligibility for individuals not currently enrolled in any other MHCP and are applying for MFPP coverage. See the Certified MFPP Provider Training Guide (DHS-7421) (PDF) for more information. (pub. 7/18/19)

Mental Health Partial Hospitalization HCPCS code H0035 update

The Centers for Medicare & Medicaid Services National Correct Coding Initiative established a medically unlikely edit for Mental Health Partial Hospitalization HCPCS code H0035 with a maximum unit of one per day beginning Jan. 1, 2019. This change went into effect before our system work was completed.
Minnesota Health Care Programs will use the 2018 hourly rate to reimburse claims for dates of services beginning Jan. 1, 2019, through June 30, 2019. Resubmit your denied or incorrectly paid claims for dates of services Jan. 1, 2019, through June 30, 2019, as follows:

1. Change the service unit to 1 unit
2. In the “Reference” (Loop: 2300, NTE01) field, enter Updated Information “UPI”
3. In the “Text” (Loop: 2300, NTE02) field, enter the number of hours provided

These instructions do not apply to claims submitted for dates of service on or after July 1, 2019. On July 12, 2019, a new per diem rate was added to our system effective July 1, 2019. Resubmit claims with dates of service before July 13, 2019, to receive the new rate. Claims with dates of service on or after July 13, 2019, do not need to be resubmitted. (pub. 7/18/19)

Enhanced rate or budget increase instructions for Personal Care Assistance (PCA) and financial management services (FMS) providers

The enhanced rate or budget increased from 5 percent to 7.5 percent beginning July 1, 2019, for people who meet eligibility requirements and use PCA or Consumer Support Grant (CSG) with budgets based on the outcome of PCA assessments. The Minnesota Department of Human Services (DHS) is in the process of requesting federal approval to increase the Consumer Directed Community Supports (CDCS) enhanced budget percentage from 5 percent to 7.5 percent.

PCA provider agencies and CSG FMS providers should follow the instructions on the Provider agency/FMS provider requirements for enhanced rate or budget provider manual webpage. CDCS FMS providers should follow the instructions on the CDCS enhanced budget process page of the CDCS Manual. In most cases, PCA agencies no longer need to manually request DHS or lead agencies to update a person’s service agreement. If an existing service agreement needs to be modified to include enhanced rate or budget information, the PCA provider agency or FMS provider must take the additional steps outlined in the Modifying existing service agreements section of the Provider agency/FMS provider requirements for enhanced rate or budget manual page.

Managed care organization (MCO) enhanced rate or budget information
Providers should check with the MCO about how the MCO will handle the enhanced rate or budget for people whose PCA or CDCS services are covered by a health plan. (pub. 7/16/19)

2019 legislature authorizes Minnesota’s Waiver Reimagine project

Minnesota’s Waiver Reimagine project earned 2019 legislative approval allowing Minnesota Department of Human Services to move forward with consolidating and simplifying Minnesota’s disability waiver programs. Minnesota’s Waiver Reimagine project aims to provide equal access to services through simplification and system-level improvements.

To learn more about the improvements and how to give feedback, see the Information about Minnesota’s Waiver Reimagine project DSD eList announcement webpage. (pub. 7/16/19)

Changes for PCA Choice agencies and financial management services (FMS) providers

PCA Choice agencies and FMS providers are required to fulfill responsibilities related to direct-support workers in PCA Choice, Consumer Directed Community Supports (CDCS) and the Consumer Support Grant (CSG).

The changes are detailed in a new contract between SEIU Healthcare Minnesota and the State of Minnesota, an updated SEIU Contract Compliance online training course, an updated PCA Choice-CDCS-CSG Reporting Spreadsheet and information about the requirement to send worker information to the Minnesota Department of Human Services each pay period. (pub. 7/12/19)
2019 Home and Community-Based Services (HCBS) billing and service documentation requirement legislative changes

Important HCBS billing and service documentation requirement provisions passed during the 2019 Minnesota Legislative Session that affect Minnesota Health Care Programs enrolled providers.

- **HCBS billing requirements** - New HCBS billing requirements were added beginning July 1, 2019. You must maintain documentation of services provided as a condition of payment. We only reimburse services provided under a federally approved waiver plan.

- **HCBS documentation requirements** – Beginning July 1, 2019, new service delivery documentation is required for services delivered on an hourly or minute-based rate and for services reimbursed at a daily (not hourly or minute-based) rate.

- **Waiver Transportation, Equipment Supply and Adult Day billing and documentation requirements** - Additional billing and documentation requirements were added for Waiver Transportation and Equipment and Supply beginning July 1, 2019, and Adult Day beginning Aug. 1, 2019.

See the [2019 Home and Community-Based Services (HCBS) billing and service documentation requirement legislative changes (PDF)](https://example.com) for more specific information. (pub. 7/9/19)

Revision to Minnesota Health Care Programs (MHCP) member ID card

The gender field on the MHCP member ID card will now be blank. The card will no longer display gender type because we do not require that information to be listed on the card. We will revise the card and remove the word gender when the current stock runs out. (pub. 7/9/19)

1st round of Opioid Prescribing Reports sent

Minnesota Department of Human Services (DHS) sent the first round of individualized Opioid Prescribing Reports on Friday, June 28, 2019. We sent reports to providers who treat Minnesotans covered by Medicaid and MinnesotaCare and prescribe opioids for pain management, including those who prescribe to fee-for-service members and those who care for members enrolled in a managed care organization.

If you registered for a MN–ITS account before June 27, 2019, you can find your report in your MN–ITS mailbox in the Miscellaneous Received file folder PRVLTR.

The Opioid Prescribing Reports will support the DHS Opioid Prescribing Quality Improvement Program. See the [Opioid Prescribing Improvement Program (OPIP)](https://example.com) website for more information. The Opioid Prescribing Reports are private data, we will provide them only directly to the health care provider. Your report compares your prescribing data to your peers, with your peers’ identifying information removed. You will get a report only if you prescribe opioids.

To provide feedback or ask questions about your report, use the [Provider Feedback Form](https://example.com) on the OPIP website.

Only those with registered MN–ITS mailboxes received reports. We will send reports again in a few weeks to those who did not receive a report in this distribution, but you must register for a MN–ITS account to get your report electronically. See the [May 30, 2019, MN–ITS Registration Letters mailed to opioid prescribers provider news message](https://example.com) for information about registering for MN–ITS. (pub. 6/28/19)
Legislature authorizes rate and budget increases for Personal Care Assistance (PCA), Consumer-Directed Community Supports (CDCS), Consumer Support Grant (CSG), Elderly Waiver (EW), Alternative Care (AC) and Essential Community Supports (ECS)

The 2019 Minnesota Legislature authorized the following rate and budget increases for services provided beginning July 1, 2019.

Rate and budget increases for CSG, CDCS and PCA
To fulfill the agreement between the state and SEIU Healthcare, the Minnesota Department of Human Services is implementing a 2.37 percent increase to CSG budgets based on the outcome of PCA assessments, CDCS budgets through the disability waivers and rates for state plan and extended PCA services.

The budget increase for CDCS through EW and AC will be 2.41 percent because of the increase in the home-delivered meals rate for EW and AC.

The increases apply to reimbursement rates, individual budgets, monthly case mix caps, grants or allocations for limits for services.

Rate increase for home-delivered meals
The rate for home-delivered meals services provided through AC, EW and ECS will increase by 3.69 percent as required by Minnesota Statutes, 256B.0915, subdivision 16(l). EW, AC and ECS monthly budgets will increase with the home-delivered meal service rate increase.

Additional information
See Minnesota Session Laws, 1st Special Session, chapter 9, article 5, section 84 for more information about the SEIU agreement.

See Long-term Services and Supports Service Rate Limits (DHS-3945) (PDF) for more information about the rate and budget increases. (pub. 6/26/19)

Billing code programming for Early Intensive Developmental and Behavioral Intervention (EIDBI) Medicaid fee-for-service (FFS) programs is complete

We have completed programming for the FFS Category I codes that went into effect Jan. 1, 2019, for EIDBI services. We will reprocess claims with dates of service beginning Jan. 1, 2019, through May 31, 2019, and they will be reflected on the June 25, 2019, remittance advice. You do not need to resubmit claims.

You may call the Minnesota Health Care Programs Provider Call Center at 651-431-2700 or 800-366-5411 if you have questions about reprocessed claims appearing on your remittance advice. (pub. 6/20/19)

Individualized Education Program (IEP) Services suspended claims

Minnesota Health Care Programs reprocessed IEP claims for the 2017-18 school year that were denied for eligibility issues. As a result, some claims were suspended and you may see suspended claims beginning on your May 29, 2019, remittance advice supplemental data (RA02). We are analyzing the suspended claims and you do not need to take action. After we process the suspended claims, the claims will either pay or deny and appear in the remittance advice claims data (RA01). You should use the information from the RA01 to reconcile your books. Refer to How to read your remittance advice webpage for further information. We are researching and examining the eligibility issues and are working on resolving them. (pub. 6/20/19)
Disability Waiver Rate System (DWRS) cost reporting required in 2020

The Minnesota Department of Human Services (DHS) will require DWRS cost reporting beginning in 2020. If you provide at least one service with a payment rate determined under the DWRS, you will need to document and submit cost information about providing DWRS services, including staff wages, program costs and administrative costs. The information collected will inform DWRS rates and the legislature.

To find out more about DWRS cost reporting, including draft workbooks, project updates and ways to contact DHS about this new requirement, visit the Disability Waiver Rate System cost reporting webpage. (pub. 6/20/19)

New diagnosis codes permitted for behavioral health services and behavioral health home (BHH) services

Minnesota Health Care Programs (MHCP) allows the use of certain unspecified and R diagnosis codes for mental, behavioral and neurodevelopmental disorders when billing up to 10 non-intensive outpatient mental health sessions, as well as up to 10 behavioral health home services claims, beginning June 1, 2019.

Allowable unspecified codes include the ICD-10 code range F01-F99 except as follows:
- Mental and behavioral disorders due to psychoactive substance use range (F10-F19)
- Unspecified disorder of adult personality and behavior (F69)
- Intellectual disabilities range (F70-F79)
- Mental disorder, not otherwise specified (F99)

Allowable R diagnosis include the ICD-10 code range “Other symptoms and signs involving general sensations and perceptions” (R44-R44.9) and “Symptoms and signs involving appearance and behavior” (R46-R46.8).

Unspecified and R diagnosis codes can be used for behavioral health home services as well as non-intensive mental health sessions including outpatient psychotherapy and psychoeducation, when provided alone.

Unspecified and R diagnosis codes cannot be used for sessions that require a diagnosis of a serious and persistent mental illness or severe emotional disturbance.

Unspecified and R diagnosis codes cannot be used in claims for inpatient or residential treatment; nor for intensive outpatient services for adults and children including:
- Children’s Therapeutic Services and Supports
- Adult Rehabilitation Mental Health Services
- Assertive Community Treatment
- Intensive treatment in foster care
- Partial hospitalization program
- Dialectical behavior therapy
- Intensive Residential Treatment Services
- Youth Assertive Community Treatment

Unspecified diagnosis code usage rationale:
- MHCP requires inclusion of a diagnosis code for most mental health services claims.
- The use of unspecified codes:
  - Provide people with more access to services
  - Gives more time for service providers to develop rapport with the people being served.
  - Allows extra time to analyze symptomology in order to reduce the risk of committing to premature diagnosis.
  - Establishes the medical necessity needed for further engagement, treatment and refinement of a sound diagnosis.
- Unspecified codes are clinically inappropriate if used for an extended time. A clinician needs a clear and specific diagnosis for ongoing treatment planning.
- Both the “Mental and behavioral disorders due to psychoactive substance use” range and the “Intellectual Disabilities” range are outside the mental health policy scope. “Unspecified disorder of adult personality and behavior” is vague and not helpful in identifying needs or supporting treatment planning. “Mental disorder, not otherwise specified” is included in the “Unspecified mental disorder” range and is too vague to be useful in determining a clear diagnosis.
R diagnosis code rationale:

- The use of R codes:
  - Increases peoples' access to help by establishing the medical necessity needed for further engagement, treatment and refine diagnosis
  - Helps clinicians focus on symptomology without committing to a diagnosis
  - Helps clinicians acknowledge and explore cultural context in some symptomology
  - Describe functional impact but not necessarily the cause

- R diagnosis codes are inappropriate to use long-term because they describe functional impact but not necessarily the cause.

We will continue to monitor the use of unspecified and R diagnosis codes. See the Mental Health Diagnostic Code Ranges section of the MHCP Provider Manual for more information. (pub. 6/13/19)

Hansaton hearing aids to be removed from Volume Purchase Contract July 1, 2019

Minnesota Health Care Programs will remove all Hansaton hearing aids from the Hearing Aid Volume Purchase Contract July 1, 2019, because they will no longer be available.

Unitron will continue to honor the warranties and repair pricing for Hansaton aids already dispensed. Contact Unitron to order parts, software and supplies for the Hansaton products. See the 2018 Hearing Aid Volume Purchase Contract and Vendors (DHS-7274F) (PDF) for Unitron contact information. (pub. 6/11/19)

MN–ITS mailbox online training available

We have produced a "Using the MN–ITS mailbox" online training video for new MN–ITS users. Watch the Using the MN–ITS mailbox training video to learn how to log in, locate your mailbox and search for, open and save a file.

Call the Minnesota Health Care Programs Provider Call Center at 651-431-2700 or 800-366-5411 if you have questions about registering and using MN–ITS. (pub. 6/11/19)

MN–ITS Registration Letters mailed to opioid prescribers

Minnesota Department of Human Services has completed sending MN–ITS account Registration Letters to opioid-prescribing providers who do not currently have a MN–ITS account, via the U.S. Postal Service.

You must register for a MN–ITS account to receive individual Opioid Prescribing Reports. We will send the reports to your MN–ITS mailbox in mid-June.

MN–ITS is the free, web-based HIPAA-compliant system for electronic billing and communication with providers. Your customized Registration Letter includes an initial user ID and password, which must be used during the registration process. Please watch for this letter and notify your administrative staff or billing office to watch for it and route it to you so you can register your account.

Call the Minnesota Health Care Programs Provider Call Center at 651-431-2700 or 800-366-5411 if you have questions about registering. (pub. 5/30/19)

Additional information

- Provider news and updates archive
- MHCP provider policies and procedures
- Latest Manual Revisions
- Training and VideoPresence opportunities: Information about most new and ongoing training
- Grants and requests for proposals
If you have questions about this information, call the MHCP Provider Call Center at 651-431-2700 or 800-366-5411.

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